Tailored Care Management Technical Advisory Group (TAG)

Meeting #38

Role of Care Management In Integrated Care and Tailored Care Management Updates

July 25, 2025

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
- Value Based Contracting
- Proposed TCM Provider Manual Updates
- Public Questions/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
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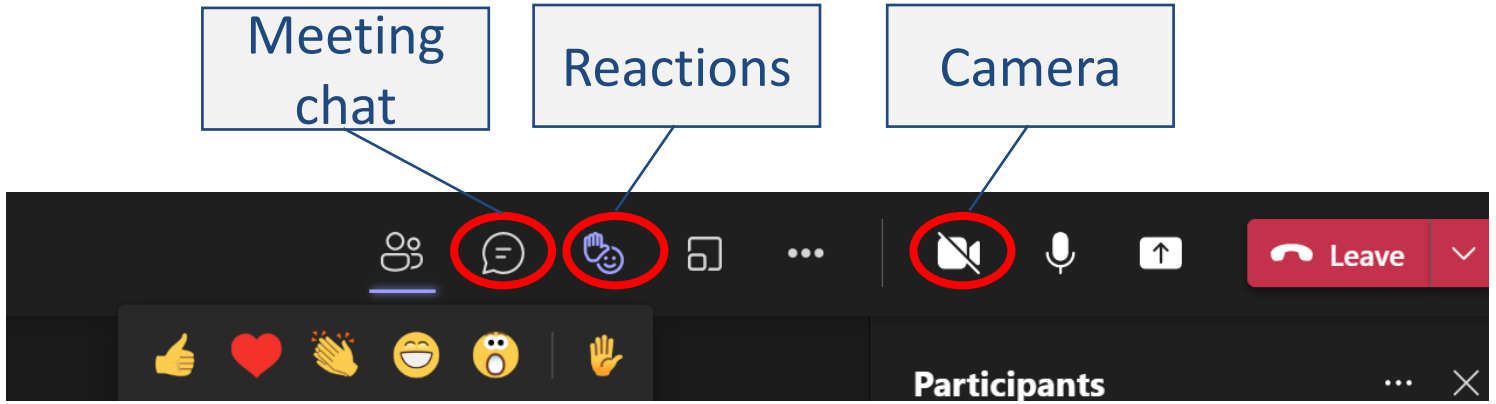
NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

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
Joanna Finer	Pinnacle Family Services	Provider Representative
Sandy Feutz	RHA	Provider Representative
Lisa Poteat	The Arc of NC	Provider Representative
Eleana McMurry	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.



Value Based Contracting

Value Based Contracting

VBC - Objectives

- Understand what Value Based Contracts are and the impact on Tailored Care Management
- Define components that impact VBC – risks, quality measures and population health

What is Value Based Contracting

It is a healthcare model that focuses on:

- Quality of care
- Provider Performance
- Member experience

The goal of VBC is to improving Member outcomes while delivering services at a reasonable cost while advancing health equity.

Providers are compensated based on results they deliver, rather than volume of services provided.

VBC emphasizes prevention and overall well- being of Members, ultimately aiming to enhance their healthcare experience.

Why is Value Based Care Important?

- Value Based contracting aligns with national reforms to payment models
- Moves Providers to Alternative Payment Models (APMs) – moves away from Fee For Service (FFS) to APMs that reduce the Total Cost of Care (TCOC)
- Moves to increase Provider accountability for both quality and TCOC, with a focus on population health

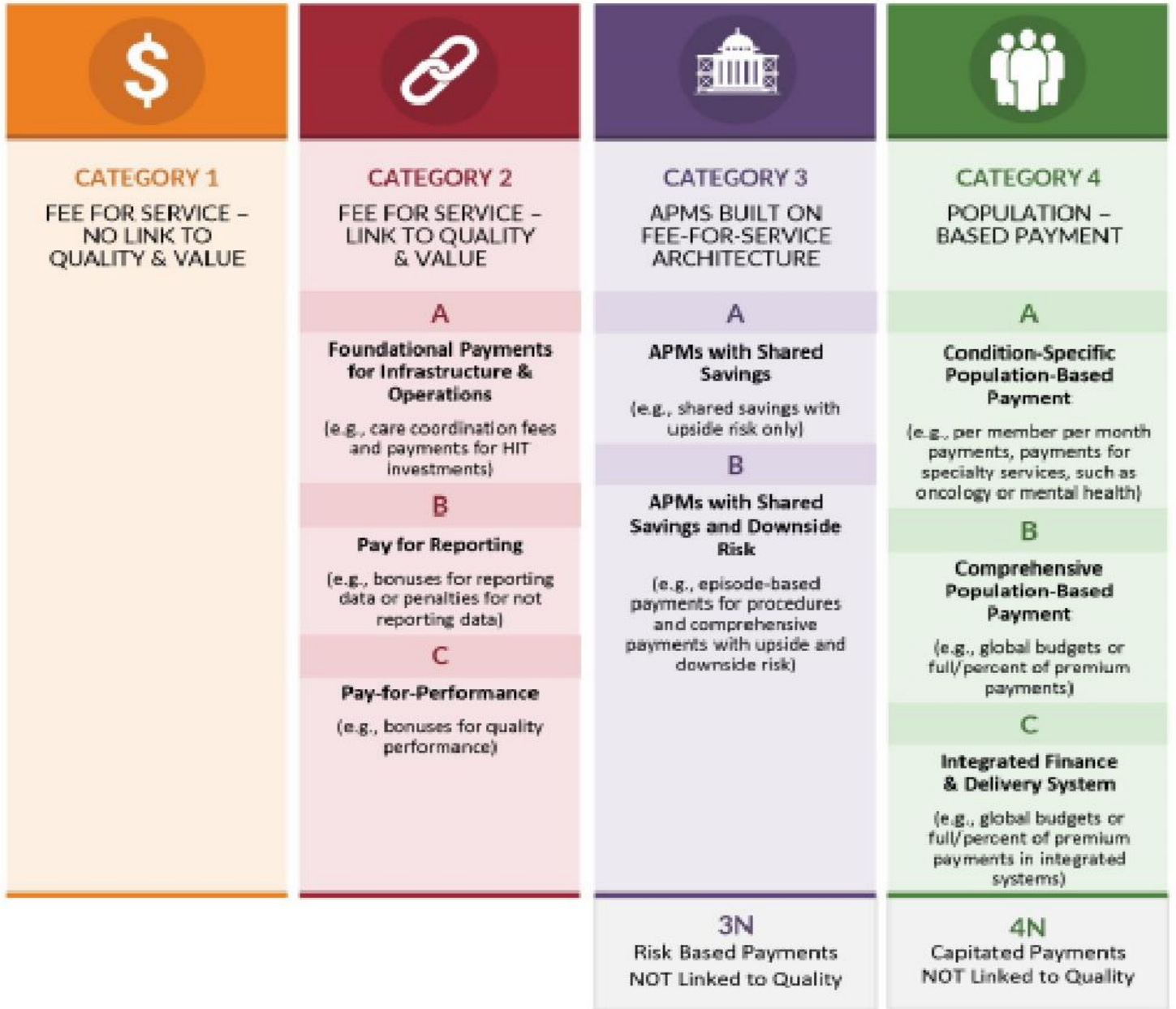
Value Based Care Movement?

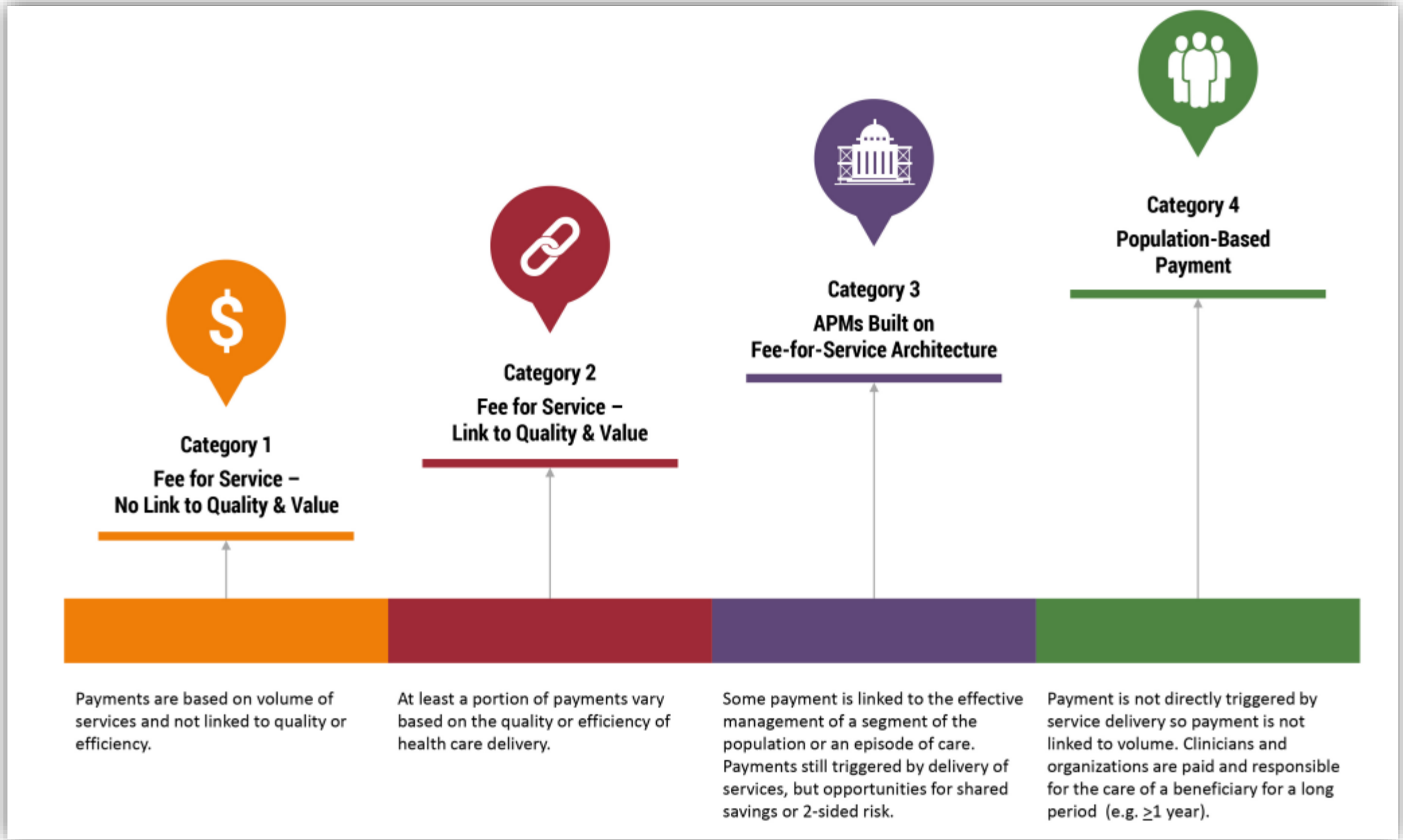
Value Based Care Movement is depicted on the following slide and is aligned with:

- Provider accountability and alignment
- Impact of payments on cost and quality performance
- Delivery of system integration and coordination
- Person-centered care

* The MITRE Corporation, Health Care Payment Learning & Action Network, “Alternative Payment Model APM Framework,” 2017.

VBC – The APM Framework




Category 1
Fee for Service –
No Link to Quality & Value
Category 2
Fee for Service –
Link to Quality & Value
Category 3
APMs Built on
Fee-for-Service Architecture
Category 4
Population-Based
Payment
Payments are based on volume of services and not linked to quality or efficiency.
At least a portion of payments vary based on the quality or efficiency of health care delivery.
Some payment is linked to the effective management of a segment of the population or an episode of care. Payments still triggered by delivery of services, but opportunities for shared savings or 2-sided risk.
Payment is not directly triggered by service delivery so payment is not linked to volume. Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g. ≥1 year).

Components of Successful VBC

Components of a Successful VBC:

- Buy in from providers on measures and terms
- Data, data and more data
- Setting providers up for success (achievable targets)
- Access to data – historical and ongoing
- Understanding of the measure and what meets the measure – “why”?
- Population Health
- Data – gaps in care to drive the work

VBC and Risks

In moving along the APM continuum, risk is taken into the equation.

Value- Based Payments have “risks” associated with them.

Changing to Value- Based Payment model includes shifting the risk from the payer to the provider.

Reminder: Value-based care ties the amount of money health care providers earn to the results of care of their members.

Types of Risk in Value Based Contracting

- Upside – providers are expected to gain revenue if they exceed the expectation on costs and quality – some of these models are what is known as “shared” savings – These are 3A

- Downside – providers expected to lose money if they fail to meet costs and quality goals

- Two-sided risk – both types of risks are included in the contracting – shared savings and downside risk – these are 3B

Considerations for Risk-Based Contracting

Understand your population

- Are you able to do risk stratification?
- Do you know which members are high risk?
- Is your panel large enough?

Understand the network

- Do you know the services available and service providers available in your network?

Considerations for Risk-Based Contracting

Data and Reporting

- Is your data assessable?
- Are you able to generate reports to track risks, services, etc.

Workflows

- Do you have solid workflows for referrals, accepting new members, care management, etc.

VBC and Quality Measures

To show Provider accountability and improvement, VBC include quality Measures

The industry standard for quality measures are the Healthcare Effectiveness Data Information Set (HEDIS) Measures

“If you cannot measure it, you cannot improve it.”

- Lord Kelvin

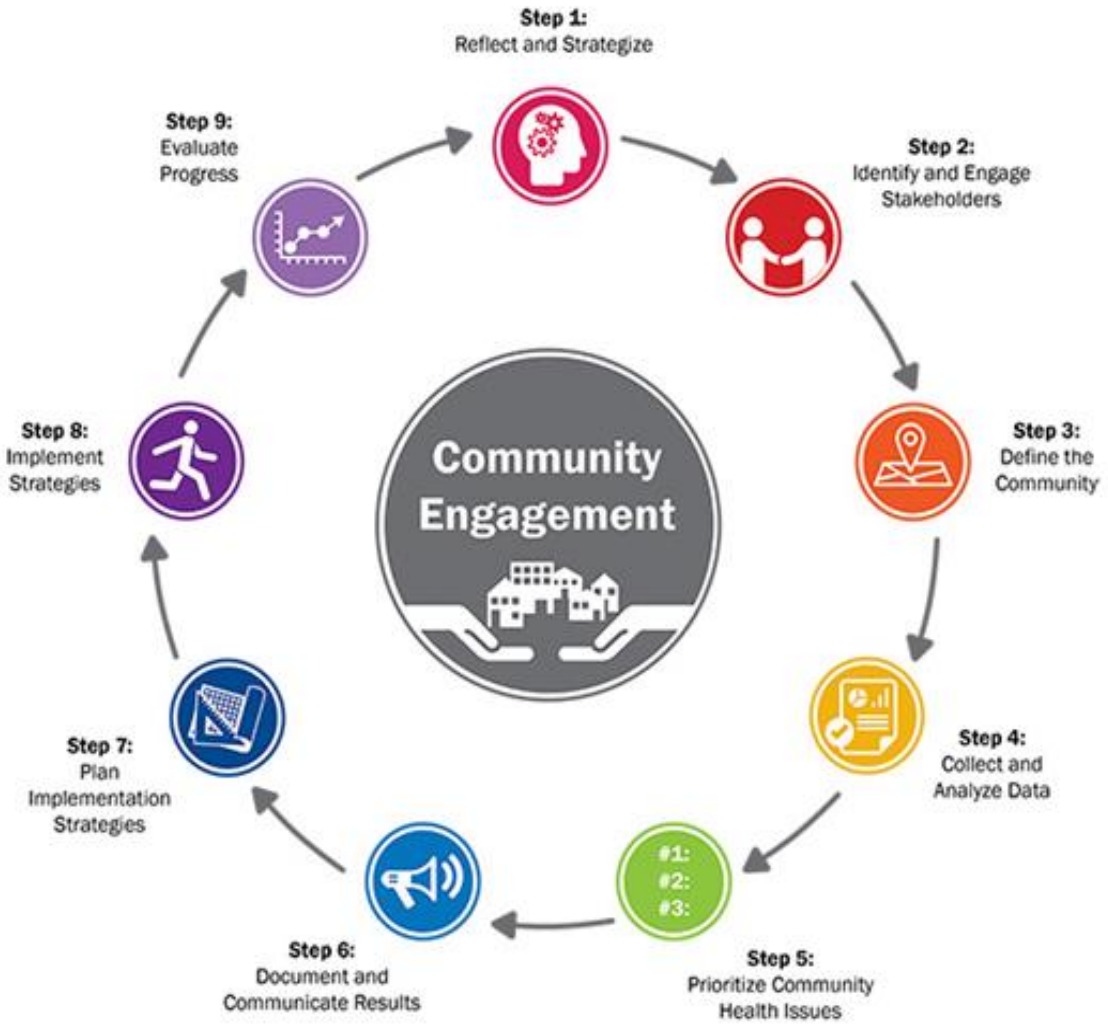
Healthcare **E**ffectiveness **D**ata **I**nformation **S**et

- Provided as a tool by the National Committee for Quality Assurance.
- Used by 90% of health plans,
- Measures performance on important domains of care and service.
- Measures cross 6 domains of care:
  1. Effectiveness of care
  2. Access/Availability of Care
  3. Experience of Care
  4. Utilization and Risk Adjusted Utilization
  5. Health Plan Descriptive Information
  6. Measures Reported Using Electronic Clinical Data Systems

Why Use HEDIS?

- Provides consistency across the healthcare landscape
- Easier to gauge performance of patient care and service
- Allows for “comparison” of plans and providers because of the consistency in measurement
- Provides a way to discover gaps in healthcare
- Improves Member outcomes
- Assists with decreasing costs of care
- Provides data for public health issues and large Member populations like smoking, cancer, asthma, diabetes.

What is Population Health?



An approach to health that aims to improve the health of the entire population to address gaps in care and to reduce health inequities among population groups.

In order to reach these objectives, it looks at and acts upon the broad range of factors and conditions that have a strong influence on health.

Why is Population Health Important?

Population Health vs. Individual Health

Population Health: Refers to the health status and health outcomes within a group of people rather than considering the health of one person at a time.

Individual Health: Looks at outcomes for an individual as "a change in the health of an individual that is attributable to an intervention or series of interventions" (The World Health Organization (WHO))

Population Health NC Medicaid Priorities

- Diabetes Prevention
- Healthy Weight
- Tobacco Cessation
- Pregnancy Intendedness
- Opioid Misuse Prevention and Treatment Program

Alliance's Model

Alliance's model includes the following:

Quarterly scorecards and payouts
Clinically Integrated Networks (CINs) receive payment and scorecard for agencies who are members
Scorecards and incentive payments lag a quarter
PCP incentives and CMA/AMH+ incentives
Includes some pay for reporting for PCPs
Alliance purchased a HEDIS reporting product for measure reporting and document retrieval

Alliance developed a continuous engagement measure

Alliance AMH+/CMA Measures

Gap Closures

Child and Adolescent Well-Care Visits (W30/WCV)

Diabetes Screening for People with Schizophrenia and Bipolar Disorder using Antipsychotic Medications (SSD)

The gap closure measures are based on year-to-date data – with the date it was pulled listed next to the measure.

Per Opportunity

Follow-up to Hospitalizations for Mental Health (FUH)

Adherence to Antipsychotic Medication for Individuals with Schizophrenia (SAA)

Per opportunity data is based on the quarter in which the opportunity to close the measure occurred.

Alliance's Primary Care Measures

Alliance has some Primary Care VBC contracts. Not all PCPs have a contract.
Alliance PCP measures include the following:
Gap Closure

- Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications (SSD)
- Child and Adolescent Well-Care Visits (W30 / WCV Combo)
- Immunizations for Adolescents (IMA)
- Cervical Cancer Screening (CCS)
- Chlamydia Screening for Women (CHL)

Per Opportunity

- Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)
- 7-Day Follow-up After Hospitalization for Mental Illness (FUH)
- HbA1c Poor Control (>9.0%) (HPC - CDC)
- Controlling High Blood Pressure (CBP)

Lessons Learned

- HEDIS Measures are calendar year measures
- Choosing a HEDIS Certified platform – dual attribution
- Quarterly payments
- Learning experience and curve
- Data
- Continued and reiterated trainings


Questions and Discussion

Proposed TCM Provider Manual Updates

Proposed TCM Provider Manual Updates

On the following slides, the Department is sharing <u>proposed</u> TCM Provider Manual updates.

We invite attendees to ask questions and provide feedback on these proposed revisions.

24-Hour Coverage Requirement

The Department proposes the below updated language on the 24-hour coverage requirement:

- In their role as Tailored Care Management providers, **AMH+ practices and CMAs are not required to provide first responder crisis response in the event that a member has an emergency medical condition or a behavioral health crisis. However, AMH+ practices and CMAs must have a process to provide crisis service providers and others (e.g., emergency department) with needed information in the event of a crisis or a transition of care** (e.g., a member is admitted to the hospital and the hospital calls the Tailored Care Management provider for help in identifying a member's guardian). Information that may need to be shared includes the Care Plan/ISP and to the extent applicable, a psychiatric advance directive. **AMH+ practices' and CMAs' process must include a plan for responding to requests 24 hours per day, seven days per week** (e.g., checking and responding to a voicemail message over the weekend and after work hours). Responses for crisis and transition events should be within 24 hours. The AMH+/CMA does not need to have a live call center.

- **This requirement is at the AMH+/CMA level, not the care manager level, and can be performed by other staff. AMH+s/CMAs may be able to build off of their existing processes to meet this requirement**—i.e., outpatient behavioral health providers are required to have 24-hour coverage for behavioral health emergency services and AMH practices are require to have 24-hour primary care coverage for services, consultation or referral, and treatment for emergency medical conditions.

Annual TCM Refresher Training Requirement

The Department proposes the below updated language on the annual TCM refresher training requirement:

- Care managers, care manager extenders, and supervisors must complete 6 hours of annual refresher trainings. These 6 hours of annual refresher training can be fulfilled by completing courses approved by the Department and available in the Area Health Education Centers (AHEC) TCM Portal.
- TCM staff can partner with their supervisors to create an education plan that is tailored to the care managers' needs and populations they serve. Available courses include elective courses, chronic health management courses, and Learning Collaborative courses that are offered through Area Health Education Centers (AHEC).
- Care managers, care manager extenders, and supervisors have the full year to complete the 6 hours of annual refresher trainings (i.e., if a care manager's deployment date is October 2022, the care manager would begin refresher training in November 2023 and would need to complete the refresher training by October 2024).

The list of 12 refresher trainings has been removed from the manual

Care Plans and ISPs (1/2)

The Department proposes the below clarifications and update to the Care Plan/ISP requirements:

Current Requirements	Proposed Clarification or Update
Each Care Plan and ISP must be individualized, person-centered, and developed using a collaborative approach including member and family participation where appropriate	▪ ***Clarification:*** Care planning for developing the Care Plan/ISP involves identifying what is most important to the member from their perspective and the perspective of others that support the member.
Care managers must develop a Care Plan for each member with behavioral health needs or an ISP for each member with I/DD and TBI needs.	▪ ***Clarification:*** Care managers working with members with co-occurring diagnoses (i.e., I/DD/TBI and behavioral health diagnoses) can develop ***either*** a Care Plan or ISP based on input from the member and/or their legally responsible person/guardian.
The Care Plan/ISP must be updated at least annually.	▪ ***Clarification:*** For individuals receiving 1915(i) services and individuals enrolled in the 1915(c) Innovations and TBI waivers, the annual Care Plan/ISPs are due during the birth date month of the member. The effective date of the annual update is always the first of the month following the birth month.
Care Plan/ISP must include the names and contact information of key providers, care team members, parents/family members/caregivers /natural supports, the county child welfare worker (for members in foster care/adoption assistance and former foster youth) and others chosen by the member to be involved in planning and service delivery	▪ ***Revised Requirement:*** Care Plan/ISP must include names and contact information of key providers **(e.g., primary care provider)**, **primary care management team members assigned/responsible for the member (i.e., care manager, supervising care manager, and extender)**, parents/family members/caregivers/natural supports, the county child welfare worker (for members in foster care/adoption assistance and former foster youth) and others chosen by the member to be involved in planning and service delivery

Care Plans and ISPs (2/2)

Additional proposed updates to the Care Plan/ISP section the TCM provider manual include:

- Additional **details on the requirements for the revising/updating the Care Plan/ISP** (as needed)
- Distinguishing the **roles and responsibilities for Care Plan/ISP development and implementation** between the care manager and service providers
  - The responsibility for implementing the Care Plan/ISP is shared among all members of the care team/person-centered planning team.
  - The care manager is ultimately responsible for monitoring and overseeing the implementation of the Care Plan/ISP.
  - The care manager is responsible for working with the member and family to develop long-term goals, while the service provider is responsible for developing short-range goals and monitoring progress at the service delivery level towards those goal (among other responsibilities for both the care manager and service provider).
- Clarifying that **care managers are not responsible for developing a Person-Centered Plan** (which is different than the Care Plan/ISP). A member's treatment/support service provider is responsible for developing the Person-Centered Plan

Medication Monitoring

The Department proposes the following updates to the medication monitoring requirement:

- Adding clarification on the care manager's role in medication adherence—i.e., documenting when the care manager conducts one or more of the following activities, based on a member's needs:
  - Identifying barriers to taking medication as prescribed
  - Assisting the member with finding solutions to identified barriers
  - Educating members on the importance of medication adherence
- Allowing a care manager extender to support the care manager conducting medication monitoring/adherence and ensuring medication reconciliation occurs

Additional Proposed Updates

Additional proposed updates to the TCM provider manual include:

Current Requirements	Proposed Update
TCM Engagement: No current requirement for the timeframe in which a care manager should engage a member in TCM.	▪ ***Clarification:*** Care managers should attempt to contact newly assigned members no later than 30 business days from the date of assignment to the AMH+/CMA. Attempted outreach should be documented in the care management data system.
Care Team: Members must have an assigned care manager.	▪ ***Update:*** AMH+/CMA must have clear documentation of the primary care manager assigned/responsible for the member and other members of the primary care team (i.e., supervising care manager, extender). If the member is served by other care managers or care manager supervisors, it needs to be documented in the care management platform.
Monitoring: Initial monitoring of AMH+s and CMAs is used to provide technical assistance rather than corrective action.	▪ ***Update:*** Initial monitoring of AMH+s and CMAs is primarily focused on providing technical assistance. However, egregious issues (e.g., concerns related to member health and safety) may result in further review and/or corrective action. The determination of corrective action for AMH+s and CMAs will be at the discretion of the Tailored Plan/LME/MCO conducting the monitoring.

Overview of 1915(i) Process and Timeline

AMH+s/CMAs are responsible for coordinating individual's 1915(i) services, in addition to performing the TCM requirements. Over the past few months, the Department convened a 1915(i), TCM Monitoring Tool workgroup of LME/MCOs, providers, and state staff to clarify and improve the 1915(i) process. Below is an overview of the 1915(i) process.

Member/LRP expresses interest in 1915(i) services or LME/MCO notifies AMH+/CMA member would benefit from services

Within 14 days

Care manager completes initial 1915(i) independent assessment and submits per LME/MCO processes

Within 14 days

Department determines eligibility for services

Within 45 days

Care manager completes the initial Care Plan/ISP (effective for 365 days)

As needed, care manager obtains prior authorization for services

As needed, care manager may complete interim care plan/ISP for immediately needed services

Care manager implements the 1915(i) Care Plan/ISP, including monitoring

At least 30 days before eligibility expires

Care manager conducts annual reassessment for 1915(i) services and develops new Care Plan/ISP

In the proceeding slides we provide additional details on this process, which will be reflected in the updated TCM Provider Manual.

Completing the Initial 1915(i) Independent Assessment and Determining Eligibility for 1915(i) Services

- Care managers are responsible for completing the 1915(i) independent assessment.
- The completion of the 1915(i) independent assessment does not trigger a full care management comprehensive assessment and may be an addendum or an update to a previous care management comprehensive assessment.
- The care manager must document in the care management platform the date the member and/or guardian/legally responsible person expressed interest in 1915(i) services, or the date of notification from the Tailored Plan/LME/MCO when one of the AMH+'s/CMA's assigned members requests or would benefit from 1915(i) services. **The care manager must complete the 1915(i) independent assessment using the Department-designated 1915(i) independent assessment tool within 14 days of that date.**
- The 1915(i) independent assessment may be, **but is not required to be, completed in person**. The 1915(i) independent assessment may also be completed or using real-time two-way video conferencing. The care manager must see the member or legally responsible person/guardian while the 1915(i) independent assessment is being completed.
- The Department determines member's eligibility for 1915(i) services **within 14 calendar days of submission of the 1915(i) independent assessment**.

Completing the Initial Care Plan/ISP and Obtaining Authorization for 1915(i) Services

- The Care Plan or ISP is the 1915(i) service order.
- After receiving an eligibility determination, the assigned organization performing **care managers will have 45 calendar days to complete the Care Plan/ISP and submit** to the member's Tailored Plans.
- The Care Plan/ISP must be signed by member and/or legally responsible person/guardian. ***The plan is effective for 365 days***.
- Some 1915(i) services require a prior authorization a review by the Tailored Plan/LME/MCO utilization management team. Care managers should follow the Tailored Plans/LME/MCO's established process for this review.
- The Tailored Plan/LME/MCO will **review the prior authorization request within 14 calendar days to complete a utilization review of the service(s)**.
- For 1915(i) services that do not require a prior authorization the services should be noted in the Care Plan/ISP, which is submitted to the Tailored Plan/LME/MCO.

Access to Immediately Needed 1915(i) Services and Interim Care Plans/ISPs:

- As needed, the care manager may complete an interim care plan or interim ISP reflecting care for immediately needed 1915(i) services.
- The interim care plan/interim ISP must be completed within 14 calendar days of the identified need(s). Regardless of whether there is an interim care plan/interim ISP, the full Care Plan/ISP should be completed within the 45 days of eligibility determination for 1915(i) services.

Implementing and Updating the 1915(i) Care Plan/ISP

- Care managers must facilitate provider choice and assignment process for members obtaining 1915(i) services.
- A 1915(i) independent assessment must be completed at least annually or when a member's circumstances or needs change significantly. Care managers will use the same 1915(i) independent assessment standardized template issued by the Department when conducting reassessments.
  - *Annual Reassessment:* The **annual independent assessment must be completed 30 days before 1915(i) eligibility expires** to ensure no gaps in services.
  - *1915(i) Assessments for New Services:* If a new service need is identified, the care manager should readminister the 1915(i) independent assessment, **but the assessment does not need to be submitted to the Department or Carelon**. Instead, care managers should keep a copy in the member's service record. Approval of 1915(i) eligibility is effective for 12 months and does not require resubmission for the addition of a new service.
- A new Care Plan/ISP is required annually and must be signed by the member and/or legally responsible person/guardian.
  - The 1915(i) annual reassessment and eligibility determination must occur before the date the member and/or legally responsible person/guardian signs the updated Care Plan/ISP plan.

Monitoring Service Access and Delivery

- Care managers should monitor that delivery of 1915(i) service delivery begins within 45 days of Care Plan/ISP approval.
- Care managers should monitor 1915(i) services at least quarterly to ensure that any restrictive interventions (including protective devices used for behavioral support) are written into the Care Plan/ISP and the Positive Behavior Support Plan (if applicable).
- Care managers should monitor that all services are provided as written in the Care Plan/ISP—monitoring methods include:
  - Face to face contacts (between the care manager and member or between the care manager and the member's care team)
  - Telephone contact between the care manager and the member's care team
  - Observation of services
  - Review of documentation and billing
- Care managers should monitor for HCBS compliance

Monitoring for HCBS Compliance

Supported Employment

- Requires monitoring at least quarterly or as needed.
- The HCBS monitoring tool should be used when the member is employed by a provider that delivers HCBS services.

Community Living and Support

- Community Living and Support provided by a Relative as Provider requires monthly monitoring to ensure the member has choice in direct support provider.
- Community Living and Support implemented by a provider agency requires monitoring at least quarterly or as needed.

Individual Placements and Supports (IPS)

- IPS should be monitored at least quarterly or as needed.

Individual Transitional Supports (ITS)

- ITS should be monitoring at least quarterly or as needed.

Public Comments