**Frequently Asked Questions: Transition of Care Management Programs for High-Risk Pregnancy and At-Risk Children to Managed Care**

| # | Category | Question | Answer |
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| **General Questions** | | | |
| G.1 | General | What populations are rolling into managed care and when? | Most beneficiaries currently served by the Pregnancy Medical Home (PMH), Obstetric Care Management (OBCM) and Care Coordination for Children (CC4C) programs will be mandatorily enrolled in PHPs beginning in November 2019. There will be limited exceptions to mandatory enrollment for certain populations who may be better served outside of Medicaid managed care, including foster children. See below for population by managed care status:<br>**1. Exempt/Excluded:**<br>a. Beneficiaries dually-eligible for Medicaid and Medicare<br>b. PACE beneficiaries<br>c. Medically needy beneficiaries<br>d. Beneficiaries only eligible for emergency services<br>e. Presumptively eligible beneficiaries, during the period of presumptive eligibility<br>f. Health Insurance Premium Payment (HIPP) beneficiaries<br>g. Members of federally recognized tribes<br>*Certain exempt/excluded populations will have the option to enroll in managed care beginning in 2019, while others will only have the option to enroll in fee-for-service or an LME-MCO.*<br><br>**2. Delayed Mandatory Enrollment for Special Populations (Year 1 begins in November 2019):**<br>a. **Year 3**: Children in foster care and adoptive placements<br>b. **Year 3:** Certain Medicaid and NC Health Choice beneficiaries with an SMI, SUD or I/DD diagnosis and those enrolled in the TBI waiver<br>c. **No earlier than Year 5:** Medicaid-only beneficiaries receiving long-stay nursing home services<br>d. **No earlier than Year 5:** Medicaid-only CAP/C and CAP/DA waiver beneficiaries<br>e. **No earlier than Year 5:** Individuals who are dually-eligible for Medicare and Medicaid |

<table>
<tr><td>G.2</td><td>General</td><td>How will beneficiaries that are exempt or excluded or on a delayed managed care timeline receive Medicaid coverage?</td><td>Medicaid eligible beneficiaries that are not transitioning to managed care will remain enrolled in the Medicaid fee-for-service program, which will operate the same as it does today.</td></tr>
<tr><td>G.3</td><td>General</td><td>What do PMP, CMHRP and CMARC stand for?</td><td>The names of programs for pregnant women and at risk children will change under managed care. The new names are to distinguish the Fee-for-Service programs from the managed care programs, since the managed care programs contain some operational and programmatic changes to account for the role of the PHP.<br><br><table><tr><th>Program Name: Fee for Service</th><th>Program Name: Managed Care</th></tr><tr><td>Pregnancy Medical Home (PMH)</td><td>Pregnancy Management Program (PMP)</td></tr><tr><td>Obstetric Care Management (OBCM)</td><td>Care Management for High-Risk Pregnancy (CMHRP)</td></tr><tr><td>Care Coordination for Children (CC4C)</td><td>Care Management for At-Risk Children (CMARC)</td></tr></table></td></tr>
<tr><td>G.4</td><td>General</td><td>What is the Pregnancy Management Program (PMP)?</td><td>This program will be consistent with the current day “PMH” program. The programmatic elements of PMP are slightly different from PMH to account for the role of the PHP. One change from the current PMH program is that there is no ability to “opt out” of the PMP program- all providers that contract with PHPs under the standard contracting terms are considered PMP providers. Another change is that the provider incentive payments will come from the PHP, and not the State, under managed care.</td></tr>
<tr><td>G.5</td><td>General</td><td>What is the contracting process for PMP?</td><td>All PMP providers must contract with PHPs. PMP providers are defined as all providers that bill global, packaged or individual pregnancy services. The contract between the provider and the PHP will contain standard contracting terms that will be identical to the terms in today’s program.</td></tr>
<tr><td></td><td>General</td><td>Will the risk screening tool for CMHRP change under managed care?</td><td>Providers will be required to adopt and administer a State-standardized screening tool to identify high-risk pregnancies. The tool will be consistent with the screening tool currently used by providers in the PMH program, with minor changes reflecting the role of the PHPs. Providers will be required to send the results of the risk screening to both the LHD (during the transition period) and the PHP.</td></tr>
<tr><td></td><td>General</td><td>Will provider incentives remain the same for PMP</td><td>For the transition period, the incentive payment structure will remain the same as it is today:</td></tr>
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| | | under managed care? | a. $50 for the completion of the standardized risk screening tool at each initial visit<br>b. $150 for completion of postpartum visit held within 56 days of delivery<br>Providers will receive, at a minimum, the same rate for vaginal deliveries as they do for caesarian sections. In addition, providers will continue to be exempt from prior approval on ultrasounds. |
| | | What is the CMHRP program? | This program will be consistent with the current day "OBCM" program. In addition to the administration of the PMP program for all enrolled pregnant women, PHPs will contract with LHDs to administer care management services for pregnant women deemed as high risk through the results of the standardized screening tool administered to all women in the PMP, and as a result of PHPs' own risk stratification efforts. |
| | | What is the CMARC program? | This program will be consistent with the current day "CC4C" program. CMARC is a set of care management services for at-risk children ages zero to five. The program coordinates services between health care providers, community program and supports, and family support programs. PHPs will contract with LHDs to administer care management services for children deemed as high risk through the results of the standardized screening tool, through referrals from pediatricians and State agencies (e.g. DSS), and as a result of PHPs' own risk stratification efforts. |
| | | What does the "transition period" refer to in the provision of CMHRP and CMARC? | PHPs are required to contract for care management services for high-risk pregnancy and at-risk children under the current model through the first three years of managed care. LHDs are given the "right of first refusal" for provision of these services during this period. The transition period starts the day the first region regions managed care and follows the PHP contract years. Year 1 launches November 2019 and Year 3 ends on June 30th 2022. The current payment model and methodology is also tied to this timeline. |
| | | What happens after the transition period ends? | PHPs will be permitted to contract with any a local care management entity (including LHDs) for the provision of CMHRP and CMARC. At that time, PHPs will negotiate standard contracting terms with their local care management entities of choice. |
| | | Can a Local Health Department be a Tier 3 Advanced Medical Home? | Yes. LHDs who attest to meeting Tier 3 practice requirements may be designated a Tier 3 AMH. See the Advanced Medical Home web page for more information. LHDs may be an AMH Tier 3 practice and provide CMHRP/CMARC services simultaneously. |
| | | Are there additional training or staffing requirements for LHD care managers during | No. Programmatic training and staffing requirements will remain consistent with today's requirements. Care managers will need to be trained on what the transition to managed care means for their day-to-day workflow. The Division of Public Health will |

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| | | the transition period? | offer training to support this transition for LHDs. |
| | | Will Local Health Departments be required to enroll in Carolina ACCESS? | No. LHDs will not be required to enroll in Carolina ACCESS, but they are permitted to do so. |
| **LHD Contracting with PHPs for Provision of PMP, CMHRP and CMARC** | | | |
| | Contracting | How will the contracting process work between PHPs and LHDs during the transition period? | During the transition period, PHPs will be required to contract with LHDs for provision of CMHRP/CMARC services. PHPs will give LHDs the "right of first refusal" as contracted providers of care management for these populations. LHDs will have 75 business days to negotiate and accept the contract.<br><br>If an LHD is unable or unwilling to provide these services through a contract with a PHP, PHPs will consult the Department to identify another LHD in the same services region that is willing and able to provide care management services for high-risk pregnant women and at-risk children. |
| | Contracting | What is the "right of first refusal?" | During the transition period, LHDs are given the exclusive right to enter a contract with a PHP for provision of CMHRP/CMARC before the PHP offers that contract to any other local care management entity. |
| | Contracting | What are the contracting requirements for CMARC and CMHRP during the transition period? | PHPs will be required to contract with LHDs using requirements consistent with today's contracts and agreements. Contracts must include provisions related to the transition to managed care.<br><br>Please refer to pages 19-27 of the Program Guide for High-Risk Pregnant Women and At-Risk Children for more detailed information on standard contracting requirements. |
| **Preventing the Duplication of Care Management Services** | | | |
| | Duplication | How will LHD Care Managers coordinate with PHP/Tier 3 AMH Care Managers to prevent the duplication of services? | PHPs and AMH Tier 3 providers will be responsible for care management services to the managed care population at large. To ensure coordination, PHPs will be required to alert LHDs when high-risk pregnant women/at-risk children are in care management within the PHP/AMH Tier 3 practice. LHD care managers coordinate with the PHP/AMH Tier 3 care manager to ensure roles do not overlap and will document roles/responsibilities in the standard documentation platform for instances where multiple care managers are serving the same beneficiary.<br><br>PHPs will be responsible for ensuring that the care management roles and responsibilities between the two entities are non-overlapping and that the member's |

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| | | | care plan(s) document respective roles and responsibilities between the PHP/AMH Tier 3 practice and the LHD, accordingly. |
| **Payments for CMHRP and CMARC** | | | |
| | Payment | How will LHDs be paid for the provision of CMHRP and CMARC? | Local Health Departments will be paid by PHPs for the provision of CMHRP and CMARC services. Additional guidance is forthcoming about the payment model and amount, but LHDs must be paid at an amount that is substantially similar to or no less than the amount paid in the fee-for-service program prior to the start of the PHP contract. After the transition period, and LHDs/other local care management providers will negotiate with PHPs for CMHRP and CMARC payment rates. |
| **Care Management Documentation System** | | | |
| | | How will care managers document the provision of care management services to beneficiaries? | Similar to the program for high-risk pregnancy, LHDs will be permitted to use the standard documentation platform that is in existence today. LHDs that operate as AMH Tier 3 providers may permitted flexibility to use a separate platform. |
| | | What is the single "care management documentation platform" that will be utilized in managed care? | Today, LHDs use the standard documentation platform that is in existence today. This will be the platform used during the transition period under managed care. |
| **Care Management for Populations in Fee-For-Service** | | | |
| | | Who is responsible for the oversight of care management for populations remaining in fee-for-service? | Populations remaining in fee-for-service Medicaid will continue to receive OBCM and CC4C as they do today. |
| | | What happens to foster children receiving care management services? | Foster children will roll into managed care during contract Year 3. Until then, they will continue to receive OBCM and CC4C services as they do today. |

## Terms for Glossary

- **Advanced Medical Home (AMH) Program:** The primary vehicle for delivering care management as North Carolina transitions to managed care. The AMH program requires PHPs to coordinate care management functions with enrolled practices, which may in some cases be performed directly by the practice or through an affiliated CIN or other partner.
- **Aged, Blind, Disabled (ABD):** Medicaid eligibility group for individuals who are categorically eligible for Medicaid on the basis of being aged, blind, or disabled.
- **Care Coordination for Children (CC4C):** Former name for care management program provided by LHDs for at-risk children ages zero to five. The program provides coordination between healthcare providers, linkages and referrals to other community programs and supports, and family supports. Fee-for-service populations will continue to receive care management under CC4C.
- **Carolina ACCESS:** North Carolina's PCCM program since the early 1990s. Under Carolina ACCESS, practices certified as meeting certain standards for clinical access and care management receive a monthly PMPM fee; the standards and payments are tiered into two levels (CAI and CAII). Since the late 1990s, DHHS has contracted with Community Care of North Carolina (CCNC) to provide care management and enhanced services for practices and beneficiaries through a regionally-based care management model PMPM.
- **Community Alternatives Program for Children (CAP/C):** A North Carolina Medicaid 1915(c) Waiver program that provides home- and community-based services to medically fragile children who are at risk for institutionalization in a nursing home because of their medical needs.
- **Community Alternatives Program for Disabled Adults (CAP/DA)**: A North Carolina Medicaid 1915(c) Waiver program that allows seniors and disabled adults ages 18 and older to receive support services in their own home, as an alternative to nursing home placement.
- **Community Care of North Carolina (CCNC)**: Community Care of North Carolina (CCNC) is a public-private partnership designed to create regional networks of primary care clinicians, hospitals, pharmacy, public health, social services and other community organizations to provide care based on the patient-centered medical home (PCMH). In this regional PCMH model, patients are partnered with a primary care provider who leads the health care team to address all of the patient's needs.
- **Dual-eligible beneficiaries:** Beneficiaries who are eligible for both Medicare and Medicaid, including those enrolled in Medicare Part A and/or Part B and receiving full Medicaid benefits and/or assistance with Medicare premiums or cost sharing.
- **Federally Recognized Tribes:** Indian entities recognized and eligible to receive services from the United States Bureau of Indian Affairs. In North Carolina, this includes the Eastern Band of Cherokee Indians.
- **Fee-for-service:** A payment model in which providers are paid for each service provided
- **Health Insurance Premium Payment (HIPP) program:** In some cases, DHHS will pay private health insurance premiums for certain individuals who are eligible for Medicaid, have private health insurance through their employer, have a high-risk illness, and are at risk of losing private coverage.
- **Intellectual/Developmental Disability (I/DD):** Category of disorders that negatively affect the trajectory of an individual's physical, intellectual, and/or emotional development. These are usually present at birth and often affect multiple body parts or systems.

- **Local Health Departments (LHDs):** LHDs have long played a critical role in North Carolina in the provision of care management services for high-risk pregnant women and at-risk children, in addition to primary care services and other critical public health functions. LHDs that provide primary care services are permitted to participate in Carolina ACCESS and AMH.
- **Managed Care:** In September 2015, the General Assembly enacted Session Law 2015-245, directing the transition of Medicaid from a fee-for-service structure to a managed care structure in order to advance high-value care, improve population health, engage and support providers, and establish a sustainable program with predictable costs. Beginning in November 2019, DHHS will delegate the direct management of certain health services and financial risks to PHPs. PHPs will receive a monthly capitated payment and will contract with providers to deliver health services to their members.
- **Medicaid:** Provides health coverage to over 2 million North Carolinians, including eligible low-income adults, children, pregnant women, elderly adults and people with disabilities. References to "Medicaid" in this document also encompass NC Health Choice, the State's comprehensive health coverage program for low-income children.
- **Medically needy:** Medicaid eligibility pathway for families, children, aged, blind, or disabled individuals, and pregnant women with income that is too high to qualify for Medicaid but who have significant medical expenses and limited assets.
- **North Carolina Department of Health and Human Services (DHHS):** DHHS manages the delivery of health- and human-related services for all North Carolinians, including the State's most vulnerable citizens – children, elderly, disabled and low-income families. It administers the State's Medicaid and NC Health Choice programs as well as a number of other programs and initiatives aimed at improving the health, safety and well-being of residents.
- **Obstetric Care Management (OBCM):** Current care management program provided by LHDs for pregnant Medicaid beneficiaries identified as being at high risk of a poor birth outcome. The care management model consists of education, support, linkages to other services and management of high-risk behavior that may have an impact on birth outcomes. Women identified as having a high-risk pregnancy are assigned a pregnancy care manager to coordinate their care and services through the end of the post-partum period.
- **Pregnancy Medical Home (PMH):** The current day PMH program provides comprehensive, coordinated maternity care to pregnant women, with a special focus on preterm birth prevention. All providers who bill for perinatal services are eligible to enroll in the program. Currently, more than 90 percent of all perinatal care provided to pregnant Medicaid patients in North Carolina is through a PMH.
- **Prepaid Health Plan (PHP):** A PHP is managed care organization to which DHHS will delegate the direct management of certain health services and financial risk. PHPs will receive a monthly capitated payment and will contract with providers to deliver health services to their members. PHPs will be subject to rigorous monitoring and oversight by DHHS across many metrics to ensure adequate provider networks, high program quality, and other important aspects of a successful Medicaid managed care program.
- **Presumptive eligibility:** Permits qualified entities to immediately extend temporary Medicaid coverage to uninsured individuals if they appear to be eligible based on income.
- **Program of All-Inclusive Care for the Elderly (PACE):** A federal program that provides a capitated benefit for individuals age 55 and older who meet nursing facility level of care. PACE features a comprehensive service delivery system and integrated Medicare and Medicaid financing

- **Serious mental illness (SMI):** Characterized by persons 18 years and older who, at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities. Diagnoses commonly associated with SMI include major depression, schizophrenia, and bipolar disorder.
- **Substance use disorder (SUD):** Recurrent use of alcohol and/or drugs that causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home.
- **Transition period:** Refers to the three year period in which PHPs are required to contract with Local Health Departments for the provision of care management for at risk children and high risk pregnancy. The transition period starts the day the first region begins managed care and follows the PHP contract years. Year 1 launches November 2019 and Year 3 ends June 30th, 2022.
- **Traumatic Brain Injury (TBI) Waiver:** A North Carolina Medicaid 1915(c) Waiver program that established pilot project in Cumberland, Durham, Johnston and Wake counties to offer rehabilitation services for adults who have suffered TBI on or after their 22nd birthday.