



Tailored Care Management Provider Manual Updates

April 19, 2022

This document provides a summary of updates in the revised [Tailored Care Management Provider Manual](#), which the Department released on April 19, 2022. Key updates and clarifications are described below:

1. **Standard Terms and Conditions for Tailored Plan Contracts with Advanced Medical Home Plus (AMH+) Practices and Care Management Agencies (CMAs) (Appendices 1 and 2).** The updated Provider Manual includes Standard Terms and Conditions for Tailored Plans to use when contracting with AMH+ practices and CMAs. The Standard Terms and Conditions reflect the Tailored Care Management requirements for providers and cover the following areas: staffing, population health and quality measurement, delivery of Tailored Care Management, transitions, community inclusion, diversion, payments, and oversight. The Standard Terms and Conditions also include additional requirements for providers serving members enrolled in the 1915(c) Innovations and TBI waivers.
2. **Final Guidance on the Use of Care Manager Extenders (requirements reflected throughout manual).** The updated Provider Manual incorporates the Department's [finalized guidance on care manager extenders](#). The updates incorporate guidance previously published in the *Guidance on the Use of Care Manager Extenders in Tailored Care Management* and describe the qualifications to be an extender, extender supervision requirements, and the Tailored Care Management functions that extenders may conduct.

The update to the Provider Manual also reflects updates to the *Guidance on the Use of Care Manager Extenders in Tailored Care Management*, which clarify:

- a. Extenders cannot work for the same organization where they receive services and that Family Navigators, as defined by Trillium Health Resources' approved LME/MCO in lieu of service description, can serve as extenders if they otherwise meet the extender qualifications; and
 - b. Only contacts delivered by the assigned care manager or extender will count towards meeting the contact requirements and be eligible for payment. In the event that the supervising care manager is providing coverage for a care manager (e.g., sick leave, vacation, staff turnovers) and delivers a contact to a member, the contact will count towards meeting contact requirements and be eligible for payment.
3. **Additional Training Requirements (pages 37 and 38).** The updated Provider Manual and finalized *Guidance on the Use of Care Manager Extenders in Tailored Care Management* describe new training requirements for all care managers, supervisors, and care manager extenders on relationship building, ethics, boundaries, and member safety (e.g., home visits). Additionally, to

ensure extenders are sufficiently prepared and capable of performing their duties, extenders' training must include practical ("hands-on") training modalities and evaluation, which may include role play, use of call scripts, and practice sessions.

4. **Care Plan Consent and Signature Requirements (pages 21 and 32).** The updated Provider Manual notes additional requirements for obtaining member consent in the Care Plan or Individual Support Plan (ISP), including requirements specific to members enrolled in the 1915(c) Innovations and TBI waivers.
5. **Multiple Contacts in One Day (page 21).** The updated Provider Manual clarifies that in the event that a care manager delivers multiple contacts to a member in one day, only one contact will count towards meeting the contact requirements.

For more information on Tailored Care Management, please visit the Department's [Tailored Care Management webpage](#), and direct any comments or questions to Medicaid.TailoredCareMgmt@dhhs.nc.gov.