Tailored Care Management Technical Advisory Group (TAG)

Meeting #14:

Tailored Care Management Updates and Year-End Retrospective

December 16, 2022

Agenda

- Welcome and Roll Call (5 min)
- Community Guide/Navigator Benefit Update (10 min)
- Year-End Retrospective and Plan for the Upcoming Year (10 min)
- Public Comments (5 min)
- Next Steps (5 min)

Appendix: Compilation of Previously Released Key Information to Support Providers

Welcome and Roll Call

Department of Health and Human Services

Kelly Crosbie, MSW, LCSW	Gwendolyn Sherrod, MBA, MHA	Eumeka Dudley, BS	Regina Manly, MSA	Loul Alvarez, MPA
Chief Quality Officer	Program Lead, Tailored Care Management	Program Lead, Tailored Care Management	Senior Program Manager, Tailored Care Management	Associate Director, Population Health
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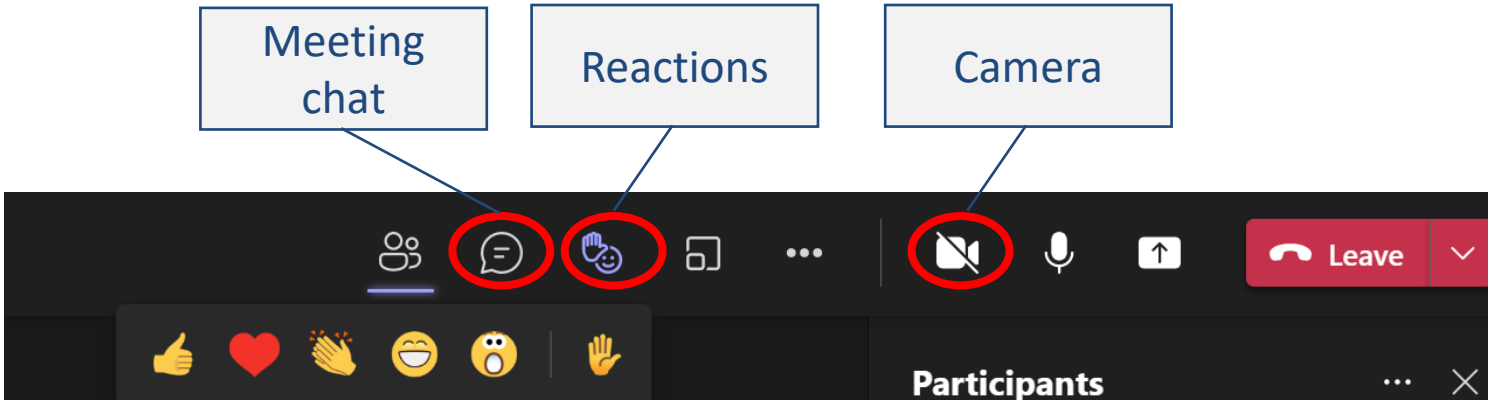
NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Tailored Care Management TAG Membership

Name	Organization	Stakeholder
Erin Lewis	B&D Integrated Health Services	Provider Representative
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.



Community Guide/Navigator Benefit Update

Community Guide/Navigator Benefit and the Transition to Tailored Care Management

Today, the community guide/navigator benefit is available to members enrolled in the Innovations waiver or obtaining 1915(b)(3) services. For most members, the Department intends to phase out the community guide/navigator benefit as of April 1, 2023, because the benefit is duplicative with Tailored Care Management.

- Individuals currently obtaining the community guide/navigator benefit can continue to do so while transitioning to Tailored Care Management services beginning December 2022 through April 1, 2023. The Department will support LME/MCOs as they provide a warm transition process with Tailored Care Management providers.
- After April 1, the community guide/navigator benefit as a sole benefit will end, and instead the benefit will be fully rolled in to Tailored Care Management, with one exception, noted below.
- After April 1, 2023, the community guide/navigator benefit will only remain in place for members enrolled in the Innovations waiver who self-direct their services. These members may continue to use community navigators to assist with self-direction activities.

Preserving the Relationship Between Members and Their Community Guide/Navigator

The Department recognizes the value of the relationships built between members and their community guides/navigators. To help preserve these relationships as the community guide/navigator benefit phases out and members transition into Tailored Care Management, the Department is announcing the below new policies:

- Members can obtain Tailored Care Management from the same organization where they obtain community guide/navigator services today
- Members may obtain both services for one month
  - If a member is receiving both services from the same organization, that organization can bill for both services
  - If a member is receiving services from different organizations, each organization can bill for the service they provide

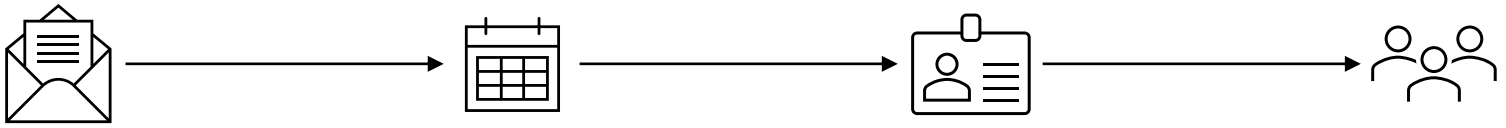
The Department's vision is for community guides/navigators to serve as care manager extenders under Tailored Care Management, bringing their valuable expertise and experiences to the member's care team.*

NOTE: Members also have the option of opting out of Tailored Care Management and receiving only community guide/navigator services until April 1, 2023. These members will then transition to Tailored Care Management, unless they are enrolled in the Innovations waiver and self-directing services. Members may choose to not participate in Tailored Care Management.

* Note: Not all community guides/navigators will be able to continue with the members they currently serve. Some may choose not to become an extender or work for an organization other than the one where the member is assigned for Tailored Care Management.

Implications for Members

Some members previously selected their community guide/navigator organization for Tailored Care Management but were assigned to another organization for Tailored Care Management; with this new policy, these members will have their original choice honored.



Impacted members to receive re-assignment letters

Re-assignments effective January 1, 2023*

Member engages in Tailored Care Management and can continue receiving community guide/navigator services for one month; member's community guide/ navigator supports them through this transition

Community guide/navigator transitions to become a care manager extender for this member

If a member did not previously choose their community guide/navigator organization for Tailored for Care Management but would like to, they can contact their LME/MCO to make that change.

*Impacted providers will see updated members in their beneficiary assignment file following the mid-December auto-assignment run

Questions?

Year-End Retrospective and Plan for the Upcoming Year

2022 Achievements

Launched Tailored Care Management

- **Model launched on December 1, 2022**

Established Provider-Based Care Management

- **71 AMH+s/CMAs certified** to-date, with additional providers in the pipeline
- **30% of eligible members assigned to AMH+s/CMAs at launch**

Trained Providers on the Model

- **Training/practice coaching for providers in certification process**
- **Approx. 4,200 individuals registered for courses** offered through AHEC including **24 Learning Collaborative Sessions** and **7 Special Update Sessions**

Built Care Management Capacity

- **$54.2 million in capacity building funding distributed** for health IT, workforce, and other processes/workflows

Promoted Member Choice to the Maximum Extent Possible

- Initial member-choice period in the Fall of 2022
- **Members can change their assignment for any reason without limit until April 1, 2023**

Where We Are Headed in 2023

Launch of Tailored Plans

- **Tailored Plans launch on April 1, 2023,** providing integrated managed care to members
- Continued roll-out of Tailored Care Management*

Additional Round of AMH/CMA Certification

- **62 providers** in the **Round 3 certification process**
- The Department is **exploring a process** for **certifying providers for additional populations**

Additional Trainings/Materials

- Making communications **clearer for members/families**
- **Trainings/materials in Spanish**
- Providers can continue to receive **AHEC training/coaching**
- Training on **1915(i) requirements**

Capacity Building Funding

- Approx. **$35 million in capacity building funds anticipated** to be distributed by June 2023
- The Department is **exploring** whether **additional funding** will be available **beyond June 2023**

Healthy Opportunities Pilots

- Tailored Plans to implement the **Healthy Opportunities Pilots** to provide services that **address social drivers of health**

** Tailored Care Management will continue as a Health Home program as of April 1, 2023*

TAG Member Reflections

Are there other accomplishments that TAG members wish to highlight?

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:

To Be Determined

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, 3:30-4:30 pm ET (presentation, minutes)

Appendix

Tailored Care Management Reference Guide

The Department has compiled previously released key information to support providers in the initial months of Tailored Care Management.

This Appendix contains references for the following Tailored Care Management topics:

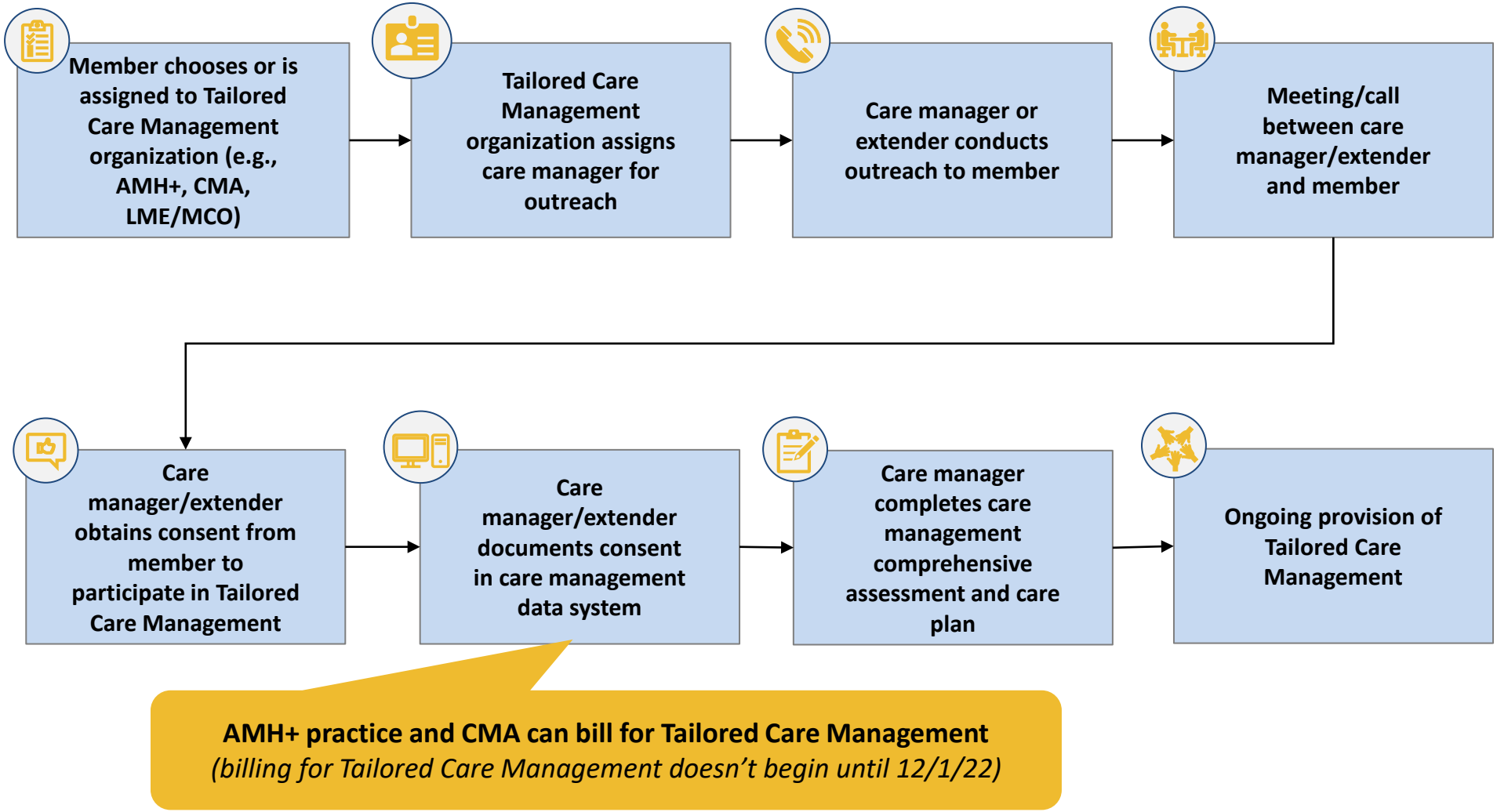
- **Populations eligible for Tailored Care Management**
- **Process flow**
- **Summary of care management comprehensive assessment and care plan/ISP requirements**
- **Contact requirements**
- **Payment approach**
- **Training requirements**

Who is Eligible for Tailored Care Management on 12/1?*

- Individuals 3+ in NC Medicaid Direct who **will enroll in a Tailored Plan on April 1, 2023**, including:
  - Innovations Waiver participants (including duals)
  - TBI Waiver participants (including duals)
  - Children and Adolescents with Serious Emotional Disorder (SED)
  - Adolescents with Severe Substance Use Disorder (SUD)
  - Adults with Serious Mental Illness (SMI) or Severe Substance Use Disorder (SUD)
  - Children (3+) and adults with intellectual/developmental disability (I/DD)
- Individuals 3+ in NC Medicaid Direct who **will stay in NC Medicaid Direct on April 1, 2023,** including:
  - Children and Adolescents in Foster Care with Serious Emotional Disorder (SED) or Severe Substance Use Disorder (SUD)
  - Dual-eligible Adults with Serious Mental Illness (SMI) or Severe Substance Use Disorder (SUD)
  - Dual-eligible Children and Adults with intellectual/developmental disability (I/DD) who are NOT on the Innovations or TBI waivers
- Children in NC Health Choice and children (0-3) who meet the above criteria will be eligible for Tailored Care Management April 1, 2023.

We often describe this criteria as “clinically eligible for a Tailored Plan”

Tailored Care Management Process Flow



Care Management Comprehensive Assessment

Completing the care management comprehensive assessment enables care managers to identify a member's needs related to physical health, behavioral health, I/DD, and TBI, in addition to unmet health-related resource needs.

Care Management Comprehensive Assessment

- **Must include an assessment of a minimum set of domains, including:**
  - Immediate care needs
  - Current service and providers across all needs
  - Physical health conditions, including dental conditions
  - Detailed medication history
  - Available informal, caregiver, or social supports
  - Functional needs, accessibility needs, strengths, and goals
  - Physical, intellectual, or developmental disabilities

Temporary Flexibilities/Program Changes for Interim Period (12/1/22 – 3/31/23)

- CMA and AMH+ care managers will have three months (90 days) to initiate contact and complete the care management comprehensive assessment.
- However, if an enrollee had a care management assessment within the last 12 months that meets all Tailored Care Management comprehensive assessment requirements, this requirement would be satisfied.
- For members in the Innovations or TBI waivers, care managers should align the timing of completing the care management comprehensive assessment and ISP with the annual ISP update.
- *Note: Care management comprehensive assessments completed in the interim period will still be valid after Tailored Plan launch on 4/1.*

Care Plan/ISP

The care plan/ISP documents a member's health-related needs and the key providers that are serving the member to assist the care manager in coordinating services. The care plan/ISP must be made available to other care team members to assist with this coordination.

Care Plan/ISP Requirements

- **Must include a minimum set of domains, including:**
  - Names and contact information of key providers, care team members, family members, and others chosen by the member to be involved in planning and service delivery
  - Clinical needs and interventions
  - Measurable goals
  - Strategies to improve self-management and planning skills
  - Strategies to mitigate risks to the health, well-being, and safety
  - Social, educational, and other services needed by the member
- **Must incorporate data including:**
  - Results of the care management comprehensive assessment
  - Claims analysis and risk scoring
  - Available medical records
  - Screening and/or level of care determination tools (e.g., LOCUS and CALOCUS)

Temporary Flexibility for Interim Period (12/1/22 – 3/31/23)

A care manager does not need to develop a new care plan/ISP if an enrollee has an active care plan/ISP that meets Tailored Care Management requirements and has been completed within the last 12 months.

Contact Requirements

During the interim period and for all members, care managers should make at least two contacts per month with at least one in-person contact quarterly.

Note: For members with an I/DD or a TBI who have a guardian or legally-responsible person (LRP), and for children/adolescent with a parent/guardian, telephonic contact may be with a guardian/LRP/parent in lieu of the member, only where appropriate or necessary. In-person contacts must involve the member.

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What Counts as a Tailored Care Management Contact?

Tailored Care Management is built around the six core Health Home services. Below are examples of activities care managers may complete in delivering a Tailored Care Management contact (see provider manual for additional details):

- **Comprehensive care management**, including
  - Completion of care management comprehensive assessments and care plan/ISP
  - Phone call or in-person meeting focused on chronic care management (e.g., management of multiple chronic conditions)

- **Care coordination,** including
  - Working with the member on coordination across settings of care and services (e.g., appointment/wellness reminders and social services coordination/referrals)
  - Assistance in scheduling and preparing members for appointments (e.g., phone call to provide a reminder and help arrange transportation)

- **Health promotion,** including
  - Providing education on members' chronic conditions
  - Teaching self-management skills and sharing self-help recovery resources
  - Providing education on common environmental risk factors including but not limited to the health effects of exposure to second- and third-hand tobacco smoke and e-cigarette aerosols and liquids and their effects on family and children

Reminder
LME/MCOs will pay AMH+s/CMAs based on the completion of the first contact each month.

What Counts as a Tailored Care Management Contact?

Tailored Care Management is built around the six core Health Home services. Below are examples of activities care managers may complete in delivering a Tailored Care Management contact (see provider manual for additional details):

- **Comprehensive transitional care/follow-up,** including
  - Visiting the member during the member's stay in the institution and be present on the day of discharge
  - Reviewing the discharge plan with the member and facility staff
  - Referring and assisting members in accessing needed social services and supports identified as part of the transitional care management process, including access to housing
  - Developing a 90-day post-discharge transition plan prior to discharge from residential or inpatient settings, in consultation with the member, facility staff, and the member's care team

- **Individual & family support,** including
  - Providing education and guidance on self-advocacy to the member, family members, and support members
  - Connecting the member and caregivers to education and training to help the member improve function, develop socialization and adaptive skills, and navigate the service system
  - Providing information to the member, family members, and support members about the member's rights, protections, and responsibilities, including the right to change providers, the grievance and complaint resolution process, and fair hearing processes

- **Referral to community & social support services,** including
  - Providing referral, information, and assistance and follow-up in obtaining and maintaining community-based resources and social support services
  - Providing comprehensive assistance securing key health-related services (e.g., filling out and submitting applications

Extender Functions

Extenders must work under the direct supervision of the care manager, and can perform the following functions:

- Performing general outreach, engagement, and follow-up with members
- Coordinating services/appointments
- Engaging in health promotion activities and knowledge sharing
- Sharing information with the care manager and other members of the care team on the member's circumstances
- Providing and tracking referrals and providing information and assistance in obtaining and maintaining community-based resources and social support services
- Participating in case conferences
- Supporting the care manager in assessing and addressing unmet health-related resource needs

When an extender performs one of these functions, it may count as a Tailored Care Management contact

When extenders conduct the functions listed above, they are conducting the function **instead** of a care manager, not **in addition to** the care manager.

* See the Tailored Care Management Provider Manual (pages 33-34) for more information.

Payments

During the interim period, there will be a single Tailored Care Management payment rate ($269.66) to reflect uniform contact requirements across acuity levels, with an add-on of $78.94 for Innovations and TBI waiver participants.

Note: As always, LME/MCOs will pay providers based on the completion of the first contact each month. AMH+s/CMAs will still need to submit a claim to the LME/MCO, and the LME/MCO will pay the provider the rate after the month of service.

Training

Care managers, supervising care managers, and care manager extenders must complete the below core modules within 90 days of hire; the remaining training modules of the Tailored Care Management training curriculum must be completed within 6 months of hire.

- An overview of the NC Medicaid Delivery system, including Tailored Care Management eligibility criteria, services available through PIHPs and future Tailored Plans, and differences between Standard Plan, PIHP, and Tailored Plan benefit packages;
- Principles of integrated and coordinated physical and behavioral health care and I/DD and TBI services;
- Knowledge of Innovations and TBI waiver eligibility criteria; and
- Tailored Care Management overview, including but not limited to the model's purpose, target population, and services, in addition to enrollees and their families' role in care planning.

Note: The Department is exploring extending these training flexibilities after Tailored Plan launch on April 1, 2023.

Provider Resources

Resource	Information
NC Medicaid Website	▪ Website: medicaid.ncdhhs.gov *(includes County and Provider Playbooks)*
NC Medicaid Behavioral Health I/DD Tailored Plan Website	▪ Website: medicaid.ncdhhs.gov/Behavioral-Health-IDD-Tailored-Plans
NC Medicaid Tailored Care Management Website	▪ Website: medicaid.ncdhhs.gov/tailored-care-management
NC Medicaid Help Center	▪ Website: medicaid.ncdhhs.gov/helpcenter
Practice Support	▪ Website: ncahec.net/medicaid-managed-care ▪ NC Medicaid Managed Care "Hot Topics" Webinar Series hosted by Dr. Dowler on the first and third Thursday of the month
Medicaid Bulletins	▪ Website: https://medicaid.ncdhhs.gov/providers/medicaid-bulletin