NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Tailored Care Management Program Updates
April 26, 2023
Updated May 29, 2023

The Tailored Care Management program launched on December 1, 2022. Recognizing that it would take providers some time to ramp up and meet the full set of program requirements, on November 2, 2022, the Department released a memo permitting temporary flexibilities and program changes for the period between December 1, 2022, and March 31, 2023. The majority of these flexibilities came to an end on March 31, 2023, and some will continue until June 30, 2023. This memo seeks to clarify the current status of each flexibility and outlines several additional program updates.

NOTE: Until Tailored Plan launch at a date to be determined, the State's local management entity/managed care organizations (LME/MCOs) will continue to operate the Tailored Care Management model. Individuals eligible for the model will still have the option to obtain Tailored Care Management from an Advanced Medical Home Plus (AMH+) practice, Care Management Agency (CMA), or plan-based care manager. Until an eligible individual engages in Tailored Care Management, their LME/MCO will be responsible for care coordination functions. Once Tailored Plans launch, Tailored Care Management will be offered by LME/MCOs in their role as both Tailored Plans and prepaid inpatient health plans (PIHPs).

1. **Populations Eligible to Obtain Tailored Care Management.** As of April 1, 2023, all individuals who will be eligible to enroll in a Tailored Plan on the determined launch date, or who would otherwise meet the clinical eligibility criteria for a Tailored Plan if they were not part of a delayed or excluded population[1] are eligible to obtain Tailored Care Management. This includes clinically eligible Medicaid beneficiaries who are children under age three or who were previously enrolled in NC Health Choice.

2. **Federal Authority.** The Department is delaying implementation of the Health Home State Plan Amendment (SPA) until July 1, 2023, in order to focus on strengthening the Tailored Care Management program before additional federal requirements apply to the program.[2] Currently, the State is using managed care authority (as described in 42 CFR § 438.208) to implement Tailored Care Management under the LME/MCOs.

[1] For example, an individual who is dually eligible for Medicare and Medicaid who has an I/DD or a child with a serious emotional disturbance who would have been eligible for a Tailored Plan if they were not in foster care.
[2] The Department is in discussion with the Centers for Medicare and Medicaid Services (CMS) regarding approval of the Health Home benefit for implementation on July 1, 2023. The State aligned Tailored Care Management requirements with the federal Health Home model to receive additional federal Medicaid matching funds to support North Carolina's Medicaid program.

3. **Tailored Care Management Assignment.** As of April 1, 2023, LME/MCOs are overseeing Tailored Care Management assignments for newly enrolled members, so long as the Department determined their readiness to do so. The LME/MCOs will continue to prioritize member choice by honoring a member's choice of organization providing Tailored Care Management whenever possible. Assignments will not change for members with existing/continuing assignments, unless a member has chosen to change assignments or the plan or State determines a change is needed (e.g., to ensure conflict-free care management or because the member is part of Transitions to Community Living).

4. **Transitions to Community Living (TCL) Population.** As of April 1, 2023, all members participating in both TCL[3] and Tailored Care Management must be assigned to the LME/MCO for Tailored Care Management. Therefore, some members who were previously assigned to an AMH+/CMA may have been reassigned. Care managers at AMH+ practices and CMAs will need to work with the member's LME/MCO to facilitate a warm handoff. Additional guidance on Tailored Care Management for the TCL population is forthcoming.

5. **Outreach, Engagement, and Completion of Care Management Comprehensive Assessments.** As of April 1, 2023, care managers must undertake best efforts to conduct outreach, engage members in Tailored Care Management, and complete the care management comprehensive assessment within 60 days of Tailored Care Management enrollment for members identified as high acuity and within 90 days of Tailored Care Management enrollment for members identified as moderate or low acuity.[4] Best effort is defined as completing at least three documented strategic follow-up attempts to contact the member if the first attempt is unsuccessful (e.g., going to the member's home or working with a known provider to meet the member at an appointment). However, if an enrollee had a care management assessment within the last 12 months that meets all Tailored Care Management comprehensive assessment requirements, this requirement would be satisfied. Care management comprehensive assessments completed between December 1, 2022, through March 31, 2023, continue to be valid. Reassessments continue to be required at least annually (see Provider Manual for other instances where reassessment is necessary). The Care Plan/Individual Support Plan (ISP) must continue to be completed within one month of the care management comprehensive assessment.

6. **Comprehensive Assessments for Individuals Enrolled in the Innovations or TBI Waivers.** The care manager should align the timing of completing the care management comprehensive assessment and ISP with the annual ISP update (i.e., annual reassessment of a member's needs, which is used to develop an updated ISP).

7. **Care Plan/ISP.** A care manager does not need to develop a new care plan/ISP if an enrollee has an active care plan/ISP that meets Tailored Care Management requirements and has been completed

[3] More information on TCL can be found here: https://www.ncdhhs.gov/about/department-initiatives/transitions-community-living

[4] Previously, care managers had three months (90 days) to initiate contact and complete the care management comprehensive assessment for all members, including those identified as high acuity.

within the last 12 months.

8. **Contact Requirements and Acuity Tiers.** As of April 1, 2023, the Department implemented acuity-based contact requirements (see below). Acuity tiers indicate that individuals with higher needs need more intensive care management. Acuity tiers serve as a guide and organizations will be assessed against contact requirements at the panel level, not the individual member level, as individual needs may diverge from the assigned acuity tier. Organizations providing Tailored Care Management should use their clinical judgment and assessment of member needs to determine the intensity of care management and the number of contacts a member needs. Individual contact needs are expected to vary as clinical needs change, even if the acuity tier remains the same.

Acuity Tier	Members with Behavioral Health Needs – Minimum Contacts	Members with an I/DD or TBI – Minimum Contacts
High	At least **4** contacts per month, including at least 1 in-person contact	At least **3** per month, including 2 in-person contacts and 1 telephonic contact
Moderate	At least **3** contacts per month and at least 1 in-person contact quarterly	At least **3** contacts per month and at least 1 in-person contact quarterly
Low	At least **2** contacts per month and at least 2 in-person contacts per year, approximately 6 months apart	At least **1** contact per month and at least 2 in-person contacts per year, approximately 6 months apart

9. **Contact Monitoring**. The first contact monitoring measurement period for acuity-based contact requirements will be for care management delivered in the period between April 1 and June 30, 2023. The Department will look at the cumulative number of contacts LME-MCOs, AMH+s, and CMAs were expected to deliver across their engaged population for that quarter, in months where at least one contact was recorded. The compliance scores for the April-June measurement period will be calculated and communicated in September 2023. The goal of this initial measurement period is for the Department to gather data on provider and plan experience in delivering acuity-based contacts. Plans, AMH+ practices, and CMAs are in compliance if they deliver at least 75% of the sum of contacts required by all members in their panel. Plans and providers that fall below this threshold may receive technical assistance. The Department will not implement any other sanctions or penalties for this measurement period and will release additional guidance on the monitoring approach in the coming months.

10. **Payments.** As part of the Health Home SPA delay, the Department is continuing the blended Tailored Care Management rate ($269.66) through June 30, 2023, with an add-on of $78.94 for Innovations and TBI waiver participants. LME/MCOs will continue to pay AMH+ practices and CMAs based on the completion of the first contact each month. AMH+s/CMAs will still need to submit a claim to the LME/MCO, and the LME/MCO will pay the provider the rate after the month of service. Acuity-based payment requirements, where the payment amount differs by acuity tier, will be effective on July 1, 2023.

11. **Training**. Effective April 1, 2023, the Department is requiring care managers, care manager extenders, and supervisors complete training on the below core modules[5] before being deployed to serve members; care managers, care manager extenders, and supervisors must complete the remaining training modules within 6 months of being deployed.*

    a. An overview of the NC Medicaid Delivery system, including Tailored Care Management eligibility criteria, services available through Prepaid Inpatient Health Plans (PIHPs) and future Tailored Plans, and differences between Standard Plan, PIHP, and Tailored Plan benefit packages
    b. Principles of integrated and coordinated physical and behavioral health care and I/DD and TBI services
    c. Knowledge of Innovations and TBI waiver eligibility criteria
    d. Tailored Care Management overview, including but not limited to the model's purpose, target population, and services, in addition to enrollees and their families' role in care planning
    e. Eligibility, assessment, and coordination of 1915(i) services

    Care Manager, Extenders and Supervisors hired on before May 22, 2023 should adhere to the following:
    - Complete the **core modules within 90 days of hire**.
    - Complete the remaining training modules of the Tailored Care Management **training curriculum within six (6) months of hire**.

12. **Community Inclusion Activities.** Starting April 1, 2023, care managers[6] were responsible for in-reach and transition activities for individuals who are not part of the TCL settlement as specified in the Community Inclusion Addendum (available here). This addendum will be updated to reflect changes for the TCL population.

13. **Diversions From Institutional Settings.** Starting April 1, 2023, care managers[7] were responsible for diversion activities for individuals who are not part of the TCL settlement. (Provider Manual Section "Diversion")

14. **System of Care Requirements.** LME/MCOs will continue to oversee System of Care activities, consistent with their current contract with the Department. Organizations providing Tailored Care Management should utilize strategies consistent with the System of Care philosophy, as outlined in the Provider Manual (Provider Manual Section "System of Care"). Additional information and training are forthcoming on System of Care requirements.

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[5] The Department may update this list of core training modules at a future date.

[6] To promote the goals of the TCL Department of Justice (DOJ) settlement and comply with the settlement's terms, TCL staff at the LME/MCOs will be limited to their TCL functions and to exclusively working with the TCL population. Other Tailored Care Management team members and LME/MCO staff are responsible for conducting in-reach and transition functions for individuals who are not a part of the TCL settlement.

[7] To promote the goals of the TCL DOJ settlement and comply with the settlement's terms, TCL staff at the LME/MCOs will be limited to their TCL functions and to exclusively working with the TCL population. Other Tailored Care Management team members and LME/MCO staff are responsible for conducting diversion functions for individuals who are not a part of the TCL settlement.

Please direct any comments or questions to Medicaid.ProviderOmbudsman@dhhs.nc.gov.