

## Tailored Care Management Capacity Building Program

### Frequently Asked Questions

To help ensure the successful implementation of Tailored Care Management, the Department has launched the Tailored Care Management Capacity Building program, under which approximately \$90 million in funding will be distributed across the state starting in 2022 and lasting through at least June 2023. Providers certified as Advanced Medical Home Plus (AMH+) practices and Care Management Agencies (CMAs) are eligible to receive capacity building funding for investments in:

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

Under the program, LME/MCOs awarded a Tailored Plan contract will partner with AMH+ practices and CMAs to achieve milestones focused on the above three areas of investment (see pages 4-6 of the [May 2021 guidance](#) for a detailed overview of the program). Funds will flow through Tailored Plans and then to AMH+ practices and CMAs. Tailored Plans must develop a “Distribution Plan” for capacity building funds that is based on an assessment of regional needs. The Department will review and approve Distribution Plans submitted by each LME/MCO, which will detail the specific capacity building needs assessed among AMH+ practices and CMAs in their region.

This document provides answers to common questions regarding the Tailored Care Management Capacity Building Program. Additional information on the program can be found here:

<https://medicaid.ncdhs.gov/tailored-care-management/tailored-care-management-capacity-building-program>.

### Capacity Building

#### 1. How can providers access capacity building funding?

To access funds, providers must participate in a capacity building needs assessment administered by future Tailored Plans and, on an ongoing basis, meet a series of targets demonstrating progress towards achieving specific capacity building milestones. Providers will receive their first distribution of capacity building funds only once they are certified as an AMH+ practice or CMA, meaning that they have passed both the desk review and site review.

#### 2. Do AMH+ practices and CMAs have to spend funds in order to be reimbursed with capacity building dollars?

No. The Department designed the capacity building program to allow providers to receive some “startup” funding for important capacity building activities from future Tailored Plans in advance of spending.

However, AMH+ practices and CMAs should be able to demonstrate how they intend to spend capacity building funds. For example, if an AMH+ practice or CMA is requesting funds associated with capacity building milestone #3 (“Purchase or upgrades of care management related HIT infrastructure and systems for AMH+ practices/CMAs”), the AMH+ practice or CMA should have a draft or executed contract for IT upgrades/purchases that specifies the associated costs.

**3. What happens if capacity building program needs exceed available funding?**

The Department has secured approximately \$90 million for the capacity building program for 2022 through 2023. There is no guarantee that providers or Tailored Plans will get more funding than what is reflected in their approved Distribution Plans.

To date, approved Distribution Plans reflect \$35,400,000 in funding; 40% of total funding has been distributed, with the remainder to be distributed throughout 2022 and 2023.

If the initial \$90 million is not fully spent (e.g., Tailored Plans and/or providers do not meet milestones or costs are lower than projected), Tailored Plans have the flexibility to submit a revised Distribution Plan to the Department requesting to redistribute unspent funds towards achievement of an identified milestone. The Department hopes to secure additional funding in the future if need exceeds the \$90 million currently available.

**4. What happens if an AMH+ practice or CMA spends more than expected on a capacity building-related purchase/milestone or anticipates changes in future capacity building needs?**

The Department understands that estimates of capacity building needs may change as providers get closer towards implementation. Providers can inform the Tailored Plan(s) with which they have a capacity building agreement of anticipated new or additional costs not initially captured in the Distribution Plan approved by the Department. Based on available funding, Tailored Plans *may* be able to distribute additional funds to providers; Tailored Plans may need to first update their Distribution Plans to reflect this change and submit the updated Distribution Plans to the Department for approval.

**5. What strategies has the Department taken to ensure capacity building funds are distributed in an equitable manner?**

The capacity building program was designed to help identify and address the specific needs of providers throughout North Carolina. In developing Distribution Plans, Tailored Plans were required to conduct an assessment of regional needs and demonstrate how they will address those needs and:

- Target investments to address health disparities and improve health and wellness for all Medicaid members;
- Ensure the needs of providers who have been historically underutilized and rural providers are identified and addressed; and
- Build a robust care management workforce and provider networks that are representative of the diverse population of the state.

In reviewing and approving Distribution Plans, the Department worked with the Tailored Plans to help ensure the program was being implemented in an equitable manner. The Department will also keep equity in mind as it reviews quarterly progress reports and releases additional funds, and in any future investments in Tailored Care Management capacity.

**6. Are there any parameters in place if capacity building funds distributed to Providers are not used appropriately?**

Capacity Building Funds are distributed only after milestones are met. DHHS may recoup funds from Tailored Plans if funds were distributed for milestones that were not actually met/were inaccurately reported. Similarly, Tailored Plans may recoup funds from providers in instances where the provider submitted inaccurate reporting (e.g. if a milestone was not actually met), but only if the Tailored Plan's capacity building contracts with providers specify the parameters for recoupment.