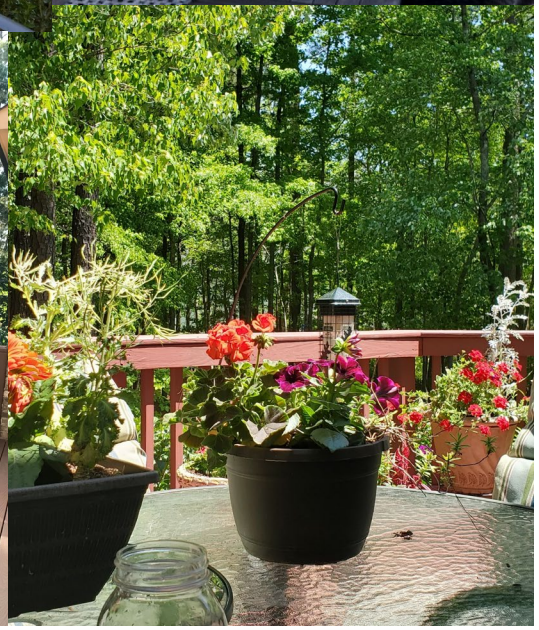
Back Porch Chat: Medicaid Managed Care Hot Topics

June 17, 2021





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Logistics for today's webinar

Question during the live webinar

Technical assistance

technicalassistanceCOVID19@gmail.com

Audio connection to webinar

Dial (646) 558 8656 or (301) 715 8592

Webinar ID: **923 3734 2902**

AGENDA

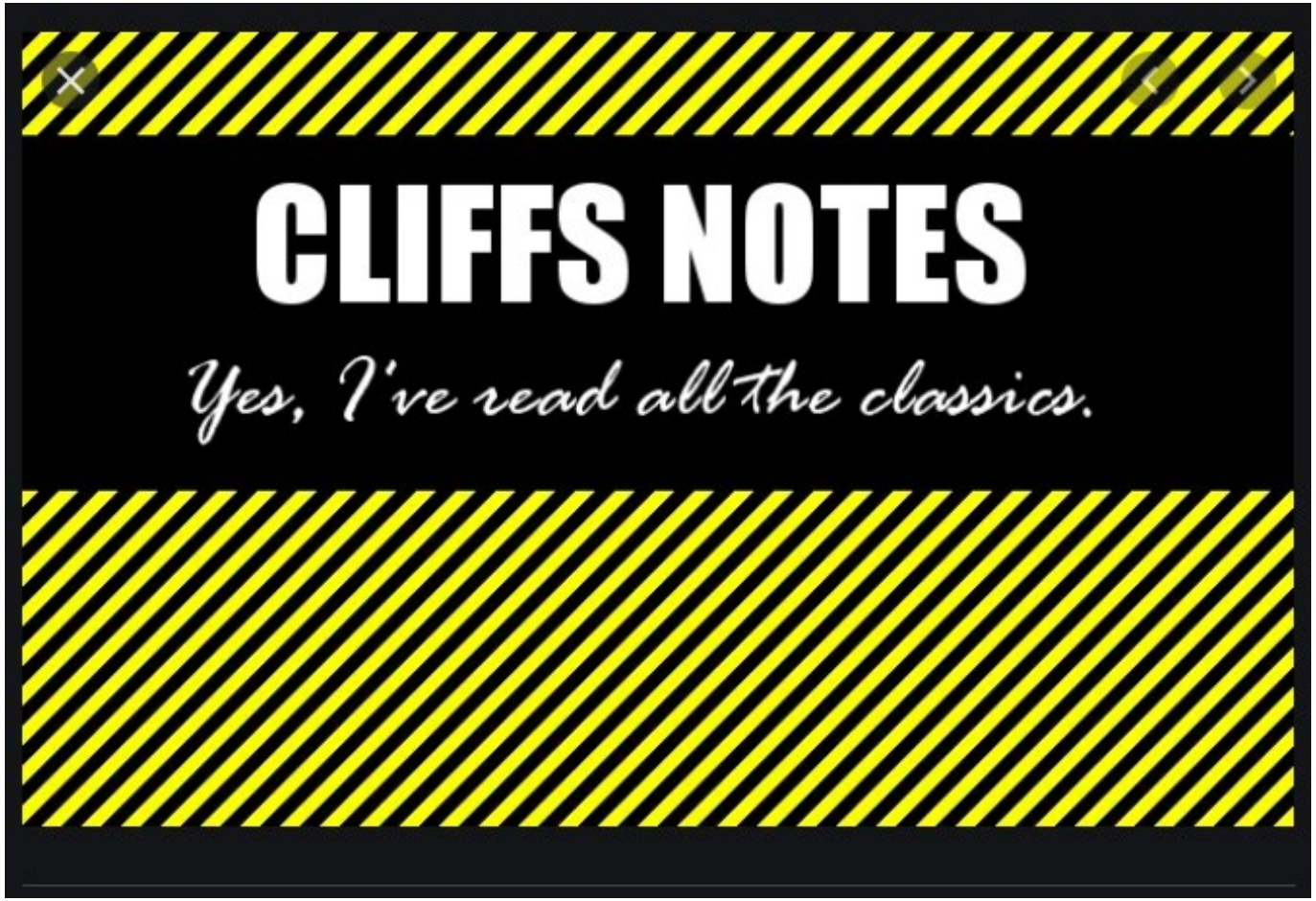
01 Quick Reference Guide for Launch

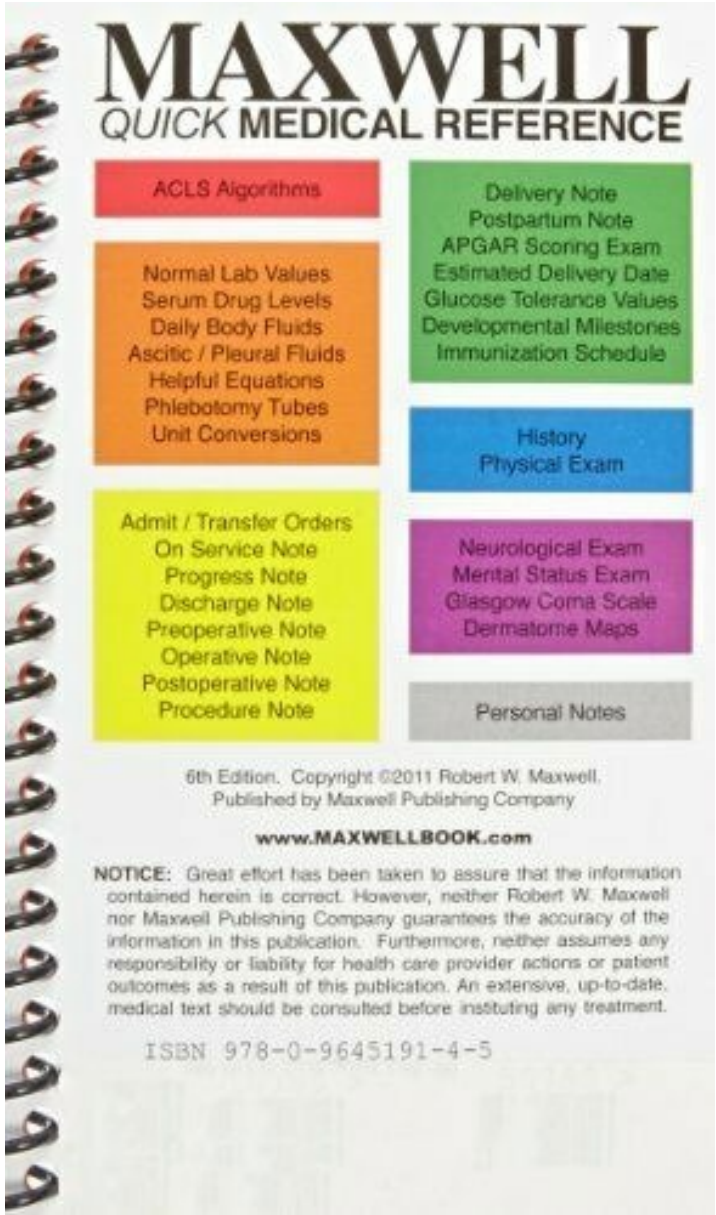
02 Paying Claims: The Process Across Plans

03 Utilization Management: Across Plans

04 Provider Questions For Plans

05 Q&A


CLIFFS NOTES
Yes, I've read all the classics.


MAXWELL
QUICK MEDICAL REFERENCE
ACLS Algorithms
Normal Lab Values
Serum Drug Levels
Daily Body Fluids
Ascitic / Pleural Fluids
Helpful Equations
Phlebotomy Tubes
Unit Conversions
Admit / Transfer Orders
On Service Note
Progress Note
Discharge Note
Preoperative Note
Operative Note
Postoperative Note
Procedure Note
Delivery Note
Postpartum Note
APGAR Scoring Exam
Estimated Delivery Date
Glucose Tolerance Values
Developmental Milestones
Immunization Schedule
History
Physical Exam
Neurological Exam
Mental Status Exam
Glasgow Coma Scale
Dermatome Maps
Personal Notes
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Day 1 Quick Reference Guide

VERIFICATION OF ELIGIBILITY AND PLAN

- **NCTracks:** Providers will be able to verify eligibility and Managed Care enrollment through the NCTracks Recipient Eligibility Verification function available in the Provider Portal
- **Real Time Eligibility Verification Method**
  a. Log into the NCTracks Provider Portal: https://www.nctracks.nc.gov/ncmmisPortal/loginAction?flow=PP
  b. Follow the Eligibility > Inquiry navigation
  c. Populate the requested provider, recipient and time period information
- **NCTracks Call Center:** 800-688-6696

PROVIDER PORTAL / PROVIDER SERVICES

- **AmeriHealth Caritas:** https://navinet.navimedix.com / **Provider Services:** 888-738-0004
- **Carolina Complete:** https://network.carolinacompletehealth.com / **Provider Services:** 833-522-3876
- **Healthy Blue:** https://provider.healthybluenc.com or https://www.availity.com / **Provider Services:** 844-594-5072
- **United Healthcare:** https://www.uhcprovider.com / **Provider Services:** 800-638-3302
- **WellCare:** https://provider.wellcare.com / **Provider Services:** 866-799-5318
- **NC Medicaid Provider Playbook**: https://medicaid.ncdhhs.gov/providers/provider-playbook-medicaid-managed-care

PRIOR AUTHORIZATIONS

- **AmeriHealth Caritas: Online:** Provider Portal / **Phone:** 833-900-2262 / **Pharmacy:** 866-885-1406
- **Carolina Complete: Online:** Provider Portal / **Phone:** 833-552-3876 / **Pharmacy:** 833-585-4309
- **Healthy Blue: Online:** Provider Portal / **Phone:** 844-594-5072 / **Pharmacy:** 844-594-5072
- **United Healthcare: Online:** Provider Portal / **Pharmacy:** CoverMyMeds https://www.covermymeds.com/main/prior-authorization-forms/optumrx/ ; SureScripts**:** https://providerportal.surescripts.net/ProviderPortal/optum/login
- **WellCare: Online:** Provider Portal / **Phone:** 866-799-5318 / **Pharmacy**: Fax: 800-678-3189 **or** SureScripts**:** https://providerportal.surescripts.net/providerportal/

Day 1 Quick Reference Guide

CLAIMS

- **AmeriHealth Caritas**: **Online:** https://navinet.navimedix.com / **Phone:** 888-738-0004
- **Healthy Blue**: **Online**: www.availity.com / **Phone**: 800-594-5072
- **Carolina Complete**: **Online:** https://network.carolinacompletehealth.com
- **United Healthcare: Online:** https://www.uhcprovider.com / **Phone:** 800-210-8315
- **WellCare: Online:** https://www.wellcare.com/en/North-Carolina/Providers/Medicaid/Claims / **Phone:** 866-799-5318

Two Claims Submission Fact Sheets are available on the Provider Playbook at: https://medicaid.ncdhhs.gov/providers/provider-playbook-medicaid-managed-care that address filing managed care claims.

NON-EMERGENCY MEDICAL TRANSPORTATION

- **AmeriHealth Caritas: Phone:** Member Services – 855-375-8811
- **Carolina Complete: Phone:** ModivCare – 855-397-3601
- **Healthy Blue: Phone:** ModivCare – 855-397-3602
- **United Healthcare: Phone:** ModivCare – 855-397-3604
- **WellCare: Phone:** One Call - 877-598-7602

PROVIDER OMBUDSMAN

Medicaid Managed Care Provider Ombudsman: **Phone:** 866-304-7062 / **Online:** Medicaid.ProviderOmbudsman@dhhs.nc.gov

PHP QUICK REFERENCE GUIDE LOCATION

- **AmeriHealth Caritas:** https://www.amerihealthcaritasnc.com/assets/pdf/provider/provider-reference-guide.pdf
- **Carolina Complete:** https://network.carolinacompletehealth.com/content/dam/centene/carolinacompletehealth/pdfs/CCHN-Current-PDF-QRG-Form.pdf
- **Healthy Blue:** https://provider.healthybluenc.com/docs/gpp/NC_CAID_QuickReferenceGuide.pdf
- **United Healthcare:** https://www.uhcprovider.com/content/dam/provider/docs/public/commplan/nc/training/NC-Medicaid-QRG.pdf
- **WellCare:** https://www.wellcare.com/North-Carolina/Providers/Medicaid

- The Provider Playbook has the latest information, tools and other resources to help providers smoothly transition to Medicaid Managed Care.

- Visit the Provider Playbook often, as resources will be added as they become available.

- Several Fact Sheets provide information on many scenarios providers may encounter after July 1.

Key Resources for Managed Care Launch

Issue	**All fact sheets listed below can be accessed via this link**: Medicaid Managed Care Fact Sheets. **Links to other resources not on the fact sheet page are provided below.**
Check Beneficiary Plan	1. Day 1 Provider Quick Reference Guide (See NCTracks information under Verification of Eligibility and Plan section) 2. What Providers Need to Know: Part 2 - After Managed Care Launch (See information under Assist Your Beneficiaries with the Transition)
Beneficiary Request to Stay in NC Medicaid Direct and Local Management Entities/ Managed Care Organizations (LME/MCO)	Policy Guidance (See 1. Request to Stay in NC Medicaid Direct and Local Management Entities/ Managed Care Organizations (LME/MCO): Beneficiary and Provider Attestation Forms 2. Behavioral Health I/DD Tailored Plan Memo on Eligibility and Enrollment)
Covered Services (clinical policies/labs/vaccines) after July 1	Day 1 Provider Quick Reference Guide (See links under PHP Quick Reference Guide Location)
Prior Authorizations (PA) after July 1	Managed Care Claims and Prior Authorizations Submission: What Providers Need to Know – Part 1 and Part 2
Prescription Medication	Outpatient Pharmacy Services Physician Administered Drug Program
Referrals after July 1	Day 1 Provider Quick Reference Guide (See health plan contact information under Prior Authorizations)
Non-Medical Emergency Transport (NEMT) after July 1	Day 1 Provider Quick Reference Guide (See health plan contact information under NEMT)
Billing (e.g., global codes) after July 1	1. Day 1 Provider Quick Reference Guide (See health plan contact information under Claims) 2. Managed Care Claims and Prior Authorizations Submission: What Providers Need to Know – Part 1 and Part 2
Social Determinants of Health (SDOH) Supports	NCCARE360 DHHS Healthy Opportunities Site Healthy Opportunities Pilots (See Healthy Opportunities Fact Sheet)
Care Management Transitions	Transition of Care for Beneficiaries Receiving Long-term Services and Supports
Questions From Providers That Have Already Been Answered	NC Medicaid Help Center Knowledge Base to search through FAQs
Difference Between Medicaid Clinical Coverage Policy Floor and Utilization Management in Managed Care	NC Medicaid Help Center Knowledge Article: Utilization Management in Managed Care

*Direct **Issues** to the health plan patient is assigned to and **Escalations** to the Medicaid Managed Care Provider Ombudsman: Day 1 Provide Quick Reference Guide (see contact information for Provider Ombudsman)*

Key Factsheets

Day One Provider Quick Reference Guide

- How to verify beneficiary eligibility and health plan
- Links/numbers for health plan provider portals
- Links/numbers for health plan prior authorization portals
- Links to health plan claims portals
- Numbers for health plan NEMT vendors
- Links/numbers for Provider Ombudsman
- Links to health plan Quick Reference Guides

What Providers Need to Know: After Managed Care Launch

- Key dates for transitioning to NC Medicaid managed care
- Key reminders for providers
- Provider contracting reminders
- Ensure your information is correct in NC Tracks
- Know where to submit claims
- Assist your beneficiaries with the transition
- Transition of care protections impacting providers
- What if beneficiaries have questions
- What if providers have questions

Transition of Care Quick Reference

Safeguard	Crossover **In effect for members transitioning on July 1, 2021**	Ongoing TOC **If a member transitions between Standard Plan Health Plans (or between Medicaid Direct and Standard Plan Health Plans) after July 1, 2021**
Ensuring continuity through data transfer	PHPs will: -intake PA data from NCTracks & LME/MCOs -intake claims and pharmacy lock in data -help ensure member continuity of care -help inform care management engagement	PHPs are required to transfer: -member's claim history -pharmacy lock-in -open & recently closed Prior Authorization (PA) data -socio-clinical summary of information -health needs screening -care plan
Prior Authorization (PA) Continuity:	PHPs will: -honor Medical and Behavioral Health PAs for the **first 90 days (September 29th)** or until the expiration, whichever is first -honor pharmacy PAs for the life of the PA If the PHP reassess and reduces a benefit it must issue appeal rights.	PHPs must honor full term of all active prior authorizations for transitioning members.
Out of Network (OON) Provider Status	PHPs will treat OON providers in parity with in-network providers for **at least 60 days (August 30th)** or until the end of the episode of care.*	PHPs must adhere to a 90-day transitional period (and longer in some circumstances) for transitioning members who experience an ongoing special condition or under an ongoing course of treatment.*
High Need Member Protections	-For existing transitioning high need members being served by LME/MCOs and CCNC, there will be a warm handoff to the PHPs -PHPs will conduct expedited follow up for a broader identified High Need transitioning population	PHPs will: -expedite the care needs screening process for all newly enrolled Aging, Blind & Disabled (ABD) members -coordinate a warm handoff for identified transitioning care managed members and all members disenrolling back to Medicaid Direct
	*The PHP shall, in instances in which a Member transitions into a PHP from Medicaid Fee-for-Service, another PHP, or another type of health insurance coverage and the Member is in Ongoing Course of Treatment or has an Ongoing Special Condition permit the Member to continue seeing his/her provider, regardless of the provider's network status, in accordance with N.C. Gen. Stat. § 58-67-88(d)-(g).	

Managed Care Launch 30-60-90 Day Plan

30 Days (August 1)

AMH/PCP Changes

- Beneficiaries have thirty (30) days to change their AMH/PCP without cause (1st instance)
- Beneficiaries can change their AMH/PCP without cause up to one time per year thereafter (2nd instance)
- Members can change their AMH/PCP with cause at any time.

1. Beneficiaries can call the health plan or;
2. Beneficiaries can call the EB if they happen to also be changing their health plan during that 30-day window.

60 Days (August 30)

Out of Network Claims Payment

- Health plan will pay claims and authorize services for Medicaid-enrolled out-of-network providers equal to that of in-network providers for 60 days post launch (or until end of episode of care, whichever is less).

90 Days (September 29)

Prior Authorizations

- Health plan must honor existing and active prior authorizations on file with the North Carolina Medicaid or NC Health Choice program for 90 days post launch (or until the end of the authorization period, whichever occurs first).

Newborns

- Health plans will treat all out-of-network providers the same as in-network providers for purposes of prior authorization and will pay out-of-network providers the Medicaid fee-for-service rate for services rendered through the earlier of:
  1. 90 days from the newborn's birth date or;
  2. The date the health plan is engaged and has transitioned the child to an in-network PCP or other provider.

Choice Period

- Mandatory beneficiaries (required to enroll in a health plan) can change health plans for any reason for 90 days post launch

Patient Panel List at Practice Level

Provider Type	Source of Panel	Additional Information
AMH Tier 3 w/ CIN	Beneficiary Assignment File	PHPs started to send Patient List via Beneficiary Assignment file on 6/4 to CINs. CINs should distribute panel down to providers.
AMH Tier 3 w/out CIN	Beneficiary Assignment File	PHPs started to send Patient List via Beneficiary Assignment file on 6/4 to AMH Tier 3s without CINs.
PCP/AMH Tier 1, 2,3	PHPs are required to make available Patient Panel through the portal on July 1, 2021	PHPs are required to make this information available by July 1 and should be communicating to AMHs
AMH Tier 1, 2, 3	NCTracks Enrollee Report	The Enrollee Report is published to NCTracks after the second check write of each month. Beginning in July it will have Medicaid Direct and Managed Care members.

What to do if you have issues?

MEMBERS: Check your Health Plan → Call your Health Plan → Contact the NC Medicaid Ombudsman

1. **CHECK** to see what health plan you are enrolled in.

   Beneficiaries were mailed a health plan welcome kit that includes their Medicaid ID card.

   If you still have questions or didn't receive the welcome kit you can call the Enrollment Broker at 833-870-5500.

2. **CALL** your health plan if you have questions about benefits and coverage.

   The number is listed on your Medicaid ID card, or you can find a list at medicaid.ncdhhs.gov/transformation.

3. **CONTACT** If you still have questions, you can reach out to the NC Medicaid Ombudsman.

   Call 877-201-3750 or visit ncmedicaidombudsman.org.

PROVIDERS: Check in NC Tracks → Call the PHP → Contact the Provider Ombudsman

1. **CHECK** in NCTracks for the Beneficiary's enrollment (Standard Plan or Medicaid Direct) and Health Plan.

   If you still have questions, call the NCTracks Call Center: 1-800-688-6696.

2. **CALL** the Health Plan (PHP) for coverage, benefits, and payment questions.

   You can find a list of health plan contact information at https://medicaid.ncdhhs.gov/transformation/health-plans/health-plan-contacts-and-resources.

3. **CONTACT** the Provider Ombudsman with unresolved problems or concerns.

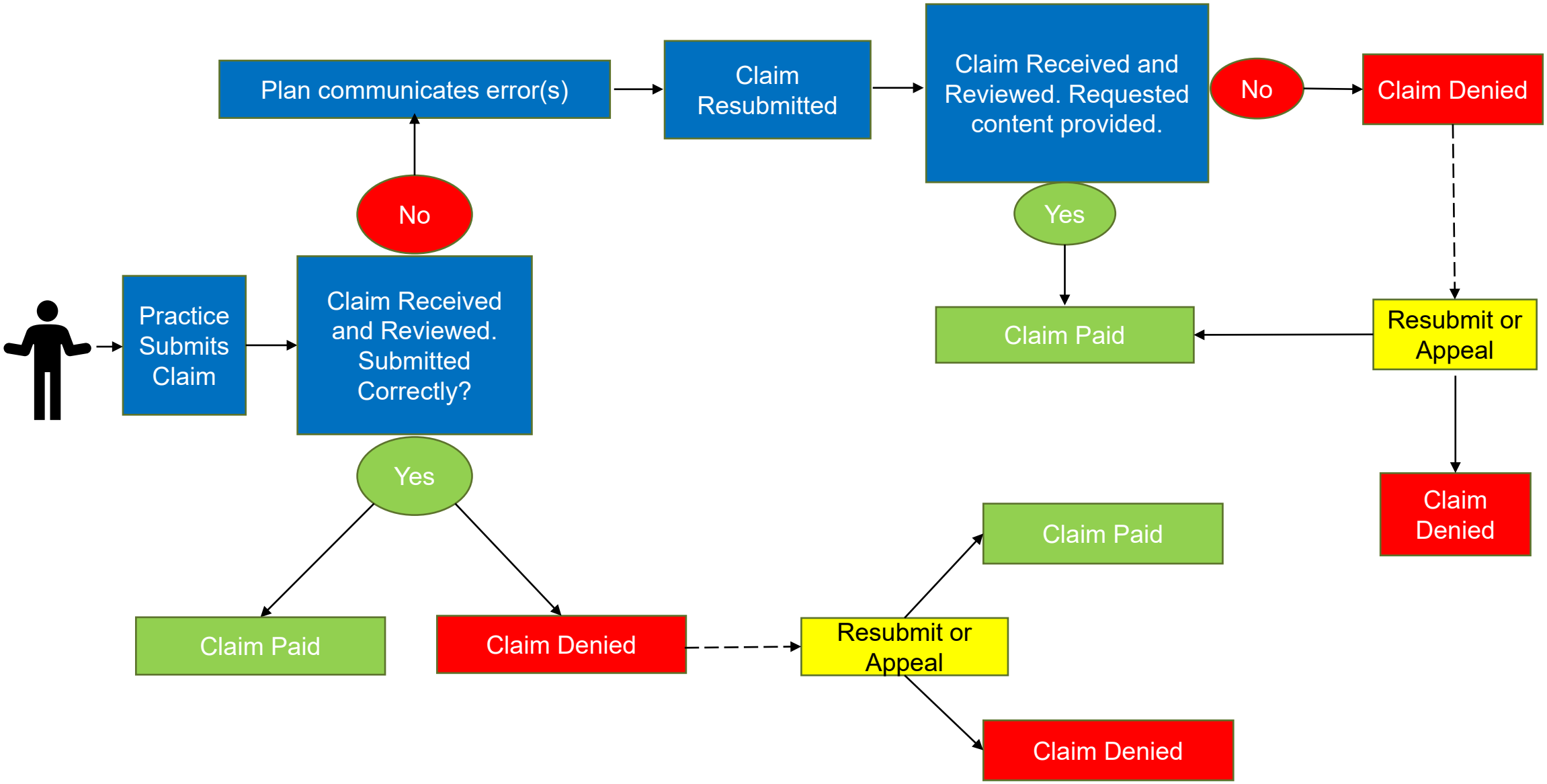
   Call 1-866-304-7062 or visit Medicaid.ProviderOmbudsman@dhhs.nc.gov.

Prompt Payment of Providers

- Health plans are responsible for **claims processing and timely payments** to providers for claims submitted within **180 days** of the date of service.
- Health plans must, **within 18 calendar days** of receiving the Medical claim, notify the provider **whether the claim is clean** or request all additional information needed to timely process the claim.
- If the claim is clean, the health plan **must pay or deny within 30 days** of receipt.
- **Health plans that do not pay claims** within the required timeframe according to prompt pay requirements **will bear interest at the annual rate of 18 percent** beginning on the date following the day on which the claim should have been paid or was underpaid.
- **In addition** to interest, a health plan shall pay the provider a **penalty equal to one percent of the claim per day**.
- Pharmacy
  - The PHP shall **within 14 calendar days** of receiving a Pharmacy Claim **pay or deny** a Clean Pharmacy Claim or pend the claim and request from the provider all additional information needed to timely process the claim.
  - A Pharmacy Pended Claim shall be **paid or denied within 14 calendar days** of receipt of the requested additional information.
- Each health plan has specific guidance to follow for enrollment in electronic funds transfers for payments. Your **banking information from NCTracks will not transfer to the health plan(s)**.

For more information, see: https://files.nc.gov/ncdma/NCMT-Provider-FactSheet-Playbook-Provider-Payment-20200331.pdf

Making Payroll



Level Setting: Definitions

- **837 File** – EDI 837 is the format established to meet HIPAA requirements for the electronic submission of healthcare claim information. It's the electronic equivalent of the CMS-1500. So basically, it's an electronic file that contains information about a patient claims. This form is submitted to a clearinghouse or insurance company instead of a paper claim.

- **Clean Claim** – A claim for services submitted to a PHP by a Medicaid Managed Care medical or pharmacy service provider which can be processed without obtaining additional information from the submitter in order to adjudicate the claim.

- **Unclean Claim** – An "unclean claim" is defined as an incomplete claim, a claim that is missing any required information for processing (i.e., patient name, ID, provide NPI, etc.), or a claim that has been suspended in order to get more information from the provider.

- **Timeframes** – A period of time during which something has taken or will take place. In this instance, timeframes outline how much time providers have to complete an action.

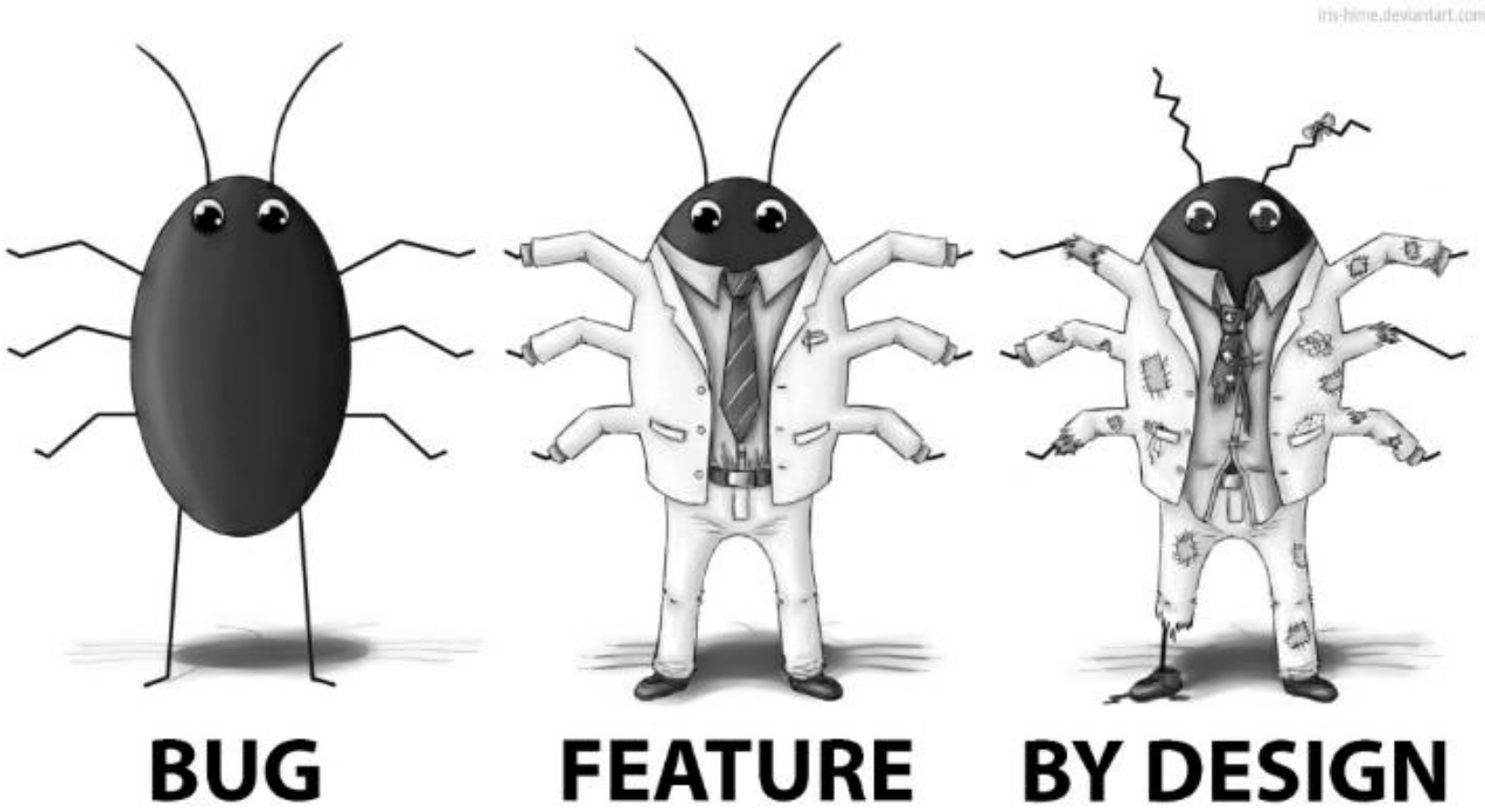
- **Dispute** – The process where providers can disagree about a claim decision.

- **Appeal** –The process where a member/provider can dispute a clinical utilization review decision.

Paying Claims: The Process Across Plans

	AmeriHealth Caritas (ACNC)	Carolina Complete Health (CCH)	Healthy Blue (BCBS)	United Healthcare (UHC)	WellCare (WCHP)
Submit Claims via:	Electronic: https://www.changehealthcare.com/solutions/revenue-performance-advisor OR ACNC Payer ID: 81671 Mail: AmeriHealth Caritas North Carolina Attn: Claims Processing Department P.O. Box 7380, London, KY 40742-7380	Electronic: CAROLINA COMPLETE HEALTH C/O CENTENE EDI DEPARTMENT e-mail: EDIBA@centene.com CCH Payer ID: 68069 Mail: Carolina Complete Health Attn: Claims PO Box 8040 Farmington MO 63640-8040	Paper -Blue Cross NC | Healthy Blue Claims Department P.O. Box 61010 Virginia Beach, VA 23466; 1-844-594-5072, Electronic, https://www.availity.com	Paper: UnitedHealthcare Community Plan PO Box 5280 Kingston NY 12402-5280 Electronic: http://www.uhcprovider.com	Paper: WellCare Claims PO Box 31224 Tampa, FL 33631-3224 Electronic or Direct Data Entry (DDE): AdminisTEP:http://www.administep.com/Signup.aspx Change Healthcare: physician.connectcenter.changehealthcare.com
Errors Notified by:	Rejected with errors within **18 days** of receipt via mailed letter or https://identity.navinet.net/Account/Login	Claim rejected with errors identified within **18 days** of receipt via mailed letter	Rejected with errors within **18 days** of receipt - Paper - Reject letter via mail or Electronic notice of status via 277CA , https://www.availity.com	Rejected with errors within **18 days** of receipt via mailed letter or Electronic notice of status via 277report https://www.uhcprovider.com/en/resource-library/edi.html?CID=none	Rejected with errors within **18 days** of receipt via mailed letter
Denials Notified by:	Denied with reasons within **18 days** of receipt via mailed letter or https://identity.navinet.net/Account/Login	Claims denial notification within **30 days** of receipt via EOP	Check write or Electronic via https://www.availity.com (Daily Check runs) within **30 days** of a clean claim submission	Check write or Electronic via http://www.uhcprovider.com (Daily Check runs) within **30 days** of a clean claim submission	Check write or Electronic via Payspan (payspanhealth.com) (Daily Check runs) within **30 days** of a clean claim submission
Claims Paid:	Check write or electronic via https://enrollments.echohealthinc.com/efteradirect/enroll (1st 7/7/21, then every M/W) within 30 days of clean claim submission	Check write or electronic within 30 days of claim submission (Weekly; either check or EFT depending on how the provider is set up)	Check write or Electronic via https://www.availity.com (Daily Check runs) within 30 days of a clean claim submission	Check write or Electronic via http://www.uhcprovider.com (Daily Check runs) within 30 days of a clean claim submission	Check write or Electronic via Payspan (payspanhealth.com) (Daily Check runs) within 30 days of a clean claim submission
Submit Claims Dispute:	Electronic: https://identity.navinet.net/Account/Login or Mail: Provider Appeals Department | AmeriHealth Caritas North Carolina | P.O. Box 7379 | London, KY 40742-7379	Electronic: Carolina Complete Health Provider Tools (https://provider.carolinacompletehealth.com/sso/login) or Mail: Carolina Complete Health Attn: Appeals and Grievances P.O. Box 8040 Farmington, MO 63640-8040	Electronic via https:https://www.availity.com or Mail - Blue Cross NC | Healthy Blue Payment Dispute Unit P.O. Box 61599 Virginia Beach, VA 23466	Electronic: https://www.uhcprovider.com/ or Mail: UnitedHealthcare Community Plan Grievances and Appeals Unit P.O. Box 31364 Salt Lake City, UT 84131-0364	Via electronic at https://provider.wellcare.com or via mail to the address as outlined on the EOP.
Dispute Timing:	Claims disputes are accepted within **30 days** of notice of action. Resolution of disputes are typically achieved within **30 days** of receipt.	Claims disputes are accepted within **30 days** of notice of action. Resolution of disputes are typically achieved within **30 days** of receipt.	https://www.availity.com – Submit claim payment disputes within **30 days** of denial Claim payment dispute decision within **30 days** of receipt of claim payment dispute	Claims disputes are accepted within **30 days** of notice of action. Resolution of disputes are typically achieved within **30 days** of receipt.	Submit claims disputes **within 30 calendar days** of receipt of denial. Claim payment dispute decision within **30 calendar days** of receipt of appeal.

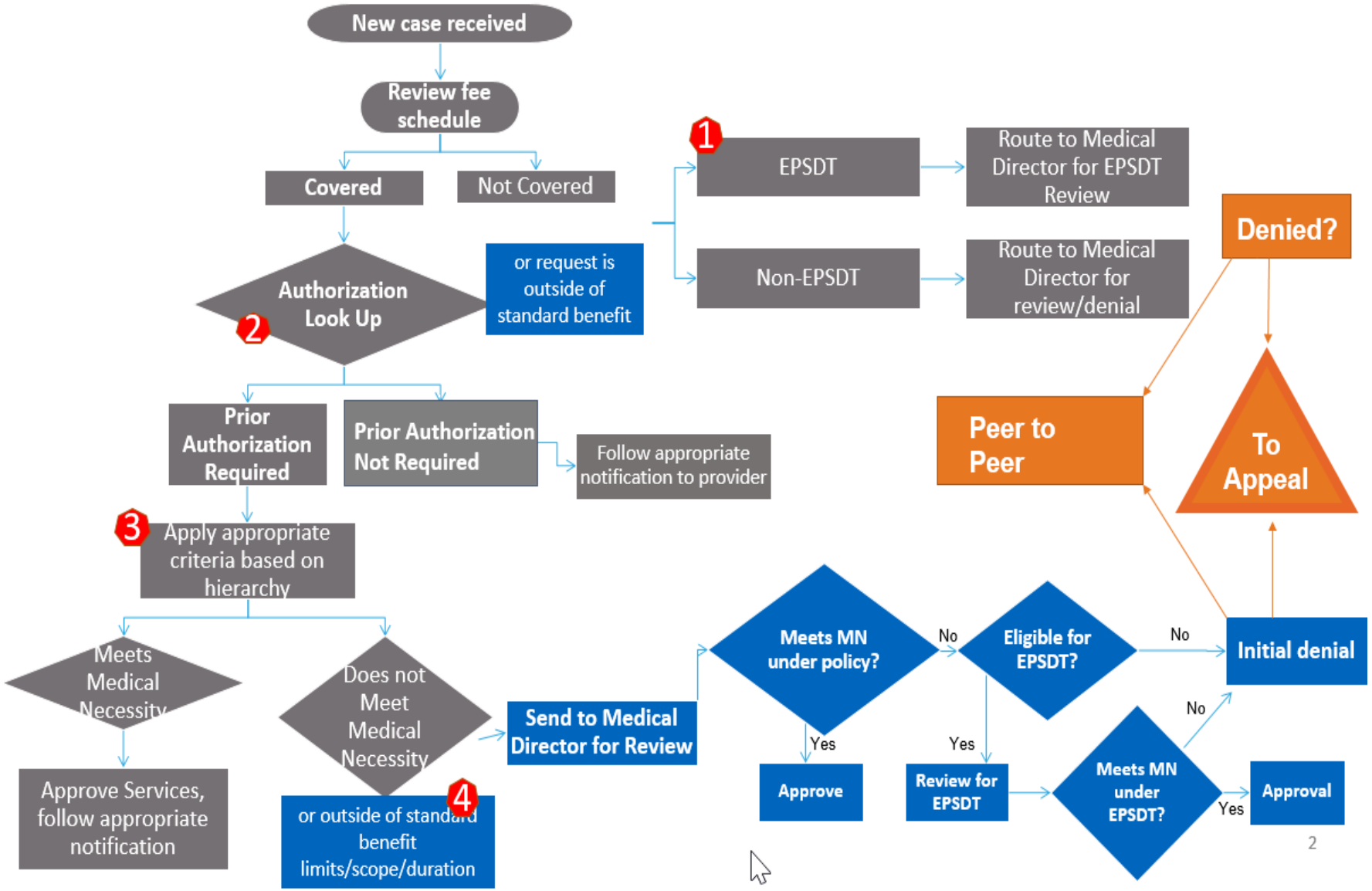
Utilization Management (UM) Process



Managing Utilization of Medicaid Services

- The Utilization Management process is driven by an Authorization Lookup Tool and reference materials developed by each PHP to determine what outpatient services require Prior Authorization and to indicate what clinical criteria should be used for the service being requested
- Medical Necessity Determinations are based on benefit coverage and limitations and clinical criteria present in clinical policies and utilization management guidelines
- The appropriate criteria guideline for each request is determined by using the Clinical Policy Hierarchy and must be no more restrictive than NC DHHS Clinical Coverage Policies
  - State Guidelines
  - Federal Medicaid Mandates including EPSDT
  - Health Plan Specific Clinical Policies
  - MCG or InterQual
- Health Plan Clinical Policies cannot be more restrictive than NC Medicaid and NC Health Choice Clinical Coverage Policies
  - If a provider feels a Health Plan policy is more restrictive, they may request review by the Health Plan or NC Medicaid
- Timelines:
  - Standard: 14 days from request or as timely as the member's clinical condition warrants
  - Expedited: 72 hours from request (inpatient treated as expedited)
  - Extension of up to 14 days if deemed in the best interest of the member (typically due to lack of needed clinical documentation)

Utilization Management Process – WellCare



Member Appeals Process – WellCare

Member requests appeal

- Provider may request on behalf of Member
- Must request within 60 days of Notice of Adverse Benefit Determination (NABD)

WellCare processes appeal

- New clinical may be provided
- Denials based on clinical criteria must be reviewed by same or similar specialty medical director who does not report to MD who issued original denial

Appeal resolution timeframes:

- Standard = 30 days
- Expedited = 72 hours
- One-time 14 day extension if in best interest of member (e.g LOI)

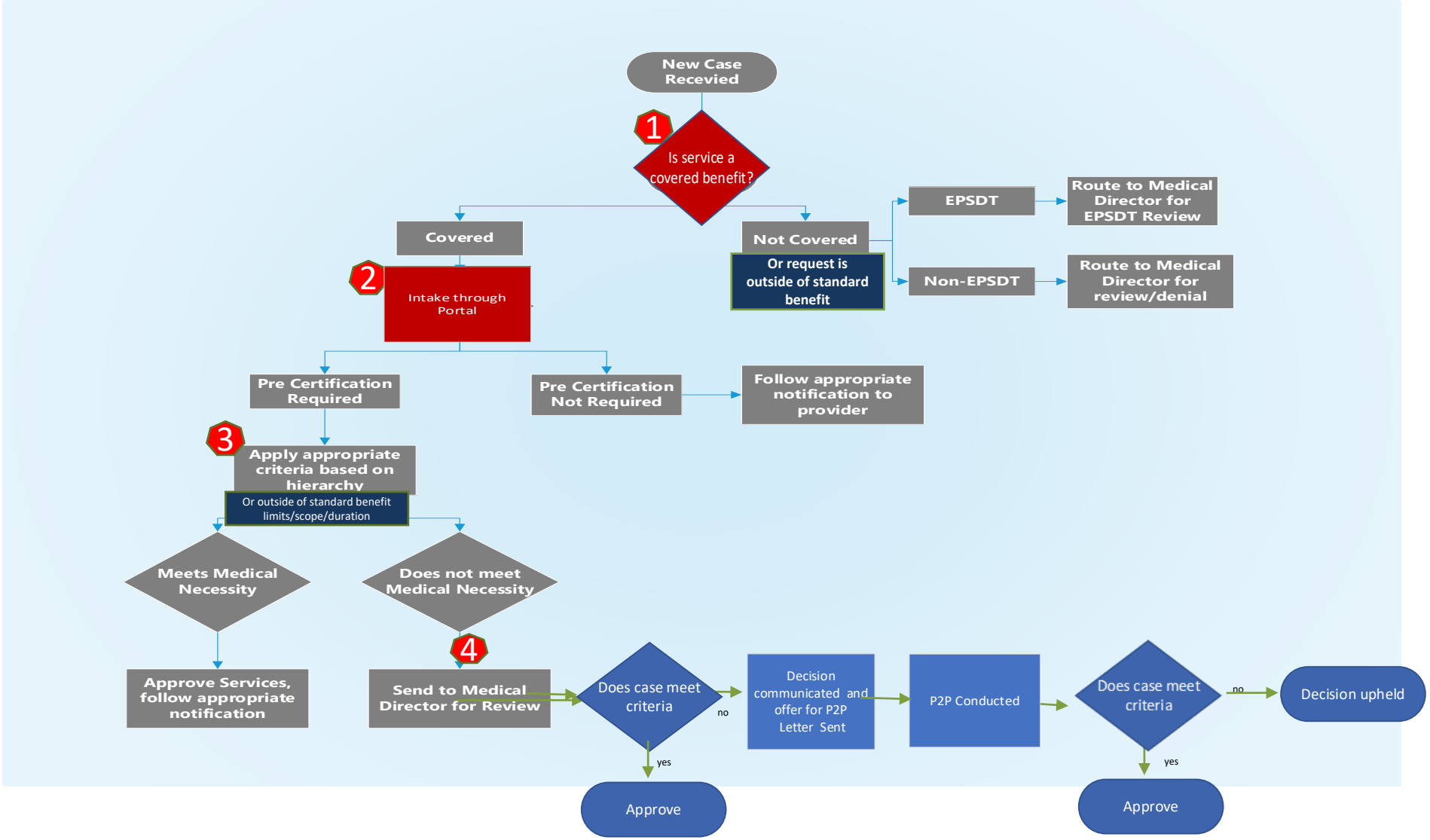
If appeal is upheld:

- Member may appeal to OAH (State Fair Hearing/SFH)
- Includes a mediation process
- Process outlined in detail in NABD letter

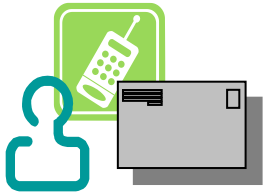
If services were ongoing and reduced or denied:

- Continuation of Benefits may apply if requested
- Services are continued until appeal (and SFH, if applicable) is resolved

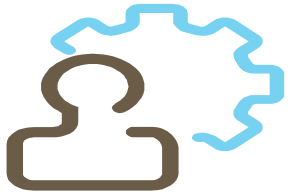
Utilization Management Process – United Healthcare



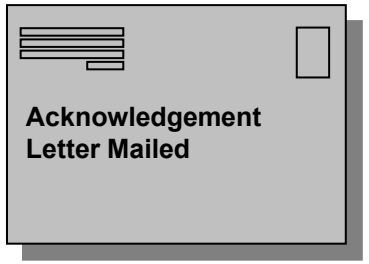
Member Appeals Process – United Healthcare



Appeal request received via call centers, mail, email, portal or fax

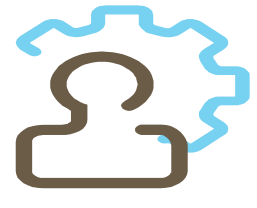


Assistance to the member may be provided in completing forms and taking other procedural steps related to an appeal



Case is reviewed for medical necessity.

Specialty Review as required



Standard Appeals resolved in 30 days

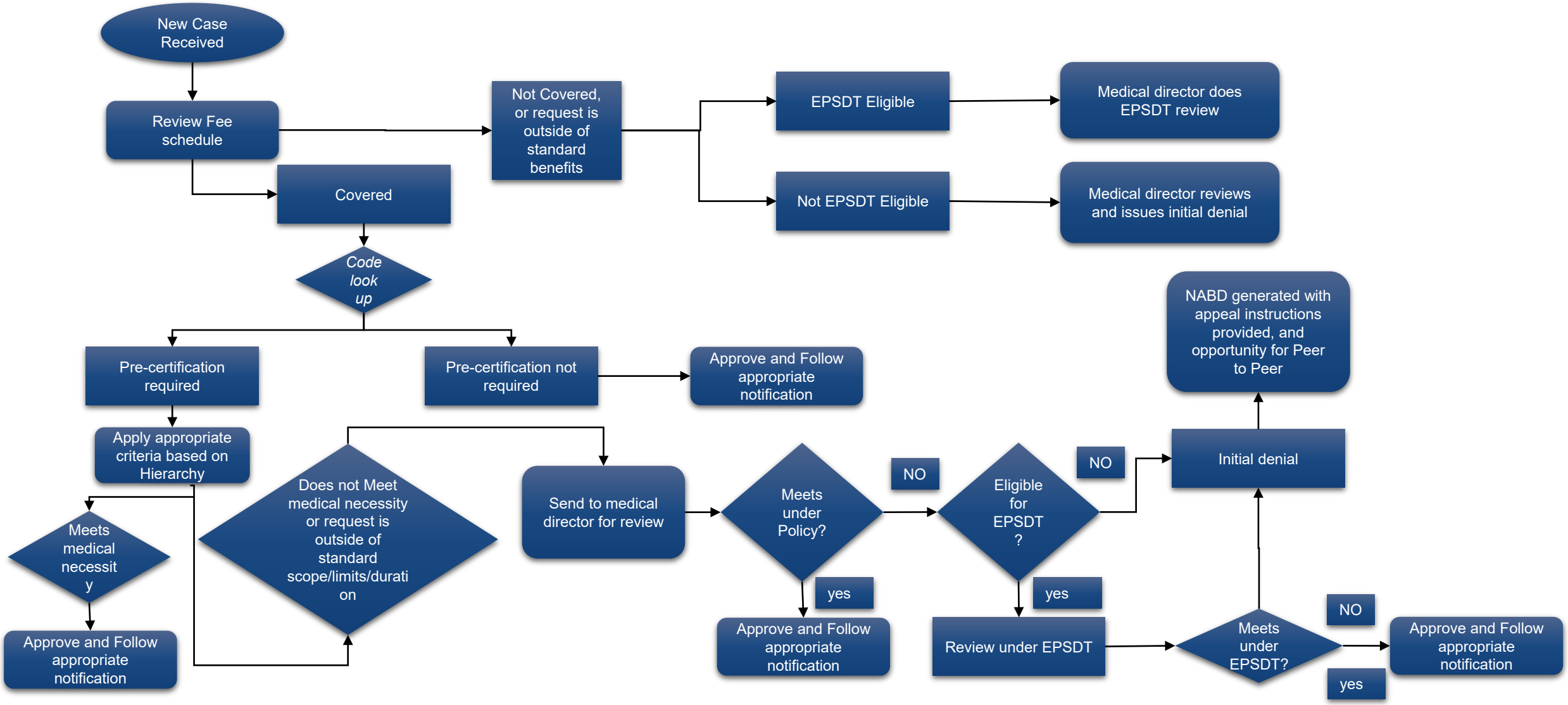
Expedited Appeals resolved in 72 hours

Adjustment made if required based on resolution

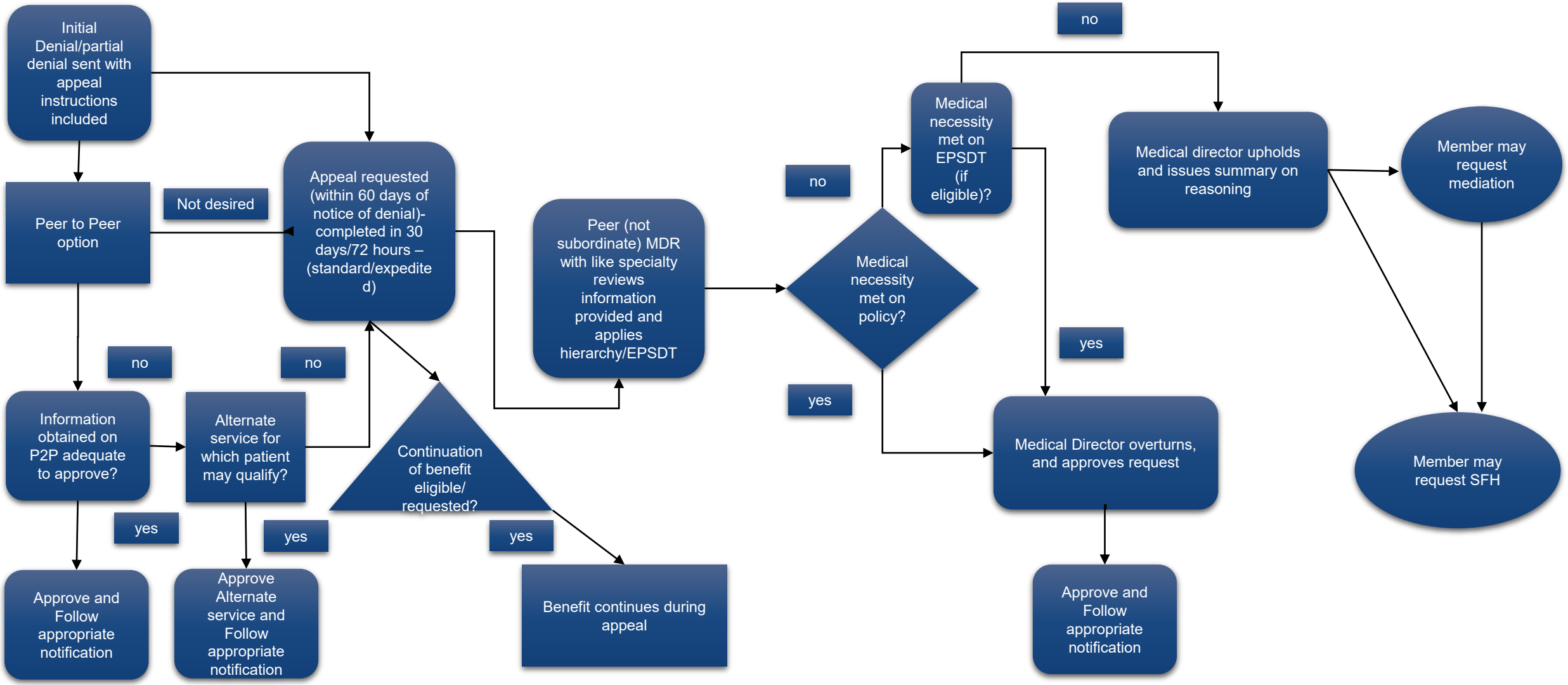
Resolution Letter Mailed

Member may request State Fair Hearing if not satisfied with the outcome of the Appeals process

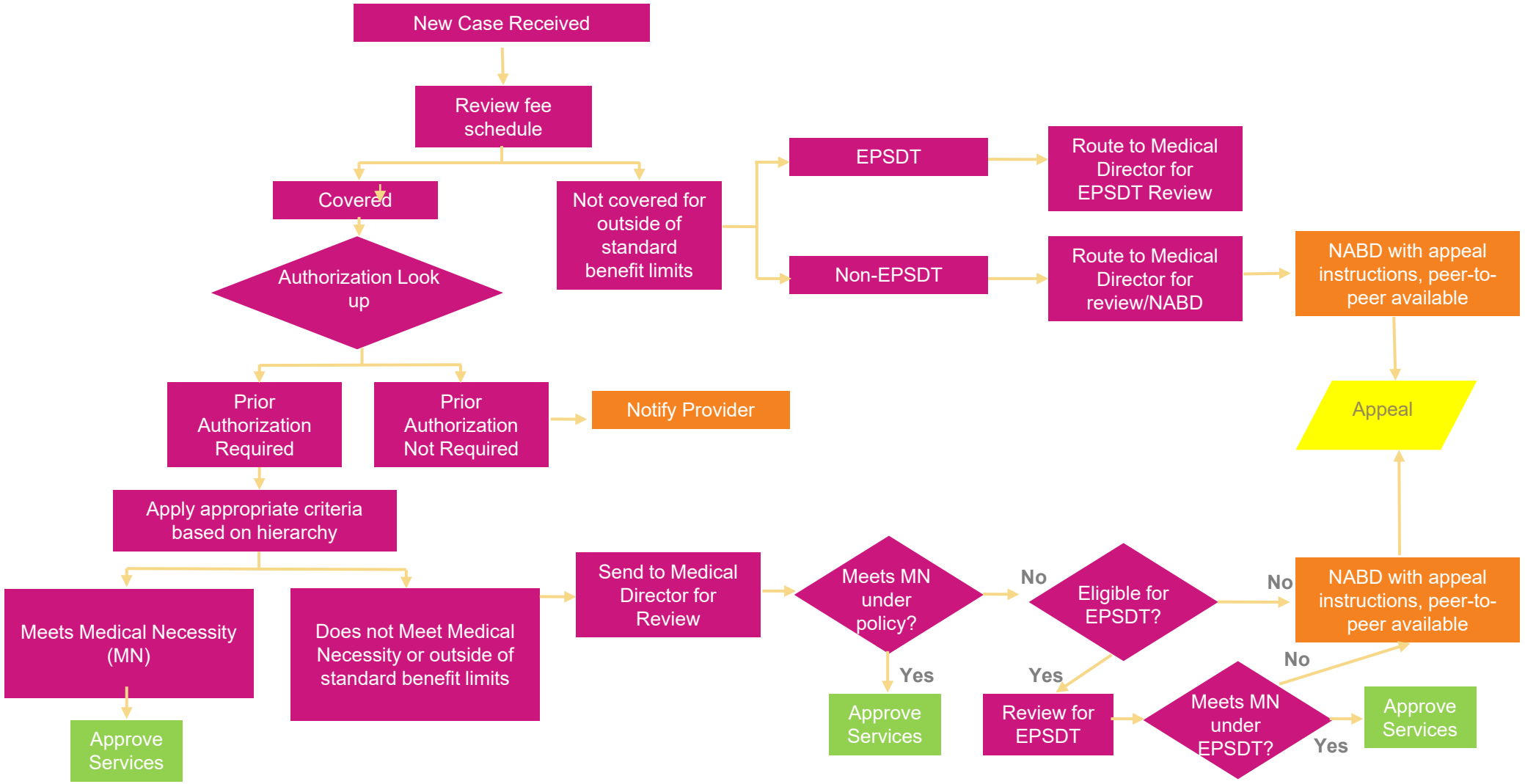
Utilization Management Process – Healthy Blue



Member Appeals Process – Healthy Blue

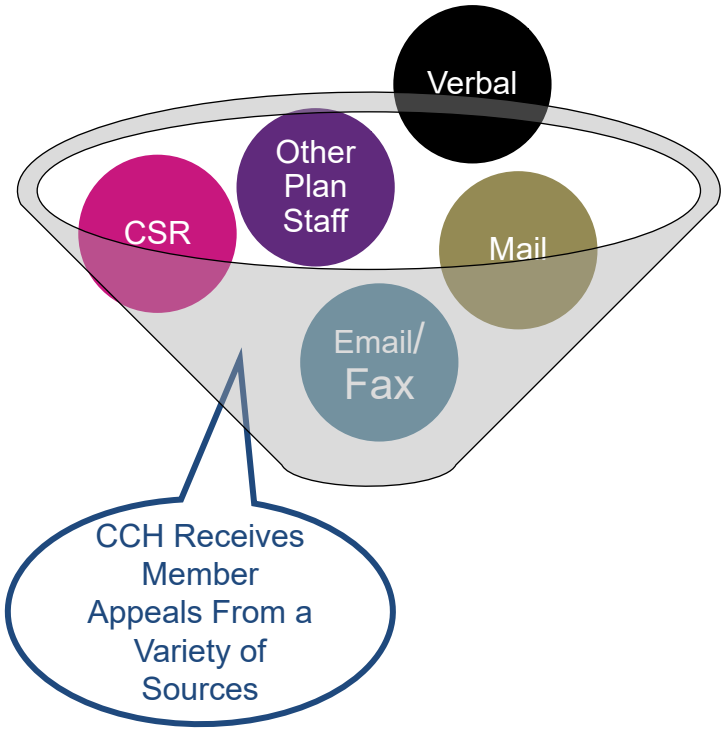


Utilization Management Process – Carolina Complete Health



carolina complete health

Member Appeals Process – Carolina Complete Health



A Member Appeal is Received by the G & A Team

Acknowledgement Letter Is Sent To Member

Appeal is Investigated & Medical Necessity is Reviewed

Rationale is Documented

Resolution Letter is Sent to Member

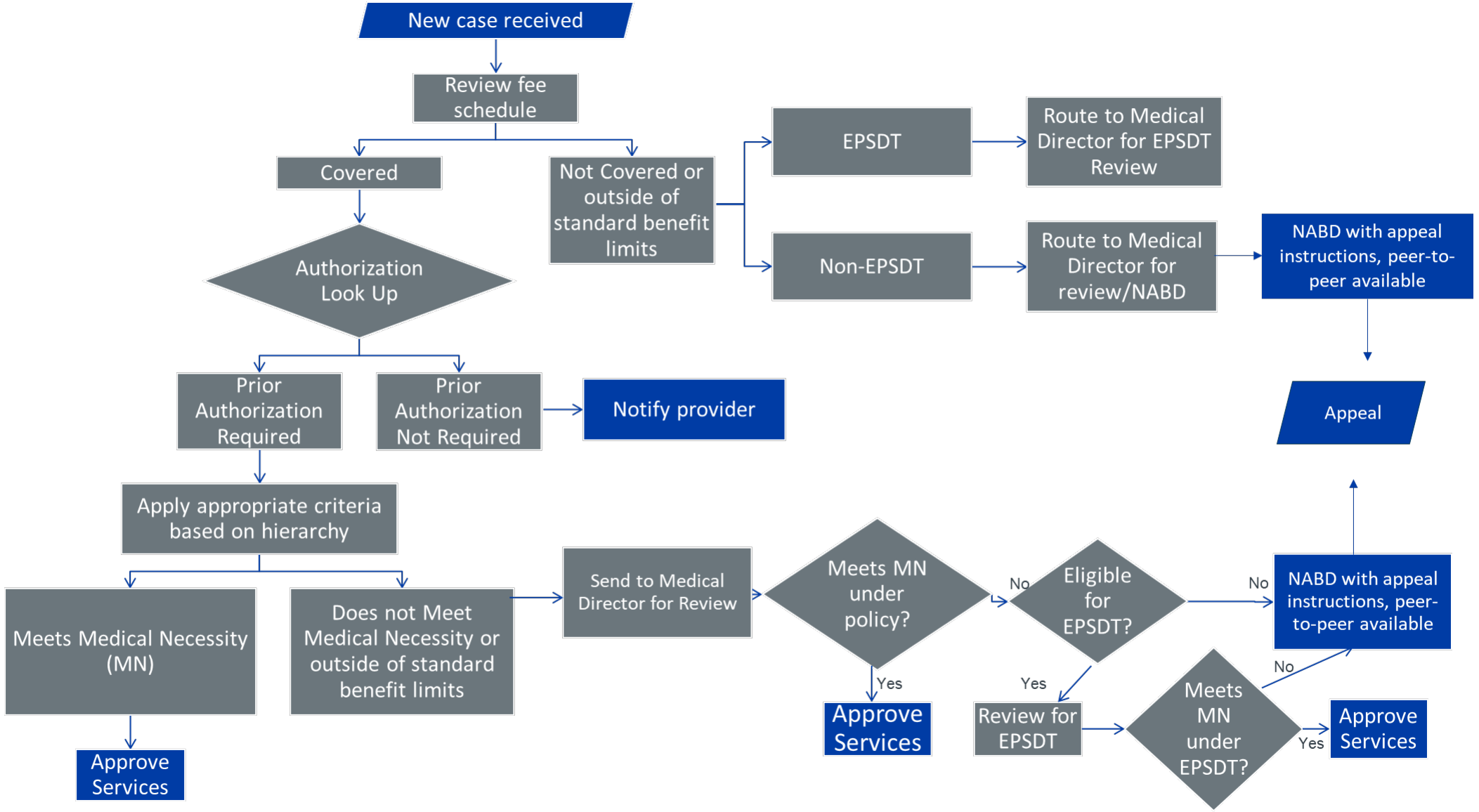
Appeals Timeline:

	Standard Appeal	Expedited Appeal
Acknowledge	5 calendar days	24 hours
Resolution	30 calendar days	72 hours
Extension	14 calendar days	14 calendar days

If a member is not satisfied with the result of an appeal to CCH they may initiate a State Fair Hearing by calling 984-236-1850 or faxing 984-236-1871.

carolina complete health

Utilization Management Process – AmeriHealth Caritas North Carolina



Member Appeals Process – AmeriHealth Caritas North Carolina

File within **60** days of NABD

Member Requests Appeal

- Provider, friend/family, or attorney may also request appeal on member's behalf
- Call Member Services at 1-855-375-8811
- Fax appeal form contained in Notice of Adverse Benefit Determination (NABD)
- Mail appeal form contained in NABD

Standard: **30** days
Expedited: **72** hours

Plan Reviews Information

- New clinical information may be provided or requested
- Review by same or similar specialty MD not reporting to initial reviewer
- Decision must occur by **14** days after new information requested

Plan Issues Decision

- Notice of Decision letter may overturn or uphold NABD
- If member disagrees, may request State Fair Hearing
  - Call Member Services at 1-855-375-8811
  - Call NC Medicaid Ombudsman at 1-877-201-3750 with questions
  - Complete and mail/fax request form in Notice of Decision

Request within **120** days of Notice of Decision

May Request State Fair Hearing

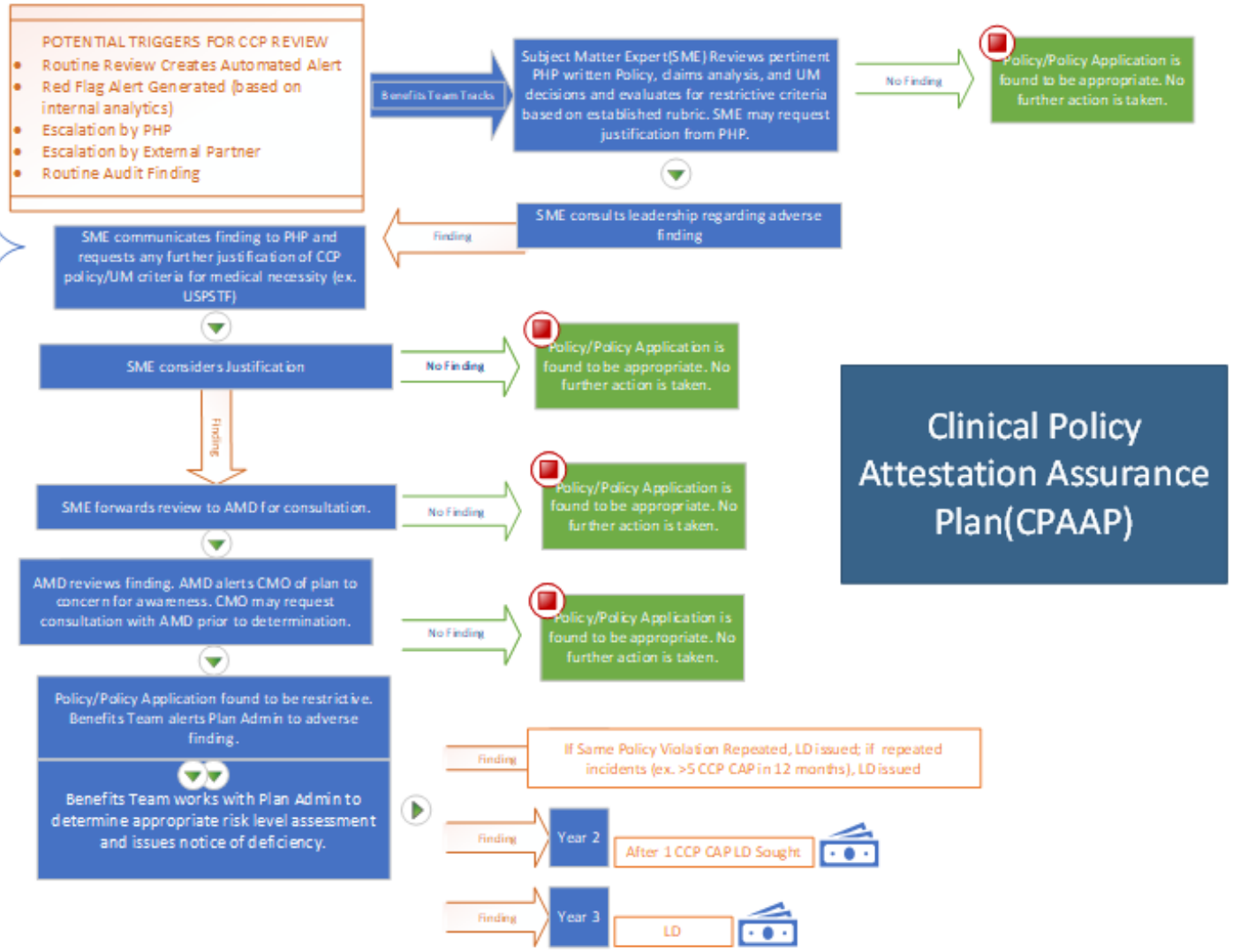
- Mediation Network of North Carolina will call to offer mediation within 5 days of receipt of request
- State Fair Hearing may overturn or uphold Notice of Decision
- If member disagrees with State Fair Hearing, may appeal to NC Superior Court
  - Must file appeal within **30** days of State Fair Hearing Decision

Members can request continuation of benefits (COB) during appeals process → Requests must be made within 10 days of receipt of Notice of Adverse Benefit Determination and services will continue throughout appeal process

Utilization Management Oversight

- Help Center Input
- Routine Review
- Alert Triggered
- Internal Escalation
- Audit Finding

- Is this a high priority item? Ex. Potential to cause harm, Immediate impact to beneficiaries, Safety concern?
- Is there evidence of a pattern?
- Potential for significant adverse provider impact?
- Is there a major financial impact?



Clinical Policy Attestation Assurance Plan(CPAAP)

Top Reasons to Contract Broadly

- **By contracting with all PHPs**, it creates greater choice for Medicaid Beneficiaries.
- **By contracting with all PHPs**, it creates better access to care for Medicaid Beneficiaries.
- **By contracting with all PHPs**, beneficiaries will not have to choose between their medical home and critical specialty care.
- In-network providers will be paid a higher rate compared to out of network providers (PHPs will cap on OON payments at 90% of fee schedule – typically FFS fee schedule).
  - NOTE: By contracting, providers avoid or eliminate the risk of getting paid less than the full Medicaid rate.
- In-network PCPs will receive additional AMH and CM PMPM payments.
  - NOTE: These payments are not available for OON providers.
- Out of Network Providers will **still** submit claims and authorization requests to the PHP if they see a beneficiary in a plan they have not contracted with.
  - NOTE: The Department has required the PHPs to use the same PA form.
- Out of Network Providers will have to develop single case agreements for out of network care, adding administrative burden.
- **Over the past year DHB has worked closely with the PHPs; PHPs understand NC Medicaid better and have improved on early contracting issues.**
  - **NOTE: If your early experience was not great, consider trying again.**
- **Many providers are contracting with all 5 plans, recognizing it is in the best interest of the beneficiaries.**

What If Questions Answered

What is the utilization management criteria for behavioral health hospitalizations and admissions under Standard Plan? Will this be consistent across plans or will each plan get to use their own criteria?

Will behavioral health services vary across health plans?

How will health plans find a provider (therapist) for beneficiaries if no one is taking new patients?

Will providers still be able to bill to the same collaborative care codes that we currently bill to?

Will the PHPs offer training to providers (PCP, social workers, case managers) on performing basic mental health assessments as well as more complex mental health assessments to address the growing need for these services for adult and pediatric patients?

What if a patient needs help after July 1st, but they do not speak English, what type of support and advocates will the PHPs provide to help them get the services they need or appeal a decision about the services they cannot obtain?

What If Questions Answered

What if a child needs specialized care that they can only get outside of the state, such as from Children Hospital of Philadelphia (CHOP)? Will the process for covering these services be the same for all the plans?

Are your clinical policies publicly posted and kept up-to-date?

Does the prompt pay interest penalty count for NC Health Choice vaccine products?

Advanced Medical Homes Tier 3 (AMH3s) do not currently receive information on hospital admissions and discharge for patients. When we transition to managed care in July, will the PHPs or CINs provide the infrastructure that allows hospital admission and discharge data to be shared with the medical home in an efficient way? If so, who is responsible for ensuring that transfer of data and what systems will be used?


QUESTIONS?

APPENDIX

Women's Health Consent Form

- PHPs are required to leverage the following forms/consents listed in DHB Policy. This guidance is listed in the PHP Billing Guidance document.
  - Applicable Women's Health Consent Forms:
    - **Hysterectomy**
    - **Abortions**
    - **Sterilizations**
- PHPs must maintain completed forms consistent with the PHP contract and federal statute.
- Here is the link to the Obstetrics and Gynecology Clinical Coverage Policies:
  - NC Medicaid: Obstetrics and Gynecology Clinical Coverage Policies (ncdhhs.gov)

Women's Health Consent Form

Sterilizations: The PHP shall require providers to complete and submit the Sterilization Consent Form outlined in Clinical Coverage Policy 1E-3 Attachment C and maintain completed consent forms consistent with the PHP contract and federal statute. The PHP shall not pay claims for this service without (1) receipt of the form from the provider, and (2) review and validation of the form by the PHP.

NC Medicaid
Sterilization Procedures

Medicaid and Health Choice
Clinical Coverage Policy No: 1E-3
Amended Date: August 15, 2020

Attachment C: The Consent Form

The Sterilization Consent form is available at
https://www.hhs.gov/opa/sites/default/files/consent-for-sterilization-english-updated.pdf

25 27 26

Form Approved: OMB No. 0937-0166
Expiration date: 4/30/2022

CONSENT FOR STERILIZATION

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from 1 (Doctor or Clinic). When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as Temporary Assistance for Needy Families (TANF) or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a 2 (Specify Type of Operation). The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least 30 days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on: 3 (Date).

I, 4, hereby consent of my own free will to be sterilized by 5 (Doctor or Clinic) by a method called 6 (Specify Type of Operation). My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health and Human Services, or Employees of programs or projects funded by the Department but only for determining if Federal laws were observed.

I have received a copy of this form.

7 (Signature) 8 (Date)

You are requested to supply the following information, but it is not required: (Ethnicity and Race Designation) (please check) 9

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Race (mark one or more):
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White

■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in 10 language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

11 (Interpreter's Signature) 12 (Date)

HHS-687 (04/22)

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before 13 (Name of Individual) signed the consent form, I explained to him/her the nature of sterilization operation 14 (Specify Type of Operation), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

15 (Signature of Person Obtaining Consent) 16 (Date)

17 (Facility)

(Address)

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon 18 (Name of Individual) on 19 (Date of Sterilization) I explained to him/her the nature of the sterilization operation 20 (Specify Type of Operation), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraph: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least 30 days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

- ☐ Premature delivery 21
  Individual's expected date of delivery: _____
- ☐ Emergency abdominal surgery (describe circumstance): 22

23 (Physician's Signature) 24 (Date)

Do not Copy

AmeriHealth Caritas North Carolina Claims Payment Processes

File within **180** days of visit

Pay clean claims within **30** days of submission

Provider Sees Patient

- Documents visit
- Obtains additional forms, if needed (i.e. CMEP checklist)
  - ACNC Clinical Policy Reference Tool to identify forms needed

Provider Submits Claim

- Change Healthcare Clearinghouse
  - Change Healthcare
- Alternative Clearinghouse
  - ACNC Payer ID: 81671
- Mail: AmeriHealth Caritas NC
  Attn: Claims Processing Dept
  P.O. Box 7380
  London, KY 40742-7380

Plan Reviews Information

1
- Fee present on fee schedule
- Required data elements
- Required attachments, if any (i.e. CMEP checklist)

2
- Authorization, if required
- Payment rules (i.e. service matches provider type)

Plan Makes Payment

- First check run on July 7th
- Check runs every Monday and Wednesday
- Electronic Funds Transfer
  - ECHO Healthcare

Plan notifies provider claim will not pay within **18** days of submission

1. Claim Rejection: refile within **180** days of date of service
   - Reason: incomplete or missing information
   - Resolution: Resubmit claim with corrections

2. Claim Denial: refile within **365** days of visit
   - Reason: limited incomplete information, no authorization, rules mismatch
   - Resolutions:
     - Add needed information and resubmit (codes signify what's missing)
     - Call Provider Services **1-888-738-0004** to correct on the call
     - File an appeal by visiting Provider Grievances and Appeals

File Appeal w/in **30** days of denial

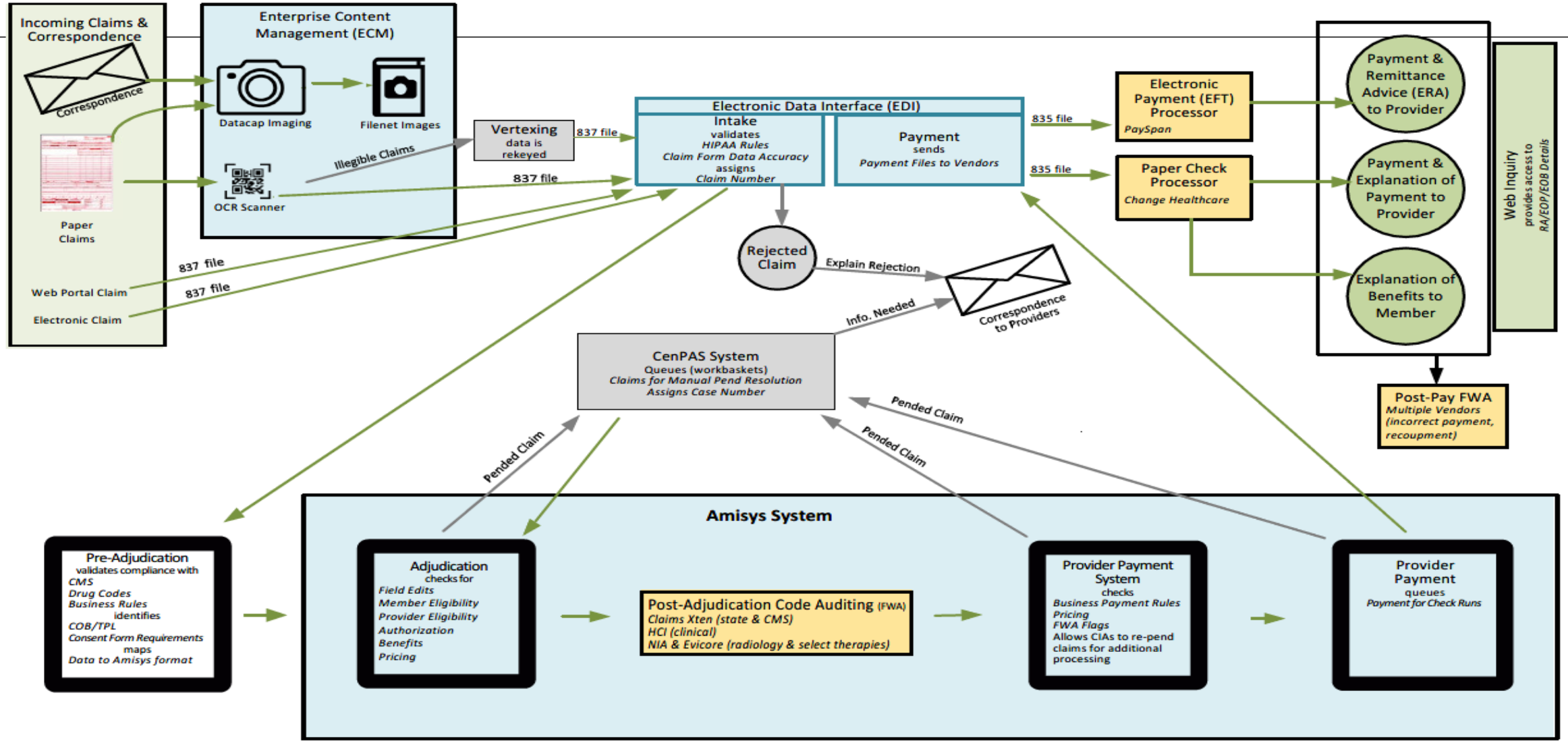
Provider Appeals

- Confirm receipt within **5** days
- May grant 30-day extension to Appeal timeframe
- Provider Appeals Committee notifies of decision within **30** days

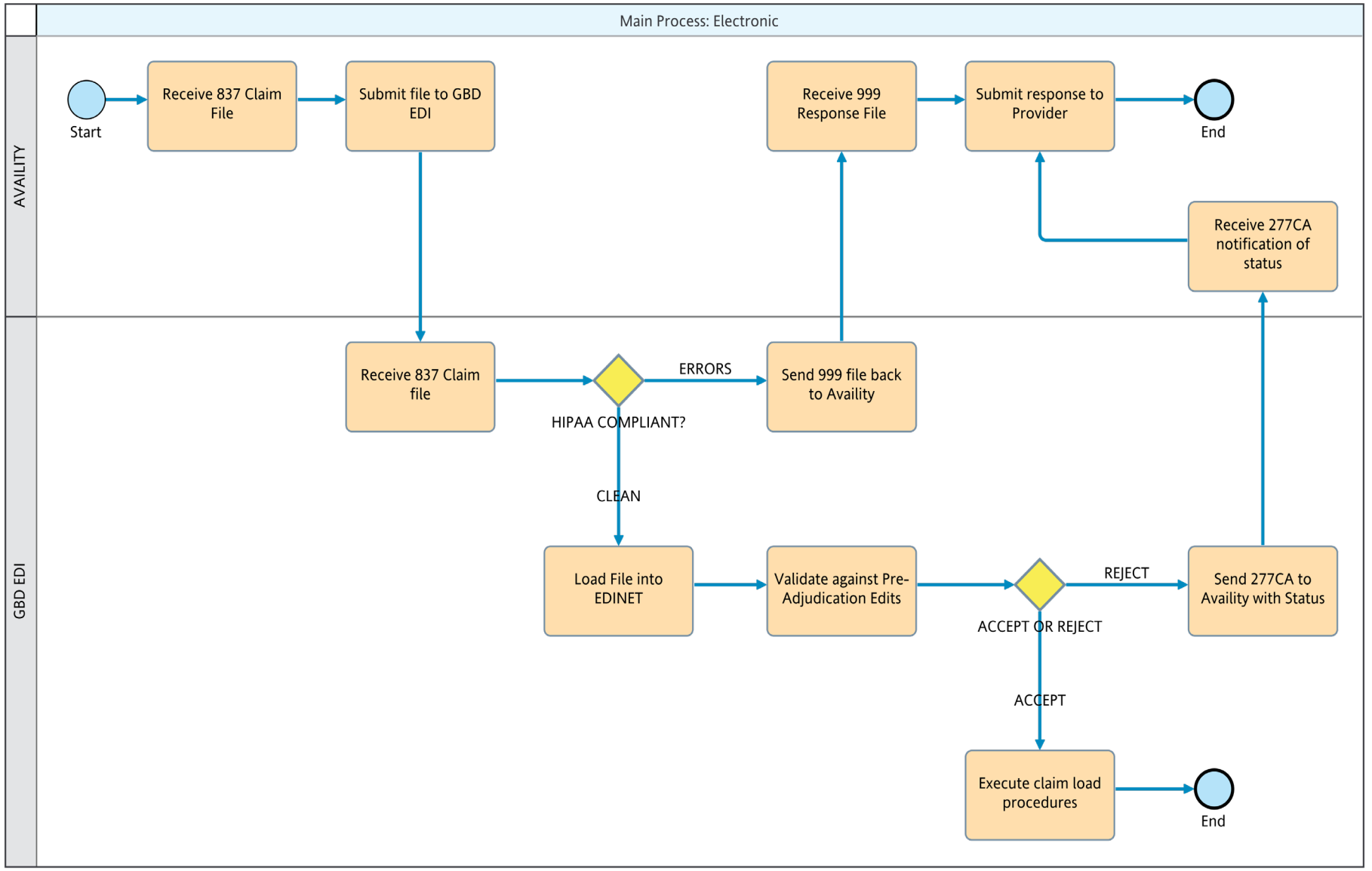
If overturned, pay claim within **30** days

If upheld, denial stands

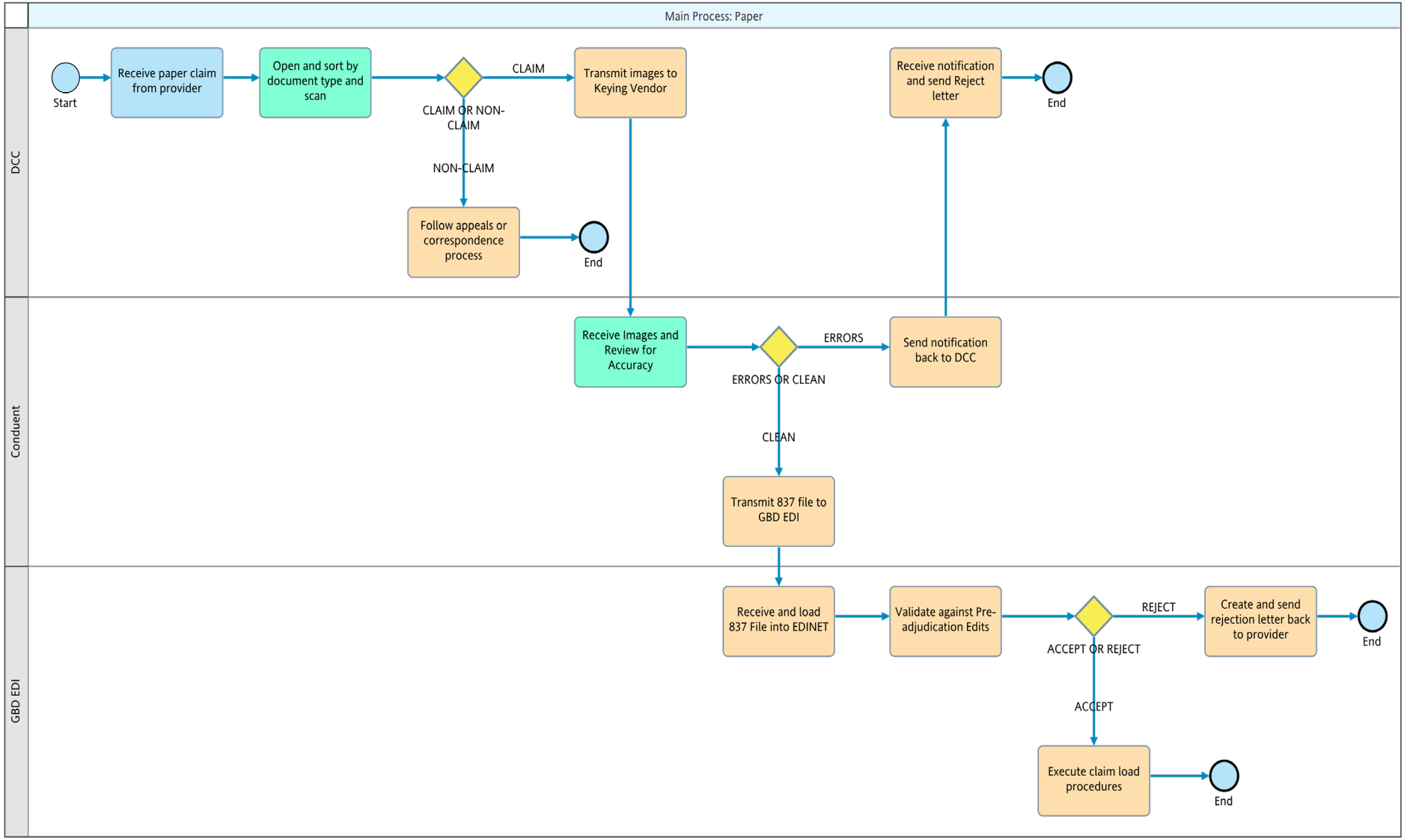
Billing Cycle – Carolina Complete Health



Billing Cycle – Healthy Blue

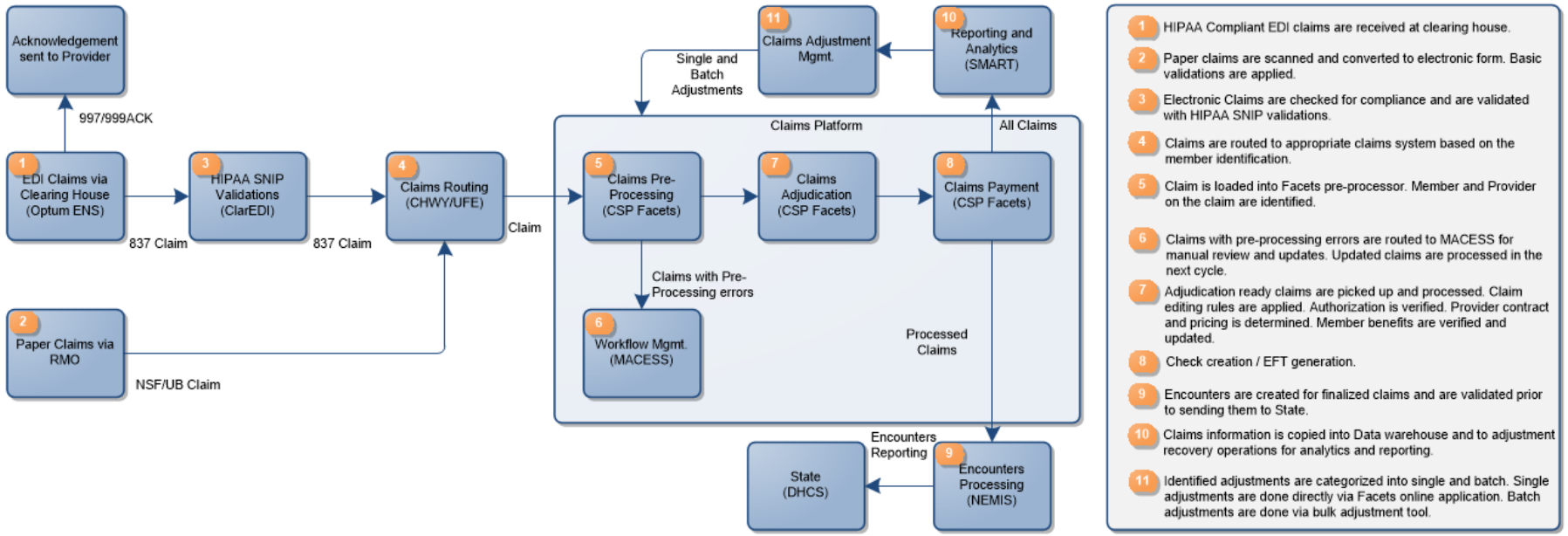


Billing Cycle – Healthy Blue



Billing Cycle – United Healthcare

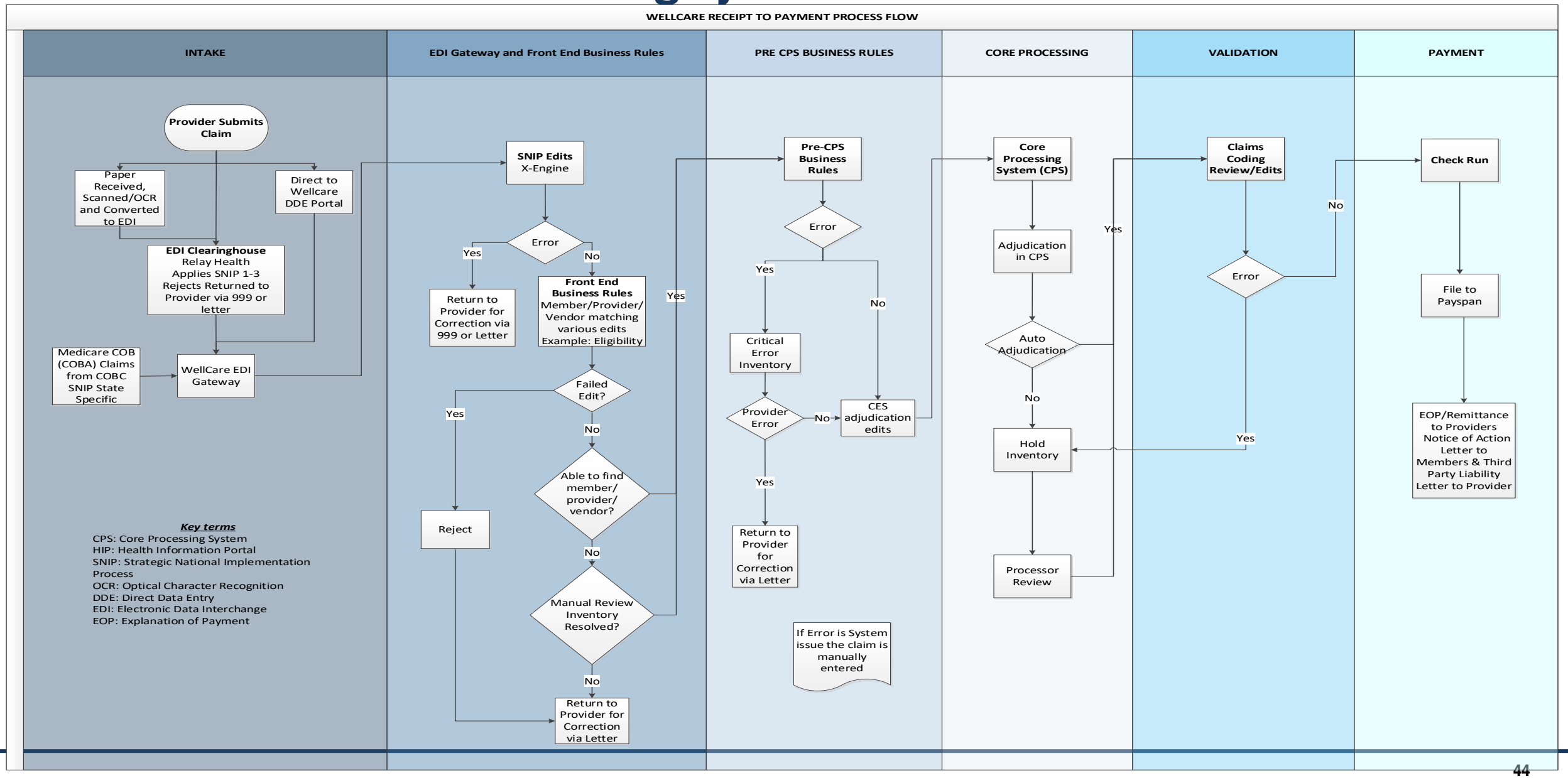
Claims Flow



Clean claims will process within 30 days of submission.

Electronic notice of status is available via 277report https://www.uhcprovider.com/en/resource-library/edi.html?CID=none
The 227 report is available for providers/healthcare professionals. Practices should work with their clearinghouse to ensure they are set-up to review the 277 report.

Billing Cycle – WellCare



What If Questions Answered

Question	ACNC	BCBS	CCH	UHC	WCHP
What is the utilization management criteria for behavioral health hospitalizations and admissions under Standard Plan? Will this be consistent across plans or will each plan get to use their own criteria?	ACNC will use criteria present in NC DHHS clinical coverage policies for behavioral health hospitalizations and admissions (PHPs are required to follow NC DHHS Clinical Coverage Policy 8B, 'Inpatient Behavioral Health Services')	Healthy Blue NC BH will utilize the NC CCP's (Policy 8-B for Inpatient) this is a mandatory policy therefore should be consistent across standard plans	Carolina Complete Health will utilize NC Medicaid clinical coverage policies for behavioral health reviews, in line with current DHHS coverage.	UHC will utilize the DHHS mandated CCP (8-B) along with other resources: American Society of Addiction Medicine (ASAM) Criteria®, Third Edition: • Level of Care Utilization System (LOCUS) Adult Version 20: • Child and Adolescent Service Intensity Instrument (CASII) Version 4.1:	We will utilize Milliman Care Guidelines (MCG) and the North Carolina Clinical Coverage policies regarding inpatient services.
Will behavioral health services vary across health plans?	All PHPs are required to offer services defined for Standard Plans (some may offer Value-Added Services) and to cover medically necessary services for Medicaid beneficiaries < 21 under EPSDT. ACNC will offer BHUC and IMD as an ILOS, Child First when member qualifies via EPSDT, and newer required services such as Peer Support. ACNC Value Added Benefits relevant to Substance Use Disorders include "Living Beyond Pain," post-discharge meals, and flexible recovery benefits.	All health planss are administering the same services mandated by the State plan. Each health plan can offer in lieu of services which can be different. Healthy Blue NC offers the following in lieu of services: BH Urgent Care, IMD	The state has defined a specific set of services for all standard plans; where we vary will be in value added and in lieu of services.	In general, all health plans offer the same services with the exception of in lieu of services and other value-added benefits.	No. WellCare is providing standard non tailored plan services (unless the member is EPSDT). For ILOS, see clinical policy and member website.

What If Questions Answered

Question	ACNC	BCBS	CCH	UHC	WCHP
How will health plans find a provider (therapist) for beneficiaries if no one is taking new patients?	Our Population Health and Provider Network Management teams work closely together to find appropriate providers for our members. We continuously evaluate our network and work to fill gaps to help ensure our members have timely access to medically necessary services. In a situation where a member needed services and no providers were available, ACNC would identify the closest provider that could offer needed services to the member, determine telehealth options, and review NCTracks to attempt to identify any local non-participating providers for outreach about contracting.	Healthy Blue NC has a team of Care Managers available to assist our members with finding outpatient providers and services. Beneficiaries will also have access to digital solutions in addition to using Quartet to help match members with providers.	CCH will focus on securing a broad and diverse network. When a network provider is not available in a particular discipline or within a reasonable timeframe for the clinical needs, our team will work with the member to find an alternative, including approval of out-of-network providers, as needed.	The Care Management program staff will assist the members in obtaining access to a therapist. If there isn't a therapist available that is in network the plan will seek other options to ensure that members have timely access to needed services.	WellCare care managers and the member's AMH3 care managers are available to assist with locating BH providers if needed for members. Member and referring provider requests for a member to see an out of network provider will be managed through our usual UM process for OON provider requests. We will refer those OON providers for outreach for contracting as well. If needed, our UM Department with work with the Non-Par provider on a SCA (Single Cae Agreement) to ensure the member is getting the care needed.

What If Questions Answered

Question	ACNC	BCBS	CCH	UHC	WCHP
Will providers still be able to bill to the same collaborative care codes that we currently bill to?	ACNC will cover both initial and subsequent psychiatric collaborative care management codes. Psychiatric collaborative care management services must be rendered under the direction of a treating physician or non-physician practitioner (NPP), typically in a primary care setting. These services are rendered when a beneficiary has a diagnosed psychiatric disorder and requires assessment, care planning, and provision of brief interventions. These beneficiaries may require assistance engaging in treatment or further assessment prior to being referred to a psychiatric care setting. Only the PCP can bill, which supports the employment of the BHCM and contracted hours with the Psychiatrist.	Yes, provided they are billing according to the most recent Clinical Coverage Policy.	Psychiatric collaborative care management services must be rendered under the direction of a treating physician or non-physician practitioner (NPP), typically in a primary care setting. These services are rendered when a beneficiary has a diagnosed psychiatric disorder and requires assessment, care planning and provision of brief interventions. These beneficiaries may require assistance engaging in treatment or further assessment prior to being referred to a psychiatric care setting.	Yes.	All services currently covered by NC Medicaid that are not tailored plan services are covered under the PHPs. This would include the Collaborative Care Codes.

What If Questions Answered

Question	ACNC	BCBS	CCH	UHC	WCHP
Will the PHPs offer training to providers (PCP, social workers, case managers) on performing basic mental health assessments as well as more complex mental health assessments to address the growing need for these services for adult and pediatric patients?	ACNC provides training to PCPs on common Behavioral Health conditions, including screening and treatment. These trainings and resources can be accessed online. We also provide referral pathways for when patients need specialized mental health care through our Let Us Know program.	Healthy Blue NC will support provider training such as SBIRT for Primary Care Providers. Additionally, HB will support Project Echo.	Toolkits and Trainings available through Resources: Behavioral Health Carolina Complete Health offers trainings for both behavioral health and physical health providers in our network at no cost. Our team provides mostly clinical, provider-focused education on topics that are geared towards improving member outcomes. The majority of our clinical trainings also offer behavioral health continuing education units also at no cost to the attendee. Trainings are completed via live/virtual instructor led webinars. https://network.carolinacompletehealth.com/resources/behavioral-health-training.html	UnitedHealthcare is committed to building high performing integrated health systems and will support providers as needed by assisting in identifying appropriate resources that may be needed to support our members.	This may be a good topic for our Quality Forums and our administrative simplification workgroup to review standard training for providers. Care managers, as part of our comprehensive assessment, assess members for behavioral health and substance use disorder needs, using standard assessment tools. AMH3 CMs are expected to do the same.

What If Questions Answered

Question	ACNC	BCBS	CCH	UHC	WCHP
As July 1 approaches, practices are hiring and onboarding new staff and getting them credentialed. How often will your PHP update provider credentials and staff list on your website?	The ACNC Online Provider Directory is updated daily, Monday through Friday, based on information from our internal provider database. Our system identifies changes to the list of providers transmitted on the NCTracks file and our internal provider database is updated once a change is identified. Additionally, dedicated Account Executives work with contracted providers to assist with provider/practice changes and data updates, reporting any changes reported to them (via a change request form) to our Provider Network Operations Team.	Medical staff will continue to be credentialed by NCDHHS prior to becoming contracted with prepaid health plans. Once a provider is credentialed with NCDHHS, the state will send updated files on a daily basis to the each of the PHPs informing them of newly credentialed providers. Healthy Blue adds	As providers onboard new staff, they should reach out to the provider relations team so that they can complete a roster to add their new practitioners to their group. *Note: In order to maintain a current provider profile, providers are required to notify NC Medicaid Program of any relevant changes to their credentialing information in a timely manner.* Providers must be credentialed on the NC Medicaid file prior to accepting or treating beneficiaries. PCPs cannot accept beneficiary assignments until they have completed their process with NC Medicaid. The directory should be updated within 48-72 hours from the time the enrollment process is complete and verified.	UnitedHealthcare does not credential providers for participation in the NC Medicaid program; NC DHHS conducts their own credentialing via their enrollment database, NC Tracks. Any new providers will have to be submitted through standard processes, validated against the state file and loaded as appropriate. Typically, they are reflected in our directory within 4 days following a load completion.	Any additions, updates or terminations for your practice should be communicated to your assigned Provider Network Specialist. Please contact our provider mailbox, NCProviderRelations@WellCare.com if you need assistance with identifying who your assigned PNS is. Once our Provider Data Management team verifies enrollment in NCTracks, they will use the effective date provided by the State. When a provider change it made, it takes approximately 24-48 hours to appear on the WellCare Provider Portal.

What If Questions Answered

Question	ACNC	BCBS	CCH	UHC	WCHP
Some health plans are requiring specialized therapists to obtain a physician order before doing an initial evaluation, but this is not a current requirement under Medicaid Direct for physical therapists, occupational therapists and speech therapists?	ACNC does not require a physician order for specialized therapists to perform an initial evaluation	If a member has the option to stay on Medicaid Direct or enroll in a PHP, then they choose. If the member does not enroll in a PHP and stay on Medicaid Direct, the PHP does not administir benefits for Medicaid Direct members. However, the PHPs will require for a prior authoriziton for pt, ot and speech therapy.	A verbal or written order must be obtained prior to the initiation of specialized therapy services, however initial evaluations may proceed without a specific order. All verbal orders must contain the date and signature of the person receiving the order, must be recorded in the beneficiary's record and must be countersigned by the physician within 60 calendar days. All verbal orders are valid up to six months from the documented date of receipt. All written orders are valid up to six months from the date of the physician's signature. Backdating is not allowed.	A physician referral is required that documents the need for a therapy evaluation. UnitedHealthcare will be utilizing therapists for review of requests for specialized therapy.	WellCare of North Carolina does not require prior approval for the initial assessment, unless the therapist is out of network, in which case prior approval for out of network provider care is required.
Who will be reviewing requests for specialized therapy? Can it be a peer instead of another health care provider type (e.g., nurse, social worker, MD)?	ACNC currently will use nurses and providers trained to perform these reviews and has the ability to consult external expert reviewers for complex cases, and our Utilization Management team is working to hire a specialized therapist reviewer.	If the information submitted does not appear to meet such criteria, the utilization manager submits the information for review by the medical director or other appropriate practitioner as part of the peer review process.	The Carolina Complete Health Utilization Management nurses would be doing the clinical review; there are specific therapy consultants available to support those reviews. If needed, level 2 review with MD will occur.	UnitedHealthcare will be utilizing therapists for review of requests for specialized therapy.	WellCare of NC's vendor utilizes peer therapists for specialized therapy reviews.

What If Questions Answered

Question	ACNC	BCBS	CCH	UHC	WCHP
When a child is referred to a child abuse specialist by the police or a mental health provider or by another specialist, does the child abuse specialist need to get approval from the child's medical home on the prior authorization before providing services to the child? If so, how should the provider obtain this approval and how much time does the provider have to obtain it?	Approval is not required for ACNC as long as the claim has the CME Program checklist signed by CME Program staff attached	Approval is not required for CME as long as the claim has the CME Checklist attached and is signed by the CME Program provider.	Authorization requirements are based on the specific services rendered. Our CCH prior auth check web tool is available for providers to confirm authorization requirements for individual services. However, a specific referral is not generally required for initial evaluation by an in-network child abuse specialist. Furthermore, it is anticipated that all currently certified Child Medical Evaluation Program clinicians will be treated as in-network for such purposes.	There is no need for a referral from the medical home for a pediatric patient to be seen by a child abuse specialist.	WellCare of North Carolina does not require authorizations for referrals to professional providers for covered services from in-network providers. The Child Medical Evaluation Program (CMEP) is covered under the Medicaid PHPs. WellCare of North Carolina is working on creating a special mailbox for submission of claims for services approved by the CMEP at UNC so they can be correctly processed and paid. WellCare does not do any review for medical necessity for CMEP services that go through the appropriate process based on the NC Medicaid Clinical Policy.

What If Questions Answered

Question	ACNC	BCBS	CCH	UHC	WCHP
Advanced Medical Homes Tier 3 (AMH3s) do not currently receive information on hospital admissions and discharge for patients. When we transition to managed care in July, will the PHPs or CINs provide the infrastructure that allows hospital admission and discharge data to be shared with the medical home in an efficient way? If so, who is responsible for ensuring that transfer of data and what systems will be used? (Part 1 of 3)	ACNC is committed to supporting providers with timely and actionable data to support optimal care for members. Because CINs often integrate data from multiple sources for affiliated practices, ACNC has collaborated with some CINs to help them connect to hospital admission and discharge data via NCHealthConnex. If you are unsure how this important information will flow to your practice, ACNC would encourage providers affiliated with a CIN to start by asking their CIN. For AMH Tier 3 providers unaffiliated with a CIN, practice leaders may contact their dedicated ACNC Account Executive for further information about how we can help practices connect.	While provider may not receive that information currently, AMH3s are required by the Department to have admission and discharge transfer (ADT) data feeds. See citations from the DHHS AMH Manual 2.1 below. CINs do provide a data setup infrastructure/capability to allow practices to meet these requirements (one of CINs' value-add to practices). Once a CIN or AMH3 practice contracts with PHP, we undergo data testing to ensure that the required data transfer occurs timely and securely.	In addition to receiving data from Health Plans, Tier 3 AMH practices are required to access admission, discharge and transfer (ADT) data; while Tier 1 and 2 practices are not required to access ADT data, they are strongly encouraged to do so. AMHs will also need timely access to certain clinical information for care oversight and management, including information about members' test results, lab values and immunizations. Practices have several options for how and where to access clinical data, such as clinical data from affiliated health systems' EHR software, or NC HealthConnex. Practices may also work through their CINs/Other Partners to obtain this data.	The DHHS AMH program requires that Tier 3 practices "demonstrate that, at a minimum, they have active access to an Admission, Discharge, Transfer (ADT) data source that correctly identifies specific empaneled Medicaid managed care members' admissions, discharges or transfers to/from an ED or hospital in real time or near real time	AMH3s as part of the AMH3 requirements must have a process to obtain ADT files. They can utilize any vendor for this, including the NC HIE. WellCare of NC will make a provider level file available through our provider portal, but this will be a daily file and will require the provider to log in to our portal to obtain it.

What If Questions Answered

Question	ACNC	BCBS	CCH	UHC	WCHP
Advanced Medical Homes Tier 3 (AMH3s) do not currently receive information on hospital admissions and discharge for patients. When we transition to managed care in July, will the PHPs or CINs provide the infrastructure that allows hospital admission and discharge data to be shared with the medical home in an efficient way? If so, who is responsible for ensuring that transfer of data and what systems will be used? (Part 2 of 3)	See response on Part 1 of 3	From the DHHS AMH Manual 2.1: https://files.nc.gov/ncdma/AMH-Provider-Manual-2.1-Final.pdf ADT Data Flows and NCCARE360 In addition to receiving data from Health Plans, Tier 3 AMH practices are required to access admission, discharge and transfer (ADT) data; while Tier 1 and 2 practices are not required to access ADT data, they are strongly encouraged to do so. AMHs will also need timely access to certain clinical information for care oversight and management, including information about members' test results, lab values and immunizations. Practices have several options for how and where to access clinical data, such as clinical data from affiliated health systems' EHR software, or NC HealthConnex. Practices may also work through their CINs/Other Partners to obtain this data.	AMHs are encouraged to access NCCARE360 for information regarding available community resources to address members' health-related resource needs. NCCARE360 is the first statewide coordinated care network to electronically connect those with identified needs to community resources and allow for a feedback loop on the outcome of that connection. As of June 2020, NCCARE360 is available in every county in North Carolina. Practices should refer to the NCCARE360 website for information about how to gain access.	See response on Part 1 of 3	See response on Part 1 of 3

What If Questions Answered

Question	ACNC	BCBS	CCH	UHC	WCHP
Advanced Medical Homes Tier 3 (AMH3s) do not currently receive information on hospital admissions and discharge for patients. When we transition to managed care in July, will the PHPs or CINs provide the infrastructure that allows hospital admission and discharge data to be shared with the medical home in an efficient way? If so, who is responsible for ensuring that transfer of data and what systems will be used? (Part 3 of 3)	See response on Part 1 of 3	AMHs are encouraged to access NCCARE360 for information regarding available community resources to address members' health-related resource needs. NCCARE360 is the first statewide coordinated care network to electronically connect those with identified needs to community resources and allow for a feedback loop on the outcome of that connection. As of June 2020, NCCARE360 is available in every county in North Carolina. Practices should refer to the NCCARE360 website for information about how to gain access. The Tier 3 AMH practice must track empaneled patients' utilization in other venues covering all or nearly all hospitals and related facilities in their catchment area, including local emergency departments (EDs) and hospitals, through active access to an admission, discharge and transfer (ADT).	See response on Part 2 of 3	See response on Part 1 of 3	See response on Part 1 of 3

What If Questions Answered

Question	ACNC	BCBS	CCH	UHC	WCHP
What if a patient needs help after July 1st, but they do not speak English, what type of support and advocates will the PHPs provide to help them get the services they need or appeal a decision about the services they cannot obtain? (Part 1 of 2)	ACNC makes a language line available to all members to discuss the member's needs and assists members with identifying providers with proficiency in the member's preferred language. ACNC hires bilingual member facing staff, when possible, to communicate directly with our members in their preferred language.	Healthy Blue NC has interpreter services available to assist our members who do not speak English. The services are available Monday - Saturday, 7 am - 6 pm Eastern Standard Time.	Carolina Complete Health provides oral interpreter and American Sign Language services free of charge to beneficiaries seeking health care-related services in a provider's service location, 24/7, and as necessary to ensure effective communication on treatment, medical history, health education, and any Contract-related matter. Beneficiaries are educated about these support services, and how to obtain them, through the New Member Welcome Packet and our Member Newsletter. We maintain a list of certified interpreters who provide services on an as-needed basis, including for urgent and emergency care, when beneficiaries request services.	Members will be supported by Care Managers as needed to receive the services that they need. They may also appeal a decision if the services that require prior authorization are not initially found to be medically necessary based on the clinical information provided. Services to help members communicate with UnitedHealthcare are provided at no cost to members. Call center agents can support members with special needs including the availability of a Language Line representative that can be conferenced in with support of over 240 languages. The agents can also provide assistance with and explain what is needed for completion of an appeal form.	WellCare of NC member service staff consists of agents who speak English and Spanish. Spanish speaking members can select a prompt from the IVR to speak with a Spanish speaking agent. If a member calls in and does not speak English, or if there are not Spanish speaking agents available, then member agents will follow instructions in Care Connects to conference in an interpreter to assist with the call. They can handle all inquiries the caller may have including initiating an appeal on the member's behalf and helping them to find a provider.

What If Questions Answered

Question	ACNC	BCBS	CCH	UHC	WCHP
What if a patient needs help after July 1st, but they do not speak English, what type of support and advocates will the PHPs provide to help them get the services they need or appeal a decision about the services they cannot obtain? Part 2 of 2)	See response on Part 1 of 2	See response on Part 1 of 2	Carolina Complete Health responds to beneficiary requests for telephonic interpreters immediately, and within five (5) business days for requests for services at provider offices. For assistance with the following interpreter services. Language Line: Toll Free 1-866-998-0338 Account Number 13982 Medicaid PIN #6329	See response on Part 1 of 2	WellCare also has several Spanish-speaking Care Coordinators who can assist members with resources and care management needs. Agents can also make arrangements for members who request to have an interpreter available on the phone during their medical, ancillary and therapy appointments.
What if a child needs specialized care that they can only get outside of the state, such as from Children Hospital of Philadelphia (CHOP)? Will the process for covering these services be the same for all the plans?	ACNC will evaluate the medical necessity of obtaining services from out of state / out of network providers. If our network cannot meet the needs of a member, we will complete single case agreements with out-of-state/out-of-network providers.	EPSDT provisions allow for consideration of such cases. Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets medical necessity.	Prior authorization is required for all out-of-network providers. Each clinical scenario will be reviewed for medical necessity and the individual merits of each case to determine if specialized care needs are not available within the network. Where necessary, our care managers will assist that member in securing the necessary care.	Out of state medically necessary services may be covered if the clinical expertise of the specialist is required to address the specific health needs of the beneficiary and an in-state provider is not available. This would typically occur when a beneficiary has an uncommon or ongoing special condition that requires a medical procedure or consultation from a specialist.	Providers who need to refer their patients out of state or out of network for care should contact utilization management where those requests will be reviewed. If appropriate services are not available from an in network /in-state provider, these cases can be arranged through a single case agreement.

What If Questions Answered

Question	ACNC	BCBS	CCH	UHC	WCHP
Are your portals open for contracted members to access? If not, when will they be?	Provider portal trainings are ongoing for ACNC; providers can register for ACNC now to get a feel for what the live environment will be like; the portal will be 'live' on 7/1.	Healthy Blue's portal training has begun, but live access to members will be at go live.	CCH portal can currently be accessed but certain functionalities may not be fully in place until July 1, 2021.	The provider portal is available for users to log on now, some of the transactions won't return results until after go-live like claims. The portal capabilities are not line of business specific, and as long as the upstream data has been loaded, it will display in the portal.	WellCare's public site with member and provider content is live. The member portal goes live 7/1 since no one is effective until 7/1. The provider portal is live but additional functionality (like the member lists, claims, claims calculator, etc) will go live 7/1. Providers can register and get set up with their contracts and do training now.

What If Questions Answered

Question	ACNC	BCBS	CCH	UHC	WCHP
Are your clinical policies publicly posted and kept up-to-date?	ACNC policies are posted on our public facing page and kept up-to-date.	Healthy Blue's policies are posted and are current.	Yes. As a provider-led entity, North Carolina physician input is a critical element of our clinical policy process. Our policies are current and publicly available via the Carolina Complete Health website; policies will be updated, when necessary, as clinical evidence emerges and/or generally accepted practice standards change.	Yes, the clinical policies are publicly posted and updated as needed.	WellCare's clinical policy website is live. WellCare has all of our clinical policies available. All policies will be updated at least annually, or as clinical evidence changes, or State policies are updated.
Does the prompt pay interest penalty count for NC Health Choice vaccine products?	Yes, the prompt pay interest penalty applies to all clean claims.	Yes, prompt pay interest penalties would apply to this for Healthy Blue.	Yes.	Yes, prompt pay penalties apply to all medical and pharmacy claims. According to prompt pay standards: Prompt Payment Standards i. The PHP shall promptly pay Clean Claims, regardless of provider contracting status. The PHP shall reimburse medical and pharmacy providers in a timely and accurate manner when a clean medical or pharmacy claim is received.	Prompt pay interest applies to NCHC vaccine claims.

Managed Care Claims and Prior Authorizations Submission: What Providers Need to Know – Part 1

WHERE SHOULD A PROVIDER SEND CLAIMS?

If there are claims for dates of service prior to July 1, 2021, claims should be submitted as they are today, through NCTracks or local management entities/managed care organizations (LME/MCOs).

For dates of service beginning July 1, 2021, claims routing depends on a beneficiary's enrollment at time of service and the service provided. Claims for beneficiaries enrolled in NC Medicaid Direct should continue to be submitted to NCTracks. Claims for members enrolled in Medicaid Managed Care should be submitted to the assigned health plan as shown on their member ID card and validated through the NCTracks Recipient Eligibility Verification methods outlined below, unless the service provided is a carved-out service.

Recipient Eligibility Verification

There are two methods of Recipient Eligibility Verification available via the NCTracks Secure Provider Portal: Real Time Eligibility Verification and Batch Eligibility Verification. As a reminder, these methods can be used for ***current*** eligibility information – future eligibility information is not available at this time.

1. Real Time Eligibility Verification Method
    a. Log into the NCTracks Provider Portal
    b. Follow the Eligibility > Inquiry navigation
    c. Populate the requested provider, recipient, and time-period information
2. Batch Eligibility Verification Method
    a. Log into the NCTracks Provider Portal
    b. Follow the Eligibility > Batch verify
    c. Upload the file by selecting browse > load from file

Additional information is included in the NCTracks Learning Management System (SkillPort) under the Provider Training Folder, CBTs, Recipient, RCP 131 Viewing Recipient Information Eligibility Providers.

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Managed Care Claims and Prior Authorizations Submission: What Providers Need to Know – Part 1

Carved Out Services

NCDHHS has defined services that will be carved out of Medicaid Managed Care and should continue to be billed through NCTracks. The services are defined on the table below.

First Revisited and Restated Section V.C. Table 2: Services Carved Out of Medicaid Managed Care[10]
Services provided through the Program of All-Inclusive Care for the Elderly (PACE)
Services documented in an Individualized Education Program (IEP), Individual Family Service Plan (IFSP), a section 504 Accommodation Plan pursuant to 34 C.F.R. § 104.36, an Individual Health Plan (IHP), or a Behavior Intervention Plan (BIP) as appropriate for each covered service and provided or billed by Local Education Agencies (LEAs)
Services provided and billed by Children's Developmental Services Agency (CDSA) that are included on the child's Individualized Family Service Plan
Dental services defined as all services billed as dental using the American Dental Association's Current Dental Terminology (CDT) codes with the exception of the two CDT codes (D0145 and D1206) associated with the "Into the Mouths of Babes" (IMB)/Physician Fluoride Varnish Program.
Services for Medicaid applicants provided prior to the first day of the month in which eligibility is determined in cases where retroactive eligibility is approved (with exception of deemed newborns) unless otherwise defined in the Contract
Fabrication of eyeglasses, including complete eyeglasses, eyeglasses lenses, and ophthalmic frames

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Managed Care Claims and Prior Authorizations Submission: What Providers Need to Know – Part 1

HOW SHOULD AN IN-NETWORK PROVIDER SUBMIT CLAIMS TO A HEALTH PLAN?

Medicaid and NC Health Choice beneficiary assignment determines claims submission process. Claims for beneficiaries enrolled with a health plan should be submitted to the assigned health plan. Please refer to the resources linked below for detailed information about claims submission and billing information for each health plan.

- **AmeriHealth Caritas of North Carolina:**
  https://www.amerihealthcaritasnc.com/provider/forms/index.aspx
- **Blue Cross and Blue Shield of North Carolina | Healthy Blue:**
  https://provider.healthybluenc.com/north-carolina-provider/resources
- **Carolina Complete Health:**
  https://network.carolinacompletehealth.com/content/dam/centene/carolinacompletehealth/pdfs/Carolina%20Complete%20Health-%202020%20Provider%20Billing%20Manual.pdf
- **United Healthcare:**
  https://www.uhcprovider.com/content/dam/provider/docs/public/admin-guides/comm-plan/NC-UHCCP-Care-Provider-Manual.pdf
- **WellCare of North Carolina:**
  https://www.wellcare.com/en/North-Carolina/Providers/Medicaid/Claims
- **DHHS:**
  https://medicaid.ncdhhs.gov/providers/claims-and-billing

HOW SHOULD AN OUT OF NETWORK PROVIDER SUBMIT CLAIMS TO A HEALTH PLAN?

Out-of-Network Providers will file services covered under Medicaid Managed Care directly with the health plan. Out-of-Network providers are required to get a prior authorization from the assigned health plan before providing services and may need to complete a single case agreement to receive payment. If the provider has engaged in good faith negotiations with the health plan but failed to contract, the out-of-network provider will be paid at 90% reimbursement. If the health plan has not yet engaged in good faith negotiations, the provider would be reimbursed at 100%. Please refer to the appropriate health plan provider directories and websites linked above for additional details.

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Managed Care Claims and Prior Authorizations Submission: What Providers Need to Know – Part 1

HOW WILL PRIOR AUTHORIZATIONS WORK?

For standard authorization decisions, the PHP will provide notice as expeditiously as the member's condition requires and no later than 14 calendar days after the receipt of the request of services. However, the PHP may receive a possible extension of up to 14 days if the member requests the extension or if the PHP justifies a need for additional information and how the extension is in the member's interest.

If the PHP extends the timeframe beyond 14 days, the PHP will provide the member and provider with a written notice of the reason for the decision to extend the timeline and inform the member of the right to file a grievance if he or she disagrees with that decision.

HOW DO EXPEDITED AUTHORIZATION REVIEWS WORK?

For expedited authorization decisions, the PHP will provide notice no later than 72 hours after receipt of the request for service. The PHP may extend the 72-hour time period by up to 14 days if the member requests the extension or if the PHP justifies a need for additional information and how the extension is in the member's interest. If the PHP extends the timeframe beyond 72 hours, the PHP will provide the member and provider with a written notice of the reason for the decision to extend the timeline and inform the member of the right to file a grievance if he or she disagrees with that decision.

WHAT IF I HAVE QUESTIONS?

For general inquiries and complaints regarding health plans, NC Medicaid has created a **Provider Ombudsman** to represent the interests of the provider community. The Ombudsman will:

- Provide resources and assist providers with issues through resolution.
- Assist providers with Health Information Exchange (HIE) inquires related to NC HealthConnex connectivity compliance and the HIE Hardship Extension process.

Provider Ombudsman inquiries, concerns or complaints can be submitted to Medicaid.ProviderOmbudsman@dhhs.nc.gov, or received through the Provider Ombudsman line at 866-304-7062. The Provider Ombudsman contact information is also published in each Health Plan's Provider Manual.
For questions related to your NCTracks provider information, please contact the NCTracks Call Center at 800-688-6696. To update your information, please log into NCTracks (https://www.nctracks.nc.gov) Secure Provider Portal and utilize the Managed Change Request (MCR) to review and submit changes.
For questions related to member eligibility, please call the NCTracks Call Center for more information: 800-688-6696.
For all other questions, please contact the NC Medicaid Help Center at 888-245-0179 or email at Medicaid.HelpCenter@dhhs.nc.gov.

What Providers Need to Know: Part 2 - After Managed Care Launch

KEY REMINDERS FOR PROVIDERS

All providers are strongly encouraged to complete the following checklist of key actions after NC Medicaid Managed Care Launch. More information on some of these items are detailed in the following pages.

- Make sure staff know the health plans with which you are contracted, and if you are an Eastern Band of Cherokee Indians (EBCI) Tribal Option provider.
- Continually review the NCTracks provider record for each applicable individual provider and organization for accuracy and submit changes using the Manage Change Request (MCR) process. Know where you need to submit claims.
- For each health plan under contract, please ensure enrollment in the Health Plan's Electronic Funds Transfer program is completed.
- Assist your beneficiaries with their transition to NC Medicaid Managed Care following the guidance below.

PROVIDER CONTRACTING REMINDERS

Health plan contracting is an ongoing process. If your office did not meet the deadline to be included in the initial launch of the Medicaid and NC Health Choice Provider and Health Plan Look-up Tool and health plan provider directories, there is still opportunity to contract with each health plan.
Explore your options with more information available here.

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What Providers Need to Know: Part 2 - After Managed Care Launch

ENSURE YOUR INFORMATION IS CORRECT

Medicaid and NC Health Choice participating providers are contractually required to update their NCTracks record within 30 days of any change. This obligation to report includes any change in the information contained in the NCTracks provider enrollment record, as well as any adverse action against the provider or any of its officers, agents, or employees. To remain in compliance and maintain the accuracy of information supplied to the health plans and beneficiaries, take the time to regularly review your provider record in NCTracks. Changes may be submitted using the MCR process available in the NCTracks Secure Provider Portal.

Review the NC DHHS Provider Administrative Participation Agreement here, or a recent publication about reporting changes here.

KNOW WHERE TO SUBMIT CLAIMS

If there are claims for dates of service prior to July 1, 2021, they should be submitted as they are today, through NCTracks or LME/MCOs.

For dates of service beginning July 1, 2021, claims routing depends on a beneficiary's enrollment at time of service and the services provided. Claims for beneficiaries enrolled in NC Medicaid Direct should continue to be submitted to NCTracks. Claims for members enrolled in Medicaid Managed Care should be submitted to the assigned health plan as shown on their member ID card and validated through the NCTracks Recipient Eligibility Verification methods, unless the service provided is a carved-out service.

Two Claims Submission Provider Fact Sheets are available on the Provider Playbook that addresses how managed care claims are filed.

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What Providers Need to Know: Part 2 - After Managed Care Launch

ASSIST YOUR BENEFICIARIES WITH THE TRANSITION

- Beneficiaries have 90 days after the effective date of initial enrollment to change their health plan or PCP/Advanced Medical Home (AMH) for any reason.
- Within eight days of being enrolled with a health plan, beneficiaries should receive their Member Welcome Packet, Member Handbook, and Medicaid Card from their health plan. During crossover in year 1, all beneficiaries will receive their welcome packet by June 6, 2021.
- Follow these steps when a Medicaid or NC Health Choice beneficiary presents at your office:
  - Verify eligibility, health plan and primary care provider enrollment. This can be done using the NCTracks Recipient Eligibility Verification tool
  - Confirm that your office participates with the member's health plan.
  - If you are not the assigned Primary Care Practice for the beneficiary but are in Network for the health plan, you can render and be paid for Primary Care Services.
  - If the beneficiary would like to have you as their assigned Primary Care Practice, you can support the beneficiary in calling the enrollment broker (during the first 90 days after managed care launch) or the beneficiary's health plan (over 90 days after managed care launch) to have them reassigned to you
  - If you are a non-participating provider for the beneficiary's Medicaid health plan, you may render services.
    - Special protection is afforded non-network providers (see the Transition of Care section below)
    - If a good-faith contracting effort has been made by the health plan and you declined to participate, then you are subject to receiving 90% of the Medicaid fee-for-service rate. If no good-faith contracting effort has occurred, or if it is in progress, then you are subject to receiving 100% of the Medicaid fee-for-service rate until the contracting effort has been resolved.

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What Providers Need to Know: Part 2 - After Managed Care Launch

TRANSITION OF CARE PROTECTIONS IMPACTING PROVIDERS

As a provider, it is important that you are aware of the transition of care protections that impact providers.

Please note:

- The PHP will honor existing and active prior authorizations on file with the North Carolina Medicaid or NC Health Choice program for services covered by the PHP for the first 90 days after launch or until the end of the authorization period, whichever occurs first.
- For the first 60 days after Launch, the PHP will pay claims and authorize services for Medicaid-enrolled out-of-network providers equal to that of in-network providers until end of episode of care or for 60 days, whichever is less (more details in N.C. Gen. Stat. § 58-67-88(d), (e), (f), and (g).).
- Additional transition of care-specific guidance will become available at: https://medicaid.ncdhhs.gov/transformation/care-management/transition-care

WHAT IF BENEFICIARIES HAVE QUESTIONS?

Most beneficiary questions about choosing a Health Plan or PCP can be answered by the Enrollment Broker Call Center which will open beginning **March 1, 2021** from 7 a.m. to 8 p.m., Monday through Sunday. To select a Primary Care Provider (PCP) and Health Plan through the Enrollment Broker, beneficiaries can:

- Call 833-870-5500, (TTY: 1-833-870-5588)
- Go online at ncmedicaidplans.gov
- Complete and return a paper enrollment form by fax or mail
- Use the NC Medicaid Managed Care mobile app

DHHS will be posting a Question-and-Answer document to the NC Medicaid Managed Care website to address common beneficiary questions about the transition to NC Medicaid Managed Care. Once a beneficiary is enrolled with a health plan, information and a new Medicaid card will be mailed within eight days. At that point, if beneficiaries have questions about their health plan or services covered, they should contact their health plan. Contact information for health plans can be found at the number on their new Medicaid card or on the NC Medicaid website here.

In addition, DHHS has partnered with Legal Aid of North Carolina to serve as the **NC Medicaid Managed Care Ombudsman** to help resolve beneficiary complaints. Contact the **NC Medicaid Managed Care Ombudsman** at ncmedicaidombudsman.org or 877-201-3750.

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What Providers Need to Know: Part 2 - After Managed Care Launch

WHAT IF I HAVE QUESTIONS?

Additional resources for providers on the transition to managed care can be found in the NC Medicaid Help Center, the Provider Playbook and on the Medicaid Transformation website.

For general provider inquiries and complaints regarding health plans, contact the **Provider Ombudsman** at Medicaid.ProviderOmbudsman@dhhs.nc.gov, or 866-304-7062. The Provider Ombudsman contact information is also published in each health plan's provider manual.

For questions related to your NCTracks provider information, please contact the NCTracks Call Center at 800-688-6696. To update your information, please log into NCTracks (https://www.nctracks.nc.gov) provider portal to verify your information and submit a MCR.

For all other questions, please contact the NC Medicaid Contact Center at 888-245-0179.

Managed Care Claims and Prior Authorizations Submission: What Providers Need to Know – Part 2

Question	WellCare (WCHP) Response	AmeriHealth Caritas (AMHC) Response	Healthy Blue Response	Carolina Complete Health (CCH) Response	United Healthcare (UNHC) Response
How to file a claim with the PHP – what are the options (virtual, fax, paper, etc.)? (1 of 3)	WellCare (WCHP) accepts both electronic and paper claims (but not faxes). Paper claims must be received on original red/white CMS claim forms so faxes are not considered compliant. Please see the provider manual, provider resource guide, and Quick reference guide at this link for detailed information regarding clean claims and step by step filing instructions. https://www.wellcare.com/en/North-Carolina/Providers/Medicaid	The claims submission process described below applies to providers who wish to submit out of network claims. This process can be found on page 4 of the AmeriHealth Caritas North Carolina (AMHC) Provider Claims and Billing Manual, which can be found at www.amerihealthcaritasnc.com:	Providers have the option of submitting claims electronically or by mail. Providers participating and those not participating with Healthy Blue may enroll with our trading partner, Availity at www.availity.com.	**Electronic Claims Submission** CCH can receive ANSI X12N 837 professional, institution or encounter transactions. In addition, it can generate an ANSI X12N 835 electronic remittance advice known as an Explanation of Payment (EOP). Providers that bill electronically have the same timely filing requirements as providers filing paper claims.	Both In-Network (INN) and Out-of-Network (OON) providers may submit claims via EDI submission, under Payer ID 87726. However, prior to doing so, they will need to enroll with our clearinghouse OptumInsight to establish a secure connection, and they (or their claims processing service) may do so by calling 866-367-9778 and selecting option 3.

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Managed Care Claims and Prior Authorizations Submission: What Providers Need to Know – Part 2

Question	WellCare (WCHP) Response	AmeriHealth Caritas (AMHC) Response	Healthy Blue Response	Carolina Complete Health (CCH) Response	United Healthcare (UNHC) Response
How to file a claim with the PHP – what are the options (virtual, fax, paper, etc.)? (2 of 3)	See response on part 1 of 3, slide 67	"In accordance with 42 C.F.R. §438.602(b), health care providers (including ordering, prescribing, or referring only providers) interested in participating in the AMHC network must be screened and enrolled as a Medicaid provider by the North Carolina Department of Health and Human Services (NCDHHS) and shall be reenrolled every three years, except as otherwise specifically permitted by DHHS in the Revised and Restated RFP 30-190029-DHB, Section V.	See response on part 1 of 3, slide 67	In addition, providers that bill electronically must monitor their error reports and evidence of payments to ensure all submitted claims and encounters appear on the reports. Providers are responsible for correcting any errors and resubmitting the affiliated claims and encounters. CCH's Payor ID is 68069. Our Clearinghouse vendors include Availity and Change Healthcare (formerly Emdeon). Please visit our website for our electronic Companion Guide which offers more instructions	UNHC uses this clearinghouse with both INN and OON providers, so there is nothing unique about this process for an OON provider. An OON provider may also submit a paper claim by mail to: UnitedHealthcare Community Plan P.O. Box 5280 Kingston, NY 12402-5240

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Managed Care Claims and Prior Authorizations Submission: What Providers Need to Know – Part 2

Question	WellCare (WCHP) Response	AmeriHealth Caritas (AMHC) Response	Healthy Blue Response	Carolina Complete Health (CCH) Response	United Healthcare (UNHC) Response
How to file a claim with the PHP – what are the options (virtual, fax, paper, etc.)? (3 of 3)	See response on part 1 of 3, slide 67	This applies to non-participating in and/or out of the State providers as well. Claims for all services provided to Plan members must be submitted by the provider who performed the services. **Submitting Claims** Providers may submit claim via electronic: *Electronic/EDI* Use the payer ID for AmeriHealth Caritas North Carolina: 81671. Additional details can also be found within the Provider Claims and Billing Guide www.amerihealthcaritasnc.com	See response on part 1 of 3, slide 67	For questions or more information on electronic filing please contact: CAROLINA COMPLETE HEALTH C/O CENTENE EDI DEPARTMENT 800-225-2573, ext. 25525 Or by e-mail at EDIBA@centene.com **Paper Claim Submission** All paper claims and encounters should be submitted to: Carolina Complete Health Attn: Claims PO Box 8040 Farmington MO 63640-8040	See response on part 1 and 2 of 3, slide 67 and 68

Managed Care Claims and Prior Authorizations Submission: What Providers Need to Know – Part 2

Question	WellCare (WCHP) Response	AmeriHealth Caritas (AMHC) Response	Healthy Blue Response	Carolina Complete Health (CCH) Response	United Healthcare (UNHC) Response
How does PHP determine if the provider made "good faith" efforts in contracting top determine reimbursement? (1 of 3)	Per our Good Faith contracting policy NC35-ND-001 (copied here), if within 30 calendar days the potential network provider rejects the request or fails to respond either verbally or in writing, WellCare may consider the request for inclusion in the NC Medicaid Managed Care Provider Network rejected by the provider. If discussions are ongoing, or the contract is under legal review, WellCare shall not consider the request rejected.	The Good Faith Contracting Policy must be developed in and submitted for approval to fulfill a PHP/DHB contract requirement. If DHB determines appropriate, AMHC is willing to share the policy in redacted form to remove information that is considered proprietary and/or confidential. AmeriHealth Caritas North Carolina will share a redacted version with DHB upon request. • AMHC offers to contract with a provider using a NC DHHS approved provider agreement in writing via letter, email, or fax;	Healthy Blue maintains a Good Faith Contracting policy and requires three unsuccessful attempts at completing a contract before the determination is made.	Definition of Good Faith Effort: The Good Faith Effort starts from when the provider receives a version of the contract which is consistent with the version approved by the Department and include the standard provisions for provider contracts found in Attachment G. Required Standard Provisions of PHP and Provider Contracts, including the prescribed provisions located therein.	Per contractual requirement, UNHC developed a "Good Faith Provider Contracting Policy" which was submitted for Department review and approval 90 days post contract award. Per those requirements, UNHC included a definition of "good faith" contracting effort and defined it as "United engaged in a good faith effort to contract with a provider of healthcare services but the provider refused or failed to meet United's objective quality standards."

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Managed Care Claims and Prior Authorizations Submission: What Providers Need to Know – Part 2

Question	WellCare (WCHP) Response	AmeriHealth Caritas (AMHC) Response	Healthy Blue Response	Carolina Complete Health (CCH) Response	United Healthcare (UNHC) Response
How does PHP determine if the provider made "good faith" efforts in contracting top determine reimbursement? (2 of 3)	The 30-day period begins when the provider has received a copy of the contract that is consistent with the version of the contract approved by the department	• an AMHC Account Executive will follow up the initial outreach within 10 business days and negotiations will continue until both parties agree on contract terms or decide not to move forward • If within 30 calendar days of receiving an agreement, the potential network provider rejects the agreement or fails to respond verbally or in writing, AMHC may consider the request for inclusion in the AMHC network rejected	See response on part 1 of 3, slide 70	The initial contract offering will serve as the first effort. If the provider does not execute the first effort, CCH will make a second effort at least 10 calendar days after the first effort taking into consideration any feedback from the provider. If the provider does not execute the agreement from the second effort, CCH will make a third and final effort at least 10 calendar days after the second effort taking into consideration any feedback from the provider from the previous efforts.	The policy expands on the process for documenting contracting outreach attempts and objective further elaborates on what it means to meet objective quality standards. In summary, Good Faith negotiation and contracting efforts are tracked in our database. We will not reimburse the OON provider more than 90% of the Medicaid fee-for-service rate if the provider refuses to contract or fails to meet objective quality standards.

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Managed Care Claims and Prior Authorizations Submission: What Providers Need to Know – Part 2

Question	WellCare (WCHP) Response	AmeriHealth Caritas (AMHC) Response	Healthy Blue Response	Carolina Complete Health (CCH) Response	United Healthcare (UNHC) Response
How does PHP determine if the provider made "good faith" efforts in contracting top determine reimbursement? (3 of 3)	See response on part 1 and 2 of 3, slides 70 and 71	• ; if discussions are ongoing or the contract is under legal review, AMHC shall not consider the request rejected. • AMHC will consider all facts and circumstances surrounding a Provider's willingness to contract, including reviews of non-standard requests, prior to determining that AMHC made a good faith effort which was not accepted	See response on part 1 of 3, slide 70	CCH will have exhausted all good faith contracting efforts after the third and final effort. The good faith contracting effort period must be at least 30 calendar days, but CCH may allow additional time if discussions are ongoing, contract revisions are being made or negotiated, the contract is under legal review by the provider or if in the opinion of CCH such additional time could lead to an executed contract.	See response on part 1 and 2 of 3, slide 70 and 71

Managed Care Claims and Prior Authorizations Submission: What Providers Need to Know – Part 2

Question	WellCare (WCHP) Response	AmeriHealth Caritas (AMHC) Response	Healthy Blue Response	Carolina Complete Health (CCH) Response	United Healthcare (UNHC) Response
What information is needed from the provider to file a claim? (1 of 4)	Paper claims must be received on original and complete red/white CMS claim forms. Please see the provider manual, provider resource guide, and quick reference guide. All of these resources including detailed information regarding clean claims and step by step instructions can be found on the public Provider Portal, which does not require a username and password, by going to: https://www.wellcare.com/en/North-Carolina/Providers/Medicaid/Forms	AMHC is required by applicable contract requirements with the Department and by applicable North Carolina and federal regulations to capture specific data regarding services rendered to its members. A detailed list of data elements, as listed here, are needed in order for a claim to be paid. This information is found in the AMHC Provider Claims and Billing Manual that can be accessed at www.amerihealthcaritasnc.com.	Electronic claim submissions will adhere to specifications for submitting medical claims data in standardized Accredited Standards Committee (ASC) X12N 837 formats. Electronic claims are validated for Compliance SNIP levels 1 to 4: • Professional claims that meet standardized X12 EDI Transaction Standard: 837P - Professional Claims • Institutional claims that meet standardized X12 EDI Transaction Standard: 837I - Institutional Claims	CCH follows Centers for Medicare & Medicaid Services (CMS) rules and regulations, specifically the Federal requirements set forth in 42 USC § 1396a(a)(37)(A), 42 CFR §447.45 and 42 CFR § 447.46; and in accordance with State laws and regulations, as applicable. Providers must bill with their NPI number in box 24Jb. We encourage our providers to also bill their taxonomy code in box 24Ja and the Member's Medicaid number in box 1a to avoid possible delays in processing.	In terms of data elements needed for a provider to file a claim - this information is available in our provider administrative guide and located on UNHC's provider website: https://www.uhcprovider.com/en/admin-guides/administrative-guides-manuals-2021/ch10-our-claims-process-2021/claims-enc-data-sub-ch10-guide.html

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Managed Care Claims and Prior Authorizations Submission: What Providers Need to Know – Part 2

Question	WellCare (WCHP) Response	AmeriHealth Caritas (AMHC) Response	Healthy Blue Response	Carolina Complete Health (CCH) Response	United Healthcare (UNHC) Response
What information is needed from the provider to file a claim? (2 of 4)	All claims must have complete and compliant data including: • Current CPT and ICD-10 (or its successor) codes • TIN • NPI number(s) • Provider and/or practice name(s) matching the W-9 initially submitted to WellCare	The following mandatory information is required on all claims, both institutional and professional: • Member's (patient's) name • Member's Plan ID number • Member's date of birth and address • Other insurance information: company name, address, policy and/or group number • Amounts paid by other insurance (with copies of matching EOBs) • Information advising if member's condition is related to employment, auto accident or liability suit	Claim submissions, whether electronic or paper, must include the following information: • Member's ID number including alpha prefix • Member's name • Member's date of birth • ICD-10-CM diagnosis code • Date of service • Place of service • Procedures, services or supplies rendered with CPT-4 codes/HCPCS codes/	Claims missing the required data will be returned, and a notice sent to the provider, creating payment delays; Such claims are not considered "clean" and therefore cannot be accepted into our system. Providers must bill with their NPI number in box 24Jb. We encourage our providers to also bill their taxonomy code in box 24Ja and the Member's Medicaid number in box 1a to avoid possible delays in processing	• Billing provider name, address, telephone number (F1) • Type of bill (F4) • Statement Covers Period (F6) • Patient Name (F8b) • Patient Birth Date (F10) • Patient Sex (F11) • Admission date (F12) • Admission Hour (F13) • Admission Type/Visit (F14) • Source of Referral for admission (F15) • Discharge Status (F17) • Condition Codes (F18-28) if applicable

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Managed Care Claims and Prior Authorizations Submission: What Providers Need to Know – Part 2

Question	WellCare (WCHP) Response	AmeriHealth Caritas (AMHC) Response	Healthy Blue Response	Carolina Complete Health (CCH) Response	United Healthcare (UNHC) Response
What information is needed from the provider to file a claim? (3 of 4)	See response on part 1 and 2 of 4, slides 73 and 74	• Date(s) of service, admission, discharge • Primary, secondary, tertiary and fourth ICD-10-CM/PCS diagnosis codes, coded to the full specificity available, which may be 3, 4, 5, 6, or 7 digits. • Name of referring physician, if appropriate • HCPCS procedures, services or supplies codes • CPT procedure codes with appropriate modifiers • CMS place of service code • Charges (per line and total)	• disease-related groups • Itemized charges • Days or units • Provider tax ID number • Provider name according to contract • Billing provider information, and rendering provider information when different than billing or when billing a group taxonomy • NPI of billing and rendering provider when applicable, or API when NPI isn't	. Claims missing the required data will be returned, and a notice sent to the provider, creating payment delays; Such claims are not considered "clean" and therefore cannot be accepted into our system. Claims eligible for payment must meet the following requirements: • The enrollee must be effective on the date of service (see information below on • identifying the enroll(lee), • The service provided must be a covered benefit under the enrollee's contract on the date of service, and Referral and prior authorization processes must be followed, if applicable.	• Occurrence Codes and Dates (F31-34) if applicable • Value Codes and Amounts (F39-41) if applicable • Revenue Code (F42) • Revenue Code Description (F43) • HCPCs, CPT Codes (F44) • Service Date (F45) • Service Units (F46) • Total Charges (F47) • Payer Name (F50A-C) • NPI (F56) • Insured Name (F58A-C) • Patients Relationship to Insured (F59A-C) • Insured's Unique Identifier (F60A-C)

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Managed Care Claims and Prior Authorizations Submission: What Providers Need to Know – Part 2

Question	WellCare (WCHP) Response	AmeriHealth Caritas (AMHC) Response	Healthy Blue Response	Carolina Complete Health (CCH) Response	United Healthcare (UNHC) Response
What information is needed from the provider to file a claim? (4 of 4)	See response on part 1 & 2 of 4, slides 73 and 74	• Days and units • Physician/supplier Federal Tax Identification Number or Social Security Number • National Practitioner Identifier (NPI) and Taxonomy • Physician/supplier billing name, address, zip code, and telephone number • Name and address of the facility where services were rendered • NDC's required for physician administered injectables that are eligible for rebate • Invoice date • Provider Signature	• Taxonomy of billing provider, attending and rendering provider when submitted • Coordination of benefits/other insurance information • Precertification number or copy of precertification • NDC, unit of measure and quantity for medical injectables	• Payment for service is contingent upon compliance with referral and prior authorization policies and procedures, as well as the billing guidelines outlined in this manual. When submitting your claim, you need to identify the enrollee. There are two ways to identify the enrollee: • The CCH enrollee number found on the enrollee ID card or the provider portal. • The Medicaid or North Carolina Health Choice Number provided by the State and found on the enrollee ID card or the provider portal	• Insured's Unique Identifier (F60A-C) • Principal Diagnosis Code (F67) • Other Diagnosis Code (F67A-Q) • Admitting Diagnosis Code (F69) • Principal procedure code and date (F74) • Other procedure codes and dates (F74a-e) • Attending provider and Identifiers (F76) • Other providers (F77-79) if applicable

For the most up to date information and/or more detailed information, please see the Medicaid Managed Care Fact Sheets.

Managed Care Claims and Prior Authorizations Submission: What Providers Need to Know – Part 2

Question	WellCare (WCHP) Response	AmeriHealth Caritas (AMHC) Response	Healthy Blue Response	Carolina Complete Health (CCH) Response	United Healthcare (UNHC) Response
In what instances would a provider/PHP need to agree to a single case agreement? (1 of 2)	Single case agreements are usually reserved for services provided by an out of network provider when no in network provider is available. This would only likely occur for a delivery out of state or mother/baby requires highly specialized care at OON facility. These are handled on a case by case basis and are not a normal occurrence.	If a non-participating provider offers needed services that a participating provider cannot offer in the member's service area, a single case agreement would be needed.	For provider/PHP to develop a Single Case Agreement, several criteria must be present: • A member is enrolled with NC Medicaid and Healthy Blue • The provider is not in-network • The member cannot be redirected to an in-network provider • The out-of-network request has been approved as medically necessary	The vast majority of SCAs will be initiated internally by Medical Management, Appeals & Grievances (A&G) or Behavioral Health. On occasion, we may get a direct request from a provider, particularly if they are waiting for a contract to be effective.	Single Case Agreements are negotiated on a case-by-case basis, and there is no default process to a Single Case Agreement if a provider decides not to enter a contractual agreement with UNHC through a good faith contracting effort. With that said, at times Single Case Agreements are created in order to ensure the member's needs are met.

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Managed Care Claims and Prior Authorizations Submission: What Providers Need to Know – Part 2

Question	WellCare (WCHP) Response	AmeriHealth Caritas (AMHC) Response	Healthy Blue Response	Carolina Complete Health (CCH) Response	United Healthcare (UNHC) Response
In what instances would a provider/PHP need to agree to a single case agreement? (2 of 2)	See response on part 1 of 2, slide 77	See response on part 1 of 2, slide 77	See response on part 1 of 2, slide 77	There are two common origins for SCAs: 1. Internal requests mainly from Medical Management, Appeals & Grievances (A&G) or Behavioral Health and 2. The much rarer request directly from a provider with an existing relationship with a member and/or the negotiator This accounts for the two common reasons where an SCA might be requested; 1) to cover services rendered OON and 2) to cover services when the existing network providers are at capacity	In such instances, UNHC would typically expect a referral from INN to an OON provider to meet medical needs, review the network to ensure there is no INN provider that can render that same service in the proximity.

Managed Care Claims and Prior Authorizations Submission: What Providers Need to Know – Part 2

Question	WellCare (WCHP) Response	AmeriHealth Caritas (AMHC) Response	Healthy Blue Response	Carolina Complete Health (CCH) Response	United Healthcare (UNHC) Response
What is the first date the PHP intends to start issuing medical and pharmacy payments after Managed Care Launch? What is the payment cycle for medical and pharmacy claims?	WCHP will issue the first medical claims payment on July 6, 2021. Pharmacy payments are issued at the point of sale and the first pharmacy payment will be issued on July 1, 2021. Both medical and pharmacy claims will be paid daily, thereafter. Check runs take place daily except for Sundays, last day of the month and national holidays.	AMHC will issue the first payment for medical and pharmacy claims on July 7, 2021. After the first payment runs on July 7, medical payment cycles will be every Monday and Wednesday, while Pharmacy cycles will run every four days.	Medical claims submitted on July 1, 2021, will be paid by July 30, 2021 or sooner. Pharmacy claims that are submitted on July 1, 2021 will be paid by July 14, 2021 or sooner. Payment disbursements for both medical and pharmacy claims are sent on Wednesdays.	CCH will be running check runs each Tuesday and Friday beginning on July 20, 2021.	UNHC's first check cycle will be on July 12, 2021. • Check cycles take two days to complete. One day for ERA (electronic remittance advice)/PRA (paper remittance advice) generation and one day for check payment either through paper or electronic EFT. Therefore, the first payment for North Carolina Medicaid will be completed on July 14, 2021. Payment cycle for both medical and pharmacy claims will be a daily check cycle.

Managed Care Claims and Prior Authorizations Submission: What Providers Need to Know – Part 2

Question	WellCare (WCHP) Response	AmeriHealth Caritas (AMHC) Response	Healthy Blue Response	Carolina Complete Health (CCH) Response	United Healthcare (UNHC) Response
What message will providers see in the Provider Portal regarding individual claim status prior to first payments being released?	WCHP's provider portal will display a banner with the date they intend on executing their first check run (July 6, 2021 for medical claims and July 1, 2021 for pharmacy claims).	There will be no provider messaging prior to first payments being released.	The claims status in our secure Provider Portal (Availity) will return the status at the time of the inquiry. Claim status will show as Pending/Paid or Denied.	CCH portal returns an EMS message queue, which includes the claim number, rejection code/message and etc. The providers will see a message displaying the claim has been accepted.	The claim will show as **Acknowledged** until the claim is processed. It will show **Pending** if: • We are waiting on additional information from the provider or • The claim is still being worked on It will show **Payable** if it is processed but waiting for the payment to be posted.

Managed Care Claims and Prior Authorizations Submission: What Providers Need to Know – Part 2

Question	WellCare (WCHP) Response	AmeriHealth Caritas (AMHC) Response	Healthy Blue Response	Carolina Complete Health (CCH) Response	United Healthcare (UNHC) Response
How can I determine which services require prior authorization for a health plan?	WCHP provides a Prior Authorization look-up Tool to determine if a PA is required prior to rendering services. WCHP's Provider Look-up tool can be found at: https://www.wellcare.com/North-Carolina/Providers/Authorization-Lookup	AMHC provides a Prior Authorization look-up Tool to determine if a PA is required prior to rendering services. AMHC's Provider Look-up tool can be found at: www.amerihealthcaritasnc.com	Healthy Blue provides a Prior Authorization look-up Tool to determine if a PA is required prior to rendering services. Healthy Blue's Provider Look-up tool can be found at: https://provider.healthybluenc.com/north-carolina-provider/prior-authorization-lookup	CCH provides a Prior Authorization look-up Tool to determine if a PA is required prior to rendering services. This tool will go live later this summer, before the launch of NC Medicaid Managed Care.	UNHC provides a Prior Authorization look-up Tool to determine if a PA is required prior to rendering services. UNHC's Provider Look-up tool can be found at: https://UHCprovider.com/priorauth

Managed Care Claims and Prior Authorizations Submission: What Providers Need to Know – Part 2

Question	WellCare (WCHP) Response	AmeriHealth Caritas (AMHC) Response	Healthy Blue Response	Carolina Complete Health (CCH) Response	United Healthcare (UNHC) Response
How can I submit a prior authorization to a health plan? (1 of 2)	WCHP submission methods: **Standard**: Online via Provider Portal: https://provider.wellcare.com/ Via fax to the numbers listed on the associated forms: https://www.wellcare.com/North-Carolina/Providers/Medicaid/Forms	AMHC submission methods: **Standard**: Online via Provider Portal: www.navinet.navimedix.com Via Fax to 833-893-2262 Call 833-900-2262 **Pharmacy**: Via fax to 877-234-4274 Call: 855-375-8811	Healthy Blue submission methods: **Standard**: Online via Provider Portal: https://provider.healthybluenc.com/north-carolina-provider/prior-authorization Via Fax to: 800-964-3627 (Inpatient) 844-445-6649 (Outpatient)	CCH submission methods: **Standard**: Online via Secure Provider Portal: http://carolinacompletehealth.com/ Use the Prior-Auth Check Tool on the website to quickly determine if a service or procedure requires prior authorization. This tool will go live later this summer, before the launch of NC Medicaid Managed care.	UNHC submission methods: **Standard**: Online via Prior Authorization and Notification Tool on Link: https://UHCprovider.com/priorauth If you're unable to use Link, call Provider Services at 877-842-3210. **Urgent**: Call Provider Services at 877-842-3210 and follow the prompts.

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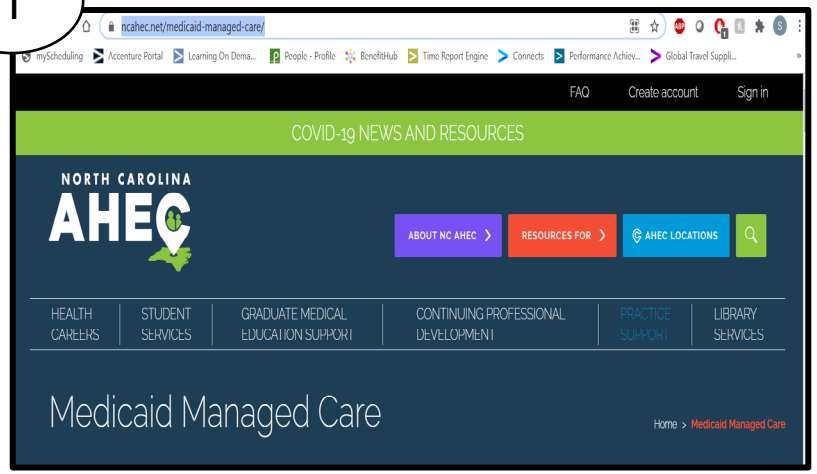
Managed Care Claims and Prior Authorizations Submission: What Providers Need to Know – Part 2

Question	WellCare (WCHP) Response	AmeriHealth Caritas (AMHC) Response	Healthy Blue Response	Carolina Complete Health (CCH) Response	United Healthcare (UNHC) Response
How can I submit a prior authorization to a health plan? (2 of 2)	**Urgent**: Call 866-799-5318 and follow the prompts. **Pharmacy**: Via Fax to 800-678-3189 Online via Surescripts portal: https://providerportal.surescripts.net/providerportal/	See response on part 1 of 2, slide 82	**Urgent**: Call 844-594-5072 **Pharmacy**: Via Fax to 844-376-2318 Call 844-594-5072	Call 833-552-3876 Via Fax to 919-670-4948 **Urgent**: Call 919-719-4161.	**Urgent**: Call Provider Services at 877-842-3210 and follow the prompts. **Pharmacy**: Online via CoverMyMeds portal: https://www.covermymeds.com/main/prior-authorization-forms/optumrx/ Online via SureScripts portal: https://providerportal.surescripts.net/ProviderPortal/optum/login

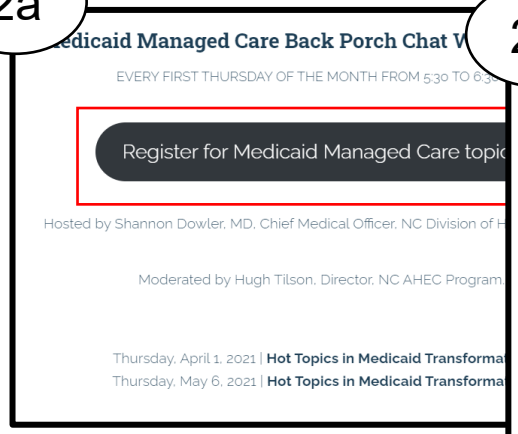
How To Sign up for the Back Porch Chat Webinar Series

1



1. Navigate to the North Carolina AHEC Medicaid Managed Care page

2a



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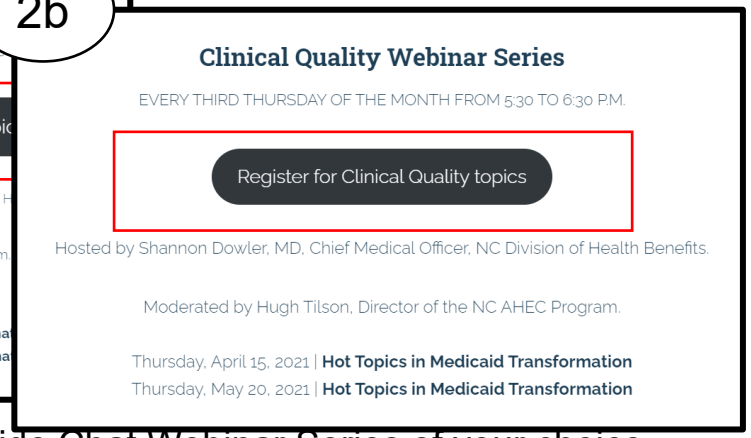
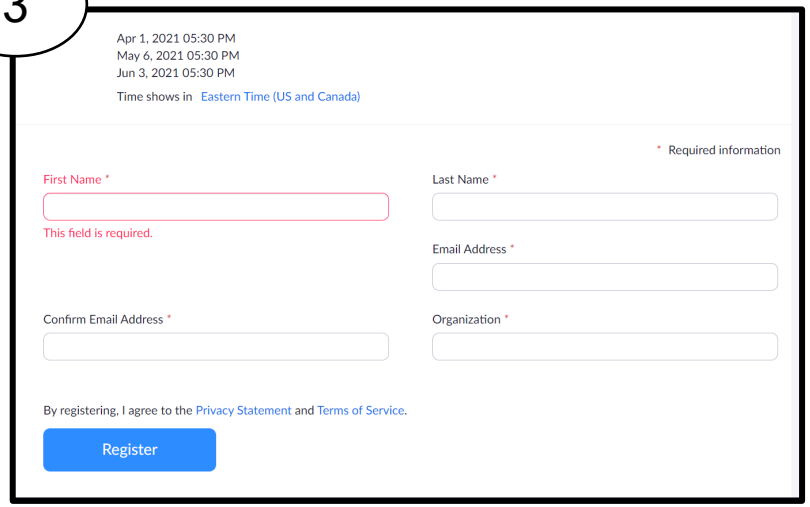


2. Scroll down to the Fireside Chat Webinar Series of your choice

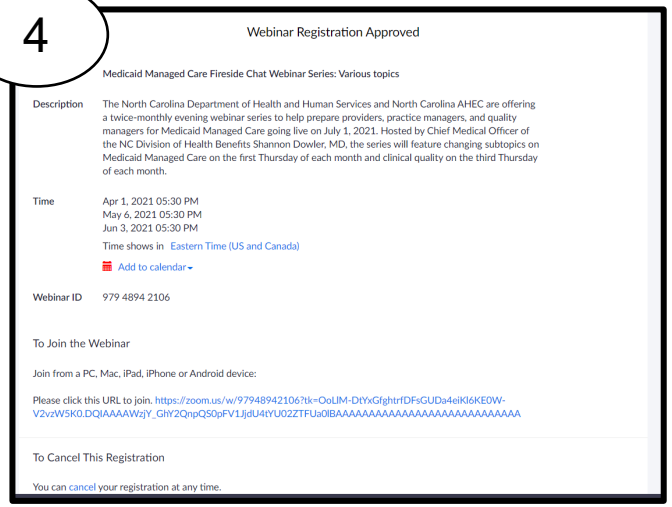
2b. Click on “Register for Medicaid Managed Care topics” or “Register for Clinical Quality topics”

3



3. Fill out all the required information and click register

4



4. When you see this page, your registration is successful.