Tailored Care Management Technical Advisory Group (TAG)

Meeting #16

General Updates on Tailored Care Management Implementation

Frequently Asked Questions (FAQs)

March 24, 2023

Agenda

- Welcome and Roll Call (5 min)
- Tailored Care Management Implementation Updates (25 min)
- Frequently Asked Questions (20 min)
- Public Comments (5 min)
- Next Steps (5 min)

Welcome and Roll Call

Department of Health and Human Services

Lauryn Walker, PhD, RN	Loul Alvarez, MPA	Gwendolyn Sherrod, MBA, MHA	Eumeka Dudley, MHS	Regina Manly, MSA	Tierra Leach, MS, LCMHC-A, NCC	Tenille Lewis, MA
Chief Population Health Officer (Interim)	Associate Director, Population Health	Program Lead, Tailored Care Management	Program Lead, Tailored Care Management	Senior Program Manager, Tailored Care Management	Program Specialist, Tailored Care Management	Program Specialist, Tailored Care Management
Contact: Medicaid.TailoredCareMgmt@dhhs.nc.gov						

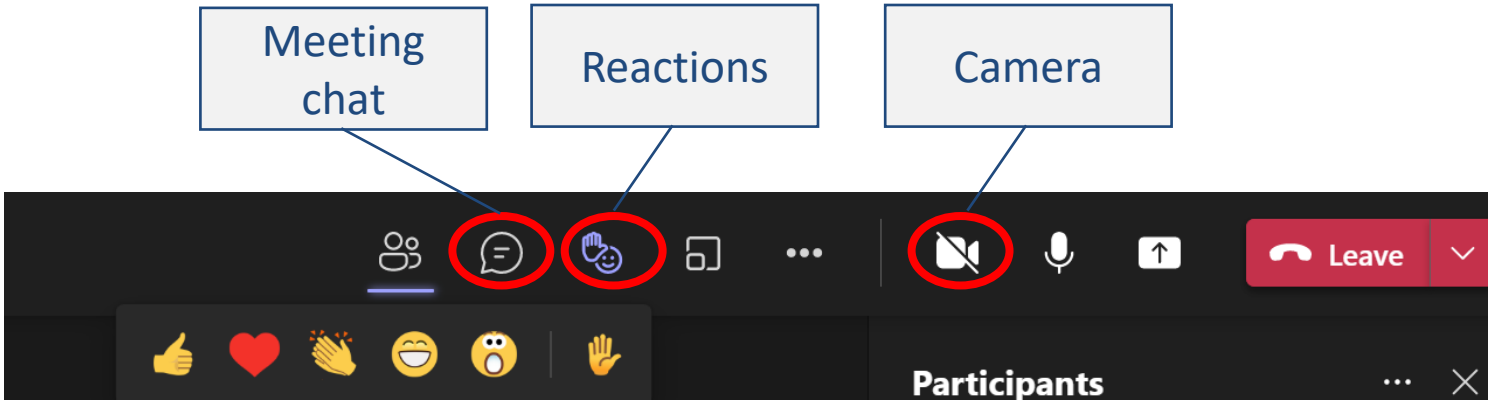
NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Tailored Care Management TAG Membership

Name	Organization	Stakeholder
Erin Lewis	B&D Integrated Health Services	Provider Representative
Lauren Clark	Coastal Horizons Center	Provider Representative
Denita Lassiter	Dixon Social Interactive Services	Provider Representative
Jason Foltz, D.O.	ECU Physicians	Provider Representative
Natasha Holley	Integrated Family Services, PLLC	Provider Representative
DeVault Clevenger	Pinnacle Family Services	Provider Representative
Lisa Poteat	The Arc of NC	Provider Representative
John Gilmore, M.D.	UNC Center for Excellence in Community Mental Health	Provider Representative
Sean Schreiber	Alliance Health	Tailored Plan Awardee
Beverly Gray	Eastpointe	Tailored Plan Awardee
Lynne Grey	Partners Health Management	Tailored Plan Awardee
Sabrina Russell	Sandhills Center	Tailored Plan Awardee
Cindy Ehlers	Trillium Health Resources	Tailored Plan Awardee
Rhonda Cox	Vaya Health	Tailored Plan Awardee
Cindy Lambert	Cherokee Indian Hospital Authority	Tribal Option Representative
Jessica Aguilar	N/A	Consumer Representative
Pamela Corbett	N/A	Consumer Representative
Alicia Jones	N/A	Consumer Representative
Cheryl Powell	N/A	Consumer Representative

Increasing Engagement

We encourage those who are able to turn on cameras, use reactions in Teams to share opinions on topics discussed, and share questions in the chat.



Tailored Care Management Implementation Updates

Delay in Tailored Plan Launch

On February 27, 2023, the Department announced Tailored Plan launch has been delayed from April 1 to October 1, 2023. Tailored Care Management implementation continues.

- Tailored Care Management, which launched on December 1, 2022, will continue to support eligible beneficiaries by offering a care manager and care team to coordinate care across providers.

- In recognition of the challenges with early implementation, the Department is **delaying implementation of the Health Home State Plan Amendment (SPA) until July 1, 2023,** in order to focus on stabilizing the Tailored Care Management program before additional federal requirements apply to the program.

  Reminder: The State aligned Tailored Care Management requirements with the federal Health Home model to receive additional federal Medicaid matching funds to support North Carolina's Medicaid program.

Launch of Acuity Tiers

Effective April 1, 2023, the Department is implementing acuity-based contact requirements. The Department is continuing the single, blended Tailored Care Management rate ($269.66) through June 30, 2023. Acuity-based payments are effective July 1, 2023.

Why is the Department using acuity tiers?

- The Department recognizes that the Tailored Care Management eligible population is not uniform and has varying levels of need. Acuity tiers recognize that people with higher needs need more intensive care management and ensure providers with higher acuity panels are adequately reimbursed for the care they are providing.
- The acuity tier algorithm categorizes members into either Behavioral Health (BH) or Intellectual/Developmental Disability (I/DD) population categories, for each of which there are three (3) acuity tiers: low acuity, moderate acuity, and high acuity.

Organizations providing Tailored Care Management should use their clinical judgment and assessment of member needs to determine the intensity of care management and the number of contacts a member needs.

Acuity tiers serve as a guide and organizations will be held to contact requirements at the panel, not the individual member level.

See Appendix for additional acuity tier contact requirements and payment rates

Contact Requirements and Compliance

The first compliance measurement period will be for the period between April 1 and June 30, 2023. The compliance scores for the April-June measurement period will be calculated and communicated September 2023.

Provider compliance to minimum contact requirements **will be assessed at the panel level <u>not</u> on a per-member basis.**

- **Panel-level monitoring provides flexibility for clinical judgement** to permit more or less contacts than their acuity tier indicates for any given individual.
- **The Department will look at the cumulative number of contacts AMH+s/CMAs were expected to deliver across their entire population for that quarter.**
- An AMH+/CMA is in compliance if they deliver **at least 75% of the sum of contacts required by all members in their panel.**

Contact Monitoring: Compliance Thresholds and Penalties

Compliance Thresholds

- The Department has established the following compliance thresholds:
  - Fully compliant: 75 – 100% of contacts met.
  - Partially compliant: 50 – 74.99% of contacts met.
  - Noncompliant: 0 – 49.99% of contacts met.
- Partially compliant and noncompliant organizations will receive technical assistance from the Department and/or LME/MCO; there will also be penalties for organizations that repeatedly demonstrate noncompliance.

Entity Found to Be *Partially Compliant*:

- First Instance: Entity is notified of issue and receives technical assistance (TA).
- Second Instance: Entity must submit a corrective action plan (CAP) if issue has not been remediated.
- Third Instance: LME/MCO subject to liquidated damages and other sanctions*; AMH+/CMA decertified.

Entity Found to Be *Noncompliant*:

- First Instance: Entity is notified of issue and receives technical assistance. Entity also required to submit a CAP.
- Second Instance: LME/MCO subject to liquidated damages/other sanctions*; AMH+/CMA decertified.

Considerations

- The Department has emphasized flexibility in its monitoring approach by establishing compliance thresholds below 100% and providing several opportunities for organizations to remedy any identified issues.
- Panel-level monitoring also accounts for members whose care management needs change within a monitoring period (e.g., “low” acuity member experiences hospitalization, “high” acuity member responds to treatment and has fewer needs).

* LME/MCO is only subject to liquidated damages and other sanctions if it is the organization delivering Tailored Care Management.

Contact Monitoring Example: Fully Compliant

The provider below has been determined to be fully compliant. No further action is needed.

Provider's Panel During Monitoring Period (3 Months)			
Acuity Tier	**Members with Behavioral Health Needs**	**Contacts Delivered for Each Acuity Tier**	**Minimum Required Contacts**
High *(4 contacts/month)*	**Five** members contacted in each month	**51**	**60** (5 members X 4 contacts per month X 3 months)
Moderate *(3 contacts/month)*	**Five** members contacted in each month	**35**	**45** (5 members X 3 contacts per month X 3 months)
Low *(2 contacts/month)*	**Ten** members contacted in each month	**46**	**60** (10 members X 2 contacts per month X 3 months)

Share of Contacts Met Calculation

$$\frac{\text{Sum of All Completed Contacts} = 51 + 35 + 46}{\text{Sum of Minimum Required Contacts for Engaged Members} = 60 + 45 + 60} = \frac{132}{165} = 80\ \%$$

The Department will only assess compliance in months where a provider makes a contact with that member. This methodology is based on the understanding that TCM is a new program and could be revised in future years.

Round 3 Certification

To stabilize current Tailored Care Management providers and ensure Round 3 providers are successful, the Department is delaying Round 3 certification for 3-6 months, with some exceptions.

Why is the Department delaying Round 3?

- Due to more panel slots being opened and filled by more Round 1 and 2 providers than expected, some counties and population segments (i.e., behavioral health, I/DD, adult, child) do not need additional provider capacity at this time.

The Department will make exceptions to the delay for providers that would fill a current gap. The Department will work with individual providers, AHEC, and the LME/MCOs on these exceptions.

Based on feedback from the field, the Department is also reviewing the certification criteria for providers that intend to serve members with co-occurring I/DD and BH to ensure providers are adequately prepared to serve these populations.

Round 3 Certification – Additional Details

The **Department is preparing provider-specific market area reports** to support Round 3 providers in decision-making. Providers may choose to:

1. Request an exception to the delay
2. Continue with delayed timeline
3. Discontinue certification process

Potential exceptions to the delay:

- AMH+ providers
- Providers requesting certification for population segments in need of provider-based care management
- Providers serving currently under-served counties
- Other exception requests will be considered as requested by the provider

What does the delay mean for Round 3 applicants?

- Applicants will still be assigned an AHEC coach after a successful desk review and can begin working with their coach to prepare for their site reviews
- The start of site reviews will be delayed by 3-6 months for those in the main Round 3 group

DHB Tailored Care Management Office Hours

The Department has launched Tailored Care Management office hours for providers to ask questions and share feedback on their experience implementing the model.

The next session will be on April 19, 2023.

Moving forward, office hours will generally be held on the third Wednesday of the month.

TCM TAG Membership Refresh

The Department plans to begin a process in April to refresh the Tailored Care Management TAG membership, which will allow current members to rotate off the TAG and new members to join.

The Department will announce more details in the coming weeks.

Tailored Care Management TAG Data Subcommittee
Subcommittee Launch

Based on feedback received from the Tailored Care Management TAG, the Department will launch a Data Subcommittee later this spring.

Purpose of the TAG Data Subcommittee

- Increase understanding of core Tailored Care Management data, system, and reporting requirements, needs, and concerns;
- Provide a forum for Tailored Care Management entities to raise issues for discussion and resolution; and
- Identify, prioritize, and provide informed recommendations on data topic issues that arise with Tailored Care Management implementation.

Tailored Care Management TAG Data Subcommittee
Membership

The Department will seek nominations for Data Subcommittee members.

Data Subcommittee Membership

- Data Subcommittee members will provide advice to the Department and the TCM TAG on data- and system-related matters.
- Data Subcommittee members will represent diverse perspectives from health plans, AMH+ practices, CMAs and CINs, and will be selected for their technical and operational subject matter expertise and ability to productively contribute to issue solutioning.
- Data Subcommittee members will be expected to:
  - ✓ Identify and consider critical Tailored Care Management-related data, data exchange and HIT priorities and concerns;
  - ✓ Identify opportunities for data system efficiencies and alignment; and
  - ✓ Serve as ambassadors to their networks, sharing and collecting input on topics and promoting dialogue and communication with stakeholders.

Questions?

Frequently Asked Questions

FAQ #1: Capacity Building Funds

- **What is the deadline for providers to spend Capacity Building Funds (CBF)?**

- The Department has not set a deadline for providers to spend CBF.
- The Department does not have the authority at this time to distribute funds to the LME/MCOs after June 30, 2023.
- Providers should continue to meet targets agreed upon with their Tailored Plan that will allow the plans to draw down funds from the Department. Once providers have met a milestone, as described in their capacity building agreement with the Tailored Plan, the funds are theirs to use as needed for TCM.

FAQ #2: Outreach and Engagement Payment

- **Will the Department consider implementing an outreach and engagement payment?**

- There will be no separate payment for outreach and engagement because federal policy only permits payments for delivery of one of the six core Health Home services as defined in the Tailored Care Management provider manual: comprehensive care management, care coordination, health promotion, comprehensive transitional care/follow-up, individual and family support, and referral to community and social support services. Federal policy does not permit payments for outreach and engagement.

- However, capacity building funds can help close funding gaps as providers continue to outreach and engage members in the model. *(see next slide for how capacity building funds can be used to support outreach and engagement)*

FAQ #3: Capacity Building Funds and Administrative Tasks

- **Can capacity building funds be used to cover time that the provider spends on non-billable administrative tasks, such as outreach that does not result in a consent or contact, researching members, reviewing member data or addressing technology challenges?**

- Yes, Milestone 6 (AMH+ practices/CMAs meeting other competencies linked to operationalizing Tailored Care Management) can be used to cover expenses related to:
  - Multiple attempts to engage a member and/or obtain consent,
  - Time spent engaging members who ultimately opt out of Tailored Care Management,
  - Time spent on researching contact information,
  - Time spent on keeping members engaged (e.g., member consented but then becomes difficult to engage, requiring care manager to make multiple attempts),
  - Time spent on reviewing claims data, and
  - Time spent addressing challenges related to Tailored Care Management data discrepancies or technology interfaces.
- Tailored Plans can reflect these expenses in their distribution plans as hours of staff time spent on outreach and administrative tasks and should set similar targets/reporting requirements with providers.

FAQ #4: Member Acuity Tiers

- **What happens if we disagree with an individual member's acuity tier? Is there a mechanism where we can dispute or change a member's acuity tier?**

- No. Individual member acuity tiers are not meant to be changed because the Department expects members to potentially fluctuate in the level of care management contacts they may need in a given month (e.g., "low" acuity member experiences hospitalization and requires more contacts, "high" acuity member responds to treatment and has fewer needs) and has accounted for this in the compliance approach. Compliance for the minimum contact requirements will be assessed at the panel level instead of the member level to account for fluctuation in individual members' needs month-to-month.
- Acuity tiers serve as a guide to the intensity of care management for members; contacts should ultimately be driven by the member's clinical needs.
- However, the Department is interested in feedback on whether there are broader trends across an entire population for a specific acuity tier.

**Note: The Department will re-run acuity tiers every six months.*

FAQ #5: Members With Immediate Needs

- **If a member presents with immediate needs (e.g., housing), can we address their needs and count this service as a Tailored Care Management contact?**

- Yes, providers can assist members with immediate needs and this service can be billed as a Tailored Care Management contact as long as the member consents to participating in Tailored Care Management and the provider documents this consent.

- Care managers can then work to conduct the care management comprehensive assessment to identify other needs and develop the care plan/ISP.

FAQ #6: Telehealth Policies

- **Can telehealth be used in the delivery of Tailored Care Management?**

- Telehealth (i.e., telephonic or two-way real time video and audio conferencing) may be used for contacts that are not required to be in-person.
- If the care manager or extender utilizes two-way real time video and audio conferencing, the care manager or extender must enable applicable encryption and privacy modes and provide notice to the member that the third-party application potentially introduces privacy risks.
- Public facing video communication applications, such as Facebook Live, Twitch, or TikTok, should not be used.

FAQ #7: Incorrect/Missing Member Contact Information

- **We are struggling to reach members due to incorrect or missing contact information. How can we address this challenge?**

- The contact information for Medicaid members is based on information provided to the Division of Social Services and may not be up-to-date or accurate.
- The Department is providing training sessions through AHEC to support providers using HIE to obtain additional contact information.
- Providers are encouraged to use a variety of strategies to track down accurate contact information for members, recognizing that providers may not have sufficient information on a member to explore all these strategies*. For example,
  - Attempting a face-to-face visit to the last known address;
  - Contacting service providers by phone;
  - Contacting collateral and emergency contacts and supports, such as a parent, guardian or legally authorized representative, or other family member (if available);
  - Accessing online criminal justice resources; and
  - Reviewing hospital alerts and ADT feeds.

*Providers are also encouraged to work with their LME/MCOs to gather any contact information that the plans may have.

FAQ #8: PCPs and Care Plans/ISPs for 1915(i) Services

- **What are the differences between a Person-Centered Plan (PCP) and Care Plan/Individual Support Plan (ISP)?**

- North Carolina Medicaid has historically required providers to complete a PCP for an individual to obtain authorization for 1915(b)(3) services.
- Federal rules require that to obtain 1915(i) benefits, an individual must obtain an independent assessment to be used to develop a service plan, called a Care Plan (for individuals with behavioral health needs) or Individual Support Plan (ISP) (for individuals with an I/DD or TBI) in North Carolina.
- In addition to the required Care Plan/ISP for individuals obtaining 1915(i) services, individuals may still have a PCP developed. For example, service providers may still complete a PCP for individuals obtaining 1915(i) services, if needed (e.g., to capture short-term goals for an individual, to authorize other non-1915(i) services). In this scenario, the individual's care manager should incorporate information from the individual's PCP into their Care Plan/ISP to the maximum extent possible.

FAQ #9: Authorization Requirements for 1915(i) Services

- **Is a Person-Centered Plan (PCP) required for an individual to access 1915(i) services?**

- No, a PCP will no longer be used for authorization of 1915(i) services.
- The Department believes that individuals who need 1915(i) services will benefit from having a single Care Plan or ISP that documents their whole-person needs, including, but not limited to, their need for 1915(i) services.
- Accordingly, the Department is requiring that for individuals in need of 1915(i) services, the Care Plan or ISP used for Tailored Care Management should also be used to document an individual's need for 1915(i) services.
- Individuals who have opted out of Tailored Care Management must still work with a care manager to develop a Care Plan/ISP to obtain 1915(i) services.

Additional Questions for Discussion

Are there other questions that TAG members would like to discuss?

Public Comments

Next Steps

Next Steps

Tailored Care Management TAG Members

- Review updates on Tailored Care Management webpage

Department

- Discuss feedback received during today's Tailored Care Management TAG meeting

Tailored Care Management TAG Meeting Cadence

Tailored Care Management TAG meetings will generally take place the fourth Friday of every month from 3:30-4:30 pm ET.

Upcoming 2023 Meetings:

April 28

Previous Meetings:

- **Meeting #1:** Friday, October 29, 2021, 3:00 – 4:30 pm ET (presentation, minutes)
- **Meeting #2:** Friday, November 19, 2021, 3:30 – 4:30 pm ET (presentation, minutes)
- **Meeting #3:** Friday, December 17, 2021, 3:30 – 4:30 pm ET (presentation, minutes)
- **Meeting #4:** Friday, January 28, 2022, 3:30 – 4:30 pm ET (presentation, minutes)
- **Meeting #5:** Friday, February 25, 2022, 3:30 – 4:30 pm ET (presentation, minutes)
- **Meeting #6:** Friday, March 25, 2022, 3:30 – 4:30 pm ET (presentation, minutes)
- **Meeting #7:** Friday, June 3, 2022, 3:30 – 4:30 pm ET (presentation, minutes)
- **Meeting #8:** Friday, June 24, 2022, 3:30 – 4:30 pm ET (presentation, minutes)
- **Meeting #9:** Friday, July 22, 2022, 3:30 – 4:30 pm ET (presentation, minutes)
- **Meeting #10:** Friday, August 26, 2022, 3:30 – 4:30 pm ET (presentation, minutes)
- **Meeting #11:** Friday, September 23, 2022, 3:30 – 4:30 pm ET (presentation, minutes)
- **Meeting #12:** Thursday, October 27, 2022, 3:30 – 4:30 pm ET (presentation, minutes)
- **Meeting #13:** Friday, November 18, 2022, 3:30 – 4:30 pm ET (presentation, minutes)
- **Meeting #14:** Friday, December 16, 2022, 3:30 – 4:30 pm ET (presentation, minutes)
- **Meeting #15:** Friday, February 24, 2023, 3:30 – 4:30 pm ET (presentation, minutes)

Appendix

Acuity Tiering, Contact Requirements, and Payments

Members with higher acuity are expected to receive more intensive care management and a higher number of contacts; providers will be compensated accordingly to account for this higher level of workload.

Tailored Care Management Contact Requirements				
Acuity Tier	**Members with Behavioral Health Needs**		**Members with an I/DD or TBI**	
	Minimum Contacts	**Final Rate (PMPM)**	**Minimum Contacts**	**Final Rate (PMPM)**
High	At least **4** contacts per month, including at least 1 in-person contact	$395.06	At least **3** per month, including 2 in-person contacts and 1 telephonic contact	$395.06
Moderate	At least **3** contacts per month and at least 1 in-person contact quarterly	$269.66	At least **3** contacts per month and at least 1 in-person contact quarterly	$269.66
Low	At least **2** contacts per month and at least 2 in-person contacts per year, approximately 6 months apart	$162.08	At least **1** contact per month and at least 2 in-person contacts per year, approximately 6 months apart	$100.81

Organizations providing Tailored Care Management will receive the appropriate care management per member per month (PMPM) payment for the first contact delivered to a member in a month but must still deliver the minimum required contacts for each member.

See Tailored Care Management Provider Manual (updated 2/23/23) and Updated Guidance on Tailored Care Management Payments (1/19/22) for more information.

Contact Monitoring – Additional Example

The provider below has been determined to be fully compliant. No further action is needed.

Provider's Panel During Monitoring Period (3 Months)						
Acuity Tier	**Total Number of Engaged Members with BH Needs**	**Number of Members Contacted in Given Month**			**Contacts Delivered for Each Acuity Tier***	**Minimum Required Contacts**
		Month 1	**Month 2**	**Month 3**		
Moderate *(3 contacts/ month)*	**5 engaged members on panel**	3 members contacted	4 members contacted	3 members contacted	**22**	**30** (3 contacts per month X number of members contacted in each month)
Low *(2 contacts/ month)*	**10 engaged members on panel**	7 members contacted	5 members contacted	8 members contacted	**34**	**40** (2 contacts per month X number of members contacted in each month)

Share of Contacts Met Calculation

$$\frac{\text{Sum of All Completed Contacts} = 22 + 34}{\text{Sum of Minimum Required Contacts for Engaged Members} = 30 + 40} = \frac{56}{70} = 80\ \%$$

** For all members contacted in each acuity tier across all three months.*