2025 LTSS Forum Q&A Session: PCS
Answers provided and vetted by DHB 6/17/2025

Q. Are the PCS Front Porch chats still continuing? Are they just for NC Medicaid Direct beneficiaries or are they for members enrolled in managed care plans, too? If managed care plan enrollees are able to attend, can the managed care plans have representatives there?

> **A.** Yes, the Front Porch Chats are held quarterly. You can refer to the NCLIFTSS website for scheduled dates and times Events Calendar - PCS - North Carolina LIFTSS. The intended target is beneficiaries of NC Medicaid Direct State Plan PCS.

Q. Why does the process for Managed Care Disenrollment process seem to change from day to day? Some providers are getting letters from NCLIFTSS warning them of a change, some may get notified may case manager, other gets no information and find out when they are not paid.

> **A.** The managed care process does not change day to day but there can be extenuating circumstances in some situations. These cases need assistance from the Transitions of Care team who can work with the health plans on your behalf. Please email the Provider Ombudsman for any issues that may occur. Update: Retroactive Disenrollment from NC Medicaid Managed Care | NC Medicaid. Regarding notification when an individual transitions from Managed Care to Medicaid Direct and receiving LTSS services in Managed Care NCLIFTSS sends an email to the authorized contact email in NCTracks to notify the provider of the return to Medicaid Direct. NCLIFTSS only emails providers based on the Disenrollment form sent by the health plan to NCLIFTSS. If a form is not sent, no notification is emailed.

Q. When are PCS training courses held and how often? Can family members be hired as paid Caregivers? If no, why not? Can In Home Aides be trained by the Agency Nurse to provide PCS services if they are not certified professionals (CNA)?

> **A.** PCS Provider Webinars are held quarterly. You can refer to the NCLIFTSS website for scheduled dates and times. No, a federal regulatory is in place that prohibits a family member from providing personal care services to a relative. In home Aides can be trained by a Registered Nurse with the agency, although, a CNA must have a CNA must be trained by DHSR guidelines and requirements.

Q. How many audit flunkers get put in prepayment review it get PCG audits?

> **A.** The PCS Unit has just begun tracking patterns and trends of providers that are found not to be in compliance while conducting the DHB Internal audit actives so the numbers are unavailable at this time.

Q. Please explain in detail EPSDT service definition, and how does a potential client explain to the doctor how to document this request

> **A.** The process is the same for EPST as outlined in CCP 3L and 3L-1, requiring a DHB 3051 and during the review that hours are determined by the DHB RN consultant.

Q. Has the DHB team discussed using NCTracks or NC Medicaid Bulletins to notify PCS providers in advance of the internal audit mailings to improve participation? I understand that only a random sample will receive the actual mailing, but all provider administrators could be on notice and be on the lookout for and possibly more likely to open and respond to the mailing.

A. No, there have been no discussions of using either NCTracks or Medicaid Bulletins to communicate the DHB Internal audit at this time. However, we are reviewing the process and evaluating its efficiency in order to determine what, if any changes need to be made.

Q. If we still have a beneficiary that still has an outstanding assessment from 2023 should we have them go ahead and reach out to NCLIFTTS now?

A. Yes. If a beneficiary has an assessment that was delayed in 2023 and still has not been conducted reach out to NCLIFTSS.

Q. What are the plans to increase the PCS providers?

A. There is no identified plan to increase the number of PCS providers; however, there is no hinderance to becoming a new PCS provider. Provider Enrollment would be able to provider more guidance on that process.

Q. The 3085 is only required if a recipient has authorization for 130 hrs, correct? Not for authorization with 110 hrs?

A. The NC Medicaid 3085 is required for any provider that provides services to a beneficiary that receives over 80 hours a month. The form is to be uploaded only once via QiRePort along with the training curriculum used.

Q. Once the provider sends the information for an audit are we notified that we are compliant? Also, should I look for an Audit every quarter?

A. When conducting the DHB Internal Audits, at the conclusion of the audit, only providers that have been found non-compliant are notified. These audits are conducted quarterly and only 100 providers are selected each quarter.

Q. 1. Is there a way to avoid the authorization review issue that affected the June 1st billing? A few agencies noticed that billing was denied for 6/1/25 due to an authorization issue. Agencies had to request a PA even though the clients had authorization?
2. Is there a way for the agency and client to be notified when a client has switched from manage care to Medicaid direct
3. Is there a way to avoid retro dis enrollment because agencies are losing money?
4. If Medicaid is not willing to provide a pay increase, then is it possible to provide more hours for the client?
5. Will there be an opportunity for Medicaid to allow family members to care for the bene?

A. 1. For any identified billing issues and resolutions, please submit a ticket to Medicaid Managed Care Ombudsman so the issue can be assigned to the appropriate party to respond, research, and resolved. 2.The provider should check the EIS monthly as those changes occur starting the 1st of each month. 3.NC Medicaid in researching the best method in managing retroactive disenrollment.4. Increases in personal care hours must be approved by the general assembly as the currently approved hours are authorized through an old session law. 5.. No, a federal regulatory is in place that prohibits a family member from providing personal care services to a relative.

Q. Should providers submit tickets to the Medicaid Managed Care Provider Ombudsman even if the issue is about a member who is not enrolled in a managed care plan?

A. Yes. If they are Medicaid direct, you should submit a ticket through the Medicaid Managed Care Provider Ombudsman.

Q. How much of the decrease in the past due backlogs is due to backlogged cases transitioning to Tailored Plans in July, if any?

A. Approximately 4% of the 16632 backlogged assessments were transitioned to Tailored Plans on 7/1/2024.

Q. Retroactive dual eligibility- what can be done to make this process easier for providers? Crazy that provider has to jump hoops to get a backdated PA going back 2-3 years with Medicaid Direct, and MCO wants their money back.

A. Retroactive dual eligibility occurs when receipt of Medicare evidence submission is delayed. Providers who are serving Medicare eligible clients enrolled in a health plan should send an email to the Provider Ombudsman so Member Operations can correct the eligibility as soon as possible. There is not an expectation that the provider corrects this themselves. Providers should email all details listed in the bulletin for assistance Update: Retroactive Disenrollment from NC Medicaid Managed Care | NC Medicaid

Q. How long does an initial request for an assessment have to be incomplete before it is considered past due? (How many calendar days after receipt?)

A. According to CCP 3L and 3L-1, initial requests for assessment should be process within 2 days.

Q. Hello! Are the stakeholder engagement meetings intended to be inclusive of PHP's? If so, are these advertised with the PHP's or could they be? Thank you!

A. The PCS Provider Webinars are held quarterly, and you can refer to the NCLIFTSS websites scheduled dates and time. The information discussed during these meetings will only pertain to NC Medicaid State Plan PCS but PHPs are welcome to attend and hear the information shared.

Q. Why are Managed Care case managers not held more accountable to be more proactive in disenrollments? For example, watching for 65th birthdays, dual eligibility, etc.

A. Health plans do submit tickets when they become aware of dual eligibility. Providers are also expected to email the Ombudsman if the provider is aware a client has Medicare and is enrolled in Managed Care so the record can be corrected

Q. Why do pcs providers not send the plan of care as requested consistently? How would the state like health plans to enforce this?

A. Plans should, because they have adopted our policy, align with what Medicaid's Direct's guidance is regarding the Service Plans. If an agency fails to complete their service plan timely and/or the beneficiary is discharged, changes providers, or become deceased, NC Medicaid will not authorize retro PAs for the beneficiary as PAs are not released until the service plan has been completed and beneficiary/legal guardian consent is required for service plan approval.

Q. Will LTSS eligibility requirements change? Any changes with dual eligibles?

A. There will be no changes to eligibility requirements.