Tailored Care Management Business Processes

VAYAHEALTH

Contents

Overview

Tailored Care Management (TCM) is North Carolina's specialized care management model for Medicaid beneficiaries with behavioral health needs, an intellectual/developmental disability (I/DD), or a traumatic brain injury (TBI). This free benefit is available to Vaya Health (Vaya) Medicaid members continuously throughout their enrollment, unless the member receives a duplicative service.

A community-based, provider-driven model, TCM is designed to advance whole-person care and promote better health outcomes. It includes a care management comprehensive assessment to identify the individual's needs and development of a holistic plan of care to guide services. Participants have a single designated care manager who works with a multidisciplinary care team to ensure their needs are met.

TCM integrates coordination of services for physical health, behavioral health, pharmacy, I/DD, TBI, and/or Long-term Services and Supports (LTSS) and helps identify and address unmet health-related resource needs. Members may receive TCM from a provider-based organization or from Vaya.

TCM services should be delivered in provider settings whenever possible. The model also prioritizes frequent in-person interactions between community-based care managers and beneficiaries and emphasizes outcomes and population health management.

In the NC Department of Health and Human Services' (NCDHHS's) view, effective, integrated and well-coordinated care management depends on care team members' ability to efficiently exchange beneficiary health information and use that information to monitor and respond to medical and nonmedical issues.

NCDHHS puts forth that a coordinated approach to beneficiary care among Behavioral Health I/DD Tailored Plans, Advanced Medical Home Plus (AMH+) practices, Care Management Agencies (CMAs), pharmacies, and physical health, behavioral health and I/DD providers is key to the success of TCM.

This document is designed to support TCM providers who are part of the Vaya network navigate TCM business processes and provide them with the information they need to care for TCM participants.

Enhanced Rate Request

Purpose of Process: To provide guidance for requesting an enhanced rate to adequately support a member's clinical needs.

Prerequisites

- Vaya Enhanced Rate Budget Worksheet
- Vaya Existing Service Rate Request
- Vaya Member- and/or Recipient-Specific Rate Request

Process

1. A TCM provider determines an enhanced rate may be needed to adequately support a member for whom they provide TCM.
2. The TCM provider **coordinates with the identified service provider** to submit an enhanced rate request to Vaya.
3. The service provider **completes an Existing Service Rate Request Form** requesting a member-specific rate. The rate justification should demonstrate the clinical need and the additional costs related to that need.
4. The service provider **submits the form and Enhanced Rate Budget Worksheet to provider.info@vayahealth.com**.
5. Vaya's Rate Setting Committee processes the request and notifies the requesting provider of their decision in a rate-setting letter.
    - If the committee approves the enhanced rate, Vaya sets up the new rate in the claims system with the effective date identified in the rate-setting letter.
      If the committee denies the request, Vaya provides information about how the member/provider can request an appeal.

Youth Screening for Out-of-State Psychiatric Residential Treatment Facility (PRTF)

Purpose of Process: To screen youth prior to linking them to an out-of-state PRTF provider. The primary aim of this process is to ensure the care manager exhausts all possibilities of keeping the youth in the state for PRTF care. This process applies to all out-of-state PRTF providers that are outside the 40-mile "in-state" requirement and includes both in-network and out-of-network providers.

Prerequisites

- **Comprehensive Clinical Assessment (CCA):** The CCA should include clear, clinical justification for the recommended level of care.
- **Child and Family Team (CFT) discussion:** A CFT should convene to discuss the recommendation and have a detailed discussion about the potential benefits and drawbacks of out-of-state placement.
- **Guardian's input and consent:** The TCM provider should obtain input and consent from the youth's guardian to ensure the placement decision aligns with the youth's best interests.

Process

1. The TCM provider **submits referrals to all in-state PRTF providers** to explore placement options, maintaining a comprehensive tracking system for all in-state PTRF referrals and the PRTF providers' responses, including reasons for denials.
2. If they have exhausted all in-state PRTF providers, the TCM provider proceeds with making referrals to out-of-state PRTF providers, **first confirming the selected provider accepts NC Medicaid and is enrolled in NCTracks.** Again, the TCM provider maintains a comprehensive tracking system for all out-of-state PRTF referrals and their responses.
3. An out-of-state PRTF provider agrees to serve the youth.
4. The TCM provider's chief medical officer, care management director, and care management supervisor staff the request for out-of-state PRTF placement. The following should be reviewed during **the staffing meeting**:
    - Number of denials received from in-state PRTF providers and reasons for the denials
    - Residential search log (comprehensive list of all providers referred to and their responses)
    - If applicable, Guardian's rationale for supporting an out-of-state PRTF placement
    - The specialty or type of therapeutic support the out-of-state PRTF provider has agreed to provide for the youth
5. The TCM provider's chief medical officer, care management director, and care management supervisor engage in a thorough **discussion and evaluation** of the information and assess the appropriateness of an out-of-state PRTF placement based on the youth's clinical needs, guardian preference, and in-state PRTF provider denials.
    a. **If the TCM provider's chief medical officer, care management director, and care management supervisor approve the out-of-state PRTF placement**, the care manager links the youth to the out-of-state PRTF provider.
    Note: An out-of-network agreement is required for non-contracted providers. The request form is available on the Provider Enrollment page of Vaya's Provider Central website.

b. **If the TCM provider's chief medical officer, care management director, and care management supervisor do not approve the out-of-state PRTF placement**, the care manager receives alternative guidance and recommendations for managing the youth's care.

PRTF Screening for Members Ages 12 and Under

Purpose of Process: To screen members ages 12 and under who are recommended to receive care in a PRTF. The screening is intended to ensure care managers follow clinical best practice and confirm less restrictive treatment options have been explored before linking members 12 and under to PRTF.

Prerequisites

CCA: The CCA should include clear clinical justification for PRTF and be dated within the previous 30 days.

Process

1. The TCM provider's clinical leadership team (e.g., chief medical officer, care management director, and care management supervisor) and the care manager, staff to evaluate the case and ensure the PRTF placement aligns with clinical best practice and the youth's best interests. The PRTF should be equipped to provide specialized care tailored to the youth's age and needs.
   a) If the internal staffing **supports PRTF placement**, the TCM provider links the youth to the PRTF and does the following:
      i. Informs the accepting PRTF of the TCM clinical leadership team's support of the PRTF admission.
      ii. Advises the accepting PRTF to include a note in the Service Authorization Request (SAR) stating that the TCM provider's clinical leadership team supports the PRTF admission.
   b) If the internal staffing **does not support PRTF placement**, reconvene the CFT to discuss the youth's needs and ensure appropriate services are provided in the least restrictive environment.

Requesting a Medical Consultation (MD to MD)

Purpose of Process: To obtain clinical consultation with the medical team at Vaya. Vaya is available, as needed, for clinical consultations for plan-based and provider-based TCM organizations, including CMAs and AMHs+, to provide subject matter expert recommendations to the care team for complex clinical issues as needed.

Vaya has multiple staffing options for guiding clinical recommendations and supporting complex cases, including meetings with our chief medical officer, clinical pharmacists, and registered nurses (RNs) and specialty needs staffing processes. If TCM providers require an additional clinical consultation, they can use the process below to request one.

Prerequisites

The TCM provider must have access to clinical consultants to provide subject matter expert advice to the care team according to a member's specific health care and wellness needs. Clinical consultants are not required to be assigned to the care team for any given member. An AMH+ practice or CMA may employ or contract with consultants or work with a CIN or other partner to meet this requirement. Consultants should be available by phone. TCM within AMH+ practices and CMAs should advise on complex clinical issues on an ad hoc basis. TCM providers should establish an internal process of consultation with their teams on a regular basis. The following consultants must be available:

- An adult psychiatrist or child and adolescent psychiatrist (depending on the population being served)
- A neuropsychologist or psychologist
- A primary care physician appropriate for the population being served to the extent the member's primary care physician is not available for consultation

Process

1. TCM providers should staff cases with their internal clinical team first to determine specific consultation needs.
2. To request an additional clinical consultation with Vaya, TCM providers can:
    - Request a clinical consultation with the RN Managers Team by emailing RNManagersTeam@vayahealth.com.
    - Request MD to MD clinical consultation by emailing a TCM External Clinical Consultation Request to SNStaffing@vayahealth.com .

Requesting Emergency Needs Respite

Purpose of Process: To provide guidance for requesting Emergency Needs Respite (ENR) for an eligible member.

ENR is a short-term (90 days or less) crisis relief service available to members ages 18 and older with a qualifying I/DD diagnosis who do not have a long-term placement available to them. ENR is an overnight respite resource that allows an initial 30-day stay based on prior approval. **There is often a waitlist for this service, which is managed by ENR contracted provider(s).**

Prerequisites

Prior authorization is required for the initial stay. Vaya's Utilization Management (UM) Team may authorize additional stays for up to 30 days at a time with clinical justification. Vaya's UM director must approve any stay beyond 90 days. Priority will be given to members who are ready for discharge from an inpatient or emergency department setting with no identified place to go.

Process

1. The TCM provider confirms member eligibility (18+ with a qualifying I/DD diagnosis).
2. The TCM provider completes the universal ENR application (available through the ENR provider) and submits it with accompanying documentation supporting I/DD diagnosis verification (e.g., psychological evaluation that confirms I/DD diagnosis and demonstrates functional deficits with evidence of I/DD prior to age 22) to the identified provider. The TCM provider may be asked to supply additional information or attend a call to discuss member-specific information with the ENR provider.
3. The ENR provider makes a decision and informs the TCM provider whether they accept or deny the request and whether the member will be placed on an ENR waitlist. The TCM provider may be asked to provide additional admission documentation as resource availability approaches. The TCM provider provides any pertinent member updates to the ENR provider as they may impact the member's need for ENR.
4. When the ENR provider informs the TCM provider that an ENR bed is available, the TCM provider submits requested documentation to support the member's admission (e.g., COVID-19 and Tuberculosis testing, guardian information, their primary care provider's name and contact information, medication orders, functional capabilities).
5. TCM providers who deliver NC Innovations Waiver services to the member for whom they are seeking ENR are required to submit a SAR to Vaya UM review, following their internal business processes. ENR providers are required to submit a SAR to Vaya UM via the Provider Portal if the TCM provider seeking ENR for the member does not deliver Innovations services to that member.
6. Vaya helps coordinate weekly virtual meetings with the TCM provider and the ENR provider to discuss members in ENR, waitlist statuses for members who are not yet placed, and any discharge efforts on an as needed basis.

TCM Transitions of Care between Providers

Purpose of Process: To ensure continuity of care for members transitioning from Vaya-based TCM to provider-based TCM or vice versa.

Prerequisites

A member is transitioning to a new TCM provider due to one of the following:

1. The member selected a new TCM provider.
2. The member was reassigned for one of the following reasons:
    a. They are moving to a county of residence that is not served by the provider.
    b. They are transitioning out of a duplicative service.
    c. They are receiving Transitions to Community Living (TCL) services.
    d. They are a new Innovations Waiver participant and their current provider does not deliver Innovations services.
    e. They are receiving Home- and Community-Based Services (HCBS) from the TCM provider.

Process

1. When a member transitions, Vaya informs their current TCM provider via a beneficiary assignment (BA) file that includes a termination code and their new TCM provider that indicates the member's active eligibility.
    a. If a member is reassigned, Vaya notifies their current TCM provider in an email that indicates the reason for reassignment. If the reason for reassignment is not TCL engagement or excluded or duplicative services, the provider will have an opportunity to make changes to continue to serve the member.
2. Vaya Care Coordination contacts the current provider by the fifth of the month to inform them who the member's new TCM provider will be.
3. The current TCM provider completes a warm handoff to the receiving TCM provider within five business days of Vaya Care Coordination's notification. The current provider should provide the following information about the member in the handoff:
    a. Most recent TCM comprehensive assessment
    b. Most recent care plan
    c. Care team members
    d. Current providers
    e. Any scheduled appointments (including transportation)
    f. Any services or care addressing social determinants of health (SDOH)
    g. Whether they are receiving Healthy Opportunity Pilot (HOP) services
    h. Any additional requested information (if available)

Rapid Response Team (RRT) Referral

Purpose of Process: To provide guidance for overseeing a child's referral to RRT. RRT is an NCDHHS cross-divisional team that meets every weekday to help resolve immediate needs for children in Department of Social Services (DSS) custody in need of placement at an identified medically necessary level of care. RRT helps remove barriers created by systemic issues and facilitates conversations among county DSS, LME/MCOs, and other stakeholders.

Prerequisites

The referring county DSS office completes a Case Document for Rapid Response Team Review form and submits it to the RRT via secure email to rapid.response.behavioralhealth@dhhs.nc.gov.

Process steps

1. NCDHHS reviews the referral, coordinates a virtual meeting, and sends a meeting invite with a link for attending to those involved with the child's case.
2. To prepare for the meeting, the TCM provider ensures they have all clinical documentation and that it offers clear details about the case and identifies systemic challenges and barriers.
3. After the meeting, the TCM provider submits a DSS Weekly Update Form to rapid.response.behavioralhealth@dhhs.nc.gov each Friday (the day of the week NCDHHS assigned to Vaya network providers) until child is placed in the recommended level of care. **The TCM provider attaches a separate DSS Weekly Update Form for each child and indicates in the body of the email any barriers RRT needs to address.**
4. The TCM provider recommends RRT's closure of the case when the child is placed in the recommended level of care.

TCM Transitions from Providers Unable to Serve Vaya Members

Purpose of Process: To provide guidance for TCM providers involved in a member's transition from a provider who is unable to serve Vaya members.

Process

1. The TCM provider learns a provider can no longer serve a member or members for whom they provide TCM.
2. The TCM provider notifies applicable staff about the provider's closure, change in contract status, or inability to serve the member(s).
3. The TCM provider ceases referrals to the provider (and any provider the Vaya Provider Directory indicates is not able to accept referrals). The TCM provider also stops submitting SARs involving the provider for services after the effective date of the provider's closure or change in contract status.
4. The TCM provider continues to provide care planning and coordination to affected members.
5. The TCM provider works with the member(s)/LRP(s) and current provider to identify and select a new provider and complete documentation required for transitioning the member(s) (e.g., most recent assessment identifying level of care, care plan).
6. The TCM provider communicates with applicable Vaya staff and/or departments, including but not limited to Provider Network Operations and UM, regarding the member(s) transfer and their new provider name, site, and service.

TCM Transitions for Members who are Hospitalized or in an Emergency Department

Purpose of Process: To provide guidance on managing care transitions for members who are admitted to inpatient or emergency department settings. As part of transitional care management, **TCM providers must respond to members' transitional care needs in real-time to ensure appropriate discharge planning and a subsequent follow-up appointment resulting in linkage to community services.**

Prerequisites

Provider-based TCM identifies a member either on the Admission Discharge Transfer (ADT) data source or via an acute transition care manager (ATCM) who has experienced an inpatient hospital admission or an emergency department visit. A hospital or emergency department may also contact a TCM provider directly to share this information.

*Note- Vaya employs ATCMs who are embedded within inpatient facilities who serve the highest volume of Vaya members. See table below.

Vaya ATCMs make best efforts to notify provider-based TCM entities by phone and/or email of members being admitted to the below facilities. However, ATCMs awareness of admissions and visits may be limited by access to hospital electronic health records; limitation of admission, discharge transfer (ADT) feed; and/or delay in hospital reporting:

Holly Hill Hospital	Old Vineyard Behavioral Health
Atrium Health NC Baptist	UNC Chapel Hill
Alamance Regional Medical Center	Novant Health Rowan
Duke Life Point/Frye South	HCA Mission Copestone/Sweeten Creek
Duke Life Point/Haywood	Advent Health
Pardee PATHS Unit	UNC Caldwell/Jonas Hill
Appalachian Regional Behavioral Health/Dix Unit	Duke Life Point/Rutherford
Catawba Valley Behavioral Health	Julien F. Keith ADATC
Freedom House FBC	Central Regional Hospital
Broughton State Hospital	UNC Youth Behavioral Health Hospital

Process

Note: TCM providers should connect with members during their hospitalization, make best efforts to be present the day of discharge and after discharge, and ensure appropriate discharge planning and connection with a follow-up appointment. TCM providers should provide ongoing support for member care transition in accordance

with transitional care management requirements as outlined in the NCDHHS Tailored Care Management Provider Manual.

1. The TCM provider learns that a member for whom they provide care has been hospitalized.
2. The TCM provider attempts to outreach the hospital's psychiatric social work team to engage directly with hospital staff and TCM member. The TCM provider advises hospital staff of their role in relation to the member and their care team and ascertains how to best support transition planning (e.g., on-site hospital visits, communication with member while they are hospitalized, participation with hospital discharge planning meetings, collaboration with engaged providers).
3. The TCM provider asks the hospital to keep them informed of member progress and date of discharge.
4. The TCM provider supports discharge planning including by securing a follow-up appointment with the member within seven days of the member's discharge, through medication reconciliation and management, and through other transitional TCM requirements.
5. The TCM provider follows the member during hospitalization and through discharge and makes best efforts to meet the member following their discharge to ensure successful care transition and support with ongoing care management requirements.