



Medicaid Managed Care
Policy Paper

North Carolina's Specialized Foster Care Plan

North Carolina Department of
Health and Human Services

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I. Introduction

Approximately 31,000 children in North Carolina are in foster care, receiving adoption assistance, or are former foster youth under age 26 (collectively referred to as “children and youth currently and formerly involved in the child welfare system”).¹ Children and youth currently and formerly involved in the child welfare system are a vulnerable and high-need population that often have specialized physical and behavioral health needs. Nationally, children and youth in foster care use both inpatient and outpatient mental health services at a 15 to 20 times greater rate than that of the general pediatric population and approximately 60% have a chronic medical condition.² These conditions frequently persist and impact health outcomes for young adults aging out of foster care. Former foster youth under age 26 experience high rates of mental illness, post-traumatic stress disorder, and chronic health conditions, such as asthma and visual and auditory impairments. They also are likely to experience barriers to maintaining access to health care coverage, further exacerbating their physical and behavioral health needs.³ Care of children and youth currently and formerly involved in the child welfare system requires a high level of coordination—not only during a child’s time in foster care but also through the reunification and aging out periods—among the many individuals and entities involved in providing for their physical, behavioral, social, emotional, educational and legal needs. This coordination is further complicated by several factors, including frequent changes in placement and caregivers, higher risk of over-use of psychotropic medications, and multi-system involvement that may result in poor cross-agency coordination and lack of access to relevant data.

As part of North Carolina’s Medicaid managed care implementation, the North Carolina Department of Health and Human Services (the Department) is designing a specialty Medicaid managed care plan—the Specialized Foster Care Plan (FC Plan)—to meet the unique needs of the State’s children and youth currently and formerly involved in the child welfare system and address many of the challenges they face today in receiving seamless, integrated, and coordinated health care. As part of the design planning process, consumers, their families and advocates identified that one of the most significant challenges facing the current system is ensuring continuity of care and providers. As such, the FC Plan, anticipated to launch on July 1, 2022, will operate statewide, enabling children and youth currently and formerly involved in the child welfare system to access a continuous, full range of physical and behavioral health services and maintain treatment plans when their placements change. More broadly, as the central entity accountable for the provision of health care services to children and youth currently and formerly involved in the child welfare system, the FC Plan will be charged with improving the level of coordination between the local County Departments of Social Services and other stakeholders involved in serving the Plan’s members.

¹ Based on October 2020 data.

² 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.

³ Ahrens, K, Garrison, M, Courtney, M. “Health Outcomes in Young Adults From Foster Care and Economically Diverse Backgrounds,” *Pediatrics* 134(6): 1067-1074, 2014, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4243069/>; National Foster Youth Institute, <https://nfyi.org/issues/health-healthcare/#:~:text=Psychosocial%20issues%20rooted%20in%20family,of%20mental%20health%20issues%2C%20unemployment%2C>; Halberg, S. “Foster care youth need critical health care after they age out,” *The Nation’s Health*, 2017; <https://www.thenationshealth.org/content/46/10/E55>

This paper outlines the State’s vision for and design of the FC Plan. It is intended to give stakeholders insight into the Plan’s key design areas, including eligibility and enrollment, benefits, care management, quality, provider participation, stakeholder engagement, and other programmatic features, as well as the anticipated procurement timeline. The FC Plan builds on many core requirements for both the Standard Plans and BH I/DD Tailored Plans; therefore, this concept paper focuses primarily on features that are unique to the FC Plan.

II. Vision for the State’s Specialized Foster Care Plan

The transition of children and youth currently and formerly involved in the child welfare system to Medicaid Managed Care requires special care and planning to ensure that provider relationships and care regimens transition smoothly. The Department has identified the following principles to guide its design and implementation of the FC Plan:

- **Seamless, person-centered care is critical to the long-term well-being of children and youth currently and formerly involved in the child welfare system.** Coordination of care across physical and behavioral health providers, child welfare agencies and other critical providers of social services and supports must be of paramount focus for the FC Plan. As such, it must have the capacity to develop integrated care plans and acquire and share information in a coordinated way across multiple entities and providers.
- **The FC Plan and its provider network must be prepared to meet the heightened behavioral health care needs and other challenges faced by children and youth currently and formerly involved in the child welfare system.** By definition, this population has been subject to adverse childhood events (ACEs), trauma that puts them at risk for higher incidence of long-term physical and behavioral health needs. The FC Plan and its provider network must have the expertise to identify and address ACEs and the full range of specialized behavioral health needs of this population. The FC Plan’s care management program must also work to ensure access to needed behavioral health services to mitigate entry into the justice system and the Plan must coordinate with the State’s Healthy Opportunities initiative to further address members’ social determinants of health.
- **The FC Plan must accept joint responsibility with the Division of Social Services for the physical and mental health of children and youth in foster care and adoptive placement.** Historically, this population has been served through a fragmented system that does not consistently foster close communication and coordination of service delivery with County Departments of Social Services. The FC Plan’s care management program will be required to work in close partnership with the County Departments of Social Services’ child welfare caseworkers (“County Child Welfare Workers”) to ensure timely access to needed services and medications as soon as children and youth come into care, throughout their time in care and through the reunification and aging out periods.
- **The FC Plan must support members during transitions in placements.** Children and youth who are removed from their homes may enter the child welfare system with few of their personal belongings, including medical supplies and medication. They require immediate access to the resources necessary to support their physical and behavioral health conditions. The FC Plan’s care management program must ensure timely provision of these needed services and supplies and continuity of physical and behavioral health care services.

- **The FC Plan must support members aging out of foster care.** Turning 18 can be especially challenging for youth in foster care for whom that birthday marks aging out of the child welfare system. By maintaining FC Plan eligibility for former foster youth under age 26, the Plan can support these members leading up to, during and following this transition. Care managers will play a critical role in supporting former foster youth under age 26, helping them maintain their Medicaid coverage and navigate their health care and health-related needs to reduce the burden they experience and enable them to focus on other priorities like securing stable housing and employment.
- **The FC Plan must support children and families during and after reunification.** When children return to their biological parents, it is imperative that they maintain continuity of health care services in order to support a seamless transition. The FC Plan care managers will be required to provide targeted support to children and their families during this transition. The FC Plan will also allow children and youth who leave foster care to remain in the FC Plan for at least 12 months following the transition.⁴
- **The FC Plan must demonstrate accountability through robust data reporting and clear quality standards.** To ensure that the FC Plan is meeting the needs of its members, the Plan must track and report on the services delivered as well as health outcomes; performance improvement plans must be specifically targeted to members' unique needs.
- **The FC Plan must account for the multiple transitions that children and youth in foster care experience, both within foster care and in and out of foster care.** The Department, local Departments of Social Services and the FC Plan must work together to ensure transition plans are in place to minimize preventable disruptions in coverage or care relationships. The FC Plan will also be required to ensure that there is an adequate provider network in place to address the complex needs of children and youth in foster care.
- **The FC Plan must promote health equity.** Children and youth from racial and ethnic minority backgrounds are disproportionately represented in the child welfare system compared to the general child population in North Carolina.⁵ At the same time, racial and ethnic disparities in children's health care access and outcomes nationally are pervasive.⁶ The FC Plan must implement, consistent with Department guidance, a health plan for children and youth currently and formerly involved in the child welfare system that advances health equity for this diverse population.

The FC Plan must support the overall goals of North Carolina's Medicaid Managed Care transformation. The Department's vision for [Medicaid Transformation](#) is to improve the health of North Carolinians through an innovative, whole-person centered and well-coordinated system of care that addresses medical and non-medical drivers of health. Consistent with North Carolina's goals for the transition to managed care, the FC Plan must operate in a way that streamlines the member experience with the health care delivery system, including timely access to needed information and a broad provider network that promotes member choice. To enable providers to allocate more resources to direct patient care, the FC Plan also must focus on reducing the administrative burden for providers through its policies and procedures.

⁴ Children and youth must maintain Medicaid eligibility to qualify for FC Plan coverage after leaving the child welfare system.

⁵ Details on racial/ethnic make up of children in foster care in NC as of federal fiscal year 2015 available [here](#).

⁶ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4374424/>

III. Procurement Process

The Department intends to procure a single statewide plan for children and youth currently and formerly involved in the child welfare system that will cover all regions of the state to mitigate disruptions in care and coverage. Only Standard Plans and Behavioral Health and Intellectual/Developmental Disability (I/DD) Tailored Plans selected to hold a contract with the Department at the time that applications under the FC Plan's procurement are due will be eligible to bid on the FC Plan. The FC Plan must operate and deliver services Statewide and comply with all licensure requirements outlined in the Standard Plan or Behavioral Health I/DD Tailored Plan Contract, whichever is applicable. The Department intends to release the FC Plan procurement in the spring of 2021 and award the contract in the fall of 2021. The launch of the FC Plan is expected to align with the launch of Behavioral Health I/DD Tailored Plans in July 2022.

IV. Eligibility and Enrollment

The following populations⁷ who are not otherwise excluded from Medicaid managed care or meet another exception will be eligible for the FC Plan:

- Children in foster care.
- Children receiving Title IV-E adoption assistance.
- Former foster care youth under age 26.⁸
- Children of individuals eligible for FC Plan enrollment.

When Standard Plans launch in July 2021, beneficiaries eligible for the FC Plan will be excluded from Standard Plan enrollment and will continue to receive care through NC Medicaid Direct and LME-MCOs as applicable until the FC Plan launches.⁹ With limited exceptions, at FC Plan launch, the Department will automatically enroll eligible individuals into the FC Plan.¹⁰ FC Plan members will have the option to opt out of the FC Plan and stay in or transfer to a Standard Plan, Behavioral Health I/DD Tailored Plan (if eligible), Tribal Option (if eligible) or NC Medicaid Direct (if eligible) at any point during the coverage year.

Children or youth who leave foster care will have the option to remain in the FC Plan for at least 12 months following the transition as long as they maintain Medicaid eligibility to promote continuity of care, support reunification and help address additional challenges that children and youth may experience after leaving foster care.¹¹

V. Benefits

⁷ The Department is seeking legislation to enroll these individuals.

⁸ 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.

⁹ Children of individuals eligible for FC Plan enrollment are not exempt from enrollment in Standard Plans and will be enrolled in Standard Plans, as eligible, upon their launch.

¹⁰ Tribal members who are eligible for the FC Plan will be enrolled into the Tribal Option or remain in NC Medicaid Direct depending on their region and will have the option to enroll in the FC Plan; individuals eligible for both the FC Plan and Medicare are also excluded from FC Plan enrollment

¹¹ Children in the former foster care eligibility group up to age 26 will be able to stay in the FC Plan for as long as they remain enrolled under that Medicaid Eligibility Group. These children will not be given the option to remain in the FC Plan after their 26th birthday (or after their 21st birthday if they aged out of foster care out of state).

The FC Plan will cover a comprehensive array of benefits, including all services that will be covered by Standard Plans¹² and the majority of Behavioral Health I/DD Tailored Plan Medicaid-covered services. Individuals eligible for the FC Plan who are on the Innovations or Traumatic Brain Injury (TBI) waiver,¹³ served by intermediate care facilities for individuals with intellectual disabilities (ICF-IID) or TRACK at Murdoch Center, eligible for North Carolina Transitions to Community Living Initiative (TCLI), or need State-funded behavioral health I/DD services will be required to enroll in a Behavioral Health I/DD Tailored Plan to access those services.¹⁴ In addition to the current benefits package, the FC Plan, with Department approval, may also use in lieu of services¹⁵ and value-added services¹⁶ to address the needs of the Plan's enrollees.

VI. FC Plan Care Management Model

Seamless and coordinated care management is one of the Department's highest priorities for members of the FC Plan. Care management that places individuals 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 caregivers more effectively manage health conditions.^{17,18,19} Such a person-centered care management approach is crucial to achieving the goals of the FC Plan, including providing integrated, whole-person care, fostering coordination and collaboration among care team members across different disciplines and settings and delivering services in a way that promotes health equity.

All beneficiaries enrolled in the FC Plan will have access to robust care management administered by the FC Plan.²⁰ Under the FC Plan care management model, the FC Plan will serve as the central locus of accountability for managing the health of all members and ensuring access to needed physical and behavioral health services, as well as health-related services, regardless of geographic location. The FC Plan will assign each member to a plan-based care manager within 24 hours who will be expected to coordinate closely with each member's primary care provider (PCP), assigned County Child Welfare worker, family members/guardians, and others, including biological parents, as appropriate, to manage the member's health care needs throughout their time enrolled in the FC Plan. The Department expects

¹² Details on the Standard Plan medical and behavioral health benefits package can be found in the Department's [RFP for Medicaid Managed Care Prepaid Health Plans](#). [Link to SP Contract (<https://files.nc.gov/ncdma/Contract--30-190029-DHB-Prepaid-Health-Plan-Services.pdf>) and reference Section V.C. Benefits and Care Management]

¹³ Individuals eligible for the FC Plan who are also on the TBI or I/DD waiver waitlist will be served by the FC Plan until the time when a waiver slot becomes available.

¹⁴ Approximately 7,000 individuals—23% of children in foster care as of January 2021—met the Behavioral Health I/DD Tailored Plan eligibility criteria; as of SFY 2018, 105 children in foster care were on the Innovations waiver. Behavioral Health I/DD 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 Behavioral Health I/DD Tailored Plans to access such services.

¹⁵ 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.

¹⁶ Value-added services are services, delivered at the FC Plan'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.

¹⁷ 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).

¹⁸ 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.

¹⁹ Hasselman, D. [Super-Utilizer Summit: Common Themes from Innovative Complex Care Management Programs](#). October 2013.

²⁰ All FC Plan members are eligible for plan-based care management, except for members participating in services that are duplicative of FC Plan care management, including members obtaining Assertive Community Treatment (ACT); members participating in Care Management for At-Risk Children; and members participating in the High-Fidelity Wraparound program.

that successful care management will necessitate close coordination with each member's providers and believes that a plan-based care management model with statewide reach will ensure continuity of care during changes in placements. Furthermore, the Department seeks to ensure close coordination between activities addressing each member's health needs and permanency goals by requiring that the FC Plan, in consultation with the Division of Social Services, co-locate care managers in County Child Welfare Services agencies throughout North Carolina. The FC Plan will also be required to align its care management approach with the North Carolina System of Care framework, which was developed to address the unique needs and challenges of children and youth with behavioral health needs through evidence-based, trauma-informed, resiliency-oriented behavioral health care.²¹

Delivery of Whole-Person, Integrated Care

FC Plan-based care managers will be responsible for the comprehensive management of each member's physical health, behavioral health, and I/DD needs, as well as unmet health-related resource needs across health care settings and foster care placements, including through the reunification and aging out transitions. The FC Plan will be required to develop a methodology for risk stratifying its members in order to align the intensity of care management with each member's level of need. As part of the core care management functions, care managers will conduct a comprehensive assessment for each member (within 14 days of enrollment for members identified as high-risk by the FC Plan's risk stratification methodology and within 30 days for all other members) 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 be completed within seven days of completion of the comprehensive assessment for members identified as high-risk and 14 days for all other members following completion of the comprehensive assessment.²² 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, among other elements.

The care manager will also be responsible for establishing a multidisciplinary care team for each member, which at a minimum must include the member, the member's assigned care manager, caretaker(s), legal guardian(s), biological parent(s) (as appropriate), the County Child Welfare worker, and the member's PCP.²³ The care manager will be responsible for convening the care team on a regular basis (no less than twice per year, or 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 care and health-related services.

Coordination and Co-Location with County Child Welfare Services Agencies

²¹ 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](#).

²² Delivery of the comprehensive assessment and development of the care plan/ISP may be accelerated, as needed, in order to manage urgent member needs.

²³ Certain requirements, such as coordination with DSS and legal guardians are not applicable to former foster youth under age 26

The Department believes the delivery of plan-based care management in close coordination with County Departments of Social Services is essential to mitigating disruptions in care and ensuring that all FC Plan members get the right care at the right time, despite changes in foster care placement or health care settings. As such, FC Plan care managers will be required to coordinate closely with each member's assigned County Child Welfare worker. To solidify this coordination, the FC Plan will physically co-locate the majority of care managers across North Carolina's network of County Departments of Social Services.²⁴ As part of the collaborative care management process, FC Plan care managers will:

- Arrange an initial meeting with the member's assigned County Child Welfare Worker within 72 hours of a member's enrollment in the FC Plan, or sooner if needed, as well as ongoing monthly check-ins.
- Assist the County Child Welfare Worker with scheduling Division of Social Services' required health assessments for the member, if necessary.
- Gather and consolidate the member's medical records.
- Coordinate the development of a crisis plan for each member.
- Identify health-related services that are necessary to support the member's biological parents and promote reunification and work with the County Child Welfare worker to make necessary referrals.
- Notify the County Child Welfare worker of a member admission to inpatient or institutional levels of care, use of behavioral health crisis services, disruption of school enrollment or involvement with the justice system within 24 hours of the event.

The FC Plan care manager will also be required to connect with County Child Welfare workers to identify whether there are any restrictions to communicating with a member's biological parent(s), such as termination of parental rights or court order restricting communication. Absent any restrictions and in accordance with North Carolina law, the FC Plan will mail copies of member materials to both the member's legal guardian and biological parent(s) and obtain consent from the biological parent(s) for certain health care treatments and procedures.²⁵

Continuity of Care and Coordination During Transitions

Transitions between plans or treatment settings (e.g., following a discharge from an institutional setting) are often a challenging time for beneficiaries. Stability and continuity of care are critical, particularly for children and youth in foster care, children receiving adoption assistance and former foster youth under age 26. 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 such transitions.

The FC Plan will be required to ensure the continuity of care for members in an active course of treatment for a chronic or acute medical or behavioral health condition as members transition from NC Medicaid Direct to the FC Plan or from one health plan to another health plan.²⁶ The care manager will notify the County Child Welfare worker, foster parent(s), and biological parent(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, FC Plan care managers will be required to connect with the member before and

²⁴ Terms of co-location will be subject to agreement by the County Child Welfare Services Agency.

²⁵ North Carolina General Statute § 7B-505.1.

²⁶ Including from one of North Carolina's Local Management Entities – Managed Care Organizations (LME/MCOs) to the FC Plan.

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after discharge, conduct discharge planning, facilitate clinical handoffs and arrange for medication management following discharge from a hospital or institutional setting or following an ED visit.

The FC Plan will be required to provide in-reach and transition services to certain members admitted to an institutional setting or an Adult Care Home (ACH).²⁷ The goal of in-reach and transition services is to 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.

The FC Plan will also be responsible for providing diversion interventions for members at risk of admission to an institutional setting or an ACH.²⁸ As part of the diversion activities, the FC Plan will assess members 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 referrals and linkages to community-based and other support services for which the member is eligible.

Support for Members Transitioning to Adulthood

The transition to adulthood can be challenging to navigate for any individual but may be particularly difficult for youth aging out of foster care, as they are more likely to lack the social and emotional supports needed to facilitate a successful transition to self-sufficiency. Former foster youth under age 26 enrolled in the FC Plan may also face challenges in navigating their own health needs when they age out of Medicaid coverage. The FC Plan's care management model builds in support to address these high-risk transition periods and reduce barriers. Care managers will facilitate robust transition planning both for members aging out of the child welfare system and those aging out of 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, post-high school education, housing and employment options, self-advocacy, health insurance coverage options after Medicaid eligibility ends and building natural supports.

For FC Plan members leaving the child welfare system, care managers will collaborate with County Child Welfare Workers as needed in the development of the Division of Social Services-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 FC Plan will also be responsible for

²⁷ The following FC Plan members will be eligible for FC Plan-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 Initiative (TCLI); 2) Members with a Serious Mental Illness (SMI) residing in an Adult Care Home (ACH) who are not also eligible for enrollment in a BH I/DD Tailored Plan; 4/3) All members in a Psychiatric Residential Treatment Facility; and 4) All members in Residential Levels II/Program Type III, and IV as defined in the Department's [Clinical Coverage Policy 8-D-2](#). Members determined eligible for TCLI and those with an SMI residing in an ACH who are also eligible for a BH I/DD Tailored Plan will be enrolled in and receive in-reach and transition services from a BH I/DD Tailored Plan.

²⁸ Members eligible for diversion activities include those meeting the following criteria: 1) Have transitioned from an institutional or correctional setting, or an Adult Care Home for adult members, within the previous six months; 2) Are seeking entry into an institutional setting; or Adult Care Home; Psychiatric Residential Treatment Facility; or Residential Treatment Levels II/Program Type, III, and IV; 3) Meet one of the following additional criteria for members with I/DD and TBI: a) Member has an aging 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 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 or guardians if one of those parents/guardians 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.

developing a Health Passport for each member as a supplement to the 90-day transition plan. The Health Passport is a document that will contain critical health care-related information, such as upcoming scheduled visits, prescribed medications and the member's medical records.

For former foster youth under age 26 aging out of Medicaid eligibility, care managers also must discuss health insurance options available to them and 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.²⁹

Comprehensive Medication Management Services

Children and youth currently and formerly involved in the child welfare system often face disruptions to their medication regimens due to frequent changes in placements and care. In particular, children and youth in foster care are prescribed psychotropic drugs at disproportionately higher rates than the general population.³⁰ As such, care managers, in consultation with the FC Plan psychiatrist and pharmacist, will be responsible for ensuring members have access to needed medications on an ongoing basis and during transitions and closely monitoring potentially dangerous aspects of each member's regimen. As part of supporting medication management, care managers will be required to:

- Deliver medication management 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/Fostering Health NC.³¹
- Ensure adequate supply of essential medications during initial member contact.
- Monitor use of psychotropic medication.
- Ensure provision of clinically appropriate metabolic monitoring for members prescribed antipsychotic medications.
- Coordinate with the member's PCP and local pharmacy to ensure access to needed prescriptions and adjust the medication regimen as appropriate.
- Leverage FC Plan psychiatrist/pharmacist expertise as necessary.

PCPs and FC Plan Care Management

The Department recognizes 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. To achieve this goal, the FC Plan will make additional payments to Advanced Medical Home (AMH) practices that provide primary care services to FC Plan members.³² In order 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:

²⁹ 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.

³⁰ "Best Practices for Medication Management for Children & Adolescents in Foster Care" from the North Carolina Pediatric Society/Fostering Health NC are available [here](#).

³¹ Id.

³² 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](#).

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- Coordinating with the member’s assigned FC Plan care manager and/or County Child Welfare Worker as appropriate.
- 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.

To ensure coordination across the health continuum, Medicaid-enrolled providers involved in the member’s care, including PCPs, behavioral health, TBI and I/DD providers, also will be eligible to receive a fee-for-service payment for participating in care team meetings with the FC Plan care managers.

Medicaid Health Home Option

The FC Plan Care Management model will operate as a federally designated Health Home, allowing North Carolina to claim an enhanced federal match rate for FC Plan members who meet Health Home eligibility.³³ The Department estimates that approximately 22% of FC Plan members will meet Health Home eligibility criteria; the Department plans to seek enhanced federal matching dollars for this group. Health Home eligibility, however, will not impact the level of care management received by FC Plan members – all FC Plan members will be assigned a care manager and receive care management services in accordance with the same requirements. The Department plans to submit a State Plan Amendment to the Centers for Medicare and Medicaid Services (CMS) to authorize the FC Plan to become a designated Health Home.

Healthy Opportunities

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. In collaboration with the Department’s Healthy Opportunities initiative, the FC Plan will be responsible for addressing four priority domains: 1) housing, 2) food, 3) transportation, and 4) interpersonal violence/toxic stress. The FC Plan is responsible for addressing these domains, and other unmet health-related resource needs, in the context of care management, quality, value-based payment, and stakeholder engagement, among other areas. The FC Plan will also be responsible for implementing the Healthy Opportunities Pilot program for its Pilot-eligible members, in accordance with Department requirements.³⁴ Integrating with the Healthy Opportunities initiative will be especially critical to former foster youth under age 26 navigating the challenges of young adulthood and in supporting children and youth and their families during the reunification process.

VII. Key Personnel Requirements

In addition to other applicable key personnel required in Standard Plans and Behavioral Health I/DD Tailored Plans that will also be required in the FC Plan (e.g., Chief Executive Officer and Chief Financial

³³ Health Homes are an optional Medicaid State Plan benefit, established by Section 2703 of the Affordable Care Act, for states to provide care coordination for Medicaid beneficiaries who have chronic conditions. States operating Health Homes can receive an enhanced, 90% federal match rate for care management services for the first eight quarters (two years) that the program is effective. The federal model is flexible according to the needs of states, as long as the model encompasses six core Health Home services: the provision of comprehensive care management; care coordination; health promotion; comprehensive transitional care/follow-up; individual and family supports; and referral to community and social support services.

³⁴ More information about the Healthy Opportunities Pilots is available [here](#).

Officer), the FC Plan must fill the following key leadership positions dedicated to the FC Plan. These individuals will oversee the Plan's delivery of services to children and youth in foster care, children receiving adoption assistance, and former foster youth under age 26, develop and implement policies and protocols that are specific to the population, and ensure collaboration across State agencies serving children and youth currently or formerly involved in the child welfare system. In addition, they will be required to have trauma-informed care experience; knowledge of the unique and complex health care needs of children and youth in foster care, children receiving adoption assistance, and former foster youth under age 26 and familiarity with the multiple State agencies that are involved with their care (e.g., Division of Social Services, Department of Public Instruction or Division of Juvenile Justice). These FC Plan-specific positions, all of whom must reside in North Carolina, shall include the following:

- **Chief Medical Officer.** The Chief Medical Officer (CMO) will be responsible for the delivery of medical and behavioral health services to all members in the FC Plan. The CMO will work in close coordination with all clinical leadership to develop clinical practice standards, policies and procedures, utilization management, pharmacy, population health and care management, quality management, and ensure an integrated approach to the physical and behavioral health of members. This individual must be a licensed pediatrician or family practice physician with a minimum of seven years working with children in a clinical setting.
- **Deputy Chief Medical Officer.** Reporting to the Chief Medical Officer (CMO), the Deputy Chief Medical Officer will assist with ensuring an integrated approach to the delivery of physical and behavioral health care services to the Plan's members. This individual must be a licensed child and adolescent psychiatrist with a minimum of five years clinical experience and two years of experience in managed care.
- **Director of Population Health and Care Management.** The Director of Population Health and Care Management will be responsible for providing oversight and leadership of all prevention/population health, care management and care coordination programs, including oversight of the FC care management model and contracted AMHs and Local Health Departments (LHDs). The individual must be a fully licensed clinician (e.g., LCSW, LCMHC, RN, MD, DO, LMFT) and have a minimum of five years of demonstrated care management/population health experience in a health care organization serving Medicaid beneficiaries.
- **Pharmacy Director.** In addition to managing the FC Plan pharmacy benefits and services, the Pharmacy Director will be responsible for leading the Plan's implementation of the medication management requirements in accordance with the contract. The individual must be a North Carolina-registered pharmacist, have demonstrated experience in medication management for high-risk children, including those involved in the child welfare system, and a minimum of three years of experience with Medicaid pharmacy benefits management.

To ensure service delivery in the FC Plan effectively meets the needs of all members, the FC Plan also will be required to provide training to all staff, including member services and provider relations staff, on the unique challenges members currently and formerly involved in the child welfare system face, including the impact of ACEs, the critical importance of closely coordinating with the Division of Social Services, and the importance of using trauma-informed and family centered approaches to service delivery and care.

VIII. Accountability for Quality

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The Department will establish a common set of quality measures as a key mechanism to ensure FC Plan accountability to the Department. All quality measures for the FC Plan will align with and build on the Department's Quality Strategy, which will be updated to include the FC Plan and which primarily emphasizes outcomes for beneficiaries over process measures.

The FC Plan will be required to report robust and dedicated measures that prioritize medical needs and experiences that are significant in the FC Plan population. Although the Department aims to align with Standard Plan and Behavioral Health I/DD Tailored Plan quality measures where possible, the Department also recognizes the need to differentiate and prioritize measures unique to the FC Plan.

The FC Plan will be required to report 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. Through the quality improvement process, the Department will review the FC Plan's stratified performance on measures; subsequently, the FC Plan will be expected to identify and implement interventions to reduce health and quality outcome disparities that are observed by the Department.

As part of the FC Plan's overarching quality strategy, the FC Plan will be required to complete at least three performance improvement projects (PIPs) each coverage year, with a minimum of one under each of the following three categories: 1) non-clinical, 2) clinical, and 3) transitions and continuity of care. For its clinical PIP(s), the FC Plan must consider how innovative use of care management can contribute to clinical performance improvement.

The Department will provide the FC Plan with a set of options under each of the three categories, and the FC Plan may choose among any of the options within a given category (see Section XIII. Appendix: Performance Improvement Projects [PIPs]). To the extent possible, the FC Plan should align PIPs with those that are being conducted for other Medicaid populations that the FC Plan is serving through its work as a Standard Plan or Behavioral Health I/DD Tailored Plan. However, the Department reserves the right to mandate specific PIPs and/or prescribe additional PIPs based on member experience and outcomes further tailored to the FC Plan.

The Department will conduct oversight and monitoring of the FC Plan and will convene monthly meetings with the FC Plan quality director to discuss opportunities for performance improvement.

IX. Provider Network & Payment

The FC Plan will include a robust network of physical health, behavioral health, I/DD, and LTSS providers across the State in order to achieve statewide reach and meet the needs of all members. To that end, the FC Plan must meet network adequacy standards. These standards generally align with the Standard Plan and Behavioral Health I/DD 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 Behavioral Health I/DD Tailored Plan contracts for certain provider types.

The FC Plan must contract with "any willing provider" for all provider types as long as the provider is enrolled in North Carolina Medicaid, accepts the Plan's network rates and meets the Department's quality standards. The FC Plan is required to implement a strong monitoring program to ensure providers are meeting member needs and program requirements. In addition, the FC Plan 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 ACEs to understand the needs of the population served by the Plan.

To encourage continued provider participation in the Medicaid program, ensure Member access and support safety net providers, the FC Plan will be subject to requirements for provider payments consistent with Standard Plans and Behavioral Health I/DD Tailored Plans. These requirements include rate floors – at NC Medicaid Direct levels or levels defined by the Department – for in-network physicians, physician extenders, pharmacies (dispensing fees), hospitals and nursing facilities. For certain in-network providers (e.g., local health departments, public ambulance providers), the FC Plan will also be required to make additional payments based on utilization of specific services. With the exception of out-of-network emergency services, post-stabilization services and services during transitions of care, the FC Plan will be prohibited from reimbursing an out-of-network provider more than 90% of the NC Medicaid Direct rate if the FC Plan 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 will be reimbursed at 100% of the NC Medicaid Direct rate.

X. Financial Management

The Department’s financial management requirements were developed to monitor and promote program sustainability. The Department expects, and will rely upon, the FC Plan to be a good steward of Medicaid Managed Care resources, focusing expenditures on services and benefits that improve member health. The Department will pay the FC Plan a per member per month capitation payment that is set in an actuarially sound manner. The FC Plan is expected to manage FC Plan expenditures within the capitation payments and have access to sufficient capital to cover any losses the FC Plan experiences. Specifically, the FC Plan must:

- Meet, at a minimum, an 88% Medical Loss Ratio (MLR) threshold in aggregate across the FC Plan as required by G.S. 108D-65.
- Purchase reinsurance to protect against the financial risk of high-cost claims or propose an alternative mechanism for managing financial risk.
- Maintain a current ratio above 1.0 as determined from the monthly, quarterly and annual financial reporting schedules.³⁵
- Maintain a defensive interval ratio above 30 calendar days as determined from the monthly, quarterly and annual financial reporting schedules.³⁶

Applicable licensure and solvency standards will apply based on whether the FC Plan is awarded to an entity operating a Standard Plan or Behavioral Health I/DD Tailored Plan.

XI. Stakeholder Engagement

Community engagement is critical to the successful implementation of the FC Plan. The FC Plan must closely collaborate with county agencies (e.g., LHDs, County Child Welfare Services agencies, local education agencies, law enforcement and judicial agencies) and community-based organizations (CBOs)

³⁵ The Current Ratio is defined as Current Assets divided by Current Liabilities.

³⁶ . The Defensive Interval is defined as cash plus cash equivalents divided by Operating Expenses minus Non-Cash Expenses divided by the period measured in days.

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(e.g., homeless shelters, faith-based organizations and consumer and peer run organizations) to help guide and support the delivery of services to members and families statewide. The FC Plan will be required to develop and implement a local community collaboration and engagement strategy that supports continued engagement with county agencies and CBOs and builds partnerships at the local level to improve the health of their members.

Additionally, the FC Plan will be required to collaborate with other Department partners to ensure that members' unique needs are met. Specifically, the FC Plan will foster relationships with the Division of Juvenile Justice, Department of Public Instruction, Department of Public Safety, Office of Minority Health and Health Disparities and the Division of Public Health, among other stakeholders, to ensure members' needs are met. In addition, the FC Plan must also have a strong understanding of and capability to meet the needs of all 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.

XII. Next Steps

The Department welcomes feedback from stakeholders as it continues to refine FC Plan design and begin operational planning. Stakeholder feedback will be crucial for ensuring a smooth transition of children and youth in foster care to managed care. Comments may be submitted to the Department using [this form](#). The form contains questions about key features of the plan and offers respondents an opportunity to suggest gaps, missing information, recommendations and identify concerns. Input received by Feb. 25, 2021, will be used by the Department as it develops the FC Plan procurement.

XIII. Appendix: Performance Improvement Projects

A. Non-Clinical PIPs

The FC Plan shall be required to develop and execute at least one non-clinical PIP annually that must be related to one or more of the following areas:

1. Improving timeliness of health assessment completion (including DSS initial and follow-up health screenings) and care plan development (e.g., implementation of data sharing and other coordination best practices).
2. Improving supports to promote diversion, in-reach and/or transition for populations in or at risk of entrance into residential treatment centers, adult care homes (ACHs) or other congregate care (including DSS-funded congregate care) settings.
3. Improving the adequacy of the behavioral health network with regards to geographic and virtual accessibility to Members, as applicable, and representation of historically underrepresented groups among providers in the network.
4. Improving educational outcomes and addressing underlying health needs/learning disabilities that contribute to poor school performance (e.g., ADHD screening and treatment, collaboration with Department of Public Instruction to track educational outcomes such as grade-appropriate reading level and kindergarten readiness).

B. Clinical PIPs

The FC plan shall be required to develop and execute at least one clinical PIP annually. The PIP must be related to one or more of the following areas, and the FC Plan must consider how innovative use of care management can contribute to clinical performance improvement in the selected area(s):

1. Improving prevention and management of acute and chronic conditions; focus area(s) may include but are not limited to the following:
 - a) Asthma
 - b) Early childhood health and development including well visits, immunizations, and developmental screenings
 - c) Tobacco screening and cessation
 - d) Behavioral-physical health integration
 - e) Birth outcomes
 - f) Maternal health
2. Improving identification and management of psychotropic medication prescribing.
3. Improving identification of and treatment for primary diagnosis of PTSD and underlying diagnoses.
4. Improving identification of and care for children with special health care needs.

5. Enhancing incorporation of trauma-informed competence and services into physical and behavioral health care delivery, particularly for children/young adults who have a history of abuse/neglect and children/young adults who are at risk for juvenile justice involvement.

C. Transitions and Continuity of Care

The FC Plan shall be required to develop and execute at least one clinical PIP annually that is related to care and continuity across foster care placements and institutional settings (e.g., psychiatric residential treatment facilities [PRTFs], juvenile justice system, from one foster care placement to another, and out-of-state placements) for this population. The FC Plan may focus on care while the enrollee is in a placement, is transitioning between placements or is transitioning out of foster care (e.g., member ages out of foster care, member is reunified with family).

1. In Placements

- a) Measures taken to conduct regular medical team care conferences, particularly before and after new placements occur, that engage all appropriate representatives for the enrollee (e.g., care manager, County Child Welfare Worker, PCP and/or BH/IDD provider).
- b) Coordination with DSS to provide all necessary supports required to enable an enrollee to remain in a placement, provided the placement is safe and suitable.
- c) Measures taken to mitigate law enforcement involvement in behavioral crises (e.g., specialized trauma-informed training for group home staff and foster care guardians, coordination with local Emergency Medical Services to promote dispatching trained mobile crisis units, rather than law enforcement, as a best practice).

2. Between Placements

- d) Development of transitional care plans to ensure continuity across placements and institutional settings (e.g., PRTFs, juvenile justice system, out-of-state placements).
- e) Processes implemented to conduct regular monitoring and timely in-person interactions with enrollees who are temporarily in out-of-county or out-of-state placements.
- f) Mechanisms to involve family (biological and foster care) and DSS in care plan development and transitional care (e.g., engaging a family partner to support transitions from institutional settings).

3. Transitions out of Foster Care

- g) Measures taken prior to enrollee exiting foster care to reduce risk of adverse outcomes, including juvenile justice system involvement and homelessness (e.g., screenings for depression and anxiety, diagnosis and treatment of SUD, social supports including housing assistance).
- h) Measures taken prior to enrollee exiting foster care to ensure successful community integration (e.g., supports to ensure community inclusion, community living skills).