Care Management for High-Risk Pregnancies (CMHRP) and Care Management for At-Risk Children (CMARC)
Medicaid Transformation Webinar Q & A
May 27, 2021

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1. Will health departments still receive funding for non-Medicaid patients?

Yes, if your health department currently receives funding under AA107 or the CMARC 318 AA to provide care management services to the individuals ineligible for Medicaid, then the funding will remain available through the end of your contract. A new CMHRP AA 107 Request for Application (RFA) is planned for release in the Fall to apply for funding for future years.

2. Will the template for care plans be changing since health plans will be reviewing care plans and the care plans?

No, as of right now, there is no indication that care plans will be changing. If there are changes, the changes will be based on National Committee for Quality Assurance (NCQA) standards, which is how the current care plan template was created.

3. Who is the contact person at CCNC who will be pulling reports from Care Impact to send to the PHPs?

Per the CCNC contract with the Division of Health Benefits (DHB), it is a team of data analysts who will run the reports and provide this information to DHB and the PHPs.

4. Insurance companies are going to have their own OB care managers for their programs (i.e.. Baby Steps/Wellcare) but are only going to take the members we close (which are the low-risk ones). Will our data be compared to theirs? Because the episodes we close are the compliant members. We close them because they are low risk, get early prenatal care, go to their appts, deliver at term, and are responsible enough to come back for their 6-week appt. It would be comparing apples to oranges. We will be at a disadvantage if this is what happens.

At this time, we are aware the PHPs will send members they deem as “Priority,” but we do not have the specifics as to how that determination is made as each PHP has their own “Priority” criteria. EVERYONE is responsible for impacting the Quality Measures, including the LHDs, PHPs and Pregnancy Management Program (PMP). CMHRP was chosen to provide *intensive* care management to members with the highest risk for an adverse birth outcome. PHPs will be providing care management to other populations and the intention is not to compare but to impact birth across the state in a positive way.

5. What should we expect from the PHPs and how can we find out which PHPs our county providers are contracted with.

Per the General Assembly, NC has moved to a Managed Care model and as a result, DHB has contracted with five Pre-Paid Health Plans who have been given full oversight of the CMHRP and CMARC programs. PHP oversight and accountability is outlined in the *Program Guide*. All LHDs should sign contracts with all PHPs in your area for CMHRP and CMARC services to ensure there is not a disruption in PMPM payments after July 1, 2021.

6. When will we be informed of benefits and incentives each PHP offers so we can communicate with our patients about them?

The PHPs have been setting up meetings with CMHRP and CMARC local leadership to introduce themselves and answer questions. This would be the setting to receive information about their benefits and incentives. You can also locate information on the Medicaid Transformation website. The link is at the end of this document. It is acceptable/encouraged that each LHD reach out to the PHPs they will be providing CM services.

7. How do we help our patients access benefits and incentives from their PHP?

The PHPs have been setting up meetings with CMHRP and CMARC local leadership to introduce themselves and answer questions. This would be the setting to receive information about their benefits and incentives. Reference website link mentioned in #6 that can be found at the end of this document.

8. How will the PHPs prioritize their patients?

Each PHP will have their own prioritization methodology, and the local health departments will receive all members who the PHP has deemed "Priority." We do not have the algorithms or requirements from each PHP that will trigger a member to be a PHP "Priority."

9. How will the lists from the PHPs increase/decrease our workload?

Since we do not have the PHP's prioritization methodology, it is unknown at this time how their lists will increase or decrease care management workload. DPH will monitor trends and will have on-going communication with DHB. DPH consultants can provide technical assistance on caseload management and prioritization.

10. Who will we be communicating with for each PHP?

The PHPs are reaching out to the local health departments for initial meetings. This would be an appropriate question to ask the individual who reaches out to your LHD.

11. Who we should be listening to regarding work processes, outcomes and data? (i.e., PHP, DHB, DPH, CCNC, etc.)

DHB is the ultimate payor source and as a part of the transition to Managed Care, they have contracted with five PHPs to oversee and provide accountability for care management services. The PHPs have in turn contracted with the LHDs to provide care management services for high-risk pregnancies and at-risk children. The PHPs have oversight of the programs; however, DPH is providing the programmatic framework and best practice model. CCNC is the vendor for the documentation and analytics platform. Ultimately, the LHDs are responsible for all requirements included in the CMHRP and CMARC *Program Guide*.

12. I would like to see a blueprint of the care manager role as well as the insurance care liaison role.

The role of the care manager (CM) is not changing; CMs are still to provide comprehensive care management services to every member eligible for services according to the Standardized Plan. Please ask each PHP for information on their liaison.

13. Previously members who qualified for MPW could roll over onto Family Planning Medicaid because the income eligibility was the same. With pregnancy and Family Planning being in separate categories for those who must enroll and those who can't enroll, how does that affect those pregnant women once they are no longer pregnant?

We have sent this question to Division of Health Benefits.

14. How we need to change our day-to-day work?

The day-to-day work of a care manager will not change. What is changing is program oversight, which will be provided by the PHPs. PHPs will also serve as an additional referral source. Moreover, the definition of the priority population will change. LHDs will continue to use VirtualHealth as the documentation platform and CareImpact as the data analytics platform. CMs will continue to use current program guidance documents to govern their day-to-day work.

15. How will this affect the in-house Medicaid workers and how they are assigned to beneficiaries?

In-house Medicaid workers are DSS employees, and their employer will make these decisions in accordance with DHHS/DHB guidance.

16. Just unsure of what will be required from the insurance plans.

Please consult the *Program Guide as* it outlines the expectations for which LHDs are being held accountable by the PHPs.

17. What is the Program Guide? Where is it located?

The *Program Guide: Management of High-Risk Pregnancies and At-Risk Children in Managed Care*. This Guide provides CMARC and CMHRP related information as it pertains to Medicaid Transformation and the transition period. This outlines the expectations for which PHPs will hold the LHDs accountable. An excerpt from DHB regarding the *Program Guide* is as follows, "This program guide provides key information to OB/GYN providers, pediatricians, LHDs, health plans and other interested stakeholders as to how the transition of care management programs for at-risk children and pregnant Medicaid beneficiaries will occur over time into the State's managed care model, how the programs will operate, and the expectations of providers, LHDs, health plans and the Department in each." The link to the *Program Guide* can be found at the end of this document.

18. What changes do we need to be focusing on?

CMHRP: Timely engagement/outreach, frequency of contact (attempted and completed), timely and appropriate documentation, utilization of core program documents and resources

CMARC: Timely engagement/outreach, frequency and timeliness of contacts (attempted and completed), timely and appropriate documentation paying special attention to care planning, and outcome measure compliance for our target population

19. Who are our points of contact for insurance questions? Who do we follow up with if there is no cohesion occurring between all these intensities? How are the insurance companies going to be communicating with us? Can we expect updates?

The PHPs are currently holding meetings with LHDs, and these questions can be addressed in that setting.

20. Who do we contact for Medicaid questions? Our Medicaid workers here at social services or the PHP's?

If the question is an overall Medicaid question, then you would contact your local DSS. If the question pertains to a specific PHP and their Medicaid coverage, then you would need to contact the respective PHP.

21. Clarity on what will count for care management activities? Program measures require patient centered interactions with pt./family/caregiver/ guardian. What percentage is required or recommended for completed LSPs, SWYCs?

Our policies reflect what is needed and timeframes for assessments. Please refer to our CMARC toolkit for timeframes on assessments.

22. How are the contracts handled for care management with LHDs?

Consult with your local health director regarding the contracts. LHDs should ensure they are contracted with each PHP in their region to prevent a lapse in PMPM payments beyond July 1, 2021
for care management services.

23. Will all Medicaid charts be receiving claims at go-live or just certain Medicaid charts like Medicaid CA-II?

It is our understanding that all charts will be receiving claims data.

24. How will Medicaid Transformation look like for members that are in need to contact their worker?

Members should still be able to contact their DSS Medicaid worker. We are unaware of any changes to that process.

25. Will patients be able to change PHP during or after pregnancy? If patient is transferred to a higher level of care due to complications and that PMP doesn't contract with that patients PHP what will happen?

We have sent this question to Division of Health Benefits**.**

26. **Will patients be required to participate with care managers, or will this continue to be a voluntary program for patients?**
    CMHRP and CMARC are voluntary programs and will continue to be voluntary programs.

27. **Are children with disabilities with SSI in NC Medicaid managed plan? Depends on the disability, there are other plans that will help these children receive care management . example: Behavioral Health I/DD Tailored Plan of Care Management.**
    More information is available on the Medicaid Transformation web page and the Behavioral Health I/DD Tailored Plan web page

28. **As a CM that covered both programs, wondering how closely the programs will follow same guidelines?**
    Both programs will follow the requirements in the *Program Guide* and both programs will align programmatically as much as possible. That said, CMHRP and CMARC serve different populations; therefore, there will be variances between programs at times.

29. **When will the dashboard for PHPs be available on CI, and when will we expect to be educated on how to use it?**
    We are awaiting confirmation from DHB and CCNC as to when this information will be available in CareImpact. DHB plans to present these timelines in a subsequent webinar. CCNC/DPH will provide education and training around the reports as they are available.

30. **What will count as care management?**
    Medicaid Transformation will require care managers to adjust their perspective on data and its impact on care management. The “big picture” of care management is impacting birth outcomes and the health and wellbeing of children 0-5 years. Everything you do for and with a member “counts” as it is moving the member to a positive outcome, which meets the overall goal improving the health of North Carolinians. DHB is focusing on specific Performance Measures and Quality/Health Outcomes Measures (pages 9 & 10 of the *Program Guide* for CMHRP and pages 12 & 13 for CMARC). The PHPs will use the Performance Measures for overall monitoring purposes, including the CAP process. The Patient-Centered Interactions (home visit, virtual visit, phone call, community encounter, practice encounter) that you are familiar with providing in today’s programs are consistent with future expectations.

31. **How will the role out of Medicaid transformation affect employment if our agency does not have the proper staffing to provide services to meet our outcomes (i.e. short supervisor and one care manager)?**
    PHPs may intervene if employment shortages occur for greater than 60 days per the *Program Guide*. Health Directors are aware of this, and internal discussions should be occurring now rather than later to properly staff the programs.

32. **Data entering into VH-the 72 hr time allowance to workers to get data in the system When Will Assessments Allow for this? (interactions allow a date of pt visit)**
    Please reach out individually to your DPH Consultant for follow up to this question.

33. **Will ADTs continue and if so, will both the PHP and CMHRP be contacting the patient at the same time to identify / screen / assess patient?**
    Yes, OB ADTs information will continue (page 21 of the *Program Guide*), and the expectation remains that the care manager will follow up within 72 hours. There is the potential that the PHPs will reach out to the patient following an ADT encounter.

34. Will we have to negotiate with PHP CM as to which CM will work with the pregnant identified woman?
PHPs are required to send their high priority pregnant members to the LHDs for intensive care management services. The PHPs are responsible to ensure the delineation of non-overlapping roles and responsibilities (page 22 of the *Program Guide*).

35. How do we ensure all pregnant women are identified by CMHRP and not missed, yet probably known by PHP CM?
The LHDs will receive the Pregnancy Risk Screening Forms just as they do today, so it is likely you will know about a pregnant member before the PHP or PHP CM. Also, if the PHP or PHP CM is aware of a high priority member who needs CMHRP services, then the PHP is mandated to share the referral with the LHD.

36. When we engage a pregnant woman, is there a set time in which we must see the FTF and what changes &/or when will changes be made in VH to collect that data?
Timely outreach expectations begin when the care manager receives a new referral; however, this does not have to be a face-to-face contact. The face-to-face programmatic guidelines for ongoing care management services will remain in place (once COVID restrictions are lifted). The Current Pregnancies Patient List will remain and will be available July 1st, and this information is captured on that report.

37. After the 3 years, is it in writing that the programs will remain in HDs if all measures are met, or can the PHPs still decide to take them over?
It is in writing that care management becomes competitive at the end of the 3 years, which means a PHP could choose to contract with the LHD, a different community program or provide services themselves (page 3 of the *Program Guide*).

38. Will the PHPs require risk screens and referrals to be timely?
The Medicaid Policy requires the Pregnancy Risk Screening Forms to be completed and submitted to the LHDs and the PHPs within 7 days (page 8 of the *Program Guide*). The PHPs are responsible collaborating with providers in the Pregnancy Management Program (PMP).

39. Will face-to-face only count for interaction?
As noted in question #30, Medicaid Transformation will require care managers to adjust their perspective on data and its impact on care management. The “big picture” of care management is impacting birth outcomes and the health and wellbeing of children 0-5 years. Everything you do for and with a member “counts” as it is moving the member to a positive outcome, which meets the overall goal improving the health of North Carolinians. DHB is focusing on specific Performance Measures and Quality/Health Outcomes Measures (pages 9 & 10 of the *Program Guide*). The PHPs will use the Performance Measures for overall monitoring purposes, including the CAP process. The Patient-Centered Interactions (home visit, virtual visit, phone call, community encounter, practice encounter) that you are familiar with providing in today’s programs are consistent with future expectations.

40. I was reading some people's questions about what actually counts as case management and I am confused about having actual "contact" vs "other interactions" counting as case management.
As noted in question #30, Medicaid Transformation will require care managers to adjust their perspective on data and its impact on care management. The “big picture” of care management is impacting birth outcomes and the health and wellbeing of children 0-5 years. Everything you do for and with a member “counts” as it is moving the member to a positive outcome, which meets the overall goal improving the health of North Carolinians. DHB is focusing on specific Performance Measures and Quality/Health Outcomes Measures (pages 9 & 10 of the *Program Guide*). The PHPs will use the Performance Measures for overall monitoring purposes, including the CAP process. The Patient-Centered Interactions (in-person visit, virtual visit, phone call) that you are familiar with providing in today’s programs are consistent with future expectations.

41. I feel this might not be the best time to transition due to still dealing with a pandemic that has not been completely dealt with.

In 2015, the NC General Assembly enacted legislation directing DHHS to transition Medicaid and NC Health Choice from fee-for-service to managed care. Under managed care, the state contracts with insurance companies, which are paid a predetermined set rate per enrolled person to provide all services. DHHS was on track to go live Feb. 1, 2020; however, new funding and program authority were required from the General Assembly to meet this timeline and Medicaid Managed Care was suspended in November 2019. In July 2020, legislation authorized the restart of Medicaid Managed Care transformation efforts with a July 1, 2021 launch date for Standard Plans.

42. What is changing about our programs and processes?

CMHRP: The most significant change within CMHRP is the addition of a priority referral source, which will come from the PHPs. There will be a slight change to the CMHRP population, which will include eligible and priority members who will receive CMHRP services. Oversight and accountability will transition to the PHPs. Otherwise, the day-to-day operations of a care manager are not changing.

CMARC: Priority referral source from PHPs, relying on the *Program Guide* for guidance, performance and outcome measures. Program oversight by PHPs is probably the most significant change for CMARC. CMARC processes have not changed except the addition to handling the PHP referral list.

43. Will the PHPs be willing to work with us?

Please reference the *Program Guide* for DHB's expectations for all parties involved in Medicaid Managed Care.

44. Are the PHP contacts going to be connecting with us through VirtualHealth email or through our supervisors? We have had direct contact from 2 of the PHPs care managers but none of the other. Seems very disorganized all the way around. Is anyone concerned about the families receiving Medicaid?

PHPs will reach out to CMHRP and CMARC local leadership via phone and/or county email addresses. All entities involved in Medicaid Managed Care are concerned about the families receiving Medicaid, and one of the goals of Managed Care are for Medicaid services to be improved and positively impact health outcomes.

45. The topic of the three-year contract is glossed over quickly in every presentation. I would like to know what are the realistic expectations around our programs continuing past the tree years? Understanding that we don't know exactly, but at least sharing the information transparently if there are indications that the PHPs wish to not continue with the LHDs.

Please see the answer to question #37. We have been transparent with the information made available to us regarding these programs, we are all devoted to NC Public Health and envision a future with care management remaining within public health, as it has been since the late 1980s. Review the Medicaid Transformation website and the *Program Guide* for the information released by DHB.

46. Are we to help clients with the process or direct them to someone in Medicaid office?

The process for applying for Medicaid remains the same, other than the clients will choose a health plan at the time of applying for Medicaid. Brokers can assist patients with understanding the value-added services each health plan provides and are best suited to their family's needs. Beneficiary information can be found on the Medicaid Transformation website.

47. What will actually be changing for CMARC? Specifically, not generally.

See the answer to question #42

48. Why after the 3 year transition is the LHD role so uncertain if history shows that the LHD does this care management best why is there even a chance that the continuation of these programs through the LHD may go?

The transition to Medicaid Managed Care provides for private entities' accountability for Medicaid services. See the answer to question #37. As well, it is important for us to focus on doing our best in meeting the needs of the individuals and families that we will serve through care management services.

49. When we need guidance from the PHPs, how accessible will they be to Care Managers? Will we have a direct contact person for each PHP?

The PHPs have been or will reach out to local CMHRP and CMARC leadership to schedule meetings to review their health plan and value-added services. This meeting would be the appropriate setting to ask this information of the PHP.

50. How can we expect PHPs to accurately determine our program measures when data in VH is almost always incorrect?

Data accuracy is also impacted by the documentation entered in VirtualHealth. Care managers should ensure they are following programmatic guidance and expectations when documenting. If you do observe inaccuracies with the data, then consult with local CMHRP and CMARC leadership to review the inaccuracies. If concerns remain, then reach out to your DPH Consultant. You will likely be encouraged to submit a ticket explaining the inaccuracy you identified along with screenshots as proof or to give the ticket receiver clarity on the inaccuracy. State CMHRP and CMARC leadership continue to monitor VirtualHealth concerns and communicate with DHB regarding these concerns.

51. What guidance will we receive to help us understand the differences between the 5 PHPs?

The PHPs have been or will be reaching out to local CMHRP and CMARC leadership to set up meetings to discuss the PHP's health plan and value-added services. These meetings would be the setting to learn more about the 5 PHPs. The Medicaid Transformation website also includes information on the 5 PHPs.

52. Many PHPs promote postpartum home visits as part of their benefits – is that going to be a role of the CMHRP CMs?

The CMHRP CMs are not able to provide a nurse home visit in the postpartum period to check on the patient's healing, baby weight, etc., which are normal components of a postpartum home visit. Even if you are a CMHRP CM with RN credentials, you cannot operate in this capacity as a care manager. LHDs are also able to provide Home Visit for Postnatal Assessment and Follow-up Care. This service is also separate from CM services but part of the Maternal Support Services Clinical Coverage Policies. CMHRP CMs should continue to make referrals to their local Newborn Home Visiting resource, often embedded within the LHDs, as appropriate. A postpartum home visit for care management needs is within the scope and role of the CMHRP CM.

53. More information about the tribal options

The *Program Guide* (page 2) has information on tribal options. If you have additional questions that are not answered by reviewing the *Program Guide* or the CMHRP/CMARC May 27, 2021 Medicaid Transformation webinar, then you can email Medicaid.Transformation@dhhs.nc.gov

54. When members belonging to foster/adoption will be merged

(Launch date July 1, 2023) The Foster Care Plan will be a statewide specialty NC Medicaid Managed Care plan to ensure access to comprehensive physical and behavioral health services while maintaining treatment plans when placements change. The Foster Care Plan will include care management services to improve coordination among service providers, families, involved entities (such as the Department of Social Services, Division of Juvenile Justice, schools) and other stakeholders involved in serving Foster Care Plan members. CMARC is a stakeholder and a member. More to come.

55. Will we be able to find info on which php the beneficiary is on?

The information will be available in CareImpact where you will find the PHP priority patients. This information will be updated monthly; however, if you or someone within your agency has access to NC Tracks, then you can access the information closer to real-time.

56. What is a beneficiary that is pregnant is automatically enrolled in a php that her provider doesn't accept, will they have to wait to change to another php before going to an appt? I have had a lot of members tell me they could not get through either online.

Members can change their PHP or provider within 90 days for any reason. After 90 days, patients can change based on an approved cause. Members can contact NC Medicaid Managed Care Mon-Sat from 7a-5p at **1-833-870-5500**. If members are not receiving the answers they need, then they can review information regarding the Medicaid ombudsman at www.ncmedicaidombudsman.org.

57. Will Virtual Health remain our platform?

Yes, VirtualHealth will remain the documentation platform.

58. What will members do if their PCP and OB have different plans?

Members will need to verify whether their desired Primary Care Provider and/or OB Provider are contracted with their chosen PHP. See the answer to question #57.

59. What changes to process will be needed when providing managed care to children and how will the different plans change the process or what requirements CMARC coordinator will have with working with each plan?

Performance and outcome measures are changing a bit (See page 37 of the Program Guide) but program guidelines and processes are not changing. Please refer to questions #30 and 42 above.

60. Knowing what the PHP expect from the local CM programs. What are they looking for in the documentation?

The PHPs' expectations are outlined in the *Program Guide*. Current documentation requirements will remain in place.

61. How will VH accurately transmit outcomes? A lot of data is not collected

Please see the answer to question #50. Data is still being collected even though PHPs do not have access to VirtualHealth and CareImpact the data will be "fed" to them from CCNC.

62. Will FTF coontacts weigh heavily now? The PHP are end-result focused. They are not concerned about the process, but the end result. If this is the case if we are able to communicate via phone why would FTF weigh so heavily. Yes, still an option but not the primary mode of contact. Some offices are still completing visits via telehealth and this may become the norm. We may also need to make adjustments.

See the answer to question #30. Historical data from LHD care managers' work within NC local health departments was analyzed, and the results indicated face-to-face contact from a care manager positively impacted the patient's likelihood of experiencing a healthy outcome, which is the desired outcome for all entities involved in care management services. Local health departments were selected to provide care management services due to their involvement in their local communities, so providing face-to-face care management has been the crux of public health care management. Telehealth visits with members are an option for the face-to-face contacts.

63. Are there special case managers who take referrals from CM CMHRP after member has completed postpartum period and still needs additional services?

Based upon the member's needs, a referral for CMARC may be appropriate. Also, PHPs have care management available for other populations. This would be an appropriate question for the scheduled PHP meetings.

64. Will we be able to contact the PHPs that give referrals the same as we do now with providers?
You will continue to receive referrals the same way you do today. The difference will be you will also receive monthly updates in CareImpact with identified PHP priority patients. The PHPs will also receive the information on members for which LHDs are providing care management services.

65. How will Medicaid be different/same for clients and parents of Medicaid clients?
Medicaid will remain the same regarding applying and basic services provided. However, patients will now have to choose a desired PHP, and the PHPs have their own value-added services.

66. How will we ensure PHPs and providers are not motivated to provide fewer services for Medicaid clients now that there is no longer a fee-for-service model?
The PHPs are focused on the outcomes and not the number of services. Services will be tailored to the needs of the beneficiary to positively impact outcomes.

67. How will providers be incorporating SDOH into their treatment and care plans?
Consult with your providers directly with their treatment and care plans. One of the overall goals of Medicaid Transformation includes SDOH inclusive of transportation, food security, interpersonal safety, housing stability and employment as a part of healthy opportunities work.

68. Clarifying CMARC CM- in case management- what we get credit for and not.
You are responsible for and get “credit” for what is described in the *Program Guide* and in your 318 AA.

69. Will CMARC/CMHRP Programs have to meet with all PHPs on a regular schedule, like quarterly?
PHPs are currently reaching out to CMHRP and CMARC local leadership to set meetings to learn more about the PHPs. This meeting would be the appropriate setting to ask this question.

70. I would like more information on how Medicaid Transportation services will changed as a result of Medicaid.
Medicaid Transportation available through DSS will remain in place; however, the PHPs will also have transportation options as part of their value-added options.

71. How can we possibly still be this much in the dark?
The day-to-day work of the CM will remain the same. This is an example of differences across the state whereby some feel the information is being repeated and others feel they are “in the dark.” Medicaid Transformation website links have been made readily available to LHDs, which outline the information known to DPH.

72. How does this effect Presumptive Eligibility Medicaid? I work with the uninsured Latina population.
The care management services you provide during the Presumptive Eligibility period should continue until it is determined the member no longer qualifies for ongoing Medicaid coverage. If your LHD receives funding to specifically provide CMHRP Non-Medicaid services (AA107), then this work will remain the same.

73. Is Blue Cross Blue Shield a provider or will it be called something else?
Blue Cross Blue Shield is a contracted PHP. Healthy Blue is the name of the Medicaid plan offered by Blue Cross Blue Shield.

74. What is being done to ensure collaboration between DSS and the health departments in relation to Medicaid Transformation?
This collaboration should occur locally between the local DSS and health department.

75. The agreement and/or contract between the Php's & LHD's, this needs to be further divulged.

These are individual agreements between the individual PHPs and LHDs, which is handled by local health department administration.

76. Requirements and expectations to help our programs be successful? What changes will be made to each?

Please review the *Program Guide*, as well as this Q&A document in its entirety as requirements, expectations and changes have been discussed throughout. Please also continue to follow the CMHRP and CMARC Toolkits, which layout programmatic expectations for success and resources.

77. How will transportation for clients be handled? (can CMHRP and CMARC members still access DSS transportation in addition to the PHP transportation)

The PHPs have transportation options as part of their value-added options.

78. Client incentives for participation with CMHARP???

Members are eligible to receive value-added services from their selected PHP. We are requesting additional information from Division of Health Benefits regarding the potential for program specific incentives offered through the LHDs.

79. What are we specifically supposed to do?

You should continue to provide care management services utilizing the available programmatic guidance, documents and resources. The core of care management is not changing, and your role as a care manager will not change. It is highly recommended that you review the Medicaid Transformation website and the *Program Guide*. As well, you should continue to ask questions related to Medicaid Transformation and care management to your local leadership and/or DPH Consultant.

80. MIIS score changes

Please reach out to your Regional Social Work Consultant with specific questions regarding MIIS score changes if your questions are not answered in subsequent webinars.

81. I want to know if face to face contacts are more accepted than phone calls?

Face-to-face contacts are a programmatic requirement for several reasons. Data has been collected from work LHD care managers have done in NC that shows outcomes are positively impacted when a member has face-to-face contacts with a care manager. Secondly, we are in the community and can provide face-to-face services whereas any entity could provide telephonic care management. Patient-Centered Interactions will continue to include in person contacts, virtual visits and phone calls.

82. How do we provide holistic care when only member interfaced contacts count? We need to be recognized for "driving the bus" and coordinating care/needs/resources/other programs/etc.

From a PHP and DHB data perspective, CMHRP and CMARC are being measured on three performance measures: 1) how much of the respective population did you penetrate, 2) did the member have a completed contact OR 3 attempted contacts within 7 days of receipt of referral and 3) does the member have a signed care plan within 15 days of receipt of referral or 30 days for CMARC The other pieces of care management are expected to be documented (i.e., all work with the patient and on behalf of the patient must be documented). Holistic care ensures the member receives necessary services, so the "credit" comes in the form of a positive birth outcome and a healthier community.

83. Do we focus more on outcomes or face to face meetings, or a combination?

Care managers should focus on what their member needs first and foremost. Focusing attention where it is due will impact outcomes. Continuous, consistent contacts, inclusive of face-to-face contacts, has been shown to positively impact outcomes.

84. After questions in the chat box I am now wondering about all the contacts that we do daily for patients such as calling and speaking with their providers, contacting and linking to community resources like transportation, and linking to other services like WIC and counseling, will those no longer count as activities. I know before during MCC and CSC days we had a limited amount of time we could bill for a patient and if they used it all before the end of the month then any additional work on that one person was kind of waste and took up time you needed to be working with others. This was particularly stressful when you had several needy clients who took up alot of your time and then you almost didn't have any time left to work with your other clients. But it looked like you weren't doing anything since you could not bill for it.

See answer to question #83. The work you do on behalf of and with the member is always necessary and beneficial. The work you are doing is captured in various reports, which shows interactions completed. In addition, your professional ethics requires member needs to be assessed, addressed and linked to appropriate resources.

85. What are the requirements and expectations of the Medicaid Providers for both programs?

Reference the Medicaid Transformation links at the end of this document.

86. What concrete changes am I going to see, as a CMHRP care manager?

See answer to questions #80 and #83. Please continue to utilize your programmatic toolkit and resources on a routine basis.

87. What states in the US had the CMHRP and CMARC programs prior to Medicaid Transformation and of those states that have moved into Medicaid Transformation, how many now have CMHRP and CMARC programs?

We are requesting additional information from Division of Health Benefits regarding other states; however, the model in North Carolina is unique from many other states in that LHDs have the opportunity to partner with privatized prepaid health plans to provide care management services.

88. How will referrals be sent from the PHPs?

This referral information will be accessed in CareImpact. Training is forthcoming.

89. How will PHP's help assist us in holding providers accountable for completing risk screens and allowing us to see the patients we need to in their office space?

See the answer to question #38.

90. What my day to day will look like come July 1st?

Your day will look very similar to today except with the slight variations noted in the webinars. Your role as a care manager and programmatic expectations remain the same.

91. Can you explain more into the different plans and what our role will be with each plan will we document differently depending on the plan.

Programmatic requirements will remain consistent with today's CMHRP and CMARC services.
Documentation expectations remain consistent. Your role within the PHPs is to manage the members who they have deemed as a priority member.

92. A day to day of what working with a patient would look like. How will we manage all those incentives that each plan is going to offer?

The day-to-day of care management will remain the same. Care managers will need to familiarize themselves with the value-added services each PHP has made available to their members; however, the individual PHP and the Medicaid Transformation website include some of this information. Members may also contact their chosen PHP to find out more information about the value-added services. You can begin by familiarizing yourself by visiting the PHP websites and value-added services.

93. I would like to know why the insurance companies also have Care management programs in place already.

See the answer to question #4. It is also important to note the PHPs have been providing internal care management for their members across the United States for years and is not new. However, in North Carolina, the LHDs have been afforded the opportunity to partner with the PHPs to provide intensive care management services to high-risk populations.

94. Will care management duties be billable?

CMHRP and CMARC duties are not billable.

95. How will the individual health plans monitor the work being documented in Virtual Health.

PHPs will receive copies of their respective members' care plans monthly. This will be an automated process implemented by the contracted documentation and data analytics vendor (CCNC), and aside from documenting in the care plans, there is no additional work the LHDs need to do to ensure the PHPs receive the care plans. PHPs will not have access to CMHRP and CMARC documentation within VirtualHealth.

96. Will there be a contact person to f/u on feedback ounce the health plans go into affect.

PHPs are currently or will be reaching out to CMHRP and CMARC local leadership to arrange meeting times to review their health plan and value-added services. This meeting would be the ideal setting to ask this question.

97. Most of our patients need behavioral health, what are they missing out on by having a PHP and not having Medicaid Direct?

We have sent this question to Division of Health Benefits**.**

98. How will it be decided whether CMHRP or PHP will follow the member?

LHDs have been chosen to provide intensive care management services to the priority PHP members; therefore, all priority members will be referred to LHDs for intensive care management.

98. Will virtual facetime/ telehealth count towards face to faces? Providers are still doing this and a lot of us are curious if we will get credit for this as well verse in person at the PMH/PHP.

Yes, virtual contacts are included as one of the Patient-Centered Interactions that are used to calculate Performance Measures.

99. Will the PHPs be able to decide to provide these services without using LHDs after the transition period and would that save them money? I feel like this can be a set up for LHDs to lose these programs.

At the end of the 3-year transition period, intensive care management becomes competitive, which means the PHPs can contract with a LHD, another community service or maintain care management themselves. We do not know their operational budgets; therefore, we cannot answer whether it will save them money by providing intensive care management services themselves.

100. My concerns are with the accuracy of data in Virtual Health and the ability to create timely and accurate reports.

See the answer to question #50.

101. What do children who are going into foster care or women going in and out of pregnancies have to do to change their health plans?

CMHRP: See the answer to question #57.
CMARC: Members can change their PHP or provider within 90 days for any reason. After 90 days, patients can change based on an approved cause. Members can contact NC Medicaid Managed Care Mon-Sat from 7a-5p at **1-833-870-5500**. If members are not receiving the answers they need, then they can review information regarding the Medicaid ombudsman at www.ncmedicaidombudsman.org.

102. How it is all going to come together and how to keep up with each PHP expectations

PHPs are required to provide oversight and accountability as outlined in the *Program Guide*.

103. Can we be assured CMARC toolkit guidance will align with DHB Program Guide?

Yes

104. I am interested in their referral process and what caseloads will look like

CMHRP: The referral process will remain the same other than LHDs will also receive PHP priority members who need intensive care management services. Caseloads cannot be determined at this time as the overall PHP priority population size is unknown. DPH will monitor this after "go live" and will discuss concerns with DHB.

CMARC: The referral process will no longer accommodate the 14-day rule. We are working on updating our policy. You will receive the PHP priority list. Caseloads cannot be determined at this time as the overall PHP priority population size is unknown. DPH will monitor this after "go live" and will discuss concerns with DHB.

105. What does oversight from PHPs look like? For example, chart audits, trainings, care coordination, etc?

The *Program Guide* details the expectations that LHDs are held accountable to from the PHPs. Your role as a care manager will not change. The PHPs are or have scheduled meetings with your local CMHRP and CMARC leadership, and during these meetings would be an ideal setting to ask these questions.

106. How it will affect the CMARC program?

The *Program Guide* details the expectations that LHDs are held
accountable to from the PHPs. Your role as a care manager will not change. The PHPs are or have scheduled meetings with your local CMHRP and CMARC leadership, and during these meetings would be an ideal setting to ask these questions.

107. Will the specific plan be listed in VH, to know who to contact for information.

The member's PHP affiliation will be available in CareImpact. If Medicaid is the primary insurance, then the PHP name will be pulled into the Personal Data tab of the VH member profile under "Plan Name."

108. How long will members have to change their enrollment provider?

See the answer to question #57.

109. How will the health plans interact with our programs?

PHPs are currently reaching out to local CMHRP and CMARC leadership. These meetings would be an ideal setting to ask these questions. The PHPs will have ongoing communication with local leadership. Review page 22 of the *Program Guide*, as well.

110. Since attempted contacts are not going to count, will it still be taken into consideration when reviews are done that we are making attempts to provide care management to at risk members?

Within one of the Performance Measures, care managers must complete contact or attempt at least 3 contacts with a member, so there is an example of attempted contacts being reflected in the data. However, to date, attempted contacts with a member do not "count" because an attempted contact does not provide actual care management to the member. It is the care management process that must be done to provide care management; however, a member does not benefit from attempted contacts with a care manager.

111. More about the various managed care options and what exactly July 1 will look like.

The PHPs have already or are currently reaching out to local CMARC and CMHRP leadership to schedule meetings to review their health plan and value-based services. This would be the ideal setting to learn more about the PHPs in managed care. You can also visit the Medicaid Transformation website. See the answer to question #92 regarding July 1st.

112. Will the plan of Safe Care Initiative continue with DSS

We have not been notified of any change.

113. Will all providers be able to operate under all of the 5 plans?

Yes, all providers *can* contract with all 5 PHPs if they choose and if they are in their coverage area. For instance, Carolina Complete is in regions 3, 4 & 5, so all providers may not contract with them.

114. Will the PHP have measures for us to meet?

Yes, there are 3 Performance Measures that will be reported to each PHP. There are also 3 Quality Measures for each program, which all entities involved in care management (PHPs, PMPs, Primary Care Providers (PCP), LHDs) will be measured. Additional information regarding measures for each county will be discussed in subsequent webinars; however, they can also be found in the *Program Guide*.

115. Do we still refer patient to DSS to establish Medicaid or do they call PHPs directly?

The Medicaid application process will not change; the only difference between applying for Medicaid coverage under Managed Care is the patient will need to select their desired PHP.

116. What does "provider-led entity" mean?

A provider-led entity is a physician governed health plan.

117. So, will other tribal members who are not a part of the Eastern Band of the Cherokee not be eligible for Tribal Option? Also, members of the non-federally recognized tribes such as Lumbee?

Tribal eligibility includes: federally-recognized tribal members and Indian Health Service (IHS)-eligible beneficiaries associated with the ECBI who live in the five-county region (Cherokee, Graham, Haywood, Jackson or Swain); Direct, lineal descendants Non-Indian children under 19 years of age; Non-Indian pregnant women carrying an Indian child; federal-recognized tribal members; IHS-eligible beneficiaries associated with the EBCI who live within a reasonable distance from the five county region (Buncombe, Clay, Henderson, Macon, Madison or Transylvania counties).

Additional resources mentioned throughout this Q & A can be found at the following links:

- **May 27, 2021 CMHRP & CMARC Medicaid Transformation Archived Webinar Link:** https://ncdhhschildrenandyouth.adobeconnect.com/p16378gtzelg/
- **Medicaid Transformation to Managed Care:** https://medicaid.ncdhhs.gov/transformation
- **Care Management in Managed Care:** https://medicaid.ncdhhs.gov/transformation/care-management
- **CMHRP in Managed Care:** https://medicaid.ncdhhs.gov/transformation/care-management/care-management-high-risk-pregnancies-cmhrp
- **CMARC in Managed Care:** https://medicaid.ncdhhs.gov/transformation/care-management/care-management-risk-children-cmarc
- **Program Guide: Management of High-Risk Pregnancies and At-Risk Children in Managed Care:** https://files.nc.gov/ncdma/Program-Guide-for-Care-Management-of-High--Risk-Pregnancies-and-At-Risk Children-in-Managed-Care-5.12.pdf
- **Tribal Option Information:** https://files.nc.gov/ncdma/documents/County/NCMT-Fact-Sheet-EBCI-Tribal-Option-Overview.pdf
- **Locating a Provider in Managed Care:** https://medicaid.ncdhhs.gov/find-a-doctor
- **Reviewing PHPs in Managed Care (this link also includes an option to search for providers:** https://ncmedicaidplans.gov/
- **NC Medicaid Ombudsman:** www.ncmedicaidombudsman.org
- **County Playbook for Medicaid Managed Care:** https://medicaid.ncdhhs.gov/counties/county-playbook-medicaid-managed-care/resources
- **DSS Role in Managed Care:** https://medicaid.ncdhhs.gov/counties/county-playbook-medicaid-managed-care/dss-role-managed-care
- **Information for Medicaid beneficiaries:** https://ncgov.servicenowservices.com/sp_beneficiary?id=bnf_index