Tailored Care Management Technical Advisory Group (TAG)

Meeting #20

NC Medicaid and Tailored Care Management Updates

July 28, 2023

Agenda

- Welcome and Roll Call
- NC Medicaid Updates
- General Tailored Care Management Updates
- AMH+/CMA Certification Process for TCL Population
- Provider Manual Update
  - Clarifications on Tailored Care Management Payment Approach, Acuity Tiers, and Billing
- Public Comments
- Next Steps

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	Tenille Lewis, MA
Chief Population Health Officer	Associate Director, Population Health	Senior Program Manager, Tailored Care Management	Program Lead, Tailored Care Management	Program Lead, Tailored Care Management	Program Specialist, Tailored Care Management	Population Health Coordinator
Contact: Medicaid.TailoredCareMgmt@dhhs.nc.gov						

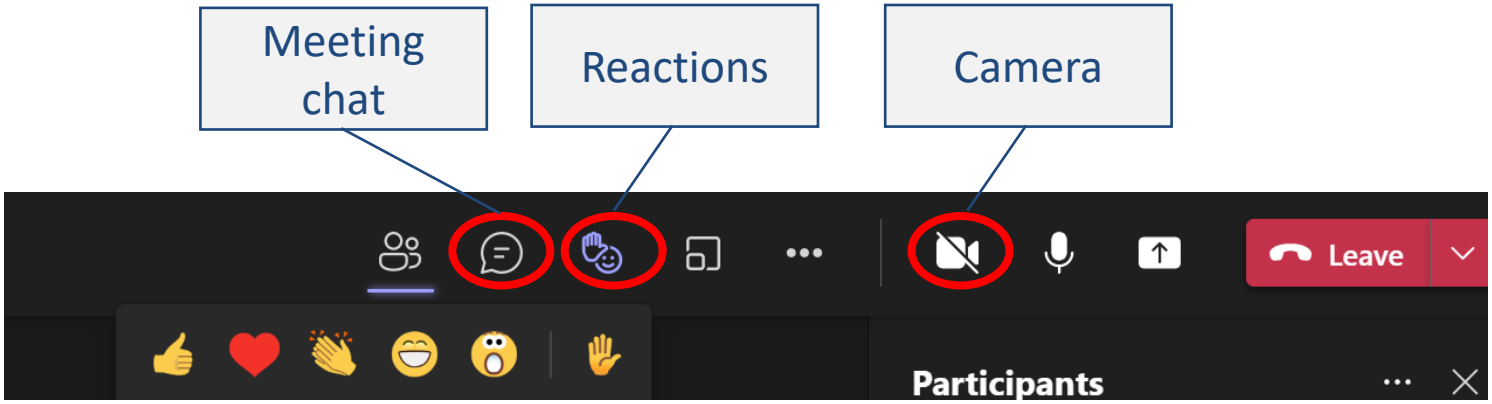
NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Launch of Refreshed 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
Donetta Wilson	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
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.



NC Medicaid Updates

Medicaid Expansion Date Announced

On October 1, 2023, the NC Department of Health and Human Services plans to move forward with Medicaid Expansion, making new access to affordable health coverage available to approximately 600,000 North Carolinians.

- Since the legislation to expand Medicaid was signed into law in March, NCDHHS has been completing the extensive policy and technical work necessary to launch expansion.
- This announcement is part of a compromise agreement NCDHHS obtained from the Centers for Medicare & Medicaid Services (CMS) that will allow the department to move forward with the necessary public notices for beneficiaries, counties and providers while still awaiting authority from the NC General Assembly.
- To launch expansion on October 1, NCDHHS will still need final authority from the NC General Assembly – either through "de-coupling" the budget and expansion or through an enacted budget – by September 1. If NCDHHS does not have authority to move forward by September 1, the earliest fallback date is Dec. 1, 2023, and depending on how late authority is given, it could fall into 2024.

Delay in Tailored Plan Launch

On July 11, 2023, the Department announced it is delaying the launch of Tailored Plans from October 1, 2023, to a date still to be determined.

- The Department continues to work with Local Management Entities/Managed Care Organizations (LME/MCOs) to enable a smooth Tailored Plan roll-out.
- Beneficiaries who will be covered by the Tailored Plans will continue to receive care as they do today.
- Tailored Care Management, which launched on December 1, 2022, will continue to support eligible beneficiaries by offering a care manager and care team to coordinate care across providers.
- The Department understands that uncertainty with Tailored Plan launch is challenging and confusing for stakeholders and beneficiaries. We will continue to work closely with LME/MCOs to launch Tailored Plans on the fastest possible timeline that can guarantee a smooth transition.

General Tailored Care Management Updates

Distribution of Additional Capacity Building Funding

The Department has distributed to LME/MCOs additional capacity building funds to support Tailored Care Management sustainability and address higher than anticipated outreach and start-up costs. LME/MCOs have begun the process to inform Advanced Medical Home Plus (AMH+) practices and Care Management Agencies (CMAs) of additional funding.

Available funding was allocated to LME/MCOs based upon:

- updated distribution plan requests,
- member assignments to AMH+s/CMAs (as of 5/30/23), and
- stewardship of previously distributed funds.

If an AMH+/CMA has not received information about whether they will receive additional capacity building funds, the Department recommends the provider contact the LME/MCOs with which they have a capacity building agreement.

Additional AMH+/CMA capacity building funds guidance can be found here.

Tailored Care Management Provider Survey and Community Outreach

The Department continues to explore how to best support provider's success and sustainability in Tailored Care Management. The below activities are in the planning phase:

- **Provider Survey** to collect information on providers' actual time and costs associated with delivering Tailored Care Management. Survey results will inform ongoing discussions about potential modifications to the rates and payment approach.
  - The Department is working with a subset of providers to ensure the survey questions address provider concerns.

- **Member and Community Engagement**. The Department is considering strategies to help create greater awareness of Tailored Care Management across potentially eligible members, providers, community organizations, and other stakeholders.

AMH+/CMA Certification Process for TCL Population

Overview of Transitions to Community Living (TCL)

TCL is North Carolina's Olmstead settlement for adults with serious mental illness and serious and persistent mental illness.

Olmstead states that people do not have to live or receive services in an institution, nursing home, or any other setting separated from others without disabilities to get the services they need. People with disabilities have the right to live in the community and those services should also be provided in the community.

North Carolina's Olmstead plan includes the following areas to achieve this vision:

- Making it easier to get services and supports in the community.
- Hiring, training, and keeping employed the direct support professionals who assist people to live, work, and do well in their own homes and communities.
- Helping people make the change to living in their own home and supporting people to keep them from having to go to an institution.
- Exploring other ways, besides guardianship, to help people make decisions.

LME/MCOs have staff dedicated to serving participants in the TCL settlement.

Individuals in TCL are eligible for Tailored Care Management in addition to their TCL services.

The following slides provide an update to the TAG on how TCL participants access Tailored Care Management and how AMH+ practices and CMAs can apply to serve TCL participants.

TCL Functions Are Not Changing

While individuals in the TCL settlement are eligible for Tailored Care Management, current TCL functions will continue to be offered and provided as they are today.

- The DOJ **TCL settlement is ongoing**, and North Carolina must continue to comply with the terms of the settlement.
- The Department believes TCL participants will benefit from the **whole-person care management** provided through Tailored Care Management.
- To meet the terms of the settlement and to best serve the needs of TCL participants, **TCL functions will continue as they do today**. LME/MCO TCL staff will continue to perform TCL in-reach, diversion, transition, and complex care functions for TCL members.
- **LME/MCO TCL staff will continue to work exclusively with the TCL population**. LME/MCOs must have separate staff to perform in-reach, transition, and diversion functions for non-TCL populations.
- While TCL members are eligible for Tailored Care Management, their **Tailored Care Management care manager will not take over established TCL functions for the TCL population.**

TCL Participants May Choose to Receive Tailored Care Management from a List of Designated Providers

To ensure TCL participants have choice of care management approach, the Department is establishing a designation process for Tailored Care Management providers to provide Tailored Care Management (not TCL services) to TCL participants.

- **For Tailored Care Management, TCL members are currently auto-assigned an LME/MCO-based care manager** to leverage LME/MCO expertise on TCL.
- 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.
  - This process is similar to the designation that an AMH+ practice or CMA has to serve children vs. adults, behavioral health vs. I/DD, Innovations/TBI waiver enrollees, etc.
- **TCL participants** who elect to receive Tailored Care Management from a provider **will continue to obtain all TCL services and functions** (i.e., diversion, in-reach, transitions, complex care) **from LME/MCO-based TCL staff**.

The Department anticipates this designation process will open in September 2023.

Designating Tailored Care Management Providers to Serve TCL Participants

The Department will establish a designation process for Tailored Care Management providers seeking to serve TCL participants to provide choice to TCL participants while complying with the terms of the DOJ settlement.

The Department's goals for the designation process are as follows:

1. Establish a designation process that does not put an undue burden on the State / LME/MCOs / providers and can be stood up quickly
2. Designation process will provide TCL participants with a sufficient number of providers to choose from
3. Ensure the well-being of TCL participants by designating providers with a proven track record of effectively supporting and serving TCL participants

This process only applies to TCL participants who elect to obtain Tailored Care Management from an AMH+ practice or CMA.

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 the following criteria will have the option to apply for designation to provide Tailored Care Management to TCL participants:

- 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 LME/MCO 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

- LME/MCOs will establish their own criteria to determine if they will support a provider's application for designation based on DHHS guidelines.
- The letter must attest to the provider's history of working effectively with TCL staff and with TCL participants.
- LME/MCOs and providers may work together to address any concerns that would prohibit LME/MCOs from providing a letter of support.

Overview of TCL Designation Process

Providers that meet the specified criteria *(discussed on previous slide)* will apply to NCQA for designation to serve the TCL population.

- Providers will be required to develop a policy and procedures for providing Tailored Care Management to TCL participants (e.g., formal procedures for coordinating with TCL staff at the LME/MCOs), which NCQA will assess based on criteria established by the Department.
- The Department will reserve the right to rescind any AMH+/CMA TCL designation if a provider fails to continue to meet all criteria.
- The Department anticipates this designation process will open in September 2023. Applications for designation will be considered on a rolling basis and applications can be made at any time.

Questions?

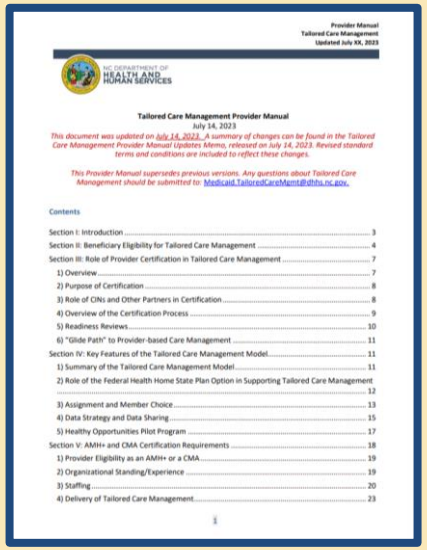
Provider Manual Updates

Updated Provider Manual

The Department released an updated Tailored Care Management Provider Manual on July 14, 2023. The updated manual is available on the Tailored Care Management webpage.

A memo summarizing all updates is posted on the webpage.

In the following slides, we highlight key updates.



Provider Manual
Tailored Care Management
Updated July XX, 2023

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Tailored Care Management Provider Manual
July 14, 2023

This document was updated on July 14, 2023. A summary of changes can be found in the Tailored Care Management Provider Manual Updates Memo, released on July 14, 2023. Revised standard terms and conditions are included to reflect these changes.

This Provider Manual supersedes previous versions. Any questions about Tailored Care Management should be submitted to: Medicaid.TailoredCareMgmt@dhhs.nc.gov.

Contents

The updated manual notes that starting on October 1, 2023, the Department intends to phase-in the Healthy Opportunities Pilots for individuals in Pilot regions obtaining Tailored Care Management through an LME/MCO-based care manager.

However,

Healthy Opportunities Launch

Due to partner feedback, the Department has decided to launch the Pilots both for LME/MCOs and AMH+s/CMAs in February 2024. The manual will be updated to reflect the new date in its next iteration.

- The Department recently received the CMS approval to include Medicaid Direct enrollees in the Healthy Opportunities Pilot. Enrollees must still live in one of the three pilot regions to be eligible for HOP services.
- The Department will phase in access to HOP services for sub-populations enrolled in Medicaid Direct in the three pilot regions, beginning with Medicaid Direct enrollees participating in Tailored Care Management (TCM).
- The Department's intent is to have the four LME MCOs that cover HOP counties, as well as AMH+s/CMAs that opt in to participating in HOP, all launch on February 1.
- AMH+s/CMAs that are not ready to participate in HOP starting February 1st will have the opportunity to participate at a later date.

If you have feedback on the proposed February 1, 2024 launch date, please send it to amanda.vanvleet@dhhs.nc.gov, leonard.a.croom@dhhs.nc.gov. and kelsi.knick@dhhs.nc.gov by EOD Friday, August 11th. Please also indicate your interest in participating in HOP. The Department will follow up with additional details and the scope of responsibilities included in participating.

Clarifications on Tailored Care Management Payment Approach, Acuity Tiers, and Billing

Contact and Payment Approach

The Provider Manual has also been updated to align with the Department's previous announcement related to not holding providers to acuity-based contact requirements at this time.

- Care managers/care teams should use their clinical judgement and the results of the care management comprehensive assessment to determine the intensity of care management and the number of contacts a member needs.
- Providers must deliver one qualifying contact in the month to receive payment. A qualifying contact is the delivery of one or more of the six Health Home services through phone/video/in-person with the member and/or legally responsible person/guardian, as indicated.
- **The Department is continuing the use of a single Tailored Care Management rate ($269.66) through June 30, 2024, with an add-on of $78.94 for Innovations and TBI waiver participants and for members obtaining 1915(i) services.**

See next slide for a scenario of how billing works under the single Tailored Care Management rate.

Example #1: Billing Under the Single Tailored Care Management Payment Rate

While all of the contacts below meet the criteria for delivering a qualifying Health Home contact, the provider only needs to submit a claim for the first contact for any given month to access the Tailored Care Management payment for the month. <u>All contacts should be documented in the care management platform.</u>

January

The care manager completes the comprehensive assessment. As part of the assessment, the care manager identifies that Bob is a member with Bipolar Disorder on an antipsychotic medication who has not yet received a diabetes screening.

Document and submit a claim

Monthly payment of $269.66

February

The care manager contacts Bob to confirm whether he has a primary care provider (PCP) and discuss the importance of getting screened for diabetes.

Document and submit a claim

The care manager helps Bob find and set an appointment with a PCP to collect a blood sample for his diabetes screening.

Document in care management platform

Do NOT submit a claim

Monthly payment of $269.66

March

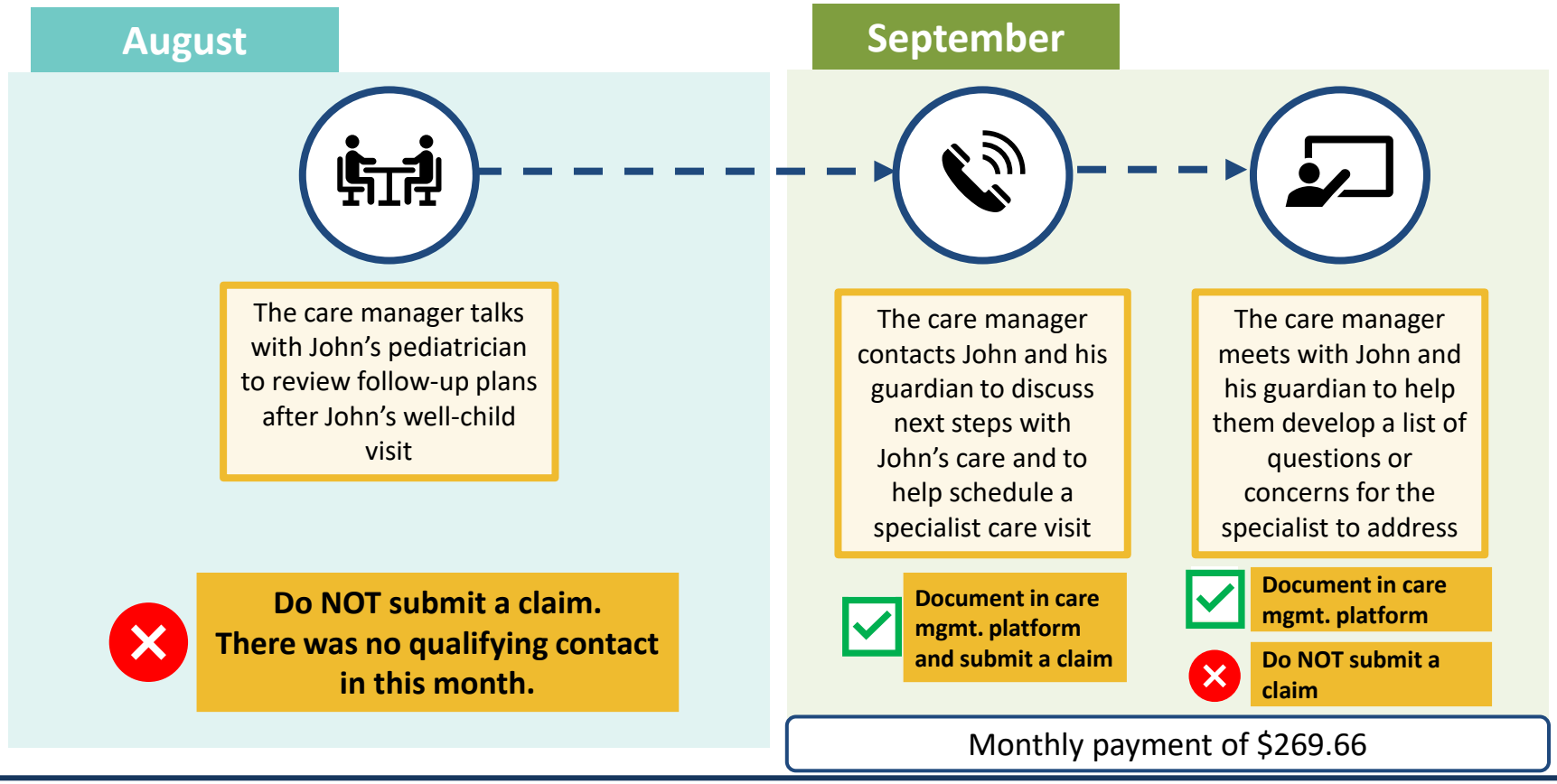
Following Bob's positive screening for diabetes, the care manager engages Bob to discuss diabetes management with his PCP and helps enroll him in a lifestyle program to manage his condition

Document and submit a claim

Monthly payment of $269.66

Example #2: Billing Under the Single Tailored Care Management Payment Rate

While connecting with other care team members is part of providing Tailored Care Management, providers must make at least one qualifying contact with the member in order to access the Tailored Care Management payment for the month.



Acuity Tier Data

While providers won't be held to acuity-based contact requirements at this time, the updated manual notes that acuity tiers continue to provide useful information for LME/MCOs and AMH+s/CMAs.

Acuity-tier data be used to inform:*	Example:
Decision making to address member needs	Prioritize outreach to high-acuity members and/or members who may have significant immediate needs (e.g., dual diagnoses)
~~**Care manager and supervising care manager assignments**~~	~~Members with I/DD needs assigned to care managers/supervising care managers with experience with that population*~~
Risk stratification	LME/MCOs, AMH+s, and CMAs use acuity tiers to segment and manage their Tailored Care Management populations
Timing for completing the care management comprehensive assessment	*See next slide*

*Note, care managers should also use the results of the care management comprehensive assessment and other available data to inform these decisions.

Acuity Tiers Should Inform the Timing for Completing the Care Management Comprehensive Assessment

The updated manual clarifies AMH+s/CMAs and care managers must undertake best efforts to complete the care management comprehensive assessment within the below timeframes. "Best effort" is defined as including at least three documented strategic follow-up attempts to contact the member if the first attempt is unsuccessful.^

1st Year of Operations

Member

Member is identified as high acuity	Assessment completed within 60 days of the effective date of Tailored Care Management assignment*
Member is identified as moderate/low acuity	Assessment completed within 90 days of the effective date of Tailored Care Management assignment*

2nd and Subsequent Years of Operations

Member

<u>All</u> members	Assessment completed within 60 days of the effective date of Tailored Care Management assignment*

^ Examples of best effort attempts include going to the home or working with a known provider to meet the member at an appointment

** Previously, manual noted as of Tailored Care Management enrollment.*

Acuity Tier FAQ #1

- **Can a member be enrolled in the Innovations waiver and assigned a behavioral health acuity tier?**

- Yes, this means the member has a co-occurring I/DD and SMI/SED/severe SUD and is enrolled in the Innovations waiver.
- These members are either assigned to the LME/MCO or an AMH+/CMA who has been certified to provide Tailored Care Management to Innovations members and the behavioral health population.
  - Acuity tier data is <u>not</u> used for *assignment to an organization* for Tailored Care Management; instead the LME/MCOs use other available data.
- Assigned care managers and supervising care managers must be qualified and trained to serve Innovations members and follow Innovation's waiver contact and other requirements.
  - Because the Innovations waiver is federally regulated, assignments must prioritize that the organization and care manager are qualified to serve this population.

Acuity Tier FAQ #2

- **What should a care manager do when they identify a member's acuity tier is higher or lower than the one assigned?**

- Care managers and supervising care managers should use their clinical judgement when determining frequency of contacts.
- The Department made acuity tier assignments based on available historical data and recognizes a member's acuity may change over the course of the year.
  - For example, a member may have been initially assigned to the moderate behavioral health acuity, but based on more recent data is likely high acuity (e.g., multiple BH-related emergency visits in the past three months, psychosis meds, unstable housing situation).
- The Department is reviewing the cumulative number of contacts delivered by an AMH+/CMA/plan across the consented and engaged member panel and will explore whether an acuity-based payment rate may be appropriate in the future.

Instances in Which Tailored Care Management Can and Cannot be Billed

Cannot Be Billed

Case Management Provided as Part of an Enhanced Behavioral Service or Other Behavioral Health Service. Case management is typically provided as part of enhanced behavioral health services (e.g., Community Support Team). Case management delivered as part of an enhanced behavioral health service should not be billed as Tailored Care Management, even if the enhanced behavioral health service provider is also the individual's CMA.

- **The updated manual clarifies this type of case management should not be billed as Tailored Care Management.** In these instances, the care plan/ISP should clearly document the scope of activities and roles/responsibilities of the care team within Tailored Care Management versus that of the other service.

Can Be Billed

Transition Into or Out of Assertive Community Treatment, Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID), and Nursing Facilities. Transitions into or out of institutional settings and the most intensive behavioral health or I/DD services are particularly critical points in a person's care.

- **The updated manual clarifies that the assigned Tailored Plan / LME/MCO, AMH+, or CMA may provide and bill for Tailored Care Management in the first and last month of a member obtaining Assertive Community Treatment, residing in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID), or residing in a nursing facility (stays of 90 days or more).**
  - Care managers should coordinate with the Assertive Community Treatment/ICF-IID/nursing facility care team and facilitate clinical handoffs.

See next slide for a scenario of billing during a transitional period.

Example: Billing During a Transition into Assertive Community Treatment (ACT)

March

Theresa lives with schizophrenia. Recently, it has been difficult for her to maintain a safe living situation, and she has had multiple short-term admissions to psychiatric hospitals.

Theresa's care team determines she is a candidate for ACT and coordinates with her care manager to connect her with the service. Theresa's care manager introduces Theresa to her ACT team.

Submit a Tailored Care Management claim and document.

Monthly payment of $269.66

April

In April, Theresa begins obtaining ACT. The care manager engages with Theresa's ACT team to ensure she experiences a smooth transition.

Submit a Tailored Care Management claim and document.

Monthly payment of $269.66

May

Theresa continues obtaining ACT.

Do NOT submit a Tailored Care Management claim.

Questions?

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:

August 25, September 22

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, 2022, 3:30 – 4:30 pm ET (presentation, minutes)
- **Meeting #14:** Friday, December 16, 2022, 3:30 – 4:30 pm ET (presentation, minutes)
- **Meeting #15:** Friday, February 24, 2023, 3:30 – 4:30 pm ET (presentation, minutes)
- **Meeting #16:** Friday, March 24, 2023, 3:30 – 4:30 pm ET (presentation, minutes)
- **Meeting #17:** Friday, April 28, 2023, 3:30 – 4:30 pm ET (presentation, minutes)
- **Meeting #18:** Friday, May 26, 2023, 3:30 – 4:30 pm ET (presentation, minutes)
- **Meeting #19:** Friday, June 23, 2023, 3:30 – 4:30 pm ET (presentation, minutes)