



**Advanced Medical Home Plus (AMH+) and Care Management Agency (CMA)  
Tailored Care Management Temporary Flexibilities and Program Changes**

November 2, 2022

*Updated December 21, 2022*

On September 29, 2022, the North Carolina Department of Health and Human Services (the Department) announced that the launch of Behavioral Health and Intellectual/Developmental Disability (I/DD) Tailored Plans (Tailored Plans) will be delayed until April 1, 2023, while the launch of Tailored Care Management will continue as planned for December 1, 2022. During this period before Tailored Plan launch, the Department aims for LME/MCOs and providers to engage as many eligible members as possible in Tailored Care Management. This is an important first step towards more integrated and coordinated care prior to Tailored Plan launch.

Recognizing this is a time of substantial change for North Carolina Medicaid enrollees, providers, and health plans, the Department will implement temporary flexibilities and program changes for the four month period between Tailored Care Management and Tailored Plan launch (12/1/2022 through 3/31/2023). The purpose of these changes is to give providers who have been certified as an Advanced Medical Home Plus (AMH+) practice or Care Management Agency (CMA) time to gain experience with the model, identify and address unexpected challenges, and be ready to launch the “full” model April 1, 2023.

*NOTE: In this interim period, the state’s local management entity/managed care organizations (LME/MCOs) will operate the model through an amendment to their existing prepaid inpatient health plan (PIHP) contract with the Department. Individuals eligible for the model will still have the option to obtain Tailored Care Management from an AMH+ practice, CMA, or plan-based care manager. Until an eligible individual engages in Tailored Care Management, their LME/MCO will be responsible for care coordination functions as they are today.*

The temporary flexibilities and program changes are as follows and the Department is also releasing revised AMH+/CMA Standard Terms and Conditions to reflect these flexibilities (see Appendix 1):

- 1. Populations Eligible to Receive Tailored Care Management.** Individuals who will be eligible to enroll in a Tailored Plan on April 1, 2023, or who would otherwise meet the clinical eligibility criteria for a Tailored Plan if they were not part of a delayed or excluded population<sup>1</sup> will be eligible to obtain Tailored Care Management on December 1, 2022, with three exceptions. NC Health Choice members, children under age three, and recent immigrants not yet meeting full Medicaid benefit requirements will not be eligible for Tailored Care Management on December 1, 2022, since these

---

<sup>1</sup> For example, an individual who is dually eligible for Medicare and Medicaid who has an I/DD or a child with a serious emotional disturbance who would have been eligible for a Tailored Plan if they were not in foster care.

populations are not served by LME/MCOs today. These delayed populations will be eligible to obtain Tailored Care Management beginning April 1, 2023, when they enroll in Tailored Plans or PIHPs.

- 2. Federal Authority.** To give plans and providers additional time to ramp up their care management and develop the capabilities to meet the full range of Health Home criteria, for the interim period, the State is planning to authorize the Tailored Care Management program using managed care authority (as described in 42 CFR § 438.208) for the LME/MCOs instead of Section 1945 Health Home Authority. The Department has submitted a Health Home State Plan Amendment to the Centers for Medicare and Medicaid Services (CMS) and is in discussion regarding approval of the Health Home benefit for implementation by April 1, 2023.
- 3. Tailored Care Management Assignment.** The Department will oversee Tailored Care Management assignments over this interim period, prioritizing member choice.
- 4. Outreach, Engagement, and Completion of Care Management Comprehensive Assessments.** Recognizing that it will take time for providers to conduct outreach, engage members in Tailored Care Management, and conduct the care management comprehensive assessment, the Department is loosening its expectations regarding the timing for initiating the care management comprehensive assessment during the interim period. CMA and AMH+ care managers will have three months, or ninety (120) days, to initiate contact and complete the care management comprehensive assessment. However, if an enrollee had a care management assessment within the last 12 months that meets all Tailored Care Management comprehensive assessment requirements, this requirement would be satisfied. Care management comprehensive assessments completed in the interim period will still be valid after Tailored Plan launch on 4/1. The Care Plan/ISP should be completed within one month of the care management comprehensive assessment (no change in policy).
- 5. Comprehensive Assessments for Individuals Enrolled in the Innovations or TBI Waivers.** The care manager should align the timing of completing the care management comprehensive assessment and ISP with the annual ISP update (i.e., annual reassessment of a member's needs, which is used to develop an updated ISP).
- 6. Care Plan/Individual Support Plan (ISP).** A care manager does not need to develop a new care plan/ISP if an enrollee has an active care plan/ISP that meets Tailored Care Management requirements and has been completed within the last 12 months.
- 7. Contact Requirements.** To promote operational simplicity at the launch of the model, the Department will be establishing uniform contact requirements for all members that do not vary by acuity level. For all members across the panel, care managers should make an average of two contacts per month; and each member should have at least one in-person contact quarterly. Regardless of this change, the Department will still transmit acuity tier data to LME/MCOs at some point prior to the 4/1/23 full launch to pass on to providers, and LME/MCOs and providers will be expected to use acuity tier data to *guide* the intensity of care management. Additionally, as was

required previously, a member must have a minimum of one contact in a month for the provider to bill for the service for that month.

- 8. Payments.** There will be a single Tailored Care Management payment rate (\$269.66) to reflect uniform contact requirements across acuity levels, with an add-on of \$78.94 for Innovations and TBI waiver participants. LME/MCOs will pay AMH+ practices and CMAs based on the completion of the first contact each month. AMH+s/CMAs will still need to submit a claim to the LME/MCO, and the LME/MCO will pay the provider the rate after the month of service.
- 9. Training.** The Department is requiring that all care managers, supervising care managers, and care manager extenders complete the below core modules within 90 days of hire. Care managers, supervising care managers, and care manager extenders must complete the remaining training modules of the Tailored Care Management training curriculum within six (6) months of hire.
  - a. An overview of the NC Medicaid Delivery system, including Tailored Care Management eligibility criteria, services available through PIHPs and future Tailored Plans, and differences between Standard Plan, PIHP, and Tailored Plan benefit packages
  - b. Principles of integrated and coordinated physical and behavioral health care and I/DD and TBI services
  - c. Knowledge of Innovations and TBI waiver eligibility criteria
  - d. 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
- 10. Community Inclusion Activities:** In-reach and transition activities as specified in the Community Inclusion Addendum (available [here](#)) will not be part of Tailored Care Management in this interim period. LME/MCOs will continue to oversee these activities, consistent with their current contract with the Department.
- 11. Diversions From Institutional Settings.** Diversion activities will not be part of Tailored Care Management in this interim period. LME/MCOs will continue to oversee these activities, consistent with their current contract with the Department. (Provider Manual Section "Diversion")
- 12. System of Care Requirements.** System of Care activities will not be part of Tailored Care Management in this interim period. LME/MCOs will continue to oversee these activities, consistent with their current contract with the Department. (Provider Manual Section "System of Care")

Please direct any comments or questions to [Medicaid.TailoredCareMgmt@dhhs.nc.gov](mailto:Medicaid.TailoredCareMgmt@dhhs.nc.gov).

## **APPENDIX 1: Standard Terms and Conditions for PIHP 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; 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 must ensure that the supervising care manager is qualified to oversee the member’s care manager.
- vi. Each care manager must be supervised by a supervising care manager. One supervising care manager must not oversee more than eight (8) care managers. Supervisors must not carry a member caseload and must provide coverage for care manager vacation, sick leave, and staff turnovers. Supervisors must review all Tailored Care Management care plans and Individual Support Plans (ISPs) and provide guidance to care managers on how to meet members’ needs.
- vii. 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 PIHP's Tailored Care Management training curriculum. All care managers, supervising care managers, and care manager extenders must complete the below core modules within 90 days of hire; care managers, supervising care managers, and care manager extenders must complete the remaining training modules of the Tailored Care Management training curriculum within six (6) months of hire:
  1. An overview of the NC Medicaid Delivery system, including Tailored Care Management eligibility criteria, services available through PIHPs and future Tailored Plans, and differences between Standard Plan, PIHP, and Tailored Plan benefit packages;
  2. Principles of integrated and coordinated physical and behavioral health care and I/DD and TBI services;
  3. Knowledge of Innovations and TBI waiver eligibility criteria; and
  4. 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.
- c. The AMH+ practice or CMA must establish a multidisciplinary care team for each member.
  - i. Depending on the member's needs, the required members of a multidisciplinary care team must include the member, the member's care manager, and the following individuals:
    1. Caretaker(s)/legal guardians;
    2. Supervising care manager;
    3. Care manager extenders (e.g., community navigators, community health workers, individuals with lived experience with an I/DD or a TBI, parents or guardians of an individual with an I/DD or a TBI or a behavioral health condition);
    4. Certified peer support specialist employed by the AMH+ practice, CMA, or CIN or Other Partner, as applicable;
    5. Primary care provider;
    6. Behavioral health provider(s);
    7. I/DD and/or TBI providers, as applicable;
    8. Other specialists;
    9. Nutritionists;
    10. Pharmacists and pharmacy techs;
    11. The member's obstetrician/gynecologist (for pregnant women);
    12. In-reach and transition staff, as applicable; and
    13. Other providers and individuals, as determined by the care manager and member.

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

- d. Track a member’s referrals and provide alerts where care gaps occur;
      - e. Monitor a member’s medication adherence;
      - f. Transmit and share reports and summary of care records with care team members;
      - g. Support data analytics and performance;
      - h. Transmit quality measures (where applicable); and
    - 8. Help schedule and prepare members (via, e.g., reminders and transportation) for appointments.
  - iii. The AMH+ practice or CMA must be able to receive and use enrollment data from the PIHP 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 PIHP;
    - 2. Receive, in a machine-readable format, and maintain up-to-date records of any other risk scoring completed and shared by the PIHP; and
    - 3. Electronically reconcile the Tailored Care Management assignment lists received from the PIHP with its list of members for whom it provides Tailored Care Management.
  - iv. The AMH+ practice or CMA must access admission, discharge, transfer (ADT) data that correctly identifies when members are admitted, discharged, or transferred to or from an emergency department (ED) or a hospital in real time or near-real time.
    - 1. The AMH+ practice or CMA must implement a systematic, clinically appropriate process with designated staffing for responding to certain high-risk ADT alerts, including:
      - a. Real-time (within minutes/hours) response to notifications of ED visits, for example by contacting the ED to arrange rapid follow-up;
      - b. Same-day or next-day outreach for designated high-risk subsets of the population; and
      - c. Additional outreach within several days after the alert to address outpatient needs or prevent future problems for other patients who have been discharged from a hospital or an ED (e.g., to assist with scheduling appropriate follow-up visits or medication reconciliations post-discharge).
  - v. AMH+ practices and CMAs must:
    - 1. Use NCCARE360 as their community-based organization and social service agency resource repository to identify local community-based resources;
    - 2. Refer members to the community-based organizations and social service agencies available on NCCARE360; and
    - 3. Track closed-loop referrals.
- b. AMH+ practices and CMAs must meet quality measurement requirements:



- i. AMH+ practices and CMAs must gather, process, and share data with PIHPs 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 PIHP'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 PIHP.
  - b. Communication: AMH+ practices and CMAs must develop policies for communicating and sharing information with members and their families and other caregivers with appropriate consideration for language, literacy, and cultural preferences, including sign language, closed captioning, and/or video capture. "Robocalls" or automated telephone calls that deliver recorded messages will not be an acceptable form of contacting members.
  - c. Contact Requirements: AMH+ practices and CMAs must have at least two (2) care manager-to-member contacts per month and at least one (1) in-person contact with the member quarterly (includes care management comprehensive assessment if it was conducted in-person).
    - i. For members with an I/DD or a TBI who have a guardian, and for children/adolescents with a parent/guardian, telephonic contact may be with a guardian in lieu of the member, only where appropriate or necessary. In-person contact must involve the member.
    - ii. In the event that a care manager or extender delivers multiple contacts to a member in one day, only one contact shall count towards meeting the contact requirements.
    - 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 must initiate contact and start the care management comprehensive assessment with all members within 120 days of Tailored Care Management enrollment.
    - ii. In the event that a member has a current completed care management comprehensive assessment that meets all Tailored Care Management comprehensive assessment requirements for a particular member within the last 12 months, that care management comprehensive assessment may be used to satisfy this requirement.

- iii. As part of completing the care management comprehensive assessment, the assigned care manager must ask for the member's consent for participating in Tailored Care Management. As part of the consent process, the care manager must explain the Tailored Care Management program. Care managers should document in the care management data system that the member provided consent, including the date of consent.
- iv. The care management comprehensive assessment must include, at a minimum, the following domains:
  - 1. Immediate care needs;
  - 2. Current services and providers across all health needs;
  - 3. Functional needs, accessibility needs, strengths, and goals;
  - 4. Other state or local services currently used;
  - 5. Physical health conditions, including dental conditions;
  - 6. Current and past mental health and substance use status and/or disorders, including tobacco use disorders;
  - 7. Physical, intellectual, or developmental disabilities;
  - 8. Detailed medication history – a list of all medicines, including over-the-counter medication and medication that has been prescribed, dispensed, or administered – and known allergies;
  - 9. Advance directives, including psychiatric advance directives;
  - 10. Available informal, caregiver, or social supports;
  - 11. Standardized unmet health-related resource need questions (to be provided by the Department) covering four priority domains:
    - a. Housing instability;
    - b. Transportation insecurity;
    - c. Food insecurity; and
    - d. Interpersonal violence/toxic stress;
  - 12. Any other ongoing conditions that require a course of treatment or regular care monitoring;
  - 13. For adults only, exposure to adverse childhood experiences (ACEs) or other trauma;
  - 14. Risks to the health, well-being, and safety of the member and others (including sexual activity and potential abuse/exploitation, or exposure to second hand smoke/aerosols and other substances);
  - 15. Cultural considerations (ethnicity, religion, language, reading level, health literacy, etc.);
  - 16. Employment/community involvement;
  - 17. Education (including individualized education plan and lifelong learning activities);
  - 18. Justice system involvement (adults) or juvenile justice involvement and/or expulsions or exclusions from school (children and adolescents);
  - 19. Risk factors that indicate an imminent need for LTSS;
  - 20. The caregiver's strengths and needs;

21. Upcoming life transitions (changing schools, changing employment, moving, etc.);
  22. Self-management and planning skills;
  23. Receipt of and eligibility for entitlement benefits;
  24. For members with an I/DD or a TBI:
    - a. Financial resources and money management;
    - b. Alternative guardianship arrangements, as appropriate;
  25. For children ages zero up to three, incorporate questions related to Early Intervention (EI) services for children, including:
    - a. Whether the child is receiving EI services;
    - b. The child's current EI services;
    - c. Frequency of EI services provided;
    - d. Which local Children's Developmental Service Agency (CDSA) or subcontracted agency is providing the services; and
    - e. Contact information for the CDSA service coordinator; and
  26. For children ages three up to 21 with a mental health disorder and/or substance use disorder (SUD), including members with a dual I/DD and mental health diagnosis, incorporate a strengths assessment process that promotes the identification of the functional strengths of each youth, family, and community.
- v. The AMH+ practice or CMA must attempt a care management comprehensive assessment for members already engaged in care management:
1. When the member's circumstances, needs, or health status changes significantly;
  2. 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);
  3. At the member's request; or
  4. After "triggering events", defined as follows:
    - a. Inpatient hospitalization for any reason;
    - b. Two emergency department visits since the last care management comprehensive assessment (including reassessment);
    - c. An involuntary treatment episode;
    - d. Use of behavioral health crisis services;
    - e. Arrest or other involvement with law enforcement/the criminal justice system, including the Division of Juvenile Justice;
    - f. Becoming pregnant and/or giving birth;
    - g. A change in member circumstances that requires an increased need for care, a decreased need for care, transition into or out of an institution, or loss of a family/friend caretaker, or any other circumstance the plan deems to be a change in circumstance;
    - h. Loss of housing; and

- i. Change in foster care placement or living arrangement (including aging out of the child welfare system).
  - vi. The AMH+ practice or CMA must ensure that the results of the care management comprehensive assessment are made available to the member's primary care, behavioral health, I/DD, TBI, and LTSS providers and the PIHP 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; and
    5. For TBI waiver enrollees: Rancho Los Amigos Levels of Cognitive Functioning Scale (as applicable).
  - ii. AMH+ practices and CMAs must ensure that all care plans and ISPs developed under Tailored Care Management include the following minimum elements:
    1. Names and contact information of key providers, care team members, family members, and others chosen by the member to be involved in planning and service delivery;
    2. Measurable goals;
    3. Clinical needs, including any behavioral health, I/DD-related, TBI-related, or dental needs;
    4. Interventions including addressing medication monitoring, including adherence;
    5. Intended outcomes;
    6. Social, educational, and other services needed by the member;
    7. Strategies to increase social interaction, employment, and community integration;
    8. An emergency/natural disaster/crisis plan;
    9. Strategies to mitigate risks to the health, well-being, and safety of the members and others;
    10. Information about advance directives, including psychiatric advance directives, as appropriate;

11. A life transitions plan to address instances where the member is changing schools, experiencing a change in caregiver/natural supports, changing employment, moving or entering another life transition;
  12. Strategies to improve self-management and planning skills; and
  13. For members with I/DD, TBI, or serious emotional disturbance (SED), the ISP should also include caregiver supports, including connection to respite services, as necessary.
- iii. 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.
  - iv. For members in the Innovations or TBI waivers, the AMH+ practice or CMA must align the timing of completing the care management comprehensive assessment and ISP with the annual ISP update (assessment to inform revised ISP).
  - v. The AMH+ practice or CMA does not need to complete a new care plan or ISP for members with an active care plan or ISP in the previous 12 months that meets all Tailored Care Management requirements.
  - vi. 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. When the member’s circumstances or needs change significantly;
    2. At the member’s request;
    3. Within 30 days of care management comprehensive (re)assessment; and/or
    4. After triggering events (see above).
  - vii. The AMH+ practice or CMA must monitor the completion of care plans/ISPs and review them for quality control.
  - viii. 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 PIHP;
    3. Other providers delivering care to the member;
    4. The member’s legal representative (as appropriate);
    5. The member’s caregiver (as appropriate, with consent);
    6. Social service providers (as appropriate, with consent); and
    7. Other individuals identified and authorized by the member.
- f. Care Coordination: The AMH+ practice or CMA must ensure the member has an ongoing source of care and coordinate the member’s health care and social services, spanning physical health, behavioral health, I/DD, TBI, LTSS, pharmacy services, and services to

- address unmet health-related resource needs. In delivering care coordination the AMH+ practice or CMA must:
- i. Follow up on referrals and work with the member's providers to help coordinate resources during any crisis event as well as provide assistance in scheduling and preparing members for appointments (e.g., reminders and arranging transportation) and
  - ii. Provide referral, information, and assistance in obtaining and maintaining community-based resources and social support services, including LTSS; I/DD and TBI services (including Innovations and TBI waiver services); and any State-funded services.
- g. Twenty-four-Hour Coverage: The AMH+ practice or CMAs must provide or arrange for coverage for services, consultation or referral, and treatment for emergency medical conditions, including behavioral health crisis, 24 hours per day, seven days per week. The AMH+ practice or CMA must:
- i. Share information such as care plans and psychiatric advance directives, and
  - ii. Coordinate care to place the member in the appropriate setting during urgent and emergent events. Automatic referral to the hospital ED for services does not satisfy this requirement.
- h. Annual Physical Exam: The AMH+ practice or CMA must ensure that the member has an annual physical exam or well-child visit, based on the appropriate age-related frequency.
- i. Continuous Monitoring: The AMH+ practice or CMA must conduct continuous monitoring of progress toward goals identified in the care plan or ISP through face-to-face and collateral contacts with the member and his or her support member(s) and routine care team reviews. The AMH+ practice or CMA must support the member's adherence to prescribed treatment regimens and wellness activities.
- j. Medication Monitoring: The AMH+ practice or CMA must conduct medication monitoring, including regular medication reconciliation (conducted by the appropriate care team member) and support of medication adherence, and metabolic monitoring (for individuals prescribed antipsychotic medications). A community pharmacist at the CIN level, in communication with the AMH+ practice or CMA, may assume this role.
- k. Individual and Family Supports: The AMH+ practice or CMA must incorporate individual and family supports by performing the following activities at a minimum:
- i. Educate the member in self-management;
  - ii. Educate and provide guidance on self-advocacy to the member, family members, and support members;
  - iii. Connect the member and caregivers to education and training to help the member improve function, develop socialization and adaptive skills, and navigate the service system;
  - iv. Provide information and connections to needed services and supports including but not limited to self-help services, peer support services, and respite services;
  - v. Provide information to the member, family members, and support members about the member's rights, protections, and responsibilities, including the right to change providers, the grievance and complaint resolution process, and fair hearing processes;

- vi. Promote wellness and prevention programs;
- vii. Provide information on establishing advance directives, including psychiatric advance directives as appropriate, and guardianship options/alternatives, as appropriate;
- viii. Connect members and family members to resources that support maintaining employment, community integration, and success in school, as appropriate; and
  - 1. For high-risk pregnant women, inquiring about broader family needs, offering guidance on family planning, and beginning discussions about the potential for an Infant Plan of Safe Care.
- I. 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.
- m. Unmet Health-Related Resource Needs: The AMH+ practice or CMA must ensure that Tailored Care Management addresses unmet health-related resource needs by performing the following activities at a minimum:
  - i. Provide referral, information, and assistance in obtaining and maintaining community-based resources and social support services, including:
    - 1. Disability benefits;
    - 2. Food and income supports;
    - 3. Housing;
    - 4. Transportation;
    - 5. Employment services;
    - 6. Education;
    - 7. Financial literacy programs;
    - 8. Child welfare services;
    - 9. After-school programs;
    - 10. Rehabilitative services;
    - 11. Domestic violence services;
    - 12. Legal services;
    - 13. Services for justice-involved populations; and
    - 14. Other services that help individuals achieve their highest level of function and independence.
  - ii. Provide comprehensive assistance securing health-related services, including assistance at initial application and renewal with filling out and submitting applications and gathering and submitting required documentation, including in-person assistance when it is the most efficient and effective approach, at a minimum, for:
    - 1. Food and Nutrition Services;
    - 2. Temporary Assistance for Needy Families;

3. Child Care Subsidy;
  4. Low Income Energy Assistance Program;
  5. NC ABLE Accounts (for individuals with disabilities);
  6. Women, Infants, and Children (WIC) Program; and
  7. Other programs managed by the PIHP 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.
  - n. Extenders may support care managers in delivering Tailored Care Management by performing activities that fall within the below categories. When an extender performs one of the functions listed below, it may count as a Tailored Care Management contact if phone or video and audio or in-person contact with the member is made:
    - i. Performing general outreach, engagement, and follow-up with members;
    - ii. Coordinating services/appointments (e.g., appointment/wellness reminders, arranging transportation);
    - iii. Engaging in health promotion activities (as defined in the Tailored Care Management Provider Manual) and knowledge sharing;
    - iv. Sharing information with the care manager and other members of the care team on the member's circumstances;
    - v. Providing and tracking referrals and providing information and assistance in obtaining and maintaining community-based resources and social support services;
    - vi. Participating in case conferences;
    - vii. Support the care manager in assessing and addressing unmet health-related resource needs.
  - o. A care manager must be solely responsible for:
    - i. Completing the care management comprehensive assessment;
    - ii. Developing the care plan (for members with behavioral health needs) or individual support plan (ISP) (for members with I/DD and TBI needs);
    - iii. Facilitation of case conferences;
    - iv. Ensuring that medication monitoring and reconciliation occur;
    - v. Continuous monitoring of progress toward the goals identified in the care plan or ISP; and
    - vi. Managing care transitions, including creating 90-day transition plans.
4. Payments
- a. To access the per member per month (PMPM) payment for any given member, the AMH+ practice or CMA must deliver at least one care management contact during the month for that member (i.e., providers will not be paid in months in which there were no member



contacts). The AMH+ practice or CMA must submit a claim to the PIHP, and the PIHP must pay the provider the PMPM rate after the month of service.

- b. Only contacts delivered by the assigned care manager or extender shall count towards meeting the contact requirements and be eligible for payment. In the event that the supervising care manager is providing coverage for a care manager (e.g., sick leave, vacation, staff turnovers) and delivers a contact to a member, the contact shall count towards meeting contact requirements and be eligible for payment.

#### 5. Oversight

- a. The AMH+ practice or CMA must comply with oversight requirements established by the PIHP 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 PIHP, 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 PIHP may terminate its contract with the AMH+ practice or CMA.