

Standard Terms and Conditions for Tailored Plan Contracts with AMH+ Practices or CMAs

Unless otherwise specified, any required element may be performed either by the Advanced Medical Home Plus (AMH+) practice or Care Management Agency (CMA) itself or by a Clinically Integrated Network (CIN) with which the AMH+ practice or CMA has a contractual agreement that contains equivalent contract requirements.

1. Staffing

- a. The AMH+ practice or CMA must assign each assigned member to a care manager who meets the qualifications specified in section “b.”.
 - i. The assigned care manager must not be related by blood or marriage or financially responsible for any of the members to whom they are assigned or have any legal power to make financial or health-related decisions for any of their assigned members.
- b. All Tailored Care Management supervising care managers, care managers, and care manager extenders must meet the following minimum qualification requirements:
 - i. Care managers serving all members must have the following minimum qualifications:
 1. A bachelor’s degree in a field related to health, psychology, sociology, social work, nursing, or another relevant human services area, or licensure as a registered nurse (RN); and
 2. Two years of experience working directly with individuals with behavioral health conditions (if serving members with behavioral health needs) or with an intellectual/developmental disability (I/DD) or a traumatic brain injury (TBI) (if serving members with I/DD or TBI needs); and
 3. For care managers serving members with long term services and supports (LTSS) needs: two years of prior LTSS and/or home and community-based services (HCBS) coordination, care delivery monitoring, and care management experience, in addition to the requirements cited above. (This experience may be concurrent with the two years of experience working directly with individuals with behavioral health conditions, an I/DD, or a TBI, above.)
 - ii. Supervising care managers serving members with behavioral health conditions must have the following minimum qualifications:
 1. A master’s-level fully Licensed Clinical Social Worker (LCSW), fully Licensed Clinical Mental Health Counselor (LCMHC), fully Licensed Psychological Associate (LPA), fully Licensed Marriage and Family Therapist (LMFT), or licensure as an RN; and
 2. Three years of experience providing care management, case management, or care coordination to the population being served.
 - iii. Supervising care managers serving members with an I/DD or a TBI must have one of the following minimum qualifications:
 1. A bachelor’s degree in a field related to health, psychology, sociology, social work, nursing, or another relevant human services area and five years of

- experience providing care management, case management, or care coordination to complex individuals with I/DD or TBI; or
2. A master's degree in a field related to health, psychology, sociology, social work (e.g., LCSW), nursing, or another relevant human services area, or licensure as an RN and three years of experience providing care management, case management, or care coordination to complex individuals with an I/DD or a TBI.
- iv. Care manager extenders must have the following qualifications:
 1. At least 18 years of age; and
 2. A high school diploma or equivalent; and
 3. Supervised by a care manager at an AMH+ practice, CMA, or Tailored Plan; and
 4. Meet one of the following requirements:
 - a. 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
 - b. Be a person with lived experience with a behavioral health condition who is a Certified Peer Support Specialist; or
 - c. 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
 - d. 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.
 - v. If a member is dually diagnosed with a behavioral health condition and an I/DD or a TBI, the AMH+ practice or CMA must ensure that the supervising care manager is qualified to oversee the member's care manager.
 - vi. Each care manager must be supervised by a supervising care manager. One supervising care manager must not oversee more than eight (8) care managers. Supervisors must not carry a member caseload and must provide coverage for care manager vacation, sick leave, and staff turnovers. Supervisors must review all Tailored Care Management care plans and Individual Support Plans (ISPs) and provide guidance to care managers on how to meet members' needs.
 - vii. Care manager extenders must be supervised by a care manager.
 - viii. Care managers must supervise no more than two (2) FTE care manager extenders.
 - ix. Care manager extenders cannot work for the same organization where they receive services.
 - x. When an AMH+ practice or CMA relies on CIN or Other Partner-employed care managers to carry out Tailored Care Management, the AMH+ practice or CMA must demonstrate that care management is sufficiently integrated with the organization's practice team, as described below:

1. The AMH+ practice or CMA must have managerial control of care management staff, defined as the opportunity, at a minimum, to:
 - a. Approve the hiring and/or placement of a care manager or extender, and
 - b. Require a replacement for any care manager or extender whose performance the AMH+ practice or CMA deems unsatisfactory.
- xi. AMH+ practices and CMAs with arrangements with CINs or Other Partners must demonstrate 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.
- xii. All supervising care managers, care managers, and care manager extenders must participate and complete the Tailored Plan's Tailored Care Management training curriculum.
- xiii. Care managers and supervising care managers must also complete training on in-reach and transition services.
- c. The AMH+ practice or CMA must establish a multidisciplinary care team for each member.
 - i. Depending on the member's needs, the required members of a multidisciplinary care team must include the member, the member's care manager, and the following individuals:
 1. Caretaker(s)/legal guardians;
 2. Supervising care manager;
 3. Care manager extenders (e.g., community navigators, community health workers, individuals with lived experience with an I/DD or a TBI, parents or guardians of an individual with an I/DD or a TBI or a behavioral health condition);
 4. Certified peer support specialist employed by the AMH+ practice, CMA, or CIN or Other Partner, as applicable;
 5. Primary care provider;
 6. Behavioral health provider(s);
 7. I/DD and/or TBI providers, as applicable;
 8. Other specialists;
 9. Nutritionists;
 10. Pharmacists and pharmacy techs;
 11. The member's obstetrician/gynecologist (for pregnant women);
 12. In-reach and transition staff, as applicable; and
 13. Other providers and individuals, as determined by the care manager and member.
 - ii. The AMH+ practice or CMA must establish a plan to activate relationships with primary care providers and other key interdisciplinary agencies/providers.
 - iii. The AMH+ practice 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. The AMH+ practice or CMA must conduct regular case conferences with

members of the multidisciplinary care team, as appropriate based on member needs.

- d. AMH+ practices and CMAs must have access to clinical consultants in order to access expert support appropriate for the needs of the panel under Tailored Care Management. The AMH+ practice or CMA may employ or contract with consultants or do so through a CIN or Other Partner, and the consultant must be available by phone to staff within AMH+ practices and CMAs to advise on complex clinical issues on an ad hoc basis. The AMH+ practice or CMA must have access to at least the following experts:
 - i. A general psychiatrist or child and adolescent psychiatrist;
 - ii. A neuropsychologist or psychologist; and
 - iii. For CMAs, a primary care physician (PCP) to the extent the member's PCP is not available for consultation.
2. Population Health and Quality Measurement
- a. AMH+ practices and CMAs must meet the following population health and health information technology (HIT) requirements:
 - i. The AMH+ practice or CMA must have implemented an electronic health record (EHR) or a clinical system of record that is in use by the AMH+ practice's or CMA's providers that may electronically record, store, and transmit member clinical information.
 - ii. The AMH+ practice or CMA must use a care management data system, whether or not integrated within the same system as the EHR (or clinical system of record), that can:
 1. Maintain up-to-date documentation of Tailored Care Management member lists and assignments of individual members to care managers;
 2. Electronically document and store the care management comprehensive assessment and re-assessment;
 3. Electronically document and store the care plan or ISP;
 4. Consume claims and encounter data using DHHS required format;
 5. Provide access to – and electronically share, if requested – member records with the member's care team to support coordinated care management, as well as the member, in accordance with federal, state, and Department privacy, security, and data-sharing requirements;
 6. Track referrals;
 7. Allow care managers to:
 - a. Identify risk factors for individual members;
 - b. Develop actionable care plans and ISPs;
 - c. Monitor and quickly respond to changes in a member's health status;
 - d. Track a member's referrals and provide alerts where care gaps occur;
 - e. Monitor a member's medication adherence;
 - f. Transmit and share reports and summary of care records with care team members;
 - g. Support data analytics and performance;

- h. Transmit quality measures (where applicable); and
 8. Help schedule and prepare members (via, e.g., reminders and transportation) for appointments.
 - iii. The AMH+ practice or CMA must be able to receive and use enrollment data from the Tailored Plan to empanel the population in Tailored Care Management. To support outreach, engagement, assessment, and care planning, the AMH+ practice or CMA (or CIN or Other Partner on its behalf) must be able to:
 1. Receive, in a machine-readable format specified by the Department, and maintain up-to-date records of acuity tiers by member, as determined by the Department and shared by the Tailored Plan;
 2. Receive, in a machine-readable format, and maintain up-to-date records of any other risk scoring completed and shared by the Tailored Plan; and
 3. Electronically reconcile the Tailored Care Management assignment lists received from the Tailored Plan with its list of members for whom it provides Tailored Care Management.
 - iv. The AMH+ practice or CMA must access admission, discharge, transfer (ADT) data that correctly identifies when members are admitted, discharged, or transferred to or from an emergency department (ED) or a hospital in real time or near-real time.
 1. The AMH+ practice 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).
 - v. AMH+ practices and CMAs must:
 1. Use NCCARE360 as their community-based organization and social service agency resource repository to identify local community-based resources;
 2. Refer members to the community-based organizations and social service agencies available on NCCARE360; and
 3. Track closed-loop referrals.
 - vi. AMH+ practices and CMAs must use the Department's acuity tiers as the primary method for segmenting and managing their populations during the first two years of the Tailored Care Management model.
 1. Tailored Plans may establish their own risk stratification methodologies beyond acuity tiering; if they do so, they must share all risk stratification results and methodologies used with AMH+ practices and CMAs.
 2. By the third year of the Tailored Care Management model, AMH+ practices and CMAs shall develop their own risk stratification approach, refining the

data and risk stratification scores they receive from Tailored Plans to incorporate critical clinical, unmet health-related resource, and other data to which they have access. Additionally, AMH+ practices and CMAs' may use patient registries to track patients by condition type/cohort.

- vii. Annually, the AMH+ practice 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+ practice or CMA must 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.
 - b. AMH+ practices and CMAs must meet quality measurement requirements:
 - i. AMH+ practices and CMAs must gather, process, and share data with Tailored Plans for the purpose of quality measurement and reporting for the quality measures specified by DHHS.
3. Delivery of Tailored Care Management
- a. Enrollment: AMH+ practices and CMAs must allow members to opt out of Tailored Care Management at any time.
 - i. In the event that a member informs the AMH+ practice or CMA that they would like to opt out of Tailored Care Management, the assigned care manager must support the member in the opt-out process, including completing and submitting the Tailored Plan's Tailored Care Management Opt-out Form, if requested by the member.
 - ii. A member who has opted out may opt back into Tailored Care Management at any time by contacting the Tailored Plan.
 - b. Communication: AMH+ practices and CMAs must develop policies for communicating and sharing information with members 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 contacting members.
 - c. Contact Requirements: AMH+ practices and CMAs must meet the following contact requirements:
 - i. Contacts for members with behavioral health needs:
 - 1. High acuity: At least four contacts per month, including at least one in-person contact with the member.
 - 2. Moderate acuity: At least three 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).
 - 3. Low acuity: At least two 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).
 - ii. Contacts for members with an I/DD or a TBI:
 - 1. High acuity: At least three contacts per month, including two in-person contacts and one telephonic contact with the member.

2. Moderate acuity: At least three contacts per month and at least one in-person contact with the member quarterly.
 3. Low acuity: At least one telephonic contact per month and at least two in person contacts per year, approximately six months apart.
 - iii. 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.
 - iv. In the event that a care manager or extender delivers multiple contacts to a member in one day, only one contact shall count towards meeting the contact requirements.
 - v. Providers must share care management contacts and other care management information using the specified reporting template from DHHS.
- d. Care Management Comprehensive Assessment: The AMH+ practice or CMA must 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" is 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).
 - i. During the first year of Tailored Plan operation, the AMH+ practice or CMA must undertake best efforts to complete the care management comprehensive assessment within the following timeframes:
 1. Members identified as high acuity: Best efforts to complete it within forty-five (45) calendar days of assignment to Tailored Care Management and no longer than sixty (60) Calendar Days after assignment to Tailored Care Management.
 2. Members identified as medium/low acuity: Within ninety (90) Calendar Days of assignment to Tailored Care Management.
 - ii. During the second and subsequent years of Tailored Plan operation, the AMH+ practice or CMA shall undertake best efforts to complete the care management comprehensive assessment within 60 days of assignment to Tailored Care Management.
 - iii. As part of completing the care management comprehensive assessment, the assigned care manager must ask for the member's consent for participating in Tailored Care Management. As part of the consent process, the care manager must explain the Tailored Care Management program. Care managers should document in the care management data system that the member provided consent, including the date of consent.
 - iv. The care management comprehensive assessment must include, at a minimum, the following domains:
 1. Immediate care needs;
 2. Current services and providers across all health needs;
 3. Functional needs, accessibility needs, strengths, and goals;
 4. Other state or local services currently used;
 5. Physical health conditions, including dental conditions;

6. Current and past mental health and substance use status and/or disorders, including tobacco use disorders;
7. Physical, intellectual, or developmental disabilities;
8. 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;
9. Advance directives, including psychiatric advance directives;
10. Available informal, caregiver, or social supports;
11. Standardized unmet health-related resource need questions (to be provided by the Department) covering four priority domains:
 - a. Housing instability;
 - b. Transportation insecurity;
 - c. Food insecurity; and
 - d. Interpersonal violence/toxic stress;
12. Any other ongoing conditions that require a course of treatment or regular care monitoring;
13. For adults only, exposure to adverse childhood experiences (ACEs) or other trauma;
14. Risks to the health, well-being, and safety of the member and others (including sexual activity and potential abuse/exploitation, or exposure to second hand smoke/aerosols and other substances);
15. Cultural considerations (ethnicity, religion, language, reading level, health literacy, etc.);
16. Employment/community involvement;
17. Education (including individualized education plan and lifelong learning activities);
18. Justice system involvement (adults) or juvenile justice involvement and/or expulsions or exclusions from school (children and adolescents);
19. Risk factors that indicate an imminent need for LTSS;
20. The caregiver's strengths and needs;
21. Upcoming life transitions (changing schools, changing employment, moving, etc.);
22. Self-management and planning skills;
23. Receipt of and eligibility for entitlement benefits;
24. For members with an I/DD or a TBI:
 - a. Financial resources and money management;
 - b. Alternative guardianship arrangements, as appropriate;
25. For children ages zero up to three, incorporate questions related to Early Intervention (EI) services for children, including:
 - a. Whether the child is receiving EI services;
 - b. The child's current EI services;
 - c. Frequency of EI services provided;
 - d. Which local Children's Developmental Service Agency (CDSA) or subcontracted agency is providing the services; and

- e. Contact information for the CDSA service coordinator; and
- 26. For children ages three up to 21 with a mental health disorder and/or substance use disorder (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.
- v. The AMH+ practice or CMA must attempt a care management comprehensive assessment for members already engaged in care management:
 - 1. At least annually;
 - 2. When the member's circumstances, needs, or health status changes significantly;
 - 3. 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);
 - 4. At the member's request; or
 - 5. After "triggering events", defined as follows:
 - a. Inpatient hospitalization for any reason;
 - b. Two emergency department visits since the last care management comprehensive assessment (including reassessment);
 - c. An involuntary treatment episode;
 - d. Use of behavioral health crisis services;
 - e. Arrest or other involvement with law enforcement/the criminal justice system, including the Division of Juvenile Justice;
 - f. Becoming pregnant and/or giving birth;
 - g. 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;
 - h. Loss of housing; and
 - i. Foster care involvement.
- vi. The AMH+ practice or CMA must ensure that the results of the care management comprehensive assessment are made available to the member's primary care, behavioral health, I/DD, TBI, and LTSS providers and the 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).
- e. Care Plan and ISP: Informed by the results from the care management comprehensive assessment, the AMH+ practice 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. The care plan/ISP must be developed and presented in a manner understandable to the member, including consideration for the member's reading level and alternate formats.

- i. 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:
 1. LOCUS and CALOCUS;
 2. CANS;
 3. ASAM criteria;
 4. For Innovations waiver enrollees: SIS; and
 5. For TBI waiver enrollees: Rancho Los Amigos Levels of Cognitive Functioning Scale (as applicable).
- ii. For 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+ practice or CMA must follow System of Care requirements, including:
 1. Involving a Child and Family Team (CFT) in facilitating the care planning process and developing the care plan or ISP;
 2. 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; and
 3. 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.
- iii. AMH+ practices and CMAs must ensure that all care plans and ISPs developed under Tailored Care Management include the following minimum elements:
 1. 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;
 2. Measurable goals;
 3. Clinical needs, including any behavioral health, I/DD-related, TBI-related, or dental needs;
 4. Interventions including addressing medication monitoring, including adherence;
 5. Intended outcomes;
 6. Social, educational, and other services needed by the member;
 7. Strategies to increase social interaction, employment, and community integration;
 8. An emergency/natural disaster/crisis plan;
 9. Strategies to mitigate risks to the health, well-being, and safety of the members and others;
 10. Information about advance directives, including psychiatric advance directives, as appropriate;

11. 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;
 12. Strategies to improve self-management and planning skills; and
 13. For members with I/DD, TBI, or serious emotional disturbance (SED), the ISP should also include caregiver supports, including connection to respite services, as necessary.
- iv. The AMH+ practice 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+ practice or CMA must 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.
 - v. The AMH+ practice or CMA must regularly and comprehensively update the care plan or ISP, incorporating input from the member and members of the care team, as part of ongoing care management:
 1. At minimum every 12 months;
 2. When the member's circumstances or needs change significantly;
 3. At the member's request;
 4. Within 30 days of care management comprehensive (re)assessment; and/or
 5. After triggering events (see above).
 - vi. The AMH+ practice or CMA must monitor the completion of care plans/ISPs and review them for quality control.
 - vii. The AMH+ practice or CMA must 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:
 1. Care team members, including the member's PCP and behavioral health, I/DD, TBI, and LTSS providers;
 2. The Tailored Plan;
 3. Other providers delivering care to the member;
 4. The member's legal representative (as appropriate);
 5. The member's caregiver (as appropriate, with consent);
 6. Social service providers (as appropriate, with consent); and
 7. Other individuals identified and authorized by the member.
- f. Care Coordination: The AMH+ practice or CMA must ensure the member has an ongoing source of care and coordinate the member's health care and social services, spanning physical health, behavioral health, I/DD, TBI, LTSS, pharmacy services, and services to address unmet health-related resource needs. In delivering care coordination the AMH+ practice or CMA must:
 - i. Follow up on referrals and work with the member's providers to help coordinate resources during any crisis event as well as provide assistance in scheduling and preparing members for appointments (e.g., reminders and arranging transportation) and

- ii. Provide 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-funded services.
- g. Twenty-four-Hour Coverage: The AMH+ practice or 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. The AMH+ practice or CMA must:
 - i. Share information such as care plans and psychiatric advance directives, and
 - ii. Coordinate care to place the member in the appropriate setting during urgent and emergent events. Automatic referral to the hospital ED for services does not satisfy this requirement.
- h. Annual Physical Exam: The AMH+ practice or CMA must ensure that the member has an annual physical exam or well-child visit, based on the appropriate age-related frequency.
- i. Continuous Monitoring: The AMH+ practice 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+ practice or CMA must support the member's adherence to prescribed treatment regimens and wellness activities.
- j. Medication Monitoring: The AMH+ practice or CMA must conduct medication monitoring, including regular medication reconciliation (conducted by the appropriate care team member) and support of medication adherence. A community pharmacist at the CIN level, in communication with the AMH+ practice or CMA, may assume this role.
- k. System of Care: The AMH+ practice or CMA must utilize strategies consistent with a System of Care 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:
 - i. Promotion of family-driven, youth-guided service delivery and development of strategies built on social networks and natural or informal supports;
 - ii. 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;
 - iii. 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
 - iv. 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 must be provided a copy of the plan.
- l. Individual and Family Supports: The AMH+ practice or CMA must incorporate individual and family supports by performing the following activities at a minimum:
 - i. Educate the member in self-management;
 - ii. Educate and provide guidance on self-advocacy to the member, family members, and support members;

- iii. Connect the member and caregivers to education and training to help the member improve function, develop socialization and adaptive skills, and navigate the service system;
- iv. Provide information and connections to needed services and supports including but not limited to self-help services, peer support services, and respite services;
- v. Provide 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;
- vi. Promote wellness and prevention programs;
- vii. Provide information on establishing advance directives, including psychiatric advance directives as appropriate, and guardianship options/alternatives, as appropriate;
- viii. Connect members and family members to resources that support maintaining employment, community integration, and success in school, as appropriate; and
 - 1. 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.
- m. Health Promotion: The AMH+ practice or CMA must:
 - i. Educate the member on members' chronic conditions;
 - ii. Teach self-management skills and sharing self-help recovery resources;
 - iii. Educate the member on common environmental risk factors including but not limited to the health effects of exposure to second and third hand tobacco smoke and e-cigarette aerosols and liquids and their effects on family and children;
 - iv. Conduct medication reviews and regimen compliance; and
 - v. Promote wellness and prevention programs.
- n. Unmet Health-Related Resource Needs: The AMH+ practice or CMA must ensure that Tailored Care Management addresses unmet health-related resource needs by performing the following activities at a minimum:
 - i. Provide referral, information, and assistance in obtaining and maintaining community-based resources and social support services, including:
 - 1. Disability benefits;
 - 2. Food and income supports;
 - 3. Housing;
 - 4. Transportation;
 - 5. Employment services;
 - 6. Education;
 - 7. Financial literacy programs;
 - 8. Child welfare services;
 - 9. After-school programs;
 - 10. Rehabilitative services;
 - 11. Domestic violence services;
 - 12. Legal services;
 - 13. Services for justice-involved populations; and

14. Other services that help individuals achieve their highest level of function and independence.
 - ii. 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:
 1. Food and Nutrition Services;
 2. Temporary Assistance for Needy Families;
 3. Child Care Subsidy;
 4. Low Income Energy Assistance Program;
 5. NC ABLE Accounts (for individuals with disabilities);
 6. Women, Infants, and Children (WIC) Program; and
 7. Other programs managed by the Tailored Plan that address unmet health-related resource needs.
 - iii. Provide referral, information, and assistance in connecting members to programs and resources that can assist in:
 1. Securing employment;
 2. Supported employment (such as through the Individual Placement and Support - Supported Employment (IPS-SE) program);
 3. Volunteer opportunities;
 4. Vocational rehabilitation and training; or
 5. Other types of productive activity that support community integration, as appropriate.
4. Transitions, Community Inclusion, and Diversions
- a. Transitional Care Management: AMH+ practices and CMAs must manage care transitions for members under care management transitioning from one clinical setting to another, including the following activities:
 - i. Assign a care manager to manage the transition;
 - ii. 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;
 - iii. Conduct outreach to the member's providers;
 - iv. Obtain a copy of the discharge plan and review the discharge plan with the member and facility staff;
 - v. Facilitate clinical handoffs;
 - vi. Assist the member in obtaining needed medications prior to discharge, ensure an appropriate care team member conducts medication reconciliation/management, and support medication adherence;
 - vii. 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;
- viii. Communicate with and educate the member and the member's caregivers and providers to promote understanding of the 90-day transition plan;
 - ix. 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;
 - x. Ensure that the assigned care manager follows up with the member within 48 hours of discharge;
 - xi. Arrange to visit the member in the new care setting after discharge/transition;
 - xii. Conduct a care management comprehensive assessment within 30 days of the discharge/transition, or update the current assessment; and
 - xiii. Update the member's care plan or ISP in coordination with the care team within 90 days of the discharge/transition.
- b. Community Inclusion Activities: AMH+ practices and CMAs must conduct the community inclusion and transition-related responsibilities outlined in *In-Reach Activities* and *Transition Activities* below for the following members (as appropriate):
- i. 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
 - ii. Adult members admitted to a state psychiatric hospital or an Adult Care Home (ACH) who are eligible for Tailored Care Management and who are not transitioning to supportive housing.
- c. In-Reach Activities: AMH+ practices and CMAs must conduct 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.
- i. Care managers must identify and engage such members and conduct the following in-reach activities:
 - 1. 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;
 - 2. Identify and attempt to address barriers to relocation to a community setting;
 - 3. 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;
 - 4. 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

5. Identify any specific trainings that facility staff may benefit from to support smooth transitions for members to live and work in community settings.
- ii. For members newly admitted to one of these facilities, in-reach activities must begin within seven days of admission.
 - iii. Not all members will be able or willing to continue with the in-reach process or begin transition planning. For those members, care managers must make best efforts to address member concerns and arrange for peer-to-peer meetings, when appropriate, and continue to engage the member and their family and/or guardians on a regular basis about the opportunity to transition to a more integrated setting.
- d. 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. Care managers must plan for effective and timely transition of members to the community and perform the following transition activities:
- i. 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;
 - ii. 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;
 - iii. Arrange for individualized supports and services that are needed to be in place upon discharge;
 - iv. 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;
 - v. Work to identify any specific training needs by receiving providers and/or agencies to ensure a seamless transition for the member;
 - vi. 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;
 - vii. Work with the facility providers to arrange for any post-discharge services, when applicable;
 - viii. 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
 - ix. Convene and engage the member's Child and Family Team through the entire transition process.
- e. Diversion: AMH+ practices and CMAs must identify members who are at risk of entry into an adult care home or an institutional setting, such as an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID), psychiatric hospital, or psychiatric

residential treatment facility, and performing diversion activities. Care managers must perform the following Diversion activities:

- i. Screen and assess members for eligibility for community-based services;
 - ii. Educate members on the choice to remain in the community and the services that would be available;
 - iii. Facilitate referrals and linkages to community support services for assistance;
 - iv. Determine whether a member is eligible for supported housing, if needed; and
 - v. Develop 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.
- f. Extenders may support care managers in delivering Tailored Care Management by performing activities that fall within the below categories. When an extender performs one of the functions listed below, it may count as a Tailored Care Management contact if phone or video and audio or in-person contact with the member is made:
- i. Performing general outreach, engagement, and follow-up with members;
 - ii. Coordinating services/appointments (e.g., appointment/wellness reminders, arranging transportation);
 - iii. Engaging in health promotion activities (as defined in the Tailored Care Management Provider Manual) and knowledge sharing;
 - iv. Sharing information with the care manager and other members of the care team on the member's circumstances;
 - v. Providing and tracking referrals and providing information and assistance in obtaining and maintaining community-based resources and social support services;
 - vi. Participating in case conferences;
 - vii. Support the care manager in assessing and addressing unmet health-related resource needs.
- g. A care manager must be solely responsible for:
- i. Completing the care management comprehensive assessment;
 - ii. Developing the care plan (for members with behavioral health needs) or individual support plan (ISP) (for members with I/DD and TBI needs);
 - iii. Facilitation of case conferences;
 - iv. Ensuring that medication monitoring and reconciliation occur;
 - v. Continuous monitoring of progress toward the goals identified in the care plan or ISP; and
 - vi. Managing care transitions, including creating 90-day transition plans.

5. Payments

- a. To access the per member per month (PMPM) payment for any given member, the AMH+ practice or CMA must deliver at least one care management contact during the month for that member (i.e., providers will not be paid in months in which there were no member contacts). The AMH+ practice or CMA must submit a claim to the Tailored Plan, and the Tailored Plan must pay the provider the PMPM rate after the month of service.
- b. Only contacts delivered by the assigned care manager or extender shall count towards meeting the contact requirements and be eligible for payment. In the event that the supervising care manager is providing coverage for a care manager (e.g., sick leave,

vacation, staff turnovers) and delivers a contact to a member, the contact shall count towards meeting contact requirements and be eligible for payment.

6. Oversight

- a. The AMH+ practice or CMA must comply with oversight requirements established by the Tailored Plan and the Department, including reporting requirements and corrective action plans.
- b. When a member is receiving a service that has potential for duplication with Tailored Care Management, the AMH+ practice or CMA delivering Tailored Care Management must explicitly agree on the delineation of responsibility with the provider delivering the potentially-duplicative service and document that agreement in the care plan or ISP to avoid duplication of services.
- c. To the extent an AMH+ practice or CMA contracts with a CIN or Other Partner, the AMH+ practice or CMA must ensure that the CIN or Other Partner meets all of the applicable Tailored Care Management requirements for the functions and capabilities that the AMH+ practice or CMA has delegated to the CIN or Other Partner.
- d. In the event of continued underperformance relative to the requirements in this contract and upon receipt of a notice of underperformance from the Tailored Plan, the AMH+ practice or CMA agrees to remediate any issues identified through a Corrective Action Plan (CAP). In the event of continued underperformance by an AMH+ practice or a CMA that is not corrected after the time limit set forth in the CAP, the Tailored Plan may terminate its contract with the AMH+ practice or CMA.

Addendum: Additional Standard Terms and Conditions for Tailored Plan Contracts with AMH+ Practices or CMAs Certified to Provide Tailored Care Management to Members Enrolled in the 1915(c) Innovations or TBI Waivers

1. 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. The Department also intends to release additional guidance on 1915(i) care coordination requirements.
 - a. AMH+ practices and CMAs serving members in the Innovations or TBI waiver must:
 - i. Support completion of assessments beyond the care management comprehensive assessment, and incorporate results into the care management comprehensive assessment.
 1. 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;
 2. Complete person-centered information toolkits and self-direction assessments; and
 3. Complete Level of Care (LOC) re-evaluation annually.
 - ii. Facilitate provider choice and assignment process for Innovations and TBI waiver enrollees.
 1. Help enrollee make informed choices of care team participants, provide information about providers, and arrange provider interviews as needed; and
 2. Convene an in-person (as clinically indicated) care team planning meeting.
 - iii. Coordinate information and resources for self-directed services for Innovations waiver enrollees, as applicable.
 1. Ensure that waiver enrollees interested in self-directed services receive relevant information and training;
 2. Assist in appointing a representative to help manage self-directed services, as applicable;
 3. Assess employer of record and manage employer and representative, as applicable; and
 4. Provide self-directed budget information.
 - iv. 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.
 1. Complete the ISP so that the Tailored Plan receives it within 60 calendar days of LOC determination.
 2. As part of developing the ISP:
 - a. Explain options regarding the services available, and discuss the duration of each service;
 - b. Include a plan for coordinating waiver services;
 - c. Ensure the enrollee provides a signature (wet or electronic) on the ISP to indicate informed consent, in addition to ensuring that the

ISP includes signatures from all individuals and providers responsible for its implementation¹; As part of the consent process, members must consent to the following:

- i. By signing this plan, I am indicating agreement with the bulleted statements listed here unless crossed through. I understand that I can cross through any statement with which I disagree.
 - ii. My care manager helped me know what services are available.
 - iii. I was informed of a range of providers in my community qualified to provides the service(s) included in my plan and freely chose the provider who will be providing the services/supports.
 - iv. The plan includes the services/supports I need.
 - v. I participated in the development of this plan.
 - vi. I understand that my care manager will be coordinating my care with the [Tailored Plan] network providers listed in this plan.
 - vii. I understand that all services under the Innovations Waiver, including Residential Supports and Supported living, should be requested to the full extent of the individual's level of medical necessity; regardless of the individual's budgeting category.
 - viii. I understand that services may be authorized in excess of the Individualized Budget.
- d. Ensure enrollee completes Freedom of Choice statement in ISP annually;
 - e. Submit service authorization request to Tailored Plan for each service; and
 - f. Ensure that delivery of waiver services begins within 45 days of ISP approval.
3. Monitor ISP implementation and resolve or escalate issues as needed:
- a. Complete monthly ISP monitoring checklist (e.g., waiver service utilization, provider choice, HCBS compliance setting, etc.);
 - b. 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
 - c. Notify Tailored Plan of LOC determination updates.

¹ 42 C.F.R. §441.301(c)(2)(ix)