Tailored Care Management Technical Advisory Group (TAG)

Meeting #17

Updates on Tailored Care Management Implementation

April 28, 2023

Agenda

- Welcome and Roll Call (5 min)
- General Updates (15 min)
- Tailored Care Management Updates (30 min)
- Public Comments (5 min)
- Next Steps (5 min)

Welcome and Roll Call

Department of Health and Human Services

Kristen Dubay, MPP	Loul Alvarez, MPA	Gwendolyn Sherrod, MBA, MHA	Eumeka Dudley, MHS	Regina Manly, MSA	Tierra Leach, MS, LCMHC-A, NCC	Tenille Lewis, MA
Chief Population Health Officer	Associate Director, Population Health	Program Lead, Tailored Care Management	Program Lead, Tailored Care Management	Senior Program Manager, Tailored Care Management	Program Specialist, Tailored Care Management	Program Specialist, Tailored Care Management
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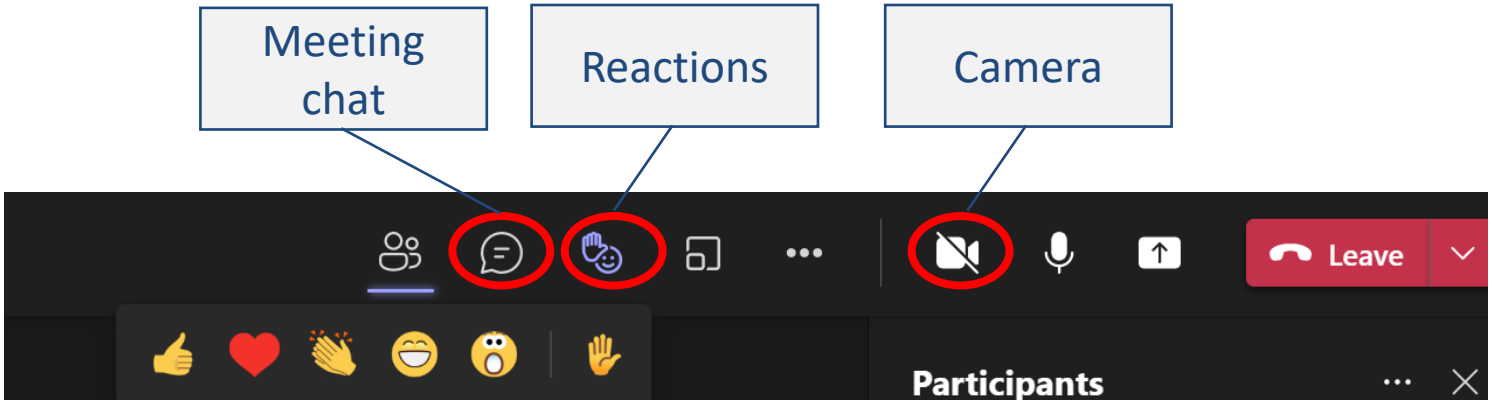
NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Tailored Care Management TAG Membership

Name	Organization	Stakeholder
Erin Lewis	B&D Integrated Health Services	Provider Representative
Lauren Clark	Coastal Horizons Center	Provider Representative
Denita Lassiter	Dixon Social Interactive Services	Provider Representative
Jason Foltz, D.O.	ECU Physicians	Provider Representative
Natasha Holley	Integrated Family Services, PLLC	Provider Representative
DeVault Clevenger	Pinnacle Family Services	Provider Representative
Lisa Poteat	The Arc of NC	Provider Representative
John Gilmore, M.D.	UNC Center for Excellence in Community Mental Health	Provider Representative
Sean Schreiber	Alliance Health	Tailored Plan Awardee
Beverly Gray	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
Rhonda Cox	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
Alicia Jones	N/A	Consumer Representative
Cheryl Powell	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.



General Updates

Medicaid Expansion

On March 27, 2023, Governor Cooper signed Medicaid expansion into law, making North Carolina the 40th state to expand Medicaid. Medicaid expansion will take effect upon the signing into law of the FY 2023-25 appropriations act.

- Medicaid expansion is expected to provide health coverage to over 600,000 people across North Carolina and bring billions in federal dollars to the state.
- Some of these individuals will be eligible for Tailored Care Management. LME/MCOs will assign eligible members to a Tailored Care Management organization, with members being assigned to an AMH+/CMA to the maximum extent possible. New members can still express choice of care management approach, consistent with current policy.
- The Department encourages plans and providers to identify individuals who they serve who may be newly eligible for Medicaid coverage (e.g., individuals using state-funded services) and connect them to resources to enroll in Medicaid.

NC Medicaid Has Resumed Annual Beneficiary Recertification Process for Medicaid Eligibility

Effective April 1, 2023, state Medicaid programs are no longer required to maintain continuous coverage for beneficiaries. Because of the COVID-19 Public Health Emergency (PHE), federal law required states to keep Medicaid beneficiaries enrolled until the end of the PHE, removing the need to reevaluate their eligibility and ensuring that beneficiaries retained coverage during the pandemic. The 2023 Consolidated Appropriations Act (also known as the Omnibus Bill), signed into law Dec. 29. 2022, removed the continuous Medicaid coverage requirement, meaning that states are resuming the Medicaid recertification process for beneficiaries.

North Carolina will begin the recertification process for Medicaid beneficiaries April 1, 2023.

What does this mean for beneficiaries?

- Recertifications will be phased over the next 12 months. Recertification could result in a beneficiary's termination or reduction of benefits if they are no longer found eligible for Medicaid or their current benefit package.

What is Medicaid recertification?

- Medicaid recertification is the process through which beneficiary information is reviewed to make sure they are still eligible for Medicaid health coverage. It is also called eligibility redetermination, renewal, ex-parté review or case review (all mean the same thing).
- Recertification takes place every 6 or 12 months based on a beneficiary's Medicaid program.

What AMH+/CMAs Need to Know About Medicaid Recertification

Tailored Care Management care managers should:

- Educate themselves and their assigned members on the Medicaid recertification process
- Encourage enrollees to update their address and contact information with their local Department of Social Services (DSS)
- As needed, ensure members take necessary steps to complete recertification process in response to letter from DSS
- If a member's Medicaid coverage is terminated, the care manager should refer members to apply for health care coverage on the federal Health Insurance Marketplace at healthcare.gov and explain they can appeal the decision or reapply at any time

See slides 11 and 12 for more information

Assisting a member with the recertification process (while the member is still enrolled in Medicaid) counts towards Tailored Care Management contact requirements. Members who are disenrolled from Medicaid are no longer eligible for Tailored Care Management.

The Department has published a toolkit for providers on the coverage unwinding which includes ready-to-use messages, templates, and other resources to insert into outreach campaigns.

What Beneficiaries Need to Know

Make sure your local Department of Social Services (DSS) has your up-to-date contact information. The local DSS may need to reach you by mail, phone, email or text message about your recertification.

- Sign-up for an Enhanced ePASS account online to make changes to your information at any time without visiting your local DSS. To create an ePASS account, logon to epass.nc.gov. For more information about ePASS and how to create an account, see the ePASS fact sheet.

Medicaid caseworkers will try to complete recertification using information from electronic resources – without contacting you. If a Medicaid caseworker needs more information to finish the recertification, they will mail you a letter.

Check your mail for information from your local DSS. If DSS needs information from you to finish their recertification, you will get a letter in the mail.

- Be careful and aware of scams. If you are not sure about information or mail you get asking for information from you, contact your local DSS.

If your health coverage is renewed – You do not need to do anything. You will get a letter telling you your NC Medicaid benefits will stay the same or have changed.

If your health coverage changes to a different Medicaid program – You do not need to do anything unless you do not agree or have concerns with your new Medicaid program. Contact your local DSS to learn more about your new benefit program.

If your coverage is terminated (ended) – You can apply for health care coverage on the federal Health Insurance Marketplace at healthcare.gov. You can appeal the decision or reapply at any time.

Source: How NC Medicaid Eligibility Recertification Works Fact Sheet

Resources for Beneficiaries and Providers

Resources for Beneficiaries	
End of Continuous Medicaid Coverage Requirement Beneficiary Home Page	https://medicaid.ncdhhs.gov/End-of-PHE-Beneficiaries
Local DSS Directory	https://www.ncdhhs.gov/localDSS
"What is ePass?" Fact Sheet	https://medicaid.ncdhhs.gov/documents/medicaid/what-epass-fact-sheet-dec-9-2022/download?attachment
How NC Medicaid Eligibility Recertification (Renewal) Works Fact Sheet	Fact Sheet in English Fact Sheet in Spanish
What is NC Medicaid Recertification (Renewal) Video	Video in English Video in Spanish
Resources for Providers	
CCU Unwinding Toolkit Home Page with communications tools for community partners, advocates, and health plans	https://medicaid.ncdhhs.gov/End%20of%20the%20CCU%20Toolkit
NC Medicaid Continuous Coverage Unwinding (CCU) Toolkit Instructions	Instructions in English Instructions in Spanish

Questions?

Tailored Care Management Updates

Update on TCM TAG Membership Refresh

With initial TAG member term lengths coming to an end, the Department is starting a process to refresh the TAG membership. The "refreshed" TAG is anticipated to launch July 2023 and will include a mix of existing TAG members continuing for a second term and new members.

- The Department has conducted outreach to existing members asking them if they would like to continue serving on the TAG.
  - Tailored Plans and the Tribal Option representatives have a permanent seat on the TAG and as part of this refresh can name a new representative from their organization.
  - Current provider TAG representatives have the option of serving a second two-year term from July 2023 – June 2025.
  - Current consumer TAG representatives have the option of serving a second term for the year between July 2023 – June 2024.
- TAG members should have a received an email from the Department on the refresh and should reply by end of day April 28, 2023.
- The Department will announce a call for new applicants in the coming weeks.

The Department believes some continuity in membership is important so that the TAG has a strong base of members who understand the role of the TAG and can help orient new members

Tailored Care Management TAG Data Subcommittee
Status Update on Subcommittee Launch

- The Department will launch a Tailored Care Management TAG Data Subcommittee in late-June to discuss and address Tailored Care Management data topics.
- Prior to the launch of the Data Subcommittee, the Department encourages stakeholders to continue to participate in the weekly technology deep dive sessions to discuss questions on Tailored Care Management data interfaces.
- Additionally, the Department is currently finalizing the membership of the Data Subcommittee.

Update on Temporary Flexibilities

For the period between December 1, 2022, and March 31, 2023, the Department enacted temporary flexibilities to help providers ramp up Tailored Care Management implementation. The majority of these flexibilities came to an end on March 31, 2023.

- In the following slides, the Department will walk through the status of each flexibility and other updates to help ensure an aligned understanding of the current status of the program requirements.
- A memo with these updates will be posted on the Tailored Care Management webpage.

Note: Until Tailored Plan launch on October 1, 2023, the LME/MCOs will continue to operate the Tailored Care Management model. Individuals eligible for the model will still have the option to obtain Tailored Care Management from an Advanced Medical Home Plus (AMH+) practice, Care Management Agency (CMA), or plan-based care manager. On October 1, 2023, Tailored Care Management will be offered by LME/MCOs in their role as both Tailored Plans and prepaid inpatient health plans (PIHPs).

Populations Eligible to Obtain Tailored Care Management

New Program Update

- **As of April 1, 2023, all individuals who will be eligible to enroll in a Tailored Plan on October 1, 2023, or who would otherwise meet the clinical eligibility criteria for a Tailored Plan if they were not part of a delayed or excluded population* are eligible to obtain Tailored Care Management.**

- This includes clinically eligible Medicaid beneficiaries who are children under age three or who were previously enrolled in NC Health Choice.

** For example, an individual who is dually eligible for Medicare and Medicaid who has an I/DD or a child with a serious emotional disturbance who would have been eligible for a Tailored Plan if they were not in foster care.*

Federal Authority

New Program Update

- **The Department is delaying implementation of the Health Home State Plan Amendment (SPA) until July 1, 2023,** in order to focus on strengthening the Tailored Care Management program before additional federal requirements apply to the program. Previously, the Health Home was set to launch on April 1, 2023.

- Currently, the State is using managed care authority (as described in 42 CFR § 438.208) to implement Tailored Care Management under the LME/MCOs.

Note: The Department is in discussion with the Centers for Medicare and Medicaid Services (CMS) regarding approval of the Health Home benefit for implementation on July 1, 2023. The State aligned Tailored Care Management requirements with the federal Health Home model to receive additional federal Medicaid matching funds to support North Carolina's Medicaid program.

Tailored Care Management Assignment

New Program Update

- **As of April 1, 2023, LME/MCOs are overseeing Tailored Care Management assignments for newly enrolled members, so long as the Department determined their readiness to do so.**
- The LME/MCOs will continue to prioritize member choice by honoring a member's choice of organization providing Tailored Care Management whenever possible.
- Assignments will not change for members with existing/continuing assignments, unless a member has chosen to change assignments or the plan or State determines a change is needed (e.g., to ensure conflict-free care management or because the member is part of Transitions to Community Living).

Transitions to Community Living (TCL)

New Program Update

- **As of April 1, 2023, all members participating in both TCL and Tailored Care Management must be assigned to the LME/MCO for Tailored Care Management.**
- Therefore, some members who were previously assigned to an AMH+/CMA may have been reassigned.
- Care managers at AMH+ practices and CMAs will need to work with the member's LME/MCO to facilitate a warm handoff.
- Additional guidance on Tailored Care Management for the TCL population is forthcoming.

More information on TCL can be found here: https://www.ncdhhs.gov/about/department-initiatives/transitions-community-living

Outreach, Engagement, and Completion of Care Management Comprehensive Assessments

New Program Update

- As of April 1, 2023, care managers must undertake best efforts* to conduct outreach, engage members in Tailored Care Management, and complete the care management comprehensive assessment:
  - Within **60 days** of Tailored Care Management enrollment for members identified as **high acuity**
  - Within **90 days** of Tailored Care Management enrollment for members identified as **moderate or low acuity**
- The above reflects the original design and timing as specified in the provider manual.
- Care management comprehensive assessments completed between December 1, 2022, through March 31, 2023, continue to be valid.
- Reassessments continue to be required at least annually *(see Provider Manual for other instances where reassessment is necessary).*

Continuing Flexibility

- If an enrollee had a care management assessment within the last 12 months that meets all Tailored Care Management comprehensive assessment requirements, this requirement would be satisfied.

** Best effort is defined as completing at least three documented strategic follow-up attempts to contact the member if the first attempt is unsuccessful (e.g., going to the member's home or working with a known provider to meet the member at an appointment).*

Care Plans and Individual Support Plans

Continuing Flexibilities

- A care manager does not need to develop a new care plan/ISP if an enrollee has an active care plan/ISP that meets Tailored Care Management requirements and has been completed within the last 12 months.

- For individuals enrolled in the Innovations and TBI waivers, the care manager should align the timing of completing the care management comprehensive assessment and ISP with the annual ISP update (i.e., annual reassessment of a member's needs, which is used to develop an updated ISP).

Consistent with the provider manual and original program guidance, the Care Plan/Individual Support Plan (ISP) must continue to be completed within one month of the care management comprehensive assessment.

Contact Requirements and Acuity Tiers

New Program Update

- **As of April 1, 2023, the Department implemented acuity-based contact requirements.**
- Acuity tiers indicate that individuals with higher needs need more intensive care management.
- Acuity tiers serve as a guide and organizations will be assessed against contact requirements at the panel level, not the individual member level, as individual needs may diverge from the assigned acuity tier.
- Organizations providing Tailored Care Management should use their clinical judgment and assessment of member needs to determine the intensity of care management and the number of contacts a member needs.
- Individual contact needs are expected to vary as clinical needs change, even if the acuity tier remains the same.

Acuity Tier	Members with Behavioral Health Needs – Minimum Contacts	Members with an I/DD or TBI – Minimum Contacts
High	At least **4** contacts per month, including at least 1 in-person contact	At least **3** per month, including 2 in-person contacts and 1 telephonic contact
Moderate	At least **3** contacts per month and at least 1 in-person contact quarterly	At least **3** contacts per month and at least 1 in-person contact quarterly
Low	At least **2** contacts per month and at least 2 in-person contacts per year, approximately 6 months apart	At least **1** contact per month and at least 2 in-person contacts per year, approximately 6 months apart

Contact Monitoring

New Program Update

- **The first contact monitoring measurement period for acuity-based contact requirements will be for care management delivered in the period between April 1 and June 30, 2023.**
  - The Department will look at the cumulative number of contacts LME/MCOs, AMH+ practices, and CMAs were expected to deliver across their entire population for that quarter, in months where at least one contact was recorded.
- **The compliance scores for the April-June measurement period will be calculated and communicated in September 2023.**
- **The goal of this initial measurement period is for the Department to gather data on provider and plan experience in delivering acuity-based contacts.**
  - This data will help the Department understand the current level of care management being delivered, inform future rate development, and give providers time to adjust to contact monitoring and improve prior to any penalties.
- **Plans, AMH+ practices, and CMAs are in compliance if they deliver at least 75% of the sum of contacts required by all members in their panel.**
  - Plans and providers that fall below this threshold may receive technical assistance.
- **The Department will not implement any other sanctions or penalties for this measurement period and will release additional guidance on the monitoring approach in the coming months.**

Payments

Continuing Flexibility

- **As part of the Health Home SPA delay, the Department is continuing the blended Tailored Care Management rate ($269.66) through June 30, 2023, with an add-on of $78.94 for Innovations and TBI waiver participants.**
- LME/MCOs will continue to pay AMH+ practices and CMAs based on the completion of the first contact each month.
- AMH+s/CMAs will still need to submit a claim to the LME/MCO, and the LME/MCO will pay the provider the rate after the month of service.

New Program Update

- **Acuity-based payment requirements, where the payment amount differs by acuity tier, will be effective on July 1, 2023.**

Training for Tailored Care Management Staff

New Program Update

- Effective April 1, 2023, the Department is requiring care managers, care manager extenders, and supervisors **complete training on the below core modules* before being deployed to serve members**; care managers, care manager extenders, and supervisors must **complete the remaining training modules within 90 days of being deployed**.
  - An overview of the NC Medicaid delivery system, including Tailored Care Management eligibility criteria, services available through Prepaid Inpatient Health Plans (PIHPs) and future Tailored Plans, and differences between Standard Plan, PIHP, and Tailored Plan benefit packages
  - Principles of integrated and coordinated physical and behavioral health care and I/DD and TBI services
  - Knowledge of Innovations and TBI waiver eligibility criteria
  - Tailored Care Management overview, including but not limited to the model's purpose, target population, and services, in addition to enrollees and their families' role in care planning
  - Eligibility, assessment, and coordination of 1915(i) services

** The Department may update this list of core training modules at a future date.*

Community Inclusion, Diversion, and System of Care

New Program Update

- **Community Inclusion Activities:** Starting April 1, 2023, care managers were responsible for in-reach and transition activities for individuals **who are not part of the TCL settlement** as specified in the Community Inclusion Addendum. The Department will be updating this addendum to reflect that the TCL population is not subject to these requirements.

- **Diversions From Institutional Settings.** Starting April 1, 2023, care managers were responsible for diversion activities for individuals who are not part of the TCL settlement *(see Provider Manual Section "Diversion" for more information).*

- **System of Care Requirements.** LME/MCOs will continue to oversee System of Care activities, consistent with their current contract with the Department. Organizations providing Tailored Care Management should utilize strategies consistent with the System of Care philosophy, as outlined in the Provider Manual *(see Provider Manual Section "System of Care" for more information).* Additional information and training are forthcoming on System of Care requirements.

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:

May 26

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)

Appendix

Acuity Tiering, Contact Requirements, and Payments

Effective April 1, 2023, the Department is implementing acuity-based contact requirements. The Department is continuing the single, blended Tailored Care Management rate ($269.66) through June 30, 2023. Acuity-based payments are effective July 1, 2023.

Tailored Care Management Contact Requirements				
Acuity Tier	**Members with Behavioral Health Needs**		**Members with an I/DD or TBI**	
	Minimum Contacts	**Final Rate (PMPM)**	**Minimum Contacts**	**Final Rate (PMPM)**
High	At least **4** contacts per month, including at least 1 in-person contact	$395.06	At least **3** per month, including 2 in-person contacts and 1 telephonic contact	$395.06
Moderate	At least **3** contacts per month and at least 1 in-person contact quarterly	$269.66	At least **3** contacts per month and at least 1 in-person contact quarterly	$269.66
Low	At least **2** contacts per month and at least 2 in-person contacts per year, approximately 6 months apart	$162.08	At least **1** contact per month and at least 2 in-person contacts per year, approximately 6 months apart	$100.81

Organizations providing Tailored Care Management will receive the appropriate care management per member per month (PMPM) payment for the first contact delivered to a member in a month but must still deliver the minimum required contacts for each member.

See Tailored Care Management Provider Manual (updated 2/23/23) and Updated Guidance on Tailored Care Management Payments (1/19/22) for more information.