North Carolina Department of Health and Human Services (DHHS)
Tailored Care Management Technical Advisory Group (TAG) Meeting #33 (Conducted Virtually)
November 22, 2024

Tailored Care Management TAG Members	**Organization**
Erin Lewis	B&D Integrated Health Services
Julie Quisenberry	Coastal Horizons Center
Billy West (absent; represented by Darlene Webb)	Daymark
Denita Lassiter (absent; represented by Michelle Ivey)	Dixon Social Interactive Services
Luevelyn Tillman (absent)	Greater Vision Counseling and Consultants
Keischa Pruden	Integrated Family Services, PLLC
Represented by Joanna Finer	Pinnacle Family Services
Sandy Feutz (absent; represented by Tormeica Allison)	RHA
Lisa Poteat (absent; represented by Liz Bolt)	The Arc of NC
Eleana McMurry, LCSW	UNC Center for Excellence in Community Mental Health
Donna Stevenson	Alliance Health
Lynne Grey	Partners Health Management
Cindy Ehlers	Trillium Health Resources
Chris Bishop (absent; represented by Rhonda Cox)	Vaya Health
Cindy Lambert (absent)	Cherokee Indian Hospital Authority
Jessica Aguilar	N/A
Pamela Corbett (absent)	N/A
Jonathan Ellis (absent)	N/A
Alicia Jones (absent)	N/A
NC DHHS Staff Members	**Title**
Kristen Dubay	Chief Population Health Officer, NC Medicaid
Andrew Clendenin	Deputy Director of Population Health, NC Medicaid
Loul Alvarez	Associate Director, Population Health, NC Medicaid
Regina Manly	Senior Program Manager, Tailored Care Management, NC Medicaid, Quality and Population Health
Gwendolyn Sherrod	Program Manager, Tailored Care Management, NC Medicaid, Quality and Population Health
Eumeka Dudley	Program Manager, Tailored Care Management, NC Medicaid, Quality and Population Health
Tierra Leach	Program Manager, Tailored Care Management, NC Medicaid, Quality and Population Health

Agenda

- Welcome and Roll Call
- Tailored Care Management Updates
- Town Hall Recap and Upcoming Provider Manual and Other Updates
- Performance Monitoring
- Reminder on Access to Tailored Care Management for Dual Eligible Populations
- Statewide Monitoring Tool
- Additional Questions/Public Comments

Town Hall Recap and Upcoming Provider Manual and Other Updates (slide 7-14) – Eumeka Dudley

The Department thanked plans and providers for participating in the Tailored Care Management Town Hall in September and October. Based on feedback shared during these meetings on ways to ease provider burden and support program sustainability, the Department is updating the Provider Manual, including the below:

- New flexibilities, revised requirements, and clarifications related to the care management comprehensive assessment.
- Clarification on sharing the results of the care management comprehensive assessment and Care Plan/ISP.
- New flexibilities on supervising care manager's role in reviewing Care Plans/ISPs.
- New requirement on initial engagement into Tailored Care Management.
- Clarification on the twenty-four-hour coverage requirement.

The manual and a memo summarizing the updates will be posted on the Tailored Care Management webpage by the end of the year; additional details are also available in the November TAG slides.

The Department sought additional feedback regarding flexibility on the requirement that the care management comprehensive assessment and Care Plan/ISP each must be made available to the broader care team within 14 days of completion. TAG attendees responded as follows:

- Multiple providers reiterated that they continually have challenges with sharing the Care Plan/ISP to providers within 14 days of completion (e.g., lack of contact information, lack of care team responsiveness, or technology issues).
- Participants asked the Department for flexibility so that if best efforts are made, the requirement can still be satisfied.

The Department will take these suggestions back as part of efforts to update the Provider Manual.

TAG attendees asked the following additional questions related to the provider manual updates:

- One provider asked if prioritizing certain domains of the care management comprehensive assessment and deferring other domains until the care manager has established trust with the member allows for flexibility in timeframe for completion of the assessment.
    - This does not change the requirements for care managers to make best effort to complete the care management comprehensive assessment within 90 days of consent and make best effort to complete the full Care Plan/ISP within 30 days of completion of the care management comprehensive assessment.

- Multiple TAG attendees requested additional clarification on the updates to the twenty-four-hour coverage requirement.
    - The Department responded that it will keep the language in the updated provider manual as is and will follow-up with additional clarification.
    - **Clarification:** No changes will be made to the twenty-four-hour coverage requirement at this time.

Additional Updates Based on the Town Hall (slides 15-19) – Tierra Leach

In addition to updates to the Tailored Care Management Provider Manual, the Department is making the following updates based on feedback received during the Town Hall:

- Revising the member assignment guidance to promote the reassignment of member who are currently served by Tailored Plans / LME/MCOs but could be served by an AMH+/CMA. The Department will implement changes to in early 2025.
- Creating two new monthly reports: one for new members that will be assigned to the provider's panel the next month, and one that will report members who will be removed from the provider's panel the next month. These reports will be available to providers via NC Tracks in the near future and the Department will provide a status update in January.
- Granting a new flexibility/process to pay AMH+s/CMAs for delivering services when the member is reassigned to the Tailored Plan / LME/MCO due to an invalid reason.

TAG attendees asked the following questions regarding these additional updates:

- One participant asked if providers have to follow a separate process with their plan to account for NC Medicaid Direct and Tailored Plan members for which delivery of care management by a provider is disrupted due to an invalid reason, or if this process can be consolidated.
    - The Department responded they will share a clarification after internally discussing.
- One participant asked if providers will be notified if a member is reassigned due to a change in their population segment.
    - Tailored Plans / LME/MCOs only proactively reassign members who are newly enrolled in the Innovations or TBI waiver if the current provider is not certified to serve Innovations or TBI waiver members. For all other changes to member population segments, Tailored Plans / LME/MCOs rely on the AMH+s/CMAs to use their clinical judgement to identify and notify the Tailored Plan / LME/MCO of members who can no longer be adequately served by the assigned AMH+/CMA. AMH+s/CMAs are encouraged to consult with the Tailored Plan / LME/MCO to collectively make decisions about whether the AMH+/CMA can continue to serve the member's needs. For example, if a member with an I/DD who is assigned to a CMA certified for the I/DD population segment receives a behavioral health diagnosis, the member can stay with their assigned provider/care manager if the CMA determines they are able to continue meeting the member's needs.
    - Providers should work with their Plans if they have questions about member reassignment.

- These members will be included on the new report that includes all members that will be removed from the provider's panel in the upcoming month.[1]

- One attendee asked who members should contact if they are unsure who their care manager is.
  - One plan responded that the members should contact their Tailored Plan / LME/MCO, and they can assist members in connecting with their care manager.

The Department continues to explore the feasibility of the other proposed changes raised by Town Hall participants. *(See slide 19 of the November TAG slides.)*

Tailored Care Management Performance Monitoring (slides 20-27) – Regina Manly

The Department is increasing its focus on strengthening data collection and monitoring to identify areas of success and areas that require support. The Department's current focus is reviewing Tailored Care Management engagement data. The cumulative Tailored Care Management engagement rate increased by 13% between October 2023 (17%) and June 2024 (30%). *(See slides for additional details.)*

As part of the performance monitoring, the Department identified those AMH+/CMAs within the top 20% of engagement rate and plan to meet with these organization to identify scalable best practices. The Department will then meet with providers with lower engagement to identify areas for technical assistance and share best practices related to engagement.

TAG attendees asked the following questions and made the following comments regarding the Tailored Care Management performance monitoring:

- One member asked the Department to explain how the engagement data was calculated.
  - The Department evaluated the presence of a claim submitted between October 2023 – June 2024 (refreshed data on 9/23/2024).
- One provider suggested that when the Department determines best practices based on those AMH+s/CMAs with the highest engagement, to identify which population segments they are serving so that recommendations can be made to their respective populations.

The Department reminded providers of the importance of submitting high-quality and accurate data through the Patient Risk List (PRL). The Tailored Plans / LME/MCOs use the providers' PRLs to populate monthly report submissions to the Department.

Reminder on Access to Tailored Care Management for Dual Eligible Populations (slides 28-29) – Gwendolyn Sherrod

Based on recent questions from stakeholders, the Department clarified that members with both Medicaid and Medicare ("dual eligibles") may obtain Tailored Care Management while enrolled in NC Medicaid Direct or Tailored Plans. Dual eligibles in the Innovations or TBI waivers are enrolled in Tailored

[1] For all other changes to member population segments, Tailored Plans / LME/MCOs rely on the AMH+s/CMAs to use their clinical judgement to identify and notify the Tailored Plan / LME/MCO of members who can no longer be adequately served by the assigned AMH+/CMA. AMH+s/CMAs are encouraged to consult with the Tailored Plan / LME/MCO to collectively.

Plans and eligible for Tailored Care Management. All other dual eligibles with significant behavioral health needs, an I/DD, or TBI, who would otherwise be enrolled in a Tailored Plan if not for being part of a group excluded from managed care, are in NC Medicaid Direct and eligible for Tailored Care Management.[2]

Tailored Care Management Statewide Monitoring Tool (slides 30-31) – Gwendolyn Sherrod

The piloting of the statewide standardized TCM Monitoring Tool by one statewide provider and at least one smaller provider in each Tailored Plan region has concluded. The tool will be available for utilization in January 2025.

Additional Questions/Public Comments (slides 32-34) – Gwendolyn Sherrod

There were no additional questions asked by TAG members.

Tailored Care Management TAG members are encouraged to send any feedback or suggestions to Medicaid.TailoredCareMgmt@dhhs.nc.gov.

[2] Members must meet the clinical eligibility for Tailored Plans to receive Tailored Care Management (*see* eligibility here) and cannot obtain both Tailored Care Management and specific duplicative services simultaneously (as defined in Section II of the Provider Manual).