

BH I/DD Tailored Plan RFA Questions and Answer Meeting: Tailored Care Management

All questions and answers within this document or previous documents are for informational purposes only. While the responses reflect the Department's current thinking with respect to the questions as they relate to the BH I/DD Tailored Plan Request for Application (RFA), they are subject to change. The requirements and responsibilities defined within the RFA will govern subsequent BH I/DD Tailored Plan contracts. It is the responsibility of LME/MCOs to carefully read the BH I/DD Tailored Plan RFA and respond to the items therein.

General Tailored Care Management Questions:

1. Q: Will the Department please provide additional information on Tailored Plan Care Management if expected RFA response is to be inclusive of more detail than what is currently provided in the Tailored Care Management Provider Manual?

A: The BH I/DD Tailored Plan RFA will provide additional information on the Tailored Care Management model beyond what is stated in the Provider Manual. LME-MCOs will have access to this information at RFA release.

2. Q: Will there be additional Tailored Care Management requirements in the RFP beyond what is in the Final Tailored Care Management Provider Manual?

A: The BH I/DD Tailored Plan RFA will provide additional information on the Tailored Care Management model beyond what is stated in the Provider Manual. LME-MCOs will have access to this information at RFA release.

3. Q: Has DHHS developed a detailed list of required trainings for Tailored Care Management?

A: The BH I/DD Tailored Plan RFA will include a list of required training domains for Tailored Care Management, the overwhelming majority of which are listed in the Tailored Care Management Provider Manual. BH I/DD Tailored Plans will be responsible for developing and implementing their own training curricula.

4. Q: Can DHHS provide more specific Federal Home requirements guidance regarding business processes, procedures, outcomes, and reporting requirements associated with this model already itemized (specifically identified) and operationalized (specifically described) within the 1115 documents to date? If not, what is the responsibility of LME-MCOs to interpret, operationalize, and apply those precepts and performance metrics in our RFA response? (Provide federal HH guidance)

A: The Department intends to submit a State Plan Amendment to CMS to authorize Tailored Care Management as a Health Home State Plan benefit. In the Tailored Care Management model, BH I/DD Tailored Plans will act as Health Homes. In its role as a Health Home, the BH I/DD Tailored Plan will ensure that members have access to care management services that meet federal Health Home requirements. 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 IT to coordinate across these services. The Tailored Care Management model incorporates each of these core services. The BH I/DD Tailored Plan RFA will reflect the BH I/DD Tailored Plan's obligations as a Health Home,

including the BH I/DD Tailored Plan's Health Home reporting obligations to the Department. CMS guidance on Health Home reporting requirements can be found at the following website: <https://www.medicaid.gov/resources-for-states/medicaid-state-technical-assistance/health-home-information-resource-center/health-home-quality-reporting/index.html>

Certification Process:

1. Q: Due to the implementation delay of Standard Plans, there seem to be conflicts with the originally anticipated timeline for AMH/CMA certifications and proof of readiness. Will the Department please explain plans to address the timeline shift to ensure care management entities are prepared and equipped to serve the Tailored Plan population.

A: Additional information about the revised timing for AMH+ and CMA certification process will be released in the coming months. As noted in the Tailored Care Management provider manual, BH I/DD Tailored Plans will be expected to complete readiness reviews to verify that each AMH+ and CMA is ready to perform the required Tailored Care Management functions

2. Q: Please clarify the timing and breadth of AMH+/CMA certification, prior to TP launch. We are concerned that practices can be certified, without actual demonstration of readiness.

A: *Additional information about the revised timing for AMH+ and CMA certification process will be released in the coming months. As noted in the Tailored Care Management provider manual, BH I/DD Tailored Plans will be expected to complete readiness reviews to verify that each AMH+ and CMA is ready to perform the required Tailored Care Management functions*

3. When can we expect to be notified which providers have passed the certification process to become an AMH+ or CMA?

A: Additional information about the revised timing for AMH+ and CMA certification process will be released in the coming months. As noted in the Tailored Care Management provider manual, BH I/DD Tailored Plans will be expected to complete readiness reviews to verify that each AMH+ and CMA is ready to perform the required Tailored Care Management functions

4. Q: When will LME-MCOs know the data on how many CMA and AMH+ per region so that we can determine the amount we will need to backfill for lack of provider capacity?

A: Additional information about the revised timing for AMH+ and CMA certification process will be released in the coming months. As noted in the Tailored Care Management provider manual, BH I/DD Tailored Plans will be expected to complete readiness reviews to verify that each AMH+ and CMA is ready to perform the required Tailored Care Management functions

5. How long does an AMH have to be functioning at Tier 3, before they can apply to be certified as an AMH+? Any length of time, prior to applying for certification?

A: To become certified as an AMH+ practice, a practice must be “actively serving” as an AMH Tier 3. The Department does not anticipate setting a minimum length of time that a practice must serve as an AMH Tier 3 prior to obtaining AMH+ certification.

Glide Path

1. Q. Regarding the glide path for AMH+ to take on care management, how might the target and pace of the glide path shift? For example, shift based on factors such as percentage of AMHs each year that are interested in becoming AMH+s, percentage of network AMHs that meet initial certification and are able to maintain certification for a certain period of time, timing of capacity building funds, amount of capacity building funds, certification timeline and length of certification process, etc.?

A: The BH I/DD Tailored Plan RFA will include additional information about the glide path towards provider-based care management.

Rates/Finance:

1. Q: Will DHHS set the rate for Tailored Care Management services delivered by AMH+ and CMAs or will BH I/DD Tailored Plans be allowed to set those rates?

A: Payments that BH I/DD Tailored Plans make to AMH+ practices and CMAs will be subject to Department-set Per Member Per Month (PMPM) rates. BH I/DD Tailored Plans will not be permitted to set their own rates.

2. Q: From what has been published it appears BH I/DD Tailored Plans will receive an administrative fee for monitoring and oversight of services by AMH+ and CMAs. Has the admin rate been set?

A: The administrative fee has not yet been finalized.

3. Q: Regarding acuity tiers - Per the BH I/DD Tailored Plan Care Management Provider Manual, both BH I/DD Tailored Plans and AMH+ and CMAs are encouraged to develop their own risk stratification approach. How will differences in Department, BH I/DD Tailored Plan, PHPs, and AMH+ and CMA risk stratification be resolved? Which type of stratification will prevail when differences? How will level of CCM payment be tied to the prevailing categorization?

A: Department-established acuity tiers will be the basis for minimum required care management contact requirements and Tailored Care Management payments. Risk stratification performed by the BH I/DD Tailored Plan, AMH+, or CMA will be distinct from the Department-established acuity tiers. The Department expects that BH I/DD Tailored Plans, AMH+ practices, and CMAs will use risk stratification for population health management purposes; BH I/DD Tailored Plan, AMH+, and CMA risk stratification will not have any impact on payment.

4. Q: Before Medicaid Transformation was suspended, NC Medicaid had reportedly determined the care management rates, but were still determining what data elements would be included to assign members to a level. Is the state able to share any more on the rates and how they will assign people to a care management level?

A: The Department will release draft Tailored Care Management payment rates with the BH I/DD Tailored Plan RFA. The Department will release additional information about the acuity tiers in the coming months.

5. Q: Acuity tier information (e.g., data elements and formulas for calculation, payment levels associated) is currently slated to be released after BH I/DD Tailored Plan award. The way acuity tiers are set, and the associated funding, will significantly impact LME/MCO strategies. Many key assumptions in our proposed approaches in the BH I/DD Tailored Plan RFA response will be heavily predicated on acuity tiering and associated costs/revenue.

A: The Department will release draft Tailored Care Management payment rates with the BH I/DD Tailored Plan RFA. The Department will release additional information about the acuity tiers in the coming months.

6. Q: What information about Acuity Tiers will be included in the BH I/DD Tailored Plan RFA that will enable LME/MCOs to successfully plan an appropriate response and ensure readiness – prior to awards and go live?

A: The Department will release draft Tailored Care Management payment rates with the BH I/DD Tailored Plan RFA. The Department will release additional information about the acuity tiers in the coming months.

7. Q: When and how will each level of acuity be defined?

A: The Department will release draft Tailored Care Management payment rates with the BH I/DD Tailored Plan RFA. The Department will release additional information about the acuity tiers in the coming months.

8. Q: Will the Tailored Care Management rate be tiered, based on risk assessment scores, High, Medium or Low?

A: Tailored Care Management payments will be according to acuity tiers. There will be separate high, medium, and low acuity tiers for behavioral health populations v. the I/DD and TBI populations.

9. Q: I have been operating under the assumption that if the LME-MCO is providing tailored plan care management to members when a Care Management Agency (CMA) or Advanced Medical Home Plus (AMH+) is not available, or the member chooses us, that we will have to follow all of the guidance in the Care Management manual and would also get the same acuity-based PMPM assuming we completed a core health home care management function. Is my assumption accurate?

A: This is correct. The same Tailored Care Management policies and payment rates apply regardless of whether Tailored Care Management is performed by a BH I/DD Tailored Plan, AMH+, or CMA.

Quality

1. Q: I have become very aware of the requirements for Complex Case Management found at NCQA Standard Q19. There are very tight timeframes around doing an initial Health Risk Assessment, etc. and all of the elements that have to be included in the assessment. I don't see those kinds of requirements and deadlines in the Tailored Care Management provider manual. I am told that the NCQA requirements around these issues are even more tight in the Health Plan accreditation standards than they even are the MHBO standards. If an accredited agency, like an LME-MCO, delegates that function to another entity, like a Tailored Care Management Agency, we would have to ensure that they follow all of those requirements, but if DHHS doesn't require them in the Provider Manual, I fear we won't be able to enforce them and it will put our accreditation at risk. Have you all had any thoughts about that?

A: The Department recognizes these issues are significant concerns for Standard Plans and BH I/DD Tailored Plans and is working with NCQA to identify a solution. When the Department reaches a resolution with NCQA, we will release additional guidance.

2. Q: The document states that the "purpose of certification will be for providers to demonstrate that they can either perform the necessary functions and activities already or show a credible pathway toward readiness at BH I/DD Tailored Plan launch." The footnote says that the Department distinguishes readiness review from pre-delegation auditing (for the purposes of National Committee for Quality Assurance (NCQA) health plan accreditation or for other purposes). The Department will prohibit BH I/DD Tailored Plans from conditioning AMH+ or CMA contracts upon pre-delegation audits or other monitoring activities that go beyond what is necessary to ensure that the provider organization has met the requirements in this manual for Tailored Care Management. Does this mean that the certification process intends to include adherence to national accreditation standards and requirements? Or is the intent to waive this as a requirement for a period of time since we are prohibited?

A: The Department recognizes these issues are significant concerns for Standard Plans and BH I/DD Tailored Plans and is working with NCQA to identify a solution. When the Department reaches a resolution with NCQA, we will release additional guidance.

3. Q: How do we comply with NCQA standards through delegation agreements with these Care Management entities if we aren't able to do a pre-delegation audit?

A: The Department recognizes these issues are significant concerns for Standard Plans and BH I/DD Tailored Plans and is working with NCQA to identify a solution. When the Department reaches a resolution with NCQA, we will release additional guidance.

Data Strategy

1. Q: ADT feed – Admission, Discharge, and Transfer data are vital to timely and appropriate coordination of care and to meeting BH I/DD Tailored Plan requirements. The current ADT feed (that is most accessible) via NC HealthConnex does not consistently offer detailed but reliable data on specific reasons and types of ADT events and the treating department.

A: We understand the limitations on current ADT feeds, including NC HealthConnex. BH I/DD Tailored Plans are required to receive ADT alerts (vendor not specified). It is expected that BH I/DD Tailored Plans will use best efforts to gather information from multiple sources as needed to most effectively manage their members' care.

2. Q: To appropriately prepare a BH I/DD Tailored Plan RFA response, it would be helpful to have further details about the exchange of data with CINs and AMHs and CMAs.

A: Please refer to North Carolina's Data Strategy for Tailored Care Management <https://files.nc.gov/ncdhhs/medicaid/Tailored-CareMgmt-DataStrategy-PolicyPaper-FINAL-20190912.pdf>, which explains the data that BH I/DD Tailored Plans must share with AMH+/CMAs. LME-MCOs can refer to Advanced Medical Home Data Specification Guidance found at <https://medicaid.ncdhhs.gov/transformation/advanced-medical-home/advanced-medical-home-data-specification-guidance>. This page details file formats and frequencies of data flows between Standard Plans (SPs) and Advanced Medical Homes (AMHs). These will serve as models for data sharing between BH I/DD Tailored Plans and AMH+s/CMAs.

3. Q: Can DHHS provide information regarding data format, frequency and level of standardization; will care plans will be limited to standardized and discrete data elements (e.g., using a standardized template and limited set of data fields and codes) or transmittable as PDFs, etc.?

A: Please refer to North Carolina's Data Strategy for Tailored Care Management <https://files.nc.gov/ncdhhs/medicaid/Tailored-CareMgmt-DataStrategy-PolicyPaper-FINAL-20190912.pdf>, which explains the data that BH I/DD Tailored Plans must share with AMH+/CMAs. LME-MCOs can refer to Advanced Medical Home Data Specification Guidance found at <https://medicaid.ncdhhs.gov/transformation/advanced-medical-home/advanced-medical-home-data-specification-guidance>. This page details file formats and frequencies of data flows between Standard Plans (SPs) and Advanced Medical Homes (AMHs). These will serve as models for data sharing between BH I/DD Tailored Plans and AMH+s/CMAs.

4. Q: The Tailored Care Management Provider Manual] says that BH I/DD Tailored Plans will be required to transmit the following data to AMH+ practices and CMAs or their designated CINs or Other Partners. Is this a bi-directional expectation? Meaning, information is expected to flow in both directions between [the BH I/DD Tailored Plan] and the AMH+/CMA providers?

A: Please refer to North Carolina's Data Strategy for Tailored Care Management <https://files.nc.gov/ncdhhs/medicaid/Tailored-CareMgmt-DataStrategy-PolicyPaper-FINAL-20190912.pdf>, which explains the data that BH I/DD Tailored Plans must share with AMH+/CMAs. LME-MCOs can refer to Advanced Medical Home Data Specification Guidance found at <https://medicaid.ncdhhs.gov/transformation/advanced-medical-home/advanced-medical-home-data-specification-guidance>. This page details file formats and frequencies of data flows between Standard Plans (SPs) and Advanced Medical Homes (AMHs). These will serve as models for data sharing between BH I/DD Tailored Plans and AMH+s/CMAs.

5. Q: Will the Department ensure access to real time law enforcement/criminal justice and Department of Juvenile Justice data feeds (e.g., through NC Health Connex) for related data, since these issues are defined triggers for assessment and re-assessment?

A: The Department is exploring ways to provide access to these data sources.

State Funded Care Management

1. Q: Will the Department be able to provide more specifics about care management requirements for the state-funded population?

A: The BH I/DD Tailored Plan RFA will provide additional information on BH I/DD Tailored Plans' care management obligations for State-funded populations. BH I/DD Tailored Plans will be required to develop an Individual Support Plan (ISP) for individuals with an I/DD or TBI obtaining State-funded care management; however, the requirements will be less intensive than those for Medicaid members.

2. Q: What are the care management expectations for individuals accessing State dollars?

A: The BH I/DD Tailored Plan RFA will provide additional information on BH I/DD Tailored Plans' care management obligations for State-funded populations. BH I/DD Tailored Plans will be required to develop an ISP for individuals with an I/DD or TBI obtaining State-funded care management; however, the requirements will be less intensive than those for Medicaid members.

3. Q. What are the care plan expectations for members receiving state funded services? Will the ISP be required?

A: The BH I/DD Tailored Plan RFA will provide additional information on BH I/DD Tailored Plans' care management obligations for State-funded populations. BH I/DD Tailored Plans will be required to develop an ISP for individuals with an I/DD or TBI obtaining State-funded care management; however, the requirements will be less intensive than those for Medicaid members.