NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Division of Health Benefits | NC Medicaid

Program Guide

Management of High-Risk Pregnancies and At-Risk Children in Managed Care

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Contents

I. Introduction

On July 1, 2021, the Department was mandated under NC Session Law 2015-245, Session Law 2018-48, and SessionLaw 2020-88 to transition most Medicaid and NC Health Choice members to fully capitated and integrated plans called Standard Plans[1]. The majority of Medicaid enrollees, including adults and children with low to moderate intensity behavioral health needs, now receive integrated physical health, behavioral health, and pharmacy services through Medicaid Managed Care.

The Cherokee Indian Hospital Authority (CIHA) contracted with the North Carolina Department of Health and Human Services to support the Eastern Band of Cherokee Indians (EBCI) in addressing the health needs of American Indian/Alaskan Native Medicaid members. This Indian Managed Care Entity is the first of its kind in the nation and established a new delivery system called the EBCI Tribal Option.

The EBCI Tribal Option is a managed care option for federally recognized tribal members and other individuals eligible to receive Indian Health Service, under 42 CFR 438.14(a). The EBCI Tribal Option launched in July 2021 alongside Standard Plans. The EBCI Tribal Option manages health care for Medicaid members residing primarily in Cherokee, Graham, Haywood, Jackson, and Swain counties and neighboring counties. The program has a strong focus on primary care, preventive health, chronic disease management, provides care coordination for all members, and ensures access to care management for members with high medical, behavioral, social, or resource needs. The EBCI TribalOption coordinates all medical, behavioral health, and pharmacy services in the North Carolina Medicaid and NC Health Choice State Plans, including monitoring the quality of services offered.

The information included in this program guide refers to care management services for at-risk children and high-risk pregnant members who are enrolled in Standard Plans or EBCI Tribal Option, or Indian Health Services (IHS) eligible. Standard Plan members will receive care management services through Local Health Departments (LHDs) or other entity that is providing local care management services. Tribal and IHS eligible Members enrolled in the EBCI Tribal Option will receive care management services through the EBCI Tribal Option. Tribal and IHS eligible Members enrolled in Standard Plans may choose to have their care management service delivered by the EBCI Tribal Option.

Medicaid Programs for Pregnant Members

NC Medicaid offers obstetrics coverage for all Medicaid members, as well as locally administered care management services for members at risk for adverse birth outcomes. Historically, these programs were referred to as the Pregnancy Medical Home (PMH) and the Pregnancy Care Management (OBCM) program. These programs operated through an administrative and technical infrastructure that linked together providers, CIHA, LHD, Community Care of North Carolina (CCNC), the Department of Health and Human Services (the Department).

The delivery of high-quality obstetric care and care management for members at-risk for adverse birth outcomes in North Carolina is a paramount concern for the Department. During the transition to managed

[1] Full text of SL 2015-245 is available at: https://www.ncleg.gov/EnactedLegislation/SessionLaws/HTML/2015-2016/SL2015- 245.html
Full text of SL 2018-48 is available at: https://www.ncleg.net/EnactedLegislation/SessionLaws/HTML/2017-2018/SL2018- 48.html
Full text of SL 2020-88 is available at: https://www.ncleg.gov/EnactedLegislation/SessionLaws/HTML/2019-2020/SL2020-88.html

care in North Carolina, existing specialized programs for eligible pregnant members (OBCM and PMH) experienced some changes to adapt with the new delivery model.

The PMH and OBCM programs were designed with significant leadership from clinicians across the state. The PMH program, for example, is the result of input from the obstetrics community, working in conjunction with CCNC and the Department. North Carolina's LHDs have a long history of providing services to assist many pregnant and postpartum individuals. LHDs have provided care management to pregnant Medicaid members identified as being at high risk of a poor birth outcome through Maternity Care Coordination (MCC) (1988-2011) and OBCM (2012-2019) and CMHRP (2019-current). The care management model has consisted of education, support, linkages to other services, management of high-risk behavior and response to social determinants of health (SDOH) that may have an impact on birth outcomes. Medicaid recipients identified as having a high-risk pregnancy were assigned a Pregnancy Care Manager to coordinate their care and services through the end of the post-partum period.

Medicaid Program for At-Risk Children

North Carolina has a long history of offering care management services for at-risk children in the Medicaid program through locally administered care management programs. Up until Medicaid Transformation, the care management program for at-risk children was entitled Care Coordination for Children (CC4C). This program operated through an administrative and technical infrastructure that linked together providers, local health departments (LHD), Community Care of North Carolina (CCNC) and the Department of Health and Human Services (the Department).

Historically, the delivery of care management services for children in North Carolina has been a paramount concern for the Department. During the transition to managed care in North Carolina, the existing specialized program for at-risk children experienced some changes to adapt with the new delivery model[2].

The CC4C program was designed with significant leadership from clinicians across the state. The CC4C program, was the result of input from the pediatrics community, working in conjunction with CCNC and the Department, LHDs have provided care management to children who are Medicaid members and identified as being at high-risk through the High Priority Infant Tracking Program (1978-1989), Child Service Coordination (CSC) (1989-2011), Care Coordination for Children (CC4C) (2011-2019) and Care Management for At-Risk Children (CMARC) (2019-current). The care management model consists of education, support, linkages to other services, management of high-risk behavior and response to social determinants of health (SDOH) that may have an impact on health outcomes. Medicaid children identified as high risk are assigned a CMARC care manager to coordinate their care and services until identified needs are met.

The Department remains committed to providing a pathway for these programs as the state transitions completed into managed care.[2] The Department has a three-fold objective: (1) to continue to provide high- quality services to Medicaid children in close partnership with clinicians across the state; (2) to provide a pathway for current providers of these services and (3) to ensure a seamless transition of services for members into the managed care environment. The Department believes that the provision of

[2] North Carolina's Quality Strategy 2021 has specific objectives for promoting both child heath, development & wellness, and women's health (Objectives 3.1 and 3.2).

this care management service at the local level is the best approach and will continue to require health plans to exclusively contract with LHDs through the first four years of managed care (defined as the "transition period")[3]. Thereafter, LHDs and health plans will negotiate program terms through the regular contracting process.

Under NC Medicaid Managed Care, the Advanced Medical Home (AMH) program is the primary vehicle for delivering local care management. AMH providers fall into one of three tiers, with requirements and payments increasing as tiers (and associated responsibilities) increase. Under AMH Tiers 1 and 2, Health Plans retain primary responsibility for ensuring that beneficiaries receive appropriate care management services. AMH Tier 3 practices, however, assume primary responsibility for care management, delivered either directly or through a Clinically Integrated Network (CIN). AMH Tier 3 practices receive an additional Care Management Fee to provide this service to their assigned patients. CIHA, qualifying LHDs and OB/GYN providers who provide full primary care services per AMH policy and meet the requirements can be an AMH. Designation as an AMH does not preclude their participation in the PMP, CMHRP, and CMARC programs. Local health departments and providers that serve as Tier 3[4] AMHs and are part of the PMP, CMHRP and CMARC programs will be eligible for both incentive payments[5].

The names of these programs changed in the following manner:

- The PMH program name became the "Pregnancy Management Program" (PMP)
- The OBCM program became "Care Management for High-Risk Pregnancies" (CMHRP)
- Tribal At-Risk Pregnancy Program
- The CC4C program name became the "Care Management for At-Risk Children" (CMARC)

Throughout the remainder of the program guide, we refer to the programs under their new names to distinguish how program operations are functioning in managed care.

This program guide provides key information to OB/GYN providers, pediatricians, CIHA, LHDs, health plans and other interested stakeholders regarding population care management programs for at-risk children and high-risk pregnant Medicaid members. Detailed information includes the programmatic operations and expectations of providers, CIHA, LHDs, health plans and the Department.

[3] Year 1 of the transition period started when Medicaid transformation launched on July 1, 2021 and Year 4 will end June 30th, 2025.

[4] Health Plans are required to offer Tier 3 AMH practices incentive payments. Health Plans have the option to offer incentive payments to AMH Tier 1 and 2 practices

[5] To learn more about the AMH Program, refer to the Care Management Strategy under Managed Care concept paper and the AMH manual.

Summary of Program Services

	The Pregnancy Management Program (PMP)	Care Management for High-Risk Pregnancies (CMHRP) and Tribal CMHRP	Care Management for At-Risk Children (CMARC) and Tribal CMARC
Target Population	All pregnant Medicaid members	Pregnant Medicaid members identified as high-risk for adverse birth outcomes	Children ages 0 to 5 years enrolled in Medicaid who meet the identified target population requirements
Program Overview	A care program with a set of mandatory standards and clinical initiatives aimed at improving the quality of pregnancy care, improving maternal and infant outcomes and reducing health care costs. There is no enrollment requirement for the PMP. All providers eligible to bill NC Medicaid for obstetric services are considered participating PMP providers.	An intense,multi-disciplinary care management program for pregnantand post-partum members identified as being high-risk for adverse birth outcomes. CMHRP assists and supports high-risk pregnant members with navigation of prenatal andpostpartum care; as well as addressing barriers affecting their care and health.	A care management program for children, birth-to-five years of age, who have long-term medical conditions, are in long-term stressful situations (been exposed to adverse childhood experiences or adversely affected by social determinants of health), children in foster care, the Infant Plan of Safe Care and/or were in a Neonatal Intensive Care Unit (NICU). CMARC promotes the medical home model, linkage to community resources, provides support to families, and addressed barriers affecting the child's care and health, such as social determinants of health.
Accountable Entity	Health Plans or EBCI Tribal Option	Health Plans or EBCI Tribal Option	Health Plans or EBCI Tribal Option
Primary Service Provider	Local maternity care providers	CIHA or LHD	CIHA or LHD
Program Coordination	The Department	The Department	The Department

II. Managing High-Risk Pregnancies Under Managed Care

All pregnant members enrolled in managed care through the health plans receive a coordinated set of high-quality clinical maternity services through the PMP. This program is administered as a partnership between health plans, the EBCI Tribal Option, and local maternity care service providers (defined as any provider of obstetric services). A key feature of the program is the PMP's continued use of the standardized screening tool (known as the Pregnancy Risk Screening (PRS) form) to identify and refer members at-risk for an adverse birth outcome to CMHRP, a more intense set of care management services that will be coordinated and provided by CIHA or LHDs. Together, these two programs (PMP and CMHRP) work to improve the overall health of pregnant, postpartum, and newborn members across the state.

Overview of PMP

The Pregnancy Management Program (PMP) will continue its commitment to clinical excellence through the provision of comprehensive, coordinated maternity care services to pregnant members enrolled in the state's managed care program. The PMP encourages adoption of the best prenatal, pregnancy, and perinatal care for Medicaid beneficiaries. Unlike the PMH program, there is no enrollment requirement for the PMP. All providers eligible to bill NC Medicaid (Medicaid) for obstetric services are considered participating PMP providers. The following represents a summary of previous features of the PMH program that were transitioned into managed care:

- Provider participation requirements remain the same, although there is no longer a process to "opt in" to the program. All providers that bill global, packaged, or individual pregnancy services contract with health plans under standard contracting terms.

- Standard contracting provisions are included. The health plans incorporate program requirements aligned with the Pregnancy Management Program (PMP) into their contracts with all maternity care providers. The contracts include process requirements such as completing and submitting the standardized risk screening tool, and clinical outcomes measures, such as decreasing the rate of nulliparous cesarean delivery. The Appendix includes a listing of the program contracting requirements that will be included. Ongoing, the Department may update program requirements based on stakeholder feedback, program performance, or emerging service delivery needs.

- The provider incentive payment structure remains the same. Individual provider contracts with health plans incorporate an incentive payment structure that promotes high-quality outcomes and is no less than the rate floors established by the Department. The incentive payment structure has been expanded to three years based on stakeholder feedback.
    1. $50 for the completion of the standardized risk screening tool at each initial visit.
    2. $150 for completion of postpartum visit held within 84 days of delivery.

Additionally, providers will receive, at a minimum, the same rate for vaginal deliveries as they do for caesarean sections. In addition, providers will continue to be exempt from prior approval on ultrasounds. The health plans are permitted to offer additional innovative payment programs and incentives to providers beyond those required by the Department to promote quality pregnancy outcomes for their enrolled population. Providers and health plans may enter into innovative payment programs at their mutual consent.

- A standardized patient screening tool will be utilized to identify high-risk pregnancies. Providers are

required to adopt, administer and submit a State-designated screening tool, known as the Pregnancy Risk Screening (PRS) form, to identify high-risk pregnancies. The PRS form is standardized across the state and is the same screening tool previously used by providers enrolled in the PMH program. The PRS form will be reviewed and updated, as needed by the Department with input from the state-convened group. PMP providers are required to send the completed PRS form to CIHA or LHD within 7 business days of completing the screening. When CIHA or LHDs receive a PRS form indicating a need for CMHRP services, then member outreach must be conducted. Additional details are provided below; see "Outreach and Engagement" performance measure. Health plans are not permitted to require prior authorization for these services.

- Maternity care providers are required to coordinate outreach and care management efforts with the LHDs or CIHA for management of pregnant patients determined to be at high-risk of adverse birth outcomes. PMP providers are required to ensure appropriate coordination with CIHA or LHD care managersfor the sub-set of their practice population who receive CMHRP services.

- The health plans are required to collect and report on a series of quality measures to ensure high-quality maternity care. The health plans must provide regular reports as prescribed to PMP practices, on the following measures (assuming a valid sample size):
    1. Prenatal and Postpartum Care: NQF 1517[6]
    2. Live Births Weighing Less than 2,500

As part of public reporting requirements, the health plans will be required to calculate and share for each participating practice that receives an incentive payment the following measures:

1. Rate of high- risk screening as a function of the total pregnant population according to health plan data; and
2. Rate of post-partum follow-up within 84 days of delivery as a function of total pregnant population accordingto health plan data.

The health plans report directly to the Department on additional quality measures and metrics that impact women's health and maternity care. For a complete list of all measures refer to the PrepaidHealth Plan Quality and Accountability[7] concept paper.

[6] Additional measures may be added for practice-level reporting based on the final quality measure set for Year 1 of Managed Care.

[7] Provider Health Plan Quality Performance and Accountability: https://files.nc.gov/ncdhhs/documents/PHP-QualityPerformance-and-Accountability_ConceptPaper_FINAL_20180320.pdf

Overview of CMHRP

In addition to administration of the PMP program for all enrolled pregnant members, the health plans have contracted with CIHA or LHDs to administer care management services for recipients deemed as high-risk for adverse birth outcomes. Outreach for CMHRP services may be initiated based on information obtained from the PRS form (the standardized screening tool administered to all pregnant members in the PMP) and will be initiated based on the results of each health plan's risk stratification, as applicable. CIHA or LHD care managers may also utilize other available information to provide CMHRP services. As noted in Section II of this Program Guide, these more intensive care management services are currently provided by CIHA or LHDs. LHDs will exclusively provide these intensive care management services under managed care through June 30, 2025.[8] After this period, LHDs will no longer be exclusively contracted with the PHPs to provide CMHRP services while CIHA's at-risk programs will continue to be required to tribal IHS eligible individuals. The following represents a summary of key CMHRP program features:

- CIHA or LHDs will continue to provide intensive care management services. During the transition period, the health plans will be required to contract with CIHA or LHDs for provision of CMHRP services. If a CIHA or LHD is unable or unwilling to provide these services through a contract with a health plan, Section IV details steps the health plan must take to ensure care management is delivered locally.

- Referrals will be submitted to CIHA or LHDs for eligibility determination and prioritization for CMHRP services. Potential recipients will be identified for CMHRP program services through the following methods: directprovider referrals, community agencies (e.g., WIC, DSS), self-referral, risk screening and risk stratification (or other identification methods) of the health plans.

- The health plans are required to offer standard contracting terms to non-tribal providers. Plans will be required to honor tribal contracting as outlined by federal, applicable state, and tribal policy. The health plans incorporate a series of state and tribal standard program requirements into their contracts with all LHDs in the CMHRP program. These contracting terms will be inclusive of ongoing collaboration and integration between the LHDs and the health plans. These terms include requirements related to outreach, patient identification and engagement, assessment and risk stratification, and deployment of interventions. These contract terms ensure a smooth transition of services into the new managed care model under the health plans' administrative authority. The Appendix includes a listing of the program contracting requirements that will be included for the CMHRP program.

- Utilization Rate and Performance Measures for high-risk pregnancies**.** CIHA or LHDs will be responsible for a series of utilization and performance measures to ensure high-quality care management service delivery for pregnant members at highest risk for adverse birth outcomes. These utilization and performance measures will also be used to evaluate program outcomes.

  Utilization (Penetration) Rate

  - Percentage of pregnant women ages 14 to 44 years (until the end of the month of her 44th birthday) who are receiving CMHRP care management services.

[8] NC Medicaid extended existing PHP-LHD exclusive contracting requirements for CMHRP and CMARC for one year to June 30, 2025 (originally June 30, 2024). See Companion Program Updated for CMHRP and CMARC Programs (July 13, 2023) for updated on contract changes and details on program oversight.

Performance Measures

- Outreach and Engagement: Members referred for care management will have a completed care management encounter with member OR 3 or more attempted encounters within 7 business days of referral.
- Active Care Management: Members engaged in care management will have a signed care plan within 15 days of engagement in CMHRP services.

The health plans will use these measures for overall monitoring purposes, including the CAP process as described in Section IV.

In addition to achieving the Utilization Rate and Performance Measures benchmark, CIHA or LHDs providing CMHRP services will be required to support health plan improvement on specific quality measures by closing care gaps and helping members engage in care. These quality measures include:

Quality Measures

- Low Birth Weight Births: Number of live, singleton births weighing <2,500 grams at birth in the CMHRPenrolled population during the measurement period.
- Timeliness of Prenatal Care: Number of members in CMHRP who received a prenatal care visit in the first trimester.
- Postpartum Care: Number of members in CMHRP who received a postpartum care visit between 7 and 84 days after delivery.

- Use of a standardized data platform for care management. CIHA or LHDs are required to use the standard documentation platform that is in existence today. CIHA or LHDs that operate as AMH Tier 3 providers may be permitted flexibility to use a separate platform.

- Coordination with other care management providers. The health plans or AMH Tier 3 providers will be responsible for care management services to the managed care population at large. To ensure coordination with CMHRP, the health plans will be required to alert CIHA or LHDs when members identified as high-risk for adverse birth outcomes are in care management within the health plan/ AMH Tier 3 practice. In addition, the health plans will be responsible for ensuring that the care management roles and responsibilities between the two entities are coordinated and do not overlap. The health plans are required to document in the member's health plan/AMH Tier 3 care plan(s), respective roles and responsibilities between the health plan/AMH Tier 3 practice and LHD. When a Medicaid member is receiving CMHRP services, the CMHRP care manager should take the care management lead. LHD care managers will be responsible for documenting roles and responsibilities in their standard documentation platform for instances where multiple care managers are serving the same enrollee to ensure that services are coordinated. If the LHD is serving a Tribal Option member, the LHD shall report activities to the Tribal Option as outlined in the agreement between the CIHA and the LHD.

- Payments to LHDs. The Department will ensure that all funding related to CMHRP is included in the capitation payment to the health plans. The health plan will be responsible for compensating contracted LHDs at an amount no less than the amount paid in the care management program prior to transition to Medicaid Managed Care. The health plans are permitted to introduce new payment models on top of the existing funding to further incentivize care management innovation.

III. Managing At-Risk Children Under Managed Care

The Medicaid program offers a set of care management services for at-risk children ages birth-to-five. The program promotes use of the medical home, links children and families to community resources and provides education and family support. Similar to the care management programs for pregnant women, responsibility for this population will be assumed by the health plans with requirements that the health plans contract with LHDs or CIHA for the provision of local care management services.

Overview of CMARC

The role currently played by LHDs in providing these key services will be continued and augmented in the managed care environment. The role of the Tribal CMARC aligns with the state's standards and the EBCI Tribal Option. The following represents a summary of key features of the CMARC or Tribal CMARC program:

- Role of CIHA or LHDs in providing services. During the transition period of managed care (July 2021-July 2025[8]), the health plans will be required to contract with LHDs for provision of CMARC services. The CMARC care management process assists the care manager in:
  - Assessing and identifying the child's needs
  - Developing & implementing a plan of care with the parent/guardian
  - Deciding on the frequency of contacts required to meet the child's and/or family's needs
  - Evaluating effectiveness of care plan and revising as needed.

  Tribal CMARC will be offered as an alternative option for federally recognized tribal members or HIS eligible in the approved counties.

- Referral criteria. The referral criteria includes the following target groups:
  - Child with Special Health Care Needs (CSHCN)
  - Infant in Neonatal intensive Care Unit (NICU)
  - Child experienced adverse childhood events including, but is not limited to:
    - Child in foster care
    - History of abuse and neglect
    - Caregiver unable to meet infant's health and safety needs/neglect
    - Parent(s) has history of parental rights termination
    - Parental/caregiver/ household substance abuse, neonatal exposure to substances
      - CPS Plan of Safe Care referral for "Substance Affected Infant"
    - EBCI Family safety*
    - Child exposed to family/domestic violence
    - Unsafe where child lives / environmental hazards or violence
    - Incarcerated family or household member
      - Parent/guardian suffers from depression or other mental health condition, maternalpostpartum depression
    - Homeless or living in a shelter/ Unstable housing
    - Other, please specify

  * Specific to Tribal CMARC referral criteria.

Situations meeting these referral criteria are detailed on the CMARC Referral form – see Appendix G.

- Referrals to CIHA or LHDs for services. Children will be identified for the CMARC program through the following methods:

- Direct provider referrals
- Hospital referrals
- Social service and support agency referrals (e.g., Women, Infants and Children [WIC], DSS)
- Direct referral by enrollees or families
- Risk stratification or other identification methods provided by the health plans or the EBCI Tribal Option
- Priority Patient and the Use of Care Impact Reports Guidance found in the CMARC Program Guidance

*** CMARC Program accepts all referrals from all community partners, including families who can make a self-referral

- Standard contracting terms. During the transition period of managed care, the health plan will be required to contract with LHDs for provision of CMARC using standard contracting terms. Plans will be required to honor tribal contracting terms as outlined by federal, applicable state, and tribal policy. The contract requirements include provisions related to outreach, population identification, family engagement, assessment and stratification of care management service levels, care plan development, integration with health plans and health providers, service provision, training, and staffing. Appendix C contains a detailed list of contract requirements.

- Process and quality measures for at-risk children**.**
  - **Performance Measures**: CIHA or LHDs will be responsible for three process measures to ensure high-quality care management for at risk children. These measures are processmeasures:
    1. **Utilization (Penetration) Rate**: Percentage of members ages 0 to 5 years that are in a CMARC Episode with a completed encounter (including email and text)
    2. **Outreach and Engagement**: Percentage of members referred for care management who had a completed care management encounter with member within 7 business days OR 3 or more attempted encounters within 7 business days of referral as the current CMARC Episode being opened
    3. **Active Care Management**: Percentage of members engaged in care management who had a care plan signed within 30 days of engagement in CMARC services.

These measures will be by the health plans to provide oversight, which could include the CAP process as described in Section IV.

  - **Quality Measures**: In addition to process measures, LHDs providing CMARC services will be required to support health plan improvement on specific quality measures by closing care gaps and helping members engage in care. These measures include:
    1. Well-Child Visits in the First 30 Months of Life: The percentage of children, enrolled in CMARC services ages 0-30 months who have received well-child visits as per the periodicity schedule.
    2. Child and Adolescent Well Visits: The percentage of children ages 3-5 years enrolled in CMARC services who have received well visits as per the periodicity schedule.
    3. Childhood Immunization Status (Combo 10): The percentage of children 2 years of age who received the recommended vaccinations for all members enrolled into CMARC services in the reported year.

- Use of a standardized data platform for care management, LHDs will be required to use the standard documentation platform.LHDs that operate as AMH Tier 3 providers may be permitted flexibility to use a separate platform. CIHA may use the approved TO platform for its at-risk programs.

- Responsibility for medically complex children and coordination with other care management services.
  - Health plans or AMH Tier 3 providers will be responsible for care management services to the managed care population at large.
  - Children with complex medical needs will be handled on a case-by-case basis with close coordination between the CMARC program and the health plan/Tier 3 AMH to establish care management roles and responsibilities.
  - The health plans will be required to alert LHDs when at-risk children identified by the LHD or a social service entity are in care management within the health plan/AMH Tier 3 practice.
  - If a child has complex medical needs or other needs best met by the health plans/Tier 3 AMH practices, then those entities will play the role of primary Care Manager, with the CMARC program providing support for social needs beyond the capacity of the health plan or Tier 3 AMH practice.
  - The health plans/Tier 3 AMH practices will designate a lead Care Manager and be the final arbiter of the roles and responsibilities' breakdown. If the CMARC care manager is currently designated as the primary care manager, the health plans/Tier 3 AMH will not change the designation without collaborating first.
  - The health plans are required to ensure that the member's care plans(s) document respective roles and responsibilities between the health plan/AMH Tier 3 practice and CIHA/LHD. CIHA or LHD Care Managers will be required to document roles/responsibilities in the standard documentation platform for instances where multiple Care Managers are serving same enrollee to ensure that services are coordinated and do not overlap.
  - The anticipated implementation of Tailored Care Management will impact the care management of children who qualify for both Tailored Care Management and CMARC Care Management. If a member qualifies for both services, CMARC care managers shall follow any guidance posted in the Tailored Care Management section of the CMARC Program Toolkit. This guidance would include the steps for a warm handoff, as receipt of both services will be seen as a duplication. See Appendix L.

- Payments to CIHA and/or LHD. The Department will ensure all funding related to care management for at-risk children is included in the capitation payment to health plans. The health plans will, in turn, be responsible for compensating contracted CIHA or LHDs. The health plans are permitted to introduce newpayment models on top of the existing funding to further incentivize care management innovation. Local care management agencies with concerns about payment amounts should reach out to the specific health plan to discuss any discrepancies. If there is no resolution, the local health department finance staff should contact the Provider Ombudsman:
  - Medicaid.ProviderOmbudsman@dhhs.nc.gov or 866-304-7062.

IV. Oversight and Accountability for Programs

The health plans are responsible for the clinical and financial management of care and services for Medicaid members who are pregnant or eligible children (ages 0 to 5 years). The Department will have rigorous oversight of all health plan operations. In addition, advisory groups of clinical leaders and other key stakeholders will continue to support the CMARC and CMHRP programs to ensure care management and clinical service providers deliver high-quality care.

General State Oversight

The Department is ultimately responsible for all aspects of the Medicaid program, including all aspects of North Carolina's transition to managed care. Under managed care, the Department delegates responsibility for managing member care to the health plans, with clear, contractually binding requirements and expectations.

Thus, the Department's primary role in a managed care environment is to hold the health plans accountable for providing high-quality care and improving outcomes by setting clear priorities and objectives, establishing standards, and evaluating the health plans against those standards.

Additionally, the Department will continue to provide support, program design and management to CIHA or LHDs providing care management for members at-risk for adverse birth outcomes and at-risk children during the transition to Medicaid managed care. This support includes:

- Continuous training to support managed care transition;
- Ongoing training on critical performance metrics and quality improvement;
- Ad hoc support for CIHA or LHDs related to programmatic guidance and implementation; as well as in the Corrective Action Plan (CAP) process;
- Continuous development and management of programmatic design, expectations, and guidance;
- Creating and maintaining program documents to promote standardization and best practice utilization; and
- Programmatic technical assistance, support and training

Role of Health Plans in Program Administration

In each care management program, health plans will have a specific set of program responsibilities. The health plans will administer each program locally in partnership with providers and CIHA or LHDs and have overall accountability and risk for outcomes.

For the programs for pregnant members, the health plans will specifically:

- Develop and execute contracts with standard contract terms for all providers who provide maternityservices;
- Reimburse participating providers, including incentive payments, as required in DHHS policy;
- Permit PMP providers to refer directly to CIHA or LHDs without prior authorization for initiation of caremanagement services;
- Refer pregnant members (identified as high-risk through the health plan's own risk stratification algorithms and methods) to CIHA or LHDs for care management services via the health plan's weekly outgoing Patient Risk List (PRL)
    - Health Plan "Direct Referrals" to LHDs should be minimal; encompassing only those referrals that need URGENT attention BEFORE the next weekly PRL file transmission
    - It is the Health Plan's responsibility to ensure EACH "Direct Referral" is included in their weekly outgoing PRL

- Administer a quality and process measurement program that will provide timely reports to PMP providers on the quality and process measures previously noted, as well as report to the Department on:
  - Number and dollar value of incentive payments paid to providers
  - Additional value-based incentive payments paid to providers
  - Rate of high-risk screening and rate of post-partum follow-up at the health plan population level;
- Offer provider supports to PMP providers engaging in the program;
- Ensure that the care management roles and responsibilities between the health plan/AMH Tier 3 practices are non-overlapping with care management services offered by CIHA or LHDs;
- Monitor for performance against the contract between the health plans and the LHDs; and
- Provide day-to-day oversight of program management and performance across PMP providers.

For the program for at-risk children, the health plans will specifically:

- Forge and strengthen linkages with primary care providers who care for children (e.g. pediatricians, Family Medicine physicians, NPs, PAs) and operate as AMH providers and coordinate with CIHA or LHDs whooperate the CMARC program;
- Permit pediatricians, other clinicians who care for children, and other entities, including social services providers, to refer directly to CIHA or LHDs without prior authorization for initiation of care management services;
- Refer children identified as at-risk through the health plan's own risk stratification algorithms and methods to CIHA or LHDs for care management services;
- Offer provider supports to clinicians caring for children (e.g., pediatricians, Family Medicine physicians,PAs, NPs) engaging in the program;
- Ensure that the care management roles and responsibilities between the health plans/AMH Tier 3 practices are non-overlapping with care management services offered by CIHA or LHDs;
- Ensure that medically needy children have a designated lead Care Manager; and
- Monitor for performance against executed contracts

CIHA or LHD Contracting and Health Plan Performance Oversight

CIHA or LHDs will need to contract with the health plans for the provision of care management services. During the transition period the health plans will give LHDs the "right of first refusal" as contracted providers of care management for these populations, offering them standard contract terms for each program (except for tribal or IHS eligible individuals). The health plans will offer contracts to every LHD in their service region for provision of these care management services. If the individual is a federally recognized individual or Indian Health Services (IHS) eligible, health plans may utilize the EBCI At-Risk Children's programs and High-Risk Pregnancy Programs. The individual served should be given a choice between the LHD and the tribal programs. The programs are inclusive of the five surrounding counties.

- LHDs will have 75 business days to accept the contract to perform care management services for thesepopulations. CIHA will be deemed an option and in network as a result of the TO at risk programs being approved
- If the LHD declines the contract, the health plan will consult the Department to identify another LHD that is willing and able to provide care management services for pregnant members at risk for adverse birth outcomes and at-risk children. The health plan will use the same 75-business-day process to contract with the new LHD.
- If the health plan is unable to contract with an alternate LHD, they will:

- Contract with another entity for the provision of local care management services; or
- Perform the services itself and retain the payment that would otherwise have passed to the LHD.

One of the health plan's primary roles is in monitoring performance according to the contract, providing risk stratification and referral data.
For CIHA or LHDs, a separate process has been developed to address areas of underperformance, should they arise. In these cases, health plans will intervene and initiate action in one of two pathways: a standardized CAP *(most likely)* or immediate termination *(rare).* The Department has developed a standardized process for health plans to address underperformance among CIHA or LHDs.

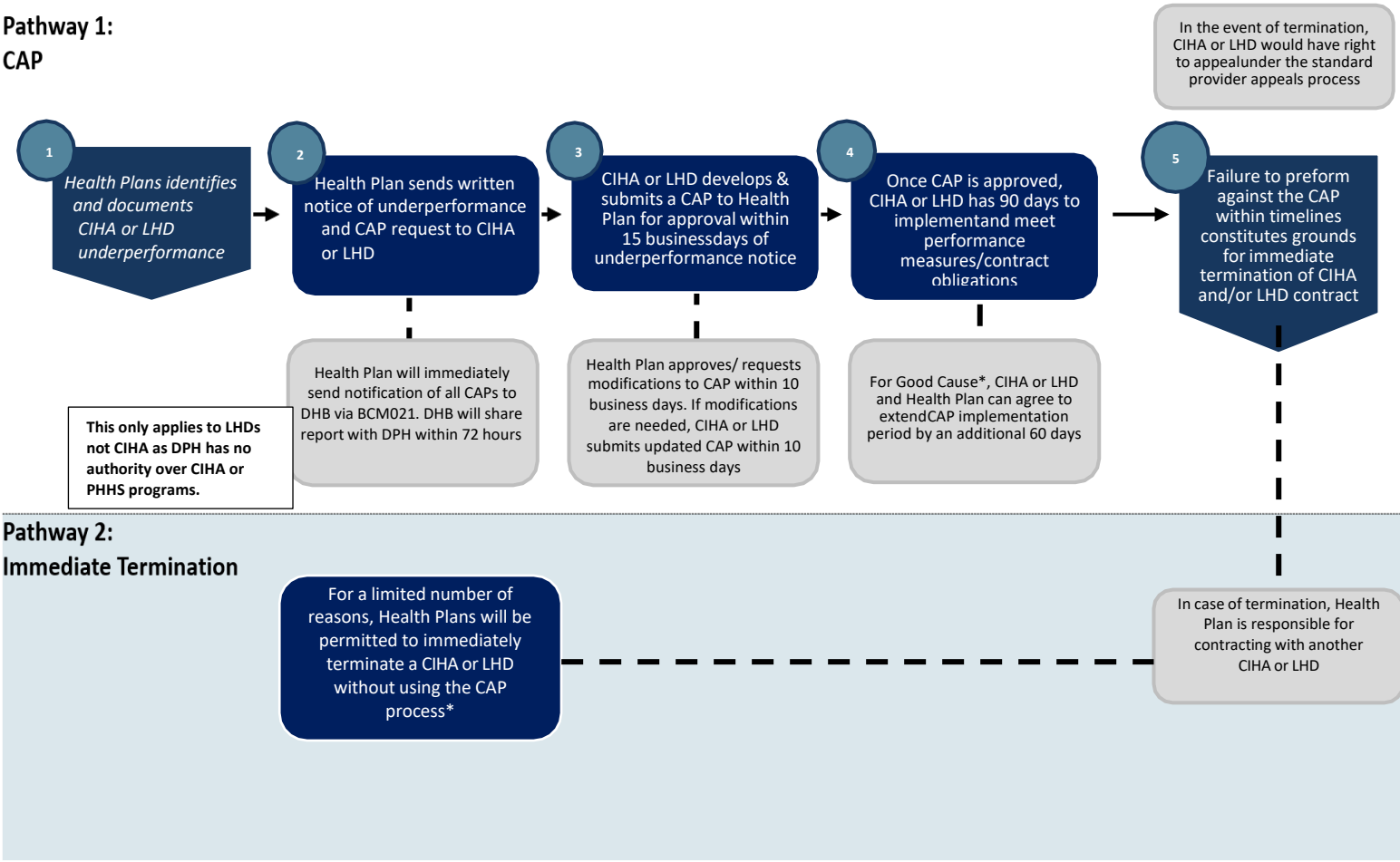
- Pathway #1: Standard Corrective Action Plan (CAP)

Step #	Pathway #1: Standard Corrective Action Plan (CAP)[9]
1	The health plan identifies and documents CIHA or LHD underperformance.
2	The health plan issues a written notice detailing underperformance to CIHA and/or LHD requesting a CAP. Health plans are required to report all CAPs to DHB immediately, using *BCM021: CMARC and CMHRP Corrective Action Plan Report*. DHB will share BCM021 with DPH within 3 business days of receiving the report.
3	CIHA or LHD will develop and submit a CAP to the health plan for approval within 15 business days of receiving notice of underperformance. CIHA or LHD must include intheir CAP a "performance improvement plan" that clearly states the steps being taken to rectify underperformance. *The health plan has the right to approve the CAP as written or request modifications within 10 business days. If modifications are requested, the LHD must resubmit an updated CAP within 10 business days.*
4	Once the CAP is approved, CIHA or LHD has 90 calendar days to implement and meet the performance measures/obligations under the contract. *For good cause, LHD and the health plan can agree to extend the implementation period by an additional 60 business days. Good cause includes a situation where the data lag makes the timeline non-feasible.* If the health plan does not follow up on the CAP at the end of the 90-day timeframe, the Department will consider the CAP satisfied.
5	Failure to perform against the CAP within the prescribed timelines constitutesgrounds for termination of the CIHA or LHD's contract by the health plan. *In the event of a termination, the CIHA or LHD would have the right to appeal thetermination under the standard provider appeals process.*

[9] The health plans will include the Department on all underperformance documentation, notification, and CAPs sent to any given LHD. The Department will share information with the Division of Public Health and the Division of Child and Family Well-Being to support training and support activities

- Pathway #2: Immediate Termination

	Pathway #2: Immediate Termination
	The health plan will be permitted to immediately terminate a LHD contract without using the CAP process, for a limited number of reasons. Specific actions for terminating a care management contract with an LHD without using the CAP process include: ▪ Instances of fraud, waste and/or abuse ▪ Specific actions by the LHD that conflict with the health plan/LHD Standard Contract Terms If a health plan terminates a contract with an LHD, they will be responsible for contracting with another LHD in their service region using the previously described "right of first refusal" process.



V. Conclusion

The State is committed to ensuring the continuation of the delivery of high-quality maternity care and critical care management services for pregnant members who are at high-risk for adverse birth outcomes and at-risk children. Care management programs will continue to thrive and provide critical services for members in need across the state. Additionally, the Department will continue to leverage the leadership of maternity care providers, pediatricians, social services organizations, CIHA or LHDs, and other stakeholders, in implementing continuous quality improvement to ensure continued success.

VI. Appendix

A. Standard Pregnancy Management Program (PMP) Contracting Requirements
B. Standard Care Management for High-Risk Pregnancies (CMHRP) Contracting Requirements
C. Standard Care Management for At-Risk Children (CMARC) Contracting Requirements
D. Tribal Option CMHRP and CMARC Requirements
E. CMHRP Pregnancy Risk Screening Form (English)
F. CMHRP Pregnancy Risk Screening Form (Spanish)
G. Tribal Option High-Risk Pregnancy Screening Form
H. CMHRP Community Referral Form
I. CMARC Referral Form for At-Risk Children
J. CMARC Tribal Option Referral Screening Form
K. CMHRP Measures Set
L. CMARC Measures Set
M. Transition of Care: Supporting CMARC Members Transitioning to Tailored Care Management
N. Healthy Opportunities Pilot Guidance for LHDs
O. Data Sharing Specification Requirements for CMARC-CMHRP
P. CMHRP Data Requirements and PRS Form Link

Appendix A: Standard PMP Contracting Requirements

1. The health plans shall incorporate the following requirements into their contracts with all providers ofmaternal care, including the following requirements for providers of the PMP:
    a. Complete and submit the standardized pregnancy risk screening (PRS) form at initial prenatal visit *and* as patient's biopsychosocial needs change to the LHD within 7 business days of completing the screening;
    b. Integrate the patient's plan of care with local CMHRP staff, which is inclusive of collaboration andcommunication, ensuring access to HIPAA compliant space for adequate patient and CMHRP staffengagement, access to patients' Electronic Medical Record (EMR) and to foster the embedded care management model;
    c. Allow HEALTH PLAN or HEALTH PLAN's designated vendor access to medical records for auditingpurposes to measure performance on specific quality indicators;
    d. Maintain or lower the rate of elective deliveries prior to 39 weeks gestation;
    e. Decrease the cesarean delivery rate among nulliparous members;
    f. Offer and provide 17 alpha-hydroxyprogesterone caproate (17p) for the prevention of preterm birthto members with a history of spontaneous preterm birth who are currently pregnant with a singleton gestation.
    g. Decrease the primary cesarean delivery rate if the rate is over the Department's designated cesarean rate; (Note: The Department will set the rate annually, which will be at or below 20 percent); and
    h. Ensure comprehensive post-partum visits occur within 84 days of delivery.

Appendix B: Standard CMHRP Contracting Requirements

1. **General Contracting Requirement**
    a. LHDs shall accept referrals from the health plans for CMHRP services.
2. **Outreach**
    a. LHDs shall refer potentially Medicaid-eligible pregnant patients for prenatal care and Medicaid eligibility determination, including promoting the use of Presumptive Eligibility determination and other strategies to facilitate early access to Medicaid coverage during pregnancy.
    b. LHDs shall conduct outreach efforts to members identified as High-Risk and needing intensive care management services. Members are identified by the PHPs' internal risk stratification system as well as provider request, member self- referral, and community referrals.
3. **Population Identification and Engagement**
    a. LHDs shall enter all Pregnancy Risk Screening (PRS) forms received from PMPs into the designated care management documentation system within five calendar days of receipt of risk screening forms.
    b. CM's professional judgement shall be utilized to determine CMHRP eligibility and outreach based on the following information: PRS data, member's EMR, available health plan data, and any additional information available to the CM.
    c. LHDs shall provide appropriate assessment and follow up to those patients identified as PHP High-risk and needing intensive CM services.
    d. LHDs shall collaborate with out-of-county PMPs and CMHRP teams to facilitate cross-county partnerships that ensure coordination of care and appropriate care management assessment and service delivery for all members in the target population.
4. **Assessment**
    a. CMHRP care managers (CM) will conduct a prompt and thorough assessment for all patients deemed as "high risk"for adverse birth outcomes who may need intensive care management services. Examples of this assessment include review of the following: prior assessment history, prior care management documentation, information from claims data/history, medical record(s), patient interview(s) and information from prenatal care provider and referral source.
    b. LHD CMs shall utilize risk screening data, patient self-report information, provider information to develop strategies to meet the needs of those patients at highest risk for poor pregnancy outcome.
    c. LHDs shall utilize assessment findings, including those conducted by the health plans, to determine level of need for care management support.
    d. LHDs shall document assessment findings in the care management documentation system.
    e. LHDs shall ensure that assessment documentation is current throughout the period of time the CMHRP CMC is working with the member and should be continually updated as new information is obtained and/or based upon program standards.
    f. LHDs shall assign engagement level as outlined according to program guidelines, based on member need(s).
5. **Interventions**
    a. LHDs shall provide care management services in accordance with program guidelines, including condition-specific pathways, utilizing those interventions that are most effective in engaging members and meeting their needs. LHDs shall prioritize face-to-face encounters (practice visits, home visits, hospital visits, community encounters); additionally, utilizing other interventions such as telephone outreach, video conferencing, professional encounters and

other interventions as needed to achieve care plan goals.

b. LHDs shall provide care management services based upon member need(s) as determined throughongoing assessment.
c. LHDs shall develop patient-centered care plans, including appropriate goals, interventions and tasksbased on standardized, statewide CMHRP programmatic guidance documents.
d. LHDs may utilize the statewide resource platform and identify additional community resources.
e. LHDs shall refer identified population to prenatal care, childbirth education, oral health, behavioral health or other needed services included in the beneficiary's health plan network.
f. LHDs shall document all care management activity in the care management documentation system.

6. Integration with Health Plans and Healthcare Providers

a. LHDs shall ensure that a designated CMHRP CM has an assigned schedule indicating their presence within the PMP.
b. LHDs shall establish a cooperative working relationship and mutually agreeable methods of patient- specific and other ongoing communication with the PMP.
c. LHDs shall establish and maintain effective communication strategies with PMP providers and other key contacts within the practice for each PMP within the county or serving residents of the county.
d. CMHRP CM shall participate in relevant PMP meetings addressing care of patients in the Target population as requested.
e. LHDs shall promote CMHRP members' awareness of in-network providers and assist health planwhen accessing referrals and resources.
f. LHDs shall assist CMHRP members in obtaining information needed as it relates to the health plans' by connecting members with the PHP's members services department, as applicable.

7. Collaboration with Health Plans

a. LHDs shall work with health plans to ensure program goals as outlined in this document (i.e., outcome and process measures) are met.
b. LHDs shall review and monitor health plans reports created for the PMP and CMHRP services toidentify individuals at greatest risk.
c. LHDs shall communicate with the health plans regarding challenges with cooperation and collaboration with maternity care providers/PMPs.
d. Where care management is being provided by a health plan and/or AMH practice in addition to CMHRP, the health plans must ensure the delineation of non-overlapping roles and responsibilities.
e. LHDs shall participate in CMHRP and other relevant meetings hosted by the health plans as resources and time permits.

8. Training

LHDs shall ensure that CMHRP CMs and their supervisors attend CMHRP training offeredby the health plan and/or DHHS, including webinars, New Hire Orientation and other CMHRP programmatic training.

a. LHDs shall ensure that CMHRP CMs and their supervisors attend continuing education sessions coordinated by the health plan and/or DHHS.
b. LHDs shall ensure that CMHRP CMs and their supervisors pursue ongoing education opportunities to stay current in evidence-based care management of pregnancy and postpartum women at risk for poor birth outcomes.
c. LHDs shall ensure that CMHRP CMs and their supervisors have access to Motivational

Interviewing, Mental Health First Aid and Trauma-Informed Care training.

9. Staffing

LHD shall:

a. Employ care managers meeting CMHRP competencies defined as having at least one ofthe following qualifications:
   i. Social workers with a Bachelor of Social Work (BSW, BA in SW, or BS in SW) or Master of Social Work (MSW, MA in SW, or MS in SW) from a Council on Social Work Education (CSWE) accredited social work degree program.
   ii. Registered nurses
   iii. Bachelor's degree in a human service field with 5 or more years of care management/case management experience working with the specific population of low-income, pregnant individuals and/or children ages 0 to 5 years
   iv. Bachelor's degree in a human service field with 3 or more years of care management/case management experience working with the specific population (low income, pregnant individuals and/or children ages 0 to 5 years and has certification as a Case Manager (CCM preferred)

   Note: Care managers providing services to the CMHRP population hired prior to Sept. 1, 2011 without a Bachelor's or Master's degree in Social Work may retain their existing position only. *This grandfathered status does not transfer to any other position.*

b. Ensure that supervisors who carry a caseload must also meet the CMHRP caremanagement competencies and staffing qualifications.
c. Ensure that Community Health Workers for Care Management for High-Risk Pregnancies' services work under the supervision and direction of a trained CMHRP CM.
d. When possible, LHDs shall include both registered nurses and social workers on their care management team to best meet the needs of the CMHRP members' medical and psychosocial needs.
e. If the LHD only has a single care manager providing services for the target population, then the LHD shall ensure access to individual(s) to provide needed resources, consultation and guidance from thenon-represented professional discipline within Public Health.
f. Engage care managers who operate with a high level of professionalism and possess an appropriate mix of skills needed to work effectively with the pregnant population at high risk for adverse birth outcomes. This skill set should reflect the capacity to address the needs of members with both medically and socially complex conditions.
g. Ensure that the team of CMHRP CMs is composed of more than one person but representing only one professional discipline (nursing or social work), seeks to hire individuals of the other discipline when making hiring decisions.
h. Ensure that CMHRP CMs must demonstrate:
   i. A high level of professionalism and possess appropriate skills needed to work effectively withthe pregnant population at high risk for adverse birth outcomes;
   ii. Proficiency with the technologies required to perform care management functions;
   iii. Motivational Interviewing skills and knowledge of adult teaching and learning principles;
   iv. Ability to effectively communicate with families and providers; and
   v. Critical thinking skills, clinical judgment and problem-solving abilities.
i. Provide qualified supervision and support for CMHRP CMs to ensure that all activities are designed to meet performance measures, with supervision to include:

i. Provision of program updates to care managers;
ii. Daily availability for case consultation and caseload oversight;
iii. Regular meetings with LHD care management staff;
iv. Utilization of reports to actively assess individual care manager performance;
v. Compliance with all supervisory expectations delineated in the CMHRP Program Manual.

j. Establish staffing arrangements to ensure continuous service delivery through appropriate management of staff vacancies and extended absences, including following the health plan/DHHS guidance about communication with the health plans about any vacancies or extended staff absences and adhering to guidance about contingency planning to prevent interruptions in service delivery.
k. Vacancies lasting longer than 60 days shall be subject to additional oversight by the health plans.

Appendix C: Standard CMARC Contracting Requirements

1. **General Requirements**
    a. LHDs shall accept referrals from health plans for CMARC services.
2. **Outreach**
    LHDs shall:
    a. Develop strong relationships with medical homes serving children ages 0 to 5 years in the county.
    b. Reach out to other possible referrals sources, including but not limited to hospitals, families and others through community events, social services agencies including DSS, and WIC using outreach materials per program guidance.
    c. Collaborate with out-of-county AMHs and other practices to facilitate cross-county partnerships to optimize care for members who receive services from outside their resident county.
3. **Population Identification**
    LHDs shall, according to additional program guidance made available to LHD staff:
    a. Locate the CMARC target population to offer CMARC services by receipt of hard copy referrals, phone copy referral, and referrals received in the standard documentation platform
    b. Ensure any reports made available for identifying the CMARC target population including those provided by the health plans, are used
    c. Review all available information about the child; determine if the member is part of the CMARC target population listed on the CMARC Referral Form (see Appendix H).
4. **Family Engagement**
    LHD shall:
    a. Contact families according to expected timeframes found in additional program guidance made available to LHD staff.
    b. Involve the parent/ caregiver (legal guardian when appropriate) in the decision-making process through a patient-centered, collaborative partnership approach to assist with improved self-care.
    c. Foster self-management skill building when working with families of children.
    d. Prioritize face-to-face family interactions (home visit, AMH office visit, hospital visit, community visit, video conferencing, etc.) over telephone interactions for children in active case status, when possible.
5. **Assessment and Stratification of Care Management Service Level**
    LHDs shall:
    a. Use the information gathered during the assessment process to determine whether the child meets the CMARC target population found on the CMARC Referral Form (Appendix G). Examples of this assessment include review of the following: prior assessment history, prior care management documentation, information from claims data/history, medical record(s), member interview(s) and information from pediatric care provider and referral source.
    b. Review and monitor the health plan reports created for the CMARC services, along with the information obtained from the family through program assessments, to assure the child is appropriately linked to preventive and primary care services and to identify individuals at risk.
    c. Document assessment findings in the care management documentation system.
    d. Ensure that assessment documentation is current throughout the period of time the CMARC CM is working with the member and should be continually updated as new information is

obtained and/or based upon program standards.

e. Use the information gained from the assessments to determine the need for and the level of service to be provided to meet the needs identified through program assessments.

6. Care Plans

LHDs shall:

a. Based on assessed needs, develop patient-centered care plans per program guidelines provided to CMARC staff, including development of appropriate goals, the use of condition-specific pathways, and utilizing interventions that are most effective in engagement member's families, meeting their needs and achieving care plan goals.
b. Identify and coordinate care with community agencies/resources needed to meet the specific needs of the child (including statewide resource platform) thereby ensuring children/families are well-linked to needed resources, including the child's AMH or other practice.
c. Provide information and/or education to meet identified needs and encourage self-management using materials that meet literacy standards.
d. Provide the level of care management services based upon the member's level of need as determined through evaluation of the care plan and ongoing assessment.

7. Integration with AMHs and Health Plans

LHDs shall:

a. Collaborate with AMH care team to facilitate implementation of patient-centered plans and goals targeted to meet the individual child's needs.
b. Ensure that the member's AMH is informed of the engagement in CMARC services, changes in the care management level of care, need for member support and follow-up, and other relevant updates.
c. Where care management is being provided by a health plan and/or AMH practice in addition to the CMARC program, collaborate with the health plans, as the health plan must ensure the delineation of non-overlapping roles and responsibilities, and the LHD must document that agreement in the child's Plan of Care to avoid duplication of services.
d. Work with health plans to ensure program goals as outlined in this document (i.e.,outcome and process measures) are met.
e. Communicate with the health plans regarding challenges with cooperation and collaboration with pediatric AMHs.
f. Review and monitor health plan's reports created for the CMARC program to identify individuals at greatest risk.
g. Participate in CMARC and other relevant meetings hosted by the health plans as resources and time permits.
h. Support CMARC members' awareness of network status with providers and support member's understanding of health plan's prior authorization processes for referrals and assist when accessing referrals and resources.

8. Service Provision

LHDs shall:

a. Document all care management activities in the care management documentation system in a timely manner as described by LHD agency policy.
b. Ensure that the services provided by CMARC meet a specific need of the family and work collaboratively with the family and other service providers to ensure the services are provided as a coordinated effort that does not duplicate services.

9. Training

LHDs shall:

a. Ensure CMARC care managers and their supervisors participate in DHHS and/or health plan-sponsored trainings including but not limited to new hire CMARC orientation (as outlined in the CMARC Training Plan), CMARC webinars, and other CMARC programmatic trainings.
b. Ensure CMARC care managers and their supervisors pursue ongoing continuing education opportunities to stay current in evidence-basedcare management of at-risk children.

10. Staffing

LHDs shall:

a. Hire care managers with at least one of the following qualifications:
    i. Social workers with a Bachelor of Social Work (BSW, BA in SW, or BS in SW) or Master of Social Work (MSW, MA in SW, or MS in SW) from a Council on Social Work Education (CSWE) accredited social work degree program.
    ii. Registered nurses
    iii. Bachelor's degree in a human service field with 5 or more years of care management/case management experience working with the specific population of low-income, pregnant individuals and/or children ages 0 to 5 years
    iv. Bachelor's degree in a human service field with 3 or more years of care management/case management experience working with the specific population (low income, pregnant individuals and/or children ages 0 to 5 years) and has certification as a Case Manager (CCM preferred)

    Note: Care managers for at-risk children hired prior to Sept. 1, 2011, without a bachelor's or master's degree in social work may retain their existing position only. This grandfathered status does not transfer to any other position.
b. Ensure that supervisors who carry a caseload must also meet the CMARC care management competencies, staffing qualifications, and expectations stated in the CMARC Training Plan.
c. Engage Care Managers who operate with a high level of professionalism and possess an appropriate mix of skills needed to work effectively with at-risk children. This skill mix must reflect the capacity to address the needs of members with both medically and socially complex conditions.
d. Ensure that CMARC care managers demonstrate:
    i. Proficiency with the technologies required to perform care management functions – particularly as pertains to claims data review and the care management documentation system;
    ii. Ability to effectively communicate with families and providers;
    iii. Critical thinking skills, clinical judgment and problem-solving abilities; and
    iv. Motivational interviewing skills, trauma-informed care, and knowledge of adult teaching and learning principles.
e. Attempt to include on the team of CMARC care managers both registered nurses and social workers to best meet the needs of the target population with medical and psychosocial risk factors.
f. Ensure access to individual(s) to provide needed resources, consultation and guidance from the non-represented professional discipline when only a single CMARC care manager is employed.
g. Explore hiring individuals of the other discipline when there is a vacancy on a team of CMARC care managers composed of more than one person representing only one professional

discipline (nursing or social work).

h. Establish staffing arrangements to ensure continuous service delivery through appropriate management of staff vacancies and extended absences, including following DHHS guidance regarding vacancies or extended staff absences and adhering to DHHS guidance about contingency planning to prevent interruptions in service delivery. Vacancies lasting longer than 60 days will be subject to additional oversight.
i. Complete and submit the vacancy contingency plan that describes how an extended absence or vacancy will be covered and the plan for hiring in the event of an extended absence (2 weeks or more) or vacancy.
j. Ensure that Community Health Workers and other unlicensed staff utilized in the CMARC program work under the supervision and direction of a trained CMARC care manager.
k. Provide qualified supervision and support for CMARC care managers to ensure that all activities are designed to meet performance measures, with supervision to include:
    i. Provision of program updates to care managers;
    ii. Daily availability for case consultation and caseload oversight;
    iii. Regular meetings with direct service care management staff; and
    iv. Utilization of monthly and on-demand reports to actively assess individual care manager performance.
l. Ensure that supervisors comply with expectations found in the DHHS Care Management At-Risk Children Supervision Guidance Document.

Appendix D: Tribal Option CMHRP and CMARC Requirements

1. **Priority Population**
   a. CIHA shall develop and use a risk stratification tool to stratify all Members[10]. CIHA shall evaluate the effectiveness of its risk stratification tool at least annually.
   b. CIHA shall develop and implement targeted interventions that are appropriate for each risk level. Interventions should be consistent with evidence-based or evidence-informed practices, clinical guidelines, and recommended treatments.
   c. CIHA shall describe its risk stratification approach and targeted interventions in the Care Management Policy.
   d. CIHA shall use risk scoring and stratification to identify Members who are part of "priority populations"[11] for Care Management and should receive a Comprehensive Assessment to determine their Care Management needs.
2. **High-Risk Pregnant women**
   a. CIHA will ensure provision of a coordinated set of high-quality clinical maternity services for Members throughout the duration of pregnancy, with special programs targeted at individuals with high-risk pregnancy. Referrals will be made to regionally enrolled Medicaid maternity care Providers.
   b. CIHA shall encourage Network PCPs serving pregnant women to use the pregnancy risk screening tool as provided by the Department, or an alternative tool as approved by the Department, to identify and refer women at risk for an adverse birth outcome to a more intensive set of Care Management services. See Appendix F for CIHA High-Risk Pregnancy Screening Form.
   c. CIHA shall enter all High-Risk Pregnancy Screening forms into the designated care management documentation system within five calendar days of receipt of risk screening forms.
   d. Care managers shall utilize professional judgement to determine CMHRP eligibility and outreach based on the following information: CIHA High-Risk Pregnancy Screening data, member's EMR, available health plan data, and any additional information available to the care manager.
3. **At-risk children**
   a. CIHA shall accept referrals for at-risk children that use existing Department-developed referral forms or use an alternative referral form for at-risk children enrolled in the Tribal Option PCCM entity approved by the Department. See Appendix I for CMARC Tribal Option Referral Screening Form.
   b. Care managers shall utilize professional judgement to determine CMARC eligibility and outreach based on the following information: CMARC referral form, member's EMR, available health plan data, and any additional information available to the care manager.
4. **Member Education and Engagement**

[10] Beneficiaries enrolled in and receiving Medicaid or Benefits through the Tribal Option PCCM entity.
[11] Priority populations, as defined in Section 6.a.iv.b.2 of the Standard Plan contract include individuals with LTSS needs; adults and children with Special Health Care Needs; individuals defined by the PHP as Rising Risk; individuals with high unmet health-related resource needs, defined at minimum to include members who are homeless, members experiencing or witnessing domestic violence or lack of personal safety, and members showing unmet health-related resource needs in three or more Healthy Opportunities domains on the Care Needs Screening; **at risk children ages 0-5**; **high risk pregnant women**; and other priority populations as determined by the PHP.

a. CIHA shall develop Member education materials, which shall be submitted to the Department for review sixty (60) days prior to use with Members.
b. CIHA shall develop educational materials to be used by the Department or Vendor partners to support PCCM and PCP selection.
    i. Materials should have sufficient information such that those interested in enrolling have adequate, written descriptions of the CIHA's rules, procedures, Benefits, services, and other information necessary for Members to make an informed decision about enrollment.
    ii. Materials are subject to review and approval by the Department at least sixty (60) Calendar Days prior to use with Members, Potential Members, and/or Authorized Representatives.
c. CIHA shall provide Tribal Option materials to the Department or Vendor partners such as the Ombudsman Program that may assist Members and Potential Members.
d. CIHA shall solicit Member feedback on an ongoing basis and incorporate Member feedback into the Member education strategy by modifying, updating, removing, changing, or adding materials, service line scripts, website content, education materials, presentations, or other administrative or operational processes.
e. CIHA shall involve the members or parent/ caregiver (legal guardian when appropriate) in the decision-making process through a patient-centered, collaborative partnership approach to assist with improved self-care.
f. CIHA shall foster self-management skill building for members and for families of children.

5. Care Management

a. CIHA shall provide 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, pharmacies, and community-based resources.
b. CIHA shall ensure that each Care Plan is individualized and person-centered, using a collaborative approach including Member and family participation where appropriate.
c. CIHA shall undertake its best efforts to complete each Care Plan within thirty (30) Calendar Days of completion of the Comprehensive Assessment.
d. CIHA shall ensure that each Care Plan incorporates findings of the Care Needs Screening (including unmet health-related resource need questions), claims analysis and risk scoring, the Comprehensive Assessment, any available Medical Records, and other sources as needed.
e. CIHA shall ensure that the Care Plan is regularly updated to address gaps in care, incorporating input from care team members and Member, as part of Care Management; and that the Care Plan will be comprehensively updated:
    i. At minimum every twelve (12) months;
    ii. When a Member's circumstances or needs change significantly;
    iii. At the Member's request; or
    iv. When a re-assessment occurs.
f. CIHA shall ensure that each Care Plan is documented and stored and made available to the Member and care team members, including the Member's assigned Network PCP.

6. Interventions

a. CIHA shall ensure that each Member has an ongoing source of care appropriate to his or her needs. CIHA shall establish policies and procedures to deliver care to, and coordinate services for, all Members, regardless of risk or need.
b. CIHA shall provide Care Coordination for all Members, which should support Members with:

i. Scheduling medical appointments;
ii. Obtaining proper medical equipment;
iii. Providing health education and health coaching; and
iv. Maintaining age-appropriate immunizations, preventive screenings, and routine well visits.

c. CIHA shall assist Members with the following activities to improve health:
i. Managing chronic disease (i.e. disease management programs);
ii. Patient self-management and goal-setting;
iii. Addressing gaps in care; and
iv. Managing medications.

d. For Members with identified unmet health-related resource needs, CIHA shall, as part of Care Coordination:
i. Coordinate services provided by community and social support providers to address Members' unmet health-related resource needs;
ii. Link Members to local community resources and social supports; and
iii. Modify their approaches based on tracking of outcomes, as needed to optimize Members' health.

e. CIHA shall coordinate with obstetricians, midwives, family physicians and other Providers involved in the care of a Member who is pregnant or recently delivered.

f. CIHA shall document all care management activity in the care management documentation system

7. Care Manager Qualifications and Training

a. CIHA shall employ care managers meeting competencies defined as having at least one of the following qualifications:
i. Social workers with a Bachelor of Social Work (BSW, BA in SW, or BS in SW) or Master of Social Work (MSW, MA in SW, or MS in SW) from a Council on Social Work Education (CSWE) accredited social work degree program.
ii. Registered nurses
iii. Bachelor's degree in a human service field with 5 or more years of care management/case management experience working with the specific population of low-income, pregnant individuals and/or children ages 0 to 5 years
iv. Bachelor's degree in a human service field with 3 or more years of care management/case management experience working with the specific population (low income, pregnant individuals and/or children ages 0 to 5 years) and has certification as a Case Manager (CCM preferred)

b. CIHA shall engage appropriate staff on the care team to meet the needs of the Members. CIHA shall ensure that
i. Tribal CMHRP care managers and their supervisors pursue ongoing education opportunities to stay current in evidence-based care management of pregnancy and postpartum women at risk for poor birth outcomes.
ii. CMARC care managers and their supervisors pursue ongoing continuing education opportunities to stay current in evidence-based care management of at-risk children.

c. CIHA shall engage care managers who operate with a high level of professionalism and possess an appropriate mix of skills needed to work effectively with the pregnant population at high risk for adverse birth outcomes. This skill set should reflect the capacity to address the needs of members with both medically and socially complex conditions.

d. CIHA shall require that Care Management staff show competency in areas including:
    i. Person-centered needs assessments and care planning;
    ii. Motivational interviewing;
    iii. Self-management;
    iv. Trauma informed care;
    v. Cultural Sensitivity;
    vi. Understanding and addressing unmet health-related resource needs, including expertise in identifying and utilizing available social supports and resources at Members' local level; and
    vii. Understanding and addressing adverse childhood experiences (ACE) and trauma.
e. CIHA shall establish staffing arrangements to ensure continuous service delivery through appropriate management of staff vacancies and extended absences to prevent interruptions in service delivery.

Appendix E: Pregnancy Risk Screening (PRS) Form for CMHRP (English) - Page 1

*Practice Name: _____

Practice Phone Number: _____

*Today's Date: _____ /_____/ _____

Date of next prenatal appointment:_____/_____/_____

Care Management for High-Risk Pregnancies (CMHRP) Pregnancy Risk Screening Form

Date of birth:_____/_____/_____

First name:_____ MI_____ Last name: _____

*EDC:___/____/_____ *Determined by what criteria*: ❑ LMP ❑ 1st trimester U/S ❑ 2nd trimester U/S

Height:____ft____in Pre-pregnancy weight:_____ Gravidity:_____Parity:_____T_____P_____A_____L

Insurance type: ❑ Medicaid (includes Presumptive) ❑Private ❑None

Medicaid ID#:_____ PHP Name: _____

***CURRENT PREGNANCY**

- ❑ Multifetal Gestation
- ❑ Fetal complications:
  - ❑ Fetal anomaly
  - ❑ Fetal chromosomal abnormality
  - ❑ Intrauterine growth restriction (IUGR)
  - ❑ Oligohydramnios
  - ❑ Polyhydramnios
  - ❑ Other(s):_____
- ❑ Chronic condition which may complicate pregnancy:
  - ❑ Diabetes
  - ❑ Hypertension
  - ❑ Asthma
  - ❑ Mental illness
  - ❑ HIV
  - ❑ Seizure disorder
  - ❑ Renal disease
  - ❑ Systemic lupus erythematosus
  - ❑ Other(s):_____
- ❑ Current use of drugs or alcohol/recent drug use or heavy alcohol use in month prior to learning of pregnancy
- ❑ Late entry into prenatal care (>14 weeks)
- ❑ Hospital utilization in the antepartum period
- ❑ Missed 2+ prenatal appointments
- ❑ Cervical insufficiency
- ❑ Gestational diabetes
- ❑ Vaginal bleeding in 2nd trimester
- ❑ Hypertensive disorders of pregnancy
  - ❑ Preeclampsia
  - ❑ Gestational hypertension
- ❑ Short interpregnancy interval (<12 months between last live birth and current pregnancy)
- ❑ Current sexually transmitted infection
- ❑ Recurrent urinary tract infections (>2 in past 6 months, >5 in past 2 years)
- ❑ Non-English speaking
  Primary language:_____
- ❑ Positive depression screening
  - ○ Tool used:_____
  - ○ Score = _____

***For LHD Use Only*:** Date RSF was received:_____

*Date RSF was entered:_____

***OBSTETRIC HISTORY**

- ❑ Preterm birth (<37 completed weeks)
  Gestational age(s) of previous preterm birth(s):
  _____weeks,_____weeks,_____weeks
- ❑ At least one spontaneous preterm labor and/or rupture of the membranes
  **If this is a singleton gestation, this patient is eligible for 17P treatment.*
- ❑ Low birth weight (<2500g)
- ❑ Fetal death >20 weeks
- ❑ Neonatal death (within first 28 days of life)
- ❑ Second trimester pregnancy loss
- ❑ Three or more first trimester pregnancy losses
- ❑ Cervical insufficiency
- ❑ Gestational diabetes
- ❑ Postpartum depression
- ❑ Hypertensive disorders of pregnancy
  - ❑ Eclampsia
  - ❑ Preeclampsia
  - ❑ Gestational hypertension
  - ❑ HELLP syndrome

❑ Provider requests care management

Reason(s):_____

Provider Comments/Notes: _____

*Person Completing Form: _____

*Credentials: _____

*Signature: _____

*Required fields

Version 2 (Rev. 12/01/2020) Submit completed form to the CMHRP staff at the local health department in the patient's county of residence.

Appendix E: Pregnancy Risk Screening (PRS) Form for CMHRP (English) - Page 2

Care Management for High-Risk Pregnancies (CMHRP) Pregnancy Risk Screening Form

Complete this side of the form as honestly as possible and give it to your nurse or doctor. The information you provide allows us to coordinate services with the care manager and provide the best care for you and your baby.

Name:_____ Date of birth:_____ Today's date: _____

Physical Address:_____ City:_____ ZIP:_____

Mailing Address (if different):_____ City:_____ ZIP:_____

County:_____ Home phone number:_____ Work phone number: _____

Cell phone number:_____ Social security number (if available): _____

Race: ❑ American-Indian or Alaska Native ❑ Asian ❑ Black/African-American
❑ Pacific Islander/Native Hawaiian ❑ White ❑ Other (specify):_____

Ethnicity: ❑ Not Hispanic ❑ Cuban ❑ Mexican ❑ Puerto Rican ❑ Other Hispanic

Education: ❑ Less than high school diploma ❑ GED or high school diploma ❑ Some college ❑ College graduate

1. Thinking back to <u>just before you got pregnant</u>, how did you feel about becoming pregnant?
   - ▫ I wanted to be pregnant sooner
   - ▫ I wanted to be pregnant now
   - ▫ I wanted to be pregnant later
   - ▫ I did not want to be pregnant then or any time in the future
   - ▫ I don't know
2. Within the last year, have you been hit, slapped, kicked or otherwise physically hurt by someone? ❑ Yes ❑ No
3. Are you in a relationship with a person who threatens or physically hurts you? ❑ Yes ❑ No
4. Has anyone forced you to have sexual activities that made you feel uncomfortable? ❑ Yes ❑ No
5. In the last 12 months were you ever hungry but didn't eat because you couldn't afford enough food? ❑ Yes ❑ No
6. Is your living situation unsafe or unstable? ❑ Yes ❑ No
7. Which statement best describes your smoking status? Check <u>one</u> answer.
   - ▫ I have never smoked, or have smoked less than 100 cigarettes in my lifetime
   - ▫ I stopped smoking BEFORE I found out I was pregnant and am not smoking now
   - ▫ I stopped smoking AFTER I found out I was pregnant and am not smoking now
   - ▫ I smoke now but have cut down some since I found out I was pregnant
   - ▫ I smoke about the same amount now as I did before I found out I was pregnant
8. Did any of your parents have a problem with alcohol or other drug use? ❑ Yes ❑ No
9. Do any of your friends have a problem with alcohol or other drug use? ❑ Yes ❑ No
10. Does your partner have a problem with alcohol or other drug use? ❑ Yes ❑No
11. In the past, have you had difficulties in your life due to alcohol or other drugs, including prescription medications? ❑ Yes ❑ No
12. Before you knew you were pregnant, how often did you drink any alcohol, including beer or wine, or use other drugs? ❑Not at all ❑Rarely ❑Sometimes ❑Frequently
13. In the past month, how often did you drink any alcohol, including beer or wine, or use other drugs? ❑ Not at all ❑Rarely ❑Sometimes ❑Frequently

*Required fields
Version 2 (Rev. 12/01/2020) Submit completed form to the CMHRP staff at the local health department in the patient's county of residence.

Appendix F: Pregnancy Risk Screening (PRS) Form for CMHRP (Spanish) - Page 1

*Practice Name: _____

Practice Phone Number: _____

*Today's Date: _____ /_____/_____

Date of next prenatal appointment:_____/_____/_____

Care Management for High-Risk Pregnancies (CMHRP) Pregnancy Risk Screening Form

Date of birth:_____/_____/_____

First name:_____ MI:_____ Last name:_____

*EDC:___/___/_____*Determined by what criteria*: ❑ LMP ❑ 1st trimester U/S ❑ 2nd trimester U/S

Height:____ft____in Pre-pregnancy weight:_____ Gravidity:_____Parity:____T____P____A____L

Insurance type: ❑ Medicaid (includes Presumptive) ❑Private ❑None

Medicaid ID#:_____ PHP Name: _____

***CURRENT PREGNANCY**

- ❑ Multifetal Gestation
- ❑ Fetal complications:
  - ❑ Fetal anomaly
  - ❑ Fetal chromosomal abnormality
  - ❑ Intrauterine growth restriction (IUGR)
  - ❑ Oligohydramnios
  - ❑ Polyhydramnios
  - ❑ Other(s): _____
- ❑ Chronic condition which may complicate pregnancy:
  - ❑ Diabetes
  - ❑ Hypertension
  - ❑ Asthma
  - ❑ Mental illness
  - ❑ HIV
  - ❑ Seizure disorder
  - ❑ Renal disease
  - ❑ Systemic lupus erythematosus
  - ❑ Other(s): _____
- ❑ Current use of drugs or alcohol/recent drug use or heavy alcohol use in month prior to learning of pregnancy
- ❑ Late entry into prenatal care (>14 weeks)
- ❑ Hospital utilization in the antepartum period
- ❑ Missed 2+ prenatal appointments
- ❑ Cervical insufficiency
- ❑ Gestational diabetes
- ❑ Vaginal bleeding in 2nd trimester
- ❑ Hypertensive disorders of pregnancy
  - ❑ Preeclampsia
  - ❑ Gestational hypertension
- ❑ Short interpregnancy interval (<12 months between last live birth and current pregnancy)
- ❑ Current sexually transmitted infection
- ❑ Recurrent urinary tract infections (>2 in past 6 months, >5 in past 2 years)
- ❑ Non-English speaking
  Primary language: _____
- ❑ Positive depression screening
  - ○ Tool used: _____
  - ○ Score = _____

***For LHD Use Only*:** Date RSF was received:_____

*Date RSF was entered: _____

***OBSTETRIC HISTORY**

- ❑ Preterm birth (<37 completed weeks)
  Gestational age(s) of previous preterm birth(s):
  _____weeks,_____weeks,_____weeks
- ❑ At least one spontaneous preterm labor and/or rupture of the membranes
  **if this is a singleton gestation, this patient is eligible for 17P treatment.*
- ❑ Low birth weight (<2500g)
- ❑ Fetal death >20 weeks
- ❑ Neonatal death (within first 28 days of life)
- ❑ Second trimester pregnancy loss
- ❑ Three or more first trimester pregnancy losses
- ❑ Cervical insufficiency
- ❑ Gestational diabetes
- ❑ Postpartum depression
- ❑ Hypertensive disorders of pregnancy
  - ❑ Eclampsia
  - ❑ Preeclampsia
  - ❑ Gestational hypertension
  - ❑ HELLP syndrome

❑ Provider requests care management

Reason(s):_____

Provider Comments/Notes: _____

*Person Completing Form: _____

*Credentials: _____

*Signature: _____

*Required fields

Version 2 (Rev. 12/01/2020) Submit completed form to the CMHRP staff at the local health department in the patient's county of residence.

Appendix F: Pregnancy Risk Screening (PRS) Form for CMHRP (Spanish) - Page 2

Formulario de Evaluación de Riesgo del Embarazo

Por favor complete este lado del formulario y entréguesela a la enfermera o el médico. Por favor responda lo más honestamente posible para que podamos proporcionarle el mejor cuidado para usted y su bebé. El equipo de cuidado mantendrá esta información privada.

Nombre:_____Fecha de nacimiento: _____ Fecha de hoy: _____

Dirección fisica:_____ Ciudad: _____ ZIP: _____

Dirección de correo:_____ Ciudad: _____ ZIP: _____

Condado:_____Número de teléfono de la casa:_____Número de teléfono del trabajo: _____

Número de teléfono celular:_____Número de Seguro Social: _____

Raza: ❑Indio Americano/Nativo de Alaska ❑Asiático ❑Negro/Africano-Americano
❑ Islas de Pacifico/Nativo de Hawái ❑Blanco ❑Otro (especifique):_____

Etnicidad: ❑No hispano ❑Cubano ❑Mexicano Americano ❑Puertorriqueño ❑Otro Hispano

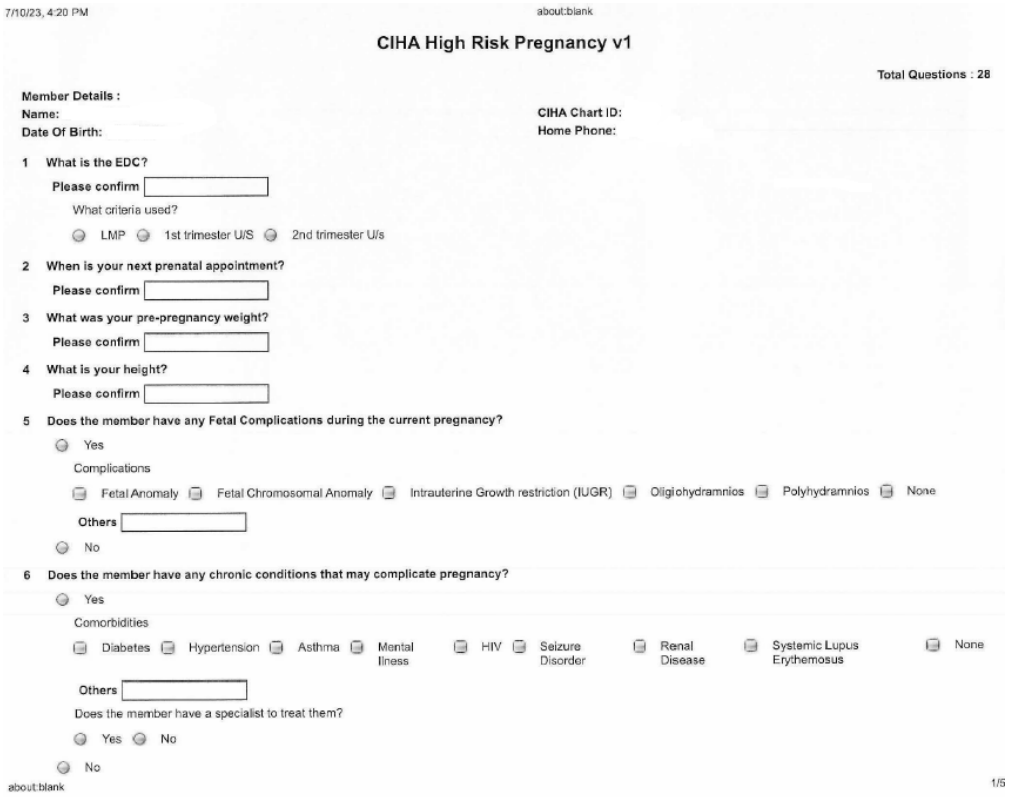
Educacion: ❑Diploma Menos de secundaria ❑ GED o Diploma de Escuela Secundaria
❑ Alguna educacion superior ❑ Graduado de la Universidad

1. Piense en el momento *justo antes* de que quedara embarazada, ¿cómo se sintió al quedar embarazada? Marque una respuesta.
   - ❑ Hubiera querido quedar embarazada mas pronto
   - ❑ Quería quedar embarazada en ese momento
   - ❑ No quería quedar embarazada en ese momento, sino después
   - ❑ No quería quedar embarazada ni en ese momento ni nunca
   - ❑ No sé
2. Durante el último año, ¿Usted ha sido golpeada, abofeteada, pateada o maltratada físicamente por alguien? ❑ Si ❑ No
3. ¿Está usted en una relación con una persona que la amenaza o la maltrata físicamente? ❑ Si ❑ No
4. ¿Alguien la ha forzado a tener actividades sexuales que le han hecho sentir incómoda? ❑ Si ❑ No
5. ¿En los últimos 12 meses estuvo usted alguna vez con hambre pero no comió porque no podía permitirse el lujo de comprar alimentos? ❑ Si ❑ No
6. ¿El lugar donde vive esta peligroso o tiene problemas conseguiendo una vivienda estable? ❑ Si ❑ No
7. Indique su situación actual respecto al habito de fumar. Marque una respuesta.
   - ❑ Yo NUNCA he fumado, o he fumado MENOS DE 100 cigarrillos en toda mi vida
   - ❑ Yo dejé de fumar ANTES de darme cuenta que estaba embarazada, y no fumo ahora
   - ❑ Yo dejé de fumar DESPUES de darme cuenta que estaba embarazada, y no fumo ahora
   - ❑ Yo fumo un poco ahora, pero he reducido la cantidad de cigarrillos que fumo desde que me di cuenta que estaba embarazada
   - ❑ Yo fumo la misma cantidad que antes de darme cuenta que estaba embarazada
8. ¿Alguno de sus padres tenía problemas con el alcohol o el uso de otras drogas? ❑ Si ❑ No
9. ¿Alguno de sus amigos tiene problemas con el alcohol o el uso de otras drogas? ❑ Si ❑ No
10. ¿Su pareja tiene problemas con el alcohol o el uso de otras drogas? ❑ Si ❑ No
11. En el pasado, ¿Ha tenido usted dificultades en su vida debido al alcohol u otras drogas, incluyendo medicinas que necesitan receta médica? ❑ Si ❑ No
12. Antes que supiera que estaba embarazada, ¿Con qué frecuencia usted tomaba cualquier alcohol, incluyendo cerveza o vino, o utilizaba otras drogas?
    ❑ Nunca ❑Raramente ❑Algunas veces ❑Frecuentemente
13. En el último mes, ¿Con qué frecuencia usted bebió alcohol, incluyendo cerveza o vino, o usó otras drogas?
    ❑ Nunca ❑Raramente ❑Algunas veces ❑Frecuentemente

*Required fields

Version 2 (Rev. 12/01/2020) Submit completed form to the CMHRP staff at the local health department in the patient's county of residence.

Appendix G: CIHA High-Risk Pregnancy Screening Form



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CIHA High Risk Pregnancy v1

Total Questions : 28

Member Details :
Name: **CIHA Chart ID:**
Date Of Birth: **Home Phone:**

1 **What is the EDC?**
Please confirm
What criteria used?
LMP 1st trimester U/S 2nd trimester U/s

2 **When is your next prenatal appointment?**
Please confirm

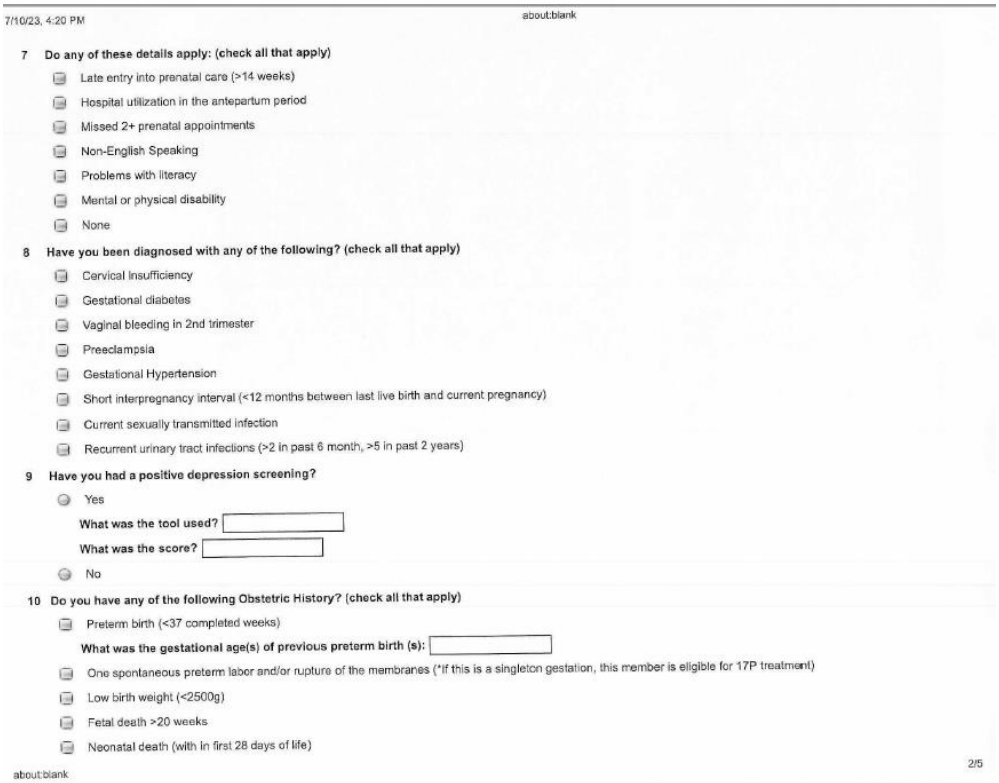
3 **What was your pre-pregnancy weight?**
Please confirm

4 **What is your height?**
Please confirm

5 **Does the member have any Fetal Complications during the current pregnancy?**
Yes
Complications
Fetal Anomaly Fetal Chromosomal Anomaly Intrauterine Growth restriction (IUGR) Oligohydramnios Polyhydramnios None
Others
No

6 **Does the member have any chronic conditions that may complicate pregnancy?**
Yes
Comorbidities
Diabetes Hypertension Asthma Mental Iliness HIV Seizure Disorder Renal Disease Systemic Lupus Erythemosus None
Others
Does the member have a specialist to treat them?
Yes No
No

about:blank 1/5



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7 **Do any of these details apply: (check all that apply)**
Late entry into prenatal care (>14 weeks)
Hospital utilization in the antepartum period
Missed 2+ prenatal appointments
Non-English Speaking
Problems with literacy
Mental or physical disability
None

8 **Have you been diagnosed with any of the following? (check all that apply)**
Cervical Insufficiency
Gestational diabetes
Vaginal bleeding in 2nd trimester
Preeclampsia
Gestational Hypertension
Short interpregnancy interval (<12 months between last live birth and current pregnancy)
Current sexually transmitted infection
Recurrent urinary tract infections (>2 in past 6 month, >5 in past 2 years)

9 **Have you had a positive depression screening?**
Yes
What was the tool used?
What was the score?
No

10 **Do you have any of the following Obstetric History? (check all that apply)**
Preterm birth (<37 completed weeks)
What was the gestational age(s) of previous preterm birth (s):
One spontaneous preterm labor and/or rupture of the membranes (*If this is a singleton gestation, this member is eligible for 17P treatment)
Low birth weight (<2500g)
Fetal death >20 weeks
Neonatal death (with in first 28 days of life)

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- Second trimester pregnancy loss
- Three or more first trimester pregnancy losses
- Cervial insufficiency
- Gestational diabetes
- Postpartum depression
- Eclampsia
- Preeclampsia
- Gestational Hypertension
- HELLP syndrome
- None

11 Does the member's provider request care management?

- Yes
- No

12 Thinking back to just before you got pregnant, how did you feel about becoming pregant? (Choose best answer)

- I wanted to be pregnant sooner
- I wanted to be pregnant now
- I wanted to be pregnant later
- I did not want to be pregnant then or any time in the future
- I don't know

13 Within the last year, have you been hit, slapped, kicked or otherwise physically hurt by someone?

- Yes
- No

14 Are you in a relationship with a person who threatens or physcially hurts you?

- Yes
- No

15 Has anyone forced you to have sexual activites that made you feel uncomfortable?

- Yes
- No

16 In the last 12 months were you ever hungry but didn't eat because you can't afford enough food?

- Yes
- No

17 Are you living situation unsafe or unstable?

- Yes
- No

18 Which statement best describes your smoking status?

- I have never smoked, or have smoked less than 100 cigarettes in my lifetime
- I stopped smoking BEFORE I found out that I was pregnant and am not smoking now
- I stopped smoking AFTER I found out that I was pregnant and am not smoking now
- I smoke now but have cut down some since I found out I was pregnant
- I smoke about the same amount now as I did before I found out I was pregnant

19 Do any of your parents have a problem with alcohol or other drug use?

- Yes
- No

20 Do any of your friends have a problem with alcohol or other drug use?

- Yes
- No

21 Does your partner have a problem with alcohol or other drug use?

- Yes
- No

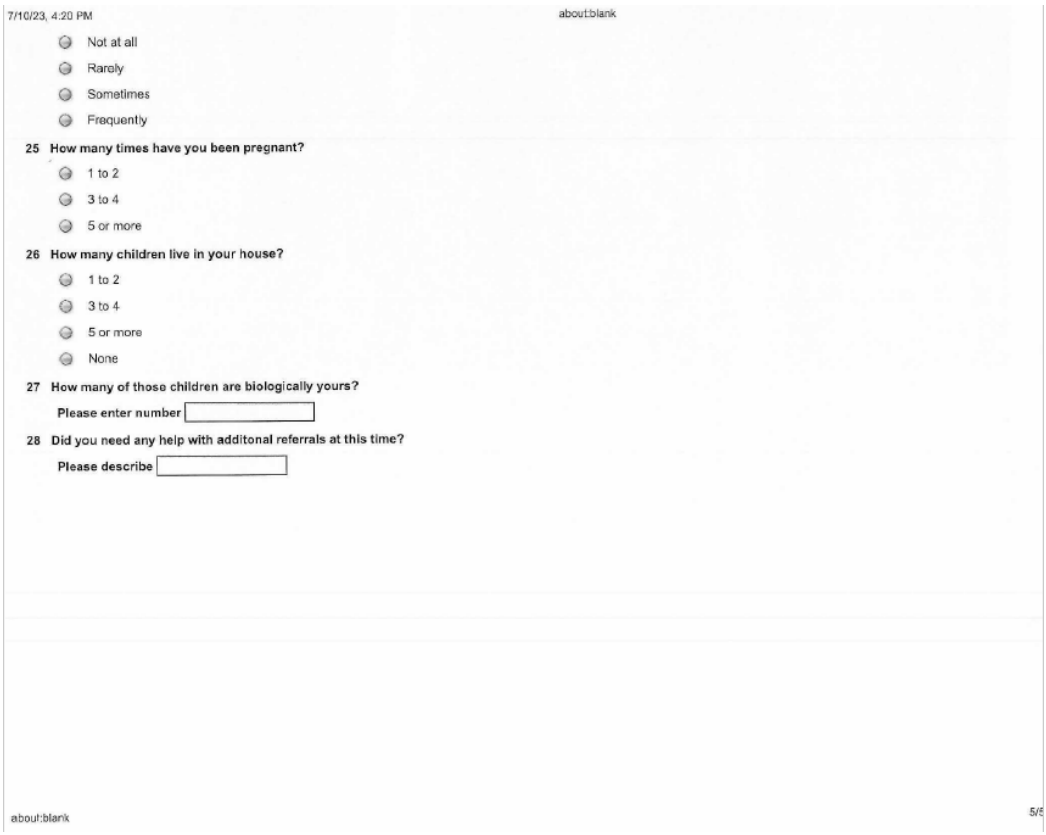
22 In the past, have you had difficulties in your life due to alcohol or other drugs, including prescription medications?

- Yes
- No

23 Before you knew you were pregnant, how often did you drink any alcohol, including beer or wine, or use other drugs?

- Not at all
- Rarely
- Sometimes
- Frequently

24 In the past month, how often did you drink any alcohol, including beer or wine, or use other drugs?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Not at all
Rarely
Sometimes
Frequently
25 How many times have you been pregnant?
1 to 2
3 to 4
5 or more
26 How many children live in your house?
1 to 2
3 to 4
5 or more
None
27 How many of those children are biologically yours?
Please enter number
28 Did you need any help with additonal referrals at this time?
Please describe
about:blank

Appendix H: CMHRP Community Referral Form

Care Management for High-Risk Pregnancies Referral

The Care Management for High-Risk Pregnancies (CMHRP) Program is available to pregnant and postpartum individuals who have or may qualify for Medicaid. Examples of potential social and/or medical factors that qualify an individual for CMHRP services are below; however, this is not an exhaustive list. Please refer individuals who may benefit from receiving CMHRP services, and eligibility will be determined once the referral is received. CMHRP services strive to increase positive birth outcomes across the state.

Working together to improve the health of mothers and babies in North Carolina.

Patient Notification	
☐	Patient is aware of this referral and has given permission for this information to be shared with the Care Management for High-Risk Pregnancies (CMHRP) Program.
☐	I am the making this referral for myself to the Care Management for High-Risk Pregnancies (CMHRP) Program.

Potential Qualifying Social and/or Medical Factors		
☐ History of preterm birth (less than 37 completed weeks)	☐ History of low birth weight (less than 2500 grams/5 lbs. 8 oz)	☐ Lack of transportation for medical appointments
☐ Chronic medical and/or behavioral health conditions which may complicate pregnancy	☐ Current substance/alcohol use (or use in the month prior to pregnancy)	☐ Unsafe living environment (Intimate Partner Violence/abuse /unstable housing/ homelessness)
☐ Fetal complications	☐ Current tobacco use	☐ Poor nutrition or lack of food

Patient Information					
Patient Name:		Date of Birth:		Due Date:	
Address (include City & Zip Code):					
County:					
Home Phone:		Cell phone:		Work/Alternate phone:	
Insurance type:	☐ Medicaid	Medicaid ID #:			
	☐ None			☐ Private	
Name of Prepaid Health plan PHP (*if known*):					
Referral Reason:					
Referral Agency			Phone Number:		
Contact Name			Date:		

Please submit this form to your local CMHRP agency, which is the county health department in most locations.

CMHRP Program Manual
CMHRP Community Referral Form
9/1/19, 2/22/21

Appendix I: CMARC Referral Form - Page 1

Care Management for At Risk Children (CMARC)
Referral Form

Internal Use: Date Referral Received:

CMARC - Target Population Birth to 5 Years	
Child's Name:	Referral Date (mm/dd/yyyy):
Date of Birth (mm/dd/yyyy):	Gender: ☐ Female ☐ Male
Race: ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Caucasian or White ☐ Black or African American ☐ Other **If Hispanic/Latino**: ☐ Mexican ☐ Mexican-American ☐ Puerto Rican ☐ Cuban ☐ Other	
Medicaid ID #:	☐ Uninsured ☐ Health Choice ☐ Private Insurance
Applied for Medicaid? ☐ Yes ☐ No	Name Private Ins. Company:
Parent or Guardian Information	
Parent/Guardian's Name:	Date of Birth (mm/dd/yyyy):
Primary Language Spoken in Home:	Needs Interpreter? ☐ Yes ☐ No
Street Address:	
P.O. Box: City:	Zip Code: County:
Home Phone #: ( ) -	Cell Phone #: ( ) -
Employer:	Work Phone #: ( ) -
Relative/Neighbor Contact Name:	Contact Phone #: ( ) -
Referring Medical Home, Agency or Organization	
Referral Organization:	Contact Person:
Contact Phone Number: - -	Contact Fax Number: - -
Contact Email:	☐ Check here if you are child's PCP/Medical Home.
Parent/Guardian Informed of Referral? ☐ Yes ☐ No	
Child's Primary Care Provider, if not listed above:	

Target Populations for Referrals[1]

☐ **Child with Special Health Care Needs (CSHCN)** - Defined as a child at increased risk for a chronic physical, developmental, behavioral, or emotional condition that has lasted or is expected to last at least 12 months and who requires health and related services of a type or amount beyond that required by children generally.

Specific concern: _____

If developmental concern, has child been referred for Early Intervention Services? ☐ Yes ☐ No

☐ **Infant in Neonatal intensive Care Unit (NICU)**

☐ **Other Please specify:**_____

Child experienced adverse childhood event: includes, but is not limited to:

- ☐ Child in foster care
- ☐ History of abuse and neglect
- ☐ Caregiver unable to meet infant's health and safety needs/neglect
- ☐ Parent(s) has history of parental rights termination
- ☐ Parental/caregiver/household substance abuse, neonatal exposure to substances
- ☐ CPS Plan of Safe Care referral for "Substance Affected Infant" **(Complete section "Infant Plan of Safe Care")**
- ☐ Child exposed to family/domestic violence
- ☐ Unsafe where child lives / environmental hazards or violence
- ☐ Incarcerated family or household member
- ☐ Parent/guardian suffers from depression or other mental health condition, maternal postpartum depression
- ☐ Homeless or living in a shelter / Unstable housing
- ☐ Other Please specify: _____

Medical Home Referral[2]

☐ Check here if primary care provider (listed above) would like to make a direct referral for CMARC care management.

Specify reason for referral if not indicated above: _____

Notes:

[1] If any of the boxes under "Target Populations for Referral" is checked, the child is eligible for CMARC Program and will receive a comprehensive health assessment.

[2] If the Medical Home provider checks the "direct referral" box, the child is automatically referred for CMARC care management. The CMARC care manager may contact the Medical Home to clarify the need, as appropriate.

DSS- 1404 (Version 3, Rev 03/2021) Submit completed form to the CMARC staff at the health department in the child's county of residence.

Appendix I: CMARC Referral Form - Page 2

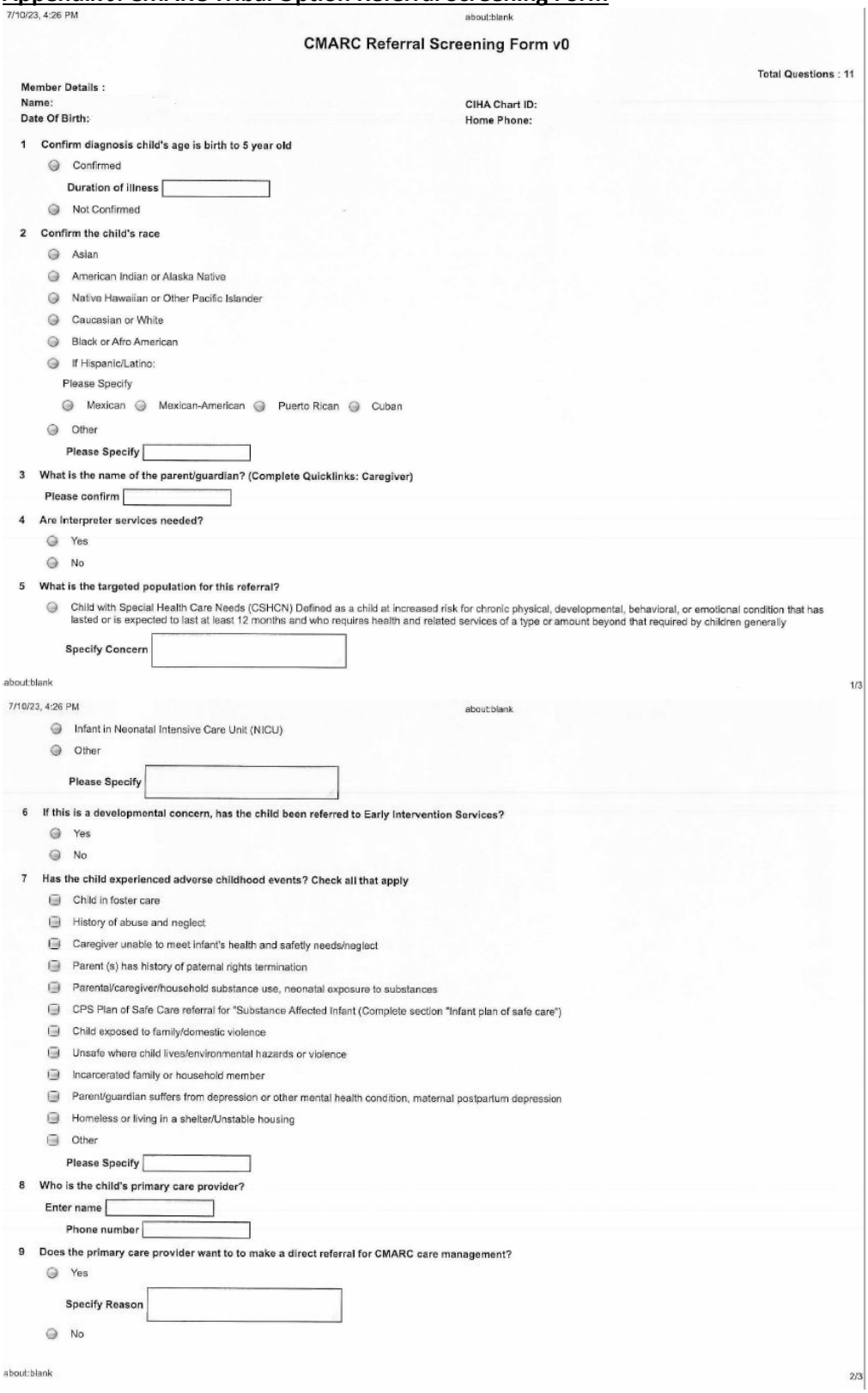
Care Management for At Risk Children (CMARC)
Referral Form

Internal Use: Date Referral Received:

Infant Plan of Safe Care	
Child's Name:	
Date of Birth (mm/dd/yyyy):	
Based on information known at intake and the services provided by CMARC, infant and family could benefit from the following (check all that apply): **Comments:**	☐ Comprehensive health assessment to identify a child's needs and plan of care, including Life Skills Progression ☐ Linkage to medical home and communication with primary care provider ☐ Services and education provided by CMARC care managers that are tailored to child and family needs and risk stratification guidelines. ☐ Identify and coordinate care with community agencies/resources to meet the specific needs of the family. Please specify below: ☐ Evidence-Based Parenting Programs ☐ LME/MCO or mental health provider ☐ Home visiting programs, if available ☐ Housing resources ☐ Food resources (WIC, SNAP, food pantries) ☐ Assistance with transportation ☐ Identification of appropriate childcare resources ☐ Other _____ ☐ Screening for referral to Infant-Toddler Program through Early Intervention for infants with diagnosis of Neonatal Abstinence Syndrome or for infants with developmental concerns ☐ Assessment of family strengths and needs and how they influence the health and wellbeing of the child

DSS- 1404 (Version 3, Rev 03/2021) Submit completed form to the CMARC staff at the health department in the child's county of residence.

Appendix J: CMARC Tribal Option Referral Screening Form



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CMARC Referral Screening Form v0

Total Questions : 11

Member Details :
Name: **CIHA Chart ID:**
Date Of Birth: **Home Phone:**

1 **Confirm diagnosis child's age is birth to 5 year old**
- ○ Confirmed
  - **Duration of illness** [ ]
- ○ Not Confirmed

2 **Confirm the child's race**
- ○ Asian
- ○ American Indian or Alaska Native
- ○ Native Hawaiian or Other Pacific Islander
- ○ Caucasian or White
- ○ Black or Afro American
- ○ If Hispanic/Latino:
  - Please Specify
  - ○ Mexican ○ Mexican-American ○ Puerto Rican ○ Cuban
- ○ Other
  - **Please Specify** [ ]

3 **What is the name of the parent/guardian? (Complete Quicklinks: Caregiver)**
- **Please confirm** [ ]

4 **Are Interpreter services needed?**
- ○ Yes
- ○ No

5 **What is the targeted population for this referral?**
- ○ Child with Special Health Care Needs (CSHCN) Defined as a child at increased risk for chronic physical, developmental, behavioral, or emotional condition that has lasted or is expected to last at least 12 months and who requires health and related services of a type or amount beyond that required by children generally
  - **Specify Concern** [ ]

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- ○ Infant in Neonatal Intensive Care Unit (NICU)
- ○ Other
  - **Please Specify** [ ]

6 **If this is a developmental concern, has the child been referred to Early Intervention Services?**
- ○ Yes
- ○ No

7 **Has the child experienced adverse childhood events? Check all that apply**
- ☐ Child in foster care
- ☐ History of abuse and neglect
- ☐ Caregiver unable to meet infant's health and safetly needs/neglect
- ☐ Parent (s) has history of paternal rights termination
- ☐ Parental/caregiver/household substance use, neonatal exposure to substances
- ☐ CPS Plan of Safe Care referral for "Substance Affected Infant (Complete section "Infant plan of safe care")
- ☐ Child exposed to family/domestic violence
- ☐ Unsafe where child lives/environmental hazards or violence
- ☐ Incarcerated family or household member
- ☐ Parent/guardian suffers from depression or other mental health condition, maternal postpartum depression
- ☐ Homeless or living in a shelter/Unstable housing
- ☐ Other
  - **Please Specify** [ ]

8 **Who is the child's primary care provider?**
- **Enter name** [ ]
- **Phone number** [ ]

9 **Does the primary care provider want to to make a direct referral for CMARC care management?**
- ○ Yes
  - **Specify Reason** [ ]
- ○ No

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10 Infant Plan of Safe Care: Based on information known at intake and the services provided by CMARC, infant and family could benefit from the following: (Check all that apply)

- ☐ Comprehensive health assessment to identify the child's needs and plan of care, including Life Skills Progression
- ☐ Linkage to medical home and communication with primary care provider
- ☐ Services and education provided by CMARC care managers that are tailored to child and family needs and risk stratification guidelines
- ☐ Screening for referral to Infant-Toddler Program through Early intervention with diagnosis of Neonatal Abstinence Syndrome of for infants with developmental concerns
- ☐ Assessment of family strengths and needs and how they influence the health and wellbeing of the child
- ☐ Identify and coordinate care with community agencies/resources to meet the specific needs of the family

Check all that apply

☐ Evidence-Based Parenting Programs ☐ LME/MCO or mental health provider ☐ Home visiting programs, if available ☐ Housing resources ☐ Food resources (WIC, SNAP, food pantries) ☐ Assistance with transportation ☐ Idenfication of appriopriate childcare ☐ Other

If Other, Please Specify

11 End of Assessment

End call

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Appendix K: CMHRP Measures Set

Performance Measure	Measure Description
Monthly & Rolling Penetration Rate	Numerator = any member[12] with a completed care management encounter[13] in the past 30 days. Denominator= Number of women ages 14 to 44 years.
Outreach Rate (CMHRP)	Numerator= Number of members with a "Completed" encounter OR 3 or more "Attempted"encounters within 7 business days of a referral by the PHP Denominator= Number of members referred for CMHRP services in the reported month
Active Management Rate(CMHRP)	Numerator=Number of members who have a care plan signed within 15 calendar days ofengaging in care management Denominator= Number of members receiving care management in the reported month.
Health Outcome Measures[14]	**Measure Description**
Low Birth Weight Births	N=Number of live, singleton births weighing <2,500 grams at birth in the CMHRP enrolledpopulation during the measurement period. D= All live, singleton births in the CMHRP program-enrolled population during the measurementperiod. Measure Steward: NC DHHS
Timeliness of PrenatalCare (PPC)	N= Number of members who received a prenatal care visit in the first trimester. D = All members who received CMHRP services who had a completed CMHRP CM contact duringthe measurement period. Measure Steward: NCQA NQF endorsed: 1517
Postpartum Care (PPC)	N = Number of members who received a postpartum care visit between 7 and 84 days afterdelivery. D = All members who received CMHRP services who had a completed CMHRP CM contact duringthe measurement period. Measure Steward: NCQA NQF endorsed: 1517

[12] A member is a Medicaid member assigned to the PHP per the beneficiary file

[13] Encounter is defined as In-person (including virtual) visit with care manager or member of care team; could include delivery of comprehensive assessment, development of care plan, or other discussion of patient's health-related needs. Phone call or active email/text exchange between member of care team and member (e.g., to discuss care plan or other health-related needs); must include active participation by both parties.

[14] All Health Outcomes Measures use technical specifications defined by the attributable measure steward and are stratified by the eligible study population.

Appendix L: CMARC Measure Set

Performance Measure	Measure Description
Utilization (Penetration) Rate	Percentage of members ages 0 to 5 years that are in a CMARC Episode with a completed **encounter**[13] (Including email & text)
Outreach and Engagement Rate (CMARC)	Percentage of members referred for care management who had a completed care management **encounter**[13] with member within 7 business days or 3 or more attempted encounters with member within 7 business days of the current CMARC Episode being open.
Active Management Rate(CMARC)	Percentage of members **engaged**[15] in care management who had a care plan signed within 30 days of engagement in CMARC services.
Health Outcome Measure14[14]	**Measure Description**
Well-Child Visits in the First 30 Months of Life (W30)	The percentage of children enrolled in CMARC services ages 0-30 who have received well-child visits as per the periodicity schedule. Measure Steward: NCQA
Child and Adolescent Well Visits (WCV)	The percentage of children ages 3-5 years enrolled in CMARC services who have receive well visits as per the periodicity schedule. Measure Steward: NCQA
Childhood ImmunizationStatus (Combo 10) (CIS)	The percentage of children 2 years of age who received the recommended vaccinations for allmembers enrolled into CMARC services in the reported year. Measure Steward: NCQA NQF endorsed: 0038

[15] Engaged in care management = placed in a new engaged episode status at any point in the month. If the member skips engaged and goes straight to managed/monitored, this start date is used.

Appendix M: Transition of Care: Supporting CMARC Members Transitioning to Tailored Care Management

Overview

This Appendix establishes the Department's expectations of LHDs transitioning CMARC members who meet Tailored Plan criteria and who will transition to Tailored Care Management (TCM). This does not serve as a replacement for Transition of Care policy[16] established by the Department or other transition of care requirement in the contract.[17]

Transition of Care Requirements

Transition of Care timelines are established in the NC DHHS Transition of Care Policy and related technical documents. Upon learning a CMARC Member is TCM eligible, the LHD will initiate the TOC activities.

1. For all Members transitioning from the LHD, the LHD shall transfer the information necessary to ensure continuity of care, including appropriate TOC data files and Member-specific, socio-clinical information.
    a. The LHD shall facilitate the transfer of Member's claims/encounter history and Prior Authorization (PA) data between LHDs and to other authorized Department Business Associates following the data transfer protocols established by the Department and in accordance with related contract and privacy and security requirements. Transferred Member-specific, socio-clinical information is also referred to as the Member's transition file. A Member's transition file content may vary based on the Member's circumstance but shall, at a minimum, include:
    a. The transitioning Member's most recent care needs screening.
    b. The transitioning Member's most recent care plan (for transitioning care- managed Members and Members disenrolling from the Managed Care Entity, if available).
    c. A list of any open adverse benefit determination notices for which the appeal timeframe has not yet expired and the status of open appeals.
    d. A TOC Warm Handoff Summary Page[18] is required for each Member.
    e. This summary page includes minimally:
        i. List current providers.
        ii. List of current authorized services.
        iii. List of current medications.
        iv. Active diagnoses.
        v. Known allergies.
        vi. Existing or prescheduled appointments, including Non-Emergency Medical Transportation (NEMT), as known.
        vii. 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.
    f. Additional information as needed to ensure continuity of care.

[16] Transition of Care Policy: https://files.nc.gov/ncdma/documents/Transformation/caremanagement/NCDHHS-Transition-of-Care-Policy-20210225.pdf
[17] General Transition of Care Requirement for CIHA is available in the Indian Managed Care Entity Contract
[18] TOC Warm Handoff Summary Page: https://medicaid.ncdhhs.gov/transition-care-warm-handoff-summary/download?attachment

2. The LHDs shall adhere to the following timeframes related to transition data and transition file content transfer:
   a. The LHDs shall transfer claims, prior authorization and pharmacy lock-in data to the appropriate receiving entity in accordance with the applicable Transition of Care Data Specification Guidance.[19]
   b. The LHDs shall initiate a warm handoff, for all eligible members and transfer the Member's transition file to the applicable health plan or receiving entity on a timeline appropriate to the Member's circumstance but occurring no later than the Member's transition date.

   Warm handoff is a member-specific meeting or knowledge transfer session between transferring entity and receiving entity. Warm handoff members are High Need members who have been identified by Medicaid Direct "transition entities" or by a Tailored Plan as warranting a verbal briefing between transition entity and receiving entity. Warm Handoffs require collaborative transition planning between both transferring and receiving entities and as possible, occur prior to the transition.
   c. If the receiving entity receives notice of a transitioning Member's enrollment and has not received the applicable transition data file or the Member's transition file within **five business days** of the transition notice date, the receiving entity will contact the LHD on the following business day to request the transition information as needed.
3. Upon receipt of the relevant Member information, the receiving entity shall ensure all data as defined by the Department, once received, is transferred to the Member's AMH Tier 3 or Clinically Integrated Network (CIN) coinsurance on the timetables established in applicable AMH Data Specification Guidance.
4. The receiving entity shall allow a Member to complete an existing authorization period established by their previous LHD.
5. The receiving entity shall assist the Member in transitioning to an in-network provider at the end of the authorization period if necessary.
6. In accordance with N.C. Gen. Stat. § 58-67-88(d)-(g), the receiving entity shall permit the Member to continue seeing their provider, regardless of the provider's network status, in the following instances: A Member transitions into a PHP from NC Medicaid Direct; another PHP or another type of health insurance coverage and the Member is in an Ongoing Course of Treatment or has an Ongoing Special Condition.

[19] Transition of Care Data Specification Guidance: https://medicaid.ncdhhs.gov/care-management/transition-care-data-specification-guidance

Appendix N: Healthy Opportunities Pilot Guidance for LHDs

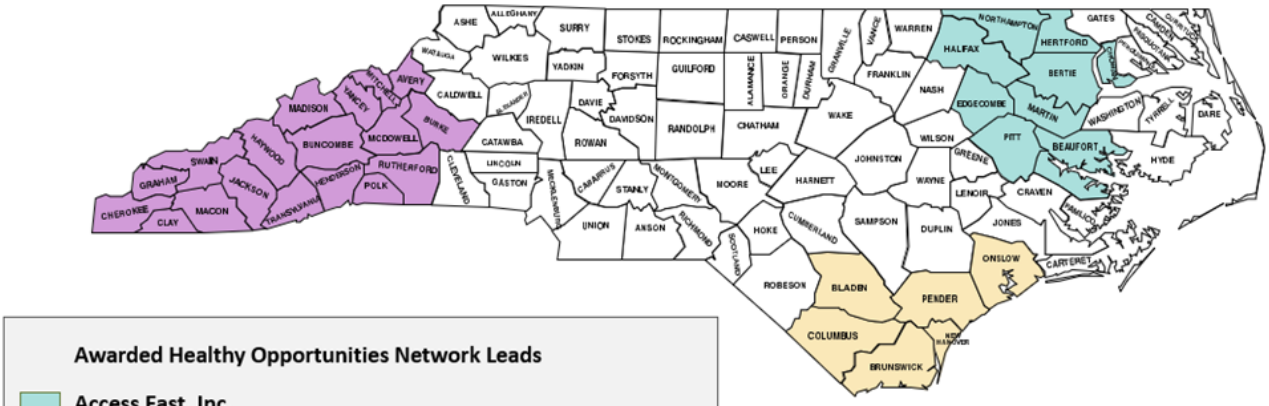
North Carolina's transition to Medicaid managed care included the launch of the Healthy Opportunities Pilots ("the Pilots") in 2022.[20] The Pilots present an unprecedented opportunity to test the impact of providing evidence-based, non-medical interventions to Medicaid enrollees. In October 2018, the Centers for Medicare and Medicaid Services (CMS) authorized up to $650 million in state and federal Medicaid funding to cover the cost of providing select Pilot services that address non-medical drivers of health in four priority domains: housing, food, transportation, and interpersonal violence/toxic stress. While access to high-quality medical care is critical, research shows that up to 80 percent of a person's health is determined by social and environmental factors and the behaviors that emerge as a result.

The Pilots allow for North Carolina's Medicaid managed care plans ("Prepaid Health Plans (PHPs)"), providers, and community-based organizations to have the tools, infrastructure, and financing to integrate non-medical services, such as medically tailored home delivered meals or short-term post hospitalization housing, that are directly linked to health outcomes into the delivery of care. The Department has developed the Healthy Opportunities Pilots Fee Schedule (Appendix B of the Healthy Opportunities Program Guide for LHDs) to define and price these non-medical interventions. The Pilots test whether Pilot services, which are delivered by local community-based organizations and social services agencies called human service organizations (HSOs), can improve health outcomes and/or reduce health care costs for Medicaid managed care enrollees experiencing certain health needs and social risk factors.

Most Human Service Organizations (HSOs) that deliver Pilot services are participating in the health care system for the first time through the Pilots. While many HSOs traditionally rely on grant funding, in the Pilots they operate as Medicaid providers by invoicing for delivered services based on a fee schedule. To operationalize the fundamental shift in business processes for these organizations, infrastructure and procedures have been put in place to assist HSOs in invoicing and paying for Pilot services. These processes seek to build HSO capacity while minimizing burden and ensuring that HSOs are able to effectively participate in the Pilots.

The Pilots operate in three regions of the state – two in eastern North Carolina and one in western North Carolina. See the map below for the identified Pilot regions. An organization in each region – called the "Healthy Opportunities Network Lead" –builds and oversees networks of HSOs that deliver Pilot services.

[20] For programmatic guidance on the Pilots, please refer to the Healthy Opportunities Program Guide for LHDs.



Awarded Healthy Opportunities Network Leads

Access East, Inc.

Beaufort, Bertie, Chowan, Edgecombe, Halifax, Hertford, Martin, Northampton, Pitt

Community Care of the Lower Cape Fear

Bladen, Brunswick, Columbus, New Hanover, Onslow, Pender

Dogwood Health Trust

Avery, Buncombe, Burke, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania, Yancey