NC Medicaid Managed Care
Provider Playbook

To ensure beneficiaries can seamlessly receive care on day one, the North Carolina Department of Health and Human Services (NCDHHS) is delaying the implementation of the NC Medicaid Managed Care Behavioral Health and Intellectual/ Developmental Disabilities Tailored Plans (Tailored Plans). Tailored Plan launch was scheduled for Oct. 1, 2023, **but will now go forward at a date still to be determined.**

Fact Sheet
Tailored Care Management

Tailored Care Management (TCM) launched Dec. 1, 2022

Tailored Care Management (TCM) is a new care management model that began Dec. 1, 2022, for eligible NC Medicaid beneficiaries. With TCM, eligible beneficiaries have a single designated care manager, supported by a multidisciplinary team, to provide integrated care management to address the beneficiary's whole-person health needs.

WHO IS ELIGIBLE FOR TCM

Individuals ages 3+ who are enrolled in NC Medicaid Direct including:

- Innovations Waiver participants (including duals)
- Traumatic brain injuiry (TBI) Waiver participants (including duals)
- Children and Adolescents with a Serious Emotional Disorder (SED)
- Adolescents with a Severe Substance Use Disorder (SUD)
- Adults with a Serious Mental Illness (SMI) or Severe SUD
- Children ages 3+ and older and adults with I/DD
- Children and adolescents in foster care with SED or SUD
- Dual-eligible adults with SMI or SUD
- Dual-eligible Children ages 3+ and older and Adults with Intellectual/Developmental Disabilities (I/DD) who are **NOT** on the Innovations or TBI waivers

Many of these beneficiaries will be enrolled in the Behavioral Health I/DD Tailored Plan, and will continue to receive TCM.

The services below are substantially similar to TCM and therefore, beneficiaries receiving these services will not receive TCM. However, there are some instances where beneficiaries may receive both services (e.g., TCM and Assertive Community Treatment (ACT), or TCM and Care Management for At-Risk Children (CMARC)) for a limited time to ensure a smooth transition. Tailored Plans will be responsible for developing and implementing protocols to ensure beneficiaries moving between these services and the TCM model experience smooth transitions.

TCM will be available to the above beneficiaries except those in the following services:

- Beneficiaries obtaining ACT or Critical Time Intervention (CTI)
- Beneficiaries residing in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IIDs) or Skilled Nursing Facilities
- Beneficiaries participating in CMARC
- Beneficiaries participating in the High-Fidelity Wraparound (HFW) program or Child ACT
- Community Alternatives Program for Children (CAP/C)
- Community Alternatives Program for Adults with Disabilities (CAP/DA)
- Program of All-Inclusive Care for the Elderly (PACE)

Children (0-3) and immigrants under the five-year ban who meet the above clinical criteria became eligible for TCM on April 1, 2023.

WHAT TAILORED CARE MANAGERS DO

Under TCM, beneficiaries will have a single care manager equipped to manage all the beneficiary's needs, spanning physical health, behavioral health, I/DD, TBI, pharmacy, long-term services and supports (LTSS) and unmet health-related resource needs. Tailored Care Managers may be an Advance Medical Home Plus (AMH+), Care Management Agency (CMA) or provided through the beneficiary's health plan. Tailored Care Managers will:

- Develop care management comprehensive assessments and care plans/individual support plans with beneficiaries
- Coordinate/refer/monitor all services (medical, pharmacy, behavioral health, waiver services, food, housing, transportation, community resource supports)
- Support beneficiaries in a crisis (with planning supports)
- Arrange for annual physicals
- Innovations and TBI waiver care coordination (if applicable)
- Convene and consult with a multidisciplinary care team
- Provide management for beneficiaries with chronic, high-risk, high-cost care management needs
- Help with medication monitoring
- Address unmet health-related resource needs
- Educate on chronic health conditions and support self-health management (eating healthier; helping you join a diabetes prevention program)
- Monitor Hospital Admission Discharge and Transfer (ADT) alerts and ensure beneficiaries with any admissions, discharges or transfers are followed
- Support transitions out of hospitals and nursing facilities

WHAT IF A BENEFICIARY WANTS TO CHANGE THEIR TCM PROVIDER?

Beneficiaries can change their TCM provider twice per year "without cause" and unlimited number of times "with cause" per year.

Beneficiaries on the Innovations and TBI waivers can choose their current care coordinator as their TCM provider or choose a different TCM provider.

Beneficiaries can also opt out of care management if they choose, and it will not affect the other services they receive in any way.

If a beneficiary wants to change their TCM provider, they should contact their LME/MCO (contact info below) who can share information on certified TCM providers by population served, age and geography.

LME/MCO	Member Services Line Phone Number
Alliance Health	800-510-9132
Eastpointe	800-913-6109
Partners Health Management	888-235-4673
Sandhills Center	800-256-2452
Trillium Health Resources	877-685-2415
Vaya Health	800-962-9003

HOW DO I KNOW WHO MY BENEFICIARY'S TCM PROVIDER IS?

PCPs can see the assigned TCM entity for any of their beneficiaries on the NCTracks Recipient Eligibility Verification results, as well as on their AMH NC Medicaid Direct/Managed Care PCP Enrollee Report in NCTracks.

Other providers may be contacted by the TCM provider for coordination of care.

HOW WILL I INTERACT WITH A TCM CARE MANAGER FOR BENEFICIAIRES I SERVE ?

A care manager may contact your office to:

- Identify the agency and the beneficiary they represent and present release of information documentation
- Explain their role in the beneficiary's care and talk about participation in the beneficiary's care team
- Ask questions about symptoms, medications and treatment
- Share concerns about/from the beneficiary
- Ask questions about lifestyle changes that would promote better health for the beneficiary
- Request support for referral to another provider

WHO IS ELIGIBLE TO BECOME A CERTIFIED TAILORED CARE MANAGEMENT PROVIDER

Advance Medical Home Plus (AMH+)

AMH+s are primary care practices actively serving as AMH Tier 3 practices, whose providers have experience delivering primary care services to the Tailored Plan eligible population or can otherwise demonstrate strong competency to serve that population. To demonstrate experience and competency to serve the Tailored Plan eligible population, each AMH+ applicant must attest that it has a patient panel with at least 100 active Medicaid patients who have an SMI, SED, or severe SUD; an I/DD; or a TBI.

Care Management Agency (CMA)

To be eligible to become a CMA, an organization's primary purpose at the time of certification must be the delivery of NC Medicaid or State-funded behavioral health, I/DD and/or TBI services, other than care management, to the Tailored Plan eligible population in North Carolina. The CMA designation is new and will be unique to providers serving the Tailored Plan population.

A list of current certified Tailored Care Management providers and the populations they are certified to serve can be found on the NC Medicaid Tailored Care Management webpage under Resources, then Other.

WHAT IF I WANT TO BECOME A CERTIFIED AMH+ OR CMA TCM PROVIDER

The process for TCM AMH+/CMA Provider Certification is managed by the National Committee for Quality Assurance (NCQA), using their web-based Interactive Review Tool (IRT). Providers will use IRT to submit their application, complete the desk review, site review, readiness review and recertification.

Key features include the ability for providers to upload documents, complete self-assessed scoring, review documents, reconcile issues, receive feedback for improvement and review results. The latest application period for new providers closed on Nov. 10, 2022, and new application periods will be announced in the future.

WHAT IF I HAVE QUESTIONS

For questions that are health-plan specific, please see contacts on the NC Medicaid Provider Contracting with Health Plans webpage.

For general inquiries and complaints regarding health plans, NC Medicaid has created a **Provider Ombudsman** to represent the interests of the provider community. The Ombudsman will:

- Provide resources and assist providers with issues through resolution.
- Assist providers with Health Information Exchange (HIE) inquires related to NC HealthConnex connectivity compliance and the HIE Hardship Extension process.

Provider Ombudsman inquiries, concerns or complaints can be submitted to Medicaid.ProviderOmbudsman@dhhs.nc.gov, or received through the Provider Ombudsman line at 866-304-7062. The Provider Ombudsman contact information is also published in each health plan's provider manual.

For questions related to your NCTracks provider information, contact the NCTracks Call Center at 800-688-6696. To update your information, log into the NCTracks Provider Portal to verify your information and submit a MCR or contact the NCTracks Call Center.