North Carolina Department of Health and Human Services (DHHS)
Tailored Care Management Technical Advisory Group (TAG) Meeting #20 (Conducted Virtually)
July 28, 2023

Tailored Care Management TAG Members	**Organization**
Erin Lewis	B&D Integrated Health Services
Julie Quisenberry	Coastal Horizons Center
Billy West	Daymark
Denita Lassiter	Dixon Social Interactive Services
Ruth Craig	ECU Physicians
Luevelyn Tillman	Greater Vision Counseling and Consultants
Keischa Pruden	Integrated Family Services, PLLC
Haley Huff	Pinnacle Family Services
Sandy Feutz	RHA
Lisa Poteat	The Arc of NC
Eleana McMurry, LCSW	UNC Center for Excellence in Community Mental Health
Donna Stevenson	Alliance Health
Donetta Wilson	Eastpointe
Lynne Grey	Partners Health Management
Sabrina Russell	Sandhills Center
Cindy Ehlers	Trillium Health Resources
Chris Bishop	Vaya Health
Cindy Lambert (absent)	Cherokee Indian Hospital Authority
Jessica Aguilar	N/A
Pamela Corbett (absent)	N/A
Jonathan Ellis	N/A
Alicia Jones (absent)	N/A
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
- 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 and Next Steps

NC Medicaid Updates (slides 7-9) – Kristen Dubay

The Department shared the below general updates on NC Medicaid.

Coverage Expansion

The Department is moving forward with essential implementation steps for the coverage expansion and announced an anticipated start date of October 1, 2023. To launch expansion on October 1, the Department will still need final authority from the NC General Assembly by September 1. If the Department does not have authority to move forward by September 1, the earliest fallback date is December 1, 2023, and depending on how late authority is given, it could fall into 2024. See announcement here.

Delay in Tailored Plan Launch

Earlier this month, the Department announced the delay of Tailored Plan launch from October 1, 2023, to a date still to be determined. Beneficiaries who will be covered by the Tailored Plans will continue to receive care as they do today. Tailored Care Management will continue to support eligible beneficiaries by offering a care manager and care team to coordinate care across providers. See announcement here.

General Tailored Care Management Updates (slides 10-12) – Tenille Lewis

Distribution of Additional Capacity Building Funding

The Department has distributed to Local Management Entities/Managed Care Organizations (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. 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/MCO(s) with which they have a capacity building agreement.

Tailored Care Management Provider Survey and Community Outreach

The Department continues to explore how to best support providers' success and sustainability in Tailored Care Management.

The Department plans to release a provider survey to collect information on providers' actual time and costs associated with delivering Tailored Care Management and is working with a subset of providers to

ensure the survey addresses provider concerns. Survey results will inform ongoing discussions about potential modifications to the rates and payment approach.

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

TAG members and other participants asked the following questions about the general Tailored Care Management updates:

- A TAG member asked if the Department plans to provide a third round of capacity building funding.
    - Capacity building funding requires state budget authorization/approval. The Department does not currently have the authorization/approval to offer additional funds but is working to identify additional strategies to support providers' sustainability in delivering the model (e.g., provider survey on time/costs and exploring the feasibility of new capacity building funds).
- A TAG member asked the Department to expand on the member and community engagement strategies the Department is considering.
    - The Department intends to develop a work group made up of TAG members and other volunteers to create a plan that identifies strategies to create greater awareness of Tailored Care Management.
    - A TAG member asked how one can volunteer for the work group if they are not a TAG member. The Department will extend invitations to TAG committee members. Non-TAG members may express interest by emailing Medicaid.TailoredCareMgmt@dhhs.nc.gov.

AMH+/CMA Certification Process for TCL Population (slides 13-20) – Tierra Leach

The Department announced plans to establish a designation for AMH+s/CMAs to provide Tailored Care Management to Transitions to Community Living (TCL) participants. The Department anticipates this designation process will open in Fall 2023. Applications for designation will be considered on a rolling basis, and applications can be submitted at any time.

TCL is North Carolina's Olmstead settlement, which states that adults with serious mental illness and serious and persistent mental illness 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. Individuals in TCL are eligible for Tailored Care Management. However, given the TCL settlement is ongoing, Tailored Care Management will not take over established TCL functions, which will continue to be offered and provided as they are today. Currently, TCL participants are auto-assigned an LME/MCO-based care manager to leverage LME/MCO expertise serving participants in the TCL settlement.

To ensure TCL participants have the choice of care management approach, the Department is establishing a designation process to allow qualified AMH+s/CMAs with experience serving the TCL population to provide Tailored Care Management to these members. The Department has established a set of objective criteria against which NCQA will evaluate providers for their TCL designation.

Providers will also be required to develop a policy and procedures for providing Tailored Care Management to TCL participants and obtain a letter of support from the LME/MCO in each region the provider seeks to serve. The letter of support must attest to the provider's demonstrated experience working effectively with TCL staff and TCL participants, and LME/MCOs will establish their own criteria to determine if they will support a provider's application based on DHHS guidelines. LME/MCOs and providers should work together to resolve any concerns that would prohibit LME/MCOs from providing a letter of support to ensure there are designated providers within each LME/MCO region.

TCL participants who elect to receive Tailored Care Management from an AMH+/CMA will continue to obtain all TCL services and functions (i.e., diversion, in-reach, transitions, complex care) from LME/MCO-based TCL staff. Please see the July Tailored Care Management TAG slide deck for more information.

Provider Manual Updates & Clarifications on Tailored Care Management Payment Approach, Acuity Tiers, and Billing (slides 21-33) – Tenille Lewis

The Department released an updated Tailored Care Management Provider Manual on July 14, 2023. The updated manual is located here, and a memo summarizing all updates is posted here. The Department highlighted key Provider Manual updates.

Healthy Opportunities Pilot

The Department plans to launch the Healthy Opportunities Pilot (the "Pilot") for Tailored Plans / LME/MCOs, AMH+s, and CMAs in February 2024. The Pilot is a Department-led program to test and evaluate the impact of providing select evidence-based, non-medical interventions related to housing, food, transportation and interpersonal safety and toxic stress to high-needs Medicaid enrollees. Members receiving Tailored Care Management are eligible for the Pilot if they live within one of the three Pilot regions. The four LME/MCOs that cover the Pilot regions will launch the Pilot on February 1, 2024. AMH+s/CMAs associated with those LME/MCOs can also choose to launch the Pilot on February 1, 2024, or if they are not ready to participate, they will have the opportunity to participate at a later date.

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

The updated Provider Manual aligns with the Department's previous announcement about not holding providers to acuity-based contact requirements at this time. 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.

The Department provided various examples of Tailored Care Management billing to address providers' questions, including how billing works under the single rate and when Tailored Care Management can and cannot be billed (see slides 26-27 and 32-33 of TAG deck).

The Department reiterated that while providers will not be held to acuity-based contact requirements at this time, acuity tiers continue to provide useful information for LME/MCOs and AMH+s/CMAs. Acuity-tier data can be used to inform decision making to address member needs, risk stratification, and the timing for completing the care management comprehensive assessment. The Department clarified that:

- Members could be enrolled in the Innovations waiver and assigned a behavioral health acuity tier because the member has a co-occurring I/DD and SMI/SED/severe SUD.
- 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. When a care manager identifies a member's acuity tier as higher or lower than the one assigned, care managers and supervising care managers should use their clinical judgement when determining the frequency of contacts.

Public Comments and Next Steps (slides 34-38) – Tenille Lewis

TAG members and other participants asked the following additional questions:

- A TAG member asked the Department if there was an update on the released of the request for proposal (RFP) for the Children and Families Specialty Plan (CFSP).
    - The Department requires legislative authority to advance the CFSP.
- A TAG member asked the Department to clarify the difference between the Healthy Opportunities Pilot and Tailored Care Management.
    - Tailored Care Management is a whole-person care management model that supports members in addressing their physical, behavioral, and non-medical needs and the Pilot will be in addition and complementary to Tailored Care Management.
    - While Tailored Care Management includes responsibilities related to addressing unmet health-related resource needs (e.g., referrals to needed social services), the Pilot provides additional structure and resources to support care managers in addressing the social needs of members. The Pilot covers the costs of non-medical interventions related to housing, food, transportation, and interpersonal safety and toxic stress for eligible members.
    - For members enrolled in the Pilot who are engaged in Tailored Care Management, the member's assigned care manager will concurrently provide Tailored Care Management and Pilot Care Management. Care managers will play a critical role in identifying members who would benefit from and qualify for Pilot services, coordinating members' access to Pilot services, and tracking and managing members' Pilot services over time. The Department will release an addendum to the Provider Manual describing Pilot-related responsibilities for AMH+s/CMAs.
- A TAG member asked the Department to clarify the timing for completing the care management comprehensive assessment, specifically whether the timeframe is based on a member being assigned or a member consenting and being engaged.
    - The Department clarified that the timeframe is based on the effective date of Tailored Care Management assignment. The Department notes that providers must undertake best efforts to complete the comprehensive assessment within this timeframe. "Best effort" is defined as including at least three documented strategic follow-up attempts to contact the member if the first attempt is unsuccessful. Examples of best effort attempts include going to the home or working with a known provider to meet the member at an appointment.
- Several TAG members asked the Department to consider reimbursing providers for work that fits under the six core Health Home services but does not involve contact with the member, such as a member is experiencing a decline in health in the month and not responding to the

care manager's attempts to engage but the care manager continues to conduct care coordination with other providers on the member's behalf.
    - The Department strongly believes that Tailored Care Management should be performed at the site of care, in the home or in the community, through face-to-face interaction between beneficiaries, providers, and care managers to the maximum extent possible.
    - The Tailored Care Management payment rate accounts for work care managers perform on a member's behalf without the member being present, including care manager-to-provider activities, but these activities are not billable contacts. One of the intents of the provider survey the Department plans to release is to further understand and collect information on providers' actual time and cost associated with delivering Tailored Care Management, including time on non-member facing activities. Survey results will inform ongoing discussions about potential rate and payment approach modifications.
- Multiple TAG members asked the Department to consider releasing further guidance on the frequency of contacts by acuity tier.
    - The Department re-emphasized that providers are not being held to acuity-based contact requirements at this time. Providers only need to submit a claim for the first contact of a given month to access the Tailored Care Management payment for the month. However, providers should ensure all contacts with the member are documented in the care management platform so that the Department can review the cumulative number of contacts delivered by an AMH+/CMA/plan across the consented and engaged member panel to see how it compares to the assumptions in the rates.
- Several TAG members asked the Department if the Patient Risk List (PRL) could be updated to allow for documentation of all contacts—successful contact with the member and/or legally responsible person/guardian, as indicated; attempted contact; and contacts on behalf of the member. A TAG member noted that allowing the documentation of all types of contacts could give the Department insight into work being done to provide care management to members.
    - The Department will take this suggestion back for internal discussion.
- A TAG member asked for clarification on the expectation of the frequency of face-to-face visits with members.
    - The Department clarified that the single Tailored Care Management payment rate of $269.66 assumes each consented and engaged member will receive two monthly contacts, including one in-person contact per quarter. However, 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 in-person versus telephonic/video contacts a member needs. The Department still strongly believes that care management should include some degree of face-to-face interactions.
- A provider shared their concern about their inability to increase panel size, which impacts their ability to be sustainable.
    - The Department recognizes that some providers require an increased panel size to help ensure sustainability in the model. The Department explained that they are in continuous conversation with LME/MCOs to identify how to assign more members to providers.

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.