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TRANSFORMATION
TODAY & TOMORROW

Care Management under the BH/IDD Tailored Plan

CENTER *for* INTEGRATIVE HEALTH
insight to innovation

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Agenda for today

Introductions

Review the NC DHHS plan for care management under the BH/IDD Tailored Plan

Identify the difference between an AMH+ and a Care Management Agency

Review the key business components needed to offer care management services

Identify next steps for your organization

From the provider perspective…

Your speakers today

- Kelsi Knick, NC DHHS
- Ben Millsap, Cansler Collaborative Resources
- Daniel Brown, Cansler Collaborative Resources
- Provider Panel
  - Natasha Holley, Integrated Family Services
  - Jerold Greer, Daymark
  - Renee White, Carolina Outreach
  - Craig Bass, Alexander Youth Network





NC Department of Health and Human Services

Behavioral Health & Intellectual and Developmental Disability Tailored Plan and Tailored Care Management Design

Kelsi A. Knick, MSW, LCSW
Senior Program Manager, Population Health

December 6, 2019

Agenda

- **Publications**
- **Care Management Guiding Principles**
- **Advanced Medical Homes**
- **Tailored Care Management Model**
- **Becoming an AMH+ or CMA**

Publications

Tailored Care Management Paper

On May 29, 2019, North Carolina's Department of Health and Human Services released "North Carolina's Care Management Strategy for Behavioral Health and Intellectual/Developmental Disability Tailored Plans."

The paper provides an overview of the Tailored Care Management design developed to date, including:

- Guiding principles
- Transition to whole-person care management
- Federal Health Home structure
- Provider-based care management
- Care management process flow
- Care manager qualifications and training
- Conflict-free care management
- Payment for care management

BH I/DD Tailored Care Management Data Strategy

On September 12, 2019, North Carolina's Department of Health and Human Services released "North Carolina's Data Strategy for Tailored Care Management ."

The paper provides an overview of the BH I/DD Tailored Care Management data strategy design developed to date, including:

- Enrollment
- Behavioral Health I/DD Tailored Plan Population Health Management & Risk Stratification
- Care Management Assignment & Engagement into Care Management
- Care Management Comprehensive Assessment
- Practice-level Risk Stratification
- Care Team Formation and Person-centered Care Planning
- Ongoing Care Management

Statement of Interest

On September 18, 2019, North Carolina's Department of Health and Human Services released "Non-binding Statement of Interest"

- This document is for potential Advanced Medical Homes Practices and Care Management Agencies
- Provides opportunity for providers who are interested to inform the Department
- Strongly encourage those interested to apply
- The Statement of Interest will ask potential AMH+ and CMAs to provide:
  - Location/Region
  - Experience/expertise (I/DD, MH, SU, TBI or combination)
  - Anticipated patient/client volume
  - Questions for the Department

DHHS received 67 Statement of Interest from across the state.

Tailored Care Management Provider Manual

Coming soon, North Carolina's Department of Health and Human Services will release a provider facing manual on how to become a AMH+ or CMA.

The manual will include:

- A description of the Tailored Care Management model and the functions AMH+ practices and CMAs will be expected to perform
- Criteria for AMH+ and CMA certification
- Process and timeline for certification
- Preliminary information about payment
- Information about AMH + and CMA oversight after the launch of BH I/DD Tailored Plans

Integration of Care

Medicaid Transformation Vision

"To improve the health of North Carolinians through an innovative, whole-person centered, and well-coordinated system of care which addresses both medical and non-medical drivers of health."

Standard Plans and BH I/DD Tailored Plans

Both Standard Plans and BH I/DD Tailored Plans will be integrated managed care products and will provide a robust set of physical health, behavioral health, long-term services and supports, and pharmacy benefits.

Standard Plans

- Will serve the majority of the non-dual eligible Medicaid population

BH I/DD Tailored Plans

- Targeted toward populations with:
  - significant behavioral health conditions—including serious mental illness, serious emotional disturbance, and substance use disorders
  - intellectual and developmental disabilities (I/DD), and
  - traumatic brain injury (TBI)
- Will offer a more robust set of behavioral health and I/DD benefits than Standard Plans and will be the only plans to offer current 1915(b)(3), 1915(c) Innovations and TBI waiver, and State-funded services

What is a BH/IDD Tailored Plan (TP)?

North Carolina will launch specialized managed care plans, called BH/IDD Tailored Plans, starting in 2021; design of these plans is just beginning.

Key Features of BH/IDD Tailored Plans:

- TPs are designed for those with significant behavioral health (BH) needs and/or intellectual/developmental disabilities (I/DDs)
- TPs will also serve other special populations, including Innovations and Traumatic Brain Injury (TBI) waiver enrollees and waitlist members
- TP contracts will be regional, not statewide
- LME-MCOs are the only entities that may hold a TP contract during the first four years; after the first four years, any non-profit PHP may also bid for and operate a TP
- LME-MCOs operating TPs must contract with an entity that holds a prepaid health plan (PHP) license and that covers the same services that must be covered under a standard benefit plan contract
- TPs will manage State-funded behavioral health, I/DD, and TBI services for the uninsured and underinsured

BH I/DD Tailored Plan Benefits

BH I/DD Tailored Plans will cover additional services targeted toward individuals with significant behavioral health, I/DD, and TBI needs.*

Behavioral Health, I/DD, and TBI Services Covered by Both Standard Plans and BH I/DD Tailored Plans	Behavioral Health, I/DD and TBI Services Covered Exclusively by BH I/DD Tailored Plans (or LME-MCOs Prior To Launch)
Enhanced behavioral health services are italicized	
State Plan Behavioral Health and I/DD Services • Inpatient behavioral health services • Outpatient behavioral health emergency room services • Outpatient behavioral health services provided by direct-enrolled providers • *Partial hospitalization* • *Mobile crisis management* • *Facility-based crisis services for children and adolescents* • *Professional treatment services in facility-based crisis program* • *Outpatient opioid treatment* • *Ambulatory detoxification* • *Research-based intensive behavioral health treatment* • *Diagnostic assessment* • Early and periodic screening, diagnostic and treatment (EPSDT) services • *Non-hospital medical detoxification* • *Medically supervised or ADATC detoxification crisis stabilization*	**State Plan Behavioral Health and I/DD Services** • Residential treatment facility services for children and adolescents • *Child and adolescent day treatment services* • *Intensive in-home services* • *Multi-systemic therapy services* • *Psychiatric residential treatment facilities* • *Assertive community treatment* • *Community support team* • *Psychosocial rehabilitation* • *Substance abuse non-medical community residential treatment* • *Substance abuse medically monitored residential treatment* • Intermediate care facilities for individuals with intellectual disabilities (ICF/IID) **Waiver Services** • Innovations waiver services • TBI waiver services • 1915(b)(3) services **State-Funded behavioral health and I/DD Services** **State-Funded TBI Services**

*DHHS plans to submit a State Plan Amendment to add the following services to the State Plan:

- Peer supports and clinically managed residential withdrawal (to be offered by both Standard Plans and BH I/DD Tailored Plans); and
- Clinically managed low-intensity residential treatment services and clinically managed population-specific high-intensity residential programs (to be offered by BH I/DD Tailored Plans only).

Side by Side	Standard Plans	Tailored Plans
Scope	Fully integrated Care	Fully Integrated Care
Entity	Prepaid Health Plans	Prepaid Health Plan
Waiver Type	1115	1115[4]
Procurement	Competitive RFP	Request for Application (RFA) to existing LME-MCOs[5]
Contracting	Accept any willing provider	Any willing provider- physical health Closed network – behavioral health
Plans available to beneficiaries	4 statewide & 1 regional	1 per region[6]
Additional Services/Funding	In-lieu & value added services	Innovations, TBI In-lieu, value added, State-funded, Federal and State Block Grants, current (b)(3), a subset of the more intensive behavioral health enhanced services

[4]The (c) waivers which currently operates under the 1915(b) waiver, will after Tailored Plan go live, operate under the 1115 waiver
[5]After initial four-year contract term, competitive RFP for Tailored Plans
[6]unless beneficiary makes an informed choice to go to SP

Key Differences: LME-MCOs and BH/IDD Tailored Plans

	CURRENT	FUTURE
Scope	Behavioral Health, IDD.TBI	Behavioral Health, IDD,TBI Physical Health, Pharmacy
Entity	Pre-paid Inpatient Health Plan	Prepaid Health Plan
Waiver Type	1915(b)(c)[3]	1115 [3]
Health Home	Does not exist in LME-MCOs	New Tailored Plan Health Home care management model
Designation	LME-MCOs as designed in current legislation	Tailored Plans selected based on requirements in RFA
Organization Type	Local political subdivisions	To be determined

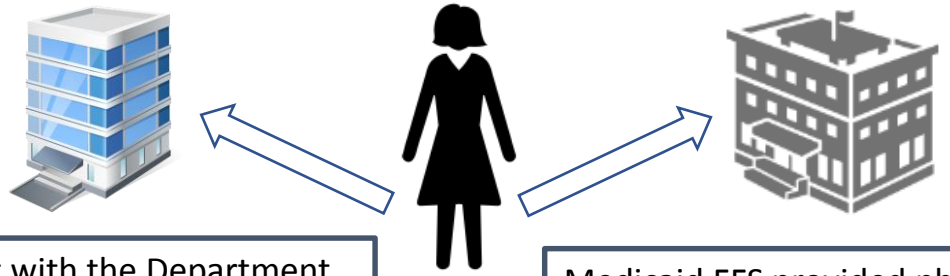
[3] Includes Innovations, TBI waiver; with managed care implementation the (c) waiver will operate under the 1115

Care Management Guiding Principles

Transition to Whole-Person Care

With the managed care transition, both types of managed care products—Standard Plans and BH I/DD Tailored Plans—will offer integrated, whole-person care.

Historical Environment

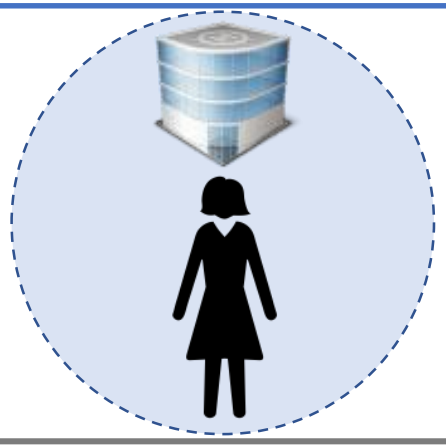


Per contract with the Department, LME-MCOs provided BH, I/DD and TBI services

Medicaid FFS provided physical health services

Managed Care Environment

PHPs will provide whole-person care



BH I/DD Tailored Care Management Model

Key Principle: Behavioral and physical health are integrated through the care team.

Overarching Principles

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

Roles and Responsibilities of Care Managers

- Management of rare diseases and high-cost procedures
- Management of beneficiary needs during transitions of care
- High-risk care management
- Chronic care management
- Management of high-risk social environments
- Identification of beneficiaries in need of care management
- Development of care management assessments/care plans
- Development & deployment of prevention and population health programs
- Coordination of services

Advanced Medical Homes

Introduction to the AMH Program

The AMH program is a key vehicle for achieving integrated, whole-person care and local care management in North Carolina.

Vision for AMH in Managed Care

*Build on the Carolina ACCESS program to **preserve broad access to primary care services** for Medicaid enrollees and **strengthen the role of primary care in care management, care coordination, and quality improvement** as the state transitions to managed care*

Today's Carolina ACCESS primary care practices* have <u>options</u>:

- Current primary care practices in Carolina ACCESS program may **continue into AMH with few changes ("Tier 1" and "Tier 2")**
- Practices ready to take on more advanced care management functions may **attest into AMH "Tier 3"****
  - Tier 3 practices may rely on **in-house care management** capacity or **contract with a Clinically Integrated Network (CIN) or other partner of their choice**
  - Unlike in Carolina ACCESS, **practices <u>ARE NOT</u> be required to contract with Community Care of North Carolina (CCNC) to participate in AMH**

*Eligibility for AMH mirrors the legacy Carolina ACCESS program and includes general practice, family practice, internal medicine, pediatrics, OB/GYN, psychiatry and neurology

Overview of the AMH Program

The AMH Program will serve as the primary vehicle for delivery of local care management under Medicaid managed care.

Tiers 1 and 2

- PHP retains primary responsibility for care management
- Practice requirements are the same as for Carolina ACCESS
- **Practices will need to interface with multiple PHPs**, which may employ different approaches to care management

AMH Payments

- **PMPM Medical Home Fees**
  - Same as Carolina ACCESS
  - Minimum payment floors

Tier 3

- PHP delegates primary responsibility for care management to the AMH
- Practice must meet all Tier 1 and 2 requirements, plus additional Tier 3 care management responsibilities
- Practices will have the option to **provide care management in-house** or **through a single CIN/other partner** across all Tier 3 PHP contracts

*PHPs should **attempt to contract with all certified Tier 3 AMHs***

AMH Payments

- **PMPM Medical Home Fees**
  - Same as Carolina ACCESS
  - Minimum payment floors
- **PMPM Care Management Fees**
  - Negotiated between PHP and practice
- **Performance Incentive Payments**
  - Negotiated between PHP and practice
  - Based on AMH measure set

Note: Tier 4 will launch on a later date and will allow practices to enter more innovative, advanced payment arrangements.

Practice Requirements: Tiers 1 and 2

Practice requirements for Tiers 1 and 2 are the same as requirements for Carolina ACCESS practices

Requirements for AMH Tiers 1 and 2

1. Perform **primary care services** that include certain preventive & ancillary services**
2. Create and maintain a **patient-clinician relationship**
3. Provide direct patient care a **minimum of 30 office hours per week**
4. Provide access to medical advice and services **24 hours per day, seven days per week**
5. **Refer to other providers** when service cannot be provided by PCP
6. Provide **oral interpretation for all non-English proficient beneficiaries and sign language** at no cost

Deep Dive on Tier 3 AMHs

Tier 3 AMHs are responsible for delivering care management at the practice level, including all Tier 1 and 2 requirements in addition to the following:

Tier 3 Responsibilities

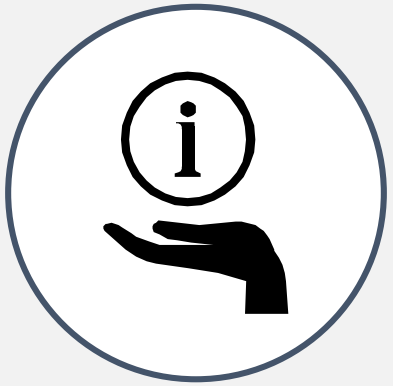
- **Risk stratify** all empaneled patients
- Provide **care management to high-need patients,** which includes (but is not limited to):
  - Conducting a **comprehensive assessment** of enrollees' needs
  - Establishing a **multi-disciplinary care team** for each enrollee
  - Developing a **care plan** for each enrollee
  - **Coordinating all needed services** (physical health, behavioral health, social services, etc.)
  - Providing **in-person assistance securing unmet resource needs** (e.g. nutrition services, income supports, etc.)
  - Conducting medication management, including regular medication reconciliation and support of medication adherence
  - Providing **transitional care management** as enrollees change clinical settings
- **Receive claims data feeds** (directly or via a CIN/other partner) and meet state-designated **security standards** for their storage and use

Tailored Care Management Model

Rationale for Tailored Care Management Model

The Tailored Care Management model is a pathway to ensuring BH I/DD Tailored Plan beneficiaries have access to the best whole-person care possible.

- **All BH I/DD Tailored Plan beneficiaries need integrated, whole-person care management.**
- **Provider-based care management** promotes **integrated care** and offers beneficiaries **choice** in how they receive care management.*
- **Community-based care management** facilitates frequent **face-to-face** interaction between beneficiaries and their care managers, who will live and work in the same communities as the individuals they serve.
- **All BH I/DD Tailored Plan beneficiaries should have access to consistent, high-quality care management regardless of geography or where their care manager is employed.**



*Beneficiaries will be able to switch care managers at any time.

Overview of Tailored Care Management Approach

Department of Health and Human Services

Establishes care management standards for BH I/DD Tailored Plans aligning with federal Health Home requirements

The BH I/DD Tailored Plan will act as the Health Home and will be responsible for meeting federal Health Home requirements

BH I/DD Tailored Plan Health Home

Care Management Approaches

BH I/DD Tailored Plan beneficiaries will have the opportunity to choose among the care management approaches; all must meet the Department's standards and be provided in the community to the maximum extent possible.

Approach 1:
"AMH+" Primary Care Practice
Practices must be certified by the Department to provide Tailored Care Management.

Approach 2:
Care Management Agency (CMA)
Organizations eligible for certification by the Department as CMAs include those that provide BH or I/DD services.

Approach 3:
BH I/DD Tailored Plan-Employed Care Manager

The Department anticipates allowing—but not requiring—CMAs and AMH+ practices to work with a **CIN or other partner** to assist with the requirements of the Tailored Care Management model, within the Department's guidelines.

Glide Path to Provider-based Care Management

Tailored Care Management will require a multiyear effort to enhance the workforce at the AMH+ and CMA level. The Department will establish a "glide path" to guide the growth of provider-based capacity.

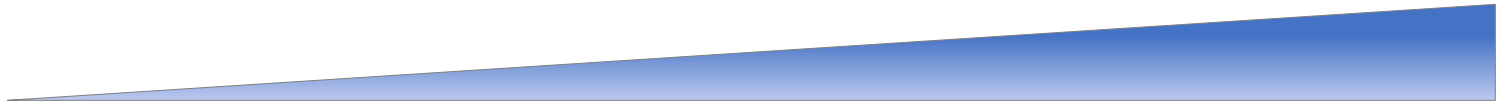
Numerator: Number of enrollees actively engaged in care management **and served by care managers based in CMAs/AMH+ practices**

Denominator: **Total** number of beneficiaries actively engaged in care management

x 100 = **X%**

Department will compare X to annual targets:

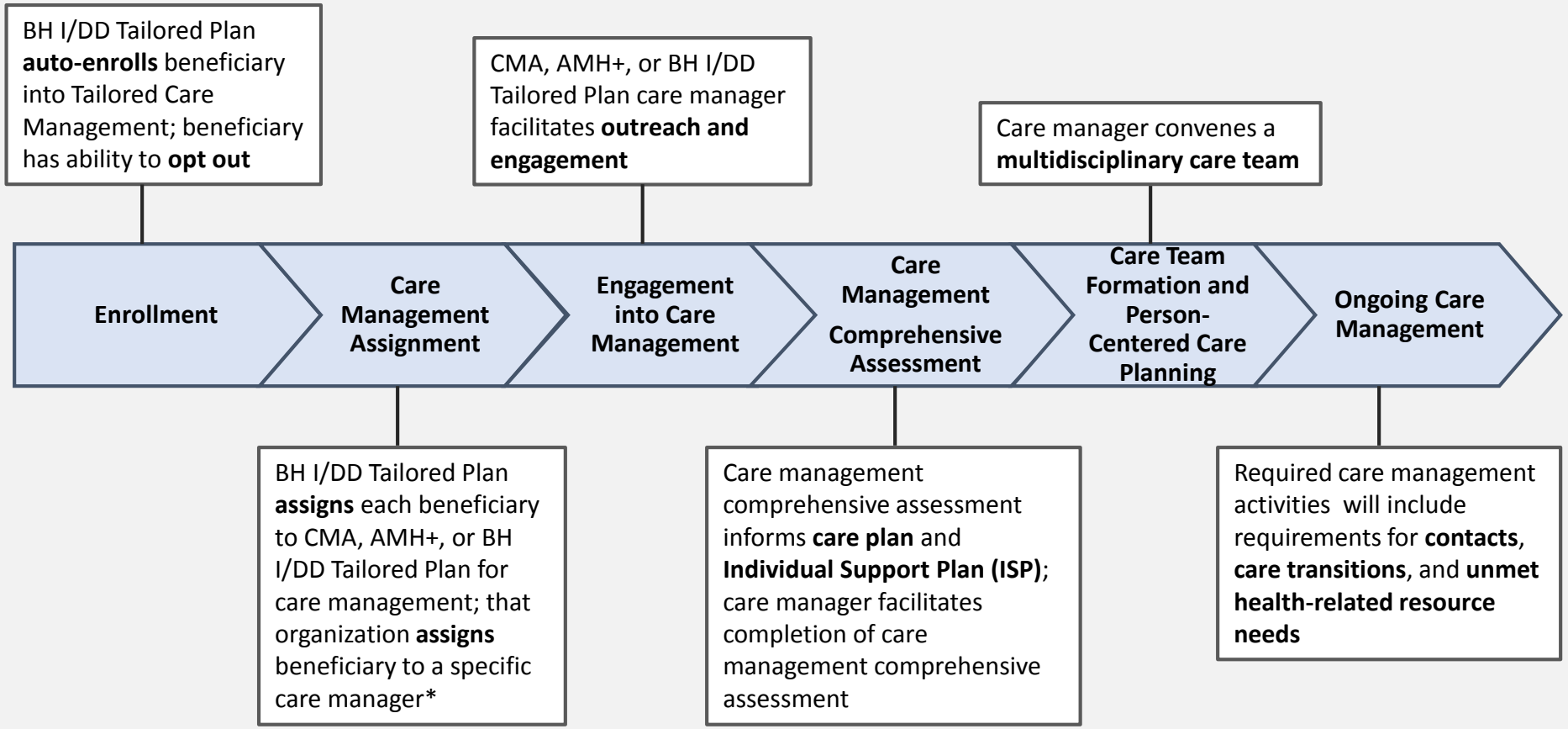
	Year 0 (May 2020)	Year 1 (Mid 2021)	Year 2 (Mid 2022)	Year 3 (Mid 2023)	Year 4 (Mid 2024)
Target percentage of beneficiaries served by care managers/ supervisors based in CMA/AMH+	**N/A**	**Target 1**	**Target 2**	**Target 3**	**Target 4 = 80%**



The Department believes that provider- and community-based care management is critical to the success of fully integrated managed care.

Care Management Process Flow

Care management design aligns with Standard Plan requirements to the greatest extent possible, but in several areas the Department is building special guardrails to meet the unique needs of the BH I/DD Tailored Plan population.



*Innovations and TBI waiver beneficiaries will have the choice of keeping their current care coordinators if the care coordinators meet all of the care manager requirements to serve BH I/DD Tailored Plan beneficiaries and federal requirements for conflict-free case management.

Acuity Tiering and Contact Requirements

The Department plans to establish a standardized methodology for determining acuity of each beneficiary based on claims history.

Acuity Tiers

- Beneficiaries will be placed into high, moderate, or low acuity tiers
- Acuity tiers will be used to guide payment levels
- Acuity tiers will also be used to guide minimum required levels of contact between care managers and beneficiaries
  - *As market experience with the model grows, the Department may transition away from these contact requirements to increase the focus on outcomes, to the extent allowed by federal Health Home requirements*

In recognition of the complex needs of the BH I/DD Tailored Plan population, the Department will also require that care managers and supervisors serving this population possess a **minimum set of qualifications**. (*see paper for details*)

Acuity Tiering and Contact Requirements

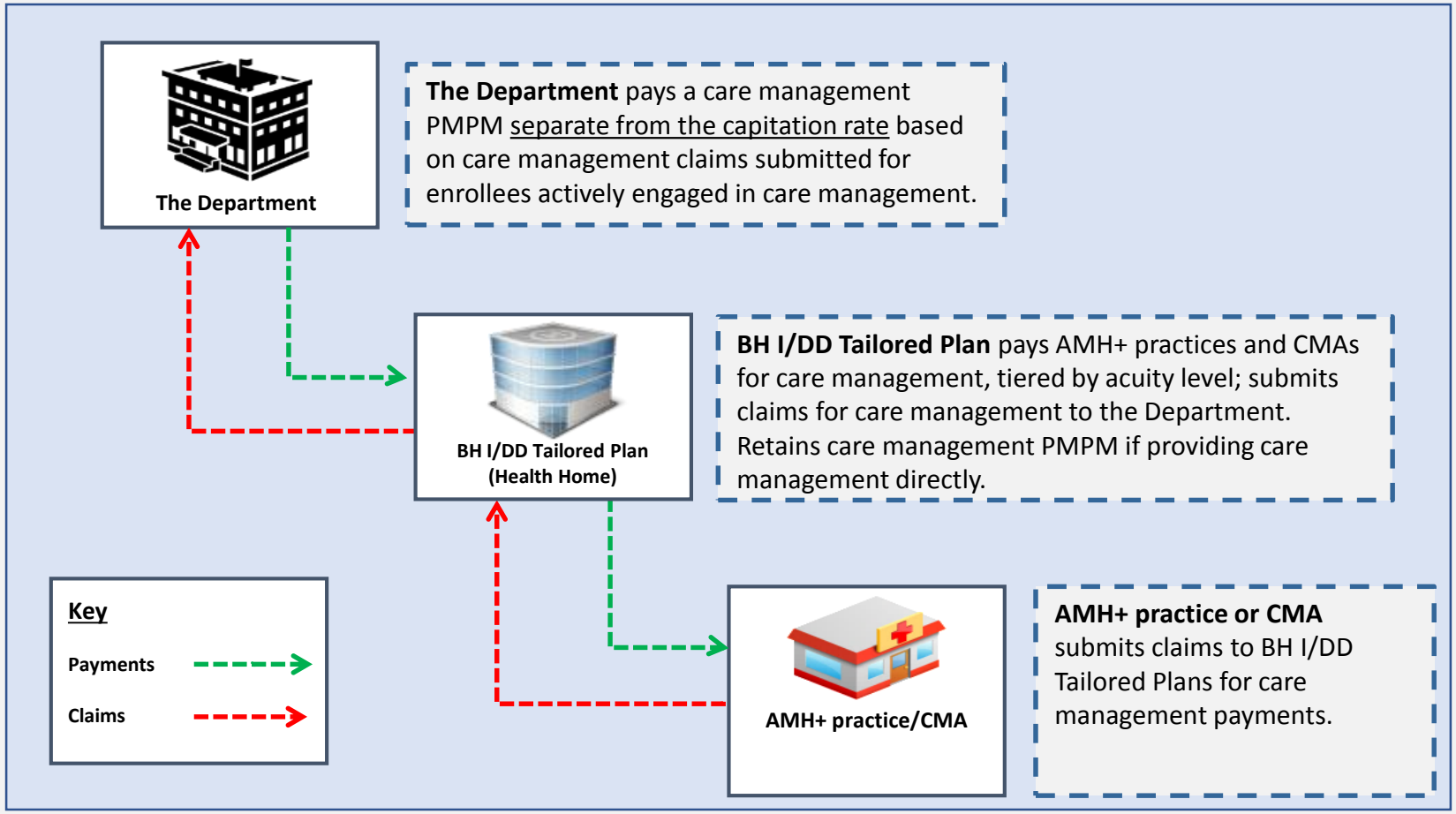
The Department plans to establish a standardized methodology for determining acuity of each beneficiary based on claims history, which will be used to guide payment levels as well as minimum required levels of contact between care managers and beneficiaries.

Contact Requirements			
	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 assessment)	At least 2 contacts per month and 2 in-person beneficiary contacts per year (includes care management 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 assessment)	At least 2 in-person beneficiary contacts per year (including care management assessment) and 1 telephonic contact per month

As market experience with the model grows, the Department may transition away from these contact requirements to increase the focus on outcomes, to the extent allowed by federal Health Home requirements

Payment for Care Management

Tailored Care Management payments will be subject to set minimum rates that are tiered by beneficiary acuity and, generally, *significantly higher* than Standard Plan care management rates.



Care Team 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 with LTSS needs: 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, in addition to the requirements cited above
Supervising care managers serving beneficiaries with behavioral health disorders	▪ A Licensed Clinical Social Worker (LCSW) or Licensed Professional Counselor (LPC), Licensed Psychological Associate (LPA) 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, and ▪ Five years of supervisory experience working directly with complex individuals with I/DD or TBI ▪ Or, a master's degree in a human services field with three years of supervisory experience working directly with complex individuals with I/DD or TBI

Quality

BH I/DD Tailored Plans will be required to report measures that assess whole-person outcomes.

Federal Health Home Quality Measures

- Adult Body Mass Index (BMI) Assessment
- Prevention Quality Indicator (PQI) 92: Chronic Condition Composite
- Care Transition – Transition Record Transmitted to Health Care Professional
- Follow-Up After Hospitalization for Mental Illness
- Plan All-Cause Readmission Rate
- Screening for Clinical Depression and Follow-Up Plan
- Initiation and Engagement of Alcohol or Other Drug (AOD) Dependence Treatment
- Controlling High Blood Pressure

Measures additional to the above federally-required set will be forthcoming.

Data and Health Information Technology

The Department will establish minimum requirements for HIT and data sharing.

IT Capabilities Supporting Care Management

- Manage population health
- Respond to individual beneficiary needs
- Track referrals and follow-ups
- Monitor medication adherence
- Respond to unmet health-related resource needs
- Document and store beneficiary care plans/ISPs
- Facilitate “warm hand-offs” of beneficiaries between plans, care managers, and care settings, as needed
- Interface with NCCARE360

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, contents, triggers, and transmission methods for critical data exchanges.

Becoming an AMH+ or CMA

Summary: AMH+/CMA Certification Process

To be certified as an AMH+/CMA a provider must:

- Meet eligibility definitions
- Show appropriate organizational standing or expertise
- Show appropriate staffing
- Demonstrate the ability to deliver all the required elements of whole-person, multidisciplinary, integrated care management
- Meet HIT and Population Health Data Requirements
- Participate in required training (after initial certification)

Eligibility

Advanced Medical Home Plus (AMH+)

Definition: Primary care practice certified by the Department as an AMH Tier 3 that has **experience delivering primary care services to the BH I/DD Tailored Plan eligible population in North Carolina, or can otherwise demonstrate strong competency to serve that population,** and will hold primary responsibility for providing integrated, whole-person care management under the Tailored Care Management model Details on AMH Tier 3 attestation can be found in the AMH Provider Manual.

To be eligible to become an AMH+, the practice must intend to become a network primary care provider for BH I/DD Tailored Plans.

Care Management Agency (CMA)

Definition: Provider organization with **experience delivering behavioral health, I/DD and/or TBI services** to the BH I/DD Tailored Plan eligible population in North Carolina that will hold primary responsibility for providing integrated, whole-person care management under the Tailored Care Management model.

To be eligible to become a CMA, an organization must have as its **primary purpose the delivery of NC Medicaid, NC Health Choice or state-funded services,** other than care management, to the BH I/DD Tailored Plan eligible population in North Carolina.

What is a CIN/Other Partner?

A "CINs or Other Partner" is an organization with which an AMH+ or CMA may be affiliated, that helps the AMH+ or CMA meet the requirements of the model. The AMH model under Standard Plans already incorporates CINs/Other Partners.

How can CINs/Other Partners Serve AMH+s/CMAs?

- Providing **local care management** staffing, functions and services
- Supporting **AMH analytics and data integration** from multiple PHPs and other sources, and providing actionable reports to AMH+s/CMAs
- **Assisting in the contracting process or directly contracting with BH I/DD Tailored Plans** on behalf of AMH+s/CMAs

- CINs/other partners may include hospitals, health systems, integrated delivery networks, IPAs, care management organizations and technology vendors
- **The Department is considering adding guardrails around care management staff organized at the CIN/Other Partner level:**
  - Majority of membership/board must be providers
  - AMH+ or CMA must have managerial control of staff

Organizational Standing

- Relevant experience
- Provider relationships and linkages
- Capacity and sustainability
- Oversight

Delivery of Tailored Care Management Services

- Policies and procedures for communication with members
- Capacity to engage members through frequent contacts
- Care management comprehensive assessment
- Sharing of comprehensive assessment results
- Reassessments
- Care Plans and Individual Supports Plans
- Documentation and storage of care plans
- Care teams

Required components of Tailored Care Management Services

- Care coordination
- Twenty four hour coverage
- Annual physical exam
- Continuous monitoring
- Medication management
- System of care
- Individual and family supports
- Health Promotion

Population Health and IT requirements for Tailored Care Management

- Use of Electronic Medical Record
- Use of care management documentation system
- Receive and use enrollment data to empanel the population in Tailored Care Management
- Use ADT information
- Use of NCCARE360
- Risk Stratification
- Internal quality improvement

AMH+ and CMA Certification Process

The certification process will be designed to ensure that DHHS can obtain a comprehensive view of each organization's ability to provide care management. Below is a sample timeline for certification

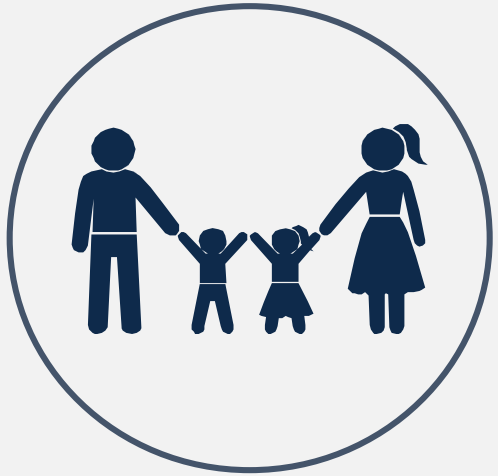
Timeframe	Application/Desk	Site Visit
February 2020	Round 1 AMH+ and CMA certification applications are due	
February –March 2020	Round 1 desk reviews and notifications are completed	
April	Round 2 AMH + and CMA certification applications are due	
April – May	Round 2 desk reviews and notifications are completed	
June- December		Site visits for Round 1 & 2 applicants
September 2020	Round 3 AMH+ and CMA certification applications are due	
November 2020	Round 3 desk reviews and notifications completed	

Reminder: Opportunities to Engage

The Department values input and feedback from stakeholders and will make sure stakeholders have the opportunity to connect through a number of venues and activities.

Ways to Participate

- Regular webinars, conference calls, meetings, and conferences
- Comments on periodic white papers, FAQs, and other publications
- Regular updates to website: https://www.ncdhhs.gov/assistance/medicaid-transformation



Groups The Department Will Engage

- Consumers, Families, Caregivers, and Consumer Representatives
- Providers
- Health Plans and LME-MCOs
- Counties
- General Public

Comments? Questions? Let's hear from you!

Comments, questions, and feedback are all very welcome at Medicaid.Transformation@dhhs.nc.gov

Mythbusters

Myth #1

“This isn’t going to be all that hard, it’s just good old case management like we used to do.”

Fact: Care Management is a team-based, person centered approach to effectively managing patients' medical, social and behavioral conditions

- Identification of beneficiaries in need of care management (e.g., screening, risk stratification, priority populations)
- Development of care management assessments/care plans
- Coordination of services
- Management of beneficiary needs during transitions of care
- Development and deployment of prevention and population health programs
- Management of rare diseases and high cost procedures (e.g., transplant, specialty drugs)
- 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)

Myth #2

“This is way too complicated, providers cannot do this.”

Fact: Behavioral Health / IDD providers are survivors!

- Area Authorities to MCOs (Reform)
- New service definitions (2006)
- Transformation V1 (LMEs to MCOs)
- CABHA
- TCLI/DOJ compliance

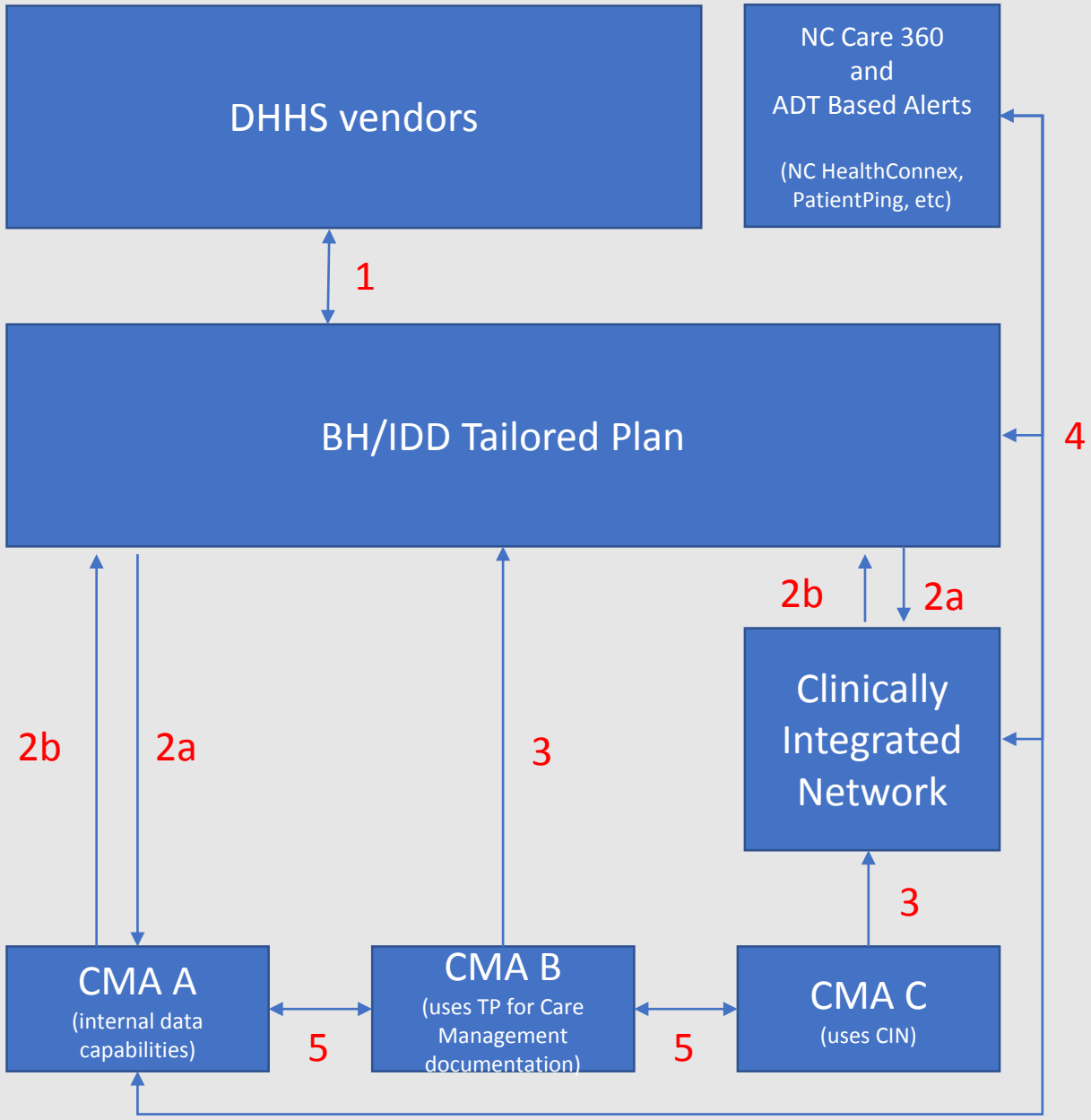
Myth #3

“We are going to be a behavioral health care management agency under the new tailored plans”

FACT: Care Management Agencies will be focused on Total Health

- Unmet health-related resource needs
- Behavioral Health (BH)
- Intellectual/Developmental Disability (I/DD)
- Substance Use (SU)
- Traumatic Brain Injury (TBI)
- Physical Health
- Pharmacy

Tailored Care Management Data Strategy Models



Tailored Care Management Data Strategy

Data Flows Outline

1. Data from NC FAST, NC TRACKS, CSRS,NCIR, HEARTS, NC CARE360
2A. Beneficiary risk scores, member information, risk stratification/scoring information, member data, medical encounter data, pharmacy data, care needs screening.
2B. Information CMA must submit to BH/IDD TP (TBD)
3. Documentation of all care management activity (care management assessment, care plan, care management documentation)
4. ADT data, SDOH Data
5. Medical Records, Care Management Assessment, other clinical data.

Definitions:

- CSRS: NC Controlled Substance Reporting System
- NCIR: NC Immunization Registry
- HEARTS:NC Healthcare Enterprise Accounts Receivable Tracking System

Go It Alone Model-CMA (A)

Strengths

- Single decision-making body/more nimble
- All data is in provider system
- Lays the groundwork for advanced APMs for provider

Challenges

- Expensive to set up
- Expensive to maintain
- Requires advanced technology infrastructure (hardware, software, and human resources)
- Requires internal data/analytics infrastructure
- Large/sophisticated enough to accept risk?

Tailored Plan as Data Partner Model—CMA (B)

Strengths

- Simple structure
- Easy set up for providers
- Cost effective for providers
- Standardized data set for LME/MCO

Challenges

- Provider may have to operate in multiple TP systems
- Data may not be readily available to provider
- Potentially more difficult path to achieve advanced APMs
- Lack of standardization: 7 different TPs may have 7 different systems

Clinically Integrated Network (CIN) as Data Partner Model—CMA C

Strengths

- All data is in CIN system and may be readily available to network providers
- Single entity to contract with for BH/IDD Tailored Plans
- Glidepath toward advanced APMs
- Spreads risk across larger population/providers

Challenges

- Multiple providers partnering together in a different way toward common goal
- Complicated legally
- Capitalizing properly

So what should providers start doing?

Identify your vision

Is this something you want to get into?

Do you have the bandwidth to do this right? How do you get the bandwidth you need?

Should you do this within some kind of partnership arrangement or go it alone?

Gather your team

Go it alone model:

This is NOT “just another program”

- Finance
- Human Resources
- Education/Training
- Information Technology
- Clinical
- Quality

Partnership Model

- Choose partners after vetting them
- Look for alignment in values
- Look for true partners

Quality Team

What can you be doing now???

What is your population?

- How many people do you serve that will be in the BH/IDD Tailored Plan who have Medicaid?
- What is the geographical spread of your population?
- How many people do you serve with chronic health conditions?
- What kinds of chronic conditions do the people you serve have?
- What are the age breakdowns and other demographics of the people you serve?

Who are the primary care providers for the people you serve?

Does your organization gather HEDIS Measures?

Education and Training

What training do you/your staff need that you can provide now that will be a value add?

Does your staff know about chronic conditions?

Need a process to ensure ongoing/continuing education requirements are completed by all involved staff

Finance

Can you bill a PMPM arrangement?

Can you monitor to ensure one of the core health home services was provided in a given month prior to billing?

Can you switch to engagement payments in your system?

Do you have systems in place to monitor the member file you will receive so you know when a new member has been assigned to you?

Information Technology

- Does your organization have the ability to receive ADT feeds?
- Can your EHR/Care Management platform push and receive data from other systems?
- Can you mine data out of your electronic health record?
- Can your care management system alert the proper care-team members of a change to an individual they support?
- Can you create a care management assessment and a care plan that meets NC standards?
- Does your system(s) meet the security requirements outlined by the state?

Clinical BH -->Whole Health

- Does your organization currently screen for chronic health conditions?
- Do you have access to vital signs, BMI, etc.?
- Have you determined how you will use the initial risk stratification information provided by the Tailored plan?
- How and what data will you use to continue to monitor the risk level of your care management population?
- Have you considered any health promotion activities?
- How do you verify referrals made are completed?
- What information will you share with primary care partners?

Formalize Partnerships

- Actively engage the partner(s) in a discussion
  - Lay out the reasons for a partnership
  - Benefits for all parties
  - Obtain initial agreement
- Determine the specific outcomes/expectations for each participant in the partnership
- Formalize the partnership (Contract, MOA, MOU, etc.)
- Develop a monitoring mechanism

Provider Panel

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Time for
Questions

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