A Guide to Care Management in North Carolina: Context & Recommendations for Care Coordination under the North Carolina Tailored Plan

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Introduction

This paper outlines past and current practices in care management and provides recommendations for implementation to inform the Tailored Plan for persons with serious behavioral health disorders, intellectual and developmental disabilities (I/DD), and traumatic brain injuries (TBI).[1] In addition to an overview of the role of care managers, this paper will discuss historical and current approaches to care management in North Carolina. The paper will also review Tennessee's and Wisconsin's Medicaid LTSS programs because both states have a substantial and exemplary history of Medicaid managed care spanning back to the 1990s.

Finally, based on interviews with national experts, we will make several recommendations on Care Coordination for North Carolina to consider (pages 13 to 17). These recommendations include:

1. Considering lived experience, not only degrees, in credentialing and hiring requirements for care coordinators;
2. Considering the importance of natural supports and person-centered planning for care coordination;
3. Incorporating effective quality measurement of care coordination that includes consumer agency, consumer understanding of services, and the utilization of consumer information within the consumer's support network; and,
4. Assuring constant communication among stakeholders to promote systems change.

NC System Approach Summary

North Carolina's Medicaid system is transforming from a predominantly fee-for-service (Medicaid Direct) system to a managed care system (Medicaid Managed Care). The Medicaid Managed Care system utilizes integrated managed care that spans physical and behavioral health services, long-term service supports (LTSS), and pharmacy benefits.[2] There are two plans under this system: the Standard Plan and the Tailored Plan. The Standard Plan will serve the majority of Medicaid and NC Health Choice enrollees, including those with mild-to-moderate behavioral health needs. The Tailored Plan will serve individuals with serious behavioral health disorders, intellectual and developmental disabilities, and traumatic brain injuries.[3]

[1] See North Carolina Department of Health and Human Service (DHHS), Medicaid Managed Care Policy Paper (May, 2019) page 1.
[2] Ibid.
[3] Ibid.

The following sections discuss issues related to previous care coordination models in North Carolina as well as the changes that will benefit the Medicaid system, people with intellectual and developmental disabilities (I/DD) and their families under the restructured care management model.

Historical Challenges

In the past, various service definitions or care coordination employed under the LME/MCO system led to an inconsistent structure of care coordination across the state."[4] Inconsistent structures, in turn, made it difficult for individuals with I/DD and their families to navigate and access care. As a result, a 2017 report by Disability Rights North Carolina found that many people with I/DD and their families do not receive necessary services, particularly medical services for which they qualify.[5] Lack of access to quality medical and related care threatens the health and wellbeing of people with I/DD as well as their family members. This issue demonstrates a need to adopt an integrated model that offers whole person care to address the multifaceted and interrelated service needs of people with I/DD across North Carolina. Care management addresses this critical need. The North Carolina Department of Health and Human Services (the Department) reports in their policy paper, "North Carolina's Care Management Strategy for Behavioral Health and Intellectual /Developmental Disability Tailored" Plans, that, "care management models that place individuals with complex needs at the center of a multidisciplinary care team facilitated by a dedicated care manager have been shown to improve individuals' health by enhancing coordination of care…"[6]

Changes Under Medicaid Managed Care Implementation

Under the new North Carolina Medicaid system, there is no longer a separation of services by type of support offered, such as physical and behavioral health services, for Tailored Plan beneficiaries. Instead, people utilizing the Tailored Plan will have access to care management, which the Department defines as "a team-based, person-centered approach to effectively managing patients' medical, social, and behavioral conditions."[7] In line with a whole person approach to healthcare, provider-based care management will ensure that Tailored Plan beneficiaries have access to person-centered services and integrated care that is offered in the person's home or community. To the extent possible, a single care manager with expertise and training in addressing behavioral health, I/DD, and/or traumatic brain injury (TBI) needs will provide fully integrated care management to include physical needs and unmet health-related resource needs.[8] Initially, Local Management Entitles- Managed Care Organizations (LME-MCOs) will exclusively operate Tailored Plan care management for the first four years of

4 See Cross System Navigation in a Managed Care Environment (2018) page 6.
5 Ibid.
6 See DHSS, Policy Paper (May, 2019) page 2.
7 Ibid 3.
8 Ibid 4.

Medicaid Care Management Implementation; however, the Department has provided a glide path for management to be primarily provider based.[9]

Care Management

Medicaid transformation is a complex process. It is crucial that stakeholders - including people with I/DD, family members, providers - and systems professionals understand the function and role of a care manager and care manager agencies. The following sections describe the work and qualifications of care managers, and care management agency processes and roles to ensure consistent understanding and practice across the North Carolina service system.

The Function of a Care Manager

The function of a care manager is to provide whole person-centered care. The Department outlines the task of care managers to include:[10]

- **Coordination of a comprehensive set of services** addressing all of the beneficiary's needs. Beneficiaries will not have separate care managers to address physical health, behavioral health, TBI, and I/DD-related needs.
- **Provision of holistic, person-centered planning.** Beneficiaries receive a care management assessment that evaluates all of their needs— from physical health, behavioral health, I/DD, and TBI services to employment and housing—and drives the development of a care plan that identifies the goals and strategies necessary to achieve them.
- **Addressing unmet health-related resource needs** (e.g., housing, food, transportation, interpersonal safety, employment) by connecting beneficiaries to local programs and services.
- **Working as part of multidisciplinary care teams** made up of clinicians and service providers who communicate and collaborate closely to efficiently address all of the beneficiary's needs.
- **Utilization of technology** that bridges data silos across providers and plans.

Care Manager Qualifications and Training

Behavioral Health (BH) I/DD Tailored Plans will be responsible for developing a training curriculum and training care managers serving their beneficiaries.[11] During the procurement phase, potential BH I/DD Tailored Plans must describe a training plan as part of the care management approach within their requests for application (RFA).[12] Care managers must receive adequate oversight and supervision from a care manager supervisor.[13] While the development and implementation of training curricula are the responsibility of the BH I/DD

[9] Ibid 8.
[10] See DHSS, Policy Paper (May, 2019) page 5 Figure 1.
[11] Ibid 8.
[12] Ibid 14.
[13] Ibid.

Tailored Plan, the Department will establish the required training guidelines for care managers and care manager supervisors.[14] The table below outlines the minimum qualifications of care managers and supervising care managers.

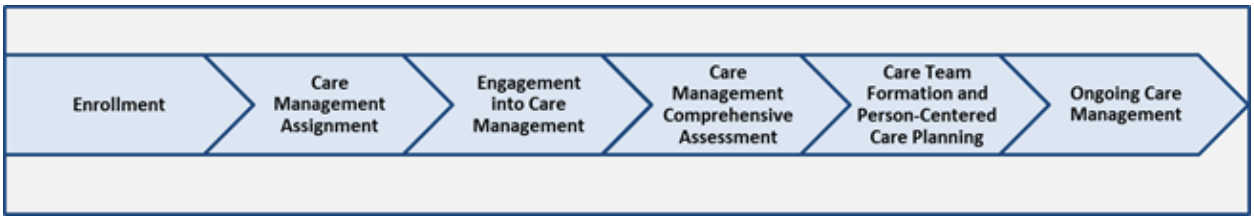
Table 1. Minimum Qualifications for Care Managers and Supervising Care Managers [15]

Position	Minimum Qualifications
Care managers serving all beneficiaries	Bachelor's degree in a field related to health, psychology, sociology, social work, nursing or another relevant human services area Two years of experience working directly with individuals with behavioral health conditions (if serving beneficiaries with behavioral health needs) or with I/DD or TBI (if serving beneficiaries with I/DD or TBI needs) (Best practice, but not required) For care managers serving beneficiaries using LTSS: two years of prior LTSS and/or Home and Community Based Services (HCBS) coordination; care delivery monitoring and care management experience; and background in social work, geriatrics, gerontology, pediatrics or human services
Supervising care managers serving beneficiaries with behavioral health disorders	A licensed master's-level clinical qualification, such as a Licensed Clinical Social Worker (LCSW), a Licensed Professional Counselor (LPC) or a licensed nurse with a Bachelor of Science in Nursing (BSN) Three years of supervisory experience working directly with complex individuals with a behavioral health condition
Supervising care managers serving beneficiaries with I/DD or TBI	Bachelor's degree in a human services field Five years of applicable I/DD experience as a care coordinator or care/case manager, or an equivalent combination of education and experience

Assignment of Care Managers

To enhance consistency, the Department has a process by which care managers will be assigned. The figure below outlines the assignment process.

Figure 1. Tailored Care Management Process Flow[16]



[14] Ibid.
[15] Ibid Table 2 page 15.
[16] Ibid Figure 4 page 11.

During the first four years of the program, the BH I/DD Tailored Plans will be operated exclusively by LME-MCOs. [17] The Department has created a glide path for most Tailored Management to gradually become provider-based, with a goal of reaching 80% provider-based Tailored Plan contracts by the end of year four.[18] During enrollment, the BH I/DD Tailored Plan will auto-enroll beneficiaries into Tailored Care Management, but beneficiaries will have the ability to opt-out.[19] During care management assignment, the BH I/DD Tailored Plan will assign a Care Management Agency (CMA), Advanced Medical Home (AMH+), or BH I/DD Tailored Plan for care management. Subsequently, the selected entity will assign a specific care manager to the beneficiary. (Qualifications for CMAs, AMH+ will be explained in the next section).

Role of Advanced Medical Homes and Care Management Agencies

In the transition to managed care, Advanced Medical Homes (AMHs), Care Management Agencies (CMAs), and BH I/DD Tailored Plans will play vital roles.[20] Qualifications for Tailored Plan Management align under Federal Health Home requirements[21] such that Tailored Care Management will be provided by AMH+, CMA, and BH I/DD Tailored Plan- Employed Care Manager.[22] Note, the AMH+ is a subset of the AMHs contracted in the Standard Plan that meets additional certification standards to serve the BH I/DD Tailored Plan population.[23]

AMH+ and CMAs will primarily provide Tailored Care Management and thus provide the assignment of care managers. Certifications for CMAs and AMH+ will be made by the Department, and "BH I/DD Tailored Plans will be required to contract for care management with all providers in their region that have demonstrated capacity for the model through the state certification process."[24] The table below provides the eligibility requirements and definitions for AMH+ and CMA. Further qualification requirements are also described below.

[17] See DHHS, Policy Paper (May, 2019) page 4, footnote 5, no less than 5 more than 7 BH I/DD Tailored Plan contracts will be awarded.
[18] Ibid Figure 3 page 9.
[19] See DHHS, Care Management Under BH I/DD Tailored Plans (2019) slide 12.
[20] See DHHS, Policy Paper (May, 2019) page 6.
[21] Ibid 5.
[22] Ibid Figure 2 page 6.
[23] Ibid page 6.
[24] Ibid.

Table 2. AMH+ and CMA Eligibility Requirements [25]

Advanced Medical Home Plus (AMH+)	Care Management Agency (CMA)
Definition: Primary care practice certified by the Department as a AMH Tier 3 that has **experience delivering primary care services to the BH I/DD Tailored Plan eligible population in North Carolina, or can otherwise demonstrate strong competency to serve that population,** and will hold primary responsibility for providing integrated, whole-person care management under the Tailored Care Management model. Details on AMH Tier 3 attestation can be found in the AMH Provider Manual To be eligible to become an AMH+, the practice must intend to become a network primary care provider for BH I/DD Tailored Plans.	**Definition:** Provider organization with **experience delivering behavioral health, I/DD and/or TBI services** to the BH I/DD Tailored Plan eligible population in North Carolina that will hold primary responsibility for providing integrated, whole-person care management under the Tailored Care Management model. To be eligible to become a CMA, an organization must have as its **primary purpose the delivery of NC Medicaid, NC Health Choice or state-funded services,** other than care management, to the BH I/DD Tailored Plan eligible population in North Carolina.

In addition to the eligibility requirements listed above, **each AMH+ and CMA must meet the following requirements to be certified[26]:**

- Meet eligibility definitions
- Show appropriate organizational standing or expertise
- Show appropriate staffing
- Demonstrate the ability to deliver all the required elements of whole-person, multidisciplinary, integrated care management
- Meet health and information technology (HIT) and Population Health Data Requirements
- Participate in required training (after initial certification)

To ensure that providers and agencies will have time to adapt and align their practices with requirements in advance, the Department will release the CMA/AMH+ requirements and certification process before the BH I/DD Tailored Plan launch."[27] Below is the certification process timeline.

[25] See DHHS, Care Management Under BH I/DD Tailored Plans (2019) slide 20.
[26] Ibid slide 19
[27] See DHHS, Policy Paper (May, 2019) page 10

Table 3. AMH+/CMA Certification Process Timeline[28]

Date	Action
Fall 2019	**DHHS** publishes CMA manual containing full certification requirements and application questions
~ January 2020	**DHHS** opens online application for providers
Throughout 2020	**DHHS** conducts **onsite reviews** and grants **provisional certification** to organizations
May 2020 – April 2021	**BH I/DD Tailored Plans** contract with provisionally certified CMAs/AMHs for Health Home (HH) care management
By April 2021, 90 days before go-live	**Final certification** of CMAs and AMH+s
July 2021	**BH I/DD Tailored Plan launch**

Care Team

Gaps in services may occur when an individual with complex needs is accessing multiple service systems.[29] In a care team model, representatives from these siloed systems form a team which places the individual in the middle of integrated services.[30] A care manager facilities the team's activities.[31] The care team will help develop the member's care plan as well as regularly update and document changes to the care plan in response to the member's needs.[32] Furthermore, the care team will exchange member's health information within the team to monitor and respond to the member's medical and non-medical needs.[33]

In addition to the member and the member's care manager, the team members may consist of the following:[34]

- Caretaker(s)/legal guardians;
- Supervising care manager;
- Primary care provider;
- Behavioral health provider(s);
- I/DD and/or TBI providers, as applicable;
- Other specialists;
- Nutritionists;
- Pharmacists and pharmacy techs;

28 See DHHS, Care Management Under BH I/DD Tailored Plans (2019) slide 22.
29 See DHHS, Policy Paper (December, 2019) page 11; DHHS, Tailored Care Management Provider Manual (2019) page 9, footnote 14.
30 See DHHS, Policy Paper (May, 2019) page 2.
31 Ibid.
32 See DHHS, North Carolina's Data Strategy for Tailored Care Management, (2019) page 2.
33 See DHHS, Tailored Care Management Provider Manual (2019) page 12.
34 Ibid page 24.

- The member's obstetrician/gynecologist (for pregnant women);
- Peer support specialist employed by the AMH+, CMA, or CIN, as applicable; and
- Other providers and individuals, as determined by the care manager and member.

The Department has not set minimum staff ratio requirements. The Tailored Plans are allowed to customize an individual's care team according to the member's specific needs. However, each team must have adequate staffing to engage with the beneficiary per the Department's engagement requirements.[35]

Certified peer support specialists are trained, self-identified persons in recovery of a mental health or substance use disorder that can provide one on one support to an individual based on mutuality.[36] Peer support services have been used effectively to assist individuals with BH needs and substance use disorder (SUD).[37] "Other providers and individuals" may include family navigators, community health workers, and others, who may serve as natural supports. Family navigators assist people with I/DD or TBI, and their families navigate systems of services through using their training and personal experience.[38] Community health workers are public health workers whose connection to the community allows them to serve as links between health/social services and the community.[39]

National Trends and Expert Recommendations

Across the nation, the majority of states operate Medicaid through some form of managed care; however, these services are mostly geared towards primary health care and behavioral health.[40] There is a current trend for managed care in LTSS and I/DD services, characterized by more than 20 states that have either planned or implemented managed care programs.[41] States have taken different approaches in the implementation of managed care for the I/DD population. Models range from provider-led programs to contracts with large, private, and multi-state MCOs.[42] This paper will review Tennessee and Wisconsin's Medicaid LTSS programs, as they are useful to inform recommendations for North Carolina's current and future Medicaid system. Both states have a substantial history of Medicaid managed care spanning back to the 1990s. Tennessee is frequently cited as one of the exemplary managed care systems in the nation, and Wisconsin utilizes a county based MCO system similar to North Carolina's regionalized LME-MCOs.

35 Ibid page 18.
36 See NC Division of Mental Health, Developmental Disabilities, & Substance Abuse Services, State-Funded Peer Support Services (2019) page 2.
37 Ibid.
38 See Trillium, Trillium Family Navigator Training (2019).
39 See DHHS, Community Health Workers (n.d.).
40 See Arlington Heritage Group Inc., How Can Managed Care Work for the I/DD Population (2019).
41 Ibid.
42 See The American Network for Community Options and Resources (ANCOR), Current Landscape: Managed Long-Term Services and Supports for People with Intellectual and Developmental Disabilities (2018) page 3.

Tennessee

Tennessee's history of managed care and MLTSS spans back into the mid-1990s for mental health services; its managed care for I/DD services started in 2016 and is called Employment and Community First (ECF) CHOICE.[43] The state has implemented an incremental approach to managed care. Tennessee is maintaining its existing 1915(c) HCBS waiver for current participants (while closing future enrollments). It has opened the ECF CHOICES program to individuals on the waitlist and individuals who choose to switch from the 1915(c) waiver.[44]

TennCare, Tennessee's Medicaid program, employs three large, multi-state MCOs that hold state contracts for medical care, behavioral health, and LTSS for people who are elderly or who have physical disabilities.[45] The MCOs provide support coordination, and the state designates training requirements.[46] For enrollees, Medicaid primary, acute, behavioral, and LTSS services are integrated under the ECF CHOICE program.[47] TennCare has a tiered benefit structure based on the needs of people in each group.[48] Persons will I/DD are designated in group 4-6.[49] Groups 7 and 8 have been added to serve I/DD individuals with more intense needs[50]; services are geared to promote employment, community integration, and individual/family empowerment.[51]

Before the ECF CHOICE waiver, Tennessee had an extensive process engaging stakeholders. In their planning process, they developed a concept paper based on public feedback and then asked for more public feedback on the concept paper.[52] Part of Tennessee's model that works well for managed care is that expectations for managed care coordination are tightly controlled by the state's contracts with MCOs, and TennCare is able to re-negotiate terms with MCOs frequently in comparison with other states.[53] Furthermore, performance metrics are included in the contract. Tennessee has focused on employment, keeping beneficiaries in their community, and providing support for families.[54] Accordingly, the most frequently utilized services in the ECF CHOICE program are employment, community integration supports, personal assistance, independent living skills training, respite, and community transportation.[55] Furthermore "over 20% of working-age individuals with I/DD working are in competitive integrated employment..."[56]

43 Ibid page 26.
44 Ibid.
45 See The Arc, For Profit Managed Care for Long Term Supports & Services (2016) slide 25.
46 See ANCOR, Current Landscape (2019) page 26.
47 Ibid.
48 Academy Health, Managed Long-Term Services and Supports (2018) slide 56.
49 See ANCOR, Current Landscape (2019) page 26.
50 Ibid page 27.
51 Academy Health, MLTSS (2018) slide 56.
52 Interview with Laura Vegas November 6, 2019.
53 Ibid; Interview with Sharon Lewis November 11, 2019.
54 Interview with Laura Vegas.
55 Academy Health, Managed Long-Term Services and Supports (2018) slide 58.
56 Ibid.

The system still contains some challenges. One challenge is that the state is still operating the traditional 1915c waiver, which means that providers have to operate through two business lines with different standards and procedures.[57] The ambitious service timelines, in some cases, have resulted in underdeveloped service plans during service initiation.[58] Furthermore, provider networks are not as robust. High training standards for ECF provider staff paired with relatively few enrollees have created a challenge to recruit and maintain staff.[59]

Support Coordinator

In Tennessee, the MCO Support Coordinator is responsible for the coordination of the individual's physical and behavioral health services, as well as long-term community based services and supports.[60] Specific activities the Support Coordinator completes include comprehensive assessment, caregiver assessment, development of the person-centered support plan (PCSP), and minimum Support Coordination contacts.[61] In the case of group 7 and 8 individuals, certain support coordination activities are completed by an Integrated Support Coordination Team, which includes the individual's Support Coordinator and a Behavior Supports Director.[62]

Wisconsin

Family Care, Wisconsin's MLTSS program for older adults, people with physical disabilities, and people with I/DD was started in 1998.[63] Implementation for MLTSS has been done on a gradual and county by county basis.[64] Family Care employs county-based and regional nonprofit MCOs who are responsible for LTSS (the state contracts with large, multi-state MCOs to provide acute and primary care services).[65] Family Care Partner program is operated in some counties and provides fully integrated managed care for older adults and people with physical disabilities as well as people who are eligible for both Medicare and Medicaid.[66] In addition, Wisconsin offers a self- directed option called Include, Respect, I Self-Direct (IRIS) program, which allows individuals to opt out of Family Care. Rather than working with a care manager, individuals work with a fiscal employer agent to "develop their person-centered plan and to identify, hire and manage provider staff."[67]

57 See ANCOR, Current Landscape (2019) page 27.
58 Ibid.
59 Ibid; Interview with Laura Vegas.
60 See Amendment #27: Employment and Community First CHOICES TennCare II demonstration (2015) page 10.
61 AMERIGROUP Tennessee, Inc., Amendment Number 10 Statewide Contract (Accessed 2019) page 6.
62 Ibid page 5.
63 See ANCOR, Current Landscape (2019) page 12.
64 Ibid.
65 Ibid.
66 Ibid.
67 Ibid.

Wisconsin has been successful in eliminating its waitlist; the last county will eliminate its waitlist in 2021.[68] Ending waitlist was a win for stakeholders and involved sitting down with county, advocates, and local entities.[69] It has resulted in fewer institutional placements, and that money has been reverted to end the waitlist.[70] As counties have transitioned to managed care, within three years they reach entitlement. Within entitlement counties, beneficiaries are able to choose a self-directed service option or choose one of the MCOs (with at least two options available in a county).[71] MCOs grew out of local county entities, and there is a strong partnership between the state and MCOs.[72] The state has annual negotiations with MCOs and is able to negotiate rates inclusive of acuity data.[73] Individual contracts with each MCO have also been a challenge as providers have to negotiate with each MCO for reimbursement rates. Furthermore, providers have reported frustration with "the lack of transparency and potential inconsistencies in payment methodology statewide."[74]

Social Service Coordinator

Within the Family Care Partnership program, care coordination is provided through an interdisciplinary team (IDT). Minimum members in the IDT for Family Care Partnership include a social service coordinator, a Wisconsin licensed registered nurse, and a Wisconsin licensed nurse practitioner.[75] Responsibilities/requirements of the IDT include:[76]

- The IDT staff is formally designated as being primarily responsible for coordinating the member's overall long-term care and health care.
- The IDT staff shall ensure coordination of long-term care services with health care services received by the member, as well as other services available from natural and community supports.
- The IDT staff will arrange for, and instruct members on how to obtain, services. (With minimum requirements specified in the contract).
- IDT staff shall, using methods that include face-to-face and other contacts with the member, monitor the services a member receives.

A social service coordinator must be a social worker certified in Wisconsin or "have a minimum of a four-year bachelor's degree in the human services area or a four-year bachelor's degree in any other area with a minimum of three (3) years' experience in social service care management or related social service experience with persons in the MCO's target

68 Ibid page 7.
69 Interview with Beth Swedeen November 15, 2019.
70 Ibid.
71 Ibid.
72 Interview with Sharon Lewis.
73 Ibid.
74 See ANCOR, Current Landscape (2019) page 13.
75 See Contract between Wisconsin Department of Health Services Division of Medicaid Services and <<Name of MCO>> (2018) page 58.

76 Ibid page 71-73.

population."[77] The Department has the discretion to exempt an individual from these requirements if the individual holds a position comparable to a social service coordinator at the time a MCO first contracts to deliver MLTSS in a new service area or to a new target population.[78]

Expert Recommendations

In addition to gathering information specifically about Tennessee's and Wisconsin's managed care systems, the following recommendations have been compiled through interviews with national experts who offered considerations according to national trends.

Care Coordination

Many states have credential and education requirements for care coordinators; however, not all states require the understanding of the I/DD population specifically.[79] At the same time, several experts have emphasized the importance of previous work experience with the I/DD population as a prerequisite for care coordinators.[80]

Current trends across the country suggest that educational background components are ideal, but not mandatory.[81] It should not be assumed that professionals such as nurses have training in aspects of managed care such as natural supports and person-centered planning.[82] Nurses may be trained to be patient centered, but not person-centered, or not person-centered in the context of a family.[83] Experts have noted that these variations in previous professional experiences may impact consistency across delivery and quality of care.

Experts also identified specific recommendations regarding certification for care coordinators. Several experts noted that an access point is needed for professionals who have experience working with the I/DD population and with LTSS but who may not have the proper "credentials".[84] Particularly for the I/DD population, there is an opportunity to consider course work as well as lived experience in regards to qualifications.[85] For instance, some states allow prior work experience to substitute for educational requirements.[86] Important aspects to consider for care coordination are background with the I/DD population (e.g. culturally competent disability knowledge), experience in behavioral health, and experience in human services.

77 Ibid page 58.
78 Ibid.
79 Interview with Sharon Lewis November 8, 2019.
80 Interview with Barbara Brent November 6, 2019; Interview with Laura Vegas November 6, 2019; Interview with Sharon Lewis; Interview with Beth Swedeen November 15, 2019.
81 Interview with Barbara Brent.
82 Interview with Barbara Brent; Interview with Laura Vegas.
83 Interview with Barbara Brent.
84 Ibid.
85 Ibid.
86 Interview with Sharon Lewis.

Training for the care coordinator role is an additional component that needs to be clearly regulated and implemented. Experts recommend that required training for care coordinators should include person-centered care, motivational interviewing, the life course approach, and identifying natural supports.[87] In particular, Charting the Life Course should be part of the person-centered planning process.[88] The life course approach considers how to support individuals to achieve their outcomes and goals in life as well as how to support families to support individuals.[89] Experts also recommend that training curricula include culturally competent knowledge[90] and supports for underserved populations (e.g. people of color, LGBTQA).

Furthermore, implementing a mentorship process, particularly when a care coordinator first starts, is a valuable and recommended practice. Participating experts noted that many coordinators receive training, but they do not have the opportunity to apply the skills they are learning; therefore, they are not receiving consistent feedback about their practices, unless something goes wrong.[91] It becomes apparent to care coordinators that there are gaps in knowledge that they may not be equipped to address.[92]

Concerns around gaps in knowledge are an important consideration; once care coordinators are hired and trained, it may be expected that they have an understanding of acute services and medical benefits that many do not possess.[93] Many care coordinators need more knowledge of supports and person-centered training to be successful in their roles. Thus having a “round table” of professionals available to care coordinators to troubleshoot client’s issues would be ideal although difficult logistically.[94]

Finally, some states, such as Wisconsin, provide care coordination through a team. However, in these interdisciplinary teams, it is essential to have clarity of roles and responsibilities. For example, we discussed with experts the importance of an understanding of person-centered training. Is it reasonable with available resources that every member of the care coordinating team has training in person-centered planning?[95] At the same time, several advantages of having an interdisciplinary team, particularly when there is clarity of roles. If a care coordinator can be separated from the “utilization [of supports] manager”, he or she may be better positioned to advocate for the individual’s needs and have a conversation with the individual about natural supports and their desired individual support plan (ISP).[96]

[87] Interview with Sharon Lewis; Interview with Beth Swedeen; Interview with Laura Vegas.
[88] Interview with Sharon Lewis.
[89] Interview with Laura Vegas.
[90] Interview with Sharon Lewis.
[91] Interview with Laura Vegas.
[92] Ibid.
[93] Ibid.
[94] Interview with Barbara Brent.
[95] Interview with Sharon Lewis.
[96] Ibid.

Overall, experts recommended that care coordinators should have an understanding of person-centered services, opportunities for natural supports and cultural competency. They also recommended that the care coordinator should ensure that, throughout the process of care coordination, the individual's desires and goals are honored. Care coordinators are ultimately responsible to the people they support, and not necessarily to seeking the cheapest option for their LME-MCO or system.[97]

Effectiveness and Quality Measures

There are few and only mixed findings about the quality and cost effectiveness of services for people with I/DD.[98] Terminology around quality measures is different across states; however, many states track process measures such as the timeliness of services, instead of quality of supports offered.[99] To strengthen quality measures, the activities and components being measured could be more robust. Current Process components considered in quality measurement often include: ensuring person-centered planning is in place, timeliness of services, ensuring required members are present for person-centered meetings, etc.[100] Experts suggest measures of satisfaction and goals and outcome attainment should also be considered. Areas measured may include:[101]

- Satisfaction of person using services with plan/goals in ISP;
- Clients' perspectives about progress towards personal goals;
- Person's understanding of the person-centered planning process;
- Person's understanding of their right to make changes to their own ISP to better align with personal goals;
- Alignment of services and supports with personal goals;
- Progress made over time to meet the goals in the support plan;
- Process for collecting and recording data to capture that progress; and,
- Process for assessing communication in coordination with client and family, state and provider.

While the quality measurement process should improve to ensure meaningful development and implementation of person-centered plans and successful achievement of the goals and outcomes of Medicaid beneficiaries, several issues that limit successful quality assurance processes. First, it is difficult to capture information that is not available in an administrative data set (e.g. consider qualitative measures).[102] Effective evaluation will require pre and post comparison of care coordination plans, which will involve a qualitative analysis that may be expense and time consuming.

97 Interview with Beth Swedeen.
98 Interview with Carli Friedman November, 2019.
99 Interview with Barbara Brent.
100 Ibid.
101 Interview with Barbara Brent; Interview with Lauren Vegas; Interview with Sharon Lewis.
102 Interview with Sharon Lewis.

Another challenge is finding a genuine measure of individuals' experiences. There should be quality measures around personal plans.[103] Further, evaluations must be designed in plain language with options that support people with all types and scope of disability to participate. Technical language may be a barrier for individuals to express their satisfaction with coordination.[104] For example, asking someone if they felt listened to while creating goals may not reflect whether they felt their goals reflected what is most important to them.[105] This is another area for development. Creating personal outcome measures would help providers fine-tune services for individuals.[106]

System Components

In the implementation stage of systems change, it is essential to communicate early and often with stakeholders.[107] This presents an opportunity for the state (or MCOs) and families to have joint communication.[108] Having transparency and stakeholder engagement in both the process of design and disseminating knowledge at the local level are important for a successful transition.[109] Some states have contracted with advocacy groups and family groups to act as communicators at the local level; this can be advantageous as they can give feedback on information before it goes out into the field.[110] The assumption that self-advocates will not read material should be avoided, as other states have found stakeholders want to be actively involved in the design and implementation of system change.[111]

An additional consideration in the dissemination of information concerning implementation is the use of technology to share information. For example, many individuals and families in rural areas may not have access to a computer or the internet; furthermore, receiving information on state letterhead could be alarming for some.[112] Consider that most people have cell phones. Cell phones can communicate palatable, small bits of information.[113] Washington, D.C. has used cell phone communication to share information in Spanish to minority communities.[114]

The use of innovative technology to support care coordination has not been widely explored.[115] For example, technology can be used to centralize case management.[116] Currently, client

103 Interview with Barbara Brent.
104 Interview with Beth Swedeen.
105 Ibid.
106 Interview with Carli Friedman
107 Interview with Barbara Brent; Interview with Sharon Lewis.
108 Interview with Barbara Brent.
109 Interview with Sharon Lewis.
110 Interview with Barbara Brent
111 Interview with Barbara Brent; Interview with Sharon Lewis.
112 Interview with Barbara Brent.
113 Ibid.
114 Ibid.
115 Interview with Laura Vegas; Interview with Beth Swedeen.
116 Interview with Sharon Lewis.

information is siloed in separate databases.[117] It would be effective for the utilization of data (e.g. goals, outcomes, service usage) if client information was contained in one place.[118] Furthermore, families and individuals should have the same access to information as providers and case managers in order to better advocate for their needs.[119] Technology should be implemented to give individuals and families access rather than simply monitoring behaviors and service use.[120]

Another challenge is that, historically, care coordination has been skewed to acute and primary care (i.e. a medical model).[121] However, presently, there is an opportunity for managed care to connect systems and now consider social determinants of health.[122] Through managed long term services and supports (MLTSS), people can be supported to have better health outcomes and stay out of the emergency room.[123] It is essential to ensure that the values of home and community based person-centered care are fully implemented in the system.[124] Furthermore, there should be a focus on building self-determination and advocacy into the process of care coordination; otherwise, there is the risk of guardian overreach.[125] Individuals should be choosing the goals they are working towards – not given goals.[126] An example of an organization that has successfully built a culture around person-centered care is INCLUSA, an MCO in Wisconsin.[127] They have strong practices to establish and incentivize outcome-based practices to assist persons with I/DD in employment as well as ensure a manageable caseload for support coordinators.[128]

Regarding contract components between the state and managed care entities, it is better to avoid “generic” contracts and have specific requirements and performance metrics built into the contract.[129] Across states, contracts may be filled with health and safety issues rather than best practice[130]. However, for advocates, it is important that contracts outline values and outcomes they want to see implemented (e.g. consider person-centered plans and related outcome measures, benchmarks for community living, job placement, etc.).[131] Having a clear contract will ensure accountability and compliance.[132]

117 Interview with Lauren Vegas.
118 Interview with Sharon Lewis.
119 Ibid.
120 Interview with Carli Friedman.
121 Interview with Beth Swedeen.
122 Interview with Laura Vegas.
123 Ibid.
124 Interview with Beth Swedeen.
125 Ibid.
126 Interview with Carli Friedman.
127 Interview with Sharon Lewis.
128 Ibid.
129 Interview with Laura Vegas.
130 Interview with Beth Swedeen.
131 Ibid.
132 Interview with Barbara Brent; Interview with Laura Vegas.

Conclusion

Care management for LTSS and I/DD services is a current trend across the nation. As North Carolina transitions its Medicaid system to a managed care model, it should consider several components of its system's model to ensure that consumers and families have access to quality person-centered services within their communities. Such components include requirements for care coordinators, consideration for natural supports, effective quality measures, and communication among stakeholders. Experts suggest that lived experience, not only degrees, are important credentialing criteria for care coordinators, that natural supports are important components in person-centered planning, that quality measurements should extend beyond utilization of services, and that communication among stakeholders should be consistent and ongoing.

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