Moving Forward:
NC Medicaid Managed Care & Human Services Update

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Bringing a little
bit of the mountains down the hill to Raleigh

North Carolina's Vision for Medicaid Managed Care

"To improve the health of North Carolinians through an innovative, whole-person centered, and well-coordinated system of care that addresses both the medical and non-medical drivers of health."

North Carolina's Goals for Medicaid Managed Care

By implementing managed care, and advancing integrated and high-value care, North Carolina Medicaid will improve population health, engage and support providers, and establish a sustainable program with more predictable costs.

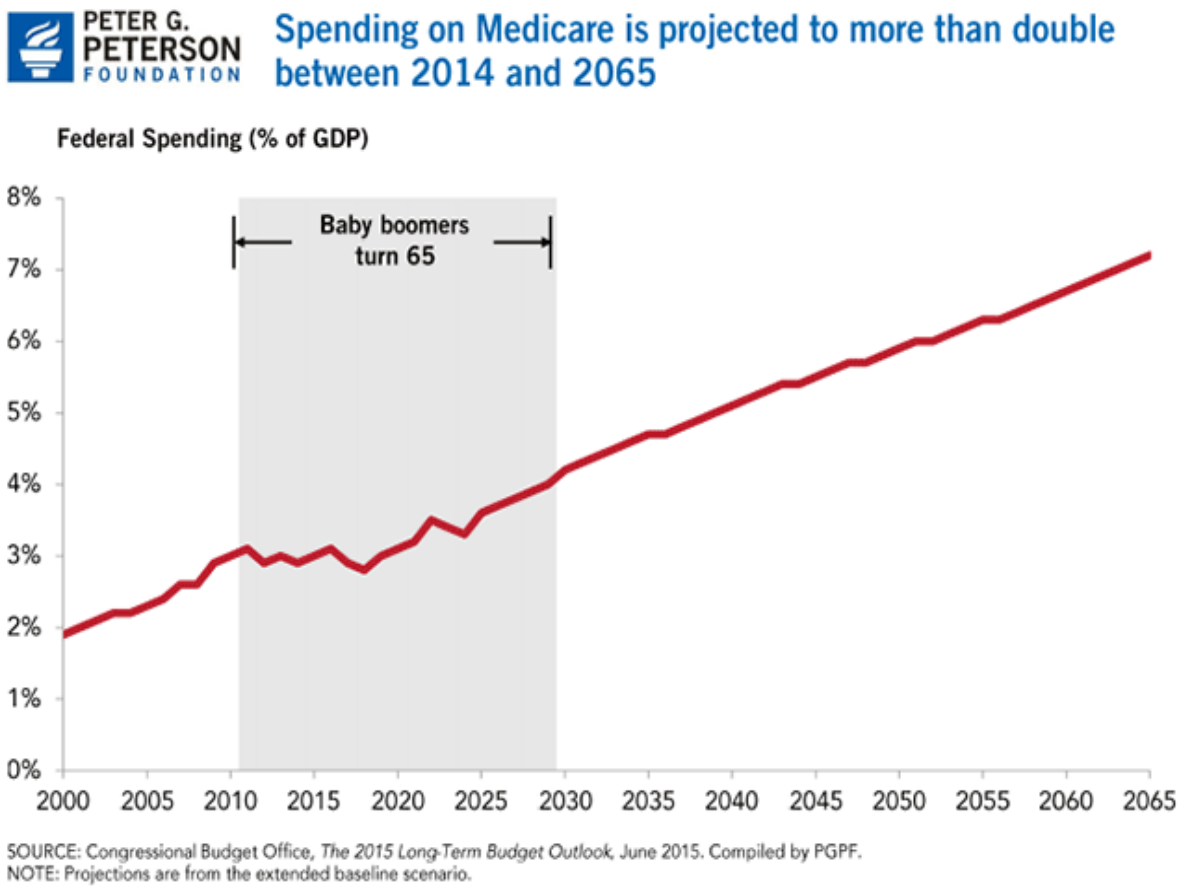
Context for Medicaid Transformation

- In 2015, the **NC General Assembly enacted Session Law 2015-245**, directing the transition of Medicaid and NC Health Choice from predominantly fee-for-service to managed care.
- North Carolina Department of Health and Human Services (DHHS) has worked to design a program that:
  - Delivers **whole-person care** through coordinated physical health, behavioral health, intellectual/developmental disability and pharmacy products and care models
  - Addresses the **full set of factors** that impact health, uniting communities and health care systems
  - Performs **localized care management** at the site of care, in the home or community
  - Maintains broad **provider participation** by mitigating provider administrative burden

But WHY Value Based Care?

And Why Now?

US Healthcare's MAJOR Challenge: High Cost



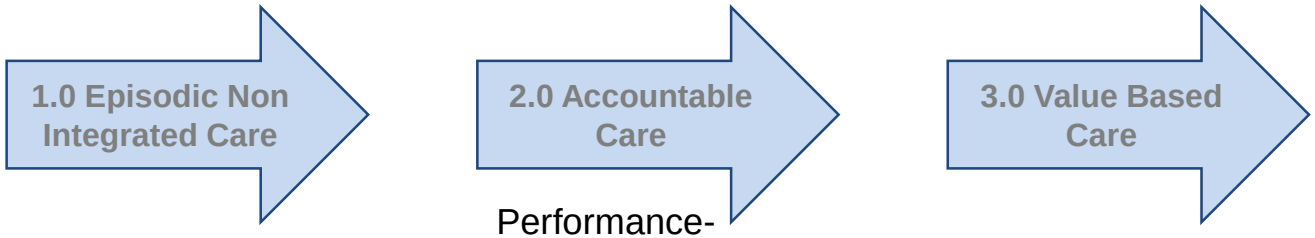
US Healthcare's MAJOR Challenge: Low Quality

Exhibit 9. Select Population Health Outcomes and Risk Factors

	Life exp. at birth, 2013[a]	Infant mortality, per 1,000 live births, 2013[a]	Percent of pop. age 65+ with two or more chronic conditions, 2014[b]	Obesity rate (BMI>30), 2013[a,c]	Percent of pop. (age 15+) who are daily smokers, 2013[a]	Percent of pop. age 65+
Australia	82.2	3.6	54	28.3[e]	12.8	14.4
Canada	81.5[e]	4.8[e]	56	25.8	14.9	15.2
Denmark	80.4	3.5	–	14.2	17.0	17.8
France	82.3	3.6	43	14.5[d]	24.1[d]	17.7
Germany	80.9	3.3	49	23.6	20.9	21.1
Japan	83.4	2.1	–	3.7	19.3	25.1
Netherlands	81.4	3.8	46	11.8	18.5	16.8
New Zealand	81.4	5.2[e]	37	30.6	15.5	14.2
Norway	81.8	2.4	43	10.0[d]	15.0	15.6
Sweden	82.0	2.7	42	11.7	10.7	19.0
Switzerland	82.9	3.9	44	10.3[d]	20.4[d]	17.3
United Kingdom	81.1	3.8	33	24.9	20.0[d]	17.1
United States	78.8	6.1[e]	68	35.3[d]	13.7	14.1
OECD median	81.2	3.5	–	28.3	18.9	17.0

[a] Source: OECD Health Data 2015.
[b] Includes: hypertension or high blood pressure, heart disease, diabetes, lung problems, mental health problems, cancer, and joint pain/arthritis. Source: Commonwealth Fund International Health Policy Survey of Older Adults, 2014.
[c] DEN, FR, NETH, NOR, SWE, and SWIZ based on self-reported data; all other countries based on measured data.
[d] 2012. [e] 2011.

Stages of Healthcare Transformation



Fee for Service

Performance-Based Payments

Quality-related payments

Transparency

Full Risk or Capitated Payments

Bundled Payments across levels of care

Population Health Focus

So, Closer to the Ground…

…What's Happening Here?

Medicaid Transformation Timeline

Timeline	Milestone
October 2018	1115 waiver approved
February 2019	Pre-paid Health Plan (PHPs) contracts awarded
July 2019	Open enrollment began for patients in Phase 1 (Auto-enrollment to begin September for Phase 1)
Summer 2019	PHPs contract with providers and meet network adequacy
November 2019	Managed care Standard Plans launch in Phase 1 regions; Phase 2 open enrollment (Auto-enrollment to begin December)
February 2020	Managed care Standard Plans launch in remaining regions

Overview of Managed Care

The majority of Medicaid and NC Health Choice beneficiaries will receive Medicaid through Prepaid Health Plans (PHPs).

- NC Medicaid providers will contract with and be reimbursed by PHPs rather than the State directly(affects ~1.6 million people)

- The PHPs will received a capitated payment, providers will primarily be paid fee-for-service at beginning, with evolving path to alternative payment models

- Two types of PHPs:
  - Commercial plans
  - Provider-led entities

Note: Certain populations will **continue in fee-for-service (FFS) programs** on an ongoing basis.

- Two types of products:
  - Standard Plans for most beneficiaries; scheduled to launch in 2020
  - Tailored Plans for high-need populations; scheduled to launch in 2021

Beneficiary Eligibility for Managed Care

The majority of Medicaid beneficiaries will transition to standard plans beginning in November 2019. Other populations will have delayed enrollment or will be exempt or excluded from managed care (remaining in FFS program):

Excluded from Medicaid Managed Care:

- Partial dual eligibles
- Qualified aliens subject to the five-year bar
- Undocumented aliens
- Medically needy
- Presumptively eligible, during the period of presumptive eligibility
- Health Insurance Premium Payment (NC HIPP) program
- Family planning
- Inmates of prisons
- Community Alternatives Program for Children (CAP/C)**
- Community Alternatives Program for Disabled Adults (CAP/DA)**
- Program of All-Inclusive Care for the Elderly (PACE)

Delayed

- Children in Foster Care
- Behavioral Health Intellectual/Developmental Disability/Traumatic Brain Injury - Tailored Plan launch

Temporarily excluded for up to 5 years:

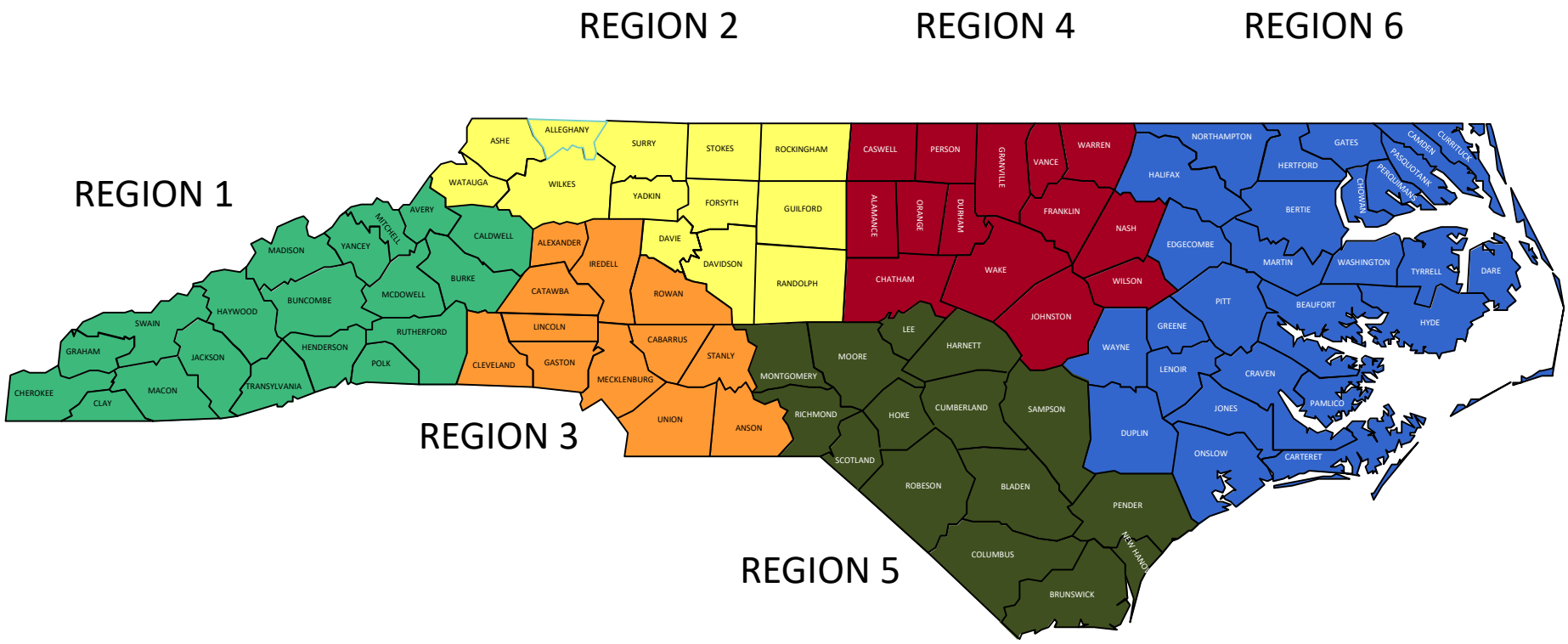
- Beneficiaries with long-term nursing facility stays
- Dual eligibles

Exempt from Medicaid Managed Care:

- Members of federally recognized tribes, including members of the Eastern Band of Cherokee Indians

*DHHS is in the process of finalizing eligibility criteria for the BH I/DD TPs; **Will require legislative change

NC Medicaid Managed Care Regions and Rollout Dates



Rollout: Feb. 2020

Contract Year 1 runs through June 30, 2020 for all regions

PHPs for NC Medicaid Managed Care

Four Statewide PHP Contracts

- AmeriHealth Caritas North Carolina, Inc.
- Blue Cross and Blue Shield of North Carolina, Inc.
- UnitedHealthcare of North Carolina, Inc.
- WellCare of North Carolina, Inc.

One Regional Provider-Led Entity

- Carolina Complete Health, Inc. (Regions 3,4 and 5)

DHHS Care Management Strategy

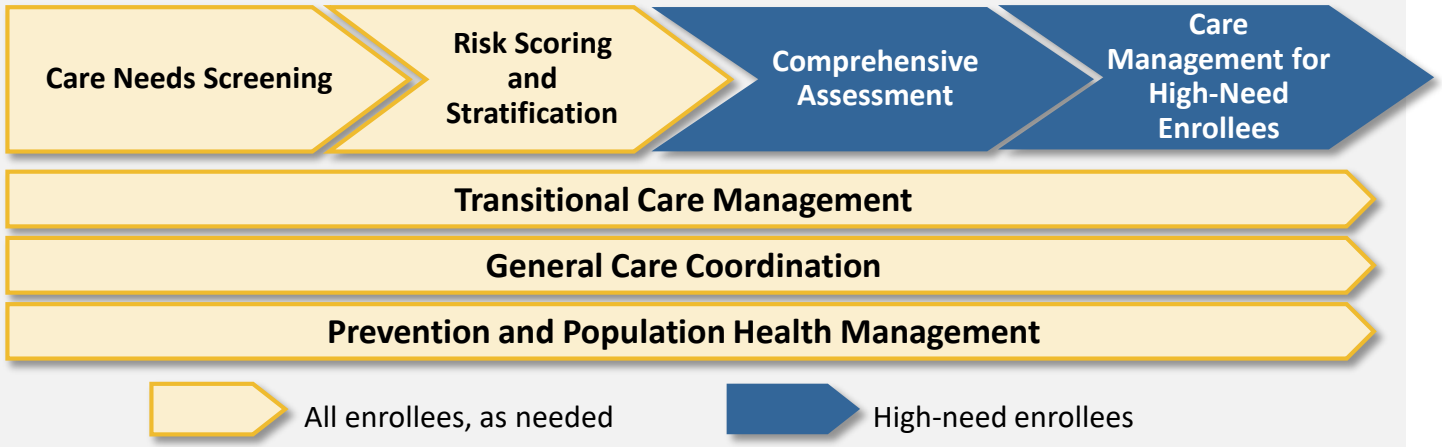
Robust care management is a cornerstone of the State's managed care transition through PHPs, AMHs, and LHDs

Care Management Guiding Principles

- ❑ Medicaid enrollees will have access to **appropriate care management**
- ❑ Care management should involve **multidisciplinary care teams**
- ❑ **Local care management** is the preferred approach
- ❑ Care managers will have access to **timely and complete enrollee-level information**
- ❑ Enrollees will have access to **programs and services that address unmet health-related resource needs**
- ❑ Care management will align with **statewide priorities for achieving quality outcomes and value**

Care Management Approach

The State has developed a process to ensure that high-need individuals and those transitioning out of the hospital will receive appropriate, local care management

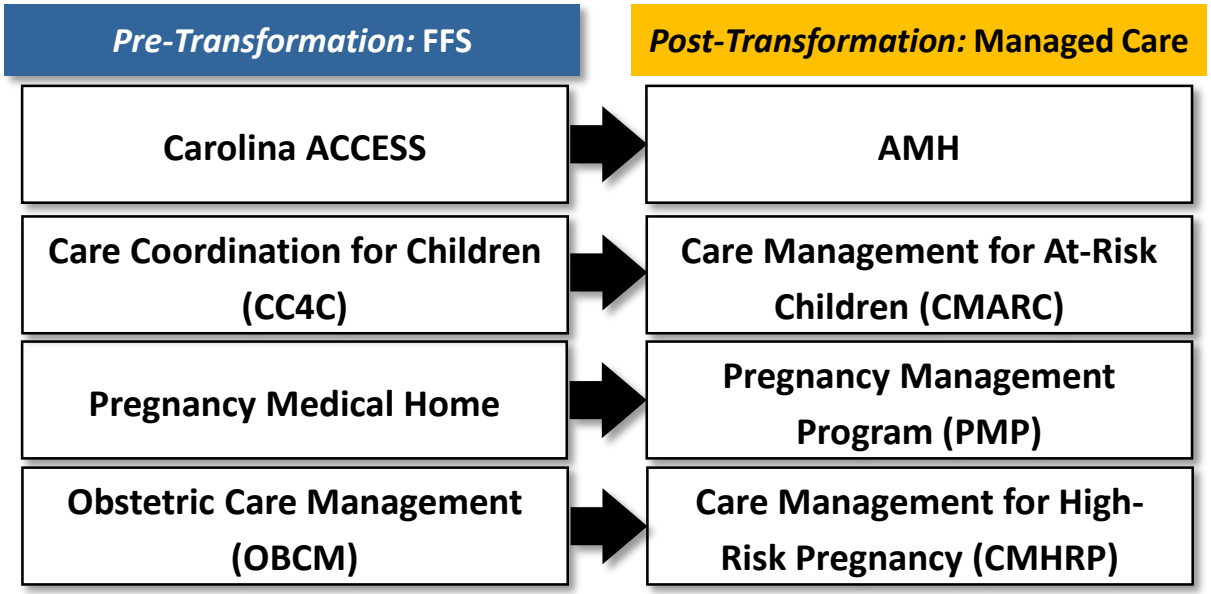


- **Processes must also be in place to identify priority populations, including:**
  - Children and adults with special health care needs*
  - Individuals in need of long term services and supports (LTSS)
  - Enrollees with rising risk
  - Individuals with high unmet resource needs (high social risk)

**Including behavioral health, substance use, increased risk for chronic conditions, and foster care populations

Evolution of Existing Programs Under Managed Care

The State will build on existing care management infrastructure under managed care



*Note: These programs will **remain in place** **post-transformation** for populations that remain in FFS coverage*

Note: Local Health Departments, Pediatric providers and Maternity Care providers can also be AMH providers

Behavioral Health Integration

As part of Medicaid transformation, physical and behavioral health benefits will be administered by one managed care plan, under two types of products: Standard Plans and BH I/DD Tailored Plans.

Behavioral Health Integration in Standard Plans

- Majority of Medicaid and NC Health Choice enrollees
- Lower-intensity behavioral health needs
- At launch of Managed Care 2019

Behavioral Health Integration in Tailored Plans

- Smaller population with significant Behavioral Health, Intellectual/Developmental Disabilities/Traumatic Brain Injuries
- Specialized services
- Delayed Launch starting 2021

Rationale for Integration

Currently, NC Medicaid beneficiaries have their behavioral health benefit administered separately from their physical health benefit through LME-MCOs.

Integrating behavioral and physical health benefits will better enable care managers and providers to deliver **coordinated, whole-person care**.

What is a BH/IDD Tailored Plan (TP)?

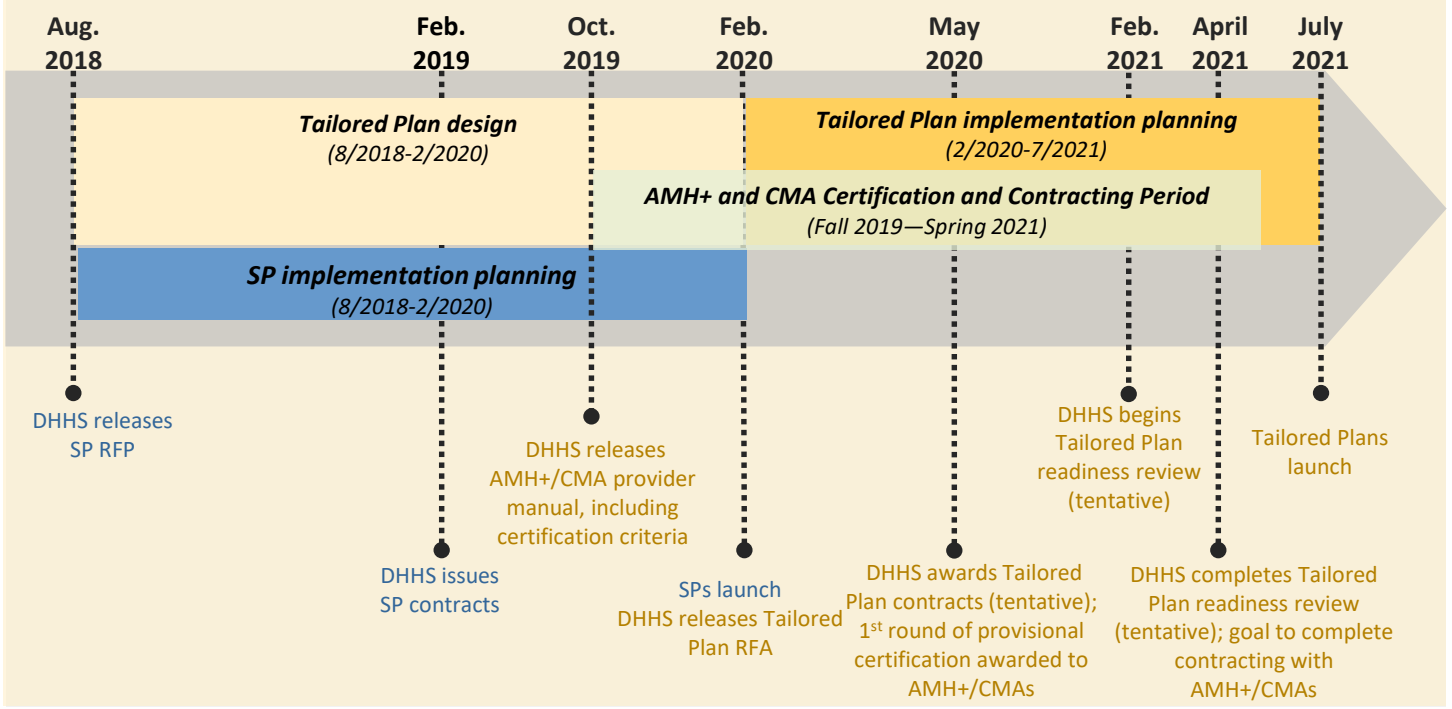
North Carolina will launch specialized managed care plans, called BH/IDD Tailored Plans, starting in 2021; design of these plans is just beginning.

Key Features of BH/IDD Tailored Plans:

- TPs are designed for those with significant behavioral health (BH) needs and/or intellectual/developmental disabilities (I/DDs)
- TPs will also serve other special populations, including Innovations and Traumatic Brain Injury (TBI) waiver enrollees and waitlist members
- TP contracts will be regional, not statewide
- LME-MCOs are the only entities that may hold a TP contract during the first four years; after the first four years, any non-profit PHP may also bid for and operate a TP
- LME-MCOs operating TPs must contract with an entity that holds a prepaid health plan (PHP) license and that covers the same services that must be covered under a standard benefit plan contract
- TPs will manage State-funded behavioral health, I/DD, and TBI services for the uninsured and underinsured

Timeline for Tailored Plan Planning & Launch

As a critical feature of Tailored Plan design, implementation planning for Tailored Care Management is in full swing.



Key Differences: LME-MCOs and BH/IDD Tailored Plans

	CURRENT	FUTURE
Scope	Behavioral Health, IDD.TBI	Behavioral Health, IDD,TBI Physical Health, Pharmacy
Entity	Pre-paid Inpatient Health Plan	Prepaid Health Plan
Waiver Type	1915(b)(c)[3]	1115 [3]
Health Home	Does not exist in LME-MCOs	New Tailored Plan Health Home care management model
Designation	LME-MCOs as designed in current legislation	Tailored Plans selected based on requirements in RFA
Organization Type	Local political subdivisions	To be determined

[3] Includes Innovations, TBI waiver; with managed care implementation the (c) waiver will operate under the 1115

Side by Side	Standard Plans	Tailored Plans
Scope	Fully integrated Care	Fully Integrated Care
Entity	Prepaid Health Plans	Prepaid Health Plan
Waiver Type	1115	1115[4]
Procurement	Competitive RFP	Request for Application (RFA) to existing LME-MCOs[5]
Contracting	Accept any willing provider	Any willing provider- physical health Closed network – behavioral health
Plans available to beneficiaries	4 statewide & 1 regional	1 per region[6]
Additional Services/Funding	In-lieu & value added services	Innovations, TBI In-lieu, value added, State-funded, Federal and State Block Grants, current (b)(3), a subset of the more intensive behavioral health enhanced services

[4]The (c) waivers which currently operates under the 1915(b) waiver, will after Tailored Plan go live, operate under the 1115 waiver
[5]After initial four-year contract term, competitive RFP for Tailored Plans
[6]unless beneficiary makes an informed choice to go to SP

Care Management Under Managed Care

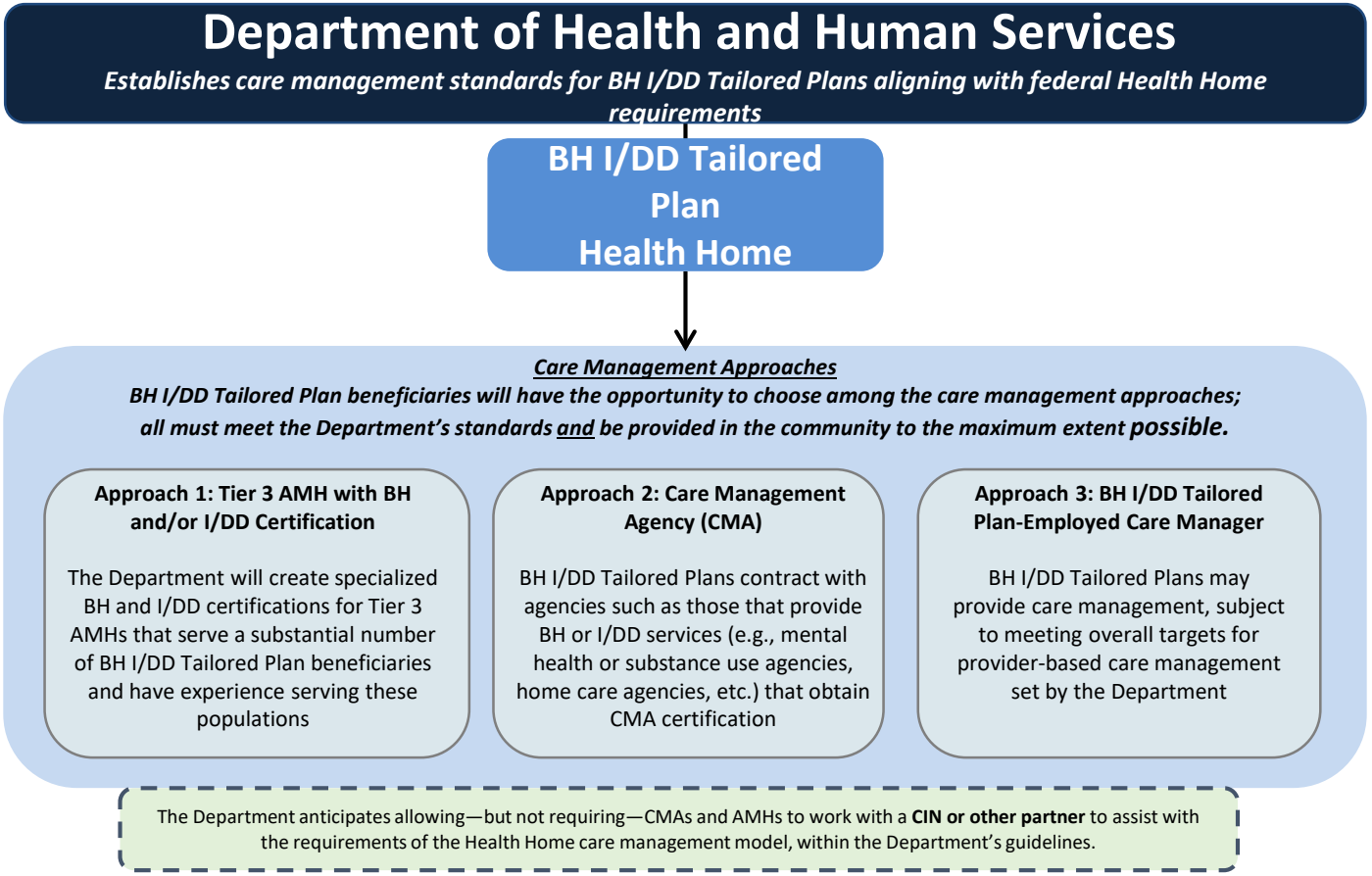
Both managed care products will offer robust care management. BH I/DD TP care management will build on SP care management design to provide services customized to individuals with behavioral health, I/DD, and TBI needs.

SP care management will be available to certain "priority populations." Primary care practices certified as Tier 3 Advanced Medical Homes (AMHs) will take the lead on care management for their patients in SPs

BH I/DD TP care management will be available to all BH I/DD TP enrollees and will be provided through:

1. Tier 3 AMHs certified by DHHS to provide care management to the BH I/DD TP population
2. Care management agencies (CMAs)–community-based organizations (e.g., behavioral health or I/DD providers) certified by DHHS to provide care management to the BH I/DD TP population
3. BH I/DD TPs

Overview of Health Home Care Management Approach



Health Home Care Management is Integral to Medicaid Transformation

Health Home care management builds upon and intersects with DHHS's strategy for AMHs, Healthy Opportunities, and VBP.

Advanced Medical Homes

BH I/DD TPs will contract with Tier 3 AMHs certified by DHHS to provide integrated Health Home care management (in addition to their role providing health care services), addressing the whole-person needs of populations with significant behavioral health or I/DD needs.

Healthy Opportunities

Health Home care managers will assess beneficiaries for unmet health-related resource needs and manage social service referrals and coordination.

Value-Based Payment

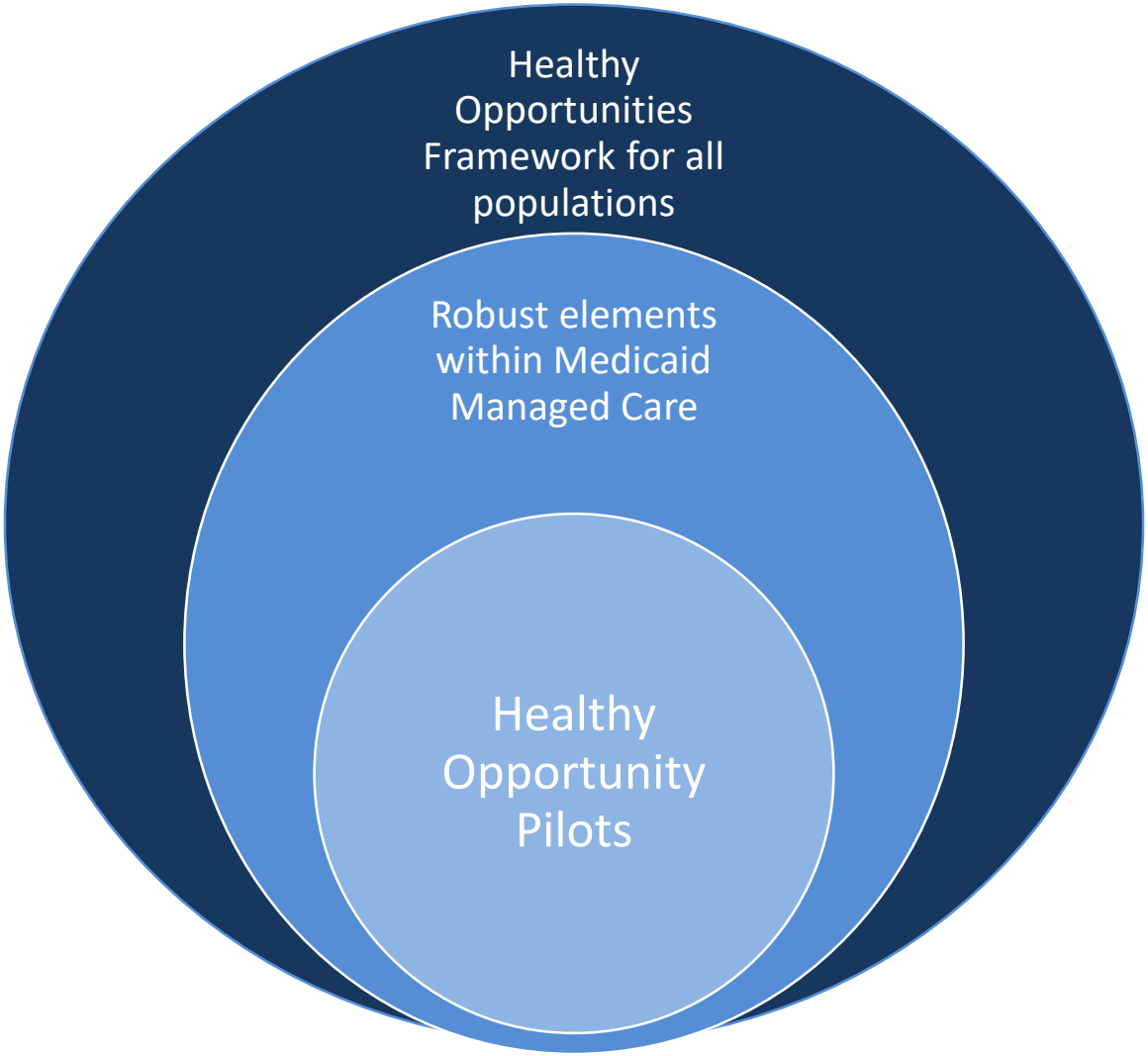
Comprehensive care management has been shown to improve health outcomes and achieve positive returns on investment, making it an important piece of population health management.[1,2] Population health management provides the foundation for providers to be successful in a value-based payment environment.

Health Home Care Management

[1]US DHHS. Evaluation of the Medicaid Health Home Option for Beneficiaries with Chronic Conditions. May 11, 2017.
[2]Long PV, Abrams M, Milstein A, et al. Effective care for high-need patients, opportunities for improving outcomes, value, and health. National Academy of Medicine; 2018.

Opportunity for Health

All North Carolinians deserve the opportunity for health. As such, we need to address the medical and non-medical drivers of health



https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities

Infrastructure and Elements across all populations

Hot Spot Map	• GIS map of social determinants of health indicators at census tract level
Screening	• Statewide Standardized Screening Questions
NCCARE360	• Statewide coordinated network with shared technology platform
Workforce Development	• Community Health Workers, Permanent Supportive Housing
Back@Home	• Rapid Rehousing for Victims of Hurricane Florence
Aligning Enrollment	• Coordinating enrollment across programs e.g., Medicaid, WIC, SNAP

Screening Questions

- Developed by Technical Advisory Group
- Drew from validated and commonly used tools (e.g PRAPARE, Accountable Health Community)
- Routine identification of unmet health-related resource needs
- Statewide collection of data
- Implementation
  - Public Review
  - Fall 2018 Pilot testing in 18 clinical sites and telephonically (n=804)
  - Ready Providers/Systems adopting
  - Encouraging everyone to use for all populations
  - Launch of Managed Care
    - PHPs Required to Include in initial Care Needs Screening
- Need to tackle data flow next

Health Screening

We believe everyone should have the opportunity for health. Some things like not having enough food or reliable transportation or a safe place to live can make it hard to be healthy. Please answer the following questions to help us better understand you and your current situation. We may not be able to find resources for all of your needs, but we will try and help as much as we can.

	Yes	No
Food		
1. Within the past 12 months, did you worry that your food would run out before you got money to buy more?		
2. Within the past 12 months, did the food you bought just not last and you didn't have money to get more?		
Housing/ Utilities		
3. Within the past 12 months, have you ever stayed: outside, in a car, in a tent, in an overnight shelter, or temporarily in someone else's home (i.e. couch-surfing)?		
4. Are you worried about losing your housing?		
5. Within the past 12 months, have you been unable to get utilities (heat, electricity) when it was really needed?		
Transportation		
6. Within the past 12 months, has a lack of transportation kept you from medical appointments or from doing things needed for daily living?		
Interpersonal Safety		
7. Do you feel physically or emotionally unsafe where you currently live?		
8. Within the past 12 months, have you been hit, slapped, kicked or otherwise physically hurt by anyone?		
9. Within the past 12 months, have you been humiliated or emotionally abused by anyone?		
Optional: Immediate Need		
10. Are any of your needs urgent? For example, you don't have food for tonight, you don't have a place to sleep tonight, you are afraid you will get hurt if you go home today.		
11. Would you like help with any of the needs that you have identified?		

NCCARE360

What is NCCARE360?

NCCARE360 is the first statewide coordinated network that includes a robust repository of shared resources and a shared technology platform to connect healthcare and human services providers together to collectively provide the opportunity for health to North Carolinians.

NCCARE360 Partners:

Foundation for Health Leadership & Innovation
Moving people and ideas into action.

NCDHHS

United Way
United Way of North Carolina

NORTH CAROLINA 211

Expound

UNITE US

NCCARE360

Three Functions

	Functionality	Partner	Timeline
Resource Directory	Directory of statewide resources verified by a professional data team adhering to AIRS standards	United Way of North Carolina	Ongoing work
Call Center Support	Call Center with a team of NCCARE360 Navigators, and the addition of text and chat capabilities.	NORTH CAROLINA 211	
Resource Repository	APIs integrate resource directories across the state to share resource data.	Expound	Phased Approach
Referral & Outcomes Platform **Community Engagement Managers**	Referral platform with closed loop functions. Community Engagement Managers for workflow, change management, continued in person support.	UNITE US	Rolled out by community January 2019 – December 2020

NCCARE360

Creating a Collaborative Network through Shared Technology Platform

A coordinated network connects providers (such as health care providers, insurers, or community organizations) through a shared technology platform to:

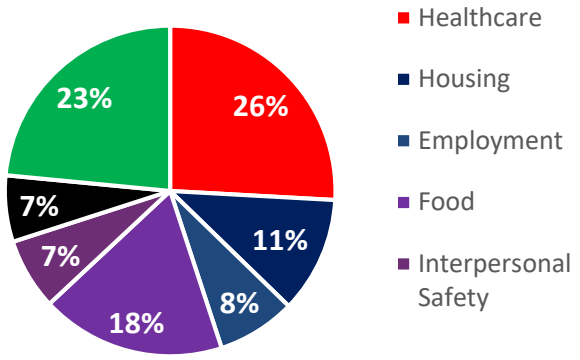
- Communicate in real-time
- Make electronic referrals
- Securely share client information
- Track outcomes together

Status Update (as of 10/18/19)

NCCARE360 Implementation Status Update	
21	Counties launched (Alamance, Beaufort, Bertie, Brunswick, Chowan, Durham, Edgecombe, Franklin, Guilford, Granville, Hertford, Johnston, Martin, New Hanover, Pender, Person, Pitt, Rockingham, Vance, Wake and Warren)
29	Counties started on implementation
1619	Organizations engaged in socialization process
396	Organizations with NCCARE360 licenses
1634	Active Users
1118	Referrals Sent

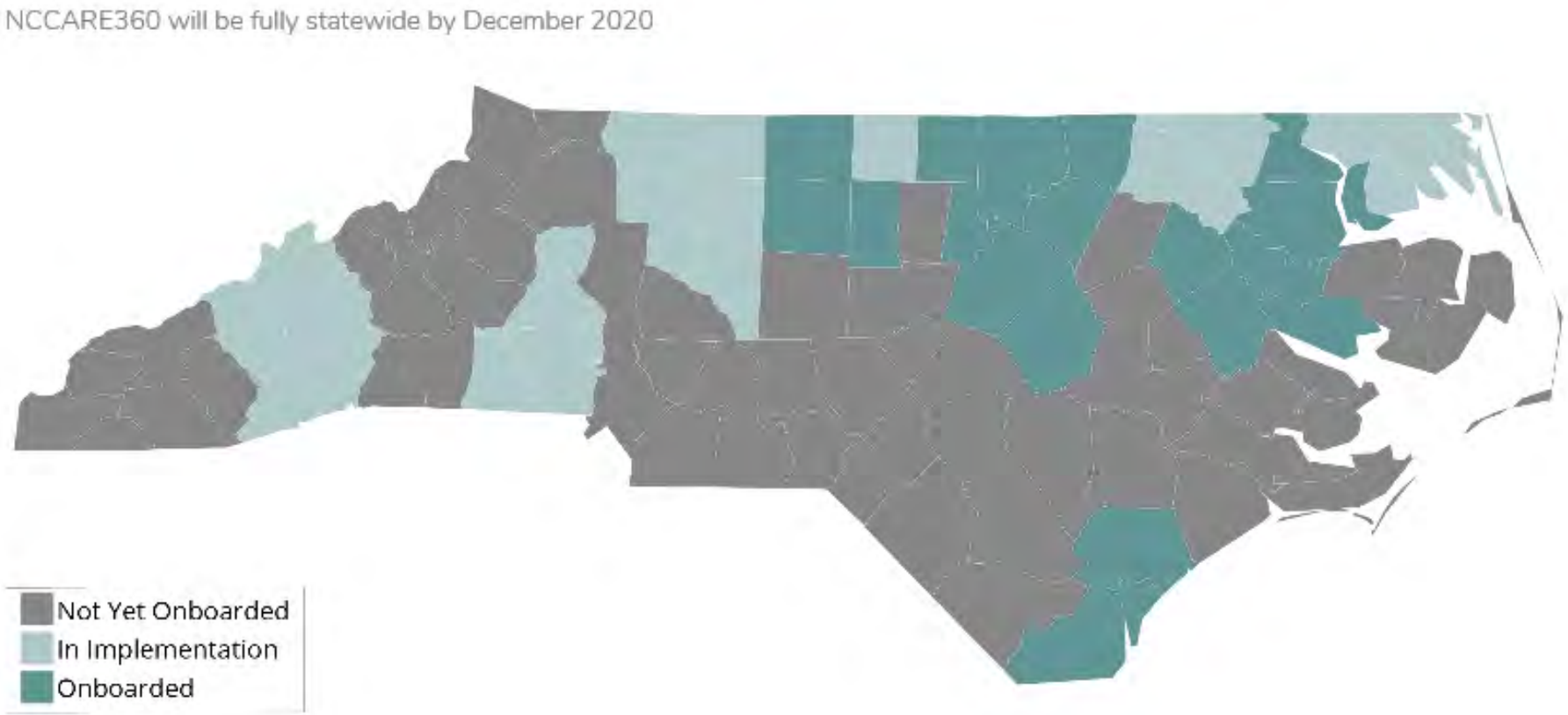
NCCARE360 Resource Repository	
2,954	Organizations verified
10,736	Programs verified

Engaged Organizations by Service Type

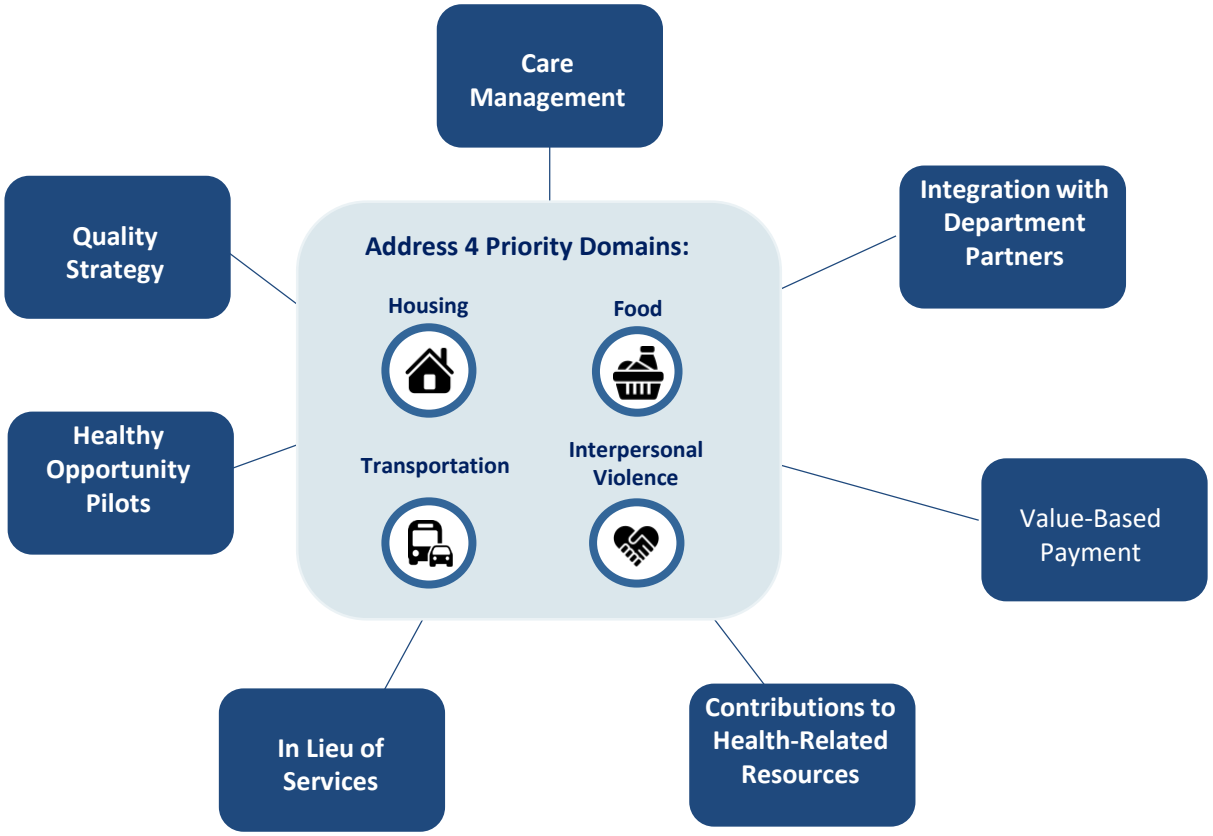


NCCARE360 will be implemented statewide by end of 2020

State Coverage – to be statewide by Dec 2020



Robust Elements within Medicaid Managed Care



Overview of Eligibility

To be eligible for pilot services, Medicaid managed care enrollees must have:

At least one Needs-Based Criteria:

Physical/behavioral health condition criteria vary by population:

- Adults (e.g., 2 or more chronic conditions)
- Pregnant Women (e.g., multifetal gestation)
- Children, ages 0-3 (e.g., Neonatal intensive care unit graduate)
- Children 0-21 (e.g., Experiencing three or more categories of adverse childhood experiences)

At least one Social Risk Factor:

- Homeless and/or housing insecure
- Food insecure
- Transportation insecure
- At risk of, witnessing or experiencing interpersonal violence

Overview of Approved Pilot Services

North Carolina's 1115 waiver specifies services that can be covered by the Pilot.

Housing

- Tenancy support and sustaining services
- Housing quality and safety improvements
- One-time securing house payments (e.g., first month's rent and security deposit)
- Short-term post hospitalization housing

Food

- Linkages to community-based food services (e.g., SNAP/WIC application support, food bank referrals)
- Nutrition and cooking coaching/counseling
- Healthy food boxes
- Medically tailored meal delivery

Transportation

- Linkages to existing public transit
- Payment for transit to support access to pilot services, including:
  - Public transit
  - Taxis, in areas with limited public transit infrastructure

Interpersonal Violence

- Linkages to legal services for IPV related issues
- Evidence-based parenting support programs
- Evidence-based home visiting services

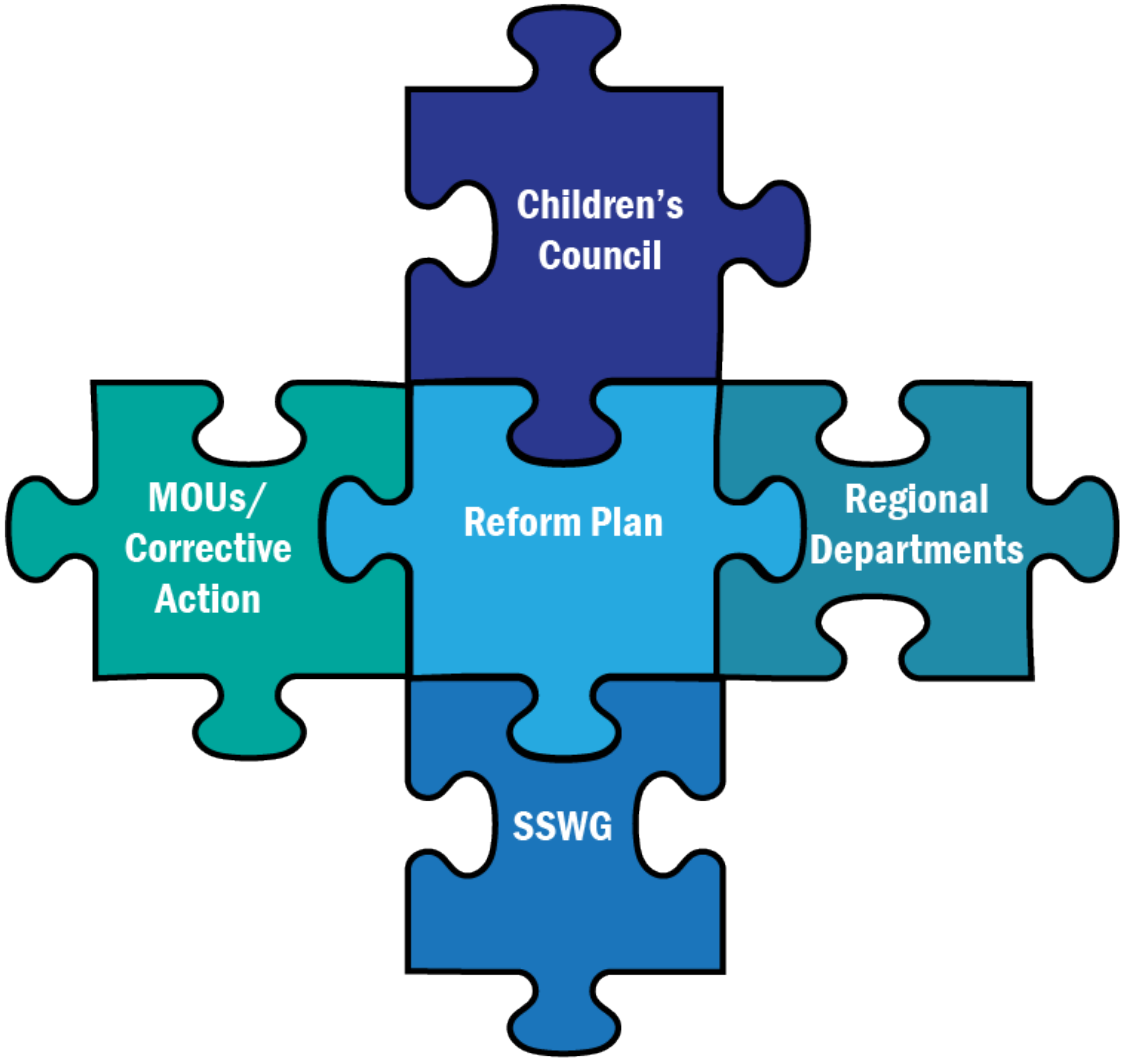
**See appendix for full list of approved pilot services.*

Process/Time Line

- Feb 2019: White Paper on Pilot Design/Request for Information on cost elements
- Spring 2019: Multiple forums for collecting input from stakeholders, Manatt/Commonwealth Fund - Advisory Group on Fee Schedule
- July 2019
  - Further guidance on Lead Pilot Entity (LPE)/Non-binding Statement of Interest
  - Pilot Service Definitions, Methodology for constructing fee schedule
- September 1: Fee schedule submitted to CMS
- Fall 2019: Request for Proposals (RFP) to determine LPEs/Pilot Regions
- Early 2020: Award LPEs/Pilot Regions
- Most of 2020: Capacity building for LPEs and regions
- Early 2021- October 2024: Service Delivery

Human Services Update

Family & Child Protection and Accountability Act - Rylan's Law

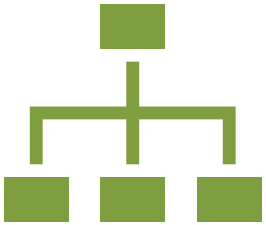


DHHS Report to Legislature

- Family and Child Protection and Accountability Act requires this report from DHHS to the Legislature to identify plans and preliminary recommendations to:
  - Provide a blueprint to shift from a centralized model of supervision to one that that is regional and can provide closer support and monitoring to counties
  - Programs affected include child welfare, adult protective services and guardianship, public assistance, and child support enforcement
  - The report focuses on reorganization of staff and identification of resources needed to begin this transition

Rylan's Law – Status

DHHS provided the legislature with plans and legislative recommendations needed to move toward regional supervision



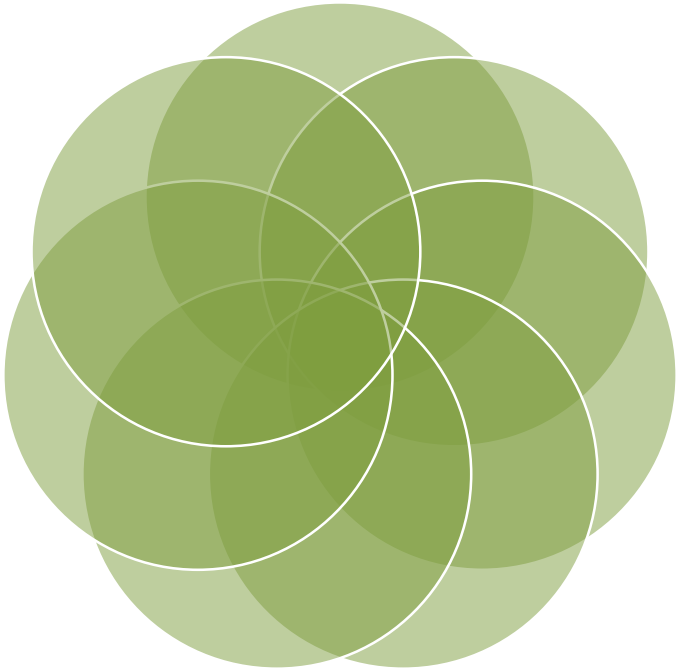
DHHS has adopted several recommendations from CSF to make organizational and programmatic changes in the Child & Family Services Plan and the State Aging Plan

DHHS is refining metrics for the data dashboard and MOU's to improve system accountability and transparency

Landscape for Systemic Change

Aging & Adult Services

Interagency Council for Coordinating Homeless Programs



Guardianship

Opioid Action Plan

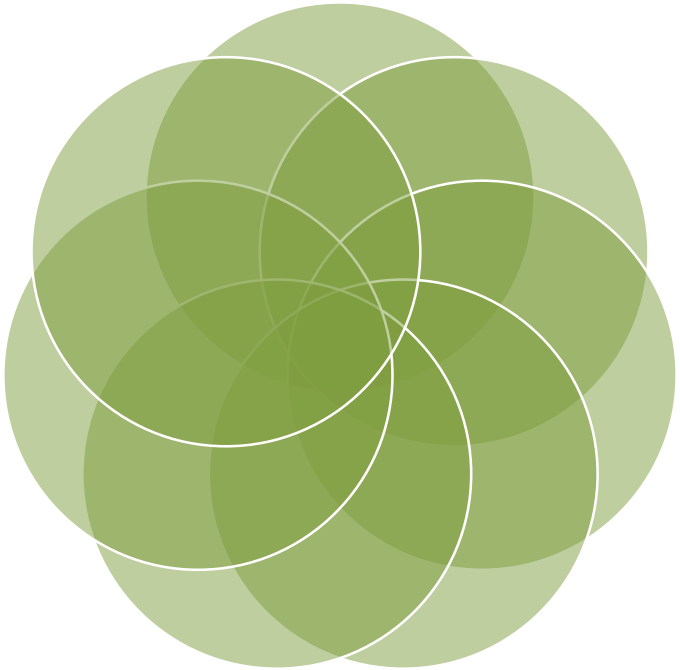
Aging Services

Adult Protective Services Modernization

Landscape for Systemic Change

Child Welfare Reform

- **Rylan's Law**
- **Family First Prevention Services Act**



Early Childhood Action Plan

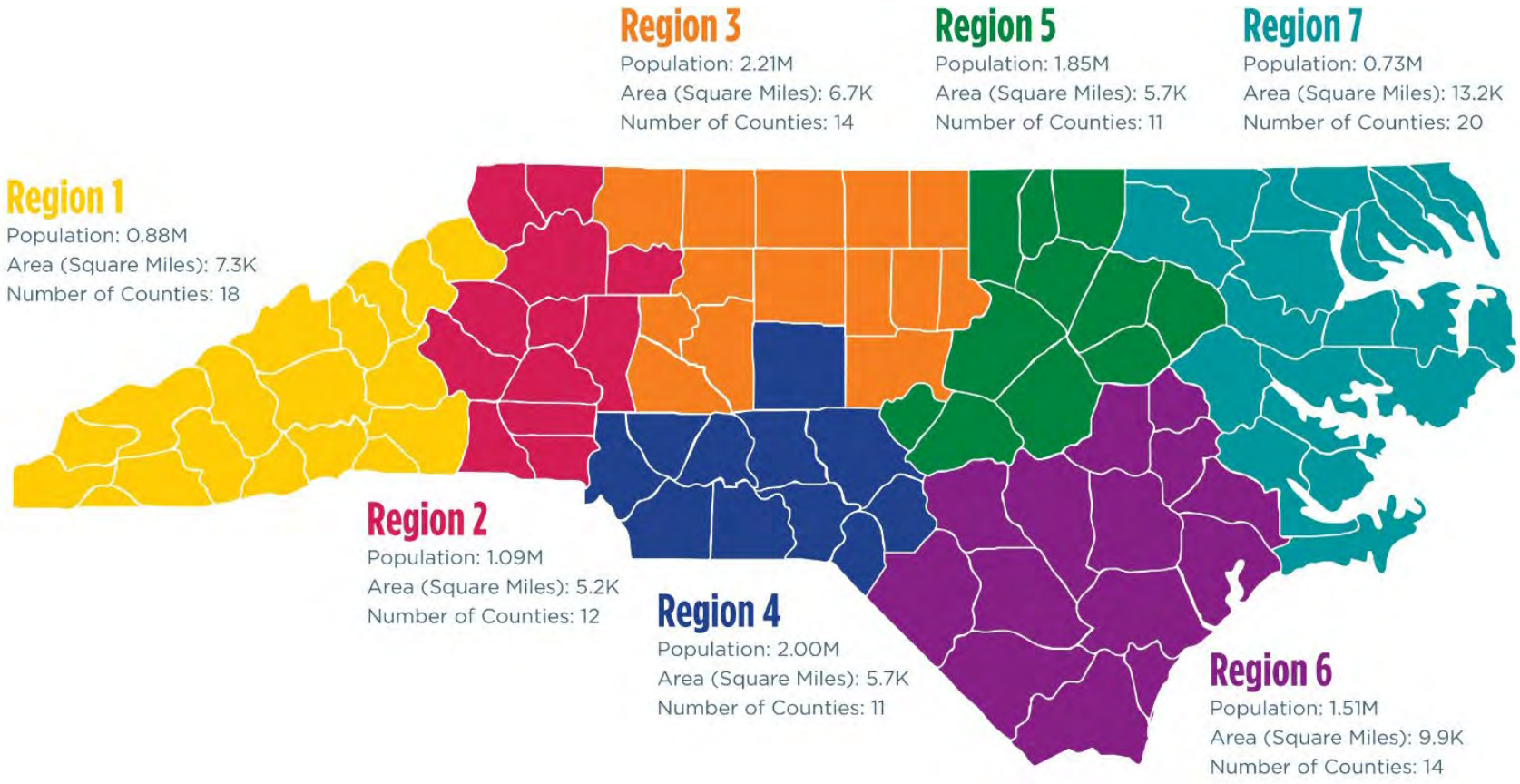
Medicaid Transformation

Opioid Action Plan

Raise the Age

Residential Redesign

*Proposed Regional Map



*Subject to change

Opioid Action Plan 2.0

Since the launch of the Opioid Action Plan, we've advanced many strategies:

- ✓ Received over **$54 million in federal funding** which provided **treatment for over 12,000 people.**
- ✓ Increased the number of **Syringe Exchange Programs,** and served over 5,000 people annually through them.
- ✓ **Trained over 3,000 providers** on clinical issues related to the epidemic, include safe prescribing of opioids and pain treatment.
- ✓ Funded **peer support specialists** with lived experience in emergency departments to connect people with substance use disorders (SUDs) to ongoing services and supports.
- ✓ Launched **a medical residency training** project that will give over 400 prescribers their DATA 2000 waiver to prescribe buprenorphine, and work with over 20 residency programs to incorporate the DATA 2000 waiver into their curriculum ongoing.

- ✓ **Funded 34 local organizations** to implement action plan strategies in their communities.
- ✓ **Enhanced the Controlled Substances Reporting System (CSRS)** to provide data visualizations so providers can make informed decisions at the point of care.
- ✓ **Integrated CSRS with electronic health records** and established data exchange with 29 states.
- ✓ **Convened a Payers Council** which made recommendations for insurance payers to respond to the opioid epidemic.
- ✓ **Raised awareness of safe drug storage**, disposal and drug take backs.
- ✓ Developed **model healthcare worker diversion prevention** protocols.
- ✓ Collected and incinerated over 100,000 pounds of medications through **Operation Medicine Drop.**
- ✓ Created a publicly accessible **data dashboard** to monitor progress.
- ✓ Established an opioid research consortium and created a **NC Opioid Research Agenda.**
- ✓ Launched multiple **public education campaigns.**

Since the launch of the Plan:

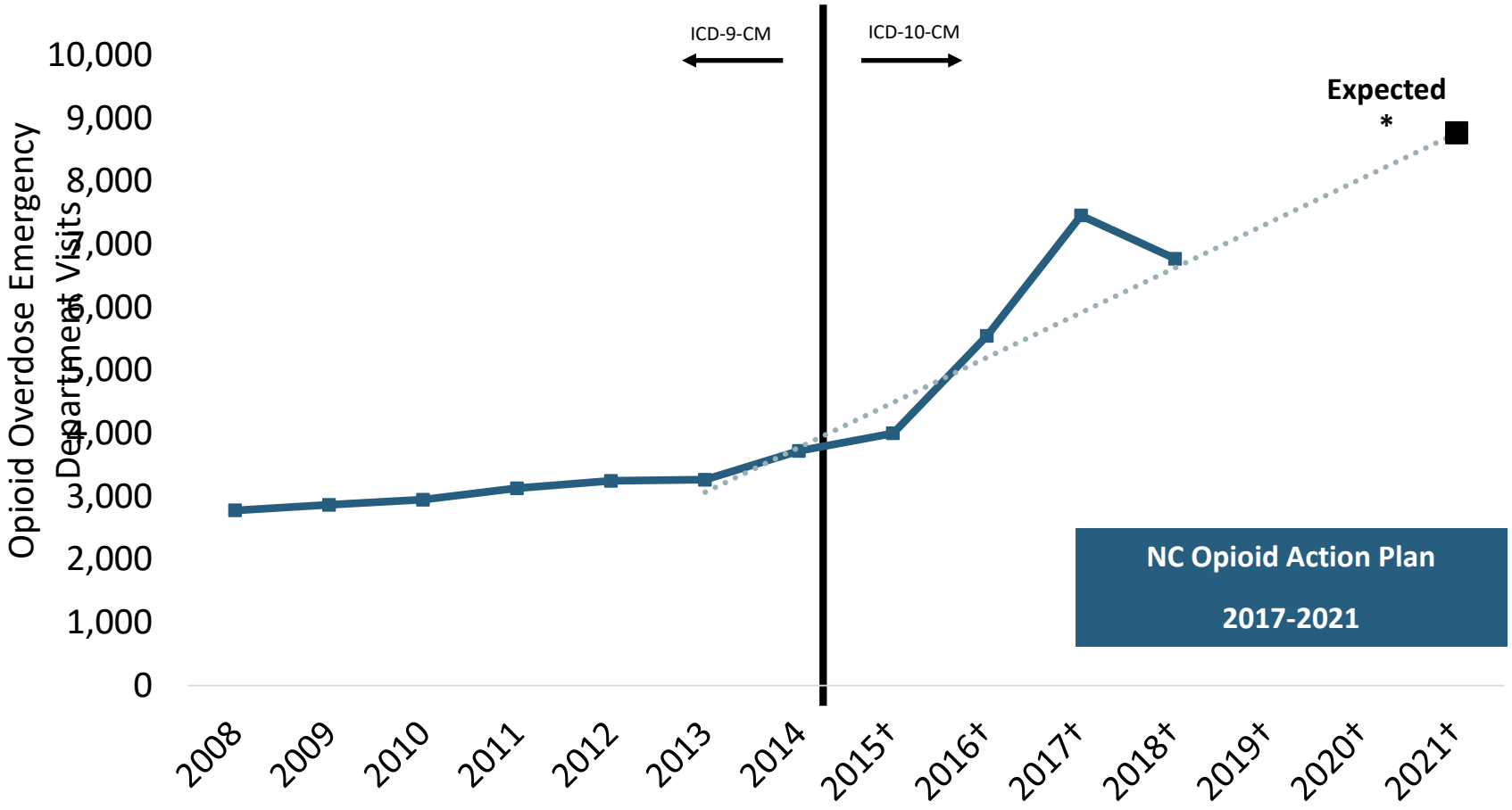
Opioid dispensing has **decreased by 24%**

Buprenorphine dispensing has **increased 15%**

Uninsured and Medicaid beneficiaries who have received opioid use disorder treatment has **increased by 20%**

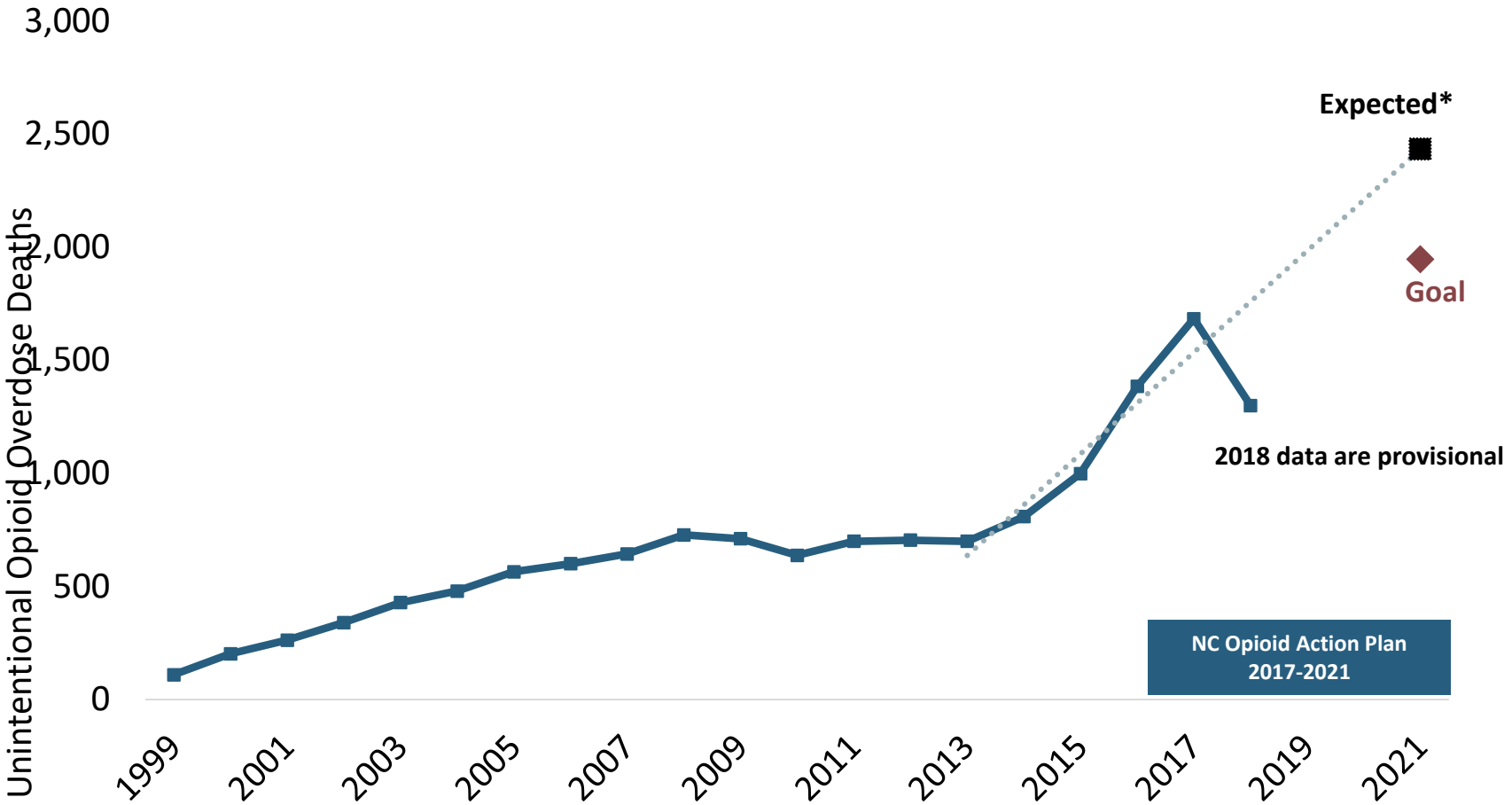
Buprenorphine is an FDA-approved medication for the treatment of opioid use disorder.

Opioid overdose emergency department visits have declined for the first time in over a decade.



*Data are preliminary and subject to change
Source: NC Division of Public Health, Epidemiology Section, NC DETECT, 2009-2018 Q3
Detailed technical notes on all metrics available from NC DHHS; Updated October 2018

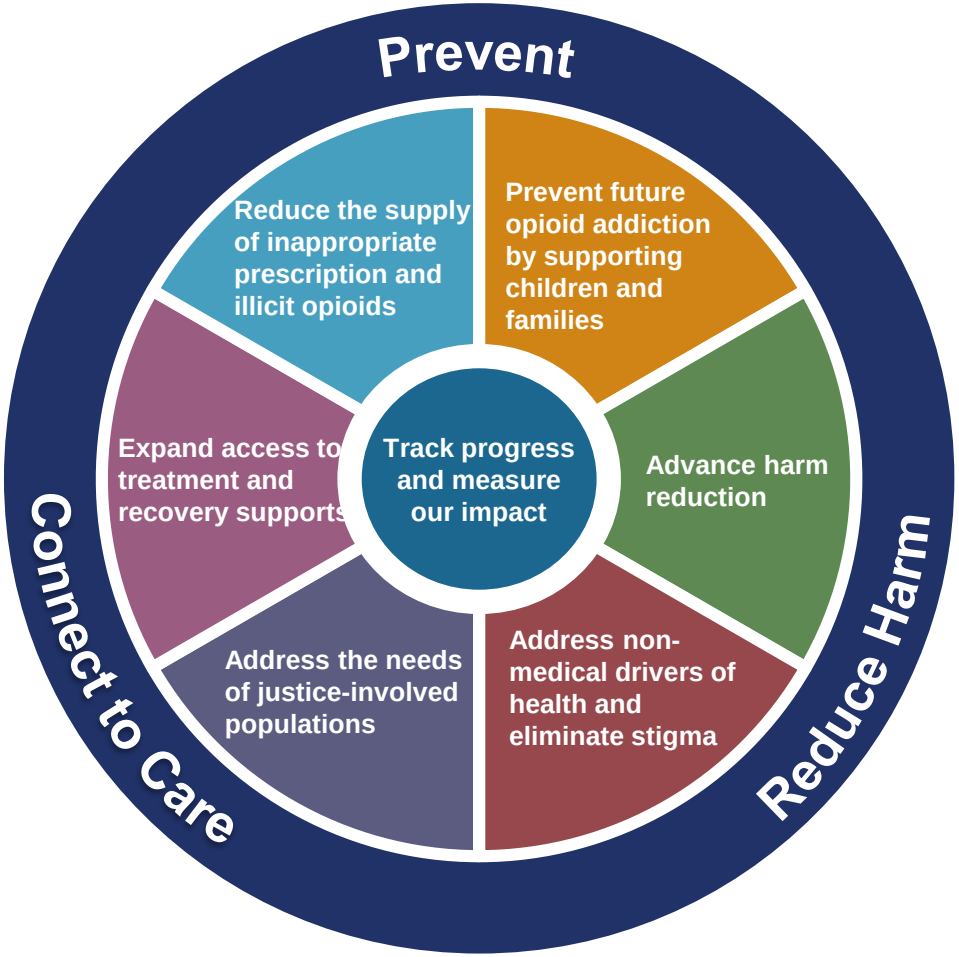
The Opioid Action Plan continues the goal to reduce expected opioid overdose deaths **by 20% by 2021.**



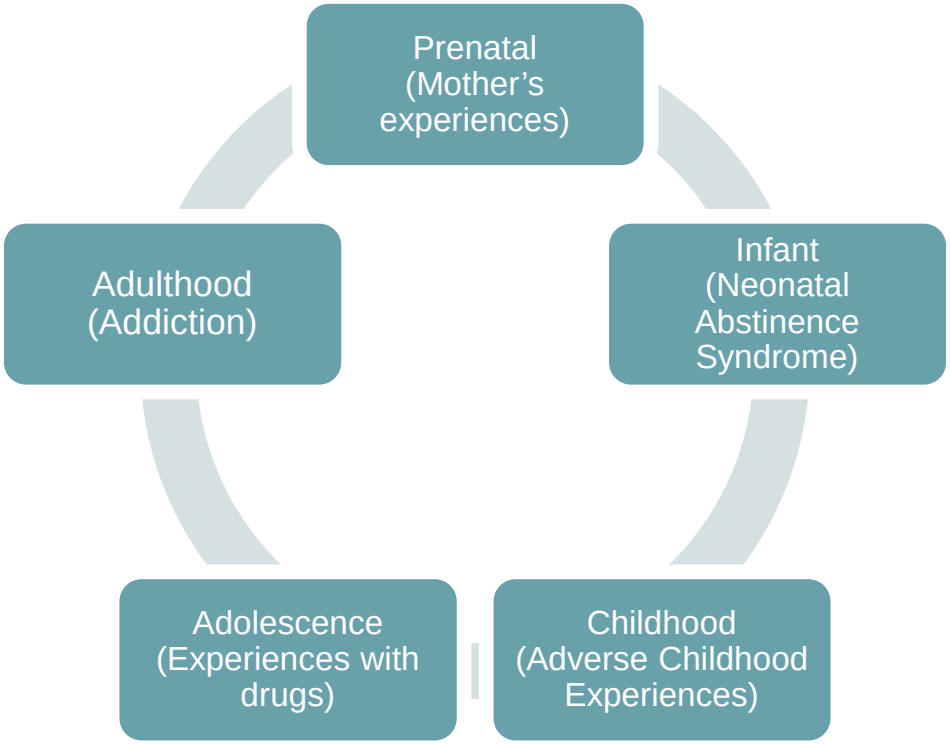
*Data are preliminary and subject to change
Source: NC State Center for Health Statistics, Vital Statistics-Deaths, ICD10 coded data, includes NC Resident deaths occurring out of state, 1999-2018 Q2
Detailed technical notes on all metrics available from NCDHHS; Updated October 2018

The Opioid Action Plan 2.0 aims to identify impactful, feasible strategies to **reduce opioid overdoses** in North Carolina and **prevent the next wave** of the epidemic.

Opioid Action Plan Version 2.0



Prevent



The epidemic is part of an intergenerational cycle of trauma and harm.

North Carolina Early Childhood Action Plan

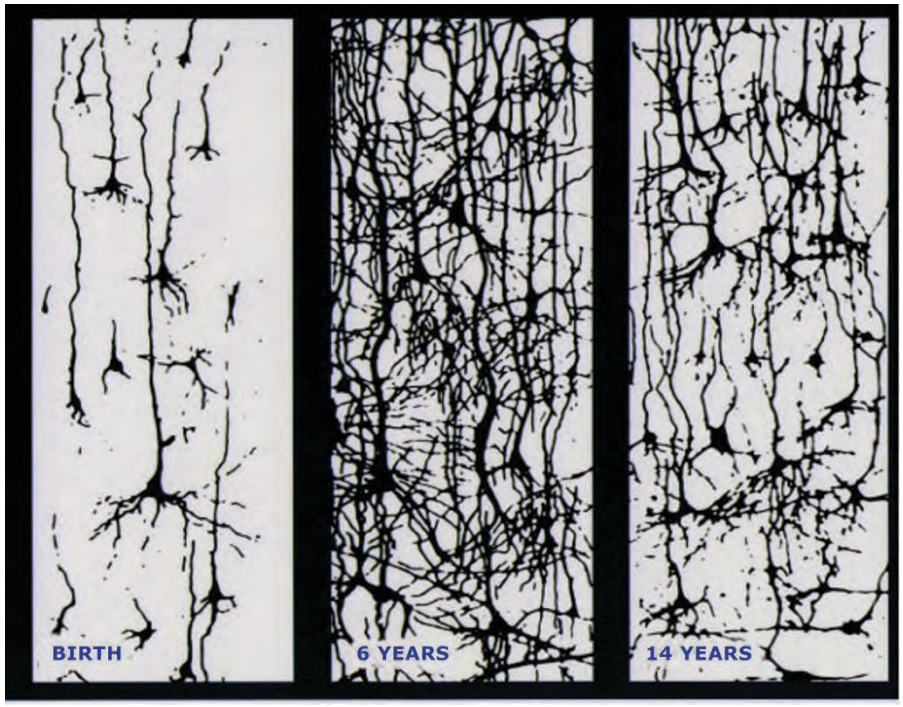
NCDHHS Division Workshop

October 23, 2019

Kick-Off Breakfast

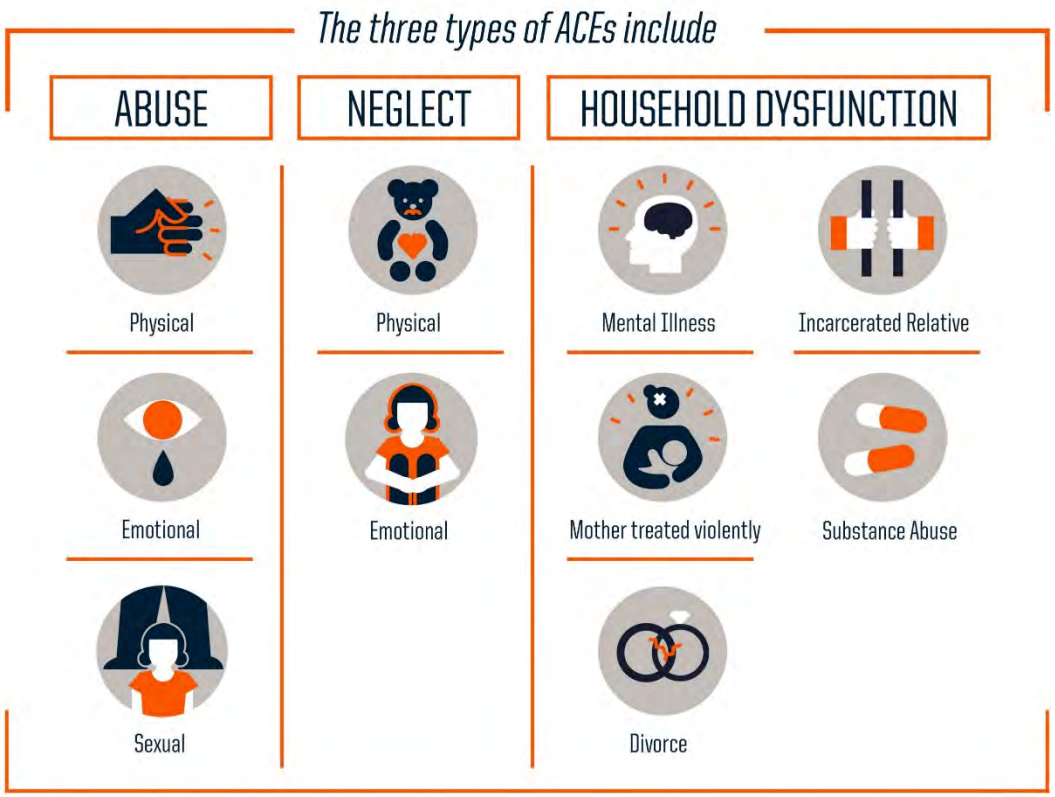

We know Early Childhood
matters

Early Childhood: A Time of Rapid Brain Development



In the first few years of life, more than 1 million new neural connections are formed every second.

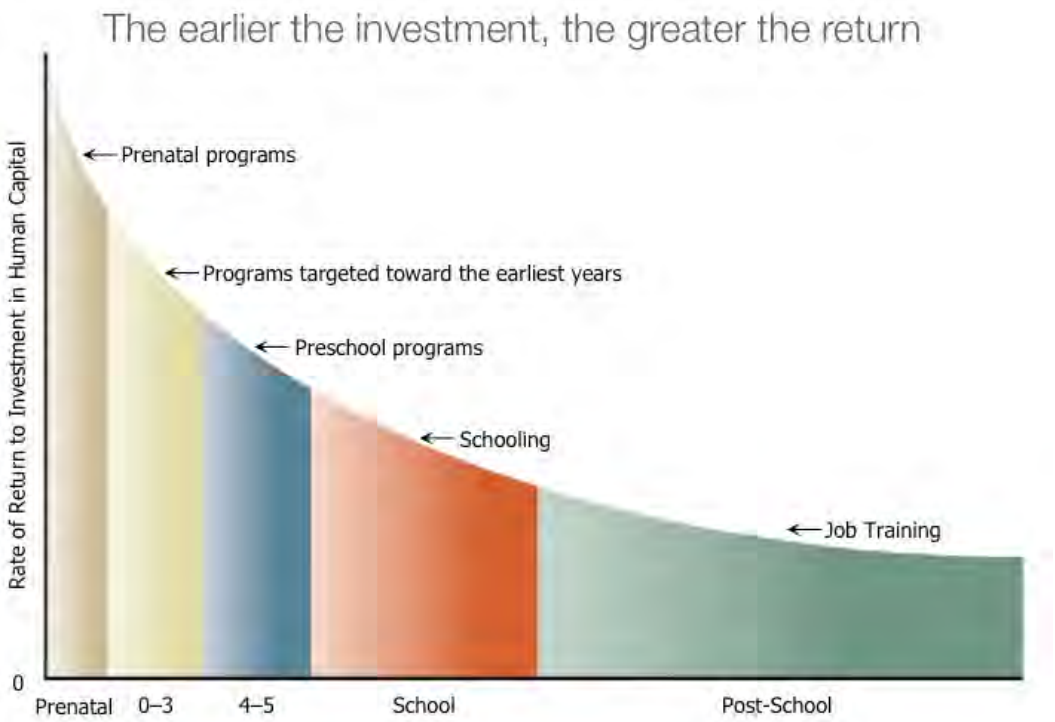
Source: Harvard Center on the Developing Child
https://developingchild.harvard.edu/resources/five-numbers-to-remember-about-early-childhood-development/



Adverse Childhood Experiences (ACEs)

Source: Robert Wood Johnson Foundation, https://www.rwjf.org/en/library/infographics/the-truth-about-aces.html

Invest in Early Childhood Development



Source: https://heckmanequation.org/resource/the-heckman-curve/

Our Early Childhood Lens For Today's Conversation

Birth – 8 Years-Old

(typically through third grade)

Age Range

Health, Child Welfare, and Early Education

Our Guiding Principles

Children and families are at the center of our work.

Brain and developmental science are fundamental.

Alleviate inequity to ensure that all of North Carolina's children can reach their fullest potential.

Build upon existing strengths and partnerships in early childhood systems.

Set bold priorities and achievable goals for North Carolina's young children.

Track progress toward all goals, ensuring transparency, accountability, and good stewardship of resources.

A few examples of new NCDHHS initiatives or investments

- **Governor Cooper Executive Order for paid parental leave for state employees**
- **$4.5 million in Preschool Development Grant funding, supporting access to early childhood education across the state for vulnerable and underserved families.**
- **$3 million to expand capacity at three perinatal/maternal substance use disorder residential treatment programs.**
- **$1.4 million in funding to expand Buncombe County's Sobriety Treatment and Recovery Teams (START) program for parents and children affected by child maltreatment and parental substance use disorders.**
- **Duke NC Summit on Early Child Health & Well-Being to engage academic community – Duke/NC State submitting a proposal to Robert Wood Johnson Foundation addressing food insecurity in children.**
- **$1.1 million in funding to support integration of pediatric and maternal mental health into primary care, including consultation line and telepsychiatry.**

Early Childhood Action Plan Structure

Each goal features:

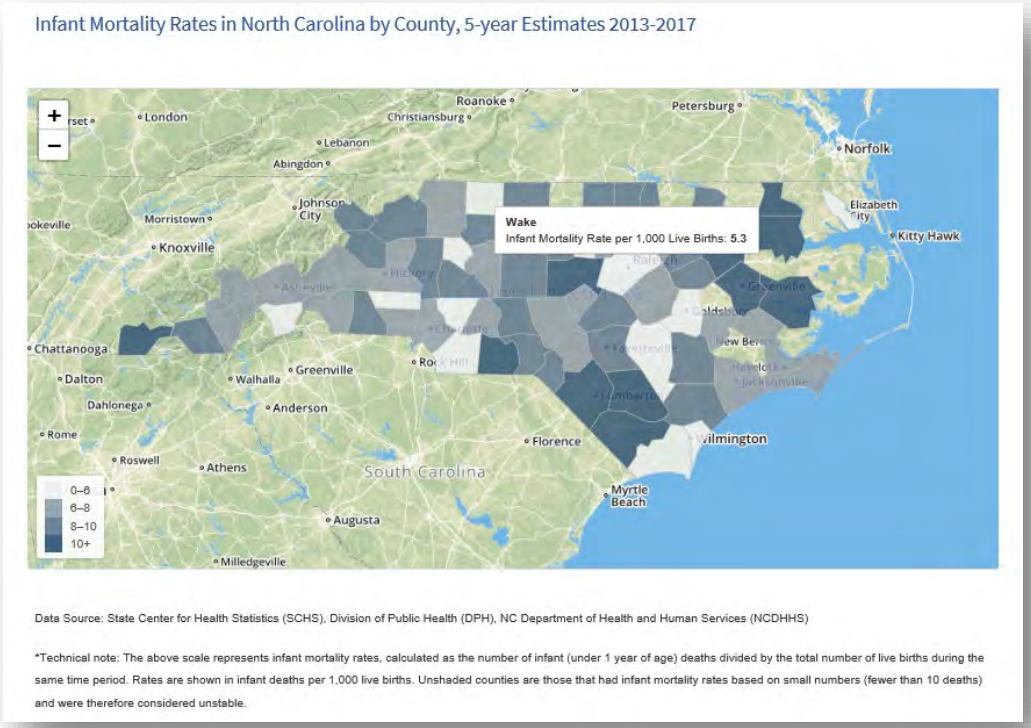
- Commitment
- 2025 Target(s)
- Sub – Targets

Each area features:

- Strategies

Early Childhood Action Plan: Data Dashboard

- Data on over 50 measures
- Interactive
- Updated regularly
- Open to the public
- Visit *ncdhhs.gov/early-childhood*



Early Childhood Action Plan

DRIVERS OF CHANGE

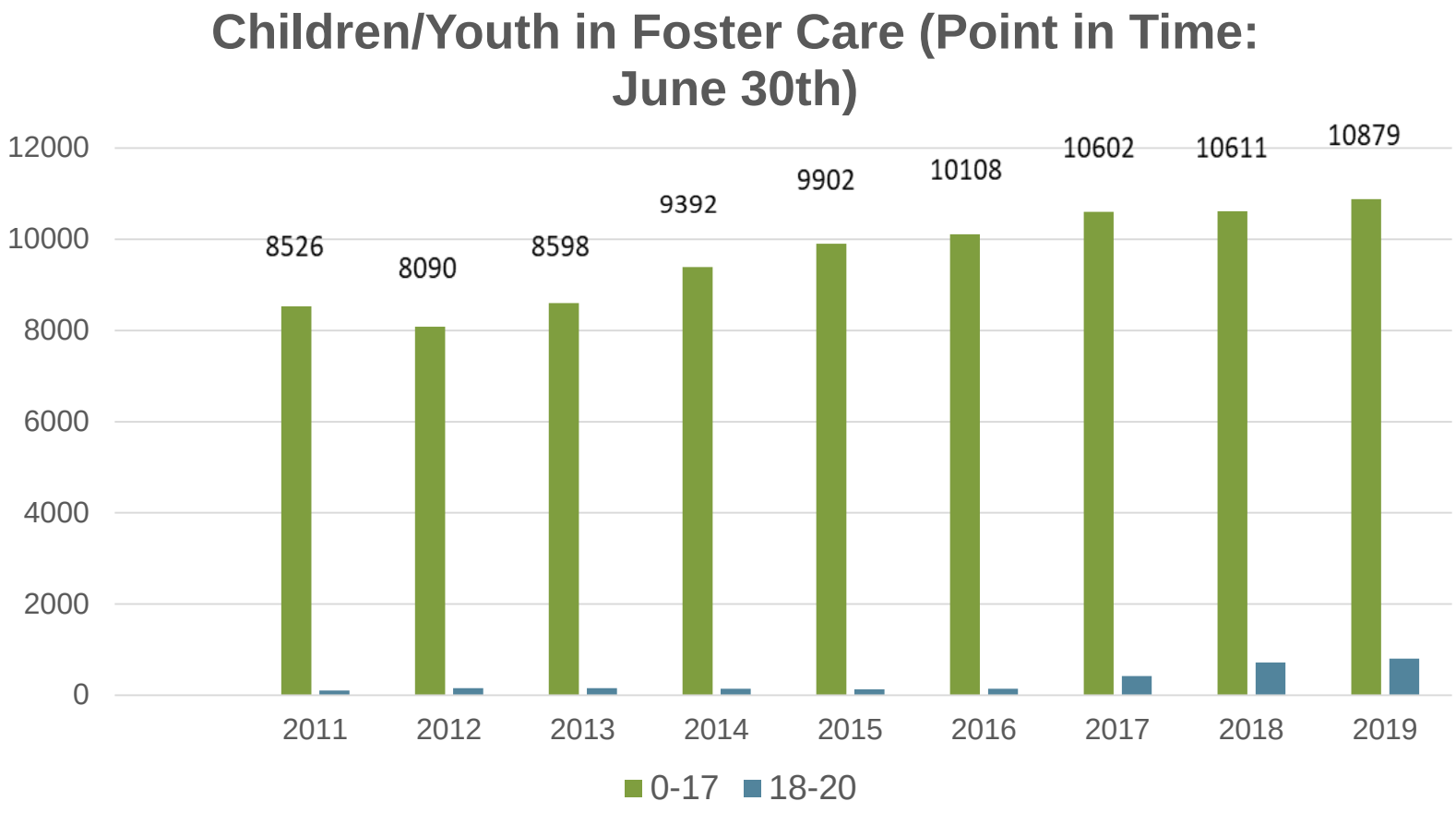
Build Public Demand

Commit State Agencies to Accountable Action

Leverage the Strengths of Partners

Families First Prevention Services Act

Overview: Foster Care in North Carolina



Source: Point –in-time data. Client Services Data Warehouse (CSDW) – Child Placement & Payment System and NCFAST

Living Arrangements of Children in Foster Care as of Oct. 31, 2018

Living Arrangement Type	# of Children
Foster Home	5146
Adoptive Home	93
Correctional Institution	59
Congregate Care	813
Home of Parents/Guardian	479
Home of Relative	2618
Hospital	120
Treatment	344
Other	1108
Runaway	52
Therapeutic Home (MH/DD/SAS)	965
Total	**11797**

Source: Point –in-time data. Client Services Data Warehouse (CSDW) – Child Placement & Payment System and NCFAST

Drivers of Reform

CHILD AND FAMILY SERVICES REVIEW OF 2015:

- **Program Improvement Plan**

LEGISLATION:

- **Rylan's Law**
- **Family First Prevention Services Act**

CHILD AND FAMILY SERVICES PLAN: 2019-2024

- **Safety, Permanency, Wellbeing, CQI, Workforce Development**

Why is Family First Important?

Family First is a significant victory for families

- **Funds evidence-based prevention services for children at risk of foster care**
- **Focuses on ensuring children in foster care are placed in the least restrictive, most family-like setting**
- **Supports kinship caregivers and provides other targeted investments to keep children safe with families**
- **Supports youth transitioning from foster care**
- **Promotes permanent families for children**

Key Family First Provisions

Allows IV-E reimbursement for services to prevent entry into foster care

Limits IV-E funding for congregate care to the first two weeks of placement*

States may opt in as early as October 2019 or delay until 2021

Other provisions to support safety, permanence and well-being

* With some exceptions

NC's Approach to Family First Implementation

- Partnership with Chapin Hall and The Duke Endowment to help with implementation of key components of Family First
- Partnership with Annie E. Casey to provide expert analysis on maximizing federal funds and fiscal planning for Family First
- Incorporate stakeholders in the planning process
- Integrate Family First into the child welfare transformation landscape

Prevention Services

OVERVIEW

States have the option to use Title IV-E funds for trauma-informed, evidence-based prevention services for eligible children and their families

ELIGIBILITY

- **Children who are “candidates” for foster care (including their parents and kin caregivers)**
- **Children in foster care who are pregnant or parenting**
- **Children and parents are eligible without regard to their income**

Services Eligible for Funding

Types of services

- **Mental health services**
- **Substance abuse assessment and treatment**
- **In-home parent skill-based programs**
- **Kinship Navigator programs**
- **Residential parent-child substance abuse treatment programs**

Additional requirements of limitations

- **No more than one year (per candidate episode)**
  - **Services can be extended for additional one year periods on a case-by-case basis**
- **Must meet certain evidence-based requirements**
- **Must be trauma-informed**
- **Services must be provided by a qualified clinician**

Which prevention services are eligible?

- **The act specifies evidence-based requirements that entail meeting “promising,” “supported” or “well-supported” criteria similar to that used by the California Evidence-Based Clearinghouse for Child Welfare**
- **HHS Secretary recently released guidance regarding the establishment of the clearinghouse and list of programs prioritized for review**
- **Services reviews will occur on a rolling basis**

Children's Bureau – Program and Services Review

Approved Programs

- Families Facing the Future – supported
- Functional Family Therapy – well-supported
- Healthy Families America – well-supported
- Methadone Maintenance Therapy – promising
- Multisystemic Therapy – well-supported
- Nurse-Family Partnership – well-supported
- Parent-Child Interaction Therapy – well-supported
- Parents as Teachers – well-supported
- Trauma-Focused Cognitive Behavioral Therapy – promising

Programs Under Review

- Motivational Interviewing
- Attachment and Biobehavioral Catch-Up
- Brief Strategic Family Therapy
- Child Parent Psychotherapy
- Incredible Years
- Interpersonal Psychotherapy
- Multidimensional Family Therapy
- Triple P – Positive Parenting Program
- Family Behavior Therapy
- Seeking Safety
- The Seven Challenges
- Homebuilders
- Nurturing Parenting
- SafeCare
- Solution Based Casework
- Ohio's Kinship Supports Intervention
- YMCA Kinship Support Services, YMCA San Diego County

Retrieved 10/18/19 https://preventionservices.abtsites.com/about/faq

Who are candidates for foster care?

- **Prevention Services are available for "candidates for foster care," which are defined as:**
  - **Children at risk of entering foster care, but who can safely remain at home, or kinship care with services that prevent going into foster care**
  - **Parents and kin caregivers where services are needed to keep a child out of care**
  - **Pregnant or parenting children, and youth in foster care**

Required Statewide Plan

- States opting into prevention services must submit a prevention plan to the Children's Bureau
- Title IV-E plan (resubmitted every five years) must include:
  - Details on services
  - Expected outcomes
  - How children and families are assessed
  - How services are monitored and evaluated
  - Type of program implementation
  - Consultation and coordination with other agencies
  - Details on workforce training and management of caseloads
  - Assurances of state's compliance with funding provisions

Congregate Care Funding Limitations

Fourteen days after entering foster care, federal reimbursement is limited to children in a:

- Foster family home
- Qualified Residential Treatment Program (QRTP)
- Specialized setting providing pre-natal, post-partum or parenting supports for youth
- Supervised setting for youth 18 or older, and living independently
- Setting providing high-quality residential care and supportive services to children who have been or are at risk of becoming sex trafficking victims

Children in Congregate Care as of 6/30/2019

Large Group Facility (Residential)	420
Small Group Home (Residential)	322
Small Group Home (Treatment)	208
Large Group Facility (Treatment)	171
Emergency Shelter	38
Dept of Juvenile Justice & Delinquency Prevention	11
Maternity Home	6
Children's Camp	3
TOTAL	1179

Source: Point –in-time data. Client Services Data Warehouse (CSDW) – Child Placement & Payment System and NCFAST

Qualified Residential Treatment Program (QRTP) Requirements

- A trauma-informed treatment model designed to address the needs, including clinical needs, of children with serious emotional or behavioral disorders or disturbances
- Facilitates participation of family members in the child's treatment program
  - Documents integration of family members into treatment process for the child, including post-discharge and maintenance of sibling connections
- Provides discharge planning and family-based aftercare support for at least six months post-discharge
- Licensed and accredited by certain independent, not-for-profit organizations
- Registered or licensed nursing staff, and other licensed clinical staff available 24 hours a day, seven days a week

Other QRTP Requirements

- **Thirty day assessment by a qualified clinician – determines the appropriateness of the placement**
- **Family and permanency team meetings**
- **A host of case plan documentation and related requirements**
- **Court approval or disapproval of the QRTP placement within 60 days**
- **Additional reporting requirements for extended QRTP placements**
  - **If a child is placed in a QRTP for an extended period, the state must submit specific documentation/justification to HHS**

Rylan's Law and FFPSA Overlap

Rylan's Law	FFPSA
Provisions to prevent removal of children from the home through supports and services; prevention, mental health, physical health, education services	Options to use federal funds to implement services and supports to prevent children from being removed from their home
Child fatality oversight and effectiveness of Community Child Protection Teams (CCPT)	Develop and implement a statewide plan to prevent fatalities that includes multiple source data collection
Requires adoption of a practice model	Trauma informed prevention services
Efforts to increase permanency	Limitations on the use of federal funding for congregate care with some exceptions
Services to older youth and youth aged out of foster care	Opportunity to extend foster care services to youth up to age 23
Establishing expectations for professional development, training and performance standards	Articulate the plan to support the delivery of trauma-informed, evidence-based services by child welfare professionals

North Carolina DHHS Family First Readiness Assessment, Planning and Initial Implementation
Project Timeline: March 2019 – August 2020

March 2019:
- Charter Executive Leadership Team (ELT)
- Charter Leadership Advisory Team (LAT)

April-May 2019:
- Implement FFPSA readiness assessment process
- Engage leaders of other systems transformation initiatives

June-July 2019:
- Clarify theory of change and articulate strategic direction
- Establish Prevention and Congregate Care working groups
- Draft Prevention Plan and Congregate Care action plans
- Explore & analyze data to identify options for candidacy and target population.
- Plan for conducting the Provider Readiness Assessment Survey to understand service array

August 2019:
- Conduct Provider Readiness Assessment Survey
- Continue to explore and analyze data to identify options for candidacy and target population.

September-October 2019:
- Make meaning of Provider Readiness Assessment findings

November-December 2019:
- Clarify target population and candidacy
- Map "supply" of services with "demand" for services
- Identify the EBPs to be included in the Prevention Plan

January - March 2020:
- Draft Prevention Plan
- Draft Congregate Care implementation plan

April 2020:
- Submit Prevention Plan to the Children's Bureau

May - August 2020:
Begin implementation

Ongoing Prevention and Congregate Care Working Group meetings to implement and monitor action plan tasks

Executive Leadership Team and Leadership Advisory Team monthly meetings AND

Phase 1: FFPSA Readiness Assessment and Planning

Phase 2: Prevention Plan & Congregate Care Strategy Implementation Plan Development

Phase 3: Prevention Plan Submission
Initial Prevention Plan Implementation
Congregate Care Plan Implementation

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES