North Carolina Department of Health and Human Services (DHHS)
Tailored Care Management Technical Advisory Group (TAG) Meeting #32 (Conducted Virtually)
July 26, 2024

Tailored Care Management TAG Members	**Organization**
Erin Lewis	B&D Integrated Health Services
Julie Quisenberry	Coastal Horizons Center
Billy West	Daymark
Denita Lassiter	Dixon Social Interactive Services
Luevelyn Tillman (absent)	Greater Vision Counseling and Consultants
Keischa Pruden	Integrated Family Services, PLLC
Haley Huff (absent; represented by Joanna Finer)	Pinnacle Family Services
Sandy Feutz	RHA
Lisa Poteat	The Arc of NC
Eleana McMurry, LCSW (absent)	UNC Center for Excellence in Community Mental Health
Donna Stevenson	Alliance Health
Lynne Grey	Partners Health Management
Cindy Ehlers	Trillium Health Resources
Chris Bishop	Vaya Health
Cindy Lambert (absent)	Cherokee Indian Hospital Authority
Jessica Aguilar	N/A
Pamela Corbett (absent)	N/A
Jonathan Ellis (absent)	N/A
Alicia Jones (absent)	N/A
NC DHHS Staff Members	**Title**
Kristen Dubay	Chief Population Health Officer, NC Medicaid
Andrew Clendenin	Deputy Director of Population Health, NC Medicaid
Loul Alvarez (absent)	Associate Director, Population Health, NC Medicaid
Regina Manly	Senior Program Manager, Tailored Care Management, NC Medicaid, Quality and Population Health
Gwendolyn Sherrod	Program Manager, Tailored Care Management, NC Medicaid, Quality and Population Health
Eumeka Dudley	Program Manager, Tailored Care Management, NC Medicaid, Quality and Population Health
Tierra Leach (absent)	Program Manager, Tailored Care Management, NC Medicaid, Quality and Population Health

Agenda

- Welcome and Roll Call
- Tailored Plan Launch: Flexibilities to Ease Provider Administrative Burden
- Tailored Care Management Updates
- Additional Questions/Public Comments

Tailored Plan Launch: Transition of Care (slide 7-9) – Regina Manly

The Department has implemented the following policy flexibilities to ease provider administrative burden at Tailored Plan launch and ensure individuals receive uninterrupted care:

- **Out of Network Provider Rates:**
  - Between July 1, 2024, and September 30, 2024, in addition to out of network requirements found in the Department's Transition of Care policy, Tailored Plans must also pay for services for Medicaid-eligible nonparticipating/out of network providers equal to those of in network providers for 91 days after Tailored Plan launch. Medically necessary services for physical and behavioral health will be reimbursed at 100% of the NC Medicaid fee-for-service rate for both in- and out- of network providers.
  - Starting on October 1, 2024, out-of-network providers with whom the Tailored Plan has made a good faith effort to contract will be reimbursed at no more than 90% of the Medicaid fee-for-service rate. *Note: Out-of-network providers must still be enrolled in NC Medicaid to be reimbursed by the Tailored Plan.*
- **Out of Network Providers Follow In-Network PA Rules:**
  - Between July 1, 2024, and Jan. 31, 2025, Tailored Plans will permit uncontracted, out of network providers enrolled in NC Medicaid to follow in-network provider prior authorization rules. Starting on Feb. 1, 2025, out-of-network providers must seek authorizations for all services.

Please see the bulletin on flexibilities for additional information. If members are experiencing issues with continuing to see their out-of-network provider during the specified dates, please submit an Ombudsman ticket.

Multiple participants noted that since Tailored Plan launch, members have experienced difficultly in accessing care—specifically primary care, medications, and non-emergency medical transportation. Participants also shared that they have experienced members being denied services because providers' staff are unaware of these flexibilities and recommended additional education on the flexibilities.

- One Tailored Plan responded that, in addition to the Department's recommendation of submitting an Ombudsman ticket, providers and members should contact their Tailored Plan about these issues and they can help.

Clarification on Clinically-Appropriate Assistive Technologies For Qualifying Contacts (slides 10-15) – Eumeka Dudley

As a reminder, the updated Provider Manual includes a new policy that notes that for members who request accommodations due to relevant health conditions, contacts can be delivered, at the discretion of the Tailored Plan / LME/MCO, AMH+, or CMA, using clinically-appropriate technologies (e.g., speech-to-text application, secure platforms for two-way instant messaging/texting).

The Department reviewed and responded to frequently asked questions regarding this new policy:

- Does a member need to have documentation of a relevant health condition to request clinically-appropriate assistive technologies for Tailored Care Management qualifying contacts?
  - Yes, as specified in the Provider Manual, member preferences for accommodation requests should be documented in the care plan/ISP and reviewed with the supervising

care manager. This update to the care plan/ISP can be made as part of the next care plan/ISP update.
    - Additionally, the care manager should update the care management service record to document the accommodations due to relevant health conditions.
- What relevant health conditions may warrant the delivery of clinically-appropriate assistive technologies?
    - An individual who has a condition that affects their ability to receive, comprehend, or process information may warrant the delivery of clinically-appropriate assistive technologies to ensure effective communication and support. The Department recognizes that there may be a variety of conditions that may warrant such technologies and leaves this at the discretion of the Tailored Plan / LME/MCO, AMH+, or CMA.
- Can communication over email count as a qualifying contact using clinically-appropriate assistive technology (e.g., speech-to-text application)?
    - Email exchange does not count as a qualifying contact at this time.

Tailored Care Management Provider Manual Update: Documentation Guidance Section (slides 16-19) – Gwendolyn Sherrod

The updated Provider Manual includes a new section (Section IX) that provides information and guidance on documentation standards to ensure clear, concise, and correct documentation. This new section also includes details of the service record, which is the official document that reflects all the aspects of Health Home service delivery and that provides the essential evidence of the quality of care delivered, and the care management service notes, which are the heart of the care management service record, documenting the care management activities conducted on behalf of a member.

One provider asked if there will be flexibilities for the time it will take for Electronic Health Records (EHR) to update platforms to comply with new documentation guidelines (e.g., the signature line/electronic signature requirement, addition of specific goals to notes).

- The Department responded that it does not expect that providers need to update their EHRs to comply and clarified that, per the Provider Manual, electronic or digital signatures on documents within the service record are permissible. In general, the documentation guidelines reflect current Tailored Care Management policy (e.g., care managers are required to conduct continuous progress towards goals identified in the Care Plan/ISP).

Transitions to Community Living (TCL) Roundtable (slides 20-21) – Gwendolyn Sherrod

The Department launched a TCL roundtable to identify and resolve gaps and needs for TCL participants transitioning from their plan-based Tailored Care Management services to a community-based provider. The roundtable will meet monthly and consist of providers with TCL distinction, the Tailored Plans / LME/MCOs, and the Department.

Update on TCM Monitoring Tool Piloting Section (slides 22-24) – Damali Alston (Alliance Health)

Alliance Health presented on the piloting of the Tailored Care Management (TCM) Monitoring Tool. The Tailored Plans / LME/MCOs conducted a pilot with Monarch. Strengths of the monitoring tool based on this pilot are that (1) the tool is comprehensive and covers all aspects of TCM requirements, and (2) the sample size was adequate.

The Tailored Plan / LME/MCO workgroup planned to meet to review ways to improve the TCM monitoring tool and the general process based on the piloting. The Tailored Plans / LME/MCO will continue to keep the TAG informed about TCM monitoring tool updates.

Additional Questions/Public Comments (slides 25-26) – Gwendolyn Sherrod

The Department opened up the meeting to the full group to provide feedback and ask questions. TAG members made the following comments:

- Multiple providers requested that the Department consider methods for measuring I/DD outcomes, noting that many Healthcare Effectiveness Data and Information Set (HEDIS) measures are more applicable for measuring behavioral health condition outcomes.
    - The Department thanked the providers for this feedback.
- Multiple providers expressed they are continuing to have issues with members they are serving being assigned back to the plans. They asked if they could still receive payments for providing care management to these reassigned members.
    - The Department noted that they are working on creating a process to resolve this payment issues. In the meantime, the Department encourages providers to submit Ombudsman tickets to resolve these problems.
- Multiple TAG members asked how they should proceed when they have reached out to an individual for the 1915(i) assessment but do not receive any response.
    - The Department responded that they will take this back to the 1915(i) team and noted that care managers should document their efforts, which should include reaching out to the individual's other providers.

Tailored Care Management TAG members are encouraged to send any feedback or suggestions to Medicaid.TailoredCareMgmt@dhhs.nc.gov.