Care Coordination by LME-MCOs in NC

Overview[i]

North Carolina no longer covers Targeted Case Management (TCM) under the Medicaid state plan (1915(b)/(c) waiver); however, children under age 21 can receive case management services through the federal EPSDT requirements, as long as such services are determined to be medically necessary.[ii]

Under the 1915(b)/(c) waiver, a number of activities that are associated with case management become the responsibility of the LME-MCOs. The LME-MCOs refer to these functions as "care coordination," which provides the following supports to consumers (see Appendix for MCO/LME contract detail):

- Education about all available MH/SA/DD services and supports, as well as education about all types of Medicaid and state-funded services.
- Linkage to needed psychological, behavioral, educational, and physical evaluations.
- Development of the Individual Support Plan (ISP) or Person Centered Plan (PCP) in conjunction with the recipient, family, and other all-service and support providers.
- Monitoring of the ISP, PCP, and health and safety of the consumer.
- Coordination of Medicaid eligibility and benefits.

LME-MCOs in NC follow state guidelines for what populations should receive care coordination services, and it is based on acuity of need. However, care coordination models and approaches vary considerably among LME-MCOs, with the result that there is not a consistent, statewide approach to care coordination.[iii]

Care Coordination for Children in the NC Child Welfare System

LME-MCOs in NC follow general state guidelines for what populations and acuity levels should receive care coordination services. In contracts with the MCOs, the state defines certain populations with "special health-care needs," who should be given priority for care coordination. MCOs are given leeway in the contracts to define additional priority populations, but those defined by the state are to be given first priority. For children, priority populations include those with:

- intellectually or developmental disability diagnoses,
- mental health diagnoses within specified diagnostic ranges, and
- any level of MH or SA diagnosis who are currently, or have been within the past 30 days, in a facility (including a YDC or detention center) operated by the DJJ or DOC for whom the MCO has received notification of discharge.[iv]

Currently, children with substantiated neglect or abuse cases, children in foster care, or children involved in the child welfare system are not state-defined priority populations to receive care coordination services.[v]

The August 2014 update of the DMH/SA/DD service definitions eliminates case management as a covered service.[vi] It is worth noting, however, that when NC covered case management under its Medicaid state plan, being in the custody of child welfare was considered a criterion for receiving case management (broad) and clinical case management (limited to the management of clinical services).[vii] It was recognized at that time that involvement with both the child welfare and mental health systems should be a trigger to receive case management services. That need has not changed, despite changes to the Medicaid state plan.

In addition, currently, for the Child with Serious Emotional Disturbance (CMSED) DMH/SA/DD benefit plan, children aged 3-5 are eligible if they meet any one of four criteria, one of which is "has substantiated physical abuse, sexual abuse, emotional abuse, or other environmental situations that raise significant concern regarding the child's emotional wellbeing." (This criterion is not included for children over age 5.) This is again recognition within NC that children involved in the child welfare system are a unique population that may need services solely on the basis of having undergone abuse and/or neglect.[viii]

State-Proposed Improvements to Care Coordination at the State Level: [ix]

MCO representatives report that care coordination determination is not clear cut, and that providers would tell you there are differences among MCOs in how those decisions are made.[x]

The Governor's Medicaid Reform Plan, released in March, highlights some proposed changes that could improve consistency of care coordination decision-making across the state:

- Employ stronger, clearer contract language and requirements that correspond to objective measures of performance and outcomes. For example, care coordination functions need more details regarding best practice models available and requirements for this function, such as expected caseloads and minimum proportions of populations to be affected.
- More technical assistance will be offered in care coordination best practices and functions, including how to identify and prioritize populations, models for intervention, how to integrate services, and measurement of outcomes

Care Coordination Practices among MCOs in NC (Cardinal, Smoky Mountain)

Neither of the LME-MCOs highlighted here considers involvement with the child welfare system a trigger for care coordination on its own. However, each MCO has developed its own system of determining what clients, beyond those state-defined priority populations, to offer care coordination services.

- **Cardinal Innovations** is finalizing a stratification system within their care coordination model, with three levels. Level III – complex case management – is comprised of clients in PRFTs and inpatient settings, or clients who have had a number of crisis-level services.

Levels I and II are in development, and these would be lower need/lower intensity of care coordination than the Level III. These levels would perhaps incorporate more of the child welfare-involved population. Cardinal also has an "other" category as a way to include some children who don't otherwise meet the state-outlined criteria for receiving priority for care coordination but whom they determine to be high need or high risk.

- **Smoky Mountain Center** uses a number of reports for risk-stratification to screen populations and select individuals for care coordination who are and will be at risk of future institutional or inpatient placement and functional decline. Examples include Top 20% of Service cost, Special Healthcare Needs, 3+ Emergency Services with a Calendar Year Report and the Supports Intensity Scale (for IDD). In addition, Smoky also accepts and screens referrals from any external or internal referral source. This has helped clarify the responsibilities of the MCO and CCNC for managing the care of quadrant IV (high BH and PH needs) enrollees.[xi]

(additional comments from Rhonda at Smoky): *I wanted to expand a little regarding my comment in the body of the summary. I realize that community partners and providers really do experience variation in CC interventions and populations, however, the contract language (at least to me) seems fairly direct about the core populations we are to prioritize. The prioritization (based on acuity), type and frequency of intervention and # of staff relative to contract requirements (especially around uninsured and IDD populations) seem to be the biggest variation. For example our DMH contract notes high risk/high cost populations and Top 20% of costs but the corresponding state funded admin budgets MCOs receive and the way budgets are allocated to CC Depts vary across MCOs. We also make it more complex because we choose to "add" populations based on the community need, etc. beyond the core contract requirements.*

These MCOs (and likely others in NC) recognize generally that child welfare-involved children and families are a unique population with a whole separate set of needs, but there is currently neither a state mandate nor adequate funding to provide broader-based care coordination services. For example, Smoky Mountain reports that funding care coordination is tricky, since it tends to start right when a child's costs are cresting in the system and it is often not until much later that you get the impact of the intervention (stabilization) that in turn brings the costs down. They are not currently funded to offer broader-based care coordination at the level they would like to (based on national best practice that intervening earlier is better, both for children and families and for long-term cost considerations). If money were available, they would intervene earlier to stabilize children and families and avoid more costs to multiple systems down the road.

APPENDIX: MCO/DMH Contract Language around Care Coordination

6.13 Care Coordination:

[MCO] shall coordinate Enrollee care by identifying priority populations and performing, at a minimum, the following Care Coordination functions, working within the Four Quadrant Model. [MCO] shall have a stated plan for addressing care coordination needs, including definition of priority populations, levels and types of care coordination tasks, referral pathways to and from medical care managers and other referral sources and resources, and objective outcome measures for care coordination effectiveness (see Attachment L). Care Coordination applies to all Medicaid eligible, including but not limited to those with dual eligibility (Medicare and Medicaid) and those served under the Innovations Waiver. Additional functions of Care Coordination for beneficiaries on the Innovations (c) waiver are specified in the Innovations Technical Manual.

a. **Care Coordination Functions**

Care Coordination shall involve connecting Enrollees to the appropriate level of care and ensuring they remain connected by identifying and addressing needs and barriers to treatment engagement. Clinical functions of care coordination shall be carried out by licensed care coordination staff for MH/SA Care Coordination or by Qualified Professionals for Care Coordination for beneficiaries with Intellectual/Developmental Disabilities. Clinical functions include but are not limited to identification of clinical needs and determination of level of care through case review, enrollee contacts, and arranging for assessments, clinical judgment in communication with providers, and assistance with and oversight of individual service plans and other clinical interventions. Administrative care coordination functions may be carried out by non-licensed staff working in a consultative role with the clinical care coordination staff. Administrative functions may include but are not limited to addressing additional support services and resources, assisting enrollees with arranging appointments, educating enrollees about other available supports as recommended by clinical care coordinators, and making phone calls to monitor enrollee attendance in treatment.

[MCO] shall coordinate Enrollee care by performing, at a minimum, the following Care Coordination/ Care Management functions.

1) **Minimums for All Enrollees, Based on Need – All clinical functions must be performed by designated Licensed Care Coordinators for the mental health and substance abuse populations. Some of the following non-clinical functions may be performed by individuals employed by [MCO] who are not designated as Care Coordinators.**

a) [MCO] shall be available twenty-four hours per day, seven days per week, to perform telephone assessments and crisis triage for enrollees receiving care coordination.

b) [MCO] shall coordinate and monitor Behavioral Health hospital and institutional admissions and discharges, including discharge planning;

c) [MCO] shall ensure that each Enrollee's privacy is protected in accordance with State and Federal law.

d) [MCO] shall develop engagement strategies for all recipients of care coordination, including identification of barriers to treatment, treatment needs, and referral needs.

e) [MCO] shall provide Enrollees with education about all available MH/SA/DD services and supports, as well as education about all types of Medicaid, state-funded services, and unpaid community supports.

f) [MCO] shall provide linkage to needed psychological, behavioral, educational, and physical evaluations;

g) [MCO] shall oversee development of the Individual Support Plan (ISP) or Person Centered Plan (PCP) in conjunction with the recipient, family, and other all service and support providers;

h) [MCO] shall monitor the ISP, PCP, and health and safety of the consumer;

i) [MCO] shall coordinate Medicaid eligibility and benefits;

j) [MCO] shall offer the same level of Care Coordination to Medicare/Medicaid dual eligible as is offered to Medicaid-only Enrollees.

2) **Care Coordination for Special Healthcare Needs Population**

[MCO] shall identify enrollees who have the following special healthcare needs.

a) Individuals with special health care needs are defined as:

i) <u>Intellectual and/or Developmental Disabilities</u>:
The following enrollees are considered a part of the Special Healthcare Needs Population:

a. Individuals who are functionally eligible for, but not enrolled in, the Innovations waiver, who are not living in an ICF-MR facility;

b. Individuals with an intellectual or developmental disability diagnosis who are currently, or have been within the past 30 days, in a facility operated by the Department of Correction (DOC) or the Division of Juvenile Justice of the Department of Public Safety (DJJ) for whom [MCO] has received notification of discharge.

ii) Child Mental Health:

The following enrollees are considered a part of the Special Healthcare Needs Population:

a. Children who have a diagnosis within the diagnostic ranges defined below:
293-297.99; 298.8-298.9; 300-300.99; 302-302.6; 302.8-302.9; 307-307.99; 308.3; 309.81; 311-312.99; 313.81 13.89; 995.5-995.59; V61.21
AND
Current CALOCUS Level of VI; or

b. Children with an MH or SA diagnosis who are currently, or have been within the past 30 days, in a facility (including a Youth Development Center and Youth Detention Center) operated by the DJJ or DOC for whom [MCO] has received notification of discharge.

iii) Adult Mental Health:

Adults who have a current LOCUS Level of VI and a diagnosis within the diagnostic ranges of: 295-295.99; 296-296.99; 298.9; 309.81

iv) Substance (non-Opioid) Dependent: Individuals with a substance dependence diagnosis AND Current ASAM PPC Level of III.7 or II.2-D or higher.

v) Opioid Dependent: Individuals with an opioid dependence diagnosis AND who have reported to have used drugs by injection within the past thirty days

vi) Co-occurring Diagnoses:

The following enrollees are considered a part of the Special Healthcare Needs Population:

a. Individuals with both a mental illness diagnosis and a substance abuse diagnosis AND Current LOCUS/CALOCUS of V or higher OR current ASAM PPC Level of III.5 or higher

b. Individuals with both a mental illness diagnosis and an intellectual or developmental disability diagnosis AND current LOCUS/CALOCUS of IV or higher

c. Individuals with both an intellectual or developmental disability diagnosis and a substance abuse diagnosis AND current ASAM PPC Level of III.3 or higher

b) **Care Coordination Functions for Special Healthcare Needs population:**

[MCO] shall prioritize and assign care coordination for enrollees within the special healthcare needs population and may identify additional priority populations. However, the special healthcare needs population defined here shall receive highest priority for care coordination. Care coordination functions should include the minimums for the general Medicaid population listed above as well as the following as clinically indicated:

i) Pursuant to 42 CFR Part 438.208(c), [MCO] shall implement mechanisms to assess each Medicaid enrollee identified as having special health care needs in order to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring; assessment mechanisms must use appropriate health care professionals, including the recipients primary care physician/CCNC Health Home.

ii) For enrollees with special health care needs who need a course of treatment or regular care monitoring, [MCO] shall be responsible for ensuring that a treatment plan is produced by the treating provider. For enrollees with recent crisis utilization not engaged in treatment with a behavioral health provider, [MCO] shall be responsible for developing a crisis plan and sharing this plan with future providers. The treatment plan must meet the following requirements:

(1) Developed with enrollees' care manager with enrollee participation, and in consultation with any specialists' care for the enrollee. The Enrollee or legally responsible person must sign the treatment plan in order for the service authorization request to be processed by Utilization Management. In the event that the Enrollee or legally responsible person does not agree with the treatment plan as developed, they will be given the option of submitting an alternate treatment plan or submitting the treatment plan as developed with a written statement or notation of their disapproval of the treatment plan.

(2) Approved by [MCO] in a timely manner (if approval required by plan).

(3) In accord with any applicable State quality assurance and utilization review standards.

(4) If a treatment plan or regular care monitoring is in place for an enrollee with special health care needs, [MCO] shall allow enrollees to directly access specialists as appropriate for the enrollee's condition and identified needs.

(5) [MCO] shall use Quality Monitoring and the Continuous Quality Improvement Process to ensure that individual treatment plans are developed consistent with 42 C.F.R. Part 438.208 and Part 456; and

(6) To ensure Enrollee participation in the treatment planning process.

iii) Care coordination provided to children in the Special Healthcare needs population should be consistent with the "System of Care" philosophy. Care Coordinators must:

i. use CFTs as the mechanism for developing Person Centered Plans (PCP), facilitate the planning process.

ii. build each CFT around the youth and family to meet their unique needs; and include relevant public and private providers, schools and natural and community supports that actively participate in the implementation, monitoring and evaluation of the PCP.

iii. ensure completion of a strengths assessment process that promotes the identification of the functional strengths of each youth, family and community and use them to build strategies

iv. included in the PCP which is based on the critical needs and unique strengths of the youth and family as identified by and in cooperation with the CFT, including sensitivity to racial, ethnic, linguistic and cultural differences of each family.

v. promote service delivery within the context of families and develop strategies built on social networks and natural or informal supports.

vi. design strategies with consideration given to maximizing the skills and competencies of family members to create greater self-sufficiency for parents and youth

vii. make significant efforts for services and supports to be delivered in the community within which the youth and family live, using the least restrictive settings possible to preserve community and family connections and manage costs.

viii. ensure regular updates to PCP to take into account changes with the youth and family, as well as the results of the supports and services provided, and document the shift of activity from formal supports to informal supports for greater self-sufficiency.

ix. ensure development of proactive and reactive crisis plans in conjunction with the PCP that anticipate crises and utilize family, team and community strengths to identify and describe who does what and when; every member of the CFT is provided a copy of the plan.

x. ensure that the majority of care coordination be performed in the community at locations and during times that are most convenient for the family and conducive to the active participation of CFT members.

3) Care Coordination for At-Risk-for-Crisis Enrollees

[MCO] shall provide follow-up activities for all At-Risk for Crisis Enrollees:

a) At-Risk for Crisis Enrollees include the following:

i) Enrollees who do not appear for scheduled appointments and are at risk for inpatient or emergency treatment; or

ii) Enrollees for whom a crisis service has been provided as the first service, in order to facilitate engagement with ongoing care; or

iii) Enrollees discharged from an inpatient psychiatric unit or hospital, a Psychiatric Residential Treatment Facility, or Facility-Based Crisis;

b) Follow-up activities shall include the following:

i) Notify an Enrollee's assigned BH provider of emergency or inpatient utilization if connected to a provider;

ii) Consult with any assigned BH provider to address appropriate level of care;

iii) Directly identify and address barriers to appropriate treatment for enrollees not yet connected to appropriate treatment providers (e.g., transportation,

need for further clinical assessment, identification of available resources, referrals);

iv) Monitor connectedness to treatment until Enrollee is no longer considered At-Risk or is well-connected to treatment

v) [MCO] shall develop relationships with local emergency departments and facilities in order to receive timely notification of patient discharges and emergency utilization;

c. <u>Four Quadrant Model for Collaboration with CCNC</u>

The Four Quadrant Care Management Model determines whether a consumer's primary concerns are related to physical health (PH) or behavioral health (BH) and assists in determining whether the Community Care of North Carolina (CCNC) network or [MCO] takes the lead on high risk/high cost Enrollees. Determination of appropriate Quadrant for a given Enrollee is a clinical judgment that can be reached in consultation with partner agencies (e.g., CCNC) based on the Enrollee's current Medical and MH/DD/SA condition complexity and risk level. Enrollees may move throughout the Quadrants over time and as conditions change. Whenever an Enrollee is receiving Care Coordination, [MCO] shall determine whether the Enrollee is also being managed by a CCNC care manager and collaborate with that CCNC care manager.

1) Four Quadrants
   a. Quadrant I
      i. Defined as Enrollees with low MH/DD/SA and low physical health complexity or risk
      ii. Enrollees determined to fall into Quadrant I are not likely to need Care Coordination, but are likely best served through AccessLine/STR referral services.
   b. Quadrant II
      i. Enrollees with high MH/DD/SA health complexity or risk and low physical health complexity or risk.
      ii. Enrollees in Quadrant II are the sole responsibility of [MCO] and the BH provider to meet MH/DD/SA needs, as well as to arrange for appropriate referrals for identified physical health needs.
   c. Quadrant III
      i. Defined as Enrollees with low MH/DD/SA and high physical health complexity or risk
      ii. Enrollees determined to fall into Quadrant III are not likely to need intensive Care Coordination, and may be served through AccessLine/STR referral services, depending on level of need and risk for developing significant behavioral health complications.

d. Quadrant IV

i. Enrollees in Quadrant IV have a high level of both MH/DD/SA and physical health complexity or risk.

ii. Enrollees in Quadrant IV are the joint responsibility of [MCO] and the BH Provider as well as the physical health providers involved in care (including Primary Care Provider and CCNC network if enrolled in CCNC). If an Enrollee is receiving care management through CCNC, [MCO] Care Coordination and CCNC Care Managers will jointly determine primary responsibility. If not enrolled in CCNC, [MCO] shall involve any applicable healthcare providers in coordination of care.

iii. When [MCO] is determined to be the lead Care Coordinator, [MCO] is responsible for updating the CCNC Care Manager on any medical issues and engaging the Care Manager for assistance as needed. CCNC Care Managers will retain responsibility for medical aspects of care management in conjunction with [MCO] Care Coordinators.

iv. When [MCO] is not determined to be the lead for Care Coordination, [MCO] shall collaborate with the primary CCNC Care Manager, offering Care Coordination functions as needed and monitoring the Enrollee's MH/DD/SA engagement. [MCO] shall continue to communicate enrollee status to the assigned CCNC Care Manager.

2) Referrals:

a. Referral pathways shall be developed between CCNC and [MCO].

b. [MCO] shall receive Care Coordination referrals from CCNC Care Managers, determine what level of Care Coordination services are needed, if any, and provide referral status feedback to referring Care Manager;

c. [MCO] shall initiate Care Management and physical health referrals to CCNC as such needs are identified, and receive and document feedback from CCNC regarding the referral status;

d. [MCO]'s CCNC networks, Behavioral Health Providers (BHPs) and Primary Care Providers have the responsibility to provide feedback to the referring source on all referrals. If Care Coordination is not warranted, [MCO] shall notify referral source and offer other options for assistance from [MCO] in getting the Enrollee connected to treatment.

3) Coordination with CCNC:

a. A minimum of monthly meetings between [MCO] and CCNC to facilitate communication is required.

b. [MCO] shall ensure the coordination of care with each Enrollee's primary care Provider/CCNC physician /Health Home for Enrollees receiving care coordination;

c. [MCO] shall include any assigned CCNC Care Managers in the development of an Enrollee's Individual Service Plans

a. [MCO] shall involve any assigned CNCC Care Managers in the development and implementation of crisis plans so that both parties may respond appropriately to Enrollee crises.

e. [MCO], with the assistance of CCNC, will encourage, support and facilitate communication between Primary Care Providers and BHPs regarding medical management, shared roles in the care and crisis plan, exchange of clinically relevant information, annual exams, coordination of services, case consultation and problem solving as well as identification of medical home for persons determined to have need.

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[i] "Special Implementation Update #94 – 1915 (b)/(c) Medicaid Waiver Expansion," NC DHHS Memorandum, February 16, 2012. http://www.ncdhhs.gov/mhddsas/implementationupdates/update094/special_IU94_2-12.pdf

[ii] TCM is still available (if there is an available provider) for children enrolled in Health Choice, children ages 0 to 3, if indicated, and for children who are legal aliens, who are currently not covered by the waiver. Email with Catharine Goldsmith, DMA Children's Behavioral Health, August 27, 2014.

[iii] Interviews with LME-MCO representatives, July 2014.

[iv] See Appendix for more details on how special health-care needs populations are defined in the state-MCO contracts.

[v] Interviews with LME-MCO representatives, July 2014.

[vi] "State-Funded MH/DD/SA SERVICE DEFINITIONS," NC DHHS, NC DMH/DD/SA, revised April 2014. http://www.ncdhhs.gov/mhddsas/providers/servicedefs/statefunded-servicedef2003-2014-8-1-14.pdf

[vii] "State-Funded MH/DD/SA SERVICE DEFINITIONS," NC DHHS, NC DMH/DD/SA, January 2003. http://www.ncdhhs.gov/mhddsas/statspublications/Manuals/apsm1026servicedef1-03.pdf, see pages 12-13

[viii] "State-Funded MH/DD/SA SERVICE DEFINITIONS," NC DHHS, NC DMH/DD/SA, revised August 2014 http://www.ncdhhs.gov/mhddsas/communicationbulletins/2014/commbulletin142/6-20-14%20Latest/benefitplaneligibilitycriteria06-17-14-3.pdf

[ix] "Proposal to Reform North Carolina's Medicaid Program: Report to North Carolina General Assembly," NC DHHS, March 2014. http://ncdhhs.gov/pressrel/2014/DHHS_Medicaid_Reform_Legislative_Report-2014-03-17.pdf

[x] Interviews with LME-MCO representatives, July 2014.

[xi] From *Smoky Mountain LME/MCO Care Coordination Executive Summary*, copies distributed at meeting with Smoky on care coordination model, August 2014.