NC Medicaid

Fact Sheet
Prompt Payment

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-service) levels, will apply to contracted physicians, physician extenders, pharmacies (dispensing fees), hospitals and nursing facilities. Rate floors for hospitals and nursing facilities will apply for a limited duration. For more information on payment to hospitals, refer to the “Addressing Hospital Supplemental Payments in the Transition to Managed Care” policy paper located on the Policy Papers page of the Medicaid Transformation website.
2. Health plans will be required to make additional payments, above those built into the per member per month (PMPM)capitated rate, to certain providers, including in-network public ambulance providers, local health departments and hospitals owned by UNC Health Care and Vidant Medical Center. DHHS proposes that these additional, utilization-based payments be made quarterly by health plans to providers, with an annual reconciliation. DHHS will make payments to health plans outside the PMPM capitation rates to cover the cost of these additional payments.
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.
5. Health plans will be required to pay PMPM primary care medical home payments for providers that meet Advanced Medical Home (AMH) standards. These payments will be equal to the payments providers receive today in the Carolina ACCESS program ($1.00, $2.50 or $5.00 per beneficiary assigned to the practice). Additional detail appears in section V.D.4.p of the PHP contract.
6. Health plans will be required to offer local health departments (LHDs) the “right of first refusal” with continued payment of PMPM payments to LHDs for Care Management for High Risk Pregnancies (formerly called Obstetric Care Management) and Care Management for At Risk Children (formerly called Care Coordination for Children) for a transitional period of three years (Nov. 1, 2019 – June 30, 2022).

PROMPT PAYMENT

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 will be required to act on additional information that is submitted by a provider within the required timeframe. 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. Providers do not have to make separate requests to the health plan for interest or penalty payments and are not required to submit another claim to collect the interest and penalty.

PROMPT PAYMENT FOR PHARMACY CLAIMS

1. 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.
2. A Pharmacy Pended Claim shall be paid or denied within 14 calendar days of receipt of the requested additional information.

PAYMENT BY ELECTRONIC FUNDS TRANSFER

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).

APPEALS

PHP	Appeals Process (underpayment, denials, etc)
AmeriHealth Caritas North Carolina	Providers must file a claim inquiry no later than 180 days from the date of service of 60 calendar days after the payment, denial or recoupment of a timely claim submission, whichever is latest. Claim inquiries must be submitted in writing to the appropriate address, by phone 888-738-0004, or through the NaviNet secure provider portal (www.navinet.navimedix.com).
Blue Cross Blue Shield North Carolina	Providers can file a claims complaint to Blue Cross NC in writing to the appropriate address, by phone at 844-594-5072, or via the Availity Portal secure provider payment appeal tool (https://www.availity.com). Blue Cross NC will resolve provider grievances within 30 calendar days. In the case that a provider disagrees with the outcome of the complaint, the provider can file an appeal. The appeal must be filed within 30 calendar days from the date which: (a) the Provider received written notice from Blue Cross NC of the decision giving rise to the right to the appeal; or (b) Blue Cross NC should have taken a required action but failed to take such action. Provider appeals must be submitted in writing to the appropriate address or via the Availity portal secure provider Payment Appeal Tool (https://www.availity.com). Blue Cross NC will acknowledge receipt of each appeal request within five calendar days of receipt of the request. Blue Cross NC will provide written notice of the decision of the appeal within 30 calendar days of receiving a complete appeal request.
Carolina Complete Health	Providers must file a claims complaint within 30 calendar days from the date of the Medicaid Remittance. A provider claim complaint must be submitted in writing to the appropriate address, by phone at 919-527-6666, or via email to QOC_CIR@CarolinaCompleteHealth.com. Carolina Complete Health has 30 calendar days to review the complaint, make a determination, and notify the provider of their decision. In the case that a provider disagrees with the outcome of the complaint, the provider can file an appeal. The appeal must be filed within 30 calendar days from the date the provider receives written notice from Carolina Complete Health of the decision giving rise to the right to appeal. Provider appeals must be submitted in writing to the appropriate address. Carolina Complete Health will acknowledge receipt of each appeal within five calendar days after receiving an appeal. Carolina Complete Health will resolve each appeal within 15 business days

United Healthcare	Providers must file a claim reconsideration within 365 calendar days of the claim processing date. A provider claim reconsideration must be submitted in writing to the appropriate address, by phone at (800)638-3302, or by using the Claims Management Application on Link (www.UHCprovider.com/link). United Healthcare has 30 calendar days to review the case, make a determination, and notify the provider of their decision. In the case that a provider disagrees with the outcome of the reconsideration, the provider can file an appeal. The appeal must be filed within 30 calendar days of the initial notice of adverse benefit determination. Provider appeals must be submitted in writing to the appropriate address, by phone at 800-638-3302, or by using the Claims Management Application on Link (www.UHCprovider.com/link). United Healthcare will acknowledge receipt of the appeal request within five calendar days of receipt of the request and will resolve the case within 30 calendar days.
WellCare	Providers must file a claims payment dispute within 30 calendar days of the date of denial of the explanation of payment (EOP) or as otherwise stated in the Provider's contract. Provider appeals must be submitted in writing to the appropriate address or by phone (844-458-6739).