



DEPARTMENT OF HEALTH
AND HOSPITALS

TRANSFORMING LOUISIANA'S LONG TERM CARE SUPPORTS AND SERVICES SYSTEM

.....
Care Coordination

Concept Brief



JANUARY 9, 2014

Care Coordination:

Introduction

As stressed in the initial concept paper released this past August on the transformation of long term supports and services, the ongoing transformation of Louisiana's long-term supports and services system will continue to be an open and collaborative process. The involvement of stakeholders across the state is critical for the successful design and implementation of Managed Long Term Supports and Services (MLTSS) in Louisiana. The purpose of the Long Term Care Advisory Group is to provide an organized venue for feedback from stakeholders in Louisiana, including participants in the current Long Term Supports and Services (LTSS) system, LTSS providers, and community-based organizations involved the support of those using LTSS. Based on feedback received during the first meeting of the advisory group, future meetings of the advisory group will focus on soliciting purposeful feedback through the use of focused work group meetings.

Background

Care coordination— the planning and management of multiple services and supports— is a critical feature of any LTSS program. The scope of the coordination depends on the state's program goals and model and may differ based upon the disability population. **If an MLTSS program is limited to long-term services and supports, service coordination may primarily focus on LTSS. To ensure a whole-person approach, there should also be explicit expectations about how care coordinators interact with primary and acute care providers, and how informal and community supports beyond those reimbursed by Medicaid will be included in the planning and in outcomes determination. This model could be similar to what is offered currently, wherein service coordination is very involved in access and approvals for LTSS and may act as a referral source or navigator to access supports and services outside of LTSS, but with little or no control over actual authorization or receipt of these non-LTSS services.**

If the MLTSS approach includes full integration of LTSS with primary, acute, and behavioral health services, care coordination will be a key integrating mechanism at the individual level and an important administrative control. Care coordination would be much more involved in access, planning, and monitoring of the full range of supports used by an individual. Care coordination would be linked to administrative processes within the MCO. This would help to ensure that persons would not only have access to a physician specialist when needed but that the MCO would make sure that the correct type of specialist is being seen at appropriate intervals to best address individual risks. This model of care coordination would also reduce duplication and support continuity of care as a person's needs and preferences change.

Under MLTSS, CMS will continue to expect that plans of care be comprehensive, individualized, person-centered, and responsive to changing needs and goals. What managed care should add is the opportunity for multiple, specialized approaches to care coordination. Examples of this ability include assigning a nurse practitioner as lead in coordinating care for individuals with multiple and complex chronic conditions, or including a mental health professional on the coordination team for LTSS recipients with significant mental health needs. With the flexibility provided through MLTSS, the opportunity and incentive to manage and coordinate care across settings and throughout transitions would also be enhanced. For instance an MLTSS program can be designed to provide care coordination to individuals who enter the nursing facility— both to promote successful return to the community when appropriate and to prevent unnecessary re-hospitalizations. Likewise, MLTSS may provide opportunities to manage and coordinate care across settings for persons with ID/DD transitioning from the state operated ICF-DD (Pinecrest) or former state facilities (CEA facilities) as these individuals represent the highest risk of return to institutional placement and often require complex and integrated supports structures. Participant self-direction might be another

instance where the approach to care-coordination is tailored to that specific model of service delivery.

This ability to provide different models and intensity of care coordination even within a single plan is a key benefit of MLTSS. This needs to be considered before deciding whether to specify caseload size and ratios or how the state should go about setting such requirements. Higher caseloads may be appropriate for low risk individuals, and lower caseloads managed by inter-disciplinary teams desirable for high-risk members with complex needs. Many innovative approaches exist and should be allowed the flexibility to succeed.

Since about 80 percent of individuals receiving services through OAAS are enrolled in both Medicare and Medicaid, and 44 percent in OCDD waiver programs, another key issue is whether and how managed care organizations coordinate their services with the benefits that are covered under Medicare. Short of complete integration (i.e., a capitated payment covering both Medicaid and Medicare services as is done in PACE), there are several ways that coordination can be achieved. Examples include reaching out to physicians and practices that serve large numbers of “duals” and educating them on plan services, placing care coordinators in such groups and practices, use of electronic records or other information-related tools to improve information sharing, and requiring information sharing and coordination in the agreements and contracts that are established with network providers.

In the initial LTSS concept paper that was released in August, DHH emphasized the importance of seeking suggestions for innovative approaches to achieve an optimal level of care coordination through the RFP(s) and seeking feedback regarding important

design elements or considerations that should be included.

Feedback to Louisiana’s Approach

As DHH continues to research best practices and lessons learned from other states and works to build the framework for the transformation to MLTSS, feedback is actively being solicited on the following areas of care coordination.

Louisiana’s Approach to Care Coordination: Workgroup Questions

1. **Should care coordination responsibilities be fully intergrated into the MCOs?**
2. **What are some care coordination improvements you hope to see in transformation to MLTSS?**
3. **MCOs can bring specialized models of care coordination to the delivery of MLTSS. What kinds of conditions or circumstances would you like to see addressed through specialized care-coordination?**
4. **Members of the Advisory Group have expressed concerns about the scope of MCO experience with providing MLTSS. How might the RFP best solicit information regarding care coordination competency?**
 - a. **Should MCOs be asked to describe their values and approach to care coordination? If so, what values/ type of approach should we be looking for?**
 - b. **What competencies are important in providing care coordination to the disability population(s)?**

Transforming Louisiana’s Long Term Care Supports and Services System

*For additional information, please visit
MakingMedicaidBetter.com/LongTermCare*

Louisiana Department of Health and Hospitals

628 North 4th Street, Baton Rouge, Louisiana 70802

(225) 342-9500