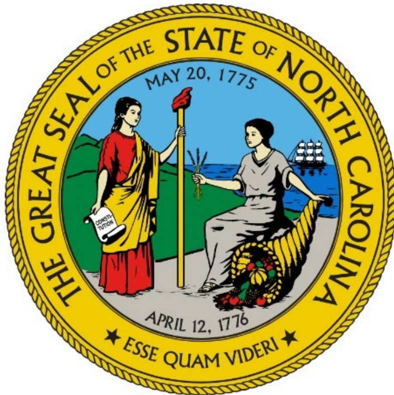


Back Porch Chat: Tailored Plan 101

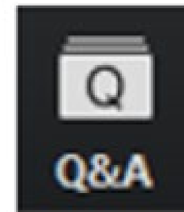
Ready, Set, Launch! Series

July 21, 2022

RCC (Relay Conference Captioning)
Participants can access real-time captioning for this webinar here:
https://www.captionedtext.com/client/event.aspx?EventID=5168992&CustomerID=290

Logistics for Today's Webinar

Question during the live webinar



Technical assistance

technicalassistanceCOVID19@gmail.com

AGENDA

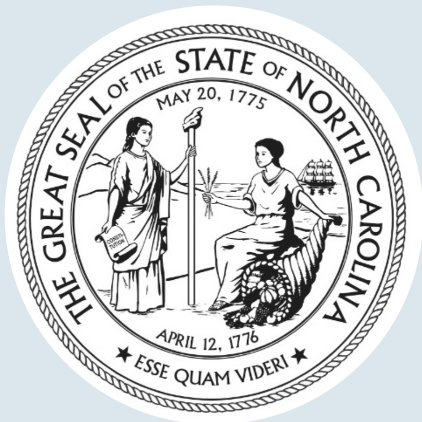
01 Integrating Physical Health and Behavioral Health

02 Tailored Care Management

03 Transitions of Care

04 Medicaid Hot Topics

05 Q&A



Integrating Physical Health and Behavioral Health

A Metaphor: A Rope Representing A Person's Health

Consider the health and well being of a person is like a rope.

If the rope is damaged, it breaks.

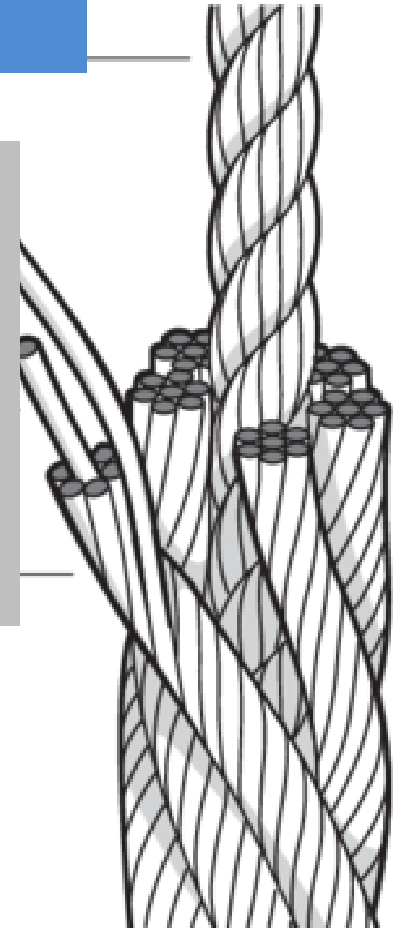
If the rope is loosely constructed, it breaks.

If the rope is not cared for, it breaks.

If the pressures placed on the rope exceed its internal supports, it breaks.

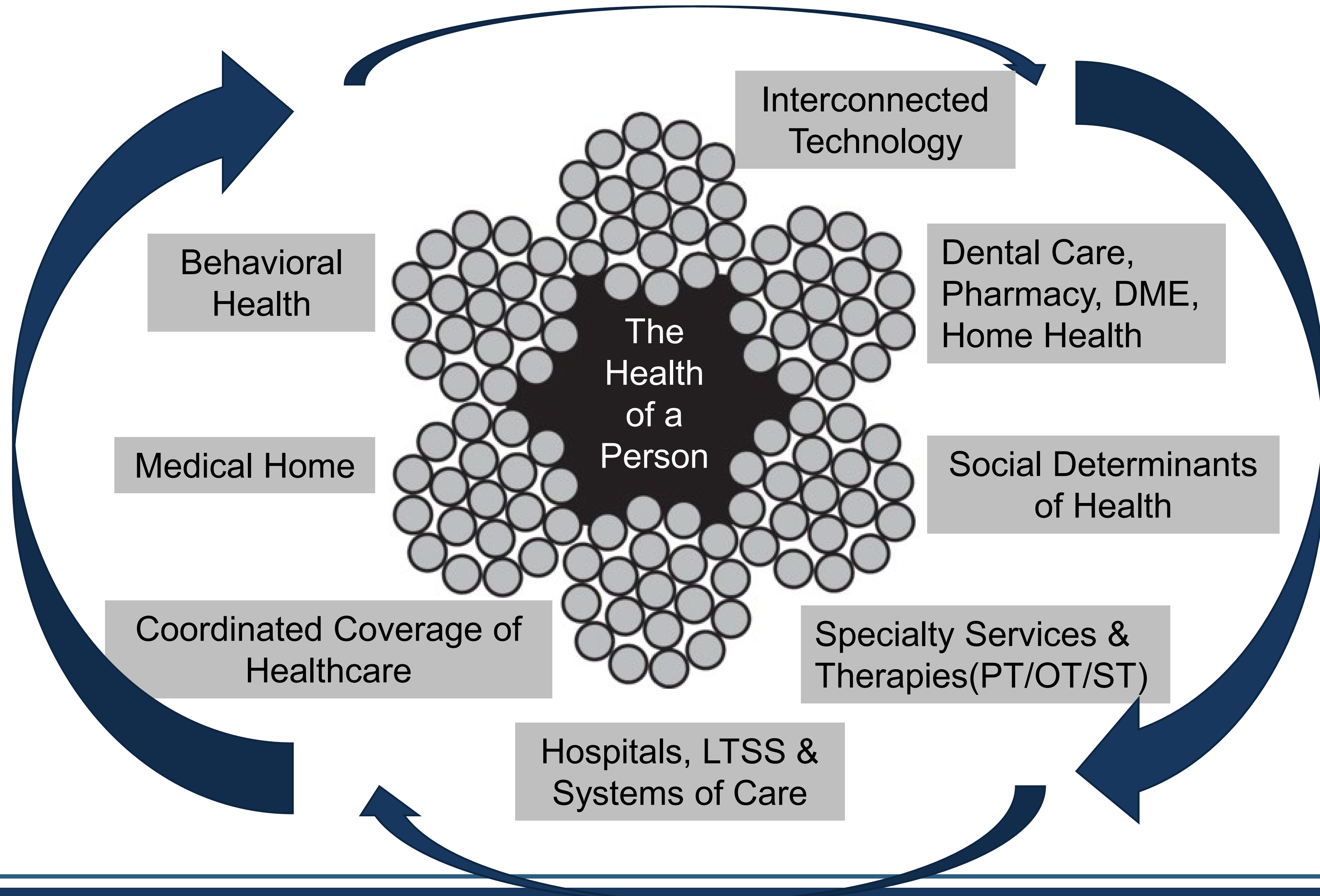
Core

Tensile strength is the load at which a rope can be expected to break. **Working load** is determined by taking the tensile strength and dividing it by a factor that more accurately reflects the maximum load that should be applied to a given rope. It is only 15-25% of the tensile strength.



Fibers and Strands Support the Core

To Ensure Optimal Health, Structured and Coordinated Strands Must Surround the Person



Each Strand Has Critical Components That Create Support to Wrap Around the Person: *Whole Person Primary Care*

Failures of Care Coordination in Care Are Like Knots in the Rope

We have established that the Working Load (what a rope can take) is only a fraction of the tensile strength.

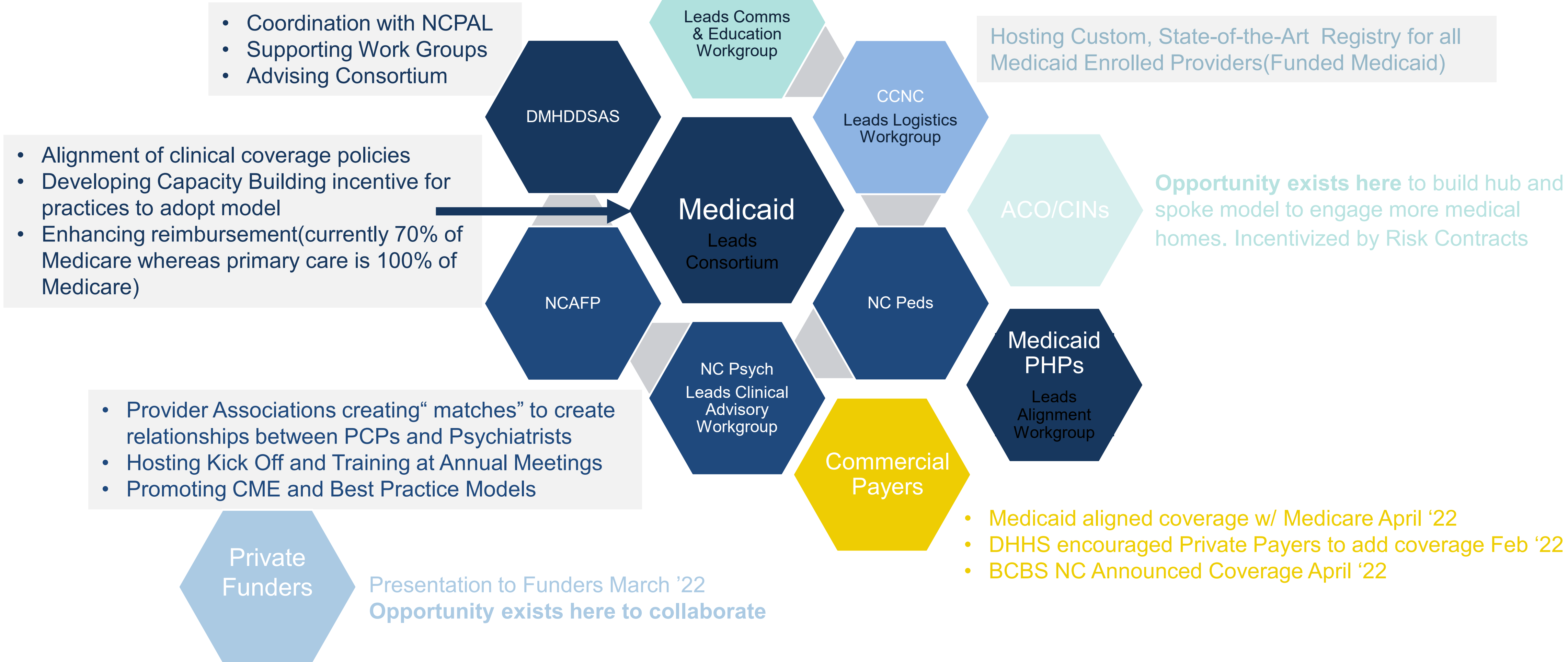
- **Consider the fact that any time you tie a knot in a rope you effectively cut the tensile strength in half.**

How often do our disconnected systems of healthcare fail the person and lead to poor outcomes?

With Transformation We are Adding Fibers and Strands to the Rope and Surrounding the Person with Whole Person Care

- **Supporting Innovative Solutions with Unique Advanced Medical Homes**
- **Enhancing Social Determinant Supports with Value Added Benefits and Healthy Opportunities**
- **Engaging in Value Based Payments tied to improved Quality and Outcomes**
- **Optimizing Member and Provider Experience with Ongoing Clinical, Payment and Operational Policy Modernizations**

Collaborative Care Consortium



Tailored Plan-Standard Plan Partnering

Tailored Plans are partnering with a Standard Plan to provide an integrated plan with behavioral health and physical health services.

Tailored Plan	Standard Plan Partner*	Leveraging Standard Plan Partner's PH Network
Alliance	WellCare Health Plan	Not at this time
Eastpointe	WellCare Health Plan	Yes, at least partially
Partners	Carolina Complete Health	Yes, at least partially
Sandhills	AmeriHealth Caritas of NC	Yes, at least partially
Trillium	Carolina Complete Health	Yes, at least partially
Vaya	WellCare Health Plan	Not at this time

More information on the Tailored Plan-Standard Plan partnering can be found in the Contracting with Tailored Plans fact sheet

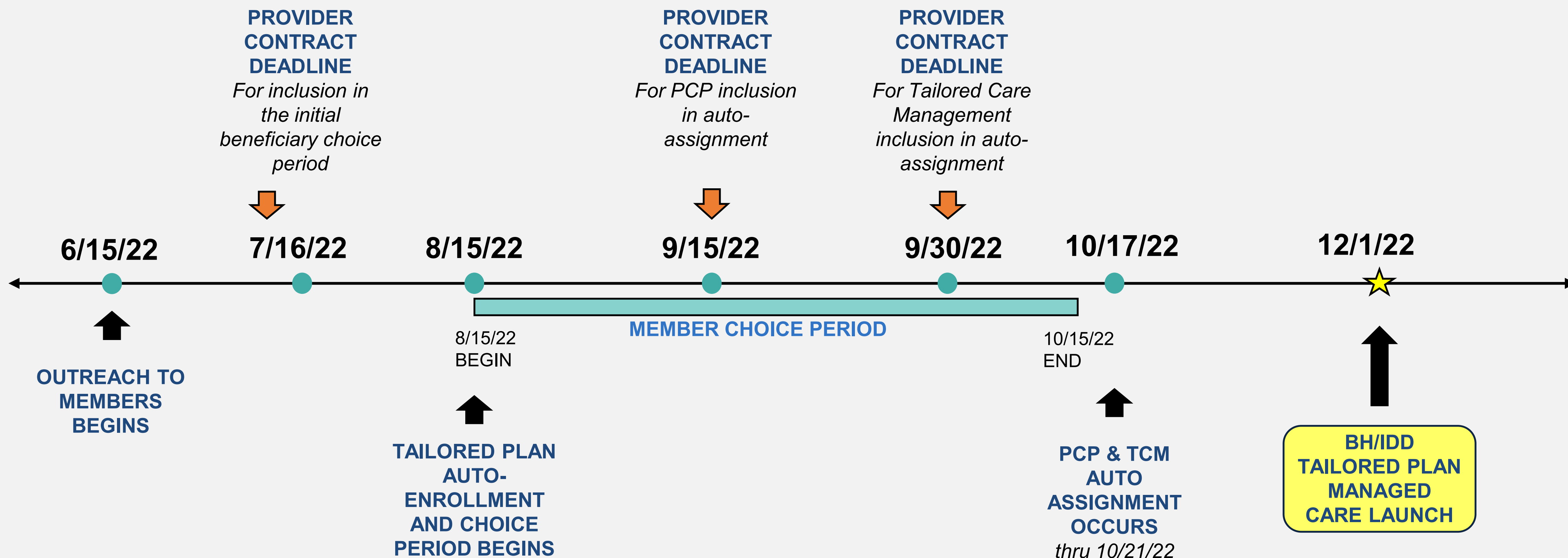
*Tailored Plans are leveraging their Standard Plan partner for a variety of different functions and additional details can be found here in the ***Contracting with Tailored Plans*** Fact Sheet.

Tailored Plan-Standard Plan Partnering

Tailored Plan	Partners and Vendors as of 4/19/2022							
	Standard Plan Partner	Primary Care Contracting Lead	Behavioral Health Contracting Lead	AMH+/CMA Contracting Lead	Hospital Contracting Lead	Pharmacy Benefit Manager (PBM)	Vision Administration	Specialties
Alliance	Wellcare	Alliance	Alliance	Alliance	Alliance	Navitus	Avesis	**Northwood**: Durable Medical Equipment (DME); **WellCare**: Complex Labs, Cardiance Imaging, Radiation Oncology, Musculoskeletal, Orthopedics, Imaging Procedures
Eastpointe	WellCare	Wellcare	Eastpointe	Eastpointe	Eastpointe/WellCare	Express Scripts	WellCare	WellCare (please reach out to Tailored Plan directly with questions
Partners	Carolina Complete Health	Carolina Complete Health	Partners	Partners	Carolina Complete Health for Physical Health; Partners for Behavioral Health	CVS Caremark	Envolve Vision	Carolina Complete Health
Sandhills	AmeriHealth	AmeriHealth	Sandhills	Sandhills	Sandhills Center/AmeriHealth	PerformRX	AmeriHealth	AmeriHealth
Trillium	Carolina Complete Health	Carolina Complete Health	Trillium	Trillium	Trillium / Carolina Health Complete Health	PerformRX	Envolve Vision	Carolina Complete Health
Vaya	WellCare	Vaya	Vaya	Vaya	Vaya	Navitus	Vaya	Vaya/ Utilization Management (UM) subcontractors TBD

Provider Contracting

Providers are encouraged to contract with all PHPs. Contact information each PHP to engage in contracting is available here.



Deadline Outline: Provider and Tailored Plan Contract Deadlines for Inclusion in Beneficiary Choice Period and Auto-Assignment

More information about Tailored Plans is available on the NC Medicaid Behavioral Health I/DD Tailored Plan webpage.

12

Provider Opt-out

- Health Plans may participate in multiple NC Medicaid Programs
  - Through direct contracts through agreements/partnerships between Health Plans
  - Each program a Health Plan participates under will have an associated provider network
- **Possible Scenarios**
  - An LME/MCO leveraging its existing BH, I/DD, TBI Medicaid Direct program network for use with the Behavioral Health I/DD Tailored Plan program network
  - An LME/MCO leveraging its existing BH, I/DD, TBI Medicaid Direct program network for use with the new Prepaid Inpatient Health Plan (PIHP) contract for Behavioral Health and I/DD Services for Medicaid Services under the Medicaid Direct program network
  - A Standard Plan leveraging its existing Standard Plan program network for physical health services for use with one or more Behavioral Health I/DD Tailored Plan program's network as part of a Tailored Plan/Standard Plan partnership agreement
- A Health Plan may leverage a provider network associated with one NC Medicaid program for use with another NC Medicaid program by amending their existing provider network participation agreements to include the new program.
- Providers may choose to accept the offer to participate in the new network or reject the offer
- Health Plans shall have outreach programs relating to the new program and participation in the program's network

More information on the Tailored Plan-Standard Plan partnering can be found in the Contracting with Tailored Plans fact sheet

Additional Contracting Scenarios

- Providers whose **practices are near the border of a BH I/DD Tailored Plan catchment area and whose patients may come from multiple BH I/DD Tailored Plan catchment areas** may consider contracting with multiple Tailored Plans in order to best serve your patients.
  - Patients do not necessarily respect catchment area borders in seeking health care and therefore may travel across catchment area borders to seek care
  - BH I/DD Tailored Plans are encouraged to contract with providers across catchment area borders in order to best serve their members' needs.
  - If a provider is out-of-network for a BH I/DD Tailored Plan (i.e., not contracted with the BH I/DD Tailored Plan directly or with the Standard Plan partner or subcontractor), then the services may not be covered by the health plan or may require additional prior approval from the health plan before being covered.

- Providers who are associated with **multi-site practices which may be in two or more catchment areas** will need to properly coordinate the care given to members in order to assure that claims are filed against the proper Tailored Plan.

- Note that some Tailored Plan members are assigned to a Tailored Plan based upon their administrative county – not the county of residence. Members may reside in counties outside their assigned Tailored Plan's catchment area. In such cases you may have members seeking care from you whose Tailored Plan is not in geographic proximity to your office.

- If a practitioner is associated with a CIN or a member of a practice or organization, it is possible that the CIN or some other organizational level may handle the contracting for all associated practitioners. The provider should refer to the CIN or organization contact in relation to contracting decisions and efforts.

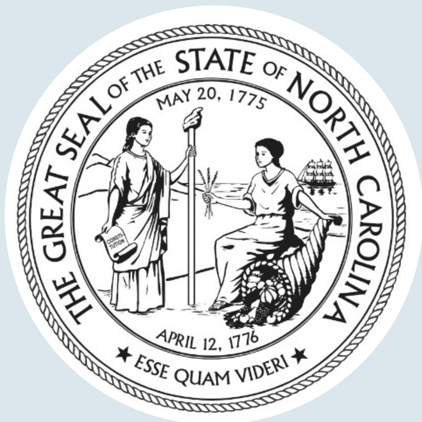
Provider Ombudsman

- For provider inquiries, concerns, complaints regarding health plans, please contact the Provider Ombudsman

- The Ombudsman will provide resources and assist providers with issues through resolution

Email: Medicaid.ProviderOmbudsman@dhhs.nc.gov

Phone: 866-304-7062



PCPs in Tailored Plans
+ Choice/Auto Assignment

Primary Care in Tailored Plans

Vision for Primary Care 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*

All Tailored Plan members can choose or will be assigned to a Primary Care Provider/Advanced Medical Home

In Tailored Plans, ONLY Advanced Medical Home +s will provide 'Tailored Care Management'

AMH Tiers 1, 2, 3 should receive $5 PMPM medical home for each Tailored Plan member assigned to their practice for primary care

AMH Tiers 3 should be offered an incentive/APM program based on the current AMH measure set. This is optional for Tiers 1 & 2.

Beneficiary Choice & Auto Assignment Period for PCP/AMH

Beneficiary choice period is Aug. 15, 2022- Oct. 15, 2022.

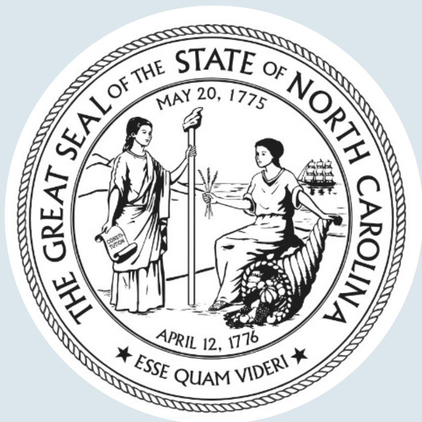
- **The contracting deadline for PCPs/AMHs is July 16, 2022 for inclusion in the initial beneficiary choice period**
- If contracting does not occur by July 16, 2022, **providers will still appear in future directories for member choice**
- After beneficiary choice period closes, beneficiaries who have not chosen a PCP/AMH provider will be automatically assigned one around October 15.
- PCPs/AMHs will still be assigned patients as long as they meet contracting deadlines for Auto Assignment
- **PCP/AMH Contracting Deadline for Providers is Sept. 15, 2022** for inclusion in auto-assignment for 12/1 launch

Some PCPs may be working with CINs to negotiate contracts.
You can check-in with your CIN on progress.

Managing PCP/AMH Patient Panels Before TP Launch

- Tailored Plan members are CURRENT Medicaid members. 90% are already assigned to primary care practices (AMH 1, 2, 3)
- Current Process for Primary Care Choice
  - **MEMBERS**: Choose a PCP at DSS during Medicaid enrollment OR auto assigned to a practice
- Members can call DSS to ask for a change in primary care if:
  - The member wants to change for any reason

- **NEW Panel Updates**
  - **All PCPs/AMHs can now look up their assigned patient panels (Medicaid Direct & Managed Care) in NCTracks portal**
  - **After launch the panel report will include TP primary care assignments AND it will include the assigned tailored care management entity**



Tailored Care Management (TCM)

What is Tailored Care Management (TCM)?

Tailored Care Management is a specialized care management model targeted toward individuals with a significant behavioral health conditions, substance use disorders, I/DD or TBI.

- Tailored Care Management is the primary care management model for Tailored Plans.*
- All Tailored Plan Members are eligible for Tailored Care Management
- All Tailored Plan members will have **1 Care Manager** responsible for coordinating all services and supports.
- Individuals enrolled in Medicaid fee-for-service (NC Medicaid Direct) (e.g., dual eligibles) will also have access to Tailored Care Management, if they otherwise would be eligible for a Tailored Plan if not for belonging to a group delayed or excluded from managed care.

Please review Oct 1, 2021, Tailored Care Management Recording for additional information on TCM

Three Tailored Care Management Entity Types

Department of Health and Human Services

Establishes care management standards for Tailored Plans

Tailored Plan

<u>Care Management Choice</u>

Tailored Plan beneficiaries will have the opportunity to choose a care management entity

Choice Period is August 15-October 15

<u>Approach 1:</u>
"AMH+" Primary Care Practice

<u>Approach 2:</u>
Care Management Agency (CMA)

<u>Approach 3:</u>
Tailored Plan-Based Care Manager

What is AMH+ and CMA?

Advanced Medical Home Plus (AMH+)

- **Definition:** Primary care practices **actively serving as AMH Tier 3 practices**, whose providers have experience delivering primary care services to the Tailored Plan eligible population.
- **Each AMH+ applicant must attest that it has a patient panel with at least 100 active Medicaid patients who have an SMI, SED, or severe SUD; an I/DD; or a TBI**.
- AMH+ practices may, but are not required to, offer integrated primary care and behavioral health or I/DD services.

Care Management Agency (CMA)

- **Definition:** Provider organizations with **experience delivering behavioral health, I/DD, and/or TBI services to the Tailored Plan eligible population**, 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's **primary purpose** at the time of certification must be the delivery of NC Medicaid, NC Health Choice, or State-funded services to the Tailored Plan eligible population in North Carolina.
- **The "CMA" designation is new and will be unique to providers serving the Tailored Plan population.**

Providers must be certified to offer Tailored Care Management. More information on certification can be found here: https://medicaid.ncdhhs.gov/media/8316/download

Glide Path to Provider-Based TCM

At launch about 30% of members will receive TCM from providers.
At launch the majority to TCM will be provided by the Tailored Plan.

Year 1	Year 2	Year 3	Year 4
30%	45%	60%	80%

Over time, the goal is to increase the % of members who receive TCM through providers in the community (see targets above).

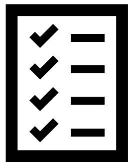
Care Management Assignment Process

Members who do not choose an organization for Tailored Care Management will receive an assignment based on the following factors:

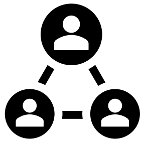
- Member's **existing primary care provider (PCP) assignment to an AMH+ practice or an existing treatment relationship with a CMA** within the Tailored Plan's network
- Member's **existing relationship with an LME/MCO Innovations waiver care coordinator**
- Member's **exceptional physical health and/or behavioral health needs:**
  - Exceptional physical needs = AMH+
  - Exceptional behavioral health need = CMA
  - Both exceptional physical and exceptional behavioral health needs = Tailored Plan (TP)
- Federal **conflict-free** case management requirements for people using home and community-based services (HCBS), which prohibit a provider organization from delivering HCBS and care management to one individual

What does TCM mean for Members & Providers?

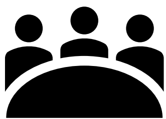
Each member in a Tailored Plan will have an assigned care manager to help them navigate all care and connect them to community resources.

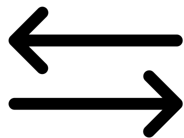


- **Members will have support to connect to their primary care providers (PCPs) and specialist.**
- **PCPs will have a resource (the care manager) if they need support meeting a member's need.**

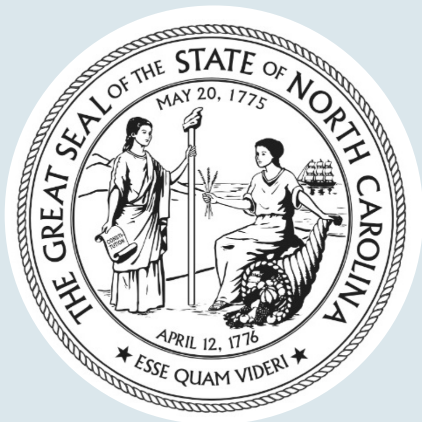


Care Managers will help with:





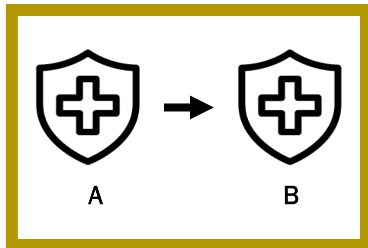
- Coordination of all services and supports
- Crisis Support
- Transitional care management (from hospital to home)
- Diversion from institutional settings
- In-reach and transitions from institutional settings (for certain populations)
- Addressing unmet health-related resource needs
- Medication monitoring



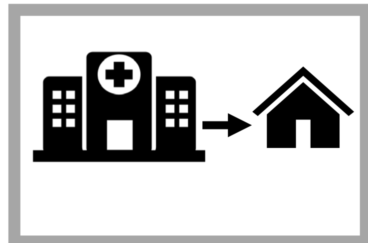
Transition of Care: Moving Members Between Standard Plans and Tailored Plans

A Note on Terminology

"Transition of Care" and "Care Transitions" have distinct meanings.



"Transition of Care" refers to the time-specific processes and safeguards established to support continuity of care when a beneficiary transitions to a new health plan or to a different healthcare delivery system (e.g., Medicaid Direct to managed care).



"Care transitions" refers to changes in a beneficiary's care setting (e.g., inpatient to community-based setting).

See AMH Provider Manual 2.0 . See also the AMH Training Page for more information on Transitional Care Management in AMH Tier 3.

The Vision for Transition of Care

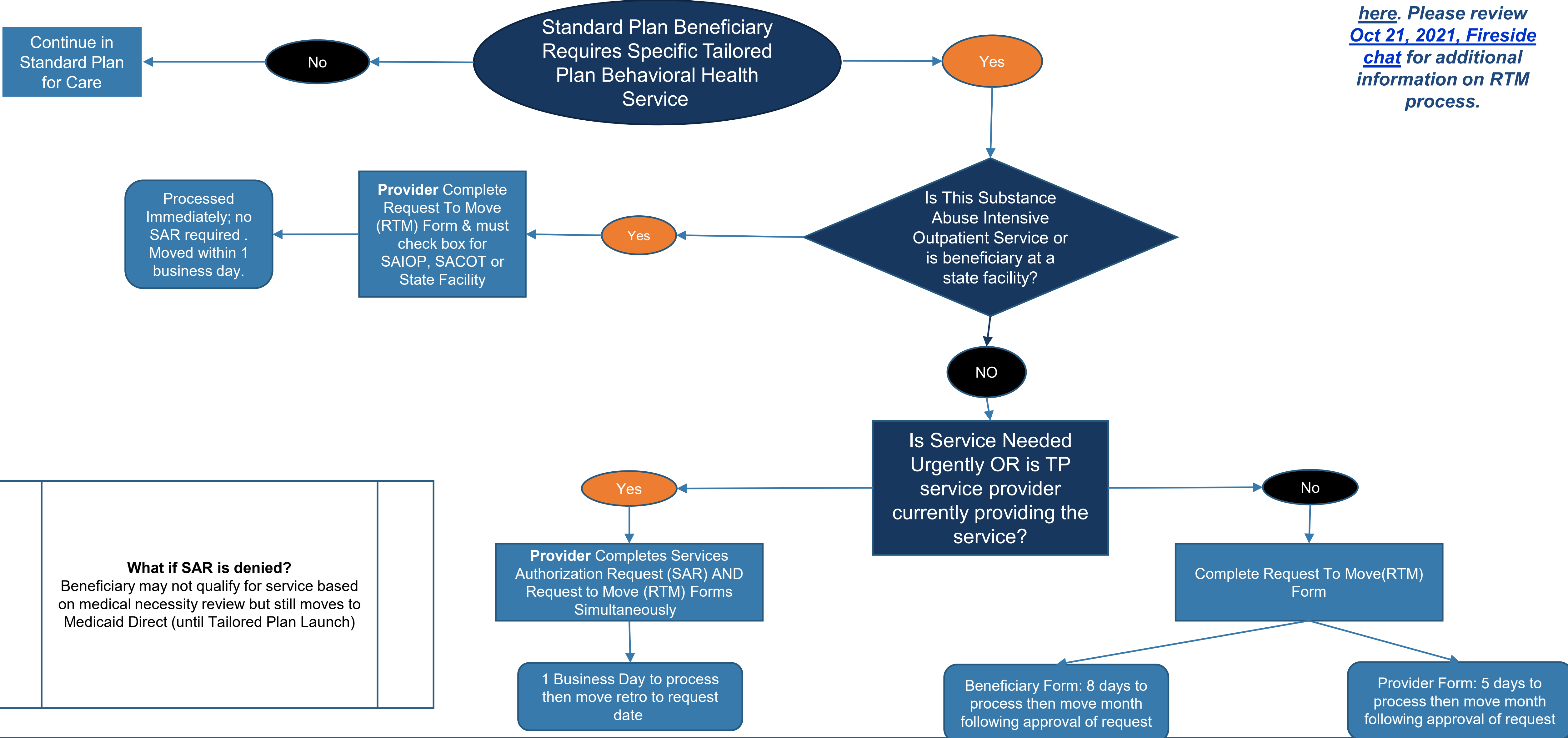
As beneficiaries move between delivery systems, the Department of Health and Human Services (Department or DHHS) intends to maintain continuity of care for each beneficiary and minimize the burden on providers during the transition.

Transition of Care – Triggers for Automatic Move to Tailored Plan/Medicaid Direct

- Innovations/TBI waiver
- Transitions to Community Living (TCL)
- Children with Complex Needs
- IDD Diagnosis
- SMI/SED Diagnosis with TP only service
- Two Psychiatric Hospitalizations in 18 months
- One State Psychiatric Hospitalization or ADATC admission
- Two Psychiatric ED visits in 18 months
- Two Behavioral Health Crisis services in 18 months
- Certain SMI/SED Diagnoses
- Clozapine or long-acting injectable Antipsychotics
- ECT
- ICF-IID

Standard Plan to Tailored Plan: The Flow

Request to Move Form can be found here. Please review Oct 21, 2021, Fireside chat for additional information on RTM process.



Service Authorization Requests

The LME-MCO Service Authorization Request (SAR) or Treatment Authorization Request (TAR) forms can be found at the following links.

- Alliance
- Eastpointe
- Partners
- Sandhills
- Trillium
- Vaya

Date of Submission: ____________

Provider Name:

Provider Address:

Site Code# and Address: | NPI#:

Member Na

Member Pa

SS#:

Address:

City, State, &

Legal Guard

Patient's Name: | DATE OF INI

Social Security #: | DOB:

Current Address: | Phone #:

City/State/Zip:

Medicaid #: - - None

Attending Provider:

Legal Guardian: ◻ None ◻ Parent ◻ DSS Other:

Class:

Class:

Psychosocial Stressors (check all that apply)

Start Date of Request: | End Date of Request:

Patient's Name:

Social Security #: | DOB:

Current Address:

City/State/Zip:

Medicaid #: - - ☐ None | County (Medicaid Eligibility):

Legal Guardian: ☐ None ☐ Parent ☐ DSS ☐ Other: | Name:

SERVICE INFORMATION

Level of Care (select only one):
☐ State Services ☐ Enhanced Services
☐ High Risk ☐ Inpatient Psych ☐ Outpatient
☐ PRTF ☐ Residential ☐ ICF/MR
☐ Innovations/B3

Type of Review (select only one):
☐ Concurrent Urgent ☐ Concurrent Routine ☐ Prospective Urgent
☐ Prospective Routine
☐ Retrospective

Type of Care (select only one):
☐ MH ☐ SA ☐ Voluntary ☐ Involuntary

Retrospective Medicaid Eligibility

I. Risk of Harm
II. Functional S
III. Co-Morbidi
IV-a. Recovery
IV-b. Recovery
V. Treatment
VI. Engagemen

I. Risk of Harm
II. Functional S
III. Co-Morbidi

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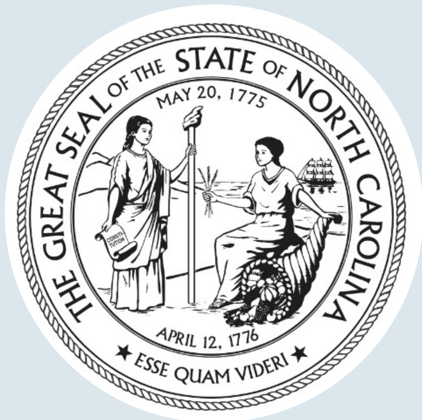


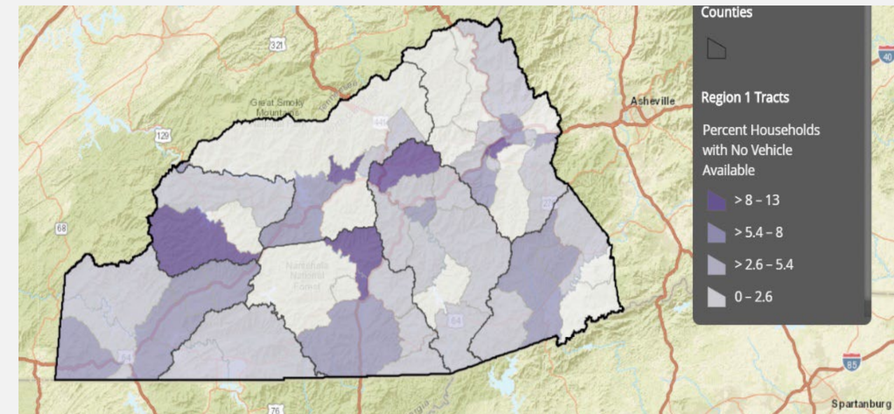
Medicaid Hot Topics

Unmet Health-Related Needs in North Carolina

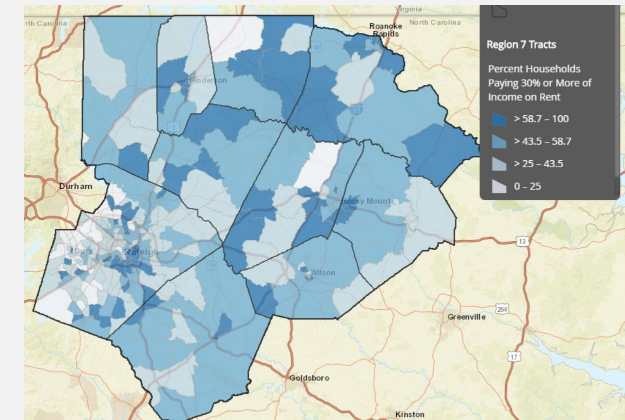
Citizens of North Carolina grapple with the impact of unmet health-related social needs every day.

- Over 1.2 million North Carolinians cannot find **affordable housing**, and one in 28 of the state's children under age six is homeless.
- NC has the 8th highest rate of **food insecurity** in the US, with more than one in five children living in food insecure households.
- 47% of NC women have experienced **intimate partner violence.**
- Nearly 25% of NC children have experienced **adverse childhood experiences** (ACEs),
- On average 7% of the state population do not have access to a vehicle and report that **lack of transportation** causes them to delay their medical care.

Percent of Households Without Access to a Vehicle*



Percent of Households Pay >30% Income on Rent



*NC Association of Local Health Department regions are represented in the maps above. For more information: [North Carolina Social Determinants of Health by Regions (arcgis.com)]

Healthy Opportunities Pilots Regions

The Department procured three (3) Network Leads (NLs) with deep roots in their community that will facilitate collaboration across the healthcare and human service providers. PHPs, Care Managers (CMs), NLs, and Human Service Organizations (HSOs) will work to implement the Pilots in three Pilot regions.

Who's involved?

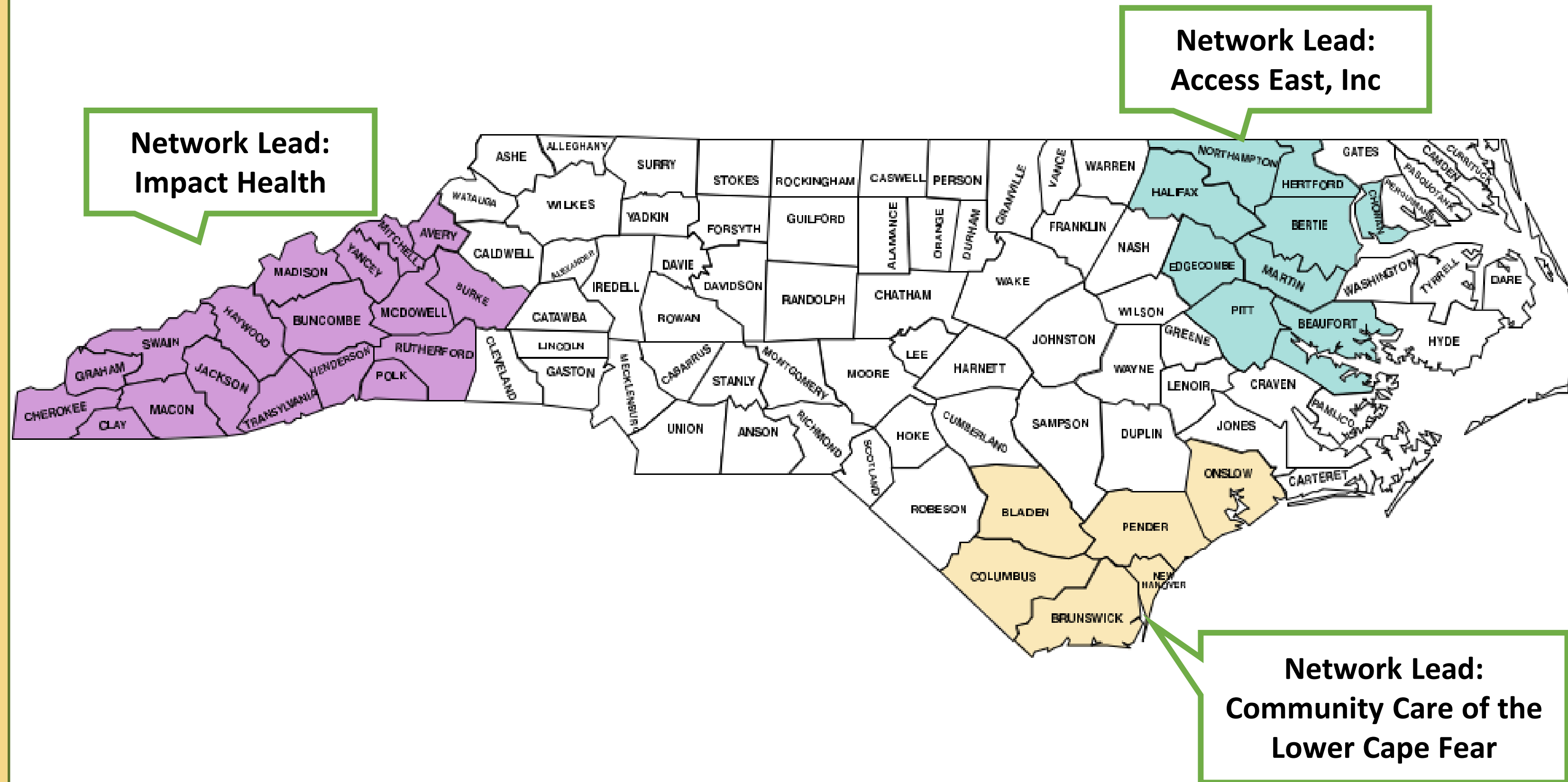
- DHHS, PHPs, CMs, NLs, HSOs, NCCARE360, and you!

Service Domains

- **Housing** (ex. Housing Navigation)
- **Transportation** (Ex. Reimbursement for Health-Related Public Transportation)
- **Food** (Ex. Food and Nutrition Access Case Management Services, Food Boxes/Meals)
- **IPV/Toxic Stress** (Ex. Evidence-Based Parenting Curriculum)
- **Cross-Domain** (Ex. Medical Respite)

Eligibility Criteria

- Enrolled in Medicaid Managed Care
- Live in a Pilot Region
- Have at least one qualifying physical/behavioral condition and one qualifying social risk factor
- Note: There are no age restrictions for eligibility!



For Additional Information Visit: Healthy Opportunities Pilots | NCDHHS

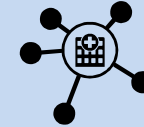
No Wrong Door: Entry Points into the Pilots

The Pilots is utilizing a "no wrong door" approach to identify and enroll individuals in the program, ensuring that individuals who first show up at various "entry points" can efficiently undergo the Pilot eligibility and service authorization process.

Provider Referral

Referral from Pilot Participating HSO

Referral from Non-Pilot Participating HSO



Self/Family Referral

PHP Identification

Care Manager Assessment

Members at all entry points will be connected to their care manager (at either their health plan or their primary care medical home)

Providers may refer members/families to the PHP. The PHPs will ensure that members are connected to their care manager for Pilot assessment.

QUESTIONS

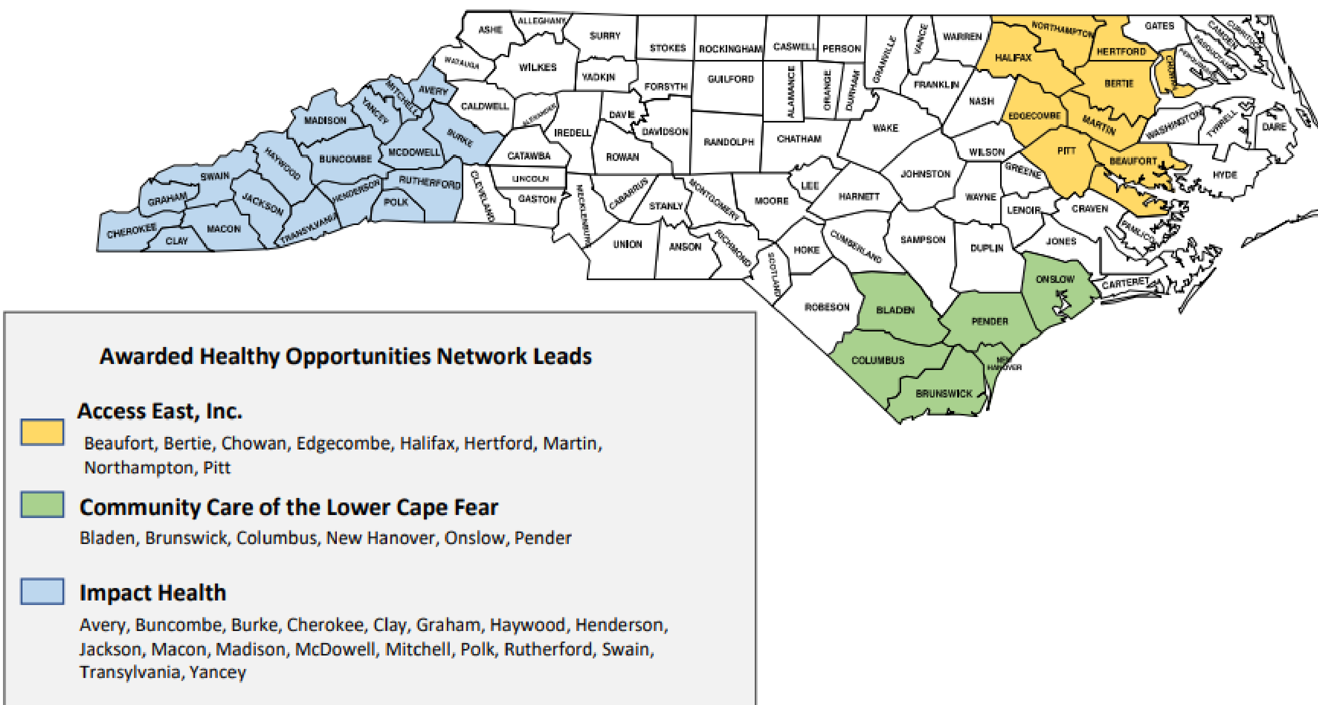
APPENDIX

Additional Healthy Opportunities Services Now Available

Healthy Opportunities is a groundbreaking pilot program that works in conjunction with the state's transition to NC Medicaid Managed Care to test and evaluate the use of Medicaid to pay for a select set of evidence-based interventions designed to address non-medical factors that drive health outcomes and costs. Qualifying Medicaid Standard Plan members in Healthy Opportunities Pilot regions may receive Evidence-Based Parenting Classes or Home Visiting Services as part of the pilots program that addresses toxic stress and Medical Respite which addresses multiple non-medical needs.

The following new services are:

- **Evidence-Based Parenting Classes**
- **Home Visiting Services**
- **Medical Respite**



For more information, please see Medicaid bulletin article Additional Healthy Opportunities Services Now Available.

Member Choice for Tailored Care Management

Tailored Plan members will be able to choose to obtain Tailored Care Management through an AMH+, CMA, or Tailored Plan.
Beneficiary choice period is Aug. 15, 2022- Oct. 14, 2022

- **Tailored Plans will provide information to members on the three different care management approaches** so that members can select an AMH+, CMA, or Tailored Plan for Tailored Care Management
- **Members will indicate their choice** of an AMH+, CMA, or Tailored Plan to provide Tailored Care Management by contacting the Tailored Plan
- **Members who do not express a preference will be assigned to an organization** that provides Tailored Care Management; the organization assigned for providing Tailored Care Management (AMH+, CMA, or Tailored Plan) will assign a care manager
- **Tailored Plans will send future Tailored Plan members a welcome packet**, which will include information about Tailored Care Management assignments
- **Members can change the organization they are assigned to** for Tailored Care Management and/or change care managers twice per year without cause and any time with cause

Functions of Tailored Care Management

Person and family-centered care planning is a core principle of Tailored Care Management. Care managers will consider the unique needs of the member and involve family members and caregivers where appropriate.

Care Management Comprehensive Assessment: As part of the care management comprehensive assessment, care managers will assess a member's available informal, caregiver, or social supports.

Care Plan/ISP Development: Each care plan and ISP must be individualized, person-centered, and developed using a collaborative approach including member and family participation where appropriate.

Care Teams: The member's care manager will establish a multidisciplinary care team that includes the member's caregivers and legal guardians, as appropriate.

Individual & Family Support: Tailored Care Management includes providing education and guidance on self-advocacy to the member and family members and connecting members and family members to resources that support maintaining employment, community integration, and success in school.

AMH+ and CMA Certification Updates

In preparation for the launch of Tailored Care Management, the Department has completed several round of AMH+/CMA certification.

Round	Application Deadline	Desk Reviews	Site Reviews	Number of Providers Certified
1	June 1, 2021	54 applicants passed desk reviews *(listing available here)*	▪ Round one site reviews were completed in June 2022	34 organizations passed the site review and are certified as CMAs/AMH+s
2	September 30, 2021	37 applicants passed desk reviews *(listing available here)*	▪ Round 1 and 2 continue to receive technical assistance through AHEC to support preparations for delivering Tailored Care Management. ▪ **All** Round 1 and 2 Providers have **completed** site reviews. NCQA is **finalizing documentation** on the final providers.	13 Certified CMAs/AMH+ Providers

Tailored Care Management HIT Systems Overview

AMH+ practices and CMAs must meet the following HIT requirements prior to Tailored Plan launch.

Use an electronic health record (EHR) or clinical system of record*

Use a care management data system

Use NCCARE360

AMH+ practices/CMAs may meet the HIT requirements by:
(1) Implementing or using their own systems;
(2) Partnering with a Clinically Integrated Network (CIN) or Other Partner; or
(3) Using the Tailored Plan's care management data system

* Use of an electronic health record (EHR) or clinical system of record is required to apply for and certify as an AMH+ practice/CMA.
See the Tailored Care Management Provider Manual for additional detail on the HIT requirements for AMH+ Practices and CMAs.

Use of Care Management Extenders in Tailored Care Management

The Department recognizes that Community Navigators, Peer Support Specialists, and Community Health Workers (CHWs) and other "care manager extenders" will play an important role in Tailored Care Management care teams and has developed guidance to provide clarification on their roles.

Vision

- Extenders will help AMH+ practices, CMAs, and Tailored Plans best meet the needs of members, build efficient care teams by creating additional workforce capacity, and allow care managers and supervisors to focus on key tasks for assigned members as well as permit them additional time for members with intensive or complex needs.

Qualifications

- Extenders must be at least 18 years of age, have a high school diploma or equivalent, be trained in Tailored Care Management, and meet lived experience and/or paid experience requirements*.
  - The Department expects that a range of individuals will be able to meet these qualifications, including, but not limited to: Certified Peer Support Specialists, CHWs, and individuals who served as Community Navigators.

Extender Functions

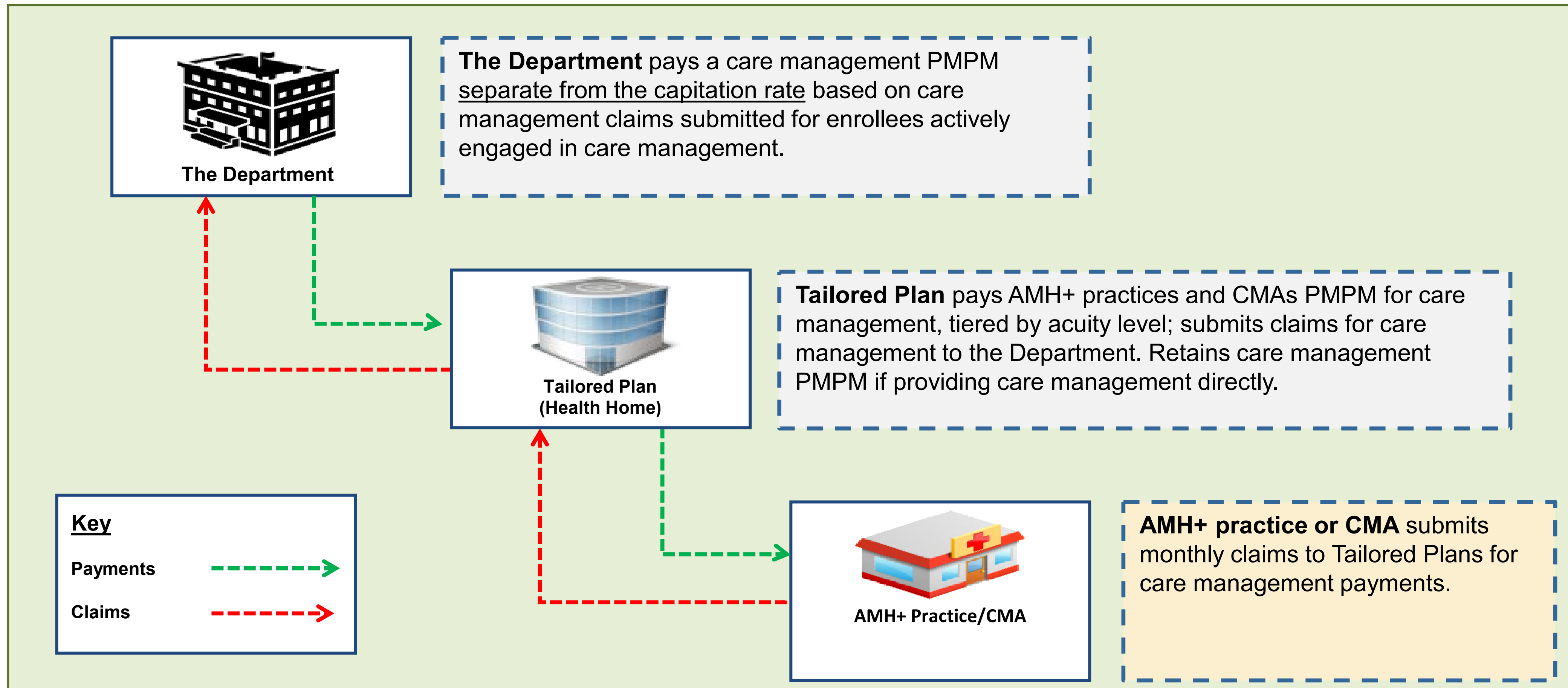
- **Extenders must work under the direction of the care manager for care management activities**, and can perform specific functions (e.g., coordinating services/appointments, engaging in health promotion activities).
- Extender functions may count as a Tailored Care Management contact.

*See Guidance on the Use of Care Manager Extenders in Tailored Care Management for more information.

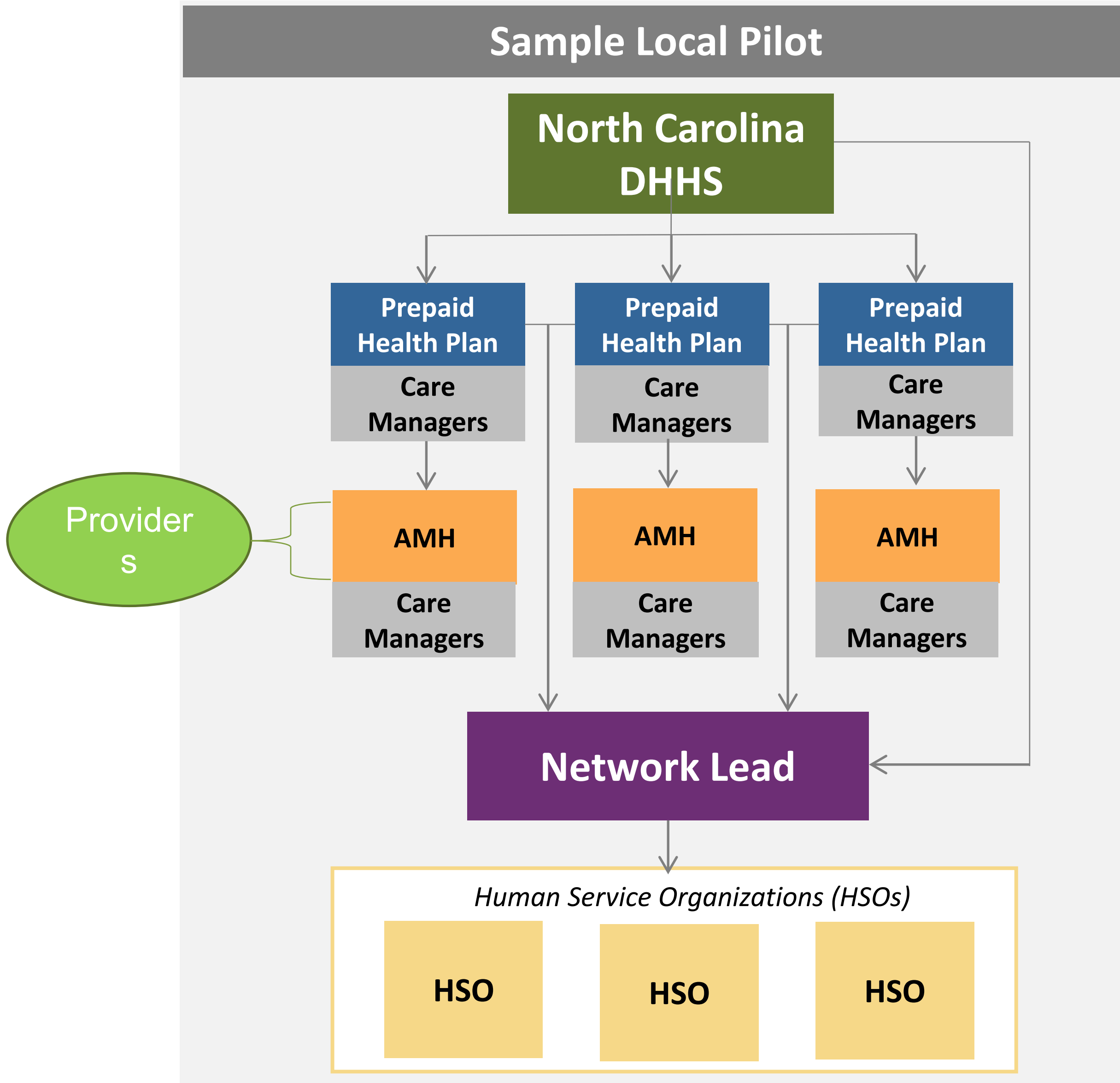
The Department is planning to release guidance on Care manager extenders in the coming weeks.

Payment for Tailored Care Management

AMH+ practices and CMAs will be paid standardized (fixed) PMPM rates, tiered by acuity.



How Will the Pilots Work?



Key Entities' Roles in the Pilots

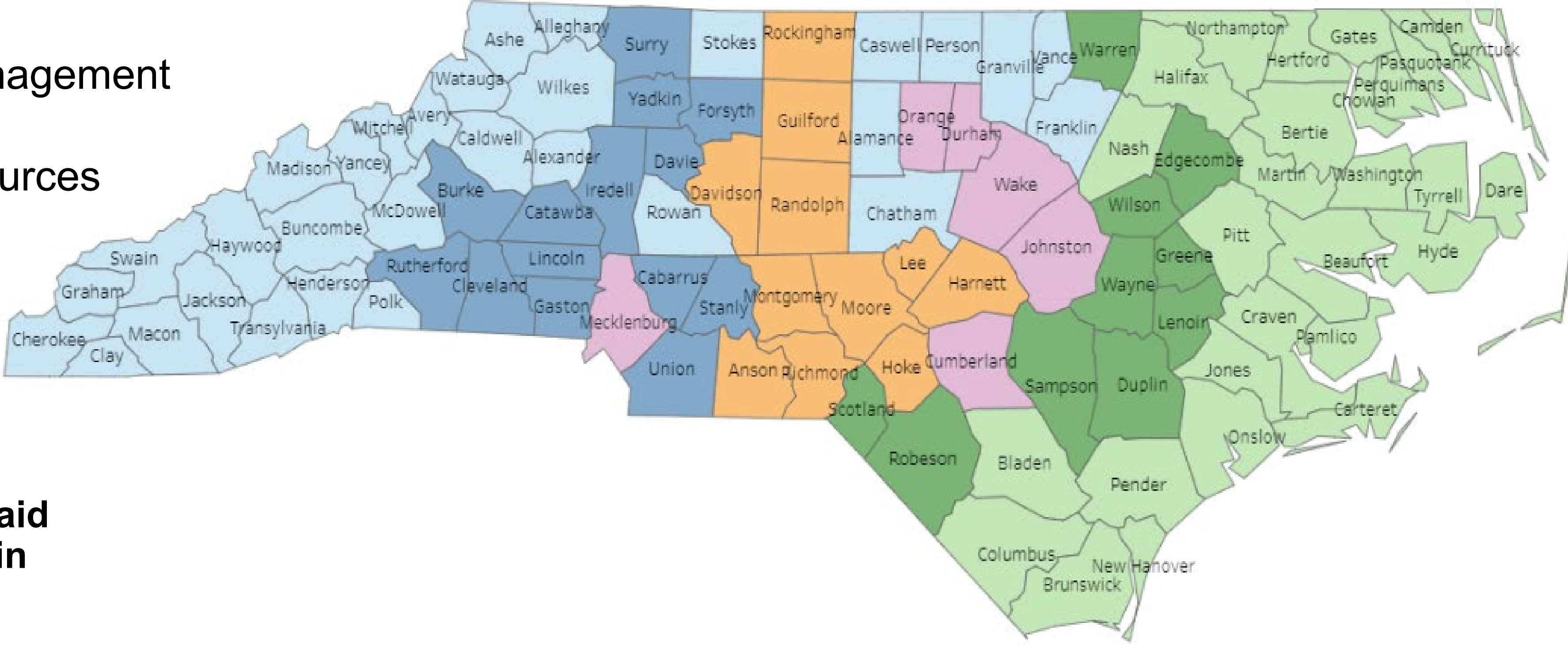
- **PHPs:**
  - Manage a Pilot budget
  - Approve member eligibility for Pilot services and authorize services
  - Ensure the provision of care management to members
  - Ensure individuals are enrolled in other federal/ state programs if eligible (e.g. SNAP and TANF)
  - Pay HSOs for Pilot services delivered and submit payment information to DHB as encounters
- **Care Managers:**
  - Interface with members to conduct care management at PHPs, Tier 3 AMHs, AMH+s, LHDs, and CMEs/CMAs
  - Assess beneficiary eligibility for Pilot services (approved by PHP); track member progress
- **Network Lead:**
  - Develop, manage, and oversee a network of HSOs
  - Serve as a connection between PHPs and HSOs
  - Define the geographic area they serve
  - Provide technical assistance to HSOs; convene Pilot entities to share best practices
  - Collect and report data to DHB to assist in evaluation and oversight
- **Human Service Organizations:**
  - Frontline social service providers that contract with the LPE to deliver Pilot services to Pilot members
  - Submit invoices and receive reimbursement for services delivered

Which Health Plans Will Provide BH I/DD Tailored Plans Services?

There are 6 Tailored Plans:

- Alliance Health
- Eastpointe
- Partners Health Management
- Sandhills Center
- Trillium Health Resources
- Vaya Health

This map shows Tailored Plan service areas as of 2/1/22



Approximately 177,000 Medicaid beneficiaries will be enrolled in Tailored Plans.