Transitioning 1915(b)(3) Services to 1915(i) Authority: *Tailored Care Management Providers*

December 14, 2022

Updated April 2023

NOTE: Information on Tailored Plan launch date and requirements for the 1915(i) independent evaluation have been updated in this presentation to reflect the latest information

Agenda

- Reminder: Tailored Plan Launch Update
- Transition of 1915(b)(3) Benefits to 1915(i) Services
- Services Transitioning to 1915(i) Authority
- Deep Dive: 1915(i) Requirements
  - Eligibility
  - Care Management
  - Tailored Care Management Providers
  - 1915(i) Service Providers
  - Network Adequacy
  - Quality
- Q&A

Tailored Care Management Provider Role in 1915(b)(3) to 1915(i) Transition

- Tailored Care Management providers are critical in supporting members in the transition from 1915(b)(3) benefits to 1915(i) services.
- Tailored Plans and Tailored Care Management providers must ensure, that for members currently obtaining 1915(b)(3) benefits, the federally required independent assessment, independent evaluation, and Care Plan/ISP for 1915(i) services are conducted prior to October 1, 2023, so that these members retain access to services.
- To streamline processes for providers and beneficiaries, 1915(i) care management/care coordination requirements are embedded into the Tailored Care Management model to the maximum extent possible *(see slide 14).*

Review of Key Dates

- **Dec. 1, 2022**: Tailored Care Management begins
- **Early 2023:** Tailored Plans must begin conducting independent evaluations and independent assessments for members currently receiving 1915(b)(3) services
- **July 1, 2023:** Service delivery begins under 1915(i) federal authority for individuals that are determined eligible and authorized prior to 7/1.
- **October 1, 2023:** Tailored Plan launch

Today's session is an introductory training for Tailored Care Management providers. The Department will conduct additional trainings providing detailed information on 1915(i) responsibilities for care managers (e.g., conducting the independent assessment).

Transition of 1915(b)(3) Benefits to 1915(i) Services

- 1915(b)(3) benefits are a set of critical Home and Community-based Services (HCBS).
- LME/MCOs currently provide 1915(b)(3) services to Medicaid beneficiaries with significant behavioral health needs, I/DD, and TBI.
- On October 1, 2023, most individuals using 1915(b)(3) services will enroll in Tailored Plans; because of federal requirements, Tailored Plans cannot offer 1915(b)(3) services.
- **To ensure that individuals maintain access to these critical services, North Carolina is transitioning 1915(b)(3) benefits to 1915(i) authority by October 1, 2023.**
- The 1915(i) services will be available through:
  - ✓ **Tailored Plans**
  - ✓ **NC Medicaid Direct**, including individuals enrolled in the Tribal Option, and
  - ✓ **Children & Families Specialty Plan (CFSP)** (upon launch).

Note: While requirements in this presentation are framed in terms of Tailored Plans, they also apply to NC Medicaid Direct and the CFSP.

Services Transitioning to 1915(i)

As part of the transition to 1915(i), the Department is either retaining benefits in their current form or expanding the scope of existing benefits, such as making some benefits available to additional populations.

Current 1915(b)(3) Service		Future 1915(i) Services
In-Home Skill Building	➤	Community Living and Support
One-time Transitional Costs	➤	Community Transition
Individual Support	➤	Individual and Transitional Support *Integrates existing Individual Support, Transitional Living Skills, and Intensive Recovery Supports into one service*
Transitional Living Skills		
Intensive Recovery Supports*		
Respite	➤	Respite
Supported Employment	➤	Supported Employment

The Department will release clinical coverage policies for the new 1915(i) services.

*North Carolina is planning to update its State Plan Amendment (SPA) to incorporate intensive recovery supports.

1915(b)(3) Services Transitioning to Other Medicaid Programs

The community navigator/community guide and deinstitutionalization 1915(b)(3) benefits will be offered under different Medicaid programs instead of under 1915(i) authority.

Current 1915(b)(3) Service		Future Coverage
Community Navigator/ Community Guide	➤	• **Tailored Care Management**, the primary care management program for beneficiaries in Tailored Plans, **will encompass** the community navigator/community guide benefit covered by 1915(b)(3). • Beneficiaries enrolled in Tailored Care Management will **have access to the range of supports offered today** by community navigators.**
Deinstitutionalization (DI) Services*	➤	• Current 1915(b)(3) DI services will only be available through **the 1915(c) Innovations waiver** as of Tailored Plan launch.

*The Department will be transitioning individuals currently receiving (b)(3) DI services to the Innovations waiver effective 4/1/2023.
**Community Navigator will continue to be offered as a standalone benefit for individuals enrolled in the Innovations waiver who are self-directing their services; however, its scope will change to only focus on self-direction functions.

Context: 1915(i) Service Requirements

Tailored Plan contracts and Tailored Care Management standard terms and conditions are being amended to include contractual requirements related to the delivery of 1915(i) services. Contractual requirements have been developed to comply with relevant federal requirements.

Key Requirements

This presentation will provide an overview of requirements in the following key areas:

- Eligibility
- Care Management
- Tailored Care Management Providers
- 1915(i) Service Providers
- Network Adequacy
- Quality

The Department has made efforts to align 1915(i) requirements with the following existing requirements, where applicable:

- **1915(c) Innovations and TBI waiver requirements**, in order to simplify processes for service providers
- **Tailored Care Management requirements**, given that all beneficiaries eligible for 1915(i) services are also eligible for Tailored Care Management

Deep Dive: 1915(i) Requirements

Process Flow: Accessing 1915(i) Services in Tailored Plans

1 Beneficiary Need Identified

- Beneficiary visits PCP, BH, I/DD, or other provider.
- PCP, BH, I/DD, or other provider identifies that the beneficiary needs a 1915(i) service.
- PCP, BH, I/DD, or other provider refers beneficiary to their care manager to determine eligibility.

2 Independent Assessment

- The beneficiary's tailored care manager, either at a Tailored Plan or AMH+/CMA, conducts the independent assessment in order to identify the beneficiary's needed services and supports, inform the independent evaluation of 1915(i) eligibility, and inform a Care Plan/ISP.

3 Independent Evaluation

- The beneficiary's care manager submits the independent assessment to Carelon, who will collect assessments for the Department.
- The Department will subsequently conduct the standardized independent evaluation to determine if beneficiary meets needs-based eligibility criteria for 1915(i) services.

4 Care Plan/ISP

- The care manager assists the beneficiary in identifying 1915(i) service provider(s).
- The care manager develops the Care Plan/ISP with the beneficiary and other identified representatives.
- The care manager ensures the Care Plan/ISP reflects the beneficiary's:
  - Needed services and supports
  - Preferences for the delivery of services, and
  - Name of the service provider.

5 Prior Authorization

- The care manager submits completed Care Plan/ISP to the beneficiary's Tailored Plan for review.
- The beneficiary's Tailored Plan conducts prior authorization of the 1915 service(s).

6 Service Delivery & Care Coordination

- The care manager follows up with 1915(i) service provider(s) to implement the authorized 1915(i) service(s) according to the Care Plan/ISP.
- The care manager provides ongoing care coordination.

Eligibility

Beneficiary Eligibility for 1915(i) Services

Eligibility for 1915(i) services varies on a benefit-by-benefit basis. Eligible populations include beneficiaries with an I/DD, TBI, serious mental illness (SMI), serious emotional disturbance (SED), or severe substance use disorder (SUD) who meet need-based criteria set by the Department.*

	I/DD	SED	SMI	SUD	TBI
Community Living and Support	✓				✓
Community Transition	✓		✓	✓	✓
Individual and Transitional Support		✓ *ages 16-21*	✓ *ages 18+*	✓	
Respite	✓	✓ *ages 3-20*		✓ *ages 3-20*	✓
Supported Employment	✓ *ages 16+*	✓ *ages 16+*	✓ *ages 16+*	✓ *ages 16+*	✓ *ages 16+*

Needs-Based Criteria
• Have a functional deficit • Can benefit from skill acquisition (e.g., self-determination, independent living) ***or*** • Can benefit from assistance in monitoring a health condition/living skills
• Moving to own community living arrangement and need initial set-up expenses/items
• At least one deficit in an instrumental activity of daily living (e.g., meal preparation)
• Unable to care for themselves in the absence of their primary caregiver
• Express the desire to work • Has a pattern of under/unemployment ***or*** • Have educational goals that relate to employment goals

*Beneficiaries are not required to meet an institutional level of care to be eligible for 1915(i) benefits.

Determining Eligibility for 1915(i) Services

A beneficiary's tailored care manager or care coordinator (if opted out of care management) has responsibility to administer an independent assessment in line with federal requirements. The Department will determine eligibility for 1915(i) services.

Independent Assessment

Responsible Entity: Care managers/coordinators, whether they are based at an AMH+/CMA or Tailored Plan, must conduct the independent assessment.

Purpose: Determine eligibility for 1915(i) services following referral from a beneficiary's PCP, BH, or I/DD provider; Identify a beneficiary's needs and 1915(i) services they would benefit from; Inform a service plan for 1915(i) services that will be incorporated into the beneficiary's Care Plan/ISP.

Independent Evaluation

Responsible Entity: The Department will conduct the independent evaluation.

Purpose: Determine the beneficiary meets the needs-based eligibility criteria for 1915(i) service(s).

Care Management

Overview: 1915(i) Requirements are Embedded into Tailored Care Management

1915(i) care management requirements are embedded into the Tailored Care Management model to the maximum extent possible and are designed to be incorporated into Tailored Care Management workflows.

1915(i) & Tailored Care Management

- **AMH+/CMA Certification.** All AMH+/CMAs must have the capability to perform Tailored Care Management for members obtaining 1915(i) benefits.
- **Care Manager Qualifications**. Qualifications for care managers serving members obtaining 1915(i) services are the same as qualifications to provide Tailored Care Management.
- **Care Manager Assignment.** The beneficiary's assigned care manager, whether at a Tailored Plan or AMH+/CMA, will provide care coordination for 1915(i) services. Members will be able to retain their care manager if they become eligible for a 1915(i) services.
- **Care Manager Training.** All care managers providing Tailored Care Management must be trained on the eligibility, assessment, and coordination of 1915(i) services.
- **Care Plan/ISP.** Care managers will incorporate incorporates the results of the 1915(i) independent assessment into the beneficiary's existing Care Plan/ISP. The beneficiary's Care Plan/ISP will be submitted to Tailored Plans for 1915(i) service authorization.
- **Care Management Comprehensive Assessment.** The beneficiary's annual care management comprehensive re-assessment will include the 1915(i) independent re-assessment.
- **Ongoing Care Management.** Care managers will monitor service delivery and support coordination of 1915(i) services for beneficiaries as part of ongoing Tailored Care Management.

Care Management: Person-Centered Planning & Care Plan/ISP

Beneficiaries obtaining 1915(i) services must have a Care Plan/ISP that identifies needed 1915(i) services, informed by the independent assessment. The Care Plan/ISP must also reflect the goals and preferences of the beneficiary.

Person-Centered Planning & Care Plan/ISP Requirements

Care managers must complete the following requirements to determine the 1915(i) services needed by a beneficiary:

- **Independent Assessment:** Conduct the independent assessment for beneficiaries and incorporate results into the beneficiary's Care Plan/ISP.
- **Care Team Meeting:** Explain options regarding the 1915(i) services available to the beneficiary (e.g., service duration) and convene a person-centered planning meeting to complete the Care Plan/ISP.
- **Service Authorization:** Submit the Care Plan/ISP to the Tailored Plan for service authorization.

Care Management: Prior Authorization

Care managers will submit the beneficiary's Care Plan/ISP to the Tailored Plan for service authorization. Tailored Plans will review and approve/deny the Care Plan/ISP.

Prior Authorization

- **Service Authorization*.** Tailored Plans must review and approve/deny a beneficiary's initial Care Plan/ISP within 60 Days of 1915(i) eligibility determination.
- **Service Initiation.** Tailored Plans must ensure 1915(i) services begin within 45 days of Care Plan/ISP approval.
- **Immediately Needed Services.** In the event a 1915(i) service is "immediately needed", care managers may complete and submit an interim plan of care to the Tailored Plan so that services may be approved.
    - Care managers must subsequently complete the full Care Plan/ISP within 60 days of eligibility determination for 1915(i) services.

"Immediately needed" 1915(i) services are defined as services that a beneficiary needs in order to:

- Facilitate discharge from an inpatient setting
- Prevent inappropriate placement in an inpatient setting
- Prevent placement outside the person's current living arrangement
- Address behavioral health/psychiatric conditions that place the person or others at risk of harm
- Prevent imminent loss of competitive integrated employment or offer of such employment

* Standard Service Authorization turnaround times apply for the 1915(i) services.

Care Management: Intersection of 1915(i) Care Coordination & Tailored Care Management

All beneficiaries eligible for 1915(i) services are eligible for Tailored Care Management. Accordingly, Tailored Care Management will incorporate all required 1915(i) care coordination activities so that a person can obtain 1915(i) care coordination through their assigned care manager.

Beneficiaries Engaged in Tailored Care Management

Responsible Entity: The beneficiary's assigned care manager, whether at a Tailored Plan or AMH+/CMA, will provide care coordination for 1915(i) services.

Beneficiaries who have Opted Out of Tailored Care Management

Responsible Entity: The beneficiary's Tailored Plan will provide care coordination for 1915(i) services (e.g., conducting independent assessment, completing Care Plan/ISP).

For beneficiaries engaged in Tailored Care Management, The Tailored Plan must:

- **Notify** the beneficiary's organization providing Tailored Care Management the beneficiary has been determined eligible for 1915(i) services.
- **Share** the results of the independent evaluation for 1915(i) services with the beneficiary's organization providing Tailored Care Management.

Care Management: Additional Care Coordination Requirements

1915(i) care coordination is required regardless of whether a beneficiary engages in Tailored Care Management. The beneficiary's assigned care manager, whether at a Tailored Plan or AMH+/CMA, will provide care coordination for 1915(i) services.

1915(i) Care Coordination Requirements

- Explaining the service authorization process
- Assisting in choosing a qualified provider to implement 1915(i) service(s) (e.g., providing a list of available providers and arranging provider interviews)
- Monitoring Care Plan/ISP goals
- Maintaining close contact with the beneficiary, providers and other members of the care team
- Promoting the delivery of services and supports in the most integrated setting that is clinically appropriate for the beneficiary
- Updating the independent assessment at least annually or as significant changes occur*
- Notifying the appropriate Tailored Plan of updates to 1915(i) service eligibility
- Monitoring of service delivery

*For beneficiaries in Tailored Care Management and obtaining 1915(i) services, the care manager must complete the independent assessment as part of the annual care management comprehensive reassessment

Care Management: Qualifications & Training

All AMH+/CMAs must have the capability to perform Tailored Care Management for individuals obtaining 1915(i) benefits. Accordingly, beneficiaries will be able to retain their care manager if they become eligible for a 1915(i) services.

Care Manager Qualifications

Qualifications for care managers serving beneficiaries obtaining 1915(i) services are the same as qualifications to provide Tailored Care Management:

- Meet North Carolina's definition of a Qualified Professional per 10A-NCAC 27G.0104

Care Manager Training

All care managers providing Tailored Care Management must be trained on the eligibility, assessment, and coordination of 1915(i) services including:

- Process for conducting the independent assessment,
- Knowledge of available resources, service options, providers,
- Requirements for ongoing coordination and monitoring of 1915(i) services, and
- Best practices to improve health and quality of life outcomes

Tailored Care Management Providers

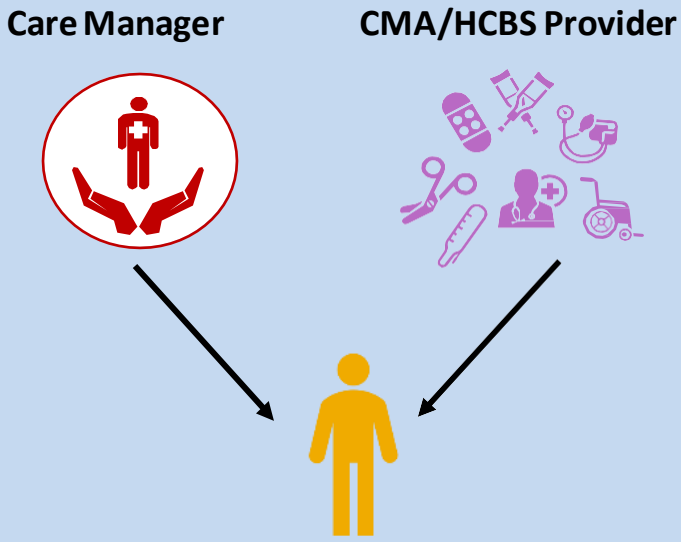
Requirements for Tailored Care Management Providers

Care coordination for 1915(i) services must comply with federal conflict of interest requirements, including conflict-free care management, in order to promote consumer choice and limit bias by a care manager when identifying HCBS needs and developing plans to access services.

Tailored Care Management Providers

Providers must abide with federal conflict-free care management requirements.

A behavioral health or I/DD provider acting as a CMA **cannot deliver both Tailored Care Management and HCBS**, including 1915(i) services, to the **same beneficiary**.



1915(i) Service Providers

Requirements for 1915(i) Service Providers

1915(i) service providers must meet provider qualifications required by the Department, as outlined in the 1915(i) SPA.

1915(i) Service Providers

All providers delivering 1915(i) services, with the exception of those delivering Community Transitions, must:

- Be enrolled in NC Medicaid;
- Meet provider qualification policies, procedures, and standards established by the Department;
- Fulfill the requirements of 10A-NCAC 27G;
- Comply with all applicable federal and state requirements (e.g., statutes, rules, policies, communication bulletins and other published instructions released by the Department); and
- Meet national accreditation within one year of enrollment.*

Providers delivering the Community Transitions 1915(i) services must:

- Meets applicable state and local regulations for type of service that the provider/supplier is providing as approved by the Tailored Plan.

Provider requirements for the following 1915(i) services will mirror 1915(c) Innovations requirements:

- Community Living and Support
- Supported Employment for IDD
- Respite

*Accreditation by the Council on Accreditation (COA), the Council on Quality and Leadership (CQL), the Council on Accreditation of Rehabilitation Facilities (CARF), or The Joint Commission

Network Adequacy

Network Adequacy

Tailored Plans have responsibility for ensuring there are sufficient 1915(i) service providers to meet the following network adequacy requirements:

	≥ 2 service providers within each Tailored Plan Region	≥ 2 service providers within 45 minutes of the beneficiary's residence	Not subject to standard
Community Living and Support	✓		
Individual and Transitional Support	✓		
Supported Employment	✓		
Respite	✓ *Out-of-home respite*	✓ *In-home respite*	
Community Transition			✓

Quality

Quality

Tailored Plans will be required to report 1915(i) quality measures in the following seven domains, in line with federal requirements:

Eligibility Requirements

- Evaluation for 1915(i) eligibility is provided to all applicants with reasonable indication that 1915(i) services may be needed
- State uses processes and instruments described in the SPA to determine 1915(i) eligibility
- 1915(i) eligibility is reevaluated at the frequency specified in the SPA (at minimum annually)

Abuse, Neglect, Exploitation

- State identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation

Service Plans

- Address assessed needs of 1915(i) participants
- Are updated annually
- Document choice of services and providers

Financial Accountability

- State maintains financial accountability for services that are authorized and furnished to 1915(i) participants

Providers

- Meet required qualifications

Oversight

- State retains authority and responsibility for program operations and oversight

HCB Settings

- Meet requirements specified in the SPA and federal regulation

Q&A

Appendix: 1915(i) Service Codes/Modifiers

1915(i) service codes and modifiers are listed below for reference.

Code	Modifier(s)	1915(i) Service
H0043	U4	Community Transition
H0045	U4	Respite
H0045	HQ U4	Respite Group Child
H0045	HQ HB U4	Respite Group Adult
H2023	U4	Supported Employment Initial
H2026	U4	SE Maintenance
T1019	U4	Individual and Transitional Support
T1019	U4 TS	Individual and Transitional Support (non-EVV, only in the community)
T2012	U4	Community Living and Supports (only in the community –non-EVV)
T2013	HQ U4	Community Living and Supports Group
T2012	GC U4	Community Living and Supports relative as provider lives in home (non-EVV)
T2013	TF U4	Community Living and Supports Individual