



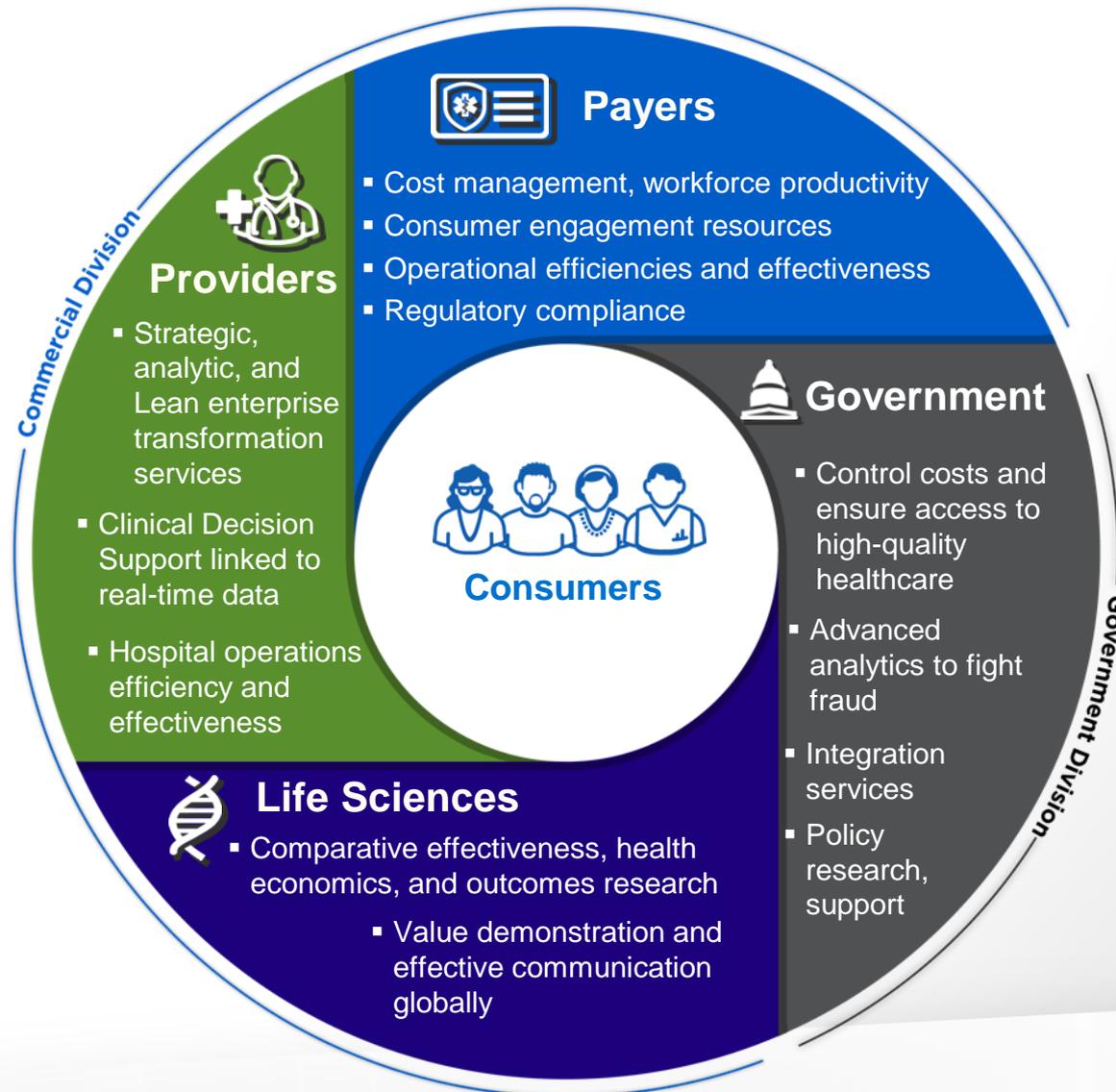
Care Coordination Models in Managed Long Term Services and Supports (MLTSS)

Presented to the Governor's Commission on Medicaid Care Management

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About Truven Health Analytics



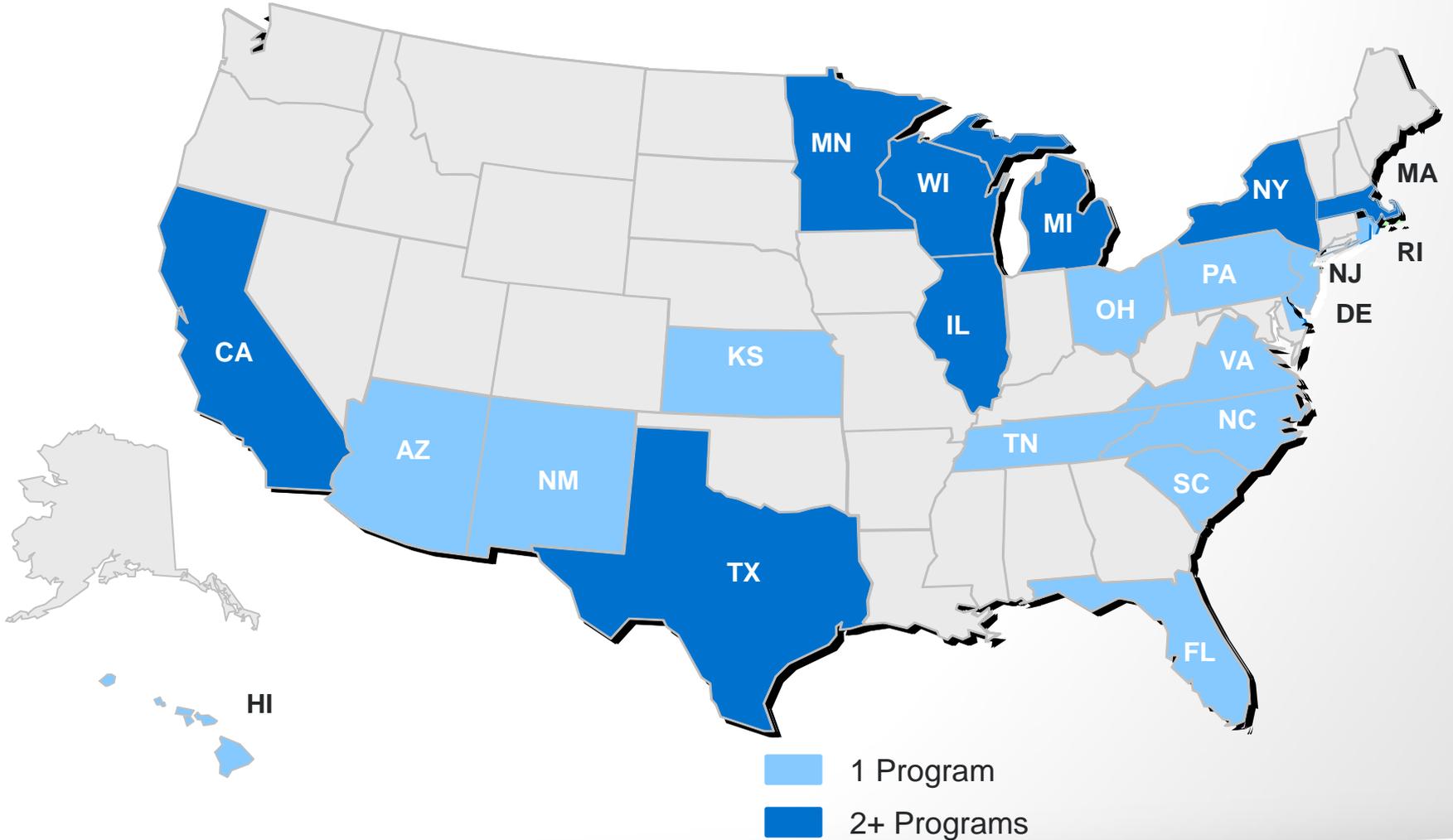
Overview

- National Update on MLTSS
- How MLTSS Changes Care Coordination
- MLTSS Care Coordination Models
- Closing Thoughts

Recent Work

- Care coordination study for the AARP Public Policy Institute
- MLTSS issue briefs for the CMS-sponsored evaluation of 1115 demonstration programs
- Policy and program development consulting for Pennsylvania's forthcoming MLTSS program, Community HealthChoices
- Stakeholder facilitation for National PACE Association
- Focus groups and site visits for the CMMI Medicare ACO evaluation
- Study of MLTSS impact on providers for federal HHS/ASPE
- MLTSS tracking

22 States Operated a Total of 31 MLTSS Programs as of December 2015



States' MLTSS Objectives

Better System Balance

- Improve access to HCBS options
- Improve nursing home diversion/transition

Better Experience

- Seamless, person-centered coordination across settings and services, including LTSS, physical and behavioral health

Better Outcomes

- Improve health and function
- Maximize independence and community inclusion

Lower Costs

- Lower growth in per-person costs
- Better budget predictability

Care Coordination of LTSS in Fee-for-Service Medicaid

Performed by:

**Aging or
Disability
Organization**

**Case
Management
Organization**

**Government
Agency**

**Assess LTSS
Needs**

**Develop LTSS
Service Plan**

**Implement &
Monitor Plan**

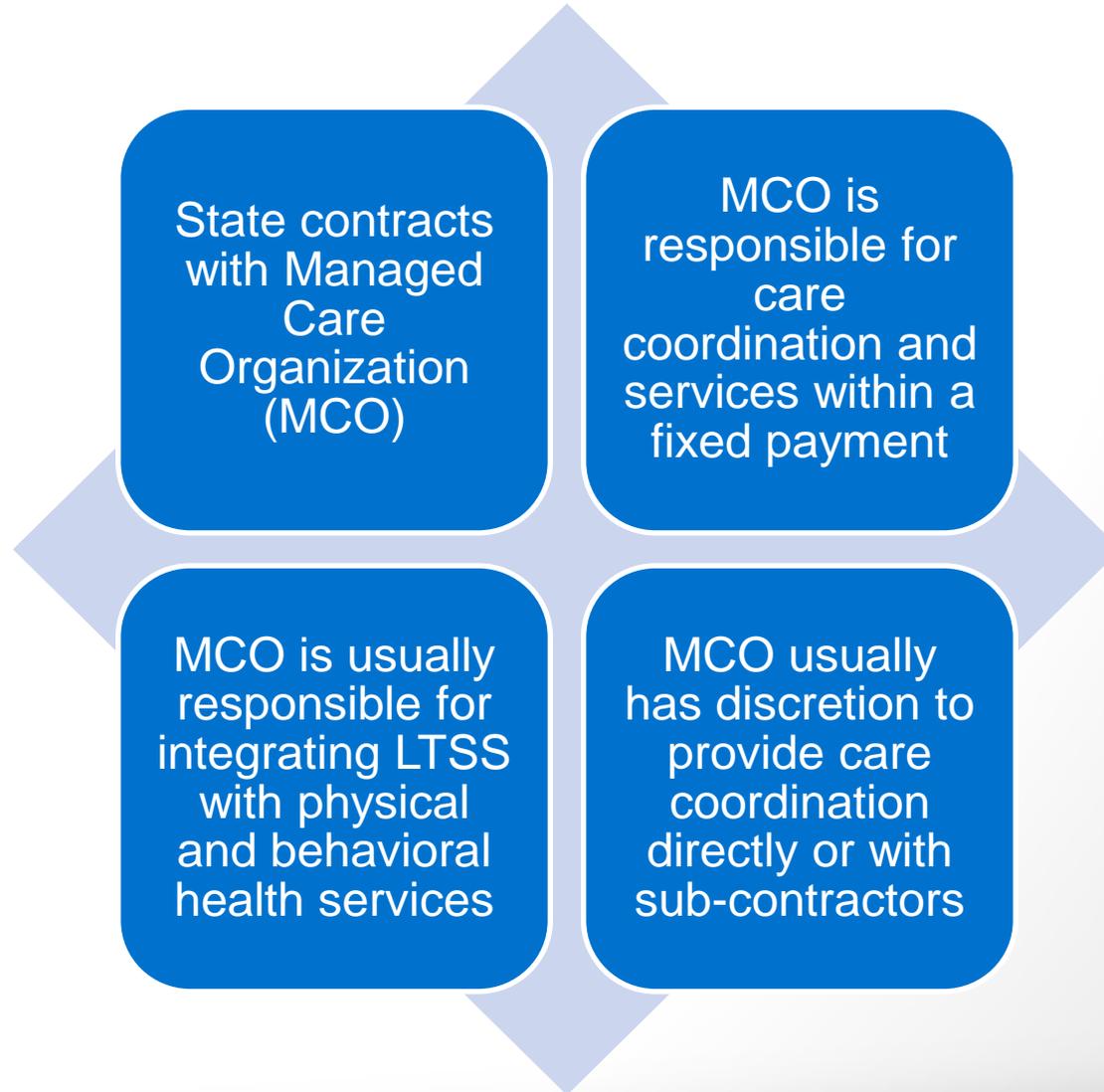
**Identify
Community
Resources**

**Monitor Health
and Safety**

**Respond to
Critical Events**

**Communicate
with Family &
Providers**

Managed Long Term Services and Supports (MLTSS)



Care Coordination Models in MLTSS

In-House

- MCO performs function directly

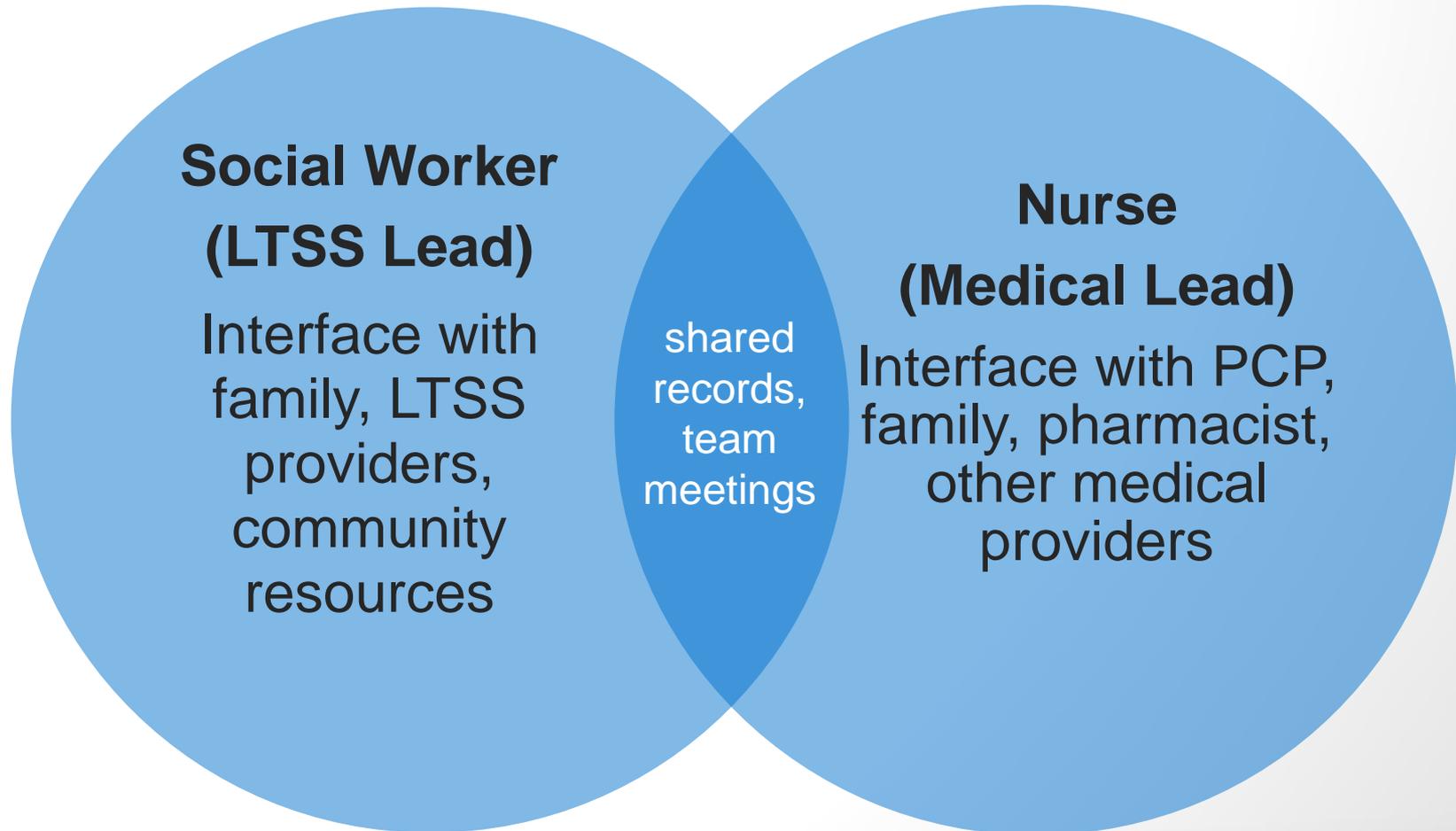
Shared Functions

- MCO performs some activities and sub-contracts with community-based organizations for some activities

Delegated

- MCO delegates the function to a sub-contractor and provides oversight

In-House Model

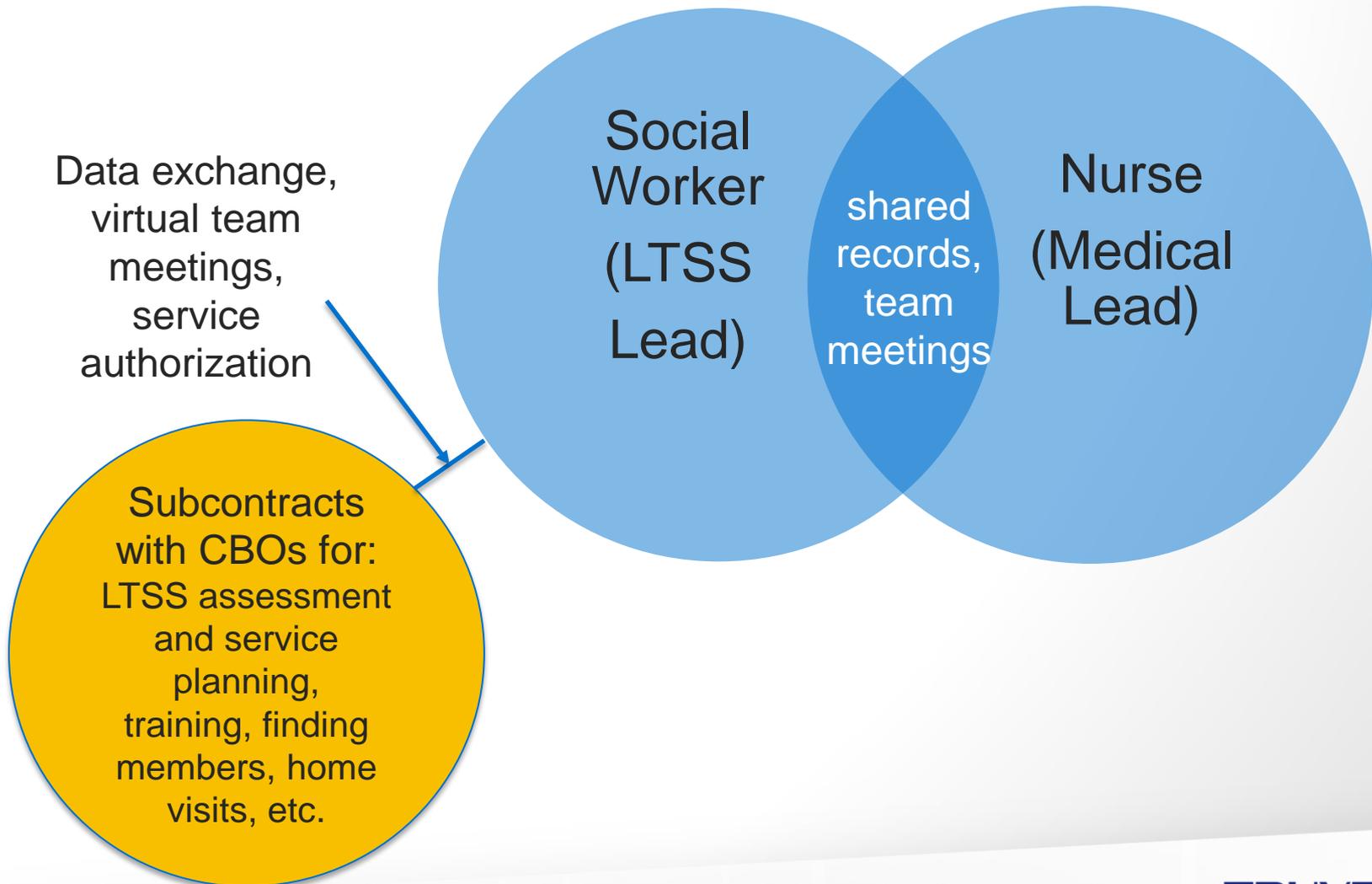


May also include pharmacy consultant, behavioral health specialists, transition specialists and others.

In-House Pros and Cons

Pros	Cons
Accountable entity has direct control over function for service authorization, quality oversight and reporting to state	Quality may be impacted if accountable entity lacks experience with LTSS or with local resources
Easier to share information/integrate service planning inside one organization	MCO may miss important information from community based organizations (CBOs)
Member experiences a single point of contact	Some members may lose longstanding care coordinator relationships

Shared Functions Model



Shared Functions Pros and Cons

Pros	Cons
Local knowledge and experience are incorporated into program	Accountability may be diluted
Fosters new business relationships between MCOs and CBOs	Significant resources must be dedicated to delineating roles, sharing information, and bridging cultures
Supports continuity of LTSS relationship for members	Member may experience multiple care coordinators/less integration

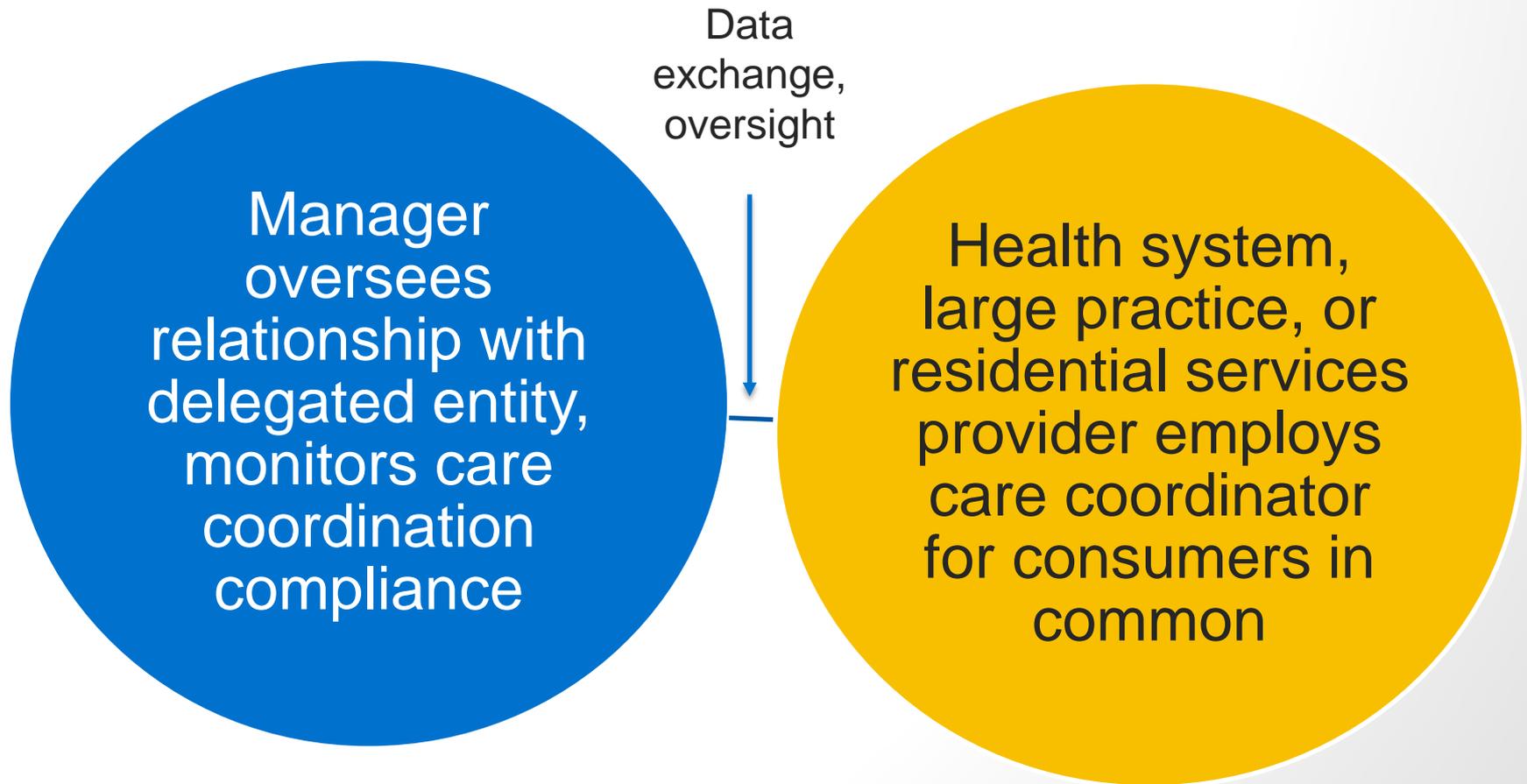
Mandating a Shared Functions Model

- 6 MLTSS programs 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, patient-centered medical homes, health homes and community health workers
 - OH My Care: AAAs for persons 60+ eligible for HCBS services
 - VA Commonwealth Coordinated Care: Behavioral Health Homes
- Most MLTSS contracts neither require nor prohibit subcontracted or delegated care coordination
- Many MCOs use multiple models

MLTSS Care Coordination Models in Illinois and Ohio

Program Feature	Illinois Integrated Care Program	Ohio MyCare Program
Shared Functions Model Mandated		√ (for 60+)
Shared Functions Model In Use	√	√
In-House Model in Use	√	√

Delegated Model



Examples of Delegated Entities

Minnesota Senior Health Options

- Clinics
- Presbyterian Homes/
Optage Housecalls

California MediConnect

- Sub-capitated MCOs
- Large multi-specialty
practices

Delegated Pros and Cons

Pros	Cons
Care coordinator usually co-located with trusted source of care for convenience and efficiency	May be difficult to avoid conflict of interest when delegated entity is a provider
May improve integration of LTSS with primary care	Care coordinator role may be difficult to protect in a busy practice environment
May provide basis for aligning incentives, depending on how sub-contract is structured (e.g., shared savings and risk)	Regulatory framework may not be adequate for risk arrangements at the sub-contractor level

Closing Thoughts

- Care coordination is essential to the success of any MLTSS program. It impacts access, quality and costs.
- Care coordination model decisions are driven by perceptions about capacity and performance, and stakeholder dynamics.
 - What are the weaknesses and strengths of the current system?
 - Do these vary by population group or geography?
 - How will the model build on strengths while addressing weaknesses?
- A tension exists between mandates and innovation. Most states strike a balance between these.
- Existing FFS care coordination entities experience significant impacts in all models. Change should be addressed directly and early.
 - Role definition
 - Information sharing
 - Process maps
- The initial model is only the starting point. Care coordination should be monitored closely and refined over time.