1915(i) State Plan Amendment Training:
Tailored Care Management & Providers Q&A July 27, 2023

Question	Answer
Where can I find Partners resources on 1915(i)?	These items may be of assistance: NCDHHS June 30, 2023 blog regarding 1915(i): https://medicaid.ncdhhs.gov/blog/2023/06/30/nc-medicaid-obtains-approval-1915i-state-plan-amendment. On demand Partners 1915(i) State Plan Amendment Training: https://www.partnerstraining.org/. Partners 1915(i) Benefit Grid: https://providers.partnersbhm.org/benefit-grids/. Provider Alert issued July 28, 2023: https://providers.partnersbhm.org/update-attention-1915b3-providers-transition-of-1915b3-codes/. Provider Communication Bulletin issued August 17, 2023: https://providers.partnersbhm.org/provider-communication-bulletin-143/.
The state draft service definition for Individual Support requires providers to be nationally accredited within 1 year of being enrolled as a Medicaid provider. For providers who provide the (b)(3) service and are not yet nationally accredited, is there a grace period to allow them to provide 1915(i) while they work to achieve national accreditation?	All providers must meet the requirements of the service definition.
Will the 1915(i) assessment be completed by the care manager?	1915(i) independent assessments and Care Plan/ISP (Individual Service Plan) development must always be conducted by a care manager.
Does the member have to go through Vocational Rehabilitation before getting 1915(i) Supported Employment?	According to the admission criteria included in the 1915(i) *draft* service definition for Supported Employment, there must be proof of Ineligibility Decision Document that the Division of Vocational Rehabilitation Services (DVRS) provides or documentation from a DVRS Counselor that DVRS funded supports have ended. Please refer to the final service definition for Support Employment, when released, to verify the admission criteria.

Where do providers submit new independent assessments to determine independent evaluation eligibility for 1915(i)? What is the turnaround time for processing?	The beneficiary's assigned care manager submits 1915(i) independent assessments to Carelon at NCMedicaid1915(i)requests@carelon.com. Carelon and the state determine turnaround time for processing.
Will the LME/MCO or the Tailored Care Management (TCM) staff complete the ISP for these clients? Will delivering agencies have to do prior authorizations for these services? Does the provider submit the prior authorization for approval for adults with Individual and Transitional Support?	The assigned care manager is responsible for Care Plan/ISP development and prior authorization submission for 1915(i) services.
Members have been told they can opt out of TCM. Are members *required* to have TCM?	Individuals who have opted out of Tailored Care Management must still work with a Tailored Plan or LME/MCO care manager to develop a Care Plan/ISP to obtain 1915(i) services.
Is the Person-Centered Plan (PCP) the equivalent of an ISP for people with IDD who do not have Innovations or TBI Waivers?	A Care Plan and ISP both incorporate the results of the care management comprehensive assessment and identifies the member/recipient's desired outcomes and the training, therapies, services, strategies, and formal and informal supports needed for the member to achieve those outcomes. The Department is using different names for this plan according to a person's needs: • For individuals with behavioral health-related needs, a care manager/care coordinator will develop a Care Plan. • For individuals with I/DD and TBI-related needs, a care manager/care coordinator will develop an ISP. Both the Care Plan and ISP must be individualized, person-centered, and developed using a collaborative approach including individual and family participation where appropriate. Additional information on Care Plans/ISPs is available in the Tailored Care Management Provider Manual found on the Tailored Care Management page at: https://medicaid.ncdhhs.gov/tailored-care-management.

What happens to the PCP? Does it go away, or will members have both? How do providers know what those policies are, and which services will still require a PCP?	The PCP will not be used for authorization of 1915(i) services. North Carolina will continue to require that providers complete a PCP to authorize the delivery of certain behavioral health services as described in the following Clinical Coverage Policies: • Clinical Coverage Policy 8A. Enhanced Mental Health and Substance Abuse Services • Clinical Coverage Policy 8A-1. Assertive Community Treatment (ACT) Program • Clinical Coverage Policy 8A-6. Community Support Team • Clinical Coverage Policy 8C. Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers • Clinical Coverage Policy 8D-1. Psychiatric Residential Treatment Facilities for Children under the Age 21 • Clinical Coverage Policy 8D-2, Residential Treatment Services • Clinical Coverage Policy 8G. Peer Support Services All individuals engaged in Tailored Care Management are required to have a Care Plan or ISP. Many individuals engaged in Tailored Care Management will also be using one of the above services. Therefore, the Department expects that many individuals—regardless of whether they are using 1915(i) services— will have both a PCP and a Care Plan/ISP.
Do care managers have to complete 1915(i) assessment for members who are already receiving the services, or are they considered "grandfathered in?"	Federal rules require that individuals obtain an independent assessment and independent evaluation to use 1915(i) services.
Is a service order required?	Please refer to the Partners benefit grid for service order requirements.
Does Electronic Visit Verification (EVV) apply to 1915(i) services?	Yes, EVV applies to: • 1915(i) Individual and Transitional Supports • 1915(i) Community Living and Supports
Can care managers start sending 1915(i) assessments to the state for the members who have never had (b)(3)?	Yes, but members currently receiving (b)(3) services will be the priority population to transition to 1915(i).
Can providers access the 1915(i) assessments?	1915(i) assessments will be accessible through the member's assigned care manager.
Who will obtain the signed release so that TCM staff may access the existing PCPs and plans?	The assigned care manager will obtain the releases.

Will care managers create the plan for individuals participating in a PSR (Psycho-Social Rehab)?	No, that is not a 1915(i) service.
Will anyone age 21 and under need to be a part of a CFT team? What if the agency does not have a CFT team?	Yes. Providers can consult the assigned TCM to get CFT started.
Do the changes and annual assessments need to be sent to the email for approval?	Following the completion of an initial 1915(i) independent assessment, an individual must obtain a 1915(i) independent assessment at least annually or when their circumstances or needs change significantly. Care managers will use the same 1915(i) independent assessment standardized template issued by the NCDHHS when conducting reassessments. The State will conduct a brief evaluation to determine if an individual meets eligibility criterion. This evaluation will be at the initial request, and reevaluation will be done during the individual's birth month.
Will PLE get the approval for the 1915(i) assessments via LME/MCO or directly?	1915(i) Assessments need to be sent directly to the State or State contractor (Carelon).
Can providers request a reply to prevent emailed 1915(i) assessments from getting lost?	Assessments are emailed to Carelon, not the LME/MCOs; therefore, Partners cannot control replies to the assessment emails.
Is CFT timing regardless of acuity level?	CFT needs to occur at least 1x/month regardless of acuity level.
What if a qualifying member's TCM-designated provider in NCTracks has not reached out to the member for a 1915(i) assessment?	Provider should contact the assigned care manager.
Is there a list of providers who will be providing 1915(i) services? How do providers locate 1915(i) providers?	You can search for providers offering specific services on Partners' website: https://www.partnersbhm.org/provider-search/#
What is the contact email/number for Partners TCM?	I/DD Care Management Referrals Phone: 833-618-7974 Email: IDD_TCM_Screening_and_Referral@partnersbhm.org MHSU Care Management Referrals Phone: 704-842-6311 Email: MHSA_CC@partnersbhm.org

Is the TCM or service provider is responsible for obtaining the service order?	The assigned care manager is responsible for the Care Plan/ISP; therefore, the care manager is responsible for obtaining the proper service order for 1915(i) services.
The PCP that is the responsibility of the service provider has a section for the order signatures. Is the PCP required to be submitted when submitting the ISP/Care Plan for approval/authorization?	1915(i) services should be included in the Care Plan/ISP developed by the care manager. If a separate PCP is required for non-1915(i) services, the servicing provider is responsible for the PCP (Person-Centered Plan) and obtaining the proper service orders.
Can Supported Employment be used for volunteer activities?	*No*, according to the State Plan Amendment, Supports and/or services to help individuals with volunteering is not covered under Supported Employment. Service definitions are being developed by the NCDHHS, which may change service requirements and limitations. Please refer to the final service definition for Support Employment, when released, to see if this limitation remains or is changed.
Currently, if providers have a family needing respite or renewal of an authorization, does the QP submit or does the TCM submit?	If the member is currently receiving (b)(3) Respite and has not been determined eligible by the NCDHHS for 1915(i) services, the member may continue to receive (b)(3) Respite. The servicing provider is still responsible for (b)(3) PCP and service authorization until the member transitions to 1915(i).
Currently our Care Plans are driven by the assessment, and there is little functionality to 'manually add' person centered plan goals. Will it be possible for participating CHN programs to upload those goals into the Care Plans?	It is best to incorporate the elements of the person-centered plan goals into the Care Plan document.
Does service authorization need to occur 60 days from the date of the 1915(i) assessment or 60 days from the date the state approves the recommendation?	The beneficiary's initial Care Plan/ISP must be reviewed and approved/denied within 60-days of 1915(i) independent evaluation eligibility determination from the State.
If there is a current PCP in place that the provider is using to submit requests, do care managers complete a new plan to override the PCP or wait until the PCP is ended?	The Care Manager is responsible for developing the beneficiary's initial Care Plan/ISP for 1915(i) services, which must be reviewed and approved/denied within 60-days of 1915(i) independent evaluation eligibility determination from the Department/State.
Are providers responsible for completing member's short-term goals?	Yes.

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Are all care managers with Partners?	The beneficiary's assigned care manager can be with Partners or AMH+/CMA.
Is there a check sheet or list of required documents to be submitted with SAR?	Please refer to the Partners benefit grid for 1915(i).
Will all service providers who currently offer (b)(3) automatically offer 1915(i) services?	1915(i) services will be added to provider contracts if they previously provided the equivalent (b)(3) service. If the provider had the equivalent (b)(3) service in their contract, they do not need to take any action.
Is there a recommended best practice when a member has been assigned the same provider for 1915(i) services and TCM, since members cannot have the same for both?	Please refer to Guidance on Conflict-Free Care Management for Tailored Plan Members from August 25, 2021: https://medicaid.ncdhhs.gov/guidance-conflict-free-care-management-tailored-plan-members/open
Where are the rates for 1915(i)?	Rates will be posted to Partners Provider Knowledge Base: https://providers.partnersbhm.org/claims-information/
If an individual is eligible for TCM, are they automatically eligible for 1915(i) services?	Individuals must have a completed 1915(i) independent assessment and independent evaluation to determine 1915(i) eligibility. Partners will determine medical necessity for the service through the prior authorization service review.