NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Tailored Care Management Provider Manual

June 18, 2024

This document was updated on June 18, 2024. A summary of changes can be found in the Tailored Care Management Provider Manual Updates Memo, released on June 18, 2024. Revised standard terms and conditions are included to reflect these changes.

This Provider Manual supersedes previous versions. Any questions about Tailored Care Management should be submitted to: Medicaid.TailoredCareMgmt@dhhs.nc.gov.

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Section I: Introduction

The North Carolina Department of Health and Human Services (the Department) is focused on building robust and effective models for managing beneficiaries' comprehensive needs through care management. Tailored Care Management is North Carolina's specialized care management model targeted toward individuals with a behavioral health condition (including both mental health and substance use disorders), intellectual/developmental disability (I/DD), or traumatic brain injury (TBI). The model is available to all NC Medicaid beneficiaries who meet the eligibility criteria, unless they are receiving a duplicative service. All members enrolled in a Behavioral Health and Intellectual/Developmental Disability Tailored Plan (Tailored Plan) are considered eligible for Tailored Care Management.[1] In addition, individuals enrolled in NC Medicaid Direct who meet the model's eligibility criteria have the opportunity to access Tailored Care Management through their Local Management Entity/Managed Care Organization (LME/MCO), which covers behavioral health and I/DD services for people in NC Medicaid Direct through a health plan called a Prepaid Inpatient Health Plan (PIHP).

The Department strongly believes that care management should be provider-based and performed at the site of care, in the home or in the community, through face-to-face interaction between beneficiaries, providers, and care managers. Provider-based care management promotes whole-person care, foster high-functioning integrated care teams, and drive towards better health outcomes.

While it is not a requirement of Tailored Care Management that provider organizations provide co-located or integrated services, the model requires provider organizations to coordinate physical health, behavioral health,[2] I/DD and TBI services. The Department recognizes that integrating physical and behavioral health care while addressing nonmedical factors that impact an individual's health is a major change and will take time to implement. The Department's vision is that Tailored Care Management provides the "glue" for integrated care, fostering coordination and collaboration among care team members across disciplines and settings. Through the Tailored Care Management model, providers and Tailored Plans / LME/MCOs are asked to work closely together in new and innovative ways.

The Department has invested in the Tailored Care Management model to support the major changes ahead by pursuing the Health Home State Plan option for the model as described below, which enables the Department to obtain enhanced federal matching funds. The Department has also provided "capacity building" funding for certified Tailored Care Management providers in certification rounds one, two, and three. The Department designed the capacity building program to allow providers to receive some "startup" funding for important capacity building activities. The Department does not currently have plans to offer capacity building funds to any future certification rounds. For additional details on capacity building, see the Department's Capacity Building webpage.

[1] Tailored Plans are fully integrated managed care plans providing the full range of physical health, BH, I/DD, TBI, LTSS, pharmacy, and unmet health-related resource needs services. Tailored Plans are targeted toward individuals with significant behavioral health disorders, I/DDs, and TBI.

[2] Throughout this manual and throughout the design of Tailored Care Management, the Department is using the term "behavioral health" to encompass both mental health and substance use disorder services.

The Department's vision is that care managers affiliated with Advanced Medical Home Plus (AMH+) practices and Care Management Agencies (CMAs)[3] provide Tailored Care Management, in addition to Tailored Plans / LME/MCOs. This manual is a resource for provider organizations that are interested in playing a central role in Tailored Care Management and are considering or have become certified as an AMH+ or a CMA.

This manual includes:

- A description of the Tailored Care Management model and the functions AMH+ practices and CMAs are expected to perform;
- Criteria for AMH+ and CMA certification;
- The process for certification;
- General information about payment; and
- Information about AMH+ and CMA oversight.

Providers should note that many of the details contained in this manual are also contained within the Tailored Plan / LME/MCO contracts.[4]

The Department is actively engaging with providers and Tailored Plans / LME/MCOs about the Tailored Care Management model through regular webinars with question and answer sessions, as well as the Tailored Care Management Technical Advisory Group (TAG). Questions about Tailored Care Management can be directed to Medicaid.TailoredCareMgmt@dhhs.nc.gov.

Section II: Beneficiary Eligibility for Tailored Care Management

Tailored Care Management is available to all NC Medicaid beneficiaries who meet the eligibility criteria and are not obtaining a duplicative service (see below for more details).

- **Tailored Plans.** Like Standard Plans, Tailored Plans are fully integrated managed care products; Tailored Plans provide a robust set of services to address members' physical health, behavioral health, I/DD, TBI, long-term services and supports (LTSS), pharmacy, and unmet health-related resource needs. Tailored Plans offer a more extensive set of behavioral health and I/DD benefits than Standard Plans and are the only plans to offer 1915(c) Innovations, TBI waiver services, and State-funded services.[5] Tailored Plans also offer 1915(i) services—home and community-based services that were previously covered under 1915(b)(3) authority. Tailored Plans are targeted toward Medicaid beneficiaries with serious mental illness (SMI), serious emotional disturbance (SED), severe substance use disorders (SUDs), I/DD, and TBI as defined in Session Law 2015-245 as amended by Session Law 2018-48. All Tailored Plan members are eligible for Tailored Care Management, unless they are receiving a duplicative service (see below for more details). The Department conducts regular reviews of encounters, claims, and other data to identify beneficiaries

[3] For definitions of these terms, see Section III. Role of Provider Certification in Tailored Care Management.
[4] Tailored Plan Contract is available at https://medicaid.ncdhhs.gov/contract-30-2020-052-behavioral-health-and-idd-tailored-plan-amendment-all-sections/download?attachment. LME/MCO contracts are posted at https://medicaid.ncdhhs.gov/providers/programs-and-services/behavioral-health-idd/lmemco-contracts-and-reports
[5] The one exception is that Eastern Band of Cherokee Indian Tribal members will be able to access the Innovations and TBI waivers through LME/MCOs.

who are eligible for a Tailored Plan.[6] Beneficiaries who have a mandatory managed care status and meet the Tailored Plan eligibility criteria are auto-enrolled in the Tailored Plan in their region, unless they actively select a Standard Plan. Full Tailored Plan eligibility criteria is available at https://medicaid.ncdhhs.gov/appendix-b-behavioral-health-idd-tailored-plan-criteria-0/download?attachment.

- **NC Medicaid Direct.** Tailored Care Management is also available through NC Medicaid Direct, where individuals access physical health services, LTSS, and pharmacy through Medicaid fee-for-service and behavioral health and I/DD services through a prepaid inpatient health plan (PIHP). Several populations are delayed or excluded from managed care;[7] instead of enrolling in a Tailored Plan, these populations will continue to obtain their Medicaid coverage and Tailored Care Management through NC Medicaid Direct. Since the LME/MCOs deliver Tailored Care Management through both Tailored Plans and NC Medicaid Direct, the member's assigned care manager will follow the member regardless of delivery system or whether the member is obtaining Tailored Care Management through an AMH+ practice, CMA, or Tailored Plan / LME/MCO, providing continuity for members during this transition.

Individuals who are federally recognized tribal members or others eligible for Indian Health Service are exempt from managed care. Eligible individuals have the opportunity to transition to a Tailored Plan to obtain Tailored Care Management or elect to obtain Tailored Care Management through their LME/MCO. The EBCI Tribal Option is considered duplicative of Tailored Care Management. Standard Plan members who are eligible for Tailored Care Management can transition to a Tailored Plan at any point during the coverage year to obtain Tailored Care Management.

Individuals cannot obtain both Tailored Care Management and the below duplicative services simultaneously:

- Assertive Community Treatment (ACT)
- Child ACT
- Critical Time Intervention
- Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID)
- Stays of 90+ days in a Skilled Nursing Facility
- Primary care case management
- High Fidelity Wraparound (HFW)
- Tribal Option
- Program of All-Inclusive Care for the Elderly (PACE)
- Care Management for At-Risk Children (CMARC)

[6] Since there are individuals who would benefit from Tailored Plan enrollment but are not identified by available data, there is also a Tailored Plan eligibility request form via which beneficiaries can request a review to determine whether they are eligible to enroll in a Tailored Plan. Additional information available at https://ncmedicaidplans.gov/en/member-resources.

[7] Populations delayed or excluded from managed care upon Tailored Plan launch (July 1, 2024) include (1) foster care, adoption, former foster youth populations; (2) individuals who are dually eligible for Medicaid/Medicare and have full Medicaid; (3) long-stay nursing home beneficiaries; (4) CAP/C and CAP/DA 1915(c) waiver enrollees (children and adults with physical disabilities and/or who are medically fragile); (5) individuals who are considered "medically needy" and in the spend-down group; (6) individuals in the Health Insurance Premium Payment (HIPP) Program.

- Community Alternatives Program for Children (CAP/C) waiver services
- Community Alternatives Program for Disabled Adults (CAP/DA) waiver services

The reason for these exclusions is that these services substantially duplicate Tailored Care Management. Upon enrollment in a Tailored Plan / LME/MCO, eligible members are auto-enrolled in Tailored Care Management unless they are receiving one of the above duplicative services, or they opt out. Members can opt out of the Tailored Care Management model at any time. Members can opt back into Tailored Care Management at any time by contacting the Tailored Plan / LME/MCO. At least once annually and following specific "triggering events" (as defined in Section V), Tailored Plans / LME/MCOs will attempt to reengage members who have opted out and members who have neither opted out nor engaged back into Tailored Care Management.

Tailored Plans / LME/MCOs are responsible for developing and implementing protocols to ensure that members moving between the above services and the Tailored Care Management model experience smooth transitions. Recognizing that transitions into or out of institutional settings and the most intensive behavioral health services are particularly critical points in a person's care, the assigned Tailored Plan / LME/MCO, AMH+, or CMA may provide and bill for Tailored Care Management in the first and last month of a member obtaining Assertive Community Treatment, residing in an ICF-IID, or residing in a nursing facility (stays of 90 days or more), which includes coordinating with the Assertive Community Treatment/ICF-IID/nursing facility care team and facilitating clinical handoffs (see Section V.4.8. Transitional Care Management). A member can continue to receive Tailored Care Management during a short-term stay in a nursing facility (less than 90 days).

For individuals enrolled in the 1915(c) Innovations and TBI waivers, Tailored Care Management encompasses waiver care coordination. Care managers serving individuals enrolled in one of these home-and community-based (HCBS) waivers are responsible for addressing members' whole-person needs alongside coordinating and monitoring their HCBS waiver services. However, if individuals enrolled in these waivers decide to opt out of Tailored Care Management, they will remain enrolled in the applicable waiver and the Tailored Plan or LME/MCO will still be required to coordinate waiver services. (See Section V.4. Delivery of Tailored Care Management for more information on requirements for serving the Innovations and TBI waiver population under Tailored Care Management).

In addition, Tailored Plans / LME/MCOs started transitioning members receiving 1915(b)(3) services to a different home and community-based services (HCBS) option called 1915(i).[8]

[8] For more information on the transition to 1915(i) services, see "NC Medicaid Transition of 1915(b)(3) Benefits to 1915(i) Authority", available at https://medicaid.ncdhhs.gov/media/11027/download?attachment. The Department anticipates ending 1915(b)(3) services effective June 30, 2024, see https://medicaid.ncdhhs.gov/blog/2024/04/16/1915b3-services-transition-1915i-services-june-30-2024.

Tailored Care Management encompasses care coordination of 1915(i) home and community-based services. Accordingly, all AMH+/CMAs must have the capability to perform Tailored Care Management for individuals obtaining 1915(i) benefits. Individuals obtaining a 1915(i) service can opt out of Tailored Care Management but will be required to obtain care coordination of their 1915(i) service(s) through a Tailored Plan / LME/MCO.

Section III: Role of Provider Certification in Tailored Care Management

1) Overview

The Department has implemented a statewide, standardized process to certify providers to conduct Tailored Care Management as described in this manual. Through this process, the Department and its certification partner, the National Committee for Quality Assurance (NCQA), determine providers' ability to deliver Tailored Care Management (see more details in Section III.4. Overview of the Certification Process). Prior to contracting with a Tailored Plan / LME/MCO to perform Tailored Care Management, the Department requires that each provider organization becomes certified with the Department and NCQA as an AMH+ or CMA.

Provider organizations participating in this model are defined as follows:

- **AMH+ practices** are primary care practices actively serving as AMH Tier 3 practices,[9] whose providers have experience delivering primary care services to the Tailored Care Management eligible population or can otherwise demonstrate strong competency to serve that population. To demonstrate experience and competency to serve this population, each AMH+ applicant must attest that it has a patient panel with at least 100 active Medicaid patients who have an SMI, SED, or severe SUD; an I/DD; or a TBI. "Active" patients are those with at least two encounters with the AMH+ applicant's practice team in the past 18 months. AMH+ practices hold primary responsibility for providing integrated, whole-person care management under the Tailored Care Management model. AMH+ practices may, but are not required to, offer integrated primary care and behavioral health or I/DD services. To be eligible to become an AMH+, the practice must intend to become a network primary care provider for Tailored Plans. While the Department expects only a minority of AMH Tier 3 practices to be ready to obtain certification as AMH+ practices at Tailored Plan launch, the Department's vision is that the Tailored Care Management model will stimulate integration of Tailored Care Management within primary care practices over time.
- **CMAs** are provider organizations with experience delivering behavioral health, I/DD, and/or TBI services to the Tailored Care Management eligible population that hold primary responsibility for providing integrated, whole-person care management under the Tailored Care Management model. The "CMA" designation is unique to providers of Tailored Care Management services for the Tailored Care Management population. To be eligible to become a CMA, an organization's primary purpose at the time of certification must be the delivery of NC Medicaid, NC Health Choice, or State-funded services, other than care management, to the Tailored Care Management eligible population in North Carolina. The bullets below provide illustrative examples of considerations that are taken into account to determine whether an organization meets this criterion; these examples are not all inclusive:

[9] To be eligible as an AMH+, a practice must be actively serving as an AMH Tier 3 for the purposes of Standard Plans, when Standard Plans launch. See AMH Provider Manual (November 2022) for information on how to enroll.

- Years of experience (e.g., two years);
- Revenue breakdown (e.g., 20%-30% of total revenue is from behavioral health, I/DD, and/or TBI services provided to Medicaid beneficiaries or uninsured individuals); and/or
- Provision of behavioral health, I/DD, and/or TBI services, besides those covered in NC Medicaid Clinical Coverage Policies 8B and 8C, to the Behavioral Health I/DD Tailored Plan eligible population is integral to the organization's mission.

AMH+ practices and CMAs must not be owned by, or be subsidiaries of, LME/MCOs.

2) Purpose of Certification

The purpose of the provider certification process is to promote provider-based care management in the market while also setting up guardrails to ensure that providers are ready to perform this critical role. Through its contracts with Tailored Plans / LME/MCOs, the Department requires Tailored Plans / LME/MCOs to contract with all certified AMH+ practices and CMAs in each region for Tailored Care Management, similar to the current requirement on Standard Plans to contract with all Tier 3 AMHs.[10]

Tailored Care Management is performed by a care management workforce spanning AMH+ practices, CMAs, Clinically Integrated Networks (CINs), and Tailored Plans / LME/MCOs. Because it will take time to build adequate provider-based infrastructure, the Department anticipates that, in the short-term, the majority of members under Tailored Care Management will be assigned to plan-based care managers. However, the Department's vision is to increase, over time, the proportion of actively engaged Tailored Plan / LME/MCO members receiving care management from AMH+ practices and CMAs as described below (see Section III.6. "Glide Path" to Provider-based Care Management).

3) Role of CINs and Other Partners in Certification

The certification process described in this manual applies to individual AMH+ practices and CMAs. However, the Department recognizes that many AMH+ practices and CMAs will choose to operate within a larger affiliated organization. The Department refers to such organizations as "Clinically Integrated Networks or Other Partners." Clinically Integrated Networks (CINs) or Other Partners are 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.[11] The Department allows 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.

The Department and NCQA's evaluation of each provider organization's application for AMH+ or CMA certification includes gaining an understanding of the role of any CIN or Other Partner in

[10] See "Section VII: Contracting and Oversight" of AMH Provider Manual (November 2022): https://medicaid.ncdhhs.gov/media/10916/download?attachment

[11] Examples of functions and capabilities for which CINs or Other Partners may assume responsibility include data aggregation, risk stratification, and care management. A CIN could be part of a hospital or health system to which an organization already belongs or is otherwise affiliated, or a group of practices. CINs can partner with other entities, such as independent nonprofit organizations delivering data/analytic support and local care management to a practice or group of practices, or population health companies that have the capability to connect providers as integrated networks of care.

supporting or facilitating Tailored Care Management. The certification application form includes the opportunity for CINs or Other Partners to answer certain questions on behalf of multiple AMH+ practices or CMAs. In particular, where the AMH+ or CMA proposes to rely on CIN or Other Partner-employed care managers to carry out Tailored Care Management, the Department and NCQA look to ensure that care management is sufficiently integrated with the organization's practice team, as Tailored Care Management requires. Thus, certification includes 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.

CINs and Other Partners supporting AMH+ practices and CMAs may take many forms, and the Department encourages innovation and market movement to support this model. As a general rule, the Department expects 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[12] 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 Tailored Plans / LME/MCOs 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 Tailored Plan / LME/MCO 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.

4) Overview of the Certification Process

All providers interested in performing Tailored Care Management must submit an application for initial certification. The Department provided capacity building funding[13] to providers in rounds one, two, and three of certification. To access funds, providers were required to participate in a capacity building needs assessment conducted by a Tailored Plan awardee. Additionally, on an ongoing basis, providers were required to meet targets mutually agreed upon by the AMH+ or CMA and Tailored Plan awardee that demonstrate progress towards achieving specific capacity

[12] In their role as either LME/MCOs and Tailored Plans.

[13] AMH+ practices and CMAs can use capacity building funding for investment in three key areas: care management-related health IT infrastructure, workforce development (hiring and training care managers), and operational readiness (developing policies/procedures/workflows and other competencies linked to operationalizing the Tailored Care Management model).

building milestones.[14] More details on this opportunity can be found in the Tailored Care Management Capacity Building webpage.

The Department understands that the model is a significant shift from the status quo for many providers. In particular, AMH+ practices are required to expand the degree to which they coordinate with behavioral health, I/DD, and TBI service providers, and CMAs are required to expand the degree to which they coordinate with physical health providers. The purpose of certification is for providers to demonstrate that they can either perform the necessary functions and activities already or show a credible pathway toward readiness for Tailored Care Management implementation.

As noted above, the Department has contracted with NCQA to support the AMH+ and CMA certification process, allowing for a single, statewide certification process. NCQA conducts functions required to drive a certification decision, and the Department maintains oversight of this process. Under the certification process, the NCQA review team first conducts a desk review of every application. The purpose of the desk review is to determine whether the organization has the potential to satisfy the full criteria.

If the NCQA review team determines that an organization has the potential to meet all certification, the NCQA review team arranges to conduct one or more site reviews.[15] These site reviews are designed not only to drive a final decision on certification, but also to increase the understanding of each organization's capacity, strengths, and areas for improvement.

Organizations that pass the site review are certified. Organizations may be certified to provide Tailored Care Management in some regions but not others, or for some populations but not others, based on the organization's capacity to serve each region and population. There is no recertification process for AMH+s/CMAs. However, in the case in which a Tailored Plan / LME/MCO identifies an AMH+/CMA has compliance issues, and the AMH+/CMA does not correct the issue under a Corrective Action Plan, the Tailored Plan / LME/MCO may terminate its Tailored Care Management contract with the AMH+/CMA (see more details in Section VII. Oversight Model after Tailored Care Management Launch).

5) Readiness Reviews

After the conclusion of the certification process, NCQA conducts readiness reviews as part of contracting with AMH+ practices and CMAs. The purpose of the readiness reviews is to verify that each AMH+ and CMA is ready to perform the required Tailored Care Management functions set

[14] Capacity building milestones are: (1) Submission of a detailed distribution plan that specifies the Tailored Plan's approach (including quarterly targets) and proposed budget for meeting the remaining capacity building milestones, for DHHS approval; (2) Submission of a Tailored Care Management training curriculum and conducting trainings for care managers employed by Tailored Plan awardee and contracted AMH+ practices and CMAs; (3) Purchase or upgrades of care management related HIT infrastructure and systems for AMH+ practices/CMAs; (4) Hiring new care managers and supervisors at AMH+ practices and CMAs; (5) Completing Tailored Care Management training for AMH+ and CMA care managers and supervisors; and (6) AMH+ practices/CMAs meeting other competencies linked to operationalizing Tailored Care Management (e.g., development of policies and procedures and education and outreach to members on the Tailored Care Management outreach).

[15] Site reviews may be virtual and/or in-person, to be determined by the review team.

out in this manual.[16] For example, readiness reviews may further examine requirements such as details on providers' staffing recruitment and projections, demonstrations of health IT requirements, and final policies and procedures. Tailored Plans / LME/MCOs only contract with certified AMH+ practices and CMAs that pass readiness reviews. All criteria described in this manual must be met for an organization to launch Tailored Care Management.

6) "Glide Path" to Provider-based Care Management

Tailored Plans / LME/MCOs are required to meet the following annual targets[17] established by the Department for the percentage of members actively engaged (i.e., those consented who received Tailored Care Management contacts throughout the year) in Tailored Care Management via certified AMH+ practices and CMAs:

- December 2022 – June 2024: 35 percent (35%);
- July 2024 – June 2025: 45 percent (45%);
- July 2025 – June 2026: 60 percent (60%); and
- July 2026 – June 2027: 80 percent (80%)

The Department will assess Tailored Plan / LME/MCO compliance with annual target percentages in the first quarter of the following contract year.

Section IV: Key Features of the Tailored Care Management Model

1) Summary of the Tailored Care Management Model

The overall goal of the Tailored Care Management model is improved health outcomes for eligible individuals. The design of the model has been shaped by the following guiding principles:

- **Broad access to care management.** Tailored Care Management is available to all eligible individuals continuously, with limited exceptions, as detailed above.
- **Dedicated care manager taking an integrated, whole-person approach.** To the maximum extent possible, each enrolled individual will receive integrated, whole-person care management from a dedicated care manager[18] with expertise and training in addressing behavioral health, I/DD, and/or TBI needs in addition to physical health needs and unmet health-related resource needs.

[16] The Department distinguishes readiness review from pre-delegation auditing (for the purposes of NCQA health plan accreditation or for other purposes). The Department prohibits Tailored Plans / LME/MCOs from conditioning AMH+ or CMA contracts upon pre-delegation audits or other monitoring activities that go beyond what is necessary to ensure that the provider organization has met the requirements in this manual for Tailored Care Management.
[17] The Department may adjust the annual required percentages at its discretion.
[18] The care manager may choose to work with "care manager extenders" such as community navigators and community health workers to support some Tailored Care Management responsibilities. For more details, see Section IV.3. Staffing, Section V.4.13. Delineation of care management functions between care managers and extenders, as well as the Care Manager Extender Guidance, available at https://medicaid.ncdhhs.gov/media/11305/download?attachment.

- **Person and family-centered planning.** Care planning for individuals will be person-centered[19] and will consider their unique needs. Parents, other family members, and caregivers can also serve as part of the individual's care team, with the individual's consent. Tailored Care Management aligns with the North Carolina System of Care framework.[20]

The Tailored Care Management model is considerably more intensive than the Standard Plan model. However, the design – particularly operational factors such as data sharing and health IT expectations – is aligned across Standard Plans and Tailored Plans as much as possible to allow providers, particularly AMH Tier 3 practices that become AMH+ practices, to take a population health approach that is as cohesive as possible across Standard Plan and Tailored Plan populations.[21]

To accomplish statewide consistency and ensure the best possible outcomes, the Department has set specific requirements that apply to every member served under the Tailored Care Management model, whether the member is being served by a plan-based care manager or a provider-based care manager. These standard requirements and design elements are detailed in this manual (see Section V. AMH+ and CMA Certification Requirements).

While the standardized elements must be in place for every individual served under the model, the model has flexibility to accommodate differing needs across the state and diverse populations.

2) Role of the Federal Health Home State Plan Option in Supporting Tailored Care Management

To obtain enhanced federal Medicaid reimbursement for Tailored Care Management, the Department submitted and received approval for a State Plan Amendment (SPA) to the Centers for Medicare & Medicaid Services (CMS) to add Tailored Care Management as a Health Home

[19] Person-centered planning is a process of determining real-life outcomes with individuals and their parents, family members, caregivers, and other natural supports, as well as developing strategies to achieve those outcomes. Person-centered planning provides for the member or the parents/family members/caregivers/natural supports of a member assuming an informed and in-command role for life planning, service, support, and treatment options. The person with a disability and his or her parents/family members/caregivers/natural supports (with the person's consent) directs the process and shares authority and responsibility with system professionals about decisions made.

[20] The North Carolina System of Care framework was developed to address the unique needs and challenges of children and youth with behavioral health needs. The core System of Care's elements are: (1) family-driven, youth-guided services; (2) interagency collaboration; (3) service coordination through a single facilitator; (4) individualized, strength- based, trauma-informed/resilience development approach; (5) culturally and linguistically competent care; (6) evidence-based or informed services provided in a home or community setting; and (7) family and youth involvement in regional and state policy development, implementation, and evaluation. Children and youth with behavioral health needs are at increased risk of experiencing gaps in care because they often receive services from multiple systems (including health, education, child welfare, and juvenile justice); are more likely to transition between Standard Plans and Tailored Plans as their diagnoses change; their acuity changes with age; and their access to services may be impacted as they age out of school-related services. Effective care plans or ISPs must reflect both the needs of the child and his or her family. For more information on the System of Care approach, visit: https://nccollaborative.org/what-is-system-of-care/

[21] For more information on the Tailored Plan population health management approach, see North Carolina's Data Strategy for Tailored Care Management Policy Paper.

State Plan benefit with an effective date as of July 1, 2023.[22] Each Tailored Plan / LME/MCO acts as the designated Health Home for its members. The Tailored Plan / LME/MCO must ensure that members have access to care management services that meet the requirements of this manual and federal Health Home requirements. The federal model is flexible according to the needs of states, as long as the model encompasses six "core" Health Home services and uses health IT to coordinate across these services.[23,24] The Tailored Care Management model incorporates each of these core services.

3) Assignment and Member Choice

Tailored Plan / LME/MCO members have three options for obtaining Tailored Care Management: through an AMH+ practice, a CMA, or plan-based care manager. Prior to launch of Tailored Care Management, members had an initial choice period and the Department made initial Tailored Care Management assignments, informed by member choice. Post-launch, Tailored Plans / LME/MCOs conduct Tailored Care Management auto-assignment for new members (after the Department determines their readiness to do so). Auto-assignment algorithms must prioritize prior relationships with provider organizations, medical complexity, geographic location, and provider capacity. On an ongoing basis, Tailored Plan / LME/MCOs make assignments, adjusting them as needed based on provider capacity and continued member choice (see below).

Tailored Plans / LME/MCOs are responsible for educating members on the three different care management approaches and must provide unbiased counseling on selecting an AMH+, CMA, or plan-based care management. As part of the member welcome packet, the Tailored Plan / LME/MCO sends members information on Tailored Care Management, including their assignment and the process and options for changing that assignment. The organization assigned for providing Tailored Care Management (AMH+ practice, CMA, or plan) assigns a care manager. Members can change the organization they are assigned to for Tailored Care Management and/or change care managers twice per year without cause and any time with cause.

Tailored Plans / LME/MCOs have a process for reassignment of members who have significant changes in their needs and may be better served by a different care management approach (CMA, AMH+, or plan based care management). Member choice will be honored in any reassignment (see below for additional information on member choice for participants in Transitions to Community Living).

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[22] More information on the submission and approval of the Health Home State Plan Amendment available at: https://www.medicaid.gov/sites/default/files/2023-07/NC-22-0024.pdf. Information on the submission and approval of an updated Health Home State Plan Amendment available at: https://www.medicaid.gov/medicaid/spa/downloads/NC-24-0014.pdf.

[23] The six required Health Home services are 1) comprehensive care management, 2) care coordination, 3) health promotion, 4) comprehensive transitional care from inpatient to other settings (including appropriate /follow-up), 5) individual and family supports (which includes authorized representatives), and 6) referral to community and social support services. 42 U.S.C. § 1396w-4 18001.

[24] Centers for Medicare & Medicaid Services: Health Homes Frequently Asked Questions Series II, available at: https://www.medicaid.gov/resources-for-states/medicaid-state-technical-assistance/health-home-information-resource-center/health-home-faq-1-21.pdf.

The Tailored Plan / LME/MCO is required to prioritize assignment to an AMH+ practice or CMA to the maximum extent possible, given capacity. In order to make assignments in a person-centered way:

- The Tailored Plan / LME/MCO is required to take into account existing provider assignment to an AMH+ practice or an existing treatment relationship with a CMA within the plans' network and give preference to that provider when making a Tailored Care Management assignment, unless there is a specific cause not to do so such as instances of conflicts of interest for Innovations and TBI waiver enrollees and individuals using 1915(i) or 1915(b)(3) services.
- The Tailored Plan / LME/MCO is required to take into account the member's medical complexity as well as behavioral health and I/DD complexity when making a Tailored Care Management assignment. In cases where children with medical complexity are receiving primary care through an AMH+ practice, the Tailored Plan / LME/MCO is required to give that AMH+ practice preference when assigning the member to a care management approach.
- The Tailored Plan / LME/MCO is required to take into account the geographic location of the member to ensure reasonable accessibility when making a care management assignment.
- The Tailored Plan / LME/MCO is required to ensure that there is capacity at an AMH+ practice or CMA before assigning a member to that AMH+ practice or CMA for care management. AMH+ practices and CMAs may set limits on their care management panel sizes (i.e., decline assignments based on capacity). The Tailored Plan / LME/MCO is required to ensure that AMH+ practices and CMAs do not select members of their panel based on acuity tier.
- The Tailored Plan / LME/MCO is required to distribute members of all acuity levels[25] across AMH+ practices, CMAs, and plan-based care management rather than group members into one approach or another solely on the basis of acuity.

There are additional assignment requirements for certain special populations, as follows:

- **Transitions to Community Living (TCL) participants** (North Carolina's Olmstead settlement for adults with serious mental illness and serious and persistent mental illness): Participants in TCL can choose to obtain Tailored Care Management from an LME/MCO or an AMH+/CMA designated to service TCL participants.

  Please see Section V.4.14. Additional Requirements for Participants in Transitions to Community Living (TCL) for details on Tailored Care Management for TCL participants.

- **Members enrolled in the Innovations or TBI waiver or using 1915(i) services:** If the individual enrolled in the Innovations or TBI waiver has an existing relationship with a care coordinator who meets the Tailored Care Management qualifications and training requirements as described below, and is employed as a care manager in the individual's Tailored Plan / LME/MCO network, the Tailored Plan / LME/MCO is required to give the individual the option of choosing his or her previous care coordinator, to the extent possible.

[25] The Department has established a standardized methodology to assign each member to a Tailored Care Management acuity tier (e.g., high, medium, low).

Care management for Innovations and TBI waiver enrollees and beneficiaries using 1915(i) services must comply with federal requirements for conflict-free case management for 1915(c) and 1915(i) programs, respectively. The Tailored Plan / LME/MCO is required to ensure that members do not obtain both 1915(c) waiver services or 1915(i) services **and** Tailored Care Management from the same provider organization. The Tailored Plan / LME/MCO must follow federal conflict free-care management requirements when making member assignments and reassignments to Tailored Care Management providers.

- **Foster care, adoption assistance and former foster youth.** These individuals will default to LME/MCO-based care management but have the option to switch to an AMH+ or CMA. In the event an individual transitions from a Tailored Plan to an LME/MCO and was assigned to an AMH+ or CMA by the Tailored Plan, the LME/MCO must assign the individual to the same AMH+ or CMA.

4) Data Strategy and Data Sharing

The Department believes that effective, integrated, and well-coordinated care management depends on care team members having the ability to efficiently exchange timely and actionable member health information and use that information to monitor and respond to medical and nonmedical events that could impact a member's well-being. The success of Tailored Care Management depends on Tailored Plans / LME/MCOs, AMH+ practices, CMAs, CINs and Other Partners, and pharmacies, as well as physical health, behavioral health, I/DD, TBI, LTSS, and social service providers collecting, using, and sharing data in support of an integrated and coordinated approach to care. The minimum health IT requirements for certification at the AMH+ and CMA level are provided below.

Building on its work with Standard Plans and the AMH program, the Department has defined and standardized, as appropriate, the data flows that are essential to support Tailored Care Management.[26] Tailored Plans / LME/MCOs are required to transmit the following data to AMH+ practices and CMAs or their designated CINs or Other Partners:

1. **Beneficiary assignment info**, including demographic data and any clinically relevant and available eligibility info.
2. **Pharmacy lock-in data** including all mandatory fields and valid values noted in the data specification document.
3. **Member claims/encounter data**, including historical physical (PH), behavioral health, and pharmacy (Rx) claims/encounter data with new data delivered monthly (PH/BH) or weekly (Rx).
4. **Acuity tiering and risk stratification data.** Tailored Plans / LME/MCOs receive an acuity tier (e.g., low, medium, high) from the Department; Tailored Plans / LME/MCOs are required to transmit acuity tier to AMH+ practices and CMAs (and results and methods of any risk stratification they conduct).

[26] Data specification guidance for the AMH program is available at: https://medicaid.ncdhhs.gov/transformation/advanced-medical-home/advanced-medical-home-data-specification-guidance

5. **Patient Risk List** including all mandatory fields and defined valid values noted in the data specification document.
6. **Quality measure performance information** at the practice level.
7. **Other data** to support Tailored Care Management (e.g., previously established care plans, ADT data, historical member clinical info).

To streamline information exchange, and reduce costs and administrative burden for all stakeholders, the Department has developed standard file layouts to assist with the exchange of most of the data required for effective Tailored Care Management.[27]

AMH+ practices, CMAs, and CINs or Other Partners involved in Tailored Care Management are expected to comply with all federal, state, and Department privacy and security requirements regarding the collection, storage, transmission, destruction, and use of data including Medicaid claims and encounters.

AMH+ practices and CMAs are considered covered entities and must comply with the terms of the NC Provider Agreement, including HIPAA requirements, and meet the following requirements:

- Must be an active and enrolled NC Medicaid provider
- Must be providing Medicaid services or care management to Medicaid beneficiaries
- Cannot be providing any administrative or IT services to other providers outside of their practice

CINs or Other Partners must submit necessary security documentation. A covered entity is responsible for ensuring their sub-subcontractors are meeting the necessary security requirements.

Security documentation required by CIN or Other Partner – The following security certifications and assessments meet the requirements:

- Year 1 Only – NIST 800-53 Rev 4 or Rev 5 Self-Assessment. The Department has a NIST 800-53 Rev 4 Self-Assessment document available which will act as the baseline assessment. The Plans can require more extensive documentation. A Self-Assessment cannot be accepted for Years 2 and beyond. Please note that if a provider is new to the organization after year 1, the self-assessment can be accepted for year 1 of that relationship. After that a self-assessment can no longer be accepted.
- Soc 2 Type 2 (Must include all five trust areas)
- HITRUST - Since HITRUST is a two-year certification, the Department of Health and Human Services (DHHS) will accept the completed certification for year 1, and the engagement letter indicating a recertification is planned for year 2.
- FedRAMP
- ISO 27001 - ISO 27001 certification is acceptable – however the Federal agencies in the future may change to a NIST based assessment only in the future. Vendors seeking an ISO

[27] Data specifications and requirements for sharing (1) beneficiary assignment and pharmacy lock-in data, (2) historical and current claims and encounters data, and (3) patient risk list data are available at: https://medicaid.ncdhhs.gov/transformation/tailored-care-management/tailored-cm-data-specifications-guidance

27001 certification may need to go back and pursue another acceptable certification or assessment in the future.

For Infrastructure providers such as Amazon Web Services (AWS), Azure, or Google or other Integration Platform as a Service (IPaaS) or Infrastructure as a Service (IaaS) providers, a SOC 2 Type 2 report from the provider is acceptable for the infrastructure components of the solution. This does not cover the application components of the solution.

AMH+ practices, CMAs, and CINs or Other Partners must certify that their requests involve only their attributable Tailored Plan / LME/MCO members and must restrict their use of the data for care management activities that are improving the quality and efficiency of care. AMH+ practices and CMAs and their CINs or Other Partners must establish appropriate administrative, technical, and physical safeguards that provide a level and scope of security that is not lower than the level and scope of security requirements established by the following federal and State guidance:

- Office of Management and Budget (OMB) in OMB Circular No. A-130, Appendix II - Security of Federal Automated Information Systems;
- Federal Information Processing Standard 200 "Minimum Security Requirements for Federal Information and Information Systems";
- Special Publication 800-53 "Recommended Security Controls for Federal Information Systems";
- The most recent Information Security and Privacy guidance shared by CMS;
- North Carolina's "Statewide Information Security Manual"[28];
- North Carolina Department of Health and Human Services' Privacy and Security Policies and Manuals.[29]

5) Healthy Opportunities Pilot Program

In October 2018, CMS approved North Carolina's 1115 demonstration for a five-year period. One component of the demonstration allows the Department to use up to $650 million of state and federal funds to implement the "Healthy Opportunities Pilot" (HOP) to evaluate the impact of providing 29 evidence-based, nonmedical services on health outcomes and costs.[30] The Department is currently requesting CMS approval to renew the 1115 waiver in order to continue operating HOP for an additional five years, modify services, and scale the program statewide. Services provided through HOP aim to address four priority Healthy Opportunities domains:

- Housing instability;
- Transportation insecurity;

[28] North Carolina's "Statewide Information Security Manual" can be found here: https://it.nc.gov/documents/statewide-information-security-manual

[29] North Carolina Department of Health and Human Services' Privacy and Security Policies and Manuals can be found here: https://policies.ncdhhs.gov/departmental/policies-manuals/section-viii-privacy-and-security/manuals/security-manual

[30] Learn more about the Healthy Opportunities Pilot Program in the Policy Paper for Interested Stakeholders (https://files.nc.gov/ncdhhs/documents/Healthy-Opportunities-Pilot_Policy-Paper_2_15_19.pdf), the Healthy Opportunities Pilots Fact Sheet (https://www.ncdhhs.gov/media/14772/download?attachment), and the Healthy Opportunities Pilots webpage (https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/healthy-opportunities-pilots).

- Food insecurity; and
- Interpersonal violence/toxic stress.

HOP service delivery launched for Standard Plan members began in March 2022 in three, predominantly rural regions of the state – two in eastern North Carolina and one in western North Carolina.[31] Medicaid enrollees residing in the HOP regions who meet eligibility criteria may be eligible to receive HOP services to address their health-related social needs. In May 2024, HOP services launched for the LME/MCO population eligible for Tailored Care Management. All LME/MCOs operating within the are required to participate in HOP implementation.

HOP services are delivered by a network of community-based organizations, referred to as Human Service Organizations (HSOs). These networks are established and managed by Healthy Opportunities Network Leads (NLs) that have contracts with all Standard Plans and LME/MCOs in their HOP region. The LME/MCOs have discretion to determine when to authorize HOP services for those who meet HOP program eligibility and service-specific eligibility criteria, subject to Department guidelines.

On May 15, 2024, the Department launched HOP for the following LME/MCO populations eligible for Tailored Care Management:

- Members engaged in Tailored Care Management,
- Members eligible for Tailored Care Management who have opted out, and
- Members eligible for, but not participating in Tailored Care Management because they are receiving ACT/HFW.

Members in a HOP region who meet the clinical eligibility criteria for Tailored Care Management meet HOP's physical or behavioral health criteria, and are eligible to participate in HOP if they also have a qualifying social risk factor (i.e., housing instability, transportation insecurity, food insecurity, or interpersonal violence/toxic stress).

Participation in HOP is optional for AMH+s/CMAs in HOP regions. In the event that an AMH+/CMA elects not to offer HOP referrals, a member can enroll in HOP through their LME/MCO, and the LME/MCO will conduct HOP-related responsibilities. The Department released the Healthy Opportunities Pilot Tailored Care Management Provider Manual Addendum outlining HOP-related responsibilities.

Care managers will play a critical role in HOP implementation, including:

- Identifying potentially HOP-eligible members;
- Assessing eligibility for HOP services;
- Recommending and obtaining Tailored Plan / LME/MCO authorization for HOP services;
- Obtaining enrollees' consent for HOP participation;
- Making referrals using NCCARE360 to HSOs that are contracted to deliver HOP services;

[31] Note that HOP regions will be geographically distinct from Standard Plan and Tailored Plan / LME/MCO regions. Details on the HOP regions, including counties covered in each region, are available at https://www.ncdhhs.gov/news/press-releases/2021/05/27/dhhs-announces-three-regions-medicaid-healthy-opportunities-pilots-major-milestone-nations-first. The HOP regions cross more than one Tailored Plan / LME/MCO region. Specific HOP regions include only portions of a Tailored Plan / LME/MCO region.

- Coordinating HOP-related services as part of overall Tailored Care Management;
- Reviewing authorized HOP services and the extent to which they are meeting the member's needs, and reassessing HOP eligibility;
- Identifying HOP services that must be discontinued, as needed;
- Disenrolling members from HOP, if a member becomes ineligible; and
- Participating in training, technical assistance, and other activities to support the Department's oversight and evaluation of HOP.

Section V: AMH+ and CMA Certification Requirements

Full requirements for certification as an AMH+ or CMA are below. At the time each organization applies for certification, the Department does not expect all requirements to be met in full but will assess whether the organization is on track to meet all requirements. The following requirements apply equally to certification by the Department and NCQA in the ramp-up to Tailored Care Management launch; readiness reviews by the Tailored Plans / LME/MCOs; oversight of AMH+ practices and CMAs by Tailored Plans / LME/MCOs; and certification of new AMH+ practices and CMAs by the Department and NCQA after launch. To the extent applicable, all requirements below that apply to AMH+ practices and CMAs also apply to Tailored Plans / LME/MCOs. AMH+s/CMAs certified to serve the Tailored Plan population are also eligible to serve the LME/MCO population; there is not a separate certification process.

1) Provider Eligibility as an AMH+ or a CMA

To become a certified AMH+ or CMA, an organization must meet the definitions at Section III.1. Overview above. The Department conducts certification of each AMH+ and CMA individually, although select questions may be addressed at the CIN or Other Partner level, as indicated on the application form.[32] There is no minimum panel size to become certified as a CMA.

2) Organizational Standing/Experience

2.1. Relevant experience. The organization must demonstrate that its past experience positions it to provide Tailored Care Management, specifically the population(s) for whom it proposes to become a certified Tailored Care Management provider. All organizations entering the certification process are **required to indicate whether they will serve the adult and/or child and adolescent population, as well as one or more of the following specialty designation type(s):**

- Behavioral health (including mental health and SUD);[33]
- TCL;[34]
- I/DD;

[32] The Department will certify AMH+ practices at the practice site level, in alignment with the current AMH certification process. The Department will certify CMAs at the level of the entire organization. However, if a potential CMA spans multiple Tailored Plan / LME/MCO regions, the Department will certify the organization at the level of each region.

[33] Organizations with the behavioral health specialty designation will not be required to provide both mental health and SUD services, but will be required to demonstrate expertise to provide Tailored Care Management for individuals with mental health and SUD needs.

[34] The TCL designation requirements are covered in Section V. 4. 14. *Additional Requirements for Participants in Transitions to Community Living (TCL)*.

- Innovations and/or TBI waiver; and/or
- Co-occurring I/DD and behavioral health.

Agencies that specialize in behavioral health are required to demonstrate their capacity to serve populations with both mental health and SUD needs as soon as possible, if that capacity is not already in place. The organization must offer an array of services that are aligned with the needs of the target population(s) in North Carolina. The Department has a general expectation that each organization is able to show at least a two-year history of providing services to the Tailored Plan / LME/MCO population in North Carolina. However, the Department encourages organizations to build new capacity for Tailored Care Management as it rolls out.

2.2. Provider relationships and linkages. 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, in order to facilitate referrals among providers as well as provide formal and informal feedback and opportunities to share best practices.

2.3. Capacity and sustainability. 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. 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.

2.4. Oversight. The organization must be able to demonstrate that it has the appropriate structures in place to oversee the Tailored Care Management model. The Department looks 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; and board approval of the application submitted by the organization.

3) Staffing

3.1. Care management staff. The organization must be able to ensure that all care managers, supervising care managers, and care manager extenders providing Tailored Care Management meet the following minimum qualification requirements, 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; ***and***
  - 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;
    or
  - 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 an I/DD or a TBI.

If an individual is dually diagnosed with a behavioral health condition and an I/DD or a TBI, the Tailored Plan / LME/MCO and assigned organization providing Tailored Care Management should use their clinical judgement in assigning a care manager and supervising care manager and must ensure that the supervising care manager is qualified to oversee the member's care manager. This applies regardless of whether a member has been dually diagnosed prior to the initial Tailored Care Management assignment process or at some point after.

In instances where a member's population segment changes (e.g., a member with an I/DD receives a behavioral health diagnosis) after a care manager at an AMH+/CMA has been assigned:

- Tailored Plans / LME/MCOs only reassign members who are newly enrolled in the Innovations or TBI waiver if the current provider is not certified to serve Innovations or TBI waiver members. The plan may reassign the member to a provider that is certified for Innovations or TBI waiver population segments to the plan.
- For all other changes to member population segments, Tailored Plans / LME/MCOs rely on the AMH+s/CMAs to use their clinical judgement to identify and notify the Tailored Plan / LME/MCO of members who can no longer be adequately served by the assigned AMH+/CMA. AMH+s/CMAs are encouraged to consult with the Tailored Plan / LME/MCO to collectively make decisions about whether the AMH+/CMA can continue to serve the member's needs. For example, if a member with an I/DD who is assigned to a CMA certified for the I/DD population segment receives a behavioral health diagnosis, the member can stay with their assigned provider/care manager if the CMA determines they are able to continue meeting the member's needs.

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 arrange/provide coverage for vacation, sick leave, and staff turnovers. They are responsible for reviewing all Tailored Care Management Care Plans and Individual Support Plans (ISPs) and provide guidance to care managers on how to meet members' needs.

- **Care manager extenders.** To bolster the care management workforce, the Department is allowing 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 / LME/MCOs 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:**

  - At least 18 years of age
    and
  - A high school diploma or equivalent (e.g., GED, certificate of completion);
    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 are 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 North

Carolina Community Health Worker Association | CHW Training and Resources (ncchwa.org);

- 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.

3.2. Clinical consultants. The Tailored Plan / LME/MCO is required to ensure that organizations providing Tailored Care Management (AMH+ practices, CMAs, or the Tailored Plan / LME/MCO 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. Clinical consultants are not providing treatment to members, so licensure outside of North Carolina is allowable. While different member needs 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; and
- 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 monthly Tailored Care Management payment for Tailored Care Management includes cost assumptions for clinical consultant time.

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.

4) Delivery of Tailored Care Management

4.1. Policies and procedures for communication with members. The AMH+ or CMA must develop policies (to be approved by the Tailored Plan / LME/MCO) for communicating and sharing information with individuals and their legally responsible person/guardian with appropriate consideration for language, literacy, accommodations due to relevant health conditions to use clinically-appropriate assistive technology, and cultural preferences, including sign language, closed captioning, and/or video capture. "Robocalls" or automated telephone calls that deliver recorded messages are not an acceptable form of contact.

4.2. Capacity to engage with members through frequent contact. Care managers/care teams should use their clinical judgement and the results of the comprehensive care management

assessment to determine the intensity of care management (i.e., the number, frequency and type of contacts based on the member's needs). The Department believes frequent member-facing contacts are critical for the success of Tailored Care Management and strongly encourages care managers to have in-person contacts with their assigned panels. As described in more detail below, to submit a claim for payment for a member in a month, a Tailored Plan / LME/MCO, AMH+, or CMA must have at least one qualifying member-facing contact in that month.

In-person contact must involve the member. Contacts that are not in-person can be real-time telephonic or two-way audio/video. Care managers should tailor the number, frequency and type of contacts based on the member's needs.[35] Telephonic or two-way real time audio/video contact may be with a legally responsible person/guardian in lieu of the member, only where appropriate or necessary. For members who request accommodations due to relevant health conditions, contacts can be delivered, at the discretion of the Tailored Plan / LME/MCO, AMH+, or CMA, using clinically-appropriate assistive technologies (e.g., speech-to-text application, secure platforms for two-way instant messaging/texting).

The Tailored Plan / LME/MCO, AMH+, or CMA must ensure that contacts are delivered in a manner that ensures the security of protected health information and are in compliance with all state and federal laws, including HIPAA and requirements related to records retention. If the care manager/extender/supervising care manager utilizes two-way real time video and audio conferencing or assistive technologies, the care manager/extender/supervising care manager must enable applicable encryption and privacy modes. Public facing audio/video communication applications, such as Facebook Live, Twitch, or TikTok, should not be used. If the care manager/extender/supervising care manager utilizes two-way instant messaging/texting with a member (for members that request accommodations due to relevant, specific health conditions), the instant messaging/texting must be via a secure portal that has met all Department required security and privacy requirements.

Member preferences for contact frequency and member accommodation requests should be documented in the Care Plan/ISP and reviewed with the supervising care manager. The updated Care Plan/ISP should be signed by the member or their legally responsible person/guardian.

To bill for and obtain the Tailored Care Management monthly rate, in any given month, the care manager, or extender where appropriate, must have at least one qualifying contact with the member. A qualifying contact is defined as a member-facing interaction (i.e., in-person, telephonic, or two-way real time audio/video and using assistive technologies, if applicable) that includes the member and/or legally responsible person/guardian, as indicated, that fulfills one or more of the six core Health Home services. The care manager, or extender where appropriate,

[35] The Tailored Care Management payment rate is developed based on set of assumptions that are anticipated to occur across the entire population served by Tailored Care Management-eligible providers (community- and Plan-based). This includes consented and engaged members receive, on average, three monthly contacts, as well as one additional in-person contact per quarter. For more details, see Updated Details on the Underlying Assumptions Behind Tailored Care Management Payment Rates (March 5, 2025), available at https://medicaid.ncdhhs.gov/tcm-rate-assumption-guidance/download?attachment

performing a Health Home activity that is not member-facing (e.g., care manager/care manager extender to other provider contact) does not count as a qualifying contact. One-way outreach where the member does not respond and engage with the care manager does not count as a qualifying contact.

For the period starting on July 1, 2023, through January 31, 2024, the Department is continuing the use of a single Tailored Care Management rate of $269.66, meaning the same rate will be paid for all members (see additional details in Section VI. Payment, including details on add-on payments for certain populations). Effective February 1, 2024, through December 31, 2024, the Department will temporarily increase the payment rate from $269.66 to $343.97. Effective January 1, 2025, through June 30, 2025, the payment rate will be $294.86. Effective February 1, 2024, the Department will increase this additional payment for individuals enrolled in the Innovations or TBI waivers and for members obtaining 1915(i) services to $79.73.

Tailored Plans / LME/MCOs, AMH+s and CMAs are expected to deliver the volume of contacts necessary to sufficiently serve each individual member. The volume is to be determined by the care manager/care teams based upon the member's needs. The Department will review the cumulative number of contacts delivered by an AMH+/CMA/plan across the consented and engaged member panel to see how it compares to the assumptions in the rates (i.e., to see if more or less contacts are being delivered than accounted for in the rates).

The Department assigns each Tailored Care Management eligible member to an acuity tier and shares this information with plans, and AMH+s and CMAs as a tool to inform decision-making related to member needs (e.g., whom to prioritize for outreach, who may have significant immediate needs), care manager and supervising care manager assignments, and to inform risk stratification. Acuity tier information is a retrospective snapshot in time based on historical claims data. A member's acuity can change at any time and care managers are expected to use their clinical judgement on the intensity of care management necessary to support a member.

Tailored Care Management is built around the six core Health Home services. Below are examples of activities care managers may complete in delivering Tailored Care Management. See sections **4.3 - 4.14** of this manual for additional details on the components of Tailored Care Management. Case management that is provided by a CMA as part of an enhanced behavioral health service definition (e.g., Community Support Team) or other behavioral health service should not be billed as Tailored Care Management. In these instances, the Care Plan/ISP should clearly document the scope of activities and roles/responsibilities of the care team within Tailored Care Management versus that of the other service.

Six Core Health Home Services:

- **Comprehensive care management,** including
  - Completion of care management comprehensive assessments and Care Plan/ISP
  - Phone call or in-person meeting focused on chronic care management (e.g., management of multiple chronic conditions)

- **Care coordination,** including
  - Working with the member on coordination across settings of care and services (e.g.,

appointment/wellness reminders and social services coordination/referrals)
    - Assistance in scheduling and preparing members for appointments (e.g., phone call to provide a reminder and help arrange transportation)

- **Health promotion,** including
    - Providing education on members' chronic conditions
    - Teaching self-management skills and sharing self-help recovery resources
    - Providing education 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

- **Comprehensive transitional care/follow-up,** including
    - Visiting the member during the member's stay in the institution and be present on the day of discharge
    - Reviewing the discharge plan with the member and facility staff
    - Referring and assisting members in accessing needed social services and supports identified as part of the transitional care management process, including access to housing
    - Developing a 90-day post-discharge transition plan prior to discharge from residential or inpatient settings, in consultation with the member, facility staff, and the member's care team

- **Individual & family support,** including
    - Providing education and guidance on self-advocacy to the member, family members, and support members
    - Connecting the member and parents/other family members/caregivers to education and training to help the member improve function, develop socialization and adaptive skills, and navigate the service system
    - 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

- **Referral to community & social support services,** including
    - Providing referral, information, and assistance and follow-up in obtaining and maintaining community-based resources and social support services
    - Providing comprehensive assistance securing key health-related services (e.g., filling out and submitting applications)

4.3. Care management comprehensive assessment.[36] The care management comprehensive assessment is a person-centered assessment of a member's health care needs, functional needs, accessibility needs, strengths and supports, goals, and other characteristics that informs the ongoing Care Plan or ISP and treatment. The Department is requiring that all Tailored Plan / LME/MCO members entering Tailored Care Management receive the care management comprehensive assessment, completed by the organization performing the Tailored Care

[36] The care management comprehensive assessment is distinct from the comprehensive clinical assessment (CCA) and does not serve as a means to approve services.

Management, to determine care needs. The care management comprehensive assessment helps to consolidate information across physical health, behavioral health, I/DD, TBI, LTSS, pharmacy, unmet health-related resource needs, and other needs and inform the Care Plan or ISP.

The AMH+ or CMA is 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" 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.

The AMH+ or CMA must undertake best efforts to complete the care management comprehensive assessment within 90 days of Tailored Care Management assignment for all new members.[37] Care management comprehensive assessments completed in the interim period between Tailored Care Management and Tailored Plan launch will still be valid after Tailored Plan launch (see below for requirements for reassessments).

The Department recognizes that some members may not be able to sit through the entire care management comprehensive assessment due to their health condition and similarly, children/adolescents may not be able to be present during the entire assessment; in these instances, the member should participate in the assessment to the maximum extent they are able to and the care manager can finish the assessment with the legally responsible person/guardian.

The Department recognizes that in limited circumstances it is necessary to complete the assessment via technology conferencing tools (e.g., audio, video, and/or web). The Department also recognizes that in some instances members will have an urgent need that needs to be addressed before completing the care management comprehensive assessment. Providers can assist members with their immediate needs prior to completion of the care management comprehensive assessment and provide any urgent links/supports to address those needs. This scenario can be billed as a Tailored Care Management contact as long as the member consents to participating in Tailored Care Management and the provider documents this consent.

Before or 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.

Required Components of Care Management Comprehensive Assessment: The AMH+ or CMA must ensure that the care management comprehensive assessment includes, at a minimum, the following domains:[38]

[37] Within 45 days of Tailored Care Management assignment is best practice. Across all members, care managers should use their clinical judgement to determine if a member need a comprehensive assessment completed earlier/more urgently.

[38] Assessment practices and requirements must also be informed by and coordinated with federally required MDS 3.0 and OASIS assessments performed by nursing facilities and home health agencies, as appropriate.

- Immediate care needs (The Tailored Plan / LME/MCO will share the results of the care needs screening, with the assigned organization providing Tailored Care Management for incorporation into the care management comprehensive assessment);
- 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 parent/family member/caregiver/natural 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 second hand 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 in foster care/adoption assistance and former foster youth, permanency planning goals;
- For members with an I/DD or a TBI:[39]
  - 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;

[39] For Innovations waiver enrollees, Tailored Plans / LME/MCOs will be required to ensure that results of the Supports Intensity Scale (SIS) are shared with the beneficiary's care manager in an electronic format to aid completion of the care management comprehensive assessment.

  - 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; and
  - Contact information for the CDSA service coordinator; and
- 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, screening, and assessment tools (e.g., American Society of Addiction Medicine (ASAM), Child and Adolescent Needs and Strengths (CANS), Adult Needs and Strengths Assessment (ANSA), Supports Intensity Scale (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 parent/caregiver/legally responsible person/guardian, or any other circumstance the plan deems to be a change in circumstance;
- Loss of housing; and
- Change in foster care placement or living arrangement (including aging out of the child welfare system.

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 made available to

the member's primary care, behavioral health, I/DD, TBI, and LTSS providers and the Tailored Plan / LME/MCO within 14 days of completion to inform care planning and treatment planning, with the member's consent (to the extent required by law).

4.4. Care Plans and Individual Support Plans (ISPs). 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.[40] 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:

- CANS;
- ASAM criteria;
- For Innovations waiver enrollees: SIS;
- For TBI waiver enrollees: Rancho Los Amigos Levels of Cognitive Functioning Scale (as applicable); and
- For member obtaining or seeking to obtain 1915(i) services: The 1915(i) assessment tool.

For Tailored Plan / LME/MCO 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; and
- 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 are 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, parents/family members/caregivers/natural supports, the County Child Welfare Worker (for Members in foster care/adoption assistance and former foster youth), 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[41];

[40] The Innovations and TBI waivers require that ISPs be developed in-person, as clinically indicated. The Department also expects AMH+ practices and CMAs to develop Care Plans and ISPs in-person for all members, to the extent possible.
[41] Inclusive of tobacco use.

- 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, changing foster care placement (as applicable), or entering another life transition; and
- Strategies to improve self-management and planning skills.
- For members with I/DD, TBI, or SED, the ISP should also include support for parent/family member/caregiver, including connection to respite services, as necessary.
- Information on the member's foster care permanency planning goals (as applicable).

Timing of the Care Plan or ISP: 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.[42] 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 must 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;
- Following a change in the member's foster care placement living arrangement or (as appropriate; and/or
- After triggering events (see above).

Documentation and Storage of the Care Plan or ISP: The AMH+ 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:

- Care team members, including the member's PCP and behavioral health, I/DD, TBI, and LTSS providers, and the assigned County Child Welfare Worker (for members in foster care/adoption assistance);
- The Tailored Plan / LME/MCO;

[42] For Innovations and TBI waiver enrollees, ISPs developed prior to Tailored Care Management launch will continue to serve as the ISP under in Year 1 of Tailored Care Management, until updated.

- Other providers delivering care to the member;
- The member's legal representative (as appropriate);
- The member's parent/caregiver (as appropriate, with consent);
- Social service providers (as appropriate, with consent); and
- Other individuals identified and authorized by the member.

Note: *The treatment/support service provider is responsible for completing the Person-Centered Plan, not the Tailored Care Management care manager.*

4.5. Care teams. 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:

- Caregiver(s)/legal guardians/foster parents/biological parents/adoptive parents/kinship caregivers/family member/natural supports (as applicable or appropriate);
- Supervising care manager;
- 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[43])
- Certified peer support specialist employed by the AMH+, CMA, or CIN or Other Partner, as applicable;[44]
- 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);
- Tailored Plan / LME/MCO-based TCL staff (e.g., Transition Coordinator, Complex Care Team, etc.) for TCL participants;
- Tailored Plan / LME/MCO-based in-reach and transition staff for individuals who are *not* participating in TCL, as applicable;
- County Child Welfare Worker and guardian ad litem (for members in foster care/adoption assistance); and
- 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 virtually from other settings. However, the AMH+ or CMA must establish a plan to activate relationships with primary care providers and other key interdisciplinary agencies/providers.

[43] Parent/guardian cannot serve as an extender for their own family member. The Department will provide additional guidance on additional trainings required for individuals with lived experience and parents/guardians to prepare them to perform the duties of an extender.
[44] Certified peer support specialists may either provide peer support services under Clinical Coverage Policy 8G or act as a care manager extender.

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+ or CMA must conduct regular case conferences with members of the multidisciplinary care 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 requires all organizations performing care management to have IT and policies 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 Tailored Care Management launch (see also Section V.5. Health IT).

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

- **Care Coordination:** The AMH+ 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 (see Section V.4.7 below). 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 scheduling and 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); 1915(i) services; and any State-funded services. For members in foster care/adoption assistance, this includes coordinating with the County Child Welfare Worker to identify and manage member needs.
- **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 annual physical 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, and metabolic monitoring for

individuals prescribed antipsychotic medications. to prescribed treatment regimens and wellness activities.

- **Medication Monitoring:** The AMH+ or CMA must conduct medication monitoring, including ensuring regular medication reconciliation occurs (conducted by the appropriate care team member), supporting medication adherence, and supporting metabolic monitoring (for individuals prescribed antipsychotic medications). A community pharmacist at the CIN level, in communication with the AMH+ or CMA, may assist with these functions, along with appropriate members of the individual's care team (e.g., PCP, community pharmacist, psychiatrist).
- **System of Care:** The AMH+ 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:
    - Promotion of family-driven, youth-guided service delivery and development of strategies built 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 parents/other family members/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:
  - Providing education on members' chronic conditions;
  - Teaching self-management skills and sharing self-help recovery resources;
  - Providing education 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;
  - Conducting medication reviews and regimen compliance; and
  - Promoting wellness and prevention programs.

4.7. Addressing unmet health-related resource needs. 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[45] 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; and
  - 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;
  - NC Achieving a Better Life Experience (ABLE) Accounts (for individuals with disabilities);
  - Women, Infants, and Children (WIC) Program; and
  - Other programs managed by the Tailored Plan / LME/MCO that address unmet

[45] Examples of food supports are: (1) Assisting an individual in accessing school meals or summer lunch programs or (2) other community-based food and nutrition resources, including but not limited to food pantries, farmers market voucher programs, cooking classes, Child and Adult Care Food programs.

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.

4.8. Transitional care management. AMH+ practices and CMAs must manage care transitions for members under care management transitioning from one clinical setting to another, through best efforts to conduct all of the following activities:[46]

- 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 (e.g., a member's PCP, pharmacist, psychiatrist) 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/caregivers 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 parents/family members/caregivers/natural supports (as appropriate) 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;

[46] For individuals with an I/DD or a TBI, the elements of transitional care management should also take place in the following "life transitions": (i) a member is transitioning out of school-related services ; (ii) a member experiences life changes such as with employment, retirement, or other life events; (iii) a member has experienced the loss of or change in primary caregiver; or (iv) a member is transitioning out of foster care.

- 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. AMH+ practices and CMAs are also responsible for additional transition-related responsibilities for the following members:

- Adults with SMI who are transitioning out of adult care homes who are not subject to the Medicaid Institution for Mental Diseases (IMD) exclusion and who are not transitioning into permanent supportive housing; and
- Children and youth (up to age 21) transitioning out of state psychiatric hospitals, psychiatric residential treatment facilities (PRTFs), and residential treatment levels II-IV and who are not transitioning into permanent supportive housing.

These activities will have the goal of facilitating the relocation of a member receiving services in one of the above settings to a community setting, while ensuring the appropriate level of services and supports that member requires. The Department has released additional guidance on transitions for these populations, detailed in the Community Inclusion Addendum and included as an appendix to the manual.

Participants in TCL. To comply with the U.S. Department of Justice TCL settlement, TCL functions (e.g., transition, in-reach, diversion, complex care functions) will continue as they do today. Care managers delivering Tailored Care Management to a TCL participant will participate in meetings with Tailored Plan / LME/MCO TCL staff during a TCL participant's transition to supportive housing and assist in the care management for the TCL population but established TCL-specific functions will remain the responsibility of Tailored Plan / LME/MCO TCL staff. Additional guidance for providing Tailored Care Management to the TCL population is included in Section 4.14 Additional Requirements for Participants in Transitions to Community Living (TCL).

Diversion. AMH+ practices and CMAs must assume primary responsibility for identifying members who are not eligible for TCL and are at risk of entry into an institutional setting, such as an ICF-IID, psychiatric hospital, or psychiatric residential treatment facility, and performing diversion activities. Diversion activities for individuals eligible for or participating in TCL remain the responsibility of Tailored Plan / LME/MCO TCL staff. For all other members, 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 supportive 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.

4.9. Innovations and TBI Waiver Care Coordination (if applicable). AMH+ practices and CMAs that are certified to provide Tailored Care Management to individuals enrolled in the 1915(c) Innovations and TBI waivers are 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, including support for:
    - 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;
    - Complete 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 Tailored Plan / LME/MCO 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 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 implementation;[47] As part of the consent process, members must consent to the following:
            - By signing this plan, I am indicating agreement with the bulleted

[47] 42 C.F.R. §441.301(c)(2)(ix)

statements listed here unless crossed through. I understand that I can cross through any statement with which I disagree.
    - My care manager helped me know what services are available.
    - I was informed of a range of providers in my community qualified to provides the service(s) included in my plan and freely chose the provider who will be providing the services/supports.
    - The plan includes the services/supports I need.
    - I participated in the development of this plan.
    - I understand that my care manager will be coordinating my care with the [Tailored Plan / LME/MCO] network providers listed in this plan.
    - 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.
    - I understand that services may be authorized in excess of the Individualized Budget.
  - Ensure enrollee completes Freedom of Choice statement in ISP annually;
  - Submit service authorization request to Tailored Plan / LME/MCO 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 Tailored Plan / LME/MCO of LOC determination updates.

4.10. 1915(i) Care Coordination (if applicable). AMH+ practices and CMAs are responsible for coordinating individuals' 1915(i) services in addition to performing the Tailored Care Management requirements detailed in this Manual. These additional requirements for members obtaining 1915(i) services include:

- Complete the independent assessment using a Department-designated tool to determine need for specific 1915(i) services.
- Support completion of assessments beyond the care management comprehensive assessment, and incorporate results into care management comprehensive assessment, including support for:
  - Complete the independent assessment for 1915(i) services as part of a member's annual care management comprehensive reassessment.

- Facilitate provider choice and assignment process for members obtaining 1915(i) services.
    - Help enrollee make informed choices of care team participants, provide information about providers, and arrange provider interviews as needed; and
    - Convene a person-centered planning meeting.
- Perform additional responsibilities related to developing and monitoring implementation of the Care Plan/ISP for members obtaining 1915(i) services beyond those required for other individuals engaged in Tailored Care Management.
    - Complete the Care Plan/ISP so that the Tailored Plan / LME/MCO receives it within 60 calendar days of 1915(i) eligibility.
        - As needed, complete an interim plan of care for immediately needed 1915(i) services,[48] with the full Care Plan/ISP being completed afterwards within the 60 days of eligibility determination for 1915(i) services.
    - As part of developing the ISP:
        - Explain options regarding the services available, and discuss the duration of each service;
        - Include a plan for coordinating 1915(i) services;
        - Ensure the enrollee provides a signature (wet or electronic) on the Care Plan or ISP to indicate informed consent, in addition to ensuring that the ISP includes signatures from all individuals and providers responsible for its implementation;[49] As part of the consent process, members must consent to the following:
            - By signing this plan, I am indicating agreement with the bulleted statements listed here unless crossed through. I understand that I can cross through any statement with which I disagree.
                - My care manager helped me know what services are available.
                - I was informed of a range of providers in my community qualified to provides the service(s) included in my plan and freely chose the provider who will be providing the services/supports.
                - The plan includes the services/supports I need.
                - I participated in the development of this plan.
                - I understand that my care manager will be coordinating my care with the [Tailored Plan / LME/MCO] network providers listed in this plan.
        - Submit the Care Plan/ISP for 1915(i) service authorization approval to Tailored Plan / LME/MCO; Monitor that Tailored Plans / LME/MCOs approve or deny a member's initial Care Plan/ISP within 60 days of

[48] Immediately needed 1915(i) services may include, but are not limited to, 1915(i) services that a member needs in order to: facilitate timely discharge from an inpatient setting or to prevent inappropriate placement in an inpatient or other restrictive setting; prevent imminent placement outside the person's current living arrangement; address severe co-occurring behavioral health and/or psychiatric conditions that place the person or others at significant risk of harm; or prevent imminent loss of competitive integrated employment or an offer of such employment.

[49] 42 C.F.R. § 441.725(b)(9)

eligibility determination for 1915(i) services; and
    - Monitor that delivery of 1915(i) service delivery begins within 45 days of Care Plan/ISP approval.
- Monitor ISP implementation and resolve or escalate issues as needed:
    - Monitor at least quarterly to ensure that any restrictive interventions (including protective devices used for behavioral support) are written into the Care Plan/ISP and the Positive Behavior Support Plan;
    - Monitor for HCBS compliance and
    - Notify Tailored Plan / LME/MCO of updates to eligibility and/or need for 1915(i) services.

4.11. Additional requirements for coordination with County Child Welfare Workers for members involved in the child welfare system served by Tailored Plans / LME/MCOs. The assigned organization providing Tailored Care Management for members in foster care/adoption assistance and former foster youth served by Tailored Plans / LME/MCOs must coordinate with the member's County Child Welfare Worker through an initial meeting and regular quarterly meetings (in-person, by video, or telephonic). The requirements in this section also apply for members in foster care/adoption assistance and former foster youth served by Tailored Plans / LME/MCOs enrolled in the 1915(c) Innovations waiver.[50]

- For members enrolled in Tailored Care Management as of April 1, 2023, Initial meetings with the County Child Welfare Worker must occur within sixty (60) calendar days of launch, or earlier, if necessary, to appropriately manage the member's health care needs. For members enrolled after the April 1, 2023, initial meetings must occur within three (3) calendar days, or earlier, if necessary.
- During the initial meeting, the assigned organization providing Tailored Care Management must:
    - Confirm that the member has received or has been scheduled to receive the DSS-required initial seven (7)-day physical examination and thirty (30)-day comprehensive medical appointment, or work with the County Child Welfare Worker to schedule the appropriate appointments;
    - Gather the following minimum information
        - DSS Child Health Summary Components, to the extent available;
        - Placement logs;
        - Member's family history and foster care placement status;
        - Immediate health care needs, including BH and Unmet Health-Related Resource Needs;
        - Member's medication history;
        - Child Maltreatment Evaluations, as applicable;
        - Key updates on member's permanency planning process;
        - Identification about whether there are any restrictions to communicating with the biological/adoptive parents, including termination of parental rights or court order restricting communication; and
        - Other information necessary for informing the care management

[50] The majority of members of the child welfare system will be served by LME/MCOs. Members of the child welfare system that are enrolled in the 1915(c) Innovations waiver will be served by Tailored Plans.

comprehensive assessment and care planning processes
    - Establish ongoing processes and timeframes for the County Child Welfare Worker to share the DSS Child Health Summary Components, to the extent available;
    - Establish a schedule of regular check-ins between the care manager and the County Child Welfare Worker (at least quarterly and more frequently, as appropriate);
    - Identify health care services and health-related services (e.g., state-funded mental health, substance use services, housing supports, and other supports) that are necessary to support the member's biological/adoptive parents and promote reunification and develop a plan for the Child Welfare Worker to make necessary referrals, as necessary and appropriate; and
    - Agree on explicit next steps and roles and responsibilities to ensure member needed services are coordinated in a timely fashion.
- During regular quarterly meetings, the assigned organization providing Tailored Care Management must gather updates on the following:
    - Member's foster care placement status;
    - Key changes in the member's health care needs, including BH and Unmet Health-Related Resource Needs;
    - Key updates on member's permanency planning process;
    - Any changes regarding restrictions to communicating with the biological/adoptive parents, including termination of parental rights or court order restricting communication; and
    - Other information necessary for informing the member's Care Plan/ISP.
- The assigned organization providing Tailored Care Management must also contact the County Child Welfare Worker within one (1) business day when any of the following occur, to the extent that information is available, and take necessary measures to ensure coordination of care:
    - Member is admitted to an inpatient level of care;
    - Member visits an ED;
    - Member is admitted to an institutional level of care or other congregate setting;
    - Member experiences a behavioral health crisis;
    - Member experiences a disruption in school enrollment (e.g., member is expelled or is required to change schools); or
    - Member becomes involved with the justice system.

4.12. Additional requirements for members aging out of foster care served by Tailored Plans / LME/MCOs. The assigned organization providing Tailored Care Management for members in foster care/adoption assistance and former foster youth served by Tailored Plans / LME/MCOs must provide the following support when a member leaves the child welfare system, including individuals who age out of custody at age eighteen (18), otherwise emancipate, or leave the child welfare system (planned or unplanned) and are aged eighteen (18) to twenty-one (21):

- Participate in the initial development of and periodic updates to each member's Transitional Living Plan[51], at the request of the County Child Welfare Worker and at the discretion of the member, including by:
    - Identifying key health care-related goals to include in the Transitional Living Plan, as well as resources and supports necessary to achieve the member's health care goals
- Participate in the development of each member's DSS Ninety (90) Day Transition Plan[52], at the discretion of the member and the County Child Welfare Worker, including by:
    - Ensuring that the member's DSS Ninety (90) Day Transition Plan includes accurate and up-to-date contact information on the member's care manager, PCP, dental home, behavioral health and I/DD provider(s), and current medications, as applicable
    - Identifying key health-related resources and supports necessary to achieve the member's health care goals and ensure they are included in the member's DSS Ninety (90) Day Transition Plan
- For members who remain enrolled in the Tailored Plan / LME/MCO after leaving the child welfare system, make best efforts to conduct a care management comprehensive assessment (or reassessment, as appropriate) within ninety (90) calendar days of the member leaving the child welfare system.

For former foster youth aging out of Medicaid coverage eligibility, the assigned organization providing Tailored Care Management must:

- At least six (6) months prior to the member aging out of Medicaid coverage eligibility, make a best effort to meet with the member (in-person, telephonic, or two-way real time audio/video) to discuss options for health insurance coverage following the birthday on which the member will age out of Medicaid coverage eligibility and plan for transitioning all current health care services and medications;
- Discuss potential health care resources that may be available to the member regardless of insurance status (e.g., the Department's Medication Assistance Program, State-funded Services, and free and charitable clinics); and
- Provide the member with clear written guidance on strategies for achieving the member's health-related goals, including, at minimum, the following:
    - Copies of the member's full Care Plan/ISP and DSS Ninety (90) Day Transition Plan, if available;
    - Summary of scheduled visits and recommended schedule of future visits;

[51] The Transitional Living Plan refers to the plan that County Departments of Social Service (County DSS) are required to develop for all children ages 14 to 17 in the custody of a County DSS and for all individuals participating in Foster Care from 18 to 21 years-old to identify specific goals and strategies that will allow the individual to function independently once they leave the child welfare system. The Transitional Living Plan must be completed when the individual turns 14 (or after an older child enters custody) and must be updated every 90 days until the individual leaves the child welfare system.

[52] The 90-Day Transition Plan is an extension of the Transitional Living Plan that County DSS are required to develop for all children aging out of agency custody at age 18 and all individuals leaving Foster Care for 18 to 21-year-olds to identify options for accessing housing, Health Insurance, education, mentoring, sexual health services, and other resources and provide the individual with critical personal documentation, including the individual's birth certificate, social security card, DSS Health Summary Components, and other legal documents.

- List of health care resources that may be available to the member regardless of insurance status, including the Department's Medication Assistance Program, State-funded mental health and substance abuse treatment programs, and free and charitable clinics;
- List of prescribed medications (including clear guidance on when medication should be taken); and
- Copies of all known medical records, including copies of DSS Child Health Summary Component forms, as applicable.

4.13. Delineation of care management functions between care managers and extenders.
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 qualifying Tailored Care Management contact if real-time phone, or real-time audio and video, or in-person contact with the member is made:

- Performing general outreach, engagement, and follow-up with members;
- Coordinating services/appointments (e.g., appointment/wellness reminders, arranging transportation);
- Engaging in health promotion activities (as defined in the Tailored Care Management Provider Manual) and knowledge sharing;
- Sharing information with the care manager and other members of the care team on the member's circumstances, including gathering information about the member's progress toward their goals;
- Providing and tracking referrals and providing information and assistance in obtaining and maintaining community-based resources and social support services;
- Participating in case conferences;
- Support the care manager in assessing and addressing unmet health-related resource needs.

A care manager must be solely responsible for:

- Completing the care management comprehensive assessment;
- Developing the Care Plan (for members with behavioral health needs) or individual support plan (ISP) (for members with I/DD and TBI needs);
- Facilitation of case conferences;[53]
- Ensuring that medication monitoring and reconciliation occur;
- Continuous monitoring of progress toward the goals identified in the Care Plan or ISP; and
- Managing care transitions, including creating 90-day transition plans.

Care managers and extenders should each document their work in the care management data system. As needed, care managers may also document the work of the extender.

[53] Case conferences may also be referred to as "planning meetings" and are conducted with members of the multidisciplinary care team, as appropriate based on member needs, to ensure communication and regular updates across the care team.

4.14. Additional requirements for participants in Transitions to Community Living (TCL). For more information on the in-reach and transition requirements for AMH+ practice and CMA-based care managers providing Tailored Care Management to individuals not participating in the TCL program (e.g., children and youth admitted to a state psychiatric hospital, PRTF, or Residential Treatment Levels II/Program Type, III, and IV), please see *Appendix 7. Community Inclusion Addendum for Members Not Participating in the Transitions to Community Living Program.*

Overview of TCL and Tailored Care Management

TCL is North Carolina's ongoing Olmstead settlement with the U.S. Department of Justice for adults with serious mental illness and serious and persistent mental illness.[54] TCL promotes recovery through providing long-term housing, community-based services, supported employment, and community integration. Further, the Department believes TCL participants will benefit from the longitudinal, whole-person care management provided through Tailored Care Management. As such, participants in TCL are able to access Tailored Care Management in addition to the TCL supports provided by the LME/MCOs.

North Carolina must continue to comply with the terms of the ongoing Olmstead settlement. To meet those terms and to best serve the needs of TCL participants, TCL functions for individuals receiving Tailored Care Management will continue as they do today. Tailored Plan / LME/MCO TCL staff will continue to work exclusively with the TCL population and are solely responsible for performing TCL in-reach, diversion, transition, and complex care functions for those individuals.[55] **Care managers delivering Tailored Care Management to a TCL participant are not responsible for TCL functions for the TCL population.** However, care managers are expected to participate in any care team meetings convened by Tailored Plan / LME/MCO TCL staff during a TCL participant's transition to supportive housing, as well as coordinating with Tailored Plan / LME/MCO TCL staff on care management functions (described in further detail below).

Designating Tailored Care Management Providers to Serve TCL Participants

To ensure that TCL participants have a choice of obtaining Tailored Care Management from a Tailored Plan / LME/MCO or AMH+/CMA, the Department established a designation process to allow TCL participants to choose to obtain Tailored Care Management (but not the TCL functions of transition, in-reach, diversion, and complex care) from a community-based Tailored Care Management provider. The Department has worked with NCQA to establish a designation process for already certified AMH+ practices or CMAs to become designated as qualified to serve TCL participants, similar to the way AMH+ practices or CMAs can be designated as qualified to serve children, individuals with I/DD, or Innovations/TBI waiver enrollees. **TCL participants will continue to obtain all TCL functions (i.e., diversion, in-reach, transitions, complex care) from Tailored Plan / LME/MCO-based TCL staff, regardless of if they elect to obtain plan-based Tailored Care Management or Tailored Care Management from a provider.**

The Department's goals for the provider designation process are to:

[54] More information on TCL can be found here: https://www.ncdhhs.gov/about/department-initiatives/transitions-community-living

[55] Tailored Plan / LME/MCOs must have separate staff to perform in-reach, transition, and diversion functions for non-TCL populations.

- Provide TCL participants with choice of Tailored Care Management entity; and
- Ensure the well-being of TCL participants by designating providers with a proven track record of effectively supporting and serving TCL participants.

The Department has established a set of objective criteria against which Tailored Care Management providers seeking TCL designation will be evaluated by NCQA:

- Certified as an AMH+/CMA and designated to serve the adult behavioral health population;
- Actively provide one or more TCL services (e.g., Transition Management Services, Community Support Team, Assertive Community Treatment, Individual Placement and Support – Supported Employment) to fidelity (where applicable);
- Serve a minimum of 25 TCL participants in each of the LME/MCO region(s) the provider seeks to serve;
- Possess a minimum of four (4) consecutive years of experience serving TCL participants;
- Not currently subject to a plan of corrective action with any state agency or LME/MCO; and
- In receipt of a letter from the LME/MCO(s) in the region(s) they seek to serve indicating the plan supports their application based upon the plan's TCL-related experience with the provider.

Providers pursuing TCL designation should engage the LME/MCO(s) in the region(s) they seek to serve to secure the required LME/MCO letter of support. LME/MCOs established specific criteria to evaluate prospective applicants and determine if they will endorse a provider's application for designation. Through their support letter, LME/MCOs are stating that the provider has demonstrated experience effectively providing quality services to TCL participants and TCL-eligible individuals. The letter must attest to the provider's demonstrated experience working effectively with TCL staff and with TCL participants. LME/MCOs and Tailored Care Management providers should make best efforts to resolve any concerns that would prohibit LME/MCOs from providing a letter of support.

Providers will also be required to develop a policy and procedures for providing Tailored Care Management to TCL participants (e.g., procedures for coordinating with TCL staff at the LME/MCOs), which will be based on criteria established by the Department and developed collaboratively with the LME/MCOs and the DHHS Olmstead team. The policy and procedures will be assessed by NCQA as part of the designation process.

All providers that meet these criteria will have the option to apply for designation to provide Tailored Care Management to TCL participants. The first cohort of Tailored Care Management providers designated to serve TCL participants launched on April 1, 2024. Additional applications for designation will be considered on a rolling basis and applications can be made at any time.

Tailored Care Management and TCL Staff Roles and Responsibilities

NOTE: "Care managers" in this section refer to the care managers delivering Tailored Care Management to a TCL participant.

TCL functions remain the sole responsibility of Tailored Plan / LME/MCO TCL staff. **Care managers are not responsible for TCL functions.** This means that Tailored Plan / LME/MCO TCL staff retain responsibility of supporting TCL participants in their transition from an Adult Care Home (ACH) or a State Psychiatric Hospital into permanent supportive housing or TCL Bridge Housing. Care managers based at AMH+ practices and CMAs who are assigned TCL participants are expected to attend Transition Team meetings convened by Tailored Plan / LME/MCO TCL staff as a part of the participant's Transition Team and coordinate with the TCL participant's providers and Tailored Plan / LME/MCO TCL staff on care management functions.

The care manager continues to be responsible for delivering whole-person care management to the TCL participant. The care manager is also responsible for providing non-housing-related care management functions during a TCL participant's transition to supportive housing, including care coordination of health care needs and non-housing, health-related resource needs.

NOTE: The LME/MCO retains the ultimate responsibility for a successful transition for TCL participants.

Roles and Responsibilities for Transition for TCL Participants:
The following activities must always be the primary responsibility of the Tailored Plan / LME/MCO TCL Transition Coordinator and cannot be delegated by the Tailored Plan / LME/MCO TCL Transition Coordinator to any entity providing care management for the TCL participant:

- Convening the Transition Team;
- Scheduling and convening transition planning/Person-Centered Plan meetings;
- Facilitating discussion of a crisis plan, disaster plan, and emergency plan;
- Leading the Transition Team pre-transition through 90-days (at minimum) post-transition, until the Transition Team meets, and the Transition Coordinator determines that lead functions can be transitioned fully to the care manager;
- Planning for and facilitating check-ins between the final transition planning meeting and move-in of the TCL participant at the community-based supportive housing;
- Ensuring that the person's Person-Centered Plan[56] addresses services and supports addressing all housing, employment/education, and community activity/inclusion needs;
- Ensuring the Complex Care Team completes assessments of the participant and assessments of appropriateness of housing for TCL participants with complex medical needs, and that their recommendations are included in the Person-Centered Plan;
- Intervening to preserve tenancy and avoid housing separations, and evaluating tenancy issues to extend rehousing tenure;
- Ensuring housing passes initial and subsequent health and safety inspection, and monitoring that the tenancy support needs delivered by providers are fulfilled; and
- Ensuring financial support needs of the TCL participant are fulfilled.

[56] North Carolina Medicaid requires providers to complete a Person-Centered Plan for an individual to obtain authorization for Medicaid State Plan services, including State Plan services provided as part of the TCL program. For Tailored Care Management and 1915(i) services, an individual must obtain an independent assessment to be used to develop a service plan, called a Care Plan (for individuals with behavioral health needs) or Individual Support Plan (ISP) (for individuals with an I/DD or TBI) in North Carolina.

The following activities are the care manager's responsibilities. Tailored Plan / LME/MCO TCL staff may take the lead role as needed. Responsibility for these tasks should be clearly identified in the TCL participant's Person-Centered Plan:

- Coordinating the Comprehensive Clinical Assessment (CCA) and ensuring completion for needed services;
- Working with the clinical provider to ensure the comprehensive Person-Centered Plan is accurate and inclusive of all clinical services, supports, and goals, based on the clinical assessment for services serving the life choices and preferences in the individual's In-Reach (IR)/TCL Tool;
- Ensuring services and supports are in place prior to the move-in;
- Educating the individual/legal guardian on the behavioral, physical health, and other recommended services, including supported employment;
- Assessing available community resources and facilitating linkages to them;
- Connecting participant with primary care/specialty care, and following up on the implementation of health care provider recommendations;
- Addressing health care and health-related resource needs (not related to housing) noted during the follow-along period and completing follow-along tasks;
- Providing non-housing-related care management functions during a TCL participant's transition to supportive housing, including care coordination of health care needs and non-housing, health-related resource needs;
- Completing the care management comprehensive assessments and developing the Care Plan/ISP (with input from the TCL Transition Coordinator and the IR/TCL Tool populated by Tailored Plan / LME/MCO TCL staff);
- Conducting Care Team meetings, as needed, and consulting with the multidisciplinary Tailored Care Management Care Team;
- Providing health promotion services;
- Developing and deploying prevention and population health programs (e.g., preventive screenings, addressing broader physical health needs);
- Ensuring medication reconciliation/monitoring occurs; and
- Conducting ongoing monitoring of 1915(i) services (if applicable).

For TCL participants with a Complex Care Team, the care manager will assist with population health activities, preventive screenings, addressing broader physical health needs, and assessment/ongoing monitoring of 1915(i) services. Additionally, the care manager is responsible for following up with healthcare providers on the implementation of the Complex Care Team's recommendations.

During a TCL participant's transition to supportive housing, the individual's care manager will stay closely involved in the transition as a member of the Transition Team and will deliver Tailored Care Management services that are not provided through TCL. As part of the Transition Team, the care manager should attend all transition planning meetings (in-person, when possible) and participate in discussions as a Transition Team member. The care manager will also be responsible for assisting individuals to expand their social networks, providing linkages to supported employment/education services, finding transportation to and engaging in chosen community activities, and developing and retaining strong relationships with their natural supports, peer

support staff, and peer run organizations. These tasks should be done in coordination with Tailored Plan / LME/MCO TCL staff.

The care manager should also assist with identifying healthcare providers (including but not limited to: primary care, physical health, behavioral health, home health, personal care services, occupational therapy, physical therapy, and speech therapy healthcare providers) and connecting/linking TCL participants to those providers as needed; and coordinating with the behavioral health and other types of providers who are responsible for supported employment/education, community integration, and tenancy supports in the follow-along period.

At the end of the follow-along period (no sooner than 90 days after move-in), the Tailored Plan / LME/MCO Transition Coordinator will convene the TCL participant's full Transition Team, including the care manager, to identify a participant's ongoing and unmet needs – including those related to employment and community integration – and update Transition Team staff roles and responsibilities and the member's Care Plan/ISP accordingly. Based on established LME/MCO criteria and standards, the LME/MCO Transition Coordinator will determine at this time if the participant is ready for the care manager and Care Team to take the lead in supporting the TCL participant in the community.

Similar to the follow-along period, the care manager's responsibilities will continue to include assessing a participant's community engagement/integration (e.g., employment and education), acquisition of services addressing their unmet health-related resource needs including transportation and connecting participants to community engagement/integration resources. The care manager will also be responsible for communicating transition-related concerns to the Transition Coordinator, specifically those related to housing, employment/education, and community activity/integration. Tailored Plan / LME/MCO TCL staff will remain on the participant's Care Team and available for support as needed.

Roles and Responsibilities for Crisis Planning and Response for Participants in TCL:
Crisis planning is essential to ensure crisis prevention and intervention services are implemented effectively, as well as to help ensure positive outcomes for TCL participant. As described below, team members (e.g., Tailored Plan / LME/MCO TCL staff, Tailored Care Management team, treatment/support service provider team) should collaborate on developing and implementing proactive crisis plan that anticipates crises—including emergencies and disasters—and describe which team members does what and when in a crisis.

Each member should have a single crisis plan included in both their Person-Centered Plan and Care Plan/ISP. Crisis plans will be individual and unique to the member based on their needs and conditions. If there are concerns with the existing crisis plan, the TCL Transition Coordinator, care manager, and service provider should work together to modify the plan to ensure quality of care for best member outcomes. Below are further details on the roles each team member plays in the development of the crisis plan as well as crisis response:

- **Treatment/support service provider:** It is the responsibility of the member's treatment/support service provider (i.e., not the care manager) to write the crisis plan, with input from all members of the Transition Team. If the member is linked with a treatment/support service provider, the treatment/support service provider would be

responsible for the first responder role. Note that the treatment/support service provider is responsible for completing the Person-Centered Plan, not the Tailored Care Management care manager.

- **TCL Transition Coordinator:** The TCL Transition Coordinator facilitates the discussions to develop the crisis plan. The TCL Transition Coordinator does not write the crisis plan.
- **Tailored Plan / LME/MCO TCL Staff:** TCL staff participates in the development of the crisis plan, but does not write the plan. In the event of a crisis where the member is not connected to a treatment/support service provider, Tailored Plan / LME/MCO TCL staff are ultimately responsible to perform the first responder role.[57] The Care Manager should ensure that the Person-Centered Plan and Care Plan/ISP, includes the member's crisis plan. Care managers should ensure information across the crisis plan, Person-Centered Plan, and ISP/Care Plan is consistent. During a crisis, the care manager should share information with the member's treatment provider, as needed—such as Care Plans and psychiatric advance directives—and coordinates care to place the member in the appropriate setting during urgent and emergent events.

Roles and Responsibilities for Diversion and In-Reach for TCL Participants:
Diversion and in-reach functions for TCL participants are performed exclusively by Tailored Plan / LME/MCO TCL staff. TCL staff may not delegate TCL diversion and in-reach functions to anyone else providing care management to the TCL participant.

- TCL diversion functions include:
    - Scheduling visits with participant/guardian to educate about permanent supportive housing options;
    - Providing opportunities to meet individuals in the community, family/natural supports, and providers;
    - Using diversion tool and Community Integration Planning guidance document to assist with participant education; and
    - Documenting decision using Informed Decision-Making tool (or other similar process).
- TCL in-reach functions include:
    - Meeting with facility owner/administrator to discuss in-reach process;
    - Contacting and scheduling meetings with TCL participant/guardian;
    - During meetings with participant, exploring interests and needs, options to live in the community, and supports available;
    - Providing opportunity to meet peers in the community, family, and providers; and
    - Using In-Reach/TCL tool and Informed Decision-Making tool to document process and decisions.

- During TCL diversion and in-reach, the care manager retains responsibility for all Tailored Care Management functions.

[57] "First responder" in this context refers to the member's treatment/support service provider. It does not refer to emergency service personnel such as EMTs, paramedics, or law enforcement.

5) Health IT

Population health management means caring for the whole population an organization is serving, not just individuals actively seeking care.[58] AMH+ practices and CMAs are expected to take responsibility for the health outcomes of their Tailored Care Management assigned populations, through the delivery of Tailored Care Management that is underpinned and driven by the use of data – both data that is generated internally to their organization and data that originates externally.

The certification requirements below align with Standard Plan Tier 3 AMH requirements to the greatest extent possible. The Department recognizes that the requirements represent a significant change for many behavioral health, I/DD, and TBI providers in particular. Therefore, the Department allows a range of options for AMH+ practices and CMAs to meet the requirements. Some AMH+ practices and CMAs may choose to meet health IT criteria by partnering with a CIN or Other Partner. The AMH+ or CMA may choose to use the Tailored Plan's / LME/MCO's care management data system as an alternative to building or maintaining its own or working with a CIN or Other Partner. As part of the certification application, organizations are asked to indicate how they plan to build these functions between the certification process and launching Tailored Care Management.

Health IT requirements that each AMH+ or CMA must meet in full prior to Tailored Care Management launch are detailed in the Tailored Care Management data strategy policy paper and summarized below:

1. **Use an electronic health record (EHR) or Clinical System of Record:** The AMH+ or CMA must have implemented an 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. The care management data system can be a care management software platform or an EHR with a care management module.

2. **Use a care management data system**: The AMH+ or CMA must use a care management data system, whether or not integrated within the EHR, that can:

    - Maintain up-to-date documentation of Tailored Care Management member lists and assignments of individual members to care managers;
    - Electronically document and store the care management comprehensive assessment and re-assessment;
    - Electronically document and store the Care Plan or ISP;
    - Consume claims and encounter data;
    - 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; and
    - Track referrals.

[58] SAMHSA-HRSA Center for Integrated Health Solutions, March 2015: https://www.thenationalcouncil.org/wp-content/uploads/2020/03/Population-Health-Management-101-3.10.15.pdf

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:

    - Real-time (within minutes/hours) response to notifications of ED visits, for example by contacting the ED to arrange rapid follow-up;
    - Same-day or next-day outreach for designated high-risk subsets of the population; and
    - 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 to ensure medication reconciliation occurs post-discharge).

4. **Use NCCARE360** to identify community-based resources and connect members to such resources.[59] AMH+ practices and CMAs must:

    - Use NCCARE360 as their community-based organization and social service agency resource repository to identify local community-based resources;
    - Refer members to the community-based organizations and social service agencies available on NCCARE360; and
    - Track closed-loop referrals.

5. **Risk stratify the population under Tailored Care Management beyond acuity tiering (encouraged, and required from Year Three onwards):** The Department expects that the standardized acuity tiering methodology described above will be the primary method that Tailored Plans / LME/MCOs, AMH+ practices, and CMAs use to segment and manage their populations under Tailored Care Management in the initial two years of the model. Tailored Plans / LME/MCOs 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 Tailored Plans / LME/MCOs 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 three of the model onward. Additionally, patient registries to track patients by condition type/cohort are encouraged but not required.

6) Quality Measurement and Improvement

The AMH+ and CMA must use their internal data to drive quality 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

[59] The Department intends to work with Tailored Plans / LME/MCOs on their use of NCCARE360 by facilitating regular meetings with Tailored Plans during the implementation, onboarding, and training process to discuss progress, challenges, and best practices. More information on NCCARE360 for providers is forthcoming.

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. AMH+ practices and CMAs whose quality performance on selected measures exceeds specified benchmarks may also receive an incentive payment from Tailored Plans / LME/MCOs in future years.

7) Training

All care managers, care manager extenders, and supervisors conducting Tailored Care Management are required to undergo an intensive training curriculum, regardless of previous experience. Each Tailored Plan / LME/MCO designs and implements a training plan, using Department guidelines on the topics that must be covered. AMH+ practices and CMAs must ensure that all care managers, care manager extenders, and supervisors undergo the required training. Care managers, care manager extenders, and supervisors working in multiple Tailored Plan regions are required to complete and pass the training curriculum in only the Tailored Plan region where they serve the most members and are not required to complete additional training curriculums for each region. The Tailored Plan / LME/MCO allows care managers, care manager extenders, and supervisors to waive out of components of the required training if the care manager, care manager extenders, or supervisor can verify that he or she has previously completed training and demonstrated competency in a specific training domain. The Tailored Plan / LME/MCO may require care managers, care manager extenders, and supervisors to complete additional region-specific trainings beyond those in the required Tailored Care Management domains. The Department requires the following domains for training, in addition to any training requirements specified in N.C. General Statute § 122c-115.4:

- Tailored Plan / LME/MCO eligibility and services
  - An overview of the NC Medicaid Delivery system, including Tailored Plan / LME/MCO, and Tailored Care Management eligibility criteria, services available through LME/MCOs and future Tailored Plans, and differences between Standard Plan, LME/MCO, and Tailored Plan benefit packages;
  - Principles of integrated and coordinated physical and behavioral health care and I/DD and TBI services;
  - Behavioral health crisis response;
  - Knowledge of 1915(c) Innovations and TBI waiver eligibility criteria;
  - Understanding HCBS and available services; and
  - Eligibility, assessment, and coordination of 1915(i) service including:
    - Process for conducting the state-designated assessment for individuals whose physical, cognitive, or mental conditions trigger a potential need for 1915(i) home and community-based services and supports,
    - Knowledge of available resources, service options, providers,
    - Requirements for ongoing coordination and monitoring of 1915(i) services, and
    - Best practices to improve health and quality of life outcome

- 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 Tailored Plan / LME/MCO 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
  - Providing education on members' chronic conditions;
  - Teaching self-management skills and sharing self-help recovery resources;
  - Providing education 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;
  - Conducting medication reviews and regimen compliance; and
  - Promoting wellness and prevention programs.

- 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)
  - Ethics, boundaries, and personal safety, including confidentiality, informed consent, mandated reporting, protected health information, HIPAA, and ensuring personal safety when entering someone's home.
  - Building a trusting relationship, including member relations and communication and conflict resolution.

- Additional trainings for care managers, care manager extenders, 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, monitoring, 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, care manager extenders, 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, care manager extenders, 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, care manager extenders, 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.

- Additional trainings for care managers, care manager extenders, and supervisors serving Members in foster care/adoption assistance and former foster youth
  - Key components of the North Carolina child welfare system, including the role of local Departments of Social Services and County Child Welfare Workers;
  - Coordination with County Child Welfare Workers;
  - Medication management for members in foster care/adoption assistance and former foster youth;
  - Incorporating foster parents, biological/adoptive parents, and kinship caregivers into the care planning process, as appropriate; and
  - Resources for youth aging out of foster care.

- Additional trainings for care managers, care manager extenders, and supervisors serving TCL Participants
  - Transitions to Community Living (TCL) Overview
  - Transitions to Community Living (TCL) Distinction for TCM Training

To ensure extenders are sufficiently prepared and capable to perform their duties, Tailored Plan / LME/MCO training curriculum for extenders includes practical ("hands-on") training modalities and evaluation, which may include role play, use of call scripts, and practice sessions.

The AMH+ or CMA must ensure that all care managers, care manager extenders, and supervisors complete training on the following core modules before being deployed to serve members; care managers, care manager extenders, and supervisors must complete the remaining training modules within six months of being deployed:

- An overview of the NC Medicaid Delivery system, including Tailored Care Management eligibility criteria, services available through LME/MCOs and future Tailored Plans, and differences between Standard Plan, LME/MCO, and Tailored Plan benefit packages,
- Principles of integrated and coordinated physical and BH care and I/DD and TBI services,
- Knowledge of Innovations and TBI waiver eligibility criteria,
- Tailored Care Management overview, including but not limited to the model's purpose, target population, and services, in addition to enrollees and their families' role in care planning,
- 1915(i) Overview and Assessment, and
- HCBS and 1915(i) services.

Current Innovations waiver care coordinators who are transitioning to a care management staffing role under Tailored Care Management have additional time to complete these trainings, not to exceed six months after launch. The AMH+ or CMA must ensure that care managers, care manager extenders, and supervisors attend annual refresher courses on training topics required by the Department, as well as based on needs determined by care manager supervisors *(see appendix for list of required refresher courses)*. Refresher courses must be completed annually, and care managers, care manager extenders, and supervisors have the full year to complete them. Tailored Plans, AMH+ and CMAs are allowed flexibility around the timing of the refresher courses as long as they correlate with the date of deployment or date of hire. Care managers, care manager extenders, and supervisors may also request targeted retraining.

In addition to the above training, Tailored Plan / LME/MCOs are 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.

Section VI: Payment

In recognition of the significant time and resource commitment required to successfully implement the Tailored Care Management model, provider payment rates are significantly higher than those paid for Standard Plan care management. From July 1, 2023, through January 31, 2024, AMH+s/CMAs were paid a monthly rate of $269.66 for each member enrolled in Tailored Care Management that obtained a qualifying Tailored Care Management contact in the month. Effective February 1, 2024, through December 31, 2024, the Department will temporarily increase the payment rate from $269.66 to $343.97. Effective January 1, 2025, the payment rate will be $294.86. A qualifying Tailored Care Management contact is defined as an interaction that includes the member and/or legally responsible person/guardian, as indicated, that fulfills one or more of the six core Health Home services (see Section V.4.2. Capacity to Engage with Members Through Frequent Contact for more information). Through January 31, 2024, the Department added

$78.94 to the monthly rates for individuals enrolled in the Innovations or TBI waivers and for members obtaining 1915(i) services to reflect additional care coordination responsibilities required for these HCBS programs. Effective February 1, 2024, the Department will increase this additional payment for individuals enrolled in the Innovations or TBI waivers and for members obtaining 1915(i) services to $79.73. For members receiving provider-based Tailored Care Management, LME/MCOs are required to pass the full amount of the monthly payment down to the provider delivering Tailored Care Management.

In order to access the monthly Tailored Care Management payment for any given member, providers must deliver one qualifying Tailored Care Management contact during the month for that beneficiary (i.e., providers will not be paid for a member in months in which there were no qualifying contacts).[60] The provider is required to submit a claim to the Tailored Plan / LME/MCO, and the Tailored Plan / LME/MCO pays the provider the monthly payment (and the Innovations/TBI waiver or 1915(i) add-on payment, if applicable) after the month of service. Only qualifying contacts delivered by the assigned care manager or extender are eligible for payment. The Department understands that a member may not be present for work done by a care manager (or extender, where appropriate) related to the six core health home services (e.g., care manager calls with providers to connect members to services/supports); a care manager should submit their Tailored Care Management claim for the date they made contact with the member and communicated the outcome of these core health home service activities. In the event that the supervising care manager or other care manager is providing coverage for a care manager (e.g., sick leave, vacation, staff turnovers) and delivers a qualifying contact to a member to ensure they are receiving Tailored Care Management in a timely manner, the contact is eligible for payment.

Providers' participation as an AMH+ or CMA does not impact fee-for-service payments for clinical services, nor does it affect payment of Medical Home Fees to primary care practices.[61]

Note: A Certified Peer Support Specialist serving as an extender who is completing qualifying Tailored Care Management contacts for a member cannot also bill for Peer Support Services provided under Clinical Coverage Policy No. 8G for the same member. In other words, for a single member, a Certified Peer Support Specialist can either conduct qualifying Tailored Care Management contacts or provide Peer Support Services under Clinical Coverage Policy No. 8G, but not both.

Section VII: Oversight Model after Tailored Care Management Launch

The Department holds Tailored Plans / LME/MCOs responsible for implementing Tailored Care Management within their regions.

[60] The Department provides additional guidance on when contacts initiated by care manager extenders will count toward contact requirements in the Care Manager Extender Guidance available at: https://medicaid.ncdhhs.gov/media/11305/download?attachment

[61] Tailored Plans are required to pay Medical Home Fees (fixed $2.50 PMPM or $5 PMPM for ABD) to all AMH practices in AMH Tiers 2 and 3, as well as $1 PMPM Medical Home Fees to Tier 1 practices. AMH+ practices will receive Medical Home Fees in the same way as other Tier 3 practices in recognition of their role as PCPs and will receive care management payments in addition under the Tailored Care Management model.

Tailored Plans / LME/MCOs are accountable to the Department through the following mechanisms:

- **Contract with the Department:** All required elements of the Tailored Care Management model reflected in this manual are included in the contract between the Department and each Tailored Plan / LME/MCO. Tailored Plans / LME/MCOs are responsible for both ensuring that their own staff adhere to the requirements and for overseeing the performance of the model at the AMH+ and CMA level.
- **Reporting requirements:** Tailored Plans / LME/MCOs are required to report data to the Department on a periodic basis, with encounter-level information on care management conducted at both the Tailored Plan / LME/MCO level and the AMH+, CMA, or CIN or Other Partner level.
- **Required elements in Tailored Plan / LME/MCO, AMH+, and CMA contracting:** Tailored Plans / LME/MCOs must include all the required elements of Tailored Care Management in their contracts with AMH+ practices and CMAs. Provider contract templates, including all sections and attachments, must be approved by the Department.

In turn, AMH+ practices and CMAs can expect to be held accountable to Tailored Plan / LME/MCOs. Each Tailored Plan / LME/MCO is required to have a written process documenting how it will identify compliance issues and allow AMH+ practices and CMAs the opportunity to correct them under a Corrective Action Plan (CAP). The process must describe clearly how a CAP may operate at the level of an individual AMH+ or CMA, and/or how a CAP may operate at the level of a CIN or Other Partner, if applicable. The Department requires each CAP process to give a minimum of 30 days to remediate any identified issues, although the parties may establish longer remediation periods by mutual agreement. To promote AMH+ practices and CMAs' ability to make informed choices about CIN or Other Partner affiliations, Tailored Plan / LME/MCOs are required to send direct notification of any CAP imposed at the CIN or Other Partner level to each AMH+ practice or CMA describing the CAP, and to notify the Department. In the event of continued underperformance by an AMH+ practice, a CMA, or a CIN or Other Partner that is not corrected after the time limit on the CAP, the Department permits the Tailored Plan / LME/MCO to stop making Tailored Care Management payments and terminate its contract with the AMH+ or CMA. The Tailored Plan / LME/MCO's policies and procedures must set out the detailed process by which this would occur, including reassigning members previously assigned to the AMH+/CMA being terminated to the Tailored Plan / LME/MCO and/or other providers. The Tailored Plan / LME/MCO's policies and procedures must also set out the details of the options certified AMH+ practices and CMAs will have in the event that a CIN or Other Partner fails to correct continued compliance problems, such as providing Tailored Care Management without contracting with a CIN or Other Partner, which would require the AMH+ practice or CMA to enter into a direct contract with the Tailored Plan / LME/MCO for Tailored Care Management, or contracting with another CIN or Other Partner that in turn will contract with the Tailored Plan / LME/MCO.[62]

Monitoring

The Tailored Plans / LME/MCOs, AMH+s, and CMAs will be monitored to ensure adherence to the required guidelines of the Tailored Care Management model and quality of services in a

[62] AMH+ practices and CMAs have the right to appeal contracting decisions made by the Tailored Plan / LME/MCOs in accordance with guidelines to be determined by the Department.

standardized and consistent way. Monitoring of the Tailored Plans / LME/MCOs, AMH+s, and CMAs will utilize a standardized statewide tool. Monitoring is conducted according to contract requirements, at least annually. Initial monitoring of Tailored Plans / LME/MCOs, AMH+s, and CMAs will be used to provide technical assistance rather than corrective actions. This tool will be introduced in the future after the launch of Tailored Plans.

Incident Report

In the event that a care manager/care team learns of a member's death during a member outreach/contact, the AMH+/CMA must complete an Incident Response Improvement System (IRIS) report. The AMH+/CMA should request the Death Certificate and/or Medical Examiner Report and upload the document as part of the IRIS report. In instances in which the care manager was conducting an initial outreach and learns of the member's death, the AMH+/CMA is not required to complete an IRIS report but should notify the Tailored Plan / LME/MCO of the member's death. In instances in which the member was receiving services from a behavioral health, I/DD, or TBI services provider in the 90 days prior to death, the treatment provider should complete the IRIS report instead of the AMH+/CMA.

Section VIII: Local Health Department Programs

North Carolina provides care management for women experiencing high-risk pregnancies and at-risk children ages zero to five through programs run by local health departments (LHDs) - Care Management for High-Risk Pregnant Women (CMHRP) and Care Management for At-Risk Children (CMARC), respectively. The Tailored Plan is required to contract with LHDs during a transitional period that will align with the transitional period established for Standard Plans. Accordingly, for the first Tailored Plan contract year, the Tailored Plan is required to extend to all LHDs the "right of first refusal" as contracted providers of CMHRP.

There is an overlap between the LHD transition period with Standard Plans and the operation of Tailored Plans. The Department has developed requirements to ensure that Tailored Plan members participating in these programs receive whole-person care management and do not experience disruption to the continuity of their care.[63]

- **CMHRP:** For the first Tailored Plan contract year, all LHDs will have "right of first refusal" as contracted providers of CMHRP. In the second year, Tailored Plans will only be required to contract LHDs that meet the benchmark assessment.[64] Women enrolling in Tailored Plans who participate in CMHRP will also be eligible for Tailored Care Management (i.e., a second care manager) to address other needs not included in the LHD model. Tailored Plans should ensure that the care management roles and responsibilities between the Tailored Care Management providers are non-overlapping with care management services offered by LHDs.
- **CMARC:** CMARC and Tailored Care Management provide duplicative services. Thus, children will not participate in both programs at the same time. CMARC members that become eligible

[63] For more information on the CMHRP program, refer to the Program Guide: Management of High-Risk Pregnancies in Tailored Plan

[64] See CMHRP/CMARC Benchmark Specification for information on the benchmark specifications that are part of the new program transition and oversight plan announced in the CMHRP and CMARC Program Update

for Tailored Care Management will transition from the LHDs to the Tailored Plans for care management services.

It is the responsibility of the Tailored Plans to ensure that care managers at AMH+ practices and CMAs have the information they need to coordinate effectively with CMHRP care managers and to manage transitions into Tailored Care Management, in the case of young children transitioning from CMARC.

Section IX. Documentation Guidance

The Department strongly believes that rigorous documentation standards are necessary in assuring that all pertinent information is contained in the member's records and that the information entered is clear, concise, and correct. Complete and accurate documentation is vital for the continuity of optimum, high quality care and will be key in supporting the Department and Tailored Plans / LME/MCOs in conducting monitoring of Tailored Care Management.

The following section details the required components of the service record and service notes that are applicable to AMH+s and CMAs. Additionally, it provides AMH+s/CMAs with general documentation guidance and information on documentation signatures. For Tailored Care Management, AMH+s/CMAs will not be held to the Records Management and Documentation Manual (RMDM) documentation standards and instead will be held to the below standards which are drawn for the RMDM, with some modifications.[65]

1) Components of the Tailored Care Management Service Record

The Tailored Care Management service record, or service record, is the official document that reflects all the aspects of Health Home service delivery. The service record is the only written evidence of the quality of care management delivered by an AMH+ or CMA to an individual. It is stored in the care management data system. The service record is the legal business record for an AMH+ or CMA, and it must be maintained in a manner that follows all applicable regulations, accreditation standards, professional practice standards, and legal standards. It is used to coordinate services and communicate important information to other providers. The individual's service record helps to ensure that the member's needs are being met, and that care is coordinated among providers. In the movement toward integrated care, it is vital for providers to recognize the need for real collaboration in the best interest of the individual, and the service record plays an important role in the facilitation of communication among providers in fostering continuity of care.

All information developed or received by the AMH+ or CMA about the assigned member receiving Tailored Care Management should be included in the service record.

The service record should include the following information or items, when applicable, as well as any other relevant information that would contribute to or address the quality of care for the individual:

[65] *APSM 45-2 Records Management and Documentation Manual (RMDM) For Providers of Publicly-Funded Mental Health, Intellectual or Developmental Disabilities, and Substance Use Services and Local Management Entities-Managed Care Organizations,* Effective December 1, 2016: https://www.ncdhhs.gov/rmanddm-3rd-edition-9-1-16/download

- Consents
    - Consent to Participate in Tailored Care Management: Consent for the AMH+/CMA to provide Tailored Care Management. Consent to participate can be verbal consent by the member. Care managers should document in the care management data system that the member provided consent to receive Tailored Care Management, including the date of consent.
    - Consent approval of Care Plan/ISP (where applicable): Informed written consent or agreement for proposed plan required on the individual's Care Plan/ISP.[66]
    - Consent to Release Information: Written consent to release/obtain information [10A NCAC 26B .0202 and .0203]
- Demographic Information / In Case of Emergency / Advance Directives
    - Individual's name – must be noted in the electronic record entries for the individual
    - Emergency information, which shall include the name, address, and telephone number of the person to be contacted in case of sudden illness or accident; the name, address, and telephone number of the individual's preferred physician; and hospital preference
    - Advance directives, including psychiatric advance directives
- Results of the Care Management Comprehensive Assessment *(See Section V.4.2. Care Management Comprehensive Assessment for all required components)*
- Medications and Lab Documents
    - Documentation of medications and dosages
- Notification of Rights
    - Evidence of a written summary of the individual's rights given to the individual/legally responsible person, according to 10A NCAC 27D .0201, and as specified in G. S. § 122C, Article 3
    - Documentation that the individual's rights were explained to the individual/legally responsible person
- Care Plan/ISP *(see Section V.4.4. Care Plans and Individual Support Plans (ISPs) for additional details on the Care Plan/ISP, including the required content of the Care Plan/ISP)*
- Discharge Information
    - Discharge plans
    - Discharge summaries
- Service Notes *(see Section IX.2. Components of Tailored Care Management Service Notes)*
- Incidents: Any incidents should be filed per IRIS requirements.
- Release/Disclosure of Information
    - Documentation of written notice given to the individual/legally responsible person that disclosure may be made of pertinent confidential information without his or her expressed consent, in accordance with G. S. § 122C-52 through 122C-56;

- Legal Information: Copies of any relevant legal papers, such as guardianship/legally responsible person designation

[66] Innovations and TBI waiver enrollees must provide a signature (wet or electronic) on the ISP to indicate informed consent. (See Section V.4.9. Innovations and TBI Waiver Care Coordination). Members obtaining 1915(i) services must provide a signature (wet or electronic) on the Care Plan or ISP to indicate informed consent. (See Section V.4.10. 1915(i) Care Coordination)

- Other Correspondence: Incoming and outgoing correspondence, including copies of all letters relating to services provided that do not fit into the other mentioned categories

2) Components of Tailored Care Management Service Notes

Care management service notes are the heart of the care management service record. Service notes document care management activities conducted on behalf of a member. All contacts completed with member or on behalf of member should be documented in the service record within 7 calendar days of the contact. Service notes serve as supporting evidence of individual's progress towards goals identified in the Care Plan or ISP and towards improved health outcomes. Service notes also reflect significant events that occur in the individual's life that may affect progress towards goals identified in the Care Plan or ISP. Service notes must accurately reflect the care management activity provided for a member, and each note serves as evidence that an activity was provided.

While there are no specific formats required for documentation, all service notes should include, but are not limited to the following:[67]

- Name of the individual on each service note page;
- Name of collateral contact, as applicable;
- Name of legally responsible person/guardian contact, as applicable;
- Health Home service/care management activity attempted or provided;
- Date of care management activity: It must accurately reflect activities and services for all time indicated for the service;
- Goal addressed/Tasks performed: This must include description of the care management activities provided, which relate to a goal/activity in the Care Plan/ISP (once developed) and a description of the results or outcome of the care management activities, any progress noted, and next steps, when applicable; and
- Staff Signature *(see Section IX.4.1. Signatures of Staff)*.

3) General Documentation Guidance

3.1. General Dos and Don'ts for Documentation. Below are general DOs and DON'Ts for documentation in the service record:

DO enter information that is:

- Accurate – Document the facts as observed or reported.
- Timely – Record significant information at the time of the event, since delays may result in inaccurate or incomplete information.
- Objective – Avoid drawing conclusions. When a professional opinion is expressed, it must be phrased to indicate clearly that it is the view of the recorder.
- Specific, Concise, and Descriptive – Record in detail rather than in general terms; be brief and meaningful without sacrificing essential facts. Thoroughly describe observations and other

[67] The list of required elements is drawn from the list of required elements in a "modified service note," Modified services notes may be used in lieu of a full service note for specific services, including Tailored Care Management. See the "Services for Which a Modified Service Note May Be Used" section within the *RMDM, Chapter 7: Service Notes and Service Grids* for additional detail.

pertinent information.
- Consistent – Explain any contradictions and give the reason for the contradiction.
- Comprehensive, Logical, and Reflective of Thought Processes – Record significant information relative to an individual's health and progress towards goals identified in the Care Plan or ISP.
- Clear – Record meaningful information and write in non-technical terms when possible.
- Inclusive of follow-up contacts, ensuring that unresolved problems from previous contacts are subsequently addressed, and recording plans for next contact [date/time], etc.
- Person-Centered/ Family Driven – Use person first language when describing individuals, behavioral characteristics, events, and all other information that produces a picture of this person.

Document pertinent findings, service/support rendered, changes in the individual's condition, and response to treatment/interventions/habilitation.

DON'T enter information that:
- Is unprofessional, critical of services carried out by others, or biased against an individual unless accompanied by a statement reflecting the need for documentation of the information. Such remarks, if made, cannot be obliterated.
- The use of the other individuals' names should be limited to those situations when the responsible professional determines that the use of the individual's name is clinically pertinent. Individuals who have a significant influence on the member receiving Tailored Care Management may be identified by name as long as the extent and type of relationship and specific influence are also included. However, when other individuals' names are included in the service record, such information should be reviewed prior to any release to determine whether the information should be disclosed or redacted.
- Is not based on fact, report, or observation.

3.2. Corrections to Service Documentation. Changes or modifications to original documentation for corrective purposes is permitted at any time and shall be in accordance with the provider's operating processes. Minimally, the following must be included in the provider's procedure guidelines:

- Corrections must be made by the individual who recorded the entry, or by another member of the care management team in collaboration with the individual;
- The original and corrected note must remain available in the service record; and
- An explanation as to the type of documentation error shall be included whenever the reason for the correction is unclear (e.g., "wrong service record").

4) Guidance on Signatures in Documentation

Electronic or digital signatures on documents within the service record are permissible.

APPENDIX 1: Standard Terms and Conditions for Tailored Plan / LME/MCO 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. Meet North Carolina's definition of a Qualified Professional per 10A-NCAC 27G .0104; ***and***
            2. 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. (This experience may be concurrent with the years of experience required to become a Qualified Professional.)
        ii. Supervising care managers serving members with behavioral health conditions must have the following minimum qualifications:
            1. 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***
            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 ***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 human services field ***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 (e.g., GED, certificate of completion); ***and***
    3. 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 should use their clinical judgment in assigning a care manager and supervising care manager and must ensure that the supervising care manager is qualified to oversee the member's care manager. This applies regardless of whether a member has been dually diagnosed prior to the initial Tailored Care Management assignment process or at some point after. In instances where a member is dually diagnosed after a care manager or supervising care manager at an AMH+/CMA has been assigned, the AMH+ practice or CMA should review their assignment of care manager/supervising care manager to confirm that it is still clinically appropriate, aiming for continuity of care, while also ensuring the care manager/supervising care manager is equipped to serve the member.

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 arrange/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. 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.

viii. Care manager extenders cannot work for the same organization where they receive services.

ix. 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.

x. 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.

xi. All supervising care managers, care managers, and care manager extenders must participate and complete the Tailored Plan / LME/MCO's Tailored Care Management training curriculum.

xii. 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. Caregiver(s)/legal guardians/foster parents/biological parents/adoptive parents/kinship caregivers/family member/natural supports;
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. Tailored Plan / LME/MCO-based TCL staff (e.g., Transition Coordinator, Complex Care Team, etc.) for TCL participants;
13. Tailored Plan / LME/MCO-based in-reach and transition staff, as applicable; and
14. 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 / LME/MCO 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 / LME/MCO;
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 / LME/MCO; and
3. Electronically reconcile the Tailored Care Management assignment lists received from the Tailored Plan / LME/MCO 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 to ensure medication reconciliation occurs 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 may 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 / LME/MCOs 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 / LME/MCOs 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 Plan / LME/MCOs 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 / LME/MCO'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 / LME/MCO.
   b. Communication: AMH+ practices and CMAs must develop policies for communicating and sharing information with members and their legally responsible person/guardian with appropriate consideration for language, literacy, accommodations due to relevant health conditions to use clinically-appropriate assistive technology, 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. Care managers/care teams should deliver Tailored Care Management as specified in *Section 4.2. Capacity to engage members through frequent contact* of the Tailored Care Management Provider Manual.
      ii. In-person contact must involve the member. Telephonic or two-way real time audio/video contact may be with a legally responsible person/guardian

in lieu of the member, only where appropriate or necessary. For members who request accommodations due to relevant health conditions, contacts can be delivered, at the discretion of the AMH+/CMA, using clinically-appropriate assistive technologies (e.g., speech-to-text applications, secure platforms for two-way instant messaging/texting).

iii. 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. The AMH+ practice or CMA shall undertake best efforts to complete the care management comprehensive assessment within ninety (90) days of assignment to Tailored Care Management.

ii. Before or 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.

iii. 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 parent/family member/caregiver/natural 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.

iv. 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., American Society of Addiction Medicine (ASAM), Child and Adolescent Needs and Strengths (CANS), Adult Needs and Strengths Assessment (ANSA), 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 parent/ caregiver/legally responsible person/guardian, or any other circumstance the plan deems to be a change in circumstance;
        h. Loss of housing; and
        i. Change in foster care placement or living arrangement (including aging out of the child welfare system.

v. 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 / LME/MCO 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. CANS;
    2. ANSA;
    3. ASAM criteria;
    4. For Innovations waiver enrollees: SIS;
    5. For TBI waiver enrollees: Rancho Los Amigos Levels of Cognitive Functioning Scale (as applicable); and
    6. For member obtaining or seeking to obtain 1915(i) services: independent assessment

ii. For Tailored Plan / LME/MCO 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 support for parent/family member/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 / LME/MCO;
3. Other providers delivering care to the member;
4. The member's legal representative (as appropriate);
5. The member's parent/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); 1915(i) 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 ensuring regular medication reconciliation occurs (conducted by the appropriate care team member), supporting medication adherence, and supporting metabolic monitoring (for individuals prescribed antipsychotic

medications). A community pharmacist at the CIN level, in coordination with the AMH+ practice or CMA, may assist with these functions, along with appropriate members of the individual's care team (e.g., PCP, community pharmacist, psychiatrist).

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 parents/other family members/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 Achieving a Better Life Experience (ABLE) Accounts (for individuals with disabilities);
6. Women, Infants, and Children (WIC) Program; and
7. Other programs managed by the Tailored Plan / LME/MCO 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 (except for members participating in Transitions to Community Living), 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/caregivers 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 parents/family members/caregivers/natural supports (as appropriate) 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").
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 accompanying 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 (i.e., not participating in Transitions to Community Living), 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 supportive 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 qualifying Tailored Care Management contact if two-way real time 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 to inform monitoring of the member's services;
    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 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 monthly Tailored Care Management payment for any given member, the AMH+ practice or CMA must deliver one qualifying care management contact during the month for that member (i.e., providers will not be paid in months in which there were no qualifying contacts). The AMH+ practice or CMA must submit a claim to the Tailored Plan / LME/MCO, and the Tailored Plan / LME/MCO must pay the provider the monthly Tailored Care Management payment after the month of service.
    b. The Plan will pay AMH+ /CMA payment for any month in which the member is assigned to the AMH+/CMA and the provider delivers one qualifying care management contact. The Plan will not withhold payment or adjust the Tailored Care Management monthly payment during a month in which the provider delivers one care management contact.
    c. Only qualifying contacts delivered by the assigned care manager or extender shall be eligible for payment. In the event that the supervising care manager or other care manager is providing coverage for a care manager (e.g., sick leave, vacation, staff turnovers) and delivers a qualifying contact to a member to ensure they are receiving Tailored Care Management in a timely manner, the qualifying contact shall be eligible for payment.
6. Oversight
    a. The AMH+ practice or CMA must comply with oversight requirements established by the Tailored Plan / LME/MCO 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 / LME/MCO, 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 / LME/MCO may terminate its contract with the AMH+ practice or CMA.

APPENDIX 2: Additional Standard Terms and Conditions for Tailored Plan / LME/MCO 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 are responsible for coordinating these individuals' waiver services in addition to performing the Tailored Care Management 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 / LME/MCO 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 implementation[68]; 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 / LME/MCO] 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 / LME/MCO 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:

[68] 42 C.F.R. §441.301(c)(2)(ix)

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 / LME/MCO of LOC determination updates.

APPENDIX 3: Additional Standard Terms and Conditions for Tailored Plan / LME/MCO Contracts with AMH+ Practices or CMAs Certified to Provide Tailored Care Management to Members Obtaining 1915(i) Services

1. AMH+ practices and CMAs are responsible for coordinating these individuals' 1915(i) services in addition to performing the Tailored Care Management requirements.
    a. AMH+ practices and CMAs serving members obtaining or seeking to obtain 1915(i) services must:
        i. Complete the independent assessment for 1915(i) services when a member expresses interest in 1915(i) services, requests to be assessed for 1915(i) services, or is referred by a provider to determine eligibility for 1915(i) services.
        ii. Support completion of assessments beyond the care management comprehensive assessment, and incorporate results into the care management comprehensive assessment.
            1. Complete the independent assessment for 1915(i) services as part of a member's annual care management comprehensive reassessment.
        iii. Facilitate provider choice and assignment process for members obtaining or seeking to obtain 1915(i) services.
            1. Help enrollee make informed choices of care team participants, provide information about providers, and arrange provider interviews as needed; and
            2. Convene a person-centered planning meeting.
        iv. Perform additional responsibilities related to developing and monitoring implementation of the Care Plan/ISP for members obtaining 1915(i) services beyond those required for other individuals engaged in Tailored Care Management.
            1. Incorporate the results of the independent assessment into the Care Plan/ISP.
            2. Complete the Care Plan/ISP so that the Tailored Plan / LME/MCO receives it within 60 calendar days of 1915(i) eligibility determination.
            3. As part of developing the Care Plan/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 Care Plan or ISP to indicate informed consent, in addition to ensuring that the Care Plan/ISP includes signatures from all individuals and providers responsible for its implementation;[69]

[69] 42 C.F.R. § 441.725(b)(9)

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 / LME/MCO] network providers listed in this plan.

d. Submit the Care Plan/ISP for service authorization to Tailored Plan / LME/MCO for each service; and
e. Ensure that delivery of 1915(i) services begins within 45 days of Care Plan/ISP approval.

4. Monitor Care Plan/ISP implementation and resolve or escalate issues as needed:
    a. Monitor at least quarterly to ensure that any restrictive interventions (including protective devices used for behavioral support) are written into the Care Plan/ISP and the Positive Behavior Support Plan;
    b. Monitor for HCBS compliance; and
    c. Notify Tailored Plan / LME/MCO of updates to eligibility and/or need for 1915(i) services.

APPENDIX 4: Additional Standard Terms and Conditions for Tailored Plan / LME/MCOs Contracts with AMH+ Practices or CMAs to Provide Tailored Care Management to Members in Foster Care, Adoption Assistance, and Former Foster Youth

In the event a member in foster care, adoption assistance, or former foster youth enrolled in an LME/MCO is served by an AMH+ practice and/or CMA, the AMH+ practice or CMA must ensure Tailored Care Management includes the following requirements:

1. Care Management Comprehensive Assessment: The AMH+ or CMA must ensure that the care management comprehensive assessment includes permanency planning goals.
    a. A triggering event prompting reassessment shall include change in foster care placement or living arrangement (including aging out of the child welfare system).
2. Care Plan/ISP: The AMH+ practice or CMA must ensure that all care plans and ISPs developed under Tailored Care Management include:
    a. Names and contact information of the County Child Welfare Worker (as applicable);
    b. A life transitions plan to address instances where the member is changing foster care placement (as applicable); and
    c. Information on the member's foster care permanency planning goals (as applicable).
3. Updates to the Care Plan or ISP: The AMH+ or CMA must ensure that each Care Plan or ISP is comprehensively updated following a change in the member's foster care placement living arrangement or (as appropriate).
4. Documentation and Storage of the Care Plan or ISP: The AMH+ or CMA must ensure that each Care Plan or ISP is documented, stored, and made available to the member's assigned County Child Welfare Worker (as applicable) within 14 days of completion of the Care Plan or ISP.
5. Care Team: The AMH+ or CMA must establish a multidisciplinary care team for each member that includes, depending on the member's needs:
    a. Caregiver(s)/legal guardians/foster parents/biological parents/adoptive parents/kinship caregivers (as applicable or appropriate), and
    b. County Child Welfare Worker and guardian ad litem (as applicable).
6. Care Coordination: In delivering care coordination, the AMH+ practice or CMA must coordinate with the County Child Welfare Worker to identify and manage member needs.
7. Coordination with County Child Welfare Workers: The AMH+ practice or CMA must coordinate with the member's County Child Welfare Worker through an initial meeting and regular quarterly meetings (in-person, by video, or telephonic).
    a. Initial meetings with the County Child Welfare Worker must occur within the following timeframes:
        i. For members enrolled in Tailored Care Management as of April 1, 2023, within sixty (60) calendar days of launch, or earlier, if necessary, to appropriately manage the member's health care needs.
        ii. For members enrolled after April 1, 2023, within three (3) calendar days, or earlier, if necessary.

b. During the initial meeting, the AMH+ practice or CMA must:
    i. Confirm that the member has received or has been scheduled to receive the DSS-required initial seven (7)-day physical examination and thirty (30)-day comprehensive medical appointment, or work with the County Child Welfare Worker to schedule the appropriate appointments;
    ii. Gather the following minimum information:
        1. DSS Child Health Summary Components, to the extent available;
        2. Placement logs;
        3. Member's family history and foster care placement status;
        4. Immediate health care needs, including BH and Unmet Health-Related Resource Needs;
        5. Member's medication history;
        6. Child Maltreatment Evaluations, as applicable;
        7. Key updates on member's permanency planning process;
        8. Identification about whether there are any restrictions to communicating with the biological/adoptive parents, including termination of parental rights or court order restricting communication; and
        9. Other information necessary for informing the care management comprehensive assessment and care planning processes.
    iii. Establish ongoing processes and timeframes for the County Child Welfare Worker to share the DSS Child Health Summary Components, to the extent available;
    iv. Establish a schedule of regular check-ins between the care manager and the County Child Welfare Worker (at least quarterly and more frequently, as appropriate);
    v. Identify health care services and health-related services (e.g., state-funded mental health, substance use services, housing supports, and other supports) that are necessary to support the member's biological/adoptive parents and promote reunification and develop a plan for the Child Welfare Worker to make necessary referrals, as necessary and appropriate; and
    vi. Agree on explicit next steps and roles and responsibilities to ensure member needed services are coordinated in a timely fashion.
c. During regular quarterly meetings, the AMH+ practice or CMA must gather updates on the following:
    i. Member's foster care placement status;
    ii. Key changes in the member's health care needs, including BH and Unmet Health-Related Resource Needs;
    iii. Key updates on member's permanency planning process;

iv. Any changes regarding restrictions to communicating with the biological/adoptive parents, including termination of parental rights or court order restricting communication; and
v. Other information necessary for informing the member's Care Plan/ISP.

d. The AMH+ practice or CMA must contact the County Child Welfare Worker within one (1) business day when any of the following occur, to the extent that information is available, and take necessary measures to ensure coordination of care
i. Member is admitted to an inpatient level of care;
ii. Member visits an ED;
iii. Member is admitted to an institutional level of care or other congregate setting;
iv. Member experiences a behavioral health crisis;
v. Member experiences a disruption in school enrollment (e.g., member is expelled or is required to change schools); or
vi. Member becomes involved with the justice system.

8. Additional Requirements for Members Aging Out of Foster Care
a. The AMH+/CMA must provide the following support when a member leaves the child welfare system, including individuals who age out of custody at age eighteen (18), otherwise emancipate, or leave the child welfare system (planned or unplanned) and are aged eighteen (18) to twenty-one (21):
i. Participate in the initial development of and periodic updates to each member's Transitional Living Plan, at the request of the County Child Welfare Worker and at the discretion of the member, including by:
1. Identifying key health care-related goals to include in the Transitional Living Plan, as well as resources and supports necessary to achieve the member's health care goals.
ii. Participate in the development of each member's DSS Ninety (90) Day Transition Plan, at the discretion of the member and the County Child Welfare Worker, including by:
1. Ensuring that the member's DSS Ninety (90) Day Transition Plan includes accurate and up-to-date contact information on the member's care manager, PCP, dental home, behavioral health and I/DD provider(s), and current medications, as applicable; and
2. Identifying key health-related resources and supports necessary to achieve the member's health care goals and ensure they are included in the member's DSS Ninety (90) Day Transition Plan.
iii. For members who remain enrolled in the LME/MCO after leaving the child welfare system, make best efforts to conduct a care management comprehensive assessment (or reassessment, as appropriate) within ninety (90) calendar days of the member leaving the child welfare system.

b. For former foster youth aging out of Medicaid coverage eligibility, the assigned organization providing Tailored Care Management must
    i. At least six (6) months prior to the member aging out of Medicaid coverage eligibility, make a best effort to meet with the member (in-person or telephonic) to discuss options for health insurance coverage following the birthday on which the member will age out of Medicaid coverage eligibility and plan for transitioning all current health care services and medications;
    ii. Discuss potential health care resources that may be available to the member regardless of insurance status (e.g., the Department's Medication Assistance Program, State-funded Services, and free and charitable clinics); and
    iii. Provide the member with clear written guidance on strategies for achieving the member's health-related goals, including, at minimum, the following:
        1. Copies of the member's full Care Plan/ISP and DSS Ninety (90) Day Transition Plan, if available;
        2. Summary of scheduled visits and recommended schedule of future visits;
        3. List of health care resources that may be available to the member regardless of insurance status, including the Department's Medication Assistance Program, State-funded mental health and substance abuse treatment programs, and free and charitable clinics;
        4. List of prescribed medications (including clear guidance on when medication should be taken); and
        5. Copies of all known medical records, including copies of DSS Child Health Summary Component forms, as applicable.

APPENDIX 5: Required Annual Tailored Care Management Refresher Trainings for Care Managers, Care Manager Extenders, and Supervisors

Care managers, care manager extenders, and supervisors must complete the following refresher trainings annually. The course titles below are from the training curriculum developed by AHEC. Tailored Plans / LME/MCOs that develop their own training curriculum instead of using AHEC's should align their refresher trainings to cover the same topics. Care managers, care manager extenders, and supervisors have the full year to complete them (i.e., if a care manager's deployment date is October 2022, the care manager would begin refresher trainings in November 2023 and would need to complete the refresher trainings by October 2024).

1. TCM: DEI, Implicit Bias, and Gaining Cultural Humility and Linguistic Humility for Tailored Care Managers
2. TCM - Increasing Independence through Assistive Technologies
3. TCM: The Intersection of Chronic Disease and Comorbid Behavioral Health Management: An Application of the SBIRT Model in Primary Care
4. TCM Role with Members Involved in the Criminal Justice System
5. TCM Role with Members with I/DD
6. Critical Incident Response and Debriefing
7. TCM: Transitions to Community Living
8. Social Determinants of Health: Practical Strategies for Assessment and Response
9. TCM Person Centered Thinking for Healthcare Professionals
10. TCM: NC Innovations Waiver and Home and Community Based Services
11. TCM: Transitional Care Services
12. Child and Family Treatment Teams in Tailored Care Management

APPENDIX 6: Additional Standard Terms and Conditions for Tailored Plan / LME/MCO Contracts with AMH+ Practices or CMAs to Provide Tailored Care Management to Transitions to Community Living Participants

In the event a participant in Transitions to Community Living (TCL) is served by an AMH+ practice and/or CMA designated to provide Tailored Care Management to TCL participants, the AMH+ practice or CMA must ensure Tailored Care Management includes the following requirements:

1. Policy to Provide Tailored Care Management to TCL Participants: The AMH+ practice or CMA must develop a detailed policy and procedures for providing Tailored Care Management to TCL participants and to coordinate with Tailored Plan / LME/MCO TCL staff performing TCL functions (i.e., transition, diversion, in-reach, complex care). These policies and procedures must include the following:
    a. A clear description of the procedures for coordinating with Tailored Plan / LME/MCO TCL diversion, in-reach, transition, and complex care team staff to ensure that TCL participants are obtaining whole-person, coordinated care management, including:
        i. Procedures for coordinating with TCL staff on communications with TCL participants and guardians (if applicable);
        ii. Approach for establishing communication channels (e.g., in-person Transition Team meetings, videoconference, phone, email) with TCL staff; and
        iii. Timelines for responding to TCL staff requests.
    b. A description of processes that will enable the AMH+/CMA to complete required activities and coordinate with Tailored Plan / LME/MCO TCL staff and transition team, including procedures for:
        i. Tracking activities and providing status updates to TCL staff;
        ii. Collecting vital documents (e.g., IDs, birth certificates);
        iii. Sharing relevant information from participant's care management comprehensive assessment, care plan, and other screenings/assessments to assist TCL staff;
        iv. Identifying, communicating and coordinating with health care providers, including behavioral health providers and other types of providers who are responsible for community integration and tenancy supports;
        v. Educating the individual/legal guardian on the behavioral, physical health, and other recommended services, including supported employment;
        vi. Addressing problems by communicating barriers to the LME/MCO Local Barriers Committee point of contact where the severity of the individual's condition is not considered a transition barrier, yet their condition warrants more complex service and support wraparound (e.g., complex behavioral, medical, and/or functional, social/familial, occupational barriers), systemic barriers (e.g., service providers/provision gaps, managed care limitations,

entitlements, community isolation), and health and safety issues that would hinder or delay transition;

vii. Assisting TCL participants to expand their social networks and retain strong relationships with their natural supports, peer support staff, and peer run organizations;

viii. Ensuring non-housing services and supports are in place prior to move-in to permanent supportive housing or TCL Bridge Housing; and

ix. Adhering to required protocols of Adult Care Homes and State Psychiatric Hospitals when visiting the facility.

c. Plan for care manager to assume leadership of the Care Team, upon handoff from the Transition Coordinator and Transition Team at the conclusion of the follow-along period, in supporting the TCL participant in the community, including:

i. Approach for assessing a participant's community engagement/integration (e.g., employment and education, community activity attendance, unpaid relationship development, etc.);

ii. Procedures for connecting participants to community engagement/integration resources and the transportation planning needed to attend;

iii. Communication protocols for inviting TCL staff to Tailored Care Management Care Team meetings, requesting TCL staff support, and tracking these requests;

iv. Procedures for communicating with TCL staff if there are any housing-related concerns or a housing separation so TCL staff can manage and evaluate the situation (note that TCL staff remain responsible for the participant's housing after transition); and

v. Reporting mechanisms to the Tailored Plan / LME/MCO on TCL participants post-transition, particularly for early identification of participants who are at risk of a housing separation (i.e., a non-tenancy support behavioral health provider is not involved).

d. Template/mock Care Plan for participants in TCL beyond all other required components of a Care Plan for an individual in Tailored Care Management. The Care Plan for TCL participants must include:

i. Natural support and if applicable guardian contact information;

ii. TCL staff contact information;

iii. Adult Care Home or State Psychiatric Facility contact information, including details on the care team;

iv. Details and contact information on where the participant transitions to (e.g., permanent supportive housing, bridge housing);

v. Roles and responsibilities between the care manager and Tailored Plan / LME/MCO TCL staff;

vi. Participant preferences/goals identified through transition process;

vii. Plan and progress on how member is advancing towards those goals;

viii. Approach to addressing personal support needs or systemic barriers that may impact a successful transition, which will be reported to the LME/MCO Local Barriers Committee point of contact; and
ix. Plan for a smooth transition between Tailored Plan / LME/MCO TCL Transition staff and the AMH+/CMA care manager post-follow-along period.

e. Plan for additional required trainings for care managers, care manager extenders, and supervisors serving TCL Participants
    i. Transitions to Community Living (TCL) Overview
    ii. Transitions to Community Living (TCL) Distinction for TCM Training

2. Transition for TCL Participants: The AMH+ practice or CMA must ensure care managers complete the following activities and requirements when a TCL participant transitions to supportive housing:
    a. As a member of the Transition Team, complete care manager responsibilities outlined in the Tailored Care Management Provider Manual, including assisting individuals to expand their social networks, link to supported employment/education services, find transportation to and engage in chosen community activities, and develop and retain strong relationships with their natural supports, peer support staff, and peer run organizations.
    b. Attend all transition planning meetings (in-person, when possible) and participate in discussions as a Transition Team member.
    c. Assist with identifying health care providers (including but not limited to: primary care, physical health, behavioral health, home health, personal care services, occupational therapy, physical therapy, and speech therapy providers) and connecting/linking TCL participants to those providers as needed.
    d. Coordinate with the behavioral health and other types of providers who are responsible for supported employment/education, community integration, and tenancy supports in the follow-along period.
    e. Provide the following Tailored Care Management functions that are not provided through TCL:
        i. Providing non-housing-related care management functions during a TCL participant's transition to supportive housing, including care coordination of health care needs and non-housing, health-related resource needs;
        ii. Completing the care management comprehensive assessments and developing the care plan/ISP (with input from the TCL Transition Coordinator and the In-Reach (IR)/TCL Tool populated by Tailored Plan / LME/MCO TCL staff);
        iii. Conducting Care Team meetings, as needed, and consulting with the multidisciplinary Tailored Care Management care team;
        iv. Providing health promotion services;
        v. Developing and deploying prevention and population health programs (e.g., preventive screenings, addressing broader physical health needs);

vi. Ensuring medication reconciliation/monitoring occurs; and
vii. Conducting ongoing monitoring of 1915(i) services (if applicable).

f. Connect participant with primary care/specialty care and follow up with healthcare providers to ensure that Complex Care Team recommendations are implemented.
g. At the end of the follow-along period (no sooner than 90 days after move-in), participate in Transition Team meeting to identify a participant's ongoing and unmet needs – including those related to employment and community integration – and assist with updating Transition Team staff roles and responsibilities and the participant's ISP or Care Plan accordingly (i.e., determine if the participant is ready for the care manager and Care Team to take the lead in supporting the TCL participant in the community).
h. After determination of participant readiness, assume lead responsibility at the conclusion of the follow-along period in supporting the TCL participant in the community, including assessing a participant's community engagement/integration (including employment and education), acquisition of services addressing their unmet health-related resource needs including transportation, connecting participants to community engagement/integration resources, and communicating transition-related concerns to the Transition Coordinator, specifically those related to housing, employment/education, and community activity/integration.

3. Diversion and In-Reach for TCL Participants: The AMH+ practice or CMA must ensure care managers do not provide the functions provided by Tailored Plan / LME/MCO TCL diversion and in-reach staff. The functions that care managers must not provide include, but are not limited to, the following:
    a. For TCL participants in TCL diversion:
        i. Scheduling visits with participant/guardian to educate about permanent supportive housing options;
        ii. Providing opportunities to meet individuals in the community, family/natural supports, and providers;
        iii. Using diversion tool and Community Integration Planning guidance document to assist with participant education; and
        iv. Documenting decision using Informed Decision-Making tool (or other similar process).
    b. For TCL participants in TCL in-reach:
        i. Meeting with facility owner/administrator to discuss in-reach process;
        ii. Contacting and scheduling meetings with TCL participant/guardian;
        iii. During meetings with participant, exploring interests and needs, options to live in the community, and supports available;
        iv. Providing opportunity to meet peers in the community, family, and providers; and
        v. Using In-Reach/TCL tool and Informed Decision-Making tool to document process and decisions.

APPENDIX 7: Community Inclusion Addendum for Members Not Participating in the Transitions to Community Living Program

This addendum to the Tailored Care Management Provider Manual addresses in-reach and transition requirements for Advanced Medical Home Plus (AMH+) practice and Care Management Agency (CMA)-based care managers providing Tailored Care Management to individuals not participating in the Transitions to Community Living (TCL) program. The Department recognizes that some Tailored Plan / LME/MCO members will benefit from in-reach and transition services and has established requirements for these services that are customized to the needs of different Tailored Plan / LME/MCO populations. AMH+ practices and CMAs are responsible for providing in-reach and transition services for certain assigned members, while specialized Tailored Plan / LME/MCO-based staff are responsible for providing these services for other members, as described in the table below.

AMH+ and CMA-Based Care Managers Responsible for Providing In-Reach and Transition Services	***Tailored Plan / LME/MCO-Based Staff Responsible for Providing In-Reach and Transition Services***
• *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 Adult Care Home (ACH) who are eligible for Tailored Care Management and who are **not** participating in the TCL program.*	• *Members admitted to a state developmental center; and* • *All members participating in the TCL program.*

AMH+s/CMAs should use their clinical judgement to identify and notify the Tailored Plan / LME/MCO if they can no longer be adequately serve a member assigned to them. AMH+/CMAs are encouraged to consult with the Tailored Plan / LME/MCO to collectively make decisions about whether the AMH+/CMA can continue to serve the member's needs.

For more information about the Tailored Plan / LME/MCO-based TCL staff and the members they are responsible for providing in-reach and transition services to, see the above Section V.4.14. Additional Requirements for Participants in TCL. Additional information on TCL in-reach and transition services is available in the TCL In-Reach and Transition Manual.

Community Inclusion Activities

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 are required to provide supports to assigned Tailored Plan / LME/MCO 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.[70]

This addendum describes the specific in-reach and transition activities that AMH+ practice and CMA-based care managers delivering the Tailored Care Management model will be required to perform for assigned members admitted to and residing in an institutional or other congregate setting, including an ACH. 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. 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:[71]

- Children and youth admitted to a state psychiatric hospital, 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*** participating in the TCL program.

In-Reach Activities

AMH+ practices and CMAs are 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

[70] In addition to the in-reach and transition activities described in this addendum, care managers are responsible for providing diversion interventions to members not eligible for the TCL program who are at risk of requiring care in an institutional setting or ACH. For additional information, see Section V.4.8. Transitional Care Management in the Tailored Care Management Provider Manual.

[71] Tailored Plan / LME/MCO-based care managers are responsible for performing in-reach and transition activities for members assigned to Tailored Plans / LME/MCOs for Tailored Care Management.

needs safely met in a community setting. Care managers are 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 are required to 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.

Transition Activities

AMH+ practices and CMAs are 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*** participating in the TCL program, 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 are 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 Section V.7. "Training" of the Tailored Care Management Provider Manual, care managers will also 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.

Additional Support for Care Managers

Tailored Plan / LME/MCO-based staff are available to support and provide consultation to AMH+ practice or CMA-based care managers providing in-reach and transition activities to their assigned members. Care managers will have guidance from Tailored Plan / LME/MCO-based staff for supporting individuals with the most complex needs, such as members with co-occurring disorders or a history of aggression and/or serious self-harm. A Tailored Plan / LME/MCO-based transition supervisor, along with a member of the Tailored Plan / LME/MCO clinical leadership, is required to participate in case discussions and transition planning for members with the most complex needs.