Medicaid Transformation Transition of Care
July 2021 Frequently Asked Questions

Question: What should we tell members who receive a letter that states they will be transitioned to NC Medicaid Direct?

Answer: NC DHHS sent letters to Medicaid beneficiaries that chose to enroll with a Standard Health Plan and as a result might lose care or services. The letter informed beneficiaries that they have been moved back to NC Medicaid Direct and the LME/MCO. If a member received this letter, then their care will continue to be managed by Partners after July 1, 2021.

If the member has further questions, please direct them to the Enrollment Broker who will be able to answer more questions. The Enrollment Broker can be reached at 1-833-870-5500.

Question: Where can I find phone numbers to gain authorizations from PHPs?

Answer: You can find phone numbers in the NC Medicaid Managed Care Day One Provider Quick Reference Guide.

Question: What if I am having trouble contacting a PHP? Who can I contact?

Answer: According to the NC DHHS published Fact Sheet, "What Providers Need to Know: Part 2 – After Managed Care Launch," you can contact the Provider Ombudsman at Medicaid.ProviderOmbudsman@dhhs.nc.gov or 1-866-304-7062.

The Provider Ombudsman can answer general provider inquiries regarding health plans.

Question: What if I am having trouble with my NCTracks provider information?

Answer: According to the NC DHHS published Fact Sheet, "What Providers Need to Know: Part 2 – After Managed Care Launch," you can contact the NCTracks Call Center at 1-800-688-6696.

Question: What can I do to help a member transfer from a Standard Plan back to NC Medicaid Direct (LME/MCO) so that they can received needed benefits?

Answer: You can help the member complete a formal request form, Request to stay in NC Medicaid Direct (Fee for Service) and LME-MCO: Provider form. Using the NC DHHS website to enter data is the fastest way to submit the form. To learn more, please visit www.ncmedicaidplans.gov/submit-forms-online.

According to the NC DHHS website, individuals can change their health plan for any reason during the first 90 days. After that, they cannot change the health plan until the Medicaid recertificate date unless they have a special reason. Reasons for changes are listed on the Health Plan Change Request form.

If the member has further questions, you can direct them to the Enrollment Broker who will be able to answer more questions. The Enrollment Broker can be reached at 1-833-870-5500.

Question: Is Partners end-dating existing authorizations for members who are covered by a Standard Plan effective July 1, 2021?

Answer: Partners has not ended these authorizations:

- Standard Plan prepaid health plans (PHPs) are receiving the prior authorization file with the authorization date range.
- Standard Plan PHPs are expected to honor authorizations issued by the LME/MCO for 90 days or until the end of the authorization date, whichever comes first.
- LME/MCOs will pay claims for authorized services up to the date of transition to a Standard Plan PHP. After the transition date, the Standard Plan PHP will pay claims.

Question: Is Partners able to authorize services for members whose assessment identifies a need for enhanced services but who appear in NCTracks as having coverage through a Standard Plan PHP while the state continues to sort assignments?

Answer: If AlphaMCS and/or NCTracks indicate that the individual is enrolled in a Standard Plan, Partners is not able to enter or process any authorizations. Providers will need to monitor NCTracks to see if/when a member's health plan changes to LME/MCO (NC Medicaid Direct), then submit a service authorization request (SAR).

Providers can assist an individuals to request to be transferred back to NC Medicaid Direct. The individual will need to call the Enrollment Broker at 1-833-870-5500 or complete an online Request to Move to NC Medicaid Direct form on the NC DHHS website.

Additional resources:

- https://www.partnersbhm.org/medicaid-transformation-update/
- https://www.ncmedicaidplans.gov/member-resources

Question: Will Partners accept retro-authorizations for members who were erroneously assigned to a Standard Plan?

Answer: Yes, Utilization Management will review for retro SARs once a member transitions back to NC Medicaid Direct.

Question: What if a member is showing as enrolled in a Standard Plan, but needs to get back to the LME/MCO? (NC Medicaid Direct)

Answer: You can help the member complete a formal request form, Request to stay in NC Medicaid Direct (Fee for Service) and LME-MCO: Provider form. Using the NC DHHS website to enter data is the fastest way to submit the form. To learn more, please visit www.ncmedicaidplans.gov/submit-forms-online.

According to the NC DHHS website, individuals can change their health plan for any reason during the first 90 days. After that, they cannot change the health plan until the Medicaid recertificate date unless they have a special reason. Reasons for changes are listed on the Health Plan Change Request form.

If the member has further questions, you can direct them to the Enrollment Broker who will be able to answer more questions. The Enrollment Broker can be reached at 1-833-870-5500.

Question: How often do we need to check NCTracks?

Answer: It is best practice to verify member eligibility inside of NCTracks at every appointment, admission or discharge from services. Any individual enrolled with Medicaid may have a plan change at any time. NCTracks is the most accurate source of information.