

**Updated December 2, 2020**

This document was updated on December 2, 2020, to reflect that applications should be submitted to a new email address: [Medicaid.TailoredCareMgmt@dhhs.nc.gov](mailto:Medicaid.TailoredCareMgmt@dhhs.nc.gov). No other updates have been made since the June 9, 2020 version.



NC DEPARTMENT OF  
**HEALTH AND  
HUMAN SERVICES**

## **Behavioral Health and Intellectual/Developmental Disability Tailored Plan**

### **Tailored Care Management Certification AMH+ and CMA Application Instructions**

#### **Instructions for AMH+ and CMA applicants:**

1. To complete this application, please copy and paste all questions into a separate word document and complete with your responses. **Please stay within the page limits indicated.**
2. The Department recognizes that many providers plan to work with Clinically Integrated Networks (CINs) or Other Partners to perform the required Tailored Care Management functions. In response to comments from stakeholders, the Department has decided to allow a pathway for CINs or Other Partners to answer certain questions, if applicable to an organization's application. Therefore, the application questions now consist of the following:
  - **AMH+ and CMA Questions.** Every organization applying to become an AMH+ or CMA must **individually** complete AMH+ and CMA Application Questions. However, if the individual organization plans to work with a CIN or Other Partner, the organization **may** choose to indicate that some or all of the **marked** questions are answered in the CIN or Other Partner Supplement. **Please note that it is never a requirement to use the CIN or Other Partner Supplement.** An organization may choose to complete the application in full, even if intending to work with a CIN or Other Partner.
  - **CIN or Other Partner Supplement.** This Supplement includes a subset AMH+ and CMA questions, reflecting functions that the Department is aware are likely to be performed by CINs or Other Partners. The Supplement is designed to be completed by the CIN or Other Partner. The Department recognizes that intended CIN or Other Partner arrangements may differ in the types of support provided, and that support may differ across individual practices. The CIN or Other Partner may complete some, but not all, questions in the Supplement, depending on the model of support they propose to provide to practices. LME/MCOs should **not** complete the CIN or Other Partner Supplement, even if they are intending to provide IT support to practices as "Other Partners."
    - Your organization must ensure that all questions on your application are complete across the AMH+ and CMA Questions, and the Supplement. It is your organization's responsibility to make it clear to the Department's reviewers what your plans are for the arrangement with the CIN or Other Partner. If the arrangement with the CIN or Other Partner will be different for different populations (e.g., CIN will support staffing for behavioral health but not I/DD), that distinction needs to be clearly reflected in how

your organization and partnering CIN or Other Partner answers the questions.

- Your organization must submit a copy of the CIN or Other Partner Supplement with the AMH+ and CMA Questions. Accordingly, your organization must coordinate with the CIN or Other Partner to complete the application, and must have the CIN or Other Partner's responses to the Supplement available when completing the AMH+ and CMA questions to ensure that the Department has a complete picture of your organization's abilities.
- Your organization must submit a signed MOU with the CIN or Other Partner as a record that your organization is actively working with that CIN or Other Partner to prepare for Tailored Care Management. The MOU should include details about the scope of the relationship (e.g., care management staffing, health IT). The MOU is non-binding.

**Please note that the Department will certify individual provider organizations, not CINs or Other Partners.** Each application is still the responsibility of the individual provider organization.

3. The Department plans to review AMH+ and CMA Questions and CIN or Other Partner Supplement "blind" to the greatest extent possible. Therefore, please do not identify your organization by name other than on the cover sheet and in attachments (organizational chart, audit, etc.).
4. When your application is complete, email the AMH+ and CMA Questions and the CIN or Other Partner Supplement (if applicable), along with your attachments (clearly labeled), to [Medicaid.TailoredCareMgmt@dhhs.nc.gov](mailto:Medicaid.TailoredCareMgmt@dhhs.nc.gov).

Behavioral Health and Intellectual/Developmental Disability Tailored Plan

Tailored Care Management Certification  
AMH+ and CMA Application Cover Sheet

<b>1. Legal Entity Name</b>	
<b>2. DBA Name</b>	
<b>3. Year Established</b>	
<b>4. Corporate Address</b>	
<b>5. Application Contact</b>	
First and Last Name	
Title/Position	
Business Phone Number	
Business Email Address	
<b>6. Organization's Lead Point of Contact (if different from Application Contact)</b>	
First and Last Name	
Title/Position	
Business Phone Number	
Business Email Address	
<b>7. Health IT Contact (if different from above contacts)</b>	
First and Last Name	
Title/Position	
Business Phone Number	
Business Email Address	
<b>8. Attestation</b>	<p>Check box to attest.</p> <p><input type="checkbox"/> Our governance Board (or equivalent) has approved this application.</p>
<b>Complete the rows below only if submitting the CIN or Other Partner Supplement.</b>	
<b>9. CIN or Other Partner Organization Name</b>	
<b>10. CIN or Other Partner Organization Contact</b>	
First and Last Name	
Title/Position	
Business Phone Number	
Business Email Address	

**Behavioral Health and Intellectual/Developmental Disability Tailored Plan**

**Tailored Care Management Certification  
AMH+ and CMA Application Questions**

**A. Organization Information**

A1. Does your organization use more than one billing TIN? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
A2. Please list all TINs that your practice has used to bill Medicaid since January 1, 2017.
A3. What billing TIN will your organization use for Tailored Care Management?
A4. In which current LME/MCO region(s) is your organization located? Please list all sites/locations, including full addresses, within those regions that would be involved in Tailored Care Management.
A5. With which LME/MCOs does your organization currently hold a contract?
A6. If known, provide the names of management level executive(s) at the level of the organization (not at the level of each individual site) who will supervise the care management team and provide close oversight of the Tailored Care Management program during startup and on an ongoing basis.

**B. Service Lines and Capacity [total page limit: 6, excluding attachments]**

B1. What is the scope of services that your organization offers? (check all that apply) <input type="checkbox"/> Mental Health <input type="checkbox"/> Adult <input type="checkbox"/> Child/adolescent <input type="checkbox"/> Substance Use Disorder (SUD) <input type="checkbox"/> Adult <input type="checkbox"/> Child/adolescent <input type="checkbox"/> I/DD <input type="checkbox"/> Innovations Waiver <input type="checkbox"/> TBI Waiver <input type="checkbox"/> Co-occurring I/DD and behavioral health <input type="checkbox"/> Adult <input type="checkbox"/> Child/adolescent <input type="checkbox"/> Internal medicine <input type="checkbox"/> Family medicine <input type="checkbox"/> Pediatrics
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<input type="checkbox"/> Other primary care <input type="checkbox"/> Other
<p>Please provide a brief description of the services you provide as well as the number of years you have provided each service. Do you have any planned changes in service scope over the next 12 months?</p>
<p>B2. What percentage of your revenue comes from the following services?</p> <ul style="list-style-type: none"> <li>• Behavioral health _____</li> <li>• I/DD and/or TBI _____</li> <li>• Internal medicine/family medicine/pediatrics/other primary care _____</li> </ul>
<p>B3. What is your payer mix (percent of clients with each pay type and percent of revenue by each pay type) across all <b>behavioral health services</b> at the sites that you anticipate serving as an AMH+ or a CMA, by client volume and by revenue? (please provide approximate percentages)</p> <ul style="list-style-type: none"> <li>• Medicaid - % Clients _____ % Revenue _____</li> <li>• Medicare - % Clients _____ % Revenue _____</li> <li>• Uninsured - % Clients _____ % Revenue _____</li> <li>• Commercial/private - % Clients _____ % Revenue _____</li> <li>• Self-pay/out of pocket - % Clients _____ % Revenue _____</li> <li>• Other - % Clients _____ % Revenue _____</li> <li>• N/A - % Clients _____ % Revenue _____</li> </ul>
<p>B4. What is your payer mix (percent of clients with each pay type and percent of revenue by each pay type) across all <b>primary care services</b> at the sites that you anticipate serving as an AMH+ or CMA, by client volume and by revenue? (please provide approximate percentages)</p> <ul style="list-style-type: none"> <li>• Medicaid - % Clients _____ % Revenue _____</li> <li>• Medicare - % Clients _____ % Revenue _____</li> <li>• Uninsured - % Clients _____ % Revenue _____</li> <li>• Commercial/private - % Clients _____ % Revenue _____</li> <li>• Self-pay/out of pocket - % Clients _____ % Revenue _____</li> <li>• Other - % Clients _____ % Revenue _____</li> <li>• N/A - % Clients _____ % Revenue _____</li> </ul>
<p>B5. What is your payer mix (percent of clients with each pay type and percent of revenue by each pay type) across all <b>I/DD and/or TBI services, including HCBS</b>, at the sites that you anticipate serving as an AMH+ or a CMA, by client volume and by revenue? (please provide approximate percentages)</p> <ul style="list-style-type: none"> <li>• Medicaid - % Clients _____ % Revenue _____</li> <li>• Medicare - % Clients _____ % Revenue _____</li> <li>• Uninsured - % Clients _____ % Revenue _____</li> <li>• Commercial/private - % Clients _____ % Revenue _____</li> <li>• Self-pay/out of pocket - % Clients _____ % Revenue _____</li> <li>• Other - % Clients _____ % Revenue _____</li> <li>• N/A - % Clients _____ % Revenue _____</li> </ul>
<p>B6. What percentage of the population you serve do you expect to have Medicaid coverage through a BH I/DD Tailored Plan? Please indicate if this information is based on collected data or best estimate. Reference: <a href="#">BH I/DD Tailored Plan Criteria</a> and <a href="#">Policy Paper</a>.</p>
<p>B7. Describe your financial capacity to provide Tailored Care Management and <b>attach your</b></p>

**organization's most recent annual audit.**

- Does your most recent audit have any conditions that would impact your operation over the next two years?
- Please confirm that your most recently audited financial report demonstrates capacity for ongoing operation at or above current levels of services volume (e.g., days in accounts receivable/payable, at least 60 days of cash on hand).

B8. Describe your billing, accounting, and reporting system in place that aligns with the Department's and BH I/DD Tailored Plan requirements.

B9. Please attach your organization's organizational chart.

**C. Summary of Intent [total page limit: 6, excluding attachments]**

Check box to attest.

☐ C1. **Attestation:** We acknowledge that we have read the certification criteria outlined above in Section V. and intend to complete the requirements if certified as an AMH+ or a CMA.

C2. The organization is applying to become:

☐ AMH+

☐ CMA

C3. For which population(s) within the BH I/DD Tailored Plan eligible population is your organization applying for certification to provide Tailored Care Management? (check all that apply)

☐ Mental Health (MH) and Substance Use Disorder (SUD)

☐ Adult

☐ Child/adolescent

☐ I/DD

☐ TBI

☐ Innovations Waiver

☐ TBI Waiver

☐ Co-occurring I/DD and behavioral health

☐ Adult

☐ Child/adolescent

C4. What volume of clients with a behavioral health condition, an I/DD, or a TBI does your organization serve in a given year?

- Behavioral health condition \_\_\_\_\_
- I/DD \_\_\_\_\_
- TBI \_\_\_\_\_

C5. **AMH+ applicants only.**

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

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

C6. Please provide a summary of your intent to become an AMH+ or a CMA. Your summary should

address the following components:

- Why you would like to become an AMH+ or a CMA;
- Your organization's history and length of experience serving the population for which you are applying for certification to provide Tailored Care Management;
- How you plan to approach integration of physical health and behavioral health, I/DD, TBI, and/or waiver services through Tailored Care Management:
  - If you are applying to become an AMH+, please describe your approach to integration with BH and/or I/DD for the purpose of care management;
  - If you are applying become a CMA, please describe your approach to integration with physical health for the purpose of care management;
  - If you are applying to become either an AMH+ or a CMA and intend to serve individuals with both BH and I/DD or BH and TBI needs, please describe your approach to integration across BH and I/DD or BH and TBI for the purpose of care management;
- A high-level analysis of your organization's ability to meet the certification criteria;
- What areas of the certification criteria you see as your biggest challenges; and
- How your organization will approach standing up Tailored Care Management as a new service line.

**C7. AMH+ applicants only:** Please describe your experience to date implementing AMH Tier 3 functions, including your leadership of risk stratification, comprehensive assessment, care planning, and other aspects of the AMH model.

**C8.** At this time, what contracting approach do you expect to take in delivering Tailored Care Management?

- ☐ Only contract directly with BH I/DD Tailored Plan (i.e., AMH+/CMA would provide all elements of Tailored Care Management in-house)
- ☐ Only contract with CIN or Other Partner, which would contract with the BH I/DD Tailored Plan on your behalf to provide Tailored Care Management
- ☐ Both/a combination

**C9.** How will your organization ensure that care management is integrated with the care being provided at the practice level, and that the practice has managerial control of care management staff?

If you plan to work with a CIN or Other Partner, please **attach a MOU between your organization and the CIN or Other Partner** and give any known details, including details of the scope of the relationship (e.g., care management staffing, health IT).

**D. Staffing [total page limit: 6, excluding attachments]**

☐ **Check box if a CIN or Other Partner will answer this question on your behalf via the CIN or Other Partner Supplement.**

**D1.** Having considered the minimum qualification requirements and contact requirements, please provide an estimate of how many dedicated FTEs you would expect to employ to perform each of the Tailored Care Management roles below, during the first two years of the model:

- Care managers serving members with behavioral health disorders
- Supervising care managers serving members with behavioral health disorders

- Care managers serving members with I/DD or TBI
- Supervising care managers serving members with I/DD or TBI

Please indicate as part of your answer how many staff your organization **currently** employs who meet the minimum criteria outlined above. What are their qualifications?

**If you intend to contract with a CIN or Other Partner for care management staff**, how will your organization ensure that care management is integrated with the care being provided at the practice level, and that the practice has managerial control of care management staff?

☐ *Check box if a CIN or Other Partner will answer this question on your behalf via the CIN or Other Partner Supplement.*

D2. Describe your recruitment strategy to attract and retain well-qualified care management staff that meet the educational and experience requirements established by the Department.

☐ *Check box if a CIN or Other Partner will answer this question on your behalf via the CIN or Other Partner Supplement.*

D3. If your organization achieves certification from the Department, describe any staffing expansion you would plan, with reference to each of the care manager staffing categories above.

D4. Describe current contracts or other formal arrangements with behavioral health, I/DD, primary care, social service, pharmacy, or other providers that you think will be valuable assets in supporting the care management role (e.g., referral protocols in place, exchange of PHI, overlapping care teams for individuals, care conferences for shared patients, administrative level relationships).

D5. Describe internal or external relationships you currently have with clinicians that could serve in the role of clinical consultant as described in Section V. If you do not have current relationships with clinicians that could serve in the role of clinical consultant, please describe your plan to develop these relationships.

#### ***E. Delivery of Tailored Care Management [total page limit: 14, excluding attachments]***

##### **Engagement and Contact Requirements**

*Check box to attest.*

☐ **E1. Attestation:** We have, or will develop, written policies and procedures for communication and information sharing with individuals, families and other caregivers, with consideration for language, literacy and cultural preferences.

☐ *Check box if a CIN or Other Partner will answer this question on your behalf via the CIN or Other Partner Supplement.*

E2. Given the description of member engagement in Section V., describe your proposed approach to actively engaging members assigned to you.

☐ *Check box if a CIN or Other Partner will answer this question on your behalf via the CIN or Other Partner Supplement.*

E3. Describe your proposed strategy to ensure that care managers meet the minimum contact requirements. Please describe any challenges you foresee in meeting the minimum contact requirements and what measures you will take to overcome these challenges.



## Care Management Comprehensive Assessment and Reassessment

☐ *Check box if a CIN or Other Partner will answer this question on your behalf via the CIN or Other Partner Supplement.*

E4. Describe how your organization will approach comprehensive assessment of each member, tailoring the requirements to the population you serve. Describe any challenges you foresee in conducting assessment and reassessment according to the requirements above. Include in your answer how you will ensure that comprehensive assessments and reassessments are conducted within the required timeframes.

## Development of Care Plan or Individual Support Plan

☐ *Check box if a CIN or Other Partner will answer this question on your behalf via the CIN or Other Partner Supplement.*

E5. Describe how your organization will approach the development of an individualized, person-centered care plan/Individual Support Plan (ISP) for each member, tailoring the minimum requirements to the population you serve (including the Innovations and TBI waiver ISP requirements if you intend to serve this population), incorporating the findings from each comprehensive assessment, and incorporating whole-person health needs. Describe any challenges you foresee in developing care plans/ISPs according to the requirements above. Include in your answer how you will ensure that care plan/ISP development is conducted within the required timeframes.

☐ *Check box if a CIN or Other Partner will answer this question on your behalf via the CIN or Other Partner Supplement.*

E6. Describe your proposed process to update each care plan or ISP as individuals' needs change and/or to address gaps in care, including, at a minimum, review and revision upon reassessment.

☐ *Check box if a CIN or Other Partner will answer this question on your behalf via the CIN or Other Partner Supplement.*

E7. Describe your proposed process to document and store each care plan or ISP in the clinical system of record.

## Operation of the Care Team

☐ *Check box if a CIN or Other Partner will answer this question on your behalf via the CIN or Other Partner Supplement.*

E8. Describe your proposed approach to ensure:

- Regular communication and information sharing across the team (via case conferences) that support care integration and care transitions; and
- Coordination of services provided by community and social support providers, as well as other care coordination as described in Section V. above.
- **If you intend to contract with a CIN or Other Partner for care management staff:** Regular communication and information sharing between the CIN or Other Partner and the provider organization.

E9. Describe the most significant challenges you envision in ensuring effective care team communication, service coordination, and health status monitoring for your panel. How will you address those challenges?

### Addressing Unmet Health-related Resource Needs

E10. Describe your organization's experience in providing referral, information, and assistance in obtaining community-based resources. Describe your proposed approach to the assistance requirements.

### Twenty-four-hour Coverage

*Check box to attest.*

☐E11. **Attestation:** Our organization will 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.

### Individual and Family Supports

☐*Check box if a CIN or Other Partner will answer this question on your behalf via the CIN or Other Partner Supplement.*

E12. Describe the methodologies you expect to use to connect members and families to appropriate resources for self-advocacy, navigating the service system, guardianship options/alternatives, employment, success in school, and family planning.

### Transitional Care Management

*Check box to attest.*

☐E13. **Attestation (AMH+ applicants):** We have access to ADT information and are experienced in using it for transitional care management per AMH Tier 3 requirements.

☐*Check box if a CIN or Other Partner will answer this question on your behalf via the CIN or Other Partner Supplement.*

E14. Describe the methodologies your organization uses or would propose to use to identify members who are in transition or at risk of readmissions and other poor outcomes, including the process you use or will use to respond to certain high-risk ADT alerts including:

- Real-time (minutes/hours) response to outreach from EDs relating to patient care or admission/discharge decisions (e.g., arranging rapid follow-up after an ED visit to avoid an admission);
- Same-day or next-day outreach for designated high-risk subsets of the population to inform clinical care, such as members with special health care needs admitted to the hospital; and
- Within a several-day period to address outpatient needs or prevent future problems for high-risk patients who have been discharged from a hospital or ED (e.g., to assist with scheduling appropriate follow-up visits or medication reconciliations post-discharge).

## Diversion

☐ Check box if a CIN or Other Partner will answer this question on your behalf via the CIN or Other Partner Supplement.

E15. Describe your organization's current or proposed approach to diversion from institutional settings, including methods for identifying members most at risk and approach to connecting members to community-based supports.

## Innovations and TBI Waiver Care Coordination (if applicable)

☐ Check box if a CIN or Other Partner will answer this question on your behalf via the CIN or Other Partner Supplement.

**Innovations and TBI waiver applicants only:**

E16. If you intend to serve the Innovations and TBI waiver population, describe your organization's proposed approach to perform the additional requirements detailed in the Provider Manual for coordinating care for this population.

## F. Health IT [total page limit: 8, excluding attachments]

### Core Health IT Systems for Care Management

Check box to attest.

☐ F1. **Attestation:** Our organization uses an EHR.

F2. Which EHR does your organization use? If planning to change EHRs, please give details.

☐ Check box if a CIN or Other Partner will answer this question on your behalf via the CIN or Other Partner Supplement.

F3. Describe what care management data system(s) your organization will use to track assessments, care plans/ISPs, and care team actions. (Note: if requirement is met by an EHR component, please detail which system and module.)

☐ Check box if a CIN or Other Partner will answer this question on your behalf via the CIN or Other Partner Supplement.

F4. Describe how your organization will import, curate, and analyze claims/encounter data to support care management.

### Data Access

F5. Describe how your organization will manage access to patient information in a way that is secure and appropriate to their role on the care team.

### Establishing Patient Panel

☐ Check box if a CIN or Other Partner will answer this question on your behalf via the CIN or Other Partner Supplement.

F6. Describe the process your organization will use to ensure that assignment files are transmitted to the practice by each BH I/DD Tailored Plan, are reconciled with the practice's panel list, and are up to date in the clinical system of record.

☐ **Check box if a CIN or Other Partner will answer this question on your behalf via the CIN or Other Partner Supplement.**

F7. Will your organization plan to use a method in addition to the Department's acuity methodology to assign and adjust risk status for each assigned patient? If so, describe the factors considered in this model, the types of data used, known data limitations, and how the model may be used to indicate patient status, status changes, etc.

**G. Quality Measurement and Improvement [total page limit: 2, excluding attachments]**

☐ **Check box if a CIN or Other Partner will answer this question on your behalf via the CIN or Other Partner Supplement.**

G1. Describe how your organization will participate in quality measure documentation, data collection and abstraction, analysis, and outreach in accordance with current Department requirements.

G2. Describe how your organization will periodically (at least annually) evaluate care management systems, processes, and services to ensure that appropriate services are being provided to members, and to drive improvement in outcomes.

**H. Training**

Check box to attest.

☐ **H1. Attestation:** Our organization will ensure that all care managers and supervising care managers complete required Tailored Care Management training as set out in this Manual.

**NON-SCORED: Building Capacity for Provider-Based Care Management**

The Department plans to make funds available to support organizations in becoming high-performing providers of Tailored Care Management and expects the areas of greatest need to be recruiting and hiring care managers, health IT infrastructure and systems related to care management, training and technical assistance on elements of the Tailored Care Management model, and operational readiness to launch the model.

To help inform how to direct capacity building funds, please rank the below based on area of greatest to lowest need at your organization (**1 being the greatest area of need, and 4 the lowest**):

\_\_\_ Recruitment and hiring of care managers

\_\_\_ Training and technical assistance on elements of the Tailored Care Management model  
(please specify)

\_\_\_ Health IT systems/infrastructure related to care management (e.g., acquisition, access, or integration of new systems, modules, or applications)

\_\_\_ Operational readiness (e.g., developing policies and procedures related to Tailored Care Management)

Please describe any other areas where capacity building funds could support your organization's success in Tailored Care Management.

**Updated December 2, 2020**

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NC DEPARTMENT OF  
**HEALTH AND  
HUMAN SERVICES**

## **Behavioral Health and Intellectual/Developmental Disability Tailored Plan**

### **Tailored Care Management Certification CIN or Other Partner Supplement**

#### ***D. Staffing [total page limit: 6]***

D1. Having considered the minimum qualification requirements and contact requirements, please provide an estimate of how many dedicated FTEs you would expect to employ to perform each of the Tailored Care Management roles below, during the first 1-2 years of the model:

- Care managers serving members with behavioral health disorders
- Supervising care managers serving members with behavioral health disorders
- Care managers serving members with I/DD or TBI
- Supervising care managers serving members with I/DD or TBI

Please indicate as part of your answer how many staff your organization **currently** employs who meet the minimum criteria outlined above. What are their qualifications?

How will your organization ensure that care management is integrated with the care being provided at the practice level, and that the practice has managerial control of care management staff?

D2. Describe your recruitment strategy to attract and retain well-qualified care management staff that meet the educational and experience requirements established by the Department.

D3. If your organization achieves certification from the Department, describe any staffing expansion you would plan, with reference to each of the care manager staffing categories above.

#### ***E. Delivery of Tailored Care Management [total page limit: 14, excluding attachments]***

##### **Engagement and Contact Requirements**

E2. Given the description of member engagement in Section V., describe your proposed approach to actively engaging members assigned to you.

E3. Describe your proposed strategy to ensure that care managers meet the minimum contact requirements. Please describe any challenges you foresee in meeting the minimum contact requirements and what measures you will take to overcome these challenges.

##### **Care Management Comprehensive Assessment and Reassessment**

E4. Describe how your organization will approach comprehensive assessment of each member, tailoring the requirements above to the population you serve. Describe any challenges you foresee in

conducting assessment and reassessment according to the requirements above. Include in your answer how you will ensure that comprehensive assessments and reassessments are conducted within the required timeframes.

### **Development of Care Plan or Individual Support Plan**

E5. Describe how your organization will approach the development of an individualized, person-centered care plan/ISP for each member, tailoring the minimum requirements above to the population each practice serves, incorporating the findings from each comprehensive assessment and incorporating whole-person health needs. Describe any challenges you foresee in developing care plans/ISPs according to the requirements above. Include in your answer how you will ensure that care plan/ISP development is conducted within the required timeframes.

E6. Describe your proposed process to update each care plan or ISP as individuals' needs change and/or to address gaps in care, including, at a minimum, review and revision upon reassessment.

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### **Operation of the Care Team**

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- Regular communication and information sharing across the team (via case conferences) that support care integration and care transitions; and
- Coordination of services provided by community and social support providers, as well as other care coordination as described in Section V. above.
- Regular communication and information sharing between the CIN or Other Partner and the provider organization.

### **Individual and Family Supports**

E12. Describe the methodologies you expect to use to connect members and families to appropriate resources for self-advocacy, navigating the service system, guardianship options/alternatives, employment, and family planning.

### **Transitional Care Management**

E14. Describe the methodologies your organization uses or would propose to use to identify members who are in transition or at risk of readmissions and other poor outcomes, including the process you use or will use to respond to certain high-risk ADT alerts including:

- Real-time (minutes/hours) response to outreach from EDs relating to patient care or admission/discharge decisions (e.g., arranging rapid follow-up after an ED visit to avoid an admission);
- Same-day or next-day outreach for designated high-risk subsets of the population to inform clinical care, such as members with special health care needs admitted to the hospital; and
- Within a several-day period to address outpatient needs or prevent future problems for high-risk patients who have been discharged from a hospital or ED (e.g., to assist with scheduling appropriate follow-up visits or medication reconciliations post-discharge).

**Diversion**

E15. Describe your organization's current or proposed approach to diversion from institutional settings, including methods for identifying members most at risk and approach to connecting members to community-based supports.

**Innovations and TBI Waiver Care Coordination (if applicable)**

**Innovations and TBI waiver applicants only:**

E16. If you intend to serve the Innovations and TBI waiver population, describe your organization's proposed approach to perform the additional requirements detailed in the Provider Manual for coordinating care for this population.

***F. Health IT [total page limit: 8, excluding attachments]***

**Core Health IT Systems for Care Management**

F3. Describe what care management data system(s) your organization will use to track assessments, care plans/ISPs, and care team actions. (Note: if requirement is met by an EHR component, please detail which system and module.)

F4. Describe how your organization will import, curate, and analyze claims/encounter data to support care management.

**Establishing Patient Panel**

F6. Describe the process your organization will use to ensure that assignment files are transmitted to the practice by each BH I/DD Tailored Plan, are reconciled with the practice's panel list, and are up to date in the clinical system of record.

F7. Will your organization plan to use a method in addition to the Department's acuity methodology to assign and adjust risk status for each assigned patient? If so, describe the factors considered in this model, the types of data used, known data limitations, and how the model may be used to indicate patient status, status changes, etc.

***G. Quality Measurement and Improvement [total page limit: 2, excluding attachments]***

G1. Describe how your organization will participate in quality measure documentation, data collection and abstraction, analysis, and outreach in accordance with current Department requirements.