NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Behavioral Health and Intellectual/Developmental Disability Tailored Plan

Updated Guidance on Tailored Care Management
May 14, 2021

In order to support providers for the launch of Behavioral Health I/DD Tailored Plans and Tailored Care Management, the Department is providing the following guidance in this document:

- An update on the timing for round 2 of the AMH+/CMA certification process
- Information on an optional supplement to the AMH+/CMA application for Historically Underutilized Providers
- Information on the Tailored Care Management capacity building program
- Information on the Tailored Care Management payment rates

The Department intends to release information on Health IT requirements for Tailored Care Management in subsequent guidance. The Department recognizes that providers and other stakeholders may have feedback or questions on the updated guidance in this document. Please send any questions or comments to Medicaid.TailoredCareMgmt@dhhs.nc.gov.

Previously released guidance on Tailored Care Management can be found at:
https://medicaid.ncdhhs.gov/transformation/tailored-care-management

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I. Background on Tailored Care Management

As North Carolina transitions its Medicaid and NC Health Choice programs from a predominantly fee-for-service delivery system to managed care, the North Carolina Department of Health and Human Services (the Department) is focused on building robust and effective models for managing beneficiaries' comprehensive needs through care management. As part of this transition, the Department has worked over the past several years with providers, Local Management Entities/Managed Care Organizations (LME/MCOs), and other stakeholders to design the Tailored Care Management model for the Behavioral Health I/DD Tailored Plan population.[1]

The Department's vision is that Tailored Care Management will provide the "glue" for integrated care, fostering coordination and collaboration among care team members across disciplines and settings, and lay the foundation for strong population health management and value-based payment arrangements. Tailored Care Management will launch in July 2022 with the implementation of Behavioral Health I/DD Tailored Plans.

1) Focus on Provider-Based Care Management

Tailored Care Management was designed on the principles that care management should be provider-based and performed at the site of care, in the home or in the community, and through face-to-face interaction between beneficiaries, providers, and care managers. As under Standard Plans, the Department strongly believes that placing care management as close as possible to the member and the site of care will drive better health outcomes.[2] Behavioral Health I/DD Tailored Plan members will obtain care management through one of three approaches: through an Advanced Medical Home Plus (AMH+) practice, Care Management Agency (CMA), or a care manager based at their Behavioral Health I/DD Tailored Plan. Only care management offered by AMH+ practices and CMAs is considered provider-based, and the Department recognizes that it will take time to build this capacity across the state.

To guide the growth of provider-based care management, the Department has established a four-year "glide path" where Behavioral Health I/DD Tailored Plans will be required to meet annual targets on the percentage of members actively engaged in Tailored Care Management via AMH+ practices and CMAs. [3] In year 1 of Behavioral Health I/DD Tailored Plan implementation, the Department is requiring that at least 30% of individuals actively engaged in Tailored Care Management obtain care management through AMH+ practices or CMAs, and by year 4, this figure must reach at least 80% (the remaining members will obtain Tailored Care Management from care managers based at Behavioral Health I/DD Tailored Plans). These glide path targets are minimum targets only, and the Department anticipates that in many geographic areas, there will be sufficient provider capacity to exceed these targets. Behavioral Health/IDD Tailored

[1] Behavioral Health I/DD Tailored Plans will launch July 2022 and provide a comprehensive set of benefits to populations with significant behavioral health conditions, I/DDs and traumatic brain injuries. In November 2020, the Department issued the Behavioral Health I/DD Tailored Plan Request for Applications (RFA), available at https://medicaid.ncdhhs.gov/transformation/requests-proposals-rfps-and-requests-information-rfis.

[2] As part of the transition to managed care, the Department will launch Standard Plans in July 2021, which serve most Medicaid beneficiaries, and a specialized plan for children in foster care in July 1, 2023.

[3] Actively engaged in Tailored Care Management is defined as a member receiving at least one of the following six core Health Home services in the past month: comprehensive care management, care coordination, health promotion, comprehensive transitional care/follow-up, individual and family support, or referral to community and social support services.

Plans will be expected to maximize provider-based care management to build sustainable service lines for providers.

II. Tailored Care Management AMH+/CMA Certification

1) AMH+/CMA Certification Timing

Pre-Behavioral Health I/DD Tailored Plan launch, the AMH+/CMA certification process will take place in two rounds.[4] Applications for round one will be due on **June 1, 2021**, as previously communicated. Applications for round two will be due on **September 30, 2021.**

The Department expects that providers that apply in round one and are certified by the Department will be ready to launch Tailored Care Management on July 1, 2022, when Behavioral Health I/DD Tailored Plans launch. Behavioral Health I/DD Tailored Plans will conduct the final review for readiness prior to Tailored Care Management launch.

The Department will allow providers that apply in round two to begin providing Tailored Care Management once as they achieve certification and complete the final Behavioral Health I/DD Tailored Plan readiness review. These providers should target launching Tailored Care Management as close to July 1, 2022 as possible, but in response to stakeholder feedback, can launch through January 1, 2023. The Department will release additional information for round 2 certification providers later this year, including how care management assignments will be implemented for providers certified through this round.

It remains the Department's vision for the Tailored Care Management program to be provider-based to the extent possible, at the onset of Behavioral Health I/DD Tailored Plan launch and increasingly over time. The updated timing guidelines described above will allow providers that are ready to begin delivering Tailored Care Management sooner the opportunity to do so, while allowing providers who are not ready for the round one application deadline more time to prepare.

2) AMH+/CMA Application - Historically Underutilized Provider Optional Supplement

As part of the Department's commitment to advancing health equity across all of its programs, the Department has developed an optional supplement to the Tailored Care Management Certification Application to give organizations the opportunity to self-identify as a Historically Underutilized Provider (HUP), if applicable.[5]

This information will be used to advance health equity through the Tailored Care Management program by, for example, informing capacity building fund distribution as described in the Behavioral Health I/DD Tailored Plan Capacity Building Update, and giving the Department the information necessary to ensure that the certification process is conducted in an equitable manner.

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[4] The application for Tailored Care Management certification can be found at: https://files.nc.gov/ncdma/Revised-Tailored-Care-Management-Application-Questions20201202.pdf. Additional information on the Tailored Care Management program is available at: https://medicaid.ncdhhs.gov/transformation/tailored-care-management.

[5] The Department defines Historically Underutilized Providers (HUP) as provider organizations owned/controlled and managed by at least fifty-one percent racial/ethnic minorities, women, people with disabilities, people who are LGBT, and/or otherwise socially and economically disadvantaged as defined in 15 U.S.C. § 637.

The optional supplement for Historically Underutilized Providers is available on the Tailored Care Management webpage.

III. Tailored Care Management Capacity Building Update

Through conversations with providers and other stakeholders on what it will take to achieve the Department's vision for Tailored Care Management, the Department has identified three key areas in which investments in providers are needed to ensure successful implementation of this ambitious new model:

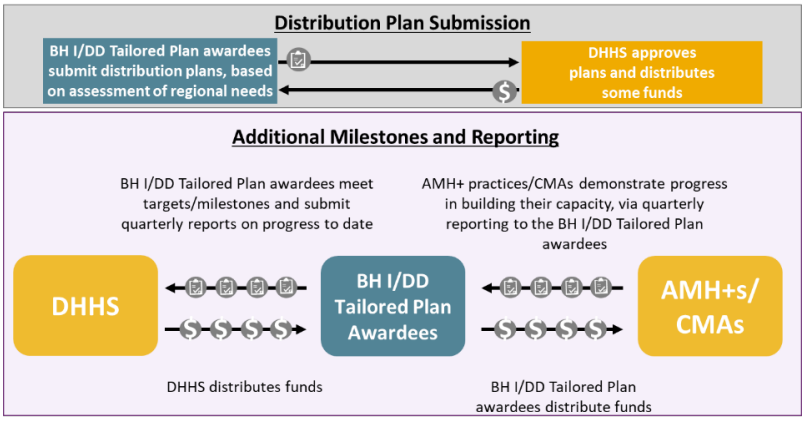
1) Care management related health information technology (HIT) infrastructure
2) Workforce development (hiring and training care managers), and
3) Operational readiness (developing policies/procedures/workflows and other competencies linked to operationalizing the model).

With this in mind, the Department has designed a Tailored Care Management capacity building program, under which approximately $90 million in capacity building funds will be distributed across the state starting in early 2022. This update provides more information on the capacity building program.

Funds Flow and Reporting

Under the program, LME/MCOs awarded a Behavioral Health I/DD Tailored Plan contract will partner with certified AMH+ practices and CMAs to achieve milestones focused on these three major areas of investments. Funds will flow from the Department to Behavioral Health I/DD Tailored Plans, and then to AMH+ practices and CMAs, and will be linked to specific milestones representing areas of investment as well as to reporting on these milestones.[6] At least 90% of funding will be associated with milestones focused on investments at the AMH+ and CMA levels and a maximum of 10% of funds will be associated with Behavioral Health I/DD Tailored Plan investments.

Figure 1. Capacity Building Funds Flow and Reporting



[6] This funds flow and reporting structure is designed to meet federal requirements for managed care performance incentive arrangements set by 42 CFR 438.6(b)(2), which allows the State to obtain federal Medicaid match for the capacity building funds and permits funds to be distributed prior to Behavioral Health I/DD Tailored Plan launch as long as funds are distributed through a Medicaid managed care plan.

Distribution Plans

As indicated in Figure 1, Behavioral Health I/DD Tailored Plans must develop a distribution plan for capacity building funds that is based on an assessment of regional needs. The distribution plan will:

- Lay out the proposed approach for meeting investment milestones and related quarterly targets for each milestone
- Indicate a proposed budget for achieving each milestone
- Indicate the proposed approach for addressing health disparities, ensuring the needs of Historically Underutilized Providers are identified and addressed, and building a care management workforce and provider networks that are representative of the diverse population in the state

The Department will review the distribution plan and budget and work with each Behavioral Health I/DD Tailored Plan to arrive at a final budget, based on available capacity building funds. Behavioral Health I/DD Tailored Plans will begin to receive funds once the Department approves their distribution plans. Behavioral Health I/DD Tailored Plans will be able to update their distribution plans throughout the capacity building period to reflect changes in their approach.

Quarterly Reports

Subsequent funding distributions, consistent with the approved quarterly budget for each milestone, will be released only after Behavioral Health I/DD Tailored Plans submit quarterly reports indicating the milestones and associated targets have been met. As such, actual capacity building payments earned by Behavioral Health I/DD Tailored Plans, AMH+ practices, and CMAs will differ based on needs (as reflected in the distribution plans) and achievement of targets/milestones.

Milestones

The Department has identified the following six capacity building milestones to enhance HIT infrastructure, build the care manager workforce, and promote operational readiness:

Figure 2. Capacity Building Milestones

Milestone 1	Submission of a detailed distribution plan that specifies the Behavioral Health I/DD Tailored Plan's approach (including quarterly targets) and proposed budget for meeting the remaining capacity building milestones, for DHHS approval
Milestone 2	Submission of a Tailored Care Management training curriculum and conducting trainings for care managers employed by Behavioral Health I/DD Tailored Plan awardee and contracted AMH+ practices and CMAs
Milestone 3	Purchase or upgrades of care management related HIT infrastructure and systems for AMH+ practices/CMAs
Milestone 4	Hiring new care managers and supervisors at AMH+ practices and CMAs
Milestone 5	Completing Tailored Care Management training for AMH+ practices and CMAs' care managers and supervisors
Milestone 6	AMH+ practices/CMAs meeting other competencies linked to operationalizing Tailored Care Management (e.g., development of policies and procedures and education and outreach to members on the Tailored Care Management model)

Sub-milestones will also be developed, including sub-milestones targeted at supporting Historically Underutilized Providers. Capacity building funding is not intended to support Behavioral Health I/DD Tailored Plan, AMH+, and CMA needs in areas other than Tailored Care Management or that are not reflected in these milestones.

Eligibility and Contracting

The following organizations are eligible to participate in the capacity building program:

- LME/MCOs awarded a Behavioral Health I/DD Tailored Plan contract
- Providers certified either as an AMH+ practice or CMA

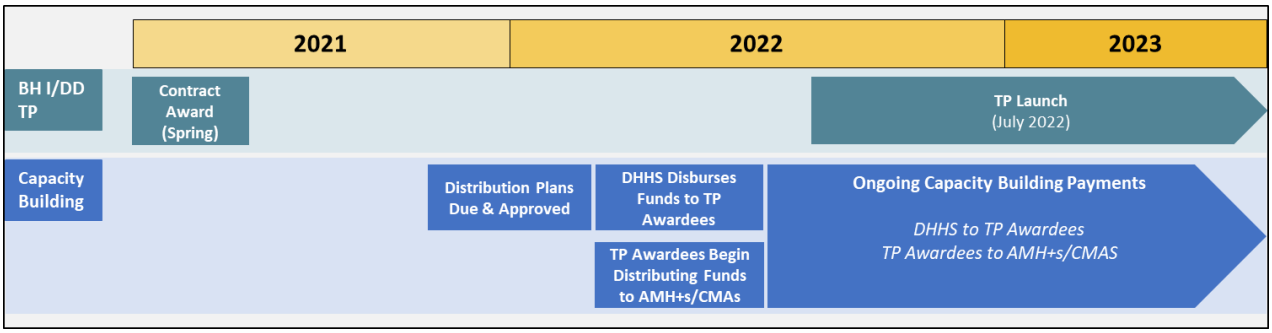
Based on the identified regional needs, LME/MCOs awarded a Tailored Plan contract will need to enter into capacity building contracts with AMH+ practices and CMAs in their region (either as new contracts or amendments to existing contracts) once they are awarded a Behavioral Health I/DD Tailored Plan Contract.

AMH+ practices and CMAs may choose to use their capacity building funds to contract with Clinically Integrated Networks (CINs) or 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 Behavioral Health I/DD Tailored Plans.

Timing

As shown in Figure 3 below, the capacity building program will launch after Behavioral Health I/DD Tailored Plan contracts are awarded and announced and will run at least through June 2023. Payments will begin in early 2022. The Department hopes to make additional funding available in future years.

Figure 3: Timeline



Next Steps

In the coming months, the Department will undertake the following next steps in preparation for the launch of the program:

- Announce Behavioral Health I/DD Tailored Plan awardees in late Spring of 2021
- Update the current LME/MCO contract for Behavioral Health I/DD Tailored Plan awardees to include the capacity building program
- Release the distribution plan template and submission deadline

Behavioral Health I/DD Tailored Plans will then conduct their regional assessments and submit their distribution plans for Departmental review and approval.

IV. Tailored Care Management Payment Rate Summary

Overview of Tailored Care Management Rates

In recognition of the significant time and resource commitment required to successfully implement the Tailored Care Management model, provider payment rates will be significantly higher than those paid for Standard Plan care management. Each Behavioral Health I/DD Tailored Plan beneficiary will be assigned to an "acuity tier," as defined by the Department; the acuity tier will determine a per member per month (PMPM) rate for each beneficiary, with providers being paid more for high acuity beneficiaries and vice versa. Acuity tiers will account for a range of beneficiary characteristics, including behavioral health, I/DD, or traumatic brain injury (TBI)-related needs, chronic physical health conditions, pharmacy utilization, service utilization (e.g., emergency department), non-health related resource needs, and other factors. The Department has released preliminary, illustrative rates by acuity tier through the Behavioral Health I/DD Tailored Plan Draft Rate Book; these are provided below. Behavioral Health I/DD Tailored Plans will be required to pass the full amount of these rates through to AMH+ and CMA providers and may not retain a portion for members assigned to an AMH+ or CMA. The Department will finalize the rates prior to Behavioral Health I/DD Tailored Plan launch.[7]

Table 1: Illustrative Tailored Care Management Rates, Contract Year 1

Acuity Tier[8]	PMPM Rate
Behavioral Health, Low Acuity	$160
Behavioral Health, Moderate Acuity	$260
Behavioral Health, High Acuity	$360
I/DD or TBI, Low Acuity	$90
I/DD or TBI, Moderate Acuity	$260
I/DD or TBI, High Acuity	$320

In order to access the PMPM rate for any given beneficiary, providers must deliver at least **one** care management contact during the month for that beneficiary (i.e., providers will not be paid in months in which there were no member contacts). The provider will be required to submit a claim to the Behavioral Health I/DD Tailored Plan, and the Behavioral Health I/DD Tailored Plan will pay the provider the PMPM rate after the month of service. The Department will provide additional guidance on billing policies and procedures prior to launch.

[7] Behavioral Health I/DD Tailored Plan capitation rates account for costs associated with Behavioral Health I/DD Tailored Plan care coordination responsibilities, oversight of the Tailored Care Management model, and other care management-related functions that will still be provided by the Behavioral Health I/DD Tailored Plan even when care management is being provided by an AMH+ or CMA.

[8] Note: The Department is considering establishing separate rates to account for the unique circumstances of Innovations and TBI waiver enrollees.

Rates were constructed by translating minimum contact requirements, as described in the next section, into estimated member-to-care manager caseload ratios, calculating staffing costs associated with maintaining the estimated caseload ratios, adding additional overhead costs, and converting all costs to a PMPM amount. Each of these steps – and key assumptions underlying them – are described below. All Tailored Care Management rates are subject to further refinement by the Department.

Care Manager Time Assumptions

Contact Requirements

As described in previous Departmental guidance and the Behavioral Health I/DD Tailored Plan request for applications, Behavioral Health I/DD Tailored Plans will monitor providers to ensure they are providing the appropriate level of care management support to assigned members, as reflected by their acuity tier. These contact requirements are described below and were developed with input from clinicians and other professionals with deep expertise working with populations with behavioral health, I/DD, and TBI needs. The Department may consider refinements to the contact requirements to better reflect the needs of the Behavioral Health I/DD Tailored Plan population. Accordingly, contact requirements are subject to change.

Table 2: Tailored Care Management Contact Requirements

Acuity Tier	Members with Behavioral Health Needs	Members with an I/DD or TBI
High	At least 4 care manager-to-member contacts per month, including at least 1 in-person contact.	At least 3 care manager-to-member contacts per month, including 2 in-person contacts.
Medium	At least 3 contacts per month and at least 1 in-person contact quarterly.	At least 3 contacts per month and at least 1 in-person contact quarterly.
Low	At least 2 contacts per month and at least 2 in-person contacts per year, approximately 6 months apart.	At least 1 contact per month and at least 2 in- person contacts per year, approximately 6 months apart.

Notes: Contacts that are not required to be in-person may be telephonic or through two-way real time video and audio conferencing. For members with an I/DD or TBI who have a guardian, telephonic or two-way real time video and audio conferencing contacts may be with a guardian in lieu of the member, where appropriate or necessary. In-person contacts must involve the member.

The Department will provide additional detail on how it plans to monitor contact requirements prior to launch. The Department anticipates that providers will have flexibility to deliver a variable number of contacts in each month without facing penalties as long the provider is delivering the minimum number of contacts on average over the course of the plan year. The Department is also considering whether "collateral" contacts with other providers, school personnel, or other individuals involved in a member's care will count toward fulfillment of contact requirements.

The draft Tailored Care Management rates are built off of the contact requirements above. In developing the rates, the Department assumed 1 hour per telephonic contact (30 minutes for the contact and 30 minutes for preparation and documentation) and 1.5 hours per in-person contact (30 minutes for the contact and 60 minutes for travel, preparation, and documentation). It assumed between 15 and 45 minutes per member per month, depending on member acuity, for additional time spent working with the member's care team. The Department also assumed five hours per week for non-member-related activities, such as staff meetings and other typical employment activities (e.g., completion of time cards, supervisor meetings, etc.), and that care managers operate at 95% capacity at any given time. Additionally, the caseloads and rates consider paid time off (PTO) for holidays and vacation.

In the below table, we describe an example time allocation for a care manager with a caseload of all moderate acuity Behavioral Health members. In practice, the Department expects that care managers' caseloads will be comprised of a mix of acuity levels.

Table 3: Example Care Manager Workload Distribution, Behavioral Health Moderate Acuity Member

Activity	Share of Care Manager Time
Member-Related Activities	**82%**
Member Contact Time (In-Person and Telephonic)	34%
Travel/Documentation/Preparation for Member Contacts	37%
Care Team Meetings/Additional Clinical Time	10%
Non-Member-Related Activities	**13%**
Non-Productive Time for Assumed Caseload Turnover	**5%**

Note: numbers may not sum due to rounding.

Caseload Assumptions

Based on the contact requirements and workload assumptions described above, the Department developed a series of caseload assumptions for purposes of constructing the rates only (i.e., the caseload assumptions are not programmatic requirements but were used to inform the rate development process). These ratios are expressed as a ratio of assigned, actively engaged members per FTE care manager that the care manager could reasonably serve while fulfilling the contact requirements. The caseload assumptions are described below for each acuity tier:

Table 4: Care Manager Caseload Assumptions

Acuity Tier	Members with Behavioral Health Needs	Members with an I/DD or TBI
High	25:1	28:1
Medium	33:1	33:1
Low	54:1	90:1

Supervising Care Manager Caseload Requirements

The Department requires that care managers providing direct services to members be supervised by a supervising care manager and that one supervising care manager will not oversee more than eight care managers.[9] AMH+ providers and CMAs with fewer than eight care managers may have a partial FTE as a supervising care manager as long as a 0.5 FTE supervising care manager is available (providers may share supervising care managers if it is more economical, as long the as required caseload ratios are maintained for each provider). Supervising care managers should not have a caseload but are expected to provide coverage for vacation and sick leave along with providing support, guidance, and quality control to care managers serving members directly.

Cost Assumptions

The Department calculated PMPM rates based on the cost of employing a sufficient number of care managers to maintain the caseload ratios described above. Care manager and supervisor base salary assumptions were derived from North Carolina-specific salary data for professionals meeting the State's minimum qualifications from the Bureau of Labor Statistics. In addition to base salaries, the personnel cost assumptions account for fringe benefits, including paid time-off (PTO). These cost assumptions are described in the table below:

Table 5: Key Staffing Cost Assumptions

Cost Component	Amount
Care Manager Personnel Costs, Per FTE	**$75,944**
Base Salary	$58,871
Benefits	$17,073
Supervising Care Manager Personnel Costs, Per FTE	**$88,488**
Base Salary	$68,595
Benefits	$19,893

Note: salary assumptions reflect statewide averages. In reality, costs per FTE care manager will vary based upon experience and licensure/education.

In addition to staffing costs, the rates account for 15% in additional program-related and overhead costs per FTE care manager. They also account for costs associated with clinical consultant time. These clinical consultant cost amounts range from $4.25 PMPM for low acuity members to $21.25 PMPM for high acuity members based on assumed amount of time required for consultants, which varies by acuity tier.

The appendix displays an example rate build-up.

[9] The Department is open to feedback from the field on the appropriate ratio of care managers to supervising care managers.

Appendix: Example Full Rate Build-Up, Moderate Acuity Member with a Behavioral Health Condition

Cost Component	PMPM Amount
Annual Care Manager Wage and Benefit Costs (1.0 FTE)	$75,944
Annual Supervisor Wage and Benefit Costs (1.0 FTE)	$88,488
Supervisor Wage and Benefit Costs Per FTE Care Manager (0.125 FTE)	$11,061
Total Wage and Benefit Costs Per FTE Care Manager (1.0 FTE Care Manager and 0.125 FTE Supervisor)	$87,004
Annual Overhead and Program-Related Costs (15% of Total Costs, Inclusive of Overhead and Program-Related Costs)	$15,354
Total Annual Costs	$102,358
Total Monthly Costs	$8,530
Total Monthly Costs Per Case (33 Cases per Care Manager)	$258
PMPM Clinical Consultant Costs	$7
Total PMPM Rate	$265

Note: Figures may not match Table 1 due to rounding.