Care Coordination in Managed Long-Term Services and Supports

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Go to www.aarp.org/carecoordination

View the Following:
• Full report
• 19 managed LTSS program profiles from 18 states
• In Brief
• Webinar recording

Reinhard
Why We Commissioned this Study

- Rapid growth of managed LTSS
- Care coordination has been a focal point of managed LTSS
- Yet, we know so little

22 States had MLTSS Programs as of May 2015

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AARP Study: How is Care Coordination Provided in MLTSS Programs?

- Analysis of 19 MLTSS contracts from 18 states
  - In-depth case studies in Illinois and Ohio

Who receives it? Who provides it? What functions are performed?

Overview of Findings

MLTSS changes how care coordination is delivered
- Services coordinated
- People who receive coordination
- Organization responsible for coordination

Level of contract specificity varies
- Qualifications of coordinators
- Caseload & contact requirements
- Role of FFS care coordination organizations

FFS care coordination organizations are impacted
- Volume and lines of business
- Business relationships
- Business processes & practices
Most Contracts Require that All Members be Offered Care Coordination

Contract Requirements Regarding Who Must Be Offered Care Coordination

- All Members: 68%
- Subset of Members: 11%
- Other: 21%

Most Contracts Require In-Person Contact with Certain or All Members

Contract Requirements Regarding In-Person Contacts

- In Person Contact Required: 87%
- Not Addressed: 13%
Nursing and Social Work Degrees are the Most Commonly Accepted Qualifications for Care Coordinators

Number of Contracts Specifying Indicated Degree as Acceptable Qualification

- Nursing: 17 contracts
- Social Work: 15 contracts
- Other Bachelor's*: 7 contracts

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

Care Coordination Requirements Sometimes Address Needs of Family Caregivers

- Provisions may address:
  - The role/presence of a family member during the assessment/care planning process
  - The needs of family caregivers are assessed along with the participant’s needs
  - The needs of family caregivers are addressed in the care planning process (e.g., the need for respite services)
  - Training needs of family caregivers (e.g. medication management, use of assistive devices) are addressed in the assessment process
  - MLTSS benefit package specifically includes services for family caregivers (e.g., training, respite, counseling) as well as services for HCBS participants
  - Participant generally has the right **not** to include family caregivers in the process, if he/she so desires
About Half of Contracts Specify Caseload Maximums

Contract Requirements Regarding Caseload Maximums

- Specified: 47%
- Not specified: 37%
- Other: 16%

MLTSS CARE COORDINATION MODELS
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

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

Shared Function Model

Social Worker (LTSS Lead)

Nurse (Medical Lead)

Data exchange, virtual team meetings, service authorization

Subcontracts with CBOs for: LTSS assessment and service planning, training, finding members, home visits, etc.
Mandating a Shared Functions Model

- 6 contracts mandate roles for community based organizations (CBOs):
  - CA MediConnect: Multi-Purpose Senior Services Programs, county In-Home Supportive Services agencies
  - 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
  - OH My Care: AAAs for persons 60+ eligible for HCBS services
  - VA Commonwealth Coordinated Care: Behavioral Health Homes, local entities providing case management for people with intellectual disabilities
- Most MLTSS contracts neither require nor prohibit subcontracted or delegated care coordination
- Many MCOs use multiple models (both build and buy)

Delegated Model

Manager oversees relationship with delegated entity, monitors care coordination compliance

Data exchange, service authorization, oversight

Health system, PCP practice, or residential services provider employs care coordinator
Conclusions

- Whether provided under FFS or MLTSS, care coordination is critical to the overall experience of individual consumers.
- State contracts vary in the specificity of care coordination requirements, but the trend is toward greater specificity.
- A range of care coordination models have emerged in the shift to MLTSS, with multiple approaches often present within a single program.
- A key decision for states and plans is whether to preserve a care coordination function for existing FFS care coordination entities.
- Existing FFS care coordination entities experience significant impacts either way.
- The relative effectiveness of care coordination models is not known at this time. Model decisions are driven by concerns about capacity and stakeholder buy-in.

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