

NC Department of Health and Human Services

Crossover to NC Medicaid Managed Care: LME-MCO Provider Education

Prepared by Trish Farnham
Senior Health Policy Analyst

[LME-MCO training date] Month Day, Year

FINAL,v2

Today's Session

What's Covered

- Summary Overview of NC's Transition to Managed Care
- Transition of Care Concept
- Overview Activities Underway to Support Members and Providers through Crossover.
- Guidance on:
 - Identifying member's PHP
 - Submitting authorization requests
- Additional Resources

What's Not Covered

- Overview of Tailored Plan
- Specific guidance on how to enroll in PHP network Specific guidance on PHP benefits.
- Please see resource links for all items not covered.
- Ongoing Transition of Care, including linkages of Standard Plan Members into LME-MCOs

INFORMATION PROVIDED IS CURRENT AS OF THIS PRESENTATION.
TRAINING MAY BE AMENDED TO PROVIDE ADDITIONAL INFORMATION OR
CLARIFICATION.

OVERVIEW OF NC'S TRANSITION TO STANDARD PLANS UNDER NC MEDICAID MANAGED CARE

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Introduction

In 2015, the NC General Assembly enacted Session Law 2015-245, directing the transition of Medicaid and NC Health Choice from predominantly fee-for-service (FFS) to managed care.

- Since then, the North Carolina Department of Health and Human Services (DHHS) has **collaborated extensively** with clinicians, hospitals, beneficiaries, counties, health plans, elected officials, advocates, and other stakeholders to shape the program, and is committed to ensuring Medicaid managed care plans:
 - Deliver **whole-person care** through coordinated physical health, behavioral health, intellectual/developmental disability and pharmacy products and care models
 - Address the **full set of factors** that impact health, uniting communities and health care systems
 - Perform **localized care management** at the site of care, in the home or community
 - Maintain broad **provider participation** by mitigating provider administrative burden

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Medicaid Transformation Vision

“To improve the health of North Carolinians through an innovative, whole-person centered, and well-coordinated system of care which addresses both medical and non-medical drivers of health.”

What do some of the terms mean?

NC Medicaid Direct

- New name for our current Medicaid program.
- Fee-for-service + LME-MCOs (or PACE)
- What everyone on Medicaid has now

NC Medicaid Managed Care

- The term used reference the five “prepaid health plans” or “PHPs” or “health plan”
- Also called “Standard Plan” or “Standard Plan Option.”
- Launch date (2/1/2020) is referenced as “Managed Care Launch (MCL),” “Managed Care Effective Date” or “Standard Plan Effective Date”

Tailored Plan

- Specialized plans for members with significant behavioral health needs and intellectual/developmental disabilities
- What the LME-MCOs will become in a few years
- **NOT the focus of today's training session.**

PHPs for NC Medicaid Managed Care

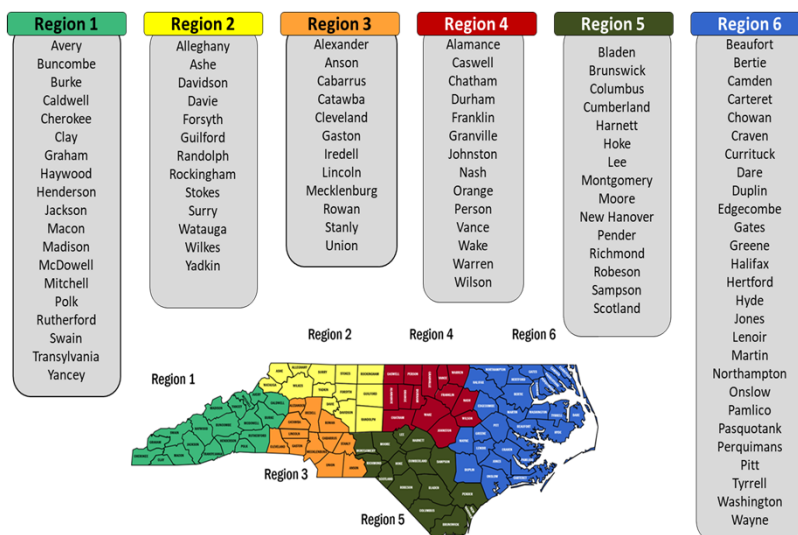
Statewide Contracts

- AmeriHealth Caritas North Carolina, Inc.
- Blue Cross and Blue Shield of North Carolina, Inc.
- UnitedHealthcare of North Carolina, Inc.
- WellCare of North Carolina, Inc.

Regional Contract – Regions 3 & 5

- Carolina Complete Health, Inc.

NC Medicaid Managed Care Regions



NOTICE: NC Medicaid Managed Care will now Launch Statewide on February 1, 2020

Managed care will now launch in one phase. Open enrollment will be extended for the 27 counties in Regions 2 and 4 until December 13, 2019. Nothing changes for the remaining 73 counties. As planned, open enrollment will begin for those 73 counties on October 14, 2019 and run through December 13, 2019.

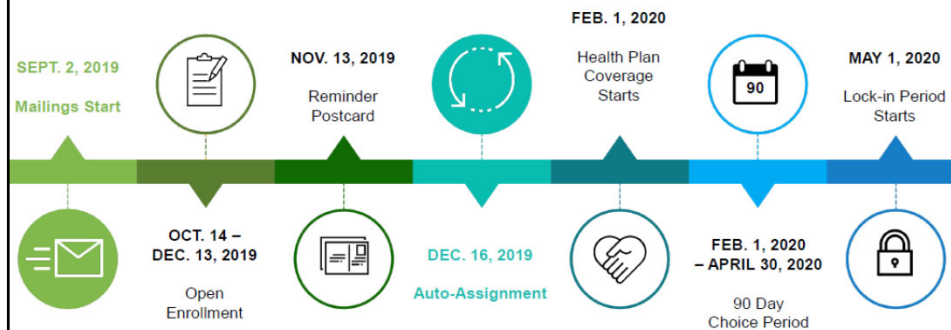
All stakeholders should continue to work towards the February 1, 2020 implementation date. It is critical that the managed care companies (PHPs) and doctors and health systems continue to work together on contracting.

The 27 counties where open enrollment will be extended include: Alamance, Alleghany, Ashe, Caswell, Chatham, Durham, Davidson, Davie, Forsyth, Franklin, Granville, Guilford, Johnston, Nash, Orange, Person, Randolph, Rockingham, Stokes, Surry, Vance, Wake, Warren, Watauga, Wilkes, Wilson and Yadkin counties

-From NC DHHS Communication about Open Enrollment Extension

Note: Resource materials may still contain earlier launch date information

Revised Enrollment and Launch Timeframe



Note: LTSS members may change plans at any time.

BH/IDD/SA/TBI Service Comparison Table	
Covered by BOTH Standard Plan and LME-MCO	Covered by ONLY LME-MCO (Tailored Plan at a later date)
State Plan BH and I/DD Services • Inpatient behavioral health services • Outpatient behavioral health emergency room services • Outpatient behavioral health services provided by direct-enrolled providers • <i>Partial Hospitalization</i> • <i>Mobile crisis management</i> • <i>Facility-based crisis services for children and adolescents</i> • <i>Professional treatment services in facility-based crisis program</i> • <i>Outpatient opioid treatment</i> • <i>Ambulatory detoxification</i> • <i>Research-Based Behavioral Health Treatment</i> • <i>Diagnostic assessments</i> • <i>Non-hospital medical detoxification</i> • <i>Medically supervised or alcohol drug abuse treatment center (ADATC) detoxification crisis stabilization</i> EPSDT	State Plan BH and I/DD Services • Residential treatment facility services • <i>Child and adolescent day treatment services</i> • <i>Intensive in-home services</i> • <i>Multi-systemic therapy services</i> • <i>Psychiatric residential treatment facilities (PRTFs)</i> • <i>Assertive community treatment (ACT)</i> • <i>Community support team (CST)</i> • <i>Psychosocial rehabilitation</i> • <i>Substance abuse intensive outpatient program (SAIOP)</i> • <i>Substance abuse comprehensive outpatient treatment program (SACOT)</i> • <i>Substance use non-medical community residential treatment</i> • <i>Substance abuse medically monitored residential treatment</i> • Intermediate care facilities for individuals with intellectual disabilities (ICF/IID) Waiver Services • Innovations waiver services • TBI waiver services • 1915(b)(3) services State-Funded BH and I/DD Services State-Funded TBI Services
Section V.C Table 3 PHP Contract 7 16 2019 Amendment	
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DHHS Vision for Transition of Care

As beneficiaries move between delivery systems, the Department intends to maintain continuity of care for each beneficiary and minimize the burden on providers during the transition.

-NC Department of Health and Human Services
(NC DHHS)

Transition of Care: Two Distinct Phases



Crossover to MCL Transition of Care

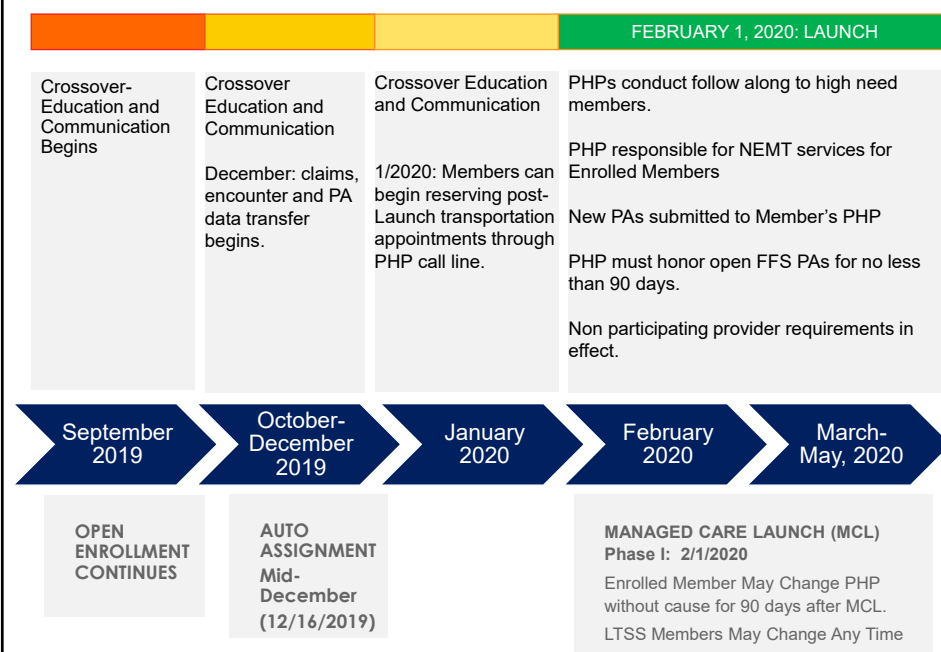
One time crossover of beneficiaries eligible for NC Medicaid Managed Care on February, 1 2020 ("Managed Care Implementation" or "MCL")

Ongoing Transition of Care

Ongoing transition of care for beneficiaries moving between PHPs, between PHPs and FFS, between FFS/LME-MCOs and PHPs

NOTE: TRANSITIONS BETWEEN *SETTINGS* ARE RELATED BUT IDENTIFIED IN SEPARATE PROTOCOLS AND NOT FOCUS OF THIS PRESENTATION

NC Medicaid Transformation: Key Crossover Activities



NC's TRANSITION TO MANAGED CARE: THE CROSSOVER DESIGN

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NC DHHS Crossover Policy Direction

As beneficiaries move between delivery systems, the Department intends to maintain continuity of care for each beneficiary and minimize the burden on providers during the transition.

PHPs have the necessary data to ensure effective service continuity for transitioning beneficiaries.

PHPs maintain service continuity by implementing DHHS requirements related to prior authorizations, non participating providers, appeal rights and identified services.

High-need beneficiaries have additional "high touch" support to ensure service continuity and reassurance through the transition.

Providers facilitate service continuity by being effectively informed on Crossover-specific requirements such as PA submissions.

PHPs, LME-MCOs and FFS vendors establish mechanisms that facilitate the effective data and knowledge transfer.

The Department ensures effective oversight through quality communication, reporting and other oversight mechanisms.

The Department's Crossover direction is enhanced by the insight and contribution of stakeholders.

Key Components of NC DHHS Crossover Design

Supporting Continuity of Care Through Data Transfer

Facilitating Uninterrupted Service Coverage

Establishing Additional Safeguards for High Need Members

Member and Provider Education

Clear and Organized Communication Between Entities

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Data Transfer at Crossover: Key Data

Claims and Encounter

- 24 months of paid and denied claims/encounter history for all services

Open and Recently Closed Prior Authorizations (PAs)

- Open and recently closed PAs (60 days).

Identified Care Plans

- Care Plans from CCNC and identified LME-MCO members receiving care coordination.
- PCS Care Plans/Assessments from PCS Vendor..
- All other treatment plans accessed from providers as needed.

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Data Transfer at Crossover: Provider Impact

Claims and Encounter	• Provider Impact: None anticipated. • Data will be transferred by NC TRACKS
Open and Recently Closed Prior Authorizations (PAs)	• Provider Impact: Identified SUD "Part 2" providers will be asked to assist in requesting consent for identified members.
Identified Care Plans	• Provider Impact: PHPs may seek care/service plans for transitioning members if not otherwise included in LME-MCO transfer. • Provider Impact: Identified SUD providers will be asked to assist in requesting consent for identified members.

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Data Transfer at Crossover: Provider Impact

Data Impacted by 42 CFR Part 2

- Title 42 of the Code of Federal Regulations (CFR) Part 2: Confidentiality of Substance Use Disorder Patient Records (Part 2) was promulgated... address concerns about the potential use of Substance Use Disorder (SUD) information in non-treatment based settings... Part 2 protects the confidentiality of SUD patient records by restricting the circumstances under which Part 2 Programs or other lawful holders can disclose such records. For more information: <https://www.samhsa.gov/sites/default/files/does-part2-apply.pdf>*
- Part 2 provider/member data, such as prior authorizations and care plans can only be transferred from the LME-MCO to the PHPs with express consent from the member; otherwise the data must be removed.
- As part of LME-MCOs' and NC DHHS' efforts to ensure PHPs have information necessary to support member needs, LME-MCOs are engaging in an effort to secure member consent from applicable members, prior to transferring the record.
- Any record where consent is not secured will be omitted from the transfer.

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Data Transfer at Crossover: Provider Impact 42 CFR Part 2 Trainings

- **NC's Transition to Medicaid Managed Care: Navigating 42 CFR Part 2 Requirements**
- **Same training, 2 options:**
 - Friday, 9/27/2019, 1:00p-2:00p
 - Friday, 10/11/2019, 1:00p-2:00p
- **To register:**
<https://attendee.gotowebinar.com/rt/7163570444590312705>
- **Description:** NC DHHS will host two identical trainings to orient applicable providers on how NC DHHS, LME-MCOs and providers will navigate 42 CFR Part 2 requirements related to the transfer of a member's substance use disorder (SUD) data during the NC's transition to NC Medicaid Managed Care. This training will supplement additional guidance provided by the NC LME-MCO network to applicable providers.
- **Target audience:** "Part 2" providers providing services to members who will be transitioning into the Standard Plan option on 2/1/2020 under NC Medicaid Managed Care.
 After registering you will receive a confirmation email containing information about joining the training.

Prior Authorization Requests for DOS Prior to Managed Care Date

- LME-MCOs will continue to process Service Authorization requests for members enrolled at 11:59 prior to MCL.
- Open and recently closed service authorizations will be transferred to Member's PHP to help ensure continuity of care.
- PHPs are required to honor open PAs for services covered by Standard Plan/PHP up to 90 days after launch.
- If PHP ends open PA after 90 days, it must provide appeal rights.

LME-MCO PRIOR AUTHORIZATIONS IN PHP WORLD

- PHPs required to honor open PAs for 90 days post MCL
- Outpatient Behavioral Health Services Provided by Directly-Enrolled Providers: Units will reset to zero.

Unmanaged Visits for Outpatient Behavioral Health Services

As referenced in the Revised and Restated RFP, PHPs are required to adhere to Department's Clinical Coverage Policy 8C, Outpatient Behavioral Health Services Provided by Directly-Enrolled Providers. This policy states in relevant part: Outpatient behavioral health services coverage is limited to eight unmanaged outpatient visits for adults and 16 unmanaged outpatient visits for children per state fiscal year (inclusive of assessment and Psychological Testing codes). For members who are authorized for services under this Clinical Coverage Policy at Managed Care Launch (MCL), the unmanaged visit count shall reset to zero. PHPs are otherwise required to adhere to Clinical Coverage Policy 8C, Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers.

Authorization Requests for DOS Prior to Managed Care Date

Member's Managed Care Date (Managed Care Effective Date = MC Effective)

Member Covered by LME-MCO

Scenario 1: Provider submits Auth request prior to Managed Care Effective Date for member transitioning to PHP for service covered by both LME-MCO and PHP. LME-MCO authorizes services as clinically indicated. Authorization will be transferred to PHPs as part of daily PA transfer file.

Member Covered by PHP

Scenario 1. PHP honors LME-MCO authorization for first 90 days. If Authorization extends beyond 90 days and the PHP ends, it must issue appeal rights.

Scenario 1: LME-MCO generated PA for service also covered by PHP

Scenario 2: Provider submits Auth request prior to MC Effective Date for member transitioning to PHP for service ONLY covered by LME-MCO. LME-MCO may process but benefit may not be available in Standard Plan.

Scenario 2: Benefit not available. PHP has no capacity or responsibility to provide. *EPSDT rules apply

Scenario 2

Scenario 3: Provider submits retroactive Auth request for pre MC effective DOS for a member formerly enrolled in LME-MCO, now enrolled in PHP. LME-MCO may only authorize for pre MC effective dates of service (DOS).

Scenario 3

Scenario 3: Provider may submit separate Auth request directly to PHP.

PA Requests at Crossover: What Providers Need to Know

- **Confirm that a Member is Transitioning to a Standard Plan**
 - Many members currently served by the LME-MCO will remain with the LME-MCO.
- **Know Member's Transition Date/Managed Care Effective Date**
 - For members transitioning to Standard Plan, this date will be **2/1/2020**.
- **Be Clear on What and When You are Submitting:**
 - **Service Auth submitted before Managed Care (MC) Effective Date?**
 - Send to LME-MCO
 - LME-MCO specific benefits may be authorized but may not be available in Standard Plan after MC Effective Date.
 - **Service Auth submitted after MC Effective Date?**
 - Will need to be submitted to PHP.
 - If retroactive request includes date of service (DOS) prior to MC Effective Date may submit to LME-MCO for only pre-MC Effective Date dates.
- **Identify Member's Managed Care Information**
 - **For Provider Portal Guidance:** See Job Aid *PHP Eligibility/Enrollment for Providers* in NC Tracks Provider Portal
- **To submit Service Auth/ Request on or after MCL**
 - Follow instructions provided directly by the PHP
 - **Coming Soon!** All PHP instructions in one place: <https://medicaid.ncdhhs.gov/providers>

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Specific LME MCO Guidance Here

- **DRAFT FOR REVIEW**

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Stop Lights for Attempted PA Requests to LME-MCO after Managed Care Effective Date

Intensive Provider Education	• Ensure providers know about PA submission requirements. • Ensure providers have information needed to resubmit PA request to proper PHP
Notification: Auto-Information Message	• If a provider attempts to enter information for a member who is now enrolled in Managed Care, it <u>may</u> not find member in PA portal and will see banner message instructing where to get additional information.
Informed Call Center Staff	• LME-MCO center staff will be informed on how to guide both members and providers.

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Appeals at Crossover

- Generally, adverse determination process and appeal rights will be processed as typical.
- Members appealing initial service request denials will be instructed on option to submit new request to PHP.
- PHPs will be required to honor Continuation of Benefits/Maintenance of Service on covered benefits until can reassess and either approve ongoing services or issue appeal rights.
- EPSDT still requirements apply.

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What Providers Need to Know: Processing Payment at Crossover

- a. Claims for dates of service prior to the member's Standard Plan Effective Date should continue to be submitted to the LME-MCO.
- b. Claims for dates of service after the member's Standard Plan Effective Date should be submitted to the member's PHP following applicable PHP protocol as provided in provider enrollment materials.
- c. Note: PHPs are required to treat claims for non-participating providers with dates of service on or after Standard Plan Effective Date equal to that of enrolled providers until the completion of the episode of care or 60 days, whichever is less.*

* N.C. Gen. Stat. § 58-67-88(d)-(g) still in effect.

Transition-Related Safeguards for High-Need Members

Data File Transfer at Crossover
Claims/Encounter Data
PA Extract
Care Plans (As Applicable)

Targeted Follow Up For High-Need Members
PHPs perform time-sensitive follow up to High Need Members

Warm Handoff
Individualized knowledge transfer sessions for members identified by DHHS, LME-MCOs, CCNC. PHPs may also initiate.

Applies to All Transitioning Beneficiaries

See High Need Member Definition

Complex Treatment/Service Circumstances

Targeted Follow Up For High-Need Members

PHPs perform time-sensitive follow up to High Need Members

Pre MCL, PHP identify and prioritize “High Need” members based on criteria and information provided.

“High Need” Members include:

- High need subset of members receiving in-home long-term services and supports or select behavioral health services.
- High need subset of members receiving behavioral health services
- Exempt members who elect to enroll in PHP.
- Members identified by CCNC, an LME-MCO or the Department who have complex treatment circumstances or multiple service interventions and necessitate a “warm handoff.”
- NEMT users with repeated or multiple appointments.

Managed Care Launch Date




Member PHP representative

Follow Up Prioritized based on Need, but must occur within 3 weeks of MCL (reported weekly to DHHS):

- Direct contact between PHP and member (in-person or phone)
- Are services in place?
- Any confusion about processes?
- Ongoing status of pre-MCL authorized services.

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Targeted Follow Up For High-Need Members: Guidance for Providers

High Need Populations

- High need subset of members receiving behavioral health services
 - Member who has utilized Mobile Crisis, Behavioral Health Urgent Care or Facility-based crisis with DOS within 365 days of MCL.
- Exempt members who elect to enroll in PHP.
- Members identified by CCNC, an LME-MCO or the Department who have complex treatment circumstances or multiple service interventions and necessitate a “warm handoff.”

Guidance for Providers

- A member's PHP may be calling or visiting. A provider can help explain this.
- Providers are not responsible for arranging but may be invited to participate.

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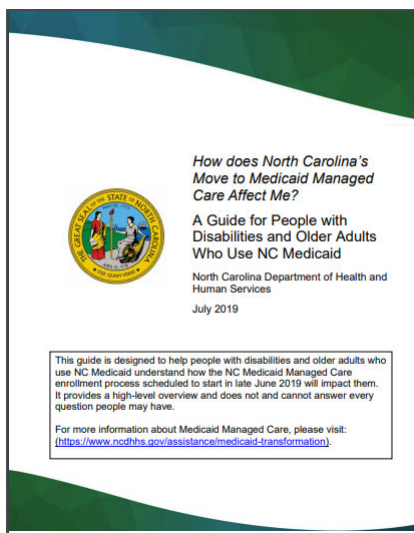
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Warm Handoff

Individualized knowledge transfer sessions for members identified by DHHS, LME-MCOs, CCNC. PHPs may also initiate.

- LME-MCOs will be identifying members who necessitate a knowledge transfer between care coordination staff and PHP staff.
- LME-MCOs may determine own criteria but likely to include:
 - Time sensitive dynamics such as
 - Imminent facility discharge
 - Precarious clinical or social dynamics such as:
 - Imminent risk of homelessness
- Providers may be asked to participate.

Member Education



Member Guide to explaining enrollment pathways for beneficiaries with disabilities and older adults.

- <https://files.nc.gov/ncdma/How--Does-Medicaid-Managed-Care-Affect-Me-Enrollment-Guide-for-LTSS-Final-for-Web-Posting.pdf>

Member Education: Non Emergency Medical Transportation (NEMT)

- At launch, PHPs will assume responsibility for NEMT for enrolled members.
- Currently, DSSs are working with the PHPs to inform of member appointment schedules and additional considerations for high need members.
- Enrolled members will be able to reserve post MCL appointments 31 days **PRIOR** to their effective date.
 - Sara selects ABC Health Plan on December 10th, 2019. Her managed care effective date will be February 1, 2020.
 - Sara has an appointment on February 2, 2020.
 - Sara can reserve her 2/2/2020 appointment directly from ABC in January, 2020.

In Development:
Additional Educational Materials to Help Members Understand this Option

Provider Note:
Providers can help educate members about this option.

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Preparing for Managed Care: Helping Members through Crossover Process

My health plan is:

My primary care provider is:

When I will start getting care through my health plan:

Number to call if I need to schedule a ride to an appointment after I start getting care through my health plan.

Number to call if I have issues getting care after my start date.

Number to call if I have questions about my supplies.

We want to ensure Members have simple, clear, “pocket reference” answers to these questions.

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Member Education

• Ways Providers Can Help:

- Help members understand their options by providing them with the Enrollment Broker contact information.
- Finalize outstanding contracting activity with PHPs so that members are clear on which PHPs.

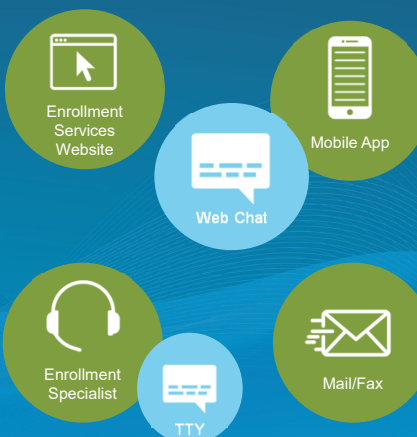
Enrollment Broker

The Enrollment Broker is responsible for choice counseling for Health Plan and Primary Care Provider (PCP) selection. As part of this, the Enrollment Broker is also responsible for mailing all notices and handling enrollment.

Options for Beneficiaries

1. Direct them to ncmedicaidplans.gov to learn more.
2. Direct them to ncmedicaidplans.gov to chat with an Enrollment Specialist.
3. Direct them to download and use the NC Medicaid Managed Care mobile app.
4. Tell them to call 1-833-870-5500 to speak with an Enrollment Specialist. The call is free.
5. Individuals with hearing impairments may contact an Enrollment Specialist via the TTY line at 1-833-870-5588.
6. Beneficiaries can also enroll by mailing or faxing their completed enrollment form.

CHANNELS FOR ENROLLMENT



Member Education

NC Medicaid Managed Care Education Resources for Members

- Enrollment Broker: www.ncmedicaidplans.gov
- General Overview: <https://files.nc.gov/ncdhhs/Medicaid-ManagedCare-OpenEnrollment-Webcast-FINAL-20190714.pdf>
- DSS Playbook
 - <https://medicaid.ncdhhs.gov/counties/county-playbook-medicaid-managed-care/county-playbook-beneficiary-outreach>

NC Medicaid Reference Guide

<https://files.nc.gov/ncdma/NCMedicaid-Reference-Guide-Medicaid-Contact-Sheet.pdf>

Educational Video

<https://www.youtube.com/watch?v=9xJyeXkypI8&t=>

RESOURCES

Need More Information Right Now?

General information from State:

Medicaid.Transformation@dhhs.nc.gov

Member is Confused about What to Do?

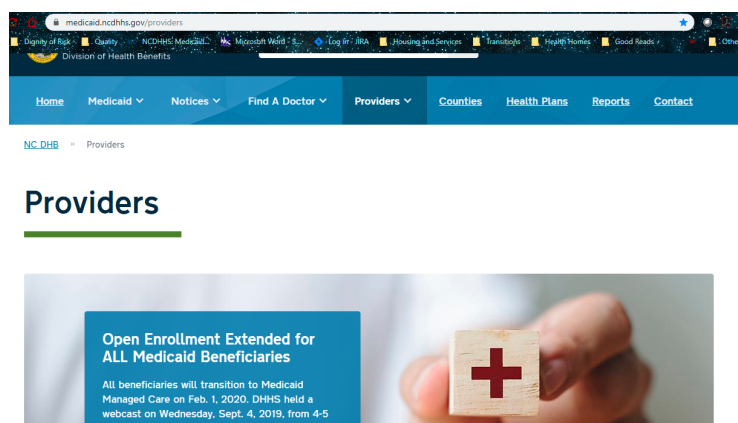
- Support the Member to Call:
 - Enrollment Broker (see earlier slide)
 - LME-MCO Call Center

Time-Sensitive Inquiries:

- Providers: NCTracks: 800-688-6696
- Beneficiaries: Enrollment Broker, LME-MCO Call Center or Medicaid Contact Center: 833-870-5500
- For urgent member or provider-specific issues: 919-527-7460 or MedicaidSWAT@dhhs.nc.gov

Provider Education: Crossover

- Bookmark this page: <https://medicaid.ncdhhs.gov/providers>



Provider Education: General Resources	
General Overview of Provider Transition to Managed Care	MCT 101 Provider Transition to Managed Care https://medicaid.ncdhhs.gov/nc-medicaid-managed-care-training-courses
Information about Provider Rates and Contracting	MCT 102 Provider Payment and Contracts https://files.nc.gov/ncdema/documents/Providers/Revised-6.26.19-Provider-Payments-and-Contracting-Webinar-4-11-19-FINAL.pdf
Information about Provider Network Adequacy Requirements, Grievances and Appeals and Other Policies	MCT 104 Key Policies for Providers in Managed Care https://files.nc.gov/ncdema/Provider-Policies-Webinar-5.9.19-Final.pdf
Information about Standard Plan and Tailored Plans	MCT 106 Behavioral Health Services: Standard Plan and Transition Period https://files.nc.gov/ncdema/MCT106-BH-Transition-Final.pdf
Information on Benefits under Managed Care	MCT 108 Clinical Policies under Managed Care https://files.nc.gov/ncdema/documents/Clinical-Policies-Webinar-FINAL20190613.pdf
To Contact the PHPs about Contracting	Please visit the NC DHHS Medicaid Provider webpage https://medicaid.ncdhhs.gov/providers

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Provider Education: Crossover-Specific Resources
• Additional materials available at: https://medicaid.ncdhhs.gov/providers – General Crossover Webinar Scheduled for Thursday, September 19, 2019 from 1:00-2:00p • To Register: Go to https://medicaid.ncdhhs.gov/provider-playbook-training-courses • https://manatt.webex.com/manatt/onstage/g.php?MTID=eee7f23a0a1c9132a1f3f6dc6d9ddd74e – Crossover Resource Web Page Coming Soon! • Guidance on Finding Members' Managed Care Status • Resources to Support Members through Transition through Managed Care • Guidance on Submitting Prior Authorizations • Contacting the PHPs • Overview of PHP Crossover Requirements * Also note Crossover-Specific Medicaid Bulletin Articles beginning with August's Bulletin.

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