June 3 NCMT Hot Topics Fireside Chat
What Ifs

Q: Where can providers find out which health plans their hospital or organization is contracted with?

A: Providers should contact their own internal contracting area for this information. Additionally, participating providers for any health plan may be accessed on the EB website by review of the health plan and Provider Look up Tool or by visiting the health plan's own provider directory on their websites. Providers can lookup site by plan and location is: https://www.ncmedicaidplans.gov/enroll/online/find/find-provider-by-plan.

Q: Advanced Medical Homes Tier 3 (AMH3s) do not currently receive information on hospital admissions and discharge for patients. When we transition to managed care in July, will the health plans or Clinically Integrated Networks (CINs) provide the infrastructure that allows hospital admission and discharge data to be shared with the medical home in an efficient way? If so, who is responsible for ensuring that transfer of data and what systems will be used?

A: AMH Tier 3 providers are required to have a source of ADT (Admission, Discharge, Transfer) data in order to meet AMH 3 requirements. If a practice is using a CIN to meet his expectation, the practice should work with the CIN to ensure the practice receives that discharge information.

Q: What if a patient has a mental health crisis that puts them in need of intensive behavioral health services, how quickly can the patient be switched to Tailored Plan or Medicaid Direct and what is the process to get the patient the intensive services?

A: If the beneficiary needs a service that is only available in the Tailored plan, they can be switched within one business day of the date of the request.

Q: What if a patient signed up for the wrong plan during the enrollment period?

A: Beneficiaries will have 90 days after Managed Care Launch (until September 30, 2021) to change their health plan for any reason. After the 90-day choice period, beneficiaries can change their health plan if they have a special or “with cause” reason or at their Medicaid recertification date.

Q: What if a patient comes to the office for services at managed care launch (MCL) and that provider is not in network with their plan?

A: The health plans' collective goal will be to develop a robust network of providers. If, however, at MCL, a member's provider is out of network (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 undergoing an ongoing course of treatment.

Q: What if a patient is admitted to a hospital on June 30th and on July 1st that hospital is not in-network with the health plan they are assigned to? What if this situation occurs on the 61st day of managed care?

A: The transition to Managed Care does not impact Diagnosis- related group (DRG)-associated claims (that are not paid on a per diem basis) if admission occurred before July 1, 2021. As noted on pg 23 of

the NC DHHS Transition of Care Policy, the Medicaid fee-for-service program will pay DRG-associated claims for Medicaid beneficiaries who are admitted to an acute care facility and eligible for full Medicaid fee-for-service coverage prior to July 1 but discharged after July 1.

Q: What if a patient needs to see a provider that is out of network?

A: Health Plans will prioritize contracting with hospitals. Hospitals that are out of network with the member's Plan will be treated in parity with in-network providers for 60 days after July 1 or until the episode of care whichever occurs first unless the member's circumstance constitutes an ongoing course of treatment or an ongoing special condition as defined in the NC DHHS Transition of Care Policy. In such case, the member's Plan will adhere to the transitional periods established in NCGS 58-67-88.

Q: If I am an Advanced Medical Home Tier 3, how do I get information on the behavioral health services my patients are receiving?

A: As beneficiaries enroll into a Standard Plan, the Plan is required to send Assignment Data, Pharmacy Lock in Data, Claims Data and Risk Stratification information down to the AMH or Clinically Integrated Networks (CIN) that the beneficiary has been assigned to. In scenarios where the beneficiaries is transitioning from one AMH Tier 3 to another the Health Plan is required to start sending this data to the new Medical Home upon receipt of the new assignment. In addition, this data continuously flows, so if there is a claim submitted to a Health Plan for a service, that information will subsequently be sent down to the Medical Home. Behavioral health encounter data generated by Local Management Entity/Managed Care Organization (LME/MCOs) will be reflected in data provided at Crossover, and subsequent BH claims submitted to the Health Plan will also be reflected in claims data. Additional data may be available directly through Health Plan or by asking the Member.

Q: What if a patient chooses a Standard Plan, but because of their behavioral health needs should be in the Local Management Entity/Managed Care Organization (LME-MCO)/Tailored Plan?

A: The Tailored Plan will provide all of the services that are provided by the Standard Plans (except for their In Lieu of Services and Value-added services may be different). This includes physical health services. Additionally, Tailored Plans must have an open network for physical health providers. There will be required standards of quality for both plans.

Q: What if a child with complex medical needs that is obtaining care from multiple academic centers, is not able to get care from one specialist or center that is not in network with all their other specialists?

A: If, however, at Managed Care Launch (MCL), a member's provider is Out of Network (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 undergoing an ongoing course of treatment. If a Standard Plan is unable to provide the covered services from a network provider on a timely basis, the Standard Plan shall adequately and timely cover services out-of-network for a beneficiary. Note that out-of-network services generally require prior approval and the plan will likely try to get the individual to a participating provider.

Q: What if we are an advanced medical home Tier 3 (AMH3) and not getting hospital discharge summaries for our patients?

A: As beneficiaries enroll into a Standard Plan, the Plan is required to send Assignment Data, Pharmacy Lock in Data, Claims Data and Risk Stratification information down to the AMH or CIN that the beneficiary has been assigned to. In scenarios where the beneficiaries is transitioning from one AMH Tier 3 to another the Health Plan is required to start sending this data to the new Medical Home upon receipt of the new assignment. In addition, this data continuously flows, so if there is a claim submitted to a Health Plan for a service, that information will subsequently be sent down to the Medical Home. Behavioral health encounter data generated by Local Management Entity/Managed Care Organization (LME/MCOs) will be reflected in data provided at Crossover, and subsequent BH claims submitted to the Health Plan will also be reflected in claims data. Additional data may be available directly through the Health Plan or further conversation with the beneficiary.

Q: How do parents manage children in different plans (one child has Medicaid and the sibling has Health Choice or one child is in Standard Plan and the other is in Tailored Plan or Medicaid Direct)?

A: While auto enrollment algorithm helps ensure that family members are enrolled in the same plan where possible, it is possible that one child may be enrolled in a Standard Plan option while another child may be excluded or exempt. Any care management will be managed separately but both plans should consider the whole family dynamics when engaging in individual care planning.

Q: How do we get information on patients discharged from mental institutions (or other inpatient stay)? Will that information flow be different for different practice types?

A: Patient discharge information is a part of Admission, Discharge, Transfer (ADT) feeds from inpatient facilities. The practice's ability to ingest ADT feed is a requirement. However, ADTs do not often contain info on mental health (MH) hospitals. Some ADT feeds have more than others (for example the NCHA feed has more than HIE feed). Clinically Integrated Networks (CINs) should establish relationships with local BH hospitals and work with the health plans who are also very invested in having community - based providers help members being discharged; the Health Plan very much wants to help the person establish with services in the community.

Standard Plans are required to send Assignment Data, Pharmacy Lock in Data, Claims Data and Risk Stratification information down to the AMH or CIN that the beneficiary has been assigned to. This data continuously flows, so if there is a claim submitted to a Health Plan for a service, that information will subsequently be sent down to the Medical Home.

Q: What if a child needs specialized care that they can only get outside of the state, such as from the Children's Hospital of Philadelphia (CHOP)? Will the process for covering these services be the same for all the plans?

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. Referring providers should work through the child's care management and with the health plans to identify appropriate providers for the covered service. As services from out-of-state providers (beyond the 40-mile radius) can be covered under certain circumstances, utilization review and prior-approval will likely be required.

All health plans have indicated an intention to use single-case agreements with providers when a situation warrants such as this scenario.

Q: When a child is referred to the Child Medical Examiner (CME) by the DSS social worker, does the CME have to be the child's PCP? If the CME is not enrolled in the same health plan as the child, is prior approval required? What if the exam is requested by another provider or law enforcement?

A: NC Medicaid has an established process for child welfare to access care for children with suspected maltreatment. NC Medicaid Clinical Policy 1A-5, Child Medical Evaluation and Medical Team Conference for Child Maltreatment defines the services and spells out the requirements for the Examination. The examiner must be enrolled in NC Medicaid. When the service is requested by the DSS social worker and is completed according to policy, the health plan will pay the Examiner 100% of the established fee whether or not the Examiner is enrolled with the health plan.

A CME exam requested by law enforcement follows a process like that described in Policy 1A-5 but is not billed to NC Medicaid. There is separate funding for these exams.

Any child maltreatment evaluation outside of these procedures by any provider would need to follow the guidelines of the child's health plan. If the provider is not the child's PCP and is out-of-network with the child's health plan, prior approval may be needed. Providers who may be asked to do such an exam should become familiar with the requirements of each of the health plans.

Q: What if a foster care child needs to switch plans, will coverage under the new plan be retroactive to the beginning of the diagnosis/event that allows them to switch plans?

A: If a child enrolled in a Standard Plan enrolls in foster care, the foster care eligibility will be retroactive in nearly every case. The Standard Plan is responsible for coordinating the child's medical care until the disenrollment evidence is reflected. Providers may serve the child while under standard plan enrollment but due to the retroactive eligibility, may bill under Medicaid Direct.

Q: What if younger child has Medicaid version of a Plan and older child has Health Choice version?

A: NC Medicaid Standard Plan option will cover Medicaid and Health Choice beneficiaries. Each beneficiary population will continue to access the same benefits currently available to them now, once enrolled in a Standard Plan. Health Choice beneficiaries will continue to be ineligible for certain services otherwise covered by the Standard Plan such as Non-Emergency Medical Transportation (NEMT) and services available through the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit.

Questions

Q: Also, for the Certificate of Medical Necessity/Prior Approval (CMN/PA) form, in the past the start date was required to match the start date of the authorization. Since some plans will require new auth (for Durable Medical Equipment [DME]/Enteral specifically) will we also have to get new CMN/PA forms since we already have them on file and they're not expiring until the end of the year?

A: 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 (Sept. 29, 2021) or until the end of the authorization period, whichever occurs first.

Q: WellCare has indicated that any clean claims (services) provided before 9/29/21 will be paid WITHOUT authorization (due to the Transition of Care plan). Do all health plans plan to adhere to this plan for transition to care? Will ALL health plans pay for clean claims WITHOUT authorization until 9/29/21?

A: For the first 60 days after Launch (Aug. 30, 2021), the health plan will pay claims and authorize services for Medicaid enrolled out-of-network providers equal to that of in-network providers until end of episode of care or for 60 days, whichever is less (extended transition periods may apply for circumstances covered in N.C. Gen. Stat. § 58-67-88(d),(e), (f), and (g).).

Q: Are all health plans required to adhere to the same prior authorization process?

A: The health plans each have their own prior authorization process, the process is not required to be the same for all health plans. Each plan's provider handbook can be found here: https://medicaid.ncdhhs.gov/transformation/health-plans/health-plan-contacts-and-resources

Q: If a behavioral health provider is referred to prior to July 1st and that provider is not part of the new plan network, will a new behavioral health provider have to be found?

A: For the first 60 days after Launch (Aug. 30, 2021), the health plan will pay claims and authorize services for Medicaid enrolled out-of-network providers equal to that of in-network providers until end of episode of care or for 60 days, whichever is less (extended transition periods may apply for circumstances covered in N.C. Gen. Stat. § 58-67-88(d), (e), (f), and (g).)

Q: Will prior authorization/referrals be required from the patient's PCP in order to see a specialist?

A: Medicaid Direct beneficiaries need a referral from their Primary Care Provider (PCP) to see a specialist. Only the PCP can refer a beneficiary to another doctor. The health plans each have their own provider handbook and referral policies. These can be found here: https://medicaid.ncdhhs.gov/transformation/health-plans/health-plan-contacts-and-resources

Q: Can we assume that referrals to behavioral health providers, for testing for a child for example, that came in from a medical provider prior to July 1st, are treated the same as Prior Authorizations - in other words, we won't need, in the first 90 days after July 1st, to get a new referral from a health plan?

A: 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 (Sept. 29, 2021) or until the end of the authorization period, whichever occurs first

Q: Will a member receive a Medicaid card from the State and the health plan like Medicare, having 2 cards?

A: When you are approved for Medicaid or NC Health Choice, you will receive an Identification (ID) card in the mail. You will receive one ID card for Medicaid and one ID card for NC Health Choice for each eligible person. If you are enrolled in managed care, you will receive a new Medicaid card and welcome packet from your health plan - these will become effective on 7/1/21. Keep in mind that you should keep the ID card in case you become eligible again. You must also present your card to your doctor, pharmacist, or other provider at each visit so they can verify your eligibility. Your primary care physician (PCP) and medical home will be printed on the card. This is the doctor you visit for general medical care and to receive a referral to a specialist. If you visit a doctor who is not your PCP without a referral, this new doctor will need to contact your PCP and obtain a referral before you receive care. If your name or PCP changes, you will receive a new ID card with the updated information. If you lose your ID card, call your county Division of Social Services office to request a replacement card.

Q: How will it work if baby is born 06/30/2021 and inpatient newborn care continues to 07/02/21 discharge date? Will we file standard Medicaid for 06/30?

A: The provider should use the NCTracks Recipient Eligibility Verification function in the Provider Portal to verify enrollment information of the newborn and bill the appropriate health plan. When a child is enrolled in a health plan, that health plan will be visible to providers when they confirm the child's eligibility. Providers should bill the health plan the child is enrolled in, regardless of whether they are in-network or out-of-network. Providers can bill all health plans regardless of contracting status during the first 90 days of a newborn's life. Providers should know they may initially get a denial, but most health plans have an extenuating circumstances review that will allow payment. Providers should work with health plans to ensure payment. More information is listed in the Provider Playbook Fact Sheet page (https://medicaid.ncdhhs.gov/providers/provider-playbook-medicaid-managed-care/fact-sheets), specifically the link to the newborn fact sheet: https://files.nc.gov/ncdma/NCMT-Provider-FactSheet-Eligibility-for-Newborns-20210521-v5.pdf

Q: September 30th is the end of the 90-day easy transition period and the day that children who do not have their vaccinations or health forms submitted are excluded from school. Children who are excluded due to missing paperwork can miss school for weeks to months. Some will detect that they are not enrolled with their PCP and if that PCP is in a different health plan will have another barrier for completing paperwork. What can we do to help families get timely documentation and minimize barriers?

A: Beneficiaries who did not select a health plan during open enrollment, which ended on May 21, were auto enrolled in a plan. NCDHHS' auto-enrollment process prioritized existing relationships between beneficiaries and their PCP and, where possible, a plan that has contracted with that provider was selected for the beneficiary. A summary of NC Medicaid Managed Care enrollment by plans and regions can be found here. Confirmation notices and health plan welcome packets will be mailed to beneficiaries through June 12. Beneficiaries have until Sept. 30, 2021 to change plans for any reason.

Whether beneficiaries chose a plan during open enrollment or were auto enrolled by NC Medicaid, everyone will have through Sept. 30, 2021, to change their health plan or primary care provider for any reason by contacting the NC Medicaid Enrollment Broker. After that, unless there is a special reason, beneficiaries must wait until their next Medicaid recertification date to change health plans. If beneficiaries only want to change their PCP, they should contact their enrolled health plan.

Most beneficiaries in NC Medicaid must be enrolled in a managed care health plan. More information can be found on the "Do I Need to Choose a Health Plan?" fact sheet. Beneficiaries are encouraged to visit the NC Medicaid Enrollment Broker website at ncmedicaidplans.gov or call the Enrollment Broker at 833-870-5500 (TTY: 833-870-5588) with any additional questions.

Q: A health plan's prior authorization requirements (for newborns or anyone else, "well-checks" or otherwise) are a product of the obligations upon which the health plan and the provider have agreed by contract. An earlier response seems to suggest that an out-of-network provider would be bound by the health plan's PA requirements—even though such a provider is, by definition, NOT in contract with that health plan. How can the provider be bound by the terms of a contract it never signed?

A: Out-of-Network Providers will file services covered under Medicaid Managed Care directly with the health plan. Out-of-Network providers are required to get a prior authorization from the assigned health plan before providing services and may need to complete a single case agreement to receive payment. If the provider has engaged in good faith negotiations with the health plan but failed to contract, the out-of-network provider will be paid at 90% reimbursement. If the health plan has not yet engaged in good faith negotiations, the provider would be reimbursed at 100%. Please refer to the appropriate health plan provider directories and websites linked above for additional details

Q: Is there an annual treatment/visit limit for rehab therapy services?

A: Carolina Complete: NC clinical guidelines state 27 visits/yr. max combined therapies. With IQ guideline review and Medical Director discussion/agreement, our UM process will tentatively continue to be review for a possibility of 36 visits with the exception of EPSDT. Please reach out to us if you have any additional questions.

Healthy Blue: Healthy Blue has the following requirements captured per DHHS benefit guidance:

ADULTS - Outpatient Specialized Therapy is limited to twenty-seven (27) therapy treatment visits, per plan year across all therapy disciplines combined (occupational therapy, physical therapy, speech, and language therapy).

CHILD – No limit

AmeriHealth: will require prior authorization for medical necessity after the 12th visit for PT, OT, and Speech Therapy and is not imposing annual visit limits for any of these modalities at this time as we will manage utilization via our planned Prior Authorization processes.

United HealthCare: As rehabilitative therapies can be provided in various settings and modalities, UHC wanted to ensure we are answering the question.

•For Admissions to WakeMed Rehab facility, there are no limitations, but the services provided must meet medical necessity.

•With COVID flexibilities, Telehealth is enabled for PT/OT/ST therapies.

From an Outpatient therapy perspective, UHC follows the guidelines provided in the NC DHHS clinical coverage policy 10A, Outpatient Specialized Therapies.

For members over 21:

•The first prior approval request within a calendar year shall be for no more than three therapy treatment visits and one month.

•The PA review vendor will authorize these three treatment visits to begin as early as the day following the submission of the PA request.

•Any subsequent PA may be obtained for up to 12 therapy treatment visits and six months.

•A beneficiary can receive a maximum of 27 therapy treatment visits per calendar year across all therapy disciplines combined (occupational therapy, physical therapy, and speech/language therapy).

•Each reauthorization request must document the efficacy of treatment

For members under 21:

All requests are reviewed for medical necessity.

WellCare: A beneficiary over the age of 21 can receive a maximum of 27 therapy treatment visits per calendar year across all therapy disciplines.

Q: Where is the provider form located for the change request?

A: The Health Plan Change Request form can be found here: https://ncmedicaidplans.gov/sites/default/files/Documents/NCEB_HealthPlanChangeForm_ENG_v13WEB_041719.pdf

Q: Is there a 27-visit cap for children over age 3 who are receiving specialized therapy services?

A: AmeriHealth: ACNC will require prior authorization for medical necessity after the 12th visit for PT, OT, and Speech Therapy and is not imposing annual visit limits for any of these modalities at this time as we will manage utilization via our planned Prior Authorization processes.

Carolina Complete: NC clinical guidelines state 27 visits/yr. max combined therapies. With IQ guideline review and Medical Director discussion/agreement, our UM process will tentatively continue to be review for a possibility of 36 visits with the exception of EPSDT. Please reach out to us if you have any other questions.

HealthyBlue: Healthy Blue has the following requirements captured per DHHS benefit guidance:

ADULTS - Outpatient Specialized Therapy is limited to twenty-seven (27) therapy treatment visits, per plan year across all therapy disciplines combined (occupational therapy, physical therapy, speech, and language therapy).

CHILD – No limit

United HealthCare: UHC reviews all children therapy requests for medical necessity.

WellCare: 27 visit cap applies to individuals over the age of 21

Q: How can out of network providers be paid full in network rates first 60 days? How does the computer pay the claim if the doc is out of network? Division of Medical Assistance (DMA) is asserting they will- has DMA tested out of network claims with the plans?

A: Out-of-Network Providers will file services covered under Medicaid Managed Care directly with the health plan. Out-of-Network providers are required to get a prior authorization from the assigned health plan before providing services and may need to complete a single case agreement to receive payment. If the provider has engaged in good faith negotiations with the health plan but failed to contract, the out-of-network provider will be paid at 90% reimbursement. If the health plan has not yet engaged in good faith negotiations, the provider would be reimbursed at 100%. Please refer to the appropriate health plan provider directories and websites linked below for additional details.

AmeriHealth Caritas of North Carolina:
https://www.amerihealthcaritasnc.com/provider/forms/index.aspx

Blue Cross and Blue Shield of North Carolina | Healthy Blue: https://provider.healthybluenc.com/north-carolina-provider/resources

Carolina Complete Health:
https://network.carolinacompletehealth.com/content/dam/centene/carolinacompletehealth/pdfs

WellCare of North Carolina: https://www.wellcare.com/en/North-Carolina/Providers/Medicaid/Claims

DHHS: https://medicaid.ncdhhs.gov/providers/claims-and-billing

There are also two Claims Fact Sheets posted on the Provider Playbook that provide more information:
https://medicaid.ncdhhs.gov/providers/provider-playbook-medicaid-managed-care/fact-sheets

Q: When will the network adequacy report come out in June? This is important for referrals and transitions of care management.

A: The Department continues to monitor the health plans' networks to measure the health plans' progress toward meeting the network adequacy standards. Practitioners seeking to know an in-network provider to whom they may refer a patient should refer to the Enrollment Broker's Provider Look-up and/or the health plan's member-facing provider directory found on the health plan's website for a listing of participating providers. The practitioner should also contact the patient's health plan for assistance on making a referral.

Q: Slide 21 indicates that the behavioral health patient's disenrollment request must be signed by "Member or Legal Guardian." Chapter 108D of the General Statutes (and related CFR provisions) do not impose any "guardianship" requirement for an authorized representative to act on an enrollee's

behalf concerning disenrollment requests. Can you clarify why the Department is referring to guardians in this context?

A: The form can be signed by an authorized representative as allowed by 42 CFR 435.923(b) which provides:

(b) Applicants and beneficiaries may authorize their representatives to -

(1) Sign an application on the applicant's behalf;

(2) Complete and submit a renewal form;

(3) Receive copies of the applicant or beneficiary's notices and other communications from the agency;

(4) Act on behalf of the applicant or beneficiary in all other matters with the agency.

Q: Can you provide response in writing to the Child Medical Evaluation (CME) question, so we have it for future reference?

A: NC Medicaid has an established process for child welfare to access care for children with suspected maltreatment. NC Medicaid Clinical Policy 1A-5, Child Medical Evaluation and Medical Team Conference for Child Maltreatment defines the services and spells out the requirements for the Examination. The examiner must be enrolled in NC Medicaid. When the service is requested by the DSS social worker and is completed according to policy, the health plan will pay the Examiner 100% of the established fee whether or not the Examiner is enrolled with the health plan.

A CME exam requested by law enforcement follows a process like that described in Policy 1A-5 but is not billed to NC Medicaid. There is separate funding for these exams.

Any child maltreatment evaluation outside of these procedures by any provider would need to follow the guidelines of the child's health plan. If the provider is not the child's PCP and is out-of-network with the child's health plan, prior approval may be needed. Providers who may be asked to do such an exam should become familiar with the requirements of each of the health plans.

Q: Will the member's Medicaid ID numbers remain the same or will the health plans assign a new ID?

A: Medicaid ID numbers are not changing with NC Medicaid Managed Care. They will stay the same for health plan members.

Q: If the current panels are messed up, how are we be sure it is 97% right? i.e., who do you think the current PCP is? Wil it be the name on the Medicaid card March 1 or algorithm-based analysis of PCP?

A: The department released this press release on 5/26: https://www.ncdhhs.gov/news/press-releases/2021/05/26/nc-medicaid-managed-care-health-plan-assignments-completed-beneficiaries

The North Carolina Department of Health and Human Services announced all Medicaid beneficiaries currently eligible to transition to managed care have selected or been assigned a health plan with 97% enrolled in a plan that includes their current primary care provider (PCP) in network.

Nearly all current beneficiaries will keep the same health care provider they have today when managed care launches on July 1. That means more families can continue to visit the practices and doctors who know them best and are familiar with their specific health care needs.

Beneficiaries who did not select a health plan during open enrollment, which ended on May 21, were auto enrolled in a plan. NCDHHS' auto-enrollment process (https://files.nc.gov/ncdma/documents/Providers/playbook/AutoEnrollment-FACTSHEET_FINAL_202310525.pdf) prioritized existing relationships between beneficiaries and their PCP and, where possible, a plan that has contracted with that provider was selected for the beneficiary. A summary of NC Medicaid Managed Care enrollment by plans and regions can be found here (https://files.nc.gov/ncdma/NC-Medicaid-Enrollment-Summary-2021-0524-noon.pdf). Confirmation notices and health plan welcome packets will be mailed to beneficiaries through June 12. Beneficiaries have until Sept. 30, 2021 to change plans for any reason.

Whether beneficiaries chose a plan during open enrollment or were auto enrolled by NC Medicaid, everyone will have through Sept. 30, 2021, to change their health plan or primary care provider for any reason by contacting the NC Medicaid Enrollment Broker (https://ncmedicaidplans.gov/). After that, unless there is a special reason, beneficiaries must wait until their next Medicaid recertification date to change health plans.

Q: Has the patient panel list been posted to NC Tracks yet so that we can see which beneficiaries have been assigned to each of our providers?

A: Participating providers for any health plan may be accessed on the EB website by review of the health plan and Provider Look up Tool or by visiting the health plan's own provider directory on their websites. Providers can lookup site by plan and location is https://www.ncmedicaidplans.gov/enroll/online/find/find-provider-by-plan.

Q: We applied for reconsideration as to 5/21. When will our healthcare system be notified of the decision?

A: Based on the information and documentation shared to support your reconsideration request, the Department was able to approve payment for the month(s) of June, your organization should have receive payment in the June check write for this time period.

Practice Name	NPI	Location Code
THE MOSES H CONE MEMORIAL HOSPITAL	1013265909	003
MOSES CONE AFFILIATED PHYSICIANS IN	1053603001	003
MOSES CONE PHYSICIAN SERVICES INC	1073881850	005
MOSES CONE PHYSICIAN SERVICES INC	1093953127	012
MOSES CONE AFFILIATED PHYSICIANS IN	1114228475	003
MOSES CONE PHYSICIAN SERVICES INC	1194233171	003

MOSES CONE AFFILIATED PHYSICIANS IN 1326346602 003

THE MOSES H CONE MEMORIAL HOSPITAL 1336564863 003

THE MOSES H CONE MEMORIAL HOSPITAL 1356372064 032

THE MOSES H CONE MEMORIAL HOSPITAL 1356372064 004

MOSES CONE MEDICAL SERVICES INC 1417383837 003

MOSES CONE MEDICAL SERVICES INC 1427095249 008

MOSES CONE AFFILIATED PHYSICIANS IN 1437643988 003

MOSES CONE MEDICAL SERVICES INC 1629376363 003

MOSES CONE PHYSICIAN SERVICES INC 1871954123 003

MOSES CONE AFFILIATED PHYSICIANS IN 1972949949 003

ARMC PHYSICIANS CARE INC 1881938405 003

ARMC Physicians Care 1083917249 003

THE MOSES H CONE MEMORIAL HOSPITAL 1336564863 003

ARMC PHYSICIANS CARE INC 1073816997 003

ARMC PHYSICIANS CARE INC 1568745149 003

ARMC PHYSICIANS CARE INC 1093017154 003

Q: If we have patients scheduled for services on or after 7/1 for a service that current Medicaid does not require Prior Authorization (PA) but the health plans do require? How should we handle these situations?

A: For the first sixty (60) days after Managed Care Launch (MCL), health plans are required to pay claims and authorize services for Medicaid eligible nonparticipating/out-of-network providers equal to that of in-network providers until the end of Episode of Care or the 60 days, whichever is less. 3Unless the Member has an Ongoing Special Condition or is under an Ongoing Course of Treatment. In these circumstances, the health plan shall follow the timeframes provided in N.C. Gen. Stat. § 58-67-88(d), (e), (f), and (g).

Q: How do we check the eligibility for the patient?

A: In NCTracks, the provider will be able to verify eligibility and Managed Care enrollment through the NCTracks Recipient Eligibility Verification function available in the Provider Portal once eligibility has been processed.

Q: What if a member's Medicaid is a month by month approval. If they are listed as Standard Plan but it has not shown in Tracks as 7/1/21-7/31/21 will they still be moved to Standard Plans? If not, how will they be moved over post 7/1?

A: While most Medicaid beneficiaries must enroll in NC Medicaid Managed Care, some people will stay in NC Medicaid Direct. These groups, or populations, are defined by their Managed Care status. More information on who must enroll, may enroll, or cannot enroll can be found here: https://medicaid.ncdhhs.gov/documents/county/county-playbook/ncmt-fact-sheet-managed-care-populations-and-enrollment-notices/download.

Q: Prior authorizations were not required for many services under the beneficiary's current plan. If authorizations will be required under the new plan, will there be a grace period?

A: There is not a grace period for entering prior authorization (PA) requests for beneficiaries moving to the Health Plans. If a beneficiary requires a procedure or office visit that requires PA, the provider must enter a PA request following the Health Plan's guidelines. Provider handbooks, clinical policies, and contact information for the Health Plans can be found here: https://medicaid.ncdhhs.gov/transformation/health-plans/health-plan-contacts-and-resources

Q: I have an after-hours clinic and the providers are billed out as just family med providers or internal medicine. How do I prevent these providers from getting auto enrolled patients?

A: Auto Assignment occurred the last week in May. Health plans are responsible for informing PCP/AMH of attributed members once assignment occurs. In addition, NC Tracks offers a monthly report to PCP/AMH to view beneficiaries assigned to them in Managed Care as well as FFS. Although the AMH Medicaid Direct/Managed Care PCP Enrollee Report does not currently identify the benefit program

(Medicaid or NC Health Choice) of the beneficiary, the report includes functionality to identify health plan members and the name of the health plan to which each is assigned beginning in future iterations. The June 2021 report contains only Medicaid Direct members and subsequent monthly reports will contain Medicaid Direct and health plan assignment information. DHHS is working to prepare a supplement to the June enrollee report that list Managed Care assignment data.

Beneficiaries have thirty (30) days from the effective date of the AMH assignment (regardless of the notification date) to change their AMH/PCP without cause (1st instance) and shall be allowed to change their AMH/PCP without cause up to one time per year thereafter (2nd instance). In addition, Members shall be allowed to change their AMH/PCP with cause at any time. During crossover in year one, most beneficiaries will have until August 1, 2021 to change their PCP/AMH for any reason.

For more information on auto assignment, and which providers were included in the algorithm, please review the "Member Enrollment: Part 2 - Primary Care Provider (PCP)/Advanced Medical Home (AMH) Auto-Assignment" Fact Sheet here: https://medicaid.ncdhhs.gov/providers/provider-playbook-medicaid-managed-care/fact-sheets

Q: Is the plan for Medicaid Direct to transition over to Managed Care over time?

A: The statewide launch of NC Medicaid Managed Care is July 1, 2021. A small percentage of beneficiaries will stay in NC Medicaid Direct

Q: If I'm out of network, I didn't agree to the health plan's policies/etc. (including PA). Is the Department saying I am subject to those policies?

A: Out-of-Network Providers will file services covered under Medicaid Managed Care directly with the health plan. Out-of-Network providers are required to get a prior authorization from the assigned health plan before providing services and may need to complete a single case agreement to receive payment. If the provider has engaged in good faith negotiations with the health plan but failed to contract, the out-of-network provider will be paid at 90% reimbursement. If the health plan has not yet engaged in good faith negotiations, the provider would be reimbursed at 100%. Please refer to the appropriate health plan provider directories and websites for additional details.

Q: Who do we reach out to at the health plan when there are problems?

A: Before July 1, 2021: NCTracks Call Center, 800-688-6696

Starting July 1, 2021:

All health plans except EBCI Tribal Option: Health Plan's Provider Support line, listed below.

EBCI Tribal Option: NCTracks Call Center, 800-688-6696

-amerihealthcaritasnc.com

Provider Support Line: 888-738-0004

Provider Contracting Questions:

844-399-0474

ProviderRecruitmentNC@amerihealthcaritas.com

-carolinacompletehealth.com

Provider Support Line: 833-552-3876

Provider Contracting Questions:

833-552-3876

networkrelations@cch-network.com

-healthybluenc.com/north-Carolina/home.html

Provider Support Line: 844-594-5072

Provider Contracting Questions:

844-415-2045

NCproviderquestions@nchealthyblue.com

-https://www.uhccommunityplan.com/nc/medicaid/medicaid-uhc-community-plan

Provider Support Line: 800-638-3302

Provider Contracting Questions:

781-419-8322

CarolinasPRTeam@uhc.com

-wellcare.com/Nc

Provider Support Line: 866-799-5318

Provider Contracting Questions:

984-867-8637

Fax: 813-283-3045

NCProviderRelations@WellCare.com

If you contact the health plans and you are not able to get assistance, then the NC Medicaid Provider Ombudsman represents the interests of the provider community by offering supportive resources and assistance in resolution of provider inquiries, concerns, or complaints regarding health plans. Inquiries may be submitted by:

Emailing Medicaid.ProviderOmbudsman@dhhs.nc.gov or Calling the Medicaid Managed Care Provider Ombudsman at 919-527-6666

Q: What if our prior auth ends July 5th? The health plan is telling us they need 14 days to process the auth request. How is this handled?

A: 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

Q: How should referrals be requested?

A: A referral authorization is not initiated by Medicaid. The primary care provider (PCP) must arrange or receive authorization for referrals and document referrals for specialty care in your medical record. Referrals may be made by phone or in writing from the PCP with the specific reason for the referral, including the number of visits and the length of time the referral is authorized. The provider who receives the referral should consult with your PCP before referring you to another (secondary) provider.

Q: Who will talk to angry patients?

A: The NC Medicaid Ombudsman will perform outreach to beneficiaries and/or their authorized representatives and be accessible in multiple, integrated ways, utilizing a "no wrong door" approach for providing information about NC Medicaid and the NC Medicaid Managed Care program.

WEBSITE will provide beneficiary-focused educational materials regarding the NC Medicaid Managed Care program. For more information visit, ncmedicaidombudsman.org.

CALL CENTER will be open at least five days a week and can accommodate after-hour calls through messaging systems. To reach the NC Medicaid Ombudsman, call 877-201-3750 from 8 a.m. to 5 p.m., Monday through Friday, except for state holidays.

OUTREACH EVENTS hosted independently by the NC Medicaid Ombudsman as well as joint events with the health plans and the Enrollment Broker.

Beneficiaries should call the NC Medicaid Ombudsman when:

• They are not getting the care they need.

• They have questions about a notice or bill they have received.

• They have already talked with their health care provider or health plan and have not been able to solve the problem.

• They have questions about the complaint or appeal process.

Q: What determines if a patient needs a referral?

A: Medicaid Direct beneficiaries need a referral from their Primary Care Provider (PCP) to see a specialist. Only the PCP can refer a beneficiary to another doctor. The health plans each have their own provider handbook and referral policies. These can be found here: https://medicaid.ncdhhs.gov/transformation/health-plans/health-plan-contacts-and-resources

Q: Carve Out - is this where we would bill Dental, Optical etc.? Same address as health plan or to Medicaid Direct?

A: NCDHHS has defined services that will be carved out of NC Medicaid Managed Care and should continue to be billed through NCTracks.

More information can be found here https://files.nc.gov/ncdma/documents/Providers/playbook/NCMT-Provider-FactSheet-Claims-Routing-Part-1-20210209-DRAFT.pdf/

The services are listed below:

Services provided through the Program of All-Inclusive Care for the Elderly (PACE)

Services documented in an Individualized Education Program (IEP), Individual Family Service Plan (IFSP), a section 504 Accommodation Plan pursuant to 34 C.F.R. § 104.36, an Individual Health Plan (IHP) or a Behavior Intervention Plan (BIP) as appropriate for each covered service and provided or billed by Local Education Agencies (LEAs)

Services provided and billed by Children's Developmental Services Agency (CDSA) that are included on the child's IFSP

Dental services defined as all services billed as dental using the American Dental Association's Current Dental Terminology (CDT) codes with the exception of the two CDT codes (D0145 and D1206) associated with the "Into the Mouths of Babes" (IMB)/Physician Fluoride Varnish Program

Services for Medicaid applicants provided prior to the first day of the month in which eligibility is determined, in cases where retroactive eligibility is approved (with exception of deemed newborns), unless otherwise defined in the Contract

Fabrication of eyeglasses, including complete eyeglasses, eyeglass lenses and ophthalmic frames