NC Medicaid Managed Care
Policy Paper

Update on North Carolina's Children and Families Specialty Plan

North Carolina Department of Health and Human Services
Division of Health Benefits

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Contents

I. Background

In September 2023, the North Carolina legislature authorized the North Carolina Department of Health and Human Services (NCDHHS) to issue a Request for Proposals (RFP) to procure the Children and Families Specialty Plan (CFSP)[1] —a single, statewide NC Medicaid Managed Care plan that will support Medicaid-enrolled children, youth, and families served by the child welfare system in receiving seamless, integrated and coordinated health. As a statewide entity, the CFSP—regardless of a where a member lives—will provide members with access to a broad range of physical health, behavioral health and pharmacy services, long-term services and supports (LTSS), and Intellectual/Developmental Disabilities (I/DD) services, as well as services to address unmet health-related resource needs. The CFSP will offer robust care management to every member, working in close coordination with the North Carolina Division of Social Services (NCDSS), County Department of Social Services (County DSS) agencies, and Eastern Band of Cherokee Indian (EBCI) Family Safety Program. The CFSP is part of North Carolina's continued Medicaid transformation, which is transitioning most people enrolled in Medicaid into a managed care program delivery system.

To prepare for the CFSP launch,[2] NCDHHS intends to issue the CFSP RFP in early 2024. As outlined in Session Law 2023-134, the CFSP is intended to launch by December 1, 2024. Upon award of the Contract and based on the Offeror responses received, the Department will work with the NCGA to confirm an appropriate launch date. Entities that meet the definition of Prepaid Health Plan (PHP) or the definition of a consortium will be eligible to bid on the CFSP.[3] This policy paper, an update to the July 2022 CFSP policy paper, summarizes the latest CFSP design that will be reflected in the forthcoming RFP, including on eligibility and enrollment, care management, provider network and quality. The CFSP design and reflects significant input over the past three years from a diverse array of community partners including families and youth with lived experience, providers, representatives from advocacy organizations, Standard Plans, LME/MCOs, the Eastern Band of Cherokee Indians (EBCI), county DSS agencies, the NC Association of County Directors of Social Services (NCACDSS), state agencies and community-based organizations, EBCI Public Health and Human Services (PHHS) Department, the Cherokee Indian Hospital Authority (CIHA) representatives, family-led organizations, consumer and family advocates, members of the Guardian ad Litem program, and the Division of Juvenile Justice. NCDHHS recognizes the complexity of implementing the CFSP and will continue to provide updates on the CFSP's design and implementation timeline, and to engage with community partners as operational planning continues and adjustments need to be made after go-live.

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1 Referred to as the Children and Families (CAF) specialty plan as authorized in Section 9E.22 of Session Law 2023-134.

2 Pending legislative approval.

3 As defined in Session Law 2023-134 here.

II. Unique Needs of Children & Families Served the Child Welfare System

NCDHHS, in collaboration with the diverse set of community partners noted above, designed the CFSP to help address the unique health and health-related needs of children, youth and families served by the child welfare system. Supporting children, youth and families served by the child welfare system requires a high level of multisector coordination aimed at preserving families and supporting reunification and permanency. Data indicates that these children and families experience greater unmet health needs than those not served by the child welfare system. In particular, children and youth in foster care have greater physical and mental health needs and worse health outcomes as compared to children in the general population.[4] For example, nationally, children and youth in foster care use both inpatient and outpatient mental health services at a rate 15 to 20 times greater than that of the general pediatric population, and approximately 60% have a chronic medical condition.[5] Without adequate supports, these conditions can persist and impact short- and long-term health outcomes into adulthood.

Former foster youth experience high rates of mental health challenges, including post-traumatic stress disorder and chronic physical health conditions, such as asthma. They are also likely to experience barriers to maintaining access to healthcare coverage, further exacerbating their physical and behavioral health needs.[6] Children and adolescents at risk of removal from their homes also may have significant chronic health conditions and other developmental, cognitive, emotional/behavioral and substance use disorder (SUD) treatment needs.[7] Parents of these children similarly are at increased risk for significant physical and behavioral health needs, such as major depression.[8] Nationwide research suggests that children are most often removed from their homes due to neglect, parental drug use, caretaker inability to cope, and physical abuse.[9] Family preservation requires access to supports that promote positive outcomes and family well-being, including behavioral health services,

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4 Kaferly, J., Orsi, R., Alishahi, M. et al. "Primary Care and Behavioral Health Services Use Differ Among Medicaid-Enrolled Children by Initial Foster Care Entry Status," International Journal on Child Maltreatment: Research, Policy and Practice 6(2):255–285, 2023.

5 Allen, K, Pires, S, Mahadevan, R. "Improving Outcomes for Children in Child Welfare: A Medicaid Managed Care Toolkit," Center for Health Care Strategies, 2012; DosReis S., JM Zito, DJ Safer, and KL Soeken. "Mental Health Services for Youths in Foster Care and Disabled Youths," American Journal of Public Health 91(7):1094-1099, 2001; Szilagyi M, "The Pediatrician and the Child in Foster Care," Pediatric Review 19:39-50, 1998; Halfon N, A Mendonca, and G Berkowitz, "Health Status of Children in Foster Care: The Experience of the Center for the Vulnerable Child," Archives of Pediatrics & Adolescent Medicine 149:386-392, 2005.

6 Ahrens, K, Garrison, M, Courtney, M. "Health Outcomes in Young Adults From Foster Care and Economically Diverse Backgrounds," Pediatrics 134(6): 1067-1074, 2014, available here; National Foster Youth Institute, available here; Halberg, S. "Foster care youth need critical health care after they age out," The Nation's Health, 2017; available here.

7 Congressional Research Service. "Child Welfare: Health Care Needs of Children in Foster Care and Related Federal Issues." November 19, 2014. Available here.

8 Id.

9 U.S. Department of Health & Human Services (USDHHS). (2021). The AFCARS report: Preliminary FY[1] 2020 estimates as of October 4, 2021 - No. 28. Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. Available here.

SUD treatment, parent skill-building programs and connections to health-related resources such as food and housing.[10]

Improving access to health care services for children and families served by the child welfare system is critical to advancing health equity. Representation of children and families served by the child welfare system is disproportionately high for people of color.[11] For example, in State Fiscal Year 2023, approximately 24% of North Carolina's child population was Black but accounted for 29% of children in foster care, whereas White children made up 62% of North Carolina's child population and accounted for 58% of children in foster care.[12] Beyond the disproportionate representation, children of color are more likely to experience negative outcomes in the child welfare system.[13]

III. Children and Families Specialty Plan Objectives

The CFSP aims to improve the health and well-being of children, youth and families served by the child welfare system. The CFSP design, outlined in greater detail in this paper, emphasizes a family-focus and seeks to:

- Improve members' near- and long-term physical and behavioral health outcomes.
- Increase timely access to physical health, behavioral health, pharmacy, LTSS and I/DD providers with experience serving children with high acuity needs, as well as unmet health-related resource needs.
- Strengthen and preserve families, prevent entry and re-entry into foster care, and support reunification and other permanency plan options.
- Coordinate care and facilitate seamless transitions for members who experience changes in treatment settings, child welfare placements, transitions to adulthood, and/or loss of Medicaid eligibility.
- Improve coordination and collaboration with county DSS agencies, EBCI Family Safety Program, and more broadly, with Community Collaboratives - a comprehensive network of community-based services and supports leveraging a system of care approach to meet the needs of families who are involved with multiple child service agencies.
- Provide services that meet children's behavioral health needs and prevent children from boarding in county DSS agency offices and Emergency Departments.

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[10] Child Welfare Information Gateway. "In-Home Services to Strengthen Children and Families" April 2021. Available here.

[11] Disproportionality and Race Equity in Child Welfare. National Conference of State Legislatures, 2021. Available here.

[12] Source: NC Office of State Budget and Management Demographer, NC Child Placement and Payment System, and NC Child Welfare Information System.

[13] Annie E. Casey Foundation Kids County Data Center. "Child population by race in the United States." Available here; U.S. Department of Health and Human Services, Administration for Children and Families Children's Bureau. "The AFCARS Report: Preliminary FY 2020 Estimates as of October 4, 2021 - No. 28." Available here.

- Advance health equity to address racial, ethnic, and geographic disparities experienced by children, youth and families served by the child welfare system.

IV. Statewide Design

One of the most significant challenges to service delivery for children, youth and families served by the child welfare system is disruption in provider relationships and care due to changes in placement. As such, the CFSP will be a single plan that operates statewide to enable children, youth and families to access a continuous, broad range of physical and behavioral health services regardless of their location in the state. The statewide design of the CFSP is optimal to allow members to maintain their provider and care manager relationships and their treatment plans when they experience a change in placement or care transition, facilitating seamless continuity of care.

To successfully meet the needs of members across the state, the CFSP will be required to be knowledgeable about local resources and to develop and submit for Department approval a Local Community Collaboration and Engagement Strategy that supports partnerships with local entities, including System of Care collaboratives and community-based organizations. Additionally, the CFSP will be required to be knowledgeable of services funded by NCDSS including, but not limited to, foster care board funding and North Carolina funding through the Family First Prevention Services Act.

V. Eligibility and Enrollment

Informed by extensive feedback from community partners, NC Medicaid-enrolled children and youth currently or formerly in foster care or receiving adoption assistance, as well as their family members, will be eligible for the CFSP; NC Medicaid-enrolled children and families receiving Child Protective Services (CPS) In-Home Services or EBCI Family Safety Program will also be eligible. The CFSP will be family-focused and prevention-oriented, helping to coordinate health and health-related services for a family unit, and providing access to staff and providers who are trained and best equipped to support the entire family. As outlined in **Table 1** below, a subset of CFSP-eligible children and youth served by the child welfare system will be auto-enrolled at CFSP launch. Given the significant reconfiguration of existing information technology systems, remaining populations will have the option to enroll beginning no sooner than July 2026.

Eligibility

As authorized under state law,[14] the following NC Medicaid enrolled populations who are not otherwise exempt or excluded from NC Medicaid Managed Care,[15] or meet another exception,[16] will be eligible for the CFSP:[17]

- Children and youth in foster care;[18]
- Children and youth receiving adoption assistance;[19]
- Former foster care youth under age 26;[20]
- Minor children of individuals eligible for CFSP enrollment while the parent remains enrolled;[21]
- Parents, caretaker relatives, guardians, and custodians with children in foster care;[22,23]
- Minor siblings of children/youth in foster care;

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14 N.C. Gen. Stat. § 108D-62.

15 The following populations are excluded from NC Medicaid Managed Care: beneficiaries who are enrolled in both Medicare and Medicaid for whom Medicaid coverage is limited to the coverage of Medicare premiums and cost sharing; qualified aliens subject to the five-year bar for means-tested public assistance under 8 U.S.C. § 1613 who qualify for emergency services under 8 U.S.C. § 1611; undocumented aliens who qualify for emergency services under 8 U.S.C. § 1611; medically needy Medicaid beneficiaries except for beneficiaries enrolled in the Innovations or TBI waivers; presumptively eligible beneficiaries, during the period of presumptive eligibility; beneficiaries who participate in the North Carolina Health Insurance Premium Payment (NC HIPP) program except for beneficiaries enrolled in the Innovations or TBI waivers; beneficiaries enrolled under the Medicaid Family Planning program, beneficiaries who are inmates of prisons or jails; beneficiaries being served through CAP/C; beneficiaries being served through CAP/DA (includes beneficiaries receiving services under CAP/Choice); and beneficiaries with services provided through the Program of All Inclusive Care for the Elderly (PACE).

16 Individuals otherwise eligible for the CFSP who are Innovations or TBI waiver enrollees, beneficiaries residing in or receiving respite services at an Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID),beneficiaries ages 18 and older who are receiving State-funded BH, I/DD and TBI services that are not otherwise available through Medicaid, beneficiaries living in State-funded residential treatment, and recipients enrolled in and being served under Transition to Community Living (TCL) must enroll in a BH I/DD Tailored Plan to access those services; they may opt-in to the CFSP when they no longer require those services. Tribal members and other individuals eligible to receive Indian Health Services, including North Carolina's federally recognized tribe (the Eastern Band of Cherokee Indians) and state-recognized tribes, may opt-in.

17 The Department may, at a later date, extend CFSP eligibility to any other member involved with the child welfare system that it determines could benefit from CFSP enrollment.

18 See here for Medicaid eligibility requirements for children and youth in foster care.

19 See here for Medicaid eligibility requirements for children receiving adoption assistance.

20 See here for Medicaid eligibility requirements for former foster care youth under age 26. NCDHHS recognizes the need to update the former foster care eligibility group description in CFSP and is working to replace legislative language with "young adults under age 26 formerly in foster care."

21 Limited to minor children of CFSP-eligible children in foster care, former foster care youth or children receiving adoption assistance.

22 The CFSP will recognize the Tribal definition of "parents, caretaker relatives, guardians, and custodians" in determining Tribal member eligibility for the Plan.

23 Pending CMS approval.

- Families receiving CPS In-Home Services, specifically:
    - Adults included in the NC In-Home Family Services Agreement as caregivers
    - Minor children included on the NC In-Home Family Services Agreement; and
- Adults identified in an open EBCI Family Safety Program case and any children living in the same home.

While North Carolina passed legislation in 2021 providing Medicaid coverage for parents who otherwise would have lost their coverage when children were removed from their homes, Medicaid expansion—launched on December 1, 2023—now provides coverage to all childless adults up to 133% of the Federal Poverty Level.[24] With Medicaid expansion and the CFSP, parents, guardians, and custodians of children/youth in foster care can maintain their Medicaid coverage regardless of where their children reside, ensuring access to health and health related services that can support family reunification.

In addition, the CFSP will be available to members of a federally recognized tribe or those eligible for Indian Health Services (IHS) who also meet eligibility for the CFSP; NCDHHS will work with the EBCI Family Safety Program to operationalize around eligibility and enrollment for these individuals.

Enrollment

Table 1: CFSP-Eligible Population Enrollment Timeline below outlines populations that NCDHHS intends, with limited exceptions, to automatically enroll into the CFSP at launch, as well as other NC Medicaid-enrolled individuals who will have the option to enroll in the CFSP no sooner than July 2026.[25]

Table 1: CFSP-Eligible Population Enrollment Timeline

Populations Auto-Enrolled at CFSP Launch	***Populations with Option To Enroll No Sooner Than July 2026***[26]
• Children and youth in foster care • Children and youth receiving adoption assistance • Former foster care youth under age	• Parents, caretaker relatives, guardians, custodians and minor siblings of children/youth in foster care • Families receiving CPS In-Home Services, specifically:

[24] For additional information on North Carolina Medicaid Expansion see here.

[25] Beneficiaries who are members of a federally recognized tribe or eligible for Indian Health Services who are eligible for the CFSP have been enrolled into the EBCI Tribal Option or remain in NC Medicaid Direct depending on their region and will have the option to enroll in the CFSP at launch; individuals eligible for Medicare or are in other managed care excluded groups are not eligible to enroll in the CFSP as outlined in footnote 14.

[26] The Department may, at a later date, extend CFSP eligibility to any other member involved with the child welfare system that it determines could benefit from CFSP enrollment.

26 • Minor children of children and youth in foster care, children receiving adoption assistance, and former foster youth while the parent is CFSP-enrolled	○ Adults included in the NC In-Home Family Services Agreement as caregivers ○ Minor children included on the NC In-Home Family Services Agreement • Adults identified in an open EBCI Family Safety Program case and any children living in the same home

Auto-enrolled individuals will have the option to opt out of the CFSP and transfer to a Standard Plan, Tailored Plan, EBCI Tribal Option or NC Medicaid Direct, if eligible, at any point during the coverage year. For those children and youth in county DSS agency custody, the County DSS Director or Director's designee will be authorized to determine which managed care plan the individual should be enrolled in consultation with the child's care team.[27]

All other CFSP-eligible populations will have the option to enroll in the CFSP no sooner than July 2026. If these individuals do not opt-in to the CFSP, they will remain in a Standard Plan, Tailored Plan, EBCI Tribal Option or NC Medicaid Direct, as eligible. All individuals eligible to participate in both the CFSP and the EBCI Tribal Option will be enrolled in the EBCI Tribal Option but will be given the choice to opt into the CFSP.[28] The Enrollment Broker will be available to educate and help individuals navigate this decision.

Continuation of Coverage

Children and youth who leave foster care and maintain Medicaid eligibility will have the option to remain in the CFSP for 12 months following the transition from foster care or opt into another managed care plan (i.e., Standard Plan, Tailored Plan or EBCI Tribal Option, if eligible). Likewise, Medicaid-enrolled parents, guardians, and custodians, as well as minor siblings, of these children and youth will remain eligible for CFSP enrollment provided their child/sibling remains eligible for the CFSP. The purpose of continuing eligibility for a year beyond the child/youth's transition is to promote continuity of care, support reunification and other permanency planning efforts, and

[27] For children and youth in the EBCI Family Safety Program, the Director of the EBCI Human Services Division, in collaboration with legally responsible persons shall make the decision in consultation with the child's care team.

[28] The EBCI Tribal Option is available to beneficiaries who live in the following counties: Buncombe, Clay, Cherokee, Graham, Haywood, Henderson, Jackson, Macon, Madison, Swain, and Transylvania. The EBCI Tribal Option is primarily offered in these counties: Cherokee, Graham, Haywood, Jackson and Swain. Individuals located outside of these counties will remain in NC Medicaid Direct. See here for more information on EBCI Tribal Option eligibility and enrollment.

help address additional challenges that children and youth may experience after leaving foster care.[29]

VI. Benefits

The CFSP will cover a comprehensive array of Medicaid-covered physical and behavioral health benefits, including all services that will be covered by Standard Plans[30] in addition to the majority of Tailored Plan services.[31] Covered benefits include early and periodic screening, diagnostic and treatment (EPSDT) services — including honoring EBCI Tribal EPSDT definitions—1915(i) Home and Community Based Services, and a broad range of behavioral health services, including outpatient, inpatient, crisis, therapeutic residential options for children (including therapeutic foster care and Psychiatric Residential Treatment Facility (PRTF)), and SUD treatment services.

Individuals otherwise eligible for the CFSP who are on the Innovations or Traumatic Brain Injury (TBI) waiver,[32] receiving intermediate care facilities for individuals with intellectual disabilities (ICF-IID) services, receiving respite services through Murdoch Center's TRACKS program, eligible for North Carolina Transitions to Community Living (TCL), or need State-funded (behavioral health, I/DD or TBI) services will not be able to access those services through the CFSP and, instead, will be required to enroll in a Tailored Plan to access those and all other Medicaid-covered services, as appropriate.[33] In addition to the current benefits package, the CFSP, with Department approval, may also offer in lieu of services[34] and value-added services[35] to address the needs of the CFSP's members.

VII. CFSP Care Management

Seamless and coordinated care management that leads to improved outcomes is one of NCDHHS' highest priorities for members of the CFSP. Care management that places individuals and families with complex needs at the center of a multidisciplinary care team, facilitated by a dedicated care manager, has been shown to improve individuals' health by enhancing coordination of care and helping beneficiaries and

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29 Children in the former foster care eligibility group up to age 26 will be able to stay in the CFSP for as long as they remain enrolled under that Medicaid Eligibility Group.

30 Details on the Standard Plan medical and behavioral health benefits package can be found in NCDHHS' RFP for Medicaid Managed Care Prepaid Health Plans, Section V.C. Benefits and Care Management.

31 See Appendix A for more details on services covered by Standard Plans, Tailored Plans and the CFSP.

32 Individuals eligible for the CFSP who are also on the TBI or I/DD waiver waitlist may be served by the CFSP until the time when a waiver slot becomes available.

33 As of January 2021, approximately 7,000 individuals—23% of children in foster care or receiving adoption assistance—met Tailored Plan eligibility criteria; as of SFY 2018, 105 children in foster care were on the Innovations waiver. Tailored Plans will be required to ensure they can meet the needs of children in foster care who utilize those waiver services. IHS-eligible/tribal members will not be required to enroll in Tailored Plans to access such services.

34 In lieu of services are services or settings that are not covered under the North Carolina Medicaid State Plan but are a medically appropriate, cost-effective alternative services.

35 Value-added services are services, delivered at the CFSP's discretion, outside of the Medicaid managed care benefit plan that are designed to improve quality and health outcomes, and/or reduce costs by reducing the need for more expensive care.

caregivers more effectively manage health conditions.[36,37,38] As described in further detail below, the CFSP will offer care management to all members enrolled in the CFSP.[39]

A. Care Management Approach

All CFSP members will have access to robust care management directed by the CFSP. Under the CFSP care management model, the CFSP will serve as the central point of accountability for managing the health of members and ensuring access to needed physical health, behavioral health, and I/DD services, as well as unmet health-related resource needs, regardless of geographic location or type of transition the member is experiencing. NCDHHS expects successful care management will require close coordination with each member's providers and believes that a plan-based care management model with statewide reach will best facilitate continuity of care during changes in placements. While CFSP care management will be plan-based, with NCDHHS' approval, the CFSP may, at its discretion, delegate care management functions to community-based entities, provided that those entities are meaningfully and increasingly integrated into the CFSP's statewide model while maintaining a seamless member experience.

The CFSP will assign each member to a care manager who will be required to coordinate closely with each member's primary care provider (PCP), and, as appropriate, care manager extenders, assigned County Child Welfare worker, EBCI Family Safety Program staff, CIHA Care Team, family members and guardians to manage the member's health care needs throughout their time enrolled in the CFSP.

To bolster the care management workforce, NCDHHS will allow the use of care manager extenders, including but not limited to Certified Family Peer Specialists (Family Partners), Certified Peer Support Specialists, and community health workers, to support certain CFSP care management functions. The purpose of using care manager extenders is to help the CFSP best meet the needs of members, build efficient care teams by creating additional workforce capacity, and allow care managers and supervisors to focus on key tasks for assigned Members as well as permit them additional time for members with intensive or complex needs. When using a care manager extender, the CFSP care manager will direct the extender's care management

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[36] Goodell, S., Berry-Millett, R., and T. S. Bodenheimer. 2009. Care Management of Patients with Complex Health Care Needs. Synth. Proj. Res. Synth. Rep. (19).

[37] Long P. V., Abrams M., Milstein A., et al. Effective Care for High-Need Patients, Opportunities for Improving Outcomes, Value, and Health. National Academy of Medicine; 2018.

[38] Hasselman, D. Super-Utilizer Summit: Common Themes from Innovative Complex Care Management Programs. October 2013.

[39] All CFSP members are eligible for CFSP care management, except for members participating in services that are duplicative of CFSP care management, including members obtaining Assertive Community Treatment (ACT) and other services as determined by the Department.

functions and ensure that the extender supports allowable activities (e.g., coordinating services/appointments by arranging transportation, etc.).

NCDHHS is committed to working with the EBCI PHHS leadership to ensure CFSP members who are served by the EBCI Family Safety Program are meaningfully served by the CFSP care management model.

B. Delivery of Whole-Person, Integrated Care

The CFSP will be responsible for the comprehensive management of each member's physical health, behavioral health, pharmacy, LTSS, I/DD, and unmet health-related resource needs across health care settings and placements, including through transitions such as permanency planning, reunification and transitioning out of county DSS agency custody. The CFSP will be required to develop a methodology for stratifying its members to align the intensity of care management with each member's level of need. NCDHHS will establish care manager caseload requirements to ensure sufficient staffing levels necessary for the CFSP to fully deliver on all elements of this care management model.

As part of the core care management functions, care managers will conduct a care management comprehensive assessment for each member and use the results to develop a care plan (for members without I/DD and TBI needs) or an individual support plan (ISP) (for members with I/DD and TBI needs). The care plan/ISP will provide a blueprint for ongoing care management and include the member's health, social, emotional, educational and other service needs and relevant permanency planning information from the member's assigned County Child Welfare worker or EBCI Family Safety Program staff as applicable, among other elements. For members receiving treatment in a congregate setting (e.g., group home or PRTF), the member's care plan/ISP will also identify the needed services, supports, and timeline to facilitate the member's transition to a family-based placement, as clinically appropriate.

The CFSP will include standard timelines that care managers must meet for administering care management comprehensive assessments and developing each member's care plan/ISP; the required timelines will differ for members identified as high-risk compared to members not identified as high-risk. Delivery of the care management comprehensive assessment and development of the care plan/ISP must be accelerated, as needed, to manage members' urgent needs/crises.

NCDHHS recognizes the importance of ensuring that care managers take all needed steps to promptly connect members, when needed, to comprehensive clinical assessments and all recommended services and supports, including physical and developmental services, residential treatment programs, therapeutic foster care settings, and behavioral health crisis services. The CFSP will be expected to develop mature network capacity to ensure timely access across all required services. Department service level expectations will require the CFSP

to closely monitor and escalate existing or developing gaps in service coverage. The CFSP also will be required to provide 24/7 support during emergencies or behavioral health crises, including working with County Child Welfare workers (or EBCI Family Safety Program staff) to secure immediate treatment services, as needed. To prevent DSS office boarding during placement crises, CFSP will be responsible for coordinating care and ensuring placement is achieved within 24-hours of determining medical necessity is met for any Medicaid State Plan enhanced behavioral health, residential treatment, and PRTF service, or an alternative service(s) deemed clinically appropriate to serve the member.

The care manager will also be responsible for establishing a multidisciplinary care team for each member. For children, this multidisciplinary care team might include but is not limited to the member, the member's assigned care manager, parent(s), guardian(s), or custodian(s) (as appropriate), the County Child Welfare worker, care manager extenders, and the member's PCP.[40] For adults, the multidisciplinary team might include but is not limited to the member's assigned care manager, the County Child Welfare worker, care manager extenders, and the member's PCP.[41] The care manager will be responsible for convening the care team on a regular basis (no less than twice per year, and more often, as appropriate) and will share the care plan/ISP with the member's care team and other representatives, as appropriate, to support delivery of the member's needed health and health-related services.

The CFSP will also be required to align its care management approach with the North Carolina System of Care framework that promotes family-driven, youth-guided services that support and build on individual strengths and needs while working to achieve desired outcomes.[42]

C. Coordination and Co-location with County DSS Agencies

Coordination

NCDHHS believes the delivery of plan-based care management in close coordination with county DSS agencies is essential to mitigating disruptions in care and facilitating the goal of achieving the right care at the right time for all CFSP members, despite changes in placements or health care settings. As such, CFSP care managers will be required to coordinate closely with each member's assigned County Child Welfare worker. For CFSP members who are

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[40] Care managers are encouraged to invite the member's other providers, including behavioral health providers, to participate in care team meetings, as appropriate. This would include the CIHA Primary Care Teams for members served by those care teams.

[41] Certain requirements, such as coordination with county DSS agencies and guardians, are not applicable to former foster youth.

[42] The core System of Care's elements are: (1) family-driven, youth-guided services; (2) interagency collaboration; (3) service coordination through a single facilitator; (4) individualized, strength-based, trauma-informed/resilience development approach; (5) culturally and linguistically competent care; (6) evidence-based or informed services provided in a home or community setting; and (7) family and youth involvement in regional and state policy development, implementation and evaluation. More information on the System of Care approach is available here.

served by the EBCI Family Safety Program instead of NCDSS or county DSS agencies, the CFSP will be required to coordinate with EBCI Family Safety Program staff in place of County Child Welfare workers.

As part of the collaborative care management process, CFSP care managers will meet and coordinate with County Child Welfare workers (or EBCI Family Safety Program staff) to:

- Share relevant health and health-related information, as permitted, and coordinate strategies to address members' health and social needs to support and promote family preservation, permanency planning and reunification, as applicable

- Assist with scheduling NCDSS-required health assessments, gathering medical records, and developing a crisis plan. Identify health and health-related services that are necessary to support family preservation for families receiving CPS In-Home Services and reunification or other permanency planning efforts for children in foster care and their families

- Obtain consent for treatment of certain health care conditions from a member's parent(s), guardian(s), or custodian(s), unless there are restrictions regarding such communication (e.g., termination of parental rights or court order restricting communication) in accordance with applicable North Carolina state law[43,44]

In addition, NCDHHS, including DHB and NCDSS, plans to engage with the CFSP and county DSS agencies on developing data-sharing processes that work for care managers as well as County Child Welfare workers.

Co-location

To support coordination between CFSP care managers and County Child Welfare workers, NCDHHS will require the CFSP to physically co-locate a portion of care managers across North Carolina's network of county DSS agencies, taking into account the State's mix of urban and rural geography and availability of physical office space.[45]

In addition, NCDHHS will require the CFSP to have dedicated DSS Liaisons who are responsible for understanding the scope of services/programs coordination through county DSS agencies, addressing issues where County Child Welfare workers are seeking to coordinate with care managers and

[43] North Carolina General Statute § 7B-505.1, 7B-600(a), 7B-903(e), and 7B-903.1(a).

[44] The CFSP will abide by the applicable EBCI Tribal Codes; NCDHHS will continue to consult with the EBCI regarding specific details for these collaborative efforts and the identification of tribal codes.

[45] CFSP care managers will not be required to co-locate with EBCI Family Support Service offices; however, co-location may be permissible at the discretion of the EBCI Tribe.

serving as a primary contact to triage and escalate member-specific issues or other questions.

NCDHHS acknowledges that there is considerable work to be done to effectively operationalize this model. Prior to the CFSP's launch, NCDHHS will facilitate a collaborative operational planning process between NCDSS leadership, county DSS agency staff, NCACDSS, EBCI PHHS Family Safety Program, NC Medicaid and other community partners (as appropriate). NCDHHS plans to release additional operational guidance based on these discussions.

D. Continuity of Care and Coordination During Transitions

Transitions between managed care plans and clinical settings (e.g., following a discharge from a hospital, crisis, residential or institutional setting) are often a challenging time for individuals and can disrupt necessary care. Stability and continuity of care are especially critical during these transitions for children and families served by the child welfare system. Therefore, in addition to conducting ongoing care management to address the member's needs as outlined in the care plan/ISP, care managers will provide transitional care management during care transitions (including assisting individuals with transitioning from congregate or other intensive treatment settings to a foster care home or other community placement).

CFSP care managers will notify the County Child Welfare worker or EBCI Family Support Safety Program staff, as appropriate, and parents(s), guardians(s) and custodian(s), as appropriate, of a change in health plan and assist in selecting a new PCP, if necessary.

To support members transitioning from treatment settings, CFSP care managers will be required to connect with the member before and after discharge, conduct discharge planning, facilitate clinical handoffs and arrange for medication reconciliation and management following discharge from a hospital or institutional setting or following an emergency department visit.

The CFSP will be required to provide in-reach, transition, and diversion services to certain members.[46,47] The goal of in-reach and transition services is to

[46] The following CFSP members will be eligible for CFSP-based in-reach and transition services: 1) Members residing in a state psychiatric hospital who are not determined eligible for the North Carolina Transitions to Community Living (TCL); 2) All members in a PRTF; and 3) All members in Residential Levels II/Program Type III, and IV as defined in NCDHHS' Clinical Coverage Policy 8-D-2. Members determined eligible for TCL and those with an SMI residing in an ACH who are also eligible for the Tailored Plan will be enrolled in and receive in-reach and transition services from a Tailored Plan.

[47] Members eligible for diversion activities through the CFSP include those meeting the following criteria: 1) Have not been determined eligible for the North Carolina TCL 2) Have transitioned from an institutional or correctional setting, or an Adult Care Home for adult members, within the previous six months; 3) Are seeking entry into an institutional setting; or Adult Care Home; PRTF; or Residential Treatment Levels II/Program Type, III, and IV; 4) Meet one of the following additional criteria for members with I/DD and TBI: a) Member has a caregiver who may be unable to provide the member their required interventions; b) Member's caregiver is in fragile health, which may include but is not limited to member

identify and engage members who may be able to have their needs met in the community and ensure the availability of appropriate services and supports for such members following discharge to the community. As part of the diversion activities, the CFSP will assess members at risk of admission to an institutional setting for eligibility for community-based services and supports including supportive housing, if needed; provide member education on the choice to remain in the community; and facilitate linkages to community-based and other support services for which the member is eligible.

E. Support for Members Transitioning Out of the Child Welfare System or Out of the CFSP

Maintaining continuity of care when transitioning out of the child welfare system can be challenging to navigate for many individuals, including children/youth who are reunified or achieve an alternate permanency plan, youth who reach the age of emancipation, and former foster youth who may lose Medicaid eligibility upon turning 26.[48] However, these transitions may be especially difficult for the young adult population who are more likely to lack the social and emotional supports needed to facilitate a successful transition to self-sufficiency and navigate their own health care needs.

The CFSP's care management model builds in support to address these high-risk transition periods. Care managers will facilitate robust transition planning both for members aging out of the child welfare system and those at risk of losing Medicaid eligibility. The care managers supporting these members will be required to have expertise in the systems and tools that are fundamental to the transition to adulthood, including independent living skills (e.g., accessing food and transportation), post-high school education, housing and employment options, self-advocacy, health insurance coverage options after Medicaid eligibility ends and building natural supports.

For CFSP members leaving the child welfare system, care managers will collaborate with County Child Welfare workers as needed in the development of the NCDSS-required transitional living plan and 90-day transition plan. Care managers will identify key health-related resources and supports necessary to achieving the member's health care goals. The CFSP will also be responsible for developing a Health Passport for each member as a supplement to the 90-day transition plan. The Health Passport is a document, available electronically and in paper formats, which will contain critical health care-related information,

caregivers who have been hospitalized in the previous 12 to 18 months, diagnosed with a terminal illness, or have an ongoing health issue that is not managed well (e.g., diabetes, heart condition, etc.); c) Member with two parents, guardians, or custodians if one of those parents/guardians/custodians dies; d) Any other indications that a member's caregiver may be unable to provide the member their required interventions; or e) member is a child or youth with complex behavioral health needs.

[48] Former foster youth under age 26 who aged out of the child welfare system outside of North Carolina remain eligible for Medicaid coverage until they reach the age of 21; former foster youth under age 26 who aged out of the child welfare system in North Carolina until they reach the age of 26.

such as upcoming scheduled visits, prescribed medications and the member's medical records.

For former foster youth aging out of the Medicaid for Former Foster Care categorical Medicaid eligibility group, care management teams also must educate members about potential Medicaid and alternative insurance options available to them (e.g., Marketplace/Qualified Health Plan (QHP) coverage, applicable EBCI tribal programs/funding options, etc.) and assist them in signing up if desired. The CFSP care managers also must make plans for transitioning all ongoing health care services and medications. The Health Passport for these members must also include a list of health care resources available to members regardless of insurance status.

F. Comprehensive Medication Reconciliation and Management Services

Children and youth currently and formerly served by the child welfare system often face disruptions to their medication regimens due to frequent changes in placements and care. As such, the CFSP will be responsible for ensuring members receive robust medication reconciliation and management. This will include, at minimum, medication reconciliation and management following health care and other life transitions (including placement changes), assistance with refilling medications, and leveraging CFSP clinical staff (e.g., psychiatrist) to assess the clinical appropriateness of members' medication regimens. The CFSP will be required to ensure medication reconciliation and management is delivered in accordance with recognized professional guidelines, such as "Best Practices for Medication Management for Children & Adolescents in Foster Care" from the North Carolina Pediatric Society.[49]

G. Primary Care Providers and CFSP Care Management

NCDHHS recognizes Primary Care Providers (PCPs) are an essential part of the care team and is committed to engaging them in the delivery of integrated, whole-person care for all members. Under the CFSP, Advanced Medical Home (AMH) practices will serve as PCPs for CFSP members. The CFSP will make payments to AMH practices that provide primary care services to CFSP members.[50] To receive these additional payments, AMHs will be required to meet an enhanced set of medical home requirements (beyond the base Carolina ACCESS requirements for PCPs) for children and youth in foster care, children receiving adoption assistance and former foster youth under age 26, including:

- Coordinating with the member's assigned CFSP care manager and/or County Child Welfare worker, as appropriate

[49] Available at https://www.ncdhhs.gov/media/12749/download?attachment.

[50] Advanced Medical Homes (AMHs) are state-designated primary care practices that have attested to meeting standards necessary to provide local care management services. More information about AMHs is available here.

- Scheduling and conducting follow-up well visits in accordance with the American Academy of Pediatrics Health Care Standards for children in foster care

- Conducting the recommended developmental, behavioral, psychosocial and other screenings as appropriate based on age and the member's clinical condition

- Completing NCDSS-required health assessment forms.

NCDHHS will conduct additional design work to determine what, if any, additional requirements AMH practices that provide primary care services to CFSP-enrolled family members of children in foster care and families receiving CPS In-Home Services must meet to receive an additional payment. NCDHHS intends to release additional guidance on this.

To ensure coordination across the health continuum, Medicaid-enrolled providers involved in the member's care, including physical health, behavioral health, I/DD, LTSS, and pharmacy providers, will be eligible to receive reimbursement from the CFSP for participating in care team meetings with the CFSP care managers.

Healthy Opportunities: An Initiative to Address Unmet Health-related Needs

North Carolina has made a key priority of optimizing health and well-being by bridging the health care system and local community resources to address all factors that impact health. The Department has identified four priority domains to address unmet health-related resource needs: housing, food, transportation and interpersonal violence/toxic stress. In collaboration with NCDHHS' Healthy Opportunities initiative, the CFSP will be responsible for implementing the Healthy Opportunities Pilot (HOP) program for its HOP-eligible members, in accordance with Department requirements.[51] Integrating with the Healthy Opportunities initiative will be especially critical to former foster youth under age 26 navigating the challenges of young adulthood; parents, guardians and custodians whose children are in the custody of county DSS agencies or EBCI Family Safety Program, and families who are receiving CPS In-Home services.

VIII. Provider Network & Payment

Provider Network

The CFSP will be required to develop and maintain a robust network of physical health, behavioral health, I/DD and LTSS providers across the State to meet the needs of all members statewide. To that end, the CFSP must meet network adequacy standards.

[51] More information about the Healthy Opportunities Pilots is available here.

These standards largely align with the Standard Plan and Tailored Plan time and distance requirements, amended in certain instances to meet minimum statewide contracting standards in place of regional standards set forth in the Standard Plan and Tailored Plan contracts for certain provider types.[52]

As authorized by the NC Legislature, the CFSP will have an "any willing provider"[53] network for all services except intensive in-home services, multisystemic therapy, residential treatment services and PRTFs. NCDHHS believes this approach balances shared goals of providing members with provider choice while ensuring the delivery of high-quality services.

To ensure sufficient availability of in-network providers for key behavioral health services, the CFSP will be required to contract with a minimum percentage of certain providers statewide, such as a minimum percentage of residential treatment service providers and PRTFs.[54] The CFSP contract will also include a detailed table outlining the wait time standards for behavioral health services.

To ensure continuity of care, NCDHHS will require the CFSP to make a good-faith effort to contract with an out-of-network provider who is treating a member with an ongoing special condition or an ongoing course of treatment and transitioning to the CFSP from another health plan or NC Medicaid Direct. During this transitional period, the CFSP will work to either onboard the provider into its network or safely transition the member to an existing in-network provider if their historical provider is not in-network.

As proposed initially, the CFSP will implement a strong monitoring program to ensure providers are meeting member needs and program requirements. Consistent with Standard Plan and Tailored Plan requirements, the CFSP will employ a Tribal Provider Contracting Specialist who will be accountable for developing tribal provider networks. In addition, the CFSP will be responsible for developing a network that includes providers representative of historically marginalized populations and ensuring network providers receive training on trauma-informed care and adverse childhood events (ACEs) to understand the needs of the population served by the Plan.

Provider Payment

As originally designed, the CFSP will be subject to requirements for provider payments consistent with Standard Plans and Tailored Plans, including rate floor requirements for in-network physicians, physician extenders, pharmacies (dispensing

[52] This also includes following the Tribal Managed Care Addendum, the Tribal Payment Policy and adherence to tribal exceptions for licensure and other provider requirements.

[53] "Any willing provider" means that the CFSP must accept into its network any provider that is Medicaid or NC Health Choice-enrolled, meets certain quality standards, and agrees to the CFSP's network rates.

[54] NCDHHS is working to determine the operational feasibility of this potential contract requirement.

fees), essential providers,[55] hospitals[56] and nursing facilities and additional utilization-based payments for certain in-network providers (e.g., local health departments, public ambulance providers). With the exception of out-of-network emergency services and primary care provider services, post-stabilization services and services during transitions of care, the CFSP will be prohibited from reimbursing an out-of-network provider more than 90% of the NC Medicaid Direct rate if the CFSP has made a good faith effort to contract with a provider but the provider has refused that contract. Out-of-network providers for emergency services, post-stabilization services and services during transitions of care and primary care provider services will be reimbursed at 100% of the NC Medicaid Direct rate.

IX. Accountability for Quality

NCDHHS will establish a common set of quality measures to ensure the CFSP's accountability to NCDHHS. All quality measures[57] for the CFSP will align with and build on NCDHHS' Quality Strategy,[58] which primarily emphasizes outcomes for beneficiaries over process measures. The CFSP quality measures prioritize relevant medical needs and experiences for the CFSP population. The CFSP will also be required to report on a set of 1915(i) service performance measures.[59]

No sooner than in the second year of the CFSP Contract, NCDHHS will implement a quality withhold program based on quality measures used to administer the CFSP, including, holding the CFSP accountable for reducing the number of children and youth boarding in emergency departments and county DSS agencies. Other performance measures subject to a withhold will align with the State's Quality Strategy. Collection of data to report on performance and quality measures will begin upon CFSP launch. Additional contract performance measures, including liquidated damages, will be included in the CFSP Contract to support reducing youth boarding in emergency departments and county DSS agencies in Contract Year 1.

The CFSP, like other managed care entities, will be required to report quality measures against a set of stratification criteria that will include race and ethnicity, geography, age and gender, where appropriate and feasible for many of the quality measures.[60] Through the quality improvement process, NCDHHS will review the CFSP's stratified quality measure performance and require the CFSP to identify and implement interventions to reduce any health and quality outcome disparities observed.

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55 Essential Providers include federally qualified health centers, rural health centers, free clinics, local health departments, and any other providers as designated by NCDHHS. Section 5.(13) of Session Law 2015-245.

56 Hospital rate floors are time-limited.

57 To include operational-focused measures.

58 The Quality Strategy will be updated regularly to include CFSP-related quality initiatives and metrics. Available here: www.medicaid.ncdhhs.gov/reports/quality-management-and-improvement.

59 The Section 1915(i) SPA - Home and Community-Based Services (HCBS) for eligible members covered by the CFSP.

60 See the Medicaid Managed Care Quality Measurement Technical Specifications Manual for more information: www.medicaid.ncdhhs.gov/reports/quality-management-and-improvement.

As part of the CFSP's overarching quality strategy, the CFSP will be required to complete at least four performance improvement projects (PIPs) each coverage year, with a minimum of one PIP in the non-clinical category, two PIPs in the clinical category and one PIP in the transitions and continuity of care category. The CFSP may be required to develop additional PIPs for specific focus areas and/or clinical measures as directed by the Department.

NCDHHS will conduct oversight and monitoring of the CFSP and will convene monthly meetings with the CFSP quality director to discuss opportunities for performance improvement.

X. Next Steps

NCDHHS intends to provide updates on the CFSP on the Department's CFSP homepage which can be found here.

Community partners are welcome to submit policy paper feedback or questions to NCDHHS at Medicaid.NCEngagement@dhhs.nc.gov with the following email subject line: (Attention: Child and Family Specialty Plan).

Appendix A: Benefits Covered by Standard Plans, Tailored Plans, and the CFSP[61]

In addition to the behavioral health services identified below, the CFSP also will cover all Medicaid State Plan physical health, pharmacy, and LTSS services.

Behavioral Health, I/DD and TBI Services Covered by Standard Plans, Tailored Plans and the CFSP	**Behavioral Health, I/DD and TBI Services Covered by Tailored Plans and the CFSP**	**Behavioral Health, I/DD and TBI Services Covered Exclusively by Tailored Plans (or LME/MCOs Prior To Launch)**
Enhanced Behavioral Health services are *italicized*		
State Plan Behavioral Health and I/DD Services • Inpatient Behavioral Health services • Outpatient Behavioral Health emergency department services • Outpatient Behavioral Health services provided by direct-enrolled providers • Psychological services in health departments and school-based health centers sponsored by health departments • Peer supports (upon approval of State Plan Amendment 19-006 by CMS) • *Partial hospitalization* • *Mobile crisis management* • *Facility-based crisis services for children and adolescents* • *Professional treatment services in facility-based crisis program* • *Opioid Treatment Program*[62] • *Ambulatory detoxification* • Research-based Behavioral Health treatment for autism spectrum disorder (ASD) • *Diagnostic assessment* • *Non-hospital medical detoxification* • *Medically supervised or alcohol*	**State Plan Behavioral Health and I/DD Services** •*Residential treatment services* •*Child and adolescent day treatment services* •*Intensive in-home services* •*Multi-systemic therapy services* •*Psychiatric residential treatment facilities (PRTFs)* •*Assertive community treatment (ACT)* • *Community support team (CST)*[63] •*Psychosocial rehabilitation* •*Substance abuse non-medical community residential treatment* •*Substance abuse medically monitored residential treatment* • **1915(i) SPA services** • Community Transition • Respite • Supported Employment/Individual Placement Supports • Community Living and	**State Plan Behavioral Health and I/DD Services** • Intermediate care facilities for individuals with intellectual disabilities (ICF-IID) **Waiver Services** • Innovations waiver services • TBI waiver services **State-funded Services**[64] **Respite services through TRACK at Murdoch**

[61] Codified at G.S. 108D-35. The CFSP will cover all services in the NC Medicaid State Plan with the exception of services carved out of Medicaid Managed Care under Section 4.(4) of Session Law 2015-245, as amended; as specified in 42 C.F.R. § 438.210..

[62] The CFSP will also be required to cover Office-Based Opioid Treatment (OBOT) services.

[63] CST includes tenancy supports.

[64] Members requiring State-funded services will need to transfer to a Tailored Plan to access those services.

Behavioral Health, I/DD and TBI Services Covered by Standard Plans, Tailored Plans and the CFSP	Behavioral Health, I/DD and TBI Services Covered by Tailored Plans and the CFSP	Behavioral Health, I/DD and TBI Services Covered Exclusively by Tailored Plans (or LME/MCOs Prior To Launch)
Enhanced Behavioral Health services are *italicized*		
and drug abuse treatment center (ADATC) detoxification crisis stabilization • *Substance abuse intensive outpatient program (SAIOP)* • *Substance abuse comprehensive outpatient treatment program (SACOT)* • Diagnostic Assessment • Comprehensive Clinical Assessment **Early and periodic screening, diagnostic and treatment (EPSDT) services as covered under 1905(a)**	Supports • Individual and Transitional Support	

Appendix B: Engagement with Community Partners

NCDHHS conducted extensive engagement with community partners to inform design of the CFSP including hosting a CFSP Workgroup and several public webinars.

Date	Topic(s)	Meeting Materials
CFSP Workgroup Meetings		
April 19, 2021	• Introduction to FC Plan Workgroup and Approach • FC Plan Overview • Statewide Design	• Recording • Presentation
May 3, 2021	• Eligibility & Enrollment • Benefits/Services	• Session 1 Recording (Introduction & Statewide Approach) • Session 2 Recording (Eligibility & Enrollment and Benefits) • Presentation
May 17, 2021	Care Management	• Recording • Presentation
June 22, 2021	Care Management, cont.	• Recording • Presentation
July 12, 2021	Quality and Outcomes	• Recording • Presentation
July 26, 2021	Provider Network	• Recording • Presentation
August 9, 2021	Workgroup Lookback and Next Steps	• Recording • Presentation
January 11, 2022	Update on North Carolina's Specialized Foster Care Plan	• Recording • Presentation
CFSP Public Webinars		
February 11, 2021	An Overview of North Carolina's Specialized Foster Care Plan	• Recording • Presentation
June 4, 2021	An Update on North Carolina's Specialized Foster Care Plan	• Presentation
February 17, 2022	Updates on North Carolina's Children	• Recording

	and Families Specialty Plan	• Presentation
November 29, 2022	Transition to Tailored Care Management for Children/Youth Served by the Child Welfare System: A Resource for County DSS Agencies and Other Stakeholders	• Recording • Presentation
March 23, 2023	North Carolina Medicaid Managed Care Transformation as of April 1, 2023: Implications for Children and Youth Served by the Child Welfare System: A Resource for DSS County Child Welfare Workers	• Recording • Presentation