Tailored Care Management Technical Advisory Group (TAG)

Meeting #33

Tailored Care Management Updates

November 22, 2024

Announcement

Please note that we request that no one record this call or use an AI software/device to record or transcribe the call. DHHS is awaiting additional direction from our Privacy and Security Office on how we need to support these AI Tools. Thank you for your cooperation.

HIPAA-covered DHHS agencies which become aware of a suspected or known unauthorized acquisition, access, use, or disclosure of PHI shall **immediately** notify the DHHS Privacy and Security Office (PSO) by reporting the incident or complaint to the following link: https://security.ncdhhs.gov/

Agenda

- Welcome and Roll Call
- Tailored Care Management Updates
  - Town Hall Recap and Upcoming Provider Manual and Other Updates
  - Performance Monitoring
  - Reminder on Access to Tailored Care Management for Dual Eligible Populations
  - Statewide Monitoring Tool
- Public Comments

Welcome and Roll Call

Department of Health and Human Services

Kristen Dubay, MPP	Andrew Clendenin, MSW	Loul Alvarez, MPA	Regina Manly, MSA	Eumeka Dudley, MHS	Gwendolyn Sherrod, MBA, MHA	Tierra Leach, MS, LCMHC-A, NCC
Chief Population Health Officer	Deputy Director, Population Health	Associate Director, Population Health	Senior Program Manager, Tailored Care Management	Program Manager, Tailored Care Management	Program Manager, Tailored Care Management	Program Manager, Tailored Care Management
Contact: Medicaid.TailoredCareMgmt@dhhs.nc.gov						

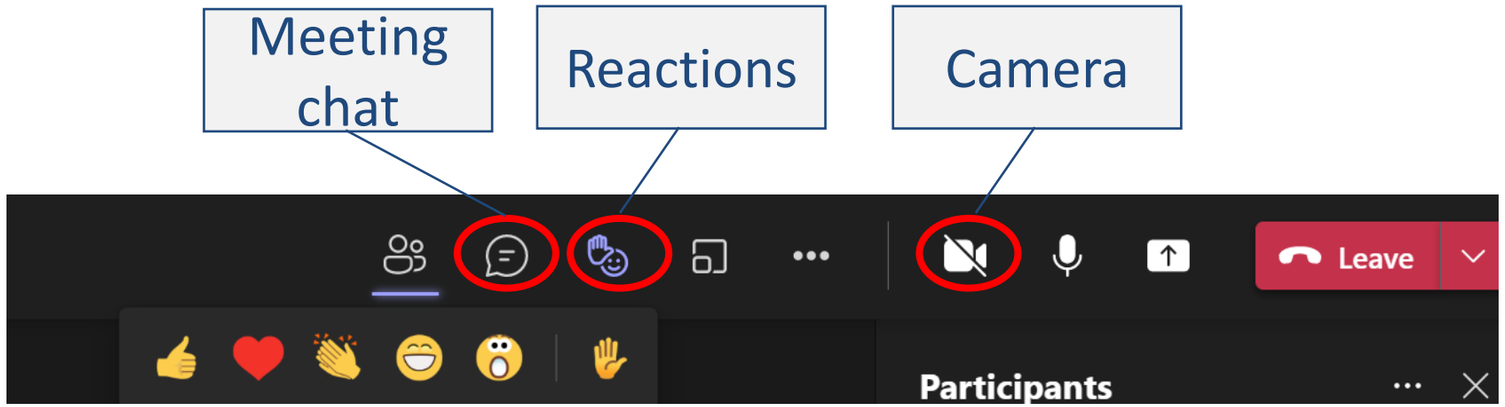
NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Tailored Care Management TAG Membership

Name	Organization	Stakeholder
Erin Lewis	B&D Integrated Health Services	Provider Representative
Julie Quisenberry	Coastal Horizons Center	Provider Representative
Billy West	Daymark	Provider Representative
Denita Lassiter	Dixon Social Interactive Services	Provider Representative
Luevelyn Tillman	Greater Vision Counseling and Consultants	Provider Representative
Keischa Pruden	Integrated Family Services, PLLC	Provider Representative
Haley Huff	Pinnacle Family Services	Provider Representative
Sandy Feutz	RHA	Provider Representative
Lisa Poteat	The Arc of NC	Provider Representative
Eleana McMurry, LCSW	UNC Center for Excellence in Community Mental Health	Provider Representative
Donna Stevenson	Alliance Health	Tailored Plan Awardee
Lynne Grey	Partners Health Management	Tailored Plan Awardee
Cindy Ehlers	Trillium Health Resources	Tailored Plan Awardee
Chris Bishop	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
Jonathan Ellis	N/A	Consumer Representative
Alicia Jones	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.



Town Hall Recap and Upcoming Provider Manual and Other Updates

Thank You for Participating in the Tailored Care Management Town Hall

Thank you for participating in the Tailored Care Management Town Hall!

Providers and plans shared many recommendations on ways to ease provider burden and support program sustainability that the Department is moving forward with in the upcoming provider manual update.

These updates are applicable to all entities providing Tailored Care Management—Tailored Plans / LME/MCOs, AMH+s, and CMAs.

Updated Tailored Care Management Provider Manual Based on Feedback from the Town Hall Sessions

The Department plans to release an updated Tailored Care Management Provider Manual by the end of the year based on feedback shared during the Town Hall sessions. The manual and a memo summarizing the updates will be posted on the Tailored Care Management webpage. Some of these updates include:

- New flexibilities, revised requirements, and clarifications related to the care management comprehensive assessment
- Clarification on sharing the results of the care management comprehensive assessment and Care Plan/ISP
- New flexibilities on supervising care manager's role in reviewing Care Plans/ISPs
- Additional updates and clarifications regarding:
  - Initial engagement into Tailored Care Management
  - Twenty-four-hour coverage requirement

Additional details are on the following slides

The Standard Terms and Conditions for Tailored Plan / LME/MCO Contracts with AMH+ Practices or CMAs (Appendix 1) were also updated to reflect policy changes, where applicable.

Updates to the Care Management Comprehensive Assessment

Based on feedback from the Town Hall, the Department is moving forward with the following new flexibilities, revised requirements, and clarifications related to the care management comprehensive assessment:

Feedback Received	New Flexibility, Revised Requirements, or Clarification
Extend timeframe to complete the care management comprehensive assessment to allow the care manager to build trust with the member.	▪ ***Revised Requirement:*** Care managers must undertake **best efforts to complete the care management comprehensive assessment within 90 days of consent** to participate in Tailored Care Management for all members newly eligible for Tailored Care Management. - Previously, the requirement was to complete the assessment within 90 days of **assignment**.
Allow certain questions on the care management comprehensive assessment to be asked later, once the member becomes more comfortable sharing information with the care manager.	▪ ***New Flexibility:*** Care managers can **prioritize certain domains based on the member's preferences and needs** and defer other domains (e.g., exposure to adverse childhood experiences (ACEs) or other trauma) until the care manager has established trust with the member—taking a more person-centered approach to the assessment
Length and scope of the care management comprehensive assessment can disincentivize members from engaging in the model.	▪ ***Clarification:*** Care managers can **rely on relevant assessments and other data*** to complete portions of the care management comprehensive assessment and then confirm the accuracy of this information with the member.
	▪ ***Clarification:*** Care managers have the flexibility to administer the care management comprehensive assessment **over the course of multiple contacts**.

*Other data includes available medical records, results from screening, and level of care determination tools.

Additional Updates to the Care Management Comprehensive Assessment

Based on feedback from the Town Hall, the Department is moving forward with the following clarifications related to the care management comprehensive assessment:

Feedback Received	New Flexibility, Revised Requirements, or Clarification
Care Managers should have flexibility to begin addressing urgent needs before needing to complete the full care management comprehensive assessment.	▪ ***Clarification:*** Care Manager can **support a member with their immediate needs before completing the care management comprehensive assessment**, when initial conversations with the member and the results of care needs screening indicate the member has urgent needs and once the member consents to participate in Tailored Care Management. - **Based on these immediate needs, a care manager can develop an initial care plan**. This initial care plan should include member information, short description of clinical needs, and a short crisis plan along with Member/Legally Responsible Person's Signature.* - The development of this initial care plan does not change the requirements for care managers to make best effort to complete the care management comprehensive assessment within 90 days of consent and make best effort to complete the full Care Plan/ISP within 30 days of completion of the care management comprehensive assessment.
Conducting full reassessments after triggering events can be time-consuming for the care manager and member.	▪ ***Clarification:*** In instance in which a reassessment is required (e.g., triggering event—such as inpatient hospitalization, becoming pregnant) and a care management comprehensive assessment was recently performed, the **reassessment may consist of an addendum or update to a previous assessment,** rather than a full reassessment, and should **capture specific updates relevant to that triggering event.**

*This initial care plan does not meet the requirement for the AMH+/CMA to develop a Care Plan/ISP for each member, as detailed in Section V.4.4. of the manual, but can be built upon to meet this requirement.

Feedback on Sharing the Care Management Comprehensive Assessment and Care Plan/ISP

The Department seeks additional feedback on the below requirements related to sharing the care management comprehensive assessment and Care Plan/Individual Support Plan (ISP):

Current Requirement	Feedback Received
Providers must make the results of the care management comprehensive assessment and the Care Plan/ISP available within 14 days of completion of each to the broader care team.	Provide flexibility on the requirement that the assessment and Care Plan/ISP each must be shared within 14 days of completion, as this can be administratively burdensome and time consuming.

Discussion Questions

The Department believes sharing these documents with members of the care team is important for coordinating care and addressing a person's whole-person needs. Sharing the information also can help avoid members being asked the same questions across different providers.

1. In addition to the primary care providers, what other providers should always receive a copy of these documents?
2. What barriers have you experienced with sharing documents with a member's primary care provider and other providers within the 14-day timeframe?
3. Have you found ways to effectively and efficiently share the necessary information in these documents (e.g., providing summary documents with pertinent information)?

Updates to Supervising Care Manager's Role in Reviewing Care Plans/ISPs

Based on feedback from the Town Hall, the Department is moving forward with the following new flexibilities regarding review of Care Plans/ISPs:

Feedback Received	New Flexibility, Revised Requirements, or Clarification
The requirement for supervising care managers to review all Care Plans/ISPs can be time consuming and administratively burdensome.	▪ ***New Flexibility:*** The provider manual removes the requirement that supervising care managers must review all Care Plans/ISPs. - Supervising care managers are responsible for providing oversight and support to ensure complete and person-centered Care Plans/ISPs - Providers and supervising care managers may determine the level of supervision needed for care managers. - Standards for the supervising care manager's monitoring of care management comprehensive assessments and Care Plans/ISPs should be documented in the provider's written policies and procedures.

The Department recommends providers develop a glide path for new care managers, in which initially all Care Plans/ISPs are reviewed, and supervising care manager's review gradually decreases over time and based upon performance.

Additional Updates and Clarifications in the Provider Manual

The updated provider manual also includes the following updates:

- ***New Requirement on Initial Engagement:*** When a new member is assigned to the provider, the **care managers should initiate contact within 10 days of assignment** in efforts to engage them in the model, including starting the care management comprehensive assessment.

- ***Clarification on 24-Hour Coverage Requirement:*** Providers must have someone available 24 hours per day, seven days per week, who can be responsive to calls; the requirement does not mean that the provider needs a 24/7 live call center.*
  - The individual who is responsive to calls should be able to help members access support services, provide crisis service providers access to needed information, and share Care Plans/ISPs, psychiatric advance directives, and other information.*

* For example, if a member is admitted to the hospital and the hospital calls the number for help in identifying a member's guardian.

Additional Updates Based on the Town Hall

TCM Member Assignment Guidance Updates

In the Town Hall, providers shared many suggestions regarding revisions to the member assignment guidance. The Department is moving forward new updates, which will be implemented in early 2025.

- The upcoming changes will promote reassigning members who are currently served by TP/LME/MCOs but could be served by an AMH+/CMA.
  - **Example:** Members who have a historical care management relationship with the Tailored Plan / LME/MCO, but could be served by an AMH+/CMA per assignment criteria.

New Tailored Care Management Enrollee Reports

Based on feedback from providers, the Department is creating two new monthly reports that will be available to providers via NC Tracks:

Report of Future Beneficiaries

- On the last day of the month (for the next month) the Department will generate a report that includes all **NEW** members assigned to the provider's panel for the next month.
- Example: Provider is assigned 2 new members effective September 1. A report generated on October 31, would include only the 2 new members.

Report of Beneficiaries with a 024 Termination Code *(i.e., those members who will be removed from provider's panel)*

- On the 3rd day of the month, the Department will generate a report that includes all beneficiaries with a 024 status. This represents members who will be **reassigned** or are **no longer eligible** for Tailored Care Management.
- Report will include the member's new provider information (provider name and NPI) for reassignments.
- Example: A report generated on September 1 would include members who are **active on the provider's panel** in June, but will **terminate** from the provider's panel October 31.

Provider Payments to Account for Member Disruptions

In the Town Hall, providers raised concerns of inadvertent/invalid reassignments that lead to an inability to bill for the monthly payment rate. The Department is granting plans the flexibility to pay AMH+s/CMAs for delivering services when the member is reassigned to the Plan due to an invalid reason, as described below.

Recap on Payment Rules

- Two entities may not receive the TCM monthly payment rate for any given member in any given month.
- Plans bill the Department for TCM on behalf of AMH+/CMAs in their network. Because of this process there should not be instances where the provider and the Plan submit a TCM claim for the same member.

- **New Flexibility/Process for Identification of Impacted Members**
  - AMH+/CMAs can contact their plan if they believe a member was reassigned to the Tailored Plan in error.
  - The Plans will confirm whether there was an inadvertent/invalid assignment and create a process by which the AMH+/CMA can bill for the member and then the plan bills the Department. The AMH+/CMA will be notified if members were reassigned due to a valid reassignment reason.
  - When the reassignment is due to a valid reason, the AMH+/CMA may not be paid for delivering Tailored Care Management services to the member.
- This solution does not apply if a member is reassigned to another AMH+/CMA.
- Tailored Plans have the option of implementing this solution and may also pay AMH+s/CMAs for misassignments back to July 2024 (if services were delivered).

Valid Reasons for Reassignment: Member Choice, Member's New Residential County Cannot be Covered by Current TCM, Changes to Member's Population Segment that Current TCM Can No Longer Meet, Current TCM is No Longer Contracted as a TCM Provider, HCBS Care Coordination Conflict, Provider Panel Related Changes, Changes to Member's Service (Foster Care/TCL), Member Receives Duplicative Services, Member is Excluded, Requested by Provider.

Additional Town Hall Feedback

In addition to the updates to the provider manual, the Department is exploring longer-term improvements to TCM based on the innovative solutions shared during the Town Hall sessions. These longer-term updates under consideration include:

- Updates to the care team structure, such as:
  - The role and qualifications of the clinical consultant
  - The qualifications for behavioral health supervising care managers
  - Supervisor-to-care manager ratio
- Further adjustments to the member assignment guidance
- How to address unengaged/unreachable members on providers' panels
- Redesigns/revisions to the training modules/requirements
- Components of the care management comprehensive assessment
- Approach to coordinating with hospital staff during a member's stay and care transition
- Improvements/standardization to data and data sharing
- Refinements to the 1915(i) care coordination process

Thank you again for sharing these valuable insights with the Department!

Tailored Care Management Performance Monitoring

Increased Focus on Data Collection and Monitoring

As Tailored Care Management reaches its second anniversary since launch, the Department is increasing its focus on strengthening data collection and monitoring to identify areas of success and areas that require support.

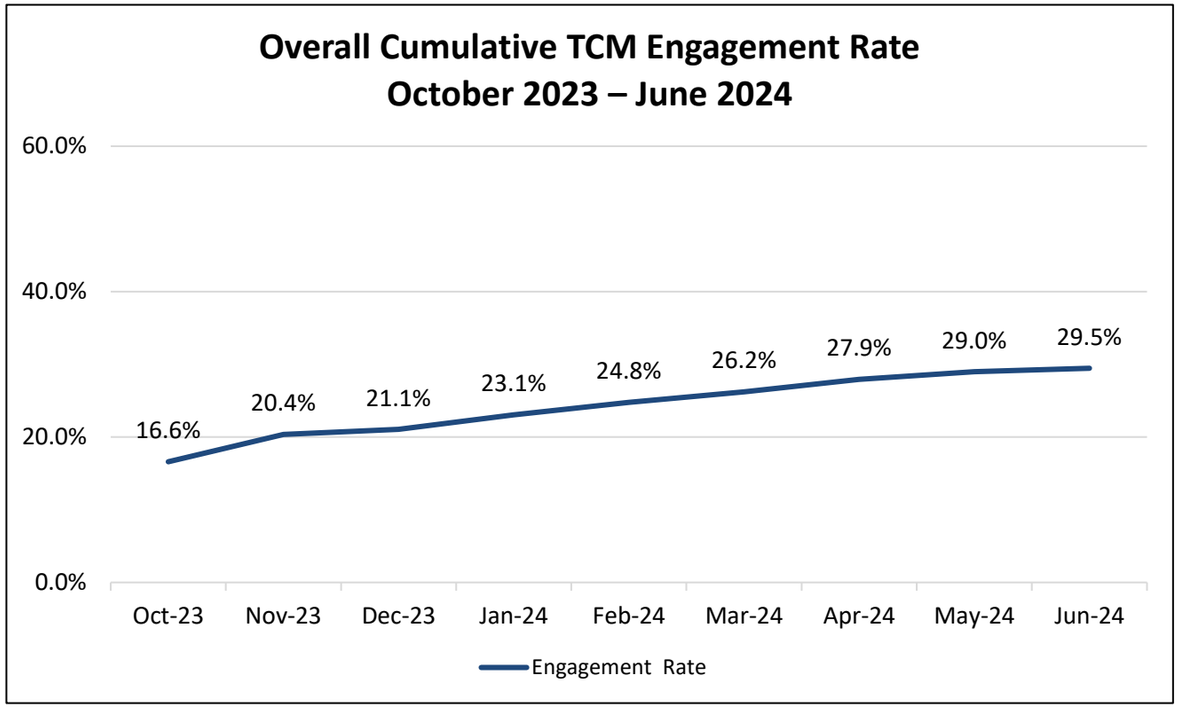
- The Department's current focus is reviewing Tailored Care Management engagement data to better understand variations in engagement by AMH+s/CMAs/ LME-MCOs, variations by LME-MCO, and differences across populations.

- In the following slides we provide an overview of what engagement data shows and the Department's next steps.

Steady Increase in Engagement

The cumulative Tailored Care Management engagement rate increased by 13% between October 2023 (17%) and June 2024 (30%).

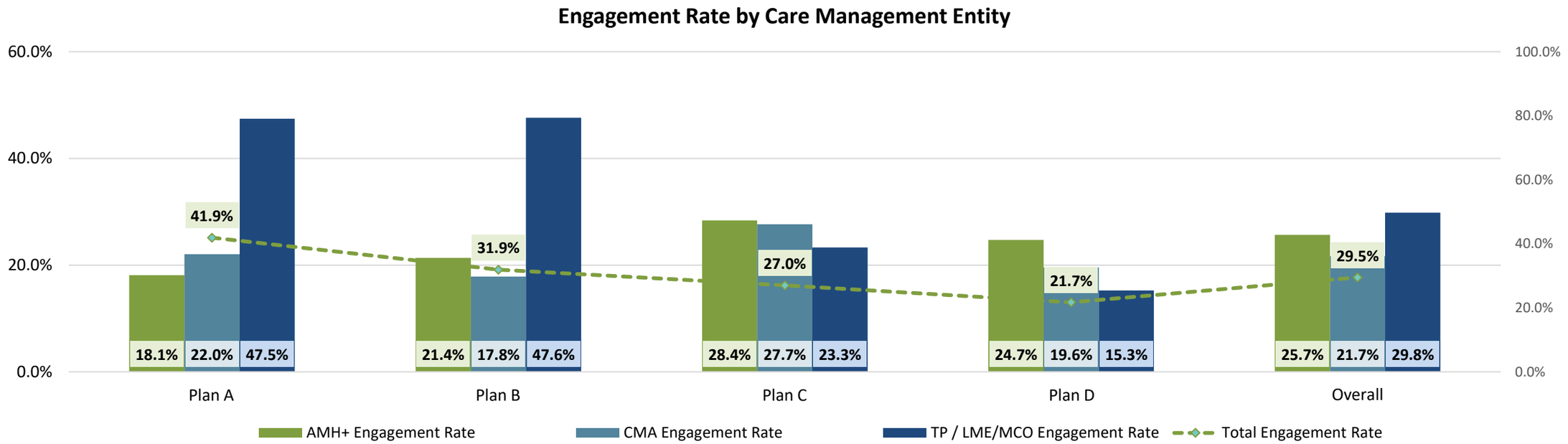
- 80,500 members (30%) of the 273,000 members in Tailored Care Management had least one claim submitted on their behalf between October 2023 and June 2024.
- Engaged members had an average of 4 claims (median of 3 claims) submitted on their behalf between October 2023 and June 2024.
- December 2023 Medicaid Expansion impacts percentages – it takes time to engage these new members.



Source: NC Analytics TCM Claims, October 1, 2023– June 30, 2024. Refreshed data 9/23/2024.

Engagement Rates Vary Across Plans and Tailored Care Management Entity Type

There is wide variability in engagement rates among Tailored Plans / LME/MCOs, AMH+s, and CMAs.

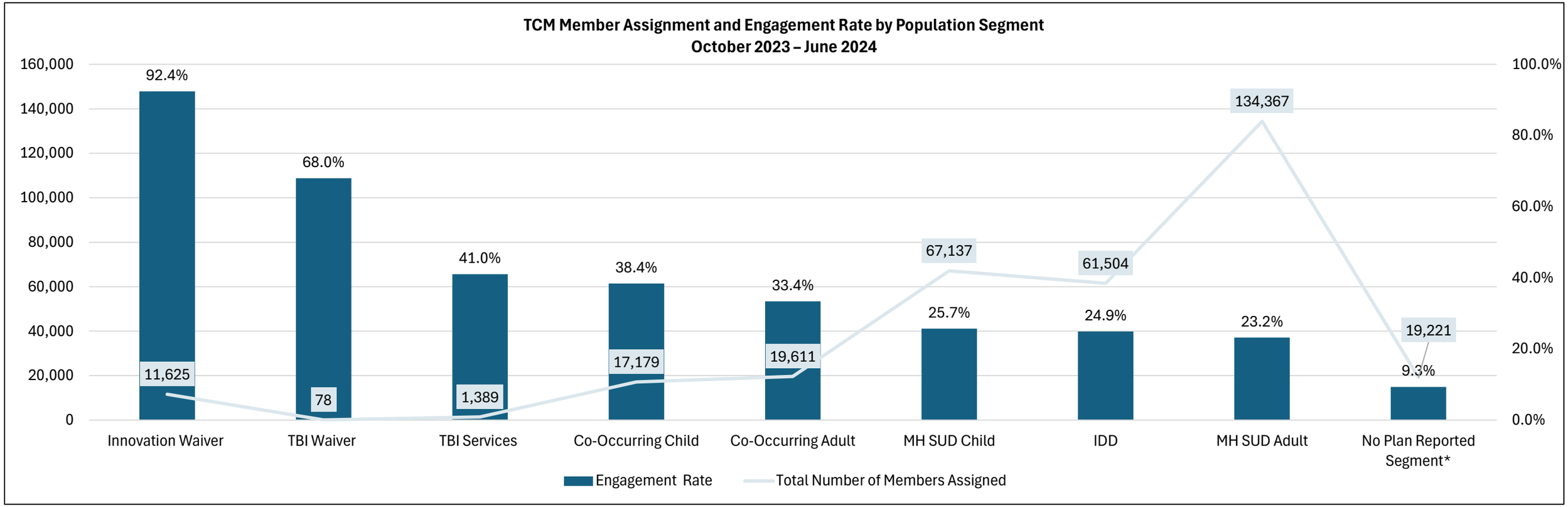


Engagement Rate	Plan A	Plan B	Plan C	Plan D	Overall
AMH+	18.1%	21.4%	28.4%	24.7%	25.7%
CMA	22.0%	17.8%	27.7%	19.6%	21.7%
Tailored Plan / LME/MCO	47.5%	47.6%	23.3%	15.3%	29.8%
Total Engagement Rate	41.9%	31.9%	27.0%	21.7%	29.5%

Source: NC Analytics TCM Claims, October 1, 2023- June 30, 2024. Refreshed data 9/23/2024.
Notes: 1) Sandhills and Eastpointe members were re-assigned to their post-consolidation LME for January 2024 data. 2) Not all members eligible for TCM will receive it. Some services may include care management that takes priority over TCM while other members may be receiving services that exclude them from TCM assignment while they receive that services. Members may also choose to opt-out of TCM program participation.

Engagement Rates by Population Segment

Members enrolled in the Innovations or TBI waiver have the highest engagement rates across population segments. Members with a mental health condition/substance use disorder account for more than 50% of the total population assigned for Tailored Care Management, but have relatively low engagement rates.

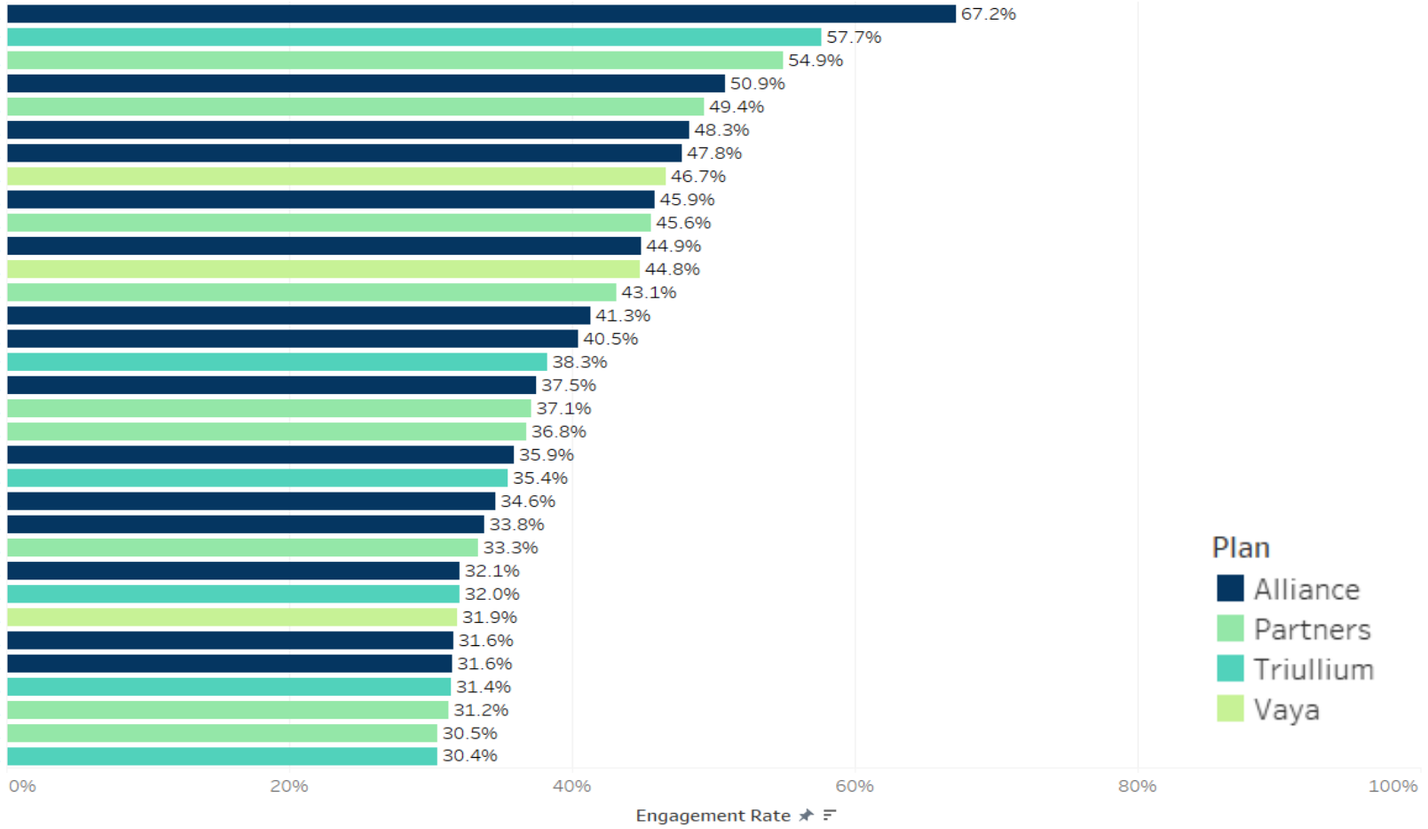


Source: NC Analytics TCM Claims, October 1, 2023– June 30, 2024. Refreshed data 9/23/2024.
Notes:* Not all members analyzed have a population segment due to data timing issues. Plans define the population segments for their membership.
Co-occurring are those individuals with an I/DD *and* a mental health condition or substance use disorder.

Next Steps

The Department identified the top 20% of AMH+s/CMAs that had the highest engagement rates and will be meeting with these organizations to identify scalable best practices. The Department will then meet with other providers with lower engagement rates to identify areas for technical assistance and share best practices related to engagement.

Top 20% of AMH+s/CMAs by Plan



Source: NC Analytics TCM Claims, October 1, 2023– June 30, 2024. Refreshed data 9/23/2024.

Notes: 1) TCM entities that have a total member count less than or equal to 10 are not shown above. 2) Engagement is based on claims. 2) Eastpointe and Sandhills were excluded in the plan level analysis above.

Top 20% Providers, Based on Engagement

The Department has identified the top 20% of providers based on engagement.

Alliance Health

- Alexander Youth Network
- Autism Society Of North Carolina
- B & D Integrated Health Services
- Community Partnerships Inc
- Easter Seals UCP North Carolina & Virginia
- Fellowship Health Resources Inc
- Fernandez Community Center LLC
- Freedom House Recovery Center Inc
- Hope Services LLC
- InReach
- Primary Health Choice Inc
- Sigma Health Services LLC
- Stephens Outreach Center Inc
- The Arc of North Carolina Inc
- University Of North Carolina At Chapel Hill

Partners Network

- Alexander Youth Network
- Clay Wilson & Associates
- Covenant Case Management Services
- Easter Seals UCP North Carolina & Virginia
- Freedom House Recovery Center Inc
- Outreach Management Services
- Pinnacle Family Services of NC LLC
- Primary Care Solutions Inc
- The Arc of North Carolina Inc

Trillium Health Resources

- Coastal Horizons Center Inc
- LeChris Health Systems of Greenville
- New Dimension Group LLC
- New Hanover Community Health Center
- Triangle Comprehensive Health Services

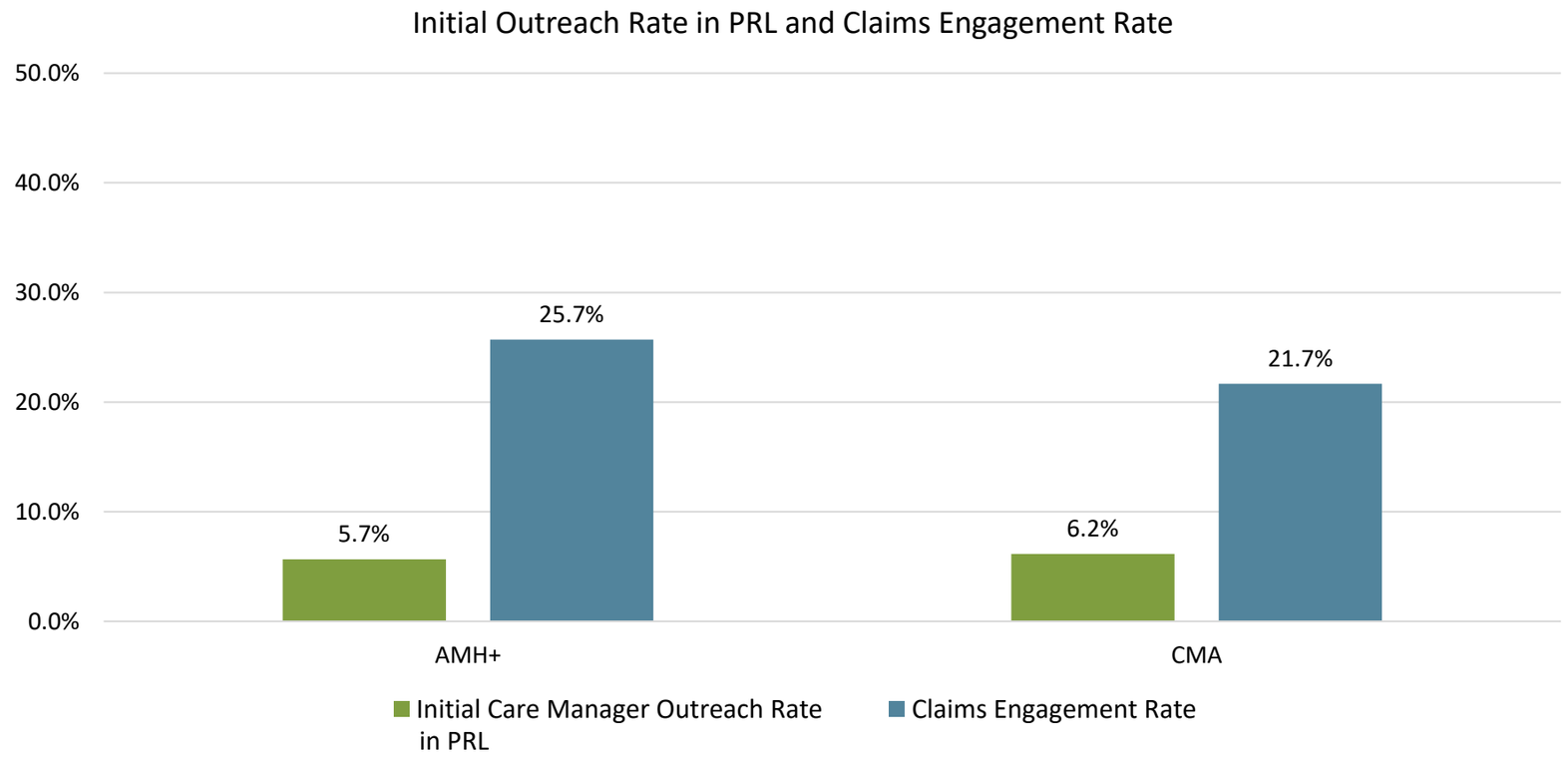
Vaya

- Freedom House Recovery Center Inc
- Pinnacle Family Services Of NC LLC
- RHA Health Services Inc

Source: NC Analytics TCM Claims, October 1, 2023– June 30, 2024. Refreshed data 9/23/2024.
Notes: 1) List is in alphabetical order. 1) TCM entities that have a total member count less than or equal to 10 are not shown above. 2) Engagement is based on claims. 2) Eastpointe and Sandhills were excluded in the plan level analysis above.

Reminder: Importance of Accurate Care Management Reporting

Data suggests that Initial Member Outreach is being underreported. The Department would like to remind providers of the importance of submitting high-quality and accurate data through the Patient Risk List (PRL). The Plans use the providers' PRLs to populate monthly report submissions to the Department.



In comparing Tailored Care Management claims with PRL data, we see that there are some members with claims who do not have an initial care manager outreach reported in the PRL.

Reminder on Access to Tailored Care Management for Dual Eligible Populations

Access to Tailored Care Management for Dual Eligibles

Based on recent questions from stakeholders, the Department would like to clarify that members with both Medicaid and Medicare ("dual eligibles") may obtain Tailored Care Management while enrolled in NC Medicaid Direct or Tailored Plans.*

Dual Eligibles Enrolled in Tailored Plans

Dual eligible members in the Innovations or TBI waivers are enrolled in Tailored Plans and eligible for Tailored Care Management.

Dual Eligibles Enrolled in NC Medicaid Direct

All other duals with significant behavioral health needs, an I/DD, or TBI, who would otherwise be enrolled in a Tailored Plan if not for being part of a group excluded from managed care, are in NC Medicaid Direct and eligible for Tailored Care Management.

Reminder: Members cannot obtain both Tailored Care Management and specific duplicative services simultaneously (as defined in the provider manual^)

*Members must meet the clinical eligibility for Tailored Plans to receive Tailored Care Management (see eligibility here).

^Duplicative services include Assertive Community Treatment (ACT); Child ACT; Critical Time Intervention; Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID); stays of 90+ days in a Skilled Nursing Facility; primary care case management; High Fidelity Wraparound (HFW); Tribal Option; Program of All-Inclusive Care for the Elderly (PACE); Care Management for At-Risk Children (CMARC).

Tailored Care Management Statewide Monitoring Tool

Tailored Care Management Statewide Monitoring Tool

The Tailored Care Management Statewide Monitoring Tool will be available for utilization in January 2025.

- The statewide standardized TCM Monitoring Tool pilot is concluding and the state is in finalizing the tool.
- The tool was piloted with one statewide provider and at least one smaller provider in each Tailored Plan region.
- TCM Statewide Monitoring Tool and Process Training scheduled for 10/16 was delayed to allow affected providers to work through recovery after Hurricane Helene.
  - The training has been rescheduled for December 13, 2024.

December TCM TAG Cancellation

Due to the holiday, the TCM TAG scheduled for December has been cancelled.

Questions?

Public Comments

Tailored Care Management TAG Meeting Cadence

Tailored Care Management TAG meetings will generally take place the fourth Friday of every month from 10:00-11:00 am ET.

There will be no additional TAGs in 2024.

Previous Meetings:

- **Meeting #1:** Friday, October 29, 2021 (presentation, minutes)
- **Meeting #2:** Friday, November 19, 2021 (presentation, minutes)
- **Meeting #3:** Friday, December 17, 2021 (presentation, minutes)
- **Meeting #4:** Friday, January 28, 2022 (presentation, minutes)
- **Meeting #5:** Friday, February 25, 2022 (presentation, minutes)
- **Meeting #6:** Friday, March 25, 2022 (presentation, minutes)
- **Meeting #7:** Friday, June 3, 2022 (presentation, minutes)
- **Meeting #8:** Friday, June 24, 2022 (presentation, minutes)
- **Meeting #9:** Friday, July 22, 2022 (presentation, minutes)
- **Meeting #10:** Friday, August 26, 2022 (presentation, minutes)
- **Meeting #11:** Friday, September 23, 2022 (presentation, minutes)
- **Meeting #12:** Thursday, October 27, 2022 (presentation, minutes)
- **Meeting #13:** Friday, November 18, 2022 (presentation, minutes)
- **Meeting #14:** Friday, December 16, 2022 (presentation, minutes)
- **Meeting #15:** Friday, February 24, 2023 (presentation, minutes)
- **Meeting #16:** Friday, March 24, 2023 (presentation, minutes)
- **Meeting #17:** Friday, April 28, 2023 (presentation, minutes)
- **Meeting #18:** Friday, May 26, 2023 (presentation, minutes)
- **Meeting #19:** Friday, June 23, 2023 (presentation, minutes)
- **Meeting #20:** Friday, July 28, 2023 (presentation, minutes)
- **Meeting #21:** Friday, August 25, 2023 (presentation, minutes)
- **Meeting #22:** Friday, September 22, 2023 (presentation, minutes)
- **Meeting #23:** Friday, October 27, 2023 (presentation, minutes)
- **Meeting #24:** Friday, November 17, 2023 (presentation, minutes)
- **Meeting #25:** Friday, December 15, 2023 (presentation, minutes)
- **Meeting #26:** Friday, January 26, 2024 (presentation, minutes)
- **Meeting #27:** Friday, February 23, 2024 (presentation, minutes)
- **Meeting #28:** Friday, March 22, 2024 (presentation, minutes)
- **Meeting #29:** Friday, April 26, 2024 (presentation, minutes)
- **Meeting #30:** Tuesday, May 21, 2024 (presentation, minutes)
- **Meeting #31:** Friday, June 28, 2024 (presentation, minutes)
- **Meeting #32:** Friday, July 26, 2024 (presentation, minutes)