

## Tailored Care Management Webinar Series Frequently Asked Questions

This document provides answers to common questions that arose over the course of the Tailored Care Management webinar series. Webinar materials and recordings are available at <https://medicaid.ncdhhs.gov/transformation/tailored-care-management/tailored-care-management-training>

### Advanced Medical Home Plus (AMH+) Practice and Care Management Agency (CMA) Certification

**1. Will there be additional opportunities to apply to become an AMH+ practice or CMA?**

Yes. Details on future rounds of certification will be posted at <https://medicaid.ncdhhs.gov/transformation/tailored-care-management>.

**2. My organization provides Medicaid and/or state-funded services to populations that will be served under the Tailored Plans. Do we need to apply as an AMH+ practice or CMA to continue to provide any of the same services we provide now?**

No. AMH+ practice and CMA certification is only required if your organization wants to provide Tailored Care Management. To provide Medicaid services beyond Tailored Care Management or state-funded services, your organization must be in-network with a Tailored Plan.

**3. If the organization applying for AMH+ practice or CMA certification spans multiple Tailored Plan regions, would it need to be certified for each region?**

AMH+ practices are certified at the site level (as opposed to the entire organization), in alignment with the current AMH process under Standard Plans. So, if an organization has multiple sites (in the same or different regions) seeking to become certified as an AMH+ practice, each of those sites will need to apply for certification.

CMA certification is granted at the organizational level (across all sites); however, if the applicant's organization spans multiple Tailored Plan regions, the organization will be certified at the regional level—meaning, they may be certified for one region but not another.

**4. Will site reviews be virtual or in-person? When will the Department release additional information on the site review process that will be conducted by NCQA?**

The first round of site reviews will be virtual. The Department and NCQA reserve the right to conduct in-person site reviews in the future, as appropriate given COVID-19 safety precautions. Providers who passed their desk reviews received information on the site review process.

### Capacity Building

**5. 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.

More details on the capacity building program are available here:

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

**6. Will AMH+ practices and CMAs be held to the estimates of members that will be served and staffing submitted in their initial capacity building needs assessments?**

No. AMH+ practices and CMAs will have the opportunity to submit updated estimates as they obtain additional data on the number of members they will be assigned.

**7. 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.

### Health Information Technology (IT) Requirements and Data Sharing

**8. Do AMH+ practice and CMA electronic health records (EHRs) need to be Certified (i.e., the Office of the National Coordinator for Health Information Technology’s criteria for certified EHR technology)<sup>1</sup>?**

No. EHRs or clinical systems of record are required to have the capability to electronically record, store, and transmit member clinical information. The Department does not presently require systems to be certified.

**9. What are the expectations around the format in which care management comprehensive assessments and care plans/Individual Support Plan (ISPs) will be shared?**

The Department is not specifying a format in which care management comprehensive assessments need to be transmitted between AMH+ practices, CMAs, Tailored Plans, members, and/or members of the care team. AMH+ practices, CMAs, and Tailored Plan-based care managers are required to make available, rather than automatically share, the care management comprehensive assessment results or care plans (for members with a behavioral health need) or ISP (for individuals with I/DD and TBI) with the member, the member’s Tailored Plan, and members of the care team. Care management comprehensive assessment results or care plans/ISPs may be made available through a secure portal, direct electronic emails, or other methods of transmission that comply with patient privacy requirements.

### Partnering with a Clinically Integrated Network (CIN) and Other Partners

**10. Can you clarify how LME/MCOs and Tailored Plans can function as a CIN or Other Partner?**

Subsidiaries of LME/MCOs, Tailored Plans, or other health plans generally may not be considered CINs or Other Partners for the purposes of Tailored Care Management, with one exception: AMH+ practices and CMAs may decide to enter into arrangements with Tailored Plans for use of their information technology (IT) products or platforms for care management in order to meet the care management data system requirements.

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<sup>1</sup> <https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Certification>

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### 11. How can providers learn more about CINs and Other Partners available in North Carolina?

In May and June 2021, the Department solicited responses to a voluntary, non-binding Statement of Interest on the type of services that CINs and Other Partners offer to providers applying to become certified as AMH+ practices and CMAs. The Department has compiled all responses received from CINs and other partners and is making this information available [here](#)<sup>2</sup>; this information does not reflect the Department's assessment or endorsement of these organizations' capabilities.

### Delivery of Tailored Care Management

### 12. How will member choice be factored into the Tailored Plan's assignment of members to an AMH+ practice, CMA, or plan-based care management?

Prior to launch, Tailored Plans will educate members on the three different Tailored Care Management approaches (AMH+ practice, CMA, or plan-based care management), provide members access to a comprehensive list of relevant, available organizations that provide Tailored Care Management, and provide unbiased counseling on selecting an approach and an organization where they will obtain Tailored Care Management. Members will have the option to select an organization at this point. Members will not be permitted to choose an organization that is not certified for their specific population group (e.g., age; BH vs I/DD vs TBI; geography/region; Innovations or TBI waiver status). For members who do not express a preference, the Tailored Plans will assign them to an organization providing Tailored Care Management, in line with North Carolina's assignment requirements. 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.

### 13. Will AMH+ practices, CMAs, and Tailored Plans be required to maintain specific care manager-to-member caseloads?

No. The Department has not established care manager-to-member caseloads that AMH+ practices, CMAs, and Tailored Plans must maintain. Providers have flexibility to build care teams as they see fit (e.g., using extenders<sup>3</sup>, adjusting caseloads, etc.), assuming they meet a certain set of programmatic requirements, including:

- Establish a multidisciplinary care team with a care manager, supervising care manager, primary care provider, behavioral health provider, I/DD and/or TBI providers, as applicable, and other specialists and individuals identified in the Provider Manual and RFA
- Ensure regular communication and information sharing across care team members
- Meet the care manager-to-supervisor ratio of no more than 8:1

At the request of providers, the Department released information about the caseload assumptions that were used to inform the rates, but these caseload assumptions are not programmatic requirements. More details on caseload assumptions informing the rate development process are available here: <https://files.nc.gov/ncdma/Updated-Guidance-on-Tailored-Care-Management-vF.pdf>

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<sup>2</sup> Providers interested in partners with a CIN and/or Other Partner noted in the Statement of Interest should reach out directly to that organization to discuss available services.

<sup>3</sup> Additional guidance on the qualifications and role of extenders is available at <https://medicaid.ncdhhs.gov/transformation/tailored-care-management>.

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### **14. Is the Tailored Care Management Comprehensive Assessment different from a Comprehensive Clinical Assessment?**

Yes, the Tailored Care Management Comprehensive Assessment is different from a Comprehensive Clinical Assessment (CCA). A CCA is a clinical evaluation performed by a licensed professional, or associate level licensed professional. The purpose of a CCA is to provide the necessary and relevant clinical data and recommendations that are used when developing the person-centered plan or service plan with the individual. The Tailored Care Management Comprehensive Assessment is a person-centered assessment of a member's health care needs, functional and accessibility needs, strengths and supports, goals, and other characteristics that will inform the care plan or ISP and treatment. The Care Management Comprehensive Assessment is performed by the member's care manager. Information from the CCA may be used as an input to inform the Tailored Care Management Comprehensive Assessment.

### **15. My organization is a fully integrated practice, with providers that are qualified to serve as the required clinical consultants. Do we need to establish relationships with separate consultants or can we use our own providers?**

No additional consultants are needed if an organization can fulfill the clinical consultant requirements with "in-house" clinicians:

- A general psychiatrist or child and adolescent psychiatrist;
- A neuropsychologist or psychologist; and
- For CMAs, a primary care physician (PCP) to the extent the beneficiary's PCP is not available for consultation

### **16. Will Tailored Plan members have the option to opt out of Tailored Care Management? If yes, will they still have access to care coordination?**

Yes, members will be able to opt out of the model at any time. To opt out, members will be able to submit an "opt out" form to the Tailored Plan. Tailored Plans will make these forms available; forms may be mailed, completed online, filled out in person with the member's care manager, or filled out over the telephone.

The Tailored Plan will provide care coordination and manage care transitions for members who opt-out of Tailored Care Management; however, these activities will be much more limited than for members in Tailored Care Management (i.e., care coordination will not be equivalent to what is performed by the LME/MCOs today).

### **17. What are care manager extenders and how do they fit into Tailored Care Management?**

Care manager extenders are care team members such as Peer Support Specialists, other individuals with lived experience and their parents or guardians, Community Navigators, and Community Health Workers who will work under the supervision of a care manager to deliver components of Tailored Care Management. Additional guidance on the qualifications and role of extenders is available at <https://medicaid.ncdhhs.gov/transformation/tailored-care-management>.

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**18. What’s the difference between a 90-day transition plan and a care plan/ISP?**

A care manager must develop a care plan or ISP for all members within 30 days of the completion of the care management comprehensive assessment. The care manager will lead the development of the care plan/ISP in collaboration with the member, the care team, and individuals identified by the member to contribute to the planning process. The care plan/ISP should reflect the beneficiary’s strengths, needs, and goals, and the types and frequency of all needed services.

A care manager will need to develop a 90-day transition for assigned members who are being discharged from a residential or inpatient setting. The plan must be developed prior to discharge in consultation with the member, facility staff and the member’s care team and outline how the member will maintain or access needed services and supports, transition to the new care setting, and integrate into their community. The 90-day transition plan should be an amendment to the care plan/ISP.

**19. How can AMH+s/CMA get access to ADT data to identify individuals in transition?**

AMH+ practices and CMAs can access ADT data connecting with NC HealthConnex or other sources of ADT information, including the North Carolina Healthcare Association. Practices can also partner with a CIN/Other Partner for access to this data.

**Conflict-Free Care Management**

**20. Which providers are impacted by conflict-free rules and how?**

Behavioral health or I/DD providers cannot deliver both Tailored Care Management (in their capacity as a CMA) and the below services to the same individual. Since AMH+ practices and Tailored Plans do not deliver HCBS, conflict-free case management rules are not applicable. Services subject to conflict-free rules are:

<b>1915(c) Innovations Waiver Services</b>	
<ul style="list-style-type: none"> <li>• Assistive Technology</li> <li>• Community Living and Support</li> <li>• Community Networking</li> <li>• Community Transition</li> <li>• Natural Supports Education</li> <li>• Residential Supports</li> <li>• Respite</li> <li>• Supported Employment</li> <li>• Specialized Consultation</li> </ul>	<ul style="list-style-type: none"> <li>• Crisis Services</li> <li>• Day Supports</li> <li>• Financial Support Services</li> <li>• Home Modifications</li> <li>• Individual Goods and Services</li> <li>• Supported Living</li> <li>• Supported Living - Periodic</li> <li>• Supported Living – Transition</li> <li>• Vehicle Adaptation</li> </ul>
<b>Traumatic Brain Injury (TBI) Waiver Services</b>	
<ul style="list-style-type: none"> <li>• Adult Day Health</li> <li>• Assistive Technology</li> <li>• Cognitive Rehabilitation</li> <li>• Community Networking</li> <li>• Community Transition</li> <li>• Crisis Support Services</li> <li>• Day Supports</li> <li>• Home Modifications</li> <li>• In Home Intensive Support</li> </ul>	<ul style="list-style-type: none"> <li>• Occupational Therapy</li> <li>• Personal Care</li> <li>• Physical Therapy</li> <li>• Residential Supports</li> <li>• Respite</li> <li>• Resource Facilitation</li> <li>• Speech Language Therapy</li> <li>• Specialized Consultation</li> <li>• Supported Employment</li> </ul>

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<ul style="list-style-type: none"> <li>• Life Skills Training</li> <li>• Natural Supports Education</li> </ul>	<ul style="list-style-type: none"> <li>• Vehicle Modification</li> </ul>
<b>Current 1915(b)(3) Waiver Services Transitioning to 1915(i) Authority for Tailored Plan Launch</b>	
<ul style="list-style-type: none"> <li>• Supported Employment</li> <li>• Individuals Support</li> <li>• Respite</li> </ul>	<ul style="list-style-type: none"> <li>• Community Living and Supports</li> <li>• Community Transitions</li> </ul>

**21. To comply with conflict-free rules, can CMAs set up “firewalls” that separate HCBS delivery and Tailored Care Management (e.g., having separate reporting structures for Tailored Care Management and service delivery, separating the care plan development function from the direct service provider function).**

No. The Department explored allowing HCBS providers/CMAs to develop firewalls between Tailored Care Management and service delivery; however, CMS informed the State that such an approach is not compliant with federal conflict-free rules.<sup>4</sup>

**Additional Care Coordination Functions for Members Enrolled in the Innovations or TBI Waiver**

**22. Will individuals on the Innovations waiver waiting list be eligible for Tailored Care Management?**

All Tailored Plan Medicaid-enrolled members, including those on the Innovations waiver waiting list, will be eligible for Tailored Care Management and be assigned to an AMH+ practice, CMA, or Tailored Plan-employed care manager. Individuals on the Innovations waiver waiting list who are not enrolled in Medicaid will not have access to Tailored Care Management, but may be able to access short-term, State-funded care management through the Tailored Plan. For additional detail on State-funded care management, please see [North Carolina’s Design for State-Funded Services Under Behavioral Health and Intellectual/Developmental Disability Tailored Plans](#).

**23. How do Tailored Care Management contact requirements relate to Innovations and TBI waiver contact requirements?**

If a member is enrolled in the Innovations or TBI waiver, the assigned organization providing Tailored Care Management should provide whichever contact requirements are higher in frequency and modality (e.g. number of in-person contacts)—the Tailored Care Management contact requirements or the applicable waiver contact requirements.

**Data Specifications**

**24. When will additional guidance on the data specifications and file formats for Tailored Care Management be available?**

The Department has released NC Medicaid data specification guidance documents on the [Tailored Care Management website](#) for the following exchanges:

- Data Specifications & Requirements for sharing Beneficiary Assignment and Pharmacy Lock-in Data to Support Tailored Care Management

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<sup>4</sup> The Department is planning to discuss with CMS the approach for conflict-free care management for Tribal members, including the extent to firewalls can be used.

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- Data Specifications & Requirements for sharing Historical and Current Claims & Encounters Data to Support Tailored Care Management
- Data Specifications & Requirements for sharing Patient Risk Data to Support Tailored Care Management

### **25. Which data exchanges have been standardized by the Department and which entities are responsible for sharing them?**

The Department has standardized the following data exchanges:

- Beneficiary assignment data, which includes member demographic, Tailored Plan eligibility and enrollment, PCP and care management assignment, and acuity tier information. Beneficiary assignment data will be transmitted from Tailored Plans to AMH+ practices and CMAs via the Beneficiary Assignment File.
- Pharmacy lock-in data that is sent from Tailored Plans to AMH+ practices and CMAs via the pharmacy lock-in file.
- Historical and current medical, dental, and pharmacy claims and encounters that are sent from Tailored Plans to AMH+ practices and CMAs via the medical and pharmacy encounters files and the historical medical, pharmacy and dental fee-for-service files, as applicable.
- Patient risk data, which will be shared bi-directionally between Tailored Plans and AMH+ practices and CMAs via the “Patient List/Risk Score” file. Tailored Plans will use this file to identify key member attributes, including unmet resource needs or enrollment in the Healthy Opportunities pilot, when they send it to AMH+ practices and CMAs. AMH+ practices and CMAs will send the Patient List/Risk Score file back to Tailored Plans with care interactions and other relevant care management information.

### **26. What are the expectations related to testing standardized data exchange files and processes that support Tailored Care Management?**

AMH+ practices, CMAs and/or their affiliated CINs/Other Partners should work with their contracted Tailored Plans on testing expectations. The Department expects Tailored Plans to have an onboarding process that includes review of all standard file layouts, associated requirements, testing and implementation expectations with their contracted AMH+ practices, CMAs and/or their affiliated CINs/Other Partners.

## **Quality**

### **27. Will AMH+ practices and CMAs be required to report and collect and report quality-related data?**

AMH+ practices and CMAs will only be required to support Tailored Plans in collecting specific clinical data elements that the AMH+ or CMA practice would be expected to generate or collect in the course of their care. For example, an AMH+ provider who orders a Hemoglobin A1c (HbA1c) test for his or her patient may be asked to report the HbA1c value. Similarly, an AMH+ or CMA provider that conducts a screening for social needs might be asked to report the date of the screening and the screening results.

### **28. How will the Department promote health equity through its Medicaid Quality Strategy?**

Tailored Plans are directed to report most quality measures stratified by key demographics such as race, ethnicity, gender, long-term services and supports (LTSS) needs status, disability status and

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geography, among others.

The Department will require Tailored Plans to participate in activities promoting health equity, and, beginning in the third contract year, will hold them financially accountable for ensuring equity in improvements for selected measures via a payment withhold. Specific interventions may include, among others, development of disparity-specific quality measure improvement targets on a program-wide and/or plan-specific basis. On an annual basis, the Department will review the plans' strategies to actively address and respond to opportunities to improve health disparities in collaboration with Department-developed, cross-plan interventions.

Tailored Plans are also expected to engage with the Department's designated External Quality Review Organization, which will develop an annual health equity report.