Medicaid Care Coordination Policies for Justice Involved Individuals with Substance Use Disorders (SUD)

Session Law 2025-64, Section 1.1.(b)

Report to

Joint Legislative Oversight Committee on Medicaid
and

Fiscal Research Division

By

North Carolina Department of Health and Human Services

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Executive Summary:

In accordance with Session Law 2025-64, Section 1.1(a), the North Carolina Department of Health and Human Services (NCDHHS), Division of Health Benefits (DHB, NC Medicaid or the Department), reviewed the legislative requirement to establish a new team-based care service for justice-involved individuals against the existing Medicaid care management service array for this population. The review determined that the current delivery systems and care management programs serving Justice Involved beneficiaries with severe substance-use disorders and those designed for Justice Involved youth meet and, in some areas, exceed the requirements of the legislation. NC Medicaid acknowledges that the needs of the Justice Involved population are diverse and may change over the course of a beneficiary's re-entry process. Because of this, Justice Involved beneficiaries can receive services from a delivery system that best meets their needs. These programs are delivered by the Local Management Entity/Managed Care Organizations (LME/MCOs) and their delegated care management entities (Care Management Agencies and Advanced Medical Home Plus practices), as well as Community Care of North Carolina (CCNC) for the NC Medicaid Direct population, and the Eastern Band of Cherokee Indians (EBCI) Tribal Option.

In addition to assessing North Carolina Medicaid's existing delivery systems and care management programs, NC Medicaid also completed a detailed comparison of additional recommendations and best practice interventions for individuals with substance use disorder or opioid use disorder (SUD/OUD), and worked internally and with the Division of Mental Health, Developmental Disabilities and Substance Use Services (DMHDDSUS) to review all eligible services covered by NC Medicaid to support and treat those with SUD, with references to SUD including Alcohol Use Disorder (AUD) and Opioid Use Disorder (OUD), in addition to services offered by DHHS to individuals with SUD and/or those who have had engagement with the justice system. Internal NC Medicaid review also confirmed that all NC Medicaid delivery systems currently require or perform SUD screening and cover prescription medications for opioid use disorder and alcohol use disorder, among many other SUD-related services for qualifying individuals. Finally, the review with DMHDDSUS highlighted multiple programs and services available for Medicaid and non-Medicaid eligible individuals for those with SUD or mental health concerns and those who are involved in the criminal justice system.

If the Department were to launch a new service in compliance with Session Law 2025-64, Section 1.1(a-b) for Justice Involved individuals, it would duplicate the existing care management services available for NC Medicaid Direct beneficiaries. Additionally, it would take the State no less than 21 months to implement this new service - if new funding were available. The estimated cost of this new service would be between $28,851,00- $34,247,000 per year.

Given the cost to stand up the new service, the significant potential for beneficiary confusion, and the operational complexity for health plans to implement a separate but similar care coordination program in addition to existing care management services, the Department recommends utilizing the existing care management infrastructure to meet the requirements of Session Law 2025-64, Section 1.1(a). This would avoid duplicative efforts, unnecessary costs and leverage existing service structure to meet the targeted support this population needs.

Lastly, in alignment with Session Law 2025-64, Section 1.1.(c), NC Medicaid and DMHDDSUS launched a statewide Accessible Communication Campaign to enhance education and outreach related to Tailored Care Management (TCM) in 2024. This initiative included provider-focused materials, a digital toolkit, and ongoing training to promote Medicaid policy changes and improve care coordination. Notably, it included a fact sheet about TCM for individuals with substance use disorders, as well. The Department is also developing informational resources for facilities serving Justice Involved populations to support communication with beneficiaries and legal guardians about care management programs available to individuals.

Overview of Existing Medicaid Care Management Programs Serving Justice Involved Beneficiaries

North Carolina Delivery Systems and Justice Involved Beneficiaries

North Carolina's Medicaid programs are delivered through two broad care delivery systems, managed care and fee-for service, with NC Medicaid Direct administering behavioral health services for individuals who are in fee-for-service. Each delivery system offers whole-person, team-based care management to beneficiaries who qualify for it. More specifically, this collection of delivery systems includes Standard Plans, Behavioral Health I/DD Tailored Plans; the Eastern Band of Cherokee Indians (EBCI) Tribal Option; the Children and Families Specialty Plan (CFSP, launched Dec. 1, 2025); NC Medicaid Direct (fee-for-service) which offers care management and coordination through the LME/MCOs as Prepaid Inpatient Health Plans (PIHP) and CCNC as a Primary Care Case Management entity (PCCMe).

The Department evaluated these five delivery system's care management to determine if they address the five required service components in Section 1.1.(a), listed below.

- Screening for alcohol use disorder, opioid use disorder and other mild to moderate substance use disorders;
- Access to and referrals for Medication Assisted Treatment (MAT) for Alcohol and Opioid Use Disorders[1];
- Recovery Support;
- Case Management; and
- Team-Based Care Coordination.

All delivery systems currently require or perform SUD screening for a broader subset of Medicaid beneficiaries, often using standardized tools. However, this report will focus on the care management delivery systems which serve the justice involved population, which appears to be the unspoken intent of the legislation.[2] Although the legislation calls for **case** management, the existing **care** management delivery systems offer more robust services than

[1] MAT combines the use of prescription medication with counseling and therapies to address SUD
[2] The assessments for the other delivery systems can be found in Appendix B.

what is traditionally covered under case management. This report will use the term care management.

G.S. 108A-40(a)(9) and (9a)[3] excludes the Justice Involved population from enrolling in a prepaid health plan in the first-year post-release. Therefore, their care management is under EBCI Tribal Option or NC Medicaid Direct. Medicaid Direct's care management is provided by the LME/MCOs and PCCMe, depending on the specific delivery system the individual is eligible for. The services outlined for the PCCMe are currently available to eligible beneficiaries, but NC Medicaid is in the process of revising the contract with the PCCMe to ensure the inclusion and prioritization of the Justice Involved population, assuring that they receive the appropriate levels of care management. During the first-year post-release, individuals have access to care management programs as described below based on their age, clinical history, and current clinical needs.

- ***Justice Involved Youth*** **–** Youth through age 21 and Former Foster Youth through age 26 qualifying under the federal Consolidated Appropriations Act of 2023, Section 5121[4], will receive both pre- and post-release Targeted Case Management services administered by LME/MCOs or the Tribal Option. Individuals in this population with a qualifying SUD, or other Tailored Plan eligibility[5] will receive Tailored Care Management (TCM) services through the LME/MCOs. Individuals who qualify under the Consolidated Appropriations Act but do not meet Tailored Plan eligibility, will receive Targeted Case Management in the post-release period.

  The Targeted Case Management services for the non-TCM eligible CAA 5121 population will be identical to TCM services. Services under CAA 5121 will be launched in phases by carceral settings, including Youth Development Centers, jails and prisons, beginning summer 2026.

  If a beneficiary's needs change or they require additional services, NC Medicaid has a process in place to reassess the beneficiary's TCM eligibility.

- ***Justice Involved Adults*** **–** Adults released from incarceration are served in NC Medicaid Direct for the first-year post-release and have access to Primary Care Case Management (PCCMe) (beginning in 2026), EBCI Tribal Option or TCM administered by the LME/MCOs, when eligible. This population would also be eligible for further Justice Involved Care Management implementations under North Carolina's 1115 waiver approved December 2024[6], if future funding becomes available.

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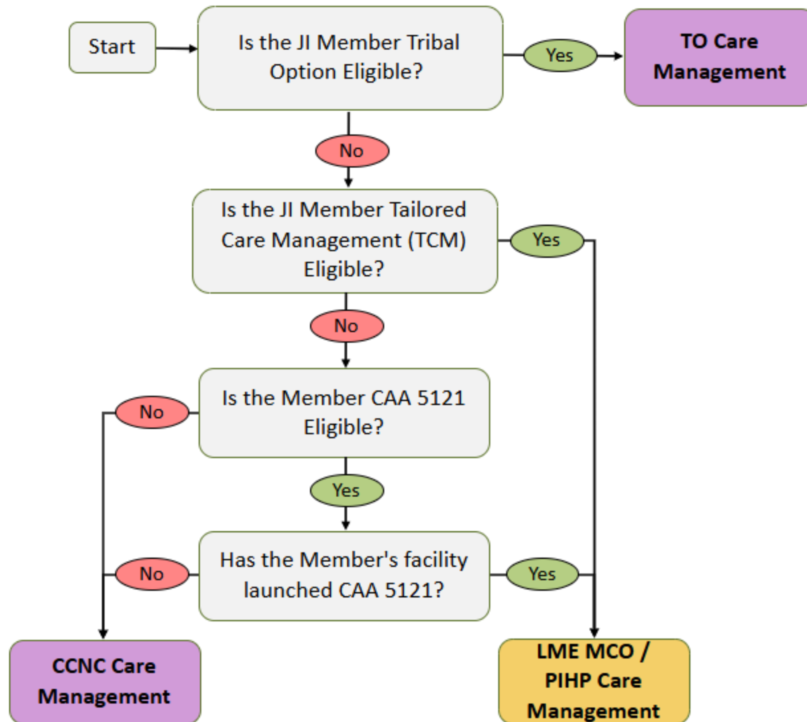
[3] As amended by SL 2024-34, Section 12.1.(a)
[4] SHO #24-004: Provision of Medicaid and CHIP Services to Incarcerated Youth. https://www.medicaid.gov/federal-policy-guidance/downloads/sho24004.pdf
[5]Tailored Care Management Provider Manual, Section II: Beneficiary Eligibility for TCM, Pages 4-7. download
[6] North Carolina Medicaid Reform Section 1115(a) Demonstration, Section 7 Reentry Demonstration Initiative, pages 26-35. download

Figure 1 – Justice Involved Care Management Post-Release Services & Providers by Beneficiary Eligibility

The graphic below (Figure 1) provides a visual representation of which care management entity a beneficiary will receive the re-entry post-release care management services based on their eligibility criteria.



Current Fulfillment of Section 1.1(a) Requirements Across TCM, PCCMe and Tribal Option Care Management

All Justice Involved beneficiaries with severe SUD qualify for TCM. TCM is a service that connects individuals with a specially trained care manager who helps them navigate the healthcare system. This service is particularly beneficial for those with a serious mental illness, severe SUD, I/DD or TBI. The goal of TCM is to provide whole-person care, addressing not only physical health and mental health needs but also social supports and other essential needs. In a review of this team-based care management program, the Department determined that TCM screens for and connects beneficiaries with all the services required in Session Law 2025-64, Section 1.1(a) (See Table 1). This also is applicable for Post-Release Targeted Case Management provided under CAA 5121, which mirrors the TCM requirements.

An analysis of PCCMe and Tribal Option care management against the services required in Session Law 2025-64, Section 1.1(a) is provided below in Tables 2 and 3. While both provide some level of support across the requirements, they are designed to be less robust than what is

provided in TCM. If beneficiaries' needs, specifically those related to mental illness and SUD, are determined severe, those beneficiaries would be assigned or reassigned to TCM.

Table 1. PIHP Program Requirements (Tailored Care Management) Compared to Session Law 2025-64, Section 1.1(a) Requirements	
Session Law 2025-64, Section 1.1(a) Requirement	**Existing Tailored Care Management Requirements**
Alcohol Use Disorder (AUD)/Opioid Use Disorder (OUD)/SUD Screening	TCM includes initial and periodic comprehensive assessments covering SUD risk (and required screening tools).[7] Care managers use an assessment that screens for SUD, documents needs and refers beneficiaries for additional screening by qualified providers if deemed appropriate.
Access to / Referrals for Medications for AUD/OUD	Care managers must coordinate medication-assisted treatment based on Medicaid clinical policies. TCM and Medicaid clinical policies require care managers to identify if a beneficiary is on or needs medications for AUD or OUD and provide referrals. TCM care plans include medication adherence support for SUD treatments.[8] The LME/MCOs are required to have SUD and mental health treatment providers in their network in order to meet all beneficiaries' needs.[9]
Recovery Support	TCM explicitly addresses recovery support, including connecting beneficiaries to peer support, recovery communities, psychosocial rehab and housing. TCM care plans must incorporate community resources for recovery.[10] The LME/MCOs conduct a transitional care assessment prior to discharge from any inpatient facility.[11] As part of the LME/MCOs diversion activities, the LME/MCOs screen and assess the beneficiary for eligibility for community-based services and facilitate referral and linkages to community-based and other support services for assistance.[12] Depending on member needs, their care team also may include Peer Support Specialists (who serve the same functions as a Peer Recovery Coach) and care manager extenders such as Community Navigators and Community Health Workers.[13] The LME/MCO also works in collaboration with the Department and with other public agencies, local, regional and statewide housing and homeless

[7] 30-2022-007-DHB_MDPIHP_Contract_20220804, Section IV.G. Care Management and Care Coordination, page 148
[8] 30-2022-007-DHB_MDPIHP_Contract_20220804, Section IV.G. Care Management and Care Coordination, page 154
[9] 30-2022-007-DHB_MDPIHP_Contract_20220804, Attachment E. PIHP Network Adequacy Standards, page 304
[10] Ibid.
[11] 30-2022-007-DHB_MDPIHP_Contract_20220804, Section IV.G. Care Management and Care Coordination, page 160
[12] 30-2022-007-DHB_MDPIHP_Contract_20220804, Section IV.G. Care Management and Care Coordination, page 163
[13] 30-2022-007-DHB_MDPIHP_Contract_20220804, Section IV.G. Care Management and Care Coordination, page 155

Table 1. PIHP Program Requirements (Tailored Care Management) Compared to Session Law 2025-64, Section 1.1(a) Requirements	
Session Law 2025-64, Section 1.1(a) Requirement	**Existing Tailored Care Management Requirements**
	populations' service providers and Department housing staff to support the expansion of supportive housing opportunities available to persons with mental illness, I/DD, TBI and/or SUDs.[14]
Case Management	Each beneficiary gets an assigned care manager who provides ongoing case management: conducting regular assessments, developing care plans, facilitating service access, monitoring progress, etc.[15] High-intensity case management for complex needs is a TCM hallmark.
Team-Based Care Coordination (Care Team)	A multidisciplinary approach is applied. The TCM care manager works with the beneficiaries' treatment providers (primary care providers, psychiatrists, therapists, etc.) and holds care team meetings as necessary.[16] TCM also requires the care manager have access to primary care, psychiatrist and psychologist consultants as necessary.

[14] 30-2022-007-DHB_MDPIHP_Contract_20220804, Section IV. D. Stakeholder Engagement and Community Partnerships, page 95
[15] 30-2022-007-DHB_MDPIHP_Contract_20220804, Section IV.G. Care Management and Care Coordination, page 148
[16] 30-2022-007-DHB_MDPIHP_Contract_20220804, Section IV.G. Care Management and Care Coordination, page 156

Table 2. PCCMe Program Requirements Compared to Session Law 2025-64, Section 1.1(a) Requirements		
Session Law 2025-64, Section 1.1(a) Requirement	**Existing PCCMe Care Management Requirements**	**Potential Enhancements**
Alcohol Use Disorder (AUD)/Opioid Use Disorder (OUD)/SUD Screening	The care needs screening that PCCMe performs includes mental health and SUD needs, including opioid usage and other SUDs.[17] PCCMe also identifies beneficiaries who have a SUD diagnosis as a priority population.[18] Many PCCMe practices implement Screening, Brief Intervention and Referral to Treatment (SBIRT) practices (PCCMe participated in SBIRT pilots).[19]	N/A
Access to/Referrals for Medications for AUD/OUD	PCCMe care managers coordinate with primary care providers (PCP) to manage chronic conditions. If a PCCMe enrollee needs MAT, the PCP can prescribe (especially office-based buprenorphine) or refer. NC Medicaid Direct covers MAT under the State Plan for those receiving PCCMe services. Medication reconciliation and medication adherence is also a part of the care management services offered, which would both be inclusive of MAT.[20]	N/A

[17] 30-2021-061-DHB CCNC PCCMe Contract, IV.B Benefits and Care Management, Page 42
[18] 30-2021-061-DHB CCNC PCCMe Contract, IV.B Benefits and Care Management, Page 42
[19] Behavioral Health Integration | Community Care of North Carolina
[20] 30-2021-061-DHB CCNC PCCMe Contract, IV.B Benefits and Care Management, Page 45

Recovery Support	PCCMe has historically offered programs like "Transitions to Community Living" with some SUD support. Recovery support is primarily via referrals to community programs or LME-MCO for State-funded SUD services. PCCMe has care managers connect patients to local resources (e.g., AA, NA, recovery housing) and peer support resources on an as-needed basis.[21] PCCMe also utilizes community health workers today, though their contract with North Carolina Medicaid does not require this.	PCCMe shall ensure that Care Management incorporates individual and family supports including providing information and connections to needed services and support including but not limited to peer support services, Psychosocial Rehabilitation and supportive housing if eligible/needed. PCCMe shall develop and implement a care management training curriculum that includes the following domains at a minimum: Self-management and self-help recovery resources (including substance use recovery).
Case Management	PCCMe assigns care managers (RNs or social workers) who provide care coordination for high-risk patients. These care managers manage the beneficiaries' chronic conditions, coordinate specialist care and address behavioral health needs.[22] PCCMe's whole model is an enhanced PCCMe providing community-based case management.[23]	The Contractor shall offer all Justice Involved enrollees care coordination appropriate to their needs.
Team-Based Care Coordination (Care Team)	The care team concept exists within PCCMe care management but not as formally as in TCM as described above.[24] PCCMe networks are community-based teams including PCPs, pharmacists and mental	N/A

[21] Ibid.
[22] 30-2021-061-DHB CCNC PCCMe Contract, IV.B Benefits and Care Management, Page 41
[23] 30-2021-061-DHB CCNC PCCMe Contract, I. Background, Page 4
[24] 30-2021-061-DHB CCNC PCCMe Contract, IV.B Benefits and Care Management, Page 46

	health and SUD providers in addition to care managers. Its model encourages team meetings among these providers for complex cases. PCCMe also works with LME/MCOs for mental health and SUD needs and includes behavioral health providers as a part of the beneficiary's care team.[25]	

[25] Ibid

Table 3. Tribal Option Program Requirements Compared to Session Law 2025-64, Section 1.1(a) Requirements	
Session Law 2025-64, Section 1.1(a) Requirement	**Existing Tribal Option Care Management Requirements**
Alcohol Use Disorder (AUD)/Opioid Use Disorder (OUD)/SUD Screening	The Tribal Option must perform a care needs screening for each beneficiary as part of its care management duties.[26] This screening covers physical and mental health and SUD needs.[27] OUD screening is part of the same care needs screening and comprehensive assessment process required for all beneficiaries.[28] While the contract does not mention "alcohol" by name in the screening step, it requires screening for any chronic mental health and SUD conditions,[29] and alcohol is included within the SUD definition.
Access to/Referrals for Medications for AUD/OUD	Tribal Option coordinates all medical, mental health, SUD needs and pharmacy services for beneficiaries, including MAT for AUD/OUD.[30] This means medications for AUD and OUD (e.g. naltrexone, acamprosate for alcohol dependence; buprenorphine, methadone, naltrexone for opioid dependence) are available to Tribal Option beneficiaries.[31] Tribal Option has an Opioid Misuse Prevention program to assist beneficiaries with safe and appropriate use of Opioids.[32] Medication reconciliation and medication adherence is a part of the care management services offered.[33]
Recovery Support	The Tribal Option provides recovery-oriented services through required care coordination and follow-up for beneficiaries with SUD.[34] The Tribal Option must coordinate with behavioral health providers and systems to ensure beneficiaries receive appropriate services beyond simply initial treatment. The Tribal Option contract indicates that behavioral health providers can be a part of the

[26] 30-2020-0114 EBCI Tribal Option, IV. B. Benefits and Care Management, page 57
[27] 30-2020-0114 EBCI Tribal Option, IV. B. Benefits and Care Management, page 58
[28] Ibid.
[29] Ibid.
[30] 30-2020-0114 EBCI Tribal Option, I. Background on EBCI Tribal Option, Page 4
[31] Clinically Managed Residential Services Clinical Coverage Policy No: 8D-5. NC Medicaid: 8D-5
[32] EBCI Tribal Option Member Handbook. Final-Approved-MEM01-TO-Member-Handbook-2025.pdf
[33] 30-2020-0114 EBCI Tribal Option, IV. B. Benefits and Care Management, page 64
[34] 30-2020-0114 EBCI Tribal Option, IV. B. Benefits and Care Management, page 65

	beneficiary's care team, if applicable.[35] Tribal Option mandates Transitional Care Management for beneficiaries after critical events like hospital or treatment facility discharges.[36] Peer support is available for beneficiaries receiving care management.[37]
Case Management	Comprehensive case management is the core of the Tribal Option model. Cherokee Indian Hospital Authority, the PCCMe, is contracted to provide care coordination/case management for all Tribal Option enrollees.[38] The program's design centers on "delivering whole-person care" and "localized care management" for beneficiaries.[39]
Team-Based Care Coordination (Care Team)	Tribal Option requires the creation of a multi-disciplinary care team for each high-need beneficiary that consists of the Beneficiary; Caretaker(s)/legal guardians; Assigned Network PCP; PCCM Care Manager; Behavioral health Provider(s); Specialists; Nutritionists; and Pharmacists and Pharmacy Techs.[40] Beneficiaries needing SUD-related services are considered high-need beneficiaries who receive support from the care team.[41]

[35] 30-2020-0114 EBCI Tribal Option, IV. B. Benefits and Care Management, page 63
[36] 30-2020-0114 EBCI Tribal Option, IV. B. Benefits and Care Management, page 64
[37] 30-2020-0114 EBCI Tribal Option, IV. B. Benefits and Care Management, page 65
[38] 30-2020-0114 EBCI Tribal Option, IV. B. Benefits and Care Management, page 59
[39]30-2020-0114 EBCI Tribal Option, I. Background, page 5
[40] 30-2020-0114 EBCI Tribal Option, IV. B. Benefits and Care Management, page 64
[41] 30-2020-0114 EBCI Tribal Option, IV. B. Benefits and Care Management, page 58

Stakeholder Working Group

Section 1.1(a) of the legislation requires that the Medicaid team based care-coordination service be developed by a working group of stakeholders established by NC Medicaid. Because of the duplicative nature of the new service contemplated in Section 1.1(a) to our existing care management models, the foundational engagement to launch the existing care management services, and the ongoing engagement with our stakeholders, a traditional workgroup was not necessary.

However, the Department presented information to the LME/MCOs regarding our recommendation to utilize the existing care infrastructure to meet the legislative requirements. The LME/MCOs provided the following feedback:

- LME/MCOs recommended not implementing a brand new service, but using existing services to meet the legislative requirements;
- LME/MCOs would want to provide more input regarding how they would report on care management services provided to the Justice Involved population, beyond the scope of their current reporting for care management services;
- LME/MCOs recommended that NC Medicaid engage with the Department of Adult Corrections to understand more about how they are supporting Justice Involved individuals with SUD/OUD before and after release; and
- LME/MCOs acknowledge that most SUD diagnoses come through claims rather than from provider referrals.

NC Medicaid also met with the State Reentry Council Collaborative (SRCC) at the end of February to solicit their feedback on the Justice Involved programs and our recommendation to forgo developing a new program. NC Medicaid did not receive any immediate feedback from the SRCC or from the public comment; however, if we receive feedback in the future, we will ensure all suggestions are considered as NC Medicaid moves forward with the Justice Involved program design and implementation.

Furthermore, when developing each of the existing care management models within the five delivery systems outlined in this report, the North Carolina Department of Health and Human Services met extensively with key stakeholders (managed care plans, provider groups, partner organizations, etc.) to discuss design and implementation. This included the elements pertaining to SUD services..

The Department also has ongoing quarterly meetings with our Tailored Care Management Technical Advisory Group and our Advanced Medical Home Technical Advisory Group to discuss how to make care management most effective for beneficiaries. This series of meetings offers stakeholders an opportunity to provide recommendations and feedback regarding the care management services and other beneficiary supports.

As the Department finalized the design for the CAA 5121 care management components, NC Medicaid met with the Department of Adult Correction (DAC), the Department of Juvenile Justice (DJJ), the Division of Mental Health, Developmental Disabilities and Substance Use

Services, and providers including LME/MCOs, PCCMe and the Tribal Option to solicit their feedback on how to best serve the Justice Involved population.

Finally, the Department has also worked collaboratively with Area Health Education Centers (AHEC) and Recidivism Reduction Educational Program Services to facilitate trainings that the LME/MCOs care managers were able to attend to ensure they are equipped with the information needed to adeptly serve this population. The Department has plans to facilitate additional trainings with care managers serving the CAA 5121 eligible population as we approach implementation of those services.

For the reasons discussed above, the Department determined that an additional working group of stakeholders was not a productive activity for NC Medicaid or stakeholders.

Planned Enhancements to Existing Requirements & Enhancements Recommended to Align with the Legislative Requirements

Planned Enhancements to Existing Requirements

The Department currently receives the "Care Management Interaction Beneficiary Report" from the LME/MCOs, PCCMe and Tribal Option. This provides information on care management engagement with beneficiaries, including the date a comprehensive assessment and care plan is completed, number of contacts in a given month, and who the assigned care manager is. In the spring of 2026 this report will also be updated to include indicators for Justice Involved individuals as a priority population. This will include an indicator for CAA 5121 eligible beneficiaries, and all other Justice Involved beneficiaries not eligible for CAA 5121. However, the Department may be limited in what individual beneficiary data it can receive regarding SUD diagnoses based on the federal SUD confidentiality protections included in 42 C.F.R. Part 2 (Confidentiality of Substance Use Disorder Patient Records). Additionally, within the current Care Management reports the Department does not receive information on the referrals that Care Managers make for beneficiaries.

NC Medicaid also is updating the contract with its PCCMe vendor, Community Care of North Carolina, to explicitly list Justice Involved as a priority population for the PCCMe to serve. This will ensure all Justice Involved members are receiving the services outlined in Table 2 above. The Department is making these modifications in a cost neutral way that will realign the Medicaid Direct populations being screened for care management needs to prioritize the JI population.

Potential Enhancements to Align with the Legislative Requirements

Following the Department's assessment of the delivery systems currently serving Justice Involved beneficiaries the team has concluded that the current requirements for LME/MCOs and Tribal Option care management for these populations meet and, in some areas, exceed the requirements of section 1.1(a). PCCMe care management and coordination requirements are not as robust as what is provided in TCM. This is by design. If beneficiaries' needs, specifically those related to mental illness and SUD, are determined severe, those beneficiaries would be assigned or reassigned to the LME/MCOs and receive TCM. The Department could consider

applying enhancements to the PCCMe care management and coordination requirements to further align with the legislative requirements but does not recommend doing so based on the existing offerings available and the additional funds which would be required.

Potential enhancements to support further alignment for PCCMe could be applied to their recovery support and case management requirements. PCCMe's current requirements in these areas are described in Table 2, along with the enhancement options. The recovery support enhancements would include additional individual and family support elements and additions to the care management training curriculum which would be beneficial for those at risk and in recovery for SUD. The case management enhancement would expand the population provided with care coordination to all Justice Involved beneficiaries but cannot be done without a fully funded Medicaid budget that includes additional resources corresponding to the costs of these enhancements.

Additional Medicaid Services Supporting Compliance with Session Law 2025-64

In addition to TCM, North Carolina Medicaid offers a range of enhanced mental health and SUD services that collectively fulfill the requirements outlined in Session Law 2025-64. These services are available to justice-involved individuals and others with SUD. They address all elements of the 1.1(a) requirements and include:

- Diagnostic Assessment (CCP 8A-5): A comprehensive clinical evaluation that includes SUD screening, ASAM level of care determination and interdisciplinary team review.[42]
- Opioid Treatment Program (OTP) Services (CCP 8A-9): Medication-assisted treatment (MAT) with methadone, buprenorphine or naltrexone, delivered by interdisciplinary teams with integrated case management and recovery support.[43]
- Substance Abuse Comprehensive Outpatient Treatment (SACOT – ASAM Level 2.5): A structured, multi-faceted outpatient program offering counseling, relapse prevention, life skills and case management.[44]
- Substance Abuse Intensive Outpatient Program (SAIOP – ASAM Level 2.1): A structured outpatient service providing individual, group, and family counseling, relapse prevention and case management.[45]
- Community Support Team (CST): A 24/7 team-based service offering direct treatment, crisis response and service coordination for individuals with complex mental health and SUD needs.[46]

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[42] Clinical Coverage Policy 8A-5, Diagnostic Assessment. Available at: https://medicaid.ncdhhs.gov/8a-5-diagnostic-assessment-0/download?attachment.
[43] Clinical Coverage Policy No: 8A, Enhanced Mental Health and Substance Abuse Services. Available at: https://medicaid.ncdhhs.gov/8a-enhanced-mental-health-and-substance-abuse-services/download?attachment.
[44] Clinical Coverage Policy No: 8A, Enhanced Mental Health and Substance Abuse Services. Available at: https://medicaid.ncdhhs.gov/8a-enhanced-mental-health-and-substance-abuse-services/download?attachment
[45] Ibid
[46] Clinical Coverage Policy No: 8A-6, Community Support Team (CST). Available at: https://medicaid.ncdhhs.gov/8a-6-community-support-team-cst/download?attachment

- Screening, Brief Intervention, and Referral Treatment (SBIRT) services: SBIRT is an ASAM level 0.5 early intervention approach for a beneficiary with non-dependent substance use to effectively help them before more extensive or specialized treatment is needed. SBIRT is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for beneficiaries with substance use disorders, as well as those who are at risk of developing these disorders. The provider shall use a standardized screening tool, such as the Alcohol Use Disorders Identification Test (AUDIT), Drug Abuse Screening Test (DAST-10) or Screening to Brief Intervention (S2BI) tool[47].
- Assertive Community Treatment (ACT): While not SUD-specific, ACT teams support individuals with co-occurring disorders and provide intensive, team-based care coordination. An Assertive Community Treatment (ACT) team consists of a community-based group of medical, behavioral health and rehabilitation professionals who use a team approach to meet the needs of a beneficiary with severe and persistent mental illness.[48] Beneficiaries eligible for ACT will not receive TCM, but rather whole person care management through ACT.
- High Fidelity Wraparound (HFW): High Fidelity Wraparound (HFW) is an intensive, team-based, person-centered supportive service that provides coordinated, integrated, family-driven care to meet the complex needs of youth/young adults who are involved with multiple systems (e.g., mental health, child welfare, juvenile/criminal justice, special education), who are experiencing serious emotional or behavioral difficulties, have dual diagnosis (mental health and/or SUD, I/DD) with complex needs and are at risk of placement in therapeutic residential settings or other institutional settings, or have experienced multiple crisis events[49]. Beneficiaries eligible for HFW will not receive TCM, but rather whole person care management through HFW.
- Clinically Managed Residential Services (ASAM Level 3.5) (pregnant and/or parenting): A 24-hour structured residential service that helps develop recovery skills to prevent immediate relapse or the continuation of substance use upon transfer to a less intensive level of care. Clinical interventions and supports must be relevant to the needs of the beneficiary and their children.
- Residential Treatment – Level III (ASAM Level 3.5): A service targeted to children under age 21 which offers a highly structured and supervised environment in a program setting only, excluding room and board. Beneficiaries with SUD treatment needs qualify for this service[50].
- Medically Monitored Intensive Inpatient Services (ASAM Level 3.7) (adults): An organized serviced delivered by clinical and support staff in a 24-hour facility. This service provides evaluation, observation, medical monitoring and addiction treatment delivered under a defined set a licensed professional approved policies and protocols.

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[47] Clinical Coverage Policy No: 8C, Outpatient Behavioral Health Services Provided by Direct Enrolled Providers, Available at: NC Medicaid:8C
[48] Clinical Coverage Policy No: 8A-1, Assertive Community Treatment (ACT). Available at: https://medicaid.ncdhhs.gov/8a-1-assertive-community-treatment-act-program/download?attachment
[49] Contract #30-2022-007-DHB_MDPIHP_Amendment 1, Attachment L. Policies, 7. Approved In Lieu of Services
[50] Clinical Coverage Policy No: 8D-2, Residential Treatment Services, page 28. Available at: NC Medicaid

- Ambulatory Withdrawal Management Without Extended On-Site Monitoring (ASAM Level 1-WM): An organized outpatient service that provides medically supervised evaluation, withdrawal management and referral. This service is for minimal risk of severe withdrawal.
- Ambulatory Withdrawal Management With Extended On-Site Monitoring (ASAM Level 2-WM): An organized outpatient service that provides medically supervised evaluation, withdrawal management and referral. This service is for moderate to severe risk of withdrawal.
- Clinically Managed Residential Withdrawal Management Services (ASAM Level 3.2-WM): An organized facility-based service delivered by trained staff who provide 24-hour supervision, observation and support for intoxication and withdrawal.
- Medically Monitored Inpatient Withdrawal Services (ASAM 3.7-WM): An organized facility-based service delivered by medical and nursing professionals who provide 24-hour medically directed observation, evaluation, monitoring and withdrawal management in a licensed facility.
- Medically managed intensive inpatient services (ASAM Level 4) – integrated into Inpatient Behavioral Health Services: A 24-hour, organized service delivered in an acute care inpatient setting that encompasses medically directed evaluation and treatment services for the stabilization of signs and symptoms of substance use.
- Medically managed intensive inpatient withdrawal management (ASAM Level 4-WM) - integrated into Inpatient Behavioral Health Services: A 24-hour, organized service delivered by medical and nursing professionals that provide medically directed evaluation and withdrawal management to sufficiently resolve the signs and symptoms of substance use withdrawal.

Covered crisis services under the NC Medicaid State Plan also include Mobile Crisis Management, Professional Treatment Services in Facility-Based Crisis Program and Child and Adolescent Facility-Based Crisis.

Additional covered community-based services for mental health and SUD also under the NC Medicaid State Plan include Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers, 1915(i) Individual Placement and Support (IPS) and 1915(i) Individual and Transitional Support (ITS).

As a part of the 1115 SUD Demonstration Waiver, standalone clinical coverage policies (CCP) that align with The American Society of Addiction Medicine, Third Edition 2013, are being developed and anticipated to promulgate Jan. 1, 2026. The associated amendment for the NC Medicaid State Plan is pending Centers for Medicare & Medicaid Services (CMS) review/approval. These services are available to all beneficiaries that meet the admission criteria for that specific service. These services include:

- Substance Abuse Intensive Outpatient Program (ASAM Level 2.1)
- Substance Abuse Comprehensive Outpatient Treatment (ASAM Level 2.5)
- Clinically Managed Residential Withdrawal Management Services (ASAM Level 3.2WM)
- Clinically Managed Residential Services (ASAM Level 3.5)

- Medically Monitored Intensive Inpatient Services (ASAM Level 3.7)
- Clinically managed low-intensity residential treatment services (ASAM Level 3.1)
- Clinically managed population-specific high intensity residential program (ASAM Level 3.3)

Other NCDHHS Team-Based Care Models Available in North Carolina to Medicaid Beneficiaries and Individuals Not on Medicaid

To provide a holistic view of services available to Justice Involved individuals, regardless of Medicaid eligibility, NCDHHS and DMHDDSUS included examples of additional programming available to these individuals. In addition to support for Justice Involved individuals with SUD provided through NC Medicaid, NCDHHS also supports various programs open to Justice Involved individuals and those with SUD. NC Medicaid has implemented a wide array of services available to Justice Involved individuals, understanding that the needs of this population are diverse. These programs are available to individuals regardless of Medicaid enrollment status, though some have specific eligibility criteria and are limited to certain counties in the state. The offerings are based on best practices and target a variety of risk factors and needs applicable to the population referenced in section 1.1(a). For more detailed overview of the programs, please see appendix F.

Table 4. Other NCDHHS Team-Based Care Models Available in North Carolina to Medicaid Beneficiaries and Individuals Not on Medicaid

Service / Program	Description
Law Enforcement Assisted Diversion (LEAD)	Pre-arrest diversion and deflection programs, commonly known as **Law Enforcement Assisted Diversion (LEAD),** receive NCDHHS support in 13 counties to provide care management for individuals with substance use, mental health and/or co-occurring disorders who have current and/or risk of future criminal justice system involvement.
North Carolina TASC (Treatment Accountability for Safer Communities)	**North Carolina TASC (Treatment Accountability for Safer Communities)** is a statewide network of provider programs offering a comprehensive set of services aimed at supporting individuals with substance use or mental health needs who are justice involved.[51] These services are available statewide regardless of Medicaid eligibility. Core TASC Services[52] • Screening and Assessment • Referral and Linkage to Treatment • Care Management/Care Coordination

[51] Programming for Justice Involved Individuals
[52] TASC, RRS & Reentry Services – Coastal Horizons Center

	• Monitoring and Reporting
Forensic Assertive Community Treatment (FACT)	**Forensic Assertive Community Treatment (FACT)** is a service delivery model designed to support individuals with serious mental illness (SMI), most frequently with primary psychotic disorders, with or without co-occurring SUD, who are involved with the criminal justice system. FACT teams provide client-focused, community-based services that are delivered by a multidisciplinary team.[53]
Priority Reentry Program	The **Priority Reentry Program** provides intensive care management and peer support services to individuals releasing from prison who have been diagnosed with a serious mental illness (SMI) and have either violent felony or sex offense history OR are prescribed Clozaril/Clozapine. The LME/MCOs provide many of the services directly (peer support, case management, linkages to services) and continuity of care for their members. These care teams provide individualized services and support.
NC-FIT (Formerly Incarcerated Transition) Wellness Clinics	**NC-FIT (Formerly Incarcerated Transition) Wellness Clinics** serve individuals with serious mental illness who are releasing from incarceration to Wake, Durham, Orange and New Hanover Counties. Referrals are received from the Department of Adult Corrections or detention centers in the counties being served, with psychiatric and primary care beginning prior to release. Once released, individuals continue receiving these services in the community.
Alcoholism and Chemical Dependency Program (ACDP)	The **Alcoholism and Chemical Dependency Program (ACDP)** provides planning and implementation of SUD screenings, treatments and reintegration services through the Department of Adult Corrections (DAC)[54].

New Team-Based Care Coordination Medicaid Service Described in Section 1.1(a)

Service Description

The Department believes that the creation of a new service would be duplicative of existing care management and Medicaid services available for Justice Involved beneficiaries and beneficiaries with SUD. In addition, a new service could be confusing for beneficiaries who may receive outreach from care managers within the existing programs and would be complex to implement. Within the Medicaid program, ensuring individuals are assigned to the appropriate care manager for their needs is a complex process that involves multiple state and Plan-

[53] Substance Abuse and Mental Health Services Administration (SAMHSA), Forensic Assertive Community Treatment (FACT): A Service Delivery Model for Individuals With Serious Mental Illness Involved With the Criminal Justice System. https://library.samhsa.gov/sites/default/files/pep19-fact-br.pdf
[54] Alcoholism and Chemical Dependency Programs | NC DAC

administered technology system. Coding those programs to appropriately assign and carve out this population for a new and different care management program would be administratively costly, time consuming and result in development of new oversight and auditing processes for the Department.

If the Legislature determined the Department must develop an additional service, the Department recommends structuring this service consistent with the TCM service described within section "Overview of Existing Medicaid Care Management Programs Serving Justice Involved Beneficiaries" of this report, which currently meets and exceeds the legislative requirements. The service would be provided through NC Medicaid Direct and EBCI Tribal Option, depending on the beneficiary's eligibility, and care management providers would include LME/MCOs, PCCM and Tribal Option. The eligible population for the service would include all Justice Involved adults within one year of their release. These individuals would be identified within Medicaid systems based on a "Formerly Incarcerated" or "FI" indicator on their Managed Care Status Code, as is consistent with SL2024-34, with one exception. The Department recommends that youth and qualifying adults eligible for CAA 5121 post-release care management remain within the existing delivery structure that will be launched in 2026. The exception is in compliance with CAA 5121 and the terms of North Carolina's "Targeted Case Management Services for Eligible Juveniles" State Plan Amendment (SPA), which was drafted in response to CAA 5121.

Implementation Activities

The proposed start date for the coverage of this service would be December 1, 2027, at the earliest. This section and the below "Additional Considerations" section both provide context on the factors influencing the proposed start date.

Prior to the launch of any new Medicaid program, service or delivery system, there are numerous design, planning and implementation activities that are required. The launch of a new care management program to meet the requirements within section 1.1(a) would include several assessment, engagement, planning and implementation activities across Department and provider teams. These are described below.

Prior to implementation, the Department teams would need to build upon the initial design and assessment efforts completed for this proposed service. This would include engagement with internal and external stakeholders, including but not limited to LME/MCOs, PCCMe and Tribal Option to discuss and collect feedback on the design, and understand the level of effort required from the care management providers for the program prior to launch. Existing capabilities, capacity and structures within each organization providing Care Management would need to be assessed. The Department also would need to complete a detailed analysis of relevant authorities, including the state plan, to identify if the service design has any impact on the authorities supporting the NC Medicaid Direct and Tribal Option delivery systems. It is important to note that the Department has limitations on possible enhancements for delivery systems based on the State Plan. The Department is currently evaluating whether a State Plan Amendment authorizing Tailored Care Management is needed. The Department also would draft and work with the LME/MCOs, PCCMe and Tribal Option to execute contract amendments to support this effort

and formalize the program requirements for the organizations and the Department. Execution of these amendments would allow the Department to finalize all remaining design details including rate setting and billing details.

Examples of implementation activities for the Care Management providers supporting this new service may include but are not limited to: eligibility, enrollment, and assignment system updates, care management system updates, updates to billing processes and procedures, testing of technical updates, protocol and procedural updates, the hiring and training of staff and readiness reviews with the Department. The core implementation activities for this group would be consistent across providers, but may differ depending on each organization's existing technical, functional, organizational and programmatic capabilities, capacity and structures.

In parallel with the provider organizations, the Department would also need to complete various implementation activities. These may include but are not limited to State Plan Amendments, billing and technical updates, updates and/or the creation of protocols, guidance documents and training, and continuous engagement with and monitoring of the implementation efforts across providers, including LME/MCOs, PCCMe and Tribal Option.

Additional Considerations

In addition to the implementation efforts described, there also may be other potential dependencies and impacts to the proposed December 1, 2027, launch date for this new service. At the Department level, this timeline estimate is based on the current capacity of the team supporting the Justice Involved workstream today and the Justice Involved CAA 5121 work which the team will continue supporting through the end of 2026. If other staff are needed to support the new service design and implementation, the Department would need to complete a thorough assessment of which other Population Health initiatives would need to be deprioritized to accommodate this. At the delivery system level, there also are dependencies based on capacity and current capabilities. For example, some of this work would be new in scope for the Tribal Option and PCCMe and may therefore take longer for them to implement. The LME/MCOs also will be supporting CAA 5121 jail and prison launches in parallel through the end of 2026 which may limit their ability to take on an additional implementation. The CAA 5121 pre- and post-release care management program can be used for comparison to illustrate the level of effort and time required across the Department and external stakeholders to stand up a Justice Involved care management program. That program will likely require at least 18 months of implementation and is only impacting one external entity (the LME/MCOs).

Financial Information for New Service

To implement the new service, NC Medicaid would need to revise the agreements with the PIHP, Tribal Option, and PCCMe to account for the affiliated costs. The total cost for a new service will be approximately $28,851,00- $34,247,000 across all contracts, with the estimated state cost falling between $10,300,000- $12,300,000, based on the 35.84% state share for FFY 2027.

NC Medicaid worked with actuarial partner, Mercer and the internal Health Financing & Economics and Provider Reimbursement teams to develop an initial service rate and associated

cost estimates for a new service similar in scope and intensity to the current North Carolina TCM program. For this scenario, Mercer and NC Medicaid's Health Financing & Economics and Provider Reimbursement teams relied directly on the current payment rate assumptions and methodology already in place for TCM. For detailed rating assumptions underlying the current TCM rate, please reference the TCM assumptions guidance document[55].

The table below illustrates the estimated modeled rate ranges for the hypothetical new service. Note that the rate represents a per member per month (PMPM) unit of service which would be payable for each engaged member in each month they receive the outlined care management service.

Table 5: Estimated Rate Ranges

Proposed New Service Cost	Estimated PMPM Rate Range		
	Lower Bound	Midpoint	Upper Bound
New Service (aligns with current TCM rate assumptions)	$289.77	$316.87	$343.97

Mercer and NC Medicaid's Health Financing & Economics and Provider Reimbursement teams also developed a fiscal impact estimate for the new service. The fiscal impact estimate utilizes estimated member month volume assumptions provided by the Department regarding the number of Justice Involved Medicaid members who are anticipated to be engaged in the outlined care management service. For more information on how the fiscal impact was calculated, see Appendix E: Financial Estimates.

Table 6: Annual Fiscal Impact Estimate

Proposed New Service Scenario	Estimated Annual Member Count (A)	Assumed Months Engaged Per Member Per Year (B)	Estimated Fiscal Impact Range (C)[56]		
			Lower Bound	Midpoint	Upper Bound
New Service Cost Annual Total	8298	12	$28,850,881	$31,548,434	$34,246,987

[55] https://medicaid.ncdhhs.gov/tcm-rate-assumption-guidance/download?attachment

[56] Fiscal impact (C) for each bound calculated as: A*B*Estimated PMPM Rate at Corresponding Bound from Table 5. Impacts are rounded to the nearest thousand

Statewide Accessible Communications and Education Initiative for Promoting Tailored Care Management and SUD Treatment

NC Medicaid collaborated with DMHDDSUS to launch a comprehensive statewide NC Medicaid Accessible Communication Campaign in August 2024. In alignment with Session Law 2025-64, Section 1.1(c), the campaign included the enhancement of communication and education efforts to promote Medicaid policy changes related to Tailored Care Management (TCM) used to support the treatment of alcohol use disorder, opioid use disorder, and other mild-to-moderate substance use disorders. This initiative was designed to enhance communication and educational materials developed for providers and community leaders and to train clinical professionals to expand Medicaid provider participation in North Carolina.

The campaign development incorporated the TCM Member Education and Community Awareness Workgroup, which created provider-focused flyers for distribution in hospitals, doctors' offices, and colleges/universities. In addition to provider-focused flyers, the Department and community workgroup created a digital toolkit that includes: printables, educational presentation slide decks, social media templates, and web page templates for providers to use within their offices to promote the NC Medicaid TCM services.

NC Medicaid remains committed to sustaining and expanding these education and communication efforts beyond the initial campaign launch should funding be available. Future initiatives may include ongoing updates to the digital toolkit, continued collaboration with provider networks, and regular training opportunities to ensure that health care professionals remain informed about Medicaid policy changes and best practices for treating substance use disorders. Additionally, NC Medicaid and DMHDDSUS will leverage community partnerships and feedback loops to refine messaging, enhance accessibility, and promote provider engagement statewide. These efforts underscore the Department's long-term goal of improving care coordination and access to evidence-based treatment for individuals with alcohol use disorder, opioid use disorder, and other mild-to-moderate substance use disorders.

NC Medicaid is also developing informational materials on the pre- and post-release care management offered under CAA 5121 to eligible individuals –youth post-adjudication up to age 21 and former foster youth up to age 26. Youth Development Centers and other facilities serving those individuals will be able to use these materials with guardians and beneficiaries when initially collecting consent and explaining care manager involvement. These materials will support clear communication about available care management and SUD services and will reinforce the Department's commitment to coordinated care during critical transition periods.

Conclusion

The existing NC Medicaid and NCDHHS services described in this report demonstrate that NC Medicaid currently meets or exceeds the requirements described in Section 1.1(a) of the legislation to support all Justice Involved beneficiaries, in addition to those with alcohol use disorder, opioid use disorder and other substance use disorders.

To launch a new service for the delivery systems serving the Justice Involved population (LME/MCOs, Tribal Option and PCCMe) as described in this report, the total cost would be between $28,851,00 and $34,247,000 annually.

Based on these estimates, the duplicative nature of the potential new service, the administrative complexity of adding a new service, the potential confusion for beneficiaries, and the comprehensive care and support available to Justice Involved beneficiaries today, the Department recommends maintaining the program requirements as they are. As with all programs and services offered through NC Medicaid, the Department will continue to work with its stakeholders to monitor and assess for deficiencies to further NCDHHS' mission to provide essential services to improve the health, safety and wellbeing of all North Carolinians.

Finally, NC Medicaid remains committed to sustaining and expanding the education and communication efforts to promote Medicaid policy changes related to Tailored Care Management (TCM) beyond the initial campaign launch. Upon funding availability, future initiatives will include ongoing updates to the digital toolkit, continued collaboration with provider networks, and leveraging community partnerships and feedback loops to refine messaging and enhance accessibility. These efforts underscore the Department's long-term goal of improving care coordination and access to evidence-based treatment for individuals with substance use disorders.

Appendix A: Session Law 2025-64

Part I. Justice-Related Medicaid Changes

SECTION 1.1.(a) The Department of Health and Human Services, Division of Health Benefits (DHB), is directed, in coordination with a working group of stakeholders established by DHB, to develop a team-based care coordination Medicaid service that includes, at a minimum, screening for alcohol use disorder, opioid use disorder, and other mild to moderate substance use disorders; prescription medications for opioid use disorder and alcohol use disorder; recovery support; and case management.

SECTION 1.1.(b) No later than October 1, 2025, the Department of Health and Human Services, Division of Health Benefits, shall submit a report to the Joint Legislative Oversight Committee on Medicaid and the Fiscal Research Division containing details on the new Medicaid service developed in accordance with this section. The report shall include all of the following: (1) The State share of the cost of the service. (2) The intended start date for the coverage of the service. (3) The types of PHP capitated contracts that will cover the service and any related proposed statutory changes to Article 4 of Chapter 108D of the General Statutes.

SECTION 1.1.(c) The Department of Health and Human Services, Division of Health Benefits, is directed to develop a statewide campaign to (i) educate health care providers and community leaders about any changes made to the Medicaid program related to the treatment of alcohol use disorder, opioid use disorder, and other mild to moderate substance use disorders, (ii) train interested providers in clinical care for alcohol use disorder, opioid use disorder, and other mild to moderate substance use disorders, and (iii) encourage substance use disorder provider participation in the Medicaid program.

SECTION 1.2. The Department of Health and Human Services (DHHS), Division of Health Benefits, shall continue to implement its policy changes to suspend, rather than terminate, Medicaid benefits upon a Medicaid beneficiary's incarceration, as required by the federal Consolidated Appropriations Act, 2024, P.L. 118-42. No later than October 1, 2025, DHHS shall submit to the Joint Legislative Oversight Committee on Medicaid and the Fiscal Research Division a report on (i) DHHS's progress implementing the automated process in the NCFAST eligibility information system that allows data sharing between county jails and DHHS and (ii) any ongoing challenges to meeting the federal requirement to suspend, rather than terminate, Medicaid benefits upon a Medicaid beneficiary's incarceration.

SECTION 1.3. Except as otherwise provided, this Part is effective when this act becomes law.

Appendix B: Definitions

Definitions

1. **Advanced Medical Home (AMH):** State-designated primary care practices that have attested to meeting standards necessary to provide local care management services.
2. **Advanced Medical Home Plus (AMH+):** Primary care practices certified by the Department as AMH Tier 3 practices, whose providers have experience delivering primary care services to the Behavioral Health I/DD Tailored Plan eligible population or can otherwise demonstrate strong competency to serve that population and have been certified by the State (prior to Behavioral Health I/DD Tailored Plan launch) or Behavioral Health I/DD Tailored Plan(s) (after launch) as such.
1. **Alcohol and Drug Abuse Treatment Center (ADATC):** State-operated treatment center that provides inpatient treatment, psychiatric stabilization and medical detoxification for adults with substance use and other co-occurring mental health diagnoses to prepare for ongoing community-based treatment and recovery.
3. **Authorized Representative**: An individual, Provider or organization designated by a Beneficiary, or authorized by law or court order, to act on their behalf in assisting with the individual's participation in NC Medicaid Managed Care. With written consent of the Beneficiary, or as otherwise legally authorized, an authorized representative may, for example, request an Appeal, file a Grievance, or request a State Fair Hearing on behalf of the Beneficiary with the exception that a Provider cannot request continuation of LME/MCOs benefits. Authorized Representative may be used interchangeably with beneficiary wherever a beneficiary has a right under this Contract for purposes of exercising a right on behalf of that beneficiary. Sometimes referred to as Legally Responsible Person (LRP).
4. **Behavioral Health:** Mental health and substance use disorder.
5. **Behavioral Health and Intellectual/Developmental Disability Tailored Plan (Behavioral Health I/DD Tailored Plan):** Has the same meaning as Behavioral Health I/DD Tailored Plan as defined in N.C. Gen. Stat. § 108D-1(4).
6. **Beneficiary:** An individual who is enrolled in the North Carolina Medicaid program but who may or may not be enrolled in NC Medicaid Managed Care.
7. **Beneficiary with Special Health Care Needs**: Populations who have or are at increased risk of having a chronic illness and/or a physical, developmental, behavioral or emotional condition and who also require health and related services of a type or amount beyond that usually expected for individuals of similar age. This includes but is not limited to individuals with: HIV/AIDS; an SMI, I/DD or SUD diagnosis; Chronic Pain; Opioid Addiction; or receiving Innovations or TBI waiver services.
8. **CAA 5121:** Section 5121 of the Consolidated Appropriations Act (CAA) of 2023 is a federal mandate that went into effect Jan. 1, 2025. It requires states to provide specific Medicaid and Children’s Health Insurance Program (CHIP) services to justice-involved youth who are incarcerated post-adjudication (meaning after a formal judgment or conviction) and enrolled in Medicaid or CHIP.

9. **Care Coordination:** The act of organizing beneficiary care activities and sharing information among all the participants involved with beneficiary's care to achieve safer and more effective care. Through organized care coordination, beneficiaries' needs and preferences are known ahead of time and communicated at the right time to the right people to provide safe, appropriate and effective care addressing the beneficiary's clinical needs and unmet health related resource needs.
10. **Care Management:** Team-based, person-centered approach to effectively managing patients' medical, social and behavioral conditions. Care Management shall include, at a minimum, the following:
    a. High-risk care management (e.g., high utilizers / high-cost beneficiaries);
    b. Care Needs Screening;
    c. Identification of beneficiaries in need of care management;
    d. Development of Care Plans (across priority populations);
    e. Development of comprehensive assessments (across priority populations);
    f. Transitional Care Management: Management of beneficiary needs during transitions of care and care transitions (e.g., from hospital to home);
    g. Care Management for special populations (including pregnant women and children at-risk of physical, development, or socio-emotional delay);
    h. Chronic care management (e.g., management of multiple chronic conditions);
        i. Coordination of services (e.g., appointment/wellness reminders and social services coordination/referrals);
    i. Management of unmet health-related resource needs and high-risk social environments;
    j. Management of high-cost procedures (e.g., transplant, specialty drugs);
    k. Management of rare diseases (e.g., transplant, specialty drugs);
    l. Management of medication-related clinical services which promote appropriate medication use and adherence, drug therapy monitoring for effectiveness, medication related adverse effects; and
    m. Development and deployment of population health programs.
11. **Care Management Agency (CMA**): Provider organization with experience delivering Behavioral Health, I/DD and/or TBI services to the Behavioral Health I/DD Tailored Plan eligible population that will hold primary responsibility for providing integrated, whole-person care management to Behavioral Health I/DD Tailored Plan beneficiaries assigned to it, under the Tailored Care Management model as certified by the State (prior to Behavioral Health I/DD Tailored Plan launch) or Behavioral Health I/DD Tailored Plan(s) (after launch).
12. **Care Management Comprehensive Assessment:** A person-centered assessment of a Beneficiary's health care needs, functional needs, accessibility needs, strengths and supports, goals and other characteristics that will inform the Beneficiary's ongoing Care Plan and treatment.
13. **Care Plan:** A written individualized person-centered plan of care for beneficiaries with Behavioral Health needs, that is developed using a collaborative approach led by the Beneficiary or their guardian when appropriate, incorporates the results of the Care Management Comprehensive Assessment, and identifies the beneficiary's desired

outcomes and the training, therapies, services, strategies, and formal and informal supports needed for the beneficiary to achieve those outcomes.

14. **Care Transitions:** The process of assisting a beneficiary to transition to a different care setting or through a life stage that results in or requires a modification of services (e.g., school-related transitions).
15. **CFR 42 Part 2:** Federal regulations in this part impose restrictions upon the use and disclosure of substance use disorder patient records ("records," as defined in this part) which are maintained in connection with the performance of any part 2 program.
16. **Community Alternatives Program for Children (CAP/C):** A North Carolina Medicaid 1915(c) waiver program that provides home- and community-based services to medically fragile children who are at risk for institutionalization in a nursing home because of their medical needs (4141.R06.00; the approved waiver document is available at the following link, accurate as of the date of execution of this Contract: https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-andwaiver-list/?entry=8233).
17. **Community Alternatives Program for Disabled Adults (CAP/DA):** A North Carolina Medicaid 1915(c) waiver program that allows seniors and disabled adults ages 18 and older to receive support services in their own home, as an alternative to nursing home placement; the approved waiver document is available at the following link, accurate as of the date of execution of this Contract: https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiverlist/?entry=8232.
18. **Community Collaboratives:** Local and regional convenings of county agencies, community-based organizations, non-profits, beneficiaries, relatives/natural supports, health care providers and peers that meet regularly to identify and address community needs through coordinated efforts and system planning.
19. **Eastern Band of Cherokee Indians (EBCI:):** A federally recognized Indian Tribe located in southwestern North Carolina whose beneficiaries are exempt from NC Medicaid Managed Care.
20. **Eastern Band of Cherokee Indians (EBCI) Tribal Option:** The tribal-designed and operated managed care primary care case management entity option developed collaboratively by the Department and the EBCI. This includes the following counties: Cherokee, Graham, Haywood, Jackson and Swain Counties. Eligible beneficiaries in the following counties may opt in: Buncombe, Clay, Henderson, Macon, Madison and Transylvania.
21. **Enrollment:** The process through which a Beneficiary selects or is auto-enrolled to a Standard Plan, Behavioral Health I/DD Tailored Plan, Medicaid Direct PIHP, Statewide Specialized Foster Care Plan and/or Tribal Option to receive North Carolina Medicaid benefits through NC Medicaid Managed Care.
22. **Fee-for-Service:** A payment model in which Providers are paid for each service provided. NC Medicaid's Fee-for-Service program is also known as NC Medicaid Direct.
23. **Health-Related Social Needs (HRSN)**: Social and economic needs that individuals experience that affect their ability to maintain their health and well-being. They put individuals at risk for worse health outcomes and increased health care use. HRSN refers to individual-level factors such as financial instability, lack of access to healthy food,

lack of access to affordable and stable housing and utilities, lack of access to health care and lack of access to transportation.

24. **In Lieu of Services (ILOS):** Services or settings that are not covered under the North Carolina Medicaid State Plan but are a medically appropriate, cost-effective alternative to a State Plan covered service.
25. **In-Reach:** The process of identifying individuals residing in an institutional setting or an adult care home whose service needs could potentially be met in a home or community-based setting, engaging them about their desire to transition to a home or community-based setting and referring them for transition, if appropriate.
26. **Indian Health Care Provider (IHCP):** Means an IHCP as defined by 42 C.F.R. § 438.14(a). In North Carolina, an IHCP is a provider of service which includes all services that Cherokee Indian Hospital Authority or the Eastern Band of Cherokee Indians offer under Medicaid. Indian Health Care Provider Purchased/Referred Care: any health service that is delivered based on a referral by, or at the expense of, an Indian health program; and provided by a public or private medical provider or hospital that is not a provider or hospital of the Indian health program.
27. **Individual Support Plan (ISP):** A written individualized person-centered plan of care for beneficiaries with I/DD, including beneficiaries who are receiving Innovations waiver services, that is developed using a collaborative approach led by the beneficiary or their guardian when appropriate, incorporates the results of the care management comprehensive assessment, and identifies the beneficiary's desired outcomes and the training, therapies, services, strategies, and formal and informal supports needed for the beneficiary to achieve those outcomes. For individuals enrolled in the Innovations waiver, the ISP also documents the waiver services that a beneficiary is authorized to obtain.
28. **Local Management Entity/Managed Care Organizations (LME/MCOs):** Has the same meaning as LME/MCOs as defined in N.C. Gen. Stat. § 122C-3(20c).
29. **Long Term Services and Supports (LTSS):** LTSS shall include:
    a. Care provided in the home, in community-based settings, or in facilities, such as nursing homes;
    b. Care for older adults and people with disabilities who need support because of age, physical, cognitive, developmental or chronic health conditions; or other functional limitations that restrict their abilities to care for themselves; and
    c. A wide range of services to help people live more independently by assisting with personal health care needs and activities of daily living such as:
        i. Eating;
        ii. Taking baths;
        iii. Managing medications;
        iv. Grooming;
        v. Walking;
        vi. Getting up and down from a seated position;
        vii. Using the toilet;
        viii. Cooking;
        ix. Driving;

x. Getting dressed; or
xi. Managing money.

d. Care management provided to individuals who, because of age, physical, cognitive, developmental or chronic health conditions or other functional limitations, are at risk of requiring formal LTSS to remain in their communities

30. **Medicaid Direct**: Refers to the Medicaid Fee-For-Service program serving beneficiaries who are not enrolled in a Prepaid Health Plan (PHP) or the EBCI Tribal Option.
31. **NC Medicaid Managed Care:** North Carolina's program under which contracted Managed Care Organizations arrange for integrated medical, physical, pharmacy, behavioral and other services to be delivered to Medicaid enrollees. NC Medicaid Managed Care will include three types of plans: (1) Standard Plans, (2) Behavioral Health I/DD Tailored Plans, and (3) Children and Families Specialty Plan. The use of NC Medicaid Managed Care is also inclusive of EBCI Tribal Option, operating as a primary care case management entity (PCCMe).
32. **Member**: Medicaid beneficiaries specifically enrolled in and receiving benefits through NC Medicaid Managed Care.
33. **Natural Supports:** Relationships with people that include coworkers, classmates, activity individuals, neighbors, family and others. These relationships are typically developed in the community through associations in schools, the workplace and participation in clubs, organizations and community activities.
34. **Outpatient Commitment**: Occurs pursuant to N.C.G.S. § 122C, Article 5, Part 7, when a judge orders a person to receive treatment in the community for their behavioral health condition. Before ordering Outpatient Commitment, the outpatient provider must agree to accept the patient into treatment and serve as the responsible party for the management and supervision of the Outpatient Commitment order.
35. **Participating Provider**: Participating provider or "par" providers are physicians or other health care providers that have a contractual agreement with a health plan and are included in the health plan's Network. Participating providers may also be called "network providers" or "in-network providers."
36. **Peer Support Services:** Peer Support Services (PSS) are an evidenced-based mental health model of care that provides community-based recovery services directly to a Medicaid-eligible adult beneficiary diagnosed with a mental health or substance use disorder. PSS provides structured, scheduled services that promote recovery, self-determination, self-advocacy, engagement in self-care and wellness and enhancement of community living skills of beneficiaries. PSS services are directly provided by Certified Peer Support Specialists (CPSS) who have self-identified as a person(s) in recovery from a mental health or substance use disorder. PSS can be provided in combination with other approved mental health or substance use services or as an independent service.
37. **Primary Care Case Management (PCCM):** A system under which a primary care case manager contracts with the Department to furnish case management services (which include the location, coordination and monitoring of primary health care services) to beneficiaries, or a PCCM entity that contracts with the Department to provide a defined set of functions as defined in 42 C.F.R. § 438.2.

38. **Prepaid Health Plan (PHP):** Has the same meaning as Prepaid Health Plan, as defined in N.C. Gen. Stat. § 108D-1(30). A PHP is an MCO. A PHP may operate a Standard Plan or a Behavioral Health I/DD Tailored Plan.
39. **Primary Care Provider (PCP):** The participating physician, physician extender (e.g., physician
assistant, nurse practitioner, certified nurse midwife) or group practice/center selected by or assigned to the beneficiary to provide and coordinate all the beneficiary's health care needs and to initiate and monitor referrals for specialized services, when required.
40. **Provider**: Provider means any individual or entity that is engaged in the delivery of services, or
ordering or referring for those services, and is legally authorized to do so by the state in which it
delivers the services. (42 C.F.R. § 438.2).
41. **Provider-based Care Management:** Care management where the care manager is affiliated with an AMH+ practice or CMA and performs care management at the site of care, in the home, or in the community through in-person and other methods of interaction between beneficiaries and providers.
42. **Standard Plan or Standard Benefit Plan:** Has the same meaning as Standard Plan as defined in N.C. Gen. Stat. § 108D-1(36).
43. **Tailored Care Management:** The care management model for all Behavioral Health I/DD Tailored Plan members and PIHP beneficiaries who meet eligibility criteria. The core health home services under Tailored Care Management include comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support, and referrals to community and social support services.
44. **Unmet Health-Related Resource Needs:** Non-medical needs of individuals that foundationally influence health, including but not limited to needs related to housing, food, transportation and addressing interpersonal violence/toxic stress.

Appendix C: Contract Links

Contract Links

- Behavioral Health I/DD Tailored Plan Contract: https://medicaid.ncdhhs.gov/contract-30-2020-052-behavioral-health-and-idd-tailored-plan-amendment-all-sections/download?attachment
- Standard Plan: https://medicaid.ncdhhs.gov/contract-30-190029-dhb-prepaid-health-plan-services-rfp/download?attachment
- Medicaid Direct Prepaid Inpatient Health Plan Contract: https://medicaid.ncdhhs.gov/medicaid-direct-prepaid-inpatient-health-plan-contract/download?attachment
- Tribal Option: To request a copy of the EBCI PCCMe contract, email medicaid.transformation@dhhs.nc.gov
- Primary Care Case Management Contract: https://medicaid.ncdhhs.gov/30-2021-061-dhb-pccm-contract/download?attachment
- Children and Families Specialty Plans: https://medicaid.ncdhhs.gov/contract-30-2024-001-dhb-children-and-families-specialty-plan-section-v/download?attachment

Appendix D: Overview of Additional Existing Medicaid Programs (Standard Plan, Tailored Plan, Children and Families Specialty Plan)

The Department conducted a review of team-based care management programs for SUD services in other delivery systems including through the Standard Plans, Children and Families Specialty Plan (launched Dec. 1, 2025) and TCM performed by the Tailored Plans. All managed care delivery systems currently require or perform substance use disorder (SUD) screening, often using standardized tools, such as the care needs screening.

With respect to the other requirements, access to those services is outlined below. Each of the care management programs provides some level of support across the requirements, although not as robust as what is provided in TCM. The TCM requirements are the same, whether they are provided by the Tailored Plan or the PIHP. For detailed TCM requirements, see Table 1 **Tailored Care Management Program Requirements Compared to Session Law 2025-64, Section 1.1(a) Requirements.**

Team-Based Care Coordination:
Tailored Plans[57] and the Children and Families Specialty Plan[58] have explicit multidisciplinary teams. Standard Plans coordinate among providers and others on a member's care team[59], but formal team meetings are not required.

MAT Coordination and Coverage:
All plans cover MAT for OUD/AUD as part of Medicaid pharmacy and mental health and SUD benefits. Coordination/referral for MAT is required in care management models (Tailored Plans[60], CFSP[61] and Standard Plans[62]).

Recovery Support:
Tailored Plans and CFSP provide robust recovery supports (peer support, housing, supported employment). Standard Plans provide basic recovery support, mainly via referrals; peer support is also based on referrals and most members needing this service would be best served in one of the aforementioned plans.

Case Management:
All programs provide case management, either through care managers or community-based teams. Intensity and specialization vary; TCM offers high-touch, multidisciplinary case management.

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[57] 30-2020-052-DHB BH I/DD Tailored Plan, Amendment 1 First Revised and Restated RFA Sections V-VI Page 149
[58] RFP #30-2024-001-DHB Children and Families Specialty Plan RFP Section V. Scope of Services Page 110
[59] Revised and Restated RFP 30-190029-DHB Request for Proposal Section V. Scope of Services Page 117
[60] 30-2020-052-DHB BH I/DD Tailored Plan, Amendment 1 First Revised and Restated RFA Sections V-VI Page 197
[61] RFP #30-2024-001-DHB Children and Families Specialty Plan RFP Section V. Scope of Services Page 152
[62] Revised and Restated RFP 30-190029-DHB Request for Proposal Section V. Scope of Services Page 131

Appendix E: Financial Estimates

NC Medicaid worked with our actuarial partner, Mercer, and internal Health Financing & Economics and Provider Reimbursement teams to develop an initial service rate and associated cost estimates for a new service similar in scope and intensity to the current North Carolina Tailored Care Management (TCM) program. For this scenario, Mercer discussed the potential scope of this service with the Department, and based on their guidance and input, Mercer and the Health Financing & Economics and Provider Reimbursement teams relied directly on the current payment rate assumptions and methodology already in place for TCM. For detailed rating assumptions underlying the current TCM rate, please reference the TCM assumptions guidance document[63].

The table below illustrates the estimated modeled rate ranges for a new service scenario. Note that each rate represents a per member per month (PMPM) unit of service which would be payable for each engaged member in each month they receive the outlined care management service.

Table 7: Estimated Rate Ranges by Service Scenarios

Proposed New Service Cost	Estimated PMPM Rate Range		
	Lower Bound	Midpoint	Upper Bound
New Service (aligns with current TCM rate assumptions)	$289.77	$316.87	$343.97

Mercer and Health Financing & Economics and Provider Reimbursement teams also developed a fiscal impact estimate for the hypothetical new service. The fiscal impact estimate utilizes estimated member month volume assumptions provided by the Department regarding the number of Justice Involved Medicaid members who are anticipated to be engaged in the outlined care management service.

The estimated fiscal impact is calculated by multiplying the total estimated member months provided by the Department and the estimated rates at each bound as outlined in Table 7 for the

[63] https://medicaid.ncdhhs.gov/tcm-rate-assumption-guidance/download?attachment

LME/MCOs, CCNC and Tribal Option. The table below displays the fiscal impact estimate associated with each point in the rate range, rounded to the nearest thousand.

Table 8: Fiscal Impact Annual Estimate

Proposed New Service Scenario	Estimated Annual Member Count (A)	Assumed Months Engaged Per Member Per Year (B)	Estimated Fiscal Impact Range (C)		
			Lower Bound	Midpoint	Upper Bound
New Service Cost Annual Total	8298	12	$28,850,881	$31,548,434	$34,246,987

The Fiscal impact (C) for each bound is calculated as: A*B*Estimated PMPM Rate at the Corresponding Bound (lower, midpoint, or upper) from Table 7. Impacts are rounded to the nearest thousand.

Limitations and Caveats

In preparing the estimates discussed in this document, Mercer utilized service change information and member volume estimates provided by the Department, and publicly available wage, benefit, and other service-related information underlying the Department's current TCM rate. These estimates are based on the current TCM rate modeling assumptions and Mercer did not perform a full rebase of the fee modeling (e.g. BLS wage and employee-related expense assumptions have not been updated to the most currently available data). The Department is solely responsible for the validity and completeness of the supplied data and information. Mercer reviewed the data and information for internal consistency and reasonableness but did not audit it. In Mercer's opinion, it is appropriate for the intended purposes. However, if the data and information are incomplete and/or inaccurate, the values shown in this report may differ significantly from values that would be obtained with accurate and complete information. Additionally, to the extent that changes or clarifications are made to the service definition beyond those discussed and provided by the Department, estimates may be impacted and need to be updated accordingly.

All estimates are based upon the information and data available at a point in time and are subject to unforeseen and random events. Therefore, any projection must be interpreted as having a likely, and potentially wide, range of variability from the estimate. Any estimate or projection may not be used or relied upon by any other party or for any other purpose than for which it was issued by Mercer. Mercer is not responsible for the consequences of any unauthorized use. Actual provider costs will differ for these projections.

Appendix F: Other NCDHHS Team-Based Care Models Available in North Carolina to Medicaid Beneficiaries and Individuals Not on Medicaid (Detailed)

In addition to support for justice involved individuals with SUD provided through North Carolina's Medicaid programs, the North Carolina Department of Health and Human Services within the state also supports various programs open to Justice Involved individuals and those with SUD. These programs are available to individuals regardless of Medicaid enrollment status, though some have specific eligibility criteria and are limited to certain counties in the state. The offerings are based on best practices and target a variety of risk factors and needs applicable to the population referenced in section 1.1(a).

Pre-arrest diversion and deflection programs, commonly known as **Law Enforcement Assisted Diversion (LEAD),** receive NCDHHS support in 13 counties (Ashe, Avery, Cumberland, Duplin, Gaston, Guilford, Montgomery, New Hanover, Pender, Robeson, Watauga and Wilkes) to provide care management for individuals with substance use, mental health and/or co-occurring disorders who have current and/or risk of future criminal justice system involvement. Justice system partners work in conjunction with community-based providers to divert individuals away from the justice system and into case management. Funding for this program flows through the LME/MCOs and they contract with providers for the LEAD program services. These individuals then receive the following:

- Ongoing case management with no graduation or exit requirements;
- Access to wraparound services, including peer support;
- Linkage to care for substance use, mental health and co-occurring disorders treatment; and
- Assistance with social determinants of health needs including shelter/housing, transportation, food access and healthcare.

North Carolina TASC (Treatment Accountability for Safer Communities) is a statewide network of provider programs offering a comprehensive set of services aimed at supporting individuals with substance use or mental health needs who are justice involved.[64] These services are available statewide regardless of Medicaid eligibility. Individuals with substance use or mental health needs are referred to TASC directly by justice system stakeholders – the courts and/or Department of Adult Corrections Community Supervision officers. The LME/MCOs can also coordinate referrals to TASC services.

Core TASC Services[65]

1. **Screening and Assessment**
    - Initial evaluation of individuals referred by the justice system to determine treatment needs
2. **Referral and Linkage to Treatment**

[64] Programming for Justice Involved Individuals
[65] TASC, RRS & Reentry Services – Coastal Horizons Center

- Connecting clients to appropriate substance use or mental health treatment providers

3. **Care Management/Care Coordination**
    - Ongoing support and coordination of services to ensure continuity of care and progress, including access to wrap-around services in the local community.
4. **Monitoring and Reporting**
    - Regular updates to the justice system on client progress in treatment and successful completion of person-centered goals

During fall/winter of 2025, **Forensic Assertive Community Treatment (FACT)** teams are launching in 10 counties across North Carolina with NCDHHS support. FACT is a service delivery model designed to support individuals with serious mental illness (SMI), most frequently with primary psychotic disorders, with or without co-occurring SUD who are involved with the criminal justice system. Like Assertive Community Treatment teams, FACT teams provide client-focused, community-based services that are delivered by a multidisciplinary team. The LME/MCOs are allocated state funds to contract with and distribute funds to providers to oversee FACT teams. These services bridge the health and criminal justice systems and are aimed at[66]:

- Improving clients' mental health outcomes and daily functioning;
- Reducing recidivism by addressing criminogenic risks and needs;
- Diverting individuals in need of treatment away from the criminal justice system; and
- Managing costs by reducing reoccurring arrest, incarceration and hospitalization.

The **Priority Reentry Program** provides intensive care management and peer support services to individuals releasing from prison who have been diagnosed with a serious mental illness (SMI) and have either violent felony or sex offense history OR are prescribed Clozaril/Clozapine.

DAC social workers will make referrals to LME/MCOs care teams for the Priority Reentry Program prior to the member's release. The LME/MCOs provide many of the services directly (peer support, case management, linkages to services) and also ensures continuity of care for their members. These care teams provide individualized services and support, including:

- Peer support and case management services;
- Basic needs upon release (shelter/housing, food, clothing, transportation, cellular device, etc.);
- Referrals to and coordination of healthcare services such as mental health care (ACTT or other available services), SUD treatment (OTP, SAIOP, OBOT, etc.), medication management, primary care and dental care; and

[66] Substance Abuse and Mental Health Services Administration (SAMHSA), Forensic Assertive Community Treatment (FACT): A Service Delivery Model for Individuals With Serious Mental Illness Involved With the Criminal Justice System. https://library.samhsa.gov/sites/default/files/pep19-fact-br.pdf

- Linkage to care for social determinants of health resources including assistance applying for Medicaid and other benefits.

NC-FIT (Formerly Incarcerated Transition) Wellness Clinics serve individuals with serious mental illness who are releasing from incarceration to Wake, Durham, Orange and New Hanover Counties. Referrals are received from the Department of Adult Corrections or detention centers in the counties being served, with psychiatric and primary care beginning prior to release. Once released, individuals continue receiving these services in the community. Additional services provided include:

- Therapeutic services (cognitive behavioral therapy, dialectical behavioral therapy, etc.);
- Access to peer support services;
- Case management and care coordination;

Linkage to social determinants of health resources including transportation; and to/from appointments, food access, assistance securing shelter/housing and food access.

The Alcoholism and Chemical Dependency Program (ACDP) provides planning and implementation of SUD screenings, treatments and reintegration services through the Department of Adult Corrections (DAC).[67]

The ACDP includes:

- Comprehensive assessment and treatment planning with participant involvement;
- Use of Cognitive-Behavior interventions ... Change Thinking to Change Behavior;
- Effort to instill change through repetition, skill practice and role play;
- Use of a gender-specific standardized curriculum;
- Discharge planning and community coordination; and

Provision of regular and consistent clinical staff supervision and training.

[67] Alcoholism and Chemical Dependency Programs | NC DAC

Appendix G: Comparison of Recommended Care Management Interventions for SUD/OUD Against Existing Delivery Systems for Justice Involved Medicaid Beneficiaries

In addition to assessing North Carolina Medicaid's five delivery systems for compliance with Section 1.1(a), the Department also completed a detailed comparison of additional recommendations and best practice interventions for individuals with SUD/OUD[68]. Many of the interventions discussed broadly in this space are beyond the scope of care management and care coordination overseen by the NC Medicaid Population Health team and the Medicaid service offerings overseen by the NC Medicaid Benefits and Clinical Policy teams. However, there are several recommendations and best practices which are within the scope of care management and care coordination. See the "Care Management" and "Care Coordination" definitions within Appendix B for additional context.

The table below describes the results of the analysis for the interventions and best practices found that are within the scope of care management and care coordination across the North Carolina Medicaid delivery systems, including those which serve the justice involved population.

Table 9. Results of Assessment Based on Current Scope of Care Management / Care Coordination

Summary of Interventions within the Scope of Care Management / Care Coordination	Local Management Entity/Managed Care Organizations		
	Intervention Provided	Community Care of North Carolina	EBCI Tribal Option
Specialized Workforce – Connections to Peer Recovery Coaches/Peer Support Specialists	Intervention Provided Informally (See Table 2)	Intervention Provided	Intervention Partially Provided (See Table 3)
Specialized Workforce – Connections to Community Health Workers	Intervention Provided	Intervention Provided	Intervention Provided Informally (See Table 3)
Specialized Workforce – Connections to Mental Health Professionals such as Therapists & Psychiatrists	Intervention Provided	Intervention Provided	Intervention Provided

[68] The Commonwealth Fund, TRANSFORMING CARE Building Comprehensive Responses to the Opioid Crisis. Building Comprehensive Responses to the Opioid Crisis | Commonwealth Fund

Address Risk Factors and Provide Non-Medical Support – Connections to Health-Related Social Needs (Ex: Housing, Transportation, etc.)	Intervention Provided	Intervention Provided	Intervention Provided
Screen all Justice Involved Individuals for SUD and Mental Health Needs	Intervention Provided	Intervention Provided	Intervention Provided
Offer Medication-Assisted Treatment (MAT) to those with OUD and other Substance-Use Disorders	Intervention Provided	Intervention Provided	Intervention Provided
Utilize medical claims data to proactively identify members with/at risk for SUD	Intervention Provided	Intervention Provided	Intervention Provided
Coordinate with Law Enforcement, Medical Professionals and Community Agencies to identify and support members with/at risk for SUD	Intervention Available to Medicaid Beneficiaries (See Appendix F)	Intervention Available to Medicaid Beneficiaries (See Appendix F)	Intervention Available to Medicaid Beneficiaries (See Appendix F)