NC Medicaid Managed Care
Provider Playbook

Fact Sheet
Care Management for High-Risk Pregnancies and Care Management for At-Risk Children

NC Medicaid Managed Care Transformation: A Fact Sheet for Care Management for High-Risk Pregnancies (CMHRP) and Care Management for At-Risk Children (CMARC) Providers

Medicaid beneficiaries identified as eligible for the Behavioral Health Intellectual/ Developmental Disabilities (I/DD) Tailored Plans (Tailored Plans) default to Local Management Entity/ Managed Care Organization (LME/MCO) enrollment until Tailored Plans launch.

WHAT IS AN LME/MCO?

As defined in N.C. Gen. Stat. § 122C-3(20c), an LME/MCO is a local management entity that is under contract with the Department to operate the combined Medicaid Waiver program authorized under Section 1915(b) and Section 1915(c) of the Social Security Act or to operate a Tailored Plan. LME/MCOs coordinate services for mental health disorders, substance use disorders, I/DDs or traumatic brain injuries (TBIs) for NC Medicaid Direct members and Eastern Band of Cherokee Indian (EBCI) Tribal Option members. There are four LME/MCOs: Alliance Health, Partners Health Management, Trillium Health Resources and Vaya Health.

WHAT ARE TAILORED PLANS ?

Tailored Plans are NC Medicaid health plans that provide physical health, pharmacy, care management and behavioral health services for beneficiaries who may have significant mental health needs, severe substance use disorders, I/DD or a TBI. Tailored Plans operate similarly to the Standard Plans (AmeriHealth Caritas, Carolina Complete Health, Healthy Blue, UnitedHealthcare and

WellCare) ; however, Tailored Plans offer enhanced behavioral health services that are not available in Standard Plans, including Innovations and TBI Waiver services and State-funded services. There are four Tailored Plans: Alliance Health, Partners Health Management, Trillium Health Resources and Vaya Health.

WHAT IS TAILORED CARE MANAGEMENT ?

Tailored Care Management (TCM) is North Carolina's specialized care management model targeted toward individuals with a significant behavioral health condition (including both mental health and substance use disorders), I/DD or TBI. TCM is aimed at promoting whole-person care, fostering high-functioning integrated care teams, and driving toward better health outcomes. Through TCM, beneficiaries will have a care manager supported by a multidisciplinary care team to address their physical health, behavioral health, I/DD, TBI, pharmacy, long-term services and supports (LTSS) and unmet health-related resource needs.

WHO PROVIDES TCM SERVICES?

Members can get TCM services through primary care providers certified as Advanced Medical Home Plus (AMH+); behavioral health, I/DD or TBI providers certified as Care Management Agency (CMA); or care managers based at an LME/MCO. NC Medicaid developed an assignment algorithm, based on various factors, including members' existing provider relationships and medical complexity, that will pair eligible members with a care management entity that provides TCM (i.e., AMH+, CMA or LME/MCO).

WHO IS ELIGIBLE FOR TCM?

TCM is available to Medicaid beneficiaries who meet clinical eligibility criteria; this includes individuals with:

- Serious Mental Illness (SMI)
- Serious Emotional Disturbance (SED)
- Severe Substance Use Disorders (SUD)
- I/DD
- TBI

TCM will be available to all Tailored Plan and NC Medicaid Direct members continuously throughout their enrollment, including individuals enrolled under North Carolina's 1915(c) Innovations and TBI waivers. Individuals who are federally recognized tribal members or others eligible for Indian Health Service (IHS) will be exempt from managed care but can choose to enroll in a Tailored Plan if otherwise eligible.

Effective April 1, 2023, children ages birth through 3 who meet TCM eligibility are enrolled in TCM.

WHAT IS TRANSITION OF CARE ?

Transition of Care (TOC) is a term that describes the process of assisting a member to transition between health plans, between care management providers or between payment delivery systems (including transitions that result in the disenrollment from managed care). Transition of Care also includes the process of assisting a member to transition between providers upon a provider's termination from the health plan's network.

HOW IS TRANSITION OF CARE RELEVANT TO THE CMARC PROGRAM ?

According to the Centers for Medicare and Medicaid Services (CMS), CMARC and TCM services are duplicative of each other and cannot be provided simultaneously. Children in CMARC who are eligible for TCM shall transition from CMARC through the Local Health Department (LHD) to the LME/MCO for TCM.

HOW WILL CMARC MEMBERS KNOW THEY ARE MOVING TO TCM ?

Eligible members will receive enrollment packets via mail. The enrollment packets contain information on transition notice (including how to choose TCM provider and primary care provider), description of TCM services, name and contact information of their TCM provider, disenrollment rights (how to opt-out of TCM), health care option guide, enrollment form and how to change their TCM provider by calling their LME/MCO.

CAN CMARC MEMBERS OPT-OUT OF TCM ?

Members may choose to opt-out of TCM services at any time.

WHAT HAPPENS WHEN A CMARC MEMBER OPTS OUT OF TCM ?

TCM-eligible CMARC members who have transitioned to the LME/MCO and opt out of TCM services will receive care coordination from the LME/MCO. Members can choose to opt back into TCM if their care needs and preferences change.

HOW WILL LHDS KNOW WHICH CMARC MEMBERS ARE TRANSITIONING TO TCM ?

In early March 2023, LHDs received a list from the Division of Child and Family Well-Being (DCFW) of CMARC members who are transitioning to TCM. This was to allow LHDs time to get ready for the warm handoff process which began on March 13, 2023. Subsequently, LHDs can identify Tailored Plan/TCM eligible members in NCTracks under the Coverage Details section. Tailored Plan/TCM eligible members will have a Tailored Care Manager subsection that will have information on the member's Tailored Care Manager and contact details.

Note: Members identified by Community Care of North Carolina (CCNC), AMHs, LME/MCOs or the Department as those with complex treatment circumstances or multiple service interventions require a warm handoff *(Refer to page 17 of the Transition of Care Policy).*

WHAT IS EXPECTED FOR CMHRP PRIOR TO TAILORED PLAN LAUNCH ?

CMHRP and TCM services can be provided simultaneously. Members currently in CMHRP will continue to receive care management from the LHDs. For newly pregnant TCM members, LME/MCOs must identify and refer high-risk pregnancies to LHDs for CMHRP services. For members receiving both CMHRP and TCM, the CMHRP and TCM care managers must collaborate to coordinate care. Up until Behavioral Health and I/DD Tailored Plan launch, LHDs will be paid for CMHRP services of new and existing members via Medicaid Direct payments from CCNC.

WHAT IS EXPECTED FOR CMHRP AT TAILORED PLAN LAUNCH ?

CMHRP and TCM services can be provided simultaneously. For contract year 1, Tailored Plans must identify and refer high-risk pregnancies to LHDs for CMHRP services. For members receiving both CMHRP and TCM, the CMHRP and TCM care managers must collaborate to coordinate care. LHDs must be contracted with Tailored Plans for members to be referred to them. Tailored Plans will compensate contracted LHDs at an amount similar to, but not less than funding levels they receive today for these services.

WHY IS CMHRP NOT CONSIDERED DUPLICATIVE, WHEN CMARC IS ?

CMS informed the Division of Health Benefits (DHB) that CMHRP services are not duplicative of TCM due to the scope of CMHRP services being narrowed to assisting and supporting high-risk pregnant members with navigation of prenatal and postpartum care. While CMHRP services include addressing barriers affecting their care and health, CMS did not deem this aspect of the service to be duplicative.

WHAT WILL HAPPEN AFTER THE FIRST YEAR LHD CONTRACT WITH TAILORED PALNS FOR CMHRP SERVICES EXPIRES ?

NC Medicaid will conduct an assessment of LHDs' performance to identify high performing LHD and inform future contracting decisions. NC Medicaid will share final benchmark assessments in October 2024. Starting in July 2025, health plans will only be required to contract with LHDs that meet the criteria in the benchmark assessments. LHDs that do not meet the benchmarks may work with health plans to negotiate maintaining their contracts, but health plans will not be required to contract with those LHDs. Beginning in July 2026, NC Medicaid will remove contracting specifications that require Health Plans to offer exclusive contracts to LHDs that provide CMHRP and CMARC services. See

Companion Program Updated for CMHRP and CMARC Programs for updated on contract changes and details on program oversight.

At the conclusion of all contracting specifications/requirements, Tailored Plan shall have the option to continue to contract with LHDs for CMHRP or to include services within TCM for members experiencing high-risk pregnancy (whether provided by the organization responsible for TCM or by another organization under contract with the Tailored Plan).

IF A MEMBER IS IN CMHRP, TCM, COMPLEX CARE AND PILOT PROGRAMS (E.G., INCK), HOW ARE THEY EXPECTED TO KEEP UP WITH MULTIPLE CARE MANAGERS?

TCM members will have a designated care manager supported by a multidisciplinary care team to provide whole-person centered care management that addresses all their needs including physical health, behavioral health, I/DD, TBI, pharmacy, LTSS and unmet health-related resource needs. For members receiving both CMHRP and TCM, members may have a TCM Care manager as well as a CMHRP care manager collaborating to coordinate care and to ensure member's needs are met. Note: If a member is receiving TCM services, they are not eligible to receive care management through Integrated Care for Kids (InCK), as it is considered to be a duplicative service.

WHAT ARE THE DIFFERENT ROLES OF THE CMHRP CARE MANAGER AND THE TCM CARE MANAGER AND HOW DO WE KEEP THEM FROM DUPLICATING SERVCIES ?

For CMHRP, the LME/MCO will ensure that the care management roles and responsibilities between the LME/MCO are non-overlapping with care management services offered by LHDs. Direct communication, and collaboration between the CMHRP care manager and the TCM care manager is key to ensuring that each care manager is aware of the goals, care plans and specific work being implemented with the patient by each care manager.

HOW WILL THIS TRANSITION AFFECT THE FUTURE OF THE CMARC PROGRAM?

CMARC member who meet TCM-eligibility, will transition to TCM. CMARC members who do not meet TCM-eligibility will remain with their respective LHDs where they will continue to receive CMARC services.

WHAT HAPPENS IF A CHILD NEEDS TO TRANSITION FROM TAILROED PLAN TO MEDICAID DIRECT DUE TO FOSTER CARE ?

Children in foster care who are eligible for TCM will be enrolled in TCM services. A child who is TCM eligible and now has foster care member status will continue to receive TCM services.

WHAT IS A WARM HANDOFF ?

A warm handoff is a member-specific meeting or knowledge transfer session between the transferring entity and the receiving entity. The warm handoff process is in place for members who have been identified as high need and warrants a verbal briefing between the transition entity and the receiving entity. This high-needs group is identified on the DHHS “High Need Member List.”

ARE ALL MEMBERS ENROLLED IN CMARC CONSIDERED HIGH NEEDS ?

Yes, CMARC members are considered a high-needs population.

WHAT IS THE PROCESS TO HANDOFF CMARC MEMBERS TRANSITIONING FROM LHDS TO LME/MCOS FOR TCM ?

For all CMARC members transitioning from the LHD, the LHD shall transfer the information necessary to ensure continuity of care, including appropriate Transition of Care (TOC) data files and member-specific socio-clinical information. A TOC Summary Page for each CMARC member will be transmitted to the receiving LME/MCO. This summary page includes minimally:

- List current providers;
- List of current authorized services;
- List of current medications;
- Active diagnoses;
- Known allergies;
- Existing or prescheduled appointments, including Non-Emergency Medical Transportation (NEMT), as known;
- 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; and
- Additional information as needed to ensure continuity of care.

Note: For members out of county, the serving county will coordinate the warm handoff.

WHAT ARE THE EXPECTATIONS FOR CMARC CARE MANAGERS ?

CMARC care managers serving members who are transitioning to LME/MCO should follow the NC Medicaid Transition of Care policy to ensure that members receive the appropriate warm handoff to the LME/MCO.

HOW WILL LHDS BE REIMBURSED FOR CMARC SERVICES AFTER NC MEDICAID DIRECT: BEHAVIORAL HEALTH AND I/DD SERVICES LAUNCH?

For CMARC Members enrolled in Medicaid Direct who are not TCM eligible, LHDs will be reimbursed at an amount similar to, but not less than the amount paid in the existing program: $4.56 per member per month for all enrolled children ages 0 through 5.

WHAT IS THE TAILORED PLAN REIMBURSEMENT RATE TO LHDS FOR CMHRP ? IS THIS NEGOTIABLE ?

The Tailored Plan shall pay LHDs they are contracted with for CMHRP services at an amount not less than $4.96 per each female ages 14 through 44 who are attributed to that county and LME/MCO. This reimbursement method is considered a per member per month (PMPM) payment as it is based upon a specific population and not a fee-for-service model. The contract terms (including PMPM) may be negotiated between the LHD and the Tailored Plan.

WILL LME/MCO CARE MANAGERS HAVE ACCESS TO VIRTUAL HEALTH ?

Yes, LME/MCOs will have 'VH Provider Portal' read-only access to Virtual Health if requested. Care managers will be able to use the information in Virtual Health to determine if a member is receiving CMHRP services in order to coordinate care with LHDs.

IF THE LME/MCOS HAVE VIRTUAL HEALTH READ-ONLY ACCESS, WHAT IS THE POINT OF THE WARM HANDOFF, CONSENT FORM, SUMMARY, ETC. WHEN THEY CAN SEE EVERYTHING ?

To maintain continuity of care for members, the LME/MCOs are required to participate in member-specific knowledge transfer sessions known as warm handoffs for high-need members transitioning to the LME/MCO for TCM. During the warm handoff process, the transitioning entity, LHD, shares and verifies member information and may provide additional context about the member as necessary.

WHAT INFORMATION WILL BE VISIBLE TO PROVIDERS IN NCTRACKS ?

LHDs can identify Tailored Plan/TCM eligible members in NCTracks under the Coverage Details section. Tailored Plan/TCM eligible members will have a Tailored Care Manager subsection that will have information on the member's Tailored Care Manager and contact details.

HOW CAN I LEARN MORE ?

For more information or questions on Transition of Care, contact Medicaid.TOC@dhhs.nc.gov.

Additional resources are here:

- Care Management for At-Risk Children
- Care Management for High-Risk Pregnancies
- LME-MCO Directory
- Transition of Care Policy
- Sample Tailored Care Management Assignment Notice
- Health Care Option Guide