Alliance Health

Provider Practice Transformation Academy

Alliance CMA/AMH+ Learning Collaborative Q&A

December 15, 2022 – Alliance's CMA/AMH+ Learning Collaborative

Does the TCM provider need to document in our care management platform when a person has opted out?

The opt-out forms will be uploaded in Jiva, but providers should also document the opt-out in the member's record.

How will Alliance notify us if a member has opted out?

The member will no longer appear on your beneficiary assignment file.

Can we utilize our own internal opt-out form instead of the Alliance form? We are across the entire state and feel it would be easier for our care managers to have one form instead of tracking multiple ones.

The Alliance opt-out form is standardized, and this is the form that must be used.

Can we assist members with calling Alliance to opt out instead of submitting the opt out form?

Yes.

Continued

Will the people who opt-out be removed from this upcoming file or will it be indicated on the file?

The December 18, 2022, assignment file will only show the opt-outs prior to last week (only 18); any new opt-outs will not show on the file. The TCM effective date for members who opt out will be end-dated on your daily incremental assignments.

Is the initial engagement contact with a member billable if consent for TCM has not yet been obtained?

Per the state, the initial engagement contact is billable before consent being obtained.

Can care management tasks be initiated before the assessment?

When the member has urgent or critical needs or is in crisis, care management tasks may be initiated before completing the assessment.

Are the remaining non-in-person monthly contacts required to be face-to face on video and does telephonic contact count?

Telephonic contact with the member and/or guardian (when applicable) also counts towards monthly contact

Our CM met a member at a library to do the CMCA, we billed code 99 ("Other") for the place of service and the claim was denied as invalid place of service.

The place of service for this type of contact should be billed as "Community."

As of April 1, 2023, what will CMAs/AMH+s have to do differently as far as services we provide if they are Medicaid Direct vs Tailored Plan?

There will be no differences in the provision of services or Tailored Care Management, only how the members are auto-assigned.

How can we tell if a member will be in the Tailored Plan or in Medicaid Direct?

Please see this guidance from the state: https://medicaid.ncdhhs.gov/media/11289/open.

When can we expect to get our final assignment list that we can feel confident contacting?

All CMAs/AMH+s will receive their new assignment file on December 18, 2022, and the state reports that corrections will be made on this file. However, remember that your assignment list will never truly be final as it will always be evolving and changing.

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How are assignment lists being sent to providers?

The file is sent as a pipe-delimited, double-quote file that is machine readable, so that it can be ingested into your care management platform. It will be the same format as the previous assignment files you have received.

Will we be requesting authorizations and writing plans for (i) Waiver members?

Yes, per the state's presentation on December 14, 2022, CMAs and AMH+s will be required to request authorizations for (i) Waiver (formerly (b)(3) services for their assigned members. The slide deck for this presentation can be found at https://public.3.basecamp.com/p/uiK8oKagbPaSGPCbCWgREtb9. Alliance will be facilitating a specific training on this topic and will announce when this training is available.

If we do not meet average 2 contacts, is anything billable at all? What constitutes an average?

The average is based on contacts over a period of time. Average contacts will be monitored at the full panel level, not the specific member level. Only the members who have engaged will be included in this number. CMAs/AMH+s can bill for all contacts; this monitoring is not tied to billing.

How are is the average of 2 contacts calculated? Will this be across all provider NPI numbers, or within a panel for each NPI?

The state is looking into how the average will be determined (i.e., per provider, per county/population, per NPI, etc.) and will get back to us with an answer.

When does the requirement to have an average of 2 contacts/per month start?

The clock starts for each member when you engage them, since you will not have any contacts with members who have not engaged.

The Provider Manual states that minimum contact requirements must be met unless the member has expressed preference for less and that preference is documented. Does that also apply to the in-person contact requirements?

If a member requests not to have in-person contacts, this must be documented in the member's record. This is also something that should be revisited with the member periodically.

Are there any resources/guides available on the patient risk list (PRL)? They are due on the seventh of each month but are there resources that specify how the PRL needs to be completed and what information needs to be included?

The state presented information about the PRL on Dece,ber 12, 2022, the slide deck from that presentation can be found at https://public.3.basecamp.com/p/p7U3SES8PVnogem6c1HWVV56. The state will also be publishing a program guide for the PRL.

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When a member is discharging from a state facility, will the warm handoff from Alliance include involving the CM in the discharge meeting(s) before the actual discharge?

Yes. alliance's integrated health consultants (IHCsss) will keep the previously assigned TCM agency informed of the member's progress while in the facility, and the agency is encouraged to participate in the discharge meeting. However, TCM agencies will not be able to bill for this contact as the member will likely not have Medicaid at this point, so the level of participation will have to be determined by each TCM agency.

Continued

November 17, 2022 – Alliance's CMA/AMH+ Learning Collaborative

The state has said that the location code was not needed to bill, just that the NPI location needed to match the member assignment. Is this accurate?

Correct, the location code is not needed to bill, only the agency's NPI number and the provider's physical address. For Alliance, please make sure you are using the NPI number that we designated as your billing NPI number in your claims.

Is "location code" the same thing as "place of service" code

No, location code is a 3-digit code used for sites in NCTracks. Place of service is where the service occurs, i.e., home, community, office.

When requesting capacity funds, will we receive an approval per our request to draw funds down? Also, what is the time frame for approvals?

Once you submit a request for funds, you should receive an email acknowledging the receipt of the request, but not an official approval. If the funds are not approved, we will let you know. Otherwise, all requests are processed weekly (requests are sent to accounts payable every Tuesday), and you should receive the funds the by the following Tuesday.

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If using Jiva, will we receive a report of all the contacts? And will all the subsequent contacts be denied?

We are working on a report to pull all the contacts in Jiva. You will submit claims for all your contacts, but only the first contact per month will be paid.

How are TCM claims billed? Through an 837?

Yes, TCM claims are billed exactly like all other service claims.

Who is responsible for completing the medication reconciliation? At the TCM provider level or are care managers just ensuring it has been completed by their care team?

An RN, MD, pharmacist, or pharmacy tech can complete medication reconciliation. A medical license is required. Your policies and procedures should outline how you will conduct medication reconciliation as a TCM entity. The member's TCM care team is responsible for completing medication reconciliation for their members. Primary care physicians will conduct their own medication reconciliation, but as a TCM entity, you are also responsible for completing your own.

Can you provide more clarity on how community guide (CG) and community navigator (CN) services will continue until the person is onboarded for TCM? Does that mean once TCM is started/billed, the person's CG/CN services will end? We want to know exactly when CG/CN actually ends. We have heard that there should be a warm handoff too from CG/CN provider to TCM provider.

The state has said that both TCM and CG/CN can be delivered to a member through March 31, 2023. On April 1, 2023, CG and CN will officially be ended. So even if a member begins receiving TCM, they can continue their CG or CN services through March 31, 2023. Providers who are currently providing CG or CN to members who are transitioning to TCM will need to warm handoff those members to the TCM provider (even if the transition is internal to the same provider; the warm handoff should occur between the staff/teams).

Is there a particular diabetes screening that is the benchmark for the HEDIS Hemoglobin A1c Control for Patients with Diabetes (HBD) measure?

The member's A1c levels are used to determine if a member meets this measure.

Are these measures for all members even if they are primary I/DD diagnosis?

No, not necessarily. We will discuss the populations that each measure includes on the upcoming lunch and learn session about HEDIS. With HEDIS measures, there are specific "value set" definitions for diagnoses, visits, etc., which include diagnosis codes, visit codes. The data will be run off claims and the value sets that HEDIS has set up for the measure.

Do text messages count as a contact?

No; per the state, text messages are not counted as a contact. Also, you can only text to numbers that have already been confirmed as the member's correct number, otherwise, the text could violate HIPAA.

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Is the initial contact a billable activity if you provide the member information regarding care management, but they are not sure if they actually want the service yet and say they will get back to you?

If you have not yet obtained have consent, you cannot bill for a contact. When the member calls back and consents to TCM, as long as that contact was via phone or face-to-face, that contact can be billed.

Is there a TCM acronym list/glossary?

We are in the process of developing one that will be posted on our website.

How will providers be notified if a member calls Alliance to opt out of TCM?

If a member opts out, the member will be removed from your beneficiary assignment file and will no longer appear on your file.

Do members have to complete the opt-out form themselves? Can the members call instead of using the form? Can the opt-out form be sent out to members?

You may complete the opt-out form for the member with the member's verbal consent. Members can always call 800-510-9132 to opt out instead of completing the form. The opt-out form was sent to all members with their TCM welcome packets, but is also posted on our Provider Practice Transformation webpage.

What will the turnaround time be for removing members who have opted out from provider panels?

We don't know the exact processing time yet, but it should be within 24 hours as the files are sent daily. Providers should receive notification the following day.

What does "the provider is responsible for the members" for ADT feeds mean if a member has not yet consented to TCM?

Unless the member has opted out of TCM, the assigned TCM agency will be responsible for responding to ADT alerts for that member and also engaging the member and getting their consent to help coordinate their care and facilitate their discharge from the hospital/facility.

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October 27, 2022 – Alliance's CMA/AMH+ Learning Collaborative

What is the date that providers will receive their panel assignment list?

November 13, 2022.

Who will connect with us so IT can setup file transfers?

We are in the process of setting up sFTP sites for all providers, and we will inform you when they are ready.

Exactly what information will be included in the beneficiary file?

The data/fields in the beneficiary file is included in this document: https://medicaid.ncdhhs.gov/documents/ncmtmanagedcarebeneficiarypharmacylock-indataspecificationsr31docx/download?attachment. There is an excel document embedded in page 4 that outlines the File Layout and lists all the fields in the Beneficiary file.

What data will be in the Patient Risk List (PRL)?

The data included in the PRL is included in this document: https://medicaid.ncdhhs.gov/ncmtmanagedcarepatientrisklistdataspecificationsr30/download?attachment. There is an excel document embedded in page 5 that outlines the File Layout and lists all the fields in the PRL.

When will providers receive claims files?

February 19, 2023.

Do the required contacts only count for contacting the member, or do "contacts" also include contacting the PCP, clinical services, or other community resources for the member?

We have sent this question to the state and they have not supplied a response yet.

Do contracts need to be updated to include the TCM billing code T1017 HT?

All TCM agencies have already signed their TCM contract, which is all that's required to bill TCM. Alliance has updated our claims system to include which providers can bill the TCM code.

Will there be an issue if a diagnosis is submitted even if it is not required?

Per the updated billing guide released on October 28, 2022, a diagnosis code will be required on the claim. Member diagnoses will come to providers on claims data, or based on the Care Management Comprehensive Assessment that your agency will complete with the member.

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Will billing be performed through Jiva or will billing be through EHRs?

There will be NO billing done through Jiva. You will bill for TCM just like you bill for all your other services, using the TCM billing code.

After receiving the initial assignment panel, will providers be assigned any additional members for TCM between December 1 and April 1?

You may receive additional members after the initial assignments, but more than likely, not many.

How do we sign up for lunch and learn sessions?

The invitations to all of the lunch and learn sessions have been sent to each agency's designated TCM email address. Providers are responsible for forwarding those invitations to their relevant staff (CMs, supervisors, and extenders) and making sure their staff attend.

Other than the patient risk list (PRL) and supplemental data files, are there any other data files AMH+s should expect to send to Alliance?

The only files AMH+s or CMAs send to Alliance is the PRL.

How will attendance at Lunch and Learns be documented?

Alliance will take attendance by asking all attendees to enter their names, positions, and agencies in the chat. Alliance will generate a list of attendees for each agency for each session and send those lists to the agency's primary contact. Providers are not expected to create certificates of attendance for their staff who attend, but are expected to document the staff's attendance in some way in the staff's personnel record.

Will upgrades to EHRs that are required to interface with CINs/CM platforms be covered by capacity funds?

If you submitted requests for funds for costs associated with EHR upgrades or enhancements in your capacity funds plan and narrative, those costs can be covered **as long as** they are directly related to operationalizing Tailored Care Management at your agency.

Can we purchase furniture with the capacity funds?

If the purchase of office furniture was included in your capacity plan narrative, then yes; they can be covered in submilestone 6.2 for operationalizing care management.

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Can you explain again what is required for staffing receipts?

The only documentation Alliance is requiring for staffing receipts is the completion of Tab A on the non-UCR invoice template, which has been sent to all the agencies. Please follow the instructions on the second page of your capacity funds request form for details on how to submit receipts. If you need another copy of the non-UCR invoice template, please contact Dana Frakes at dfrakes@AllianceHealthPlan.org.

Will there be a session on billing for TCM?

We will be discussing billing at our next collaborative in November.

Will the Supports Intensity Scale (SIS) be available in Jiva?

Not at this time. The SIS is an assessment tool owned by a third party and we do not have permissions to replicate it in Jiva.

What is the filing deadline for submitting claims.

180 days.

How do we refer someone for a Section 8 voucher through Alliance

Send a request to one of Alliance's supporting housing specialists/team members.
Supportive housing staff in Cumberland, Durham, Johnson, Orange, and Wake:

Manager:	Laressa Witt – lwitt@AllianceHealthPlan.org
Specialists:	Cliff Gajda – cgajda@AllianceHealthPlan.org
	Chris Peterkin – cpeterkin@AllianceHealthPlan.org
	Angela Boyd – aboyd@AllianceHealthPlan.org

Supportive housing staff in Mecklenburg:

Manager:	Ashley Pharr-Godbee – apharr-godbee@AllianceHealthPlan.org
Specialists:	Patricia Bryant – pbryant@AllianceHealthPlan.org
	John Cuyler – jculyer@AllianceHealthPlan.org
	Janeva Tucker – jtucker@AllianceHealthPlan.org

Can you clarify Kelly Crosbie's response when asked about year 1 quality measures? Specifically, she stated that in year 1, CMAs would not be held to quality measures.

TCM entities will not be "held to" the quality measures in the first year of TCM. However, your organization should still be monitoring your quality measures. We are introducing these measures now so that providers can be proactive with starting to work on these measures. Providers will need to establish protocols and practices for these measures and educate your care management staff about them, so that you will be ready to meet the measure at year 1. Agencies should start monitoring and implementing interventions towards those goals so that the measures are met by the time agencies are held accountable for meeting them.

Continued

Will HEDIS measures be used as incentives for value-based contracting?

There will be an incentive payment if you meet the benchmarks for these measures. This is why it is beneficial for providers to start working towards meeting these measures BEFORE the end of year one. This will be discussed further in our learning collaborative next month.

Are the HEDIS measures part of Jiva?

Yes, the HEDIS measures that Alliance has selected to monitor will be located in the Clinical Quality Dashboard in Jiva.

Do we need to purchase the HEDIS measures?

Alliance's practice transformation team will be providing ongoing education about these measures and offering support to providers throughout the first year and beyond. You do not need to purchase anything in regards to the measures. However, you may purchase them if you feel you need more information that what is being provided to you.

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September 22, 2022 – Alliance's CMA/AMH+ Learning Collaborative

Where will the approved CMA agencies be posted?

We will post the finalized list on Alliance's website once we receive the final list of the agencies who have passed the readiness review from the state.

How do we set staff up for training?

Staff will need to register for the TCM trainings through AHEC.

Where can providers/staff sign up for the trainings that Alliance requires (not through AHEC)?

Alliance will require certain trainings specific to the populations served by a CMA/AMH+. Alliance will schedule these trainings individually and invite CMAs and AMH+s to attend. Currently, those trainings will be the following topics:

- EPSDT for Care Management
- Clinical Quality Measures
- Population Health for Care Management

Note that these trainings are **not** the same as the trainings that are required for **all** provider staff.

Has the state clarified if TCM will include the use of telehealth to meet the contact requirements?

We have not received an answer to this question yet, we are still waiting on the state to clarify.

Has there been further guidance from the state about whether contacts with parents alone will count toward the contact requirements, or will the child need to be part of each contact?

The state has not addressed this; we will ask them to address this question.

Will the Jiva training be recorded?

No, but there will be several sessions/options to attend. The training will be interactive.

Has there been any consideration regarding extender qualifications, specifically the 2 years of paid experience requirement?

No; to our knowledge, the state is not considering changing this requirement at this time.

Continued

Why are associate professionals not be allowed to serve as extenders? This could allow providers to train these staff for future care manager roles.

The state has not commented on this, we will ask if the state can consider this.

Since children in DSS custody will be assigned to the Tailored Plan for TCM, is the request for panel size still relevant?

Yes. Tailored Plans have to report both TCM and Medicaid Direct member panels separately to the state each week. If the only Medicaid Direct members you serve are in foster care, you would not need to submit a Medical Direct panel, only your TCM panel.

What is Medicaid Direct?

Medicaid Direct is the Medicaid fee-for-service program serving members that are not enrolled in a prepaid health plan (PHP) or the EBCI Tribal Option. These services are billed directly through Medicaid, not through the LME/MCO or Tailored Plans. Practice transformation sent an email including a fact sheet for Medicaid Direct to all TCM providers on September 30, 2022. If you do not have a copy of this, please request one from your Practice Transformation specialist.

Regarding panel sizes, are the Medicaid Direct panel numbers only relevant for children?

No, the panels should include anyone that is Medicaid Direct that is eligible for TCM.

How do agencies determine if their Medicaid direct members are eligible for TCM?

If a member is Tailored Plan eligible, then they are eligible for TCM. Please refer to the Medicaid Direct fact sheet that was sent to all providers on September 30, 2022; this document outlines the populations that qualify for Medicaid Direct.

Several of the services that are excluded from TCM are Medicaid Direct. Are you able to define what services in Medicaid Direct are eligible for TCM?

The state did not specify what services are eligible for TCM, only the services that are excluded. Note that not all Medicaid Direct members will be coming to the Tailored Plans, some will be assigned to Standard Plans.

When will members have the option to choose a TCM provider versus being auto-enrolled?

The member choice period started on August 15, 2022, and ends on October 14, 2022. If a member has not chosen a TCM provider by October 15, 2022, the member will be assigned to a TCM entity based on Alliance's assignment logic. The state will then make the official assignment at launch.

How will the acuity designation be communicated (e.g., modifier or other)?

Each member's acuity tier will be included in the beneficiary file that is sent to each CMA/AMH+, through Jiva, or clinically integrated network.

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Will members be able to choose TCM providers who have not received notification that they have passed the readiness review?

Yes. Alliance's Access line is tracking which TCM provider members select. If a member selects a TCM provider who does not end up passing the readiness review, they will be assigned a TCM provider through Alliance's assignment logic (unless they select another provider).

Can senior leadership attend the supervisory collaborative, or just the CM supervisor?

No, this collaborative is limited to CM supervisors only. Alliance's practice transformation team and McSilver will ensure communication is in line with requirements for Tailored Care Management.

Will the Tailored Care Management monitoring tool be released before go-live/Tailored Plan launch?

We are currently piloting the monitoring tool that Alliance developed with Monarch, but the state has said that they will issue a standardized monitoring process across Tailored Plans, so the monitoring process/tools have not been finalized. The monitoring tool(s) will be sent to providers in advance of on-site monitoring.

Can you provide the requirements/expectations of care management notes? There has been no direction given regarding guidelines of care management notes. The guidance regarding service notes in the records management and documental manual does not completely make sense for TCM.

This question has been sent to the state and we will hopefully get an answer soon.

How will on-site monitoring reviews work for agencies that have a remote workforce (care managers and extenders working from home offices)?

The reviews can be done by logging into the agency's EHR remotely.

When/where will members receive info/training on how to access the member portal to be able to see assignment information?

We are working on developing the Member Portal but are not sure when it will be ready. Members will be informed how to access the portal once it is developed.

Have ACTT programs and other excluded programs been informed of the warm handoff requirements, or should we be reaching out to our internal ACT teams?

The requirements for warm handoffs to and from excluded services (including ACTT) were presented at the All Provider meeting on September 21, 2022. However, if your agency provides ACTT (or other excluded service), we recommend that you have discussions with those teams/staff about the expectations with warm handoffs.

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August 25, 2022 – Alliance's CMA/AMH+ Learning Collaborative

For those CM entities that pass readiness review by 9/30/22, when will member assignments go out?

The data sharing starts November 4, 2022. Those CM entities will receive their assignments on that date.

Can providers be involved in conversations with the state regarding the changes and updates that are being made?

We are not sure if the state is involving providers in their decision-making process. We encourage providers to contact the state directly with questions and concerns.

Can Monarch share some lessons learned that would be most relevant for the rest of the CMAs/AMH+s?

Monarch will plan "lessons learned" sessions in the coming months. Monarch will also be presenting lessons learned at this year's i2i conference in Pinehurst. Also, Monarch has also presented lessons learned at previous collaboratives on February 24, 2022, and June 23, 2022.

Please clarify "conflict-free" Tailored Care Management. Are only HCBS services considered a conflict?

HCBS services CANNOT be provided by the same provider who provides Tailored Care Management. Any service under the Innovations Waiver (C waiver) or the future 1915(i) waiver (currently called (b)(3) Medicaid services) are considered HCBS services. Therefore, any provider of Innovations or (b)(3) services to a member cannot also serve as that member's Tailored Care Management agency.

Will TCM assignments show in NCTRACKS? How will providers know when a member is assigned to another agency for care management to collaborate with them?

The assignment file will go to the state, the state will load the information into the NCFAST, and it is then transferred to NCTRACKS. Then it comes back to us for us to send to providers. Any provider working with a member can look up that member in NCFAST or NCTRACKS to see who their assigned care management entity is.

Is a master's degree required for behavioral health care management supervisors?

Per the updated provider manual and standard terms and conditions, there is no requirement that BH supervisors have a master's degree, provided that the staff has a license (full or associate-level), certification, registration, or permit issued by the governing board regulating a human service profession OR is a registered nurse licensed by the NC Nursing Board, AND has at least 3 years of experience providing care management, case management, or care coordination to the population served.

For proposed I/DD supervisors, can the bachelor's degree be in a non-human service area?

Per the updated provider manual and standard terms and conditions, yes. The update has removed the requirement for a bachelors' degree to be in a human service field, but the requirement that a master's degree is in a human services field has remained.

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What qualifies as care management experience?

AHEC has released this guidance: "Care managers need to have care coordination, care management, or case management experience. Experience is inclusive of care management/case management/care coordination assessment, treatment planning/PCP/ISP development, referral and follow-up and any of the other requirements of the functions/services that a TCM care manager must provide. Providers are responsible for ensuring that the people they hire have sufficient experience that mirrors the required care management functions in the policy." It is also important that all relevant experience is documented in the staff's personnel record.

If a staff has 5 years of I/DD QP experience, will they meet the new qualifications for I/DD supervisor?

Potentially, it depends on whether they have 5 years of experience providing care management, case management, or care coordination to complex individuals with an I/DD or a TBI, specifically. A staff person may have experience working with the I/DD (or MH/SU) population in a role other than care management/coordination, which would count towards obtaining QP status, but would not be considered part of the 5 years of care/case management/coordination experience.

Would staff who have their LCSW but do not have a masters (grandfathered LCSWs) qualify as a BH supervisor?

To our knowledge, the state is only requiring a "license, provisional license, certificate, registration or permit issued by the governing board regulating a human service profession" to be a care management supervisor. Any LCSW would qualify to be a BH supervisor, provided the LCSW has the required care management experience.

Can the LCAS supervise any population or only members who have primarily substance use disorders?

To date, the state has not issued any guidance regarding the populations that different licensures or certifications may serve.

Would experience as a special education teacher count towards meeting QP requirements?

It depends on the type of work performed by the potential staff person. If the person worked with children in a capacity that would qualify as "MH/DD/SA experience with the population served", then that experience can count towards QP experience requirements. If your agency decides to hire a staff with educational experience, it is imperative that you document in that staff's personnel record how you determined that the staff meets the QP qualifications, as written in 10A NCAC 27G .0104 (19).

Would "license-eligible" staff (those who have not passed the licensure test) qualify as a BH supervisor?

No, in order to meet qualifications as a BH supervisor, the staff must have a license or associate-level license. Staff must pass the licensure test in order to receive associate-level licensure.

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Will Alliance allow providers who passed the site review to be included in the member choice period, even if they have not yet passed readiness review?

Yes. Any provider who has an executed Tailored Care Management contract will be included as a member choice during the choice period. Alliance is currently contracting with all CMAs and AMH+s regardless of whether or not they have passed the readiness review. The Tailored Care Management contract states that passing the readiness review is required to operate as a Tailored Care Management entity.

Will the state be clarifying the requirement that "only contacts by the assigned care manager" will count as a contact? This does not account for crisis/after-hours coverage or care management coverage when the assigned CM is on PTO or leave.

The state has indicated that they will be changing this language, but the change has not been published yet, and the state has not indicated when this change will be made.

Are there special diagnoses to send on billing for TCM PMPM since claims processing systems are very particular about HCPCS/Dx combinations?

There are no restrictions on the diagnosis with billing Tailored Care Management (HCPC code is T1017 with modifier HT).

The state's quality reporting system is largely based on CPT II codes. BH providers are not accustomed to sending these codes, yet a number of indicators would be impacted by data from BH providers. Do BH providers send these codes to the state? If not, should BH providers start preparing to do this, and does Alliance's claims system consumer them?

No, BH providers generally do not send CPT II codes to the state. Alliance's system can accept CPT II codes; however, claims with those codes will be denied, as they are not part of our covered code list for Tailored Plan.

Are these reports (BCM-029, BCM-0, BCM-0, BCM-051) published or announced by the state on the NC DHHS site?

These are state reports but we are not sure if the state has intentions to announce or publish them. Per the updated standard terms and conditions: "Providers must share care management contacts and other care management information using the specified reporting template from DHHS."

In the current TCM provider manual, there are references to "health home" services, but nothing tied directly to documentation of the health home service activity in a contact note. Is it a NC DHHS requirement that documentation include the health home service provided?

The state has not yet issued guidance on how to document care management or what must be included in those notes. However, for monitoring purposes, you should have this information included in your contact documentation. All documentation should support the service billed.

Continued

July 28, 2022 – Alliance's CMA/AMH+ Learning Collaborative

Site Staffing Plan – For Readiness Review, is NCQA/DHHS requiring an actual brick and mortar site in a specific county in order to serve members in that county?

No, you do not have to have an actual site in a county in order to serve members in that county. However, you do have to have a contract with the Tailored Plan in which a member resides in order to serve that member.

Since the clock starts at the member's enrollment in the Tailored Plan, what is the projected timeline from enrollment to assignment to Tailored Care Management with a CMA/AMH+?

Assignment will happen almost immediately after enrollment. As soon as members are enrolled, the assignment logic is run and assignments are made, then that information goes back to the state. This should all occur within a 24-hour period.

Have the billing codes for Tailored Care Management been published?

Billing guidance from the state is still in draft, but includes that the billing code and modifier for Tailored Care Management is T1017 H.

Since we will get our list of assigned members on or around November 4, can we start engaging (text/phone call) those members prior to December 1, 2022 to start setting up appointments?

No. CMAs and AMH+s are not under contract until December 1, so any contact you have with members prior to that date would violate HIPAA. However, you will have almost a month to plan for the engagement of those members once you receive the member data.

Can capacity building funds be used to pay for care management staff time to attend all of the required care management trainings, including agency-based trainings like company orientation?

Technically, no; capacity building funds are only to be used for functions that are specific to care management and are not designed to cover non-CM-related trainings. Staff time for attending trainings would be covered by funds allotted for staff salaries (Milestone 4). However, the funds allotted for staff salaries were calculated to cover the costs of administrative overhead, which can include trainings other than care management training. No receipts are required for those trainings as it's covered in the salary costs included in Milestone 4.

Are care management staff required to complete CPR and First Aid training?

All of the trainings required for new staff providing MH/SU/IDD services in the North Carolina Administrative Code (NCAC 10A 27E, 27G, etc.) are required for care management staff. This includes CPR and First Aid training as outlined in 10A NCAC 27G .0202 and General Statutes 122C-60. It is best practice for all staff working directly with members to have current, valid CPR and First Aid certification.

Continued

Is certification as a peer support specialist sufficient to meet criteria for a care manager/QP?

A certified peer support specialist (CPSS) would meet the requirements to be a care manager extender. However, if a CPSS also meets the educational and experience requirements to be a qualified professional, then that person could serve as a care manager.

Can an associate professional (AP) be a care manager?

No, associate professionals do not have the required experience and cannot be care managers until they obtain the required experience to achieve QP status.

Does experience have to be paid for it to count towards QP experience?

No, the North Carolina Administrative Code does not specify that experience must be paid, only that it is full-time equivalent. Unpaid internships can be counted towards experience as long as that experience is directly with the MH/SU/IDD population. All experience should be documented as part-time or full-time in the personnel record.

Where can I find the qualified professional (QP) qualifications?

The requirements are located in 10A NCAC 27G .0104 (19), at this link: https://files.nc.gov/ncdhhs/Attachment-C.-10a-ncac-27g-.0104-2-Staff-Defin.pdf.

Has the state waived the requirement for all experience to be post-graduate/degree in order to count towards QP experience?

Yes – the state approved a waiver of the requirement that QP experience must be post-graduate from Jan 1, 2022, through December 31, 2023. Unless the waiver is renewed, after that date, the post-graduate experience requirement will be reinstated.

If an agency uses the Alliance templates for verification of education and experience, will those be accepted in future audits?

Yes, if your agency uses the education and experience – primary source verification tools and completes them fully and accurately, they will be accepted for Alliance audits.

How do we access the resource documents shared by Alliance's practice transformation team?

https://www.alliancehealthplan.org/providers/network/provider-updates-and-support/provider-practice-transformation/.

Continued

June 23, 2022 – Alliance's CMA/AMH+ Learning Collaborative

Alliance had previously announced that Jiva training would take place July 18-20. Is that still the case?

Yes, the dates are tentatively set for July 18-20, provided there are enough staff signed up to attend.

Are CMAs/AMH+s responsible for members who have never engaged or who have said they don't want Care Management?

Yes – Tailored Care Management involves managing a "panel" of members. All members assigned to your organization will be on your panel. If a member is in your assigned panel, you are responsible for crisis coverage for that member. If you have responded to a crisis for the member, that would be considered part of engagement.

If members are not engaged or refused care management, at what point are they "discharged" or sent back to the Tailored Plan?

CMAs and AMH+s will need to manage their panel of assigned members regardless of whether or not they have engaged. The state has discussed pulling back members once a year, but this is not in writing. As we move forward, Alliance will communicate how and when unengaged members we will be "pulled back" and reassigned to another care management entity.

Agencies who are not in Rounds 1 or 2 cannot access the AHEC care management trainings. Is there any support Alliance can give?

Once the state announces a Round 3, if you apply, you will be able to access the AHEC trainings. In the meantime, please reach out to Alliance's Practice Transformation Team and we can provide you some resources and guidance:

dstevenson@alliancehealthplan.org
dfrakes@alliancehealthplan.org
mjeter@alliancehealthplan.org

Will the state hold listening sessions with providers?

To date, we have not heard that they will. We will ask the state about this on the next state call.

Will there be a database to ensure staff are not working with different care management organizations at the same time?

To date, we have not heard that there will be any comprehensive database at the state level, and Alliance does not plan to create one for our counties/providers. It is unlikely that this will be created due to logistics and lack of time.

Continued

Per the Provider Manual, a billable contact can only be made by the assigned care manager or extender. How will Alliance know who the assigned care manager is? If that assigned staff leaves, how does that re-assignment impact billing?

As of this date, claims are not specific to a Care Manager, they are billed under the NPI number of the care management organization. Alliance will not know who the assigned Care Manager is unless the organization is using Jiva and has entered that information in Jiva. The claim will not include who provided the contact, therefore, there should be no billing issues when assigned care managers change.

Continued

May 26, 2022 – Alliance's CMA/AMH+ Learning Collaborative

What happens to members assigned to a CMA who choose not to engage? Do they go back to the Tailored Plans for monitoring or are agencies supposed to keep them in a tracker to attempt engagement again at a specific interval?

Members who are assigned to your agency will be left in your panel to manage and your will need to continue to attempt to engage them. They would only be pulled back to the Tailored Plan and recycled after the first year of the contract. Your agency will receive ADT feeds on the members in your panel, regardless of if they have engaged or not.

Can you give examples of the types of questions a consultant would need to answer? We are finding it impossible to find consultants because we do not know what types of things would be in the scope.

Consultants will be needed when situations arise that your clinical staff may not be able to answer (such as questions related to physician health). We cannot tell you the specific types of questions that you may need a consultant for, it will vary with each agency and with each member.

Are capacity funds released after site review or readiness review?

The site review. Once Alliance is notified by the state that an organization has received NCQA certification (i.e., has passed the site review), they will be sent the capacity building funds grant to sign. Capacity funds may be distributed as soon as that grant has been signed and executed.

If we used a recruiting service like "Headhunter," would that be a reimbursable expense that capacity funds could be used for?

Yes, this would fall under milestone 6.

How soon after receiving notification of NCQA certification can we expect Alliance to reach out regarding the grant and capacity building funds?

Your agency's practice transformation specialist will reach out to you within 24 hours of receiving notification from the state that your agency has passed the site review.

Will agencies be able to get members after the initial assignments?

Yes; as new members are assigned to Tailored Care Management, they will be assigned to CMAs/AMH+s per the assignment logic. However, members will only be assigned "en masse" at go-live.

On the state's "Updated Tailored Care Management Rate Guidance-1/24/2022," page 4 draws the "what-if" scenario of a care manager having a full case load of medium acuity members, declaring that case load as 46. On page 7, the rate modeling for medium acuity is illustrated, but the case load is 32, and this model includes the extender time. How do I reconcile the difference in 46 and 32?

We have informed the state of this discrepancy and are awaiting clarification.

Continued

Regarding declared capacity and auto assignment: Since Mercer assumed 37% successful engagement, would agencies need to declare a capacity of nearly 300% of actual capacity in order for auto-assignment to provide enough cases to reach a maintenance caseload?

Each agency will need to determine its capacity based on its own projected engagement rates. With Alliance, capacity will be assessed per county. Note that engagement rate will vary for each agency depending on county served, services provided, etc. Organizations may want to overestimate capacity to ensure that teams will have full caseloads after engagement. For example, if you have actual capacity of 100 in a specific county and project that members in that county will engage at a rate of 30%, then you may want to consider declaring a higher capacity than 100 (potentially up to 170 to counteract the 70 members that you anticipate will not engage). We will be discussing this in further detail at the next learning collaborative.

If we declare capacity at 100 and then two months later, we only have 50% engaged, do we relate back to Alliance that we have 50 slots available?

Yes, unless you want to overestimate your capacity to try to reduce the difference between assigned members and lower number of members who will engage (based on projections). We will be discussing this in further detail at the next learning collaborative.

Will AHEC be offering care management trainings on demand or routinely enough for organizations to get all trained if hired early or beyond October?

Per NC AHEC, all required trainings will be live by the end of August (with the possible exception of waiver trainings). Some are already scheduled to occur live in June and July, and some are already recorded and can be taken at any time. All of the trainings will be recorded, so they will be available "on demand." If you have current employees who will be transferring to care management, those staff can start taking the trainings that have already been recorded.

Will listed training courses related to I/DD be required for MH/SUD CMAs, and vice versa?

Per the information we have received as of today, that is correct.

The current required trainings that have been developed on the AHEC site equal 52.5 hours. Does this include the trainings that are still in development?

No, this only the includes the trainings that have already been developed. Alliance is estimating a total of 70 hours to complete all the AHEC trainings, once they are all developed.

Are care manager extenders required to take all of the CM trainings?

Yes, the trainings are required for everyone who is participating in care management/on the care management team.

Will Jiva training occur before the readiness review?

Jiva training is scheduled for July 17 through July 20; the readiness reviews start on July 15. Therefore, for many providers, the Jiva training will occur prior to their readiness review.

Continued

Who is the best person to work with on understanding Jiva?

Supervisors will be educated in the Jiva train-the-trainer sessions, and we will make sure they fully understand the system in that training and be able to train your staff.

Can agencies send more than one staff person to Jiva training?

The Jiva training will be a "train-the-trainer" format that is specifically for managers/supervisors who are overseeing or supervising care management teams. If your agency has hired more than one, you may send all of those staff.

When can we begin registering for the upcoming Jiva train-the-trainer training?

Once you have hired your manager/supervisor(s), inform your practice transformation specialist and we will compile a list for invitation to the training.

Is the ability to change TO Jiva or change FROM Jiva a possibility after contracts are executed?

Yes; please let us know if you plan to change platforms. However, we strongly recommend that organizations finalize the platform they will use sooner than later, and to try to not switch if it can be avoided. It would not be wise to make that decision right before launch, as you would have expended time and resources that would then be wasted (i.e., staff time for platform-specific training, funds for HIT, etc.).

Will Jiva be tied to the new Alliance ACS system that launched in mid-May?

No, access to all Alliance platforms will be via Provider Portal. The provider profile will be in ACS, not in Jiva.

How will Jiva interface with our care management platforms?

We will be extracting a member file from ACS and sending that to providers – it will not come from Jiva. There is no interface between Jiva and care management platforms.

Will readiness reviews BEGIN on July 15, or are to be COMPLETED by July 15?

Readiness reviews are scheduled to begin on July 15.

Will the readiness reviews still be happening when the member choice period starts? If so, is it possible that our agency may not be listed as an option for member choice yet?

Readiness reviews will run from July 15 through September 15, and the member choice period begins on August 15, so some providers will be still going through their readiness review when the member choice period starts. Organizations will not be included in the list of options for member choice until they pass the readiness review, which may occur after the member choice period begins.

Continued

When will information related to the readiness review be released so agencies can prepare?

At this point, we do not know the process, the order reviews will occur, how to request a review, etc. The workgroup led by NCQA will be working through June to establish the process and develop a review tool. However, NCQA has stated that the readiness review will be based on the Provider Manual, which is also what the desk review and the site review were based on. To prepare for the readiness review, your agency should focus on implementing and operationalizing all the policies and procedures, workflows, etc. that were reviewed at the site review.

What are the fundamental differences between site review and readiness review?

The readiness reviews will focus on how your agency has implemented and operationalized the policies, procedures, workflows, etc. that were submitted and reviewed as part of the site review.

Have there been any updates on when round 3 would begin and its timeline?

We have not received any updates; the state has not yet announced when round 3 will start.

Continued

April 28, 2022 – Alliance's CMA/AMH+ Learning Collaborative

Is member choice of CMA/AMH an opt in or opt out process?

Opt out

Does member choice happen through the Enrollment Broker for TPs?

At this point we are not sure as we have not seen the member choice letter yet. The state will be releasing that letter in May and Alliance will share it with all agencies when it is received. Note that the members will be given choice before they are assigned to Alliance; Alliance's role will be managing member choice when members want to change their assigned CMAs/AMH+.

Does the Tailored Plan (Alliance) assist the member in changing their Primary Care Physician (PCP) if needed?

Yes, members can call Alliance's Member and Recipient Services Department (i.e., Member Access line) to request a change or submit a request through the Alliance website. Alliance Member Access staff will explain the process, including if/how it affects their CMA/AMH+ assignment, and assist members in switching their PCP.

Is the assignment logic the same for all Tailored Plans?

No; the state published guidelines and Alliance presented the state with an Alternative Assignment Policy, which the state accepted. Each Tailored Plan may be using their own individualized logic.

Can CMAs/AMH+'s stop assignment of members to them when they are at capacity?

Yes. Alliance is working on developing a Provider Profile within the Alliance Claims System (ACS) that will allow agencies to indicate which counties are currently open for assignments and which are not.

Will the assignment logic be applied only after the member choice period closes?

Yes, and the logic will run consistently after that time for new members, etc.

When will CMAs be made aware of their assigned members?

CMAs/AMH+'s will be notified of their assignments by November 7, 2022.

Continued

March 24, 2022 - Alliance's CMA/AMH+ Learning Collaborative

What changed with Cohort 5 that the engagement rate is higher for them? (36%)?

Increased engagement can be attributed to care managers/teams connecting with people through pharmacies, psychiatrists, etc., as well as through IPS teams.

Can we get a report of the number of IDD members that are not on the Innovations waiver?

These are the counts of non-Innovations members with an IDD diagnosis, as of the end of February 2022.

Measurement Period: 3/1/2021 - 2/28/2022	
Non-Innovations Members (Based on Paid Claims - IDD Dx)	
County	**Distinct Count of Members**
Cumberland	836
Durham	658
Johnston	410
Mecklenburg	1,242
Orange	140
Wake	1,567
Total	**4,798**

What does the geographical coverage look like for the agencies that have passed desk review at this point?

We do not know at this point as there are only a few agencies who have been certified. We will know more once we have a better idea of how many agencies have been certified and in which areas they will be providing Tailored Care Management.

Do you have projections of members who may be assigned to an AMH+ (due to more complex physical health needs) vs a CMA?

Alliance's assignment logic will be discussed in next month's collaborative (April 28, 2022). However, we will not be able to give specific numbers at that time, as the logic is still under development.

Do you have any estimates on what Medicaid expansion could add to the number of Tailored Plan members?

Potentially, most of growth would be seen in the Standard Plan rather than the Tailored Plan.

Continued

Are the "Alliance members per County" numbers representative of the member's Medicaid county or the physical address of the person?

Medicaid county.

As a CMA applicant that is partnering with a primary care agency, how will we be able to ensure we keep those patients and they are not assigned elsewhere?

The assignments will be based on member choice. Members who are assigned to the primary care agency will need to choose your CMA as their Tailored Care Management provider. The primary care agency would need to communicate this to the members.

Additionally, the CMA and primary care agency must have a signed MOA or MOU outlining their relationship around care management.

How does the activity rate compare to the engagement rate in the pilot? For example, out of the 25% engaged, how often are they participating per month?

Currently, Monarch's report does not include a per member per month (PMPM) percentage, only the number of contacts per month. This is something they can look at reporting on in the future.

Will the providers have an opportunity to request more members after providing an initial number (after more staff are hired and the provider could provide care management to more members)?

Yes, agencies will be able to manage their own capacity and whether or not to accept members. This will factor into the assignment logic.

For Alliance's Tailored Plan eligible members, do you have member numbers broken out by disability type (MH/SU) or by qualifying criteria (i.e., ED utilization, crisis utilization, medication, etc.)?

We do not have this now but will look into whether or not this is an option.

Is Alliance paying Monarch an engagement rate, and will the state pay an engagement rate at/after go-live?

No, the only "engagement" funding that will be provided are the capacity building funds, which can help pay for staff salaries that will be engaging members. The state will be paying a per member per month (PMPM) rate for each member that meets the requirements after go-live.

Will agencies be able to run care management or supervisory reports (that will show # of days to first contact, engagement rate, etc.) via Jiva?

The reports will be run externally from Jiva; your practice transformation specialist will share them monthly.

Continued

Are agencies restricted from beginning marketing until on or after June 15th?

Tailored Plans cannot begin marketing until 6/15/22. CMAs/AMH+s should not market prior to then because there will not be any Tailored Plan information to refer to until that date.

Regarding the 24/7 requirement: what will happen if CMA members call the Tailored Plan's crisis line? If a true emergency, will they be served and CMA contacted?

A response will be initiated by the Tailored Plan and the CMA will be contacted.

How will hospitals/crisis services know where the member is receiving Tailored Care Management from (aside from relying on member report)?

Hospitals/crisis services will utilize the same process that they do currently when providing emergency services– the member's AMH+/CMA assignment should be included in the member's profile information.

Continued

March 15, 2022 – Update from Practice Transformation

What trainings will be provided through AHEC?

AHEC will be facilitating trainings on most of the topics included under Tailored Care Management in the RFA and the Provider Manual. Alliance is working on a gap analysis to determine any gaps in the trainings offered by AHEC, and Alliance will provide the required trainings that are identified through that process. A training schedule will be addressed in future CMA Collaborative meetings.

If a CMA works with multiple Tailored Plans and another TP uses a different training option, will Alliance honor that?

Yes. If the training is completed with a different MCO, you will need to submit documentation of training completion for your staff to Alliance.

How will individual's choices work with member assignment?

Member choice is the primary factor in determining how/where a member will be assigned. Members will receive a letter notifying them of the options available to them and if they indicate a preference for a Tailored Care Management provider, the member will be assigned to that provider. A workflow is being developed to clarify this process.

Since providers of Innovations Waiver services cannot provide care management for those members, how can we estimate how many Innovations Waiver members Alliance will be assigning to CMAs/AMH+s?

More information about this will be presented in future CMA Collaboratives when we discuss the member assignment logic.

How will agencies know how many members to expect to be assigned to them? Will Alliance assign clients to agencies?

Alliance will assign members for Tailored Care Management to CMAs and AMH+s. Alliance is currently developing the assignment logic based on the state's guidance and this will be discussed in a future CMA Learning Collaborative. Refer to the document entitled "Staffing, Caseload, and Financial Modeling" for methods organizations can use to project the number of Tailored Care Management members that will be assigned to them.

Who should we contact regarding updates that need to be made to NCQA documentation?

Any questions regarding your submission for the NCQA site review should be directed to your AHEC coach. If you have specific questions about the tools Alliance has presented, please reach out to your assigned Alliance Practice Transformation Specialist.

Will members under the Standard Plans be able to receive Care Management?

The Standard Plan provides their own Care Management for their members. Standard Plan members are not eligible for Tailored Care Management (this is only for Tailored Plan members).

Continued

If we want to serve additional Alliance counties outside of our office location, will Alliance allow us to serve members in those areas for Tailored Care Management?

Tailored Care Management is an open network, but the state has said that they did not intend for CMAs/AMH+s to provide Tailored Care management outside of the region in which they are already operation. We have reached out to the state for clarification on this and will update you as soon as we know.

Continued

February 22, 2022 - Alliance's CMA/AMH+ Learning Collaborative

Will the Peer Extenders be allowed to help complete the care management assessment, as long as the Care Manager finalizes it?

Peer Extenders can assist in gathering information needed for the assessment, but only Care Managers can complete it.

What is the engagement rate for the pilot? How long have you allowed for initial member engagement?

For the pilot the engagement rate of those assigned is 26%. The day to initial contact = 25 days. Please consider that the cohorts are small and Monarch does not have enhanced services in Wake County.

Has there been any additional discussion with DHHS about payment towards engagement activities?

There has not been any further discussion about additional payment/funding for engagement efforts since the Updated Guidance for CMA dated January 18, 2022.

What were the cohort sizes during the Pilot that were actively engaged?

Cohort 1 = 50, Cohort 2 = 72, Cohort 3 = 117, Cohort 4 = 49, Cohort 5 = 51.

Will Alliance Health be using DHHS Acuity Tiering logic or will they be modifying the logic? Or staying with the Johns Hopkins' logic?

DHHS will determine the acuity tiers for all members based on their algorithm; the Tailored Plans will not be involved in this process. DHHS has not yet released details regarding the algorithm.

How long does it take from hiring to when the care manager is prepared to see clients?

The pilot's training time was approximately 1 month. You can expect training to take 4-6 weeks. This training time includes your agency onboarding training, CMA specific training and care management platform training.

What are your thoughts about the ratio of Care Managers vs. Peer Extenders for the most effective teams?

One peer extender can support 2-4 care managers. Please note: The Alliance capacity fund plan will be slightly different and will be discussed with your agency when you receive the scope of work for capacity funds.

Continued

For the initial assignments, will DHHS make the assignments with their algorithm?

DHHS will assign the member to an acuity tier, but the Tailored Plans will assign members to CMAs and AMH+s using the DHHS-approved assignment logic. Tailored Care Management assignment will follow primary care provider (PCP) assignment. Alliance will incorporate the following factors into the assignment logic:

- Member choice
- High physical or behavioral health needs? physical health needs = AMH+; behavioral health needs = CMAs.
- Current and historical service connection.
- Member's geographic location
- AMH+/CMA current capacity to accept referrals

Alliance will manually assign members enrolled in the Innovations or TBI waivers, children ages 0-5, or any member without sufficient historical data to run the assignment logic.

Can you provide more detail about consultants as a staff specialty?

If you are an integrated practice and your psychologist/psychiatrist/primary care physician are part of your staff, you would not need additional consultants. If you have external consultants, then you need a memorandum of agreement (MOA) or memorandum of understanding (MOU).

Is there a credentialing process within Alliance Health that the Care Managers have to go through?

No.

Will there be a JIVA demo in the near future for Providers?

JIVA demos will be available in mid-April, as we are going through an upgrade. Alliance Health will be providing a demo to NCQA on 2/28/2022.

Can Alliance Health share the number of Medicaid-eligible by population and by county for provider estimates?

Alliance can share the number of Tailored Plan-eligible members each agency is serving in the Alliance catchment area, and also total number of members served in each county. However, please use these numbers with caution. Reach out to your assigned practice transformation specialist for more information.

Is there a requirement to sign an agreement with Alliance Health to use JIVA within the next 2 weeks?

There is a user agreement for those agencies planning to use JIVA. That contract is being finalized and should be sent out before the end of March. You can review a recorded JIVA demo and also request a demo if needed. Reach out to your practice transformation specialist to schedule.

Has Alliance Health determined what the fee would be for providers to utilize JIVA or how it may be charged (i.e. PMPM, flat monthly, etc)?

It has not been determined yet.

Continued

January 6&7, 2022 – Alliance's Practice Transformation Kickoff

Topic: Application and Site Review

Can you give us an update on what you are hearing from the State about the last round of CMA Applications?

The state does not give the LMEs/MCOs updates on the CMA applications. Providers will get a response before the LMEs/MCOs do.

Is there a date for applications for round 3?

There will be a round 3, but the state has not yet announced when they will open the application process for round 3.

If we are interested in applying, can we still enter round two or will we have to wait for round three?

The deadline for applying in round 2 was 9/30/21, so if you did not apply by then, you will need to wait for the round 3 application process to open.

What is the anticipated time between desk review approval and the NCQA site visit?

Per AHEC, this timeframe has varied between agencies. For more specific information, please contact your AHEC coach.

Topic: Care Management Platforms/Jiva

What is the estimated cost for providers to use JIVA PMPM?

We are not yet sure of the actual cost, only that it will be a "nominal fee".

Is it possible for Alliance to schedule a brief Jiva demo for providers who plan to use it? It would be helpful to be able to describe the functionality a bit better during the site review.

Alliance has a Jiva demo recording; if you would like to receive the demo, you can contact your assigned Practice Transformation Specialist to request that the demo be sent to you. Alliance has offered to demo Jiva directly with the NCQA reviewers, but the state has not yet responded to this request.
Note that even though there is a demo recording, we have planned a fairly large system upgrade. Look for JIVA demonstration as a topic on an upcoming CMA Collaborative or work with your Practice Transformation Specialist to receive a demonstration of JIVA.

Continued

If providers use their own CM platform - do we have to mirror the exact assessment question language in Alliance has in JIVA?

No. All of the requirements of the Care Management Comprehensive Assessments (CMCA) are listed in detail in both the Provider Manual and the RFA itself. You will need to ensure that your care management platform meets all the requirements.

Can providers use JIVA for Alliance and apply for Capacity Funds for a CM Platform for members not in Alliance catchment area?

This would not be in a CMA's best interest, as platforms are expensive to purchase, maintain and upgrade. It would be a better investment to ask the LME/MCO in the members' other catchment area to use their platform.

Topic: Capacity Building Fund Plans/Budgeting

On a recent AHEC call, DHHS seemed reluctant to provide provider startup funding when the Tailored Plan offered Care Management software, whether the provider could practically use it or not. Any update on this DHHS stance?

Startup funding can be offered to the agencies for use of the LME/MCOs platforms; the state, however, does not know the costs of any of this, hence they cannot provide any information. We suggest working with the LME/MCOs you are contracted with to get this information.

Is it true that one MCO would distribute all capacity monies to the agency based on where the agency's headquarters are even if that agency serves members under multiple MCOs?

One LME/MCO suggested this idea during the state call on 1/5/22. The state has yet to determine how this will be handled.

Do we need to send updated budgets? A lot of information has changed since we first turned them in.

Capacity Fund Plans are fluid documents and will change as circumstances change. It is expected that your plans will be updated as needed; please send Alliance (Donna Stevenson – dstevenson@alliancehealthplan.org) any updates you make to your plan

Topic: Collaboration/Streamlining

Could there be a central repository for reporting to keep agencies from duplicating efforts?

Alliance is working on a recommendation concerning this, as well as similar recommendations, and we'll see if it's possible.

Will it be possible for all Tailored Plans to use the same approach to funding CMAs that cross multiple Tailored Plans (also training, reviews, CMPs, reporting, capacity plans)? Will there be a core/universal training for care managers that is accepted state-wide, regardless of the employing agency/TP?

We are currently working with the state and other LME/MCOs to streamline this as much as possible.

Continued

Will the CMA Collaborative continue after the TP launch?

Yes, it will continue for as long as agencies have a need.

Topic: Acuity Tiering

How will acuity tiering be done?

Per the AHEC Learning Collaborative call on 1/5/21, acuity tiering done every 6 months. Tiers are based on claims information from 3 to 6 months prior. New members will be assigned to a mid-level tier until the next acuity tiering cycle. All members grouped into either Behavioral Health (BH) or Intellectual or Developmentally Disabled (IDD) based on the members' diagnosis and services received.

How will Tailored Plans and/or CMAs/AMH+s be notified of acuity tiers?

Per the AHEC Learning Collaborative call on 1/5/21. DHB will send acuity tiering for members monthly to the Tailored Plans (TPs); TPs will use the Patient Risk list to share members' acuity tiers with CMA/AMH+ each month.

Topic: General Care Management

If your agency provides Therapeutic Foster Care, OPT Plus, High Fidelity, OPT, IAFT, Rapid Response services, do you have to become a Care Management Agency?

No – providers are not required to become CMAs regardless of the services they provide. Each agency will need to review the requirements and determine if their agency can meet those requirements while having a return on their investment. This is an individual agency's decision; Alliance can offer ideas of things to consider in making this decision.

What are the benefits of becoming a Care Management Agency?

The benefits will vary by agency based on different factors; please refer to the "Making the Decision to Become a CMA/AMH+" in the Practice Transformation Academy on our website, located here: https://www.alliancehealthplan.org/providers/network/provider-updates-and-support/provider-practice-transformation/ If you would like to discuss further, please contact someone on the Practice Transformation Team, or Donna Stevenson.

Can CMAs/AMH+s provide both Tailored Care Management and I/DD state-funded services to the same individual? It is clear that a firewall exists for Innovations and HCBS services, but what about members who do not have Medicaid and are solely state-funded?

Members have to have Medicaid in order to be eligible for Tailored Care Management. There are members with I/DD who do have Medicaid and are receiving state-funded services (due to lack of availability of appropriate Medicaid services), but we have not heard from the state if conflict-free care management applies to them. We will post additional information when it is received.

Continued