NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Behavioral Health and Intellectual/Developmental Disability Tailored Plan

Updated Guidance on Tailored Care Management Payments
January 19, 2022

Overview of Tailored Care Management Rates

Note: This memorandum is an updated version of previous guidance released on May 14, 2021. Through this update, we provide the final Tailored Care Management rates for contract year 1 and provide additional detail on the development of the rates. Key updates to the previous guidance are in red.

In recognition of the significant time and resource commitment required to successfully implement the Tailored Care Management model, provider payment rates will be significantly higher than those paid for Standard Plan care management. Each Tailored Plan member will be assigned to an "acuity tier," as defined by the Department; the acuity tier will determine a per member per month (PMPM) rate for each beneficiary, with providers being paid more for high acuity beneficiaries and vice versa. Acuity tiers will account for a range of beneficiary characteristics, including behavioral health, I/DD, or traumatic brain injury (TBI)-related needs, chronic physical health conditions, pharmacy utilization, service utilization (e.g., emergency department), non-health related resource needs, and other factors. Tailored Plans will be required to pass the full amount of these rates through to AMH+ and CMA providers and may not retain a portion for members assigned to an AMH+ or CMA.[1] In Table 1 below, the Department provides final rates by acuity tier for contract year 1, which will begin on December 1, 2022. These rates were updated to reflect more recent wage data and account for new guidance from the Department on use of care manager "extenders" in the Tailored Care Management model.[2] The Department has also established an "add-on" payment that will be available for all members enrolled in the Innovations or TBI 1915(c) waivers to account for the additional monthly care management responsibilities associated with the waivers. We describe the Department's approach to developing the updated rates in greater detail below.

Table 1: Tailored Care Management Rates (PMPM), Contract Year 1

Acuity Tier[3]	Preliminary Rate (PMPM)[4]	Final Rate (PMPM)
BH, Low Acuity	$160	$162.08
BH, Moderate Acuity	$260	$269.66
BH, High Acuity	$360	$395.06
I/DD or TBI, Low Acuity	$90	$100.81

[1] Tailored Plan capitation rates account for costs associated with Tailored Plan 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 even when care management is being provided by an AMH+ or CMA.
[2] Guidance on care manager extenders can be found on the Tailored Care Management web page.
[3] Note: The Department is considering establishing separate rates to account for the unique circumstances of Innovations and TBI waiver enrollees.
[4] As established in the Tailored Care Management Draft Rate Book.

Acuity Tier[3]	Preliminary Rate (PMPM)[4]	Final Rate (PMPM)
I/DD or TBI, Moderate Acuity	$260	$269.66
I/DD or TBI, High Acuity	$320	$395.06
New: Innovations/TBI Waiver Add-on Payment	N/A	$78.94

In order to access the PMPM rate for any given beneficiary, providers must deliver at least **one** care management contact during the month for that member (i.e., providers will not be paid in months in which there were no member contacts). The provider will be required to submit a claim to the Tailored Plan, and the Tailored Plan will pay the provider the PMPM rate after the month of service. The Department will provide additional guidance on billing policies and procedures prior to launch.

Rates were constructed by translating minimum contact requirements, as described in the next section, into estimated 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 PMPM amount. 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.

Care Manager Time Assumptions

Contact Requirements

As described in previous Departmental guidance and the Tailored Plan request for applications (see the Tailored Care Management webpage for these materials), Tailored Plans will monitor providers to ensure they are providing the appropriate level of care management support to assigned members, as reflected by their acuity tier. These contact requirements are described below and were developed with input from clinicians and other professionals with deep expertise working with populations with behavioral health, I/DD, and TBI needs. The Department may consider refinements to the contact requirements to better reflect the needs of the Tailored Plan population. Accordingly, contact requirements are subject to change.

Table 2: Tailored Care Management Contact Requirements

Acuity Tier	Members with BH Needs	Members with an I/DD or TBI
High	At least 4 care manager-to-member contacts per month, including at least 1 in-person contact.	At least 3 care manager-to-member contacts per month, including 2 in-person contacts.
Medium	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.

Notes: Contacts that are not required to be in-person may be telephonic or through two-way real time video and audio conferencing. For members with an I/DD or TBI who have a guardian, telephonic or two-way real time video and audio conferencing contacts may be with a guardian in lieu of the member, where appropriate or necessary. In-person contacts must involve the member.

The Department will provide additional detail on how it plans to monitor contact requirements prior to launch. The Department anticipates that providers will have flexibility to deliver a variable number of contacts in each month without facing penalties as long the provider is delivering the minimum number of contacts on average over the course of the plan year. The Department is also considering whether "collateral" contacts with other providers, school personnel, or other individuals involved in a member's care will count toward fulfillment of contact requirements.

The Tailored Care Management rates are built off of the contact requirements above. In developing the rates, the Department assumed 1 hour per telephonic contact (30 minutes for the contact and 30 minutes for preparation and documentation) and 2 hours per in-person contact (1 hour for the contact and 1 hour for travel, preparation, and documentation; this represents a 30 minute increase in contact time relative to the assumptions underlying the draft rates). It assumed between 15 and 45 minutes per member per month, depending on member acuity, for additional time spent working with the member's care team. The Department also assumed five hours per week for non-member-related activities, such as staff meetings and other typical employment activities (e.g., completion of time cards, supervisor meetings, etc.), and that care managers operate at 95% capacity at any given time. Additionally, the caseloads and rates consider paid time off (PTO) for holidays and vacation.

In the below table, we describe an example time allocation for a care manager with a caseload of all moderate acuity BH members. In practice, the Department expects that care managers' caseloads will be comprised of a mix of acuity levels.

Table 3: Example Care Manager Workload Distribution, BH Moderate Acuity Member

Activity	Share of Care Manager Time
Member-Related Activities	**82%**
Member Contact Time (In-Person and Telephonic)	36%
Travel/Documentation/Preparation for Member Contacts	36%
Care Team Meetings/Additional Clinical Time	10%
Non-Member-Related Activities	**13%**
Non-Productive Time for Assumed Caseload Turnover	**5%**

Note: numbers may not sum due to rounding.

New: Care Manager Extender Assumptions

DHHS 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 AMH+/CMA providers and Tailored Plans to leverage care management "extenders" to support certain non-clinical functions, including providing general outreach and assisting with scheduling appointments. Additional guidance on the role of on care manager extenders can be found on the Tailored Care Management web page.

In finalizing 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). In general, the Department has assumed that extenders will be able to take over a greater share of activities for lower acuity members. Table 4 describes the Department's assumptions around the share of productive time borne by care managers and extenders by acuity tier.

Table 4: Care Team Workload Assumptions (% of Productive Time Covered by Each Position)

Acuity Tier (*Assumptions Do Not Differ Across BH and I/DD/TBI Populations*)	Care Manager	Extender
High	80%	20%
Medium	70%	30%
Low	60%	40%

Caseload Assumptions

Based on the contact requirements and workload assumptions described above, the Department developed a series of caseload assumptions for purposes of constructing the rates only (i.e., the caseload assumptions are not programmatic requirements but were used to inform the rate development process). These ratios are expressed as a ratio of assigned, actively engaged members per FTE care manager that could reasonably be served while ensuring that members receive all required contacts. Table 5 below describes the Department's revised caseload assumptions; these assume that extenders are taking over a share of care manager responsibilities for each member, as described in the previous section and Table 4 above, allowing each FTE care manager to serve a larger number of members.

Table 5: Care Manager Caseload Assumptions (Actively Engaged Members Per FTE Care Manager)

Acuity Tier	Members with BH Needs	Members with an I/DD or TBI
High	29:1	29:1
Medium	46:1	46:1
Low	87:1	142:1

Supervising Care Manager Caseload Requirements

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.[5] AMH+ providers 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

[5] The Department is open to feedback from the field on the appropriate ratio of care managers to supervising care managers.

coverage for vacation and sick leave along with providing support, guidance, and quality control to care managers serving members directly.

Cost Assumptions

The Department calculated PMPM rates based on the cost of employing a sufficient number of care managers to maintain the caseload ratios described above. Care manager, supervisor, and extender 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. In addition to base salaries, the personnel cost assumptions account for fringe benefits, including paid time-off (PTO). In developing the final rates, the Department has updated its staffing cost assumptions to reflect more recent wage data. These cost assumptions are described in the table below:

Table 6: Key Staffing Cost Assumptions

Cost Component	Preliminary Rate Assumption	Final Rate Assumption
Care Manager Personnel Costs, Per FTE	**$75,944**	**$80,461**
Base Salary	$58,871	$62,373
Benefits	$17,073	$18,088
New: Extender Personnel Costs, Per FTE	N/A	**$60,545**
Base Salary	N/A	$46,934
Benefits	N/A	$13,611
Supervising Care Manager Personnel Costs, Per FTE	**$88,488**	**$89,750**
Base Salary	$68,595	$69,574
Benefits	$19,893	$20,176

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. They also account for costs associated with clinical consultant time. These clinical consultant cost amounts range from $4.25 PMPM for low acuity members to $21.25 PMPM for high acuity members based on assumed amount of time required for consultants, which varies by acuity tier.

The appendix displays an example rate build-up for a moderate acuity member with BH needs.

New: Innovations/TBI Waiver Add-On Payment

In addition to the rate adjustments described above, the Department has also determined that it will offer an additional PMPM "add-on" payment for members enrolled in the State's Innovations or TBI 1915(c) waivers in order to account for additional care manager responsibilities for these populations. For members enrolled in these 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. The Department recognizes that these functions will require additional care manager time and has decided to establish an "add-on" payment to account for this. The "add-on"

payment will be automatically applied to the regular PMPM care management payment for members enrolled in the Innovations or TBI waiver during the billing month.

The Innovations/TBI waiver add-on payment will be $78.94 PMPM for all members regardless of acuity tier. 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. It does not assume that extenders will be able to fulfill any responsibilities related to Innovations/TBI waiver care coordination.

Appendix: Example Full Rate Build-Up, Moderate Acuity Member with a Behavioral Health Condition

Cost Component	PMPM Amount – Preliminary Rates	PMPM Amount – Final Rates
Annual Care Manager Wage and Benefit Costs (1.0 FTE)	$75,944	$80,461
New: Annual Extender Wage and Benefit Costs (1.0 FTE)	N/A	$60,545
Annual Supervisor Wage and Benefit Costs (1.0 FTE)	$88,488	$89,750
Supervisor Wage and Benefit Costs Per FTE Care Manager (0.125 FTE)	$11,061	$11,219
Total Care Team Wage and Benefit Costs (Preliminary Scenario – 1.0 FTE Care Manager and 0.125 FTE Supervisor; Final Scenario – 0.7 FTE Care Manager, 0.3 FTE Extender, and 0.125 FTE Supervisor)	$87,004	$85,705
Annual Overhead and Program-Related Costs (15% of Total Costs, Inclusive of Overhead and Program-Related Costs)	$15,354	$15,124
Total Annual Costs	$102,358	$100,829
Total Monthly Costs	$8,530	$8,402
Total Monthly Costs Per Case (33:1 Under Preliminary Scenario; 32:1 Under Final Scenario Reflective of Managed Caseload Across Care Manager and Care Extender)	$258	$263
PMPM Clinical Consultant Costs	$7	$7
Total PMPM Rate	$265	$269.66

Note: Numbers are rounded to the nearest dollar for illustrative purposes (with the exception of the total PMPM rates).