

DESK REVIEW GUIDE AND EVALUATION TOOL

Certification Process for Provider Organizations Applying as AMH+ Practices or CMAs to Perform Tailored Care Management

Overview

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

The Department will conduct an AMH+ and CMA certification process to promote provider-based care management while also setting up guardrails to ensure that providers are ready to perform this critical role by Behavioral Health I/DD Tailored Plan launch. There are four stages of the AMH+ and CMA certification process: (1) Providers interested in being certified to deliver Tailored Care Management as an AMH+ or CMA will submit a written application to the Department. (2) The Department will first conduct a “desk review” of every application. The purpose of the desk review will be to determine whether the organization has the potential, based on Department established criteria outlined in the Tailored Care Management Provider Manual and this application, to satisfy the full set of Tailored Care Management criteria at Behavioral Health I/DD Tailored Plan launch. (3) If the Department determines that an organization has the potential to meet all certification criteria by launch, the Department will arrange to conduct one or more site visits. At the conclusion of the site visit(s), the Department will determine whether to certify each organization. (4) After the conclusion of the certification process, Behavioral Health I/DD Tailored Plans will conduct readiness reviews and further site visits as part of contracting with AMH+ practices and CMAs.

This document serves as a guide for individuals designated by the Department as “Reviewers” to review and rate responses to the North Carolina Medicaid AMH+ and CMA Certification Application for Tailored Care Management at the desk review stage. The Department is also making this document publicly available to give applicants more guidance on what Reviewers will be looking for when assessing an application (see note to applicants on pages 2-3.)

The Tailored Care Management certification requirements are set forth in the Tailored Care Management [Provider Manual](#).¹ When reviewing applications, Reviewers will need to reference the [Provider Manual](#) and [Application Questions](#). Reviewers may also wish to reference the Tailored Care Management [Data Strategy Policy Paper](#), which elaborates on health IT and data-related requirements.

¹ The BH I/DD Tailored Plan Request for Applications (RFA) also contains the Tailored Care Management requirements. To the extent that any requirements vary between the Provider Manual and the RFA, AMH+ and CMA applicants will only be evaluated on the requirements in the Provider Manual during the desk review stage. Providers will be evaluated on any other requirements detailed in the RFA during the site visit stage.

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This guide provides Reviewers with guidance for how to rate each provider application, based on a review of two types of criteria:

- 1. Preliminary Application Review Criteria** – criteria that each organization must meet **in full** in order for the Department to process the application. If organization does not meet **all** preliminary review criteria at the time of application, the rest of the application will not be evaluated, and the organization will not advance to the site visit stage. There are 11 required preliminary review criteria (see page 6).
- 2. Rating Criteria** – criteria that Reviewers will rate on a 3-point rating scale of *does not meet*, *partially meets*, and *meets*. Ratings of *partially meets* or *meets* would be considered a passing rating that moves the application forward to the site visit stage. There are 15 rating criteria (see below).² For each of these criteria, the Reviewer is asked to assess the strength of the provider’s response relative to the criteria in the Provider Manual. Organizations are not expected to meet these criteria fully today, but are expected to be able to articulate a plan for readiness by Behavioral Health I/DD Tailored Plan launch, applying the following rating definitions:

Rating	Rating Definition
Meets	Organization articulates a clear understanding of the requirements and clearly describes how it either: <ol style="list-style-type: none">Fully meets the requirements today, orHas a concrete strategy and realistic timeline to meet the requirements fully by Behavioral Health I/DD Tailored Plan launch.
Partially Meets	Organization generally understands the requirements and includes a strategy and realistic timeline to meet the requirements by Behavioral Health I/DD Tailored Plan launch, but the current strategy does not concretely define one or more key elements of the requirements.
Does Not Meet	Organization has described a strategy that does not demonstrate a clear understanding of the requirements and/or does not include specific actions to ensure that the requirements are fully met in time for Behavioral Health I/DD Tailored Plan launch.

Note to Applicants:

In forming your responses to the application questions, please take special note that Reviewers will look for details on *how* your organization will address the requirement that is the focus of the question. Your answers should not merely repeat the Tailored Care Management Provider Manual language accompanied by a commitment that your organization will perform the requirements. Instead, your answers should specify the processes, personnel, outside resources, etc. that your organization will use to operationalize each aspect of the Tailored Care Management model and achieve its objectives.

² For organizations seeking certification to provide Tailored Care Management for the Innovations and TBI waiver populations, there are 16 evaluated criteria.

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The purpose of the desk review is to determine that the applicant organization has given serious thought as to how it will operationalize the Tailored Care Management model, including an overview of the policies and procedures that will be needed or revised to efficiently operate the model. In addition to describing your organization’s proposed approach to implementing Tailored Care Management, you should ensure that your application identifies perceived challenges to implementation and associated mitigation strategies to address each challenge. By providing this information in your response, it will help the Department confirm your understanding of the complexity of this undertaking and awareness of the potential changes to your organization’s existing financial and clinical operations that may be required to be successful.

Desk Review Process Flow



- 1. Preliminary Application Review:** Prior to Reviewers evaluating each application, a designated “Gatekeeper” will conduct a Preliminary Application Review before redacting the organization’s name on the application. This review will entail the following:
 - a. AMH+ Applications
 - i. Check each incoming application for required **preliminary review criteria**, including general **eligibility** to be an AMH+ (see pages 6-7). If organization does not meet all preliminary review criteria, notify organization and do not evaluate application.
 - ii. Check each incoming application for **completeness**. If application is not complete, notify organization; if organization is able to rectify within one week after application submission deadline for current desk review round, it may resubmit. If one-week buffer has passed, notify organization of timeline for next review cycle.
 - iii. If AMH+ application has met preliminary review criteria and is complete, **notify** organization that application has been received and will undergo the desk review evaluation process.
 - iv. **Redact name of organization throughout application and assign unique identifier for each application.** Reviewers will review applications “blind.”
 - b. CMA Applications
 - i. Check each incoming application for required **preliminary review criteria**, except eligibility, which Reviewers will determine in step 2 below. If organization does not meet all preliminary review criteria, notify organization and do not evaluate application.
 - ii. Check each incoming application for **completeness**. If application is not complete, notify organization; if organization is able to rectify within one week after application submission deadline for current desk review round, it may resubmit. If one-week buffer has passed, notify organization of timeline for next review cycle.

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- iii. **Redact name of organization throughout application and assign a unique identifier for each application.** Reviewers will review applications “blind.”

2. Review Team Secondary Checks:

- a. Assign each application to a **review team of three individuals plus fiscal specialist.**
- b. For CMA applications, determine **eligibility** (see page 7). If organization does not meet eligibility requirements, notify organization of reason for ineligibility and do not evaluate application. Because the CMA eligibility determination is qualitative in nature, CMA applicants that disagree with a CMA eligibility determination may pursue a reconsideration process. Under the reconsideration process, trained members of the review team who did not previously review the application would conduct a separate review and arrive at a determination of whether the organization is eligible to become a CMA. Applicants that are determined not to meet CMA eligibility criteria under the reconsideration may pursue an appeal through Office of Administrative Hearings (OAH), if desired.
- c. (If applicable) Before completing full review of each application, review team collectively determines whether a single application should be evaluated and rated separately for different populations at the desk review stage. In the Provider Manual, the Department reserves the option to grant or deny certification separately for different populations and/or for different Behavioral Health I/DD Tailored Plan regions. For example, a large agency may have separate operations for I/DD and behavioral health. **Note that even if the desk review creates only one rating across populations, the Department could still come to different certification decisions by population after the site review.** When deciding whether to create multiple ratings by population per application, Reviewers should balance the objectives of (1) keeping the desk review simple with (2) taking into account significant differences within the organization that are clear on the face of the application. To assess, **refer to application question C3 for the populations for which the organization is applying for certification** and consider the following questions:
 - i. Is there a difference in length of experience between populations (question C6)?
 - ii. Is there a difference in the staffing model and recruitment strategy (questions D1-2)?
 - iii. Is there a difference in how the care team will be constructed across populations (question E8)?
 - iv. Is there a difference in health IT readiness across populations (e.g., if different providers within the organization use different platforms) (questions F1-4)?

If the answer to one or more of these questions is yes and the differences between populations are meaningful, Reviewers should consider evaluating the application separately for each population.

3. **Desk Reviews:** Review team collectively (a) reviews each application; (b) arrives at rating determination of *does not meet*, *partially meets*, or *meets* for each rated category (i.e., Categories 2-6); and (c) determines overall rating of “pass” or “fail” for the application.
 - a. Fiscal specialist joins a portion of the team meeting to inform the rating determination for Category 2: Organizational Standing/Experience.

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- b. Review team uses the following prioritization/ranking order to qualitatively determine an **overall rating for the application** (i.e., pass/fail determination of whether the application should proceed to the site review). This order is listed from the categories considered most to least important in determining overall rating:
 - i. Category 2. Organizational Standing/Experience
 - ii. Category 4. Delivery of Tailored Care Management
 - iii. Category 3. Staffing
 - iv. Category 5. Health IT
 - v. Category 6. Quality Measurement and Improvement
4. **Decision Conveyed to Applicant:** Short written notification is sent to each applicant: If applicant fails the desk review, the notification identifies areas of deficiency.
5. **Reconsideration (if applicable):** Providers that fail the desk review may pursue a reconsideration process whereby trained members of the review team who did not previously review that application conduct a complete review and arrive at a pass/fail determination (e.g., if Review Team A conducted the initial review, then Review Team B would conduct the reconsideration review. Review Team B would not be informed that the review is a reconsideration).
 - a. A new fiscal specialist would be identified for the reconsideration review.
 - b. Providers that fail via the reconsideration process may pursue an appeal through OAH, if desired.
 - c. Providers that pursue a reconsideration will not be permitted to update applications in the same round before the reconsideration review; instead, if a provider fails the initial review, and updates the application based on feedback, the provider can re-submit the updated application during a future round.

Draft updated 4/6/2021 – The Department reserves the right to release additional updates.

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Checklist for Preliminary Application Review Criteria

Organization must meet all preliminary review criteria. If the organization does not meet all items, do not evaluate the application.

- Eligible to apply (see next page)**
- Attested to question 8 on cover sheet (Board approval of application)
- Provided attachment per question B7 (most recently audited financial report)
- Provided attachment per question B9 (organizational chart)
- Attested to question C1 (intention to complete all requirements)
- Attested to question C5 (behavioral health I/DD patient panel volume – **AMH+ applicants only**)
- Attested to question E1 (develop written policies and procedures for communication)
- Attested to question E11 (24-hour coverage)
- Attested to question E13 (operational admission, discharge, and transfer (ADT) system – **AMH+ applicants only**)
- Attested to question F1 (electronic health record (EHR))
- Attested to question H1 (intention to attend required trainings)

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Category 1: Eligibility (preliminary review criterion; not evaluated)

Organization must meet eligibility criteria in full (see Provider Manual page 5). If organization clearly does not meet all eligibility criteria (e.g., not an NC Medicaid provider), do not evaluate the application.

AMH+ Applications

- Practice is currently included in NC Tracks as a Tier 3 AMH practice.
- Practice has 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 (question C5).

CMA Applications

- Organization’s primary purpose is the delivery of NC Medicaid, NC Health Choice, or State-funded services, other than care management, to the Behavioral Health I/DD Tailored Plan eligible population in North Carolina (*the bullets below provide illustrative examples of considerations that will be taken into account to determine whether an organization meets this criterion; these bullets are not all inclusive*):
 - 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) – as indicated by questions B1-B3 and B5; and/or
 - Provision of behavioral health, I/DD, and/or TBI services, besides those covered in NC Medicaid Clinical Coverage Policies [8C](#) and [8B](#), to the Behavioral Health I/DD Tailored Plan eligible population is integral to the organization’s mission.

Category 2: Organizational Standing/Experience

2.1. Relevant experience

- **Certification requirement [Provider Manual, p. 14].** *The organization must demonstrate that its past experience positions it to provide Tailored Care Management to the Behavioral Health I/DD Tailored Plan population, specifically the subpopulation(s) for whom it proposes to become a certified Tailored Care Management provider. All organizations entering the certification process will be 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): 1) mental health and substance use disorder, 2) I/DD, 3) TBI, 4) Innovations waiver, 5) TBI waiver, and/or 6) co-occurring I/DD and behavioral health. Agencies that specialize in behavioral health will be required to demonstrate their willingness and 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 populations in North Carolina. **The Department has a general expectation that each organization will be able to show at least a two-year history of providing services to the Behavioral Health I/DD Tailored Plan population in North Carolina.***

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- Refer to questions **B1, C3-C6**.
- Look for:
 - *In question C6, the length of the organization’s history of services aligns with the population(s).*
 - *For behavioral health agencies, the organization’s level of experience treating individuals with both mental health and SUD needs (question C6).*

2.2. Provider Relationships and Linkages

- **Certification requirement [Provider Manual, p. 15].** *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.*
- Refer to question **D4**.
- Look for:
 - *The extent to which the organization has one or more contracts or formal relationships in place with at least one organization in a category that is outside the applicant’s designation, across behavioral health, I/DD, primary care, and social services (to receive a rating of meets, organization must have at least three contracts or formal relationships in distinct categories outside of the applicant’s designation; to receive a rating of partially meets, organization must have at least one of these contracts or formal relationships).*
 - *The concreteness and clarity of the organization’s plan to strengthen and formalize relationships with specific providers in at least one of the provider types listed in question D4.*

2.3. Capacity and Sustainability

- **Certification requirement [Provider Manual, p. 15].** *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.*
- Refer to questions **A6, B2-B9, D3**, audited financial statements, and organizational chart attachments (rated by Department’s fiscal specialist).
- Look for:
 - *GAAP balanced budget, positive fund balance, and 60 days cash on hand.*

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- *An organizational chart that indicates who is responsible for budget and financial management.*
- *Clear understanding of where Tailored Care Management will fit into the organization (e.g., title of the executive who will have accountability for Tailored Care Management, supervisory structure for care management, key non-clinical supporting staff identified).*
- *For each population for which the organization has applied to provide Tailored Care Management, evidence that the organization has considered whether Medicaid client volume for the age(s)/disability(ies) applied for are enough to sustain the service line for the organization.*

2.4. Oversight

- **Certification requirement [Provider Manual, p. 15].** *The organization must be able to demonstrate that it has the appropriate structures in place to oversee the Tailored Care Management model. The Department will look for evidence of a strong governance structure. Organizations may demonstrate strong governance by showing that they have a governing board and bylaws in place; a committee structure that enables appropriate oversight of budget, other fiduciary matters, compliance, and conflicts of interest; and board approval of the application submitted by the organization.*
- Refer to questions **A6, B9** and organizational chart and bylaws (if attached).
- Look for:
 - *Organization has provided chart showing reporting relationships among senior executive/management leadership and has described how these relationships correspond to Tailored Care Management.*

Category 3: Staffing

3.1. Care Management Staff

- **Certification requirement [Provider Manual, p. 15-16].** *The organization must be able to ensure that all care managers providing Tailored Care Management meet the following minimum qualification requirements, whether they are employed by the organization itself or employed at the Clinically Integrated Network (CIN) or Other Partner level [see Provider Manual p. 15-16 for qualification requirements]. The organization must ensure that each care manager is supervised by a supervising care manager. One supervising care manager must not oversee more than eight care managers. Supervisors should have no caseload, but will provide coverage for vacation, sick leave, and staff turnovers. They will be responsible for reviewing all Tailored Care Management care plans and Individual Support Plans (ISPs) for quality control and will provide guidance to care managers on how to meet members' needs.*
- Refer to questions **D1-D3, D5, C9** and the attached MOU between the organization and the CIN or Other Partner (if applicable).

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- *Note: Most/all organizations will NOT have required care manager staffing in place at time of application. The Department review should be based around evidence that the organization has thought through the necessary staffing ramp-up. Look for:*
 - *Clear description of the number of current staff who meet the minimum qualifications for Tailored Care Management.*
 - *Analysis of number of Tailored Care Management staff needed that is clearly linked to both (1) estimated population and population types given in the application and (2) clearly linked to required supervisor ratios. Approximate quantifications are acceptable.*
 - *In question C9, if organization will secure Tailored Care Management staff employed at the CIN level, the degree to which the description ensures managerial control is retained at the provider level.*
 - *In question D2, credibility of the recruitment strategy that includes clear timelines and sources for staff.*

3.2. Clinical Consultants

- **Certification requirement [Provider Manual, p. 16].** *The Behavioral Health I/DD Tailored Plan will be required to ensure that organizations providing Tailored Care Management (AMH+ practices, CMAs, or the Behavioral Health I/DD Tailored Plan itself) have access to clinical consultants in order to access expert support appropriate for the needs of the panel under Tailored Care Management. Clinical consultants are not part of the care team for any given member; rather, the role of clinical consultants is to provide subject matter expert advice to the care team. The AMH+ or CMA may employ or contract with consultants or do so through a CIN or Other Partner, and the consultant should be available by phone to staff within AMH+ practices and CMAs to advise on complex clinical issues on an ad hoc basis. While different member needs will require different expertise, the AMH+ or CMA must ensure that it has access to at least the following experts:*
 - *An adult psychiatrist or child and adolescent psychiatrist (based upon the population served)*
 - *A neuropsychologist or psychologist*
 - *For CMAs, a primary care physician to the extent that the beneficiary's PCP is not available for consultation.*

AMH+ practices and CMAs may demonstrate that they have access to clinical consultants themselves, or via the CIN or Other Partner, or can contract with other provider organizations to arrange access.

- Refer to question **D5**.
- Look for:
 - *Clarity with which the organization describes relationships with clinicians in at least two of the categories of clinical consultant that are appropriate for the proposed population.*
 - *Demonstrated understanding of how the organization would leverage these clinical consultants to support Tailored Care Management (e.g., when core clinical care team members or ancillary clinical team members, such as sub-specialists, are not available*

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due to vacation, sick leave, or lack of after-hours coverage; when there is disagreement within the clinical team; when evidence-based treatments are not working and/or unavailable).

- *Note: Most or all organizations will NOT have the required clinical consultants in place at the time of the application; this is acceptable.*

Category 4: Delivery of Tailored Care Management

4.1. Policies and Procedures for Communication with Members

- **Certification requirement [Provider Manual, p. 17].** *The AMH+ or CMA must develop policies (to be approved by the Behavioral Health I/DD Tailored Plan) for communicating and sharing information with individuals and their families and other caregivers with appropriate consideration for language, literacy, and cultural preferences, including sign language, closed captioning, and/or video capture. “Robocalls” or automated telephone calls that deliver recorded messages will not be an acceptable form of contact.*
- **This requirement is not rated.** (Attestation of Board approval is a preliminary review criterion.)

4.2. Capacity to Engage with Members through Frequent Contact

- **Certification requirement:** *See Manual p. 17-18.*
- Refer to questions **E2-E3, D2-D3.**
- Look for:
 - *Clear description of how organization is linking minimum contact requirements to staffing planning (questions D2 and D3) and the population that will be under care management, in its planning assumptions.*
 - *Specific description of any situations in which organization may be challenged to meet contact requirements, and potential solutions to those challenges (e.g., COVID-19, in rural areas, transportation barriers, language barriers).*

4.3. Care Management Comprehensive Assessments and Reassessments

- **Certification requirement:** *See Provider Manual p. 18-20.*
- Refer to question **C7, E4.**
- Look for:
 - *Description that includes specifics of how the organization approaches assessment and reassessment (e.g., reference to current assessment tools and description of how they would be adapted for Tailored Care Management, reference to who will perform the assessment, where and how).*

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- *Evidence of tailoring the assessment requirements to the population served by the organization.*
- *Understanding of the challenge of conducting assessments within 60 or 90 days of Behavioral Health I/DD Tailored Plan enrollment and strategies to implement.*

4.4. Care Plans and ISPs

- **Certification requirement:** *See Provider Manual p. 20-22.*
- Refer to questions **C7, E4-E7, F3.**
- Look for:
 - **Question E4:** *Description includes specifics of how the comprehensive care management assessment will drive the content of the care plan/ISP; specifics on how whole person needs (physical, behavioral, I/DD, LTSS, etc.) will be reflected in care plans/ISPs.*
 - **Question E5:**
 - *Description includes specifics of how the organization will approach development of written care plans/ISPs, linking to current practices and clearly describing how this would be adapted to Tailored Care Management.*
 - *Description includes specifics of how the organization will ensure accurate medication monitoring, including regular medication reconciliation (conducted by the appropriate care team member) and support of medication adherence.*
 - **Question E6:** *Description includes specifics of how the organization will monitor and update the care plan/ISP as individuals' needs change.*

4.5. Care Teams

- **Certification requirement:** *See Provider Manual p. 22-23.*
- Refer to questions **E8-E9, F3, F5.**
- Look for:
 - **Questions E8-E9:**
 - *Clear and realistic description of how the organization will work with other organizations to establish care teams that include team members not employed by the AMH+ or CMA and/or whose locations are outside its walls.*
 - *Specific description of how the organization will share pertinent care plan and ISP data with care team members across physical health, behavioral health, and/or I/DD.*
 - *Specific description of how case conferences will be operationalized and interpretation of "regular" timing that is tailored to the specific population served.*
 - *Answer acknowledges challenge of pulling together multidisciplinary team and provides at least one strategy to mitigate.*
 - **Question F5:** *Clear description of secure, role-based access.*

4.6. Required Components of Tailored Care Management

- **Certification requirement:** *See Provider Manual p. 23-25.*
- Refer to questions **E8, E11-E12.**
- Look for:
 - **Question E8:** *Clear and realistic description of how communication between provider types will be carried out.*
 - **Question E12:** *Description of individual and family support approach that is tailored to the population served by the organization.*

4.7. Addressing Unmet Health-related Resource Needs

- **Certification requirement:** *See Provider Manual p. 25-26.*
- Refer to questions **D4, E10, E13.**
- Look for:
 - **Question D4:** *Evidence of referral and advisory relationships (e.g., joint care teams or care conferences for shared patients or clients) with community organizations.*
 - **Question E10:** *Experience in assistance role, or answer demonstrates understanding of what will need to be done to add capability.*

4.8. Transitional Care Management

- **Certification requirement:** *See Provider Manual p. 26-27.*
- Refer to questions **E8, E10, E13-E15.**
- Look for:
 - *Clinically appropriate methodology for identifying members in transition.*
 - *For CMAs, concrete answer about when ADT functionality will be in place.*
 - *Concrete answer about how ADT alerts will be monitored and conveyed to care managers, including strategy to meet timeframes for responding to transitional care management needs (e.g., strategy to provide real-time response to emergency department outreach, conduct same-day or next-day outreach to designated high-risk subsets of the population, and within several days address outpatient needs).*
 - *For diversion:*
 - *Clear description of approach to connecting person to community-based supports.*
 - *Reference to Community Integration Plans.*

4.9. Innovations and TBI Waiver Care Coordination (if applicable)

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- **Certification requirement:** *See Provider Manual p. 28-29.*
- Refer to question **E16**.
- Failing this requirement means that the organization will not be certified to provide Tailored Care Management to the waiver population, but it does not mean that the entire application fails, if the organization is seeking certification for other populations. Look for:
 - *Clear description of strategy to ensure completion of required assessments for waiver population.*
 - *Clear description of strategy to provide additional information and resources for waiver population using self-directed services.*
 - *Clear description of strategy to perform additional responsibilities developing and monitoring implementation of the ISP.*

Category 5: Health IT

5.1. Use an Electronic Health Record (EHR)

- **Certification requirement [Provider Manual, p. 29].** *The AMH+ or CMA must have implemented an EHR that is in use by the AMH+ practice's or CMA's providers to record, evaluate and transmit member clinical information, including medical adherence.*
- Refer to question **F1**.
- **This requirement is not rated.** Re-check that organization has provided attestation of EHR use in **F1**. If not, the application does not pass.

5.2. Use a Care Management Data System

- **Certification requirement [Provider Manual, p. 31].** *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;*
 - *Incorporate claims and encounter data;*
 - *Provide role-based access to each member of the multidisciplinary care team;*
 - *Electronically and securely transmit (at minimum) the care management comprehensive assessment, care plan or ISP and reports/summaries of care to each member of the multidisciplinary care team;*
 - *Track care management encounters electronically, including the date and time of each encounter, the personnel involved, and whether the encounter was in person or telephonic; and*

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- *Track referrals*
- Refer to questions **F3-F4, F6**.
- Look for:
 - *Organization names a care management platform that it either owns/controls or has a clear plan to utilize (via CIN or Other Partner or Behavioral Health I/DD Tailored Plan) and describes how the platform will meet each of the above requirements. Organizations MAY elect to access Behavioral Health I/DD Tailored Plan-based platform to meet requirement, but Behavioral Health I/DD Tailored Plans may not require them to do so.*
 - *Organization concretely describes how it will import, curate, and analyze claims/encounter data for care management.*

5.3. Use ADT Information

- **This requirement is not rated separately** (covered by Transitional Care Management, 4.8, above).

Category 6: Quality Measurement and Improvement

- **Certification requirement [Provider Manual, p. 31].** *AMH+ practices and CMAs will be required to gather, process, and share data with Behavioral Health I/DD Tailored Plans for the purpose of quality measurement and reporting. At least annually, the AMH+ or CMA must evaluate the Tailored Care Management services it provides to ensure that the services are meeting the needs of empaneled members, and refine the services as necessary.*
- Refer to questions **G1-G2**.
- Look for:
 - *Description of continuous quality improvement (CQI) process, including development of period quality improvement plans, that integrates use of quality measure data (e.g., Healthcare Effectiveness Data and Information Set (HEDIS) measures) and member feedback to select operational areas that require action to achieve performance benchmarks.*
 - *Concrete example of subject area and process that includes leadership and participants in CQI, feedback loop to providers, and consequences/follow-up of failure to achieve benchmarks.*
 - *Experience reporting HEDIS measures.*

Category 7: Training (preliminary review criterion; not evaluated)

- **This requirement is not rated.** (Attestation of intention to attend required training is a preliminary review criterion.)

Draft updated 4/6/2021 – The Department reserves the right to release additional updates.

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Evaluation Worksheet. Application Identifier: _____

Preliminary Application Review Criteria			
Criteria			“Check” if Met Criterion “X” if Did Not Meet Criterion
a. Eligible to apply			
b. Attested to question 8 on cover sheet (Board approval of application)			
c. Provided attachment per question B7 (most recently audited financial report)			
d. Provided attachment per question B9 (organizational chart)			
e. Attested to question C1 (intention to complete all requirements)			
f. Attested to question C5 (behavioral health I/DD patient panel volume – AMH+ applicants only)			
g. Attested to question E1 (develop written policies and procedures for communication)			
h. Attested to question E11 (24-hour coverage)			
i. Attested to question E13 (operational ADT system – AMH+ applicants only)			
j. Attested to question F1 (EHR)			
k. Attested to question H1 (intention to attend required trainings)			
Rated Criteria			
Category (as published in Provider Manual)	Requirements (as published in Provider Manual)	Questions	Rating
2. Organizational Standing/Experience	2.1. Relevant experience	B1, C3-C6	
	2.2. Provider relationships and linkages	D4	
	2.3. Capacity and sustainability	A6, B2-B9, D3	
	2.4. Oversight	A6, B9	

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3. Staffing	3.1. Care management staff	D1-D3, D5, C9	
	3.2. Clinical consultants	D5	
4. Delivery of Tailored Care Management	4.2. Capacity to engage with members through frequent contact	E2-E3, D2-D3	
	4.3 Care management comprehensive assessments and reassessments	C7, E4	
	4.4. Care plans and ISPs	C7, E4-E7, F3	
	4.5 Care teams	E8-E9, F3, F5	
	4.6. Required components of Tailored Care Management	E8, E11-E12	
	4.7. Addressing unmet health-related resource needs	D4, E10, E13	
	4.8. Transitional care management	E8, E10, E13-E15	
	4.9. Innovations and TBI waiver care coordination	E16 <i>(if applicable)</i>	
5. Health IT	5.2. Use a care management data system	F3-F4, F6	
6. Quality Measurement and Improvement	6.1 Quality measurement and improvement	G1-G2	
Overall Rating			