June 17 NCMT Managed Care Hot Topics Questions

Q: Please confirm what type/how many sessions of counseling are approved for Medicaid Postpartum depression?

A: For NC Medicaid Direct Beneficiaries, postpartum depression counseling is covered under NC Medicaid Clinical Coverage Policies 1M-3, Health and Behavior Intervention and 8C, Outpatient Behavioral Health Services.

Under 1M-3, Health and Behavior Intervention, Health and Behavior Intervention (HBI) counseling services are covered during the pregnancy and continue through the end of the month in which the 60th postpartum day occurs. A total of eleven hours of HBI services are allowed per pregnancy and postpartum period. Claims for additional units will be considered for reimbursement through the adjustment process only when conditions of coverage are met, and documentation supports medical necessity.

HBI services for pregnant and postpartum women should be face-to-face in the home or clinic (not the area mental health center). It can be provided by telephone when life-threatening situations exist. HBI services may be provided in addition to services provided by the area mental health center. The two agencies may not provide the same service for the same reason or criteria. Counseling services must be coordinated to ensure continuity of care.

Refer to the policy for more detailed information regarding coverage requirements, coding, and time limitations.

Under 8C, Outpatient Behavioral Health Services, outpatient behavioral health services for Medicaid Beneficiaries 21 years of age and over, is limited to eight unmanaged outpatient visits per state fiscal year (inclusive of assessment and Psychological Testing codes). Services for Medicaid Beneficiaries under 21 years of age are limited to 16 unmanaged outpatients visits per state fiscal year (inclusive of assessment and Psychological Testing codes). After these visit limitations are met, Prior Approval is required for additional visits. Refer to the policy for more detailed information on requirements, coding, and time limitations.

Q: We are a stand-alone medication assistance therapy provider. We are working on our first contract and have been told prior auths are required for patients which is not required with Medicaid. This will prevent us from taking care of patients in an accessible manner. Can you describe if this is applicable to all 5 health plans?

A: WCHP provides a Prior Authorization look-up Tool to determine if a PA is required prior to rendering services. WCHP's Provider Look-up tool can be found at: https://www.wellcare.com/NorthCarolina/Providers/Authorization-Lookup

AMHC provides a Prior Authorization look-up Tool to determine if a PA is required prior to rendering services. AMHC's Provider Look-up tool can be found at: www.amerihealthcaritasnc.com

Healthy Blue provides a Prior Authorization look-up Tool to determine if a PA is required prior to rendering services. Healthy Blue's Provider Look-up tool can be found at: https://provider.healthybluenc.com/north-carolinaprovider/prior-authorizationlookup

CCH provides a Prior Authorization look-up Tool to determine if a PA is required prior to rendering

services. This tool will go live later this summer, before the launch of NC Medicaid Managed Care.

UNHC provides a Prior Authorization look-up Tool to determine if a PA is required prior to rendering services. UNHC's Provider Look-up tool can be found at: https://UHCprovider.com/priorauth

Q: Are PHP's going to allow teletherapy for specialized services (OT/PT/SLP)? If so, for how long?

A: The health plans are required to follow Medicaid's COVID flexibilities per the COVID-19 special bulletins, including those relevant to telehealth for outpatient specialized therapies (e.g.: 11, 34, 36, 67, 169). For details, please see the managed care contract amendment 4/5 at the bottom of this webpage: https://medicaid.ncdhhs.gov/transformation/health-plans.

Q: Where do we enter the Medicaid ID# on the claim? There is also a member ID - not sure where the two belong.

A: Contact your contracted health plans provider services line below or review your provider manual or php training information for more details.

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

EBCITribalOption.com Provider Support Line: 800-688-6696 (NCTracks Call Center)

Provider Contracting Questions 800-260-9992 Provider.Services@cherokeehospital.org

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

Q: Related to the PCP change form, there was mention of a department form. Has that been published? Does that need to be utilized or does each PHP have their own process?

A: AMHC members should call Member Services to change their PCP.

Q: Who does the PCP contact if the patient needs to see an out of network provider? Is the specialist our office referred the patient to supposed to handle it or do we as the PCP have to handle the issue?

A: Regarding the 2 questions, providers should contact a patient's PHP prior to referring a patient to an out-of-network provider.

Q: Why aren't hearing aids covered every 4 years?

A: Not all hearing aids need to be replaced at the 4-year mark. Therefore, Medicaid doesn't replace hearing aids that are working properly and meet the patient's amplification needs.

Q: Does anything change with how Federally Qualified Health Center (FQHC) will be paid by PHP's?

A: The PHP shall require the use the T1015 HCPCS code, including appropriate HI and SC modifiers as defined in Clinical Coverage Policy No: 1D-4 (https://medicaid.ncdhhs.gov/media/8092/open).

Q: Do we need to add the approved PA number on claims that are transferring to the health plans as of July 1?

A: Any outstanding approved prior authorizations from NC Medicaid will be transferred automatically to the PHP with a 90-day grace period. You should not have to submit your prior authorization number to the PHP after July 1, but we recommend keeping your PA numbers in case any unexpected error occurs. Please feel free to reach out to the Help Center with any further questions and have a great day

Q: Why are some of the health plans requiring opticians to sign a contract with the health plan and a separate one for the eyeglasses?

A: If a vision provider provides services that are not covered through the third-party vendor (Envolve, EyeMed or March Vision), then the provider may be required to contract with the health plan and the third-party vendor to authorizations and payment. Keeping in mind that opticians may provide eyeglasses and medically necessary contact lenses, it may be possible that some health plans are covering medically necessary contact lenses through the health plan instead of the third-party vendor. If the third-party vendor is managing both eyeglasses dispensing fee and medically necessary contact lenses, contracting with the third-party vendor only should sufficient. Please reach out to the specific health plans for clarification.

Q: Can the Provider Ombudsman make site visits to educate the social workers and financial counselors on the NEMT process for outpatient dialysis patients? We serve over 2000 patients and there are some questions and concerns regarding ModivCare. Thanks!

A: The Department has connected the provider to ModivCare, who will be following up with the provider directly.

Q: United HC why are you requiring prior authorization for evaluations as well as Treatment for Specialized Therapies? We've never had to do this for Medicaid before.

A: We do not Prior auth for Evals. We are asking for Verbal/Written order from Referring provider.

Q: Can you guarantee that patients will not have to travel farther to see an in-network specialist than they have to travel to see a provider now out of network with the plan but has historically participated with NC Medicaid under the original model. If not, we will not have quality outcomes.

A: PHPs are expected to establish and maintain provider networks sufficient to ensure that all covered services are available and accessible in a timely manner. PHPs are also required to negotiate with any willing provider and treat OON providers as in-network for 60 days after launch. Further, if a PHP does not have an in-network provider reasonably available to the member without delay, then the PHP shall cover the service (pre-approved if required) from an out-of-network provider until such time as the deficiency is addressed. (include time/distance criteria for network adequacy)

Q: Are there any differences for BH inpatient admission notifications vs. medical/physical admission (across the plans)?

A: CCH: There are no differences between BH/PH notification for inpatient admissions. Notifications can be made through the portal, via phone or fax. Inpatient behavioral health services prior authorization requirements apply. Partial hospitalization prior authorization requirements apply.

ACNC will follow NC DHHS Clinical Coverage Policy 8B which stipulates that BH Inpatient admissions require Prior Authorizations which should be requested within 48 hours of admission. As such, ACNC does not require admission notification for BH inpatient admissions but does require notification for medical/physical admissions.

BCBS: Require precertification of all inpatient elective admissions. The referring PCP or specialist is responsible for precertification. The requesting physician identifies the need to schedule a hospital admission; to do so, you can either: 1) Submit your request through our website at https://provider.healthybluenc.com/north-carolina-provider/prior-authorizationlookup. or 2) Fax the request to 1-800-964-3627

For Behavioral Health Inpatient, fax to 1-844-439-3574

For Behavioral Health Outpatient, fax to 1-844-429-9636

Or call Healthy Blue Provider Services at 1-844-594-5072.

Prior Authorizations can also be requested through Interactive Care Reviewer (ICR), our online precertification tool which you can access through the Availity Portal at www.availity.com. (Select Patient Registration > Authorizations & Referrals). Please contact NC_Provider@healthybluenc.com if you have any further questions!

UHC: BH and Medical UM notifications all require notification of admissions within 24 hours. The requests can be made by phone or provide portal.

WellCare: Notifications by hospitals would be the same for both types of admissions by the next business day. The phone number to contact is the same for both.

Q: Can a PCP send patients to the hospital employed specialists (which is most specialists) including labs and imaging if the hospital is out of network? That's important as the hospital may be the only game in town or nearby.

A: PHPs are expected to establish and maintain provider networks sufficient to ensure that all covered services are available and accessible in a timely manner. PHPs are also required to negotiate with any willing provider and treat OON providers as in-network for 60 days after launch. Further, if a PHP does not have an in-network provider reasonably available to the member without delay, then the PHP shall cover the service (pre-approved if required) from an out-of-network provider until such time as the deficiency is addressed. (add covered time period and reimbursement)

Q: Is the requirement of a documented "face to face" visit with the member a requirement of DME providers including those who conduct all business via mail order?

Q: If yes, does the state follow the published CMS listing for the face-to-face documentation or is it also required on consumable supplies? How does the state define initiation of service, is it necessary to renew the face to face when a member changes supplier?

A: Per the 5-series of DME/POS policies, subsection 3.2.1, criterion c, "a documented face-to-face encounter with the beneficiary and the ordering physician, physician assistant, or nurse practitioner related to the primary reason the beneficiary requires durable medical equipment and medical supplies has occurred no more than six (6) months prior to the initiation of durable medical equipment and medical supplies". NC applies this requirement to the initiation of all DME/POS. Reauthorization requests for ongoing medical equipment, supplies and appliances do not require a face-to-face encounter note. For more details please see the face-to-face encounters FAQs and the 5-series of DME/POS policies here: https://medicaid.ncdhhs.gov/providers/programs-services/medical/durable-medical-equipment.

Q: Will all the managed care insurances need prior authorization to continue therapy being that the child has been coming to therapy?

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

Q: How do we find the information on how to suppress EOBs?

A: We recently reached out to each PHP and asked how they will be handling EOBs with sensitive information.

The PHPs all responded that they will not send EOBs at all, will not send them for sensitive services, or will only send them following NC Medicaid EOB guidelines. I have copied each answer from the PHPs below:

WellCare:

We do not send EOBS to NC members, we send the REOMB from an SIU perspective using the state criteria below:

5. Recipient Explanation of Medical Benefit (REOMB)

a. The PHP shall create the REOMB using the previous month's claims for North Carolina Medicaid and the previous month's paid claims (i.e. February claims comprise March REOMB sample).

b. The PHP shall include the following in the REOMB: i. List of services provided and billed to the PHP;

ii. The name of the provider administering the service;

iii. The date on which the service was administered;

iv. The paid and unpaid services; and

v. The reason a service was not paid.

c. The PHP shall exclude those claims that include sensitive procedure information, claims that have been adjusted, and Medicare crossover claims when creating the REOMB as defined by the Department. Sensitive procedure information shall be defined as any procedures for allergies newborn treatment and care, and any treatment for a Member's reproductive health including but not limited to screening and treatment for communicable diseases, pregnancy, and sterilization.

d. The PHP shall exclude sensitive procedure information for minors when creating the REOMB sample as defined by the Department. Minor shall be defined in accordance with NC Chapter 48A.

e. The PHP shall send a REOMB for at least ten percent (10%) of all claims or 500 claims for the month, whichever is less. (Excluded claims include those in referenced in this Section).

f. The PHP shall send the REOMB via US mail to randomly selected Members that have been approved by the Department. The PHP shall collect responses from the REOMB mailing.

g. The PHP shall use a Department approved sampling method to determine population for the REOMB and include it in the PHP's annual Fraud Prevention Plan.

h. The PHP shall follow the defined Department policies for investigating and reporting suspected fraud, waste, and abuse identified from the REOMB response.

i. The PHP shall provide ad hoc REOMB to a Member upon request

Healthy Blue:

Per DHHS guidance, Healthy Blue is not required to send members EOBs and if a member receives STD/Family Planning Program/Services, there will not be a notification mailed stating the services were rendered.

AMHC: No, we do not send Explanation of Benefits to members.

UHC: UHC will not send EOBs for all services but will provide REOMBs (these are retro EOBs part of the Program Integrity process) consistent with DHHS requirements.

CCH: CCH has programmed our system to NOT mail an SVF/EOB when a member received sensitive services (i.e. HIV related services), however, the member will be able to view these services via the member portal.

If this does not answer your question, please reach out to the specific PHP directly. Contact information for the PHPs can be found here: https://medicaid.ncdhhs.gov/transformation/health-plans/health-plan-contacts-and-resources

Q: Will Providers have to have an EHR database that will be compatible with the PHP's they contract with and also with other providers since this is supposed to be "Whole Person" construct for the consumers???

A: Please review the information available on the NC DHHS website here https://medicaid.ncdhhs.gov/blog/2021/06/14/nc-medicaid-ehr-incentive-program-announcements

There is also a link to FAQ"s on the subject here https://medicaid.ncdhhs.gov/providers/programs-and-services/nc-medicaid-electronic-health-record-incentive-program/nc-medicaid-electronic-health-record-incentive-program-faq

The NC HIEA (NC Health Connex) happens to lead the mission of linking every health care provider in NC Medicaid and house a plethora of information regarding electronic health records. There link is here https://hiea.nc.gov/providers/how-connect

Q: Who determines if the Plan is more restrictive than the Medicaid clinical policy?

A: Policies from prepaid health plans (PHPs) cannot be more restrictive than current NC Medicaid and NC Health Choice clinical coverage policies; however, pursuant to 42 CFR 438.210(a)(3), an MCO may place appropriate limits on a service for the purpose of utilization management.

Here are some examples:

A PHP can require a referral or prior authorization prior to approving a service, and that is not considered more restrictive.

A PHP cannot be more restrictive in amount, duration and scope of services provided under the NC Medicaid fee-for-service program.

If medical necessity for a service is determined and it is a covered service, it is acceptable to have limitations placed for utilization management (UM) as long as the service is ultimately able to be provided in a way that reasonably achieves the purpose for which the services are furnished.

For location, there should be no limitations applied to policies if medical necessity is met.

A PHP can direct a beneficiary to a preferred location as long as the covered service is available within the Department's defined network adequacy standard for that specialty and does not create undue transportation or access barriers.

Additionally, continuity of care standards should apply and allow for continued service in an existing therapy relationship regardless of location.

Q: If we utilize a radiologist or pathologist that does not participate with a plan - do we need to get an authorization? We do the technical service and they are billing the professional

A: AMHC: Yes, out of network providers require prior authorization for any service.

UHC: For UHC the first 60 days all out of network providers will be paid as in network. For the first 30 days UHC will not deny for no prior auth if one is missed. After 30/60 time period- Per our reimbursement policy for Adjunct Services Policy, Professional:

https://www.uhcprovider.com/en/health-plans-by-state/north-carolina-health-plans/nc-comm-plan-home/nc-cp-policies/reimbursement-community-state-policies-nc.html

CCH: The authorization rules are as follow:

Radiology – High Tech imaging and cardiac services are authorized by NIA. All other radiology services will not require authorization (par and non-par providers)

Labs – Genetic and drug testing – authorization is required for all providers. All other labs, authorization is required for non-participating independent labs.

BCBS: Yes, all out-of-network services will require a prior authorization.

WellCare: The imaging services do not require an authorization, whether technical or professional until 9/28/2021, under the TOC Policy with WellCare

Q: Our office was under the impression we would be paid the same and treated like an in-network provider for 90 days from July 1st? Especially during the change period for patients. Is the timeframe really 60 days for 100% payment for services?

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: Do you feel that NC tracks will ever have the client policy # listed for the MCO plans?

A: The June 2021 PCP/AMH Enrollee 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. More information to come, but this will be delivered to the provider inboxes once ready. In the interim, providers can see health plan assignment at the individual level now through the Recipient Eligibility Verification function in NC Tracks. In addition, PHPs have sent Advanced Medical Home (AMH) Tier 3 providers (or their CIN partners) the beneficiary assignment file which has their panel assignments. If they are an AMH Tier 3 and a member of a Clinically Integrated Network (CIN) and have not received their report, the CIN may still have their panel information

Please refer to the main Fact sheet page here to access the new panel management fact sheet that was updated this week for more information on how to view eligibility for patients in NCTracks: https://medicaid.ncdhhs.gov/providers/provider-playbook-medicaid-managed-care/fact-sheets.

Q: Also, can you send the link for the 1 PA form we should be using -- we are a DME company and have found PA forms for each MCO provider?

A: WCHP provides a Prior Authorization look-up Tool to determine if a PA is required prior to rendering services. WCHP's Provider Look-up tool can be found at: https://www.wellcare.com/NorthCarolina/Providers/Authorization-Lookup

AMHC provides a Prior Authorization look-up Tool to determine if a PA is required prior to rendering services. AMHC's Provider Look-up tool can be found at: www.amerihealthcaritasnc.com

Healthy Blue provides a Prior Authorization look-up Tool to determine if a PA is required prior to rendering services. Healthy Blue's Provider Look-up tool can be found at: https://provider.healthybluenc.com/north-carolinaprovider/prior-authorizationlookup

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Q: What are the visit limits for under 21 for OT and PT?

A: CCH: For individuals under 21, (EPSDT) all requests are reviewed for medical necessity and will not be denied based solely upon a benefit limitation.

ACNC: ACNC will require prior authorization for medical necessity after the 12th visit for PT and OT and is not imposing annual visit limits for these therapies at this time. We will manage utilization via our planned Prior Authorization processes.

WellCare: There is no visit limitation for medically necessary PT/OT for beneficiaries under 21.

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

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.

Q: Will each PHP be giving additional guidance on filing health checks for children. The EPSDT guides are lacking specifics on modifiers??

A: DHB revised the Health Check Guide and created a new Health Choice Guide to provide additional guidance to PHPs. Please refer to the following links for more information: file:///C:/Users/sandra.n.achonye/Downloads/Health_Check_Billing_Program-Guide-2021_FINAL.pdf

file:///C:/Users/sandra.n.achonye/Downloads/Health%20Choice%20Guidance%20Annual%20Screening_FINAL.pdf

Q: For DME providers, is the NC DMA Request for Prior Approval CMN/PA needed as the order form for every order or just for supplies requiring a PA? Can we use our own physician orders?

A: The 5-series of DME/POS policies indicate that providers must keep certain documentation on file whether PA is required or not. Among these documents is the prescription and a completed and signed CMN/PA form. For more details, please see subsections 5.0 and 7.2 of the DME/POS policies here: https://medicaid.ncdhhs.gov/providers/programs-services/medical/durable-medical-equipment

Q: Will the Medicaid Managed Care Plan ID# be available in NCTracks?

A: The June 2021 PCP/AMH Enrollee 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. More information to come, but this will be delivered to the provider inboxes once ready. In the interim, providers can see health plan assignment at the individual level now through the Recipient Eligibility Verification function in NC Tracks. In addition, PHPs have sent Advanced Medical Home (AMH) Tier 3 providers (or their CIN partners) the beneficiary assignment file which has their panel assignments. If they are an AMH Tier 3 and a member of a Clinically Integrated Network (CIN) and have not received their report, the CIN may still have their panel information

Please refer to the main Fact sheet page here to access the new panel management fact sheet that was updated this week for more information on how to view eligibility for patients in NCTracks: https://medicaid.ncdhhs.gov/providers/provider-playbook-medicaid-managed-care/fact-sheets.

Q: After 7/1, if a person is with a plan and their preferred provider does not participate in it, can the person see the preferred provider while that plan change is processing? How would the claim be supported during that plan transition period?

A: If at MCL, a member's provider is OON with the member's PHP, 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: How will we know when the patient’s certification period begins/ends?

A: To verify when a patient's certification period begins/ends, providers should Verify eligibility, health plan and primary care provider enrollment. This can be done using the NCTracks.

Recipient Eligibility Verification tool. More information can be found in the Claims Part 1 Fact Sheet on the Provider Playbook

Q: Where can I find out which plan(s) members are enrolling with and their rankings?

A: You can find out this information through NCTracks.

Q: How will we know which members have an active PA on July 1?

A: You can find out this information through NCTracks.

Q: Can a member go directly to the state by passing the appeals process, if so desired?

A: No; if there is a Notice of Adverse Benefit Determination (NABD) issued by a Health Plan, the beneficiary must go through the Appeal process before they can escalate to the state. The beneficiary can file a grievance at any time, but that would have no bearing on the outcome of the appeal with respect to the service determination.

Q: For secondary claim filing, will the primary EOB's need to be attached with each claim?

A: Billing polices vary per health plan, please refer to their claims/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 do not receive a response or want to report a concern, please send this to the provider ombudsman at Medicaid.ProviderOmbudsman@dhhs.nc.gov.

For more information on claims and billing, the Department has also published fact sheets on the provider playbook (https://medicaid.ncdhhs.gov/providers/provider-playbook-medicaid-managed-care/fact-sheets) regarding "What Providers Need to Know around Claims Submission Guidelines and Resources https://medicaid.ncdhhs.gov/providers/provider-playbook-medicaid-managed-care/fact-sheets) as well as a frequently asked questions matrix that details each health plan's response (https://medicaid.ncdhhs.gov/providers/provider-playbook-medicaid-managed-care/fact-sheets).

Contact information for health plans as well as their quick reference guides 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

Q: How and by what means are Care Management services paid? Will it change from the current process?

A: Expectations and requirements of Care Management payment is detailed in the Advanced Medical Home (AMH) Provider Manual Section. III, AMH Payment Model, pages 14 & 15, which can be found at: https://files.nc.gov/ncdma/documents/Transformation/Advanced-Medical-Home-Provider-Manual.pdf . This section of the manual provides a summary table to the payments under the model as well as detailed information on each type of payment. If you have any questions or need further assistance, please contact Medicaid.Transformation@dhhs.nc.gov.

Q: Have floor rates been revisited for PHPs for behavioral health? We still have one fee schedule that is 14% below the current Medicaid floor.

A: MCO's & PHP's 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/PHPs and providers. The managed care rates paid by the State to the PHPs took into account the current fee for service rates.

Q: Will there be visit limits for the members to primary and specialty care?

A: None of the PHPs have any visit limits for NC Medicaid beneficiaries. NC Medicaid direct beneficiaries will still have the limit of 22 visits annually.

Q: Is there a rate floor for medication assistance therapy regardless of provider type?

A: Office based opioid treatment (OBOT) is a rate floor program and PHPs are required to reimburse Medicaid providers (no less than 100 percent of the applicable Medicaid Direct rate) unless the PHP and provider mutually agree to an alternative reimbursement arrangement.

The opioid treatment program (OTP) however does not have a rate floor therefore health plans have the authority to negotiate rates regardless of what FFS reimburses at. The State cannot get involved in this negotiation process as this is entirely up to the health plans and providers.

Q: Will there be a record of the Q&As available to everyone?

A: The Q&As as well as all of our previous Q&As can be found on the AHEC Medicaid Managed Care website. https://www.ncahec.net/medicaid-managed-care/. Please allow a couple of weeks for the Q&A from this webinar to be posted.

Q: We have electronic eligibility checked by our system. Will the electronic responses we receive identify which eligibility the patient has?

A: The June 2021 PCP/AMH Enrollee 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. More information to come, but this will be delivered to the provider inboxes once ready. In the interim, providers can see health plan assignment at the individual level now through the Recipient Eligibility Verification function in NC Tracks. In addition, PHPs have sent Advanced Medical Home (AMH) Tier 3 providers (or their CIN partners) the beneficiary assignment file which has their panel assignments. If they are an AMH Tier 3 and a member of a Clinically Integrated Network (CIN) and have not received their report, the CIN may still have their panel information

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Q: For behavioral health outpatient therapy services, what date to the unmanaged visits reset at zero?

A: The unmanaged visits are per State fiscal year which is 7/1 through 6/30.

Q: For OT/PT/ST service current Choice PA auths, I am hearing conflicting answers. Are auths going to be continued for 90 days OR the end date of the current auth- whichever is sooner? Or for the full 90 days regardless of the end date of the choice pa auth?

A: To ensure continuity of care for members, NC Medicaid's managed care contract requires the PHPs to honor all existing and active prior authorizations (PAs) on file with the NC Medicaid or NC Health Choice program for the first 90 days after managed care implementation or until the expiration/completion of a PA, whichever occurs first. PHPs have the option to honor existing PAs beyond 90 days, but this is not

required. We recommend providers contact the individual PHPs for specific questions about their PA processes. Contact information can be found here: https://medicaid.ncdhhs.gov/transformation/health-plans/health-plan-contacts-and-resources.

Q: How do we submit peer support and outpatient mental health therapy authorizations?

A: WCHP Submission Methods:

Standard: Online via Provider Portal: https://provider.wellcare.com/

Via fax to the numbers listed on the associated forms: https://www.wellcare.com/NorthCarolina/Providers/Medicaid/Forms

Urgent: Call 866-799-5318 and follow the prompts.

Pharmacy: Via Fax to 800-678-3189 Online via Surescripts portal: https://providerportal.surescripts.net/providerportal/

AMHC submission methods:

Standard: Online via Provider Portal: www.navinet.navimedix.com Via Fax to 833-893-2262 Call 833-900-2262

Pharmacy: Via fax to 877-234-4274 Call: 855-375-8811

Healthy Blue submission methods:

Standard: Online via Provider Portal: https://provider.healthybluenc.com/north-carolinaprovider/prior-authorization

Via Fax to 800-964-3627 (Inpatient) 844-445-6649 (Outpatient)

Urgent: Call 844-594-5072

Pharmacy: Via Fax to 844-376-2318 Call 844-594-5072

CCH submission methods:

Standard: Online via Secure Provider Portal: http://carolinacompletehealth.com/

Use the Prior-Auth Check Tool on the website to quickly determine if a service or procedure requires prior authorization. This tool will go live later this summer, before the launch of NC Medicaid Managed care. Call 833-552-3876 Via Fax to 919-670-4948

Urgent: Call 919-719-4161.

UNHC submission methods:

Standard: Online via Prior Authorization and Notification Tool on Link: https://UHCprovider.com/priorauth If you're unable to use Link, call Provider Services at 877-842-3210.

Urgent: Call Provider Services at 877-842-3210 and follow the prompts. Call 833-552-3876

Via Fax to 919-670-4948 Urgent: Call 919-719-4161.

Q: Will the members new ID cards show if their plan is considered a HealthChoice plan?

A: AmeriHealth Caritas and UnitedHealthcare have separate ID cards for NC Health Choice beneficiaries. For the other 3 PHPs, the ID cards do not specifically indicate NC Health Choice. Providers should check Medicaid eligibility information in NCTracks for all patients.

Q: Healthy blue says a referral is not required from the PCP when a specialist wants to send to a specialist. UHC just said it is required. Is this correct?

A: BCBS: Referrals to in-network specialists are not required. However, some specialty services require precertification. We encourage members to consult with their PCPs prior to accessing nonemergency specialty services.

UHC does not require a referral to see a specialist

Q: Are Clinically Integrated networks (CIN's) required to contact all hospital discharges or only the top 20-25% of high-risk patients?

A: In accordance with the AMH Provider manual, the expectation is to provide short-term, transitional care management, along with medication management, to all empaneled patients who have an ED visit or hospital admission/discharge/transfer and who are at high risk of readmission and other poor outcomes. Additional details can be obtained in the AMH Provider Manual, Requirement 4, Pages 11/12, which can be found at: https://files.nc.gov/ncdma/documents/Transformation/Advanced-Medical-Home-Provider-Manual.pdf

Q: How do outpatient therapists (OT/PT/ST) obtain PAs? A recent MAHEC webinar stated that our PAs would have to be submitted by PCPs? Currently we submit these ourselves via ChoicePA. Will there be any webinars specifically for OT/PT/ST?

A: In managed care each PHP will manage its own PA process and use its own PA vendor. The managed care contract does not require that outpatient specialized therapy services only be ordered by the member's primary care physician. Please refer back to the May 20th webinar focused on Specialized therapy on the AHEC website. https://www.ncahec.net/medicaid-managed-care/

Q: What are the PHPs doing to contact each of the contracted practices to make sure that they are setup correctly and ready to go by 07/1?

A: Dedicated Account Executives are assigned to each of our practices in order to assist them in the transition. In addition, our provider manual and website, there are resources for providers to assist and answer questions regarding billing, EFT, claims submission, etc.

https://www.amerihealthcaritasnc.com/provider/index.aspx

https://www.amerihealthcaritasnc.com/provider/forms/index.aspx

Also, providers can subscribe to our network news alert system for news and updates.

https://www.amerihealthcaritasnc.com/provider/newsletters-and-updates/network-news.aspx

The following is a summary of our provider education/outreach activities:

Provider Orientation Webinars

Link to CCH Education & Training Resources:
https://network.carolinacompletehealth.com/resources/education-and-training.html

•On-demand recorded orientation trainings – CCH comprehensive orientation is recorded and posted in full-length version and modules for providers to view on-demand and attest. PowerPoint version is also posted as well as the PHP-streamlined core orientation recording and slides. We have also been email blasting the links out to providers.

•Live orientation webinars have and are still being conducted for individual health systems, individual CINs (for example: 6 different live webinars were hosted at various times for CCPN), and open invitation live orientation webinars started with 4 live sessions From April – June and are now held on the First Friday of the month 12:30PM- Register in advance and the Fourth Wednesday of the month 12:00PM: Register in advance. The PE Coordinators have also been conducting 1:1 live orientations upon request.

Provider Training Webinars and Info Related to Portal and Billing

Link to CCH Portal Education (also covered in orientation):
https://network.carolinacompletehealth.com/resources/manuals-and-forms.html

Link to CCH Claims and Billing Education (also covered in orientation):

https://network.carolinacompletehealth.com/resources/claims-and-billing.html

2021 Scheduled Payspan Provider Portal Webinars (3rd Wednesday of each month)

- July 21, 2021 | 1:30PM – 3:00PM EST
- Aug 18, 2021 | 1:30PM - 3:00PM EDT
- Sep 15, 2021 | 1:30PM - 3:00PM EDT
- Oct 20, 2021 | 1:30PM - 3:00PM EDT
- Nov 17, 2021 | 1:30PM - 3:00PM EST
- Dec 15, 2021 | 1:30PM - 3:00PM EST

Other Training: CCH has also posted training recordings and materials related to other topics including but not limited to behavioral health, compliance, Medicaid transformation, prior auths, claims/billing, and other.

Provider Communications: CCH has been conducting ongoing 1:1 provider outreach from the PE and PR teams based on assignment and inbound provider questions. These interactions are documented in our QuickBase CRM system. CCH has also been communicating with providers via email and our website to provide tips, training, updates, and general information to ensure they are ready for go-live.

Link to a listing of Provider Communication Email Blasts:
https://network.carolinacompletehealth.com/ProviderUpdates/cchn-bulletins-and-newsletters.html

Link to CCH Provider Updates:

https://network.carolinacompletehealth.com/ProviderUpdates/ProviderUpdates.html

Link to CCH Medicaid Transformation Updates:

https://network.carolinacompletehealth.com/ProviderUpdates/medicaid-transformation-updates.html

Additional training and education materials

Link to CCH Provider Resources that include all manuals, forms, policies and other educational materials:
https://network.carolinacompletehealth.com/resources.html

Pre-delegation audits & meet & greets

- CCH network and plan have been partnering to conduct kick-off meet and greets and pre-delegation audits with all LHDs and AMHs. These meetings include representation from Provider Engagement, Provider Relations, Population Health and Operations.

JOC Meetings

- CCH network and plan have been partnering to conduct JOC meetings with health systems/hospitals and clinical integrated networks. These meetings include representatives from all primary operational areas for the plan including but not limited to Provider Engagement/Relations, Population Health, Claims/Billing, UM, Quality, and Contracting.

Provider Services Call Line & Network Relations Email

- The PR team has been fielding incoming inquiries and questions from providers via the Provider Support Phone Line and the Network Relations Email. These calls/emails are triaged and if needed are sent to the appropriate SME for follow-up.

Provider Engagement Team Email/Phone

- The Provider Engagement and Corporate Connections Team have been and will continue to field questions/calls from their assigned providers. These questions/calls/inquiries are documented in our CRM system to ensure proper follow-up.

Help Stat Email Inbox

- CCHN has created a "Help Stat" feature on every page of our provider-facing website to ensure providers can get a quick response and reach the appropriate person to get the help they need when they need it. This feature promotes our "no wrong door" vision of engaging our providers.

HealthyBlue has conducted virtual provider trainings. These sessions include General Provider Orientations, LTSS Orientations, Behavioral Health Orientations and Delegated Care Management Orientations and Telehealth Orientations. All sessions were posted to the HealthyBlue NC website.

Remaining scheduled sessions are planned and can be located at https://provider.healthybluenc.com/north-carolina-provider/training-academy . Additionally, HealthyBlue NC Network Relations Consultants have (and continue) to reach out to providers via phone or email.

Providers who are in need of education regarding claims submission, ERA's/ERT, Portal, Website and User Accounts should submit a request to the nc_provider_training@healthybluenc.com

UNHC hosts NC Medicaid provider education & training webinars every Tuesday and Thursday. Providers are encouraged to register for as many sessions as needed, via the links below.

Tuesday: https://bit.ly/2WT0Xya

Thursday: https://bit.ly/38W5plp

In addition to the Tuesday & Thursday sessions, we've launched a new virtual provider series which occurs every Friday through 7/30/21. Providers may access the schedule and register via the link on our provider facing portal, https://www.uhcprovider.com/content/dam/provider/docs/public/commplan/nc/training/UHCCP-NC-Provider-Overview.pdf.

WellCare has been working for 2 years, visiting providers as they are loaded and providing orientations and getting them registered on our Provider Portal. We have been holding monthly Orientation Webinars and Provider Portal Webinars. The orientation includes how to register with PaySpan for EFT. WellCare has 32 field reps., with an assigned territory by county or zip code and the assigned rep., is the account manager for the office. We also have a mailbox, NCProviderRelations@WellCare.com that providers can outreach to find out who their assigned rep., is.

Q: Do the other PHPs also follow bright futures recommendations? Does DHB hold all PHPs to following bright futures?

A: DHB does not require that the PHPs follow the Bright Futures guidelines, but it is encouraged.

The Medicaid Direct Health Check program guide can be found here: https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html

Health Plan contacts and resources can be found here: https://medicaid.ncdhhs.gov/transformation/health-plans/health-plan-contacts-and-resources

Q: Can all health plans go to a daily check write like healthy blue?

A: AmeriHealth Caritas has a Monday/Wednesday check write that cannot be changed.

CCH: We believe our current cadence of twice a week check writes is more than adequate to ensure all accurately submitted claims are paid on time. We will re-evaluate this cadence if the situation calls for it. We will write checks on Tuesdays and Fridays every week.

UHC's standard processing, once we are passed the initial review period, involves a daily checkwrite occurring at 6:00pm CST, M-F.

WellCare has a daily check write, except for Sundays

Q: Will there be a Nurse Practitioner/ MD/ psychiatrist signature needed on service order for peer supports services? Will there be a Nurse Practitioner/ MD/ psychiatrist signature needed on service order when the clinician is associate level for outpatient therapy?

A: The service order for Peer Support Services must be signed by a physician or other licensed clinician per his or her scope of practice. https://medicaid.ncdhhs.gov/media/8107/open

For outpatient therapy for Medicaid Beneficiaries under the Age of 21, a written service order by a Physician, Licensed Psychologist (doctorate level), Nurse Practitioner (NP) or physician assistant (PA) is required for Associate Level Professionals prior to or on the first date of treatment (excluding the initial assessment). Services provided by the licensed professionals listed in Subsection 6.1 of CCP 8C, other than the Associate Level Professionals, do not require a separate written service order. These licensed professionals shall document the service or services they are providing, document the medical necessity of the service(s) being provided, and this documentation shall be signed by the licensed professional providing the service.

For outpatient therapy for Medicaid Beneficiaries Ages 21 and Over, a written service order by a Physician, Licensed Psychologist (doctorate level), Nurse Practitioner (NP) or physician assistant (PA) is required for Associate Level Professionals prior to or on the first date of treatment (excluding the initial assessment). Services provided by the licensed professionals listed in Subsection 6.1 of CCP 8C, other than the Associate Level Professionals, do not require a separate written service order. These licensed professionals shall document the service or services they are providing, document the medical necessity of the service(s) being provided, and this documentation shall be signed by the licensed professional providing the service. https://medicaid.ncdhhs.gov/media/8204/open

Q: For Healthy Blue on the Availity website, if you try to search for a member's # it ask for a pre-fix, these patients will not have a prefix - will that be corrected before 7-1-2021?

A: Healthy Blue member ID cards will have the alpha prefix of GJN, and the member's Medicaid ID is also listed on their Healthy Blue ID card. Some functionality in Availity was not live until 7/1, including the eligibility pages. All functionality is live now and searching by the member's Medicaid ID or Healthy Blue ID number should render results. Please email us at NC_Provider@healthybluenc.com if you have further questions.

Q: Will this recording be sent to participants?

A: This recording as well as all of our previous recordings can be found on the AHEC Medicaid Managed Care website. https://www.ncahec.net/medicaid-managed-care/

Q: Where can I get a copy of this slide program?

A: This slide deck as well as all of our previous slide decks can be found on the AHEC Medicaid Managed Care website. The deck is normally published before the meeting https://www.ncahec.net/medicaid-managed-care/