

Fact Sheet

What Providers Need to Know Part 2, After Children and Families Specialty Plan Launch

Post-launch Checklist and Information

The Children and Families Specialty Plan (CFSP) will launch Dec. 1, 2025. The CFSP, operated by Healthy Blue Care Together (HBCT), is a single, statewide NC Medicaid Managed Care health plan designed to support NC Medicaid-enrolled children, youth and young adults currently and formerly served by Child Welfare. This fact sheet supplements the What Providers Need to Know Before Children and Families Specialty Plan Launch Part 1 fact sheet and provides additional information providers need to know after the launch of CFSP.

KEY DATES

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

- Oct. 5, 2025: Eligible beneficiaries were auto enrolled in the CFSP
- Oct. 9, 2025: Enrollment Broker began mailing CFSP Transition Notices to beneficiaries
- Oct. 17 - 23, 2025: PCP auto-assignment and care management assignment completed
- **Oct. 23 – Dec. 1, 2025:** Health Plan and Primary Care Provider (PCP) Choice Period.

CFSP members* may change their PCP at any time without cause until June 30, 2026.

- Nov. 3, 2025: HBCT mails CFSP Welcome Packets and ID cards to beneficiaries
- Dec. 1, 2025: CFSP launch

* Members includes themselves and their legally responsible person(s), such as the authorized representative or legal guardian.

KEY REMINDERS FOR PROVIDERS

All providers are strongly encouraged to complete the following checklist of key actions after CFSP launch. Detailed information for some of these items is available on the following pages.

- Make sure your office staff know with which health plans you are contracted.
- Continually review the NCTracks provider record for each applicable individual provider and organization for accuracy and submit changes using the Manage Change Request (MCR) process. Changes must be reported within 30 calendar days.
- Ensure office staff understand that the CFSP program with Healthy Blue Care Together is a separate program from the Standard Plan with Healthy Blue.
- Know where to submit claims based on the beneficiary's assignments on the date the service is rendered.
- For each health plan under contract, be sure enrollment in the health plan's electronic funds transfer program is complete.
- Assist beneficiaries with the transition to the CFSP following the guidance in the "Assist Members with the Transition" section below.

PROVIDER CONTRACTING REMINDERS

Health plan contracting is an ongoing process. There are consequences for non-participation impacting both providers and members. For example, PCPs who do not contract with health plans risk losing patients, as members will choose a PCP from their health plan's in-network providers. Health plans will auto-assign members to providers in their network of providers if a beneficiary does not select a PCP.

NC Medicaid strongly encourages PCPs and Advanced Medical Homes (AMHs) to work with HBCT to ensure they are contracted to support service continuity for patients.

Note providers must contract with HBCT to participate in the CFSP, even if they are already contracted with Healthy Blue for Standard Plan.

For more information on contracting with a health plan, contact them directly. More information on contracting can be found on the [Provider Contracting with Health Plans page](#).

MAKE SURE INFORMATION IS CORRECT

Per the [NCDHHS Provider Administrative Participation Agreement](#), NC Medicaid participating providers are contractually required to update their NCTracks record within 30 days of any change.

The obligation to report includes any change in information contained in the NCTracks provider enrollment record and any adverse action against the provider or any of its officers, agents or employees.

To remain compliant and maintain accuracy of the information supplied to the health plans and members, providers should regularly review their provider record in NCTracks. Changes may be submitted using the MCR process available in the NCTracks Secure Provider Portal. Health plans can only update certain information in their files upon receipt of the information from NCTracks.

Confirm individual providers are correctly affiliated to all organizations billing on their behalf and to each appropriate location within that organization. This is done through a review of the individual provider's NCTracks record and is essential to ensure provider directories display accurate results. Information will be displayed in the [NC Medicaid Provider and Health Plan Lookup Tool](#). When a member searches for an individual doctor at a specific organization's location, the affiliated

information from NCTracks is used in the search. Therefore, all individual providers should check their affiliations not only to the group NPI, but also to the specific location(s) where services are rendered.

KNOW HOW TO SUBMIT CLAIMS

Claims for dates of service prior to Dec. 1, 2025, should be submitted as they are today, through NCTracks or Local Management Entities/Managed Care Organizations (LME/MCOs). A limited set of services are carved out of managed care and should continue to be billed through NCTracks after CFSP launch. These include dental services, eyeglasses and Child Development Services Association (CDSA) services included on an Individualized Family Service Plan (IFSP) provided by independent practitioners.

For dates of service beginning Dec. 1, 2025, claims routing depends on a member's enrollment at time of service and the services provided.

Claims for beneficiaries enrolled in NC Medicaid Direct should continue to be submitted to Prime Therapeutics.

Claims for members enrolled in the CFSP should be submitted as instructed by HBCT (shown on the member ID card) and validated through the NCTracks Recipient Eligibility Verification methods, unless the service provided is a carved-out service.

Two "Claims Submission" provider fact sheets are available in the [Provider Playbook](#) to address how managed care claims are filed.

ASSIST MEMBERS WITH THE TRANSITION

It is important all office staff know which health plans providers are contracted with and take the initiative to assist patients with the transition to managed care. Please note:

CFSP members* may change their PCP at any time without cause until June 30, 2026. Members can choose a different PCP from the one they received during auto-assignment. After June 30, 2026, members can change their PCP twice a year without cause. Contact information can be found on the [Health Plan Contacts and Resources](#) webpage.

Once enrolled with the CFSP, members will receive a Member Welcome Packet, Member Handbook and Member ID Card from Healthy Blue Care Together. Follow these steps when an NC Medicaid beneficiary presents at your office:

- Confirm that your office participates with the CFSP.
- Verify eligibility, PCP and health plan enrollment using the NCTracks Recipient Eligibility Verification/Response or by calling the NCTracks Automated Voice Response System (AVRS) at 800-723-4337.
- To mitigate any confusion associated with newly issued NC Medicaid Member ID cards, providers and pharmacies should always verify eligibility through NCTracks and not rely solely on the information shown on a Member ID.

Health plans are required to generate an identification card for each member enrolled in their health plan that contains the member's NC Medicaid ID number. Some health plans also include their health plan member ID as well. However, member ID cards are not required to provide services including pharmacies. Therefore, members should not be turned away due to the lack of a Member ID card in their possession.

- If you are not the assigned PCP for the member but are in-network for the CFSP, you can render and be paid for primary care services.
- If the member would like to have you as their assigned PCP, they should call Healthy Blue Care Together to have them assigned to you.
- If you are a non-participating provider for the CFSP, you may render services. Special protection is afforded to non-network providers (see the Transition of Care section below). If a good-faith contracting effort has been made by the CFSP and you declined to participate, then you are subject to receive 90% of the Medicaid fee-for-service rate. Good faith contracting requirements and information are available in the contract and plan policies.

* Members includes themselves and their legally responsible person(s), such as the authorized representative or legal guardian.

TRANSITION OF CARE PROTECTIONS IMPACTING PROVIDERS

As a provider, it is important to understand the transition of care protections that impact providers. Please note:

The CFSP will honor existing and active prior authorizations on file with NC Medicaid Direct for services covered by the health plan for the first seven months after launch (until June 30, 2026) or until the end of the authorization period, whichever occurs first.

For the first seven months after launch (until June 30, 2026), the CFSP will pay claims and authorize services for Medicaid-enrolled out-of-network providers equal to that of in-network providers until end of episode of care or 60 days, whichever is less (extended transition periods may apply for circumstances covered in N.C. Gen. Stat. § 58-67-88(d), (e), (f), and (g).).

- If a member transitions between health plans, a prior authorization authorized by their original health plan will be honored for the life of the authorization by their new health plan.
- For more information on the flexibilities available at CFSP launch, please review the Flexibilities to Ensure Continuity of Care and Ease Provider Administrative Burden at Children and Families Specialty Plan Launch bulletin. For more general information on Transitions of Care, see the Transition of Care webpage on the NC Medicaid website.

WHAT IF MEMBERS HAVE QUESTIONS?

Once a member is enrolled with the CFSP, a Welcome Packet, Member Handbook and a new Member ID card will be mailed to them. If members have questions about their health plan, want to change their PCP or AMH, or have questions about services covered, they should contact their health plan.

Contact information for health plans can be found on their new Medicaid card or under the [Health Plan Contacts and Resources](#) page. Members who want to change their health plan should contact the NC Medicaid Enrollment Broker at 833-870-5500, (TTY: 833-870-5588), 7 a.m. to 5 p.m., Monday through Saturday.

Beneficiaries can contact the NC Medicaid Ombudsman if they have questions or problems the health plan or provider cannot answer. Call **877-201-3750** or visit ncmedicaidombudsman.org.

WHAT IF I HAVE QUESTIONS?

Additional resources for providers on the transition to NC Medicaid Managed Care can be found in the [NC Medicaid Help Center](#), the [Provider Playbook](#) and on the [Medicaid Transformation](#) website. The **Day One Quick Reference Guide** can also be found on the Provider Playbook [Fact Sheet](#) page.

For general provider inquiries and complaints regarding health plans, contact the **Provider Ombudsman** at Medicaid.ProviderOmbudsman@dhhs.nc.gov or 866-304-7062. The Provider Ombudsman contact information is published in the health plan's provider manual.

For questions related to your NCTracks provider information, contact the NCTracks Call Center at 800-688-6696. To update your information, please log into the [NCTracks Provider Portal](#) to verify your information and submit an MCR. For all other questions, contact the NC Medicaid Contact Center at 888-245-0179.

