Tailored Care Management Provider Manual Addendum:
Healthy Opportunities Pilot Standard Terms & Conditions for AMH+s/CMAs
August 2023

Healthy Opportunities Pilot Standard Terms and Conditions between LME/MCOs offering both Tailored Plan and Prepaid Inpatient Health Plan (PIHP) products (hereafter referred to Tailored Plan / LME/MCO) and AMH+/CMAs Serving as a Designated Pilot Care Management Entities.

1. Background

The Department has implemented a statewide, standardized process to certify Advanced Medical Home practices (AMH+s) and Care Management Agencies (CMAs) to provide Tailored Care Management for eligible members enrolled in Tailored Plans and Local Management Entity/Managed Care Organizations (LME/MCOs). Refer to DHHS-Tailored Plan and DHHS- LME/MCO contracts for additional detail regarding Tailored Care Management requirements.

2. Scope

The scope of this Policy covers the agreement between the Tailored Plan / LME/MCO and AMH+/CMAs outlined below and in the DHHS-Tailored Plan /LME/MCO Contracts.

The scope of the terms below covers the agreement between the Tailored Plan / LME/MCO and AMH+/CMA serving as a Designated Pilot Care Management Entity.[1] As this is a pilot program, the Department will continually review and update entity requirements based on the on-the-ground experience of Designated Pilot Care Management Entities. To the extent an AMH+ practice or CMA contracts with a Clinically Integrated Network (CIN) or Other Partner, the AMH+ practice or CMA must ensure that the CIN or Other Partner meets all of the applicable Tailored Care Management and Pilot requirements for the functions and capabilities that the AMH+ practice or CMA has delegated to the CIN or Other Partner. Applicable Tailored Care Management and Pilot requirements are outlined below and in the DHHS-Tailored Plan / LME/MCO Contract.

Standard Terms and Conditions for Tailored Plan / LME/MCO Contracts with AMH+s/CMAs Participating in the Healthy Opportunities Pilot. The AMH+/CMA must:

General

- Conduct all Pilot-related responsibilities detailed in the Tailored Care Management Provider Manual Addendum: Healthy Opportunities Pilot Guidance for AMH+s/CMAs (hereafter, referred to as "the HOP Addendum").
- Be onboarded onto and utilize NCCARE360's Pilot-specific functionality for the Healthy Opportunities Pilot. The Department will cover the cost of NCCARE360 use for Medicaid members for functionality required by the Department.
- Follow any future DHHS-developed guidance documents or protocols related to the provision of Pilot-related care management.
- Adhere to requirements regarding the collection, storage, and exchange of information related to Pilot sensitive services (including but not limited to Interpersonal Violence-related services),

[1] A Designated Pilot Care Management Entity is a Designated Care Management Entity that is also assuming care management responsibilities related to the Healthy Opportunities Pilot.

as described in the *Interpersonal Violence-Related Healthy Opportunities Pilot (IPV)-Related Services: Conditions, Requirements, and Standards* attachment of the DHHS-Tailored Plan / LME/MCO contract. These include requirements to:
    - Provide training for staff with access to any Pilot data on handling IPV-related data;
    - Limit access to IPV-related data to those who have received IPV-related training and require access to IPV-related data; and
    - Require collection, documentation, review, and use of instructions about how and when to safely contact Pilot Members *[see Refer to and Confirm Delivery of Pilot Services sub-section below for more detail].*
- The Tailored Plan / LME/MCO is not permitted to add any additional oversight, monitoring, or reporting requirements above and beyond what is enumerated in these terms and conditions.

Identify Potentially Pilot-Eligible Members

- Assess potentially Pilot-eligible Members for Pilot program eligibility, including qualifying physical/behavioral qualifying criteria and social risk factor(s) (see Appendix in the HOP Addendum for eligibility criteria).
- Undertake best efforts to conduct outreach attempts to the Member within three business days, in accordance with the HOP Addendum upon receipt of a referral of a potentially Pilot-eligible member.
- Utilize the DHHS-standardized Social Determinants Of Health (SDOH) Screening Questions, other SDOH screenings, the Tailored Care Management Comprehensive Assessment, other evidence-based assessment tools, and findings from regular Tailored Care Management check-ins with members to identify Pilot-eligible individuals.
- Assess Members' Pilot eligibility during engagement into Tailored Care Management and/or in the course of delivering ongoing Tailored Care Management.

Assess Pilot Eligibility and Recommend Pilot Services

- Assess potentially Pilot-eligible members referred to the AMH+/CMA for Pilot eligibility assessment from external sources (e.g., the Tailored Plan / LME/MCO, provider, HSO) and members assigned to the AMH+/CMA that are currently engaged in Tailored Care Management, for qualifying criteria and recommend specific Pilot services.
- Use the Pilot Eligibility and Service Assessment (PESA) to document standardized information regarding Pilot eligibility and recommended services (see the HOP Addendum *Section III.B. Assessing Pilot Eligibility and Recommending Pilot Services*
- Complete the PESA for the initial Pilot eligibility assessment/service recommendations and anytime there is a change to a member's Pilot service needs or eligibility.
- Utilize NCCARE360 to transmit the enrollment and authorization request to the member's Tailored Plan / LME/MCO for service authorization.

Obtain Pilot Consent

- Obtain or verify all required consents from the member using the DHHS-standardized 'Consent Form for NC Medicaid Coverage of Healthy Opportunities Pilot Services' prior to the member being enrolled in the Pilot and receiving Pilot services and record consent in NCCARE360.

Refer to and Confirm Delivery of Pilot Services

- Upon Pilot enrollment, integrate Pilot care management activities into Tailored Care Management. For members who were not previously engaged in Tailored Care Management prior to Pilot enrollment, the AMH+/CMA will provide both Pilot care management and Tailored Care Management moving forward.
- Conduct outreach to the member about authorized Pilot services.
- Record during initial Pilot enrollment and adhere to in all subsequent outreach instructions about how and when to safely contact the member. These instructions should be applied for all members, informed by and specific to each member, and include information about the following:
    - Safe methods to contact (phone, text, email, letter),
    - Whether it is safe to leave a voicemail,
    - Safe days of the week and times to contact,
    - Whose contact information is recorded, if not the member's (i.e., a parent/guardian for minors, a relative or another individual helping to coordinate services), and
    - Additional information on how outreach to the member can be safely conducted (e.g., "when calling, please say you are from the library," or "Client requested to receive all Pilot communications from their HSO case manager, Mr. Bob Smith. Please contact the HSO case manager at XXX-XXX-XXXX to coordinate communications with the client.")
- Include in the member's Care Plan or Individual Support Plan (ISP) information on Pilot enrollment status, authorized Pilot services and Pilot-related needs.
- Make referrals for authorized Pilot services using NCCARE360 upon receiving Tailored Plan / LME/MCO authorization.
    - Tailored Plan / LME/MCOs will monitor receipt of invoices from Human Service Organizations (HSOs) to ensure that referrals are occurring and services are being delivered in a timely manner.
- Follow-up with the HSO (if the referral is not accepted) and elevate the issue to the appropriate Network Lead as required.
    - Network Leads will oversee HSO network performance across their Pilot region.
- Tailored Plan / LME/MCOs are not required to monitor HSO referral acceptance as HSO performance is predominately a Network Lead function.
- Once an HSO begins providing a Pilot service to a Pilot enrollee:
    - Track the status of a referral to an HSO to ensure that Pilot service delivery is initiated.
    - Coordinate with the HSO that accepted the referral in order to track the outcomes of authorized Pilot service(s) and to ensure Pilot service(s) are meeting the enrollee's needs, as needed.
    - Update the Pilot service delivery outcome(s) in the Pilot section of a member's Care Plan/ISP.
- In the event an HSO is terminated from the Pilot network or cannot fulfill Pilot services, the AMH+/CMA will be notified of the HSO's termination by the Network Lead. Following notice of an HSO's termination, The AMH+/CMA must:
    - Close the existing case with the suspended or terminated HSO and send a new referral for the remainder of the authorized or passthrough service period to another HSO to fulfill for Pilot enrollees currently receiving services through the HSO (i.e., HSO has accepted the referral and enrollee has an 'open case' in NCCARE360), or

    - Redirect the outstanding referral or generate a new referral to another HSO to fulfill for Pilot enrollees who have been referred to the HSO but have not yet received services (i.e., HSO has not accepted the referral).
- Pilot services are generally duplicative of services provided by congregate care and institutional settings (e.g., housing and food). Members residing or receiving care in a congregate or institutional setting do not meet Pilot eligibility criteria based on their access to services within the congregate or institutional setting.
    - Upon five (5) days of being notified that a Pilot-enrolled member has entered a stay in a congregate care or institutional setting, the AMH+/CMA must assess the need to continue, suspend, or terminate Pilot services.
        - If the stay is projected to be longer than 30 days, the AMH+/CMA should terminate Pilot services, and prior to discharge, reassess the member for Pilot eligibility and service needs.
        - For stays projected to be shorter than 30 days, the AMH+/CMA should determine which referrals should be closed out in NCCARE360 for the length of the stay. The AMH+/CMA should send new referrals using NCCARE360 to restart the services post-discharge (e.g., delivery of a healthy food box would no longer be needed and should be closed out for the duration of the stay, whereas telephonic-based housing case management may continue to benefit enrollee health, depending on the member's circumstances).
    - For those currently residing in congregate care or institutional settings, the AMH+/CMA may assess Pilot eligibility and service needs prior to discharge/transition so long as service delivery starts upon the return to the community.
    - Congregate/Institutional settings include the settings listed in the HOP Addendum [See Section *III.B5: Members Receiving Care in Congregate Care Settings]*:

Expedited Referral to Passthrough Services

- Identify potentially-Pilot eligible members that are currently in Tailored Care Management or who have been referred to the AMH+/CMA for a Pilot assessment, who would benefit from one of the passthrough services [See HOP Addendum *Section III.D: Expedited Referrals for Passthrough Pilot Services*.]
- Upon identification of a member who would benefit from a passthrough service, and once required consents are obtained, send the PESA to the Tailored Plan / LME/MCO recommending an additional duration of the service beyond the 30-day passthrough period, indicating that the member is provisionally enrolled in Pilot and pre-authorized to receive a Pilot service for passthrough period of 30-days.
- Upon identification of a member who would benefit from a passthrough service, refer the member to an HSO that delivers Pilot service for a passthrough period of 30-days, simultaneously with the transmittal of the PESA to the Tailored Plan / LME/MCO.
- If the member is deemed eligible by the Tailored Plan / LME/MCO for additional Pilot services beyond the 30-day passthrough period:
    - Generate a referral to the same HSO to deliver the remaining Pilot services past the initial 30-days.
    - Engage with the member to inform them that they are authorized to receive the full duration of the Pilot service.

- If the member is deemed ineligible by the Tailored Plan / LME/MCO for additional Pilot services beyond the 30-day passthrough period:
    - Do not issue another referral for the remaining Pilot services past the initial 30 days.
    - Engage with the member to inform them and direct them to other Pilot or non-Pilot services to meet their needs.

Reassess Pilot Service Mix Review and Eligibility

- Conduct a Pilot service mix review every 3 months and reassess Pilot eligibility every 6 months and update the status of the assessment within the member's PESA in NCCARE360 using the notes field.
- Identify Pilot enrollees requiring 3-month and 6-month reassessments and schedule and conduct the service mix review and/or eligibility reassessment in a manner that is aligned with the guidance provided in the HOP Addendum.
- Tailored Plan / LME/MCOs will review data collected in NCCARE360 to monitor requirements for Pilot service mix reviews and eligibility reassessment through spot audits of member PESAs but will not require additional reporting of AMH+/CMA.

Transitions between Designated Pilot Care Management Entities and and/or Health Plans

- Support transitions of care for Pilot enrollees as described in the HOP Addendum [See Section *III.J: Supporting Pilot-Enrolled Members Transitioning between Designated Pilot Care Management Entities and/or Health Plans.]*
- If a member experiences a transition of care scenario where they remain Pilot-eligible, the AMH+/CMA must:
    - Coordinate a timely warm handoff, or a transfer of care between Designated Pilot Care Management Entities for effective knowledge transfer or to ensure patient continuity of care with regards to Pilot services
    - Use the NCCARE360 functionality to send the new Tailored Plan / LME/MCO or Designated Pilot Care Management Entity a summary of services using a Transition of Care Referral Request [See Pilot Transition of Care Protocol for more detail.]
    - In the case that a referral for services has not yet been accepted by the HSO, the AMH+/CMA must close the case.
    - For services that were accepted by the HSO and not yet started, the AMH+/CMA must contact the HSO to close the case for the Pilot service.
- If a member experiences a transition of care scenario where they are no longer Pilot-eligible, the AMH+/CMA must disenroll the member from the Pilot, work with the HSO to close the case for the service(s), and coordinate with the HSO to ensure any pending Pilot services that were authorized and started at the time of Pilot enrollment are delivered, as described in the HOP Addendum [See Section *III.F: Discontinuation of Pilot Services and Disenrollment from Pilot*.

Discontinuation of Pilot Services

- If an AMH+/CMA identifies a Pilot service to be discontinued, it must:
    - Document the service(s) to be discontinued and rationale (e.g., if the service is no longer meeting the member's need) and notify the Tailored Plan / LME/MCO via NCCARE360.

- Close out any open referrals for the discontinued service(s) in NCCARE360 and communicate with HSO regarding enrollee status.
- Document discontinued service(s) and rationale for discontinuation in the Member's PESA within NCCARE360 and the member's Care Plan/ISP.
- Communicate with the member and provide transition support by identifying other Pilot and non-Pilot services and programs to meet ongoing needs.
- Continue to deliver Tailored Care Management.

Disenrollment from the Pilot

- Identify the following circumstances that result in Pilot-disenrollment:
  - The enrollee is no longer enrolled in Medicaid;
  - The enrollee has moved out of a Pilot region;
  - The enrollee is receiving duplicative services/programs that disqualify them from the Pilot (e.g., congregate/institutional settings);
  - Member wishes to opt out of the Pilot;
  - The enrollee has not been responsive for more than 6 months and has not responded to requests for the 3 month service mix review and the 6 month eligibility assessment; or
  - The enrollee transitions to another delivery system that has yet to launch the Pilot (i.e., transitions to the Tribal Option).
- Document information and rationale for Pilot disenrollment in the PESA and transmit it to the Tailored Plan / LME/MCO for verification.
- Upon receipt of the disenrollment decision from the Tailored Plan / LME/MCO:
  - Communicate with the member regarding the change(s) to Pilot services.
  - Close out any open referrals for the discontinued service(s) in NCCARE360 and communicate with HSO(s).
  - Inform the HSO of the date of disenrollment within ten (10) days of receiving this notification.
  - Coordinate with the HSO to ensure any Pilot services that were authorized and started at the time of Pilot enrollment or pending passthrough services are delivered to the member.
  - Document Tailored Plan / LME/MCO decision on Pilot disenrollment in the member's Care Plan/ISP.
  - Provide transition support by identifying non-Pilot services and programs to meet the needs of the member.
  - Continue to deliver Tailored Care Management.

Member and Provider Grievances

- If an AMH+/CMA has any grievances related to the Pilot, it may transmit those issues directly to the Tailored Plan / LME/MCO.
- If the AMH+/CMA is made aware of any Pilot-related member grievances, it will transmit them directly to the Tailored Plan / LME/MCO.
- Address member-related grievances routed by the Tailored Plan / LME/MCO in a timely manner, and document the action taken using standard member grievance documentation policies for non-Pilot issues.

Pilot Payments

- The Tailored Plan / LME/MCO shall receive funds from the Department and make the following Pilot payments to AMH+/CMA:
    - **Pilot Care Management Payments**:
        1. For each member enrolled in the Pilot, the Tailored Plan / LME/MCO shall pay AMH+s/CMAs serving as a Designated Pilot Care Management Entity an additional, DHHS-standardized, Pilot Care Management add-on payment, on top of existing monthly Tailored Care Management payments for each member that receives Tailored Care Management in that month.
        2. The Tailored Plan / LME/MCO shall use the Pilot Care Management add-on payment rate and payment approach outlined in the Healthy Opportunities Pilot Payment Protocol to pay AMH+s/CMAs for Pilot-related care management and is not permitted to negotiate rates. The Department reserves the right to modify this payment approach in the future, as needed and communicate any modifications through the Healthy Opportunities Pilot Payment Protocol.
    - To access the add-on payment for any given member enrolled in the Pilot, the AMH+ practice or CMA must deliver one qualifying Tailored Care Management contact during the month for that Pilot enrolled member (i.e., providers will not be paid for either Tailored Care Management or the Pilot in months in which there were no qualifying contacts). A contact made with a member related to the Pilot counts as a Tailored Care Management contact. The AMH+ practice or CMA must submit a claim to the Tailored Plan / LME/MCO, and the Tailored Plan / LME/MCO must pay the provider the monthly Tailored Care Management payment plus add-on payment after the month of service.

Tailored Plan / LME/MCO-Initiated Pilot Contract Termination

- The Tailored Plan / LME/MCO must terminate a Pilot-related portion of a contract if a provider loses its certification as an AMH+/CMA.
- The Tailored Plan / LME/MCO may terminate a Pilot-related contract with an AMH+/CMA with cause associated with Pilot-related performance.
    - The AMH+/CMA will continue to serve the member in the delivery of Tailored Care Management, so long as the member is assigned to the AMH+/CMA for Tailored Care Management.
- Prior to Pilot contract termination with cause related to Pilot performance, the Tailored Plan / LME/MCO must notify the AMH+/CMA of the underperformance issues and give the AMH+/CMA 90 business days to remedy any Pilot-related underperformance.
    - The AMH+/CMA must acknowledge receipt of the notice within three business days.
    - The AMH+/CMA must develop and submit a corrective action plan (CAP) to the Tailored Plan / LME/MCO within 15 business days of receiving notice of underperformance.
    - The AMH+/CMA must include in their CAP a “performance improvement plan” that clearly states the steps being taken to rectify underperformance.
- The Tailored Plan / LME/MCO must notify the Department of any Pilot underperformance within 45 business days of notifying the AMH+/CMA.
- If the Tailored Plan / LME/MCO moves forward with the termination of a Pilot contract because the AMH+/CMA does not remedy its underperformance issues after the 90 business days, the Tailored Plan / LME/MCO must provide written notice to the AMH+/CMA of the decision to terminate. The notice, at a minimum, must include:
    - The reason for the Tailored Plan / LME/MCO’s decision; and
    - The effective date of termination.

- The Tailored Plan / LME/MCO must also provide written notice to the Department regarding the termination of any Pilot-related contracts with an AMH+/CMA within 15 business days of notifying the AMH+/CMA. The notice must include, at a minimum:
    - The reason for the Tailored Plan / LME/MCO's decision;
    - Outcomes of any actions to address underperformance; and,
    - The effective date of termination.
- The Tailored Plan / LME/MCO must notify Unite Us of the terminated contract in order to be removed from the Pilot-related components of the NCCARE360 platform.
- For any terminated contracts, the Tailored Plan / LME/MCO must follow all requirements in the Pilot Transition of Care Protocol to ensure continuity of care for members, including providing Pilot care management to Pilot enrollees from AMH+/CMAs that lose their designation as a Designated Pilot Care Management Entity.

AMH+/CMA-Initiated Pilot Contract Termination

- AMH+/CMA may terminate a Pilot-related portion of a contract with a Tailored Plan / LME/MCO at any time.
    - AMH+/CMA must notify the Department and the Tailored Plan / LME/MCO of its intent to terminate the Pilot-related contract 45 business days before doing so.
    - For any terminated contracts, the Tailored Plan / LME/MCO must follow all requirements in the Pilot Transition of Care Protocol to ensure continuity of care for members, including providing Pilot care management to Pilot enrollees from AMH+/CMAs that lose their designation as a Designated Pilot Care Management Entity.
    - The AMH+/CMA will continue to serve the member in the delivery of Tailored Care Management, so long as the member is assigned to the AMH+/CMA for Tailored Care Management.
- AMH+/CMA must notify Unite Us of the terminated contract in order to be removed from the Pilot-related components of the NCCARE360 platform.
- AMH+/CMA must notify the Tailored Plan / LME/MCO of the end date of the Pilot-portion of its contract.
- AMH+/CMA must meet the data storage requirements outlined in the NC Provider Participation Agreement (Paragraph 7.a).