



NC Department of Health and Human Services

MCT 111: Care Management for Long-Term Services and Supports Populations

Kelly Crosbie, Deputy Director

**Trish Farnham, Senior Policy Analyst
Quality and Population Health**

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Context for Medicaid Transformation

In 2015, the NC General Assembly enacted Session Law 2015-245, directing the transition of Medicaid and NC Health Choice from predominantly fee-for-service (FFS) to managed care.

Since then, the North Carolina Department of Health and Human Services (DHHS) has **collaborated extensively** with clinicians, hospitals, beneficiaries, counties, health plans, elected officials, advocates, and other stakeholders to shape the program, and is committed to ensuring Medicaid managed care plans:

- Deliver **whole-person care** through coordinated physical health, behavioral health, intellectual/developmental disability and pharmacy products and care models
- Address the **full set of factors** that impact health, uniting communities and health care systems
- Perform **localized care management** at the site of care, in the home or community
- Maintain broad **provider participation** by mitigating provider administrative burden

Terms and Acronyms Used Today

- **ABD:** “Aged, Blind, Disabled” Medicaid Eligibility Category
- **ADT:** Admission, Discharge and Transfer Data
- **AMH:** Advanced Medical Home
- **LTSS:** Long Term Services and Supports
- **NCQA:** National Committee for Quality Assurance
- **PCP:** Primary Care Provider
- **PHP:** Prepaid Health Plan

The LTSS High Priority Care Manager

Individuals and their families have a strong, highly competent, consistent case manager or case management entity who serves as the person's ally and follows the person through services and across lifespan.

Summarized from *What Whole Person Care Means 2014 Stakeholder Synthesis*

Guiding Principles for Care Management under NC Medicaid Managed Care

- Medicaid enrollees will have access to **appropriate care management**
- Care management should involve **multidisciplinary care teams**
- **Local care management** is the preferred approach
- Care managers will have access to **timely and complete enrollee-level information**
- Enrollees will have access to **programs and services that address unmet health-related resource needs**
- Care management will align with **statewide priorities for achieving quality outcomes and value**

Key Aspects of Care Management in NC Medicaid Managed Care

Care Management

Members with high medical, behavioral or social needs should have access to a program of care management that includes the involvement of a multidisciplinary care team and the development of a written care plan.

-Revised and Restated
RFP 30-190029-DHB

Everyone screened for care management through care needs screening.

Provided to identified “priority populations” including LTSS.

Team-based support and coordination driven by person centered care plan and identified goals.

Coordination of physical, behavioral and social services.

Includes transitional care management to assist through transitions.

NC Medicaid's Care Management "Priority Populations"



Individuals with Long Term Services and Support Needs

Individuals identified by the PHP as at Rising Risk

Adults and children with Special Health Care Needs

Individuals with high unmet health-related resource needs

High-Risk Pregnant Women

At-Risk Children 0-5

Other priority populations as identified by the PHP.

All members identified as needing LTSS or at risk of needing LTSS shall be categorized as part of priority population and shall receive care management

NC DHHS Definition of LTSS for Purposes of Defining LTSS Care Management Priority Population

Individuals with Long Term Services and Support Needs

- Care provided in the home, in community-based settings, or in facilities, such as nursing homes;
- Care for older adults and people with disabilities who need support because of age; physical, cognitive, developmental, or chronic health conditions; or other functional limitations that restrict their abilities to care for themselves;
- A wide range of services to help people live more independently by assisting with personal and health care needs and activities of daily living; and,
- Care provided to individuals who, as a result of age, physical, cognitive, developmental or chronic health conditions or other functional limitations, are at risk of requiring formal LTSS services to remain in their communities.

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NC LTSS Care Management Priorities

- Ensure access to comprehensive care management for populations with or at risk for LTSS needs via screening, risk stratification or referral
- Ensure the PHP/AMH Comprehensive Assessment evaluates a member's clinical, non-clinical, social support and caregiver support needs in order to develop a person-centered care plan
- Embed the LTSS care management process in the broader PHP/AMH care management process to ensure a seamless experience for members
- Balance beneficiary protections with PHP flexibility and innovation
- Align LTSS care management policy with policies for other priority populations to the extent appropriate
- Leverage role of social service and community-based organizations in identifying, referring and developing care plans for individuals with LTSS needs

Facts about LTSS Care Management

- **Fact: All LTSS members will receive some form of care management.**

Light Touch

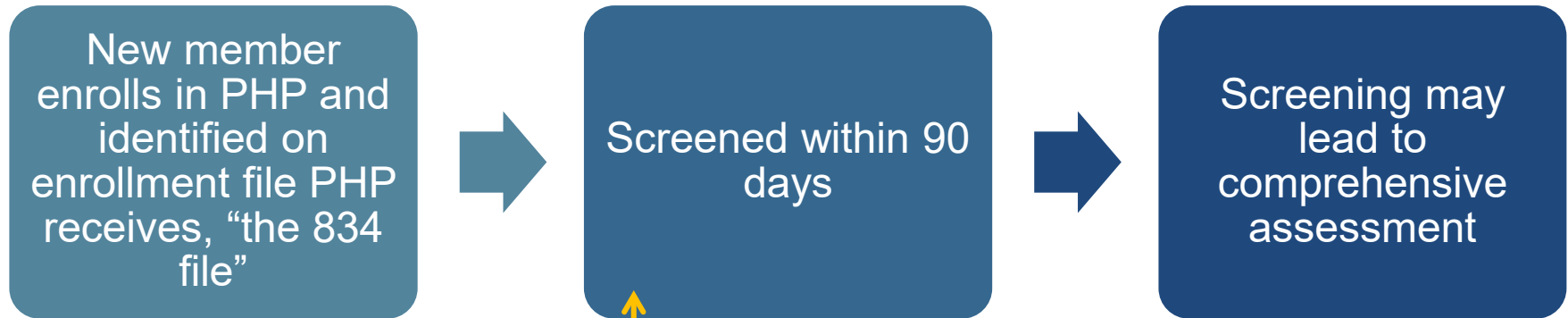
Intensive



- **Fact: Care management will be comprehensive**
 - Will integrate supports necessary to address social needs related to social determinants of health
 - housing, toxic stress, transportation, food insecurity
 - Will integrate person-driven goals related to continuing education, employment, etc.
 - Will consider caregiving-related needs of unpaid caregivers
- **Fact: Most PHPs are keeping their LTSS care management in house.**

How is a Person Determined to Be Part of the LTSS Priority Population if Person Doesn't Already Receive LTSS Services?

The LTSS Care Management Process: A Summarized Overview, Part I



LTSS Distinction: PHPs are required to have expedited screening process for newly enrolled ABD members. Not every ABD member will require care management.

NOTE: PHPs indicating screenings for newly enrolled ABD members will occur between 1 and 5 days.

Factors Considered in Screening

The purpose of the Care Needs Screening shall be to provide the PHP with general information about Members' health and to identify Members with unmet health-related resource needs who may require a Comprehensive Assessment, as defined by the Contract, for care management.

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Chronic or acute conditions

Chronic pain

Behavioral Health Needs

Medication

Other

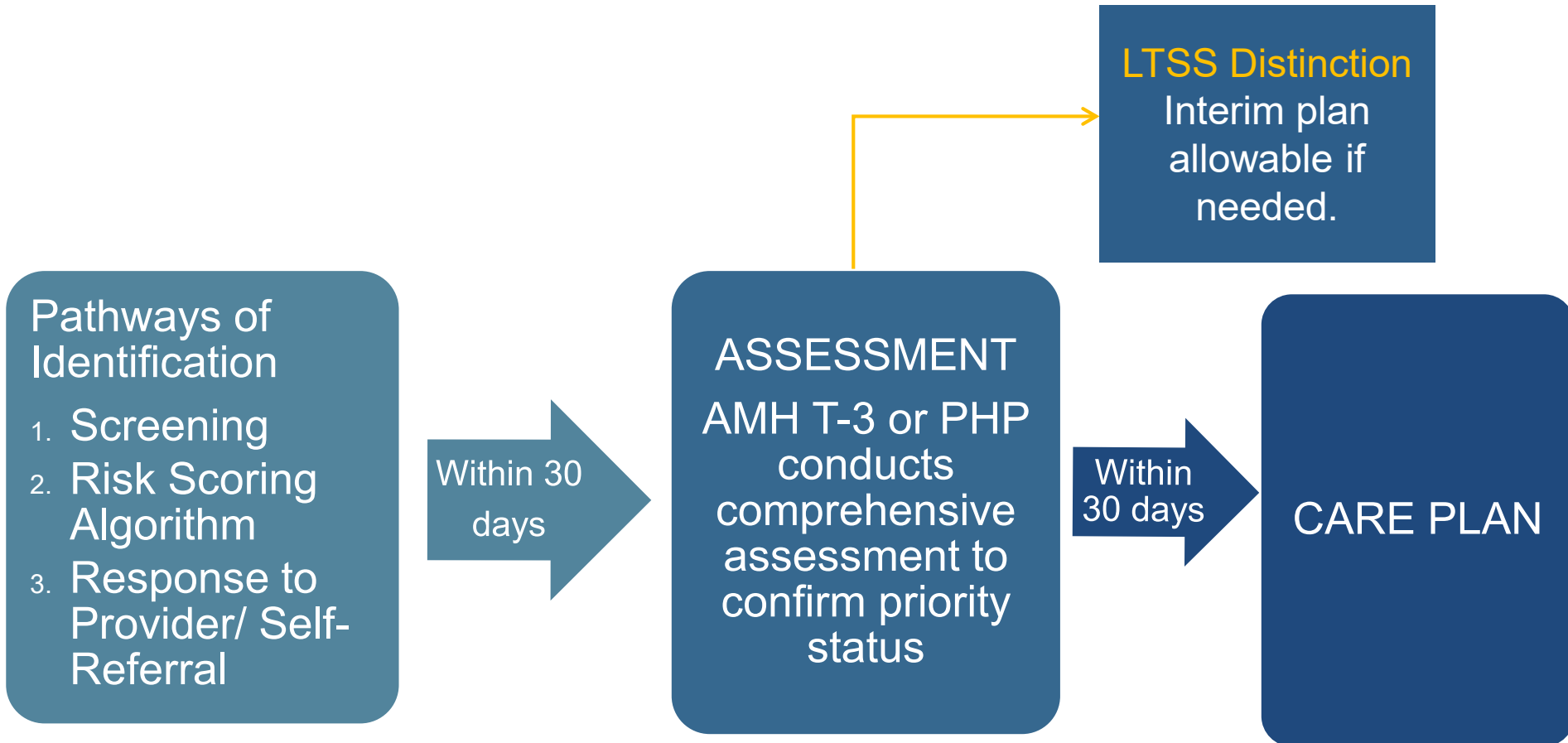
Housing Needs

Food Insecurity

Transportation Needs

Interpersonal Safety

The LTSS Care Management Process: A Summarized Overview, Part II



Pathways to Comprehensive Assessment

- Screening
- Identified through risk scoring and stratification algorithm.
- Referral
 - Self
 - Provider
 - Other social service agency

Pathways of Identification

1. Screening
2. Algorithm
3. Response to Provider/
Self-Referral

Comprehensive Assessment: Summary

Generally, Assessment:

- Is required for every member identified as High Priority Population.
- Is comprehensive, person-centered and tailored to the member's needs, following requirements specified in Contract.
- Is conducted in a location comfortable to the member.
- Is appropriate to member's demographic/needs.
- Meets timelines and routing requirements outlined the Contract.
- May not delay provision of necessary services.
- Conducted annually; change in circumstance or at member's request.

ASSESSMENT
AMH T-3 or PHP
conducts
comprehensive
assessment to
confirm priority
status

What does a comprehensive assessment include?

Member's immediate care needs

Member's current services

Others state or local services uses

Physical and dental health conditions

Current and past mental health conditions and substance use disorders

The Comprehensive Assessment shall be a person-centered assessment of a Member's health care needs, functional needs, accessibility needs, strengths and supports, goals and other characteristics that will inform whether the Member will receive care management and will inform the Member's ongoing care plan and treatment.

Medications-prescribed and taken

Unmet needs related to housing, transportation, food and toxic stress

Ongoing special conditions that require a course of treatment

Factors indicating need or at imminent risk of requiring LTSS

Caregiving-related needs of member's unpaid, informal caregiver

Additional optional assessment domains such as childhood trauma

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Comprehensive Assessment: LTSS Considerations

An Assessment for LTSS Priority Members Also:

- Assesses members who may be at risk for future LTSS needs.
- Integrates the caregiving-related needs of unpaid caregivers.
- Is informed by and coordinates with federally mandated assessments (MDS 3.0 and OASIS).

Care Planning Considerations

Generally, Care Planning is

- Is informed by screening and assessment.
- Is individualized, person-centered and collaborative.
- Should not delay needed services
- Should include the specific requirements and follow timelines as outlined in RFP.

Generally, a Care Plan:

- Must include, at minimum, content outlined in Contract.
- Should be regularly updated, at minimum at points specified in contract.
- Documented and available to care team members, including AMH/PCP

The LTSS Care Management Process: A Summarized Overview, Part III



Care Management, Generally

Care Management Functions:

- Provided in accordance with Care Plan.
- Care Management provided to every high need member.
- Works to addressing social resource needs, including but not limited to economic, housing and legal issues adversely affecting health.
- Informing member of care management rationale and functions; disclosure of information to third parties; appeals and grievances processes.

Care Management, Generally (continued)

Care Management Design:

- Designated care manager for every high need member
- Multidisciplinary Care Team, including the member and representative.

Care Management, LTSS-Specific Requirements

- All regular care management requirements.
- Comprehensive Assessment.
- Care Manager may put interim plan in place.
- Transitional Care/Care Transitions requirements, as outlined in the Contract.
- Transition planning must include linkage to appropriate housing options.
- Revise a Member's care plan in accordance with time and events identified in the Contract.
- Transition out of an institutions considered *change in circumstance*, triggering re-assessment

So what does all that mean?

Abe is 52 years old and has a disability related to a car accident a year ago. He receives Medicaid and PCS. He lives alone and doesn't work right now but misses it. He has several doctors and struggles to get to key appointments. He experiences depression and is still adapting to living with his disability.

Abe would be eligible for care management from his PHP.

His care manager would assess his needs and with Abe develop a care plan.

His care manager would make sure that Abe's doctors are sharing information and coordinating with each other.

Care management could include things like:

- Helping Abe find a therapist to help with his depression;
- Supporting Abe in finding community resources to assist in adapting to his disability.
- Assisting Abe in accessing necessary transportation.
- Helping Abe advance his interest in returning to work through goal setting and service linkage.

Closing Out Care Plan (including LTSS)

- Generally,
 - PHP must have Care Plan close out policies and procedures, including member notification.
- LTSS Continuity of Care Requirement:
 - If LTSS eligibility ends and care management is no longer required, care manager shall continue role after the determination that the LTSS High Priority designation is no longer appropriate for a time specified by the circumstance and in the care plan.

A Note about Transitional Care Management

- Broader than just LTSS Priority Population, but disproportionately impacts LTSS beneficiaries.
- PHPs shall manage care transitions between clinical settings.
- PHPs required to develop transitional care management policies and procedures.
- Must have methodology for identifying members at risk of readmissions/poor outcomes.
- PHPs must have access to ADT file and establish processes for appropriate response to ADT alerts.
- Transitional Care Management specific functions apply to both care transitions and transitions of care between health plans/payment delivery systems.

A Note About HIV Care Management

- PHPs may contract with local HIV case managers at their discretion.
- The PHPs shall coordinate with local Ryan W. White HIV programs and providers.

Care Management Qualifications and Training

- Care Teams must be led by RN or LCSW and integrate appropriate team members, including those specified in the Contract.
- Care management staff must show competencies in person-centered care planning; motivational interviewing, trauma informed care and other requirements identified in Contract.
- Care manager must receive training in the areas identified in the Contract.
- Care manager must be conflict-free.

Care Management Qualifications and Training: LTSS Specific Considerations

- **Additional Requirements:**
 - 2 years of prior LTSS and/or HCBS coordination, care delivery monitoring and care management experience
 - Prior experience with social work, geriatrics, gerontology, pediatrics, or human services.
- **Additional Required Trainings/Competencies:**
 - LTSS-specific person-centered assessment and care planning
 - LTSS cultural competency
 - Independent living principles
 - Navigating the Medicare program
 - Employment-related supports
 - School-related services and concepts such as the Individual Education Plan (IEP) process and school-related transition planning
 - Participation in LTSS-related trainings as identified by DHHS

Oversight of Care Management

- **Readiness Review**
- **Rigorous reporting and monitoring.**
 - Member level, LTSS specific
 - Tracking why and how members are screened and assessed.
 - Trending in care planning
 - Monitoring of member to care manager ratios.
 - Collaboration with other DHB reporting and oversight related to member services, utilization management and adverse determinations.
- **LTSS Members are part of broader NC DHHS Quality Strategy**
 - External Quality Review
 - NCQA Accreditation with LTSS Distinction by Year 3 of Contract

LTSS in NC Medicaid Managed Care

The populations using LTSS are extremely diverse in terms of individuals' care needs, service utilization and spending. Over the next five years, the transition of programs that support these citizens will offer significant opportunities to improve care coordination, access to community-based services and outcomes for these vulnerable populations...

North Carolina's Vision for Long-term Services and Supports Transition to Managed Care



Questions?

Staying Current

- **Questions we didn't cover? Email:**
Medicaid.Transformation@dhhs.nc.gov
- **Stay Updated:**
 - NC Medicaid Transformation website
 - Providers may benefit from signing up for NC TRACKS Email Distribution List.
 - More opportunities to come!
- **More provider resources and to register for Webinars:**
 - <https://medicaid.ncdhhs.gov/provider-transition-managed-care>
- **Additional Resources for the LTSS Community**
 - [How Will NC Medicaid Managed Care Open Enrollment Affect Me?](#)
 - *How does North Carolina's Move to Medicaid Managed Care Affect Me? A Guide for People with Disabilities and Older Adults Who Use NC Medicaid*
 - Related webinar

Upcoming DHHS-Sponsored Webinars

- **For August 15, 2019: MCT 112**
 - **Supporting the LTSS Community through the Transition to Managed Care**
 - As NC transitions to managed care, North Carolina is establishing processes for ensuring providers and members have a smooth transition. This webinar will discuss activities related to Prior Authorization submissions and provider payment considerations at the time of transition.
- **For September 5, 2019: MCT 113**
 - **NC's Transition to Managed Care: The Crossover Series**
 - This session provides general crossover guidance, with a focus on identifying beneficiary managed care detail and guidance on submitting prior authorization requests during the crossover period.
- **For September 19, 2019: MCT 114**
 - **NC's Transition to Managed Care: The Crossover Series (Continued)**
 - This session is a continuation of the session on Sept. 5, 2019, providing a brief review of topics previously covered and additional guidance for supporting beneficiaries through the transition to Medicaid Managed Care.