NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Behavioral Health and Intellectual/Developmental Disability Tailored Plans

Responses to Non-Binding Statement of Interest for Potential Clinically Integrated Networks (CINs) and Other Partners

Aug. 9, 2021

Contents

In order to support providers for the launch of Behavioral Health and Intellectual/Developmental Tailored Plans and Tailored Care Management, the Department is providing public-facing information to potential AMH+ practices and CMAs about the type of services offered by CINs and Other Partners that may assist with meeting the requirements for Tailored Care Management.

The Department recognizes that providers and other stakeholders may have questions on the information in this document. Please send any questions or comments related to the Tailored Care Management program to Medicaid.TailoredCareMgmt@dhhs.nc.gov. Contact information for each CIN or Other Partner is also included in Table 1.

For additional guidance and resources on Tailored Care Management please visit: https://medicaid.ncdhhs.gov/transformation/tailored-care-management

The information included in this document reflects responses to the Statement of Interest and does not reflect the Department's assessment or endorsement of these organizations capabilities.

Introduction

Behavioral Health and Intellectual/Developmental Disability Tailored Plans will launch on July 1, 2022, serving individuals with serious behavioral health disorders (serious mental illness, serious emotional disturbance, and/or severe substance use disorders), intellectual/developmental disabilities (I/DDs), and traumatic brain injuries (TBIs). Individuals in Behavioral Health and Intellectual/Developmental Disability Tailored Plans will have access to care management that takes a whole person approach, is community based, and is grounded in authentic relationships. In alignment with this vision, the North Carolina Department of Health and Human Services (the Department) aims for Tailored Care Management—the care management program for Behavioral Health and Intellectual/Developmental Disability Tailored Plans—to be provided primarily by care managers affiliated with provider organizations that the Department certifies as Advanced Medical Home Plus (AMH+) practices and Care Management Agencies (CMA).[1]

Many AMH+ practices and CMAs will choose to contract with a "**Clinically Integrated Network (CIN) or Other Partner**" to share responsibility for specific functions and capabilities required to operate as an AMH+ practice or CMA and meet the requirements of the Tailored Care Management model. AMH+ practices and CMAs may choose to contract with any individual CIN or multiple CINs and/or Other Partners that best meet their needs. **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.**

Note: AMH+ practices and CMAs may also decide to enter into arrangements with LME/MCOs in their capacity as Behavioral Health and Intellectual/Developmental Disability Tailored Plan awardees (or later, as Behavioral Health and Intellectual/Developmental Disability Tailored Plans) for use of their health information technology (HIT) products or platforms for care management, in order to meet the care management data system requirements. In this scenario, the Behavioral Health and Intellectual/Developmental Disability Tailored Plan would be considered an "Other Partner" (not a CIN) for HIT support only. The Department understands LME/MCOs are having conversations with potential AMH+ practices and CMAs to act as an "Other Partner" for HIT support and did not expect LME/MCOs to respond to this Statement of Interest.

The Department understands that providers pursuing AMH+ practice or CMA certification are looking for additional information about the North Carolina CIN or Other Partner market to understand their options for contracting in advance of the certification process and Behavioral Health and Intellectual/Developmental Disability Tailored Plan launch. To this end, in May and June 2021, the Department solicited responses from CINs or Other Partners to this voluntary, non-binding Statement of Interest on the type of services they offer that may assist AMH+ practices and CMAs with meeting the requirements for Tailored Care Management.

The Department received responses from six CINs or Other Partners that intend to serve AMH+ practices and CMAs across different regions of the state. All responses provided by CINs or Other Partners are provided in Table 1:

- **Table 1.1** provides an overview of each responding CIN or Other Partner including contact information.
- **Table 1.2** provides a list of services offered by CINs or Other Partners, including HIT functions.
- **Table 1.3** provides additional information on the contracting and fee structure for each CIN or Other Partner.

[1] Additional information on the Tailored Care Management model is provided available in the Tailored Care Management Provider Manual and the Department's Care Management Strategy for Behavioral Health and Intellectual/Developmental Disability Tailored Plans.

Table 1. Information Provided by CINs and Other Partners

	Vidant Integrated Care (VIC) / Access East	Blaze Advisors dba NC ONEcare	Collaborative Health Network (CHN)	Emtiro Health	MediSked	The Arc of NC
Table 1.1 Overview of CINs and Other Partners						
1. Are you presently contracted with AMH practices as a CIN or Other Partner to AMH practices? If yes, how many AMH lives will you be covering?						
	Yes, 105,000 lives	No	No	Yes, between 100,000 - 150,000 lives on 7/1/21.	No	No
2. Identify the Behavioral Health and Intellectual/Developmental Disability Tailored Plan region(s) in which you would be interested in serving as a CIN or Other Partner.						
Region 1		✓	✓	✓	✓	✓
Region 2		✓	✓	✓	✓	✓
Region 3		✓	✓	✓	✓	✓
Region 4		✓	✓	✓	✓	✓
Region 5		✓	✓	✓	✓	✓
Region 6	✓	✓	✓	✓	✓	✓
Region 7	✓	✓	✓	✓	✓	✓
3. Is your entity a current[2]:						
Integrated delivery network	✓					
Managed services organization (MSO)		✓				

[2] CINs and Other Partners also had the choice to indicate they were a hospital/health system or an independent practice association. No CINs or Other Partners indicated these options.

	Vidant Integrated Care (VIC) / Access East	Blaze Advisors dba NC ONEcare	Collaborative Health Network (CHN)	Emtiro Health	MediSked	The Arc of NC
Another provider-based network or association		✓	✓			
Another provider						✓
Technology vendor		✓			✓	
Another type of entity (please briefly describe)		✓ Accountable Care Organization		✓ Emtiro Health is a Population Health Management Company that empowers and supports providers in their journey toward delivering whole-person care and succeeding in value-based contract arrangements.		
4. Indicate the types of providers your organization intends to serve. Check all that apply.						
CMAs operated by BH providers	✓	✓	✓	✓	✓	
CMAs operated by I/DD or TBI providers	✓	✓	✓	✓	✓	✓
AMH+ practices	✓			✓	✓	
5. Please provide the contact information you would like to make publicly available for interested providers to reach out to.						

	Vidant Integrated Care (VIC) / Access East	Blaze Advisors dba NC ONEcare	Collaborative Health Network (CHN)	Emtiro Health	MediSked	The Arc of NC
Contact Person and Title	Ron Gaskins (President, VIC) Debra Thompson (President, Access East)	Kye Gardner (Director of Business Operations)	Chris Thompson (Senior Consultant)	Kelly Garrison (President & CEO)	Rachel Hendrickson (Business Development Manager)	Lisa Poteat (Deputy Director)
Email	ronald.gaskins@vidanthealth.com; dthompso@vidanthealth.com	kgardner@blazeadvisors.com	cthompson@canslermail.com	kellygarrison@emtirohealth.org	rachel_hendrickson@medisked.com	Lpoteat@arcnc.org
Phone	(252) 847-6696; (252) 847-1220	(910) 599-2582	(704) 918-8551	(336) 978-6542	(330) 807-1621	(910) 322-0569
Website	www.vidantintegratedcare.org; www.accesseast.org	www.blazeadvisors.com	www.collaborativehn.com	www.emtirohealth.org	www.medisked.com	www.arcnc.org
Table 1.2 Services						
6. Indicate the services you would be able to provide to AMH+ practices or CMAs to meet Tailored Care Management requirements.						
Care management staffing	✓			✓		
Clinical consultants	✓	✓		✓		✓
Clinical protocols/workflows	✓	✓	✓	✓		
Health information technology (HIT) services, including, but not limited to, a care management data system	✓	✓	✓	✓	✓	✓
Other		✓ ACO Development, Value-Based Contract		✓ Emtiro Health has developed a customized		

	Vidant Integrated Care (VIC) / Access East	Blaze Advisors dba NC ONEcare	Collaborative Health Network (CHN)	Emtiro Health	MediSked	The Arc of NC
		Negotiation and Management		assessment to evaluate practice capabilities as compared to DHHS-DHB requirements to operate as an AMH+ or CMA. Following this assessment Emtiro Health's Provider Support team will develop a comprehensive roadmap with goals tailored to the practice's short and long term goals.		
7. If you expect to offer a care management data system to AMH+ practices or CMAs, indicate the functions your system is capable of offering.						
Maintain up-to-date documentation of members enrolled in Tailored Care Management and assignments of individual members to care managers	✓	✓	✓	✓	✓	✓
Electronically document and store care management comprehensive assessments and re-assessments	✓	✓	✓	✓	✓	✓
Electronically document and store care plans and individual support plans (ISPs)	✓	✓	✓	✓	✓	✓
Consume claims and encounter data	✓	✓	✓	✓	✓	✓

	Vidant Integrated Care (VIC) / Access East	Blaze Advisors dba NC ONEcare	Collaborative Health Network (CHN)	Emtiro Health	MediSked	The Arc of NC
Provide role-based access to members of the multidisciplinary care team	✓	✓	✓	✓	✓	✓
Electronically and securely transmit care management comprehensive assessments, care plans or ISPs, and care reports/summaries to multidisciplinary care team members to support case conferences	✓	✓	✓	✓	✓	✓
Electronically track care management encounters	✓	✓	✓	✓	✓	✓
Track referrals	✓	✓	✓	✓		✓
Support risk stratification, including identification of rising risk patients	✓	✓	✓	✓	✓	✓
Provide clinical care alerts based on changing clinical/claims information	✓	✓	✓	✓		✓
Support practice population health analytics	✓	✓	✓	✓	✓	✓
Integrate with local Electronic Health Records or clinical systems to exchange data	✓	✓	✓	✓	✓	✓
Other care management services (not mentioned; please briefly describe)		✓				

	Vidant Integrated Care (VIC) / Access East	Blaze Advisors dba NC ONEcare	Collaborative Health Network (CHN)	Emtiro Health	MediSked	The Arc of NC
		Remote Patient Engagement, Telehealth, and Virtual Crisis Response				
8. Does your organization expect to be able to provide access to ADT data to support care management performed by AMH+ practices or CMAs?						
Yes	✓	✓	✓	✓	✓	✓
9. Please provide any additional details on the capabilities reflected in questions #6, #7, and #8 that you think would be useful to providers (up to two pages).						
See Appendices A-E						
Table 1.3 Contracting & Fees						
10. Does your organization intend to contract with Behavioral Health and Intellectual/Developmental Disability Tailored Plans on behalf of AMH+ practices or CMAs?						
Yes	✓	✓			✓	
No				✓		✓
Unsure			✓			
11. Will your organization charge fees to providers that obtain AMH+ practice or CMA certification to use your services? If yes, how will these fees be structured (e.g., PMPM, one-time cost upfront, per user cost, etc.)?						
CIN or Other Partner Response	Yes. We are flexible on the structure. PMPM, one-time costs upfront, per user costs are all possibilities.	At the outset, fees will be a fractional PMPM depending on the tools and services utilized by the CMA.	Yes, and the structure is based on level of involvement within the CHN.	Platform fees include a one-time initiation and data integration fee, with an ongoing PMPM, based upon the population. Consulting fees are	Fees: One-time activation, monthly implementation and monthly PMPM ongoing post go-live.	Yes, structure to be determined.

	Vidant Integrated Care (VIC) / Access East	Blaze Advisors dba NC ONEcare	Collaborative Health Network (CHN)	Emtiro Health	MediSked	The Arc of NC
				based on a T&M model. Care Management Fees are based upon a PMPM.		
12. If your organization will charge fees to providers, what will be the cost of those fees?						
CIN or Other Partner Response	Contingent upon the resources requested by the provider and the specific arrangement preferred.	Fees will be a fractional PMPM depending on the tools and services utilized by the CMA.	Depends on the level of involvement in the CIN.	Providers will be charged fees based upon an analysis of provider requirements. Emtiro will provide a detailed proposal including estimated costs, milestone schedule, and a draft Scope of Services.	Pricing may be impacted by factors such as contract length, size or other. Additional discovery required.	To be determined.

Appendix. Additional Information from CINs and Other Partners

Additional information and attachments provided by CINs and Other Partners is included below in Appendices A – E. No additional information was provided by Collaborative Health Network (CHN).

Appendix A. Vidant Integrated Care (VIC) / Access East

Please provide any additional details on the capabilities reflected in questions #6, #7, and #8 that you think would be useful to providers (up to two pages). ***6. Indicate the services you would be able to provide to AMH+ practices or CMAs to meet Tailored Care Management requirements.*** ***7. If you expect to offer a care management data system to AMH+ practices or CMAs, indicate the functions your system is capable of offering.*** ***8. Does your organization expect to be able to provide access to ADT data to support care management performed by AMH+ practices or CMAs?***
Access East has over a 20 year history of complex care management with Medicaid beneficiaries and will continue providing care management services for AMH Tier 3 practices in July 2021. We have multidisciplinary team members including experienced RNs, LCSWs, Pharmacists, and support staff that engage with practice level clinical teams to ensure whole person-centered care. Today we serve patients with multiple chronic physical and behavioral health conditions as well as social determinants of health issues. We collaborate with local behavioral health organizations to provide care management services today. Access East collaborates with community organizations and resources to meet the needs of patients and families. Access East utilizes Epic's EMR and a population health platform which meets qualifications for encounter and claims data, tracking referrals and encounters, and providing alerts. Through Epic's Care Link, practices can access care management data such as comprehensive assessments, care plans, and information to support practice level engagement. Risk stratification tools, identification of high risk patients, and dashboards are features used today to manage patients. Access East has established workflows and meets requirements including completion of comprehensive assessments, care plan development, and supporting team based care. Our population health platform supports analytics and provides dashboards that include claims and clinical data. We utilize NC Care 360 as our SDOH referral and tracking tool and Collective Medical for real time ADT feeds.
Is there any other information you would like to make available to potential AMH+ practices or CMAs?
No.

Appendix B. Blaze Advisors dba NC ONEcare

Please provide any additional details on the capabilities reflected in questions #6, #7, and #8 that you think would be useful to providers (up to two pages).

6. ***Indicate the services you would be able to provide to AMH+ practices or CMAs to meet Tailored Care Management requirements.***
7. ***If you expect to offer a care management data system to AMH+ practices or CMAs, indicate the functions your system is capable of offering.***
8. ***Does your organization expect to be able to provide access to ADT data to support care management performed by AMH+ practices or CMAs?***

NC ONEcare originated out of a high-performance network of behavioral health, primary care, social service, and hospital organizations who came together within a system of care to increase disease detection, streamline access to care, and create integrated/effective care teams around each patient. Today, the ONEcare model is deployed by 10,000+ multi-disciplinary clinicians across multiple ONEcare networks managing over 500,000 patient lives annually, many of which are under an alternate payment model contract rewarding quality improvement and cost reduction. The ONEcare technologies in use by these ONEcare networks are being offered to CMA providers in NC who are interested in leveraging both the technology, data, and population health management experience of Blaze Advisors and the ONEcare solution to improve the outcomes of their CMA model. Many current CMA's already belong to a ONEcare network in NC and new partners may be able to participate in or develop their own ONEcare network to enjoy value-based incentives available to Accountable Care Organizations. The ONEcare model is built around the "4 C's" of care integration:

- Catch – The disease or symptom early. Preferably during routine primary care and outpatient BH visits. This requires clinician confidence in the model, the ONEcare network, and open, destigmatizing dialogue with the patient.
- Care – In the least restrictive, most convenient setting with minimal delays. For many lower risk patients, coordinated care between the primary care physician and a BH clinician is effective. This frees up psychiatry/psychology for more complex cases.
- Connect – The patient to needed services, whether medical or social services. Where needs are multiple and/or urgent, liaison with care management and confirm resolution.
- Collaborate – To improve patient and network health outcomes. Engage the care team and staff difficult cases via Virtual Grand Rounds to raise the didactic learning of the network.

While the most important component of a ONEcare network is the human element (whether in the form of executive leadership, clinical expertise, and/or the close follow up of a care manager or intake staff), ONEcare uses a suite of care management, care coordination, virtual patient engagement, and population health analytics tools to automate communication, alerts, data aggregation, and analytics. Specifically:

- Clinical Intelligence Engine (CIE): The population health data warehouse and analytics engine that powers NC ONEcare. Onboards and matches disparate patient data such as claims, ADT (Admission, Discharge, and Transfer), EMR encounter, pharmacy, lab, and ONEcare care coordination and remote patient engagement data. The CIE runs multiple risk stratification algorithms enhanced with machine learning to provide real-time assessment of static and dynamic patient risk. Changes in risk and gaps in care are communicated to the care manager and care team through the Care Optimization System.
- Care Optimization System (COS): The care coordination, communication, and referral platform that links the patient's care team with guided referrals, observational risk assessments, SDOH screening, care alerts, secure communications, and task management. Integrated with the Clinical Intelligence Engine and ONEtouch.
- ONEtouch Care Management Information System (CMIS): The NC ONEcare Care Management planning, documentation, and communication platform. Provides secure care team and stakeholder access to selected forms. Integrated with the ONEtouch Remote Patient Engagement System and the CIE.
- ONEtouch Remote Patient Engagement System (RPE): An interconnected app that can be downloaded by the patient, care manager, and care team to facilitate wellness checks, screenings, health education, telehealth, and crisis response. Integrated with the ONEtouch CMIS, COS, and CIE. In addition to the above technologies, NC ONEcare provides implementation, training, and technical support for the above technologies. NC ONEcare is also able to provide access to clinical consultation and advisory services. Finally, NC ONEcare can organize participating members into self-governed regional and supra-regional clinically

integrated networks capable of soliciting, executing, and operationalizing value-based payer contracts with managed care organizations, including Tailored and Standard Plans.
Is there any other information you would like to make available to potential AMH+ practices or CMAs?
We look forward to meeting with you. The benefits of NC ONEcare, from our perspective, are accelerating your CMA launch and performance with a proven technology solution, an experienced behavioral health and population health management team for support, and a glidepath to value based contracting which does not require capital or relinquishing control of your contract governance. Please read more about the ONEcare model and solutions at www.blazeadvisors.com.

Appendix C. Emtiro

Please provide any additional details on the capabilities reflected in questions #6, #7, and #8 that you think would be useful to providers (up to two pages). ***6. Indicate the services you would be able to provide to AMH+ practices or CMAs to meet Tailored Care Management requirements.*** ***7. If you expect to offer a care management data system to AMH+ practices or CMAs, indicate the functions your system is capable of offering.*** ***8. Does your organization expect to be able to provide access to ADT data to support care management performed by AMH+ practices or CMAs?***
See information provided on pages 14-15.
Is there any other information you would like to make available to potential AMH+ practices or CMAs?
For more information, please visit: www.emtirohealth.org

EMTIRO HEALTH®
inspired support.

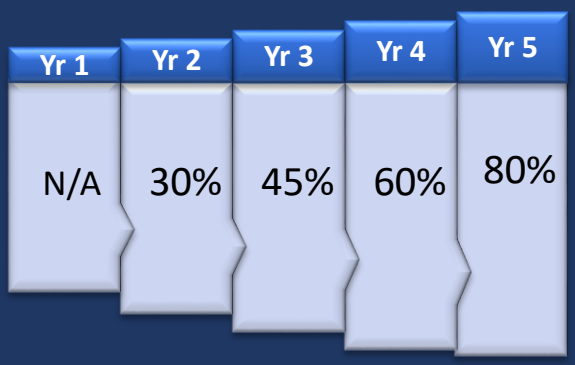
Tailored Plan Services

Let's Talk AMH+ and CMA.

With the launch of Tailored Plans in July 2022, Care Management Agencies will be required to provide AMH Tier 3 compliant care management services to Medicaid patients with severe mental illness (SMI), substance use disorders (SUD), and Intellectual and Developmental Disabilities (IDD) or Traumatic Brain Injury (TBI). Additionally, AMH Tier 3 practices will be eligible to offer behavioral services to Medicaid patients in accordance with AMH+ requirements.

Tailored Care Management will require a multi-year effort to enhance the workforce at the AMH+ and CMA level. The Department has established the following "glide path" to illustrate their vision of having Tailored Care Management delivered at the practice and provider level at an increasing rate over 5 years.

The following chart provides the annual target percentage of beneficiaries served by care managers/supervisors based in AMH+ practices/CMAs.



AMH+ and CMA practices must:

- Meet all AMH Tier 3 requirements as outlined below.
- Demonstrate historical experience working with BH population
- Support at least 100 active Medicaid patients with Severe Mental Illness, Sever Emotional Disturbance, Substance Abuse, or IDD/TBI

Tier 3 Advanced Medical Homes (AMH) practices must:

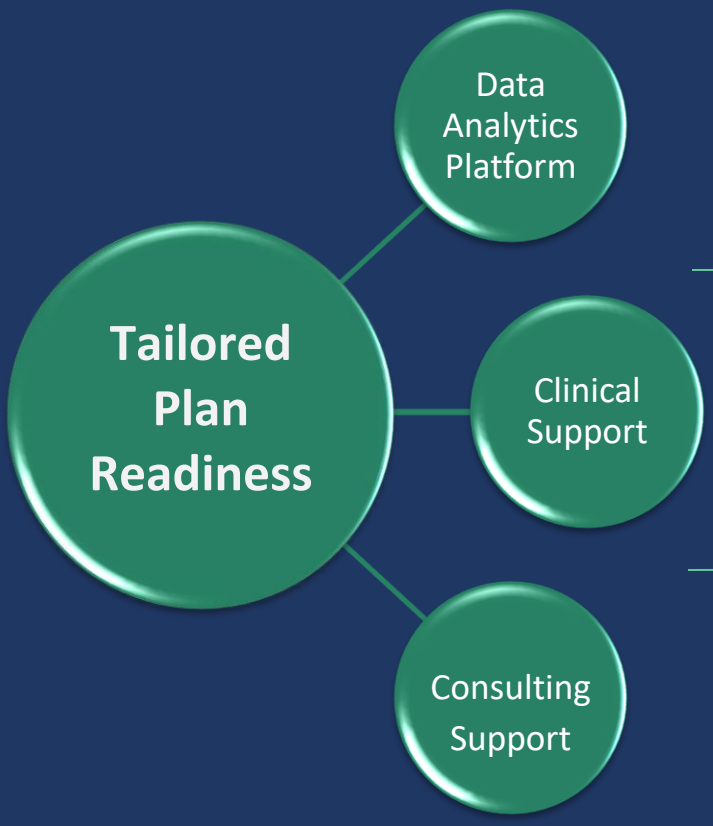
- Receive claims, beneficiary assignment, pharmacy lock-in, and initial care needs screening data feeds
- Meet data security standards for storage and use
- Risk stratify all patients
- Provide care management services to all high-needs patients
- Develop a Comprehensive Care Plan for all patients receiving care management, that encompasses mental, physical and social needs.
- Provide short-term, transitional care management along with medication management to all patients who have an emergency department (ED) visit or hospital admission/discharge/ transfer or who are otherwise at high risk of readmissions

About Emtiro Health

Emtiro Health has over 20 years' experience at the intersection of data analytics, population health, and care management and is equipped with experienced multidisciplinary teams and deep partnerships across our communities to help your practice succeed as an AMH+ or CMA.

Emtiro Health Tailored Plan Services

Whether you are a Medicaid primary care practice or a CMA that wants to provide Tailored Care Management services, Emtiro offers a suite of services to ensure that your practice is ready to meet all requirements. Our Pop Health+ Platform is designed to meet all Tier 3, Tailored plan requirements, our clinical staff and care model can be customized to meet each provider's needs, and our consultants have extensive experience in transforming practices to meet national standards or emerging Medicaid requirements.



- **Meets AMH+ & Tailored Plan requirements** as well as NCQA care management standards
- **Integrates with Provider data sources** including EMR, ADT, NCCare360, NC HealthConnex, NC Immunization Registry, and more
- **Risk Stratification** including CDPS+Rx and Social Vulnerability Index
- **Robust data analytics** including Contract, Care Team Performance, and SLA dashboards/reports

- **NC based care management team** including care managers and community health workers
- **Resource bank** including social workers, pharmacists, and housing specialists
- **Right sized clinical support** to meet each provider's needs
- **Care Coordination** (Prevention Wellness, Care Coordination patients)

- **Behavioral Health Integration Readiness Assessment**
- **Practice-centered Implementation Assistance** for BH Integration Models (Co-location, PCBH, CoCM)
- **Tailored Plan AMH+ Consultative Support** on Care Plan Elements and Optimal EHR Use.

Why Partner with Emtiro?

- ✓ **Reduces burden** of AMH+ attainment, we are your AMH guide and support team
- ✓ **Proven platform** meets AMH Tier 3 & AMH+ requirements
- ✓ **Meets all NC SLA requirements** that will be tied to risk-based payments
- ✓ **No risk or penalty** **for signing up with us** before you need the service

For more information about Emtiro Health and available services, please visit www.emtirohealth.org

Appendix D. MediSked

Please provide any additional details on the capabilities reflected in questions #6, #7, and #8 that you think would be useful to providers (up to two pages). ***6. Indicate the services you would be able to provide to AMH+ practices or CMAs to meet Tailored Care Management requirements.*** ***7. If you expect to offer a care management data system to AMH+ practices or CMAs, indicate the functions your system is capable of offering.*** ***8. Does your organization expect to be able to provide access to ADT data to support care management performed by AMH+ practices or CMAs?***
See information provided on pages 17-18.
Is there any other information you would like to make available to potential AMH+ practices or CMAs?
https://www.medisked.com/northcarolina/

June 3, 2021

To Whom it May Concern,

MediSked, LLC is pleased to respond to the Non-binding Statement of Interest as an Other Partner. We appreciate this opportunity to continue current discussions and pave the way for new discussions with CMAs and AMH+ practices in North Carolina.

MediSked's care management offering is distinctive from others in that we are one of the few premier technology vendors that has in-depth experience in supporting statewide Medicaid transformation using integrated care management built on the foundation of the federal Health Home State Plan option. MediSked is the technology partner to New York State's I/DD Care Coordination Organization (CCO)/Health Homes, providing an integrated care management solution that all seven of the CCOs use to effectively coordinate care, improve outcomes, and manage costs. MediSked is currently working with one of North Carolina's LME/MCOs to implement our care management suite and has deep connections to providers and statewide groups in North Carolina. MediSked's familiarity with the unique landscape in North Carolina, combined with our expertise in partnering with organizations through Medicaid systems change, positions us as the ideal technology partner for care management activities.

We understand the importance of making sure you have a best-in-class software solution that is also affordable and scalable. MediSked's care management solution offers robust functionality for coordinating care, from enrollment to care planning, transitions, and assessments, to data interchange and connectivity, and more. It is configurable and flexible, giving control over how the solution works for you and your partners, and offering cost-savings in the form of efficiencies and competitive pricing that takes into account the environment that all stakeholders in North Carolina are operating in.

As North Carolina is transitioning its Medicaid and NC Health Choice programs' care delivery system from predominately fee-for-service (FFS) to Medicaid managed care, CMAs and AMH+ practices have a partner in MediSked that understands the unique needs and workflows for serious mental illness and severe substance use disorders (SUD), I/DD, and TBI. This partnership can continue to grow and adapt through this managed care transformation and scale into the future.

Since 2003, MediSked has been the leading trusted technology partner to health and human service organizations across the country. Every day we live our mission to be the leading brand in holistic solutions that improve lives, drive efficiencies, and generate innovations for human service organizations that support our community. We believe our commitment to these goals and our philosophy of client collaboration and consulting would make us the ideal partner for your initiative.

1-866-MEDISKED · (866) 633-4753 www.medisked.com info@medisked.com medisked

MediSked Response to question 9: A leader in waiver management and integrated technology solutions, MediSked serves provider organizations, care coordination/case management entities, payers, and government agencies. We offer a full-featured software ecosystem of platforms designed for agencies serving I/DD, behavioral and mental health, aging, and other populations receiving long-term and community-based services and supports. As a company, MediSked focuses on building software that enables technologies and business processes that encourage interoperability, software reusability, and integration with clinical data. MediSked's BH/IDD Tailored Plan Care Management Suite offers a highly integrated set of tools for improving quality of care while offering efficiencies and reducing costs. Already deployed at a similar agency in North Carolina, the BH/IDD Tailored Plan Care Management Suite is designed to meet the unique needs of agencies like yours, from customized assessment options and configurable care planning tools, to powerful reporting from a warehouse of actionable data. MediSked also offers to CMAs and AMH+ practices extensive industry knowledge gained through hands-on, collaborative relationship-driven software development. We have engaged experts in government, care management, and provider agencies to participate in our MediSked Advisor Council. The critical input these leaders provide, combined with our highly skilled staff, ensure we deliver industry-leading solutions to our clients. MediSked approaches every client relationship as a partnership. Our extensive experience in the health and human services field, combined with our collaborative approach, position us as the partner you need as you navigate North Carolina's Medicaid transformation to BH/IDD Tailored Plans. We are currently the technology partner to an LME/MCO in the state and have worked closely with North Carolina provider agencies for years. As a technology partner, MediSked's goal would be to serve as both consultant and technology vendor, leveraging our experience with similar projects and working with you to design the interoperable and scalable solution you need.

Sincerely,

Doug Golub
President

Tom Hogan
Executive Vice President

Brian Uzwiak
Vice President Technology Operations

Andrew Wheeler
Vice President Product and Market Strategy

Appendix E. The Arc of NC

Please provide any additional details on the capabilities reflected in questions #6, #7, and #8 that you think would be useful to providers (up to two pages). ***6. Indicate the services you would be able to provide to AMH+ practices or CMAs to meet Tailored Care Management requirements.*** ***7. If you expect to offer a care management data system to AMH+ practices or CMAs, indicate the functions your system is capable of offering.*** ***8. Does your organization expect to be able to provide access to ADT data to support care management performed by AMH+ practices or CMAs?***
Focus on IDD needs, outcomes, work flow and quality of life indicators.
Is there any other information you would like to make available to potential AMH+ practices or CMAs?
No response.