NC Medicaid

Children and Families Specialty Plan Claims Information Session

Nov. 13, 2025

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Health Benefits

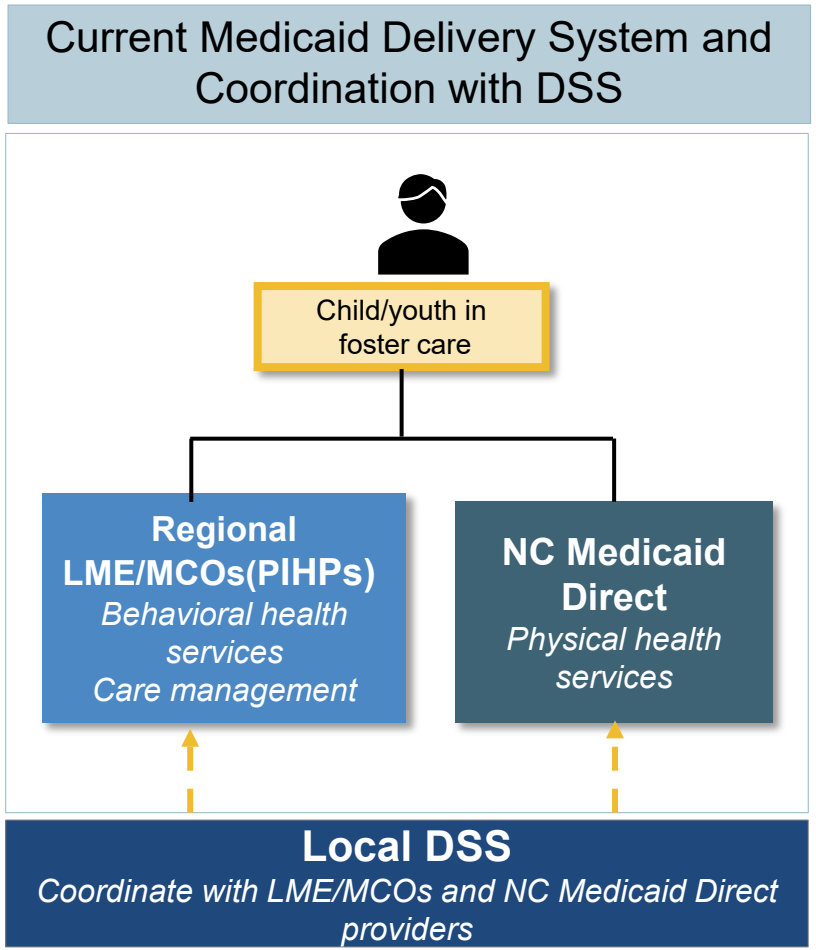
Adolph Simmons
Deputy Director,
Managed Care Business Operations

Agenda

- Opening Remarks
- CFSP: What's Changing
- Day 1 Provider Information
- CFSP: Where To Go For Help
- Q&A

Designed to Address Current System Challenges

Children and youth served by the child welfare services receive Medicaid services through a split system of care, which has created challenges around coordination and meeting the population's unique needs.



- **Disruptions in continuity of care and providers** due to population's frequent movement between placements.
- **Lack of service coordination, impeding timely access to care,** due to transitions between various regional entities; no one entity is accountable for provision of whole-person care and care coordination.
- **Challenges meeting needs of children and youth in foster care with complex physical and behavioral health or I/DD needs,** resulting in restrictive residential or out-of-state placements.
- **Limited focus on unique needs of populations exposed to Adverse Childhood Experiences and provision of trauma-informed care** as part of health care service delivery and care management.
- **Limited array of available community-based services** across the state to support children remaining in family settings or the least restrictive setting possible.

How to Determine Member Eligibility

Medicaid Member Eligibility

Medicaid member eligibility should be verified through NCTracks, the recognized Real-Time Eligibility (RTE) system for providers contracting with the NC Medicaid

Member eligibility validation can be accomplished through three ways in NCTracks:

Real Time Eligibility Verification Method

1. Log into the NCTracks Provider Portal
2. Follow the Eligibility > Inquiry navigation
3. Populate the requested provider, member, and time-period information

Batch Eligibility Verification Method

1. Log into the NCTracks Provider Portal
2. Follow the Eligibility > Batch verify
3. Upload the file by selecting browse > load from file

Via Automatic Voice Verification

Call the NCTracks Call Center at 800-688-6696 for voice verification.

Claim Filing and Payment Timelines

	Medical Claims	Pharmacy Claims
Timely Filing	Within 365 calendar days of covered service or discharge, or a time period set by the health plan that is no less than 365 calendar days	Within 365 calendar days of date of provision of care
Timely Filing for Retroactive Enrollees	365 calendar days of the approved enrollment	365 calendar days of the approved enrollment
Notify Providers of Clean* / Pended Claims	18 calendar days of receiving claims	14 calendar days of receiving claims
Pay or deny claims upon clean submission or a claim becomes clean	Within 30 calendar days of clean submission / becoming clean	Within 14 calendar days of clean submission / becoming clean
Deny claims if no additional information is submitted from the provider	90 days of the date the additional information was requested	90 days of the date the additional information was requested

***Clean Claim:** *A claim submitted to a health plan by a participating provider which can be processed without obtaining additional information from the Participating Provider or their authorized representative in order to adjudicate the claim.* Reference the What Providers Need to Know Before Children and Families Specialty Plan Launch (Part 1) for more information.

Common Billing Errors

Failure to Follow Health Plan Billing Guidance

Transition to the Child and Family Specialty Plan (CFSP) requires providers to follow billing guidance from Healthy Blue. Healthy Blue must adhere to State and Federal claims processing requirements, with potential additional plan-specific requirements

Taxonomy Errors

Providers must select a taxonomy from the Provider Permission Matrix based on their license and scope of practice for credentialing purposes.

- For information on how to view the taxonomies you are enrolled in, please check the Taxonomy Enrollment Requirement Reminders for Claim Payment bulletin.
- It's important for providers to verify the taxonomies they are enrolled in and ensure accurate taxonomy data is submitted to health plans through their clearinghouses to avoid claim denials. For more information on including taxonomies in submissions, please check the Claims Denied – Taxonomy Codes Missing, Incorrect, or Inactive bulletin.
- For how to view and update taxonomies on the provider profiles, please check the View and Update Taxonomy on the Provider Profile in NCTracks User Guide.

Prior Authorization

Providers should check PA requirements for Healthy Blue as outlined in the lookup tools in Children and Family Specialty Plan (CFSP) Managed Care Claims and Prior Authorizations Submission:
Frequently Asked Questions – Part 2 and the Managed Care Claims and Prior Authorizations Submission: Frequently Asked Questions – Part 2 prior to patient visits to avoid unnecessary claim denials.

Coordination of Benefits

Providers should check if a patient has other insurance before submitting a claim. If the patient does have other coverage, providers should include coordination of benefits when submitting secondary claims to health plans. Refer to the TPL Billing Guide for more information.

When is Prior Authorization Required?

Prior authorization is necessary for:

- Inpatient Services
- Non-covered Services
- Certain Prescribed Medications
- Diagnostic and Treatment Services that fall within EPSDT
- Services performed by an out of network (OON) provider; except for emergency services or post stabilization services
- Services identified by each plan per the plan's prior authorization requirements *

**See Maintaining Continuity of Care slide for CFSP PA relaxation guidelines*

Reference the i Children and Family Specialty Plan (CFSP) Managed Care Claims and Prior Authorizations Submission:

Frequently Asked Questions – Part 2 and/or the Managed Care Claims and Prior Authorizations Submission: Frequently Asked Questions – Part 2 Fact Sheets for more information.

Maintaining Continuity of Care

In addition to transition of care requirements for members in an ongoing course of treatment, the Department and Healthy Blue Care Together will offer the following flexibilities to support providers to reduce administrative burden during the transition.

Policy Lever	Duration	Time Frame
Relax Medical PA requirements	211 days	12/1/2025 – 6/30/2026
Relax Pharmacy PA requirements	211 days	12/1/2025 – 6/30/2026
Non-Par Providers Paid at Par Rates	211 days	12/1/2025 – 6/30/2026
Non-Par Providers Follow In-Network Prior Authorization Rules	122 additional days	7/1/2026 – 10/31/2026
Ability to Switch PCP	211 days	12/1/2025 – 6/30/2026
Continuity of Care for Ongoing Course of Treatment	7 months	12/1/2025 – 6/30/2026

Note: *The Department may opt to extend any of these flexibilities after the designated timeframe above, based on CFSP operations to ensure the stability of Medicaid operations for CFSP beneficiaries.*

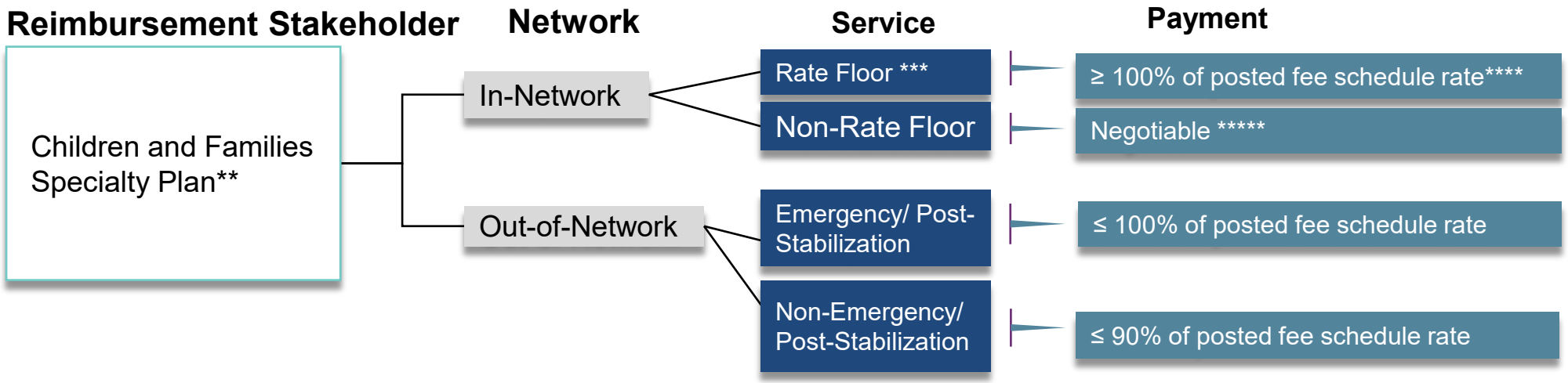
Member Payments

Outside of copays, providers may not bill Medicaid beneficiaries for:

1. Services covered by NC Medicaid, if the provider accepts the member as a Medicaid beneficiary

2. Services or goods NOT covered by NC Medicaid unless the beneficiary was notified in advance the service is not covered by Medicaid, and the beneficiary is financially responsible.

Reimbursement Methods



How do I determine which fee schedules are rate floors?

Fee schedules marked with an asterisk (*) indicate rate floors (e.g., Nursing Facility Rates). Rate floors represent the NC Medicaid Direct (fee-for-service) rates health plans must reimburse Medicaid providers at no less than 100% of the applicable NC Medicaid Direct rate, unless the health plan and provider mutually agree to an alternative reimbursement arrangement.

Program	Fee Schedule	Excel	Revision Date
Laboratory	Laboratory	Download File	2022-10-21
Dialysis	Dialysis+	Download File	2022-10-21
Community Alternatives Program+	CAP for Children (CAP/C)+	Download File	2023-01-13
Targeted Case Management	HIV Case Management	Download File	2022-10-21
Hearing Aid Program	Hearing Aid Program	Download File	2023-01-19
Nursing Facility Rates*	SNF Short Stay Managed Care	Download File	2023-01-20

See the Provider Requirements related to Billing Medicaid Beneficiaries bulletin for more information.

** CFSP has the authority to maintain a closed network for behavioral health services and may require an out of network agreement to receive payment.

*** For any provider subject to a rate floor as outlined in Section V.B.4.iv. Provider Payments, Healthy Blue Care Together (HBCT) may include a provision in the provider's contract that CFSP will pay the lesser of billed charges or the rate floor only if the provider and the CFSP have mutually agreed to an alternative reimbursement amount or methodology which includes a "lesser than" provision, with the exception of the Durable Medical Equipment, the Physician Administered Drug Program rate floors, and any rate floor program that receives a supplemental payment based on that program's rate floor rate that has been built into Health Plan Capitation rates.

**** Unless provider and HBCT have agreed to an alternative rate or reimbursement methodology through provider contracts.

***** Providers should refer to their respective contracts with HBCT for the negotiated service rates.

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Director,
Provider Relationship Account Management
Healthy Blue Care Together

CFSP Provider Readiness Webinar

November 13, 2025

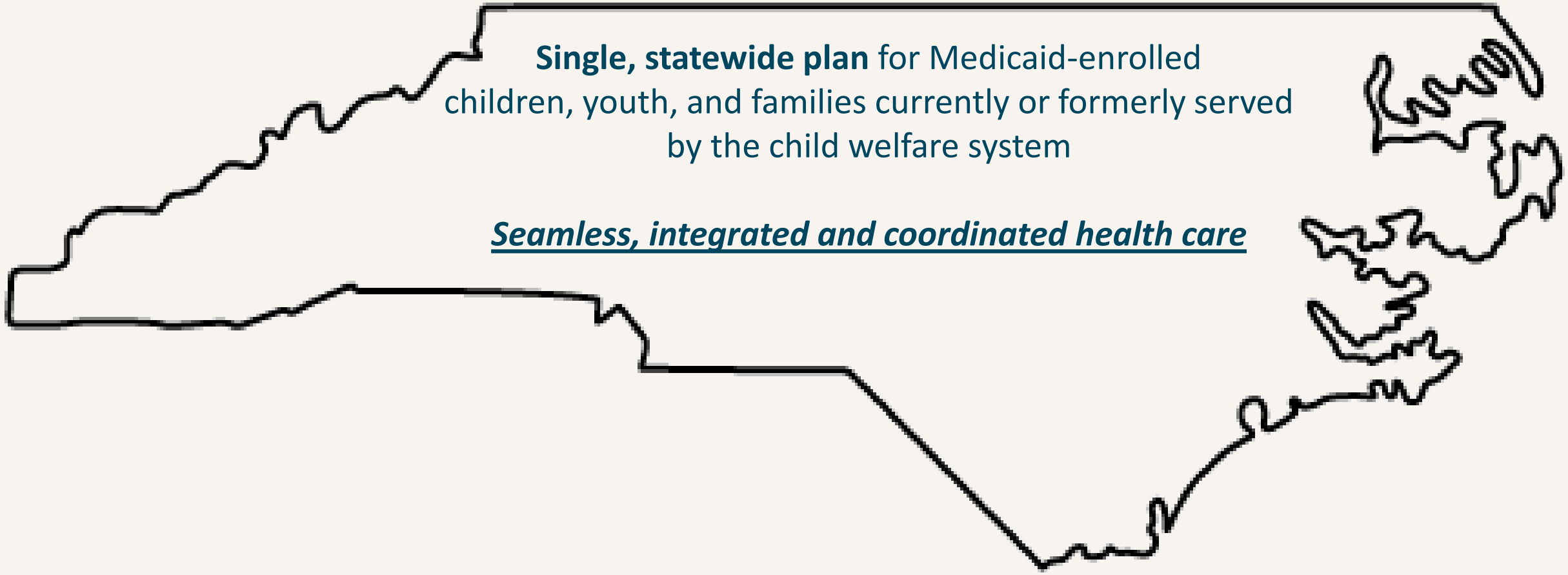
Agenda

- Introduction
- Overview of the Children and Families Specialty Plan (CFSP)
- Populations and Launch Plan
- Day 1 Priorities
- Provider Readiness: Where to Find Important Information
- Provider Readiness: Claims, Prior Authorizations, Electronic Payment Services
- Points of Contact
- Provider Education Events

On August 15, 2024,
Blue Cross and Blue Shield of North Carolina (Blue Cross NC)
was selected to operate the Children and Families Specialty Plan (CFSP).

Blue Cross NC will manage the CFSP under the name Healthy Blue Care Together.

Blue Cross NC's Children and Families Specialty Plan (CFSP)



Single, statewide plan for Medicaid-enrolled children, youth, and families currently or formerly served by the child welfare system

Seamless, integrated and coordinated health care

Key Objectives

Strengthen and preserve families

Help avoid boarding in local DSS offices & Emergency Departments

Increase access to services

Improve member outcomes

Improve coordination & collaboration with stakeholders

Coordinate care and facilitate seamless transitions (including during child welfare placements)

Who Will Be Auto-Enrolled on December 1?

Populations Auto-Enrolled at CFSP Launch*
Launch date: December 1, 2025

- Children and youth in foster care
- Children and youth receiving adoption assistance
- Young adults under age 26 formerly in foster care
- Minor children of populations listed above

**** 12 months post-reunification for continuity.***

**** With the exception of Eastern Band of Cherokee Indian Tribal members and other limited groups, these eligibility groups will be auto enrolled at CFSP launch.***

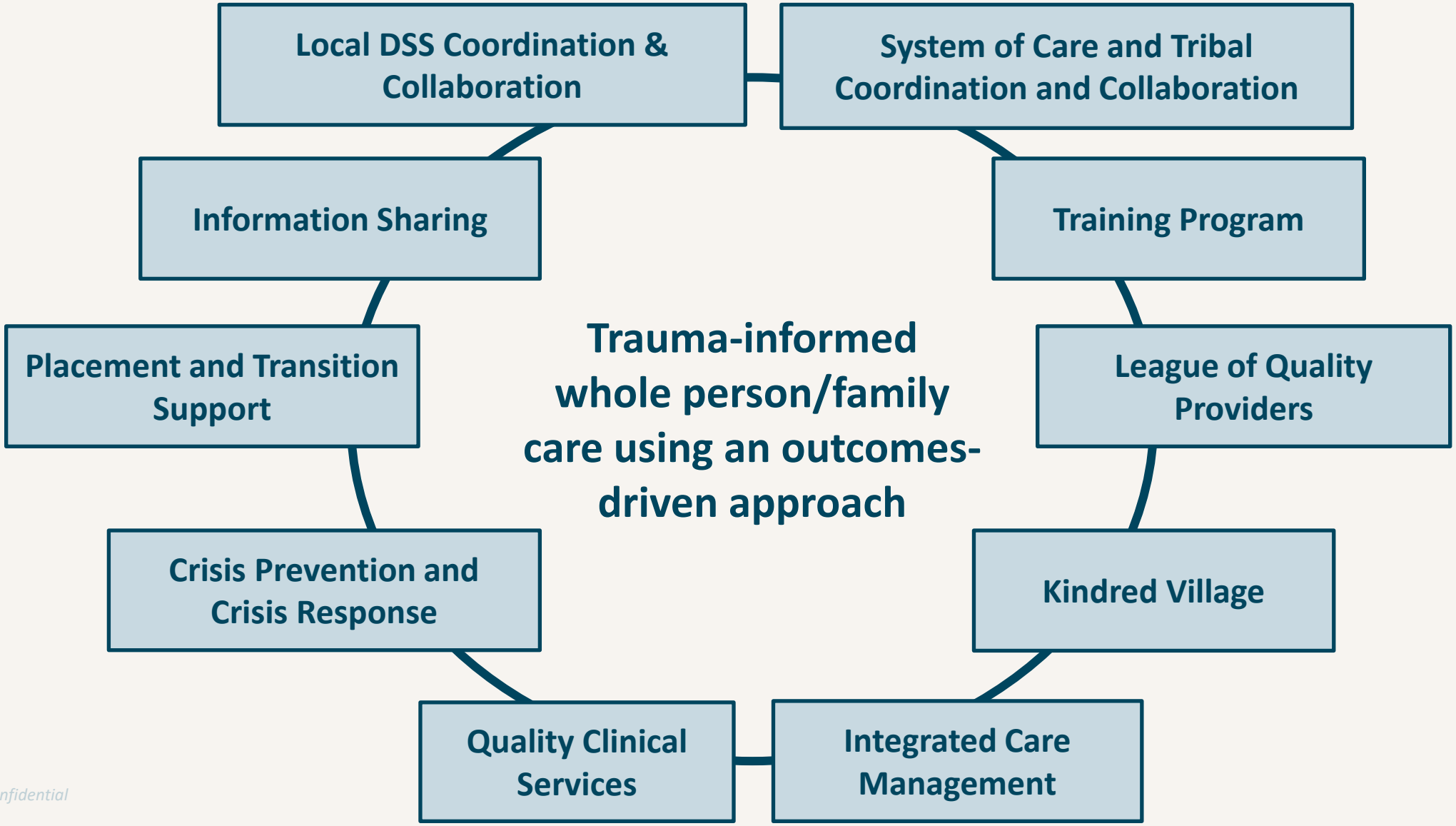
Exceptions to CFSP-Eligible Population

These population groups will not be enrolled in the CFSP and will remain on Tailored Plans:

- Waiver Enrollees
  - Intellectual and Developmental Disabilities (I/DD) Innovations
  - Traumatic Brain Injury (TBI)
- Individuals in Transition to Community Living (TCL)
- State Funded Residential (SFR)
- Individuals in Intermediate Care Facilities (ICF)

May Choose: Tribal Members and other individuals eligible to receive Indian Health Services, including the Eastern Band of Cherokee Indians (North Carolina's federally recognized tribe).

CFSP Core Activities



Day 1 Priorities

- Individuals get the care they need.
- Providers can submit claims for payment to the CFSP.
- Members can access necessary medications.
- Members are enrolled and have ID cards in hand prior to the CFSP launch.
- Members have timely access to information and are directed to the right resources.
- CFSP has adequate provider networks per contract definitions.
- Calls made to call centers are answered promptly.
- Local DSS agencies are trained on CFSP and care management platform.

Network Contracting

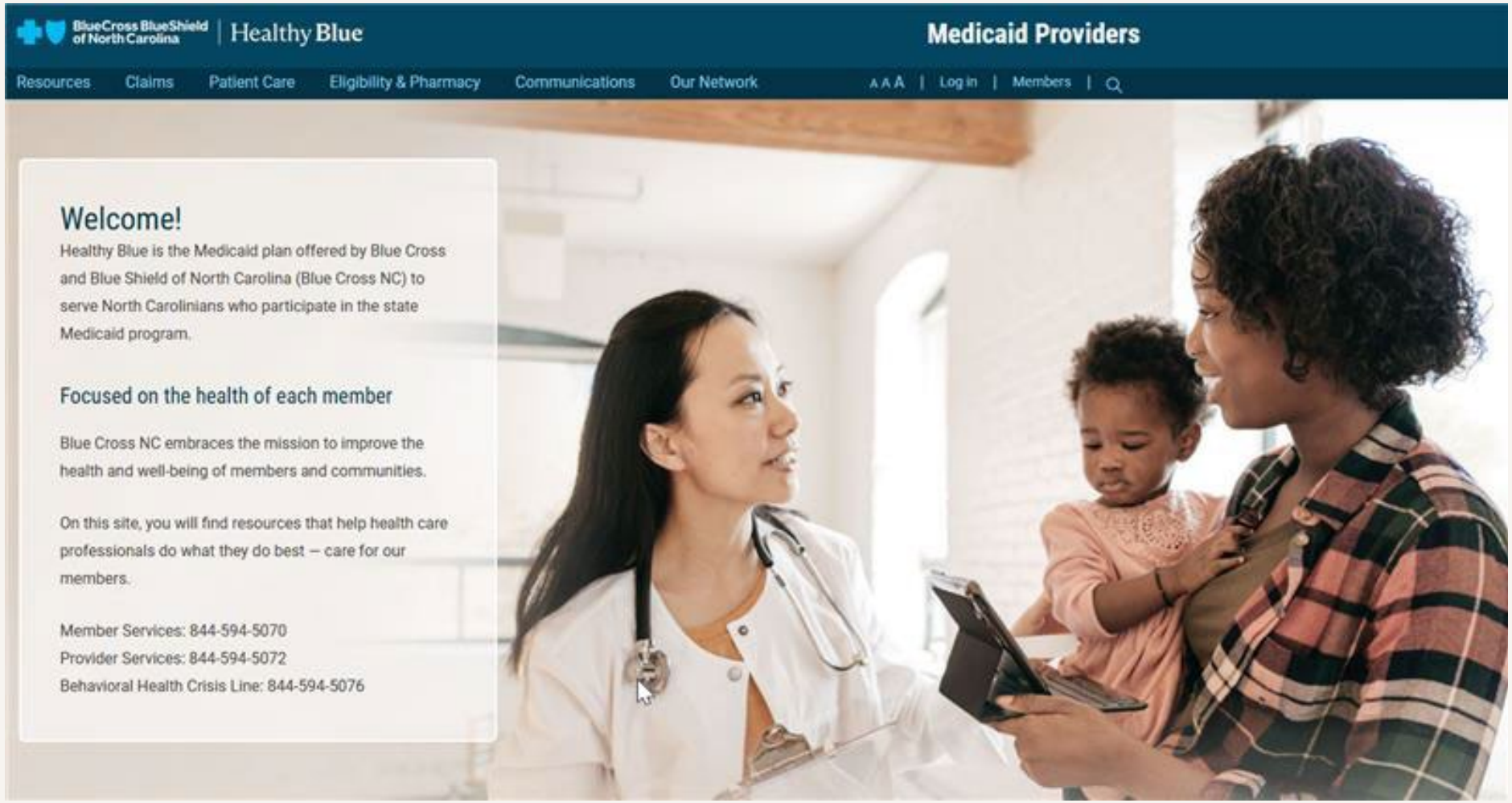
Listening, engaging, and building together

- Network Expansion
- Contracting Process
- Support for New Providers
- Reimbursement
- Standardized Cross-Plan Participation
- Innovation and Value-Based Opportunities
- Commitment to Providers

Provider Readiness: Where to Find Important Information

Public Provider Website

https://provider.healthybluenc.com



Availity Portal

- Availity (https://www.availity.com) is a web portal that is used by providers to securely access patient information such as eligibility, benefits, claim status, authorizations, and other proprietary information.
- Providers can use a single login to access multiple health plan providers at **no cost**.
- The registration process is easy.
- Multiple resources and trainings about site navigation are available.
- **Payer ID 00602**

Provider Website vs. Availity Portal

Provider Website	Availity Portal
•Accessible to all providers, regardless of participation status •Open access without registration/login •Claim forms •Precertification Look Up Tool — Prior Authorization Requirements Look-Up Tool •Provider Manual •Clinical Practice Guidelines •News and announcements •Provider Directory •Fraud, waste and abuse resources •Preferred Drug List (PDL) •Medical Policies •Access to Healthy Blue Care Together website	•Precertification Look Up Tool •Total Member View •Multiple eligibility and benefits inquiry •Provider Online Reporting •Pharmacy authorizations and benefits •Claims dispute submission •Claims dispute inquiry •Medical appeal prior authorization submission •Maternity identification •HEDIS® attestation •Remittance inquiry •Reimbursement tool
https://provider.healthybluenc.com	https://www.availity.com

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Provider Readiness: Verifying Eligibility, Requesting Prior Authorizations & Claims Submissions

Verifying Eligibility and Benefits

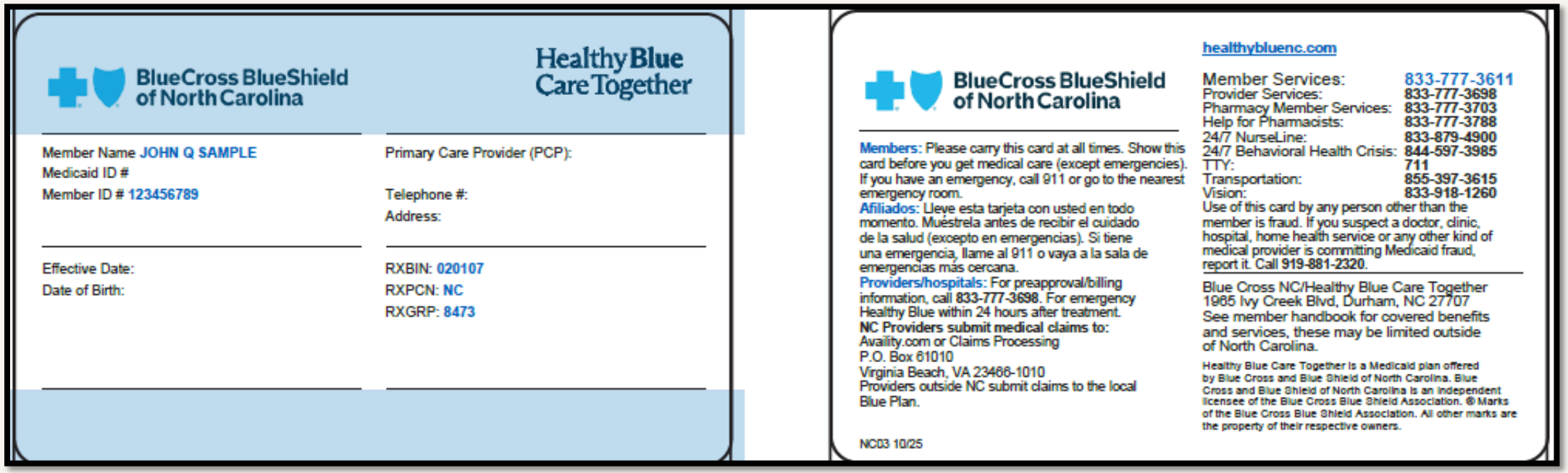
Prior to rendering services, providers are responsible for verifying member eligibility.

Member eligibility can be checked within Healthy Blue systems by:

- Submitting a batch 270/271 transaction using your electronic data interchange (EDI) software vendor or your clearinghouse.
  - For more information, register for one of the Availity® Getting Started with EDI webinars.
- Submit a request on Availity Secure Provider Portal
  - Go to https://www.availity.com.
  - Select **Patient Registration** > **Eligibility and Benefits**.
  - Select **Healthy Blue** from the drop-down list.
  - Complete any required fields and submit the request.
    - For more information, register for one of Availity's new user trainings.
- OR Log in to NCTracks

Member ID Cards & PCP Assignments

- Primary Care Provider (PCP) Changes – Between Dec. 1, 2025, and June 30, 2026, CFSP members may change their PCP **for any reason**.



Continuity of Care Requirements

Medical Prior Authorizations (PAs)	Pharmacy Prior Authorizations (PAs)
• HBCT will honor existing medical PAs for both physical and behavioral health services **until June 30, 2026, or until the PA expires**, whichever comes first. • From December 1, 2025, to June 30, 2026, HBCT **will not deny services if they meet medical necessity**, even if a provider submits a PA after the service date or requests a retroactive PA. • This flexibility **does not apply to ongoing reviews for inpatient hospital stays**. • These rules apply to both in-network and out-of-network providers.	• HBCT will honor existing pharmacy PAs (from NC Medicaid Direct and other health plans) for the life of the PA until June 30, 2026. • HBCT will consider previous PA and current drug therapy as necessary, when making coverage determinations. • This flexibility applies to both in-network and out-of-network providers.

Out-of-Network Providers

December 1, 2025 – June 30, 2026:

- Medicaid-eligible out-of-network providers will be paid the same as in-network providers for services, according to the Department's Transition of Care policy.
- Medically necessary services for both physical and behavioral health will be covered at 100% of the NC Medicaid fee rate, for both in-network and out-of-network providers.

Starting July 1, 2026:

- Out-of-network providers, whom HBCT has tried to contract with, will be reimbursed up to 90% of the Medicaid fee rate.
- Out-of-network primary care providers will receive full reimbursement unless there's an agreed alternative payment plan.
- All out-of-network providers must be enrolled in NC Medicaid to get paid.

Prior Authorization for Out-of-Network Providers:

- From December 1, 2025, to October 31, 2026, out-of-network providers can use in-network authorization rules.
- Starting November 1, 2026, out-of-network providers must obtain authorizations for all services.

Prior Authorization Requirements

- Requirements for outpatient services can be viewed via the Prior Authorization Lookup Tool at https://provider.healthybluenc.com.
- Services may be listed as requiring prior authorization that may not be covered benefits for a particular member. Please verify benefit coverage prior to rendering services.
- To determine coverage of a particular service or procedure for a specific member:
  - Access eligibility and benefits information on Availity.
  - Use the Precertification Lookup Tool, located under *Payer Spaces Applications* on Availity at https://www.availity.com.

Request Prior Authorization and Notification

Prior Authorization (PA) requests can also be submitted digitally. Providers can access the authorization application through Availity Essentials at Availity.com.

Log in to https://www.availity.com using your Availity credentials, then:

- From the Availity Portal homepage, select **Patient Registration** from the top navigation bar
- Select **Authorizations & Referrals**
- Select **Authorizations**
- Select the payer and organization
- Select **Submit**

For over-the-phone submissions, please call Provider Services at 833-777-3698, select option 2.

Clean Claims

- As part of the CFSP network, you can expect your claims to be processed efficiently and accurately. Our standard turnaround time (SLA) for claims payment is 30 calendar days from the date we receive your claim.
- A clean claim is a claim submitted for reimbursement that contains the required data elements and any attachments we request.

- To qualify as a clean claim, we require the following attachments:
  - A Medicare remittance notice if the claim involves Medicare as a primary payer and Healthy Blue Care Together provides evidence it does not have a crossover agreement to accept an electronic remittance notice.
  - Description of the procedure or service, which may include the medical record if a procedure or service rendered has no corresponding CPT® or HCPCS code.
  - Physician notes, if the claim for services provided is outside of the time or scope of the authorization or if the authorization is in dispute.

Claims Submissions

We accept both *CMS-1500* and *UB-04* claims. You can submit paper claims, but we encourage you to submit single claims through direct data entry through the secure Availity portal or batch / multiple claims by **electronic submission through Availity's EDI gateway using Payer ID 00602**.

Using our digital tools or EDI reduces claims/payment processing expenses and offers:

- Faster processing than paper
- Enhanced claims tracking
- Real-time submissions directly to our payment system
- HIPAA-compliant submissions
- Reduced claim rejections and adjudication turnaround time

There is a **filing limit of 365 days from the date of service**. It is the responsibility of the provider's office to ensure electronic claims are completed and submitted without rejection.

(Please note we do not accept faxed or emailed claims.)

Claim Status Inquiries

You can research the status of claim status using the Availity Portal's Claims Status feature or by calling Provider Services.

To access Claims Status through Availity, you must be assigned the Claims Status role by your Availity Administrator.

Once you have the role assignment follow these steps:

- From Availity's home page, select **Claims & Payments** | **Claim Status.** In the *Organization* field, select the organization and in the *Payer* field, select **Healthy Blue**.
- You can also access the status of a claim from eligibility and benefits response on Availity. Select the **Go To** button located in the top right-hand corner of the patient eligibility information screen.

Register for the *Availity New User Webinar* to learn more about Claims Status Inquiry.

Rejected Versus Denied Claims

Rejected claims do not enter the adjudication system because they have missing or incorrect information.

Denied claims go through the adjudication process but are denied for payment.

- There are two types of notices you may get in response to your claim submission, rejected or denied.
- You can find claims status information on Availity Portal at **https://www.availity.com** or by calling Healthy Blue Care Together Provider Services at **833-777-3698.**
- If you need to appeal a claim decision, submit a copy of the *Explanation of Payment* (*EOP*), letter of explanation and supporting documentation.
- If your claim is administratively denied, you may file an appeal. As part of the appeal, you must demonstrate that you notified or attempted to notify us within the established time frame and that the services are medically necessary.

Electronic Payment Services

Enrolling in electronic funds transfer (EFT) provides the following benefits:

- Claims payments are deposited to your account faster.
- EFT payments don’t get delayed or lost in the mail.
- EFT payments are more protected from fraud.
- You save time with fewer trips to the bank.
- You save money by reducing your associated labor and case security costs.

Registering for electronic remittance advice (ERA) provider the following benefits:

- Easy access to online remittance advice.
- Transactions can be uploaded and posted to your system automatically.

Electronic payment services (continued)

Electronic claims payment through **electronic funds transfer (EFT)** is a secure and fast way to receive payment, reducing administrative processes. EFT deposits are assigned a trace number that is matched to the 835 Electronic Remittance Advice (ERA) for simple payment reconciliation.

Providers and facilities can register, enroll, and manage account changes for EFT through EnrollSafe at **enrollsafe.payeehub.org.**

EnrollSafe enrollment eliminates the need for paper registration.

For more convenience, you can also enroll for online **Electronic Remittance Advice (ERA)**. The 835 eliminates the need for paper remittance reconciliation.

Use Availity to register and manage ERA account changes with these easy steps:

- Log in to Availity.
- Select My Providers > Enrollment Center > ERA Enrollment.

Note: If you use a clearinghouse or vendor, please work with them on ERA registration and receiving your ERAs.

Remittance Information & Payment Schedule

- You can view your remittance information on Availity using the Remittance Inquiry tool accessed through Payer Spaces.
- To use Remittance Viewer (835), you must be signed up for 835 either through your own EDI software or clearinghouse.
- Training on these tools is available through Availity live webinar sessions.
- Process and pay clean claims within 30 days of receipt.
- Providers have up to 365 days to submit claims according to NC timely filing guidelines.
- Weekly payment schedule.

Points of Contact & Provider Education Events

Healthy Blue Care Together Points of Contact (POCs)

Phone:	Healthy Blue Care Together Provider Services **833-777-3698**
Email:	General questions can be sent to: **NC_provider@healthybluenc.com** Contracting inquiries or questions can be sent to**:** **NC_contracting@healthybluenc.com**
Dedicated In-Person/Virtual Visits:	Your existing Healthy Blue Provider Relationship Account Consultant (PRAC) along with a CFSP Specialty Provider Liaison will serve as your personal points of contact for matters related to claims, authorization, and service delivery.

Additional points of contact are available in the Healthy Blue Care Together provider manual, located at ***provider.healthybluenc.com***

Provider Education Events

Healthy Blue Care Together is conducting office hours for specific topics and for general education, support, and training to our provider community. Office hours are conducted virtually via WebEx and will continue post go-live.

Register online:
Provider.healthybluenc.com

Click on Training Academy, then “Schedule and Registration” under Events to Keep You Up To Date

Upcoming CFSP Events & Office Hours	
Date	**Office Hours Topic**
12-Nov	Children and Families Specialty Plan (CFSP): Top Interest Topics
19-Nov	CFSP Asheville Conference
20-Nov	Children and Families Specialty Plan (CFSP): Top Interest Topics

Thank You

We appreciate you taking the time to attend our training and hope the information covered today answered any of your questions.

In a world of escalating healthcare costs, we work to educate our members about the appropriate access to care and their involvement in all aspects of their healthcare.

We look forward to working with you to continue this education and provide valuable healthcare to our members — your patients.

Provider website:
https://provider.healthybluenc.com

Healthy Blue Care Together
Provider Services phone #:
833-777-3698

Resources

- A copy of today's presentation and recording will be available on the NC Medicaid website at medicaid.ncdhhs.gov/providers/provider-playbook-medicaid-managed-care/provider-playbook-training-courses
- Provider fact sheets for the Children and Families Specialty Plan are available at medicaid.ncdhhs.gov/providers/provider-playbook-nc-medicaid-managed-care