FREQUENTLY ASKED QUESTIONS FROM THE OCTOBER 25, 2022 PCS STAKEHOLDER MEETING

Q: Regarding Disenrollment- What type of notice is given to the provider?

A: All Medicaid beneficiaries are provided a notice of change to their benefits in advance or shortly after a retroactive change has been made. For details on how each PHP notifies their members, please reach out directly to the assigned PHP.

> **Transition of Care (TOC) policy states:** Coordination with entities necessary to ensure Member continuity of care upon
> disenrollment, including but not limited to:
> (1) Coordination with appropriate assessment entities, as applicable, to ensure no disruption in the Member's enrollment in a comparable FFS or program; and
> (2) Informing the Member's current Medicaid providers of the anticipated disenrollment.

Q: Why don't Health Plans have the ability to disenroll a member into Medicaid Direct, when appropriate?

A: Although a member is enrolled in managed care, NC Medicaid has a coordinated disenrollment process for all Medicaid beneficiaries which includes a notice of change in their benefits as well as a coordinated transition from Managed Care to Medicaid Direct. Upon the identification of the approved program change date, the Medicaid eligibility categories will change in the state's Medicaid Management Information System (MMIS).

Q: Since not all Managed Care company authorizes in monthly hours, for example, WellCare. Can we ask the Standard Plans to all state authorizations in terms of monthly hours?

A: Standard plans may use hour or units to reflect the authorization of services for managed care enrollees. Providers should reach out to their assigned health plan regarding details on their process of reflecting the authorization of services or review their contractual agreement with the assigned health plan.

Q: Can a provider request evaluation for TCLI by the applicable LME for a resident who a member of the Tailored Plan is.

A: Most MCOs want a referral through RSVP which is on the TCL website. Anyone can make a referral using that tool. It is easy. We would love more referrals for people living in ACHs!

> If the individual is in the community with SMI/SPMI and being considered for admission into an ACH, they can submit the referral for TCL using this link. The individual will need to have the preadmission screening completed thru RSVP.
> https://www.myhousingsearch.com/pre_screening/ncdrst/DiversionScreeningTool.html
>
> If the individual is already in an ACH/FCH they have two options:
> 1. They can submit the referral for TCL using the link above also and the LME/MCOs will verify the ACH admission date and that the individual can't be diverted to initiate in reach. OR
> 2. They can contact the TCL section in the LME/MCO directly and tell them the individual's information and they are in an ACH/FCH and want to refer them for TCL. The LME/MCO will verify SMI/SPMI, Medicaid/Financially eligible, and then initiate in reach.

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Q: What is a provider to do when a resident or family member asks their opinion of the proposed transition, and the providers opinion is that it is ill advised?

A: If a Beneficiary/family member asks about a transition, the provider should refer to the service plan and make recommendations based on the supports and services identified in the plan that would be needed for a safe and effective discharge.

Q: What causes the delay in entering Medicare eligibility into NC Tracks?

A: Delays can occur for a variety of reasons; a single cause has not been identified.

Q: What happens if a provider is the first to identify Medicare enrollment but the manage care company and Medicaid do not show such status on NC Tracks and the 3051 form is filed before the provider is notified?

A: If a provider identifies Medicare enrollment, referred to as dual eligibility, and NC Tracks does not show this status, the provider should notify the Provider Ombudsman for research and resolution.

Q: Why is so much responsibility placed on the provider for the disenrollment's when we don't have ability to authorize? (Just a concern)

A: To ensure a smooth transition for Medicaid members/beneficiaries and to reduce harm or a lapse in services, providers are required to initiate steps to begin and follow through the disenrollment process.

Q: We are having a big problem with disenrollment from either PHP's or Medicaid Direct and it retroactively taking effective so far back so 3 to 6 months which causes a big problem for us getting an authorization and getting reimbursed for services. Why do they retro the change?

A: Members/beneficiaries may have a status change that occurs before it can be entered in the state's systems. When changes occur before the data can be entered, NC Medicaid enters the benefit change retroactively to the first date of the change. For instance, in the case of a dually eligible individual, if the Medicare evidence is delayed, when it is entered, the date will default back to the effective date of the dual eligibility.

Q: Can each PHP determine their timely filing requirements or are they required to use the Medicaid Direct timely filing requirement.

A: Per the Standard Plan contract, plans may require that claims be submitted within one hundred eighty (180) Calendar Days after the date of the provision of care to the Member by the health care provider and, in the case of health care provider facility claims, within one hundred eighty (180) Calendar Days after the date of the Member's discharge from the facility. The PHP may require that claims be submitted within three hundred sixty-five (365) Calendar Days after the date of the provision of care to the Member for pharmacy point of sale claims. Providers are allowed to appeal a timely filing denial and in most cases the PHPs have agreed to allow extensions.

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Q: Regarding retro-disenrollment's. Once the 3051 is submitted to Liberty, does Liberty coordinate the retro auth approval with DHB LTSS? This is supported by the LTSS Disenrollment Form and the auth transferred by the PHP, but the provider does not have to reach out to DHB directly to notify that the 3051 has been submitted to Liberty, correct? Thank you for your time.

A: Correct; when a 3051 is submitted and a PA gap is identified, DHB and Liberty work together to reconcile the retroactive authorization approval.