Trillium HEALTH RESOURCES

Transforming Lives. Building Community Well-Being.

Trillium 1915(i) Quick Reference Guide

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CONTENTS

INTRODUCTION

The 1915(i) services are for members who want support to live in their home and communities. These services are non-medical behavioral health services, such as supported employment. They are provided at a member's home, residence, or community and are not for members living in an institution. "1915(i)" is the name of the authority that allows Medicaid to offer Home and Community Based (HCBS) services under the State Plan. That means these services are an 'entitlement' for anyone on Medicaid who meets eligibility requirements.

Members can receive these services while on the Registry of Unmet Needs for Innovations. Federal conflict-free care management requirements state a provider cannot provide Tailored Care Management (TCM) and 1915(i) services to the same member. Members who are enrolled in Community Alternatives Program for Children (CAP/C) or Community Alternatives Program for Adults (CAP/DA) can receive some 1915(i) services. These members cannot receive Respite or Community Transition but are eligible to receive all other services.

TYPES OF 1915(I) SERVICES

Community Living and Support (CLS)

(Prior Authorization Required)

Members learn skills to help them live independently at home and participate in the community such as learning to manage eating, bathing, dressing, personal care, hygiene, and other daily activities. They also learn life skills such as shopping and banking and extra support for health and safety.

Limitations:

- Beneficiaries in school (3-21 y/o): 15 hours/week in school; 28 hours/week during breaks.
- Relatives who live in the same home as a member who is under 18 years old may not provide CLS.
- Relatives who live in the same primary residence as a member, who is over 18 years old, can provide CLS if the relative meets the required staffing qualifications.

- 1915(i) CLS and SE may not exceed a combined limit of 40 hrs. per week. Example: If receiving 25 hours per week of CLS, SE cannot exceed 15 hours per week.
- Transportation to and from the school setting is not covered.
- Members who are enrolled in Innovations or TBI waiver are not eligible for 1915(i) services.
- This service may not be provided during the same time as any other direct support Medicaid service.

Service Hour Limits:

- Members who are of school age receive up to 15 hours per week when school is in session, and 28 hours per week when school is out of session.
- Members 22 years of age and older may be authorized up to 28 hours per week.
- If member is aged 18 and has graduated (graduation with a degree with standard course of study or occupational course of study, GED, or Certificate of Completion) they are eligible for over 22 years of age limits.

Clinical Coverage Policy: 8H-5, Community Living and Supports

Community Transition

(Prior Authorization Required)

Members can get up to $5,000 in credit to help them move from an approved institution or setting to their own home. Approved settings can be a state-operated health care facility, a foster or group home, a psychiatric residential treatment facility, a community intermediate care facility (ICF-IID) and more. Funding can be used for security deposit for an apartment or house, essential home furnishings, like furniture, kitchen utensils and linens, moving expenses, and set-up fees for utilities (like phone, internet, gas).

Limitations:

- Available up to 3 months in advance of a member's move to an integrated living arrangement, and up to 90 consecutive days post move in date.
- Has a limit of $5,000 per member during a 5-year period.
- Only covers the actual items purchased, not the time spent helping the member to purchase them.

- May be provided only in a private home or apartment with a lease in the member's/legal guardian's/ representative's name or a home owned by the member.
- May not be provided by family members.
- Services cannot duplicate items that are currently available from a roommate.
- Furnished only to the extent that the member is unable to meet such expenses, or when the support cannot be obtained from other sources or services.
- May not be provided to members enrolled in the CAP/C or CAP/DA wavier.
- May not be provided to a member residing in an Institution for Mental Disease (IMD) regardless of the facility type.

Service Hour Limits:

No Service Hour Limits

Clinical Coverage Policy: 8H-6, 1915(i) Community Transition

Eligible Transition Settings Include:

- State developmental centers
- Community Intermediate Care Facilities (ICF-IID)
- Nursing facilities
- Licensed group homes
- Alternative Family Living (AFL) settings
- Foster homes
- Adult Care Homes (ACH)
- State-operated healthcare facilities
- Psychiatric Residential Treatment Facilities (PRTF)

Individual and Transitional Support (ITS)

(Prior Authorization Not Required)

Members get personalized support for their recovery from mental health issues or substance use disorders. Members participate in and guide their recovery process, have access to transportation, help to find housing, manage their finances, and continue their education.

Limitations:

- The duration and frequency must be based on member need and progress made by the member toward goals outlined in the care plan. It is expected that the service intensity will titrate down as the member demonstrates improvement.
- ITS cannot be provided during the same authorization period as ACT, CST, IIH, MST, PSR, or those ages 16-21 who reside in Medicaid funded group residential treatment facility or any other duplicative service.
- ITS cannot be provided if the service is otherwise available under the Rehabilitation Act of 1973 or under the Members with Disabilities Education Act.
- Family members or LRP are not eligible to provide this service.
- ITS cannot be provided during the same time as another direct support Medicaid service.
- This service may not be provided in a group.
- Even though this service is under a NPA all documentation is still required for the services to include the 1915(i) Assessment, CMCA, and Care Plan.

Service Hour Limits:

No Service Hour Limits

Clinical Coverage Policy: 8H-3 1915(i) Individual and Transitional Support (ITS)

Individual Placement & Support for Mental Health & Substance Use (IPS)

(Prior Authorization Not Required)

Helps members find, get, and keep a job that is right for them. A specialist will help them with career planning and discovery, resume help and job interview practice. Help with learning assigned job tasks and how to get to work.

Limitations:

- Members must be 16 years or older, with SMI, SPMI, SED and/or severe SUD diagnoses.
- Members can receive IPS from only one provider during any authorization period.

- Billable only for direct employment services and support, not for meetings, paperwork, or travel time.
- Service does not have a hard limit. IPS-SE is not billed fee-for-service, but rather the NC Core Milestone payment model.
- The duration and frequency at which IPS is provided must be based on medical necessity and progress made by the member toward goals outlined in the Career Profile.
- Services are based on the level of intensity required to acquire stable employment or interventions required for continued employment.
- Members with sole IDD or TBI diagnoses would not qualify for IPS-SE.
- IPS-SE uses braided funding and shared caseloads between Trillium and Employment and Independence for People with Disabilities (EIPD). IPS-SE teams will refer and support members in connecting with EIPD, which is necessary for provider reimbursement.
- Must have gone through services by Employment and Independence for People with Disabilities (EIPD) before you can get Member Placement and Support.
- Services must not be provided during the same auth period as ACT.
- 1915(i) SE and CLS may not exceed a combined limit of 40 hrs. per week
  - Even though this service is under the NPA all documentation is still required for the services to include 1915(i) Assessment, CMCA, and Care Plan. The Care Plan must be shared with the IPS-SE provider and is the service order.

Service Hour Limits:

No Service Hour Limits

Clinical Coverage Policy: 8H-2, 1915(i) Individual Placement & Support (IPS) for Mental Health & Substance Use

NC Core Milestone Payment Model

NCDHHS developed a standardized NC Core Milestone payment model. The NC Core Milestone payment model offers reimbursement to providers when the individual member accomplishes specific outcomes toward gaining and maintaining employment.

- **Milestone 1:** Initial Career/Education Exploration and Initial Career Profile Development (Trillium Funded) – Discuss the individual's interest in employment and education. The IPS team will share information on the wide

array of supports and resources in the IPS program. The initial development of the Career Profile includes exploring and documenting information from the individual in each section of the Career Profile. IPS-SE Provider completes referral to EIPD. Milestone 1 payment is earned for completion of the initial development of the Career Profile.

- **Milestone 2:** Career Profile Completion (Trillium Funded)– Continued development and completion of the first iteration of the Career Profile. Gather and document more information for each section of the Career Profile. Identify and document supports from EIPD, behavioral health providers, and natural supports. Milestone 2 payment is earned for completion of the first iteration of the Career Profile which is more comprehensive than Milestone 1.
- **Milestone 3A**: IPS Job Search (EIPD Funded) – ESP and/or EPM assists the individual with developing and/or refining skills and tools that support a successful job search. Milestone 3A payment is earned when there has been 15 employment applications submitted, or employment has been secured.
- **Milestone 3B**: IPS Employer Networking (EIPD Funded) – IPS Employer Networking involves systematic job development in which the Employment Specialist outreaches, visits, and develops relationships with employers to learn about their business needs and hiring preferences. Employers are selected based on job seeker preferences and should be directly related to the Career Profile vocational goals. Employer Networking involves face-to-face meetings. Milestone 3B is earned when there has been a minimum of 12 face-to -face contacts with employers or if employment has been secured there must be documented face-to-face employer contacts, but there is no minimum requirement.
- **Milestone 3C:** IPS Job Placement + 3 Days Support (EIPD Funded) – IPS Job Placement + 3 Days of support is the time spent with the individual providing specific coaching and training needs that support job retention. Supports can be onsite or offsite given the individual's disclosure preferences. Milestone 3C is earned when there is evidence of 3 individual face-to-face contacts on or after the first day of employment.
- **Milestone 4:** Job Support and Vocational Recovery (EIPD Funded) - Phase where direct job supports are provided at a minimum weekly. Focused on issues that can result in job loss or issues that resulted in job loss in the past. These job supports are typically identified in the Career Profile and the ESP

works with the individual on how to overcome challenges that have resulted in job loss in the past. Milestone 4 is earned when the individual begins showing signs of requiring less intensive job supports and have overcome challenges that could have resulted in job loss.

- **Milestone 5A**: IPS Vocational Recovery + 30 Days (EIPD Funded) - Job supports are provided monthly to fine tune and monitor progress made in the previous milestone. Continue to evaluate for issues that could result in job loss, but overall, the individual is working independently. Milestone 5A is earned when the Individual continues to maintain employment 30 days post the date of Vocational Recovery.
- **Milestone 5B**: IPS Vocational Recovery + 60 Days (EIPD Funded) - Job supports are provided monthly to fine tune and monitor progress made in the previous milestone. Continue to evaluate for issues that could result in job loss, but overall, the individual is working independently. Milestone 5B is earned when the individual continues to maintain employment 60 days post the date of Vocational Recovery.
- **Milestone 5C:** IPS Vocational Recovery + 90 Days (EIPD Funded) - Follow along supports are provided monthly to fine tune and monitor progress made in the previous milestone. Continue to evaluate for issues that could result in job loss, but overall, the individual is working independently. Milestone 5C is earned when the individual continues to maintain employment 60 days post the date of Vocational Recovery.
- **Milestone 6**: Long-Term Job Retention (Trillium Funded)- A time-unlimited support. Monthly face-to-face contacts based on the individual's Career Profile and identified needs. This Milestone may earned monthly as the individual maintains employment and the IPS-SE provider has a minimal of at least one face to face contact.
- **Milestone 7**: Career Advancement, Optional (Trillium Funded) – The IPS team support the individual when employed and determines they would like to work towards and internal promotion, an external job that would result in advancement/growth, and increase in pay and a new title. Milestone 7 is earned when the individual obtains a job providing better growth.
- **Milestone 8:** Educational Advancement, Optional (Trillium Funded) – IPS team provides supports when the individual is interested in pursuing an educational program that supports their employment goals. Milestone 8 is earned at the

completion of an educational program and a copy of certificate or grade report at the end of quarter/semester (as appropriate), pass of fail.

- Milestone 9: Vocational Recovery & Independence (Trillium Funded) – The individual has stable employment and no longer needs direct support from IPS team. Milestone 9 is earned when the individual has met the goals identified in their Carrer Profile and if ready to discharge.

IPS Reminders for Care Managers

- Members can still receive IPS if already employed.
- Educational goals must be related to Career Goals.
- Billing code is H2023 U4.
- No prior authorization is needed.
- Long-term goals should be person-centered.
- Short-term goals for IPS are optional on the Care Plan.
- Use IPS team as a resource to connect with members.
- Maintain ongoing collaboration with IPS team during eligibility process.
- Signed Care Plan must be provided to IPS team to begin IPS Services.
- Timeliness is essential to maintain member engagement and avoid dropout.
- Part of the IPS model is "zero-exclusion" criteria, meaning an individual is not disqualified from engaging in employment because of readiness factors such as active substance use, criminal background issues, transportation, treatment or medication adherence, or personal presentation/hygiene.

Respite

(Prior Authorization Required)

Gives caregivers a break, while knowing that their loved one is cared for. Overnight, weekends, and emergency care for the members could be provided in or out of the home.

Limitations:

- Respite must not be provided by any person or legal guardians if they live in the same home as the member.
- Respite may not be billed on the same day as Residential Supports.
- Emergency care applies to family emergencies and does not include out-of-home crisis.

- This service may not be used as a regularly scheduled daily service for member support.
- Respite may not be used for members who are living alone or with a roommate.
- Members enrolled in the CAP/C or CAP/DA waiver are not eligible for Respite services.

Service Hour Limits:

No more than 1200 units (300 hours) can be provided in a plan year.

Clinical Coverage Policy: 8H-4, 1915(i) Respite

Supported Employment for Member's with Intellectual/ Developmental Disabilities (IDD) or Traumatic Brain Injury (TBI)-(SE)

(Prior Authorization Required)

Members with severe mental illness find competitive, community employment and provides ongoing, member services with a focus on employment. Services include personalized counseling to understand how work may affect a member's benefits, ongoing treatment to help manage medications, symptoms, and other behavioral health needs. An employment specialist and peer support helps members to succeed with their job and advance professionally.

Limitations:

- Members must have gone through services by Employment and Independence for People with Disabilities (EIPD) before they can get Supported Employment.
- 1915(i) SE and CLS may not exceed a combined limit of 40 hrs. per week.
- SE may not be provided by family members who live in the same household as the member.
- May not be provided if the service is otherwise available under a program funded under the Rehabilitation Act of 1973 or under the Members with Disabilities Education Act.
- May not be provided to a member living in an ICF-IID
- Pre-employment and Employment Stabilization Phase: A maximum of 20 hours per week for up to 180 days of services for initial job development, training, and support. If the member obtains employment and their schedule and support

needs require more than 20 hours a week of services, additional hours can be authorized.

- Employment Stabilization Phase: Based on the members' work schedule and support needs, not to exceed 40 hours a week. Services can be authorized for up to 365 days if the work schedule/ needs are not expected to change.
- Long-Term Supported Employment Phase: For a member who is stable in their employment and has minimal support needs, a maximum of 10 hours per month may be approved annually for periodic long-term support. If there is an increased support need, additional hours may be authorized. For a member with ongoing support needs, SE may be authorized for the number of hours necessary to support the member to remain stable in their employment; not to exceed 40 hours a week.

Service Hour Limits:

- Pre-employment and Employment Stabilization Phase:20 hours per week (80 unit per week) for up to 180 consecutive days, additional hours may be considered
- Employment Stabilization Phase: 40 hours per week (160 units per week)
- Long-Term Supported Employment Phase: Up to 40 hours per week (160 units per week)

Clinical Coverage Policy: 8H-1, 1915 (i) Supported Employment for I/DD and TBI

ELIGIBILITY FOR 1915(I) SERVICES

Who is Eligible for 1915(i) Services

- Members must have an eligible condition.
- Members must have eligible NC Medicaid Health plan:
  - NC Medicaid Direct, Tailored Plans, EBCI Tribal Option and The Children and Families Specialty Plan (upon launch).
  - (Trillium Medicaid Insurance Active: Medicaid B, TP Medicaid)
- Members on the waitlist for Innovations Services may be eligible to receive 1915(i) services while they wait.
- Members are not required to meet an institutional level of care to be eligible for 1915(i) services.

NC Medicaid's Member Eligibility for 1915(i) Services

Eligibility for 1915(i) services varies on a benefit-by-benefit basis and is determined after an assessment is approved. Eligible populations must have a NC Medicaid health plan managed by an LME/MCO and include individuals with I/DD, SED, SMI, SPMI, SUD, and TBI.

1915(i) Services	I/DD (Intellectual/Developmental Disability)	SED (Serious Emotional Disturbance)	SMI and/or SPMI (Serious Mental Illness)/ Severe and Persistent Mental Illness)	SUD (Severe Substance Use Disorder)	TBI (Traumatic Brain Injury)
Community Living and Support	✓ All Ages				✓ All Ages
Supported Employment	✓ Ages 16+				✓ Ages 16+
Individual Placement and Support Services		✓ Ages 16+	✓ Ages 16+	✓ Ages 16+	
Respite Care	✓ Ages 3+	✓ Ages 3-20		✓ Ages 3-20	✓ Ages 3+
Individual and Transitional Support		✓ Ages 16-21	✓ Ages 18+	✓ Ages 16+	
Community Transition	✓ All Ages		✓ All Ages	✓ All Ages	✓ All Ages

Community Living and Support (CLS) is available for people with Intellectual and developmental disabilities (I/DD) or Traumatic brain injury (TBI) with a needs-based criteria of having 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.

Supported Employment (SE) is available to people ages 16 or older with Intellectual and developmental disabilities (I/DD) or Traumatic brain injury (TBI) with a needs-based criteria of express the desire to work, has a pattern of under/unemployment or have educational goals that relate to employment goals.

Individual Placement and Support (IPS) is available to people ages 16 or older with severe and persistent mental illness (SPMI), serious mental illness (SMI), serious emotional disturbance (SED), and substance use disorder (SUD).

Respite Care is available for people with serious emotional disturbance (SED); ages 3-20, substance use disorder (SUD); ages 3- 20, intellectual and developmental disabilities (I/DD); ages 3 or older, and traumatic brain injury (TBI); ages 3 or older with a needs-based criteria of being unable to care for themselves in the absence of their primary caregiver

Individual and Transitional Support (ITS) is available to people with substance use disorder (SUD); ages 16 or older, serious mental illness (SMI); ages 18 or older, severe and persistent mental illness (SPMI); ages 18 or older, and serious emotional disturbance (SED); ages 16-21 with a needs-based criteria of at least one deficit in an instrumental activity of daily living (e.g., meal preparation)

Community Transition service is available to people with intellectual and developmental disabilities (I/DD), traumatic brain injury (TBI), substance use disorder (SUD), serious mental illness (SMI), and severe and persistent mental illness (SPMI) with a needs-based criteria of moving to own community living arrangement and need initial set-up expenses/items.

Who is not Eligible for 1915(i) Services

Recipients of Standard Plan, NC Innovations or TBI Waiver members are not eligible for 1915(i) services.

PROCESS FOR ACCESSING 1915(I) SERVICES

Member Need Identified: Member visits their Primary Care Physician (PCP), BH, I/DD, or another provider. PCP, BH, I/DD, or another provider identifies that the member needs a 1915(i) service. PCP, BH, I/DD, or other providers refer the member to their care manager to determine eligibility

Independent Assessment: Member's tailored care manager, either at a Tailored Plan or AMH+/CMA, conducts an independent assessment using the 1915(i)-assessment tool to identify the member's needed services and supports, inform the independent evaluation of 1915(i) eligibility, and inform a Care Plan/ISP.

Independent Evaluation: Member'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 the member meets needs-based eligibility criteria for 1915(i) services.

Care Plan/ISP

The care manager:

- assists the member in identifying a 1915(i)-service provider(s).
- develop the Care Plan/ISP with the members and other identified representatives.
- ensures the Care Plan/ISP reflects the members' needed services and supports along with preferences for the delivery of services, and name of the service provider.

Prior Authorization: The care manager submits completed Care Plan/ISP to the members' Tailored Plan for review. The Tailored Plan conducts prior authorization of the 1915(i) service(s). NPA: *IPS and ITS*

Service Delivery and 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 and provides ongoing care coordination.

1915(I) ASSESSMENT TOOL

A member's Care Manager or Care Coordinator (if opted out of care management) has responsibility to administer an independent assessment in line with federal requirements using the standardized 1915(i) assessment tool.

The regulations require a "face-to-face" assessment. Therefore, the assessment must be completed in person or via telehealth (i.e., two-way audio/visual). It must be completed annually (this assessment will correspond with the members' birth month moving forward). Must be performed by the Care Manager or Care Coordinator (i.e., cannot be performed by the provider of the 1915(i) service).

1915(i) Assessment Tool Components

- Demographics of Member: Member Name, Medicaid ID (MID), Date of Birth, Tailored Plan or LME/MCO
- Relevant Diagnosis(es) – This is an optional field as a diagnosis is not required for the 1915(i) assessment.
- Requires Treatment Service(s) for – Indicate what types of treatment services the member needs. This is a critical component to determine which 1915(i) services the member may need/receive.
- Care Manager/Agency Information: Name and Agency
- Health Plan: Trillium Health Resources
- Date member Requested 1915(i) Service(s): The initial date will not carry over year to year (for both annual and reassessments). If it is a reassessment for a new 1915(i) service, please include the new date the member requested an additional 1915(i) service. If it is an annual reassessment for ongoing 1915(i) service(s), please include the new date the member confirmed.
- Date 1915(i) Assessment Completed
- Is this a reassessment: Yes or No

Name	
MID (Medicaid ID)	
DOB	
Relevant Diagnosis(es) (optional)	
Requires Treatment Service(s) for: *Select All that Apply*	☐ I/DD ☐ TBI ☐ SMI ☐ SED ☐ SUD
Care Manager/ Agency	
Health Plan	
Date Individual Requested 1915(i) Service	
Date 1915(i) Assessment completed	
Is this a reassessment?	☐ Yes ☐ No

Functional Assessment: Assessment of a member's functional deficit(s). Assessors will indicate if the member needs no, some, or total assistance in the functional area indicated. Deficits are measured in the following areas:

- Activities of Daily Living (ADLs) – ambulation, bathing, dressing, etc.
- Instrumental Activities (i.e., IADLs) – meal prep, housekeeping, laundry, etc.
- Social & Work Tasks –interacting with others, responding to negative feedback, etc.
- Cognitive/Behavioral Tasks- speech/language/communication, self-direction, etc.
- Assessors can document comments as necessary (but comments are not required).

Beneficiary reports/assessor has identified a need for services based on beneficiary having at least one functional deficit below:

	Assistance Needed None	Assistance Needed Some	Assistance Needed Total	Comments (e.g., who assists, equipment used, problems or issues for caregivers, type of assistance needed)
Activities of Daily Living	☐	☐	☐	
Ambulation	☐	☐	☐	
Bathing	☐	☐	☐	
Dressing	☐	☐	☐	
Eating	☐	☐	☐	
Grooming	☐	☐	☐	
Toileting	☐	☐	☐	
Transfer	☐	☐	☐	
• To from bed	☐	☐	☐	
• To from car	☐	☐	☐	
	☐	☐	☐	
Instrumental Activities	☐	☐	☐	
Home maintenance	☐	☐	☐	
Housekeeping	☐	☐	☐	
Laundry	☐	☐	☐	
Meal Prep	☐	☐	☐	

Money Management	☐	☐	☐	
Shopping/errands	☐	☐	☐	
Transportation	☐	☐	☐	
• Use of	☐	☐	☐	
• Scheduling	☐	☐	☐	

	Assistance Needed None	Assistance Needed Some	Assistance Needed Total	Comments (e.g., who assists, equipment used, problems or issues for caregivers, type of assistance needed)
Social and Work	☐	☐	☐	
Interacting with others	☐	☐	☐	
Responding to negative feedback	☐	☐	☐	
Responding to change	☐	☐	☐	
Screening out environmental stimuli	☐	☐	☐	
Maintaining stamina	☐	☐	☐	
Handling time pressures and multiple tasks	☐	☐	☐	
Ability to learn new tasks	☐	☐	☐	
Acceptable speed of completing tasks	☐	☐	☐	
Cognitive/Behavior	☐	☐	☐	
Speech/ Language/ Communication	☐	☐	☐	
Self-Direction	☐	☐	☐	
Social Development	☐	☐	☐	
Learning	☐	☐	☐	
Vocational Development	☐	☐	☐	
Maladaptive Behavior	☐	☐	☐	
Psychosis/ Hallucinations	☐	☐	☐	
Mild Memory Loss	☐	☐	☐	
Moderate Memory Loss	☐	☐	☐	
Other:	☐	☐	☐	
	☐	☐	☐	
	☐	☐	☐	
	☐	☐	☐	
	☐	☐	☐	

Additional Assessment Questions: The last portion of the assessment contains additional questions. Assessors can document comments as necessary (but comments are not required).

Does the individual require support to manage a medical or health condition? ☐ Yes ☐ No

Comment: _____

Does the individual need support to acquire or maintain employment? ☐ Yes ☐ No

Comment: _____

Is the caregiver of the beneficiary in need of respite? ☐ Yes ☐ No

Comment: _____

Is the individual in need of rehabilitative service for IADLs, Social Skills, or Employment Skills? ☐ Yes ☐ No

Comment: _____

Is the individual in need of habilitative service for ADLs, IADLs, Social Skills, or Employment Skills? ☐ Yes ☐ No

Comment: _____

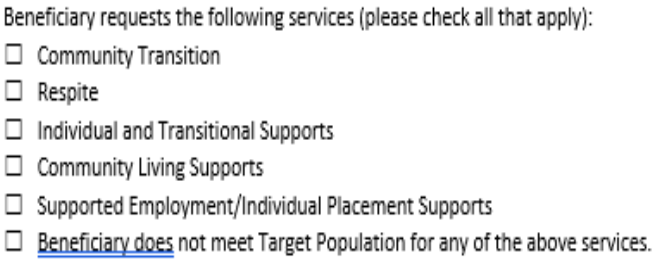
Current Living Arrangement (i.e., At home w/ Family, Group Home, ACH, etc.):

_____

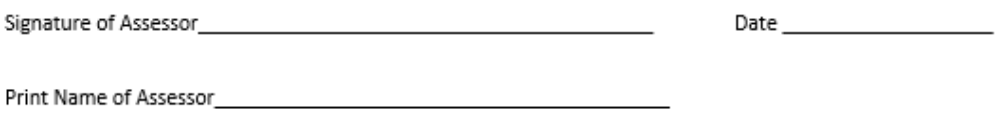
Are there plans for the individual to move to an independent living arrangement within the next 60 days? ☐ Yes ☐ No

Comment: _____

Requested Services: The assessor can select the services requested by/for the member based on the assessment. Assessor can select all services that might apply.


Beneficiary requests the following services (please check all that apply):
- ☐ Community Transition
- ☐ Respite
- ☐ Individual and Transitional Supports
- ☐ Community Living Supports
- ☐ Supported Employment/Individual Placement Supports
- ☐ Beneficiary does not meet Target Population for any of the above services.

Assessor Information: The bottom of the assessment has a space for the signature of the assessor, the printed name of the assessor and a date of the assessment. Signature can be digital.


Signature of Assessor_____ Date _____

Print Name of Assessor_____

1915(I) REASSESSMENT

The 1915(i)-service provider works with the Care Manager or Care Coordinator to support completion of the 1915(i) assessment. If the Care Manager or Care Coordinator is having difficulty with contacting the member, the service provider should support them in getting connected with the member as delays in 1915(i) assessment completion impact service delivery. The 1915(i)-service provider should also work with the Care Manager or Care Coordinator to understand the status of the1915(i) assessment completion.

CARELON 1915(I) ASSESSMENT REVIEW TIMEFRAME

The North Carolina Department of Health and Human Services (NCDHHS or Department) will determine eligibility for 1915(i) services. The Department, with support from Carelon (the state selected assessment vendor), will conduct an independent evaluation to determine if the Medicaid 1915(i)-Option Set of Services, member meets the needs-based eligibility criteria for 1915(i) service(s). The Care Management entity that submitted the assessment and the members/LRP will receive notification of eligibility decisions after a decision is made.

The standard timeframe for when a decision is made is approximately 2 weeks. If additional information has been requested from the assessor or the total number of assessments have increased for a review period, the review process may take longer. If a decision is not received within 2 weeks and Carelon has not requested additional information, it is recommended that the person who submitted the assessment (i.e., care manager/care coordinator) reach out to Carelon to request the status of the review. The service provider should reach out to the Care Manager or Care Coordinator to understand status of the 1915(i) eligibility.

- **Internal TCM:** Trillium staff will follow the 1915(i) Step Action Plan
- **External TCM:** Submitter will email Carelon at NCMedicaid1915iRequests@Carelon.com

Note: Carelon approval/denial 1915(i) eligibility letters are sent to the health plan and member. However, Trillium does not distribute these letters and is not required to be part of the service record.

CARE PLAN/INDIVIDUAL SUPPORT PLAN (ISP)

Members 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 member. The care manager is responsible for driving and completing the person-centered planning process and development of the Care Plan/ISP.

Service providers must support the person-centered planning process and the development of the Care Plan/ISP by doing the following:

- **Independent Assessment:** Work with the member's care manager to ensure that the annual re-assessment happens timely to support appropriate re-authorization of services.
- **Care Team Meeting:** Participate in the Care Plan/ISP meeting and support the member in updating short range goals or establishing new goals based on the member's progress.
- **Care Plan Implementation:** Identify and provide direct support for staff in implementing the members' goals.

For members obtaining or seeking to obtain 1915(i) services, there are additional requirements for the member's Care Plan/ISP to incorporate results from the member's 1915(i) independent assessment and the member's desired type, amount, and duration of 1915(i) services. Additional information is needed because Care Managers or Care Coordinator will submit the Care Plans/ISP to Trillium to authorize needed 1915(i) services needed.

These additional Care Plans/ISP requirements apply for all members obtaining 1915(i) services, regardless of whether they are engaged in TCM. As part of developing the Care Plan/ISP for these members, the member's Care Managers or Care Coordinator must:

- Explain options about the services available and discuss the duration of each service.
- Include in the Care Plan/ISP a plan for coordinating 1915(i) services.
- Ensure the member/LRP provides a signature (wet or electronic) on the Care Plan/ISP to indicate informed consent, in addition to ensuring that the Care Plan/ISP includes signatures from all members and providers responsible for its implementation. As part of the consent process, members must consent to the following:
  - By signing this plan, I am indicating agreement with the bulleted statements listed here unless crossed through. I understand that I can cross through any statement with which I disagree.
  - My Care Manager helped me know what services are available.
  - I was informed of a range of providers in my community qualified to provide the service(s) included in my plan and freely chose the provider who will be providing the services/supports.
  - The plan includes the services/supports I need.
  - I participated in the development of this plan.
  - I understand that my care manager will be coordinating my care with the Trillium network providers listed in this plan.

The Care Manager/Care Coordinator and 1915(i) providers must work together to ensure the ISP/Care Plans are completed in a timely manner and are fully completed with the correct information on them to avoid issues.

- TCM will Incorporate the results of the independent assessment into the Care Plan/ISP.

- TCM will complete the Care Plan/ISP within 60 calendar days of 1915(i) eligibility determination.
- Explain options regarding the services available and discuss the duration of each service.
- Include a plan for coordinating waiver services
- Care Manager/Care Coordinator will complete long-range goals, and 1915(i) service provider will complete the short-range goals.
- Ensure the member provides a signature (wet or electronic) on the Care Plan or ISP to indicate informed consent, in addition to ensuring that the Care Plan/ISP includes signatures from all members and providers responsible for its implementation.
- Plans must align with the birth month. Dates: Initial Start Date through last day of member's birth month. Example: Birthday is in May the end date of the plan would need to be May 31st.
  - Primary IDD or TBI Diagnosis > ISP
  - Primary MH Diagnosis > Care Plan
- Care Plan/ISP for CLS: There should be one Care Plan/ISP for the member. The TCM provider creates the plan and the provider providing the CLS services are responsible for the Short-range goals.
- Service Order Signatures: The care plan does not have a specific signature place for service orders, but a service order is required for 1915(i) ISP and ITS. Per the TCM manual both the care manager and service provider should be signing the care plan so either signature would meet the service order requirement if QP or another accepted licensure. (CCP 5.4 Service Order)

Plan Year: One year from the effective date of the plan.

- The plan year is one year from the last required signature on the original plan.
- If a new plan is written during the plan year, this does not start the plan year over. For example, if the first plan was written on 11/25/2024, the first signature was obtained on 11/25/2024 and the last required signature was obtained on 12/1/2024, then the plan year is from 12/1/2024 – 11/24/2025, no matter how many additional plans are written during the year
- Effective Date: The date of the last required signature on the plan. Plan Expiration Date: One year from date of the first signature.

CARE PLANS FOR IPS MEMBERS

The Care Plan must reflect the Member's Employment Goal and NC CORE H2023 U4 Milestones 1 –9, 7 and 8 are optional. TCMs must send IPS-SE providers the Care Plan before they can begin service delivery. The IPS-SE fidelity model measures 'rapid engagement' in the service, so timely access to the Care Plan is essential for the IPS-SE provider's fidelity. IPS-SE NC Core Milestones do NOT require a prior authorization request to be submitted

Interim Plan of Care

As confirmed in the Tailored Care Management Provider Manual, TCM's can complete

an interim plan of care for members that have immediate need for 1915(i) services. This allows members to begin 1915(i) services while the TCM continues to gather information to complete the Care Plan, which must be completed within 60 days of eligibility determination.

The following information should be presented in the interim plan:

- **Member information:** Name, Medicaid ID, DOB, Diagnosis
- **Goal:** Brief description of clinical needs, including any behavioral health, I/DD-related, or TBI-related needs
- **Needed 1915(i) Services:** Type, amount, and duration of 1915(i) services
- Short crisis plan

1915(I) SERVICE BILLING CODES

Providers should not bill 1915(i) services until a member has been deemed eligible for 1915(i) services (which happens after the 1915(i) assessment has been completed) and the member's 1915(i) services have been authorized by Trillium. When submitting 1915(i) service claims providers need to ensure they are using the correct code and site location for services.

The following codes can be leveraged after the member has been authorized for 1915(i) services:

Code	Modifier(s)	1915(i) Service
H0043	U4	Community Transition
H0045	U4	Respite
H0045	HQ U4	Respite Group
H2023	U4	Supported Employment Initial
H2023	HQ U4	SE Initial Group
H2026	U4	SE Maintenance
H2026	HQ U4	SE Maintenance Group
T1019	U4	Individual and Transitional Support (subject to EVV)
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	TF HQ U4	Community Living and Supports Group (subject to EVV)
T2012	GC U4	Community Living and Supports relative as provider lives in home (non-EVV)
T2013	TF U4	Community Living and Supports Individual (subject to EVV)
T1017 T1017	HT U4	TCM for 1915(i) *(Two separate lines on the same claim are required)*

TRILLIUM I OPTION BENEFIT PLAN

By clicking this link below, you can review the CURRENT Trillium Health Resources Benefit plans. Please be sure to check these regularly in the event of changes and updates to available services and certain limits/conditions. Medicaid 1915(i)-Option Set of Services

1915(I) UM NOTES FOR TAILORED CARE MANAGERS

General Reminders:

- TARs are reviewed in the order in which they are received, and within UM timeframes for standard and expedited requests.
- Expedited TARs are allowed when the members' health or safety are at risk; please document how health or safety is at risk in comment section
- Backdating is not allowed – The TAR can only be approved from the date of submission.
- 1915(i) services can only be approved while 1915(i) insurance is active – please check the end date in TBS and ensure that the end date of your request does not extend beyond the insurance end date. Requests that are after the insurance end date must be denied per state contract.
- The Benefit Plan has HARD LIMITS. There are no exceptions to these hard limits. Respite: 1200 units per Plan Year (even if there is a provider change). Plan Year is

defined as 1 year from the effective date of the plan (the date of the last required signature on the plan). Writing a new plan does not start the Plan Year over.

- CLS:
  - **Child:** 60 units/week. in school and 112 units/wk. out of school for members who are under age 22.
  - **If a child (up to 22)** is not in school and is seeking adult level of services (112 units/wk.), you must provide documentation of school completion/certificate or diploma. If no documentation is provided, we will deny any request over the child amount.
  - **Adult:** 112 units/ week.
- CLS with SE: No more than 40 hours/wk. total.

- Documentation Reminders
- Check the Benefit Plan to ensure all required documents are uploaded with your request.
- Please provide psychological eval completed by psychologist, including IQ and adaptive testing, and rendering an IDD or related diagnosis. If there is no psychological, there must be assessments/documentation (1915(i) assessment, CMCA, school psychoeducational evaluation, CCA, IEP) that identifies at least 3 functional limitations that can be clearly attributed to IDD. If the functional limitations are most likely due to MH diagnoses, then the member may not qualify for 1915(i) IDD services.
- Please provide 1915(i) Assessment.
- If there is a clear IDD diagnosis, that diagnosis should be listed on the plan and TAR/Smartsheet.
- Goals in the plan are based on the members' needs and how they relate to the service definition/clinical coverage policy. Goals or interventions reflecting "see short range goals" would not be sufficient.
- For Initial request for 1915(i) SE, you must provide DVRS/VR/EIPD documentation. If transitioning from SE from another funding source, we will treat the request as continuation. If transitioning from previous MCO, need to have auth printout. If we have the previous authorizations, we will treat the request as a continuation. Members can move across different codes of SE without providing DVRS/VR/EIPD documentation. If previously approved for any SE code, then there is no need to provide new DVRS/VR/EIPD documentation.

- For SE, we need to have a statement that member is making at or above minimum wage in the plan, or a pay stub can be uploaded. If the member declines to provide rate of pay, the provider needs to document that the pay rate was requested and that member declined to share.

Signature Reminders

- Plan signatures – required member/guardian and TCM signature. (Fact sheet indicates provider signatures are required but we are allowing flexibility on this at this time.) Also, we will note any issues with signatures (electronic vs. handwritten, etc.).
- Handwritten signatures require a handwritten date (Records Management and Documentation Manual, pg. 39). Electronic signatures require an electronic DATESTAMP (Records Management and Documentation Manual, pg. 14).
- Please review ALL the signatures on the plan (Service Order, TCM, provider QP and member or LRP) to ensure the plan is effective for the entire date range being
- requested. The date of the LAST signature on the plan signals the EFFECTIVE/START DATE of the plan, and 1 year from the date of the FIRST signature signals the EXPIRATION DATE of the plan. For example, member signature date 1/15/2025, TCM signature date 1/15/2025, Provider QP signature date 1/20/2025. Effective date: 1/20/2025. Expiration date: 1/14/2026. Keep in mind that active goals are needed throughout the entire plan period.

Code and Unit Reminders

- Ensure service code and units being requested on the TAR matches the service code and units on the plan (Example: one CLS code on ISP and a different CLS code requested in TAR is not allowed and must be denied – they must match for approval.)
- 1915(i) CLS for children:
  - For child level of CLS, the Plan should be clear about how many weeks there are at each frequency (in school versus out of school). For example:
    - 35 weeks. at 60 units per week
    - 17 weeks. at 112 units per week
    - If TCM does not provide a schedule or include the breakdown in the plan, we will assume: 1 week. off for Spring break, 12 weeks. off for Summer, 2 weeks. off for Fall break, 2 weeks. off for Christmas break.

- It may be clearer and easier to put the total units per lifetime in the TAR.

- For using multiple CLS codes:
  - For an adult, up to 28 hours per week of multiple CLS services can be requested, as long as no more than 28 hours per week of combined CLS services are utilized. The plan must detail how codes are intended to be used, and all codes requested on Tars must be present in the plan. For instance:
    - ISP indicates that members will receive:
    - For plan year of 1/1/2026 – 12/31/2026, Plan would say 20 hours per week (4171units per week) for (T2012 GC U4) live in caregiver, 8 hours per week (1669 units per week) for staff (T2013 TF U4).
    - TAR would request (T2012 GC U4) 5840 units per lifetime, (T2013 TFU4) 5840 units per lifetime.

For a child, up to 28 hours per week of multiple CLS services can be requested for out-of-school periods, as long as no more than 28 hours per week of combined CLS services are utilized. Up to 15 hours per week of multiple CLS services can be requested during school, as long as no more than 15 hours per week of combined CLS services are utilized. The plan must detail how codes are intended to be used, and all codes requested on TARs must be present in the plan. For instance:

- ISP indicates that members will receive:
- For a plan year of 1/1/2026 – 12/31/2026, Plan would say in school frequency 10 hours per week (40 units per week) live in caregiver (T2012 GC U4), 5 hours per week (20 units per week) for staff (T2013 TF U4) for a total of 35 wks., for a total of 2100 u/l. Plan would say out of school 14 hours per week (56 units per week) for live in caregiver (T2012 GC U4), 14 hours per week (56 units per week) for staff (T2013 TF U4) for a total of 17 wks. (1904 u/l).
- TAR would request (T2012 GC U4) 4004 units per lifetime, (T2013 TF U4) 4004 per lifetime.
  - Keep in mind that the above examples are based on an ideal of a full calendar year. In your member's plan, you will need to adjust the dates based on the effective dates of insurance and the dates of signatures, as this determines the effective dates of the plan.

Changing Providers

- When changing service providers for same service-
  - (1) a discharge summary must be submitted by the TCM or previous provider, and
  - (2) an updated plan signed by individual/guardian and TCM indicating change in providers must be submitted. Include details (dates/units for old provider and dates/units for new provider) regarding the change so TARs may be processed appropriately.
  - TCM must provide number of units of respite used by previous provider to ensure that no more than 1200 u/yr are authorized. This information can be provided in the plan, the Discharge Summary, the provider notes, or the Smartsheet note section.

Requesting Additional Units

- External TCMs: When requesting a unit correction due to incorrect initial calculation on the original TAR, submit a TAR and state in the provider's note that you are requesting a Post Auth Adjustment to add units. The units will be added if appropriate, and the TAR will be UTP (unable to process)/denied as a duplicate after the units are added to the existing authorization.

  If Trillium TCM, submit on Smartsheet. State in the note section that you are requesting a Post Auth Adjustment to add units. If appropriate, the units will be added, and the TAR will be UTP (unable to process)/denied as a duplicate after the units are added to the existing authorization.
- When requesting additional units to increase services, ensure the plan supports the request. Please be aware the benefit plan delineates hard limits.
- For clarity, please clearly state the total updated units you are requesting for the auth, or clearly state that you are requesting that the units you are requesting should be added to the current units in the existing auth. For example, the provider's note would say:
  - Please adjust total units in existing auth to 500 for a total of 500 units. OR
  - Please add 500 units to the existing 100 units in the auth for a total of 600 units.

- Please be aware that adjustments can be made from the date the TAR is created forward or date entered on the Smartsheet.

Other Reminders

- State Funded Day Supports: If member has 1915(i) insurance, then they are not able to access SFDS. Per the service definition SFDS may not be provided to HCBS Waiver recipients or individuals receiving IDD or TBI related meaningful day services.
- Please note: Members receiving 1915(i) services are unable to access certain other services. For members receiving 1915(i) CLS, they are excluded from receiving CLFS services. However, for members receiving CLFS Level 1, they may be able to receive 1915(i) Respite if they have 1915(i) insurance and they are residing with a caregiver. Please review service definitions and Benefit Plans to ensure all documentation is in place and criteria is met to access both services.
- Once a TAR is completed, the decision is available for your review in TBS – The decision will be noted in the TAR Provider Notes and/or in Clinical Documents. Recommendations are often included in the Provider Notes and the note in Clinical Documents. Also, Provider may view the authorization under Authorizations in Provider Direct.
- If a UM clinician contacts you regarding a TAR under review, please respond to that clinician via email.
- Communication regarding completed TARs should go through UM@trilliumnc.org, not the UM clinicians.

HCBS MONITORING REQUIREMENTS FOR 1915(I) SERVICES

For ongoing monitoring of the 1915(i) services, the Care Manager/Care Coordinator is responsible for completing the following activities monthly:

- Monitoring Care Plan/ISP goals.
- Maintaining close contact with the members, 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 member inclusive of HCBS requirements.
- Updating the independent assessment at least annually

- **Note:** For members in TCM and obtaining 1915(i) services, the Care Manager or Care Coordinator must complete the independent assessment as part of the annual care management comprehensive reassessment.

- Notifying Trillium of updates to 1915(i) service eligibility.
- Monitoring of 1915(i) service delivery. As a requirement of monitoring, the TCM provider must meet with the member face-to-face at least once per quarter (this can be in person or with two-way audio-visual communication) and conduct telephonic follow-up with the member for the other months in the quarter.

Impacted Services

- **Residential Supports** (provided in 5600 b and c group homes, licensed 5600(f), AFLs,
- and unlicensed AFLs)
- **Day Supports** (provided in 2300 licensed day programs and adult day healthcare programs certified under 131D).
- Supported Employment

Non-Impacted Services:

Services provided under the CAP/C waiver and in privately owned homes.

HCBS Care Management Monitoring:

Care Management monitoring ensures all members are receiving services in appropriate HCBS settings and provides continuous monitoring and oversight system. HCBS settings elements were added into existing Care Coordination monitoring tools. Impacted and non-impacted services will be monitored.

Requirements:

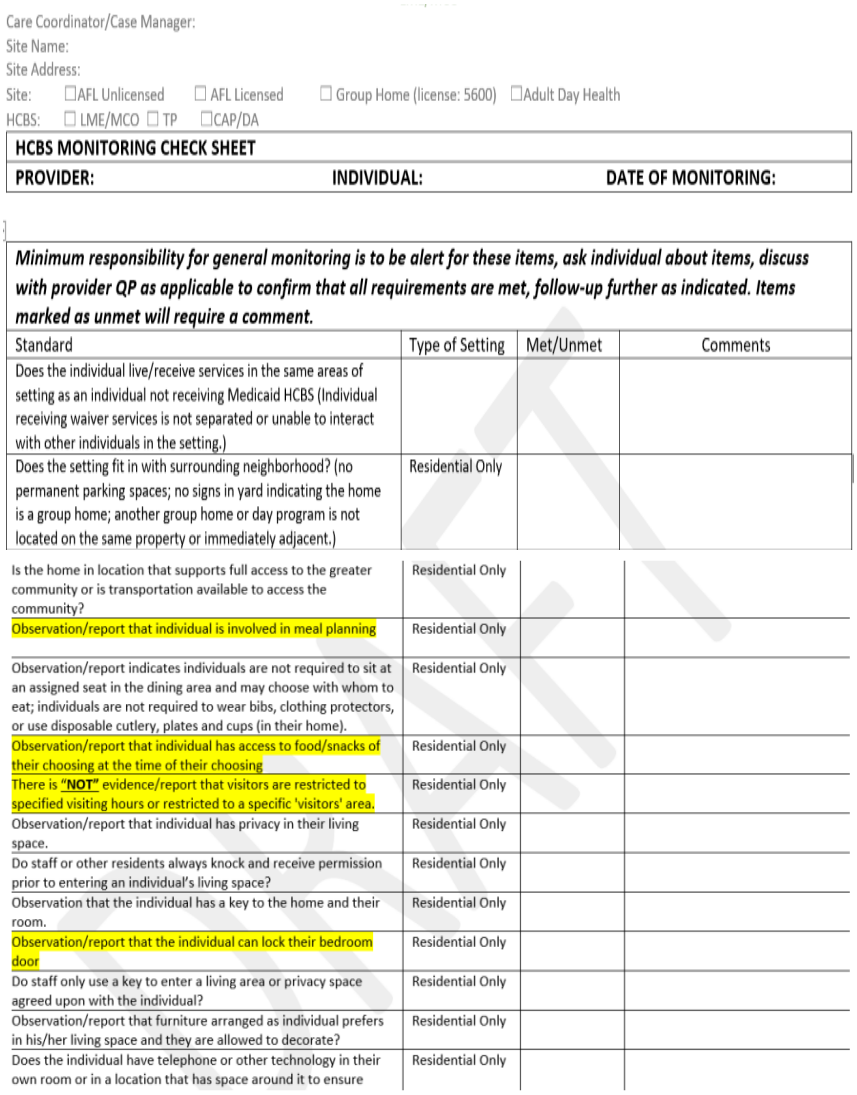
- **Residential Services:** Monthly Face-to-Face
- **Day Support:** Quarterly Face-to-Face
- **Private Home:** Quarterly Face-to-Face

Addressing HCBS Setting Non-Compliance

- Care Manager or Care Coordinator shall note the issue of Concern of noncompliance.
- Care Manager or Care Coordinator will follow TCM's Agency procedures for reporting the non-compliant issue.

- If non-compliance is determined, the Care Manager or Care Coordinator shall follow their reporting processes to the Trillium.
- The Care Manager or Care Coordinator shall work with Trillium to determine if a site should go into remediation.
- If a site goes into remediation. The provider site shall receive written communication regarding the noncompliant issue/s.
- The written communication shall include timelines to resolve the issue and return the setting to compliance.
- The site shall be monitored to ensure the noncompliant issue is resolved.
- Once resolved the HCBS setting returns to compliant.

HCBS Monitoring Tool



Care Coordinator/Case Manager:
Site Name:
Site Address:
Site: ☐AFL Unlicensed ☐ AFL Licensed ☐ Group Home (license: 5600) ☐Adult Day Health
HCBS: ☐ LME/MCO ☐ TP ☐CAP/DA

HCBS MONITORING CHECK SHEET		
PROVIDER:	**INDIVIDUAL:**	**DATE OF MONITORING:**

Minimum responsibility for general monitoring is to be alert for these items, ask individual about items, discuss with provider QP as applicable to confirm that all requirements are met, follow-up further as indicated. Items marked as unmet will require a comment.			
Standard	Type of Setting	Met/Unmet	Comments
Does the individual live/receive services in the same areas of setting as an individual not receiving Medicaid HCBS (Individual receiving waiver services is not separated or unable to interact with other individuals in the setting.)			
Does the setting fit in with surrounding neighborhood? (no permanent parking spaces; no signs in yard indicating the home is a group home; another group home or day program is not located on the same property or immediately adjacent.)	Residential Only		
Is the home in location that supports full access to the greater community or is transportation available to access the community?	Residential Only		
Observation/report that individual is involved in meal planning	Residential Only		
Observation/report indicates individuals are not required to sit at an assigned seat in the dining area and may choose with whom to eat; individuals are not required to wear bibs, clothing protectors, or use disposable cutlery, plates and cups (in their home).	Residential Only		
Observation/report that individual has access to food/snacks of their choosing at the time of their choosing	Residential Only		
There is **"NOT"** evidence/report that visitors are restricted to specified visiting hours or restricted to a specific 'visitors' area.	Residential Only		
Observation/report that individual has privacy in their living space.	Residential Only		
Do staff or other residents always knock and receive permission prior to entering an individual's living space?	Residential Only		
Observation that the individual has a key to the home and their room.	Residential Only		
Observation/report that the individual can lock their bedroom door	Residential Only		
Do staff only use a key to enter a living area or privacy space agreed upon with the individual?	Residential Only		
Observation/report that furniture arranged as individual prefers in his/her living space and they are allowed to decorate?	Residential Only		
Does the individual have telephone or other technology in their own room or in a location that has space around it to ensure	Residential Only		

Observation indicates the individual is working in an integrated setting.	Supported Employment Only		
Observation/report that there are NO changes in appearance since last visit.			
Observation/report at site indicates that schedules of individuals for physical therapy (PT), occupational therapy (OT), medications, restricted diet, etc., are not posted in a general area for all to view.			
Evidence/Observations of personal preference assessments to identify the kinds of work and activities individual wants to participate in?			
Observation indicates that the individual has unrestricted access in the setting (there are no gates, Velcro strips, locked doors, or other barriers preventing individuals' entrance to or exit from certain areas of the setting (excluding staff office/staff living quarters; individual has unscheduled access to food, phone, internet, etc.)			
Observation/report indicates that tables and chairs are at a convenient height and location so that individuals can access and use the furniture; that appliances are accessible to individuals (e.g., the microwave at any site is accessible or the home washer/dryer are front loading for individuals in wheelchairs).			
Observation indicates that staff communicate with individuals in a respectful manner with individuals in the setting while providing assistance and during the regular daily activities.			

HCBS Monitoring Examples

What should you do?

- Ask the staff what the agency policy is regarding the noncompliant issue.
- Note the staff's response and interaction.
- Document the monitoring non-compliance.
- Address non-compliance with their supervisor.
- Report the non-compliance to Trillium.
- Trillium shall confirm provider policy and procedure aligns with HCBS settings rule. G (Subpart G-HCBS Waiver Requirements). Trillium will determine the setting compliance.
- If setting is not complaint Trillium will formally advise the provider agency of the non-compliant issue.
- Provide technical assistance (if requested).
- Provide timeframe for the provider to remediate compliance.
- Care Manager or Care Coordinator will revisit the setting to monitor compliance.

1915(I) TIMEFRAMES

- Once a member is identified to need 1915(i) services there is a 90-day expectation for service delivery.
- Care Management Comprehensive Assessment (CMCA) must be initiated within 30 days of assignment and completed within 60 days of assignment.
- Care Manager or Care Coordinator will complete 1915(i) Assessment and submit it to Carelon for review.

- A 1915(i)-assessment submitted may outreach to Carelon if the submitter has not received an approval or denial response by 2 weeks from the date the 1915(i) assessment was submitted to Carelon.
- Care Plan/ISP must be approved or denied within 60 days of eligibility determination.
- Make best effort to proactively share the results of the CMCA within 14 days of completion with the member, the member's legally responsible person/guardian (where applicable), the member's primary care, behavioral health, I/DD, and TBI providers (including 1915(i) providers).
- Must ensure 1915(i) services begin within 45 days of Care Plan/ISP approval.
- Must conduct monthly monitoring with face-to-face being conducted quarterly

Note: Internal Trillium Care Managers and Care Coordinators need to follow the Step Action Plan for additional required timeframes.

POINT OF CONTACTS

- Providers should email UM@TrilliumNC.org for questions related to utilization management of 1915(i) services.
- Providers can reach out to their TCM consultant by phone or email if they have difficulty finding contact information for members so their TCM consultant can look in Trillium's system.
- For questions related to contracting, providers should email NetworkServicesSupport@TrilliumNC.org.
- Providers can contact the PSSL at (855) 250-1539 or via email at NetworkServicesSupport@TrilliumNC.org with any questions The PSSL is open Monday through Saturdays from 7 a.m. to 6 p.m.
- Trillium also has a link on our website located under "For Provider", then under "How do I…?". Providers can submit questions on the following topics by clicking 1915(i) Question Submission Form.
  - Who is assigned to Trillium TCM staff, contact information for member, 1915(i) insurance eligibility coverage, 1915(i) assessment needed, ISP/Care Plan needed, Service authorization needed, Claims/Billing need and 1915(i) service code issue.

RESOURCES

- Provider Directory | Trillium Health Resources
- Person Centered Service Plan 42 CFR 441.725
- Person-Centered Service Planning in HCBS: Requirements and Best Practices
- Tailored Care Management Provider Manual (January 2025)
- Tailored Care Management: Conflict-Free Care Management Guidance | NC Medicaid
- NC Medicaid Program Specific Clinical Coverage Policies
- Records Management and Documentation Manual | NCDHHS
- Trillium My Learning Campus for Providers
- Trillium Health Resources Tailored Care Management Providers List
- Tailored Care Management Providers Forms and Training | Trillium Health Resources
- NC Medicaid Enrollment Broker-Check Enrollment Status
- NC Medicaid Ombudsman
- Medicaid
- NCTracks Providers
- NC DMH/DD/SAS Homepage
- Tailored Plan Provider Quick Reference Guide
- PCP/Provider Request for Care Manager Name or Assignment Referral Form
- Billing Codes & Rates | Check Write Schedule | Trillium Health Resources
- EIPD Local Office Listing
- Subpart G-HCBS Waiver Requirements

CITATIONS

1. *NC Medicaid 1915(i) Services | NC Medicaid*
2. *Home | Trillium Health Resources*