April 15 NCMT Hot Topics Fireside Chat
What Ifs

Q: Will Medicaid medication copays be different for the health plans?

A: The medication copayments will be the same for all health plans and Medicaid Direct.

Q: At managed care launch will the health plans have access to information on preferred medications that were tried and failed?

A: Prior to launch, the health plans will be provided with 2 years' worth of historical claims information on each patient

Q: What if a patient needs an urgent medication such as a non-preferred insulin and the prior authorization (PA) has not been approved yet and 7 hours has passed?

A: The health plans are required to provide a 72-hour emergency fill for any medication that requires a PA.

Q: If a pharmacy chooses to override a denial because it is in the best interest of the patient, is there any assurance that the health plans will cover the cost retroactively?

A: Cadence for adding these drugs will be the same as current. As drugs in categories that we actively manage are added to our medication database (normally a few days after release), health plans will also be notified of these medications. Except in extraordinary circumstances, new to market medications default to Non-Preferred status upon introduction. If a drug is in the database, it will process correctly in the POS system even if it is not on the online posted PDL document.

Q: What if a patient has a prescription for a medication from a physician that is not in network and I fill the prescription. Will I be paid?

A: As long as the provider is a Medicaid enrolled provider, the prescription will be covered. All health plans will honor all prescriptions written by a Medicaid enrolled provider. Just as today, your online response will be your authorization that a claim is covered.

Q: How do we bill specialty drugs (e.g., hemophilia) to health plans?

A: There are no medications "carved out" from health plans. All medications need to be billed to the beneficiary's health plan. Plans for the most part will require pharmacies to bill similarly to current. However, please contact the health plan for specific guidance for billing issues if there are questions.

Q: Will pharmacies still get paid a tiered dispensing rate?

A: Health plans have notified the state that they will be paying pharmacies a flat dispensing rate that is based on the state's Cost of Dispensing Study (CODS).

Q: Will pharmacy lock-in change in managed care? Will pharmacy lock-in apply to children?

A: health plans have legislative language specifying the criteria to be used for member selection and states that both Medicaid and Health Choice members are eligible for enrollment in the lock-in program. Medicaid Direct is in the process of changing our selection criteria to align with the health plans. We

currently don't lock-in children under 18 and would expect the health plans to operationalize their program in the same way.

Q: How does a pharmacy appeal non-payment decision?

A: Should a provider want to question an appeal; you may reach out to the Provider Ombudsman.

Regarding this specific scenario, only the member can appeal this type of health plan decision. If a health plan denies payment in whole or in part for any reason other than because the claim is not considered a "clean claim", it is considered an adverse benefit determination that the member can appeal. In this situation, the health plan is required to provide written notification to the Member who will have 60 days to request an appeal with the health plan. If the Member is dissatisfied with the decision of the health plan, the Member may appeal that decision to the Office of Administrative Hearings. If the Member authorizes a provider to act as it's representative, the provider may file the appeal on behalf of the Member.

Q: How quickly will health plans respond to the changes in the price of medications?

A: The health plans will use the same ingredient cost pricing databases used by the State. Therefore, they will be updated in the same manner and at the same time. This includes, for example, National Average Drug Acquisition Cost (NADAC), Wholesale Acquisition Cost (WAC), and State Maximum Allowable Cost (MAC) rates. For NADAC appeals, a provider must appeal directly to the national NADAC appeals vendor. For State MAC appeals, providers may appeal rates using the form on the State's website.

Q: If there is a coding error with a medication on the shelf or some other situation that impacts the 5 health plans, will pharmacies have to call all 5 plans to resolve?

A: The State will oversee the weekly preferred drug list (PDL) (coverage) file that will be distributed to all plans. Should a provider believe there is an error in the file you may call the health plan (or NC Tracks) you are trying to bill and open a ticket for investigation.

Q: Will billing and payment for vaccines be different in managed care?

A: Vaccines will be billed to each beneficiary's health plan (or Medicaid Direct if still in fee for service). Vaccines may be billed via a medical claim or a point-of-sale (POS) Pharmacy claim. You must consult with the health plan to obtain the exact billing specifications.

Q: If an out of network provider bills for a vaccine, will the administration fee be paid if the vaccine is covered by vaccines for children (VFC)? What about non-VFC vaccines?

A: Providers need to be Medicaid enrolled to bill and be reimbursed by Medicaid. Out of network providers will get paid at 100% for Covid vaccine administration, other vaccine administrations may not be covered at 100% if out of network.

Q: If a health plan refuses to cover an in-office medication that is usually covered by the state, how can we appeal?

A: This is not something a provider can directly appeal with the health plan. If the health plan denies coverage for a requested medication, this is considered an adverse benefit determination that can be

appealed by the Member. The provider can file the appeal on behalf of the member only to the extent that the member has authorized them to do so, but it's still a member appeal, not the provider's appeal. The health plan is required to provide written notification to the Member who will have 60 days to request an appeal with the health plan. If the Member is dissatisfied with the decision of the health plan, the Member may appeal that decision to the Office of Administrative Hearings.

Q: How will in-office procedures like intrauterine device (IUD) placement be billed?

A: Same as Medicaid Direct - retrospective as per the rates and insertion charges listed on our fee schedule. If the provider received the IUD from a pharmacy, we would expect to see only an administration charge from the medical provider (the drug would have been paid to the pharmacy).

Q: Will limits for durable medical equipment (DME) be the same in managed care as in Medicaid Direct? (What if a health plan employs a more restrictive quantity limit on a medical supply like a spacer for an inhaler?)

A: health plans are required 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". The contract allows for health plans to employ different prior authorization (PA) and quantity/lifetime expectancy limits as part of their utilization management program as long as they are evidence-based and provide a reasonable pathway to coverage. health plans are expected to follow Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) guidelines for Medicaid beneficiaries 0-20yoa, and the home health final rule at 42CFR, 440.70 for everybody else. Both of these federal regulations allow for medical necessity reviews on a case-by-case basis.

Q: What if a beneficiary has equipment before the managed care launch that is still required after launch? (Will people have to return current durable medical equipment (DME) and replace with new equipment from an in-network provider at launch?)

A: To ensure continuity of care, health plans are expected to honor existing prior authorizations (PAs) for 90 days after launch and treat out-of-network providers as in-network for 60 days.

Q: How will plans ensure network adequacy for durable medical equipment (DME)? (What is the definition of an adequate network for a small community? What if there is a lack of durable medical equipment (DME) suppliers in rural and other underserved areas?)

A: Although explicit network adequacy standards for durable medical equipment (DME) providers was not included in the managed care contract, health plans are expected to establish and maintain provider networks sufficient to ensure that all covered services are available and accessible in a timely manner. health plans are also required to negotiate with any willing provider and treat out of network providers as in-network for 60 days after launch. Further, if a health plan does not have an in-network provider reasonably available to the member without delay, then the health plan shall cover the service (pre-approved if required) from an out-of-network provider until such time as the deficiency is addressed.

Q: Will the health plans have different preferred diabetic medical supplies?

A: For point of sale pharmacy all health plans and Medicaid Direct will have the same preferred Roche diabetic medical supplies. Submission of diabetic supplies under the durable medical equipment (DME) benefit to the health plans and Medicaid Direct will remain the same.

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Q: Will health plans cover durable medical equipment (DME) that is not currently covered by Medicaid?

A: health plans are required 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". Additionally for unlisted items, health plans are expected to follow Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) guidelines for Medicaid beneficiaries 0-20yoa, and the home health final rule at 42CFR, 440.70 for everybody else (i.e., states are prohibited from having absolute exclusions of coverage on equipment, supplies, and appliances w/o a medical necessity review and appeal rights for denials).

Q: What if a child has a growth spurt and wheelchair needs to be changed out or modified earlier than usual lifetime expectancy?

A: The contract requires health plans to implement and adhere to all Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) policies and protocols which means that for Medicaid beneficiaries 0-20-year-old, policy limits would not apply so long as medical necessity is established.

Q: What if a physician office provides a medical supply like a nebulizer and wants to bill it as durable medical equipment (DME) like they do now in fee-for-service? (Currently many practices stock durable medical equipment (DME) such as nebulizers to prevent delay in care. Will this be allowed by the managed care organizations?)

A: health plans are expected to establish and maintain provider networks sufficient to ensure that all covered services are available and accessible in a timely manner. health plans are also required to negotiate with any willing provider and treat out of network providers as in-network for 60 days after launch. If a physician office is enrolled with Medicaid to bill for durable medical equipment (DME), any willing provider provisions provide that they should be permitted to enroll the same way with the health plans.

Q: How do we bill new health plans vs traditional Medicaid?

A: We have quick resource guides on our website in our provider playbooks for each health plan. It contains detailed information about billing for each health plan. Additionally, that information should be included in any contract or other information you may sign with a health plan. Finally, we are pulling together a 1 pager with contact information for all health plans for things that may be critical on day one - who to call, how to request prior authorizations, how to bill, etc. and it will be posted on our website in our provider playbook in the coming days.

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Questions

Q: Does the durable medical equipment (DME) rate floor include manual code reimbursement?

A: Manual priced procedure codes will follow the manual pricing methodology for established codes

Q: Will weight scales be made available that are sensitive enough to measure neonates or can health plans and pharmacies decide not to provide those if found to be necessary under Early, Periodic, Screening, Diagnosis and Treatment (EPSDT)?

A: If a prescriber orders an infant scale for a Medicaid beneficiary, a Medicaid enrolled durable medical equipment (DME) supplier can submit a prior authorization request through NCTracks and, per EPSDT guidelines, it will be reviewed for medical necessity on a case-by-case basis. In managed care, the prepaid health plans will be expected to follow the contractual requirement which states: "The health plan shall determine whether a service is medically necessary on a case by case basis, taking into account the medical necessity criteria specific to EPSDT defined in 42 U.S.C. § 1396d(r) and 42 C.F.R. §§ 441.50-62 and the particular needs of the child."

Q: Will we see what health plan the patient is under via their eligibility we pull monthly?

A: You will be able to verify a beneficiary's managed care enrollment information through the NCTracks Recipient Eligibility Verification tool. Information about eligibility verification can be found on the "Managed Care Claims Submission: What Providers Need to Know – Part 1" Fact Sheet available at https://medicaid.ncdhhs.gov/providers/provider-playbook-medicaid-managed-care/fact-sheets. Although not to be used as verification of coverage, primary care providers receiving the Advanced Medical Home (AMH) Medicaid Direct/Managed Care PCP Enrollee Report will also see the beneficiary's assigned health plan beginning in July 2021 when managed care assignments become effective.

Q: Will it be necessary to receive a denial from durable medical equipment (DME) before submitting a request through Early, Periodic, Screening, Diagnosis and Treatment (EPSDT), even if an item that is being requested is not on the (DME) fee schedule?

A: The Managed Care contract states: "The health plan shall determine whether a service is medically necessary on a case by case basis, taking into account the medical necessity criteria specific to EPSDT defined in 42 U.S.C. § 1396d(r) and 42 C.F.R. §§ 441.50-62 and the particular needs of the child." There is no requirement for an item to first be denied before EPSDT guidelines are applied.

Q: The practices who were denied the glidepath received a notification, but it didn't specify why the practice was denied. How would a practice figure out why they were denied?

A: Practices received denials for April glidepath payment due to the Department's inability to confirm the provider's attestation for contracting and/or testing status with the reported Health Plans. Practices that believe you have been denied this payment in error, are to contact the Health Plans you attested with and confirm your contracting and testing status in writing. With this confirmation from the health plans, providers are asked to submit this documentation to Medicaid.Transformation@dhhs.nc.gov, with the subject line of "Advanced Medical Home (AMH) Glidepath Payment Reconsideration". Reconsideration requests must be received by April 25th to be included in the next payment cycle. Please note, the confirmation documentation must indicate that all requirements were completed prior to the March 30th deadline.

Q: I need some clarity on billing guidelines for health plans; is there any way for the state to ask the health plans to do more education on specific claim billing and prior authorizations?

A: There are a number of Department-developed fact sheets related to claims/billing guidelines that have been posted on the Provider Playbook Fact Sheet page (https://medicaid.ncdhhs.gov/providers/provider-playbook-medicaid-managed-care/fact-sheets) - two that are related to Claims submissions (inclusive of prior authorizations), and one for prompt payment. The Department also has links to each of the health plan training pages where the health plans have their claims/billing trainings posted, those can be found here: https://medicaid.ncdhhs.gov/providers/provider-playbook-medicaid-managed-care/provider-playbook-training-courses. Each of the health plans are required to provide training to their contracted providers, these are provided on an ongoing basis and should be available on demand as well. Providers should reach out to their health plans for more information on these trainings.

Q: Is there a website that we can access, that would tell us which plan our members are enrolled in?

A: Although there is no website that offers beneficiary assignment information, providers will be able to confirm managed care enrollment information through the Recipient Eligibility Verification function of NCTracks. The Department is modifying the functionality of this tool to allow providers to verify eligibility for the following month, which means you should be able to see the projected managed care enrollment status beginning in June. This is not a guarantee that Medicaid coverage or managed care assignment for the following month will stay the same but will offer information as it is available at the time of your inquiry.

In addition, primary care providers receiving the Advanced Medical Home (AMH) Medicaid Direct/Managed Care PCP Enrollee Report will also see the beneficiary's assigned health plan beginning in July 2021 when managed care assignments become effective. Again, this is not to be used as verification of coverage or managed care assignment. All providers should verify eligibility prior to

Q: In regard to the vaccines for children (VFC) vaccines and health plans: Will there be different rates possible with admin fees with health plans? How will this work with kids over 18 years of age with health plans and payment for vaccines by Medicaid through health plans?

A: Administration rates will be the same if the provider is in the member's health plan network. IF the provider is out of network, rates may not be paid at 100%. Related to kids over 18 years of age..... Vaccine rates will be paid as listed on the plan's fee schedule (which will mirror the Medicaid Direct fee schedule). If the provider is in the member's health plan network, rates will be paid as they are for Medicaid Direct. If out of network, rates paid may not be at 100%. You may contact the managed care health plans for this information as well.

Q: Is it possible to have the expired license notice emailed to the managing employee listed in NC Tracks? Any thoughts of making a unique section for this in status management?

A: Yes, a message will be posted to the Message Center Inbox on the secure provider portal 60 days prior to license expiration. If your license is expiring, you will need to update it promptly in NCTracks or your provider record may be suspended and/or terminated. NCTracks receives automatic updates from the Medical Board on license renewals, but providers still need to validate the information.

Q: When will NC Medicaid Re-verifications be required?

A: NC Medicaid is making every effort to ensure NC beneficiaries and providers receive the information they need regarding NC Medicaid Managed Care. Most NC Medicaid beneficiaries must be recertified every twelve months. Local DSS agencies are continuing to complete recertifications. The only difference is due to the Covid-19 Public Health Emergency (PHE), an individual will not lose Medicaid benefits during the Covid-19 crisis. If a caseworker determines an individual is ineligible for NC Medicaid at recertification the Medicaid will be extended through the PHE. These cases will be reviewed again at the end of the PHE.

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 webpage.

Q: Will all behavioral health providers receive a rate floor? If not, why not.

A: Health plan's and Managed Care Organizations (MCO's) have the ability to negotiate rates, so for most services there is not a rate floor.

Q: We are in a Clinically Integrated Network (CIN) and were told that to limit our patient panel size, we have to do it through the health plan's portal. Is this correct?

A: NC Medicaid providers participating as a Carolina ACCESS/Community Care of North Carolina provider may select or modify their panel size during their initial enrollment application, or through the Manage Change Request (MCR) process. This panel size limitation applies to NC Medicaid Direct enrollees. For Medicaid Managed Care, providers are encouraged to establish their panel size during the contracting process with the health plan. Once contracted, the health plan must offer information regarding the use of their portal or other means to modify the information.

For assistance with modifying the panel size (referred to as the enrollment limit) on your NCTracks record, refer to the user guides available at https://www.nctracks.nc.gov/content/public/providers/provider-user-guides-and-training/fact-sheets.html, or contact the NCTracks Call Center at 800-688-6696. To reach the appropriate health plan for assistance, please see the Provider Support Line information for each plan at https://medicaid.ncdhhs.gov/transformation/health-plans/health-plan-contacts-and-resources.

Q: Like for Pharmacy, if a durable medical equipment (DME) provider (contracted with a health plan) provides supplies prescribed by a physician who is not contracted with health plan, will the health plans still pay for the items prescribed?

A: All five health plans have indicated that yes, they would accept orders from an out-of-network prescriber as long as the prescriber was enrolled in Medicaid. But, of course, the durable medical equipment (DME) supplier in this hypothetical scenario would have to be in-network with the health plan.

Q: Will all Community Alternative Programs (CAP) programs remain in Fee For Service (FFS)?

A: Yes

Q: Where can we go to verify patient eligibility for patient appointments? Do we have to check NC Tracks as well as the health plans site to verify patient eligibility?

A: This information can be found in NC Tracks, you will only need to mine NC Tracks

Q: Where can we look up online and ask questions regarding Medicaid Managed Care?

A: Please reach out here to ask questions regarding Medicaid Managed Care. https://medicaid.ncdhhs.gov/transformation

Q: Is there a list that details which patients are going to covered under which new health plan? Is it possible to see this information prior to 7/1/21 outside of NC Tracks?

A: Basic information about beneficiaries included in the transition to managed care is found in the Introduction to Medicaid Transformation Part 1: Overview Fact Sheet, which is available in the County Playbook for Medicaid Managed Care at https://medicaid.ncdhhs.gov/counties/county-playbook-medicaid-managed-care/managed-care-overview. This link will also offer fact sheets with information about enrollment timelines and services. For more detailed information, explore the various resources available on the Medicaid Managed Care Transformation website at https://medicaid.ncdhhs.gov/transformation.

Q: Why weren't all Local Management Entities – Managed Care Organizations (LME-MCOs) incorporated on one data platform to use for the Tailored Plan? As a provider, we will have multiple databases to use to provide Care Management.

A: Providers will have the option of working with Tailored Plans or Clinically Integrated Network (CINs) /Other Partners to acquire a care management data system that works for their practices and populations. Tailored Plans and CINs/Other Partners are not required to offer a common system but are required to have systems that meet common standards around functionality, data integration, and interoperability. The Department will also be working with Tailored Plans and Providers to establish data standards to reduce provider burden and facilitate data exchange.

Q: How do providers get information from all of the Local Management Entities – Managed Care Organizations (LME-MCOs) to get a number of persons served who will be on the Standard Plan versus the Tailored Plan? This information is needed to be able to complete the Care Management Application that is due by June 1st.

A: This information is not needed specifically to complete the Transitional Care Management (TCM) application. Providers need to rely on their knowledge of the number of consumers for which they are currently providing care, their assessment of their current population's care management needs and/or potential eligibility and their capacity for services provision based on estimates of this population's needs.

Q: We have persons served that are receiving the enrollment information for the Standard Plan when they are receiving services that should be under the Tailored plan such as Long-Term Vocational Services. What are we as providers able to do to help direct our participants, so they get the correct plan and not lose services they are currently receiving?

A: Providers can inform these patients of their choices and that they may lose certain services if they enroll in a Standard Plan. It is important to note that these beneficiaries keep these services if they remain in NC Medicaid Direct. If they do enroll in a Standard Plan, they can disenroll at any time for any reason.