

# **Transition of Current Programs for High-Risk Pregnancy and At-Risk Children into Managed Care**

**November 15, 2018**

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***Part I:***  
***North Carolina's Medicaid***  
***Transformation***

# Overview of Managed Care Transition

North Carolina is preparing to transition to managed care which will advance high-value care and improve population health—especially for pregnant women and high-risk children

The majority of Medicaid beneficiaries will receive Medicaid through Prepaid Health Plans (PHPs)

- NC Medicaid providers will need to contract with PHPs and will be reimbursed by PHPs rather than the state directly
- Two types of PHPs:
  - Commercial plans
  - Provider-led entities

**Note:** Certain populations will continue to receive fee-for-service (FFS) coverage on an ongoing basis; Carolina ACCESS will continue for these populations

PHPs will offer two types of products:

- Standard plans for most beneficiaries; scheduled to launch in 2019–2020
- Tailored plans for high-need populations; will be developed in later years

# DHHS Care Management Strategy

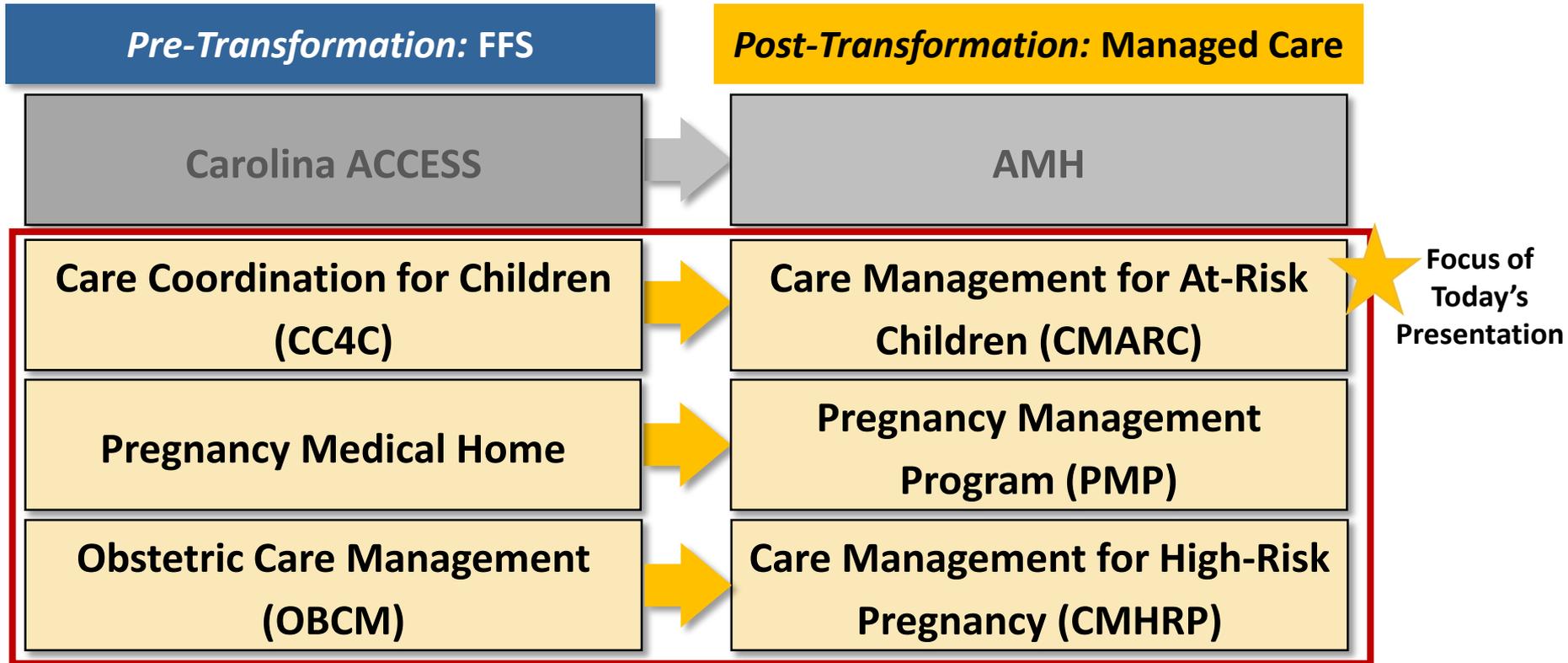
Robust care management is a cornerstone of the State's managed care transition

## Care Management Guiding Principles

- Medicaid enrollees will have access to **appropriate care management**
- Care management should involve **multidisciplinary care teams**
- Local care management** is the preferred approach
- Care managers will have access to **timely and complete enrollee-level information**
- Enrollees will have access to **programs and services that address unmet health-related resource needs**
- Care management will align with **statewide priorities for achieving quality outcomes and value**

# Evolution of Existing Programs Under Managed Care

The State will build on existing care management infrastructure under managed care



Note: These programs will **remain in place post-transformation** for populations that remain in FFS coverage

Note: Local Health Departments, Pediatric providers and Maternity Care providers can also be AMH providers

***Part II:***

***Transition of Current Programs for  
High-Risk Pregnant Women and At-  
Risk Children to Managed Care***

## Review of Current Programs

**Maternity care providers, pediatric providers and Local Health Departments (LHD) have long played a critical role in the provision of health care and care management services for high-risk pregnant women and at-risk children, and will continue to do so under managed care**

- Currently, North Carolina provides high-quality maternity care for all women. Care management services for high risk pregnant women and at-risk children are managed by locally administered programs
  - Pregnancy Medical Home (“PMH”)
  - Obstetric Care Management (“OBCM”)
  - Care Coordination for Children (“CC4C”)
- The PMH, OBCM and CC4C programs were designed with significant leadership from clinicians across the state

**The PMH Program 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**

# Key Elements of the Transition to Managed Care

**Goal of the Transition to Managed Care:** Continue to provide high-quality services to women and children in close partnership with providers across the state

1

PHPs will administer each program locally and have overall accountability for program outcomes

2

Populations not moving into managed care will continue to be served by the programs in the same manner as today

3

Maternity providers will still receive incentives\* and all maternity and pediatric providers will still have direct access to care managers to help manage patient populations

4

DHB requires PHPs to offer LHDs right of first refusal under the current model during the transition period, starting from the implementation of managed care

5

After the end of the transition period, PHPs will negotiate program terms with care management providers of choice, which could be LHDs or other providers

# Overview: IT and Payments for Care Management Services

During the transition period, care managers will continue to use a standardized care management platform and payments for services will remain consistent.

## Standardized Data Platform for Care Management

- A standard care management documentation platform will be used for care management
- LHD providers that also operate as AMH Tier 3 providers may be permitted flexibility to use a separate platform

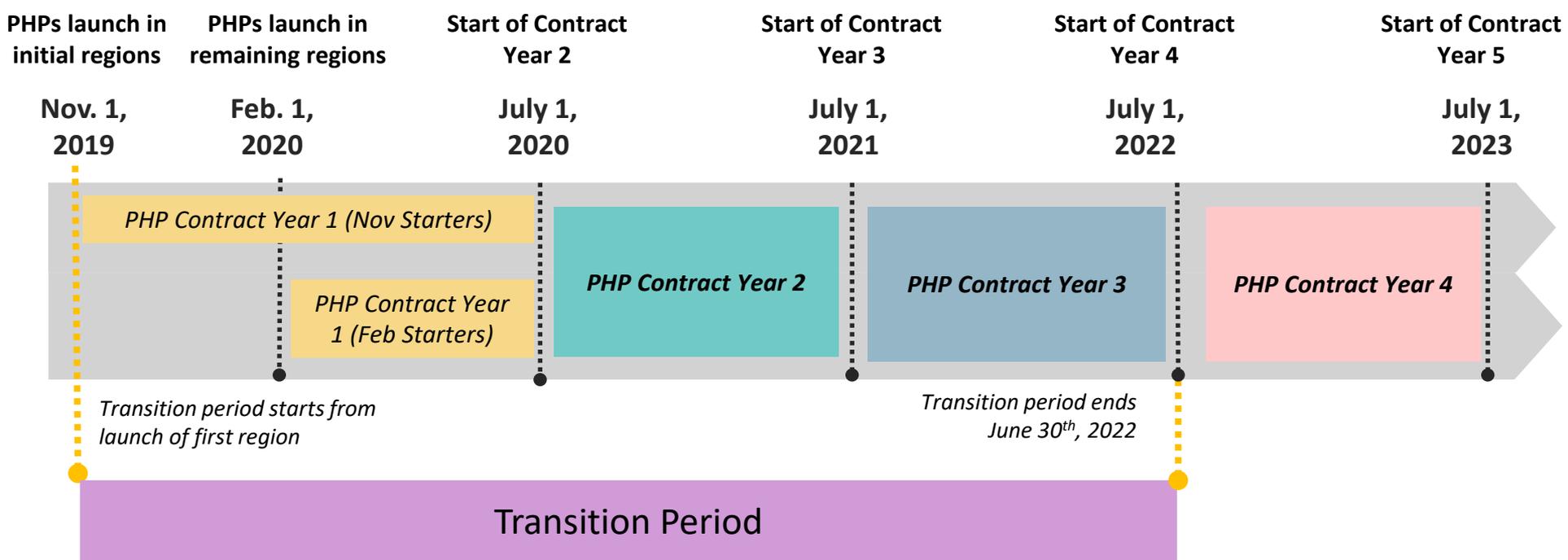
## Payments to LHDs

- Funding related to care management for high-risk pregnancies and at-risk children is included in the capitation payment to PHPs
- PHPs will compensate contracted LHDs at an amount similar to but no less than funding levels they receive today for these services

*Additional detail is forthcoming on both the IT infrastructure and methodology for payments.*

# Transition Period for ARC/HRP Programs

The State will convene Advisory Groups to promote provider leadership, examine existing programs and make design recommendations for after the transition period.



Two Advisory Groups will launch in 2019 and be dedicated to making recommendations to improve outcomes for both pregnant women and at-risk children.

***Part III:***  
***Pregnancy Management Program***  
***Under Managed Care***

# Overview: Pregnancy Management Program

The Pregnancy Management Program will continue providing comprehensive, coordinated services to pregnant women

## Participation & Standard Contracting Terms

- **Participation Requirements:** There will no longer be a process to opt into the program
  - All providers that bill global, packaged or individual maternity services will contract with PHPs under standard contracting terms
- **Contracting Terms:** Remain the same and include:
  - Complete the standardized risk-screening tool at each initial visit;
  - Decrease primary cesarean delivery rate;
  - Monitor and report on quality measures related to maintaining or lowering elective deliveries;
  - Ensure comprehensive post-partum visits within 56\* days of delivery

Refer to Appendix A for a complete list of contract terms.

\*Change from 60 days to align with quality measurement.

# Pregnancy Management Program Payments and Incentives

**Providers will continue receive payment at levels consistent with today's payment model**

## Payments and Incentives to Providers

- Pregnancy Management Program providers will **receive regular fee schedule payments** in addition to incentive payments
  - Providers will receive, at a minimum, the same rate for vaginal deliveries as they do for caesarian sections
- Provider **incentive payment structure will be remain at the same** levels during the transition period
  - \$50 for the completion of the standardized risk screening tool at each initial visit;
  - \$150 for completion of postpartum visit held within 56\* days of delivery
- **PHPs may offer both additional contracting terms and provide additional incentive payments** to PMPs; participation in any additional programs is optional for the provider
- **No prior authorization** needed for ultrasounds

**In Managed Care, PHPs will pay providers. Providers must contract with PHPs to receive both payment for services and incentive payments.**

# Risk Screening Tool for High-Risk Pregnancies

**Maternity care providers will use a State-developed risk screening form that is consistent with today's tool**

- Providers will be required to adopt and administer a State-designated screening tool to identify high-risk pregnancies
- The content of the tool will be standardized across the State and will be the same as the tool currently used by providers enrolled in the PMH program \*
- PMPs are required to share results of screening with LHD and PHP

**In conjunction with an Advisory Group (discussed later), DHHS will be responsible for maintaining updates to the risk-screening tool.**

# Tracking the Quality of Maternity Care in North Carolina

**PHPs will provide additional insights to providers on their performance against key measures**

PHPs will provide regular reports to PMP practices on the following measures:

- Prenatal and Postpartum Care: NQF 1517
- Live Births Weighing Less than 2,500 g: NQF 1382

As part of public reporting, PHPs will calculate and share the following measures (for each participating practice that receives an incentive payment)

- Rate of high risk screening as a function of total pregnant population according to PHP data
- Rate of post-partum follow-up within 56 days of delivery as a function of total pregnant population according to PHP data

***Part IV:***  
***Managing High-Risk Pregnancies***  
***Under Managed Care***

# Overview: Care Management for High-Risk Pregnancies

During the transition period, LHDs will continue to provide care management services for high-risk pregnant women

## Similarities to today's program

- The CMHRP program will be similar to today's OBCM program. For example:
  - LHDs will continue to provide care management services to high-risk women, not subject to preauthorization from the PHP
  - Program eligibility and the risk screening form will be the same as the one used today
  - Care management staffing requirements will remain consistent with current policy
- PHPs will incorporate a series of standard program requirements into their contracts with all LHDs in the CMHRP program
  - **The contract terms are generally the same as those that exist today** and include:
    - Requirements related to outreach, patient identification and engagement, assessment, and deployment of interventions

# Key Differences in CMHRP in Managed Care

**LHDs must for account for key differences under the transition to managed care**

## Key Programmatic Differences

- Differences in standard contract terms:
  - Requirements incorporate the changes of moving to managed care (e.g. collaboration and integration with PHPs).
  - LHDs will be required to coordinate with the PHP/AMH in cases where a woman has more than one care manager
  - LHDs are required to accept referrals from the PHP for the CMHRP program
- LHDs will be required to contract with each PHP to provide care management services
  - PHPs will give LHDs the “right of first refusal” as contracted providers of care. LHDs will have 75 business days to accept the contract
- LHDs will receive payments from PHPs
- LHDs will be required to share data with PHPs\*

# CMHRP Quality Measures

LHDs will be evaluated against several process and outcome measures to ensure high quality care for high risk pregnant women

#	Process Measures
1	Percentage of women engaged (patient given a case status and goal developed) in CMHRP services among patients meeting eligibility criteria (priority patients) during the month
2	Percentage of patients identified as priority who are “deferred”
3	Percentage of engaged patients who are receiving intensive care management with a face-to-face intervention in the past 30 days

#	Outcome Measures
1	Prenatal and Postpartum Care: NQF 1517
2	Live Births Weighing Less than 2,500 g: NQF 1382

LHDs will be held accountable to these measures, as they will feed the corrective action plan process, described later on.

***Part V:***  
***Managing At-Risk Children Under  
Managed Care***

# Overview: Care Management for At-Risk Children

During the transition period, LHDs will continue to provide care management services for at-risk children

## Similarities to today's program

- The CMARC program will be similar to today's CC4C program. For example:
  - LHDs will continue to provide care management services to at-risk children, not subject to pre-authorization from the PHP
  - Children who are the target population for today's program will be the target population in CMARC.
  - LHDs will continue to accept referrals for CMARC from providers, social service organizations, their own outreach efforts, community agencies and direct referral by families.
  - Care management staffing requirements will remain consistent with current policy.
- PHPs will incorporate a series of standard program requirements into their contracts with all LHDs in the CMARC program.
  - **These terms are generally the same as those that exist today, and include:**
    - Provisions related to outreach, population identification, family engagement, assessment and stratification of care management service levels, plan of care development, integration with health providers, service provision, training, and staffing.

# Key Differences in CMARC in Managed Care

**LHDs must for account for key differences under the transition to managed care**

## Key Programmatic Differences

- Similar to HRP, the key differences of the program under managed care include:
  - Requirements incorporate the changes of moving to managed care (e.g. collaboration and integration with PHPs)
  - LHDs will be required to coordinate with the PHP/AMH in cases where a child has more than one care manager
  - LHDs are required to accept referrals from the PHP for CMARC
  - LHDs will be required to contract with each PHP to provide care management services
    - PHPs will give LHDs the “right of first refusal” as contracted providers of care. LHDs will have 75 business days to accept the contract
  - LHDs will receive payments from PHPs
  - LHDs will be required to share data with PHPs\*

# Referral Criteria for CMARC Eligibility

- Many children currently receiving CC4C services will be exempt from managed care, and will continue receiving FFS benefits (e.g. children in foster care)
- **The referral criteria will be identical to today's program** (see Appendix E)
- **Children will be identified for the CMARC program using a form consistent with today's, and through the following methods:**
  - Direct provider referrals;
  - Social service agency referrals (e.g. Women, Infants and Children [WIC], Division of Social Services [DSS]);
  - Community agencies;
  - Direct referral by enrollees or families; and
  - Risk stratification or other identification methods by PHPs
    - *LHDs must accept referrals made by PHPs*

# Responsibility for Medically Complex Children

- If a child has complex medical needs or other needs best met by care managers at the PHP or at a Tier 3 AMH practice, then those entities will play the role of primary care manager
  - CMARC program will provide support for social needs beyond the capacity of the PHP or Tier 3 AMH practice
- Children with complex medical needs will be handled on a case-by-case basis.
  - PHPs/Tier 3 AMH practices will designate a lead care manager
- As with HRP, PHPs will be responsible for ensuring non-overlapping roles and responsibilities between all care management entities

# CMARC Quality Measures

**LHDs will be held accountable to several process and outcome measures to ensure high quality care for at-risk children**

#	Process Measures
1	% of children identified and referred for CMARC services who had a completed contact
2	% of children identified and referred for CMARC services who are engaged in active care management

LHDs will be held accountable to these measures, as they will feed the corrective action plan process, described later on.

#	Outcome Measures
<b>Children 0-5 engaged in CMARC</b>	
1	Well visits 3-6 yrs old
2	2 year old immunizations (Combination 3)
3	Annual dental visit

***Part V:***  
***General Oversight and Accountability***

# General State Oversight

## DHB will assume responsibility for continuous quality improvement and clinical leadership for PMP/CMHRP and CMARC

### Advisory Groups

- DHB will establish two state-level clinical advisory groups dedicated to improving outcomes for pregnant women and at-risk children
  - **PMP/CMHRP Advisory Group**
    - Comprised of: Maternity providers, Social Services Providers, LHDs, PHPs, DHB, and DPH.
  - **CMARC Advisory Group**
    - Comprised of: Pediatric providers, LHDs, PHPs, DHB, and DPH.
- The Advisory Groups' responsibilities include:
  - Promote provider leadership in the ongoing evolution of both care management programs
  - Address strategic programmatic issues/concerns
  - Inform process/quality measures
  - Make design recommendations for program structure after transitional period
- The role of the groups is Advisory in nature; DHB maintains ultimate authority to implement specific programmatic changes.

# PHP Role in Administration of Programs

**PHPs will have overall accountability and risk for program outcomes and have a number of responsibilities for ensuring programs are effectively run**

## **PHP responsibilities include:**

- Develop and execute contracts w/ providers;
- Reimburse participating providers (including incentive payments);
- Permit direct referral to LHDs without prior authorization;
- Use their own stratification system to identify high-risk pregnant women/at-risk children that would benefit from care management services;
- Administer quality and process measure program;
- Offer provider training/supports;
- Ensure non-duplication of services when there is more than one care management entity involved; and
- Provide day-to-day oversight of program management and performance.

# PHP Role in Quality Performance Oversight

PHP's primary role is in monitoring program quality and outcomes, and working with LHDs and other providers to continuously improve services. There are two pathways of action.

## Corrective Action Plan (Likely)

For LHDs, a separate process has been developed to address areas of underperformance, should they arise.

**In these cases, PHPs will intervene through a standardized corrective action plan process:**

1. The PHP identifies LHD underperformance and issues a written notice
2. If underperformance continues beyond the remediation period, the PHP will request a CAP.
3. Once a CAP is approved the LHD has 90 business days to implement against it
4. Failure to perform against the CAP constitutes grounds for immediate termination
5. LHDs have the right to appeal the termination under standard appeals processes

## Grounds for Termination (Rare)

For a limited number of reasons, such as for fraud or inadequate staffing, PHPs will be permitted to immediately terminate a LHD without using the CAP process. Terminations are permitted for reasons including:

- Fraud/abuse,
- failure to utilize required staffing,
- failure to implement/use the designated care management documentation system,
- Inadequate training for staff

If a PHP 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

**Questions?**

# ***Appendix***

## Appendix A: PMP Standard Contracting Requirements

**PHPs shall incorporate the following requirements into their contracts with all providers of perinatal care, including the following requirements for providers of the Pregnancy Management Program:**

1. Complete the standardized risk-screening tool at each initial visit.
2. Allow PHP or PHP's designated vendor access to medical records for auditing purposes to measure performance on specific quality indicators;
3. Maintain or lower the rate of elective deliveries prior to 39 weeks gestation;
4. Decrease the cesarean section rate among nulliparous women;
5. 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. Complete a high-risk screening on each pregnant Medicaid beneficiary in the program and integrating the plan of care with local pregnancy care management;
6. 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%); and
7. Ensure comprehensive post-partum visits occur within 56 days of delivery.

# Appendix B: CMHRP Standard Contracting Requirements (1 of 5)

## **General Contracting Requirement**

1. LHDs shall accept referrals from PHPs for Care Management for High Risk Pregnancy services.

## **Care Management for High-Risk Pregnancy: Outreach**

1. LHD shall refer potentially Medicaid-eligible pregnant women 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.
2. LHD shall contact patients identified as having a priority risk factor through claims data (Emergency Department utilization, antepartum hospitalization, utilization of Labor & Delivery triage unit) for referral to prenatal care and to engage in care management.

## **Care Management for High-Risk Pregnancy: Population Identification and Engagement**

1. LHD shall review and enter all pregnancy risk screenings received from Pregnancy Management Programs covered by the pregnancy care managers into the designated care management documentation system within five (5) calendar days of receipt of risk screening forms.
2. 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.
3. LHDs shall accept pregnancy care management referrals from non-Pregnancy Management Program prenatal care providers, community referral sources (such as Department of Social Services or WIC programs), patient self-referral, and provide appropriate assessment and follow up to those patients based on the level of need.
4. LHDs shall review available PHP 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.
5. LHDs shall collaborate with out-of-county Pregnancy Management Programs and Care Management for High Risk Pregnancy 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.

## Appendix B: CMHRP Standard Contracting Requirements (2 of 5)

### **Care Management for High-Risk Pregnancy: Assessment and Risk Stratification**

1. LHD shall conduct a prompt, thorough assessment by review of claims history and medical record, patient interview, case review with prenatal care provider and other methods, on all patients with one or more priority risk factors on pregnancy risk screenings and all patients directly referred for care management for level of need for care management support
2. LHDs shall utilize assessment findings, including those conducted by PHPs to determine level of need for care management support.
3. LHDs shall document assessment findings in the care management documentation system.
4. LHDs shall ensure that assessment documentation is current throughout the period of time the care manager is working with the patient and should be continually updated as new information is obtained.
5. LHDs shall assign case status as outlined according to program guidelines, based on level of patient need.

### **Care Management for High-Risk Pregnancy: Integration with PHPs and Healthcare Providers**

1. LHDs shall assign a specific care manager to cover each Pregnancy Management Program provider within the county or serving residents of the county. LHDs shall ensure that an embedded or otherwise designated care manager has an assigned schedule indicating their presence within the Pregnancy Management Program.
2. LHDs shall establish a cooperative working relationship and mutually-agreeable methods of patient-specific and other ongoing communication with the Pregnancy Management Program.
3. LHDs shall establish and maintain effective communication strategies with Pregnancy Management Program providers and other key contacts within the practice for each Pregnancy Management Program within the county or serving residents of the county.
4. LHDs shall assure the assigned care manager participates in relevant Pregnancy Management Program meetings addressing care of patients in the Target Population.
5. LHDs shall ensure awareness of PHP enrollees' "in network" status with providers when organizing referrals.
6. LHDs shall ensure understanding of PHPs' prior authorization processes relevant to referrals.

## Appendix B: CMHRP Standard Contracting Requirements (3 of 5)

### Care Management for High-Risk Pregnancy: Training

1. LHDs shall ensure that pregnancy care managers and their supervisors shall attend pregnancy care management training offered by, PHP and/or DHHS, including webinars, new hire orientation or other programmatic training.
2. LHDs shall ensure that pregnancy care managers and their supervisors shall attend continuing education sessions coordinated by PHP and/or DHHS.
3. LHDs shall ensure that pregnancy 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.
4. LHDs shall ensure that pregnancy care managers and their supervisors shall utilize Motivational Interviewing and Trauma Informed Care techniques on an ongoing basis.

### Care Management for High-Risk Pregnancy: Staffing

1. LHDs shall employ care managers meeting pregnancy care management competencies defined as having at least one of the following qualifications:
  - a) Registered nurses;
  - b) 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 accredited social work degree program.
  - c) Care Managers for High Risk Pregnancy hired prior to September 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.
2. LHDs shall ensure that Community Health workers for Care Manager for High-Risk Pregnancy services work under the supervision and direction of a trained OB care manager.

## Appendix B: CMHRP Standard Contracting Requirements (4 of 5)

### Care Management for High-Risk Pregnancy: Staffing (cont'd)

1. LHDs shall include both registered nurses and social workers in order to best meet the needs of the Target Population with medical and psychosocial risk factors on their team.
2. If the LHD only has a single Care Manager for High-Risk Pregnancy, the LHD shall ensure access to individual (s) to provide needed resources, consultation and guidance from the non-represented professional discipline.
3. 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 a pregnant population at high risk for poor birth outcome. This skill mix should reflect the capacity to address the needs of patients with both medically and socially complex conditions.
4. LHDs shall ensure that with a team of Care Managers for High-Risk Pregnancy composed of more than one person, but representing only one professional discipline (nursing or social work), they must seek to hire individuals of the other discipline when making hiring decisions.
5. LHDs shall ensure that Pregnancy Care Managers must demonstrate:
  - a) A high level of professionalism and possess appropriate skills needed to work effectively with a pregnant population at high risk for poor birth outcomes
  - b) Proficiency with the technologies required to perform care management functions
  - c) Motivational interviewing skills and knowledge of adult teaching and learning principles;
  - d) Ability to effectively communicate with families and providers; and
  - e) Critical thinking skills, clinical judgment and problem-solving abilities.

## Appendix B: CMHRP Standard Contracting Requirements (5 of 5)

### Care Management for High-Risk Pregnancy: Staffing (cont'd)

1. LHDs shall provide qualified supervision and support for pregnancy care managers to ensure that all activities are designed to meet performance measures, with supervision to include:
  1. Provision of program updates to care managers.
  2. Daily availability for case consultation and caseload oversight.
  3. Regular meetings with direct service care management staff.
  4. Utilization of reports to actively assess individual care manager performance.
  5. Compliance with all supervisory expectations delineated in the Care Management for High Risk Pregnancy Program Manual.
2. LHDs shall establish staffing arrangements to ensure continuous service delivery through appropriate management of staff vacancies and extended absences, including following PHP/DHHS guidance about communication with PHP about any vacancies or extended staff absences and adhering to guidance about contingency planning to prevent interruptions in service delivery.
3. Vacancies lasting longer than 60 days shall be subject to additional oversight by PHPs.

# Appendix C: CMARC Standard Contracting Requirements (1 of 6)

## **Care Management for At-Risk Children: General Requirements**

1. LHDs shall accept referrals from PHPs for children identified as requiring Care Management for At-Risk Children.

## **Care Management for At-Risk Children: Outreach**

1. LHDs shall educate patients, Advanced Medical Homes, other practices and community organizations about the benefits of the Care Management for At-Risk Children Program and target populations for referral; disseminate the Care Management for At-Risk Children Referral Form either electronically and/or in a paper version to potential referral sources.
2. LHDs shall Communicate regularly with the Advanced Medical Homes and other practices serving children, to ensure that children served by that medical home are appropriately identified for Care Management for At-Risk Children services.
3. LHDs shall collaborate with out-of-county Advanced Medical Homes and other practices to facilitate cross-county partnerships to optimize care for patients who receive services from outside their resident county.
4. LHDs shall identify or develop if necessary, a list of community resources available to meet the specific needs of the population.
5. LHDs shall utilize the statewide resource platform, when operational, and identify additional community resources and other supportive services once the platform has been fully certified by the State.

## **Care Management for At-Risk Children: Population Identification**

1. LHDs shall use any claims-based reports and other information provided by PHPs, as well as Care Management for At-Risk Children Referral Forms received to identify priority populations.
2. LHDs shall establish and maintain contact with referral sources to assist in methods of identification and referral for the target population.
3. LHDs shall communicate with the medical home and other primary care clinician's the Care Management for At-Risk Children target group and how to refer to the Care Management for At-Risk Children program.

## Appendix C: CMARC Standard Contracting Requirements (2 of 6)

### **Care Management for At-Risk Children: Family Engagement**

1. LHDs shall involve families (or legal guardian when appropriate) in the decision-making process through a patient-centered, collaborative partnership approach to assist with improved self-care.
2. LHDs shall foster self-management skill building when working with families of children.
3. LHDs shall prioritize face-to-face family interactions (home visit, PCP office visit, hospital visit, community visit, etc.) over telephone interactions for children in active case status, when possible.

### **Care Management for At-Risk Children: Assessment and Stratification of Care Management Service Level**

1. LHDs shall use the information gathered during the assessment process to determine whether the child meets the Care Management for At-Risk Children target population description.
2. LHDs shall review and monitor PHP reports created for the PMH program and CC4C 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.
3. LHDs shall use the information gained from the assessment to determine the need for and the level of service to be provided.

### **Care Management for At-Risk Children: Plan of Care**

1. LHDs shall provide information and/or education to meet families' needs and encourage self-management using materials that meet literacy standards.
2. LHDs shall ensure children/families are well-linked to the child's Advanced Medical Home or other practice; provide education about the importance of the medical home.
3. 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.

## Appendix C: CMARC Standard Contracting Requirements (3 of 6)

### Care Management for At-Risk Children: Plan of Care (cont'd)

1. LHDs shall identify and coordinate care with community agencies/resources to meet the specific needs of the child; use information found in the Care Management for At-Risk Children program Linking Families to Needed Support spreadsheet as well as any locally-developed resource list (including statewide resource platform) to ensure families are well linked to resources to meet the identified need.
2. LHDs shall provide care management services based upon the patient's level of need as determined through ongoing assessment.

### Care Management for At-Risk Children: Integration with PHPs and Health Providers

1. LHDs shall collaborate with Advanced Medical Home PCP/care team to facilitate implementation of patient-centered plans & goals targeted to meet individual child's needs.
2. 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 Advanced Medical home PCP and/or care team.
3. Where care management is being provided by a PHP and/or Advanced Medical Home practice in addition to the CC4C program, the PHP 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.
4. 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 Advanced Medical home PCP and/or care team and to the PHP.
5. LHDs shall ensure awareness of PHP enrollee's "in network" status with providers when organizing referrals.
6. LHDs shall ensure understanding of PHPs' prior authorization processes relevant to referrals.

## Appendix C: CMARC Standard Contracting Requirements (4 of 6)

### Care Management for At-Risk Children: Service Provision

1. LHDs shall document all care management activities in the care management documentation system in a timely manner as described by LHD agency policy.
2. LHDs shall ensure that the services provided by Care Management for At-Risk Children 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.

### Care Management for At-Risk Children: Training

1. LHDs shall participate in DHHS/PHP-sponsored webinars, trainings and continuing education opportunities as provided.
2. LHDs shall pursue ongoing continuing education opportunities to stay current in evidence-based care management of high risk children.

### Care Management for At-Risk Children: Staffing

1. LHDs shall hire care managers meeting Care Management for At-Risk Children care coordination competencies and with at least one of the following qualifications:
  - a) Registered nurses;
  - b) 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 accredited social work degree program.
    1. Care Managers for At-Risk Children hired prior to September 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.
  - c) 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.

## Appendix C: CMARC Standard Contracting Requirements (5 of 6)

### Care Management for At-Risk Children: Staffing

1. LHDs shall ensure that Care Management for At-Risk Children Care Managers must demonstrate:
  - a) Proficiency with the technologies required to perform care management functions – particularly as pertains to claims data review and care management documentation system;
  - b) Ability to effectively communicate with families and providers; and
  - c) Critical thinking skills, clinical judgment and problem-solving abilities.
  - d) Motivational interviewing skills, Trauma Informed Care, and knowledge of adult teaching and learning principles
2. LHDs shall ensure that the team of Care Management for At-Risk Children 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.
3. If the LHD has only has a single Care Management for At-Risk Children care manager, the LHD shall ensure access to individual(s) to provide needed resources, consultation and guidance from the non-represented professional discipline.
4. A LHD with a team of Care Management for At-Risk Children 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.
5. LHDs shall maintain services during the event of an extended vacancy.
6. 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.
7. 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.

## Appendix C: CMARC Standard Contracting Requirements (6 of 6)

### Care Management for At-Risk Children: Staffing

1. LHDs shall ensure that Community Health Workers and other unlicensed staff work under the supervision and direction of a trained Care Management for At-Risk Children Care Manager.
2. LHDs shall provide qualified supervision and support for Care Management for At-Risk Children care managers to ensure that all activities are designed to meet performance measures, with supervision to include:
  - a) Provision of program updates to care managers.
  - b) Daily availability for case consultation and caseload oversight.
  - c) Regular meetings with direct service care management staff.
  - d) Utilization of monthly and on-demand reports to actively assess individual care manager performance.
3. LHDs shall ensure that supervisors comply with expectations found in the DHHS Care Management for At-Risk Children Supervision Guidance Document.
4. LHDs shall ensure that supervisors who carry a caseload must also meet the Care Management for At-Risk Children care management competencies and staffing qualifications.

# Appendix D: Pregnancy Medical Home Screening Form

Practice Name: \_\_\_\_\_  
 Practice Phone Number: \_\_\_\_\_  
 Today's date: / /

  
**CCNC PREGNANCY MEDICAL HOME RISK SCREENING FORM**

First name: \_\_\_\_\_ MI \_\_\_\_\_ Last name: \_\_\_\_\_ Date of birth: / /  
 EDC: / / By what criteria:  LMP  1<sup>st</sup> trimester U/S  2<sup>nd</sup> trimester U/S  
 Height: \_\_\_\_\_ Pre-pregnancy weight: \_\_\_\_\_ Gravidity: \_\_\_\_\_ Parity: T P A L  
 Insurance type:  Medicaid (includes Presumptive)  Private  None Medicaid ID#: \_\_\_\_\_

**CURRENT PREGNANCY**

Multifetal gestation

Fetal complications:

- Fetal anomaly
- Fetal chromosomal abnormality
- Intrauterine growth restriction (IUGR)
- Oligohydramnios
- Polyhydramnios
- Other: \_\_\_\_\_

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 2<sup>nd</sup> 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 = \_\_\_\_\_

**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 pregnancy care management

Reason(s): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Provider comments/notes: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Printed Name of Person Completing Form \_\_\_\_\_ Credential(s) \_\_\_\_\_ Signature \_\_\_\_\_  
 For OBCM Program only: Date RSF was received: \_\_\_\_\_ Date RSF was entered: \_\_\_\_\_

**CCNC Pregnancy Medical Home 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 pregnancy 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: \_\_\_\_\_ Social security number: \_\_\_\_\_

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.
  - A. I have never smoked, or have smoked less than 100 cigarettes in my lifetime.
  - B. I stopped smoking BEFORE I found out I was pregnant and am not smoking now.
  - C. I stopped smoking AFTER I found out I was pregnant and am not smoking now.
  - D. I smoke now but have cut down some since I found out I was pregnant.
  - E. 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

# Appendix E: CC4C Screening and Referral Form

## Care Coordination for Children (CC4C) Referral Form

Internal Use: Date Referral Received:

CC4C - Target Population Birth to 5 Years			
Child's Name:		Referral Date (mm/dd/yyyy):	
Date of Birth (mm/dd/yyyy):		Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	
Race: <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Caucasian or White <input type="checkbox"/> Black or African American			
Medicaid ID #:		<input type="checkbox"/> Uninsured <input type="checkbox"/> Health Choice <input type="checkbox"/> Private Insurance	
Applied for Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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:		<input type="checkbox"/> Check here if you are child's PCP/Medical Home.	
Parent/Guardian Informed of Referral? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Name of Child's Primary Care Provider, Practice Name, and Phone # (if not listed above):			
Target Populations for Referrals <sup>1</sup>			
<input type="checkbox"/> <b>Child with Special Health Care Needs (CSHCN)</b> - 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? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<input type="checkbox"/> <b>Child in Foster Care</b> who needs to be linked to a medical home.			
<input type="checkbox"/> <b>Infant in Neonatal Intensive Care Unit (NICU)</b>			
<b>Child Exposed to Toxic Stress.</b> *Toxic stress includes, but is not limited to: <ul style="list-style-type: none"> <li><input type="checkbox"/> Current domestic/family violence</li> <li><input type="checkbox"/> Caregiver unable to meet infant's health and safety needs/neglect</li> <li><input type="checkbox"/> Parent(s) has history of parental rights termination</li> <li><input type="checkbox"/> Parental/caregiver substance abuse, neonatal exposure to substances</li> <li><input type="checkbox"/> CPS Plan of Safe Care referral for "Substance Affected Infant" (<b>Complete section "Infant Plan of Safe Care"</b>)</li> <li><input type="checkbox"/> Unstable home</li> <li><input type="checkbox"/> Unsafe where child lives</li> <li><input type="checkbox"/> Parent/guardian suffers from depression or other mental health condition</li> <li><input type="checkbox"/> Homeless or living in a shelter</li> <li><input type="checkbox"/> Other Please specify: _____</li> </ul>			
Medical Home Referral <sup>2</sup>			
<input type="checkbox"/> Check here if primary care provider (listed above) would like to make a direct referral for CC4C care management. Specify reason for referral if not indicated above: _____			
Notes:			
<sup>1</sup> If any of the boxes under "Target Populations for Referral" is checked, the child is eligible for CC4C Program and will receive a comprehensive health assessment.			
<sup>2</sup> If the Medical Home provider checks the "direct referral" box, the child is automatically referred for CC4C care management. The CC4C care manager may contact the Medical Home to clarify the need, as appropriate.			