Tailored Plan and North Carolina's Six LME/MCOs

Frequently Asked Questions for Physicians

1. **What is a Local Management Entity/Managed Care Organization (LME/MCO)?**
   LME/MCOs are local government organizations that operate as Prepaid Inpatient Health Plans (PIHPs) to manage whole-person health care services for Medicaid beneficiaries enrolled in Behavioral Health and Intellectual/Developmental Disability Tailored Plan.

   LME/MCOs also manage behavioral health, I/DD, and traumatic brain injury (TBI) services for Medicaid beneficiaries who were carved out of managed care and remain in NC Medicaid Direct. There are six LME/MCOs that each serve specific counties (see map). Member enrollment with each LME/MCO is based on the county of Medicaid eligibility (administrative county), not where the member resides or where the provider is located. For this reason, it is important to be in-network with all six LME/MCOs.

2. **What is a Tailored Plan and who is served by Tailored Plan in North Carolina?**
   The behavioral Health and I/DD Tailored Plan operates as managed care health plans. The transformation to Tailored Plan was authorized by the General Assembly and designed by NCDHHS to serve special Medicaid populations (outlined below). Tailored Plan manages physical health care, pharmacy benefits, behavioral health, I/DD and TBI services, long-term services and supports, and unmet healthcare-related resource needs as a single health plan. Expanding whole-person care is the driving force for better health outcomes for patients.

   Criteria established by the General Assembly and implemented by NCDHHS determine who is served by a Tailored Plan:

TAILORED PLAN ENROLLMENT CRITERIA

NC Medicaid will identify beneficiaries who qualify for a Tailored Plan based on programs, diagnoses, admissions or visits and services only available through the Tailored Plans.

PROGRAMS	TAILORED PLAN-ONLY SERVICES
• Innovations Waiver (or waiting list) • TBI Waiver (or waiting list) • Transition to Community Living (TCL)	• Have used a Medicaid service that will be available only through the Tailored Plan • Have used a mental health, substance use, I/DD or TBI service funded with state, local, federal or non-Medicaid funds
DIAGNOSES	**ADMISSIONS/VISITS**
• Children with complex needs • Qualifying I/DD diagnosis code • Qualifying mental illness or substance use disorder diagnosis code and used a Medicaid-covered enhanced behavioral health service during the lookback period* • Psychotic disorder (primary or secondary to a mood disorder), use of clozapine or a long-acting injectable antipsychotic medication, or receive electroconvulsive therapy (ECT) during the lookback period*	• Admission to a state psychiatric hospital or Alcohol and Drug Abuse Treatment Center (ADATC), including but not limited to individuals who have had one or more involuntary treatment episode in a State-owned facility • Two or more visits to the emergency department for a psychiatric problem; two or more psychiatric hospitalizations; or two or more episodes using behavioral health crisis services during the lookback period*

3. **How is my patient enrolled in Tailored Plan?**
Patients are auto-enrolled into Tailored Plan if they are currently eligible based on the criteria above. A provider or member may submit a Request to Move to LME/MCO to the NC Medicaid Enrollment Broker if a patient has used or needs services available only through an LME/MCO. NCDHHS will also identify those who need to move based on specific service utilization (e.g., multiple inpatient stays for behavioral health needs).

4. **How are claims paid in a Tailored Plan?**
Providers should submit claims to the patient's LME/MCO per the attached grid: "Paying Claims: The Process Across Plans." All LME/MCOs will pay for emergency and post-stabilization care services regardless of prior authorization or contracting status.

5. **Are prior authorizations required for services when Tailored Plan launches?**
At launch, LME/MCOs will honor existing and active Prior Authorizations for services and pharmacy for the first six months or the length of the authorization period, whichever is less. If a beneficiary transitions between health plans after Tailored Plan launch, a prior authorization from their original health plan will be honored for the life of the authorization by their new health plan. During the first 90 days of Tailored Plan, LME/MCOs may offer additional flexibilities to ensure continuity of care. All LME/MCOs will pay for emergency and post-stabilization care services regardless of prior authorization or contracting status.

6. **What if I'm not yet in-network for an LME/MCO but have a Tailored Plan member who wants to be seen?**
We encourage providers to continue to see these patients and, during the first 90 days of Tailored Plan, you will be paid at 100% of the Medicaid rate for covered services. If you remain out of network after 90 days, you will be reimbursed at 90% of the Medicaid rate (prior authorization may be required). File your claim directly with the applicable LME/MCO. Refer to "Paying Claims: The Process Across Plans" grid for more information.

7. **What is Tailored Care Management and who provides it?**
Tailored Care Management (TCM) is a new care management model. Eligible beneficiaries have a single designated care manager supported by a multidisciplinary team to provide integrated care management addressing the beneficiary's whole-person health needs. TCM may be provided by a Tailored Care Manager at an LME/MCO, an Advanced Medical Home Plus (AMH+) practice, or a Care Management Agency (CMA). If your patient chooses to opt out of this valuable service, their LME/MCO provides care coordination, a less intensive model of support.

8. **How do I participate in Tailored Plan provider networks?**
Providers who want to participate should contact the Tailored Plan directly to discuss the process and requirements. Each Tailored Plan will have its own provider contract templates and processes. All provider contract templates have been approved by NCDHHS and contain provisions required by NCDHHS.

- **Alliance Health**: ProviderNetwork@alliancehealthplan.org; 855-759-9700
- **Eastpointe**: networkoperations@eastpointe.net; 888-977-2160
- **Partners Health Management**: contracts@Partnersbhm.org; 877-964-1454 (choose option 4, option 2)
- **Sandhills Center**: providercontracts@sandhillscenter.org; 855-777-4652
- **Trillium Health Resources**: networkservicessupport@trilliumnc.org; 855-250-1539
- **Vaya Health**: provider.info@vayahealth.com Phone: 866-990-9712, (choose option 3)

	Alliance	Eastpointe	Partners	Sandhills	Trillium	Vaya
Submit Claims via:	Electronic: Alliance Claim System (ACS) - Alliance Health (alliancehealthplan.org) EDI Payer ID: 23071 Paper: (only with prior approval) 5200 W. Paramount Parkway, Suite 200, Morrisville, NC 27560	Electronic: Providers – Welcome to Eastpointe.net EDI file 837: Payer ID 08044 Paper: Eastpointe will only accept paper claims from Out-of-Network providers (OON). Eastpointe Claims Department PO BOX 14552 Lexington, KY 40512	Electronic: Provider Connect Paper: Electronic submission is preferred, an OON provider may also submit a paper claim by mail. Physical Health: P.O. Box 8002 Farmington, MO 63640-8002 Behavioral Health: 901 S New Hope Road Gastonia, NC 28054 **Payer ID:** Physical Health - Payer ID 68069 Behavioral Health - Payer ID 13141	Electronic: Change Healthcare EDI Payer ID 837I, 837P: SHC00 Submit paper, key in portal or 837's all through Change Healthcare	Electronic: BH electronic claims BH-IDD Provider Portal: https://www.ncinno.org/ PH electronic claims: PH Provider Portal: provider.trilliumhealthresources.org EDI: 837I, 837P (BH 56089 or 43071; PH 68069) Paper: Behavioral health and I/D: Trillium Health Resources PO Box 240909 Apple Valley, MN 55124 Physical health: Carolina Complete Health Attn: Claims PO Box 8040 Farmington, MO 63640-8040	Electronic: Vaya's Provider Portal Login Page - Provider Central at www.vayahealth.com EDI: 837I, 837P: AVS01 Paper: Vaya accepts paper claims for emergency and post-stabilization care Vaya Health, Attn: Claims Processing 200 Ridgefield Ct Suite 218 Asheville, NC 28806
Denials Notified by:	Within **18 calendar days** of receiving a clean claim	Within **18 calendar days** of receiving a clean claim	Within **18 calendar days** of receiving a clean claim	Within **18 calendar days** of receiving a clean claim	Within **18 calendar days** of receiving a clean claim	Within **18 calendar days** of receiving a clean claim
Submit Claims Dispute:	Providers may submit a claims dispute through certified US mail, or through email at Claimsreconsiderations@Alliancehealthplan.org	Provider Appeal Form Mail Eastpointe Director of Grievance and Appeals 450 Country Club Road Lumberton, NC 28360 Email: grievanceappeals@eastpointe.net	https://www.partnersbhm.org/tailoredplan/providers/appeals-submissions/ Mail: Partners Health Management 901 S. New Hope Rd., Gastonia NC 28054	Provider Appeal Form found in the Provider Support Portal Mail: Provider Network Grievance and Appeals Coordinator 3802 Robert Porcher Way Greensboro, NC 27410 Fax: 910-673-6202	Provider Direct Portal Mail: Trillium Health Resources Attn: Appeals Department 201 West First Street Greenville, NC 27858	Electronic: Provider Appeal Form Mail: Vaya Health Attn: Claims Reconsiderations 200 Ridgefield Ct. Suite 218 Asheville, NC 28806 Phone: 1-866-990-9712 or 828-258-3395 ext. 1600 Email: ClaimsReconsideration@vayahealth.com
Dispute Timing:	Submit within **30 days** of denial A decision will be made within **30 calendar days** of receipt of a complete appeal request	Submit within **30 days** of denial Eastpointe will provide a written **resolution** letter within **30 calendar days** of receipt of the grievance/complaint	Submit within **30 days** of denial Decision will be made within **30 calendar days** of the receipt of the standard appeal request.	Submit within **30 days** of denial Decision will be made within **30 days** from receipt of the Grievance and/or Appeal.	Submit within **30 days** of denial Grievances and complaints are resolved within **30 calendar days** of receipt	Submit within **30 days** of denial Grievances and complaints are resolved within **30 calendar days** of receipt
Prior Auth Services:	Providers will search by procedure code for prior authorization requirements. Details on Prior Authorization Submission Process will be posted here: https://www.alliancehealthplan.org/tp/providers/clinical-resources/	The provider will use the "Look-up Tool" located on our website. The provider enters the service code and the Tool will report if a PA request is needed (as well as a link to where the PA request can be submitted, if required). https://www.eptestitransact.com/HSP_HT/iTransact/Provider/AuthorizationLookup.aspx	Providers will consult Benefit Grids outlining service codes, service limits, level of care and documentation requirements needed for service authorization requests (SARs) located at: https://providers.partnersbhm.org/benefit-grids	There is a list of services that require prior authorization in the provider handbook and on the website. Right now we use a "master grid," which tells the PA requirements, but that will be re-worked for TP. https://www.sandhillscenter.org/for-providers/provider-forms	Trillium Health Resources Benefit Plan will include all services and which services need a prior authorization. The Benefit Plan will be available on Trillium's website at www.trilliumhealthresources.org under For Providers, Benefit Plans | Service Definitions	Providers can determine the services that require prior authorization by reviewing Vaya's authorization guidelines, available at the following link: https://providers.vayahealth.com/authorization-billing/authorization-info/authorization-guidelines/