

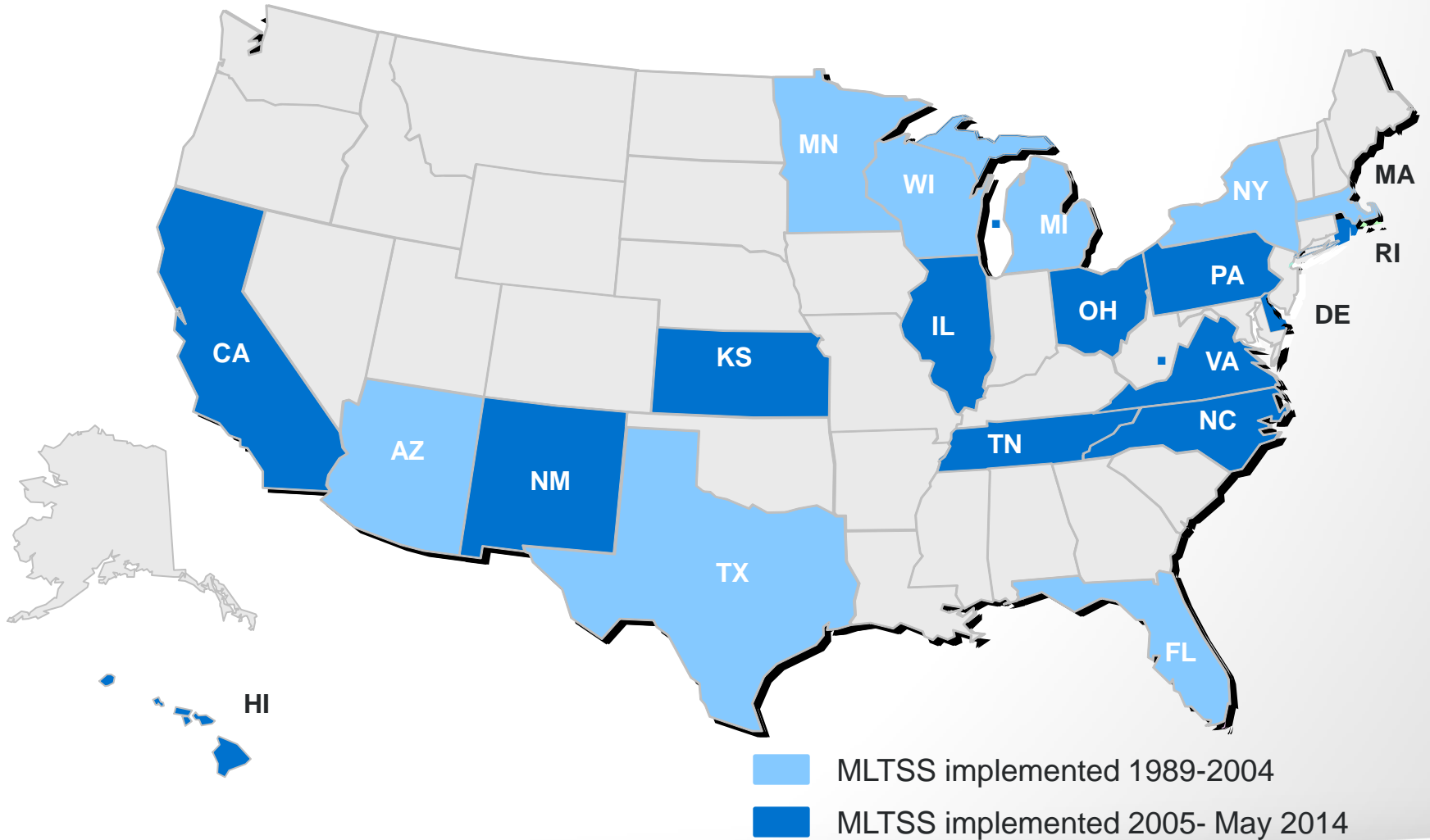


National HCBS Conference, September 16, 2014

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

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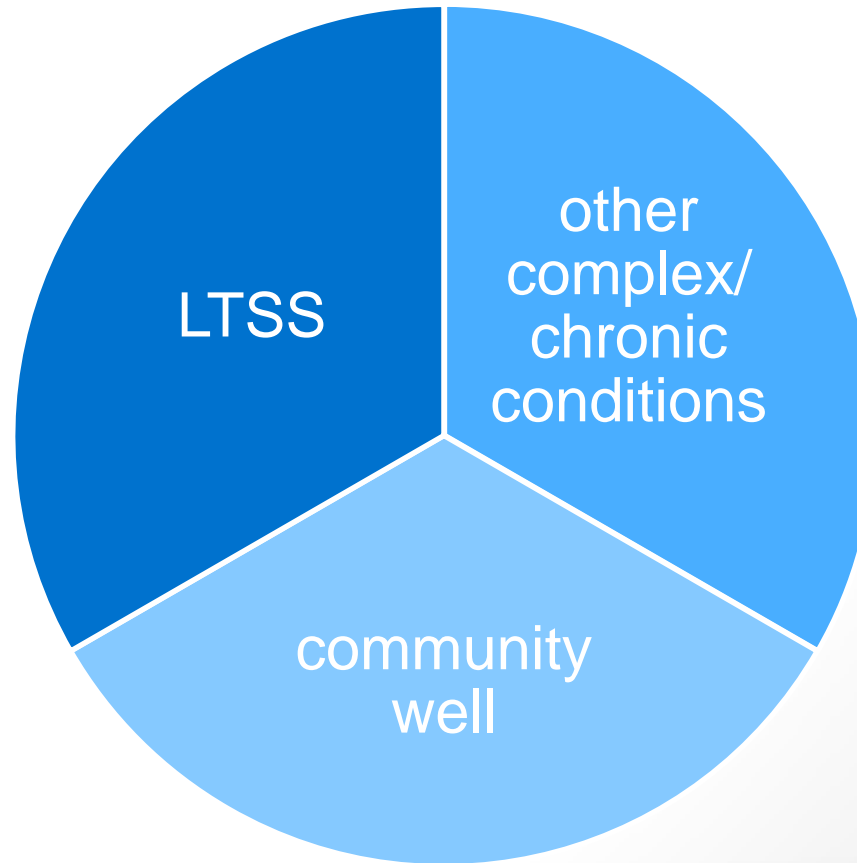
20 States Had MLTSS Programs as of August 2014



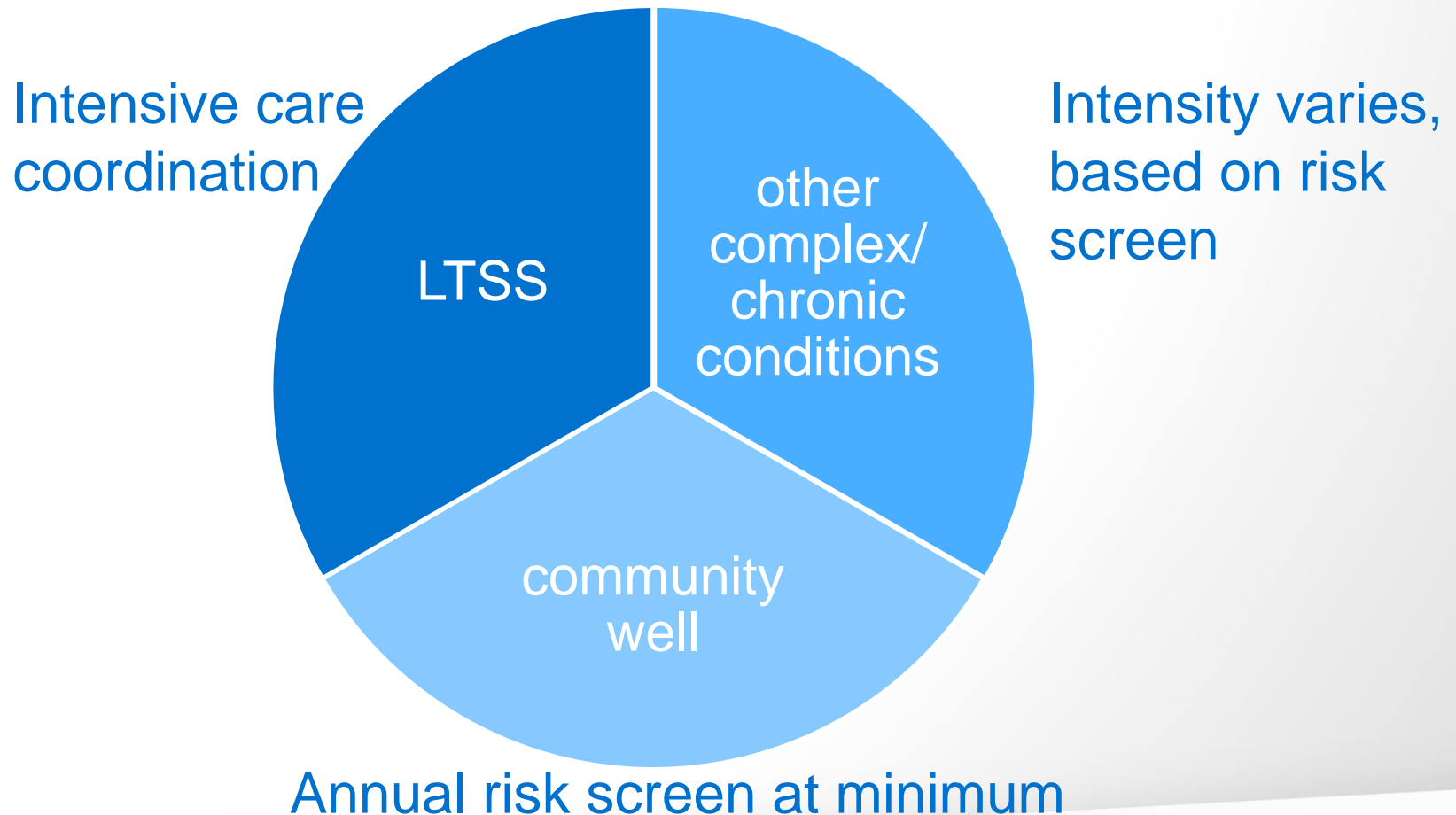
Overview

- 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

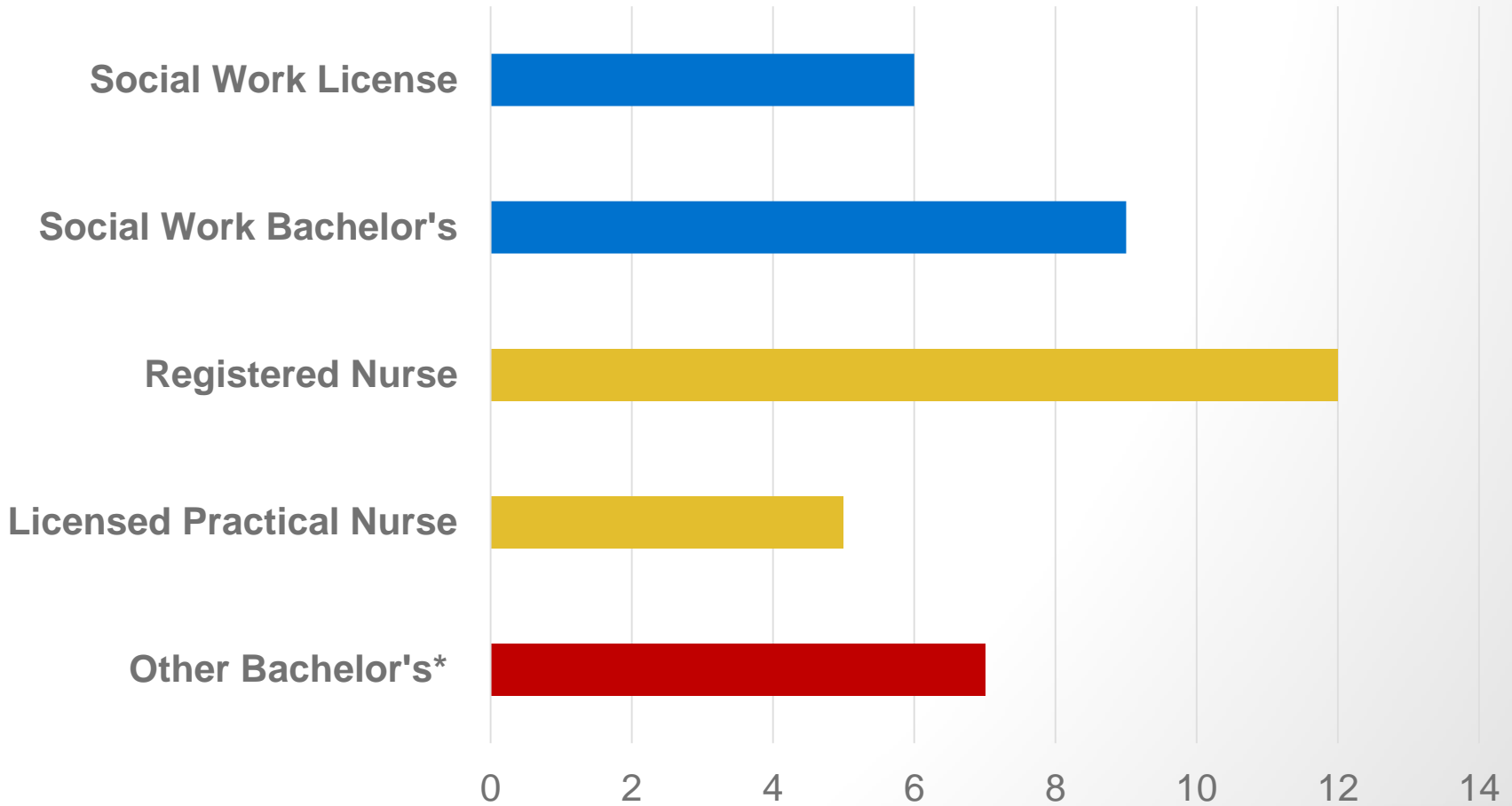
MLTSS program eligibility varies by functional and medical need.



When eligibility extends beyond people with LTSS needs, aspects of care coordination do as well.



Number of Contracts Specifying Degree or License as Acceptable Qualification

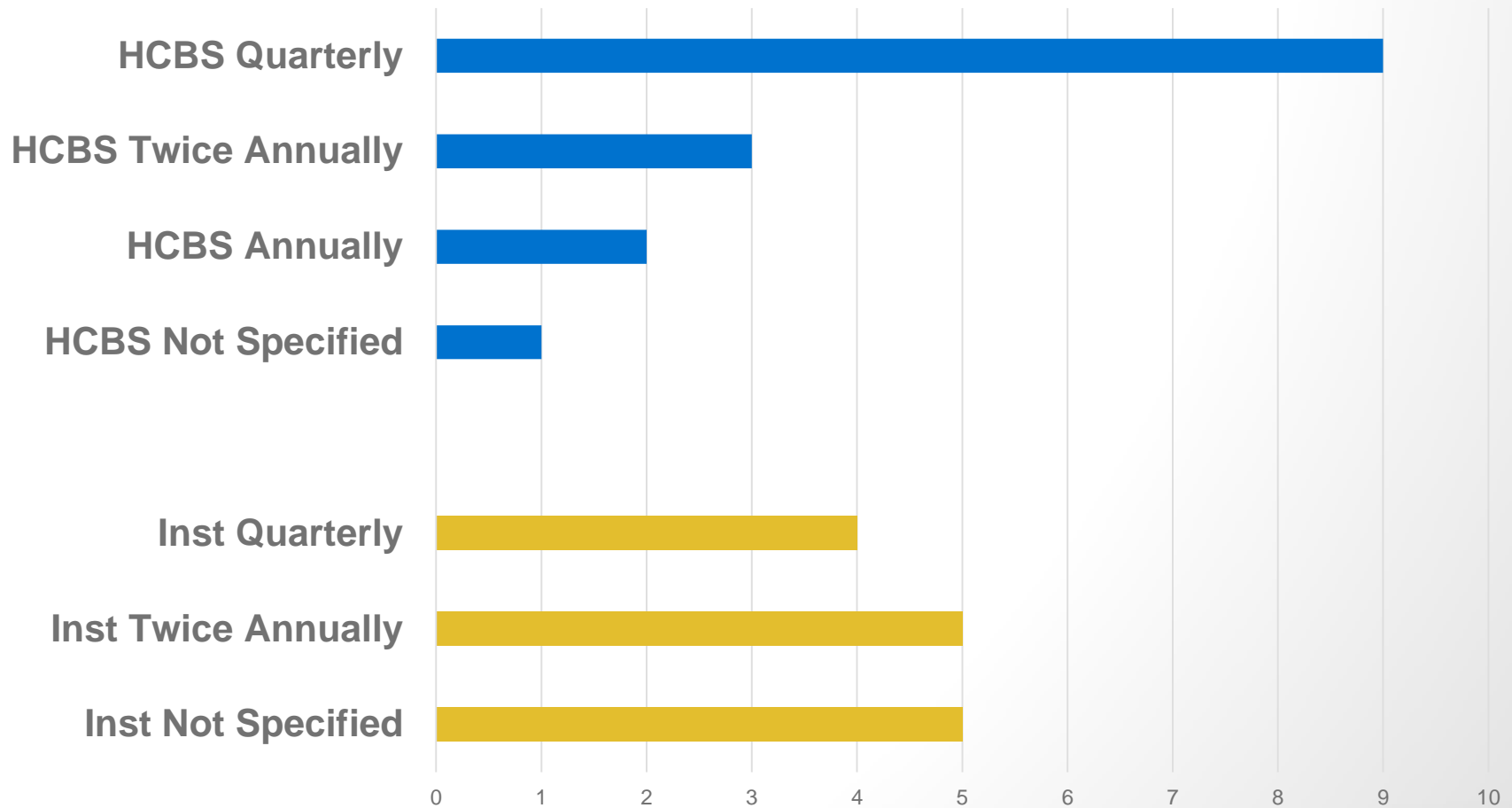


*Includes Health, Human Services, Education, Sociology, Psychology, Gerontology

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



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

Enrollee Category	No. of Contracts That Specify	Caseload Range Specified
HCBS	6	48-75
Assisted Living	2	60
Nursing Home	5	100-175
Self-Directing Supports	2	40
Money Follows Person	2	30-70

- 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

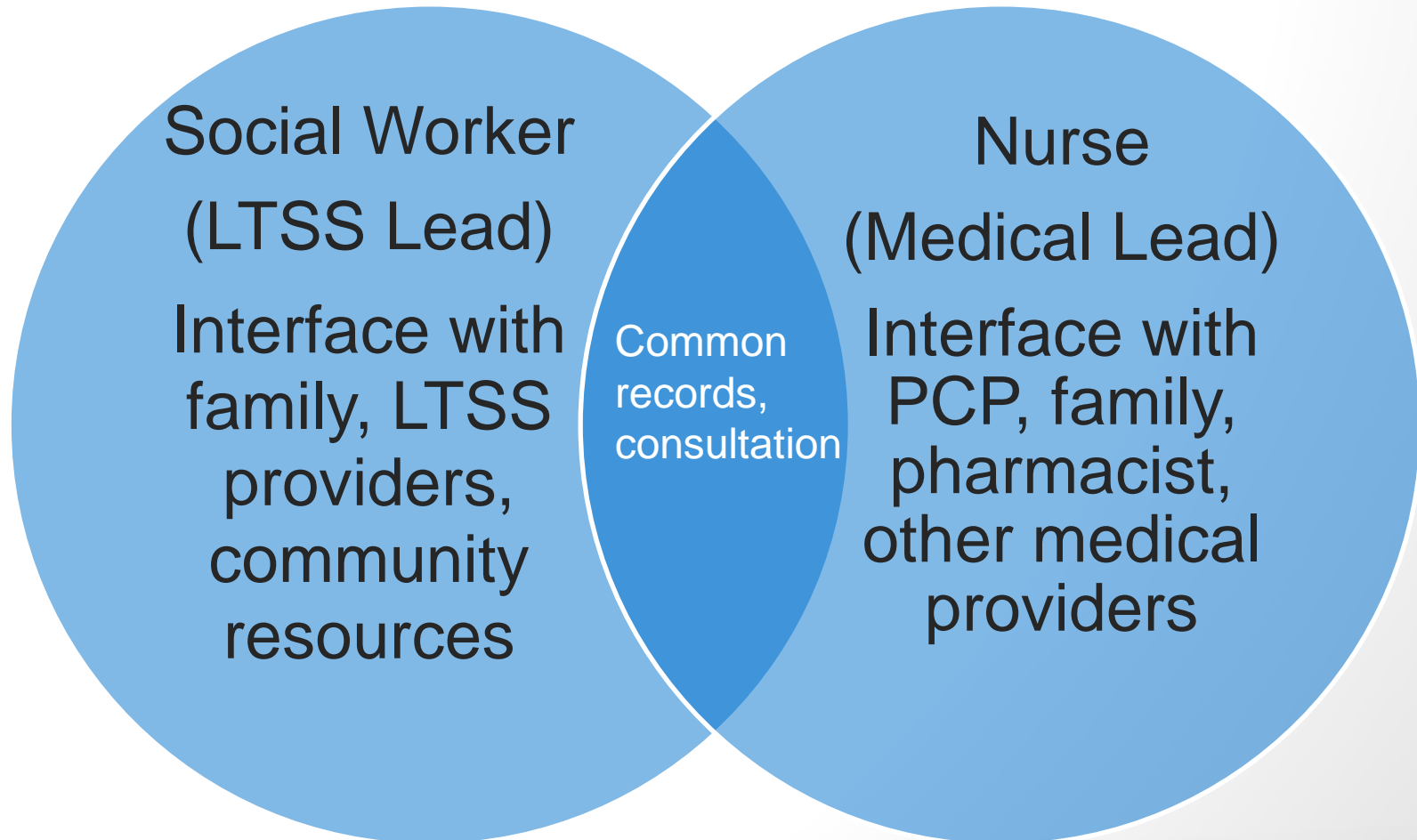
Money Follows the Person and similar nursing home transition programs

- 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

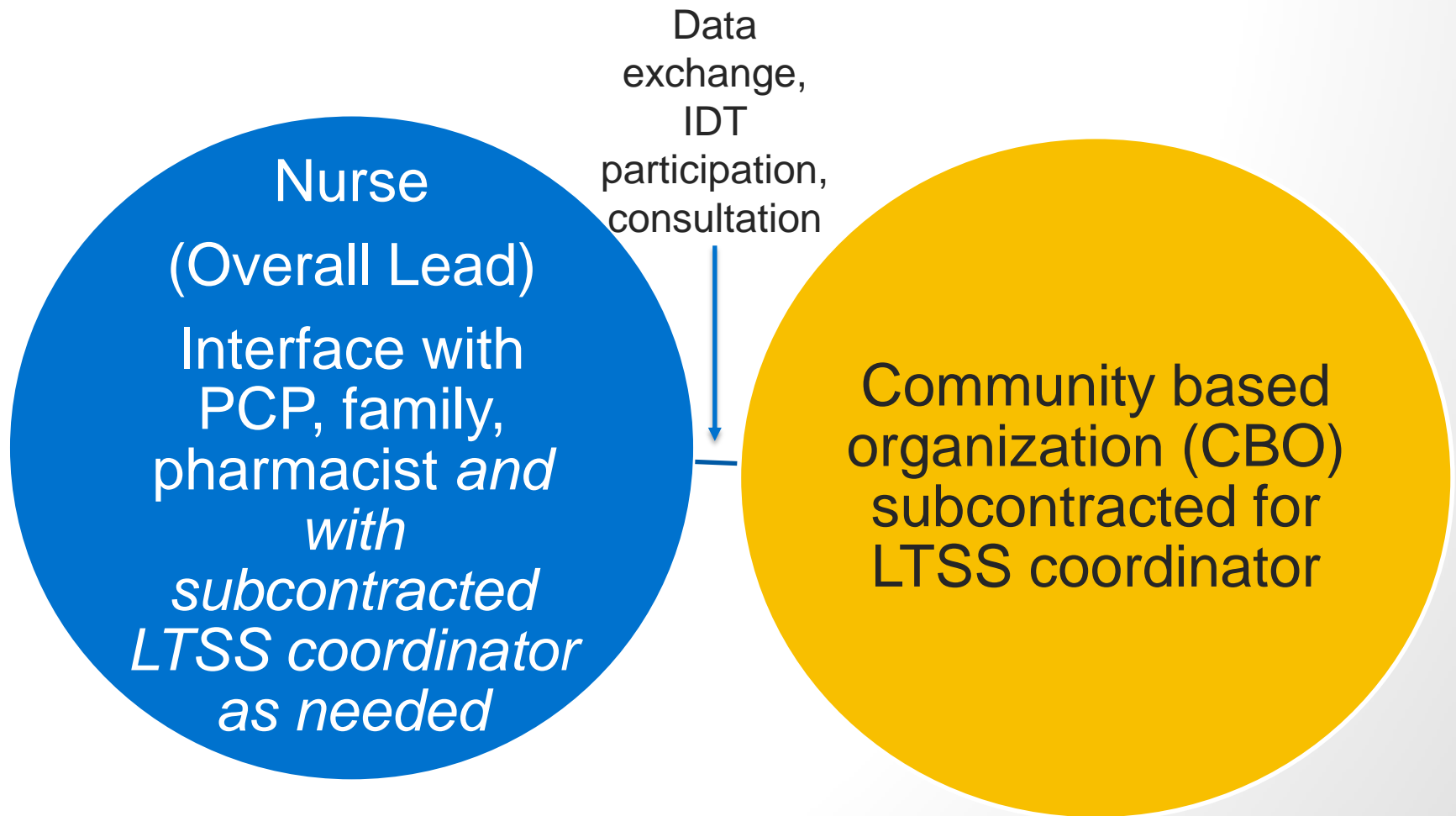
- 3 contracts specify roles for community based organizations (CBOs):
 - MA SCO: Aging Services Access Points (ASAPs)
 - MA One Care: Independent Living Centers, and ASAPs for enrollees 60+
 - NM Centennial Care: “local resources,” which include Indian Health Service, Tribal health providers, Urban Indian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

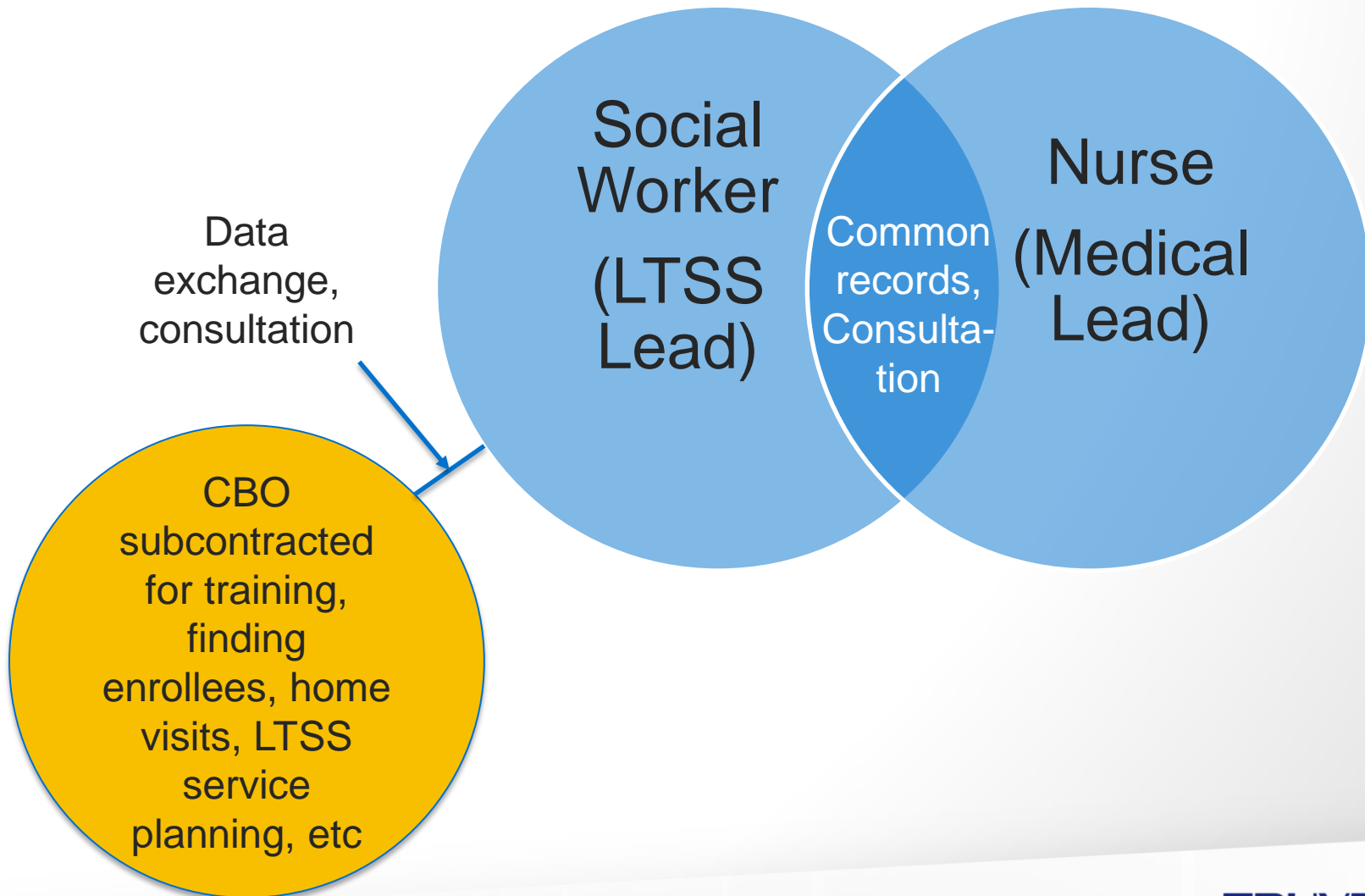


May also include pharmacy consultant, behavioral health specialists, transition specialists.

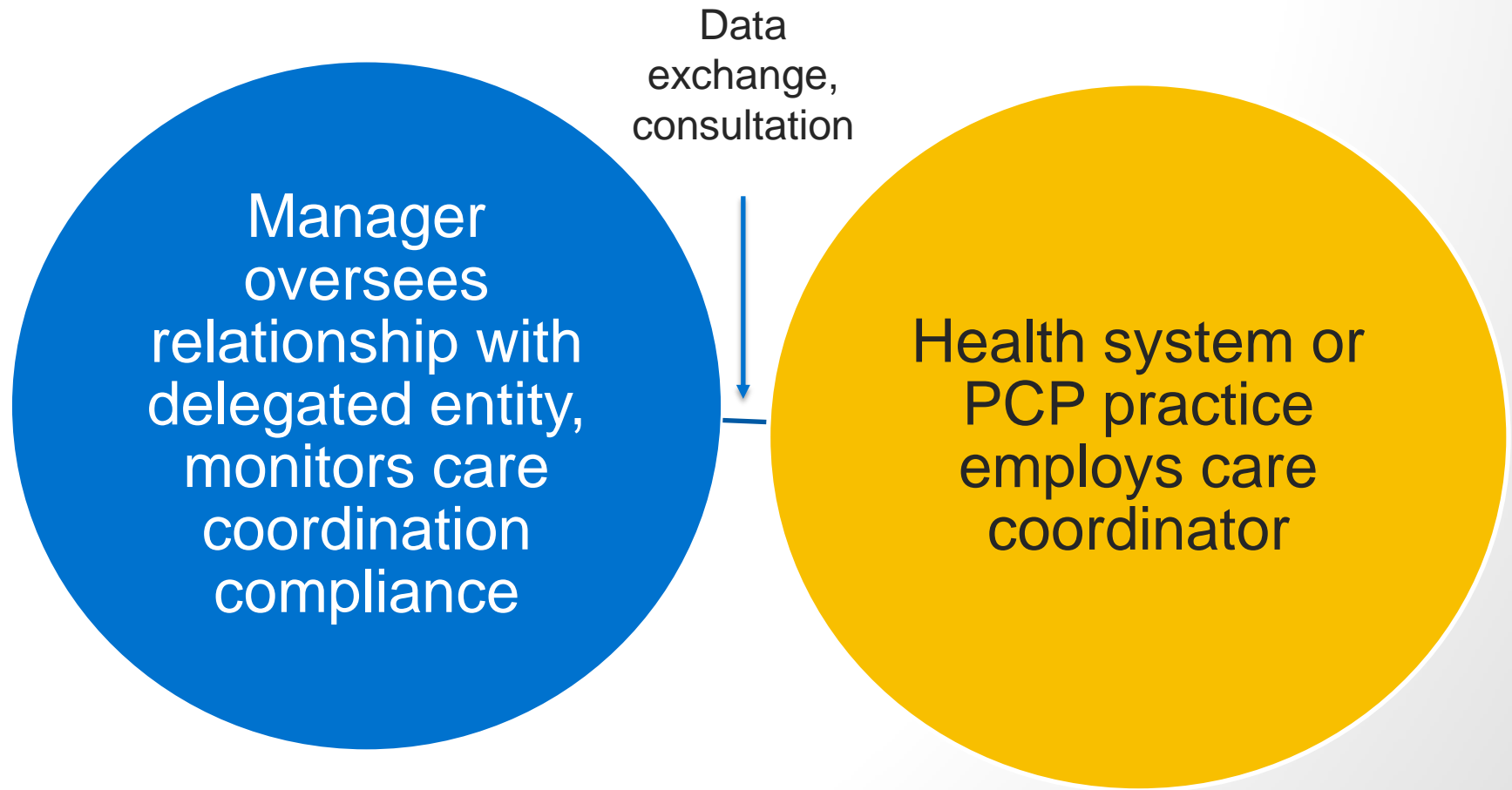
Subcontract All LTSS Coordination (rare)



Subcontract Selected Tasks (more common)



Delegated model



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