MA-3435 COMMUNITY CARE OF NORTH CAROLINA/CAROLINA ACCESS
REVISED 12/01/11-CHANGE NO. 19-11

I. BACKGROUND

In 1991, Carolina ACCESS (CA) was implemented on a county by county basis and became statewide in 1998. The purpose is to improve access to primary care, improve quality of care and utilization of services, and provide a more cost effective system of care. This is accomplished by linking recipients to a medical home where there is a primary care provider (PCP) to deliver and coordinate health care.

In 1996, Medicaid began using the existing CA infrastructure to build an enhanced - managed care plan, Community Care of North Carolina (CCNC). CCNC was formerly known as ACCESS II & III. CCNC developed networks of CA providers in order to deliver community directed care. Each network has an administrative entity to plan and administer the local and state wide managed care initiatives. Each network brings together key players in the community who provide services to Medicaid and North Carolina Health Choice (NCHC) recipients. Depending on community resources these players include primary care providers, DSS agencies, health departments, and others. In November 2009, these two programs were given one name, Community Care of North Carolina/Carolina ACCESS, CCNC/CA.

Even with the addition of CCNC, some recipients continue to know the program as Carolina ACCESS. Efforts are being made to assist recipients to identify with CCNC, in addition to Carolina ACCESS (CA). Not all primary care providers choose to join with a network. There will continue to be PCPs who are Carolina ACCESS providers only.

Every PCP, participating in CA or CCNC, must first be enrolled in Carolina ACCESS and must complete a Carolina ACCESS provider contract and agreement before becoming a PCP. A provider cannot move into a network unless he has first been approved as a CA provider. For the purpose of this section, Medicaid managed care will be identified as CCNC/CA.

In 2005, the General Assembly passed legislation requiring NCHC children ages 6-18 to be linked to a CCNC/CA provider unless exempt. All Medicaid recipients who fail to choose a CCNC/CA provider will be auto enrolled, unless they qualify for an exemption.

The Recipient and Provider Services Section of DMA works with the managed care section to provide training and policy implementation of CCNC/CA with the local DSS agencies. The Managed Care Section continues to be responsible for policy development.

(I.)

The Managed Care Section works closely with the provider community and the local network administrative entities. Regional managed care consultants (MCC) develop and coordinate community involvement in the CCNC/CA program.

II. POLICY PRINCIPLES

CCNC offers additional managed care services. Carolina ACCESS provides the Medicaid and North Carolina Health Choice(NCHC) enrollee with a primary care doctor, whose practice serves as the enrollees medical home, who manages care for continuity and ensures services are provided that are medically necessary. CCNC provides primary care management, disease management, prevention, medical coordination of treatment for all enrollees. A chronic care initiative provides enhanced services to the aged, blind, and disabled Medicaid recipients. It also includes a comprehensive and integrated package of screening and assessment, intensive chronic care management, pharmacy review, transitional support and quality improvement across the continuum of care. The primary focus is to enroll every recipient into CCNC/CA, with a preference to enroll into a CCNC network. This section outlines the specific procedures and requirements for enrollment into CCNC/CA.

III. DMA RESPONSIBILITY

A. Recipient Services

1. Recipient Services provides the following:

   a. Distributes CCNC/CA policy, and

   b. Coordinates with the Managed Care Section for all county functions relating to CCNC/CA enrollment and education.

2. The Medicaid Program Representatives (MPR) do the following:

   a. Provide technical assistance in establishing county protocols and procedures.

   b. Inform and train DSS supervisory staff on Managed Care policies.

   c. Monitor the CCNC/CA provider directory to assure it is current and accurate.

   d. Communicate state policies and/or procedures regarding CCNC/CA to the county DSS.

   e. Work with the DMA managed care section on CCNC/CA issues affecting the county’s ability to carry out its role.

(III.)

B. Managed Care

The Managed Care Section does the following:

1. Develops Managed Care policy, educational material, and standardized forms.

2. Trains MPRs.

3. Monitors enrollment and overrides.

4. Investigates complaints and inquiries.

5. Maintains a monthly enrollment progress report with specific county enrollment numbers and percentages.

6. Assures provider recruitment, enrollment, and education.

7. Assists with development and expansion of CCNC/CA.

8. Provides health check program consultants.

9. Work with the MPRs on CCNC/CA initiatives affecting the DSS.

10. Facilitates communication and collaboration between the DSS and the CCNC network administrative staff.

11. Monitors overrides. For worker errors, a report is created and forwarded to the MPR supervisor.

IV. COUNTY DSS RESPONSIBILITIES

A. Designate a county CCNC/CA contact and back-up person or a managed care representative.

B. Maintain a current and accurate county CCNC/CA Primary Care Provider Directory.

C. Explain CCNC/CA at each application and redetermination to <u>all</u> mandatory and optional Medicaid a/rs and NCHC recipients and offer enrollment. Give Medicaid a/rs a copy of the CCNC/CA Member Handbook.

D. Give a copy of the <u>DMA-9016</u> (Medicaid) or the <u>DMA-9017</u> (NCHC), CCNC/CA: The Benefits of Being a Member handout to <u>all</u> mandatory and optional a/rs at each application and redetermination.

(IV.)

E. Assist the a/r in choosing a medical home/PCP based on location of the recipient, medical history, or physical needs. Assist the a/r in locating medical providers, e.g., dentists.

F. Auto enroll all mandatory a/rs in CCNC/CA. Auto enroll all optional a/rs unless they opt out. Please refer to VII for enrollment rules.

G. At application or redetermination (when necessary), complete the CCNC/CA Enrollment Form, DMA- 9006 to link recipients with a medical home/PCP or to exempt recipients from participation, using the exempt policy to determine the appropriate exempt code. Make timely changes for a medical home/PCP as requested by the recipient. Enter the appropriate change reason code if applicable.

H. Key the CCNC/CA PCP provider number or exempt code in EIS.

I. Educate enrollees on CCNC/CA policies found in IX, Recipient Education, below.

J. Providers may begin the enrollment process for CCNC/CA by having the recipient complete a CCNC/CA Enrollment Form while at the provider's office. This form is sent to the local DSS for keying into EIS. Providers are responsible for the initial education and providing explanation of CCNC/CA benefits to the recipient. At the next redetermination or client contact, the IMC is responsible for continuing the CCNC/CA education process.

K. Refer CCNC/CA enrollees or providers with questions or concerns outside the scope of CCNC/CA enrollment and education to the appropriate individual or agency.

V. CCNC/CA CONTACT PERSON AND BACK-UP PERSON

A. The county DSS must designate a CCNC/CA contact and back up person. For counties that have a Managed Care Representative (MCR), the MCR will be the contact.

1. Report the name and phone number of the county CCNC/CA contact and backup to your MPR.

2. If there are any changes in your contact or backup, notify your MPR within five work days.

3. The MPRs will inform the Managed Care Section regarding the CCNC/CA contact and back up.

(V.)

4. The Managed Care Section will maintain a master list based on contacts and backups as reported to the MPR.

B. Duties of the CCNC/CA Contact Person and Back-Up Person

1. The CCNC/CA contact is a resource for state managed care staff, MPRs, and Managed Care consultants to relay any information to the county regarding recipient enrollment and education.

2. The CCNC/CA contact may assume additional responsibilities pertaining to CCNC/CA education and enrollment at the county discretion. Examples of additional duties include: maintaining the county provider directory, working the exempt reports, enrolling SSI recipients, or educating enrollees.

3. The CCNC/CA contact (unless a Managed Care Representative) is NOT a resource for recipients and providers. Recipients will be instructed to contact their caseworker regarding enrollment and education issues. Providers will be instructed to contact their Managed Care Consultant.

4. If a DSS needs to relay information regarding a CCNC/CA enrollee to another county, the county can choose to communicate directly, contact the MPR, contact the regional managed care consultant or contact the state managed care office at 919-855-4780. The state managed care section will provide the CCNC/CA contact list to each county's designated contact person on a quarterly basis.

VI. CCNC/CA PROVIDER (PRIMARY DOCTOR/MEDICAL HOME) DIRECTORY

The county DSS is responsible for maintaining the provider directory .The county may designate who maintains the directory. For example, it may be the CCNC/CA contact, a Medicaid supervisor or caseworker, or administrative or clerical staff.

The directory must be maintained in two formats. Maintain one directory for Income Maintenance Caseworkers (IMCs) to use to enroll recipients in CCNC/CA. This directory includes the provider number. Maintain a second directory to mail to the recipients to choose a medical home. This directory does not include the provider number.

On the directories, identify the provider as either a CA1 (CA, shown on the MP screen as CACC) or a CA11 (CCNC, shown on the MP screen as CCNC).

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It is very important to maintain a current and accurate county directory to assure recipients are linked with an appropriate Primary Care Provider (PCP). For example, do not enroll a new patient with a provider who only accepts established patients, or do not enroll a recipient who is under age 20 with a provider who does not see patients under age 20.

Each county may customize the provider directory to meet its needs. For example, you may choose to list providers by specialty, availability, location, restrictions, etc. DMA provides the following tools for the county to maintain the directory.

The county caseworkers must utilize the existing CCNC/CA Provider Directory for enrollment of Medicaid or NCHC children.

A. NCXPTR

1. Provider Directory (DHREJ Carolina ACC Pvdr Directry) updated nightly in EIS.

2. Monthly Availability Report (DHREJ Carolina ACC Pvdr Availbty) updated monthly in EIS.

   The Provider Directory and Availability Reports are indexed by county. To select the report for just your county, follow these steps:

   From the V22: Latest Report, key an "X" to the left of the report name From the V15: Report Name, key an "S" to the left of COUNTY$. Use F7/F8 to page backward/page forward to find your county. Key an "S" to the left of your county number. Refer to EIS 1061, XPTR Report Distribution System, for complete instructions to access reports on NCXPTR including how to browse reports and options available while browsing.

B. EIS

EIS has three Carolina ACCESS Primary Care Provider Information Screens, (MP). These screens contain all information necessary to enroll individuals in CCNC/CA including availability and restrictions. It is very important to verify the restrictions on the MP screens to link recipients appropriately. The restrictions are listed below.

01 No restriction

02 Established patients only

06 MPW only

07 Nephrology patients only (in same or contiguous counties)

08 Chronic infectious disease patients only (in same or contiguous counties)

09 Oncology patients only (in same or contiguous counties)

10 Established patients and siblings

11 Newborn only

14 Two track clinics; facilities serving two distinct populations

15 Age restrictions- refer to Notepad (PF 4/16) on MP Screen in EIS

C. Weekly Update

The Provider Services Section faxes a weekly list to the county CCNC/CA Contact, summarizing changes in the Provider Directory. The CCNC/CA Contact is responsible for forwarding the update to the person who maintains the directory.

VII. ENROLLMENT

A. Enrollment Rules

The county DSS must enroll recipients in CCNC/CA or exempt recipients from participation, using the exempt policy to determine the appropriate exempt code. Refer to sections VII. B, and C. below to determine who is Mandatory, Optional or Ineligible.

EIS requires (at application and review) for Medicaid and NCHC children a **valid** (active on the Managed Care Provider Database) CCNC/CA Provider or Exempt number be keyed in the CCNC/CA Provider/Exempt Number field on the DSS-8125.

1. The county DSS must auto enroll all recipients who are mandatory and those optional in CCNC/CA at application, redetermination, or any time a recipient contact the agency to request a change in CCNC/CA enrollment status. **Do not automatically exempt optional groups unless they opt out. If a recipient in an optional coverage group is not available to opt out or choose a primary care provider, they must be auto enrolled.**

2. The Benefits of Being a Member DMA-9016 and/or DMA-9017 must be explained to all recipients who are mandatory or optional.

(VII.A.)

3. Each eligible Medicaid and North Carolina Health Choice (NCHC) recipient chooses a primary care provider from a directory of participating Primary Care Providers (PCPs) who meets the recipient's criteria. Before enrollment always:

   a. Verify the provider availability, and

   b. Verify provider restrictions, and

   c. Review the recipient's enrollment history, location of residence, and type of medical care.

4. If the recipient fails to choose a primary care provider or is not available to make a choice, and is in a mandatory or optional category for enrollment, the Income Maintenance Caseworker, (IMC) must assign an appropriate medical home/PCP based on the criteria listed above. Recipients should not be assigned to a medical home/PCP outside of a 30 mile radius from the recipient's residence.

5. If the recipient has an enrollment history in EIS or case record with a CA or a CCNC provider in the previous 12 months, (including breaks in eligibility), assign to the most recent provider seen, if appropriate. If no history exists, auto assign to a CCNC provider. If no CCNC provider fits the criteria in VII.A. 2. above, assign to a CA provider.

6. Each family member may have a different medical home/PCP. For example, a mother may choose a family practitioner for herself and a pediatrician for her children.

7. Complete the CCNC/CA Enrollment Form, **DMA- 9006,** for all Medicaid and North Carolina Health Choice (NCHC) recipients and file in the case record. If exempt, complete the form with the appropriate exemption code and file in the case record.

8. ICF-MR has been removed from the list of living arrangement codes that does not allowed enrollment.

(VII.A.)

9. If a recipient under an optional category group opts out of CCNC/CA enrollment, the Income Maintenance Caseworker must key the appropriate opt out exemption code. See VII.D. below.

10. The effective date of enrollment is always the on-going month after the action processes in EIS.

11. Do not enroll in CCNC/CA when the recipient:

    a. Is ineligible for CCNC/CA (MAF-D, MAF-W, MQB, Q, B, or E, MRF, RRF, illegal aliens), or

    b. Has a living arrangement code of 16,17,50,58,60,70,71,72,73,75, or

    c. Meets the deductible later than the second month of the certification period, or

    d. Is a CAP recipient with a monthly deductible, or

    e. Has no ongoing eligibility (open/shut/retroactive eligibility only).

12. Manually remove the CA provider number when:

    a. Keying a county transfer (non-SSI), or

    b. Changing cases from authorized to deductible status.

    c. Changing NCHC (MIC, J, K, A, S) to Optional Extended Coverage (MIC, L).

13. There are four enrollment reference tools for the county to use as needed.

    a. EIS generates a monthly Carolina ACCESS (CA) Enrollment Report by county (DHREJ CAR ACC ENROLLMENT REPORT). It is available in NCXPTR.

    b. For NCHC, EIS generates a monthly Carolina ACCESS Enrollment Report by county (DHREJ CAR ACC ENROLL RPT NCHC). It is available in NCXPTR.

    c. Managed Care posts a monthly County Progress Enrollment Report on the DMA website:http://www.ncdhhs.gov/dma/medicaid/index.htm. The report is found under the Publications link at the website.

(VII.A.13.)

d. The Carolina ACCESS Provider Availability Report generated by EIS. The report name and number is: DHREJ CAROLINA ACC PVDR AVAILBTY. It is available in NCXPTR.

B. Mandatory and Optional Coverage Groups:

MANDATORY	OPTIONAL
AAF/Work First	MPW
MIC (N) and MIC (1)	HSF
MAF	IAS
MAABD (without Medicare)	MAABD (with Medicare)
SAD/SAA (without Medicare)	SAD/SAA (with Medicare)
MIC-J and MIC-K	End Stage Renal Disease Patients
Native American (not a member of a Federally Recognized Tribe)	SSI recipients under age 19
	Native Americans (a member of a Federally Recognized Tribe)
	Benefit Diversion Cases

C. Ineligible Group Coverage Groups:

INELIGIBLE
MQB, RRF/ MRF
Recipients in “Deductible” status
Cap Cases with a monthly deductible
Aliens eligible for Emergency Medicaid only
Nursing Facility residents (does not include ICF-MR)
MAF-D
MIC-L
MAF-W

D. Exempt Codes: The following exempt codes are system generated.

CODE	PROGRAM	DEFINITION
9999901	Medicaid	Coverage groups ineligible for CCNC/CA (MQB, MRF, RRF, illegal alien classifications)
9900010	Medicaid	SSI recipients without Medicare. Code is assigned by the Social Security Administration.
9900011	Medicaid	SSI recipients with Medicare (dual eligibles). Code is assigned by the Social Security Administration.
9900029	Medicaid	Non-SSI transfers from one county to another.
9900045	Medicaid	Approved Benefit Diversion Cases (AAF). Also used when the state mandates Medicaid be reopened until a determination for ongoing eligibility can be made.
9900050	Medicaid	SSI recipients become non-SSI and previously exempted with ’10 code (ex-parte).

9900058	Medicaid	Recipients who are Incarcerated.
9900059	Medicaid	Recipients, age 21-64, who are in an Institution for Mental Disease.
9900060	Medicaid	SSI recipients become non-SSI and previously exempted with '11 code (ex-parte).
9900070	Medicaid	Mass exemption by practice; **USED ONLY BY THE STATE.**

The following exempt codes must be manually keyed into EIS.

9999902	Medicaid	Recipients residing in a nursing facility (living arrangement 50, 58, 60) or patient in a psychiatric facility (living arrangement codes 70, 71, 72, 73, 75).
9999906	Medicaid	Recipients who are enrolled in **PACE.**
9900006	Medicaid or NCHC	Temporary code: WHEN APPROVED by DMA 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 recipients 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 recipients < 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	Recipient has other primary health insurance and PCP does not participate in CCNC/CA. Code applies to recipients with Tri-Care, CHAMPUS, and VA.
9900032	Health Choice or Medicaid	Temporary code used for a recipient receiving NCHC or Medicaid who is established with a non-participating PCP.
9900646	Medicaid or SA	Dual eligible recipient opted not to enroll.
9900647	Medicaid	No provider is available for the recipient to choose for a PCP within a 30 mile radius from the recipient's home, and the recipient does not choose a PCP at a greater distance. Or; Caseworker is unable to *auto enroll* the recipient to a PCP located within a 30 mile radius from the recipient's home.

E. Exempt Reports

1. Counties must establish internal procedures to approve and track exemptions.

2. To help track exemptions, EIS generates two monthly reports. Both reports are in NCXPTR. Refer to EIS 1061, XPTR Report Distribution System.

(VII.E.2.)

a. Exempt Report (DHREJ EXEMPT PVDR CODE REPORT), and

b. SSI Exempt Report (DHREJ SSI EXEMPT MEDICARE REPORT).

3. The state Managed Care Section monitors the exemption reports. When exemptions are excessive, state staff forwards this information to the supervisor of the Medicaid Program Representatives (MPR).

4. The MPR works with counties on an individual basis for corrective action.

VIII. ASSIGNMENT PROTOCOLS FOR MEDICAID AND NORTH CAROLINA HEALTH CHOICE (NCHC) RECIPIENTS

A. Face to Face Applications and Redeterminations

The linking of an a/r (except MIC-L) with a CCNC/CA provider and primary home occurs during the regular application and review process.

1. Explain the benefits and requirements of CCNC/CA to all mandatory and optional Medicaid and North Carolina Health Choice applicants and recipients.

2. Provide each Medicaid and North Carolina Health Choice applicant/recipient (a/r) with a CCNC/CA primary care provider directory. Do not include the PCP's provider number in the directory.

3. Make every effort to help the a/r choose a doctor for each person during the interview based on provider availability, restrictions, and medical needs. It is preferred that the recipient choose a provider who is participating in a Community Care North Carolina (CCNC) network. This will provide more managed care services to the recipient. However, if the a/r is already established with a CA provider and does not want to change, he does not have to.

4. If the a/r cannot choose or refuses to choose a PCP and is not otherwise exempt, choose a PCP for the Medicaid recipient based on his enrollment history, location of residence, and type of care.

   a. Refer to VII. A. 1-7, above for auto enrollment instructions.

   b. See VIII.G, H, or J below for exemptions requiring DMA Managed Care approval.

5. Caseworkers will enter code 9900647 if they are unable to *auto enroll* a recipient to a PCP located within a 30 mile radius from the recipient's home.

6. Caseworkers will enter code 9900647 if no provider is available for a recipient to choose for a PCP within a 30 mile radius from the recipient's home and the recipient does not choose a PCP at a greater distance.

7. Dual eligible (Medicaid/Medicare) recipients:

   Caseworkers will enter code 9900646 if they have explained and offered CCNC/CA and the dual eligible recipient opted not to enroll.

8. Complete the CCNC/CA Enrollment Form, **DMA- 9006,** and file it in the case record.

9. Follow EIS instructions to enter the provider number or exemption number at application disposition or redetermination.

10. If temporary codes 9900006 or 9900023 are present at redetermination, follow procedures in VIII.A.1-6 above. TEMPORARY CODES 9900006 and 9900023 can not be reassigned without approval from the DMA Managed Care Section.

11. If six month temporary code 9900020 is present and the recipient continues to claim a medical exemption, follow procedures in VIII.H below.

12. The CCNC/CA handbook and the DMA-9016, CCNC/CA: The Benefits of Being A Member-Medicaid, handout must be given to all mandatory and optional Medicaid applicants/recipients. Include the PCP's name and phone number if known.

13. The DMA-9017, CCNC/CA: The Benefits of Being a Member- NCHC handout must be given to all NCHC recipients. Include the PCP's name and phone number if known.

B. Mail-In Applications and Re-Enrollment or MIC/NCHC Ex Parte Re-Enrollment

1. During the processing period for Medicaid or North Carolina Health Choice, if not already enrolled, auto enroll all mandatory and optional recipients.

2. Complete the CCNC/CA Enrollment Form, DMA-9006 and file it in the case record. If exempt, complete the form with the appropriate exemption code. See VIII.G, H, or J below for exemptions requiring DMA Managed Care approval.

3. Mail the CCNC/CA handbook including the Primary Care Provider name and phone number and the DMA-9016, CCNC/CA: The Benefits of Being A Member-Medicaid.

4. The DMA-9017, CCNC/CA: The Benefits of Being a Member-NCHC handout including the Primary Care Provider name and phone number must be mailed to all NCHC recipients.

C. Auto Newborns

1. When you are notified by any source that a baby was born to a mother receiving Medicaid, approve an auto newborn application within 5 workdays.

2. If the mother is available:

   a. Explain CCNC/CA and provide the mother with a CCNC/CA primary care provider directory.

   b. Assist the mother in choosing a PCP for the newborn at this time.

   c. If the mother chooses a Primary Care Provider or the newborn is otherwise exempt; complete the DMA-9006, CCNC/CA Enrollment Form.

   d. If the mother does not make a choice, assign an appropriate PCP for the newborn. To help choose a Primary Care Provider it is recommended that you contact the hospital, the Maternity Care Coordinator (MCC), or a hospital representative to verify the attending pediatrician.

   e. Give the recipient the CCNC/CA handbook including the Primary Care Provider name and phone number and the DMA-9016, CCNC/CA: The Benefits of Being a Member–Medicaid.

3. If the mother is not available:

   a. Assign an appropriate PCP for the newborn. To help choose a Primary Care Provider it is recommended that you contact the hospital, the Maternity Care Coordinator (MCC), or a hospital representative to verify the attending pediatrician.

(VIII.C.3.)

b. Complete the DMA-9006, CCNC/CA Enrollment Form and file in the case record.

c. Mail the recipient the CCNC/CA handbook including the Primary Care Provider name and phone number and the DMA-9016, CCNC/CA: The Benefits of Being a Member–Medicaid.

D. SSI Recipients

1. SSI recipients are automatically enrolled in Medicaid. EIS generates a Medicaid approval notice to all approved SSI Medicaid recipients which reads:

   Carolina ACCESS is a managed health care service under Medicaid. With this service your health care is supervised by a primary care doctor. You are required to participate in this program unless you receive Medicare. You must contact your county department of social services within 30 days if you want to choose your primary care doctor. If you do not contact the department of social services, a doctor will be assigned to you. If you receive Medicare and would like to participate, call your department of social services for details. If you receive Medicare, Medicare is responsible for your prescription drugs.

2. When the SSI recipient calls the DSS:

   a. Explain CCNC/CA, and

   b. Assist in choosing an appropriate medical home/PCP, and

   c. Complete the CCNC/CA Enrollment Form, DMA-9006 and enroll in CCNC/CA and

   d. Mail SSI recipients the CCNC/CA Handbook and the DMA-9016, CCNC/CA, The Benefits of Being A Member-Medicaid, handout.

3. Review the SSI without Medicare exempt report (9900010) on a monthly basis:

   a. If a recipient has been on the list over 30 days, assign an appropriate PCP.

   b. Mail the recipient the DMA-9008, Important Notice About Your Medicaid - SSI Recipient without Medicare. List the PCP you have assigned him to on the cover letter. Ask that he contact you if he does not want this Primary Care Provider.

(VIII.C.3.)

c. If you do not hear from the recipient by the 10th day, enroll the recipient in CCNC/CA.

d. Mail SSI recipients the CCNC/CA Handbook and the DMA-9016, CCNC/CA: The Benefits of Being A Member-Medicaid, handout including the name and phone number of the Primary Care Provider (PCP) to which he is assigned.

4. Contact SSI recipients with Medicare (9900011) by phone or mail by using the DMA-9009, Important Notice About Your Medicaid - SSI Recipient with Medicare, (Figure 5) to explain the benefits of CCNC/CA and provide a CCNC/CA provider directory.

E. County Transfers

1. When a non-SSI recipient transfers from one county to another county, manually delete the PCP number (EIS will not process the transfer until removed). EIS automatically assigns the 9900029 exempt code on the last working day of the month when the county transfer processes.

2. When an SSI recipient transfers from one county to another county, EIS automatically inserts 9900010 or 9900011 in the provider field.

3. **DMA strongly recommends** that the new county contact recipients transferring into their county by phone or by mail using the DMA-9010, Important Notice About Your Medicaid – County Transfer, (Figure 6). Provide a CCNC/CA provider directory and ask the recipient to contact you to enroll in CCNC/CA.

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

F. Provider Disenrollment

1. When DMA terminates a CCNC/CA provider, EIS deletes the PCP number for each recipient who was assigned to that PCP and generates a temporary exemption code (9900070). DMA mails a DMA-9011, Community Care of North Carolina/Carolina ACCESS – Introduction Letter, to each recipient to explain that the PCP will no longer be providing his care and to instruct him to contact his caseworker to re-enroll in CCNC/CA.

(VIII.F.)

2. In addition, DMA faxes each county contact person a list of the recipients previously linked with that provider number. **DMA strongly encourages** the county to contact each recipient to re-enroll in CCNC/CA as soon as possible. The recipients' names and addresses are available in NC/XPTR in DHREJ 'CA ENROLLEES TERM PROV NO.'

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

G. Recipient requests a non-participating Primary Care Provider (PCP)

1. If a recipient wishes to see a doctor who is not participating in CCNC/CA, explain that he must enroll and choose a participating PCP from the current directory.

2. Explain that the DMA Managed Care Section will try to recruit the non - participating provider. Complete the CCNC/CA Enrollment Form, DMA-9006 with a detailed explanation about why the exemption is needed. If the Medicaid recipient refuses or cannot make a choice, assign an appropriate PCP based on the restrictions and availability on the Enrollment Form. Fax a copy of the CCNC/CA Enrollment Form to:

   Managed Care Section
   Division of Medical Assistance
   FAX: 1-919-715-5235

   If a county has a managed care representative (MCR), the DMA Managed Care Section has authorized the MCR to approve or deny this temporary exemption. If the county has an MCR, submit a copy of the enrollment form to the MCR.

3. DMA Managed Care or the MCR will fax within 24 hours the approval or denial of the request back to the fax number from which it was received.

4. If exemption is denied, enroll the recipient with the PCP on the Enrollment Form or use another applicable exempt code if recipient meets the criteria.

5. If exemption is approved, enter the exemption code given on the returned CCNC/CA Enrollment Form. The DMA Managed Care Section will attempt to recruit the non-participating provider. If successful, DMA managed care will fax the county information that this provider has been enrolled and will provide the PCP number. Enroll the client when notification is received.

(VIII.)

H. Medical Exemption

If a recipient requests an exemption from participating in CCNC/CA for a medical reason such as: medical care is complicated, terminal illness, sees many specialists, taking chemotherapy, mental illness or developmental delay, follow managed care policy for exempting recipients for medical reasons.

Recipients who identify themselves as an End Stage Renal Disease patient do not have to go through the exemption process. Exempt with code 9900022.

1. Explain to the recipient that only the DMA Managed Care Section can authorize a medical exemption except for end stage renal disease. This exemption does not require state authorization.

2. Complete the CCNC/CA Enrollment Form, DMA-9006 with a detailed explanation about why the exemption is needed and fax it to:

   Managed Care Section
   Division of Medical Assistance
   FAX: 1-919-715-5235

   Key exempt code 9900023, "Medical exemption requested, Decision pending" on the 8125.

3. Give or mail the a/r the DMA-9002, CCNC/CA Medical Exemption Request. Instruct him to give the form to his doctor to document the reason for his exemption. The doctor will forward the completed form directly to DMA (address provided on form). Also provide to the recipient the CCNC/CA toll free number 888/245-0179 if he has additional questions.

   Do not give a DMA-9002, Community Care of North Carolina/Carolina ACCESS (CCNC/CA) Medical Exemption Request, to an a/r who identifies himself as having a terminal illness or has had a major organ transplant. Fax a copy of the CCNC/CA Enrollment Request to the DMA Managed Care at 1-919-715-5235. **If the county has a managed care representative (MCR), the DMA Managed Care Section has authorized the MCR to approve or deny these 2 medical exemptions only. If the county has a MCR, submit** a copy of **the enrollment form to the MCR. All other medical exemption requests must be faxed to the DMA Managed Care Section.**

4. Upon receipt of the CCNC/CA Medical Exemption Request, DMA-9002, from the doctor, the Managed Care Section will determine if the recipient is permanently exempt, six month exempt, or not exempt.

5. If additional information is required from the county record, a representative from the managed care section will contact the CCNC/CA contact person.

6. When a determination is made, the managed care contact person will be notified of the decision. If the medical exemption is approved delete the temporary code number (9900023) and enter the permanent (9900021) or six month (9900020) medical exempt code. Managed Care will provide the approved code to be used. If denied, assign a PCP.

7. If DMA Managed Care does not receive a DMA-9002, CCNC/CA Medical Exemption Request, from the doctor within 30 days, DMA Managed Care will fax back to the county notification that the exemption is denied. Assign a PCP.

8. It is not necessary to change recipients who are currently exempt with a 9900020 code for medical reasons until the next redetermination. At that time delete the exempt code and follow procedures in VIII.B. or 1 – 7 above for medical exemption.

I. Recipient Disenrollment

1. When the county is informed by a recipient, MPR, Managed Care Consultant, or provider that a recipient must be disenrolled from a PCP, the worker must link the recipient with a new provider as soon as possible. This will avoid potential override requests.

2. If the recipient must be disenrolled due to worker error (adult assigned to a pediatrician, male to an OB/GYN, PCP accepts established patients only, etc.) the county worker must re-enroll the recipient with an appropriate provider as soon as he becomes aware of the error.

3. **DMA strongly recommends** contacting all disenrolled recipients by phone or letter DMA-9012, Important Information about your Medicaid or NC Health Choice, Primary Care Provider Disenrolls Recipient to explain the benefits of CCNC/CA and to allow the recipient to choose a new provider.

J. Temporary Exemptions

1. When a caseworker determines that a recipient needs to be temporarily exempt for a reason not included in the exempt code chart in VII. D., obtain approval to exempt from the DMA Managed Care section. Complete the CCNC/CA Enrollment Form, DMA-9006.

(VIII.J.)

2. Have the recipient choose a medical home (PCP) and include the name and provider number on the form. If the recipient has not selected a PCP, put the name of the auto assigned PCP on the form.

3. Provide a detailed explanation for requesting the temporary exemption.

4. FAX the enrollment form to:

   Managed Care Section
   Division of Medical Assistance
   FAX: 1-919-715-5235

   If the county has a managed care representative (MCR), the State Managed Care Section has authorized the MCR to approve or deny the temporary exemption. If the county has a MCR, submit the enrollment form to the MCR.

5. DMA Managed Care will return the decision to the fax number provided. The decision will be marked “denied” or “approved” with an exempt code.

6. If approved, enter the assigned exempt code number.

7. If denied, enroll with the provider listed on the enrollment form.

IX. RECIPIENT EDUCATION

CCNC/CA provides medical homes with primary care providers who coordinate the health care of their enrollees. In doing so, it is essential that the applicant/recipient receives education on how to appropriately access his medical provider. The recipient must be advised to make an appointment with his PCP as soon as possible so that he can establish a relationship with that PCP. If a recipient is not established, the PCP can refuse to refer or authorize him to be seen by another provider. This could result in the recipient being responsible for the medical bill. Recipients should not wait until they are sick or injured to make an appointment to become established with their PCP.

At application, redetermination or any time a recipient contacts the agency regarding CCNC/CA, educate him on the following topics.

A. **Explain the benefits of a medical home: CCNC/CA provides the recipients with a primary care doctor who manages care for continuity and ensures services are provided that are medically necessary. The recipient can receive immunizations, checkups, mammograms, physicals, cholesterol and diabetic screenings.**

(IX.)

B. Explain that the name of the medical home, along with the address and telephone number, will appear on the recipient's Medicaid card or be provided to the NCHC recipient on a notice which will be mailed.

C. Explain that the PCP provides medical advice 24 hours a day, 7 days per week. The number to call after the office closes is listed on the Medicaid card and the NCHC notice.

D. Instruct the recipient to take his Identification card when seeking any medical service.

E. Instruct the recipient to call the Primary Care Provider (PCP) before going to any other doctor.

F. Explain to the a/r there is no need to go to the emergency room unless he thinks the medical problem threatens his life or risks his health without immediate attention (or if pregnant, the life of the unborn child).

G. Instruct the recipient to call 911 when he feels his life or health is in immediate danger.

H. Explain that it is necessary to get the PCP's approval before seeking specialty care. If he does not get approval, he may be responsible for the medical bill.

I. Explain to the recipient he must go to his PCP for regular preventive care such as, immunizations, checkups, mammograms, physicals and cholesterol and diabetic screening.

J. Explain to the recipient that some services do not need PCP approval such as dental or mental health services. The CCNC/CA handbook has a complete list of exempt services.

K. Explain to the recipient that he may change providers by contacting his caseworker at the department of social services.

L. Explain the rights and responsibilities as a member.

M. Explain the restrictions on the number of visits for Medicaid recipients.

N. Review the Benefits of Being a Member (DMA-9016- Medicaid, or DMA-9017- NCHC).

O. Answer recipient questions about CCNC/CA policies.

X. INFORMATION AND REFERRAL RESPONSIBILITY

The county DSS is not responsible for resolving recipient complaints, billing or claims issues, overrides, provider recruitment or enrollment. The county is responsible for referring all inquiries or concerns from providers and recipients to the appropriate place. Please use the following guide.

A. Complaints

1. The complaint process is an important component of CCNC/CA. It ensures providers are meeting their contractual obligations and that enrollees have access to appropriate and timely medical care. There are four categories of recipient complaints:

    a. Quality of Care Complaints -This category includes complaints of substandard medical care or refusal to refer to a specialist issue.

    b. Professional Conduct -This category includes inappropriate behavior by the provider or office staff such as rudeness or verbal abusiveness as well as complaints alleging physical, sexual or substance abuse.

    c. Contract Violations - This category includes complaints related to appointment availability, telephone coverage after office hours, office wait times, hospital admitting privileges, and disenrollment issues.

    d. Program Fraud or Abuse - This includes inappropriate billing practices, maximizing reimbursement through coding, unauthorized use of a PCP referral number, and requesting cash payments from enrollees prior to billing Medicaid or NCHC.

2. When a CCNC/CA enrollee contacts the DSS regarding any of the above complaints, the employee receiving the call must:

    a. Ensure that the identifying information of both the enrollees and providers involved remains confidential.

    b. Explain to the enrollee that he must register his complaint in writing to the Division of Medical Assistance (DMA).

    c. Give or mail the enrollee the CCNC/CA Complaint Form and Complaint Form Instructions, DMA 9001. Ask him to read the instructions carefully and complete and sign the form and mail to the address on the form. Also provide the CCNC/CA toll free number 888/245-0179.

(X.A.2)

d. The Managed Care Section at DMA is responsible for all research, tracking, and follow-up.

e. If additional information is required from the county record, the Managed Care section will contact the CCNC/CA contact person.

B. Overrides

Overrides are authorization numbers issued by HP that allow providers to receive reimbursement for medical services when unusual circumstances warrant. Overrides may be granted due to worker error or any exceptional medical situation, program malfunctions, or extenuating circumstances beyond the control of the responsible parties.

1. When a provider contacts the DSS requesting an override for a past date of service, the employee receiving the call must:

   a. Advise the provider he must complete the CCNC/CA Override Request form and submit it to HP if a denial for EOB 270 or 286 or the Primary Care Provider has been contacted and has refused to authorize treatment for past service. The request must be submitted within six months of the date of service. The Override Request form can be accessed at DMA's web page at http://www.ncdhhs.gov/dma/medicaid/index.htm

   b. HP either approves or denies the override request and telephones or faxes the provider the decision.

   c. If a change in the provider number or exempt status is required, this information is relayed to the CCNC/CA contact to key in EIS for the ongoing month.

2. When a recipient contacts the DSS to request an override, instruct the recipient to contact the provider to request the override. **ONLY A PROVIDER MAY REQUEST AN OVERRIDE.**

3. HP (formerly EDS) generates a monthly Override Report. The Managed Care Section monitors this report.

   a. When overrides due to worker error are excessive, the Managed Care Section will relay this information to the MPR supervisor.

   b. The MPR will work with counties on an individual basis for corrective action.

(X.)

C. General CCNC/CA Provider Inquiries

If a provider contacts DSS, make the following referrals:

QUESTION	REFERRAL
Verify Medicaid and NCHC eligibility	HP Automated Voice Response (AVR) 800-723-4337
Billing inquiries, claim resolution, or override requests	HP Provider Services 800-688-6696
Recruitment	Community Care Consultant 888/245-0179
Provider education, training, workshops	Community Care Consultant 888/245-0179or HP 800-688-6696
Provider Enrollment and Changes in PCP Agreement	CSC (Computer Sciences Corporation) 866-844-1113.
Health Check Questions	Community Care Consultant 888/245-0179
Questions regarding CCNC/CA	Community Care Consultant 888/245-0179
ER Management Report	HP Provider Services 800-688-6696

D. CCNC/CA Recipient Inquiries

1. If a recipient contacts the DSS regarding a general Medicaid question or issue relating to CCNC/CA education or enrollment, refer the recipient to his IMC. The IMC (and supervisor, if necessary) will make every attempt to answer CCNC/CA questions or resolve issues relating to education and enrollment. For CCNC/CA questions outside the scope of education and enrollment which the IMC cannot answer, refer the recipient to the Managed Care Customer Service 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 CARE-LINE, Information and Referral Service number at 1-(800) 662-7030 or if in the Triangle area, call (919) 733-4851.

2. If a CCNC/CA enrollee contacts the DSS regarding a North Carolina Health Choice question on medical or provider services that cannot be resolved by the IMC or supervisor, refer the recipient to DMA at 919-855-4000.

(X.)

E. CCNC/CA Forms

1. The DMA-9006, CCNC/CA Enrollment Form, DMA-9002, CCNC/CA Medical Exemption Request, and the DMA-9001, Carolina Complaint, package (which is mandatory). Please make copies for your use.

2. EIS generates notices to all NCHC recipients who have been linked to a CCNC/CA provider, indicating the provider name along with the daytime and after hours phone numbers.

3. EIS generates notices to all NCHC recipients who have been linked to a CCNC/CA provider, indicating the provider name along with the daytime and after hours phone numbers.

4. EIS generates notices to all NCHC recipients who have changed their CCNC/CA provider, indicating the change and the new provider's information.

F. Instructions for Acquiring Material

1. PCP Directory – Forward the material to your CCNC/CA Contact or the person responsible for maintaining the directory.

2. CCNC/CA Reports – Follow your county's retention schedule for retaining reports.

3. SSI documentation – This should remain in the county. Consult with your supervisor about the best person to keep this documentation.

4. Provider complaint documentation – Send all records, notes, and forms to:

   Managed Care Section
   Division of Medical Assistance
   2501 Mail Service Center
   Raleigh, NC 27699-2501

   If you are currently investigating or following up with any contractual issues, forward this information to your Community Care Consultant.

5. Override requests – Shred this information based on your county's policy.

(X.F.)

6. Exempt Requests – The County must file this documentation regarding exempt request in the recipient's case record.

7. Provider Contracts and any other information related to providers – Shred according to your county policy.

8. CCNC/CA handbooks, per instructions on the DMA-2000a, contact 919-855-4160 to request.