NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Updated Details on the Underlying Assumptions Behind Tailored Care Management Payment Rates

March 5, 2024

Note: This memorandum provides details on the underlying assumptions behind the Tailored Care Management rates effective July 1, 2024, and supersedes previous rate guidance.[1] The updated assumptions reflect changes to rates based on North Carolina's annual review of provider costs and the time spent delivering Tailored Care Management services to members.

Overview of Tailored Care Management Payment Rates

Tailored Care Management is North Carolina's specialized care management model targeted toward individuals with a behavioral health condition (including both mental health and substance use disorders), intellectual/developmental disability (I/DD), or traumatic brain injury (TBI). To obtain enhanced federal Medicaid reimbursement for Tailored Care Management, the Department submitted and received approval from the Centers for Medicare & Medicaid Services (CMS) to add Tailored Care Management as a Health Home State Plan benefit.[2]

In recognition of the significant time and resource commitment required to successfully implement the Tailored Care Management model, provider payment rates utilize a different payment approach and are significantly higher than those paid for Standard Plan care management. Tailored Care Management rates are separate from the Tailored Plans' / Local Management Entity/Managed Care Organizations' (LME/MCOs) risk-based managed care capitation rates. Tailored Care Management providers—Tailored Plans / LME/MCOs, Advanced Medical Home Plus (AMH+) practices, and Care Management Agencies (CMAs)—will be paid a retrospective monthly rate for each member enrolled in Tailored Care Management that obtained a qualifying Health Home contact (as defined below) in the month. Tailored Plans / LME/MCOs are required to pass the full amount of these rates through to AMH+ practices and CMAs and may not retain a portion for members assigned to an AMH+ or CMA.[3] The Tailored Care Management monthly payment rate is the same for all three types of Tailored Care Management providers.

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[1] The payment rate guidance was originally published on January 19, 2022 (https://medicaid.ncdhhs.gov/updated-tailored-care-management-rate-guidance-jan-24-2022/download?attachment). A Tailored Care Management Program Update, published June 13, 2023, superseded that guidance and included the final rates effective July 1, 2023, through January 31, 2024 (https://medicaid.ncdhhs.gov/tailored-care-management-program-updates-20230613/download?attachment).

[2] More information on the submission and approval of the Health Home State Plan Amendment available at: https://www.medicaid.gov/sites/default/files/2023-07/NC-22-0024.pdf.

[3] Tailored Plan / LME/MCO capitation rates account for costs associated with Tailored Plan / LME/MCO care coordination responsibilities, oversight of the Tailored Care Management model, and other care management-related functions that will still be provided by the Tailored Plan / LME/MCO even when care management is being provided by an AMH+ or CMA.

From July 1, 2023, through January 31, 2024, the Tailored Care Management monthly payment rate was $269.66. In Fall 2023, North Carolina conducted its first annual review of provider costs and the time spent delivering Health Home services to members. This review identified several aspects of the underlying rate assumptions that differed from previous assumptions. As a result of this review, North Carolina increased the payment rate:[4]

- Effective February 1, 2024, through June 30, 2024, there is a new temporary rate of $343.97.
- Effective July 1, 2024, going forward, the rate will be $294.86 (See Table 1).

The Department also increased the monthly rate for the "add-on" payment from $78.94 to $79.73, which is available for all members enrolled in the Innovations or TBI 1915(c) waivers or obtaining 1915(i) services to account for the additional monthly care coordination responsibilities required for these services.

Table 1: Tailored Care Management Monthly Payment Rates

Payment	From July 1, 2023, through January 31, 2024	From February 1, 2024, through June 30, 2024	Effective July 1, 2024, ongoing
Tailored Care Management Monthly Payment Rate	$269.66	$343.97	$294.86
Innovations Waiver/TBI Waiver/1915(i) Monthly Add-on Payment Rate	$78.94	$79.73	$79.73

This rate update reflects the feedback received from the provider community related to the level of effort required to implement the Tailored Care Management model and reflects increases to wages and other employee-related expenses based on market data and inflation compared to when the initial Tailored Care Management rates were established.

To bill for and obtain the Tailored Care Management monthly payment rate, in any given month, the care manager, or extender where appropriate, must have at least one qualifying contact with the member. A qualifying contact is defined as a member-facing interaction (telephone call, two-way real time video, or in-person) that includes the member and/or legally responsible person/guardian, as indicated, that fulfills one or more of the six core Health Home services.[5] The care manager, or extender where appropriate, performing a Health Home activity that is not member-facing (e.g., care manager/care manager extender to other provider contact) does not count as a qualifying contact.[6] See the Tailored Care Management Provider Manual, which can be found on the Tailored Care Management webpage here, for additional billing guidance.

[4] The payment rate increase is contingent on CMS approving an updated Health Home State Plan Amendment, which the Department intends to submit to CMS in March 2024.
[5] See Tailored Care Management Provider Manual (version published on February 9, 2024), Section V.4.2, available at: https://medicaid.ncdhhs.gov/documents/providers/playbook/tcm-provider-manual-20240209/download?attachment.
[6] See illustrative scenarios on what qualifies as a contact in the Tailored Care Management Technical Advisory Group (TAG) Meeting #26 (January 26, 2024) slide deck, available at: https://medicaid.ncdhhs.gov/tcm-tag-meeting-jan-26-2024-presentation/download?attachment

Below we provide details on the assumptions and inputs for the new rates.

Care Manager Time Assumptions

Rates were constructed by translating contact assumptions, as described in the next section, into estimated consented and engaged member-to-care manager caseload ratios, calculating staffing costs associated with maintaining the estimated caseload ratios, adding additional overhead costs, and converting all costs to a monthly rate. Each of these steps – and key assumptions underlying them – are described below. All Tailored Care Management rates are subject to further refinement by the Department.

Contact Assumptions

The Department believes frequent member-facing contacts, including in-person contacts, are critical for the success of Tailored Care Management. Contact assumptions were developed based on input from clinical experts and provider survey information on the average amount of time and effort Tailored Care Management providers are expected to spend on contacts and other activities for members who receive a qualifying Health Home contact in a month, in addition to time spent on outreach to engage them. These contact assumptions are for purposes of constructing the payment rates only and do not reflect programmatic requirements. Providers must only complete one qualifying member-facing contact in a month to bill for the Tailored Care Management monthly payment rate. Care managers and care teams should use their clinical judgement and the results of the comprehensive assessment to determine the intensity of care management and number of contacts a member needs.

Engaged Member Contact Assumptions

The payment rate assumes consented and engaged members will receive three monthly telephonic or two-way real time video contacts, as well as one additional in-person contact per quarter. The Department assumed one hour per telephonic or two-way real time video contact (30 minutes for the contact and 30 minutes for preparation and documentation) and two hours per quarterly in-person contact (one hour for the contact and one hour for travel, preparation, and documentation). In addition to these member-facing contacts, the Department also assumed one monthly collateral contact for each consented and engaged member that is 15- 30 minutes in length for the care manager to connect with the member's care team or other relevant clinicians and providers.

As noted previously, these contact assumptions do not reflect programmatic requirements. To submit a claim for payment in a month, the Tailored Plan / LME/MCO, AMH+, or CMA must have at least one qualifying member-facing contact in that month. Care managers should tailor the frequency of contacts based on the member's needs.

Outreach Assumptions

The Department assumed outreach activities are required to establish relationships and keep consented members engaged. The rates reflect that an average of five to six outreach attempts, 10-20 minutes in duration, are required to engage a member for two months.

The Department recognizes that as Tailored Care Management is ramping up, additional outreach efforts may be necessary. The temporary payment rate from February 1, 2024, through June 30, 2024, includes consideration for a higher volume of care manager outreach (i.e., beyond five to six outreach attempts) as providers make initial connection and engagement with their assigned panels.

These outreach assumptions are for purposes of constructing the payment rates only and do not reflect programmatic requirements.

Workflow Assumptions

Care Manager Workflow Assumptions

In addition to the time care managers spend on contacts and outreach, the Department also assumed that care managers would spend five hours per week on non-member-related activities, such as training, staff meetings, and other typical employment activities (e.g., completion of timecards, supervisor meetings, etc.), and that care managers operate at 95% of their average, consented and engaged caseload at any given time.

In the below table, we illustrate an example time allocation for a care manager.

Table 2: Example Care Manager Workflow Distribution

Activity	Share of Care Manager Time
Member-Related Activities	**82%**
Outreach Activities for Assigned Panel	9%
Member Contact Time (In-Person and Telephonic)	34%
Travel/Documentation/Preparation for Member Contacts	34%
Care Team Meetings/Additional Clinical Time	5%
Non-Member-Related Activities	**13%**
Non-Productive Time Associated with Not Having a Full Caseload	**5%**

Care Manager Extender Workflow Assumptions

The Department expects that certain components of Tailored Care Management will always be led by a care manager. However, it recognizes that it may be most efficient for Tailored Plans / LME/MCOs, AMH+ practices, and CMAs and to leverage care manager extenders to support certain non-clinical functions, including providing general outreach and assisting with scheduling appointments. Additional guidance on the role of care manager extenders can be found on the Tailored Care Management webpage and in the Tailored Care Management Provider Manual.

In the Tailored Care Management rates, the Department assumed that a share of care manager productive time would be replaced by extenders who would take up certain non-clinical functions. This results in care managers being able to serve more members per FTE and reduces costs associated with the model. We describe these costs in greater detail below. Table 3 describes the Department's assumptions around the share of productive time borne by care managers and extenders.

Table 3: Care Team Workflow Assumptions (% of Productive Time Covered by Each Position)

Care Manager	Extender
70%	30%

Supervising Care Manager Workflow Assumptions

The Department requires that care managers providing direct services to members be supervised by a supervising care manager and that one supervising care manager will not oversee more than eight care managers.[7] AMH+ practices and CMAs with fewer than eight care managers may have a partial FTE as a supervising care manager as long as a 0.5 FTE supervising care manager is available (providers may share supervising care managers if it is more economical, as long the as required caseload ratios are maintained for each provider). Supervising care managers should not have a caseload but are expected to provide coverage for vacation and sick leave along with providing support, guidance, and quality control to care managers serving members directly.

Caseload Assumptions

Based on the contact and workflow assumptions described above, the Department developed a caseload assumption for purposes of constructing the rates only (i.e., the caseload assumption is not a programmatic requirement but was used to inform the rate development process). This ratio is expressed as a ratio of consented and actively engaged members per FTE care manager that could reasonably be served while ensuring that members receive all necessary contacts. Table 4 below describes the Department's caseload assumptions; this assumes that extenders are taking over a share of care manager responsibilities for each member, as described in the previous section and Table 3 above, allowing each FTE care manager to serve a larger number of members. Because there are additional care manager activities required to support members enrolled in the Innovations or TBI 1915(c) waivers or obtaining 1915(i) services (i.e., those eligible for the add-on payment), the Department assumed that if a care manager is serving members eligible for the add-on payment, their caseload would be lower. (The assumptions for the Innovations/TBI Waiver and 1915(i) services add-on payment rate are described in greater detail below.)

Table 4: Care Manager Caseload Assumptions (Consented and Actively Engaged Members Per FTE Care Manager)

Caseload of Members Not Receiving Add-On Payment	Caseload of Members Also Receiving Add-On Payment	Blended Average Caseload Including Members Receiving Add-On Payment
30.5:1	23.8:1	25.5:1

Note: Based on experience to date, blended average caseload assumes that 75% of a care manager's caseload are members enrolled in the Innovations or TBI 1915(c) waivers or obtaining 1915(i) services, and are therefore eligible for the add-on payment. In reality, the percentage of a care manager's caseload eligible for the add-on payment will vary among care managers.

[7] See Tailored Care Management Provider Manual (version published on February 9, 2024), Section V.3, available at: https://medicaid.ncdhhs.gov/documents/providers/playbook/tcm-provider-manual-20240209/download?attachment.

Cost Assumptions

The Department-calculated monthly payment rate is based on the cost of employing a sufficient number of care managers, extenders, and supervisors to align with the caseload ratio described above. Care manager, extender, and supervisor base salary assumptions were derived from North Carolina-specific salary data for professionals meeting the State's minimum qualifications from the Bureau of Labor Statistics reports reflective of salary information as of May 2022 with additional wage inflation to reflect a State Fiscal Year 2025 estimated wage level. In addition to base salaries, the personnel cost assumptions account for fringe benefits, including health insurance and paid time-off (PTO), in addition to employer-paid taxes. These cost assumptions are described in the table below:

Table 5: Key Staffing Cost Assumptions

Cost Component	Payment Rate Assumption
Care Manager Personnel Costs, Per FTE	**$80,621**
Base Salary	$62,497
Benefits and Employer-Paid Taxes	$18,124
Extender Personnel Costs, Per FTE	**$69,012**
Base Salary	$53,498
Benefits and Employer-Paid Taxes	$15,514
Supervising Care Manager Personnel Costs, Per FTE	**$95,869**
Base Salary	$74,317
Benefits and Employer-Paid Taxes	$21,552

Note: Salary assumptions reflect statewide averages. In reality, costs per FTE care manager will vary based upon experience and licensure/education.

In addition to staffing costs, the rates account for 15% in additional program-related and overhead costs per FTE care manager. The rates also account for costs associated with clinical consultant time.

The appendix at the end of this document displays an example rate build-up.

Innovations/TBI Waiver and 1915(i) Services Add-On Payment Rate

The Department offers an additional "add-on" payment rate for members enrolled in the State's Innovations or TBI 1915(c) waivers and members obtaining 1915(i) services in order to account for additional care manager responsibilities for these populations. For members enrolled in the 1915(c) waivers, care managers will be required to conduct additional care coordination activities, including monitoring 1915(c) waiver contact requirements, explaining the individual budgeting tool, and other related responsibilities. Similarly, for members obtaining 1915(i) services, additional care coordination activities include completing the 1915(i) independent assessment, incorporating the results of the assessment into the care management comprehensive assessment, and monitoring implementation of the Care Plan/ISP for members obtaining 1915(i) services beyond those required for other individuals engaged in Tailored Care Management. The Department recognizes that these functions require additional care manager time and established a monthly add-on payment rate to account for this. The add-on payment rate is automatically applied to the Tailored Care Management payment rate for members enrolled in the Innovations or TBI waiver or obtaining 1915(i) services during the billing month.

The Innovations/TBI waiver and 1915(i) services add-on payment rate is $79.73. This amount reflects the care manager personnel and other overhead costs described above and assumes that care managers will spend approximately 15 additional hours per member per year on these activities. This rate also reflects increases to wages and benefits based on inflation similar to what is outlined in the prior section. It does not assume that extenders will be able to fulfill any responsibilities related to Innovations/TBI waiver care coordination or 1915(i) services care coordination. These assumptions are for purposes of constructing the add-on payment rate only and do not reflect programmatic requirements.

Appendix: Example Full Rate Build-Up (Excluding Waiver/1915(i) Add-On Payment Rate)

Cost Component	Tailored Care Management Final Payment Rate
Annual Care Manager Wage and Benefit Costs (1.0 FTE)	$80,621
Annual Extender Wage and Benefit Costs (1.0 FTE)	$69,012
Annual Supervisor Wage and Benefit Costs (1.0 FTE)	$95,869
Total Care Team Wage and Benefit Costs (0.7 FTE Care Manager, 0.3 FTE Extender, and 0.125 FTE Supervisor)	$89,122
Annual Overhead and Program-Related Costs (15% of Total Costs, Inclusive of Overhead and Program-Related Costs)	$15,727
Total Annual Costs	$104,850
Total Monthly Costs	$8,737
Total Monthly Costs Per Engaged and Consented Member (30.5:1)	$287
Monthly Clinical Consultant Costs Per Engaged and Consented Member	$8
Total Tailored Care Management Payment Rate	**$294.86**

Note: Numbers are rounded to the nearest dollar for illustrative purposes (with the exception of the total Tailored Care Management payment rate).