NC Medicaid Managed Care
Provider Playbook

Fact Sheet
Provider Payment and Reimbursement

Understanding payment and reimbursement requirements

NCDHHS establishes provider payment requirements for health plans, aiming to encourage ongoing provider participation in NC Medicaid. This measure helps ensure beneficiary access and supports safety net providers while maintaining current reimbursement levels. These mechanisms are designed to mitigate the risk of health plan redirection towards alternative providers. The final capitation rates will reflect the prescribed reimbursement levels.

NCDHHS established provider payment requirements for health plans are listed below.

CLAIM PAYMENTS

Rate Floor Claim Payments

Health plans are required to pay services identified as rate floors no less than 100% of the posted fee schedule rate unless the provider and health plan have agreed to an alternative rate or reimbursement methodology through provider contracts. The alternative reimbursement methodology may include a lesser of provision where the health plan would pay the lesser of the billed amount and the defined rate. An alternative reimbursement agreement is not required for health plans to pay more than 100% of the rate floor rate. Rate floor services can be identified as those with an asterisk (*) on the fee schedules.

Non-Rate Floor Claim Payments

Non-rate floor program service rates are negotiable between the health plans and providers. Providers should refer to their respective contracts with each health plan for the negotiated service rates.

Out of Network Claim Payments

If the provider has engaged in a good faith contracting effort with the health plan but the provider has refused that contract, then the health plan, after considering all facts and circumstances surrounding a provider's willingness to contract, may deem the provider as an out-of-network provider in accordance with the health plan's Good Faith Contracting policy. After Standard Plan evaluation based on their good faith contracting policy, a health plan is prohibited from paying an out of network

(OON) provider at more than 90% of applicable Medicaid fee-for-service rate, inclusive of rate floor services.

NCDHHS has established OON policy flexibilities for the transition to NC Medicaid Managed Care. Behavioral Health and Intellectual/Developmental Disability (I/DD) Tailored Plan policy flexibilities will be announced prior to launch. Health systems and providers are strongly encouraged to continue contract negotiations with health plans and finalize contracts to avoid reduced reimbursements.

ProviderPayments

A provider who accepts a patient as a Medicaid patient shall agree to accept Medicaid payment, plus any authorized deductible, co-insurance, co-payment and third party payment, as payment in full for all Medicaid covered services or supplies provided This excludes payments from legally liable third parities, and authorized cost-sharing amounts as permitted by the Department. A provider shall not bill or otherwise seek payment from a Medicaid patient for any items or services covered by the Department.

Generally, out of pocket costs apply to all Medicaid enrollees other than services and enrollees exempted by law. Out of pocket costs cannot be imposed for certain services including emergency services, family planning services, pregnancy-related services or preventive services for children. Additionally, certain enrollees including children, terminally ill individuals and individuals residing in an institution are exempted from paying out of pocket costs.

Please see the Provider Requirements related to Billing Medicaid Beneficiaries bulletin and Cost Sharing Out of Pocket Costs guidance for more information.

MEDICAL HOME PAYMENT

Primary Care Medical Home Payments

Health plans will be required to pay Per Member Per Month (PMPM) primary care medical home payments for providers that meet Advanced Medical Home (AMH) standards.

For Standard Plans, AMH Tiers 1-3 practices will be paid $2.43 PMPM for most Members and $4.85 PMPM for Members in the aged, blind, and disabled Medicaid eligibility group.

For Tailored Plans, AMH Tiers 1-3 practices will be paid $4.85 PMPM for all Tailored Plan members regardless of aged, blind, and disabled status.

The Children and Families Speciality Plan (CFSP) shall pay Medical Home Fees to AMH practices for any month in which the CFSP Member is assigned to that AMH practice as their primary care provider (PCP). Medical Home Fees for AMH practices shall be no less than $4.85 PMPM.

CARE MANAGEMENT PAYMENT

Tailored Care Management:

Care Management providers (AMH+ and CMAs) will be paid a monthly standard rate when they provide Tailored Care Management (TCM) to assigned members in that month. TCM providers will

submit a TCM claim to their respective Tailored Plan for the first TCM contact of each month in order to receive the standard TCM rate. More information can be found in the Tailored Care Management Provider Billing Guide.

Local Health Departments

For contract years 1-4, Standard Plans are required to pay in-network local health departments (LHDs) for Care Management for At-Risk Children (CMARC) and Care Management for High-Risk Pregnant Women (CMHRP) services an amount substantially similar to or no less than the amount paid in the fee-for-service program prior to NC Medicaid Managed Care launch.These amounts are:

- CMHRP: $4.81 PMPM for all PHP member women ages 14 through 44 residing in the LHD county/service area.
- CMARC: $4.42 PMPM for all PHP member children through age 5 residing in the LHD county/service area.

Beginning contract year 5, Standard Plans will compensate LHDs/other providers of care management services at net mutually agreed upon rates.

For contract year 1, Tailored Plans are required to pay in-network LHDs CMHRP an amount substantially similar to or no less than the amount paid in the fee-for-service program prior to NC Medicaid Managed Care launch as noted above. Beginning contract year 2, Tailored Plans will compensate LHDs/other providers of care management services at net mutually agreed upon rates.

Children and Families Speciality Plan (CFSP):

The CMHRP and CMARC programs are not included under the CFSP. Members who are eligible for these programs will instead receive care management through the CFSP Care Management model.

DIRECTED PAYMENTS

Standard Plans and Tailored Plans will be required to make additional payments, above those built into the PMPM capitated rate, to certain providers, including, but not limited to in-network local health departments, faculty physicians affiliated with the teaching hospitals for each University of North Carolina medical school and hospitals owned by UNC Health Care and Vidant Medical Center. NCDHHS calculates these additional, utilization-based payments on a quarterly basis with an annual reconciliation. NCDHHS will make payments to health plans outside the PMPM capitation rates to cover the cost of these additional payment.

CFSP will be required to make additional payments, above those built into the PMPM capitated rate, to certain providers, including but not limited to in-network local health departments. NCDHHS calculates these additional, utilization-based payments on a quarterly basis with an annual reconciliation. NCDHHS will make payments to health plans outside the PMPM capitation rates to cover the cost of these additional payments. Additionally, utilization-based payments for faculty physicians affiliated with the teaching hospitals for each University of North Carolina medical school and hospitals owned by UNC Health Care and Vidant Medical Center will not be included this year because it's a partial year; these addtional utilization-based payments will resume next year.