Provider Transition to Medicaid Managed Care 101

Question	Answer
1. Can you please re-state the Tier 1, 2, & 3 PMPM amounts? I did not understand the statement "Tier 3 PMPM will be the same as Tier 1 & 2."	https://files.nc.gov/ncdma/AMH_FAQs_2.8.2019.pdf
2. AMH Tier III that wants to do their care management in house, will receive the CAII fee of $2.50 PMPM, and an additional $2.50 PMPM for care management. Did I understand that correctly?	Tier 3 providers will receive the same PMPM as tier 2 providers. Care management fees are negotiable between the provider and the PHP.
3. How do we attest to Tier 3?	AMH Tier Attestation Job Aid (PDF, 630 KB)
4. I see that the PHPs will be required to pay the 100 percent Medicaid rate, but no specifics about the PMPM care management piece ($2.50 standard/$5 complex).	Medical Home Fees under the AMH program will initially be the same as those established under Carolina ACCESS. All AMHs will receive Medical Home Fees (see below for amounts by tier). In exchange for taking on additional care management functions, Tier 3 AMHs will also be eligible for an additional, negotiated Care Management Fee from PHPs.
5. If we attested to Tier 3 should we start discussing with these PHP's the Tier 3 negotiations? Will the payments for Tier 3 start on the starting date?	Medical Home Fees and Care Management Fees will commence once the practice has contracted with a PHP and no earlier than November, 2019.
6. Also, AMH program is for MD offices only--correct not, for instance, therapy only practices?	See page 8 https://files.nc.gov/ncdma/documents/Providers/Programs_Services/amh/AMH_Provider-Manual_08272018.pdf
7. Are there any particular effects of MMC on non-AMH, non-primary care, therapy-based providers such as Speech therapists occupational therapists, physical therapists, etc. Particularly related to value-based payments.	No, the Department has not set guidelines that would specifically impact these provider types with respect to value-based payments (VBP). However, VBP arrangements will be decided through PHP-provider contract negotiations, so PHPs and providers could choose to enter into value-based payment arrangements. The Department will be releasing more guidance on VBP over time, so please see updated guidance as it becomes available.
8. What is the care management fee? That is the question not being answered.	Practices will have contracting leverage to negotiate acceptable Care Management Fees

9. Please provide clarification as to what healthcare areas the AMH program is relative...will this be relevant to OTs, PTs, SLPs?	page 8 https://files.nc.gov/ncdma/documents/Providers/Programs_Services/amh/AMH_Provider-Manual_08272018.pdf
10. Ms. Knick, you repeated the commitment to local, imbedded care management. Yet, there are no payment provisions within any of the PHP provider agreements released thus far. CIN agreements also fail to offer funding for imbedded care management	We understand your concern. We are working with the PHPs who will soon be sending out AMH contracts that mirror the DHHS AMH program with rates for required components (service fee, medical home fee, care management fee, incentive payment).
11. What region is Scotland County in?	https://files.nc.gov/ncdhhs/medicaid/Managed-Care-Regions-and-Rollout.pdf
12. You indicate "medically needy" are excluded from MCO's. How do you define "medically needy?"	Medically needy is a Medicaid classification for individuals whose countable income and/or resources exceed the categorically needy limits. These individuals must meet a deductible before being authorized for Medicaid.
13. Will excluded categories be permanent or just during the first five years of the rollout?	This is defined by Legislation.
14. Can I clarify that all dual eligible members (Traditional Medicare/NC Medicaid full plan) will be excluded from the managed care transition? I may have misunderstood that at the beginning of the presentation.	Years 1-2 of Managed Care - Dual eligible are excluded. Year 3-4 when Tailored Plans become available Duals eligible for TP will be eligible to choose NC Medicaid Direct or PHP-TP for BH/IDD
15. So do I understand correctly that this will not apply to patients in a SNF for five years?	They will be excluded initially after 90 day stay.
16. I may have missed this part. How will CAP/Children's waivers be handled?	They will be excluded initially. CAP-C waiver is delayed until Tailored Plans are offered in 2021.
17. Once the beneficiary qualifies for a PHP will their coverage automatically be covered for year, verses now the type of plan they can have, can change month to month? Sorry if this is a duplicate not sure I did it right the first time.	Once eligibility is established all 'Mandatory' individuals can only change their PHP with cause during their annual certification period. They will have a 90-day choice period annually that gives them the chance to change without cause. If the individual is an 'Exempt' status, they may change at any time (ex. Tribal member) or return to NC Medicaid Direct. PCP changes are done by the individual contacting the PHP.
18. Will you provide guidance as to where the definition of "medical necessity" is located? (re slide 22)	Medical necessity from the RFP: the North Carolina definition of medical necessity, defined in 10A NCAC 25A.0201

19. In reference to beneficiaries changing their PCP, what are the WITH CAUSE reasons that they can change their PCPs more than once per year?	1. The Member moves out of the PHP Region(s), 2. The PHP does not, because of moral or religious objection, cover a service the Member seeks. 3. The Member needs concurrent, related services that are not all available within a PHP's provider network, and the Member's provider determines receiving services separately would subject the member to unnecessary risk. 4. A Member receiving LTSS would be required to change his or her residential, institutional or employment supports provider based on a change in status from in-network to out-of-network. 5. The Member's complex medical condition(s) would be better served under a different PHP. A Member is considered to have a complex medical condition if the condition could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function. 6. The Member's complex medical condition(s) would be better served under the Medicaid Fee-For-Service/LME/MCO delivery system in the case of a Medicaid Managed Care Member who meets BH I/DD Tailored Plan eligibility (including having a qualifying event, as defined by the Department) prior to launch of the BH I/DD Tailored Plans. 7. A family member becomes newly eligible or redetermined eligible and is enrolled in or chooses a different PHP than the Member. 8. Poor performance of the PHP, as determined by the Department, after evaluation of PHP performance. 9. Other reasons, including poor quality of care, lack of access to covered services or lack of access to providers experienced with meeting specific need, as defined by the Department.
20. Each plan, and patient eligibility, will be found at each of the respective payors websites and NOT NCTracks? Additionally, for clarification, Medicaid will NOT be secondary to any of the Managed Care plans?	NCTracks, correct, if the beneficiary is managed care Medicaid is paying the PHP a capitation payment to provide services. Medicaid will not be a secondary pay source.
21. What are with "WITH CAUSE" reasons?	See the answer to #19 above.
22. How will Skilled Nursing facilities be notified of a member's election or enrollment into a Managed Care Medicaid plan?	NCTracks
23. Will NCTracks remain hub for Medicaid & NCHC benefit plans?	For the Fee For Service, NCTracks and the data warehouse will house claims covered by FFS.
24. Has the department considered the opportunity for Providers to identify currently served beneficiaries for the opportunity to assist in education and easing the burden of transition?	No

25. Can the department define who will be responsible for payment should the beneficiary choose to change PHP during their allotted window for a specific Date of Service?	If the beneficiary is auto-assigned the PHP will not be allowed to be changed until the next month; therefore, the PHP will be responsible for claims during the month they are the beneficiaries PHP.
26. Will enrolled participants be able to still receive care at their local health department for OB/GYN services, immunizations, etc., or will they have to go to the PCP for every medical service?	This is in the RFP, it comes after children's services but doesn't say children's services as part of this statement. The PHP shall not require Members to obtain a referral or prior authorization for Local Health Department services.
27. Will there still be one eligibility look up option like we currently have with CSRA/NCTracks?	Yes, NCTracks
28. I am a local health dept. does this mean we can only see patients that have us listed on the Medicaid card?	If you have a Medicaid ID number you should be able to verify eligibility in NCTracks.
29. So, enrollment limits are up to the pre-paid provider plans?	Yes
30. What if a provider is enrolled with NC Medicaid but not with the new PHP, will they still pay for the services?	In Medicaid Managed Care, providers will contract directly with PHPs to receive reimbursement for treatment and services provided to those enrolled in Medicaid Managed Care. You do not need to contract with a PHP to receive reimbursement for patients remaining in Medicaid Fee-for-Service; you just need to be an enrolled Medicaid provider. PHPs are prohibited from paying out-of-network providers that refused to accept a PHP contract or failed to meet objective quality standards more than 90 percent of the Medicaid FFS rate. This excludes emergency and post-stabilization services.
31. Will we need to credential each provider with each of the four statewide PHP contracts?	Providers will continue to enroll with NC Medicaid using an online application available in NCTracks. To minimize administrative burden to providers, the Provider Data Contractor will supplement this data from NCTracks and submit to the PHPs to make quality determinations during contracting activities. Providers must contract with PHP's in order to receive reimbursement for services under Medicaid Managed Care.

32. Does all of this apply as well to current Out of State enrolled providers?	The Department encourages provider network outreach include out of state providers and providers within 40-45 miles of contiguous state boarder. This is important, in our estimation, to ensure that there will be sufficient patient access within the time/distance access requirements for provider network adequacy. The PHP shall reimburse out-of-state providers (that are also out-of-network) for medically necessary services according to the Medicaid Fee-for-Service rates specified in State Plan Amendments 4.19-A and 4.19-B (Medicaid) and Amendments 7.2.2 and 8.4.3 (NC Health Choice) when the services meet any of the following criteria: a. Are more reasonably available than can be provided by an enrolled in-state provider; or b. The care and services are provided in any one of the following situations: 1. In response to an Emergency Medical Condition; 2. The health of the Member would be endangered if the care and services were postponed until the Member returns to North Carolina; or 3. The health of the Member would be endangered if travel were undertaken to return to North Carolina.
33. Do we have to credential with each individual PHP or will it be certain ones based on region?	A provider may choose to contract with as many PHPs as necessary to support their practice's business needs.
34. Will NCTracks still be the central source for provider credentialing and recipient eligibility verification for the foreseeable future?	Yes
35. Where is a list of providers who are carved out of managed care?	Refer to RFP 30-190029-DHB Section V. Scope of Services. https://files.nc.gov/ncdhhs/30-19029-DHB-1.pdf
36. Are general dental practice offices carved out of managed care?	Refer to RFP 30-190029-DHB Section V. Scope of Services. https://files.nc.gov/ncdhhs/30-19029-DHB-1.pdf
37. We are adding a new PhD Psychologist to our pediatric practice in November. Will we have any problem getting her credentialed and paid by the PHP?	Providers will credential with NC Medicaid using an online application available in NCTracks. This is the same process used today. Providers may contract with PHP's in order to receive reimbursement for services under Medicaid Managed Care.

38. Will private providers also be receiving "direct or pass through payments" due to uncertainty during the transition?	DHHS is working with CMS to get approval for converting current cost settlements for certain providers to directed payments per 42 CFR 438.6(c). These are additional payments made by PHPs to certain providers for a particular service, for which DHHS would reimburse PHPs outside of the prospective PMPM and maternity event capitated rates based on utilization of that particular service. As such, the capitation rates assume continuation of reimbursement consistent with current fee schedules. Any changes to this approach will be reflected in final rates.
39. How will a provider know what their reimbursement rates will be for services/client?	ALL fee schedules will be posted on the DHB website at: https://medicaid.ncdhhs.gov/providers/fee-schedule-index
40. Reimbursement will now be from each PHP (4-5) opposed to one with NCTracks?	Reimbursement for services provided by a provider contracted with a PHP will come from the PHP. FFS providers will be reimbursed through NCTracks.
41. Will the new rate affect the existing Rural Health Clinics rate they are receiving now?	RHC rate reimbursement will be based on the RHC's respective NC Medicaid FFS fee schedule.
42. Will the EMS Cost Report still be filed, or will the change in payment take its place?	FFS EMS cost reports will still be required.
43. I work for a small Occupational Therapy Office for pediatrics, we currently accept Medicaid and are reimbursed by Medicaid, will we now be paid by PHP or by the Medicaid system?	Reimbursement for services rendered to Medicaid only beneficiaries will be paid by PHPs that providers should be contracted with. Reimbursement for services rendered to dually eligible beneficiaries will be paid by Medicaid based on FFS.
44. As far as the rate floor for payment is concerned, does the Medicaid FFS rate as a rate floor apply to all services in Medicaid managed care, including LTSS services?	DHHS will establish rate floors set at FFS levels as allowed by 438.6(c)(1)(iii)(A) for in-network physicians, physician extenders, hospitals and nursing facilities. The rate floor for each FQHC/RHC rate will be their respective Medicaid FFS Fee Schedule rate, and rates for all ancillary services (i.e. radiology, etc.) will be the based on the Medicaid Physician fee schedule.
45. Where can we locate information on how to contact the four insurances to become in network?	For more information on how to become a PHP network participating provider, please see health plan contact information provided on our website at https://medicaid.ncdhhs.gov/health-plan-contact-information.
46. Will the four PHPs awarded contracts be active in all regions of the state?	Four statewide PHP contracts were awarded and will offer Standard Plans in all regions of North Carolina. One regional PHP contract was awarded to a provider-led entity which will offer plans in Regions 3 and 5.

47. We have contacted some of PHP and they do not know what is going on--when will there be a definitive plan on their part or what is your cut off for the PHP to know what is going on and relay that to providers?	Following award of the PHP contracts the Department has been working very closely with the health plans. These efforts have included a robust PHP on-boarding that encompassed several weeks, as well as regularly scheduled routine meetings on an array of topics including but not limited to submission of their deliverables as well as provider education and other Departmental administrative oversight meetings. Due to the general nature of this question, it is hard to assess the nature of the inquirer's concerns that were presented to the health plan(s) and what specifically the health plans were unable to address. Please send specificity regarding this inquiry to Medicaid.Transformation@dhhs.nc.gov.
48. Can you review the names of the five Managed Care again, (for example BCBS of NC, UHC) joined the Webinar late?	• AmeriHealth Caritas North Carolina, Inc. • Blue Cross and Blue Shield of North Carolina • UnitedHealthcare of North Carolina, Inc. • WellCare of North Carolina, Inc. A regional PHP contract was awarded to Carolina Complete Health, a provider-led entity, which will offer plans in Regions 3 and 5.
49. How does a provider contact the PHP to begin the contracting process? Are there links listed on your website?	Providers may choose to reach out directly to the PHPs that have been awarded Prepaid Health Plan Contracts. • Please refer to the NC Medicaid Managed Care Prepaid Health Plan Contract Awards Fact Sheet. • PHP Contact Information may be accessed here.
50. Will the PHP's be contacting providers, or do we need to reach out to them?	As PHPs begin receiving the State Medicaid provider files, they will reach out to providers regarding their interest in provider network contracting opportunities. However, Providers may choose to reach out directly to the PHPs that have been awarded Prepaid Health Plan Contracts. • Please refer to the NC Medicaid Managed Care Prepaid Health Plan Contract Awards Fact Sheet. • PHP Contact Information may be accessed here.
51. Where can we get contact information for starting contract negotiations for each of the PHP's?	PHP Contact Information may be accessed here.
52. How do you contact the PHP's if they haven't contacted your office?	Providers may choose to reach out directly to the PHPs that have been awarded Prepaid Health Plan Contracts. • Please refer to the NC Medicaid Managed Care Prepaid Health Plan Contract Awards Fact Sheet. • PHP Contact Information may be accessed here.
53. Where do you find the information to contact those four PHPs?	Providers may choose to reach out directly to the PHPs that have been awarded Prepaid Health Plan Contracts. • Please refer to the NC Medicaid Managed Care Prepaid Health Plan Contract Awards Fact Sheet. • PHP Contact Information may be accessed here.

54. Where can providers find contact information for the PHP's in order to initiate becoming in network with them?	PHP Contact Information may be accessed here.
55. Is there contact information for the PHPs available on the website?	PHP Contact Information may be accessed here.
56. Where can we find contact info for all the PHP's?	PHP Contact Information may be accessed here.
57. My health department is in region 6. Should we enroll w/ the regional plan, Carolina Complete Health, Inc. for those transient population who may end up getting service from my LHD?	The Local Health Department will need to make a business decision about the PHPs with whom they contract. If historical patient demographics and utilization patterns indicate that patients from surrounding areas (e.g., Regions 3 & 5) are accessing services at that provider location (i.e., Region 6), than it may be in your interest to contract with the provider led entity, Carolina Complete Health.
58. What specific rules will deter PHPs from contracting with a sole source provider for patient supplies, protecting patient choice and access to durable medical equipment and supplies?	PHPs must contract with "any willing qualified provider." In accordance with Section 5.(6)d. of Session Law 2015-245, except as otherwise allowed under the Contract, the PHP shall not exclude eligible providers from its network except under the following circumstances: a. When a provider fails to meet Objective Quality Standards; or b. Refuses to accept network rates (which shall not be lower than any applicable rate floors). For more information on these PHP contracting requirements, please reference the Prepaid Health Plan Request for Proposal (PFP RFP) page 152 of 221 located on our website.
59. If a provider is already enrolled with NC Medicaid or Health Choice will they also need to enroll with each PHP or will this happen automatically?	No, there is no automatic process for network participation with a Prepaid Health Plan. As PHPs begin receiving the State Medicaid provider files, they will reach out to providers regarding their interest in provider network contracting opportunities. However, Providers may choose to reach out directly to the PHPs that have been awarded Prepaid Health Plan Contracts. • Please refer to the NC Medicaid Managed Care Prepaid Health Plan Contract Awards Fact Sheet. • PHP Contact Information may be accessed here
60. UHC Closed Network, well NC Medicaid help existing providers help, with becoming enrolled in this closed network?	None of the Prepaid Health Plans (PHPs) that have been awarded Medicaid managed care contracts have "closed networks." If providers encounter problems initiating the contracting process due to "closed networks," please contact the Division of Health Benefits Provider Ombudsman at Medicaid.ProviderOmbudsman@dhhs.nc.gov.

	PHPs must contract with "any willing qualified provider." For additional information on provider contracting with PHPs, please see policy paper entitled Supporting Provider Transition to Medicaid Managed Care published May 2018. There is also an earlier webinar on the same topic that can be found here.
61. Some PHP's are requiring that contracts are signed by April 30th. Others do not have their contracts ready. Why is here such a difference in the PHP contracts?	There is no State requirement for provider contract signings.
	Please know that the State is in the process of approving all PHP provider contracts. Some plans may have made a business decision to wait on contracting with providers until such time as their contracts are completely approved by the State. This avoids having to go back to providers with amendments to previously executed contracts.
	That being said, providers may sign PHP contracts that have not been officially approved as long as they understand that the PHP may come back with contract amendments following State approval.
62. Do you need to sign contracts with all four PHP's?	It is important for providers to remember that Medicaid beneficiaries will now have "choice" in selecting their health plan as well as their Advanced Medical Home/Primary Care Physician (AMH/PCP). Therefore, providers that limit their PHP network participation should anticipate only seeing enrolled members that chose that/those particular health plan/s.
	And, for those Medicaid beneficiaries that do not select a PHP, they will be auto-assigned to a PHP according to the State's algorithm. Providers not participating in those plans should not expect to see members.
	For more information on beneficiary plan selection and the auto-assignment process please revisit the webinar slide deck and recording entitled Provider Transition to Medicaid Managed Care.
63. Are all PHPs required to contract only with large entities? Does DHHS oversee if there is discrimination?	PHPs must contract with "any willing qualified provider."
	In accordance with Section 5.(6)d. of Session Law 2015-245, except as otherwise allowed under the Contract, the PHP shall not exclude eligible providers from its network except under the following circumstances:
	c. When a provider fails to meet Objective Quality Standards; or
	d. Refuses to accept network rates (which shall not be lower than any applicable rate floors).
	For more information on these PHP contracting requirements, please reference the Prepaid Health Plan Request for Proposal (PFP RFP) page 152 of 221 located on our website.

	If providers encounter problems initiating the contracting process due to perceived discrimination in the contracting process, please contact the Division of Health Benefits Provider Ombudsman at Medicaid.ProviderOmbudsman@dhhs.nc.gov.
64. Are providers obligated to contract with all PHP's? What happens if a provider does not choose to contract with a particular PHP?	No, providers are not obligated to contract with all PHPs.
	In making business decisions that limit PHP provider network participation, providers/practices need to consider how their patient volume and payor (Medicaid) mix will be impacted.
	Providers that limit their PHP network participation will be considered out-of-network and will receive reduced reimbursement for treatment (presuming prior approval rules are followed) and services provided to members that are affiliated or enrolled in PHPs for which they are not a participating provider.
	Providers should familiarize themselves with out-of-network payment and reimbursement situations specific to: transition of care, emergency and post-stabilization services. Please refer to the Prepaid Health Plan Request for Proposal (PFP RFP) page 166 of 221 located on our website.
65. How will specialists be affected? Does each provider need to contract with the PHPs? Will each PHP have different rules regarding referrals and authorizations? Is there help for provider enrollment?	Yes, specialists are impacted by the transition to Medicaid managed care.
	Providers that limit their PHP network participation will be considered out-of-network and will receive reduced reimbursement for treatment (presuming prior approval rules are followed) and services provided to members that are affiliated or enrolled in PHPs for which they are not a participating provider.
	Providers should familiarize themselves with out-of-network payment and reimbursement situations specific to: transition of care, emergency and post-stabilization services. Please refer to the Prepaid Health Plan Request for Proposal (PFP RFP) page 166 of 221 located on our website.
	The Department has worked hard to mitigate administrative burden for providers. As previously covered in earlier design documents and policy papers, considerable effort was made to ease administrative burden to support provider transition to managed care. Administrative simplification efforts have included: • Standardizing and simplifying administrative processes across PHPs wherever appropriate; • Incorporating a centralized and streamlined provider enrollment and credentialing process;

	• Ensuring transparent and fair payments for providers; • Establishing a single statewide drug formulary that all PHPs will be required to utilize; • Requiring PHPs to cover the same services as Medicaid fee-for-service (with exception of services carved out of Medicaid managed care); • Using the Department's definition of "medical necessity" when making coverage decisions; and • Using standard prior authorization forms.
	Yes, assistance is available regarding provider enrollment. Please contact the Division of Health Benefits Provider Ombudsman at Medicaid.ProviderOmbudsman@dhhs.nc.gov.
66. An early slide indicated that the timeline for PHP contracting is Summer 2019. Many providers are already receiving contracts from CINs and PHPs and are being pressured to sign by the end of April, without Tier 3 payments. What should they do?	There is no State requirement for provider contract signings by a particular date.
67. The state needs to have consistent guidelines across all PHPs on limiting Medicaid panels- I have heard from several big city pediatricians who will not sign up for any contracts prior to launch unless they are able to limit their panel.	Thank you for sharing this concern. Please know that DHHS is considering this issue and will release guidance when a decision is made.
68. I am a sole practitioner doing mental health OPT with less than 10 clients. How do I go about contracting/enrolling with the PHPs and is the credentialing process different from the enrollment/contracting process or is it all one process?	Providers seeking network participation with PHPs may obtain contact Information for contracting representatives for each of the PHPs here.
	Today, a provider must be enrolled, through the North Carolina Medicaid provider enrollment process in order to be paid for treatment and services delivered to Medicaid beneficiaries. Similarly, in managed care, a provider must also be a Medicaid enrolled provider to deliver services (whether those services are in-network or out-of-network). Under managed care, providers will enroll in North Carolina Medicaid just like the current enrollment process.

	The centralized credentialing and recredentialing policies as designed are intended to be uniformly applied by all health plans. To minimize administrative burden on providers as NC Medicaid transitions to managed care, the Provider Data Contractor (PDC), WiPro, will supplement the state's existing provider data to support the PHP's ability to make their objective quality determinations.
	As we indicated in earlier policy papers, the Department will be establishing a nationally recognized, third party Credentials Verification Organization (CVO) solution. The CVO will not be operational when Medicaid managed care launches. However, during this transition period, the Department will ensure providers still experience a seamless and largely invisible credentialing process as they transition to managed care.
	Additional detail surrounding provider credentialing is available through MCT 104 – Provider Policies, NC Medicaid Managed Care 104 at the bottom of this page.
69. If a provider is already contracted with say, BCBS of NC, is there a separate credentialing/contract for the BCBS of NC PHP?	Yes, there should be a separate contract addenda (including fee schedule, and other value based payment arrangements) for NC Medicaid Managed Care. Contact the Provider Services Department and inquire how to add NC Medicaid to your existing contract.
70. I am confused. So Providers should contract with every PHP that their consumers are under? or that would be considered out of network?	Yes, that is correct. Providers that limit their PHP network participation will be considered out-of-network and will receive reduced reimbursement for treatment (presuming prior approval rules are followed) and services provided to members that are affiliated or enrolled in PHPs for which they are not a participating provider.
	Providers should familiarize themselves with out-of-network payment and reimbursement situations specific to: transition of care, emergency and post-stabilization services. Please refer to the Prepaid Health Plan Request for Proposal (PFP RFP) page 166 of 221 located on our website.
71. Will and if so when do providers that are currently contracted with NCTracks and CSC need to re-credential?	The provider re-credentialing date will not change for currently enrolled Medicaid providers.
	For additional information on Medicaid managed care credentialing and recredentialing processes, please refer to the Prepaid Health Plan Request for Proposal (PFP RFP) page 154 of 221.
72. So to understand this correctly, if we do not have a contract with a particular PHP, we would be out of network for the pt and receive no reimbursement?	Yes, that is correct. Providers that limit their PHP network participation will be considered out-of-network and will receive reduced reimbursement for treatment and services provided to members that are affiliated or enrolled in PHPs for which they are not a participating provider.

	Providers should familiarize themselves with out-of-network payment and reimbursement situations specific to: transition of care, emergency and post-stabilization services. Please refer to the Prepaid Health Plan Request for Proposal (PFP RFP) page 166 of 221 located on our website.
73. Is it true providers would be best served by completing PHP/CIN contracting prior to the May 18 deadline for submitting provider panels for printed enrollment brochures.	There is no State requirement for provider contract signings to be completed by a particular date.
	Assurances of network adequacy and capacity are an ongoing oversight and monitoring function that will be performed by the Division of Health Benefits (DHB). DHB will be asking the PHPs to submit network adequacy reports as early as June 2019 and then at varying intervals during the summer of 2020 and again through go-live and beyond. PHPs must be able to demonstrate they can meet the access and availability standards to ensure the Medicaid beneficiaries can receive services.
	After Medicaid managed care launch, as indicated in the PHP RFP (see page 158 of 221), the Medicaid health plans must meet federal statutory requirements to update paper directories at least monthly and shall update electronic versions no later than every ten (10) business days after the PHP receives updated provider information.
74. If providers are receiving contracts from PHP's but have attest to Tier 3 - when will the contracts include the CM addition fees and incentive payments?	We recommend that providers work through their PHP contracting representative to address this issue. As soon as AMH Tier 3 Attestation is completed, providers should be able to contact the health plan to obtain and negotiate contract addenda/fee schedules for AMH certification/Tier status that is attained.
	Please see previously released AMH Frequently Asked Questions where there was additional detail provided regarding the PHP contracting process.
75. What is the deadline for the PHPs to PROVE their network adequacy?	Assurances of network adequacy and capacity are an ongoing oversight and monitoring function that will be performed by the Division of Health Benefits (DHB). DHB will be asking the PHPs to submit network adequacy reports as early as June 2019 and then at varying intervals during the summer of 2020 and again through go-live and beyond.
76. Will Billing Services also need to sign up with the new Payers?	Yes, is the short answer to this question.
	Providers that are considering using billing agents need to review PHP contracts carefully and ask questions of PHP contracting representatives about subcontracting requirements for billing agents. It is possible that PHPs may already have billing agents that meet their requirements and they will only accept claims submissions from those vendors.
	Providers may choose to remain Medicaid fee-for-service provider only.

	However, it is important to note that nearly 1.6 million Medicaid beneficiaries will be transitioning to managed care later this year and early next year. It will be important for providers to assess their patient volume and payer mix in order to make an informed business decision.
77. Does a provider have to join a managed care or can they stay on Medicaid?	Providers that do not become network participating providers with PHPs should anticipate reduced revenue from Medicaid managed care. Some Medicaid revenue could be anticipated from those Medicaid beneficiaries that are exempt or excluded from enrolling in Medicaid managed care and remain in the Medicaid fee-for-service program.
	For a complete listing of eligible Medicaid populations, please refer to the Prepaid Health Plan Request for Proposal (PFP RFP) located on our website. In addition, the NC Medicaid Managed Care Prepaid Health Plan Contract Awards Fact Sheet may also provide useful information for providers.
	Assurances of network adequacy and capacity are an ongoing oversight and monitoring function that will be performed by the Division of Health Benefits as well as its contracted external quality review vendor (EQRO).
	At least initially, PHPs must file their Network Access Plan thirty (30) days after Contract Award; as specified by the Department; annually and within thirty (30) days of a significant change. In addition, each PHP must demonstrate capacity to serve the expected enrollment on an entire regional basis.
78. But there has to be a *Deadline* for network adequacy- What is it?	Assurances of network adequacy and capacity are an ongoing oversight and monitoring function that will be performed by the Division of Health Benefits (DHB). DHB will be asking the PHPs to submit network adequacy reports as early as June 2019 and then at varying intervals during the summer of 2020 and again through go-live and beyond.
	In addition, each PHP must comply and cooperate with EQRO network adequacy validations and activities.
	For a complete overview of the North Carolina Medicaid Managed Care Network Adequacy Standards please reference the PHP RFP Section VII. Attachment F (page 55 of 121). In addition, providers may also reference the PHP RFP Section V. Scope of Services on Provider Network and Provider Network Management (beginning on page 145 of 221).
79. Same Deadline to show network adequacy for the Nov. 2019 vs Feb 2020 launch? (i.e., do the	Yes, the statewide PHPs and regional PHP will demonstrate compliance with network adequacy standards on the same schedule and at the same time.

parts of the state starting later in Feb 2020 have longer to decide which PHP to sign up for?)	Assurances of network adequacy and capacity are an ongoing oversight and monitoring function that will be performed by the Division of Health Benefits (DHB). DHB will be asking the PHPs to submit network adequacy reports as early as June 2019 and then at varying intervals during the summer of 2020 and again through go-live and beyond.
	Providers should plan accordingly to initiate the contracting process with PHPs. The process for completing credentialing, reviewing contracts and related fee schedules and value-based payment arrangements and subsequent negotiation takes time. We encourage providers to make business decisions that will support their readiness for roll out at each phase of implementation to ensure they maintain patients/Medicaid revenue.
	For more information on beneficiary plan selection and the auto-assignment process please revisit the webinar slide deck and recording entitled Provider Transition to Medicaid Managed Care.
	For a complete overview of the North Carolina Medicaid Managed Care Network Adequacy Standards please reference the PHP RFP Section VII. Attachment F (page 55 of 121). In addition, providers may also reference the PHP RFP Section V. Scope of Services on Provider Network and Provider Network Management (beginning on page 145 of 221).
80. What would happen if we choose not to sign up with any of the PHPs?	Certainly, providers need to make informed business decisions about becoming network participating providers with the pre-paid health plans (PHPs).
	With nearly 1.6 million Medicaid beneficiaries transitioning to managed care later this year and early next year, it will be important for providers to assess their patient volume and payer mix. If a provider does not see patients that rely on Medicaid coverage and Medicaid revenue is inconsequential , then perhaps it would not be prudent to contract with PHPs.
	However, if providers are treating and/or providing services to Medicaid beneficiaries that will be transitioning to managed care, want to continue to do so, and have a high percentage of Medicaid revenue in their payor mix, then contracting with PHPs may be necessary. Providers that do not become network participating providers with PHPs should anticipate little to no revenue from Medicaid managed care. Some Medicaid revenue could be anticipated from those Medicaid beneficiaries that are exempt or

	excluded from enrolling in Medicaid managed care and remain in the Medicaid fee-for-service program.
	For a complete listing of eligible Medicaid populations, please refer to the Prepaid Health Plan Request for Proposal (PFP RFP) located on our website. In addition, the NC Medicaid Managed Care Prepaid Health Plan Contract Awards Fact Sheet may also provide useful information for providers.
81. For behavioral health will Medication Management ant therapy fall under the standard plan?	Yes
82. As it relates to Behavioral health care/mental health services for SPMI, how will this new move towards PHPs affect the current MCO provider? Will the MCO still oversee MH/IDD/SA services?	They will oversee MH/IDD/SUD services for those identified as Tailored Plan eligible. For the services that are offered through the TP, the TP, not the LME MCOs will provide the oversight of those providers contracted with them. Provider will have to contract with the TP to continue to serve their SPMI beneficiaries. Beneficiaries enrolling in Standard Plans will receive their behavioral health services through the Standard Plan.
83. Can you define "behavioral"? For example, we are a pediatrics practice...do you consider patients with an ADHD/ADD dx to be "behavioral" need?	The term behavioral health is an all-inclusive term that usually includes mental health and substance use services. Generally, the IDD population is called out separately and isn't included as part of the BH "package"
84. Does the LME cover all aspect of the care for the Medicaid beneficiaries unlike it does today?	When they become Tailored Plans. Until that time, physical health and pharmacy care needs will continue to be covered under FFS for those members who are determined to be tailored plan eligible. Beneficiaries enrolling in Standard Plans will receive their physical and behavioral health services through the Standard Plan. Beneficiaries will not be enrolled in both a Standard Plan and an LME-MCO.
85. 5How will children move between moderate and severe mental health plans, especially foster children? It seems like this will create another barrier to care if the PCP is not signed up for the tailored plan.	Tailored Plans will not have a closed network for physical health providers. Individuals who are Tailored Plan eligible may choose to enroll in the Standard Plan. There will be special consideration for the Foster Care population, but that design work has not begun.
86. Can you explain how this affects Substance Abuse Comprehensive Outpatient	The intent is to cover these services in both the Standard Plan and the Tailored Plan. However, SACOT is currently the only one that is covered in both plans.

Program and Substance Abuse Intensive Outpatient Program enhanced services?	
87. When does the clock for the 4-year exclusion for LME/MCO operation of Tailored Plans start to run - from July 2021 or some earlier date?	July 1, 2021
88. Will specialized behavioral services such as Trauma Focused Cognitive Behavioral Therapy, which is currently reimbursed at a higher rate than standard psychotherapy with the LME/MCO continue to be covered with the LME/MCO as a tailored plan or the w/PHP?	This example is a treatment modality for therapy so it would be coverable by both plans.
89. I am a Licensed Independent practitioner as an LPC with Medicaid and NC Health Choice. I provide services in Guilford and Randolph counties. When will I start billing the PHP and not the LME MCO or NCTracks?	It will depend on if the beneficiary is in Tailored Plan eligible or enrolled in the Standard Plan. You treat beneficiaries in SP region 2 which goes live in November 2019. If you are serving individuals who are enrolled in the SP, you will need to have a contract with the plan that beneficiary is enrolled in. There are 4 statewide PHP plans that impact your region. You will begin to bill the appropriate SP on Nov. 1, 2019. For those individuals who are TP eligible and do not want to move to the SP, you will continue to bill the LME MCO or NCTracks as you do today until TP go live.
90. We are a DME provider that provides power wheelchairs. Will these new plans affect us or are these plans for behavioral health patients?	Standard Plans are responsible for DME. For individuals who are Tailored Plan eligible prior to go live will continue to bill FFS. After go live, they will bill the Tailored Plan.
91. State Psychiatric Hospitals obtain authorization for acute services, via the LME/MCO; Medicaid claims are billed to the LME/MCO and payment received from LME/MCO...is this changing?	It will depend on if the beneficiary is in Tailored Plan eligible or enrolled in the Standard Plan. DSOHF will contract with both the Standard plan and the Tailored Plan.
92. Will this new Managed Care, phase out the MCO/LME's? Will Outpatient Mental Health Providers still be under NCTracks?	All Medicaid providers will be enrolled in NCTRACKS. LME-MCOs will submit RFAs to become Tailored Plans.

93. To be clear, the new Payers that have been chosen as Standard Plans will do away with the current LME/MCO structure?	LME-MCOs will submit RFAs to become Tailored Plans. Prior to Tailored Plan go live, LME-MCOs will still provide services for individuals who are Tailored Plan eligible who are eligible for services under the LME-MCO. Populations that are currently excluded from the LME-MCOs will continue to receive Behavioral Health Services and medical services through FFS. Beneficiaries enrolled in Standard Plans will not also be enrolled with an LME-MCO.
94. Will substance abuse services be covered under standard plan, and will PHPs include this service?	Most Substance Abuse Services will be covered by the Standard Plans.
95. Where does approval/roll-out of the new Innovations 1915 Waiver fall on this timeline?	The Innovations waiver renewal is still under review by CMS. The target date for implementation of the renewal is July 1, 2019.
96. How will Mental Health Beneficiaries know what plan to enroll in?	DHB has contracted with an Enrollment Broker who will assist beneficiaries in enrolling in a plan.
97. Hello - The guidance from NC Medicaid has been clear that the PHPs will be required to cover all Medicaid services that are covered today. Yet, all of the Medicaid clinical policies were updated recently to direct recipients to contact their PHP for coverage criteria.	Except for a limited number of policies, the current Medicaid policies are to serve as the floor for coverage. They can expand on that coverage, but they must cover what is in our policy. That is why beneficiaries must check with their PHP for exact coverage. Also, the PHP may have a policy that requires PA and Medicaid does not require PA for that service, for example. Or the reverse may occur.
98. This seems to indicate that the PHPs will have a large amount of discretion in coverage. Can you speak more to how the department will guide coverage requirements?	With respect to service authorizations, and as required by federal law, the Department will require PHPs to ensure all decisions that deny a service authorization request, or limit a service in amount, duration or scope that is less than requested, be made by a licensed provider who has the appropriate clinical expertise in treating the enrollee's condition or disease. PHPs also will be prohibited from setting benefit limits that are more stringent than in the current fee-for-service program, consistent with federal requirements.
99. Will providers still submit for authorization through Choice PA or will we do that through the particular PHP?	Starting Nov. 1, 2019, for Medicaid and NCHC beneficiaries in regions 2 and 4 who are part of the population who enroll in a Standard Plan, out-patient therapy PA requests will need to be submitted to the beneficiary's PHP (or its PA vendor) not through ChoicePA. Any PAs approved by ChoicePA before Nov. 1 will be transitioned to the PHPs and will be honored for 90 days. This same process will play out again in regions 1, 3, 5 & 6 in Feb 2020. PA requests for beneficiaries receiving services through a CDSA will continue to be submitted through ChoicePA because this population is "carved out" of managed care. PA requests for Medicaid and NCHC beneficiaries who are part of the

	population who will enroll in Tailored Plans, should continue to be submitted through ChoicePA until PHP contracts for Tailored Plans are awarded beginning in 2021.
100. Do any of these upcoming changes affect Ambulance Transports?	This seems to be out of context; what upcoming changes?
101. Will prior authorization remain the same or change when implementation of PHP's. For example, currently PT/OT/ST's use Choice PA to submit their information for a prior approval of services. Will this remain or change with this transition?	Starting Nov. 1, 2019, for Medicaid and NCHC beneficiaries in regions 2 and 4 who are part of the population who enroll in a Standard Plan, out-patient therapy PA requests will need to be submitted to the beneficiary's PHP (or its PA vendor) not through ChoicePA. Any PAs approved by ChoicePA before Nov. 1 will be transitioned to the PHPs and will be honored for 90 days. This same process will play out again in regions 1, 3, 5 & 6 in Feb 2020. PA requests for beneficiaries receiving services through a CDSA will continue to be submitted through ChoicePA because this population is excluded or "carved out" of managed care. PA requests for Medicaid and NCHC beneficiaries who are part of the population who will enroll in Tailored Plans, should continue to be submitted through ChoicePA until PHP contracts for Tailored Plans are awarded beginning in 2021.
102. How does this apply to hospice?	In the first year of managed care implementation, all PHPs will be required to cover all State Plan LTSS, including home health, hospice, home infusion therapy, private duty nursing and durable medical equipment. Medicaid only Hospice recipients will be enrolled in Managed Care.
103. How will hospices be included in Medicaid Managed Care?	In the first year of managed care implementation, all PHPs will be required to cover all State Plan LTSS, including home health, hospice, home infusion therapy, private duty nursing and durable medical equipment. Medicaid only Hospice recipients will be enrolled in Managed Care.
104. Will prior authorizations still be submitted to choice pa?	Starting Nov. 1, 2019, for Medicaid and NCHC beneficiaries in regions 2 and 4 who are part of the population who enroll in a Standard Plan, out-patient therapy PA requests will need to be submitted to the beneficiary's PHP (or its PA vendor) not through ChoicePA. Any PAs approved by ChoicePA before Nov. 1 will be transitioned to the PHPs and will be honored for 90 days. This same process will play out again in regions 1, 3, 5 & 6 in Feb 2020. PA requests for beneficiaries receiving services through a CDSA will continue to be submitted through ChoicePA because this population is "carved out" of managed care. PA requests for Medicaid and NCHC beneficiaries who are part of the population who will enroll in Tailored Plans, should continue to be submitted through ChoicePA until PHP contracts for Tailored Plans are awarded beginning in 2021.
105. Will all PHPs be required to follow current Medicaid Clinical Coverage policies or will each	See the answers to questions 97 and 98.

PHP develop their own policies?	
106. How is developmental disability defined?	80 FR 44795 Developmental disability. The term “developmental disability” means a severe, chronic disability of an individual that: (1) Is attributable to a mental or physical impairment or combination of mental and physical impairments; (2) Is manifested before the individual attains age 22; (3) Is likely to continue indefinitely; (4) Results in substantial functional limitations in three or more of the following areas of major life activity: (i) Self-care; (ii) Receptive and expressive language; (iii) Learning; (iv) Mobility; (vi) Self-direction; (vii) Capacity for independent living; and Start Printed Page 44809 (viii) Economic self-sufficiency. (5) Reflects the individual's need for a combination and sequence of special, interdisciplinary or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated. (6) An individual from birth to age nine, inclusive, who has a substantial developmental delay or specific congenital or acquired condition, may be considered to have a developmental disability without meeting three or more of the criteria described in paragraphs (1) through (5) of this definition, if the individual, without services and supports, has a high probability of meeting those criteria later in life.
107. How will prescriptions be covered?	Each managed care health plan will cover prescription drugs as a part of their pharmacy benefit.
108. What services might be "carved out" by PHPs for managed care?	Individuals who are dually eligible, participants in CAP/DA and CAP/C will not be enrolled in managed care in years 1-4. Participants in the Program of All-Inclusive Care for the Elderly (PACE) are permanently carved out; Medically Needy and individual residing in State operated facilities will not be enrolled in managed care.
109. I see that CAP/C and CAP/DA beneficiaries are excluded from Managed Care. What does this transition mean for home care agencies providing Personal Care Services (PCS)?	CAP/C and CAP/DA participants will not enroll in managed care in years 1-4. Additionally, individuals who are dual eligible will not be enrolled in Managed care in years 1-4. Medicaid Only beneficiaries receiving state plan services will be enrolled in Managed Care. Medicaid Only beneficiaries receiving PCS will be enrolled in Managed care and PCS providers will bill PHPs. Agencies providing PCS will need to enroll with PHP to continue providing services to beneficiaries enrolled in managed care.

110. When will the providers (acute care hospitals) receive a copy of the individual UM policies?	After approval by the Department.
111. Does this change effect Skilled Nursing Care Facilities?	Medicaid Only beneficiaries who have been in Skilled nursing facilities less than 90 days will enrolled in Managed care.
112. I haven't heard much about how this affects Early Intervention services through agencies such as CDSA. Is the assumption that those services will transition based on which program they are insured under?	Services provided by Child Development Service Agencies (CDSAs) are excluded or “carved out” of managed care.
113. How does this affect medical transportation?	NEMT?
114. What changes can Adult Day Health programs expect who serve CAP/DA recipients?	Adult Day health programs will continue to serve CAP/DA participants and bill as a fee for service.
115. One of the slides mentioned a delay or temporary exclusion for long term care for the transition. Can you provide more detail on this topic for long term care?	In the first year of managed care implementation, all PHPs will be required to cover all State Plan LTSS, including nursing facilities for up to 90 consecutive days, home health, personal care, hospice, home infusion therapy, private duty nursing and durable medical equipment. Individuals who are dually eligible, participants in CAP/DA and CAP/C will not be enrolled in managed care in years 1-4; individuals with >90 days stay in nursing facility will not be enrolled in managed care. Participants in the Program of All-Inclusive Care for the Elderly (PACE) are permanently carved out; Medically Needy and individual residing in State operated facilities.
116. We are a hospice, home health agency, and have a palliative care physician practice. I am most interested in how our PC physicians will be required to get authorization to perform home visits or hospital visits.	The MD must enroll with each plan that covers their beneficiaries, then follow their policy for what services need prior authorization.
117. Who can we contact regarding new adult routine benefits and the plans that will cover this benefit?	Adult wellness is required by the RFP. Check with each PHP for the full extent of their coverage benefit beyond that.

118. Will the prior authorization process that is in effect with Medicaid and Choice PA required currently still be a requirement moving forward with the PHP's?	Starting Nov. 1, 2019, for Medicaid and NCHC beneficiaries in regions 2 and 4 who are part of the population who enroll in a Standard Plan, out-patient therapy PA requests will need to be submitted to the beneficiary's PHP (or its PA vendor) not through ChoicePA. Any PAs approved by ChoicePA before Nov. 1 will be transitioned to the PHPs and will be honored for 90 days. This same process will play out again in regions 1, 3, 5 & 6 in Feb 2020. PA requests for beneficiaries receiving services through a CDSA will continue to be submitted through ChoicePA because this population is "carved out" of managed care. PA requests for Medicaid and NCHC beneficiaries who are part of the population who will enroll in Tailored Plans, should continue to be submitted through ChoicePA until PHP contracts for Tailored Plans are awarded beginning in 2021.
119. How does this program affects community pharmacies right now?	Each managed care health plan will include a pharmacy benefit which is required to align with the NC Medicaid PDL and pharmacy clinical coverage criteria.
120. Will there be any webinars/training on how this will affect Skilled nursing facilities?	Yes, Medicaid will provide additional information in a number of formats which will include webinars and training.
121. Will NCTracks still be used for submitting auths or will each plan have its own way of doing authorizations?	Starting Nov. 1, 2019, for Medicaid and NCHC beneficiaries in regions 2 and 4 who are part of the population who enroll in Standard Plans, DMEPOS PA requests will need to be submitted to the beneficiary's PHP (or its PA vendor) not through NCTracks. Any PAs approved by NCTracks before Nov. 1 will be transitioned to the PHPs and will be honored for 90 days. This same process will play out again in regions 1, 3, 5 & 6 in Feb 2020. PA requests for beneficiaries who are dually eligible for Medicare and Medicaid, if an item is not covered by Medicare, and Medicaid requires PA, should still be submitted through NCTracks because this population is "carved out" of managed care. PA requests for Medicaid and NCHC beneficiaries who are part of the population who will enroll in Tailored Plans, should continue to be submitted through NCTracks until PHP contracts for Tailored Plans are awarded beginning in 2021.

122. Will Prior Authorizations for therapy services still be handled through ChoicePA (CCME) or via each PHP specifically?	Starting Nov. 1, 2019, for Medicaid and NCHC beneficiaries in regions 2 and 4 who are part of the population who enroll in a Standard Plan, out-patient therapy PA requests will need to be submitted to the beneficiary's PHP (or its PA vendor) not through ChoicePA. Any PAs approved by ChoicePA before Nov. 1 will be transitioned to the PHPs and will be honored for 90 days. This same process will play out again in regions 1, 3, 5 & 6 in Feb 2020. PA requests for beneficiaries receiving services through a CDSA will continue to be submitted through ChoicePA because this population is "carved out" of managed care. PA requests for Medicaid and NCHC beneficiaries who are part of the population who will enroll in Tailored Plans, should continue to be submitted through ChoicePA until PHP contracts for Tailored Plans are awarded beginning in 2021.
123. I wanted to clarify about Skilled Nursing Facilities. Did I understand that they are excluded for up to five years meaning that can opt to enroll during that time or not enroll? Is that right?	Individuals who are dually eligible, participants in CAP/DA and CAP/C will not be enrolled in managed care in years 1-4. Participants in the Program of All-Inclusive Care for the Elderly (PACE) are permanently carved out; Medically Needy and individual residing in State operated facilities will not be enrolled. Medicaid Only Individuals with >90 days stay in nursing facility will not be enrolled in managed care. Medicaid only Individual with less than 90 day stay (short term placements) will be enrolled in Managed Care.
124. Will we still be getting our Prior Approvals through NCTracks?	Starting Nov. 1, 2019, for Medicaid and NCHC beneficiaries in regions 2 and 4 who are part of the population who enroll in Standard Plans, DMEPOS PA requests will need to be submitted to the beneficiary's PHP (or its PA vendor) not through NCTracks. Any PAs approved by NCTracks before Nov. 1 will be transitioned to the PHPs and will be honored for 90 days. This same process will play out again in regions 1, 3, 5 & 6 in Feb 2020. PA requests for beneficiaries who are dually eligible for Medicare and Medicaid, if an item is not covered by Medicare, and Medicaid requires PA, should still be submitted through NCTracks because this population is "carved out" of managed care. PA requests for Medicaid and NCHC beneficiaries who are part of the population who will enroll in Tailored Plans, should continue to be submitted through NCTracks until PHP contracts for Tailored Plans are awarded beginning in 2021.

125. For DME, how will prior approvals be done? currently they are thru NCTracks, will this change to each PHP?	Starting Nov. 1, 2019, for Medicaid and NCHC beneficiaries in regions 2 and 4 who are part of the population who enroll in Standard Plans, DMEPOS PA requests will need to be submitted to the beneficiary's PHP (or its PA vendor) not through NCTracks. Any PAs approved by NCTracks before Nov. 1 will be transitioned to the PHPs and will be honored for 90 days. This same process will play out again in regions 1, 3, 5 & 6 in Feb 2020. PA requests for beneficiaries who are dually eligible for Medicare and Medicaid, if an item is not covered by Medicare, and Medicaid requires PA, should still be submitted through NCTracks because this population is "carved out" of managed care. PA requests for Medicaid and NCHC beneficiaries who are part of the population who will enroll in Tailored Plans, should continue to be submitted through NCTracks until PHP contracts for Tailored Plans are awarded beginning in 2021.
126. If the excluded list is not covered under managed care, will those services fall under original Medicaid?	Yes
127. Has the appeal process with the PHPs been completed? If not, when will that period end? Concerns are with making sure that the PHP players do not change - and that we have all the available contracts from all applicable PHPs.	The appeal process with the PHPs have not been completed. The Department cannot provide a timeframe for completion of this process. The Department cannot respond to this concern as there is the protest process that has not been completed. Not sure of the context of the available contracts, the five awarded?
128. Will the timely filing limit be what it is now with the individual PHPs? For example, we currently have one year to file with Medicaid. Will this apply or will it be based on the PHPs individual requirements?	The PHP Contract provides that a provider shall submit all claims to the PHP for processing and payments within one hundred-eighty (180) calendar days from the date of covered service or discharge (whichever is later). However, the provider's failure to submit a claim within this time will not invalidate or reduce any claim if it was not reasonably possible for the provider to submit the claim within that time. In such case, the claim should be submitted as soon as reasonably possible, and in no event, later than one (1) year from the time submittal of the claim is otherwise required.
129. Will PHPs be required to use standard billing requirements (i.e. modifiers) or are we going to have to know which plan requires which modifier for which code.	From a fee schedule perspective, the PHPs are being provided standard modifier sets. The State is currently undergoing ways to provide guidance on how to used prescribed modifiers.
130. Will NCTracks still be the billing system in which independent practitioners use?	This question cannot be answered since the type of service is not identified.

131. What kind of timeline can be expected for receiving payment and billing with PHP's for behavioral health counseling?	The PHP Contract's requirements relating to the prompt payment of claims applies to physical and behavioral health covered services. Refer to Section V.H.1.d. of the PHP Contract for specifics on prompt payment standards.
132. Will those with a tailored plan continue to use NCTracks for claims and reimbursement before the tailored plans transition to using PHP's?	Tailored Plans do not come on line until 2021, and that program design is not yet finalized so this question cannot be answered.
133. 3There are seven of these events. Are they required for Medicaid?	Provider education and engagement opportunities are designed to offer providers support to effectively transition to Medicaid Managed Care. Participation in upcoming events and webinars are encouraged, yet not required by NC Medicaid.