Moving Forward:
NC Medicaid Managed Care & Human Services Update

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NC Medicaid

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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.”
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

Spending on Medicare is projected to more than double between 2014 and 2065.

Federal Spending (% of GDP)

SOURCE: Congressional Budget Office, The 2015 Long-Term Budget Outlook, June 2015. Compiled by PGPF.
NOTE: Projections are from the extended baseline scenario.
## US Healthcare’s MAJOR Challenge:
Low Quality

### Exhibit 9. Select Population Health Outcomes and Risk Factors

<table>
<thead>
<tr>
<th></th>
<th>Life exp. at birth, 2013&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Infant mortality, per 1,000 live births, 2013&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Percent of pop. age 65+ with two or more chronic conditions, 2014&lt;sup&gt;b&lt;/sup&gt;</th>
<th>Obesity rate (BMI&gt;30), 2013&lt;sup&gt;a&lt;/sup&gt;&lt;sup&gt;c&lt;/sup&gt;</th>
<th>Percent of pop. (age 15+) who are daily smokers, 2013&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Percent of pop. age 65+</th>
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<tbody>
<tr>
<td>Australia</td>
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<td>3.6</td>
<td>54</td>
<td>28.3&lt;sup&gt;e&lt;/sup&gt;</td>
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<td>14.4</td>
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<tr>
<td>Canada</td>
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<td>4.8&lt;sup&gt;e&lt;/sup&gt;</td>
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<td>-</td>
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<tr>
<td>France</td>
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<td>24.1&lt;sup&gt;d&lt;/sup&gt;</td>
<td>17.7</td>
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<tr>
<td>Germany</td>
<td>80.9</td>
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<td>23.6</td>
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<td>21.1</td>
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<tr>
<td>Japan</td>
<td>83.4</td>
<td>2.1</td>
<td>-</td>
<td>3.7</td>
<td>19.3</td>
<td>25.1</td>
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<tr>
<td>Netherlands</td>
<td>81.4</td>
<td>3.8</td>
<td>46</td>
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<tr>
<td>New Zealand</td>
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<td>30.6</td>
<td>15.5</td>
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<tr>
<td>Norway</td>
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<td>2.4</td>
<td>43</td>
<td>10.0&lt;sup&gt;d&lt;/sup&gt;</td>
<td>15.0</td>
<td>15.6</td>
</tr>
<tr>
<td>Sweden</td>
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<td>Switzerland</td>
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<tr>
<td>United Kingdom</td>
<td>81.1</td>
<td>3.8</td>
<td>33</td>
<td>24.9</td>
<td>20.0&lt;sup&gt;d&lt;/sup&gt;</td>
<td>17.1</td>
</tr>
<tr>
<td><strong>United States</strong></td>
<td><strong>78.8</strong></td>
<td><strong>6.1&lt;sup&gt;e&lt;/sup&gt;</strong></td>
<td><strong>68</strong></td>
<td><strong>35.3&lt;sup&gt;d&lt;/sup&gt;</strong></td>
<td><strong>13.7</strong></td>
<td><strong>14.1</strong></td>
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<tr>
<td>OECD median</td>
<td>81.2</td>
<td>3.5</td>
<td>-</td>
<td>28.3</td>
<td>18.9</td>
<td>17.0</td>
</tr>
</tbody>
</table>

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

1.0 Episodic Non Integrated Care
- Fee for Service

2.0 Accountable Care
- Performance-Based Payments
- Quality-related payments
- Transparency

3.0 Value Based Care
- 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

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

- 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

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

- Care Needs Screening
- Risk Scoring and Stratification
- Comprehensive Assessment
- Care Management for High-Need Enrollees

Transitional Care Management

General Care Coordination

Prevention and Population Health Management

- All enrollees, as needed
- High-need enrollees

**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.

**Pre-Transformation: FFS**
- Carolina ACCESS
- Care Coordination for Children (CC4C)
- Pregnancy Medical Home
- Obstetric Care Management (OBCM)

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

**Post-Transformation: Managed Care**
- AMH
- Care Management for At-Risk Children (CMARC)
- Pregnancy Management Program (PMP)
- Care Management for High-Risk Pregnancy (CMHRP)

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

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

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aug. 2018</td>
<td>DHHS releases SP RFP</td>
</tr>
<tr>
<td>Feb. 2020</td>
<td>Tailored Plan implementation planning (2/2020-7/2021)</td>
</tr>
<tr>
<td>May 2020</td>
<td>AMH+ and CMA Certification and Contracting Period (Fall 2019—Spring 2021)</td>
</tr>
<tr>
<td>Feb. 2021</td>
<td>DHHS issues SP contracts</td>
</tr>
<tr>
<td>Apr. 2021</td>
<td>DHHS releases AMH+/CMA provider manual, including certification criteria</td>
</tr>
<tr>
<td>Jul. 2021</td>
<td>DHHS begins Tailored Plan readiness review (tentative)</td>
</tr>
<tr>
<td></td>
<td>Tailored Plans launch</td>
</tr>
</tbody>
</table>

DHHS awards Tailored Plan contracts (tentative); 1st round of provisional certification awarded to AMH+/CMAs

DHHS completes Tailored Plan readiness review (tentative); goal to complete contracting with AMH+/CMAs
### Key Differences: LME-MCOs and BH/IDD Tailored Plans

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

³ Includes Innovations, TBI waiver; with managed care implementation the (c) waiver will operate under the 1115
<table>
<thead>
<tr>
<th>Side by Side</th>
<th>Standard Plans</th>
<th>Tailored Plans</th>
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</thead>
<tbody>
<tr>
<td><strong>Scope</strong></td>
<td>Fully integrated Care</td>
<td>Fully Integrated Care</td>
</tr>
<tr>
<td><strong>Entity</strong></td>
<td>Prepaid Health Plans</td>
<td>Prepaid Health Plan</td>
</tr>
<tr>
<td><strong>Waiver Type</strong></td>
<td>1115</td>
<td>1115⁴</td>
</tr>
<tr>
<td><strong>Procurement</strong></td>
<td>Competitive RFP</td>
<td>Request for Application (RFA) to existing LME-MCOs⁵</td>
</tr>
<tr>
<td><strong>Contracting</strong></td>
<td>Accept any willing provider</td>
<td>Any willing provider—physical health</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Closed network—behavioral health</td>
</tr>
<tr>
<td><strong>Plans available to beneficiaries</strong></td>
<td>4 statewide &amp; 1 regional</td>
<td>1 per region⁶</td>
</tr>
<tr>
<td><strong>Additional Services/Funding</strong></td>
<td>In-lieu &amp; value added services</td>
<td>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</td>
</tr>
</tbody>
</table>

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

**Department of Health and Human Services**

*Establishes care management standards for BH I/DD Tailored Plans aligning with federal Health Home requirements*

**BH I/DD Tailored Plan**

**Health Home**

**Care Management Approaches**

* BH I/DD Tailored Plan beneficiaries will have the opportunity to choose among the care management approaches; all must meet the Department’s standards and be provided in the community to the maximum extent possible.

**Approach 1: Tier 3 AMH with BH and/or I/DD Certification**

The Department will create specialized BH and I/DD certifications for Tier 3 AMHs that serve a substantial number of BH I/DD Tailored Plan beneficiaries and have experience serving these populations.

**Approach 2: Care Management Agency (CMA)**

BH I/DD Tailored Plans contract with agencies such as those that provide BH or I/DD services (e.g., mental health or substance use agencies, home care agencies, etc.) that obtain CMA certification.

**Approach 3: BH I/DD Tailored Plan-Employed Care Manager**

BH I/DD Tailored Plans may provide care management, subject to meeting overall targets for provider-based care management set by the Department.

The Department anticipates allowing—but not requiring—CMAs and AMHs to work with a CIN or other partner to assist with the requirements of the Health Home care management model, within the Department’s guidelines.
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. Population health management provides the foundation for providers to be successful in a value-based payment environment.

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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

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

<table>
<thead>
<tr>
<th>Category</th>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food</td>
<td>1. Within the past 12 months, did you worry that your food would run out before you got money to buy more?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Within the past 12 months, did the food you bought just not last and you didn't have money to get more?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Housing/Utilities</td>
<td>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)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4. Are you worried about losing your housing?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>5. Within the past 12 months, have you been unable to get utilities (heat, electricity) when it was really needed?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transportation</td>
<td>6. Within the past 12 months, has a lack of transportation kept you from medical appointments or from doing things needed for daily living?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interpersonal Safety</td>
<td>7. Do you feel physically or emotionally unsafe where you currently live?</td>
<td></td>
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<tr>
<td></td>
<td>8. Within the past 12 months, have you been hit, slapped, kicked or otherwise physically hurt by anyone?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>9. Within the past 12 months, have you been humiliated or emotionally abused by anyone?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Optional: Immediate Need</td>
<td>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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>11. Would you like help with any of the needs that you have identified?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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:
# Three Functions

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


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)**

<table>
<thead>
<tr>
<th>NCCARE360 Implementation Status Update</th>
<th>NCCARE360 Resource Repository</th>
</tr>
</thead>
<tbody>
<tr>
<td>21 Counties launched</td>
<td>2,954 Organizations verified</td>
</tr>
<tr>
<td>(Alamance, Beaufort, Bertie, Brunswick, Chowan, Durham, Edgecombe, Franklin, Guilford, Granville, Hertford, Johnston, Martin, New Hanover, Pender, Person, Pitt, Rockingham, Vance, Wake and Warren)</td>
<td>10,736 Programs verified</td>
</tr>
<tr>
<td>29 Counties started on implementation</td>
<td></td>
</tr>
<tr>
<td>1619 Organizations engaged in socialization process</td>
<td></td>
</tr>
<tr>
<td>396 Organizations with NCCARE360 licenses</td>
<td></td>
</tr>
<tr>
<td>1634 Active Users</td>
<td></td>
</tr>
<tr>
<td>1118 Referrals Sent</td>
<td></td>
</tr>
</tbody>
</table>

NCCARE360 will be implemented statewide by end of 2020

**Engaged Organizations by Service Type**

- **Healthcare**: 23%
- **Housing**: 7%
- **Employment**: 7%
- **Food**: 18%
- **Interpersonal Safety**: 8%
- **Other**: 11%
State Coverage – to be statewide by Dec 2020

NCCARE360 will be fully statewide by December 2020
Robust Elements within Medicaid Managed Care

Address 4 Priority Domains:
- Housing
- Food
- Transportation
- Interpersonal Violence

Care Management

Quality Strategy

Healthy Opportunity Pilots

In Lieu of Services

Contributions to Health-Related Resources

Integration with Department Partners

Value-Based Payment
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
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

Children’s Council

MOUs/Corrective Action

Reform Plan

Regional Departments

SSWG
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 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
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

Opioid Action Plan

Guardianship

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
Opioid Action Plan
Residential Redesign
Medicaid Transformation
Raise the Age
*Proposed Regional Map

Region 1
- Population: 0.88M
- Area (Square Miles): 7.3K
- Number of Counties: 18

Region 2
- Population: 1.09M
- Area (Square Miles): 5.2K
- Number of Counties: 12

Region 3
- Population: 2.21M
- Area (Square Miles): 6.7K
- Number of Counties: 14

Region 4
- Population: 2.00M
- Area (Square Miles): 5.7K
- Number of Counties: 12

Region 5
- Population: 1.85M
- Area (Square Miles): 5.7K
- Number of Counties: 11

Region 6
- Population: 1.51M
- Area (Square Miles): 9.9K
- Number of Counties: 14

Region 7
- Population: 0.73M
- Area (Square Miles): 13.2K
- Number of Counties: 20

*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

Reduce the supply of inappropriate prescription and illicit opioids

Prevent future opioid addiction by supporting children and families

Expand access to treatment and recovery supports

Address the needs of justice-involved populations

Address non-medical drivers of health and eliminate stigma

Advance harm reduction

Track progress and measure our impact

Connect to Care

Reduce Harm
Prevent

Prenatal
(Mother’s experiences)

Infant
(Neonatal Abstinence Syndrome)

Adulthood
(Addiction)

Adolescence
(Experiences with drugs)

Childhood
(Adverse Childhood Experiences)

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

The three types of ACEs include:

- **ABUSE**
  - Physical
  - Emotional
  - Sexual

- **NEGLECT**
  - Physical
  - Emotional

- **HOUSEHOLD DYSFUNCTION**
  - Mental Illness
  - Incarcerated Relative
  - Mother treated violently
  - Substance Abuse
  - Divorce

Invest in Early Childhood Development

The earlier the investment, the greater the return

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.
• $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

Children/Youth in Foster Care (Point in Time: June 30th)

- 0-17
- 18-20

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

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

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](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

<table>
<thead>
<tr>
<th>Facility Type</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Large Group Facility (Residential)</td>
<td>420</td>
</tr>
<tr>
<td>Small Group Home (Residential)</td>
<td>322</td>
</tr>
<tr>
<td>Small Group Home (Treatment)</td>
<td>208</td>
</tr>
<tr>
<td>Large Group Facility (Treatment)</td>
<td>171</td>
</tr>
<tr>
<td>Emergency Shelter</td>
<td>38</td>
</tr>
<tr>
<td>Dept of Juvenile Justice &amp; Delinquency Prevention</td>
<td>11</td>
</tr>
<tr>
<td>Maternity Home</td>
<td>6</td>
</tr>
<tr>
<td>Children's Camp</td>
<td>3</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>1179</strong></td>
</tr>
</tbody>
</table>

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

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

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

**May-August 2020:**
Begin implementation

**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

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

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- Identify the EBPs to be included in the Prevention Plan

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

**May-August 2020:**
Begin implementation

YFS / CCS Quarterly Provider Meeting 10/25/2019

Executive Leadership Team and Leadership Advisory Team monthly meetings AND

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

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