Tailored Care Management Technical Advisory Group (TAG)

Meeting #26

NC Medicaid and Tailored Care Management Updates & Refresher on Qualifying Contacts

January 26, 2024

Announcement

Please note that we are not recording this call, and 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

- Update on Tailored Care Management Payment Rate
- Additional NC Medicaid and Tailored Care Management Updates
- Overview of Qualifying Contacts
- Qualifying Contacts Scenarios
- Tailored Care Management Data Interfaces Consolidation
- Discussion

Welcome and Roll Call

Department of Health and Human Services

Kristen Dubay, MPP	Loul Alvarez, MPA	Regina Manly, MSA	Eumeka Dudley, MHS	Gwendolyn Sherrod, MBA, MHA	Tierra Leach, MS, LCMHC-A, NCC
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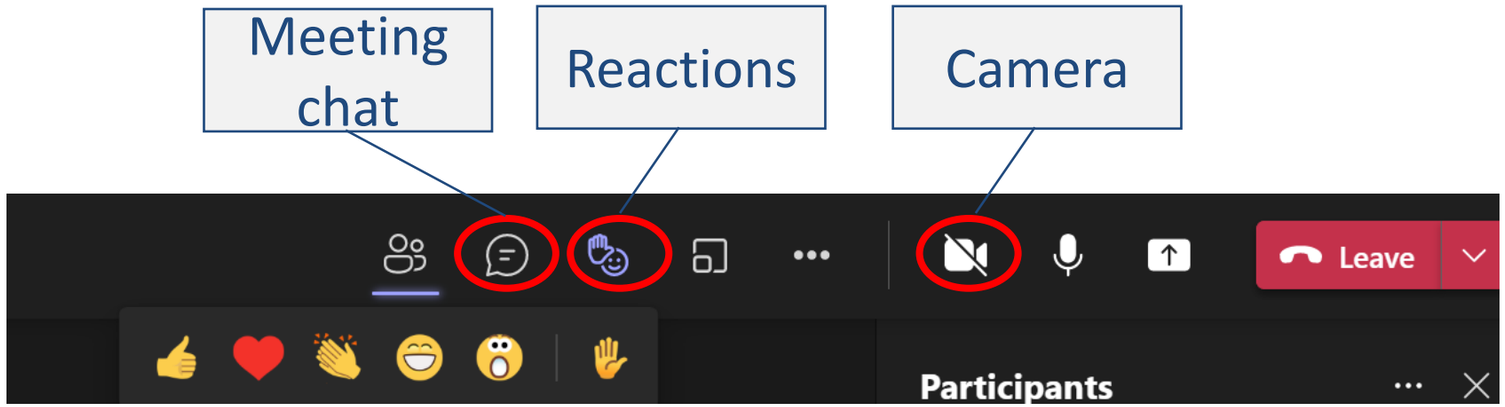
NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

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
Ruth Craig	ECU Physicians	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.



Update on Tailored Care Management Payment Rate

Tailored Care Management Payment Rate Increase

Thank you for the continuous collaboration on improving the Tailored Care Management model. Based on the feedback from the provider rate survey and other forums, and considering currently available budget, the Department is in the final stages of increasing the monthly payment rate. The change will be confirmed via a public notice sent later this month.

- Effective February 1, 2024, through June 30, 2024, the Department will **temporarily increase the payment** rate from $269.66 to **$343.97 (a 28% increase) for each member with a qualifying contact in the month.**
- Effective July 1, 2024, the payment rate will be **$294.86 for each member with a qualifying contact in the month—a 9% payment rate increase**.
- The add-on for Innovations and TBI waiver participants and for members obtaining 1915(i) services will be **$79.73 starting on February 1, 2024.**

No other changes are planned at this time. We are committed to continue working with AMH+s/CMAs and plans to ensure the models success.

Additional Details on the Payment Rate Increase

- The payment rate increases will be effective for Tailored Care Management qualifying contacts delivered on or after the dates noted in the previous slide. Months with qualifying contacts prior to February 2024 will paid at $269.66.
- The Department is still determining the time required for NC Medicaid and LME/MCOs to implement the payment rate increases in their systems.
- The Department will systematically reprocess all submitted claims with dates of service occurring on or after the dates noted in the previous slide.

Additional NC Medicaid and Tailored Care Management Updates

LME/MCO Consolidation (Overview)

Guiding Principles

1. What is best for the people we serve and for the providers who deliver services?
2. What will promote the value of whole-person care and move us to tailored plans faster?
3. What will reduce complexity, create less disruption, and make things easier for everyone involved?

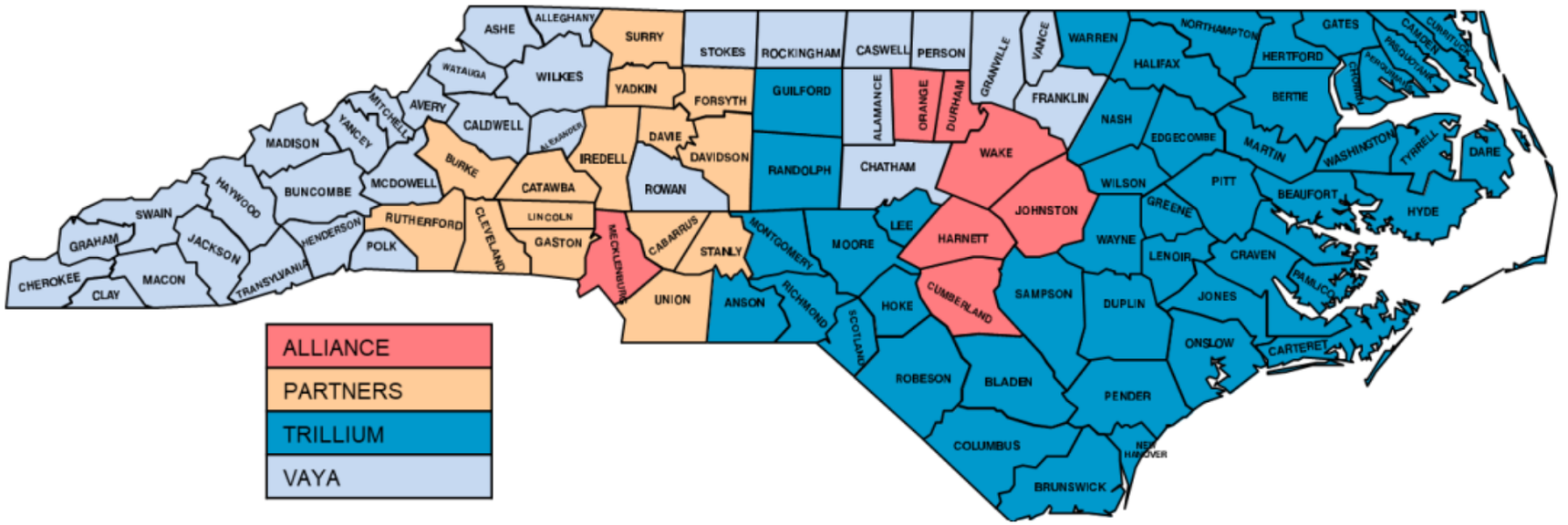
Secretary's Directive (11/1)

- Sandhills Center will be dissolved and Eastpointe will be the surviving entity with all counties in the Sandhills Center catchment area aligned to Eastpointe except as follows: Davidson counties will align with Partners Health Management; Harnett County will align with Alliance Health; and Rockingham County will align with Vaya Health.
- Eastpointe shall consolidate with Trillium Health Resources. DHHS has approved the consolidation agreement between the 2 entities.
- Consolidation is effective on 2/1/2024.

DHHS has released FAQs on consolidation for providers and beneficiaries

LME/MCO Consolidation County Realignment

LME/MCO COVERAGE MAP (AS OF FEB.1, 2024)



LME/MCO	Resulting LME/MCO County Alignment*
Trillium	**Anson**, Beaufort, Bertie, Bladen, Brunswick, Camden, Carteret, Chowan, Columbus, Craven, Currituck, Dare, **Duplin**, **Edgecombe**, Gates, **Greene**, **Guilford**, Halifax, Hertford, **Hoke**, Hyde, Jones, **Lee**, **Lenoir**, Martin, **Montgomery**, **Moore**, Nash, New Hanover, Northampton, Onslow, Pamlico, Pasquotank, Pender, Perquimans, Pitt, **Randolph**, **Richmond**, **Robeson**, **Sampson**, **Scotland**, Tyrrell, **Warren**, Washington, **Wayne**, **Wilson**
Alliance	Cumberland, Durham, **Harnett**, Johnston, Mecklenburg, Orange, Wake
Partners	Burke, Cabarrus, Catawba, Cleveland, Davie, **Davidson**, Forsyth, Gaston, Iredell, Lincoln, Rutherford, Stanly, Surry, Union, Yadkin
Vaya	Alamance, Alexander, Alleghany, Ashe, Avery, Buncombe, Caldwell, Caswell, Chatham, Cherokee, Clay, Franklin, Graham, Granville, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Person, Polk, **Rockingham**, Rowan, Stokes, Swain, Transylvania, Vance, Watauga, Wilkes, Yancey

***Bold Counties** will be realigned as part of LME/MCO consolidation effective on Feb. 1, 2024*

LME/MCO Consolidation Milestones & Status

Key Milestone	Dates	Status
County and Member LME/MCO Reassignment in DHHS and LME/MCO systems	12/18/2023 - 1/6/2024	**Complete**
PIHP Welcome Packets Mailing	1/8/2024 – 1/18/2024	**In Progress**
Enrollment Broker LME/MCO Assignment Letter Mailing	1/8/2024 – 1/20/2024	**In Progress**
Plan-Based TCM Reassignment	1/10/2024 – 1/17/2024	**In Progress**
Warm Handoff Process for High Needs Members	1/15/2024 – 2/9/2024	**In Progress**
Consolidation Go-Live	2/1/2024	**Pending**
LME/MCO Consolidation Flexibilities	2/1/20204 - 5/31/2024	**Pending**
TCM Provider Contracting & Panel Submission Deadline	4/30/2024	**Pending**
Provider-Based TCM Reassignment from OON TCM Providers	5/15/2024 – 5/22/2024	**Pending**
TCM Inserts Mailed to Members that Are Reassigned for OON TCM Providers	5/23/2024 – 5/30/2024	**Pending**

LME/MCO Consolidation Policy Flexibilities

The Department is enacting Policy Flexibilities supporting Transition of Care (TOC) and Tailored Care Management (TCM) due to PIHP consolidation <u>for a duration of 120 days beginning on 2/1/24.</u>

Policy Flexibilities relaxing prior authorization (PA) requirements for Behavioral Health and I/DD Services

- The goal of this flexibility is to alleviate the burden to providers during the transition period. The Department and other vendors will send PAs to PIHPs, but PIHPs must also implement other flexibilities to support providers during the transition.
- Each LME/MCO submitted a Consolidation Plan to the Department for approval detailing how they plan to enact PA flexibilities for Members.
- PIHPs can implement flexibilities in a variety of ways, including:
  - Allow for retroactive PA (at no penalty to the provider and or member).
  - Waive PA for specific services and allow retroactive services.
  - Note: For inpatient hospitalizations, PIHPs can still allow for concurrent review.

Policy Flexibilities Supporting Tailored Care Management (TCM):

- Members will be able to continue to see their current Tailored Care Management provider, regardless of contracting status with their new LME/MCO, for the TOC period (120 days beginning 2/1/2024).
- Members that are assigned to a provider-based TCM entity will not be reassigned as long as their current TCM provider completes a contract with the member's new LME/MCO by the contracting deadline of 4/30/2024.

Update on Launch of Provider-Based Tailored Care Management for Transitions to Community Living (TCL) Participants

To ensure TCL participants have choice of care management approach, the Department is establishing a process to allow TCL members to choose to obtain Tailored Care Management (but not TCL functions) from an AMH+ practice or CMA designated by NCQA to provide Tailored Care Management to TCL participants. The Department is seeking to have at least one TCL designated Tailored Care Management provider in each LME/MCO region to begin serving TCL participants on April 1, 2024. Below are key dates on launching this process:

- AHEC will be hosting two upcoming TCL trainings:
  - **Transitions to Community Living (TCL) Part 1: Overview** on Tuesday, February 6th, 2PM-4PM (discount code: TCMTCL)
  - **Transitions to Community Living (TCL) Part 2: Distinction for Tailored Care Management Training** on Monday, February 12th, 1PM-2PM (discount code: TCLDistinction)
- **NCQA Office Hours:** The week of February 12th (TBD on exact date/time)
- **TCL Distinction Applications Open:** February 19, 2024 – March 1, 2024
- **NCQA Application Review Period:** March 1, 2024 – March 25, 2024
- **Launch of first cohort of Tailored Care Management providers designated for TCL:** April 1, 2024

Please see the TAG presentation from July 2023 for an overview of TCL and the AMH+/CMA TCL designation process.

Criteria for TCL Designation Process

The Department has established a set of objective criteria against which providers will be evaluated by NCQA. All providers that meet this criteria will have the option to apply for designation to provide Tailored Care Management to TCL participants.

Designation Criteria

- Already certified as an AMH+/CMA and designated to serve the adult behavioral health population
- Actively provide one or more TCL services (e.g., TMS, CST, ACT, IPS-SE) to fidelity *(where applicable)*
- Serve a minimum of 25 TCL participants in each of the region(s) the provider seeks to serve
- Possess a minimum of four years of experience serving TCL participants
- Not currently subject to a plan of corrective action with any state agency
- **In receipt of a letter from the LME/MCO(s) in the region(s) they seek to serve indicating the plan supports their application based upon the plan's TCL-related experience with the provider**

Overview of Qualifying Contacts

Member-Facing Contacts are a Critical Component of Delivering Tailored Care Management

The Department believes that frequent contact with members promotes whole-person care, fosters high-functioning integrated care teams, and drives towards better health outcomes.

Member-Facing Contact Expectations

- Care managers/care teams should use their clinical judgement and the results of the comprehensive care management assessment to determine the intensity of care management and the number of contacts a member needs.
- The current payment rate assumes:[1]
  - Providers deliver **two qualifying member-facing contact in a month**.
  - Providers deliver **one in-person contact per quarter**.

    (additional detail on what is defined as a qualifying contact and an in-person contact are on the following slides)
- Providers expected to **conduct the comprehensive care assessment in-person**.[2]

Payment Approach

- To bill for the monthly payment rate, providers **must deliver at least one successful qualifying member-facing contact** either in-person or through two-way real time phone/video.
  - Email, text, or voicemail do not count as a qualifying contact.
- **Contacts that are not member-facing are not billable**

[1] Tailored Care Management rates are built off these contact expectations, but these are not requirement for a provider/plan to receive payment. Any future changes to the assumptions would impact the rate amounts.
[2] The Provider Manual notes that AMH+s/CMAs are expected to make a best effort attempt to complete the care management comprehensive assessment in person, in a location that meets the member's needs. Additional detail, including how "best effort" is defined, can be found in the Manual.

What Counts as a Qualifying Contact?

A qualifying contact is the member-facing delivery of one or more of the six Health Home services. Plan/providers receive payment for the first qualifying contact delivered. A non-member-facing Health Home activity does not count as a qualifying contact (e.g., care manager to PCP contact). Below are examples of activities care managers may complete in delivering a qualifying member-facing 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)
- **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

*To bill for Tailored Care Management in any given month, **at least one qualifying contact** must be delivered to the member and/or legally responsible person/guardian, as indicated, through telephone call, two-way real time video, or in-person.*

What Counts as a Qualifying Contact? *(continued)*

- **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
  - 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

- **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

Reminder

*To bill for Tailored Care Management in any given month, **at least one qualifying contact** must be delivered to the member and/or legally responsible person/guardian, as indicated, through telephone call, two-way real time video, or in-person.*

What Counts as an In-Person Contact?

In-person contacts are an important component of Tailored Care Management. The current payment rate assumes the care managers deliver one in-person contact per quarter, but the Department also recognizes that care managers/care teams should use their clinical judgement and member's preference to determine the frequency in-person contacts.

- An in-person contact is a meeting in which the **member is physically present** and the care team provides one or more of the Health Home services.
- An in-person meeting for which the member is not present (i.e., a care manager-guarding meeting) may be considered a contact, but **not** an in-person contact.
- Plans/providers are expected to report in-person contacts. The Department uses this data to understand the frequency in which in-person contacts occur.

Who Can Provide Health Home Services to the Member?

To bill for Tailored Care Management in any given month, the care manager, or extender where appropriate, must have a qualifying contact with the member.

Certain components of Tailored Care Management must always be led by a care manager. For example, working with the member/guardian/legally responsible person to:

- Complete the care management comprehensive assessment
- Develop the care plan (for members with behavioral health needs) or individual support plan (ISP) (for members with I/DD and TBI needs)
- Manage care transitions, including creating 90-day transition plans

Extenders must work under the direct supervision of a care manager, and can perform the following functions, which can count as a qualifying Tailored Care Management contact if phone, video and audio, or in-person contact with the member is made. For example, performing general outreach, engagement, and follow-up with members.

Additional details on the extender function can be found in the Provider Manual and the Care Manager Extender Guidance.

Contact Reporting

Plans/providers are required to report contacts with a member in a given month. This information allows the Department to assess Tailored Care Management engagement and informs rate assumptions.

- Plans/providers should utilize the **Patient Risk List (PRL)/BCM051** to report Tailored Care Management contacts.
  - The PRL is completed by AMH+/CMAs for Provider-Assigned members and follows the same structure as BCM051.
  - The LME/MCO will combine those files with the data for their own LME-assigned members to produce the final BCM051.
- **Only** the number of successful qualifying contacts should be reported (e.g., **not** text communications, collateral contacts, or unsuccessful attempts)

Instructions on Populating the PRL/BCM051 Contact Data Fields

BCM051 Field Name	Patient Risk List Field Name	Instructions
Number of Beneficiary Interactions	Number of CM Interactions	Enter the total number of days a provider has **successful qualifying contacts** with a member in a given month.
Number of Face-To-Face Beneficiary Interactions	Number of Face-To-Face Encounters	Enter the total number of days a provider has **in-person qualifying contacts** with a member in a given month.

Qualifying Contacts Scenarios

Qualifying Event Scenarios

In the following slides, we present a series of illustrative scenarios that seek to clarify questions and confusion amongst plans and providers on what qualifies as a contact.

These scenarios are based on surveys distributed to LME/MCOs and AMH+s/CMAs.

Scenario: Jane Doe

In December of 2022, Jane Doe's assigned care manager attempts to contact her via telephone and leaves a voicemail message.

Jane Doe does not call the care manager back in the month of December.

This is NOT a qualifying contact
- Do NOT report on PRL/BCM051
- Do NOT submit a claim

Continue to document in care management platform

In March of 2023, Jane Doe's assigned care manager schedules a doctor's appointment for her and texts her about the upcoming appointment. Jane Doe texts back noting she plans to attend the appointment.

This is NOT a qualifying contact
- Do NOT report on PRL/BCM051
- Do NOT submit a claim

Continue to document in care management platform

In both December 2022 and March 2023, the provider/plan should report in the PRL/BCM051 <u>zero</u> "CM Interactions" and <u>zero</u> "Face-to-Face Encounters" with Jane Doe.

Key Takeaways: Qualifying contact with a member that can be billed must be either in person or through a two-way real time phone/video call. One-way contact (e.g., emailing, texting, or leaving a voicemail) does not qualify as a billable contact.

Scenario: Bill Smith

In January 2023, the following events occur:

On January 5th, Bill Smith speaks over the phone with his care manager to schedule his Medicaid Recertification appointment and coordinate transportation.	**This is the 1st qualifying contact of the month (not in-person contact)** • Report on PRL/BCM051 • Submit a claim for reimbursement Continue to document in care management platform
On January 9th, Bill Smith's care manager sends an email to review the transportation and appointment process, Bill sends a reply with a question, to which the care manager responds with an answer.	**This is NOT a qualifying contact (email exchanges are not considered a two-way real time contact)** • Do NOT report on PRL/BCM051 • Do NOT submit a claim Continue to document in care management platform
On January 11th, Bill Smith's care manager accompanies him to complete his Medicaid Recertification.	**This is a qualifying contact (in-person contact)** • Report on PRL/BCM051 • Do NOT submit a claim (a claim was already submitted for the month) Continue to document in care management platform
On January 15th, Bill Smith has a follow-up conversation with his care manager via videoconference to learn more about social support services.	**This is a qualifying contact (not in-person contact)** • Report on PRL/BCM051 • Do NOT submit a claim (a claim was already submitted for the month) Continue to document in care management platform

In January 2023, the provider/plan should report in the PRL/BCM051 three "CM interactions" and one "Face-to-Face Encounter" with Bill Smith.

Key Takeaways: Number of overall qualifying contacts with a member in a given month is inclusive of both in-person contacts (i.e., being physically present with a member) and not in-person contacts (i.e., phone calls or video calls). Email, text, or voicemail, do not count as a qualifying contact.

Scenario: John Brown

In February 2023, the following events occur:

On February 6th, John Brown's guardian calls his assigned care manager and schedules an appointment to complete the care management comprehensive assessment.

This is the 1st qualifying contact of the month (not in-person)
- Report on PRL/BCM051
- Submit a claim for reimbursement

Continue to document in care management platform

On February 12th, John Brown and his care manager meet in-person to complete his care management comprehensive assessment.

This is a qualifying contact (in-person)
- Report on PRL/BCM051
- Do NOT submit a claim (a claim was already submitted for the month)

Continue to document in care management platform

Later that same day, John Brown realizes he forgot to ask a follow-up question about managed care services and has a telephone conversation with his care manager to receive an answer.

Only one contact in a given day should be reported
- Do NOT report on PRL/BCM051
- Do NOT submit a claim

Continue to document in care management platform

In February 2023, the provider/plan should report in the PRL/BCM051 <u>two</u> "CM Interactions" and <u>one</u> "Face-to-Face Encounters" with John Brown.

Key Takeaways: Number of overall qualifying contacts with a member in a given month is inclusive of both in-person and non-in-person contacts (i.e., two-way real time phone/video call). If more than one event that qualifies as a contact occurs in the same day, only one should be reported.

Scenario: Sam Anderson

In March 2023, the following events occur:

On March 6th, Sam Anderson speaks over the phone with his assigned care manager extender to ask questions about available assistance with his medication and schedules an in-person meeting.

This is the 1st qualifying contact of the month (not in-person)
- Report on PRL/BCM051
- Submit a claim for reimbursement

Continue to document in care management platform

On March 9th, Sam Anderson's assigned care manager extender travels to Sam Anderson's residence to provide assistance with job applications.

This is a qualifying contact (in-person)
- Report on PRL/BCM051
- Do NOT submit a claim (a claim was already submitted for the month)

Continue to document in care management platform

In March 2023, the provider/plan should report in the PRL/BCM051 <u>two</u> "CM interactions" and <u>one</u> "Face-to-Face Encounters" with Sam Anderson.

Key Takeaways: Care manager extenders can deliver in-person and not in-person qualifying contacts to a member, where appropriate, which should be reported and can be billed for the monthly rate.

Scenario: Leslie Wilson

In April 2023, the following events occur:

On April 17th, Leslie Wilson's legal guardian meets with her care manager at the local library to retrieve educational materials on self-advocacy, Jane Doe is not present.

This is the 1st qualifying contact of the month (not in-person)
- Report on PRL/BCM051
- Submit a claim for reimbursement

Continue to document in care management platform

On April 20th, Leslie Wilson receives a phone call from her care team wishing her a happy birthday, she responds with a heartfelt thank you.

This is NOT a qualifying contact (no Health Home service was provided)
- Do NOT report on PRL/BCM051
- Do NOT submit a claim

Continue to document in care management platform

On April 22nd, Leslie Wilson's care manager sees an important announcement made by NC DHHS regarding Tailored Care Management and texts the link to Leslie Wilson.

This is NOT a qualifying contact (text exchanges are not considered a two-way real time contact)
- Do NOT report on PRL/BCM051
- Do NOT submit a claim

Continue to document in care management platform

In April 2023, the provider/plan should report in the PRL/BCM051 <u>one</u> "CM Interactions" and <u>zero</u> "Face-to-Face Encounters" with Leslie Wilson.

Key Takeaways: The member has to be physically present for a contact to qualify as in-person. Additionally, the care manager must deliver at least one of the six Health Home services for an event to qualify as a contact.

For Discussion

- **How can the Department be helpful in addressing confusion on contacts and supporting accurate reporting?**

Tailored Care Management Data Interfaces Consolidation

TCM Data Interfaces Consolidation Overview

Based on feedback from TCM Providers, the Department has been exploring the idea of combining of the PIHP and TP versions of the TCM Data Interfaces.

- Listening to TCM Providers, it has been expressed that one file with both PIHP and TP members would be preferred over two separate files.
- The Department has discussed and aligned with the Privacy and Security Office (PSO), on feasibility of the new design so long as contractual obligations are met.
- LME-MCOs have agreed and aligned that this enhancement would be beneficial to their operations.
- **Discussion:** The Department would like to hear feedback from TCM Providers and/or their CINs/Data Partners on if the TCM Data Interfaces Consolidation is an enhancement that would be beneficial to their operations?

TCM Data Interfaces to consider:

- Beneficiary Assignment File
- Patient Risk List
- Professional, Institutional, Pharmacy, and Dental Claims
- Pharmacy Lock-in file

TCM Data Interfaces Consolidation - Proposed Solution

There will be no changes to current file layouts of the TCM data interfaces. Below are the mechanisms by which Health Plans will identify if a member is enrolled in Tailored Plan or Medicaid Direct through the 834 file.

Member Benefit Plan: Loop 2300 Ref HD04:

- If a member's benefit plan (Loop 2300 ref HD04) value is **PHPB, PHPC, or TBI they are enrolled with a PIHP**.
- If a member's benefit plan (Loop 2300 ref HD04) value is **TPMC, TPINV, or TPTBI they are enrolled with a TP**.
- Benefit Plan information can by utilized by TCM Providers on Beneficiary Assignment file (see scenarios in next slide).
- *Note: a member cannot be enrolled in both PIHP and TP benefit plans for the same enrollment period.*

Provider Information: Loop 2310 Ref NM101-109:

- Loop 2310 repeats up to 30 times to share provider and plan assignment information. When a member is assigned to an LME-MCO or TP, the following will occur in at least one iteration of loop 2310 Ref NM101-109:
  - Ref NM101 will equal "Y2"
  - Ref NM106 will equal either "LME MCO" or "PHPTP"
  - Ref NM108 will equal "SV" or "XX" - SV is populated atypicalID and XX is populated for an NPI number.
  - Ref NM109 will equal the LME-MCO or TP's atypical ID/NPI number. In the case of Alliance, this will be either "ALLTAL00" or "3404933" allowing Plans to differentiate between Alliance the TP and Alliance the LME-MCO respectively.

TCM Data Interfaces Consolidation - Proposed Scenarios

Below are scenarios of how the Beneficiary Assignment (BA) file will function. These scenarios apply to when a member's health plan changes from PIHP to TP and when a member's TCM Provider & health plan changes. All other previously shared scenarios relating to the BA file and maintenance type code behavior remain intact.

Sc.	Scenario Description	Interface Name	File Creation Date	Source Entity	Benefit Plan	Enrollment Start Date	Enrollment End Date	TCM Begin Date	TCM End Date	TCM Provider	CIN/Data Partner	Maintenance Code	Expected Behavior
1	Medicaid Direct (MD) to Tailored Plan Transition (same LME-MCO) No Change in Member TCM Provider (Same NPI & Loc Code) Activity Date: 6/19/24	Weekly BA full file	6/16/2024	LME-MCO 1	PHPC	12/1/2022	12/31/9999	12/1/2022	12/31/9999	TCM-1	CIN-1	021	Weekly BA full file prior to transitioning to Tailored Plan
		Weekly BA full file	6/23/2023	LME-MCO 1	PHPC	12/1/2022	6/30/2024	12/1/2022	6/30/2024	TCM-1	CIN-1	024	LME-MCO 1 BA File to Contracted TCM Provider 1, CIN 1: Plan eligibility and Benefit Plan change from PIHP to TP. LME-MCO 1 will continue to send this member to TCM Provider 1, CIN 1. PIHP Benefit Plan will end on 6/30/2024, TP enrollment will begin on 7/1/2024.
				LME-MCO 1	TPINV	7/1/2024	12/31/9999	7/1/2024	12/31/9999	TCM-1	CIN-1	001	
		EOM BA Full File	6/30/2024	LME-MCO 1	PHPC	12/1/2022	6/30/2024	12/1/2022	6/30/2024	TCM-1	CIN-1	024	EOM BA full file will reflect same as 6/23 file.
				LME-MCO 1	TPINV	7/1/2024	12/31/9999	7/1/2024	12/31/9999	TCM-1	CIN-1	001	
		Weekly BA full file	7/7/2024	LME-MCO 1	TPINV	7/1/2024	12/31/9999	7/1/2024	12/31/9999	TCM-1	CIN-1	001	July BA full file will no longer show PIHP enrollment
2	Medicaid Direct (MD) to Tailored Plan Transition (same LME-MCO) Change in Member TCM Provider and/or affiliated CIN (Different NPI & Loc Code) Same Plan to different TCM Providers Activity Date: 8/7/2024	Weekly BA full file	8/4/2024	LME-MCO 1	PHPC	12/1/2022	12/31/9999	12/1/2022	12/31/9999	TCM-1	CIN-1	021	LME-MCO 1 BA File To Contracted TCM Provider 1, CIN 1.
		Weekly BA full file - TCM -1	8/11/2024	LME-MCO 1	PHPC	12/1/2022	8/31/2024	12/1/2022	8/31/2024	TCM-1	CIN-1	024	Member Benefit plans changes to TP and TCM provider changes. LME-MCO continues to send member until 8/31/2024
		Weekly BA full file - TCM-2	8/11/2024	LME-MCO 1	TPINV	9/1/2024	12/31/9999	9/1/2024	12/31/9999	TCM-2	CIN-2	001	TP 1 BA File To Contracted TCM Provider 2, CIN 2.
		EOM BA Full File - TCM-1	8/31/2024	LME-MCO 1	PHPC	12/1/2022	8/31/2024	12/1/2022	8/31/2024	TCM-1	CIN-1	024	LME-MCO 1 EOM BA File To Contracted TCM Provider 1, CIN 1 last BA file sent to TCM 1 CIN 1
		EOM BA Full File TCM-2	8/31/2024	LME-MCO 1	TPINV	9/1/2024	12/31/9999	9/1/2024	12/31/9999	TCM-2	CIN-2	001	TP 1 EOM BA File To Contracted TCM Provider 2, CIN 2.

TCM Data Interfaces Consolidation - Proposed Scenarios

Sc.	Scenario Description	Interface Name	File Creation Date	Source Entity	Benefit Plan	Enrollment Start Date	Enrollment End Date	TCM Begin Date	TCM End Date	TCM Provider	CIN/Data Partner	Maintenance Code	Expected Behavior
3	**Medicaid Direct (MD) to Tailored Plan Transition (same LME-MCO)** **No Change in Member TCM Provider (Same NPI & Loc Code)** **Change in Member Address** **Enrollement Change: 9/1/2024** **Address Change: 8/23/24**	Weekly BA full file	8/25/2024	LME-MCO 1	PHPC	8/1/2024	8/31/2024	8/1/2024	8/31/2024	TCM-1		024	LME-MCO 1 sends BA file to TCM-1. New address delivered; PIHP Benefit plan end dated
			8/25/2024	LME-MCO 1	TPINV	9/1/2024	12/31/9999	9/1/2024	12/31/9999	TCM-1		001	Same BA file shows TP Benefit plan started for next month
		EOM BA Full File	8/25/2024	LME-MCO 1	PHPC	8/1/2024	8/31/2024	8/1/2024	8/31/2024	TCM-1		024	LME-MCO 1 sends BA file to TCM-1. New address delivered; PIHP Benefit plan end dated; TP benefit plan started
			8/25/2024	LME-MCO 1	TPINV	9/1/2024	12/31/9999	9/1/2024	12/31/9999	TCM-1		001	
		Weekly BA full file	9/1/2024	LME-MCO 1	TPINV	9/1/2024	12/31/9999	9/1/2024	12/31/9999	TCM-1		001	TP Benefit plan started; new address delivered
		EOM BA Full File	9/30/2024	LME-MCO 1	TPINV	9/1/2024	12/31/9999	9/1/2024	12/31/9999	TCM-1		001	TP Benefit plan started; new address delivered

For all other TCM Data Interfaces (Claims files, Patient Risk List, Pharmacy Lock-in), TCM Providers can utilize the Beneficiary Assignment file to determine whether a member is enrolled with a PIHP or TP.

TCM Data Interfaces Consolidation - Proposed Timeline

2/9/2024

- The Department drafts updated data specifications for all TCM Data Interfaces and shares for Plan and TCM Provider/CIN/Data Partners review.

3/29/2024

- Plans and TCM Providers/CINs/Data Partners complete development.

4/12/2024

- Plans and TCM Providers/CINs/Data Partners complete internal testing and validation.

Post 4/12/2024

- Consolidated TCM Interfaces are tested through the Department's E2E testing by Plans and participating TCM Providers/CINs/Data Partners.

TCM Data Interfaces Consolidation – Next Steps

Request: Please provide the Department your inputs and alignment on consolidating the TCM Data Interfaces **by 2/2/2024**. In your responses, please provide feedback on the proposed solution and timeline shared in the previous slides.

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 3:30-4:30 pm ET.

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)