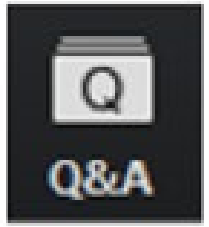
Back Porch Chat: Medicaid Managed Care Hot Topics

April 15, 2021

RCC (Relay Conference Captioning)
Participants can access real-time captioning for this webinar here: https://www.captionedtext.com/client/event.aspx?EventID=4768105&CustomerID=324

Logistics for today's COVID-19 Forum

Question during the live webinar



Technical assistance

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AGENDA

01 Pharmacy Coverage

02 Durable Medical Equipment (DME) Coverage

03 General Updates

04 Q&A

Pharmacy Benefit Design in Managed Care

The pharmacy benefit will be a **“carve-in”** benefit in managed care.

State will **oversee and manage** the managed care pharmacy benefit

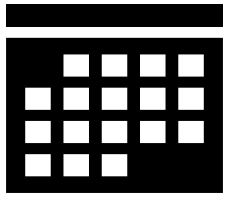
- North Carolina Session Law 2016-121 Section 5(6)(b) mandates health plans will be **required to use the same drug formulary** established by the Department.
- Health plans will be required to follow the same clinical coverage policies and prior authorization criteria as those used in the FFS PDL/Prior Approval program (for preferred and nonpreferred classes)
- After year 1, health plans will be allowed to propose changes to the PDL and PA clinical coverage policies for review and approval by the Department for the following year
  - *Department does not have to apply approved clinical coverage policy changes to all health plans
- The **same process** for PDL changes followed today, **will continue**
  - Changes may be made with State approval
  - A Single PDL will be applied across all 5 plans and FFS, for the life of the contract
- Plans will pay pharmacies the same State approved Dispensing Fee and Ingredient Costs

How a Newly FDA Approved Drug Gets on the PDL

New medications are approved by the FDA

- Default is for medications to be non-preferred until reviewed by PDL Panel

State adds new drug(s) to non-preferred status every 1-3 months to the PDL online



State performs full PDL review annually, at a minimum. This is how new drugs can be moved to preferred status

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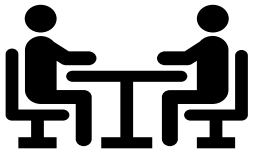
Annual PDL review posted for 45 days for public comment



PDL Panel convenes to review public comment and state updates in PDL categories prior to sending to DHHS secretary for final sign-off

For more information on the PDL, please navigate to the website.

Process for Adding Clinical Criteria

State reviews new medications for potential clinical criteria

State Pharmacy & Therapeutics Committee review of criteria

Physician Advisory Group reviews and provides feedback of criteria

Public posting for 45 days

Standard Plans Will Have Single Preferred Drug List (PDL)

- All plans follow NC Single PDL
- All plans follow existing Medicaid policy and clinical criteria

PDL approval process will remain the same after moving into managed care

What Happens After Year 1?

- Plans may make recommendations for the PDL, but recommendations go through the same consideration and approval process

- Changes approved will be made to the single PDL and implemented across all plans

Lifecycle of a Pharmacy Claim

Provider prescribes medication to patient

Pharmacy enters order and submits claim to Pharmacy Benefits Manager (PBM) for Standard Plan or NCTracks for Medicaid Direct

If approved, beneficiary leaves the pharmacy with medicine

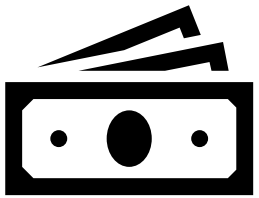
If denied, further action is required by the provider

Patient goes to the Pharmacy counter for their prescription

Health plan PBM or NCTracks electronically approves or denies claim

Health Plan PBM or NC Tracks pays Pharmacy

What Can Pharmacies Expect?



Payment From Plans

- All plans will reimburse providers within 14 days or less
- Interest and penalties apply to late payments
- Claims appeal process is managed by each plan

COVID-19 Flexibilities

- Vaccine administration
- 14-day supplies
- 5% increase in dispensing fee
- **90-day fills***
- **Mail and delivery fees from local/community pharmacies***

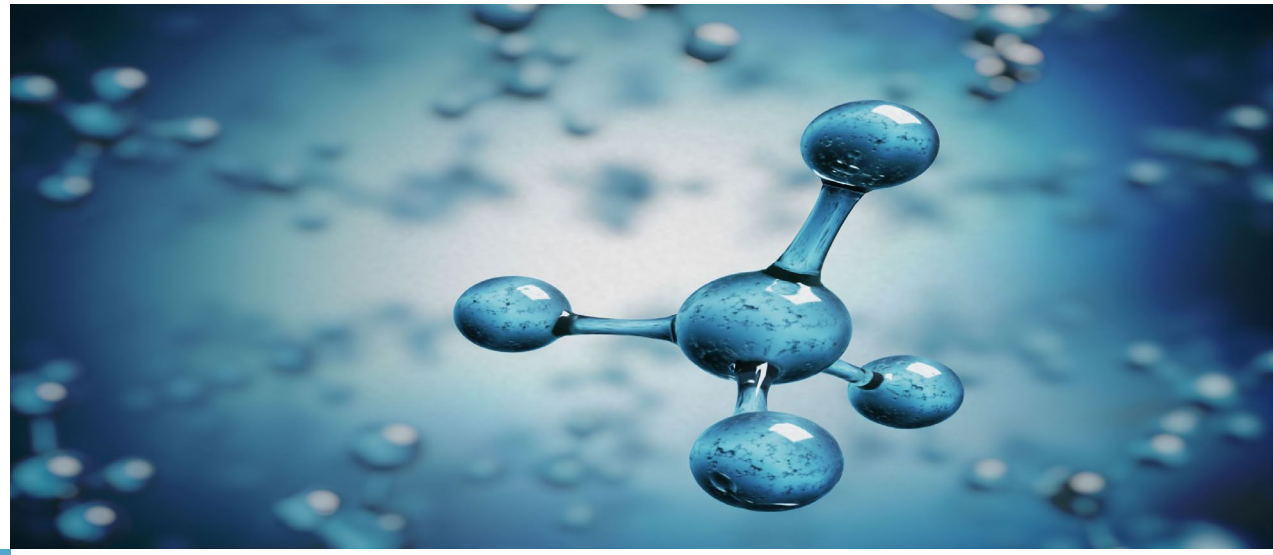
340B

- Managed care plans will process 340B claims in the same way as Medicaid Direct
- 340B pharmacies will continue to require the 8 and 20 codes in the claim submission
- PDP claims from 340B providers will continue to require UD modifier

***Policy that will become permanent beyond the public health emergency**

Network Adequacy

State expects to see a broad pharmacy network across all plans.



Plans must contract with “any willing provider” based on the State’s fee schedule.

Plans cannot choose to exclude independent pharmacies from participating.

Mitigating Transition Risks

- Pharmacists can provide 72-hr emergency fills
- Medicaid Call Center support
- NCTracks portal to help rectify eligibility issues
- Contact numbers to the health plans and DHB
- DHB and health plan help sheets
- Historical claims & PA data for each member is sent over to the health plans prior to launch
- Out of Network providers will be covered for the first 60 days

What Ifs Pharmacy: Asked and Answered

Can the 5 health plans develop a narrow network for pharmacy?

It feels like the PDL changes frequently. How often will the PDL change after launch and how will we be notified when a change occurs?

Will the PDL differ across the health plans in the future?

How often will new drugs that enter the market get on the PDL?

Will the criteria for HepC drugs remain the same in managed care?

Will the PDL provide a range of dermatological creams and lotions to use to treat patients?

What Ifs Pharmacy

What if a low English proficiency patient goes to the pharmacy on the Friday night for a prescription that needs to be filled right away and the name on their Medicaid card doesn't match the prescription name exactly?

Will Medicaid medication copays be different for the health plans?

At managed care launch will the health plans have access to information on preferred medications that were tried and failed?

What if a patient needs an urgent medication such as a non-preferred insulin and the PA has not been approved yet and 72 hours has passed?

If a pharmacy chooses to override a denial because it is in the best interest of the patient, is there any assurance that the health plans will cover the cost retroactively?

What if a patient has a prescription for a medication from a physician that is not in network and I fill the prescription. Will I be paid?

What Ifs Pharmacy

How do we bill specialty drugs (e.g., hemophilia) to health plans?

Will pharmacies still get paid a tiered dispensing rate?

Will pharmacy lock-in change in managed care? Will pharmacy lock-in apply to children?

How does a pharmacy appeal non-payment decisions?

How quickly will health plans respond to the changes in the price of medications?

If there is a coding error with a medication on the shelf or some other situation that impacts the 5 health plans, will pharmacies have to call all 5 plans?

Physicians Drug Program (PDP)

The PDP refers to medications ordered and delivered in the doctor's office and is a policy that must be followed exactly

The PDP contains approximately 900 medications such as albuterol, ceftriaxone, Depo-Provera, and IUDs

No prior authorization is applied to PDP medications; providers will bill plans directly

The PDP for each plan should operate as it does today in Medicaid Direct; if you receive denials, contact health plan directly. If issue is unresolved, contact Provider Ombudsman

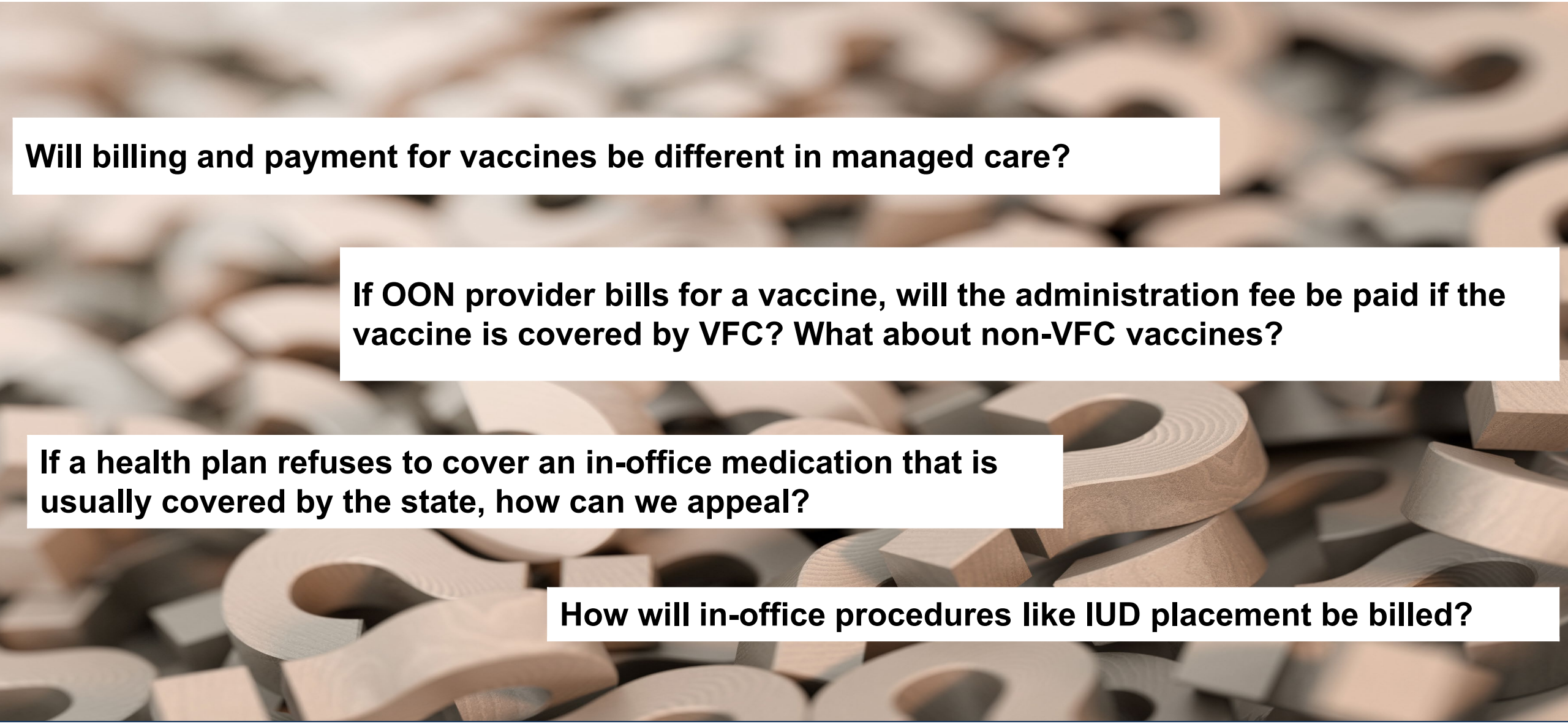
For more information on the PDP, please navigate to the website.

Vaccines

- Vaccines for Children (VFC) program
- NC Health Choice vaccines
- Medicare rates will be paid for COVID-19 vaccine
- **Pharmacist-administered vaccines will be billed to the plans in addition to Medicaid Direct***
- **Administration fees from medical providers will be billed to the plans in addition to Medicaid Direct***
- **Vaccine administration will be billable at pharmacies using point of sale (POS) or medical claims***

**New with Managed Care*

What Ifs PDP/Vaccines Asked and Answered



Will billing and payment for vaccines be different in managed care?

If OON provider bills for a vaccine, will the administration fee be paid if the vaccine is covered by VFC? What about non-VFC vaccines?

If a health plan refuses to cover an in-office medication that is usually covered by the state, how can we appeal?

How will in-office procedures like IUD placement be billed?

DME, Orthotics, Prosthetics and Supplies (DMEPOS)

- Durable Medical Equipment, Prosthetics, Orthotics, & Supplies (DMEPOS) coverage is included in managed care transition
- Beneficiaries who do not enroll in a Standard Plan will continue to receive DMEPOS via Medicaid Direct
- DMEPOS policies are not required to be followed exactly as defined in Medicaid Direct today
- Health plans may employ different limits and PA requirements as part of their utilization management program
- DMEPOS network adequacy standards are not specifically outlined in Standard Plan contract

DMEPOS Managed Care Coverage Guardrails

Managed Care Contract Obligations with DHB:

"…Furnish covered benefits in an amount, duration and scope no less than... under the Medicaid Fee-for-Service program…"

"…To reasonably achieve the purpose for which the services are furnished…."

"…Establish and maintain a Medicaid Managed Care Provider Network... sufficient to ensure that all services covered under the Contract are available and accessible to all Members in a timely manner..."

"In developing its Network, Department expects health plans to negotiate with <u>any willing provider</u> in good faith regardless of provider or health plan affiliation"

DMEPOS Rate Floor and COVID Flexibilities

Session Law 2020-88, Senate Bill 808 (rate floor):

- "For the first three years of the initial standard benefit plan prepaid health plan capitated contracts... the rate floor for durable medical equipment under managed care shall be set at one hundred percent (100%) of the Medicaid fee-for-service rates for durable medical equipment."

COVID flexibilities made permanent:

- Automatic blood pressure cuffs (HCPCS A4670)
- Weight scales (E1639)
- Portable pulse oximeters for purchase (E0445)

DMEPOS Before and After Managed Care Launch

For beneficiaries enrolled in standard plans on July 1, 2021:

- "The health plan must honor existing and active prior authorizations on file with the North Carolina Medicaid or NC Health Choice program for the first ninety (90) days after implementation...“

- "For the first sixty (60) days after Medicaid Managed Care launch, the health plan shall pay claims and authorize services for Medicaid eligible nonparticipating/out of network providers equal to that of in network providers..."

DMEPOS Items Not Listed for Coverage in Medicaid Direct

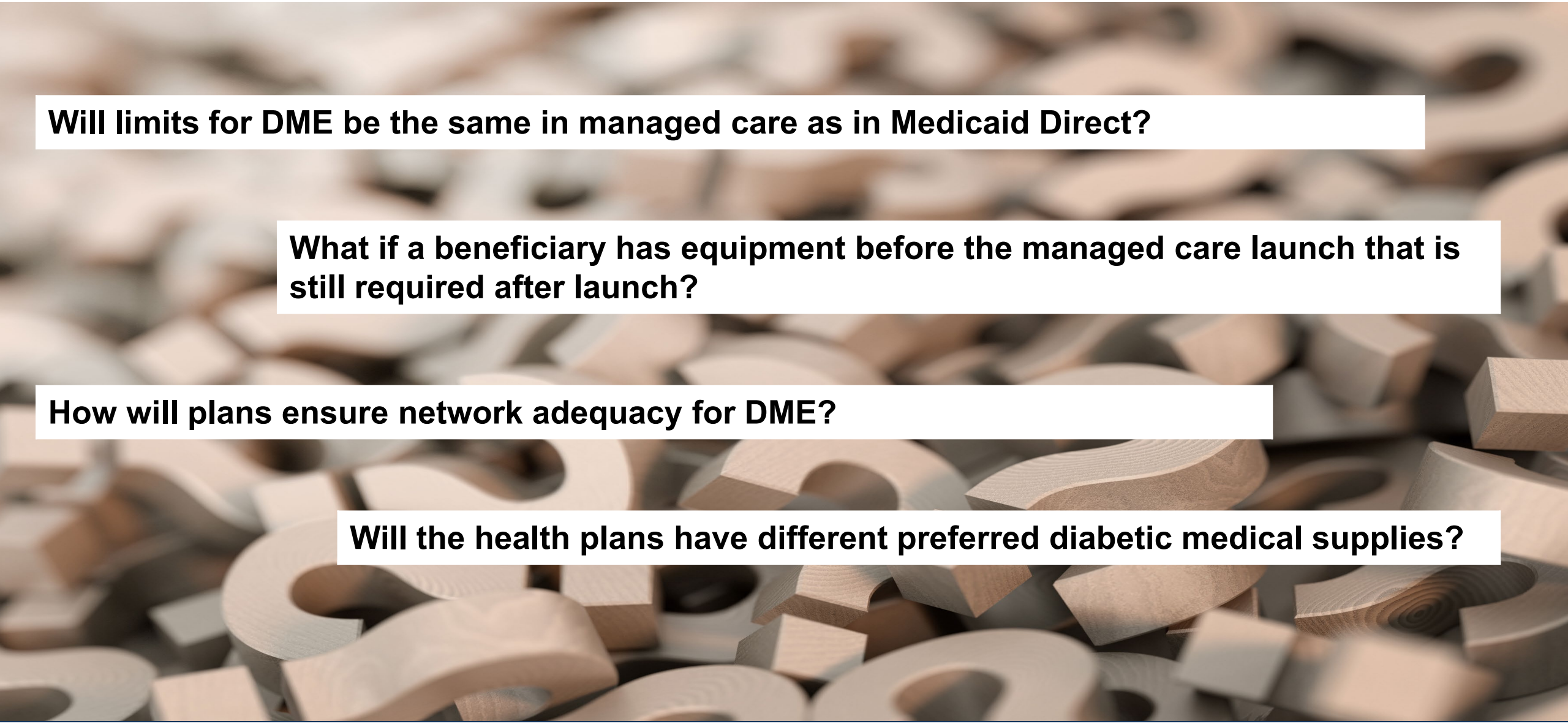
EPSDT for Beneficiaries 0-20:

- "The health plan shall determine whether a service is medically necessary on a case-by-case basis, taking into account the medical necessity criteria specific to EPSDT... and the particular needs of the child."

The "Home Health Final Rule" at 42CFR, 440.70:

- States are prohibited from having absolute exclusions of coverage on equipment, supplies, and appliances without a medical necessity review and appeal rights for denials.

What Ifs DMEPOS Asked and Answered



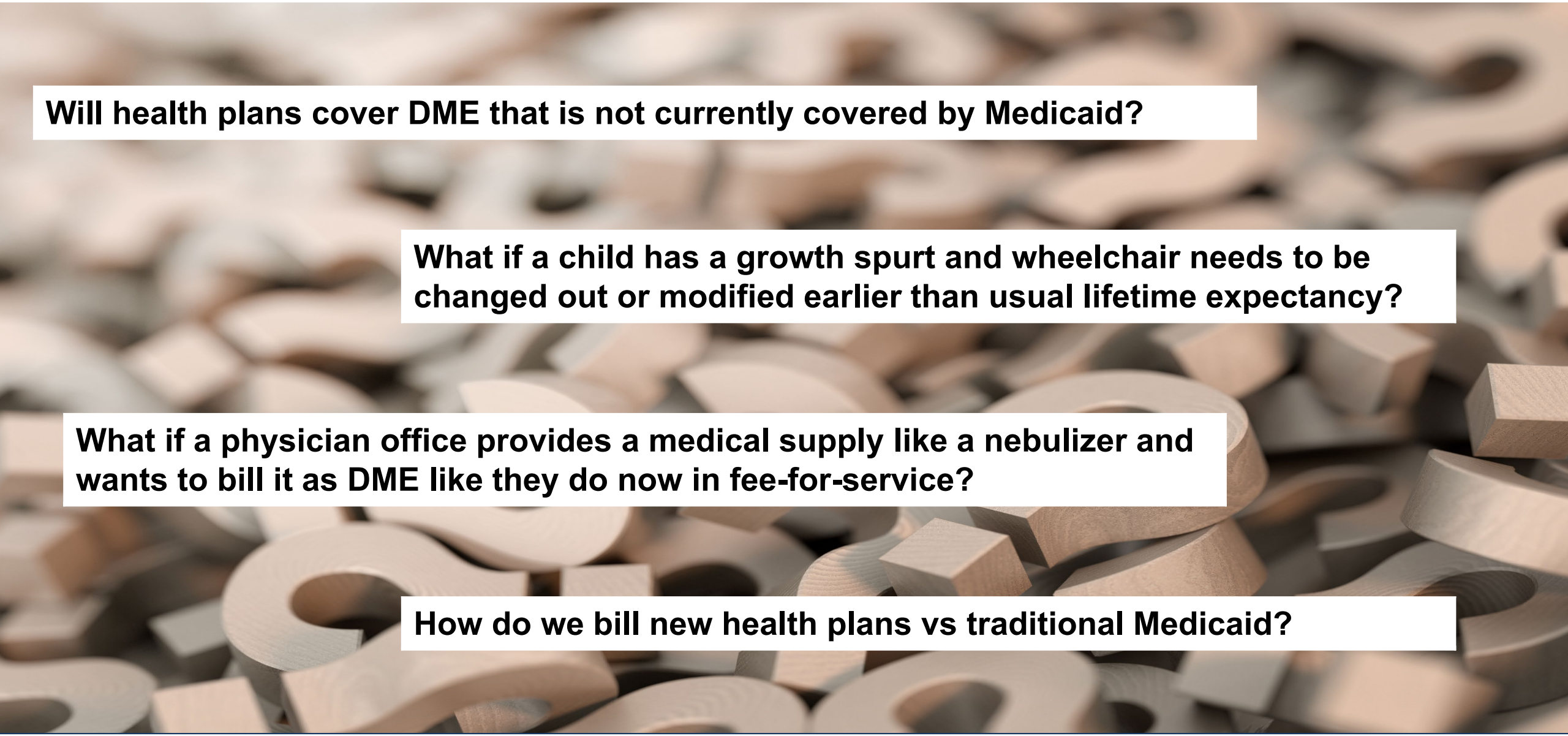
Will limits for DME be the same in managed care as in Medicaid Direct?

What if a beneficiary has equipment before the managed care launch that is still required after launch?

How will plans ensure network adequacy for DME?

Will the health plans have different preferred diabetic medical supplies?

What Ifs DMEPOS



Will health plans cover DME that is not currently covered by Medicaid?

What if a child has a growth spurt and wheelchair needs to be changed out or modified earlier than usual lifetime expectancy?

What if a physician office provides a medical supply like a nebulizer and wants to bill it as DME like they do now in fee-for-service?

How do we bill new health plans vs traditional Medicaid?

General Updates

- The Numbers
- Medical Home Investments
- Managed Care Enrollment Stats
- What If Session Pending
- Future Back Porch Chat Foci
- Family Planning Medicaid and COVID-19 Testing, Treatment, Vaccine

1A-22 Medically Necessary Circumcision

NC Medicaid added circumcision coverage for the following diagnoses effective January 1, 2021:

- **Newborn Male Circumcision:**
  - Circumcision performed to lower the risk of acquiring HIV
- **Non-Newborn Male Circumcision:**
  - Circumcision performed to lower the risk of acquiring HIV
  - Recurrent balanitis or balanitis xerotica obliterans
  - Congenital Chordee

Providers billing for medically necessary circumcisions performed for the prevention of disease for newborn and non-newborn male beneficiaries should submit diagnosis Z29.8 (Encounter of other specified prophylactic measures) with appropriate circumcision procedure code.

- Evidence base points to benefits of circumcision to prevent undesirable conditions such as: HIV, HPV, HPV-associated cancers, and other urogenital infections.
- Preventive Care Always Requires Shared Decision Making
- Health Equity is a driver of this policy change.
- Medicaid is a Payer. You are the doctor

More information regarding circumcision can be found by navigating the webpage.

Implementation of Rate Floors for Facility-Based Crisis and Mobile Crisis Services

Effective July 1, 2021, NC Medicaid will increase fee-for-service rates and establish rate floors for facility-based crisis and mobile crisis management services that will mandate minimum reimbursement rates to aid in contracting between providers and health plans, including Local Management Entitles/Managed Care Organizations (LME-MCOs) and Prepaid Health Plans (health plans).

Updating the rates and imposing a rate floor on LME-MCOs and health plans will help to:

- Stabilize the behavioral health crisis system during the transition to NC Medicaid Managed Care; and
- Support behavioral health crisis providers in the contracting process with health plans.

The following changes will be effective July 1, 2021:

- Fee schedules for procedure code S9484 will be set at $30 per unit;
- Fee schedules for procedure code H2011 will be set at $90 per unit; and
- LME-MCO and health plan contracts will be updated to include the rate floor.

These new rate floors may create additional capacity and opportunities for enhanced performance by behavioral health crisis service providers, especially those serving geographies that allow for higher utilization of staffing resources. In light of the Department's commitment to sustainable rates for facility-based crisis and mobile crisis management services, the Department encourages health plans and providers to be innovative in effectively meeting the behavioral health crisis response and de-escalation needs of the communities they serve.

No other changes to the behavioral health fee schedule or managed care reimbursement requirements are anticipated for an effective date of July 1, 2021, other than COVID-19 actions. NC Medicaid will continue to evaluate how to support rates for walk-in clinic crisis services.

For more information, please see Implementation of Rate Floors for Facility-Based Crisis and Mobile Crisis Services.

NCTracks Changes to Provider Verification Process

Currently, NCTracks sends notifications for expiring credentials (licenses, certifications and accreditations) to all enrolled providers required to be licensed, certified and/or accredited. These notices are sent to the Provider Message Center Inbox beginning 60 days in advance of the expiration date of the credential.

Effective May 9, 2021, NC Medicaid is taking additional steps to ensure providers meet their contractual obligation and responsibility to keep credentials current on their NCTracks enrollment record by making system modifications to begin a process of 45- and 60-day notifications of suspension if a provider fails to update their credential prior to the expiration date on file with NCTracks. Providers were first informed of this forthcoming system modification in March of 2018.

Choosing from providers with complete and up-to-date licensure, certification and accreditation information allows NC Medicaid beneficiaries to make informed choices to achieve the best health outcomes. System modifications alerting providers to update expiring credentials will assist providers in meeting federal and State enrollment and credentialing requirements and will assist NC Medicaid in removing unlicensed providers and expired credentials from provider records. With updated provider information, NC Medicaid will be able to transmit accurate provider data to health plans and other departmental partners who serve Medicaid beneficiaries.

Please see NCTracks Changes to Provider Verification Process for additional information on the timeline for notifications, suspension and termination as well as what happens when credentials expire.

Provider Data Updates

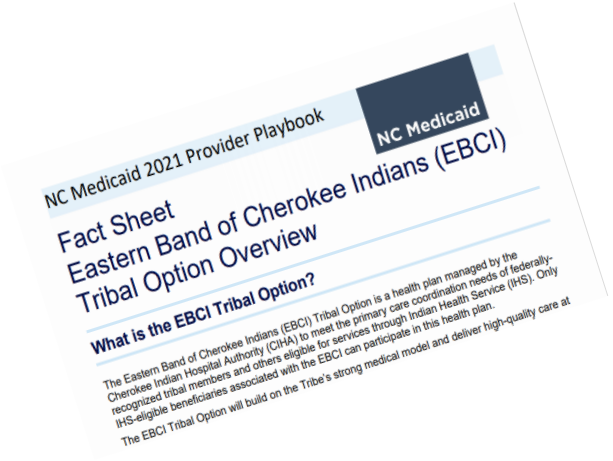
Providing the most accurate and complete provider information is a top priority so Medicaid and NC Health Choice beneficiaries can make the most informed choice for their health plan and primary care provider. NCTracks is the “system of record” for provider enrollment data, which is then shared with health plans to inform contracting and provider directories.

In our review, the primary challenge with accurate data has been encouraging providers to keep their information accurate and current on all applicable enrollment records. If provider information is not current, then the data that flows forward to the health plans and the enrollment broker will not be accurate.

It is critical that all providers take the time now to review their provider records in NCTracks and submit changes as needed using the Manage Change Request (MCR) process.

Please see Provider Data Updates for additional information and resources.

Medicaid Provider Playbook Fact Sheets


NC Medicaid 2021 Provider Playbook

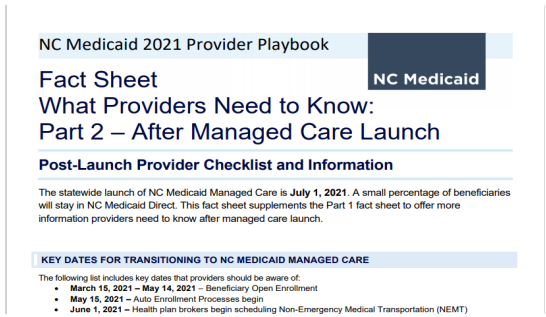
NC Medicaid

Fact Sheet
Eastern Band of Cherokee Indians (EBCI)
Tribal Option Overview

What is the EBCI Tribal Option?

The Eastern Band of Cherokee Indians (EBCI) Tribal Option is a health plan managed by the Cherokee Indian Hospital Authority (CIHA) to meet the primary care coordination needs of federally-recognized tribal members and others eligible for services through Indian Health Service (IHS). Only IHS-eligible beneficiaries associated with the EBCI can participate in this health plan.

The EBCI Tribal Option will build on the Tribe's strong medical model and deliver high-quality care at


NC Medicaid 2021 Provider Playbook

NC Medicaid

Fact Sheet
What Providers Need to Know:
Part 2 – After Managed Care Launch

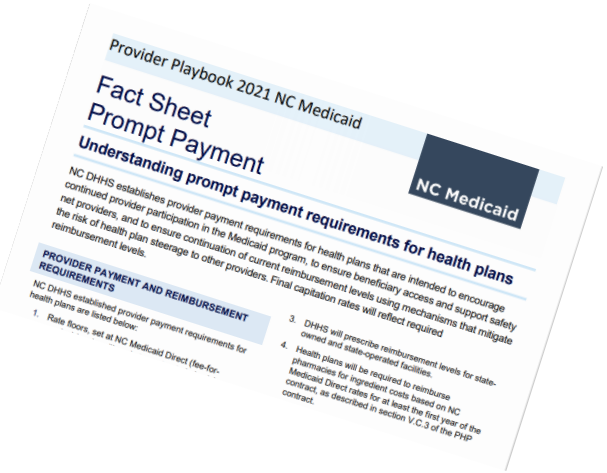
Post-Launch Provider Checklist and Information

The statewide launch of NC Medicaid Managed Care is **July 1, 2021**. A small percentage of beneficiaries will stay in NC Medicaid Direct. This fact sheet supplements the Part 1 fact sheet to offer more information providers need to know after managed care launch.

KEY DATES FOR TRANSITIONING TO NC MEDICAID MANAGED CARE

The following list includes key dates that providers should be aware of:

- **March 15, 2021 – May 14, 2021** – Beneficiary Open Enrollment
- **May 15, 2021 –** Auto Enrollment Processes begin
- **June 1, 2021 –** Health plan brokers begin scheduling Non-Emergency Medical Transportation (NEMT)


Provider Playbook 2021 NC Medicaid

Fact Sheet
Prompt Payment

NC Medicaid

Understanding prompt payment requirements for health plans

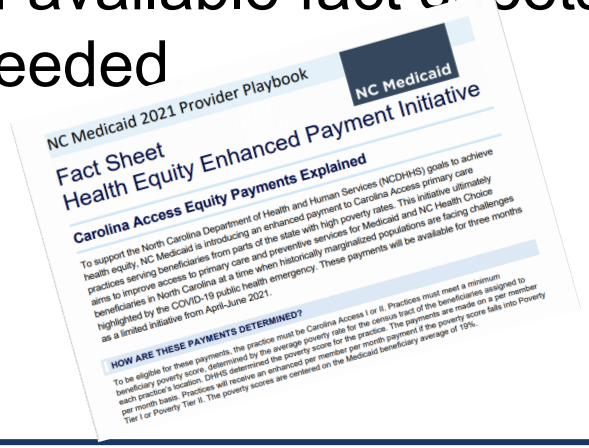
NC DHHS establishes provider payment requirements for health plans that are intended to encourage continued provider participation in the Medicaid program, to ensure beneficiary access and support safety net providers, and to ensure continuation of current reimbursement levels using mechanisms that mitigate the risk of health plan steerage to other providers. Final capitation rates will reflect required reimbursement levels.

PROVIDER PAYMENT AND REIMBURSEMENT REQUIREMENTS

NC DHHS established provider payment requirements for health plans are listed below:

1. Rate floors, set at NC Medicaid Direct (fee-for-
3. DHHS will prescribe reimbursement levels for state-owned and state-operated facilities.
4. Health plans will be required to reimburse pharmacies for ingredient costs based on NC Medicaid Direct rates for at least the first year of the contract, as described in section V.C.3 of the PHP contract.

In an ongoing effort to address provider concerns and questions that continue to arise, the provider team has created the fact sheet executive summary as another tool to be utilized at the executive level. This slide can be used to increase executive knowledge of available fact sheets and to steer questions toward the appropriate fact sheet as needed


NC Medicaid 2021 Provider Playbook

NC Medicaid

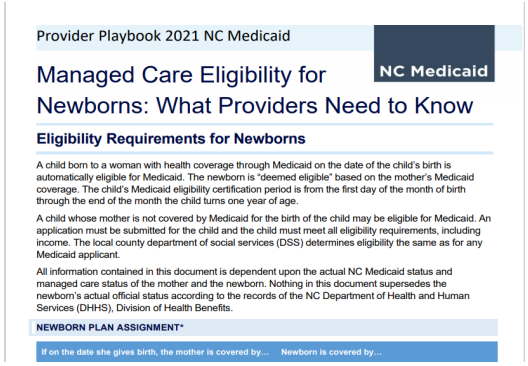
Fact Sheet
Health Equity Enhanced Payment Initiative

Carolina Access Equity Payments Explained

To support the North Carolina Department of Health and Human Services (NCDHHS) goals to achieve health equity, NC Medicaid is introducing an enhanced payment to Carolina Access primary care practices serving beneficiaries from parts of the state with high poverty rates. This initiative ultimately aims to improve access to primary care and preventive services for Medicaid and NC Health Choice beneficiaries in North Carolina at a time when historically marginalized populations are facing challenges highlighted by the COVID-19 public health emergency. These payments will be available for three months as a limited initiative from April–June 2021.

HOW ARE THESE PAYMENTS DETERMINED?

To be eligible for these payments, the practice must be Carolina Access I or II. Practices must meet a minimum beneficiary poverty score, determined by the average poverty rate for the census tract of the beneficiaries assigned to each practice's location. DHHS determined the poverty score for the practice. The payments are made on a per member per month basis. Practices will receive an enhanced per member per month payment if the poverty score falls into Poverty Tier I or Poverty Tier II. The poverty scores are centered on the Medicaid beneficiary average of 19%.


Provider Playbook 2021 NC Medicaid

NC Medicaid

Managed Care Eligibility for
Newborns: What Providers Need to Know

Eligibility Requirements for Newborns

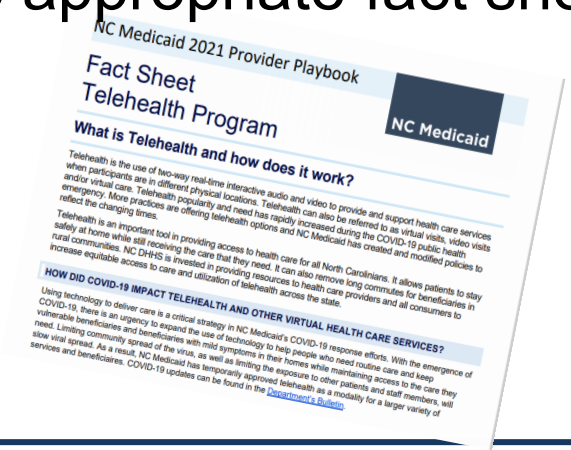
A child born to a woman with health coverage through Medicaid on the date of the child's birth is automatically eligible for Medicaid. The newborn is "deemed eligible" based on the mother's Medicaid coverage. The child's Medicaid eligibility certification period is from the first day of the month of birth through the end of the month the child turns one year of age.

A child whose mother is not covered by Medicaid for the birth of the child may be eligible for Medicaid. An application must be submitted for the child and the child must meet all eligibility requirements, including income. The local county department of social services (DSS) determines eligibility the same as for any Medicaid applicant.

All information contained in this document is dependent upon the actual NC Medicaid status and managed care status of the mother and the newborn. Nothing in this document supersedes the newborn's actual official status according to the records of the NC Department of Health and Human Services (DHHS), Division of Health Benefits.

NEWBORN PLAN ASSIGNMENT*

If on the date she gives birth, the mother is covered by…	Newborn is covered by…


NC Medicaid 2021 Provider Playbook

Fact Sheet
Telehealth Program

NC Medicaid

What is Telehealth and how does it work?

Telehealth is the use of two-way real-time interactive audio and video to provide and support health care services when participants are in different physical locations. Telehealth can also be referred to as virtual visits, video visits and/or virtual care. Telehealth popularity and need has rapidly increased during the COVID-19 public health emergency. More practices are offering telehealth options and NC Medicaid has created and modified policies to reflect the changing times.

Telehealth is an important tool in providing access to health care for all North Carolinians. It allows patients to stay safely at home while still receiving the care that they need. It can also remove long commutes for beneficiaries in rural communities. NC DHHS is invested in providing resources to health care providers and all consumers to increase equitable access to care and utilization of telehealth across the state.

HOW DID COVID-19 IMPACT TELEHEALTH AND OTHER VIRTUAL HEALTH CARE SERVICES?

Using technology to deliver care is a critical strategy in NC Medicaid's COVID-19 response efforts. With the emergence of COVID-19, there is an urgency to expand the use of technology to help people who need routine care and keep vulnerable beneficiaries and beneficiaries with mild symptoms in their homes while maintaining access to the care they need. Limiting community spread of the virus, as well as limiting the exposure to other patients and staff members, will slow viral spread. As a result, NC Medicaid has temporarily approved telehealth as a modality for a larger variety of services and beneficiaries. COVID-19 updates can be found in the Department's Bulletin.

Additional Managed Care Plan Services

Use this guide to view **added services** each health plan offers. **Some services may only be available for members who qualify.** For questions, call **1-833-870-5500** (TTY: 1-833-870-5558).

EBCI TRIBAL OPTION

Education
- Up to $250 General Educational Development (GED) exam voucher, materials and life skills training
- Up to $750 voucher for Associate Degree tuition and materials
- Up to $250 voucher for a computer if accepted and enrolled full time in an institution of higher education

Prenatal
- Up to $75 in gift cards if go to prenatal appointments

Wellness
- Offers of nutrition, cooking, and exercise classes

Youth
- 1 pair sport shoes per calendar year
- Car safety seat with installation and use education

Other
- Cherokee Language classes and supplemental learning materials
- Transportation for job training and other activities to implement person's care plan

WellCare
Beyond Healthcare. A Better You.

Education
- $120 GED voucher, including GED testing, tutoring, and reading scholarships

Prenatal
- Up to $450 in rewards for baby products; stroller, playpen, car seat, or diapers

Wellness
- $75/year rewards gift cards
- 20% CVS discount card
- 24-week voucher for Weight Watchers®

Youth
- Boy Scouts, Girl Scouts and 4-H Club membership

Other
- Hearing aid (up to $300)
- Up to $120 yearly for over-the-counter drugs
- Cell phone with 350 monthly minutes, free texts, 3 GB data
- Rides to covered services for Health Choice members and rides to classes and events for all members

UnitedHealthcare
Community Plan

Education
- Up to $160 GED exam voucher, materials, and life skills training

Prenatal
- Free electronic breast pump
- Up to $100 in rewards for baby products

Wellness
- $75/year rewards gift cards
- 13-week voucher for Weight Watchers®

Youth
- $75 yearly for membership at Boys and Girls Club or YMCA

Other
- $100 yearly value in alternative healing, acupuncture, massage therapy
- Up to $150 for hypoallergenic mattress cover and pillowcase for asthma
- Cell phone with 350 monthly minutes, free texts
- Free meal delivery up to 14 days after hospital stay, if qualify

HealthyBlue

Education
- $50 annual gift card for school supplies
- GED exam voucher (up to $160 value)
- 24 hours of online tutoring for eligible members ages 6-18, if qualify

Wellness
- Up to $75 yearly rewards for doctor visits
- 13-week voucher for WW® (formerly Weight Watchers)
- 3 months of fresh fruits and veggies for qualifying members

Youth
- $75 yearly for membership like Boys and Girls Club, Boy Scouts, or Girl Scouts
- Up to $150 for after school activities

Other
- Cell phone with monthly data, minutes and bonus minutes
- $20 Uber gift card for college students for grocery stores, local events

AmeriHealth Caritas North Carolina

Education
- GED program with free practice and regular tests

Prenatal
- High-risk pregnancy home educational visits

Wellness
- $75/year rewards gift cards
- Weight Watchers® membership for qualifying members

Youth
- Boys & Girls Club membership, ages 18 and younger
- Home visits, supplies for children with asthma, ages 2-18

Other
- Pain management education and support
- Extra pair of glasses and eye exam every 2 years, ages 21-64
- 2 meals per day for up to 7 days after hospital stay
- Smart phone with 1,000 minutes, unlimited texts, & 1 GB data per month

carolina complete health

Education
- GED exam voucher, study materials
- $75/year value school supplies, online tutoring, members grades PreK-12 before GED

Prenatal
- Up to $100 per year for new mothers; car seat, diapers, diaper bag, breast pump, high-risk pregnancy visits

Wellness
- $75 per year rewards card
- $120 per year for approved healthy foods at Walmart®
- Up to 14 weeks of Weight Watchers® and online tools

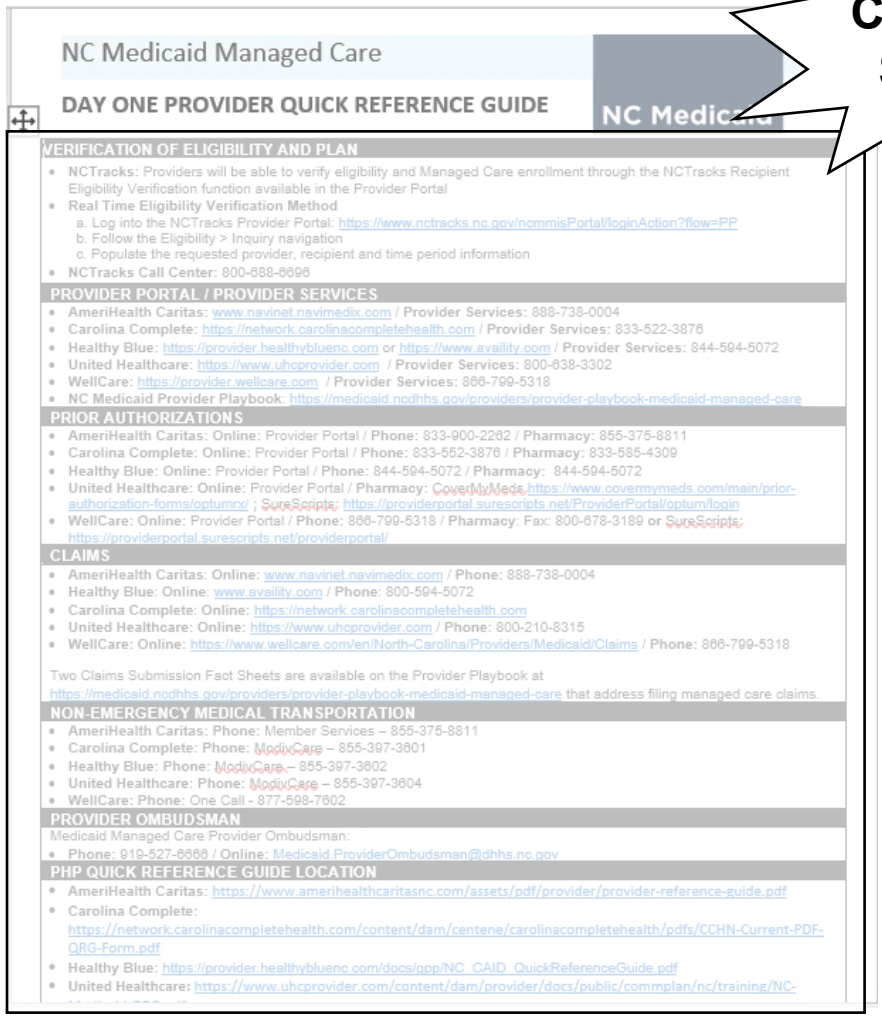
Youth
- $75 per year value after school sports/activities/youth club membership, ages 6-18

Other
- $125/year for glasses, contacts for members ages 21 & up
- $120/year per household for over-the-counter products
- Cell phone with 250 monthly minutes, free calls, texts

Provider Quick Reference Guide (QRG)

A consolidated QRG a provider can turn to on Day 1 of Managed Care go-live to assist with:

- Verifying a beneficiary is eligible and identifying their plan
- Locating health plan provider portals and contact numbers
- Requesting a prior authorization
- Submitting a claim
- Arranging NEMT
- Contacting the Provider OMBUDSMAN and
- Finding detailed health plan QRGs.



NC Medicaid Managed Care

DAY ONE PROVIDER QUICK REFERENCE GUIDE

NC Medicaid

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:** www.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:** 855-375-8811
- **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/

CLAIMS

- **AmeriHealth Caritas: Online:** www.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:** 919-527-6666 / **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-

COMING SOON

31


QUESTIONS?

APPENDIX

NC Medicaid Managed Care Timeline

March 1, 2021

Mailings Started
EB Call Center

March 15, 2021 – May 14, 2021

Open Enrollment

April 15, 2021

Reminder Postcard

May 15, 2021

Auto-Enrollment

July 1, 2021

Health Plan Coverage Starts

July 1, 2021– Sept. 30, 2021

90 Day Choice Period

Managed Care Populations

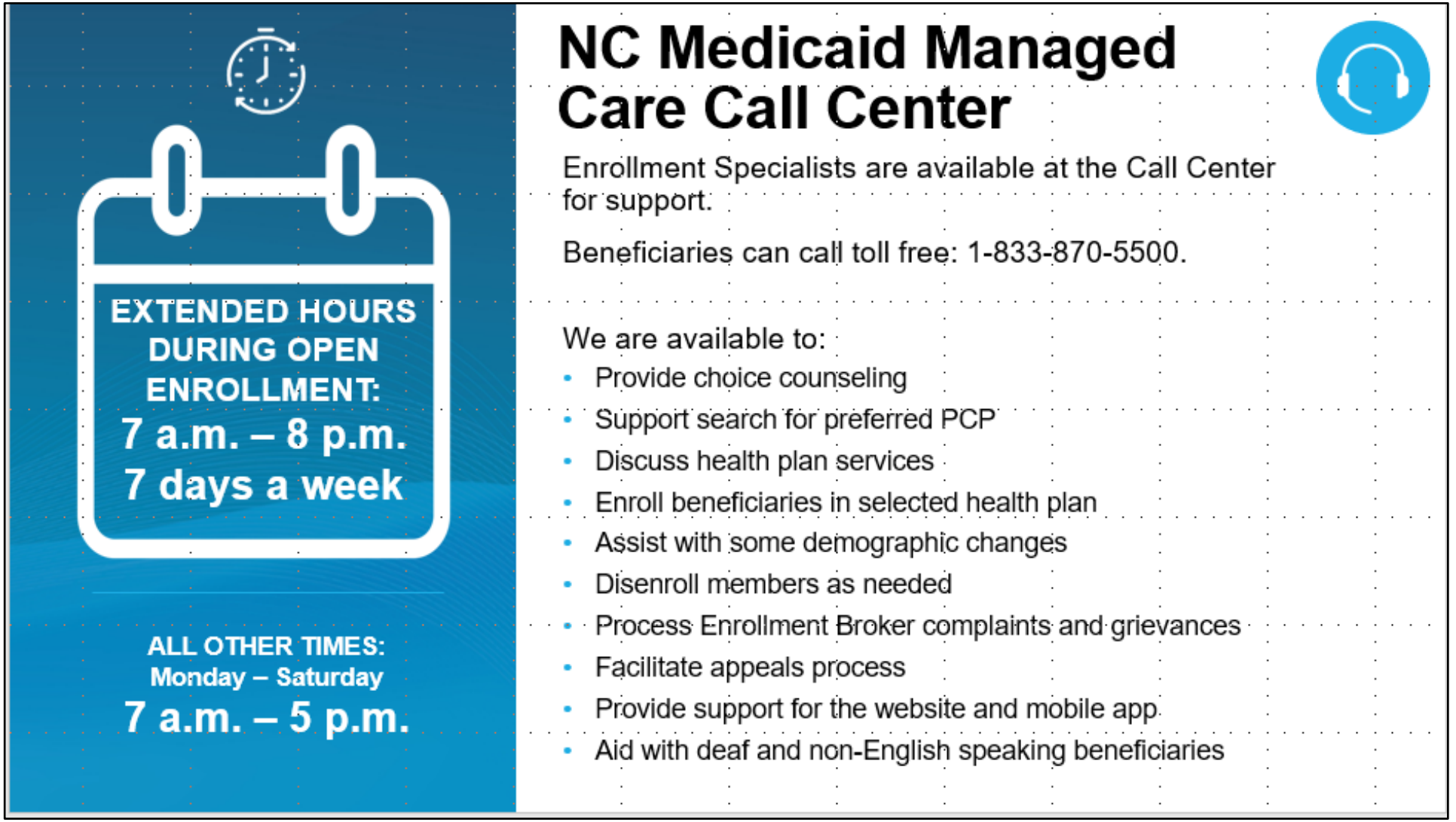
While most Medicaid beneficiaries will enroll in NC Medicaid Managed Care, some people will not. The table below outlines who must enroll, who may enroll, and who cannot enroll.

MANDATORY	EXEMPT	EXCLUDED[1,2]
Must enroll in a health plan	**May enroll** in a health plan or stay in NC Medicaid Direct	**Cannot enroll** in a health plan; stay in NC Medicaid Direct
Most Family & Children's Medicaid, NC Health Choice, Pregnant Women, Non-Medicare Aged, Blind, Disabled	Federally recognized tribal members/IHS eligible beneficiaries, beneficiaries eligible for behavioral health Tailored Plans	Family Planning Program, Medically Needy, Health Insurance Premium Payment (HIPP), Program of All-Inclusive Care for the Elderly (PACE), Refugee Medicaid

[1]Some individuals are temporarily excluded and become mandatory later. This includes dually-eligible Medicaid/Medicare, Foster Care/Adoption, Community Alternatives Program for Children (CAP-C), and Community Alternatives Program for Disabled Adults (CAP-DA).

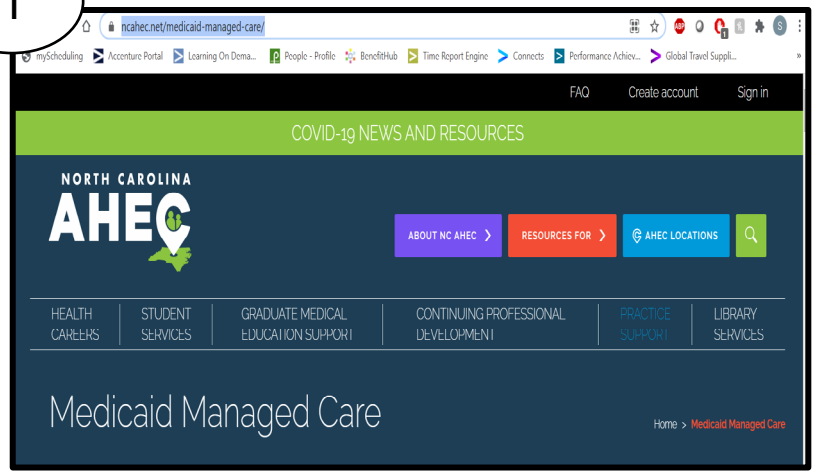
[2]Some federally recognized tribal members/IHS eligible beneficiaries are excluded and may enroll in the EBCI Tribal Option.

Medicaid Managed Care Call Center is LIVE!



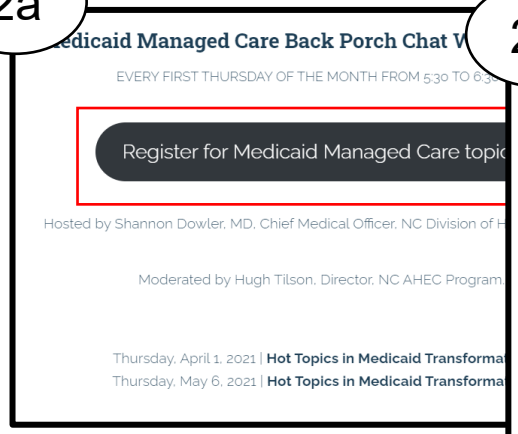
How To Sign up for the Back Porch Chat Webinar Series

1

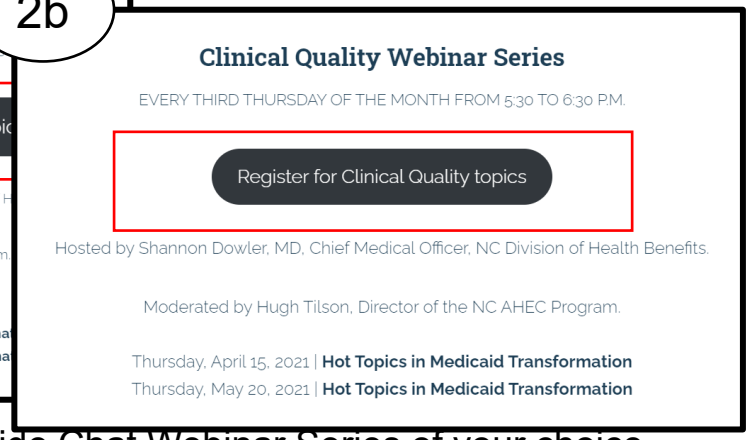


1. Navigate to the North Carolina AHEC Medicaid Managed Care page

2a



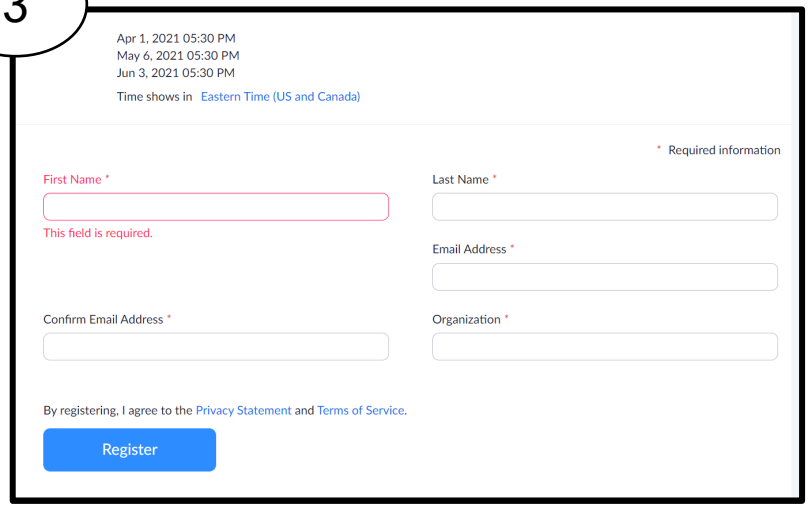
2b



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

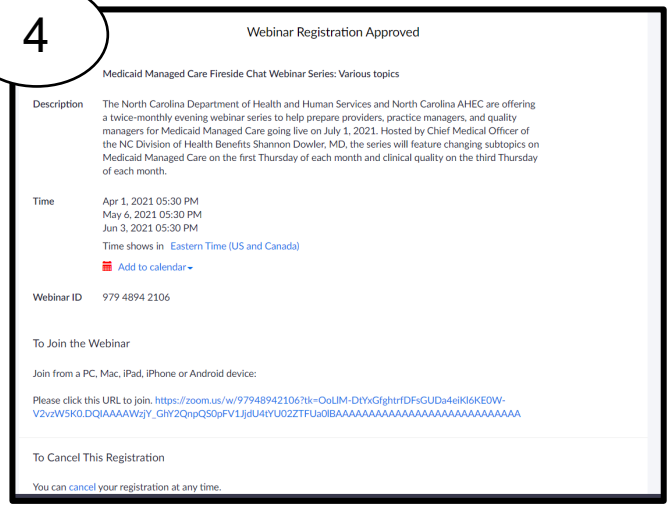
2b. Click on “Register for Medicaid Managed Care topics” or “Register for Clinical Quality topics”

3



3. Fill out all the required information and click register

4



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