NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Tailored Care Management Provider Manual Updates

January 17, 2025

This document provides a summary of updates in the revised Tailored Care Management Provider Manual, which the Department released on January 17, 2025. These updates include clarifications to misconceptions and feedback providers shared during the Tailored Care Management Town Hall sessions on ways the Department can help ease provider burden and support program sustainability. The requirements in the updated Provider Manual are effective as of the date of publication.

Key updates and clarifications are described below:

1. **Clarification on Applicability of the Provider Manual to Tailored Plans / Local Management Entities/Managed Care Organizations (LME/MCOs) (page 4).** The updated manual clarifies that the requirements in the manual apply to AMH+ practices, CMAs, and Tailored Plans / LME/MCOs in their role as Tailored Care Management providers. Tailored Plans/ LME/MCOs are also held accountable to the requirements in Tailored Plan / LME/MCO contracts.

2. **Clarification on Eligibility for Tailored Care Management (page 6).** The updated manual clarifies that individuals are ineligible for Tailored Care Management when incarcerated. Upon release, an individual may be re-enrolled in Tailored Care Management if they remain eligible or become newly eligible.

3. **New Flexibility on Supervising Care Manager's Role in Reviewing Care Plans/ISPs (pages 22 and 69-70).** The updated Provider Manual removes the requirement that supervising care managers must review all Care Plans/Individual Support Plans (ISPs). The Department has added new language requiring supervising care managers to be responsible for providing oversight and support to ensure complete and high-quality Care Plans/ISPs. AMH+s/CMAs and supervising care managers may determine the level of supervision needed for care managers. AMH+s/CMAs must document standards for the supervising care manager's monitoring of care management comprehensive assessments and Care Plans/ISPs in the AMH+/CMA's written policies and procedures. The Standard Terms and Conditions for Tailored Plan / LME/MCO Contracts with AMH+ Practices or CMAs (Appendix 1) were revised as well to reflect this update.

4. **Extension of Temporary Tailored Care Management Payment Rate (pages 25 and 60-61)**. The updated provider manual reflects that the Department will extend the temporary payment rate of $343.97 through June 30, 2025. Effective July 1, 2025, the payment rate will be $294.86. The previous iteration of the manual noted the payment rate of $343.97 was effective through December 31, 2024.

5. **Revised Requirement on Timeframe to Complete the Care Management Comprehensive Assessment (pages 28).** The updated manual notes care managers must undertake best efforts to complete the care management comprehensive assessment within 90 days of an individual's consent to participate in Tailored Care Management for all members newly eligible for Tailored Care Management. The previous iteration of the manual indicated that care managers must undertake best efforts to complete the care management comprehensive assessment within 90 days of Tailored Care Management *assignment* for all new members. The Standard Terms and Conditions for Tailored Plan / LME/MCO Contracts with AMH+ Practices or CMAs (Appendix 1) were revised as well to reflect this update.

6. **Clarification on Limited Circumstances in which the Care Management Comprehensive Assessment Can Be Completed Using Technology Conferencing Tools (page 28).** Care managers are expected to make best efforts to complete the care management comprehensive assessment in person, recognizing that, in limited circumstances, it may be necessary to complete it using technology conferencing tools (e.g., audio, video, and/or web). The updated provider manual provides additional clarification around these limited circumstances. For example, if a member is in a physical setting where the care manager is not permitted access, or the member declines a timely in-person meeting, then it may be necessary to complete the assessment via HIPAA compliant technology conferencing tools. A care manager should document in the care management data system when the assessment is completed using such tools and the circumstances that required use of technology conferencing tools.

7. **New Flexibility and Clarifications on the Process for Conducting the Care Management Comprehensive Assessment (page 28).** The manual clarifies that care managers can administer the care management comprehensive assessment over the course of multiple contacts. This change seeks to enable a more person-centered approach, where care managers can prioritize certain domains based on the member's preferences and needs and defer other domains until the care manager has established trust with the member. Additionally, to reduce asking members questions that may have already been answered in other interactions with the health care system, the manual clarifies that care managers can rely upon relevant assessments and other data shared (e.g., available medical records, results from screening, level of care determination tools) with the AMH+/CMA to complete portions of the care management comprehensive assessment and then confirm the accuracy of this information with the member and/or legally responsible person/guardian.

8. **Clarification on Ability to Address Urgent Needs Prior to the Care Management Comprehensive Assessment (page 28-29).** The manual details how a care manager can support

a member with their immediate needs before completing the care management comprehensive assessment, when initial conversations with the member and the results of care needs screening indicate the member has urgent needs. In these instances, once the member consents to participate in Tailored Care Management, the care manager can begin to support the member with their immediate needs, and based on these immediate needs, care managers should develop an interim care plan or interim individual support plan. The interim care plan/interim ISP should include member information, goal, and a short crisis plan. If the interim care plan/interim ISP is for 1915(i) services, then it must include information on the needed 1915(i) services and a signature of the member and/or legally responsible person/guardian. This interim care plan/interim ISP does not suffice to meet the requirement for the AMH+/CMA to develop a Care Plan/ISP for each member (i.e., the full Care Plan/ISP should be more comprehensive, as detailed in Section V.4.4. of the manual), but can be built upon to meet this requirement.

9. **Clarification on the Requirements for Reassessment (page 31 and 77-78).** Care managers are required to attempt reassessment of the care management comprehensive assessment in specific circumstances, included defined triggering events (e.g., inpatient hospitalization, becoming pregnant—full list of triggering events detailed in Section V.4.4). The updated manual clarifies that, in instances in which an assessment may have been recently performed, the reassessment may consist of an addendum or update to a previous assessment, rather than conducting a full reassessment, and should capture specific updates relevant to the triggering event. The Standard Terms and Conditions for Tailored Plan / LME/MCO Contracts with AMH+ Practices or CMAs (Appendix 1) were revised as well to reflect this update.

10. **Clarification on Sharing of Care Management Comprehensive Assessment Results and the Care Plan/ISP (pages 31 and 33).** The updated provider manual clarifies that care managers should make best effort to proactively share the results of the care management comprehensive assessment and Care Plan/ISP with the member, the member's legally responsible person/guardian (where applicable), member's primary care, behavioral health, I/DD, and TBI providers (including 1915(i) providers) within 14 days. For others in the broader care team (e.g., specialists, social service providers, Tailored Plan / LME/MCO), care managers do not always need to proactively share these documents but should use their judgement and knowledge of the member's needs for identifying when to share these documents proactively. Care managers should also share these documents when it is at the request of the member and/or legally responsible person/guardian.

11. **Revised Requirements on the Care Manager's Role in Medication Reconciliation (page 36-37 and 81-82).** The updated manual provides additional clarification on the care manager's role in medication reconciliation, including ensuring medication reconciliation is completed annually, and at transitions of care, in which new medications are ordered, or existing orders are rewritten. A community pharmacist in communication with the care manager may assist with medication reconciliation, along with appropriate members of the individual's care team (e.g., members' pharmacist, primary care physician, psychiatrist, or other relevant prescribing clinicians.) The care manager's role is not to complete medication reconciliation, but to ensure

the process occurs. (Note, the Department will provide access to additional training on medication reconciliation in 2025.)

12. **Clarification on Attempted Visits During a Member's Stay in a Facility (pages 39 and 85).** Previous iterations of the provider manual noted that, as part of transitional care management, a care manager or care team member is required to visit a member during their stay in a facility and be present on the day of discharge. The Department recognizes that in some instances care managers may not be able to connect with the member directly during their stay. The updated manual notes that care managers should document unsuccessful attempts to connect with the member directly and note when they are able to connect with the member or a hospital social worker, or other facility staff working with the member.

13. **Clarification on Care Manager's Role in 1915(i) Care Coordination (pages 42-44)** Care Managers should convene a person-centered planning meeting, including the member's selected 1915(i) provider(s), write goal(s) for each 1915(i) service, and obtain the signature of the 1915(i) provider on the Care Plan/ISP. **Note:** Please refer to 4.10. 1915(i) Care Coordination for additional requirements for members obtaining 1915(i) services.

14. **Additional language added to closed loop referrals (pages 56 and 74)** The updated manual shares the expectation that even if there are no NCCARES360 resources, closed-loop referrals should be tracked to ensure that follow-up is completed, and members needs are met.

15. **Clarification on Documenting and Storing Release of Information (pages 55 and 72).** The updated provider manual clarifies that release of information documents can be documented and stored in either the AMH+/CMA's EHR or care management data system.

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.