NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Division of Health Benefits | NC Medicaid

Program Guide

Management of High-Risk Pregnancies in Tailored Plan

April 3, 2024

Contents

I. Introduction

On July 1, 2021, the Department was 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 enrollees, including adults and children with low to moderate intensity behavioral health needs, are receiving integrated physical health, behavioral health, and pharmacy services through Medicaid Managed Care.

On December 1, 2022, Local Management Entity/Managed Care Organizations (LME/MCOs) along with Tailored Care Management (TCM) providers began providing Tailored Care Management services. Through TCM, NC Managed Care Behavioral Health Intellectual/Developmental Disabilities Tailored Plan (Tailored Plan) eligible Members have a single designated care manager supported by a multidisciplinary care team to provide whole-person care management that addresses all of their needs including physical health, behavioral health, intellectual/developmental disabilities (I/DDs), traumatic brain injuries (TBI), pharmacy, long-term services and supports (LTSS) and unmet health-related resource needs. Tailored Plan is an integrated health plan for individuals with significant behavioral health needs and/or intellectual/developmental disabilities (I/DDs). Tailored Plan will also serve other special populations, including Innovations and Traumatic Brain Injury (TBI) waiver enrollees and waitlist members, and be responsible for managing the state's non-Medicaid behavioral health, developmental disabilities and TBI services for uninsured and underinsured North Carolinians.

The information included in this program guide refers to care management services for high-risk pregnant members who are enrolled in Tailored Plans and receive care management through Local Health Departments (LHD).

Medicaid Programs for Pregnant Beneficiaries
NC Medicaid offers obstetrics coverage for all Medicaid beneficiaries, 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, Cherokee Indian Hospital Authority (CIHA), LHDs, 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 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

[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

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 members with high risk for adverse birth outcomes were assigned a Pregnancy Care Manager to coordinate their care and services through the end of the post-partum period.

The Department remains committed to providing a pathway for these programs as the state transitions completely to managed care[2]. The Department has a three-fold objective: (1) to continue to provide high-quality services to pregnant Medicaid beneficiaries in close partnership with clinicians across the state; (2) to provide a pathway for current providers of these services; and (3) 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. Therefore, Tailored Plans contract exclusively with the LHDs through contract year 1 (defined as the "transition period")[3]. Thereafter, providers, LHDs, and Tailored Plans will negotiate program terms through 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 programs will be eligible for incentive payments[5].

Tailored Plans will provide the same services as Standard Plans but will also provide additional services that serve individuals with significant behavioral health conditions, I/DDs, and TBI as well as people using State-funded Services. Tailored Plans will offer Tailored Care Management as the predominant care management model for its Medicaid members.

[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).
[3] The transition period follows the BH I/DD Tailored Plans contract years. Year 1 starts when Tailored Plans launch.
[4] Tailored Plans are required to offer Tier 3 AMH practices incentive payments. Tailored 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.

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)

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, LHDs, Tailored Plans and other interested stakeholders regarding Care Management for High-Risk Pregnancies (CMHRP) within the Medicaid population. Detailed information includes programmatic operation and expectations of providers, LHDs, Tailored Plans and the Department.

Summary of Program Transition

	The Pregnancy Management Program (PMP)	Care Management for High-Risk Pregnancies(CMHRP)
Target Population	All pregnant Medicaid members	Pregnant Medicaid members identified as high-risk for adverse birth outcomes
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 pregnant and post-partum members identified as being high-risk for adverse birth outcomes. CMHRP assists and supports high-risk pregnant members with navigation of prenatal and postpartum care; as well as addressing barriers affecting their care and health.
Accountable Entity	Tailored Plans	Tailored Plans
Primary Service Provider	Local maternity care providers	LHD
Program Coordination	The Department	The Department

II. Managing High-Risk Pregnancies Under Managed Care

All pregnant members enrolled in managed care through the Tailored Plan to receive a coordinated set of high-quality clinical maternity services through the PMP. This program is administered as a partnership between Tailored Plans and local maternity care service providers (defined as any provider of perinatal 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 are coordinated and provided by 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 will contract with a Tailored Plan under standard contracting terms.

- Standard contracting provisions will be included. The Tailored Plans incorporate program requirements aligned with the Pregnancy Management Program into their contracts with all maternity care providers. The continuation of these program requirements will ensure a smooth transition of services. The contracts include processrequirements, 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 will, at a minimum, remain the same. Individual provider contracts with Tailored Plans will incorporate an incentive payment structure that promotes high-quality outcomes and is no less than the rate floors established by the Department. For the transition period, the incentive payment structure will remain at an amount no less than the amount paid in the program prior to transition to Medicaid Managed Care
    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 cesarean sections. In addition, providers will continue to be exempt from prior approval on ultrasounds.

The Tailored 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 Tailored 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 and administer 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 consistent with the 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 standardized PRS form to the LHD within 7 business days of completing the screening. When LHDs receive a PRS form indicating a need for CMHRP services, member outreach must be conducted. Additional details are provided further below; see "Outreach and Engagement" performance measure. Tailored 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 for management of pregnant patients determined to be at high-risk of adverse birth outcomes. PMP providers are required to ensure appropriate coordination with LHD care managers for the sub-set of their practice population who receive CMHRP services.

- The Tailored Plans will be required to collect and report on a series of quality measures to ensure high- quality maternity care. The Tailored 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[6]
    2. Live Births Weighing Less than 2,500

As part of public reporting requirements, the Tailored Plans will be required to calculate and share the following measures for each participating practice receiving an incentive payment:

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

The Tailored 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 SP and TP Quality Measurement Technical Specifications[7].

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

[7] North Carolina's Medicaid Quality Measurement Technical Specifications Manual for Standard Plans and Behavioral Health Intellectual/Developmental Disability Tailored Plans: https://medicaid.ncdhhs.gov/medicaid-managed-care-quality-measurement-technical-specifications-manual/download?attachment

Overview of CMHRP

In addition to administration of the PMP program for all enrolled pregnant members, the Tailored Plans contract with 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 Pregnancy Risk Screening (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. 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 first year of Tailored Plan launch. The following represent a summary of key features of the CMHRP program:

- LHDs will continue to provide intensive care management services. During the first contract year, Tailored Plans will be required to contract with LHDs for the provision of CMHRP services. If an LHD is unable or unwilling to provide these services through a contract with a Tailored Plan, Section III outlines the steps Tailored 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 Tailored Plans.

- The Tailored Plans will be required to offer standard contracting terms. The Tailored 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 CMHRP program, and incorporate the changes of moving to managed care, including ongoing collaboration and integration between the LHDs and the Tailored Plans. These terms include requirements related to outreach, member 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 Tailored 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**.** 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 members 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 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 Tailored Plans will use these measures for overall monitoring purposes, including the CAP process as described in Section III.

In addition to achieving the Utilization Rate and Performance Measures benchmark, LHDs providing CMHRP services will be required to support Tailored 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 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 are 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.

- Coordination with other Tailored Care Management (TCM) providers. Tailored Plans or TCM providers will be responsible for care management services to the managed care population in Tailored Plans. To ensure coordination with CMHRP, the Tailored Plans will be required to alert LHDs when high-risk pregnant members are in Tailored Care Management within the Tailored Plan/TCM provider. In addition, the Tailored Plans will be responsible for ensuring that the care management roles and responsibilities between the two entities are coordinated and do not overlap. The Tailored Plans (TP) will also be required to ensure that the member's care plan(s) in the TP documentation platform includes documentation of respective roles and responsibilities between the Tailored Plan/TCM Provider 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/responsibilities in their 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 Tailored Plans. The Tailored Plan will be responsible for compensating contracted LHDs at an amount no less than the amount paid in the program prior to transition to Medicaid Managed Care. Tailored Plans are permitted to introduce new payment models on top of the existing funding to further incentivize care management innovation.

III. Oversight and Accountability for Programs

Tailored Plans are responsible for the clinical and financial management of care and services for Medicaid members who are pregnant. The Department will have rigorous oversight of all Tailored Plan operations. In addition, advisory groups of clinical leaders and other key stakeholders will engage in ongoing development of the 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 Tailored Plans, with clear, contractually binding requirements and expectations.

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

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

- Rollout training sessions in preparation for transition to Tailored Plans;
- 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 Tailored Plans in Program Administration

In the care management program, Tailored Plans will have a specific set of program responsibilities. The Tailored Plans will administer each program locally in partnership with providers and/or LHDs and have overall accountability and risk for outcomes. For the programs for pregnant members, the Tailored 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 LHDs without prior authorization for initiation of caremanagement services;
- Refer pregnant members identified as high-risk (through the Tailored Plan's own risk stratification algorithms) to LHDs for care management services via the TP's weekly outgoing Patient Risk List (PRL)

    - Tailored 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 Tailored 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 Tailored Plan population level
- Offer provider supports to PMP providers engaging in the program;
- Ensure that the care management roles and responsibilities between the Tailored Plans/TCM providers are non-overlapping with care management services offered by LHDs.
- Monitor for performance against the contract between Tailored Plans and LHDs; and
- Provide day-to-day oversight of program management and performance across PMP providers.

LHD Contracting and Tailored Plan Performance Oversight

LHDs will need to contract with Tailored Plans for the provision of care management services for the first year. In contract Year 1, the Tailored Plans will give LHDs the "right of first refusal" as contracted providers of care management for these populations, offering them standard terms. Tailored Plans will offer contracts to every LHD in their service region for provision of these care management services to members with a high-risk pregnancy.

- 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 Tailored 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. The Tailored Plan will use the same 75-business-day process to contract with the new LHD.
- If the Tailored 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 theLHD.

After contracts are executed and the launch of the Tailored Plan, one of the Tailored 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, Tailored 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 Tailored Plans to address underperformance among LHDs.

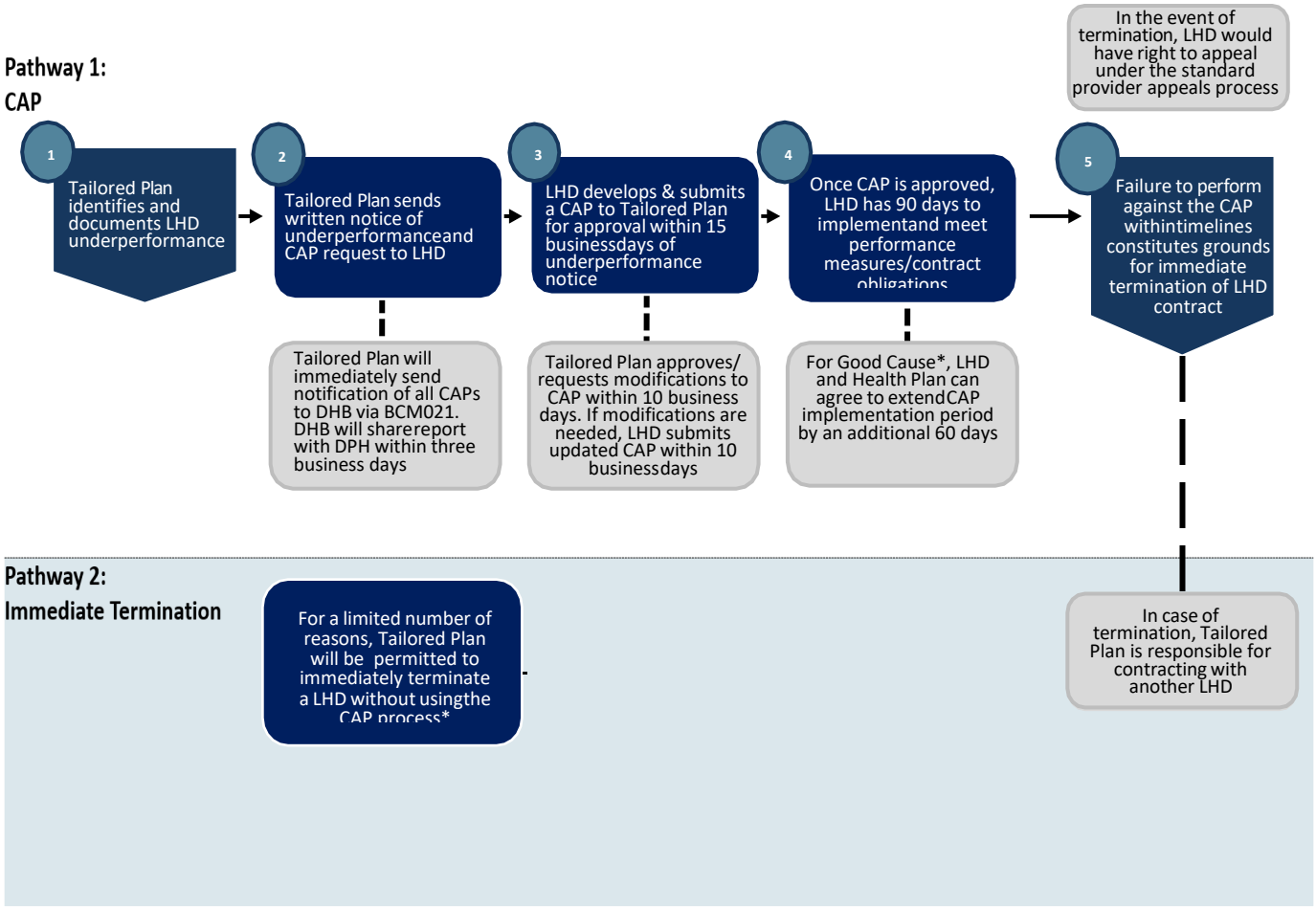
- Pathway #1: Standard Corrective Action Plan (CAP)

Step #	Pathway #1: Standard Corrective Action Plan (CAP)[8]
1	The Tailored Plan identifies and documents LHD underperformance.
2	The Tailored Plan issues a written notice detailing underperformance to the Local Health Department requesting a CAP. Tailored Plans are required to report all CAPs to DHB immediately, using *BCM021: CMHRP Corrective Action Plan Report*. DHB will share BCM021 with DPH within 3 business days of receiving the report.
3	The LHD will develop and submit a CAP to the Tailored 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 tailored plan has the right to approve the CAP as written or request modifications within 10 business days. If modifications are requested, the LHDmust resubmit an updated CAP within 10 business days.*
4	Once the CAP is approved, the LHD has 90 calendar days to implement and meetthe performance measures/obligations under the contract. *For good cause, LHD and the tailored plan can agree to extend the implementationperiod by an additional 60 business days. Good cause includes a situation where the data lag makes the timeline non-feasible.* If the tailored 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 LHD contract by the Tailored Plan. *In the event of a termination, the LHD would have the right to appeal thetermination under the standard provider appeals process.*

[8] The BH I/DD Tailored 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 Tailored Plan will be permitted to immediately terminate a LHD contractwithout using the CAP process, for a limited number of reasons. Specific actions for terminating a care management contract with an LHD withoutusing the CAP process include: ▪ Instances of fraud, waste and/or abuse ▪ Specific actions by the LHD that conflict with the health plan/LHDStandard Contract Terms If a Tailored Plan terminates a contract with a LHD, they will be responsible forcontracting with another LHD in their service region using the previously described "right of first refusal" process.



IV. Conclusion

The transition to managed care represents a significant shift in the administration of health care benefits to members 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 members who are at high-risk for adverse birth outcomes. 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 best practice for patients. The Department believes that these 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, social services organizations, LHDs, and other stakeholders, in implementing continuous quality improvement to ensure continued success.

V. Appendix

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

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

1. The Tailored 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 and submit the standardized pregnancy risk screening (PRS) form at initial prenatal visit *and* as member's biopsychosocial needs change to LHD within 7 business days of completing the screening;
    b. Integrate the member'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 staffengagement, access to patients' Electronic Medical Record (EMR) and to foster the embedded care management model;
    c. Allow Tailored 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 delivery rate among nulliparous members;
    f. Offer and provide 17 alpha-hydroxyprogesterone caproate (17p) for the prevention of preterm birth to 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 20percent); 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 identified as high-risk for adverse birth outcomes from the Tailored 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 for adverse birth outcomes and needing intensive care management services. Members are identified by the Tailored Plan's internal risk stratification as well as provider request, members self-referral, and community referrals

3. Population Identification and Engagement

a. LHDs shall review and 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 andservice delivery for all members in the target population.

4. Assessment

a. CMHRP care managers (CM) will conduct a prompt and thorough assessment for all members in the Tailored Plan 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 Tailored Plans, to determinelevel 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 theCMHRP CM 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 memberneed(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 Tailored Plan network.
f. LHDs shall document all care management activity in the care management documentation system.

6. Integration with Tailored 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 Tailored Plan when accessing referrals and resources.
f. LHDs shall assist CMHRP members in obtaining information needed as it relates to the Tailored Plans by connecting members with the Tailored Plan's members services department, as applicable.

7. Collaboration with Tailored Plans

a. LHDs shall work with Tailored Plans to ensure program goals as outlined in this document (i.e., outcome and process measures) are met.
b. LHDs shall review and monitor Tailored Plans reports created for the PMP and CMHRP services to identify individuals at greatest risk.
c. LHDs shall communicate with the Tailored Plans regarding challenges with cooperation and collaboration with maternity care providers/PMPs.

d. Where care management is being provided by a Tailored Plan and/or AMH+ practice in addition to CMHRP, the Tailored Plans must ensure the delineation of non-overlapping roles and responsibilities.
e. LHDs shall participate in CMHRP and other relevant meetings hosted by the Tailored Plans as resources and time permits.

8. Training

a. LHDs shall ensure that CMHRP CMs and their supervisors attend CMHRP training offered by the Tailored Plan and/or DHHS, including webinars, New Hire Orientation and other CMHRP programmatic training.
b. LHDs shall ensure that CMHRP CMs and their supervisors attend continuing educationsessions coordinated by the Tailored Plan and/or DHHS.
c. 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.
d. 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

a. LHDs shall 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. LHDs shall ensure that supervisors who carry a caseload must also meet the CMHRP care management competencies and staffing qualifications.
c. LHDs shall ensure that Community Health Workers for Care Management for High-Risk Pregnancy'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. LHDs shall engage care managers who operate with a high level of professionalism and possess anappropriate 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. LHDs shall ensure that if the team of CMHRP CMs is composed of more than one care manager but represents only one professional discipline (nursing or social work), it seeks to hire individuals of the other discipline when making hiring decisions.
h. LHDs shall 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. LHDs shall 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. LHDs shall establish staffing arrangements to ensure continuous service delivery through appropriate management of staff vacancies and extended absences, including following the healthplan/DHHS guidance about communication with the Tailored Plans about any vacancies or extendedstaff 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 Tailored Plans.

Appendix C: 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 C: 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 D: 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 D: 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 E: 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 F. CMHRP Measures Set

Performance Measure	Measure Description
Monthly & Rolling Penetration Rate	Numerator = any member[9] with a completed care management encounter[10] 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 ofengaging in care management Denominator= Number of members receiving care management in the reported month.
Health Outcome Measures[11]	**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

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

[10] 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.

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

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

Overview

This Appendix establishes the Department's requirements 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[12] established by the Department or other transition of care requirement in the contract.

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[13] 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.

[12] Transition of Care Policy: https://files.nc.gov/ncdma/documents/Transformation/caremanagement/NCDHHS-Transition-of-Care-Policy-20210225.pdf

[13] 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.[14]
   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.

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

Appendix H. Healthy Opportunities Pilot Guidance for LHDs

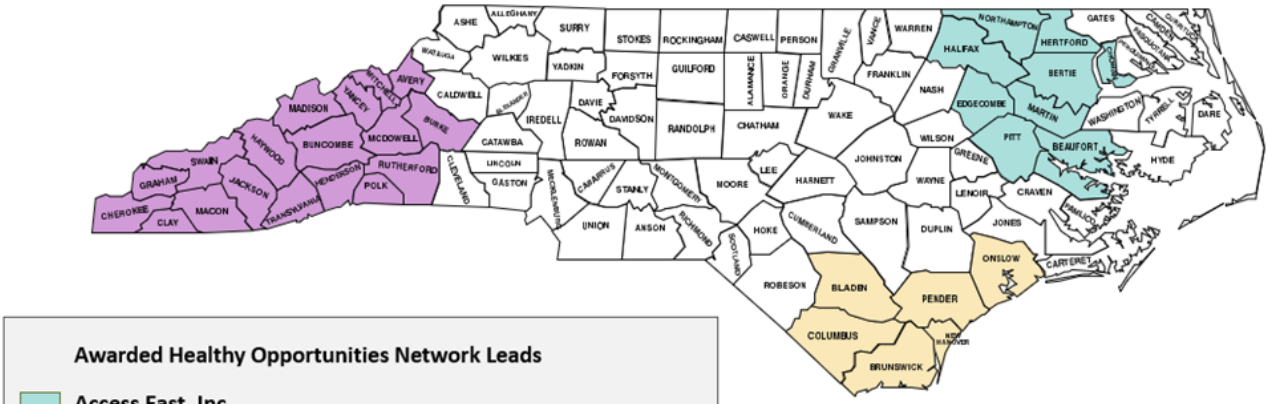
North Carolina's transition to Medicaid managed care included the launch of the Healthy Opportunities Pilots ("the Pilots") in 2022.[15] The Pilots present an unprecedented opportunity to test the impact of providing evidence-based, non-medical interventions to Medicaid enrollees. In October 2018, the 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.

[15] 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, Polk, Rutherford, Swain, Transylvania, Yancey