NC Medicaid Managed Care
County Playbook

Fact Sheet
Children and Families Specialty Plan Roles and Responsibilities

The Children and Families Specialty Plan (CFSP) is a new NC Medicaid Managed Care health plan that requires close collaboration between local Department of Social Services (DSS) leadership, Medicaid caseworkers and CFSP care management.

Local DSS leadership, including directors and their designees, must remain informed of all CFSP member circumstances and communicate any changes to county child welfare (CW) caseworkers, Medicaid caseworkers and CFSP care managers.

KEY ROLES AND COUNTY DSS STRUCTURE

All local DSS staff play an important role in managing the health care of CFSP members. Local DSS maintains placement authority. County CW caseworkers communicate changes in circumstances with the CFSP care manager and Medicaid caseworkers.

Directors and supervisors should communicate with each other in and across county lines to deliver updates to member information and make sure actions are completed timely.

The CFSP care manager will handle the member's care plan, including items such as coordinating with providers and helping to set appointments on behalf of the members. The table below summarizes the responsibilities of county CW caseworkers and Medicaid caseworkers.

Local DSS – CFSP Areas of Oversight	Summary of CFSP Local DSS Responsibilities
CFSP eligibility and enrollment	• County CW caseworkers must identify potential Medicaid-eligible individuals in a timely manner and assist CFSP care managers with disenrollment for member transitions as applicable • Medicaid caseworkers should continue to determine Medicaid eligibility and manage ongoing cases with updated information
Co-location between the CFSP and local DSS staff	• Local DSS agencies must collaborate with the CFSP to evaluate the feasibility of co-locating CFSP care managers and,

Local DSS – CFSP Areas of Oversight	Summary of CFSP Local DSS Responsibilities
	if agreed, establish physical space, schedules and protocols for co-location • Local DSS agencies must address logistics and support staff through the transition
Coordination between the CFSP care manager and local DSS staff	• County CW caseworkers must collaborate closely with CFSP care managers through regular meetings, including within 72 hours of a member's enrollment and monthly thereafter, to ensure timely evaluations, care planning and crisis management • County CW caseworkers will provide updates on the member's health, placement and family planning, participate in multidisciplinary care teams and lead foster care and transition planning efforts • Work with CFSP care managers to develop transitional living plans and identify Child and Family Team members

THE ROLE OF THE CHILDREN AND FAMILIES SPECIALTY PLAN CARE MANAGER

The CFSP care manager provides consultation, education and system navigation for local DSS support staff. CFSP care managers offer regular, in-person or virtual availability to support complex member cases. Additional CFSP care manager responsibilities include:

- Serve as a primary point of contact to support local DSS Medicaid funded emergency placement issues
- Participate in regularly scheduled meetings with local DSS representatives, as requested
- Participate in ad hoc discussions to answer specific local DSS questions or provide updates to local DSS
- Hold office hours to be available for questions or updates
- Local DSS must collaborate with the member's assigned CFSP care manager to ensure all communications, referrals and assessments reflect county office coordination
- Ensure CFSP care manager and county CW caseworkers contact information is current
- Ensure county CW caseworkers use all available CFSP capabilities and staffing supports

NC CAREPOINTS CONNECT PORTAL

NC CarePoints Connect is a digital platform that enhances access to vital health-related information for county CW caseworkers. This tool provides a unified view of member health data, supporting caseworkers in delivering informed and coordinated care.

Key features of CarePoints Connect:

- Access to current and past conditions and diagnoses
- Comprehensive medication and health care claim history
- Service information, including provider details and service dates
- Updates on requested healthcare services
- Access to Member ID cards and grievance/appeals information

Caseworkers can also update member records with critical information such as immunizations and allergies to facilitate collaborative care planning.

The platform includes up-to-date contact details for care managers and supervisors. Additionally, the integrated FindCare tool assists in connecting members with available providers. Training is available in NCSWLearn and office hours are available for demonstrations and questions each week.

To access the training:

Log into your NCSWLearn account via NCSWLearn.org → Select **Online Courses** → Select **General Tab** → Select the On-Demand Courses titled “NC CarePoints Connect: A Brief Overview”

COMMUNICATION PROCESS CHANGES

County CW caseworkers are required to participate in regular meetings with CFSP care managers, including within 72 hours following a member’s enrollment in CFSP (or earlier, if necessary) and monthly thereafter. During the initial meetings, communication regarding the members’ existing and ongoing needs are required. At the monthly meeting, the county CW caseworkers is expected to provide key updates.

During the initial meeting, county CW caseworkers and CFSP care managers should:

- Communicate whether the member received or is scheduled to receive needed evaluations/assessments. This includes:
- DSS-required seven-day physical examination
- DSS-required 30-day comprehensive medical appointment
- Mental health evaluation, developmental evaluation and dental evaluation
- Work with the CFSP care manager to schedule appropriate appointments, if such assessments/evaluations have not been scheduled
- Share key information necessary to inform a member’s assessment and care planning processes (e.g., court-ordered medical services, psychotropic medication usage, DSS Child Health Summary Components).
- Align on an ongoing process and timeframe to share DSS Child Health Summary Components, to the extent available and applicable, with the CFSP care manager
- Support development of a plan for managing potential future crises for the member
- Align with the CFSP care manager on explicit next steps and roles/responsibilities to ensure member receives services needed in a timely fashion

In addition, county CW caseworkers are expected to participate in a member’s multidisciplinary care team at least twice per calendar year and any ad-hoc crisis or transition planning meetings.

Monthly meetings between the county CW caseworkers and CFSP care managers should cover:

- Key changes in member's health care needs
- Family preservation and permanency planning process
- Other information necessary to inform Member's Care Plan/Individual Support Plan
- Member's placement status
- Any changes regarding restrictions to communicating with a member's parent(s), caretaker relative(s), guardian(s) or custodian(s), including termination of parental rights or court order restricting communication

The CFSP shall make best efforts for required meetings to occur in person. Video conferencing tools are permitted when necessary.

As appropriate, additional resources may be included in required meetings such as CFSP care manager supervisors, local DSS directors and other staff.

ESCALATIONS

Local DSS support staff will continue to use existing county processes to escalate issues and concerns. Medicaid caseworkers and county CW caseworkers can escalate issues to local DSS supervisors and directors. Local DSS supervisors and directors can escalate issues to North Carolina Department of Health and Human Services (NCDHHS) DSS.

If there are issues between local DSS support staff and CFSP care management staff, escalations can be made to the CFSP care manager's supervisor, care navigator or the Regional County DSS liaison. If the issue persists, the existing local DSS escalation process should be followed. If escalation is needed beyond this, the Regional County DSS liaison can escalate the issue to the State.

CO-LOCATION

Co-location is designed to support ongoing communication, coordination, and collaboration between local DSS staff and CFSP care management staff. Local DSS offices may opt to host an on-site CFSP care management navigator or care manager.

Co-located care managers are assigned CFSP members and work to support members in person, virtually and over the telephone. Co-located care managers provide regular, in-person availability to support complex cases.

Co-located care navigators will not be assigned CFSP members. Navigators are best used in counties with more than 100 CFSP members who can accommodate on-site CFSP care management staff. Care navigators serve as a liaison between county CW caseworkers and CFSP care managers. Navigators can triage and escalate issues related to CFSP care managers and address CFSP member and health plan related questions.

Other care navigator responsibilities include:

- Provide consultation, education and system navigation for local DSS support staff

- Serve as the primary point of contact to support local DSS emergency placement issues and coordinate with HBCT placement coordinators throughout each region
- Coordinate co-training opportunities offered by HBCT
- Point of escalation for any care manager performance issues
- Participate in regularly scheduled meetings with local DSS support staff, as requested
- Conduct office hours for local DSS support staff