| Question | Answer(s) |
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| Will all recipients who are moving to managed care be assigned a PHP before July 1? We have some families that have not heard of managed care nor selected a plan. | Yes - all members who are transitioning to managed care were auto enrolled into a health plan the last week in May. The Health Plans have sent out their welcome packets and ID cards to members. If you are unsure if your patients are transitioning, you can verify eligibility through the NCTracks Recipient Verification methods. More information on how to verify eligibility can be found here in the "Panel Management" Fact Sheet as well as the "Managed Care Claims and Prior Authorizations Submission: What Providers Need to Know - Part 1" Fact Sheet: https://medicaid.ncdhhs.gov/providers/provider-playbook-medicaid-managed-care/fact-sheets<br><br>In addition, your members are able to call the health plan member services line they enrolled in to request a new welcome packet and ID card if needed. |
| When reading information, I have interpreted the guidance that dual eligibles (Medicare and Medicaid) in skilled nursing facilities, will not fall under Managed Medicaid? Is this a correct interpretation? | Yes, that is correct. Beneficiaries receiving both Medicare and Medicaid are sometimes called “duals” because they are dually eligible for both programs. Duals are temporarily excluded from NC Medicaid Managed Care and will remain in NC Medicaid Direct at this time. The way these beneficiaries receive services will not change and they do not need to do anything at this time. If they have questions, they can contact their local Department of Social Services (DSS) or call the NC Medicaid Contact Center at 888-245-0179. |
| You mentioned prior approvals. Is there information regarding obtaining prior approvals through each plan at this time? | Yes - information on prior approvals for each can be found on the Provider Playbook Fact Sheet page, specifically in the following two fact sheets: https://medicaid.ncdhhs.gov/providers/provider-playbook-medicaid-managed-care/fact-sheets<br>1) Managed Care Claims and Prior Authorizations Submission: What Providers Need to Know - Part 1<br>2) Managed Care Claims and Prior Authorizations Submission: Frequently Asked Questions - Part 2<br><br>For more information - please contact your contracted health plan's provider services line. |
| How will we know if it is health choice or regular medicaid by the PHP? | Providers can verify eligibility, health plan and primary care provider enrollment using the NCTracks Recipient Eligibility Verification tool. More information on how to verify eligibility can be found here in the "Panel Management" Fact Sheet as well as the "Managed Care Claims and Prior Authorizations Submission: What Providers Need to Know - Part 1" Fact Sheet: https://medicaid.ncdhhs.gov/providers/provider-playbook-medicaid-managed-care/fact-sheets.<br><br>Their Medicaid or Health Choice status will also display on the patients ID Card they receive from their health plan. |
| For telehealth claims- will the PHPs require the Place of service 12 and modifiers GTCR like Medicaid currently does | This may vary by health plan. Please reach out to your contracted health plan's provider services line. |
| Will the Medicaid ID# be required on the PHP claims? | This varies by health plan:<br><br>AmeriHealth Caritas North Carolina: Providers should use their AmeriHealth Caritas NC member ID on their PAs and claims.<br><br>Carolina Complete Health: Prior authorizations and claims do not require the use of a separate PHP ID, rather a NC Medicaid or NC Health Choice ID.<br><br>Healthy Blue (Blue Cross Blue Shield): For prior authorizations and claims, providers can use either the NC Medicaid or NC Health Choice ID or our system generated Subscriber ID.<br><br>WellCare of North Carolina: Providers are able to submit authorizations and claims with either the NC Medicaid or NC Health Choice ID or the WellCare member ID.<br><br>United Healthcare Community Plan of North Carolina: Claims expects to receive the PHP ID on the claim submission, but we do havethere is member pick logic set in the system to select the appropriate member based on either the NC Medicaid or NC Health Choice ID, or the Name and Date of Birth if the PHP ID is not available. |
| Will the invoices and post dispensing forms still be required? | Medicaid Clinical Coverage Policy 7, Hearing Aid Services is the minimum coverage criteria for all health plans. However, billing requirements may differ from plan to plan. Please contact each health plan with which you are contracting for health plan specific billing requirements. |
| What is the process if a member is assigned to a PHP and should have remained in Medicaid Direct? | Providers and members can contact the Enrollment Broker at 1-833-870-5500 (TTY: 1-833-870-5588) if the member would like to stay in NC Medicaid Direct. There is paperwork that the beneficiary or provider can fill out. |

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| If a provider has a contract with the Medcaid PHP but not with the PHP's hearing aid vendor (WellCare Example), whose responisbility is it to start good faith negotiations? Also, since there is a contract with the PHP, does this mean the provider should expect 100% payment for Hearing Aid services until the PHP engages the provider about contracting with the vendor or the vendor contacts the provider? | The Department has not issued guidance on who is responsible for beginning good faith negotiations, but if a provider wishes to provide covered services to NC Medicaid Managed Care members and wishes to contract with a Prepaid Health Plan (PHP) or a PHP's vendor , the provider should take steps to begin those negotiations. Otherwise, transition of care and crossover provisions notwithstanding, the provider will be considered out-of-network for covered services for which the provider is not contracted and will likely have to seek prior authorization for any covered services provided to a PHP's (and its subcontractors) member. It is also likely that in the scenario described, that once a provider seeks prior approval for a covered service for which they are not contracted, the PHP and/or vendor will likely initiate good faith contracting attempts to bring the provider into the network. If after the process outlined in the PHP's good faith contracting policy is exhausted and the provider has not accepted a contract for the covered service with the PHP/vendor, then the PHP and vendor will be able to consider the provider out-of-network for that service and are prohibited from reimbursing the provider more than 90% of the applicable Medicaid fee-for-service rate. |
| Will medical necessity be subject to the same rules under the Medicaid plans or will this now vary by PHP? | Medical Necessity will be determined by the appropriate entity (PHP or Medicaid Direct) unless it is a mandatory policy which has to be followed exactly. Medicaid Clinical Coverage Policy 7, Hearing Aid Service is NOT a mandatory (i.e required') policy so the health plan may determine medical necessity. Auditory Implant External Parts Clinical Coverage Policies (13A and 13B) are mandatory policies. Therefore the health plans are required to follow them exactly except for prior approval and claims PROCESSES. |