

Medicaid Managed Care
Policy Paper

North Carolina's Care Management Strategy for Behavioral Health and Intellectual/Developmental Disability Tailored Plans

North Carolina Department of
Health and Human Services

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This document is part of a series of Department of Health and Human Services policy papers that provide additional details to stakeholders regarding the transition of North Carolina Medicaid and NC Health Choice programs to a managed care model. This technical paper is written primarily for providers and health plans that will participate directly in Medicaid Managed Care; however, anyone may respond and provide feedback to the Department, including beneficiaries, advocates or other interested parties. Some topics mentioned in this document may be covered in more detail in other policy papers in the series. For more information, stakeholders are encouraged to review the Amended North Carolina Section 1115 Demonstration Waiver and previously released policy papers available at ncdhhs.gov/nc-medicaid-transformation.

Input is welcome and appreciated. Send comments to Medicaid.Transformation@dhhs.nc.gov.

I. Introduction

The first priority of the North Carolina Department of Health and Human Services (the Department) is the health and well-being of the individuals we serve. As North Carolina transitions its Medicaid and NC Health Choice programs from a predominantly fee-for-service (FFS) delivery system to managed care, the Department is focused on building robust and effective models for managing beneficiaries' comprehensive needs through care management.

Over a five-year period, the majority of Medicaid and NC Health Choice beneficiaries will transition to one of two types of prepaid health plans (PHPs), customized to the populations they serve.^{1,2}

- Standard Plans will launch starting in November 2019 (in two regions in November 2019 and in the remaining four regions in February 2020) and will serve the vast majority of Medicaid beneficiaries (approximately 1.6 million).
- Behavioral Health and Intellectual/Developmental Disability (BH I/DD) Tailored Plans will launch in July 2021 and will serve approximately 115,000 individuals with more serious behavioral health disorders (serious mental illness (SMI), serious emotional disturbance (SED), and/or substance use disorders (SUD)), intellectual/developmental disabilities (I/DDs), and traumatic brain injuries (TBIs).³

The Department's goal for the transition to managed care is to improve the health of North Carolinians through an integrated and well-coordinated system of care that addresses both medical and nonmedical drivers of health. In a significant change from today's structure, both Standard Plans and BH I/DD Tailored Plans will be fully integrated managed care plans with a benefit package that spans *both physical and behavioral health services*, as well as long-term services and supports (LTSS) and pharmacy benefits.⁴ For individuals enrolling in BH I/DD Tailored Plans, this integration is an opportunity to begin breaking down silos among physical health, behavioral health, I/DD and TBI services, LTSS, pharmacy benefits, and unmet health-related resource needs.

Care management is at the heart of BH I/DD Tailored Plan design. Care management will provide the "glue" for integrated care, fostering coordination and collaboration among care team members across disciplines and settings. The care management design, as described next, is built on the principle that provider- and community-based care management is crucial to the success of fully integrated managed care. As under Standard Plans, the Department strongly believes that placing care management as close as possible to the beneficiary and the site of care will drive better health outcomes.

The care management model for the BH I/DD Tailored Plan population, called "Tailored Care Management," will be built on the foundation of the federal Health Home State Plan option as described below. Tailored Care Management will build on the Standard Plan care management model, but will be more intensive and customized, reflecting the specific needs of the population. Those targeted for enrollment in BH I/DD Tailored Plans may cycle through multiple health care, social service, criminal justice and other systems, without

¹ For purposes of this paper, the term "Medicaid" refers to North Carolina Medicaid and NC Health Choice programs, unless specifically described otherwise.

² The Department is also considering creating a Specialized Foster Care Plan.

³ The full BH I/DD Tailored Plan eligibility criteria are available in the [BH I/DD Tailored Plan Eligibility and Enrollment Final Policy Guidance](#). Individuals eligible for BH I/DD Tailored Plans will by default remain in FFS and Local Management Entities-Managed Care Organizations (LME-MCOs) prior to BH I/DD Tailored Plan launch, but will be able to choose to enroll in a Standard Plan.

⁴ Certain high-intensity behavioral health, I/DD and TBI services will be available only in BH I/DD Tailored Plans, in recognition of the more intensive needs of the population.

coordination across systems and services. Care management models that place individuals with complex needs at the center of a multidisciplinary care team facilitated by a dedicated care manager have been shown to improve individuals' health by enhancing coordination of care, and helping beneficiaries and caregivers more effectively manage health conditions.^{5,6,7}

In alignment with the Department's broader goals for the transition to Medicaid managed care, the design of Tailored Care Management is being guided by the following core principles:⁸

1. **Broad access to care management.** Tailored Care Management will be available to all BH I/DD Tailored Plan beneficiaries continuously throughout their enrollment, unless beneficiaries are already receiving intensive care coordination or case management services through other programs or services, such as intermediate care facilities for individuals with intellectual disabilities.⁹
2. **Single care manager taking an integrated, whole-person approach.** To the maximum extent possible, each BH I/DD Tailored Plan beneficiary will receive integrated, whole-person care management from a single care manager with expertise and training in addressing behavioral health, I/DD and/or TBI needs in addition to physical health needs and unmet health-related resource needs. Care managers will have access to timely beneficiary-level information to guide their work. By default, individuals enrolled in the Innovations and TBI waivers will be enrolled in Tailored Care Management to receive whole-person services, rather than care coordination solely for home- and community-based services (HCBS) as currently provided. Care managers serving individuals enrolled in one of these HCBS waivers will be responsible for addressing beneficiaries' whole-person needs alongside coordinating their HCBS waiver services.
3. **Person- and family-centered planning.** Care planning for BH I/DD Tailored Plan beneficiaries will be person-centered¹⁰ and will consider the unique needs of the beneficiary. Family members and other informal caregivers can also serve as members of beneficiaries' care teams, with beneficiaries' consent.
4. **Provider-based care management.** To the maximum extent possible, care managers for BH I/DD Tailored Plan beneficiaries will be embedded within provider organizations—primary care practices, or behavioral health or I/DD providers—to support collaboration among providers and beneficiaries, and to place care management as close to the site of care as feasible (see section II for more information on the Department's targets for provider-based care management).¹¹

⁵ Goodell, S., Berry-Millett, R., and Bodenheimer, T. S. 2009. [Care Management of Patients with Complex Health Care Needs](#). *Synth. Proj. Res. Synth. Rep.* (19).

⁶ Long, P. V., Abrams, M., Milstein, A., et al. [Effective Care for High-Need Patients: Opportunities for Improving Outcomes, Value, and Health](#). National Academy of Medicine; 2018.

⁷ Hasselman, D. [Super-Utilizer Summit: Common Themes from Innovative Complex Care Management Programs](#). October 2013.

⁸ For the Standard Plan approach, see the Department's [Care Management Strategy under Managed Care](#).

⁹ See *Approach for Avoiding Duplication of Care Management* section for additional detail.

¹⁰ Person-centered planning is a process of determining real-life outcomes with individuals and their families, as well as developing strategies to achieve those outcomes. Person-centered planning provides for the individual or the family of a beneficiary assuming an informed and in-command role for life planning, service, support and treatment options. The person with a disability and his/her family or the legally responsible person directs the process and shares authority and responsibility with system professionals about decisions made.

¹¹ As discussed below, providers performing the care management role will be required to undergo a rigorous state certification process. BH I/DD Tailored Plans will be required to contract with all *certified* AMH+ practices and CMAs in their region, not "any willing provider."

5. **Community-based care management.** Care managers should live near and be actively engaged in the communities of beneficiaries; have frequent face-to-face interaction with beneficiaries; and have deep familiarity with local resources, including social services and supports.
6. **Community inclusion.** BH I/DD Tailored Plan care managers will support beneficiaries in living meaningful, productive lives in the community of their choice to the greatest extent possible.
7. **Choice of care managers.** BH I/DD Tailored Plan beneficiaries may choose a care manager and may change care managers without cause.
8. **Consistency across the state.** Regardless of geography or the type of organization providing care management, all BH I/DD Tailored Plan beneficiaries will have access to consistent, high-quality care management.
9. **Harness existing resources.** Tailored Care Management will build on existing care management infrastructure in the state, particularly Local Management Entities-Managed Care Organizations (LME-MCOs) and the Advanced Medical Homes rolling out for the Standard Plan population. Care management activities will align with overall statewide priorities for achieving quality and value.

This paper outlines the key components of the Tailored Care Management model and provide a road map for the work ahead. The Department welcomes feedback from Medicaid beneficiaries, families and other stakeholders as it continues to refine the Tailored Care Management model.

Key Terminology

North Carolina recognizes that standardized, industrywide definitions related to care management and care coordination do not exist. For the purposes of its care management strategy, North Carolina has developed the following definitions.

Care Management: A team-based, person-centered approach to effectively managing patients’ medical, social and behavioral conditions, which includes:

- Management of rare diseases and high-cost procedures (e.g., transplant, specialty drugs)
- Management of beneficiary needs during transitions of care (e.g., from hospital to home)
- High-risk care management (e.g., high utilizers, high-cost beneficiaries)
- Chronic care management (e.g., management of multiple chronic conditions)
- Management of high-risk social environments (e.g., adverse childhood events, domestic violence)
- Identification of beneficiaries in need of care management (e.g., screening, risk stratification, priority populations)
- Development of care management assessments/care plans (across targeted populations)
- Development and deployment of prevention and population health programs
- Coordination of services (e.g., appointment/wellness reminders, social services coordination/referrals)

Care Coordination: The process of organizing patient care activities and sharing information among all the participants concerned with a beneficiary’s care to achieve safer and more effective care. Through organized care coordination, beneficiaries’ needs and preferences are known ahead of time and communicated at the right time to the right people to provide safe, appropriate and effective care. Local Management Entities-Managed Care Organizations (LME-MCOs) currently provide care coordination to select groups of beneficiaries. As described below, Tailored Care Management is broader than and inclusive of care coordination.

Case Management: Federal regulations define case management as “services furnished to assist individuals eligible under the [Medicaid] State Plan who reside in a community setting or who are transitioning to a community setting, in gaining access to needed medical, social, and other services” (42 CFR 44.169). See section II for information on avoiding duplication between care management and case management embedded in enhanced behavioral health services. Case management provided within the Innovations and TBI waivers, which currently addresses only waiver services, will be incorporated into Tailored Care Management.

II. Transition to Whole-Person Care Management in BH I/DD Tailored Plans

The design of the Tailored Care Management model reflects the Department's broader goal for integrated care in the Medicaid managed care environment. In the current North Carolina Medicaid environment, physical health services are provided in the FFS system and are coordinated (for the majority of beneficiaries) by Community Care of North Carolina (CCNC), North Carolina's statewide primary care case management program. Meanwhile, the Department currently contracts with LME-MCOs to provide care coordination for behavioral health, I/DD and TBI services only.¹² Whereas Medicaid beneficiaries currently may have a CCNC care manager for their physical health services and an LME-MCO care coordinator for their behavioral health, I/DD and TBI services, the Department envisions that BH I/DD Tailored Plan beneficiaries will have a single designated care manager trained to provide fully integrated care management that addresses all of their needs, spanning physical health, behavioral health, I/DD, TBI, pharmacy, LTSS and unmet health-related resource needs (Figure 1).¹³

Today's LME-MCOs will have exclusive rights to operate BH I/DD Tailored Plans in the first four years of the program (July 2021–June 2025).¹⁴ In order to win a BH I/DD Tailored Plan contract, each LME-MCO will need to demonstrate the ability to oversee and implement the Tailored Care Management. Tailored Care Management will have key differences from today's model of care coordination under LME-MCOs. Tailored Care Management will be available throughout the entire duration of a beneficiary's enrollment in a BH I/DD Tailored Plan;¹⁵ will be based in provider settings to the maximum extent possible, to support integrated care and collaboration; will prioritize frequent in-person interactions between care managers and beneficiaries; and will place additional emphasis on outcomes and population health management. The Department recognizes that under today's system, LME-MCOs often work to address beneficiaries' needs beyond the scope of their contract for care coordination. The BH I/DD Tailored Plan Health Home model will allow BH I/DD Tailored Plans to build on efforts undertaken under the current framework while more comprehensively integrating physical health and designating a distinct role for providers.

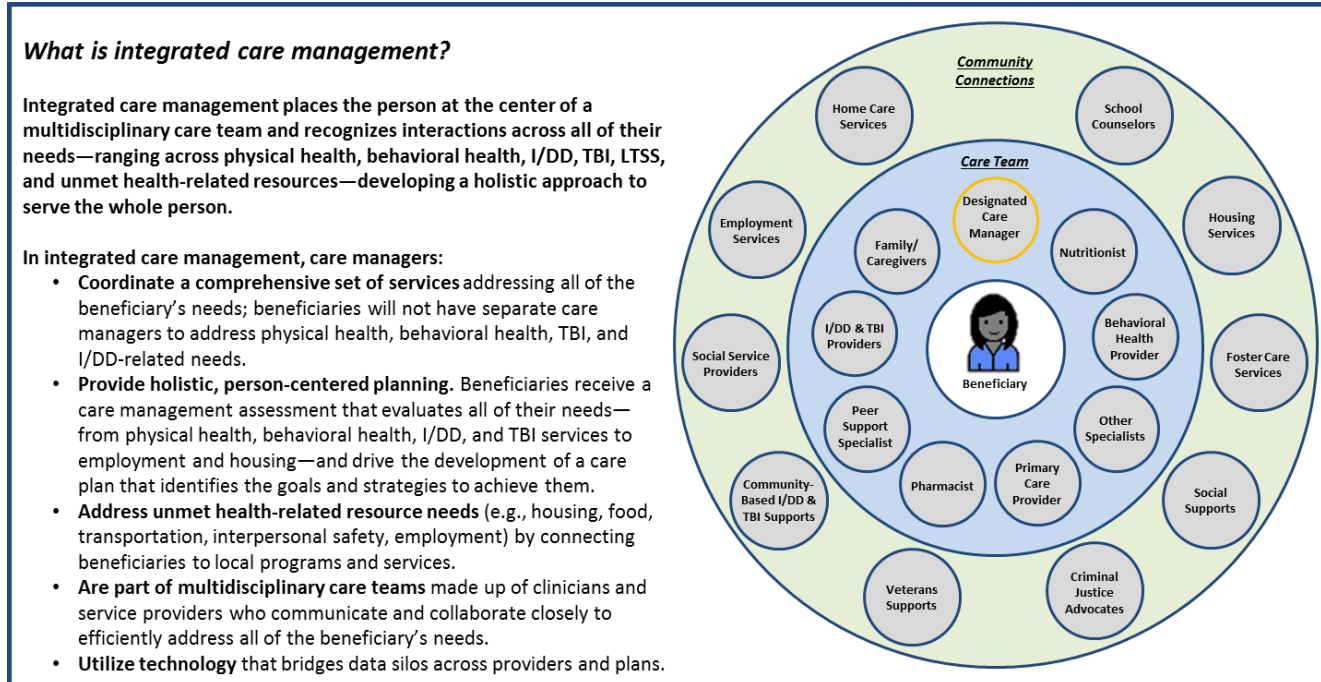
¹² Certain populations, such as children under age 3 and children enrolled in NC Health Choice, are excluded from LME-MCOs.

¹³ Beneficiaries dually enrolled in Medicare and Medicaid (duals) will receive Medicaid-covered physical health services, LTSS and pharmacy through Medicaid FFS; care managers serving these beneficiaries will be required to coordinate across Medicaid FFS and the BH I/DD Tailored Plan. High-risk pregnant women receiving care management from local health departments during the first year of BH I/DD Tailored Plan operation will be eligible for a second care manager (see *Approach for Avoiding Duplication of Care Management* for more details).

¹⁴ DHHS will award no less than five and no more than seven BH I/DD Tailored Plan contracts.

¹⁵ As described below under the *Approach for Avoiding Duplication of Care Management*, there may be limited periods when a beneficiary is not eligible for Health Home care management because of receipt of a duplicative service.

FIGURE 1. INTEGRATED CARE MANAGEMENT



III. The Tailored Care Management Model

Federal Health Home Structure

The Department plans to submit a State Plan Amendment to the Centers for Medicare and Medicaid Services (CMS) to authorize BH I/DD Tailored Plans to offer and oversee care management as federally designated Health Homes.¹⁶ Health Homes are an optional Medicaid State Plan benefit, established by Section 2703 of the Affordable Care Act, for states to build a robust care management infrastructure for Medicaid beneficiaries who have chronic conditions.¹⁷ States operating Health Homes can receive an enhanced, 90 percent federal match rate for care management services for the first eight quarters (two years) that the program is effective. The federal model is flexible according to the needs of states, as long as the model encompasses six “core” Health Home services and uses health information technology to coordinate across these services.^{18,19} CMS expects Health Homes to operate within a culture of continuous quality improvement to enhance health outcomes and quality of life by taking a fully integrated care management approach, to coordinate with all of the individual’s care providers, to establish prevention strategies, and to educate beneficiaries so they have

¹⁶ North Carolina’s 1115 Demonstration Waiver to implement managed care was approved in October 2018. A separate State Plan Amendment (SPA) will be submitted to add Health Homes as a State Plan benefit.

¹⁷ Centers for Medicare & Medicaid Services. [Consolidated Implementation Guide: Medicaid State Plan – Health Homes.](#)

¹⁸ The six required Health Home services are: 1) Comprehensive care management; 2) care coordination; 3) Health promotion; 4) Comprehensive transitional care/follow-up; 5) Individual and family supports; and 6) Referral to community and social support services.

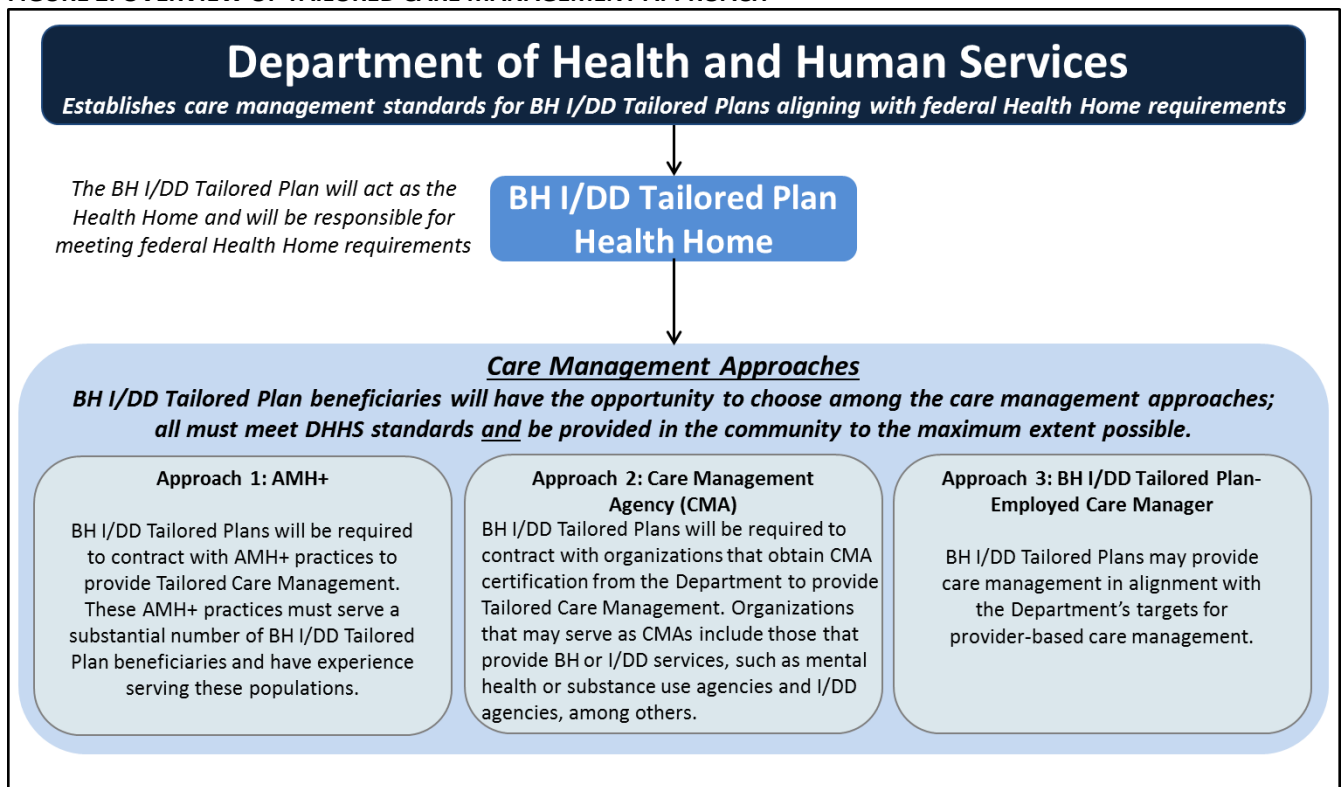
¹⁹ Centers for Medicare & Medicaid Services. [Health Homes Frequently Asked Questions Series II.](#)

the knowledge and skills to support wellness.^{20,21} The Department is designing the model to incorporate each of these core services and thereby meet all federal Health Home requirements.

Roles and Responsibilities for Tailored Care Management

The Department, BH I/DD Tailored Plans, Tier 3 Advanced Medical Homes (AMHs), and Care Management Agencies (CMAs) will all play a vital role in the success of the managed care transition and the Tailored Care Management strategy. The Department’s vision is that Tailored Care Management will be provided primarily by care managers embedded within Tier 3 AMHs that have demonstrated capacity to provide integrated care management for the BH I/DD Tailored Plan population, and by CMAs—other behavioral health and I/DD providers that serve the BH I/DD Tailored Plan population today (approaches 1 and 2 in Figure 2). The AMH program will go live in November 2019 to serve the Standard Plan population.²² A **subset** of AMHs that are able to meet certification standards for the Tailored Care Management model (known as “AMH+” practices) will provide care management to the BH I/DD Tailored Plan beneficiaries. The “CMA” designation is new and will be unique to providers serving the BH I/DD Tailored Plan population. Organizations that may be certified as CMAs by the Department will include behavioral health and/or I/DD providers with the experience and capacity to provide care management to the BH I/DD Tailored Plan population.

FIGURE 2. OVERVIEW OF TAILORED CARE MANAGEMENT APPROACH



BH I/DD Tailored Plans will be required to contract for care management with all providers in their region that have demonstrated capacity for the model through the state certification process (i.e., the design for care

²⁰ Centers for Medicare & Medicaid Services. [Consolidated Implementation Guide: Medicaid State Plan – Health Homes.](#)

²¹ North Carolina previously operated a Health Home program targeted toward individuals with chronic physical conditions (enhanced federal match from 2011 to 2013). The Department will not be able to claim enhanced Health Home match for individuals who were enrolled in the previous Health Home program.

²² Information about the Advanced Medical Home program is available on the Department’s [AMH website.](#)

management is **not** “any willing provider”). The Department understands that in practice, beneficiaries will be assigned across a **mix** of the three approaches to ensure beneficiary choice, capacity, expertise and quality, subject to an overall four year “glide path” toward predominantly provider-based care management, as described below. The Department, BH I/DD Tailored Plans, and the AMH+ practices and CMAs providing care management will each have distinct roles and responsibilities.

Department Roles and Responsibilities

The Department is ultimately responsible for all aspects of the Medicaid program, including North Carolina’s transition to managed care and implementation of BH I/DD Tailored Plans. The Department will perform the following functions:

- **Oversight of BH I/DD Tailored Plans.** The Department will contract with each BH I/DD Tailored Plan, enroll beneficiaries into each plan, and perform general oversight in a fashion similar to its oversight of Standard Plans. As under Standard Plans, the Department will conduct oversight of contractual performance measures and issue sanctions or corrective action plans as necessary. The Department’s external quality review organization (EQRO) will play a role in oversight of each BH I/DD Tailored Plan.
- **Payment to BH I/DD Tailored Plans.** The Department will pay BH I/DD Tailored Plans a capitated managed care rate; a separate per-member per-month (PMPM) care management payment for each beneficiary under active Tailored Care Management; and an “engagement” PMPM payment, as described in the *Payment for Care Management* section.
- **Certification of Care Management Agencies and Advanced Medical Homes.** To promote implementation of care management that is based in community-based provider settings, the Department will launch a process to certify CMAs and AMHs (to become AMH+ practices) that can specialize in providing Tailored Care Management to BH I/DD Tailored Plan populations in accordance with robust standards, and will place contracting requirements on BH I/DD Tailored Plans to enter agreements with these organizations.

BH I/DD Tailored Plan Roles and Responsibilities

BH I/DD Tailored Plans, serving as the federally defined Health Homes for beneficiaries, will oversee all aspects of Tailored Care Management and will be ultimately responsible for ensuring that beneficiaries receive care management in compliance with the Department’s requirements. They will perform the following functions:

- **Assignment to an organization providing care management.** BH I/DD Tailored Plans will develop networks of AMH+ practices and CMAs and assign each beneficiary to one of these specially qualified organizations or to its own staff, according to one of the three approaches in Figure 2 above and taking the beneficiary’s preferences into account.
- **Administration of care management payment claims and distribution to CMAs and AMH+ practices.** BH I/DD Tailored Plans will issue monthly claims to the Department for the PMPM care management and engagement payments and will be responsible for making payments to CMAs and AMH+ practices for care management.
- **Coordination among AMH+ practices, CMAs, other providers and organizations addressing unmet health-related resource needs.** By creating and maintaining strong relationships with local providers and social service agencies across the delivery system, BH I/DD Tailored Plans will create pathways for

frontline providers and social service agencies to work together, both within the traditional healthcare system and outside its boundaries.²³

- **Training.** BH I/DD Tailored Plans will be responsible for training all care managers serving their beneficiaries and developing training curricula encompassing training topics specified by the Department.
- **Population health management.** BH I/DD Tailored Plans will be expected to take a population-wide view of their assigned beneficiaries. Mirroring expectations for Standard Plans, BH I/DD Tailored Plans will be required to establish prevention and population health programs aligned with priorities in the Department’s Quality Strategy.²⁴ BH I/DD Tailored Plans will be expected to assign a risk status to each beneficiary,²⁵ track the progress of beneficiaries via claims and clinical data, and provide CMAs and AMH+ practices with dashboards that deliver utilization, quality and other performance data.

Care Management Approaches—CMAs, AMH+ Practices and BH I/DD Tailored Plans

CMAs, AMH+ practices and BH I/DD Tailored Plans will be responsible for organizing and providing care management to each BH I/DD Tailored Plan beneficiary once the beneficiary is assigned to them by the BH I/DD Tailored Plan, in accordance with the Department’s requirements detailed below.

Provider-based Care Management

The Department is committed to giving BH I/DD Tailored Plan beneficiaries access to provider-based care management that is performed at the site of care, in the home or in the community, where face-to-face interaction is possible. The Department’s strategy will include the following components:

- **Provider-based targets that will increase over a four-year “glide path.”** Recognizing that the expansion of the population eligible for care management services will require a multiyear effort to enhance the workforce at the AMH+ and CMA level, the Department will establish a glide path for the provision of provider-based care management (see Figure 3). The glide path aims to create a planned approach for most Tailored Care Management to move to being primarily provider-based over the first four-year BH I/DD Tailored Plan contract, while creating a smooth transition for beneficiaries and current care coordinators. Through this glide path, the Department will establish targets for the proportion of Tailored Care Management occurring at the level of certified CMAs and AMH+ practices, which will ramp up over the first four years of BH I/DD Tailored Plan implementation, aligning with the initial period in which LME-MCOs will have exclusive rights to operate the BH I/DD Tailored Plans. The starting target percentage at BH I/DD Tailored Plan launch will assume that BH I/DD Tailored Plans will retain their current workforce of LME-MCO care coordinators at their launch and that these care coordinators will obtain the requisite training to serve as Health Home care managers. Calculation of actual percentages compared with the targets will be performed at the start of each contract year. During

²³ BH I/DD Tailored Plans will also play a critical role in North Carolina’s Healthy Opportunities Pilots (the Pilots) when they launch. The Pilots, authorized by the state’s 1115 waiver, will launch in late 2020 in two to four geographic areas of the state to test evidence-based interventions designed to reduce costs and improve health by more intensely addressing housing instability, transportation insecurity, food insecurity, interpersonal violence and toxic stress for eligible Medicaid beneficiaries. For more information on the Healthy Opportunities Pilots, see [“North Carolina’s Healthy Opportunities Pilots: A Review of Proposed Design for Interested Stakeholders.”](#)

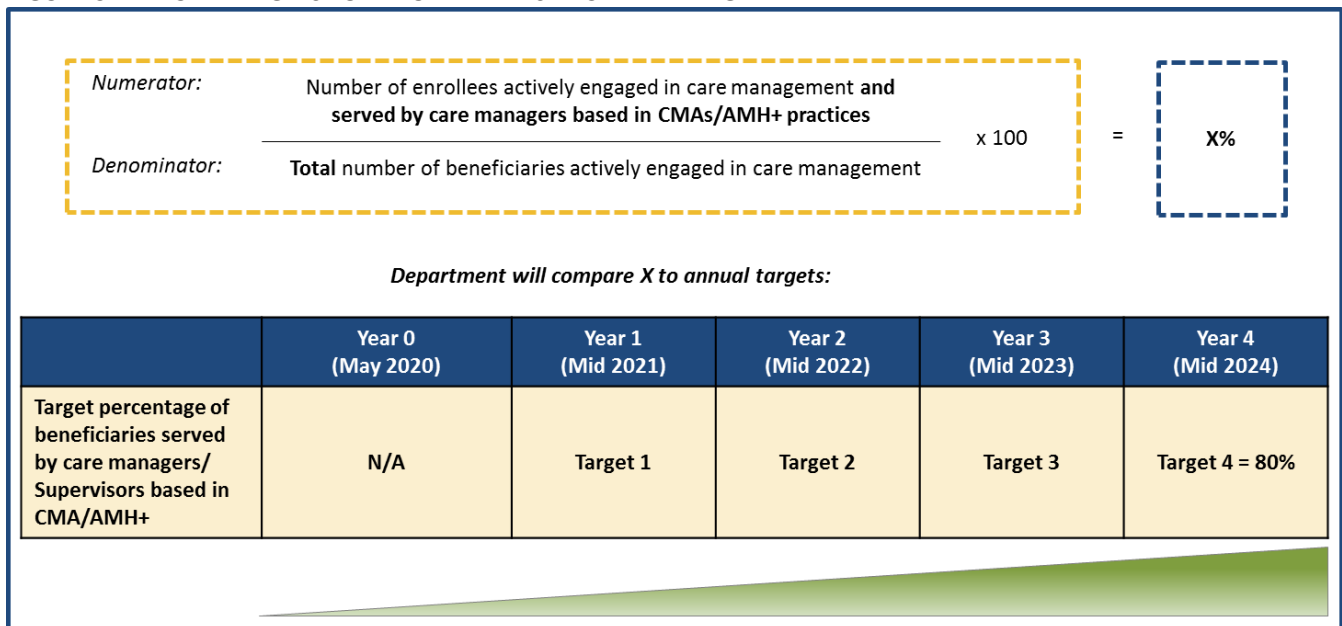
²⁴ Priorities contained in the [Quality Strategy](#) include diabetes, asthma, obesity, hypertension, tobacco cessation, infant mortality, low birth weight, and early childhood health and development.

²⁵ As described below, the Department plans to develop a standardized methodology for assigning acuity tiers to beneficiaries for the purposes of payment and monitoring of the intensity of care management.

these four years, BH I/DD Tailored Plans will be required to work with CMAs and AMH+ practices to grow their capacity to provide care management to the BH I/DD Tailored Plan population.

Ultimately, the Department’s goal is for at least 80 percent of care management across the state to be provider-based by July 2024, the beginning of the fourth year of BH I/DD Tailored Plan implementation. However, the glide path takes into account the Department’s anticipation that BH I/DD Tailored Plans will continue to employ care managers to provide care management to beneficiaries in regions where capacity among AMH+ practices and CMAs may be insufficient, as well as employ staff with the requisite experience to oversee AMH+ practices and CMAs in the delivery of provider-based care management. In alignment with federal regulations, BH I/DD Tailored Plans will also be responsible for providing care coordination to beneficiaries who opt out of Tailored Care Management (see *Care Management Process Flow*).²⁶

FIGURE 3. ANNUAL TARGETS FOR PROVIDER-BASED CARE MANAGEMENT



- Direct certification process for CMAs and AMH+ practices and required contracting with certified CMAs and AMH+ practices.** As described above, the Department plans to implement a direct process to certify providers and agencies to deliver provider-based care management under this model as AMH+ practices or CMAs. Because of the specialized needs of BH I/DD Tailored Plan populations, as well as the requirements to meet Health Home standards, this certification process will be more extensive than the previously established attestation process for entry into Tier 3 of the AMH program. To be successful in gaining certification, providers will be required to show that care managers and supervisors have experience serving populations with behavioral health, I/DD and/or TBI needs; that the organization has the ability to operationalize delivery of all aspects of the Tailored Care Management model described in this paper; and that the organization has the capacity and financial sustainability to establish care management as a service line. Certified CMAs and AMH+ practices will be required to convene and coordinate multidisciplinary care teams for their beneficiaries, but do not necessarily need to have all the care team members on staff or embedded in the practice—providers of various specialties may virtually participate in care teams from other settings. The Department envisions that most CMAs and AMH+ practices will be existing provider organizations in North Carolina that already carry out functions

²⁶ [42 CFR 438.208 – Coordination and continuity of care.](#)

similar to the new Tailored Care Management model. The Department plans to launch the CMA/AMH+ requirements and certification process well in advance of the BH I/DD Tailored Plan launch, to allow ramp-up time for the providers and agencies to align with all required aspects of the model prior to launch. **At the conclusion of the certification process, BH I/DD Tailored Plans will be required to contract with all Tier 3 AMH+ practices and certified CMAs to provide Tailored Care Management to their beneficiaries.**

- **Role for Clinically Integrated Networks/Other Partners.** Tier 3 AMH practices contracting with Standard Plans must meet a set of standards that describe a range of care management capabilities. Tier 3 AMH practices may—but are not required to—work with “Clinically Integrated Networks (CINs) or other partners” to perform data management and/or advanced care management on their behalf. A “CIN or other partner” may be a hospital, health system, integrated delivery network, or Independent Practice Association (IPA); another provider-based network or association; or a technology vendor. Most practices attesting for entry into AMH Tier 3 under Standard Plans indicated that they would be working with a CIN or another partner to meet the requirements of the model.²⁷ Similar to AMH certification under Standard Plans, the Department is anticipating allowing—but not requiring—CMAs and AMH+ practices to work with a CIN or another partner to assist with the requirements of the Tailored Care Management model, as long as any care management organized at the CIN level is fully integrated with the care team (i.e., with care managers embedded at the practice level and with the care team) and in full communication with external providers as specified in the Department’s requirements.
- **Capacity-building funding.** The Department recognizes that there is a gap between today’s delivery system and the integrated care management model it envisions for the BH I/DD Tailored Plan population, and that it will take several years to implement the glide path. In its 1115 waiver application submitted to CMS in November 2017, the Department requested capacity-building funding in order to develop the Tailored Care Management delivery system. At the time of publication, the Department remains in discussions with CMS. To the extent that capacity-building funding is approved, the Department will design a distribution methodology that allows funding to be used for training and onboarding of new care management staff and for strengthening health information technology used for care management, particularly at the CMA/AMH+ level.

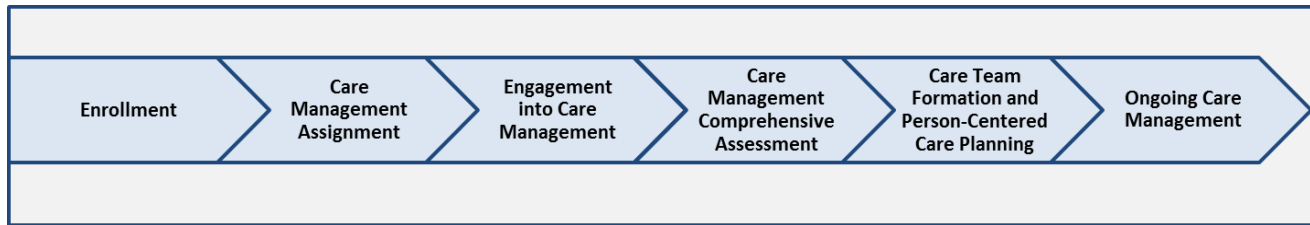
Care Management Process Flow

The Department, BH I/DD Tailored Plans, and AMH+ practices and CMAs will work together to ensure that every BH I/DD Tailored Plan beneficiary has access to care management. The care management process is outlined below and displayed in Figure 4.

²⁷ More detail on the role of CINs/other partners is contained in a [February 2019 policy paper](#) on this topic. The Department anticipates releasing additional guidance on the role of CINs and other partners for BH I/DD Tailored Plans as part of provider-facing information closer to the launch of the provider certification process.

1. **“Opt-Out” Enrollment and Care Management Assignment.** At BH I/DD Tailored Plan launch, the Department will auto-enroll eligible individuals into the BH I/DD Tailored Plan in their region. With enrollment into the BH I/DD Tailored Plan, a beneficiary will be auto-enrolled into care management if he/she is not enrolled in a service or program that is duplicative of the Tailored Care Management model.

FIGURE 4. TAILORED CARE MANAGEMENT PROCESS FLOW



If a beneficiary opts out of Tailored Care Management, BH I/DD Tailored Plans will still be required to provide the minimum level of care coordination set by federal requirements, funded through the capitation rate.²⁸ If a beneficiary enrolled in the Innovations or TBI waiver opts out of Tailored Care Management, he/she will still be entitled to waiver services, and the BH I/DD Tailored Plan must provide care coordination for HCBS in compliance with the waivers.

If a beneficiary does not opt out, the BH I/DD Tailored Plan will be responsible for assigning the beneficiary to an AMH+, to a CMA, or to the plan itself for care management. The assignment process will seek to uphold beneficiary choice and preserve the beneficiary’s established relationships wherever possible, including with any provider or primary care practice that has become certified as a CMA or AMH+.²⁹ The assigned AMH+, CMA or BH I/DD Tailored Plan will, in turn, be responsible for assigning a specific care manager to the beneficiary. All beneficiaries will have the option of switching care managers at any time, either within the same organization or across CMAs/AMH+ practices within the BH I/DD Tailored Plan network. Recognizing that Innovations and TBI waiver beneficiaries may have close relationships with their current care coordinators, Innovations and TBI waiver beneficiaries will have the choice of keeping their current care coordinator if the care coordinator meets all the Health Home care manager requirements to serve BH I/DD Tailored Plan beneficiaries.³⁰

2. **Engagement into Care Management.** BH I/DD Tailored Plans will be required to share with each AMH+ or CMA a roster of assigned beneficiaries and their current demographic information to facilitate outreach and engagement in care management. The assigned AMH+, CMA or BH I/DD Tailored Plan will be responsible for engaging the individual in care management services and for documenting his/her consent. The Department recognizes that some beneficiaries may never engage in care management or may formally opt out, but AMH+ practices, CMAs and BH I/DD Tailored Plans will be required to attempt to engage all assigned beneficiaries.

²⁸ 42 CFR § 438.208, “Coordination and Continuity of Care.” Note that the requirements for “care coordination” in the BH I/DD Tailored Plan contract will meet federal requirements but will not align exactly with today’s LME-MCO care coordination model.

²⁹ While it is possible that a beneficiary would be assigned to a CMA or AMH+ at which the beneficiary is not currently receiving services, guidance for the assignment process will prioritize aligning with current provider relationships, wherever possible and subject to conflict considerations (discussed below).

³⁰ Care managers for beneficiaries enrolled in the Innovations or TBI waiver must meet federal requirements for conflict-free case management.

3. **Care Management Comprehensive Assessment.** The care management comprehensive assessment will be a required, comprehensive, in-person evaluation of BH I/DD Tailored Plan beneficiaries' physical health, behavioral health, I/DD, TBI, pharmacy, LTSS and unmet health-related resource needs. The care manager will conduct the care management comprehensive assessment and will use information obtained as the basis for each beneficiary's care plan or Individual Support Plan (ISP). Since many BH I/DD Tailored Plan beneficiaries will have complex needs, this process will pull together current and historical information provided by the beneficiary, as well as information received from available healthcare records and historical LME-MCO records, input received through consultation with other healthcare providers and social supports, and other clinical assessments or level of care determination tools, as appropriate. The care management comprehensive assessment will incorporate the Department's standardized screening questions to identify health-related resource needs across the Department's four Healthy Opportunity domains—food insecurity, housing instability, transportation needs and interpersonal violence/toxic stress.³¹ Reassessment will be required at least annually, upon beneficiary request, after changes in scores on level of care determination tools, after care transitions, after joining the Innovations/TBI waiver waiting list, and/or after a significant change in health or functional status.
4. **Care Team Formation and Person-Centered Care Planning.** Consistent with federal requirements, BH I/DD Tailored Plan beneficiaries (and their authorized representative, to the extent applicable) will play a role in the development of their own care plans or ISPs through a person-centered planning process within a care team.³² The care manager will be responsible for bringing together the appropriate group, which, in addition to the beneficiary, should generally include key primary care, behavioral health, I/DD, and/or specialist providers as well as peer supports and support members.^{33,34} The care manager will lead the development of the care plan or ISP (for individuals with an I/DD or TBI, including those enrolled in the Innovations or TBI waiver) in collaboration with the beneficiary, the multidisciplinary care team, and individuals identified by the beneficiary to contribute to the planning process.³⁵ The care plan/ISP will be required to reflect the beneficiary's strengths, needs, and goals, and the types and frequency of all needed services, including those addressing unmet health-related resource needs, as well as the person responsible for providing each service and any areas that may require further follow-up or revisions to the plan. For beneficiaries enrolled in the Innovations or TBI waiver, the ISP will document the beneficiary's approved waiver services.
5. **Ongoing Care Management.** As noted above, all BH I/DD Tailored Plan beneficiaries actively engaged in care management will have a designated care manager who, along with the other care team members, will be responsible for integrating behavioral and physical healthcare and, where applicable, I/DD or TBI-related supports, by providing linkages to and coordinating their services. **The Department strongly believes that for Tailored Care Management to be successful, care managers must formalize and activate relationships across the traditional physical/behavioral health divide and between the traditional healthcare system and community and social services.** Therefore, the Department will place requirements on care management activities that are more specific than those under Standard Plans, including (but not necessarily limited to) those outlined below. As market experience with the

³¹ See the Department's [Updated Standardized Screening Questions for Health-Related Resource Needs](#).

³² [42 CFR § 441.275\(b\)—Person-Centered Service Plan](#).

³³ "Support members" means family, informal and formal caregivers.

³⁴ BH I/DD Tailored Plans will be required to ensure that the multidisciplinary care team includes peer supports for beneficiaries with behavioral health disorders, if desired by the beneficiary; this requirement will not apply for beneficiaries with I/DDs or TBIs.

³⁵ Centers for Medicare & Medicaid Services. [Consolidated Implementation Guide: Medicaid State Plan – Health Homes](#).

model grows, the Department may transition away from process requirements to increase the focus on outcomes to the extent allowed by federal Health Home requirements.

- Case conference requirements.** Care managers (whether based at the AMH+, CMA or BH I/DD Tailored Plan level) will be required to conduct regular case conferences with the full care team, spanning physical and behavioral health, I/DD and TBI supports, and pharmacy, where applicable. Since regular, on-the-ground communication across settings is essential to the success of the model, the Department will require all organizations performing care management to have information technology and policies and procedures in place to support such regular communication and information sharing.
- Contact requirements.** Given the importance of trusted, high-quality relationships in care management, the Department will establish minimum levels of contact between care managers and beneficiaries engaged in the model, including contact that is provided face-to-face within the practice setting, the home or another community setting. The Department plans to establish a standardized methodology based on claims history for determining the acuity of each beneficiary, which will be used to guide both these minimum contact requirements and minimum dollar amounts for care management fees as set out below (“Care Management Payments”).

TABLE 1. REQUIRED MINIMUM CARE MANAGER CONTACTS, BY ACUITY TIER³⁶

	High Acuity	Moderate Acuity	Low Acuity
Beneficiaries with Behavioral Health Disorders	At least 4 contacts per month; at least 1 of these in-person with beneficiary	At least 3 contacts per month; 1 in-person beneficiary contact quarterly (includes care management comprehensive assessment)	At least 2 contacts per month and 2 in-person beneficiary contacts per year (includes care management comprehensive assessment)
Beneficiaries with I/DDs or TBIs	At least 2 in-person beneficiary contacts per month; 1 telephonic contact per month or as needed	At least 3 contacts per month; 1 in-person beneficiary contact quarterly (includes care management comprehensive assessment)	At least 2 in-person beneficiary contacts per year (including care management comprehensive assessment) and 1 telephonic contact per month

- Care transition requirements.** When a beneficiary transitions from one setting to another, such as from the hospital back to the community, care managers will be required to provide transitional care management to prevent unplanned or unnecessary readmissions, emergency department visits, or adverse outcomes. Specifically, care managers will be required to create and implement a 90-day transition plan (as an amendment to the care plan/ISP), in consultation with the beneficiary, relevant facility staff, and the beneficiary’s providers and social supports, that outlines how the beneficiary will access needed services and supports, transition to the new setting, and integrate into his/her community. Transitional care management will also be

³⁶ Innovations/TBI waiver beneficiaries will be placed in the highest tier of care management upon waiver enrollment. They will be reassessed after six months to determine whether they should remain in the high-acuity tier. Prior to BH I/DD Tailored Plan launch, BH I/DD Tailored Plans should determine the frequency of service monitoring visits that each Innovations/TBI waiver beneficiary is required to receive from his or her care coordinator under the waiver and place the beneficiary in the appropriate acuity tier to ensure that he or she does not have fewer care manager contacts at the launch of BH I/DD Tailored Plans. In addition, this process will ensure that organizations providing care management can receive appropriate reimbursement for the number of contacts required by the waiver.

required for “life transitions,” such as when a beneficiary is transitioning from school to adult services or when a beneficiary experiences the loss of, or a change in, his/her primary caregiver.

- **Requirements to address unmet health-related resource needs.** Throughout the Tailored Care Management model, service providers and care managers will be required to address both the medical and nonmedical drivers of beneficiaries’ health. In light of the needs of the BH I/DD Tailored Plan population, the Department will place additional (as compared to the care management requirements under Standard Plans) requirements concerning unmet health-related resource needs for Tailored Care Management. Specific activities that will be required include in-person assistance with securing health-related services (e.g., assistance with filling out and submitting applications to programs such as Food and Nutrition Services, Temporary Assistance for Needy Families and ABLEnow Accounts).³⁷ Care managers will also be required to assist with referral to, information about, and obtaining and maintaining community-based resources and social support services (e.g., housing, transportation and employment services).

In addition to the care management features described above, the Department is developing specialized care management features for other populations, including beneficiaries with LTSS needs and individuals involved in the criminal justice system, among others.³⁸ The Department is also considering implementing the High-Fidelity Wraparound model as the Tailored Care Management model for children with serious emotional disturbance who meet Department-established eligibility criteria for the High-Fidelity Wraparound program.

Care Manager Qualifications and Training

In recognition of the complex needs of the BH I/DD Tailored Plan population, the Department will require that care managers serving this population possess the minimum qualifications outlined in Table 2.³⁹ Current LME-MCO care coordinators may become BH I/DD Tailored Plan care managers if the care coordinator meets the education and experience requirements to serve as a BH I/DD Tailored Plan care manager and obtains all required training. The Department will require that all care managers be overseen by supervisors with additional experience to ensure that care managers receive the support they need to address beneficiaries’ complex health and social needs. In addition to the members of the multidisciplinary care team, the organization providing care management under the model (whether an AMH+, a CMA or the BH I/DD Tailored Plan itself) will be required to ensure that care managers and supervisors have access to clinical consultants—behavioral neurologists, adult or child psychiatrists, and primary care providers—to advise on complex clinical issues as they arise.⁴⁰

The Department will set the required training domains for care managers and care manager supervisors, while BH I/DD Tailored Plans will be responsible for developing and implementing training curricula that meet the Department’s requirements. Potential BH I/DD Tailored Plans will be required to include training plans as part of the care management approach described in their request for application (RFA) responses during the Department’s procurement phase. Training domains will include (but will not be limited to) integrated care management, trauma-informed care, addressing unmet health-related resource needs, and person-centered

³⁷ When the Healthy Opportunities Pilots launch, some BH I/DD Tailored Plan beneficiaries also will be eligible for additional Pilot services, which will be integrated into the portfolio of services coordinated by care managers. See the Department’s [Healthy Opportunities Pilots Fact Sheet](#), November 14, 2018.

³⁸ The Tailored Care Management model requirements for beneficiaries with LTSS needs will align with those for Standard Plans to the maximum extent possible. For additional detail, see [North Carolina’s Vision for Long-term Services and Supports under Managed Care](#).

³⁹ The minimum qualifications for Health Home care managers and supervisors are distinct from and intentionally higher than the requirements for “Qualified Providers” outlined in 10 A NCAC 27G.0104.

⁴⁰ Consultants may be contracted or employed by the organization.

planning. Additionally, training will encompass domains specific to the BH I/DD Tailored Plan beneficiaries, such as 1915(c) waiver eligibility criteria, HCBS, physical comorbidities relevant to people with behavioral health disorders and/or I/DD, and local supportive housing and supported employment programs. The trainings will also place strong emphasis on strategies to support community integration and diversion from institutional settings.⁴¹

TABLE 2. MINIMUM CARE MANAGER AND SUPERVISING CARE MANAGER QUALIFICATIONS

Position	Minimum Qualifications
Care managers serving all beneficiaries	Bachelor’s degree in a field related to health, psychology, sociology, social work, nursing or another relevant human services area Two years of experience working directly with individuals with behavioral health conditions (if serving beneficiaries with behavioral health needs) or with I/DD or TBI (if serving beneficiaries with I/DD or TBI needs) (Best practice, but not required) For care managers serving beneficiaries using LTSS: two years of prior LTSS and/or HCBS coordination; care delivery monitoring and care management experience; and background in social work, geriatrics, gerontology, pediatrics or human services
Supervising care managers serving beneficiaries with behavioral health disorders	A licensed master’s-level clinical qualification, such as a Licensed Clinical Social Worker (LCSW), a Licensed Professional Counselor (LPC) or a licensed nurse with a Bachelor of Science in Nursing (BSN) Three years of supervisory experience working directly with complex individuals with a behavioral health condition
Supervising care managers serving beneficiaries with I/DD or TBI	Bachelor’s degree in a human services field Five years of applicable I/DD experience as a care coordinator or care/case manager, or an equivalent combination of education and experience

Conflict-free Care Management

The Department plans to give individuals enrolled in the 1915(c) Innovations and TBI waivers, in the same way as other BH I/DD Tailored Plan beneficiaries, a choice of provider- or plan-based care management. In cases where a waiver enrollee is receiving provider-based care management, the AMH+ or CMA must comply with all federal requirements for conflict-free case management for 1915(c) waiver enrollees, which call for the separation of case management and care plan development from waiver service delivery functions.⁴² Thus, a waiver enrollee cannot obtain both waiver services and care management from employees of the same CMA. However, for example, a CMA could embed care managers of an independent CIN within its practice to provide care management to enrollees receiving waiver services from the CMA.

Additionally, the Department is devising oversight measures that BH I/DD Tailored Plans will need to exercise to protect against provider conflicts of interest in relation to all beneficiaries, whether or not they are waiver enrollees. As part of their utilization management process, BH I/DD Tailored Plans will be required to review the utilization patterns of all enrollees receiving care management (whether from BH I/DD Tailored Plans, AMH+ practices or CMAs). The utilization review will look for utilization patterns that may suggest that care managers have steered beneficiaries in a way that favors particular providers, favors more costly interventions over more cost-effective ones, or results in under- or overutilization of services. As part of their standard utilization management responsibilities, BH I/DD Tailored Plans will assess whether beneficiaries are receiving the appropriate level of care corresponding to their clinical information. Additionally, BH I/DD Tailored Plans

⁴¹ For Standard Plan care manager training requirements, see the care management section of the North Carolina Request for Proposal for Medicaid Managed Care Prepaid Health Plan ([Section V – Scope of Services](#), August 9, 2018).

⁴² [42 CFR §431.301\(c\)\(1\)\(vi\) – Conflict-Free Case Management](#).

will be held ultimately responsible for ensuring that no care managers serving BH I/DD Tailored Plan beneficiaries (whether employed by BH I/DD Tailored Plans, AMH+ practices or CMAs) are related by blood or marriage to any of their enrollees, are financially responsible for any of their enrollees, or have any legal power to make financial or health-related decisions for any of their enrollees. In instances where BH I/DD Tailored Plans provide care management directly to beneficiaries, the BH I/DD Tailored Plan will be required to create separate departments for and firewalls between utilization management and care management, overseen by separate clinical leadership. The Department will conduct oversight of these firewalls to monitor for potential conflicts.

Approach for Avoiding Duplication of Care Management

CMS guidance stipulates that states must ensure that one beneficiary does not receive duplicative care management from multiple sources, such as a managed care plan or case management provided through a waiver or service.⁴³ Many of North Carolina’s enhanced behavioral health services that will be available to BH I/DD Tailored Plan beneficiaries currently include case management in their service definitions. The Department will release further guidance on the interface of Tailored Care Management with these services and how BH I/DD Tailored Plans should avoid duplication of services and payments. BH I/DD Tailored Plans will bear ultimate responsibility for ensuring that there is no duplication of care management services and payments.

The Department is considering the following policies:

- Recognizing that among the enhanced behavioral health services, assertive community treatment (ACT) and multi-systemic therapy (MST) provide more robust case management and are held to fidelity standards, the Department’s approach to these services may differ from the approach to other enhanced behavioral health services with case management. The Department would welcome feedback on whether ACT and MST should be incorporated into the Tailored Care Management model.
- Beneficiaries residing in intermediate care facilities for individuals with intellectual disabilities (ICF/IID) will continue to obtain case management as they do today and will not obtain Tailored Care Management; however, Health Home care managers will provide transitional care management to BH I/DD Tailored Plan beneficiaries in ICF/IIDs if they are being discharged and transitioning to community-based settings.

Approach to Local Health Department Programs

Currently, North Carolina provides care management for women experiencing high-risk pregnancies and at-risk children ages 0–5 through programs run by local health departments (LHDs)—the Pregnancy Medical Home (PMH)/Obstetric Care Management (OBCM) programs and the Care Coordination for Children (CC4C) program.⁴⁴ In the managed care environment, the PMH/OBCM and CC4C programs will be known as Care Management for High-Risk Pregnant Women (CMHRP) and Care Management for At-Risk Children (CMARC), respectively. For a three-year transitional period (November 2019–July 2022), Standard Plans will be required to extend to LHDs the “right of first refusal” as contracted providers of CMHRP and CMARC.

⁴³ Centers for Medicare & Medicaid Services. [Consolidated Implementation Guide: Medicaid State Plan – Health Homes](#).

⁴⁴ The PMH/OBCM program consists of education, support, linkages to community and health-related resources, and services for and management of high-risk conditions that may have an impact on birth outcomes. CC4C provides coordination between healthcare providers, linkages and referrals to other community programs and supports, and family supports to children ages 0–5 who have experienced adverse life events (including, but not limited to, parental substance abuse or neonatal exposure to substances).

There is one year of overlap between this transition period and the BH I/DD Tailored Plan launch (July 2021–June 2022). Accordingly, the Department has developed BH I/DD Tailored Plan requirements specific to both programs to ensure that BH I/DD Tailored Plan beneficiaries participating in these programs receive whole-person care management and do not experience disruption to the continuity of their care. The Department will require BH I/DD Tailored Plans to extend LHDs “right of first refusal” as contracted providers of care management for high-risk pregnant women for the first BH I/DD Tailored Plan contract year (July 2021–June 2022). LHDs that accept the contract will continue to provide care management to address BH I/DD Tailored Plan beneficiaries’ pregnancy-related needs. Additionally, BH I/DD Tailored Plan beneficiaries participating in care management for high-risk pregnant women will be eligible for a second care manager (employed by an AMH+, a CMA or the BH I/DD Tailored Plan, in limited circumstances) who will address needs not addressed by the LHD. BH I/DD Tailored Plans must ensure that AMH+ and CMA care managers coordinate with LHD care managers to address all of their beneficiaries’ needs, share pertinent information and make sure services are not duplicated.

BH I/DD Tailored Plan-eligible children ages 0–5 who are already enrolled in CMARC at the time of the BH I/DD Tailored Plan launch will continue to receive CMARC through the CMARC transition period. However, children who meet eligibility criteria for CMARC *after* the BH I/DD Tailored Plan launch will receive similar care management through the new Tailored Care Management model described in this paper.

Payment for Care Management

Care Management Payments

The Department is developing requirements governing care management payments to BH I/DD Tailored Plans, as well as downstream payments from BH I/DD Tailored Plans to AMH+ practices, and CMAs. *Unlike* care management payments under Standard Plans, Tailored Care Management payments will be:

- Paid to BH I/DD Tailored Plans on a PMPM basis *separate* from the managed care capitation rate
- Subject to set minimum rates, tiered by beneficiary acuity (i.e., the state will set the minimum dollar amount of each per-member per-month payment that an AMH+ or CMA will receive)⁴⁵
- In general, paid at *significantly higher* rates than for Standard Plan care management
- Paid *only* for beneficiaries who are “actively engaged” in care management

The Department will set care management rates that will vary according to the acuity tier of each beneficiary and his/her needs. The BH I/DD Tailored Plan will be responsible for billing the Department for care management payments each month. In turn, AMH+ practices and CMAs will bill BH I/DD Tailored Plans monthly, demonstrating that they have delivered at least one of the Health Home core services in that month and attesting that they have adhered to the minimum contact requirements associated with a beneficiary’s acuity tier. The Department will reserve the right to audit care plans and other records at any time.

Engagement Payments

Tailored Care Management will be available to all BH I/DD Tailored Plan beneficiaries, unless they are already receiving intensive care coordination or case management services through other programs or services. However, not all beneficiaries who enroll in Tailored Care Management will necessarily respond to their

⁴⁵ Under Standard Plans, care management fee rates paid to Tier 3 practices are negotiated, with no fixed minimum rate.

assigned care manager and engage in care management. Recognizing the potential difficulty in engaging individuals in services, the Department intends to permit BH I/DD Tailored Plans to submit claims for “engagement payments” to fund outreach to beneficiaries, and is developing the parameters for what activities will be covered by such payments. The Department will establish limits on the number of times that engagement payments may be billed for an individual beneficiary. As with care management payments, AMH+ practices and CMAs will be responsible for submitting claims to BH I/DD Tailored Plans for months in which they have attempted to engage a beneficiary.

Link to Value Based Payment

In all aspects of the Medicaid Transformation, the Department is committed to paying for outcomes, focusing on increasingly tying provider payments to measures related to value, while giving plans flexibility to contract creatively with different providers based on their capacity to take on risk.⁴⁶ Further details of the Department’s Value Based Payment strategy are forthcoming and will include the role of BH I/DD Tailored Plans.

Accountability and Quality

The Department will establish a common set of quality measures as a key mechanism to ensure BH I/DD Tailored Plan accountability to the Department. All quality measures for BH I/DD Tailored Plans will align with and build on the Department’s Quality Strategy, which will be updated to include BH I/DD Tailored Plans and which primarily emphasizes *outcomes* for beneficiaries over process measures.⁴⁷ BH I/DD Tailored Plans will be required to report robust and dedicated measures that prioritize person-centeredness and personalization of goals, as well as management of a wide range of comorbidities. Outcomes such as beneficiary choice, independent living, employment and community participation will be considered alongside clinical quality measures. These outcomes may be measured through the use of beneficiary surveys, or by linking Medicaid data to data from other state agencies. Although the Department aims to align with Standard Plan quality measures when possible, the Department also recognizes the need to differentiate and prioritize alternative measures for the BH I/DD Tailored Plans to reflect the needs and experiences of beneficiaries. As for Standard Plans, the Department will introduce financial incentives at the BH I/DD Tailored Plan level over time, tied to performance on these population-based quality measures.

In addition to the quality measures developed by the Department, BH I/DD Tailored Plans will be required to report to the Department all federal Health Home quality measures (Table 3). The Department will submit these measures annually to CMS *for all beneficiaries in the Health Home program* (i.e., all beneficiaries actively engaged in Tailored Care Management in the state).⁴⁸

The Department will conduct oversight of BH I/DD Tailored Plans in a fashion similar to Standard Plan monitoring and oversight. While it is the BH I/DD Tailored Plans that will have primary accountability to the Department for the requirements of the Tailored Care Management model, the Department will initially play a direct role in provider accountability through the certification process for CMAs and AMH+ practices described above. After the Department’s initial certification of AMH+ practices and CMAs, BH I/DD Tailored Plans will be primarily responsible for conducting monitoring and oversight on an ongoing basis to ensure AMH+ practices and CMAs meet specific requirements, such as care manager qualifications and contact requirements. BH I/DD

⁴⁶ See [“North Carolina Medicaid – Initial Value-Based Payment Guidance,”](#) February 2019.

⁴⁷ North Carolina Department of Health and Human Services. [North Carolina’s Medicaid Managed Care Quality Strategy.](#) March 20, 2018.

⁴⁸ Mann, C. [State Medicaid Director letter – Health Home Core Quality Measures.](#) Centers for Medicare & Medicaid Services. January 15, 2013.

Tailored Plans will be required to include their policies and procedures for oversight of AMH+ practices and CMAs within their care management plans submitted for the Department’s approval as part of BH I/DD Tailored Plan procurement. When necessary, BH I/DD Tailored Plans will be expected to report and/or terminate underperforming AMH+ practices and CMAs.

TABLE 3. FEDERAL HEALTH HOME QUALITY MEASURES

Quality Measure	Measure Description
Adult Body Mass Index (BMI) Assessment	Percentage of members ages 18–74 who had an outpatient visit and who had their BMI documented during the measurement year or the year prior to the measurement year
Prevention Quality Indicator (PQI) 92: Chronic Condition Composite	The total number of hospital admissions for chronic conditions per 100,000 Health Home beneficiaries age 18 and older
Care Transition – Transition Record Transmitted to Health Care Professional	Care transitions: percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care, for whom a transition record was transmitted to the facility, primary physician or other healthcare professional designated for follow-up care within 24 hours of discharge
Follow-Up After Hospitalization for Mental Illness	Percentage of discharges for members age 6 and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days of discharge
Plan All-Cause Readmission Rate	For members age 18 and older, the number of acute inpatient stays during the measurement year that were followed by both an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission
Screening for Clinical Depression and Follow-Up Plan	Percentage of patients age 18 and older screened for clinical depression using a standardized tool <i>and</i> follow-up documented
Initiation and Engagement of Alcohol or Other Drug (AOD) Dependence Treatment	Percentage of adolescent and adult members with a new episode of AOD dependence who received the following: Initiation of AOD treatment Engagement of AOD treatment
Controlling High Blood Pressure	The percentage of patients ages 18–85 who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year

Data and Health Information Technology (HIT)

The efficient exchange of timely and actionable beneficiary health information will be critical to Tailored Care Management. BH I/DD Tailored Plans, AMH+ practices and CMAs, as well as physical health, behavioral health and I/DD providers, will be expected to regularly collect, use and share data in support of an integrated and coordinated approach to patient care, using the data to manage population health, respond to individual beneficiary needs, track referrals and follow-ups, monitor medication adherence, and respond to unmet health-related resource needs.

In accordance with federal Health Home requirements, BH I/DD Tailored Plans will be expected to ensure that AMH+ practices and CMAs maintain systems and processes that allow for interdisciplinary care team communication and care coordination. Systems should also be capable of documenting and storing beneficiary care plans/ISPs, and providing role-limited “views” of plans for the beneficiary and members of his/her care team. BH I/DD Tailored Plans, AMH+ practices and CMAs will also be expected to facilitate “warm handoffs” of

beneficiaries between plans, care managers and care settings, as needed, ensuring the beneficiary care team members have access to timely and complete beneficiary clinical information. BH I/DD Tailored Plans will play a supporting role in transitional care management by contracting with institutions in their provider networks (hospitals, residential settings, rehabilitation settings, other treatment settings, and long term services and supports providers) to establish policies and procedures to facilitate beneficiary transitions (e.g., notifications of beneficiary admission/discharge and other information sharing). Additionally, BH I/DD Tailored Plans, AMH+ practices and CMAs will be expected to interface with NCCARE360 (the new statewide coordinated care network to facilitate connection of individuals with identified needs to community resources) on similar timelines as those being set for Standard Plans and other providers. The details of the HIT expectations at the level of each CMA and AMH+ will be forthcoming as part of the rollout of the certification process.

To support care manager data use, BH I/DD Tailored Plans will be expected to share information with AMH+ practices and CMAs including, but not limited to, care management assignment rosters, beneficiary summary information (e.g., demographics, enrollment history, care manager history, medication summaries), risk stratification results, and historical claims and encounter data. The Department will work with BH I/DD Tailored Plans, AMH+ practices and CMAs after contracts are awarded to develop consensus around specific data formats, content, triggers and transmission methods for these critical data exchanges.

IV. Next Steps

The Department is eager to continue engaging with stakeholders as it refines its Tailored Care Management model and begins operational planning. The Department expects that providers, potential BH I/DD Tailored Plans, potential AMH+ practices and CMAs, beneficiaries, and advocacy groups will play important roles in this planning process to promote a smooth rollout of Tailored Care Management. Later this year, the Department will develop and publish the process by which potential AMH+ practices and CMAs will apply for and obtain certification to provide care management to the BH I/DD Tailored Plan population. This work will include developing an application for an organization to serve as an AMH+ or as a CMA and determining how the Department will evaluate whether a potential AMH+ or CMA is prepared to provide care management to the BH I/DD Tailored Plan population. Future planning will also include work around care management for populations obtaining state-funded services and the distribution of available capacity-building funds.

Comments may be submitted to Medicaid.Transformation@dhhs.nc.gov. Input received by June 28, 2019, will be used by the Department as it develops the Request for Applications.