NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

ROY COOPER • Governor

KODY H. KINSLEY • Secretary

August 19, 2022

SIGNATURE REQUEST MEMORANDUM

TO: Kody H. Kinsley, Secretary

THROUGH: Jay Ludlam, Assistant Secretary for Medicaid DS JL

FROM: Betty J Staton, SPA Manager

RE: State Plan Amendment

Section 1945 of the Social Security Act for the Health Homes State Plan Option
Transmittal #2022-0024

Purpose
Attached for your review and signature is a Medicaid State Plan amendment, summarized below, and submitted on August 19, 2022, with a due date of December 26, 2022

Clearance
This amendment has been reviewed for both accuracy and completeness by:

Betty J. Staton, Emma Sandoe, Lotta Crabtree, Adam Levinson and Jay Ludlam.

Background and Summary of Request
It is recommended that you sign the Medicaid State Plan Amendment submission per Centers for Medicare and Medicaid Services (CMS) protocol as head of the Single State Agency administering the Medicaid program.

The Medicaid State Plan Amendment (SPA) requests authority for the following change to North Carolina's Medicaid State Plan:

- This Medicaid State Plan Amendment authorizes North Carolina's Health Home benefit, called Tailored Care Management. The Health Home benefit will be available to NC Medicaid beneficiaries with a significant behavioral health condition (including both mental health and severe substance use disorders), intellectual/developmental disability (I/DD), or traumatic brain injury (TBI), as defined in this State Plan Amendment. The goal for the Health Home program is to advance the delivery of high-quality, integrated, whole-person care through better coordination and collaboration across all of an enrollee's needs.

- This amendment is effective December 1, 2022

Your approval of this Medicaid State Plan Amendment is requested. If you have any questions or concerns, please contact me or Betty J. Staton at (919) 538-3215.

Health Homes Introduction

Program Authority

NC Response

1945 of the Social Security Act

The state elects to implement the Health Homes state plan option under Section 1945 of the Social Security Act.

Name of Health Homes Program:
NC Response: Tailored Care Management

Executive Summary

Provide an executive summary of this Health Homes program including the goals and objectives of the program, the population, providers, services and service delivery model used

NC Response:

North Carolina is undergoing a large-scale Medicaid transformation, transitioning the majority of its Medicaid population from a fee-for-service delivery system for physical health benefits and prepaid inpatient health plans for behavioral health and intellectual/developmental disability (I/DD) benefits to integrated managed care plans. Under this transformation, authorized via the state's 1115 demonstration, there will be three types of integrated managed care products, all of which will provide a robust set of physical health, behavioral health, long-term services and supports (LTSS), and pharmacy benefits:

(1) Standard Plans launched July 1, 2021, and serve the majority of beneficiaries.
(2) Behavioral Health and I/DD Tailored Plans (Tailored Plans), set to launch December 1, 2022. All Tailored Plan members will have a significant behavioral health condition (encompassing mental health conditions (i.e., serious and persistent mental illness (SPMI), serious mental illness (SMI) or serious emotional disturbance (SED)) and severe substance use disorders (SUD)), an I/DD, and/or a traumatic brain injury (TBI).
(3) Children and Families Specialty Plan for Medicaid-enrolled children, youth, and families served by the child welfare system, which will launch after Tailored Plans.

Beneficiaries who are delayed or excluded from integrated managed care will remain enrolled in their current Medicaid delivery system, called NC Medicaid Direct. In NC Medicaid Direct, beneficiaries eligible for full Medicaid benefits obtain physical health services, LTSS, and pharmacy through Medicaid fee-for-service and behavioral health and I/DD services through a capitated prepaid inpatient health plan (PIHP). Additionally, Medicaid beneficiaries who are federally recognized tribal members or qualify for services through the Indian Health Service are exempt from integrated managed care; most are enrolled in the Eastern Band of Cherokee Indians (EBCI) Tribal Option, an Indian managed care entity operated by the Cherokee Indian Hospital Authority offering primary care case management (PCCM) . Individuals in the EBCI Tribal Option obtain their physical health, behavioral health, LTSS, and pharmacy benefits through NC Medicaid Direct.

North Carolina intends to launch its Health Home benefit, called Tailored Care Management, on December 1, 2022, concurrent with the launch of Tailored Plans. The Health Home benefit will be available to all NC Medicaid beneficiaries who meet the eligibility criteria as described in this SPA. The

goal for the Health Home program is to advance the delivery of high-quality, integrated, whole-person care through better coordination and collaboration across all of an enrollee's needs.

The Health Home benefit will be offered through two delivery systems: Tailored Plans, which are comprehensive Medicaid managed care plans, and PIHPs offering behavioral health, I/DD, and TBI services in NC Medicaid Direct. Tailored Plans and PIHPs are administered by local management entity-managed care organizations (LME-MCOs), which are North Carolina's regionally-based and publicly-owned health plans that will deliver and oversee Tailored Care Management.

All members enrolled in a Tailored Plan are considered eligible for Tailored Care Management. Standard Plan members and individuals in the Children and Families Specialty Plan (once launched) who are eligible for Tailored Care Management will be able to transition to a Tailored Plan at any point during the coverage year to obtain Tailored Care Management.

For individuals enrolled in NC Medicaid Direct, beneficiaries who meet Tailored Care Management eligibility criteria will have the opportunity to access the Health Home benefit through a PIHP (as described in further detail in the "Enrollment of Participants" section). At any point during the year, individuals receiving services through the EBCI Tribal Option will have the opportunity to transition to a Tailored Plan to obtain Tailored Care Management or elect to obtain Tailored Care Management through a PIHP.

Generally, eligible Medicaid beneficiaries will be auto-enrolled in the Health Home benefit (Tailored Care Management) offered by the Tailored Plan or PIHP in their region, with the option to opt out of Tailored Care Management. Health Home members will be assigned to one of three approaches for obtaining Tailored Care Management: a primary care practice certified by the state as an Advanced Medical Home Plus (AMH+) practice, a behavioral health or I/DD provider certified by the state as a Care Management Agency (CMA), or a plan-based care manager. Members will have the ability to exercise choice in their assignment and change that assignment. To become an AMH+ practice or CMA, organizations must go through a state-designed certification process.

The organization that an individual is assigned to will assign a care manager who will work with a multidisciplinary care team in delivering Tailored Care Management, inclusive of the six core Health Home services.

Each Health Home member will be assigned to an "acuity tier" based on known health conditions and experience. The acuity tier determines an expected service intensity and monthly case rate for each member, with providers being paid more for high-acuity members and vice versa. Payments are retrospective and a provider must demonstrate that it has delivered at least one Health Home core service in the previous month in order to access the payment.

General Assurances

☒ The state provides assurance that eligible individuals will be given a free choice of Health Homes providers

☒ The state provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services.

☒ The state provides assurance that hospitals participating under the state plan or a waiver of such plan will be instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Homes providers.

☒ The state provides assurance that FMAP for Health Homes services shall be 90% for the first eight fiscal quarters from the effective date of the SPA. After the first eight quarters, expenditures will be claimed at the regular matching rate.

☒ The state provides assurance that it will have the systems in place so that only one 8-quarter period of enhanced FMAP for each Health Homes enrollee will be claimed.

☒The state provides assurance that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.

Health Home Geographic Limitations

⦿ Health Homes services will be available statewide.
○ Health Homes services will be limited to the following geographic areas.
○ Health Homes services will be provided in a geographic phased-in approach.

Health Homes Population and Enrollment Criteria

Categories of Individuals and Populations Provided Health Homes Services

The state will make Health Homes services available to the following categories of Medicaid participants:

☒ Categorically Needy (Mandatory and Options for Coverage) Eligibility Groups
☒ Medically Needy Eligibility Groups

- *Additional groups (Optional Medically Needy) will display as options for selection. Select any of these groups as included in the population of this Health Homes program.*

  Mandatory Medically Needy

  ☒ Medically Needy Pregnant Women
  ☒ Medically Needy Children under Age 18

  Optional Medically Needy (select the groups included in the population)

  Families and Adults

  ☒ Medically Needy Children Age 18 through 20
  ☒ Medically Needy Parents and Other Caretaker Relatives

  Aged, Blind or Disabled

  ☒ Medically Needy Aged, Blind or Disabled
  ☒ Medically Needy Blind or Disabled Individuals Eligible in 1973

Population Criteria

The state elects to offer Health Homes services to individuals with

☐ Two or more chronic conditions
☒ One chronic condition with the risk of developing another chronic condition

Specify the conditions included

☐ Mental Health Condition
☐ Substance Use Disorder
☐ Asthma
☐ Diabetes
☐ Heart Disease
☐ BMI over 25
☒ Other (specify)

Name: **NC Response**: Intellectual and Developmental Disability (I/DD), Traumatic Brain Injury (TBI), and Severe Substance Use Disorder (SUD)
Description: **NC Response** - See below for description

Specify the criteria for at risk of developing another chronic condition:
NC Response:
Individuals with an I/DD defined as those:
● Having a qualifying I/DD diagnosis, e.g. Autistic Spectrum Disorder, Down Syndrome, Fetal Alcohol Syndrome, mild, moderate, severe, or profound developmental disabilities. *For full list of qualifying I/DD diagnoses see Table 2* in NC's Tailored Plan Eligibility and Enrollment Criteria: https://files.nc.gov/ncdhhs/BH-IDD-TP-EligibilityUpdate-AppendixB-0020221-Updates.pdf.
● Being enrolled in the NC Innovations 1915(c) home and community-based services waiver targeted to people with an I/DD.
● Being on the NC Innovations waiver waiting list.
● Having used a Medicaid-covered I/DD service that will only be available through a Tailored Plan or via fee-for-service as described in NC's Tailored Plan Eligibility and Enrollment Criteria (i.e., used a service that is not offered through a Standard Plan).
● Having used an I/DD service funded with state, local, federal, or other non-Medicaid funds as described in NC's Tailored Plan Eligibility and Enrollment Criteria.

Research shows that individuals with I/DD are at high risk for a second chronic condition. Data from the National Core Indicator (NCI) surveys show that people with an I/DD diagnosis have a high prevalence of co-occurring obesity (33.6%), mood disorders (30%), anxiety disorders (27%), mental illness or psychiatric diagnoses (12%). One study found that chronic pain impacts 13-15% of the population (McGuire 2013). A number of medical conditions are also common to individuals with Autism, including obesity (33.6% prevalence for children ages 2 to 17; Hill 2015), psychiatric disorders (33% prevalence in those aged 15 and older; Doshi-Velez 2014), and gastrointestinal disorders (24.3% prevalence in those aged 15 and older; Doshi-Velez 2014).

References
Doshi-Velez, Finale, et al. "Comorbidity Clusters in Autism Spectrum Disorders: An Electronic Health Record Time-Series Analysis." (2014). Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3876178/

Hill, Alison Presmanes, et al. "Obesity and Autism." (2015). Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4657601/

McGuire, Brian E, and Susan Kennedy. "Pain in People with an Intellectual Disability." (2013). Available at: https://www.researchgate.net/profile/Brian-Mcguire/publication/236060422_Pain_in_people_with_an_intellectual_disability/links/5c3202e0a6fdccd6b59768e1/Pain-in-people-with-an-intellectual-disability.pdf

National Core Indicators. "NCI Charts (2017-2018)." (2018). Available at: https://www.nationalcoreindicators.org/charts/

North Carolina Department of Health and Human Services. "Appendix B — Criteria for Behavioral Health I/DD Tailored Plan Exemption from Mandatory Enrollment in NC Medicaid Standard Plans." (2021). Available at: https://files.nc.gov/ncdhhs/BH-IDD-TP-EligibilityUpdate-AppendixB-0020221-Updates.pdf

Individuals with a TBI defined as those:

- Being enrolled in the NC TBI 1915(c) home and community-based services waiver.
- Being on the NC TBI waiver waiting list.
- Having used a TBI service funded with state, local, federal, or other non-Medicaid funds as described in NC's Tailored Plan Eligibility and Enrollment Criteria.

Research shows that individuals with TBI often are at high risk for a second chronic condition. For example, one study indicates that common comorbidities people with TBI may develop post-TBI include hypertension (20.1%), anxiety (19.6%), high cholesterol (17.1%), and diabetes (8.7%) (percentages show prevalence in study population; Hammond 2019). The Agency for Healthcare Research and Quality (AHRQ) notes that depression prevalence post-TBI ranges from 12.2% to 76.6% (AHRQ 2011*).* People with TBI are almost nine times more likely to commit suicide than are other people of similar age, sex, psychiatric diagnosis, and history of SUD (Ahmedani 2017), and 4.5 times more likely to suffer from SUD one year after injury (Weil, Corrigan, and Karelina 2016).

References

Agency for Healthcare Research and Quality (AHRQ). "Comparative Effectiveness Review Number 25, Effective Health Care Program: Traumatic Brain Injury and Depression Executive Summary." (2011). Available at: https://effectivehealthcare.ahrq.gov/sites/default/files/related_files/depression-brain-injury_executive.pdf

Ahmedani, Brian K, et al. "Major Physical Health Conditions and Risk of Suicide." (2017). Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6602856/

Hammond, Flora M, et al. "Prevalence of Medical and Psychiatric Comorbidities Following Traumatic Brain Injury." (2019). Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6602856/

North Carolina Department of Health and Human Services. "Appendix B — Criteria for Behavioral Health I/DD Tailored Plan Exemption from Mandatory Enrollment in NC Medicaid Standard Plans." (2021). Available at: https://files.nc.gov/ncdhhs/BH-IDD-TP-EligibilityUpdate-AppendixB-0020221-Updates.pdf

Weil, Zachary M., John D. Corrigan, and Kate Karelina. "Alcohol Abuse After Traumatic Brain Injury: Experimental and Clinical Evidence." (2016). Available at: https://www.sciencedirect.com/science/article/abs/pii/S0149763415302359

Individuals with a severe SUD defined as:

- Having a qualifying SUD diagnosis code and associated service utilization indicative of severe impairment (use of a Medicaid-covered enhanced behavioral health service, as described in NC's Tailored Plan Eligibility and Enrollment Criteria during the lookback period). For full list of qualifying SUD diagnoses, see Table 5 in NC's Tailored Plan Eligibility and Enrollment Criteria.
- Having used a Medicaid-covered SUD service that will only be available through a Tailored Plan or via fee-for service as described in NC's Tailored Plan Eligibility and Enrollment Criteria (i.e., used a service that is not offered through a Standard Plan).
- Having used an SUD service funded with state, local, federal, or other non-Medicaid funds as described in NC's Tailored Plan Eligibility and Enrollment Criteria.
- Having an admission to a state alcohol and drug abuse treatment center (ADATC), including, but not limited to, individuals who have had one or more involuntary treatment episode(s) in a state-owned facility.

Individuals with SUD are at risk for additional chronic conditions due to current alcohol or other non-opioid substance use, or a history of such. Excessive alcohol use can lead to the development of high blood pressure (1.3 – 2.8 times higher risk), heart disease (1.1 times higher risk), stroke (1.7 – 2.2 times higher risk), liver disease (5.1 – 6 times higher risk), and cancer (1.2 – 6.5 times higher risk) (CDC and Rehm, et al. 2010). Cocaine use is associated with mental illness (10-40% likelihood (American Addiction Centers)), HIV (19% prevalence), hepatitis B (47% prevalence), and hepatitis C (15% prevalence among injecting drug users worldwide) (United Nations Office on Drugs and Crime). Cocaine use also accounts for 25% of non-fatal heart attacks in individuals ages 18-45 (Antai-Otong 2006).

Additionally, about 50% of those who experience a mental illness during their lives will also experience an SUD and vice versa (Ross 2012, Kelly 2013).

References

American Addiction Centers. "The Risks and Side Effects of Cocaine Addiction" (2021). Available at: https://americanaddictioncenters.org/cocaine-treatment/risks

Antai-Otong, Deborah. "Medical Complications of Cocaine Addiction: Clinical Implications for Nursing Practice." (2006). Available at: http://people.uncw.edu/noeln/Articles/Medical-cocaine.pdf

Kelly, Thomas M, and Dennis C Daley. "Integrated Treatment of Substance Use and Psychiatric Disorders." (2013). Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3753025/

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Ross, Stephen, and Eric Peselow. "Co-Occurring Psychotic and Addictive Disorders: Neurobiology and Diagnosis." (2012). Available at: https://pubmed.ncbi.nlm.nih.gov/22986797/

United Nations Office on Drugs and Crime. "World Drug Report 2012." (2012). Available at: https://www.unodc.org/documents/data-and-analysis/WDR2012/WDR_2012_web_small.pdf

☒One serious and persistent mental health condition.

Specify the criteria for a serious and persistent mental health condition

NC Response:

Individuals with a serious and persistent mental health condition defined by:

● Having a qualifying mental health diagnosis code highly associated with serious and persistent mental illness (e.g., primary psychotic disorders) (see below).

● Having a qualifying mental health diagnosis code and associated service utilization indicative of severe impairment (use of a Medicaid-covered enhanced behavioral health service, as described in NC's Tailored Plan Eligibility and Enrollment Criteria during the lookback period). Qualifying mental health criteria:

-For certain diagnoses, North Carolina also requires that the person have associated service utilization indicative of severe impairment (use of a Medicaid-covered enhanced behavioral health service) consistent with an SED or an SMI. For a full list of diagnoses and behavioral health enhanced services, see Tables 3.1, 3.2, 4.1, 4.2, and 6 in NC's Tailored Plan Eligibility and Enrollment Criteria

-Use of electroconvulsive therapy

-Use of clozapine or long-acting injectable antipsychotics

-Suicide attempt

● Having used a Medicaid-covered behavioral health service that will only be available through a Tailored Plan or via fee-for-service as described in NC's Tailored Plan Eligibility and Enrollment Criteria (i.e., used a service that is not offered through a Standard Plan).

● Having used a mental health service funded with state, local, federal, or other non-Medicaid funds as described in NC's Tailored Plan Eligibility and Enrollment Criteria.

● Having two or more psychiatric hospitalizations or readmissions within 18 months.

● Having an admission to a state psychiatric hospital, including, but not limited to, individuals who have had one or more involuntary treatment episodes in a state-owned facility.

● Having two or more visits to the emergency department for a psychiatric problem within 18 months.

● Having two or more episodes using Behavioral Health crisis services within 18 months.

● Being served by the Transitions to Community Living Initiative, North Carolina's Olmstead settlement for individuals with serious mental illness or serious and persistent mental illness.

● Being classified as a child with complex needs, as that term is defined in the 2016 settlement agreement between North Carolina and Disability Rights of North Carolina. The settlement defines children with complex needs as Medicaid-eligible children ages 5 and under 21, who have been diagnosed with a developmental disability (including Intellectual Disability and/or Autism Spectrum Disorder) and a mental health disorder, who are at risk of not being able to return to or maintain placement in a community setting.

Enrollment of Participants

Participation in a Health Homes is voluntary. Indicate the method the state will use to enroll eligible Medicaid individuals into a Health Home

☐Opt-in to Health Homes provider

☒Referral and assignment to Health Homes provider with opt-out

Describe the process used

NC Response

The Health Home benefit, called Tailored Care Management, will be available to all NC Medicaid beneficiaries who meet the eligibility criteria. The Health Home benefit will be offered through two delivery systems: Tailored Plans, which are comprehensive Medicaid managed care plans, and North Carolina's fee-for-service program (NC Medicaid Direct), which covers behavioral health and I/DD services through PIHPs. LME-MCOs—North Carolina's regionally-based and publicly-owned managed care plans that will deliver and oversee Tailored Care Management—will administer Tailored Plans and PIHPs and serve as the Health Home for all members enrolled in Tailored Care Management. Tailored Care Management will be the default care management model for individuals who meet Health Home eligibility and are enrolled in Tailored Plans and PIHPs, with the exception of members obtaining duplicative care management (discussed below).

As described below, individuals enrolled in other delivery systems (i.e., Standard Plans, Children and Families Specialty Plan) who are eligible for the Health Home benefit will have the option to transition into a Tailored Plan and/or NC Medicaid Direct at any point during the plan year to obtain it. Throughout North Carolina's managed care launch, the state has regularly communicated with beneficiaries on the managed care transition and their managed care choices. The Department has contracted with an enrollment broker to educate beneficiaries on Medicaid managed care and provide choice counseling and enrollment assistance.

Accessing Tailored Care Management through a Tailored Plan

The majority of the Health Home population will be enrolled in Tailored Plans. All Tailored Plan members have a significant behavioral health condition (e.g., SPMI, SMI, SED, or severe SUD), an I/DD, and/or TBI. As described in this SPA, North Carolina is proposing that all members eligible for a Tailored Plan would also be eligible for the Health Home benefit (Tailored Care Management) unless they are receiving a duplicative service.

Prior to Tailored Plan and Tailored Care Management launch in December 2022, the North Carolina Department of Health and Human Services (the Department) will identify through claims, encounters, and enrollment data which beneficiaries are eligible for a Tailored Plan. Beneficiaries meeting the above criteria who are not otherwise part of a population that is delayed or excluded from managed care will be auto-enrolled in a Tailored Plan. Members of federally recognized tribes and beneficiaries eligible to receive services from the Indian Health Service are exempt from integrated managed care; these individuals who otherwise meet Tailored Plan clinical criteria will have the option to enroll in a Tailored Plan but will not be auto-enrolled. The Department will notify these individuals of their option to enroll in a Tailored Plan, through which they would receive Tailored Care Management. For those who are not

identified through the data review, there is a process to request enrollment in a Tailored Plan as described below.

After Tailored Plan launch, Standard Plan members who become eligible for a Tailored Plan will be able to transition to a Tailored Plan at any point during the coverage year; when they make this transition, they can obtain Tailored Care Management. If a Standard Plan member believes they may be eligible for a Tailored Plan, but has not been determined eligible based on data review, they can themselves, or with support from a guardian/legally responsible person or provider, complete a form indicating the reason(s) they believe they are eligible for a Tailored Plan. Once received, the Department (or its contractors) will review the forms and follow up with the beneficiary, their guardian/legally responsible person, and/or their provider for more information as needed. If the request is approved, the Department will send a letter to the beneficiary to let them know that they will be enrolled in a Tailored Plan, with the Tailored Plan providing access to Health Home services. If the request is not approved, the Department will send a letter to the beneficiary to let them know that they will continue to be enrolled in their Standard Plan. The letter will also tell them how they can appeal if they do not agree with the decision.

Accessing Tailored Care Management through a PIHP

Individuals enrolled in NC Medicaid Direct (North Carolina's fee-for-service delivery system) will also have access to the Health Home benefit (Tailored Care Management) through a PIHP if they meet the Health Home eligibility criteria. The Department will auto-enroll all Health Home-eligible NC Medicaid Direct members into Tailored Care Management through a PIHP, unless they are receiving a duplicative service (as described below). The Department will also notify beneficiaries who are delayed, exempt, or excluded from managed care of the process to be determined eligible to obtain Tailored Care Management through a PIHP (this process is similar to that described above for Standard Plan members to be determined eligible to transition to a Tailored Plan).

Special Considerations for EBCI Tribal Option Members

Individuals enrolled in the EBCI Tribal Option, an Indian managed care entity offering PCCM that is run by the Cherokee Indian Hospital Authority, are eligible for Tailored Care Management. Since the EBCI Tribal Option is duplicative of Tailored Care Management, at any point during the year, individuals receiving services through the EBCI Tribal Option will have the opportunity to transition to a Tailored Plan to obtain Tailored Care Management or elect to obtain Tailored Care Management through the PIHP.

Special Considerations for Individuals Eligible for the Children and Families Specialty Plan (CFSP)

Individuals eligible for the CFSP, a delayed managed care population, who also meet Health Home eligibility criteria will have access to Tailored Care Management either through a PIHP or through a Tailored Plan. Prior to the launch of the CFSP, CFSP-eligible individuals will remain enrolled in NC Medicaid Direct (since they are currently delayed from managed care). If they also meet the Health Home eligibility criteria, they will be auto-enrolled in Tailored Care Management through the PIHP. After the launch of the CFSP, individuals who meet the CFSP eligibility criteria will be default enrolled into the CFSP. The CFSP will offer a robust, whole-person care management program that is substantially

equivalent to and duplicative of Tailored Care Management, but will not serve as a Health Home. Individuals enrolled in the CFSP who also meet Tailored Plan eligibility criteria will have the option to switch their enrollment at any time to a Tailored Plan in order to access Tailored Care Management.

Tailored Care Management Approaches

Regardless of the delivery system they are enrolled in (i.e., Tailored Plan or PIHP), eligible members will have three options for obtaining Tailored Care Management: through an AMH+ practice, a CMA, or a care manager based at an LME-MCO. Prior to launch, North Carolina's enrollment broker will send members a welcome letter explaining Tailored Care Management and providing information on the three different care management approaches; members will have the option to select which approach and organization they prefer. For members who do not express a preference, members will be assigned based on algorithm that accounts for variables determined by the Department to assign them to an organization where they will obtain Tailored Care Management. The Tailored Care Management assignment algorithm accounts for provider relationships, physical and behavioral health complexity, geographic proximity, and federal conflict-free case management rules, among other factors. As part of the member welcome packet, the LME-MCO will send members information on Tailored Care Management, including their assignment and the process and options for changing that assignment. LME-MCOs will also provide counseling to members on care management approaches. Auto-assignment prior to initial launch will be conducted by the Department. After the initial launch, on an ongoing basis, the LME-MCO will complete Tailored Care Management assignments, in line with the Department's auto-assignment requirements, and send the assignment information as part of the member welcome packet. Members can change the organization they are assigned to for Tailored Care Management and/or change care managers twice per year without cause and any time with cause. The organization assigned for providing Tailored Care Management (AMH+ practice, CMA, or LME-MCO) will assign an individual care manager.

Duplicative Services

For individuals who are obtaining Tailored Care Management through an AMH+ practice or CMA (the delegated provider), the LME-MCO will not be providing any duplicative care management or care coordination services; Tailored Care Management is designed to encompass the care coordination and care transitions requirements of 42 CFR 438.208. Rather, the LME-MCO will be responsible for ensuring that the federal regulatory requirements are met. In the scenario where a beneficiary is obtaining a duplicative care management service—defined as Assertive Community Treatment (ACT), Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID), services for a long stay in a nursing facility, High Fidelity Wraparound, the EBCI Tribal Option, Care Management for At-Risk Children, Community Alternatives Program for Children (CAP/C), Community Alternatives Program for Disabled Adults (CAP/DA), or care management provided by the state's PCCM vendor—the LME-MCO will be responsible for ensuring that the member does not also obtain Tailored Care Management. Tailored Care Management may be provided for one month if a beneficiary is transitioning to or from ACT, a long-stay in a nursing facility, or ICF-IID to or from Tailored Care Management. The Department will ensure that individuals in the Program of All-Inclusive Care for the Elderly (PACE), who are excluded from both Tailored Plans and PIHPs, do not also receive Tailored Care Management since it is a duplicative service. As the Department reviews and approves new in lieu of services (ILOS) and State

Plan services, the Department will monitor whether these new services are duplicative of Tailored Care Management and will perform the activities below to prevent duplication.

North Carolina will use multiple strategies to ensure members do not receive services that are duplicative of Tailored Care Management, including through LME-MCO oversight and system requirements and quarterly reporting/monitoring requirements:

- LME-MCO Oversight/Reporting Obligations. LME-MCOs are contractually obligated to ensure that members do not receive a duplicative service and must submit, for state review and approval, their policies and procedures for ensuring members do not receive duplicative care management from multiple sources.

- Claims Submission and Adjudication. LME-MCOs are required to develop a "billing edit" as part of their claims processing system(s) that will not allow billing for both Tailored Care Management and a duplicative service for the same beneficiary in a single month except for months in which a member is transitioning services. AMH+ practices and CMAs that furnish Tailored Care Management services to a beneficiary will submit a Tailored Care Management claim (with the appropriate billing code) to the beneficiary's LME-MCO. Upon receiving claims from AMH+ practices and CMAs, LME-MCOs will adjudicate the claims, ensuring that payment is not made for duplicative services (e.g., the edit would ensure that for a single beneficiary, a provider would not get paid for delivering Assertive Community Treatment in the same month that an AMH+ gets paid for delivering Tailored Care Management). AMH+/CMA Tailored Care Management claims that meet all the requirements and rules will be processed. LME-MCOs will issue payment to AMH+s/CMAs for claims that meet all the requirements and will submit a Tailored Care Management claim to North Carolina Medicaid to request payment. LME-MCOs must also ensure that they are not submitting a claim to the Department for Tailored Care Management in a month that a provider delivered a duplicative service to a beneficiary.

Supports for Individuals not Receiving Tailored Care Management

Individuals who opt out or are not engaged in Tailored Care Management will receive care coordination through the Tailored Plan or PIHP. North Carolina will not claim the enhanced Health Home match for these individuals.

Assurance

☒The state provides assurance that it will clearly communicate the individual's right to opt out of the Health Homes benefit or to change Health Homes providers at any time and agrees to submit to CMS a copy of any letter or communication used to inform the individuals of the Health Homes benefit and their rights to choose or change Health Homes providers or to elect not to receive the benefit.
☐Other (describe)

Health Home Providers

Types of Health Home Providers

☒ Designated Providers

Indicate the Health Homes Designated Providers the state includes in its program and the provider qualifications and standards

☐ Physicians
☐ Clinical Practices or Clinical Group Practices
☐ Rural Health Clinics
☐ Community Health Centers
☐ Community Mental Health Centers
☐ Home Health Agencies
☐ Case Management Agencies
☐ Community/Behavioral Health Agencies
☐ Federally Qualified Health Centers (FQHC)
☒ Other (Specify)

Provider Type/Description:

NC Response:

Provider Type	Description
LME-MCOs, in their role administering Tailored Plans and PIHPs	Through the procurement of Tailored Plans, North Carolina determined that each LME-MCO, as carriers of Tailored Plans and PIHPs, would be qualified to serve as a Health Home. Tailored Plans are fully integrated managed care plans that North Carolina has procured to serve individuals with significant behavioral health needs, I/DD, and TBI. PIHPs are a limited benefit managed care product that manage behavioral health and I/DD services. As a Health Home, LME-MCOs will perform the following functions: ● Contract with all AMH+s/CMAs in their region. ● Assign members to a care management approach/provider and honor member's preference in approach: AMH+ practice, CMA, or a care manager based at the plan. (The Department will conduct initial care management assignment prior to program launch.) ● Employ care managers who work with multidisciplinary care teams in delivering Tailored Care Management to members assigned to them. ● Ensure that care managers at the assigned organization providing Tailored Care Management deliver care management contacts, informed by the member's acuity tier:

	Members with behavioral health needs: - High acuity: at least four care manager-to-member contacts per month, including at least one in-person contact. - Moderate acuity: at least three contacts per month and at least one in-person contact quarterly. - Low acuity: at least two contacts per month and at least two in-person contacts per year, approximately six months apart. Members with an I/DD or TBI: - High acuity: at least three care manager-to-member contacts per month, including two in-person contacts. - Moderate acuity: at least three contacts per month and at least one in-person contact quarterly. - Low acuity: at least one contact per month and at least two in-person contacts per year, approximately six months apart. ● Distribute appropriate payments to CMAs and AMH+ practices for delivering Tailored Care Management to assigned members. ● Train all care managers to deliver Tailored Care Management. ● Conduct oversight of AMH+ practices and CMAs. ● Consume and use physical health, BH, I/DD, and TBI claims, pharmacy and encounter data, clinical data, Admission, Discharge, Transfer (ADT) data, risk stratification information, and/or unmet health-related resource needs data. ● Share and transmit data to AMH+ practices and CMAs in support of Tailored Care Management. ● Provide regular reports to the state, including those required by CMS. ● Hold primary responsibility for delivering Tailored Care Management for the population assigned to them via a care manager and multidisciplinary care team. (See “Health Home Delivery System” for more details on Tailored Plans’ role and requirements.)
AMH+ Practices	Organizations must go through a state-designed certification process to become an AMH+ practice. AMH+ practices must:

	● Be primary care practices actively serving as a state-designated Advanced Medical Home Tier 3 practice or state-designated primary care practices that have attested to meeting standards necessary to provide local care management services and reflect capacity for data-driven care management and population health capabilities for their assigned populations. ● Have experience delivering primary care services to the Tailored Care Management-eligible population or otherwise demonstrate strong competency to serve that population. Primary care practices, Rural Health Clinics, Federally Qualified Health Centers, community health centers, and Local Health Departments may apply to be AMH+ practices. ● Attest to having 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 encounters with the AMH+ applicant's practice team in the past 18 months. ● Meet all requirements specified as part of the certification process (e.g., requirements related to health information technology (IT), staffing, quality measurement and improvement). (See "Other Health Homes Provider Standards" for more details on the certification process and provider requirements.) AMH+ practices will hold primary responsibility for delivering Tailored Care Management for the population assigned to them via a care manager and multidisciplinary care team.
CMAs	Organizations must go through a state-designed certification process to become a CMA. CMAs must have ● Experience delivering behavioral health, I/DD, and/or TBI services to the Tailored Care Management-eligible population. Organizations including Community Mental Health Centers, clinical practices/clinical group practices, and community-based behavioral health agencies may apply to be CMAs. ● The primary purpose, at the time of certification, of delivering NC Medicaid, NC Health Choice, or state-funded services, other than care management, to the Tailored Care Management-eligible population in North Carolina. ● Met all requirements specified as part of the certification process (e.g., requirements related to health information technology (IT), staffing, quality measurement, and improvement). (See "Other Health Homes Provider

	Standards" for more details on the certification process and provider requirements.) CMAs will hold primary responsibility for delivering Tailored Care Management for the population assigned to them, via a care manager and multidisciplinary care team.

☐ Teams of Health Care Professionals
☐ Health Teams

Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Home Services

NC Response

Health Home services and providers have been incorporated into North Carolina's Tailored Plan and PIHP infrastructure. The Health Home structure is as follows:

● LME-MCOs, as carriers of the Tailored Plan and PIHP products, will serve as the Health Homes for individuals who meet the Tailored Care Management Health Home eligibility criteria. These individuals will have the choice of obtaining Health Home services (Tailored Care Management) from one of three approaches: through an AMH+ practice, a CMA, or a care manager based at a plan (see the "enrollment" section of the SPA for additional details on assignment and choice). LME-MCOs will also hold primary responsibility for delivering Tailored Care Management for the population assigned to them via a care manager and multidisciplinary care team.

● AMH+ practices and CMAs will hold primary responsibility for delivering Tailored Care Management for the population assigned to them via a care manager and multidisciplinary care team. North Carolina's vision is to increase over time the proportion of actively engaged Tailored Plan and PIHP members receiving Tailored Care Management from AMH+ practices and CMAs (as opposed to a care manager based at the LME-MCO). To help achieve this vision, North Carolina has established a four-year "glide path" where LME-MCOs will be required to meet escalating annual targets on the percentage of members actively engaged in Tailored Care Management via AMH+ practices and CMAs.

● Clinically Integrated Networks (CINs) or Other Partners—AMH+ practices and CMAs may partner with CINs or Other Partners for support with specific functions and capabilities required to operate as an AMH+ practice or a CMA. CINs/Other Partners may offer a wide range of support, including care manager staffing support, assistance with meeting health IT requirements, and supporting AMH+ and CMA data integration, analytics, and use (e.g., importing and analyzing claims/encounter data).

● Care Managers/Supervising Care Managers—the organization that an individual is assigned to for Tailored Care Management (AMH+ practice, CMA, or LME-MCO) will assign a care manager who will work with a multidisciplinary care team in delivering Tailored Care Management.

● Care Manager Extenders (e.g., Peer Support Specialists, Community Navigators, Community Health Workers (CHWs), people with lived experience and with an I/DD or TBI, parents or guardians of an individual with an I/DD or a TBI or a behavioral health condition* may support care managers in

delivering certain components Tailored Care Management (see "Other Provider Health Home Standards" for details on extender qualifications**.**
* A parent/guardian cannot serve as an extender for their own family member))

Care managers (or supervising care managers) will closely supervise extenders and ensure that they work within their training and scope. Extenders may support care managers in delivering Tailored Care Management by performing activities that fall within the below categories:
-Performing general outreach, engagement, and follow-up with members
-Coordinating services/appointments (e.g., appointment/wellness reminders, arranging transportation)
-Engaging in health promotion activities (as defined in the Tailored Care Management Provider Manual) and knowledge sharing
-Sharing information with the care manager and other members of the care team on the member's circumstances
-Providing and tracking referrals and providing information and assistance in obtaining and maintaining community-based resources and social support services
-Participating in case conferences
-Support the care manager in assessing and addressing unmet health-related resource needs

● Multi-disciplinary care team—includes the member, care manager, and the following individuals, varying based on the member's needs:
- Caregivers(s)/legal guardians
- Supervising care manager
- Primary care provider
- Behavioral health provider(s)
- I/DD and/or TBI providers
- Other specialists
- Nutritionists
- Pharmacists and pharmacy techs
- Obstetrician/gynecologist (for pregnant women)
- Care manager extenders (e.g., Peer Support Specialist, Community Navigator, CHW)
- In-reach and transition staff
- Other providers and individuals, as determined by the care manager and member

Organizations providing care management (AMH+ practices, CMAs, and LME-MCOs) do not necessarily need to have all the care team members on staff or embedded in the AMH+ practice or CMA – providers of various specialties may participate in care teams virtually from other settings. Organizations must establish a plan to activate relationships with primary care providers and other key interdisciplinary agencies/providers. Additionally, organizations must have written policies and procedures to ensure that multidisciplinary care team formation and communication occur in a timely manner and that the care team is documented in the care plan or ISP and is regularly updated. To implement such policies, care managers will be required to conduct regular case conferences with members of the multidisciplinary care team, as appropriate based on member needs.

● Clinical Consultants—care managers will also have access to clinical consultants in order to secure expert support appropriate for the needs of their members, including a general psychiatrist or child and

adolescent psychiatrist, a neuropsychologist or psychologist, and a primary care physician, as appropriate.

Supports for Health Home Providers

Describe the methods by which the state will support the Health Homes providers in addressing each of the eleven components of a Health Homes program

1. Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered Health Home services;
2. Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines;
3. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders;
4. Coordinate and provide access to mental health and substance abuse services;
5. Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings; transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric system to an adult system of health care;
6. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families;
7. Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services;
8. Coordinate and provide access to long-term care supports and services;
9. Develop a person-centered care plan for each individual, that coordinates and integrates all of his or her clinical and non-clinical health care-related needs and services;
10. Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate; and
11. Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.

Description

NC Response:

The state is supporting providers of Health Home services by:

Establishing Health Home requirements for the LME-MCO in the Tailored Plan and PIHP contracts, including the LME-MCO's role in supporting and overseeing Health Home providers**.** North Carolina conducted a rigorous Request for Applications process to select the entities serving as Tailored Plans. North Carolina also is facilitating an intensive readiness process to ensure the LME-MCOs will be ready to oversee and perform all aspects of Tailored Care Management upon Tailored Plan launch, including developing training curricula and providing ongoing technical assistance to AMH+ practices and CMAs. (See the "Health Homes Service Delivery Systems" section for more details on the Tailored Plan's role in the model.)

Implementing a certification process to ensure community-based providers have the infrastructure for and are otherwise prepared to offer Health Home services at launch. (See the "Health Homes Service Delivery Systems" section for more details on the LME-MCO's role in the model.)

Ensuring all care managers, supervisors, and care manager extenders receive high-quality, intensive training. Each LME-MCO will design and implement a training plan that includes the following required domains identified by North Carolina in the Tailored Plan and PIHP contracts: Tailored Plan eligibility and services, whole-person health and unmet resource needs, community integration, components of Health Home care management, health promotion, and other care management skills (e.g., transitional care management best practices). Care managers, supervisors, and care manager extenders who serve members with an I/DD or TBI, children, pregnant and postpartum women with SUD or SUD history, and members with LTSS needs will receive additional trainings. LME-MCOs must submit their training programs to the state for approval and are responsible for ensuring all care managers, supervising care managers, and care manager extenders serving its members, whether based at the LME-MCO, AMH+, or CMA, are trained. The training program will ensure that care managers and care manager extenders will address each of the eleven components of the Health Home program and provide the six core Health Home services. The LME-MCO will identify core modules that care managers and care manager extenders must complete before being deployed to serve members; care managers and care manager extenders must complete the remaining training modules within thirty days of being deployed to serve members.

Publishing a Tailored Care Management provider manual. The manual describes the functions AMH+ practices and CMAs will be expected to perform, including activities care managers must perform on an ongoing basis. The manual also outlines Health IT and data sharing requirements, the care management assignment process and the role of member choice in that process, care manager qualifications, and the approach to AMH+ practice/CMA oversight.

Offering statewide technical assistance (TA). The state launched a statewide technical assistance program to support AMH+ practices and CMAs in becoming successful high-quality providers of Tailored Care Management. The TA program is designed to help providers operationalize Tailored Care Management, including through identifying gaps related to workflows/technology/personnel to succeed in the model, and developing and implementing solutions to address those gaps. TA modalities include dedicated one-on-one practice coaching, group learning opportunities (e.g., learning collaboratives), written best practices, and on-demand subject matter expertise.

Providing capacity building funding. The state has designed a capacity building program, which is designed to meet federal requirements for managed care performance incentive arrangements set by 42 CFR 438.6(b)(2). Through the capacity building program, funds are distributed to LME-MCOs, AMH+ practices, and CMAs to be used for investment in three key areas: care management-related Health IT infrastructure, workforce development (hiring and training care managers), and operational readiness (developing policies/procedures/workflows and other competencies linked to operationalizing the Tailored Care Management model). Under the program, LME-MCOs are eligible to obtain funding if they achieve state-determined milestones related to these three major areas of investments; they then distribute funding to AMH+ practices and CMAs.

Maintaining a centralized webpage with resources for Health Home providers. The Tailored Care Management provider manual, guidance documents, and other resources are available at the Tailored Care Management webpage: https://medicaid.ncdhhs.gov/transformation/tailored-care-management, which is updated regularly.

Other Health Homes Provider Standards

The state's requirements and expectations for Health Homes providers are as follows

NC Response

The state's requirements and expectations for the LME-MCOs in their role as Health Homes are summarized in the section "Health Homes Service Delivery Systems." LME-MCOs are required to contract with all certified AMH+ practices and CMAs in their geographic region and AMH+/CMAs will deliver Tailored Care Management for assigned members.

In order to achieve the designation of an AMH+ or CMA, providers must undergo the following certification process:

Submit a written application and undergo a "desk review." The state, or its designee, will review each application to assess whether the provider organization is on track to satisfy the full criteria to deliver Tailored Care Management at Tailored Plan and PIHP launch or at a target certification date (if after initial launch).

The application desk review assesses the below categories.

Eligibility – To be eligible to become an AMH+, the applicant must have 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+ practice applicants must also be actively serving as a state-designated Advanced Medical Home Tier 3 practice and intend to become a network primary care provider for Tailored Plans. To be eligible to become a CMA, the applicant'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 Tailored Care Management-eligible population in North Carolina. Additionally, applicants must have experience delivering behavioral health, I/DD, and/or TBI services to the Tailored Care Management-eligible population.

Organizational Standing and Experience - Applicants must demonstrate:
● Relevant experience to provide Tailored Care Management to the Tailored Care Management-eligible population, specifically the subpopulation(s) for whom it proposes to become a certified Tailored Care Management provider (e.g., adult, child, I/DD, or TBI populations).
● Active, working relationships with community providers that offer a wide scope of clinical and social services, including strong reciprocal relationships among relevant behavioral health, I/DD, and primary care providers, in order to facilitate referrals among providers as well as provide formal and informal feedback and opportunities to share best practices.
● The capacity and financial sustainability to establish care management as an ongoing line of business.
● Appropriate structures in place to oversee the Tailored Care Management model, including evidence of a strong governance structure.

Staffing – Applicants must be able to ensure that all care managers providing Tailored Care Management meet or will meet minimum qualification requirements and will be supervised by a supervising care manager. At the time of certification, applicants must provide an estimate of how many care managers/supervisors they intend to employ and describe their recruitment strategy to attract and retain well-qualified care management staff.

Care managers serving all members must have the following minimum qualifications:
● Meet North Carolina's definition of a Qualified Professional per 10A-NCAC 27G .0104.
● 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 requirement cited above. (This experience may be concurrent with the years of experience required to become a Qualified Professional.)

Supervising care managers serving members with behavioral health conditions must have the following minimum qualifications:
● A license, provisional license, certificate, registration or permit issued by the governing board regulating a human service profession (including Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), Licensed Clinical Addiction Specialist (LCAS), Licensed Clinical Mental Health Counselor (LCMHC), Licensed Psychological Associate (LPA)), or a Registered Nurse (RN) license issued by the North Carolina Board of Nursing; and
● Three years of experience providing care management, case management, or care coordination to the population being served.

Supervising care managers serving members with an I/DD or a TBI must have <u>one</u> of the following minimum qualifications:
● A bachelor's degree and five years of experience providing care management, case management, or care coordination to complex individuals with I/DD or TBI;
<u>or</u>
● A master's degree in a human services field and three years of experience providing care management, case management, or care coordination to complex individuals with an I/DD or a TBI.

A care manager extender is defined as an individual who:

a. Is at least 18 years of age;
b. Has a high school diploma or equivalent;
c. Is trained in Tailored Care Management (as described later in this document);
d. Is supervised by a care manager (or supervising care manager) at an AMH+ practice, CMA, or LME-MCO,
<u>and meets one of the below requirements</u>:
- Be a person with lived experience with an I/DD or a TBI with demonstrated knowledge of and direct personal experience navigating the North Carolina Medicaid delivery system.*
<u>or</u>
-Be a person with lived experience with a behavioral health condition who is a Certified Peer Support Specialist.
<u>or</u>

- A parent or guardian of an individual with an I/DD or a TBI or a behavioral health condition who has at least two years of direct experience providing care for and navigating the Medicaid delivery system on behalf of that individual (parent/guardian cannot serve as an extender for their family member).*
or
-Has two years of paid experience performing the types of extender functions described in the "Provider Infrastructure" section above, with at least one year of paid experience working directly with the Tailored Care Management-eligible population.

* North Carolina will require additional trainings for individuals with lived experience and parents/guardians to prepare them to perform the duties of an extender.

Delivery of Tailored Care Management – Applicants must:
● Describe their approach to linking minimum contact requirements to staffing plans.
● Describe their approach for meeting all the required components of Tailored Care Management, including
-Completing care management comprehensive assessments and reassessments;
-Developing written care plans/individual support plans (ISPs);
-Establishing and activating multidisciplinary care teams, including the sharing of pertinent data across the team and conducting case conferences;
-Delivering ongoing Tailored Care Management, inclusive of the six core Health Home services;
-Addressing unmet health-related resource needs; and
-Identifying members in transition and delivering transitional care management.

If an applicant will serve the Innovations and TBI waiver populations, it must also describe its approach to addressing the additional care coordination requirements for this population.

Health IT – Applicants must:
● Attest to having an electronic health record (EHR) or clinical system of record that is in use by the organization's providers to record, evaluate, and transmit member clinical information, including medical adherence.
● Describe which care management data system(s) they will use to track assessments, care plans/ISPs, and care team actions. Upon launching Tailored Care Management, AMH+s/CMAs must have a care management data system that can:
- Maintain up-to-date documentation of Tailored Care Management member lists and assignments of individual members to care managers;
- Electronically document and store the care management comprehensive assessment and re-assessment;
- Electronically document and store the care plan or ISP;
- Consume claims and encounter data;
- Provide role-based access to each member of the multidisciplinary care team;
- Provide access to – and electronically share, if requested – member records with the member's care team to support coordinated care management, as well as the member, in accordance with federal, state, and Department privacy, security, and data-sharing requirements; and
- Track referrals.

● Applicants must share when ADT alerts/functionality will be in place and describe how ADT alerts will be monitored and conveyed to care managers. Upon launching Tailored Care Management, AMH+ practices and CMAs must have access to ADT data that correctly identifies when members are admitted, discharged, or transferred to or from an ED or a hospital in real time or near real time.

Quality Measurement and Improvement – Applicants must describe how they will participate in quality measurement documentation, data collection and abstraction, analysis, and outreach in accordance with current North Carolina Medicaid requirements.

Upon launching Tailored Care Management, AMH+ practices and CMAs must gather, process, and share data with LME-MCOs for the purpose of quality measurement and reporting. At least annually, the AMH+ or CMA must evaluate the Tailored Care Management services it provides to ensure that the services are meeting the needs of empaneled members and refine the services as necessary.

Training - Applicant must attest that care managers and supervising care managers will complete required trainings provided by LME-MCOs.

Undergo a site review - North Carolina will arrange to conduct one or more site reviews 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. Organizations are not expected to meet all criteria fully at the point of the site review but must be on track to meet the criteria by Tailored Plan and PIHP launch or at a target certification date (if after initial launch).

Conduct readiness reviews and further site visits – The Department and LME-MCOs will conduct final readiness reviews and additional site reviews (as needed) to ensure AMH+ practices and CMAs are ready to begin delivering Tailored Care Management. Readiness reviews will occur as part of Tailored Plan and PIHP contracting with AMH+ practices and CMAs and will examine numerous aspects of provider readiness, including providers' staffing, health IT capabilities, and final policies and procedures.

Health Homes Service Delivery Systems

Identify the service delivery system(s) that will be used for individuals receiving Health Homes services

☒ Fee for Service
☐ PCCM
☒ Risk Based Managed Care

The Health Plans will be a Designated Provider or part of a Team of Health Care Professionals

⦿ Yes
○ No

Provide a summary of the contract language that you will impose on the Health Plans in order to deliver the Health Homes services

NC Response

The Tailored Plan and PIHP contracts include requirements for the LME-MCOs both in their role overseeing the Health Home program and as a Health Home providers. North Carolina will conduct

readiness reviews, end-to-end testing, and other activities to verify that LME-MCOs are prepared to oversee and perform all aspects of Tailored Care Management.

In their oversight role, LME-MCOs will perform the following functions:
● Auto-enroll all members eligible for Tailored Care Management into Tailored Care Management.
● Contract with all AMH+ practices and CMAs in their region.
● Provide members choice in selecting a Tailored Care Management approach/provider (AMH+ practice, CMA, or plan-based care manager) and assign those who did not express choice to an approach and provider.
● Develop and ensure that AMH+ practices and CMAs also develop policies for communicating and sharing information with members and their families and other caregivers with appropriate consideration for language, literacy, and cultural preferences, including sign language, closed captioning, and/or video capture.
● Ensure that all care managers meet minimum qualification requirements
● Have IT infrastructure and data analytic capabilities to support the Department's vision for care management, including the capabilities to:
-Consume and use physical health, behavioral health, I/DD and TBI claims, pharmacy and encounter data, clinical data, ADT data, risk stratification information, and/or unmet health-related resource seeds data; and
-Share and transmit data with AMH+ practices and CMA.
● Provide oversight and conduct monitoring of AMH+ practices and CMAs to ensure all Tailored Care Management requirements are met.
● Ensure compliance with federal requirements for conflict-free case management for members enrolled in a 1915(c) waiver or who are obtaining 1915(i) services.
● Complete and submit all required reporting to the state.
● Ensure that members do not receive duplicative care management services.
- LME-MCOs are contractually obligated to ensure that members do not receive a duplicative service and must submit, for state review and approval, their policies and procedures for ensuring members do not receive duplicative care management from multiple sources.
- LME-MCOs are required to develop a "billing edit" as part of their claims processing system(s) that will not allow billing for both Tailored Care Management and a duplicative service for the same beneficiary in a single month except for months in which a member is transitioning services. AMH+ practices and CMAs that furnish Tailored Care Management services to a beneficiary will submit a Tailored Care Management claim (with the appropriate billing code) to the beneficiary's LME-MCO. Upon receiving claims from AMH+ practices and CMAs, LME-MCOs will adjudicate the claims, ensuring that payment is not made for duplicative services (e.g., the edit would ensure that for a single beneficiary, a provider would not get paid for delivering Assertive Community Treatment in the same month that an AMH+ gets paid for delivering Tailored Care Management). AMH+/CMA Tailored Care Management claims that meet all the requirements and rules will be processed. LME-MCOs will issue payment to AMH+s/CMAs for claims that meet all the requirements and will submit a Tailored Care Management claim to North Carolina Medicaid to request payment. LME-MCOs must also ensure that they are not submitting a claim to the Department for Tailored Care Management in a month that a provider delivered a duplicative service to a beneficiary.

In their role as a Health Home provider, plans will perform the following functions for members assigned to them and engaged in Tailored Care Management:*
● Meet all the required components of Tailored Care Management, including
- Completing care management comprehensive assessments and reassessments;
- Developing written care plans/ISPs;
- Establishing and activating multidisciplinary care teams, including the sharing of pertinent data across the team and conducting case conferences;
- Delivering ongoing Tailored Care Management, inclusive of the six core Health Home services;
- Addressing unmet health-related resource needs; and
- Identifying members in transition and delivering transitional care management.
● Have a care management data system that can
- Maintain up-to-date documentation of Tailored Care Management member lists and assignments of individual members to care managers;
- Electronically document and store the care management comprehensive assessment and re-assessment;
- Electronically document and store the care plan or ISP;
- Consume claims and encounter data;
- Provide access to – and electronically share, if requested – member records with the member's care team to support coordinated care management, as well as the member, in accordance with federal, state, and Department privacy, security, and data-sharing requirements; and
-Track referrals.
● Access ADT data that correctly identifies when 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 perform these functions for members assigned to them for Tailored Care Management.

Assurance
☒ The state provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review.

The state intends to include the Health Home payments in the Health Plan capitation rate
○ Yes
⦿ No

Select one or more of the options to indicate which payment methodology(ies) will be used to pay the Health Plans:
○ Fee-for-Service methodology that is described in the Payment Methodologies screen
⦿ Alternative Model of Payment that is described in the Payment Methodologies screen
○ Other payment methodology. If Other is selected, describe the payment methodology

Assurances

☒ The state provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review.

☒ The state provides an assurance that at least annually, it will submit to the regional office as part of their capitated rate actuarial certification a separate Health Homes section which outlines the following

- Any program changes based on the inclusion of Health Homes services in the health plan benefits
- Estimates of or actual (base) costs to provide Health Homes services (including a detailed description of the data used for the cost estimates)
- Assumptions on he expected utilization of Health Homes services and number of eligible beneficiaries (including detailed description of the data used for utilization estimates)
- Any risk adjustments made by plan that may be different than overall risk adjustments
- How the final capitation amount is determined in either a percent of the total capitation or an actual PMPM

☒ The state provides assurance that it will design a reporting system/mechanism to monitor the use of Health Homes services by the plan ensuring appropriate documentation of use of services

☒ The state provides assurance that it will complete an annual assessment to determine if the payments delivered were sufficient to cover the costs to deliver the Health Homes services and provide for adjustments in the rates to compensate for any differences found

☐ Other Service Delivery System

Describe if the providers in this other delivery system will be a designated provider or part of the Team of health care professionals and how payment will be delivered to these providers

Health Homes Payment Methodologies

Payment Methodology

The state's Health Homes payment methodology will contain the following features

☐ Fee for Service
☐ PCCM (description included in Service Delivery section)
☐ Risk Based Managed Care (description included in Service Delivery section)
☒ Alternative models of payment, other than Fee for Service or PMPM payments (describe below)

☒ Tiered Rates based on:

☐ Severity of each individual's chronic conditions

☐ Capabilities of the team of health care professionals, designated provider, or health team

☒ Other, provide a description

NC Response:

Payments will be tiered based on the severity of each member's chronic conditions and whether each member has an I/DD or TBI, or behavioral health condition, or is enrolled in North Carolina's Innovations or TBI waivers.

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided:

NC Response:
Health Home providers will be paid a retrospective monthly rate for each member based on the member's acuity, with rates being higher for members determined to be at a higher acuity. There will be three acuity tiers—high, moderate, and low—for members with behavioral health needs and members with an I/DD or TBI, as described below. In addition, North Carolina will pay Health Homes an additional amount on top of the member's tiered rate if the member is enrolled in the Innovations or TBI waiver, in order to account for the additional case management responsibilities required for 1915(c) waivers. Member acuity tiers will be determined based on an algorithm developed by North Carolina. The algorithm will account for a range of member characteristics reflecting level of clinical need, including behavioral health, I/DD, or TBI-related needs, chronic physical health conditions, pharmacy utilization, service utilization (e.g., emergency department), housing stability/homelessness, and other factors.

Payment rates are as follows:

Members with behavioral health needs:
- High: $395.06
- Moderate: $269.66
- Low: $162.08

Members with an I/DD or TBI:
- High: $395.06
- Moderate: $269.66
- Low: $100.81

Individuals enrolled in the Innovations or TBI waiver will be assigned to an acuity tier based on the criteria above, and the state will add $78.94 to the monthly rates for these members to reflect additional care coordination responsibilities required by the waivers.

Provide a comprehensive description of the policies the State will use to establish Health Homes alternative models of payment. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain the nature of the payment, the activities and associated costs or other relevant factors used to determine the payment amount, any limiting criteria used to determine if a provider is eligible to receive the payment, and the frequency and timing through which the Medicaid agency will distribute the payments to providers

NC Response

Each Health Home member will be assigned to an acuity tier that corresponds with a monthly rate, as explained above. North Carolina will make payments to LME-MCOs on a retrospective, monthly basis for Health Home services delivered by the LME-MCO as well as those delivered by AMH+ practices and CMAs. In order to access the payment for any given member, the LME-MCO must demonstrate that at

least one core Health Home service was delivered to the member during the previous month. For members obtaining Health Home services through AMH+ practices and CMAs, LME-MCOs will make payments to their providers in months when a core Health Home service was delivered, passing down 100% of the payments. For each member assigned to them who has received a Health Home service that month, AMH+ practices and CMAs will be required to submit a claim to the LME-MCO demonstrating that they delivered at least one core Health Home core service during the previous month. LME-MCOs may retain the entirety of the payment for members receiving Health Home services through a plan-based care manager.

By linking payment to a member's intensity of care management, reflected by the member's acuity, North Carolina's payment model will encourage the provision of high-quality care management and ensure members are receiving the right care, at the right place, at the right time. It will also ensure that LME-MCOs and AMH+ practices and CMAs are only reimbursed in months in which Health Home services are delivered and that payment will align with the expected level of intensity based on a member's needs.

Rates were developed based on care manager, care manager extender, and supervising care manager labor costs (including salary, fringe benefits, and vacation/sick time) combined with expected caseloads and adding costs associated with administration/overhead and required clinical consultant time. Salaries were derived from state-specific wage data from the Bureau of Labor Statistics. Caseloads were developed based on the estimated time needed to deliver the minimum number of care management contacts to each member each month, time needed for travel and other non-member facing time (e.g., coordination with providers), and the annual productive time for each care manager.

North Carolina will review rates at least annually and review the provider costs (salary, fringe benefits, and administration/overhead) and the time spent delivering Health Home services to members when determining the appropriateness of the rates.

Effective Date: 12/1/2022
Website where rates are displayed: https://medicaid.ncdhhs.gov/transformation/tailored-care-management

Assurances

☒ The state provides assurance that it will ensure non-duplication of payment for services similar to Health Homes services that are offered/covered under a different statutory authority, such as 1915(c) waivers or targeted case management.

Describe below how nonduplication of payment will be achieved

NC Response

In order to avoid the duplication of payment for similar services, the state analyzed programs and settings that offer beneficiaries services similar to Health Home services. Through this analysis, North Carolina determined that the following services are duplicative of Tailored Care Management:

- Case management provided through Assertive Community Treatment.
- Case management provided through Intermediate Care Facilities for Individuals with Intellectual Disabilities.

● Case management provided through nursing facilities for individuals who have resided in, or are likely to reside there, for a period of 90 days or longer.
● Case management provided through the Community Alternatives Program for Children (CAP/C).
● Case management provided through the Community Alternatives Program for Disabled Adults (CAP/DA).
● Care management provided through the High-Fidelity Wraparound program.
● Care management provided through the EBCI Tribal Option.
● Care management provided through the Program of All-Inclusive Care for the Elderly.
● Care management provided by the state's PCCM vendor.
● Care Management for At-Risk Children (program offered by North Carolina Medicaid and administered by the state's local health departments providing care management services for at-risk children ages zero to five).

As the Department reviews and approves new in lieu of services (ILOS) and State Plan services, the Department will monitor whether these new services are duplicative of Tailored Care Management and will perform the activities below to prevent duplication.

North Carolina has developed multiple strategies to ensure members do not receive services that are duplicative of Tailored Care Management, including through LME-MCO oversight and systems requirements and quarterly reporting/monitoring requirements:

- LME-MCO Oversight/Reporting Obligations. LME-MCOs are contractually obligated to ensure that members do not receive a duplicative service and must submit, for state review and approval, their policies and procedures for ensuring members do not receive duplicative care management from multiple sources.

- Claims Submission and Adjudication. LME-MCOs are required to develop a "billing edit" as part of their claims processing system(s) that will not allow billing for both Tailored Care Management and a duplicative service for the same beneficiary in a single month except for months in which a member is transitioning services. AMH+ practices and CMAs that furnish Tailored Care Management services to a beneficiary will submit a Tailored Care Management claim (with the appropriate billing code) to the beneficiary's LME-MCO. Upon receiving claims from AMH+ practices and CMAs, LME-MCOs will adjudicate the claims, ensuring that payment is not made for duplicative services (e.g., the edit would ensure that for a single beneficiary, a provider would not get paid for delivering Assertive Community Treatment in the same month that an AMH+ gets paid for delivering Tailored Care Management). AMH+/CMA Tailored Care Management claims that meet all the requirements and rules will be processed. LME-MCOs will issue payment to AMH+s/CMAs for claims that meet all the requirements and will submit a Tailored Care Management claim to North Carolina Medicaid to request payment. LME-MCOs must also ensure that they are not submitting a claim to the Department for Tailored Care Management in a month that a provider delivered a duplicative service to a beneficiary.

☒ The state meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), 1902(a)(30)(A), and 1903 with respect to non-payment for provider-preventable conditions.

☒ The state provides assurance that all governmental and private providers are reimbursed according to the same rate schedule, unless otherwise described above.
☒ The state provides assurance that it shall reimburse providers directly, except when there are employment or contractual arrangements consistent with section 1902(a)(32).

Health Home Services

Service Definitions

Provide the state's definitions of the following Health Homes services and the specific activities performed under each service

Comprehensive Care Management

Definition NC Response

Comprehensive care management is defined as a team-based, whole-person-centered approach for effectively managing patients' medical, social, behavioral, I/DD, and TBI conditions and LTSS needs.

As part of delivering comprehensive care management, care managers must develop a care plan for each Health Home member with behavioral health needs and/or an individual support plan (ISP) for each Health Home member with I/DD and TBI needs. Each care plan and ISP must be individualized, person-centered, and developed using a collaborative approach including the member, family participation where appropriate, and the multidisciplinary care team. Care plans and ISPs must incorporate the results of the care management comprehensive assessment, claims analysis and risk scoring, any available medical records, and screening and/or level of care determination tools. On an ongoing basis, the care manager will ensure that members receive all needed services in accordance with their care plan/ISP.

Comprehensive care management also includes the following activities:

- High-risk care management (e.g., high utilizers);
- Identification of members in need of care management;
- Development of comprehensive assessments;
- Chronic care management (e.g., management of multiple chronic conditions);
- Management of unmet health-related resource needs and high-risk social environments;
- Management of high-cost procedures (e.g., transplant, specialty drugs);
- Management of rare diseases (e.g., transplant, specialty drugs); and
- Management of medication-related clinical services that promote appropriate medication use and adherence, drug therapy monitoring for effectiveness, and medication-related adverse effects.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum
NC Response

LME-MCOs will be required to have IT infrastructure and data analytic capabilities to:

● Consume and use physical health, behavioral health, I/DD and TBI, pharmacy and claim and encounter data; ADT data; risk stratification information and/or unmet health-related resource needs data; and
● Share administrative and clinical information about their attributed members with their AMH+ practices and CMAs—or their designated CIN or other partner—including assignment files; eligibility and enrollment data; historical physical, behavioral health, and pharmacy claims (including pharmacy lock-in); encounter data; acuity tiering and risk stratification information; and quality measure performance.

AMH+ practices, CMAs, and LME-MCOs must have care management platforms—or "data systems"—that allow care managers to understand who their assigned populations are, document and monitor member care needs, and respond as those needs change. Specifically, these organizations will be required to have care management data systems that can:

● Maintain up-to-date documentation of members enrolled in Tailored Care Management and assignments of individual members to care managers;
● Electronically document and store care management comprehensive assessments, re-assessments, care plans, and ISPs;
● Consume and store claims and encounter data;
● Provide access to—and electronically share, if requested—member records with the member's care team to support coordinated care management, as well with as the member, in accordance with federal, state, and North Carolina Department of Health and Human Services privacy, security, and data-sharing requirements; and
● Track referrals.

AMH+ practices, CMAs, and LME-MCOs are also required to use ADT data that correctly identifies when members are admitted, discharged, or transferred to or from an emergency department or a hospital in real time or near real time.

Additionally, AMH+ practices and CMAs will be required to have an EHR or a clinical system of record that is in use by the AMH+ practice's or CMA's providers that may electronically record, store, and transmit member clinical information.

Scope of service

The service can be provided by the following provider types
☐ Behavioral Health Professionals or Specialists
☐ Nurse Practitioner
☐ Nurse Care Coordinators
☐ Nurses
☐ Medical Specialists
☐ Physicians
☐ Physician's Assistants
☐ Pharmacists
☐ Social Workers
☐ Doctors of Chiropractic
☐ Licensed Complementary and alternative Medicine Practitioners

☐ Dieticians
☐ Nutritionists
☒ Other (specify)
NC Response

Provider Type	Description
Care manager, in collaboration with a multidisciplinary care team (Care manager qualifications are described in the "Other Health Homes Provider Standards" section)	AMH+ practice, CMA, and plan-based care managers will be the primary point of contact for members and will take a lead role in delivering comprehensive care management. The care manager will convene and coordinate with the multidisciplinary care team, including primary care, behavioral health, I/DD, and/or specialist providers to help ensure the member's care management needs are identified and addressed (as documented in the care plan/ISP). Care managers may also supervise care manager extenders in delivering services, within the scope of the extender responsibilities described in the "Other Health Home Provider Standards" section.

Care Coordination

Definition NC Response
Care coordination is defined as the act of organizing member care activities and sharing information among all the participants involved with a Health Home member's care to achieve safer and more effective care. Through organized care coordination, members' needs and preferences are known ahead of time and communicated at the right time to the right people to provide safe, appropriate, and effective care.

The organization providing Tailored Care Management must coordinate the member's health care and social services, spanning physical health, behavioral health, I/DD, TBI, LTSS, and pharmacy services and services to address unmet health-related resource needs.

Care coordination includes:
● Ensuring the member has an ongoing source of care;
● Coordination across settings of care;
● Coordination of services (e.g., appointment/wellness reminders and social services coordination/referrals);
● Following up on referrals and working with the member's providers to help coordinate resources during any crisis event as well as providing assistance in scheduling and preparing members for appointments (e.g., reminders and arranging transportation); and
● Provision of referral, information, and assistance in obtaining and maintaining community-based resources and social support services, including LTSS, I/DD, and TBI services.

For individuals enrolled in the 1915(c) Innovations and TBI waivers or receiving 1915(i) state plan HCBS, Tailored Care Management will encompass care coordination services stipulated by the applicable

authority. Care managers serving these individuals will be responsible for addressing members' whole-person needs alongside coordinating and monitoring their 1915(c) or 1915(i) HCBS. For example, additional requirements for individuals enrolled in the Innovations or TBI waiver include:

● Supporting completion of assessments beyond the care management comprehensive assessment (e.g., NC Innovations Risk/Support Needs Assessment, TBI Risk/Support Needs Assessment, Level of Care reevaluation), and incorporating results into care management comprehensive assessment.
● Facilitating provider choice and assignment process for Innovations and TBI waiver enrollees. Tailored Care Management for Innovations and TBI waiver enrollees will comply with federal requirements for conflict-free case management for 1915(c) waiver enrollees: LME-MCOs will be required to ensure that members do not obtain both 1915(c) waiver services and Tailored Care Management from employees of the same provider organization certified as a CMA.
● Coordinating information and resources for self-directed services, as applicable in each waiver.
● Performing additional responsibilities related to developing and monitoring implementation of the ISP for Innovations and TBI waiver enrollees beyond those required for other individuals engaged in Tailored Care Management.

Additional requirements for individuals obtaining 1915(i) HCBS include:

● Conducting the independent assessment to determine need for specific 1915(i) services.
● Assisting the member/legally responsible person (if applicable) in choosing a qualified provider to implement each service in the Care Plan/ISP. Tailored Care Management for individuals obtaining 1915(i) HCBS will comply with federal requirements for conflict-free case management: LME-MCOs will be required to ensure that members do not obtain both 1915(i) HCBS and Tailored Care Management from employees of the same provider organization certified as a CMA.
● Monitoring Care Plan/ISP goals and maintaining close contact with the member, providers, and other members of the care team.
● Monitoring service delivery to comply with 1915(i) HCBS requirements.

If individuals enrolled in the Innovations or TBI waivers or using 1915(i) HCBS decide to opt out of Tailored Care Management, they will remain enrolled in the applicable waiver and the LME-MCO will still be required to coordinate waiver services.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

NC Response

Member physical health, behavioral health, and pharmacy claims (including pharmacy lock-in data) and encounter data will enable AMH+ practices, CMAs, and LME-MCOs to coordinate services and care. Additionally, the care management platform will help ensure that AMH+ practices, CMAs, and LME-MCOs document and monitor members' needs and respond as those needs change. ADT data, and AMH+ practices' and CMAs' EHR (or clinical system of record) data will also support the organizing of patient care activities and sharing of information.

AMH+ practices, CMAs, and LME-MCOs must use NCCARE360, North Carolina's statewide coordinated care network, to electronically connect those with identified unmet health-related resource needs to

community resources and allow for a feedback loop on the outcome of that connection. Specifically, these organizations must

● Use the NCCARE360 resource repository to identify health service organizations (community-based organizations and social service agencies) that offer services specific to a member's unmet health-related needs;
● Refer and directly connect members to community resources identified via NCCARE360; and
● Track closed-loop referrals to confirm services were received.

Scope of service

The service can be provided by the following provider types

☐ Behavioral Health Professionals or Specialists
☐ Nurse Practitioner
☐ Nurse Care Coordinators
☐ Nurses
☐ Medical Specialists
☐ Physicians
☐ Physician's Assistants
☐ Pharmacists
☐ Social Workers
☐ Doctors of Chiropractic
☐ Licensed Complementary and alternative Medicine Practitioners
☐ Dieticians
☐ Nutritionists
☒ Other (specify)

NC Response

Provider Type	Description
Care manager, in collaboration with a multidisciplinary care team (Care manager qualifications are described in "Other Health Homes Provider Standards" section)	AMH+ practice, CMA, and plan-based care managers will take a lead role coordinating the member's health care and social services, spanning physical health, behavioral health, I/DD, TBI, LTSS, and pharmacy services and services to address unmet health-related resource needs. The care manager will be the primary point of contact for members and will coordinate and convene the multidisciplinary care team. Care managers may also supervise care manager extenders in delivering services, within the scope of the extender responsibilities described in the "Other Health Home Provider Standards" section.

Health Promotion

Definition

NC Response
Health promotion means the education and engagement of a Health Home member in making decisions that promote achievement of the following goals: good health, pro-active management of chronic conditions, early identification of risk factors, and appropriate screening for emerging health problems.

Health promotion services includes:
● Providing education on members' chronic conditions;
● Teaching self-management skills and sharing self-help recovery resources;
● Providing education on common environmental risk factors including but not limited to the health effects of exposure to second- and third-hand tobacco smoke and e-cigarette aerosols and liquids and their effects on family and children;
● Conducting medication reviews and regimen compliance; and
● Promoting wellness and prevention programs.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

NC Response
Claims and encounter data will enable AMH+ practices, CMAs, and LME-MCOs to identify members with or at risk for chronic conditions or other emerging health problems and target and tailor health promotion activities.

The care management platform will enable AMH+ practices, CMAs, and LME-MCOs to document and respond to members' health promotion needs. The care management comprehensive assessment will assess the need for health promotion services and the care plan/ISP will document the plan for addressing those needs. AMH+ practices, CMAs, and LME-MCOs must document, store, and make the ISP/care plan available to the member and the following representatives within 14 days of completion of the care plan or ISP:

● Care team members, including the member's PCP and behavioral health, I/DD, TBI, and LTSS providers;
● The LME-MCO (if applicable);
● Other providers delivering care to the member;
● The member's legal representative (as appropriate);
● The member's caregiver (as appropriate, with consent);
● Social service providers (as appropriate, with consent); and
● Other individuals identified and authorized by the member.

Scope of service

The service can be provided by the following provider types
☐ Behavioral Health Professionals or Specialists

☐ Nurse Practitioner
☐ Nurse Care Coordinators
☐ Nurses
☐ Medical Specialists
☐ Physicians
☐ Physician's Assistants
☐ Pharmacists
☐ Social Workers
☐ Doctors of Chiropractic
☐ Licensed Complementary and alternative Medicine Practitioners
☐ Dieticians
☐ Nutritionists
☒ Other (specify)

NC Response

Provider Type	Description
Care manager, in collaboration with a multidisciplinary care team (Care manager qualifications are described in the "Other Health Homes Provider Standards" section)	AMH+ practice, CMA, and plan-based care managers will be the primary point of contact for members and will take a lead role in delivering health promotion. The care manager will convene and coordinate with multidisciplinary care teams, including primary care, behavioral health, I/DD, and/or specialist providers. Care managers may also supervise care manager extenders in delivering services, within the scope of the extender responsibilities described in the "Other Health Home Provider Standards" section.

Comprehensive Transitional Care from Inpatient to Other Settings (including appropriate follow-up)

Definition NC Response

Transitional care is defined as the process of assisting a Health Home member to transition to a different care setting or through a life stage that results in or requires a modification of services (e.g. school-related transitions).

Regardless of the organization providing Tailored Care Management, consistent with 42 C.F.R. § 438.208(b)(2)(i), the LME-MCO will oversee care transitions for all members who are moving from one clinical setting to another to prevent unplanned or unnecessary readmissions, emergency department visits, or adverse outcomes.

Transitional care includes the following activities:

● Ensuring that a care manager is assigned to manage the transition.
● Having a care manager or care team member visit the member during the member's stay in the institution and be present on the day of discharge.
● Conducting outreach to the member's providers.

● Obtaining a copy of the discharge plan and reviewing the discharge plan with the member and facility staff.
● Facilitating clinical handoff.
● Referring and assisting members in accessing needed social services and supports identified as part of the transitional care management process, including access to housing.
● Assisting members in obtaining needed medications prior to discharge, ensuring an appropriate care team member conducts medication reconciliation/management, and supporting medication adherence.
● Developing a 90-day post-discharge transition plan prior to discharge from residential or inpatient settings, in consultation with the member, facility staff, and the member's care team, that outlines how the member will maintain or access needed services and supports, transition to the new care setting, and integrate into their community.
● Communicating and providing education to the member and the member's caregivers and providers to promote understanding of the 90-day transition plan.
● Assisting with scheduling of transportation, in-home services, and follow-up outpatient visits with appropriate providers within a maximum of seven calendar days, unless required within a shorter time frame.
● Ensuring that the assigned care manager follows up with the member within 48 hours of discharge.
● Arranging to visit the member in the new care setting after discharge/transition.
● Conducting a care management comprehensive assessment within 30 days of the discharge/transition, or update the current assessment.
● Updating the member's care plan or ISP in coordination with the care team within 90 days of the discharge/transition based on the results of the care management.
● Conducing transitional care management for life transitions (for individuals with I/DD or TBI).
● Identifying and engaging individuals in institutional settings whose service needs could potentially be met in a home or community-based setting.
● Developing and executing a person-centered plan for an individual to move from an institutional setting to a home or community-based setting.
● Identifying individuals living in the community who are at risk of entry into an institutional setting, and providing additional, more intensive supports in order to prevent further deterioration of their condition that could result in placement in an institutional setting.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

NC Response

AMH+ practices, CMAs, and LME-MCOs are required to use ADT data that correctly identifies when members are admitted, discharged, or transferred to or from an emergency department or a hospital in real time or near real time. These organizations must implement a systematic, clinically appropriate process with designated staffing for responding to certain high-risk ADT alerts, including:

● Real-time (within minutes/hours) response to notifications of emergency department visits, for example by contacting the emergency department to arrange rapid follow-up;
● Same-day or next-day outreach for designated high-risk subsets of the population; and
● Additional outreach within several days after the alert to address outpatient needs or prevent future problems for other patients who have been discharged from a hospital or an emergency department (e.g., to assist with scheduling appropriate follow-up visits or medication reconciliations post-discharge).

The care management platform will enable AMH+ practices, CMAs, and LME-MCOs to document and respond to members' transitional care needs.

Scope of service

The service can be provided by the following provider types

☐ Behavioral Health Professionals or Specialists
☐ Nurse Practitioner
☐ Nurse Care Coordinators
☐ Nurses
☐ Medical Specialists
☐ Physicians
☐ Physician's Assistants
☐ Pharmacists
☐ Social Workers
☐ Doctors of Chiropractic
☐ Licensed Complementary and alternative Medicine Practitioners
☐ Dieticians
☐ Nutritionists
☒ Other (specify)

Provider Type	Description
Care manager, in collaboration with a multidisciplinary care team (Care manager qualifications are described in the "Other Health Homes Provider Standards" section)	AMH+ practice, CMA, and plan-based care managers will take a lead role in managing care transitions for members transitioning from one clinical setting to another. The care manager will be the primary point of contact for members and will convene and coordinate with the multidisciplinary care team, including staff from the institutional setting the member is transitioning from or to. Care managers may also supervise care manager extenders in delivering services, within the scope of the extender responsibilities described in the "Other Health Home Provider Standards" section.

Individual and Family Support (which includes authorized representatives)

Definition

NC Response
Individual and family support is defined as the coordinating of information and services to support Health Home members (or their caretakers/guardians) to maintain and promote the quality of life, with particular focus on community living options.

Individual and Family Support includes the following activities:

● Educating the member in self-management;
● Providing education and guidance on self-advocacy to the member, family members, and support members;
● Connecting the member and caregivers to education and training to help the member improve function, develop socialization and adaptive skills, and navigate the service system;
● Providing information and connections to needed services and supports including but not limited to self-help services, peer support services, and respite services;
● Providing information to the member, family members, and support members about the member's rights, protections, and responsibilities, including the right to change providers, the grievance and complaint resolution process, and fair hearing processes;
● Providing information on establishing advance directives, including advance instructions for mental health treatment, as appropriate, and guardianship options/alternatives, as appropriate;
● Connecting members and family members to resources that support maintaining employment, community integration, and success in school, as appropriate; and
● For high-risk pregnant women, inquiring about broader family needs and offering guidance on family planning and beginning discussions about the potential for an Infant Plan of Safe Care.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum
NC Response

Claims and encounter data will enable AMH+ practices, CMAs, and LME-MCOs to identify individual and family support activities that would help maintain and promote a member's quality of life.

The care management platform will enable AMH+ practices, CMAs, and LME-MCOs to electronically share member records, including the care plan/ISP, with caregivers so that they can stay informed and updated on the member's needs and treatment plan.

Scope of service

The service can be provided by the following provider types
☐ Behavioral Health Professionals or Specialists
☐ Nurse Practitioner
☐ Nurse Care Coordinators
☐ Nurses
☐ Medical Specialists
☐ Physicians
☐ Physician's Assistants
☐ Pharmacists
☐ Social Workers
☐ Doctors of Chiropractic

☐ Licensed Complementary and alternative Medicine Practitioners
☐ Dieticians
☐ Nutritionists
☒ Other (specify)

Provider Type	Description
Care manager, in collaboration with a multidisciplinary care team (Care manager qualifications are described in the "Other Health Homes Provider Standards" section)	AMH+ practice, CMA, and plan-based care managers will be the primary point of contact for members and will take a lead role in delivering individual and family supports. The care manager will convene and coordinate with the multidisciplinary care team, including primary care, behavioral health, I/DD, and/or specialist providers. Care managers may also supervise care manager extenders in delivering services, within the scope of the extender responsibilities described in the "Other Health Home Provider Standards" section.

Referral to Community and Social Support Services

Definition
NC Response
Referral to community and social supports is defined as providing information and assistance for the purpose of referring Health Home members to resources that address their unmet health resource needs identified in the care plan/ISP. Unmet health resource needs are defined as non-medical needs of individuals that foundationally influence health, including but not limited to needs related to housing, food, and transportation, and addressing interpersonal violence/toxic stress.

Specific services include:

● Providing referral, information, and assistance and follow-up in obtaining and maintaining community-based resources and social support services, including: disability benefits (e.g., SSI/SSDI Outreach, Access, and Recovery (SOAR) caseworkers); food and income supports; housing; transportation; employment services; education; child welfare services; domestic violence services; legal services; services for justice-involved populations; and other services that help individuals achieve their highest level of function and independence.
● Using NCCARE360 to identify community-based resources, and connect members to such resources and track closed-loop referrals.
● Providing comprehensive assistance—available either in-person or electronically, at the member's preference and depending on what is the most efficient, effective, and feasible approach—securing key health-related services, including assistance at initial application and renewal with filling out and submitting applications, and gathering and submitting required documentation, at a minimum to: Food and Nutrition Services; Temporary Assistance for Needy Families; Child Care Subsidy; Low Income Energy Assistance Program; ABLEnow Accounts (for individuals with disabilities); Women, Infants and Children (WIC) Program; and other programs that address unmet health-related resource needs.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

NC Response

AMH+ practices, CMAs, and LME-MCOs must use NCCARE360, North Carolina's statewide coordinated care network, to electronically connect those with identified unmet health-related resource needs to community resources and allow for a feedback loop on the outcome of that connection. Specifically, these organizations must

- Use the NCCARE360 resource repository to identify health service organizations (community-based organizations and social service agencies) that offer services specific to a member's unmet health-related needs;
- Refer and directly connect members to community resources identified via NCCARE360; and
- Track closed-loop referrals to confirm services were received.

The care management platform will enable AMH+ practices, CMAs, and LME-MCOs to document and monitor member needs and respond as those needs change.

Scope of service

The service can be provided by the following provider types

☐ Behavioral Health Professionals or Specialists
☐ Nurse Practitioner
☐ Nurse Care Coordinators
☐ Nurses
☐ Medical Specialists
☐ Physicians
☐ Physician's Assistants
☐ Pharmacists
☐ Social Workers
☐ Doctors of Chiropractic
☐ Licensed Complementary and alternative Medicine Practitioners
☐ Dieticians
☐ Nutritionists
☒ Other (specify)

NC Response

Provider Type	Description
Care manager, in collaboration with a multidisciplinary care team (Care manager qualifications are described in the "Other Health Homes Provider Standards" section)	AMH+ practice, CMA, and plan-based care managers will be the primary point of contact for members and will take a lead role in convening and coordinating multidisciplinary care teams in providing information on and delivering referrals to community and social support services. The care manager will provide members with assistance to obtain the support services and track closed-loop referrals to confirm services were received. Community-based organizations and social services providers will assist in linking members to services that address unmet health-related needs (e.g., housing, food, transportation, and addressing interpersonal violence/toxic stress). Care managers may also supervise care manager extenders in delivering services, within the scope of the extender responsibilities described in the "Other Health Home Provider Standards" section.

Health Homes Patient Flow

Describe the patient flow through the state's Health Homes system. Submit with the state plan amendment flow-charts of the typical process a Health Homes individual would encounter.

Health Homes Monitoring, Quality Measurement and Evaluation

Monitoring

Describe the state's methodology for calculating cost saving (and report cost savings annually in Quality Measure Report). Include savings that result from improved coordination of care and chronic disease management achieved through the Health Homes Program, including data sources and measurement specifications, as well as any savings associated with dual eligibles, and if Medicare data was available to the state to utilize in arriving at its cost-savings estimates

NC Response

North Carolina will calculate savings achieved through the Health Home program resulting from improved coordination of care and chronic disease management by comparing costs for individuals receiving the Health Home intervention (i.e., Tailored Care Management) to eligible individuals not receiving the Health Home intervention.

For the cost savings calculation, North Carolina will primarily rely on a cost of care measure developed using Medicaid claims and encounter data. For dual-eligible members, North Carolina plans to explore the use of Medicare claims data to calculate cost savings across both the Medicare and Medicaid programs. The state currently has concerns with the quality and timeliness of the Medicare claims data

for purposes of evaluating Tailored Care Management, but the state plans to work with its external vendors to improve the usability of these data.

North Carolina will assess cost savings associated with the Health Home program by comparing health care costs between individuals obtaining Tailored Care Management and individuals in a comparison group who are not receiving the intervention. To establish the comparison group, North Carolina will identify individuals who are similar to those participating in the program but opt out of Tailored Care Management or individuals who do not engage in Tailored Care Management. The comparison group will be identified through two stages. The first stage involves identifying eligible comparison members broadly defined as those who have never received the Health Home intervention. The second stage will identify members out of this pool of eligible comparison group who are most similar to those receiving the Health Home intervention in order to reduce selection bias into the program.

The use of a comparison group with similar characteristics provides a measure of expected costs for the Health Home population absent the influence of the Health Home program. Propensity scores will be used to match members in the treatment group with members in the comparison group who had a similar probability of being enrolled in the Health Home based on observable health condition and demographic characteristics. The result is that the matched non-Health Home group will be selected to have observable characteristics comparable to those members in a Health Home.

Demographic and health condition covariates will be identified for each member, and each will be incorporated into the propensity scoring methodology. Covariates will be included if they affect the outcome(s) regardless of whether they predict enrollment into a Health Home.[1] These covariates will include characteristics such as age, gender, county of residence, member months, LTSS needs, dual eligibility status, HCBS waiver status and/or member months, specific health conditions, and Chronic Illness and Disability Payment System (CDPS) risk score. Data for all covariates will be measured at baseline.

Once the populations are matched, a difference-in-differences (DiD) analysis will be performed to compare the per member per month (PMPM) costs for the two populations during the baseline period and the remeasurement period. The difference-in-differences analysis will allow for an expected cost for the Health Home population to be calculated by taking into account expected changes in costs without the Health Home intervention. This is accomplished by subtracting the average change in the comparison group from the average change in the treatment group. This removes biases from the remeasurement period comparisons due to permanent differences between the two groups and controls for external factors that impacted both groups similarly (e.g., the COVID-19 public health emergency).

To calculate cost savings, the expected costs of Health Home members (i.e., change in costs for the comparison group between the baseline and remeasurement period) will be subtracted from the actual costs of Health Home members (i.e., change in costs for the treatment group during the same time period) to determine the cost savings. To calculate the total cost savings, the expected cost will be subtracted from the sum of the actual and administrative costs (i.e., any PMPM payments for each Health Home member). These difference-in-differences calculations will be conducted through regression analysis using appropriate statistical modelling for the relevant outcome using best practices recommended in the literature (e.g., linear regression, log transformed costs, and/or two-part hurdle

model in the event of a high prevalence of members with zero costs).[2] Regression analysis will allow for calculation of statistical significance of the DiD estimate and the ability to include additional control variables (e.g., any remaining unbalanced covariates following propensity score matching).

If cost data for Medicare claims/encounters are available, these data will be incorporated into the analysis to provide a complete picture of costs for dual eligible members. If Medicare cost data are not available, then dual eligible members will either be excluded from the analysis or analyzed separately. A separate analysis would allow the State to identify any cost savings specific to Medicaid.
In the event that members who meet the eligibility requirements are excluded from the final analysis (e.g., due to the member being a statistical outlier in terms of cost), the final report will document the process used to determine exceptions. The approach outlined above assumes that an appropriate comparison group can be identified. If an appropriate comparison group cannot be identified, alternate data sources, statistical methods, or actuarial approaches could be considered.

1) See e.g., Austin, P.C., "An Introduction to Propensity Score Methods for Reducing the Effects of Confounding in Observational Studies," *Multivariate Behav Res*. 2011 May; 46(3): 399–424; available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3144483/

2) See e.g., Mihaylova, B., Briggs, A., O'Hagan, A., and Thompson, S. G., "Review of Statistical Methods for Analysing Healthcare Resources and Costs," *Health Econ*. 2011 Aug; 20(8): 897–916; available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3470917/; Buntin and Zaslavsky (2004). "Too much ado about two-part models and transformation? Comparing methods of modeling Medicare expenditures." *Journal of Health Economics* 23(3): 525-542; or Long. J.S., *Regression Models for Categorical and Limited Dependent Variables,* 1997, SAGE Publications, Thousand Oaks, CA.

Describe how the state will use health information technology in providing Health Homes services and to improve service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider)

NC Response

LME-MCOs will be required to have IT infrastructure and data analytic capabilities to:

● Consume and use physical health, behavioral health, I/DD and TBI, pharmacy, and claim and encounter data; ADT data; and risk stratification information and/or unmet health-related resource needs data; and
● Share administrative and clinical information about their attributed members with their AMH+ practices and CMAs—or their designated CIN or other partner—including assignment files; eligibility and enrollment data; historical physical, behavioral health, and pharmacy claims (including pharmacy lock-in); encounter data; acuity tiering and risk stratification information; and quality measure performance.

AMH+ practices, CMAs, and LME-MCOs must have care management platforms—or "data systems"—that allow care managers to understand who their assigned populations are, document and monitor member care needs, and respond as those needs change. Specifically, these organizations will be required to have care management data systems that can:

● Maintain up-to-date documentation of members enrolled in Tailored Care Management and assignments of individual members to care managers;
● Electronically document and store care management comprehensive assessments, reassessments, care plans, and ISPs;
● Consume and store claims and encounter data;
● Provide access to—and electronically share, if requested—member records with the member's care team to support coordinated care management, as well as with the member, in accordance with federal, state, and North Carolina Department of Health and Human Services privacy, security, and data-sharing requirements; and
● Track referrals.

AMH+ practices, CMAs, and LME-MCOs are also required to use ADT data that correctly identifies when members are admitted, discharged, or transferred to or from an emergency department or a hospital in real time or near real time. These organizations must implement a systematic, clinically appropriate process for designated staffing for responding to certain high-risk ADT alerts, including:

● Real-time (within minutes/hours) response to notifications of emergency department visits, for example by contacting the emergency department to arrange rapid follow-up;
● Same-day or next-day outreach for designated high-risk subsets of the population; and
● Additional outreach within several days after the alert to address outpatient needs or prevent future problems for other patients who have been discharged from a hospital or an emergency department (e.g., to assist with scheduling appropriate follow-up visits or medication reconciliations post-discharge).

AMH+ practices, CMAs, and LME-MCOs will be required to use NCCARE360, North Carolina's statewide coordinated care network, to electronically connect those with identified unmet health-related resource needs to community resources and allow for a feedback loop on the outcome of that connection. Specifically, these organizations will be required to:
● Use the NCCARE360 resource repository to identify health service organizations (community-based organizations and social service agencies) that offer services specific to a Health Home member's unmet health-related needs;
● Refer and directly connect members to community resources identified via NCCARE360; and
● Track closed-loop referrals to confirm services were received.

AMH+ practices and CMAs will also be required to have an EHR or a clinical system of record that is in use by the AMH+ practice's or CMA's providers that may electronically record, store, and transmit member clinical information.

Quality Measurement and Evaluation

☒ The state provides assurance that all Health Homes providers report to the state on all applicable quality measures as a condition of receiving payment from the state
☒ The state provides assurance that it will identify measurable goals for its Health Homes model and intervention and also identify quality measures related to each goal to measure its success in achieving the goals

☒ The state provides assurance that it will report to CMS information submitted by Health Homes providers to inform evaluations, as well as Reports to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS

☒ The state provides assurance that it will track avoidable hospital readmissions and report annually in the Quality Measures report