North Carolina Department of Health and Human Services (DHHS)

Tailored Care Management Technical Advisory Group (TAG) Meeting #17 (Conducted Virtually)

April 28, 2023

Tailored Care Management TAG Members	**Organization**
Erin Lewis	B&D Integrated Health Services
Lauren Clark (absent)	Coastal Horizons Center
Denita Lassiter	Dixon Social Interactive Services
Jason Foltz, D.O.	ECU Physicians
Natasha Holley (absent)	Integrated Family Services, PLLC
DeVault Clevenger	Pinnacle Family Services
Lisa Poteat	The Arc of NC
John Gilmore, M.D. (absent)	UNC Center for Excellence in Community Mental Health
Sean Schreiber (absent; represented by Donna Stevenson)	Alliance Health
Beverly Gray (absent; represented by Donetta Wilson and Lou Ann Simmons)	Eastpointe
Lynne Grey (absent)	Partners Health Management
Sabrina Russell	Sandhills Center
Cindy Ehlers	Trillium Health Resources
Rhonda Cox (absent)	Vaya Health
Cindy Lambert (absent)	Cherokee Indian Hospital Authority
Jessica Aguilar	Consumer Representative
Pamela Corbett (absent)	Consumer Representative
Alicia Jones (absent)	Consumer Representative
Cheryl Powell (absent)	Consumer Representative
NC DHHS Staff Members	**Title**
Kristen Dubay	Chief Population Health Officer, NC Medicaid
Loul Alvarez	Associate Director, Population Health, NC Medicaid
Gwendolyn Sherrod	Program Lead, Tailored Care Management, NC Medicaid, Quality and Population Health
Eumeka Dudley	Program Lead, Tailored Care Management, NC Medicaid, Quality and Population Health
Regina Manly	Senior Program Manager, Tailored Care Management, NC Medicaid, Quality and Population Health
Tierra Leach	Program Specialist, Tailored Care Management, NC Medicaid, Quality and Population Health
Tenille Lewis	Program Specialist, Tailored Care Management, NC Medicaid, Quality and Population Health

Agenda

- Welcome and Roll Call
- General Updates
- Tailored Care Management Updates
- Public Comments and Next Steps

Welcome and Roll Call (slides 3-6) – Tenille Lewis and Kristen Dubay

The Department introduced Kristen Dubay as the new Chief Population Health Officer for NC Medicaid.

General Updates (slides 7-13) – Regina Manly

The Department shared an update on coverage expansion and resuming the annual beneficiary recertification process for Medicaid eligibility.

Coverage Expansion

Governor Cooper signed coverage expansion into law, which will take effect upon the signing into law of the FY 2023-25 Appropriations Act. Coverage expansion is expected to provide health coverage to over 600,000 people across the State, with some of these individuals being eligible for Tailored Care Management. The Department encouraged plans and providers to identify individuals who they serve who may be newly eligible for Medicaid coverage (e.g., individuals using state-funded services) and connect them to resources to enroll in Medicaid.

Annual Beneficiary Recertification Process

Medicaid recertification is the process through which beneficiary information is reviewed to make sure beneficiaries are still eligible for Medicaid health coverage. It is also called eligibility redetermination, renewal, ex-parté review or case review (all mean the same thing).

Effective April 1, 2023, state Medicaid programs are no longer required to maintain continuous coverage for beneficiaries. Because of the COVID-19 Public Health Emergency (PHE), federal law required states to keep Medicaid beneficiaries enrolled until the end of the PHE, removing the need to reevaluate their eligibility and ensuring that beneficiaries retained coverage during the pandemic. The federal 2023 Consolidated Appropriations Act (also known as the Omnibus Bill), signed into law December 29, 2022, removed the continuous Medicaid coverage requirement, meaning that states are resuming the Medicaid recertification process for beneficiaries.

North Carolina began the recertification process for Medicaid beneficiaries on April 1, 2023, and recertifications will be phased over the next 12 months. Recertification could result in a beneficiary's termination or reduction of benefits if they are no longer found eligible for Medicaid or their current benefit package.

To assist with the Medicaid recertification process, Tailored Care Management care managers should:

- Proactively assist Tailored Care Management eligible beneficiaries with recertification and other benefits assistance as necessary

- Educate themselves and their assigned members on the recertification process
- Encourage members to update their address and contact information with their local Department of Social Services (DSS)
- As needed, ensure members take the necessary steps to complete the recertification process in response to letter(s) from their local DSS
- If a member's coverage is terminated, the care manager should refer members to apply for health care coverage on the federal Health Insurance Marketplace at healthcare.gov and explain they can appeal the decision or reapply at any time

Assisting a member with the recertification process (while the member is still enrolled in Medicaid) counts towards Tailored Care Management contact requirements. Members who are disenrolled from Medicaid are no longer eligible for Tailored Care Management.

The Department has published a toolkit for providers on the coverage unwinding which includes ready-to-use messages, templates, and other resources to insert into outreach campaigns.

What beneficiaries need to know about recertification:

- Make sure your local Department of Social Services (DSS) has your up-to-date contact information. The local DSS may need to reach you by mail, phone, email, or text message about your recertification.
- Sign-up for an Enhanced ePASS account online to make changes to your information at any time without visiting your local DSS. To create an ePASS account, logon to epass.nc.gov. For more information about ePASS and how to create an account, see the ePASS fact sheet.
- Medicaid caseworkers will try to complete recertification using information from electronic resources – without contacting you. If a Medicaid caseworker needs more information to finish the recertification, they will mail you a letter.
- Check your mail for information from your local DSS. If DSS needs information from you to finish their recertification, you will get a letter in the mail.
- Be careful and aware of scams. If you are not sure about information or mail you get asking for information from you, contact your local DSS.
- If your health coverage is renewed – You do not need to do anything. You will get a letter telling you your NC Medicaid benefits will stay the same or have changed.
- If your health coverage changes to a different Medicaid program – You do not need to do anything unless you do not agree or have concerns with your new Medicaid program. Contact your local DSS to learn more about your new benefit program.
- If your coverage is terminated (ended) – You can apply for health care coverage on the federal Health Insurance Marketplace at healthcare.gov. You can appeal the decision or reapply at any time.

Tailored Care Management Updates (slides 14-28) – Eumeka Dudley and Tenille Lewis

The Department reviewed updates on the Tailored Care Management TAG membership refresh and TAG Data Subcommittee. The Department also presented an update on temporary program flexibilities enacted between December 1, 2022, and March 31, 2023 (please see TAG slides for more information).

Update on Tailored Care Management TAG Refresh
With initial TAG member term lengths coming to an end, the Department is starting a process to refresh the TAG membership. The "refreshed" TAG is anticipated to launch July 2023 and will include a mix of existing TAG members continuing for a second term and new members. The Department has conducted outreach to existing members asking them if they would like to continue serving on the TAG and will announce a call for new applicants in the coming weeks.

Status Update on Tailored Care Management TAG Data Subcommittee Launch
The Department will launch a Tailored Care Management TAG Data Subcommittee in late June to discuss and address Tailored Care Management data topics. Prior to the launch of the Data Subcommittee, the Department encourages stakeholders to continue to participate in the weekly technology deep dive sessions to discuss questions on Tailored Care Management data interfaces. Additionally, the Department is currently finalizing the membership of the Data Subcommittee.

Tailored Care Management Program Updates
The Tailored Care Management program launched on December 1, 2022. Recognizing that it would take providers some time to ramp up and meet the full set of program requirements, the Department released a memo in November 2022 permitting temporary flexibilities and program changes for the period between December 1, 2022, and March 31, 2023. The majority of these flexibilities came to an end on March 31, 2023, while some will continue until June 30, 2023. The Department published a new memo to clarify the current status of each flexibility and outline several additional program updates. The Department walked through the status of each temporary flexibility and other updates to help ensure an aligned understanding of the status of Tailored Care Management program requirements.

TAG members asked the following questions and provided the following feedback on the temporary flexibilities and other Tailored Care Management program updates.

- A TAG member asked if providers using an LME/MCO's care management data platform can use their own care management comprehensive assessment if it was developed and approved during the AMH+/CMA certification process overseen by NCQA.
    - The Department responded that the State does not require AMH+ practices and CMAs to use an LME/MCO's care management comprehensive assessment template and that providers should discuss their concerns with their LME/MCO.
      Note: Unless otherwise specified in their LME/MCO contracts, contracted AMH+s/CMAs are not required to use LME/MCOs' care management comprehensive assessment template. However, AMH+s/CMAs must ensure that the results of care management comprehensive assessments are made available to LME/MCOs and individuals' other providers within 14 days of completion (see Provider Manual section "Sharing of Care Management Comprehensive Assessment Results").
- A TAG member asked if members participating in Transitions to Community Living (TCL) will have consumer choice honored if they want to choose a provider instead of the LME/MCO for Tailored Care Management.

    - The Department responded that as of April 1, 2023, all members participating in both TCL and Tailored Care Management must be assigned to the LME/MCO for Tailored Care Management. The LME/MCOs have dedicated TCL staff (e.g., Transition Coordinators, Complex Care Team staff, Diversion Specialists, In-Reach staff) that provide important services specially designed for TCL members that must be coordinated carefully. Most AMH+ practices and CMAs are not familiar with these TCL services and requirements at this time. The Department is working to develop ways to allow for TCL member choice of Tailored Care Management providers that are fully knowledgeable of TCL requirements, but the Department requires additional time to establish these options to ensure a seamless process for TCL members. Additional guidance on assignment and choice of provider-based care management for members participating in TCL will be released in the near future.
- A TAG member asked if best efforts for outreach and engagement into Tailored Care Management is defined as an initial contact attempt followed by three follow-up attempts at least 48 hours apart.
    - The Department responded that yes, that is correct.
- A TAG member asked how the Department will collect data on all of the contacts completed for a member for compliance purposes if providers only bill for the first contact in a month.
    - The Department responded that it collects data on all contacts delivered to members through the patient risk list.
- A TAG member requested more information on 1915(i) training requirements.
    - The Department responded that training on 1915(i) services is one of the required core trainings. MAHEC is developing a training for care managers and extenders that provides an overview of 1915(i) services and how to complete HCBS monitoring.
    - The Department will also work with MAHEC to ensure consistent messaging on the timelines to complete core trainings, the remaining training modules, and annual refresher trainings.
- A TAG member asked if there will be additional capacity building funds for Round 3 providers.
    - The Department responded that there are no additional capacity funds, including for Round 3 providers, at this time. The Department only has authority to distribute capacity building funds through June 30, 2023.
- A TAG member raised two issues that providers have been experiencing:
    1) Many members prefer not to be contacted as much as is required by the acuity-based contact requirements for Tailored Care Management.
    2) Care managers are spending a lot of time reaching out to members of the care team, coordinating referrals, and linking members to services. The current rates are insufficient to account for these types of care manager-to-provider contacts.
    - The Department thanked the TAG member for their feedback and noted that members can express their preference for fewer contacts, which must be documented in the care plan/ISP. Additionally, the Department is looking into these issues further and is committed to supporting AMH+/CMA stability and success in the model.

- A TAG member noted that they've heard different viewpoints on whether Tailored Care Management is an administrative function versus a service. Can the Department clarify?
    - Tailored Care Management is a service, not an administrative function. Tailored Care Management was designed to align with federal Health Home requirements, which include six core services: comprehensive care management; care coordination; health promotion; comprehensive transitional care and follow-up; individual and family support; and referral to community and social services.
- A TAG member asked how providers who deliver a service to a Standard Plan member that would make them eligible for Tailored Care Management can facilitate the member's transition to Tailored Care Management.
    - If a provider believes a Standard Plan member is eligible for Tailored Care Management or other services only available through a Tailored Plan or PIHP (i.e., mental health, substance use disorder, I/DD or TBI support needs not available in Standard Plans), then providers can work with members to submit the "Request to Move to NC Medicaid Direct or LME/MCO" form (available here). The form can be submitted online at ncmedicaidplans.gov/submit-forms-online or by calling the Enrollment Broker at 833-870-5500 (TTY: 711 or RelayNC.com) to request a downloadable version that can be mailed or faxed. The form can be filled out by a doctor, therapist or other I/DD, mental health or substance use disorder provider for the member.

      If the request is approved, beneficiaries will receive a notice from the Enrollment Broker. If the beneficiary is denied, Medicaid will send the beneficiary a denial letter that includes information on the beneficiary's right to appeal the decision and the denial reason. The beneficiary has 30 days from the date of the denial notice to request a State Fair Hearing (appeal).

      A video outlining how to submit requests is available online at ncmedicaidplans.gov/submit-forms-online.
- A TAG member asked how coverage expansion will affect the glide path to provider-based care management. Additionally, the TAG member asked if the Department has any estimates on the number of new Tailored Care Management eligible individuals due to coverage expansion and the number of individuals in Tailored Care Management who could lose coverage through the annual recertification process.
    - The Department responded that it is in the process of assessing the impacts coverage expansion will have on Tailored Care Management, including the glide path.
- A TAG member asked for clarification on the dates associated with the contract years for the provider-based glide path requirements in the Tailored Care Management Provider Manual. Providers have used these percentages to project staffing assumptions in future years of the Tailored Care Management program.
    - The dates for each contract year are listed below, and the Department will include this information in the next iteration of the Provider Manual.

        - Contract Year 1: December 2022 – September 2023
        - Contract Year 2: October 2023 – June 2024
        - Contract Year 3: July 2024 – June 2025
        - Contract Year 4: July 2025 – June 2026
        - Contract Year 5: July 2026 – June 2027
- A TAG member asked a question on the Healthy Opportunities Pilots and the NCCARE360 consent and referral process.
    - The Healthy Opportunities Pilots have yet to launch for the Tailored Plan/Tailored Care Management population. The Department will provide an update on Pilot launch for the Tailored Care Management population at an upcoming TAG meeting and invite Healthy Opportunities staff to join to help answer questions. Questions regarding the Pilots in the Standard Plan population can be sent to Leonard Croom (Leonard.A.Croom@dhhs.nc.gov) or Andrea Price-Stogsdill (Andrea.Price-Stogsdill@dhhs.nc.gov).
- A TAG member asked how the Department will monitor member preferences for fewer contacts since that information is not included on the patient risk list.
    - Care managers can document a member's preference in the care plan/ISP. One TAG member noted that they have added a "flag" in their data system to identify members who have requested fewer contacts.
    - The Department will monitor for compliance with contact requirements at the panel level to account for variations in individual member preferences. 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). Compliance scores for the April-June measurement period will be calculated and communicated September 2023. The goal of this initial measurement period is for the Department to gather data on provider and plan experience in delivering acuity-based contacts. Plans, AMH+ practices, and CMAs are in compliance if they deliver at least 75% of the sum of contacts required by all members in their panel.

Public Comments and Next Steps (slides 29-32) – Gwen Sherrod

The Department noted for TAG members and other stakeholders to review the latest updates on the Tailored Care Management web page. The Department will also discuss the feedback received during today's Tailored Care Management TAG meeting.

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