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UPDATE ON MEDICAID TRANSFORMATION

The day after the November 19th webinar, NC DHHS released a statement that Medicaid Transformation had been suspended until the budget impasse is resolved. A few points related to the suspension:

- There is NO IMPACT on Medicaid beneficiaries and their services. All services will continue to be provided as they have been.
- Open enrollment is also suspended. This means that Medicaid beneficiaries do NOT need to select a Prepaid Health Plan for the Standard Plan before December 13th.
- The Enrollment Broker Call Center will be operational until December 13th to answer questions for Medicaid beneficiaries. Beneficiaries can continue to contact the Medicaid Contact Center (888-245-0179).
- The **NC DHHS Medicaid Transformation website** indicates that providers should continue to contract with health plans.
- The NC General Assembly will be back in session on January 14, 2020 and may take up the budget veto and related issues at that time.

A. Medicaid Beneficiary Enrollment

1. **How does a family/individual know about the different medical plans? How can families/individuals make an informed decision over the telephone?** Right now, only Medicaid beneficiaries who are assigned to the Standard Plan or have the option to be in the Standard Plan are choosing a Prepaid Health Plan/Standard Plan. Every Prepaid Health Plan/Standard Plan offers the same medical and behavioral health services that are covered by Medicaid. So comparisons amongst the Prepaid Health Plan/Standard Plans can be related to things like special benefits, hours of operation, providers who are in their network. All of that information can be accessed through the Medicaid Enrollment Broker:
    - Review enrollment information at ncmedicaidplans.gov or the NC Medicaid mobile app
    - Call the Enrollment Broker at 1- 833-870-5500 (TTY: 1-833-870-5588)
    - Webchat the Enrollment Broker at ncmedicaidplans.gov

When you call or webchat with an Enrollment Broker Specialist, you do not need to make a decision. You can do that after you have researched it and have had questions answered—when you are comfortable that you have the information needed to make a decision. You have until December 13, 2019 to make that decision.

2. **Will enrollment packages be sent to each Medicaid beneficiary or each household? What will the envelope with the enrollment information that is coming in the mail look like? Manilla envelope or standard? Will it have the DHHS logo?** According to the Enrollment Broker Specialist, how the information will be sent out—to an individual, authorized representative or household--can actually vary across counties. **It is an important time to receive information so any Medicaid beneficiary is encouraged to open all mail they receive from NC DHHS and their local department of social services.** The reason for variation in how it is addressed is because it is based on how DSS has entered information for each family or beneficiary. Regardless of how it is sent, the actual information that is sent is the same statewide. These reminders have been in the form of a formal letter notifying the beneficiary of their eligibility in the Medicaid Managed Care Implementation, the enrollment packet, postcard reminders, and reminders for Medicaid beneficiaries that would have been a part of Phase 1 but are now included in the statewide implementation.

3. **When do individuals receive the Health Plan book (enrollment materials)? Will individuals who are staying in NC Medicaid Direct and with LME/MCOs receive anything?** Enrollment packages were mailed back in July 2019 for some Medicaid beneficiaries who live in the counties where managed care implementation was originally scheduled to begin in November 2019. On October 1, 2019, enrollment packages were beginning to be mailed to all Medicaid beneficiaries who qualify for the Standard Plan and all Medicaid beneficiaries who have the OPTION to be in the Standard Plan.

   One big category of Medicaid beneficiaries who will have the OPTION to be in the Standard Plan are those individuals with intellectual-developmental disabilities who are waiting for an Innovations Waiver slot. Each person on the waiting list will be able to choose to be on the Standard Plan while he/she is waiting for that Innovations Waiver slot. But keep in mind, State-funded services are ONLY available through the LME/MCOs (later to be the BH/IDD Tailored Plans). So someone on the waiting list could lose services they are currently getting if the services are State-funded and the person chooses to go under the Standard Plan.

4. **What if families do nothing to sign up for a new plan? What if a family or individual realizes they signed up for the wrong plan or the plan does**

not address their needs? The open enrollment period to choose a Standard Plan ends on December 13, 2019 for all Medicaid beneficiaries who are eligible for the Standard Plan. You should not have received an enrollment package if you do not qualify for or have the option to be in Standard Plan. On December 16, 2019, NC DHHS will begin AUTO-ASSIGNMENT for individuals who qualify for the Standard Plan. That means that any Medicaid beneficiary who qualifies and has not self-selected a Standard Plan will be assigned one by NC DHHS. That individual will be able to switch Standard Plans for 90 days after the go live date of the Standard Plans, currently February 1, 2020, without question. If you had the option of enrolling in the Standard Plan but did not take any action, you will remain with the LME/MCO.

5. **What are the metrics used in the algorithm that will be used for auto-assignment to the Standard Plan?**
   The auto-assignment algorithm for the crossover population is defined according to the following components, in this order:
   1. Whether beneficiary is a beneficiary of a special population (e.g., foster care, BH I/DD TP eligible, a member of a federally recognized tribe);
   2. Beneficiary's geographic location;
   3. Historic provider-beneficiary relationship if available in recent claim data;
   4. Plan assignments for other family members; and
   5. Equitable plan distribution with enrollment subject to PHP enrollment ceilings and floors.

   The auto-assignment algorithm for beneficiaries enrolled **after crossover open enrollment** is defined according to the following components, in this order:
   1. Whether beneficiaries are members of a special population (e.g., foster care, BH I/DD TP);
   2. Plan assignments for other family members;
   3. Beneficiaries' geographic location;
   4. Previous PHP enrollment during previous 12 months (for those who have churned on/off Medicaid managed care); and
   5. Equitable plan distribution with enrollment subject to PHP enrollment ceilings and floors.

   Source: NC DHHS, page 9, "Beneficiaries in Managed Care", https://files.nc.gov/ncdhhs/documents/BeneficiariesInManagedCare_ConceptPaper_FINAL_20180309.pdf

6. **Does the Enrollment Broker know the added benefits each Standard Plan will offer?** Yes, NC DHHS has been distributing a Health Plan comparison chart that shows the different additional benefits that each PHP is offering to Medicaid beneficiaries in the Standard Plan. You can compare the

plans and the special benefits they are offering in your county by going to: https://ncmedicaidplans.gov/choose/compare-plans-1.

7. **Is the Enrollment Broker able to counsel an individual with IDD who is on the Innovations waitlist on the potential loss of State services if he/she is considering a move to the Standard Plan until a slot opens? Is there a way for the Enrollment Broker to have flagged information on households where there are family members with different needs and on different Plans so that they can assist in a more useful way?** If you want the Enrollment Broker Specialist to help you in choice counseling based on the services you have been receiving, you will need to **self-identify** the services and needs you or the beneficiary who you are representing has. That way the Enrollment Broker is able to counsel individuals with IDD who may be on the Innovations waitlist and will lose State services if they move to the Standard Plan. The Enrollment Broker Specialists have a script that they must read outlining that the individual will lose benefits if a Medicaid beneficiary makes the switch. An Enrollment Broker Specialist doesn't have any way of knowing specifics about your service needs from the NC FAST database. NC FAST is the information system the Enrollment Broker has access to and it is the one that DSS uses for eligibility. It does not have service and diagnostic information. Therefore, the Enrollment Broker will only be able to see if you have "Medicaid for disabled" or "Medicaid for Infants and Children." Because of this it is important to **self-identify** so that the Enrollment Broker can best counsel you or your family on the plans that will best serve each Medicaid beneficiary.

According to the NC DHHS guidelines, the Enrollment Broker, at a minimum, will be able to:

- Accept BH I/DD Tailored Plan eligibility information from the Department and use to support choice counseling and PHP selection;
- Accept from the Department updates on beneficiaries who the Department determines to be eligible to enroll in BH I/DD TP either through historical claims analysis or other means;
- Train staff to provide consumer-specific supports to BH I/DD TP population to support plan choice;
- Provide choice counseling to enrollees who meet the BH I/DD TP eligibility criteria and explain the differences in covered BH and I/DD services between standard plans and LME-MCOs, and that the standard plan enrollees will not be able to access services covered by only the LMEMCOs; and
- After launch of BH/IDD TPs, accept and act on requests for transfers from standard plans to BH I/DD TPs as allowable by the Department.

SOURCE:
https://files.nc.gov/ncdhhs/documents/BeneficiariesInManagedCare_ConceptPaper_FINAL_20180309.pdf

8. **If an individual gives the Enrollment Broker Specialist their NCID, will they then know if the individual has been assigned to the Standard or Tailored plan?** Yes, the Enrollment Broker has access to the data that is in the State's eligibility database, NC FAST. NC FAST does tell the Enrollment Broker Specialist which Plan a beneficiary is in.

9. **Where do you get the NCID number?** The process for applying for Medicaid through your county department of social services has not changed. If you have already done that, you should have a NCID (or Medicaid) number. If you need to request a replacement card, you should contact your county department of social services. As of the go live date of the Standard Plans, currently February 1, 2020, if you are with a Standard Plan, you will request a replacement card through your assigned Standard Plan.

10. **What is the difference between NC Medicaid Direct and NC Medicaid managed care? What populations will stay under NC Medicaid Direct?** NC Medicaid Direct is fee-for-service. That means that the Medicaid beneficiary can go to any provider who is enrolled with Medicaid and that provider will bill NC Medicaid directly for that service. NC Medicaid Direct does not offer any care management services.

    Under NC Medicaid managed care, a Medicaid beneficiary chooses a health plan that they qualify for. That health plan, which could be a Standard Plan or the LME/MCO (later to be a Tailored Plan), has a network of providers from which the beneficiary may receive services. NC Medicaid managed care also offers a Medicaid beneficiary care coordination or care management services. A care manager can assist the Medicaid beneficiary in navigating the system and in ensuring that all of the physical, behavioral, pharmacy and unmet health needs of that beneficiary are coordinated.

    A key thing to know is that anyone who is staying with the LME/MCOs right now is also in NC Medicaid Direct for their physical healthcare. The Standard Plans are integrated in that they cover physical and behavioral healthcare as well as pharmacy services.

    Other populations that will stay with NC Medicaid Direct include:
    - Beneficiaries dually eligible for Medicaid and Medicare
    - Program of all-inclusive care for the **elderly** (PACE) beneficiaries

- Medically needy beneficiaries (those with high medical expenses whose income exceeds the maximum threshold, but who would otherwise qualify)
- Beneficiaries eligible for only emergency services
- Presumptively eligible enrollees during the period of presumptive eligibility (gives uninsured people immediate, temporary Medicaid if they appear to be eligible based on income)
- Health insurance premium payment (HIPP) beneficiaries (if you are at risk of losing or cannot use your private health insurance because you have a high-risk illness and cannot pay your premiums)
- Family planning beneficiaries (is designed to reduce unintended (unplanned) pregnancies and improve the well-being of children and families in North Carolina)
- Prison inmates

To learn more about NC Medicaid Direct, call **1-888-245-0179**.

11. **When there are two families in one household, can there be two points of contact for Medicaid?** Yes. Even while living at the same address, each family will have a "head of household" or authorized representative. This person will serve as the main point of contact between the family and North Carolina Medicaid.

12. **Can family members have different Plans within one household?** Yes. The NC Medicaid Managed Care plans are not per family. Rather, each individual family member will be enrolled in a plan that meets their needs. In this way, the needs of each family member will be met.

13. **Are all 5 Standard Plans in all 100 counties of North Carolina? If not, what do families do?**
    Four of the Standard Plans are in all 100 counties of North Carolina and they are:
    - AmeriHealth Caritas
    - Healthy Blue
    - United Healthcare
    - Wellcare

    There is one Standard Plan, Carolina Complete Health, which will only be available to Medicaid beneficiaries who live in Regions 3, 4 and 5. Medicaid beneficiaries who live in Regions 3, 4 and 5 are the only ones who have a choice of all 5 of the Standard Plans. To know which counties are in Regions 3, 4 and 5, go to: https://files.nc.gov/ncdhhs/medicaid/Managed-Care-Regions-and-Rollout.pdf

14. **At what age can a Medicaid beneficiary use the Enrollment Broker Services directly without parental/guardian assistance?** Medicaid beneficiaries that are minors can call in and use the Enrollment Broker services directly at any time if they are able to provide their Medicaid information and answer questions without being coached by another person.

B. Eligibility

1. **What does a family/individual do if the medical plan they select does not provide the current services they are receiving?** Let's start with the foundation of the Standard and Tailored Plans. We know that:
    - Every Prepaid Health Plan that is a Standard Plan will offer the same basic medical and behavioral health services within their Plan. Every LME/MCO also offers the same basic mental health, substance use disorder and intellectual/developmental disability services across all LME/MCOs.
    - If you are currently in a service that is ONLY offered through the LME/MCOs (and later through the BH/IDD Tailored Plan), you will automatically remain with the LME/MCO.

    The bottom line is that you should not lose your current service just because of this transition to managed care. If you do lose your current service, talk with your provider to understand if it is because you no longer medically need the service or for another reason. Your provider can assist you in straightening this out.

2. **Can families/individuals currently on the Innovations Waiver decide what plan they want to be on?** No, Medicaid beneficiaries who are on the Innovations Waiver will remain with the LME/MCOs for their IDD services and with NC Medicaid Direct for their physical healthcare services for now. On July 2021, Medicaid beneficiaries who are on the Innovations Waiver will transition to the BH/IDD Tailored Plan where their IDD services and physical health services will be integrated under the Tailored Plan. At this point in time, individuals who stay with the LME/MCOs and who will be under the Tailored Plans do not have a choice of plans. They are offered, to the extent possible, a choice of providers.

3. **What happens to IDD beneficiaries who make changes? Are they dropped from their current provider?** All Medicaid beneficiaries with an IDD diagnosis are qualified to receive services under the LME/MCO (to be the BH/IDD Tailored Plan in July 2021). Some of these individuals are waiting for a slot to open on the Innovations Waiver. These individuals may be receiving

State-funded IDD services while they are on the waiting list. State-funded IDD services are ONLY available through the LME/MCOs. State-funded IDD services will NOT be available under the Standard Plan. Therefore, if a Medicaid beneficiary who uses IDD services chooses to move to a Standard Plan, he/she could possibly lose a service they are receiving if it is a State-funded IDD service.

4. **How does the State know which is the appropriate plan for families and individuals currently on Innovations Waiver?** Let's remember that each Medicaid beneficiary will be assigned to a Plan based on his/her individual needs and not by family. If a Medicaid beneficiary is on the Innovations Waiver, he or she can ONLY be with the LME/MCO right now and with the BH/IDD Tailored Plan beginning on July 2021. That individual will also continue receiving his or her physical healthcare through NC Medicaid Direct (fee-for-service) until the Tailored Plan goes into effect in July 2021.

5. **Is this mostly for those that have Medicaid as their primary insurance? If your secondary insurance is Medicaid, do you still have to select a Plan?** Even if Medicaid is your secondary insurance, you may still qualify for the Standard Plan. In that case, you will have to select a Standard Plan.

6. **How does a youth transitioning to adulthood who turns 18 years old continue to receive services?** Eligibility for Medicaid as an adult, just as is the case for children, is processed through the local department of social services. In the circumstance of a child who has been in the foster care system through to the age of 18, they may be eligible for the expanded Foster Care Program through age 20 or for Medicaid under the category of "Medicaid to Former Foster Care Children" up to 26 years old.

7. **How will the Standard Plan implementation impact Medicaid for One?** Medicaid eligibility requirements have not changed in any way through this Medicaid Transformation. Therefore, Medicaid for One (also known as Family of One) HAS NOT CHANGED.

C. Services Within the Standard Plans or LME/MCOs (Tailored Plans)

1. **What happens when someone is put in the Standard Plan and has to switch to Tailored Plan because of a hospitalization or two? Who pays in the interim even with the expedited process, while it is being reviewed?** If a Medicaid beneficiary becomes qualified for LME/MCO services (later to be the BH/IDD Tailored Plan) while they are in the hospital, their Standard Plan will continue to pay for inpatient care. Inpatient care is covered under the Standard Plan. The Standard Plan will also be responsible

for processing the transition to the LME/MCO (later to be the Tailored Plan), if that individual becomes qualified for the LME/MCO services.

2. **How will this impact mental health outpatient therapy?** Outpatient behavioral health services provided by direct-enrolled providers and outpatient opioid treatment services are a part of the Standard Plan benefit package that every Prepaid Health Plan will offer. These services are also covered under the LME/MCO (and under the BH/IDD Tailored Plan beginning in July 2021).

3. **What happens if a specialty isn't available in a certain network, does that mean transportation is going to be provided to a place that is farther away if medically necessary?** If that service is a part of the benefit package and it is medically necessary for the Medicaid beneficiary, it is the responsibility of the Plan manager to ensure that service is accessible to the Medicaid beneficiary. The Plan manager is also responsible for ensuring that the beneficiary can get to the service or the service can come to the beneficiary.

4. **How will transportation be handled?** Non-Emergency Medical Transportation (NEMT) scope of service, per the DHHS fact sheet, WILL NOT CHANGE:

   For all beneficiaries – NC Medicaid Managed Care and NC Medicaid Direct – transportation will be available if the beneficiary receives a Medicaid covered service provided by a qualified Medicaid provider (enrolled as a North Carolina Medicaid and NC Health Choice provider). Medicaid only pays for the least expensive means suitable to the beneficiary's needs.

   For beneficiaries in the **Standard Plan**, the PHP in which the beneficiary is enrolled for Medicaid will provide the transportation. PHPs/Standard Plans will be contracting with statewide and regional NEMT brokers to arrange and provide NEMT to enrolled members.

   For beneficiaries in **NC Medicaid Direct/LME/MCOs**, county DSS agencies will continue to arrange NEMT. Counties will continue to follow North Carolina NEMT policies, and providers will continue to bill NC Medicaid directly for reimbursement. Remember that, if you are with the LME/MCO, your physical healthcare is provided under NC Medicaid Direct.

5. **How do we increase providers within plans?** Generally, DHHS looks at provider networks to determine if they are **adequate**. Both PHPs and

LME/MCOs have to meet provider network adequacy. How do they define adequate? The network should be sufficient to provide adequate access to all services covered under the Medicaid and NC Health Choice programs for all beneficiaries, based on standards developed by the State. North Carolina's network adequacy standards include time and distance standards for providers who serve adult and pediatric beneficiary needs. To recognize the special needs of accessibility to behavioral health services, the standards will include specific measurements for those services.

Source: DHHS, "Network Adequacy", page 2
https://files.nc.gov/ncdhhs/documents/NetworkAdequacy_ConceptPaper_Final_20180215.pdf

6. **Will the physical healthcare part of the Tailored Plans also be a closed network?** No, when the BH/IDD Tailored Plans go live in July 2021, they will be operating the physical health services under the 1115 Medicaid waiver. An 1115 Medicaid waiver has different requirements than the current Medicaid waiver that LME/MCOs are under. One of those different requirements is that the provider network is OPEN. This means that the Tailored Plan will accept into their network any willing Medicaid provider for the physical health care services.

7. **Will every doctor be a provider with ALL plans?** Any doctor who wishes to provide services to Medicaid beneficiaries in the Standard Plan, will have to first be accepted and credentialed by NC Medicaid and then must have a contract with each Standard Plan they would like to be in network with. Doctors who accept Medicaid will not automatically be included in every Standard Plan.

8. **Can parents schedule appointments now for their Medicaid-eligible children for services such as physicals and, if the provider isn't in network with the PHP, will the appointment still be honored/paid for by Medicaid?** *We do not have an answer for this question at this time. We have requested a response from NC DHHS.*

9. **Will providers be paid for some period of time (e.g. a grace period) if a Medicaid beneficiary presents at a provider office where they have received services in the past and the provider turns out not to be in network with the individuals plan?** *We do not have an answer for this question at this time. We have requested a response from NC DHHS.*

D. Services Outside of the Standard Plans or LME/MCOs (Tailored Plans)

1. **What happens to the people who are getting State funds? Those who don't qualify for Medicaid and have no insurance. Will there still be State (formerly known as IPRS) funds?** State-funded services will still be available to those individuals who do not qualify for Medicaid or are waiting for an Innovations Waiver slot to open. There are limited State funds and it is not an entitlement program like Medicaid, therefore individuals who are uninsured are NOT guaranteed to receive a service even if it is medically needed.

2. **There are some behavioral health services that Medicaid does not currently cover for ages under 3. Having managed care now, will all services under the Plan the individual qualifies for be inclusive to all ages?** The 0-3 population of Medicaid beneficiaries will be placed in a Plan (Standard Plan, LME/MCO or NC Medicaid Direct) based on the same eligibility requirements as any other Medicaid beneficiary.

3. **To what extent can CDSAs currently bill through Medicaid? Are there plans to expand their Medicaid billing capacity in the future?** Children's Developmental Service Agencies (CDSAs) are currently able to bill through Medicaid and that will not change. They are considered a provider that will continue under NC Medicaid Direct and, therefore, do not have to be in a network with a Standard Plan or LME/MCO. CDSAs will bill by each service unit provided directly to NC Medicaid regardless of what Plan the beneficiary is in.

4. **To what extent can Local Education Agencies currently bill through Medicaid? Are there plans to expand their Medicaid billing capacity in the future?** Local Education Agencies are currently able to bill through Medicaid and that will not change. They are considered a provider that will continue under NC Medicaid Direct and, therefore, do not have to be in a network with a Standard Plan or LME/MCO. LEAs will bill by each service unit provided directly to NC Medicaid regardless of what Plan the beneficiary is in.

5. **Will NC Pre-K children who receive speech therapy that is sometimes billed through Medicaid still receive that service and funding?** These services will not be changed and will continue to be offered under NC Medicaid Direct. A Medicaid beneficiary, even those who are in the Standard Plan or LME/MCO (later to be Tailored Plan), will be covered through Medicaid as they have been before.

E. Transitions of Care

1. **What is the role of the Plan manager in a transition of care from the Standard Plan to the Tailored Plan?** Standard Plan managers are responsible for covering episodes of care and the Standard Plan benefit package includes inpatient and emergency services—where many beneficiaries will be when they may require a transition to the Tailored Plan. If a Medicaid beneficiary meets medical necessity for a level of service that is not included in the Standard Plan benefits, it is the role of the Standard Plan to process the request for transition to the LME/MCO (later to be the Tailored Plan). NC DHHS has developed timeframes by which they will consider transition requests that are up to 48 hours for expedited requests and up to seven calendar days for other transition requests.

2. **If a family switches to the Tailored Plan, are there any penalties?** Families will NOT have any penalties if their family member switches to the Tailored Plan. A Medicaid beneficiary can only switch to the Tailored Plan if he/she has a specific diagnosis and requires services that are only available under the Tailored Plan. It will be up to NC DHHS to decide if a Medicaid beneficiary is eligible for the Tailored Plan.

3. **When DJJ staff believes that a child requires Tailored Plan services, but the child is currently in the Standard Plan, what is the process the DJJ staff should use to have that reviewed?** If DJJ staff have obtained a signed release from the Medicaid beneficiary allowing them to interact with the beneficiaries providers, they may wish to establish a relationship with the child's care manager/Advanced Medical Home as soon as possible. The care manager is in a position to make recommendations related to the beneficiaries care.

4. **Does admission to the State Hospital trigger the process for a Medicaid beneficiary to be moved to the Tailored Plan? Is that the responsibility of the State hospital?** *We do not have an answer for this question at this time. We have requested a response from NC DHHS.*

F. General

1. **Why do all counties have to be switched at the same time? NC DHHS was going to address the bugs on a smaller scale before having everyone switch. That seemed like a better idea.** NC DHHS originally intended to have a staggered start to Medicaid Managed Care. One of the benefits to a staggered start would have been to resolve any issues in processes prior to Medicaid Managed Care statewide implementation. A significant reason that NC DHHS has gone to a statewide implementation plan is because the budget impasse between the Governor and the NC

General Assembly has delayed the availability of any new funding. The budget bill includes over $200 million of new, one-time funding that would be transferred to NC DHHS for them to pay for this shift to managed care. Presumably, without that funding, making this shift would be too difficult and potentially disrupt services for Medicaid beneficiaries.

2. **How can families give ongoing input into the user-friendliness of forms and processes?** Many of the forms and processes will be specific to the Standard Plan or LME/MCO. In that case, you can contact the member services section of your Plan. To give input at the State level on forms and processes that NC DHHS is using:

   Email: Medicaid.Transformation@dhhs.nc.gov

   US Mail:

   Department of Health and Human Services
   Division of Health Benefits
   1950 Mail Service Center
   Raleigh, NC 27699-1950

   Drop-off:

   Dorothea Dix Campus
   Department of Health and Human Services
   Adams Building Reception
   101 Blair Drive
   Raleigh, NC 27603

3. **What costs are associated with the new plan?** If we are talking about co-payments, that answer would have to be answered on a beneficiary-by-beneficiary basis and possibly even by service. We would encourage you to contact the Enrollment Broker either by phone or webchat to talk about your specific Medicaid benefits.

G. Foster Care and Adoption Assistance

Questions related to foster care and adoption assistance are important. NC DHHS is currently developing a strategy/plan to address foster care and adoption assistance. We do not have answers to the questions below at this time.

1. What has been decided about children in the foster care system and how they fit into the Medicaid Transformation?

2. What has been decided about children who qualify for adoption assistance and how they fit into the Medicaid Transformation?

3. Will Medicaid Transformation resolve the issue of Medicaid county of residence? What will happen when someone in the foster care system switches schools out of county and it changes from one LME/MCO to another and the funds are held up because the home is still in the other county? Will this continue to be an issue under the new system? How will it be addressed?

4. What steps do individuals in the foster care system have to take if they turn 26, still need services, and no longer qualify for their parents/legal guardians health insurance and have qualified for Medicaid in the past? Will they automatically receive a Medicaid card**?** We do know that they will not automatically receive a Medicaid card. That individual will need to work with their local department of social service to review their eligibility for Medicaid as an adult.

5. What is put in place for youth who phase out of the NC LINKS program from DSS?