NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Virtual Office Hours – Questions and Answers

Question	Answer
It is our understanding that authorization will only be required for those items that require it now via fee for service Medicaid. Can you please confirm?	PHPs can require authorizations for services for which it is not required currently, if the criteria for the authorization is not more restrictive than the current criteria.
Can you please confirm if NC MCOs will be allowed to implement restricted/limited pharmacy networks (in the managed Medicaid program? For example, a network that only includes one national pharmacy chain provider etc.	First, Session Law 2015-245 provides that "PHPs may not exclude providers from their networks except for failure to meet objective quality standards or refusal to accept network rates." Additionally, per Session Law 2018-49, the General Assembly applied a statute from the insurance statutes, G.S. §58-51-37, Pharmacy of Choice, which basically requires a PHP to open its pharmacy network to any pharmacy willing to accept the PHPs network rates. So, this means that independent pharmacies must be allowed to participate in a PHP's network if the pharmacy accepts the network rates and meets a PHP's objective quality standards.
I am trying to determine if behavioral health services will still be billed through the Local Management Entities, or will this also transition to the Prepaid Health Plans? This may not be the appropriate email for this question, but I had difficulty locating a name and had no luck trying to use the available phone numbers. And I'd like to get an answer verses having to do the hour "virtual office" meeting. I work at Appalachian State University and help support a community psychology clinic that offers outpatient-based counseling services with a licensed clinical psychologist. I need to know if we should continue to work with Vaya or if we need to credential her through the prepaid health plans. Any assistance would be greatly appreciated. Thanks.	Please visit the site, which provides specific details about Tailored Plans: https://files.nc.gov/ncdhhs/documents/files/BH-IDD-TailoredPlan_ConceptPaper_20181109.pdf?CkZhWxchGeNGBa2wXQSrSwWPrqi41aVP
Will we have a specific representative from each PHP that we can reach out to with problematic issues and escalations?	The contact information for each PHP's NC Medicaid Reps can be accessed via the NC DHHS website at https://medicaid.ncdhhs.gov/health-plan-contact-information
I am struggling to get in touch with anyone from United Healthcare. The number provided online takes me to a representative who knows nothing about United Health care being a Medicaid provider. Please help	The contact information for each PHP's NC Medicaid Reps can be accessed via the NC DHHS website at https://medicaid.ncdhhs.gov/health-plan-contact-information

What is the status of the PHP Provider Manuals? Can you advise which have been approved?	Four Provider Manuals are still under review between the Plans and the Department. AmeriHealth is the only Provider Manual approved at this time. Exact timing of approval of the other four are dependent of approved changes.
How will providers access fee schedules from each contract/heath plan so that we can ensure we are billing correctly?	Providers can access fee schedules on the NC DHHS website at https://medicaid.ncdhhs.gov/fee-schedule-index
Will existing authorizations in place when managed care rolls out be honored/Grandfathered? If so; how will the PHPs be made aware of the authorizations so that payment can be made?	For managed care enrolled beneficiaries, 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.
Will Pharmacy authorizations remain the same?	Yes, Pharmacy authorizations will remain the same.
Will all providers who are currently enrolled with NC Medicaid in NC Tracks be considered "credentialed" for PHPs, or will we have to credential all our providers prior to PHP go-lives? We've called multiple people & have been unable to get an answer to this question.	Yes, all providers who are currently enrolled/credentialed in NCTracks will be shared with the PHP's. Providers will still need to contract with the PHP's.
I got all printing information from United but was unable to connect with contract administrators for behavioral health. Region 1. I met with the organization twice at MAHEC, but all the numbers do not work.	Please provide contact information so this concern can be escalated to United.
Can you please say once again how we search for providers contacts? It was help/plan/contact. I want to be sure to have that link. Thanks	Please see the link below: https://medicaid.ncdhhs.gov/health-plan-contact-information
It has communicated that there will be the same form to request Prior Auths across each PHP. However, will this PA only apply to specific plan. If a beneficiary switches plans, will a new PA need to be obtained?	PHPs are required to honor previously adjudicated PAs by the source PHP if the service end date is after the receiving PHP effective date.
Say a beneficiary does not choose a health plan on their own & are auto assigned a plan. Do you foresee any issues with them being assigned to a plan their current PCP is not a part of? As a provider we would be concerned with billing issues if something like this may happen.	No, the department does not foresee this as an issue. Per the PHP Auto Assignment Logic, Rule 3 is assigning the beneficiary based on their current or historic PCP. The only scenario this would not occur, is if the provider is contracted with a health plan that is not in the beneficiary's region.
Will NCTracks continue to be available for filing claims for our cases state-wide or will we need to use a different filing mechanism with each PHP and Regional contract?	PHP's will reimburse for services rendered to a member in managed care. Billing for Medicaid direct services/members will stay the same (via NCTracks).

If a patient previously lived in a Phase 1 county but has now relocated to a Phase 2. What should they do to update their information? And are they able to receive care in their new place of residence? Are they able to receive care at an office that has not gone live yet, without any issues for the patient?	Per normal processes today, beneficiaries are required to inform their DSS county when they have moved. A beneficiary seeks services from a practice that is part of Phase 2 launch if the service is covered by the State Plan and the provider is enrolled in Medicaid.
What does "AMH" stand for?	AMH is an acronym for Advanced Medical Home.
Do you know if the private companies will have different policies regarding pre-approval etc.?	PHPs are required to use the State Clinical Coverage Policies as the standard guide. PHPs may have differing policies regarding prior approval, but they must meet the minimum requirements set forth by the NC Medicaid State Plan
Some patients have commercial insurance provided by an employer but also have Medicaid as a secondary payer. Will this scenario continue? If so, will the individual with secondary Medicaid participate in a Standard Plan or NC Medicaid Direct?	Beneficiaries with commercial insurance may be eligible for Standard Plan enrollment, and Standard Plans would be the secondary payer. Generally, beneficiaries enrolled in Medicaid, however, will remain in NC Medicaid Direct as defined in SL 2018-49.
Will the PHP a consumer chooses post in NC-Tracks prior to the 11/1 date or will we have to wait until 11/1 to verify eligibility and determine what PHP consumers have chosen?	Providers will have to wait until 11/1. Currently, NCTracks does not show future eligibility.
When can we see the provider manuals from AmeriHealth?	Providers may request a provider manual from each of the PHPs, including the final versions and draft versions if the PHP's manual is still under review.
If a consumer needs to change from a standard plan to a tailored plan, has the Enrollment Broker developed an electronic form that we as providers can submit to assist in the process of getting this changed? Is it possible to get the change expedited? What is the timeframe that it takes to make this change?	There will be a form on the website that can be completed and sent in. If there is an urgent need for a service and there is a service authorization request attached to the Provider form. Timelines are being finalized.
Are behavioral health providers subject to the rate floor?	Rate floors extend to physicians and physician extenders. All other provider types would not be subject to the rate floor.
Another question, there was a comment about fee schedules where the speaker said the current fee-per-service rates will be met for a few types of providers. I did not hear anything about independent providers (e.g., speech therapists).	Rate floors extend to physicians and physician extenders. All other provider types would not be subject to the rate floor.
It has been communicated that the same form will be used to request Prior Authorizations across each PHP. However, will this PA only apply to specific plan? If a beneficiary switches plans, will a new PA need to be obtained?	PHPs are required to honor previously adjudicated PAs by the source PHP if the service end date is after the receiving PHP effective date.

does the readiness review include the provider manual?	Ensuring that all PHPs have complete and approved provider manuals will be included as a part of the Department's readiness review.
Say a beneficiary does not choose a health plan on their own & are auto assigned a plan. Do you foresee any issues with them being assigned to a plan their current PCP is not a part of? As a provider we would be concerned with billing issues if something like this may happen.	No, the department does not foresee this as an issue. Per the PHP Auto Assignment Logic, Rule 3 is assigning the beneficiary based on their current or historic PCP. The only scenario this would not occur, is if the provider is contracted with a health plan that is not in the beneficiary's region.
Will these types of virtual office hours, live webinar updates, and continuing support be provided for the phase 2 regions?	Yes, the virtual office hours, live webinar updates, and training support will be provided for the phase 2 regions.
If the patient discovers their preferred PCP doesn't take their plan, how does the patient get care when they are waiting for the switch to become effective from MCO A to MCO B?	The patient would either see their assigned PCP in MCO A to receive services or referrals, or see another eligible primary care doctor within MCO as network. Once they transfer to MCO B they can see their preferred PCP once they are in network.
If a patient previously lived in a Phase 1 county but has now relocated to a Phase 2. What should they do to update their information? And are they able to receive care in their new place of residence? Are they able to receive care at an office that has not gone live yet, without any issues for the patient?	Per normal processes today, beneficiaries are required to inform their DSS county when they have moved. a beneficiary can go to a practice that is part of Phase 2 launch if the service is covered by the State Plan and the provider is enrolled in Medicaid.