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

**Application Questions**

*Please copy and paste all questions below into a document and answer all questions. Please stay within the page (side) limits indicated below for each section. Please note that applications will be reviewed “blind.” Therefore, please do not identify your organization by name other than in Section A and in attachments (organizational chart, audit etc.).*

*When your application is complete, email your answers and attachments (clearly labeled) to Kelsi.knick@dhhs.nc.gov. The first deadline for applications is February 7, 2020.*

***A. Organization Description and Contact Information***

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| A1. Legal Entity Name |
| A2. DBA Name |
| A3. Year Established |
| A4. Corporate Address |
| A5. Does your organization use more than one billing TIN?   * Yes * No * Unknown |
| A6. Please list all TINs that your practice has used to bill Medicaid since January 1, 2017. |
| A7. What billing TIN will your organization use for Tailored Care Management? |
| A8. Application Contact   * First Name * Last Name * Title/Position * Business Phone Number * Business Email Address |
| A9. Organization Primary Point of Contact *(if different from Application Contact)*   * First Name * Last Name * Title/Position * Business Phone Number * Business Email Address |
| A9. Health IT Contact *(if different from above contacts)*   * First Name * Last Name * Title/Position * Business Phone Number * Business Email Address |
| A10. In which current LME-MCO region(s) is your organization located? Please list all sites/locations within those regions that would be involved in Tailored Care Management. |
| A11. If known, provide the names of management level executive(s) who will supervise the care management team and provide close oversight of the Tailored Care Management program during startup and on an ongoing basis. |
| * A12. **Attestation:**  Our governance Board (or equivalent) has approved this application. |

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

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| B1. What is the scope of services that your organization offers? (check all that apply)   * Mental Health * Substance Use Disorder (SUD) * I/DD, TBI, Innovations Waiver, and/or TBI Waiver * Co-occurring I/DD and behavioral health * Internal medicine/family medicine/pediatrics/other primary care * Other   Please provide the number of years you have provided each service. Do you have any planned changes in service scope over the next 12 months? |
| B2. (Behavioral Health organizations): Does your organization currently serve populations with both SUD and mental health needs? If not, please indicate the timeframe on which you will build capacity to do so. |
| B3. What volume of clients with a behavioral health condition, an I/DD, or a TBI does your organization serve in a given year? |
| B4. What percentage of your revenue comes from the following services?   * Behavioral health * I/DD * Internal medicine/family medicine/pediatrics/other primary care |
| B5. What is your payer mix across all **behavioral health services** at the sites that you anticipate serving as an AMH+ or a CMA, by client volume and by revenue? (please provide approximate percentages)   * Medicaid * Medicare * Uninsured * Commercial/private * Self-pay/out of pocket * Other |
| B6. What is your payer mix across all **primary care services** at the sites that you anticipate serving as an AMH+ or CMA, by client volume and by revenue? (please provide approximate percentages)   * Medicaid * Medicare * Uninsured * Commercial/private * Self-pay/out of pocket * Other |
| B7. What is your payer mix across all **I/DD services** at the sites that you anticipate serving as an AMH+ or a CMA, by client volume and by revenue? (please provide approximate percentages)   * Medicaid * Medicare * Uninsured (State Funded) * Commercial/private * Self-pay/out of pocket * Other |
| B8. What percentage of the population you serve do you expect to be covered by the Medicaid BH I/DD Tailored Plans? Please indicate if this information is based on collected data or best estimate. |
| B9. Describe your financial capacity to provide Tailored Care Management and **attach your 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 demonstrating 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). |
| B10. Describe your billing, accounting, and reporting system in place that aligns with the Department’s and BH I/DD Tailored Plan requirements. |
| B11. **Please attach your organization’s organizational chart.** |

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

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| * 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:   * An AMH+ * A 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 and Substance Use Disorder (SUD) * Adult * Child/adolescent * I/DD and TBI (populations that are not enrolled in the Innovations or TBI Waiver) * Adult * Child/adolescent * Innovations Waiver and/or TBI Waiver * Adult * Child/adolescent * Co-occurring I/DD and behavioral health * Adult * Child/adolescent |
| C4. 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 to be covered by BH I/DD Tailored Plans; * 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;   + If you are applying become a CMA, please describe your approach to integration with physical health; * 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. |
| C5. For AMH Tier 3 practices intending to be certified as AMH+ practices, please describe your experience to date serving as an AMH Tier 3 practice, including your leadership of risk stratification, comprehensive assessment, care planning, and other aspects of the AMH model. |
| C6. 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 |
| C7. If you plan to work with a CIN or Other Partner, please give any known details, including details of how care manager staffing would be organized at the CIN level versus AMH+ or CMA level. 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? |

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

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| 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? |
| 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. |
| 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. above. |

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

**Engagement and Contact Requirements**

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

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| 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**

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| 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 you serve, 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. |
| 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**

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| 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. |
| 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**

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| E10. Is your organization experienced in providing referral, information and assistance in obtaining community-based resources? Describe your proposed approach to the assistance requirements above. |

**Twenty-four-hour Coverage**

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| * 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**

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| E12. Describe your methodologies do 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**

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| E13. **Attestation (AMH Tier 3 practices):** we have access to ADT information and are experienced in using it for transitional care management per AMH Tier 3 requirements. |
| 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**

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| 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. |

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

**Core Health IT Systems for Care Management**

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| * F1. **Attestation:** Our organization uses an EHR. |
| F2. Which EHR does your organization use? If different, which EHR will your organization use to facilitate Tailored Care Management? |
| F3. Describe what care management platform(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. |

**Data Access**

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| 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**

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| 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]***

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| 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***

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