Tailored Care Management Technical Advisory Group (TAG)

Meeting #1: Kick-Off

October 29, 2021

Agenda

- Introductions (15 min)
- Tailored Care Management Program Overview (10 min)
- Key Program Updates (5 min)
- Tailored Care Management TAG Overview and Expectations (15 min)
- Discussion
  - Care Management Extenders (20 min)
  - Key Topics for the Tailored Care Management TAG (10 min)
- Public Comments (10 min)
- Next Steps (5 min)

Introductions

Department of Health and Human Services

Kelly Crosbie, MSW, LCSW	Krystal M. Hilton, MPH	Gwendolyn Sherrod, MBA, MHA	Keith McCoy, MD	Mya W. Lewis, MHA
Chief Quality Officer NC Medicaid, Quality and Population Health	Associate Director of Population Health, NC Medicaid, Quality and Population Health	Senior Program Manager for Special Programs, NC Medicaid, Quality and Population Health	Deputy CMO for Behavioral Health and IDD Community Systems, Chief Medical Office for Behavioral Health and IDD	IDD and TBI Section Chief, Division of Mental Health, Developmental Disabilities and, Substance Abuse Services

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Tailored Care Management TAG Membership

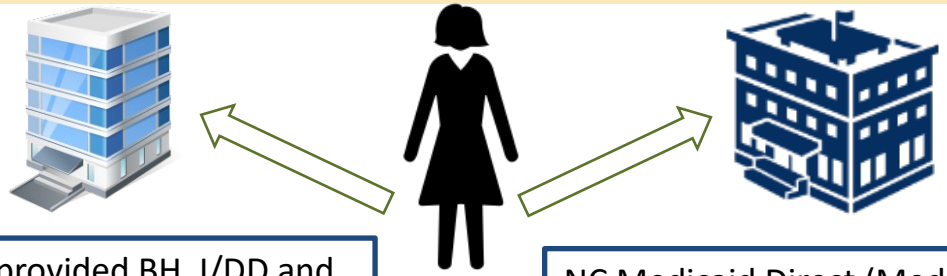
Name	Organization	Stakeholder
Doug Finley	A Small Miracle	Provider Representative
Erin Lewis	B&D Integrated Health Services	Provider Representative
Lauren Clark	Coastal Horizons Center	Provider Representative
Denita Lassiter	Dixon Social Interactive Services	Provider Representative
Jason Foltz, D.O.	ECU Physicians	Provider Representative
Natasha Holley	Integrated Family Services, PLLC	Provider Representative
Lisa Poteat	The Arc of NC	Provider Representative
Austin Hall, M.D.	UNC Center for Excellence in Community Mental Health	Provider Representative
Sean Schreiber	Alliance Health	Tailored Plan Awardee
Josh Walker	Eastpointe	Tailored Plan Awardee
Lynne Grey	Partners Health Management	Tailored Plan Awardee
Sabrina Russell	Sandhills Center	Tailored Plan Awardee
Cindy Ehlers	Trillium Health Resources	Tailored Plan Awardee
Rhonda Cox	Vaya Health	Tailored Plan Awardee
Cindy Lambert	Cherokee Indian Hospital Authority	Tribal Option Representative
Jessica Aguilar	N/A	Consumer Representative
Pamela Corbett	N/A	Consumer Representative
Alicia Jones	N/A	Consumer Representative
Cheryl Powell	N/A	Consumer Representative

Tailored Care Management Program Overview

Transition to Whole-Person Care

NC Medicaid and NC Health Choice are transitioning from predominantly fee-for-service to managed care. Managed care products will offer whole-person care and enable the delivery of physical and behavioral health through one plan, such as a BH and I/DD Tailored Plan.

Historical Environment

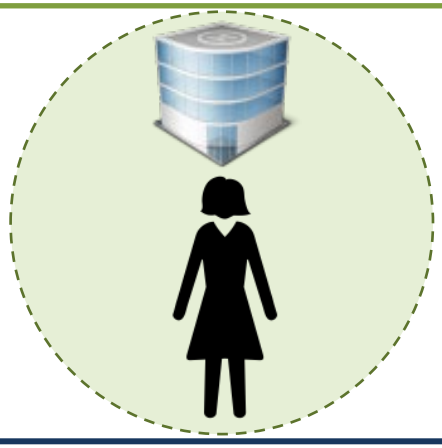


LME-MCOs provided BH, I/DD and TBI services

NC Medicaid Direct (Medicaid FFS) provided physical health services

Integrated Managed Care Environment

Plans will provide whole-person care



Transition to Tailored Care Management

Tailored Care Management is the primary care management model for Tailored Plans and reflects the Department's broader goal for integrated, whole-person care under one Medicaid managed care plan.

Current State	Future State: Tailored Plans
LME-MCOs coordinate BH, I/DD and TBI services **CCNC coordinates physical health services** *LME-MCO care coordination is only available to a subset of the population served by LME-MCOs* 	**Tailored Plans will provide integrated, whole-person care management** *Tailored Care Management will be available to all enrollees unless they are obtaining duplicative services* 

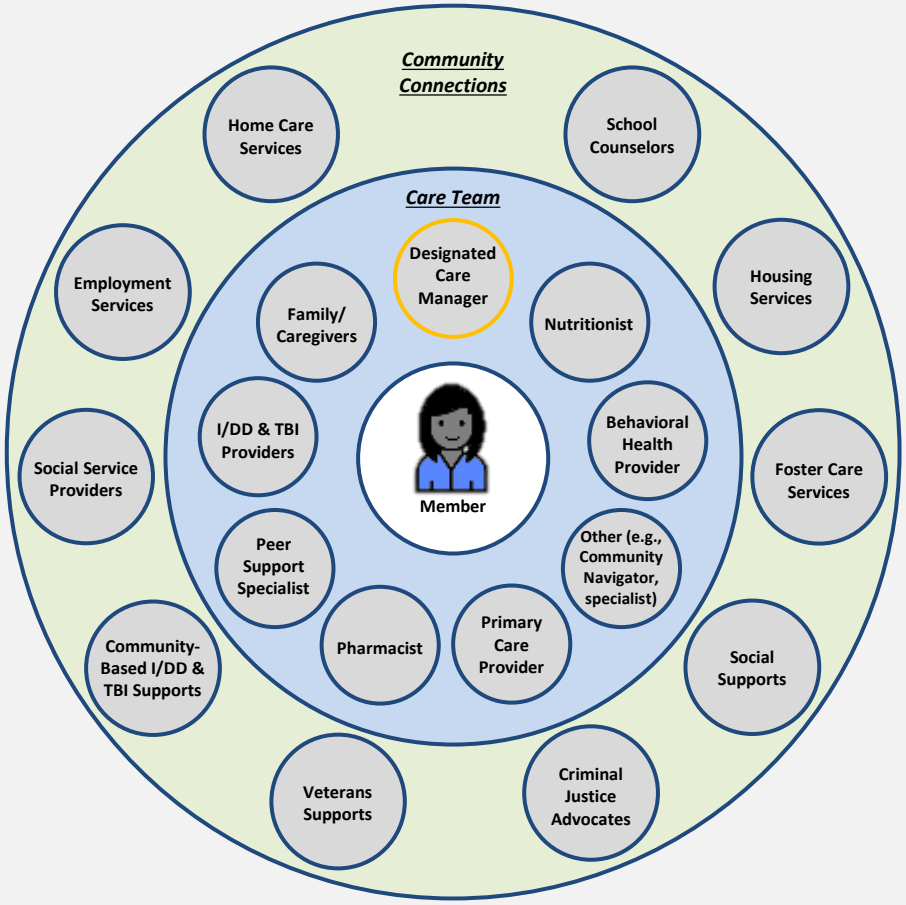
What is Integrated Care Management?

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.



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

AMH+ practices and CMAs are allowed, but not required, 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

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**. "Active" patients are those with at least two encounters with the AMH+ applicant's practice team in the past 18 months.
- **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**.

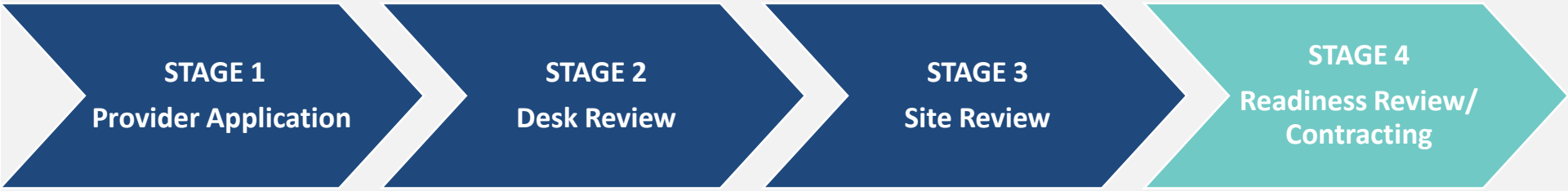
Care Management Agency (CMA)

- **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 Tailored Plan population.

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

AMH+ and CMA Certification Process

Providers must be certified to offer Tailored Care Management. In both the periods before and after Tailored Plan launch, there will be a single, statewide AMH+/CMA certification process for determining whether a provider organization should be certified.



- The Department has contracted with the National Committee for Quality Assurance (NCQA) to conduct desk and site reviews going forward according to the Department's previously published criteria.*
  - NCQA works to improve health care quality through the administration of evidence-based standards, measures, programs, and accreditation. One of their areas of expertise is in conducting provider certification and recognition programs.
- NCQA will also conduct recertification of providers on the Department's behalf.
- The Department will maintain oversight over these processes.

Tailored Plans (LME/MCOs) will conduct additional review of certified AMH+ practices and CMAs shortly before Tailored Care Management launch to verify that they are ready to perform the required Tailored Care Management functions.

The purpose of the provider certification process is to promote provider-based care management while also setting up guardrails to ensure that providers are ready to perform this critical role by Tailored Plan launch.

**AMH+/CMA certification is separate from NCQA's PCMH program and NCQA case management certification and does not qualify as NCQA health plan accreditation.*

Tailored Care Management HIT Systems Overview

AMH+ practices and CMAs must meet the following HIT requirements prior to Tailored Plan launch.

Use an electronic health record (EHR) or clinical system of record*

Use a care management data system

Use NCCARE360 (once operational)

AMH+ practices/CMAs may meet the HIT requirements by:

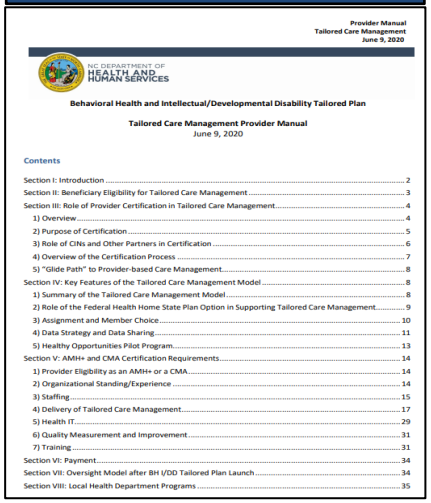
(1) Implementing or using their own systems;
(2) Partnering with a Clinically Integrated Network (CIN) or Other Partner; or
(3) Using the Tailored Plan's care management data system

* Use of an electronic health record (EHR) or clinical system of record is required to apply for and certify as an AMH+ practice/CMA.
See the Tailored Care Management Provider Manual for additional detail on the HIT requirements for AMH+ practices and CMAs.

Data Strategy Source Documents

The Tailored Care Management Provider Manual and the Tailored Plan Contract are the source documents for the data requirements and dataflows. The Tailored Care Management Data Strategy FAQ and Care Management Data System Guidance also discuss the data exchange and HIT requirements.

Tailored Care Management Provider Manual[1]



Provider Manual
Tailored Care Management
June 9, 2020

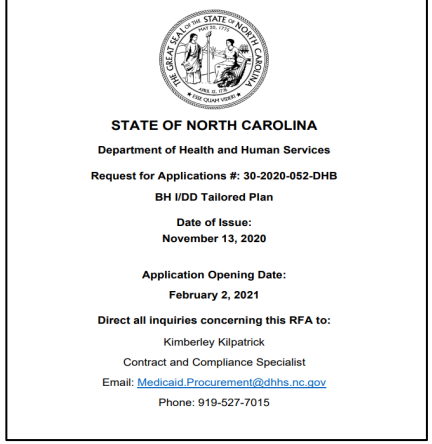
NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Behavioral Health and Intellectual/Developmental Disability Tailored Plan

Tailored Care Management Provider Manual
June 9, 2020

Contents

Tailored Plan Contract[2]



STATE OF NORTH CAROLINA

Department of Health and Human Services

Request for Applications #: 30-2020-052-DHB

BH I/DD Tailored Plan

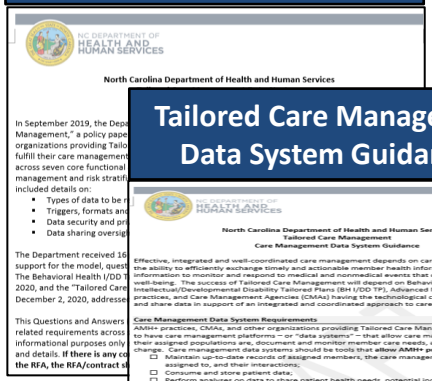
Date of Issue:
November 13, 2020

Application Opening Date:
February 2, 2021

Direct all inquiries concerning this RFA to:

Kimberley Kilpatrick
Contract and Compliance Specialist
Email: Medicaid.Procurement@dhhs.nc.gov
Phone: 919-527-7015

Tailored Care Management Data Strategy FAQ[3]



NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

North Carolina Department of Health and Human Services

In September 2019, the Depa
Management," a policy pape
organizations providing Tailo
fulfill their care management
across seven core functional
management and risk stratifi
included details on:

- Types of data to be r
- Triggers, formats an
- Data security and pr
- Data sharing oversig

The Department received 16
support for the model, quest
The Behavioral Health I/DD T
2020, and the "Tailored Care
December 2, 2020, addresse

This Questions and Answers
related requirements across
informational purposes only
and details. **If there is any co**
the RFA, the RFA/contract s

Tailored Care Management Data System Guidance[4]

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

North Carolina Department of Health and Human Services
Tailored Care Management
Care Management Data System Guidance

Effective, integrated and well-coordinated care management depends on care team members having the ability to efficiently exchange timely and actionable member health information and use that information to monitor and respond to medical and nonmedical events that could impact a member's well-being. The success of Tailored Care Management will depend on Behavioral Health and Intellectual/Developmental Disability Tailored Plans (BH I/DD TP), Advanced Medical Home Plus (AMH+) practices, and Care Management Agencies (CMAs) having the technological capabilities to collect, use and share data in support of an integrated and coordinated approach to care.

Care Management Data System Requirements

AMH+ practices, CMAs, and other organizations providing Tailored Care Management will be expected to 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. Care management data systems should be tools that allow AMH+ practices and CMAs to:

- ☐ Maintain up-to-date records of assigned members, the care managers those members are assigned to, and their interactions;
- ☐ Consume and store patient data;
- ☐ Perform analyses on data to share patient health needs, potential indicators of changing needs (e.g., new visits with specialists, new medications) and potential care gaps (e.g., missed appointments, flagging outdated assessments or care plans, gaps in medication adherence);
- ☐ Maintain care management documentation (e.g., assessments, care plans, care manager interaction notes);
- ☐ Reporting on care management performance, both internally (e.g. supervisor reporting) and externally (e.g., encounter data with BH I/DD TPs, quality reporting with BH I/DD TPs).
- ☐ Transmitting a practice's care management data to another selected system, if needed; and
- ☐ Provide access to - and electronically share, if requested - member records (e.g., assessments, care plans, summary of care documentation) with the member's care team to support coordinated care management, as well as the member.[1]

Care management data systems may be part of – or separate from – an organization's Electronic Health Record (EHR) or clinical system of record, or other analytic and reporting tools. However, the most effective care management data systems will be integrated with an organization's EHR or clinical system of record to support responsive and informed care delivery; they may also link to Admission, Discharge, and Transfer (ADT) data sources to help care managers centrally track unexpected service needs.

The Department will provide additional information about technical data standards in the future.

1. https://files.nc.gov/ncdma/Tailored-Care-Management-Provider-Manual20201202.pdf
2. https://www.ips.state.nc.us/IPS/AGENCY/PDF/13929701.pdf
3. https://medicaid.ncdhhs.gov/media/9912/download?attachment
4. https://medicaid.ncdhhs.gov/media/9913/download?attachment

Key Program Updates

Certification Process Updates

In preparation for the launch of Tailored Care Management, the Department has initiated two rounds of AMH+/CMA certification. Fifty-four providers passed desk reviews in the first round, and thirty-nine providers have submitted applications for the second round.

Round	Application Deadline	Desk Reviews/Site Reviews	Expected Date to Launch Tailored Care Management
1	June 1, 2021	▪ Desk reviews: Summer 2021 ▪ Site reviews: Fall 2021	July 1, 2022
2	September 30, 2021	▪ Desk reviews: Fall 2021 ▪ Site reviews: Winter 2022	July 1, 2022 – January 1, 2023

- **Round one** providers that passed the desk review are receiving **technical assistance** to support preparations for delivering Tailored Care Management.
- More information on **round one site reviews** is expected to be available in November.
- **Round two desk reviews** are expected to be completed by mid-December.

Capacity Building Updates

To help ensure the successful implementation of Tailored Care Management, the Department is launching the Tailored Care Management Capacity Building program, under which approximately $90 million in funding will be distributed across the state starting in early 2022 and through at least June 2023.*

- Providers certified as AMH+ practices and CMAs will be eligible to receive funding for investments in
  - Care management related health information technology (HIT) infrastructure
  - Hiring and training care managers
  - Activities related to operational readiness, such as developing policies/procedures/workflows
- Funds will flow through LME/MCOs awarded a Tailored Plan contract. LME/MCOs (future Tailored Plans) will complete a capacity building needs assessment with each AMH+ practice and CMA to understand and document each provider's specific capacity building needs.
- To access funds, providers must participate in these assessments and, on an ongoing basis, meet targets, mutually agreed upon by the AMH+/CMA and LME/MCO, that demonstrate progress towards achieving specific capacity building milestones.

AMH+ practices and CMAs may choose to use their capacity building funds to contract with CINS/Other Partners for the purpose of capacity building (e.g., to make HIT investments). CINs or Other Partners will not be eligible to receive capacity building funds directly from the Department or Tailored Plans.

***NOTE: Funding for the program is dependent the North Carolina General Assembly passing a state budget, which the Department hopes will occur by the end of the year. The Department hopes to make additional funding available in future years.**

For more details on the capacity building program see: https://files.nc.gov/ncdma/Updated-Guidance-on-Tailored-Care-Management-vF.pdf

Tailored Care Management TAG Overview and Expectations

Tailored Care Management TAG Overview

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

Purpose

- Tailored Care Management TAG will be the **primary venue for dialogue** among providers, Tailored Plans, consumers/families/guardians, 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.

Tailored Care Management TAG Overview – *continued*

The Tailored Care Management TAG will advise and inform the Department on key aspects of the design, implementation, and evolution of Tailored Care Management.

Member Expectations

- Members will begin serving in October 2021 and will occupy term lengths described on the next slide
- Members are expected to **consistently attend and participate in monthly meetings** to provide meaningful feedback on policy and programmatic issues related to Tailored Care Management
- Members will **take issues raised in the TAG back to their organizations and communities** to promote dialogue and communication between the Tailored Care Management TAG and a broader group of stakeholders

Tailored Care Management TAG Eligibility & Term Lengths

The Tailored Care Management TAG will be comprised of three types of representatives with varying eligibility and term lengths.

Provider Representatives

Eligibility

- Year One of Tailored Care Management TAG: Employee of a provider organization that is a certification candidate* to become an AMH+ or CMA

- *After* Year One of Tailored Care Management TAG: Employee of a provider organization certified by the Department as an AMH+ or CMA

Term Length

- Approximately two-three years (after the initial year of Tailored Care Management TAG operation)

Consumer Representatives

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

Term Length

- One year (October 2021 – September 2022), with option for the Department to extend to a second year

Tailored Plan Representatives

Eligibility

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

Term Length

- N/A

**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.*

Care Management Extenders

Extenders in Tailored Care Management

The Department recognizes that care management extenders have a valuable role to play in Tailored Care Management and is developing guidance on the scope of their potential responsibilities in response to stakeholder feedback.

Types of Extenders

- Community navigators/guides
- Community health workers
- *Potentially* certified peer support specialists

The Department is assessing the extent to which certified peer support specialists will play a role in Tailored Care Management v. focus on their core function (delivery of peer support services).

Goals for Use of Extenders

1. Maximize the reach and penetration of the Tailored Care Management model and help address workforce constraints
2. Strengthen the care management extender workforce
   - Preserve the knowledge and relationships held by community navigators, especially their connections to the I/DD and TBI communities
   - Create new opportunities for extenders

For Discussion: Extender Role in Tailored Care Management

The Department envisions that care management extenders will play a key role in many components of Tailored Care Management.

Tailored Care Management Functions	For Feedback: Care Management Extender's Role
Care Coordination	Activities that fall within one of the below categories: ▪ Performing general outreach and follow-up with members ▪ Coordinating services/appointments (e.g., appointment/wellness reminders, arranging transportation) ▪ Engaging in health promotion and knowledge sharing ▪ Sharing information with clinicians 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
Ensuring Annual Physical Exam is Obtained	
Transitional Care Management	
Individual and Family Supports	
Health Promotion	
Addressing Unmet Health-Related Resource Needs	

Extender activities may count as a contact if a phone or in-person contact is made.

Care managers will always lead:
- Completion of care management comprehensive assessment
- Development of care plan or individual support plan (ISP)
- Facilitation of case conferences

For Discussion: Extender Role in Tailored Care Management, *cont.*

In considering the role of extenders in Tailored Care Management, the Department is accounting for the following guardrails:

Guardrails

- Extenders should always be supervised by a care manager.
- Extenders should be acting within their current scope as defined by North Carolina clinical coverage policies (CCP) and the statewide certification program for community health workers (under development).
- When extenders are playing a role in Tailored Care Management, their role should be paid for through the Tailored Care Management monthly rate—they should not be able to bill for a duplicative service.
  - The Department will no longer permit community navigator to be billed as a discrete billable service because it is almost entirely duplicative of Tailored Care Management.

Key Topics for the Tailored Care Management TAG

Tailored Care Management TAG Key Topics

The Department envisions that the Tailored Care Management TAG will cover a range of design and implementation topics pre-Tailored Plan launch, as well as ongoing implementation and future visioning issues post-Tailored Plan launch.

Pre-Launch

- Care management workforce
- Capacity building
- Care management assignment
- Conflict-free care management
- Quality measures and incentives
- Healthy Opportunities Pilots
- Integrated Care for Kids (InCK)
- Data strategy

Post-Launch

- Strategies to address early challenges in implementation
- Program design beyond year one
- Value-based payments/alternative payment models
- Capacity building year two milestones
- Member engagement strategies
- Incentives to promote on-site integration of physical health and behavioral health/I/DD/TBI care

Tailored Care Management TAG Key Topics – *continued*

The Department is seeking your input on key topics that should be prioritized for discussion via the Tailored Care Management TAG.

For Discussion:

1. What policy issues should be addressed *immediately* for the Tailored Care Management program to be successful over the next year?

2. What policy issues must be addressed *over the next year* for the Tailored Care Management program to be successful over the next 3 – 5 years?

Public Comments

Next Steps

Tailored Care Management TAG Meeting Cadence

Tailored Care Management TAG meetings will generally take place the last Friday of every month from 3-4 pm ET, with two exceptions due to holidays over the next couple months.

Upcoming 2021 Meetings

Friday, November 19
3:30 – 4:30 pm ET

Friday, December 17
3:30 – 4:30 pm ET

2022 Meetings, through End of Tailored Care Management TAG Year One

January 28, February 25, March 25, April 22, May 27, June 24, July 22, August 26, September 23

Next Steps

Tailored Care Management TAG Members

- Share today's discussion key takeaways with your networks

Department

- Prepare for November 19th Tailored Care Management TAG session

Appendix

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, members, counties, health plans, elected officials, advocates, and other stakeholders to shape the program.

Medicaid Managed Care Overview

With the transition to managed care, the Department 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 Plans are anticipated to launch in **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).

Components of Tailored 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

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)

Core Principles of Tailored Care Management Model

The Department has established the following core principles for Tailored Care Management:

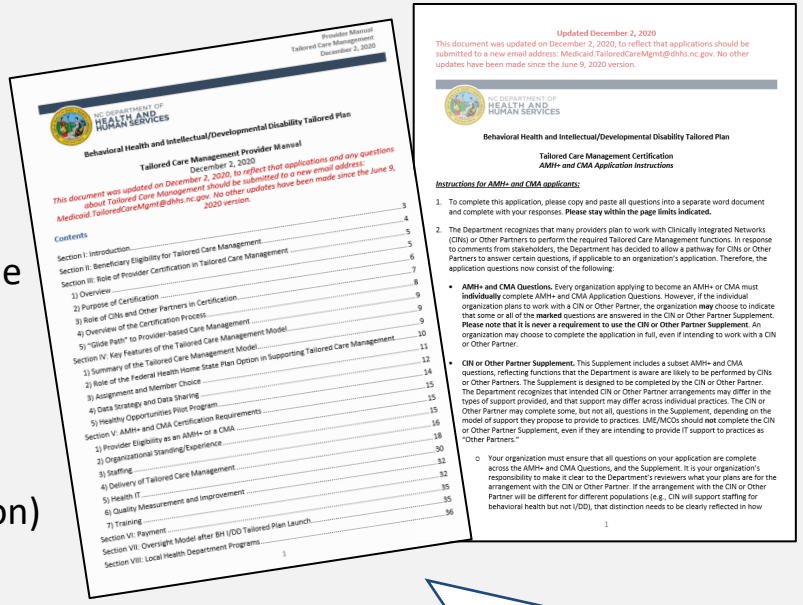
- Broad access to care management
- Single care manager taking an integrated, whole-person approach
- Person- and family-centered planning
- Provider-based care management
- Community-based care management
- Community inclusion
- Choice of care managers
- Consistency across the state
- Harness existing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

Certification Requirements Overview

The AMH+ and CMA certification application assesses whether organizations are credibly on track to deliver Tailored Care Management by Tailored Plan launch.

Requirements:

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



Behavioral Health and Intellectual/Developmental Disability Tailored Plan

Tailored Care Management Provider Manual

December 2, 2020

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

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Behavioral Health and Intellectual/Developmental Disability Tailored Plan

Tailored Care Management Certification
AMH+ and CMA Application Instructions

Instructions for AMH+ and CMA applicants:

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

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

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Organizations do not have to be fully ready now, but in their applications should have described their plans to achieve readiness by Tailored Care Management launch.

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

Extenders Will Be Permitted to Practice within Scope

Care management extenders will be a part of the Tailored Care Management care team within their defined scope of responsibilities.

	Summary of Current Scope of Responsibilities in North Carolina	Minimum Qualifications in NC
Community Navigators	▪ *Self-Determination*: providing education on decision-making, risk-taking, and problem-solving; promoting self-advocacy and collaboration with others ▪ *Self-Direction*: providing training, information, coaching, and technical assistance to individuals who choose to self-direct services and supports ▪ *Tenancy Support*: supporting individuals in obtaining housing ▪ *Community Connections:* supporting the individual in identifying resources and building community	▪ High school diploma or equivalent ▪ Meets core competencies and qualified in the customized needs of the participant as described in the ISP
Community Health Workers	▪ *Cultural Liaison*: ensuring individuals receive culturally/linguistically appropriate care ▪ *Navigator*: linking/referring individuals to needed health/social services ▪ *Health and Wellness Promoter*: providing information about healthy behaviors and support individuals in reducing health-related risk behaviors ▪ *Advocate*: supporting individuals in advocating for their own health; educating providers about their clients	▪ High school diploma or equivalent ▪ Statewide certification program and core competency training at community colleges under development

Sources: NC Innovations 1915(c) HCBS Waiver (as of May 1, 2020); Final Report and Stakeholder Recommendations of the NC CHW Initiative; Peer Support Services Clinical Coverage Policy