Lifespan Waiver: Proposed Community Resource Coordination Contrasted with Existing Targeted Case Management under Section 13

September 8, 2023

Dimension	**Targeted Case Management**	**Community Resource Coordination**
Rate	**Paid hourly**, requires documentation of units of time.	**Flexible options for how the service is paid for** including possibility of monthly unit to reduce administrative burden of providers and DHHS, while also adopting a more value-based payment strategy to focus on the outcomes and quality of the service rather than documentation of units of time.
Purpose	**Under Chapter 13 Targeted Case Management Services** are those covered services...to identify the medical, social, educational and other needs (including housing and transportation) of the eligible member, identify the services necessary to meet those needs, and facilitate access to those services. Case management consists of intake/assessment, person centered plan development, coordination/advocacy, monitoring, and evaluation.	**Lifespan Community Resource Coordination (CRC)** is proposed to cover services that assist a member to identify and pursue goals and outcomes that support the member to sustain community living and community integration. The service goes beyond identification of needs, and needs-driven planning, to strengths and outcome-based planning. The CRC will facilitate access to an array of different supports, not just services. The CRC's coordination/advocacy and monitoring roles go beyond strictly addressing services.
Function	**Comprehensive Case Manager** is the one reimbursable case manager per member beginning 11/1/09. Comprehensive Case Managers must focus on coordinating and overseeing the effectiveness of <u>all</u> providers and benefits in responding to the member's assessed needs. Comprehensive Case Managers ensure that the individual care plan is effectively implemented and adequately addresses the assessed needs of the member.	**The Community Resource Coordinator (CRC)** in Lifespan is proposed to work collaboratively with care coordinators for behavioral health homes. Both will include distinctly different, non-duplicative roles. In addition to coordinating and overseeing the effectiveness of service providers not overseen by the care coordinator, the CRC is responsible for coordinating and monitoring the effectiveness of all supports a member has available and including that coordination component in implementation of the person-centered plan. In addition to monitoring for service provider responsiveness to the member's assessed needs, the CRC is also responsible for ensuring all supports available to the member are responding effectively to the member's goals and outcomes related to community living and community integration, which may be

		strengths-based, and which are identified in the person-centered plan.
Re-Assessment Terms	**Comprehensive Assessment and Periodic Re-assessment** of an eligible member to determine service needs, including those activities that focus on needs identification, to determine the need for any medical, educational, social or other services.	**Comprehensive Assessment and Periodic Re-assessment** of an eligible member to determine services and needs for other types of non-paid supports and assistance to reach specific goals and outcomes identified by the member. Assessment activities focused on strengths and goal/outcome identification where the need of the member may be for something other than services.
Individual Planning	**Development and Periodic Revision of the Individual Plan of Care** which specifies the goals and actions to address the medical, social, educational, and other services needed by the eligible individual. Re-evaluation of the individual plan of care must occur as a change in the member's needs occurs or at a minimum every ninety (90) days.	**Development and Periodic Revision of the Individual Person-Centered Plan** specifies the member's vision and goals for community living and community integration, identifying the needs the member has to achieve this vision and reach their goals. Addressing these goals will include how natural people (not limited to family/guardian), community resources, etc. can assist the member to achieve and sustain their vision for optimal community living and community integration. Re-evaluation of the person-centered plan occurs when a member's goals and/or needs may change, or when a member is not satisfied with one or more of the supports and services s/he receives as part of the person-centered plan. Re-evaluation occurs at minimum every sixty (60) days in the first year of enrollment in Lifespan and thereafter, at minimum, every ninety (90) days
Role	**The Targeted Case Manager develops and periodically revises the Individual Care Plan** and to the extent possible: a. Ensures the active participation of the member and as appropriate, the member's parent(s) or legal guardian; b. Works with the member (and others as appropriate) to develop goals; and c. Identifies a course of action to respond to the member's assessed needs.	**The Community Resource Coordinator develops and periodically revises the Individual Person-Centered Plan** and to the extent possible: a. Ensures the active participation of the member and as appropriate, the member's parent(s) or legal guardian; and other natural/community supporters of the member whom the member wishes to involve. b. Works with the member (and others as appropriate) to develop goals and outcomes, not just to address assessed needs but also to address a member's vision for optimal community living and community integration; and

		c. Identifies a course of action to respond to, not only the member's assessed needs, but also the member's vision for optimal community living and community integration.
Authorization	**Medical necessity** is required for authorization of services through TCM.	**Waiver services** are authorized based on comprehensive assessment of strengths and needs, the member's desired goals/outcomes, and whether the service supports the individual's person-centered plan and helps sustain community living.
Referrals	**Referral and Related Activities** that help and eligible member obtain needed services. As part of the coordination function, the comprehensive case manager must avoid the duplication of services. The case management referral activity is completed once the referral and linkage has been made. These activities are for the purpose of linking the member with medical, social, educational providers or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan. These activities include: Making referrals to providers for needed services, including documentation, and Scheduling appointments for the member.	**The Community Resource Coordinator (CRC)** proposed role does not only engage in referral to assist a member to obtain needed services. The CRC also may engage in referral to assist a member to develop relationships and access community resources that further the member's ability to sustain community living, increase community integration and successfully realize the goals and outcomes in their person-centered plan. The referral role does not stop once the referral and linkage has been made. The CRC role continues to ensure the member successfully accesses the relationship, community resources and/or services, to which they were referred. This includes collaborating, in a non-duplicative way, with Maine VR counselors and behavioral health home care coordinators, as applicable.
Collateral Contact	**Collateral Contact** is a contact on behalf of a member by a comprehensive case manager to seek or share information about the member in order to achieve continuity of care, coordination of services, and the most appropriate mix of services for the member.	**Collateral Contact** by a CRC is proposed to go beyond solely allowing this to address services and their continuity, coordination and appropriateness. The CRC may engage in collateral contacts to facilitate the desired goals and outcomes of the individual in ways that may or may not involve the use of other services.
Monitoring	**Monitoring and Follow-Up Activities** that include activities and contacts that are necessary to ensure that the individual care plan is effectively implemented and adequately addresses the needs of the eligible member. This includes contact with the member as needed to monitor the care plan objectives and, if appropriate, periodic contact with the member's family,	**Monitoring and Follow-Up Activities** that include activities and contacts that are necessary to ensure that the individual person-centered plan is effectively implemented and adequately addresses the member's goals, outcomes and needs related to achievement of the optimal vision for community living and community integration. This includes contact with the member as needed to

	providers, or other entities. Monitoring may involve either face-to-face or telephone contact. These activities may be conducted as frequently as necessary, but not less than annually, to help determine whether 1. Services are being furnished in accordance with the individual care plan; 2. Services in the care plan are adequate to address the needs of the member; and 3. Needs or status of the member has changed which requires necessary adjustments in the care plan and service arrangements with providers or service termination.	monitor the person-centered plan objectives and, with the member's consent, periodic contacts with all others involved in assisting the member with implementation of his/her person-centered plan. Monitoring may involve either face-to-face or virtual contact. These activities may be conducted as frequently as necessary, but not less than semi-annually, to help determine whether 1. The member is being supported to develop and utilize his/her own capacities and strengths to achieve his/her vision for optimal community living and community integration. 2. Services and other supports and resources are being furnished in accordance with the individual person-centered plan, with services emphasizing support for the member to build his/her own capacities and strengths and support for the member to access unpaid relationships and resources that reduce the need for paid services and paid staff whenever possible; 3. The supports, resources and services in the person-centered plan are adequate and effective to address the goals, outcomes and needs of the member; and 4. Goals, outcomes and related needs have changed, or the member's situation has changed in a way that requires necessary adjustments in the person-centered plan, the roles of natural and community resources, paid service arrangements with providers or service termination/initiation.