**Program Guide**

**Care Management for Members with LTSS Needs 2.0**

**April 2021**

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1. INTRODUCTION

# North Carolina’s Vision for Long Term Services and Supports in Managed Care

People who rely on Medicaid Long Term Services and Supports (LTSS) are among North Carolina’s most vulnerable citizens. The Department wants to ensure that this population experiences a seamless transition to NC Medicaid Managed Care and receives high-quality, accessible services that foster well-being and facilitate engagement in community life. The populations using LTSS are extremely diverse in terms of individuals’ care needs, service utilization and spending. Managed care can offer significant opportunities to improve care coordination, access to community-based services, and outcomes for these vulnerable populations, but requires special planning and preparation to ensure relationships with long-standing clinical and non-clinical providers will not be disrupted in the transition, that Health Plans will be experienced in serving populations LTSS needs—including people with disabilities—in a culturally competent manner, and that quality of care will be measured in a way that is meaningful to people who use LTSS.

# The LTSS Framework for Care Management

Members with LTSS needs are one of the Department’s priority populations for Health Plan care management. The Department recognizes that members with LTSS needs have unique and sometimes challenging service dynamics that are best supported by robust care management protocols. Under managed care, Health Plans assume expanded and specific care management responsibilities for members with LTSS needs.

The *NC Medicaid LTSS Care Management Program Guide* (Program Guide) is intended to guide Health Plan development of care management practices for members with LTSS needs. To this end, the Department has identified eight guiding principles around which Health Plan LTSS care management practices should be organized:

**Guiding Principle I:** Health Plan care management policies and practices should align with and support the Department’s vision of a robust coordinated care process for members with LTSS needs.

**Guiding Principle II:** Health Plan care management policies and practices are required to adopt a “whole person”, person-centered, approach in identifying and addressing a member’s physical, behavioral and psycho-social needs.

**Guiding Principle III:** Health Plan care management policies and practices prioritize member self-determination and advance the goals of the *Americans with Disabilities Act*[[1]](#footnote-1)and the U.S. Supreme Court’s subsequent *Olmstead v. L.C.* decision.[[2]](#footnote-2)

**Guiding Principle IV**: Health Plan care management policies and practices should recognize service dynamics specific to the LTSS population, including:

* the use of state-sponsored programs;
* the role of natural and informal supports in service delivery;
* the impact of housing and living arrangements on access to and quality of services and supports

**Guiding Principle V:** Health Plan care management policies and practices should recognize the time-sensitive, often urgent service needs that a member with LTSS needs may require, particularly as the member transitions from a clinical care settings such as the hospitals or nursing facilities back to the community. Further, policies and practices should recognize the dynamic nature of an LTSS beneficiary’s care management needs, with levels of engagement often fluctuating based on clinical condition, support availability and other member-specific factors.

**Guiding Principle VI:** Health Plan care management policies and practices should be sensitive to a member’s experience at times of transition that may result in significant changes in service delivery and support availability. Examples include becoming Medicare-eligible; school-related transitions, and disenrollment related to long-term facility stays and enrollment in waiver programs.

**Guiding Principle VII:** Care management is voluntary and may not be required by all beneficiaries utilizing LTSS services.

**Guiding Principle VIII:** Care management may be time limited, with the duration to reflect the member’s needs.

This Program Guide is informed and inspired by experiences within North Carolina’s LTSS community. The Program Guide integrates requirements, clarifications and guidance to fully articulate the Department’s intended direction for serving LTSS members in a managed care environment. The Program Guide’s contents are aligned with the broad direction of the National Committee for Quality Assurance (NCQA) LTSS Distinction standards[[3]](#footnote-3) and Centers for Medicare and Medicaid Services (CMS) Managed Long Term Services and Supports Quality Measures technical guidance.

The guidance included in this Program Guide is intended to balance the need for robust member protections with the flexibility Health Plans need to develop responsive and innovative practices.

# The Scope of the NC Medicaid LTSS Care Management Program Guide

This Program Guide is directed at Health Plans and their care management teams who will be serving members with LTSS needs. While informed by the experience of NC’s fee-for-service (FFS) program, the guidance provided in this document may not be entirely applicable outside the manage care service delivery model

The Program Guide augments and clarifies the Department’s care management requirements as they relate to members with LTSS needs. The Program Guide details the required and recommended practices related to care management provided to Health Plan members who meet the established definition of *Long-Term Services and Supports.[[4]](#footnote-4)*

The Program Guide is intended to clarify and supplement the requirements established in the Health Plans contract (“the Contract”), as reflected in the NC DHHS DHB, *Revised and Restated Request for Proposal #: 30-190029-DHB, Prepaid Health Plan Services.* It should not be interpreted as supplanting relevant requirements in the Contract. In the case of inadvertent inconsistency between the Health Plans Contract and the Program Guide, the Health Plan Contract remains the authority document. Information referenced as “guidance” in this document is advisory.

Importantly, the Department intends this Program Guide to be the first in a compilation of LTSS-focused guidance to the Health Plans. At a minimum, the Department intends to draft a comparable, companion guide which will focus on LTSS quality management program design and practices. The Department also intends to issue a resource supplement to this Program Guide, to assist care managers in their orientation.

While the content of the Program Guide was developed in strong collaboration with LTSS subject matter experts throughout NC Medicaid and the Department, LTSS-related practices and requirements outside the scope of the Quality and Population Health section of NC Medicaid are not included in this Program Guide at this time.

# Defining the LTSS Priority Population

Members who are eligible for or currently utilize LTSS services or at risk of requiring LTSS services are considered the LTSS Priority Population. This designation requires the Health Plans to outreach to every member meeting the criteria to engage in screening and as appropriate assessment and care planning activities.

Recognizing that the majority of LTSS service utilizers have Medicaid eligibility in the *Aged, Blind or Disabled* (ABD) eligibility categories, the Department intends for Health Plans to identify and engage newly-enrolled ABD members to apply appropriate, pro-active care management interventions that will reduce or delay member dependence on formal LTSS services. Guidance for doing so is reflected in the Health Plan’s contract and the *Screening Members for LTSS Needs* section within this Guide.

Importantly, not all priority population members will elect or qualify for care management. Participation in care management is not a requirement or criteria for receiving clinically indicated services the member may require.

# Program Guide Applicability to Care Management Entity Supporting Members with LTSS Needs

The information in the Program Guide applies to LTSS care management practices regardless of the designated or contracted entity providing the care management.

# Applicable Citations Referenced in the Program Guide

The Program Guide references and clarifies content within the following sections of the Health Plan’s Contract.

Definitions, Contract Term, General Terms and Conditions, Other Provisions and Protections[[5]](#footnote-5)

Benefits and Care Management,[[6]](#footnote-6) specifically the following subsections:

* + - 1. *Care Management*
			2. *Transitions of Care*

Members,[[7]](#footnote-7) specifically the following subsection:

* + - 1. *Member Engagement*
1. CARE MANAGEMENT CONSIDERATIONS FOR MEMBERS WHO NEED LTSS

# Overarching Intended Care Management Design

As noted in the *Background* and as articulated in the Department’s LTSS-related contract requirements, the Department believes that care management provided to members with LTSS needs be comprehensive, person-centered and advance the Department’s policy direction. This requires a Health Plan integrate practices tailored to the LTSS population into its care management program and that its care management program accommodate the dynamics and circumstances experienced by members with LTSS needs.

This Program Guide provides LTSS-specific clarification and guidance on the following components of the Health Plans care management program:

* Outreach to Members Who May Qualify as a Member of the LTSS Priority Population
* Screening Members for LTSS Needs
* Conducting a Comprehensive Assessment with Members with Identified LTSS Needs
* Care Planning of Members with LTSS Needs
* Care Management for Members with LTSS Needs
* Managing Care Transitions for Members with LTSS Needs
* Guidance on LTSS Care Management Ratios
* LTSS-Specific Care Management Qualifications and Training
* Protections during Transitions of Care (TOC) for Members with LTSS Needs

# Outreach to Members Who May Qualify as a Member of the LTSS Priority Population

## Outreach: Summary of Related Contract Requirements

As noted in *Revised and Restated RFP 30-190029-DHB,* a member may self-refer to initiate an assessment of potential identification as a member of the Health Plan LTSS High Priority Population category. As also noted:

Members, their families, and caregivers need support in the transition to Medicaid Managed Care and as members in the Medicaid Managed Care program. The Health Plans will be responsible, individually and in partnership with the Department and other entities specified in this Contract, for assisting members and their families with understanding Medicaid Managed Care, navigating the health care system, improving overall member health through various avenues including maintaining a Member Services department, conducting member and community outreach, and providing education before, during, and after Medicaid Managed Care implementation.[[8]](#footnote-8)

This section of the Program Guide provides Health Plans with additional care management-related guidance for effectively meeting these requirements.

## Outreach: Additional Guidance for Supporting Members with LTSS Needs

A Health Plan’s outreach mechanisms should include methods for identifying members who may require LTSS care management but do not currently receive LTSS-specific services. Outreach mechanisms should recognize the service pathways typically experienced by members who may require LTSS supports. Pathways include but are not limited to: the hospital discharge process; enrollment in the CDSA network; the public-school system; engagement with Councils on Aging, Centers for Independent Living and through other community-based resources.

Social services often used by the LTSS population are acceptable sources of referral for a comprehensive assessment on behalf of a member. These include but are not limited to: Centers for Independent Living; Area Agencies on Aging; Division of Vocational Rehabilitation regional offices; local providers of non-Medicaid LTSS services; school systems and hospitals.

A Health Plan’s LTSS-related outreach materials should include information about the opportunity for LTSS care management to members who are at risk of needing, but do not yet receive, LTSS services.

# Screening Members for LTSS Needs

## Screening Members for LTSS Needs: Summary of Related Contract Requirements

As reflected in the Health Plans Contract’s definition of Long Term Services and Supports (LTSS) and noted in this Program Guide, members at risk of requiring LTSS services may also be deemed eligible for LTSS High Priority Care Management. The Department *does not require* a member to be *eligible* for an identified LTSS service to be deemed “at risk” of requiring services in the future.

The Care Needs Screening is a required mechanism to identify members of an identified “priority population”. Generally, Health Plans are required to “undertake best efforts” to conduct screenings on all newly enrolled members within 90 days of enrollment.[[9]](#footnote-9)

Medicaid beneficiaries in the *Aged, Blind or Disabled* (ABD) Medicaid eligibility categories represent the largest proportion of Medicaid LTSS utilizers. Additionally, newly enrolled ABD members may have urgent and unmet LTSS needs that place them at risk of requiring formal LTSS services, including possible institutionalization. To be responsive to this potential need, Health Plans shall provide an expedited, streamlined screening for all newly enrolled members who are in the *Aged, Blind or Disabled* Medicaid eligibility categories.

To preserve Health Plan’s flexibility and encourage innovative screening practices, the Department does not define “expedited” nor does it mandate a specific protocol for expediting screenings. The Department will evaluate Health Plan screening timeframes through reports generated by the Health Plan.

## Screening for LTSS Needs: Additional Guidance for Supporting Members with LTSS Needs

Health Plans are not required to develop separate and distinct Care Needs Screening tools to determine a member’s LTSS-related needs. However, the screening process used should be inclusive enough to screen for members who may be at risk, but do not yet require, LTSS services and minimize the burden on members having to tell and re-tell their history to obtain services. The Department recommends the following screening topics for identifying members “at risk” of LTSS:

* The need for support with Activities of Daily Living (ADLs) and/or Instrumental Activities of Daily Living (IADLs) not otherwise covered in NC’s state plan services;
* The presence of memory loss or cognitive issues due to a chronic condition or disability;
* The presence or reliance on paid or unpaid caregivers to manage ADL and/or IADL needs;
* The member’s need for medical monitoring or multiple clinical interventions related to a chronic condition or disability;
* Safety risk factors, both physical (e.g., risk of falls or weight loss), environmental (e.g., home structure) or behavioral (e.g. driving with decreased cognitive functioning).

# Conducting a Comprehensive Assessment with Members with Potential LTSS Needs

## Comprehensive Assessment: Summary of Related Contract Requirements

As noted in the Contract, the Department requires Health Plans to conduct a comprehensive assessment for anyone identified as a potential member of a Priority Population. Along with meeting other specifications outlined in the Contract, this assessment should be comprehensive, person-centered and tailored to the member’s needs and demographic.

For members being assessed for potential identification in the LTSS Priority Population, Health Plan shall integrate the following elements into Comprehensive Assessment process:

* Risk factors that indicate an imminent need for LTSS; and
* The caregiving-related needs of a member’s unpaid, informal caregiver.

If appropriate to the member’s circumstance, the Health Plan’s comprehensive assessment shall also be informed by and coordinate with federally required MDS 3.0 and OASIS assessments performed by nursing facilities and home health agencies, respectively.

As noted above, the Contract requires periodic reassessment of the member’s designation as a member of a care management priority population group. This reassessment may result in a change in status and a reduction or increase in services or care management.

NC’s LTSS community has identified the “service cliff” sometimes experienced by beneficiaries and their families when long-term services are reduced because of a change in condition or because of reaching an age-related eligibility limit. Changes in LTSS service provision, even if clinically warranted or predicted, may be initially disruptive to members and their caregivers. To mitigate the impact of service changes, the Department requires LTSS care managers to remain involved in a member’s life even if LTSS services are otherwise discontinued. The duration and level of continued Care Management involvement shall be determined by the member’s individual circumstance and reflected in the member’s care plan.

## Comprehensive Assessment: Additional Guidance for Supporting Members with LTSS Needs

In addition to the requirements provided in the Health Plan contract, the Department encourages Health Plans to assess for and where appropriate, integrate supports to address the following dynamics disproportionately experienced by LTSS beneficiaries:

* specific health status or condition;
* clinical history/medication regimen;
* ADL and IADL needs;
* behavioral or cognitive support needs;
* visual or hearing related support needs;
* social Functioning Support Needs (appropriate interaction with others);
* risk of abuse, neglect, exploitation;
* informal caregiver needs, goals and capacity;
* risk of isolation and interest in life enrichment opportunities;
* risk of housing instability and environmental safety concerns;
* risk of institutionalization;
* risk of emergent health needs during natural disaster;
* necessary supports for returning to competitive work;
* interest in and need for disability-related counseling;
* interest in and need for peer supports;
* opportunities to regain independence;
* other dynamics identified by the Health Plans.

# Care Planning of Members with LTSS Needs

## Care Planning: Summary of Related Contract Requirements

A Health Plan’s Care-planning process must incorporate all elements, practices and timeframes identified in the Contract. Notably, the Department expects the care plan development and ongoing care planning process be person-centered and collaborative. The care planning process should reflect the outcomes of the screening and/or assessments and incorporate supports for needs identified and well as acknowledge the strengths and abilities of the member.

The resulting care plan must include, at minimum, the content outlined in Contract documents and available to care team members, including the member’s AMH/PCP. The Care Plan should be regularly updated, following timelines, and triggering events identified in the Contract.

## Care Planning: Additional Guidance for Supporting Members with LTSS Needs

Consistent with person-centered practices, the Health Plan’s care planning processes for LTSS members should engage, where appropriate and authorized by the member,

* Member’s direct support staff;
* Representatives from non-Medicaid in-home or care management services used by the member;
* Member’s family and friends as identified by the member.

# Care Management for Members with LTSS Needs

## Care Management: Summary of Related Contract Requirements

The Department recognizes the central, vital role quality care management plays in effectively supporting high priority members.

As noted in the Department’s *North Carolina’s Care Management Strategy under Managed Care* concept paper:

Care management is foundational to the success of North Carolina’s health care system for Medicaid enrollees, supporting high-quality delivery of the right care at the right place, and at the right time in the right setting. Care management is a team-based, person-centered approach to effectively managing patients’ medical, social, and behavioral conditions.[[10]](#footnote-10)

To this end, the Department has established robust expectations for the Health Plan’s care management program and the program’s functions and activities. These requirements are more fully detailed in the Health Plan’s contract and include the expectations that care management be available to every priority population member and provided in accordance with the member’s Care Plan.

Further, care management must include, minimally the following functions as clinically appropriate:

* Coordination of physical, behavioral health and social services;
* Medication management, including regular medication reconciliation and support of medication adherence;
* Progress tracking through routine care team reviews;
* Referral follow-up;
* Peer support;
* Training on self-management, as relevant;
* Transitional care management as needed.

The Department further requires that care management be structured in a manner that addresses social resource needs, including but not limited to economic, housing, and legal issues adversely affecting health. Care managers must also inform members of care management rationale and functions; disclosure of information to third parties; appeals and grievances processes.

In addition to these general requirements, the Department has established care management requirements specifically applicable to members with LTSS needs. These LTSS-specific requirements are referenced and discussed in various sections of this Program Guide and summarized in the adjoining footnote.[[11]](#footnote-11)

# Care Management: Additional Guidance for Supporting Members with LTSS Needs

Inter-agency partnership is essential to quality care planning and effective coordination of care. Quality outcomes for members with LTSS needs may hinge on the Health Plan’s effective engagement with other entities involved in the member’s supports. Recognizing this dynamic, the Department has highlighted the following specific public and private partners that often play a key role in the LTSS member’s life. These entities should be viewed as collaborators in advancing a member’s personal goals or health outcome. These entities should be integrated into a member’s care planning process as appropriate and if authorized by the member.

* **The Member’s School.** Recognizing both the interrelated nature of Medicaid and school-sponsored programs and the Department’s priority on “whole person” care planning, the Health Plan should:
* Coordinate person-centered care planning activities with the identified representative from the member’s school, as appropriate and supported by the member’s authorized representative;
* Ensure the member’s comprehensive assessment and care plan are informed by a member’s Individual Education Plan (IEP) programming;
* **The LTSS Member’s Children’s Developmental Services Agency (CDSA) Program.** Members may be receiving care management from the CDSA program, managed by the Division of Public Health. A Health Plan should coordinate with CDSA program in the event a member may also qualify for LTSS care management.
* **Third Party Payers.** Members with LTSS needs may be covered by third-party payers. To create a more cohesive, coordinated care experience for members and their families, Health Plans should make documentable efforts to coordinate care strategies with providers or care managers available through the third-party coverage.
* **Employment Resources.** People with disabilities continue to have employment rates that are significantly lower than the nondisabled population.[[12]](#footnote-12) With over 70% of the Health Plan’s Year 1 ABD population projected to be between the ages of 22 and 64, the Department anticipates meaningful work may be an identified goal for many members. Accordingly, a care manager may need to coordinate and link with appropriate employment support and resources, including supported employment and benefits counseling. The Department strongly encourages Health Plans to develop organizational competency in accessing and coordinating with employment resources such as the Division of Vocational Rehabilitation and the Employment Security Commission to provide effective support for members interested in employment.
* **Housing Resources.** Permanent Supportive Housing (PSH) is an evidence-based practice that provides long term, safe, sanitary, and secure housing combined with individualized services and supports. The Department provides PSH to vulnerable populations throughout the state through multiple programs and partnerships. The Department encourages Health Plan-supported care managers and housing specialists to be familiar with the PSH resources available in North Carolina.
* **Additional Identified Publicly Sponsored Resources that Support Community-Based Living.** North Carolina has a rich network of organizations that advance community and independent living supports but are outside the scope of the NC Medicaid Program. While not an exhaustive list, Health Plans are strongly encouraged to understand and collaborate with these state or state-sponsored programs, as appropriate.

# Managing Care Transitions for Members with LTSS Needs

## Care Transitions: Summary of Related Contract Requirements

As part of its care management program, the Health Plan is required to assist members who are transitioning between clinical settings. While transitions are experienced within all Medicaid populations, they are often disproportionately experienced by members of the LTSS community. The Health Plan’s contract specifies requirements for both the transitional care program and care transition (also referenced as “transition care management”) functions. As reflected in the Health Plan contract, care transition functions include, at minimum:

* Outreach to the member’s AMH/PCP and all other medical providers;
* Facilitation of clinical handoffs;
* Obtaining a copy of the discharge plan and verify that the care manager of the member receives and reviews the discharge plan with the member and the facility;
* Ensuring that a follow-up outpatient and/or home visit is scheduled within a clinically appropriate time window;
* Conduct medication management, including reconciliation, and support medication adherence;
* Ensure that a care manager is assigned to manage the transition;
* Ensure that the assigned care manager rapidly follows up with the member following discharge;
* Develop a protocol for determining the appropriate timing and format of such outreach.

In addition to the general care transition functions identified in the contract and restated above, the Department has clarified that transitional care management also applies to transition from nursing facilities and other institutional settings and such transition also triggers a reassessment.

As also noted in the contract, the Department expects Health Plan housing specialists to ensure members who are transitioning from nursing facilities and back into community settings are connected to necessary housing resources.

To note, transitional care management function applies to care transitions between clinical settings, as provided in this section and to *Transitions of Care* as outlined in the subsequent section.

The Department has also clarified that *care transitions* refer to the activities surrounding a member’s change in care setting and when a member has a fundamental modification in services because of a change in life circumstance.

## Care Transitions: Additional Guidance for Supporting Members with LTSS Needs

In addition to the care transition requirements specified in Health Plan contract, the Department has invested in activities that cultivate stronger care transitions. For hospital transitions, the Department has long promoted the Care Transitions Intervention Model as conceptualized by Eric A. Coleman, M.D., MPH. The Department has also established practice standards to guide long-term care transitions.

In addition to aligning Health Plan transition practices to the models and standards referenced here, the Department advises that a Health Plan fully integrate housing-related activities into its transition design and practice.

Often the most significant care transition experienced by school-aged members with LTSS support needs is the transition out of secondary education. The end of school-based programming is a vulnerable, and potentially confusing time for impacted members and their families. As provided in the Health Plan contract and outlined in other sections of this Program Guide, a member’s care manager should engage with a member’s school and collaborate on school-based transition planning.

# Guidance on LTSS Care Management Ratios

The Department does not currently require the Health Plan adhere to set care management to member ratios in its care management caseloads. The Department will rely on reporting and other monitoring mechanisms to evaluate the Health Plan’s efficacy in proving care management to LTSS members in a manner that follows the Department’s LTSS Policy Direction as outlined in this Guide.

# LTSS-Specific Care Management Qualifications and Training

## Qualifications and Training: Summary of Related Contract Requirements

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.

In addition to competencies required for all care managers, the Health Plan contract establishes LTSS-specific care management competencies. Care managers working with members with LTSS needs must have:

* Two 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.

Further, care manager serving members with LTSS needs must have competency in the additional areas:

* LTSS-specific person-centered assessment and care planning;
* LTSS cultural competency;
* Independent living principles;
* Understanding and navigating the Medicare program;
* Understanding and navigating available employment-related supports;
* Understanding navigating school-related services and concepts such as the Individual Education Plan (IEP) process and school-related transition planning.

In addition to ensuring care planning teams and care managers meet the qualifications and competency requirements outlined in the contract, Health Plans must also ensure care managers receive adequate training on the topics identified in the Contract in addition to any LTSS-specific training the Department identifies.

## Developing Care Management Competencies: Additional Guidance for Supporting Members with LTSS Needs

The Department recommends Health Plans develop the internal capacity to access and where needed, coordinate with state programs, benefits and community services often used by NC’s LTSS community. Notably, a number of these resources may not be available to members in managed care. Because of North Carolina’s current Medicaid Managed Care enrollment and eligibility requirements, a member who does not currently use an identified service may require it upon transitioning out of the Standard Plan Health Plans. To ensure continuity of care and to fulfill transition of care-related requirements, Health Plans should build operating knowledge about the scope and eligibility requirements of these programs.

# Protections During Transitions of Care (TOC) for Members with LTSS Needs

## Transitions of Care: Summary of Related Contract Requirements

The Department has clarified that Transitions of Care is the process of assisting a member to transition between Health Plans or between other payment delivery systems, including transitions that result in the disenrollment from the managed care program. Transition of care also includes the process of assisting a member to transition between providers upon a provider’s termination from the Health Plan’s provider network.

The Department has also clarified that the transitional care management function applies to identified members experiencing a transition of care. For transitions of care across service delivery systems, transitional care managers will follow the protocols established by the DHHS Transition of Care Policy and reflected in the Health Plan’s Transition of Care Policy.

## Transitions of Care: Additional Guidance for Supporting Members with LTSS Needs

As will be reflected in its Transition of Care Policy, the Department anticipates care managed populations will likely require additional, personalized assistance from the Health Plan through any transition of care experienced by a care-managed member.

Further, the Department anticipates that transitions of care resulting in disenrollment will disproportionately impact members with LTSS needs. The Department will expect the Health Plans to establish protocols for identifying members who have a pending/anticipated change to their service delivery model. The Health Plans should consider the following disenrollment scenarios as it develops its TOC protocols. This list is not exhaustive but reflects the most likely disenrollment scenarios for members with LTSS needs:

* A member becomes Medicare-eligible (“Dual”), triggering an auto disenrollment from the Health Plans into the FFS service delivery model.
* A CAP/DA or CAP/C program waiver slot becomes available to the member and the member elects to utilize it;
* A member enrolls in PACE;
* An Innovations or TBI waiver slot becomes available to a Tailored Plan (TP)- eligible member and the member elects to utilize it;
* A member requires a nursing facility stay that exceeds 90 days or is admitted to a state-sponsored Neuro-Medical Center or Veterans’ Home.

As also referenced in the Department’s Transition of Care Policy, Health Plans should develop processes that:

* Identify a care managed member who will experience predictable transitions of care (e.g. becoming Medicare-eligible);
* Assist the member to prepare for the anticipated transition, through education, preparatory care planning and assistance with identifying and linking to appropriate options counseling and “receiving” entities;
* Ensure the member has been linked to identified “receiving” fee-for-service (FFS) program in a manner that ensures no disruption in the member’s care;
* Ensure the transitional care manager remains available to address follow-up questions after disenrollment from the receiving program.
1. CONCLUSION

The transition to managed care represents a significant shift in NC Medicaid’s LTSS design and invites new opportunities for providing well-coordinated, whole person supports to members with LTSS needs. The requirements and guidance reflected in this Program Guide represent an initial step in a long-term effort to build off the opportunities managed care creates to develop high-quality, accessible services that foster well-being and facilitate engagement in community life.

1. Information about the ADA is available at <https://www.ada.gov/> [↑](#footnote-ref-1)
2. Information about *Olmstead v. L.C* is available at <https://www.ada.gov/olmstead/olmstead_about.htm> [↑](#footnote-ref-2)
3. For additional information about NCQA LTSS Distinction, please visit: <https://www.ncqa.org/programs/health-plans/long-term-services-and-supports/> [↑](#footnote-ref-3)
4. *Revised and Restated RFP 30-190029-DHB, Section III, pg. 25* [↑](#footnote-ref-4)
5. *Revised and Restated RFP 30-190029-DHB, Section III.A* [↑](#footnote-ref-5)
6. *Revised and Restated RFP 30-190029-DHB, Section V.C* [↑](#footnote-ref-6)
7. *Revised and Restated RFP 30-190029-DHB, Section V.B* [↑](#footnote-ref-7)
8. *Revised and Restated RFP 30-190029-DHB, Section V*. pg. 22 [↑](#footnote-ref-8)
9. *Revised and Restated RFP 30-190029-DHB, Section V*., pg. 112 [↑](#footnote-ref-9)
10. *North Carolina’s care Management Strategy under Managed Care*, NCDHHS, March 9, 2019, pg. 3. [↑](#footnote-ref-10)
11. Requirements in accordance with 42 C.F.R. § 438.208 and identified in the *Revised and Restated RFP 30-190029-DHB, Section V*, pg. 118

Care Management for individuals receiving or at risk of requiring Long Term Services and Support (LTSS)

1. The Health Plan shall meet all general care management requirements for members with LTSS needs and shall meet additional requirements for members with LTSS Revised and Restated RFP 30-190029-DHB Request for Proposal Section V. Scope of Services Page 119 of 214 needs as described in this subsection and in accordance with 42 C.F.R. §438.208.

2. The Health Plan shall conduct a Comprehensive Assessment for all members identified as needing LTSS. The PHP shall use a Comprehensive Assessment tool to conduct such assessments that meets all requirements for Comprehensive Assessments given above.

3. The Health Plan shall ensure that the care manager may elect to put an interim plan in place to ensure that the member’s needs are met while the Care Plan is developed.

4. The Health Plan shall provide transitional care management for members with LTSS from a nursing facility or other institution that includes outreach to a member’s prior care managers, member’s PCP and all other medical providers. The Health Plan shall define transition out of an institution as a change in member circumstance and cause for re-assessment.

5. The Health Plans transitional housing specialist shall ensure that members using LTSS transitioning from nursing facilities to the community are connected to appropriate housing options as needed.

6. The Health Plan shall re-assess member needs for members with LTSS needs, and review and revise a member’s care accordingly, at least every twelve (12) months, at the request of the member, or when the member’s circumstances change. A change in member circumstances could include an increased need for care, decreased need for care, transition into or out of an institution, loss of a family/friend caretaker, or any other circumstance the plan deems to be a change in circumstance. The Health Plan shall participate in Department sponsored webinars, trainings and continuing education opportunities about LTSS-related practices and requirements as identified by the Department. [↑](#footnote-ref-11)
12. [*Person with a Disability: Labor Force Characteristics—2017*, US Department of Labor, Bureau of Labor Statistics, June 21, 2018.](https://www.bls.gov/news.release/disabl.nr0.htm) [↑](#footnote-ref-12)