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Partners'/CCHN Tailored Plan
General Information Session Office Hours
April 7th, 2026
12:00PM

Agenda

General Information and Policy Notifications

- Who We Are: Partners and Carolina Complete Health
- Initiatives
- Known Issues
- Hot Topics and FAQs

Operational Information

- Verifying Member Eligibility
- Provider Portal: ProviderConnect
  - Connecting to Partners
  - Prior Authorization (Submission, Timeframes, Evolent)
- Claims, Billing, and Payment (Submission, EFT)

Provider Resources

- Partners' Provider Communications
- Provider Support and Who to Contact
- Questions
- Additional Provider Resources

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Poll Update

Your experience matters to us, and we want to understand how we can support you in the most meaningful way. When you have a moment, please complete the poll on your screen so we can learn what you need from us.

(Partners/CCH staff please do not participate)

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Carolina Complete Health and Partners

- **Partners Health Management** and **Carolina Complete Health** bring a shared vision for true partnerships with all providers across the system of care, which is reflected in our network management model.
- As the only Provider-led Entity (PLE), **CCH** seeks out physician and clinician expertise in medical policy and aim to give providers a voice in how to best to care for their patients while reducing administrative burden.
- Since **Partners'** inception as a managed care organization, **Partners** has executed a strategy of collaboration with providers.
- Our mutual goals is to aid provider success as they offer accessible, robust and effective services for members.

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Provider Support and Who to Contact

Who	What	How
Partners Providers Services Line	• Claims questions • Prior Auth questions • Grievances and Appeals • Portal (ProviderConnect) • Member assignment	1-877-398-4145; 7 a.m. to 6 p.m. Monday-Saturday
Carolina Complete Health Network Provider Relations	• Tailored Plan Physical Health Contracting	**NetworkRelations@cch-network.com**
Carolina Complete Health Provider Engagement	• Payspan • Panel Status • Education	CCHN Provider Engagement Team

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Upcoming Changes

Important Physical Health Update: Claim Dispute Timely Filing

- For claims with dates of service 4/1/26 and after, contracted providers **have 90 calendar days from the date of the Explanation of Payment (EOP) or Electronic Remittance Advice (ERA) to submit a claim dispute.** Non-par providers have 60 calendar days from the EOP/ERA to submit a claim dispute. This was previously 365 calendar days for claims processed by Carolina Complete Health.
- **What's not changing:** Providers have 365 calendar days from the date of service/date of discharge to file first time claims and 365 calendar days from the date of service/date of discharge to file a claim correction

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Important Physical Health Updates: UM Vendor Changes

Service	Current Physical Health Vendor	Future State Physical Health Vendor
Radiation Oncology	None	Evolent: effective no earlier than 5/1/26
Musculoskeletal Surgery	None	Evolent: effective 4/1/26
Interventional Pain Management	None	Evolent: effective 4/1/26
Cardiovascular Procedures	None	TurningPoint: effective 5/1/26
Genetic Testing	None	EviCore effective no earlier than 5/1/26.

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Important Physical Health Updates: UM Vendor Changes

- **EviCore:** Lab Management for genetic testing
  - Clinical Guidelines
  - eviCore Provider Web Portal: https://www.evicore.com/
  - Phone: 1-888-333-8641
- **Evolent**: Radiation Oncology, Musculoskeletal Surgery, Interventional Pain Management, Advanced Imaging.
  - Web resources: https://www1.radmd.com/all-health-plans/carolina-complete-health
  - Provider Portals: https://www.evolent.com/provider-portal
    - Rad Oncology: utilize the CarePro Provider Portal
    - Advanced Imaging, MSK, and IPM: utilize the RadMD™ Provider Portal
  - Phone: 1-800-424-4889
- **TurningPoint:** Cardiovascular Procedures
  - Portal: http://www.myturningpoint-healthcare.com
  - Phone: 984-377-8573 | 855-909-5444
  - Fax: 833-986-1059

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Important Physical Health Updates: Centene Vision

- For dates of service on or after April 1, 2026, Centene Vision will process claims for **routine eye benefits only** for North Carolina Medicaid members. This change applies to Partners Tailored Plan members.
- All **medical claims** with dates of service on or after April 1, 2026, must be submitted as physical health and processed by Carolina Complete Health.
- **Claims Submitted by Date of Service:**

Prior to April 1			On or After April 1		
Routine	**OD Medical**	**Med/Surg**	**Routine**	**OD Medical**	**Med/Surg**
Centene Vision	Centene Vision	Partners Physical Health	Centene Vision	Partners Physical Health	Partners Physical Health

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Important Physical Health Updates: Upfront Rejections

- Effective April 1, 2026, Carolina Complete Health will be moving from claims denials to upfront rejections for certain adjudication codes. If providers receive this rejection, they will need to make the appropriate corrections to the claim and resubmit the claim.
- Please see the January 30 bulletin for a list of updated rejection codes.

Provider Tips to Avoid These Rejections:

- Verify you are billing in accordance with credentialing information in NC Tracks for NPI and taxonomy information.
- Ensure you are billing the NPI and taxonomy information in the appropriate box on the claim and in alignment with the CCH Provider Billing Manual. This information begins on page 48 through 74.
  - For example, when services are rendered at a service facility location that differs from the billing address listed in field 33, providers are required to complete box 32, 32a, and 32b as outlined on page 58 of the Provider Billing Manual.

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Important Physical Health Updates: Hospital Inpatient Claims

- Beginning April 15, 2026, any hospital inpatient claim billed as physical health greater than $250k will no longer be reviewed post payment and will move to a pre- payment review.
- For any hospital inpatient claim with a header or total billed amount at or more than $250,000, please include an itemized bill.

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Initiatives

Attention Providers and Members – Breast Cancer Awareness

For more information on Breast Cancer Screenings, **scan QR code below**.

[Prevention and Population Health Programs - Partners Health Management]

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Shared Decision-Making Guides

Partners Health Management offers shared decision-making tools that support provider-member conversations and personalized whole person care. These resources allow providers and members to work together to help members make informed decisions and focus on what matters to the members about their health goals.

- **Improves member engagement**
- **Supports personalized care**
- **Strengthens chronic disease management**
- **Aligns with whole person care**

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Shared Decision-Making Guides

Available tools:

- Partners KERUNIT page: KERUNIT - Partners Health Management - Provider Knowledge Base
- Diabetes Medication decision aid: https://carethatfits.org/diabetes-medication-choice/
- Depression Medicaid decision aid: Depression Medication Choice – care that fits
- My Life, My Healthcare (I CAN) Tool kit: My Life My Healthcare – care that fits

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Known Issues Tracker (KIT)

Known Issues Tracker

- Both Partners and CCH maintain a Known Issues Tracker.
- Physical Health Tailored Plan providers may reference this weekly for issues related to claims and other operational areas.
- Partners: https://providers.partnersbhm.org/claims-information/
- CCH: https://network.carolinacompletehealth.com/content/dam/centene/carolinacompletehealth/pdfs/CCH_Known_Issues_Tracker_Current.pdf

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Known Issues Tracker Updated

Status	Health Plan	Date Issue Identified	Number of Days Outstanding	Category	Provider Type	Number of Impacted Providers	Interest Owed	Estimated Fix Date	Issue Description	Resolution
Open	Tailored Plans - Partners	12/11/2025	84	Claims; Configuration	DME	83	Yes	5/1/2026	Identified an issue with claims denying EX35 DENY: BENEFIT MAXIMUM HAS BEEN REACHED and EXBe BENEFIT LIMITS MAY NOT BE EXCEEDED WITHOUT PRIOR AUTHORIZATION when the provider obtained a medical necessity pre-authorization to allow for additional units. (This item was previously closed on 9/05/25)	System configuration logic is being updated. A manual process is in place to prevent further denials. Claims impacted will be identified and will be reprocessed once the system fix is completed. No further action needed from providers at this time.
Open	Tailored Plans - Partners	5/20/2025	296	Claims; Configuration	All	648	Yes	4/3/2026	Identified issue with member enrollment file causing claims to deny 'L6 - Please submit to Primary Insurer' incorrectly and eP: Requires Primary EOB; Auth Req'd for EPSDT Consideration.	System configuration logic is being updated. Claims impacted will be identified and will be reprocessed once the system fix is completed. No further action needed from providers at this time.

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Claims and Rates Information - Partners Health Management - Provider Knowledge Base

KIT is housed, at the link above, click Documents and Forms, then Known Issues Tracker

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Hot Topics

NC Medicaid Updates

Pharmacy Benefits Administrator Provider Webinars and Contact Information

This bulletin updates the previously published NC Medicaid Direct Pharmacy Benefits Administrator Provider Transition Overview and Webinars bulletin.

https://medicaid.ncdhhs.gov/blog/2026/03/30/pharmacy-benefits-administrator-provider-webinars-and-contact-information

Value-Based Payment Update: AMH Standardized Performance Incentive Program

Following stakeholder engagement and review of departmental priorities, NC Medicaid will not be implementing the Advanced Medical Home (AMH) Standardized Performance Incentive Program (SPIP) at this time.

https://medicaid.ncdhhs.gov/blog/2026/03/30/value-based-payment-update-amh-standardized-performance-incentive-program

NC Medicaid Ombudsman Program – NC MedHelp

How are Medicaid Ombudsman Issues Changing?

- **NCMedHelp** will be managing NC Medicaid Ombudsman services.
- NCMedHelp is made possible by the Kate B. Reynolds Charitable Trust and the funding is supporting former ombudsmen at LANC, CCLA, and PLS to continue to do similar work – this collaboration is called NCMedHelp.
- These NCMedHelp staff are called Health Benefits Resolution Specialists (HBRS).
- https://ncmedhelp.org/

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NC Medicaid Ombudsman Program – NC MedHelp

History of NC Medicaid Ombudsman Services

- Charlotte Center for Legal Advocacy, Pisgah Legal Services and Legal Aid of North Carolina administered the NC Medicaid Ombudsman Program, created in 2021 to help with North Carolina's transition to Medicaid Managed Care.
- In August 2025, NCDHHS announced the end of LANC's Ombudsman contract.
- In January 2026, NCDHHS took over the Medicaid Ombudsman program.
- Now administered by the Medicaid Contact Center (MCC)
  - Smaller team
  - Inability to call DSS offices, Medicaid Plans, or community organizations with beneficiaries
  - No outreach

NC Medicaid Ombudsman Program – NC MedHelp

What Services Will Health Benefits Resolution Specialists (HBRS) Offer?

- **Resolving Barriers to Care**

Assisting with improper medical billing, pharmacy-level processing errors, and reliability issues with Non-Emergency Medical Transportation.

- **System & Enrollment Resolution**

Correcting data errors (ex: incorrect "other insurance" listings) and addressing access barriers at the county DSS or Managed Care Plan level.

- **Navigating Formal Disputes**

Providing hands-on assistance with filing grievances and appeals against health plans.

- **Education & Connection**

Informing members of their rights and connecting them to community-based resources for housing, food security, and other social needs.

If you need to appeal a denial or termination, an HBRS can also connect you to an attorney.

NC Medicaid Ombudsman Program – NC MedHelp

Which Organization Do I Call?

Charlotte Center for Legal Advocacy • Cabarrus, Cleveland, Gaston, Lincoln, Mecklenburg, Stanly, & Union counties • **(855) 972-4357** or Apply Online at https://charlottelegaladvocacy.org/

Pisgah Legal Services • Avery, Buncombe, Burke, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania, Yancey counties and the Qualla Boundary

• **(828) 407-4464** or Apply Online at https://www.pisgahlegal.org/

Legal Aid of North Carolina • All other NC counties • **(855) 972-4357, (866) 219-5262,** or Apply Online at https://legalaidnc.org/justicehub/

Important Updates

- **Well Child Visits Added as Core Services for Federally Qualified Health Center/Rural Health Center Claims**
- Effective Nov. 9, 2025, retroactive back to May 1, 2024, Federally Qualified Health Center (FQHC) and Rural Health Center (RHC) claims will be updated to process Well Child Visit procedures (99381\EP–99385\EP and 99391\EP–99395\EP) as core services, with updates to pricing and editing.
- This update will also enable providers to submit non-core ancillary services on the same claim as core services. Non-core services will finalize in a paid status with a reimbursement amount of $0.

- **Primary Care Provider/Advanced Medical Home Auto-Assignment Fact Sheet Now Available**
- The fact sheet outlines the key responsibilities of practices receiving auto-assigned members
- https://medicaid.ncdhhs.gov/blog/2025/10/10/primary-care-provideradvanced-medical-home-auto-assignment-fact-sheet-now-available

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Important Updates

2026 Community Alternatives Program Consumer Direction Schedule of Trainings

The 2026 initial training dates for Community Alternatives Program consumer direction are now available.

https://medicaid.ncdhhs.gov/blog/2025/12/29/2026-community-alternatives-program-consumer-direction-schedule-trainings

Individual Ordering Provider NPI Must Be Included on Drug Testing Claims

Effective for dates of service on or after Feb. 1, 2026, claims for certain drug testing procedure codes must include an individual ordering provider NPI.

https://medicaid.ncdhhs.gov/blog/2025/12/29/individual-ordering-provider-npi-must-be-included-drug-testing-claims

Updates to Clinical Coverage Policy 1S-11: Genetic Testing Gene Expression

Clinical Coverage Policy 1S-11 will include coverage for AlloMap® effective Jan. 1, 2026.

https://medicaid.ncdhhs.gov/blog/2025/12/29/updates-clinical-coverage-policy-1s-11-genetic-testing-gene-expression

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Opportunities: Medicaid Managed Care Webinar Series: Fireside (Winter)/Back Porch (Spring) Chats on Hot Topics

May 21, 2026 from noon-1 p.m. | Topic TBD

Webinar Registration - Zoom

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TP Care management Communications with PCP Practices – Contact Information

Tailored Care Management (TCM) Assignment Questions:

- NCTracks is the source of truth for TCM assignment
- If questions remain after checking NCTracks, please reach out to the Care Connections team through a single email group distribution:
- screeningandreferral@partnersbhm.org
- Member Services Line: If you have any questions or need more information on anything, please call Member and Recipient Services Monday-Saturday, 7 a.m. – 6 p.m., **1-888-235-4673**, or Relay NC 711 or TTY **1-800-735-2962** (English) and **1-888-825-6570** (Spanish). We are here for you.

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How to Make a Referral for Partners' Tailored Care Management?

Tailored Care Management Referral Questions:

- You can email Partners a referral for Tailored Care Management through screeningandreferral@partnersbhm.org
- Please include the Member Medicaid Number on the email
- The Screening and Referral Team at Partners will verify the members' eligibility for Tailored Care Management
- They will see if they are already connected to Tailored Care Management
- The team will then follow up with the Primary Care Practice who made the referral to close the loop.
- The turn around time is typically the same business day or next business day for follow up

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Member ID Card and Eligibility Check

PCP Member Choice Update

- Partners is committed to providing members with the best possible Primary Care Provider (PCP) choices. However, members may sometimes be unable to select their preferred PCP due to panel limits.

- A “panel limit” refers to the maximum number of members a physician can manage in their practice. This limit is determined by factors such as the physician’s available time, the complexity of members’ needs and the practice’s capacity to ensure quality care. Maintaining an appropriate panel size is essential to provide adequate attention, prevent burnout and improve care quality.

- If a provider’s panel limit is reached and we cannot confirm the member’s established relationship with that provider, documentation is required to assign the member to the PCP. Providers must submit a letter on office letterhead, including the member’s name, date of birth, Medicaid ID and confirmation of either an established relationship or acceptance of the member. Alternatively, we can accept claims history showing at least six months of primary care treatment.

- Documentation should be sent by email to **PCP@PartnersBHM.org** or by fax to **704-884-2736** (Attention: Member PCP Choice).

- For questions, contact Renee Jenkins, Member Engagement Support Specialist, at **704-842-6488**

https://providers.partnersbhm.org/provider-communication-bulletin-159/#5

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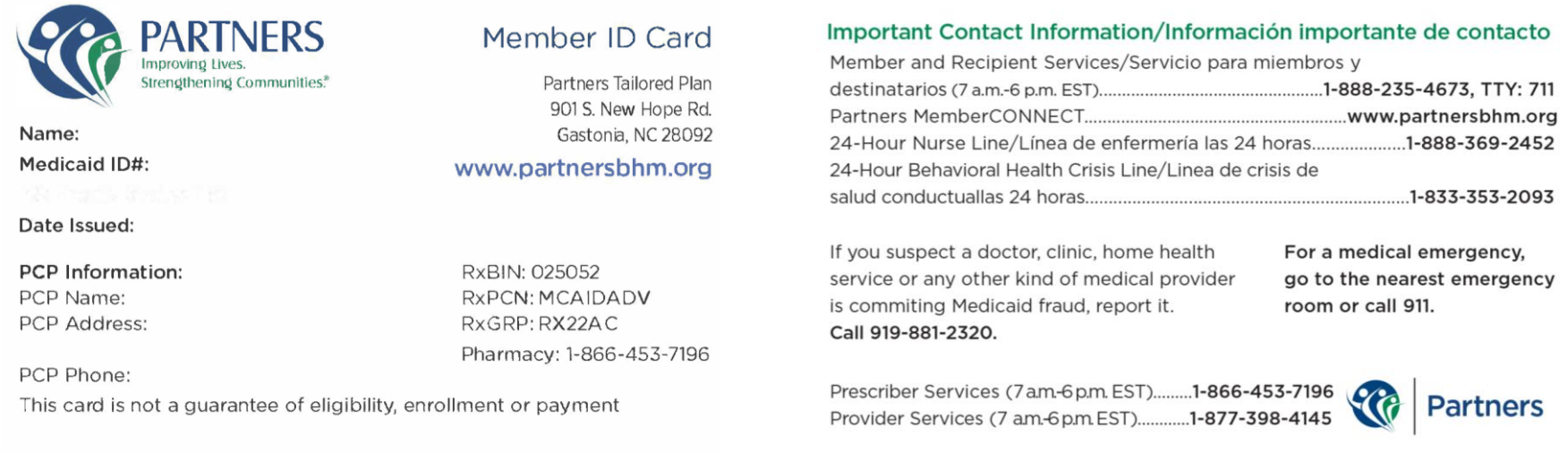
Partners Tailored Plan Member ID Cards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Member ID Card

Partners Tailored Plan
901 S. New Hope Rd.
Gastonia, NC 28092
www.partnersbhm.org

Name:
Medicaid ID#:
Date Issued:

PCP Information:
PCP Name:
PCP Address:
PCP Phone:

RxBIN: 025052
RxPCN: MCAIDADV
RxGRP: RX22AC
Pharmacy: 1-866-453-7196

This card is not a guarantee of eligibility, enrollment or payment

Important Contact Information/Información importante de contacto

Member and Recipient Services/Servicio para miembros y destinatarios (7 a.m.-6 p.m. EST).....1-888-235-4673, TTY: 711
Partners MemberCONNECT.....www.partnersbhm.org
24-Hour Nurse Line/Línea de enfermería las 24 horas.....1-888-369-2452
24-Hour Behavioral Health Crisis Line/Linea de crisis de salud conductuallas 24 horas.....1-833-353-2093

If you suspect a doctor, clinic, home health service or any other kind of medical provider is commiting Medicaid fraud, report it. **Call 919-881-2320.**

For a medical emergency, go to the nearest emergency room or call 911.

Prescriber Services (7 a.m.-6 p.m. EST).....1-866-453-7196
Provider Services (7 a.m.-6 p.m. EST).....1-877-398-4145

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Possession of an ID card does not guarantee eligibility.

Check member eligibility through one of the methods below:

1. NCTracks
2. Secure web portal: https://providers.partnersbhm.org/category/providerconnect/
3. Provider Line: 1-877-398-4145.

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ProviderConnect: Secure Provider Portal

ProviderConnect

- **Partners ProviderCONNECT Portal Setup**

  To access ProviderCONNECT, in-network contracted providers must identify one individual who will serve as their Local Administrator and will be responsible for managing all other users who access Partners' ProviderCONNECT for that provider organization.

- **Action needed**
  - Designated portal administrators must complete Partners Health Management ProviderCONNECT set-up form: **https://www.surveymonkey.com/r/MBXQSBF**
  - Once you complete the survey, you will receive an email from Partners in 1-2 business days with next steps.
  - For questions about this form please contact credentialingteam@partnersbhm.org.
  - **If you are unsure if your organization has a Local Administrator, you can see the organizations already connected and their Local Administrator at this link on Partners' Provider Knowledge Base https://providers.partnersbhm.org/identifying-a-local-administrator/**

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ProviderConnect

- View additional information on ProviderConnect using the following links:
  - https://providers.partnersbhm.org/category/providerconnect/
  - https://providers.partnersbhm.org/providerconnect-local-administrator-instructions/
  - https://providers.partnersbhm.org/provider-alert-local-administrators-can-now-set-up-users-in-providerconnect/

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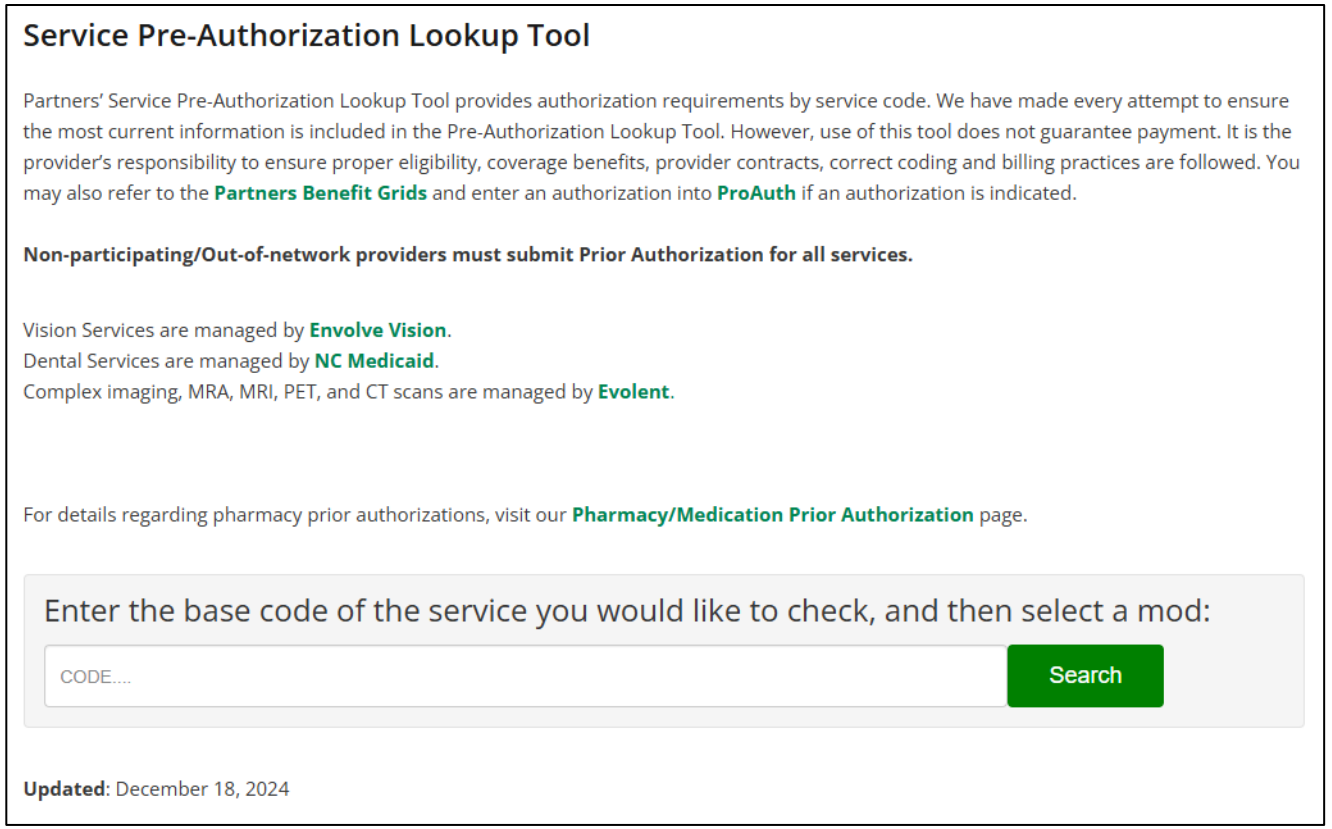
Prior Authorizations

Pre-Authorization Lookup Tool

How can providers determine which services require prior authorization for a health plan?

Partners Benefit Grids and Service Pre-Authorization Lookup Tool can be located at: https://providers.partnersbhm.org/benefits/



Service Pre-Authorization Lookup Tool

Partners' Service Pre-Authorization Lookup Tool provides authorization requirements by service code. We have made every attempt to ensure the most current information is included in the Pre-Authorization Lookup Tool. However, use of this tool does not guarantee payment. It is the provider's responsibility to ensure proper eligibility, coverage benefits, provider contracts, correct coding and billing practices are followed. You may also refer to the **Partners Benefit Grids** and enter an authorization into **ProAuth** if an authorization is indicated.

Non-participating/Out-of-network providers must submit Prior Authorization for all services.

Vision Services are managed by **Envolve Vision**.
Dental Services are managed by **NC Medicaid**.
Complex imaging, MRA, MRI, PET, and CT scans are managed by **Evolent**.

For details regarding pharmacy prior authorizations, visit our **Pharmacy/Medication Prior Authorization** page.

Enter the base code of the service you would like to check, and then select a mod:

CODE.... Search

Updated: December 18, 2024

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Submitting Authorizations

Electronic Submission (Preferred)	Manual Submission
ProAUTH via ProviderCONNECT Secure Provider Portal: • https://id.partnersbhm.org/ • ProAuth is Partners platform for authorization submission through our secure provider portal, ProviderCONNECT. • Providers will be given instructions to access ProAuth when they join the network and access ProviderCONNECT. • **ProAuth is the preferred method for service authorization request submission.**	**Phone:** • 1-877-398-4145 **Fax or Email with the** Manual Authorization Request Form • **Physical Health Fax Numbers:** Inpatient Requests 336-527-3208 Outpatient Requests 704-884-2613 Transplant Requests 866-753-5659 Pharmacy PADP Requests 704-772-4300 • **UM Physical Health Email Addresses:** For Service Requests: PHManualAuthorizations@partnersbhm.org For Questions that are GENERAL and without Protected Health Information (PHI): PHUMQuestions@partnersbhm.org

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Logging into ProAuth

- All Authorization Requests must be submitted through ProAuth
- ProAuth can only be accessed vis the ProviderConnect portal
- Log into ProAuth through ProviderConnect portal
  - Chrome is the recommended browser
- ProviderConnect Login – https://id.partnersbhm.org/
- Logins and passwords are obtained from your organizations' Local Administrator
- Local Administrators may inquire about login issues/questions via email at: providerconnectsupport@partnersbhm.org

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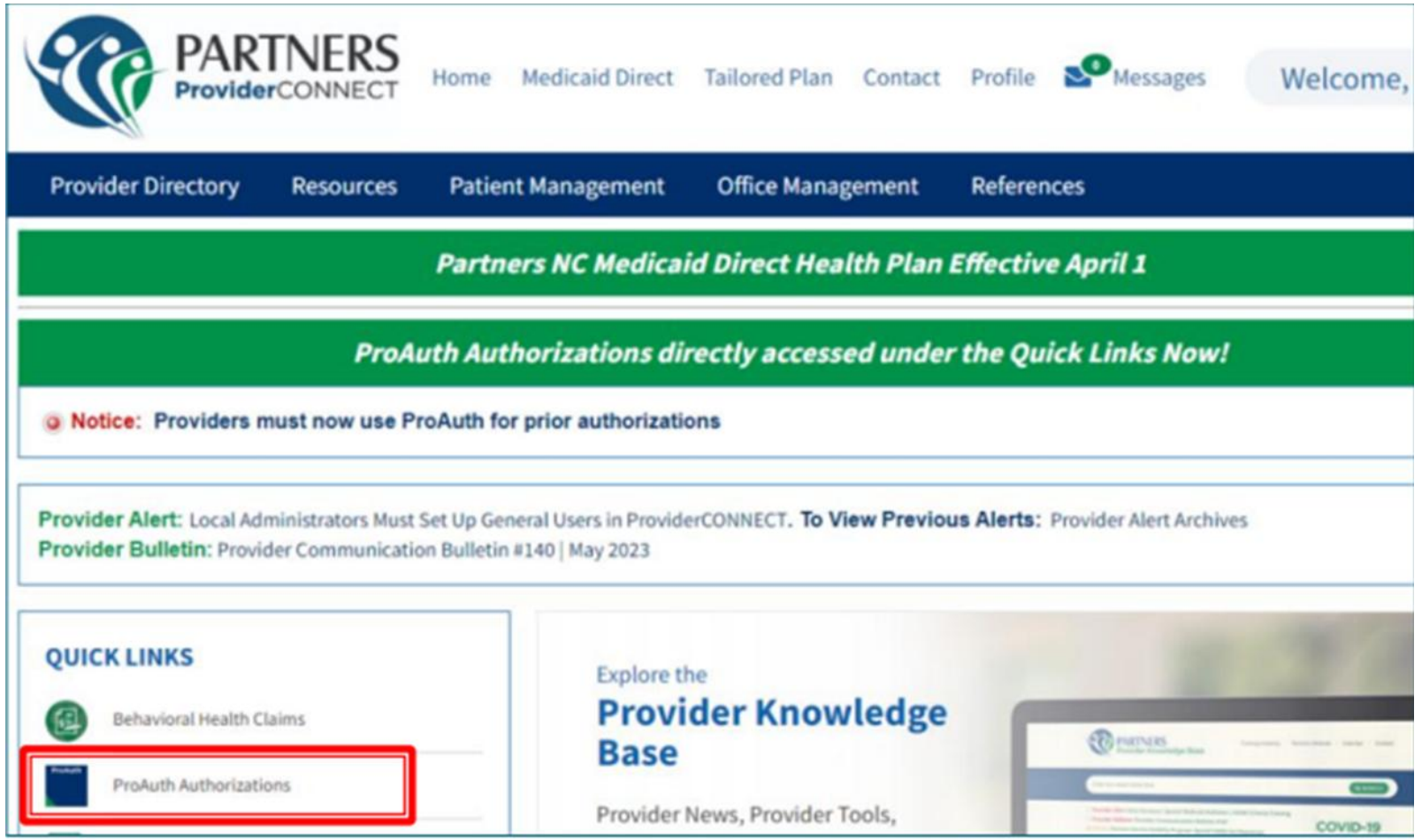
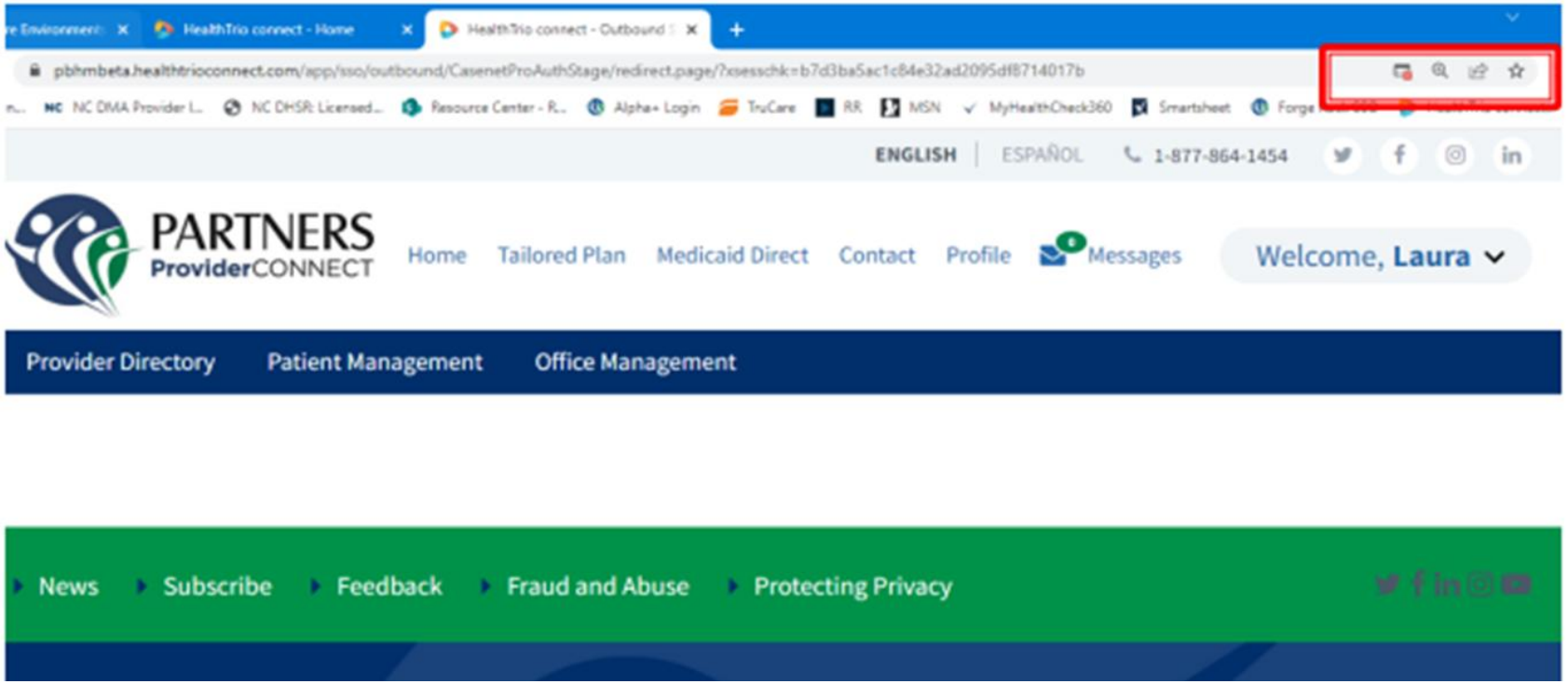
Getting to ProAuth

- From the ProviderConnect homepage, use the Quick Links on the left to access ProAuth Authorizations:



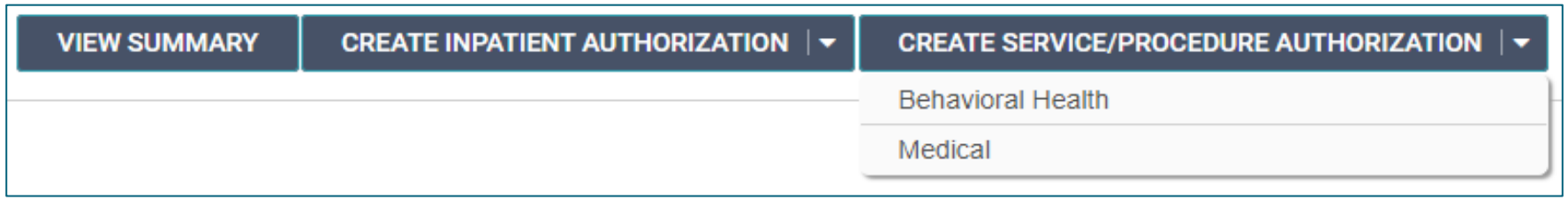
Getting to ProAuth (cont)

- If the link goes to a page with no information or an error message, you may need to turn off the pop-up blocker and change the setting to Always Allow
- This may need to be done twice, but once pop-ups are allowed, you won't have to fix it again.



Submitting an Authorization Request

- From the Member Search screen, the options to Create an Authorization are the same but at the bottom of the screen.



Additional ProAuth Training

- https://www.partnerstraining.org/
- On-demand webinar: Register and view instant playback
- **Supporting Documentation and Q&A**

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Durable Medical Equipment

- Tailored Plans offer the same physical health services as Standard Plans and Medicaid Direct.
- For a Partners Tailored Plan member, you can request authorization for DME using the ProAuth tool in ProviderCONNECT.
- DME billed on a medical claim must be submitted to Partners using the physical health submission methods. CCH will process the claims. This includes CPT codes on applicable DME Fee Schedules.
- DME billed at Pharmacy Point-of-sale, i.e. Diabetic Supplies on the PDL, are managed through Partner's Pharmacy PBM, CVS Caremark®.
- When submitting a claim for manually priced DME items, an invoice must be attached to the claim for reimbursement review.
- Providers must use the correct modifier for DME services as applicable for the services rendered.
- Relevant DME clinical coverage policies include:
  - Physical Rehabilitation Equipment and Supplies, 5A-1 (PDF)
    - For guidance in reference non-invasive osteogenic stimulation, please refer to policy titled Osteogenic Stimulation, NC.CP.MP.194 (PDF)
  - Respiratory Equipment and Supplies, 5A-2 (PDF)
    - Prior approval is required prior to the initiation of oxygen therapy and for continuation of active oxygen therapy on at least an annual basis.
  - Nursing Equipment and Supplies, 5A-3 (PDF)
  - Orthotics and Prosthetics, 5B (PDF)

Resource: Partners Physical Health DME Provider Guide

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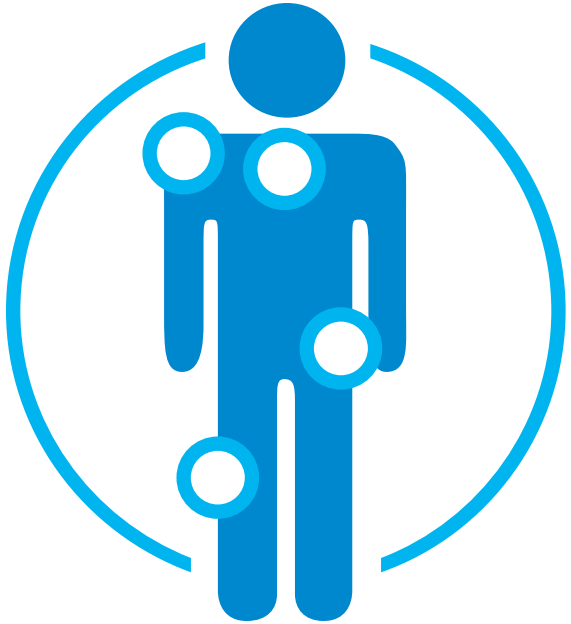
Evolent (Formerly National Imaging Associates, Inc.)

- Partners, through its partnership with Carolina Complete Health, will use Evolent (formerly National Imaging Associates, Inc.) to provide the management and prior authorization of **non-emergent, advanced, outpatient imaging services.**
- Any services rendered on and after February 1, 2025 will require authorization. Only non-emergent procedures performed in an outpatient setting require authorization with Evolent.
- Providers may submit prior authorization requests to Evolent now, however they are not required during the flexibility period.

- CT/CTA
- CCTA
- MRI/MRA
- PET Scan
- MUGA Scan
- Myocardial Perfusion Imaging
- Stress Echocardiography
- Echocardiography



Excluded from the Program Procedures Performed in the following Settings:

- Hospital Inpatient
- Observation
- Emergency Room

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Evolent (Formerly National Imaging Associates, Inc.)

Item	Key Point(s)
RadMD Access & Features	▪ **Prior authorization requests can be made online at: www1.RadMD.com** ▪ RadMD Website – Available 24/7 (except during maintenance) ▪ Request authorization (ordering providers only) and view authorization status ▪ Upload clinical information ▪ View Evolent's Clinical Guidelines ▪ Frequently Asked Questions ▪ Quick Reference Guides ▪ Checklist ▪ RadMD Quick Start Guide ▪ Claims/Utilization Matrices ▪ View and manage Authorization Requests with other users (Shared Access) ▪ Requests for additional Information and Determination Letters ▪ Clinical Guidelines ▪ Other Educational Documents To sign up for RadMD Go to: **www1.RadMD.com** Click the New User button and set up a unique username/account ID and password for each individual user in your office. NIA-Carolina Complete Health educational documents: **www1.RadMD.com**

Resource: Evolent Resource Page for Partners Providers

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Authorization, Notification, and Determination Timeframes

Authorization Type	Timeframe for Provider	Timeframe for Determination
Standard Service Request (Inpatient)	All non-emergency inpatient admissions require prior authorization. Prior authorization should be requested at least fourteen (14) calendar days before the scheduled service delivery date or as soon as need for service is identified.	72 hours
Standard Service Request (Outpatient)	Prior authorization should be requested at least fourteen (14) calendar days before the scheduled service delivery date or as soon as need for service is identified.	14 days
Urgent Service Request (Inpatient)	Emergency admissions will require notification via authorization submission within one (1) business day, following the date of admission.	72 hours
Urgent Service Request (Outpatient)	Prior authorization should be requested as soon as need for service is identified, prior to service being performed.	72 hours
Retrospective Review	Retrospective review is an initial review of services provided to a beneficiary, but for which authorization and/or timely notification was not obtained due to extenuating circumstances. Providers may request a retrospective review up to 90 days after the date of service (DOS) or date of admission (DOA) in the case of an inpatient request.	30 days

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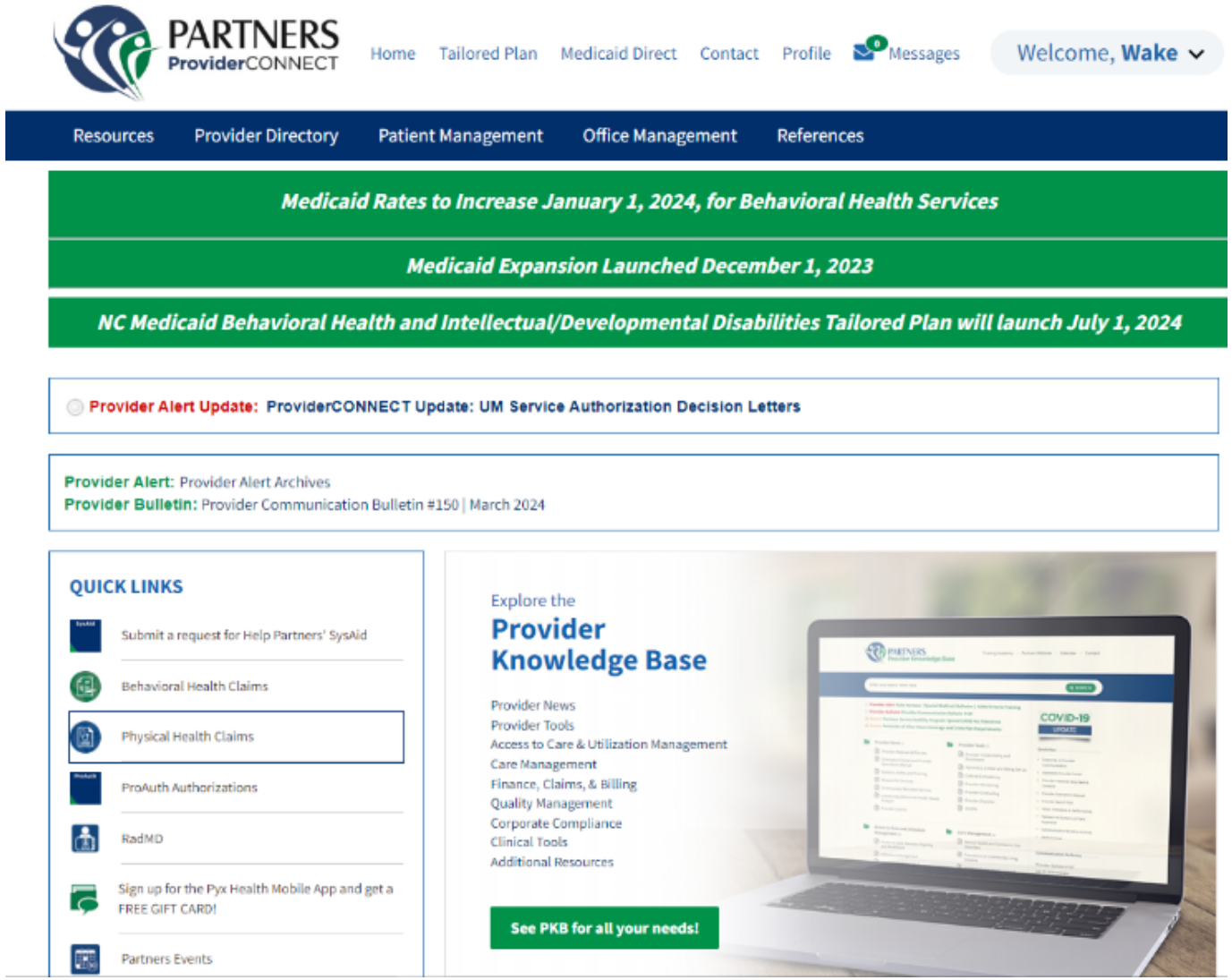
Claims and Payments

Submitting Claims

- You can submit your Physical Health Claims through ProviderConnect



Submitting Claims

Method	Physical Health Claims Submission	Behavioral Health Claims Submission
Electronic	ProviderConnect, https://id.partnersbhm.org/ then choose **Physical** Health Claims to submit **Physical** Health Claims, this brings you to Availity.	ProviderConnect, https://id.partnersbhm.org/ then choose **Behavioral** Health Claims to submit **Behavioral** Health Claims, this brings you to Alpha+.
Paper	Partners Health Management Attn: Claims PO Box 8002 Farmington, MO 63640-8002	Partners Health Management 901 S. New Hope Road, Gastonia, NC 28054
Clearinghouse/SFTP	Provider's Clearinghouse connection to Availity, then the claim can be passed for processing.	Behavioral Health Claims will be submitted to Alpha+
Payor ID	68069	13141

Medicaid claims should be submitted within 365 days from date of service.

Questions:

Phone: 704-842-6486 Fax: 704-854-4203

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Clearinghouse and Set Up of New Payers

Existing Availity Trading Partners

If you are currently sending EDI Transactions for other Health Plans via a secure FTP account with Availity, follow your standard business process to work with Partners Health Management. If you need assistance, please refer to the resources in this EDI Quick Start Guide for Availity.

New to Availity?

If you do not already have an Availity Account, please register with the links below:

1. Go to www.availity.com
2. Click **Register** and complete the process. For registration guidance or tips, we recommend you refer to the following resource prior to starting your registration application:
   - Register and Get Started with Availity Portal microsite
   - EDI Quick Start Guide for Availity
   - Submitting a Claim on Availity Essentials

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Provider Payments

- **Clean claims will be resolved (finalized paid or denied) 95% within 15 calendar days** and 99% within 30 calendar days following receipt of the claim.
- Carolina Complete Health AMH payments are paid out on the 20th of every month
- Partners check run scheduled is weekly on Mondays, with payment issued to providers on Tuesdays.
- Remittance Advice, also referred to as an 835 or Explanation of Payment (EOP), are issued with payment and can be accessed several ways:
  - Payspan: https://www.payspanhealth.com/
  - Physical copy if you receive paper check

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Electronic Funds Transfer for Claims

Behavioral Health Claims	Physical Health Claims
Partners EFT process: Please contact Partners Vendor Group for EFT and banking information set: vendorsetup@partnersbhm.org	Payspan: A Faster, Easier Way to Get Paid (PDF) https://www.payspanhealth.com/nps To contact Payspan: Call 1-877-331-7154, Option 1 or email providersupport@payspanhealth.com Monday thru Friday 8:00 am to 8:00 pm est. Providers must register with each line of business (LOB): there will be registration codes specific for Partners. Payspan offers monthly training sessions for providers covering the following topics: How to Register with Payspan (New User) How to Add Additional Registration Codes to an Existing Payspan Account How to navigate through the Payspan web portal How to view a payment How to find a remit How to change bank account information How to add new users Registration information can be found through CCH: https://network.carolinacompletehealth.com/training

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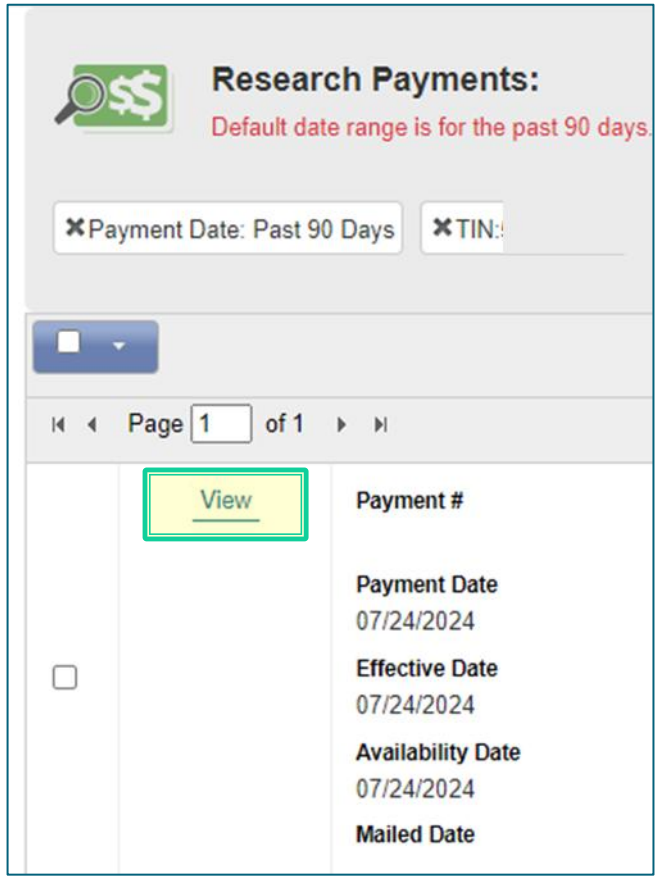
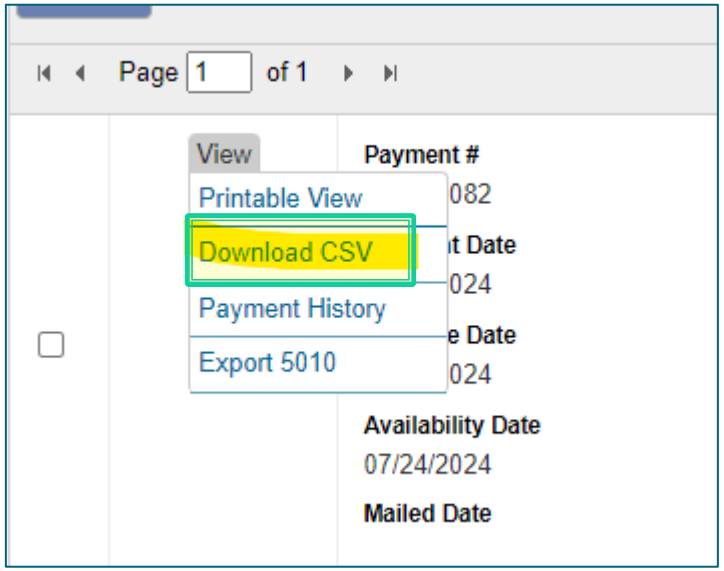
Access ERA in Payspan

1



Scroll down and click ‘View all EOP’

2



Download CSV

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Medical Home Payment and Reporting

Where can practices find their Medical Home fee Capitation Reports?	Via Payspanhealth.com. For providers not yet enrolled, visit https://www.payspanhealth.com/ and click register or contact Payspan: Call 1-877-331-7154, Option 1 – Monday thru Friday 8:00am to 8:00pm EST. Also see attached guide. Using Payspan to Access Medical Home Payments (PDF)
What section of that portal should they be directed to?	In Payspan, under Payment details, click View, then Download CSV. Open the excel document and save a copy for your records.
What system or portal do they need access to, to obtain said reporting? On what date of the month is the enrollment count for the Medical Home PMPM payment captured?	1st of the month
When does your plan project that these payments will be made to practices each month?	20th of each month. First couple of months may be close to end of the month.

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Claims Reconsideration Process

- Partners works diligently with Providers to resolve their issues; however, there are times when a Provider is dissatisfied with a Claims Processing outcome.
- If dissatisfied with the Claims Processing outcome, Providers can complete the **Reconsideration Form** listed below.
- Claims Analysts will review claims submitted on the form for accuracy and provide the research outcome.
- If dissatisfied with the outcome of the Claims Reconsideration, Providers have the option to **File a Grievance/Complaint**.

Email claims reconsideration review form to claimsdepartment@partnersbhm.org.
The form is located at https://providers.partnersbhm.org/claims-information/.
A grievance can be submitted if provider is unsatisfied with the outcome of the claim review. https://providers.partnersbhm.org/grievance- incident-reporting/.

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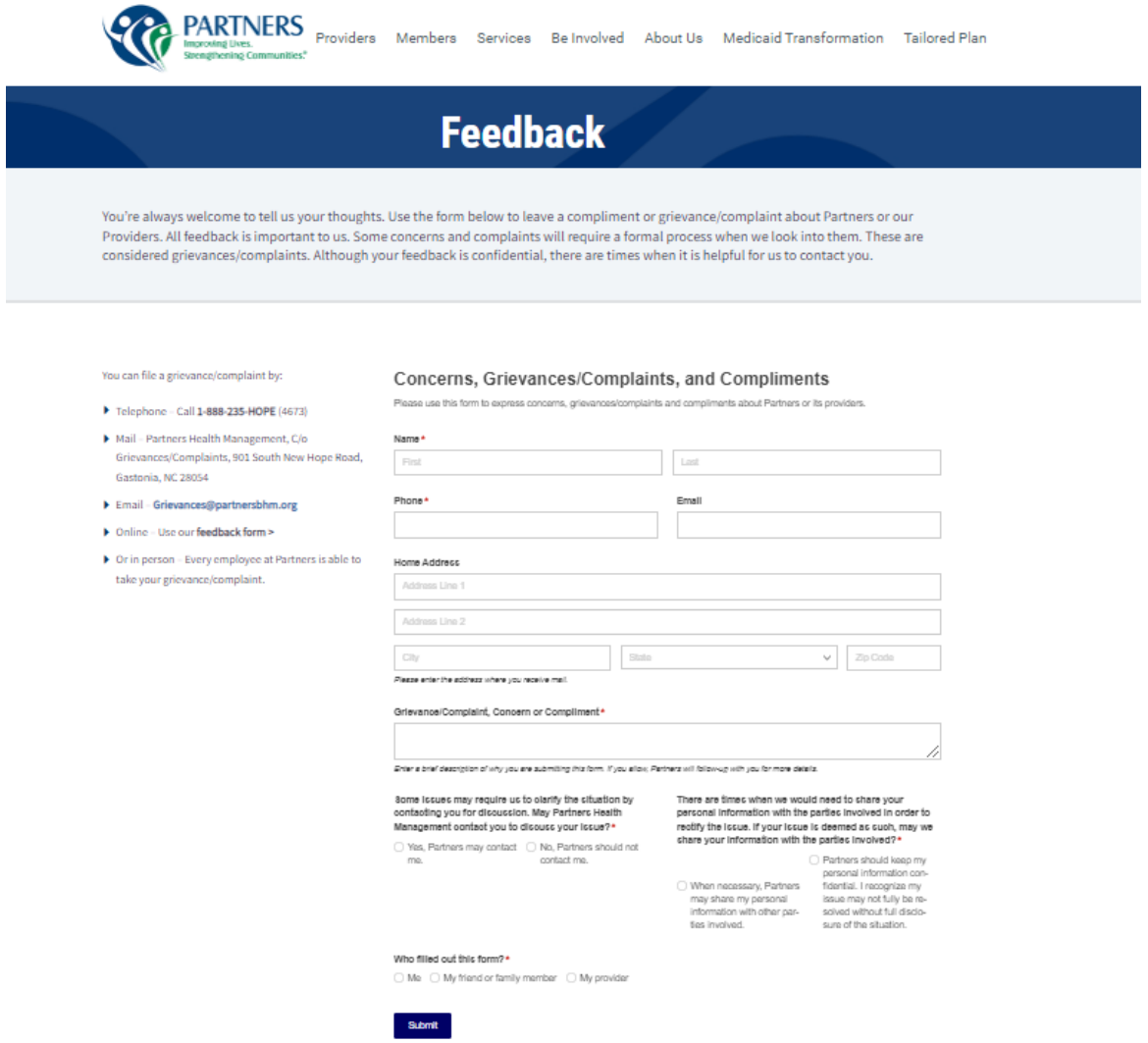
Ways Providers Can File a Grievance

- Intake Points: Any Partners staff may receive provider grievances via the following methods:
  - Telephone – Call 1-888-235-HOPE (4673)
  - Mail – Partners Health Management, c/o Grievance/Complaint, 901 South New Hope Road, Gastonia, NC 28054
  - Email – Grievances@partnersbhm.org
  - Online –Feedback form https://www.partnersbhm.org/feedback/
  - In person – Every employee at Partners is able to receive your grievance or complaint.
  - ProviderCONNECT (Provider Portal)



Partners will provide providers any reasonable assistance in completing forms and other procedural steps.

ProviderCONNECT

File a Grievance/Complaint

/ Additional Resources / File a Grievance/Complaint

Grievances (also called concerns or complaints) are defined as "an expression of dissatisfaction about matters involving the MCO or MCO Provider Network." Grievances/complaints are expressions of dissatisfaction about any matters other than an "action" (summarized as Utilization Management Department decisions to deny, reduce, suspend or terminate any requested services).

Anyone at Partners can receive a grievance/complaint. Grievances/complaints may be submitted via telephone, mail, email, Partners' website, or in person.

The Legal Department is responsible for assigning grievances/complaints to appropriate staff or departments for resolution. The Legal Department also tracks, monitors, and ensures that the grievance/complaint is resolved. Timelines regarding resolution are available in the **Provider Operations Manual**.

If the person filing the grievance/complaint is a member or recipient, or is someone acting by or on behalf of a member or recipient, and would like to request an extension to the resolution of the grievance/complaint, the request* should be submitted either in person, by calling 1-877-864-1454, or in writing to the following address:

Partners Behavioral Health Management
c/o Grievances
901 South New Hope Road
Gastonia, NC 28054
**Include the grievance/complaint reference number located at the top of the Grievance Acknowledgement letter in the request.*

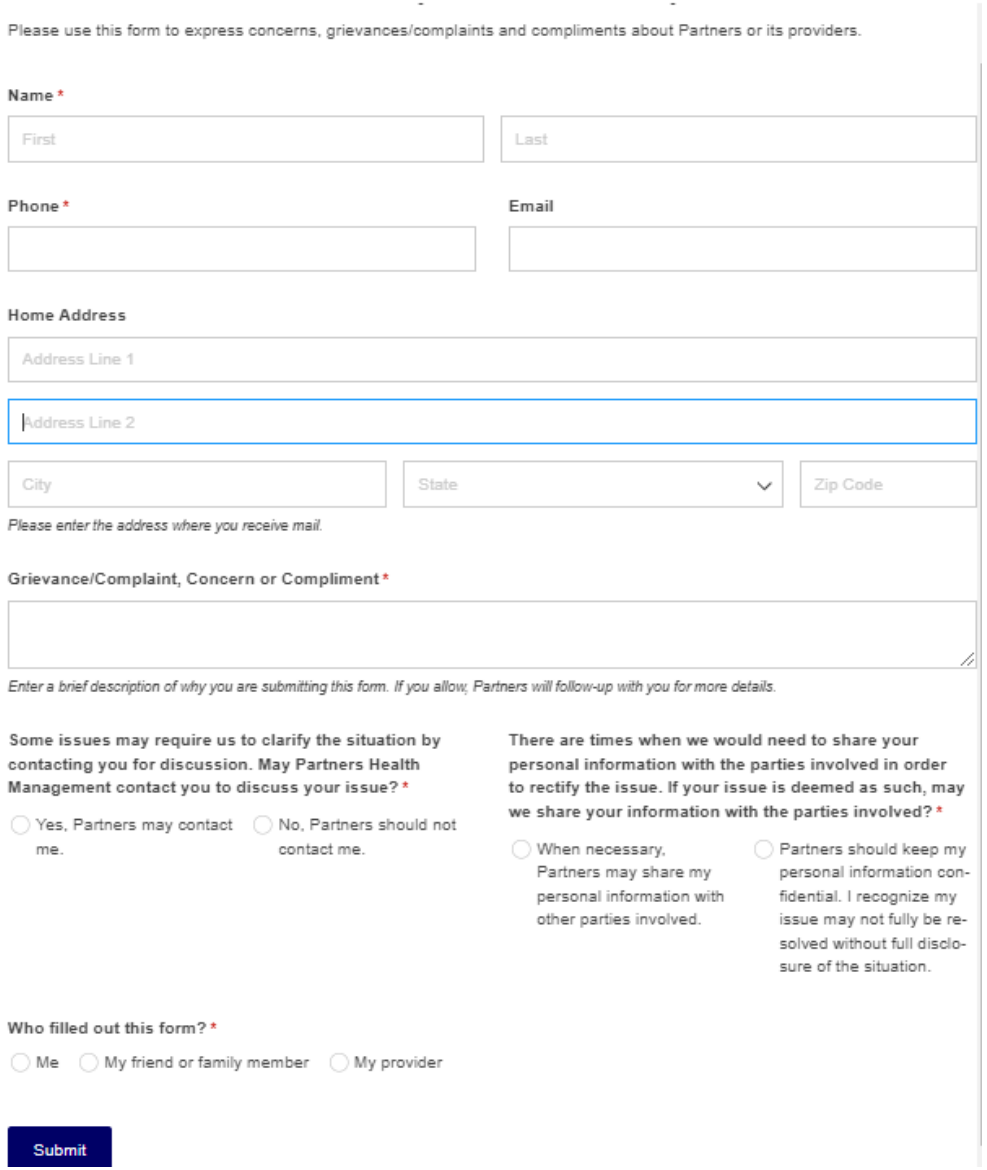
Please remember that:

- Any person or organization has the right and ability to bring a grievance/complaint.
- Upon enrollment and upon request, the grievance/complaint process must be shared with all enrollees and families of enrollees accordingly.
- Additionally, Providers must inform enrollees and families that they may contact Partners directly about any grievance/complaint.
- Providers must publish and make available the toll-free Partners' Customer Services number for enrollees and family members, along with the telephone number for the Disability Rights of North Carolina.
- Partners has a standardized appeal process for grievances/complaints that is outlined in the **Provider Operations Manual**.
- Providers must keep documentation on all grievances/complaints received, including dates received, the issues included in the grievances/complaints, and resolution information.
- Any unresolved grievances/complaints should be referred to Partners.

If you have questions regarding this process, please call 1-877-864-1454 or email **Grievances@PartnersBHM.org**

Grievance/Complaint Online Form

Grievance/Complaint Online Form



Please use this form to express concerns, grievances/complaints and compliments about Partners or its providers.

Name *

First | Last

Phone * | **Email**

Home Address

Address Line 1

Address Line 2

City | State | Zip Code

Please enter the address where you receive mail.

Grievance/Complaint, Concern or Compliment *

Enter a brief description of why you are submitting this form. If you allow, Partners will follow-up with you for more details.

Some issues may require us to clarify the situation by contacting you for discussion. May Partners Health Management contact you to discuss your issue? *

Yes, Partners may contact me. | No, Partners should not contact me.

There are times when we would need to share your personal information with the parties involved in order to rectify the issue. If your issue is deemed as such, may we share your information with the parties involved? *

When necessary, Partners may share my personal information with other parties involved. | Partners should keep my personal information confidential. I recognize my issue may not fully be resolved without full disclosure of the situation.

Who filled out this form? *

Me | My friend or family member | My provider

Submit

Partners will provide providers any reasonable assistance in completing forms and other procedural steps.

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Partners Provider Communications

- Physical Health Provider Communications

This Link will take you to the Communications page for Physical Health Communications

- Provider Alerts

This Link will take you to the Partners Provider Knowledge Base where you will see Partners Provider Communications and Alerts.

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Questions?

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Additional Resources

- Pro Auth Additional Resources
- Claims/Payments Additional Resources
- Personal Care Services Additional Resources
- Skilled Nursing Facilities Additional Resources
- General Provider Resources

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Pro Auth Additional Resources

Submitting an Authorization Request

- From the Dashboard:
  - At the top right of the screen click either:
    - Create Inpatient Authorization or
    - Create Service/Procedure Authorization

  - **Inpatient services** must be submitted as an Inpatient Authorization
    - **NOTE:** Inpatient level of care is provided by hospitals
    - **ICF-IID** is not considered Inpatient
  - **Outpatient services** must be submitted as a Service/Procedure Authorization

For either option, you must select **Behavioral Health** or **Medical**

- Behavioral Health includes mental health, substance use and intellectual and developmental disabilities
- Medical is physical health services only

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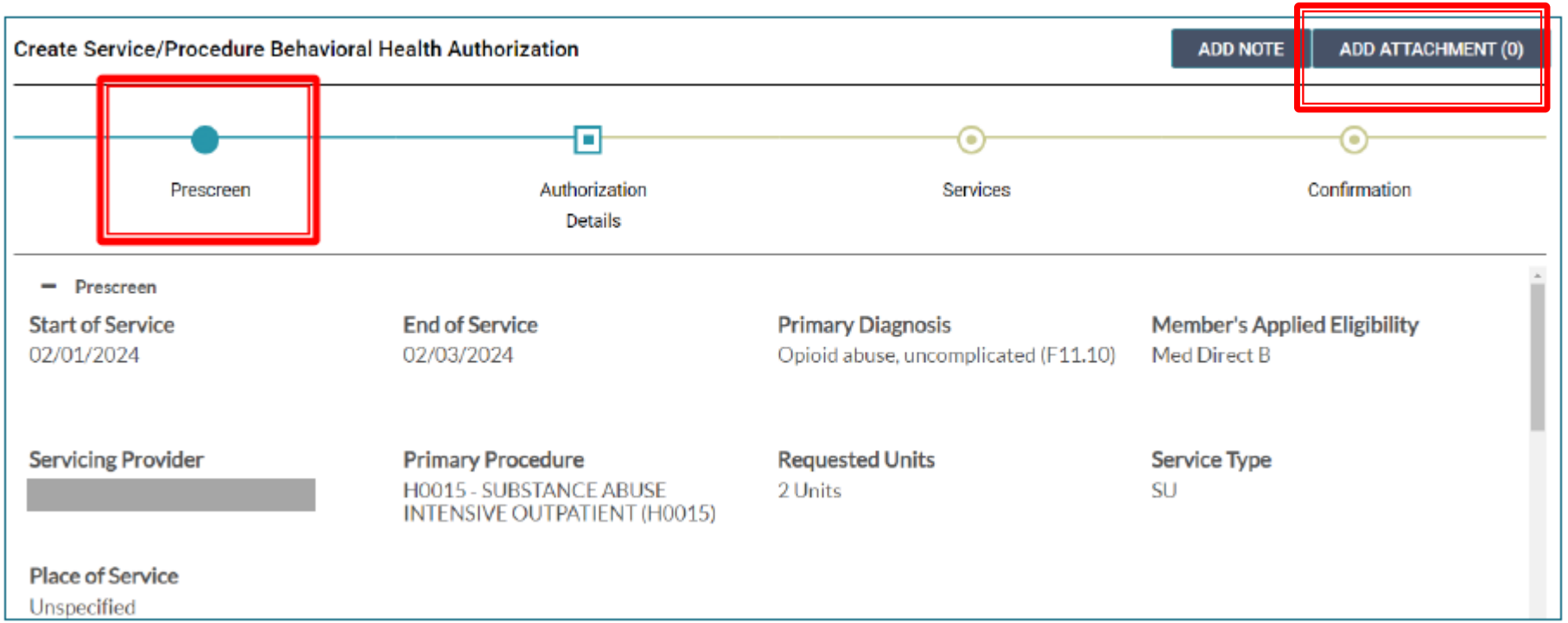
Uploading Documentation in ProAuth

- In the Prescreen section, there will be a button to “ADD ATTACHMENT” in the upper right-hand corner.
- Tip: Minimize the zoom on the browser screen if you are not seeing the buttons.



Submitting Authorizations Manually

- Providers can find the Partners Manual Authorization Request Form here: https://providers.partnersbhm.org/utilization-management/
- This form is to be used for the following situations:
  - The ProAuth/TruCare system is not available and is not expected to be available for an extended period. For example; 4 hours or more; this information will be communicated via the Partners website.
  - The Provider is an out-of-network and/or non-participating provider who is serving a Partners member who either requires specialty treatment not available in the network, is out of the catchment area when a crisis occurs or lives in another catchment area, but Medicaid is not expected to change. For example, members living in residential situations outside of the Partners catchment area but continue to have Medicaid from one of Partners counties.
  - A service is being requested that is not in the Partners Benefit Plan and is not an available drop-down option for services in the ProAuth/TruCare system. For example, an EPSDT Medicaid request for a service not included in the Partners Medicaid Benefit Plan.

Claims/ Payments Additional Resources

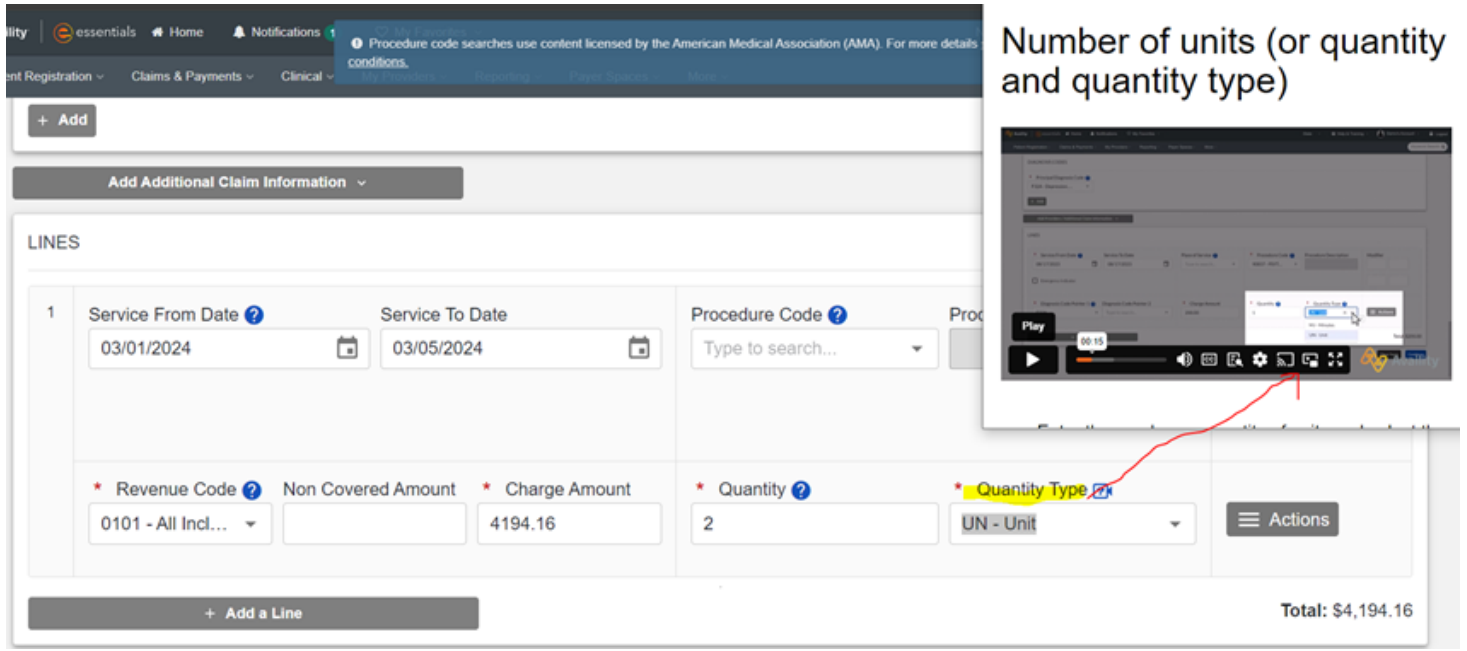
How to File Claims as an OON Provider

- OON Providers must submit all first-time claims for reimbursement no more than one hundred eighty (180) calendar days from the Date of Service, or in the case of a health care provider facility, within one hundred eighty (180) calendar days after the date of the member's discharge from the facility. See page two for OON Provider Claim Submission guidance.
- Providers should use the appropriate paper claim form type (CMS 1500 or UB 04) and submit to:
  - Partners Health Management
  - PO Box 8002
  - Farmington, MO 63640-8002
- OON Providers who have an EDI/Clearinghouse claim submission process, may submit physical health claims to Payer ID 68069.

Note for Home Health and Community Based Personal Care Services: OON Providers subject to EVV requirements, must submit claims through Electronic Visit Verification (EVV). Partners utilizes HHAeXchange as the EVV vendor. Please view the Partners EVV Welcome Letter for additional details on connecting with the HHA portal.

Availity Tips

- Providers should be able to see an updated number of units dropdown.
- Availity has included a video detailing to new unit's process.



Availity Tips

- For Additional Training, Log Into Availity
- Select **Get Trained** under **Help & Training** (Essentials) or **Help & Resources** (Essentials Pro).
- For Availity customer support for Availity products and applications, call 1-800-282-4548.
- For information about Availity product training, view **ALC FAQ** and **ALC User Guide**.

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PCS Per Diem Rate Change: Provider Tips

- Provider should bill their usual and customary charge. Continue using the same claim form type.
- When billing per diem, each day of care should be listed on a separate line.
- **A claim line that spans multiple dates or includes a unit greater than one, will deny.**
- Claims lines submitted for dates of service on or after the effective date must be billed for a single date of service and bill 1 unit.
- Claims created in advance under the current guidelines of 1 unit = 15 minutes will not be compatible with the new billing guidelines of 1 unit per day.

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Inpatient Claims Submission Tips

- Physical Health Claims
  - Physical Health claims uses the primary diagnosis on inpatient claims to determine the claim is physical health vs. behavioral health and processes the claim accordingly.
  - If an inpatient claim has a primary diagnosis for physical health but the member also received behavioral health services during the stay, the claim will be processed using the appropriate DRG for the full stay.
- Behavioral Health Claims
  - Behavioral Health claims uses the primary diagnosis on inpatient claims to determine if the claim is behavioral health vs. physical health. If an inpatient claim has a behavioral health primary diagnosis, the claim will be processed at the per diem rate for the room and board revenue code.

Outpatient Claims Submission Examples

- Child presents for an EPSDT Well Child Check and the PCP also manages ADHD diagnoses

Service Line CPT Code	Service Line Primary Diagnoses Code
99393	Z00129
99401	F909
99213	F909
92551	Z00129

- Adult member sees their PCP for ADHD management and has a cough. The PCP runs a COVID test during the visit.

Service Line CPT Code	Service Line Primary Diagnoses Code
99214	F909
87636	R051

- Today, these claim scenarios today are billed to Medicaid Direct, and July 1, 2024, they will be processed by Carolina Complete Health for Partners' Tailored Plan providers.
- Please use the physical health claim submission steps outlined on Slide 13.

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Payment Expectations

- Providers can expect the first checkwrite by July 9, 2024.
- This checkwrite will include dates of service July 1, 2024, forward.
- Partners will include interest and penalties as part of claims processing according to the contractual agreement.
- The payment will be reflected on the Remittance Advice/Explanation of Payment using Claim Adjustment Reason Code (CARC) 225 – Penalty or Interest Payment by Payer.

Medical Home Fees and Common Questions

Report Details Available in Payspan

PayerName
PaymentNumber
PaymentDate
TotalPaymentAmount
PayeeName
PayeeTIN
LOB
PCPName
PCPNPI
MemberProduct
MemberName
MemberID1
MemberID2
MemberCOVDate
MemberMonths
CAPPaymentAmount

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Medical Home Fees and Common Questions

- **Where can practices find their Medical Home fee Capitation Reports?** Payspan portal. Providers are receiving training on how to navigate reports available on Payspan by CCHN, our provider team. Via Payspanhealth.com. For providers not yet enrolled, visit https://www.payspanhealth.com/nps and click register or contact Payspan: Call 1-877-331-7154, Option 1 – Monday thru Friday 8:00am to 8:00pm EST. Also see attached guide. Using Payspan to Access Medical Home Payments (PDF)
- **What system or portal do they need access to, to obtain said reporting? What section of that portal should they be directed to?** In Payspan, under Payment details, click View, then Download CSV. Open the excel document and save a copy for your records.
- **On what date of the month is the enrollment count for the Medical Home PMPM payment captured?** 1st of the month
- **When does your plan project that these payments will be made to practices each month? i.e., 15th of each month, by the first of the month, etc**. 20th of each month. First couple of months may be close to end of the month.
- **What type of monthly reporting is provided with each payment? Can practices download copies of these reports for their records?** Payspan reports are available for practices to review payments.
  - What details are provided in this report to assist practices with balancing their finances? See next slide.

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Personal Care Services Provider Resources

Personal Care Services Referral Process

The steps for submitting a new referral for PCS includes the following:

1. Partners DHB-3051 form should be completed by the member's primary care provider or physician.
2. Fax the completed form to Partners at **704-457-5261**.
3. Once this form is completed, a member of our team will contact you within 30 days to schedule a face-to-face meeting to complete your assessment.
4. After the assessment has been completed and the start date has been determined, an authorization will be created/submitted by Carolina Complete Health (CCH) and will be shared with the Provider agency. Providers will receive notification of authorization via ProviderCONNECT.

If you have questions related to PCS forms, please submit them to **Partners_PCSInquiry@PartnersBHM.org**

Important Reminder: Personal Care Services

- The rate methodology for providers rendering Personal Care Services (PCS) in congregate setting was originally planned to change effective Jan. 1, 2025. To provide additional support, the rate methodology changes will be delayed until April 1, 2025.
- **Impacted Providers**: Personal Care Services for Beneficiaries in Congregate Settings
  - Special Care Home – 99509-SC
  - Adult Care Homes – 99509-HC
  - Combination Homes – 99509-TT
  - Supervised Living Facilities for adults with MI/SA – 99509-HH
  - Supervised Living Facilities for adults with I/DD- 99509-HI
  - Family Care Homes – 99509-HQ
- **Impacted Procedure Codes:** Only procedure code 99509 and modifiers SC, HC, TT, HH, HI, HQ will be impacted by the change.
- For additional details, review the information in the December 20th Medicaid Bulletin: "Personal Care Services Rate Reimbursement Methodology for Individuals Living in Congregate Settings"
- **Impacted CPT Code**: Only procedure code 99509 and modifiers SC, HC, TT, HH, HI, HQ will be impacted by the change.
- Reimbursement will no longer be based on the actual time spent delivering the service on a specific day. Instead, reimbursement will be based on a calculated per diem (daily) rate.
- Per diem rates will be based on the number of total units prior-approved for PCS services to each specific beneficiary for an authorized period.

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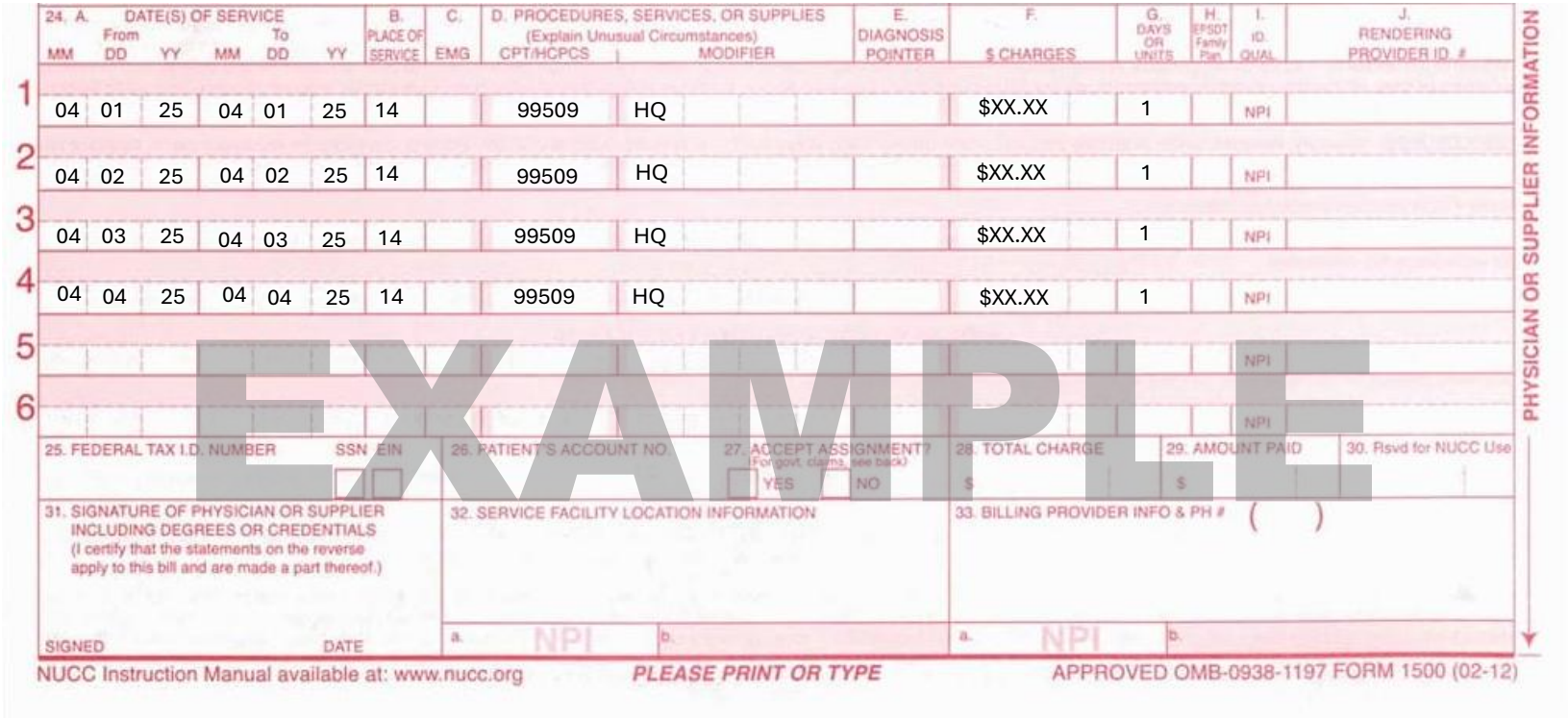
SAMPLE Per Diem Claim



24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 04	01	25	04	01	25	14		99509	HQ		$XX.XX	1		NPI	
2 04	02	25	04	02	25	14		99509	HQ		$XX.XX	1		NPI	
3 04	03	25	04	03	25	14		99509	HQ		$XX.XX	1		NPI	
4 04	04	25	04	04	25	14		99509	HQ		$XX.XX	1		NPI	
5														NPI	
6														NPI	

EXAMPLE

25. FEDERAL TAX I.D. NUMBER SSN EIN | 26. PATIENT'S ACCOUNT NO. | 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO | 28. TOTAL CHARGE $ | 29. AMOUNT PAID $ | 30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.

33. BILLING PROVIDER INFO & PH # ( ) a. NPI b.

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** APPROVED OMB-0938-1197 FORM 1500 (02-12)

- Representation of how to bill the service line(s) on the claim.
- Providers should enter appropriate diagnoses code(s) and all other required claim fields.

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PCS Per Diem Rate Change: Q&A

- Q: Can multiple claims be billed at one time?
  - A: Yes, 1 claim line = 1 date of service, and a full month of claim lines (28, 29, 30 or 31 lines) can be on a claim.
- Q: Can a claim be submitted weekly?
  - A: Yes
- Q: Should the calculated daily rate be included in the claim when filing?
  - A: No, the provider should bill 1 unit per day and Carolina Complete Health's billing system will calculate the daily rate.
- Q: With this new change, does billing have to be completed monthly, only?
  - A: No, billing can be completed at the same cadence as before; however, 1 unit must be billed per day.
- Q: Will the last day of the month be automatically cutback to the lower percentage if the approved PCS hours are runs out before the end of the month?
  - A: Yes

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Personal Care Services (continued)

- **If your organization provides Personal Care Services to Medicaid Direct Members, please see below opportunities from NC Medicaid:**
  - NC Medicaid provided virtual office hours January through March to address any questions about the daily rate reimbursement process.
  - NC Medicaid met with providers during office hours and reviewed with them previously paid claims and walk them through how to submit claims that align with the daily per diem methodology
  - PowerPoint Presentation PCS Rate Methodology Changes

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PCS Reminder

- **EVV**: PCS billed by taxonomy 253Z00000X with CPT 99509 and an HA or HB modifier are subject to EVV requirements and claims must be submitted through HHAeXchange.
  - All providers are expected to be fully compliant with EVV requirements.
  - EVV data must be validated prior to claims adjudication.
  - Claims without the required EVV criteria will deny.
  - Partners works with HHAeXchange as its EVV partner.
- **Non-EVV:** Other physical health PCS services (i.e Congregate Care settings) can be billed through Availity via the Partners' Portal: ProviderCONNECT.

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Contracting with Partners Tailored Plan

- Physical Health Providers may enter a contract with Partners Tailored Plan through our physical health partner, Carolina Complete Health
- Please initiate your contract with the Contract Request Form
- You may also reach out to the Carolina Complete Health Network team via email at: networkrelations@cch-network.com

Note: Prior to contracting, providers must be credentialed with NC Medicaid. NCTracks is the system of record for provider enrollment data.

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Skilled Nursing Facilities (SNF) Additional Resources

Skilled Nursing Facility FAQ's

Q: What is the Skilled Nursing Facility (SNF) admission process under Partners Tailored Plan?

A: Partners' Utilization Management (UM) team works with hospital discharge planners to identify eligible members. SNFs submit admission requests to Partners Intake. After UM reviews for medical necessity, approval is sent, and SNFs submit the DHB-2039 form to DSS to begin financial eligibility review.

Q: When is a PASRR evaluation required?

A: All admissions require a PASRR Level 1 Screening. If positive for SMI, ID/DD, or related conditions, a Level 2 Evaluation is conducted to assess placement needs and specialized services.

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Skilled Nursing Facility FAQ's

Q: Who coordinates services once a member is admitted to a SNF?

A: The Care Transitions Team (CTT) enrolls the member in TruCare, coordinates with SNFs on discharge plans, and ensures tracking and support through weekly Clinical Huddles. If the member is a Level 2 on the PASRR, they will have a Tailored Care Manager (TCM) assigned to coordinate care.

Q: What happens if a member is discharged within 90 days?

A: The CTT creates a 90-day Transition Plan and facilitates post-discharge services, including transportation, home support and outpatient appointments. A warm handoff is made to the TCM.

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Skilled Nursing Facility FAQ's

Q: How is Medicaid disenrollment handled for members in SNFs?

A: If a member remains in a SNF for 90 consecutive days, they are disenrolled from the Tailored Plan and moved to NC Medicaid Direct on the first day of the following month. CTT submits the LTSS Disenrollment Form and notifies the TCM and SNF of the change.

Partners will not be doing Physical Health but will be coordinating care for Behavioral Health/IDD.

Q: Who can hospital staff contact for help?

A: CTT Referrals: CTT_inpatientED_Referrals@partnersbhm.org

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Skilled Nursing Facility Medicaid Disenrollment

Medicaid Disenrollment

- If member remains in SNF for 90 consecutive days, they are disenrolled from the Tailored Plan and transferred to NC Medicaid Direct on the first of the following month.
- If discharge results in admission to CAP/C, CAP/DA or PACE, CTT will also complete the LTSS Disenrollment Form.
- CTT submits the LTSS Disenrollment Form to the state and notifies involved parties (UM, TCM, SNF).
- CTT will support the Provider and Network team during this process by submitting the LTSS Disenrollment form.
- CTT will facilitate a warm hand-off by communicating discharge plans directly to the member's assigned Tailored Care Manager (TCM) via email or phone call after notification of the discharge. CTT will document warm hand-off in TruCare notes.

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General Provider Resources

Provider Resources

Learn More About Partners Health Management

- https://www.partnersbhm.org/tailoredplan/
- https://www.partnersbhm.org/tailoredplan/providers/manuals-forms-and-policies/
- https://www.partnersbhm.org/wp-content/uploads/partners-quick-reference-guide.pdf
- https://www.partnersbhm.org/tailoredplan/pharmacy/
- https://www.partnersbhm.org/tailoredplan/providers/provider-training-materials/
- https://providers.partnersbhm.org/claims-information/

- NC DHHS Tailored Plan Toolkit

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Tailored Plan Transportation Services

Non-Emergency Medical Transportation (NEMT)

Non-Emergency Medical Transportation (NEMT) is the new name for your transportation benefits under the Tailored Plan.

Members and/or their guardian will need to use **Modivcare**, Partners' transportation vendor, to access this service.

Tailored Plan Members: Call Member Services at **1-888-235-4673** and choose the "Transportation" option starting May 16, 2024, to schedule rides that will begin July 1, 2024.

What appointments are covered?

- Medical, dental and vision
- Behavioral health
- Prescription pick-up following Primary Care Provider (PCP) appointments
- Women Infants Children (WIC)
- Non-medical appointments such as educational classes and weight-control classes, including Weight Watchers

https://www.partnersbhm.org/tailoredplan/members/tailored-plan-transportation-services/

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Food Assistance and Resources

- Partners is here to help you find free or low-cost food programs close to home. This page lists community food pantries, meal programs and other organizations that provide groceries or prepared meals across our service area.
- These resources are offered by local nonprofits, churches and community groups. Partners shares this information to help connect you with the support available in your community.
- If you need help finding food resources, contact **Partners Member and Recipient Services** at **1-888-235-HOPE (4673)**, Monday-Saturday, 7 a.m.–6 p.m.
- https://www.partnersbhm.org/food-resources/

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DHHS SNAP Information

- This week, NCDHHS announced that November benefits for the 1.4 million North Carolinians who rely on the Supplemental Nutrition Assistance Program (SNAP) will be delayed as the federal government shutdown continues.
- On Oct. 10, the U.S. Department of Agriculture (USDA) directed NCDHHS to delay the issuance of November SNAP benefits due to the ongoing federal shutdown. As of today, NCDHHS has not received the necessary federal funding for the program.
- Additionally, the USDA sent guidance and a notice to states on Friday, Oct. 24, 2025, stating it would not be using the roughly $6 billion in federal contingency funds available to keep the SNAP program running for November. The notice also explained that the federal government would not reimburse any state funds used to cover SNAP benefits. SNAP benefits in North Carolina represent about $230 million to $250 million each month. NCDHHS will stay in close communication with federal partners and will issue SNAP benefits to beneficiaries as soon as federal funding is provided.

DHHS SNAP Information

- **NCDHHS is providing the following guidance for people who depend on food and nutrition benefits:**
- **Continue to Apply and Renew:** All residents should continue to apply for SNAP benefits and submit renewal paperwork on time. County DSS offices remain open and are processing all applications to prevent a backlog when funding is restored.
- **Check Your Balance:** Any benefits currently on your EBT card are still available to use. Check your balance on the ebtEDGE app, at ebtEDGE.com, or by calling the number on the back of your card (1-888-622-7328).

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Thank you for joining us today for this informational session

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