



**Tailored Care Management
Questions and Answers**
February 2, 2021

AMH+ and CMA Eligibility

1. What is the difference between an AMH+ and a CMA?

Advanced Medical Home Plus (AMH+) practices will be primary care practices actively serving as AMH Tier 3 practices,¹ whose providers have experience delivering primary care services to the BH I/DD Tailored Plan eligible population or can otherwise demonstrate strong competency to serve that population. To demonstrate experience and a competency to serve the BH I/DD Tailored Plan eligible population, each AMH+ applicant must attest that it has a patient panel with at least 100 active Medicaid patients who have an SMI, SED, or severe SUD; an I/DD; or a TBI. “Active” patients are those with at least two visits with the AMH+ applicant’s practice team in the past 18 months. AMH+ practices will hold primary responsibility for providing integrated, whole-person care management under the Tailored Care Management model. AMH+ practices may, but are not required to, offer integrated primary care and behavioral health or I/DD services. To be eligible to become an AMH+, the practice must intend to become a network primary care provider for BH I/DD Tailored Plans. While the Department expects only a minority of AMH Tier 3 practices to be ready to obtain certification as AMH+ practices at BH I/DD Tailored Plan launch, the Department’s vision is that the Tailored Care Management model will stimulate integration of Tailored Care Management within primary care practices over time.

Care Management Agencies (CMAs) will be provider organizations with experience delivering behavioral health, I/DD, and/or TBI services to the BH I/DD Tailored Plan eligible population, 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’s primary purpose at the time of certification must be 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. The “CMA” designation is new and will be unique to providers serving the BH I/DD Tailored Plan population.

The bullets below provide illustrative examples of considerations that will be taken into account to determine whether a CMA applicant’s primary purpose meets the requirement above; these bullets are not all inclusive:

- Years of experience (e.g., two years);
- Revenue breakdown (e.g., 20-30% of total revenue is from behavioral health, I/DD, and/or TBI services provided to Medicaid beneficiaries or uninsured individuals); and/or
- Provision of behavioral health, I/DD, and/or TBI services, besides those covered in NC Medicaid Clinical Coverage Policies 8C and 8B, to the BH I/DD Tailored Plan eligible population is integral to the organization’s mission.

¹ To be eligible as an AMH+, a practice must be actively serving as an AMH Tier 3 for the purposes of Standard Plans, when Standard Plans launch. In the period prior to Standard Plan launch, to apply for AMH+ certification, the practice must have successfully attested into Tier 3 and be intending to contract with Standard Plans as a Tier 3 practice. See AMH Provider Manual for information on how to enroll as an AMH Tier 3.

2. **What does “active” mean in the requirement for AMH+ practices to serve at least 100 active Medicaid patients who have an SMI, SED, or severe SUD; an I/DD; or a TBI?**

“Active” patients are those with at least two visits with the AMH+ applicant’s practice team in the past 18 months.

3. **To be eligible to become a CMA, does care management have to be the primary focus of the organization? If my organization currently provides only care management services (no other services) to the BH I/DD Tailored Plan population, are we eligible to be a CMA?**

No. To be eligible to become a CMA, an organization’s primary purpose at the time of certification must be 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.

4. **My organization currently provides Medicaid, Innovations waiver, TBI waiver, 1915(b)(3) waiver, and/or State-funded services to populations that will be served under BH/I DD Tailored Plans (e.g., partial hospitalization services, opioid treatment services, financial management services, day support services). We currently submit claims for these services through our LME/MCO. Do we need to apply as a CMA to continue to provide these same services under the BH/I DD Tailored Plans?**

No. Your organization is not required to apply to become a CMA to provide Medicaid, Innovations waiver, TBI waiver, 1915(b)(3) waiver, and/or State-funded services under BH I/DD Tailored Plans. However, your organization will need to contract with a BH I/DD Tailored Plan instead of an LME/MCO effective July 2022 to continue to obtain reimbursement for these services.

Separately, if your organization desires to provide Tailored Care Management to the BH I/DD Tailored Plan population and meets the eligibility criteria to become an AMH+ or CMA, it will be required to apply for certification to become an AMH+ or CMA. For AMH+ and CMA eligibility criteria, see question #1.

5. **Can a provider offer Tailored Care Management and be an HCBS service provider for the same member? For example, can a provider currently serving individuals as a day program for I/DD also offer Tailored Care Management to the same individuals?**

Organizations that currently provide Innovations, TBI, or 1915(b)(3) waiver services cannot provide both Tailored Care Management and a waiver service to the same member. These organizations can only provide Tailored Care Management to beneficiaries who are not obtaining waiver services through that organization. The Department intends to release additional guidance for BH I/DD Tailored Plans and providers on conflict-free care management requirements.

AMH+ and CMA Applications

6. **Will providers that previously submitted applications for AMH+ or CMA certification have to resubmit a new application?**

Yes. Providers that previously submitted applications for AMH+ or CMA certification must resubmit their application. Previously submitted applications will not be evaluated for certification decisions.

7. **Will Tier 3 AMHs have to resubmit Tier 3 attestation to become part of the BH I/DD Tailored Plan contracted network?**

No, the process for a primary care practice to attest as a Tier 3 AMH is not changing. Practices seeking to become a Tier 3 AMH should continue using NC Tracks to attest to Tier 3 AMH practice

requirements. BH I/DD Tailored Plans will contract with Tier 3 AMH practices to act as primary care providers in their networks.

Current Tier 3 AMH practices interested in delivering Tailored Care Management will need to submit an application to the Department to become certified as AMH+ practices, as specified in the Tailored Care Management Provider Manual.

Tier 3 AMHs that are not certified as AMH+ practices can serve as primary care providers in BH I/DD Tailored Plan networks without resubmitting Tier 3 attestation.

Clinically Integrated Networks (CINs) and Other Partners

8. What is a CIN, and how do I know if I'm in one?

Clinically Integrated Networks (CINs) or Other Partners are entities with which provider practices choose to partner to share responsibility for specific functions and capabilities required to operate as an AMH+ practice or a CMA. Examples of functions and capabilities for which CINs or Other Partners may assume responsibility include data aggregation, risk stratification, and care management staffing, as long as the AMH+ or CMA maintains managerial control of care management staff.² CINs or Other Partners may include hospitals, health systems, integrated delivery networks, independent practice associations (IPAs), other provider-based networks and associations.

Provider organizations choose whether to sign a formal agreement with a CIN; the Department does not require provider organizations to contract with or join a CIN.

9. If I'm in a CIN, do I automatically qualify as an AMH+ or CMA, and does the CIN do all that work for us?

No. The Department will allow AMH+ practices and CMAs to work with CINs and Other Partners for specific functions and capabilities to meet certification requirements. However, the Department will certify individual provider organizations, not CINs or Other Partners, as AMH+ practices and CMAs. AMH+ practices and CMAs are ultimately responsible for ensuring that services provided to members by the CIN or Other Partner are in alignment with the Tailored Care Management requirements.

While every organization applying to become an AMH+ or CMA must individually complete the questions identified as "AMH+ and CMA Questions" on the Tailored Care Management certification application form, the Department has allowed a pathway for CINs or Other Partners to answer certain application questions via the "CIN or Other Partner Supplement." Provider organizations choosing to have a CIN support their application must submit both the "AMH+ and CMA Questions" and the "CIN or Other Partner Supplement" together to the Department as a unified, provider-specific application.

10. What if I'm in more than one CIN?

The Department will certify individual provider organizations, not CINs or Other Partners, as AMH+ practices and CMAs. Therefore, AMH+ practices and CMAs may partner with more than one CIN or

² Certification will include an evaluation of whether the AMH+ or CMA has managerial control of care management staff, defined as the opportunity, at minimum, to a) approve hiring/placement of a care manager and b) require a replacement for any care manager whose performance the AMH+ or CMA deems unsatisfactory.

Other Partner, as needed, to support the Tailored Care Management model. AMH+ practices and CMAs are ultimately responsible for ensuring that services provided to members by the CIN or Other Partner are in alignment with the Tailored Care Management model. AMH+ practices and CMAs contracting with a CIN or Other Partner should clearly lay out the CIN or Other Partner's roles and responsibilities for each partner.

11. Can you provide a list of established CINs in North Carolina?

The Department does not maintain an exhaustive list or endorse any CINs in North Carolina.

Health Information Technology (IT) and Data Strategy

12. If we don't use an EHR currently to provide Innovation services, do we need to acquire one prior to applying?

Provider organizations must have an EHR in place at the time of application to obtain certification as an AMH+ practice or CMA.

13. Will EHRs be required to have functionality to directly engage with patients?

No. While all care managers must have access to an EHR and care management data system, the Department is not requiring organizations providing Tailored Care Management to engage members directly using these platforms. However, all providers will still be expected to meet federal interoperability and information sharing requirements, as stipulated by CMS and the Office of National Coordinator for HIT (ONC), and as applicable to their organization.

14. Are there any specific data or technology requirements?

Yes. Provider organizations applying to obtain certification as an AMH+ practice or CMA must have an EHR in place at the time of application. In addition, certified AMH+ practices and CMAs must have a care management data system, which may comprise EHRs and/or separate care management platforms, in place prior to Tailored Care Management launch that has the ability to:

- I. Maintain up-to-date documentation of members enrolled in Tailored Care
- II. Assign members to care managers
- III. Electronically document and store the care management comprehensive assessment and re-assessment
- IV. Electronically document and store Care Plans and ISPs
- V. Consume claims and encounter data
- VI. Provide role-based access to members of the multidisciplinary care team
- VII. Electronically and securely transmit (at minimum) the care management comprehensive assessment, Care Plan or ISP and reports/summaries of care to each member of the multidisciplinary care team to support case conferences
- VIII. Track care management encounters electronically, including date and time of each attempted encounter, method of attempt (in-person, telephonic), personnel involved, and whether the attempt was successful
- IX. Track referrals
- X. Allow care managers to:
 - i. Identify risk factors for individual members
 - ii. Develop actionable Care Plans and ISPs
 - iii. Monitor and quickly respond to changes in a member's health status
- XI. Track a member's referrals and provide alerts where care gaps occur
- XII. Monitor a member's medication adherence

AMH+ practices and CMAs must have access to admission, discharge, transfer (ADT) data that correctly identifies when attributed members are admitted, discharged, or transferred to or from an ED or a hospital in real time or near-real time. AMH+ practices and CMAs will also be expected to use NCCARE360 once certified as fully functional statewide to identify community-based resources and connect members to such resources.

The Department recognizes that the requirements will represent a significant change for many behavioral health, I/DD, and TBI providers in particular. Therefore, the Department will allow a range of options for AMH+ practices and CMAs to meet the requirements. Some AMH+ practices and CMAs will choose to meet health IT criteria by partnering with a CIN or Other Partner. The AMH+ or CMA may choose to use the BH I/DD Tailored Plan's care management data system as an alternative to building or maintaining its own or working with a CIN or Other Partner.

More information on data and technology requirements are included in the BH I/DD Provider Manual and BH I/DD Tailored Plan RFA.

15. Will there be a separate session focused on addressing questions related to the security requirements for providers to be a CMA?

The Department will consider whether to hold a separate webinar on Tailored Care Management data/IT/security requirements.

Financial Capability, Rates, Capacity Building

16. Will there be allowances on the financial capability question of the AMH+/CMA application given that many providers have been financially impacted by COVID-19?

The Department will look for evidence that applicants have the capacity and financial sustainability to establish care management as an ongoing line of business, as evidenced by the most recently completed audited financial statement containing the audit year and prior year information. The organization should also provide 2020 fiscal year draft statements if the audited statement has not been completed. Applicants that feel the current financial statements do not fully and accurately describe the organization's long-term sustainability may accompany the financial statements with a narrative explaining the financial impact of COVID-19 on the organization, including its impact on cash flow, accounts payable and accounts receivable, indebtedness, and budget projections of the following two fiscal years.

17. Will the Department restrict or cap the administrative rate that BH I/DD Tailored Plans will be allowed to retain from the Tailored Care Management payments they receive from the state?

The BH I/DD Tailored Plan capitation rate accounts for the cost of administering the Tailored Care Management model. The BH I/DD Tailored Plan capitation payment is separate from payments for delivering Tailored Care Management; payments for delivering Tailored Care Management will be outside of the BH I/DD Tailored Plan capitation rate.

In cases where an AMH+ practice or CMA is providing Tailored Care Management to a member, the BH I/DD Tailored Plan will be required to pass down the entire Tailored Care Management payment to the AMH+ practice or CMA and will not be permitted to retain any of that payment to account for administrative costs. In cases where a BH I/DD Tailored Plan is providing Tailored Care Management to a member, the BH I/DD Tailored Plan will retain the Tailored Care Management payment.

18. Could you share more about the acuity tiers for Tailored Care Management?

The Department will define the criteria for high, moderate, and low BH I/DD Tailored Care Management acuity levels and establish a standardized methodology for assigning each BH I/DD Tailored Plan member to an acuity tier. The Department will share this information before BH I/DD Tailored Plan launch.

19. Do we have the population totals for each tier mentioned for the PMPMs?

The Department will share additional information about acuity tiers prior to BH I/DD Tailored Plan launch. BH I/DD Tailored Plans will share acuity tiering results with AMH+ practices and CMAs for every assigned member and will share any changes to a member's acuity tier assignment.

20. Are the rates in the RFA finalized?

No. Final capitation rates and Tailored Care Management payment rates will be released as part of an updated rate book in early 2022 prior to BH I/DD Tailored Plan launch.

21. Is there a timeline you can share by which providers can expect to receive information about the capacity building funding that will be made available?

The Department anticipates releasing additional information on capacity building by June 2021.

Oversight

22. How will the Department ensure that Tailored Care Management is provided in a standardized, high quality way statewide across the various BH I/DD Tailored Plans and the regions they serve?

The Department has taken various steps to ensure the Tailored Care Management model is deployed consistently and in a high-quality manner across the state. These efforts include:

- Developing a robust set of requirements for Tailored Care Management, as specified in the BH I/DD Tailored Plan RFA and Tailored Care Management Provider Manual.
- Designing and overseeing the AMH+ practice and CMA certification process prior to BH I/DD Tailored Plan launch.
- Requiring BH I/DD Tailored Plans to submit for Departmental approval a Tailored Care Management training program that includes the training domains set by the Department.
- Developing a standardized payment methodology for payments for Tailored Care Management, including payments to BH I/DD Tailored Plans and payments from BH I/DD Tailored Plans to AMH+ practices and CMAs.
- Setting robust reporting requirements for BH I/DD Tailored Plans.

23. What role will BH I/DD Tailored Plans have in monitoring AMH+ practices and CMAs?

The BH I/DD Tailored Plan will be responsible for ensuring that AMH+ practices and CMAs are meeting the requirements of the Tailored Care Management model as specified in the BH I/DD Tailored Plan RFA. If the BH I/DD Tailored Plan contracts directly with a CIN or Other Partner that is acting on behalf of an AMH+ practice or CMA, the BH I/DD Tailored Plan shall monitor the CIN or Other Partner directly. BH I/DD Tailored Plans will be required to report quarterly to the Department on their contracts with AMH+ practices and CMAs, including naming the providers that are out of compliance with Tailored Care Management requirements and those that have remediated identified issues. In addition, BH I/DD Tailored Plans will be required to notify the Department within 14 days if a specific AMH+ practice or CMA is not meeting Tailored Care Management requirements.

Care Management Staffing

24. Does a care manager have to be employed by an AMH+ practice or CMA?

Care managers can be employed by a BH I/DD Tailored Plan, AMH+ practice or CMA, or by a CIN or Other Partner acting on behalf of an AMH+ practice or CMA.

25. There was a caseload number; is that still the case?

There are no caseload requirements for Tailored Care Management. Instead, there are minimum contact requirements for how often a care manager must be in contact with a member.

26. Will AMH+ practices and CMAs receive Tailored Care Management training for their staff by the BH I/DD Tailored Plans or will each AMH+ and CMA provide independent staff training?

BH I/DD Tailored Plans will be responsible for training all care managers according to requirements in the BH I/DD Tailored Plan RFA, whether the care manager is based at the BH I/DD Tailored Plan, AMH+, or CMA.

General – Tailored Care Management Model

27. The glide path to provider-based care management requires that 30% of Tailored Care Management be provider-based in the first year of BH I/DD Tailored Plans. How will the Department ensure sustainability for providers at only 30% of the population in the first year?

The Department will have various mechanisms in place to monitor that BH I/DD Tailored Plans are actively working increase provider-based care management and ensure that AMH+ practices and CMAs have a sufficient population in the early years of BH I/DD Tailored Plans to start and maintain operations:

- BH I/DD Tailored Plans will be required to contract with all AMH+ practices and CMAs certified to provide Tailored Care Management.
- The 30% target for provider-based care management in the first year of BH I/DD Tailored Plans is a floor, not a ceiling, and if there is capacity in a BH I/DD Tailored Plan's network for more than 30% of Tailored Care Management to be provider-based, the BH I/DD Tailored Plan is expected to take advantage of that capacity and assign a greater proportion of members to provider-based care management at an AMH+ practice or CMA in order to create a sustainable panel for AMH+ practices and CMA.
- The BH I/DD Tailored Plan RFA provides factors that BH I/DD Tailored Plans must consider when assigning members to a care management approach. For example, BH I/DD Tailored Plans will be required to take into account the member's existing provider relationships at an AMH+ practice or a CMA within the BH I/DD Tailored Plan's network and give preference to that provider when making a Tailored Care Management assignment unless there is a specific cause not to do so, including in instances of conflict of interest for Innovations and TBI waiver enrollees.
- BH I/DD Tailored Plans will be required to submit for Departmental approval their methodology for assigning eligible members to Tailored Care Management as well as a plan for supporting the development of provider-based care management.
- BH I/DD Tailored Plans will be required to assign each AMH+ and CMA a justifiably sized population that allows and incentivizes the AMH+ practice or CMA to substantially engage in the Tailored Care Management model.
- The Department will require BH I/DD Tailored Plans to submit a quarterly report on the percentage of members actively engaged in Tailored Care Management that are receiving

care management through a provider-based care management approach (i.e., care management through an AMH+ or CMA).

- Beginning in the second contract year, BH I/DD Tailored Plans that do not meet the annual targets for provider-based care management will be subject to a liquidated damage of up to \$100,000 for each percentage point below the requirement.

28. Please explain how behavioral health and I/DD services will be handled during the transition period between July 2021 and July 2022. Being able to operationalize processes that will distinguish between what our contracted Medicaid PHPs are responsible for handling and what our contracted LME/MCOs are responsible for handling is critically important.

Between the launch of Standard Plans in July 2021 and BH I/DD Tailored Plans in July 2022, behavioral health and I/DD providers will retain their contracts with LME/MCOs to serve Medicaid beneficiaries who do not enroll in Standard Plans. These beneficiaries include, but are not limited to, beneficiaries who will enroll in BH I/DD Tailored Plans and the Statewide Children in Foster Care (CFC) Plan and dual eligibles. Behavioral health and I/DD providers that offer services covered by Standard Plans are encouraged to contract with Standard Plans during this period and ongoing. The list of behavioral health and I/DD services covered by Standard Plans is below, alongside the list of services that will be unique to the LME/MCOs prior to BH I/DD Tailored Plan launch.³

Behavioral Health Services Covered in Standard Plans and BH I/DD Tailored Plans	
BH, I/DD, and TBI Services Covered by <u>Both</u> Standard Plans and BH I/DD Tailored Plans	BH, I/DD and TBI Services Covered by Only LME/MCOs Prior To BH I/DD Tailored Plan Launch (These services will later be covered by BH I/DD Tailored Plans, but will not be covered by Standard Plans)
Enhanced BH services are <i>italicized</i>	
<p>State Plan BH and I/DD Services</p> <ul style="list-style-type: none"> • Inpatient BH services • Outpatient BH emergency room services • Outpatient BH services provided by direct-enrolled providers • Psychological services in health departments and school-based health centers sponsored by health departments • Peer supports • <i>Partial hospitalization</i> • <i>Mobile crisis management</i> • <i>Facility-based crisis services for children and adolescents</i> 	<p>State Plan BH and I/DD Services</p> <ul style="list-style-type: none"> • Residential treatment facility services • <i>Child and adolescent day treatment services</i> • <i>Intensive in-home services</i> • <i>Multi-systemic therapy services</i> • Psychiatric residential treatment facilities (PRTFs) • <i>Assertive community treatment (ACT)</i> • <i>Community support team (CST)</i>⁵ • <i>Psychosocial rehabilitation</i> • <i>Substance abuse non-medical community residential treatment</i> • <i>Substance abuse medically monitored residential treatment</i> • <i>Substance abuse intensive outpatient program (SAIOP)</i> • <i>Substance abuse comprehensive outpatient treatment program (SACOT)</i> • Intermediate care facilities for individuals with intellectual disabilities (ICF-IID) <p>Waiver Services</p> <ul style="list-style-type: none"> • Innovations waiver services

³ The Department will release a list of behavioral health and I/DD benefits that will be covered by the Children in Foster Care Plan in the coming months.

⁵ CST includes tenancy supports.

Behavioral Health Services Covered in Standard Plans and BH I/DD Tailored Plans	
BH, I/DD, and TBI Services Covered by <u>Both</u> Standard Plans and BH I/DD Tailored Plans	BH, I/DD and TBI Services Covered by Only LME/MCOs Prior To BH I/DD Tailored Plan Launch (These services will later be covered by BH I/DD Tailored Plans, but will not be covered by Standard Plans)
Enhanced BH services are <i>italicized</i>	
<ul style="list-style-type: none"> • <i>Professional treatment services in facility-based crisis program</i> • <i>Outpatient opioid treatment⁴</i> • <i>Ambulatory detoxification</i> • Research-based BH treatment for Autism Spectrum Disorder (ASD) • Diagnostic assessment • <i>Non-hospital medical detoxification</i> • <i>Medically supervised or alcohol and drug abuse treatment center (ADATC) detoxification crisis stabilization</i> • Early and periodic screening, diagnostic and treatment (EPSDT) services 	<ul style="list-style-type: none"> • TBI waiver services • Current 1915(b)(3) services <p>State-funded services</p>

29. Can you please address how this affects Self Direction in NC? Training and support is now provided by community navigator agencies, which appear to be going away.

Tailored Care Management will encompass most of the functions now provided by community navigators. Community navigator functions that are not part of the Tailored Care Management model, such as training and support for self-direction, will be incorporated into an amended financial support services definition.

30. Is Approach 3 in the slide below the Behavioral Health MCOs?

Yes, that's correct. Approach 3 means that Tailored Care Management can be provided by BH I/DD Tailored Plan-based care managers, though the goal is to increase over time the amount of Tailored Care Management provided by AMH+ practices and CMAs (Approaches 1 and 2).

⁴ BH I/DD Tailored Plans will also be required to cover OBOT services as detailed in *Section VII.B. Summary of Medicaid and NC Health Choice Covered Services & Clinical Coverage Policies.*

Three Approaches to Delivering Tailored Care Management

