

Medicaid Managed Care
Proposed Concept Paper

North Carolina's Care Management Strategy under Managed Care

North Carolina Department of
Health and Human Services

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This document is part of a series of concept papers that the Department of Health and Human Services scheduled for release from late 2017 through early 2018 to provide additional details to stakeholders regarding the transition of North Carolina Medicaid and NC Health Choice programs to a predominantly managed care model. This technical paper is written primarily for providers and health plans that will participate directly in Medicaid managed care, but anyone may respond and provide feedback to the Department, including beneficiaries, advocates or other interested parties. Some topics mentioned in this document may be covered in more detail in other concept papers in the series. For more information on the Department’s proposal, stakeholders are encouraged to review the Amended North Carolina Section 1115 Demonstration Waiver Application and previously released concept papers available at ncdhhs.gov/nc-medicaid-transformation. Input is welcome and appreciated. Send comments to Medicaid.Transformation@dhhs.nc.gov.

I. Introduction

North Carolina is preparing to transition its Medicaid and NC Health Choice programs from a predominantly fee-for-service delivery system¹ to managed care, which will advance high-value care, improve population health, engage and support providers, and promote predictable and sustainable costs. In designing this transition, the goal of the Department of Health and Human Services (the Department) is to improve the health of North Carolinians through an innovative, person-centered and well-coordinated system of care that addresses medical and nonmedical drivers of health.

Most Medicaid and NC Health Choice² enrollees will begin transitioning to prepaid health plans (PHPs), which are integrated managed care products that will provide physical and behavioral health services, long-term services and supports, and pharmacy benefits, and will address health-related resource needs. The Department intends to offer different types of PHPs, customized to the populations they serve. For example:

- **Standard plans** will launch the first year of managed care and will serve the vast majority of Medicaid enrollees.
- **Behavioral health and intellectual and developmental disability tailored plans (BH I/DD TPs)** will launch in the third year of managed care and focus on specialized needs of individuals with behavioral health disorders, I/DD and traumatic brain injury (TBI).^{3,4}

Over a five-year period, the majority of North Carolina Medicaid beneficiaries will phase into managed care, with the largest portion enrolling in Year 1 (scheduled for July 2019–June 2020). The appendix includes the populations that will phase into managed care by year of implementation.

Care management is foundational to the success of North Carolina’s health care system for Medicaid enrollees, supporting high-quality delivery of the right care at the right place, and at the right time in the right setting. Care management is a team-based, person-centered approach to effectively managing patients’ medical, social and behavioral conditions. Since the mid-1990s, North Carolina has operated a statewide primary care case management (PCCM) program. Since the early 2000s, the Department has contracted with Community Care of North Carolina (CCNC) to implement the PCCM program, which

¹ The Department currently has a managed care delivery system for behavioral health and intellectual and developmental disabilities services through the local management entities/managed care organizations (LME/MCOs). “Fee-for-service,” as used throughout this concept paper, refers to only physical health services.

² For purposes of this concept paper, the term “Medicaid” refers to North Carolina Medicaid and NC Health Choice programs, unless specifically described otherwise.

³ North Carolina is seeking legislative approval to incorporate behavioral health benefits into standard plans and to create Behavioral Health and Intellectual and Developmental Disability tailored plans (BH I/DD TPs).

⁴ As of March 9, 2018, the proposed target population for initial enrollment in BH I/DD TPs includes individuals with a qualifying I/DD diagnosis, including those enrolled in or on the waiting list for the Innovations waiver; individuals enrolled in the TBI waiver who are on the waiting list for the TBI waiver or have used a state-funded TBI service; individuals enrolled in the Transition to Community Living Initiative; individuals with a serious mental illness or serious emotional disturbance diagnosis who have used a Medicaid-covered enhanced behavioral health service or a state-funded behavioral health service within the past year; and individuals with a qualifying substance use disorder diagnosis who have used a Medicaid-covered enhanced behavioral health service or state-funded behavioral health service within the past year. Other individuals with a TBI, serious mental illness, serious emotional disturbance or substance use disorder may also be eligible to enroll in a BH I/DD TP. For additional details on BH I/DD TPs, please see the BH I/DD TP [concept paper](#).

serves the vast majority of North Carolina’s Medicaid population through a system of primary care practices (known as Carolina ACCESS) and a regionally based care management model.

Consistent with the Department’s commitment to transparency throughout the managed care planning, design and implementation process, the Department is releasing this concept paper to provide information about how care management will be structured as North Carolina transitions to managed care; specifically, how the roles of PHPs, provider practices and other entities (such as local health departments) will work together to provide a seamless care management system for enrollees. **This concept paper focuses exclusively on care management design for standard plans** and is not intended to address care management for children in foster care or beneficiaries enrolled in BH I/DD TPs, which will be addressed in future papers.

The Department welcomes feedback on this concept paper as it continues to refine the approach to care management.

Guiding Principles

Aligning with its broader goals for the transformation to Medicaid managed care, the Department has established the following guiding principles for its Medicaid care management strategy:

1. All Medicaid enrollees will have access to appropriate care management and coordination support across multiple settings of care, including a strong basis in primary care and connections to specialty care and community-based resources.
2. Enrollees with high medical, behavioral or social needs should have access to a program of care management that includes the involvement of a multidisciplinary care team and the development of a written care plan.
3. Local care management—care management that is performed at the site of care, in the home or in the community where face-to-face interaction is possible—is the preferred approach, building on the strengths of the current care management structure.
4. Care managers will have access to timely and complete enrollee-level information.
5. As part of care management and care coordination, enrollees will have access to direct linkages to programs and services that address unmet health-related resource needs affecting social determinants of health, along with follow-up and ongoing planning.
6. Care management activities will align with overall statewide priorities for achieving quality outcomes and value.⁵

While designing this care management strategy, the Department kept in mind the appropriate balance between maintaining stability and flexibility: Stability for Medicaid enrollees and providers during the transition to managed care, and flexibility for PHPs as they enter North Carolina’s Medicaid system for the first time. This strategy will build on the successes of today’s Medicaid care management approach

⁵ The Department has established clear aims, goals and objectives for quality improvement in managed care, and how those priorities will be advanced through statewide interventions, including care management and the AMH model. Additional information on the Department’s vision for advancing quality and value-based care will be provided in a forthcoming concept paper to be released this spring.

while simultaneously promoting a single point of accountability, and encouraging PHPs to innovate and improve care outcomes.

Roles and Responsibilities for Care Management

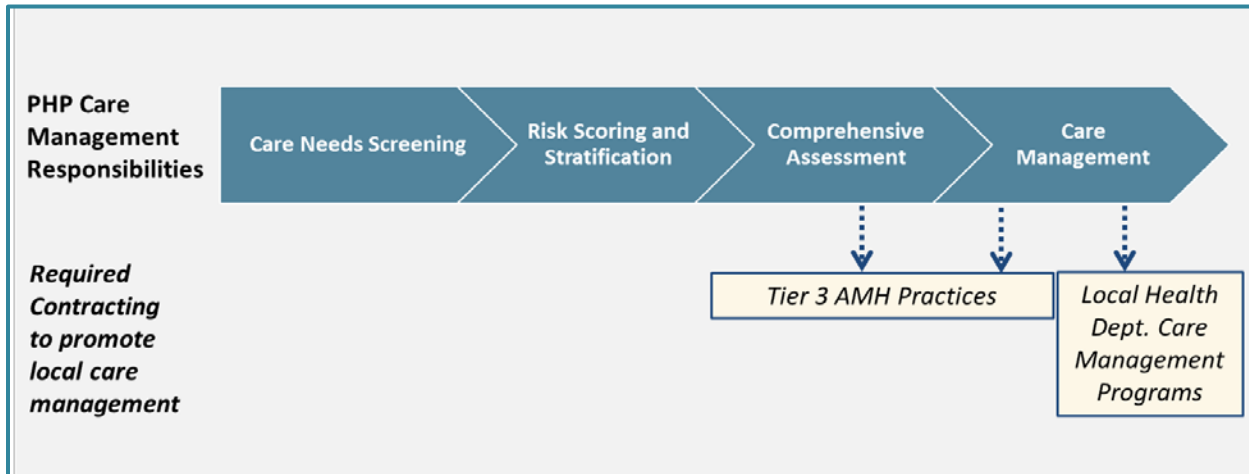
The Department, PHPs, providers and local health departments have distinct roles and responsibilities in the system of care management for standard plan enrollees.

- **The Department** is ultimately responsible for all aspects of the Medicaid program, including North Carolina's transition to managed care. The Department will develop policies to ensure the success of the managed care program, while partnering with and holding PHPs accountable for providing high-quality care and improving outcomes. The Department will ensure accountability by setting clear clinical, quality and administrative priorities and objectives, and establishing standards and evaluating plans against those standards.

The Department also will assume direct responsibility for establishing State-level clinical leadership going forward and will work with current clinical leaders to ensure continued dialogue with providers and a focus on quality improvement. To ensure that the system builds on the successes of the PCCM program and minimizes disruption for providers, the Department will standardize certain requirements to ensure a consistent care management approach across PHPs. Finally, the Department will play a monitoring role in all aspects of care management to ensure that PHP enrollees are being appropriately identified for care management and are receiving high-quality services.

- **The PHPs' role**, as the entities at financial risk, is to oversee, fund and organize all aspects of care management and provider contracting in a way that improves health outcomes and manages total cost of care for their enrollees. PHPs have an actuarial responsibility for the populations that they serve and, as a result, have an incentive to align with the Department's vision for ensuring enrollees who would benefit from high-quality care management receive it. PHPs will bear responsibility for ensuring that each enrollee has access to appropriate care, including care management and care coordination and, within the State's parameters, will have flexibility in how to organize resources to meet these goals. As set out in Section III below, PHPs will be required to complete care needs screenings and to perform claims analysis and risk scoring to identify enrollees at risk; stratify their populations by level of need; perform comprehensive assessments for those identified as part of "priority populations"; and ensure that care management takes place in as local a setting as possible, as described in Figure 1 and under "Accountability for Care Management."

Figure 1. PHP Care Management Functions Required to Be Held at the Local Level



Providers’ roles in care management will vary according to their care management readiness. The Advanced Medical Home (AMH) program will be the framework under which providers can choose to take primary responsibility for care management, either at the individual practice level or in a contractual relationship with a care management/population management entity (e.g., a Clinically Integrated Network)—and receive higher reimbursement for such responsibility—or choose to coordinate with PHPs’ care management approaches. The AMH program and its evolution are at the heart of North Carolina’s strategy for care management and are described in “Section II. Defining and Delivering Care Management in the Context of Managed Care.” **The Department will require PHPs to contract with a large majority of AMH practices in each of their regions that have demonstrated advanced care management capabilities (known as Tier 3 and 4 practices, as described in Section II), with the minimum percentage to be defined in the PHP contract.**⁶ For enrollees who obtain primary care at Tiers 1 or 2 AMHs or through primary care practices that choose not to participate in the AMH program at any level, PHPs will perform care management. To monitor how PHPs plan to organize care management resources and programs within each region, the Department will require that each PHP submit to the Department for approval an annual “local care management plan” that describes its approach for delivering local care management.

- **Local Health Departments** will remain crucial in providing care management for high-risk pregnant enrollees and at-risk infants and young children. “Section IV. Care Management Programs for High-risk Pregnancy and At-risk Children” describes the Department’s plans to preserve and strengthen the specific care management programs currently implemented by local health departments. **For the first two years of managed care, the Department will require PHPs**

⁶ The Department is currently considering requiring PHPs to contract with 80% of Tier 3 practices in each region and welcomes feedback on this approach: see p. 1 for the Department contact email address.

to contract with Local Health Departments at the same payment levels as today for the delivery of Obstetric Case Management (OBCM) and Care Coordination for Children (CC4C).

KEY TERMINOLOGY

North Carolina recognizes that standardized, industrywide definitions related to care management and care coordination do not exist. For the purposes of its care management strategy, North Carolina has developed the following definitions:

Care Management: A team-based, person-centered approach to effectively managing patients' medical, social and behavioral conditions, including:

- Management of rare diseases, high-cost procedures (e.g., transplant, specialty drugs);
- Management of enrollee needs during transitions of care (e.g., from hospital to home);
- High-risk care management (e.g., high utilizers/high-cost beneficiaries);
- Chronic care management (e.g., management of multiple chronic conditions);
- Management of high-risk social environments (e.g., adverse childhood events, domestic violence);
- Identification of enrollees in need of care management (e.g., screening, risk stratification, priority populations);
- Development of comprehensive assessments/care plans (across targeted populations);
- Development and deployment of prevention and population health programs; and
- Coordination of services (e.g., appointment/wellness reminders and social services coordination/referrals).

Care Coordination: The process of organizing patient care activities and sharing information among all participants concerned with an enrollee's care to achieve safer and more effective care. Through organized care coordination, enrollees' needs and preferences are known ahead of time and communicated at the right time to the right people to provide safe, appropriate and effective care.

Case Management: Federal regulations define case management as, "Services furnished to assist individuals, eligible under the [Medicaid] State Plan who reside in a community setting or who are transitioning to a community setting, in gaining access to needed medical, social, and other services." (42 CFR 44.169)

Local Care Management: Care management that occurs in a hospital or emergency department, a physician's office, a local health department, an enrollee's home, or in other community-based settings where face-to-face care management is available.

Designated Care Management Entity: An entity that the PHP contracts with to assume responsibility for performing specific care management and/or care coordination functions. Designated care management entities in North Carolina include, but are not limited to:

- AMH practices;
- Local health departments; and
- Other contracted entities capable of performing care management for a designated cohort of enrollees.

The Advanced Medical Home Program

Table 3. Phase 1 Sample New Beneficiary Timeline Example

Key Activity	Example date
New beneficiary applies and is determined eligible for Medicaid without making PHP selection	Nov. 1, 2019
Beneficiary auto-assigned to PHP	Nov. 1, 2019
90-day choice period begins	Nov. 1, 2019
Beneficiary may change PHPs without cause	Nov. 1, 2019 – Jan. 30, 2020
90-day choice period ends	Jan. 30, 2020
Member may change PHPs with cause or at redetermination	Ongoing

Strong primary care is essential to the success of any health care system. Through AMHs, North Carolina seeks to build on the Carolina ACCESS program to preserve broad access to primary care services for Medicaid enrollees and to strengthen the role of primary care in care management, care coordination, and quality improvement as the state transitions to managed care. The AMH program provides clear financial incentives for practices to become more focused on cost and quality outcomes over time by gradually aligning incentive payments for practices to specified measures, including increasing provider accountability for total cost of care as well as health outcomes—which in turn will link to PHPs’ quality incentives set by the Department. The Department understands that payment reform takes time and that it is essential to preserve the strengths of today’s system in the transition to managed care. Therefore, the AMH design also includes a central commitment to maintaining high levels of provider participation in Medicaid to preserve access for enrollees; to introducing changes to payment models with sufficient time for providers to prepare; and to providing support to providers in this transition.

The AMH program offers providers a range of options for partnering with PHPs in the provision of care management. Providers may choose to maintain contracting arrangements similar to Carolina ACCESS, under which they will coordinate with different PHPs’ care management strategies; *or* they may choose to move into the primary role in which the PHP delegates responsibility for the provision of care management, either alone or with a network of other practices. Providers may also choose not to participate in the AMH program. The difference between these options is defined by the AMH tier structure described next.

The AMH program will launch concurrently with the implementation of managed care. Particularly in the introductory years of the program, the Department will maintain a leadership role in the design and implementation of the AMH program. Doing so will maximize stability for both patients and providers and to allow higher-tier practices to implement a unified care management approach across all PHP populations, to the greatest extent possible.

A Technical Advisory Group consisting of experts, providers and (after procurement is complete) PHPs, will advise the Department on crucial aspects of program design and provide real-time feedback on the program’s implementation.

The Department welcomes feedback on the AMH design approach outlined next.

AMH Tier Structure

North Carolina's Medicaid program boasts high rates of provider participation among primary care and other types of practices,⁷ including practices in diverse settings and with widely varying care management capabilities. The AMH program offers four tiers of participation, with practice requirements, payment models and performance incentive payment expectations differing by tier.

The Department will establish a single, statewide set of standards for practice eligibility for the AMH program and for each AMH tier. In the first year of program launch, the tier structure will provide continuity and predictability to the full range of practices participating in the current Carolina ACCESS program. Over time, the tier structure will evolve to encourage practices to align with the Department's care management goals, while ensuring practices and enrollees are supported in this transition.

The Department's decision to form multiple tiers for practices was based on the diversity of the delivery system and the legacy of North Carolina's PCCM program. Many practices already belong to clinically integrated networks (CINs) or health systems that have both care management staff and the capacity to use data to risk stratify a patient panel and target care management approaches to sub-populations. Other providers may be intending to join such networks or systems, and still other advanced practices may independently have similar capacities. At the same time, many practices, particularly those serving a smaller proportion of Medicaid patients, may not be ready or willing to take on primary responsibility for care management. Through the tier structure, the AMH design will provide options for the full spectrum of practices. Table 1 provides a high-level overview of each of the four AMH tiers.

⁷ As of state fiscal year 2017, there were approximately 69,000 providers enrolled in the Medicaid program. North Carolina Medicaid and NC Health Choice, Annual Report for State Fiscal Year 2017, https://files.nc.gov/ncdma/documents/AnnualReports/AnnualReport_SF2017_20171230.pdf.

Table 1. AMH Tiers

AMH Tier	Managed Care Launch Year	Design in Years 1 and 2 of Managed Care					Design After Year 2
		Practice Requirements	Primary Responsibility for Care Management	Medical Home Fee (paid by PHP) ⁸	Care Management Fee (paid by PHP)	PHP Performance Incentives to Practices	Vision
Tier 1	1	Carolina ACCESS I requirements	PHP responsible; must coordinate with practices	\$1 PMPM	None	None required, but PHPs encouraged to begin offering performance incentive payments based on AMH measures	Tier 1 will be phased out after two years
Tier 2	1	Carolina ACCESS II requirements	PHP responsible; must coordinate with practices	\$2.50 (most enrollees) or \$5.00 (members of the aged, blind and disabled eligibility group) PMPM	None		<ul style="list-style-type: none"> • State may modify Carolina ACCESS II requirements based on feedback • The Department will continue to set minimum medical home fees based on Carolina ACCESS II; practices can negotiate higher rates • PHPs will offer AMHs performance incentive payments
Tier 3	1	Carolina ACCESS II plus select CPC+ care management requirements	Practices responsible; AMH practices may arrange that care management functions will be performed at the CIN	\$2.50 (most enrollees) or \$5.00 (members of the aged, blind and disabled eligibility group) PMPM	Negotiated between practices (or CINs on behalf of practices) and PHPs	PHP must pay performance incentive payments to practices if practices meet performance thresholds on standard AMH measures, which may include total cost of care	<ul style="list-style-type: none"> • State may “raise the bar” on Carolina ACCESS II and customize the CPC+ -based care management requirements • State will continue to require both medical home fees and care management fees • PHPs will offer AMHs performance incentive payments
Tier 4	3	<i>Will launch after Year 2</i>					<ul style="list-style-type: none"> • Practices responsible for care management as in Tier 3 • PHP payment models will need to meet state thresholds for amounts that the practice potentially owes or foregoes annually based on performance.

⁸ Contracts may exceed these minimum fees. Additionally, PHPs and practices in Tiers 1–3 are encouraged *at any time* to enter alternative payment methodologies including by taking on higher levels of accountability for quality and cost than specified above as minimums. The purpose of the staggered launch of Tier 4 is to gain further market input on the thresholds for an arrangement to be considered Tier 4.

Care Management Responsibilities

Participating practices will apply to the Department and demonstrate capabilities for one of four AMH tiers. A practice's care management responsibilities will vary by AMH tier. In AMH Tier 1 and 2 practices, PHPs will have primary responsibility for care management, and practices will be required to closely coordinate and interact with each PHP for which they have a contract. AMH Tier 3 is a more advanced phase for practices ready to take on care management responsibility, often as part of a system or CIN. PHPs will provide oversight for care management delivered in Tier 3 practices. Tier 4 is designed to capture the most advanced payment arrangements between practices and PHPs, and care management responsibilities at the practice level, as in Tier 3. Tier 4 will launch in Year 3 of managed care (July 2021–June 2022), which will allow time for development of standards related to payment arrangements, including downside risk tied to total cost of care. In the intervening time, alternative payment methodologies between PHPs and practices are encouraged in Tier 1, 2 or 3 practices.

Clinically Integrated Networks

Clinically integrated networks (CIN) will offer shared care management and data sharing functionality across multiple sites to support practices in meeting the AMH Tier 3 practice requirements. A CIN may be a health system or a voluntary network of independent providers. The Department anticipates that most, but not all, Tier 3 practices will be part of a CIN.

Practice Eligibility and Requirements

Practices will be eligible to participate in the AMH program if they are primary care practices as defined by the current requirements for participation in the Carolina ACCESS program.⁹ Prior to the launch of managed care, the Department will implement a centralized process for designating practices into the appropriate tier.

The Department welcomes feedback on the AMH practice eligibility requirements outlined below, particularly from providers and practices interested in entry into AMH Tiers 3 and 4.

Tiers 1 and 2 are designed to incorporate the Carolina ACCESS program requirements and payment models into a managed care environment, allowing providers the ability to operate in a manner similar to how they operate today, with the difference that they will need to coordinate with multiple PHPs that will assume primary responsibility for care management. To allow providers the ability to operate like today, the Department will hold the requirements for Tier 1 and 2 practices constant at the current Carolina ACCESS requirements for a transitional period encompassing the first two years after managed care is launched.¹⁰ Practices currently in Carolina ACCESS I will be grandfathered into AMH Tier 1, although they may alternatively choose to enter Tier 2 or 3. After the first two years, Tier 1 will phase out, and practices will be able to move to Tier 2, 3 or 4. As is the case today for Carolina ACCESS, providers may alternatively remain in-network for Medicaid without belonging to the AMH program, although AMH participation is encouraged.

Tier 3 is designed to be a more advanced tier for practices ready to take on care management responsibility in addition to the requirements in Tier 2. To successfully receive designation as AMH Tier 3, a practice must demonstrate that it is adequately equipped—either by itself or through participation in a CIN or health system—to perform care management for its population. In addition to requiring that AMH Tier 3 practices

⁹ As is the case today, some practices may overlap between being a Pregnancy Medical Home and a Carolina ACCESS provider, and thus eligible to be an AMH.

¹⁰ Carolina ACCESS standards include providing direct patient care at a minimum of 30 office hours per week; providing access to medical advice and services 24 hours a day, seven days per week; and providing referrals to other providers when the service cannot be provided by the PCP. The full set of standards can be found at <https://dma.ncdhhs.gov/providers/programs-services/community-care-of-north-carolina-carolina-access>.

meet the legacy Carolina ACCESS requirements referenced earlier, they must attest that they (or their CIN or health system) can conduct more sophisticated care management functions, including:¹¹

- Risk stratifying all patients in their panel;
- Providing targeted, proactive, relationship-based care management to all higher-risk patients;
- Providing short-term or transitional care management;
- Providing medication reconciliation support to targeted higher-risk patients;
- Ensuring patients with emergency department visits receive a follow-up interaction within one week of discharge; and
- Contacting at least 75 percent of patients who were hospitalized in target hospitals within two business days.

The above functions are based on the federal Comprehensive Primary Care Plus (CPC+) model that tests advanced primary care functions in nearly 5,000 primary care practices nationally and places special emphasis on practice-level care management. Prior to the launch of managed care, the Department may make modifications to these functions to ensure that they align with the specific needs of North Carolina's Medicaid population.

The Department will design a single attestation form for practices to attain the Tier 3 designation. Practices will be required to attest to their ability and willingness to deliver each of the Tier 3 functions and describe in detail their care management infrastructure (number and type of care management staff, data systems, etc.). Practices entering Tier 3 will be expected to either have devoted care management staff and infrastructure, or to be part of a CIN that centrally provides care management staff and population health management capabilities, including in-person, local-based forms of care management.

For practices that are part of CINs, the Department will certify individual practices rather than the CINs themselves. However, the Department will permit CINs to apply as one group on behalf of their individual member practices. Through this process, the Department can balance holding practices accountable for care management while acknowledging that CINs may serve as the mechanism for practices to deliver local care management to Medicaid enrollees in an efficient manner.

As a key mechanism to support local forms of care management, **the Department will require PHPs to contract with a large majority of AMH practices in each of their regions that have demonstrated advanced care management capabilities, with the minimum percentage to be defined in the PHP contract.** The Department is currently considering requiring PHPs to contract with 80 percent of Tier 3 practices in each region and welcomes feedback on this approach. Through the Department's withhold program,¹² PHPs will have an incentive to contract with more than this set percentage of AMH Tier 3 practices within each PHP region. The Department proposes that a significant portion of the PHP's first year withhold payments be tied to this requirement. The inclusion of these financial incentives will encourage PHPs to contract with as many certified AMH Tier 3 practices as possible and will give the Department a powerful lever to ensure that PHPs

¹¹ The CPC+ model of the Centers for Medicare & Medicaid Services (CMS) is an articulation of strong care management capacity at the practice level that has been tested in 14 states. The full set of CPC+ standards can be found on CMS's Center for Medicare and Medicaid Innovation's website at <https://innovation.cms.gov/Files/x/cpcplus-practicecareedlvreqs.pdf>.

¹² The Department will implement a PHP withholds program where a portion of each PHP's capitation rate is withheld and then paid back to the PHP when the PHP meets reasonably achievable performance targets.

delegate responsibility for care management to qualified practices and CINs. After the launch of Tier 4, the Department will plan to revise the minimum contracting requirement on PHPs to encompass Tier 3 and Tier 4.

The Department and PHPs will play a role in promoting accountability of AMH practices. As described earlier, the Department will oversee a central function by which practices are enrolled into standard tiers that will then equally apply across all PHP contracts. From the first year of managed care onward, the Department plans to continue to support a centralized process for tier placement, with the frequency of re-tiering to be determined. At the same time, PHPs will play a crucial frontline role in monitoring practice compliance with AMH requirements. If a PHP finds that a practice does not meet the requirements of the relevant tier, it may, with notice, place the practice in a lower tier for its PHP only. If the practice disagrees with this finding, it may appeal the decision through the PHP's provider appeal processes. PHPs will also be required to notify the Department if they move a practice to a lower tier.

Vision for Practice Requirements in Year 3 of Managed Care and Beyond

In the third year of managed care and moving forward, requirements for AMH Tier 2 practices will remain substantially the same. However, the Department may modify these requirements based on feedback from the AMH Technical Advisory Group, providers and other stakeholders. For Tier 3 practices, the Department will continue to set practice requirements building on the Carolina ACCESS and CPC+ requirements established in the two-year transitional period, **and will raise its expectations over time based on feedback from the AMH Technical Advisory Group, providers and other stakeholders.** AMH Tier 4 practice requirements and certification will be initially identical to Tier 3, but will allow for additional criteria related to alternative payment arrangements as described earlier.

Based on strong feedback from the field and low rates of adoption in North Carolina, the Department does not intend to switch to an accreditation-based system (e.g., NCQA, URAC, The Joint Commission) for recognizing AMH practices across any tiers.

AMH Payment Model

Today, Medicaid makes fee-for-service payments to Carolina ACCESS I and II practices. On top of the fee-for-service payment, Medicaid pays Carolina ACCESS I practices \$1 per member per month (PMPM) for their assigned enrollees and Carolina ACCESS II practices either \$2.50 PMPM (for most assigned enrollees) or \$5 PMPM (for assigned enrollees who are members of the aged, blind and disabled eligibility category). These fees compensate practices for maintaining a high degree of access for Medicaid patients and, in the case of Carolina ACCESS II, for participation with CCNC's care management and quality improvement programs.

To promote a smooth transition to managed care, the Department will set a standardized payment framework for AMH practices that will differ by tier and to which PHPs will be required to adhere. The Department will no longer make payments to practices; all payments will flow through PHPs. This framework will have the following four components, which are also displayed in Table 2 below.

- **Clinical Services Payments.** All AMH practices will continue to receive payments for clinical services provided to PHP members. PHPs will be required to comply with minimum rate floors set at the Medicaid fee-for-service levels for all physicians and physician extenders. PHPs and practices participating in their networks will be free to negotiate higher amounts or alternative payment arrangements.
- **Medical Home Fees.** In addition to reimbursement for clinical services, practices in all tiers will continue to receive payments from PHPs equivalent to today's Carolina ACCESS payments (see Table 1), known as "medical home fees." Like today's Carolina ACCESS fees, medical home fees will provide practices with stable funding for participation in PHP-led care management, care coordination, quality

improvement and population health activities. These fees will be fixed at Carolina ACCESS levels for at least the first two years of the program; although PHPs and practices participating in their networks will be free to negotiate higher amounts.

- **Care Management Fees.** Care management fees are additional non-visit-based payments available to Tier 3 practices in recognition of the more significant care management responsibilities these practices, either on their own or as part of a CIN or health system, will be performing on behalf of the PHP. Care management fee levels will be negotiated between PHPs and practices; however, PHPs will be required to report the level of care management fees paid under each contract.
- **Performance-based Payments.** In the first two years after managed care launch, PHPs will be contractually required to design and offer performance-based payments in Tier 3 only, and will be required to make only upside payments (though PHPs and providers will be permitted to enter into upside- and downside-arrangements). The Department will allow PHPs to offer performance-based payments in all tiers upon managed care launch, but in future years, the Department will require such payments, thus expanding the reach of value based payment (VBP) in the state. While the Department will require PHPs to base their performance-based payment designs on the standard AMH quality measure set (below), PHPs will have freedom to design their own benchmarking and weighting approaches to establish the relationship between quality measurement performance and provider performance-based payments, subject to the Department monitoring and review.

The Department will carefully monitor the market impacts of the AMH payment model during the first two years of the program to inform future policy.

All payment arrangements must be guided by the Health Care Payment Learning and Action Network (HCP LAN) Categories 2 through 4, which reflect levels of VBP,¹³ From year 3, Tier 4 will be reserved for PHPs and practices entering into alternative payment arrangements. Although arrangements in Tier 4 will be diverse, the Department will set minimum thresholds for the amounts that practices potentially owe or forego annually based on performance to be considered Tier 4.¹⁴

Table 2. Components of AMH Payment from PHPs, by Tier and Year of Managed Care Implementation

Tier	Clinical Services Payments		Medical Home Fees		Care Management Fees		Performance Based Payments	
	Years 1-2	Years 3+	Years 1-2	Years 3+	Years 1-2	Years 3+	Years 1-2	Years 3+
Tier 1	✓	n/a	✓	n/a		n/a	✓*	n/a
Tier 2	✓	✓	✓	✓			✓*	✓
Tier 3	✓	✓	✓	✓	✓	✓	✓	✓
Tier 4**	n/a	✓	n/a	✓	n/a	✓	n/a	✓

✓ = Required payment from PHP to AMH practice
 * = PHP is encouraged to offer payment, but is not required
 **= In tier 4, payment elements, at the discretion of practices and AMHs, may be combined into alternative payment arrangements that may change the balance or merge the payment components (e.g. partial capitation with a performance-based percentage)

¹³ Within the HCP LAN Alternative Payment Models Framework, Category 2 alternative payment models are fee-for-service with a “link to quality and value”; Category 3 alternative payment models are “built on fee-for-service infrastructure,” such as those with upside gainsharing and/or downside risk; and Category 4 alternative payment models are population-based payment models. For additional information about the HCP LAN Alternative Payment Models Framework, please see: <http://hcp-lan.org/workproducts/apm-whitepaper.pdf>.

¹⁴ In setting such thresholds, the Department is interested in aligning with MACRA’s definition of the “Medicaid Medical Home Model Nominal Amount Standard” to ensure that North Carolina providers who participate in both Medicare Advanced Alternative Payment Models and the AMH model can maximize the available payment incentives offered by CMS for so doing.

The Department welcomes feedback on the AMH payment model outlined above, particularly from providers and practices interested in entry into AMH Tiers 3 and 4.

Quality Measures

The Department will require PHPs to monitor the performance of AMHs in all tiers and calculate performance-based payments (for Tier 3 in Year 1 and all tiers in Year 3 and beyond). The Department will establish a common set of measures to form the basis for PHPs’ performance incentive programs and to monitor quality of care at AMHs, total cost of care and other performance measures. The quality measure set for AMHs will be based off a set of priority measures¹⁵ for PHPs, will be finalized six months prior to managed care implementation and will be updated annually. Table 3 displays the Department’s current thinking on possible performance measures for the first two years of managed care.¹⁶

Table 3. Sample Set of Proposed High-Level AMH Performance Measures for Years 1 and 2 of Managed Care

Measures Category	Sample Specific Measures
Measures Tied to Quality Strategy Objectives	<ul style="list-style-type: none"> • How people rated their personal doctor • Percentage of individuals with a mental health disorder, substance use disorder or I/DD with a primary care visit • Childhood immunization status • Well child visits in third–sixth years of life • Cervical cancer screening • Follow-up after hospitalization for mental illness • Comprehensive diabetes care, poor control • Medication management for asthma • Controlling high blood pressure • Medical assistance with tobacco cessation
Total Cost of Care	<i>Methodology to be defined in coming year</i>
Key Performance Indicators	<ul style="list-style-type: none"> • Emergency department utilization • Inpatient utilization • Readmission rates

Data Sharing

North Carolina recognizes that all practices participating in the AMH program, regardless of their tier, will periodically need access to multiple types of data to perform certain functions and manage population health.

AMH Tier 3 and 4 practices will have particularly robust data needs owing to their roles in delivering care coordination and care management in the community. To ensure that AMHs have sufficient data to support their care management efforts, PHPs will be required to share the following types of information with all AMH practices:

1. Assignment/attribution files identifying enrollees for whom the practice is accountable;
2. Results of PHPs’ risk stratification for attributed enrollees, including cost and utilization outliers;
3. Initial enrollee-level care needs screening data collected by PHPs;

¹⁵ Additional information on the Department’s vision for advancing quality and value-based care will be provided in a forthcoming concept paper to be released this spring.

¹⁶ This measure set will be refined and customized with input from the AMH Technical Advisory Group. Of note, customization will be required for pediatrics practices.

4. Enrollee-level summary information, including gaps, medication summaries and pertinent utilization events; and
5. Practice-level quality measure performance information.

The Department will include general requirements for furnishing items 1 through 4 in the PHP request for proposals (RFP) and resulting contracts, whereas PHPs will retain discretion regarding the format, structure, content and timelines for transmitting such information. The PHP RFP and contracts will also include requirements to furnish quality measure performance information (item 5), with the policy goal of ensuring that providers receive consistently specified and recognizable quality reports from all PHPs on an at least quarterly basis using the quality and efficiency measures defined by the Department. The Department will work with the AMH Technical Advisory Committee after managed care procurement to define how format, contents and timelines should be aligned across PHPs.

In addition to the requirements listed above, PHPs will be required to make timely enrollee-level claims and encounter data available to AMH Tier 3 and 4 practices, either directly or through CINs. This requirement is designed to facilitate the enhanced care management functional requirements and cost accountability of Tiers 3 and 4 in the AMH program. Finally, to encourage data transfer from PHPs to AMH practices, the Department is considering tying withholds to PHPs' demonstration of PHP-to-AMH data transfer. Post-PHP award, the Department will gather input from representatives from PHPs and selected providers to design a common encounter data format and expected timelines that all PHPs will be required to adopt for applicable Tiers 3 and 4 practices.

To ensure data security and the appropriate and effective use of the data, Tier 3 and 4 practices and the CINs acting on their behalf that seek access to enrollee-level claims and encounter data will need to demonstrate that they have the requisite 1) health information technology infrastructure, 2) data privacy and security policies, and 3) care management capabilities and processes. The Department will work with PHPs and providers to establish the minimum requirements for access to enrollee-level claims and encounter data, and while there will be a requirement for data sharing in common data specifications, PHPs will have several ways that they can meet this requirement.

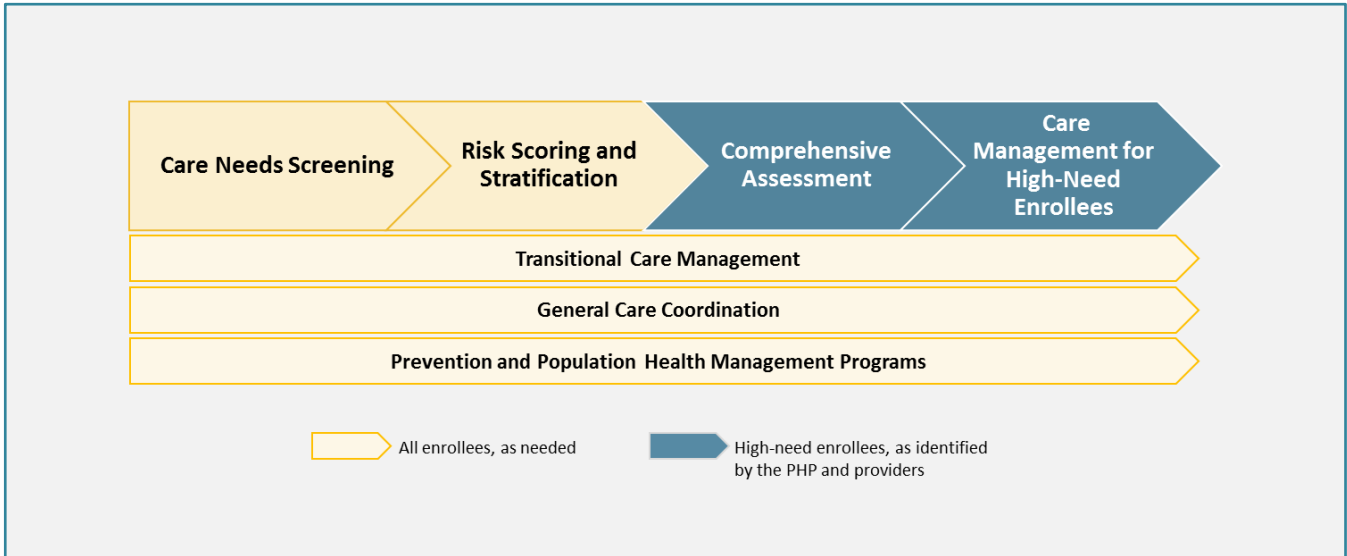
II. Defining and Delivering Care Management in the Context of Managed Care

As described earlier, PHPs will bear responsibility for care management, although in many cases care management will be performed by "designated care management entities" including higher-tier AMH practices and local health departments. Regardless of the extent of this delegation, care management will be guided by a unified framework, to be included in PHP procurement, that encompasses the Department's expectations for:

- Coordination of care and disease management for all enrollees;
- Identification and assessment of members of "priority populations" through:
 - Care needs screenings;
 - Risk scoring and stratification; and
 - Comprehensive assessment;
- Delivery of care management to high-need populations; and
- Delivery of transitional care management for enrollees in transition between settings.

This section describes the policies that North Carolina has developed to ensure that PHPs, either directly or through delegation with oversight, meet all enrollees’ care management needs. Special programs for high-risk pregnant enrollees and at-risk young children are covered separately in *Section IV. Accountability for Care Management*.

Figure 3. Care Management Process Flow



Coordination of Care and Disease Management for All Enrollees

While care management will be focused on populations with significant needs (described in more detail next), **all** PHP enrollees will have a specific person or designated care management entity responsible for coordinating their services, including follow-up on referrals, coordination across types of providers (e.g., physical and behavioral health, primary care and specialty care), and coordination with community and social support providers. PHPs must provide information and dedicated staff support, such as community health workers, social workers or other types of staff, to link enrollees with the local community resources and social services necessary to meet any identified unmet resource needs related to social determinants of health. When an enrollee transitions between delivery systems (for example, from fee-for-service to managed care or from an LME-MCO to a PHP), PHPs will provide coordination to ensure services are not interrupted during the transition and that the new managed care entity has access to relevant prior screenings.

In addition, PHPs will also offer disease management programs to address enrollees’ ongoing health needs and those that are in alignment with the North Carolina’s Quality Strategy,¹⁷ such as diabetes, asthma, obesity, tobacco use, hypertension management and opioid abuse programs.

¹⁷ Additional information on the Department’s vision for advancing quality and value-based care will be provided in a forthcoming concept paper.

Identification and Assessment of “Priority Populations” for Care Management

Care management begins with robust processes to identify patients who will most benefit from it. The Department has defined a set of priority populations for care management:

- Enrollees with LTSS needs;
- Adults and children with “special health care needs,” a category that includes enrollees with HIV/AIDS¹⁸ (see box);
- Enrollees at rising risk;
- Enrollees with high unmet resource needs related to social determinants of health; and
- Any other priority groups identified by the PHP.

PHPs (or their designated care management entities, as described earlier) will identify members of these priority populations through a combination of screening, analysis and assessment. Additionally, the Department will explore opportunities for providing PHPs with initial data support to facilitate efficient startup of PHP care management activities.

- **Care Needs Screening:** Aligning with federal regulations, PHPs will be required to make best efforts (at least two contact attempts) to screen **all** enrollees for their care needs within 90 days of enrollment.¹⁹ While PHPs will use their own tools to perform screenings, the Department will define standard questions relating to core social determinants of health.
- **Risk Scoring and Stratification.** PHPs will each bring methodologies by which they identify enrollees at risk, using a combination of claims analysis and clinical, screening and other data. Typically, such methodologies will feed a proprietary risk stratification and scoring system for each PHP. PHPs will be responsible for using their methodologies to identify members of the priority populations. While the

SPECIAL HEALTH CARE NEEDS

Federal regulations require states to identify Medicaid managed care enrollees with special health care needs. For each of these enrollees, managed care plans are required to perform a comprehensive assessment to determine “any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring.” A state may also choose to require that managed care plans develop treatment/service plans for enrollees with special health care needs. (42 CFR 438.208)

States have the flexibility to establish their own definitions for enrollees with special health care needs. North Carolina is defining populations with special health care needs as follows:

- **Adults with Special Health Care Needs.** Adults who have or are at increased risk of having a chronic illness and/or a physical, developmental, behavioral or emotional condition and who also require health and related services of a type or amount beyond that usually expected for individuals of similar age. These include but are not limited to individuals with HIV/AIDS; a serious mental illness, I/DD or substance use disorder diagnosis; chronic pain; and those who are receiving 1915(b)(3), Innovations or TBI waiver services.
- **Children with Special Health Care Needs.** Children who have or are at increased risk of having a serious or chronic physical, developmental, behavioral or emotional condition and who also require health and related services of a type or amount beyond that usually expected for the child’s age. These include but are not limited to children or infants in foster care; requiring care in a neonatal intensive care unit; with neonatal abstinence syndrome; in high-stress social environments/toxic stress; receiving early intervention; with a serious emotional disturbance, intellectual/developmental disability or substance use disorder diagnosis; and/or receiving 1915(b)(3), Innovations or TBI waiver services.

¹⁸ At the launch of managed care, North Carolina will fully transition responsibility for HIV care management to PHPs. PHPs may choose whether to contract with current HIV care management providers as designated care management entities.

¹⁹ 42 CFR 438.208(3).

methodologies and tools will predominantly be designed by the PHPs, the Department will monitor them to ensure that priority populations are being adequately identified.

- **Comprehensive Assessment.** The most intensive stage of the identification and assessment process is the comprehensive assessment. Within 30 days of an enrollee being identified as part of a priority population, PHPs will be required to perform this assessment to identify whether care management is required and, if so, the enrollee's needs. Enrollees with LTSS needs and those requiring higher levels of care management for behavioral health needs or an I/DD (e.g., those individuals eligible for a BH I/DD TP, but who choose to stay in standard plans) will automatically be determined as requiring ongoing care management.

SOCIAL DETERMINANTS OF HEALTH IN CARE MANAGEMENT

In addition to being required to use care management and care coordination to address physical and behavioral health, PHPs will be required to address beneficiaries' unmet resource needs related to social determinants of health (SDOH). PHPs will be responsible for helping address these needs within four Department-identified priority domains: food, housing, transportation and interpersonal safety/toxic stress. Strategies to address SDOH have been embedded in five elements of the Department's care management model:

1. **Gathering enrollee information.** PHPs will be required to include standardized questions that address the four priority SDOH domains in the Care Needs Screening.
2. **Enrollee stratification.** PHPs must consider enrollees with high unmet resource needs related to social determinants of health a priority population as part of the risk scoring and stratification methodology.
3. **Conducting comprehensive assessments.** PHPs must ensure that the comprehensive assessment gathers information on the unmet resource needs of beneficiaries across the four priority SDOH domains.
4. **Care management for high-need enrollees.** For individuals identified as having high unmet resource needs and eligible for care management services, PHPs must help address unmet resource needs through various strategies, including having a comprehensive understanding of local community-based resources, offering in-person help securing health-related services that can improve health and family well-being, providing access to a housing specialist for homeless beneficiaries, and providing access to medical-legal partnerships for legal issues adversely affecting health, subject to availability and capacity.
5. **General care coordination for other enrollees.** For beneficiaries who do not require intensive care management services, PHPs will be responsible for coordinating services provided by community and social support providers and linking beneficiaries to community resources and social supports.

Additional detail on North Carolina's strategies to address social determinants of health in its Medicaid managed care program is forthcoming in a separate concept paper.

Delivery of Care Management to High-Need Populations in Standard Plans

“High-need populations” are members of priority populations identified as in need of care management. North Carolina recognizes that PHP enrollees with significant medical, behavioral and/or social needs will benefit from high-intensity care management, including regular face-to-face visits with a care manager who is based locally, when possible. All enrollees requiring high-need care management will be assigned a care manager. Within 30 days of the comprehensive assessment, the care manager will complete a care plan identifying the services and supports that the enrollee requires, identify and coordinate with the member’s care team, and initiate care management to ensure that the enrollee accesses needed services.²⁰

While care management is individualized, the Department will require that all care managers conduct medication reconciliation, follow-up on referrals, peer support, training on self-management and any transitional care management required for a high-need enrollee. In addition, high-needs care management must include interventions targeted toward addressing enrollees’ unmet resource needs, such as by ensuring enrollees receive in-person assistance to secure health-related services like food or transportation, connecting homeless enrollees to housing specialists or ensuring access to medical-legal partnerships to address legal issues adversely affecting health.

For all enrollees receiving high-needs care management, PHPs and care managers, respectively, will re-administer the comprehensive assessment and update the care plan at least annually, when an enrollee’s circumstances or needs change significantly, or at the enrollee’s request. Should the care team determine based on the re-assessment that the enrollee no longer requires a course of treatment or regular care monitoring, PHPs will develop processes to close out care management, including a clear enrollee notification process.

CARE MANAGEMENT FOR ENROLLEES WITH LTSS NEEDS

North Carolina will comply with all federal requirements related to care coordination and care management for populations with LTSS needs, and will ensure that appropriate protections for populations that need LTSS are built into North Carolina’s care management strategy. At a minimum, care management requirements for populations with LTSS needs will include:

- **Comprehensive Assessments and Person-Centered Care Plans.** North Carolina will require that all PHPs use a standardized set of questions or assessment tool to comprehensively assess individuals requiring LTSS. Based on the results of the comprehensive assessment, DHHS will require PHPs to develop person-centered care plans for all enrollees who need LTSS.
- **Care Managers.** North Carolina will require PHPs to adhere to minimum, State-developed care-manager-to-enrollee ratios for enrollees with LTSS needs. Care managers for enrollees with LTSS needs will be required to have, at a minimum, a Bachelor’s degree in social work or a related human services field and two years of prior experience in LTSS and/or home- and community-based care coordination, care delivery monitoring and care management, and in social work, geriatrics, gerontology, pediatrics or human services. In addition, PHPs will be required to train care managers serving enrollees with LTSS needs in person-centered needs assessment and care planning related to LTSS populations, execution of comprehensive assessments of enrollees, transitional care management, cultural competency, independent living, and motivational interviewing or comparable training.

²⁰ Potential care team members may include the enrollee, his/her caretaker, the PCP, the behavioral health provider(s), specialists and/or a pharmacist.

Transitional Care Management

When an enrollee transitions from one setting to another, such as from the hospital back to the community, PHPs or local care management entities will provide transitional care management to prevent unplanned or unnecessary readmissions, emergency department visits or adverse outcomes. Certain higher-risk transitions—such as a discharge from an inpatient stay of more than two weeks, discharge from inpatient behavioral health services or discharge from the neonatal intensive care unit—will trigger higher-touch transitional care management. Coordination during transitions will include facilitation of clinical handoffs, medication reconciliation, confirmation that follow-up visits are scheduled and occur, and contact with the assigned care manager within 48 hours of discharge.

Care Manager Training and Qualifications

The Department is setting baseline expectations for care manager training and qualifications. Care managers must have competency in areas including:

- Person-centered needs assessments and care planning;
- Motivational interviewing;
- Self-management;
- Trauma-informed care;
- Cultural competency; and
- How to address unmet resource needs, including social supports and resources available in an assigned enrollee's community.

Training and qualifications for care managers will vary based on the populations being managed. Care managers who are assigned to manage enrollees with LTSS and/or behavioral health needs will be required to obtain additional specialized training on topics such as independent living or behavioral health crisis response to ensure they are able to serve the unique needs of these populations.

III. Care Management Programs for High-risk Pregnancy and At-risk Children

Currently, North Carolina provides care management for women experiencing high-risk pregnancies and at-risk children through a suite of locally run programs—the Pregnancy Medical Home (PMH)/Obstetric Care Management (OBCM) programs and the Care Coordination for Children (CC4C) program. Local health departments have long played a crucial role in the provision of care and case management services in PMH/OBCM and CC4C programs. Community Care of North Carolina (CCNC) and the Department provide programmatic oversight, evaluation and training for both programs, including convening of clinical leaders for the PMH program. As North Carolina transitions to managed care, the Department intends to preserve key components of these programs in the first several years, while introducing opportunities for PHPs, local health departments, PMHs and AMHs to offer innovations that improve outcomes.

With the launch of managed care, PHPs will assume responsibility for care management for women experiencing high-risk pregnancies and for at-risk children. When managed care is implemented, all funding related to the provision of high-risk pregnancy care and services for at-risk young children will be included in the capitation payments to PHPs. As described further below, in the first two years of managed care, PHPs will be required to contract with willing local health departments to provide care management services for both

populations. Key components of both care management models will remain in place, including the convening of providers to share best practices and support individual practices' efforts to improve outcomes.

The Department will play a clinical leadership role in the continuation of these programs. As noted previously, the Department will establish a state-level clinical leadership body dedicated to advising across a number of clinical areas, including high-risk pregnancies and at-risk children. The clinical leadership body will be responsible for making recommendations on treatment guidelines and quality measures, and will work to build on and strengthen the existing programs. For pregnancy and at-risk children programs, the Department will include participants from leading clinical providers and, as applicable, social services providers, to inform programmatic changes over time.

High-Risk Pregnancy Care Management

Pregnancy Medical Home Transition

Launched in 2011, the PMH program provides comprehensive, coordinated maternity care to pregnant and postpartum women, with a special focus on preterm birth prevention. All providers who bill for perinatal services are eligible to enroll in the program.²¹ Currently, more than 90 percent of all perinatal care provided to pregnant Medicaid patients in North Carolina is through a PMH.²²

Recognizing the importance of maintaining these providers as crucial access points and the impact PMHs have had on improving outcomes for high-risk women, the Department will require that many components of the PMH program stay in place during the transition to managed care, while allowing PHPs to phase in their own additional programs intended to improve outcomes.

Specifically, PHPs will be required to incorporate a minimum set of existing PMH requirements into their contracts with providers who offer pregnancy services. These requirements include:

- Ensuring that no elective deliveries are performed before 39 weeks of gestation;
- Decreasing the cesarean section rate among nulliparous women;
- Completing a Department-specified high-risk screening on each pregnant Medicaid enrollee in the program and integrating the plan of care with local care management; and
- Cooperating with open chart audits.

The Department seeks to align payment with improved outcomes through continuing the current incentive payment structure. To maximize stability for providers, the Department will require that PHPs pay providers the current levels of PMH incentive payments through the end of the first year of managed care, which are (1) completing a standardized risk-screening tool at initial visit (\$50), and (2) conducting a postpartum visit (\$150).²³ The Department recognizes that there is room for PHPs to build on the current PMH incentive program to more closely tie payments to clinical outcomes and patient risk. Therefore, during the first year of managed care, the Department will work with PHPs and providers to design the parameters by which PHPs will be permitted to offer their own incentive structures for PMH providers in the mid- to long-term. The

²¹ The program includes obstetricians, general/family practitioners, federally qualified health centers (FQHCs), nurse practitioners, nurse midwives and others. Any provider who bills global, package or individual pregnancy procedures can participate in the PMH program.

²² Accessed at <http://www.ncmedsoc.org/wp-content/uploads/2016/03/NCOGS-Medicaid-Reform-Talking-Points-Mar-29-2016.pdf>.

²³ In the first year of managed care, PHPs must adhere to this payment structure but will be free to layer on additional incentive payments.

Department will convert the current rate bump for vaginal deliveries into the permanent fee-for-service rate floor.

Similar to today, in managed care, PMH providers will continue to use a standardized screening tool,²⁴ refer high-risk pregnant members for care management services and be provided with care management support through the OBCM program, as described later. Currently PMH providers also have access to practice supports, which assist individual practices in achieving pregnancy outcomes and provide additional opportunities to convene and discuss best practices, programmatic improvements and clinical models. Practice supports will continue to be available under managed care.

Pregnancy Care Management Transition

Since 1987, local health departments have provided multi-disciplinary care management to pregnant and postpartum Medicaid enrollees identified as being at high risk of a poor birth outcome. The care management model consists of education, support, linkages to community and health-related resources, and services and management of high-risk conditions that may have an impact on birth outcomes. With the managed care transition, North Carolina intends to build upon the program's successes in delivering care management locally and with PMH providers.

At managed care launch, PHPs will be required to contract with local health departments to provide OBCM services at similar payment levels as today, and will be offered the right of first refusal in each geographic area in which they operate. Contracting directly with a local health department will count toward the PHP's requirement to deliver care management services locally. If a local health department chooses not to provide OBCM services,²⁵ PHPs will be responsible for providing OBCM functions at the local level. To support local health departments, PHPs will be responsible for developing or procuring an electronic care management system of record that will allow OBCM staff to document activities and allow for communication between PHP and OBCM staff.

Local health departments electing to provide OBCM services moving forward will be responsible for the oversight and provision of services locally, which may include interfacing with multiple PHP information systems, taking data and reports from multiple PHPs, and assigning patients to OBCM staff.²⁶ If a local health department is underperforming based on mutually agreed-upon metrics, PHPs will notify the local health department about the area of underperformance. If underperformance continues, a PHP may terminate its agreement with a local health department for the provision of OBCM services, with the local health department having appeal rights to the PHP.

During a transitional period of the first two years of managed care, the Department will monitor the performance of the OBCM program and consult with stakeholders to generate recommendations on the longer-term delivery of high-risk pregnancy services under managed care.

In future years, the Department aims to move toward a more market-driven approach for delivering OBCM services, through which local health departments will compete with other care management entities to provide these services. The market-driven approach will include accountabilities of adequate and services in

²⁴ PHPs will be required to adopt the PMH standardized screening tool currently used in PMH practices, with modifications to reflect the transition to managed care.

²⁵ Local health departments opting not to offer OBCM services will still be permitted to contract with PHPs for the provision of medical services for Medicaid beneficiaries.

²⁶ If a local health department were part of a CIN and was using that CIN's care management platform, it is possible that the local health department could integrate care management information for all patients across a single platform in a manner similar to Tier 3 and 4 AMHs.

rural areas. High-performing local health departments will be well positioned in this environment since they can help PHPs meet targets for local delivery of multi-disciplinary care management, especially in rural areas, and will have established relationships with PHPs.

At-Risk Young Children

The CC4C program—a care management program for at-risk young children ages zero to five—provides coordination between health care providers, linkages and referrals to other community programs and supports, and family supports. Local health departments have been providing care management services to at-risk infants and children since 1989. Recognizing that CC4C serves a crucial role for at-risk children and that there is a need for stability for at-risk children during the transition to managed care, North Carolina intends to require that PHPs maintain the program during the first two years of managed care, while working with stakeholders on recommendations for long-term integration of programs addressing adverse childhood experiences and the social determinants of health for children of all ages in managed care.²⁷

In the first two years of managed care, PHPs will be required to contract with local health departments at similar payment levels as today to provide CC4C services. For most of the population, CC4C eligibility criteria will remain the same. However, PHPs will be responsible for very medically complex high-risk children. Similar to OBCM, local health departments will have right of first refusal for CC4C services; if they elect to retain responsibility for this function, they will be responsible for using PHPs’ electronic care management platforms, assigning enrollees to CC4C staff for service coordination and providing program oversight. Also similar to OBCM, PHPs will have the ability to terminate underperforming local health departments, and if termination occurs, local health departments will have appeals rights.

After the first two years of managed care, the Department intends to give PHPs the flexibility to use a competitive procurement process to select an entity or entities to provide CC4C services. As in the OBCM program, the Department expects that high-functioning local health departments will be well positioned to compete to provide CC4C services in the future environment. PHPs will have an incentive to contract with local health departments since they will help PHPs meet requirements for a minimum percentage of local care management.

The Department welcomes feedback on the transition of PMH, OBCM and CC4C programs.

IV. Accountability for Care Management

Moving forward, PHPs will be important partners in advancing the Department’s quality strategy²⁸ and, in turn, improving outcomes for enrollees. Key provisions of this strategy will include:

- **PHPs reporting on a mandated set of quality measures, tied to Department quality goals.** PHPs will be required to report measures and develop quality improvement programs tied to those measures. PHPs will be held financially accountable for achieving changes in quality outcomes through withholds.
- **Linking quality improvement targets to provider payments.** As mentioned previously, PHPs will also be required to develop performance incentive programs for providers and hit early value-based purchasing

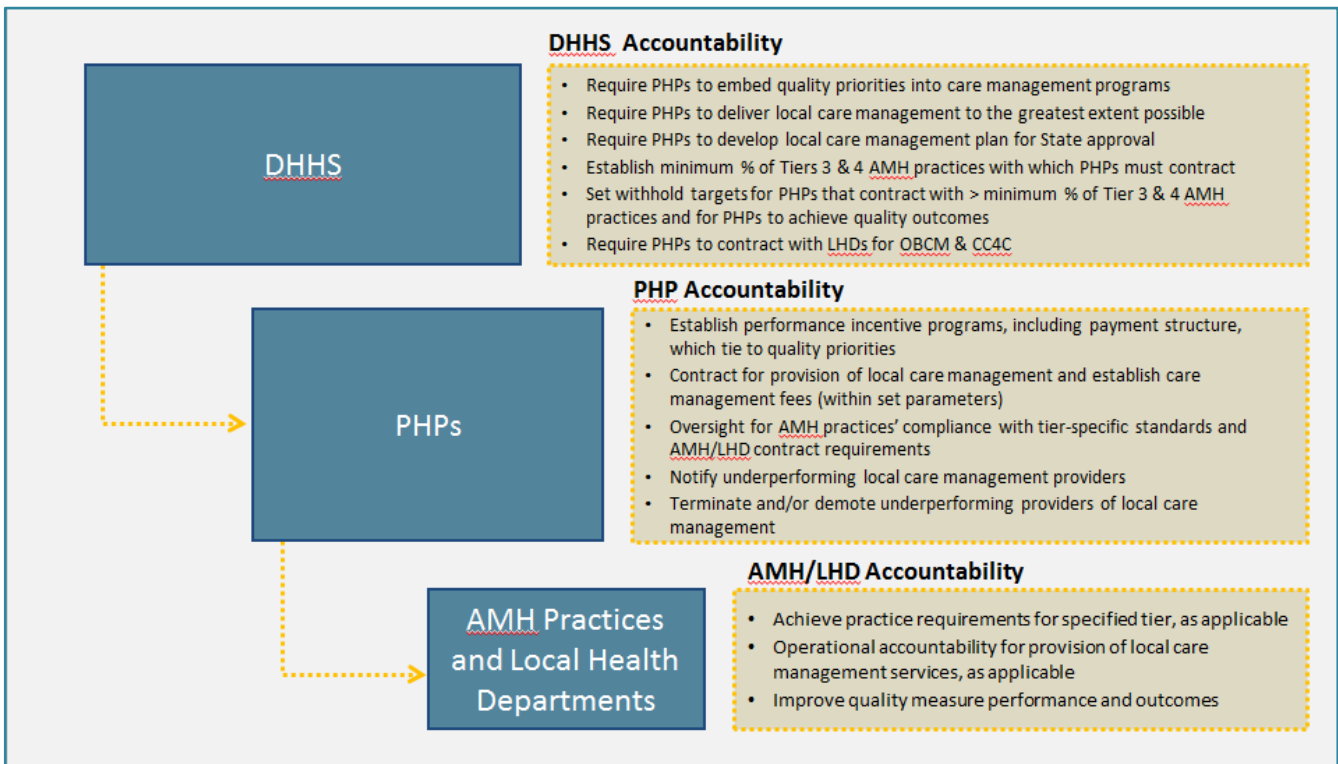
²⁷ Children, such as foster children, who will not be enrolling in managed care during the first two years will be eligible to receive CC4C services through the fee-for-service program, similar to today’s model.

²⁸ Additional information on the Department’s vision for advancing quality and value-based care will be provided in a forthcoming concept paper.

targets. Both initiatives will allow providers to share in the financial benefits of improved quality outcomes.

The PHP's care management program is a key component of the plans' ability to move the dial on delivery of high-quality care. Notably, when PHPs are held accountable for outcomes, they, in turn, work to strengthen care management programs and provider relationships (and incentive programs) to ensure that outcomes can be improved. The importance of this broader continuous quality improvement mechanism places emphasis on ensuring that the care management program has appropriate accountability at all levels.

Figure 2. Structure for Accountability for Care Management



As described throughout this paper, the Department will place parameters around how PHPs will structure care management, with special emphasis on ensuring that care management is delivered to the greatest extent possible at a local level. The Department will require PHPs to contract with a minimum percentage of AMH Tiers 3 and 4 practices in their regions, and will incent PHPs to contract with more than this minimum threshold. PHPs will play a crucial monitoring and oversight role for the AMH practices and will be responsible for monitoring each practice's compliance with tier-specific requirements. If a PHP determines that a practice is not meeting requirements for its tier, it will have the ability to move the practice to a lower tier.

The designated care management entities themselves are, in turn, accountable to PHPs. AMH practices, as the front-end providers of care management, have accountability for achieving Department-set tier mandates. Tier 3 AMHs will have responsibility for the local provision of care management services, including deployment of trained care management staff, as appropriate, and most likely within the context of a CIN. Additionally, AMH practices will be required to work toward achievement of quality measures and, eventually, will be financially tied to performance against quality goals and targets. As part of delivering care management locally, PHPs will also contract with local health departments providing OBCM and CC4C services. Participating local health departments will be held to a minimum set of standards related to data sharing, implementation and use of PHPs' electronic care management platforms, and staff training. If a local health department continually underperforms, the PHP will have the ability to terminate its contract with that local health department.

V. Next Steps

The Department is eager to continue to engage with stakeholders as it refines its care management approach and begins operational planning. The Department expects that providers, potential PHPs, enrollees and advocacy groups will play an important role in this planning process to ensure a smooth, high-impact rollout of the care management strategy at managed care implementation.

North Carolina will continue to plan its stakeholder engagement strategy for managed care launch. Recognizing that stakeholder input is crucial to the success of the AMH program, the Department will convene an AMH Technical Advisory Group of Department staff, existing medical home providers, PHPs (once awarded), and other experts and stakeholders. The advisory group will be tasked with providing recommendations on AMH quality measures, the market impact of the AMH program and the evolution of practice requirements by tier over time. The Department will also continue to plan for its clinical leadership role in a managed care environment to include provider, PHP and other stakeholder representatives, and to be launched in advance of implementation.

Appendix: Estimated Comprehensive Managed Care Enrollment by Cohort Based on the Department’s Proposed Phase in Schedule

POPULATION COHORT WITH PROPOSED TIMING FOR COMPREHENSIVE MANAGED CARE ENROLLMENT	BENEFICIARIES BASED ON SFY 2016 HISTORICAL ENROLLMENT		
	Estimated Average Beneficiaries by Group	Estimated Average Beneficiaries by Cohort	Cohort as Percent of Total Beneficiaries
Year 1: Standard Plan - Aged, Blind, Disabled	140,000	1,525,000	73%
Year 1: Standard Plan - All Other	1,385,000		
Year 3: Tailored Plan - Non-Duals	85,000	135,000	6%
Year 3: Tailored Plan - Duals	27,000		
Year 3: Foster Children	23,000		
Year 5: Non-Dual LTSS	5,000	217,000	10%
Year 5: Full Duals (Non-TP)	212,000		
Excluded: Family Planning	103,000	208,000	10%
Excluded: Medically Needy	23,000		
Excluded: Other	82,000		
Total	2,085,000	2,085,000	100%

Source

Exhibit prepared Feb. 8, 2018, by the Department’s Division of Health Benefits based on [“Population Profiles,”](#) released Nov. 9, 2017, and available on the Medicaid website at ncdhhs.gov/medicaid-transformation.

Notes

- Estimates are based on SFY 2016 historical experience and do not include projected enrollment growth.
- Timing for managed care enrollment is proposed and subject to change.
- Tailored plan population estimates are subject to change based on legislation and data availability.
- “Non-dual LTSS” includes CAP/C, CAP/DA and individuals with a nursing facility stay of 90 days or more.
- “Excluded: Other” is primarily comprised of partial dual eligible enrollees.
- See source documentation for calculation methodology, assumptions and limitations.