Updated: BH I/DD Tailored Plan RFA Questions and Answers LME/MCO CEO Meeting

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 Tailored Plan Request for Application (RFA), they are subject to change. The requirements and responsibilities defined within the RFA will govern subsequent Tailored Plan contracts. It is the responsibility of LME/MCOs to carefully read the RFA and respond to the items therein.

Procurement:

1. Q: RFA Submission: Will DHHS allow electronic submissions for the RFA response due to COVID-19 or will hard copy submissions be required? If hard copy submissions are required, will the designated DHHS office be available to accept hand delivery on Monday, January 18, 2021 (Martin Luther King Jr. Day)?

A: The delivery method for responses has not been determined, but details and instructions will be outlined in the BH I/DD Tailored Plan RFA. Upon issuance of the BH I/DD Tailored Plan RFA, any questions regarding the process for submitting an application can be submitted through the formal Q&A process that will be outlined in the BH I/DD Tailored Plan RFA.

2. Q: The Standard Plan RFP requires the bidder to "disclose all sanctions imposed against the offeror as part of a managed care contract in the past seven (7) years." How is the term "sanctions" defined? Does it include EQR plans of correction?

A: Sanctions are typically punitive actions to correct or enforce compliance with federal, state and contract requirements.
The PHP RFP/contract identifies specific actions referred to as "intermediate sanctions," such as civil penalties, appointment of temporary management, suspension of enrollment etc. Under the PHP RFP/contract, those actions are separate and distinct from the imposition of "liquidated damages" and "remedial actions," such as immediate remediation, corrective action plans, or education/training. Sanctions may also include contract termination, or other significant or serious actions taken to address contract performance.

LME/MCOs will need to carefully read the terms of its contracts and the BH I/DD Tailored Plan RFA to determine what contractual compliance or performance related actions are required to be disclosed in the application.

3. Q: Please provide examples of, or provide more information about, what would be considered a potential conflict of interest required to be disclosed by an RFA applicant.

A: Applicants will be required to:
Disclose any relationship to any business or associate with whom the Applicant is currently doing business that creates or may give the appearance of conflict of interest related to the BH I/DD Tailored Plan RFA and any Contract that may be awarded to Applicant because of the BH I/DD Tailored Plan RFA.

Disclose any entity principal, staff member or subcontractor known by the Applicant to have a conflict of interest or potential conflict of interest related to the BH I/DD Tailored Plan RFA and any Contract that may be awarded to Applicant because of the BH I/DD Tailored Plan RFA.

In addition, LME/MCOs are encouraged to review the PHP RFP/contract at Section V. Scope of Work, A. Administration and Management, 9. Staffing and Facilities, i. Conflict of Interest for other details and references to applicable federal and state laws. The BH I/DD Tailored Plan RFA will likely have similar requirements.

4. Q: There are numerous references in the Standard Plan RFP to requests for detailed descriptions of experience in other markets. How or will these types of experience requirements translate to the BH I/DD Tailored Plan RFA?

A: For the Offeror to demonstrate they are qualified to meet the Department's demands, the required prior experience and what is relevant is outlined in the BH I/DD Tailored Plan RFA.

IT/Data:

1. Q: For LME/MCOs who plan to pursue SOC2 certification, as opposed to HITRUST certification, which of the five SOC 2 "Trust Service Criteria" (TSC) below will be required by NC-DHHS as part of the SOC2 Type 2 requirements (understanding the number of SOC2 TSCs which will be required is critical to understanding the scope and financial impact of obtaining the required certifications):
    - Security
    - Availability
    - Processing integrity
    - Confidentiality

A: Soc2 type must encompass all the criteria mentioned:

- Security
- Availability
- Processing integrity
- Confidentiality
- Privacy

Marketing:

1. Q: Given that members assigned to Tailored Plans will not have a choice between Tailored Plans (although they may opt out of TP and elect to enroll with a Standard Plan), what marketing restrictions/ requirements will be applicable to the Tailored Plans?

A: The Department has several requirements and restrictions in the BH I/DD Tailored Plan RFA detailing parameters under which BH I/DD Tailored Plans may market or distribute materials. The focus of BH I/DD Tailored Plan marketing is to educate potential Members *in their region* about health plan options, while ensuring the protection of Members from coercive, confusing or misleading practices. Specifically, BH I/DD Tailored Plans shall not engage in activities that seek to target Members currently enrolled in other BH I/DD Tailored Plans.

Provider Handbook

1. Q: Will DHHS provide a template for the Provider Handbook or will the BH I/DD Tailored Plans be permitted to develop their own documents so long as they include required provisions/ sections? If a template or list of specific provisions will be provided, when will that be made available?

A: The BH I/DD Tailored Plans will be permitted to develop their own provider manual that offers information and education to Network Primary Care Physicians (PCPs). The specific list of provision that must be included in the manual are included in the BH I/DD Tailored Plan RFA. The Department will not be providing a template.

Provider Network:

1. Q: In the August 24, 2020 Q&A document, the Department stated that "it is the responsibility of each managed care plan to provide oversight and monitoring of their individual provider networks" which did not really answer the question that was posed. Specifically, we are seeking additional guidance about what level and type of monitoring and oversight will be required for the various provider categories, especially licensed providers, to minimize duplication with licensure bodies, other PHPs, and accrediting organizations? For example, will there be any specific requirements to conduct post-payment reviews, billing audits or routine monitoring on a particular timeframe (e.g. once every 2 years)?
If there are specific monitoring requirements, will they apply equally across the board (e.g. hospital, primary care practice, radiology lab, home health) or will they be based on provider risk category?
And how does the Department plan to prepare providers for this level of monitoring by multiple PHPs and LME/MCOs? (There is concern that FFS providers are not prepared for, or anticipating, an increased level of oversight from managed care entities.)
Will you be reaching out to the provider associations? Hospitals in particular are resistant to LME/MCO monitoring as it stands today. The concern is that upon go-live, providers will be subjected to a great deal of duplicative monitoring, reviews and audits and to the extent the Department can either minimize duplication or work with provider associations to prepare them for the requirements, it would be helpful. We would like to avoid a large outcry from provider groups that they are being overly monitored.

A: The BH I/DD Tailored Plan plan for oversight and monitoring of its provider network is developed by the BH I/DD Tailored Plan and presented to NC Medicaid through the BH I/DD Tailored Plan Network Access Plan. The plan should include, amongst other things, the BH I/DD Tailored Plan quantifiable and measurable process for monitoring and assuring the sufficiency of the Network to meet the health care needs of all members, the strategies to ensure access and availability of services and build sufficient provider capacity, and other plans for oversight of the network. As to the issue of duplication, the Department is committed to reducing provider administrative burden, and will consider if coordination of reviews and audits of providers is feasible under Medicaid Managed Care.

2. Q: Can the Department provide more detail about the anticipated roles and responsibilities of the centralized Credentials Verification Organization (CVO) with respect to the Tailored Plans?
Currently, the LME/MCOs are responsible for conducting all of the necessary verifications and background checks for providers seeking to enroll in our networks, duplicating to a certain extent the functions of NCTracks enrollment. We are also required to conduct re-credentialing every 3 years. It would be incredibly helpful to understand more detail about the Department's planned credentialing and enrollment requirements for LME/MCOs when the CVO goes live, and how those requirements will align with the credentialing mandates of our accrediting bodies.

A: The awarded Provider Data Management (PDM)/ CVO vendor will be responsible for all enrollment, credentialing and verification functions to include NCQA guidelines and CMS Requirements. The PDM/CVO will not be live until approximately July 2023.

3. Q: Within what time frame will the LME/MCOs be required to have contracts in place with physical health providers? Our assumption is that that they will have to be enrolled prior to TP go-live, so how will the LME/MCOs be funded to perform this function?
What specific credentialing and enrollment requirements will be applicable to physical health providers for Tailored Plan go-live?

A: A time frame has not been established for when physical health provider networks must be in place, but BH I/DD Tailored Plans should have a plan for building and maintaining their entire provider network (physical health and behavioral health) with a goal of meeting the adequacy and accessibility standards outlined in the BH I/DD Tailored Plan RFA for all members. The Department will convey to the BH I/DD Tailored Plans timelines for submission of information relating to the provider networks including submissions of the network during readiness reviews and timelines for submission after the BH I/DD Tailored Plans go live. All providers (physical health and behavioral health) who participate in BH I/DD Tailored Plans will have to go through the Department's NC Medicaid/NC Health Choice provider enrollment process as part of the credentialing and enrollment process, and should not be contracted with by the BH I/DD Tailored Plan until that credentialing/enrollment has been completed. BH I/DD Tailored Plans are to accept the Department's provider enrollment process as the centralized credentialing process and will use the information from that process in making decisions relating to contracting with providers as applicable.

4. Q: Will the "Good Faith Contracting Policy" referenced in the Standard Plan RFP be a requirement in the BH I/DD Tailored Plan RFA? If so, can you provide more detail about this policy (or a sample policy) and how this would be applicable to BH I/DD Tailored Plans, particularly given that BH I/DD TPs will be permitted to retain their existing closed networks for behavioral health services?

A: Yes, the "Good Faith Contracting Policy" will apply to BH I/DD Tailored Plans. Even with a closed behavioral health network, a BH I/DD Tailored Plan could be subject to out-of-network payment provisions. Those provision apply based upon a BH I/DD Tailored Plans good faith contracting effort and/or if the BH I/DD Tailored Plan has exercised its authority to maintain a closed network for behavioral health services.

5. Q: The Standard Plan RFP references a requirement to "identify any provider appeal rights that will be provided in addition to those required in the Contract." The current LME/MCO contract with DHB does not contain specific provider appeal requirements. Any such requirements are set forth by our accrediting bodies or in applicable law. Can the Department provide clarity about what appeal rights will be in the TP contract and/or what additional appeal rights not set forth in the Contract will need to be identified in the RFA response?

A: Please refer to the Standard Plan contract. The requirements will be the same for the BH I/DD Tailored Plan.

<u>Contracting:</u>
1. Q: If the LME/MCO subcontracts with a Standard Plan for a Nurse Line, will that be sufficient to meet the Standard Plan requirements set forth at Session Law 2018-48 (HB403), Section 4. 10.a.5:

"LME/MCOs operating BH IDD Tailored Plans shall contract with an entity that holds a PHP license and that covers the services required to be covered under a Standard Benefit Plan contract."

A: Section 4. of S.L. 2015-245, as amended by Section 1. of S.L. 2018-48, requires LME/MCOs operating BH I/DD Tailored Plans to contract with an entity that holds a PHP license and that covers the services required to be covered under a standard benefit plan contract.

Under the RFA, the Department's goal is to ensure that the needs of beneficiaries are met through the provision of whole-person, integrated care for behavioral health and physical health services managed by the BH I/DD Tailored Plans while complying with the spirit and intent of the law. Because LME/MCOs have not historically managed physical health services and benefits, the Department will expect RFA applicants to demonstrate how it will build and manage its physical health network that provides whole-person, integrated care.

As part of the RFA, applicants will be required to demonstrate: (1) that they have contracted with an entity that holds a PHP license and that covers the services required to be covered under a standard benefit plan contract (not an affiliate, subsidiary, or subcontractor of an entity that holds a PHP license); and (2) its approach for how it will build and manage a physical health network that provides whole-person, integrated care to beneficiaries. It will be in the discretion of the applicant to determine the nature and scope of the services covered under its contract with an entity that holds a PHP license (not an affiliate, subsidiary, or subcontractor of an entity that holds a PHP license). However, the Department intends to hold applicants fully accountable for meeting the requirements of the RFA and the law in its evaluation of the applicants' RFA responses.

2. Q: Similarly, if the LME/MCO contracts with a PBM affiliated with or owned by a Standard Plan, will that be sufficient from the Department's perspective to meet the requirements of Session Law 2018-48?

A: Section 4. of S.L. 2015-245, as amended by Section 1. of S.L. 2018-48, requires LME/MCOs operating BH I/DD Tailored Plans to contract with an entity that holds a PHP license and that covers the services required to be covered under a standard benefit plan contract.

Under the RFA, the Department's goal is to ensure that the needs of beneficiaries are met through the provision of whole-person, integrated care for behavioral health and physical health services managed by the BH I/DD Tailored Plans while complying with the spirit and intent of the law. Because LME/MCOs have not historically managed physical health services and benefits, the Department will expect RFA applicants to demonstrate how it will build and manage its physical health network that provides whole-person, integrated care.

As part of the RFA, applicants will be required to demonstrate: (1) that they have contracted with an entity that holds a PHP license and that covers the services required to be covered under a standard benefit plan contract (not an affiliate, subsidiary, or subcontractor of an entity that holds a PHP license); and (2) its approach for how it will build and manage a physical health network that provides whole-person, integrated care to beneficiaries. It will be in the discretion of the applicant to determine the nature and scope of the services covered under its contract with an entity that holds a PHP license (not an affiliate, subsidiary, or subcontractor of an entity that holds a PHP license). However, the Department intends to hold applicants fully accountable for meeting the requirements of the RFA and the law in its evaluation of the applicants' RFA responses.

3. Q: When will the LME/MCO be required to have an executed contract with a Pharmacy Benefit Manager or any other delegated functions in place – go live or readiness review or some other date?

A: No deadlines have been established relating to contracting with providers, but BH I/DD Tailored Plans should have a plan for building and maintaining their entire provider network (physical health, behavioral health and pharmacy benefits) with a goal of meeting the adequacy and accessibility standards outlined in the BH I/DD Tailored Plan RFA for all members. The Department will convey to the BH I/DD Tailored Plans timelines for submission of information relating to the provider networks including submissions of the network during readiness reviews and timelines for submission after the Tailored Plans go live. As for contracts to delegate functions to vendors (including a PBM), the BH I/DD Tailored Plans should review the BH I/DD Tailored Plan RFA carefully for any requirements related to such arrangements which may be required as part of the response to the BH I/DD Tailored Plan RFA.

Program Integrity/Compliance:

1. Q: The Standard Plans are required to send out Recipient Explanation of Medical Benefits (REOMB) for at least 10% of all claims or 500 claims for the month, whichever is less. What will the required number be for TPs?

A: Please refer to the Standard Plan contract. The requirements will be the same for the BH I/DD Tailored Plan.

Tailored Plan Eligibility:

1. Q: How often does DHHS plan to update/re-calculate TP eligibility? The intent of the question isn't to focus on the number as we are expecting fluctuations to some extent, but we have routinely asked for a schedule from DHHS regarding when/how often they are going to run the eligibility numbers. Having this info will help us greatly in our planning, both as part of BH I/DD Tailored Plan readiness, but also ongoing. To clarify, we aren't asking about the look back period. We are asking about a schedule for when DHHS will run eligibility in general. This has already been happening, thus is not directly tied to the BH I/DD Tailored Plan RFA.

A: NC Medicaid currently runs the BH I/DD Tailored Plan eligibility algorithm on Medicaid/NCHC claims and encounters on a monthly basis. We also plan to do monthly updates on other criteria; however, we are dependent on other entities to provide the information (e.g., Innovations waitlist, TCLI, Children with Complex Needs).

2. Q: Will all dual eligibles (Medicare/ Medicaid) be excluded from TP managed care for 4 years?

A: Pending any needed legislative change, The Department has proposed that beneficiaries who are dually eligible for Medicare and full Medicaid who also meet the Tailored Plan eligibility criteria would continue to receive their BH and IDD benefits through the BH I/DD Tailored Plans while their physical health and LTSS benefits would continue to be covered through Medicaid Direct as they do today.

Tribal:

1. Q: Do EBCI members have choice to enroll in BH/IDD TP? The Standard Plan RFP at p. 7 of 60; 10(b) states choice is between Medicaid FFS, enrollment in a tribal plan, or a PHP only.

A: Yes, EBCI members have choice to enroll in BH/IDD TP if they meet BH I/DD Tailored Plan eligibility. The Tribal Option care managers will receive training, that at a minimum, that covers waivers services available only through BH I/DD TP, eligibility criteria and the process for a Member who needs a waiver service that is available only through BH/IDD TP to transfer to a BH/IDD TP.

Crisis Management:

1. Q: Will the Tailored Plan follow the same Access to Care (Emergent, Urgent, Routine) timeframes that currently apply to LME/MCOs?

A: Please refer to the Standard Plan contract. There are plans to update the SUD "routine" to 48 hours.

2. Q: Currently, outside of crisis services, the LME/MCO is responsible for scheduling assessments for individuals who are not connected to services. If the assumption is that most Medicaid enrollees are assigned to a BH I/DD Tailored Plan because they are receiving enhanced services, will the LME/MCO be required to schedule appointments for medical and behavioral health services for BH I/DD Tailored Plan enrollees or will we simply be required to give them the phone number/ contact info to schedule directly with a plan provider?

A: As part of transitional care management, the BH I/DD Tailored Plan will be responsible for assisting with scheduling certain appointments.

3. Q: If an individual enrolled in a Standard Plan calls the LME/MCO in crisis, will the LME/MCO be expected to manage the call or conduct a warm transfer to the Standard Plan crisis line?

A: A warm transfer to the Standard Plan Behavioral Health crisis line would be indicated for callers where such a transfer is clinically appropriate, based upon a triage process.

Transitions of Care:

1. Q: When will the Transition of Care meetings reconvene so that we can ensure that DHHS, LME/MCOs and Standard Plans are in alignment with respect to transition of members between plans? When will the Transition of Care provisions in the current DHB contract be revised to reflect prior feedback from LME/MCOs (e.g. using the terminology "Transferring Entity" and "Referring Entity" to ensure reciprocity and clarity)?

A: NC Medicaid will reactivate planning sessions between the LME/MCOS and the Standard Plans in October. Medicaid is currently reviewing all Transitions of Care (ToC) requirements and will provide updates when meetings reconvene. LME/MCOs will be receiving a re-engagement letter and a kickoff session will be scheduled to reactivate the planning sessions.

Healthy Opportunities:

1. Q: What are the specific requirements and scope of work for LME/MCOs regarding collaboration with regional awardees, SP PHPs, and others on Healthy Opportunities prior to TP go live?

A: NC Medicaid is planning to re-engage Standard Plans and the LME/MCOs in pilot design meetings in October/November 2020. We'll be discussing the Standard Plan responsibilities in the pilots, and will be seeking their engagement to co-design the responsibilities with the Department.

2. Q: Does DHHS have an estimated date of decision regarding the awardees of the Healthy Opportunities Pilot?

A: The Department is still finalizing a new pilot timeline, including LPE award date.

ILOS:

1. Q: Which in lieu of services will be eligible for TP? Which will not?

A: As mentioned on the September 15, 2020 LME/MCO CEO call, NC Medicaid will not be reviewing current In Lieu of Services prior to BH I/DD Tailored Plan contract award to determine which ones will be appropriate for the BH I/DD Tailored Plans. Once BH I/DD Tailored Plan contracts are awarded, the plans will be informed of when to submit ILOS for review.

State Funded Services:

1. Q: What educational or other efforts will the Department take to ensure that providers and consumers understand that non-Medicaid funding/ services are not an entitlement, and that the non-Medicaid benefit plan does not cover physical health? Due to the commingling of these plans in the BH I/DD Tailored Plan RFA and the white papers, we believe there is already confusion among stakeholders that may be creating false or unrealistic expectations.

A: MHDDSAS has issued separate State Funded Services policy papers and held a stakeholder webinar making clear that State Funded Services are not entitlements. We will work collaboratively with our BH I/DD Tailored Plan partners to regularly communicate these concepts through established stakeholder engagement forums.

2. Q: How will the Department differentiate between non-Medicaid and Medicaid requirements with respect to access to care standards/ provider choice etc.?

A: The BH I/DD Tailored Plan RFA separately outlines these standards for State Funded Services and Medicaid

3. Q: What additional funding does the department anticipate will be available to meet the standards outlined in the BH I/DD Tailored Plan requirements for members enrolled in non-Medicaid benefit plans?

A: DMHDDSAS expects BH I/DD Tailored Plans to fulfill contract obligations with resources as provided through federal block grants and state allocations

4. Q: Can the Department provide more detail about the anticipated requirements for scheduling appointments for non-Medicaid members outside of crisis services?

A: As part of transitional care management, the BH I/DD Tailored Plan will be responsible for assisting with scheduling certain appointments.

Quality:

1. Q: Will the measures listed in the Standard Plan RFP Section VII. Attachment E. Table 1. Survey and General Measures also be required of the BH I/DD Tailored Plans or will these be modified?

A: BH I/DD Tailored Plans will have a specific measure set included in the BH I/DD Tailored Plan RFA. Many of the measures overlap with measures in the Standard Plan. The Department has made several changes to the set of quality measures that appeared as a draft set in the BH I/DD Tailored Plan Policy Paper. These changes reflect updates made by national organizations including quality measure stewards and payers and accrediting organizations that maintain widely used measure sets. In addition, they reflect investments the Department has made in data analytics capacity that now allow it to independently monitor a larger number of measures.

2. Q: Will the priority measures listed be the same for Tailored Plans?

A: BH I/DD Tailored Plans will still need to report a streamlined set of priority measures which will cover the full range of enrollee health, including both physical and behavioral health. These measures will be very similar to Standard Plan priority measures, but will have additional emphasis on behavioral health, Long Term Services and Supports, and Traumatic Brain Injury needs, consistent with the populations that the BH I/DD Tailored Plans will serve. The Department will continue to calculate and monitor performance on measures not calculated by the BH I/DD Tailored Plans that are not included in the priority set, and may engage with plans related to performance on these measures, but they will not be included in priority or withhold sets.

3. Q: When will the measurement period begin?

A: BH I/DD Tailored Plan quality measurement will follow calendar years, so the first measurement period will begin on the January 1st of the first year after BH I/DD Tailored Plans begin operations.

4. Q: The Standard Plan RFP at Question #7 references a request for quality metrics "for the three (3) consecutive most recent annual HEDIS reporting periods with the past five (5) years available for the specific HEDIS metrics below and audited by a NCQA-approved auditing firm." These metrics include Children and Adolescents Access to Primary Care Practitioners; Comprehensive diabetes control; Follow-up After Hospitalization for Mental Illness; Frequency of Ongoing Prenatal Care; and Well-Child Visits in the First 15 Months of Life. Give that our current data access allows us to report only on follow-up after hospitalization for MI, how will this question differ in the BH I/DD Tailored Plan RFA, i.e. what metrics will be required in place of the HEDIS measures?

A: BH I/DD Tailored Plan requirements for completing their BH I/DD Tailored Plan RFP will be listed in the BH I/DD Tailored Plan Offeror's Proposal and will be consistent with BH I/DD Tailored Plans' expected access to data. After launch, all HEDIS measures calculated by BH I/DD Tailored Plans will require auditing by an NCQA-approved auditing firm; BH I/DD Tailored Plans will contract with an approved auditor, which will determine when auditing begins. More information about HEDIS compliance audits can be found here. HEDIS audits are separate from, and in addition to, EQR reviews.

5.. Q: In regard to the two specific Performance Improvement Plans programs listed in the Standard Plan RFP, one for children and one for pregnancy/maternal health, will these be the same in the Tailored Plan or will Tailored Plans have a different focus?

A: As with the quality measure set, Standard Plan Performance Improvement Plans (PIPs) will be updated and streamlined to reflect current Department priorities, capacity and expectations. BH I/DD Tailored Plans will be required to implement PIPs like Standard Plans, but with an additional focus on behavioral health. Further details will be available in the BH I/DD Tailored Plan RFA.

6. Q: With respect to question #45 of the Standard Plan RFP, Attachment O, which requests "examples of at least 10 HEDIS measures stratified by geography, race/ethnicity, and gender. The Offeror shall describe the IT infrastructure and data analytic capabilities used to support the analysis, analysis of the measures, and associated QI programs implemented to address health disparities. Include measure indicators; analysis to find drivers; PDSA or other methodological approach for evaluation; interventions; planned metrics, realized metrics, and overall impact of the QI/PIP":
Given that the LME/MCOs do not currently do HEDIS reporting, what measures will be required in the BH I/DD Tailored Plan RFA for this section?
How will the requirements addressing health disparities and public health measures be altered to more accurately reflect our current responsibilities?

A: For the BH I/DD Tailored Plan RFP response, BH I/DD Tailored Plans will have the ability to report measures for which they have access to data. Given the history of health disparities and unmet population health needs in North Carolina, and given that public health, health equity and quality improvement have been core priorities for the Department, the Department expects that candidate BH I/DD Tailored Plan entities that have served North Carolina enrollees in previous roles have experience conceptualizing and implementing efforts to reduce disparities and addressing public health priorities in their populations.

7. Q: Can the Department provide more specific guidelines about the proposed templates and/or key fields for reports included in Attachment J: Reporting Requirements?

A: Those templates are in development and will be shared with BH I/DD Tailored Plan after award and during the implementation process.

<u>Tailored Care Management:</u>
AMH+/CMA Certification
1. Q: At BH I/DD Tailored Plan launch, all criteria must be met. What criteria [is the Department] referring to, is there a tool or detailed description we can review? There are general descriptions but no real defined criteria for how these expectations will be assessed.

A: To perform Tailored Care Management, Advanced Medical Home Plus (AMH+) practices and care management agencies (CMAs) must be able to meet requirements for Tailored Care Management that are established in the RFA. Additional information about the AMH+/CMA certification process will be released in the coming months.

2. Q: What evidence will CMAs have to produce to demonstrate that they have experience or expertise in integrated care or a structure that supports integrated care?

A: As part of their application to become a CMA, organizations will be required to describe how they plan to approach integration of physical health and behavioral health, I/DD, TBI, and/or waiver services through Tailored Care Management. Organizations applying to become a CMA will specifically be required to describe their approach to integration with physical health for the purpose of care management. Prior to BH I/DD Tailored Plan launch, as part of the desk review process and site visits, the Department will evaluate whether the organization's approach is satisfactory. BH I/DD Tailored Plans will assume this responsibility at the point of launch.

3. Q: With regard to the following statement at Section V.2.3 of the Tailored Care Management Provider Manual, what will be the minimum standards established by DHHS to determine if the provider can sustainably support care management functions as a going concern? "The organization must have the capacity and financial sustainability to establish care management as an ongoing line of business, as evidenced by an audited financial statement."

A: As part of the AMH+/CMA application process, organizations seeking AMH+ or CMA certification will be required to describe their financial capacity to provide Tailored Care Management and attach their most recent annual audit. In addition, they will be required to respond to the following prompts:

- Does your most recent audit have any conditions that would impact your operation over the next two years?
- Please confirm that your most recently audited financial report demonstrates capacity for ongoing operation at or above current levels of services volume (e.g., days in accounts receivable/payable, at least 60 days of cash on hand).
- The Department will assess the information provided in the application as part of the desk review process.

4. Q: Page 5 [of the Tailored Care Management Provider Manual] it says, "After BH I/DD Tailored Plan go-live, BH I/DD Tailored Plans will assume full responsibility for certification and oversight of AMH+ practices and CMAs." Will the state provide the corresponding materials or will we be required to develop our own?

A: Additional information about the AMH+/CMA certification process will be released in the coming months.

5. Q: The process for AMH+/ CMA certification has deeply concerning parallels to the State's prior CABHA certification process. When will the LME/MCOs receive more detail about the proposed readiness reviews we will be required to conduct? This would ideally include details about the specific certification requirements and the process for providers to challenge LME/MCO findings, if we determine that a provider does not meet requirements for certification. How will the Department support LME/MCOs in this readiness review process, especially with respect to anticipated provider challenges of LME/MCO readiness review determinations?

A: Additional information about the AMH+/CMA certification process will be released in the coming months.

6. Q: Prior Q&As repeatedly state that "Additional information about the revised timing for AMH+ and CMA certification process will be released in the coming months" but it is challenging for us to prepare for this process in the absence of detailed requirements. Can the Department provide specific dates and milestones for when this information will be shared?

A: The Department commits to giving LME/MCOs sufficient time to prepare for assuming the lead role in the AMH+/CMA certification process at BH I/DD Tailored Plan launch.

7. Q: How will the BH I/DD Tailored Plan be informed about what population that an organization may be certified for in a region? Or that they are certified in one region but not another?

A: The Department will notify BH I/DD Tailored Plans about the populations and regions for which an organization is certified. Additional information about this process will be released in the coming months.

8. Q: How is the phrase "a high-functioning service line" defined or determined as referenced at Section V.2.3 of the Tailored Care Management Provider Manual: "Tailored Care Management must be recognized by the organization's leadership and governing body as integral to the mission of the organization and as such be supported by a budget and management team appropriate to maintain Tailored Care Management as a high-functioning service line." Will there be specific benchmarks for this requirement?

A: The AMH+/CMA certification process, including the desk review and site visit, will be aimed at determining whether a provider organization is capable of offering Tailored Care Management as a "high-functioning service line." The Tailored Care Management Provider Manual (see Section IV: Key Features of the Tailored Care Management Model and Section V: AMH+ and CMA Certification Requirements) and the forthcoming BH I/DD Tailored Plan RFA outline the Department's expectations and requirements for high-functioning Tailored Care Management.

Glide Path:

1. Q: We understand that the Department will provide additional information about the glide-path in the BH I/DD Tailored Plan RFA and respectfully offer the following for the Department's consideration. The proposed annual target for provider-based care management should also include the number of certified practices available in a given region to take on Tailored Care Management responsibilities. This becomes more important in light of the information as stated in the 6/9/2020 Tailored Care Management Provider Manual update requiring BH I/DD Tailored Plans to ensure there is capacity at an AMH+ practice or CMA before making an assignment, but also allowing AMH+ practices and CMAs to decline assignments based on capacity. As a system, we are still in the early stages of understanding of provider capacity and how long it will take providers to ramp up. Would the Department consider setting a goal of increasing by a percentage each year (e.g. 10%) as opposed to the glide path being a rigid requirement by the end of year 4?

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

CIN:

1. Q: If AMH+ and CMA are allowed to work with CINs, who is the contract between, the BH I/DD Tailored Plan and the agency or the "network?" Who is enrolled with the BH I/DD Tailored Plan as the "provider"?

A: The BH I/DD Tailored Plan can contract with either the CIN/Other Partner, AMH+, or CMA. The State will not have oversight of CINs/Other Partners (i.e., it will not certify CINs/Other Partners or validate their capabilities). For AMH+ and CMA practices that partner with CINs, the State will certify individual practices rather than the entire CIN/Other Partner.

The AMH+ or CMA is the enrolled provider.

2. Q: Will Standard Plan entities or affiliates be permitted to own or have CMA subsidiaries or run a CIN that supplies care managers for a BH I/DD Tailored Plan service? If so, can the BH I/DD Tailored Plan

establish a non-profit entity to operate an AMH+/CMA/CIN and "furthers the authorized purposes of the public authority" pursuant to NCGS § 159-42.1?

A: Standard Plan and BH I/DD Tailored Plan subsidiaries may not act as a CINs or Other Partners with one exception: the Department recognizes that AMH+ practices and CMAs may decide to enter into arrangements with BH I/DD Tailored Plans for use of their information technology (IT) products or platforms for care management, in order to meet the care management data system requirements. In this scenario, the BH I/DD Tailored Plan would be considered an "Other Partner" (not a CIN) for health IT support only.

The Department requests additional clarification on the scenarios in which the LME/MCO posing this question envisions that a Standard Plan or BH I/DD Tailored Plan entity or affiliate would seek to serve as an AMH+ or CMA.

3. Q: With respect to the following statement in the Tailored Care Management Manual Section III.3: "As a general rule, the Department will expect arrangements with CINs or Other Partners to include strong clinical leadership at the CIN or Other Partner level that has deep experience in NC Medicaid or NC Health Choice and/or has supported similar efforts in other states." Expectations are practically and legally unenforceable so it would be helpful if the Department would stop using that word if the intention is for this to be an enforceable requirement. What requirements will the Department put in place or allow BH I/DD Tailored Plans to put in place to make this expectation enforceable? (This in particular reminds us of CABHA challenges.)

A: The BH I/DD Tailored Plan contract will establish legal obligations for BH I/DD Tailored Plans. The Tailored Care Management Provider Manual is not a legally binding document.

4. Q: The same section of the Tailored Care Management Provider Manual states that "AMH+ practices and CMAs intending to work with a CIN or Other Partner must sign a formal agreement with that organization that ensures the CIN or Other Partner can receive and use patient data in compliance with the Health Insurance Portability and Accountability Act (HIPAA) and state regulations, as well as any other data elements mutually agreed upon by the practice and the CIN or Other Partner." Will BH I/DD Tailored Plans be required to monitor this requirement?

A: The Department expects AMH+ practices and CMAs will meet all federal and state requirements, and data-sharing stipulations specified by the Department and their contracted BH I/DD Tailored Plans. BH I/DD Tailored Plans will not be responsible for monitoring all data-sharing arrangements entered into by AMH+ practices or CMAs.

<u>Care Management Assignment:</u>
1. Q: What will the timeline be for engagement with BH I/DD Tailored Plan members around care management assignment so that we can onboard this massive number of people for assignment to [their] care management choice? Will the state [be] doing a mailing campaign like they did for Standard Plans?

A: At least thirty (30) days prior to BH I/DD Tailored Plan launch, BH I/DD Tailored Plans will be required to send members a Tailored Care Management enrollment packet, with information on their BH I/DD Tailored Care Management assignment and options for changing their assignment.

2. Q: What is “cause” for changing care management outside of the 2x times without cause a member can change care manager/management entity?

A: The Department considers the following as appropriate cause for changes in care management approach (i.e., Tailored Care Management provided by the BH I/DD Tailored Plan v. an AMH+ practice v. CMA), assigned organization providing Tailored Care Management, and care manager:
The AMH+, CMA, BH I/DD Tailored Plan or care manager has failed to furnish accessible and appropriate services to which the member is entitled.
The AMH+, CMA, BH I/DD Tailored Plan or care manager is not able to reasonably accommodate the member’s needs.
There is a change in the accessibility of the AMH+, CMA, BH I/DD Tailored Plan or care manager, including but not limited to the following:
The organization or care manager moves to a location that is not convenient for the member.
There is a significant change in the hours the AMH+ practice or CMA is open, and the member cannot reasonably meet during the new hours.
There is a significant change in the hours the care manager is available, and the member cannot reasonably meet during the new hours.

Engagement in Tailored Care Management:
1. Q: BH I/DD Tailored Plans will be required to make payments for Tailored Care Management only for members who are actively engaged in the model. How is actively engaged in the model defined? Will providers be able to bill Medicaid for just mailing letters for those with low acuity?

A: Active engagement in Tailored Care Management is defined as a member receiving at least one of the six core Health Home services in that month: 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. CMS guidance on the core Health Home core service definitions and related activities can be found at the following website: https://www.medicaid.gov/sites/default/files/2020-02/health-homes-section-2703-faq.pdf. The BH I/DD Tailored Plan RFA will provide additional information on these services in the context of Tailored Care Management.

Providers will not be able to bill Medicaid just for mailing letters to low acuity members.

2. Q: Can the Department please clarify how this is being defined and what tasks will be considered engagement when care management (done by any entity) is conducting outreach to members?

A: Active engagement in Tailored Care Management is defined as a member receiving at least one of the six core Health Home services in that month: 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. CMS guidance on the core Health Home core service definitions and related activities can be found at the following website: https://www.medicaid.gov/sites/default/files/2020-02/health-homes-section-2703-faq.pdf. The BH I/DD Tailored Plan RFA will provide additional information on these services in the context of Tailored Care Management.

3. Q: Can the Department provide a specific definition of the term “actively engaged” as used at Section III.5 of the Tailored Care Management Provider Manual, i.e. “BH I/DD Tailored Plans will be required to meet annual targets established by the Department for the percentage of members actively engaged in

Tailored Care Management via certified AMH+ practices and CMAs."

A: Active engagement in Tailored Care Management is defined as a member receiving at least one of the six core Health Home services in that month: 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. CMS guidance on the core Health Home core service definitions and related activities can be found at the following website: https://www.medicaid.gov/sites/default/files/2020-02/health-homes-section-2703-faq.pdf. The BH I/DD Tailored Plan RFA will provide additional information on these services in the context of Tailored Care Management.

The BH I/DD Tailored Plan RFA will provide additional information about the Department's methodology for calculating progress towards annual targets for the percentage of members actively engaged in Tailored Care Management via certified AMH+ practices and CMAs.

Care Management Comprehensive Assessment:

1. Q: With respect to the statement "When the member's circumstances, needs, or health status changes significantly;" referenced at Section V.4.3 of the Tailored Care Management Provider Manual, is the definition of "significantly" directly tied to the list of triggering events listed on page 20?

A: The Department will not define what constitutes a member's circumstances or health status changing significantly. The care manager, in consultation with the care team, will be required to take an individualized, person-centered approach for determining what changes to members' circumstances, needs or health status require a reassessment (e.g., a natural disaster that causes temporary displacement from home). The triggering events described in the Tailored Care Management Provider Manual are other examples of significant changes.

2. Q: With respect to the "Cultural considerations (ethnicity, religion, language, reading level, health literacy, etc.);" referenced at Section V.4.3 of the Tailored Care Management Provider Manual, NCQA reviews and scores each of those items separately, except for religion. Will the process be the same in Tailored Care Management?

A: No, the Department will not be assessing how the provider organization intends to implement each required component of the care management comprehensive assessment.

Clinical Consultants:

1. Q: The document [Tailored Care Management Provider Manual] states on page 16, section 3.2. Clinical consultants. The BH I/DD Tailored Plan will be required to ensure that organizations providing Tailored Care Management (AMH+ practices, CMAs, or the BH I/DD Tailored Plan itself) have access to clinical consultants in order to access expert support appropriate for the needs of the panel under Tailored Care Management. Clinical Consultants the manual says the PMPM rate will accommodate these expenses but the payment methodology is FFS- which is it a PMPM or FFS? And how much access is adequate? How is this determined per site to be met can we see the calculation included in the rate? Do we even have these types of "experts" available within all areas of the state? What is the %FTE of availability required? If this is not better defined it could end up being a contract only with no real clinical consultation at all, similar to the failed CABHA previously rolled out by the state.

A: Tailored Care Management payments will be paid to BH I/DD Tailored Plans on a per-member per-month (PMPM) basis for members actively engaged in Tailored Care Management. This PMPM payment

will account for the cost of using clinical consultants. The clinical consultants must be available to provide subject matter expert advice to the care team by phone or virtually; they are not expected to be part of the care team. The BH I/DD Tailored Plan RFA will include additional information about the assumptions around consultant availability that will be accounted for in the Tailored Care Management rates.

Other Tailored Care Management Functions:

1. Q: Care Manager Requirements: We have concerns about the care manager needing to be physically present at the time of a discharge. This may not be feasible for various reasons. We suggest that the requirement should instead focus on a comprehensive transition plan that is well understood by the member and the member's care team.

A: The Department appreciates this feedback and will take it into consideration.

2. Q: Can a BH I/DD Tailored Plan delegate medication monitoring and medication reconciliation to a pharmacy benefit manager (PBM) as long as information is shared with BH I/DD Tailored Plan/CMA/AMH+? We believe this will be a more cost effective approach.

A: No, delegating medication monitoring and reconciliation to a Pharmacy Benefit Manager does not meet the Tailored Care Management requirements because it does not promote whole-person care.

Innovations Waiver:

1. Q: Can the Department provide more specificity about the roles and responsibilities related to Innovations care management between the MCO and the care management provider? For example, with respect to home modification/ vehicle adaptation, will the BH I/DD Tailored Plan or the provider be responsible for arranging for the work, performing inspections, etc.?

A: For Innovations waiver enrollees, care managers will be responsible for roles that care coordinators play today, regardless of whether the care manager is employed by a BH I/DD Tailored Plan, AMH+ practice, or CMA.

Payment and Billing:

1. Q: What is the state's expectation of how the MCO will bill them for the care management PMPM i.e., "paper" invoice, electronic file?

A: Additional information on billing for Tailored care management will be released later.

2. Q: What is the expectation to get this payment to the AMH+/CMAs i.e., will it be a manual process, or an electronic 820 file generated, or up to each individual MCO?

A: Additional information on method of payment will be released later.

Care Management Training:

1. Q: Can the required Tailored Care Management trainings be pre-recorded and accessible through a learning management system? This need for this will become particularly relevant for training new care managers after BH I/DD Tailored Plans are live and the bulk of initially hired care mangers have already been trained.

A: Yes, pre-recorded trainings accessible through a learning management system will be permitted. Prior to BH I/DD Tailored Plan launch, all BH I/DD Tailored Plans will need to submit to the Department their Tailored Care Management training approach, including training modalities, as part of their Care Management Policy.

2. Q: Given the likely turnover for provider care management staff, will there be requirements for how often BH I/DD Tailored Plans must offer training on core modules and will the cost of that frequency be taken into consideration in rate setting?

A: The BH I/DD Tailored Plan will be required to ensure that care management staff are fully trained on the required curriculum within 30 days of deployment. Care management staff will be required to complete certain trainings prior to deployment and others within 30 days of deployment. Training costs will be accounted for in the Tailored Care Management rates.

<u>Alignment with NCQA Accreditation Criteria:</u>
1. Q: On page 5 [of the Tailored Care Management Provider Manual] the Department will require BH I/DD Tailored Plans to contract with all certified AMH+ practices and CMAs in each region for Tailored Care Management, similar to the current requirement on Standard Plans to contract with all Tier 3 AMHs. So this means the requirement under NCQA CR7A will not be able to be completed as required per our NCQA accreditation. How does the state intend to address this for Tailored Plans?

A: The Department recognizes this issue is a concern and is working with NCQA to identify a solution. When the Department reaches a resolution with NCQA, we will release additional guidance.

2. Q: Will the AMH+ and CMAs be required to meet the same criteria for communication as BH I/DD Tailored Plans must meet? Also, there are some very specific things that are required to be communicated to members that receive behavioral health services per NCQA accreditation, what is the requirement on this for these organizations who are not NCQA accredited but required for BH I/DD Tailored Plan to use?

A: No, as organizations providing Tailored care management, AMH+ practices and CMAs will not be required to meet the same communication requirements as the BH I/DD Tailored Plans in their capacity as health plans. The Department will work closely with BH I/DD Tailored Plans on the interaction of NCQA accreditation with Tailored Care Management.

3. Q: If the Department intends to hold BH I/DD Tailored Plans responsible for implementing Tailored Care Management within their regions, why are we limited in our scope, i.e. prohibited from completed pre-delegation reviews? That seems to be a conflictual message.

A: With this policy, the Department is aiming to mitigate reporting burden on providers. The Department is in communication with NCQA regarding issues related to accreditation.

4. Q: The Department will require each Corrective Action Plan (CAP) process to give a minimum of 30 days to remediate any identified issues, although the parties may establish longer remediation periods by mutual agreement. In some instances, allowing 30 days to correct an issue may place the organization at risk as it relates to accreditation status. I suggest this be re-worded or reconsidered as content.

A: The Department recognizes this issue is a concern and is working with NCQA to identify a solution. When the Department reaches a resolution with NCQA, we will release additional guidance.

System of Care:

1. Q: Our next concern relates to the following statement in footnote 13 [of the Tailored Care Management Provider Manual] at Section IV.1, "The North Carolina System of Care framework was developed to address the unique needs and challenges of children and youth with behavioral health needs. Children and youth with behavioral health needs are at increased risk of experiencing gaps in care because they often receive services from multiple systems (including health, education, child welfare, and juvenile justice); are more likely to transition between Standard Plans and BH I/DD Tailored Plans as their diagnoses change; their acuity changes with age; and their access to services may be impacted as they age out of school-related services. Effective care plans or ISPs must reflect both the needs of the child and his or her family." Given that different plans can have different System of Care strategies, etc., how will this approach support continuity of care?

A: The Department appreciates this question and will consider it as part of future care management design.

Data Requirements and HIT:

1. Q: The Tailored Care Management Provider Manual] says that AMH+ and CMAs, etc. will be expected to comply with all federal, state, and Department privacy and security requirements regarding the collection, storage, transmission, destruction, and use of data including Medicaid claims and encounters. Who will be identified to assess this and make the determination that they comply? Will providers also be required to have SOC 2 or HITRUST certifications? If not, this will have a negative impact on the ability of BH I/DD Tailored Plan to maintain these credentials.

A: AMH+ practices and CMAs will be expected to comply with all federal, state, and Department privacy and security requirements. Entities contracting with these providers will be responsible for ensuring necessary systems and protocols are in-place to securely collect, store, use, and transmit claims, encounter, and clinical data, among other data types that may be exchanged.

2. Q: If we choose to allow CMAs and/or AMH+ to use our CM Platform, are we able to charge them for use of these tools?

A: Yes, BH I/DD Tailored Plans will be permitted to charge CMAs and AMH+ practices for use of the BH I/DD Tailored Plan's care management platform or other IT infrastructure.

3. Q: Data Systems: We also appreciate the Department will allow AMH+ practices and CMAs to use the BH I/DD Tailored Plan's IT products as needed to meet the care management data system requirements. We believe this will help these entities meet these requirements sooner and more efficiently, however we still support that BH I/DD Tailored Plans should be permitted to negotiate a withhold for the use of the BH I/DD Tailored Plans' care management platform or other needed IT infrastructure. Please confirm that the Department will allow for this.

A: BH I/DD Tailored Plans will be permitted to charge CMAs and AMH+ practices for use of the BH I/DD Tailored Plan's care management platform or other IT infrastructure.

4. Q: The Standard Plan RFP stated that "The Department is currently developing a process for overseeing and updating data specification guidance for the AMH program, including through the Data

Subcommittee of the AMH Technical Advisory Group. Upon procurement of the BH I/DD Tailored Plans, the Department expects to engage AMH+ practices, CMAs and CINs involved in Tailored Care Management as part of this process." Can DHHS provide more information about the data format, frequency and level of standardization for care plans - for example, 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. To appropriately prepare an RFA response, it would be helpful to have further details about the exchange of data with CINs and AMHs and CMAs.

A: The Department will provide information on data standardization engagement opportunities in the coming months. The Department has engaged providers and Standard Plans in preparation for Standard Plan implementation and anticipates doing something similar with AMH+/CMA providers and BH I/DD Tailored Plans.

5. Q: Similarly, in response to our previous question about whether the Department will "ensure access to real time law enforcement/criminal justice and DJJ data feeds (e.g., through NC Health Connex) for related data, since these issues are defined triggers for complex care management assessment and re-assessment", the Department responded that it "is exploring ways to provide access to these data sources." Can you provide further detail about this exploration and/or include LME/MCOs in the planning and discussion around this data sharing?

A: The Department is continually working to improve connections within the justice system at all of the key intercepts. The Department will include the LME/MCOs in future discussions around data needs and operationalizing any data-sharing agreements.

6. Q: How will the Department ensure that NC HealthConnex (or other sources of ADT data) is ready to widely support Medicaid Transformation (e.g., making a twice daily, reliable, detailed feed available to all PHPs, AMH+s and CMAs)? When will this feed become available?

A: The Department encourages all organizations seeking to use NC HealthConnex data and services to contact NC HealthConnex about the frequency and completeness of data.