Division of Health Benefits | NC Medicaid

Program Guide

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

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I. Introduction

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

The Cherokee Indian Hospital Authority (CIHA) has entered into a contract 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 beneficiaries. This Indian Managed Care Entity is the first of its kind in the nation and will establish 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 is set to launch in July 2021 along with Standard Plans. The EBCI Tribal Option will manage health care for approximately 4,000 Tribal Medicaid beneficiaries residing primarily in Cherokee, Graham, Haywood, Jackson, and Swain counties. The program will have a strong focus on primary care, preventive health, chronic disease management and provide care management for all members and care management service plans for high-need members. The EBCI Tribal Option will coordinate 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 manual refers to care management services for at-risk children and high-risk pregnancy women who are enrolled in Standard Plans and receiving care management through Local Health Departments. Tribal Members or individuals eligible of Indian Health Services (IHS), enrolled in the EBCI Tribal Option will receive care management services through the EBCI Tribal Option. Tribal Members or IHS eligibles, enrolled in Standard Plans may choose to have their care management service delivered by the EBCI Tribal Option

Current Medicaid Programs for Pregnant Women and At-Risk Children

Currently, North Carolina provides high-quality obstetric care for all Medicaid beneficiaries, as well as care management services for high-risk pregnancies and at-risk children in the Medicaid program through locally administered programs – the Pregnancy Medical Home (PMH), the Pregnancy Care Management (OBCM) program and the Care Coordination for Children (CC4C) program. These programs operate through an administrative and technical infrastructure that links together providers, local health departments (LHD), Community Care of North Carolina (CCNC) and the Department of Health and Human Services' Division of Health Benefits (DHB) and Division of Public Health (DPH) (The Department).

[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/Sessions/2019/Bills/Senate/PDF/S808v8.pdf

Delivering excellent clinical obstetric care and providing care management for high-risk pregnancies and at-risk children in North Carolina is a paramount concern for the Department. During the transition, existing specialized programs for pregnant individuals and at-risk children will change. However, the Department is committed to providing a pathway for transitioning these programs as the state moves to managed care[2].

The PMH, OBCM and CC4C 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, from the overall design of the program to the development of clinical pathways and other program features that have evolved over time. CCNC has traditionally played a role in convening of clinicians to engage in, and evolve, the PMH program. Additionally, LHDs have long played a critical role in the provision of care management services for high-risk pregnancies and at-risk children. The Department and CCNC have provided programmatic oversight, evaluation and training for both care management programs.

During the move to managed care, the Department has a three-fold objective: (1) to continue to provide high-quality services to pregnant Medicaid beneficiaries and children in close partnership with clinicians across the state; (2) to provide a pathway for current providers of these services to transition to managed care; and (3) to ensure a seamless transition of services for beneficiaries into the managed care environment. The Department believes that the provision of these care management services at the local level is the best approach and will require health plans to contract under the current model through the first three years of managed care (defined as the "transition period")[3]. Thereafter, providers, LHDs and health plans will negotiate program terms through the regular contracting process.

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

[3] The transition period starts the day the first region begins managed care and follows the health plans contract years. Year 1 launches July 2021 and Year 3 ends June 30th,2024. The transition period was changed from two years to three years as a result of stakeholder feedback.

Current Programs for Pregnant Women

Pregnant Medicaid beneficiaries are offered services based on the level of risk of an adverse birth outcome. All pregnant beneficiaries are eligible to participate in the PMH program, while those that are determined to be high-risk also receive OBCM Services.

Pregnancy Medical Home (PMH) Launched in 2011, the PMH program provides comprehensive, coordinated maternity care with a special focus on preterm birth prevention. All providers who bill for perinatal services are eligible to enroll in the program. Currently, more than 90 percent of all perinatal care provided to pregnant Medicaid beneficiaries in North Carolina is through a PMH. To qualify for participation as a PMH, the provider must agree to meet certain requirements, such as:

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

In addition to agreeing to requirements on pregnancy services, the PMH program pays providers incentive payments for 1) completing a standardized risk screening tool at initial visit ($50), and (2) conducting a postpartum visit ($150). The standardized risk screening tool identifies high-risk pregnant beneficiaries for care management services in OBCM. Today, the PMH program operates through CCNC, who provides regionally based support to enrolled practices and convenes clinicians on a routine basis and in conjunction with Department leadership to review programmatic requirements, performance and other items.

Pregnancy Care Management (OBCM) Since 1986, LHDs have provided care management to pregnant Medicaid beneficiaries identified as being at high risk of a poor birth outcome. The care management model consists of education, support, linkages to other services, 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 are assigned a Pregnancy Care Manager to coordinate their care and services through the end of the post-partum period. Today, the Department provides programmatic oversight, evaluation and training for OBCM. CCNC provides the technology infrastructure, including the documentation platform and the data analytics platform.

Current Program for At-Risk Children – Care Coordination for Children (CC4C)

CC4C is a care management program for at-risk young children ages zero to five providing coordination between healthcare providers, linkages and referrals to other community programs and supports, and family supports. LHDs have been providing services to at-risk children since 1986. Each child served by CC4C is linked to a specific Medical Home and a CC4C Care Manager. The care manager, in collaboration with the child's family, coordinates the child's care to ensure they obtain appropriate medical care, social services and other supports. Today, the program operates identically to OBCM, noted above, with the program also interfacing significantly with the Division of Social Services (DSS).

Under managed care, the names of these programs will change in the following manner:

- The PMH program name will become the "Pregnancy Management Program" (PMP)
- The OBCM program will become "Care Management for High-Risk Pregnancies" (CMHRP)
- The CC4C program will become "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 will change in managed care. Populations not moving into managed care will continue to be served by the programs in the same manner as today.[4]

Under managed care, North Carolina will designate Advanced Medical Homes (AMH), a subset of which will be paid higher reimbursement amounts for assuming primary responsibility for care management services for Medicaid beneficiaries. AMH providers will fall into one of four tiers, with requirements and payments increasing as tiers (and associated responsibilities) increase. Qualifying LHDs and OB/GYN providers who provide full primary care services per AMH policy can be an AMH, and 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 and 4[5] AMHs and are part of the PMP/CMHRP and CMARC programs will be eligible for both incentive payments[6].

This program guide provides key information to OB/GYN providers, pediatricians, LHDs, health plans and other interested stakeholders as to how the transition of care management programs for at-risk children and pregnant Medicaid beneficiaries will occur over time into the State's managed care model, how the programs will operate, and the expectations of providers, LHDs, health plans and the Department in each.

[4] To learn more about which populations will be enrolled in managed care, refer to the Beneficiaries in Medicaid Managed Care concept paper.

[5] 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.

[6] 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 Transition

	The Pregnancy Management Program (PMP)	Care Management for High-Risk Pregnancies (CMHRP)	Care Management for At-Risk Children (CMARC)
Target Population	All pregnant Medicaid beneficiaries enrolled in health plans	Pregnant Medicaid beneficiaries identified at risk for adverse birth outcomes	Children ages zero-to-five enrolled in Medicaid who meet the identified target group
Overview of Services Provided	Comprehensive, coordinated maternity care services with a focus on preventing pre-term birth	Governed by best practice, this more intense multi-disciplinary service provides care management for pregnant and post-partum beneficiaries identified as being at risk of adverse birth outcomes. Assisting and supporting high-risk pregnant beneficiaries with navigation of prenatal and postpartum care; as well as addressing barriers affecting their care and health.	Suite of coordinated care management services, promotes the medical home, linkage to community resources and provides support to families
Accountable Entity	Health Plans	Health Plans	Health Plans
Primary Service Provider	Local maternity care providers	LHDs who coordinate care with maternity care providers	LHDs who work with primary care/AMH providers and social services organizations
Program Coordination	The Department will continue to engage with a statewide advisory group of experts similar to the current Pregnancy Medical Home OB Champion Model. Details are forthcoming.	The Department and a statewide advisory group	The Department and a statewide advisory group

II. Managing High-Risk Pregnancies Under Managed Care

All pregnant beneficiaries enrolled in managed care through the health plans will continue to receive a coordinated set of high-quality clinical maternity services through the PMP. This program will be administered as a partnership between health plans and local maternity care service providers (defined as any provider of perinatal services). A key feature of the program will be the continued use of the standardized screening tool to identify and refer beneficiaries at risk for an adverse birth outcome to CMHRP, a more intense set of care management services that will be coordinated and provided by LHDs. Together, these two programs will work to improve the overall health of pregnant, postpartum, and newborn beneficiaries 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 beneficiaries enrolled in the state's managed care program. Providers can expect the parameters of the program to be consistent with the PMH program that exists today during a three-year transition into the managed care environment. The following represents a summary of current features of the PMP program that will be transitioned into managed care:

- Provider participation requirements will 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 will contract with health plans under standard contracting terms which are identical to the terms in today's program.

- Standard contracting provisions will be included. The health plans will incorporate program requirements aligned with the PMH program into their contracts with all maternity care providers. The continuation of these program requirements will ensure a smooth transition of services into the new managed care model under the health plan's administrative authority. The contracts will include process requirements, such as completing the standardized risk-screening tool, and clinical outcomes measures, such as decreasing the rate of nulliparous cesarean section. 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 will remain the same during the transition period. Individual provider contracts with health plans will incorporate an incentive payment structure that promotes high-quality outcomes and is consistent with the rate floors established by the Department in managed care. For the transition period, the incentive payment structure will remain the same as it is today:[7]
    1. $50 for the completion of the standardized risk screening tool at each initial visit;
    2. $150 for completion of postpartum visit held within 56 days of delivery.

  Additionally, providers will receive, at a minimum, the same rate for vaginal deliveries as they do for caesarian sections. In addition, providers will continue to be exempt from prior approval on ultrasounds.

[7] The timeframe of the incentive program has been expanded to three years, as is identical to the transition period, based on stakeholder feedback.

The health plans will be 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 will be required to adopt and administer a State-designated screening tool to identify high-risk pregnancies. The tool will be standardized across the state and will be consistent with the screening tool currently used by providers enrolled in the PMH program. The tool will be reviewed and updated as needed by the Department with input from the state-convened group. PMP providers will be required to send the completed standardized risk screening tool to both the health plan and the LHD 7 business days. As described further below, LHDs that receive the standardized screening form from a PMP provider that indicates a need for care management services must attempt to reach members identified to initiate care management services. Health plans are not permitted to conduct prior authorization for these services.

- Maternity care providers will be required to coordinate outreach and care management efforts with the LHDs for management of pregnant patients determined to be at risk of adverse birth outcomes. Similar to today, all PMP providers will be required to ensure appropriate coordination with LHD care managers for the sub-set of their practice population who receive CMHRP services described below.

- The health plans will be required to collect and report on a series of quality measures to ensure high-quality maternity care. The health plans will provide regular reports as prescribed to PMP practices, on the following measures (assuming a valid sample size):

    1. Prenatal and Postpartum Care: NQF 1517[8]
    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 according to health plan data.

  The health plans will also 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 Prepaid Health Plan Quality and Accountability concept paper.

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

Overview of the CMHRP

In addition to administration of the PMP program for all enrolled pregnant members, the health plans will contract with LHDs to administer care management services for recipients deemed as at risk for adverse birth outcomes. Outreach services for CMHRP services are initiated based on information obtained from the standardized screening tool administered to all pregnant patients in the PMP and as a result of each health plan's risk stratification efforts. 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 LHDs. LHDs will exclusively continue to provide these intensive care management services under managed care through the three-year transition period. The following represent a summary of key features of the CMHRP program:

- LHDs will continue to provide intensive care management services. During the transition period, the health plans will be required to contract with LHDs for provision of CMHRP services. If an 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 LHDs for eligibility determination and prioritization for CMHRP services. Potential recipients will be identified for CMHRP program services through the following methods: direct provider 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 will be required to offer standard contracting terms. The health plans will incorporate a series of standard program requirements into their contracts with all LHDs in the CMHRP program. The provisions are aligned with those in place today in the OBCM program, but incorporate the changes of moving to managed care, including ongoing collaboration and integration with 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 will 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.

- Process and quality measures for high-risk pregnancies**.** LHDs will be responsible for a series of process measures to ensure high-quality care management for high-risk pregnant women. A sub-set of these process measures will, in turn, be used to evaluate program outcomes.

Utilization (Penetration) Rate

- Percentage of pregnant women ages 14-44 who are receiving CMHRP care management services.

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 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 process measures, 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 measures include:

Quality Measures

- Low Birth Weight Births: Number of live, singleton births weighing <2,500 grams at birth in the CMHRP enrolled 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. LHDs will be required to use the standard documentation platform that is in existence today. LHDs that operate as AMH Tier 3 providers may be permitted flexibility to use a separate platform.[9]

- 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 LHDs when high-risk pregnant beneficiaries 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 will also be required to ensure that the member's care plan(s) document respective roles and responsibilities between the health plan/AMH Tier 3 practice and LHD. When a Medicaid recipient is receiving CMHRP services, the CMHRP care manager should take the care management lead. LHD care managers will be responsible for documenting roles/responsibilities in the standard documentation platform for instances where multiple care managers are serving the same enrollee to ensure that services are coordinated.

- 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 substantially similar to or no less than the amount paid in the existing program. 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 currently offers a set of care management services for at-risk children ages zero-to-five. The program promotes use of the medical home, links children and families to community resources and provides education and family support. To ensure these services continue to be provided in a seamless fashion during the move to managed care, current services provided under the CC4C program will transition into CMARC. 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 for the provision of local care management services.

The role currently played by LHDs in providing these key services will be continued and augmented in the managed care environment. Generally speaking, program administration for the CMARC program is similar to the CMHRP program, noted above. The following represents a summary of key features of the CMARC program:

- Continued role of LHDs in providing services. For the first three years of managed care, the health plans will be required to contract with LHDs for provision of CMARC services. If an LHD is unable or unwilling to contract, Section IV details the steps the health plans must take to ensure care management is delivered locally.

- Referral criteria. A significant percentage of the children currently receiving CMARC services will meet exemption criteria for managed care and will continue receiving fee-for-service benefits. To ensure consistency between the Medicaid Direct and managed care populations, the referral criteria will be identical to today's program. The CMARC program will accept referrals for children identified in the following target groups;
    - Children with Special Health Care Needs (CSHCN);
    - Children with experience in the Infant in Neonatal intensive Care Unit (NICU);
    - Children with experience of 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" (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

    Situations meeting these referral criteria are furthered detailed on the program screening form – see Appendix G.

- Referrals to LHDs for services. Children will be identified for the CMARC program through the following methods:
  - Direct provider referrals
  - Hospital Referrals
  - Social service agency referrals (e.g. Women, Infants and Children [WIC], DSS)
  - Direct referral by enrollees or families
  - Risk stratification or other identification methods by health plans.

  When an at-risk child is identified for CMARC by an entity outside the health plan (e.g. pediatric practice), they will be encouraged to make the referral directly to the LHD. If the entity only refers to the health plan, the health plan will make the referral to the LHDs.

- Standard Contracting Terms. For the first three years of managed care, the health plan will be required to contract with LHDs for provision of CMARC using standard contracting terms. To ensure fidelity to today's model, the language of the current agreement will be largely preserved-adapted only to reflect the new role of the health plans. The contract requirements include provisions related to outreach, population identification, family engagement, assessment and stratification of care management service levels, plan of care 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**.** LHDs will be responsible for a series of process measures to ensure high-quality care management for at risk children. These measures include process measures such as:

  Utilization (Penetration) Rate

- Percentage of members ages 0-5 who are receiving CMARC care management services.

  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 30 days of enrollment in CMARC services.

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

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:

- **Quality Measures**

   - Well-Child Visits in the First 30 Months of Life: The rate of well-child visits for children ages 0-30 months for all members enrolled into CMARC services in the reported year.
   - Child and Adolescent Well Visits: The rate of well-child visits for children ages 3-5 years of age for all members enrolled into CMARC services in the reported year.
   - 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. Similar to the program for high-risk pregnancy, LHDs will be required to use the standard documentation platform that is in existence today. LHDs that operate as AMH Tier 3 providers may be permitted flexibility to use a separate platform.

- 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. 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. Children with complex medical needs, in particular, 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 on a case by case basis. The health plans/Tier 3 AMH practices will designate a lead Care Manager and be the final arbiter of the roles/responsibilities breakdown.

  As with the CMHRP program and more generally, 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. The Health plans will also be required to ensure that the member's care plans(s) document respective roles and responsibilities between the health plan/AMH Tier 3 practice and LHD. 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.

- Payments to Local Health Departments. 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 LHDs at an amount substantially similar to or no less than the amount paid in the existing program. The health plans are permitted to introduce new payment models on top of the existing funding to further incentivize care management innovation.

IV. Oversight and Accountability for Programs

The health plans are responsible for the clinical and financial management of care and services for Medicaid beneficiaries who are pregnant, as well as care at-risk children. The Department will have rigorous oversight of all health plan operations. In addition, the Department will formally convene advisory groups of clinical leaders

and other key stakeholders to engage in ongoing development of the CMARC and CMHRP programs to ensure high-quality performance of providers of care management and clinical services.

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 patient 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 LHDs providing care management for recipients at-risk for adverse birth outcomes and at-risk children during the transition to Medicaid managed care. This support includes:

- Rollout training sessions in preparation for managed care transition;
- Ongoing training on critical performance metrics and quality improvement;
- Ad hoc support for 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 program, health plans will have a specific set of program responsibilities. The health plans will administer each program locally in partnership with providers and LHDs, and have overall accountability and risk for outcomes. For the programs for pregnant women, the health plans will specifically:

- Develop and execute contracts with standard contract terms for all providers who provide maternity services;
- Reimburse participating providers, including incentive payments, as required in DHHS policy;
- Permit PMP providers to refer directly to LHDs without prior authorization for initiation of care management services;
- Refer women identified as high-risk through the health plan's own risk stratification algorithms and methods to LHDs for care management services;
- 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 LHDs;

- Monitor for performance against the contract; 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 LHDs who operate the CMARC program;
- Permit pediatricians, other clinicians who care for children, and other entities, including social services providers, to refer directly to 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 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 LHDs;
- Ensure that medically-needy children have a designated lead Care Manager; and
- Monitor for performance against executed contracts
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LHD Contracting and Health Plan Performance Oversight

LHDs will need to contract with the health plans for the provision of care management services. During the three-year transitional period, the health plans will give LHDs the "right of first refusal" as contracted providers of care management for these populations, offering them standard terms for each program. The health plans will offer contracts to every LHD in their service region for provision of these care management services.

- LHDs will have 75 business days to accept the contract to perform care management services for these populations.
- If the LHD declines the contract, the health plan will consult the Department to identify another LHD in the same service region that is willing and able to provide care management services for pregnant recipients 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.

After contracts are executed and from the start of managed care, one of the health plan's primary roles is in monitoring performance according to the contract, providing risk stratification and referral data.

For 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 LHDs.

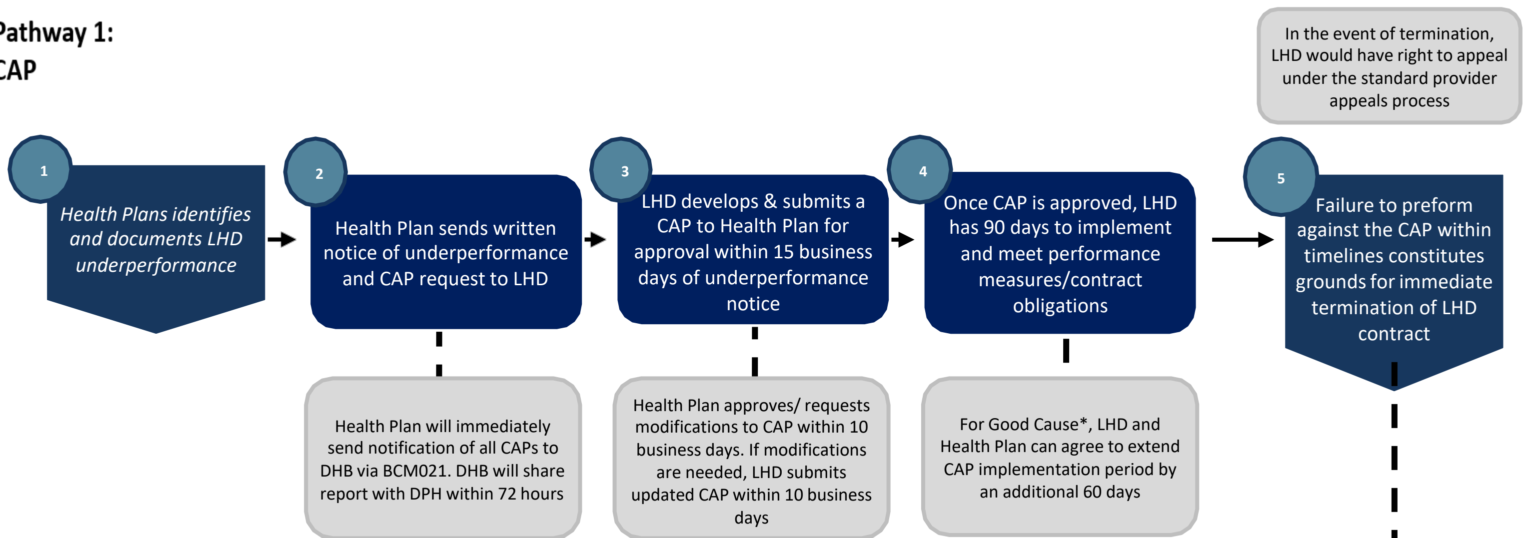
- Pathway #1: Standard Corrective Action Plan (CAP)

Step #	Pathway #1: Standard Corrective Action Plan (CAP)[10]
1	The health plan identifies and documents LHD underperformance.
2	The health plan issues a written notice detailing underperformance to the Local Health Department 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 72 hours or receiving the report.
3	The LHD will develop and submit a CAP to the health plan for approval within 15 business days of receiving notice of underperformance. The LHD must include in their 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, the 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 constitutes grounds for termination of the LHD's contract by the health plan. *In the event of a termination, the LHD would have the right to appeal the termination under the standard provider appeals process.*

[10] 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 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 transition to managed care represents a significant shift in the administration of health care benefits to women and children across the state. The State is committed to ensuring the continuation of the delivery of high-quality maternity care and critical care management services for pregnant women who at risk for adverse birth outcomes and at-risk children. The Department designed features of these clinical and care management programs under the managed care model and the transition period to prevent any disruptions and to ensure continued excellence for patients. The Department believes that these programs will continue to thrive and provide critical services for women and children in need across the state and will continue to leverage the leadership of maternity care providers, pediatricians, social services organizations, LHDs, and other stakeholders, as is currently the case in continuously monitoring and updating these programs to ensure their 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. CMHRP Pregnancy Risk Screening Form (English)
E. CMHRP Pregnancy Risk Screening Form (Spanish)
F. CMHRP Community Referral Form
G. CMARC Referral Form for At-Risk Children
H. CMHRP Measures Set
I. CMARC Measures Set

Appendix A: Standard Pregnancy Management Program (PMP) Contracting Requirements

1. The health plans shall incorporate the following requirements into their contracts with all providers of maternal care, including the following requirements for providers of the PMP:
    a. Complete the standardized risk screening tool at initial prenatal visit *and* as patient's biopsychosocial needs change;
    b. Integrate the patient's plan of care with local CMHRP staff, which is inclusive of collaboration and communication, ensuring access to HIPAA compliant space for adequate patient and CMHRP staff engagement, access to patients' EMR and to foster the embedded care management model;
    c. Allow HEALTH PLAN or HEALTH PLAN's designated vendor access to medical records for auditing purposes 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 section rate among nulliparous women;
    f. Offer and provide 17 alpha-hydroxyprogesterone caproate (17p) for the prevention of preterm birth to women 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 56 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 in an attempt to engage patients identified as needing intensive care management services as having a priority risk factor by: the health plan risk stratification, provider request, hospital utilization (Admissions, Discharges and Transfers)through claims data (emergency department utilization, antepartum hospitalization, utilization of labor and delivery triage unit) for referral to prenatal care and to engage in care management.
3. **Population Identification and Engagement**
    a. LHDs shall review and enter all pregnancy risk screenings received from PMPs covered by the pregnancy Care Managers into the designated care management documentation system within five calendar days of receipt of risk screening forms.
    b. LHDs shall utilize risk screening data, patient self-report information and provider referrals to develop strategies to meet the needs of those patients at highest risk for poor pregnancy outcome.
    c. LHDs shall accept pregnancy care management referrals from non-PMP prenatal care providers, community referral sources (such as DSS or WIC programs), patient self-referral, and provide appropriate assessment and follow up to those patients based on the level of need.
    d. LHDs shall review available health plan data reports identifying additional pregnancy risk status data, including regular, routine use of the Obstetric Admission, Discharge and Transfer (OB ADT) report, to the extent the OB ADT report remains available to LHDs.
    e. LHDs shall collaborate with out-of-county PMPs and CMHRP teams to facilitate cross-county partnerships to ensure coordination of care and appropriate care management assessment and services for all patients in the Target Population.
4. **Assessment and Risk Stratification**
    a. CMHRP CMs 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. LHDs shall utilize assessment findings, including those conducted by the health plans, to determine level of need for care management support.
    c. LHDs shall document assessment findings in the care management documentation system.
    d. LHDs shall ensure that assessment documentation is current throughout the period of time the CMHRP Care Manager is working with the patient and should be continually updated as new information is obtained and/or based upon program standards.
    e. 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 through ongoing assessment.
c. LHDs shall develop patient-centered care plans, including appropriate goals, interventions and tasks based on standardized, statewide CMHRP programmatic guidance documents.
d. LHDs shall utilize the statewide resource platform and identify additional community resources once the Department certifies it as fully functional.
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 Care Manager 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. LHD care manager 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 plan when accessing referrals and resources.
f. LHDs shall assist CMHRP members in obtaining information needed as it relates to the health plans' prior authorization processes relevant to referrals.

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 to identify individuals at greatest risk.
c. LHDs shall communicate with the health plans regarding challenges with cooperation and collaboration with maternity care providers.
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**
   a. LHDs shall ensure that CMHRP Care Managers and their supervisors attend CMHRP training offered by the health plan and/or DHHS, including webinars, New Hire Orientation or other programmatic training.
   b. LHDs shall ensure that CMHRP Care Managers and their supervisors attend continuing education sessions coordinated by the health plan and/or DHHS.
   c. LHDs shall ensure that CMHRP Care Managers and their supervisors pursue ongoing continuing education opportunities to stay current in evidence-based care management of pregnancy and postpartum women at risk for poor birth outcomes.
   d. LHDs shall ensure that CMHRP Care Managers and their supervisors have access to Motivational Interviewing, Mental Health First Aid and Trauma-Informed Care training.
9. **Staffing**
   a. LHDs shall employ care managers meeting CMHRP competencies defined as having at least one of the following qualifications:
      i. Registered nurses;
      ii. 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.
      iii. Care managers providing services to the CMHRP population hired prior to Sept. 1, 2011 without a Bachelors or Masters degree in Social Work may retain their existing position only. This grandfathered status does not transfer to any other position.
      iv. LHDs shall ensure that supervisors who carry a caseload must also meet the CMHRP care management competencies and staffing qualifications.
   b. LHDs shall ensure that Community Health Workers for Care Management for High-Risk Pregnancies' services work under the supervision and direction of a trained CMHRP Care Manager.
   c. 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.
   d. 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 the non-represented professional discipline within Public Health.
   e. LHDs 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 patients with both medically and socially complex conditions.
   f. LHDs shall ensure that the team of CMHRP Care Managers 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.
   g. LHDs shall ensure that CMHRP Care Managers must demonstrate:
      i. A high level of professionalism and possess appropriate skills needed to work effectively with the 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.

h. LHDs shall provide qualified supervision and support for CMHRP 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 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.

i. LHDs shall 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.

j. 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 children identified as in need of CMARC services.
2. **Outreach**
    a. LHDs shall educate patients, AMHs, other practices and community organizations about the benefits of the CMARC Program and target populations for referral; disseminate the CMARC Referral Form either electronically and/or in a paper version to potential referral sources.
    b. LHDs shall communicate regularly with the AMHs and other practices serving children zero to five years of age, to ensure that children served by that medical home are appropriately identified for CMARC services.
    c. LHDs shall collaborate with out-of-county AMHs and other practices to facilitate cross-county partnerships to optimize care for patients who receive services from outside their resident county.
    d. LHDs shall identify or develop if necessary, a list of community resources available to meet specific needs of the population.
    e. LHDs shall utilize the statewide resource platform, when operational, and identify additional community resources and other supportive services once the platform is fully certified by the State.
3. **Population Identification**
    a. LHDs shall use any available claims-based reports and other information provided by the health plans, as well as CMARC Referral Forms received to identify priority populations.
    b. LHDs shall establish and maintain contact with referral sources to assist in methods of identification and referral for the target population.
    c. LHDs shall communicate with the medical home and other primary care clinician's the CMARC target group and how to refer to the CMARC program.
4. **Family Engagement**
    a. LHDs shall 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.
    b. LHDs shall foster self-management skill building when working with families of children.
    c. LHDs shall prioritize face-to-face family interactions (home visit, PCP 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**
    a. LHDs shall use the information gathered during the assessment process to determine whether the child meets the CMARC target population description.
    b. LHDs shall review and monitor the health plan reports created for the PMH program and CMARC services, along with the information obtained from the family, to assure the child is appropriately linked to preventive and primary care services and to identify individuals at risk.
    c. LHDs shall use the information gained from the assessment to determine the need for and the level of service to be provided.
6. **Plan of Care**
    a. LHDs shall provide information and/or education to meet families' needs and encourage self-management using materials that meet literacy standards.

b. LHDs shall ensure children/families are well-linked to the child's AMH or other practice; provide education about the importance of the medical home.
c. LHDs shall provide care management services in accordance with program guidelines, including condition-specific pathways, utilizing those interventions that are most effective in engaging patients, meeting their needs and achieving care plan goals.
d. LHDs shall identify and coordinate care with community agencies/resources to meet the specific needs of the child (including statewide resource platform) to ensure families are linked to resources to meet the identified need.
e. LHDs shall provide care management services based upon the patient's level of need as determined through ongoing assessment.

7. Integration with Health Plans and Health Providers

a. LHDs shall collaborate with AMH PCP/care team to facilitate implementation of patient-centered plans and goals targeted to meet the individual child's needs.
b. LHDs shall ensure that changes in the care management level of care, need for patient support and follow-up, and other relevant updates (especially during periods of transition) are communicated to the AMH PCP and/or care team as necessary.
c. Where care management is being provided by a health plan and/or AMH practice in addition to the CMARC program, 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. LHDs shall ensure that changes in the care management level of care, need for patient support and follow-up, and other relevant updates (especially during periods of transition) are communicated to the AMH PCP and/or care team and to the health plan.
e. LHDs shall ensure awareness of health plan enrollee's in-network status with providers when organizing referrals.
f. LHDs shall ensure understanding of health plan's prior authorization processes relevant to referrals.

8. Service Provision

a. LHDs shall document all care management activities in the care management documentation system in a timely manner as described by LHD agency policy.
b. LHDs shall 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

a. LHDs shall participate in DHHS/health plan-sponsored webinars, new hire orientation, training sessions and continuing education opportunities as provided.
b. LHDs shall pursue ongoing continuing education opportunities to stay current in evidence-based Care Management of At-Risk children.

10. Staffing

a. LHDs shall hire Care Managers meeting CMARC care coordination competencies and with at least one of the following qualifications:
    i. Registered nurses;

   ii. Social workers with a bachelor's degree in social work (BSW, BA in SW, or BS in SW) or master's degree in social work (MSW, MA in SW, or MS in SW) from a Council on Social Work Education (CWSE) accredited social work degree program.
   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. *LHDs shall engage Care Managers who operate with a high level of professionalism and* possess an appropriate mix of skills needed to work effectively with high-risk children. This skill mix must reflect the capacity to address the needs of patients with both medically and socially complex conditions.
c. LHDs shall ensure that Care CMARC Managers must 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.
d. LHDs shall ensure that the team of CMARC Care Managers shall include both registered nurses and social workers to best meet the needs of the target population with medical and psychosocial risk factors.
e. If the LHD has only has a single CMARC Care Manager, the LHD shall ensure access to individual(s) to provide needed resources, consultation and guidance from the non-represented professional discipline.
f. An LHD with a team of CMARC Care Managers composed of more than one person but representing only one professional discipline (nursing or social work), shall seek to hire individuals of the other discipline when making hiring decisions.
g. LHDs shall maintain services during the event of an extended vacancy.
h. In the event of an extended vacancy, LHDs shall complete and submit the vacancy contingency plan that describes how an extended staffing vacancy will be covered and the plan for hiring, if applicable.
i. LHDs shall 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.
j. LHDs shall ensure that Community Health Workers and other unlicensed staff work under the supervision and direction of a trained CMARC Care Manager.
k. LHDs shall 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. LHDs shall ensure that supervisors comply with expectations found in the DHHS Care Management for At-Risk Children Supervision Guidance Document.

m. LHDs shall ensure that supervisors who carry a caseload must also meet the CMARC care management competencies and staffing qualifications.

Appendix D: Pregnancy Risk Screening (PRS) Form for CMHRP (English)

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

*Practice Name: ______________________

Practice Phone Number: ______________________

*Today's Date: ____ /____/ ______

Date of next prenatal appointment:_____/_____/______

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.

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 just before you got pregnant, 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 one 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 E: Pregnancy Risk Screening (PRS) Form for CMHRP (Spanish)

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

*Practice Name: ______________________

Practice Phone Number: ______________________

*Today's Date: _____ /_____/ _________

Date of next prenatal appointment:_______/_______/_________

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 <u>spontaneous</u> 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.

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 consiguiendo 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 F: 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 G: CMARC Community Referral Form

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
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 2, Rev. 02/2021) Submit completed form to the CMARC staff at the health department in the child's county of residence.

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):	☐ 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 2, Rev. 02/2021) Submit completed form to the CMARC staff at the health department in the child's county of residence.

Appendix H. CMHRP Measures Set

Performance Measure	Measure Description
Monthly & Rolling Penetration Rate	Numerator = any member[15] with a completed care management encounter[11] in the past 30 days. Denominator= Number of women ages 14-44 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 of engaging in care management Denominator= Number of members receiving care management in the reported month.
Health Outcome Measures[12]	**Measure Description**
Low Birth Weight Births	N=Number of live, singleton births weighing <2,500 grams at birth in the CMHRP enrolled population during the measurement period. D= All live, singleton births in the CMHRP program-enrolled population during the measurement period. Measure Steward: NC DHHS
Timeliness of Prenatal Care (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 during the 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 after delivery. D = All members who received CMHRP services who had a completed CMHRP CM contact during the measurement period. Measure Steward: NCQA NQF endorsed: 1517

[11] 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.
[12] All Health Outcomes Measures use technical specifications defined by the attributable measure steward and are stratified by the eligible study population.

Appendix I. CMARC Measure Set

Performance Measure	Measure Description
Monthly & Rolling Penetration Rate	Numerator = any member with a completed care management encounter[14] in the past 30 days. Denominator = Number of members ages 0-5 years.
Outreach Rate (CMARC)	Numerator= Number of members with a completed encounter **OR** 3 or more "Attempted" encounters within 7 business days of the referral by PHP. Denominator= Number of members referred for CMARC services in the reported month.
Active Management Rate (CMARC)	Numerator= Number of members who have a care plan signed within 30 calendar days of engaging in care management. Denominator= Number of members receiving CMARC care management in the reported month.
Health Outcome Measure[14]	**Measure Description**
Well-Child Visits in the First 30 Months of Life (W30)	The rate of well-child visits for children ages 0-30 months for all members enrolled into CMARC services in the reported year. Measure Steward: NCQA
Child and Adolescent Well Visits (WCV)	The rate of well-child visits for children ages 3-5 years of age for all members enrolled into CMARC services in the reported year. Measure Steward: NCQA
Childhood Immunization Status (Combo 10) (CIS)	The percentage of children 2 years of age who received the recommended vaccinations for all members enrolled into CMARC services in the reported year. Measure Steward: NCQA NQF endorsed: 0038