TRANSCRIPT OF
PROVIDER POLICIES, MEDICAID MANAGED CARE WEBINAR
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Tim Brown — Welcome everyone. Thank you for joining today's webinar. My name is Tim Brown, and I am the producer at WebEx, and I will be your organizer for today's webinar presentation on North Carolina's Key Policies for Providers in Managed Care. Today's presentation is the fourth in a series of eight provider education modules that are planned on Medicaid transformation. Notifications on additional provider education modules will be forthcoming and posted to the Medicaid transformation website. We have a few housekeeping items before we get started. If you experience technical difficulties during the WebEx session, please dial 1-866-779-3239. Or you can message the WebEx producer using the Q&A panel. During the presentation, all participants will remain in listen-only mode, and as a reminder, this event is being recorded for rebroadcast. We will be holding a Q&A session at the conclusion of today's presentation. We encourage you to submit written questions at any time using the presentation, using the Q&A panel at the bottom right of your screen. Please type your questions in the text field and hit Send. Please keep the dropdown as All Panelists. With that, we invite you to sit back, relax, and enjoy today's presentation. I would now like to introduce your first speaker for today, Sharon Woda, Managing Director at Manatt Health. Sharon, you now have the floor.

Sharon Woda — Good afternoon, everyone, and thank you for joining the webinar today. The presentation today, as Tim mentioned, is the fourth in a series of topical webinars on Medicaid managed care transition. The presentation today is intended to ensure that providers understand key provisions in the move to managed care. We have already touched on and covered in a prior webinar series information on information on payment and contracting policies, which we know are our top, top of mind. Today we will focus on managed care requirements, expectations, and implications specific to credentialing, network adequacy, appeals and ombudsman processes. Our presenter today will be Melanie Whitener, Provider Services Medicaid Managed Care Consultant. After Melanie presents, we will have a Q&A timeframe, so please make use of your Q&A button on the bottom right hand of your screen. And we will also be helped by other individuals in the Department, including Lynn Teska, Senior Program Analyst, Christina Bunch, Provider Operations Manager, and Chandra Lockley, Provider Operations Consultant. I will now turn it over to Melanie to start us on

the presentation. Melanie?

Melanie Whitener Thank you, Sharon. And thank you all for joining us today to gain a better understanding of the key policies for providers in Medicaid managed care. Next slide, please.

We will begin with the North Carolina Medicaid Managed Care Transformation Vision, followed by a deeper dive into the key provider policies, and we'll end by discussing more opportunities for provider engagement in answering your questions. Next slide.

This is the vision for Medicaid managed care that we as an organization continue to reiterate during our state _____ events. We do this so that all will remain focused on the vision of North Carolina Medicaid, which is to be innovative and whole-person centered by integrating both the physical and behavioral-health needs of members as we transition into a well-coordinated system of care that addresses both the medical and the non-medical drivers of health. Next slide, please.

So, how did we get here, and why are we making this change? Well, in 2015, the General Assembly enacted a law that directed the transition of Medicaid and NC Health Choice beneficiaries from a predominantly fee-for-service system to a managed care system. Since that time, we have been collaborating with clinicians, hospitals, beneficiaries, counties, other health plans, elected officials, advocates, and many other stakeholders to help shape the program. DHHS is committed to ensuring that Medicaid managed care plans deliver whole-person care, that they focus on the full set of factors that impact health, that they perform local care management services, and finally, our focus for today's webinar, that plans maintain broad provider participation in a program by helping to mitigate provider administrative burdens. Next slide, please.

This slide represents a timeline of significant events. In October 2018, we received federal approval from CMS for the 1115 waiver. In February of this year, DHHS awarded contracts to five pre-paid health plans. In alphabetical order, the four state-wide plans are AmeriHealth Caritas of North Carolina, Blue Cross Blue Shield of North Carolina, UnitedHealthcare of North Carolina, and WellCare of North Carolina. A fifth prepaid health plan, Carolina Complete Health, is a regional, provider-led entity operating in Regions 3 and 5. Coming in the next couple months, the first beneficiary open enrollment period will begin as Maximus starts sending welcome packets to beneficiaries enrolling in managed care effective November 1, 2019. Maximus is the enrollment broker contracted by North Carolina Medicaid to ensure that Medicaid

and NC Health Choice beneficiaries understand the benefits of Medicaid managed care and receive choice counseling to select a prepaid health plan. By later this summer, PHPs will be working to finalize contracts with providers so they can build their provider network to meet the network adequacy standards established by North Carolina Medicaid. You may have already been contacted by one or more prepaid health plans, but if you have not been contacted, and you are interested in joining their network, you may proactively reach out to the PHP using the PHP contact information available on the North Carolina Medicaid provider web page.

November 1st will be a historic day for North Carolina Medicaid. Managed Care will launch in Regions 2 and 4. These regions span across the northern part of the state from Witahy County in the west to Nash and Wilkin County in the east. Also in November, the open enrollment period will begin for beneficiaries in the remaining managed care regions, which span from Cherokee County at the far western tip of our great state, all the way along the southern border and up the coast of North Carolina. Managed care for these regions will launch in February of 2020. A map of the managed care regions is available on the North Carolina Medicaid Transformation website. Next slide, please.

Now we would look more closely into Key Provider Policies, including Provider Enrollment and Credentialing, Provider Network and Directories, PHP Provider Relations and Engagement, and Provider Grievances, as well as the Ombudsman Program. Next slide.

So, first we will look at provider enrollment in centralized credentialing. Provider credentialing is a critical part of the federally regulated screening and enrollment process. Today, in order to render and receive payment for services delivered to Medicaid and NC Health Choice beneficiaries, a provider must enroll in North Carolina Medicaid and NC Health Choice benefit plans using the provider enrollment process available in NCTracks. In Medicaid managed care, providers must also enroll in North Carolina Medicaid to deliver either in or out-of-network services to enrolled Medicaid or NC Health Choice beneficiaries. To reduce the administrative burden and maximize efficiency as we transition to managed care, providers will continue to use a single centralized enrollment process, the one available in NCTracks, and DHHS will supplement that information through a centralized credentialing process. Prepaid health plans may not include any provider or practice location in its provider network until that provider is enrolled in North Carolina Medicaid. The PHP must validate the active enrollment status of a provider in Medicaid before adding the

provider or a new location for that provider to the PHP contract. After the initial validation, PHPs will continue to confirm a provider's Medicaid enrollment status monthly. So, the provider completes their enrollment application in NCTracks. Upon approval, NCTracks shares the provider information with our centralized provider data contractor, or PDC. The primary source verifies additional credentialing information in accordance with NCQA standards and then sends that information on to the PHP. The PHP will then use the information provided to make quality determinations for provider network participation that would notify the provider of their decision and finalize the contract. Next slide, please.

Credentialing information is shared with the PHP on the North Carolina Medicaid Provider Credentialed file. NCTracks supplies the enrollment and demographic data on the file, including NDI, service location, correspondence and contact information, taxonomies, Medicaid and NC Health Choice health plan enrollment status, as well as other applicable indicators, such as an essential provider indicator, and the AMH peer level for that provider. The Provider Data Contractor, or the PDC, supplements the credentialing data provided by NCTracks by adding for individual providers their work history, education, malpractice history, board certification, DEA and CDS certification, and Medicaid board sanction information. For organization or facility providers, that supplemental data offered by the PDC may include verification of liability insurance and the amount of the coverage, evidence of accreditation from the Joint Commission or other accrediting body, or reports of disciplinary action for the last five years. Additional information related to the PDC credentialing data for individual and facility or organization providers is offered in the appendix of this presentation and will be available when the presentation is posted to the Provider Transition to Managed Care website. The PDC publishes the North Carolina Medicaid Credentialed file in a secure file transfer protocol, or FTP website, and they will do this on a daily basis. PHCs will then access and download the file to identify and outreach to participating providers and make quality decisions during contracting. Next slide, please.

PHPs will establish and maintain a provider network participation committee to make quality determinations using objective quality standards. The qualify determination process is part of the PHP credentialing and re-credentialing policy, which will be made available to providers on the PHP's website. Objective quality standards must assess a provider's ability to deliver care, must include specific defined thresholds for adverse quality determination, must meet standards

established by NCQA's, and must not be discriminatory. PHPs must accept the verified provider information made available to the NC Medicaid Provider Credentialed file, to make quality determinations for provider network participation. Although the PHP may ask for additional information to be published in their provider directory, they may not ask providers to supply additional credentialing information in order to make quality determinations for participation in their network. Providers who receive an adverse quality determination are permitted to appeal to the PHP or resubmit missing or incomplete data to the provider data contractor. Next slide, please.

PHPs must make quality determinations for 90% of providers within 30 calendar days and for 100% of providers within 45 calendar days of the committee's receipt of complete credentialing and verified information. Once the decision is made, the PHP has five business days to provide written notification to the provider. So the entire enrollment credentialing and quality review process from beginning to end should take no more than 75 business for newly enrolling providers. Next slide, please.

Providers may contact the PDC Help Desk by e-mail or by phone to inquire about data provided to the PHP. The Help Desk will assist providers with any disputes on the information provided to the PHP, and will offer assistance to correct the data or provide missing information. The PDC Help Desk will also verify that the key indicators used to obtain information were correct, and will guide the provider on how to provide additional or updated information. As we transition to managed care, each individual provider and organization is encouraged to review the accuracy of the information on their NCTracks provider record, confirm that current rendering service locations are active and correct, confirm that the license, accreditation and certification information is correct as applicable for your provider taxonomy, and confirm that the managing relationship information is up to date and correct for all active individuals on that provider record, including their name, date of birth, and Social Security number. For individual providers, also ensure that organization affiliations are current by MPI and service location. Taking a few minutes now to ensure the accuracy of the information on the NCTracks provider records may simplify the contracting process with the PHP. Next slide, please.

Before we move on to our next topic, we also wanted to provide some PHP contracting reminders. Once enrolled in a North Carolina Medicaid program, a provider must also sign a contract with PHPs to be officially recognized as an in-network provider. PHPs are required to contract

with any willing, qualified provider, and although we hope that you will contract with each PHP, providers are not required to do so. DHHS is developing a set of standard contracting provisions that will be included in all contracts between providers and PHPs. Although the contract provisions are still undergoing review with DHHS, North Carolina Medicaid has set policies for most payments to providers, as well as for the timeliness of those payments. I encourage you to review the North Carolina Medicaid Managed Care 102 Provider Payment and Contracts presentation to learn more about what and how providers should expect to be paid under managed care. The presentation is available on Medicaid's Provider Transition to Managed Care website, and there is a hyperlink at the bottom of this slide that will also connect you to the presentation. Next slide, please.

Now we will take a closer look at provider network requirements and directories. Network adequacy is the plan's ability to provide beneficiaries with timely access to all covered health care services through its efficient number of in-network providers. PHP networks must include any willing qualified provider, as well as all essential providers. Essential providers are identified in the footnote of this slide, and include federally qualified health centers, rural health centers, free and charitable clinics, state veterans' homes, and local health departments. To ensure that certain time and distance standards are met, DHHS established the Network Adequacy Standards defined in the table on the right side of this slide. Standards vary by the type of provider and the type of service rendered, as well as whether the county is designated as urban or rural. Although not displayed in the slide, appointment wait time standards have also been established to ensure that beneficiaries can access services without an unreasonable delay. Wait time standards vary by the urgency of the care needed and the type of the service involved. A network adequacy monitoring and oversight system will be put in place to ensure that health plans have adequate capacity to provide care to all beneficiaries in their service area. Key components of a monitoring and oversight will include the regular submission of provider network data and reports by the PHP to demonstrate network adequacy. DHHS will also monitor beneficiary complaints related to access to care, and when necessary will issue corrective action plans when health plans are not being compliant. Next slide, please.

Although out-of-network services generally require PHP prior approval, PHPs must offer out-of-network coverage if their network is unable to provide the necessary covered service in a timely manner, and they must continue that coverage for the duration of the network's inability

to offer that service in a timely manner from in-network provider. CHPs must also provide female members with direct access to an in-network women's health specialist for covered routine and preventive healthcare needs and must also offer direct access to family planning providers, regardless of their network status without requiring prior approval. Next slide, please. Medicaid and NC Health Choice beneficiaries will have a couple different options for locating in-network providers. In addition to the assistance that will be provided by the enrollment broker, PHPs must maintain a consumer-facing provider directory that is available both online and in written format. As mentioned previously, although PHPs cannot ask providers for additional information to make quality determinations, they may ask providers for certain information for use in their provider directory. Examples of the information that PHPs may request include the address of a service location, the provider linguistic capabilities, and whether or not that provider is accepting new patients, or new beneficiaries. When new information is received, the PHP must update the online provider directory within 10 business days. In addition, PHPs must share their provider director information with Maximus, the beneficiary enrollment broker, on a daily basis to support PHP's choice counseling and selection. So, once you are a participating in-network provider with a PHP, your information will automatically become available on the PHP, as well as the enrollment broker provider directory. Next slide, please.

So, now we will move on to PHP Provider Relations and Engagement. Through their Provider Relations Division, each PHP will offer provider training and education specific to Medicaid managed care requirements, policies and procedures, and they must also offer training and technical assistance on all PHP-specific administrative and clinical practices, policies, procedures, programs and requirements. PHP provider education will begin when newly contracted providers receive an enrollment notice and welcome packet, which is required within five days of contracting. The welcome packet will contain orientation information, as well as instructions on how to access the online PHP provider manual. The PHP provider manual will offer a wealth of information on numerous topics, including clinical practice standards and utilization management programs, member rights and responsibilities, and the provider appeals and grievance process. In addition to the welcome packet and provider manual, providers will receive training on PHP prevention and population health management programs, among other topics, within 30 days of contracting. Next slide, please.

Providers will also have resources for ongoing support. The providers

service line will assist with enrollment, service authorization and reimbursement issues, and staff will be trained and able to respond to policies and areas of the provider manual in one touch. PHPs will offer a web-based portal to provide access to program and provider-specific information including the provider manual, and DHHS will contact provider surveys to ensure provider satisfaction as well as compliance with performance standards as outlined in the provider and PHP contract. Next slide, please.

I mentioned previously that a PHP provider manual will offer information related to provider grievances and appeal. We will take a closer look at that process now and offer a bit of information about the ombudsman program.

The PHP will have in place a provider appeals and grievance system. This will be distinct from that offered to members and it must include a grievance process for providers to bring issues to the PHP, as well as an appeal's process for providers to challenge certain PHP decisions.

Examples of grievances and appeals are offered in the table. If a provider's information is inaccurate in the PHP directory, or the provider is not satisfied with the resolution of a payment dispute, the provider may file a grievance with the PHP. If a provider wishes to challenge a PHP decision, for example, a PHP denies a prior approval request, or a provider is denied participation in the network due to quality issues, then the provider may appeal the decision to the PHP. The PHP must be transparent with its appeals and grievance process and procedure by making it available to the provider on their online portal. Next slide please.

Because provider grievances and appeals differ by definition, the process for resolution is also distinctly defined. PHPs must handle provider grievances promptly, consistently, fairly and in compliance with state and federal law, as well as DHHS requirements. Providers will be able to submit grievances through the pre-paid health plan provider portal and PHPs must also be able to accept grievances referred to them from DHHS.

Provider grievances must be resolved in a timely manner. And although there is no formal process to appeal grievances to the state, PHPs must share information about the type and the frequency of provider grievances so that DHHS may monitor for broad and recurring issues. DHHS will not review individual provider grievances. Next slide please.

For provider appeals, DHHS has outlined requirements for how PHPs

must handle the appeals and will review each PHP provider appeals policy. Providers have the right to appeal certain actions taken by the PHP. These actions may include program integrity related findings or activities, findings of fraud, waste or abuse by the PHP, and the finding or recovery of an overpayment by the PHP.

Additional provider appeal criteria is offered in the appendix of this presentation and will be available when the presentation is posted to the provider transition to managed care website. PHP will establish a committee to review and making decisions about appeals. Providers will be able to submit appeals electronically, just as they can grievances, they can submit their appeals electronically through the PHP provider portal.

Providers must exhaust the PHP internal appeals process before seeking recourse under any other process permitted by contractor law. And providers do have the right to be represented by an attorney during the appeals process if they choose to do so. Next slide please.

Providers have 30 calendar days to appeal a PHP decision. A PHP may extend the 30-day timeline for good cause for the reasons stated in the bubble on this slide. Providers will receive acknowledgement of their appeal request from the PHP within five calendar days of their receipt of request. And a PHP must establish a committee to review and make decisions on provider appeals. Written notice of a committee's appeal decision must be provided within 30 calendar days of receiving the completed appeal request. And the notification must include information about future appeal rights as they apply.

If the appeal involved a question of whether the provider meets objective quality standards, the committee must include an external peer reviewer. Next slide please.

When provider appeals involve suspension or withhold of provider payment, PHPs must limit the issues to whether the PHP had good cause to withhold or suspend that payment. The appeal will not address whether the provider has or has not committed fraud or abuse. PHPs will notify DHHS within 10 business days of the suspension or withhold of any provider's payment. PHPs must offer an in-person or telephone hearing and issue a written decision within 15 business days of receiving the provider's appeal. If no good cause is found, the PHP must reinstate any suspended or withheld payments within five business days and they also must pay interest and penalties. Also within five days, the PHP must notify DHHS of any provider appeal regarding provider suspension or withhold or any findings or recovery of an overpayment of any action

related to fraud, waste or abuse, or if a provider has sued the PHP. Next slide please.

A provider ombudsmen service will be available when a provider submits a complaint about a pre-paid health plan. The PHP provider manual will offer information and instruction on how providers can submit complaints to the ombudsmen service. Additional information will be provided at a later date. Next slide please.

DHHS remains committed to ensuring that providers receive education and support hearing and beyond the transition to Medicaid managed care. So, now we will look at provider opportunities for engagement.

Providers should know that we value their input and their feedback and we're making every effort to provide opportunities to connect with providers through a multitude of activities. We are in the midst of a series of topic based webinars that offer education to providers on key topics to effectively serve Medicaid and NC Health Choice beneficiaries in the transition to managed care. And we also offer fact sheets and FAQs to assist in understanding the Medicaid changes.

The North Carolina Medicaid website serve as a central hub for providers to access resources about the transition to managed care. In addition to the Medicaid transformation links provided on this slide, the main Medicaid webpage www.medicaid.ncdhhs.gov offers links to additional engagement opportunities. From the main Medicaid web page, choose providers; then choose providers transitioning to Medicaid managed care.

In addition to the presentations and recordings for this series of webinar training courses, there's information for PHP meet and greets currently being held all across the state. PHP meet and greets offer providers and practice staff the opportunity to meet PHP representatives to ask questions about joining their network.

DHHS is also hosting virtual office hours, which is an opportunity for providers to ask questions regarding the transition to Medicaid managed care in a real time format. So, please review these websites frequently to stay abreast of new information and opportunities for engagement. And because we value your feedback, we encourage you to continue submitting your questions and concerns to the Medicaid transformation and email address provided on the website.

You see on your screen a snapshot of upcoming provider education opportunities. Five additional webinars are scheduled in the coming

	weeks that will cover topics on beneficiary policies, behavioral health services regarding standard plans and the transition period, advanced medical home or AMH contracting with PHPs, clinical policies and healthy opportunities in Medicaid managed care. In addition, you see a link to the PHP meet and greet and the virtual office hour schedules on the right side of the slide. Again, we encourage you to visit the Medicaid website often and to look for upcoming events and webinars advertised through special Medicaid bulletin and NC tracked provider communication. Thank you for joining us today for the North Carolina Medicaid managed care 104 webinar on key providers in managed care. I will now transition to Sharon Woda for the Q&A session.
Sharon Woda	Okay, thank you Melanie. I'm gonna ask a series of question here. My first one will be to Christina, and a question we got was how can I make sure that the CBO reviews and verifies the latest information about me?
Christina	North Carolina Medicaid will share information with the PHPs on a daily basis. So it's critical to keep your information up to date in NC track. And if you need to update your information, you can log into the secure NC track provider portal and complete a managed change request.
Sharon Woda	Chandra, I think the next question's for you. Once I'm contracted with the PHP, do I need to update my credentialing information with each PHP or do I still go through the centralized CBO?
Chandra	No. You only need to update your information in NC track. PHPs may only ask you for information that doesn't pertain to credentialing, such as information used in the provider directory.
Sharon Woda	Okay, great. And a couple more questions here that we got on the credentialing. What additional data will the CBO use to supplement the information that's already in NC track?
Female Speaker	So, they will use the primary source verifications of the criteria that's listed out for individuals and facilities. There's set information that will be provided for each type. We can refer this FAQ to where you can go to find that information that's listed out.
Sharon Woda	I think there's a slide in the webinar on this right?
Female Speaker	There was.

Sharon Woda We're just struggling to turn to it, but there's a slide in the webinar and the webinar slides will be available. But you see that extra information on there and it's things like medical --

Female Speaker Medical school, education, you know, work history, board certification. Things of that nature.

Sharon Woda Okay, great, great. And Chandra, do we need to reach out to the PHP or is our enrollment through NC track enough to automatically enroll us with the PHP?

Chandra If you don't contract with a certain PHP, then you would be considered out of network with that plan. Out of network services generally require prior approval from the PHP and PHPs are only required to cover out of network services if in network providers can't cover the service on a timely basis. Do a next week's webinar on beneficiary policy will detail how beneficiaries can shed to see if their providers are in network doing the PHP selection process.

Sharon Woda That's helpful so that enrollment with tracks is not automatically enrolled in PHP. There needs to be a separate contracting process. Another question here, if I'm already a North Carolina Medicaid provider, do I need to reapply at this time?

Female Speaker You enroll through NC tracks and if you're already a provider, then you've done everything you need to do, just keep your information up to date with NC tracks.

Sharon Woda Question here more broadly, and maybe Melanie you can take this one. When a quality determination is done, is that only for primary care providers or is that for specialty providers as well?

Melanie Whitener Quality determination?

Sharon Woda Yes. So question is is a quality determination only done for primary care providers or is that for specialty as well when the PHP is looking to determine the full in network status?

Melanie Whitener Quality determinations could apply to either primary care or specialty providers, really to any provider that is requesting participation with the PHP.

Sharon Woda I think another couple of network questions here for you Melanie. If you don't have a contract with all five PHPs, will you be out of network? And if so, what really happens when you're out of network? What does

that mean?

Melanie Whitener — If you do not have a contract with a PHP, then the services that you provide would be considered out of network. I do encourage all providers to participate with each PHP if they can. If they can agree on a rate, then the PHP is required to contract with you as a willing qualified provider. So, I do encourage that so that you are available in network for all of your patients.

Sharon Woda — Great. And Melanie one last one, is there a penalty for not contracting with all the PHPs?

Melanie Whitener — There is not a penalty to the provider for not contracting. However, depending on the service that you are offering, there could be a penalty in your reimbursement rate. Instead of receiving 100% of the Medicaid reimbursement rate, for example, you would receive 90% of the Medicaid reimbursement rate. So, there could be penalties involved in the reimbursement you receive.

Sharon Woda — Okay great. We have a question here on the PHP trainings. Could you provide any more information about the trainings that PHPs will provide and how they will be organized? That's for Lynn.

Lynne Testa — Sharon, thanks. The PHPs are required to develop a training plan with training topics and dates and submit the plans to the department once the department awards a PHP contract. And just for those of you participating today, know that we are very much in the process of reviewing the training plans that are being submitted by the health plans. The health plans must revise and resubmit the plan annually or more frequently if they make substantive changes. PHPs will provide additional information about trainings once you contract with them.

Sharon Woda — Okay, thanks Lynn. Next question can either be for Christina or Chanda. Do you mind repeating the name of the provider data contractor again, the PDC?

Christina — Sure, be happy to. It is Y Pro Info Crossing is the PDC contractor.

Sharon Woda — Great. Shandra, another question just on the transition. I'm concerned that the transition is going to cause a lot of confusion among my patients. How can I help them navigate that?

Shandra — Well, we will have a webinar next week that will focus on beneficiaries policies. We'll make sure to share information that will be helpful in advising your patients, such as their access to a member services line to

answer questions.

Sharon Woda — Great, thank you. There is a specific question about outpatient facilities, I think we're going to defer to the Q&A. But we did want to let people know that generally there will be a clinical policies webinar coming up in the next few weeks so that people can take a look at that and see that will cover the clinical policies that are being set by the state. Another question here on if the information that we have is current and satisfactory in NC track, so if everything's okay in NC track, do we assume we pass the quality items for participation with the PHP or I think that's probably a hard one to answer, if there's any additional thoughts or context the folks are going to have on that, feel free to chime in.

Female Speaker — I don't think I would assume that that puts you into the contracting network. I think we would need to defer this FAQ for a better answer.

Sharon Woda — Okay, fair enough. There is a question early on this managed care reply to the special date of ophthalmology and the answer is yes it does, so that is included. There is also a question of – I think we listed the managed care organizations that are contracted with the state, that has not changed. So, you can refer to the state website for that information.

Female Speaker — It's entitled health plan contact information. If you go into the Medicaid provider landing page and then click on provider Medicaid information, you'll see when that next landing page comes up that there's an icon for all of the health plan contact information and that was just recently refreshed.

Sharon Woda — Okay. There's a couple of questions that have come in through the Q&A on the concerns over the contracts being provided by the PHP providers, vis-à-vis the state timeline for review of those contracts and just the overall timeline overall for providers needing a contract. I think we're gonna go ahead and defer that to a FAQ, but what I will say is that there is an AMH contracting webinar to address some of these specific concerns with AMH providers that has been new link scheduled for May 30. So, I would mark that down on your calendar and it will address some of those timeline issues 'cause we are hearing them in the market and we want it to be responsive. So the state, they change for that, but I know there's a lot more providers involved than just AMH, so we'll defer the rest of that to an FAQ, but that is something that the state taxes are working on and aware of.

Quick question here that I'll just see if the group can answer: how will

members receive information about their Medicaid PHP plans, especially if their address has changed. So, anyone here can speak towards that member process or should we defer that to the beneficiary webinar? Okay, so I think we'll cover that in the beneficiary webinar that's coming up next week. Also, that will also cover 'cause I see some questions coming in about how will Medicaid beneficiaries be sorted into the PHPs. And that will also cover, again, the assignment of Medicaid beneficiaries to a particular primary care provider AMH practice. So, that will also be covered in the beneficiary webinar.

All right, I think through that we have addressed all Q&As, so we're gonna give folks a little bit of time back in their day. So, thank you for attending the webinar. Please look for future webinars and of course if you think of a burning question, or a question you want us to answer, please feel free to send it and even after the Webinars, we're updating the FAQs on a very frequent basis and we'd be happy to include them. Thank you very much.

Male Speaker — Ladies and gentlemen, thank you for attending today's webinar. This concludes today's event. You may now disconnect your lines.

End of webinar.