Site Review Protocol

State of North Carolina: AMH+/ CMA Certification Program
Contract Number: 30-2021-054-DHB

Last modified: 1/24/23

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Overview

As North Carolina transitions its Medicaid and NC Health Choice programs from a predominantly fee-for-service delivery system to managed care, the Tailored Care Management model will be a critical element of the Behavioral Health and Intellectual/Developmental Disability (I/DD) Tailored Plans. The vision of the North Carolina Department of Health and Human Services (the Department) is that by the fourth year of Behavioral Health (BH) I/DD Tailored Plans, 80% of Tailored Care Management will be provider-based, performed by care managers affiliated with certified Advanced Medical Home Plus (AMH+) practices and Care Management Agencies (CMA).

NCQA will conduct an AMH+ and CMA certification process to promote provider-based care management, while also putting guardrails in place to ensure that providers are ready to perform this critical role by BH I/DD Tailored Plan launch. The AMH+ and CMA certification process has eight stages:

1. Providers notify NC DHHS about their desire to participate in the TCM program.
2. NC DHHS confirms that the provider is eligible and sends this information to NCQA.
3. NCQA creates a unique Interactive Review Tool (IRT) license for the provider and contacts the provider after this is complete.
4. The provider submits an application through IRT at **https://irt.ncqa.org/.** Instructions for submitting the application and attachments will be sent to providers from **nctailoredcaremgmt@ncqa.org**.
5. NCQA conducts a “desk review” of the application. Desk review entails checking the application for completeness and evaluating submitted attachments based on established scoring criteria outlined in the Desk Review Protocol. Desk review determines whether the organization has the potential to satisfy the full set of Tailored Care Management criteria prior to TCM service line launch.
6. Once NCQA completes the desk review, it notifies NC DHHS of the decision. NC DHHS contacts the provider and relays this decision.
7. Provider continues with TA with AHEC. NCQA contacts the provider to schedule a site review. The provider then submits the required documentation for site review in IRT, which is evaluated by NCQA prior to the site review.
8. NCQA conducts one or more (virtual) site visits with each provider. After this is complete, NCQA determines if the organization will be certified.

After completion of the certification process, NCQA and Behavioral Health I/DD Tailored Plans conduct readiness reviews as part of contracting with AMH+ practices and CMAs.

This document is a guide for individuals designated as reviewers by NCQA to review and rate responses to the North Carolina Medicaid AMH+ and CMA Certification Application for Tailored Care Management at the site review stage.

The Department is making this document publicly available to give applicants guidance on what reviewers look for when assessing an application.

Key Roles and Responsibilities

- **North Carolina Department of Health and Human Services (the Department):** Maintains oversight for all functions leading to implementation of the Tailored Care Management model and certification of providers.
- **National Committee for Quality Assurance (NCQA):** Vendor for the Department that conducts desk reviews, virtual site reviews, and readiness reviews.
- **Providers or Prospective Advanced Medical Homes Plus (AMH+) and Care Management Agencies (CMA):** Organizations that submit applications for certification as an AMH+ or CMA to become providers of Tailored Care Management services.
- **North Carolina Area Health Education Centers (AHEC):** A program that provides and supports educational activities and services, with a primary care focus in rural communities. For this project, AHEC provides technical assistance to providers.
- **Clinically Integrated Networks (CINs) or Other Partners:** Entities with which provider practices choose to partner to share responsibility for specific functions and capabilities required to operate as an AMH+ practice or a CMA. CINs or Other Partners may participate in site reviews, but organizational leaders should be able to speak to what the CIN or Other Partner will do.
- **Provider representative:** Individuals from the applicant organization who have oversight and management responsibilities. Although a consultant may be in attendance for the site review, oversight must clearly fall to employees of the provider organization. Provider representatives should have a working knowledge of the documentation provided and the provider's strategies to become an AMH+ or CMA.

  Roles/titles below are examples only. Larger entities typically include, but are not limited to, organization executive-level staff. Smaller entities may have a partner type relationship.

  a. Chief Executive Officer (CEO)
  b. Chief Operating Officer (COO)
  c. Chief Financial Officer (CFO)
  d. Chief Medical Officer (CMO) or Medical Director
  e. Chief Compliance Officer (CCO)
  f. Chief Information Security Officer (CISO)
  g. Quality Director
  h. Clinical Director
  i. Director of (Tailored) Care Management
  j. Practice Manager

- **Reviewers:** Surveyors who evaluate submitted materials on behalf of NCQA.

Element Structure

Program scoring is structured as the following:

Scoring Structure	Example Elements

• Category
  • Standard
  ○ Element
  ○ Element
  ○ Element
  • Standard
  ○ Element
  ▪ Factor
  ▪ Factor
  ▪ Factor
  ○ Element
  ▪ Factor
  ▪ Factor
  ▪ Factor
	• Staffing (STF)
	  • STF 1 – Care Management Staff
	  ○ STF 1A – Recruitment & Retention Workplan
	  ○ STF 1B – Memorandum of Agreement
	  ○ STF 1C – CIN Contract
	  • STF 2 – Clinical Consultants
	  ○ STF 2A – Clinical Consultants P&P
	  1. Description of relationships with clinicians in three categories of clinical consultants appropriate for the proposed population.
	  2. Plan for how the organization will leverage clinical consultants' expertise to support TCM.
	  ○ STF 2B – Clinical Consultants CVs & Signed Agreements
	  1. A general psychiatrist or child and adolescent psychiatrist.
	  2. A neuropsychologist or psychologist.
	  3. PCP (CMAs only).

Overall Rating Criteria

Tailored Care Management certification requirements are set forth in the Tailored Care Management Provider Manual. When reviewing applications, reviewers reference the Provider Manual and Application Questions. Reviewers may also reference the Tailored Care Management Data Strategy Policy Paper, which elaborates on health IT and data-related requirements. This guide provides reviewers with guidance on rating provider applications based on review of the rating criteria.

Rating Criteria: Criteria reviewers rate on a 3-point rating scale *(does not meet, partially meets, meets).* An overall rating of *meets* is considered a passing rating that moves the application forward to the decision-making stage. Providers can *partially meet* individual elements and still pass the site review. For each criterion, reviewers assess the strength of the provider's response relative to the requirements in the Provider Manual. Organizations are not expected to meet criteria fully at this point but must be able to articulate a plan for all requirements by the launch of Tailored Care Management service line. Please applying the following rating definitions:

Rating	Rating Definition
Meets	The organization articulates a clear understanding of the requirements and clearly describes how it either: a. Fully meets requirements currently, ***or*** b. Has a concrete strategy and a realistic timeline with supporting evidence to meet requirements fully by the launch of Tailored Care Management service line.
Partially meets	The organization has demonstrated progress toward meeting the requirements, but does not concretely define one or more key elements of the requirements.

Rating	Rating Definition
Does not meet	The organization does not demonstrate clear understanding of the requirements and/or does not include specific documentation to ensure that requirements are met by the launch of Tailored Care Management service line.
Not Applicable (N/A)	The requirement is not appliable to the organization that is under review.

Elements for Passing Site Review	
Must *Meet* Criteria	**Must *Partially Meet* or *Meet* Criteria**
• FIN 1 – Capacity and Sustainability • STF 1B – Care Management Staff (can also be N/A) • STF 1C – CIN Contract (can also be N/A) • HIT 1 – Electronic Health Record (EHR) • HIT 2 – Care Management Data System • HIT 3 – Admission, Discharge, Transfer • HIT 5 – NCCARE360	• ORG 1 – Provider Relationships and Linkages • FIN 2 - Oversight • STF 1A – Recruitment and Retention Workplan • STF 2 – Clinical Consultants • TCM 1 – Policies and Procedures for Communication with Members • TCM 2 – Capacity to Engage with Members through Frequent Contact • TCM 3 – Care Management Comprehensive Assessments • TCM 4 – Care Plans and Individual Support Plans (ISPs) • TCM 5 – Care Teams • TCM 6 – Required Components of Tailored Care Management • TCM 7 – Addressing Unmet Health-related Resource Needs • TCM 8 – Transitional Care Management • *TCM 9 – Innovations and TBI Waiver Care Coordination (if applicable)* • HIT 4 – HIT Workplan • QMI 1 – Quality Measurement and Improvement • TRN 1 – Training

Site Review Process

All document submissions and reviews occur in NCQA's IRT system.

1. **Provider Passes Desk Review.** The provider passes the desk review and advances to the site review.
2. **Provider Completes Technical Assistance.** Before the site review is scheduled, the provider undergoes technical assistance with AHEC.
3. **Site Review Is Scheduled.** After the organization and AHEC agree that the site is ready to move forward, AHEC notifies NCQA that the site review can be scheduled. NCQA contacts the provider to schedule the site review. ***Note:*** *The scheduling process is subject to change.*
4. **Provider Submits Required Documentation for Site Review.** An NCQA analyst contacts the provider directly to request required documentation for the upcoming site review. The provider submits the required documentation in IRT.
5. **Preliminary Document Review.** Before the site review, an NCQA analyst conducts a preliminary document review to determine if documents have been received and are up to date. If any paperwork is missing or inadequate, the analyst notifies the main contact listed on the application.
6. **Site Review Is Scheduled.** After the NCQA analyst confirms that all documentation has been submitted, the NCQA Analyst notifies the NCQA reviewer, who thoroughly reviews the contents of the documentation.
7. **Preliminary Criteria Review.** Site review teams include one main reviewer, a fiscal specialist, and an executive reviewer. Before the live virtual site review, all documentation is reviewed by the main reviewer against criteria defined in the Provider Manual and this Site Review Protocol. Reviewers cross-reference the newly submitted documents with the originally submitted application and desk review evaluation report to identify key areas of focus for the site review. The main reviewer identifies questions or concerns and use their findings to help guide discussion during the (virtual) site review. The financial reviewer may also be brought into this portion of the review if the organization is unable to attest to their continued financial health.
8. **(Virtual) Site Review.** One main reviewer is present during the site review. The fiscal specialist is available if necessary.
   a. *(If applicable)* The review team determines whether a single application should be evaluated and rated separately for different populations at the site review stage. The Department reserves the option to grant or deny certification separately for different populations and/or for different Behavioral Health I/DD Tailored Plan regions (refer to the Provider Manual for details). For example, a large agency may have separate operations for I/DD and for Behavioral Health.
   b. After the site review is completed, the review team collectively determines a rating of *does not meet*, *partially meets* or *meets* for each rated category and determines an overall rating of "Pass" or "Fail" for the site review.
   c. The fiscal specialist may join the team meeting to inform the rating determination for IRT Category FIN 1-C – Changes to Financial Statements if the organization has submitted new financial documents and the fiscal specialist has identified concerns.
   d. The executive reviewer performs a quality assurance review.
   e. NCQA notifies the Department of the overall rating for the site review.
9. **Decision Conveyed to Applicant.** NC DHHS sends written notification to the applicant. If the applicant fails the site review, the notification identifies areas of deficiency.

10. **Second Site Review *(if applicable).*** If an organization fails, it can return to the TA phase and then complete a second site review.

Site Review Objectives

- Confirm that the organization has the financial capacity to operate Tailored Care Management on a long-term basis and that it understands the amount and uses of capacity-building funds needed for the service line start-up. *(Applies only if provider has submitted new financial statements during the site review.)*
- Confirm that attestations are accurate and in place.
- Confirm that drafts of recruitment plans are in place and appropriate.
- Confirm that work plans in each area are complete and align with the planned launch date of the Tailored Care Management service line.
- Confirm that draft policies and procedures, care management comprehensive assessment tools, and other documents have been developed, are appropriate to the requirements, and are operationally feasible to meet requirements by the launch of Tailored Care Management service line.
- Confirm that plans for acquisition and integration, as well as oversight and monitoring, of all necessary health information technology capabilities are in place and feasible by the launch of the Tailored Care Management service line.
- Confirm that the organization has adequate plans for ensuring that care managers are trained appropriately.

Provider Manual Requirement to IRT Element Crosswalk

Provider Manual Requirement Name	IRT Element Name
2.2 Provider Relationships and Linkages	ORG 1A – Provider Relationships & Linkages
2.3 Capacity and Sustainability	FIN 1E – Changes to Net Income/Changes to Net Assets
2.3 Capacity and Sustainability	FIN 1F – Changes to Net Working Capital
2.3 Capacity and Sustainability	FIN 1G – Changes to Total Equity/Total Net Assets
2.3 Capacity and Sustainability	FIN 1H – Financial Projections
2.4 Oversight	FIN 2C – Governance Structure
3.1 Care Management Staff	STF 1A – Recruitment and Retention Workplan
3.1 Care Management Staff	STF 1B – Memorandum of Agreement
3.1 Care Management Staff	STF 1C – CIN Contract
3.2 Clinical Consultants	STF 2A – Clinical Consultants P&P
3.2 Clinical Consultants	STF 2B – Clinical Consultant CVs and Signed Agreements
4.1 Policies and Procedures for Communication with Members	TCM 1A – Communication with Members, Families, and Caregivers P&P
4.2 Capacity to Engage with Members through Frequent Contact	TCM 2A – Care Manager Outreach and Member Engagement P&P
4.3 Care Management Comprehensive Assessments	TCM 3A – CM Comprehensive Assessment Tools
4.3 Care Management Comprehensive Assessments	TCM 3B – CM Comprehensive Assessment P&P
4.4 Care Plans and Individual Support Plans (ISPs)	TCM 4A – Care Plan and/or ISP Tool
4.4 Care Plans and Individual Support Plans (ISPs)	TCM 4B – Mock Care Plan and/or ISP
4.5 Care Teams	TCM 5A – Team Formation and Communication P&P
4.5 Care Teams	TCM 5B – Case Example
4.6 Required Components of Tailored Care Management	TCM 6A – Communication Among Provider Types P&P
4.6 Required Components of Tailored Care Management	TCM 6B – Tailored Care Management P&P
4.7 Addressing Unmet Health-related Resource Needs	TCM 7A – Addressing Unmet Health Related Resource Needs
4.8 Transitional Care Management	TCM 8A – Transitional Management and Member Outreach P&P
4.9 Innovations and TBI Waiver Care Coordination (if applicable)	TCM 9A – TBI Waiver Care Coordination P&P
5.1 Use an electronic health record (EHR)	HIT 1A – Electronic Health Record (EHR)
5.2 Use a care management data system	HIT 2A – Care Management Data System (CM Data System)
5.3 Use ADT information	HIT 3A – Admission, Discharge, Transfer (ADT)
5.1-5.3 Health IT Workplan	HIT 4A – HIT Workplan
5.4 Use NCCARE360	HIT 5A – NCCARE360
6 Quality Measurement and Improvement	QMI 1A – Continuous Quality Improvement (CQI) P&P
6 Quality Measurement and Improvement	QMI 1B – High Priority TCM and CQI Example
7 Training	TRN 1A – TCM Care Manager Training Plan
7 Training	TRN 1B – TCM Care Manager Training Plan Optional Elements

Requirements

Organizational Information (ORG)

ORG 1 – Provider Relationships and Linkages

Requirement: *[Section V, Part 2.2, Provider Manual page 16]*

The organization must have active, working relationships with community providers that offer a wide scope of clinical and social services, including strong reciprocal relationships among relevant behavioral health, I/DD and primary care providers, to facilitate referrals among providers as well as provide formal and informal feedback and opportunities to share best practices.

Application Instructions/Questions: *Describe current contracts or other formal arrangements with behavioral health, I/DD, primary care, social service, pharmacy, or other providers that you think will be valuable assets in supporting the care management role (e.g., referral protocols in place, exchange of PHI, overlapping care teams for individuals, care conferences for shared patients, administrative level relationships). [Question B10]*

ORG 1A – Provider Relationships & Linkages

IRT element header: Does the provider have the following?

Factors

1. At least one established relationship per county, in distinct categories outside the organization's designation, that includes: resource name, address, and counties served.
2. At least three established relationships per county, in distinct categories outside the organization's designation, that includes: resource name, address, and counties served.

Scoring

Meets	Partially Meets	Does Not Meet
2 Factors	1 Factor	0 Factors

☑ Look for the following evidence in the applicant's materials:

- The concreteness and clarity of the organization's plan to strengthen and formalize relationships with specific providers in at least one provider type listed in *Question B10* of the application.
- **Provider Relationships and Linkages Work Plan,** with a list of names and categories of relevant providers with which the organization has active working relationships.
- Established relationships in distinct categories outside the organization's designation by the time of program launch.
  - ***Example:*** *Memorandum of Agreement currently in place with the providers identified,* ***OR*** *a description of existing, reliable relationships with relevant providers that includes the organization's address and counties served.*

Capacity (FIN)

FIN 1 – Capacity and Sustainability

Requirement: *[Section V, Part 2.3, Provider Manual page 17]*

This requirement will be evaluated during the desk review portion of the certification process.

The organization must have the capacity and financial sustainability to establish care management as an ongoing line of business, as evidenced by an audited financial statement, or income statement AND balance sheet. Tailored Care Management must be recognized by the organization's leadership and governing body as integral to the mission of the organization and as such be supported by a budget and management team appropriate to maintain Tailored Care Management as a high-functioning service line.

The fiscal specialist conducting this portion of the review reserves the right to reach out to providers with any questions they may have about submitted narrative responses or financial documents.

The provider will answer the following question regarding the continued financial health of the organization located within the site review portion of the application:

- Since desk review, have there been any substantive changes to the financial health of your organization, such that more recent financial statements show deterioration in the metrics below benchmark noted in C3 of the desk review?
- If the answer is yes, the provider will upload a document that includes a detailed explanation of the major driver(s) of these changes and what the organization is doing to improve performance. Providers will also submit an updated income statement and balance which reflect this deterioration. If there were no changes, select "N/A" for all factors for the questions in the application below:
- Has Net Income fallen below benchmark?
  - If yes, these three items are needed:
    - Explanation of the major driver(s) of these changes
    - What the organization is doing to improve performance
    - Updated Income Statement (Profit and Loss)
- Has Net Working Capital fallen below benchmark?
  - If yes, these three items are needed:
    - Explanation of the major driver(s) of these changes
    - What the organization is doing to improve performance
    - Updated Balance Sheet
- Has Total Equity fallen below benchmark?
  - If yes, these three items are needed:
    - Explanation of the major driver(s) of these changes
    - What the organization is doing to improve performance
    - Updated Balance Sheet

FIN 1E – Changes to Net Income/Changes Net Assets

Factors

1. Does the explanation provided include major drivers that sufficiently address the change in financial standing?
2. Does the organization have a concrete and realistic plan to improve this performance metric?
3. Is Income Statement Provided?

Scoring

Meets	Partially Meets	Does Not Meet	N/A
3 Factors	1-2 factors	0 Factors	N/A – Attestation Provided

FIN 1F – Changes to Net Working Capital

Factors

1. Does the explanation provided include major drivers that sufficiently address the change in financial standing?
2. Does the organization have a concrete and realistic plan to improve this performance metric?
3. Is a Balance Sheet provided?

Scoring

Meets	Partially Meets	Does Not Meet	N/A
3 Factors	1-2 factors	0 Factors	N/A – Attestation Provided

FIN 1G – Changes to Total Equity/Total Net Assets

Factors

1. Does the explanation provided include major drivers that sufficiently address the change in financial standing?
2. Does the organization have a concrete and realistic plan to improve this performance metric?
3. Is a Balance Sheet provided?

Scoring

Meets	Partially Meets	Does Not Meet	N/A
3 Factors	1-2 factors	0 Factors	N/A – Attestation Provided

FIN 1H – Financial Projections

Factors

1. Was an acceptable rationale for updates to projected population or service volumes that impact revenues or expenses provided?
2. Was an acceptable summary of how capacity-building funds will be used to fill gaps (e.g., staffing, HIT) by Tailored Care Management launch provided?

Scoring

Meets	Partially Meets	Does Not Meet
2 Factors	1 Factor	0 Factors

FIN 2 – Oversight

Requirement: *[Section V, Part 2.4, Provider Manual page 17]*

The organization must be able to demonstrate that it has the appropriate structures in place to oversee the Tailored Care Management model. The Department will look for evidence of a strong governance structure. Organizations may demonstrate strong governance by showing that they have a governing board and bylaws in place; a committee structure that enables appropriate oversight of budget, other fiduciary matters, compliance, and conflicts of interest. If the organization does not have a board of directors, financial oversight must still be specified in order to pass this requirement.

FIN 2C – Governance Structure

IRT element header: Does the Governance Structure document contain the following criteria?

Factors

1. Governance Board and Bylaws or reporting structure.
2. Committee Structure.
3. Financial Oversight.

Scoring

Meets	Partially Meets	Does Not Meet
3 Factors	1-2 Factors	0 Factors

Reviewer Instructions:

☑ Look for the following evidence in the applicant's materials:
- Governance Structure Bylaws and/or Charter.
- Committee Structure.
- Financial Oversight.

☑ If the applicant does not have a board of directors, the organization must still provide proof of financial oversight.

Staffing (STF)

STF 1 – Care Management Staff

Requirement: *[Section V, Part 3.1, Provider Manual page 18]*

The organization must be able to ensure that all care managers providing Tailored Care Management meet the following minimum qualification elements, whether they are employed by the organization itself or employed at the CIN or Other Partner level:

☑ Care managers serving all members must have the following minimum qualifications:
- Meet North Carolina's definition of a Qualified Professional per 10A-NCAC 27G .0104;
- For care managers serving members with LTSS needs: two years of prior LTSS and/or HCBS coordination, care delivery monitoring, and care management experience. (This experience may be concurrent with the years of experience required to become a Qualified Professional.)

☑ Supervising care managers serving members with behavioral health conditions must have the following minimum qualifications:

- A license, provisional license, certificate, registration or permit issued by the governing board regulating a human service profession (including Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), Licensed Clinical Addiction Specialist (LCAS), Licensed Clinical Mental Health Counselor (LCMHC), Licensed Psychological Associate (LPA)), or a Registered Nurse (RN) license issued by the North Carolina Board of Nursing; ***and***
- Three years of experience providing care management, case management, or care coordination to the population being served.

☑ Supervising care managers serving members with an I/DD or a TBI must have ***one*** of the following minimum qualifications:

- A bachelor's degree ***and***
- Five years of experience providing care management, case management, or care coordination to complex individuals with I/DD or TBI;
- A master's degree in a human services field ***and***
- Three years of experience providing care management, case management, or care coordination to complex individuals with I/DD or TBI

If a member is dually diagnosed with a behavioral health condition and an I/DD or a TBI, the BH I/DD Tailored Plan and assigned organization providing Tailored Care Management must ensure that the supervising care manager is qualified to oversee the member's care manager.

The organization must ensure that each care manager is supervised by a supervising care manager. One supervising care manager must not oversee more than eight care managers. Supervisors should have no caseload, but will provide coverage for vacation, sick leave, and staff turnovers. They will be responsible for reviewing all Tailored Care Management care plans and Individual Support Plans (ISPs) and will provide guidance to care managers on how to meet members' needs.

☑ Care manager extenders. To bolster the care management workforce, the Department will allow AMH+ practices and CMAs to use care manager extenders, such as community navigators, community health workers, and certified peer support specialists, to support certain Tailored Care Management functions. The Department's vision is that extenders will help AMH+ practices, 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. Care manager extenders must have the following qualifications: members with an I/DD or a TBI must have ***one*** of the following minimum qualifications:

- At least 18 years of age ***and***
- A high school diploma or equivalent ***and***
- Meet one of the following 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 (note that a parent/guardian cannot serve as an extender for their family member) ***or***

- 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.

When using an extender, the care manager should direct the extender's care management functions and ensure that the extender is only charged with responsibilities within the scope of functions specified in this document. The care manager and supervising care manager must ensure that all services are well-coordinated, including functions delegated to extenders. Extenders also cannot work for the same organization where they receive services.

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 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

CIN Relationship Requirement [if applicable]: The Department will allow AMH+ practices and CMAs to work with CINs and Other Partners to meet certification requirements. However, they are not required to do so to become certified. Certification will include an evaluation of whether the AMH+ or CMA has managerial control of care management staff, defined as the opportunity, at minimum, to a) approve hiring/placement of a care manager and b) require a replacement for any care manager whose performance the AMH+ or CMA deems unsatisfactory. As a general rule, the Department will expect arrangements with CINs or Other Partners to include strong clinical leadership at the CIN or Other Partner level that has deep experience in NC Medicaid or NC Health Choice and/or has supported similar efforts in other states.

Subsidiaries of LME/MCOs, BH I/DD Tailored Plans, or other health plans generally may not be considered CINs or Other Partners for the purposes of Tailored Care Management, with one exception as follows: the Department recognizes that AMH+ practices and CMAs may decide to enter into arrangements with BH I/DD Tailored Plans for use of their information technology (IT) products or platforms for care management, in order to meet the care management data system requirements described below. In this scenario, the BH I/DD Tailored Plan would be considered an "Other Partner" (not a CIN) for health IT support only. AMH+ practices and CMAs intending to work with a CIN or Other Partner must sign a formal agreement with that organization that ensures the CIN or Other Partner can receive and use patient data in compliance with the Health Insurance Portability and Accountability Act (HIPAA) and state regulations, as well as any other data elements mutually agreed upon by the practice and the CIN or Other Partner.

STF 1A – Recruitment and Retention Workplan

IRT element header: Does the Recruitment and Retention Workplan include the following?

Factors

1. Internal and external sources for recruitment; connections in place at site review and those in process.
2. Analysis of care manager and supervisor staffing required to meet the needs and requirements of the population types and numbers noted in the application.
3. The estimated number of care manager candidates to be recruited from each source in program years 1–3.
4. Based on existing direct care staff turnover or other sources/methods, the estimated turnover rate of care managers and supervisors; retention tactics to reduce turnover.
5. The lead professional assigned to recruitment/retention.
6. A demonstrated knowledge of the hiring market for care managers and supervisors.
7. A recruitment, credentialing, and training plan for care manager extenders (i.e., pharmacists, community health workers [CHWs], patient navigators), if used. (This factor can be N/A.)
8. Current staff who meet the minimum qualifications for Tailored Care Management roles and will undertake Tailored Care Management roles at launch.

Scoring

Meets	Partially Meets	Does Not Meet
8 Factors	4-7 Factors	0-3 Factors

STF 1B – Memorandum of Agreement

IRT element header: Was a Memorandum of Agreement with CIN or Other Partner provided (if applicable)?

Scoring

Meets	Does Not Meet	N/A
Yes	No	N/A

STF 1C – CIN Contract

IRT element header: Was a CIN contract provided (if applicable)?

Scoring

Meets	Does Not Meet	N/A
Yes	No	N/A

Reviewer Instructions:

☑ ***Note:*** All factors for the STF1A - Recruitment and Retention Workplan are scored on a Y/N basis, besides factor 7. N/A is accepted for this factor if the organization does not use care manager extenders.

☑ Look for the following evidence in the applicant's materials:

- Measurable progress on a plan to have the following components by the time of program launch:
  - A clear description of the number of current staff who meet the minimum qualifications for Tailored Care Management.
  - Analysis of the number of Tailored Care Management staff needed that is clearly linked to 1.) the estimated population and population types stated in the application. Approximate quantifications

are acceptable. If the organization secures Tailored Care Management staff employed at the CIN level, check for the degree to which the description ensures that managerial control is retained at the provider level [refer to attached **STF 1B – Memorandum of Agreements** between organization and CIN].

- Credibility of the recruitment strategy, which includes clear timelines and sources for staff.
- A detailed **STF 1A – Recruitment and Retention Workplan** that includes:
  - Internal and external sources for recruitment; connections in place at site review and those in process.
  - Updated (from the initial application) analysis of care manager and supervisor staffing required to meet the needs and requirements of the population types and numbers noted in the application.
  - The estimated number of care manager candidates to be recruited from each source in program years 1–3.
  - Based on existing direct care staff turnover or other sources/methods, the estimated turnover rate of care managers and supervisors; retention tactics to reduce turnover.
  - The lead professional assigned to recruitment/retention.
  - A demonstrated knowledge of the hiring market for care managers and supervisors.
- A recruitment, credentialing, and training plan for care manager extenders (i.e., pharmacists, community health workers [CHWs], patient navigators), if used.
  - Current staff who meet the minimum qualifications for Tailored Care Management roles and will undertake Tailored Care Management roles at launch.
  - Updated timeline for recruitment, as needed.
- If using **CIN** or Other Partners **[STF 1C – CIN Contract]**:
  - A CIN contract, including all costs for CIN services.
  - A documented oversight/management plan detailing managerial control over CIN or Other Partner-employed care managers/supervisors.
  - A formal agreement ensuring that the CIN or Other Partner can receive and use patient data in compliance with the HIPAA and state regulations, as well as any other data elements mutually agreed on by the practice and the CIN or Other Partner.

STF 2 – Clinical Consultants

Requirement: *[Section V, Part 3.2, Provider Manual page 19]*

The BH I/DD Tailored Plan will be required to ensure that organizations providing Tailored Care Management (AMH+ practices, CMAs, or the BH I/DD Tailored Plan itself) have access to clinical consultants in order to access expert support appropriate for the needs of the panel under Tailored Care Management. Clinical consultants are not part of the care team for any given member; rather, the role of clinical consultants is to provide subject matter expert advice to the care team. The AMH+ or CMA may employ or contract with consultants or do so through a CIN or Other Partner, and the consultant should be available by phone to staff within AMH+ practices and CMAs to advise on complex clinical issues on an ad hoc basis. While different member needs will require different expertise, the AMH+ or CMA must ensure that it has access to at least the following experts:

- A general psychiatrist or child and adolescent psychiatrist
- A neuropsychologist or psychologist
- For CMAs, a primary care physician (PCP) to the extent the beneficiary's PCP is not available for consultation

AMH+ practices and CMAs may demonstrate that they have access to clinical consultants themselves or can contract with other provider organizations to arrange access. The per member per month (PMPM) rate for Tailored Care Management will take these costs into consideration.

STF 2A – Clinical Consultants P&P

IRT Introduction: Does the Clinical Consultants P&P provided include the following?

Factors

1. Description of relationships with clinicians in three categories of clinical consultants appropriate for the proposed population.
2. Plan for how the organization will leverage clinical consultants' expertise to support TCM.

Scoring

Meets	Partially Meets	Does Not Meet
2 Factors	1 Factor	0 Factors

STF 2B – Clinical Consultant Curricula vitae (CVs) and Signed Agreements

IRT element header: Were CVs and Signed Agreements from Clinical Consultants provided for the following experts?

Factors

1. A general psychiatrist or child and adolescent psychiatrist.
2. A neuropsychologist or psychologist.
3. For CMAs, a primary care physician (PCP), to the extent the beneficiary's PCP is not available for consultation. (This factor can be N/A.)

Scoring

Meets	Partially Meets	Does Not Meet
3 Factors (or 2 Factors if Factor 3 is N/A)	1-2 Factors	0 Factors

Reviewer Instructions:

☑ ***Note:*** All factors for the STF2A – Clinical Consultants P&P are scored on a Y/N basis, besides factor 3. N/A is accepted for this factor.

☑ Look for the following evidence in the applicant's materials:

- Measurable progress on a plan to have the following components by the time of TCM service launch:
  - A clear description of the organization's relationships with clinicians in at least two categories of clinical consultants appropriate for the proposed population.
  - A demonstrated understanding of how the organization will leverage clinical consultants to support Tailored Care Management (e.g., when core clinical care team members or ancillary clinical team members, such as subspecialists, are not available due to vacation, sick leave, or lack of after-hours coverage; when there is disagreement within the clinical team when evidence-based treatments are not working and/or are unavailable).
- Additional components to be submitted before the site review:
  - Names, CVs, and signed contractual agreements for the following clinical consultants, at a minimum:
    - A general psychiatrist or child and adolescent psychiatrist.
    - A neuropsychologist or psychologist.
    - For CMAs, a primary care physician (PCP), to the extent that the beneficiary's PCP is not available for consultation.

Delivery of Tailored Care Management (TCM)

TCM 1 – Policies and Procedures for Communication with Members

Requirement: *[Section V, Part 4.1, Provider Manual page 20]*

The AMH+ or CMA must developpolicies (to be approved by the BH I/DD Tailored Plan) for communicating and sharing informationwith individuals and their families and other caregivers with appropriate consideration for language, literacy, and cultural preferences, including sign language, closed captioning, and/or video capture. “Robocalls” or automated telephone calls that deliver recorded messages will not be an acceptable form of contact.

TCM 1A – Communication with Members, Families, and Caregivers P&P

IRT element header: Does Communication P&P with Members, Families, and Caregivers include the following requirements?

Factors

1. Communication accommodations for language preference.
2. Communication accommodations for literacy level.
3. Communication accommodations for cultural references.
4. Communication accommodations for sign language.
5. Communication accommodations for close captioning and/or video capture.

Scoring

Meets	Partially Meets	Does Not Meet
5 Factors	2-4 Factors	0-1 Factors

Reviewer Instructions:

☑ Look for the following evidence in the applicant’s materials:

- A **draft of P&Ps for communication with members, families, and caregivers** in person, via two-way, real-time audio/video service, by telephone, text, email, and/or through other methods.
- Communication should accommodate language, literacy, cultural references, sign language, closed captioning, and/or video capture. (Robocalls are not considered an acceptable form of communication.)

TCM 2 – Capacity to Engage Members Through Frequent Contact

Requirement: *[Section V, Part 4.2, Provider Manual page 20]*

The Department is setting minimum requirements for contact between members and care managers under the Tailored Care Management model. While the Department is not setting specific minimum staffing ratios to allow flexibility for providers to customize care teams according to needs, it is the responsibility of the AMH+ or CMA to have adequate staffing in place to meet the Department's requirements for engagement. For each member, the level of minimum contacts will be defined by the same "low," "moderate," and "high" acuity tiers that will be used to adjust payments. The Department intends to establish a standardized methodology to assign each BH I/DD Tailored Plan member to an acuity tier and will release additional detail on the methodology prior to BH I/DD Tailored Plan launch. The cumulative minimum contacts required for all members shall serve as a guide for the provider to establish the necessary capacity to adequately engage their panel. Provider compliance to minimum contact requirements will not be assessed on a per-member basis, but whether the provider cumulatively delivers at least 75% of the grand sum of contacts required by all members in their panel. (see IV. 1. Summary of the Tailored Care Management Model, Provider Manual).

The minimum contact requirements will be as follows:

- Care manager contacts for members with behavioral health needs:
  - *High Acuity:* At least four care manager-to-member contacts per month, including at least one in-person contact with the member.
  - *Moderate Acuity:* At least three care manager-to-member contacts per month and at least one in-person contact with the member quarterly (includes care management comprehensive assessment if it was conducted in- person).
  - *Low Acuity:* At least two care manager-to-member contacts per month and at least two in-person contacts with the member per year, approximately six months apart (includes the care management comprehensive assessment if it was conducted in-person).
- Care manager contacts for members with an I/DD or a TBI:
  - *High Acuity:* At least three care manager-to-member contacts per month, including two in-person contacts and one telephonic contact with the member.
  - *Moderate Acuity:* At least three care manager-to-member contacts per month and at least one in-person contact with the member quarterly.
  - *Low Acuity:* At least one telephonic contact per month and at least two in person care manager-to-member contacts per year, approximately six months apart.

  For members with an I/DD or a TBI who have a guardian, telephonic contact may be with a guardian in lieu of the member, only where appropriate or necessary. In-person contact must involve the member.

TCM 2A – Care Manager Outreach and Member Engagement P&P

IRT element header: Does Care Manager Outreach and Member Engagement Based on Acuity P&P include the following requirements?

Factors

1. Clear description of how the organization links minimum contact requirements, based on acuity level, to staffing planning and the population that will be under care management.
2. Specific description of situations in which the organization may be challenged to meet contact requirements, and potential solutions to those challenges.

Scoring

Meets	Partially Meets	Does Not Meet
2 Factors	1 Factor	0 Factors

Reviewer Instructions:

☑ Look for the following evidence in the applicant's materials:

- Measurable progress on a plan to have the following components by the time of TCM Service launch:
  - A clear description of how the organization links minimum-contact requirements to staff planning, and the population that will be under care management, in its planning assumptions.
  - A description of specific situations in which the organization may be challenged to meet contact requirements, and potential solutions to those challenges (e.g., COVID-19, in rural areas, transportation barriers, language barriers).
- Additional components to be reviewed during site review:
  - A **draft of the P&Ps directed to care manager** outreach to members, family, and caregivers, aimed at overcoming challenges to meeting minimum contact requirements, including incorporating communication methods in 4.1 and other tactics.

TCM 3 – Care Management Comprehensive Assessment

Requirements: *[Section V, Part 4.3, Provider Manual page 21]*

The Department is requiring that all BH I/DD Tailored Plan members entering Tailored Care Management receive the care management comprehensive assessment, completed by the organization performing the Tailored Care Management, to determine care needs. The AMH+ or CMA will be expected to make a best effort attempt to complete the care management comprehensive assessment in person, in a location that meets the member's needs. "Best effort" will be defined as including at least three documented strategic follow-up attempts to contact the member if the first attempt is unsuccessful, e.g., going to the home or working with a known provider to meet the member at an appointment. The Department recognizes that in limited circumstances it will be necessary to complete the assessment via technology conferencing tools (e.g., audio, video, and/or web). During the first year of BH I/DD Tailored Plan operation, the AMH+ or CMA must undertake best efforts to complete the care management comprehensive assessment within the following timeframes:

- Members identified as high acuity: within 60 days of BH I/DD Tailored Plan enrollment.
- Members identified as moderate/low acuity: within 90 days of BH I/DD Tailored Plan enrollment.

During the second and subsequent years of BH I/DD Tailored Plan operation, the AMH+ or CMA must undertake best efforts to complete the care management comprehensive assessment within 60 days of BH I/DD Tailored Plan enrollment for all members.

Required Components of Care Management Comprehensive Assessment: The AMH+ or CMA will be required to ensure that the care management comprehensive assessment includes, at a minimum, the following domains:

- Immediate care needs
- Current services and providers across all health needs
- Functional needs, accessibility needs, strengths, and goals
- Other state or local services currently used
- Physical health conditions, including dental conditions
- Current and past mental health and substance use status and/or disorders, including tobacco use disorders
- Physical, intellectual, or developmental disabilities
- Detailed medication history – a list of all medicines, including over-the-counter medication and medication that has been prescribed, dispensed, or administered – and known allergies
- Advance directives, including psychiatric advance directives
- Available informal, caregiver, or social supports
- Standardized unmet health-related resource need questions (to be provided by the Department) covering four priority domains:
  - Housing instability
  - Transportation insecurity
  - Food insecurity; and
  - Interpersonal violence/toxic stress
- Any other ongoing conditions that require a course of treatment or regular care monitoring
- For adults only, exposure to adverse childhood experiences (ACEs) or other trauma
- Risks to the health, well-being, and safety of the member and others (including sexual activity and potential abuse/exploitation, or exposure to secondhand smoke/aerosols and other substances)
- Cultural considerations (ethnicity, religion, language, reading level, health literacy, etc.)
- Employment/community involvement
- Education (including individualized education plan and lifelong learning activities);
- Justice system involvement (adults) or juvenile justice involvement and/or expulsions or exclusions from school (children and adolescents)
- Risk factors that indicate an imminent need for LTSS
- The caregiver's strengths and needs
- Upcoming life transitions (changing schools, changing employment, moving, etc.)
- Self-management and planning skills
- Receipt of and eligibility for entitlement benefits
- For members with an I/DD or a TBI:
  - Financial resources and money management
  - Alternative guardianship arrangements, as appropriate
- For children ages zero up to three, incorporate questions related to Early Intervention (EI)services for children, including:
  - Whether the child is receiving EI services

  - The child's current EI services
  - Frequency of EI services provided
  - Which local Children's Developmental Service Agency (CDSA) or subcontracted agency is providing the services
  - Contact information for the CDSA service coordinator
- For children ages three up to 21 with a mental health disorder and/or SUD, including members with a dual I/DD and mental health diagnosis, incorporate a strengths assessment process that promotes the identification of the functional strengths of each youth, family, and community

Requirements for Reassessment: The AMH+ or CMA must attempt a care management comprehensive assessment for members already engaged in care management:

- At least annually
- When the member's circumstances, needs, or health status changes significantly
- After significant changes in scores on State-approved level-of-care determination and screening tools (e.g., Level of Care Utilization System (LOCUS) and Child and Adolescent LOCUS (CALOCUS), American Society of Addiction Medicine (ASAM), Child and Adolescent Needs and Strengths (CANS), SIS)
- After "triggering events" as defined below; or
- At the member's request.

Triggering events prompting reassessments include:

- Inpatient hospitalization for any reason
- Two emergency department (ED) visits since the last care management comprehensive assessment (including reassessment)
- An involuntary treatment episode
- Use of behavioral health crisis services
- Arrest or other involvement with law enforcement/the criminal justice system, including the Division of Juvenile Justice
- Becoming pregnant and/or giving birth
- A change in member circumstances that requires an increased need for care, a decreased need for care, transition into or out of an institution, or loss of a family/friend caretaker, or any other circumstance the plan deems to be a change in circumstance
- Loss of housing; and
- Foster care involvement.

The AMH+ or CMA must ensure that the member receives a reassessment within 30 days of when it detects the triggering change or event. For triggering events and in other circumstances in which an assessment may have been recently performed, reassessment may consist of an addendum or update to a previous assessment.

Sharing of Care Management Comprehensive Assessment Results: The AMH+ or CMA must ensure that the results of the care management comprehensive assessment are shared with the member's primary care, behavioral health, I/DD, TBI, and LTSS providers and the BH I/DD Tailored Plan within 14 days of completion to inform care planning and treatment planning, with the member's consent (to the extent required by law).

TCM 3A – CM Comprehensive Assessment Tools

IRT element header: Were sufficient Care Management Comprehensive Assessment Tool(s) provided for the following populations? If the organization is not servicing the population, please select "N/A." If the organization is servicing the population but did not provide the required documentation for that population, please select "No."

Factors

1. Mental Health and Substance Use Disorder (Adult)
2. Mental Health and Substance Use Disorder (Child/Adolescent)
3. Intellectual Developmental Disability (I/DD – Adult)
4. Intellectual Developmental Disability (I/DD – Child/Adolescent)
5. Innovations Waiver (Adult)
6. Innovations Waiver (Child/Adolescent)
7. Traumatic Brain Injury (TBI) Waiver – (Adult)
8. Traumatic Brain Injury (TBI – Adult)
9. Traumatic Brain Injury (TBI – Child/Adolescent)
10. Co-occurring I/DD and Behavioral Health (Adult)
11. Co-occurring I/DD and Behavioral Health (Child/Adolescent)

Scoring

Meets	Partially Meets	Does Not Meet
10 Factors = Yes or N/A	1-9 Factors = Yes or N/A	0 Factors

TCM 3B – CM Comprehensive Assessment P&P

IRT element header: Did the Care Management Comprehensive Assessment P&P include the following criteria?

Factors

1. Description of the organization's approach to assessment and reassessment.
2. Evidence of tailoring requirements to the populations served by the organization.
3. Understanding of the challenges of conducting the assessments and reassessments.

Scoring

Meets	Partially Meets	Does Not Meet
3 Factors	1-2 Factors	0 Factor

Reviewer Instructions:

☑ Look for the following evidence in the applicant's materials:

- Measurable progress on a plan to have the following components by the time of TCM Service Launch:
  - A description of the organization's specific approach to assessment and reassessment (e.g., current assessment tools and how they will be adapted for Tailored Care Management; who will perform the assessment, where and how; approaches for overcoming challenges such as low response rates).
  - Evidence of tailoring assessment requirements to the population served by the organization.
  - An understanding of the challenges of conducting assessments within 60 or 90 days of BH I/DD Tailored Plan enrollment and strategies to implement.

- Additional components to be submitted before the site review:
  - Draft of **care management comprehensive assessment tool(s)** appropriate to the population(s) applicant is applying to serve, including mock-up of member care management comprehensive assessment for each population type the applicant is planning to serve.
    - TCM 3A – Please ensure that the provider has submitted a separate Care Management Comprehensive Assessment for each population they serve. If they serve a specific population listed and have not provided an assessment, select "No" for that population.
  - Provide strategies and timeline, updated from the written application, for assessment and reassessments for years 1 and 2 outlined in the **Care Management Comprehensive Assessment P&Ps.**

TCM 4 – Care Plan and Individual Support Plan (ISP)

Requirements: *[Section V, Part 4.4, Provider Manual page 24]*

The AMH+ or CMA must develop a care plan for each member with behavioral health needs and/or an ISP for each member with I/DD and TBI needs. Each care plan and ISP must be individualized, person-centered, and developed using a collaborative approach including member and family participation where appropriate. Care plans and ISPs must incorporate the results of the care management comprehensive assessment (including unmet health-related resource need questions), claims analysis and risk scoring, any available medical records, and screening and/or level of care determination tools, including the following, as appropriate, unless modified by the Department:

- LOCUS and CALOCUS
- CANS
- ASAM criteria
- For Innovations waiver enrollees: SIS; and
- For TBI waiver enrollees: Rancho Los Amigos Levels of Cognitive Functioning Scale (as applicable).

For BH I/DD Tailored Plan members ages three to 21 with mental health conditions and/or SUD who are receiving mental health or substance use services, the AMH+ or CMA must follow System of Care requirements, including:

- Involving a Child and Family Team (CFT) in facilitating the care planning process and developing the care plan or ISP
- Using the strengths assessment to build strategies included in the care plan or ISP that address the critical needs and unique strengths of the youth and family as identified by and in cooperation with the CFT
- Regularly updating the care plan or ISP to respond to changes with the youth and family, as well as the results of the supports and services provided, and document the shift of activity from formal supports to informal supports for greater self-sufficiency.

Required Content of Care Plan or ISP: AMH+ practices and CMAs will be required to ensure that all care plans and ISPs developed under Tailored Care Management include the following minimum elements:

- Names and contact information of key providers, care team members, family members, and others chosen by the member to be involved in planning and service delivery
- Measurable goals
- Clinical needs, including any behavioral health, I/DD-related, TBI-related, or dental needs

- Interventions including addressing medication monitoring, including adherence
- Intended outcomes
- Social, educational, and other services needed by the member
- Strategies to increase social interaction, employment, and community integration;
  An emergency/natural disaster/crisis plan
- Strategies to mitigate risks to the health, well-being, and safety of the members and others
- Information about advance directives, including psychiatric advance directives, as appropriate
- A life transitions plan to address instances where the member is changing schools, experiencing a change in caregiver/natural supports, changing employment, moving, or entering another life transition
- Strategies to improve self-management and planning skills.
- For members with I/DD, TBI, or SED, the ISP should also include caregiver supports, including connection to respite services, as necessary

Timing of the Care Plan: The AMH+ or CMA must make best efforts to complete an initial care plan or ISP within 30 days of the completion of the care management comprehensive assessment. “Best effort” is defined as including at least three documented strategic follow-up attempts to contact the member if the first attempt is unsuccessful. The AMH+ or CMA must ensure that development of the care plan or ISP does not delay the provision of needed services to a member in a timely manner, even if that member is waiting for a care plan or ISP to be developed.

Updates to the Care Plan or ISP: The AMH+ or CMA will be required to ensure that each care plan or ISP is regularly, comprehensively updated, incorporating input from the member and members of the care team, as part of ongoing care management:

- At minimum every 12 months
- When the member’s circumstances or needs change significantly
- At the member’s request
- Within 30 days of care management comprehensive (re)assessment; and/or
- After triggering events (see above).

Documentation and Storage of the Care Plan or ISP: The AMH+ or CMA will be required to ensure that each care plan or ISP is documented, stored, and made available to the member and the following representatives within 14 days of completion of the care plan or ISP:

- Care team members, including the member’s PCP and behavioral health, I/DD, TBI, and LTSS providers
- The BH I/DD Tailored Plan
- Other providers delivering care to the member
- The member’s legal representative (as appropriate)
- The member’s caregiver (as appropriate, with consent)
- Social service providers (as appropriate, with consent)
- Other individuals identified and authorized by the member.

TCM 4A – Care Plan and/or ISP tool

IRT element header: Were sufficient Draft Care Plans and/or ISP Tool(s) provided for the following populations? If the organization is not servicing the population, please select "N/A." If the organization is servicing the population but did not provide the required documentation for that population, please select "No."

Factors

1. Mental Health and Substance Use Disorder (Adult)
2. Mental Health and Substance Use Disorder (Child/Adolescent)
3. Intellectual Developmental Disability (I/DD – Adult)
4. Intellectual Developmental Disability (I/DD – Child/Adolescent)
5. Innovations Waiver (Adult)
6. Innovations Waiver (Child/Adolescent)
7. Traumatic Brain Injury (TBI) Waiver – (Adult)
8. Traumatic Brain Injury (TBI – Adult)
9. Traumatic Brain Injury (TBI – Child/Adolescent)
10. Co-occurring I/DD and Behavioral Health (Adult)
11. Co-occurring I/DD and Behavioral Health (Child/Adolescent)

Scoring

Meets	Partially Meets	Does Not Meet
10 Factors = Yes or N/A	1-9 Factors = Yes or N/A	0 Factors

TCM 4B – Mock Care Plan and/or ISPs

IRT element header: Were sufficient Mock Care Plans and/or ISPs provided for the following populations? If the organization is not servicing a population, please select "N/A." If the organization is servicing a population but did not provide the required documentation for that population, please select "No."

Factors

1. Mental Health and Substance Use Disorder (Adult)
2. Mental Health and Substance Use Disorder (Child/Adolescent)
3. Intellectual Developmental Disability (I/DD – Adult)
4. Intellectual Developmental Disability (I/DD – Child/Adolescent)
5. Innovations Waiver (Adult)
6. Innovations Waiver (Child/Adolescent)
7. Traumatic Brain Injury (TBI) Waiver – (Adult)
8. Traumatic Brain Injury (TBI – Adult)
9. Traumatic Brain Injury (TBI – Child/Adolescent)
10. Co-occurring I/DD and Behavioral Health (Adult)
11. Co-occurring I/DD and Behavioral Health (Child/Adolescent)

Scoring

Meets	Partially Meets	Does Not Meet

10 Factors = Yes or N/A	1-9 Factors = Yes or N/A	0 Factors

Reviewer Instructions:

☑ Look for the following evidence in the applicant's materials:

- Measurable progress on a plan to have the following components by the time of program launch:
  - A clear description that specifies how the comprehensive care management assessment will drive the care plan/ISP and how whole-person needs (e.g., physical, behavioral, I/DD, LTSS) will be reflected in care plans/ISPs.
    - A clear description of the organization's approach to developing written care plans/ISPs, linking to current practices and clearly describing how the approach will be adapted to Tailored Care Management.
    - A clear description that specifies how the organization will ensure accurate medication monitoring, including regular medication reconciliation (conducted by the appropriate care team member) and support of medication adherence.
  - How the organization will monitor and update the care plan/ISP as individuals' needs change.

TCM 5 – Care Teams

Requirements: *[Section V, Part 4.5, Provider Manual page 25]*

The AMH+ or CMA must establish a multidisciplinary care team for each member under Tailored Care Management. Depending on the member's needs, the required members of a multidisciplinary care team will include the member, the member's care manager and the following individuals, depending on the member's needs:

- Caretaker(s)/legal guardians
- Supervising care manager
- Primary care provider
- Behavioral health provider(s)
- I/DD and/or TBI providers, as applicable
- Other specialists
- Nutritionists
- Pharmacists and pharmacy techs
- The member's obstetrician/gynecologist (for pregnant women);
- Care extenders, as applicable
- In-reach and transition staff, as applicable
- Other providers and individuals, as determined by the care manager and member

The AMH+ or CMA does not necessarily need to have all the care team members on staff or embedded in the practice – providers of various specialties may participate in care teams virtuallyfrom other settings. However, the AMH+ or CMA must establish a plan to activate relationships with primary care providers and other key interdisciplinary agencies/providers.

The AMH+ or CMA must have written policies and procedures to ensure that multidisciplinary care team formation and communication occur in a timely manner and that the care team is documented in the care plan and is regularly updated. To implement such policies, the AMH+ orCMA will be required to conduct regular case conferences with members of the multidisciplinarycare team, as appropriate based on member needs.

Since regular, on-the-ground communication across settings is essential to the success of the model, the Department will require all organizations performing care management to have IT andpolicies and procedures in place that support communication and information sharing. If it does not already have the capacity to do so, the AMH+ or CMA must demonstrate that it will have the ability to electronically and securely transmit the care plan to each member of the multidisciplinary care team, by BH I/DD Tailored Plan launch (see also Section V. 5. Health IT).

TCM 5A – Team Formation and Communication P&P

IRT element header: Does the Team Formation and Communication P&P meet the following requirements?

Factors

1. Work with other organizations to establish care teams that include team members not employed by the AMH+ or CMA and/or whose locations are outside its walls.
2. Share pertinent care plan and ISP data with care team members across physical health, behavioral health and/or I/DD.
3. Operationalize case conferences for interpretation of "regular" timing tailored to the specific population served.
4. Address challenges of forming multidisciplinary team and provide at least one strategy to mitigate issues.

Scoring

Meets	Partially Meets	Does Not Meet
4 Factors	1-3 Factors	0 Factors

TCM 5B – Case Example

IRT element header: Does the case example provided include the following criteria?

Factors

1. A list of care team members.
2. Sample Case conference agenda.
3. Target length of the conference for regular and special situations.

Scoring

Meets	Partially Meets	Does Not Meet
3 Factors	1-2 Factors	0 Factors

Reviewer Instructions:

☑ Look for the following evidence in the applicant's materials:

- Measurable progress on a plan to have the following components by the time of program launch:
  - A clear and realistic description of how the organization will work with other organizations to establish care teams that include team members not employed by the AMH+ or CMA and/or whose locations are outside its walls.
  - A specific description of how the organization will share pertinent care plan and ISP data with care team members across physical health, behavioral health, and/or I/DD.
  - A specific description of how case conferences will be operationalized, and the interpretation of "regular" timing tailored to the specific population served.
  - Acknowledges the challenge of forming a multidisciplinary team and provides at least one strategy to mitigate issues.
  - A clear description of secure, role-based access.

- Additional components to be submitted before the site review:
  - Team formation:
    - A list of potential care team members by type (e.g., MD, psychologist, LCSW, RN, pharmacist, nutritionist, peer support specialist) and the population served.
    - Strategies for developing an individualized care team for each member.
    - Strategies for including other providers with whom the organization does not have a formal relationship.
    - Strategies for informing care team members of their expected role in case conferences.
    - A timeline from the member's enrollment in Tailored Care Management to complete care team assembly (for external partners who will be part of the care team).
  - Team operation:
    - Communication methods among team members (e.g., Will all team members be expected to attend all case conferences? If not, who are the "regular" members? When will other designated members be expected to attend?).
  - Team formation and operation — Case example:
    - A description of a case example/vignette of a sample member of each population the organization will serve.
    - For each case example, provide:
      - A list of care team members.
      - A sample case conference agenda.
      - The target length of the conference for regular or special situations.

TCM 6 – Required Components of Tailored Care Management

Requirements: *[Section V, Part 4.6, Provider Manual page 26]*

Once care management has been initiated through the completion of the comprehensive care management assessment and formation of the care team, the AMH+ or CMA will be responsible for ensuring that care management is carried out according to the care plan or ISP. The AMH+ or CMA will be required to ensure that all of the following components of Tailored Care Management are available to enrolled members:

- **Care Coordination:** The AMH+ or CMA must coordinate the member's health care and social services, spanning physical health, behavioral health, I/DD, TBI, LTSS, and pharmacy services and services to address unmet health-related resource needs. Care coordination includes following up on referrals and working with the member's providers to help coordinate resources during any crisis event as well as providing assistance in schedulingand preparing members for appointments (e.g., reminders and arranging transportation). Care coordination also includes provision of referral, information, and assistance in obtaining and maintaining community-based resources and social support services, including LTSS; I/DD and TBI services (including Innovations and TBI waiver services); and any State-fundedservices.
- **Twenty-Four-Hour Coverage:** AMH+ practices and CMAs must provide or arrange for coverage for services, consultation or referral, and treatment for emergency medical conditions, including behavioral health crisis, 24 hours per day, seven days per week. Automatic referral to the hospital ED for services does not satisfy this requirement. This requirement includes the ability to (1) share information such as care plans and psychiatric advance directives, and (2) coordinate care to place the member in the appropriate setting during urgent and emergent events. In their role as Tailored Care Management entities, AMH+ practices and CMAs are not required to provide first responder crisis response in the event that a member receiving Tailored Care Management has an emergency medical condition or a

behavioral health crisis.

- **Annual Physical Exam:** The AMH+ or CMA must ensure that the member has an annualphysical exam or well-child visit, based on the appropriate age-related frequency.
- **Continuous Monitoring:** The AMH+ or CMA must conduct continuous monitoring of progress toward goals identified in the care plan or ISP through face-to-face and collateral contacts with the member and his or her support member(s) and routine care team reviews. The AMH+ or CMA must support the member's adherence to prescribed treatment regimens andwellness activities.
- **Medication Monitoring:** The AMH+ or CMA must conduct medication monitoring, includingregular medication reconciliation (conducted by the appropriate care team member) and support of medication adherence. A community pharmacist at the CIN level, in communication with the AMH+ or CMA, may assume this role.
- **System of Care:** The AMH+ or CMA must utilize strategies consistent with a System of Care[34] philosophy for children and youth, including knowledge of child welfare, school, and juvenile justice systems. For children and youth receiving behavioral health services, care management must include:
  - Promotion of family-driven, youth-guided service delivery and development of strategiesbuilt on social networks and natural or informal supports
  - Development of, with families and youth, strategies that maximize the skills and competencies of family members to support youth and caregivers' self- determination and enhance self-sufficiency
  - Verifiable efforts for services and supports to be delivered in the community within which the youth and family live, using the least restrictive settings possible in order to preserve community and family connections and manage costs; and
  - Development and implementation of proactive and reactive crisis plans in conjunction with the care plan or ISP that anticipate crises and utilize family, team and community strengths to identify and describe who does what and when; every member of the CFT shall be provided a copy of the plan.
- **Individual and Family Supports**: The AMH+ or CMA must ensure that the care management **approach** incorporates individual and family supports including:
  - Educating the member in self-management
  - Providing education and guidance on self-advocacy to the member, family members, and support members
  - Connecting the member and caregivers to education and training to help the member improve function, develop socialization and adaptive skills, and navigate the service system
  - Providing information and connections to needed services and supports including but not limited to self-help services, peer support services, and respite services
  - Providing information to the member, family members, and support members about the member's rights, protections, and responsibilities, including the right to change providers, the grievance and complaint resolution process, and fair hearing processes
  - Promoting wellness and prevention programs
  - Providing information on establishing advance directives, including psychiatric advance directives as appropriate, and guardianship options/alternatives, as appropriate; Connecting members and family members to resources that support maintaining employment, community integration, and success in school, as appropriate; and
    - For high-risk pregnant women, inquiring about broader family needs, offering guidance on family planning, and beginning discussions about the potential for an Infant Plan of Safe Care.

- **Health Promotion:** The AMH+ or CMA must address the following items for health promotion:
  - Physical comorbidities of BH I/DD Tailored Plan populations
  - Key issues and interventions for metabolic disorders (e.g., diabetes and heart disease); Self-management and self-help recovery resources (including substance use recovery); Roles and responsibilities for medication management; and
  - Use of IT in care management comprehensive assessments, care planning, and ongoing care coordination and management, including the use of NCCARE360.
- Describe your proposed approach to ensure:
  - Regular communication and information sharing across the team (via case conferences) that support care integration and care transitions; and
  - Coordination of services provided by community and social support providers, as well as other care coordination as described in Section V. above.
  - If you intend to contract with a CIN or Other Partner for care management staff: Regular communication and information sharing between the CIN or Other Partner and the provider organization
- Describe the methodologies you expect to use to connect members and families to appropriate resources for self-advocacy, navigating the service system, guardianship options/alternatives, employment, success in school, and family planning.

TCM 6A – Communication Among Provider Types P&P

IRT element header: Does the Communication Among Provider Types P&P include the following requirements?

Factors

1. Description of communication and information sharing that supports care integration and care transitions.
2. Clear and realistic description of how communication between provider types will be carried out to facilitate an individual and family-support approach tailored to the population served.

Scoring

Meets	Partially Meets	Does Not Meet
2 Factors	1 Factor	0 Factors

TCM 6B – Tailored Care Management P&P

IRT element header: Does the Tailored Care Management P&P include the following requirements?

Factors

1. Care Coordination
2. Twenty-four-Hour Coverage
3. Annual Physical Exam
4. Continuous Monitoring
5. Medication Monitoring
6. System of Care
7. Individual and Family Supports
8. Health Promotion

Scoring

Meets	Partially Meets	Does Not Meet
8 Factors	4-7 Factors	0-3 Factors

Reviewer Instructions:

☑ Look for the following evidence in the applicant's materials:

- Measurable progress on a plan to have the following components by the time of program launch:
  - A draft of P&Ps for communication among provider types to include:
    - A clear and realistic description of how communication between provider types will be carried out.
    - A description of individual and family support approach tailored to the population served by the organization.
  - Draft P&Ps for care coordination, 24-hour coverage, annual physical exam, continuous monitoring, medication monitoring, system of care, individual and family support, and health promotion (refer to the requirements above).

TCM 7 – Addressing Unmet Health-Related Resource Needs.

Requirements: *[Section V, Part 4.7, Provider Manual page 28]*

The AMH+ or CMA must ensure that Tailored Care Management addresses unmet health-related resource needs by performing the following activities at a minimum:

- Provide referral, information, and assistance in obtaining and maintaining community-based resources and social support services, including:
  - Disability benefits
  - Food and income supports
  - Housing
  - Transportation
  - Employment Services
  - Education
  - Financial literacy programs
  - Child welfare services
  - After-school programs
  - Rehabilitative services
  - Domestic violence services
  - Legal services
  - Services for justice-involved populations
  - Other services that help individuals achieve their highest level of function and independence
- The AMH+ or CMA must provide comprehensive assistance securing health-related services, including assistance at initial application and renewal with filling out and submitting applications and gathering and submitting required documentation, including in-person assistance when it is the most efficient and effective approach, at a minimum, for:
  - Food and Nutrition Services
  - Temporary Assistance for Needy Families
  - Child Care Subsidy

- Low Income Energy Assistance Program
- ABLEnow Accounts (for individuals with disabilities)
- Women, Infants, and Children (WIC) Program
- Other programs managed by the BH I/DD Tailored Plan that address unmet health- related resource needs.

- The AMH+ or CMA must provide referral, information, and assistance in connecting members to programs and resources that can assist in:
  - Securing employment
  - Supported employment (such as through the Individual Placement and Support – Supported Employment (IPS-SE) program)
  - Volunteer opportunities
  - Vocational rehabilitation and training; or
  - Other types of productive activity that support community integration, as appropriate.

TCM 7A – Addressing Unmet Health Related Resource Needs

IRT element header: Does the Referral Process P&P include the following requirements?

Factors

1. Referral, information, and assistance in obtaining and maintaining community-based resources and social support services.
2. Comprehensive assistance securing health-related services, including assistance at initial application and renewal with filling out and submitting applications and gathering and submitting required documentation, including in-person assistance when it is the most efficient and effective approach.
3. Referral, information, and assistance in connecting members to programs and resources.

Scoring

Meets	Partially Meets	Does Not Meet
3 Factors	1-2 Factors	0 Factors

Reviewer Instructions:

☑ Additional components to be submitted for the site review:

- Measurable progress on a plan to have the following components by the time of program launch:
  - Evidence of referral and advisory relationships (e.g., joint care teams or care conferences for shared patients or clients) with community organizations.
  - Experience in an assistance role, or the answer demonstrates that the organization understands the process of adding capability.

TCM 8 – Transitional Care Management

Requirements: [*Section V, Part 4.8, Provider Manual page 29]*

AMH+ practices and CMAs must manage care transitions formembers under care management transitioning from one clinical setting to another, through best efforts to conduct all of the following activities:

- Ensure that a care manager is assigned to manage the transition
- Have a care manager or care team member visit the member during his/her stay in the institution and be present on the day of discharge
- Conduct outreach to the member's providers
- Obtain a copy of the discharge plan and review the discharge plan with the member and facility staff
- Facilitate clinical handoffs
- Assist the member in obtaining needed medications prior to discharge, ensure an appropriate care team member conducts medication reconciliation/management, and support medication adherence
- Prior to discharge from a residential or an inpatient setting, in consultation with the member, facility staff, and the member's care team, create and implement a 90-day transition plan as an amendment to the member's care plan or ISP that outlines how the member will maintain or access needed services and supports, transition to the new care setting, and integrate into his or her community. The 90-day transition plan must incorporate any needs for training of parents and other adults to care for a child with complex medical needs post-discharge from an inpatient setting. Development of a 90-day transition plan is not required for all ED visits, but may be developed according to the care manager's discretion
- Communicate and provide education to the member and the member's caregivers and providers to promote understanding of the 90-day transition plan
- Facilitate arrangements for and scheduling of transportation, in-home services, and follow-up outpatient visits with appropriate providers within a maximum of seven calendar days, unless required within a shorter time frame
- Ensure that the assigned care manager follows up with the member within 48 hours of discharge
- Arrange to visit the member in the new care setting after discharge/transition
- Conduct a care management comprehensive assessment within 30 days of the discharge/transition, or update the current assessment and
- Update the member's care plan or ISP in coordination with the care team within 90 days of the discharge/transition.

Transitions for Special Populations.

The Department is committed to providing all individuals with serious mental illness, serious emotional disturbance, or intellectual or developmental disabilities the opportunity to live in their communities and to meaningfully participate in community life to the greatest extent possible. To this end, as part of their role in providing care management, AMH+ practices and CMAs will be required to provide supports to assigned Behavioral Health I/DD Tailored Plan members admitted to and residing in institutional and select other congregate settings to prepare them for and help them transition to a less restrictive setting, if the member chooses to do so. Following a transition from one of these settings, AMH+ practices and CMAs will be required to provide pre- and post-transition supports needed to ensure their assigned members can live safely and to thrive in their communities. AMH+ practices and CMAs will assume primary responsibility for in-reach and/or transition activities for assigned members who are part of the following populations:

- Children and youth admitted to a state psychiatric hospital, psychiatric residential treatment facility (PRTF), or Residential Treatment Levels II/Program Type, III, and IV as defined in the Department's Clinical Coverage Policy 8-D-2 ("Residential Treatment Levels"); and
- Adult members admitted to a state psychiatric hospital or an ACH who are eligible for Tailored Care Management and who are *not* transitioning to supportive housing.

In-reach activities comprise identifying and engaging individuals in institutional or other congregate settings whose service needs could potentially be met in home or community-based settings. Transition activities consist of developing and executing a person-centered plan for an individual to move from an institutional or other congregate setting to a home or community-based setting.

Transitions for Special Populations: In-Reach Activities. AMH+ practices and CMAs will be responsible for in-reach activities for assigned members under 18 admitted to or residing in a state psychiatric hospital and members admitted to or residing in a PRTF or congregate child residential treatment settings who may be able to have their needs safely met in a community setting. Care Managers will be responsible for identifying and engaging such members and conducting the following in-reach activities:

- Provide age and developmentally appropriate education and ensure that the member and their family and/or guardians are fully informed about the available community-based options; this may include accompany them on visits to community-based services
- Identify and attempt to address barriers to relocation to a community setting
- Provide the member and their family and/or guardians opportunities to meet with other individuals with similar diagnoses and shared lived experience, who are living, working, and receiving services in community settings
- Ensure that the member and their family and/or guardians who may be eligible for supportive housing are fully informed about the available options; and
- Identify any specific trainings that facility staff may benefit from to support smooth transitions for members to live and work in community settings.

For members newly admitted to one of these facilities, in-reach must begin within seven days of admission. Not all members will be able or willing to continue with the in-reach process or begin transition planning. For those members, Care Managers will be required to make best efforts to address member concerns and arrange for peer-to-peer meetings, when appropriate; and continue to engage

Transitions for Special Populations: Transition Activities. AMH+ practices and CMAs will be responsible for transition activities for assigned members under age 21 residing in a state psychiatric hospital and all members residing in an ACH who are *not* transitioning to supportive housing and assigned members in a PRTF or Residential Treatment Levels II/Program Type, III, and IV. The goal of the required transition activities is to facilitate the transition of a member receiving services in an institutional or other select congregate setting (including an ACH) to a community setting, while ensuring access to appropriate services and supports. Care Managers will be responsible for planning for effective and timely transition of members to the community and performing the following transition activities:

- Collaborate with the appropriate individuals, specialists, and providers needed to facilitate a smooth transition to the community, including but not limited to, facility providers and discharge planners, the member's community-based primary care provider (PCP), education specialists, and other community providers and specialists as relevant to the member's needs
- Assist the member with selecting a community-based PCP and other clinical and behavioral health specialists prior to discharge and actively engage them in the transition planning process
- Arrange for individualized supports and services that are needed to be in place upon discharge

- Collaborate with the member and their family and/or guardians to identify and schedule post-discharge appointments for the critical services necessary to address the member's specific needs, such as complex behavioral health, primary care and medical needs
- Work to identify any specific training needs by receiving providers and/or agencies to ensure a seamless transition for the member
- Address any barriers to discharge planning to the most integrated setting possible, such as transportation, housing, and training for family members and/or guardians prior to discharge
- Work with the facility providers to arrange for any post-discharge services, when applicable
- Review the discharge plan with the member and their family and/or guardians and facility staff and assist the member in obtaining needed prescription on the day of discharge; and
- Convene and engage the member's Child and Family Team through the entire transition process.

In-Reach and Transition Training Requirements. In addition to the comprehensive training requirements for Care Managers providing Tailored Care Management outlined in Category 7 "Training" [*Section V, Part 7, Provider Manual page 35]*, Care Managers also will complete a separate curriculum on the domains that are critical to ensuring the health and well-being of members receiving in-reach and transition services, including:

- The array of available community services and supports
- Engagement methods, including assertive engagement and active listening skills
- Motivating and working with a member's family and/or guardians and facility staff, including linguistic and cultural needs
- Developing an interdisciplinary transition plan; and
- Components of the permanent supportive housing model.

Diversion.

AMH+ practices and CMAs must assume primary responsibility for identifying members who are at risk of entry into an adult care home or an institutional setting, such as an ICF-IID, psychiatric hospital, or psychiatric residential treatment facility, and performing diversion activities. Diversion activities must include:

- Screening and assessing the member for eligibility for community-based services
- Educating the member on the choice to remain in the community and the services that would be available
- Facilitating referrals and linkages to community support services for assistance
- Determining whether the member is eligible for supported housing, if needed; and
- Developing a Community Integration Plan that clearly documents that the member's decision to remain in the community was based on informed choice, and the degree to which the member's decision has been implemented.

TCM 8A – Transitional Management and Member Outreach P&P

IRT element header: Does Transitional Management and Member Outreach P&P address the following?

Factors

1. Transitions for Special Populations.
2. Transition Activities.
3. In-Reach and Transition Training Requirements.
4. Diversion.

Scoring

Meets	Partially Meets	Does Not Meet
4 Factors	2-3 Factors	0-1 Factors

Reviewer Instructions:

☑ Look for the following evidence in the applicant's materials:

- Since the desk review, measurable progress on a plan to have the following components by the time of program launch:
  - A clinically appropriate methodology for identifying members in transition.
    - For CMAs, a concrete answer for when ADT functionality will be in place.
  - A concrete answer for how ADT alerts will be monitored and conveyed to care managers, including the strategy to meet time frames for responding to transitional care management needs (e.g., processes for providing real-time response to ED outreach; conducting same-day or next-day outreach to designated high-risk subsets of the population and within several days for outpatients).
  - For diversion:
    - A clear description of the approach to connecting person to community-based supports.
    - A reference to community integration plans.
- An additional plan for in-reach and transition activities for special populations:
  - In-reach activities that include education to inform members and their family/guardian about available community-based options (including supportive housing), identifying barriers to relocations, and opportunities to meet with other individuals with similar diagnoses and shared lived experiences.
  - Transition activities that include collaboration with appropriate individuals (e.g., clinical specialists, education specialists, community-based primary care provider, family/guardians), arrangement for individualized support services upon discharge, identifying barriers to discharge planning (e.g. transportation, housing, training family, and/or guardians), post-discharge services (if applicable), prescription assistance, and engaging with the member's Child and Family Team through the entire transition process.
- Additional components to be submitted before the site review:
  - A draft of P&Ps for identifying and contacting members in populations served that are in, or about to be in, active care transition. P&Ps detail community inclusion activities, pre- and post-transition supports, and in-reach activities and transition activities for special populations.
  - A draft of P&Ps regarding ADT alert monitoring and responding to transitional care management needs within time frames (e.g., emergent, same day, next day) and connecting to community supports.

TCM 9 – Innovation and TBI Waiver Care Coordination (if applicable)

Requirements: [*Section V, Part 4.9, Provider Manual page 31*]

AMH+ practices and CMAs that are certified to provide Tailored Care Management to individuals enrolled in the 1915(c) Innovations and TBI waivers will be responsible for coordinating these individuals' waiver services in addition to performing the Tailored Care Management requirements detailed in this Manual. These additional requirements for individuals enrolled in the Innovations or TBI waiver include:

- Support completion of assessments beyond the care management comprehensive assessment and incorporate results into care management comprehensive assessment.
  - Complete preliminary intake and screenings for the waivers, including NC Innovations Risk/Support Needs Assessment and TBI Risk/Support Needs Assessment, to see if the waiver can meet the individual's needs;
  - Support enrollee in completing person-centered information toolkits and self- direction assessments; and
  - Complete Level of Care (LOC) re-evaluation annually.
- Facilitate provider choice and assignment process for Innovations and TBI waiver enrollees.
  - Help enrollee make informed choices of care team participants, provide information about providers, and arrange provider interviews as needed and
  - Convene an in-person (as clinically indicated) care team planning meeting.
- Coordinate information and resources for self-directed services for Innovations waiver enrollees, as applicable.
  - Ensure that waiver enrollees interested in self-directed services receive relevant information and training
  - Assist in appointing a representative to help manage self-directed services, as applicable.
  - Assess employer of record and manage employer and representative, as applicable; and
  - Provide self-directed budget information.
- Perform additional responsibilities related to developing and monitoring implementation of the ISP for Innovations and TBI waiver enrollees beyond those required for other individuals engaged in Tailored Care Management.
  - Complete the ISP so that the BH I/DD Tailored Plan receives it within 60 calendar days of LOC determination.
  - As part of developing the ISP:
    - Explain options regarding the services available, and discuss the duration of each service
    - Include a plan for coordinating waiver services
    - Ensure enrollee completes Freedom of Choice statement in ISP annually
    - Submit service authorization request to BH I/DD Tailored Plan for each service; and
    - Ensure that delivery of waiver services begins within 45 days of ISP approval.
  - Monitor ISP implementation and resolve or escalate issues as needed
    - Complete monthly ISP monitoring checklist (e.g., waiver service utilization, provider choice, HCBS compliance setting, etc.)
    - Monitor at least quarterly to ensure that any restrictive interventions (including protective devices used for behavioral support) are written into the ISP and the Positive Behavior Support Plan; and
    - Notify BH I/DD Tailored Plan of LOC determination updates.

TCM 9A – TBI Waiver Care Coordination P&P

IRT element header: If applicable, does the TBI Waiver Care Coordination P&P meet the following requirements?

Factors

1. Ensure completion of required assessments for the waiver population.
2. Provide additional information and resources for the waiver population using self-directed services.
3. Develop and monitor ISP implementation.
4. Facilitate provider choice and assignment process for Innovations and TBI waiver enrollees.

Scoring

Meets	Partially Meets	Does Not Meet
4 Factors	1-3 Factors	0 Factors

Reviewer Instructions:

☑ If the organization does not provide service to individuals enrolled in Innovation or TBI waivers, please select N/A for all factors in this section.

☑ Look for the following evidence in the applicant's materials:

- Measurable progress on a plan to have the following components by the time of program launch:
  - Failing this requirement means that the organization will not be certified to provide Tailored Care Management to the waiver population but does not mean that the entire application fails if the organization is seeking certification for other populations. Look for:
    - A clear description of a process for ensuring completion of required assessments for the waiver population.
    - A clear description of a process for providing additional information and resources for the waiver population using self-directed services.
    - A clear description of a process for developing and monitoring ISP implementation.
- Additional components to be submitted before the site review:
  - **Draft Innovations and/or TBI Waiver Care Coordination P&Ps** for completing required assessments for the waiver population, providing information and additional resources for the waiver population using self-directed services and developing and monitoring implementation of the ISP.

Health IT (HIT)

Requirements: [*Section V, Part 5, Provider Manual page 33]*

Health IT requirements that each AMH+ or CMA must meet in full prior to BH I/DD Tailored Plan go-live are detailed in the Tailored Care Management data strategy policy paper and summarized below.

1. Use an electronic health record (EHR): The AMH+ or CMA must have implemented an EHR or clinical system of record that is in use by the AMH+ practices or CMA's providers to electronically record, store, and transmit member clinical information, including medication adherence.
2. Use a care management data system: The AMH+ or the CMA must use a care management data system, whether or not integrated within the EHR, that can:
   a. Maintain up-to-date documentation of Tailored Care Management member lists and assignments of individual members to care managers
   b. Electronically document and store the care management comprehensive assessment and re-assessment
   c. Electronically document and store the care plan or ISP
   d. Incorporate claims and encounter data
   e. Provide role-based access to each member of the multidisciplinary care team
   f. Electronically and securely transmit (at minimum) the care management; comprehensive assessment, care plan or ISP and reports/summaries of care to each member of the multidisciplinary care team
   g. Track care management encounters electronically, including the date and time of each encounter, the personnel involved, and whether the encounter was in person or telephonic; and
   h. Track referrals
3. Use ADT information: The AMH+ or CMA must access admission, discharge, transfer (ADT) data that correctly identifies when members are admitted, discharged, or transferred to or from an ED or a hospital in real time or near-real time (see Section V. 4.8. Transitional Care Management). The AMH+ or CMA must implement a systematic, clinically appropriate process with designated staffing for responding to certain high-risk ADT alerts, including:
   a. Real-time (within minutes/hours) response to notifications of ED visits, for example by contacting the ED to arrange rapid follow-up
   b. Same-day or next-day outreach for designated high-risk subsets of the population; and
   c. Additional outreach within several days after the alert to address outpatient needs or prevent future problems for other patients who have been discharged from a hospital or an ED (e.g., to assist with scheduling appropriate follow-up visits or medication reconciliations post-discharge).
4. Use NCCARE360 once certified as fully functional statewide to identify community-based resources and connect members to such resources. AMH+ practices and CMAs must:
   a. Use NCCARE360 once certified as fully functional statewide as their community-based organization and social service agency resource repository to identify local community- based resources
   b. Refer members to the community-based organizations and social service agencies available on NCCARE360; and
   c. Track closed-loop referrals.

5. Risk stratify the population under Tailored Care Management beyond acuity tiering (encouraged, and required from year 3 of BH I/DD Tailored Plans onwards):
   a. The Department expects that the standardized acuity tiering methodology described above will be the primary method that BH I/DD Tailored Plans, AMH+ practices, and CMAs use to segment and manage their populations under Tailored Care Management in the initial two years of the model. BH I/DD Tailored Plans will have the option of establishing their own risk stratification methodologies beyond acuity tiering; if they do so, they will be required to share all risk stratification results and methodologies used with AMH+ practices and CMAs. As the Tailored Care Management model matures, AMH+ practices and CMAs will be expected to develop their own risk stratification approaches, refining the data and risk stratification scores they receive from BH I/DD Tailored Plans to incorporate critical clinical, unmet health-related resource, and other data to which they have access. The Department will require risk stratification at the AMH+ or CMA level from year 3 of the model onward. Additionally, patient registries to track patients by condition type/ cohort are encouraged but not required.
6. Use NCCARE360 once certified as fully functional statewide to identify community-based resources and connect members to such resources. AMH+ practices and CMAs must:
   a. Use NCCARE360 once certified as fully functional statewide as their community-based organization and social service agency resource repository to identify local community-based resources
   b. Refer members to the community-based organizations and social service agencies available on NCCARE360; and
   c. Track closed-loop referrals.
7. HIT Workplan, that includes:
   a. A description of a plan to ensure appropriate monitoring/oversight of health IT platforms, including the EHR, care management data system and ADT feeds (e.g., a plan to manage ongoing updates and upgrades, troubleshoot issues).
   b. A workflow plan describing how the care management data system will be incorporated into routine organization practices to support timely, responsive, informed care management. Should include the expected use groups of the care management data system, how each user group will be expected to use the system, who the key individuals at the organization will be for managing system maintenance and/or vendor content.
   c. A training plan to support workflow integration and the use of the care management data system, which describes whether this training will differ by user group.

HIT 1 – Electronic Health Record (EHR)

HIT 1A – Electronic Health Record (EHR)

IRT element header: Did the organization provide a signed contract, agreement, or LOI regarding the use of an EHR or equivalent clinical system that is capable of electronically recording, storing, and transmitting member clinical information?

Scoring

Meets		Does Not Meet
Yes		No

HIT 2 – Care Management Data System

HIT 2A – Care Management Data System

IRT element header: Did the organization provide a signed contract, agreement, or LOI regarding the use of a Care Management Data System that fulfills the requirements stated in the provider manual?

Scoring

Meets		Does Not Meet
Yes		No

HIT 3 – Admission, Discharge, Transfer (ADT)

HIT 3A – Admission, Discharge, Transfer (ADT)

IRT element header: Did the organization provide a signed contract, agreement, or LOI with an entity indicating that Admission, Discharge, and Transfer (ADT) feeds have been connected and tested **OR** provide other proof ADT connectivity?

Scoring

Meets		Does Not Meet
Yes		0 Factors

HIT 4 – HIT Workplan

HIT 4A – HIT Workplan

IRT element header: Does the organization's HIT workplan meet the following requirements?

Factors

1. A description of a plan to ensure appropriate monitoring/oversight of health IT platforms, including the EHR, care management data system and ADT feeds (e.g., a plan to manage ongoing updates and upgrades, troubleshoot issues).
2. A workflow plan describing how the care management data system will be incorporated into routine organization practices to support timely, responsive, informed care management. Should include the expected user groups of the care management data system, how each user group will be expected to use the system, who the key individuals at the organization will be for managing system maintenance and/or vendor content.
3. A training plan to support workflow integration and the use of the care management data system, which describes whether this training will differ by user group.

Scoring

Meets	Partially Meets	Does Not Meet
3 Factors	1-2 Factors	0 Factors

HIT 5 – NCCARE360

HIT 5A – NCCARE360

IRT element header: Did the provider submit evidence of NCCARE360 implementation / connectivity **OR** a plan for onboarding to NCCARE360?

Scoring	Meets		Does Not Meet
	Yes		No

Reviewer Instructions:

☑ Look for the following evidence in the applicant's materials:

- A signed and executed contract or LOI with a health IT vendor or entity (e.g., CIN/Other Partner) indicating that an EHR or clinical system of record that meets Tailored Care Management requirements—including the capability to electronically record, store, and transmit member clinical information—will be tested, accepted, and implemented by the Tailored Care Management launch.
- A signed and executed contract or LOI with a health IT vendor or entity (e.g., CIN/Other Partner) indicating that a care management data system that meets Tailored Care Management requirements will be tested, accepted, and implemented by the Tailored Care Management launch.
- A signed and executed contract or LOI with an entity (e.g., NC HealthConnex or other entity that provides ADT-based alerts in service region) indicating that Admission, Discharge and Transfer (ADT) feeds that meet Tailored Care Management requirements will be connected, tested, accepted, and implemented for use and in coordination with "active" workflows by the Tailored Care Management launch, ***or*** other proof of ADT connectivity.
- A health IT workplan that includes:
  - A description of a plan to ensure appropriate monitoring/oversight of health IT platforms, including the EHR, care management data system, and ADT feeds (e.g., a plan to manage ongoing updates and upgrades, troubleshoot issues).
  - A workflow plan describing how the care management data system will be incorporated into routine organization practices to support timely, responsive, informed care management. Should include the expected use groups of the care management data system, how each user group will be expected to use the system, who the key individuals at the organization will be for managing system maintenance, and/or vendor content.
  - A training plan to support workflow integration and use of the care management data system, which describes whether training will differ by user group.
- Proof of NCCARE360 connectivity or a plan to onboard to NCCARE360 (once fully functional and available).
  - The organization meets the category if it provides either of these.

Quality Measurement and Improvement (QMI)

QMI 1 – Quality Measurement and Improvement

Requirements: *[Section V, Part 6, Provider Manual page 35]*

After launch of BH I/DD Tailored Plans, AMH+ practices and CMAs will be required to gather, process, and share data with BH I/DD Tailored Plans for the purpose of quality measurement and reporting. The Department will publish quality measure requirements each year. Elements of the list may be modified on an as-needed basis, but new measures will be added only during annual updates. The Department is in the process of finalizing quality requirements, including the collection instruments to be used. AMH+ practices and CMAs may be required to perform tasks including abstracting data from patient charts; performing quality assurance to validate the accuracy of data in patient charts that is used for quality measurement purposes; using additional codes to fully document patient status and needs in order to improve the accuracy of quality measurement; and explaining to patients the purpose of certain state-sponsored surveys, how the state and health plans will use survey results, and how their information will be kept confidential.

AMH+ practices and CMAs may be required to administer brief surveys to capture patient- reported outcomes such as quality of life. AMH+ practices and CMAs may also be required to participate in activities related to the development of new quality measures or survey instruments, such as supporting recruitment of enrollees to participate in focus groups piloting survey questions or sharing feedback on the staff time and resources required to administer a pilot instrument. The NC-TOPPS interview tools will remain in place for eligible members with mental health and SUD diagnoses. The BH I/DD Tailored Plan will ensure administration of the NC-TOPPS interview tool to members with behavioral health utilization in a form and manner specified by the Department. If the BH I/DD Tailored Plan delegates this responsibility, the AMH+ or CMA care manager will be required to ensure that information is correctly entered.

The AMH+ and CMA must use their internal data to drive improvement using a systematic process. At least annually, the AMH+ or CMA must evaluate the Tailored Care Management services it provides to ensure that the services are meeting the needs of empaneled members and refine the services as necessary. The AMH+ or CMA should use a combination of clinical data, care management encounter data and quality scores to generate a set of internal targets and set annual goals for improvement.

QMI 1A – Continuous Quality Improvement (CQI) P&P

IRT element header: Does the Continuous Quality Improvement (CQI) P&P meet the following requirements?

Factors

1. Process for developing periodic quality improvement plans that integrates use of quality measure data (e.g., HEDIS measures) and member feedback to select operational areas that require action to achieve performance benchmarks.
2. Concrete example of subject area and process for including leadership and participants in CQI, feedback loop to providers and consequences/follow-up for failure to achieve benchmarks.
3. Quality measure documentation, data collection and abstraction, analysis and outreach in accordance with current Department requirements.
4. Periodic (at least annual) evaluation of care management systems, processes and services to ensure that appropriate services are being provided to members, and to drive improvement in outcomes.

Scoring	Meets	Partially Meets	Does Not Meet
	4 Factors	1-3 Factors	0 Factors

QMI 1B – High Priority TCM and CQI Example

IRT element header: Did the organization provide the following?

Factors

1. A list of high-priority TCM areas for quality monitoring in years 1 and 2 post-launch.
2. An example of CQI applied to one high-priority TCM area.

Scoring	Meets	Partially Meets	Does Not Meet
	2 Factors	1 Factor	0 Factors

Reviewer Instructions:

☑ Look for the following evidence in the applicant's materials:

- Measurable progress on a plan to have the following components by the time of program launch: A description of a continuous quality improvement (CQI) process, including development of periodic quality improvement plans, that integrates use of quality measure data (e.g., Healthcare Effectiveness Data and Information Set[1] [HEDIS®] measures) and member feedback to select operational areas that require action to achieve performance benchmarks.
- A concrete example of the subject area and a process for including leadership and participants in CQI, a feedback loop to providers, and consequences/follow-up for failure to achieve benchmarks.
- Experience reporting HEDIS measures.
- Additional components to be submitted before the site review:
  - A list of high-priority Tailored Care Management areas for quality monitoring in years 1 and 2 post-launch.
  - A draft of CQI P&Ps.
  - An example of CQI applied to one high-priority Tailored Care Management area listed above.

[1]HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Training (TRN)

TRN 1 – Training

Requirements: [*Section V, Part 7, Provider Manual page 31*]

The Department will require the following domains for training, in addition to any training requirements specified in N.C. General Statute § 122c- 115.4:

- BH I/DD Tailored Plan eligibility and services
  - BH I/DD Tailored Plan eligibility criteria, services available only through BH I/DD Tailored Plans, and differences between Standard Plan and BH I/DD Tailored Plan benefit package; Principles of integrated and coordinated physical and behavioral health care and I/DD and TBI services
  - Behavioral health crisis response; and
  - Knowledge of 1915(c) Innovations and TBI waiver eligibility criteria.
- Whole-person health and unmet resource needs
  - Understanding and addressing ACEs, trauma, and trauma-informed care
  - Understanding and addressing unmet health-related resource needs, including identifying, utilizing, and helping the member navigate available social supports and resources at the member's local level; and
  - Cultural competency, including LTSS needs, cultural sensitivity considerations for tribal populations and forms of bias that may affect BH I/DD Tailored Plan members.
- Community Integration
  - Independent living skills
  - Skills to conduct diversion from adult care homes and other congregate settings, institutional settings, and correctional facilities
  - Knowledge of supportive housing; and
  - Available programs and resources to assist members in securing employment, supported employment, apprenticeships, volunteer opportunities, vocational rehabilitation and training, or other types of productive activities that support community integration.
- Components of Health Home care management
  - Health Home Overview: What is a Health Home? Whom does it serve? What is care management? How do members and their families participate in care planning?; and Working effectively with a multidisciplinary care team, scheduling team meetings, planning agendas and facilitating meetings.
- Health promotion
  - Common physical comorbidities of BH I/DD Tailored Plan populations
  - Key issues and interventions for metabolic disorders (e.g., diabetes and heart disease); Self-management and self-help recovery resources (including substance use recovery); Roles and responsibilities for medication management; and
  - Use of IT in care management comprehensive assessments, care planning, and ongoing care coordination and management, including use of NCCARE360.
- Other care management skills
  - Transitional care management best practices
  - Supporting health behavior change, including motivational interviewing
  - Person-centered practices, including needs assessment and care planning, addressing LTSS and other needs

- Preparing members for and assisting them during emergencies and natural disasters Understanding the needs of the justice-involved population; and
- Understanding and navigating the Medicare program, including preparation for Medicare eligibility and enrollment and other programs that serve dually eligible members, such as Programs of All-Inclusive Care for the Elderly (PACE)

- Additional trainings for care managers and supervisors serving members with an I/DD or a TBI
  - Understanding various I/DD and TBI diagnoses and their impact on the individual's functional abilities, physical health and behavioral health (i.e., co-occurring mental health diagnosis), as well as their impact on the individual's family and caregivers; Understanding HCBS, related planning, and 1915(c) services and requirements
  - Accessing and using assistive technologies to support individuals with an I/DD or a TBI; Understanding the changing needs of individuals with and I/DD or a TBI as they age, including when individuals age out of school-related services; and
  - Educating Members with an I/DD or a TBI about consenting to physical contact and sex.
- Additional trainings for care managers and supervisors serving children
  - Child- and family-centered teams
  - Understanding of the System of Care approach, including knowledge of child welfare, school, and juvenile justice systems; and
  - Methods for effectively coordinating with school-related programming and transition- planning activities.
- Additional trainings for care managers and supervisors serving pregnant and postpartum women with SUD or SUD history:
  - Best practices for addressing the needs of pregnant and postpartum women with SUD or SUD history, such as general knowledge about pregnancy, medication- assisted treatment, SUD and breastfeeding, and infant opioid withdrawal.
- Additional trainings for care managers and supervisors serving members with LTSS needs
  - Methods for coordinating with supported employment resources available through the Department, the Division for Vocational Rehabilitation, and other general employment resources such as the Employment Security Commission.

    The AMH+ or CMA must ensure that all care managers complete training on all core modules identified by the BH I/DD Tailored Plan before being deployed to serve members; care managers must complete the remaining training modules within 30 days. Current Innovations waiver care coordinators who are transitioning to care managers under Tailored Care Management will have additional time to complete these trainings, not to exceed six (6) months after launch. The AMH+ or CMA must ensure that care managers and supervisors attend annual refresher courses on training topics based on needs determined by care manager supervisors; care managers and supervisors may also request targeted retraining.

    In addition to the above training, BH I/DD Tailored Plans will be required to provide ongoing technical assistance to AMH+ practices and CMAs going through the certification process to enable them to become high-performing providers of Tailored Care Management.

TRN 1A – TCM Care Manager Training Plan

IRT element header: Does the TCM Care Manager Training Plan meet all of the following requirements?

Factors

1. BH I/DD Tailored Plan eligibility and services.
2. Whole-person health and unmet resource needs.
3. Community integration.
4. Components of Health Home care management.
5. Health promotion.
6. Other care management skills.

Scoring

Meets	Partially Meets	Does Not Meet
6 Factors	1-5 Factors	0 Factors

TRN 1B – TCM Care Manager Training Plan Optional Elements

IRT element header: Does the TCM Care Manager Training Plan meet all of the following requirements that apply to the provider? If the requirement does not apply, please select "N/A."

Factors

1. Additional trainings for care managers and supervisors serving members with an I/DD or a TBI.
2. Additional trainings for care managers and supervisors serving children.
3. Additional trainings for care managers and supervisors serving pregnant and postpartum women with SUD or SUD history.
4. Additional trainings for care managers and supervisors serving members with LTSS needs.

Scoring

Meets	Does Not Meet
4 Factors = Yes or N/A	0 Factors

Reviewer Instructions:

☑ Look for the following evidence in the applicant's materials:

- **TCM Care Manager Training Plan** to ensure that all care managers complete required training modules within a reasonable period and before their scheduled deployment, including support the organization will provide to care managers (e.g., strategies for ensuring adequate time and space are provided for training).

AMH+/CMA Certification Site Review Protocol

AMH+/CMA Site Review Documents Checklist for Providers

This document serves as a guide for submitting documentation to supplement the site review. For more details on the requirements, please reference the Provider Manual, Community Inclusion Addendum (4.8), and **Site Review Protocol**.

Please ensure that your document does not contain any PHI/PII. PHI/PII must be redacted prior to submitting your files.

All submitted documents must adhere to the following guidelines:

1. Individually save each document as a Word, Excel, PowerPoint, or PDF file with the element name (i.e., ORG1A), an underscore and the document name as listed on the Site Review Documents Check-List beginning on the following page (e.g., ORG 1A_Provider Relationships and Linkages Workplan).
2. If the workplan or policies and procedures differ for each population the provider is applying to be certified for, please clearly label that in the document header and file name. *Providers only need to submit documents for the populations they are applying to serve*. The naming convention should be "**ELEMENT_Document Name_Population**." For each population, use the following abbreviations:
    a. BH (Mental Health and Substance Use Disorder)
        i. BH_Adult
        ii. BH_Child
    b. I-DD (Intellectual and Developmental Disabilities)
    c. TBI (Traumatic Brain Injury)
    d. Innovations (Waiver)
    e. Co_I-DD_BH (Co-occurring I/DD and Behavioral Health)
        i. Co_I-DD_BH_Adult
        ii. Co_I-DD_BH_Child
    f. Examples:
        i. TCM3A_CM Comprehensive Assessment P-P_Innovations
        ii. TCM6B_Draft_TCM P-P_Annual Physical Exam_ BH_Child

Items noted with an asterisk (*) may meet more than one subcategory. Please ensure that such document contains sufficient evidence to meet that criterion.

REQUIREMENTS		DOCUMENTS
ORG – Organization Informational Standing Experience Rating		
ORG 1	**Provider Relationships & Linkages**	☐ ORG 1A_Provider Relationships and Linkages Workplan
FIN – Capacity		
FIN 1	**Capacity and Sustainability**	☐ FIN1 _Letter of Written Attestation *Organization should attest to no deterioration in the financial health of the organization, as compared to the audited financial statement or income statement and balance sheet submitted at desk review.* ☐ FIN1E_Changes to Net Income *(if applicable)* ☐ FIN1E_Updated Income Statement *(if applicable)* ☐ FIN1F_Changes to Net Working Capital *(if applicable)* ☐ FIN1F_Updated Balance Sheet *(if applicable)* ☐ FIN1G_Changes to Total Equity *(if applicable)* ☐ FIN1G_Updated Balance Sheet *(if applicable)* ☐ FIN1H_YTD Statement of Operations and Financial Projections for 2024 and 2025 *Must include rationale for updates to projected population or service volumes that impact revenue AND Summary of how capacity building funds will be used to fill gaps (e.g., staffing, HIT) by TCM launch.*
FIN 2	**Oversight**	☐ FIN 2C_Governance Structure Bylaws Charter
STF – Staffing		
STF 1	**Care Management Staff**	☐ STF1A_Recruitment and Retention Workplan ☐ *STF1B_MOU (if applicable)* ☐ *STF1C_CIN Contract (if applicable)*

REQUIREMENTS		DOCUMENTS
STF 2	**Clinical Consultants**	☐ STF2A_Clinical Consultants P-P *OR* ☐ STF2A_Clinical Consultants Workplan ☐ *STF2B_CVs and Signed Agreements (if applicable)*
TCM – Delivery of Tailored Care Management		
TCM 1	**Policies and Procedures for Communication with Members**	☐ TCM1A_Draft Communication P-P with Members Families and Caregivers
TCM 2	**Capacity to Engage with Members through Frequent Contact**	☐ TCM2A_Draft Member Engagement P-P
TCM 3	**Care Management Comprehensive Assessments and Reassessments**	CM Comprehensive Assessment Tool(s) for each population: ☐ TCM3A_CM Comprehensive Assessment Tool_MH_SUD_Adult ☐ TCM3A_CM Comprehensive Assessment Tool_MH_SUD_Child ☐ TCM3A_CM Comprehensive Assessment Tool_I-DD_Adult ☐ TCM3A_CM Comprehensive Assessment Tool_I-DD_Child ☐ TCM3A_CM Comprehensive Assessment Tool_Innov_Adult ☐ TCM3A_CM Comprehensive Assessment Tool_Innov_Child ☐ TCM3A_CM Comprehensive Assessment Tool_TBI_Adult ☐ TCM3A_CM Comprehensive Assessment Tool_TBI_Child ☐ TCM3A_CM Comprehensive Assessment Tool_ Co_I-DD_BH_Adult ☐ TCM3A_CM Comprehensive Assessment Tool_Co_I-DD_BH_Child ☐ TCM3A_CM Comprehensive Assessment P-P

REQUIREMENTS		DOCUMENTS
TCM 4	**Care Plans and Individual Support Plans (ISPs)**	<u>Draft Care Plan and/or ISP tool for each population:</u> ☐ TCM4A_Draft Care Plan_MH_SUD_Adult *OR* ☐ TCM4A _ISP Tool_MH_SUD_Adult ☐ TCM4A_Draft Care Plan_MH_SUD_ Child *OR* ☐ TCM4A _ISP Tool_MH_SUD_Child ☐ TCM4A _Draft Care Plan_ I-DD_Adult *OR* ☐ TCM4A _ISP Tool_I-DD_Adult ☐ TCM4A _Draft Care Plan_ I-DD_ Child *OR* ☐ TCM4A _ISP Tool_I-DD_Child ☐ TCM4A _Draft Care Plan_ TBI Waiver_Adult *OR* ☐ TCM4A _ISP Tool_TBI Waiver_Adult ☐ TCM4A _Draft Care Plan_ TBI_Adult *OR* ☐ TCM4A _ISP Tool_ TBI_Adult ☐ TCM4A _Draft Care Plan_ TBI_ Child *OR* ☐ TCM4A _ISP Tool_ TBI_ Child ☐ TCM4A _Draft Care Plan_ Innov_Adult *OR* ☐ TCM4A _ISP Tool_ Innov_Adult ☐ TCM4A _Draft Care Plan_ Innov_Child *OR* ☐ TCM4A _ISP Tool_ Innov_Child ☐ TCM4A _Draft Care Plan_ Co_I-DD_BH_Adult *OR* ☐ TCM4A _ISP Tool_Co_I-DD_BH_Adult ☐ TCM4A _Draft Care Plan_ Co_I-DD_BH_ Child *OR* ☐ TCM4A _ISP Tool_Co_I-DD_BH_ Child <u>Mock Care Plan and/or ISP tool for each population you serve:</u> ☐ TCM4B_Mock Care Plan_MH_SUD_Adult *OR* ☐ TCM4B_ISPTool_MH_SUD_Adult ☐ TCM4B_Mock Care Plan_MH_SUD_Child *OR* ☐ TCM4B _ISP Tool_MH_SUD_Child ☐ TCM4B_Mock Care Plan_ I-DD_Adult *OR* ☐ TCM4B _ISP Tool_I-DD_Adult ☐ TCM4B_Mock Care Plan_ I-DD_ Child *OR* ☐ TCM4B _ISP Tool_I-DD_Child ☐ TCM4B_Mock Care Plan_ Innov_Adult *OR* ☐ TCM4B _ISP Tool_ Innov_Adult ☐ TCM4B_Mock Care Plan_ Innov_ Child *OR* ☐ TCM4B _ISP Tool_ Innov_Child ☐ TCM4A _Draft Care Plan_ TBI Waiver_Adult *OR* ☐ TCM4A _ISP Tool_TBI Waiver_Adult ☐ TCM4B_Mock Care Plan_ TBI_Adult *OR* ☐ TCM4B_ISP Tool_ TBI_Adult ☐ TCM4B_Mock Care Plan_ TBI_ Child *OR* ☐ TCM4B_ISP Tool_ TBI_Child ☐ TCM4B_Mock Care Plan_Co_I-DD_BH_Adult *OR* ☐ TCM4B_ISP Tool Co_I-DD_BH_Adult ☐ TCM4B_Mock Care Plan_Co_I-DD_BH_Child *OR* ☐ TCM4B_ISP Tool Co_I-DD_BH_Child
TCM 5	**Care Teams**	☐ TCM5A_Team Formation and Communication P-P ☐ TCM5B_Case Example

REQUIREMENTS		DOCUMENTS
TCM 6	**Required Components of Tailored Care Management**	☐ TCM6A_Draft Communication Among Provider Types P-P ☐ TCM6B_Draft TCM P-P_Care Coordination ☐ TCM6B_Draft TCM P-P_24-Hr Coverage ☐ TCM6B_Draft TCM P-P_Annual Physical Exam ☐ TCM6B_Draft TCM P-P_Continuous Monitoring ☐ TCM6B_Draft TCM P-P_Medication Monitoring ☐ TCM6B_Draft TCM P-P_System of Care ☐ TCM6B_Draft TCM P-P_Individual and Family Support ☐ TCM6B_Draft TCM P-P_Health Promotion
TCM 7	**Addressing Unmet Health-related Resource Needs**	☐ TCM7A_Referral Process P-P
TCM 8	**Transitional Care Management**	☐ TCM8A_Draft Transitional Mgmt P-P (and member outreach)
TCM 9	***Innovations and TBI Waiver Care Coordination (if applicable)***	☐ *TCM9A_Draft TBI Waiver Care Coordination P-P (if applicable)*
	HIT – Health IT	
HIT 1	**Use an electronic health record**	☐ HIT1A _ HIT Vendor Contract _EHR
HIT 2	**Use care management data system**	☐ HIT2A_ HIT Vendor Contract _CM
HIT 3	**Use ADT information**	☐ HIT3A_ HIT Vendor Contract _ADT
HIT 4	**HIT Workplan**	☐ HIT4A_HIT Workplan
HIT 5	**Use NCCARE360**	☐ HIT5A_NCCARE360 Onboarding Plan *OR* ☐ HIT5A _NCCARE360 Contract
	QMI – Quality Measurement and Improvement	
QMI 1	**Quality Measurement and Improvement**	☐ QMI1A_Draft CQI P-P
QMI 1	**High Priority TCM and CQI Example**	☐ QMI1B_List High Priority TCM Areas ☐ QMI1B_CQI Example
	TRN – Training	
TRN 1	**Training**	☐ TRN1A_TCM Care Manager Training Plan

Multi-site AMH+ Site Review Documents Checklist for Providers

This document serves as a guide for submitting documentation to supplement the site review. For more details on the requirements, please reference the Provider Manual, Community Inclusion Addendum (4.8), and **Site Review Protocol**.

Please ensure that your document does not contain any PHI/PII. PHI/PII must be redacted prior to submitting your files.

All submitted documents must adhere to the following guidelines:

1. AMH+ providers with more than one site must fill out the checklist below and provide additional information for all the sites they are applying to certify. Select an option from the "Shared?" column to indicate if the documentation submitted can be shared as evidence among all locations. AMH+ providers are certified at the site level and this checklist allows for the site review to be completed at the same time for all locations.
    a. When naming site-specific documents, using the table below, add the site number to the end of the file name. The naming convention should be "**0.0_Document Name_Site#**" (e.g. TCM 4A_Draft Care Plan_BH_Site2).
2. Individually save each document as a Word, Excel, PowerPoint or PDF file with the subcategory number (i.e., FIN 2), an underscore and the document name as listed on the Site Review Documents Check-List beginning on the following page (e.g., FIN 2C_Governance Structure).
3. If the workplan or policies and procedures differ for each population the provider is applying to be certified for, please clearly label that in the document header and file name. *Providers only need to submit documents for the populations they are applying to serve*. The naming convention should be "**0.0_Document Name_Population**." For each population, use the following abbreviations:
    a. BH (Mental Health and Substance Use Disorder)
        i. BH_Adult
        ii. BH_Child
    b. I-DD (Intellectual and Developmental Disabilities)
    c. TBI (Traumatic Brain Injury)
    d. Innovations (Waiver)
    e. Co_I-DD_BH (Co-occurring I/DD and Behavioral Health)
        i. Co_I-DD_BH_Adult
        ii. Co_I-DD_BH_Child
    f. Examples:
        i. TCM 3_CM Comprehensive Assessment P-P_Innovations
        ii. TCM 6_ Draft_TCM P-P_Annual Physical Exam_ BH_Child

Items noted with an asterisk (*) may meet more than one subcategory. Please ensure that such document contains sufficient evidence to meet that criterion.

LIST OF AMH+ LOCATIONS	
AMH+ Site 1 **Site Name:** **Site NPI:** **Site Address:** **Location Code:**	**AMH+ Site 6:** **Site Name:** **Site NPI:** **Site Address:** **Location Code:**
AMH+ Site 2 **Site Name:** **Site NPI:** **Site Address:** **Location Code:**	**AMH+ Site 7:** **Site Name:** **Site NPI:** **Site Address:** **Location Code:**
AMH+ Site 3: **Site Name:** **Site NPI:** **Site Address:** **Location Code:**	**AMH+ Site 8:** **Site Name:** **Site NPI:** **Site Address:** **Location Code:**
AMH+ Site 4: **Site Name:** **Site NPI:** **Site Address:** **Location Code:**	**AMH+ Site 9:** **Site Name:** **Site NPI:** **Site Address:** **Location Code:**
AMH+ Site 5: **Site Name:** **Site NPI:** **Site Address:** **Location Code:**	**AMH+ Site 10:** **Site Name:** **Site NPI:** **Site Address:** **Location Code:**

REQUIREMENTS		DOCUMENTS
ORG – Organization Informational Standing Experience Rating		
ORG 1	**Provider Relationships & Linkages**	☐ ORG1A_Provider Relationships and Linkages Workplan
FIN – Capacity		
FIN 1	**Capacity and Sustainability**	☐ FIN1 _Letter of Written Attestation *Organization should attest to no deterioration in the financial health of the organization, as compared to the audited financial statement or income statement and balance sheet submitted at desk review.* ☐ FIN1E_Changes to Net Income *(if applicable)* ☐ FIN1E_Updated Income Statement *(if applicable)* ☐ FIN1F_Changes to Net Working Capital *(if applicable)* ☐ FIN1F_Updated Balance Sheet *(if applicable)* ☐ FIN1G_Changes to Total Equity *(if applicable)* ☐ FIN1G_Updated Balance Sheet *(if applicable)* ☐ FIN1H_YTD Statement of Operations and Financial Projections for 2024 and 2025 *Must include rationale for updates to projected population or service volumes that impact revenue AND Summary of how capacity building funds will be used to fill gaps (e.g., staffing, HIT) by TCM launch.*
FIN 2	**Oversight**	☐ FIN2C_Governance Structure Bylaws Charter
STF – Staffing		
STF 1	**Care Management Staff**	☐ STF1A_Recruitment and Retention Workplan ☐ *STF1B_MOU (if applicable)* ☐ *STF1C_CIN Contract (if applicable)*
STF 2	**Clinical Consultants**	☐ STF2A_Clinical Consultants P-P *OR* ☐ 3.2STF2A_Clinical Consultants Workplan

REQUIREMENTS		DOCUMENTS
		☐ *STF2B_CVs and Signed Agreements (if applicable)*
TCM – Delivery of Tailored Care Management		
TCM 1	**Policies and Procedures for Communication with Members**	☐ TCM1A_Draft Communication P-P with Members Families and Caregivers
TCM 2	**Capacity to Engage with Members through Frequent Contact**	☐ TCM2A_Draft Member Engagement P-P
TCM 3	**Care Management Comprehensive Assessments and Reassessments**	<u>CM Comprehensive Assessment Tool(s) for each population:</u> ☐ TCM3A_CM Comprehensive Assessment Tool_MH_SUD_Adult ☐ TCM3A_CM Comprehensive Assessment Tool_MH_SUD_Child ☐ TCM3A _CM Comprehensive Assessment Tool_I-DD ☐ TCM3A_CM Comprehensive Assessment Tool_I-DD_Child ☐ TCM3A_CM Comprehensive Assessment Tool_Innov_Adult ☐ TCM3A_CM Comprehensive Assessment Tool_Innov_Child ☐ TCM3A _CM Comprehensive Assessment Tool_TBI_Adult ☐ TCM3A_CM Comprehensive Assessment Tool_TBI_Child ☐ TCM3A _CM Comprehensive Assessment Tool_Co_I-DD_BH_Adult ☐ TCM3A_CM Comprehensive Assessment Tool_Co_I-DD_BH_Child ☐ TCM3A_CM Comprehensive Assessment P-P
TCM 4	**Care Plans and Individual Support Plans (ISPs)**	<u>Draft Care Plan and/or ISP tool for each population:</u> ☐ TCM4A_Draft Care Plan_MH_SUD_Adult *OR* ☐ TCM4A _ISP Tool_MH_SUD_Adult ☐ TCM4A_Draft Care Plan_MH_SUD_Child *OR* ☐ TCM4A _ISP Tool_MH_SUD_ Child ☐ TCM4A _Draft Care Plan_ I-DD_Adult *OR* ☐ TCM4A _ISP Tool_I-DD_Adult ☐ TCM4A _Draft Care Plan_ I-DD_Child *OR* ☐ TCM4A _ISP Tool_I-DD_Child ☐ TCM4A _Draft Care Plan_ TBI_Adult *OR* ☐ TCM4A _ISP Tool_ TBI_Adult ☐ TCM4A _Draft Care Plan_ TBI_Child *OR* ☐ TCM4A _ISP Tool_ TBI_Child ☐ TCM4A _Draft Care Plan_ Innov_Adult *OR* ☐ TCM4A _ISP Tool_ Innov_Adult ☐ TCM4A _Draft Care Plan_ Innov_Child *OR* ☐ TCM4A _ISP Tool_ Innov_Child ☐ TCM4A _Draft Care Plan_ Co_I-DD_BH_Adult *OR* ☐ TCM4A _ISP Tool_Co_I-DD_BH_Adult ☐ TCM4A _Draft Care Plan_ Co_I-DD_BH_Child *OR* ☐ TCM4A _ISP Tool_Co_I-DD_BH_Child

REQUIREMENTS		DOCUMENTS
		Mock Care Plan and/or ISP tool for each population you serve: ☐ TCM4B _Mock Care Plan_MH_SUD_Adult *OR* ☐ TCM4B _ISP Tool_MH_SUD_Adult ☐ TCM4B _Mock Care Plan_MH_SUD_Child *OR* ☐ TCM4B _ISP Tool_MH_SUD_ Child ☐ TCM4B _Mock Care Plan_ I-DD_Adult *OR* ☐ TCM4B _ISP Tool_I-DD_Adult ☐ TCM4B _Mock Care Plan_ I-DD_Child *OR* ☐ TCM4B _ISP Tool_I-DD_Child ☐ TCM4B _Mock Care Plan_ Innov_Adult *OR* ☐ TCM4B _ISP Tool_ Innov_Adult ☐ TCM4B _Mock Care Plan_ Innov_Child *OR* ☐ TCM4B _ISP Tool_ Innov_Child ☐ TCM4B_Mock Care Plan_ TBI_Adult *OR* ☐ TCM4B_ISP Tool_ TBI_Adult ☐ TCM4B_Mock Care Plan_ TBI_Child *OR* ☐ TCM4B_ISP Tool_ TBI_Child ☐ TCM4B_Mock Care Plan_Co_I-DD_BH_Adult *OR* ☐ TCM4B_ISP Tool Co_I-DD_BH_Adult ☐ TCM4B_Mock Care Plan_Co_I-DD_BH_Child *OR* ☐ TCM4B_ISP Tool Co_I-DD_BH_Child
TCM 5	**Care Teams**	☐ TCM5A_Team Formation and Communication P-P ☐ TCM5B_Case Example
TCM 6	**Required Components of Tailored Care Management**	☐ TCM6A_Draft Communication Among Provider Types P-P ☐ TCM6B_Draft TCM P-P_Care Coordination ☐ TCM6B _Draft TCM P-P_24-Hr Coverage ☐ TCM6B _Draft TCM P-P_Annual Physical Exam ☐ TCM6B _Draft TCM P-P_Continuous Monitoring ☐ TCM6B _Draft TCM P-P_Medication Monitoring ☐ TCM6B _Draft TCM P-P_System of Care ☐ TCM6B _Draft TCM P-P_Individual and Family Support ☐ TCM6B _Draft TCM P-P_Health Promotion
TCM 7	**Addressing Unmet Health-related Resource Needs**	☐ TCM7A_Referral Process P-P
TCM 8	**Transitional Care Management**	☐ TCM8A_Draft Transitional Mgmt P-P (and member outreach)
TCM 9	***Innovations and TBI Waiver Care Coordination (if applicable)***	☐ *TCM9A_Draft TBI Waiver Care Coordination P-P (if applicable)*
		HIT – Health IT
HIT 1	**Use an electronic health record**	☐ HIT1A _ HIT Vendor Contract_EHR
HIT 2	**Use care management data system**	☐ HIT2A_ HIT Vendor Contract_CM

REQUIREMENTS		DOCUMENTS
HIT 3	**Use ADT information**	☐ HIT3A_HIT Vendor Contract_ADT
HIT 4	**HIT Workplan**	☐ HIT4A_HIT Workplan
HIT 5	**Use NCCARE360**	☐ HIT5A_NCCARE360 Onboarding Plan *OR* ☐ HIT5A_NCCARE360 Contract
QMI – Quality Measurement and Improvement		
QMI 1	**Quality Measurement and Improvement**	☐ QMI1A_Draft CQI P-P ☐ QMI1B_List High Priority TCM Areas ☐ QMI1B_CQI Example
TRN – Training		
TRN 1	**Training**	☐ TRN1A_TCM Care Manager Training Plan