North Carolina Department of Health and Human Services (DHHS)
Tailored Care Management Technical Advisory Group (TAG) Meeting #19 (Conducted Virtually)
June 23, 2023

Tailored Care Management TAG Members	**Organization**
Erin Lewis (absent)	B&D Integrated Health Services
Lauren Clark (absent; represented by Julie Quisenberry)	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 (absent; represented by John Nash)	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 (absent; represented by Adrienne Beatty)	Trillium Health Resources
Rhonda Cox (absent; represented by Chris Bishop)	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
- Policy Changes to Address Tailored Care Management Implementation Challenges
- Distribution of Additional Capacity Building Funding
- Other Planned Activities
- Public Comments and Next Steps

Policy Changes to Address Tailored Care Management Implementation Challenges (slides 8-13; Appendix slides 26-28) – Regina Manly

The Department shared the below updates on policy changes to address Tailored Care Management implementation challenges. The Department has updated the Tailored Care Management Provider Manual to reflect these updates and other changes.

Continuation of a Single Tailored Care Management Rate Through June 2024

The Department will continue the use of a single Tailored Care Management monthly rate ($269.66) through June 30, 2024, with an add-on of $78.94 for Innovations and Traumatic Brain Injury (TBI) waiver participants and for members obtaining 1915(i) services. See announcement here. To bill for and obtain the Tailored Care Management monthly rate, in any given month, the care manager, or extender where appropriate, must have a qualifying contact with the member. A qualifying contact is defined as an interaction that includes the member and/or legally responsible person/guardian, as indicated, that fulfills one or more of the six core Health Home services (see Appendix in TAG slide deck or Provider Manual for more information on core Health Home services). If providers met these criteria, they may bill for the months when they delivered one qualifying contact to the member. The Department clarified that these have been the criteria since Tailored Care Management launch in December 2022.

Suspension of Acuity-Based Contacts and Updates to Contact Monitoring Approach

The Department is suspending acuity-based contact requirements for Local Management Entities/Managed Care Organizations (LME/MCOs), Advanced Medical Home Plus (AMH+) practices, and Care Management Agencies (CMAs) 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.

The single Tailored Care Management rate of $269.66 assumes each consented and engaged member will receive two monthly contacts, including one in-person contact per quarter. The Department is not enforcing these contact expectations and expects members may receive above or below this volume in reality based on the member's needs. The Department will continue to review the cumulative number of contacts and explore whether an acuity-based approach may be appropriate in the future.

Although the Department is suspending acuity-based contact requirements at this time, it noted that acuity tier data provide useful information and should be used by LME/MCOs and AMH+s/CMAs for other purposes. Acuity tier information should guide decision-making to address member needs (e.g., data can help care managers identify members to prioritize for outreach who may have significant needs), the timing for completing the care management comprehensive assessment, care manager and supervising care manager assignments, and risk stratification.

Clarification of In-Person Contact Expectations

The Department recognizes that some members may not be able to sit through the entire care management comprehensive assessment due to their health condition and similarly, children/adolescents may not able to be present during the entire assessment; in these instances, the member should participate in the assessment to the maximum extent they are able to and the care manager can finish the assessment with the legally responsible person/guardian. Telephonic or two-way real time video contact may be with a legally responsible person/guardian in lieu of the member, only where appropriate or necessary. In-person contact must involve the member. Contacts that are not required to be in-person may be telephonic or through two-way real time video.

The Department also recognizes that in some instances members will have an urgent need that needs to be addressed before completing the care management comprehensive assessment. Providers can assist members with their immediate needs prior to completion of the care management comprehensive assessment and provide any urgent links/supports to address those needs. This scenario can be billed as a Tailored Care Management contact as long as the member consents to participating in Tailored Care Management and the provider documents this consent.

Distribution of Additional Capacity Building Funding (slides 14-17) – Eumeka Dudley

The Department has identified additional capacity building funds to support the higher than anticipated outreach and start-up costs to achieve Tailored Care Management program sustainability. As with previous rounds of capacity building funds, these resources will be distributed by the Department to the LME/MCOs based on completed milestones. Available funding will be allocated to the LME/MCOs based on each plan's number of assigned members to AMH+s/CMAs (as of 5/30/23), updated distribution plan requests, and stewardship of previously distributed funds.

The Department reviewed its priorities for distributing this round of capacity building funds and provided additional details on the process for distributing those funds.

Other Planned Activities (slides 18-20) – Eumeka Dudley

The Department is hosting focus groups with Tailored Care Management providers to discuss providers' experience with implementation. In addition to the updates discussed in this meeting, the Department is continuing to take steps to address challenges identified by the field; this includes actions such as determining opportunities for increasing AMH+/CMA assignment panels, evaluating the underlying assumptions of the Tailored Care Management rate methodology, and releasing an updated Provider Manual and Summary of Changes.

Public Comments and Next Steps (slides 22-25) – Regina Manly & Tenille Lewis
TAG members and other participants asked the following additional questions:

- Several TAG members asked the Department to consider including two-way electronic communication, such as email or text exchanges with follow-ups and responses, as an acceptable method to deliver a qualifying contact. Providers noted that some members may

have limited phone plans, a hearing impairment, or may not have the ability to answer phone calls during working hours.
    - The Department clarified that email and text exchanges currently are not considered a qualifying contact. The Department continues to explore potential changes to the model and payment approach and as part of that process will consider the role of email and text.
- A TAG member asked for clarification as to whether every contact within a month must be a qualifying contact.
    - The Department clarified that in order to bill for the monthly Tailored Care Management payment, providers must deliver one qualifying Tailored Care Management contact during the month for that member (i.e., providers will not be paid for a member in months in which there were no qualifying contacts). Providers may have additional contacts with members, but only one qualifying contact is needed for payment.
- A TAG member asked the Department to confirm that the initial consent for AMH+s and CMAs can be provided verbally.
    - The Department confirmed that consent can be provided verbally. Before or as part of completing the care management comprehensive assessment, the assigned care manager must ask for the member's consent for participating in Tailored Care Management. As part of the consent process, the care manager must explain the Tailored Care Management program. Care managers should document in the care management data system that the member provided consent, including the date of consent.
    - For individuals enrolled in the 1915(c) Innovations or TBI waivers and those obtaining 1915(i) services, members must provide a signature (wet or electronic) on the care plan or ISP to indicate informed consent, in addition to ensuring that the ISP includes signatures from all individuals and providers responsible for its implementation.
- A provider shared that they are finding it difficult to afford interpretation services for some of their members and requested the Department to look into reimbursing interpreters as part of the Tailored Care Management rate.
    - The Department will take this suggestion back for internal discussion.
- A TAG member asked for further explanation on the work being done to increase panel sizes and when providers should expect to see the increased assignments.
    - The Department explained that they are currently partnering with LME/MCOs in a two-phase process to identify members who could potentially be reassigned from the LME/MCOs to increase provider panels.
        - In Phase 1, the Department and LME/MCOs are reviewing members' historical relationships with specific providers and adjusting assignments where possible and appropriate. The Department and LME/MCOs have identified approximately 5,000 members that fall into this category. Reassignment based on historical relationships will be effective July 1, 2023.
        - In Phase 2, the Department and LME/MCOs are reviewing three different member groups.

- Group 1 consists of members who have an AMH+ practice as their primary care provider (PCP). Reassignments for this group of members should be effective August 1, 2023.
- Group 2 consists of members with co-occurring I/DD and behavioral health conditions who could be better served by either a behavioral health provider or I/DD provider. The Department and LME/MCOs are reassessing each member's assignments to ensure their assigned provider can support their primary condition. Reassignments for this group of members should be effective August 1, 2023.
- Group 3 consists of all other members currently assigned to LME/MCOs.
- The Department will also make maps available to providers of the current distribution of members assigned to LME/MCOs by county. Providers can use these maps to understand where there is a need for more Tailored Care Management providers and request an increase in their panel size accordingly.

- Several providers recommended that the Department work with the LME/MCOs to include AMH+s/CMAs in ongoing and future discussions around changes to the assignment policy/algorithm as a way to reduce the instances of members dropping from provider panels and promote continuity of care.
    - The Department noted that the auto-assignment algorithm takes into account the importance of continuity of care for members by requiring LME/MCOs to give preference to existing provider relationships when making a Tailored Care Management assignment.
    - The Department noted that they appreciate provider feedback in improving the assignment process and will consider how to work with LME/MCOs to continue to engage AMH+s/CMAs in these discussions. The Department learns from provider-submitted tickets to the Ombudsman, conducts research as to why a member was inappropriately assigned, and works with LME/MCOs to make adjustments accordingly. Providers can submit a ticket by contacting the NC Medicaid Managed Care Provider Ombudsman at 866-304-7062 or Medicaid.ProviderOmbudsman@dhhs.nc.gov
    - Several TAG members asked if the Department could dedicate a session of the Tailored Care Management TAG to walking through the auto-assignment algorithm.
        - The Department will consider making a presentation for providers to get a sense as to how the algorithm determines which members are best fit to be assigned to LME/MCOs v. AMH+s v. CMAs.
- A TAG member asked if capacity building funds could be used to purchase bus passes for members to access social services (e.g., attend Alcoholics Anonymous and Narcotics Anonymous meetings), which Non-Emergency Medical Transportation (NEMT) services does not cover.
    - The Department clarified that capacity building funds should not be used to purchase bus passes for members and that providers should spend funds in accordance with their capacity building agreement with the LME/MCOs. Capacity building funding is tied to completing milestones related to investments in care management-related health information technology (HIT) infrastructure, hiring and training care managers, and

activities related to operational readiness (e.g., developing policies/procedures/workflows).

- A TAG member asked when Healthy Opportunities Pilot resources will be available for the Tailored Care Management population.
    - The Department is finalizing the launch date for Healthy Opportunities Pilots for the Tailored Care Management population and will announce the date in a forthcoming update.

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.