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Preliminary Findings from an AARP Public Policy Institute Study of Care Coordination in MLTSS Programs

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20 States Had MLTSS Programs as of August 2014

- MLTSS implemented 1989-2004
- MLTSS implemented 2005- May 2014
Overview

- Study for the AARP Public Policy Institute
- How is care coordination being provided in MLTSS programs?
  - Who receives care coordination?
  - Who provides it?
  - What are some key aspects of the role?
  - What models are emerging?
- Analysis of care coordination specifications from 15 MLTSS contracts in 14 states
  - AZ, DE, FL, HI, IL, KS, MA, MN, NM, NY, RI, TN, TX, WI
- Case study in Illinois; additional case study to be conducted
MLTSS program eligibility varies by functional and medical need.
When eligibility extends beyond people with LTSS needs, aspects of care coordination do as well.

- Intensive care coordination
- LTSS
- Other complex/chronic conditions
- Community well

Intensity varies, based on risk screen

Annual risk screen at minimum
Number of Contracts Specifying Degree or License as Acceptable Qualification

- Social Work License
- Social Work Bachelor's
- Registered Nurse
- Licensed Practical Nurse
- Other Bachelor's*

*Includes Health, Human Services, Education, Sociology, Psychology, Gerontology
Care coordinators usually work collaboratively with one another

- Most programs staff care coordination with a mix of nurses and social workers working collaboratively

- The lead is usually established by the predominant needs of the enrollee, with nurses and social workers consulting one another as needed

- Nurses are usually the point of contact for primary care providers (PCPs)
Number of Contracts Specifying Minimum In-Person Contacts by Care Coordinator

- **HCBS Quarterly**: Longest bar
- **HCBS Twice Annually**: Medium bar
- **HCBS Annually**: Short bar
- **HCBS Not Specified**: Shortest bar
- **Inst Quarterly**: Medium bar
- **Inst Twice Annually**: Shortest bar
- **Inst Not Specified**: Longest bar

Bar lengths correspond to the number of contracts specifying minimum in-person contacts.
Family caregivers’ needs may be considered, with caveats, but usually not required

- The enrollee or representative must consent to having the family caregiver involved in the assessment and service planning process

- This is usually encouraged in contracts, along with providing contact information to the family caregivers

- A few contracts explicitly require that caregivers receive needed training

- Most contracts include respite as a covered benefit, which may be beneficial to family caregivers
Fewer than half the contracts specify caseload maximums

<table>
<thead>
<tr>
<th>Enrollee Category</th>
<th>No. of Contracts That Specify</th>
<th>Caseload Range Specified</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCBS</td>
<td>6</td>
<td>48-75</td>
</tr>
<tr>
<td>Assisted Living</td>
<td>2</td>
<td>60</td>
</tr>
<tr>
<td>Nursing Home</td>
<td>5</td>
<td>100-175</td>
</tr>
<tr>
<td>Self-Directing Supports</td>
<td>2</td>
<td>40</td>
</tr>
<tr>
<td>Money Follows Person</td>
<td>2</td>
<td>30-70</td>
</tr>
</tbody>
</table>

- In 4 contracts, caseload is not addressed
- In 4 contracts, the contractor must submit its caseloads and rationale
Cultural Competence

- All contracts require that translation and interpretation services be available on request at no cost to the enrollee
- 4 contracts indicate a preference for care coordinators who speak prevalent languages
Self-directed supports

- 10 contracts specify an ongoing role for the care coordinator when the enrollee chooses self-directed supports
  - Inform the enrollee of the option
  - Help the enrollee execute the option
  - Help the enrollee develop a back-up plan
  - Monitor the service plan
  - Revisit the choice at regular intervals
Money Follows the Person and similar nursing home transition programs

- 13 contracts specify a role for the care coordinator in MFP-like transitions
  - Assess need and develop transition plan
  - Arrange for transitional supports as needed
  - Monitor transition plan
  - Provide special documentation for State
Participation of community organizations and health providers in care coordination functions

- 3 contracts specify roles for community based organizations (CBOs):
  - MA SCO: Aging Services Access Points (ASAPs)
  - MA One Care: Independent Living Centers, and ASAPs for enrollees 60+
  - NM Centennial Care: “local resources,” which include Indian Health Service, Tribal health providers, Urban Indian providers, patient-centered medical homes, health homes, core service agencies and community health workers

- Most contracts neither require nor prohibit subcontracted or delegated care coordination

- Many contractors use a hybrid of the following models
Typical in-house model

Social Worker (LTSS Lead)
Interface with family, LTSS providers, community resources

Nurse (Medical Lead)
Interface with PCP, family, pharmacist, other medical providers

Common records, consultation

May also include pharmacy consultant, behavioral health specialists, transition specialists.
Subcontract All LTSS Coordination (rare)

Nurse
(Overall Lead)
Interface with PCP, family, pharmacist and with subcontracted LTSS coordinator as needed

Community based organization (CBO) subcontracted for LTSS coordinator

Data exchange, IDT participation, consultation
Subcontract Selected Tasks (more common)

- Data exchange, consultation
- CBO subcontracted for training, finding enrollees, home visits, LTSS service planning, etc

Social Worker (LTSS Lead)

Nurse (Medical Lead)

Common records, consultation
Delegated model

Manager oversees relationship with delegated entity, monitors care coordination compliance

Data exchange, consultation

Health system or PCP practice employs care coordinator
Preliminary Conclusions

- No consensus yet on the ideal MLTSS care coordination model. No evidence of relative effectiveness.
- A few states have specified roles for traditional care coordination entities, but most are allowing the market to decide roles.
- Specifications for minimum qualifications, caseloads, contact requirements vary across states.
- Nurses and social workers usually work collaboratively in these models, with “lead” status determined by the predominant need of the enrollee.
- Risk stratification models are extending a less intensive form of care coordination to enrollees who may not have LTSS needs, but are at risk.