NC Medicaid Managed Care
Provider Playbook

Fact Sheet
North Carolina's Transition of 1915(b)(3) Benefits to 1915(i)

Frequently Asked Questions (FAQs)

Home and community-based services (HCBS) provide opportunities for community integration, enabling Medicaid enrollees to obtain services in their community. North Carolina's local management entities/managed care organizations (LME/MCOs) provide 1915(b)(3) services, which offer a critical set of HCBS to Medicaid enrollees with significant behavioral health needs and intellectual/developmental disabilities (I/DD).

Because Behavioral Health I/DD Tailored Plans will be operating under North Carolina's 1115 demonstration, they will no longer be able to provide services under the 1915(b)(3) authority. To ensure that individuals maintain access to these critical services when Tailored Plans launch, North Carolina is transitioning 1915(b)(3) services to 1915(i) services.

With this transition, North Carolina is expanding the populations eligible for some of these important services. Trainings provided by NCDHHS on the 1915(b)(3) to 1915(i) transition, can be accessed at the below links:

- Tailored Care Management (TCM) Provider Slides
- Service Provider Slides

Federal rules require that to obtain 1915(i) benefits, an individual must obtain an independent assessment to determine eligibility for 1915(i) services and to be used to develop a Care Plan for individuals with behavioral health needs or an Individual Support Plan (ISP) for individuals with an I/DD or traumatic brain injury (TBI) in North Carolina. This fact sheet provides answers to common questions about North Carolina's transition from 1915(b)(3) to 1915(i) services.

Timeline for 1915(b)(3) to 1915(i)

WHEN WILL THE 1915(B)(3) TO 1915(I) TRANSITION OCCUR? WHAT IS REQUIRED FOR INDIVIDUALS CURRENTLY OBTAINING 1915(B)(3) SERVICES TO MAINTAIN THESE SERVICES WITH THE 1915(I) TRANSITION?

Starting on July 1, 2023, 1915(i) services are available. The Department is committed to ensuring that individuals currently obtaining 1915(b)(3) services do not experience disruption in their covered services during the transition to 1915(i) authority. At the same time, the Department recognizes that it is a significant lift for LME/MCOs, advanced medical home plus (AMH+) practices, and care management agencies (CMAs) to conduct 1915(i) assessments and develop and/or update Care Plans/ISPs to meet 1915(i) requirements.

To ensure a smooth transition, the Department is phasing-in individuals' transition from 1915(b)(3) to 1915(i) services and recommends that LME/MCOs initially prioritize individuals who will enroll in a Tailored Plan on July 1, 2024. **All individuals who have an open 1915(b)(3) service authorization will transition to 1915(i) services by July 1, 2024.** This means that to transition their 1915(b)(3) service authorization to 1915(i), they must have completed a 1915(i) assessment and have a Care Plan/ISP in place that meets 1915(i) requirements by Tailored Plan launch.

WILL INDIVIDUALS CURRENTLY OBTAINING 1915(B)(3) SERVICES MAINTAIN ACCESS TO THESE SERVICES WHEN 1915(I) SERVICES LAUNCH?

Yes, individuals currently obtaining 1915(b)(3) services will maintain access to their current services until they have completed a 1915(i) assessment and transition to 1915(i) services according to the phased approached described in the transition timeline (refer to the above question "When will the 1915(b)(3) to 1915(i) transition occur?") The phase-in process is designed to ensure that individuals experience continuity of care, while ensuring that the transition meets federal requirements.

WHEN CAN INDIVIDUALS WHO HAVE NOT PREVIOSULY OBTAINED 1915(B)(3) SERVICES OBTAIN 1915(I) SERVICES ?

Individuals who have not previously obtained 1915(b)(3) services can obtain 1915(i) services assuming that they have completed a 1915(i) assessment, are evaluated as eligible for the service, and have a Care Plan/ISP in place that meets 1915(i) requirements.

1915(i) Independent Assessment & Care Plan/ISP Requirements

WHY ARE INDIVIDUALS REQUIRED TO OBTAIN A 1915(I) INDEPENDENT ASSESSMENT TO USE 1915(I) SERVICES?

Federal rules require that individuals obtain an independent assessment to use 1915(i) services. Individuals must obtain a 1915(i) independent assessment to:

- Confirm they are eligible for 1915(i) services,
- Identify and confirm their needed services and supports, and
- Provide information necessary for completing their Care Plan/ISP.

WHAT ARE THE COMPONENTS OF THE 1915(I) ASSESSMENT? WHAT TRAININGS ARE AVAILABLE FOR CARE MANAGERS ON HOW TO COMPLETE THE 1915(I) ASSESSMENT?

Care managers/care coordinators must use the standardized template for the 1915(i) independent assessment issued by the Department, accessible on the Tailored Care Management webpage. Through the 1915(i) assessment, care managers/care coordinators will identify whether individuals need assistance in the following domains:

- Activities of daily living (e.g., dressing)
- Instrumental activities (e.g., meal prep)
- Social and work (e.g., ability to learn new tasks)
- Cognitive/behavior (e.g., speech/language/communication)

AHEC provided trainings for LME/MCO and AMH+/CMA care managers/care coordinators on how to complete the 1915(i) independent assessment in February 2023. Training materials for the assessment training are in the 1915(i) Tailored Care Manager Assessment Training presentation.

WHAT IS THE DIFFERENCE BETWEEN A CARE PLAN AND AN INDIVIDUAL SUPPORT PLAN (ISP)?

A Care Plan and ISP both (a) incorporate the results of the care management comprehensive assessment, and (b) identifies the member/recipient's desired outcomes and the training, therapies, services, strategies, and formal and informal supports needed for the member to achieve those outcomes. The Department is using different names for this plan according to a person's needs:

- For individuals with behavioral health-related needs, a care manager/care coordinator will develop a Care Plan.
- For individuals with I/DD and TBI-related needs, a care manager/care coordinator will develop an ISP.

Both the Care Plan and ISP must be individualized, person-centered, and developed using a collaborative approach including individual and family participation where appropriate. Additional information on Care Plans/ISPs is available in the Tailored Care Management Provider Manual found on the Tailored Care Management webpage.

WHO IS RESPONSIBLE FOR COMPLETING THE 1915(I) ASSESSMENT AND CARE PLAN/ISP FOR INDIVIDUALS WHO ARE LOOKING TO OBTAIN 1915(I) SERVICES?

The entities responsible for completing the 1915(i) assessment and Care Plan/ISP are described below. 1915(i) independent assessments and Care Plan/ISP development must always be conducted by a care manager/care coordinator and may not be conducted by a care manager extender.

Now Through Tailored Plan Launch:

LME/MCOs are responsible for:

- Identifying their members with open 1915(b)(3) service authorizations;
- Conducting outreach to these individuals;
- Completing the 1915(i) assessment for these individuals and submitting the 1915(i) independent assessment to Carelon, the Department's vendor that will collect independent assessments. The Department will subsequently determine eligibility for 1915(i) services; and
- Updating or completing the individual's Care Plan/ISP to account for the individual's needed 1915(i) services and supports.

For individuals obtaining TCM, LME/MCOs may also delegate the responsibility for completing the 1915(i) independent assessment and Care Plan/ISP to the individual's assigned AMH+ or CMA.

Post Tailored Plan Launch:

For individuals who have engaged in TCM, the organization where an individual obtains TCM (i.e., AMH+, CMA, LME/MCO, or Tailored Plan) is responsible for:

- Completing the 1915(i) independent assessment and reassessments for individuals in- need of 1915(i) services;
- Transmitting the 1915(i) independent assessment to Carelon, the Department's vendor that will collect independent assessments. The Department will subsequently determine eligibility for 1915(i) services;

- Updating or completing the individual's Care Plan/ISP to account for the individual's needed 1915(i) services and supports;
- Transmitting the 1915(i) independent assessment and Care Plan/ISP to the individual's LME/MCO or Tailored Plan for service authorization.

The Tailored Plan or LME/MCO care coordinator will be responsible for conducting these functions for individuals who have not engaged in TCM.

WHEN SHOULD 1915(I) ASSESSMENTS BE SUBMITTED TO INDIVIDUALS' LME/MCOS? WHEN SHOULD 1915(I) ASSESSMENTS BE SUBMITTED TO CARELON?

Care managers/care coordinators will submit 1915(i) independent assessments to either an individual's LME/MCO or to Carelon, as described below. Carelon is the Department's vendor collecting individuals' assessments to enable the Department's eligibility determination for 1915(i) services.

Care managers/care coordinators may send 1915(i) assessments for these individuals directly to Carelon. As a best practice, care managers/care coordinators should communicate to the individual's assigned LME/MCO that 1915(i) assessments have been submitted to Carelon for the LME/MCOs' awareness. Please note: Some LME/MCOs want care managers/care coordinators to send the assessment to them for tracking purposes, so please work with the individual's assigned LME/MCO so that they are aware of the status of 1915(i) assessment completion.

The care manager/care coordinator should submit completed 1915(i) assessments to Carelon via secure e-mail to NCMedicaid1915irequests@carelon.com.

In order to ensure that the care manager/care coordinate receives Carelon's secure communication regarding 1915(i) assessment determinations, care managers/care coordinators must include the following information in your email submissions with completed 1915(i) assessments for review:

- Provider or MCO contact's first and last name,
- Contact's direct email address and phone number, and
- Beneficiary's name and MID (as listed on the assessment).

HOW OFTEN DOES A 1915(I) INDEPENDENT ASSESSMENT HAVE TO BE COMPLETED?

Following the completion of an initial 1915(i) independent assessment, an individual must obtain a 1915(i) independent assessment at least annually or when their circumstances or needs change significantly. Care managers/care coordinators will use the same 1915(i) independent assessment standardized template issued by the Department when conducting reassessments.

For individuals who are engaged in TCM, completion of the annual 1915(i) independent assessment should be incorporated into the individual's annual care management comprehensive assessment to minimize the number of assessments that an individual is required to undergo.

WHAT INFORMATION SPECIFIC TO 1915(I) SERVICES MUST BE INCLUDED IN THE CARE PLAN/ISP? IS THERE A REQUIRED TEMPLATE TO USE?

While there is no required template for a Care Plan or ISP, TCM requirements outline the minimum elements that must be included in the content of a Care Plan/ISP (see Section 4.4. Care Plans and Individual Support Plans in the Tailored Care Management Provider Manual.

For individuals obtaining or seeking to obtain 1915(i) services, there are additional requirements for the member's Care Plan/ISP to incorporate results from the individual's 1915(i) independent assessment and the individual's desired type, amount, and duration of 1915(i) services. Additional information is needed because care managers/care coordinators will submit Care Plans/ISPs to an individual's Tailored Plans or LME/MCO to authorize needed 1915(i) services.

This approach is like the use of the ISP in service authorization for Innovations waiver enrollees. These additional Care Plans/ISP requirements apply for all individuals obtaining 1915(i) services, regardless of whether they are engaged in TCM.

As part of developing the Care Plan/ISP for these members, the member's care manager must:

- Explain options regarding the services available and discuss the duration of each service;
- Include in the Care Plan/ISP a plan for coordinating 1915(i) services;
- Ensure the enrollee provides a signature (wet or electronic) on the Care Plan/ISP to indicate informed consent, in addition to ensuring that the Care Plan/ISP includes signatures from all individuals and providers responsible for its implementation. As part of the consent process, members must consent to the following:
    - By signing this plan, I am indicating agreement with the bulleted statements listed here unless crossed through. I understand that I can cross through any statement with which I disagree.
    - My care manager helped me know what services are available.
    - I was informed of a range of providers in my community qualified to provides the service(s) included in my plan and freely chose the provider who will be providing the services/supports.
    - The plan includes the services/supports I need.
    - I participated in the development of this plan.
    - I understand that my care manager will be coordinating my care with the [Tailored Plan or LME/MCO] network providers listed in this plan.

HOWDO THE 1915(I) REQUIREMENTS FOR CARE PLANS/ISP RELATE TO THE CARE PLAN/ISP REQUIREMENTS FOR TAILORED CARE MANAGEMENT?

To the extent that an individual is engaged in TCM, information from an individual's 1915(i) assessment should be incorporated into the same Care Plan/ISP that is used for TCM. The Department believes that individuals who need 1915(i) services will benefit from having a single plan that documents their whole-person needs, including, but not limited to, their need for HCBS.

IS A PERSON-CENTERED PLAN (PCP) REQUIRED FOR AN INDIVIDUAL TO ACCESS 1915(I) SERVICES?

While NC Medicaid has historically required providers to complete a PCP for an individual to obtain authorization for 1915(b)(3) services, the PCP will not be used for authorization of 1915(i) services.

As noted above, the Department believes that individuals who need 1915(i) services will benefit from having a single Care Plan or ISP that documents their whole-person needs, including, but not limited to, their need for 1915(i) services. Additionally, because 1915(i) services are HCBS, they are subject to federal conflict-free rules, meaning that one provider organization cannot both deliver 1915(i) services and conduct the 1915(i) independent assessment and Care Plan/ISP development for the same individual. For additional guidance please see the Department's Guidance on Conflict-Free Care Management for Tailored Plan Members.

Accordingly, the Department is requiring that for individuals in need of 1915(i) services, the Care Plan or ISP used for TCM should also be used to document an individual's need for 1915(i) services. Individuals who have opted out of TCM must still work with a Tailored Plan or LME/MCO care coordinator to develop a Care Plan/ISP to obtain 1915(i) services. As noted above, for all individuals obtaining 1915(i) services, the Care Plan/ISP will be submitted to Tailored Plans or LME/MCOs for 1915(i) service authorization.

The Department will continue to require that providers complete a PCP to authorize the delivery of certain behavioral health services as described in the following Clinical Coverage Policies:

- Clinical Coverage Policy 8A, Enhanced Mental Health and Substance Abuse Services
- Clinical Coverage Policy 8A-1, Assertive Community Treatment (ACT) Program
- Clinical Coverage Policy 8A-6, Community Support Team
- Clinical Coverage Policy 8D-1, Psychiatric Residential Treatment Facilities for Children under the Age 21
- Clinical Coverage Policy 8D-2, Residential Treatment Services
- Clinical Coverage Policy 8G, Peer Support Services

All policies can be located on the NC Medicaid Program Specific Clinical Coverage Policies page.

CAN INDIVIDUALS HAVE BOTH A PCP AND CARE PLAN/ISP?

All individuals engaged in TCM are required to have a Care Plan or ISP. Many individuals engaged in TCM will also be using services (e.g., Enhanced Mental Health and Substance Abuse Services) that require a separate PCP for service authorization (see above response for list of services). Therefore, the Department expects that many individuals engaged in TCM will have both a PCP and a Care Plan/ISP.

To reduce the time required to complete the PCP and Care Plan/ISP and ensure consistency across these documents, an individual's care manager/care coordinator should incorporate information from the individual's PCP into their Care Plan/ISP to the maximum extent possible and vice versa. See the Example Scenarios of Individuals with Both a PCP and Care Plan/ISP located at the bottom of this fact sheet.

1915(i) Operational Questions (Billing, Providers, etc.)

WHAT HAPPENS AFTER A MEMBER HAS BEEN DEEMED ELIGIBLE FOR 1915(I) SERVICES?

Once a member has been deemed eligible for 1915(i) services, the member's plan or Carelon will inform the care manager/care coordinator of the member's eligibility determination. After the individual is deemed eligibility, the care manager/care coordinator should work to complete the following steps:

Care Plan/ISP Development:

- The member's care manager/care coordinator should work with the beneficiary to **identify a 1915(i) service provider for their 1915(i) services**.
    - If the service provider had already been identified, the care manager/care coordinator should notify the service provider that the member has been deemed eligible for 1915(i) services.
    - The service provider must comply with conflict free case management (so the provider cannot be a provider affiliated with the same organization as the member's care manager).
- Then the care manager/care coordinator works to **develop the Care Plan/ISP** with the beneficiary and any other individuals identified by the beneficiary.
    - Refer to the 1915(i) Independent Assessment & Care Plan/ISP Requirements section of this fact sheet above for more information on the Care Plan/ISP development).

Prior Authorization Submission:

- The care manager/care coordinator submits the completed Care Plan/ISP along with the prior authorization to the member's Tailored Plan or LME/MCO for review.
    - Note: A member's eligibility for 1915(i) services does not imply approval of/authorization of a particular 1915(i) service. The member's Tailored Plan or

LME/MCO will review the PA request to complete a utilization review of the service(s).

- The Tailored Plan or LME/MCO will complete the review of the prior approval and returns a decision to the member's care manager/care coordinator.

Service Delivery & Care Coordination:

- After the prior approval has been approved by the member's Tailored Plan or LME/MCO, the care manager/care coordinator works with the 1915(i) service provider to implement the authorized 1915(i) service(s) according to the Care Plan/ISP.
- Throughout the delivery of the 1915(i) services, the care manager provides ongoing care coordination for the 1915(i) services.

WHAT ARE THE 1915(I) SERVICE BILLING CODES?

Providers should not bill 1915(i) services until a member has been deemed eligible for 1915(i) services (which happens after the 1915(i) assessment has been completed) and the member's 1915(i) services have been authorized by the member's Tailored Plan or LME/MCO.

The following codes can be leveraged after the member has been authorized for 1915(i) services:

Code	Modifier(s)	1915(i) Service
H0043	U4	Community Transition
H0045	U4	Respite
H0045	HQ U4	Respite Group
H2023	U4	Supported Employment Initial
H2023	HQ U4	SE Initial Group
H2026	U4	SE Maintenance
H2026	HQ U4	SE Maintenance Group
T1019	U4	Individual and Transitional Support (subject to EVV)
T1019	U4 TS	Individual and Transitional Support (non-EVV, only in the community)
T2012	U4	Community Living and Supports (only in the community, non-EVV)
T2013	TF HQ U4	Community Living and Supports Group (subject to EVV)
T2012	GC U4	Community Living and Supports relative as provider lives in home (non-EVV)
T2013	TF U4	Community Living and Supports Individual (subject to EVV)
T1017 T1017	HT U4	TCM for 1915(i) *(Two separate lines on the same claim are required)*

During the transition period, there will be some individuals who will leverage 1915(b)(3) services while they transition to 1915(i) services. The below codes are the 1915(b)(3) services:

Code	Modifier(s)	1915(b)(3) Service
H0043		Community Transition
H0045		Respite

H0045	HQ	Respite Group
H2023		Supported Employment Initial
H2023	HQ	SE Initial Group
H2026		SE Maintenance
H2026	HQ	SE Maintenance Group
T1019	HE	Individual Support (In Home Services Only) (subject to EVV)
T1019	TS	Individual Support (non-EVV, only in the community)
H2022	U4	Transitional Living Skills (In Home Services Only) (subject to EVV)
H2022	HA	Transitional Living Skills Case Rate (not subject to EVV)
T1012	U4	Intensive Recovery Support
T2013		In-Home Skill Building Individual (In Home Services Only) (subject to EVV)

WHEN CAN TCM PROVIDERS BILL THE 1915(I) ADD-ON RATE?

The 1915(i) add-on payment is for the coordination services which are required for 1915(i) services under federal regulations. The 1915(i) TCM add-on rate cannot be leveraged until after the member has been deemed eligible for 1915(i) services.

This means that TCM providers cannot bill the 1915(i) add-on payment for completion of the assessment. The 1915(i) add-on payment is not available for billing prior to a member being deemed eligible for 1915(i) services.

For example, if a member is deemed eligible for 1915(i) services on Oct. 1, 2023, then the 1915(i) add-on payment cannot be billed prior to Oct. 2, 2023. The 1915(i) add-on payment is only intended to be billed monthly.

FOR MEMBERS CURRENTLY RECEIVING 1915(B)(3) SERVICES, CAN THEY KEEP THEIR CURRENT PROVIDERS AS THEY TRANSITION TO 1915(I) SERVICES?

Care coordination for 1915(i) services must comply with federal conflict of interest requirements, including conflict-free case management, in order to promote consumer choice and limit bias by a care manager. A behavioral health or I/DD organization/provider of TCM cannot deliver both TCM and HCBS, including 1915(i) services, to the same member.

1915(i) services must comply with conflict free case management requirements. Therefore, a member can keep their current 1915(b)(3) provider if the provider:

- Is not also their care manager (due to conflict free requirements),
- Is not affiliated with the same organization as their care manager, and
- Is contracted with the member's Tailored Plan or LME/MCO to provide 1915(i) services.

FOR MEMBERS CURRENTLY ON THE INNNOVATIONS WAITLIST, CAN THEY KEEP THEIR SPOT ON THE WAITLIST IF THEY BEGIN 1915(I) SERVICES?

Yes, members currently on the Innovations waitlist will keep their spot on the Innovations waitlist and continue to use of 1915(i) services.

Members who are enrolled in the Innovations or TBI waiver will no longer be eligible for 1915(i) services, as they will have access to similar services through the Innovations or TBI waiver.

WHAT ARE THE RATES FOR THE 1915(I) SERVICES?

NC Medicaid expects Tailored Plans or LME/MCOs to pay 1915(i) services at a rate which is no less than the rate which the service was paid under 1915(b)(3) or Innovations (for Community Living and Supports). Each Tailored Plan or LME/MCO has established their own fee schedules for these rates, therefore NC Medicaid will not establish a fee schedule for 1915(i) services.

The 1915(i) TCM Add-On rate is $78.94, which mirrors the Innovations add-on payment rate.

Please see the below mapping of the 1915(b)(3) services to 1915(i) services.

Current 1915(b)(3) Service		**Future 1915(i) Service**
In-Home Skill Building	➢	Community Living and Support
One-time Transitioning Costs	➢	Community Transition
Individual Support	➢	Individual and Transitional Support[1]
Transitional Living Skills		
Intensive Recovery Supports		
Respite	➢	Respite
Supported Employment	➢	Supported Employment

Individual and Transitional Support integrates the existing Individual Support, Transitional Living Skills and Intensive Recovery Supports services into one service.

WHAT ARE THE HCBS MONITORING REQUIREMENTS FOR 1915(I) SERVICES?

For ongoing monitoring for the 1915(i) services, the care manager/care coordinator are responsible for completing the following activities monthly:

- Monitoring Care Plan/ISP goals.
- Maintaining close contact with the beneficiary, providers and other members of the care team.
- Promoting the delivery or services and supports in the most integrated setting that is clinically appropriate for the beneficiary inclusive of HCBS requirements.
- Updating the independent assessment at least annually or as significant changes occur.
    - Note: For beneficiaries in TCM and obtaining 1915(i) services, the care manager must complete the independent assessment as part of the annual care management

comprehensive reassessment.
- Notifying the appropriate Tailored Plan/PIHP of updates to 1915(i) service eligibility.
- Monitoring of 1915(i) service delivery.

As a requirement of monitoring, the TCM provider must meet with the member face-to-face at least once per quarter (this can be in person or with two-way audio-visual communication) and conduct telephonic follow-up with the member for the other months in the quarter.

Please also review the HCBS Monitoring Tool Training deck.

Example Scenarios of Individuals with Both a PCP and Care Plan/ISP

Scenario A. Individual with Serious Mental Illness (SMI) is not Obtaining a 1915(i) Service; Has Both a Care Plan and PCP

Scenario A

- Joe has a SMI and is enrolled in a Tailored Plan.
- He is engaged in Tailored Care Management and has a care manager based at a CMA.
- Joe is currently obtaining the following service:
  - ✓ Community Support Team (not a 1915(i) service)

- Joe has a **PCP** that details his rehabilitative goals and is used for the authorization of the Community Support Team service.
- Joe's **PCP** is developed by his service provider.

- Joe has a **Care Plan** that was developed by his care manager upon Joe's engagement in Tailored Care Management.
- Joe's **Care Plan** incorporates information from his PCP, including his rehabilitative goals.

Scenario B. Individual with SMI is Obtaining a 1915(i) Service; Has Both a Care Plan and PCP

Scenario B

- Ana has an SMI and is enrolled in an LME/MCO.
- She is engaged in Tailored Care Management and has a care manager based at a CMA.
- Ana is obtaining the following two services:
  - ✓ Community Transition (a 1915(i) service), and
  - ✓ Peer Support Services (not a 1915(i) service)

- Ana has a **PCP** that details her rehabilitative goals and is used for the authorization of Peer Supports Services.
- Ana's **PCP** is developed by her service provider.

- Ana has a **Care Plan** that was developed by her care manager upon Ana's engagement in Tailored Care Management.
- Ana's **Care Plan** incorporates information from her PCP, including her rehabilitative goals.
- After being determined eligible for 1915(i) services, Ana's care manager updates her **Care Plan** with her desired type, amount, and duration of 1915(i) services.
- Ana's care manager submits her 1915(i) assessment and **Care Plan** to her LME/MCO for service authorization.

Scenario C. Individual with Intellectual and Developmental Disability (I/DD) is Obtaining a 1915(i) Service; Has Only an ISP

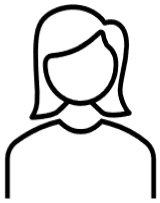
Scenario C

- Roger has an Intellectual and Developmental Disability (I/DD). He is enrolled in a Tailored Plan.
- Roger is obtaining the following service:
  - ✓ Community Transition (a 1915(i) service)
- Roger has opted out of Tailored Care Management. To help coordinate his 1915(i) service, he instead has a care coordinator based at this Tailored Plan.

- Roger does not have a PCP.

- Roger did not have an existing **Individual Support Plan (ISP)** prior to being determined eligible for a 1915(i) service.
- After being determined eligible for 1915(i) services, Roger's care coordinator develops an **ISP** with his desired type, amount, and duration of 1915(i) services.
- Roger's care coordinator submits his 1915(i) assessment and **ISP** to his Tailored Plan for service authorization.

Scenario D. Individual with Severe SUD is Obtaining a 1915(i) Service; Has Both a Care Plan and PCP



Scenario D

- Mia has a Severe SUD and is enrolled in a Tailored Plan.
- Mia is obtaining the following two services:
  - ✓ Supported Employment (a 1915(i) service), and
  - ✓ Peer Support Services (not a 1915(i) service)
- She has opted out of Tailored Care Management. To help coordinate her 1915(i) service, she instead has a care coordinator based at her Tailored Plan.

- Mia has a **PCP** that details her rehabilitative goals and is used for the authorization of Peer Supports Services.
- Mia's **PCP** is developed by her service provider.

- Mia did not have an existing **Care Plan** prior to being determined eligible for a 1915(i) service.
- After being determined eligible for 1915(i) services, Mia's care coordinator develops a **Care Plan,** incorporating information from her PCP.
- Mia's care coordinator includes in her **Care Plan** her desired type, amount, and duration of 1915(i) services.
- Mia's care coordinator submits her 1915(i) assessment and **Care Plan** to her Tailored Plan for service authorization.