Tailored Care Management:

Overview of the AMH+ and CMA Certification Process

December 17, 2020

Agenda

- Tailored Care Management Model Overview
- Application Process for AMH+ Practices and CMAs
- Q & A

Medicaid Managed Care Overview

Over the next two years, North Carolina will transition from a predominantly fee-for-service delivery system to Medicaid managed care. With this transition, the state will offer four types of managed care products that will provide integrated, whole-person care.

Standard Plan

Standard Plans will provide integrated physical health, behavioral health, pharmacy, and long-term services and supports to the majority of Medicaid beneficiaries, as well as programs and services that address other unmet health related resource needs. Standard Plans will launch in **July 2021.**

BH I/DD Tailored Plan

Behavioral Health (BH) Intellectual/ Developmental Disability (I/DD) Tailored Plans will provide the same services as Standard Plans, as well as additional specialized services for individuals with significant behavioral health conditions, I/DDs, and traumatic brain injury, as well as people utilizing state-funded and waiver services. The Department released the BH I/DD Tailored Plan Request for Applications (RFA) on November 13, 2020 and expects these plans to launch in **July 2022**.

Specialized Plan for Children in Foster Care

A Specialized Plan for Children in Foster Care will be available to children in foster care and will cover a full range of physical health, behavioral health, and pharmacy services.

EBCI Tribal Option

The Eastern Band of Cherokee Indians (EBCI) Tribal Option will be available to tribal members and their families and will be managed by the Cherokee Indian Hospital Authority (CIHA).

Tailored Care Management Model

Tailored Care Management Model

Tailored Care Management is the primary care management model for BH I/DD Tailored Plans, and operates on the key principle that physical health, behavioral health, and I/DD-related needs 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 beneficiary needs during transitions of care
- Management of rare diseases and high-cost procedures
- 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 and 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.

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-Based Care Manager

The Department will allow – but not require – AMH+ practices and CMAs 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.

Numerator: Number of members actively engaged in Tailored Care Management provided by care managers based in AMH+ practices or CMAs certified by the Department

Denominator: Total number of members actively engaged in Tailored Care Management

x 100 = **X%**

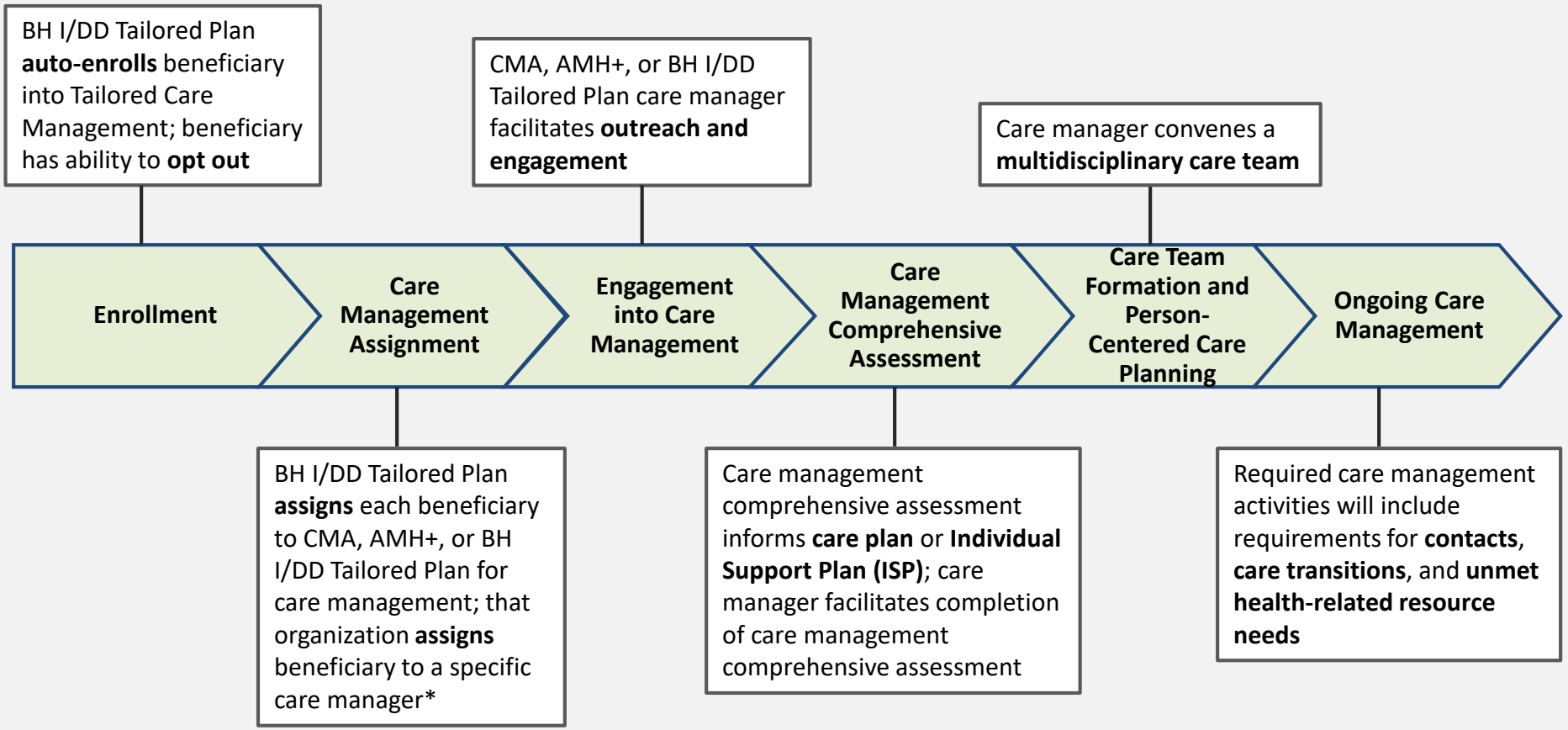
Department will compare X to annual targets that will be measured during the 1st quarter of the subsequent contract year:

	Year 0 (Mid 2021)	Year 1 (Mid 2022)	Year 2 (Mid 2023)	Year 3 (Mid 2024)	Year 4 (Mid 2025)
Target percentage of beneficiaries served by care managers/ supervisors based in AMH+ practice/CMA	**N/A**	**30%**	**45%**	**60%**	**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

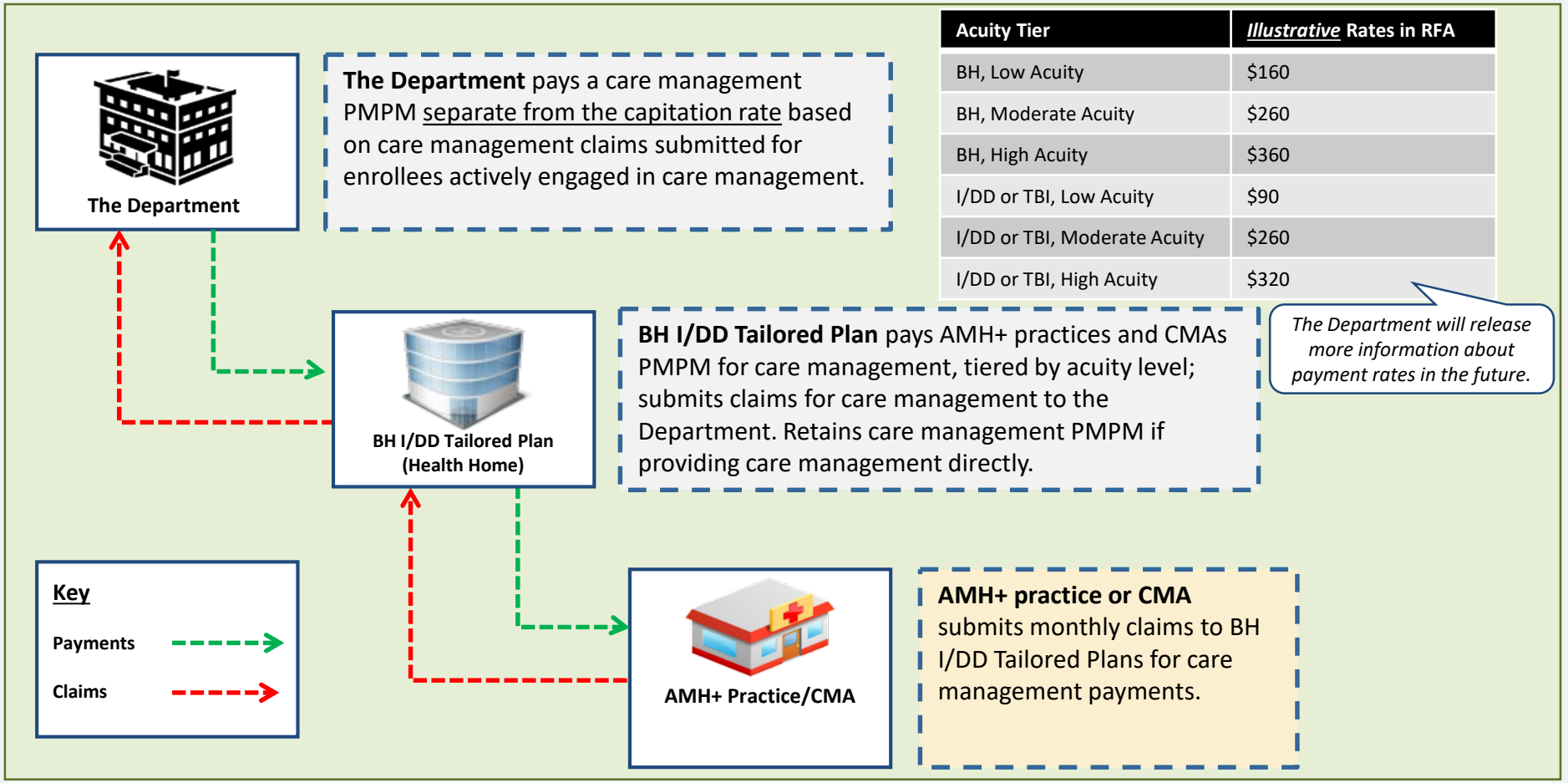
Care management design aligns with Standard Plan requirements to the greatest extent possible, but in several areas the Department has built special guardrails to meet the unique needs of the BH I/DD Tailored Plan population.



*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.

Payment for Care Management

AMH+ practices and CMAs will be paid standardized (fixed) PMPM rates, tiered by acuity. These rates will be *significantly higher* than Standard Plan care management rates.

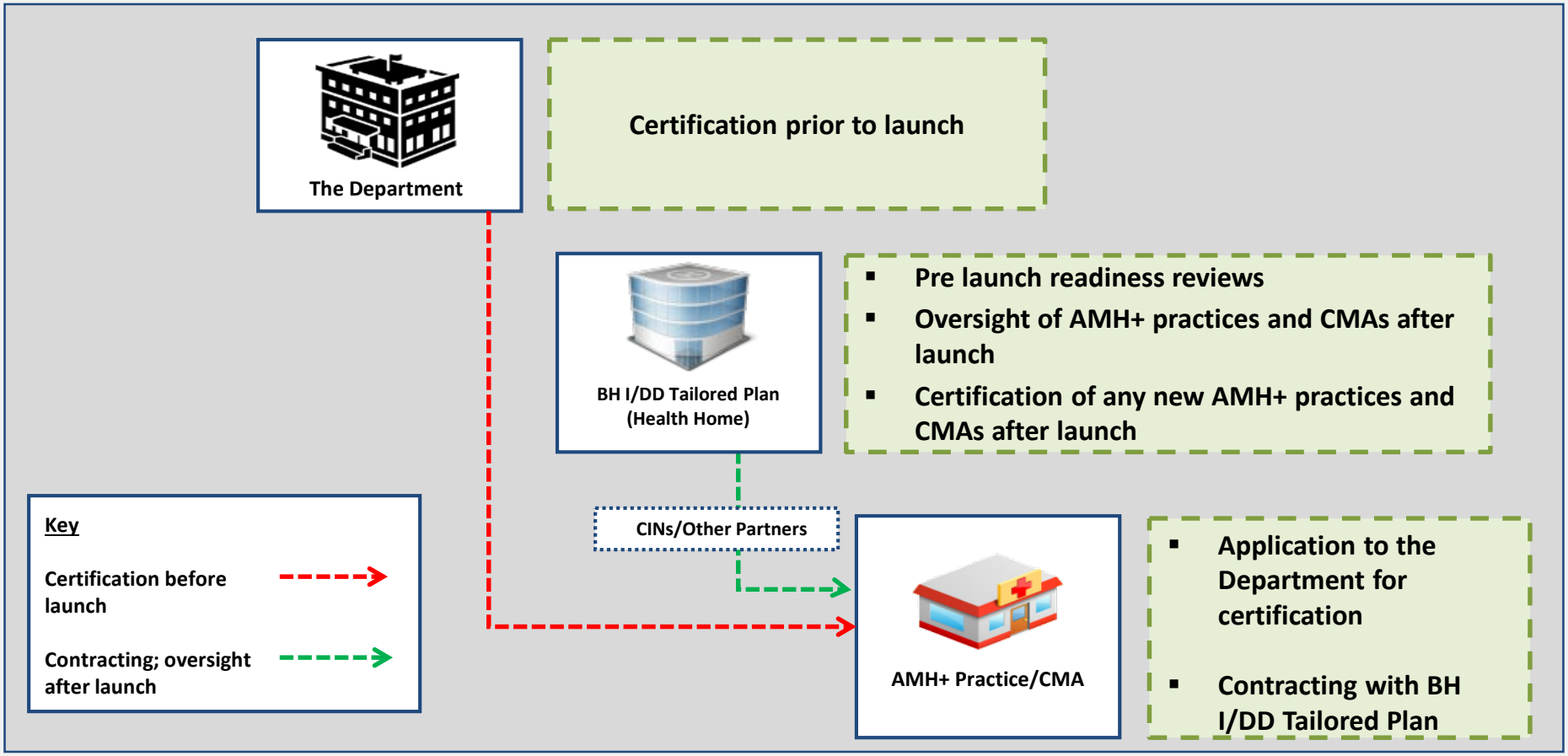


Acuity Tier	*Illustrative* Rates in RFA
BH, Low Acuity	$160
BH, Moderate Acuity	$260
BH, High Acuity	$360
I/DD or TBI, Low Acuity	$90
I/DD or TBI, Moderate Acuity	$260
I/DD or TBI, High Acuity	$320

Application Process for AMH+ Practices and CMAs

Overview: Certification and Oversight

Providers must be certified as an AMH+ practice or CMA to perform Tailored Care Management. The Department is leading the certification process prior to BH I/DD Tailored Plan launch. After launch, BH I/DD Tailored Plans will lead the certification process and conduct oversight of the model in each region.



AMH+/CMA Certification Process is Open!

The AMH+ and CMA certification process will include desk reviews and site visits in three rounds prior to July 2022 BH I/DD Tailored Plan launch. Providers will have additional opportunities to apply for certification post-launch.

Round	Application Deadline	Desk Reviews/Site Visits
1	**March 1, 2021**	▪ Desk reviews: March – May 2021 ▪ Site visits: July – August 2021
2	Spring 2021	▪ Desk reviews: Summer 2021 ▪ Site visits: Fall 2021
3	Fall 2021	▪ Desk reviews: Fall 2021 ▪ Site visits: Winter 2022

Providers can submit an application to be considered for certification as an AMH+ or CMA in the first round *from now through March 1, 2021*. The application form is available at https://files.nc.gov/ncdma/Revised-Tailored-Care-Management-Application-Questions20201202.pdf and should be submitted to Medicaid.TailoredCareMgmt@dhhs.nc.gov.

AMH+ and CMA Certification Process

For the period prior to BH I/DD Tailored Plan launch, DHHS will facilitate desk reviews and site visits to determine whether a provider organization should be certified to perform Tailored Care Management.

DHHS Role: DHHS has responsibility for stages 1-3, culminating in a certification decision for each application.

BH I/DD Tailored Plan Role (LME-MCO): Oversight transitions to plan level.

STAGE 1
Provider Application

STAGE 2
Desk Review

STAGE 3
Site Visits

STAGE 4
Readiness Review/ Contracting

The AMH+ and CMA certification process is separate from the Medicaid enrollment process.

Desk Review: The Department will review each written application to determine whether the organization has the potential to satisfy the full criteria at BH I/DD Tailored Plan launch.

Site Visit: The Department will arrange to conduct one or more site visits with providers that "pass" the desk review to drive a final decision on certification, and to increase understanding of each organization's capacity, strengths, and areas for improvement, including need for capacity building funding.

Role of CIN or Other Partners in Application Process

In response to comments from stakeholders, the Department has decided to allow a pathway for CINs or Other Partners to answer certain questions, if applicable to an organization's application.

How may CINs or Other Partners Serve AMH+ practices and CMAs?

- Supporting application process by completing the **CIN or Other Partner Supplement**
- Providing **local care management** staffing, functions and services
- Supporting **AMH+ and CMA analytics and data integration**
- **Assisting in the contracting process or directly contracting with BH I/DD Tailored Plans** on behalf of AMH+ practices/CMAs

How does the certification process work if a provider has not yet decided whether to contract with a CIN or Other Partner?

- **The Department will certify individual AMH+ practices and CMAs, not CINs**
- Organizations that have not yet decided whether/how to affiliate with a CIN or Other Partner **may** begin the application process now
  - *Final certification decision prior to BH I/DD Tailored Plan launch will include assessment of how roles and responsibilities will be shared between provider and CIN or Other Partner*

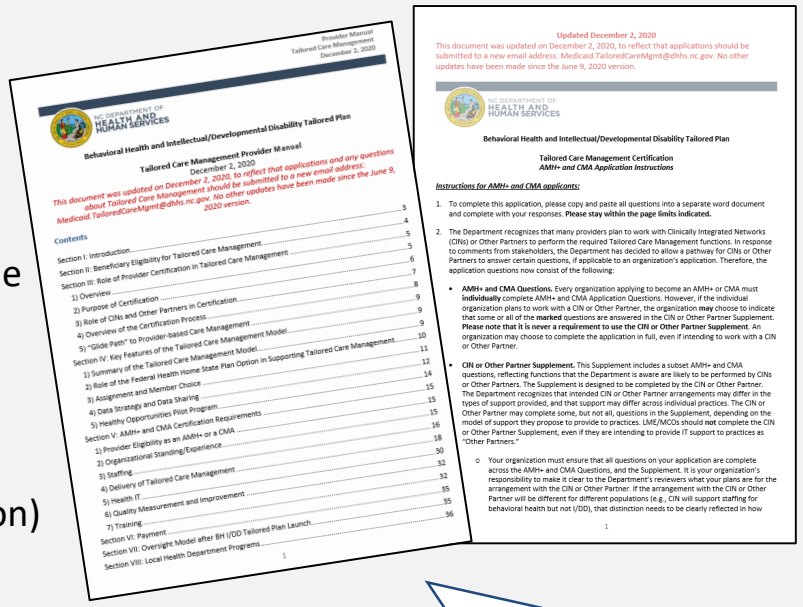
A "CIN or Other Partner" is an organization with which an AMH+ or CMA may be affiliated that helps the AMH+ or CMA meet the requirements of the model.

Certification Requirements Overview

The AMH+ and CMA certification application will assess whether organizations are credibly on track to deliver Tailored Care Management by BH I/DD Tailored Plan launch.

Requirements:

1. Meet **eligibility definitions** as an AMH+ or CMA
2. Show appropriate **organizational standing/experience**
3. Show appropriate **staffing**
4. Demonstrate the ability to deliver all **required elements** of the Tailored Care Management model
5. Meet **health IT** requirements
6. Meet **quality measurement and improvement** requirements
7. Participate in **required training** (occurs after initial certification)



Behavioral Health and Intellectual/Developmental Disability Tailored Plan

Tailored Care Management Provider Manual

December 2, 2020

This document was updated on December 2, 2020, to reflect that applications and any questions about Tailored Care Management should be submitted to a new email address: Medicaid.TailoredCareMgmt@dhhs.nc.gov. No other updates have been made since the June 9, 2020 version.

Contents

Updated December 2, 2020

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Behavioral Health and Intellectual/Developmental Disability Tailored Plan

Tailored Care Management Certification

AMH+ and CMA Application Instructions

Instructions for AMH+ and CMA applicants:

1. To complete this application, please copy and paste all questions into a separate word document and complete with your responses. **Please stay within the page limits indicated.**
2. The Department recognizes that many providers plan to work with Clinically Integrated Networks (CINs) or Other Partners to perform the required Tailored Care Management functions. In response to comments from stakeholders, the Department has decided to allow a pathway for CINs or Other Partners to answer certain questions, if applicable to an organization's application. Therefore, the application questions now consist of the following:

- **AMH+ and CMA Questions.** Every organization applying to become an AMH+ or CMA must **individually** complete AMH+ and CMA Application Questions. However, if the individual organization plans to work with a CIN or Other Partner, the organization **may** choose to indicate that some or all of the **marked** questions are answered in the CIN or Other Partner Supplement. **Please note that it is never a requirement to use the CIN or Other Partner Supplement**. An organization may choose to complete the application in full, even if intending to work with a CIN or Other Partner.
- **CIN or Other Partner Supplement.** This Supplement includes a subset AMH+ and CMA questions, reflecting functions that the Department is aware are likely to be performed by CINs or Other Partners. The Supplement is designed to be completed by the CIN or Other Partner. The Department recognizes that intended CIN or Other Partner arrangements may differ in the types of support provided, and that support may differ across individual practices. The CIN or Other Partner may complete some, but not all, questions in the Supplement, depending on the model of support they propose to provide to practices. LME/MCOs should **not** complete the CIN or Other Partner Supplement, even if they are intending to provide IT support to practices as "Other Partners."
  - Your organization must ensure that all questions on your application are complete across the AMH+ and CMA Questions, and the Supplement. It is your organization's responsibility to make it clear to the Department's reviewers what your plans are for the arrangement with the CIN or Other Partner. If the arrangement with the CIN or Other Partner will be different for different populations (e.g., CIN will support staffing for behavioral health but not I/DD), that distinction needs to be clearly reflected in how

1

- Organizations do not have to be fully ready now, but must be able to describe their plans to achieve readiness.
- **The Department intends to provide "capacity building" funding for provider organizations. More detail on this opportunity will be forthcoming.**

Organizations should cross-reference the Tailored Care Management Provider Manual when completing the Application Form.

1. Eligibility

Advanced Medical Home Plus (AMH+)

- **Definition:** Primary care practices **actively serving as AMH Tier 3 practices**, 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 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**.
- **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**.

Care Management Agency (CMA)

- **Definition:** 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.

AMH+ practices or CMAs must not be owned by, or be subsidiaries of, BH I/DD Tailored Plans.

Certification will be Organized by Population

Organizations must indicate the population(s) for which they are applying to be certified.

- **Mental Health and Substance Use Disorder** (SUD)
  - Adult
  - Child/adolescent
- **I/DD**
- **TBI**
- **Innovations Waiver**
- **TBI Waiver**
- **Co-occurring I/DD and Behavioral Health**
  - Adult
  - Child/adolescent

- The Department will certify AMH+ practices at the **practice site level**, in alignment with the current AMH certification process.
- The Department will certify CMAs at the level of the **entire organization**. However, if a potential CMA spans multiple BH I/DD Tailored Plan regions, the Department will certify the organization at the level of each **region**.

2. Organizational Standing/Experience

Certification Criteria	Key Application Content	What DHHS will be Looking For
2.1. Relevant experience	▪ Information provided about current scope of services and populations ▪ Description of organization's history and length of experience	▪ Alignment of prior experience with population: generally, **at least 2 year history** of services aligned with population served, in NC ▪ Integration of mental health and SUD for BH agencies
2.2. Provider relationships and linkages	▪ Description of current contracts and arrangements with other providers, including those that could play the "clinical consultant" role	▪ Relationships/formal linkages in place ▪ Plan for strengthening relationships for "clinical consultant" roles
2.3. Capacity and sustainability	▪ Attachment of most recently audited financial report ▪ Description of leadership team for Tailored Care Management	▪ Evidence of financial capacity (e.g., balanced budget) ▪ Clear leadership roles and accountability
2.4. Oversight	▪ Board approval ▪ Organizational chart ▪ Description of how management and oversight will occur	▪ Appropriate structures in place to oversee the Tailored Care Management model ▪ Strong governance with appropriate executive and management structure and approval of the application

Category 3: Staffing

By BH I/DD Tailored Plan launch, care managers at AMH+ practices and CMAs must meet minimum requirements below:

Care Management Staff	Minimum Requirements
Care managers serving all members	▪ A bachelor's degree in a field related to health, psychology, sociology, social work, nursing, or another relevant human services area, or licensure as a registered nurse (RN); and ▪ Two years of experience working directly with individuals with behavioral health conditions (if serving members with behavioral health needs) or with an I/DD or a TBI (if serving members with I/DD or TBI needs); and ▪ For care managers serving members with LTSS needs: two years of prior LTSS and/or HCBS coordination, care delivery monitoring, and care management experience, in addition to the requirements cited above. (This experience may be concurrent with the two years of experience working directly with individuals with behavioral health conditions, an I/DD, or a TBI, above.)
Supervising care managers serving members with behavioral health conditions	▪ A master's-level fully Licensed Clinical Social Worker (LCSW), fully Licensed Clinical Mental Health Counselor (LCMHC), fully Licensed Psychological Associate (LPA), fully Licensed Marriage and Family Therapist (LMFT), or licensure as an RN; and ▪ Three years of experience providing care management, case management, or care coordination to the population being served.
Supervising care managers serving members with I/DD or a TBI (must have <u>one</u> of the following minimum qualifications)	▪ A bachelor's degree in a field related to health, psychology, sociology, social work, nursing, or another relevant human services area and five years of experience providing care management, case management, or care coordination to complex individuals with I/DD or TBI; or ▪ A master's degree in a field related to health, psychology, sociology, social work (e.g., LCSW), nursing, or another relevant human services area, or licensure as an RN and three years of experience providing care management, case management, or care coordination to complex individuals with an I/DD or a TBI.

Category 4: Delivery of Tailored Care Management

Certification Criteria	Key Application Content	What DHHS will be Looking For
4.1. Policies and procedures for communication with members	▪ Attestation that the organization will develop policies	▪ [Attestation]
4.2. Capacity to engage with members through frequent contact	▪ Description of strategy to meet minimum contact requirements	*Clear strategy for how the organization will meet each of the minimum requirements **and** tailor to the population being served.*
4.3. Care management comprehensive assessments and reassessments	▪ Description of approach to care management comprehensive assessment	
4.4. Care plans and Individual Support Plans (ISPs)	▪ Description of approach to care plans/ISPs	
4.5. Care teams	▪ Description of approach to developing care team and convening regular conferences, including foreseen challenges ▪ Description of strategy to share and manage access to patient information	

Category 4: Delivery of Tailored Care Management

Certification Criteria	Key Application Content	What DHHS will be Looking For
4.6. Required components of Tailored Care Management	▪ Description of approach to meet each of the required components ▪ Attestation to provide or arrange for 24/7 coverage for services, consultation or referral, and treatment for emergency medical conditions	*Experience and capabilities for:* ▪ Care coordination ▪ Twenty-four hour coverage ▪ Ensuring annual physical exam is carried out ▪ Continuous monitoring ▪ Medication monitoring ▪ System of Care ▪ Individual and family supports ▪ Health promotion
4.7. Addressing unmet health-related resource needs	▪ Description of relationships with community organizations ▪ Description of experience in addressing unmet health-related resource needs	▪ Experience and competency providing referral, information and assistance
4.8. Transitional care management	▪ Attestation of access to ADT data ▪ Description of methodologies to respond to ADT data ▪ Description of transition approaches for special populations and diversion from institutional settings	▪ Experience and capability managing transitions ▪ Plan for achieving ADT access, if not in place ▪ Evidence of an approach to identifying and diverting members who are at risk of requiring care in an adult care home or an institutional setting
4.9. Innovations and TBI Waiver Care Coordination (if applicable)	▪ Description of approaches to address additional requirements if serving this population	▪ Experience serving this population

Category 5: Health Information Technology

Certification Criteria	Key Application Content	What DHHS will be Looking For
5.1. Use an Electronic Health Record (EHR)	▪ Attestations that EHR is in place ▪ Description of EHR	▪ EHR must be in place **at the time of application**
5.2. Use a care management data system	▪ Description of care management data system ▪ Description of how claims/encounter data will be imported, curated, and analyzed	▪ Description of system in place or planned at the organization and/or proposal to work with BH I/DD Tailored Plan or CIN ▪ **<u>Note: no requirement</u> to use the BH I/DD Tailored Plan's care management data system**
5.3. Use ADT information	▪ Attestation of access to ADT data ▪ Description of methodologies to respond to ADT data	▪ Plan for achieving ADT access, if not in place today
5.4. Use NCCARE360	[Use of NCCARE360 is **not required now,** but will be required when the application is certified as being fully deployed].	
5.5. Risk stratify the population under Tailored Care Management beyond acuity tiering	[Currently **optional**] ***Encouraged, and required from Year Three of BH I/DD Tailored Plans onwards***	

Category 5: Health Information Technology

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.

AMH+ Practice and CMA Dataflows

BH I/DD Tailored Plan to AMH+ and CMA Dataflows

BH I/DD Tailored Plans will be expected to share the following data in a machine-readable format with AMH+ practices, CMAs, or their designated CINs or Other Partners, for their attributed members to support Tailored Care Management:

- **Member assignment information**, including demographic data and any clinical relevant and available eligibility information
- **Member claims/encounter data**, including historical physical (PH), behavioral health (BH), and pharmacy (Rx) claims/encounter data with new data delivered monthly (PH/BH) or weekly (Rx)
- **Acuity tiering and risk stratification information**
- **Quality measure performance information** at the practice level (format TBD)
- Other data or information that may be used to support Tailored Care Management (e.g., previously established care plans, ADT data, historical member clinical information)

Additional AMH+ and CMA Data Requirements

AMH+ practices and CMAs will also be expected to acquire and use the following data to support Tailored Care Management:

- **Admission, Discharge, and Transfer (ADT)** information
- **Relevant clinical information** for population health care management processes, including data from the care management comprehensive assessment, care plan, and referral data

Category 6: Quality Measurement and Improvement

Certification Criteria	Key Application Content	What DHHS will be Looking For
6. Ability to use data to drive internal quality improvement through quality measurement and continuous quality improvement (CQI)	▪ Description of plan to evaluate care management systems, processes, and services (internal QI) ▪ Description of plan to participate in quality measure documentation and data analysis (i.e., how the provider would use quality measure data from the BH I/DD Tailored Plan; or gather information to share with the BH I/DD Tailored Plan as needed)	▪ Approach for using internal data to drive improvement using a systematic process ▪ Experience using and reporting quality measures

Category 6: Quality Measurement and Improvement

After launch of BH I/DD Tailored Plans, AMH+ practices and CMAs will be required to gather, process, and share data with BH I/DD Tailored Plans – as well as use data shared by BH I/DD Tailored Plans – for the purpose of quality measurement and reporting.

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 ones are on the next slide.

Category 7: Training

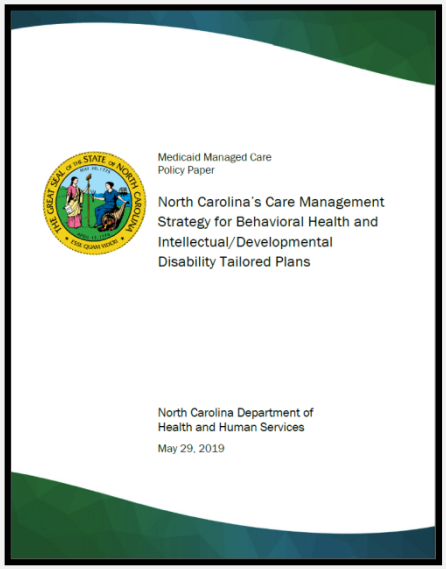
Each BH I/DD Tailored Plan will design and implement a training plan, within DHHS guidelines on the topics that must be covered.

Certification Criteria	Key Application Content	What DHHS will be Looking For

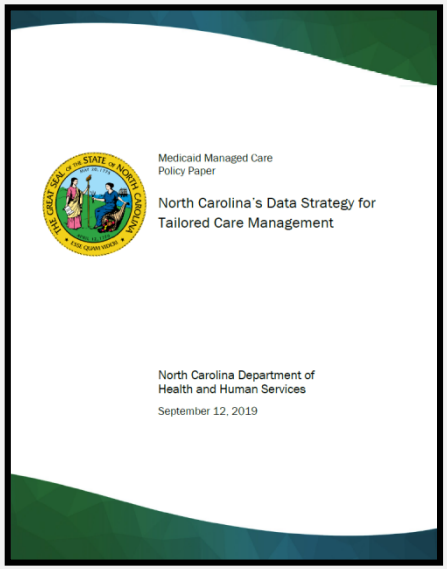
7. Training	▪ Attestation of intention to complete required trainings	Ensure care managers and supervisors will complete required trainings on:
		▪ BH I/DD Tailored Plan eligibility and services
		▪ Whole-person health and unmet resource needs
		▪ Community integration
		▪ Components of Health Home care management
		▪ Health promotion
		▪ Other care management skills
		▪ Additional trainings for care managers and supervisors serving the following populations:
		  ▪ Members with I/DD or TBI
		  ▪ Children
		  ▪ Pregnant and postpartum women with SUD or SUD history
		  ▪ Members with LTSS needs

Information about the Tailored Care Management Model

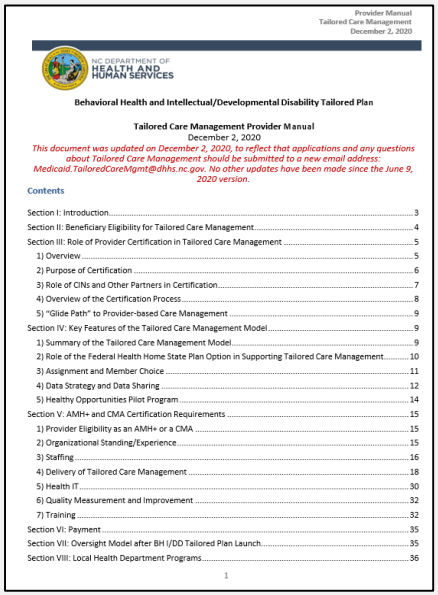
Key documents can be found on the NC DHHS Medicaid webpage. Organizations should submit applications to become AMH+ practices or CMAs to Medicaid.TailoredCareMgmt@dhhs.nc.gov.



May 2019: Concept Paper



September 2019: Data Strategy Paper


Provider Manual
Tailored Care Management
December 2, 2020

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Behavioral Health and Intellectual/Developmental Disability Tailored Plan

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December 2, 2020

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June/December 2020*: Final Provider Manual and Application Questions

**In December 2020, the Department made minor updates to the Provider Manual and application questions released in June 2020 to reflect an updated email address for submitting applications.*

Q & A