

North Carolina Medicaid Managed Care Transformation as of 4/1/23: Implications for Children/Youth Served by the Child Welfare System

A Resource for DSS County Child Welfare Workers

March 23, 2023

Agenda

- **Meeting Objectives**
- **Terminology**
- **Background**
- **Medicaid Coverage and Care Management as of 4/1/23**
- **Care Management Assignment**
- **Requirements for Coordination between Care Managers & DSS County Child Welfare Workers**
- **Questions & Additional References**

- Review background and timeline for latest Medicaid Managed Care transformation efforts
- Discuss the Medicaid eligibility and care management landscape for children and youth served by the child welfare system as of April 1, 2023
- Highlight DSS county child welfare worker and care manager responsibilities for the children and youth served by the child welfare system

Terminology

Terminology / Definitions

- **NC Medicaid Direct**: North Carolina's health program for Medicaid beneficiaries who are not enrolled in health plans.
- **Local Management Entity(LME)/Managed Care Organization (MCO)**: the political subdivision organized pursuant to N.C.G.S. §122C-3(20- c), and which is responsible for authorizing, managing and reimbursing providers for all Medicaid and State-funded mental health, substance abuse, and developmental disability services pursuant to contracts with the Department for those Enrollees within the LME/MCOs defined catchment area.
- **Care Management**: Team-based, person-centered approach to effectively managing patients' medical, social and behavioral conditions.
- **Tailored Care Management**: NC's specialized integrated care management model for Medicaid beneficiaries with a serious mental illness (SMI), a serious emotional disturbance (SED), a severe substance use disorder (SUD), an intellectual/developmental disability (I/DD), or those who are receiving services for a traumatic brain injury (TBI). Tailored Care Management will be delivered by a care manager who is based at a health plan or in a community provider setting at an Advanced Medical Home Plus (AMH+) practice or Care Management Agency (CMA).
- **Tailored Care Management Assignment Letters**: Assignment letters that will be sent to beneficiaries who are eligible for Tailored Care Management.

Terminology / Definitions Cont'd

- **Warm Handoff:** Time-sensitive, member-specific planning for care-managed members or other members identified by either the transferring or receiving entity to ensure continuity of service and care management functions. Warm Handoffs require collaborative transition planning between both transferring and receiving entities and as possible, occur prior to the transition.
- **Transferring Entity:** The entity (e.g., CCNC) that is disenrolling the transitioning member and transferring the member's information.
- **Receiving Entity:** The entity (e.g., LME/MCO) that is enrolling the transitioning member and receiving the member's information.
- **Beneficiary Consent Form:** Form that beneficiaries or their guardian sign to provide permission for their information to be transferred.
- **Transition of Care:** The process by which a beneficiary's healthcare coverage moves between service delivery systems, including between health plans.
- **Transition of Care (TOC) Warm Handoff Summary Form:** This form is required for beneficiaries with high needs to be completed to support the transition from CCNC to LME/MCO.

Background

Updated Timeline

December 1, 2022
*Tailored Care
Management Launch*



October 1, 2023
Tailored Plan Launch

★ April 1, 2023
New Medicaid Direct
LME/MCO Contract Launch

Focus for Today:
*Impact on children and youth in
foster care, receiving adoption
assistance, and former foster
youth under the age of 26.*

Reminder: Current Medicaid Eligibility & Care Management for Children/Youth Served by the Child Welfare System

○ Medicaid Eligibility

- Most children and youth in foster care, receiving adoption assistance, and former foster youth under the age of 26 receive Medicaid health services through NC Medicaid Direct (health care program for Medicaid beneficiaries who are not enrolled in health plans).

○ Care Management

- Eligible children and youth began receiving Tailored Care Management on December 1, 2022; they continue to be enrolled on an on-going basis as they become eligible.
- Those not eligible for Tailored Care Management receive care coordination/care management through **Community Care of North Carolina (CCNC)** or through **Care Management for At-Risk Children (CMARC)** program, as they did prior to Tailored Care Management launch.

Children and Youth in the Tribal Child Welfare System

- Most Tribal members and other individuals eligible to receive Indian Health Services, including North Carolina's federally recognized tribe (the Eastern Band of Cherokee Indians (EBCI)) and state-recognized tribes, receive Medicaid health services through the EBCI Tribal Option.
- Individuals enrolled in the EBCI Tribal Option who meet Tailored Care Management eligibility must opt-in to receive these services.

**Medicaid Coverage and Care Management
as of 4/1/23**

Medicaid Enrollment for Children & Youth Served by the Child Welfare System

Most children and youth served by the child welfare system* will continue to receive their Medicaid services as they do today.



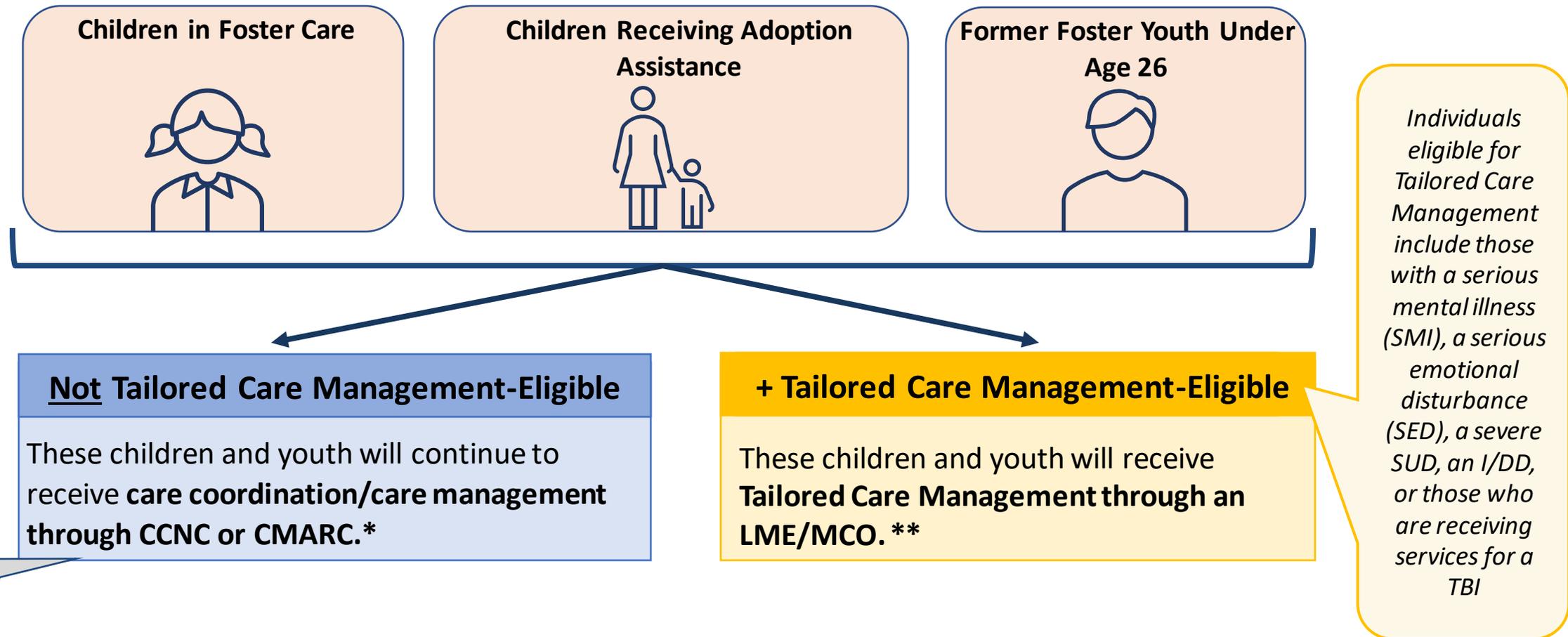
will continue to be enrolled in NC Medicaid Direct

- NC Medicaid Direct is North Carolina’s health care program for Medicaid beneficiaries who are not enrolled in a Standard Plan or EBCI Tribal Option.
- NC Medicaid Direct provides beneficiaries with physical health, pharmacy, long term services and supports, and behavioral health services (including for mental health disorder, substance use disorder (SUD), intellectual/developmental disability (I/DD) or traumatic brain injury (TBI)).

* This presentation does not address Medicaid enrollment and care management for children/youth receiving Child Protective Services (CPS) preventive services.

Care Management for Children & Youth Served by the Child Welfare System

Most children and youth served by the child welfare system will continue to receive care management as they do today; children ages 0 – 3 will be eligible to receive Tailored Care Management as of 4/1.



See slide 15 for more detail

*Individuals receiving Tailored Care Management may not receive CMARC as the services are considered duplicative.

** Some children and youth may receive Tailored Care Management through provider-based care management.

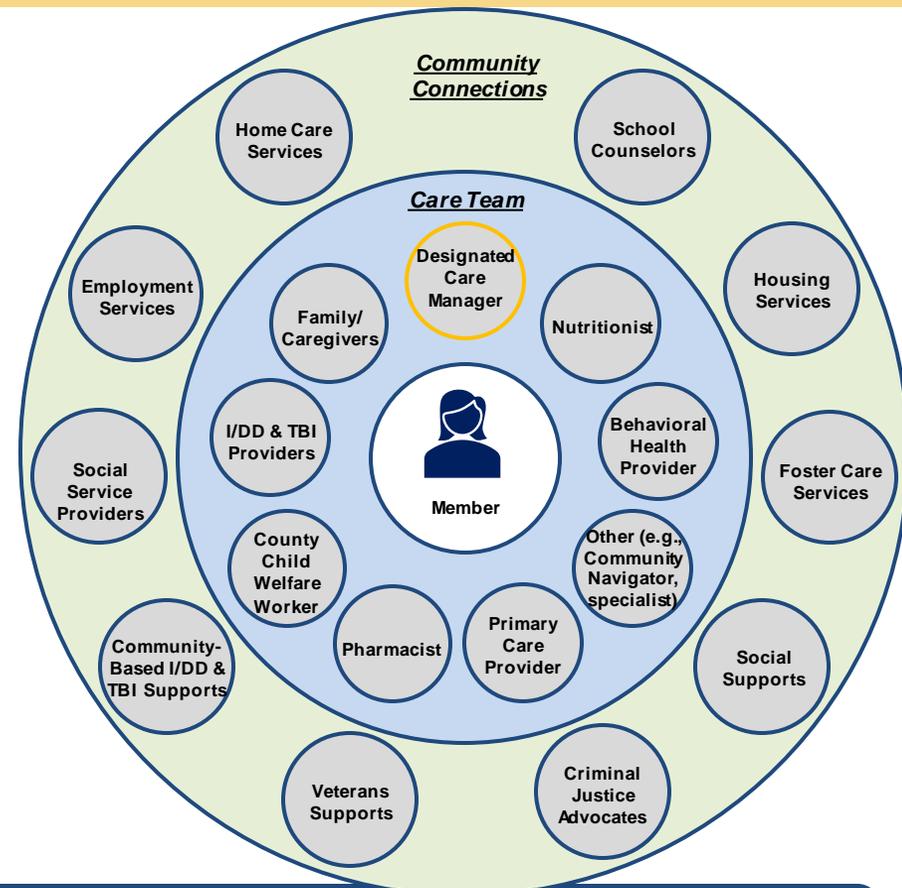
Reminder: What is Tailored Care Management?

Under Tailored Care Management, members will have a single care manager who will manage all of a member's needs, spanning physical health, behavioral health, I/DD, TBI, pharmacy, LTSS, and unmet health-related resource needs.

Tailored Care Management will allow eligible children/youth to receive integrated care management. Integrated care management places the person at the center of a multidisciplinary care team and recognizes interactions across all their needs, developing a holistic approach to serve the whole person.

With Tailored Care Management, care managers:

- **Coordinate a comprehensive set of services** addressing all of the member's needs; members will not have separate care managers to address physical health, behavioral health, TBI, and I/DD-related needs.
- **Provide holistic, person-centered planning.** Members receive a care management assessment that evaluates all of their health and health-related needs and drives the development of a care plan that identifies the goals and strategies to achieve them.
- **Address unmet health-related resource needs** (e.g., housing, food, transportation, interpersonal safety, employment) by connecting members to local programs and services.
- **Are part of multidisciplinary care teams** made up of clinicians and service providers who communicate and collaborate closely to efficiently address all of the member's needs.
- **Utilize technology** that bridges data silos across providers and plans.



Upon Tailored Care Management launch, DSS County Child Welfare Workers will only have to coordinate care management with a single care manager for children who are eligible for Tailored Care Management.

Overview of CCNC and CMARC for Children/Youth Served by the Child Welfare System

CCNC

Eligibility

- Children/youth who are not Tailored Care Management eligible and are:
 - Ages 0 – 5 prescribed medication;
 - Ages 0 – 5 identified as high-risk*; or
 - Ages 5 +

Functions

- **CCNC serves as lead** coordinating physical health, behavioral health, and unmet health-related resource needs with DSS
- **CCNC works with LME/MCO** to coordinate the delivery of behavioral health services
- **LME/MCO supports coordination of BH services** at request of CCNC or DSS Child Welfare Worker and assigns care coordinator to member at DSS caseworker request

CMARC

Eligibility

- Children/youth who are not Tailored Care Management eligible and are:
 - Ages 0 – 5 with special health care needs (except for those prescribed medication or identified as high-risk)

Functions

- Local Health Departments (LHDs) serves as lead in providing a suite of care management services in coordination with primary care providers and social services organizations
- If a child has complex medical needs, the CCNC care manager will collaborate with CMARC to provide development supports and service assistance

Pulling It All Together: Medicaid Coverage & Care Management for Children & Youth in Foster Care, Receiving Adoption Assistance and Former Foster Youth < 26

	Is the child/youth diagnosed with a SMI, SED, a severe SUD, an I/DD, or receiving services for a TBI?*	Child/youth will receive Medicaid Services through:	Child/youth will receive Care Management through:
Children/youth in foster care, receiving adoption assistance and former foster youth < 26	Yes	NC Medicaid Direct	Tailored Care Management
	No	NC Medicaid Direct	CCNC or CMARC

Full diagnosis list for Tailored Care Management Eligibility can be found here: <https://www.ncdhhs.gov/media/10969/download>

Scenario 1

Brayden is 3-years-old and in foster care. Brayden has a traumatic brain injury.



3-year-old in
Foster Care



*Is Brayden eligible for
Tailored Care Management
on 4/1?*

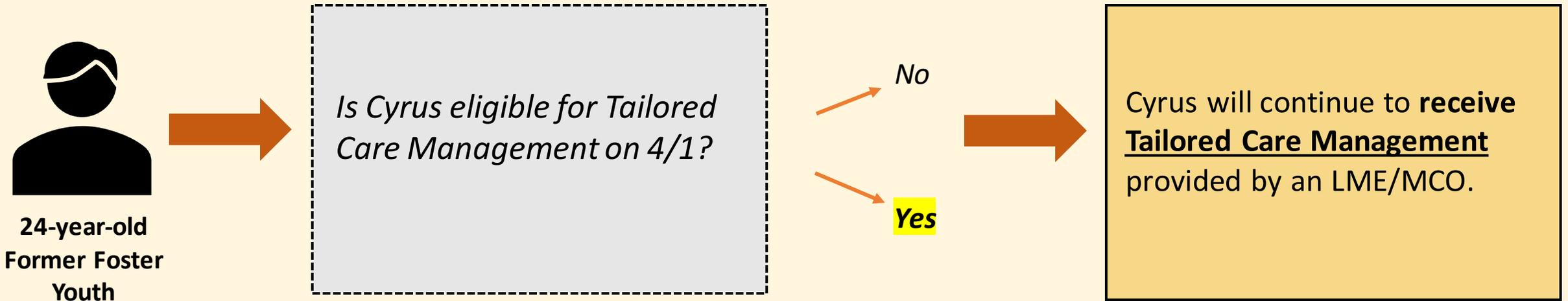
No
Yes



Brayden will receive Tailored
Care Management.

Scenario 2

Cyrus is 24-years-old and a former foster care youth. Cyrus has a serious mental illness (SMI).



Scenario 3

Ruth is 2-years-old and in foster care. Ruth is showing signs of developmental delays.



2-year-old in
Foster Care



*Is Ruth eligible for Tailored
Care Management on 4/1?*

No
Yes



Ruth will continue to **receive**
Care Management for At-Risk
Children (CMARC) through the
local health department.

Scenario 4

David is 7-years-old and in foster care; he has no known behavioral health concerns.



7-year-old in
Foster Care



Is David eligible for Tailored Care Management on 4/1?

No
Yes



David will continue to **receive care coordination through Community Care of North Carolina (CCNC)** in partnership with an LME/MCO.

Care Management Assignment

Tailored Care Management Assignment Letter

Since 12/1, LME/MCOs have been sending assignment letters to individuals who become eligible for the Tailored Care Management.

- **Assignment letters are sent to a member's Authorized Representative(s)** as identified in the member's 834-eligibility file, a standard Medicaid enrollment file.
- Depending on each individual circumstance, **the Authorized Representative may be the County DSS Director, DSS County Child Welfare Worker, or other individual (e.g., foster or kinship parent).**
- **The LME/MCO will send assignment letters to the Authorized Representative of any member who enters foster care after April 1, 2023 who is Tailored Care Management eligible.**

Tailored Care Management Assignment Letter

Overview of Tailored Care Management

Tailored Care Management Provider Contact Information

This letter is to be sent to NC Medicaid Direct members who qualify for Tailored Care Management.

For extra support to get and stay healthy, you have access to Tailored Care Management at no cost to you. Tailored Care Management provides you with a care manager, who is trained to help people with mental health, substance use, intellectual/developmental disability and/or traumatic brain injury needs. Your care manager works with you, your team of medical professionals and your approved family members (or other caregivers) to consider your unique health-related needs and find the services you need in your community.

Your care manager can:

- Do a full assessment of your needs and help develop a set of health goals and a plan to achieve those goals
- Help arrange your appointments and transportation to and from your provider
- Answer questions about what your medicines do and how to take them
- Follow up with your doctors or specialists about your care
- Connect you to helpful resources in your community

Your Tailored Care Management provider may be your primary care provider (PCP) (also called an Advanced Medical Home +, or AMH+), a Care Management Agency (CMA) or [LME/MCO Name]'s Care Management department.

Your Tailored Care Management provider is:

[Tailored Care Management Provider Name]
[Contact Information]

You can choose or change your Tailored Care Management provider during the year. If you want to choose or change your Tailored Care Management provider, you can call Member Services at [Member Services Toll-Free Number] or submit the form: [Form name/submission mechanism].

You can also choose not to have a care manager and not receive the Tailored Care Management benefit. [LME/MCO Name] will help you coordinate services, but the coordination will be more limited than Tailored Care Management. For example, you will not meet with a care manager on a regular schedule. This will not impact which providers you can see or what services are covered for you through [LME/MCO Name]. You can choose not to have Tailored Care Management at any time by calling Member Services at [Member Services Toll-Free Number] or submit the form: [Form name/submission mechanism].

Tailored Care Management Assignment Letters will continue to look like this.

Member Services Contact Information

Opt-out Information

Verifying Assignment for a New Foster Child

When a child enters foster care, the DSS County Child Welfare Worker can verify Medicaid enrollment and care management assignment by leveraging existing resources

- **Verify with the removal parent**
- If the DSS County Child Welfare Worker does not have access to the Child Welfare System, they can **contact the DSS County Medicaid Case Worker or office designee to obtain the information**
- For members presumed to be Tailored Care Management eligible, **contact the LME/MCO assigned to your county.**
 - If you need to locate the LME/MCO assigned to your county, please click this link: [LME/MCO Directory](#) or see slides 39 & 40

Tailored Care Management Change Request and Opt Out

Members or their legal guardians can choose a different Tailored Care Management provider or choose to opt out of Tailored Care Management

All Tailored Care Management eligible members are given **three choices**:

- **keep** their assigned Tailored Care Management provider,
- request to **change** their Tailored Care Management provider, or
- **opt out** of Tailored Care Management.

If a member or their legal guardian chooses to change their Tailored Care Management provider or opt out Tailored Care Management, they should contact their LME/MCO.

Requirements for Coordination between Care Managers and DSS County Child Welfare Workers

Coordination with DSS for Tailored Care Management Eligible Children/Youth

Care Managers delivering Tailored Care Management must collaborate with DSS County Child Welfare Workers by:

- Ensuring participation in the multidisciplinary care team
- Arranging an initial meeting in-person, by video, or telephonic within 60 days for members enrolled in LME/MCO upon initial launch or 3 days for members enrolled in LME/MCO after initial launch to:
 - Schedule required appointments and gather necessary information
 - Establish ongoing processes and timeframes for sharing the DSS Child Health Summary Components
 - Establish a schedule of regular check-ins (at least quarterly and more frequently, as appropriate)
 - Identify health care services and health-related services that are necessary to support the Member's biological/adoptive parents and promote reunification and develop a plan for the DSS County Child Welfare Worker to make necessary referrals
- Contacting the DSS County Child Welfare Worker within one day when member is admitted to an inpatient level of care, visits an emergency department, experiences a behavioral health crisis, is admitted to an institutional level of care or other congregate settings, experiences disruption in school enrollment, or becomes involved with the justice system
- Supporting members aging out of foster care including developing a Transitional Living Plan and 90-day transition plan

Required Timeframes for Tailored Care Management Activities

The following Tailored Care Management activity timeframes apply to all children/youth receiving Tailored Care Management; the yellow rows indicate activity timeframes that apply solely to children/youth served by the child welfare system

Activity	Timeframe
Share Tailored Care Management enrollment packet with Member, including information on Tailored Care Management assignment options for changing their assignment as part of the Member Welcome Packet	<ul style="list-style-type: none"> At initial NC Medicaid Direct: BH and I/DD Services Launch: 30 days prior to launch After NC Medicaid Direct: BH and I/DD Services Launch: Within 8 days of LME/MCO enrollment
Initiate contact with assigned Members who have been enrolled in in Tailored Care Management to start the care management comprehensive assessment	<ul style="list-style-type: none"> Within 30 days of LME/MCO assignment
Conduct initial meeting between Care Manager and DSS County Child Welfare Worker	<ul style="list-style-type: none"> For members enrolled at launch (4/1): Within 60 days of launch, or earlier, if necessary, to appropriately manage the Member's healthcare needs For members enrolled after launch (after 4/1): Within 3 days, or earlier, if necessary, to appropriately manager the Member's healthcare needs
Contact DSS County Child Welfare Worker in the event the Member is admitted to an inpatient/institutional level of care, visits ED, becomes involved with justice system, or experiences disruption in school enrollment or a BH crisis	<ul style="list-style-type: none"> Within 1 day
Complete Comprehensive Assessment	<ul style="list-style-type: none"> Members identified as high-acuity: Within 45 days of assignment to Tailored Care Management and no longer than 60 days Members identified as medium/low acuity: Within 90 days of assignment to Tailored Care Management
Make care management comprehensive assessment available to Member's PCP, BH, I/DD, TBI and LTSS Providers and the LME/MCO	<ul style="list-style-type: none"> Within 14 days of completion to inform care planning and treatment planning
Comprehensive assessment reassessment	<ul style="list-style-type: none"> At least annually

Required Timeframes for Tailored Care Management Activities

Activity	Timeframe
Complete initial Care Plan/ISP (note: the LME/MCO must not withhold services pending completion of the Care Plan/ISP)	<ul style="list-style-type: none"> • Within 30 days of the completion of the care management comprehensive assessment
Update Care Plan/ISP	<ul style="list-style-type: none"> • At minimum every 12 months, within 30 days of re-assessment, when a Member's circumstances or needs change significantly, at the Member's request or following a change in the Member's foster care placement living arrangement
Document/store and make Care Plan/ISP available to Member and care team members	<ul style="list-style-type: none"> • Within 14 days of completion of the care plan/ISP
Medication management (focus on medication reconciliation/review)	<ul style="list-style-type: none"> • Within 7 days of initial contact with the Member
Ensure post-partum visit with physician	<ul style="list-style-type: none"> • Within 56 days of delivery
Follow up with Member after inpatient/ED discharge	<ul style="list-style-type: none"> • Within 48 hours
Comprehensive Assessment/reassessment following inpatient/ED discharge	<ul style="list-style-type: none"> • Within 30 days
Update Care Plan/ISP following inpatient/ED discharge	<ul style="list-style-type: none"> • Within 90 days of Comprehensive Assessment/reassessment
Reassessment for Members leaving the Child Welfare System but remaining enrolled in the PIHP	<ul style="list-style-type: none"> • Within 90 days of Member leaving the Child Welfare System
Discuss health insurance options for individuals aging out of Medicaid at age 26	<ul style="list-style-type: none"> • 6 months prior to the Member's 26th birthday
Outreach related to high-risk ADT (admission, discharge, transfer) alert	<ul style="list-style-type: none"> • Real-time, same-day or next-day outreach
Care Needs Screening for Members who have opted out of care management	<ul style="list-style-type: none"> • Within 90 days of LME/MCO enrollment

Tailored Care Management Contact Requirements

Organizations providing Tailored Care Management must meet the minimum contact requirements for members according to their acuity tier. The Department will send information about a member's acuity tier to LME/MCOs. Contacts that are not required to be in-person may be telephonic or through two-way real time video and audio conferencing.

Tailored Care Management Contact Requirements		
Acuity Tier	Members with Behavioral Health Needs	Members with an I/DD or TBI
High	At least 4 care manager-to-member contacts per month, including at least 1 in-person contact.	At least 3 care manager-to-member contacts per month, including 2 in-person contacts and 1 telephonic contact
Moderate	At least 3 contacts per month and at least 1 in-person contact quarterly	At least 3 contacts per month and at least 1 in-person contact quarterly
Low	At least 2 contacts per month and at least 2 in-person contacts per year, approximately 6 months apart	At least 1 contact per month and at least 2 in-person contacts per year, approximately 6 months apart

NOTE: For members dually diagnosed with a BH condition and I/DD or TBI, the organizations providing Tailored Care Management shall determine whether the contact requirements for BH or I/DD conditions apply, based on what is clinically appropriate.

CCNC Coordination with DSS for Non-Tailored Care Management Eligible Children/Youth in Foster Care

Care Management from CCNC

- The foster care population is identified as a priority population
- CCNC care managers must work with DSS County Child Welfare Workers to:
 - Closely coordinate, regularly communicating, sharing information, and offering to meet within 7 days of a child/youth's identification as high-risk
 - Conduct a medical history review and screenings (e.g., SDOH)
 - Provide medication management and education
 - Assist with foster family navigation through the health care system
 - Respond to inquiries promptly, as necessary, to appropriately manage the behavioral health needs
 - Coordinate services and supports and linkages to resources to meet the child/youth's care planning needs
 - Support development and implementation of treatment and crisis plans, as well as transition planning for those entering or leaving foster care
 - For members with behavioral health needs, coordinate with LME/MCOs, as needed or requested.

CMARC Coordination with DSS for Non-Tailored Care Management Eligible Children/Youth in Foster Care

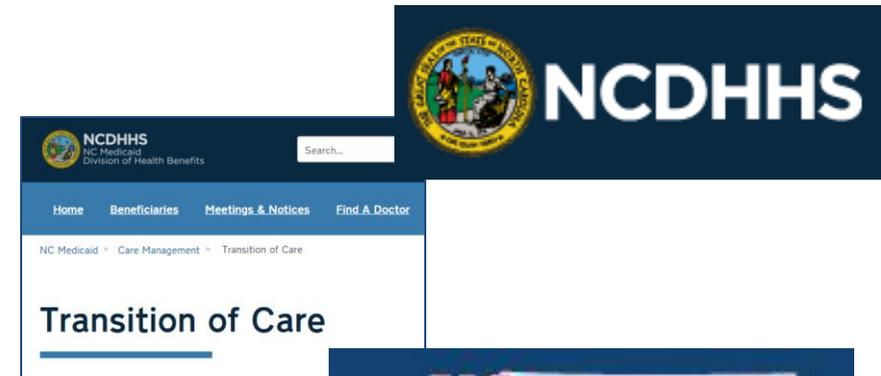
Care Management from CMARC

- CMARC is the primary care management program for children under age 5 in foster care/adoption assistance (unless they are identified as high-risk or prescribed medication)
- CMARC care managers must work with DSS County Child Welfare Workers to:
 - Establish an ongoing relationship
 - Schedule 7-day and 30-day appointments with the established Primary Care Provider
 - Provide referral information and follow up on referrals made for physical and behavioral health services, as well as specialized therapies, pharmacy, vision, and dental services
 - Provide referrals for applicable social determinants of health community resources (e.g. food, housing, transportation, etc.)

Questions & Additional References

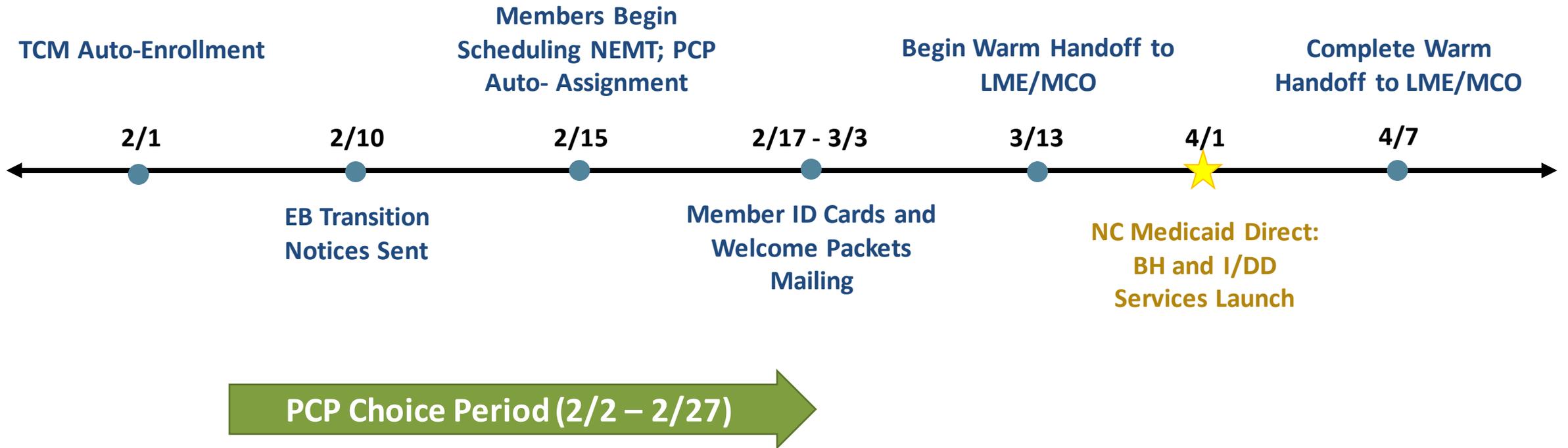
Please Email Questions to:
Medicaid.NCEngagement@dhhs.nc.gov

- NC Medicaid Website: [NC DHHS: North Carolina Department of Health and Human Services](#)
- Tailored Care Management: [Tailored Care Management FAQ](#)
- Transition of Care Policy: [Microsoft Word - NC DHHS Transition of Care Policy Update 1.3 20230101 FINAL](#)
- Medicaid Help Center: [NC Medicaid Help Center - NC Medicaid Help Center \(servicenowservices.com\)](#)
- Provider Support: [NC DHHS: Providers](#)
- Reports Dashboard: [Dashboards | NC Medicaid \(ncdhhs.gov\)](#)



Appendix

Timeline and Major Milestones



Reminder: Overview of Warm Handoff Process for Tailored Care Management

- As children and youth served by the child welfare system become eligible for Tailored Care Management, CCNC must complete a warm handoff to the child's LME/MCO
- These members will be identified on the DHHS "Warm Handoff List" and a CCNC "TOC Warm Handoff summary form."
- The Transferring Entity (CCNC) shares the Warm Handoff member list with the Receiving Entity (LME/MCO)
- The Transferring Entity (CCNC) is expected to produce a TOC Warm Handoff Summary Form for each member identified for a Warm Handoff and a TOC summary page for ALL members disenrolling from the transferring entity (CCNC).

A Warm Handoff is a member specific meeting/knowledge transfer session. CCNC must fill-out a two-page "warm handoff summary sheet" on each transitioning member.



LME/MCO

PIHP must:

- Directly contact the member or their Authorized Representative to confirm continuity of services
- Receive most up to date demographic information on the beneficiary

*CCNC is used as an example here

Transition of Care Policy Highlights

The transferring entity (CCNC) is expected to produce a TOC Warm Handoff Summary Form for each member identified for a Warm Handoff and a TOC summary page for ALL members disenrolling from the transferring entity (CCNC). This summary should include, the following details:

- List of current providers
- List of current authorized services
- List of current medications
- Foster Care Information
- DSS Child Welfare Worker
- Active diagnoses
- Known allergies
- Existing or prescheduled appointments, including Non-Emergency Medical Transportation (NEMT), as known
- Any urgent or special considerations about a member's living situation, caregiving supports, communication preferences or other Member- specific dynamics that impact the Member's care and may not be readily identified in other transferred documents
- Additional information as needed to ensure continuity of care

Summary of Care Management Supports for Medicaid Direct Enrollees

NC Medicaid Direct Care Management Overview				
Not Tailored Care Management Eligible				Tailored Care Management Eligible
Physical Health Services		Behavioral Health Services		Physical and Behavioral Health Services
Program	Primary Care Case Management (PCCM)	Care Management for At-Risk Children (CMARC)	Prepaid Inpatient Health Plan (PIHP)	Tailored Care Management
Service Entity	Community Care of North Carolina (CCNC)	Local Health Departments	Local Management Entity/Managed Care Organization (LME/MCO)	Prepaid Inpatient Health Plan (PIHP)
Delivery Model	Statewide	County Based	Regional	Regional
FC Populations Served	All Ages	Foster Care Youth Age 0 to Age 5	Foster Care Youth with a Diagnosis of BH, I/DD, TBI, SUD	Foster Care Youth who meet Tailored Care Management eligibility criteria
Key Services Provided	<ul style="list-style-type: none"> Care Needs Screenings Comprehensive Assessment Transitional Care services (for PCCM and CMARC enrollees) Care Plan development and support with health goal setting Medication Management (for PCCM and CMARC enrollees) Assistance with obtaining medical appointments, referrals, and DME Service utilization monitoring SDOH need identification and resource linkage Collaboration with LME/MCO care coordinators for children needing intensive BH services 	<ul style="list-style-type: none"> Care Plan development and support with health goal setting Assistance with obtaining medical appointments, referrals, and DME Service utilization monitoring Developmental Screenings with members who have been referred for adverse childhood experiences (ACE's) or Toxic Stress Face to Face visits Foster Care Referrals Plan of Safe Care (POSC) referrals Neonatal Intensive care unit referrals SDOH need identification and resource linkage 	<ul style="list-style-type: none"> Transitional Care Assessment Educate and connect enrollees to clinically relevant mental health, I/DD, TBI, and SUD services and supports Coordinate Behavior Health specialist appointment setting and referrals Provide 24/7 Behavioral Health Crisis Support 	<ul style="list-style-type: none"> Comprehensive Assessments and care planning/individual support planning Innovations and TBI waiver care coordination (if applicable) Coordination of services and consultation with multidisciplinary care team Transitional care management Diversion from institutional settings Addressing unmet health-related resource needs Management of rare diseases and high-cost procedures; high-risk care management; chronic care management Medication monitoring
Link to Learn More	Home Community Care of North Carolina (communitycarenc.org)	Care Management for At-Risk Children (CMARC) NC Medicaid (ncdhhs.gov)	NC DHHS: LME/MCO Directory	Tailored Care Management NC Medicaid (ncdhhs.gov)

FAQs About Medicaid Coverage for Children Entering Foster Care

WHAT HAPPENS IF A CHILD ENROLLED IN A HEALTH PLAN ENTERS FOSTER CARE?

Once the local Department of Social Services (DSS) Medicaid program is aware that a child has entered foster care, the Medicaid caseworker adds foster care evidence in NC FAST, NCDHHS' eligibility system.

- If a child is enrolled in a Standard Plan at the time they enter foster care, the child will be disenrolled from the Standard Plan and transitioned back to NC Medicaid Direct.
- When the child transitions to NC Medicaid Direct, the Standard Plan works with NC Medicaid Direct care management providers to coordinate the transition of care management, services, and supports.

WHAT IS THE HEALTH PLAN DISENROLLMENT PROCESS TIMELINE?

During the first month of the child's placement in foster care, Medicaid and Child Welfare staff coordinate to update the child's eligibility evidence in NC FAST.

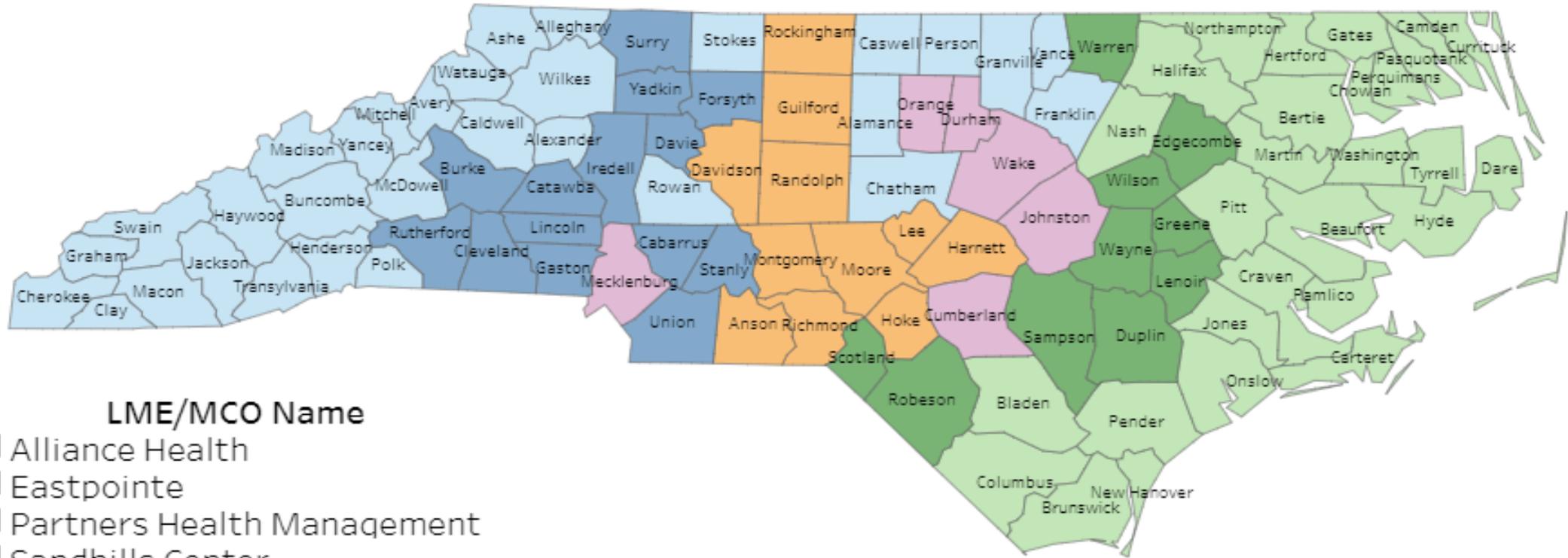
- The new foster care evidence on the child's case will then trigger a change in their Managed Care Status in NC FAST (and NCTracks by the next Business Day)
- The child will then be flagged to receive Medicaid coverage under NC Medicaid Direct, **retroactive to the first day of the month** that the child entered foster care.
- Medicaid coverage can be made retroactive by up to **three (3) months** if medically necessary, removing the barrier to timely access to care.

HOW DOES THE HEALTH PLAN DISENROLLMENT PROCESS IMPACT HOW PROVIDERS SHOULD SUBMIT CLAIMS?

When seeing a foster care youth, providers can look up their eligibility in NCTracks and either bill the SP or NC Medicaid Direct.

- If you are not contracted with the Standard Plan, you can still provide services and then wait to bill NC Medicaid Direct.
- If the child's caseworker is processing the Medicaid application for the first time, you can still provide services and then wait to bill NC Medicaid Direct.
- Claims may be submitted up to **one year post the date that service was provided**, allowing time for foster care youth to transition back to NC Medicaid Direct.

LME/MCO Map



LME/MCO Name

- Alliance Health
- Eastpointe
- Partners Health Management
- Sandhills Center
- Trillium Health Resources
- Vaya Health

This map shows LME/MCO configuration as of 2/1/22.

LME/MCO Contact Information

Alliance Health Office

5200 Paramount Parkway, Suite 200

Morrisville, NC 27560

Phone: 919-651-8401

Fax: 919-651-8672

Crisis Line: 877-223-4617

Counties Served: Cumberland, Durham, Johnston, Mecklenburg, Orange, Wake

Trillium Health Resources Office

201 W. First Street

Greenville, NC 27858-1132

Phone: 866-998-2597

Crisis Line: 877-685-2415

Counties Served: Bladen, Brunswick, Carteret, Columbus, Halifax, Nash, New Hanover, Onslow, Pender, Beaufort, Bertie, Camden, Chowan, Craven, Currituck, Dare, Gates, Hertford, Hyde, Jones, Martin, Northampton, Pamlico, Pasquotank, Perquimans, Pitt, Tyrrell, Washington

Eastpointe Office

514 East Main Street

Beulaville, NC 28518

Phone: 800-913-6109

Fax: 910-298-7180

Crisis Line: 800-913-6109

Counties Served: Duplin, Edgecombe, Greene, Lenoir, Robeson, Sampson, Scotland, Warren, Wayne, Wilson

Vaya Health

200 Ridgefield Court, Suite 206

Asheville, NC 28801

Phone: 828-225-2785

Fax: 828-225-2796

Crisis Line: 800-849-6127

Counties Served: Alamance, Alexander, Alleghany, Ashe, Avery, Buncombe, Caldwell, Caswell, Chatham, Cherokee, Clay, Franklin, Graham, Granville, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Person, Polk, Rowan, Stokes, Swain, Transylvania, Vance, Watauga, Wilkes, Yancey

Partners Health Management Office

901 South New Hope Road

Gastonia, NC 28054

Phone: 704-884-2501

Fax: 704-884-2713

Crisis Line: 833-353-2093

Counties Served: Burke, Cabarrus, Catawba, Cleveland, Davie, Forsyth, Gaston, Iredell, Lincoln, Rutherford, Stanly, Surry, Union, Yadkin

Sandhills Center Office

1120 Seven Lakes Drive

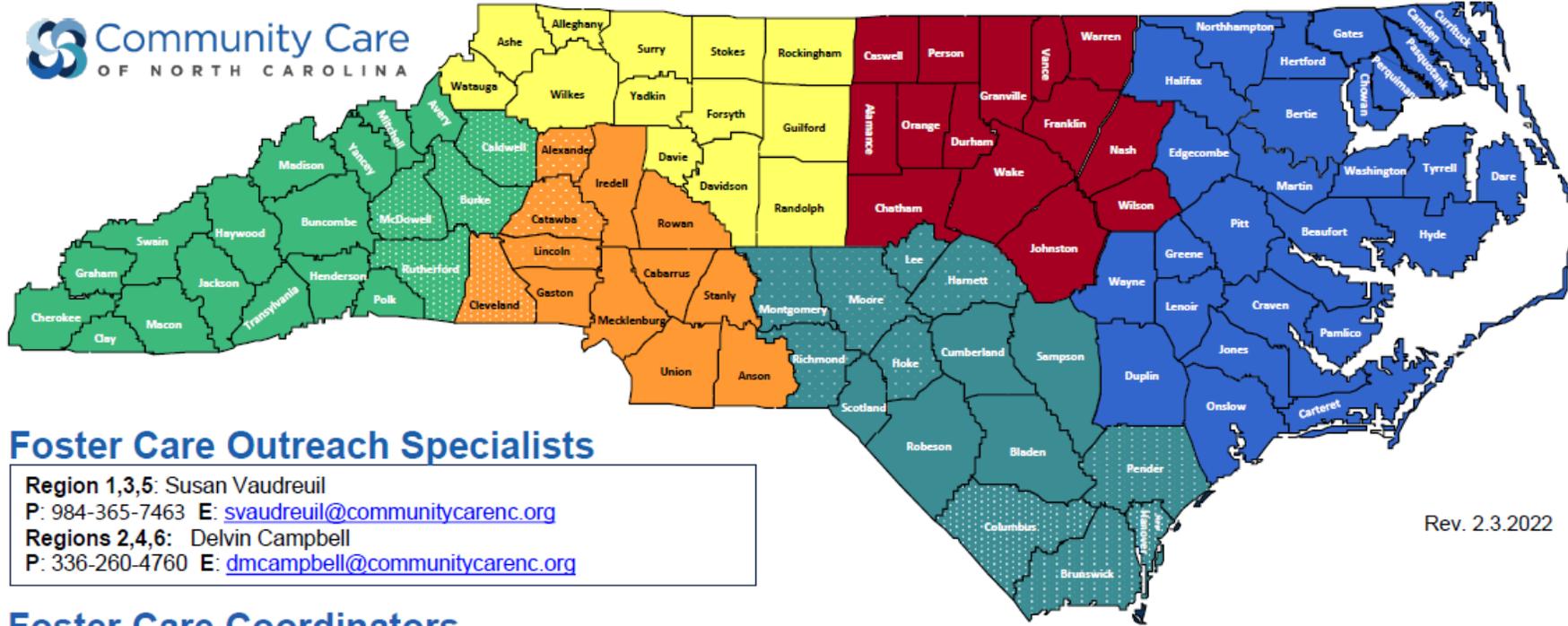
West End, NC 27376

Phone: 910-673-9111

Fax: 910-673-6202

Crisis Line: 800-256-2452

Counties Served: Anson, Davidson, Guilford, Harnett, Hoke, Lee, Montgomery, Moore, Randolph, Richmond, Rockingham



Rev. 2.3.2022

Foster Care Outreach Specialists

Region 1,3,5: Susan Vaudreuil
P: 984-365-7463 **E:** svaudreuil@communitycarenc.org
Regions 2,4,6: Delvin Campbell
P: 336-260-4760 **E:** dmcampbell@communitycarenc.org

Foster Care Coordinators

Region 1:
 Jennifer Jones
P: 828-772-6282 **E:** jwjones@communitycarenc.org
 Brandy Garcia
P: 828-244-8950 **E:** brgarcia@communitycarenc.org
Counties: Burke, Caldwell, McDowell, Rutherford

Region 2: Melissa Graves
P: 336-312-3950 **E:** mcgraves@communitycarenc.org

Region 3:
 Katelyn Mullins
P: 704-214-6312 **E:** kmullins@communitycarenc.org
 Brandy Garcia
P: 828-244-8950 **E:** brgarcia@communitycarenc.org
Counties: Alexander, Catawba, Cleveland, Lincoln

Region 4: Sara Owens
P: 919-896-1031 **E:** sowens@communitycarenc.org

Region 5:
 Bobbie McLaughlin
P: 910-690-6749 **E:** bmclaughlin@communitycarenc.org
Counties: Harnett, Hoke, Lee, Montgomery, Moore, and Richmond
 Laurie Jacobs
P: 910-523-8575 **E:** ljacobs@communitycarenc.org
Counties: Bladen, Cumberland, Robeson, Sampson, and Scotland
 Steve Taylor
P: 910-995-8115 **E:** sctaylor@communitycarenc.org
Counties: Brunswick, Columbus, New Hanover, and Pender

Region 6: Dana Franklin
P: 252-424-9269 **E:** dhfranklin@communitycarenc.org