Exhibit B(5)

COMMUNITY BASED CARE MANAGEMENT PROGRAM

The Community Based Care Management (CBCM) Program requirements described in this Exhibit B(5) are for care rendered during a CY and defined in the PH-MCO specific CBCM Program approved by the Department per Section I below. Proposals submitted for the CBCM program must increase the use of community-based staff, including certified Community Health Workers where appropriate, to encourage the use of preventive services, identify and resolve barriers to care, and mitigate social determinates of health.

I. Community Based Care Management (CBCM) Program Requirements

A. CBCM activities and funding must primarily be focused on:

1. Addressing social determinants of health,
2. Reducing preventable admissions and readmissions,
3. Reducing non-emergent visits to the emergency department (ED),
4. Supporting the Diabetes Prevention Program (DPP) per Exhibit M(1), Standard V.F,
5. Enhancing behavioral and physical health coordination of services,
6. Targeting providers/organizations that serve a large volume of complex MA recipients including pregnant women;
7. Increasing access to pediatric dental preventive and restorative services;
8. Localized efforts to promote health education and wellness and encouraging the use of preventive health services; and
9. Expansion and capacity building of home-based support services for new parents.

Funding may only be used for approved CBCM services, as defined in the approval letter from the Department.

B. The PH-MCO must implement a minimum of one rapid cycle quality improvement pilot program per year. Rapid cycle quality improvement implies that changes are made and tested over periods of three months or less, rather than the standard twelve-month measurement period. At least one rapid cycle quality improvement pilot program needs to be implemented by the end of the second quarter. Rapid cycle quality improvement pilot programs should be implemented with community-based organizations and will focus on improving health outcomes and address social determinants of health. If a rapid cycle quality improvement pilot program is demonstrating success, the PH-MCO must progressively expand the program.

C. Community based staff must spend the majority of time in face-to face-encounters with members in a community setting, provider outpatient setting, hospital, or ED.

D. CBCM activity must involve care coordination by licensed and non-licensed team members as defined by the latest version of the Operations 15 report. Emphasis should be placed on expanding the use of non- licensed professionals to increase face-to-face interaction with members. Examples of licensed providers include but are not limited to: physicians, dentists, dental hygienists, public health dental hygiene practitioners (PHDHPs), physician's assistants, Certified Registered Nurse Practitioners (CRNPs), nurse midwives, RNs, LPNs, MSWs, dieticians, psychologists, and pharmacists. Examples of non-licensed team members include but are not limited to: medical assistants/technicians, community health workers, doulas, paramedics/EMTs, faith-based ministries, and peer specialists. This list of examples is not fully inclusive. These team members' activities need to be accounted for on the Operations 15 report.

Community based staff can be employed by the PH-MCO, employed by a provider organization, or hired by a third party through a contract with the PH-MCO. The PH-MCO will be responsible for reporting the targeted providers/organizations, targeted recipients, and define the financial spending for each arrangement (see more details below). Because of limited funding, the PH-MCO should target providers/organizations that serve a large volume of complex MA recipients including high risk pregnant women. Preference should be given to large health systems, FQHCs and high-volume dental providers. Preference should be given to programs that focus on co-location of care management services for consumers with Persistent Serious Mental Illness (PSMI) and Substance Use Disorder (SUD).

E. Payment arrangements can include but not be limited to: practice PMPM payments for care management services, payment for direct or contractual employment costs for FTEs, payment of care management CPT codes including transition of care codes, payment for special needs transportation to access MA services, and payment of pharmacy medication management codes.

F. When selecting providers/organizations to fund CBCM, the PH-MCO must require that the provider/organizations make use of electronic medical records with the intent of achieving Meaningful Use under the CMS specifications for Medicare or Medicaid. Providers/organizations that receive direct or indirect funding must be willing to participate in best practice collaborative learning sessions.

G. If the PH-MCO does business in multiple HealthChoices zones, CBCM Program funds can be allocated across any zone in which they are licensed.

H. The PH-MCO is required to develop and submit a proposal to the Department prior to implementing its CBCM Program. The CBCM Program may include multiple programs for use of the CBCM funds. If multiple programs are identified, each one must follow the requirements below. Proposals are due no later than **October 1, 2019** and must be submitted to the appropriate folder in Docushare using the CBCM Proposal template. Each CBCM proposal must include:

1. An initial CBCM program description that lists targeted providers/organizations, an initial six (6) and twelve (12) months budget, and operations timeline that outlines the startup of the program from January 1, 2020 through December 31, 2020.
2. For rapid cycle quality improvement pilot programs, include the budget for the pilot phase of the program. If the program is expanded, a revised budget for the expanded program must be submitted.
3. The targeted providers/organizations, larger volume health systems, FQHC's, or co-location of services being involved with CBCM. The PH-MCO will be responsible for reporting the targeted providers/organizations, targeted recipients, and define the financial spending for each arrangement.
4. The number of FTE's involved with or employed as a CBCM worker whether the FTE is full or part-time, licensed or unlicensed, contracted or part of the PH-MCO staff.
5. Measurable goals for each CBCM program.
6. An outline of interventions that the CBCM worker will be performing for each of the targeted providers.
7. Outline payment mechanisms and time frames to providers for CBCM.
8. Program Budget, which should include the payment terms.

I. A PH-MCO's approved CBCM program will remain in effect until December 31 of each calendar year. The PH-MCO may only submit one quarterly revision for the Department's review and approval. The PH-MCO must complete and submit the CBCM Proposal Change Form, that is available on Docushare. Changes must be submitted no later than close of business on the last day of each calendar quarter. No changes will be accepted for the fourth quarter. No other revisions will be accepted.

J.

The PH-MCO will establish an evidenced-informed, outcomes-based Maternal, Infant and Early Childhood Home Visitation Program for all first-time parents and parents of infants with additional risk factors. In addition to post-partum home visits, the PH-MCO will provide a minimum of two home visits

for all first-time parents and parents of infants with additional risk factors. These home visits must cover parent education on infant development and assessment of social determinates of health including identification of strengths and areas for improvement. The home visiting care manager/parent coaches will work to assist the parents with resources to address the identified needs. After the two home visits, if further follow up is warranted, the PH-MCO should refer the family to available evidence- based home visiting programs, positive parenting programs, child care or other family support programs in the community. If there are concerns about the infant's development, the PH-MCO should refer the family to Early Intervention for evaluation and services if eligible. The PH-MCO will follow-up with parents to identify and resolve any barriers and to ensure progress in obtaining all referred services.

If the PH-MCO currently implements an evidenced-based home visitation program for first time parents and parents of infants with additional risk factors, focus should be placed on expanding the program to new geographic areas and new populations.

Evidenced-informed, outcomes-based programs have a two-generation approach, aimed at improving the well-being of both parents and children across the lifespan. They are all steeped in the Strengthening Families Protective Factors Framework. Children are more likely to thrive when their families have the support they need from the beginning. Home visitors evaluate families' strengths and needs and provide services tailored to those needs, such as: teaching positive parenting skills and parent-child interactions, providing information on a wide range of topics including breastfeeding, safe sleep practices, injury prevention and nutrition, conduct screenings and provide referrals to address postpartum depression, substance use disorders and family violence, as well as developmental screenings of children and connecting families to other services and resources as needed. The list of approved evidence-based home visitation programs/models can be found at https://homvee.acf.hhs.gov/

K. The PH-MCO must implement their evidenced-informed, outcomes-based Maternal, Infant and Early Childhood Home Visitation Program no later than the end of second quarter of the calendar year. The PH-MCO needs to actively recruit and enroll community-based non-medical DPP providers. CBCM funds may be used for DPP infrastructure, data reporting and training of DPP coaches. CBCM funds cannot be used for any other DPP expenses.

II. Payments to the PH-MCO

A. The Department will make payments for CBCM based on a per member per month (PMPM) rate, noted in Appendix 3f. Effective January 1, 2018, CBCM payments to the PH-MCO will be net of those Members between ages 21 and

64 that have been determined by the Department to be in an IMD for 16 or more days in a calendar month and effective July 1, 2018, the Member's condition is not related to Substance Used Disorder (SUD). The CBCM payments are part of the monthly capitation process, as identified in Appendix 3b.

1. If the PH-MCO has unspent CBCM funds, as determined by the Department, determined as of June 30 of the subsequent calendar year, the Department may reduce a future payment to the PH-MCO by the unspent amount or the Department may direct unspent CBCM funds provided to the PH-MCO per this Exhibit for the current or a prior program year. Any directed CBCM funds are to be used in support of an initiative to improve access to care or improved quality outcomes for Members.
2. If at any time the Department determines CBCM funds were not disbursed in accordance with the approved CBCM plan, upon advanced written notice to the PH-MCO, the Department may elect to reduce a future payment to the PH-MCO by the amount identified.
3. The Department will not reimburse the PH-MCOs for CBCM related expenses in excess of payments made by the Department. However, PH-MCOs can chose to spend more than funds paid by the Department to improve quality or access to care.

III. Payments to Providers

The PH-MCO should make payment to providers within the approved time period for the approved CBCM program, as identified above.

IV. Reporting

A. Clinical Reporting

1. All PH-MCOs must submit an analysis of their Comprehensive Care Management in addition to submitting a sub-analysis of the Community Based Case Management program. These analyses must be submitted as part of Operations Report #15 to the Department on the scheduled reporting due date(s).
2. An analysis of CBCM services should be a subset of the Comprehensive Care Management Program which details each provider involved as well as the Community Based Care Management interventions utilized during member interactions that impacted or reduced preventable readmissions or non-emergent visits to the ED, increased use of preventive care, or enhanced coordination of BH/PH services. For dental related services,

MCO will report the impact of CBCM activity to increase the CMS 416 rate of preventive dental services as well as the HEDIS pediatric dental rate.

3. The PH-MCOs will report on the clinical and financial outcomes of the program. The analyses should be a subset of the Operations 15 report and must describe the program's return on investment (ROI).

B. Financial Reporting

The PH-MCO must submit three quarterly financial reports and a final annual financial report for all approved CBCM expenditures paid within one program year. PH-MCOs must submit the financial report in a format approved by the Department. Reports are due upon request from the Department. The final annual financial report is due by June 30 of the subsequent calendar year.

V. Clinical Review

The Department may choose to perform a review of the Community Based Care Management program. The PH-MCO must reasonably cooperate with Department staff during the review process.