February 18 NCMT Hot Topics Fireside Chat

Q: None of my offices are listed with Healthy Blue or CCH? Are you going to delay mailing the "pick a plan" letters until the enrollment broker is correct?

A: Mailings will not be delayed. Enrollment Packets will begin mailing March 1, 2021.

Q: What can we tell patients if they state they cannot reach their Medicaid caseworker at DSS to change their PCP?

A: Beneficiaries can contact the NC Medicaid Contact Center to update their PCP.

Q: How do newborns get into a PHP plan? How does the parent know what plans the PCP takes?

A: Newborns will be auto enrolled in a health plan. Parents can use the Medicaid and NC Health Choice Provider and Health Plan Lookup Tool to see which health plans the PCP accepts or ask the PCP directly.

Q: Can practices please get blank enrollment forms so that we can assist patients in filling out and faxing it while they are in the office?

A: No, blank Enrollment Forms will not be provided to providers. Enrollment Forms are pre-populated and specific to each beneficiary regarding their choices.

Q: Will the local health departments (DSS) have a role in the enrollment of patients into PHPs?

A: No, local DSS offices will not provide choice counseling or enroll beneficiaries in health plans. DSS offices will refer beneficiaries to the Enrollment Broker.

Q: Will there be clear instructions for those members who are eligible for the Tailored Plan, to opt out of the plan selection process?

A: Yes, the language in the Transition Notice for beneficiaries who are eligible for Tailored Plans states that they will remain in NC Medicaid Direct unless they choose to enroll in a health plan. The notice also directs them to contact the Enrollment Broker for additional information.

Q: Do you mean Health Choice as well? You keep talking about Medicaid. How will we know if the patient has health choice or Medicaid?

A: There are two methods of Recipient Eligibility Verification available via the NCTracks Secure Provider Portal: Real Time Eligibility Verification and Batch Eligibility Verification. As a reminder, these methods can be used for current eligibility information – future eligibility information is not available at this time. Additional information is included in the NCTracks Learning Management System (SkillPort) under the Provider Training Folder, CBTs, Recipient, RCP 131 Viewing Recipient Information Eligibility Providers.

Q: Are the enrollment forms that will be mailed to beneficiaries pre-populated with their information?

A: Yes, Enrollment Forms are pre-populated for beneficiaries who must enroll in a health plan. Enrollment Forms are not pre-populated for exempt beneficiaries.

Q: With enrollment packets, will the beneficiary get current PCP, so it is easy for them to choose?

A: Beneficiaries will choose a PCP during open enrollment. If they want to keep their current provider as their PCP, they can choose a health plan that the PCP is contracted with.

Q: If a member changes PHPs without cause, will they receive the additional benefits from each PHP they enroll in (cell phone, wellness, etc.)

A: Members are only eligible for services and additional benefits by the health plan they are enrolled in.

Q: When the member calls to change their provider, is the change instant where the patient can be seen by the practice that day or does it require a 30-transfer process where the member must wait for approval.

A: NC Medicaid will only allow PCP changes for the 1st of the following month following the change. Health plans may work with members through their own systems/policies to allow the member to see new providers before the PCP becomes official on the first of the following month. However, NC Medicaid will not allow for mid-month PCP changes.

Q: I thought that newborns up until age 18 years of age, are not being enrolled into the managed care HMO? Please advise.

A: Beneficiaries of any age will be enrolled in Managed Care depending on their Managed Care status.

Q: Do patients need to make sure that their PCP/specialist and hospital are all within their plan they select?

A: Yes, if the beneficiary wants to keep their current provider or specialist as their PCP, they should choose a health plan that they are contracted with. The Enrollment Broker can provide further assistance if the beneficiary has questions.

Q: Can practices please get blank enrollment forms so that we can assist patients in filling out and faxing it while they are in the office? We have lot of grandparents that are guardians for younger children that are unable to do technology.

A: No, blank Enrollment Forms will not be provided to providers. Enrollment Forms are pre-populated and specific to each beneficiary regarding their choices.

Q: Can the PCP change forms Angel Murray mentioned be used after 7-1 too?

A: The current PCP Enrollment Form can only be used for NC Medicaid Direct after July 1, 2021.

Q: If a PHP I am signed up with is not listed on the provider look up website, can they pick a PHP not listed? Or do they have to pick from the listed PHPs no matter what I tell them

A: For beneficiaries to choose a specific provider as their PCP, the PCP must be contracted with a health plan. Beneficiaries can search by provider name to choose a health plan.

Q: Under the enrollment packets - Do you have the flyer like you had last year so that I can post in office.

A: Enrollment Packet materials can be found on the County Playbook here: https://medicaid.ncdhhs.gov/counties/county-playbook-medicaid-managed-care/beneficiary-notices

Q: I presume you are mailing information to recipients? What about returned mail for people that are moving?

A: Returned mail will be collected by the Enrollment Broker and shared with NC Medicaid. It is important that beneficiaries contact their Medicaid caseworker to update their address in NC FAST.

Q: If a patient completes the enrollment form with the Practice name not the actual name of the PCP in the practice will that work?

A: The Enrollment Broker will call the beneficiary directly if additional information is needed.

Q: So, what is DSS's role in Medicaid Transformation? Just the selection of the PCP?

A: DSS does not provide choice counseling or enrollment assistance. DSS will refer to beneficiaries to the Enrollment Broker for assistance.

Q: What about when PCPs are open on the weekend and the patient has the wrong name on the card-how does that get fixed so we can see the patient that day? And holidays (since we are open when insurance companies are not)

A: Providers can pull patient information from NCTracks to verify that the patient is assigned to them. Providers can call the health plan directly.

Q: If the Provider no longer wants to continue seeing this patient who is responsible for getting this patient changed.

A: The health plan is responsible for assigning the member to a new PCP.

Q: If a patient sees a practice within an organization with multiple sites, what should they enter on the enrollment form when asked Provider name (Provider's name, specific practice name, or main organization name)?

A: Beneficiaries should include the provider's first and last name.

Q: How will providers know if the patient has Healthchoice or has Medicaid? This is important in the regards to Private versus VFC vaccine.

A: There are two methods of Recipient Eligibility Verification available via the NCTracks Secure Provider Portal: Real Time Eligibility Verification and Batch Eligibility Verification. As a reminder, these methods can be used for current eligibility information – future eligibility information is not available at this time. Additional information is included in the NCTracks Learning Management System (SkillPort) under the Provider Training Folder, CBTs, Recipient, RCP 131 Viewing Recipient Information Eligibility Providers.

Q: In terms of educating patients on provider selection, what are the guidelines on talking points with our patients - sounds as though we are not to encourage our patients to continue care with current practice (i.e. let them know we would like them to continue with us)? Could you clarify how to best manage this process or respond to patient questions.

A: The Enrollment Broker has been contracted to provide unbiased, third-party support to the beneficiary community. If your patients have questions, you should be directing them to the Enrollment Broker for assistance.

Q: When there are multiple siblings in the family, does the member have to choose a PHP for each child or will all be enrolled into the same one?

A: No, siblings do not have to be enrolled in the same health plan.

Q: When will the PHPs have access and be pulling their credentialing and provider information from NC Tracks?

A: This is live today - the health plans receive daily provider data files from the Department.

Q: Can we use the "alternate location" section to enter specific provider addresses? Will that allow them to populate under locations in a provider search?

A: No, The EB will allow you to enter city, zip, and county, however you must still enter the name of the org or provider in the search area. Under Provider name or Organization name.

Q: Within the provider search tool, will the provider be listed by Affiliated Locations or Primary Service Locations?

A: Provider information displayed in the Tool is sourced from the provider NCTracks record and supplemented with health plan contract data from the provider affiliation file.

Q: I have a midwife affiliated w/ my facility. I accessed my Certified Midwife's Medicaid enrollment to do a Managed Change request to update her hours of operation. However, the application is requiring me to add DEA information for her. She is indicating that she does NOT have a DEA. What do I do?

A: Non-subscribers will not have a DEA License. The Provider Permission Matrix set the standards for enrollment, and those requirements are set forth by clinical Policy, if a provider is not writing or dispensing medication then they will not be required to submit a DEA license. Currently the Provider Permission Matrix list the following requirements as it relates to taxonomy 367A00000X Advance Practice Midwife / Nurse Midwife to participate in NC Medicaid as an instate, border or out of state providers states a DEA license is required. Will the system allow this to be bypassed if the provider does not have one? Yes.

Q: There is some questions regarding how the information will be listed for providers with service location vs affiliation. Many providers only have one location listed as a service location but are then affiliated to lots of locations. We need clarification re: if a specialist (not a PCP) must list all service locations on the individual provider record or is the affiliation to the group all that is needed?

A: Provider information displayed in the Tool is sourced from the provider NCTracks record and supplemented with health plan contract data from the provider affiliation file

Q: On Tuesdays webinar for Directory demo, it was stated that updating rosters with PHPs doesn't impact what is showing on the Directory and that its completely driven by NCTracks. Was that incorrect? It sounds like it's a mix of NC Tracks plus PHP provider rosters updates.

A: In the Directory demo, it was stated that provider information displayed in the Tool is sourced from the provider NCTracks record and supplemented with health plan contract data. Although it is important to keep contracted health plans current on changes to information in their agreement, the

only provider directory information sourced from the health plan is the managed care status (i.e. PCP, AMH, OTHR, NEMT). For an affiliation provider change to be reflected in the Medicaid and NC Health Choice Provider and Health Plan Lookup Tool when an organization's roster of affiliated providers change, a Manage Change Request (MCR) must be submitted for the NCTracks individual provider record to report the change under the individual to organization affiliations.

Q: Will the reports be made available again in the future - quarterly or yearly?

A: The reports are updated at least weekly; they are located here: https://medicaid.ncdhhs.gov/providers/provider-playbook-medicaid-managed-care/trending-topics

Q: What if we have multiple locations and providers, though they have a primary location, may provide services at other locations from time to time. Would clients be assigned to these providers at these other locations since they are listed in NC tracks with these addresses?

A: A beneficiary must first select or be assigned to a Health Plan. The beneficiary does not need to select multiple locations. The beneficiary shall select an AMH PCP Practice with which the individual provider is affiliated.

Q: Will the member secure tool have the same data as the current public facing tool?

A: No, the secure tool lists only primary care providers that will be selectable by members after members select their Health Plan.

Q: When I look in the Provider Directory sometimes physicians are listed with their name, sometimes with physician name and practice name. I would like our physicians to have their name and the practice name. How do we make that happen?

A: Provider information displayed in the Tool is sourced from the provider NCTracks record and supplemented with health plan contract data. To ensure that accurate information is displayed, please review the NCTracks provider record, and make any necessary updates using the Manage Change Request (MCR) process. Also, confirm that the information given to health plans during contracting is up to date.

Q: We have a provider who works on a prn basis in a local urgent care. In the provider directory she is listed in all these UC locations + our practice. Should we be educating our patients with Medicaid to pick her and our practice location when they choose her as a PCP in our practice?

A: A beneficiary must first select or be assigned to a Health Plan. The beneficiary does not need to select multiple locations. The beneficiary shall select an AMH PCP Practice with which the individual provider is affiliated.

Q: We have been given conflicting information on this subject. Which addresses will appear in the Directory for an Individual Provider at the "Provider-Level Search" - - - the active SERVICE locations OR the AFFILIATED locations on that Provider's record?

A: Provider information displayed in the Tool is sourced from the provider NCTracks record and supplemented with health plan contract data from the provider affiliation file

Q: Will PHPs list the group practice in directory? As of now only individual providers are showing but beneficiary usually look up the practice not the individual providers. Please consider adding group practices!

A: Organization can be searched along with Provider and Plan

Q: When you search for a practice in the Provider Search Tool and select "show providers" the Provider names are listed but NOT their professional designation. We have PA's, PNP's, MD's, DO's in our practice. Shouldn't our professional designation be attached to our names?

A: The information is derived from NCTracks which recognizes a provider's taxonomy code which is reflective of a provider's professional designation. If the professional designation is incorrect, the provider should submit an MCR to modify their taxonomy. Note: This will cause the MCR to go through the credentialing process. (For organizations, the specialty is dependent on the specialty of the individual affiliated providers).

Q: We are consolidated agency (LHD and DSS) and the provider directory lists DSS and corporate addresses as locations. Should we have this corrected?

A: If a user identifies issues with search functions displaying unexpected results, they are encouraged to first, check to make sure their information is correct in NCTracks. Second, if health plan affiliations are incorrect, if you are in a CIN, check with your CIN. If not a provider with a CIN, check with the PHP you believe you are contracted with. Third, if those sources have the correct information but your still appears to be incorrect in the Directory use the "Report an Error" link in the top right corner on any page of the Lookup Tool.

Q: We have received conflicting information re: if locations must be added in the service location section vs just being affiliated. We are a large health plan and need to ensure the information is correct on our providers.

A: Provider information displayed in the Tool is sourced from the provider NCTracks record and supplemented with health plan contract data. To ensure that accurate information is displayed, please review the NCTracks provider record, and make any necessary updates using the Manage Change Request (MCR) process. Also, confirm that the information given to health plans during contracting is up to date.

Q: How do groups remove providers no longer affiliated with the group if the group does not have access to that providers NCTracks application to end date the affiliation?

A: If provider/organization information in the online directory is out-of-date or inaccurate, the provider's Office Administrator should complete a Manage Change Request (MCR) in NCTracks to correct it (inclusive of updates to demographic information).

If the Provider Affiliation information is incorrect, the Office Administrator for the affiliated provider must update the group affiliation on the individual provider's record.

Any information that is updated on an Organization or Individual NCTracks Provider Record will be reflected in the provider directory after the NCTracks MCR is complete.

Q: What happens if you look up for your providers, one shows just two plans, Medicaid direct and WellCare and the other shows Medicaid direct, Americartras, United, and WellCare. Then you search by Organization and it shows Healthyblue, Medicaid direct, United, WellCare, Americartras, But the providers signed the same contracts, one has Two plans but the other shows more,

A: If a user continues to identify issues with search functions displaying unexpected results, users are encouraged to use the "Report an Error" link in the top right corner on any page of the Lookup Tool. These errors will be reviewed by the Provider Operations Team who will respond to the user's feedback.

If the unexpected results are related to the Health Plan Accepted information, the Department encourages providers to work with their health plans directly to remediate these discrepancies. If the discrepancies continue, then the Department encourages providers to reach out to the Provider Ombudsman. These types of inquiries, concerns or complaints can be submitted to Medicaid.ProviderOmbudsman@dhhs.nc.gov, or received through the Provider Ombudsman line at 919-527-6666. The Provider Ombudsman contact information is also published in each health plan's provider manual.

Q: The example used for alternate locations was multiple locations in 1 county. Our practice has 1 address and 50 providers that provide services in the patient homes in 12 counties. This is our concern for accurate listings of service locations. How can we assure that the information in NC Tracks will reflect this?

A: If provider/organization information in the online directory is out-of-date or inaccurate, the provider's Office Administrator should complete a Manage Change Request (MCR) in NCTracks to correct it (inclusive of updates to demographic information).

If the Provider Affiliation information is incorrect, the Office Administrator for the affiliated provider must update the group affiliation on the individual provider's record.

Any information that is updated on an Organization or Individual NCTracks Provider Record will be reflected in the provider directory after the NCTracks MCR is complete.

Q: When you do provider search by planin blue E plan when you search a pediatric provided in Halifax county, no provider is there, where I know that we already have executed contract with blue E

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Q: I am noticing that my locations are being listed by the legal entity name and not our DBA name in the provider directory. How can we be listed by our DBA and not our legal entity name since our patients know us by our DBA and not the legal entity under which we are contracted with a PHP.

A: The ability to search by DBA Name was deployed to production in mid-February - please try using this functionality again. Provider information displayed in the Tool is sourced from the provider NCTracks record and supplemented with health plan contract data. To ensure that accurate information is displayed, please review the NCTracks provider record, and make any necessary updates using the Manage Change Request (MCR) process. Also, confirm that the information given to health plans during contracting is up to date.

Q: Why does the PHP have to provide provider level data when those affiliations are already in NCTracks? This is different than earlier guidance that the PHPs could not ask the provider for any additional information.

A: Individual provider affiliation to an organization is captured and stored in NCTracks. The Enrollment Broker receives provider affiliation data from NCTracks. Providers may report concerns to the DHB Provider Ombudsman at 919.527.6666.

Q: But there is a high chance (currently) that the provider directory is wrong, and then the member is getting inaccurate information to make that choice.

A: Provider information displayed in the Tool is sourced from the provider NCTracks record and supplemented with health plan contract data. To ensure that accurate information is displayed, please review the NCTracks provider record, and make any necessary updates using the Manage Change Request (MCR) process. Also, confirm that the information given to health plans during contracting is up to date.

Q: We have been trying to correct our Provider lookup information for weeks, how do we go about doing this?

A: If a user continues to identify issues with search functions displaying unexpected results, users are encouraged to use the “Report an Error” link in the top right corner on any page of the Lookup Tool. These errors will be reviewed by the Provider Operations Team who will respond to the user’s feedback.

If the unexpected results are related to the Health Plan Accepted information, the Department encourages providers to work with their health plans directly to remediate these discrepancies. If the discrepancies continue, then the Department encourages providers to reach out to the Provider Ombudsman. These types of inquiries, concerns or complaints can be submitted to Medicaid.ProviderOmbudsman@dhhs.nc.gov, or received through the Provider Ombudsman line at 919-527-6666. The Provider Ombudsman contact information is also published in each health plan’s provider manual.

Q: DHB/DHHS initially said that the PHPs could not ask providers for any additional information, they should use NCTracks information solely. Has this changed?

A: The Department's policy is that a PHP may not request any additional information which would be used in credentialing a provider because the PHP must accept the Department's credentialing of a

provider through enrollment as a Medicaid provider. However, this does not prevent a PHP from asking for other information necessary for business purposes such as panel size, whether the panel is open, the hours of operations, etc. and how to set up payment, like EFT information.

Q: We have a termination policy for multiple missed appointments for ALL pts. Can we continue to "eliminate" pts who are noncompliant or for conduct reasons? If not, what is our recourse for managing these patients?

A: Health plans have processes in place for non-responsive patients.

Q: How will unanswered questions be addressed?

A: The unanswered questions will be addressed offline after the webinar and will then be posted on the website here https://www.ncahec.net/medicaid-managed-care/

Q: Are the Q&A to these chats posted anywhere?

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Q: How do we get a patient who we have never seen before removed from the panel even after doing the outreach? How can we remove non-compliant or age- inappropriate patients??

A: For FFS:

Beneficiaries should go to their DSS income maintenance caseworker (IMC) to change their CCNC practice. Beneficiaries can also call DHB Call Center to change their assigned CCNC practice; Beneficiaries may be directed to the DHB Call Center for assistance if their DSS IMC is unresponsive to requests to change their CCNC practice.

For Managed Care

Below are the different ways beneficiaries can change their PCP/AMH:

• Beneficiaries can select a PCP/AMH at application, recertification, or through choice counseling with the Enrollment

Broker when they select a health plan.

• Beneficiaries can contact their health plan to change their PCP/AMH. Contact information can be found in the

Member Handbook on the Health Plan Contacts and Resources Page.

• Beneficiaries can change their PCP/AMH through the Enrollment Broker if they are also changing or selecting a

health plan.

Q: Given that people can be assigned to a practice when they can't get scheduled with their existing PCP, how will continuity of care issues be managed? What incentives/consequences will there be for

PCPs that are not able to see their own patients in a reasonable length of time, thereby disrupting their patients' continuity of care?

A: PHPs will be receiving 24 months of claims history which will be shared with AMH Tier 3

Q: Will there be a coordinated effort led by the state to help make the transition from the current mobile crisis access points to the access points at the standard plans. As a crisis provider we have started reaching out to standard plans but have seen nothing publicly as to how this process will work.

A: PHP are required to have a BH crisis line. All but one of the PHP are using LME MCOs to work these lines. Healthy Blue is staffing their BH Crisis line themselves. PHPs are required to contract with Mobile Crisis Management providers and ensure network capacity/adequacy. The providers should work with the individual PHP on the process and individual contract provisions

Q: And our practice allows free movement amongst the three offices for access improvement. If enrolled with one office and seen at another, is that an issue?

A: Currently beneficiaries are assigned at the NPI and Location level. This will continue to be the case in Managed Care. However, Primary Care Services can be rendered at other locations that are also in Network for the PHP.

Q: Aren't all these PHPs changes going to totally mess up all the quality metrics?

A: The quality measures, unless a custom measure, will continue to utilize technical specifications by the national measure steward and will use the same data sources to collect data as is currently in practice. For example, a HEDIS (NCQA measure) still requires the same source and collection method of data (claims, eCQMs) to produce the rate but the Health Plans will be accountable for collecting the majority of the measures and reporting to NC Medicaid. Please refer to the Quality Strategy and NC Medicaid Technical Specifications for specific measure information.

Q: If a patient changes PCPs "'for cause" and then change their minds, are they prevented from choosing that PCP again?

A: Beneficiaries will have 30 days from the receipt of notification of their AMH/PCP assignment to change their AMH/ PCP without cause. Beneficiaries will also have 30 days to change their AMH or PCP without cause after their initial AMH/PCP visit, and up to one additional time every 12 months. Beneficiaries may change their AMH or PCP with cause at any time. Beneficiaries may contact the Enrollment Borker to initiate a change in the AMH/PCP.

Q: So if you have a patient who had blatantly been noncompliant with your policies and have signed they understand that noncompliance may result in discharge and you notify them and discharge them. How can you get them off your panel if the patient won't select a new PCP?

A: For FFS:

Beneficiaries should go to their DSS income maintenance caseworker (IMC) to change their CCNC practice. Beneficiaries can also call DHB Call Center to change their assigned CCNC practice; Beneficiaries may be directed to the DHB Call Center for assistance if their DSS IMC is unresponsive to requests to change their CCNC practice.

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health plan.

Q: Will DHHS or anyone else provide any training for the 5 PHP's regarding behavioral health issues? It does not appear that they have a deep understanding of behavioral health issues that they will be managing. Thanks.

A: The PHPs have been trained on all services to be covered by as part of Medicaid Managed Care including behavioral health. Additionally, we continue to assess their staff readiness through a series of readiness reviews and interviews to validate their understanding of the NC Medicaid program. We appreciate the feedback and will continue to work with our PHPs to ensure they have a clear understanding of services covered by Standard Plans and Tailored Plans.