NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Tailored Care Management Provider Manual Updates

April 4, 2023

This document provides a summary of updates in the revised Tailored Care Management Provider Manual, which the Department released on February 23, 2023. The requirements in the updated Provider Manual are effective on April 1, 2023. The Department plans to release another update to the Provider Manual in the coming months to reflect delay in Tailored Play launch until October 1, 2023, and ongoing learnings from the implementation of Tailored Care Management.

Key updates and clarifications are described below:

1. **Availability of Tailored Care Management in NC Medicaid Direct (update reflected throughout manual).** The updated Provider Manual clarifies that individuals in NC Medicaid Direct will have access to Tailored Care Management if they meet eligibility criteria, unless they are receiving a duplicative service (see pages 3-6 of the manual for more information). Eligible beneficiaries in NC Medicaid Direct have the opportunity to access Tailored Care Management through their Prepaid Inpatient Health Plan (PIHP).
   Note: Individuals will continue to receive Tailored Care Management through their current PIHP in the period prior to Tailored Plan launch. After Tailored Plans launch, the vast majority of Health Home members will transition to Tailored Plans; given that LME-MCOs administer both Tailored Plans and PIHPs, North Carolina does not expect any disruptions in care management.

2. **Individuals Eligible for Tailored Care Management Who Are Federally Recognized Tribal Members or Others Eligible for Care through the Indian Health Service (IHS) (pages 5-6).** The update clarifies that the Eastern Band of Cherokee Indians (EBCI) Tribal Option is considered duplicative of Tailored Care Management, meaning that individuals cannot obtain care management through the EBCI Tribal Option and Tailored Care Management at the same time. Eligible individuals currently enrolled in the EBCI Tribal Option can transition to a Tailored Plan or PIHP at any time if they wish to obtain Tailored Care Management.

3. **Individuals Eligible for Tailored Care Management in Standard Plans (pages 5-6).** The update also clarifies that Standard Plan members who are eligible for Tailored Care Management will be able to transition to a Tailored Plan at any point during the coverage year to obtain Tailored Care Management.

4. **Care Coordination Requirements for Members Obtaining 1915(i) Services (requirements reflected throughout manual).** The updated Provider Manual notes that North Carolina is transitioning its current 1915(b)(3) home and community-based services (HCBS) to a different option for offering

HCBS called 1915(i). 1915(i) services will be available through both Tailored Plans and PIHPs.[1] For individuals obtaining 1915(i) services, Tailored Care Management – whether delivered by an AMH+, CMA, or plan-based care manager – must encompass care coordination of 1915(i) services.

Specifically, the manual reflects the following updates:

- Individuals seeking to obtain 1915(i) services must work with their care manager to complete a 1915(i) independent assessment to confirm they are eligible for 1915(i) services as well as identify and confirm their needed services and supports (page 36)
- Care managers serving individuals obtaining 1915(i) services must incorporate results from an individual's 1915(i) assessment into their Care Plan/Individual Support Plan (ISP) (page 27)
- Care managers must conduct the required care coordination activities for individuals obtaining 1915(i) services, regardless of whether an individual is engaged in Tailored Care Management (pages 36-38)
- Care managers must complete required training on eligibility, assessment, and coordination of 1915(i) services (page 44)

Additionally, the Provider Manual includes new information on the 1915(i) "add-on" payment for individuals obtaining 1915(i) services to account for the cost of conducting 1915(i) care coordination in addition to other Tailored Care Management requirements (page 47).

5. **Care Management Requirements for Members in Foster Care, Adoption Assistance, and Former Foster Youth (requirements reflected throughout manual).** The updated Provider Manual includes additional care management requirements for members served by the child welfare system, inclusive of members in foster care, receiving adoption assistance, and former foster youth. Specific requirements have also been added for members who are aging out of the foster care system.

   Specifically, the Provider Manual reflects the following updates:

   - Members served by the child welfare system will default assignment to PIHP-based care management, with specified exceptions (page 14)
   - There are specific care management responsibilities for members served by the child welfare system, including related to:
     - Care management comprehensive assessment components and requirements for reassessment (pages 25-27)
     - Care Plan/ISP requirements (pages 27-29)
     - Inclusion of the County Child Welfare Worker and/or guardian ad litem in the member's care team (pages 29-30)
     - Care coordination (pages 30-31)
     - Coordination with County Child Welfare (pages 38-39)
     - Period when a member is aging out of foster care (pages 39-41)

[1] For more information on the 1915(b)(3) to 1915(i) transition, please see: https://public.3.basecamp.com/p/WsjPry4mngKWrhurDAwC82wJ/

- Additional training for care managers, care manager extenders, and supervisors serving members in foster care/adoption assistance and former foster youth (page 46)

6. **Additional Standard Terms and Conditions (STCs) for Tailored Plan/PIHP Contracts with AMH+ Practices and CMAs:** The updated Provider Manual includes the following new STCs for Tailored Plans/PIHPs to use when contracting with AMH+ practices and CMAs.
    - **STCs for AMH+/CMAs Providing Tailored Care Management to Members Obtaining 1915(i) Services (Appendix 3)**, which reflect the new requirements described above in Question 4.
    - **STCs for AMH+/CMAs for Providing Tailored Care Management to Members in Foster Care, Adoption Assistance, and Former Foster Youth (Appendix 4)**, which reflect the new requirements described above in Question 5.

7. **Update to "Glide Path" Annual Targets for Provider-Based Care Management (pages 10-11).** The updated Provider Manual reflects an update to annual targets for the percentage of members actively engaged in Tailored Care Management via AMH+ practices and CMAs to account for Tailored Care Management launch in December 2022. The updated percentages are as follows:
    - Contract Year 1 (December 2022 – March 2023): 30 percent (30%);
    - Contract Year 2 (April 2023 – June 2024): 30 percent (30%);
    - Contract Year 3 (July 2024 – June 2025): 45 percent (45%);
    - Contract Year 4 (July 2025 – June 2026): 60 percent (60%); and
    - Contract Year 5 (July 2026 – June 2027): 80 percent (80%).

8. **Updates to Assignment and Member Choice (pages 12-14).** The updated Provider Manual notes that the Department made initial Tailored Care Management assignments in the period between December 1, 2022, and March 31, 2023, honoring member choice.[2] The manual also describes that Tailored Plans/PIHPs are required to have a process for reassigning members who have significant changes in their needs and may be better served by a different care management approach. Finally, the manual notes that Tailored Plans/PIHPs will allow members who are Transition to Community Living (TCL) participants to choose their previous transition coordinator or Complex Care Manager as their care manager for Tailored Care Management, to the extent possible.

9. **Revisions to Minimum Requirements for Contact Between Members and Care Managers/ Extenders (pages 22-24).** The updated Provider Manual clarifies the Department's policy on minimum contacts between members and care managers/extenders, including the following clarifications:
    - Provider compliance to minimum contact requirements will be assessed at the panel level, *not* on a per-member basis. A provider is considered fully compliant if they deliver at least 75% of the sum of contacts required by engaged members in their panel.
    - Contacts that are not required to be in-person may be telephonic or through two-way real time video and audio conferencing.

[2] Starting April 1, 2023, Tailored Plans/PIHPs are responsible for making Tailored Care Management assignments for newly enrolled Medicaid members using a methodology consistent with the Department's requirements.

- To bill for a contact, a care manager must provide one of the six core Health Home services when delivering a Tailored Care Management contact. The Provider Manual includes a list of examples of billable activities.

10. **Care Management Comprehensive Assessments Completed in Interim Period (pages 24-25).** The updated Provider Manual notes that care management comprehensive assessments completed in the interim period between December 1, 2022, through March 31, 2023, will still be valid after April 1, 2023.[3]

11. **Core Training Modules for Care Managers, Care Manager Extenders, and Supervisors (pages 46-47).** The updated Provider Manual specifies the following core training modules that all care managers, extenders, and supervisors must complete before being deployed to serve members: Tailored Plan eligibility and services, principles of integrated and coordinated care, knowledge of Innovations and TBI waiver eligibility, and an overview of Tailored Care Management (e.g., model's purpose, target populations, services, role of enrollees and their families in care planning). The manual also notes that care managers, extenders, and supervisors must complete the remaining training modules within 90 days of being deployed.

12. **Required Annual Tailored Care Management Refresher Trainings for Care Managers, Care Manager Extenders, and Supervisors (Appendix 5).** The updated Provider Manual includes the list of required refresher courses that care managers, care manager extenders, and supervisors must complete annually.

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.

[3] The Department will clarify in a future update to the Provider Manual how the delay of Tailored Plan launch impacts this policy.