



NC DEPARTMENT OF
**HEALTH AND
HUMAN SERVICES**

Behavioral Health and Intellectual/ Developmental Disability Tailored Plan

**TAILORED CARE MANAGEMENT
AMH+/CMA PROVIDER CERTIFICATION**

APPLICATION

Instructions for AMH+ and CMA applicants:

1. Please use this application for reference only. Providers will need to complete a separate application through NCQA’s Interactive Review Tool (IRT) which is available at <https://irt.ncqa.org/>.
2. NCQA will reach out to applicants from the ntailoredcaregmt@ncqa.org email with instructions on how to submit the application in IRT.
3. Providers may reach out to ntailoredcaregmt@ncqa.org for questions. Do not submit this application and attachments via email.

TAILORED CARE MANAGEMENT CERTIFICATION
AMH+ and CMA Application Cover Sheet

1. Legal Entity Name	
2. DBA Name (if different from above)	
For items 3-5, please refer to Appendix B at the end of this document	
3. NPI Number	
4. Location Code	
5. Corporate Address	
6. Tax ID Number	
7. Primary Application Contact	
First and Last Name	
Title/Position	
Business Phone Number	
Business Email Address	
8. Organization’s Alternative Point of Contact (if applicable)	
First and Last Name	
Title/Position	
Business Phone Number	
Business Email Address	
9. Organizational Approval	<i>Check box to attest.</i> <input type="checkbox"/> Our governance board (or executive leadership) has approved this application.
Complete the rows below only if using a Clinically Integrated Network (CIN) or other Partner.	
10. CIN or Other Partner Organization Name	
11. CIN or Other Partner Organization Contact	
First and Last Name	
Title/Position	
Business Phone Number	
Business Email Address	

Behavioral Health and Intellectual/ Developmental Disability Tailored Plan

TAILORED CARE MANAGEMENT AMH+/CMA PROVIDER CERTIFICATION

Application Questions

When responding to the items in this application and preparing documents to submit before site review, **please note that we ARE NOT looking for language taken directly from the Provider Manual;** we are looking for your organization's unique processes and descriptions of how you will implement and support this program.

A. Organization Information (ORG)

A1. In which current Local Management Entities/Managed Care Organizations (LME/MCO) region(s) is your organization located? For CMAs, please list one administrative site (address, NPI, location code) for each county you will serve members. Members served in the counties where you do not have a site may be assigned to one of the listed Administrative sites. For AMH+s, please list all sites/locations (full addresses, NPIs, location code, and county served) within those regions that would be involved in Tailored Care Management (TCM). If your organization has over 10 locations that will provide TCM services, please attach a spreadsheet that includes all practices with their full address, NPI, location code, and county.

Refer to the end of the application for accessing NPI and Location codes through the Provider Directory Listing Report.

Example format for providers with fewer than 10 locations:

LME / MCO Region		
1. Location Address		
a. NPI and Location Code		
b. County served		
2. Location Address		
a. NPI and Location Code		
b. County served		
LME / MCO Region		
1. Location Address		
a. NPI and Location Code		
b. County served		
2. Location Address		
a. NPI and Location Code		
b. County served		

A2. With which LME/MCOs does your organization currently hold a contract?

A3. *(If applicable)* Please provide any known details of the scope of your organization's relationship with a CIN or other partner.

B. Intent and Service Lines (ISL)

B1. What scope of services does your organization currently offer?
(check all that apply)

Mental Health / Substance Use Disorder (SUD)

- Mental Health / SUD (Adult)
- Mental Health / SUD (Child)

I/DD (Intellectual/Developmental Disability)

- I/DD (Adult)
- I/DD (Child/Adolescent)

Innovations Waiver

- Innovations Waiver (Adult)
- Innovations Waiver (Child/Adolescent)

TBI Waiver (Traumatic Brain Injury)

- TBI Waiver (Adult)

TBI

- TBI (Adult)
- TBI (Child)

Co-occurring I/DD and Behavioral Health

- Co-occurring I/DD and Behavioral Health (Adult)
- Co-occurring I/DD and Behavioral Health (Child)

- Internal medicine
- Family medicine
- Pediatrics
- Other primary care
- Other

Check box to attest.

B2. Attestation: Our organization acknowledges that we have read the certification criteria outlined in Section V. of the Provider Manual and that we intend to complete the requirements if certified as an AMH+ or a CMA.

B3. Our organization is applying to become:

- AMH+
- CMA

B4. For which population(s) in the BH I/DD Tailored Plan eligible population is your organization applying for certification to provide TCM? *(check all that apply below)*

For all those populations, also list your associated Medicaid patient volume, a brief description of the services your organization provides to the population, and the number of years your organization has provided the services.

Population	Associated Medicaid Patient Volume	Number of Years Providing Service	Description of Services
<input type="checkbox"/> Mental Health / SUD (Adult)			
<input type="checkbox"/> Mental Health / SUD (Child)			
<input type="checkbox"/> I/DD (Adult)			
<input type="checkbox"/> I/DD (Child/Adolescent)			
<input type="checkbox"/> Innovations Waiver (Adult)			
<input type="checkbox"/> Innovations Waiver (Child/Adolescent)			
<input type="checkbox"/> TBI Waiver (Adult)			
<input type="checkbox"/> TBI (Adult)			
<input type="checkbox"/> TBI (Child)			
<input type="checkbox"/> Co-occurring I/DD and Behavioral Health (Adult)			
<input type="checkbox"/> Co-occurring I/DD and Behavioral Health (Child)			

B5. Do you plan any changes in service scope over the next 12 months? **[YES] [NO]**

If yes, please explain these changes:

B6. At this time, what type of Care Management system does your organization plan to utilize? (Please select one)

- Tailored Plan Care Management system.
- CIN or Other Partner's Care Management system.
- Internal Care Management system.

B7. AMH+ applicants only.

Attestation: Our practice has a patient panel with at least 100 active Medicaid patients who have a SMI (Serious Mental Illness), SED (Serious Emotional Disturbance), severe SUD, I/DD, or TBI ("Active" patients are those with at least two encounters with the AMH+ practice team in the past 18 months).

What is the total number of active Medicaid patients with an SMI, SED, severe SUD, I/DD, or TBI? _____

B8. AMH+ applicants only.

Describe your experience to date implementing AMH Tier 3 functions, including your leadership of risk stratification, comprehensive assessment, care planning, and other aspects of the AMH model.

- B9. Attestation: Our organization has read the Provider Manual requirement related to Provider Relationships and Linkages. Our organization will prepare the following documents three weeks prior to the site review.
- ORG1A_Provider Relationships and Linkages Workplan
 - ORG2A_Three or more contracts or established relationships per county, in distinct categories outside of the organization's designation that includes: resource name, address, and counties served.

B10. Describe your current contracts or other formal arrangements with behavioral health, I/DD, primary care, social services, pharmacy, or other providers 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).

C. Financial (FIN)

C1. Attestation: Our organization has read the Provider Manual requirement related to Capacity and Sustainability.

C2. Consolidated entities only.

Attestation: We have discussed this application with our parent company, and they have approved its submission.

C3. Attach your organization’s most recent annual financial statements or audit. This statement must be from within the past 2 years (e.g., for 2022 applicants, only 2020 or 2021 audited statements are acceptable). If an audited statement within this time frame is unavailable, attach the most recent reviewed (by independent CPA) financial statement or internally prepared financial statements (income statement and balance sheet).

Using the most recent financial statements, enter the following information in the “Actual” column:

Metric	Actual	Benchmark
Net income (Change in net assets)		>\$0
Net working capital (Current assets minus current liabilities)		>\$0
Total equity (Total net assets)		>\$0

C4. Applicants whose actual amount(s) presented in Question C3 are below benchmark only.

For each instance where the actual amount is below the benchmark, provide a detailed explanation, including, but not limited to:

1. The major driver(s) for the actual amount being below the benchmark.
2. The actual amounts from the prior 3 years.
3. What your organization is doing to improve performance, including more recent financial statements (partial or full year) to support improvement.

Explanation of net income/change in net assets:

Explanation of net working capital (current assets minus current liabilities):

Explanation of total equity/total net assets:

C5. Applicants that submitted financial statements that were not audited or reviewed by an independent CPA only.

Attach your accounting policies that detail your process for recording/reviewing journal entries, as well as monthly and annual financial review processes.

C6. Attestation: Our organization has read the Provider Manual requirement related to Oversight. Our organization will prepare the following document three weeks prior to the site review:

- FIN2C_Governance Structure Bylaws and/or Charter

C7. Attach your organization's organizational chart.

- This should include the reporting structure of your organization, as well as the name and title of each individual on the chart.
- If known, also provide the names of management level executive(s) at the level of the organization (not at the level of each individual site) who will supervise the care management team and provide close oversight of the TCM program during startup and on an ongoing basis. If any positions are vacant at the time, please note this.
- Indicate the individual(s) responsible for budget and financial management.

C8. Attach documentation that includes evidence of board approval for TCM participation.

- This should be any documentation confirming the resolution by the governing board and/or executive-level decision approving participation in TCM.

D. Staffing (STF)

D1. Attestation: Our organization has read the Provider Manual requirement related to Care Management Staff. Our organization will prepare the following documents three weeks prior to the site review:

- STF1A_Recruitment and Retention Workplan
- STF1B_MOU with CIN or Other Partner (if applicable)
- STF1C_CIN Contract (if applicable)

D2. Attestation: Our organization has read the Provider Manual requirement related to Care Management Staff. Our organization will prepare the following documents three weeks prior to the site review:

- STF2A_Clinical Consultants P-P (Policies & Procedures) OR STF2A_Clinical Consultants Workplan
- STF2B_CVs and Signed Agreements from Clinical Consultants (if applicable)

E. Delivery of Tailored Care Management (TCM)

Check box to attest

E1. Attestation: Our organization has read the Provider Manual requirement related to Policies and Procedures for Communication with Members. Our organization will prepare the following document three weeks prior to the site review:

- TCM1A_Draft Communication P-P with Members Families and Caregivers

E2. Attestation: Our organization has read the Provider Manual requirement related to Capacity to Engage with Members through Frequent Contact. Our organization will prepare the following document three weeks prior to the site review:

- TCM2A_Draft Member Engagement P-P

E3. Attestation: Our organization has read the Provider Manual requirement related to Care Management Comprehensive Assessments and Reassessments. Our organization will prepare the following documents three weeks prior to the site review:

- CM Comprehensive Assessment Tool(s) for each population the organization is applying to serve:
 - TCM3A_CM Comprehensive Assessment Tool_Mental Health & SUD
 - TCM3A_CM Comprehensive Assessment Tool_I-DD
 - TCM3A_CM Comprehensive Assessment Tool_TBI
 - TCM3A_CM Comprehensive Assessment Tool_Innovations
 - TCM3A_CM Comprehensive Assessment Tool_Co_I-DD_BH
 - TCM3B_CM Comprehensive Assessment P-P
 - TCM3B_CM Comprehensive Assessment Timeline (may be included in P&P)

E4. Attestation: Our organization has read the Provider Manual requirement related to Care Plans and Individual Support Plans (ISPs). Our organization will prepare the following documents three weeks prior to the site review Note: The submission of these documents is dependent on the population(s) served by your organization:

- TCM4A_Draft Care Plan and/or ISP tool for each population the organization is applying serve:
 - TCM 4A_Draft Care Plan and/or ISP tool for Mental Health / SUD (Adult)
 - TCM 4A_Draft Care Plan and/or ISP tool for Mental Health / SUD (Child)
 - TCM 4A_ISP tool for I/DD (Adult)
 - TCM 4A_ISP tool for I/DD (Child)
 - TCM 4A_ISP tool for Innovations Waiver (Adult)
 - TCM 4A_ISP for Innovations Waiver (Child)
 - TCM 4A_ISP tool for TBI Waiver
 - TCM 4A_ISP tool for TBI (Adult)
 - TCM 4A_ISP tool for TBI (Child)
 - TCM 4A_Draft Care Plan and/or ISP tool for Co_I/DD and BH (Adult)
 - TCM 4A_Draft Care Plan and/or ISP tool for Co_I/DD and BH (Child)
- TCM4B_Mock Care Plan and/or ISP tool for each population the organization is applying to serve:
 - TCM 4B_Mock Care Plan and/or ISP tool for Mental Health / SUD (Adult)
 - TCM 4B_Mock Care Plan and/or ISP tool for Mental Health / SUD (Child)
 - TCM 4A_Mock Care Plan and/or ISP tool for Co_I/DD and BH (Adult)
 - TCM 4A_Mock Care Plan and/or ISP tool for Co_I/DD and BH (Child)

E5. Attestation: Our organization has read the Provider Manual requirement related to Care Teams. Our organization will prepare the following documents three weeks prior to the site review:

- TCM5A_Team Formation and Communication P-P
- TCM5B_Case Example (list of team members, position descriptions, case conference agenda, and target length of conference)

E6. Attestation: Our organization has read the Provider Manual requirement related to Required Components of Tailored Care Management. Our organization will prepare the following documents three weeks prior to site review:

- TCM6A_Draft Communication Among Provider Types P-P
- TCM6B_Draft Tailored Care Management P-P to include:
 - o _Draft TCM P-P_Care Coordination
 - o _Draft TCM P-P_24-Hr Coverage
 - o _Draft TCM P-P_Annual Physical Exam
 - o _Draft TCM P-P_Continuous Monitoring
 - o _Draft TCM P-P_Medication Monitoring
 - o _Draft TCM P-P_System of Care
 - o _Draft TCM P-P_Individual and Family Support
 - o _Draft TCM P-P_Health Promotion

E7. Attestation: Our organization will 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.

E8. Our organization has read the Provider Manual requirement related to Addressing Unmet Health-related Resource Needs. Our organization will prepare the following document three weeks prior to the site review:

- TCM7A_Referral Process P-P

E9. Attestation **(AMH+ applicants only)**: We have access to ADT information and are experienced in using it for transitional care management, per AMH Tier 3 requirements.

E10. Attestation: Our organization has read the Provider Manual requirement related to Transitional Care Management. Additionally, our organization will prepare the following document three weeks prior to the site review.

- TCM8A_Draft Transitional Mgmt P-P (and member outreach)

Please check the box directly below if your organization will not be providing Innovations and TBI Waiver Care Coordination. If your organization will be providing these services, please proceed to E11.

Requirement TCM9 is Not Applicable to our organization

E11. Attestation: Our organization has read the Provider Manual requirement related to Innovations and TBI Waiver Care Coordination. Our organization will prepare the following document three weeks prior to the site review:

- TCM9A_Draft Innovations and TBI Waiver Care Coordination P-P

F. Health IT (HIT)

F1. Attestation: Our organization has read the Provider Manual requirement related to Using an Electronic Health Record (EHR). Our organization will prepare the following document three weeks prior to the site review:

- HIT 1A_Signed and Executed HIT Vendor Contract or Entity for HIT Vendor Contract or Entity_EHR
-

F2. Attestation: Our organization has read the Provider Manual requirement related to Using a Care Management Data System. Our organization will prepare the following document three weeks prior to the site review:

- HIT2A_Signed and Executed HIT Vendor Contract or Entity for HIT Vendor Contract or Entity_CM Data System
-

F3. Attestation: Our organization has read the Provider Manual requirement related to Using ADT Information. Our organization will prepare the following documents three weeks prior to the site review:

- HIT3A_Signed and Executed HIT Vendor Contract **OR** Entity for HIT Vendor Contract or Entity_ADT
 - HIT4A_HIT Workplan
-

F4. Attestation: Our organization has read the Provider Manual requirement related to using NCCARE360. Our organization will prepare the following document three weeks prior to the site review:

- HIT5A_NCCARE360 Onboarding Plan **OR** NCCARE360 Contract
-

G. Quality Measurement and Improvement (QMI)

G1. Attestation: Our organization has read the Provider Manual requirement related to Quality Measurement and Improvement. Our organization will prepare the following documents three weeks prior to the site review:

- QMI1A_Draft CQI P-P (Continuous Quality Improvement)
 - QMI1B_List High Priority TCM Areas (for Quality Monitoring)
 - QMI1B_CQI Example (to one TCM area)
-

H. Training (TRN)

H1. Attestation: Our organization has read, the Provider Manual requirement related to Training. Our organization will prepare the following document three weeks prior to the site review:

- TRNIA_Care Manager Training Plan
-

Attestation: Our organization will share the aforementioned required site review documents with our Area Health Education Center (AHEC) coach during the technical assistance period prior to site review.

Post-Application Notes and Instructions

North Carolina Department of Health and Human Services will notify your organization of the decision status of the desk review application.

Organizations that pass the desk review portion of the Tailored Care Management Certification process will proceed to technical assistance (TA) with North Carolina Area Health Education Centers (AHEC). TA will help prepare your organization for the site review.

For questions related to the site review, please contact your AHEC coach, once assigned.

Appendix

A. Documents for providers to submit with the desk review application

1. Audited financial statements (if available)
 - a. This statement must be from within the past 2 years (e.g., for 2022 applicants, only 2020 or 2021 audited statements are acceptable).
 - b. **If an audited statement within this time frame is unavailable, attach the most recent reviewed (by CPA) financial statement or internally prepared financial statements (income statement *and* balance sheet).**
2. Organization chart
3. Evidence of Board Approval for TCM participation

B. Provider NPI and Location Code Instructions

The **Provider Directory Listing Report** (generated bi-weekly) contains all active Medicaid and NC Health Choice providers that will be published on the Enrollment Broker (EB) website in the Medicaid and NC Health Choice Provider and Plan Lookup Tool. This list includes Primary Care Providers (PCPs) and specialty providers who are contracted with a Health Plan and/or Tribal Option, as well as providers who are not participating in managed care, to reflect the NC Medicaid Direct provider population.

Before submitting your application for AMH+/CMA Certification with the State of North Carolina, download and utilize the **Provider Directory Listing Report** (NOT the NCTracks Provider Portal) to locate the NPI, Location Code, and Practice Site Address for each location you would like to have certified.

If you are an NC Medicaid enrolled provider and are unable to find your practice's information in the Provider Directory Listing Report, or if your practice's information is outdated, please contact NCTracks for assistance by using the contact information on the [website](#).

NCTracks can assist you with both the update and NCTracks enrollment process if necessary.

Follow these steps to access the Provider Directory Listing Report.

1. Click the following link to visit the **Trending Topics** section of the NCDHHS website
2. Click the **Provider Directory Listing Report** link under the **Provider Directory Listing Report** subhead in the **Interim Reports to Assist Providers in Verifying Their Records** section to download the latest copy of the report.



Interim Reports to Assist Providers in Verifying Their Records

Provider Directory Listing Report

The [Provider Directory Listing Report \(generated March 15, 2022\)](#) contains all active Medicaid and NC Health Choice providers that will be published on the Enrollment Broker (EB) website in the Medicaid and NC Health Choice Provider and Plan Lookup Tool. This list includes Primary Care Providers (PCPs) and specialty providers who are contracted with a Health Plan and/or Tribal Option as well as providers who are not participating in managed care to reflect the NC Medicaid Direct provider population.

The report also identifies practices slated to be included in the auto-assignment process due to their participation with the Advanced Medical Home program, and gives providers the opportunity to correct erroneous demographic and affiliation data on their enrollment record in the secure [NCTracks Provider Portal](#).

3. If necessary, click **Enable Editing** to access the report and read the “Instructions” tab.
4. Filter the columns in “Provider Directory Listing Report” tab until you locate the practice site that will be undergoing certification.

Note: Only one NPI and location code should be provided for each practice site address. Multiple practice site addresses should not have the same NPI and location code combination.