Source: The following information is presented in its entirety from North Carolina Department of Health and Human Services, (2022). *Medicaid Delivery Reform and Value-Based Payment Update*. Pages 8-12. Downloaded 1/19/23 from https://medicaid.ncdhhs.gov/media/12183/download?attachment

Transition to Comprehensive Managed Care

The transition to comprehensive managed care, including the launch of Standard Plans, followed by the launch of Tailored Plans and the Children and Families Specialty Plan, marks a major change in the Medicaid delivery system towards more integrated whole-person care, where both physical health and behavioral health needs are covered under a single managed care plan. Prior to this shift, physical health services were delivered through a fee-for-service program with Primary Care Management, while behavioral health and I/DD services were historically delivered by local, limited benefit, managed care plans.

- **Standard Plans.** On July 1, 2021, the Department transitioned most Medicaid and NC Health Choice beneficiaries to fully capitated and integrated managed care plans called Standard Plans. The majority of Medicaid and NC Health Choice members, including adults and children with low to moderate intensity behavioral health needs, receive integrated physical health, behavioral health, long-term services and supports and pharmacy services through Standard Plans.
- **Tailored Plans.** Managed care eligible Medicaid and NC Health Choice beneficiaries with I/DD, TBI, and/or more serious behavioral health disorders, who meet the criteria specified by NC Session Law 2018-48, will be enrolled into Tailored Plans, which are regional, specialized managed care products focused on the needs of these populations. Tailored Plans will offer the same services as Standard Plans in addition to 1915(c) Innovations and TBI waiver services as well as several specialized behavioral health and I/DD services. Tailored Plans are anticipated to launch on April 1, 2023.
- **Children and Families Specialty Plan.** In addition to Standard Plans and Tailored Plans, the Department intends to launch a single statewide Children and Families Specialty Plan (CFSP) to mitigate disruptions in care and coverage for children, youth, and families served by the child welfare system. Designed to meet the unique health care needs of this population, the CFSP will enable children, youth, and families served by the child welfare system across the state to access a full range of physical health and behavioral health services, including a number of specialized behavioral health services, and maintain treatment plans even if placement changes occur. The CFSP will serve as the central entity accountable for the care of these beneficiaries and ensure that they receive the care they need when and where they need it, regardless of geographical location. The Department continues to refine the CFSP design as it awaits legislation to authorize the CFSP and issue a CFSP Request for Proposals.

Other Payment and Delivery System Initiatives and Reforms

In tandem with the launch of these new comprehensive managed care plans, the Department also has made significant investments in a number of other key reforms, including: improving access to and quality of primary care, catalyzing community-based care management, and connecting Medicaid members to resources that address non-medical needs (e.g., the need for healthy food) which affect health. To reinforce and align incentives with these changes to the Medicaid delivery system, the Department also set out a vision to advance the use of innovative payment models that reward health care providers for delivering high-quality, high-value care and achieving improved health outcomes, as opposed to paying only for the volume of services delivered.

- **Advanced Medical Homes (AMH).** The AMH model is designed to strengthen the ability of primary care practices to offer access to care for managed care members (including extended office hours and remote forms of access), enhance comprehensiveness of primary care, ensure care management at the local level, and reinforce preventive care. AMHs provide comprehensive primary and preventive care services to managed care members, including patient-centered access, team-based care, population health management, care coordination across medical and social settings, and care management for high-risk populations. For most Medicaid populations, care management – whether episodic or chronic – directly involves the AMH care team. The AMH payment model includes three types of non-visit based payments: medical home fees, which provide funding for care coordination support and quality improvement for all AMHs; care management fees, which are payments for providing care management and population health activities for AMHs that assume primary responsibility for care management; and performance incentive payments, which are additional payments that are contingent on reporting and/or performance on the AMH performance and quality metrics. There are different AMH pathways depending on the level of care management, the payment model and the populations primarily served:
    - **Tier 1 and Tier 2 AMH:** In AMH Tier 1 and 2, practices must continue to meet the same requirements that they met for Carolina ACCESS prior to Medicaid Transformation. Tier 1 and 2 practices receive PMPM payments equivalent to what they received prior to managed care launch. For their members attributed to AMH Tier 1 and 2 practices, Health Plans are responsible for care management of high-need members, care coordination across settings, transitional care management and other bridging functions that go beyond the Carolina ACCESS requirements above.
    - **Current Tier 3 AMH:** AMH Tier 3 practices that offer care management must meet all Tier 1-2 requirements above plus additional requirements that reflect their capacity for data-driven care management and population health capabilities for their assigned populations.
    - **Potential Tier 3 AMH alternative track (under development):** The AMH Tier 3 alternative track will be for AMH practices that do not provide local care

management but do have contracts involving higher level Alternative Payment Models (APMs). This model is currently under development and details will be forthcoming.

- **AMH+:** AMH+ practices will be primary care practices actively serving as AMH Tier 3 practices, whose providers have experience delivering primary care services to the Tailored Plan eligible population or can otherwise demonstrate strong competency to serve that population. AMH+ practices must successfully apply for and be certified to provide Tailored Care Management.

- **Tailored Care Management.** The Behavioral Health and Intellectual/Developmental Disability (I/DD) Tailored Care Management model seeks to provide whole-person and provider-based care management that promotes integrated care, offers members choice, and addresses a broad range of behavioral health needs. Through Tailored Care Management, Behavioral Health I/DD Tailored Plan members will have a single designated care manager supported by a multidisciplinary care team to provide whole-person care management that addresses all of their needs, spanning physical health, behavioral health, I/DD, traumatic brain injuries (TBI), pharmacy, long-term services and supports (LTSS) and unmet health-related resource needs. To meet the care management needs of the Tailored Plan population, the AMH program's design has been modified to include two designations called AMH+ (see definition above under AMH) and "Care Management Agency" (CMA), which will act as the provider-based sites for care management. CMAs are largely behavioral health, I/DD, or TBI providers with demonstrable experience serving the Tailored Plan population that successfully apply for and are certified to provide Tailored Care Management.
- **Pregnancy Management Program (PMP).** The PMP provides comprehensive, coordinated maternity care with a special focus on preterm birth prevention for all pregnant women enrolled in Medicaid health plans. This program is administered as a partnership between managed care plans and local maternity care service providers (defined as any provider of perinatal services). A key feature of the program is the use of a standardized screening tool to identify and refer women at risk for an adverse birth outcome to the Care Management for High-Risk Pregnant Women (CMHRP) program.
- **Care Management for High-Risk Pregnancies (CMHRP).** The CMHRP program is the primary vehicle for delivering care management to pregnant women who may be at risk for adverse birth outcomes. This program builds on the legacy model of care management for pregnant women administered in the local health departments (LHDs) since 1988. Those individuals referred for a more intense set of CMHRP care management services have those services coordinated and provided by LHDs, which include assisting and supporting high-risk pregnant women with navigation of prenatal and postpartum care; as well as addressing barriers affecting their care and health.
- **Care Management for At-Risk Children (CMARC).** The CMARC program offers a set of care management services, which includes promoting the medical home, linking to community resources and providing support to families, for at-risk children ages zero-

to-five. The program coordinates services between health care providers, community program and supports, and family support programs. Managed care plans administer this program through contracts with Local Health Departments (LHDs).

- **North Carolina Integrated Care for Kids (NC InCK).** NC InCK is a pilot model that aims to improve the way children under age 21 and their families receive care and support services. NC InCK focuses on prevention, early identification and treatment of behavioral and physical health needs, and integrated care coordination and care management. Participating practices integrate care and care management across physical health, behavioral health and 10 core child service areas to deliver child and family-centered care. All children and youth from birth to age 21 who are insured by Medicaid or CHIP (NC Health Choice) and who live in five North Carolina counties: Alamance, Durham, Granville, Orange, and Vance, are automatically enrolled in NC InCK beginning in January 2022.
- **Postpartum Coverage Extension.** NC Medicaid postpartum health care coverage was extended from 60 days to 12 months for eligible beneficiaries in North Carolina starting on April 1, 2022 and is currently authorized through March 2027. The benefit also provides 12 months of continuous (ongoing) postpartum coverage to eligible beneficiaries who were pregnant or gave birth between Feb. 1, 2022, and March 31, 2022. Beneficiaries are eligible to receive 12 months of ongoing postpartum health care coverage beginning the date their pregnancy ends through the last day of the month, 12 months after the birth event. Beneficiaries remain eligible even if certain changes occur that may affect eligibility (such as a change in income or household/family unit).
- **Healthy Opportunities and Addressing Unmet Social Needs**. As part of its commitment to whole-person care, the Department is also forging links to supports for unmet social needs such as access to stable housing, healthy food, transportation, and supports for interpersonal safety. The Department is encouraging health plans and providers to address the unmet social needs of their Medicaid members, and as part of this effort has mandated screenings to identify needs for food, housing, and other social needs, is tracking screening performance as a quality measure, and has developed and required use of a tool called NCCARE360 to make and track referrals to community service providers. In certain regions in the state, Healthy Opportunities Pilots further enable referrals to community-based organizations that provide non-medical services that are reimbursable according to an established fee schedule. Examples of these services include healthy food delivery, non-medical transportation, and violence intervention services. Recognizing the added responsibilities that come with Pilot participation, Tier 3 AMHs serving as a Designated Pilot Care Management Entity or their delegated CIN/Other Partner will receive an additional, DHHS-standardized, Pilot Care Management payment, on top of existing care management and medical home payments, for each Medicaid member assigned to a Pilot- participating Tier 3 AMH regardless of Pilot enrollment at Pilot launch.
- **Value-Based Payment (VBP)**. The Department remains focused on ensuring health plans are rewarding high-value care and innovative approaches in line with the Department's quality strategy via value-based payment (VBP) contracts with participating providers. Value-based payment or alternative payment models (APMs)

reward health care providers for delivering high-quality, high-value care and achieving improved health outcomes, as opposed to paying only for the volume of services delivered. The Department has set targets for the proportion of Standard Plan payments to providers that must be made under these types of value-based payment arrangements in each of the first five years of Medicaid managed care. The Department has also defined sets of quality measures on which these arrangements can be based. Both Standard and Tailored Plans are working to establish value-based payment contracts and are reporting to the Department on the nature of those contracts through regular assessments, projections, and plan-specific value-based payment strategies.