NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Health Benefits

ROY COOPER • Governor
KODY H. KINSLEY • Secretary
JAY LUDLAM • Deputy Secretary, NC Medicaid

June 8, 2023

Sarah deLone, Director
Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850

SUBJECT: State Plan Amendment
Title XXI, Social Security Act
Transmittal #2023-0017

Dear Ms. deLone:

Please find attached a North Carolina's Children's Health Insurance Program (CHIP) State Plan Amendment under Title XXI of the Social Security Act. The affected sections are 1.4, 1.4-TC, 2.2, and 9.10. The purpose of this SPA is to implement Health Service Initiatives (HSI) that will create a Breastfeeding Hotline to provide support to all North Carolina families, and a Substance Use and Parenting Intervention Health Service Initiative, to address the social and health challenges that are associated with families and addiction.

The proposed effective date is July 01, 2023.

Your approval of this state plan amendment is requested. If you have any questions or concerns, please contact me or Betty J. Staton at (919) 538-3215.

Sincerely,

DocuSigned by:
Jay Ludlam
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Jay Ludlam
Deputy Secretary

Enclosures

TEMPLATE FOR CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT
CHILDREN'S HEALTH INSURANCE PROGRAM

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

State/Territory:_____North Carolina_____
(Name of State/Territory)

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, (42 CFR, 457.40(b))_____ DocuSigned by: Jay Ludlam 06565C1624A8E4C8... 06/09/23 | 2:15 PM EDT (Signature of Governor, or designee, of State/Territory, Date Signed)

submits the following Child Health Plan for the Children's Health Insurance Program and hereby agrees to administer the program in accordance with the provisions of the approved Child Health Plan, the requirements of Title XXI and XIX of the Act (as appropriate) and all applicable Federal regulations and other official issuances of the Department.

The following State officials are responsible for program administration and financial oversight (42 CFR 457.40(c)):

Name: Kody Kinsley Position/Title: Secretary, NC DHHS
Name: Jay Ludlam_ Position/Title: Deputy Secretary for Division of Health Benefits
Name: Melanie Bush_ Position/Title: Chief Operating Officer- NC Medicaid

Disclosure Statement This information is being collected to pursuant to 42 U.S.C. 1397aa, which requires states to submit a State Child Health Plan in order to receive federal funding. This mandatory information collection will be used to demonstrate compliance with all requirements of title XXI of the Act and implementing regulations at 42 CFR part 457. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-1148 (CMS-10398 #34). Public burden for all of the collection of information requirements under this control number is estimated to average 80 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Introduction: Section 4901 of the Balanced Budget Act of 1997 (BBA), public law 1005-33 amended the Social Security Act (the Act) by adding a new title XXI, the Children's Health Insurance Program (CHIP). In February 2009, the Children's Health Insurance Program Reauthorization Act (CHIPRA) renewed the program. The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, further modified the program. The HEALTHY KIDS Act and The Bipartisan Budget Act of 2018 together resulted in an extension of funding for CHIP through federal fiscal year 2027.

This template outlines the information that must be included in the state plans and the State plan amendments (SPAs). It reflects the regulatory requirements at 42 CFR Part 457 as well as the previously approved SPA templates that accompanied guidance issued to States through State Health Official (SHO) letters. Where applicable, we indicate the SHO number and the date it was issued for your reference. The CHIP SPA template includes the following changes:

- Combined the instruction document with the CHIP SPA template to have a single document. Any modifications to previous instructions are for clarification only and do not reflect new policy guidance.
- Incorporated the previously issued guidance and templates (see the Key following the template for information on the newly added templates), including:
  - Prenatal care and associated health care services (SHO #02-004, issued November 12, 2002)
  - Coverage of pregnant women (CHIPRA #2, SHO # 09-006, issued May 11, 2009)
  - Tribal consultation requirements (ARRA #2, CHIPRA #3, issued May 28, 2009)
  - Dental and supplemental dental benefits (CHIPRA # 7, SHO # #09-012, issued October 7, 2009)
  - Premium assistance (CHIPRA # 13, SHO # 10-002, issued February 2, 2010)
  - Express lane eligibility (CHIPRA # 14, SHO # 10-003, issued February 4, 2010)
  - Lawfully Residing requirements (CHIPRA # 17, SHO # 10-006, issued July 1, 2010)
- Moved sections 2.2 and 2.3 into section 5 to eliminate redundancies between sections 2 and 5.
- Removed crowd-out language that had been added by the August 17 letter that later was repealed.
- Added new provisions related to delivery methods, including managed care, to section 3 (81 FR 27498, issued May 6, 2016)

States are not required to resubmit existing State plans using this current updated template. However, States must use this updated template when submitting a new State Plan Amendment.

Federal Requirements for Submission and Review of a Proposed SPA. (42 CFR Part 457 Subpart A) In order to be eligible for payment under this statute, each State must submit a Title XXI plan for approval by the Secretary that details how the State intends to use the funds and fulfill other requirements under the law and regulations at 42 CFR Part 457. A SPA is approved in 90 days unless the Secretary notifies the State in writing that the plan is disapproved or that specified additional information is needed. Unlike Medicaid SPAs, there is only one 90 day review period, or clock for CHIP SPAs, that may be stopped by a request for additional information and restarted after a complete

response is received. More information on the SPA review process is found at 42 CFR 457 Subpart A.

When submitting a State plan amendment, states should redline the changes that are being made to the existing State plan and provide a "clean" copy including changes that are being made to the existing state plan.

The template includes the following sections:

1. **General Description and Purpose of the Children's Health Insurance Plans and the Requirements**- This section should describe how the State has designed their program. It also is the place in the template that a State updates to insert a short description and the proposed effective date of the SPA, and the proposed implementation date(s) if different from the effective date. (Section 2101); (42 CFR, 457.70)
2. **General Background and Description of State Approach to Child Health Coverage and Coordination**- This section should provide general information related to the special characteristics of each state's program. The information should include the extent and manner to which children in the State currently have creditable health coverage, current State efforts to provide or obtain creditable health coverage for uninsured children and how the plan is designed to be coordinated with current health insurance, public health efforts, or other enrollment initiatives. This information provides a health insurance baseline in terms of the status of the children in a given State and the State programs currently in place. (Section 2103); (42 CFR 457.410(A))
3. **Methods of Delivery and Utilization Controls**- This section requires the State to specify its proposed method of delivery. If the State proposes to use managed care, the State must describe and attest to certain requirements of a managed care delivery system, including contracting standards; enrollee enrollment processes; enrollee notification and grievance processes; and plans for enrolling providers, among others. (Section 2103); (42 CFR Part 457. Subpart L)
4. **Eligibility Standards and Methodology-** The plan must include a description of the standards used to determine the eligibility of targeted low-income children for child health assistance under the plan. This section includes a list of potential eligibility standards the State can check off and provide a short description of how those standards will be applied. All eligibility standards must be consistent with the provisions of Title XXI and may not discriminate on the basis of diagnosis. In addition, if the standards vary within the state, the State should describe how they will be applied and under what circumstances they will be applied. In addition, this section provides information on income eligibility for Medicaid expansion programs (which are exempt from Section 4 of the State plan template) if applicable. (Section 2102(b)); (42 CFR 457.305 and 457.320)
5. **Outreach-** This section is designed for the State to fully explain its outreach activities. Outreach is defined in law as outreach to families of children likely to be eligible for child health assistance under the plan or under other public or private health coverage programs. The purpose is to inform these families of the availability of, and to assist them in enrolling their children in, such a program. (Section 2102(c)(1)); (42 CFR 457.90)
6. **Coverage Requirements for Children's Health Insurance**- Regarding the required scope of health insurance coverage in a State plan, the child health assistance provided must consist of

any of the four types of coverage outlined in Section 2103(a) (specifically, benchmark coverage; benchmark-equivalent coverage; existing comprehensive state-based coverage; and/or Secretary-approved coverage). In this section States identify the scope of coverage and benefits offered under the plan including the categories under which that coverage is offered. The amount, scope, and duration of each offered service should be fully explained, as well as any corresponding limitations or exclusions. (Section 2103); (42 CFR 457.410(A))

7. **Quality and Appropriateness of Care**- This section includes a description of the methods (including monitoring) to be used to assure the quality and appropriateness of care and to assure access to covered services. A variety of methods are available for State's use in monitoring and evaluating the quality and appropriateness of care in its child health assistance program. The section lists some of the methods which states may consider using. In addition to methods, there are a variety of tools available for State adaptation and use with this program. The section lists some of these tools. States also have the option to choose who will conduct these activities. As an alternative to using staff of the State agency administering the program, states have the option to contract out with other organizations for this quality of care function. (Section 2107); (42 CFR 457.495)
8. **Cost Sharing and Payment**- This section addresses the requirement of a State child health plan to include a description of its proposed cost sharing for enrollees. Cost sharing is the amount (if any) of premiums, deductibles, coinsurance and other cost sharing imposed. The cost-sharing requirements provide protection for lower income children, ban cost sharing for preventive services, address the limitations on premiums and cost-sharing and address the treatment of pre-existing medical conditions. (Section 2103(e)); (42 CFR 457, Subpart E)
9. **Strategic Objectives and Performance Goals and Plan Administration**- The section addresses the strategic objectives, the performance goals, and the performance measures the State has established for providing child health assistance to targeted low income children under the plan for maximizing health benefits coverage for other low income children and children generally in the state. (Section 2107); (42 CFR 457.710)
10. **Annual Reports and Evaluations**- Section 2108(a) requires the State to assess the operation of the Children's Health Insurance Program plan and submit to the Secretary an annual report which includes the progress made in reducing the number of uninsured low income children. The report is due by January 1, following the end of the Federal fiscal year and should cover that Federal Fiscal Year. In this section, states are asked to assure that they will comply with these requirements, indicated by checking the box. (Section 2108); (42 CFR 457.750)
11. **Program Integrity**- In this section, the State assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. (Sections 2101(a) and 2107(e); (42 CFR 457, subpart I)
12. **Applicant and Enrollee Protections**- This section addresses the review process for eligibility and enrollment matters, health services matters (i.e., grievances), and for states that use premium assistance a description of how it will assure that applicants and enrollees are given the opportunity at initial enrollment and at each redetermination of eligibility to obtain health benefits coverage other than through that group health plan. (Section 2101(a)); (42 CFR 457.1120)

Program Options. As mentioned above, the law allows States to expand coverage for children through a separate child health insurance program, through a Medicaid expansion program, or through a combination of these programs. These options are described further below:

- **Option to Create a Separate Program-** States may elect to establish a separate child health program that are in compliance with title XXI and applicable rules. These states must establish enrollment systems that are coordinated with Medicaid and other sources of health coverage for children and also must screen children during the application process to determine if they are eligible for Medicaid and, if they are, enroll these children promptly in Medicaid.
- **Option to Expand Medicaid-** States may elect to expand coverage through Medicaid. This option for states would be available for children who do not qualify for Medicaid under State rules in effect as of March 31, 1997. Under this option, current Medicaid rules would apply.

  Medicaid Expansion- CHIP SPA Requirements
  In order to expedite the SPA process, states choosing to expand coverage only through an expansion of Medicaid eligibility would be required to complete sections:
  - 1 (General Description)
  - 2 (General Background)

  They will also be required to complete the appropriate program sections, including:
  - 4 (Eligibility Standards and Methodology)
  - 5 (Outreach)
  - 9 (Strategic Objectives and Performance Goals and Plan Administration including the budget)
  - 10 (Annual Reports and Evaluations).

  Medicaid Expansion- Medicaid SPA Requirements
  States expanding through Medicaid-only will also be required to submit a Medicaid State plan amendment to modify their Title XIX State plans. These states may complete the first check-off and indicate that the description of the requirements for these sections are incorporated by reference through their State Medicaid plans for sections:
  - 3 (Methods of Delivery and Utilization Controls)
  - 4 (Eligibility Standards and Methodology)
  - 6 (Coverage Requirements for Children's Health Insurance)
  - 7 (Quality and Appropriateness of Care)
  - 8 (Cost Sharing and Payment)
  - 11 (Program Integrity)
  - 12 (Applicant and Enrollee Protections)

- **Combination of Options-** CHIP allows states to elect to use a combination of the Medicaid program and a separate child health program to increase health coverage for children. For example, a State may cover optional targeted-low income children in families with incomes of up to 133 percent of

poverty through Medicaid and a targeted group of children above that level through a separate child health program. For the children the State chooses to cover under an expansion of Medicaid, the description provided under "Option to Expand Medicaid" would apply. Similarly, for children the State chooses to cover under a separate program, the provisions outlined above in "Option to Create a Separate Program" would apply. States wishing to use a combination of approaches will be required to complete the Title XXI State plan and the necessary State plan amendment under Title XIX.

Where the state's assurance is requested in this document for compliance with a particular requirement of 42 CFR 457 et seq., the state shall place a check mark to affirm that it will be in compliance no later than the applicable compliance date.

Proposed State plan amendments should be submitted electronically and one signed hard copy to the Centers for Medicare & Medicaid Services at the following address:

Name of Project Officer
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, Maryland 21244
Attn: Children and Adults Health Programs Group
Center for Medicaid and CHIP Services
Mail Stop - S2-01-16

Section 1. General Description and Purpose of the Children's Health Insurance Plans and the Requirements

1.1. The state will use funds provided under Title XXI primarily for (Check appropriate box) (Section 2101)(a)(1)); (42 CFR 457.70):

Guidance: Check below if child health assistance shall be provided primarily through the development of a separate program that meets the requirements of Section 2101, which details coverage requirements and the other applicable requirements of Title XXI.

1.1.1. ☐ Obtaining coverage that meets the requirements for a separate child health program (Sections 2101(a)(1) and 2103); OR

Guidance: Check below if child health assistance shall be provided primarily through providing expanded eligibility under the State's Medicaid program (Title XIX). Note that if this is selected the State must also submit a corresponding Medicaid SPA to CMS for review and approval.

1.1.2. ☐ Providing expanded benefits under the State's Medicaid plan (Title XIX) (Section 2101(a)(2)); OR

Guidance: Check below if child health assistance shall be provided through a combination of both 1.1.1. and 1.1.2. (Coverage that meets the requirements of Title XXI, in conjunction with an expansion in the State's Medicaid program). Note that if this is selected the state must also submit a corresponding Medicaid state plan amendment to CMS for review and approval.

1.1.3. ☒ A combination of both of the above. (Section 2101(a)(2))

North Carolina's Title XXI Plan, North Carolina Health Choice for Children Program (NCHC) is a combination plan consisting of:

a. Medicaid Expansion Group:

-Children ages 0 (newborn) through 12 months with family income greater than 194% and up to 210% of Federal Poverty Level;

-Children ages 13 months through 5 years with family income greater than 141% and up to 210% of the Federal Poverty Level;

-Children ages 6 through 18 years with family income greater than 107% and up to 133% of the Federal Poverty Level

b. Separate Child Health Program:

Uninsured children from ages 6 through 18 years with family income between 133% and 211% of the Federal Poverty Level and who do not qualify for Medicaid.

1.1-DS ☐ The State will provide dental-only supplemental coverage. Only States operating a separate CHIP program are eligible for this option. States choosing this option must also complete sections 4.1-DS, 4.2-DS, 6.2-DS, 8.2-DS, and 9.10 of this SPA template. (Section 2110(b)(5))

1.2. ☐ Check to provide an assurance that expenditures for child health assistance will not be claimed prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS. (42 CFR 457.40(d))

1.3. ☐ Check to provide an assurance that the State complies with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35. (42CFR 457.130)

Guidance: The effective date as specified below is defined as the date on which the State begins to incur costs to implement its State plan or amendment. (42 CFR 457.65) The implementation date is defined as the date the State begins to provide services; or, the date on which the State puts into practice the new policy described in the State plan or amendment. For example, in a State that has increased eligibility, this is the date on which the State begins to provide coverage to enrollees (and not the date the State begins outreach or accepting applications).

1.2. Provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this SPA (42 CFR 457.65). A SPA may only have one effective date, but provisions within the SPA may have different implementation dates that must be after the effective date.

Original Plan
Effective Date: October 1, 1998

Implementation Date: October 1, 1998

The chart below incorporates five Modified Adjusted Gross Income (MAGI) CHIP State Plans by reference. The MAGI State Plans are attached to this file as appendices in .PDF format.

SPA #15-0001
Purpose of SPA: The primary purpose of SPA #15-001 is to implement program eligibility changes to reflect Affordable Care Act and State legislative requirements. The North Carolina Legislature has not amended any legislation affecting program benefits or cost sharing since 2011. This SPA also documents the repeal of North Carolina's CHIP buy-in program effective October 1, 2015.

Proposed effective date: October 1, 2015

Proposed implementation date: October 1, 2015

SPA #18-0007
Purpose of SPA: To implement provisions for temporary adjustments to enrollment and redetermination policies and cost sharing requirements for children in families living and/or working in Governor declared or federally declared disaster areas in North Carolina. In the event of a natural disaster, the State will notify CMS that it intends to provide temporary adjustments to its enrollment and/or redetermination policies and cost sharing requirements, the effective and duration date of such adjustments, and the applicable Governor or FEMA declared disaster areas.

Proposed effective date: September 13, 2018

Proposed implementation

date: September 13, 2018

SPA #19-0007
Purpose of SPA: To comply with updated template as well as to demonstrate compliance with Mental Health parity. The North Carolina CHIP program, North Carolina Health Choice (NCHC), is the only North Carolina (NC) benefit plan to which the final rule applies. The North Carolina Division of Medical Assistance (DMA) has completed an analysis of the NCHC benefit package and has determined that NC is compliant with the final rule.

Title XXI (Health Choice) services authorized by this State Plan are reimbursed at the Medicaid established rate for the provided service. Unless otherwise authorized within this section of the State Plan, Title XXI services are prospectively reimbursed and not subject to cost settlement.

Proposed effective date: October 1, 2017

Proposed implementation

date: October 1, 2017

SPA #20-0005
Purpose of SPA: To implement provisions for temporary adjustments to enrollment and redetermination policies and cost sharing requirements for children in families living and/or working in Governor or Federally-declared disaster areas in North Carolina. In the event of a natural disaster or public health emergency, the State will notify CMS that it intends to provide temporary adjustments to its enrollment and/or redetermination policies and cost sharing requirements, the effective and duration date of such adjustments, and the applicable Governor or Federally-declared disaster or public health emergency areas.

Proposed effective date: March 13, 2020

Proposed implementation date: March 13, 2020

SPA # 20-20014
Purpose of SPA: To implement a Health Service Initiative (HSI) that will expand an early literacy program that encourages reading for children age 0-5 years old through the Reach Out and Read initiative.

Proposed effective date: July 01, 2020

Proposed implementation date: July 01, 2020

SPA # 20-0010
Purpose of SPA: To comply with updated template as well as to demonstrate Substance Use-Disorder prevention that promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act) requirements for children in CHIP.

Proposed effective date: October 24, 2019

Proposed implementation

date: October 24, 2019

SPA # 22-0014
Purpose of SPA: To implement 12-month postpartum option, and to comply with continuous eligibility exception regulations for children in CHIP.

Proposed effective date: April 1, 2022

Proposed implementation date: April 1, 2022

SPA # 22-0013
Purpose of SPA: To implement the Managed Care delivery system to the Children's Health Insurance Program (CHIP). North Carolina Division of Health Benefits has completed an analysis of the NCHC Managed Care Requirements and has determined that NC is compliant with the final rule.

Proposed Effective Date: July 1, 2021

Implementation date: July 1, 2021

SPA # 22-0034
Purpose of SPA: The purpose of this SPA is to demonstrate compliance with the American Rescue Plan Act provisions that require states to cover treatment (including treatment of a condition that may seriously complicate COVID-19 treatment), testing, and vaccinations for COVID-19 without cost sharing in CHIP.

Proposed effective date: March 11, 2021

Proposed implementation date: March 11, 2021

SPA# 23-0017
Purpose of SPA: To implement Health Service Initiatives (HSI) that will create a Breastfeeding Hotline to provide support to all North Carolina families, and a Substance Use and Parenting Intervention Health Service Initiative, to address the social and health challenges that are associated with families and addiction

Proposed Effective Date: July 1, 2023

Proposed Implementation date: October 1, 2023

1.4- TC **Tribal Consultation** (Section 2107(e)(1)(C)) Describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment, when it occurred and who was involved.

The state must comply with the state notice procedures as required in 42 CFR section 431.408 prior to submitting an application to extend the demonstration.

The state must also comply with tribal and Indian Health Program/Urban Indian Organization consultation requirements at section 1902(a)(73) of the Act, 42 CFR section 431.408(b), State Medicaid Director Letter #01-024, and contained in the state's approved Medicaid State plan, when any program changes to the demonstration, either through amendment as set out in STC 6 or extension, are proposed by the state. The Division of Health Benefits is in constant and almost daily communication with the Eastern Band of Cherokee Indians. For this SPA submission, the Tribe reviewed and asked for come considerations, and the state amended the SPA per their requests. After the revisions, the Tribe approved the SPA as written.

Section 2. General Background and Description of Approach to Children's Health Insurance Coverage and Coordination

Guidance: The demographic information requested in 2.1. can be used for State planning and will be used strictly for informational purposes. THESE NUMBERS WILL NOT BE USED AS A BASIS FOR THE ALLOTMENT.

Factors that the State may consider in the provision of this information are age breakouts, income brackets, definitions of insurability, and geographic location, as well as race and ethnicity. The State should describe its information sources and the assumptions it uses for the development of its description.

- Population
- Number of uninsured
- Race demographics
- Age Demographics
- Info per region/Geographic information

2.1. Describe the extent to which, and manner in which, children in the State (including targeted low-income children and other groups of children specified) identified , by income level and other relevant factors, such as race, ethnicity and geographic location, currently have creditable health coverage (as defined in 42 CFR 457.10). To the extent feasible, distinguish between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements). (Section 2102(a)(1)); (42 CFR 457.80(a))

Guidance: Section 2.2 allows states to request to use the funds available under the 10 percent limit on administrative expenditures in order to fund services not otherwise allowable. The health services initiatives must meet the requirements of 42 CFR 457.10.

2.2. **Health Services Initiatives-** Describe if the State will use the health services initiative option as allowed at 42 CFR 457.10. If so, describe what services or programs the State is proposing to cover with administrative funds, including the cost of each program, and how it is currently funded (if applicable), also update the budget accordingly. (Section 2105(a)(1)(D)(ii)); (42 CFR 457.10)

North Carolina will be sunsetting the previous HSI, Reach out and Read, effective October 2022. The funds used through the CHIP HSI allowed the organization to expand services to all counties in the state, to extend the number of practices participating in the program and to further activities in research to improve care for social emotional wellbeing for children. The program continues to operate in the state using existing funds and these funds helped the program expand services beyond current operations.

Moving forward, North Carolina will expand and improve the delivery of services for maternal and child health by using a statewide breastfeeding hotline as well as a parenting intervention for caregivers with substance use disorder. These HSIs will help to improve the wellbeing of families within the state and support positive social and emotional development of infants and children.

North Carolina CHIP Health Services Initiative (HSI) for Statewide Breastfeeding Hotline

General Description and Purpose

North Carolina will implement and administer a centralized, statewide breastfeeding hotline to expand breastfeeding support to all families in our state. The 24-hour hotline will provide accessible, consistent breastfeeding support and messaging, and facilitate referrals to local resources including, but not limited to, the North Carolina Women, Infants, and Children (WIC) Program and the Breastfeeding Peer Counselor Program. This HSI will directly support families in the first year of the baby's life, as well as supporting maternity centers by providing breastfeeding support after the family leaves the maternity center. The statewide breastfeeding hotline would allow parents to access professional lactation support regardless of their geographic location or financial means and at critical times when parents are vulnerable to misinformation and immediately when needed and useful, such as when struggling to breastfeed at home. North Carolina will engage with the Eastern Band of Cherokee Indians (EBCI), and other Tribal entities in the development of the Breastfeeding Hotline.

Over a two-year period, the initiative will create and implement the North Carolina Statewide Breastfeeding Hotline:

- Create a phone-based platform that the >118,000 North Carolina families with new babies can call 24 hours per day to receive professional breastfeeding and infant feeding support.
- Establish partnerships with the 4 International Board-Certified Lactation Consultants (IBCLC) training programs in North Carolina (two of which are at Historically Black

Colleges and Universities (HCBUs)) to utilize their recent graduates, or student/mentor pairs to field calls.

- Expand existing state referral resource lists so local referrals can be initiated, if needed for the family.
- Train maternity center staff about the availability of the Hotline so they can share information with families upon maternity center discharge.
- Train pediatric, family medicine, and obstetrician office physicians and staff about the availability of the Hotline, which is particularly important in rural counties of the state with no maternity center or outpatient lactation consultants.
- Create a public-facing webpage with breastfeeding resources for families, and advertisement of the Hotline.

The Project

Breastfeeding is widely accepted as an effective strategy to promote positive health outcomes for both mothers and their infants. Breastmilk is nutritionally superior to other forms of infant feeding and offers substantial immunological and health benefits for both the mother and infant. As Baby Friendly USA states: "Breastfeeding is the single most powerful and well-documented preventative modality available to health care providers to reduce the risk of common causes of infant morbidity."[1] Breastfeeding provides short and long term benefits to the mother and infant, and reduces disease burden and death in both populations by significantly lowering rates of leukemia, diabetes, asthma, otitis media, necrotizing enterocolitis, and Sudden Infant Death Syndrome in infants, and Type 2 diabetes, breast and ovarian cancers, hypertension, and heart disease in mothers.[2] Recent evidence has shown that mothers who have received the COVID-19 vaccine provide protection to their infant through the transfer of antibodies in breast milk.[3] There is a proven link between breastfeeding and the reduction of food insecurity. The World Alliance for Breastfeeding Action notes that breastfeeding helps to prevent malnutrition, ensures food security for infants and young children, and thus helps to bring people out of the hunger and poverty cycle.[4] The benefits for families and babies last long after breastfeeding has stopped.

Despite growing data about these benefits, the rate of any breastfeeding in North Carolina decreases dramatically in the first few months of life, dropping from 85% when infants leave the maternity center to 56% at 6 months, according to North Carolina data from the CDC's most recent National Immunization Survey/Breastfeeding Report Card.[5] And, rates of exclusive breastfeeding at 3 months old in North Carolina are 38% and only 20% at 6 months old, well below the Healthy People 2030 goal of 42.5% exclusive breastfeeding at 6 months old.[6]

Most North Carolina families are initiating breastfeeding immediately after the infant's birth, but upon discharge from the maternity center families face many barriers in identifying or obtaining the skilled support needed to address their concerns about breastfeeding. Families encounter issues in accessing care due to limited or complete lack of lactation consultants in their county, barriers to insurance reimbursement of lactation professionals, high out of pocket costs for private lactation professionals, and limited lactation knowledge among their health care providers.

In order to decrease these barriers and assist families with breastfeeding, we will create the North Carolina Breastfeeding Hotline, modeled after existing successful statewide breastfeeding hotlines in other states, including Tennessee, Ohio, Oklahoma, and Arizona. The North Carolina Breastfeeding Hotline will provide accurate evidence-based breastfeeding information, counseling and encouragement during the prenatal and postpartum period by lactation professionals. The accessibility of the Breastfeeding Hotline 24/7 permits families to receive unbiased information at critical time periods when pediatric and obstetric offices may not be available, or lack the expertise to adequately support breastfeeding success. In addition to advertising widely and broadly, we will explore adding the Hotline as a resource on the NC Care 360 site, so the resource is easily accessible to all.

The HSI will support North Carolina families to achieve optimal infant feeding by implementing the following project components and objectives:

- **Create a statewide Breastfeeding Hotline that is available for free to residents of all 100 North Carolina counties.** We will partner with a contractor with North Carolina experience providing on-demand ~~text-based~~ pregnancy support for North Carolina families. Greater than 50% of North Carolina's counties do not have any outpatient lactation services[7]; we will pay special attention to reaching families in those areas of high need. Medical providers may also use the hotline for professional assistance while helping a patient.
  - ***By 6 months after receiving funds:*** The North Carolina Statewide Breastfeeding Hotline will be fully operational and available to all families in the state, with 24 hour per day coverage.
  - ***By the end of FFY '24*** Based on numbers of calls from states with similar hotlines, our goal will be to assist 400 families per month by phone ~~or text~~ conversations by the end of FFY '24.
- **Hire International Board-Certified Lactation Consultants (IBCLCs) and Clinical Lactation Consultants (CLCs).** The contractor will hire IBCLCs and CLCs to field the calls ~~and texts~~ and serve as an immediate source of evidence-based information and guidance, creating a rotating schedule for full-time coverage. Additionally, given the racial and socioeconomic disparities in breastfeeding initiation and continuation throughout North Carolina,[8] we plan to partner with the four North Carolina lactation training programs, including those administered by HBCUs (North Carolina A&T and Johnson C. Smith University). Students and recent graduates can gain the clinical hours needed to be eligible for the IBCLC exam with the guidance of their IBCLC preceptors. This will provide both coverage for the Hotline, and the much-needed opportunity for real-world lactation support experience for NC lactation consultants entering the workforce, allowing for more representation of traditionally under-represented groups within the field of lactation consulting.
  - ***By 6 months after receiving funds:*** The North Carolina Statewide Breastfeeding Hotline will hire the needed number of IBCLCs and CLCs.
  - ***By the end of FFY '24***: We will partner with NC IBCLC training programs to involve at least 4 student/preceptor pairs to provide Hotline support.
- **Expand and improve lactation resources referral list.** The contractor will collaborate with the North Carolina Breastfeeding Coalition to update and keep current the county-based lactation resource list.[7] This referral list can be used by the

Hotline staff if follow up is needed by a family. Hotline staff can connect families with existing vetted resources in their local area. We will explore the potential of linking this resource list with NC Care 360, the state's SDOH referral platform.[9]

- ***By the end of FFY '24*** We will update and make more widely available the lactation resource list and have a system in place for continual updating.

- **Dissemination of opportunity.** The contractor will outreach to maternity center staff, and outpatient physician office providers and staff regarding the availability of the Hotline. As is the case in other states with successful statewide breastfeeding hotlines, we expect the majority of referrals and information distribution about the Hotline to come from maternity centers. The contractor will involve our WIC colleagues throughout the state to help disseminate information about the Hotline. We will develop a public-facing webpage with easy to access information about the Hotline.
  - ***By 6 months after receiving funds:*** Webpage will be operational.
  - ***By the end of FFY '24*** 100% of the maternity centers statewide (which includes hospitals with birthing centers, and free-standing birthing centers) will have information to distribute to families about the Hotline.
- **Data tracking and Impact Measurement.** The contractor will track incoming calls including number of calls~~/texts~~, type of issue/problem, number of mothers served, problem resolution using follow-up surveys, and qualitative participant data obtained from randomly choosing participants to receive satisfaction surveys. The contractor and state will also follow trends of statewide breastfeeding rates at various infant ages, although this data is reported by the CDC three years after collection, so there will be a delay in measuring this aspect of success.
  - ***By the end of FFY '24*** System developed for tracking use. 90% of incoming calls will have above data collected.
- **Quality measurement and assurance.** The Hotline staff will follow up with callers with automated surveys at 4, 8, and 12 weeks after the initial call. The follow up touchpoints will monitor for problem resolution, current infant feeding practices (breastmilk, formula, or combination), and satisfaction with the Hotline service. Additionally, quality assurance will be monitored by a supervisor reviewing recordings of select calls ~~or reading text message exchanges.~~ Finally, a pediatrician and IBCLC, will be available for more challenging cases.
  - ***By the end of FFY '24:*** We will collect responses from 20% of callers with responses to automated surveys, tracking data points noted above.

North Carolina provides assurances that funds under this HSI will not supplant or match CHIP Federal funds with other Federal funds, nor allow other Federal funds to supplant or match CHIP Federal funds.

Outcome and Evaluation

The state will document the initiative's progress on performance and outcomes, reporting semi-annually on the following metrics of success:

- the number of families served (distinguishing first-time callers from repeat callers);
- the number of infants in low-income families served;
- questions/issues addressed, problem resolution using follow-up surveys;

- the number of maternity centers that provide information about the Hotline to families prior to discharge;
- statewide breastfeeding rates at various infant ages; and
- qualitative participant data.

These metrics will allow us to show the need for timely access to breastfeeding promotion and support during critical period, and its impact on breastfeeding success.

North Carolina CHIP Health Services Initiative (HSI) for Substance Use Disorder and Parenting Intervention

Purpose and Background

North Carolina will support The North Carolina Perinatal and Maternal Substance Use, CASAWORKS for Families Initiatives (Initiatives) and the Eastern Band of Cherokee Indians Women's Residential program staff to receive Circle of Security Parenting (COSP) training to address the social and health challenges that are associated with families and addiction. Providing this program to women who receive SUD services through the Initiative will reduce the likelihood of child maltreatment and improve parent/child relationships. North Carolina will also fund the hiring of a mental health consultant to manage and oversee this program, including performing research analysis for quality metrics.

The North Carolina Perinatal and Maternal Substance Use and CASAWORKS for Families Initiatives represent a nationally recognized state-wide approach to the many social and health challenges associated with families and addiction. The Initiatives are comprised of 27 programs, utilizing evidence-based treatment models, located in 13 counties across the state.

Women with substance use disorders and associated co-morbidities in the programs are supported to engage with family-centered, gender-responsive, trauma informed substance use disorder treatment with their children. Research and clinical experience show that women are motivated to engage with treatment and recovery based on concern for their children or pregnancy but that they are often unwilling to seek treatment if it means leaving their children. All the programs in the Initiatives are considered cross-area services, and this helps to meet the need of pregnant and parenting women who do not have gender- or family-responsive treatment in their home communities. Women and their families in need of services can access these programs through a toll-free hotline, which also maintains bed availability for the residential programs statewide. Through this capacity management system health care providers, Department of Social Services social workers, treatment providers and others can consult with a Licensed Clinical Addiction Specialist and refer women and their children to the services they need in any of the programs statewide (https://ncpoep.org/guidance-document/treatment-matters/nc-perinatal-and-maternal-substance-abuse-and-the-casaworks-for-families-residential-initiatives/).

Programs provide family-centered, trauma informed services that include, but are not limited to:

- Evidence-based substance use and mental health disorder treatment services for pregnant and parenting women;

- Parenting education & support;
- Provide or arrange for treatment and prevention services for children;
- Referral for and coordination with medical care for women;
- Referral for and coordination with pediatric and developmental services for children;
- Case management; and
- Access to childcare and transportation.

Key Benefits of the Initiatives

With the support of a gender responsive and trauma informed system of care, women receiving treatment through the Initiatives report:

- High engagement in prenatal care among pregnant women;
- Healthy newborn birth weights for pregnant women who enter treatment prior to delivery;
- Lower recidivism with child welfare among families engaging with treatment services;
- Fewer number of days in out-of-home foster care placement for children of parents involved with child welfare as compared to parents with substance use problems not engaged in the services;
- Successful engagement with pediatric care for families involved with services;
- Increased affectional bonds and reduced conflict among families engaged in parenting programs;
- Successful engagement in the work force.

The families served by the Initiatives and the EBCI's women's program are some of those with the highest needs in our state system. Intergenerational substance use, trauma and child welfare involvement are all common. Successful intervention with evidence-based parenting programs can break the cycle of addiction and trauma in families and reduce suffering and loss for children and their parents, reducing future costs to the state, and improving child health and welfare outcomes. In SFY 21, there were 642 new and continuing women receiving services across the Initiatives. Upon admission, 28% of the women were pregnant and they had 646 children in their physical custody.

The following is an overview of some demographics of the client population:

- **History of SUD**: Had a Moderate or Severe Substance Use Disorder 96%
- **Trauma History**: Experienced Incest/Sexual Abuse (prior year) 13%; Experienced Physical Abuse (within 3 mo. prior to admission) 23%
- **Pregnancy Status At admission**: Pregnant 28%
- **Insurance Coverage:** Medicaid 82%; No Insurance 8%; Private Insurance 1%; Other 5%; Unknown 4%
- **Client Education Status:** < High School Education 35%; High School or GED 33%; > High School Education 32%
- **Treatment Mandate:** Mandated to Treatment 50% (By CJ System 16%; By DSS 297 34%- some are mandated by both systems)
- **Support Needs At Admission:** Housing Services 71%; Needed Transportation To Access Services 69%; Had food insecurity 63%; Unemployed 48%

We propose two connected approaches to directly address the physical, social and emotional health of children ages 0-5 whose mothers are receiving treatment for substance use disorders (SUDs) in these programs.

Program Description

1.) **Training in Circle of Security-Parenting for Clinical Staff**:

We are requesting funding to allow 35 staff members from the women's SUD treatment programs in the Initiatives and EBCI women's program, to receive training in Circle of Security Parenting. Written and designed by Kent Hoffman, Glen Cooper, and Bert Powell, the Circle of Security- Parenting (COSP) program is based in attachment theory and utilizes simple diagrams and videos to make the program's concepts easy for caregivers to understand. The attachment process is a biological process in humans and applies to all cultures; however, it is important to consider the attachment process within a cultural context. The COSP staff will work with the NC pilot to ensure that the trainings and interventions address the culturally diverse populations served by the programs statewide.

COSP is both an intervention and a framework to help caregivers understand their child's relationship needs for a secure base from which to venture out to explore the world, and to which to return in times of distress- called the "circle of security".[10,11] COSP increases parents' skills around recognizing and responding appropriately to children's needs and reflecting on their interactions with their children. The body of literature to support its use continues to grow and includes over 40 publications in 2020. Please see https://www.circleofsecurityinternational.com/wp-content/uploads/COS-Bibliography-1.20.pdf for all publications.

COSP is primarily a group-based parenting intervention, with content that applies to parents of children of any age, but it can also be used with caregivers and/or caregiver/child dyads individually. COSP is an eight-session manualized program which uses handouts and an eight-chapter DVD that contains key concepts about healthy caregiver-child attachment and includes examples of effective and ineffective parent-child interactions.[12] Each weekly chapter on the DVD contains approximately 15 minutes of recorded content and has four to six recommended pauses during which the facilitator stops the recording and leads a discussion using process questions (supplied by the program) or reviews included handouts. The suggested time for each session is approximately 1.5 hours.

Dr. Evette Horton, the Director of Child Clinical Services at UNC Horizons, completed training in COSP and then, recognizing that COSP had not been widely used with women in treatment for substance use disorders, tested the program with women at UNC Horizons for her doctoral dissertation in 2013. She analyzed data for a cohort of clients who received the full COSP curriculum using Parenting Scale scores.[13] The Parenting Scale (PS) has two factors related to discipline, lax and over-reactive, and a total score. The participants' mean scores on the Parenting Scale's total, lax, and over-reactive factors showed significant improvement from pretest to posttest, indicating a *reduction* in harsh parenting practices such as spanking, yelling, and threatening and an *increase* in the mother's ability to consistently respond to her

child's misbehavior. These findings are important because both types of parenting behaviors are associated with child maltreatment.

Training in COSP is now offered online, with various schedules, but totaling four full days of training. Completion of the 4-day Circle of Security Parenting Training© is required in order to use the DVD-based parent education program. After the training, facilitators are given a license to use the COSP manual, DVD, and handouts with parents. These materials are included in the price of the training. The program developers indicate that COSP training is appropriate for both professionals and paraprofessionals who work with parents. For more information, please refer to the website: https://www.circleofsecurityinternational.com/.

2.) **Expert Support for COSP Implementation and for UNC Horizons' Child Development Center**:

We are proposing to support the Horizons Program to hire (time-limited for 2 years) a mental health consultant focused on early childhood (minimum of master's level, preference for doctoral level) with expertise in attachment and child development who would spend three-quarters of their time as the lead for the Circle of Security project proposed above, and one quarter of their time in the UNC Horizons' Child Development Center providing trainings and consultations in the center and/or virtually, as needed due to COVID restrictions.. As the lead for the COSP project, this person would:

- Schedule the COSP trainings, act as the liaison between all the clinicians being trained and the COSP trainers and troubleshoot any issues with the virtual training sessions.
- Design and implement the data collection system to evaluate the project, including distributing evaluation instruments (likely the Parenting Scale) to all programs participating in the project, maintaining contact and providing reminders regarding data collection, and following up regarding any missing data.
- Work with a database designer to develop a database to collect the outcome data.
- Input and analyze data from the project.
- Facilitate monthly sessions of the existing Perinatal Learning Collaborative focused on attachment, implementation of the COSP curriculum, and fidelity to the curriculum, and answer question or address issues clinicians may be confronting in the parenting groups.
- Serve as the main contact for the project with the Division of MH/DD/SAS Special Populations Team Lead.
- Create and disseminate reports to the Division of MH/DD/SAS Special Populations Team Lead both quarterly and as needed regarding implementation and outcomes.
- Provide individual fidelity coaching and troubleshooting to programs throughout the two-year initiative period.

The remaining 25% of the mental health consultant's time would be spent at the UNC Horizons' Child Development Center (HCDC). The HCDC is onsite at the UNC Horizons SUD treatment program in Carrboro, NC, and is a 5-star, licensed center with the capacity to serve 41 children ages 6 weeks to 5 years. All of the children in the center have mothers who are receiving SUD treatment services at Horizons. The

HCDC serves approximately 65-70 children per year. While the race/ethnicity data varies slightly from year to year, in general the population served is approximately 20% African American, 25% bi-racial, 45% Caucasian, 5% Hispanic and 5% Native American. All families have incomes that place them below the federal poverty line. As a group, the children in the center have faced significant adversity prior to coming to Horizons due to a combination of poverty, early traumatic experiences, prenatal drug exposure, lack of stable housing and daily routines, and disrupted attachments in early life. Dr. Horton has collected scores for a cohort of the residential children (unpublished data) at Horizons using the TESI (Traumatic Events Screening Inventory) and has found that over 80% have experienced one or more serious traumatic events. They bring a wide range of emotional, developmental, and health concerns. Common issues include developmental delays, anxiety disorders, attachment disorders, PTSD, ADHD, behavior problems, difficulty regulating emotion, poor social skills, adjustment disorders, and somatic illnesses. Each year approximately 80% of the families coming into Horizons have had a history involvement with Child Protective Services.

During the COVID pandemic the HCDC closed only briefly (March 23-May 11, 2020) and then resumed operations for families in the Horizons' residential programs only. This change resulted in a lower census for the HCDC but freed up staff to allow for the addition of school-age children. The HCDC extended its license to cover school-age children, and then those children in the residential programs were invited onsite to attend their Zoom classes while being supervised by teachers in the HCDC. One of the group treatment rooms was converted into a classroom for the children, and each child had their own carol to use for Zoom sessions and classwork. The HCDC provided breakfast and lunch for all of the children, and transportation to and from the residential programs. The school-age program lasted from August 2020 to March 2021, when public school resumed in-person operations. The HCDC then resumed allowing children of outpatient women to attend if their caregivers are vaccinated. The census in the HCDC has been lower this past year than normal given staffing challenges in both the center and the residential programs that have resulted in lower-than-normal patient populations. The number of students in the HCDC is increasing, however, and we anticipate a return to normal operations within the next year.

In order to further support the teachers in the HCDC in meeting the day to day needs of the children, the mental health consultant would work with the teachers on professional development, including a two-tier training (virtual if needed due to COVID restrictions) in Circle of Security Parenting for Classrooms.[14,15] See https://www.circleofsecurityinternational.com/wp-content/uploads/An-Overview-of-COSP-Classroom-Approach-V20.9.pdf for more information) which is similar to the model described above for the providers and includes training in the Circle of Security Parenting for Classrooms model and 6 – 8 months of follow up support via a virtual learning collaborative at the center. The consultant would also be available to work one-on-one with teachers dealing with challenging behaviors in the classroom. The consultant will assess the impact of this two-tiered program with pre/post assessments, such as the Teacher Opinion Survey-Revised and the Goal Achievement Scale, which assess the teachers' perceived efficacy in managing children's challenging behaviors

and ability to meet children's social and emotional needs.[16,17] The consultant will share lessons learned from this work with other programs in the state.

Population Impacted

We estimate that approximately 650 women in treatment for substance use disorders will receive education through the COSP curriculum over the two-year project period, and 650 children ages 0-5 will benefit from their mothers' participation in the program. Over the two years, approximately 120 unduplicated children ages six weeks to five years will benefit from enhanced training and support for their teachers in the UNC Horizons' Child Development Center.

Outcome Measures

We will track the outcomes of this program with the following measures:

1. Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment
2. Well-Child Visits in First 15 Months of Life

These are HEDIS measures that are measured in the full population, ensuring that we are able to monitor for changes between counties that have implemented the program and those that have not.

Budget

We project the total cost of these initiatives to be $899,158, of which $695,948 will come from the state's federal CHIP allotment. The state's share of the cost will amount to $203,210 the source of the non-federal share will be funding from the NC General Assembly. The state's preferred effective date for program launch is July 1, 2023.

~~North Carolina will expand and improve the delivery of an AAP-endorsed, evidence-based model to promote early literacy, early learning and school readiness as part of routine pediatric primary care visits for children, birth to age 5. This HSI will contribute to transforming the standard of pediatric care for young children in North Carolina to sharpen the focus on activities that support social and emotional development.~~

~~Over a three-year period, the initiative will support Reach Out and Read in North Carolina to:~~

- ~~Expand to about 40 new clinic sites in targeted North Carolina counties, reaching approximately 30,000 children who are currently unserved;~~
- ~~Increase the number of infants, birth to 6 months, served;~~
- ~~Train roughly 120 new pediatric primary care providers to deliver the Reach Out and Read model;~~
- ~~Prepare all providers (new and existing) in the "Back to Birth" component of the intervention, so all clinics can begin at birth, rather than 6 months of age; and~~
- ~~Boost the percentage of clinics meeting the highest quality standards~~

by providing training and technical assistance.

The state will document the initiative's progress on performance and outcomes, reporting semi-annually on the following metrics: the number of children served; the number of children in low-income families served; the number of providers completing core training on the Reach Out and Read model; the number of providers trained to deliver the Reach Out and Read model from birth to 6 months of age; the number of new clinic sites launched; and the percentage of clinics achieving the highest quality rating (12/14 quality standards met.)

We project the total cost of the 3-year initiative to be $3,013,000, of which $2,400,432.30 will come from the state's federal CHIP allotment. The state's share of the cost will amount to $643,056; the source of the non-federal share will be funding from the NC General Assembly. The state's preferred effective date for program launch is July 1, 2020.

The Project

In the earliest stages of a child's life, brain development is occurring at an unprecedented rapid pace, mediated by the nurturing, language-rich interactions that strengthen the parent-child bond and support social and emotional development. Such early responsive caregiving sets the stage for early literacy, early learning, and school readiness. In addition, reading aloud with children eases family stress and fosters feelings of safety and security, building resilience and enabling families and children to cope with social and emotional challenges.

Parents play a vital role in fostering healthy child development and they rely on supportive anticipatory guidance delivered by their child's health care provider during routine well-child visits. Recognizing these important factors, in 2014 the American Academy of Pediatrics (AAP) issued a policy statement making clear that literacy promotion is an essential component of pediatric primary care practice.1

1 Literacy Promotion: An Essential Component of Primary Care Pediatric Practice, American Academy of Pediatrics Policy

Starting in infancy, the AAP recommends that pediatric providers advise parents about the importance of reading aloud with their children and counseling them on developmentally appropriate shared-reading activities and the value of providing developmentally appropriate books at health supervision visits for children in low-income families.

Reach Out and Read2, a clinic-based pediatric primary care intervention, operating in all 50 states and D.C., delivers on the benefits contemplated in the 2014 AAP Policy Statement. Pediatric care providers are trained to recognize and reinforce the strengths parents bring to the relationship with their infants and young children. The provider enters the exam room with a

new, developmentally appropriate book which is used as a tool for observing the parent-child relationship and the child's developmental stage, modeling effective dialogic reading techniques, and providing anticipatory guidance to parents, as referenced in the AAP policy statement.

Reach Out and Read works with a National Book Committee and a variety of large publishing partners, like Scholastic and All About Books, to develop a curated selected of high-quality books to serve the developmental needs of Reach Out and Read's children/families and providers. They also work to make books available in a variety of languages to serve the cultural needs of families. Publishers create specific catalogs for Reach Out and Read and providers are able to select from the hundreds of vetted titles the books that they would like to utilize with the children/families in their community.
In North Carolina, Reach Out and Read currently operates in 340 clinic locations in 88 counties. It is delivered by 1,700 pediatric care providers to roughly 263,000 young children, an estimated 75 percent of whom are in low-income families, and are covered under Medicaid or CHIP. This intervention can be implemented at a cost of $15/child/year, which covers basic expenses including provider training, technical assistance, books, and evaluation. A component of Reach Out and Read's engagement with providers also involves connecting providers to community resources such as libraries to train providers on how to connect children with programs and instructions to complete library card applications.
NCDHHS considers books to be essential materials to the program. The documented benefits that Reach Out and Read delivers aligns with the goals of the North Carolina Early Childhood Action Plan and NCDHHS' interests in assuring a robust medical home that not only attends to the medical needs of children and families, but also addresses health-related social needs.

The HSI will enable more of North Carolina's children and families to benefit from Reach Out and Read by implementing the following project components and objectives:

- **Expand to all 100 North Carolina Counties.** In addition to establishing Reach Out and Read in the 12 North Carolina counties that are unserved3, we will focus expanding to "hard to reach" locations in counties that already host Reach Out and Read. Such counties may include those with rural areas, those with fewer available health care options, or with limited capacity to explore opportunities like Reach Out and Read. We also will focus attention on counties where

Statement, 2014
https://pediatrics.aappublications.org/content/pediatrics/134/2/404.full.pdf 2 Find information about Reach Out and Read and the evidence supporting its effectiveness.
https://www.reachoutandread.org/about/ ; https://www.reachoutandread.org/why-we-matter/the-evidence/
3 Yancey, Mitchell, Avery, Watauga, Alleghany, Harnett, Sampson, Bladen, Greene, Halifax, Martin, and Tyrrell

well-child visit compliance is low.

By the end of FFY '22, Reach Out and Read will operate in 100% of NC counties, up from 88%. About 40 new clinic sites, will bring the total to 380 clinics statewide. An additional 120 pediatric primary care providers will be trained to deliver the Reach Out and Read model to 30,000 additional children from birth to age 5.

- **Begin at birth in all clinics.** While Reach Out and Read historically launched at the child's 6- month visit, research supports starting Reach Out and Read at the earliest well-child visit after a child is born (generally, the 2-week visit.) Doing so helps to take advantage of every opportunity to influence early brain development and establish nurturing family routines.

By the end of FFY '22, Reach Out and Read will have put in place a plan to increase the number of clinics that implement the intervention from birth from 85 (25%) to 380 clinics (100%), the effort will be complete after three to five years.

- **Improve quality so more clinics attain the highest Reach Out and Read quality rating.** We aim to ensure quality and fidelity to the evidence-based Reach Out and Read model by providing training and technical assistance. Clinics that meet 12 out of 14 quality standards earn the highest quality designation.

By the end of FFY '22, 90% of clinics will have attained the highest quality rating, an increase from 58% of clinics that currently meet that goal.

- **Increase support for robust Medical Engagement and Training.** Activities will focus on facilitating continuous learning and aligning research that supports the pediatric primary care providers' role with children and families. Other activities include developing CME-certified coursework available on the ROR-Carolinas Online Learning Community, partnering with providers on Quality Improvement work and supporting education and training for medical residents. This work is intended to connect with the needs of specific sites and also advance the field of primary care, in general.

By the end of FFY '22, at least one research project launched to evaluate the impact of Reach Out and Read on well-child visit compliance.
Over a three-year period, the HSI will be implemented according to a phased-in approach, as shown in Table 1. A supporting budget for each phase is presented in Table 2. Site quality standards are described in Figure 1. The state intends to use these HSI funds for three years.

- North Carolina provides assurances that the HSI program will only

~~target children under the age of 19.~~

- ~~North Carolina provides further assurances that funds under this HSI will not supplant or match CHIP Federal funds with other Federal funds, nor allow other Federal funds to supplant or match CHIP Federal funds.~~

9.10. Provide a 1-year projected budget. A suggested financial form for the budget is below. The budget must describe: (Section 2107(d)) (42CFR 457.140)

- Planned use of funds, including:
  - Projected amount to be spent on health services;
  - Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
  - Assumptions on which the budget is based, including cost per child and expected enrollment.
  - Projected expenditures for the separate child health plan, including but not limited to expenditures for targeted low income children, the optional coverage of the unborn, lawfully residing eligibles, dental services, etc.
  - All cost sharing, benefit, payment, eligibility need to be reflected in the budget.

- Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.
- Include a separate budget line to indicate the cost of providing coverage to pregnant women.
- States must include a separate budget line item to indicate the cost of providing coverage to premium assistance children.
- Include a separate budget line to indicate the cost of providing dental-only supplemental coverage.
- Include a separate budget line to indicate the cost of implementing Express Lane Eligibility.
- Provide a 1-year projected budget for all targeted low-income children covered under the state plan using the attached form. Additionally, provide the following:
  - Total 1-year cost of adding prenatal coverage
  - Estimate of unborn

children covered in year 1 North Carolina anticipates

a notable impact on the budget.

- **CHIP Budget**

STATE: North Carolina	**FFY Budget**
Federal Fiscal Year	**2024**

STATE: North Carolina	**FFY Budget**
State's enhanced FMAP rate	**77.19% FFY2024 Q1; 76.14% FFY2024 Q2 - Q4**
Benefit Costs	
Insurance payments	0
Managed care	$660,002,208
per member/per month rate	$192.97
Fee for Service	$131,644,139
Total Benefit Costs	**$791,646,347**
(Offsetting beneficiary cost sharing payments)	0
Net Benefit Costs	**$791,646,347**
Cost of Proposed SPA Changes – Benefit	**0**
Administration Costs	
Personnel	$6,063,607
General administration	$9,202,142
Contractors/Brokers	0
Claims Processing	$981,309
Outreach/marketing costs	0
Health Services Initiatives	$669,345
Other	0
Total Administration Costs	**$16,916,403**
10% Administrative Cap	$87,960,705
Cost of Proposed SPA Changes	$669,345
Federal Share	$617,762,155
State Share	$190,800,595
Total Costs of Approved CHIP Plan	**$808,562,750**

NOTE: Include the costs associated with the current SPA.

The Source of State Share Funds: Appropriations