

Transcript for Virtual Office Hours for Providers: Medicaid Managed Care Hot Topics

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4:00 pm – 5:00 pm

Presenters:

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Chris Weathington

It's 4pm, let's get started. Thank you for participating in today's virtual office hour session with North Carolina Medicaid to discuss the latest Medicaid managed care hot topics, North Carolina Medicaid in North Carolina AHEC have partnered to ensure that health care providers across all 100 North Carolina counties have the information and support they need to adapt to and thrive under Medicaid managed care. This collaboration produces educational programming and AHEC Practice Support coaches to provide one to one assistance directly to practices. My name is Chris Worthington and I'm the director of AHEC practice support, and I'll moderate today's session. Before I turn it over to the panelists, let me run through this through some logistics, everyone other than our presenters is muted and the chat function is turned off, you can ask questions or make comments by using the q&a feature on the black bar on the bottom of the screen, we've learned in past sessions that the presenters will often address your questions during their presentation. We encourage you to wait until the presenters are through with their brief presentations before submitting a question, please know that we will send any questions we do not get to today, to the health plans in North Carolina Medicaid so that we can respond directly to you, and also incorporate your questions into future FAQs and other documents for presentations. If you have questions that are not related to today's topic is fine to go ahead and submit those, we will not be able to address those questions today. We will record the session, and add this recording, along with these slides on the NC AHEC website as soon as possible, usually by the next business day. Now I'm going to introduce today's panelists, and turn it over to them for a brief presentation before we get into the q&a. We've got Darryl Frazier, our manager for provider operations and Erica White, the provider relations team lead for North Carolina Medicaid, Darryl and Erica I'll just turn this over to you.

Darryl Frazier

Thank you, Chris. Good afternoon, North Carolina Medicaid and NC Health Choice providers and interested parties. Thank you for joining us today. Today, I also want to especially recognize the rule and independent providers. We know you are out there as a safety net provider for your community, and I want you to know that we are here for you. Today we will touch on the following topics. The Medicaid provider ombudsman, ombudsman statistics and call center statistics. I will share with you a checklist of reminders. We will address managed care transition period and key dates, also covered common Medicaid managed care billing errors, as well as the provider verification process and points to remember.

So why is the Medicaid provider ombudsman, and why does North Carolina need an ombudsman. First for your edification as I didn't know, by definition, ombudsman is defined as an official appointed to investigate individuals complaints against maladministration, especially a public authorities. Why do we need an ombudsman. Well, it was created for providing inquiries concerns and complaints regarding BHPs, but I want you to know that you can contact us for anything, and we will be here to assist you. As you can see on the screen, we have the web address, Medicaid dot provider ombudsman at DHHS NC gov or you can reach us via telephone at 1-866-304-7062. And for your information, our ombudsman is really an ombudswoman. So, I want to give you some stats. Regarding to provider ombudsman. Since the launch of the D H helps DHHS Help Center, we have received or handle 494 inquiries. Currently, we are working 44 cases of those 44 cases, 29 were with the PHPs and 15 are being worked our group. Now also wanted to share this slide with you for transparency, and also to give you a snapshot glimpse into what our call centers are hearing from providers. As you can see from this slide, during the past. The first two weeks of launch. We handled almost 20,000 telephone calls, which were referred to the PHPs. Some of the reasons covered provider enrollment, which are not surprised we continue to preach provider enrollment and making sure your record is accurate. Also we have questions about network status prior authorizations, demographics, benefits, and claims. I think the next time you see these tax claims and reimbursement will probably be at the top. Next slide please.

Also to assist you. I hope you are familiar with our website. We have created a checklist of reminders for providers, but to ensure your success. We want you to keep the quick reference guide handy. This includes all telephone numbers, email addresses, and many different resources, including PHP information nctracks information and DHB information. Also ensure that your staff knows the health plans that your contract that we have. Or if you operate in western North Carolina know if you are a member network member of Eastern Band Cherokee. And we continue to preach enrollment, from the previous slide you can see we're providing enrollment was at the top of the list so we asked you to continue to review your provider record to make sure it's accurate, and to make sure any affiliated providers that their record is correct and if not you can complete and manage change requests. Also with the number of

claim problems we have, we want you to know where to submit claims for each health plan on the contract, please ensure enrollment and health plans the electronic funds transfer program is completed. We want to make sure if you're enrolled that you also have the means to receive your payments, and most importantly assist your patients assist them with their transition to Medicaid managed care, and if you're not sure what to do refer them to the enrollment broker call center, which is listed at the bottom in the last checklist that telephone number is 833-870-5500.

Next slide. And again I'm going to ask, are you familiar with the DHHS NC Medicaid website. We have 10s, if not hundreds of fact sheets out there to assist you and to guide you, the ones that I want to point out today and share with you include managed care claims, and prior authorization submission. There's both a part one and part two. The part one contains references to resources for each of the prepaid health plans. Part Two gives you an overview of frequently asked questions so perhaps some of the inquiries that you're submitting to us, if you access this fact sheet, especially part two, your questions may be addressed in the q&a. Part Two also includes the provided payment schedule from July to October, so you can anticipate when to receive the reimbursement. And at the lower portion of the as the third bullet, we also have a fact sheet on combined health plan quick reference guide, we refer to it as the QRG. And this is updated contact numbers designed for clients to use beginning at day one and on. It gives you access to all the information that you encounter on a day to day basis. We have received many questions regarding prior authorizations and claims. You can use this Quick Reference Guide to assist you in addressing those concerns. Next slide please. Also we are receiving so many questions regarding prior authorizations and referrals, and I thought it was important to share this slide with you. As you can see, it is divided into three areas. First the general information regarding health plan questions, and their dedicated lines, established by each of the health plans to address your questions. If you have a question, and it is regarding the health plan, please contact health plan directly. Also there's information regarding prior authorizations. If the member transitions between health plans between July, 1 2021, a prior authorization by the original health plan will be honored and it should be honored for the life. If that is not the case, please contact ombudsman so we can assist you. And also regarding prior authorizations all providers should confirm with the PHP with whom the beneficiaries enroll the service that they are provided request pa prior to performing the service. So that's the general information is specific to you. The first 60 days. We go regarding PA health plan will pay, or should pay any claim authorized service for any Medicaid roll out of network provider equal to that and networks. So for the first 60 days, whether you're in network or out of network, or that claim should be paid at 100% of the Medicaid fee schedule. Also during the first 60 days, referrals are not needed. Patients should be able providers to be able to see patients regardless of whether they in network or out of network. And after 60 days, referrals of care are only needed when a member is seeing a provider who is not in network with the PHP, with whom the beneficiary is a role at 90 day period September 30, this is the last day the health plan must

honor existing and active PAs. At this time, I'm going to turn it over to Erica White. Thank you. Next slide.

Erica White

This slide is about adding a billing rendering and attending provider taxonomy to professional institutional epi claims, health plans have identified a common billing error of providers submitting professional and institutional epi claims, specifically ASC X 112837-P and ASC X 12837-I with missing or invalid provider rendering provider and attending provider taxonomy codes. When billing North Carolina to Medicaid direct claims providers may have direct may have directed clearing houses to append billing provider when the provider or attending provider taxonomy codes to the claim. This process may not have been established for enough time Medicaid met and being submitted to the prepaid health clinics, causing these payments were denied for missing or invalid taxonomies. Providers should work with their clearinghouse to ensure that the same processes are followed. When submitting claims to North Carolina Medicaid direct in the PHP, please refer to the July 9 2021 common billing error taxonomy codes missing incorrect or inactive bulletin for additional guidance for submitting valid text on the next five NC tracks changes to the provider verification process. Currently, NC track stands notifications for expiring credentials, including licenses certifications and accreditations, to all enrolled providers required to be licensed, certified or accredited. These notices are sent to the provider message center inbox beginning 60 days in advance of the expiration date of the credential. Since May 9 2021 North Carolina Medicaid has taken additional steps to ensure providers meet contractual obligations to keep credentials current time either notifications or suspensions and termination. Provider recertification letter, those out 60 days prior to credential expiration date. Reminder letters are sent at 30 calendar days. And 14 calendar days, final notices said seven days prior to expiration.

When credential expires suspension is next. And with the suspension the taxonomy code, requiring expired credentials is suspended claims will pend and not pay until suspension is lifted. Notification, the suspension letter generated as recertify suspension at 60 days, the amount of time the suspension will remain in place, 60 days and the amount of time suspension will remain in place until credential is renewed, and submit. Termination taxonomy code terminated on the 61st calendar day. Providers must reapply to Medicaid in those time to health choice. Next five final points to remember, North Carolina Medicaid managed care information has been added to the recipient eligibility eligibility response page, North Carolina Medicaid will continue to post the enrollee report in the nctracks provider message inbox for North Carolina Medicaid direct and all health plans. Just the in network PCP, even if it is not the assigned PCP PCPs are encouraged to use their care management resources to help members with barriers. Next.

Chris Weathington

Okay. Thanks a lot, Erica, I appreciate that. I'm going to go ahead and look at the questions that are in the inbox and ask each of you to help us answer them. First, Michael. Maybe you can help us here, what happens if a provider is having a recurring issue with the provider directory.

Michael

Hey, thanks, um, if a user is having issues with search functions displaying unexpected results. We encourage those users to use the reporting area link in the top right corner, that's found on any page and lookup tool. Those areas we will be reviewed by the provider operations team who respond to users feedback. If those results are related to the health plan accepted information, Medicaid encourages providers to work with their health plans directly to remediate those discrepancies. If they continue, however, NC Medicaid encourages providers to reach out to the provider ombudsman. These hasn't increased concerns or complaints can be submitted to the email Medicaid.providerombudsman@dhhs.nc.gov, or also through the provider ombudsman line at 866-304-7062 that provider ombudsman contact information is also published in each health plans Provider Manual.

Chris Weathington

Thank you Michael, Julia I'm going to send this question your way. The question is do I need authorization to provide primary care for a member who was not assigned to me.

Julia

Thank you Chris for that question, members do not need authorization to see in network PCPs. Even if it's not their assigned PCP, we do encourage all primary care providers to help members engage with their assigned practice or help members change their assignment. After the transition of care period, a members will, will need a prior authorization to see a PCP who is not in network.

Chris Weathington

I'm gonna direct this question to Shaundra Shaundra how the group's removed providers, no longer affiliated with the group. If the group does not have access to that providers NC tracks application to the end date, the affiliation.

Shaundra

If a provider information is on the online directly it's kind of out of date, or it's inaccurate, the providers office administrator can reach out to NCtracks, if they don't have access to that providers record and explain to them. One, they don't have access to the providers record, however they need to make some changes. They will then allow them to submit or receive a pin number that belongs to that providers enrollment record. And at that point that can submit a managed change request, and they do that by visiting NC tracks, and that allows them to go in and update on that affiliations tab. If the providers affiliations information is incorrect. What's the opposite administrator has corrected that information, it should be reflected and fit well on the provider's record, as well as the EB directory. Any information that is updated on that organization or the individual record within NC tracks will then be reflected on the provider directory. After the NC tracks in CRS

Chris Weathington

Thank you, Shandra. Connie, where should a provider file claims.

Connie

Thank you. If there are claims prior to July 1 2021 claims should be submitted as they are --in nctracks or local management is managed care organization LME/MCOs. For dates of service, beginning July, 1 2021 claims routing depends on the beneficiary enrollment at the time of service and the service provider claims for beneficiaries enrolled in NC Medicaid direct to be submitted through nctrack [unintelligible]

Shaundra

Shaundra what has changed about the nctracks recipient eligibility response. Can you come back to me on that question please my screen just went out.

Chris Weathington

Sure, sure. Erica. How can providers view their panel with each PHP after launch.

Erica White

Okay, um, NC Medicaid will continue to post the enrollee report in the NC -- message inbox for North Carolina Medicaid direct and all health plans. Amh tier threes will receive their, their member list through the 834 beneficiary file. In addition, all AMHs and PCPs will receive a signed enrollee panel information from each health plan.

Chris Weathington

Okay, thank you, Erica, Darryl, this question is for you. What are the nctracks recipient eligibility verification methods.

Darryl Frazier

Thanks Chris. I'm happy to address that as I saw that information in the county playbook. Last night, on the website. There are two methods of receiving eligibility verification available via NC track secure Provider Portal, one real time eligibility verification and two, batch eligibility verification. As a reminder, these methods can be used for current and future eligibility information thank you Chris.

Chris Weathington

Okay, Michael, who should providers contact if they wish to contract with the health plan.

Michael

Providers should reference the health plan contracts and Resources page to contact the health plan with whom they want to contract. Additionally more information can also be found a provider contracting with health plans page, both those URLs can be found on the nctracks website. In the provider and user guide training manual, and also on the NC Medicaid website. That website is listed on our previous slides.

Chris Weathington

Thank you. Connie, how long does it take to contract with a health plan.

Connie

The open enrollment and auto enrollment deadlines. allow plans to process provider contracts and ensure that the provider can be paid. This typically takes at least two to three weeks, but it may take longer. Additional time is then needed to transmit information to NC Medicaid for inclusion in the provider directory for open enrollment, and in the auto enrollment process, primary care providers, or PCP need to contract with health plans in a timely fashion to avoid losing patients as health plans will assign beneficiaries to in network providers.

Chris Weathington

Thank you. Shaundra. This is a question we have, can I still contract with the health plans after July one

Shaundra

Absolutely, regardless of executed contracts. At any time, this is an ongoing process. Providers may contract with one or more health plans at any time and providers are encouraged to continue contract negotiations with health plans and finalize the contract as soon as possible.

Chris Weathington

This is another question for you. What has changed about the nctracks recipient eligibility response.

Shaundra

When not relying on Medicaid managed care information has been added to the recipient eligibility response page, and this includes the health plan name, and contact information as well as the health plans, assignment for PHP AMH. Due to the copout surfaces and the necessity to display other benefit plan information is very important for providers to give special attention to the service types and copay section under each benefit claim.

Chris Weathington

Erica this question is for you. How does a primary care provider practice determine what tier status they are?

Erica White

Primary care provider practices have the ability to attest to an advanced medical home tier status within nctracks in 2019 any Carolina access two practice was grandfathered into the Amh program as a tier two, You can view this through the nctracks Provider Portal.

Chris Weathington

Can you tell us more about the provider ombudsman?

Julia

Absolutely, Chris, thank you. The North Carolina Medicaid provider ombudsman represents the interests of the provider community. We do that by offering supportive resources and assistance and resolution to providers inquiries, concerns or complaints regarding the PHPs of managed care Medicaid direct or healthy choice. This is separate from the health plans provider grievances and appeals process in which health plans are expected to resolve complaints and provide a summary, a final resolution to North Carolina Medicaid. The provider ombudsman will investigate, and address complaints of alleged maladministration or violation of rights against the health plans. When problems persist after following the health plans process, you can call the provider ombudsman at 866-304-7062, or email at Medicaid.providerombudsman@dhhs.nc.gov

Chris Weathington

Thank you, Julia, Darryl I'm gonna throw this question to you, what type of providers can become an advanced medical home.

Darryl Frazier

Advanced Medical Home, also known as AMH. These will be primary care providers. So first, AMH eligibility is the same as Carolina access eligibility eligible providers are generally single or multi specialty groups led by allopathic and osteopathic physicians in the following specialties, general practice, family practice, internal medicine, PS, and some OB GYN providers. Thank you.

Chris Weathington

Thank you, Darryl, Michael. This questions just come in when I look in the provider directories, sometimes the physicians are listed with their name, sometimes with the physician name and practice name. I would like our physicians to have their name and the practice name, how do we make that happen.

Michael

Yeah so provider information displayed in the lookup tool is sourced straight from the providers nctracks record, and also supplemented with Health Plan Contract data. So, to ensure that accurate information is displayed. Providers can review the nctracks record and make any necessary updates using the manage change request or MCR process. It's also important to confirm that the information given to health plans during the contracting process is up to date.

Chris Weathington

Thank you. Shaundra this is a question for you, for you, can you walk us through how to submit MCR through nctracks.

Shaundra

The office administrator, or a managing employee, have access to submit NCRs on a on a on the behalf of the provider. Once the office administrator goes into this secure provider portal which is located in NC tracks, they're going to use their entity ID, and then they're going to navigate to the status and management page once they're there at the status and management page, they have a couple of options, they're going to click on a little radio button that's left over to the left of the screen, next to the NPI, they're going to select that NPI in which they need to change or submit the MCR four. There are user guidelines, and a host of information located at <https://www.nctracks.nc.gov/content/public/providers/provider-user-guides-and-training.html>, or you can get a full assistance by calling nctracks at 1-800-688-6696. The user guides and trainees do offer a complete list page by page, blow by blow visual of how to submit and do an MCR depending on if it's to change taxonomy update an address or even add a different service type. So, those user guides and training and back sheets are amazing so I would encourage all providers to go out and pull one of those user guides in fact sheets.

Chris Weathington

Thank you. Okay, then I'm gonna go to some additional questions that just come in Shaundra, would you like to answer this question, I think the question came in is what email address

should be used to contact NC tracks regarding removing expired affiliations to providers we no longer have access to.

Shaundra

So there's no email address that you can submit that information to with regards to wanting that to be removed, you can reach out to nctracks by dialing the 1800-6886696. Any record that needs to have any updates or changes to if you don't have access to it you'll have to request that access. Once you notify NC track that they do not have the ability that you don't have the ability to change it, then they'll walk you through the process, and usually give you an authorization or a PIN number, as long as you can verify you are who you say you are with regards to being either a managing employee that was formerly attached to the record, or being an office administrator, that was firmly attached to the record nctracks does not have the ability within itself. To remove information from anyone's record. It is really required by the provider, the OA, or the managing employee to update that information. However, the first step is to reach out by calling that 1-800-688-6696 number, and they will be able to assist you.

Chris Weathington

Thank you. This is a question that's come in today are our specialists required to submit prior authorizations for their services, or is this the responsibility of the advanced medical home or the PCP. Currently there is some confusion around referral and prior authorization requirements, after the grace period for in network providers, it would be helpful if more education and resources are made available for specialty services, seeing Medicaid beneficiaries. Does anyone want to take that question?

Darryl Frazier

Chris, this is Darryl I'll take that question regarding PA, as it relates to a specialist. First, my advice would be, contact each of the PHPs which you are contracting with, and speak to one of their reps about their pa authorization process, but in general, for the it really depends on the service, but that will be best answered by the PHP. Okay.

Chris Weathington

Just looking down here this list here. This one is in here and Katie you may want to just express what what you've expressed to the, the person that she responded to, just so that everyone knows the answer to this question, we are having an issue with prior auths and WellCare in

regards to enteral feeding supplies we've sent questions and not received any responses at this time is there a suggestion on how to get these questions we have, we feel we've reached out for several weeks with the same questions and no responses.

Katie

Yeah Chris that's, that's a good question. So, um, it's similar to how Darryl answered the last question we are encouraging providers to reach out to your contract and health plans, or the health plans that you're submitting claims in prior authorizations to, we have been getting feedback that providers are, you know, unable to reach the health plans are getting conflicting information from what the department is telling providers. So in these examples, we ask. As I wrote in the answer for you guys to submit these to the provider ombudsman, I shared in the beginning of the webinar, the provider ombudsman is a group that is here to assist and escalate cases as needed. It is really important when you submit these emails to the provider ombudsman that you include as much information as possible so you can include your MPI. If you can include like the PA number or the claims number, that would be super helpful, and also the specific health plan that you're having an issue with, or that you want to direct your question to. If we don't have that information, it'll take a little longer because someone will need to get back to you to get that information. If.

Erica White

If it is a general question, we can route that to all the health plans, but it is best if you narrow down your question or concern to one or two individual health plans, then you'll get a response, a little quicker but that would be my response Chris, thanks.

Chris Weathington

Yeah and I think just to note to everyone when you're sending your issues to the provider ombudsman be as specific as possible. It's kind of hard to address the problems if it's just very generalized so specificity really really helps. So Katie while we have you do PCPs need to submit a referral through the patient's insurance to see a specialist that is in network.

Katie

Yeah I provided a lengthy response, um, it varies by health plan. Um, most of the health plans don't require referrals to be entered if you are an in network specialist that answers that question if you're out of network, the health plans, treat them a little differently. And similar to the PA question that was asked, we can look to get that published into like maybe a fact sheet or an upcoming bulletin. I also encourage y'all to look at the NC Medicaid knowledge base and

searching in there because we do have a lot of published Q and A's in that tool as well. I'm not sure if we have this one but that is a really useful tool. So, if we don't have a publish I'll check after this we'll look to get one published in that knowledge base and then also in an upcoming bulletin.

Chris Weathington

Thank you Katie now I believe you said also at the multi specialty practices out of network the PCPs and specialists will be treated as in network for prior auth rules for the first 60 days after July one which was go live but beginnings day 61 the out of network providers will require prior offer services furnished to the, to the members but yeah Thank you Katie. The. There was a question here, Katie while we have your very popular right now. Who can I speak with specifically regarding hospice patients in a skilled nursing facility, I emailed the ombudsman. But I need additional clarity. What would you suggest there, in that case.

Katie

Yeah, if you've emailed the ombudsman and gotten a canned response, um, you can submit it again ask for an escalation ask for a direct callback. We do have hundreds of cases coming into the ombudsman these days so where we can provide a an answer to a commonly asked question the team does do that but if for any reason your initial question was not answered just reply back and ask for a call back, Ask for clarifying information we've gotten even a couple of those in today as an example and so we are making sure these are getting to the correct business needs if your initial question isn't answered so I just asked for your patience and to send that in one more time and we'll make sure you get a call back in an answer.

Chris Weathington

Katie, another question for you. I promise I'll give you a break. Should we update the Member ID that is listed on the card, or submit claims with the old Medicaid ID number.

Katie

Yeah so, that depends on the patient's eligibility, I've not heard of providers being able to change the ID on a card, but the to answer the question on you know how to bail or how to submit claims it does depend on the members eligibility so you verify that and NC tracks or using the health plans portal. And then depending on the health plan. Most allow you to submit claims using the Medicaid ID. I believe there is one plan that asks for the PHP specific member

ID to submit claims but we do have that published it was published in a bulletin. Once I am done being called on for questions, I will go find that bulletin and add it to the response that I've already submitted but, um, we do have that out there. We're also looking to publish another bulletin next week and we're going to repeat that q&a Because we have been getting a lot of those questions coming in about how to submit claims, in which ID to submit them for so that will continue to be published in our upcoming provider bulletins.

Chris Weathington

This question came in is how long does the managed care organization have to respond to prior auth concerns that we might have.

Katie

Yeah, so if they're submitted to the provider ombudsman we're triage and those are typically responding within seven to 14, or the ask is that they respond within seven to 14 days, we're seeing responses, being resolved quicker. That is dependent, like I mentioned earlier on the level of detail that's submitted in those questions, so if you provide, you know the PA number your contact information, your MPI the PHPs are closing those out actually within a couple, two calendar days. But it really depends on the type of question for those.

Chris Weathington

Thank you Katie, Shaundra this is a question for you. We are, we were not the office administrator or the OA, or the managing employee for many of our ex employees. So it sounds like calling into nctracks will not help us remove our affiliation with EX employees. That leaves a lot of misinformation on the directory.

Shaundra

Yes that would do just that lead misinformation providers are required to keep their records updated. I understand that many providers individually have their own records that they own, and maybe they have an O A or A managing employee NC tracks, however, as well as the state do not have the ability to actually go in and six, those records, if you will, if you will send your question over to the provider ombudsman listserv, along with an NPI for your group. We'll try to determine what your next best steps are, unfortunately, like I said before, nctracks doesn't have the ability to go in and change or update your record for an individual providers so we'll have to figure out perhaps another way to kind of get around that, as individual providers do

have their records. But if you'll submit your question through the investment listserv, we'll try to see if we can get some answers for you, or figure out your best next step,

Chris Weathington

Thank you. This is a question that may be a little bit of a specialty question, and if we don't know the answer we can take it back but our sterilization forms for all carriers, sent to CSRA and will providers be able to find out if sterilization forms had been approved or denied on NC tracks, or on the carrier's websites no carriers are up right now. To answer this question,

Darryl Frazier

Chris, this is Darryl I think that's a good question that should be submitted to the ombudsman. Upon receipt of that inquiry, we will work with DHB club operations, who's responsible for pregnancy care and OB GYN to address that concern.

Chris Weathington

Thank you, Darryl. Just as a reminder, today's slide presentation, we put that in the q&a box for you to access but you can also accidentally access it on the NC AHEC website and the Medicaid managed care section, we have virtual office hours on the fourth Thursday of every month. We also have a webinar on the third Thursday of every month, led by Dr. Shannon Dowler and periodically throughout the year beginning in September we'll have webinars around advanced medical homes. This will compliment a host of various webinars, related to various aspects of Medicaid managed care whether it's the standard plans or the, the eventual tailored care plans. There'll be a number of different types of educational programs available to you. I don't see any other questions that have come in the q&a box it looks like we might finish a little bit early today. I'm just going to turn it over to the Medicaid team and see if you have any other closing comments or thoughts that you'd like to share with the audience.

Darryl Frazier

Yes again Chris, thank you very much. This meeting virtual office hours today, hosted by DHP provider ops. Most importantly, we want providers to know that we are here for them, and using the provider ombudsman telephone number or web address is the best means to reach us, and we will make sure those inquiries reach the subject matter experts within Medicaid

Chris Weathington

And just as I said that there was, there was one last question I'm gonna try to go ahead and squeeze this one in for everybody. And then we'll close the question is if we start to bill, if we started to build claims on July 1 when should we expect payments from the MediCal managed care plans.

Darryl Frazier

Chris, I don't have that answer handy, but I know on our website, we do have the check right out on our website. So, I can definitely answer that offline.

Chris Weathington

Okay, well thank you so much Darryl and Erica, Shaundra, Katie, Michael and Julia and Nevin. I want to thank all of you for your work today to present this important information to our members of our audience and just note that to all of you who are providing care to patients during this pandemic. And during this transition with Medicaid managed care just know how much we appreciate each and every one of you for the good work you're doing to serve the citizens of North Carolina, and just know that we are here for you it's not a perfect process, anytime you start something brand new, it's certainly a transition. Your feedback is very important to Medicaid because it's how we make the process better. And also enables us to provide you with some information that maybe hasn't been shared with you before, so thank you so much and have a good evening.