May 20 NCMT Hot Topics Fireside Chat
What Ifs

Q: Will all health plans reimburse both medical and routine diagnosis on the same visit?

A: The health plans will not be required to pay both medical and routine on the same day because current Medicaid Clinical Coverage Policies (CCP) 6A and 6B state in Attachment B.B.1.c. "General ophthalmological exams and office visits must not be billed by the same provider on the same day as a routine eye exam (S0620 or S0621) or a refraction only (92015). Since Medicaid CCP does not require payment of medical and routine vision services on the same day by the same provider, health plans will not be required to do so, either.

Q: For hearing aids, some managed care companies are using hearing aid third party companies and these companies are mostly used for adult hearing aid services. Will audiologists be able to get pediatric friendly devices (with tamper proof battery doors, etc.) and be reimbursed for ongoing maintenance and earmolds?

A: The State's contract with the health plans requires that all health plans and third-party vendors meet the floor of current clinical coverage policy. They may NOT be more restrictive than current policy (CCP). Providers and members may expect to have access to at least the same services provided under current Medicaid CCP.

Q: When a patient is seen in June 2021 and orders glasses through the state that do not arrive until after July 1st, 2021, to whom should the provider bill the dispensing fee?

A: The receiving health plan (the health plan the beneficiary moved to) is responsible for the dispensing fee covered under the original prior approval. This is true when a beneficiary moves from Medicaid Direct to a health plan or from one health plan to another. If the provider doesn't enroll with the new health plan, the health plan will honor the prior approval and pay the dispensing fee, but the provider will not be reimbursed more than 90% of FFS rate.

Q: Will EPSDT now apply when you have an NC Health Choice child receiving physical therapy or occupational therapy and if so, does it change the referral process for providers making the referral?

A: Per any Medicaid clinical coverage policy, subsection 2.2.2 "EPSDT does not apply to NCHC beneficiaries."

Q: When will we know which agencies and therapists are signed up with which health plans?

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

The provider directory is updated daily with information consolidated from health plans and NCTracks. https://www.ncmedicaidplans.gov/enroll/online/find/find-plan-by-provider

Q: In many cases a particular speech therapy practice is the sole or preferred provider for one school. What If the speech therapy practice is not contracted with the children's health plans on July 1?

A: Services provided by Local Education Agency (LEA) (public schools) or billed by LEAs are carved-out of managed care. If an LEA submits claims for services provided by a contractor, then that service will be

paid directly by Medicaid to the LEA and carved-out of managed care. A contractor doing their own billing must submit claims to the beneficiary's health plan. health plans are required by the managed care contract to work with out-of-network providers as if they are in-network for the first 60 days after managed care launches. Medicaid recommends that providers contract with as many health plans as possible to prevent continuity of care issues.

Q: Does the patient's assigned primary care physician (PCP)/PCP practice have to make the referral for occupational therapy or can any in-network provider that the patient is seeing make that referral?

A: The managed care contract does not require that outpatient specialized therapy services only be ordered by the member's primary care physician.

Q: Will the process for referring patients to specialized therapists be the same across plans?

A: Plans will often work together to ensure processes are comparable across plans to reduce provider burden. However, Plans have the flexibility to establish Plan-specific processes and referral requirements. Plans are not allowed to change the amount, duration and scope of service requirements established in Clinical Coverage Policy.

Q: One health plan has implemented speech therapist rate cuts statewide for their commercial plans. Will there be pay cuts for Medicaid speech therapists?

A: No. There is no current plan to update the Medicaid Direct rate for outpatient specialized therapy providers.

Q: Standard plans do not cover occupational therapy and behavioral health services for beneficiaries over 21 years old. Is there a plan to cover these services for this age group?

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". Given that when PA requirements are met, NC Medicaid covers occupational therapy (OT) for beneficiaries over 21yoa when provided by home health agencies, hospital outpatient clinics, and physician offices that employ OTs, the health plans are expected to cover OT for this population of members as well. The Standard Plan will cover BH services for individuals over the age of 21.

Q: What if all outpatient specialized therapies could continue to submit prior authorizations (PA) through Choice PA and The Carolinas Center for Medical Excellence (CCME) after July 1, 2021 and have those PAs transferred to the health plans during the transition period (one centralized, low provider burden PA process across all the plans for specialized therapies)?

A: In managed care each health plan will manage its own PA process and use its own PA vendor. CCME will continue to review PAs for beneficiaries who remain in Medicaid Direct after 7/1/2021.

Q: Some health plans are requiring specialized therapists to obtain a physician order before doing an initial evaluation, but this is not a current requirement under Medicaid Direct for physical therapists, occupational therapists, and speech therapists?

A: Even though PA is not required for a specialized therapy evaluation, specialized therapy claims must include the NPI of the individual practitioner who signed the order for therapy services. In managed care

the health plans are required to cover the same services in amount, scope, and duration as in Medicaid Direct. The managed care contract allows health plans to employ different PA criteria as part of their utilization management program as long as they are evidence-based and provide a reasonable pathway to coverage. Requiring an order for a specialized therapy evaluation would not be considered more restrictive.

Q: Who will be reviewing requests for specialized therapy? Can it be a peer instead of another health care provider type (e.g., nurse, social worker, MD)?

A: There does not appear to be a requirement specified in the managed care contract for specialized therapy PA reviews to be carried out by therapist-peer reviewers.

AMHC: "Reviewers can consult with external peer reviewers for complex cases, but do not offer routine review by a therapy peer for every request at present."

BCBS: "Healthy Blue will have licensed Physical Therapists, Speech Therapist, and a PM&R [phys medicine and rehab] physician reviewing all therapy requests."

CCHE: "Nurses will be able to approve therapy cases that are determined to meet coverage criteria. If there is a question regarding coverage, then therapy peer advisors will be summoned for their expertise and the recommendations of those peer specialists will be utilized by the UM team to render final decisions."

UNHC: "Will use therapist-peers to review cases."

WCHP: "Clinical determinations are rendered only by clinical peer reviewers with appropriate clinical experience and similar specialty expertise as the requesting provider."

Q: How do we know which specialized therapy providers are in a health plan's network?

A: Participating providers for any health plan may be accessed on the EB website by review of the health plan and Medicaid and NC Health Choice Provider and Health Plan Lookup Tool or by visiting the health plan's own provider directory on their websites. OT/PT/ST providers are subject to a specific network adequacy standard measured by how far (in time or distance) a member must travel from their home to at least 2 providers OF EACH TYPE (each type must have compliance). The Department has considered the readiness of the health plan's networks as we set limits on participation in the auto-enrollment process. (JV: provider lookup site by plan and location is https://www.ncmedicaidplans.gov/enroll/online/find/find-provider-by-plan

Q: Will the State use outcome metrics to track the quality and value of specialized services provided by the health plans

A: The Health Plan measures are found here in the Medicaid Technical Specifications. https://files.nc.gov/ncdma/Technical-Specifications-Manual-20210401.pdf

Q: How will ChoicePA specialized therapy authorizations approved prior to 7/1 be managed by the health plans:

> **a. Will the authorization be recognized by the health plan on 7/1 or will providers have to contract with the patient's health plan and submit a new authorization beginning 7/1?**

b. If the authorization is honored by the health plan and ends after 7/1, where should the claim for services delivered on 7/1 be sent? Where should the claims for services delivered after 7/1 and until the authorization expires be sent (NCTracks or the health plan)?

A: The health plan must honor existing and active prior authorizations on file with the NC Medicaid or NC Health Choice program for the first 90 days after managed care implementation to ensure continuity of care for members. Claims for dates of service before July 1 should be submitted through NCTracks for payment. For beneficiaries who crossover into a managed care plan on July 1, claims for dates of services on and after July 1 should be submitted to the member's health plan.

Q: Since the Department has a standardized prior authorization request form for use with all 5 health plans:

a. Will specialized therapy providers have to use the standardized prior authorization request form? If yes, where is the form posted?
b. Will specialized therapy providers need to submit the same information to the health plan that is currently being sent to ChoicePA and The Carolinas Center for Medical Excellence (CCME) for authorization, reauthorization, and discharge requests?
c. Will re-authorizations continue to be accepted through the ChoicePA web portal or will each insurance carrier (health plan) have a separate authorization process?

A: The health plan shall use a standardized prior authorization request form developed by the Department." The form may be optional for health plans who utilize an electronic portal for PA submissions. The information necessary for PA submissions will be specified by each health plan. After July 1, PA submissions for managed care members should be submitted to each member's health plan. For beneficiaries who remain in Medicaid Direct, PA requests should continue to be submitted to CCME through the ChoicePA portal.

Q: Will the 5 health plans have to follow the same clinical policy coverage policies for Medicaid Direct for the first 4 years of managed care? What will change in the 5th year?

A: There is no managed care contractual requirement for the outpatient specialized therapies policies to be followed exactly by the health plans for 4 years. In managed care the health plans are required to cover the same services in amount, scope, and duration as in Medicaid Direct. The managed care contract allows health plans to employ different PA criteria as part of their utilization management program as long as they are evidence-based and provide a reasonable pathway to coverage.

Q: Will the health plans have access to the prior authorization records for specialized therapy services reviewed and approved by The Carolinas Center for Medical Excellence (CCME)?

A: Active PAs for managed care members transferred from NCTracks to the member's health plan would only include technical information like service approved, start and end date of authorization, units/visits approved, and provider NPIs. There is no requirement for CCME to transfer to a member's health plan any records used in the determination of medical necessity.

Q: How is third party liability determined for children with commercial and Medicaid insurance? Does pay and chase apply?

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

Q: Will the services provided through EPSDT be different across plans? For example, right now vitamins are covered for children with nutrition deficiency; will this remain the same across plans?

A: The EPSDT benefit guarantees are federal in their origin. Social Security Act, §1905(a)(r) [42 CFR 1396 (d)(r)] allow any service the federal Medicaid program covers to be available to children under 21 years of age when they are found medically necessary to 'correct or ameliorate' a health condition. Implementation of the EPSDT benefit is consistent across MCO contracts and is uniform across the state. Q2) Will the services provided through EPSDT (therapy, etc.) be different for across plans? A: Generally, services provided for most children will be accessible regardless of their Plan. Some very intensive services (Residential Treatment, as an example), along with Innovation Waiver services will be available under Tailored Plans. Q3) Right now vitamins are covered for children with nutrition deficiency; will this remain the same across plans? A) Some 'over-the-counter' drugs or vitamins may be covered differently as a 'value-added' benefit across the plans. For children with specialized medical needs, these products may be covered when they are found medically necessary to 'correct or ameliorate' a health condition by a professional review applying EPSDT criteria.

Q: Will any services not be available to beneficiaries receiving Innovation Waiver services who stay on Medicaid Direct? How does a Medicaid beneficiary know if they should be in Standard Plan or Tailored Plan or Medicaid Direct?

A: Individuals who remain on the Innovations waiver and in Medicaid Direct will continue to have access to the same services. The individual can confirm the plan in which they are enrolled by contacting the enrollment broker. Individuals who qualify for a Tailored Plan received notices informing them of their status and that they were exempt from enrolling in Standard Plans.

Q: Will Medicaid Direct medically fragile children have the same benefits when they transition?

A: Medically fragile children participating in the Community Alternatives Program for Children 1915(c) HCBS waiver are temporarily excluded from Managed Care. These children will not transition to Managed Care. For those Medically fragile children choosing to transition to Managed Care, their benefits should be, at a minimum, equal to the services they were receiving in the waiver.

Q: Is there a website where families can learn about upcoming changes to the Medicaid program?

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

For more information, please visit the NC Medicaid enrollment website at https://ncmedicaidplans.gov/

Q: What if a patient changes from one health plan to another health plan after July 1 and we have a prior authorization (PA) from the first health plan, will the new plan honor the PA of the first health

plan through the end date and if not, how long does the provider have to submit a new request for authorization?

A: The member's originating health plan is required to transfer the member's active Prior Authorizations to the member's new health plan. Upon the member's transition, the member's new health plan will honor the remainder of the authorization.

Q: How will families learn about any changes in accessing NEMT for their treatment? How do we ensure that the transportation process does not get interrupted?

A: Welcome Packets mailed to health plan members will include information related to scheduling NEMT. Health plans will also do proactive outreach to their members who are frequent NEMT users prior to Managed Care Launch. Providers can encourage their patients to contact their health plan directly regarding NEMT.

Q: If a child is in a plan that does not have an adequate network to deliver services that the child needs, how do we make sure the child gets the services they need?

A: Standard Plan shall adequately and timely cover services out-of-network for a beneficiary, if the Standard Plan's network is unable to provide the covered services from a network provider on a timely basis, then the plan shall continue to cover the service out-of-network until the gap is addressed. 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: Are provider minimum rates (floor rates) expected to be honored for the first 4 years of managed care? Will the rates and reimbursement policy change in year 5?

A: Other than this statement about hospital outpatient services, the managed care contract does not include rate floors for outpatient specialized therapy providers.

"The health plan shall reimburse all in-network hospitals no less than the applicable Medicaid Fee-for-Service rate (“rate floor”) for inpatient and outpatient services (as allowed under 42C.F.R. § 438.6(c)(1)(ii)(A)) and utilize the applicable Fee-for-Service payment methodology, unless the health plan and hospital have mutually agreed to an alternative reimbursement amount or methodology."

Q: Is there a standard time period for authorization and re-authorization for all health plans?

A: "For standard authorization decisions, the health plan shall provide notice as expeditiously as the Member’s condition requires and no later than fourteen (14) calendar days following receipt of the request of services."

"For expedited authorization decisions, consistent with 42 C.F.R. § 438.210(d)(2), the health plan shall provide notice no later than seventy-two (72) hours after receipt of the request for service."

Q: How will DHB and plans ensure that non-English speaking individual, get the information and access they need?

A: DHB continues to prioritize making materials and information available in languages other than English. The enrollment notices mailed to beneficiaries are available in Spanish, and the Enrollment

Broker Call Center has language line assistance for non-English speaking beneficiaries. Beneficiaries can also request the information they need from both DHB and the health plans in the language they need.

Q: Will each plan dictate which DME services or Private Duty Nursing agencies to select from?

A: To ensure continuity of care during the managed care cross-over, the health plans are expected to work with out-of-network providers as if they in-network until the end of an episode of care or 60 days, whichever is less. After the cross-over period, the health plans may assist a member in transitioning to an equivalent in-network provider. However, if a health plan does not have an in-network provider reasonably available to the member without delay, then the health plan is expected to cover the service from an out-of-network provider until such time as the deficiency is addressed.

Q: Currently there are parameters for Medicaid devices given to children (e.g., #G tubes); will the quantity limits change or stay the same?

A: The 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". However, the contract allows for health plans to employ different prior authorization and quantity limits as part of their utilization management program as long as they are evidence-based. For Medicaid beneficiaries 0-20yoa health plans are expected to follow EPSDT guidelines.

Q: Will there be more DME supplies (e.g.., central line flushes, catheter flushes) covered that were not previously covered?

A: The 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". However, since Medicaid's DME policies are not among the 18 required to be followed exactly, the health plans may cover additional DME items not currently listed for coverage in Medicaid Direct.

Q: If we send a child to a CDSA and they make a plan of care and decide the child need speech therapy and physical therapy and refer the child for the services, but the therapist evaluates the child and determines the child also needs OT, should we go back to the CDSA so that the OT is included in the plan of care? What is the pathway for referrals? Is CDSA in charge of the referrals?

A: Yes, this referral should go back to the CDSA.

Q: Will case managers be assigned for medically complex children and will their goals be the same as was with CCNC case managers?

A: The Department has established priority populations likely to require health plan care management, including individuals with LTSS needs and children and adults with special health care needs. health plans will utilize a number criteria including the member's current care management status to identify a transitioning member as being part of the priority population. CCNC will transfer all care plans for transitioning beneficiaries under active care management to the beneficiary's new Health Plan to inform the health plan's care management engagement.

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Questions

Q: Are cochlear implants covered for both ears or just one?

A: According to the 1A-4 Cochlear and Auditory Brainstem Implant policy:

"5.1.5 Simultaneous Bilateral Cochlear Implants:

Medicaid and NCHC shall require prior approval for simultaneous bilateral cochlear implants. Health record documentation must be submitted with the prior approval request indicating that the requirements of Subsection 3.2.6 have been met."

Bilateral Cochlear Implants are covered.

Q: Why is coverage for hearing aids only for those under age 21?

A: Hearing aids are an optional service under the Centers for Medicare and Medicaid. To date, NC has only covered this optional service for children under the Early and Periodic Prevention Screening, Diagnostic and Treatment component of Medicaid's Federal statutes and regulations for children under 21 years of age.

Q: For the UHC program, will hearing aids be provided by the 3rd party or will it be at the discretion of the audiologist?

A: United has a contracted audiology network and they are trained and authorized to dispense hearing aids.

Q: What percentage of current Medicaid eye glass dispensers are signed with health plans TODAY?

A: The Department is unable to provide the percentage of Medicaid eye dispensers that are signed with health plans at this time, but the Department is monitoring the health plans' networks for compliance with all network adequacy standards, including the specialties for Optometry and Ophthalmology. If a health plan's network is unable to provide a service to a member on a timely basis because in-network providers are not available without undue delay, then the health plan shall cover the service from an out-of-network provider until the network deficiency is addressed.

Q: For audiology, are educational audiologists included or is it just clinical?

A: If this question is referring to the provision of Hearing Aids services, 2 types of audiologists are included-

1) A North Carolina licensed audiologist who also has a doctorate in audiology;
2) A North Carolina licensed audiologist (who is not a doctor of audiology) who is also licensed as a N.N. Hearing Aid Dealer and Fitter.

Q: Any update on status of Children's Developmental Services Agencies (CDSA) contracted providers, specifically CBRS (Community Based Rehabilitative Services), also known as Special Instruction ... carved out or included in transition?

A: Currently, only services on the ISFP that are provided and billed for are carved out of managed care. We do not have a current timeline for SB549.

Q: To relieve administrative burden on the provider, can we please have health plans use the same PA criteria for outpatient specialized therapies?

A: Although the 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 managed care contract also permits the health plans to place appropriate limits on a service based on medical necessity, or for utilization control provided the services furnished can be reasonably expected to achieve their purpose. For more details, please see Section V.C.1.d and V.C.1.e of the managed care contract here: https://medicaid.ncdhhs.gov/transformation/health-plans.

Q: Why doesn't specialized therapies have rate floors?

A: Rate floors have generally been established for provider types where such rate floors were either (1) required by federal and/or state law, or (2) for provider types with reimbursement arrangements supported by assessments and/or intergovernmental transfers.

Q: Is there a timeline for SB 594 potentially being passed? Are they trying to get it passed before July 1? If it passes, does that mean that Children's Developmental Services Agencies (CDSA) contracted providers would continue to bill through NC Tracks?

A: We do not have a current timeline for SB549. As the bill is currently written, services that are on the IFSP and provided by CDSA contracted providers would be carved out of managed care. But, until such legislation is enacted, those providers would not be carved out at Standard Plan launch.

Q: When are the proposed Children's Developmental Services Agencies (CDSA) changes going to be approved? Prior to July 1?

A: We do not have a current timeline for SB549 to be approved.

Q: NC Medicaid Policy did not call out FDA approved cochlear implants (CIs) for single-sided deafness (SSD) as an exclusion, and covered CI's for 'ear to be implanted'. Is coverage of CIs for SSD at the Health Plan's discretion? Or will NC ensure this is covered?

A: At this time, coverage decisions related to Cochlear Implants for beneficiaries with single-sided deafness is at the discretion of the health plan. The ambiguous wording of the 1A-4 policy has been brought to the attention of the clinical policy department for future policy revisions.

Q: In regard to metabolic nutrition, are the health plans required to have providers use the state oral nutrition request form? Are they also required to have a provider use the states Certificate of Medical Necessity/Prior Authorization (CMN/PA) form? We have our own order forms and we have our own CMN. We are hoping to be able to use our company forms and not the state specific forms.

A: The oral nutrition product request form is no longer required by Medicaid Direct. Please see subsection 5.3.6 of policy 5A-3 here: https://medicaid.ncdhhs.gov/providers/programs-services/medical/durable-medical-equipment. If the health plan requires a PA form be submitted with a PA request, then it must be the standard form developed by state. Otherwise, the managed care

contract does not require that the 5-series of DME/POS policies be followed exactly by the health plans. For more information about each health plan's requirements, please visit: https://medicaid.ncdhhs.gov/transformation/health-plans/health-plan-contacts-and-resources.

Q: Why is there a difference in how hearing aids vs optical services are covered for adults?

A: Both services are optional services under the Centers for Medicare and Medicaid Services, which means each State may determine coverage for adults. Numerous studies through NC commissions and task forces have researched covering hearing aids for adult Medicaid beneficiaries. Currently, the State provides hearing aids for beneficiaries 21 years of age and under, according to Early and Periodic Screening, Diagnostic and Treatment federal requirements.

Q: Durable Medical Equipment (DME) products supplied under NC Medicaid are required to have a completed NC Medicaid CMN/PA form as well as the DWO form signed and completed and on file each year for the supplies to be provided. Will the NC Medicaid CMN/PA form be required to be on file under these new MCO plans being it is a state generated form? Or as with most of these plans currently, will the completed DWO be sufficient?

A: If the health plan requires a PA form be submitted with a PA request, then it must be the standard form developed by state. Otherwise, the managed care contract does not require that the 5-series of DME/POS policies be followed exactly by the health plans. For more information about each health plan's requirements and contact information, please visit: https://medicaid.ncdhhs.gov/transformation/health-plans/health-plan-contacts-and-resources.

Q: Is a prenatal visit with the mother on Medicaid covered as part of the Bright Futures visit schedule to engage the family with a medical home for the infant who plans to go to that practice for care?

A: A prenatal visit with the mother on Medicaid is not included in North Carolina's Periodicity Schedule and Coding Guide for Early Periodic Screening under the Health Check program. Please see the Health Check Program guide for more information: https://files.nc.gov/ncdma/documents/Medicaid/EPSDT/09-20-2018_Health-Check_Program%20Guide%20Final.pdf

Q: When will we be able to see in NC Tracks which MCO Medicaid recipients have chosen?

A: Based on provider feedback regarding the AMH Medicaid Direct/Managed Care PCP Enrollee Report, NC Medicaid is in the process of updating functionality to include health plan members and the name of the health plan to which each is assigned. Although the timeline for the addition is still being determined, the report will only display the health plan name beginning in July 2021 when managed care assignments become effective.

Q: Will the health plans require the PCP name to be printed on the claim form for payment processing?

A: This may vary per health plan, please refer to their billing policies that are posted on their provider portals. Please reach out to your contracted health plan via their provider services line for more information. if you are unable to get a response or want to report a concern, please send this to the provider ombudsman at Medicaid.ProviderOmbudsman@dhhs.nc.gov.

More information on billing (https://files.nc.gov/ncdma/documents/Providers/playbook/NCMT-Provider-FactSheet-Claims---PA-Routing-Part-2-FAQ-20210405-DRAFT.pdf) and contact information for health plans can be found at the bottom of the Fact Sheet page on the Provider Playbook: https://medicaid.ncdhhs.gov/providers/provider-playbook-medicaid-managed-care/fact-sheets

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

Carolina Complete Health: https://network.carolinacompletehealth.com/resources/manuals-and-forms.html

Healthy Blue (Blue Cross Blue Shield): https://provider.healthybluenc.com/north-carolina-provider/manuals-and-guides

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

Q: It was relayed to ST/OT/PT providers who operate under the current 10 series that our rates will not change for the first year. After that, we will have to negotiate. Is that no longer the case? Will we have to negotiate now instead of July 2022?

A: Speech therapist (ST), Occupational therapist (OT), and physical therapist (PT) are not designated as rate floor programs. health plans are not required to pay the FFS rates and are allowed to negotiate rates with providers on non-rate floor programs. Providers can begin negotiating rates now for services with no rate floors under Managed Care.

Q: Will this session be located somewhere to view at later date?

A: You can view this session and other past session under the NC AHEC website at https://www.ncahec.net/medicaid-managed-care/

Q: Thank you for hosting this forum - where should future questions be directed? Thank you!

A: Future questions can be sent to questionscovid19webinar@gmail.com

Q: I am a solo practitioner and very concerned about negotiating a rate? Are all SLPs paid the same rate within a given health plan? Or might 10 different SLPs within a single county receive 10 different rates for the same service?

A: MCO's & health plans have the authority to negotiate rates regardless of what FFS reimburses at unless of course there is a rate floor. The State cannot get involved in this negotiation process as this is entirely up to the MCO's/health plans and providers.

Q: Will the rates the MCO pay providers be the same as Medicaid FFS for year 1? At one point, I thought the rates were to stay the same as Medicaid for at least 1 year

A: The rates the MCO pay providers will only be the same as Medicaid FFS if the program/service has a designated rate floor.

Q: With home infusion services under the hit program we have no coverage for supplies will that change under the new plans?

A: Refer to the Medicaid Policy for Home Infusion Therapy 3H1. Also, check each plan with how they are implementing.