



Program Guide

Management of High-Risk Pregnancies and At-Risk Children in Managed Care

Nov. 7, 2018

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I. Introduction

North Carolina is preparing to transition its Medicaid and NC Health Choice programs from a predominately fee-for-service delivery system to managed care. Under managed care, most Medicaid and NC Health Choice beneficiaries will enroll in prepaid health plans (PHP), integrated managed care products providing physical and behavioral health services, long-term services and supports, and pharmacy benefits.

Currently, North Carolina provides high-quality obstetric care for all pregnant women and care management services for high-risk pregnant women in the Medicaid program and for at-risk children through locally administered programs – the Pregnancy Medical Home (PMH) and Obstetric Care Management (OBCM) programs and the Care Coordination for Children (CC4C) program. These programs operate through an administrative and technical infrastructure that links together providers, local health departments (LHD), Community Care of North Carolina (CCNC) and the Department of Health and Human Services (The Department).

During this transition, existing specialized programs for pregnant women and at-risk children will change. Delivering excellent clinical obstetric care and providing care management for high-risk pregnant women and at-risk children in North Carolina is a paramount concern for the Department. The Department is committed to providing a pathway for transitioning these programs as the state moves to managed care¹.

The PMH, OBCM and CC4C programs were designed with significant leadership from clinicians across the state. The PMH program, for example, is the result of input from the obstetrics community, working in conjunction with CCNC and the Department, from the overall design of the program to the development of clinical pathways and other program features that have evolved over time. CCNC has traditionally played a role in leading the convening of clinicians to engage in, and evolve, the PMH program. Additionally, LHDs have long played a critical role in the provision of care management services for high-risk pregnant women and at-risk children. The Department and CCNC currently provide programmatic oversight, evaluation and training for both care management programs.

During the move to managed care, the Department has a three-fold objective: (1) to continue to provide high-quality services to women and children in close partnership with clinicians across the state; (2) to provide a pathway for current providers of these services to transition to managed care;” and (3) to ensure a seamless transition of services for beneficiaries into the managed care environment. The Department believes that the provision of these care management services at the local level is the best approach, and will require PHPs to contract under the current model through the first three years of managed care (defined as the “transition period”)². Thereafter, providers, LHDs and PHPs will negotiate program terms through the regular contracting process.

¹ [North Carolina’s Quality Strategy](#) has specific objectives for promoting both child health, development & wellness, and women’s health (Objectives 3.1 and 3.2).

² The transition period starts the day the first region begins managed care and follows the PHP contract years. Year 1 launches November 2019 and Year 3 ends June 30th, 2022. The transition period was changed from two years to three years as a result of stakeholder feedback.

Current Programs for Pregnant Women

Pregnant women are offered services based on the level of risk of an adverse birth outcome. All pregnant women are eligible to participate in the PMH program, while those that are determined to be high-risk also received OBCM Services.

Pregnancy Medical Home (PMH) Launched in 2011, the PMH program provides comprehensive, coordinated maternity care to pregnant women, with a special focus on preterm birth prevention. All providers who bill for perinatal services are eligible to enroll in the program. Currently, more than 90 percent of all perinatal care provided to pregnant Medicaid patients in North Carolina is through a PMH. To qualify for participation as a PMH, the provider must agree to meet certain requirements, such as:

- Ensuring that no elective deliveries are performed before 39 weeks of gestation;
- Decreasing the cesarean section rate among nulliparous women;
- Completing a Department-specified high-risk screening on each pregnant Medicaid enrollee in the program and integrating the plan of care with local care management; and
- Cooperating with open chart audits.

In addition to agreeing to requirements on pregnancy services, the PMH program pays providers incentive payments for 1) completing a standardized risk-screening tool at initial visit (\$50), and (2) conducting a postpartum visit (\$150). The standardized screening tool identifies high-risk pregnant women for care management services in OBCM. Today, the PMH program operates through CCNC, who provides regionally-based support to enrolled practices and convenes clinicians on a routine basis and in conjunction with Department leadership to review programmatic requirements, performance and other items.

Obstetric Care Management (OBCM) Since 1986, LHDs have provided care management to pregnant Medicaid beneficiaries identified as being at high risk of a poor birth outcome. The care management model consists of education, support, linkages to other services, management of high-risk behavior and response to social determinants of health that may have an impact on birth outcomes. Women identified as having a high-risk pregnancy are assigned a pregnancy Care Manager to coordinate their care and services through the end of the post-partum period. Today, CCNC and the Department provide programmatic oversight, evaluation and training for OBCM. CCNC provides the technology infrastructure and analytics.

Current Program for At-Risk Children – Care Coordination for Children (CC4C)

CC4C is a care management program for at-risk young children ages zero to five providing coordination between healthcare providers, linkages and referrals to other community programs and supports, and family supports. LHDs have been providing services to at-risk children since 1986. Each child served by CC4C is linked to a specific Medical Home and CC4C Care Manager. The Care Manager, in collaboration with the child's family, coordinates the child's care to ensure they obtain appropriate medical care, social services and other supports. Today, the program operates identically to OBCM, noted above, with the program also interfacing significantly with the Division of Social Services (DSS).

Under managed care, the names of these programs will change in the following manner:

- The PMH program name will become the “Pregnancy Management Program” (PMP)
- The OBCM program will become “Care Management for High-Risk Pregnancy” (CMHRP)
- The CC4C program will become “Care Management for At-Risk Children” (CMARC)

Throughout the remainder of the program guide, we refer to the programs under their new names to distinguish how program operations will change in managed care. Populations not moving into managed care will continue to be served by the programs in the same manner as today.³

Under managed care, North Carolina will designate Advanced Medical Homes (AMH), a subset of which will be paid higher reimbursement amounts for assuming primary responsibility for care management services for Medicaid beneficiaries. AMH providers will fall into one of four tiers, with requirements and payments increasing as tiers (and associated responsibilities) increase. Qualifying LHDs and OB/GYN providers who provide full primary care services per AMH policy can be an AMH, and designation as an AMH does not preclude their participation in the PMP, CMHRP, and CMARC programs. Providers that serve as Tier 3 and 4⁴ AMHs and are part of the PMP/CMHRP and CMARC programs will be eligible for both kinds of incentive payments⁵.

This program guide provides key information to OB/GYN providers, pediatricians, LHDs, PHPs and other interested stakeholders for how the transition of care management programs for pregnant women and at-risk children will occur over time into the State’s managed care model, how the programs will operate, and the expectations of providers, LHD’s, PHP’s and the Department in each.

³ To learn more about which populations will be enrolled in managed care, refer to the [Beneficiaries in Medicaid Managed Care](#) concept paper.

⁴ PHPs are required to offer Tier 3 AMH practices incentive payments. PHPs have the option to offer incentive payments to AMH Tier 1 and 2 practices.

⁵ To learn more about the AMH Program, refer to the [Care Management Strategy under Managed Care](#) concept paper and the AMH manual.

Summary of Program Transition

	The Pregnancy Management Program (PMP)	Care Management for High-Risk Pregnancy (CMHRP)	Care Management for At-Risk Children (CMARC)
Target Population	All pregnant women enrolled in PHPs	Pregnant women determined to have a high-risk pregnancy enrolled in PHPs	Children ages zero-to-five who meet specified criteria enrolled in PHPs
Overview of Services Provided	Comprehensive, coordinated maternity care services with a focus on preventing pre-term birth	More intense multi-disciplinary care management services for pregnant and post-partum women identified as being at high risk of a poor birth outcome	Suite of coordinated care management services between health care providers, linkages and referrals to community programs and supports and family supports
Accountable Entity	PHPs	PHPs	PHPs
Primary Service Provider	Local maternity care providers	LHDs who work with maternity care providers	LHDs who work with primary care/AMH providers and social services organizations
Program Coordination	The Department and a statewide advisory group of experts	The Department and a statewide advisory group of experts to the Department	The Department and a statewide advisory group of experts to the Department

II. Managing High-Risk Pregnancies Under Managed Care

All pregnant women enrolled in managed care through the PHPs will continue to receive a coordinated set of high-quality clinical maternity services through the PMP. This program will be administered as a partnership between PHPs and local maternity care service providers (defined as any provider of perinatal services). A key feature of the program will be the continued use of the standardized screening tool to identify and refer women at risk for an adverse birth outcome to the CMHRP program, a more intense set of care management services that will be coordinated and provided by LHDs. Together, these two programs will work to improve the overall health of women and newborns across the state.

Overview of PMP

The PMP program will continue its commitment to clinical excellence through the provision of comprehensive, coordinated maternity care services to pregnant women enrolled in the state's managed care program. Providers can expect the parameters of the program to be consistent with the PMH program that exists today during a three-year transition into the managed care environment. The following represents a summary of current features of the PMP program that will be transitioned into managed care:

- Provider participation requirements will remain the same, although there is no longer a process to “opt in” to the program. All providers that bill global, packaged or individual pregnancy services will contract with PHPs under standard contracting terms which are identical to the terms in today's program.
- Standard contracting provisions will be included. PHPs will incorporate program requirements aligned with the PMH program into their contracts with all maternity care providers. The continuation of these program requirements will ensure a smooth transition of services into the new managed care model under the PHP's administrative authority. The contracts will include process requirements, such as completing the standardized risk-screening tool, and clinical outcomes measures, such as decreasing the cesarean section rate among nulliparous women. The Appendix includes a listing of the program contracting requirements that will be included. Ongoing, with input from a state-convened advisory group of maternity care providers, PHPs and other stakeholders (described in Section IV) will make recommendations on future updates that the Department may consider.
- The provider incentive payment structure will remain the same during the transition period. Individual provider contracts with PHPs will incorporate an incentive payment structure that promotes high-quality outcomes and is consistent with the rate floors established by the Department in managed care. For the transition period, the incentive payment structure will remain the same as it is today:⁶
 1. \$50 for the completion of the standardized risk screening tool at each initial visit;
 2. \$150 for completion of postpartum visit held within 56 days of delivery.

Additionally, providers will receive, at a minimum, the same rate for vaginal deliveries as they do for caesarian sections. In addition, providers will continue to be exempt from prior approval on ultrasounds.

⁶ The timeframe of the incentive program has been expanded to three years, as is identical to the transition period, based on stakeholder feedback.

PHPs will be permitted to offer additional innovative payment programs and incentives to providers beyond those required by the Department to promote quality pregnancy outcomes for their enrolled population. Providers and PHPs may enter into innovative payment programs at their mutual consent.

- A standardized patient screening tool will be utilized to identify high-risk pregnancies. Providers will be required to adopt and administer a State-designated screening tool to identify high-risk pregnancies. The tool will be standardized across the state and consistent with the screening tool currently used by providers enrolled in the PMH program. The tool will be reviewed and updated as needed on a regular basis by the Department with input from the state-convened group. PMP providers will be required to send the results of the screening tool to both the PHP and the LHD. As described further below, LHDs that receive the standardized screening form from a PMP provider that indicates a need for care management services must initiate care management services. PHPs are not permitted to conduct prior authorization for these services.
- Maternity care providers will be required to coordinate outreach and care management efforts with the LHDs for management of women determined to be “high risk.” Similar to today, all PMP providers will be required to ensure appropriate coordination with LHD Care Managers for the sub-set of their practice populations that are deemed high-risk who receive services under CMHRP described below.
- PHPs will be required to collect and report on a series of quality measures to ensure high-quality maternity care. PHPs will provide regular reports to PMP practices on the following measures (assuming a valid sample size):
 1. Prenatal and Postpartum Care: NQF 1517⁷
 2. Live Births Weighing Less than 2,500 g: NQF 1382.

As part of public reporting requirements, PHPs will be required to calculate and share for each participating practice that receives an incentive payment the following measures: 1) Rate of high-risk screening as a function of the total pregnant population according to PHP data; and 2) Rate of postpartum follow-up within 56 days of delivery as a function of total pregnant population according to PHP data.

PHPs will also report directly to the Department on additional quality measures and metrics that impact women’s health and maternity care. For a complete list of all measures refer to the [Prepaid Health Plan Quality and Accountability](#) concept paper.

⁷ Additional measures may be added for practice-level reporting based on the final quality measure set for Year 1 of Managed Care.

Overview of the CMHRP

In addition to administration of the PMP program for all enrolled pregnant women, PHPs will contract with LHDs to administer care management services for pregnant women deemed as high-risk. This program, the CMHRP, will be triggered based on the result from the standardized screening tool administered to all pregnant women in the PMP and as a result of PHPs' own risk stratification efforts. As noted in Section II of this Program Guide, these more intensive care management services are currently provided by LHDs. LHDs will exclusively continue to play this role under managed care through the three-year transition period. The following represent a summary of key features of the CMHRP program:

- LHDs will continue to provide care management services. During the transition period, PHPs will be required to contract with LHDs for provision of CMHRP services. If an LHD is unable or unwilling to provide these services through a contract with a PHP, Section IV details steps the PHP must take to ensure care management is delivered locally.
- PHPs will be required to offer standard contracting terms. PHPs will incorporate a series of standard program requirements into their contracts with all LHDs in the CMHRP program. The provisions are aligned with those in place today in the OBCM program, but incorporate the changes of moving to managed care, including ongoing collaboration and integration with PHPs. These terms include requirements related to outreach, patient identification and engagement, assessment and risk stratification, and deployment of interventions. These contract terms will ensure a smooth transition of services into the new managed care model under the PHP's administrative authority. The Appendix includes a listing of the program contracting requirements that will be included for the CMHRP program.
- Process and quality outcomes measures for high-risk pregnancy. LHDs will be responsible for collecting and reporting on a series of process measures to ensure high-quality Care Management for high risk pregnant women. A sub-set of these process measures will, in turn, be used to evaluate program outcomes.
 - **Process Measures**
 - 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: Benchmark of 85 percent
 - Percentage of patients identified as priority who are "deferred": Benchmark less than 10 percent
 - Percentage of engaged patients who are receiving intensive care management with a face-to-face intervention in the past 30 days: Benchmark of 80 percent

The frequency of reporting and the distribution of reports will be established in a forthcoming white paper detailing the data strategy to support the CMHRP program. The PHPs will use select measures in these reports for overall monitoring purposes, including the CAP process as described in Section IV.

In addition to process measures, LHDs providing CMHRP services will be required to report on outcomes measures aligned with statewide quality measures that support high-quality maternal care. These measures include:

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

As with the CMHRP process measures, details on the frequency and distribution of these reports will be established in forthcoming guidance.

- Use of a standardized data platform for care management. LHDs will be permitted to use the standard documentation platform that is in existence today. LHDs that operate as AMH Tier 3 providers may be permitted flexibility to use a separate platform. Additional details on the data system, including program analytics and reporting, will be shared in a subsequent paper.⁸
- Coordination with other care management providers. PHPs or AMH Tier 3 providers will be responsible for care management services to the managed care population at large. To ensure coordination with CMHRP, PHPs will be required to alert LHDs when high-risk pregnant women are in care management within the PHP/ AMH Tier 3 practice. In addition, PHPs will be responsible for ensuring that the care management roles and responsibilities between the two entities are non-overlapping. PHPs will also be required to ensure that the member's care plans(s) document respective roles and responsibilities between the PHP/AMH Tier 3 practice and LHD. LHD Care Managers will be responsible for documenting roles/responsibilities in the standard documentation platform for instances where multiple Care Managers are serving the same enrollee to ensure that services are coordinated and do not overlap.
- Payments to LHDs. The Department will ensure that all funding related to care management for high-risk pregnancies is included in the capitation payment to PHPs. PHPs will, in turn, be responsible for compensating contracted LHDs at an amount substantially similar to or no less than the amount paid in the existing program. PHPs are permitted to introduce new payment models on top of the existing funding to further incentivize care management innovation.

⁸ This provision has changed in response to stakeholder feedback.

III. Managing At-Risk Children Under Managed Care

The Medicaid program currently offers a set of care management services for at-risk children ages zero-to-five. The program coordinates services between health care providers, community program and supports, and family support programs. To ensure these services continue to be provided in a seamless fashion during the move to managed care, current services provided under the CC4C program will transition into CMARC. Similar to the care management programs for pregnant women, responsibility for this population will be assumed by the PHPs with requirements that PHPs contract with LHDs for the provision of local care management services.

The role currently played by LHDs in providing these key services will be continued and augmented in the managed care environment. Generally speaking, program administration for the CMARC program is similar to the CMHRP program, noted above. The following represents a summary of key features of the CMARC program:

- Continued role of LHDs in providing services. For the first three years of managed care, PHPs will be required to contract with LHDs for provision of CMARC services. If an LHD is unable or unwilling to contract, Section IV details the steps the PHP must take to ensure care management is delivered locally.
- Referral criteria. A significant percentage of the children currently receiving CC4C services will meet exemption criteria for managed care and will continue receiving fee-for-service benefits. To ensure consistency between the FFS and managed care populations, the referral criteria will be identical to today's program. The CMARC program will accept referrals for children with the following needs:
 - Children with Special Health Care Needs;
 - Children exposed to severe stress in early childhood, including, but not limited to:
 - Extreme poverty in conjunction with continuous family chaos;
 - Recurrent physical or emotional abuse;
 - Chronic neglect;
 - Severe and enduring maternal depression;
 - Persistent parental substance use;
 - Repeated exposure to violence in the community or within the family;
 - Children in neonatal intensive care needing help transitioning to community/Medical Home care.

Situations meeting these referral criteria are further detailed on the program screening form – see Appendix G.

- Referrals to LHDs for services. Children will be identified for the CMARC program through the following methods:
 - Direct provider referrals;
 - Social service agency referrals (e.g. Women, Infants and Children [WIC], DSS);
 - Direct referral by enrollees or families; and
 - Risk stratification or other identification methods by PHPs.

When an at-risk child is identified for CMARC by an entity outside the PHP (e.g. pediatric practice), they will be encouraged to make the referral directly to the LHD and PHP. If the entity only refers to the PHP, the PHP will make the referral to the LHDs.

- Standard Contracting Terms. For the first three years of managed care, PHPs will be required to contract with LHDs for provision of CMARC using standard contracting terms. To ensure fidelity to today's model, the language of the current agreement will be largely preserved-adapted only to reflect the new role of the PHPs. The contract requirements include provisions related to outreach, population identification, family engagement, assessment and stratification of care management service levels, plan of care development, integration with PHPs and health providers, service provision, training and staffing. The Appendix contains a detailed list of contract requirements.
- Process and quality outcomes measures for at-risk children. LHDs will be responsible for collecting and reporting on a series of process measures to ensure high-quality care management for at risk children. These measures include process measures such as:
 - Percentage of children identified and referred for CMARC services who had a completed contact (Target 7.5 percent); and
 - Percentage of children identified and referred for CMARC services who are engaged in active care management (Target 5.5 percent).⁹

The frequency of reporting and the distribution of reports will be established in a forthcoming white paper detailing the data strategy to support the CMARC program. The PHPs will use select measures in these reports for overall monitoring purposes, including the CAP process as described in Section IV.

As noted in the Appendix, the Department will compare results from selected quality measures for CMARC program enrollment versus individuals not enrolled in the program. Specifically, children that are engaged in care management services will be compared against the entire zero to five population against a subset of measures:

- Percentage of well visits three to six years old
- Two-year-old immunizations (Combination 3)
- Annual dental visits

The Appendix contains the list of measures used in the CC4C program that will transition into the CMARC program. The frequency of reporting and the distribution of reports will be established in subsequent communication.

- Use of a standardized data platform for care management. Similar to the program for high-risk pregnancy, LHDs will be permitted to use the standard documentation platform that is in existence today. LHDs that operate as AMH Tier 3 providers may be permitted flexibility to use a separate platform. Additional details on the data system, including program analytics and reporting, will be shared in a subsequent paper.

⁹ These targets are subject to change based on updates to process measures in preparation for FY2019.

- Responsibility for medically complex children and coordination with other care management services. PHPs or AMH Tier 3 providers will be responsible for care management services to the managed care population at large. If a child has complex medical needs or other needs best met by PHPs/Tier 3 AMH practices, then those entities will play the role of primary Care Manager, with the CMARC program providing support for social needs beyond the capacity of the PHP or Tier 3 AMH practice. Children with complex medical needs, in particular, will be handled on a case-by-case basis with close coordination between the CMARC program and PHP/Tier 3 AMH to establish care management roles and responsibilities on a case by case basis. PHPs/Tier 3 AMH practices will designate a lead Care Manager and be the final arbiter of the roles/responsibilities breakdown.

As with the CMHRP program and more generally, PHPs will be required to alert LHDs when at-risk children identified by the LHD or a social service entity are in care management within the PHP/AMH Tier 3 practice. PHPs will also be required to ensure that the member's care plans(s) document respective roles and responsibilities between the PHP/AMH Tier 3 practice and LHD. LHD Care Managers will be required to document roles/responsibilities in the standard documentation platform for instances where multiple Care Managers are serving same enrollee to ensure that services are coordinated and do not overlap.

- Payments to Local Health Departments. The Department will ensure all funding related to care management for at-risk children is included in the capitation payment to PHPs. PHPs will, in turn, be responsible for compensating contracted LHDs at an amount substantially similar to or no less than the amount paid in the existing program. PHPs are permitted to introduce new payment models on top of the existing funding to further incentivize care management innovation.

IV. Oversight and Accountability for Programs

PHPs are responsible for the clinical and financial management of care and services for pregnant women and at-risk children. The Department will have rigorous oversight of all PHP operations. In addition, the Department will formally convene clinical leaders within each program into an advisory group to engage in ongoing development of the program to ensure high-quality performance of providers of care management services.

General State Oversight

The Department is ultimately responsible for all aspects of the Medicaid program, including all aspects of North Carolina's transition to managed care. Under managed care, the Department delegates responsibility for managing patient care to PHPs, with clear contractually binding requirements and expectations. Thus, the Department's primary role in a managed care environment is to hold PHPs accountable for providing high-quality care and improving outcomes by setting clear priorities and objectives, establishing standards and evaluating PHPs against those standards. For areas in which CCNC has historically played a strong clinical leadership role—for example, high-risk pregnancy and at-risk children—the Department will either assume those responsibilities directly, or delegate them to PHPs.

One area that the Department will assume direct responsibility for is continuous quality improvement and clinical leadership. As part of this effort, the Department will establish two state-level clinical advisory groups dedicated to improving outcomes for both pregnant women and at-risk children enrolled in each care management program. The role of these groups is advisory in nature; the Department maintains ultimate authority to implement specific programmatic changes. The following summarizes the major features of each of these groups:

	PMP/CMHRP Advisory Group (Pregnancy Care)	CMARC Advisory Group (At-Risk Children)
Key Responsibilities of Advisory Group	<ul style="list-style-type: none"> ▪ Promote provider leadership in the ongoing evolution of the care management program ▪ Maintain and build upon existing care pathways ▪ Review PMP/CMHRP critical process/quality measures and assess possible changes during and after the transitional period; ▪ Address PMP/CMHRP programmatic issues and concerns relating to the managed care transition); ▪ Examine evidence for outcomes of programs, including Division of Public Health (DPH)-calculated mortality measures; ▪ Make design recommendations for program structure after transitional period. 	<ul style="list-style-type: none"> ▪ Promote provider leadership in the ongoing evolution of the care management program ▪ Inform the following on an ongoing basis: <ul style="list-style-type: none"> ○ Critical process/quality measures, ○ Program evaluation and design ○ Recommendations for the post-transition period ○ Value-based payment model design ▪ Examine evidence for outcomes of programs; ▪ Make design recommendations for program structure after transitional period.
Key Participants	<ul style="list-style-type: none"> ▪ OB and other maternity care providers ▪ LHDs ▪ All PHPs ▪ Department staff, including DPH 	<ul style="list-style-type: none"> ▪ Pediatric providers ▪ Social Service Providers ▪ LHDs ▪ All PHPs ▪ Department staff, including DPH

Additionally, the Department, in conjunction with DPH, will continue to provide support to LHDs providing care management for high-risk pregnant women and at-risk children during the transition to Medicaid managed care. This support includes:

- Rollout training sessions in preparation for managed care transition;
- Defining expectations for coordination with PMP and AMH practices;
- Developing standardized terms and conditions for contracts between LHDs and PHPs;
- Ongoing training on critical performance metrics; and
- Ad hoc support for LHDs in the CAP process described below.

Role of PHPs in Program Administration

In each program, PHPs will have a specific set of program responsibilities. PHPs will administer each program locally in partnership with providers and LHDs, and have overall accountability and risk for outcomes. For the programs for pregnant women, PHPs will specifically:

- Develop and execute contracts with standard contract terms for all providers who provide maternity services;
- Reimburse participating providers, including incentive payments, as required in DHHS policy;
- Permit PMP providers to refer directly to LHDs without prior authorization for initiation of care management services;
- Refer women identified as high-risk through the PHP's own risk stratification algorithms and methods to LHDs for care management services;
- Administer a quality and process measurement program that will provide timely reports to PMP providers on the quality and process measures previously noted, as well as report to the Department on:
 - Number and dollar value of incentive payments paid to providers
 - Additional value-based incentive payments paid to providers
 - Rate of high-risk screening and rate of post-partum follow-up at the PHP population level
- Offer provider supports to PMP providers engaging in the program;
- Ensure that the care management roles and responsibilities between the PHP/AMH Tier 3 practices are non-overlapping with care management services offered by LHDs; and
- Provide day-to-day oversight of program management and performance across PMP providers and LHDs.

For the program for at-risk children, PHPs will specifically:

- Forge and strengthen linkages with primary care providers who care for children (e.g. pediatricians, Family Medicine physicians, NPs, PAs) and operate as AMH providers and coordinate with LHDs who operate the CMARC program;
- Permit pediatricians, other clinicians who care for children, and other entities, including social services providers, to refer directly to LHDs without prior authorization for initiation of care management services;
- Refer children identified as at-risk through the PHP's own risk stratification algorithms and methods to LHDs for care management services;
- Administer a quality and process measure program, as noted previously;
- Offer provider supports to clinicians caring for children (e.g. pediatricians, Family Medicine physicians, PAs, NPs) engaging in the program;

- Ensure that the care management roles and responsibilities between the PHP/AMH Tier 3 practices are non-overlapping with care management services offered by LHDs;
- Ensure that medically-needy children have a designated lead Care Manager; and
- Provide day-to-day oversight of program management and performance.

LHD Contracting and PHP Performance Oversight

LHDs will need to contract with PHPs for the provision of care management services. During the three-year transitional period, PHPs will give LHDs the “right of first refusal” as contracted providers of care management for these populations, offering them standard terms for each program. PHPs will offer contracts to every LHD in their service region for provision of these care management services.

- LHDs will have 75 business days to accept the contract to perform care management services for these populations.
- If the LHD declines the contract, PHPs will consult the Department to identify another LHD in the same service region that is willing and able to provide care management services for high-risk pregnant women and at-risk children. The PHP will use the same 75-business-day process to contract with the new LHD.
- If the PHP is unable to contract with an alternate LHD, they will:
 - Contract with another entity for the provision of local care management services; or
 - Perform the services itself and retain the payment that would otherwise have passed to the LHD.

After contracts are executed and from the start of managed care, one of the PHP’s primary roles is in monitoring program quality and outcomes, and working with LHDs and other providers to continuously improve services. Separate from PHP oversight of LHDs and their provision of CMHRP and CMARC, providers must follow the oversight previously set forth in State-defined guidance. Refer to the [Supporting Provider Transition to Medicaid Managed Care](#) white paper for additional information.

For LHDs, a separate process has been developed to address areas of underperformance, should they arise. In these cases, PHPs will intervene and initiate action in one of two pathways: a standardized CAP (*most likely*) or immediate termination (*rare*).

- Pathway #1: Standard CAP. The Department has developed a standardized process for PHPs to address underperformance among LHDs. The standardized process includes:

Step #	CAP Step Description ¹⁰
1	The PHP identifies and documents LHD underperformance.
2	The PHP issues a written notice of underperformance to the LHD and indicates a defined period, within a reasonable timeframe, within which the LHD must remediate the underperformance. The notice of underperformance is shared with the Department at the same time it is sent to the LHD.
3	If underperformance continues beyond the remediation period set forth in the letter, the PHP issues a subsequent notice of underperformance with request for a CAP to the LHD.
4	The LHD submits a CAP to the PHP for approval within 15 business days of receiving notice of underperformance. The LHD must include in their response a “performance action plan” that clearly states the steps being taken to rectify underperformance. <i>The PHP has the right to approve the CAP as written or request modifications within 10 business days. If modifications are requested, the LHD must resubmit an updated CAP within 10 business days.</i>
5	Once approved, the LHD has 90 business days to fully implement the CAP and meet the performance measures/obligations under the contract. For good cause, LHD and PHP can agree to extend the implementation period by 60 business days. Good cause includes a situation where the data lag makes the timeline non-feasible.
6	Failure to perform against the CAP within the prescribed timelines constitutes grounds for termination of the LHD by the PHP. In the event of a termination, the LHD would have the right to appeal the termination under the standard provider appeals process.

¹⁰ The PHP will include the Department on all underperformance documentation, notification, and CAPs sent to any given LHD. The Department will share information with the Division of Public Health to support training and support activities.

- **Pathway #2: Immediate Termination:** For a limited number of reasons, PHPs will be permitted to immediately terminate a LHD without using the CAP process. Specific actions for terminating a care management contract with an LHD without using the CAP process include:
 - Instances of fraud, waste and/or abuse
 - Specific actions by the LHD that conflict with the PHP/LHD Standard Contract Terms, including:
 - Failure to utilize required staffing with the expected credentials;
 - Failure to maintain required staffing coverage that allow for continuous service delivery during staff vacancies;
 - Failure to implement/use the designated care management documentation system for the CMHRP and CMARC programs;¹¹ and
 - Failure to meet training requirements for LHD 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.

V. Conclusion

The transition to managed care represents a significant shift in the administration of health care benefits to women and children across the state. The State is committed to ensuring the continuation of the delivery of high-quality obstetric care and critical care management services for pregnant women and at-risk children. The Department designed features of these clinical and care management programs under the managed care model and the transition period to prevent any disruptions and to ensure continued excellence for patients. The Department believes that these programs will continue to thrive and provide critical services for women and children in need across the state and will continue to leverage the leadership of maternity providers, pediatricians, social services organizations, LHDs, and other stakeholders, as is currently the case in continuously monitoring and updating these programs to ensure their continued success.

¹¹ Local Health Departments that are certified Tier 3 Advanced Medical Home providers will be permitted the flexibility to use a separate care management documentation system of their choosing. All providers of CMHRP and CMARC services will be required to document all necessary programmatic data elements in their designated care management documentation system.

VI. Appendix

- A. Standard Pregnancy Management Program Contracting Requirements
- B. Standard Care Management for High-Risk Pregnancy Contracting Requirements
- C. Standard Care Management for At-Risk Children Contracting Requirements
- D. CMARC Process and Outcomes Measures
- E. PMP and CMHRP Process and Outcomes Measures
- F. Current Screening Form for High-Risk Pregnancy
- G. Current CMARC Screening Form for At-Risk Children

Appendix A: Standard Pregnancy Management Program Contracting Requirements

1. PHPs shall incorporate the following requirements into their contracts with all providers of perinatal care, including the following requirements for providers of the PMOP:
 - a. Complete the standardized risk-screening tool at each initial visit.
 - b. Allow PHP or PHP's designated vendor access to medical records for auditing purposes to measure performance on specific quality indicators;
 - c. Maintain or lower the rate of elective deliveries prior to 39 weeks gestation;
 - d. Decrease the cesarean section rate among nulliparous women;
 - e. 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 integrate the plan of care with local pregnancy care management;
 - f. 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 percent); and
 - g. Ensure comprehensive post-partum visits occur within 56 days of delivery.

Appendix B: Standard CMHRP Contracting Requirements

1. General Contracting Requirement

- a. LHDs shall accept referrals from PHPs for CMHRP services.

2. Outreach

- a. LHDs 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.
- b. LHDs 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.

3. Population Identification and Engagement

- a. LHDs shall review and enter all pregnancy risk screenings received from PMPs covered by the pregnancy Care Managers into the designated care management documentation system within five calendar days of receipt of risk screening forms.
- b. 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.
- c. LHDs shall accept pregnancy care management referrals from non-PMP prenatal care providers, community referral sources (such as DSS or WIC programs), patient self-referral, and provide appropriate assessment and follow up to those patients based on the level of need.
- d. 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.
- e. LHDs shall collaborate with out-of-county PMPs and CMHRP 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.

4. Assessment and Risk Stratification

- a. 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.
- b. LHDs shall utilize assessment findings, including those conducted by PHPs, to determine level of need for care management support.
- c. LHDs shall document assessment findings in the care management documentation system.
- d. 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.
- e. LHDs shall assign case status as outlined according to program guidelines, based on level of patient need.

5. Interventions

- a. LHDs shall provide care management services in accordance with program guidelines, including condition-specific pathways, utilizing those interventions that are most effective in engaging patients and meeting their needs. This includes face-to-face encounters (practice visits, home visits,

hospital visits, community encounters), telephone outreach, professional encounters and /or other interventions needed to achieve care plan goals.

- b. LHDs shall provide care management services based upon level of patient need as determined through ongoing assessment.
- c. LHDs shall develop patient-centered care plans, including appropriate goals, interventions and tasks based on MCHRP guidance documents.
- d. LHDs shall utilize the statewide resource platform and identify additional community resources once the State certifies it as fully functional.
- e. LHDs shall refer identified population to childbirth education, oral health, behavioral health or other needed services included in the enrollee's PHP network.
- f. LHDs shall document all care management activity in the care management documentation system.

6. Integration with PHPs and Healthcare Providers

- a. LHDs shall assign a specific Care Manager to cover each PMP 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 PMP.
- b. LHDs shall establish a cooperative working relationship and mutually-agreeable methods of patient-specific and other ongoing communication with the PMP.
- c. LHDs shall establish and maintain effective communication strategies with PMP providers and other key contacts within the practice for each PMP within the county or serving residents of the county.
- d. LHDs shall assure the assigned Care Manager participates in relevant PMP meetings addressing care of patients in the Target Population.
- e. LHDs shall ensure awareness of PHP enrollees' in network status with providers when organizing referrals.
- f. LHDs shall ensure understanding of PHPs' prior authorization processes relevant to referrals.

7. Collaboration with PHP

- a. LHDs shall work with PHPs to ensure program goals are met.
- b. LHDs shall review and monitor PHP reports created for the PMP and CMHRP services to identify individuals at greatest risk.
- c. LHDs shall communicate with PHP regarding challenges with cooperation and collaboration with PMP and non-PMP prenatal care providers.
- d. Where care management is being provided by a PHP and/or AMH practice in addition to the high-risk pregnancy program, the PHP must ensure the delineation of non-overlapping roles and responsibilities, and the LHD must document that agreement in the Plan of Care to avoid duplication of services.
- e. LHDs shall participate in pregnancy care management and other relevant meetings hosted by the PHP.

8. Training

- a. 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.
- b. LHDs shall ensure that pregnancy Care Managers and their supervisors shall attend continuing education sessions coordinated by PHP and/or DHHS.

- c. 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.
- d. LHDs shall ensure that pregnancy Care Managers and their supervisors shall utilize Motivational Interviewing and Trauma-Informed Care techniques on an ongoing basis.

9. Staffing

- a. LHDs shall employ Care Managers meeting pregnancy care management competencies defined as having at least one of the following qualifications:
 - i. Registered nurses;
 - ii. 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.
 - iii. Care Managers for High Risk Pregnancy hired prior to Sept. 1, 2011 without a bachelor's or master's degree in social work may retain their existing position only. This grandfathered status does not transfer to any other position.
- b. LHDs shall ensure that Community Health workers for Care Manager for High-Risk Pregnancy services work under the supervision and direction of a trained OB Care Manager.
- c. LHDs shall include both registered nurses and social workers to best meet the needs of the Target Population with medical and psychosocial risk factors on their team.
- d. 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.
- e. 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.
- f. 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.
- g. LHDs shall ensure that Pregnancy Care Managers must demonstrate:
 - i. A high level of professionalism and possess appropriate skills needed to work effectively with a pregnant population at high risk for poor birth outcomes;
 - ii. Proficiency with the technologies required to perform care management functions;
 - iii. Motivational interviewing skills and knowledge of adult teaching and learning principles;
 - iv. Ability to effectively communicate with families and providers; and
 - v. Critical thinking skills, clinical judgment and problem-solving abilities.
- h. 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:
 - i. Provision of program updates to Care Managers.
 - ii. Daily availability for case consultation and caseload oversight.
 - iii. Regular meetings with direct-service care management staff.
 - iv. Utilization of reports to actively assess individual Care Manager performance.
 - v. Compliance with all supervisory expectations delineated in the CMHRP Program Manual.

- i. 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.
- j. Vacancies lasting longer than 60 days shall be subject to additional oversight by PHPs.

Appendix C: Standard CMARC Contracting Requirements

1. General Requirements

- a. LHDs shall accept referrals from PHPs for children identified as requiring CMARC.

2. Outreach

- a. LHDs shall educate patients, AMHs, other practices and community organizations about the benefits of the CMARC Program and target populations for referral; disseminate the CMARC Referral Form either electronically and/or in a paper version to potential referral sources.
- b. LHDs shall communicate regularly with the AMHs and other practices serving children, to ensure that children served by that medical home are appropriately identified for CMARC services.
- c. LHDs shall collaborate with out-of-county AMHs and other practices to facilitate cross-county partnerships to optimize care for patients who receive services from outside their resident county.
- d. LHDs shall identify or develop if necessary, a list of community resources available to meet specific needs of the population.
- e. LHDs shall utilize the statewide resource platform, when operational, and identify additional community resources and other supportive services once the platform is fully certified by the State.

3. Population Identification

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

4. Family Engagement

- a. 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.
- b. LHDs shall foster self-management skill building when working with families of children.
- c. 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.

5. Assessment and Stratification of Care Management Service Level

- a. LHDs shall use the information gathered during the assessment process to determine whether the child meets the CMARC target population description.
- b. 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.
- c. LHDs shall use the information gained from the assessment to determine the need for and the level of service to be provided.

6. Plan of Care

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

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

7. Integration with PHPs and Health Providers

- a. LHDs shall collaborate with AMH PCP/care team to facilitate implementation of patient-centered plans and goals targeted to meet the individual child's needs.
- b. 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 AMH PCP and/or care team.
- c. Where care management is being provided by a PHP and/or AMH 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.
- d. 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 AMH PCP and/or care team and to the PHP.
- e. LHDs shall ensure awareness of PHP enrollee's in-network status with providers when organizing referrals.
- f. LHDs shall ensure understanding of PHPs' prior authorization processes relevant to referrals.

8. Service Provision

- a. LHDs shall document all care management activities in the care management documentation system in a timely manner as described by LHD agency policy.
- b. LHDs shall ensure that the services provided by CMARC 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.

9. Training

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

10. Staffing

- a. LHDs shall hire Care Managers meeting CMARC care coordination competencies and with at least one of the following qualifications:
 - i. Registered nurses;
 - ii. 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.

Note: Care Managers for At-Risk Children hired prior to Sept. 1, 2011, without a bachelor's or master's degree in social work may retain their existing position only. This grandfathered status does not transfer to any other position.

- b. LHDs shall 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.
 - c. LHDs shall ensure that Care CMARC Managers must demonstrate:
 - i. Proficiency with the technologies required to perform care management functions – particularly as pertains to claims data review and the care management documentation system;
 - ii. Ability to effectively communicate with families and providers;
 - iii. Critical thinking skills, clinical judgment and problem-solving abilities; and
 - iv. Motivational interviewing skills, trauma-informed care, and knowledge of adult teaching and learning principles.
 - d. LHDs shall ensure that the team of CMARC 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.
 - e. If the LHD has only has a single CMARC Care Manager, the LHD shall ensure access to individual(s) to provide needed resources, consultation and guidance from the non-represented professional discipline.
 - f. An LHD with a team of CMARC 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.
 - g. LHDs shall maintain services during the event of an extended vacancy.
 - h. 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.
 - i. 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.
 - j. LHDs shall ensure that Community Health Workers and other unlicensed staff work under the supervision and direction of a trained CMARC Care Manager.
 - k. LHDs shall provide qualified supervision and support for CMARC Care Managers to ensure that all activities are designed to meet performance measures, with supervision to include:
 - i. Provision of program updates to Care Managers;
 - ii. Daily availability for case consultation and caseload oversight;
 - iii. Regular meetings with direct service care management staff; and
 - iv. Utilization of monthly and on-demand reports to actively assess individual Care Manager performance.
 - l. LHDs shall ensure that supervisors comply with expectations found in the DHHS Care Management for At-Risk Children Supervision Guidance Document.
-

- m. LHDs shall ensure that supervisors who carry a caseload must also meet the CMARC care management competencies and staffing qualifications.

Appendix D: Process and Quality Outcomes Measures for At-Risk Children

LHDs will be measured on a series of critical performance measures related to the provision of services to at-risk children. Reporting, tracking and hitting to-be-determined benchmarks on these measures will feed into the CAP process.

Critical Performance Measures:

1. Percentage of children identified and referred for CMARC services who had a completed contact (Target: 7.5 percent)
2. Percentage of children identified and referred for CMARC services who are engaged in active CMARC care management (Target: 5.5 percent)¹²

Additional performance measures to be collected and reported on:

3. Percentage of children engaged in active CMARC care management who had the following assessments completed:
 - a. Health Assessment
 - b. Survey of Well-Being of Young Children (SWYC)
4. Percentage of children engaged in active CMARC care management with a Toxic Stress condition and are not in foster care who had a Life Skills Progression (LSP) completed.

Additionally, LHDs will track and report information on health outcomes related to the provision of CMARC services. Performance on these measures will not feed into the CAP process.

Health Outcomes Measures

1. Children age zero to five engaged in CMARC
 - a. Well visits for children three to six years old
 - b. Two-year-old immunizations (Combination 3)
 - c. Annual dental visit
2. Children age zero to five in foster care and engaged in CC4C ¹³
 - a. Well visits for children three to six years old
 - b. Childhood Immunization Status: Two-year-old immunizations (Combination 3 vaccines)
 - c. Annual dental visit

The results for 1 and 2 will be determined from claims data from the Department or PHP; the rates for children engaged in CMARC will be compared to the results for the entire zero to five population.

¹² These targets are subject to change based on updates to process measures in preparation for FY2019.

¹³ Applicable in managed care only when foster children roll into managed care

Appendix E: Process and Quality Outcomes Measures for High-Risk Pregnant Women

LHDs will be measured on a series of critical performance measures related to the provision of services for high-risk pregnant women. Reporting, tracking and hitting to-be-determined benchmarks on these measures will feed into the CAP process.

CMHRP: Process Measures

1. Percentage of women engaged (patient given a case status and goal developed) in OBCM services among patients meeting eligibility criteria (priority patients) during the month: Benchmark of 85 percent
2. Percentage of patients identified as priority who are “deferred”: Benchmark less than 10 percent
3. Percentage of engaged patients who are receiving intensive care management with a face-to-face intervention in the past 30 days: Benchmark of 80 percent

CMHRP: Outcomes Measures

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

Appendix F: Current Screening Form

Practice Name: _____
Practice Phone Number: _____ Today's date: __/__/____
First name: _____ MI _____ Last name: _____ Date of birth: __/__/____
EDC: __/__/____ By what criteria: LMP 1st trimester U/S 2nd trimester U/S
Height: _____ Pre-pregnancy weight: _____ Gravidity: _____ Parity: ___T ___P ___A ___L
Insurance type: Medicaid (includes Presumptive) Private None Medicaid ID#: _____
Provider requests pregnancy care management
Reason(s): _____

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
- 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

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 or more prenatal appointments
 - Cervical insufficiency
 - Gestational diabetes
 - Vaginal bleeding in 2nd trimester
 - Hypertensive disorders of pregnancy
 - Preeclampsia
 - Gestational hypertension
 - Short interpregnancy interval (<12 months between last live birth and current pregnancy)
 - Current sexually transmitted infection
 - Recurrent urinary tract infections (>2 in past 6 months, >5 in past 2 years)
 - Non-English speaking
 - Primary language: _____
 - Positive depression screening
 - Tool used: _____
 - Score = _____

Printed Name of Person Completing Form Credential(s)

Signature _____

CCNC Pregnancy Medical Home Risk Screening Form: Self-Assessment

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.

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.
- I have never smoked, or have smoked less than 100 cigarettes in my lifetime.
 - I stopped smoking BEFORE I found out I was pregnant and am not smoking now.
 - I stopped smoking AFTER I found out I was pregnant and am not smoking now.
 - I smoke now but have cut down some since I found out I was pregnant.
 - I smoke about the same amount now as I did before I found out I was pregnant.
8. Did any of your parents have a problem with alcohol or other drug use? **Yes No**
9. Do any of your friends have a problem with alcohol or other drug use? **Yes No**
10. Does your partner have a problem with alcohol or other drug use? **Yes No**
11. In the past, have you had difficulties in your life due to alcohol or other drugs, including prescription medications? **Yes No**
12. Before you knew you were pregnant, how often did you drink any alcohol, including beer or wine, or use other drugs? **Not at all Rarely Sometimes Frequently**
13. In the past month, how often did you drink any alcohol, including beer or wine, or use other drugs?

Not at all Rarely Sometimes Frequently

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 degree

Appendix G: Current Screening Form

Medicaid ID #: Date: _____

Uninsured Health Choice Private Insurance County child resides in: _____

Patient's Name: _____

Date of Birth (mm/dd/yyyy): Age: _____ Gender: **Female Male** _____

Primary language spoken in the home: Needs Interpreter? **Yes No**

Race: **Asian American Indian or Alaska Native Native Hawaiian or other Pacific islander Caucasian or White Black or African-American**

Ethnicity: **Hispanic Puerto Rican Hispanic Cuban Hispanic Mexican Hispanic Other**

Parent or Guardian Information

Parent/Guardian's Name: _____

Street Address: _____ City: _____

P.O. Box: State: _____ ZIP Code: _____

Home Phone #: _____ Cell Phone #: () _____

Relative/Neighbor Contact Name: Contact Phone #: () _____

Employer: _____ Employer Phone #: _____

The family was informed of the CC4C Referral? **Yes No**

Referring Agency Information

Referral Source/Agency: _____ Contact Person: _____

Contact Phone Number: _____ Contact Fax Number: _____

Check here if you are the child's primary care provider (Medical Home).

Priority Referrals

- The child has special healthcare needs (CSHCN). Title V defines CSHCN as "those who have or are 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 also require health and related services for a type or amount beyond that required by children generally."

Specific concern: _____

- The child is in foster care and does not have a medical home.
- Infant in Neonatal Intensive Care Unit (NICU)

- The child is exposed to some sort of toxic stress*.

*Toxic stress includes, but are not limited to:

- Current domestic/family violence
- Caregiver unable to meet infant's health and safety needs/neglect
- Parent(s) has history of parental rights termination
- Parental/caregiver substance abuse, neonatal exposure to substances
- CPS Plan of Safe Care referral for "Substance Affected Infant" (Complete section "Infant Plan of Safe Care")
- Unsafe where child lives
- Homeless or living in a shelter
- Parent/guardian suffers from depression or other mental condition
- Unstable home

Other Please specify: _____

Medical Home Referral

- Check here if primary care provider (Medical Home) would like to make a direct referral for CC4C care management

Please state reason for referral: _____

Notes:

1. If any of the boxes under reason/requirement for referral is checked, the child is eligible for CC4C Program and will receive a comprehensive assessment.
2. If the Medical Home provider checks the "direct referral" box, the child is automatically referred for a comprehensive assessment.