MANAGED CARE

REVISED 12/19/18 – CHANGE NO. 13-18

Current Change Notice: 13-18

- The Managed Care policy has been revised in online Family and Children's Medicaid Manual, section MA-3263, Managed Care
- Section 15080, Managed Care has been removed from the IEM
- Section 15082, Local Management/Managed Care Organization has been removed from the IEM

I. MANAGED CARE

Managed care provides for the delivery of Medicaid and North Carolina Health Choice (NCHC) health services as well as additional services through contracted arrangements between state Medicaid agencies and other healthcare agencies.

A. Community Care of North Carolina (CCNC)/Carolina Access (CA)

CCNC/CA connects Medicaid and NCHC beneficiaries with a Primary Care Provider (PCP). The primary focus is to enroll every beneficiary into CCNC/CA, with a preference to enroll into a CCNC network. The PCP provides the following services:

1. Primary Care Management
2. Disease Management
3. Prevention
4. Medical Coordination of Treatment

B. A chronic care initiative provides enhanced services to the aged, blind, and disabled Medicaid beneficiaries, which also includes:

1. Comprehensive and Integrated Package of Screening and Assessment
2. Intensive Chronic Care Management
3. Pharmacy Review
4. Transitional Support
5. Quality Improvement Across the Continuum of Care

C. Local Management Entity/Managed Care Organization (LME/MCO)

LME/MCO connects Medicaid beneficiaries with a behavioral health home for all behavioral health servicesCOMMUNITY CARE OF NORTH CAROLINA (CCNC)/CAROLINA ACCESS (CA)

Certain Medicaid beneficiaries are mandatory or have the option to select a PCP while others are non-participating.

CCNC/CA			
Program	**Mandatory**	**Optional**	**Non-Participating**
MAABD (with Medicare/dually eligible)		**X**	
MAABD (without Medicare)	**X**		
MIC/NCHC	**X**		
MAF (C, N, and M)	**X**		
MAF-D and W (BCCM)			**X**
SAD/SAA (with Medicare/dually eligible)		**X**	
SAD/SAA (without Medicare)	**X**		
MQB, RRF/MRF			**X**
MPW		**X**	
HSF		**X**	
IAS		**X**	
SSI beneficiaries under age 19		**X**	
End Stage Renal Disease Patients		**X**	
Native American (a member of a Federally Recognized Tribe)		**X**	
Native American (not a member of a Federally Recognized Tribe)	**X**		

II. TYPES OF EXCEMPTIONS

Beneficiaries may request a medical or temporary exemption from participating in CCNC/CA. The exemption reasons are as follows.

A. Medical

1. Give the a/b the DMA-9002, CCNC/CA Medical Exemption Request which must be given to their doctor to complete and forward to DMA (address on the form) for the following reasons:

    a. Chronic illnesses and sees multiple specialists

    b. Currently undergoing chemotherapy

    c. Impaired mental/cognitive status

When the DMA-9002 is not received within 30 calendar days, DHB will notify the county that the exemption was denied; assign a PCP.

Do not give the DMA-9002 to an applicant who identifies himself as having a terminal illness or has had a major organ transplant; individual is exempt.

Complete DMA-9006, Carolina ACCESS Enrollment Form for Recipients of Medicaid and Health Choice and fax to the Managed Care Section at 919-715-8548. Enter exempt code 9900023, "Medical exemption requested, Decision pending".

2. Beneficiaries who identify themselves as an End Stage Renal Disease patient do not have to go through the exemption process. Use exempt code 9900022. This exemption does not require state authorization.

B. Temporary

1. For reasons, other than what is listed on the exemption chart below, Medicaid staff must:

    a. Complete DMA-9002, providing a detailed explanation for requesting the temporary exemption, and

    b. Fax the form to Managed Care at 919-715-8548. DHB Provider Services will provide a decision within 5 business days.

2. If approved, enter the assigned exempt code.

3. If denied, enroll with PCP listed on the form.

Exemption Codes

CODE	PROGRAM	DEFINITION
9999901	Medicaid	Coverage groups ineligible for CCNC/CA (MQB, MRF, RRF, illegal alien classifications)
9900010	Medicaid	SSI beneficiaries without Medicare. Code is assigned by the Social Security Administration.
9900011	Medicaid	SSI beneficiaries with Medicare (dual eligible). Code is assigned by the Social Security Administration.
9900029	Medicaid	Non-SSI transfers from one county to another.
9900045	Medicaid	Also, used when the state mandates Medicaid be reopened until a determination for ongoing eligibility can be made.
9900050	Medicaid	SSI beneficiaries become non-SSI and previously exempted with '10 code (ex-parte).
9900058	Medicaid	Beneficiaries who are Incarcerated.
9900059	Medicaid	Beneficiaries, age 21-64, who are in an Institution for Mental Disease.
9900060	Medicaid	SSI beneficiaries become non-SSI and previously exempted with '11 code (ex-parte).
9900070	Medicaid	Mass exemption by practice; **USED ONLY BY THE STATE.**
9999902	Medicaid	Beneficiaries residing in a nursing facility (living arrangement 50, 58, 60) or patient in a psychiatric facility (living arrangement codes 70, 71, 72, 73, and 75).
9999906	Medicaid	Beneficiaries who are enrolled in **PACE.**
9900006	Medicaid or NCHC	Temporary code: WHEN APPROVED by DHB managed care.
9900012	Medicaid	Native Americans who have a valid Indian Health Service identification card who have opted out to enroll in CCNC/CA.
9900013	Medicaid	MPW beneficiaries opting out of enrollment or pregnant women in any category who have started prenatal care with a non-CCNC/CA.
9900015	Medicaid or NCHC	HSF & IAS SSI beneficiaries < 19 years of age. Self-identified who have opted out.
9900020	Medicaid or NCHC	Six-month medical exemption **REQUIRES STATE APPROVAL.**
9900021	Medicaid or NCHC	Permanent medical exemption **REQUIRES STATE APPROVAL.**
9900022	Medicaid or NCHC	End stage renal disease patients (does not require state approval).
9900023	Medicaid or NCHC	Temporary code "Medical exemption requested. Decision pending".
9900025	Medicaid	Beneficiary has other primary health insurance and PCP does not participate in CCNC/CA. Code applies to beneficiaries with Tri-Care, CHAMPUS, and VA.
9900032	Medicaid or NCHC	Temporary code used for a beneficiary receiving NCHC or Medicaid who is established with a non-participating PCP.

9900646	Medicaid or SA	Dual eligible beneficiary opted not to enroll.
9900647	Medicaid	No provider is available within a 30-mile radius from the beneficiary's home, and the beneficiary does not choose a PCP at a greater distance. Or; Medicaid staff is unable to *auto enroll* the beneficiary to a PCP located within a 30-mile radius from the beneficiary's home.
9900648	Medicaid	Placeholder code for residents of Adult Care Homes. State Use Only.
9900649	Medicaid	Placeholder code for residents of ICF-MR. State Use Only.

III. APPLICATION

A. Explain the benefits and requirements of CCNC/CA to:

1. All in-person applicants including other applicants if contacting by telephone

   a. This is also post eligibility,

   b. You cannot delay processing an application for selection of PCP.

2. Auto Newborn

   If the mother is not available at report of auto newborn, consult with the hospital and assign the attending pediatrician.

3. SSI Beneficiaries

   Beneficiaries are notified by the Social Security Administration (SSA) at SSI approval of the requirement to participate in CCNC/CA unless they receive Medicare. Beneficiaries are directed to contact the local department of social services within 30 calendar days.

   a. With Medicare

      (1) Complete and mail DMA-9009, SSI Recipient with Medicare.

      (2) When contact is made, make the appropriate changes.

      (3) When there is no contact; assign the PCP that was proposed on the DMA-9009.

   b. Without Medicare

(1) Complete and mail the DMA-9008, SSI Recipient without Medicare.

(2) When contact is made, make the appropriate changes.

(3) When there is no contact, assign the PCP that was proposed on the DMA-9008.

Refer to the CCNC/CA Teaching Tool to help educate applicants on the CCNC/CA Managed Care program.

B. Instruct the applicant to choose a PCP; making every effort to help in the selection.

1. If the applicant does not choose or refuses to choose a PCP and is not otherwise exempt, assign a PCP based on enrollment history and/or location of residence.

2. When there is no available PCP within a 30-mile radius of the applicant's home, select exempt code 9900647 (see the chart below for exemption codes).

3. When a dual eligible applicant opts not to enroll in CCNC/CA, select exempt code 9900646, and mail the DMA-9006, Carolina ACCESS Enrollment Form for Recipients of Medicaid and Health Choice.

C. If the applicant chooses a non-participating PCP.

1. Enter exempt code 9900006 and contact the DMA Provider Services Regional Consultant.

2. Provider Services will contact the non-participating PCP for enrollment recruitment.

3. If the PCP does not enroll, a letter will be mailed to the beneficiary providing instructions to choose a PCP, or a PCP will be auto assigned by NC Tracks.

D. Provide the beneficiary with.

1. CCNC/CA Handbook,

2. DMA-9016,CCNC/CA: The Benefits of Being a Member-Medicaid, and/or

3. DMA-9017, CCNC/CA: The Benefits of Being a Member-NCHC.

IV. RECERTIFICATION

A. Do not change the beneficiary's PCP unless a change is requested. If a beneficiary is being deleted from the case, then their managed care must be end dated, along with other evidence related to that beneficiary.

B. When a beneficiary is dis-enrolled/terminated by the PCP, Medicaid staff must link the beneficiary with a new PCP.

Contact beneficiary by phone or mail a DMA-9012, Primary Care Provider Disenrolls Recipient, to allow beneficiary to choose a new PCP.

V. CHANGE IN SITUATION

A. Request for Change of PCP

1. When a beneficiary requests a change in their current PCP, make sure it is a participating PCP, and assign the new PCP.

2. The PCP will be printed on the Medicaid card.

B. County Transfer

1. When a SSI beneficiary transfers from one county to another county, enter either exempt code 9900010 (without Medicare) or 9900011 (with Medicare/dual eligible).

2. When a non-SSI beneficiary transfers from one county to another county, enter exempt code 9900029.

The new county contacts the beneficiaries transferring into their county by phone or by mail using the DMA-9010, Important Notice About Your Medicaid – County Transfer.

No further follow-up is required until the next scheduled recertification or the beneficiary chooses a PCP and contacts the agency. At that time the beneficiary must enroll in CCNC/CA or be otherwise exempt.

VI. BENEFICIARY COMPLAINTS AND INQUIRIES

A. Beneficiaries may make complaints regarding their PCP. DHB addresses the following complaints:

1. Quality of Care

2. Professional Conduct

3. Contract Violations

4. Program Fraud and Abuse

Inform beneficiary that the complaint must be submitted to DHB in writing, via the DMA-9001, CCNC/CA Complaint Form and Complaint **Form Instructions.**

B. Beneficiary Inquiries

1. Medicaid/NCHC

   a. Make every attempt to answer CCNC/CA questions or resolve issues relating to education and enrollment.

   b. For any CCNC/CA questions unable to be answered; refer the beneficiary to the DHB Call Center, Monday-Friday, except state holidays, at 1-888-245-0179. In the Triangle area, call (919) 855-4780 (English/Spanish). For the hearing-impaired call, the DHHS Customer Service Center, Information and Referral Service number at 1-800-662-7030.

VII. PROVIDER INQUIRIES

When a provider contacts DSS, make the following referrals:

QUESTION	REFERRAL
Verify Medicaid and NCHC eligibility	Automated Voice Response System (AVRS) 800-723-4337
Billing inquiries, claim resolution, or override requests	DHB Claims Analysis 919-855-4045
CCNC/CA Provider Recruitment	DMA Regional Consultant
Provider education, training, workshops	DMA Regional Consultant or NC Tracks 800-688-6696
Provider Enrollment	NC Tracks 800-688-6696
Changes in PCP Agreement	DMA Regional Consultant

Health Check Questions	DHB Clinical Policy/EPSDT Program 919-855-4260
Questions regarding CCNC/CA	DMA Regional Consultant
ER Management Report	For CCNC Providers, refer to their Local CCNC Network

VIII. LOCAL MANAGEMENT ENTITY/MANAGED CARE ORGANIZATION (LME-MCO)

Medicaid beneficiaries must receive behavioral health services though the LME/MCO that serves their appropriate region, unless non-participating. NC Behavioral Health is a 1915 (c) waiver that operates concurrently with the 1915(b) NC MH/IDD/SAS Health Plan. Medicaid beneficiaries are automatically enrolled with LME-MCO.

LME-MCO		
Program	**Mandatory**	**Non-Participating**
MAABD (with or without Medicare)	**X**	
MIC	**X**	
NCHC		**X**
MAF (C, N, and M)	**X**	
MAF-D		**X**
MAF-W (BCCM)	**X**	
SAD/SAA (with Medicare/dually eligible)	**X**	
SAD/SAA (without Medicare)	**X**	
MQB only		**X**
RRF/MRF		**X**
MPW	**X**	
HSF	**X**	
IAS	**X**	
Beneficiaries in a "Deductible" status		**X**
Beneficiaries ages 0 through the month of their third birthday, except those participating in the Innovations program.		**X**
Non-qualified aliens or qualified aliens during the five (5) year disqualification period (any aid program/category) with Medicaid classification: 1G, 1F, NF, NH, MF, MH, NG, NI, CG, MG, and WG.		**X**

Beneficiaries must contact their LME directly to request behavioral health, developmental disability and substance abuse services. LME-MCO will arrange services for the beneficiary.

Contact Information for The Local Management Entity-Managed Care Organizations (LME-MCO) Managed Care Organizations (MCO) – current contacts.

IX. APPLICATION

A. Medicaid staff must explain:

1. Enrollment with an LME-MCO is automatic for most beneficiaries. NOTE: Children under age 3 are not included as beneficiaries.

2. If the beneficiary needs any behavioral health services, the LME-MCO must provide those services.

3. Participation in LME-MCO begins on the authorization date of Medicaid.

4. A Medicaid a/b who decides not to receive his behavioral health services through LME-MCO will be responsible for payment of those services received.

B. For approvals, the DMA-5011 Managed Care Organization (MCO) Health Plan Welcome Letter will be mailed to the beneficiary.

X. RECERTIFICATION

No LME-MCO action required.

XI. CHANGE IN SITUATION

A. County Transfer

1. The DMA-5011 Managed Care Organization (MCO) Health Plan Welcome Letter is issued by NC FAST and mailed to customers to notify them that a LME-MCO will be responsible for providing behavioral health services in their new county.

2. The LME-MCO information will be printed on the Medicaid card.

B. Out of County Placement

1. Beneficiaries placed outside of their Medicaid county of residence for any of the following reasons, remain enrolled with the LME-MCO providing services to their resident county:

a. Residential care

b. Adult care home

c. Long term care

d. Foster care

XII. INCORRECT COUNTY

SSI Medicaid Cases

When the Medicaid case is in the incorrect county of residence because the SDX shows the wrong county:

Notify the Social Security Administration (SSA) with a DMA-5049i, Referral to Local Social Security Office, with the correct county name indicated.

XIII. APPEALS AND HEARINGS

All requests for an appeal related to services with the LME-MCO will start with the LME-MCO. Instruct the beneficiary to contact his/her assigned LME-MCO.