NC Medicaid Managed Care
Policy Paper

Update on North Carolina's Children and Families Specialty Plan

North Carolina Department of
Health and Human Services

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I. Background

As part of its Medicaid managed care transformation efforts, the North Carolina Department of Health and Human Services (NCDHHS) intends to launch the Children and Families Specialty Plan (CFSP)[1] (formerly referred to as the "Specialized Foster Care Plan" or "FC Plan")—a single, statewide NC Medicaid Managed Care plan—that will support Medicaid and North Carolina Health Choice (NC Health Choice)-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 member's geographic location—will provide members with access to a broad range of physical health, behavioral health, pharmacy, long-term services and supports (LTSS), Intellectual/Developmental Disability (I/DD) services, and resources to address unmet health-related needs; the statewide design will also enable the CFSP to maintain members' treatment plans. The CFSP will offer robust care management to every member, working in close coordination with the state Division of Social Services (DSS), County Department of Social Services (County DSS) offices and Eastern Band of Cherokee Indian (EBCI) Family Safety Program.

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. These children and families generally experience greater unmet health needs than those not served by the child welfare system. 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.[2] 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.[3] Children and adolescents at risk of removal from their homes may also have significant chronic health conditions and other developmental, cognitive, emotional/behavioral and substance use disorder (SUD) treatment needs.[4] Parents of these children similarly are at increased risk for significant physical and behavioral health needs, such as major depression.[5] Family preservation requires access to supports that promote positive outcomes and family well-being, including behavioral health services, SUD treatment, parent skill-building programs and connections to health-related resources such as food and housing.[6]

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[1] The Children and Families Specialty Plan (CFSP) is a placeholder name. In 2022, NCDHHS intends to identify a new name for the CFSP to better represent the objective of the managed care plan and its target populations.

[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, 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.

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

[5] Id.

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

Improving access to health care services for children and families served by the child welfare system is also critical to advancing health equity. Representation of children and families served by the child welfare system is disproportionately high for people of color.[7] For example, in State Fiscal Year 2021, approximately 25% of North Carolina's child population was Black but accounted for 29% of children in foster care, whereas White children made up 64% of North Carolina's child population but accounted for 57% of children in foster care.[8] Beyond the disproportionate representation, children of color are more likely to experience negative outcomes in the child welfare system.[9]

This policy paper, an update to the CFSP policy paper released in February 2021, summarizes the current CFSP design, with a focus on key changes made as a result of stakeholder feedback related to eligibility and enrollment, care management, provider network and quality. It also provides information on the anticipated CFSP procurement timeline based on the design changes. NCDHHS recognizes the complexity of implementing the CFSP and will continue to provide updates on the CFSP's design and implementation timelines as operational planning continues.

Notably, the CFSP is just one of a number of reform initiatives NCDHHS and its partners are advancing to meet the needs of families served by the State's child welfare system. A multi-sector workgroup is working to unify these efforts across the State's child- and family-serving systems to achieve positive outcomes for children and families. The workgroup expects to release a policy brief that identifies how the State intends to begin addressing current system challenges for children and youth with high acuity behavioral health needs in February 2022.

II. Stakeholder Engagement

In February 2021, NCDHHS outlined the State's initial vision and design for a specialty NC Medicaid Managed Care plan for children and youth currently and formerly served by the child welfare system. NCDHHS received extensive stakeholder feedback on the policy paper and in response, decided to delay the launch of the Plan to allow for additional time to engage with stakeholders and refine the Plan design based on their input.

Beginning in April 2021, NCDHHS convened a CFSP Workgroup, a diverse set of stakeholders including families and youth with lived experience, providers, representatives from advocacy organizations, Standard Plans, LME/MCOs, the Eastern Band of Cherokee Indians (EBCI), state and County DSS offices, the NC Association of County Directors of Social Services (NCACDSS), state agencies and community-based organizations to establish a forum for bi-directional feedback on Plan design. In a series of working sessions between April 2021 and January 2022, Workgroup members provided feedback to NCDHHS on key aspects of the CFSP to ensure that it meets the unique needs of children, youth and families served by the child welfare system. Beyond the Workgroup, NCDHHS also held listening sessions and discussions with stakeholders that support this population, including additional state and County DSS representatives, EBCI Public Health and Human Services (PHHS) Department and the Cherokee Indian Hospital Authority (CIHA) representatives, families and youth with lived experience, family-led organizations, consumer and family advocates, members of the Guardian ad Litem program and the Division of Juvenile Justice.

[7] Disproportionality and Race Equity in Child Welfare. National Conference of State Legislatures, 2021. Available here.
[8] Data provided by the North Carolina Division of Social Services via email on January 27, 2022.
[9] 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.

Leveraging the recommendations received throughout this stakeholder engagement process, NCDHHS refined the CFSP design to better serve the children, youth and families who will be served by the Plan. NCDHHS anticipates engaging in continued stakeholder activities, including but not limited to continuing to work with DSS, the County DSS offices, and the EBCI PHHS/CIHA/EBCI Tribal Option.

III. Children and Families Specialty Plan Objectives

NCDHHS is developing the CFSP 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 access to physical health, behavioral health, pharmacy, LTSS and I/DD services, as well as unmet health-related resource needs;
- Strengthen and stabilize families, prevent entry into foster care and support reunification and other permanency goals;
- Coordinate care and facilitate seamless transitions for members who experience changes in treatment settings, child welfare placements and/or loss of Medicaid eligibility upon turning 26;
- Improve coordination and collaboration with County DSS offices, EBCI Family Safety Program, and more broadly, with the System of Care—a comprehensive network of community-based services and supports—to meet the needs of families who are involved with multiple child service agencies; and
- Advance health equity to address racial and ethnic 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. To address this challenge, 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. Stakeholders largely agreed that 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.

V. Eligibility and Enrollment

NCDHHS received extensive stakeholder feedback about the populations eligible for the Children and Families Specialty Plan (CFSP). In the initial Department design proposal, the CFSP design focused on enrolling children and youth who are currently or were formerly in foster care as well as children receiving adoption assistance. Based on stakeholder feedback and in concert with North Carolina's

broader child welfare transformation work, NCDHHS proposes a pioneering approach, significantly expanding the populations eligible for the CFSP to include Medicaid and NC Health Choice-enrolled families of children and youth in foster care, as well as Medicaid and NC Health Choice-enrolled children and families receiving Child Protective Services (CPS) In-Home Services or EBCI Family Safety Program-equivalent. Stakeholders highlighted important benefits, such as coordination of health and health-related services for a family unit by a single plan and access to staff and providers who are trained and best equipped to support families served by the child welfare system, as reasons for proposing to expand the CFSP eligibility beyond children and youth in foster care. This updated proposed design centers on family-focused, prevention-oriented care.

This proposed plan, once receiving legislative authority, could require significant reconfiguration of existing information technology systems to facilitate serving and providing care to family units.

Eligibility

Pending legislative approval, the following Medicaid and NC Health Choice-enrolled populations who are not otherwise exempt or excluded from NC Medicaid Managed Care[10], or meet another exception[11], will be eligible for the CFSP:

- Children and youth in foster care
- Children receiving adoption assistance
- Former foster care youth under age 26[12]
- Minor children of individuals eligible for CFSP enrollment[13]
- Parents, guardians, custodians and minor siblings of children/youth in foster care[14]
- 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

Notably, in 2021, North Carolina passed legislation that will allow Medicaid-enrolled parents of children entering the foster care system to temporarily keep their Medicaid coverage after their children leave

[10] 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 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); beneficiaries with services provided through the Program of All Inclusive Care for the Elderly (PACE); and certain uninsured individuals receiving COVID-19 testing during the public health emergency.

[11] Individuals otherwise eligible for the CFSP who are Innovations or TBI waiver enrollees, beneficiaries residing in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID), or eligible for the 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.

[12] Former foster youth 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.

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

[14] The CFSP will recognize the Tribal definition of "parents, guardians, and custodians" in determining Tribal member eligibility for the Plan.

the home.[15] This will enable parents who would otherwise have lost their Medicaid coverage at the time when a child was removed to continue accessing physical and behavioral health services, which are often critical to support family reunification. Medicaid-enrolled parents, guardians, custodians and minor siblings of children/youth in foster care will remain eligible for CFSP enrollment so long as they are working toward reunification.

In addition, this Plan 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
NCDHHS, with limited exceptions, plans to automatically enroll the following populations into the CFSP:[16]

- Children and youth in foster care
- Children receiving adoption assistance
- Former foster care youth under age 26
- Minor children of children and youth in foster care, children receiving adoption assistance, and former foster youth who are eligible for CFSP enrollment

These 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 DSS 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.[17]

All other CFSP-eligible populations will have the option to enroll in the CFSP as follows:

- Parents, guardians, custodians and minor siblings of children/youth in foster care
- 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

If these individuals do not opt-in to the CFSP, they will remain in a Standard Plan, Tailored Plan, or EBCI Tribal Option, 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. The Enrollment Broker will be available to educate and help individuals navigate this decision.

Given the system reconfigurations needed to operationalize the CFSP, NCDHHS anticipates it may be necessary to phase-in enrollment for CFSP-eligible populations. NCDHHS anticipates launching the CFSP with individuals who will be auto-enrolled, followed by individuals eligible to opt-in. NCDHHS will issue

[15] Section 9D.14 of S.L. 2021-1802021 Appropriations Act. Available here.
[16] 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 10.
[17] 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.

further guidance following additional operational planning but prior to release of the CFSP Request for Proposals (RFP).

Continuation of Coverage
Children and youth who leave foster care and maintain Medicaid eligibility will have the option to remain in the CFSP for at least 12 months following the transition from foster care. 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 help address additional challenges that children and youth may experience after leaving foster care.[18]

VI. Benefits

The CFSP will cover a comprehensive array of Medicaid- and NC Health Choice-covered physical and behavioral health benefits, including all services that will be covered by Standard Plans[19] in addition to the majority of Tailored Plan services.[20] 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.[21]

Individuals otherwise eligible for the CFSP who are on the Innovations or Traumatic Brain Injury (TBI) waiver,[22] 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 (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- and NC Health Choice-covered services, as appropriate.[23] In addition to the current benefits package, the CFSP, with Department approval, may also offer in lieu of services[24] and value-added services[25] to address the needs of the CFSP's members.

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[18] 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.

[19] 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.

[20] See Appendix for more details on services covered by Standard Plans, Tailored Plans, and the CFSP.

[21] Per G.S. 108A-70.21, NC Health Choice-enrolled children receive benefits that are equivalent to those provided for dependents under North Carolina's Medicaid program except for long-term care services, non-emergency medical transportation, and Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits.

[22] 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.

[23] 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.

[24] 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.

[25] 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.

VII. CFSP Care Management

Seamless and coordinated care management 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 caregivers more effectively manage health conditions.[26,27,28] Stakeholders were generally supportive of the originally proposed care management design and provided input to further refine and improve the already robust care management approach. As described in further detail below, the CFSP will provide care management to all members enrolled in the Plan.[29] NCDHHS will refine the CFSP's care management model to ensure it meets the needs of parents and siblings of children/youth in foster care and families receiving CPS In-Home services and communicate updates in a future policy paper.

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 and behavioral health services, as well as health-related services, regardless of geographic location or type of transition the member is experiencing. 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, 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.

NCDHHS expects 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 best facilitate continuity of care during changes in placements. Several stakeholders advocated for a larger role for provider-based care managers in the CFSP care management model. Many noted that some community-based providers have considerable expertise working with children and families served by the child welfare system; others highlighted the value of community-based care management in connecting members with needed services and with local agencies that align with cultural humility and sensitivity. While NCDHHS believes that a plan-directed care management model will allow for more effective management of a highly mobile population and streamline coordination with County DSS offices and EBCI Family Safety Program, which are core components of the CFSP care management model, it also recognizes the considerable value of community-based care management. Accordingly, 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. 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.

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[26] 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).

[27] 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.

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

[29] 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 members participating in the High-Fidelity Wraparound program.

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 needs across health care settings and placements, including through transitions such as permanency planning, reunification and transitioning out of DSS 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. Based on stakeholder feedback, NCDHHS will establish care manager caseload requirements to ensure sufficient staffing levels. NCDHHS agrees with stakeholders that establishing reasonable caseload ratios is likely to promote a more robust care management staffing model and intends to establish minimum ratios 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 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. NCDHHS will set standards outlining the timelines that the CFSP must meet for administering comprehensive care management 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 comprehensive assessment and development of the care plan/ISP must be accelerated, as needed, to manage members' urgent needs/crises.

Many stakeholders emphasized 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 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 will also be required to provide 24/7 support during emergencies or behavioral health crises, including working with County Child Welfare workers (or EBCI Family Support Services representatives) to secure immediate treatment services, as needed.

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 and the member's PCP.[30] For adults, the multidisciplinary team might include but is not limited to the member's assigned care manager, the County Child Welfare worker, and the member's PCP.[31] 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.

[30] 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.
[31] Certain requirements, such as coordination with DSS and guardians, are not applicable to former foster youth.

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.[32]

Coordination and Co-Location with County DSS

Coordination

NCDHHS believes the delivery of plan-directed care management in close coordination with County DSS offices 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 foster care 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 served by the EBCI Family Safety Program instead of DSS/County DSS offices, 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 regularly meet and coordinate with County Child Welfare workers 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 DSS-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; and
- 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.[33,34]

Co-location

To support coordination between CFSP care managers and County Child Welfare workers, NCDHHS intends to require the CFSP to physically co-locate a portion of care managers across North Carolina's network of County DSS offices, taking into account the State's mix of urban and rural geography and

[32] 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.

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

[34] 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.

availability of physical office space.[35] This requirement aligns with feedback that NCDHHS received from a survey it undertook in collaboration with the North Carolina Association of County Directors of Social Services (NCACDSS) Executive Team in August 2021 which found more than half of County DSS offices interested in the co-location model. 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 offices, addressing issues where County Child Welfare workers are seeking to coordinate with care managers, and 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 plans to facilitate a collaborative operational planning process between state DSS leadership, County DSS staff, NCACDSS, NC Medicaid and other stakeholders (as appropriate). NCDHHS plans to release additional operational guidance based on these discussions.

In addition, stakeholders encouraged NCDHHS to establish a centralized platform for secure, bi-directional sharing of key member data between the CFSP and County DSS offices. NCDHHS recognizes the importance of streamlined data sharing and plans to engage with the CFSP and state and County DSS on developing processes that work for care managers as well as County Child Welfare workers.

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).

Stakeholders were supportive of requiring the CFSP to ensure the continuity of care for all members in an active course of treatment for a chronic or acute physical or behavioral health condition as members transition from NC Medicaid Direct to the CFSP or from one health plan to another health plan. As proposed in the original design, the care manager 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 management following discharge from a hospital or institutional setting or following an Emergency Department visit.

Consistent with the initial design, the CFSP will be required to provide in-reach, transition, and diversion

[35] 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,

services to certain members.[36,37] 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. 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.

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.[38] 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. Stakeholders were very supportive of providing targeted supports to members transitioning to adulthood. 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 DSS-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, that will contain critical health care-related information, such as upcoming scheduled visits, prescribed medications and the member's medical records.

[36] 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.

[37] 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; PRTF; 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.

[38] 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.

For former foster youth aging out of the former foster youth categorical Medicaid eligibility group, care managers also must educate members about 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.

Comprehensive Medication 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 all members receive robust medication management. This will include, at minimum, leveraging CFSP care managers and members' physicians to ensure members have access to needed medications on an ongoing basis and during transitions (including placement changes), closely monitoring potentially dangerous aspects of each member's regimen, and ensuring close coordination with the County Child Welfare worker. The CFSP will be required to ensure medication 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/Fostering Health NC.[39]

In addition, the CFSP will be required to closely monitor members prescribed psychotropic medications. Children and youth in foster care are prescribed psychotropic drugs at disproportionately higher rates than the general population, putting them at greater risk of potential overuse.[40] For members prescribed psychotropic medications, care managers will be required to work closely with CFSP psychiatrists and pharmacists to ensure the delivery of clinically appropriate metabolic monitoring (in addition to ensuring access and monitoring potential interactions, as described above).

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. To achieve this goal, the CFSP will make additional payments to Advanced Medical Home (AMH) practices that provide primary care services to CFSP members.[41] The initial design of the CFSP outlined that, 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:

- Coordinating with the member's assigned CFSP 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;

[39] Id.

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

[41] 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.

- Conducting the recommended developmental, behavioral, psychosocial and other screenings as appropriate based on age and the member's clinical condition;
- Completing DSS-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 will release additional guidance on this.

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, 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. In collaboration with NCDHHS' Healthy Opportunities initiative, the CFSP will be responsible for addressing four priority domains: 1) housing, 2) food, 3) transportation, and 4) interpersonal violence/toxic stress. The CFSP will also be responsible for implementing the Healthy Opportunities Pilot program for its Pilot-eligible members, in accordance with Department requirements.[42] 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 DSS 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. These standards generally 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.[43]

Based on stakeholder feedback, NCDHHS will update the CFSP's provider contracting design. The CFSP will have an "any willing provider"[44] network for all services *except* intensive in-home services, multisystemic therapy, residential treatment services and PRTFs.[45] NCDHHS believes this revised approach balances shared goals of providing members with provider choice while ensuring the delivery of high-quality services.

[42] More information about the Healthy Opportunities Pilots is available here.
[43] This also includes following the Tribal Managed Care Addendum, the Tribal Payment Policy and adherence to tribal exceptions for licensure and other provider requirements.
[44] "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.
[45] Subject to legislative authority.

In addition, stakeholders sought to ensure that the CFSP maximizes timely access to critical behavioral health services to help avoid long waits for services and placements in inappropriate settings while awaiting treatment. To ensure sufficient availability of in-network providers for key behavioral health services, the CFSP may be required to contract with a minimum percentage of certain providers statewide, such as a minimum percentage of residential treatment service providers, PRTFs, and crisis service facilities.[46] 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 plan or NC Medicaid Direct. During this transitional period, the CSFP will work to either onboard the provider into its network or safely transition the member to an existing in-network provider.

As had been 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 fees), essential providers,[47] hospitals[48] 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, 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 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 for the CFSP will align with and build on NCDHHS' Quality Strategy, which will be updated to include the CFSP, and which primarily emphasizes outcomes for beneficiaries over process measures. The proposed quality measures prioritize medical needs and experiences that are significant in the CFSP population.

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

[47] 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.

[48] Hospital rate floors are time-limited.

Stakeholders highlighted several important considerations, including the desire to measure how the CFSP serves families as a unit and the need to monitor the extent to which providers are accepting new referrals for children and youth served by the CFSP. In response to stakeholder feedback, NCDHHS is adding two quality measures to assess the proportion of providers accepting new referrals for children and youth enrolled in the CFSP. Stakeholders also recommended capturing metrics that seek to measure the risk of trafficking, placement stability and participation of parents, guardians, or custodians in care planning while in DSS/EBCI Family Safety Program custody. Given the nature and limitations of quality measures, NCDHHS will explore the entity or agency that is best positioned to capture additional measures related to these and other family-based outcomes.

Like with Standard Plans, Tailored Plans and EBCI Tribal Option, the CFSP 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, NCDHHS will review the CFSP's stratified performance on measures and require the CFSP to identify and implement interventions to reduce any health and quality outcome disparities observed.

As part of the CFSP's overarching quality strategy, the CFSP 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 children and youth served by the child welfare system. For its clinical PIP(s), the CFSP must consider how innovative use of care management can contribute to clinical performance improvement. NCDHHS will conduct oversight and monitoring of the CFSP and will convene monthly meetings with the Plan quality director to discuss opportunities for performance improvement.

In light of the CFSP eligibility expansion to families of children/youth in foster care and families receiving CPS In-Home Services, NCDHHS will revisit the CFSP's overall quality design to determine whether new requirements are needed to assess the quality of service delivery to these additional populations.

X. Timing & Next Steps

NCDHHS welcomes feedback from stakeholders as it continues to refine the CFSP design. Given the expansion of the CFSP eligibility and related needed systems changes, the procurement and implementation preparation timeline for the CFSP has been revised to the following:

- **Release CFSP Request for Proposals (RFP)**[49]**:** Summer 2022
- **Award CFSP Contract:** Fall 2022
- **Implementation Planning for CFSP Launch:** Fall 2022 – Winter 2023
- **Launch CFSP:** By December 2023

Stakeholders are welcome to submit feedback and recommendations to NCDHHS at Medicaid.NCEngagement@dhhs.nc.gov. Input received by March 4, 2022, will inform the CFSP design prior to finalizing the RFP. NCDHHS intends to issue another paper to outline additional CFSP design decisions made prior to the RFP's release.

[49] NCDHHS will procure a single statewide CFSP that operates and delivers services statewide. Only Standard Plans and Tailored Plans will be eligible to bid on the CFSP.

Appendix: Benefits Covered by Standard Plans, Tailored Plans, and the CFSP[50]

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

BH, I/DD, and TBI Services Covered by Standard Plans, Tailored Plans, and the CFSP	BH, I/DD and TBI Services Covered by Tailored Plans and the CFSP	BH, I/DD and TBI Services Covered Exclusively by Tailored Plans (or LME/MCOs Prior To Launch)
Enhanced BH services are *italicized*		
State Plan BH and I/DD Services • Inpatient BH services • Outpatient BH emergency room services • Outpatient BH services provided by direct-enrolled providers • Psychological services in health departments and school-based health centers sponsored by health departments • Peer supports • *Partial hospitalization* • *Mobile crisis management* • *Facility-based crisis services for children and adolescents* • *Professional treatment services in facility-based crisis program* • *Outpatient opioid treatment*[51] • *Ambulatory detoxification* • Research-based BH treatment for Autism Spectrum Disorder (ASD) • *Diagnostic assessment* • *Non-hospital medical detoxification* • *Medically supervised or alcohol and drug abuse treatment center*	**State Plan BH 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)*[52] • *Psychosocial rehabilitation* • *Substance abuse non-medical community residential treatment* • *Substance abuse medically monitored residential treatment* • *Substance abuse intensive outpatient program (SAIOP)*	**State Plan BH 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**[53] **Respite services through TRACK at Murdoch**

[50] Standard Plans, Tailored Plans, and the CFSP will cover all services in the NC Medicaid and NC Health Choice State Plans 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. Per G.S. 108A-70.21, NC Health Choice-enrolled children receive benefits that are equivalent to those provided for dependents under North Carolina's Medicaid program except for long-term care services, non-emergency medical transportation, and Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits.

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

[52] CST includes tenancy supports.

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

BH, I/DD, and TBI Services Covered by Standard Plans, Tailored Plans, and the CFSP	BH, I/DD and TBI Services Covered by Tailored Plans and the CFSP	BH, I/DD and TBI Services Covered Exclusively by Tailored Plans (or LME/MCOs Prior To Launch)
Enhanced BH services are *italicized*		
(ADATC) detoxification crisis stabilization • Early and periodic screening, diagnostic and treatment (EPSDT) services	• *Substance abuse comprehensive outpatient treatment program (SACOT)*	