

Tailored Care Management 101 Training Series

Introduction to Tailored Care Management

October 1, 2021

Tailored Care Management Webinar Series

Today's webinar is a part of a series to help develop a shared understanding of the Tailored Care Management model across the North Carolina provider and stakeholder communities.

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

 *Today's Focus*

Tailored Care Management Webinar Series

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

○ A recording of today's presentation will be available at the below website.

For more information on Tailored Care Management, please visit:

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

Presenters

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NC DEPARTMENT OF
**HEALTH AND
HUMAN SERVICES**

Agenda

- **North Carolina's Medicaid Transformation**
- **Tailored Care Management Overview**
- **Federal Health Home Structure**
- **Delivery of Tailored Care Management**
- **Next Steps and Additional Information**
- **Q&A**

North Carolina's Medicaid Transformation

Context for Medicaid Transformation

- In 2015, the **NC General Assembly enacted Session Law 2015-245**, directing the transition of Medicaid and NC Health Choice from predominantly fee-for-service to managed care.
- Since then, the North Carolina Department of Health and Human Services (the Department) has **collaborated extensively** with clinicians, hospitals, beneficiaries, counties, health plans, elected officials, advocates, and other stakeholders to shape the program.

Medicaid Managed Care Overview

With the transition to managed care, the state will offer four types of managed care products that will provide integrated, whole-person care.

Standard Plan

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

Tailored Plan

Tailored Plans will provide the same services as Standard Plans, as well as additional specialized services for individuals with significant behavioral health conditions, I/DDs, and traumatic brain injury, as well as people utilizing state-funded and waiver services. Tailored Plan will launch **July 2022**.

Specialized Plan for Children in Foster Care

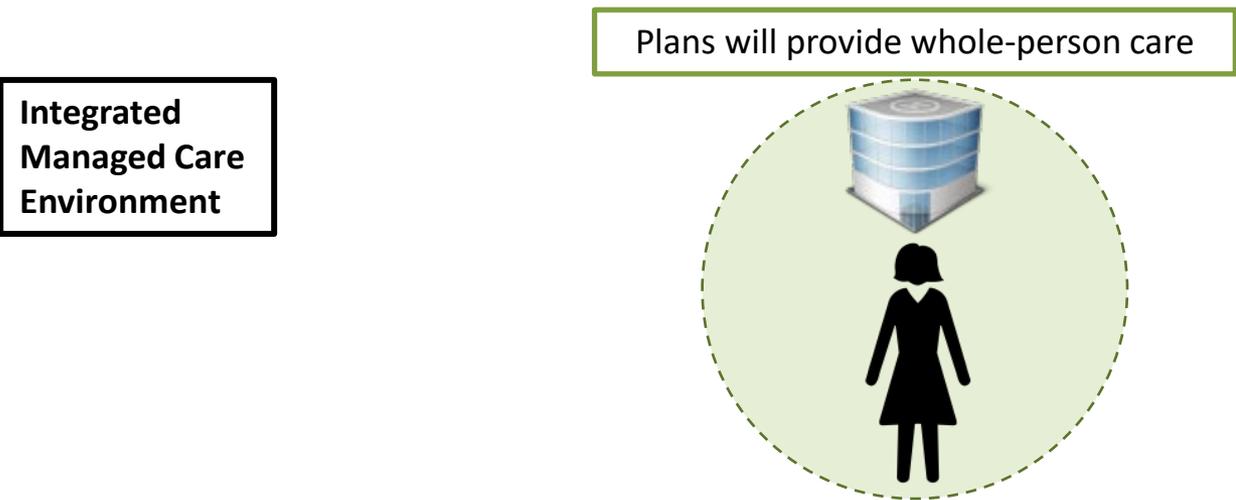
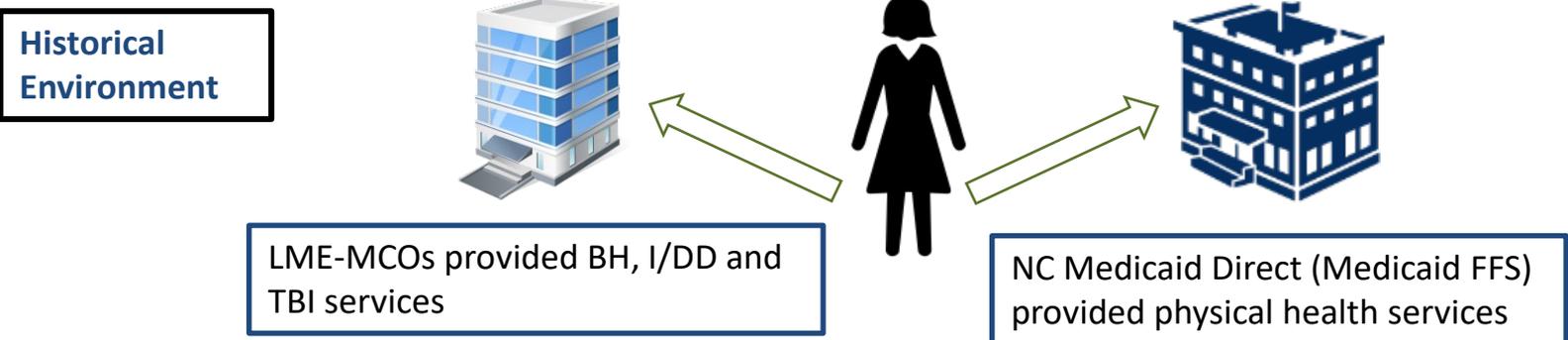
The Specialized Foster Care Plan will be available to children and youth currently and formerly involved in the child welfare system and will cover a full range of physical health, behavioral health, and pharmacy services. The Specialized Foster Care Plan will launch **July 2023**.

EBCI Tribal Option

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

Transition to Whole-Person Care

Managed care products will offer whole-person care and enable the delivery of physical and behavioral health through one plan.



Tailored Care Management

Core Principles of Tailored Care Management Model

Tailored Care Management is the primary care management model for Tailored Plans.

Core Principles

- Broad access to care management
- Single care manager taking an integrated, whole-person approach
- Person- and family-centered planning
- Provider-based care management
- Community-based care management
- Community inclusion
- Choice of care managers
- Consistency across the state
- Harness existing resources



Tailored Care Management Eligibility

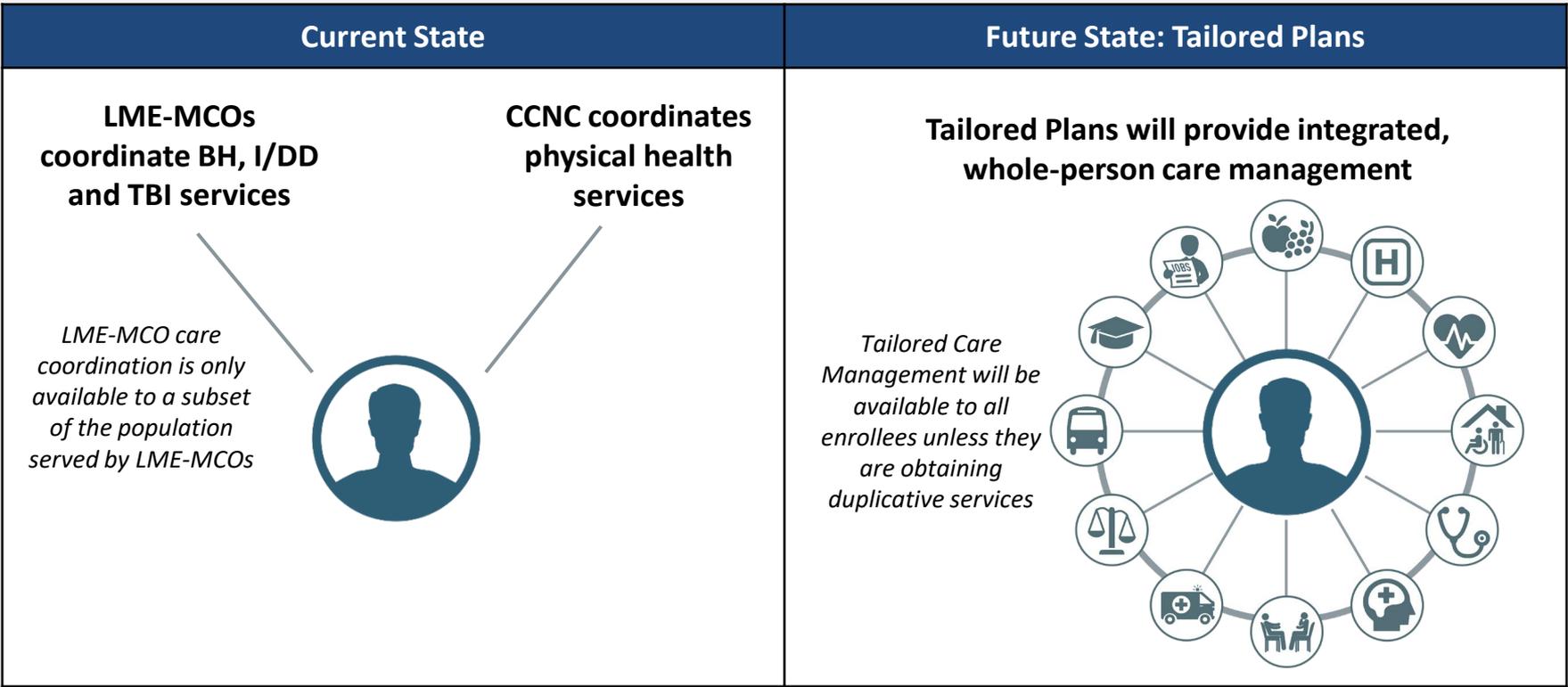
- **All Tailored Plan Members are eligible for Tailored Care Management, including individuals enrolled in the 1915(c) Innovations and TBI waivers.**
- **Individuals enrolled in Medicaid fee-for-service (e.g., dual eligibles) will also have access to Tailored Care Management, if they otherwise would be eligible for a Tailored Plan if not for belonging to a group delayed or excluded from managed care.**

The Department has determined that the below services are duplicative of Tailored Care Management and an individual will not be allowed to receive both simultaneously:

- Case management provided through Assertive Community Treatment (ACT)
- Case management provided through Intermediate Care Facilities for Individuals for Intellectual Disabilities (ICF-IIDs)
- Care management provided through the High-Fidelity Wraparound program
- Care Management for At-Risk Children (CMARC)

Current vs. Future State

Tailored Care Management reflects the Department's broader goal for integrated, whole-person care under one Medicaid managed care plan.



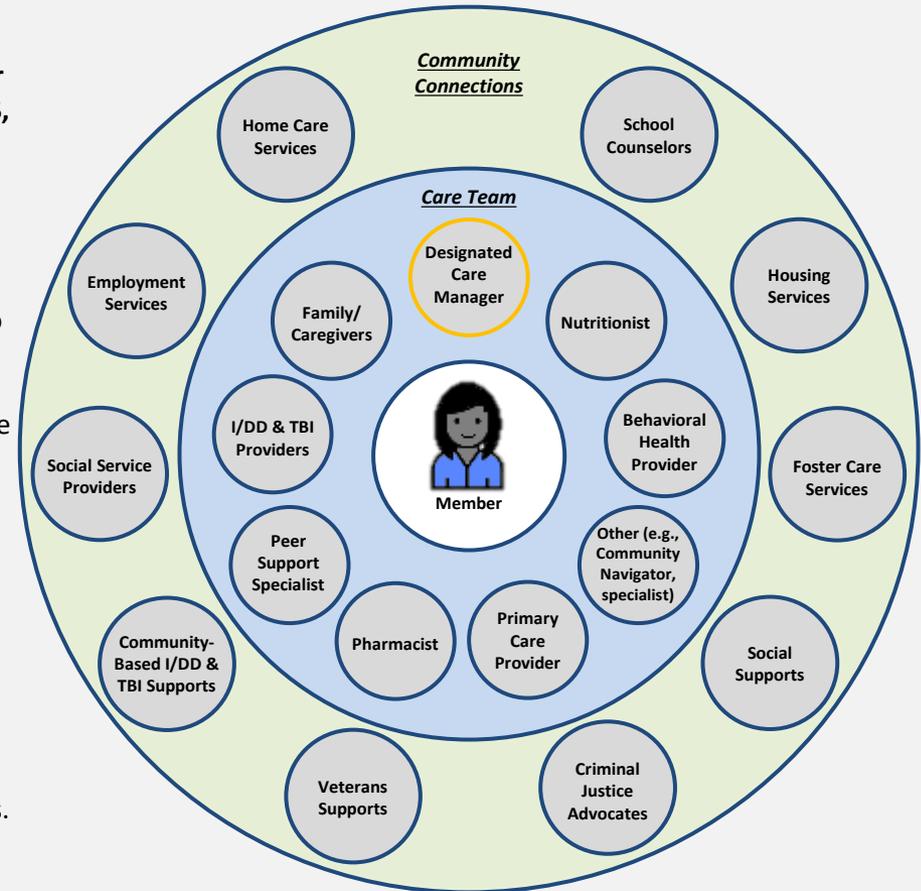
What is integrated Care Management?

Under Tailored Care Management, members will have a single care manager who will be equipped to manage all of members' needs, spanning physical health, behavioral health, I/DD, TBI, pharmacy, LTSS, and unmet health-related resource needs.

Integrated care management places the person at the center of a multidisciplinary care team and recognizes interactions across all of their needs—ranging across physical health, behavioral health, I/DD, TBI, LTSS, and unmet health-related resources—developing a holistic approach to serve the whole person.

In integrated care management, care managers:

- **Coordinate a comprehensive set of services** addressing all of the member's needs; members will not have separate care managers to address physical health, behavioral health, TBI, and I/DD-related needs.
- **Provide holistic, person-centered planning.** Members receive a care management assessment that evaluates all of their needs—from physical health, behavioral health, I/DD, and TBI services to employment and housing—and drive the development of a care plan that identifies the goals and strategies to achieve them.
- **Address unmet health-related resource needs** (e.g., housing, food, transportation, interpersonal safety, employment) by connecting members to local programs and services.
- **Are part of multidisciplinary care teams** made up of clinicians and service providers who communicate and collaborate closely to efficiently address all of the member's needs.
- **Utilize technology** that bridges data silos across providers and plans.



Components of Care Management

Tailored Care Management includes the following activities:

- Development of care management comprehensive assessments and care plans/individual support plans
- Coordination of services
- Innovations and TBI waiver care coordination (if applicable)
- Consultation with multidisciplinary care team
- Transitional care management
- Diversion from institutional settings
- In-reach and transitions from institutional settings (for certain populations)
- Addressing unmet health-related resource needs
- Management of rare diseases and high-cost procedures; high-risk care management; chronic care management
- Medication monitoring
- Development and deployment of prevention and population health programs

Federal Health Home Structure

Federal Health Home Overview

Tailored Care Management was designed to align with federal Health Home requirements.

- The Medicaid Health Home State Plan Option is intended to help states improve care coordination and care management for Medicaid beneficiaries with complex needs.
- Health Homes provide integrated care management of physical and behavioral health and long-term services and supports for high-need, high-cost Medicaid populations.
- By better coordinating care and linking people to needed services, Health Homes help improve health care quality and reduce costs.
- States receive enhanced federal reimbursement for implementing a Health Home program.

Tailored Care Management and Federal Health Home Structure

- The Department will submit a Medicaid State Plan Amendment to add Tailored Care Management as a Health Home State Plan benefit.
- Tailored Plans will serve as the federally-designated Health Homes; in this capacity, the Tailored Plans will be responsible for meeting federal Health Home requirements and conducting oversight of AMH+ practices and CMAs in their networks to ensure that they are meeting applicable requirements as well
- Tailored Care Management, as defined in the Tailored Plan contract and Tailored Care Management provider manual, includes the six core Health Home services:
 - Comprehensive care management
 - Care coordination
 - Health promotion
 - Comprehensive transitional care/follow-up
 - Individual & family support
 - Referral to community & social support services

Delivery of Tailored Care Management

Three Approaches to Delivering Tailored Care Management

Department of Health and Human Services

Establishes care management standards for Tailored Plans aligning with federal Health Home requirements.

The Tailored Plan will act as the Health Home and will be responsible for meeting federal Health Home requirements

**Tailored Plan
(Health Home)**

Care Management Approaches

Tailored Plan beneficiaries will have the opportunity to choose among the care management approaches; all must meet the Department's standards and be provided in the community to the maximum extent possible.

Approach 1:
“AMH+” Primary Care Practice
Practices must be certified by the Department to provide Tailored Care Management.

Approach 2:
Care Management Agency (CMA)
Organizations eligible for certification by the Department as CMAs include those that provide BH or I/DD services.

Approach 3:
Tailored Plan-Based Care Manager

The Department will allow – but not require – AMH+ practices and CMAs to work with a **CIN or other partner** to assist with the requirements of the Tailored Care Management model, within the Department's guidelines.

AMH+ and CMA Definitions

Note: 10/8 webinar to provide a detailed overview of how to become an AMH+/CMA



Advanced Medical Home Plus (AMH+)

Definition: Primary care practices **actively serving as AMH Tier 3 practices**, whose providers have experience delivering primary care services to the Tailored Plan eligible population or can otherwise demonstrate strong competency to serve that population. To demonstrate experience and competency to serve the Tailored Plan eligible population, **each AMH+ applicant must attest that it has a patient panel with at least 100 active Medicaid patients who have an SMI, SED, or severe SUD; an I/DD; or a TBI.**

AMH+ practices may, but are not required to, offer integrated primary care and behavioral health or I/DD services.

To be eligible to become an AMH+, the practice must intend to become a network primary care provider for Tailored Plans.



Care Management Agency (CMA)

Definition: Provider organizations with **experience delivering behavioral health, I/DD, and/or TBI services to the Tailored Plan eligible population**, that will hold primary responsibility for providing integrated, whole-person care management under the Tailored Care Management model.

To be eligible to become a CMA, an organization's **primary purpose** at the time of certification must be the delivery of NC Medicaid, NC Health Choice, or State-funded services, other than care management, to the Tailored Plan eligible population in North Carolina. The "CMA" designation is new and will be unique to providers serving the BH I/DD Tailored Plan population.

The Tailored Plan must contract with all organizations in its region that receive AMH+ or CMA certification to provide Tailored Care Management.

Glide Path to Provider-based Care Management

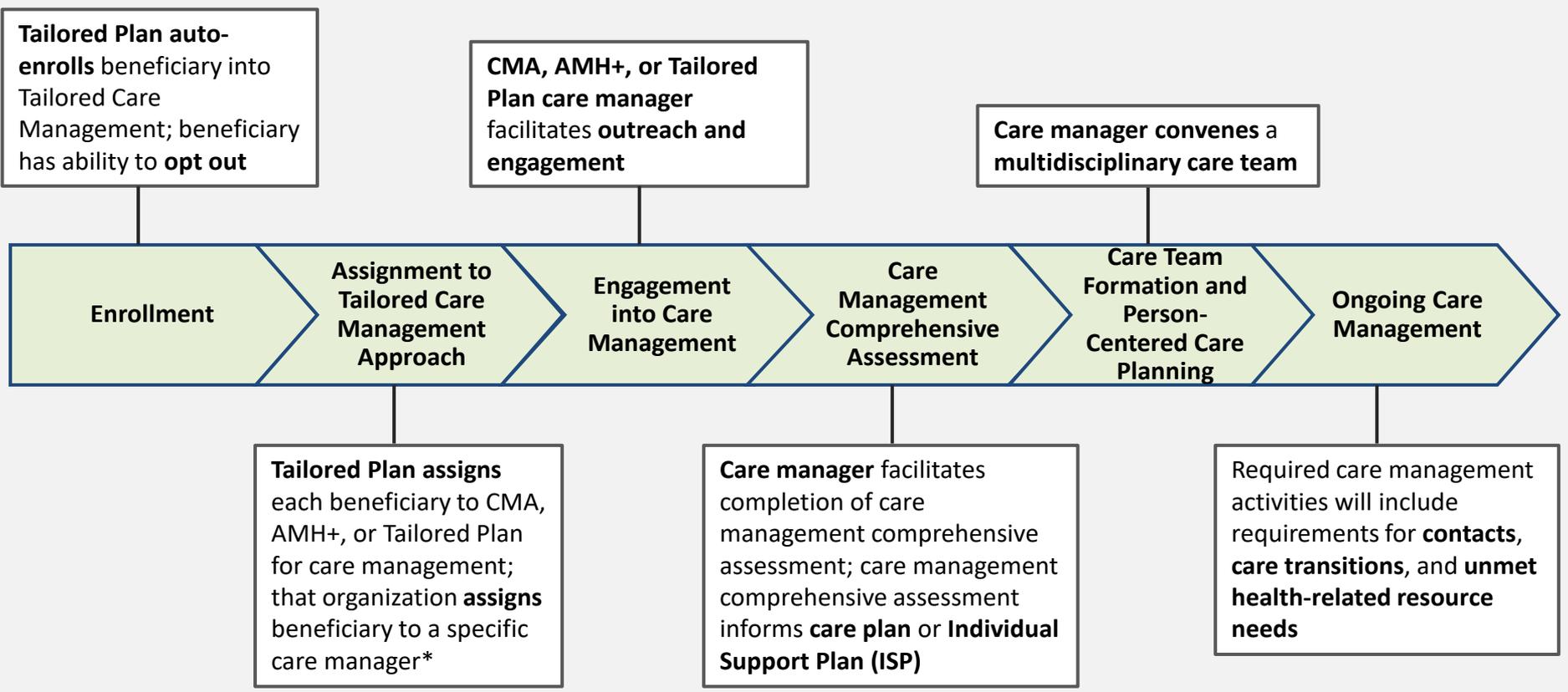
The Department’s vision is to increase, over time, the proportion of actively engaged members receiving care management from AMH+ practices and CMAs (i.e., provider-based care management). To guide the growth of provider-based capacity, the Department established a multiyear “glide path” with annual targets to be met by Tailored Plans.

	2022	2023	2024	2025
Target percentage of beneficiaries <u>“actively engaged”</u> in Tailored Care Management based in AMH+ practice/CMA	30%	45%	60%	80%



The Department believes that provider- and community-based care management is critical to the success of fully integrated managed care.

Tailored Care Management Process Flow



NOTE: Members can change the organization they are assigned to for Tailored Care Management and/or change care managers twice per year without cause and anytime with cause (see [provider manual](#) for description of what qualifies as cause)

*Innovations and TBI waiver beneficiaries will have the choice of keeping their current care coordinators if the care coordinators meet all of the care manager requirements to serve BH I/DD Tailored Plan beneficiaries and federal requirements for conflict-free case management.

Next Steps and Additional Information

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 **Upcoming
Webinar**

Tailored Care Management TAG Overview

In October, the Department will launch the Tailored Care Management Technical Advisory Group (TAG), which will advise and inform the Department on key aspects of the design, implementation, and evolution of Tailored Care Management.

Approach

- Tailored Care Management TAG will be the **primary venue for dialogue** among providers, Tailored Plans, consumer representatives, the Department, and other key stakeholders for evolution of the Tailored Care Management program.
- TAG members will **advise the Department** on topics including but not limited to workforce, capacity building, conflict-free care management, quality measurement and incentives, Healthy Opportunities Pilots, member engagement, data strategy, and other ongoing program design.
 - Recommendations of the TAG will be advisory only; decisions to act upon recommendations will be made at the sole discretion of the Department.
- Members will **take issues raised in the TAG back to their organizations** to promote dialogue and communication between the Tailored Care Management TAG and a broader group of stakeholders
- The TAG will **meet monthly** starting on October 29, 2021

Tailored Care Management TAG Applications

The Department is seeking applications for providers and consumer representatives to participate in the Tailored Care Management TAG. The application will be posted on the Tailored Care Management TAG webpage (launching shortly) and will be due on 10/15, links to these resources will be accessible at <https://medicaid.ncdhhs.gov/transformation/tailored-care-management>.

Provider Representative Eligibility

- Year One of Tailored Care Management TAG: Employee of a provider organization that is a certification candidate to become an AMH+ or CMA
 - *A certification candidate is defined as a provider that has at least passed the desk review stage of the certification process and is continuing to move toward full certification or has since become fully certified by the Department.*
- After Year One of Tailored Care Management TAG: Employee of a provider organization certified by the Department as an AMH+ or CMA

The Department envisions that the Tailored Care Management TAG will include representation from a diversity of providers (e.g., historically underutilized providers, and diversity across provider type, size, geography, and populations served). Each provider organization that applies should identify one individual to represent their organization on the Tailored Care Management TAG.

Consumer Representative Eligibility

- Medicaid enrollee who expects to participate in Tailored Care Management; or
- Individual (e.g., family member or guardian) representing a consumer who will participate in Tailored Care Management

The Department envisions that the Tailored Care Management TAG will include consumer representatives reflecting diversity across race and ethnicity, geography, age, and/or disability groups.

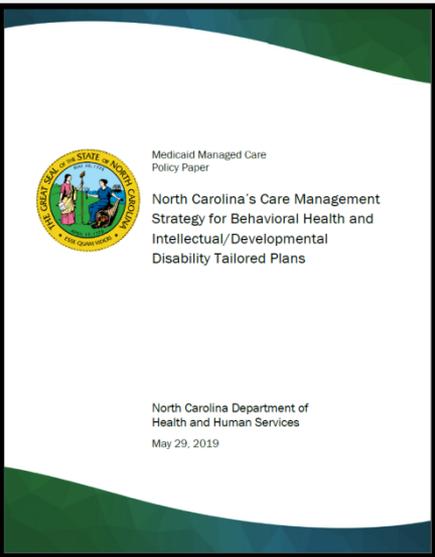
Tailored Plan Representative Eligibility

- Employee of an LME/MCO awarded a Tailored Plan contract

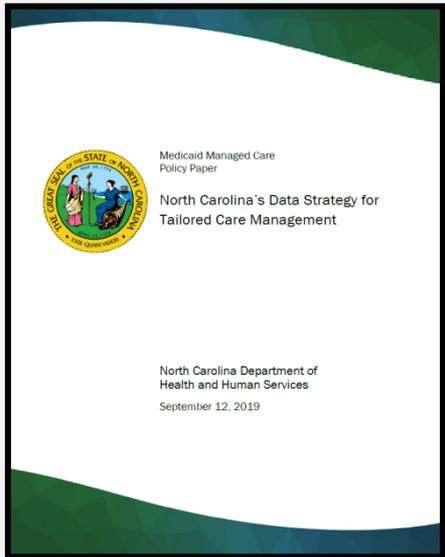
Each Tailored Plan awardee should identify one representative to sit on the Tailored Care Management TAG.

Information about the Tailored Care Management Model

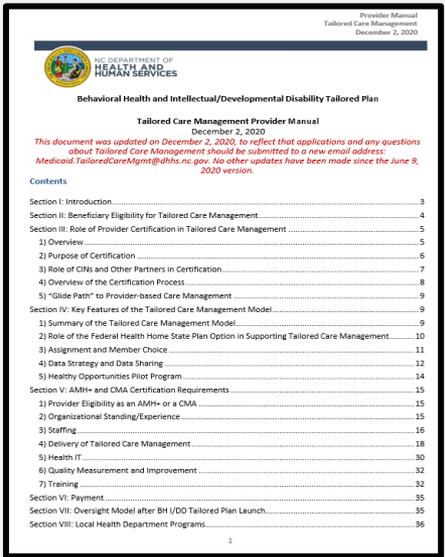
Key documents can be found on the Department’s Medicaid webpage.



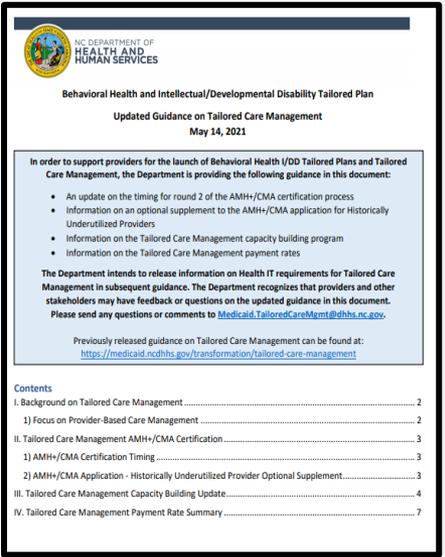
May 2019: [Concept Paper](#)



September 2019: [Data Strategy Paper](#)



June/December 2020*: [Final Provider Manual and Application Questions](#)



May 2021: [Updated Guidance](#)

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

Information about the Tailored Care Management Model

The BH I/DD Tailored Plan Request for Applications (RFA) and draft rate book are available at: <https://medicaid.ncdhhs.gov/transformation/requests-proposals-rfps-and-requests-information-rfis>

Request for Application 30-2020-052-DHB BH I/DD Tailored Plan
Section V. Scope of Services, A - B

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Nov 2020: [RFA](#)

RFA #30-2020-052-DHB
Section IX. Medicaid Tailored Plan Draft Rate Book

Behavioral Health/Intellectual and
Development Disabilities Tailored Plan Draft
Rate Book
Contract Year 1
North Carolina Department of Health and
Human Services

November 9, 2020

Nov 2020: [Draft Rate Book](#)

Questions?