

Care Management under BH I/DD Tailored Plans: *Information for Providers*

August 29, 2019

Agenda

- **Background and Guiding Principles**
- **Tailored Care Management Model**
- **Becoming an AMH+ or CMA**
- **Statement of Interest Process**
- **Q & A**

Background and Guiding Principles

Context: Medicaid Transformation

- In 2015, the **NC General Assembly enacted Session Law 2015-245**, directing the transition of Medicaid and NC Health Choice from predominantly fee-for-service to managed care.
- Since then, the North Carolina Department of Health and Human Services (DHHS) has **collaborated extensively** with clinicians, hospitals, beneficiaries, counties, health plans, elected officials, advocates, and other stakeholders to shape the program, and is committed to ensuring Medicaid managed care plans:
 - Deliver **whole-person care** through coordinated physical health, behavioral health, intellectual/developmental disability and pharmacy products and care models
 - Address the **full set of factors** that impact health, uniting communities and health care systems
 - Perform **localized care management** at the site of care, in the home or community
 - Maintain broad **provider participation** by mitigating provider administrative burden

Standard Plans and BH I/DD Tailored Plans

Both Standard Plans and BH I/DD Tailored Plans will be integrated managed care products and will provide a robust set of physical health, behavioral health, long-term services and supports, and pharmacy benefits with a focus on whole-person care.

Standard Plans

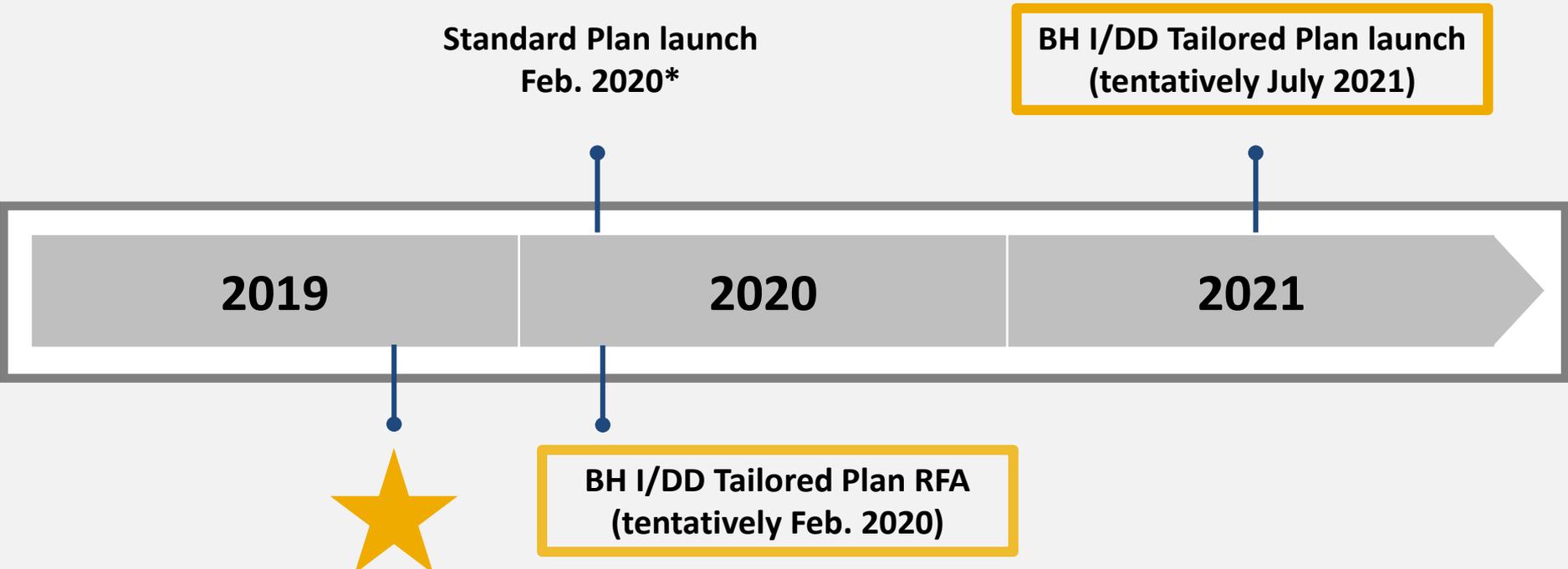
- Will serve the majority of the non-dual eligible Medicaid population

BH I/DD Tailored Plans

- Targeted toward populations with:
 - significant behavioral health conditions—including serious mental illness, serious emotional disturbance, and severe substance use disorders
 - intellectual and developmental disabilities (I/DD), and
 - traumatic brain injury (TBI)
- Will offer a more robust set of behavioral health and I/DD benefits than Standard Plans and will be the only plans to offer current 1915(b)(3), 1915(c) Innovations and TBI waiver, and State-funded services

BH I/DD Tailored Plan Timeline

The BH I/DD Tailored Plan Request for Applications (RFA) will be released in early 2020.



The provider certification process for Tailored Care Management will start this fall with the release of the Provider Manual and will occur simultaneously with the BH I/DD Tailored Plan procurement process.

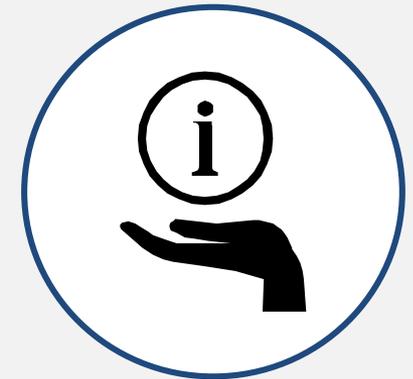
*State-wide Standard Plan launch of Feb. 2020 reflects the [DHHS announcement](#) on Sept. 3, 2019.

Tailored Care Management Model

Guiding Principles for Tailored Care Management

The Tailored Care Management model is a pathway to ensuring BH I/DD Tailored Plan beneficiaries have access to the best whole-person care possible.

- All BH I/DD Tailored Plan beneficiaries need integrated, whole-person care management.
- **Provider-based care management** promotes **integrated care** and offers beneficiaries **choice** in how they receive care management.*
- **Community-based care management** facilitates frequent **face-to-face** interaction between beneficiaries and their care managers, who will live and work in the same communities as the individuals they serve.
- All BH I/DD Tailored Plan beneficiaries should have access to **consistent, high-quality care management** regardless of geography or where their care manager is employed.



In May 2019, the Department released a [Concept Paper](#) and received stakeholder comments. The Department will capture final design decisions for BH I/DD Tailored Plan Year 1 in the BH I/DD Tailored Plan RFA and AMH+/CMA Provider Manual.

*Beneficiaries will be able to switch care managers at any time.

BH I/DD Tailored Care Management Model

Key Principle: Behavioral and physical health are integrated through the care team.

Overarching Principles

- Broad access to care management
- Single care manager taking an integrated, whole-person approach
- Person- and family-centered planning
- Provider-based care management
- Community-based care management
- Community inclusion
- Choice of care managers
- Consistency across the state
- Harness existing resources



Roles and Responsibilities of Care Managers

- Management of rare diseases and high-cost procedures
- Management of beneficiary needs during transitions of care
- High-risk care management
- Chronic care management
- Management of high-risk social environments
- Identification of beneficiaries in need of care management
- Development of care management assessments/care plans
- Development & deployment of prevention and population health programs
- Coordination of services

Three Approaches to Delivering Tailored Care Management

Department of Health and Human Services

Establishes care management standards for BH I/DD Tailored Plans aligning with federal Health Home requirements.

The BH I/DD Tailored Plan will act as the Health Home and will be responsible for meeting federal Health Home requirements

**BH I/DD Tailored Plan
(Health Home)**

Care Management Approaches

BH I/DD Tailored Plan beneficiaries will have the opportunity to choose among the care management approaches; all must meet the Department's standards and be provided in the community to the maximum extent possible.

Approach 1:
“AMH+” Primary Care Practice
Practices must be certified by the Department to provide Tailored Care Management.
APPLICABLE FOR PROVIDERS

Approach 2:
Care Management Agency (CMA)
Organizations eligible for certification by the Department as CMAs include those that provide BH or I/DD services.

Approach 3:
**BH I/DD Tailored Plan-
Employed Care Manager**

The Department will allow – but not require—CMAs and AMH+ practices to work with a **CIN or other partner** to assist with the requirements of the Tailored Care Management model, within the Department's guidelines.

Glide Path to Provider-based Care Management

Tailored Care Management will require a multiyear effort to enhance the workforce at the AMH+ and CMA level. The Department will establish a “glide path” to guide the growth of provider-based capacity.

$$\begin{array}{l}
 \text{Numerator:} \\
 \text{Denominator:}
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 \frac{\text{Number of enrollees actively engaged in care management and served by care managers based in CMAs/AMH+ practices}}{\text{Total number of beneficiaries actively engaged in care management}} \times 100 = X\%$$

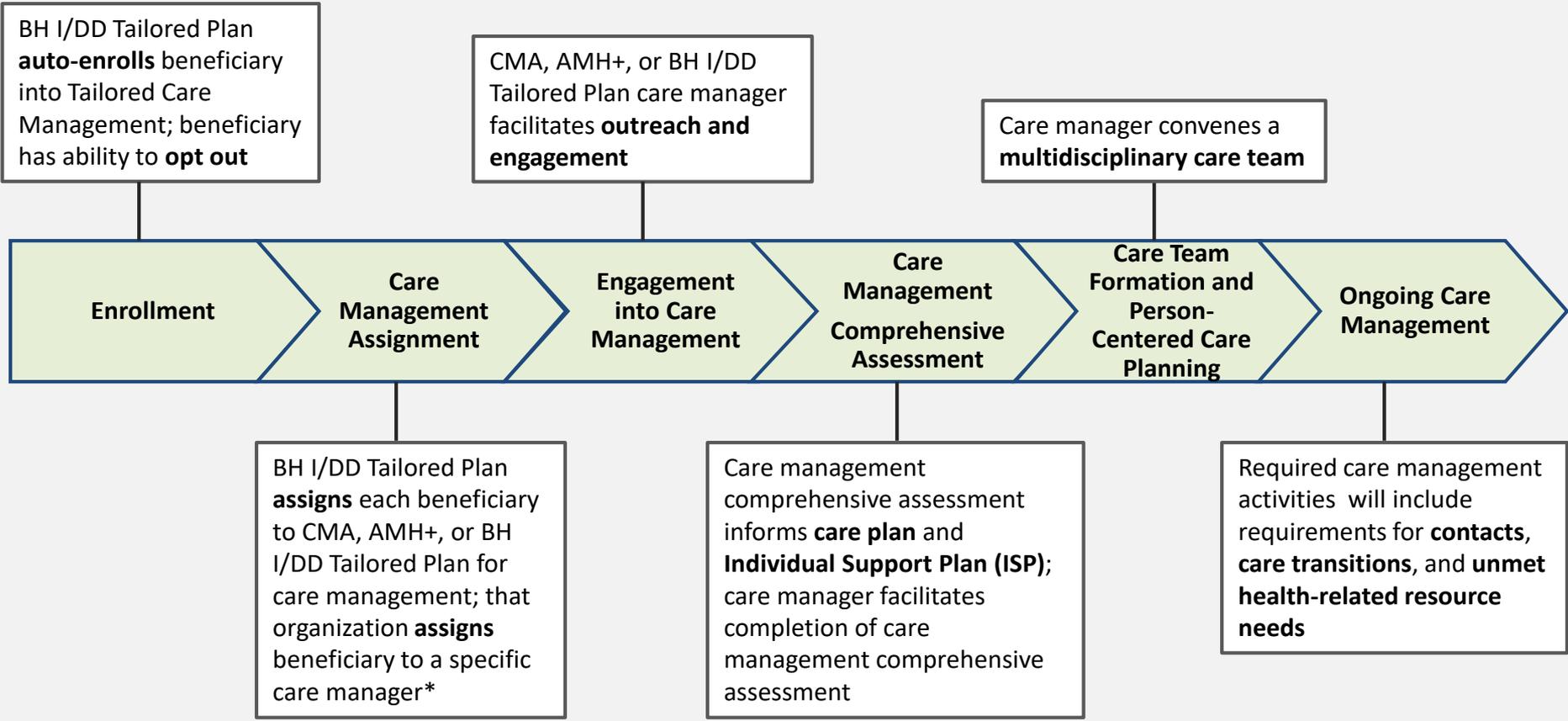
Department will compare X to annual targets:

	Year 0 (May 2020)	Year 1 (Mid 2021)	Year 2 (Mid 2022)	Year 3 (Mid 2023)	Year 4 (Mid 2024)
Target percentage of beneficiaries served by care managers/supervisors based in CMA/AMH+	N/A	Target 1	Target 2	Target 3	Target 4 = 80%

The Department believes that provider- and community-based care management is critical to the success of fully integrated managed care.

Care Management Process Flow

Care management design aligns with Standard Plan requirements to the greatest extent possible, but in several areas the Department is building special guardrails to meet the unique needs of the BH I/DD Tailored Plan population.



*Innovations and TBI waiver beneficiaries will have the choice of keeping their current care coordinators if the care coordinators meet all of the care manager requirements to serve BH I/DD Tailored Plan beneficiaries and federal requirements for conflict-free case management.

Care Team Qualifications

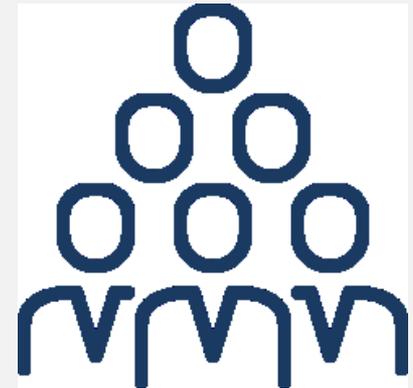
Position	Minimum Qualifications
<i>Care managers serving all beneficiaries</i>	<ul style="list-style-type: none"> ▪ Bachelor’s degree in a field related to health, psychology, sociology, social work, nursing or another relevant human services area ▪ Two years of experience working directly with individuals with behavioral health conditions (if serving beneficiaries with behavioral health needs) or with I/DD or TBI (if serving beneficiaries with I/DD or TBI needs) ▪ (Best practice, but not required) For care managers serving beneficiaries with LTSS needs: two years of prior LTSS and/or HCBS coordination; care delivery monitoring and care management experience; and background in social work, geriatrics, gerontology, pediatrics or human services, in addition to the requirements cited above
<i>Supervising care managers serving beneficiaries with behavioral health disorders</i>	<ul style="list-style-type: none"> ▪ A Licensed Clinical Social Worker (LCSW) or Licensed Professional Counselor (LPC), or a licensed nurse with a Bachelor of Science in Nursing (BSN) ▪ Three years of supervisory experience working directly with complex individuals with a behavioral health condition
<i>Supervising care managers serving beneficiaries with I/DD or TBI</i>	<ul style="list-style-type: none"> ▪ Bachelor’s degree in a human services field, and ▪ Five years of supervisory experience working directly with complex individuals with I/DD or TBI ▪ Or, a master’s degree in a human services field with three years of supervisory experience working directly with complex individuals with I/DD or TBI

Acuity Tiering and Contact Requirements

The Department plans to establish a standardized methodology for determining acuity of each beneficiary based on claims history.

Acuity Tiers

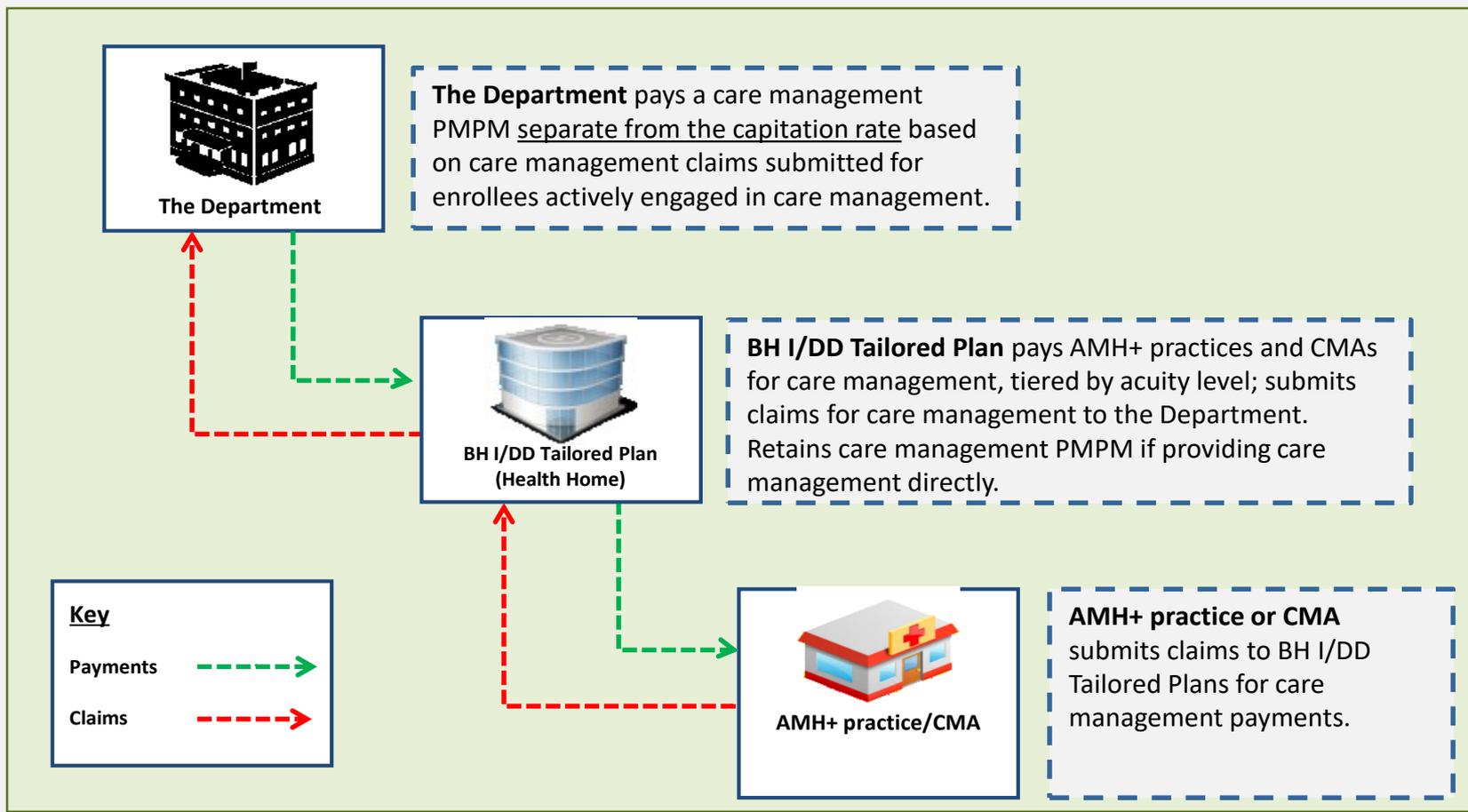
- Beneficiaries will be placed into high, moderate, or low acuity tiers
- Acuity tiers will be used to guide payment levels
- Acuity tiers will also be used to guide minimum required levels of contact between care managers and beneficiaries
 - *As market experience with the model grows, the Department may transition away from these contact requirements to increase the focus on outcomes, to the extent allowed by federal Health Home requirements*



In recognition of the complex needs of the BH I/DD Tailored Plan population, the Department will also require that care managers and supervisors serving this population possess a **minimum set of qualifications**.

Payment for Care Management

Tailored Care Management payments will be subject to set minimum rates that are tiered by beneficiary acuity and, generally, *significantly higher* than Standard Plan care management rates.



Quality

BH I/DD Tailored Plans will be required to report measures that assess whole-person outcomes.

Federal Health Home Quality Measures

- Adult Body Mass Index (BMI) Assessment
- Prevention Quality Indicator (PQI) 92: Chronic Condition Composite
- Care Transition – Transition Record Transmitted to Health Care Professional
- Follow-Up After Hospitalization for Mental Illness
- Plan All-Cause Readmission Rate
- Screening for Clinical Depression and Follow-Up Plan
- Initiation and Engagement of Alcohol or Other Drug (AOD) Dependence Treatment
- Controlling High Blood Pressure

Measures additional to the above federally-required set will be forthcoming.

Data and Health Information Technology

The Department will establish minimum requirements for HIT and data sharing.

IT Capabilities Supporting Care Management

- Manage population health
- Respond to individual beneficiary needs
- Track referrals and follow-ups
- Monitor medication adherence
- Respond to unmet health-related resource needs
- Document and store beneficiary care plans/ISPs
- Facilitate “warm hand-offs” of beneficiaries between plans, care managers, and care settings, as needed
- Interface with NCCARE360



The Department will work with BH I/DD Tailored Plans, AMH+ practices, and CMAs after contracts are awarded to develop consensus around specific data formats, contents, triggers, and transmission methods for critical data exchanges.

Becoming an AMH+ or CMA

Summary: AMH+/CMA Certification Process

To be certified as an AMH+/CMA a provider must:

- Meet eligibility definitions
- Show appropriate organizational standing or expertise
- Show appropriate staffing
- Demonstrate the ability to deliver all the required elements of whole-person, multidisciplinary, integrated care management
- Meet HIT and Population Health Data Requirements
- Participate in required training (after initial certification)



Eligibility



Advanced Medical Home Plus (AMH+)

Definition: Primary care practice certified by the Department as an AMH Tier 3 that has **experience delivering primary care services to the BH I/DD Tailored Plan eligible population in North Carolina, or can otherwise demonstrate strong competency to serve that population**, and will hold primary responsibility for providing integrated, whole-person care management under the Tailored Care Management model. Details on AMH Tier 3 attestation can be found in the [AMH Provider Manual](#).

To be eligible to become an AMH+, the practice must intend to become a network primary care provider for BH I/DD Tailored Plans.



Care Management Agency (CMA)

Definition: Provider organization with **experience delivering behavioral health, I/DD and/or TBI services** to the BH I/DD Tailored Plan eligible population in North Carolina that will hold primary responsibility for providing integrated, whole-person care management under the Tailored Care Management model.

To be eligible to become a CMA, an organization must have as its **primary purpose the delivery of NC Medicaid, NC Health Choice or state-funded services**, other than care management, to the BH I/DD Tailored Plan eligible population in North Carolina.

What is a CIN/Other Partner?

A “CINs or Other Partner” is an organization with which an AMH+ or CMA may be affiliated, that helps the AMH+ or CMA meet the requirements of the model. The AMH model under Standard Plans already incorporates CINs/Other Partners.

How can CINs/Other Partners Serve AMH+s/CMAs?

- Providing **local care management** staffing, functions and services
 - Supporting **AMH analytics and data integration** from multiple PHPs and other sources, and providing actionable reports to AMH+s/CMAs
 - **Assisting in the contracting process or directly contracting with BH I/DD Tailored Plans** on behalf of AMH+s/CMAs
- CINs/other partners may include hospitals, health systems, integrated delivery networks, IPAs, care management organizations and technology vendors
 - **The Department is considering adding guardrails around care management staff organized at the CIN/Other Partner level:**
 - Majority of membership/board must be providers
 - AMH+ or CMA must have managerial control of staff

AMH+/CMA Certification Process

The CMA certification process will be designed to ensure that DHHS can obtain a comprehensive view of each organization’s ability to provide care management .

Date	Action
Fall 2019	DHHS publishes CMA manual containing full certification requirements and application questions
~ January 2020	DHHS opens online application for providers
Throughout 2020	DHHS conducts onsite reviews and grants provisional certification to organizations
May 2020– April 2021	BH I/DD Tailored Plans contract with provisionally certified CMAs/AMHs for HH care management
By April 2021, 90 days before go-live	Final certification of CMAs and AMH+s
July 2021	BH I/DD Tailored Plan launch

Provisional certification will begin a year before launch to allow AMH+s/ CMAs to prepare for the role

Forthcoming Statement of Interest Process

The Department will publish a non binding Statement of Interest to understand provider interest in Tailored Care Management as well as to ensure that questions are adequately covered in the forthcoming Manual.

The Statement of Interest will ask potential AMH+s and CMAs to provide:

- Location/region
- Experience/expertise (I/DD, Behavioral Health/SUD or both)
- Anticipated patient/client volume
- Questions for the Department

Q & A