NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Tailored Care Management Provider Manual Updates

July 14, 2023

This document provides a summary of updates in the revised Tailored Care Management Provider Manual, which the Department released on July 14, 2023. 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 use of Tailored Plans, LME/MCOs, and PIHPs (throughout manual).** The updated manual clarifies that all members who will be enrolled in a Tailored Plan are considered eligible for Tailored Care Management unless they are obtaining a duplicative service. Additionally, all individuals enrolled in NC Medicaid Direct who meet the model's eligibility criteria—beneficiaries with serious mental illness (SMI), serious emotional disturbance (SED), severe substance use disorders (SUDs), intellectual/developmental disability (I/DD), or traumatic brain injury (TBI) and are not obtaining a duplicative service—have the opportunity to access Tailored Care Management through their Local Management Entity/Managed Care Organization (LME/MCO). LME/MCOs cover behavioral health and I/DD services for people in NC Medicaid Direct. The terms "Tailored Plans / LME/MCOs" are used throughout the document to refer to these plans and populations.

2. **Standardization of the Uses of "Parents, Other Family Members, Caregivers, Natural Supports, Legally Responsible Person/Guardian" (throughout manual).** At the request of stakeholders, the Provider Manual standardizes the use of parents, other family members, caregivers, natural supports, and legally responsible persons/guardians, where appropriate.

3. **Clarification on Eligibility for Tailored Care Management During Transition Into or Out of Assertive Community Treatment, Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID), and Nursing Facility (page 6).** The updated Provider Manual clarifies that the assigned Tailored Plan / LME/MCO, AMH+, or CMA may provide and bill for Tailored Care Management in the first and last month of a member obtaining Assertive Community Treatment, residing in an ICF-IID, or residing in a nursing facility (stays of 90 days or more), which includes coordinating with the Assertive Community Treatment/ICF-IID/nursing facility care team and facilitating clinical handoffs. A member can continue to receive Tailored Care Management during a short-term stay in a nursing facility (less than 90 days).

4. **Years for "Glide Path" to Provider-based Care Management (page 11).** The updated Provider Manual clarifies the time periods for the glide path targets for the percentage of members actively engaged (i.e., those consented who received Tailored Care Management contacts throughout the

year) in Tailored Care Management via certified AMH+ practices and CMAs. The timing and targets are as follows:

- December 2022 – June 2024: 35 percent (35%);
- July 2024 – June 2025: 45 percent (45%);
- July 2025 – June 2026: 60 percent (60%); and
- July 2026 – June 2027: 80 percent (80%).

Note that the percentage for December 2022 – June 2024 has been updated to 35% to align with the most recent Tailored Plan / LME/MCO contract amendments.

5. **Choice for Transitions to Community Living (TCL) Participants (pages 13-14).** The manual states that participants in TCL (North Carolina's Olmstead settlement for adults with serious mental illness [SMI] and serious and persistent mental illness [SPMI]) will be auto-assigned to a care manager based at an LME/MCO to comply with the terms of the settlement. At this time, only LME/MCOs are prepared to provide the specialized care management functions required under the terms of North Carolina's Olmstead settlement with the U.S. Department of Justice. The Department is beginning a process to designate AMH+s/CMAs as being qualified to serve TCL participants, which will go live later in 2023. Individuals in the settlement will be able to choose to obtain Tailored Care Management through one of these designated AMH+ practices or CMAs at that time. Additional information about this process will be released during Summer 2023.

6. **Conflict-Free Care Management for Members Enrolled in Innovation or TBI Waiver or Using and 1915(i) Services (page 14).** Care management for Innovations and TBI waiver enrollees and beneficiaries using 1915(i) services must comply with federal requirements for conflict-free case management for 1915(c) and 1915(i) programs, respectively. The Tailored Plan / LME/MCO is required to ensure that members do not obtain both 1915(c) waiver services or 1915(i) services and Tailored Care Management from the same provider organization. The updated manual clarifies that Tailored Plan / LME/MCO will follow federal conflict free-care management requirements when making member assignments and reassignments to TCM providers.

7. **Updates to Data Sharing Requirements (page 15).** The updated Provider Manual adds the patient risk list to the data Tailored Plans / LME/MCOs will share with providers and notes that the pharmacy lock-in data Tailored Plans / LME/MCOs share should include all mandatory fields and values noted in the data specification guidance for Tailored Care Management.

8. **Healthy Opportunities Pilot Program Launch for AMH+s/CMAs (page 17-18).** The update notes that starting on October 1, 2023, the Department intends to phase-in the Healthy Opportunities Pilots for individuals in Pilot regions obtaining Tailored Care Management through a Tailored Plan or LME/MCO-based care manager. AMH+s and CMAs serving members in Pilot regions will launch the Pilots based on their readiness and capacity to do so. The Department will release an addendum to the Provider Manual describing Pilot-related responsibilities.

9. **Assignment of Care Manager and Supervising Care Manager for Members Dually Diagnosed with a Behavioral Health Condition and an I/DD or a TBI (page 20).** The update clarifies that the assigned

organization providing Tailored Care Management should use their clinical judgment in assigning a care manager and supervising care manager if an individual is dually diagnosed with a behavioral health condition and an I/DD or a TBI. This applies regardless of whether a member has been dually diagnosed prior to the initial Tailored Care Management assignment process or at some point after. In instances where a member is dually diagnosed after a care manager or supervising care manager has been assigned, the AMH+, CMA, or Tailored Plan / LME/MCO should review their assignment of care manager/supervising care manager to confirm that it is still clinically appropriate, aiming for continuity, as long as the care manager/supervising care manager is qualified to serve the member.

10. **Education Requirements for Extenders (page 21).** The update clarifies that individuals with the equivalent of a high school diploma, such as a GED or certificate of completion, qualify to serve as care manager extenders if they meet all other requirements for extenders.

11. **Clinical Consultants (page 22).** The update notes that clinical consultants may be licensed outside of North Carolina because they are not providing treatment to members.

12. **Updated Policies on Acuity Tiers, Acuity-Based Contacts, and Contact Monitoring (pages 23-25).** The updated Provider Manual includes the following updates and clarifications regarding acuity tiers and contact monitoring:
    - Tailored Plans / LME/MCOs, AMH+s, and CMAs will not be held to acuity-based contact requirements at this time. Instead, providers are expected to deliver the volume of contacts necessary to sufficiently serve each individual member. The volume is to be determined by a member's care manager and care team.
    - The Department will review the cumulative number of contacts delivered by an AMH+/CMA/plan across the consented and engaged member panel to see how it compares to the assumptions in the rates. With this information, the Department will explore whether an acuity-based approach may be appropriate in the future to better align the payment rates with the level of effort required to engage meaningfully with different populations.

13. **Suspension of Acuity-Based Payment and Establishment of Single Tailored Care Management Payment Rate (pages 23-25 and 48-49).** The updated manual notes that:
    - For the year starting on July 1, 2023, through June 30, 2024, the Department is continuing the use of a single Tailored Care Management rate of $269.66, meaning the same rate will be paid for all members.
    - Consistent with existing policy, the Department will pay an add-on of $78.94 for Innovations and TBI waiver participants and for members obtaining 1915(i) services.
    - Consistent with existing policy, providers must deliver one qualifying contact in the month to receive payment. The updated Provider Manual clarifies that a qualifying contact is defined as an interaction that includes the member and/or legally responsible person/guardian, as indicated, that fulfills one or more of the six core Health Home services.
    - The Department understands that a member may not be present for work done by a care manager (or extender, where appropriate) related to the six core health home services (e.g., care manager calls with providers to connect members to services/supports); a care manager should submit their Tailored Care Management claim for the date they made

contact with the member and communicated the outcome of these core health home service activities

14. **Acuity Tier Data Should Be Used for Other Purposes (page 23).** The update states that while Tailored Plans / LME/MCOs, AMH+s, and CMAs will not be held to acuity-based contact requirements at this time, acuity tier information shared with plans, AMH+s, and CMAs should guide:
    - Decision making to address member needs (e.g., data can help care managers identify members to prioritize for outreach and those who may have significant needs);
    - Determining the urgency of completing the care management comprehensive assessment;
    - Making care manager and supervising care manager assignments; and
    - Conducting risk stratification.

15. **Clarification on Billing for Case Management Provided as Part of an Enhanced Behavioral Service or Other Behavioral Health Service Versus Tailored Care Management (page 24).** Case management that is provided by a CMA as part of an enhanced behavioral health service definition (e.g., Community Support Team) or other behavioral health service should not be billed as Tailored Care Management. In these instances, the care plan/ISP should clearly document the scope of activities and roles/responsibilities of the care team within Tailored Care Management versus that of the other service.

16. **Updates to Care Management Comprehensive Assessment Policies (pages 25-26).** The update clarifies the following items regarding the care management comprehensive assessment:
    - For members identified as high acuity, the assessment should be completed within 60 days of the effective date of Tailored Care Management assignment. (Previously, manual noted as of Tailored Care Management enrollment.)
    - Members identified as moderate/low acuity: within 90 days of the effective date of Tailored Care Management assignment. (Previously, manual noted as of Tailored Care Management enrollment.)
    - During the second and subsequent years of operation, the AMH+ or CMA must undertake best efforts to complete the care management comprehensive assessment within 60 days of Tailored care management assignment for all members. (Previously, manual noted as of Tailored Care Management enrollment.)
    - The Department recognizes that some members may not be able to sit through the entire care management comprehensive assessment due to their health condition and similarly, children/adolescents may not able to be present during the entire assessment; in these instances, the member should participate in the assessment to the maximum extent they are able to and the care manager can finish the assessment with the legally responsible person/guardian.
    - The Department also recognizes that in some instances members will have an urgent need that needs to be addressed before completing the care management comprehensive assessment. Providers can assist members with their immediate needs prior to completion of the care management comprehensive assessment and provide any urgent links/supports to address those needs. This scenario can be billed as a Tailored Care Management contact

as long as the member consents to participating in Tailored Care Management and the provider documents this consent.

17. **Care Management Extender Functions (page 42-43).** The update clarifies that it is within the extenders' scope to gather information about a member's progress towards goals identified in the care plan or ISP and share with the care manager and other members of the care team.

18. **Updated Training Policies (pages 47-48).** The updated Provider Manual includes the following updates to the Tailored Care Management training requirements, which align with the Tailored Care Management Flexibilities and Program Changes Update that the Department published on May 31, 2023:
    - Training on 1915(i) Overview and Assessment, Home and Community Based Services (HCBS), and 1915(i) services is added to the list of core training modules staff must complete before being deployed to serve members.
    - Care managers, extenders, and supervisors must complete the remaining training modules outside of the core training modules within six (6) months of being deployed to serve members.

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.