Question	Asker Name	Asker Email	Answer(s)
How long does it usually take for the Ombudsman to respond to questions?	Terri Roberts	terri.roberts@mahec.net	Initial response time is no later than 24 hrs upon receipt of question.
How do we get a copy of the slides used during this presentation?	Colleen Aitken	caitken@gapgi.com	The recording of this presentation, slides, and Q&As will be published to the NC AHEC website after the webinar completes. These will be located below the registration link.
When you talk about the expired credentials, what documents are you referring too? The only reminders I am currenlty receiving are for license(s).	Trisha David	tdavid@boice-willis.com	Please note that re-verfications are currently on-hold due to the pandemic. Other expired credentials may also be related DEA as well as other accreditations , NC Tracks receives some provider license information directly form the licesneing authority , such as the Medical Board . And you will recieve reminders related to any expired credentials that may be needed via the provider portal, Currently, NCTracks sends notifications for expiring credentials (licenses, certifications and accreditations) to all enrolled providers required to be licensed, certified and/or accredited. These notices are sent to the Provider Message Center Inbox beginning 60 days in advance of the expiration date of the credential. Effective May 9, 2021, NC Medicaid is taking additional steps to ensure providers meet their contractual obligation and responsibility to keep credentials current on their NCTracks enrollment record by making system modifications to begin a process of 45 and 60 day notifications of suspension if a provider fails to update their credential prior to the expiration date on file with NCTracks. Providers were first informed of this forthcoming system modification in March of 2018. Please see Medicaid bulletin here: https://medicaid.ncdhhs.gov/blog/2021/04/14/nctracks-changes-provider-verification-process
Could you please show the slide for contact information for the Ombudsman again?	Albert Marts	IXOYC77@gmail.com	Provider Ombudsman inquiries, concerns or complaints can be submitted toMedicaid.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.
If a patient's PCP moves to a new location (different address, still with same company) how does the patient change that or update that with Medicaid?	Cameron Canipe	cameron.canipe@atriumhealth.org	If a patient's PCP moves to a different location that is not convenient for them, the patient can request a PCP change with their health plan directly.
Where is the Provider Playbook?	Debra Forgette	debra.forgette@atriumhealth.org	https://medicaid.ncdhhs.gov/providers/provider-playbook-medicaid-managed-care
Forgive me if this has already been answered somewhere.. will patients receive insurance cards from their new plan or will they receive a new medicaid card with the new plan notated on it?	Sabrina Jumper	bree.dayspring@gmail.com	After a beneficiary enrolls, their health plan will mail their welcome packer and a new ID card. Initial mailings will occur after auto assignment, beginning the week of May 16. The beneficiary's new health plan will be available starting July 1, 2021. Until that start date, the beneficiary will receive care and services the way they do now.
We recently received a management fee payment that we believe includes the Health Equity payment, Glidepath Payment, and our normal Carolina Access however this payment did not give a breakdown of how much for each. Where can this be located or accessed? We know that we will need to track the use of these payments but need to know how much is for payment type.	Trisha David	tdavid@boice-willis.com	Providers are paid the AMH and/or HEQ payment on top of each PMPM, so as long as Providers know the amount of the AMH glidepath payment and the HEQ payment, they should be able to determine the breakout.

What if the office administrator no longer has access to the provider's who have left the practice NCTracks application to complete a mange change request to remove them from the practice?	Heide Dorfman	hsdorfman@aol.com	This is a great example of an item that the Provider Ombudsman can assist with. Provider Ombudsman inquiries, concerns or complaints can be submitted toMedicaid.ProviderOmbudsman@dhhs.nc.gov, or received through the Provider Ombudsman line at 919-527-6666.
Are there plans to discuss the Health Equity Payment for April, May and June of this year? Melissa Domenech, PA. Lexington Family Physicians	Pam Musgrave	pmusgrave@lexingtonfamilyphysicians.com	Health Equity Payments was presented on March 25th. You can find the presentation and slides on the NC AHEC website located below the registration link.
I don't think I got an answer to this...how does the patient update their PCP info with Medicaid?	Cameron Canipe	cameron.canipe@atriumhealth.org	Is this related to your other question, re: if the patient has already selected a plan? If yes, then the patient will need to change their PCP with their health plan. If the patient wants to change their PCP now, the patient should follow the normal PCP change process (through their DSS caseworker or the NC Medicaid Contact center).
If they have already chose a plan, but then found out their PCP is moving to a different location...	Cameron Canipe	cameron.canipe@atriumhealth.org	If the beneficiary has already chosen a plan, they will have to change their PCP through their health plan.
if changes are currently being made to the individual provider enrollment through MCR; how often is the information updated with the PHP's for that the provider ?	Tamara McLamb	tmclamb@jeffersandmann.com	Updates to provider information NCTracks will be shared with the PHPs within 1-2 business days of the MCR being approved.
Do we need to have any concerns if the PHP Plan site have incorrect information, but the enrollment site data is correct as well as NCTracks? Can patients enroll on the PHP Plan site or just the NC Medicaid Site?	Paula Locklear	paula.locklear@sr-ahec.org	Patients can only enroll with a health plan through the Enrollment Broker - by calling, online (ncmedicaidplans.gov), mailing/faxing their enrollment form, or using the mobile app.
When we see Medicaid direct listed with our practice in the provider directory, what does this mean we can still see our patients who are Medicaid managed care beneficiaries or will this mean we are only able to see a small number of patients? Also what does this mean in terms of reimbursement rates?	Chris Weathington	chris.weathington@gmail.com	If Medicaid Direct displays in the directory, this means that the practice serves the Medicaid Direct Program. Reimbursement rates will not change if the provider remains serving Medicaid Direct patients. If there are no other health plan listed, then that means the practice is not contracted with a health plan and will not be assigned patients who are transitioning to managed care at this time. If these patients come to your office, you will be able to provide services, but those would be considered out of network and would be subject to out of network reimbursement rates - more information can be found here: https://files.nc.gov/ncdma/NCMT-Provider-FactSheet-Need-to-Know-After-Launch-20210331.pdf
Okay, thanks, will that contact info be listed on the card they receive?	Cameron Canipe	cameron.canipe@atriumhealth.org	Health plan information, yes. There are "Health Plan Quick Reference Guides" at the bottom of the provider playbook. Here, you will be able to see example Medicaid Cards for each health plan. https://medicaid.ncdhhs.gov/providers/provider-playbook-medicaid-managed-care/fact-sheets
Could you please provide clarification as to how the poverty scores and poverty levels are determined for the practice locations, in regards to the Health Equity Payment Intiative? What beneficiary census tract year is used in determining the practice average? And, how are the member counts determined, is based off current enrollment? Will the practice poverty level tiers be released to the public for review?	Amanda Holladay	aholladay@jcmcpa.net	NC Medicaid released information on how the poverty scores were determined here: https://files.nc.gov/ncdma/NCMT-Provider-FactSheet-Health-Equity-Payments-20210331.pdf The payments are based on an average of the poverty census tract in which assigned beneficiaries live for each practice location. NC Medicaid used the 2018 ACS 5-year estimates to determine the poverty level of the census tract and assigned membership pulled from February 2021 data. Practices that averaged above a 17% poverty rate for beneficiary's census tract received a $9PMPM and those above 21% received a $18PMPM. Both the Medicaid contact center and AHEC can answer questions about the practice's poverty score.

For multiple locations for a group practice, an individual provider is affiliated to the Group NPI. Should, a further step be made to affiliate the individual provider to each service location in addition to the group level, even if each service location is listed in the individual provider's enrollment?	Tamara McLamb	tmclamb@jeffersandmann.com	Yes, an individual provider should make sure each service location(s) match(es) the group service location(s). Yes, providers should affiliate in NCTracks to all Service Locations at which they perform services.
How will the enrollment broker know a practice	Shanon Farrell	shanon.farrell@seahec.net	N/A
If the beneficiary is currently enrolled to the group practice through Carolina Access, does the beneficiary have to choose an individual provider for the PCP or will the beneficiary be able to choose the Practice as the PCP for the PHPs?	Tamara McLamb	tmclamb@jeffersandmann.com	The beneficiary will need to choose the practice as the PCP. However, the beneficiary will be able to see the individual provider that practices with the group.
In regards to Occupational, Physical and Speech Therapy services: 1) Is Medicaid going to continue to they continuing to cover teletherapy? a. If so, for how long? b. Will the reimbursement stay the same?	Toinette Laguerre	admin@PEDIATRICBOULEVARD.COM	COVID teletherapy flexibilities remain current and will continue through the end of the public health emergency. During this time, we are updating the outpatient specialized therapy policies to make teletherapy options permanent. We expect to complete this process before the public health emergency expires. The current reimbursement rates include a legislatively mandated enhancement of 5%. At this time, we do not expect the 5% enhancement to become permanent. Thank you.
In regards to Occupational, Physical and Speech Therapy services: Are prior authorizations still going to be required through Choice PA?	Toinette Laguerre	admin@PEDIATRICBOULEVARD.COM	If a beneficiary elects a standard plan, and crosses over into managed care on July 1, 2021, then their managed care health plan will administer all aspects of covered services including any PA requirements. If the beneficiary is part of a group temporarily exempt or excluded from managed care, then Medicaid Direct fee-for-service will continue to administer their covered services, and PA through CCME's ChoicePA portal would still be required. However, there are two exceptions. If a beneficiary moves into managed care on July 1, but receives services provided and billed by a CDSA, then those CDSA services would be "carved-out" of managed care and continue to be administered by Medicaid Direct. This is also true for services provided by LEAs or billed by LEAs (public schools). Thank you.

3) Will all recipients with a Medicaid Managed Care plan appear in NC tracks with their updated active Medicaid Managed Care Health plan?	Toinette Laguerre	admin@PEDIATRICBOULEVARD.COM	The Advanced Medical Home (AMH) Medicaid Direct/Managed Care Primary Care Provider (PCP) Enrollee Report, initially made available on March 15, 2021, is delivered each month to the NCTracks Secure Provider Portal Message Inbox the Monday before the second checkwrite. The Office Administrator for that NCTracks provider record, as well as those provisioned as an Enrollment Specialist, will be able to access the report, which will open as an Excel spreadsheet. The AMH Medicaid Direct/Managed Care PCP Enrollee Report contains a list of all NC Medicaid beneficiaries that have been assigned to the identified NPI in the past 12 months and contains the following information: NPI/Atypical ID Provider Name Service Location Address (to which the beneficiary is assigned) Medicaid Identification Number Recipient Name Date of Birth Active (Y or N) Assignment Program (i.e. Med-Dir for NC Medicaid Direct) Effective Date (of assignment) End Date (of assignment) Last Office Visit (based on paid claims from the billing NPI) Total Visits (based on paid claims for the past 12 months) To effectively use the report, add filters or sort the report based on an Active status of "Y". In this way, the provider can narrow the results to only display those currently assigned to the identified NPI. PCP changes are always effective the first day of the following month and will be reflected on new monthly report. The most unique feature of the AMH Medicaid Direct/Managed Care PCP Enrollee Report is the identification of the most recent office visit and total number of office visits paid within the past 12 months. This information is offered on the report so providers may confirm whether an active relationship exists with the beneficiary. The dates and number of visits is based on paid claims when the identified NPI in the

4) Will we be able to check eligibility for all recipients who have Medicaid with any of the Medicaid Managed Care plans?	Toinette Laguerre	admin@PEDIATRICBOULEVARD.COM	The Advanced Medical Home (AMH) Medicaid Direct/Managed Care Primary Care Provider (PCP) Enrollee Report, initially made available on March 15, 2021, is delivered each month to the NCTracks Secure Provider Portal Message Inbox the Monday before the second checkwrite. The Office Administrator for that NCTracks provider record, as well as those provisioned as an Enrollment Specialist, will be able to access the report, which will open as an Excel spreadsheet. The AMH Medicaid Direct/Managed Care PCP Enrollee Report contains a list of all NC Medicaid beneficiaries that have been assigned to the identified NPI in the past 12 months and contains the following information: NPI/Atypical ID Provider Name Service Location Address (to which the beneficiary is assigned) Medicaid Identification Number Recipient Name Date of Birth Active (Y or N) Assignment Program (i.e. Med-Dir for NC Medicaid Direct) Effective Date (of assignment) End Date (of assignment) Last Office Visit (based on paid claims from the billing NPI) Total Visits (based on paid claims for the past 12 months) To effectively use the report, add filters or sort the report based on an Active status of "Y". In this way, the provider can narrow the results to only display those currently assigned to the identified NPI. PCP changes are always effective the first day of the following month and will be reflected on new monthly report. The most unique feature of the AMH Medicaid Direct/Managed Care PCP Enrollee Report is the identification of the most recent office visit and total number of office visits paid within the past 12 months. This information is offered on the report so providers may confirm whether an active relationship exists with the beneficiary. The dates and number of visits is based on paid claims when the identified NPI in the
5) Will we continue to use NC Tracks to submit claims to the Infant Toddler Program?	Toinette Laguerre	admin@PEDIATRICBOULEVARD.COM	Hello, Thank you for your inquiry. The Infant Toddler program is handled through the Division of Public Health and they would be best suited to address this question for you. We have included their contact information below: Program contact info: DPH Early Intervention/NC Infant Toddler Program https://publichealth.nc.gov/contacts.htm https://beearly.nc.gov/index.php/contact/central-office Phone: (919) 707-5520 Thank you, NC Medicaid Division of Health Benefits

I have two providers who should be up for Re-verification in June, however, I have not received a Re-verification notice for either of them yet. Shouldn't I have already received notification by now since it is less than 2 mo. away. Should I contact someone about this?	Tina Flynn	tina@pedcenter.net	Yes - if you have questions please contact the NCTracks Call Center; 800-688-6696 or NCTracksprovider@nctracks.com. If you need additional assistance, please contact the Provider Ombudsman at Medicaid.ProviderOmbudsman@dhhs.nc.gov, or through the Provider Ombudsman line at 919-527-6666. The Provider Ombudsman contact information is also published in each Health Plan's Provider Manual.
How will the enrollment broker know if a practice is capable of taking more patients? While their NC Tracks may show they are open to new patients, their capacity could be limited.	Shanon Farrell	shanon.farrell@seahec.net	The enrollment broker does not determine panel size. 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 NC 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.
On the provider directory site for our organization, we were missing 2 of the PHPs we contract with, one of the PHPs were corrected on March 9th and then when the last PHP was added to our list in the directory, the PHP the was added on March 9th was deleted! Please help!!!!	Heide Dorfman	hsdorfman@aol.com	Please submit this to the Provider Ombudsman, 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.
Has network adequacy been met by all php's?	Shanon Farrell	shanon.farrell@seahec.net	N/A
My NC Tracks enrollment cap is supposed to be 1200. I currently have 1358 on my last list. Hoow can this happen? How can we cap the enrollment so that we are not overwhelmed at Go Live?	ANA HODGES	anahodges@me.com	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 NC 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.
That is a common question - is there a place where we can find the breakdown of PMPM CA management fee / health equity and glidepath payments. I determined mine by looking at the RA and doing the math, but it is not spelled out there.	Sara Naff-Mlo	snaffmlo@abcasheville.com	The RAs show the management fees broken out by cohort, but not broken out by AMH glidepath vs HEQ payments. Providers should have been paid the AMH and/or HEQ payment on top of each PMPM, so as long as Providers know the amount of the AMH glidepath payment and the HEQ payment, they should be able to determine the breakout.

FOr the question of provider enrollment panel cap, the PHPs do not have a way to cap. They recommended using the cap on NC Tracks. We have asked the PHPs directly.	ANA HODGES	anahodges@me.com	The health plans are required to “allow AMH/PCPs to set limits on panel size and have a process to do so.” We are working with the health plans now to release a provider playbook fact sheet on the details for this.
If we don’t sign up with PHPs, what does that mean for being able to see our current Medicaid beneficiaries?	Chris Weathington	chris.weathington@gmail.com	• Generally, covered services are expected to be delivered to beneficiaries by a PHP's network of participating providers. • PCPs who do not contract with health plans by established deadlines, risk losing patients, as beneficiaries may only select in-network (contracted) PCPs during open enrollment and health plans will assign beneficiaries to in-network providers only. • Providers who do not contract with health plans in a timely fashion may also miss out on the ability to earn per member per month (PMPM) payments through the Advanced Medicaid Home (AMH)program. • If a contract is not in place by Medicaid Managed Care launch on July 1, 2021, and the provider has not engaged in good faith negotiations, the provider is at risk for being reimbursed at 90% of the current Medicaid fee for service rate and subject to additional prior authorizations. • Providers who wish to participate in a PHP's network should continue to negotiate a contract with the PHP, even after managed care launch. Provider contracting is a continual process, and a Medicaid/NC Health Choice enrolled provider may always ask to join a PHP's provider network.