

## **March 18 NCMT Hot Topics Fireside Chat**

### **What Ifs**

**Q: I have a small practice and many of my patients have Medicaid. If I don't get paid in a normal speed, I won't make payroll. How can I make sure I get paid right away?**

A: Health plans are subject to a prompt payment provision for payment of medical and pharmacy claims regardless of whether the provider is a participating or non-participating provider. If the health plan fails to meet the prompt payment time period, then the health plan must pay interest and a penalty to the provider.

**Q: What if I can't get the Provider Ombudsman to change my information in the provider directory tool to correctly reflect the health plans that I am contracted with?**

A: The Provider Ombudsman should be used to escalate issues or concerns that have already been addressed with your CIN or health plan, and those attempts to resolve are unsuccessful. The ombudsman would liaison the issue, if it comes in via the ombudsman line or email, and we will reach out to the CIN/health plan to ensure closure on items that are reported to the ombudsman.

**Q: What if a clinic has smaller satellite sites that don't meet Tier 3 after hours coverage?**

A: In order to be a Tier 3, a practice needs to meet Carolina Access 2 standard--which include access standards. If it is not reasonable for the satellite site to have those hours, then it would make sense to transition member assignment to the primary site that meets CA 2/AMH 3 standards. The patient can still be seen at any satellite site.

**Q: What if I see someone who is on a plan I don't accept? Will I still get paid?**

A: Yes. The health plans' collective goal will be to develop a robust network of providers. If, however, at MCL, a member's provider is OON with the member's health plan, authorizations and payment will be managed under the same criteria as in-network providers for the first 60 days or until the episode of care concludes, whichever is less. Additional OON safeguards exist for beneficiaries experiencing an ongoing special condition or are undergoing an ongoing course of treatment.

**Q: What if a patient is dismissed from a practice, will the patient still be assigned to that practice?**

A: We understand that practices do have protocols for dismissing patients. We suggest that they work with their health plans on patients who are still assigned that the practice wishes to dismiss. We encourage practices to use care management support to help patients with barriers to care. The health plan can also help manage patients with barriers.

**Q: What if my patient enrolled in a plan I don't contract with? How long will it take after they call to change their plan?**

A: A plan change is effective the first of the month following the beneficiary's request. However, a member may not be able to change plans after the 90-day choice period unless they have an approved reason - with cause.

**Q: What if I do all the right things and see the right patients and I still don't get paid?**

A: Review health plan contract, provider manual and other materials on how to appeal when a claim is not paid; follow process for dispute resolution as specific in contract with health plan, and if still not resolved then could contact the Provider Ombudsman for further assistance.

**Q: What if I have a technology-dependent child and the managed care plan denies request for durable medical equipment (DME) they currently have? What if the home care agency has not contracted with their plan?**

A: To note, many technology dependent children will not transition to the Standard Plan option, as they may be a part of carved out eligibility groups. For those who do, the health plan contract requires the health plans to “Furnish covered benefits in an amount, duration and scope no less than the amount, duration, and scope for the same services furnished to beneficiaries under the Medicaid Fee-for-Service program (42 C.F.R. § 438.210(a)(2))” and to “Ensure that services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished 42 C.F.R. § 438.210(a)(3)(i)”. This means health plans cannot adopt more stringent/restrictive UM policy than what is currently authorized under Clinical Coverage Policy and must adhere to the medical necessity standard when reviewing any authorization request. At MCL, health plans must continue services authorized under fee-for-service/Medicaid Direct for the first 90 days after MCL or until the authorization expires, whichever occurs first. If reassessed at 90 days and member is determined to no longer meet medical necessity, health plan must issue appeal rights. To note, many technology dependent children will not transition to the Standard Plan option, as they may be a part of carved out eligibility groups. For those who do, the health plan contract requires the health plans to “Furnish covered benefits in an amount, duration and scope no less than the amount, duration, and scope for the same services furnished to beneficiaries under the Medicaid Fee-for-Service program (42 C.F.R. § 438.210(a)(2))” and to “Ensure that services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished 42 C.F.R. § 438.210(a)(3)(i)”. This means health plans cannot adopt more stringent/restrictive UM policy than what is currently authorized under Clinical Coverage Policy and must adhere to the medical necessity standard when reviewing any authorization request. At MCL, health plans must continue services authorized under fee-for-service/Medicaid Direct for the first 90 days after MCL or until the authorization expires, whichever occurs first. If reassessed at 90 days and member is determined to no longer meet medical necessity, health plan must issue appeal rights.

Re: Home Care part of question: It’s also important to note that while the goal is to bring providers into the health plan network, that health plans are required to pay claims and authorize services for Medicaid eligible OON providers equal to that of in-network providers for the for the first 60 days or until the episode of care concludes, whichever occurs first. Additional transitional period safeguards exist for members with an ongoing special condition or undergoing an ongoing course of treatment who are utilizing OON providers at the transition.

**Q: What if a patient on a standard plan moves into Foster Care? What if they move to a new county overnight and are moved without their medicines?**

A: The State Team, in collaboration with health plans and Foster Care stakeholders are finalizing TOC disenrollment protocols to support the seamless transition between Standard Plan and Medicaid Direct. When a child is taken into custody, the health plan will identify this child as a priority member for care

management if not previously identified. The disenrollment protocols will also establish clear, after hours "one call" option for DSS case workers to contact the health plan and to receive support in coordinating urgent care needs.

**Q: How many times can a person change their plan in the first 60 days? How about their PCP?**

A: A beneficiary can change plan selection as many times as they wish during the 90-day choice period. The 90 days begins with the effective date of their assigned/chosen plan. For individuals who are part of the transition to managed care effective 7/1/21, they have until 9/30/21 to change plans for any reason.

**Q: What if there is not a pediatric specialist in my community that my patient needs, and the plan wants to send my patient to an adult provider?**

A: Health plans are required to have networks that are sufficient to ensure that all services covered under the Contract are available and accessible to all Members in a timely manner. Further, health plans must demonstrate that their networks meet the time and distance standards for pediatric specialists specifically. A health plan must timely cover services on an out-of-network basis for a member if the health plan's network is unable to provide the covered services a timely basis.

**Q: What if my patient sees a specialist, and has for a long time, that does not take their new plan? Do I have to find them a new specialist? Can they see them out of network?**

A: Yes. The health plans' collective goal will be to develop a robust network of providers. If, however, at MCL, a member's provider is OON with the member's health plan, authorizations and payment will be managed under the same criteria as in-network providers for the first 60 days or until the episode of care concludes, whichever is less. Additional OON safeguards exist for beneficiaries experiencing an ongoing special condition or are undergoing an ongoing course of treatment.

**Q: What if a patient switches plan but has continuous enrollment? How do I manage quality performance?**

A: Medicaid will use continuous enrollment guidelines as defined by the measure steward (HEDIS) to determine attribution to the overall Medicaid program, the Health Plan and the AMH practice.

**Q: What if a patient is not continuously enrolled in a Medicaid plan? What happens to their quality data when they are on and off Medicaid?**

A: Good question. Currently Medicaid only has access to Medicaid data. So, if a member received care while uninsured or other-insured, Medicaid wouldn't have record of that care.

**Q: What if a patient's PCP is not in network, will it take a long time for the patient to switch PCPs or plans?**

A: If an individual changes plans, the new plan is effective the first of the next month.

**Q: When will it start costing my practice money if our withhold metrics are not good?**

A: That depends on the contract you signed with your Health Plan. NC's withhold program will not begin 18 months after managed care launch. This means DHB to health plan withholds could begin in 2023 which corresponds with measurement year 2022 (calendar year)

**Q: How will the hospital/practice bills be paid when a newborn is aligned to a health plan that is not part of the hospital/practice network?**

A: All enrolled Medicaid providers will be paid Medicaid FFS rates and subject to in-network prior authorization requirements for up to 90 days post birth, per our revised guidance. For more information, see: <https://files.nc.gov/ncdma/NCMT-Provider-FactSheet-Eligibility-for-Newborns-20210315.pdf>

**Q: I am an employed physician in a health system, and no one seems to know what plans we are accepting. What do I do?**

A: Call your contracting office, call your CIN, call the health plan. If none of these can help you, contact the Provider Ombudsman.

**Q: When will I know what plans the hospital and specialists in my community will take so I can start to understand my network options?**

A: You can view providers and health plans through our Medicaid and NC Health Choice Provider and Health Plan Lookup Tool. <https://www.ncmedicaidplans.gov/enroll/online/find/find-provider?lang=en>

**Q: What if kids/families move to another county/region, how quickly will PCP and or health plan transition happen?**

A: As long as the PCP is in network, the provider can get paid for the visit even if they are not the same provider. Since most plans are statewide, the assigned plan will not be changed. If they move out of a plan coverage area, the individual will be assigned to a different plan. That will be effective the following month.

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### Questions

**Q: Please explain the difference between the health plan giving a standard authorization decision and an expedited authorization decision.**

A: For expedited authorization decisions, the health plan will provide notice no later than 72 hours after receipt of the request for service. The health plan may extend the 72-hour time period by up to 14 days if the member requests the extension or if the health plan justifies a need for additional information and how the extension is in the member's interest. If the health plan extends the timeframe beyond 72 hours, the health plan will provide the member and provider with a written notice of the reason for the decision to extend the timeline and inform the member of the right to file a grievance if he or she disagrees with that decision.

**Q: Please explain the different between Medicaid Direct and Managed care.**

A: Under the fee-for-service model, DHHS reimbursed physicians and health care providers based on services provided, or procedures ordered. This model will now be known as NC Medicaid Direct. Some people will stay in NC Medicaid Direct. Under Managed Care, the State is contracting with insurance companies, called Prepaid Health Plans or health plans. These health plans will be paid a capitated rate, which is a pre-determined set rate per person to provide health care services. This model is known as NC Medicaid Managed Care.

**Q: How can I remove members from my panel if they will not engage with my practice?**

A: PCP are encouraged to use their care management resources to help members with barriers to engage. PCPs should also work with their Health Plans to help members with barriers to engagement or to find a better PCP fit if all options have been exhausted.

**Q: Has there been any training for the health plans on Behavioral Health issues?**

A: We had onboarding for the plans that included information on our BH policies as well as calls with the plans to ask questions. Please let us know if you feel additional training is needed.

**Q: How do I get a list of my assigned members? How often do I get that list?**

A: AMH Tier 3s will receive their member list monthly through the 834/Beneficiary File. All other PCPs will be able to log into each Health Plan's Provider Portal for a current monthly list. DHB will continue to post member assignment lists in NCTracks for Medicaid Direct & all Health Plans (using data received from the Health Plans).

**Q: If there are no other specialists of my type in the local area and a patient is contracted with a health plan outside my network, will the patient have to travel to see an in-network specialist?**

A: A health plan must have a network of providers that is sufficient to ensure that all covered services are available and accessible to all members in a timely manner. If the health plan's network is unable to provide a covered service on a timely basis (without undue delay), then the health plan shall provide timely access to an out-of-network provider, and shall continue to provide the access to an out-of-

network provider until the Network's deficiency is addressed. Please note that the health plan can require that this access be prior-approved as an out-of-network service.

**Q: Will standard plans receive IPRS/State funding? Or what entity will that remain with?**

A: Standard Plans will not receive IPRS/State Funding. Only BH I/DD Tailored Plans will be responsible for IPRS/State funded services.

**Q: Will women covered by Medicaid for Pregnant Women transition to managed care?**

A: Most Medicaid for Pregnant Women (MPW) will enroll in managed care. If the pregnant woman is eligible for both Medicaid and Medicare, then they are eligible for tailored plans, are eligible for the Tribal Option, etc.

**Q: Will Pediatric practices be able to give the Covid vaccine in the office? Will it be supplied by the State Immunization branch?**

A: The managed care health plans and Medicaid Direct (fee for service) will both pay for COVID-19 vaccine administration.

**Q: Will the temporary vaccine rate increase for Medicaid now scheduled to end March 31st be extended?**

A: At the present time NC Medicaid expects to continue the COVID-19 vaccine administration rates that were increased to \$40 per dose of vaccine (for both single dose and multi-dose vaccines) in March 2021 (see COVID-19 Special Bulletin #162) through the end of the federal public health emergency. However, that rate MAY be updated in the future based upon a number of factors.

**Q: What if we have assigned beneficiaries who do not come to us for their care? Will our quality goals/targets be measured to include them? And, how do we remove them from our panel if they do not come to us for their care?**

A: AMH Tier 3s should be able to utilize their care management staff to engage patients who have barriers to engaging in care. Quality measures will be including everyone your assigned panel. If the member wishes to be assigned to another practice, they can contact the Health Plan to be reassigned. If AMHs have exhausted all engagement options, you can work with your health plan to address the assignment.

**Q: What if a patient's PCP is enrolled with their health plan but their dermatologist and pulmonologist are not in that network?**

A: NC Medicaid Managed Care is designed to for members to access services through a network of providers contracted with their health plan. If a member chooses a health plan based on her primary care provider (i.e. the PCP is in-network for the chosen health plan), but other providers are not in-network, then the member will need to move to specialists who are in-network with her health plan. Note that periods of transition of care will permit a member to continue to see an out-of-network provider for a specific period of time until they transition to an in-network provider. Additionally, a member will have opportunity to switch their health plan through open enrollment and then 90 days following managed care launch.

**Q: How many times can beneficiaries change health plans after go live? Within the 90 days? After the 90 days?**

A: Beneficiaries can contact the enrollment call center at 833-870-5500 (TTY: 833-870-5588) to change health plans during the first 90 days after their coverage effective date. If a beneficiary wants to change their health plan outside of the 90-day choice period "with cause," they must contact the enrollment call center and submit the Health Plan Change Request form. With cause reasons are detailed in the health plan Contract Section VII. Attachment M.1. page 84 of 110. In addition, during their yearly eligibility recertification process, beneficiaries have the option to choose a new health plan.

Note: Beneficiaries who are exempt can change their health plan at any time.

**Q: After July 01, will the PDL continue to change every 3-6 months or will it remain the same for at least one year?**

A: All managed care health plans will utilize the same PDL as the state's fee for service program. The PDL will continue to manage and updated by the state. Significant updates to the PDL, which have been occurring once annually for a few years, might begin to happen twice annually beginning in 2021. This change is unrelated to the managed care launch and was slated for 2021 before managed care launch was scheduled for July 1. So, the current plans are to potentially update the PDL every 6 months.

**Q: What should we do if we have already put in a change request for the patient, but it is not getting changed through NCTracks?**

A: If you are referring to a PCP change request made to the local Social Service office that is not reflected in the NCTracks Recipient Eligibility Verification function, then there are some things to consider:

1. Was the "CCNC/CA Enrollment Form for Medicaid recipients" completed and signed by the patient? Social Service is only able to process PCP changes submitted on this form with the patient/caretaker's signature. NOTE: The form is at <https://medicaid.ncdhhs.gov/providers/forms/community-care-nccarolina-access-forms> (DHHS Provider webpage/Forms)
2. Has the month changed? PCP changes are always for the ongoing month pursuant to processing deadlines. For example, if the form was submitted in March and processed prior to March 30th, then the change will display in the NCTracks eligibility verification beginning April 1st. If processed on March 31st or in April, the change will not display until beginning May 1st.
3. If the answer to both of these questions is yes, the next best course of action is to request that the beneficiary contact their local Social Service office or the NC Medicaid Contact Center at 888-245-0179 to request a change.
4. Please note that PCP changes can be requested through this process for NC Medicaid Direct (FFS) beneficiaries. Beginning July 1, managed care enrolled beneficiaries will contact their health plan to request a PCP change.

PCP changes are processed through the NC Medicaid beneficiary eligibility system and transmitted to NCTracks nightly to be displayed in the NCTracks Recipient Eligibility Verification function.

**Q: We have a vaccine policy and many families ("non-vaxers") have elected to go elsewhere. They likely will be reassigned to us. What steps do we take to help them find a new home?**

A: Members can call the health plan and find a medical home that better meets their needs. You can assist them with contacting their Health Plan.

**Q: Practices have to explain how they used the health equity payments. Will practices have to attest to how they used their Glidepath payments?**

A: No, practices will not have to attest to how the glidepath funds were used.

**Q: If a specialist receives a referral for a beneficiary that is enrolled with a health plan that the specialist accepts, are they required to accept the referral?**

A: Although specialty providers must keep their NC Medicaid provider enrollment record and health plan contract information current, including the acceptance of new patients; and although we encourage collaboration with offices from which a specialty provider may receive referrals, all providers may continue to follow the guidance provided in the North Carolina Administrative Code 10A NCAC 22J .0106 with regard to the acceptance and billing of NC Medicaid patients.

In fact, it references health plan obtaining information about a provider's willingness to accept new patients. So, my response would be that providers may continue to follow the NC Administrative Code (10A NCAC 22J.0106) for guidance on the acceptance and billing of patients

**Q: In regard to dismissal of patients, is there a written policy for us? What are the written directives from DHHS on this procedure?**

A: There is not a written policy. Practices must follow their own policy. Health Plans will expect PCPs to use their resources (like care management) to try and engage all patients and help patients with barriers to care. If patients are terminated from a practice due to practice policy, then the practice should notify the Health Plan per the terms of their contract with the Health Plan.

**Q: What happens if one of our current patients visit one of our clinics, but has another PCP listed on their insurance card? Will the PT be required to change the PCP before we can provide health care services, or will our site still be reimbursed if we provide services?**

A: The member will not be required to change PCPs before receiving care from the clinic and the provider will be reimbursed for services rendered, so long as the clinic is in the member's health plan network. If the clinic is not in network at launch, the health plan must still reimburse for services on parity with reimbursement for in-network providers.

**Q: Also, if a practice is not currently accepting any new Medicaid patients will they have to open this up for open enrollment?**

A: That's a good question and something the practice needs to consider. Members may be choosing plans you have not contracted with, so you may lose patients from your panels and then not gain any through auto-assignment from the health plans you have contracted with. So, it's a decision left to the practice.

**Q: Providers currently bill Medicaid on a weekly basis and receive payment weekly. Will the health plans follow the same model?**



A: Each health plan follows their own schedule for payment, one health plan will pay twice a week while others will issue payment

**Q: Can a patient have Medicaid & private insurance at the same time? If so, is there ever a situation where we are expected to bill the Medicaid family for a co-pay or similar? What are the third-party liability (TPL) rules?**

A: Yes, a patient may have Medicaid and private insurance at the same time. The PCP must follow the rules and regulations of the private insurance carrier, there may be instances where the private insurance carrier requires a co-payment, deductible or co-insurance from a Medicaid beneficiary. Whether the PCP charges a co-pay is a function of the contract with the private insurance carrier. TPL Rules; There is a requirement for the PCP to bill the private insurance carrier first. The PCP may then submit the claim to the health plan to determine if an additional payment will be made not to exceed the Medicaid allowed amount. The process ensures that Medicaid is the payer of last resort.

**Q: Many pediatric patients will transition to adult providers at 18 years old. What is the process to ensure that the patient maintains coverage during the transition?**

A: The health plan will support, as needed, the member's transition to an adult provider including assistance in identifying a new provider (through the Member Call Line or through care management supports) and ensuring that the member's health record is shared, as needed, in accordance with professional standards and state and federal law. If the member is transitioning between or to an AMH Tier 3 practice, the member's health plan will begin transmitting the member's claims.

**Q: Is Carolina Complete expected to contract with providers/hospitals outside of their region since beneficiaries may travel outside of the region?**

A: To furnish services to meet Members' accessibility needs, health plans are encouraged to contract with providers outside of the health plans' Region(s). An individual Member's accessibility and health plan's network adequacy may be satisfied, in part, by contracting with providers across a regional border where appropriate. health plans are NOT expected to contract beyond their region(s) for purposes of ensuring access while a member travels, such access is not part of the accessibility and network adequacy standards with which the health plan must comply.

**Q: Our Women's Health Department is considered a specialist and not considered a PCP. Will patients be required to obtain a referral from their PCP to continue receiving services from us?**

A: If the provider in question is a women's health specialist AND is an in-network provider for the member's health plan, then according to federal regulation and the health plan Contract, the health plan shall provide female enrollees with direct access to a women's health specialist within the provider network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the enrollee's designated source of primary care if that source is not a women's health specialist.

**Q: What are some of the acceptable reasons for patient to change their plan?**

A: Beneficiaries can contact the enrollment call center at 833-870-5500 (TTY: 833-870-5588) to change health plans during the first 90 days after their coverage effective date. If a beneficiary wants to change their health plan outside of the 90-day choice period "with cause," they must contact the enrollment call

center and submit the Health Plan Change Request form. With cause reasons are detailed in the health plan Contract Section VII. Attachment M.1. page 84 of 110. In addition, during their yearly eligibility recertification process, beneficiaries have the option to choose a new health plan.

Note: Beneficiaries who are exempt can change their health plan at any time.

**Q: Is there a financial penalty for patients OR the provider if a patient sees a PCP different from the one assigned to them?**

A: If you are not the assigned Primary Care Practice for the beneficiary but are in Network for the health plan, you can render and be paid for Primary Care Services.

If you are a non-participating provider for the beneficiary's Medicaid health plan, you may render services.

- Special protection is afforded non-network providers (see the Transition of Care section below)

- If a good-faith contracting effort has been made by the health plan and you declined to participate, then you are subject to receiving 90% of the Medicaid fee-for-service rate. If no good-faith contracting effort has occurred, or if it is in progress, then you are subject to receiving 100% of the Medicaid fee-for-service rate until the contracting effort has been resolved.

**Q: What if a patient has started prenatal care with us before Managed Medicaid, does not enroll and is auto enrolled in a plan we are not contracted with. Will we still get paid if we see this patient?**

A: If a beneficiary comes to your practice and they are not enrolled with you, or with the health plans that you are contracted, you can still deliver the services they need.

The health plan will honor existing and active prior authorizations on file with the North Carolina Medicaid or NC Health Choice program for services covered by the health plan for the first 90 days after launch or until the end of the authorization period.

**Q: How does transition get addressed with pediatric to adult health care?**

A: Practices of all AMH tiers should assist members through this transition following clinical guidelines and related AMH requirements. The health plan can also support the member's transition to an adult provider, as needed, including assistance in identifying a new provider (through the Member Call Line or through care management supports) and ensuring that the member's health record is shared, as needed, in accordance with professional standards and state and federal law. If the member is transitioning between or to an AMH Tier 3 practice, the member's health plan will begin transmitting the member's claims and risk information to the new AMH prior to the transition.

**Q: Are the OON services granted when there are shortages of providers paid at 100% Medicaid rate?**

A: As health plan must adequately and timely cover services out-of-network for a Member if the health plan's Network is unable to provide the covered service on a timely basis, considering the urgency of the need for services. health plan shall cover the Member's out-of-network services for the duration of the Network's inability to provide them in network.

**Q: How does a practice determine if they are a Tier 1 or Tier 2?**

A: Tier 1: LME/MCO Liaisons and Family Navigator co-located at juvenile justice and child welfare offices.  
Tier 2: Includes Targeted Case Management for Youth with low to moderate level needs and access to DSS/JJ Liaisons and Family Navigator. Applicants can offer additional ideas on how to meet other Care/Coordination/care coordination needs of their child welfare and juvenile justice population in this tier.

**Q: What is the difference in payment in network vs out of network?**

A: In Network: health plans will be required to contract with “any willing qualified provider.” Health plans must offer these provider types contracts with these payment terms. Health plans are required to contract with “any willing qualified provider”

-Payment to in-network hospitals, physicians, and physician extenders must be no less than 100% of the Medicaid fee-for-service (FFS) rate, unless the health plan and provider mutually agree to an alternative reimbursement arrangement.

-Health plans must offer these provider types contracts with these payment terms.

-Providers can negotiate higher rates or alternative payment arrangements, but are not required to do so.

-Special payment provisions apply to certain provider types.

-Provider types that do not have a rate floor must negotiate rates

Out of Network: health plan payment levels to out-of-network (OON) providers depends on why the provider is OON and the type of service provided.

-Out of Network services are generally subject to prior approval by the health plan

Situations in which health plans must pay 100% of FFS to OON providers:

-The provider has not been offered a contract or is still engaged in good faith negotiations

-All family planning providers

-Out of state providers that deliver emergency and post-stabilization services

-In state providers that deliver emergency and post-stabilization services

**Q: We just received our panel list and there are patients who are still on our list even after multiple requests to have them removed, what are providers to do?**

A: PCP are encouraged to use their care management resources to help members with barriers to engage. PCPs should also work with their Health Plans to help members with barriers to engagement or to find a better PCP fit if all options have been exhausted.

**Q: Will medication prior authorizations and imaging authorizations go through the individual's health plan via the health plan website/health plan phone number?**

A: Yes, medication and imaging authorizations should go through the individual's health plan via the health plan website/health plan phone number. Providers should refer to the instructions in the specific health plans provider manual.

**Q: Can a health plan set a minimum quality rating scale for the quality incentive payments and refuse to pay any incentives to a tier 3 practice who does not meet the minimum?**

A: Yes, health plans are able to set targets as they deem appropriate. DHB sets targets for health plans.

**Q: Do the health plan's replace Medicaid?**

A: NC Medicaid Managed Care helps you get the most out of your Medicaid benefits. Instead of one Medicaid program there are many health plans to choose from.

All health plans are required to have the same Medicaid services, such as office visits, blood tests and X-rays. Health plans may also offer added services such as programs to help you quit smoking, eat healthier and have a healthy pregnancy. Health plans work with different doctors and health care professionals. Each health plan has its own network of qualified doctors and health care professionals. To keep your doctor, clinic, or other provider, find out which health plans they work with and choose one of those health plans. For more information, please visit the NC Medicaid enrollment website at <https://ncmedicaidplans.gov/>

**Q: What process can providers take to remove patients from their panel that aren't their patients since providers will be held to quality standards?**

A: PCP are encouraged to use their care management resources to help members with barriers to engage. PCPs should also work with their Health Plans to help members with barriers to engagement or to find a better PCP fit if all options have been exhausted.

**Q: Did the tailored plan excluded patients get letters letting them know that they did not have to do anything? We've gotten several calls from them trying to sign up and find out that they don't have to. Did the letters just go to eligible patients?**

A: Thank you for contacting the NC Medicaid Help Center. NC Medicaid is making every effort to ensure NC beneficiaries and providers receive the information they need regarding NC Managed Care. Some populations may enroll in a health plan or stay in NC Medicaid Direct. These include: Federally recognized tribal members and IHS-eligible beneficiaries and beneficiaries who would be eligible for behavioral health tailored plans. Since the tailored plan beneficiaries have the option to enroll in a health plan or stay in NC Medicaid direct, yes, they received a transition notice.

If you have additional questions, please contact <https://www.ncdhhs.gov/divisions/social-services/local-dss-directory> for further assistance. There also many additional resources listed on the <https://medicaid.ncdhhs.gov/providers> webpage.

**Q: If we are contracted with all plans, can we still see members not assigned to our practice?**

A: Yes, if you are not the assigned Primary Care Practice for the beneficiary but are in Network for the health plan, you can render.

**Q: Who is the provider ombudsman?**

A: The NC Medicaid Provider Ombudsman represents the interests of the provider community by offering supportive resources and assistance in resolution of provider inquiries, concerns, and complaints regarding health plans.

Separate from the health plan's Provider Grievance and Appeals process in which health plans are expected to resolve complaints and provide a summary of final resolution to NC Medicaid, the Provider Ombudsman will investigate and address complaints of alleged maladministration or violations of rights against the health plans when problems persist after following the health plan's process.

Additionally, the Ombudsman will assist providers with Health Information Exchange (HIE) inquiries related to NC HealthConnex connectivity compliance and the HIE Hardship Extension process.

Inquiries may be submitted by:

Emailing [Medicaid.ProviderOmbudsman@dhhs.nc.gov](mailto:Medicaid.ProviderOmbudsman@dhhs.nc.gov) or Calling the Medicaid Managed Care Provider Ombudsman at 919-527-6666

The Provider Ombudsman contact information, as well as the health plan's Provider Grievance and Appeal Process, can also be found in each health plan's Provider Manual linked on the Health Plan Contacts and Resources Page.

**Q: What's the consequence of network inadequacy if the plan can request an exemption? Why will the health plan care? How does the pediatric urologist fix the kidney problem over a telehealth connection?**

A: A health plan shall establish and maintain a Medicaid Managed Care Provider Network supported by written agreements with providers, that is sufficient to ensure that all services covered under the Contract are available and accessible to all members in a timely manner. If a health plan's network is unable to provide timely access to an in-network provider, then the health plan shall adequately and timely cover out-of-network services for a Member considering the urgency of the need for service. The health plan shall cover the Member's out-of-network services for the duration of the health plan's network inability to provide the services on a timely basis in-network.

As to exceptions, exceptions requests must be submitted by a health plan when the health plan is unable to meet one or more network adequacy standards in a county or region (as applicable). The health plan must indicate in the exception the reason they are unable to contract with sufficient number of providers to meet the adequacy standard, identify the impacted population, provide a plan for ensuring that members get the services they need, and a plan for filling the gap in the network. The Department is not obligated to approve any exception request, and if we do not approve of a request, then the health plan would be placed under a Corrective Action Plan relating to the failure to comply with the network adequacy standards.

Note that the Department has a number of remedies at its disposal when a health plan is determined to not meet the requirements of the health plan Contract. Such remedies include remedial actions, intermediate sanctions, liquidated damages, and/or termination of the Contract in the event that the Department determines, in its sole discretion, that the Contractor has violated any provision of the Contract.

**Q: What are some of the acceptable reasons for patient to change their plan?**

A: Without cause disenrollment requests can occur at any time and include:

- i. During the initial ninety (90) calendar days following the effective date or date of notice of new health plan enrollment (referred to as the choice period).
- ii. At least once every twelve (12) months that coincides with the Member's redetermination period.
- iii. If a Member experiences a delay in his or her eligibility redetermination decision from the Department, during the period when the redetermination decision is delayed.
- iv. When the temporary loss of Medicaid eligibility has caused the Member to miss his or her annual disenrollment opportunity.
- v. If the Department imposes temporary management in accordance with 42 C.F.R. § 438.706, suspends new enrollment in accordance with 42 C.F.R. § 438.702(a)(4), or grants Members the right to terminate enrollment without cause in accordance with 42 § C.F.R. 438.702(a)(3) as intermediate sanctions against the health plan.

With cause disenrollment requests can occur at any time for the following reasons to request disenrollment from the health plan:

- i. The Member moves out of the health plan Region(s).
- ii. The health plan does not, because of moral or religious objection, cover a service the Member seeks.
- iii. The Member needs concurrent, related services that are not all available within a health plan's provider network, and the Member's provider determines receiving services separately would subject the member to unnecessary risk.
- iv. A Member receiving LTSS would be required to change his or her residential, institutional or employment supports provider based on a change in status from in-network to out-of-network.
- v. The Member's complex medical condition(s) would be better served under a different health plan, or the Medicaid Fee-For-Service/LME/MCO delivery system in the case of a Medicaid Managed Care Member who meets BH I/DD Tailored Plan eligibility (including having a qualifying event, as defined by the Department) prior to launch of the BH I/DD Tailored Plans. A Member is considered to have a complex medical condition if the condition could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function.
- vi. A family member becomes newly eligible or redetermined eligible and is enrolled in or chooses a different health plan than the Member.
- vii. Poor performance of the health plan, as determined by the Department, after evaluation of health plan performance.
- viii. Other reasons, including poor quality of care, lack of access to covered services or lack of access to providers experienced with meeting specific need, as defined by the Department.

For more information, please visit the Provider Playbook on the DHHS website (<https://medicaid.ncdhhs.gov/providers/provider-playbook-medicaid-managed-care>) and review the "Medicaid Managed Care Member Enrollment: Part 1 – Health Plan Auto-Enrollment" Fact Sheet ([https://files.nc.gov/ncdma/NCMT\\_Provider\\_FactSheet-AutoEnrollment\\_20201027.pdf](https://files.nc.gov/ncdma/NCMT_Provider_FactSheet-AutoEnrollment_20201027.pdf)).

**Q: Will the second Hep B vaccine be paid in the first 2 months they are seen?**

A: Vaccines for NC Medicaid beneficiaries are covered under the federal "Vaccines for Children" program. NC Medicaid reimburses for the vaccines administered through this program based on the

recommended vaccination schedule, which will include two doses of the Hep B vaccine in the first two months of life.

More information about the Vaccines for Children program can be found here:

[https://immunize.nc.gov/family/nc\\_immnz\\_program.htm](https://immunize.nc.gov/family/nc_immnz_program.htm)