NCCDD:

Tailored Care Management Progress

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Agenda

- What Should I/DD Individuals Know About TCM?
- TCM Rate Information
- Update On TCM
- Care Extenders
- TCM for TCL Participants
- Questions

What should I/DD individuals know about TCM?

What Do Care Managers Do?

- Work towards closing gaps in a member's physical and mental health care.
- Complete a full review of a member’s care needs.
- Work with member and their team to prepare care management comprehensive assessments and care plans/individual support plans that reflect the member’s needs and goals.
- Help schedule appointments and transportation to and from Medicaid-covered providers.
- Follow-up with doctors or specialists about members health care needs
- Help with medication monitoring. Help get answers to questions about medicines and how to take them.
- Monitor hospital Admission Discharge and Transfer (ADT) alerts and assist with any admissions, discharges or transfers
- Help members to transitions out of hospitals and nursing facilities back home.
- Provide Innovations and TBI waiver care coordination (if applicable)
- Connect members to local programs and community resources to help address health-related resource needs, such as housing, food, transportation and employment.

Successful Care Management

- Plan team meetings well in advance of required deadlines
- Include members in the development of the agendas for each team meeting
- Develop trusting relationships with members and team/community
- Be aware of member's personal history, health conditions, and specific needs
- Always include caregivers and natural supports in care assessments
- Track and celebrate member success with the care management team
- Document everything creating a historical reference of the member's care
- Prioritize members with high support needs and high risk
- Gather support from leadership and upper management to provide the most informed services for members
- Continual Professional development in areas to provide quality services to members
- Maintain Member/patient advocacy
- Be responsive to member's support needs

Getting connected to 1915(i) services

How do Tailored Care Managers help someone get connected to 1915(i) services?

- With the approval of the 1915(i) services, members currently receiving 1915(b)(3) services began the transition to 1915(i) services July 1, 2023. Prior to receiving 1915(i) services, members must have a completed 1915(i) assessment performed by their TCM provider or care coordinator and have been deemed eligible for 1915(i) services.
- For more information on the transition of 1915(i) services, see the fact sheet: Transition of 1915(b)(3) Benefits to 1915(i).

Please note that members receiving Innovations Waiver services are not eligible for 1915(i) services.

Getting Connected with Innovations Services

How do Tailored Care Managers help someone get connected to the Innovations Waiver?

- If an individual is eligible for the Innovations Waiver, your LME-MCO, Tailored Care Management care manager, can assist you in getting connected to services. There are only a certain number of NC Innovations Waiver slots. If the slots are full, your name will be added to the Registry of Unmet Need (RUN).

- To be part of North Carolina's Innovations Waiver, you must:
  - Meet the requirements for Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) level of care
  - Be at risk of moving to an ICF-IID or currently live in an ICF-IID and want to move to an HCBS setting
  - Be able to stay safe, healthy and well in the community while using NC Innovations Waiver services
  - Need and use NC Innovations Waiver services listed in your person centered plan at least once a month
  - Want to use NC Innovations Waiver services instead of living in an ICF-IID
  - For more information about the Innovations Waiver Waitlist, please see our new dashboard: Innovations Waitlist Dashboard | NC Medicaid (ncdhhs.gov)

TCM Rate Information

Blended Rate Will Continue Through June 2024

On June 13, 2023, the Department announced that it will continue the blended 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.

- To bill in any given month, the care manager, or extender where appropriate, must provide **one** qualifying contact. ***A qualifying contact is the delivery of one or more of the six Health Home services*** through phone/video/in-person with the member/guardian.
- Contacts should be based on a member's need, not member's assigned acuity
- 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 blended rate after the month of service.

What Counts as a Qualifying Contact?

Tailored Care Management is built around the six core Health Home services. Below are examples of activities care managers may complete in delivering a qualifying Tailored Care Management contact (see Provider Manual for additional details):

- **Comprehensive care management**, including
  - Completion of care management comprehensive assessments and care plan/ISP
  - Phone call or in-person meeting focused on chronic care management

- **Care coordination,** including
  - Working with the member on coordination across settings of care and services (e.g., appointment/wellness reminders and social services coordination/referrals)
  - Assistance in scheduling and preparing members for appointments (e.g., phone call to provide a reminder and help arrange transportation)

- **Health promotion,** including
  - Providing education on members' chronic conditions
  - Teaching self-management skills and sharing self-help recovery resources
  - Providing education on common environmental risk factors including but not limited to the health effects of exposure to second- and third-hand tobacco smoke and e-cigarette aerosols and liquids and their effects on family and children

What Counts as a Qualifying Contact? *cont.*

- **Comprehensive transitional care/follow-up,** including
  - Visiting the member during the member's stay in the institution and be present on the day of discharge
  - Reviewing the discharge plan with the member and facility staff
  - Referring and assisting members in accessing needed social services and supports identified as part of the transitional care management process, including access to housing
  - Developing a 90-day post-discharge transition plan prior to discharge from residential or inpatient settings, in consultation with the member, facility staff, and the member's care team

- **Individual & family support,** including
  - Providing education and guidance on self-advocacy to the member, family members, and support members
  - Connecting the member and caregivers to education and training to help the member improve function, develop socialization and adaptive skills, and navigate the service system
  - Providing information to the member, family members, and support members about the member's rights, protections, and responsibilities, including the right to change providers, the grievance and complaint resolution process, and fair hearing processes

- **Referral to community & social support services,** including
  - Providing referral, information, and assistance and follow-up in obtaining and maintaining community-based resources and social support services
  - Providing comprehensive assistance securing key health-related services (e.g., filling out and submitting applications

Update on Tailored Care Management

I/DD Provider Metrics

- All the LME/MCOs are serving the IDD population.

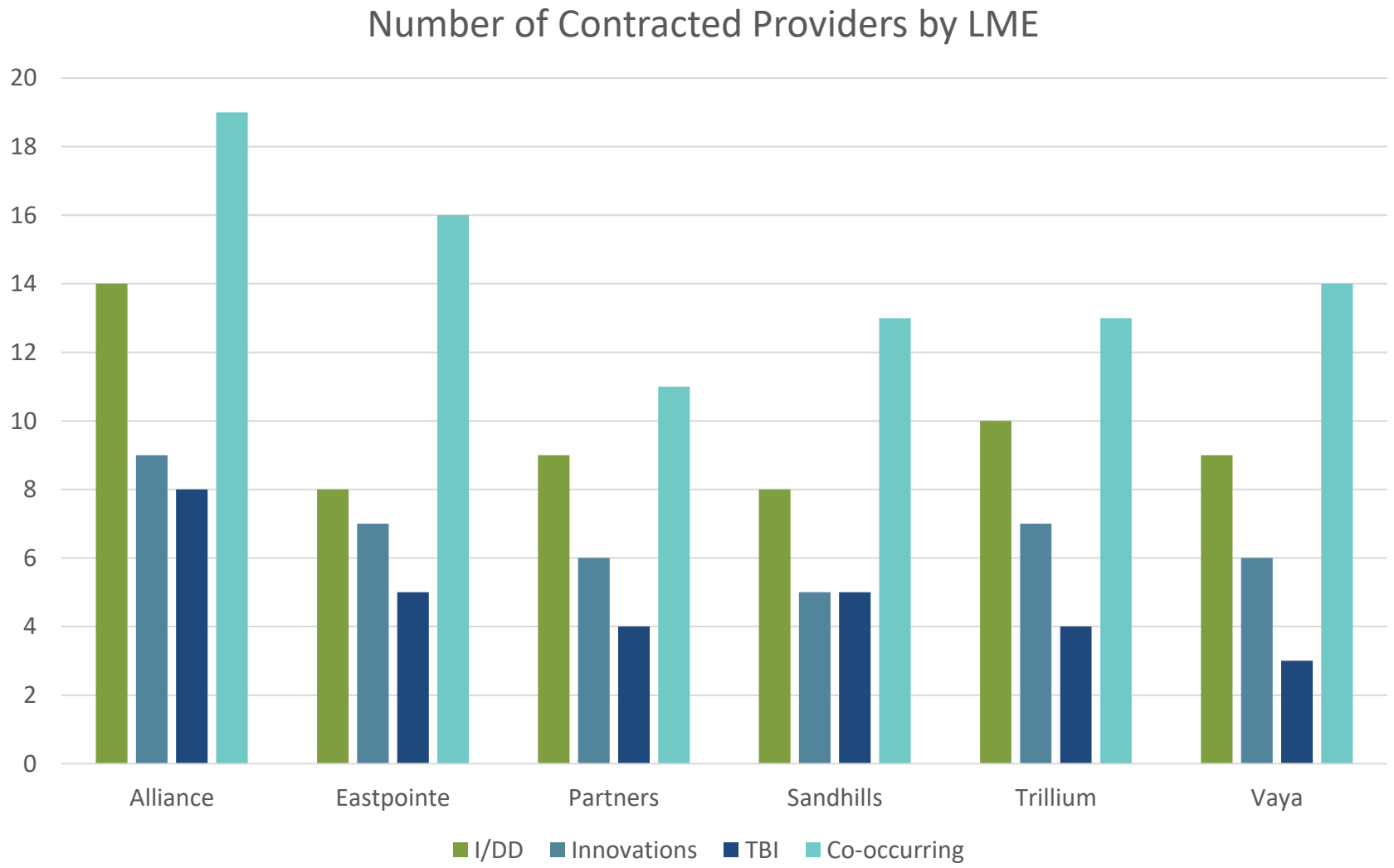
- **24** Community TCM providers Certified for IDD
  - **13** are also certified to serve members on the Innovations Waiver
  - **4** TCM providers Certified to serve members on the TBI Waiver

- **30** Community TCM providers Certified for Co-occurring IDD/BH adult
- **28** Community TCM providers Certified for Co-occurring IDD/BH child

Round 3 of Community TCM Provider certification is in process.

- **6** Providers working on certification for I/DD
- **7** Providers working on certification for Co-occurring IDD/BH adult
- **7** Providers working on certification for Co-occurring IDD/BH child

Contracted Providers by Disability by LME



NC Medicaid Tailored Care Management Priorities

a) Maintaining TCM continuity of care for members

- Examining reassignment rules to minimize inappropriate member reassignments
- Resolving reports of member disruption to understand if system changes are needed

b) Financial Viability of Tailored Care Management Services

- Distributed additional capacity building funds to address unexpected start-up costs and challenges
- Comparing underlying rate assumptions to experience in the field & exploring alternate rate options
- Reviewing TCM claims and payments
- Examining potential TCM policy flexibilities to support financial viability
- Working with Plans to increase CMA/AMH+ member panels

c) Increase Awareness of TCM Services among Members and Community Partners

- Working with DMH to develop plain language materials for members, guardians, families, and providers.
- Presenting to and engaging with provider organizations

d) Improve Accuracy and Completeness of Data Shared

- Continue to support both Plan and Provider access to complete and accurate data shared through Tailored Care Management data interfaces.

Maintaining TCM Continuity of Care for Members

Examining reassignment rules to minimize inappropriate member reassignments

The Department continues to work with AMH+s/CMAs and LME/MCOs to maintain continuity of care for members.

DHHS formed a TCM AA Collaborative consisting of TCM Providers, LME/MCOs and CINs/Data Partners with a focus on:

- Members are assigned to a TCM provider that can meet their care needs, and are reassigned if needs can no longer be met by the assigned provider
- Allow space for LME-MCOs and Providers to employ clinical judgment to inform reassignment decisions
- Allow flexibility for using different data sources and/or code sets that enable better assessment of care needs

TCM AA Collaborative Goals:

- Assessing reassignment guidance through lens of continuity of care, focusing on the largest drivers of reassignment
- Approach for the TCM AA Collaborative is to review reassignment scenarios that generate unnecessary reassignments

Key Progress To Date

TCM AA Collaborative has identified changes to top 2 drivers of member reassignment. These modifications will reduce member reassignment significantly.

Tailored Care Management Reassignment and Continuity of Care

The Department has formed a TCM Auto Assignment (AA) Collaborative to focus on strategies to minimize reassignments and disruptions in care management.

- The first TCM AA Collaborative met on September 20, 2023.
- The workgroup will bring periodic updates to the Tailored Care Management TAG on key activities.

TCM AA Collaborative

TCM TAG Committee Members	Benchmarks Member Agencies	LME/MCOs
NCPC Member Agencies	CINs	DHB

Financial Viability of Tailored Care Management Services

Provider Rate Assumption Survey

On September 18, 2023, the Department released a survey to collect information on providers' actual time and costs associated with the delivery of Tailored Care Management. Survey results will inform ongoing discussions about potential modifications to the rates and payment approach. Any changes to the rates and payment approach would go into effect after July 2024.

- The deadline for survey responses closed **October 6, 2023**.

Respondent Rate: 81%

- Each provider and LME/MCO was invited to **complete a single survey**.
- The survey include the sections noted in the table on the right.

Next Steps

- DHB completes analysis of data.
- DHB reviews results with Mercer for consideration of rate model options.

Survey Sections	
Time Spent	• Time spent with members/guardians
Contact	• In-person and telephonic contacts
Engagement	• Time spent to successfully engage members
Panel	• Experience with panel by member acuity and over time
Staff	• Experience with care management teams
Expenses	• Expenses (e.g., software, consultant time for quality checks of data)

Increase Awareness of TCM Services among Members and Community Partners

Member Education and Community Awareness

As previously announced, the Department launched a Tailored Care Management workgroup to develop a community engagement campaign, which will focus on developing strategies to create greater awareness of Tailored Care Management across potentially eligible members, providers, community organizations, and other stakeholders.

- The workgroup is generating strategies to develop a community education campaign.
- The workgroup is meeting weekly to develop a plan that focuses on multi-media approach.
- The workgroup will bring periodic updates to the Tailored Care Management TAG to solicit feedback on key activities.

- How can **you** Help?
  - Give suggestions and feedback on how we can get information out.
  - Distribute the TCM member education materials within your organizations.
  - Distribute the TCM member education materials within your community and circle of influence.
  - Distribute the TCM member education materials within the advocacy groups you are a part of.

Improve Accuracy and Completeness of Data Shared

Continue to support Plan and Provider access to complete, accurate data shared through TCM data interfaces.

DHB formed a Data Subcommittee will consider data, data exchange, and HIT priorities and concerns related to the Tailored Care Management program.

Purpose of the Data Subcommittee

- **Increase understanding** of core Tailored Care Management data, system, and reporting requirements, needs, and concerns
- **Provide a forum** for Tailored Care Management entities to raise issues for discussion and resolution
- **Identify, prioritize, and provide informed recommendations** on data topic issues that arise with Tailored Care Management implementation

Care Extenders

Update on Care Extenders

Care Manager Extenders are valued members of the member's Care Management Team

Certificate of completion was a clarification added in April 2023 Provider Manual Update

Care manager extenders qualifications

- At least 18 years of age
- A high school diploma or equivalent (GED, ***certificate of completion***)

Meet one of the following requirements:

- Be a person with lived experience with an I/DD or a TBI with demonstrated knowledge of and direct personal experience navigating the North Carolina Medicaid delivery system
- Be a person with lived experience with a behavioral health condition who is a Certified Peer Support Specialist

TCM for TCL Participants

Intersection of Transitions to Community Living and Tailored Care Management

Health Home Authority requires members have choice of TCM provider. Thus, we must continue to fulfill the requirements of the DOJ settlement while establishing a designation process for Community-Based TCM providers (i.e., AMH+ practices and CMAs) to serve TCL participants.

Approach for Providing Tailored Care Management 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 and with a Letter of Support from the LME/MCO**.
    - 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**.

TCL Participants Will Be Able to Choose to Receive Tailored Care Management from a List of Designated Providers

To ensure TCL participants have a choice of obtaining Tailored Care Management from an LME/MCO, AMH+, or CMA, the Department is establishing a designation process to allow TCL participants to choose to obtain Tailored Care Management (but not TCL functions) from an AMH+ practice or CMA.

Approach for Providing Tailored Care Management to TCL Participants

- **For Tailored Care Management, TCL participants are currently auto-assigned an LME/MCO-based care manager** to leverage LME/MCO expertise on TCL.
- The Department is establishing a designation process for already certified AMH+ practices or CMAs and Round 3 Tailored Care Management provider applicants to become designated as qualified to serve TCL participants.
    - This process is similar to the way AMH+ practices or CMAs can be designated as qualified to provide Tailored Care Management services to children, individuals with I/DD, or Innovations/TBI waiver enrollees.
- **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 later in 2023 and will provide an update on the specific date.

TCL Functions Are Not Changing

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

LME/MCO TCL Staff Will Continue to Perform TCL Functions

- 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. Members in TCL will be able to access Tailored Care Management in addition to their TCL services.
- To meet the terms of the settlement, **TCL functions will continue as they do today**. Existing 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.**

Additional Items Under Review or In-Progress

- Evaluating the underlying assumptions of the rate methodology to determine if changes are appropriate based on experience in the field.
- Clarifying TCM program expectations and updating where needed.
- Reviewing policy expectations and provider manual guidance.
- Working with LME/MCOs to determine opportunities for increases in AMH+/CMA assignment panels.

Questions?