

NC MEDICAID

VIRTUAL OFFICE HOURS

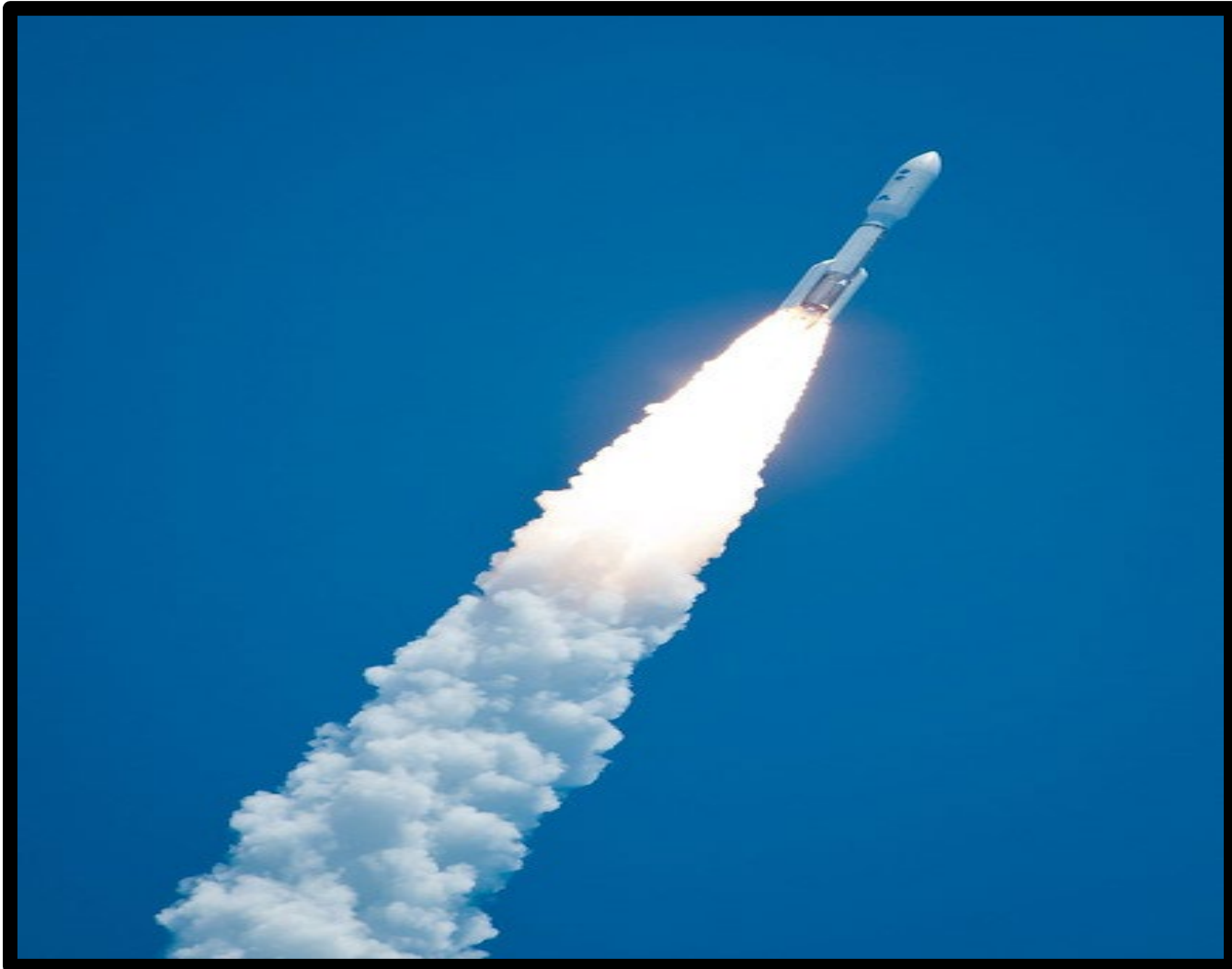
Hearing Aid and Auditory Implant Parts Services in Medicaid Managed Care

Ronda Owen, Program Manager

June 24, 2021

Managed Care Launch!

July 1, 2021



Medicaid Managed Care Eligibility

Categories of Beneficiary Participation Eligibility

Status of Medicaid Managed Care Enrollment, Per Legislation	Populations
Mandatory (Must enroll)	<ul style="list-style-type: none">▪ Most Family & Children's Medicaid, NC Health Choice, Pregnant Women, Non-Medicare Aged, Blind, Disabled.
Excluded (Cannot enroll, stays in NC Medicaid Direct)	<ul style="list-style-type: none">▪ Family Planning Program, Medically Needy, Health insurance premium payment (HIP), Program of all-inclusive care for the elderly (PACE), Refugee Medicaid▪ Some beneficiaries are temporarily excluded and become Mandatory later. This includes dually-eligible Medicaid/Medicare, Foster Care/Adoption, & Community Alternatives Program for Children (CAP-C) and Disabled Adults (CAP-DA).
Exempt (May enroll or stay in NC Medicaid Direct)	<ul style="list-style-type: none">▪ Federally recognized tribal members, beneficiaries who would be eligible for behavioral health tailored plans (until they become available). Target launch date for Tailored Plans is July 1, 2022.

Network Adequacy Standards for PHPs

“...Establish and maintain a Medicaid Managed Care Provider Network... sufficient to ensure that all services covered under the Contract are available and accessible to all Members in a timely manner...”

Urban Standard:
≥ 2 providers (of each provider type) within 30 minutes or 10 miles for at least 95% of Members

Rural Standard:
≥ 2 providers (of each provider type) within 30 minutes or 30 miles for at least 95% of Members

Managed Care Contract Obligations with DHB

PHP Obligations in Managed Care

Make a good faith effort to enroll every willing provider, including negotiating rates in a manner that ensures network adequacy

Accept any willing provider unless the provider declines the contract terms and conditions or the provider isn't qualified to contract with the PHP

Honor Transition of Care guidelines when a member with prior approval for a service moves from one payor (Medicaid Direct or another PHP) to a new 'receiving' PHP

Managed Care Contract Obligations with DHB

PHP Obligations in Managed Care

“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 PHP may place appropriate limits on a service based on medical necessity, or for utilization control...provided the service furnished can be reasonably expected to achieve their purpose”

“The PHP shall develop a utilization management (UM) program... based on nationally-recognized evidence-based clinical practice guidelines... to support UM and prior authorization for services not otherwise defined in mandated clinical coverage policies.”

Pre-Paid Health Plans (PHP) and Locations

AmeriHealth Caritas of NC - PHP; Statewide

Blue Cross and Blue Shield of NC - PHP; Statewide

UnitedHealthcare of NC - PHP; Statewide

WellCare of NC - PHP; Statewide

Carolina Complete Health, Inc - PHP; Regions 3, 4, & 5

Eastern Band of Cherokee Indians (EBCI) Tribal Option –
Primary Care Case Management managed by the Cherokee Indian Hospital Authority. For federally recognized Tribal members and others eligible for services through the federal Indian Health Service agency.

Counties in Regions 3, 4, & 5

Carolina Complete Health – Medicaid Providers and Beneficiaries in Regions 3, 4, & 5 Have an Additional Option

REGION 3 – Alexander, Anson, Cabarrus, Catawba, Cleveland, Gaston, Iredell, Lincoln, Mecklenburg, Rowan, Stanly, and Union

REGION 4 – Alamance, Caswell, Chatham, Durham, Franklin, Granville, Johnston, Nash, Orange, Person, Vance, Wake, Warren, and Wilson

REGION 5 – Bladen, Brunswick, Columbus, Cumberland, Harnett, Hoke, Lee, Montgomery, Moore, New Hanover, Pender, Richmond, Robeson, Sampson, Scotland

PHPs and Contracting Information Phone Lines

AmeriHealth Caritas North Carolina

ProviderRecruitmentNC@amerihealthcaritas.com

(844) 399-0474

Carolina Complete Health * *Only in Regions 3, 4, & 5*

networkrelations@cch-network.com

(833) 552-3876

HealthyBlue

NCproviderquestions@ncealthyblue.com

(844) 415-2045

UnitedHealthcare

CarolinasPRTeam@uhc.com

(866) 686-9332

WellCare of North Carolina

NCProviderRelations@wellcare.com

(984) 867-8637

PHP & Third Party Vendor Contact Information

AmeriHealth Caritas North Carolina (844) 399-0474

None

Carolina Complete Health (833) 552-3876

None

HealthyBlue (844) 415-2045

None

UnitedHealthcare of North Carolina (866) 686-9332

None

WellCare of North Carolina (984) 867-8637

Hear USA (855) 243-5508

Additional Health Plan Information

- **Provider Support Phone Numbers and Emails**
- **Provider Manuals**
- **Provider Contract Templates**
- **Member Handbooks**

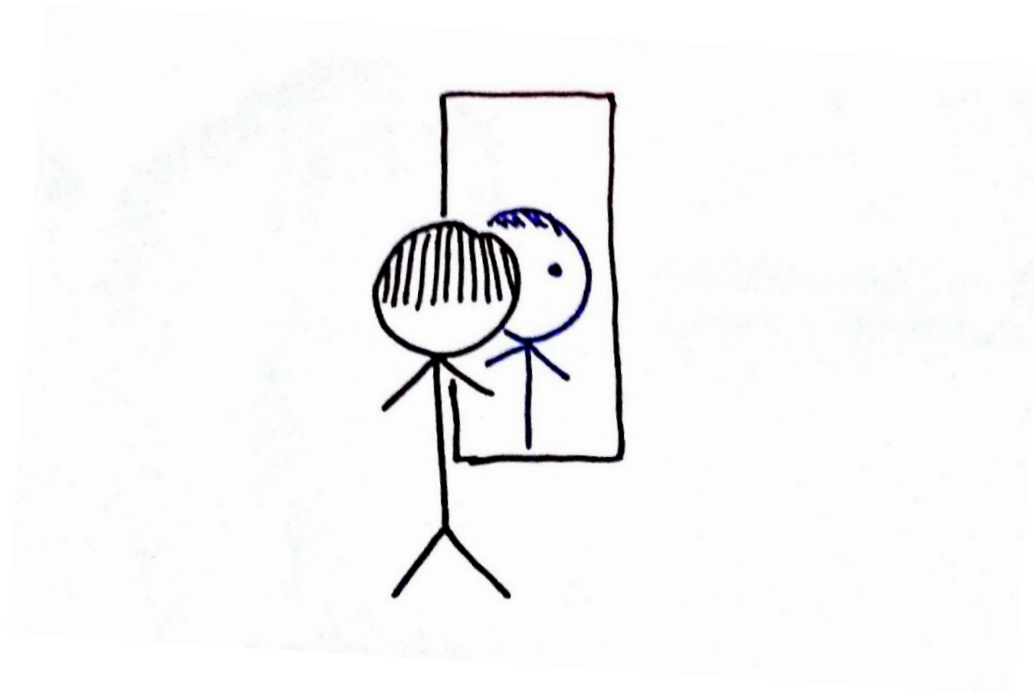
<https://medicaid.ncdhhs.gov/transformation/health-plans/health-plan-contacts-and-resources>

YOU

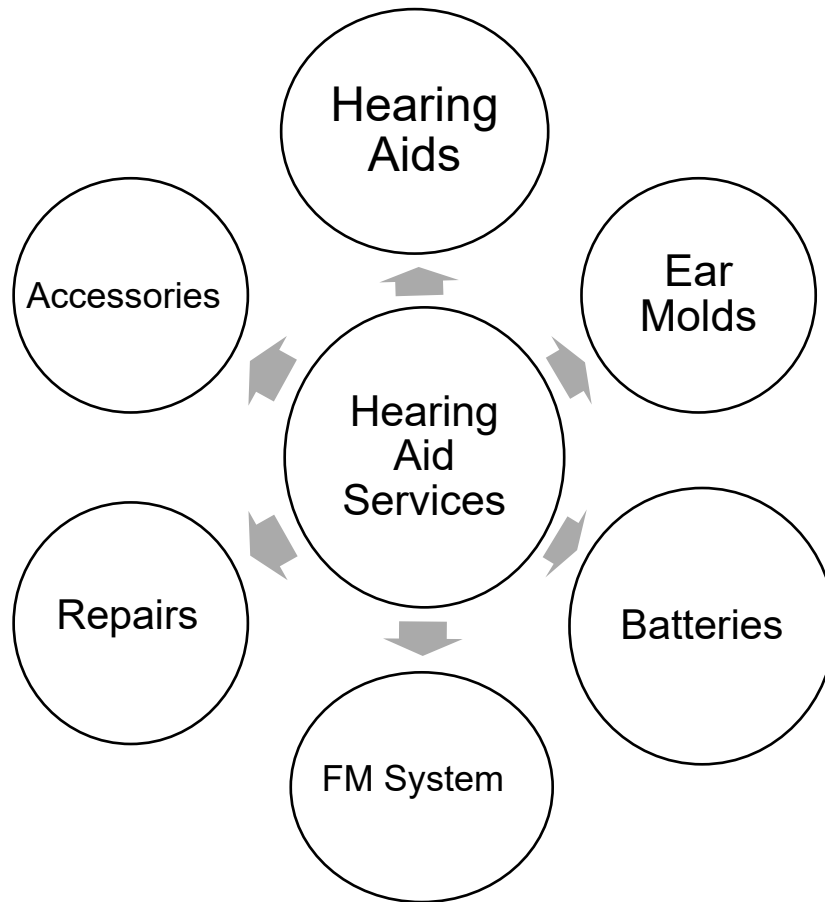
Are a Great Resource For Your Medicaid Patients

- **Enrollment Broker at (833) 870-5500**
- **NC Medicaid Ombudsman at (877)-201-3750**
- **Local County Department of Social Services**
- <https://medicaid.ncdhhs.gov/medicaid>

Medicaid and Health Choice Hearing Aid and Auditory Implant Services Mirror One Another



Covered Hearing Aid Services



Eligible Population

Children under the age of 21

Qualified Providers

Individual with a NC Hearing Aid Dealer and Fitters License

Audiologist with NC Audiology License and NC Hearing Aid Dealer and Fitter License

Doctor of Audiology with a NC Audiology License

Hearing Aid Services in Managed Care

What to Expect in Managed Care

What Will NOT Change:

Covered Population

Only children under 21 years of age will be eligible for hearing aid services.

Minimum Coverage

Health plans coverage may not be more restrictive than current NC Medicaid Clinical Coverage Policy.

What WILL Change:

Services Managed by Health Plans

Fully carved into managed care

All hearing aid services will be managed by the health plans.

Value Added Service

WellCare will offer one hearing aid every two years for adult members who meet medical necessity criteria.

Hearing Aid Services in Managed Care

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'The Floor' – Current Hearing Aid Policy

PEDIATRIC – Policy 7

Hearing Aid Services Clinical Coverage Policy

<https://medicaid.ncdhhs.gov/media/8730/open>

Hearing Aid Services in Managed Care

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Value Added Service

WellCare will offer one hearing aid every two years for adult members who meet medical necessity criteria.

Health Plans' Responsibilities

Health Plans will manage their own:

- **Provider network (adequate access to care)**
- **Clinical coverage policies (ensuring they are not more restrictive than current Medicaid policies)**
- **Utilization management and prior approval (not through NCTracks)**
- **Claims processing (not through NCTracks)**
- **Third-party hearing services vendors (Hear USA)**

Value Added Service

Value-Added Service Definition

Services that are not covered by a state's Medicaid program that a PHP wants to provide. Unlike In Lieu of Services, value-added services are not considered when setting Medicaid capitation rates.

Value-Added Service Examples

- \$75 per year healthy rewards gift card
- YMCA membership for diabetic support
- \$75 per year voucher for Boys & Girls Club
- Car seat for new mothers
- Up to 14 weeks of Weight Watchers

Hearing Aid Services in Managed Care

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What WILL Change:

Services Managed by Health Plans

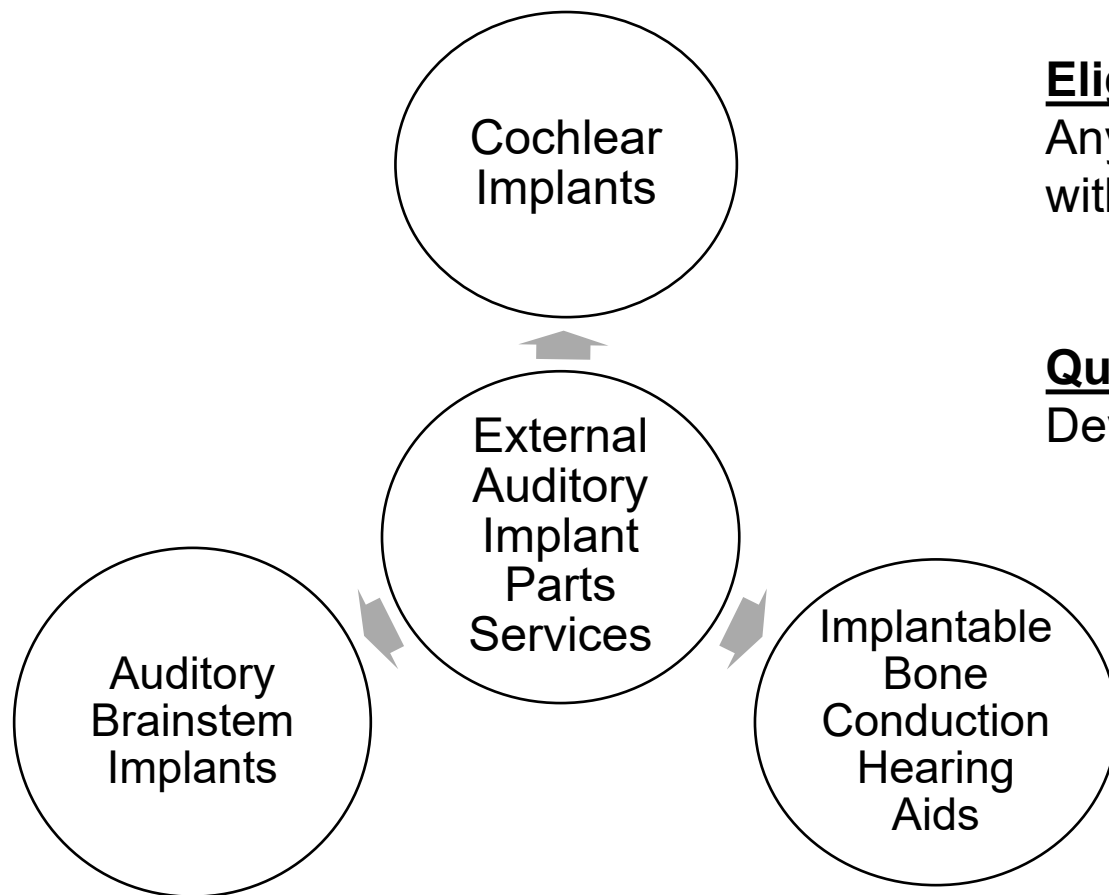
Fully carved into managed care

All hearing aid services will be managed by the health plans.

Value Added Service

WellCare will offer one hearing aid every two years for adult members who meet medical necessity criteria.

Covered Auditory Implant Parts Services



Eligible Population

Any beneficiary who is implanted with an auditory implant

Qualified Providers

Device manufacturers

What to Expect in Managed Care

What Will NOT Change:

Required Policy

The auditory implant parts policies **13A** and **13B** are included in a group of policies that, under the contract between NCDHB and the health plans, must be followed exactly by the health plans.

Note: Providers will continue to be the implant manufacturers

What **WILL** Change:

Services Managed by Health Plans

Fully carved into managed care
All auditory implant parts services will be managed by the health plans.

‘Required’ – Current Auditory Implant Parts Services

13A – Cochlear and Auditory Brainstem External Parts Replacement and Repair

<https://medicaid.ncdhhs.gov/media/8593/open>

13B – Soft Band and Implantable Bone Anchored Hearing Aid External Parts Replacement and Repair

<https://medicaid.ncdhhs.gov/media/7071/open>

What to Expect in Managed Care

What Will NOT Change:

Required Policy

The auditory implant parts policies **13A** and **13B** are included in a group of policies that, under the contract between NCDHB and the health plans, must be followed exactly by the health plans.

Note: Providers will continue to be the implant manufacturers

What WILL Change:

Services Managed by Health Plans

Fully carved into managed care

All auditory implant parts services will be managed by the health plans.

Health Plans' Responsibilities

Health Plans will manage their own:

- **Provider network (clinicians can easily access device manufacturers)**
- **Clinical coverage policies (ensuring they are identical to current Medicaid policies 13A & 13B)**
- **Utilization management and prior approval (not through NCTracks)**
- **Claims processing (not through NCTracks)**

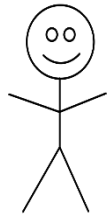
Questions Frequently Asked by Providers (so far!)



What is Capitation ? How does it Work?

10,000 Foot View

NC Medicaid



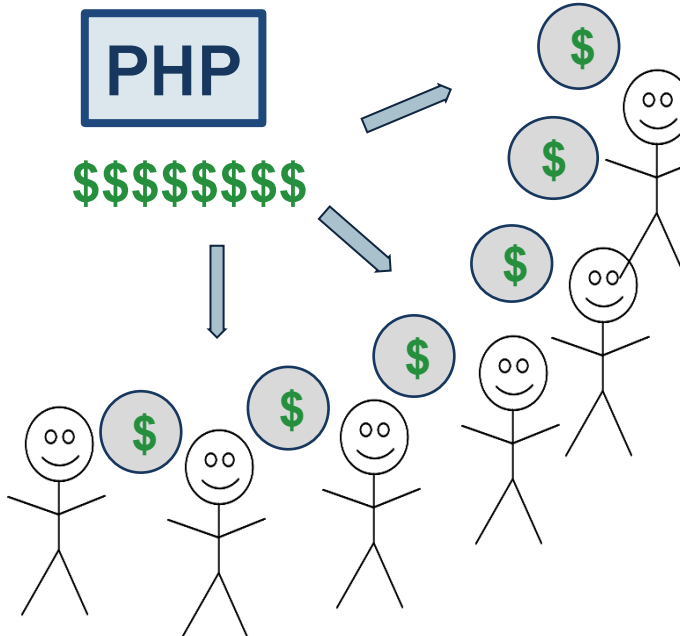
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(Capitated Payment for Term)



PHP

\$\$\$\$\$\$\$\$

Provider Network



End of Term

PHP +\$

PHP 0

PHP -\$

Transition of Care for Hearing Aid Services

Provider obtains hearing aid services PA under one PHP but member transfers to another PHP before hearing aids, parts, batteries, etc. are dispensed

- **Bill the dispensing fee to the new *'receiving'* PHP**
- **Provider is in-network with receiving PHP - 100% of Negotiated Rate**
- **Provider is out-of-network with receiving PHP**
 - **Enroll with PHP – 100% Negotiated Rate**
 - **Remain out-of-network – no more than 90% FFS rate (if PHP made a good faith effort to enroll provider)**
 - **Exception during first 60 days after launch (July 1– August 31)**
 - **100 % of Negotiated Rate, in or out of network**

Out-of-Network Provider Payments by PHPs

Except for a member continuity of care circumstance, out-of-network providers who provide non-emergency or post-stabilization services where the PHP has made a “good faith” effort to contract with a provider who has refused that contract or where the provider was excluded from the PHP network for failure to meet objective quality standards

PHPs are prohibited from reimbursing at more than 90% of the Medicaid FFS rate

“**Good faith/quality**” means the plan engaged in a good faith effort to contract but the provider refused or the provider was excluded from the network for failure to meet objective quality standards.

Out-of-Network Provider Payments by PHPs

Including for a member continuity of care circumstance, out-of-network (OON) Providers who provide non-emergency or post-stabilization services where the PHP has not made a “good faith” effort to contract with a Provider who has refused that contract and where the provider was not excluded from the PHP network for failure to meet objective quality standards

In the absence of a negotiated agreement, PHPs are required to reimburse provider at 100% of the Medicaid FFS rate

“Not good faith/quality” means the plan has not engaged in an effort to contract with the provider nor has the provider been excluded for failure to meet objective quality standards.

Member Enrollment and Eligibility

How Providers Determine Member's Plan

- **Insurance Card – does not guarantee eligibility**
- **NCTracks – Recipient Eligibility Portal**
(With MEDICAID ID NUMBER or NAME & DATE OF BIRTH)
 - **Medicaid Direct or PHP Election/Assignment**
 - **Eligibility status as of date of inquiry**

Contracting with the Health Plans

How Does a Provider Contract with a PHP?

- Medicaid will continue to credential providers- no additional credentialing is required
- If the PHP does not have a third-party hearing services vendor, contact the PHP for contracting guidance
- If the PHP has a third-party hearing services vendor administering any hearing services, contact the third-party hearing services vendor for contracting guidance

Resources for Assistance

Who Do I Contact if I Need Help?

Medicaid Direct (Fee-for-Service)

- Medicaid Contact Center
- NCTracks Call Center

Managed Care

- PHP Call Center
- Third-Party Hearing Services Vendor Call Center

Additional Provider Resources

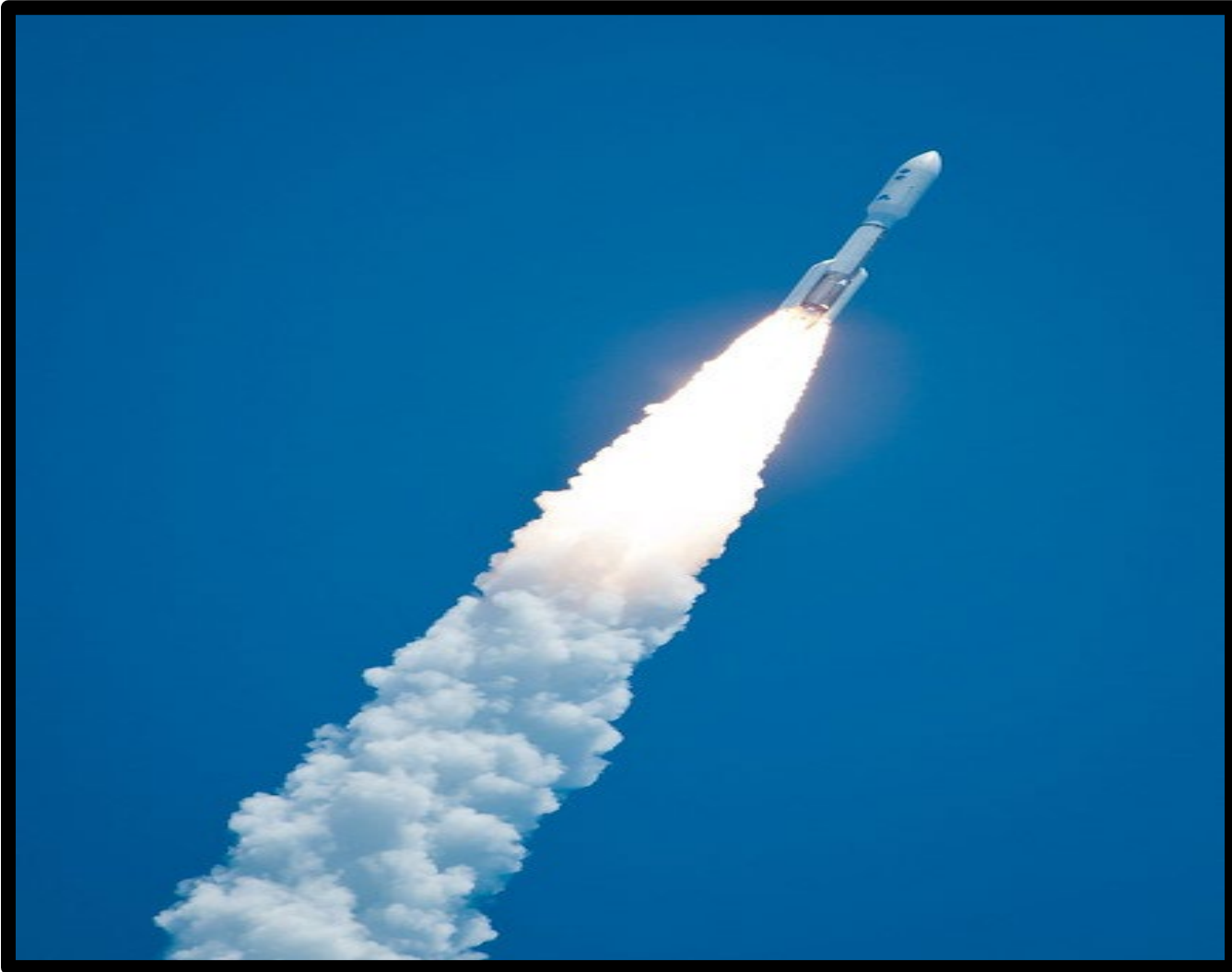
Resources for Medicaid Direct and Managed Care

- **PHP and PHP's Hearing Services Third Party Vendor**
- **Medicaid Contact Center at (888) 245-0179**
- **Email: Medicaid.Transformation@dhhs.nc.gov Medicaid**
- **NCTracks Call Center at (800) 688-6696**
- **Provider Playbook: Medicaid Managed Care**

<https://medicaid.ncdhhs.gov/blog/2021/03/01/nc-medicaid-help-center-now-available-convenient-way-providers-find-information>

Thank You for Your Continued Partnership!

See you on the other side!



ANY
QUESTIONS
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