Tailored Care Management 104:

Partnering with a Clinically Integrated Network and Other Partners

October 22, 2021

Tailored Care Management Webinar Series

Today's webinar is a part of a series to help develop a shared understanding of the Tailored Care Management model across the North Carolina provider community and any anyone else who is interested.

Date *Fridays 12 -1 PM*	**Topic**
October 1, 2021	Introduction to Tailored Care Management
October 8, 2021	Becoming an AMH+/CMA
October 15, 2021	Health IT Requirements and Data Sharing
October 22, 2021	**Partnering with a Clinically Integrated Network and Other Partners**
October 29, 2021	Delivery of Tailored Care Management
November 5, 2021	Transitional Care Management Community Inclusion Activities
November 19, 2021	Conflict-Free Care Management and Additional Care Coordination Functions for Members Enrolled in the Innovations or TBI Waiver
December 3, 2021	Billing
December 10, 2021	Oversight and Quality Measurement/Improvement

Tailored Care Management Webinar Series

- Time permitting, we will be holding a Q&A session at the conclusion of today's presentation.
  - You may ask a question at any time throughout the presentation, using the Q&A text box
  - Q&A Text Box is located at the lower right-hand side of the screen
  - Simply type in your question and click send

For additional questions on Tailored Care Management, please email:
Medicaid.TailoredCareMgmt@dhhs.nc.gov

- A recording of today's presentation and the slide deck will be available at the below website.

For more information on Tailored Care Management, please visit:
https://medicaid.ncdhhs.gov/transformation/tailored-care-management

Presenters

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Chief Quality Officer NC Medicaid, Quality and Population Health	Associate Director of Population Health, NC Medicaid, Quality and Population Health	Senior Program Manager for Special Programs, NC Medicaid, Quality and Population Health	IDD and TBI Section Chief, Division of Mental Health, Developmental Disabilities and, Substance Abuse Services

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Agenda

- **Key Updates**
- **Overview of CINs/Other Partners**
- **CIN/Other Partner Capabilities**
- **CIN/Other Partner Use Cases**
- **Support & Resources Available to AMH+ Practices & CMAs**
  - CINs/Other Partners Available in NC
  - Technical Assistance
  - Capacity Building
- **Question & Answer**

Key Updates

Forthcoming Guidance: Use of Care Management Extenders in Tailored Care Management

Providers and other stakeholder have raised questions regarding how Community Navigators, Peer Support Specialists, and community health workers (CHWs) fit into the Tailored Care Management model. The Department recognizes that these experienced individuals will play an important role in Tailored Care Management care teams and is in the process of developing guidance to provide clarification on their roles.

The Department is committed to building a robust Tailored Care Management workforce that is led by care managers and includes care manager extenders (e.g., Community Navigators, Peer Support Specialists, and Community Health Workers).

Forthcoming guidance will address:

- Functions that extenders can perform within the model
- How extenders can help fulfill the member contact requirements
- Training and supervision requirements
- Qualifications needed to serve as an extender

To inform the guidance, the Department will seek input from the Tailored Care Management Technical Advisory Group (launching 10/29)

The Department is also considering the extent to which the care management extender policies as well as other feedback we have received will affect Tailored Care Management rates.

Overview of CINs/Other Partners

What is a CIN/Other Partner & How Can They Help?

A "CIN or Other Partner" is an organization with which an AMH+ practice or CMA may be affiliated that helps them meet the requirements of the model. AMH+ practices and CMAs may choose to contract with any individual CIN or multiple CINs and/or Other Partners that best meet their needs.

CINs/Other Partners may offer a wide range of support, including:

- Providing community-based care management staffing
- Providing care management functions and services
- Meeting the HIT requirements (e.g., care management data systems)
- Supporting AMH+ and CMA data integration, analytics, and use (e.g. importing and analyzing claims/encounter data)
- Clinical consultation—to provide subject matter expertise and advice to the care team

Partnering with one or more CINs or Other Partner may help make the model more cost effective and financially sustainable for AMH+ practices and CMAs (e.g., partnering for HIT support versus an AMH+ practice/CMA purchasing a system on their own).

Who May Act as a CIN or Other Partner?

- Hospital or health system
- Another provider-based network or association
- Integrated delivery network
- Another provider
- Independent Practice Association (IPA) or Managed Services Organization (MSO)
- Technology Vendor
- Tailored Plans may serve as an "Other Partner" for health IT support.*

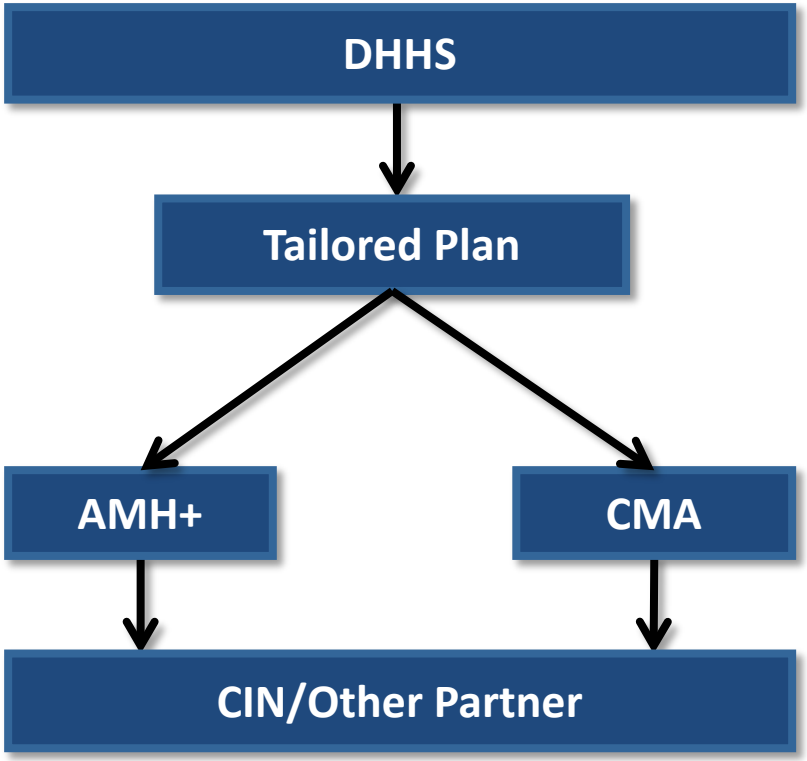
This is not an exhaustive list. CINs and Other Partners supporting AMH+ practices and CMAs may take many forms, and the Department encourages innovation and market movement to support this model.

*AMH+ practices and CMAs may decide to enter into arrangements with Tailored Plans for use of their information technology (IT) products or platforms for care management, in order to meet the care management data system requirements only."

Source: https://files.nc.gov/ncdhhs/medicaid/Tailored-CareMgmt-DataStrategy-PolicyPaper-FINAL-20190912.pdf

AMH+/CMA Accountability for CINs/Other Partners

AMH+ Practices/CMAs that choose to contract with a CIN/Other Partner will still have a relationship with Tailored Plans and be responsible for ensuring CINs/Other Partners perform contracted functions in-line with the Tailored Care Management requirements.



- **The State will be certifying AMH+ Practices and CMAs, <u>not</u> CINs/Other Partners**
- **The State will not have oversight of CINs or validate their capabilities.**

CIN/Other Partner Capabilities

Why Would an AMH+/CMA Contract with a CIN/Other Partner?

CINs/Other Partners can assist AMH+ practices and CMAs with


Providing Community-Based Care Management Staffing


Providing Care Management Functions and Services


Meeting HIT requirements


Supporting Data Integration, Analytics, and Use


Access to Clinical Consultation

Staffing

CINs/Other Partners can help AMH+ practices and CMAs meet Tailored Care Management staffing requirements.

AMH+/CMA Care Management Staffing Requirements

- Assign all assigned members to a care manager who meets the minimum qualifications and who is accountable for active, ongoing care management
- Ensure each care manager is supervised by a supervising care manager
- Establish a multidisciplinary care team for each member based on the member's needs
- Have access to clinical consultants to provide subject matter expert advice to the care team

Potential CIN/Other Partner Responsibilities

- Provide care management staff and other infrastructure through a health system, integrated delivery network or other care management partner
  - AMH+ practices/CMA must maintain 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

Members must be assigned to a single care manager who will deliver integrated care management across physical and behavioral health (i.e., a member should not be split between a CIN/Other Partner care manager and an AMH+/CMA directly employed care manager.)

Functions and Services: Comprehensive Assessments and Care Planning

AMH+ practices and CMAs will be required to conduct a care management comprehensive assessment and develop a care plan or Individual Support Plan (ISP) for all members assigned to them.

Care Management Comprehensive Assessment and Care Plan/ISP Requirements

- **Care Management Comprehensive Assessment:**
  - Person-centered assessment of a member's health care needs, functional needs, accessibility needs, strengths and supports, goals, and other characteristics informing the care plan/ISP
  - Must include a minimum set of domains such as immediate care needs, detailed medication history, cultural considerations, risk factors for LTSS, among other domains
  - Must make a best effort to complete within 60 or 90 days of Tailored Plan enrollment for members identified as high or moderate/low acuity, respectively
- **Care Plan/ISP:**
  - Must be individualized and person-centered and developed using a collaborative approach
  - Must incorporate findings from care management comprehensive assessment, claims analysis and risk scoring, any available medical records, and screening and/or level of care determination tools
  - Must make a best effort to complete within 30 days of the care management comprehensive assessment
  - Must include a process to update the care plan/ISP regularly

Potential CIN/Other Partner Tasks

- Provide tools for practices to streamline administration of care management comprehensive assessments
- Perform the assessment, using CIN/Other Partner-employed care managers
- Identify and aggregate actionable data that can be used to inform care plan/ISP development
- Perform or assist in the development of the care plan/ISP using CIN/Other Partner-employed care managers
- Develop workflows for updating the care plan/ISP on an ongoing basis

Functions and Services: Care Transitions

AMH+ practices and CMAs must support member care transitions in real or near real-time.

AMH+/CMA Care Transition Requirements

- Implement systematic, clinically appropriate care management processes for responding to high-risk ADT alerts
- Ensure that a care manager is assigned to manage the transition
- Ensure that care manager or care team member visits the member during his/her stay in an institutional setting and is present on the day of discharge
- Assist member in obtaining needed medications prior to discharge; medication reconciliation/management, and support medication adherence
- Create and implement a 90-day transition plan
- Conduct/update care management comprehensive assessment; update care plan/ISP
- Facilitate arrangements for and scheduling of transportation, in-home services, and follow-up outpatient visits with appropriate providers

See provider manual for additional requirements

Potential CIN/Other Partner Responsibilities

- Develop protocols to support care transitions, including responding to high-risk ADT alerts
- Perform or assist with care transitions using CIN/Other Partner-employed care managers

HIT Requirements

AMH+ practices/CMAs may meet the HIT requirements by:

- Partnering with a Clinically Integrated Network (CIN) or Other Partner;
- Using the Tailored Plan's care management data system; or
- Implementing or using their own systems.

Use an electronic health record (EHR) or clinical system of record*

Use a care management data system

Use NCCARE360 (once operational)

* Use of an electronic health record (EHR) or clinical system of record is required to apply for and certify as an AMH+ practice/CMA.
See the Tailored Care Management Provider Manual for additional detail on the HIT requirements for AMH+ Practices and CMAs.

Data Integration, Analytics, and Use: ADT Data

CINs/Other Partners can assist AMH+ practices and CMAs in accessing ADT data through a health information exchange (HIE) or other source

AMH+ Practice & CMA Requirements

- Track assigned member's ED and inpatient utilization by **accessing real- or near real-time Admission, Discharge, and Transfer (ADT) data**
- Implement a **systematic, clinically appropriate** process for responding to high-risk ADT alerts

- AMH+ practices/CMAs and their CINs/Other Partners are encouraged to work with NC's **health information exchange**, HealthConnex, or other entities to access ADT data

Health Information Exchange (HIE):

A secure electronic network that enables the safe and secure transmission of protected patient health information between authorized health care providers.

ADT Data Cont'd

AMH+ practices/CMAs and their CINs/Other Partners are encouraged to work with HIEs to establish data use agreements to enable data sharing

Potential CIN/Other Partner Tasks

- **Facilitate access to an ADT feed** for the AMH+ practice's or CMA's assigned members
- Develop systems and process to **incorporate ADT information** into the AMH+ practice's or CMA's EHR, clinical system of record, and/or care management data systems
- **Develop workflows and alerts** to facilitate follow-up and outreach for member in need of care management based on ADT alerts
- Incorporate ADT information into **risk stratification and risk-scoring** processes, if conducted

Data Integration, Analytics, and Use: Claims and Other Data Sources

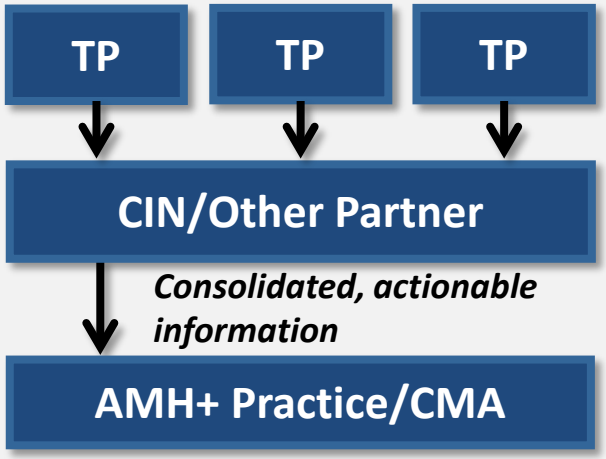
CINs/Other Partners can support AMH+ practices and CMAs in managing and creating actionable information from Tailored Plan claims and other data sources.

Potential CIN/Other Partner Support

- **Receiving**, **aggregating**, and **transmitting**:
  - Member assignment data
  - Quality performance data
  - Encounter data
  - Clinical data
- Standardizing and securely storing member data from **multiple Tailored Plans**
- Assisting with **risk scoring and stratification**, if conducted
- Perform analytics to develop **care management approaches** and **provide actionable information** to care managers

Multiple Data Types

- Member Assignment
- Quality Performance
- Encounter
- Clinical



Clinical Consultants

CINs/Other Partners can provide AMH+ practices and CMAs access to clinical consultants to provide subject matter expert advice to the care team.

AMH+ Practice & CMA Requirements

AMH+ practices or CMAs must ensure that they have access to at least the following experts:

- An adult psychiatrist or child and adolescent psychiatrist (depending on the population being served)
- A neuropsychologist or psychologist
- For CMAs: A primary care physician appropriate for the population being served, to the extent the member's PCP is not available for consultation

AMH+ practices and CMAs may employ or contract with consultants or do so through a CIN or Other Partner.

Clinical consultants should be available by phone to staff within AMH+ practices and CMAs to advise on complex clinical issues on an ad hoc basis.

CIN/Other Partner Use Cases

Use Case 1: CMA & Other Partner

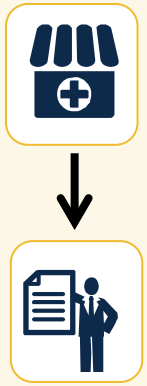
Provider X is a large-sized independent, unaffiliated practice that provides co-located physical health and behavioral health services

- Meets the CMA certification requirement
- Has in-house care managers
- Has an EHR, but otherwise has limited technical and staff capacity to consume and analyze patient data to inform care interventions
- Does not have care management data system

Tailored Plan Y offers HIT and analytics support and access to a care management date system

Provider X can contract with Tailored Plan Y for HIT support, including:

- Access to a care management data system
- Importing and analyzing claims/encounter data to support care management
- Quality measure documentation, data collection and analysis



Use Case 2: CMA & CIN

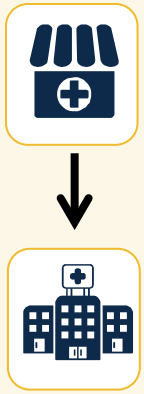
Provider Y is a small independent, unaffiliated I/DD provider

- Meets the CMA certification requirement
- Has no in-house HIT functionality or care management staff

Network X is an integrated delivery network that employs care managers and has robust HIT capabilities

Provider Y can contract with Network X as a CIN or Other Partner for support, including:

- Care management staff (must be embedded within Provider Y's site)
- Access to an EHR
- Access to a care management data system
- Quality measurement and reporting



Provider Y cannot provide care management to individuals who they also deliver 1915(c) Innovations or TBI waiver services.

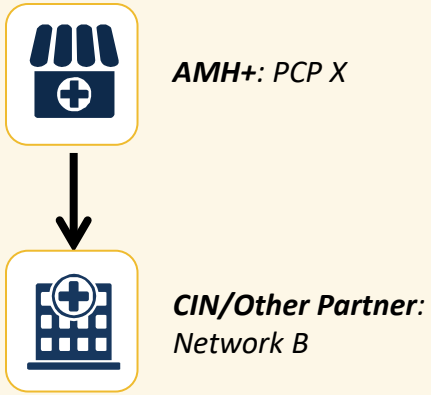
Use Case 3: AMH+ & CIN

PCP X is a current Tier 3 AMH with experience delivering primary care services to the Tailored Plan eligible population

- Meets the AMH+ certification requirement
- Has an EHR, a care management system, and staff and analytic capabilities to consume and analyze patient data to inform care interventions
- Has care management staff
- Does not have access to clinical consultants

Network B is an integrated delivery network with subject matter experts in all areas

PCP X can contract with Network B for access to clinical consultants (e.g., adult psychiatrist and psychologist)



Support & Resources Available to AMH+ Practices & CMAs

Examples of CINs/Other Partners Available in NC

To help providers get more information about potential CINs and Other Partners, the Department released a non-binding statement of interest earlier this year. Six organizations responded with information about their capabilities.

VIDANT™ Integrated Care	BlazeAdvisors	chn COLLABORATIVE HEALTH NETWORK
EMTIRO HEALTH inspired support.	medisked	The Arc North Carolina

Additional Information

Together, the CINs/Other Partners that responded to the statement of interest will cover all seven Tailored Plan Regions. Not all are available in every region.

The types of providers the CINs/Other Partners intend to serve vary:

- CMAs and AMH+ practices : Vidant Integrated Care, Emtiro Health, Medisked
- CMAs only: Blaze Advisors and Collaborative Health Network
- CMAs operated by I/DD or TBI providers only: The Arc of NC

Their services vary, but may include:

- Care management staffing
- Clinical consultants
- Clinical protocols/workflows
- Health information technology (HIT) services, including, but not limited to, offering a care management data system

Additional information and contact information is available at: https://medicaid.ncdhhs.gov/responses-statement-interest-potential-cins-and-other-partners/download?attachment

Technical Assistance

The Department is offering technical assistance (TA) program that will help providers become certified AMH+ practices and CMAs and prepare them to be successful high-quality providers of Tailored Care Management.

- NC Medicaid contracted with NC Area Health Education Centers (AHEC) to provide education and practice support services to providers who applied for AMH+ practice/CMA certification and passed the desk review. In addition, these services are available pre- and post- Tailored Plan Go Live to TCM organizations at no cost.

- Practice support coaches have extensive expertise in behavioral health and I/DD and provide TA and education at no cost :
  - 1:1 virtual or onsite technical assistance
  - Tailored Care Management Gap Analysis Tool in preparation for on-site review (*approved by NC Medicaid and required*)
  - Learning collaboratives & education modules, with opportunity to earn continuing education (CE) credits
  - AHEC offers TA in additional areas including Medicaid managed cared education and issue resolution, clinical workflow redesign and process improvement, quality and health equity improvement, EHR optimization, telehealth integration, HIE training and optimization, social determinants of health, workflows optimization, billing/coding and practice needs assessments.
- For additional questions, please contact practicesupport@ncahec.net. Practice Support information is available at Practice Support | NC AHEC.

Capacity Building

To help ensure the successful implementation of Tailored Care Management, the Department is launching the Tailored Care Management Capacity Building program, under which approximately $90 million in funding will be distributed across the state starting in early 2022 and through at least June 2023.*

Providers certified as AMH+ practices and CMAs will be eligible to receive funding for investments in

- Care management related health information technology (HIT) infrastructure
- Hiring and training care managers
- Activities related to operational readiness, such as developing policies/procedures/workflows

Funds will flow through LME/MCOs awarded a Tailored Plan contract. LME/MCOs (future Tailored Plans) will complete a capacity building needs assessment with each AMH+ practice and CMA to understand and document each provider's specific capacity building needs.

To access funds, providers must participate in these assessments and, on an ongoing basis, meet targets, mutually agreed upon by the AMH+/CMA and LME/MCO, that demonstrate progress towards achieving specific capacity building milestones.

AMH+ practices and CMAs may choose to use their capacity building funds to contract with CINS/Other Partners for the purpose of capacity building (e.g. to make HIT investments). CINs or other partners will not be eligible to receive capacity building funds directly from the Department or Tailored Plans

***NOTE: Funding for the program is dependent the North Carolina General Assembly passing a state budget, which the Department hopes will occur by the end of the year. The Department hopes to make additional funding available in future years.**

For more details on the capacity building program see: https://files.nc.gov/ncdma/Updated-Guidance-on-Tailored-Care-Management-vF.pdf

Questions?

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