



## Documentation for Care Management

Part of being a Care Management Agency (CMA) or Advanced Medical Home + practice (AMH+) is meeting the minimum requirements for care management delivery and payment through documentation. The Tailored Plan's role is to ensure that documentation for provided care management is timely, accurate and complete.

### Why is documentation important?

A crucial part of service delivery depends on the documentation done in the process of delivering that service. The documentation should “tell the member’s story” and provide a view of the care management journey with the member. Good documentation is vital to tracking improved member outcomes and improves the overall quality of care for the member. In addition, documentation should support the claims billing process.

Required documentation paints a picture of the strengths and needs of the members to inform the care plan or individual service plan (ISP) for the member to make progress towards goals. It is important to note that the goals included in the plan are determined by the member’s choice of the areas to work on, and documentation should likewise reflect those areas.

The goals of standardized documentation are to:

- Tie goals to organizational objectives and mission.
- Link the goals to quality-improvement initiatives.
- Incorporate goal discussions in every meeting.

### Documentation requirements include the following:

Documentation requirements include the following:

- Care management comprehensive assessment (CMCA)
- Unmet health related needs screening (also known as social determinants of health)
- Care plan and individual service plan
- Notes/encounters/interactions
- Ninety-day post discharge transition plan, as applicable

*Continued*

# What are the documentation timelines for CMCA's and care plans/ISPs?

1. The CMA/AMH+ is required to initiate the CMCA within 30 days of enrollment in the Tailored Plan.
2. For **high acuity** members, the CMCA must be completed within 45-60 days of enrollment; for **moderate** and **low acuity** members, the CMCA must be completed within 90 days of enrollment.
3. The CMCA must be sent to all identified providers of services within 14 days of completion.
4. The care plan/ISP must be completed within 30 days of the completion of the CMCA.
5. The care plan/ISP must be sent to all identified providers of services within 14 days of completion.

Note that the timelines to complete the CMCA changes with contract years, as follows:

- During Tailored Plan contract year 1:
  - For members identified as high acuity, Tailored Care Management organizations make best efforts\* to complete the CMCA within 45 days and no longer than 60 days of the member's enrollment in the Tailored Plan.
  - For members identified as medium/low acuity: Within 90 days of Tailored Plan enrollment.
- During contract years after year 1: Tailored Care Management organizations make best efforts\* to complete the CMCA for new members within 60 days of Tailored Plan enrollment.

\* "Best Efforts" are defined as at least three documented strategic follow-up attempts to contact the member, such as going to the member's home or working with a known provider to meet the member at an appointment, if the first attempt is unsuccessful.

## Other notes:

If your CMA/AMH+ uses Jiva as your care management platform, the CMCA includes the unmet health related needs screening. If your organization is not using Jiva, you will need to ensure that these screening questions are included in your platform's documentation process. The unmet health related needs screening should be completed and updated along with the CMCA at a minimum.

Notes/encounters/interactions must be documented within your platform for every attempted or completed encounter or interaction, including outreach to support systems for the members.

Ninety-day post-discharge transition plans are informed by the CMCA and the CMCA should be updated when individuals are discharging from a residential or inpatient setting.

## Reference:

RFA Section V A - B