NC Medicaid Provider Frequently Asked Questions Repository

Topics

On Nov. 19, 2019, North Carolina suspended the implementation of Medicaid Managed Care. Managed Care policy papers, fact sheets and other documents and information include content that was effective when published and may not reflect changes in timing, schedules and other details due to the suspension. Please direct questions about Managed Care to the Medicaid Contact Center at 888-245-0179.

Question	Answer	Topic	Publish Date
Advanced Medical Home (AMH)			
Will providers still receive management fees and if so, who will be responsible for paying them and will it be the same rate for all plans	Advanced Medical Home (AMH) providers will receive the same medical home fee for enrolled beneficiaries as they currently receive under Carolina ACCESS. For Medicaid Direct (fee-for-service) beneficiaries enrolled in Carolina ACCESS, the fee will be paid through NCTracks. For beneficiaries enrolled in managed care, the medical home fee will be paid by the PHP.	AMH	9/25/2019
When will the PHP's have access to the list of ACO's/CIN's that attested to AMH level 3 capabilities?	Although AMH providers may identify a Clinically Integrated Network (CIN) during the attestation process, they are not obligated to contract with that CIN. For this reason, PHPs are encouraged to obtain the information from the AMH during the contracting process.	AMH	9/25/2019
Will specialists be required to obtain authorizations from a patient's PCP like we used to have to do with Carolina Access?	For managed care enrolled beneficiaries, PHPs must establish and maintain a referral and prior authorization process with the AMH at its center. PHPs will offer a Provider Manual to all contracted providers which will offer education about the PHP and managed care requirements, including information related to provider responsibilities and billing.	AMH	9/25/2019
Is the Attestation period still open?	The AMH Attestation Tool is still available for providers to review their current AMH status and attest to a higher tier. The Tool is available under Quick Links on the NCTracks secure Provider Portal Status and Management page.	AMH	9/25/2019
Our CIN vendors are not yet offering component services but rather are rigidly offering only "comprehensive" care management, data aggregation, and empanelment reconciliation support. Can you offer advice as to how to proceed in our CIN negotiations?	Please refer to: https://medicaid.ncdhhs.gov/blog/2019/04/01/advanced-medicaid-home-update	AMH	9/25/2019
Is there a listing (or will a list be made available) of State known CINs and/or AMH Tier 3 entities that are preforming Care Mgmt activities in house?	This question is answered on FAQ #A7 (Will DHHS produce a list of approved CINs and other partners?) on the NC Medicaid website at https://files.nc.gov/ncdma/AMH_FAQs_2.8.2019.pdf.	AMH	9/25/2019
Will our current case managers still be available to us for AMH?	Care management may change depending on the business agreements of the provider and their AMT tier designation. Care management for AMH Tier 2 providers is the responsibility of the Prepaid Health Plan. Care management for AMH Tier 3 providers is the responsibility of the provider.	AMH	9/25/2019

How closely will AMH parallel with PCMH? If you are a level III PCMH practice, will that be enough to attest for AMH Tier 3?	Attestation for AMH Tier aligns with guidelines to NCQA Primary Care Medical Home certification but will require separate attestation using the NCTracks AMH Attestation Tool.	AMH	9/25/2019
Who are considered AMH providers?	AMH providers are practices that offer primary care services to their patients. Participation in Carolina ACCESS is the gateway for participating in Carolina ACCESS. Existing Carolina ACCESS providers were grandfathered into the AMH program in the fall of 2018 as an AMH Tier 1 or Tier 2 depending on their Carolina ACCESS status. New providers who wish to join the AMH program must first request Carolina ACCESS participation in NCTracks.	AMH	9/25/2019
How do we find out what Tier we are in?	The Office Administrator for existing AMH providers may confirm their AMH Tier status using the AMH Attestation Tool on the NCTracks Secure Provider Portal Status and Management Page. Choose the NPI and location for your inquiry and NCTracks will identify the AMH Tier to which you are currently assigned.	AMH	9/25/2019
When you launch Medicaid MCO, will the Carolina Access/AHM program go away?	The Carolina ACCESS program will continue to be available for Medicaid Direct beneficiaries. The AMH program will serve Medicaid Managed Care members.	AMH	9/25/2019
Behavioral Health			
Will Behavioral Health LME's remain as they are or be converted to the new model?	Low intensity behavioral health services will be covered under Standard Managed Care Plans. LME-MCOs will continue to provide high intensity behavioral health services until the Behavioral I/DD Tailored Plans are introduced for qualifying high-need populations with a serious mental illness, serious emotional disturbance, substance use disorder, I/DD, or traumatic brain injury beneficiaries. For more information, see https://files.nc.gov/ncdhhs/TailoredPlan-CareManagement-PolicyPaper-FINAL-20180529.pdf	Behavioral Health	9/25/2019
Are IDD duals (Medicare and Medicaid) required to join a TP? Does your status as an NC Innovations Waiver recipient matter? What if you are a dual and on the waiting list? **What about duals on CAP-DA? Stay in FFS or choose SP and keep waiver or wait list spot?**	Beneficiaries with Medicare and Medicaid are excluded from enrollment in Medicaid Managed Care for up to five years. NC Innovations Waiver participants are also excluded from Standard Plan enrollment but will be required to participate in the Behavioral IDD Tailored Plan slated for implementation in July 2021. If an Innovations Waiver participant chooses to enroll in a Standard Plan, their waiver participation must be ended. Being on a waiting list does not exempt a mandatory beneficiary from enrolling in managed care. CAP participants are excluded from Medicaid Managed Care. For more information about beneficiary enrollment requirements, see the MCT 104 webinar available at https://medicaid.ncdhhs.gov/provider-playbook-training-courses#mct-104---provider-policies,-nc-medicaid-managed-care-104	Behavioral Health	9/25/2019

Will current Behavioral Health Providers be able to take Medicaid if not currently a provider for United Health or other companies mentioned?	See MCT 106: https://medicaid.ncdhhs.gov/nc-medicaid-managed-care-training-courses#mct-106:-behavioral-health-services:-standard-plans-and-transition-period	Behavioral Health	9/25/2019
For a child who has Medicaid and is under 3 and affiliated w/ the ITP/CDSA program, how will the "fee for service" versus managed care/maximum # of visits effect these children?	Managed care will follow our policies as a floor. Health plans may offer additional pass through visits beyond what we allow. The individual will need to check with the plan.	Behavioral Health	9/25/2019
Working with a Child advocacy center that needs to understand where they fit in MCT Reform. They have 300-400 MCT patients and services they provide fall under 2 buckets really - Medical Exams (CME - certified medical exam I think w/ colposcopy) and Behavior Health (Comprehensive Clinical Assessments & Therapy). Do they go live in Feb. with the Medical Exams (Standard Plan) or do both fall under the delayed services (Tailored Plan)?	It will all depend on the enrollment of their members. The Carousel Center / Child Advocacy Center will need to contract with and/or bill the PHPs for those beneficiaries who are enrolled with a PHP and will continue to bill Medicaid Direct/MCOs for those individuals who are Tailored Plan eligible. The CME for sexually abused children will always be billed to the PHP or Medicaid Direct, again, depending on the enrollment of the member. The main CME office in Chapel Hill can work with them if they have questions about the billing.	Behavioral Health	11/25/2019
Will social workers be allowed to submit the Request (for beneficiaries) to Stay in NC Medicaid Direct and LME-MCO Provider Form?	The NC Medicaid Direct and LME-MCO Provider Form may be filled out by a doctor, therapist or other I/DD, Mental Health, or Substance Use Disorder provider of the person enrolled in NC Medicaid – this includes social workers. The NC Medicaid Direct and LME-MCO Beneficiary Form can be filled out by the beneficiary or your legal guardian or legally responsible person, or your care manager/care coordinator may assist in this process – this could include the hospital social worker. If the social worker is any of the above, then they would be able to fill out the beneficiary form.	Behavioral Health	11/25/2019
Will state operated hospital providers be allowed to expedite requests (for beneficiaries) to stay in Medicaid Direct? If so, how should expedited requests be handled?	The provider may submit a service authorization request with the provider form if a tailored plan services is required. There is not another expedited request process at this time.	Behavioral Health	11/25/2019

Will state operated hospital providers be notified of the decisions when they submit requests to stay in Medicaid Direct on behalf of beneficiaries? If so, how?	Beneficiaries will be notified of the decision.	Behavioral Health	11/25/2019
Care and Quality			
What types of providers are eligible to apply to be an advanced medical home provider?	Participation in the Carolina ACCESS program is the gateway for participation as an Advanced Medical Home. A list of eligible Carolina ACCESS taxonomies is available at https://www.nctracks.nc.gov/content/public/providers/provider-enrollment/supporting-information.html.	Care and Quality	9/25/2019
AMH stands for: Advanced medical what?	It stands for Advanced Medical Home. Please refer to the AMH Provider Manual at: https://files.nc.gov/ncdma/documents/Providers/Programs_Services/amh/AMH_Provider-Manual_08272018.pdf Additional information is available at: https://medicaid.ncdhhs.gov/advanced-medical-home	Care and Quality	9/25/2019
I'm still not clear on the regions. Can/Will Medical Homes be included in or serve more than one region?	A regional map is available on the Medicaid Transformation website at https://www.ncdhhs.gov/assistance/medicaid-transformation. Although not required, providers are encouraged to explore contracting options with each PHP.	Care and Quality	9/25/2019
Considering your focus on oversight, when do you expect the EQR RFP to be released? Will the RFP include Readiness Review services?	For information on the Request for Proposal for NC Medicaid External Quality Review Organization Services, go to https://www.ncdhhs.gov/request-information	Care and Quality	9/25/2019
Have you established timelines for the continuity of care plan for beneficiaries who will be enrolled in the new plans?	The PHP must honor existing and active prior authorizations on file with the Medicaid or NC Health Choice for the first ninety (90) days after implementation to ensure continuity of care for Members. For the first sixty (60) days after Medicaid Managed Care launch, the PHP shall pay claims and authorize services for Medicaid eligible nonparticipating/out of network providers equal to that of in network providers until end of episode of care or the 60 days, whichever is less.	Care and Quality	9/25/2019

What will happen with Prior Approval requests and approvals when Medicaid Managed Care is launched? As a DME provider, currently we upload to NCTracks, so does this new change mean NCTracks will be going away?	For NC Medicaid Direct beneficiaries, prior approval requests will follow the current process and be submitted via NCTracks. For managed care enrolled beneficiaries, PHPs must establish and maintain a referral and prior authorization process with the AMH at its center. Providers, including DME providers, will request prior authorization as necessary from the PHP with which the beneficiary is enrolled, using a standardized prior authorization request form developed by the Department. In addition, the PHP must honor existing and active prior authorizations on file with the Medicaid or NC Health Choice program for the first ninety (90) days after implementation to ensure continuity of care for Members.	Care and Quality	9/25/2019
Is this correct: For Tier 2, practices already participating in Carolina ACCESS may be grandfathered in based on their standing in CAI or II. CAII practices will be grandfathered in, while current CAI practices will be required to indicate their intent to join Tier 2 by selecting an option on the NCTracks site	In September 2018, participating Carolina ACCESS (CAI) and Community Care of NC (CAII) providers were grandfathered into the AMH program in preparation for managed care. CAI providers were grandfathered in as AMH Tier 1 providers and CAII providers were grandfathered in as AMH Tier 2 providers. AMH providers have the option to attest to a higher tier (up to Tier 3) using the AMH Attestation Tool available on the NCTracks secure Provider Portal Status and Management page. The AMH Tier Attestation Job Aid is available at https://www.nctracks.nc.gov/content/public/providers/provider-user-guides-and-training.html	Care and Quality	9/25/2019
Eyeglasses now come from Nash Correctional, will they be coming from individual labs now?	Fabrication of eyeglasses, including complete eyeglasses, eyeglasses lenses, and ophthalmic frames are services carved out of managed care. The process for these services will not change with managed care.	Care and Quality	9/25/2019
How might you see the rather broad range of partners involved in Food Security for example to be involved with the PHP's as a provider? I would anticipate many are not currently a provider.	Providers may continue to use current community resources to address food insecurities. In the future, food insecurities will be part of the Healthy Opportunities initiative. For more information, visit the Healthy Opportunities website at https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities	Care and Quality	9/25/2019
I had begun the application submission process for Advanced Medical Home Tier Attestation through NCTracks however on submission, I receive the response below. When I contacted the NCTracks Call Center I was referred to you. Would you please advise as to why the application failed to save AMH tier status and answers?	The Office Administrator identified on the provider record must answer the attestation questions affirmatively, confirming their intent to perform all required components, in order to successfully attest to a higher tier. An AMH Tier Attestation Job Aid is available at: https://www.nctracks.nc.gov/content/public/providers/provider-user-guides-and-training.html to offer additional guidance.	Care and Quality	9/25/2019

Can an independent practice participate in more than one CIN?	AMHs will be free to choose and contract with any individual CIN or multiple CINs and/or other partners that best meet their needs. For more information, see the policy paper available at https://medicaid.ncdhhs.gov/advanced-medical-home.	Care and Quality	9/25/2019
During the webinar on 01/24/2019, it was stated that Care Managers will receive training to equip them to handle physical, behavioral health, TBI, and I/DD service coordination and needs. Who will provide this training?	Behavioral I/DD Tailored Plans will be responsible for training all care managers serving their beneficiaries and developing training curricula encompassing training topics specified by the Department. For more information, see the policy paper at https://medicaid.ncdhhs.gov/behavioral-health-idd-tailored-plans.	Care and Quality	9/25/2019
Are there plans to pay for care management/coordination by MCD managed care as Medicare currently does?	Medical homes that elect to perform care management functions and attest that they can do so, will be reimbursed for providing care management.	Care and Quality	9/25/2019
How will the standard plan regions impact the future of the LME/MCOs?	Standard plan regions will not impact the Tailored Plan regions.	Care and Quality	11/12/2019
Will there be a more seamless process for mental health providers to provide services to Medicaid consumer who seek out their services, regardless of whether the provider is an in-network provider or not with the MCO/LME?	LME-MCOs will still have closed provider networks. Out of network providers may be offered single-case agreements. The provider will need to reach out to the LME-MCO for additional information.	Care and Quality	11/12/2019
Will there be changes in the Clinical Coverage Policies for Enhanced Benefit Services? And, if so, how much time prior to implementation will recipients, families, and providers must review potential changes in those services?	Our process would be the same as the changes to the other clinical coverage policies. Policies are posted for 45-day public comment.	Care and Quality	11/12/2019
Will patients still need 6-month authorization for specialized therapies	In the current fee for service out-patient therapies program, 6-month authorizations are not required, but represent the maximum length of a given authorization period. In managed care, health plans are free to continue the same restrictions as in fee for service or be less restrictive.	Care and Quality	11/12/2019
For children who receive outpatient community-based speech therapy in their home or daycare, will those services mean that children will fall under a Standard or Tailored plan?	Out-patient speech therapy will be available to children in both standard and tailored plans.	Care and Quality	11/12/2019

Will participants in the new plans be offered similar managed and unmanaged visits with SARS for obtaining any additional mental health OPT services?	Outpatient mental health will be available under both the Standard Plans and the Tailored Plans. Unmanaged visits are noted in the policy though the plans may be more flexible.	Care and Quality	11/12/2019
How would children under 21 with Autism benefit with this waiver?	Research-based Intensive Behavioral Health Treatment for Autism Spectrum Disorder is covered under both the Standard Plans and the Tailored Plans.	Care and Quality	11/12/2019
What will be the effect upon people that are on the IDD waiver who have Medicare as their primary coverage and NC Medicaid as secondary?	Individuals with intellectual/developmental disabilities may be in standard plans, although most I/DD services are not covered. If an individual request a service that is covered by Tailored Plans and the child is under 21, it should be reviewed under EPSDT for medical necessity if deemed appropriate. It should then trigger the process to transition to Tailored Plans for the beneficiary. If an adult requests a service covered by the Tailored Plan, it should trigger the process to transition to Tailored Plans. This process is still under development by DHHS. The following services are NOT covered by Standard Plans (and are only covered by Tailored Plans): Residential treatment facility services for children and adolescents; Child and adolescent day treatment services; Intensive in home services; Multisystemic therapy services; Psychiatric residential treatment facilities; Assertive community treatment; Community Support team; Psychosocial rehabilitation; Substance abuse non-medical community residential treatment; Substance abuse medically monitored residential treatment; Clinically managed low-intensity residential treatment services; Clinically managed population-specific high-intensity residential programs; Intermediate care facilities with intellectual disabilities; Innovations waiver services; TBI waiver services; 1915(b)(3) services.	Care and Quality	11/12/2019
Are rules regarding inpatient vs outpatient observation status going to remain the same as well?	The Department will be providing a standardized Prior Authorization Form for all services, excluding pharmacy. The form will not be differentiated for physical or behavioral health or levels of care, and inpatient and outpatient will use the same form.	Care and Quality	11/12/2019
Will people be forced to change to another doctor's practice, or will they still have choice?	All members that are mandatory/eligible for the standard plan under Medicaid Managed Care will have an open enrollment/choice period to enroll with a Health Plan and participating PCP/AMH. If the member does not select during the choice period, members will be auto-assigned by the PHP to an in-network PCP/AMH. Prior history with an in-network PCP/AMH is included in the auto-assignment process. Following managed care implementation, members will have 90 days to change their assigned PCP/AMH.	Care and Quality	11/12/2019

How often will patients be able to change their managed care provider? Monthly or Annually?	Beneficiaries can change their PCP/AMH without cause twice per year: Beneficiaries will have thirty (30) days from notification of their PCP/AMH assignment to change their AMH/PCP without cause. After the first 30 days, beneficiaries will be allowed to change their AMH/PCP without cause up to one time per year thereafter. Beneficiaries can change their AMH/PCP with cause at any time. With-cause reasons to change PCP/AMH should be outlined in the health plan's member handbook.	Care and Quality	11/12/2019
We are wondering what mechanisms will ensure that 1) care is truly coordinated with 2) the client's decisions guiding the course. And how will we insure best clinical care while honoring the non-clinical and social support functions needed to promote recovery of a more valuable, healthy life?	NC DHHS is committed to improving the health and well-being of North Carolinians through an innovative, whole-person centered and well-coordinated system of care that addresses both medical and non-medical drivers of health. NC DHHS works to advance this vision through interrelated legislative, contractual and policy requirements, including those related to care management, quality management and social determinants of health. For additional information, including the state's 1115 waiver application, please visit the Department's webpage for NC Medicaid Transformation https://www.ncdhhs.gov/assistance/medicaid-transformation Please consider reviewing the information available at the links provided for each specific topic listed below: • NC 1115 Waiver Fact Sheet: https://files.nc.gov/ncdhhs/CMS-1115-Approval-FactSheet-FINAL-20181024.pdf • Advanced Medical Homes (includes care management resources): https://medicaid.ncdhhs.gov/advanced-medical-home • Quality Management and Improvement: https://medicaid.ncdhhs.gov/quality-management-and-improvement • Healthy Opportunities/Social Determinants of Health: https://files.nc.gov/ncdhhs/documents/Healthy-Opportunities-Pilot_Policy-Paper_2_15_19.pdf	Care and Quality	11/12/2019
For individuals who are on the Innovations waiver who have Private Health insurance as primary and Medicaid as secondary, will their tailored plan be any different than those that have Medicare as Primary and Medicaid secondary?	The Tailored Plans are health plans. Individuals on the Innovations waiver will still be assigned to a TP based on their Medicaid County of eligibility regardless of other insurance.	Care and Quality	11/12/2019
Regarding the registry of unmet needs for innovations waiver services, will people have to wait to be on a tailored plan?	Individuals on the Registry of Unmet Needs (waiting list) will be Tailored Plan eligible.	Care and Quality	11/12/2019

Will the current case managers for Cap recipients continue, or will they be managed thru the contracts	Beneficiaries enrolled in CAP programs are excluded from Medicaid Managed Care.	Care and Quality	11/12/2019
In having only one plan (Standard/Tailored), will the patients be allowed to change the plan mid-stay?	Beneficiaries can change their PCP/AMH without cause twice per year.	Care and Quality	11/12/2019
Are referrals from the PCP going to be necessary for the patients to see specialist under the new plans?	PHPs may require a referral for any medical services not provided by the AMH/PCP except where specifically provided in the Department-PHP contract and in federal and state statute and regulations. However, PHPs must allow direct access to specialists in several circumstances: 1) PHPs must provide female Members with direct access to a women's health specialist within the provider network for covered care necessary to provide women's routine and preventive health care services; this shall be in addition to the Member's designated source of primary care if that source is not a women's health specialist; 2) The PHPs shall allow Members with complex conditions or special health care needs to select a specialist as their PCP or otherwise allow such Members direct access to a specialist as appropriate to the Member's condition or diagnosis. 42 C.F.R. § 438.208(c)(4). 3) PHPs must provide direct access to Tribal members eligible to receive covered services from an Indian Health Care Provider with direct access, defined as no referral or prior authorization required, to the IHCP. Additionally, PHPs may not require a referral or prior authorization for emergency services; family planning services, children's screening services through the local health department or school-based clinics.	Care and Quality	11/12/2019
A pediatric practice (A), who signed with all PHP's, shares call with another peds practice (B) that is only contracted with 2 PHP's. What is the process and reimbursement if a patient from Practice A goes to a sick walk-in clinic at Practice B having selected a plan that they are not contracted with? While the 2 practices are separate entities, they share a co-management agreement for rotating weekend sick visits, however don't plan to contract with all PHP's and want to ensure they understand how to work through this obstacle.	If Practice B treats a member enrolled with a PHP for which Practice B is non-participating, out-of-network guidelines may apply. Practice B would seek billing/claims guidance from the members' Health Plan	Care and Quality	11/25/2019

Is speech therapy a "Carved out" service under managed care?	Outpatient specialized therapies (including speech therapy) is NOT a carved out service under Medicaid Managed Care. Speech therapists serving individuals who are enrolled in managed care will seek reimbursement from the member's Health Plan. Speech therapists / practices will not automatically be enrolled in the plans for their geographic areas. Providers who wish to contract with one or more Health Plans may find contact information at https://medicaid.ncdhhs.gov/health-plans/health-plan-contacts-and-resources Additionally, the Provider Playbook is a great resource for information pertaining to Medicaid Managed Care: https://medicaid.ncdhhs.gov/providers/provider-playbook-medicaid-managed-care	Care and Quality	11/25/2019
Claims / Billing / Finance			
I have heard that we will be billing Family Planning and state supplied vaccines through Medicaid as we currently do. Is this correct? We are very small and do not meet criteria to bill private insurances and still are not sure how this will affect us.	PHPs must pay for family planning services regardless of if the provider is in-network. Medicaid patients may see any Medicaid enrolled provider that offers family planning services, regardless of the provider's network status; however, providers do need the capability to bill the PHP to receive reimbursement. For populations solely in the Family Planning Medicaid program (MAFD), providers will continue to bill NCTracks, as beneficiaries in this eligibility category are excluded from Managed Care. Providers will continue to use state supplied vaccines for Vaccines for Children (VFC) eligible children. For managed care enrolled children, the PHP will reimburse for the vaccine administration. For Medicaid Direct beneficiaries, vaccine administrations will continue to be billed to NCTracks. Local Health Departments are encouraged to secure PHP contracts as an essential provider to be reimbursed for services as an in-network provider.	Claims / Billing / Finance	9/25/2019
Can you describe how the current MRI/DSH payments will be addressed through the transformation?	For information related to MRI/DSH, see the "Provider Payment and Contracts, NC Medicaid Managed Care 102" recorded webinar or transcript available at https://medicaid.ncdhhs.gov/provider-playbook-training-courses#mct-102---provider-payment-and-contracts,-nc-medicaid-managed-care-102	Claims / Billing / Finance	9/25/2019
Currently we receive an EFT from Medicaid every week because there is a published Check write schedule - going forward, will we continue to receive these weekly EFTs, or will they be coming from a different PHP defined check write schedule?	PHPs must reimburse medical and pharmacy providers in a timely and accurate manner. At a minimum, a PHP must pay or deny a clean medical claim within 30 calendar days. For pharmacy claims, a PHP must pay or deny a clean claim within 14 calendar days. For more information, see Addendum 1 of the Request for Proposal for Medicaid Managed Care Prepaid Health Plans at https://www.ncdhhs.gov/assistance/medicaid-transformation. Also check with each PHP to confirm their payment schedule.	Claims / Billing / Finance	9/25/2019

Have reimbursement guidelines been established to identify acceptable turnaround times for payments to providers? Such as: 1 month, 2 months, 3 months? When will providers know what to expect regarding payment time frames? Tracy Harrington, Venture Rehab Group	PHPs must reimburse medical and pharmacy providers in a timely and accurate manner. At a minimum, a PHP must pay or deny a clean medical claim within 30 calendar days. For pharmacy claims, a PHP must pay or deny a clean claim within 14 calendar days. For more information, see Addendum 1 of the Request for Proposal for Medicaid Managed Care Prepaid Health Plans at https://www.ncdhhs.gov/assistance/medicaid-transformation. Also check with each PHP to confirm their payment schedule.	Claims / Billing / Finance	9/25/2019
Will rates remain the same or will there be capitated rates given providers and PHPs the ability to negotiate rates?	PHPs will receive a monthly capitated payment for each enrolled member and will contract with providers to deliver health services to their members. Although rate floors, requiring PHPs to reimburse at 100 percent of the Medicaid fee-for-service rate, have been established for some provider types, all providers may negotiate their reimbursement arrangements with each PHP. Claims for managed care enrolled beneficiaries will be adjudicated by the PHP based on the agreed upon fee schedule.	Claims / Billing / Finance	9/25/2019
Will the payment/reimbursement rates change? Will the fees/allowable vary by carrier or will each PHP set their own?	Provider payment requirements are detailed in the Request for Proposal for NC Medicaid Managed Care Prepaid Health Plans, Addendums 1 and 4, which is available at https://www.ncdhhs.gov/request-information. Although rate floors, requiring PHPs to reimburse at 100 percent of the Medicaid fee-for-service rate, have been established for some provider types, all providers may negotiate their reimbursement arrangements with each PHP.	Claims / Billing / Finance	9/25/2019
When providers who do not accept Medicaid and now do not receive their Medicaid crossover from Medicare claims, when will they begin to receive their claims?	Medicaid/NC Health Choice participating providers will contract with PHPs to receive payment for services rendered to managed care enrolled beneficiaries. PHPs may only contract with Medicaid enrolled providers. In addition, beneficiaries receiving both Medicare and Medicaid are excluded from managed care enrollment for up to five years. If a beneficiary is not enrolled with a PHP, then providers will use the current claims adjudication process for payment.	Claims / Billing / Finance	9/25/2019
Will we still file our fee for service and other claims in NCTracks?	Yes, providers must file our fee for service and other claims in NCTracks.	Claims / Billing / Finance	9/25/2019

Will the timely filing limit change based on the PHP's current limit?	Pursuant to N.C. Gen. Stat. § 58-3-225(f), the PHP may require that claims be submitted within one hundred eighty (180) calendar days after the date of the provision of care to the Member by the health care provider and, in the case of health care provider facility claims, within one hundred eighty (180) calendar days after the date of the Member's discharge from the facility. However, the PHP may not limit the time in which claims may be submitted to fewer than one hundred eighty (180) calendar days. Unless otherwise agreed to by the PHP and the provider, failure to submit a claim within the time required does not invalidate or reduce any claim if it was not reasonably possible for the provider to file the claim within that time, provided that the claim is submitted as soon as reasonably possible and in no event, except in the absence of legal capacity of the provider, later than one (1) year from the time submittal of the claim is otherwise required.	Claims / Billing / Finance	9/25/2019
Will request for payment for services/ claims still be forwarded to NCTracks or will all claims filing now be through the PHP's?	Medicaid/NC Health Choice beneficiary assignment determines claim submission requirements. Claims for Medicaid/NC Health Choice beneficiaries enrolled with a PHP will be submitted to the PHP with which the beneficiary is assigned. If the beneficiary is not enrolled with a PHP, then the beneficiary is in the NC Medicaid Direct program, or Medicaid Direct, and claims would be submitted to NCTracks.	Claims / Billing / Finance	9/25/2019
Will there be a centralized clearinghouse for processing billing claims to all PHPs?	For managed care enrolled beneficiaries, claims must be submitted to the PHP with which the beneficiary is enrolled.	Claims / Billing / Finance	9/25/2019
Will there be a batch inquiry process to obtain Medicaid beneficiary enrolled PHP details needed for billing?	NCTracks has been modified to include PHP and AMH/PCP enrollment information. Using the same NCTracks eligibility verification process, providers can confirm beneficiary enrollment as NC Medicaid Direct or if managed care, the PHP and AMH/PCP to which the beneficiary is assigned.	Claims / Billing / Finance	9/25/2019
What is considered "prompt pay"?	PHPs must reimburse medical and pharmacy providers in a timely and accurate manner. For medical claims, a PHP must pay or deny a clean medical claim within thirty calendar days. For pharmacy claims, a PHP must pay or deny a clean claim within 14 calendar days. For more information, see Addendum 1 of the Request for Proposal for Medicaid Managed Care Prepaid Health Plans at https://www.ncdhhs.gov/assistance/medicaid-transformation.	Claims / Billing / Finance	9/25/2019
Will the PHPs accept electronic claims from my HER?	PHPs must have the automated capability to identify, process and reprocess claims.	Claims / Billing / Finance	9/25/2019
Would the NPI be required on claims for patients being referred to another provider?	PHPs must establish and maintain a referral and prior authorization process with the Advanced Medical Home at its center. More specific information will be available to providers in the PHP Provider Manual. Once a provider is contracted with a PHP, the PHP will provide the necessary links to access their provider manual.	Claims / Billing / Finance	9/25/2019

What is the rate floor relative to the current Medicaid fee schedule?	Provider payment requirements are detailed in the RFP for NC Medicaid Managed Care Prepaid Health Plans, Addendums 1 and 4, which is available at https://www.ncdhhs.gov/request-information. Rate floors, requiring PHPs to reimburse at 100% of the Medicaid fee-for-service rate, have been established for some provider types, while others will need to negotiate their reimbursement arrangements with the PHPs. The Department intends to have the rate period end on June 30, 2020 to align the future rate periods with the state fiscal year.	Claims / Billing / Finance	9/25/2019
Hope the go live of these php programs won't be like NCTracks and payments won't be delayed? Do we need to plan for 30 days working capital since we get paid on weekly basis now?	PHPs must reimburse medical and pharmacy providers in a timely and accurate manner. For medical claims, a PHP must pay or deny a clean medical claim within thirty calendar days. For pharmacy claims, a PHP must pay or deny a clean claim within fourteen calendar days. For more information, see Addendum 1 of the Request for Proposal for Medicaid Managed Care Prepaid Health Plans at https://www.ncdhhs.gov/assistance/medicaid-transformation	Claims / Billing / Finance	9/25/2019
Will any of these plans be a capitated plan?	PHPs will receive a monthly capitated payment for each enrolled member and will contract with providers to deliver health services to their members. PHPs will be subject to rigorous monitoring and oversight by DHHS across many metrics to ensure adequate provider networks, high program quality, and other important aspects of a successful Medicaid managed care program. Claims for managed care enrolled beneficiaries will be adjudicated by the PHP based on their fee schedule.	Claims / Billing / Finance	9/25/2019
Will the Pharmacy (Point of service) program be included in the capitated rates? If not, then how will it be considered within the Managed Care Program?	PHPs will receive a monthly capitated payment and will contract with providers to deliver health services, including pharmacy, to their members. PHPs are required to adhere to the DHHS defined preferred drug list, cover all outpatient drugs for which the manufacturer has a Centers for Medicare and Medicaid Services (CMS) rebate agreement and for which DHHS provides coverage, and furnish covered benefits in an amount, duration, and scope no less than that of the same services furnished under Medicaid's fee-for-service program.	Claims / Billing / Finance	9/25/2019
CMS approved the coverage of acute kidney dialysis treatments in the outpatient facilities beginning January 1, 2017. NC Medicaid currently excludes payment of acute dialysis treatments in the outpatient setting. Are there plans to include payment for acute dialysis treatments in the outpatient setting within Managed Care?	According to the Medicaid's End-Stage Renal Disease Services (ESRD) clinical coverage policy (https://files.nc.gov/ncdma/documents/files/1A-34.pdf), acute dialysis treatments are currently reimbursed in accordance with Outpatient Hospital Reimbursement Methodology when performed in a non-ESRD certified hospital outpatient facility. Services described in this policy are part of Medicaid Managed Care and PHPs will, at minimum, offer coverage according to the ESRD policy. Providers are encouraged to discuss the potential for additional coverage of services with each PHP during contracting.	Claims / Billing / Finance	9/25/2019

What is the DME Fee Schedule?	Current Medicaid fee schedules are available on the Medicaid Provider webpage (https://medicaid.ncdhhs.gov/providers). In Medicaid managed care, there are no rate floors for DME medical equipment providers. DME providers will need to negotiate their reimbursement arrangements with the PHPs. For more information on rates, see the 'MCT 102 - Provider Payment and Contracts' presentation available on the 'Providers Transitioning to Managed Care' link on the webpage referenced above, or review Addendum 1 (Scope of Services) and 4 (Draft Rate Book) of the Request for Proposal for NC Medicaid Managed Care Prepaid Health Plan available at https://www.ncdhhs.gov/request-information.	Claims / Billing / Finance	9/25/2019
Will the rates remain the same for the first year?	Provider payment requirements are detailed in the Request for Proposal for NC Medicaid Managed Care Prepaid Health Plans, Addendums 1 and 4, which is available at https://www.ncdhhs.gov/request-information. Rate floors, requiring PHPs to reimburse at 100 percent of the Medicaid fee-for-service rate, have been established for some provider types, while others will need to negotiate their reimbursement arrangements with the PHPs with each contract. The Department intends to have the rate period end on June 30, 2020 to align the future rate periods with the state fiscal year.	Claims / Billing / Finance	9/25/2019
For DME, why are fee schedule rates determined by Provider negotiation with Managed Care PHP?	Provider payment requirements are established to comply with state law, encourage continued provider participation in the Medicaid program to ensure Member access, and support safety net providers by sustaining current reimbursement levels using mechanisms that mitigate the risk of PHP steerage to other providers.	Claims / Billing / Finance	9/25/2019
Why aren't all providers offering the same fee schedule rate?	Provider payment requirements are established to comply with state law, encourage continued provider participation in the Medicaid program to ensure Member access, and support safety net providers by sustaining current reimbursement levels using mechanisms that mitigate the risk of PHP steerage to other providers.	Claims / Billing / Finance	9/25/2019
Do you expect rate floors to be the same a current Medicaid fee for service rates?	DHHS has established rate floors at fee-for-service levels for specific provider types but higher rates may be negotiated with the PHP. Providers with no rate floor requirement must negotiate rates with the PHP. For more information, see Addendum 4 (Draft Rate Book) of the Request for Proposal for NC Medicaid Managed Care Prepaid Health Plan available at https://www.ncdhhs.gov/request-information.	Claims / Billing / Finance	9/25/2019

How will this affect RHCs that are paid AIR?	PHPs must reimburse FQHCs and RHCs at no less than the Medicaid fee schedule for covered services; including the T1015 rate as a rate floor for all core services, and the Medicaid physician fee schedule for all non-core services. For wrap-around payments, the federal rules permit DHHS to continue making additional wrap around payments over and above the Health Plan payments. To accomplish this, DHHS will calculate a quarterly PPS reconciliation to determine quarterly wrap around payments in order to ensure that FQHC/RHCs receive aggregate payments equal to the PPS per-visit rate that is required by federal law. Annually, for those FQHC and RHC providers that are currently cost settled, DHHS will make an additional wraparound payment representing the difference between Medicaid costs and payments received for those services. For more information on rates, see the 'MCT 102 - Provider Payment and Contracts' presentation at https://medicaid.ncdhhs.gov/provider-playbook-training-courses#mct-102---provider-payment-and-contracts,-nc-medicaid-managed-care-102	Claims / Billing / Finance	9/25/2019
Are there any plans for the Fee Schedule to be changed (It's been the same for several years)	For managed care, provider payment requirements are detailed in the Request for Proposal for NC Medicaid Managed Care Prepaid Health Plans, Addendums 1 and 4, which is available at https://www.ncdhhs.gov/request-information. Rate floors, requiring PHPs to reimburse at 100 percent of the Medicaid fee-for-service rate, have been established for some provider types, while others will need to negotiate their reimbursement arrangements with the PHPs with each contract. The Department intends to have the rate period end on June 30, 2020 to align the future rate periods with the state fiscal year.	Claims / Billing / Finance	9/25/2019
Will there be any payment interruptions?	PHPs must reimburse medical and pharmacy providers in a timely and accurate manner. For medical claims, a PHP must pay or deny a clean medical claim within thirty calendar days. For pharmacy claims, a PHP must pay or deny a clean claim within fourteen calendar days. For more information, see Addendum 1 of the Request for Proposal for Medicaid Managed Care Prepaid Health Plans at https://www.ncdhhs.gov/assistance/medicaid-transformation.	Claims / Billing / Finance	9/25/2019
Why do pediatricians receive lower reimbursement than adults? We take care of 70% of the patients and receive 30% of the money.	Medicaid fee schedules, available at https://medicaid.ncdhhs.gov/providers, are established according to provider type. Reimbursement for the CPT/HCPCS code billed is the same regardless of the age of the beneficiary served.	Claims / Billing / Finance	9/25/2019
Will our reimbursement still include the monthly maintenance fee?	Carolina ACCESS and AMH providers will continue to receive the same medical home fee ($2.50/$5.00) for providing care coordination to enrolled beneficiaries. For managed care beneficiaries, the AMH medical home fee will be paid by the PHP so providers will need to be contracted with the PHP to receive payment. For fee-for-service beneficiaries, the Carolina ACCESS medical home fee will be paid through NCTracks as it is today.	Claims / Billing / Finance	9/25/2019

Should Providers expect their Fee for Service Rates to be Cut? By how much?	Provider payment requirements are detailed in the Request for Proposal NC Medicaid Managed Care Prepaid Health Plans, Addendums 1 and 4, which is available at https://www.ncdhhs.gov/request-information. Rate floors, requiring PHPs to reimburse at 100% of the Medicaid fee-for-service rate, have been established for some provider types, while others will need to negotiate their reimbursement arrangements with each PHP.	Claims / Billing / Finance	9/25/2019
Will the current Provider Tax change or be discontinued?	Medicaid managed care changes do not affect federal or state tax requirements.	Claims / Billing / Finance	9/25/2019
So, providers can continue to be fee-for-service, but will be charged $2 to $2.50 per claim?	Providers may choose to not contract with a PHP, but with the exception of out of network emergency services, post-stabilization services and services provided during transitions in coverage, the PHP shall be prohibited from reimbursing an out of network provider more than ninety (90) percent of the Medicaid fee-for-service rate if the PHP has made a good faith effort to contract with a provider but the provider refused, or if the provider was excluded from the PHP's network for failure to meet Objective Quality Standards. For more information, see Out of Network Provider Payments in Addendum 1 of the Request for Proposal for Medicaid Managed Care Prepaid Health Plans at https://www.ncdhhs.gov/assistance/medicaid-transformation. If the beneficiary is in the fee-for-service program, then claims continue to be submitted to NCTracks.	Claims / Billing / Finance	9/25/2019
Will Independent OT, PT and SLP providers remain at the same rate of reimbursement	There is no rate floor or other rate requirement in the contract with the PHPs for independent Occupational Therapist, Physical Therapist, Speech Language Pathologist providers. These provider types will need to negotiate rates with the PHPs.	Claims / Billing / Finance	9/25/2019
Are HCBS LTSS providers and Home Health providers subject to the rate floor requirement?	DHHS has established rate floors at fee-for-service levels for specific provider types but higher rates may be negotiated with the PHP. Providers with no rate floor requirement must negotiate rates with the PHP. For more information, see Addendum 4 (Draft Rate Book) of the Request for Proposal for NC Medicaid Managed Care Prepaid Health Plan available at https://www.ncdhhs.gov/request-information.	Claims / Billing / Finance	9/25/2019
How do you define, PHP's "prompt payment of services" when at the current NCTracks payment are made within a week after billed?	PHPs must reimburse medical and pharmacy providers in a timely and accurate manner. For medical claims, a PHP must pay or deny a clean medical claim within thirty calendar days. For pharmacy claims, a PHP must pay or deny a clean claim within fourteen calendar days. For more information, see Addendum 1 of the Request for Proposal for Medicaid Managed Care Prepaid Health Plans at https://www.ncdhhs.gov/request-information	Claims / Billing / Finance	9/25/2019

Will Medicaid negotiate a payment rate with PHP, or will each individual provider have to negotiate with PHP for a reimbursement rate?	Providers will negotiate a payment rate with each PHP. DHHS has established rate floors at fee-for-service levels for specific provider types but higher rates may be negotiated. Providers with no rate floor requirement must negotiate rates with the PHP. For more information, see Addendum 1 (Scope of Services) and Addendum 4 (Draft Rate Book) of the Request for Proposal for NC Medicaid Managed Care Prepaid Health Plan available at https://www.ncdhhs.gov/request-information.	Claims / Billing / Finance	9/25/2019
Will rate floors be set for Durable Medical Equipment? If not, is there any guidance on how DME rates may be affected?	In Medicaid managed care, there are no rate floors for DME medical equipment providers. DME providers will need to negotiate their reimbursement arrangements with the PHPs. For more information on rates, see the 'MCT 102 - Provider Payment and Contracts' presentation at https://medicaid.ncdhhs.gov/provider-playbook-training-courses#mct-102---provider-payment-and-contracts,-nc-medicaid-managed-care-102, or review Addendum 1 (Scope of Services) and Addendum 4 (Draft Rate Book) of the Request for Proposal for NC Medicaid Managed Care Prepaid Health Plan available at https://www.ncdhhs.gov/request-information.	Claims / Billing / Finance	9/25/2019
Are the rate floors published on the website final or proposed?	For information on rates, see the 'MCT 102 - Provider Payment and Contracts' presentation available at https://medicaid.ncdhhs.gov/provider-playbook-training-courses#mct-102---provider-payment-and-contracts,-nc-medicaid-managed-care-102, or review Addendum 4 (Draft Rate Book) of the Request for Proposal for NC Medicaid Managed Care Prepaid Health Plan available at https://www.ncdhhs.gov/request-information.	Claims / Billing / Finance	9/25/2019
How will this relate to optometry practices glasses provided?	PHPs shall not cover the fabrication of eyeglasses, including complete eyeglasses, eyeglass lenses, and ophthalmic frames. Eye exams for individuals who must participate in managed care will be covered by PHPs.	Claims / Billing / Finance	9/25/2019
Can you please provide the reimbursement guidelines for PHP vs FFS where will claim go and who will reimburse?	Reimbursement for services provided by a provider contracted with a PHP will be submitted to the PHP and reimbursed by the PHP's. Fee-for-service providers will be reimbursed through NCTracks.	Claims / Billing / Finance	9/25/2019
If a patient must be seen by a specialist outside of the pep scope of care, does the payment for the specialist come of the pep management care fee or does the specialist file care to patient health plan?	The specialist would submit a claim to the PHP for services rendered.	Claims / Billing / Finance	9/25/2019
Can you tell me where I can find the policy you just spoke about that you can't charge a Medicaid recipient a No Charge fee?	See the April 2018 NC Medicaid Bulletin available at https://medicaid.ncdhhs.gov/providers/medicaid-bulletins.	Claims / Billing / Finance	9/25/2019

RHC is set up for both Medicare and Medicaid. Right now, they get one letter for each NPI with one Cost Based Rate RHC at the end of the year telling them the billable rate. As a result, their billing system is set up for the one rate regardless of if the patient is Medicaid or Medicare. In the new changes, will this stay the same, or will they get a Cost Based Rate for each separately?	This will remain the same.	Claims / Billing / Finance	11/25/2019
Rural health center has a consultant that does their year-end cost report for the rural health arrangement. Will that same report need to happen? And if so, does this get submitted to Medicaid Direct or will each PHP need a separate report?	They will continue to submit one annual Medicaid cost report to the Division.	Claims / Billing / Finance	11/25/2019
Will providers again bill Medicaid directly?	Yes, if they are involved in Medicaid Direct, where it is a carved-out service.	Claims / Billing / Finance	11/25/2019
Who will be managing state/IPRS funds in 2020 and beyond?	Department will continue to manage IPRS funds.	Claims / Billing / Finance	11/25/2019
What will be NCTracks role in reimbursement of funds to providers?	NCTracks will continue to reimburse providers for beneficiaries/services covered under Medicaid Direct (Fee-for-Service). PHPs will reimburse providers for beneficiaries/services covered under Medicaid Managed Care. NCTracks will also cover carved-out services.	Claims / Billing / Finance	11/25/2019
As a DME provider, will reimbursement for each PHP be the same?? and how will DME contract with the PHP's?	Each provider will negotiate with the PHP they choose to be affiliated with.	Claims / Billing / Finance	11/25/2019
Will Assisted Living Providers continue to bill Medicaid directly through NCTracks for their compensation?	It depends on whether beneficiary is in Medicaid Direct (claims submit through NCTracks) or a PHP (claims billed to the PHP).	Claims / Billing / Finance	11/25/2019
Has the PHP's capitation rate included a COLA? If so, what %. And how would the COLA translate into increased provider rates?	PHP capitation rates are built off of historic data and are projected to provide for all reasonable, appropriate and attainable costs that are required under the terms of their contract with the Department and for the operation of the PHP. PHPs will contract with providers and while PHPs have to comply with Department-established rates floors for certain in-network provider, PHPs and providers can mutually agree to different rates through the PHP / provider contract.	Claims / Billing / Finance	11/25/2019

Fiscal Agent/GDIT			
What role will CSRA play with Medicaid Managed Care as they are currently the fiscal agent for NC Medicaid	GDIT, using the NCTracks system, will continue to offer services as they do today. Under Medicaid Managed Care, CSRA will continue to offer enrollment and credentialing services and verify beneficiary eligibility, including identification of the PHP and AMH assignment. For NC Medicaid Direct beneficiaries not enrolled in managed care, CSRA will also continue to evaluate prior approval requests and adjudicate claims.	Fiscal Agent/GDIT	9/25/2019
Will NCTracks / GDIT play any role in the new Managed Care processes?	GDIT is the Fiscal Agent for North Carolina.	Fiscal Agent/GDIT	9/25/2019
Will this mean NCTracks will no longer be used after November 2019/ Feb 2020?	No, NCTracks will still be functional.	Fiscal Agent/GDIT	9/25/2019
Healthy Opportunities			
When you mentioned regions for the Health Opportunities Pilots...does that mean Medicaid regions or are other geographically defined areas eligible?	For more information on the Healthy Opportunities Pilots, go to https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/healthy-opportunities-pilots.	Healthy Opportunities	9/25/2019
For Health Opportunities Pilots, many of the areas of focus are the very issues most facing individuals with IDD. How can we dovetail those efforts?	For more information on the Healthy Opportunities Pilots, go to https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/healthy-opportunities-pilots	Healthy Opportunities	9/25/2019
Long-Term Services and Supports			
When do the changes effect Skilled Nursing Homes and Assisted Living Facilities?	Please refer to: https://files.nc.gov/ncdhhs/documents/LTSS-Vision_ConceptPaper_FINAL_20180405.pdf	LTSS	9/25/2019
How will this effect skilled nursing facilities with residents being cared for under Medicaid? Will NC remain a case mix state!	Beneficiaries who reside in a nursing facility for a period of ninety (90) days or longer and are not being served by the Community Alternatives Program for Disable Adults (CAP/DA) will be temporarily excluded from managed care enrollment for a period of up to five (5) years. If an individual enrolled in a PHP resides in a nursing facility for ninety (90) days or more, such individual shall be disenrolled from the PHP on the first day of the month following the ninetieth (90th) day of the stay and enrolled in the Medicaid Fee for-Service program. DHHS is conducting a series of webinars related to the transition to managed care. Long Term Support Services (LTSS) is a topic for these webinars. Please look for opportunities for engagement at https://medicaid.ncdhhs.gov/providers/provider-playbook-medicaid-managed-care	LTSS	9/25/2019
Member Operations			

Do Medicaid enrollees get to pick which MCO they will receive services for, or will they be assigned?	Beneficiaries will have a choice of PHP and AMH/PCP. If the beneficiary is required to enroll in managed care and a choice is not made, auto assignment will occur. For more information related to beneficiary enrollment, review the MCT 104 webinar available at https://medicaid.ncdhhs.gov/provider-playbook-training-courses#mct-104---provider-policies,-nc-medicaid-managed-care-104. Information is also in the Medicaid Managed Care County Playbook available at https://medicaid.ncdhhs.gov/county-playbook-medicaid-managed-care.	Member Operations	9/25/2019
What if you only have beneficiaries who have Medicaid secondary - do you need to contract with PHP's? Are these folks carved out (most ABD)?	Beneficiaries who are dually eligible with Medicare and Medicaid are excluded from enrollment in Medicaid Managed Care for up to five years. For information related to beneficiary enrollment requirements, see the recorded webinars available on the Provider Transition to Medicaid Managed Care Training Courses at: https://medicaid.ncdhhs.gov/provider-playbook-training-courses	Member Operations	9/25/2019
What specific groups will be held back from the standard plans?	Beneficiaries with partial benefits (i.e. Qualified Medicare Beneficiaries, MAFD) and beneficiaries in Community Alternative Programs (CAP) and the Program for All-Inclusive Care for the Elderly (PACE) are among those excluded from managed care enrollment. In addition, managed care enrollment for some beneficiaries will be delayed until Behavioral Health Tailored Plans are available, or until managed care is available statewide. For complete information regarding beneficiary enrollment in managed care, see the 'MCT 105 - Beneficiary Policies, NC Medicaid Managed Care' presentation available at: https://medicaid.ncdhhs.gov/provider-playbook-training-courses#mct-105---beneficiary-policies,-nc-medicaid-managed-care-105	Member Operations	9/25/2019
Will there be any requirement to provide family planning and abortion services?	As required by federal law, PHPs will cover family planning services and supplies regardless of a provider's network status and will cover and pay for emergency services without regard to prior authorization or network status.	Member Operations	9/25/2019
For clarification, can an individual be enrolled in both a Standard Plan and Tailored Plan simultaneously?	A beneficiary may not be enrolled in both plans at the same time. Beneficiaries enrolled in the Standard Plan who believe they qualify for a tailored plan may apply for participation once tailored plans launch.	Member Operations	9/25/2019
Any thoughts about where Therapeutic Foster Care children would be considered, either Tailored or Standard Plan?	Beneficiaries in foster care, those who are former foster care youth and those in adoptive placement are excluded from managed care until 2021 and will remain in NC Medicaid Direct.	Member Operations	9/25/2019
Will Medicaid recipients have a deductible as do most current BC/BS clients?	No, they will have the same copays as Medicaid/Health Choice as they do currently.	Member Operations	11/25/2019

What happens if a beneficiary becomes dual eligible several months after enrollment in a PHP?	Beneficiaries that are Medicaid and Medicare eligible are excluded from Managed Care for up to five years. When a beneficiary becomes dual eligible it will trigger a redetermination of Managed Care status. For more information about beneficiary enrollment requirements, see the MCT 104 webinar available at https://medicaid.ncdhhs.gov/provider-playbooktraining-courses#mct-104---provider-policies,-ncmedicaid-managed-care-104	Member Operations	11/25/2019
We understand the Community Alternatives Program for Children (CAP-C) and CAP-Disabled Adults (CAP-DA) are excluded services from Managed Care. Today there are medically fragile children who receive nursing under the State Plan program of Private Duty Nursing (PDN) and waiver services under CAP-C, how will a child be both in and out of Managed Care at the same time?	A Member will not be Medicaid Direct and in Managed Care simultaneously. Beneficiaries who are on these waivers are excluded from Managed Care at this time. For additional information, please visit: https://medicaid.ncdhhs.gov/providers/provider-playbook-medicaid-managed-care/virtual-office-hours, under the topic Long term Support and Services.	Member Operations	11/25/2019
Will there be an effect on Medicaid eligibility? There are many people I see who don't qualify for Medicaid or are too mentally burdened to be able to apply, who would be seriously helped by being able to access Medicaid.	Medicaid eligibility for beneficiaries will continue to be determined by the local departments of social services. Medicaid eligibility has not changed because of Managed Care. Individuals must be eligible for Medicaid in order to be enrolled in Medicaid Managed Care.	Member Operations	11/25/2019
How will hospital case managers be able to distinguish between the PHP recipients of these plans versus clients of standard commercial WellCare or BCBS plans? ...distinguishing prefix or #?	Similar to how providers verify recipients today - providers should look up the recipient's information in NCTracks to verify eligibility and enrollment in a Medicaid Managed Care Plan.	Member Operations	11/25/2019
Do individuals in region 3 and 5 get to select a PHP or will it only be Carolina Complete Health?	Individuals in Regions 3, 4, and 5 will have an opportunity to select any PHP that is available in their region, including WellCare, United Healthcare, Healthy Blue, AmeriHealth Caritas, and Carolina Complete Health. Beneficiaries in Regions 1, 2, and 6 will have an opportunity to select all PHPs except for Carolina Complete Health.	Member Operations	11/25/2019

Will the DSS have direct contact with PHP's for changes for clients etc.	Changes to beneficiary information is made in NC FAST by a caseworker, this information is sent to PHPs nightly on the 834-eligibility file. PHPs are required to submit weekly reports to the Department for Changes in Member Circumstances that they receive. These reports are provided to the DSS Offices to work through and make changes in NC FAST where applicable.	Member Operations	11/25/2019
Will the communications that go to members requesting their PHP selection include information about Tailored Plans?	Yes, it includes information on how members can request to stay in NC Medicaid Direct if they need services related to developmental disability, mental illness, traumatic brain injury, or substance use disorder. Examples of the notices can be found at https://medicaid.ncdhhs.gov/counties/county-playbook-medicaid-managed-care/county-playbook-enrollment-materials	Member Operations	11/25/2019
When will a beneficiary have the opportunity to change PHPs?	Beneficiaries can reach out to the enrollment broker to change their health plan within their 90-day choice period. Members will have 90 days from their plan effective date to change their health plan. If a beneficiary wants to change their health plan outside of the 90-day choice period they will have to have fill out the Health Plan Request form with one of the reasons below: • In need of Long-Term Services & Supports (LTSS) • Provider No Longer in Health Plan • Family Member is in a Different Heath Plan • Poor Performance of Health Plan • Health Plan will not Cover Service for Moral or Religious Reasons	Member Operations	11/25/2019
How often can patients re-enroll?	Beneficiaries can re-enroll after Day 1 (when health plans begin coverage for members) under the following circumstances: a. New Applicants – Enrollment is effective the month the application is approved. (This may mean a portion of their eligibility period will be NC Medicaid Direct.) b. Beneficiaries with Change of Circumstance Impacting Enrollment - Enrolled or disenrolled effective the month following the change. c. At Redetermination – Beneficiaries may choose to remain with current health plan or make a change. Beneficiaries have a 90-DAY CHOICE PERIOD in which to change health plans for any reason. The 90-days starts as of the effective date of enrollment.	Member Operations	11/25/2019
Will there be a standard list of benefits for the standard plan and the tailored plan or will the benefits vary based on who the managed care provider is?	To see the full list of NC Medicaid covered services provided by the health plans and those only provided by NC Medicaid Direct, go to ncmedicaidplans.gov.	Member Operations	11/25/2019

How we will differentiate between a Health Choice member and a Medicaid member after the transition?	Per normal practice, providers are encouraged to verify eligibility and Managed Care enrollment through the Provider Portal in NCTracks prior to providing services. The Provider Portal will not show Managed Care information until go-live at the earliest.	Member Operations	11/25/2019
If one of our long-term recipients asks us for enrollment assistance, where can we go to assist them, can we help answer their questions and/or help make their choices?	ncmedicaidplans.gov provides information on Managed Care, each plan available, and instructions to choose a health plan and PCP. Instructions on enrolling via the mobile app and website can be found at https://medicaid.ncdhhs.gov/counties/county-playbook-medicaid-managed-care/county-playbook-beneficiary-outreach	Member Operations	11/25/2019
How will the enrollment brokers be located in communities to assist with enrolling individuals in PHP's?	There are enrollment specialists located in each county DSS office to assist beneficiaries in enrolling. The Enrollment Broker also conducts enrollment events in the communities and attends outreach events. Events can be found at ncmedicaidplans.gov/events.	Member Operations	11/25/2019
Who will enter the PHP in NC FAST? What will the Medicaid cards look like and where will they be sent from?	The Enrollment Broker will enter the PHP information into their system, and this information will be passed to NC FAST. Example of Medicaid Managed Care Cards can be found in the provider manual and member handbook, both of which are available on the individual health plan's websites.	Member Operations	11/25/2019
Will enrollment brokers refer people to other services and resources (such as PACE for Medicaid-only) or only to PHPs/PLE?	Enrollment specialists will refer beneficiaries to the Medicaid Contact Center or their local DSS for information on programs such as PACE.	Member Operations	11/25/2019
Will enrollment brokers be prepared to assess and assist consumers who have low literacy levels so that they can effectively choose a plan?	Enrollment specialists are trained to assist consumers of all literacy levels.	Member Operations	11/25/2019
Will a beneficiary have to select a PCP when selecting a PHP. If so, can the beneficiary see any credentialed provider within the practice?	A beneficiary does not have to select a PCP when selecting a PHP, although it is encouraged. A beneficiary will select a PCP at the practice level.	Member Operations	11/25/2019
If we are in region 1, 2, or 6 and a patient from region 5 comes to our office with the Carolina Complete Health insurance. Would the patient be considers as out of network?	If the provider is not contracted with Carolina Complete Health, they will be considered out of network.	Member Operations	11/25/2019

If a beneficiary enrolled in a PHP because medically needy, or requires long term care, or becomes dually eligible - will they remain in the PHP or be removed from it?	Beneficiaries that are Medically Needy, in Long Term care for >90 days, or beneficiaries with Medicare and Medicaid are excluded from enrollment in Medicaid Managed Care for up to five years. These beneficiaries will be removed from their PHP once their status changes to one of the above. For more information about beneficiary enrollment requirements, see the MCT 104 webinar available at https://medicaid.ncdhhs.gov/provider-playbooktraining-courses#mct-104---provider-policies,-ncmedicaid-managed-care-104	Member Operations	11/25/2019
Will there be appeal rights for beneficiaries who do not agree with their initial benefit placement (standard vs. tailored?	Members who are determined to be mandatory for managed care can submit a request to stay in NC Medicaid Direct if they need services related to developmental disability, mental illness, traumatic brain injury, or substance use disorder. If that request is denied, they will have appeal rights.	Member Operations	11/25/2019
Please explain the process for PHP selection for newborns.	Please see the fact sheet on the Provider Playbook: https://files.nc.gov/ncdma/NCMedicaid-Provider-FactSheet-Eligibility-for-Newborns-v1-20191021.pdf	Member Operations	11/25/2019
Will children who have Medicaid through CAP remain fee for service? What about Disability? Cardinal? CDSA enrolled children?	Please see the fact sheet on the County Playbook: https://files.nc.gov/ncdma/FactSheet1-Intro-Medicaid-Transformation-Part1-20190521.pdf and https://files.nc.gov/ncdma/NCMedicaid-FactSheet-CDSA-and-Managed-Care-v1-20191025.pdf	Member Operations	11/25/2019
NC Medicaid Managed Care Transition Update Webinar			
What studies has the state of NC performed that shows that managed care has been successful in other states (GA, FL, TX)?	Please refer to: https://www.ncdhhs.gov/assistance/medicaid-transformation	NC Medicaid Managed Care Transition Update Webinar	9/25/2019
Good afternoon. Will webcasts be recorded? If yes, will the video links be sent to participants? Thank you	Webinar presentations, recordings, and transcripts are made available on the Provider Playbook for Medicaid Transformation at https://medicaid.ncdhhs.gov/providers/provider-playbook-medicaid-managed-care	NC Medicaid Managed Care Transition Update Webinar	9/25/2019
Does NC DHHS expect to utilize the NCTracks MMIS system through the planned implementation of the Section 1115 Waiver, and/or is it envisioned that alternate MMIS systems will be developed and brought online?	Please refer to: https://www.ncdhhs.gov/assistance/medicaid-transformation/proposed-program-design	NC Medicaid Managed Care Transition Update Webinar	9/25/2019
My question wasn't presented for an answer. Will it be addressed later?	Please send an email with any questions you may have related to Medicaid Managed Care to: Medicaid.Transformation@dhhs.nc.gov	NC Medicaid Managed Care Transition Update Webinar	9/25/2019

Is there a web location for the entire 1115 waiver as approved?	To review the 1115 Waiver and related documents, go to https://www.ncdhhs.gov/assistance/medicaid-transformation/proposed-program-design	NC Medicaid Managed Care Transition Update Webinar	9/25/2019
Can you show slide of the regions? How do we know what region we are in?	Please refer to: https://files.nc.gov/ncdhhs/medicaid/Managed-Care-Regions-and-Rollout.pdf	NC Medicaid Managed Care Transition Update Webinar	9/25/2019
If regional education is requested (patients and providers), will you provide (region 6 specifically) how do you go about setting that up?	Please see the Provider Playbook for Medicaid Transformation at: https://medicaid.ncdhhs.gov/providers/provider-playbook-medicaid-managed-care	NC Medicaid Managed Care Transition Update Webinar	9/25/2019
If my questions were not specifically answered, who may we reach out to for further clarification?	In addition to the information on the Medicaid Transformation website (https://www.ncdhhs.gov/assistance/medicaid-transformation), providers are encouraged to review the training courses and question and answer section on the Provider Playbook for Medicaid Transformation at: https://medicaid.ncdhhs.gov/providers/provider-playbook-medicaid-managed-care If there are additional questions, providers may contact the Medicaid SWAT team at: MedicaidSWAT@dhhs.nc.gov or by calling 919-527-7460.	NC Medicaid Managed Care Transition Update Webinar	9/25/2019
After this conference call what is the website for questions?	Please email: Medicaid.Transformation@dhhs.nc.gov	NC Medicaid Managed Care Transition Update Webinar	9/25/2019
How long will the FFS plan be in operation after Managed Care is launched in all regions of NC?	Beneficiaries ineligible or excluded from managed care will remain in the Medicaid Direct program. In addition, some services are carved out of managed care and will continue to be covered under Medicaid Direct processes. For more information, review the resources available at: https://medicaid.ncdhhs.gov/providers/provider-playbook-medicaid-managed-care	NC Medicaid Managed Care Transition Update Webinar	9/25/2019
Any clue as to time line for key actions to be completed	Additional announcements about managed care will be made on the Medicaid Transformation website https://www.ncdhhs.gov/medicaid-transformation.	NC Medicaid Managed Care Transition Update Webinar	9/25/2019
Question we have is Medicaid program as it is today totally going away? What are the populations that will continue to operate as fee for service?	The present-day Medicaid, fee-for-service program, will continue to operate to serve excluded, exempt and delayed populations, although it will be a smaller program now called Medicaid Direct. For a complete understanding of Medicaid managed care mandatory, excluded, exempt and delayed populations 2015-245 as amended by S.L. 2016-121; Sections 4 - 6 of S.L. 2018-49; and S.L. 2018-48.	NC Medicaid Managed Care Transition Update Webinar	9/25/2019
What is the name of the policy that was released on May 18th?	The policy paper that was released on May 18, 2018 was entitled "Supporting Provider Transition to Medicaid Managed Care." It can be found at https://files.nc.gov/ncdhhs/documents/ProviderTransition_PolicyPaper_FINAL_20180518.pdf	NC Medicaid Managed Care Transition Update Webinar	9/25/2019

Where can providers find research on how managed care organizations have helped Medicaid patients in other states? The feedback on social media in other states is not positive regarding how Medicaid patients are managed in other states who have MCOs.	See information provided on the Medicaid.gov website at https://www.medicaid.gov/medicaid/managed-care/index.html	NC Medicaid Managed Care Transition Update Webinar	9/25/2019
To clarify, will recipients with SMI/IDD receive a letter to select a Standard Plan for 02-20?	Individuals who are Tailored Plan eligible, identified as "exempt" will receive an enrollment packet for managed care as they have a choice to remain in the current LME-MCO/fee for service system or choose a Standard Plan. Individuals who are on the Innovations or TBI waivers will not receive an enrollment packet/letter from the Enrollment Broker.	NC Medicaid Managed Care Transition Update Webinar	11/25/2019
Do you know whether or not the Enhanced Services such as Day TX and/or Intensive In-home Services will continue to be billed to the LME.	Enhanced Services such as Day Treatment and/or Intensive In-home will continue to be billed to the LME-MCOs. Those services will only be available in Tailored Plans once those plans are implemented as proposed in July 2021.	NC Medicaid Managed Care Transition Update Webinar	11/25/2019
If recipient chooses different PCP from our practice and presents to our office will our charge deny?	PHPs are required to pay out of network providers for at least 60 days after we go live with managed care. Additionally, transition of care requirements specify that PHPs will honor prior authorizations for up to 90 days after managed care go live.	NC Medicaid Managed Care Transition Update Webinar	11/25/2019
If recipients mail in the enrollment packet, or if they call in, will the information be keyed into the system by 12/16/19 before auto assignment begins?	As we receive those, we have a day turnaround time in order to process all the applications. Our goal is to get everyone to mail them in prior to the deadline in the system so they get the plan of their choice.	NC Medicaid Managed Care Transition Update Webinar	11/25/2019

How quickly does the website update when a PCP joins a PHP/PLE plan?	There are a couple steps that have to take place after a provider has submitted their contract. The health plan needs to do a few validations of some of the information, which is just routine and then they need to go through the actual steps of loading the contract into their claim payment system, so as a provider, you have negotiated very hard and gotten the rates in the terms that you want. Now the health plan has to load those into their system. Once they have completed the process and they can pay you as a provider, they then push the information to the enrollment broker and the enrollment broker is able to display it. It is a requirement of our contract with the health plan that before they promote, before they advertise that you are in network, they have to have the ability to pay you on the next payment cycle. So that puts pressure on the health plans to load your information before they can start advertising that you are in their network. So, it does take anywhere from four weeks, potentially longer and therefore, we are recommending that providers have their contracts completed and sent into the health plans by November 15 in order to fully participate.	NC Medicaid Managed Care Transition Update Webinar	11/25/2019
Will the State continue to provide FFS payment to non PCPs who choose not to contract with all the PHPs whenever they service patients who are insured with one of the PHPs?	No, in fact the North Carolina Medicaid Direct program, for those individuals who are eligible for Standard Plans, their payment, any services provided by a provider for Standard Plan members should be, and must be billed to a health plan in order to be reimbursed. That is why we encourage providers to contract with health plans in order for them to continue to receive steady payments. There is a transition period where providers will be able to get paid, but that period requires them to get prior authorization and do the administrative work the health plans require. At some point, health plans are permitted to actually pay lower than the existing Medicaid rate for services provided. We really encourage providers to reach out to the health plans, go on to the North Carolina Medicaid website. We have a link to all of the phone numbers for each of the health plans. If no one has reached out to you, please reach out to them and get a contract and get it signed.	NC Medicaid Managed Care Transition Update Webinar	11/25/2019
Will there be an open enrollment period every year?	Yes. For each individual, we do have an open enrollment period of 90 days at the point of redetermination. Redetermination is when a Medicaid eligible individual has to go through the process of resubmitting or validating information to verify they are still eligible for Medicaid upon completion of that period. They are auto assigned back into the plan they were with, but they do have that 90 days after assignment to change plans, so if for whatever reason they do not like the health plan they are with upon redetermination, they can choose a new health plan.	NC Medicaid Managed Care Transition Update Webinar	11/25/2019

What to do if patient comes for appointment without their card?	You should check NCTracks for Medicaid eligibility. That is something that all providers should do. And then it is about finding out what health plan they are assigned to, understanding what services they are looking at and working with a member to be sure they get enrolled in the right health plan by referring them to the Enrollment Broker.	NC Medicaid Managed Care Transition Update Webinar	11/25/2019
What is the process to change doctors after Feb.1, and what channels must we go through?	In order for an individual to change their PCP after they have been enrolled with a health plan, they would simply reach out to the member service line at that health plan or their care manager who is working with them and they will be able to change their PCP through that health plan.	NC Medicaid Managed Care Transition Update Webinar	11/25/2019
Non-Emergency Medical Transportation (NEMT)			
How will Medicaid Transformation affect Medicaid Transportation for the counties?	For managed care enrolled beneficiaries, non-emergency medical transportation will be covered by their assigned PHP. For more information, please see the Non-Emergency Medical Transportation (NEMT) Fact Sheet available at: https://files.nc.gov/ncdma/FactSheet4-NEMT-20190521.pdf.	NEMT	9/25/2019
How will NEMT Providers be selected by the PHPs?	For information related to Non-Emergency Medical Transportation under Medicaid managed care, please see the fact sheet available at https://files.nc.gov/ncdma/NCMedicaid-FactSheet-Non-Emergency-Medical-Transportation--NEMT--final-v2.0.pdf.	NEMT	9/25/2019
Will the PHPs be reaching out to the counties about existing contracts concerning Non-Emergency Medicaid Transportation?	Health plans should be contacting counties and may contract with them to use existing NEMT providers, including county-owned transportation services or fleets. DHHS does not need to participate in these discussions. If there are issues or questions related to NEMT, the health plans or the DSS offices should bring them to NC Medicaid for discussion and resolution. Please refer to: https://files.nc.gov/ncdma/FactSheet4-NEMT-20190521.pdf	NEMT	9/25/2019
So, for clarification with NEMT, beneficiaries that have a PHP, the PHP will arrange and pay for NEMT services. Those individuals that are not in a PHP (CAP/DA, dual eligible) will have county DSS to arrange NEMT services?	Correct. For beneficiaries enrolled in Medicaid Managed Care, health plans are required to provide nonemergency medical transportation (NEMT) services. Health plans may use transportation brokers to arrange and provide transportation, or contract directly with transportation providers. For beneficiaries in NC Medicaid Direct, county DSS agencies will continue to arrange NEMT. Counties will continue to follow North Carolina NEMT policies, and providers will continue to bill NCTracks for reimbursement. Please refer to: https://files.nc.gov/ncdma/FactSheet4-NEMT-20190521.pdf	NEMT	9/25/2019

When determining appropriate travel time to care, how is the role of public transportation considered? Many recipients may not have personal cars...	For additional information on PHP network adequacy standards please see policy paper, "Prepaid Health Plan Network Adequacy and Accessibility Standards," published February 15, 2018 on the Medicaid transformation website. PHPs that are unable to meet the state's network adequacy standards may request an exception for a specific access to care gap in a specific region. To determine whether an exception is granted, the Department may consider several factors, including geographic considerations. For managed care enrolled beneficiaries, non-emergency medical transportation will be covered by their assigned PHP. For more information, please see the Non-Emergency Medical Transportation (NEMT) Fact Sheet available at: https://files.nc.gov/ncdma/FactSheet4-NEMT-20190521.pdf.	NEMT	9/25/2019
How will transportation services for beneficiaries change? Will the PHP broker those services?	PHPs will administer NEMT for qualifying beneficiaries enrolled in Medicaid Managed Care. For beneficiaries not enrolled with a PHP, NEMT services are handled the same way it is today.	NEMT	9/25/2019
For counties providing Medicaid Transportation, what changes can be expected?	PHPs will cover transportation for members enrolled in the Medicaid Managed Care Standard Plan. For members not enrolled with a PHP, transportation is handled the same way it is today.	NEMT	9/25/2019
Network Adequacy			
Does the any willing provider provision apply to both retail and specialty pharmacy networks the PHPs will build?	Yes, it applies to both retail and specialty pharmacy networks.	Network Adequacy	9/25/2019
Why were regions 3&4 selected for the PLE?	As required by Section 4. (6) b. of Session Law 2015-245, as amended by Session Law 2016-121, a PLE must cover any region in its entirety in which the PLE is contracted.	Network Adequacy	9/25/2019
Pharmacy			
Will all Medicaid Managed Care plans follow the same formulary?	NC Medicaid aims to implement standardization where possible. The Health Plans will follow the same Preferred Drug List (PDL).	Pharmacy	11/12/2019
Optical			
Is routine vision going to be fee for service or will it be under managed care?	The Standard Plan includes coverage of routine eye exams, prescribing corrective lenses and dispensing visual aids. However, the fabrication of eyeglasses, including complete eyeglasses, eyeglasses lenses, and ophthalmic frames are carved out of managed care and would be provided to beneficiaries using the current process.	Optical	9/25/2019
Plan Administration			
Will there be provider led PHP's?	There are four statewide PHP contracts and one regional Provider-Led Entity awarded. For more information, see https://medicaid.ncdhhs.gov/health-plan-contact-information	Plan Administration	9/25/2019

Who will be the contact if a provider has a problem with a plan that they cannot get resolved?	The PHP shall handle provider appeals and grievances promptly, consistently, fairly, and in compliance with state and federal law and Department requirements.	Plan Administration	9/25/2019
Is there a need to contract with the PLE for regions 3 and 5 if already contracted with another statewide PHP's?	No, it is not required.	Plan Administration	9/25/2019
Will all the PHP's be used across the state or will each region have a PHP?	PHPs are statewide with the exception to the PLE which is limited to three regions.	Plan Administration	9/25/2019
Will each PHP have their own portal for checking eligibility, claims, and guidelines or will we still go through the NCTracks website for this information?	Providers may continue to use the NCTracks eligibility verification function to verify eligibility and managed care enrollment information. Each PHP will also offer the option to check eligibility and submit claims and will make a Provider Manual available to all in-network providers.	Plan Administration	9/25/2019
Will providers who are contracted with various PHP's such as BCBS and United and are not contacted with Medicaid such as Partners or Cardinal be able to now see Medicaid clients?	All providers must be enrolled in NC Medicaid to contract with the PHPs.	Plan Administration	9/25/2019
What exactly does Prepaid Health Plan mean? Will they get a set amount of money per member, and will that eventually result in capitation for providers?	DHHS is delegating the direct management of certain health services and financial risks to PHPs. PHPs will receive a monthly capitated payment for each enrolled member and will contract with providers to deliver health services to their members. PHPs will be subject to rigorous monitoring and oversight by DHHS across many metrics to ensure adequate provider networks, high program quality, and other important aspects of a successful Medicaid managed care program. Claims for managed care enrolled beneficiaries will be adjudicated by the PHP based on their fee schedule.	Plan Administration	9/25/2019
Objective Quality Standards- How is this defined? How will DHHS ensure that this is measured in an objective and consistent manner?	DHHS must approve PHP policies regarding credentialing and contracting. Objective quality standards must assess a provider's ability to deliver care, include thresholds for adverse quality determinations, meet standards established by National Committee for Quality Assurance (NCQA), and not be discriminatory. Providers denied in-network participation due to objective quality standards have the right to appeal the decision. DHHS monitors provider appeals.	Plan Administration	9/25/2019

What does PHP stand for? Are they the same as LME or MCO's? How can an agency become a PHP?	For a complete overview of the types of managed care plans and glossary of terms, please see North Carolina's Proposed Program Design for Medicaid Managed Care that was released in August 2017 at https://files.nc.gov/ncdhhs/documents/files/MedicaidManagedCare_ProposedProgramDesign_REVFINAL_20170808.pdf . As defined in Session Law 2018-248 SECTION 1. Section 4 of S.L. 2015-245, as amended by Section 2(b) of S.L. 2016-121, Section 11H.17(a) of S.L. 2017-57, and Section 4 of S.L. 2017-186, reads as rewritten: "Prepaid Health Plan. – For purposes of this act, a Prepaid Health Plan (PHP) shall be defined as an entity, which may be a commercial plan or provider-led entity, that operates or will operate a capitated contract for the delivery of services pursuant to subdivision (3) of this. section, or a local management entity/managed care organization (LME/MCO) that operates or will operate a BH IDD Tailored Plan pursuant to subdivision (10) of this section. Question # 36 for definition of a PHP. An LME may be a PHP. LME-MCO (Local Management Entity/Managed Care Organization)—A local management entity that is paid a capitated rate by DHHS to provide mental health, developmental disability, and substance abuse services to Medicaid beneficiaries pursuant to a combination of a section 1915(b) and a section 1915(c) waiver. For the Medicaid population, these entities are recognized under CMS Medicaid managed care rules and are also operating the 1915(b) and (c) waivers as Prepaid Inpatient Health Plans (PIHP). LME-MCOs also manage federal block grant, State, local and county funds for other behavioral health services.	Plan Administration	9/25/2019
Please explain how the extra layer of a PHP is saving money while providing a better level of care to patients?	In September 2015, the General Assembly enacted Session Law 2015-245, directing the transition of Medicaid from a fee-for-service structure to a managed care structure. The Departments intends to implement managed care in a manner that advances high-value care, improves population health, engages and supports providers, and establishes a sustainable program with predictable costs. DHHS will delegate the direct management of certain health services and financial risks to PHPs which will receive a monthly capitated payment and will contract with providers to deliver health services to their members. PHPs will be subject to rigorous monitoring and oversight by DHHS across many metrics to ensure adequate provider networks, high program quality, and other important aspects of a successful Medicaid managed care program.	Plan Administration	9/25/2019
What is the reason for this change; how will it help with the beneficiaries' care?	It was mandated by the NC General Assembly under Session Law 2015-245. For additional information see https://files.nc.gov/ncdma/Provider-Transition-To-Medicaid-Managed-Care-101_Final.pdf; page 4	Plan Administration	9/25/2019

Thank you so much for doing a fantastic job with such an incredibly complex transition. It is so reassuring to clearly see how the patients are top priority. It's very exciting to envision how this will benefit them!!! I do have a respectable question. Why was My Health not selected in the spirit of physician led entities? They have been such a large part of the care management work in NC that has taken place over the last 20 years.	Please refer to the NC Medicaid Managed Care PHP Contract Awards Fact Sheet: https://files.nc.gov/ncdhhs/medicaid/Medicaid-Factsheets-PHP-2.4.19.pdf	Plan Administration	9/25/2019
So, by statewide does that mean Regions 3 &5 will be included in the Plan coverage?	Yes, all regions will be covered.	Plan Administration	9/25/2019
What is the timeline for the regional plans to be selected besides Carolina Complete Health, and does Carolina Complete Health count as 1 of the 2 regional plans?	PHP contracts have been awarded. Statewide PHP contracts were awarded to the AmeriHealth Caritas North Carolina, Inc, Blue Cross and Blue Shield of North Carolina, UnitedHealthcare of North Carolina, Inc., and WellCare of North Carolina, Inc. One regional PHP contract was awarded to Carolina Complete Health, a provider-led entity, which will offer plans in Regions 3, 4, and 5.	Plan Administration	9/25/2019
When will the new plans "go live" and when will the new plan year start officially?	Medicaid Managed Care will go live statewide on February 1, 2020.	Plan Administration	9/25/2019
Will Personal Care Services be transitioned as well?	Services covered in the NC Clinical Coverage Policy 3L, State Plan Personal Care Services are included in managed care. For more information, see Addendum 1 (Scope of Services) of the Request for Proposal for Medicaid Managed Care Prepaid Health Plans at https://www.ncdhhs.gov/assistance/medicaid-transformation	Plan Administration	9/25/2019
Is there a vision for how those that are uninsured might be still cared for from a community or regional level? Currently it seems like this is provided by a variety of non-profits and others and until or if Medicaid expansion occurs this still seems like a very important audience to address.	Medicaid Managed Care changes apply to Medicaid and NC Health Choice eligible beneficiaries. Review the North Carolina's Proposed Program Design for Medicaid Managed Care document, available at https://www.ncdhhs.gov/assistance/medicaid-transformation/proposed-program-design, for any program specific information related to the uninsured.	Plan Administration	9/25/2019

Will the PHPs that are awarded contracts have to cover EPSDT services according to current DMA policy?	The PHP shall include a provision that requires all in-network PCPs to perform EPSDT screenings for Members less than 21 years old, according to federal and State guidelines. For Members that are in Medicaid Direct EPSDT, the current process is and will be applicable.	Plan Administration	11/12/2019
Can you give an example of differences between plans?	Please see the Enrollment Broker website for the Plan comparison chart.	Plan Administration	11/12/2019
Is there an expectation that Carolina Complete Health will eventually be opened as an option for the other Regions at some point in the future?	Region 4 has been added to Carolina Complete Health's catchment area.	Plan Administration	11/12/2019
Prior Authorization			
Will ST, OT, PT providers have a central Choice PA auth site or will each MCO have discretion over whether pre-preauthorization is required?	PHPs must establish and maintain a referral and prior authorization process with the AMH at its center. Providers will request prior authorization as necessary from the PHP with which the beneficiary is enrolled, but PHPs must use a standardized prior authorization request form developed by the Department. In addition, the PHP must honor existing and active prior authorizations on file with the Medicaid or NC Health Choice program for the first ninety (90) days after implementation to ensure continuity of care for Members.	Prior Authorization	9/25/2019
We provide PT, OT and Speech for Medicaid beneficiaries. Under the Managed Care plan: **1. Will this change our submissions for prior authorization? Currently Medicaid has two programs (Health Choice or straight Medicaid) which we have to specify at the time of requesting.** **2. Will this be necessary with the addition of these new, managed programs as well?**	For beneficiaries enrolled with a Health Plan, prior authorization requests must be submitted to the Health Plan for which the beneficiary is enrolled. The Health Plans must honor open and existing prior authorizations on file for up to 90 days following Managed Care Launch to ensure continuity of care. Health Plan authorization requirements may vary, but they must establish and maintain a referral and prior auth process that cannot be more restrictive than NC DHHS's clinical coverage policies. Health Plans must use a standardized Prior Auth Request Form. For beneficiaries that remain in Medicaid Direct, prior auth requests will be submitted in the same manner as you do today.	Prior Authorization	11/25/2019

What are the required turnaround times for PHPs to respond to authorization and referral requests?	PHPs must establish and maintain a referral and prior authorization process with the Advanced Medical Home at its center. Providers will request prior authorization as necessary from the PHP with which the beneficiary is enrolled, using a standardized prior authorization request form developed by the Department. PHPs must cover benefits in an amount, duration, and scope no less than those covered under current clinical coverage policies. In addition, the PHP must honor existing and active prior authorizations on file with the North Carolina Medicaid or NC Health Choice program for the first ninety (90) days after implementation to ensure continuity of care for Members. Plans may be more permissive than our policy, but not more restrictive.	Prior Authorization	11/25/2019
Provider Contracting			
Will there be new contract enrollment processes for us as providers with these new PHPs if we currently do not have a contract on file with them, or if we have a current contract with say BCBS, will this require a new/different contract with BCBS?	Even though a provider may be contracted with the commercial side of an insurance carrier, a contract specific to Medicaid is required for NC Medicaid Managed Care. Please refer to: https://medicaid.ncdhhs.gov/providers/provider-playbook-medicaid-managed-care	Provider Contracting	9/25/2019
Can PHPs start now on building networks (contracting with professionals) or do they have to wait until the protest "period" is done?	PHP's are currently contracting with providers.	Provider Contracting	9/25/2019
Do hospitals and physicians MUST sign with all 4 insurers, or can we vet and verify which ones to work with?	PHPs are required to contract with “any willing qualified provider” but providers are not required to contract with every PHP.	Provider Contracting	9/25/2019
When will providers start getting information, we need to contact the 4 Medicaid Managed Care entities to establish contracts?	The PHP contact information is located at: https://medicaid.ncdhhs.gov/health-plan-contact-information. Providers may contact the PHP.	Provider Contracting	9/25/2019
Will those payers who are awarded the state contract have discretion of their networks and can they close their networks to providers who want to contract with them and qualify as Medicaid providers?	PHPs are required to contract with any willing and qualified Medicaid enrolled provider except if the provider fails to meet the PHPs objective quality standards or the provider does not agree to the network rates.	Provider Contracting	9/25/2019
Do we wait for the PHP to contact us or do we reach out to them? What if we don't hear from them?	Providers that wish to contract with a PHP may proactively contact their office. A list of PHP contacts is available at https://medicaid.ncdhhs.gov/health-plan-contact-information	Provider Contracting	9/25/2019

If we are already contracted with the 4 statewide PHP will we need to do a separate enrollment for the Managed Care Plans?	Yes. Even though a provider may be contracted with the commercial side of an insurance carrier, a contract specific to Medicaid is required for Medicaid Managed Care.	Provider Contracting	9/25/2019
If we are an out of network provider for private insurance how will this work with the PHPs?	Enrollment process is similar to process today - providers must be enrolled as a Medicaid or NC Health Choice provider to be paid for services to a Medicaid beneficiary. NC Medicaid providers will need to complete a separate contract with each Prepaid Health Plan (PHP) to participate in Medicaid Managed Care. PHPs are required to contract with any willing and qualified Medicaid enrolled provider except if the provider fails to meet the PHPs objective quality standards or the provider does not agree to the network rates.	Provider Contracting	9/25/2019
Are providers expected to sign up with all 4 statewide PHPs? When will providers be able to begin to enroll with PHPs?	No, not required to sign up with all PHP. Providers can begin enrolling with PHPs now.	Provider Contracting	9/25/2019
If our organization already has contracts in place, do we need to negotiate a new contract with these PHPs?	Yes, providers must negotiate a new contract with the PHPs.	Provider Contracting	9/25/2019
If a provider is contracted with one of the PHPs, does that ensure contracting with the others?	No, a provider that is contracted with one PHP does not automatically ensure contracting with the other PHPs. NC Medicaid providers will need to complete a separate contract with each Prepaid Health Plan (PHP) to participate in Medicaid Managed Care.	Provider Contracting	9/25/2019

We are a Rural Health Center. We have been told that since we signed a contract with UHC, that we must accept them as a PHP regardless. What thoughts do you have? We were not given any options. We will not receive the reimbursement as we are now.	PHPs are required to contract with any willing qualified provider, but providers are not required to contract with each PHP. Contracts with PHPs under Medicaid managed care are separate and apart from commercial insurance contracting. PHPs must reimburse Federally Qualified Health Centers and Rural Health Centers, at no less than the Medicaid fee schedule for covered services; including the T1015 rate as a rate floor for all core services, and the Medicaid physician fee schedule for all non-core services. For wrap-around payments, the federal rules permit DHHS to continue making additional wrap around payments over and above the Health Plan payments. To accomplish this, DHHS will calculate a quarterly PPS reconciliation to determine quarterly wrap around payments in order to ensure that FQHC/RHCs receive aggregate payments equal to the PPS per-visit rate that is required by federal law. Annually, for those FQHC and RHC providers that are currently cost settled, DHHS will make an additional wraparound payment representing the difference between Medicaid costs and payments received for those services. For more information on rates, see the 'MCT 102 - Provider Payment and Contracts' presentation available at: https://medicaid.ncdhhs.gov/provider-playbook-training-courses#mct-102---provider-payment-and-contracts,-nc-medicaid-managed-care-102	Provider Contracting	9/25/2019
How does Medicaid Managed Care affect providers such as independent practitioners as defined by policy Medicaid Policy 10A and 10 B?	Medicaid managed care includes the services provided in clinical coverage policy 10A and 10B. These provider types would need to consider contracting with PHPs in order to receive payments for services rendered to beneficiaries enrolled in managed care.	Provider Contracting	9/25/2019
Will solo practitioners, e.g., a speech-language pathologist in private practice, be less likely to receive contracts than larger practices? What are examples of "quality objectives" that will be utilized when contracting decisions are made?	No, PHPs are required to contract with any willing and qualified Medicaid enrolled provider except if the provider fails to meet the PHPs objective quality standards or the provider does not agree to the network rates. A PHP's objective quality standards are the standards the PHP uses in contracting decisions. These may assess a provider's ability to deliver care and include specific defined thresholds for adverse quality determinations but must meet standards established by the NCQA and not be discriminatory. In addition, a PHPs objective quality standard must only be based upon the Medicaid-enrolled provider information provided by the Department to each PHP through the Credentialed Provider File and/or the provider information provided by the PDC.	Provider Contracting	9/25/2019
Will there be a set number of providers per region?	No, there are no limitations on the number of providers with which a PHP may contract.	Provider Contracting	9/25/2019
Do we have to be enrolled with all the PHPs?	No, a provider may choose to contract with as many state-wide PHPs or regional PLEs as necessary to support their practice's business needs.	Provider Contracting	9/25/2019
How will managed care effect Durable Medical Equipment?	DME will be covered by capitated PHP contracts for all individuals who are mandatorily enrolled in managed care.	Provider Contracting	9/25/2019

When providers are working with the PHP network to negotiate the contracts is there a possibility of evergreen contracts?	DHHS does not anticipate the PHP provider contracts will have "Evergreen" provision due to the possible future changes to managed care under the waiver and the requirement for providers to be re-validated as Medicaid providers every three years.	Provider Contracting	9/25/2019
Do PHPs include home health care agencies?	PHPs will contract with home health care agencies if those agencies serve individuals who are in managed care and the agency is willing to contract with the PHP.	Provider Contracting	9/25/2019
Can a provider sign contracts with multiple PHP's?	Yes, providers may sign multiple contracts with awarded PHPs.	Provider Contracting	9/25/2019
Why are insurance companies sending us letters to join their Medicaid managed care groups?	Under Medicaid managed care, PHPs will be responsible for establishing and maintaining an adequate network of providers to meet the health care needs of their beneficiaries by contracting with a diverse range of providers and establishing provider payment rates, subject to certain rules set by the Department. In preparation for Medicaid transformation, it is anticipated that Health Plans intending to submit a proposal to be part of Medicaid managed care will be initiating discussions with providers regarding contracting opportunities. Building provider networks is a standard business operation for health insurance companies, and a robust network is a key component of successful Medicaid Managed Care programs. Before Medicaid Managed Care becomes operational and PHPs begin to serve beneficiaries, Health Plans will be required to demonstrate that they meet North Carolina's Medicaid network adequacy standards. During the procurement process, potential PHPs will have flexibility in how they demonstrate their ability to meet those standards in the future.	Provider Contracting	9/25/2019
Do ancillary service providers, for example, laboratories, follow these same guidelines?	Ancillary services will be covered by capitated PHP contracts for all individuals who are mandatorily enrolled in managed care.	Provider Contracting	9/25/2019
Will LEA's be required to join PHP's?	As outlined in SL 2015-245 as amended by SL 2017-57, PHPs shall not cover services prescribed in an Individualized Education Program (IEP) provided or billed and performed by schools or individuals contracted with by Local Education Agencies.	Provider Contracting	9/25/2019
"Will all PHPs have speech therapy benefits in some way or will only certain plans cover speech therapy?"	Each PHP will be expected to provide all required services in accordance with legislation and specified by the Department.	Provider Contracting	9/25/2019
Will dental providers be required to participate in Medicaid managed care?	North Carolina Session Law 2015-245, as amended by Session Law 2016-121, excludes dental services from Medicaid managed care.	Provider Contracting	9/25/2019

Two companies have already contracted with me. Will the others be contacting me?	No, a provider that is contracted with one PHP does not automatically ensure contracting with the other PHPs. NC Medicaid providers will need to complete a separate contract with each Prepaid Health Plan (PHP) to participate in Medicaid Managed Care.	Provider Contracting	9/25/2019
We recently acquired providers from North Carolina and our group application along with affiliating the providers to our new group number are currently still in process ... can we go ahead and contract with the MCO plans?	PHPs may only contract with actively enrolled Medicaid and NC Health Choice providers. Once the providers have been enrolled through NCTracks the providers will be eligible for enrollment with the Health Plans.	Provider Contracting	9/25/2019
When can Specialists expect to see contracts and how do they fit into the transformation?	The PHP contact information is located on the Medicaid website. Providers may contact the PHP. All enrolled active NC Medicaid Providers information from NCTracks will be sent to the PDC. The PDC will supplement the enrollment information and forward to the PHPs for quality determinations.	Provider Contracting	9/25/2019
At this point, which health plans have started reaching out to providers? I've only received correspondence from one health plan - AmeriHealth Caritas	The PHP contact information is located on the Medicaid website. NC Medicaid providers will need to complete a separate contract with each Prepaid Health Plan (PHP) to participate in Medicaid Managed Care.	Provider Contracting	9/25/2019
Will practices be able to request a cap on their attributed Medicaid population and, if so, how will this be done, especially with each PHP? How will this be managed?	This information will be gathered by the PHP during the contracting process.	Provider Contracting	9/25/2019
Right now, current provider contracts are ending with the local DSS in June. will we renew with DSS in July then with the PHP s later? or will the contracts pass directly to PHP s after ending in July.	Managed care changes will only apply to managed care enrolled beneficiaries. Services provided to Medicaid Direct beneficiaries will remain the same. For information related to beneficiary enrollment requirements, see the recorded webinars available on the Provider Transition to Medicaid Managed Care Training Courses at: https://medicaid.ncdhhs.gov/provider-playbook-training-courses	Provider Contracting	9/25/2019
When we reach out to the PHP what info do, they need from us?	PHPs must use the credentialing information provided by NCTracks and the PDC to make contracting decisions. However, PHPs may ask additional questions related to age restrictions, etc.	Provider Contracting	9/25/2019
Once we sign the contract from PHP, is there anything else the provider needs to do to complete the process?	Once the PHP contract is finalized, the information is automatically sent to the Enrollment Broker to be available in the Medicaid Managed Care Provider Directory. This process may take one to two weeks.	Provider Contracting	9/25/2019

Will we only be able to see patients in our region? Example patient is in region 1, can they see a region 5 provider?	Beneficiary enrollment data will be viewed by all regions. It will not be restricted by region.	Provider Contracting	9/25/2019
Please clarify that an Agency contracted with one PHP in one geographical area, can the provider in that area (ex. area 5) see a client from another area (ex. area 1) My Agency has had problems under the current MCOs for "dislocated children".	Although not required, providers are encouraged to contract with any PHP serving the region from which the beneficiaries Medicaid is administered.	Provider Contracting	9/25/2019
Does negotiating contracts mean that different providers will be reimbursed at different rates for the same levels of service?	Providers will be reimbursed according to their contract (e.g., value-based payments or other incentive arrangements) as well as any applicable state provider rate floors.	Provider Contracting	9/25/2019
Will ALL providers who want to provide services NOT be accepted into Managed Care?	PHPs are required to contract with any willing and qualified Medicaid enrolled provider except if the provider fails to meet the PHPs objective quality standards or the provider does not agree to the network rates. A PHP's objective quality standards are the standards the PHP uses in contracting decisions. These may assess a provider's ability to deliver care and include specific defined thresholds for adverse quality determinations but must meet standards established by the NCQA and not be discriminatory. In addition, a PHPs objective quality standard must only be based upon the Medicaid-enrolled provider information provided by the Department to each PHP through the Credentialed Provider File and/or the provider information provided by the PDC.	Provider Contracting	9/25/2019
Can a PLE bid for and receive one of the 3 statewide contracts? The enabling legislation and RFI dated November 2017 indicate this is possible but please confirm.	Yes, a PLE can bid on one of the statewide contracts.	Provider Contracting	9/25/2019

Can a PHP decline an agreement for a willing provider?	PHPs are required to contract with any willing and qualified Medicaid enrolled provider except if the provider fails to meet the PHPs objective quality standards or the provider does not agree to the network rates. A PHP's objective quality standards are the standards the PHP uses in contracting decisions. These may assess a provider's ability to deliver care and include specific defined thresholds for adverse quality determinations but must meet standards established by the NCQA and not be discriminatory. In addition, a PHPs objective quality standard must only be based upon the Medicaid-enrolled provider information provided by the Department to each PHP through the Credentialed Provider File and/or the provider information provided by the PDC.	Provider Contracting	9/25/2019
It was mentioned earlier that it will be 30 days for reimbursement to begin post contract and network building, will 30 days be the standard reimbursement time vs the current weekly pay that NC Medicaid provides?	PHPs must reimburse medical and pharmacy providers in a timely and accurate manner. For medical claims, a PHP must pay or deny a clean medical claim within thirty calendar days. For pharmacy claims, a PHP must pay or deny a clean claim within fourteen calendar days. For more information, see Addendum 1 of the Request for Proposal for Medicaid Managed Care Prepaid Health Plans at https://www.ncdhhs.gov/assistance/medicaid-transformation	Provider Contracting	9/25/2019
If a PHP contract for a Health Department lists certain services provided, such as a Primary Care services, and the HD does not have those services, will they be held accountable for offering them in the future? In this case, PHP's are not willing to amend the wording of the contracts, so the Health Director is hesitant to sign.	Local Health Depts. are essential providers so PHPs must offer a contract with them for the covered services they provide. Providers can negotiate contract terms. The RFP gives quite a bit of guidance regarding LHDs. DPH can also support the LHD with these kind of issues.	Provider Contracting	11/25/2019
Provider Enrollment / Credentialing			
Will all providers have to be credentialed with all the plans and if so, what is the process	Providers must be actively enrolled in NC Medicaid prior to contracting with a PHP (Health Plan). Provider enrollment still happens through NCTracks. A Provider Data Contractor (PDC) verifies credentialing data for enrolled providers and forwards the credentialing information to the Health Plans for quality determinations. Providers contract directly with the Health Plan(s). Refer to training webinar 104 posted on the Provider Playbook Training Courses page: https://medicaid.ncdhhs.gov/provider-playbook-training-courses	Provider Enrollment / Credentialing	9/25/2019

How do providers enroll to be an Advanced Medical Home?	All practices must have completed the Carolina ACCESS enrollment process through NCTracks before they will be permitted to enroll in an AMH tier. Practices not currently enrolled in Carolina ACCESS may apply to participate through NCTracks at any time. Practices will not be required to contract with CCNC (i.e., become a CAII practice) in order to participate in the AMH program.	Provider Enrollment / Credentialing	9/25/2019
How do providers enroll to be an Advanced Medical Home?	Non-Carolina ACCESS providers who wish to join the AMH program must first request Carolina Access participation during their initial Medicaid provider enrollment application or via a Managed Change Request submitted in NCTracks under the primary care NPI. See "How to Enroll, Update or Terminate CCNC/CA Managed Care Plans" available at https://www.nctracks.nc.gov/content/public/providers/provider-user-guides-and-training/fact-sheets.html for more information. Once approved for Carolina ACCESS, the provider will automatically be approved as an AMH Tier 2 provider. The provider may then choose to attest to a higher tier using the AMH Attestation Tool, available under Quick Links on the NCTracks secure Provider Portal Status and Management page. There is a link to the "AMH Tier Attestation Job Aid" at the link offered above.	Provider Enrollment / Credentialing	9/25/2019
How will current NC providers become credentialed with the new payers - will providers be required to credential with each PHP or will credentialing remain centralized with NCTracks?	PHPs will rely upon the provider credentialing information to determine if a provider meets the PHP's provider "quality standard" and therefore should be allowed to participate in the PHP's provider network. The Department designed a streamlined process to facilitate providers enrolling with a PHP for the first time as well as providers currently participating in North Carolina Medicaid or NC Health Choice. The PDC will be responsible for obtaining the primary source-verified credentialing data for North Carolina Medicaid and NC Health Choice enrolled providers. Neither the PHPs nor the PDC will be permitted to reach out to providers to update the provider's credentialing information, though providers are encouraged to keep their credentialing file up to date. To ensure that PHPs have access to information from a credentialing process that is held to consistent, current standards, the credentialing data is intended to be primary source-verified under the standards of NCQA. Please refer to: https://medicaid.ncdhhs.gov/blog/2019/04/01/centralized-provider-credentialing	Provider Enrollment / Credentialing	9/25/2019

Does this transformation require additional credentialing and new contracts for providers?	To ease administrative burden for providers, NC DHHS has a centralized credentialing and recredentialing process. Provider enrollment activities continue to go through NCTracks. Provider enrollment information is forwarded to the PDC to supplement credentialing data and submit to the PHPs to make quality determinations for contracting considerations. It is a provider's choice to enter into a contract with the Health Plan(s).	Provider Enrollment / Credentialing	9/25/2019
How do current NC providers become credentialed with the new MCO's? How soon can the credentialing be done?	Providers must be actively enrolled in NC Medicaid prior to contracting with a PHP (Health Plan). Provider enrollment still happens through NCTracks. A PDC supplements credentialing data for enrolled providers and forwards the credentialing information to the Health Plans for quality determinations. Providers contract directly with the Health Plan(s). Contracting is happening now. Refer to training webinar 104 posted at: https://medicaid.ncdhhs.gov/provider-playbook-training-courses#mct-104---provider-policies,-nc-medicaid-managed-care-104	Provider Enrollment / Credentialing	9/25/2019
Will providers need to enroll with the PHPs or if a provider with Medicaid will it be an automatic transition? If enrollment is required, will any of the PHPs institute a closed network thus not allowing all providers to contract?	Once enrolled/credentialed via NCTracks, providers must sign a contract with Prepaid Health Plans (PHPs) to be officially "in network" with that PHP. https://medicaid.ncdhhs.gov/providers/provider-playbook-medicaid-managed-care	Provider Enrollment / Credentialing	9/25/2019
Will our current credentialing as a Medicaid provider automatically be grandfathered into the new PHP network?	Once enrolled/credentialed via NCTracks, providers must sign a contract with PHPs to be officially "in network" with that PHP. https://medicaid.ncdhhs.gov/providers/provider-playbook-medicaid-managed-care	Provider Enrollment / Credentialing	9/25/2019
How do providers contact these selected health plans?	Providers must be actively enrolled in NC Medicaid prior to contracting with a PHP. The PHP contact information is located on the Medicaid website. NC Medicaid providers will need to complete a separate contract with each Prepaid Health Plan (PHP) to participate in Medicaid Managed Care.	Provider Enrollment / Credentialing	9/25/2019
For a Personal Care Service Provider, what is the procedure for joining a php?	Services covered in the NC Clinical Coverage Policy 3L, State Plan Personal Care Services are included in Medicaid Managed Care. Providers must be actively enrolled in NC Medicaid prior to contracting with a PHP. Once enrolled/credentialed via NCTracks, providers can contract with the PHPs. Please refer to: https://medicaid.ncdhhs.gov/providers/provider-playbook-medicaid-managed-care	Provider Enrollment / Credentialing	9/25/2019

Will there be one credentialing process for providers (with all 5 entities)?	Yes, all enrolled active NC Medicaid providers' information from NCTracks will be sent to the PDC. The PDC will supplement the enrollment information and forward to the PHPs for quality determinations. Please refer to the April Special Medicaid Bulletin https://files.nc.gov/ncdma/documents/files/SpecialBulletin-April-2019-PDC-for-Medicaid-Managed-Care_1.pdf	Provider Enrollment / Credentialing	9/25/2019
As a DME Provider, how do we contact PHP's to negotiate contracts?	Durable Medical Equipment (DME) will be covered by capitated PHP contracts for all individuals who are mandatorily enrolled in managed care. To comply with the any willing provider requirement for Standard Plans, PHPs must contract with providers willing to accept reimbursement at or above the rate floor (or in an alternative payment arrangement providers and PHPs mutually agree upon) unless the provider does not meet "objective quality" standards. PHP contact information: "	Provider Enrollment / Credentialing	9/25/2019
Where is the contact information for the MCO's for providers to start credentialing process?	Please refer to: https://medicaid.ncdhhs.gov/health-plan-contact-information	Provider Enrollment / Credentialing	9/25/2019
Is their detailed PHP information (contact department, telephone, fax, website) available?	Please refer to: https://medicaid.ncdhhs.gov/health-plan-contact-information	Provider Enrollment / Credentialing	9/25/2019
Will CCNC be a part of any the chosen Managed Care Providers	CCNC will continue to offer services to Medicaid Direct beneficiaries enrolled with a primary care provider.	Provider Enrollment / Credentialing	9/25/2019
Will there be handouts or information that the PCP can obtain (printed) to give to our current Medicaid population to inform them of these changes? Brochures? Posters?	A County Playbook for Medicaid Managed Care, containing information and fact sheets for beneficiaries is available at https://medicaid.ncdhhs.gov/county-playbook-medicaid-managed-care	Provider Enrollment / Credentialing	9/25/2019
With a July 1 enrollment start date (in regions 2 and 4), when do PHPs need to have their networks finalized? In time for that selection process?	Potential PHPs may have already started their efforts to build out their networks. Providers may have already been approached by potential PHPs and asked to sign Letters of Intent (LOIs) or initiate the contracting process. However, providers may choose not to sign LOIs at this time and consider its contracting options after PHPs have been selected by the Department. To be considered for Auto Enrollment on December 16, 2019, provider contracts must be signed and mailed to Health Plans by November 15, 2019. Contracting can still continue after that date.	Provider Enrollment / Credentialing	9/25/2019

When do we start the credentialing process? And do we contact the PDC directly?	To ease administrative burden for providers, provider enrollment activities continue to go through NCTracks. Provider enrollment information is supplemented by the PDC, and then sent to the PHPs to make quality determinations for contracting considerations.	Provider Enrollment / Credentialing	9/25/2019
As a solo private behavioral health provider that sees Medicaid children how do I continue to do this work?	A provider must maintain active enrollment with NC Medicaid and be contracted with the PHP in order to be paid for services rendered to managed care enrolled beneficiaries. If the treating provider is not contracted with a beneficiary's PHP, out of network guidelines may apply. For eligible beneficiaries not enrolled with a PHP at the time of service, Medicaid fee-for-service program guidelines still apply.	Provider Enrollment / Credentialing	9/25/2019
What is the process for applying for districts?	Providers will continue to enroll and credential with NC Medicaid through NCTracks and will contract with PHPs to provide and receive payment for services rendered to managed care enrolled beneficiaries. Separate PHP contracting is not required for each region. Once contracted with a PHP, the provider can offer in-network services to beneficiaries enrolled with that plan regardless of the region in which their Medicaid originates.	Provider Enrollment / Credentialing	9/25/2019
Will all physicians have to re-credential?	Providers will continue to enroll and re-credential with NC Medicaid through NCTracks according to current requirements.	Provider Enrollment / Credentialing	9/25/2019
If, for example, BCBS is granted the contract, will we have to re-credential with them for the Medicaid program, as happened with the Medicare HMO plan?	Please refer to the April 2019 Medicaid Special Bulletin Provider Data Contractor for Medicaid Managed Care: Guidance for Providers at: https://files.nc.gov/ncdma/documents/files/SpecialBulletin-April-2019-PDC-for-Medicaid-Managed-Care_1.pdf	Provider Enrollment / Credentialing	9/25/2019

When Medicaid managed care launch, do we need to re-enroll providers with the MCO plans or we must enroll in the Medicaid first (NCTracks) & then report to MCO?	During the transition period, providers will continue to enroll and reenroll in Medicaid using the current process under NCTracks. The Department will supplement its existing enrollment data with additional needed data. Specifically, the Department proposes to contract with a national provider data clearinghouse for verified primary-source information that meets an accrediting organization's standards for an accredited credentialing process. Together, this complete provider information (verified provider enrollment data plus managed care credentialing data) will be provided to PHPs. The PHPs will be expected to accept the information collected for Medicaid enrollment and the data from the national clearinghouse and use that combined data in their contracting process until the Provider Data Management /Credentials Verification Organization solution is fully implemented. PHPs internal provider network quality committees will use the information provided through this process. Providers will not be expected to give credentialing information to every PHP with which they intend to enter into a contract. The Department expects to prohibit PHPs, through the PHP contract, from requesting additional information from providers for use in making objective quality contracting decisions. Providers will interact with individual PHPs to establish their contract. For additional information on provider enrollment and credentialing, please see previously published policy papers on "Supporting Provider Transition to Medicaid Managed Care," as well as "Centralized Credentialing and Provider Enrollment." Both papers can be found on the Medicaid transformation website at: https://www.ncdhhs.gov/medicaid-transformation	Provider Enrollment / Credentialing	9/25/2019
What is an example of an "objective quality concern" that would allow a PHP to not contract with an otherwise willing provider?	As indicated in the "Supporting Provider Transition to Medicaid Managed Care," Policy paper, examples of objective quality concerns may include a history of malpractice concerns or fraud, waste or abuse enforcement actions.	Provider Enrollment / Credentialing	9/25/2019
Can credentialing be done through CAQH?	Credentialing will continue to be complete using the centralized credentialing process available in NCTracks.	Provider Enrollment / Credentialing	9/25/2019

Do we need to re-enroll if we are already enrolled? Will we have to re-enroll our providers that have already been credentialed and approved by Medicaid?	No, if you are already a Medicaid enrolled provider you will not need to re-enroll. However, to meet accreditation standards for managed care, PHPs will need additional information about providers that is not part of the existing credentialing process. This additional information is necessary because the existing Medicaid provider enrollment process (including credentialing) does not generally meet PHP's standards for a credentialing/contracting process or the standards necessary for a plan to be accredited by a nationally recognized accrediting organization. As mentioned during the webcast, providers should review Appendix C (Practitioner's) and Appendix D (Facilities) of the Centralized Credentialing and Provider Enrollment Policy paper that was released March 20, 2018. These appendices will clarify the additional required information or documentation that providers will need to provide to remain an enrolled Medicaid provider.	Provider Enrollment / Credentialing	9/25/2019
Will currently enrolled providers have to update current provider records in NCTracks (or in another system) to be eligible to contract / be credentialed by the PHP's (at the beginning of the waiver roll out)?	Yes, currently enrolled Medicaid providers will need to update information or documentation at their normal re-validate anniversary to remain an enrolled Medicaid provider. As mentioned during the webcast, providers should review Appendix C (Practitioner's) and Appendix D (Facilities) of the Centralized Credentialing and Provider Enrollment Policy paper that was released March 20, 2018. These appendices will clarify the additional required information or documentation that providers will need to provide to remain an enrolled Medicaid provider.	Provider Enrollment / Credentialing	9/25/2019
How will SLPs, PTs, and OTs fit into the managed care system? What do they need to do to prepare for this transition? As a Speech Pathology company that serves children in several areas across NC, will we have to be providers with all PHP's to serve the children we see with Medicaid? How do these proposed changes affect the delivery of speech, OT, and PT services? How do these proposed changes affect the delivery of speech, OT, and PT services? How will this affect outpatient specialized service providers (OT, PT, SLP)?	SLPs, PTs, and OTs serving individuals who are required to enroll in managed care will need to contract with PHPs to continue to be reimbursed for those services. As outlined in SL 2015-245 as amended by SL 2017-57, PHPs shall not cover services documented in an IEP including audiology, speech therapy, occupational therapy, physical therapy, nursing, and psychological services provided or billed Local Education Agencies or services provided and billed by a Children's Developmental Services Agency (CDSA) that is included on the child's Individualized Family Service Plan. Information on North Carolina's move to Medicaid Managed Care and guidance to providers may be found on the Medicaid Transformation website at: https://www.ncdhhs.gov/medicaid-transformation	Provider Enrollment / Credentialing	9/25/2019
Will group practices (therapy) be affected by this transformation?	Yes. Group therapy practices will need to contract with PHPs to provide group therapy services for beneficiaries enrolled in Medicaid Managed Care.	Provider Enrollment / Credentialing	9/25/2019

Will border providers still be eligible to contract with PHPs as they can enroll Medicaid now?	Yes, the Department will encourage that the PHP provider network outreach includes providers within 40-45 miles of contiguous state boarder. This is important, in our estimation, to ensure that there will be enough patient access within the time/distance access requirements for provider network adequacy.	Provider Enrollment / Credentialing	9/25/2019
Will mid-level providers still be required to credential with a PHP if that PHP has not previously credentialed midlevel's?	PHPs are required to contract with any willing and qualified Medicaid enrolled provider except if the provider fails to meet the PHPs objective quality standards or the provider does not agree to the network rates. A PHP's objective quality standards are the standards the PHP uses in contracting decisions. These may assess a provider's ability to deliver care and include specific defined thresholds for adverse quality determinations but must meet standards established by the NCQA and not be discriminatory. In addition, a PHPs objective quality standard must only be based upon the Medicaid-enrolled provider information provided by the Department to each PHP through the Credentialed Provider File and/or the provider information provided by the PDC.	Provider Enrollment / Credentialing	9/25/2019
Did Lynne say PHP's could delegate credentialing to another entity?	No. In covering content for Provider Enrollment and Credentialing (slide 11) it was specifically stated that the Department will not permit PHPs to delegate any part of the credentialing process, including the quality determination, to another entity.	Provider Enrollment / Credentialing	9/25/2019
Will DME providers be required or encouraged to enroll or is this simply for primary care and specialists?	DME will be covered by capitated PHP contracts for all individuals who are mandatorily enrolled in managed care. To comply with the any willing provider requirement for Standard Plans, PHPs must contract with providers willing to accept reimbursement at or above the rate floor (or in an alternative payment arrangement providers and PHPs mutually agree upon) unless the provider does not meet "objective quality" standards.	Provider Enrollment / Credentialing	9/25/2019
When you all are referencing to home health- is this also independent practitioner providing OT, PT, SLP services in the home?	No, home health in this context is not referencing independent practitioners providing OT, PT, SLP services in the home.	Provider Enrollment / Credentialing	9/25/2019
Please define "providers" are these physicians or other types of "providers"	Providers includes all providers including physicians delivering services in the managed care program.	Provider Enrollment / Credentialing	9/25/2019
If the initial quality measures are the same, could it be determined during credentialing whether providers meet the quality standards?	No, we do not foresee that objective quality standards will be similar across all PHPs. Objective quality standards will be determined by each PHP and will be reviewed and approved by the DHHS.	Provider Enrollment / Credentialing	9/25/2019
Will Pharmacists be credentialed?	All enrolled active NC Medicaid providers' information from NCTracks will be sent to the PDC. The PDC will supplement the enrollment information and forward to the PHPs for quality determinations.	Provider Enrollment / Credentialing	9/25/2019

Some of our providers are currently subject to onsite visits when enrolling or reverifying. Will this process be continued through PHPs and if a provider has had a successful site visit within the last 6 months would they need to repeat the site visit?	Site visits will continue to be conducted during the NCTracks application process as it is a federally mandated requirement applicable to certain providers depending on the provider's risk level in accordance to the provider's taxonomy including the type of services provided.	Provider Enrollment / Credentialing	9/25/2019
What is GDIT doing to reduce delays in processing of MCRs in the NCTracks Portal?	Medicaid Cost Reports are being processed timely by GDIT. If you are experiencing a delay, please contact NCTracks 800-688-6696.	Provider Enrollment / Credentialing	9/25/2019
Just got a notification that Carolina Complete Health - Centene is trying to credential one of my physicians through CAQH. Can someone please address this?	All enrolled active NC Medicaid providers information from NCTracks will be sent to the PDC. The PDC will supplement the enrollment information and forward to the PHPs for quality determinations.	Provider Enrollment / Credentialing	9/25/2019
Can Agencies add new providers with the health plan and, if so, what are the standards?	All enrolled active NC Medicaid providers information from NCTracks will be sent to the PDC. The PDC will supplement the enrollment information and forward to the PHPs for quality determinations.	Provider Enrollment / Credentialing	9/25/2019
With NCTracks taking an extended amount of time to approve the MCRs, how are we handling new clinicians that are "In Process" with NC-Tracks getting enrolled/credentialed with the PHPs? Is an MCR only pushed to the PHPs if it has been approved?	MCRs are being processed timely by GDIT. If you are experiencing a delay, please contact NCTracks 800-688-6696.	Provider Enrollment / Credentialing	9/25/2019
If our group changes from single specialty to Multi specialty what steps must be taken for this to be completed for 29 providers and 4 locations?	To change a taxonomy, the group should submit an MCR through NCTracks. No further steps need to be taken for the individual providers affiliated with the group NPI.	Provider Enrollment / Credentialing	9/25/2019
If we do not bill Medicaid but do bill state health insurance, we need to be enrolled as a Medicaid provider on NCTracks?? We bill BCBS for state employees.	The State Health Plan does not apply to NC Medicaid beneficiaries.	Provider Enrollment / Credentialing	9/25/2019
Is the PDC collecting the primary source verification, and information to supplement NCTracks, and if so, how is this occurring?	A file from NCTracks is being sent daily to the PDC. The PDC will source verify the information daily or when applicable.	Provider Enrollment / Credentialing	9/25/2019

Will the PSV process apply to all providers include group practices - or is does this apply mainly to IDTF's, ASC?	The process will apply to all providers except providers connected to LME/MCO providers.	Provider Enrollment / Credentialing	9/25/2019
Is speech therapy service being transitioned to managed care? If so, what is the process to become credentialed/contracted with the new providers?	Yes, Speech Therapy Services are being transitioned to Medicaid Managed Care. Please refer to the PHP RFP Section V. Scope of Services (Page 60 of 221) – Table 1: Summary of Medicaid and NC Choice Covered Services for additional details and key reference documents. To ease provider administrative burden, a centralized enrollment and credentialing process is a key component of the Medicaid Managed Care program design. Specific details of what is envisioned through these processes can be found in previously published policy papers (May 18, 2018 and March 20, 2018) that are located on the Medicaid website.	Provider Enrollment / Credentialing	9/25/2019
How will NCTracks be utilized with Medicaid Managed Care?	Like today, NCTracks will be utilized to enroll providers in Medicaid and credential those providers until such time as a PDM/CVO vendor is contracted by the state.	Provider Enrollment / Credentialing	9/25/2019
Once the PDM/CVO is implemented does the State anticipate acceptance of paper applications? Or, will it only accept provider applications thru the online portal?	The state envisions that once the PDM/CVO is operational, that providers will use an electronic application to enroll. The application is envisioned to be interactive and have fields which may be pre-populated and/or will auto-populate for some fields.	Provider Enrollment / Credentialing	9/25/2019
URAC also provides CVO Accreditation. Will that be acceptable for the CVO (In addition to NCQA)?	Using a competitive bid process, the Department plans to engage an independent, third party, nationally recognized CVO and PDM solution. The types of bidders that may submit responses regarding their organization's qualifications is not known to the DHHS at this time.	Provider Enrollment / Credentialing	9/25/2019
When enrolling and becoming credentialed with PHPs, the web course said providers would only have to complete the process one time. Will that one time cover up to all 15 PHPs, and they determine our participation from the application information provided?	Yes, that is correct. PHPs will have access to credentialed providers information and will use a PHP Provider Network Participation Committee to decide whether to contract with a provider. This Committee cannot request additional information to make its quality determination. To comply with the any willing provider requirement, PHPs operating Standard Plans must contract with providers willing to accept reimbursement at or above the rate floor (or in an alternative payment arrangement providers and PHPs mutually agree upon) unless the provider does not meet "objective quality" standards. In addition, there are specific requirements for PHPs to include all essential providers (i.e., federally qualified health centers, rural health centers, local health departments, veterans' homes and charitable/free clinics) in their provider networks.	Provider Enrollment / Credentialing	9/25/2019

Is every current Medicaid provider guaranteed that they will be able to transition to a PHP network or do the individual PHP networks choose their own providers?	PHPs will have access to credentialed providers information and will use a PHP Provider Network Participation Committee to decide whether to contract with a provider. This committee cannot request additional information to make its quality determination. PHPs operating Standard Plans must comply with the any willing provider requirement requiring PHPs to contract with providers willing to accept reimbursement at or above the rate floor (or in an alternative payment arrangement providers and PHPs mutually agree upon) unless the provider does not meet "objective quality" standards. In addition, there are specific requirements for PHPs to include all essential providers (i.e., federally qualified health centers, rural health centers, local health departments, veterans' homes and charitable/free clinics) in their provider networks. PHPs operating Tailored Plans are permitted as outlined in Session Law 2018-48 to operate closed provider networks for behavioral health, intellectual and developmental disability and traumatic brain injury services	Provider Enrollment / Credentialing	9/25/2019
If we are currently serving MD/NCHC patient, will we be able to continue with the patients care if they choose a plan that as a provider we are not credentialed with?	Providers should not anticipate that they will continue to provide medical treatment and services to beneficiaries that choose to participate in a plan with whom they are not contracted unless there is an out-of-network arrangement (on a case-specific basis) established with the PHP or the beneficiary agrees to pay privately.	Provider Enrollment / Credentialing	9/25/2019

Will NCTracks be a part of the PDM/CVO process? Will NCTracks still be used to process Medicaid claims and prior authorizations, or will the PHP be responsible?"	During the transition period, providers will continue to enroll and reenroll in Medicaid using the current process under NCTracks. The Department will supplement its existing enrollment data with additional needed data. Specifically, the Department proposes to contract with a national provider data clearinghouse for verified primary-source information that meets an accrediting organization's standards for an accredited credentialing process. Together, this complete provider information (verified provider enrollment data plus managed care credentialing data) will be provided to PHPs. The PHPs will be expected to accept the information collected for Medicaid enrollment and the data from the national clearinghouse and use that combined data in their contracting process until the PDM/CVO solution is fully implemented. PHPs internal provider network quality committees will use the information provided through this process. Providers will not be expected to give credentialing information to every PHP with which they intend to enter into a contract. The Department expects to prohibit PHPs, through the PHP contract, from requesting additional information from providers for use in making objective quality contracting decisions. Providers will interact with individual PHPs to establish their contract. For additional information on provider enrollment and credentialing, please see previously published policy papers on "Supporting Provider Transition to Medicaid Managed Care," as well as "Centralized Credentialing and Provider Enrollment." Both papers can be found on the Medicaid transformation website at https://www.ncdhhs.gov/medicaid-transformation. Regarding claims processing, NCTracks will continue to process Medicaid fee-for-service claims. Claims for managed care beneficiaries will be processed by PHPs with whom they are enrolled.	Provider Enrollment / Credentialing	9/25/2019

Will providers currently enrolled need to re-enroll through the new process or will they be "grand-fathered" in?	No, providers will not be "grandfathered." Currently enrolled Medicaid providers will not need to re-enroll to remain Medicaid providers. However, they will need to update information or documentation to remain an enrolled Medicaid provider. This additional information is necessary because the existing Medicaid provider enrollment process (including credentialing) does not generally meet PHP's standards for a credentialing/contracting process or the standards necessary for a plan to be accredited by a nationally recognized accrediting organization. As mentioned during the webcast, providers should review Appendix C (Practitioner's) and Appendix D (Facilities) of the Centralized Credentialing and Provider Enrollment Policy paper that was released March 20, 2018. These appendices will clarify the additional required information or documentation that providers will need to provide to remain an enrolled Medicaid provider.	Provider Enrollment / Credentialing	9/25/2019
Where can we locate the credentialing information?	Information on provider enrollment and credentialing can be accessed through previously published Policy papers on the Medicaid Transformation website at https://files.nc.gov/ncdhhs/documents/ProviderTransition_PolicyPaper_FINAL_20180518.pdf and https://files.nc.gov/ncdhhs/documents/Credentialing_ConceptPaper_FINAL_20180320.pdf.	Provider Enrollment / Credentialing	9/25/2019
What is PDM/CVO?	Using a competitive bid process, the Department plans to engage an independent, third party, nationally recognized CVO and PDM solution. Additional information on the integrated PDM/CVO solution can be found in two earlier published policy papers located on the Medicaid Transformation website at https://files.nc.gov/ncdhhs/documents/ProviderTransition_PolicyPaper_FINAL_20180518.pdf and https://files.nc.gov/ncdhhs/documents/Credentialing_ConceptPaper_FINAL_20180320.pdf	Provider Enrollment / Credentialing	9/25/2019
Why don't you use CAQH?	As indicated in the policy paper, "Supporting Provider Transition to Medicaid Managed Care," the Department will be establishing an integrated PDM and CVO. An RFP for the PDM/CVO will be issued soon. Once a vendor is selected and contracted with the DHHS, all credentialing will be done through the state's centralized credentialing process.	Provider Enrollment / Credentialing	9/25/2019

Will NCTracks continue to be used as the credentialing platform?	During the transition period, providers will continue to enroll and reenroll in Medicaid using the current process under NCTracks. The Department will supplement its existing enrollment data with additional needed data. Specifically, the Department proposes to contract with a national provider data clearinghouse for verified primary-source information that meets an accrediting organization's standards for an accredited credentialing process. For additional information on provider enrollment and credentialing, please see previously published policy papers on "Supporting Provider Transition to Medicaid Managed Care," and "Centralized Credentialing and Provider Enrollment." Both policy papers can be found on the Medicaid Transformation website at https://www.ncdhhs.gov/medicaid-transformation.	Provider Enrollment / Credentialing	9/25/2019
I've heard that each PHP can ask practices for more information after centralized credentialing. Is that true?	No, this is not accurate. PHPs will have access to credentialed providers information and will use a PHP Provider Network Participation Committee to decide whether to contract with a provider. This Committee cannot request additional information to make its quality determination. However, PHPs may request other administrative information necessary for contracting such as payment flows.	Provider Enrollment / Credentialing	9/25/2019
What have you planned to preserve current patient physician relationship since they are enrolled with their pep with ca program, can you allow this relationship to continue if provider enroll in one or more of these php and plea?	Refer to North Carolina's Proposed Program Design for Medicaid Managed Care | August 2017, page 45 https://files.nc.gov/ncdhhs/documents/files/MedicaidManagedCare_ProposedProgramDesign_REVFINAL_20170808.pdf	Provider Enrollment / Credentialing	9/25/2019
How will providers enroll with the new PHP?	See: https://medicaid.ncdhhs.gov/health-plan-contact-information	Provider Enrollment / Credentialing	9/25/2019

I just watched the webinar: MCT 102 Provider Payment and Contracts, NC Medicaid Managed Care102. It discussed payment for multiple types of providers but did not specifically mention Urgent Care centers. Will Urgent Care centers be treated as Primary Care or Specialty Care or something else entirely different? **We are not currently enrolled with a PHP and do not currently accept Medicaid but are interested in possibly moving towards accepting this population.**	The provider type and classification is based on the services provided. Provider applicants must meet all program requirements and qualifications before they can be enrolled with NC Medicaid. Organizations and individual providers must be actively enrolled with NC Medicaid in order to be considered for PHP contracting, at which time your eligible and qualifying provider type can be included in your PHP contracting discussions. The following link offers more information on NC DHHS Provider enrollment: https://www.nctracks.nc.gov/content/public/providers/provider-enrollment.html	Provider Enrollment / Credentialing	11/25/2019
Tailored Plan			
When will more information about the tailored plan will be coming out?	Review the information on the Behavioral Health and Intellectually/Developmental Disability Tailored Plan website, available at https://medicaid.ncdhhs.gov/behavioral-health-idd-tailored-plans, or the MCT 106 webinar on the Provider Playbook Training Courses webpage at https://medicaid.ncdhhs.gov/provider-playbook-training-courses	Tailored Plan	9/25/2019