Guidance on the Use of Care Manager Extenders in Tailored Care Management

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Under Tailored Care Management, all Tailored Plan members will have access to a dedicated care manager who will work with a multidisciplinary care team to deliver integrated, whole-person care management addressing a member's physical health, behavioral health, intellectual/developmental disability (I/DD), traumatic brain injury (TBI), long-term services and supports (LTSS), and/or pharmacy needs, in addition to unmet health-related resource needs. The purpose of this document is to provide guidance on how "care manager extenders" (hereafter, referred to as extenders) can support care managers in delivering Tailored Care Management and fulfilling the member contact requirements.

The North Carolina Department of Health and Human Services' (the Department's) vision is that extenders will help Advanced Medical Home Plus (AMH+) practices, Care Management Agencies (CMAs), and Tailored Plans best meet the needs of members, build efficient care teams by creating additional workforce capacity, and allow care managers and supervisors to focus on key tasks for assigned members as well as permit them additional time for members with intensive or complex needs. This document provides guidance on the Department's expectations regarding the use of extenders, including their qualifications, functions they may perform, training, and payment considerations.

Note: *This guidance only applies to extenders. The specific roles and functions for other members of the care team (e.g., primary care provider, psychiatrist, pharmacist) are outside the scope of this guidance document. See the Tailored Care Management Provider Manual for a full list of potential care team members and requirements.*[1]

Extender Qualifications

For the purposes of Tailored Care Management, an extender is defined as an individual who:

- Is at least 18 years of age;
- Has a high school diploma or equivalent;
- Is trained in Tailored Care Management (as described later in this document);
- Is supervised by a care manager at an AMH+ practice, CMA, or Tailored Plan, and meets one of the below requirements:
    - Be a person with lived experience with an I/DD or a TBI with demonstrated knowledge of and direct personal experience navigating the North Carolina Medicaid delivery system.
      or
    - Be a person with lived experience with a behavioral health condition who is a Certified Peer Support Specialist.
      or
    - A parent or guardian of an individual with an I/DD or a TBI or a behavioral health condition and has at least two years of direct experience providing care for and navigating the Medicaid delivery system on behalf of that individual (parent/guardian cannot serve as an extender for their family member).
      or

[1] The latest version of the Tailored Care Management Provider Manual is available at https://medicaid.ncdhhs.gov/transformation/tailored-care-management.

- Has two years of paid experience performing the types of functions described in the "Extender Functions" section below, with at least one year of paid experience working directly with the Tailored Care Management eligible population.

The Department expects that a range of individuals will be able to meet these qualifications, including, but not limited to:

- Certified Peer Support Specialists;
- Community health workers (CHW), defined as individuals who have completed the NC Community Health Worker Standardized Core Competency Training (NC CHW SCCT);
- Individuals who served as Community Navigators prior to the implementation of Tailored Plans;
- Family Navigators, as defined by Trillium Health Resources' approved LME/MCO in lieu of service description;
- Parents or guardians of an individual with an I/DD or a TBI or a behavioral health condition (parent/guardian cannot serve as an extender for their own family member); and
- A person with lived experience with an I/DD or a TBI or a behavioral health condition.

Extender Functions

The Department expects that certain components of Tailored Care Management will always be led by a care manager. However, based on a review of the scope of responsibilities currently performed by Community Navigators and Certified Peer Support Specialists and included in the CHW core competency training, the Department has identified functions that an extender may perform as part of Tailored Care Management.

Care Manager-Only Activities
A care manager must be solely responsible for: • Completing the care management comprehensive assessment; • Developing the care plan (for members with behavioral health needs) or individual support plan (ISP) (for members with I/DD and TBI needs); • Facilitation of case conferences; • Ensuring that medication monitoring[2] and reconciliation occur; • Continuous monitoring of progress toward the goals identified in the care plan or ISP; and • Managing care transitions, including creating 90-day transition plans.

[2] The AMH+ or CMA or Tailored Plan care manager must conduct medication monitoring, including regular medication reconciliation (conducted by the appropriate care team member) and support of medication adherence. A community pharmacist at the clinically-integrated network (CIN) level, in communication with the AMH+ or CMA, may assume this role.

Extender Functions

Extenders may support care managers in delivering Tailored Care Management by performing activities that fall within the below categories:

- Performing general outreach, engagement, and follow-up with members;
- Coordinating services/appointments (e.g., appointment/wellness reminders, arranging transportation);
- Engaging in health promotion activities (as defined in the Tailored Care Management Provider Manual) and knowledge sharing;
- Sharing information with the care manager and other members of the care team on the member's circumstances;
- Providing and tracking referrals and providing information and assistance in obtaining and maintaining community-based resources and social support services;
- Participating in case conferences;
- Support the care manager in assessing and addressing unmet health-related resource needs.

A care manager should directly supervise extenders and ensure that they are only performing functions within their training, scope, and abilities, given that some extenders will have limited experience working with individuals with significant behavioral health, I/DD, and TBI needs. Supervising care managers, care managers, and extenders should be in regular communication and coordinate their efforts to mitigate duplicative or inappropriate outreach to assigned members.

Extender Functions and Contact Requirements

When an extender performs one of the functions listed above, it may count as a Tailored Care Management contact if phone, video and audio, or in-person contact with the member is made.

The care manager must deliver the majority of contacts. For rate modeling purposes only, the Department estimated extenders will conduct approximately 40% of contacts for low-acuity members, 30% of contacts for moderate-acuity members, and 20% of contacts for high-acuity members. These percentages are not requirements and the Department recognizes that care manager and extender contacts will vary across members. Additionally, there may be times when most or all contacts are done by the care manager — for example, during the completion of a care management comprehensive assessment and development of the ISP. AMH+ practices, CMAs, and Tailored Plans can consider these estimates and factors when developing staffing plans.

Tailored Care Management Contact Requirements

Acuity Tier	Members with behavioral health needs	Members with an I/DD or a TBI
High	At least 4 member contacts per month, including at least 1 in-person contact.	At least 3 member contacts 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).

Extender Tailored Care Management Training Requirements

To ensure that extenders are prepared to support Tailored Plan members, the Department will require that all extenders complete the full Tailored Care Management training curriculum, regardless of whether they are based at an AMH+ practice, CMA, or Tailored Plan. Additionally, to ensure extenders are sufficiently prepared and capable to perform their duties, extenders' training must include practical ("hands-on") training modalities and evaluation, which may include role play, use of call scripts, and practice sessions.

As described in the Tailored Plan Request for Applications, each Tailored Plan is designing and will implement a training plan using Department guidelines on the topics that must be covered (See Appendix for list of topics). Tailored Plans are required to identify core modules that care managers and extenders must complete before being deployed to serve members; care managers and extenders must complete the remaining training modules within 30 days of being deployed to serve members.

Tailored Care Management Payment Considerations

As described in previous Departmental guidance, AMH+ practices, CMAs, and Tailored Plans will be paid a retrospective monthly Tailored Care Management rate for each member who has engaged in Tailored Care Management in the previous month that varies based on the member's acuity, with rates being higher for members determined to be at a higher acuity. The Department is not requiring a specific caseload for care managers and instead, as specified above, has defined the expected number of contacts a member should receive based on their acuity tier. Within the monthly payment rate, AMH+ practices, CMAs, and Tailored Plans have the flexibility to staff care managers and extenders to meet the contact requirements, as long as they meet parameters established by the Department, including that:

- Care managers must be supervised by a supervising care manager;
- Extenders cannot work for the same organization where they receive services;
- Extenders must be supervised by a care manager and remain within the scope delineated in this guidance document;
- Care managers should supervise no more than two FTE extenders;
- One supervising care manager will not oversee more than eight care managers (AMH+ providers and CMAs with fewer than eight care managers may have a partial FTE; see the January 2022 guidance for more information); and
- Only contacts delivered by the assigned care manager or extender will count towards meeting the contact requirements and be eligible for payment. In the event that the supervising care manager is providing coverage for a care manager (e.g., sick leave, vacation, staff turnovers) and delivers a contact to a member, the contact will count towards meeting contact requirements and be eligible for payment.

The Department conducted financial modeling to determine how the use of extenders impacts payment rates and determined that the use of extenders does not necessitate an increase in the rates[3] because

[3] This analysis is part of a broader effort the Department is undertaking to review and update rates.

extenders should make care managers more efficient. When extenders conduct the functions listed above, they are conducting the function **instead** of a care manager, not **in addition to** the care manager. For example, for some lower-acuity members, the extender may play a significant role in delivering Tailored Care Management and meeting contact requirements, freeing up time for care managers to focus on key tasks for assigned members as well as permit them additional time for members with intensive or complex needs

Note: A Certified Peer Support Specialist serving as an extender who is completing Tailored Care Management contacts for a member cannot also bill for Peer Support Services, provided under Clinical Coverage Policy No. 8G for the same member. In other words, for a single member, a Certified Peer Support Specialist can either conduct Tailored Care Management contacts **or** provide Peer Support Services under Clinical Coverage Policy No. 8G, but not both.

Questions on this policy may be submitted via email to Medicaid.TailoredCareMgmt@dhhs.nc.gov.

Appendix

Tailored Care Management Training Topics

Tailored Plans must develop and implement a care management training curriculum that includes the following domains at a minimum:

- Tailored Plan eligibility and services
- Whole-person health and unmet resource needs
- Components of Health Home/Tailored Care Management
- Ethics, boundaries, and personal safety
- Building a trusting relationship
- Community integration
- Health promotion
- I/DD- and TBI-specific trainings (if working with members from these communities)
- Transitional care management
- Skills to support health behavior change, including motivational interviewing
- Person-centered needs assessment and care planning, including LTSS and other needs
- Preparing members for and assisting them during emergencies and natural disasters
- Infection control and prevention practices
- Understanding virtual/telehealth applications
- Needs of justice-involved individuals
- Additional trainings for serving:
    - Children
    - Children with complex needs
    - Pregnant and postpartum persons with substance use disorder (SUD) or with SUD history
    - Members with LTSS needs