Medicaid Delivery Reform and Value-Based Payment Update

North Carolina Department of
Health and Human Services

November 16, 2022

I. Context and Purpose

The North Carolina Department of Health and Human Services (the Department) has previously articulated, and remains dedicated to a key goal for all Medicaid transformation efforts: to improve the health of North Carolinians through an innovative, whole-person centered and well-coordinated system of care, which addresses both medical and non-medical drivers of health. The Department believes that a whole-person centered approach to care can help address the inequities that North Carolinians experience in health outcomes, and it is focused on ensuring that equity is centered in all of its transformation work. Medicaid transformation offers an opportunity to help address health disparities, advance health equity, and promote trusted, team-based care that is centered in the community. As the Department moves forward with Medicaid transformation, it remains committed to building upon successes and learning from critical feedback.

In this program update, the Department outlines its current thinking on how to further evolve its vision of improved health through an equitable, innovative, whole-person centered and well-coordinated system of care, building on the efforts discussed below, and seeks stakeholder feedback on the direction of future reforms. Specifically, the Department seeks feedback on its intention, described in more detail in this document, to pursue reform efforts around primary care and maternal and infant health, and intentional integration of physical health care, behavioral health care, and care addressing non-medical needs that impact health outcomes for all members. The Department is developing a complementary over-arching vision for advancing behavioral health and physical health integration more broadly in Medicaid, to be released in the future for additional stakeholder input.

The Department recognizes that many stakeholders have a desire to participate in actively shaping the Department's delivery and payment reform strategies. These stakeholders include health plans, providers, people with Medicaid coverage, families and advocates, Local Health Departments (LHDs), Clinically Integrated Networks (CINs) and other partners who support provider reforms, and community-based organizations (CBOs). Each of these stakeholders have important roles to play in ensuring future reforms result in an effective and cohesive approach to advance the health of North Carolina Medicaid members. While timelines for new reforms and model changes will crystalize as design work progresses, the Department remains committed to engaging stakeholders as reforms are developed, and before any significant programmatic or payment changes are implemented.

II. Background

Building on Recent Transformation Efforts

The Department implemented transformative changes to Medicaid in North Carolina with the launch of Managed Medicaid in July of 2021. The transition to comprehensive managed care, including the launch of Standard Plans, to be followed by the launch of Tailored Plans and the Children and Families Specialty Plan, marks a major change in the Medicaid delivery system towards more integrated whole-person care, where both physical health and behavioral health needs are covered under a managed care plan. In tandem with the launch of these new comprehensive managed care plans, the Department laid out its overarching strategy to improve the quality of care in Medicaid. In line with that quality strategy, the Department has made significant investments in improving access to and quality of primary care, catalyzing community-based care management, and connecting Medicaid members to resources that address non-medical needs (e.g., the need for healthy food) through Healthy Opportunities Pilots in three regions and through care management statewide. To reinforce and align incentives with these changes to the Medicaid delivery system, the Department also set out a vision to advance value-based

payment (VBP), the use of innovative payment models that reward health care providers for delivering high-quality, high-value care and achieving improved health outcomes, as opposed to simply paying for the volume of services delivered. The Appendix to this document includes more information on these efforts and reforms for interested stakeholders.

Learning From the COVID-19 Pandemic

The health care sector faced unprecedented strains on the frontline of the COVID-19 pandemic, resulting in economic and workforce impacts. Through these struggles, the pandemic emphasized the importance of a flexible, community-based workforce (such as community health workers, care managers, and doulas) that can be deployed to support the whole-person needs of Medicaid members. Likewise, the pandemic accelerated the use of telehealth and underscored its potential to broaden access to care and improve health outcomes. The Department successfully deployed "isolation supports" for those who tested positive for COVID-19 but had barriers to appropriately isolate, demonstrating the importance of addressing social and economic factors. The Department has and will continue to incorporate these pandemic tools of flexible workforce, use of telehealth, and addressing social and economic factors and the lessons from their implementation into future reform efforts.

Finally, the COVID-19 pandemic laid bare the inequities communities of color experienced by way of higher mortality rates and the presence of severe disease. This underscores the need for equity to be woven into the foundation of all reform efforts. The Department welcomes stakeholder comments on other lessons learned from the COVID-19 pandemic that should inform the Department's thinking going forward.

Acknowledging NC Provider & Stakeholder Feedback and Readiness for Delivery and Payment Reform

Through stakeholder engagement, comments on an earlier VBP White Paper, and targeted interviews, the Department has heard support for delivery and payment reforms in Medicaid. Stakeholders voiced that those reforms should provide increased flexibilities in care delivery, including telehealth, enhanced access to behavioral health services and the provision of other types of care that are not typically reimbursed in a fee-for-service structure (e.g. nurses providing telephonic clinical support or community health workers (CHWs) connecting individuals to address social drivers of health), especially for those patients who are under-resourced. In addition, the Department has heard broad interest in considering how delivery and payment reform could be used to improve health equity. Even with these opportunities, due to the complexity of launching managed care, and the pressure on the healthcare sector brought on by the COVID-19 pandemic and resultant workforce and economic challenges, the Department acknowledges the variability of NC Medicaid stakeholder readiness for further delivery and payment reform. Stakeholders have also expressed concerns that moving too quickly toward value-based payment models could leave some providers behind, furthering disparities. And for all providers, ensuring reliability of assigned and attributed patient panels, access to accurate, timely data, aligned quality metrics across plans and payers, and appropriate and accurate risk adjustment methodologies are critical for success. The Department seeks to prioritize and advance reforms that are responsive to these challenges, incorporate lessons learned during the COVID-19 pandemic and managed care roll out, increase provider flexibility and stability, and above all, allow providers to provide the highest value of care for members.

Driving Alignment Across Health Care Payers

The Department continues to seek to align with broader local and national trends, including movement towards innovative payment arrangements and new care delivery models, in a way that minimizes administrative, financial and operational impacts on provider business models. For example, many large health systems in the state participate in Medicare Accountable Care Organizations (ACOs) or have

entered value-based payment contracts with commercial payers. Many health plans are also pursuing their own payment initiatives and innovative care models. The Department hopes to build upon and align with this existing activity, while incentivizing increased adoption of such reforms in the Medicaid context. The Department recognizes that this alignment, and alignment in related areas (such as in quality measures used in value-based payment) is crucial to reducing administrative burden for providers who contract with multiple payers. North Carolina is one of four states partnering with the Centers for Medicare and Medicaid Services (CMS) and the Health Care Payment Learning and Action Network (HCP-LAN) on the State Transformation Collaborative, an initiative to support alignment across payers in components of innovative payment arrangements and encourage their adoption.

III. Department Perspectives on Future Reforms

Primary Care Reforms

Advancing coordinated, whole-person primary care continues to be a critical strategy to address health disparities and improve health outcomes for all North Carolina Medicaid members. Whole-person and coordinated primary care means establishing a dependable medical home for all members, with a particular focus on individuals with complex needs or chronic conditions, and those experiencing significant life transitions such as pregnancy or use of long-term care. The medical home serves as a platform to integrate the full spectrum of care for medical, behavioral and non-medical needs, and serves as a foundational point of high value preventive care for each of North Carolina's Medicaid members.

Primary Care Initial Thinking and Interim Steps

North Carolina Medicaid is committed to continue advancing its Advanced Medical Home (AMH) Program. The current AMH Program has been developed and implemented to strengthen the quality of and access to comprehensive, coordinated primary care and provides a medical home to greater than 95% of Standard Plan members. AMH primary care practices are critical to providing comprehensive primary and preventive care services to managed care members, including consistently providing patient-centered access (including extended office hours and remote forms of access), team-based care, chronic disease care, population health management, and care coordination across medical and social settings. Specific types of AMHs offer advanced services or models of care and payment. Tier 3 AMHs provide care management for high-risk populations (e.g. "local care management"), delivering care management that otherwise would be done by managed care plans. "Advanced Medical Home Plus" (AMH+) practices will offer specialized care management to the Tailored Plan population. See the Appendix for more details on these programs.

As an interim step towards advancing the AMH Program**, the Department plans to launch an optional alternative Tier 3 AMH pathway while broader reforms are being considered.** The Tier 3 alternative track will be for AMH practices that do not provide local care management but do have contracts involving higher level Alternative Payment Models (APMs). The Department aims, with this update, to recognize and test other pathways AMH practices may be taking to achieve whole-person, coordinated care, including by adopting new payment approaches that increase flexibility to improve care delivery. Current Tier 3 AMH practices that provide care management will be able to continue as Tier 3 without any changes to their requirements in this interim update. Further details on this optional Tier 3 alternative track will be shared in the coming months.

The Department is also now considering how to further evolve the AMH Program in the following years and further strengthen the quality of primary care. While it recognizes the progress made to date, there remains opportunity to improve and advance whole-person primary care.

Key Strategies to Advance Coordinated, Whole-Person Primary Care

Based on assessments of existing programs and ongoing stakeholder interviews related to opportunities and barriers, the Department has identified a preliminary set of key strategies to advance strong, coordinated, and whole-person centered primary care, which will inform its approach to future payment and other reform work. Specifically, the Department seeks to:

- Ensure Medicaid members, and particularly historically underserved populations, have timely access to high quality primary care
- Meaningfully engage members in their own care by building trusted member relationships with an impactful, community-based care team, including care managers, community health workers, CBOs that can provide social support services, Primary Care Providers (PCPs), behavioral health providers, and others that have a close understanding of the community being served
- Create financial flexibility and increase incentives for primary care and the community-based care team to focus on whole-person, integrated member needs across the system of care, including addressing physical, behavioral health, and social needs in a comprehensive and holistic way, closing care gaps with a focus on eliminating disparities, providing meaningful care management, smoothing care transitions, and encouraging appropriate settings of care
- Engage and support providers, particularly independent, small, and Historically Underutilized Providers (HUP)[1] by ensuring adequate service payment, investing in provider capacity for payment and care delivery reform, and reducing administrative burden
- Support and incentivize actionable data at the point of care, improve data sharing, and ensure data is accurate and reliable
- Create predictability and transparency for providers regarding panel assignment, attribution and management

Request for Stakeholder Comment on Primary Care

The Department is seeking stakeholder feedback on strategies and reforms that could help advance strong, coordinated, and whole-person centered primary care in North Carolina Medicaid specifically on these questions:

1. **Key Strategies for Future Design:** The department is interested in feedback on the key strategies above to guide future design.
    a. Should the Key Strategies listed above be the focus of the Department's further efforts to improve and advance whole-person primary care? Please be specific if you would recommend changes, additions, or deletions.

[1] The Department defines HUPs as provider organizations owned/controlled and managed by at 51 percent racial/ethnic minorities, women, people with disabilities, people who are LGBT, and/or otherwise socially and economically disadvantaged as defined in 15 U.S.C. § 637.

b. What are specific policy or payment interventions that would help advance these strategies?

2. **Current Care Management:** The Department has prioritized community-based, local care management in the design of the AMH model as an important tool in supporting coordinated, whole-person care.

    a. How has this worked in supporting members? Is local care management through AMHs being implemented in a way that is truly integrated with local primary care providers? Do AMH providers believe they are better supported to meet the needs of their patients and coordinate their care under this care management model?

    b. What changes are needed in the policies around practice-level care management to better support members in accessing coordinated, whole-person care?

3. **Current Payment model:** Current payment models for primary care are fee-for-service with an additional AMH payment model that includes medical home fees, care management fees, and performance incentive payments (more details on payments in the AMH payment model are included in the Appendix).

    a. How are the medical home fees, care management fees, and performance incentive payments working to deliver coordinated, whole-person care now? Which payments do AMH providers receive directly, and how are these payments being used to support coordinated, whole-person care? Is there continued rationale to maintain this structure of multiple separate payments?

    b. Are AMH providers able to use some or all of these payments to better serve patients and increase access? Do they provide enough flexibility to support whole-person care (for example, to employ a robust care team that includes care managers and community health workers)?

    c. What APMs are practices currently participating in and how do they increase flexibility to support whole-person care?

    d. What additional changes are needed to payment to support coordinated, whole-person care?

Maternal and Infant Health Reform

Medicaid and NC Health Choice provide insurance coverage for more than one in two North Carolina births, and insure three in seven of North Carolina's children. Further, inequitable maternal and infant health outcomes persist in North Carolina, most notably across race. Coordinated, whole-person maternity care is one of many policy strategies to help improve pregnancy outcomes, as well as ensure longer term health for pregnant women, infants, and children. In considering future reforms, the Department recognizes the opportunity to promote the alignment of care across the continuum of reproductive and pregnancy care, as well as other preventive and chronic care – including but not limited to supporting and strengthening connections, transitions, and access to primary care, behavioral health care, dental services and care management of medical and non-medical needs – so that all pregnant women realize improved outcomes. Focused attention on strengthening connections to care among pregnancy providers and other provider types through coordinated hand-offs and transitions will positively impact those at high-risk for adverse outcomes in particular.

Current State and Initial Thinking

North Carolina has a variety of initiatives focused on maternal and infant health (explained in more detail in the Appendix), and there are many stakeholders involved in care, including a wide array of providers, care managers, LHDs, and other care team members. In November 2021, the North Carolina general assembly passed a law that creates a new benefit providing 12 months of continuous postpartum coverage to eligible Medicaid members at or below 196% FPL. As of April 1, 2022, pregnant women have coverage for full Medicaid benefits beyond the maternity-focused benefits previously included in the Medicaid for Pregnant Women (MPW) program. This coverage extension (currently authorized through March 2027), alongside the existing maternal health infrastructure, provides a critical opportunity for engaging members in pregnancy-related and other physical and behavioral health care following birth.

Specifically, the Department is interested in providing additional support to maternity providers by strengthening the links to care management; increasing utilization of new postpartum benefits to bolster access to reproductive life planning, linkages to primary care after pregnancy, and access to behavioral health care; strengthening payment links to quality outcomes; and considering ways to integrate and expand the maternal and infant health workforce.

Key Strategies to Advance Coordinated, Whole-Person Care for Maternal and Infant Health

Based on assessments of existing programs and stakeholder interviews of opportunities and barriers, the Department has identified a preliminary set of key strategies of strong, coordinated, and whole-person centered maternal and infant health, which will inform its approach to future reforms focused on maternal and infant health:

- Ensure Medicaid members have timely access to high quality maternal and infant care
- Ensure pregnant women are connected to services such as primary care, mental health care, substance use treatment, and any needed specialty care that continues during and after the postpartum period, especially with the new postpartum 12-month extension
- Reinforce evidence-based clinical care and care management models while ensuring the providers have the needed flexibility to leverage the most appropriate care for a member's unique needs
- Meaningfully engage members in their own care by building trusted member relationships with a care team that has a close understanding of the community being served, including care managers, community health workers, CBOs that can provide social support services, maternal and infant health providers, primary care providers, behavioral health providers, and others
- Ensure that payment supports evidence-based care across the continuum, while also considering ways incentives can be used to reward improving maternal outcomes and reducing inequities, addressing physical, behavioral health, and social needs in a comprehensive and holistic way, smoothing care transitions to primary care providers, and making connections to community-based supports
- Support and incentivize actionable data at the point of care, improve data sharing, and ensure data is accurate and reliable. Data accessible to and shared between pregnancy providers, care managers, and primary care is important to strengthening connections to care and improving outcomes

Request for Stakeholder Comment on Maternal and Infant Health

The Department seeks stakeholder feedback on key strategies and reforms that could help advance strong, coordinated, and whole-person centered maternal and infant health in North Carolina Medicaid specifically on these questions:

1. **Key Strategies:** The department is interested in feedback on the key strategies above to guide future design.
    a. Should the Key Strategies listed above be the focus of the Department's reform efforts in maternal and infant health? Please be specific if you would recommend changes, additions, or deletions.
    b. What specific policy or payment interventions would support these strategies?
2. **Current Care Management:** The Department ensures pregnant women get the care management services that they need through referrals from the Pregnancy Management Program, which screens pregnant women for risks, and then connects high-risk individuals to the Care Management for High-Risk Pregnancy (CMHRP) Program. The local health departments in each county have historically provided care management for individuals in CMHRP.
    a. Are care managers currently sufficiently integrated with pregnancy providers and coordinating needed care and services for high-risk pregnant women? If not, what could be improved (e.g., the pregnancy provider has the opportunity to be responsible for care management to further integrate the care manager with the pregnancy provider)?
    b. What are critical successes and lessons learned from PMP and CMHRP that should be incorporated or built upon as the Department seeks to advance maternal health transformation?
3. **Current Payment:** Pregnancy care inclusive of prenatal care and the delivery is largely paid through a global pregnancy payment that is consistent for vaginal or Cesarean section deliveries. There are additional payments providers are eligible to earn through PMP based on the completion of pregnancy risk screenings and postpartum visits.
    a. Are the current global payments incentivizing the right care for all patients? What about for high-risk patients? How can this be improved?
    b. Should the current global payments be more closely linked with important outcomes for pregnancy care? If so, what measures do you think best represent high quality care for pregnant women?
    c. Are the additional incentive payments under PMP for screening and postpartum visits best paid as extra incentive payments? What else should or could be incentivized with an additional payment?
    d. How could pregnancy providers use care management payments to employ a robust and flexible care management team that includes community health workers?

IV. Conclusion

The Department values feedback from stakeholders on the outlined approach to future reforms in Medicaid in the focus areas of Primary Care and Maternal and Infant Health. Specifically, the

Department requests stakeholder input on whether the approaches noted above effectively balance the needs of the field and whether other considerations should be factored into future state-driven reforms and initiatives. Comments on the focus areas, goals, and opportunities stated above, as well as additional detail on the current landscape of reform efforts in North Carolina, specific opportunities to align across payers, and the timing of and provider and payer readiness for future reforms are appreciated.

The Department plans to release additional information on a new pathway for AMH practices that do not provide local care management but do have contracts involving higher level APMs. The Department will also be releasing a complementary vision for integrated physical and behavioral health and will be seeking stakeholder feedback to establish populations of interest, identify gaps in integrated care, and develop a set of proposed initiatives to address these gaps, building on the foundation of integrated and comprehensive managed care plans.

The Department will use submitted stakeholder feedback to inform the evolution of the state's future program design and implementation, and it remains committed to ongoing stakeholder engagement as this work progresses.

We encourage stakeholders to provide feedback by emailing Medicaid.NCEngagement@dhhs.nc.gov (subject line "VBP Feedback") **by December 19th, 2022.**

Appendix

The North Carolina Department of Health and Human Services (the Department) has previously articulated, and remains dedicated to a key goal for all Medicaid transformation efforts: to improve the health of North Carolinians through an innovative, whole-person centered and well-coordinated system of care, which addresses both medical and non-medical drivers of health. The Department believes that a whole-person centered approach to care can help address the inequities that North Carolinians experience in health outcomes, and it is focused on ensuring that equity is centered in all of its transformation work. Medicaid transformation offers an opportunity to help address health disparities, advance health equity, and promote trusted, team-based care that is centered in the community.

The Department's Medicaid Managed Care Quality Strategy, developed in partnership with community stakeholders, underpins the Department's vision for an innovative, whole-person, well-coordinated system of care through three central aims: Better Care Delivery; Healthier People, Healthier Communities; Smarter Spending. These Aims create a lens through which North Carolina defines and drives the overall vision for advancing the quality of care provided to Medicaid members in the state, including payment and delivery reform.

In alignment with this strategy, the Department has pursued several initiatives to advance improved health and whole-person, well-coordinated care over the last several years in its Medicaid delivery system and across managed care plans (e.g. Standard Plans, Tailored Plans, and the Child and Families Specialty Plan).

Transition to Comprehensive Managed Care

The transition to comprehensive managed care, including the launch of Standard Plans, followed by the launch of Tailored Plans and the Children and Families Specialty Plan, marks a major change in the Medicaid delivery system towards more integrated whole-person care, where both physical health and behavioral health needs are covered under a single managed care plan. Prior to this shift, physical health

services were delivered through a fee-for-service program with Primary Care Management, while behavioral health and I/DD services were historically delivered by local, limited benefit, managed care plans.

- **Standard Plans.** On July 1, 2021, the Department transitioned most Medicaid and NC Health Choice beneficiaries to fully capitated and integrated managed care plans called Standard Plans. The majority of Medicaid and NC Health Choice members, including adults and children with low to moderate intensity behavioral health needs, receive integrated physical health, behavioral health, long-term services and supports and pharmacy services through Standard Plans.

- **Tailored Plans.** Managed care eligible Medicaid and NC Health Choice beneficiaries with I/DD, TBI, and/or more serious behavioral health disorders, who meet the criteria specified by NC Session Law 2018-48, will be enrolled into Tailored Plans, which are regional, specialized managed care products focused on the needs of these populations. Tailored Plans will offer the same services as Standard Plans in addition to 1915(c) Innovations and TBI waiver services as well as several specialized behavioral health and I/DD services. Tailored Plans are anticipated to launch on April 1, 2023.

- **Children and Families Specialty Plan.** In addition to Standard Plans and Tailored Plans, the Department intends to launch a single statewide Children and Families Specialty Plan (CFSP) to mitigate disruptions in care and coverage for children, youth, and families served by the child welfare system. Designed to meet the unique health care needs of this population, the CFSP will enable children, youth, and families served by the child welfare system across the state to access a full range of physical health and behavioral health services, including a number of specialized behavioral health services, and maintain treatment plans even if placement changes occur. The CFSP will serve as the central entity accountable for the care of these beneficiaries and ensure that they receive the care they need when and where they need it, regardless of geographical location. The Department continues to refine the CFSP design as it awaits legislation to authorize the CFSP and issue a CFSP Request for Proposals.

Other Payment and Delivery System Initiatives and Reforms

In tandem with the launch of these new comprehensive managed care plans, the Department also has made significant investments in a number of other key reforms, including: improving access to and quality of primary care, catalyzing community-based care management, and connecting Medicaid members to resources that address non-medical needs (e.g., the need for healthy food) which affect health. To reinforce and align incentives with these changes to the Medicaid delivery system, the Department also set out a vision to advance the use of innovative payment models that reward health care providers for delivering high-quality, high-value care and achieving improved health outcomes, as opposed to paying only for the volume of services delivered.

- **Advanced Medical Homes (AMH).** The AMH model is designed to strengthen the ability of primary care practices to offer access to care for managed care members (including extended office hours and remote forms of access), enhance comprehensiveness of primary care, ensure care management at the local level, and reinforce preventive care. AMHs provide comprehensive primary and preventive care services to managed care members, including patient-centered access, team-based care, population health management, care coordination across medical and social settings, and care management for high-risk populations. For most Medicaid populations, care management – whether episodic or chronic – directly involves the AMH care team. The AMH payment model includes three types of non-visit based payments:

medical home fees, which provide funding for care coordination support and quality improvement for all AMHs; care management fees, which are payments for providing care management and population health activities for AMHs that assume primary responsibility for care management; and performance incentive payments, which are additional payments that are contingent on reporting and/or performance on the AMH performance and quality metrics. There are different AMH pathways depending on the level of care management, the payment model and the populations primarily served:

  - Tier 1 and Tier 2 AMH: In AMH Tier 1 and 2, practices must continue to meet the same requirements that they met for Carolina ACCESS prior to Medicaid Transformation. Tier 1 and 2 practices receive PMPM payments equivalent to what they received prior to managed care launch. For their members attributed to AMH Tier 1 and 2 practices, Health Plans are responsible for care management of high-need members, care coordination across settings, transitional care management and other bridging functions that go beyond the Carolina ACCESS requirements above.

  - Current Tier 3 AMH: AMH Tier 3 practices that offer care management must meet all Tier 1-2 requirements above plus additional requirements that reflect their capacity for data-driven care management and population health capabilities for their assigned populations.

  - Potential Tier 3 AMH alternative track (under development): The AMH Tier 3 alternative track will be for AMH practices that do not provide local care management but do have contracts involving higher level Alternative Payment Models (APMs). This model is currently under development and details will be forthcoming.

  - AMH+: AMH+ practices will be primary care practices actively serving as AMH Tier 3 practices, whose providers have experience delivering primary care services to the Tailored Plan eligible population or can otherwise demonstrate strong competency to serve that population. AMH+ practices must successfully apply for and be certified to provide Tailored Care Management.

- **Tailored Care Management.** The Behavioral Health and Intellectual/Developmental Disability (I/DD) Tailored Care Management model seeks to provide whole-person and provider-based care management that promotes integrated care, offers members choice, and addresses a broad range of behavioral health needs. Through Tailored Care Management, Behavioral Health I/DD Tailored Plan members will have a single designated care manager supported by a multidisciplinary care team to provide whole-person care management that addresses all of their needs, spanning physical health, behavioral health, I/DD, traumatic brain injuries (TBI), pharmacy, long-term services and supports (LTSS) and unmet health-related resource needs. To meet the care management needs of the Tailored Plan population, the AMH program's design has been modified to include two designations called AMH+ (see definition above under AMH) and "Care Management Agency" (CMA), which will act as the provider-based sites for care management. CMAs are largely behavioral health, I/DD, or TBI providers with demonstrable experience serving the Tailored Plan population that successfully apply for and are certified to provide Tailored Care Management.
- **Pregnancy Management Program (PMP).** The PMP provides comprehensive, coordinated

maternity care with a special focus on preterm birth prevention for all pregnant women enrolled in Medicaid health plans. This program is administered as a partnership between managed care plans and local maternity care service providers (defined as any provider of perinatal services). A key feature of the program is the use of a standardized screening tool to identify and refer women at risk for an adverse birth outcome to the Care Management for High-Risk Pregnant Women (CMHRP) program.

- **Care Management for High-Risk Pregnancies (CMHRP).** The CMHRP program is the primary vehicle for delivering care management to pregnant women who may be at risk for adverse birth outcomes. This program builds on the legacy model of care management for pregnant women administered in the local health departments (LHDs) since 1988. Those individuals referred for a more intense set of CMHRP care management services have those services coordinated and provided by LHDs, which include assisting and supporting high-risk pregnant women with navigation of prenatal and postpartum care; as well as addressing barriers affecting their care and health.
- **Care Management for At-Risk Children (CMARC).** The CMARC program offers a set of care management services, which includes promoting the medical home, linking to community resources and providing support to families, for at-risk children ages zero-to-five. The program coordinates services between health care providers, community program and supports, and family support programs. Managed care plans administer this program through contracts with Local Health Departments (LHDs).
- **North Carolina Integrated Care for Kids (NC InCK).** NC InCK is a pilot model that aims to improve the way children under age 21 and their families receive care and support services. NC InCK focuses on prevention, early identification and treatment of behavioral and physical health needs, and integrated care coordination and care management. Participating practices integrate care and care management across physical health, behavioral health and 10 core child service areas to deliver child and family-centered care. All children and youth from birth to age 21 who are insured by Medicaid or CHIP (NC Health Choice) and who live in five North Carolina counties: Alamance, Durham, Granville, Orange, and Vance, are automatically enrolled in NC InCK beginning in January 2022.

- **Postpartum Coverage Extension.** NC Medicaid postpartum health care coverage was extended from 60 days to 12 months for eligible beneficiaries in North Carolina starting on April 1, 2022 and is currently authorized through March 2027. The benefit also provides 12 months of continuous (ongoing) postpartum coverage to eligible beneficiaries who were pregnant or gave birth between Feb. 1, 2022, and March 31, 2022. Beneficiaries are eligible to receive 12 months of ongoing postpartum health care coverage beginning the date their pregnancy ends through the last day of the month, 12 months after the birth event. Beneficiaries remain eligible even if certain changes occur that may affect eligibility (such as a change in income or household/family unit).

- **Healthy Opportunities and Addressing Unmet Social Needs**. As part of its commitment to whole-person care, the Department is also forging links to supports for unmet social needs such as access to stable housing, healthy food, transportation, and supports for interpersonal safety. The Department is encouraging health plans and providers to address the unmet social needs of their Medicaid members, and as part of this effort has mandated screenings to identify needs for food, housing, and other social needs, is tracking screening performance as a quality measure, and has developed and required use of a tool called NCCARE360 to make and track referrals to community service providers. In certain regions in the state, Healthy Opportunities

Pilots further enable referrals to community-based organizations that provide non-medical services that are reimbursable according to an established fee schedule. Examples of these services include healthy food delivery, non-medical transportation, and violence intervention services. Recognizing the added responsibilities that come with Pilot participation, Tier 3 AMHs serving as a Designated Pilot Care Management Entity or their delegated CIN/Other Partner will receive an additional, DHHS-standardized, Pilot Care Management payment, on top of existing care management and medical home payments, for each Medicaid member assigned to a Pilot-participating Tier 3 AMH regardless of Pilot enrollment at Pilot launch.

- **Value-Based Payment (VBP)**. The Department remains focused on ensuring health plans are rewarding high-value care and innovative approaches in line with the Department's quality strategy via value-based payment (VBP) contracts with participating providers. Value-based payment or alternative payment models (APMs) reward health care providers for delivering high-quality, high-value care and achieving improved health outcomes, as opposed to paying only for the volume of services delivered. The Department has set targets for the proportion of Standard Plan payments to providers that must be made under these types of value-based payment arrangements in each of the first five years of Medicaid managed care. The Department has also defined sets of quality measures on which these arrangements can be based. Both Standard and Tailored Plans are working to establish value-based payment contracts and are reporting to the Department on the nature of those contracts through regular assessments, projections, and plan-specific value-based payment strategies.