

Fact Sheet

Introduction to Standard Plans

What are Standard Plans?

North Carolina moved to a managed care model in 2021. Under NC Medicaid Managed Care, the State contracts with insurance companies, called health plans. The health plans are paid a capitated rate, which is a pre-determined set rate per person to provide health care services.

Most NC Medicaid beneficiaries are enrolled in Standard Plans.

Standard Plans offer physical health, pharmacy, care management and basic behavioral health services for members. Each Standard Plan offers additional Value - Added Services for beneficiaries who may qualify at no cost. Claims are submitted to the member's Standard Plan, and the Standard Plan pays the providers.

CHOICES FOR ENROLLMENT

Beneficiaries have four Standard Plan options to choose from when they enroll:

- AmeriHealth Caritas
- Carolina Complete Health
- Healthy Blue
- UnitedHealthcare Community Plan

NC Medicaid has other Medicaid programs beneficiaries can enroll if qualified, including the Behavioral Health Intellectual/Developmental Disabilities Tailored Plans, NC Medicaid Direct, Children and Families Specialty Plan and Eastern Band of Cherokee Indians (EBCI) Tribal Option. Beneficiaries interested in a different Medicaid program should contact the NC Medicaid Enrollment Broker (EB).

The EB can assist beneficiaries with questions about choosing or changing a health plan. The EB call center can be reached at 833-870-5500, and more information is available on the [NC Medicaid Enrollment Broker website](#).

STANDARD PLAN CONTRACTING

Health plan contracting is an ongoing process. Providers must be actively enrolled with NC Medicaid prior to contracting. Resources about provider enrollment applications are available on the [NC Medicaid Provider Enrollment webpage](#). To contract with a Standard Plan please use the following process:

- Complete the Provider Enrollment Application in NCTracks.
- Primary Care Providers (PCPs) can elect to become a Community Care of North Carolina/Carolina Access (CCNC/CA) provider during their enrollment application in NCTracks.
- Once actively enrolled, providers contract directly with NC Medicaid Managed Care health plans (including Standard Plans).
 - Approved CCNC/CA providers will default to an Advanced Medical Home (AMH) Tier 2 provider for NC Medicaid Managed Care and may attest to meeting AMH Tier 3 criteria using the AMH Tier Attestation Tool. See the NCTracks AMH Tier Attestation Job Aid under [Quick Links](#). More information about the AMH program, including the AMH Provider Manual is available [NC Medicaid Advanced Medical Home webpage](#).

To initiate contracting with a Standard Plan, providers should contact the health plan. Contact information is available on the [Medicaid Health Plan Contacts and Resources webpage](#).

KEY REMINDERS FOR PROVIDERS

All providers are strongly encouraged to:

- Regularly review each applicable individual and organization NCTracks provider record for accuracy, and submit changes using the Manage Change Request (MCR) process.
 - Medicaid providers are contractually required to update their NCTracks record within 30 days of any change, including new circumstances that change their Exclusion/Sanction question response.
- Ensure staff know the Standard Plans with which their providers are contracted.
- Know where to submit claims for each Standard Plan.
- For each health plan under contract, ensure enrollment in the health plan's Electronic Funds Transfer program is complete.

NC Medicaid recommends providers and pharmacies use NCTracks Recipient Eligibility Verification/Response to confirm beneficiary eligibility and not rely solely on the information shown on a Member ID card. Follow these steps when a Standard Plan beneficiary presents at your office:

Verify eligibility, health plan assignment and primary care provider enrollment using the NCTracks Recipient Eligibility Verification/Response or call the NCTracks Call Center for more information, 800-688-6696.

Confirm your practice participates with the assigned health plan and obtain the beneficiary's health plan Member ID to file claims.

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, they should call the Member Services Department for their health plan and ask to be reassigned to you.

Member ID cards are not required to render services. Therefore, beneficiaries should not be turned away due to the lack of a Member ID card in their possession.

CLAIMS INFORMATION

- **AmeriHealth Caritas:** Online: navinet.navimedix.com Phone: 888-738-0004
- **Healthy Blue:** Online: availability.com Phone: 800-594-5072
- **Carolina Complete Health:** Online: network.carolinacompletehealth.com/claims Phone: 833-552-3876
- **United Healthcare:** Online: uhcprovider.com Phone: 800-638-3302

NC Medicaid Managed Care Provider Claims fact sheets are available on the [Provider Playbook](#), under Programs and Services.

NC MEDICAID PROVIDER OMBUDSMAN

The Provider Ombudsman is separate from the managed care health plans' issue resolution processes and should be used only after contacting the health plan(s) or seeking information and guidance through the [NC Medicaid Help Center](#).

The health plan grievance and appeal process for providers can be found in the health plan's Provider Manual or linked on the [Health Plan Contacts and Resources page](#). Inquiries may be submitted to Medicaid.ProviderOmbudsman@dhhs.nc.gov or by calling the Provider Ombudsman at 866-304-7062.

