

NC Medicaid Managed Care Transformation: A Fact Sheet for CMARC and CMHRP Providers

April 17, 2023

1. What are Tailored Plans?

Tailored Plans (TPs) are NC Medicaid health plans that provide physical health, pharmacy, care management and behavioral health services for beneficiaries who may have significant mental health needs, severe substance use disorders, intellectual/developmental disabilities (I/DD) or traumatic brain injury (TBI). Tailored Plans operate similarly to the Standard Plans (AmeriHealth Caritas, Carolina Complete Health, Healthy Blue, UnitedHealthcare and WellCare), however Tailored Plans offer enhanced behavioral health services that are not available in Standard Plans, including Innovations and TBI Waiver services and State-funded services. There are six Tailored Plans: Alliance Health Tailored Plan, Eastpointe Tailored Plan, Partners Health Management Tailored Plan, Sandhills Center Tailored Plan, Trillium Health Resources Tailored Plan and Vaya Health Tailored Plan.

2. What is Tailored Care Management?

[Tailored Care Management](#) (TCM) is North Carolina's specialized care management model targeted toward individuals with a significant behavioral health condition (including both mental health and substance use disorders), I/DD or TBI. Tailored Care Management is aimed at promoting whole-person care, fostering high-functioning integrated care teams and driving toward better health outcomes. Through Tailored Care Management, beneficiaries will have a care manager supported by a multidisciplinary care team to address their physical health, behavioral health, I/DD, TBI, pharmacy, long-term services and supports (LTSS) and unmet health-related resource needs.

3. Who provides Tailored Care Management services?

Members can get Tailored Care Management services through primary care providers certified as Advanced Medical Home Plus (AMH+); behavioral health, I/DD or TBI providers certified as Care Management Agency (CMA); or care managers based at a Local Management Entity/Managed Care Organization (LME/MCO). NC Medicaid developed an assignment algorithm, based on various factors including members' existing provider relationships and medical complexity, that will pair eligible members with a care management entity that provides Tailored Care Management (i.e., AMH+, CMA or LME/MCO).

4. What is a Local Management Entity/Managed Care Organization (LME/MCO)?

LME/MCOs coordinate services for mental health disorder, substance use disorder, I/DD or TBI for NC Medicaid Direct members and EBCI Tribal Option members. There are six LME/MCOs: Alliance Health, Eastpointe, Partners Health Management, Sandhills Center, Trillium Health Resources and Vaya Health.

Eligibility

5. Who is eligible for Tailored Care Management?

Tailored Care Management is available to Medicaid beneficiaries who meet clinical eligibility criteria; this includes individuals with:

- Serious mental illness (SMI)

- Serious emotional disturbance (SED)
- Severe substance use disorders (SUD)
- Intellectual/Development Disabilities (I/DD)
- Traumatic Brain Injury (TBI)

Tailored Care Management will be available to all TPs and NC Medicaid Direct members continuously throughout their enrollment, including individuals enrolled under North Carolina's 1915(c) Innovations and TBI waivers. Individuals who are federally recognized tribal members or others eligible for Indian Health Service (IHS) will be exempt from managed care but can choose to enroll in a TP if otherwise eligible.

6. Are children ages birth through 3 eligible for Tailored Care Management?

Only children ages birth through 3 enrolled in the NC Innovations Waiver have started receiving Tailored Care Management since its launch in December 2022. All other children ages birth through 3 who meet Tailored Care Management eligibility will get Tailored Care Management beginning April 1, 2023. Until then, they will continue to receive care coordination/care management as they do today. For example, children in foster care who receive care management through the Care Management for At-Risk Children (CMARC) program provided by Local Health Departments (LHDs) will continue to receive CMARC. Members that are not TCM eligible in CMARC will continue to receive CMARC from LHDs.

Transition of Care

7. What is Transition of Care?

Transition of Care (TOC) is a term that describes the process of assisting a member to transition between health plans, between care management providers or between payment delivery systems (including transitions that result in the disenrollment from managed care). Transition of Care also includes the process of assisting a member to transition between providers upon a provider's termination from the health plan's network.

8. How is Transition of Care relevant to Care Management for At-Risk Children (CMARC) Program?

According to the Centers for Medicare and Medicaid Services (CMS), CMARC and TCM services are duplicative of each other and cannot be provided simultaneously beginning on July 1, 2023. Children in CMARC who are eligible for Tailored Care Management will transition from CMARC through the Local Health Department to the LME/MCO for Tailored Care Management on April 1, 2023. However, LHDs will have until June 30, 2023, to disenroll these members from CMARC.

9. How will CMARC members know they are moving to LME/MCO for Tailored Care Management?

Eligible members have started receiving enrollment packets via mail beginning January 23, 2023. The enrollment packets contain information on transition notice (including how to choose TCM provider and primary care provider), description of TCM services, name and contact information of their TCM provider, disenrollment rights (how to opt-out of TCM), health care option guide, enrollment form and how to change their TCM provider by calling their LME/MCO.

10. Can CMARC members opt-out of TCM?

Members may choose to opt-out of Tailored Care Management services at any time.

11. What happens when a CMARC member opts out of TCM?

From April 1, 2023 to June 30, 2023, CMARC members who opt out of TCM can continue to receive CMARC services. Effective July 1, 2023, CMARC members who opt out of TCM will be disenrolled from CMARC but will receive care coordination from the LME/MCO. Members can choose to opt back into Tailored Care Management if their care needs and preferences change.

12. How will LHDs know which CMARC members are transitioning to LME/MCO?

In early March 2023, LHDs received a list from the Division of Child and Family Well-Being (DCFV) of CMARC members who are transitioning to LME/MCO. This was to allow LHDs time to get ready for the warm handoff process which began on March 13, 2023. Members identified by Community Care of North Carolina (CCNC), AMHs, LME/MCOs or the Department as those with complex treatment circumstances or multiple service interventions require a warm handoff (*Refer to page 16 of the [Transition of Care Policy](#)*).

13. What is expected for CMHRP at NC Medicaid Direct: Behavioral Health and I/DD Services Launch (April 1, 2023)?

Care Management for High-Risk Pregnancies (CMHRP) and Tailored Care Management services can be provided simultaneously. Members currently in CMHRP will continue to receive care management from the LHDs. For newly pregnant TCM members, LME/MCOs must identify and refer high-risk pregnancies to LHDs for CMHRP services. For members receiving both CMHRP and Tailored Care Management, the CMHRP and TCM care managers must collaborate to coordinate care. Between April 1, 2023 and September 30, 2023, LHDs will be paid for CMHRP services of new and existing members through Medicaid Direct payments through CCNC. There is no requirement for new contracts between LME/MCOs and LHDs.

14. What is expected for CMHRP at Tailored Plan Launch (Oct. 1, 2023)?

CMHRP and Tailored Care Management services can be provided simultaneously. TPs must identify and refer high-risk pregnancies to LHDs for CMHRP services. For members receiving both CMHRP and Tailored Care Management, the CMHRP and TCM care managers must collaborate to coordinate care. LHDs must be contracted with TPs for members to be referred to them. TPs will compensate contracted LHDs at an amount similar to, but not less than funding levels they receive today for these services.

15. Why is CMHRP not considered duplicative, when CMARC is?

CMS informed the Division of Health Benefits (DHB) that CMHRP services are not duplicative of Tailored Care Management due to the scope of CMHRP services being narrowed to assisting and supporting high-risk pregnant members with navigation of prenatal and postpartum care. While CMHRP services include addressing barriers affecting their care and health, CMS did not deem this aspect of the service to be duplicative.

16. What will happen after the 1-year contract for CMHRP services expires?

At the conclusion of Contract Year 1 (October 2024), TP shall have the option to continue to contract with LHDs for CMHRP or to include services within Tailored Care Management for members experiencing high-risk pregnancy (whether provided by the organization responsible for Tailored Care Management or by another organization under contract with the Behavioral Health I/DD Tailored Plan).

17. If a member is in CMARC/CMHRP, TCM, complex care and pilot programs (e.g., InCK), how are they expected to keep up with multiple care managers?

LME/MCO members will have a designated care manager supported by a multidisciplinary care team to provide whole-person centered care management that addresses all their needs including physical health, behavioral health, I/DD, TBI, pharmacy, LTSS and unmet health-related resource needs. For members receiving both CMHRP and Tailored Care Management, members may have a TCM Care manager as well as a CMHRP care manager collaborating to coordinate care and to ensure member's needs are met. Note: If a member is receiving TCM services, they are not eligible to receive care management through Integrated Care for Kids (InCK), as it is considered to be a duplicative service.

18. What are the different roles of the CMHRP care manager and the TCM care manager and how do we keep from duplicating services?

For CMHRP, the LME/MCO will specifically ensure that the care management roles and responsibilities between the LME/MCO are non-overlapping with care management services offered by LHDs. Direct communication, and collaboration between the CMHRP care manager and the TCM care manager is key to ensuring that each care manager is aware of the goals, care plans and specific work being implemented with the patient by each care manager.

19. How will this transition affect the future of the CMARC program?

CMARC members who do not meet eligibility for TCM will remain with their respective LHDs where they will continue to receive care management or care coordination services.

20. What happens if a child needs to transition from Tailored Plan to Medicaid Direct due to foster care?

A child who needs to transition from a Tailored Plan to Medicaid Direct due to the foster care member status will continue to receive TCM services from the LME/MCO.

Transition of Care Expectations

21. What is a warm handoff?

A warm handoff is a member-specific meeting or knowledge transfer session between the transferring entity and the receiving entity. The warm handoff process is in place for members who have been identified as high need and warrants a verbal briefing between the transition entity and the receiving entity. This high-needs group is identified on the DHHS "High Need Member List."

22. Are all members enrolled in CMARC considered high needs?

Yes, CMARC members are considered a high-needs population.

23. What is the process to handoff CMARC members transitioning from LHDs to LME/MCOs for Tailored Care Management?

For all CMARC members transitioning from the LHD, the LHD shall transfer the information necessary to ensure continuity of care, including appropriate Transition of Care (TOC) data files and member-specific socio-clinical information. A TOC Summary Page for each CMARC member will be transmitted to the receiving LME/MCO. This summary page includes minimally:

- List current providers;
- List of current authorized services;
- List of current medications;
- Active diagnoses;
- Known allergies;
- Existing or prescheduled appointments, including Non-Emergency Medical Transportation (NEMT), as known;
- Any urgent or special considerations about a member's living situation, caregiving supports, communication preferences or other member-specific dynamics that impact the member's care and may not be readily identified in other transferred documents; and
- Additional information as needed to ensure continuity of care.

Note: For members out of county, the serving county will coordinate the warm handoff.

24. What are the expectations for CMARC care managers?

CMARC care managers serving members who are transitioning to LME/MCO should follow the NC Medicaid [Transition of Care policy](#) to ensure that members receive the appropriate warm handoff to the LME/MCO.

Payment

25. How will LHDs be reimbursed for CMARC services after NC Medicaid Direct: Behavioral Health and I/DD Services Launch?

Until June 30, 2023, LHDs will continue to receive payments for TCM-eligible CMARC members they are actively serving. Effective July 1, 2023, CMARC and TCM will be considered duplicative services and LHDs will not be reimbursed for members who are enrolled in TCM. For CMARC Members enrolled in Medicaid Direct who are not TCM eligible, LHDs will continue to be reimbursed at an amount similar to, but not less than the amount paid in the existing program: \$4.56 per member per month for all enrolled children ages 0 through 5.

26. What is the LME/MCO Reimbursement Rate to LHDs for CMHRP? Is this negotiable?

The LME/MCO shall pay LHDs they are contracted with for CMHRP services at an amount not less than \$4.96 per each female ages 14 through 44 who are attributed to that county and LME/MCO. This

reimbursement method is considered a per member per month (PMPM) payment as it is based upon a specific population and not a fee-for-service model. The contract terms (including PMPM) may be negotiated between the LHD and LME/MCO.

Others

27. Will LME/MCO care managers have access to Virtual Health?

Yes, LME/MCOs will have 'VH Provider Portal' read-only access to Virtual Health if requested. Care managers will be able to use the information in Virtual Health to determine if a member is receiving CMHRP services in order to coordinate care with LHDs.

28. If the LME/MCOs have Virtual Health read-only access, what is the point of the warm handoff, consent form, summary, etc. when they can see everything?

To maintain continuity of care for members, the LME/MCOs are required to participate in member-specific knowledge transfer sessions known as warm handoffs for high-need members transitioning to the LME/MCO for TCM. During the warm handoff process, the transitioning entity, LHD, shares and verifies member information and may provide additional context about the member as necessary.

29. What information will be visible in NCTracks?

Member information in NCTracks includes, among other things, identifiers for managed care status: whether a member is in Standard Plan or Tailored Plan, Medicaid status (active/inactive).

30. How can I learn more?

For more information or questions on Transition of Care, contact Medicaid.TOC@dhhs.nc.gov.

Additional resources are here:

- Care Management for At-Risk Children: <https://medicaid.ncdhhs.gov/care-management/care-management-risk-children-cmarc>
- Care Management for High-Risk Pregnancies: <https://medicaid.ncdhhs.gov/care-management/care-management-high-risk-pregnancies-cmhrp>
- Tailored Plan Service Area Map: <https://medicaid.ncdhhs.gov/tailored-plan-service-area-map>
- Transition of Care Website: <https://medicaid.ncdhhs.gov/care-management/transition-care>
- Transition of Care Policy: <https://medicaid.ncdhhs.gov/media/12260/download?attachment>
- Sample enrollment packet: <https://medicaid.ncdhhs.gov/media/10340/download?attachment>
- Health care enrollment guide: <https://medicaid.ncdhhs.gov/media/11888/download?attachment>