

**Research Report**

# Care Coordination in Managed Long- Term Services and Supports

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## Additional Information

Care coordination information from 18 states is summarized in this report. Detailed information tables for each of the 18 states are available at <http://www.aarp.org/carecoordination>.

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# Executive Summary

Effective care coordination for people with complex health care needs has become a major area of focus across the entire health care spectrum. Better care coordination is considered essential to connecting medical and supportive services, improving consumer experience, and reducing costs. Effective care coordination is particularly important for people receiving long-term services and supports (LTSS). People with LTSS needs interact frequently with the health care system, have physical or cognitive limitations that require ongoing supports, and often have chronic health conditions that require continuous monitoring.

Traditional Medicaid care coordination models for LTSS populations are changing rapidly. A primary driver of change is the rapid shift in state LTSS purchasing strategies from fee-for-service to managed care. Almost half the states have undertaken major initiatives to contract with health plans to provide comprehensive care coordination for Medicaid beneficiaries with LTSS needs, in both institutional and community-based settings. Specifically, in 2014, 18 states had Medicaid managed long-term services and supports (MLTSS) programs for older people and adults with physical disabilities. This shift to managed care is bringing with it significant changes in care coordination for people receiving LTSS.

## THE PURPOSE

This study examines the characteristics of care coordination models that are emerging in MLTSS programs and the impact these models are having on traditional LTSS case management systems. The study has two major components: 1) a review of 19 contracts between states and MLTSS plans in the 18 states (Massachusetts has separate contracts for its two MLTSS programs), focusing on care coordination specifications; and 2) in-depth case studies of care coordination models in recently implemented MLTSS programs in Illinois and Ohio. Since both states were in early stages of MLTSS implementation, the case

studies provided insight not only into new care coordination models, but also into the disruption taking place among traditional case management organizations.

## FINDINGS

- **Most state MLTSS programs require that all members receive some level of care coordination.** Plans typically determine the level and intensity of care coordination by stratifying members into at least three risk groups—low, medium, and high.
- **Care coordination is being defined more broadly in MLTSS than in traditional case management programs.** It generally includes comprehensive coordination of all health and social services and extends to people with a variety of needs, including medical, LTSS, and behavioral health.
- **A care coordinator is usually a nurse or social worker.** The nurse typically is the health care lead, and the social worker is the LTSS lead. They generally have a mixed caseload that includes some members living in home- and community-based settings (including assisted living), some in nursing facilities, and some living independently with little or no need for LTSS. Most often, they work for a health plan, but sometimes they work for a community-based organization or health system. They often work out of their own homes, with occasional visits to the office for meetings.
- **Three care coordination models have emerged in MLTSS programs: In-House, Shared Functions, and Delegated.** For the In-House model, health plans provide care coordination directly with their own staff. For the Shared Functions model, plans subcontract with traditional case management organizations for some functions and retain others. For the Delegated model, plans delegate the entire function to a health system or other entity that has an existing relationship with

the member. Multiple models can and do exist within a single MLTSS program, and within a single contractor.

- **Whether mandated or not, many collaborative Shared Functions arrangements are emerging.** Some states require MLTSS contractors to implement Shared Functions models with traditional case management organizations, while others leave the decision to the contractors.
- **Shared Functions models have preserved a role for traditional case management organizations and tapped into their expertise, but they have also created challenges.** Role delineation and information exchange between the collaborators have been challenging in the early phases of implementation, requiring significant effort to create a seamless experience for the member.
- **Care coordination specifications vary considerably across states.** In addition to deciding whether to mandate relationships with traditional case management organizations, states face several key choices in specifying care coordination requirements, including eligibility for care coordination, minimum qualifications of care coordinators, minimum frequency of contact with members, and whether to specify the maximum number of members who may be assigned to one care coordinator.
- **The importance of family caregivers is often acknowledged in contracts, though little specificity is provided about their role.** The most common mention of family caregivers is in the context of assessment, usually as a

source of information that should be sought out by the care coordinator with consent of the member, and sometimes as someone whose training needs should be assessed. Some contracts include provisions for providing care coordinators' contact information to family caregivers. Few contracts require family caregiver training as a covered benefit.

- **The shift from fee-for-service models to managed care models for LTSS is having a major impact on the traditional case management providers for home- and community-based services.** In response, some case management providers are changing their practices and business models to become more competitive in the new market-based environment. The shift requires significant resources and may prove too difficult a challenge for smaller organizations that do not have sufficient capacity or willingness to adapt.

## CONCLUSION

Care coordination for people with LTSS needs is evolving significantly as states move to MLTSS. Federal and state policy, market forces, and available infrastructure are all influencing the models of care. The comparable impact of these models on consumer health, experience, and cost is not known, but the immediate impact on traditional LTSS systems is clear. Given that care coordinators are, and will remain, a critical point of contact for consumers who use LTSS, a greater understanding of the relative effectiveness of emerging models is an issue of high policy priority.

# 1. Introduction

Care coordination is a critical support for people who use long-term services and supports (LTSS). LTSS and health systems are experimenting with models that connect these services to improve cost-effectiveness and create a more person-centered experience.<sup>1,2</sup> As a result, the role of care coordination is changing and becoming more important than ever. Innovation in care coordination is happening in both fee-for-service and managed-care delivery systems, but recently has been most notable in managed care. Several states have mounted significant, managed long-term services and supports (MLTSS) programs.<sup>3</sup> These have included both Medicaid-only programs and Medicare-Medicaid demonstration programs.

As MLTSS is implemented, the leading care coordination role shifts. Traditionally, local private and public agencies have provided case management under Medicaid Home and Community-Based Services (HCBS) programs. In MLTSS, health plans and other contractors become responsible for comprehensive care coordination that includes LTSS.

Many forces are influencing the care coordination models emerging in MLTSS programs. Perhaps most significantly, states provide guidance through their MLTSS contracts and related policy. Contracts often leave significant discretion to the contractors, however, and this is reflected in the diversity of models implemented to date. As health plans consider their options, they weigh the potential effectiveness of building their own care coordination capacity against the benefits of partnering with traditional agencies. Traditional agencies must assess their capacity to do business in very different ways as they consider the risks

## Study Components

The study included in-depth case studies in Illinois and Ohio, and review of contracts for MLTSS programs in the following states:

<i>Arizona</i>	<i>New Jersey</i>
<i>California</i>	<i>New Mexico</i>
<i>Delaware</i>	<i>New York</i>
<i>Florida</i>	<i>Ohio</i>
<i>Hawaii</i>	<i>Rhode Island</i>
<i>Illinois</i>	<i>Tennessee</i>
<i>Kansas</i>	<i>Texas</i>
<i>Massachusetts</i>	<i>Virginia</i>
<i>Minnesota</i>	<i>Wisconsin</i>

and benefits of pursuing new partnerships with health plans.

This report presents findings from a study that examined the models and characteristics of care coordination that have emerged in MLTSS programs.

## APPROACH

The study had two components. The first was a review of 19 Medicaid contracts from 18 states that, in 2014, had MLTSS for older people and adults with physical disabilities. (Massachusetts has separate contracts for its two MLTSS programs.) The scope of this study does not include MLTSS for people with intellectual/developmental disabilities or mental illness. The review involved searching the most recent contract available for specific features across a number of domains. Findings from the

- 1 For a discussion of several fee-for-service and managed care approaches to care coordination, see: Schraeder, C. and P. Shelton, eds. 2011. *Comprehensive Care Coordination for Chronically Ill Adults*. Wiley-Blackwell, West Sussex, UK.
- 2 The Scan Foundation has articulated key principles that should underpin care coordination models. See: Scan Foundation. December 2013. *Achieving Person-Centered Care through Care Coordination*. Policy Brief #8. Accessed November 21, 2014, at [http://thescanfoundation.org/sites/thescanfoundation.org/files/tsf\\_policybrief\\_8\\_person\\_centered\\_care\\_dec\\_2013.pdf](http://thescanfoundation.org/sites/thescanfoundation.org/files/tsf_policybrief_8_person_centered_care_dec_2013.pdf).
- 3 Truven Health Analytics estimates that the number of LTSS users enrolled in MLTSS programs increased from 389,000 in 2012 to over 1 million by the end of 2014. Presented at the National HCBS Conference, Arlington, Virginia, September 16, 2014.



contract review are summarized in section 3, “Characteristics of Care Coordination in MLTSS,” of this brief.

The second component was two in-depth case studies. To see care coordination models in context, we conducted a visit to Illinois that focused on one health plan’s model and a visit to Ohio that looked at a health plan-Area Agency on

Aging partnership model from the perspective of several organizations. The case studies are presented in section 4, “Case Studies.”

The synthesis of the contract review and case study findings brought into focus three care coordination models, described in the next section.

## 2. Emerging Models of Care Coordination

Care coordination varies across MLTSS programs and continues to evolve as states implement new programs and modify existing ones. Certain characteristics, though, are common across programs. A typical care coordinator is a nurse or social worker with a mixed caseload that includes some members living in HCBS settings (including assisted living) with nursing facility-level needs, some in nursing facilities or assisted living, and some living independently with little or no need for LTSS. The care coordinator usually works for a health plan, but sometimes works for a community-based organization (CBO) or health system under contract to a health plan. Regardless of who the employer is, the care coordinator often works out of his or her home, with occasional visits to the office for meetings and information exchange.

In the 18 states reviewed, we identified three basic models of care coordination, each of which has many variations. The three models are In-House, Shared Functions, and Delegated. In most states, MLTSS contractors have discretion to use any model they choose. Within any given program, it is not uncommon to see competing contractors using different models.

### IN-HOUSE MODEL

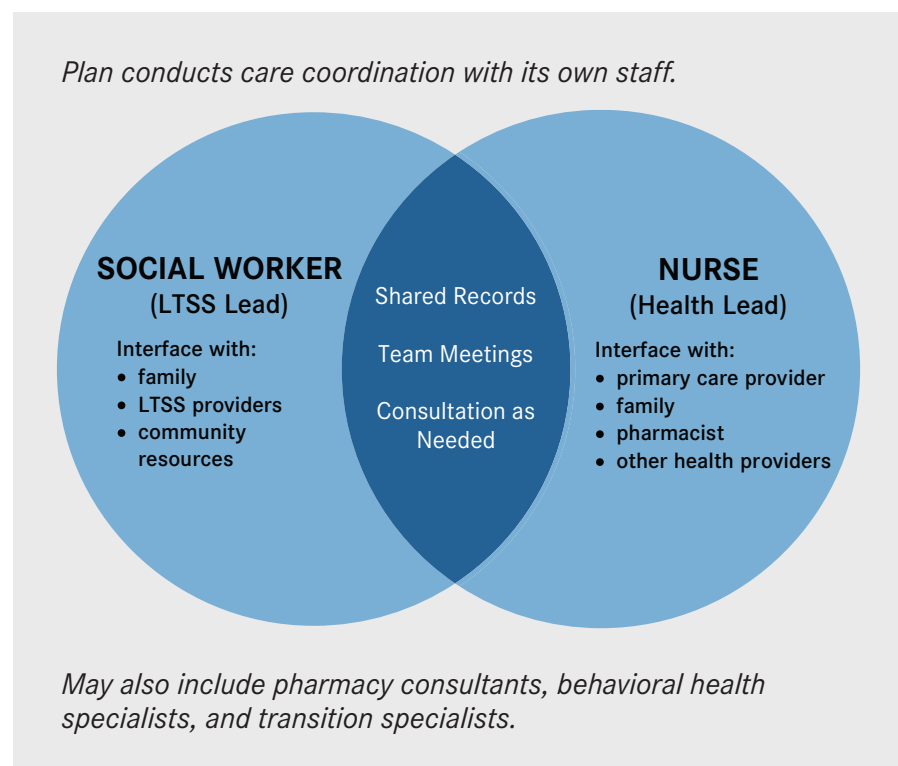
Figure 1 illustrates the basic structure of the In-House model, in which the contractor, usually a health plan, hires its own staff to conduct care coordination.

Typically, the staff includes registered nurses and licensed social workers, with nurses assigned to members with

significant health care needs and social workers assigned to members with LTSS and other social needs. The two work collaboratively, sharing information and consulting each other as needed. Communication with the primary care provider (PCP) is usually, but not exclusively, conducted by the nurse. Some plans have behavioral health specialists who carry caseloads of members with behavioral health needs, while others employ behavioral health consultants to support care coordinators as needed. Internal pharmacy consultants are also common.

Many variations exist on the composition and credentials of the care coordination staff, but the common element of the In-House model is that the contractor has chosen to develop sufficient internal capacity to conduct all or most care coordination functions directly. The advantage of this approach for the plan is that it can implement

FIGURE 1  
In-House Model



and adjust its care coordination capacity without the transactional costs involved in negotiating business relationships with external partners. The disadvantage, particularly in a market that is new to a plan, is that valuable community partnerships and experience may be more difficult to obtain.

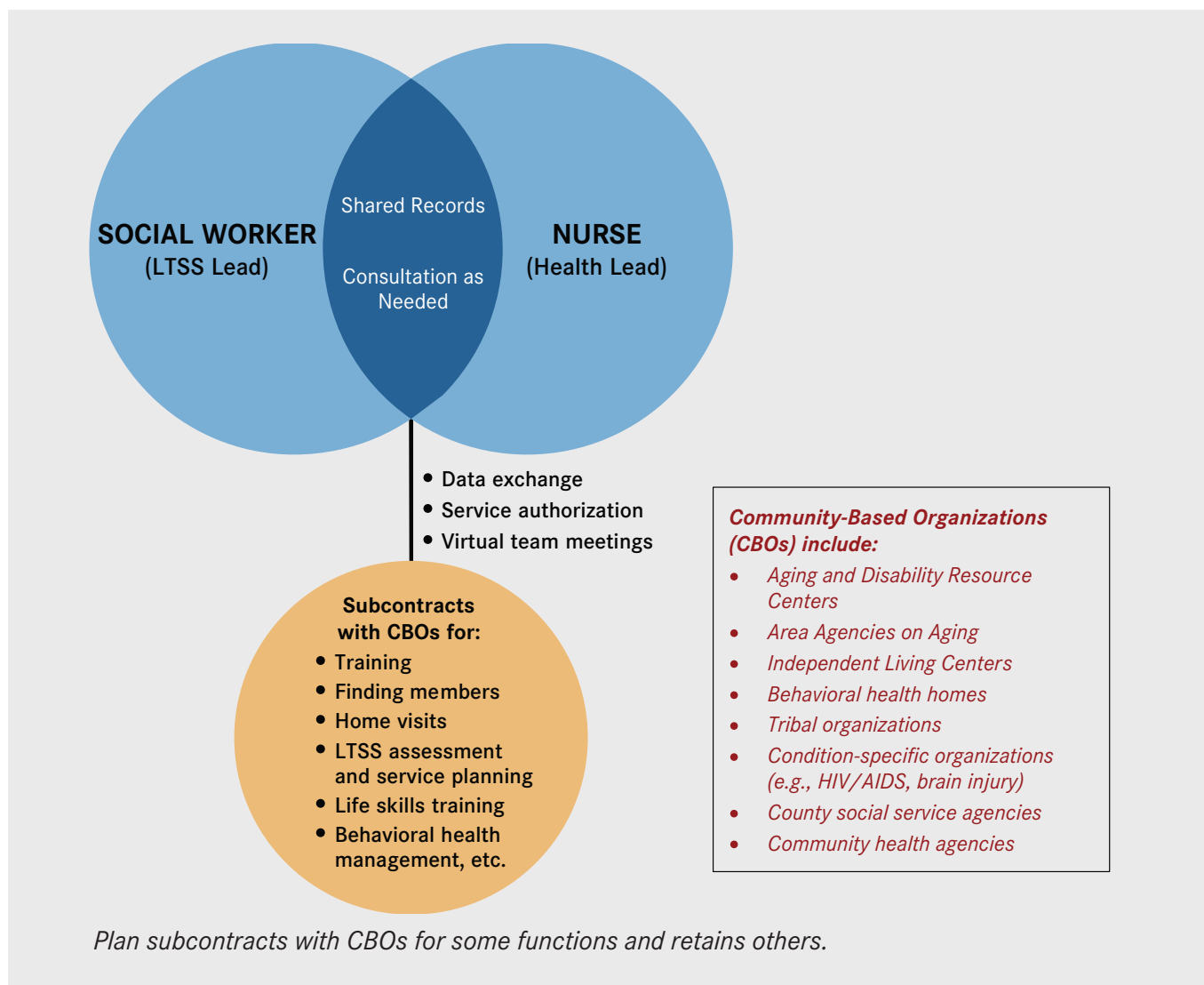
### SHARED FUNCTIONS MODEL

Figure 2 illustrates the Shared Functions model, in which the health plan executes subcontracts with CBOs for some care coordination functions, and retains other functions internally.

This model includes variation by function, type of CBO, populations shared, and payment method. CBO functions can include finding and making initial contact with members who are

difficult to locate, making home visits, conducting assessments, and preparing LTSS service plans. Some CBOs have subcontracts to do all of these functions, while others have subcontracts that include only one or two functions. CBOs engaged in this model include Aging and Disability Resource Centers, Area Agencies on Aging (AAAs), and Independent Living Centers with experience providing case management in traditional HCBS waiver programs. In more recently implemented programs, behavioral health homes are emerging as partners to health plans for members with serious mental illness. Other types of CBOs currently engaged in Shared Functions models include tribal organizations, condition-specific groups, county social services

FIGURE 2  
Shared Functions Model



*“The [MyCare Ohio] Plan is required to contract with AAAs to perform Waiver Service Coordination for, at a minimum, individuals age sixty (60) and older. The ICDS [Integrated Care Delivery System] Plan may perform Waiver Service Coordination as part of comprehensive Care Management and/or contract with entities that have experience working with people with disabilities, including, but not limited to, centers for independent living and disability-oriented case management agencies, etc.”*

–Ohio Contract

agencies, and community health agencies. Typically, a CBO is subcontracted for a specific subpopulation of members, such as those with LTSS needs, HIV/AIDS or other conditions requiring very specialized services, tribal members, and so on. Payment to the CBO is made either on a fee-for-service basis or as a subcapitated per-person-per-month amount for all functions contained in the subcontract.

Five states (California, Massachusetts, New Mexico, Ohio, Virginia) mandate a Shared Functions model for at least some aspect of care coordination, but the model is not limited to those states. Health plans in other states have used this approach as a strategy to build capacity quickly or build valuable community relationships.

In the Shared Functions model, staff at the CBO typically become members of an interdisciplinary team led by staff at the health plan. Communication, data exchange, and coordination of functions among team members are critical and can be challenging. CBOs usually have limited access to plans’ information systems, making full integration of the team difficult, at least

initially. Also, in situations where the CBO conducted the care coordinator function in the predecessor fee-for-service program, adjusting to a Shared Functions model takes time and a commitment to working out differences in business practices, infrastructure, and culture.

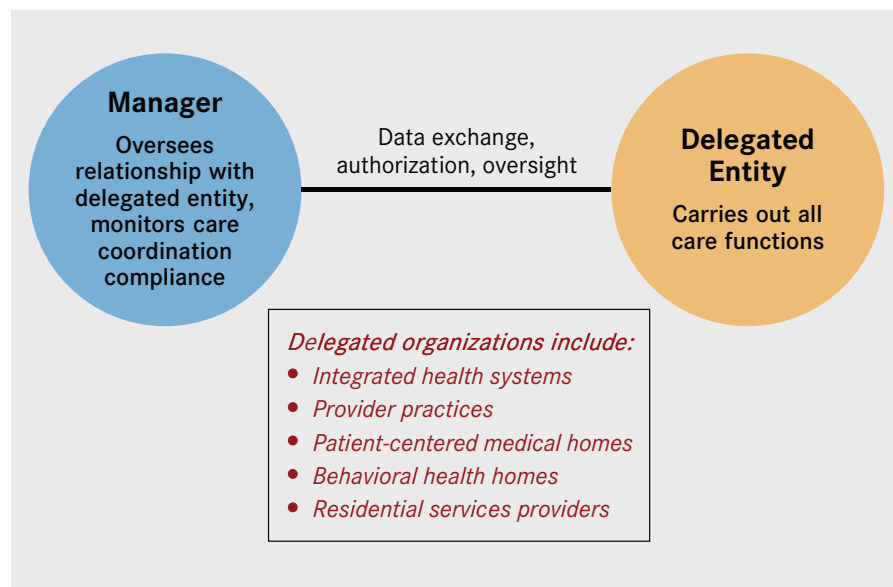
### DELEGATED MODEL

Figure 3 illustrates the Delegated model. Like the previous model, this one is implemented through a subcontract with a third party. However, in the Delegated model, the health plan delegates the entire care coordination function, retaining only a

monitoring and compliance function.

The delegated entity is usually a health organization, such as an integrated health system or a large physician practice. Typically, the delegation occurs specifically for members who are associated with the health system. Since this will not include all members, the health plan must also have its own capacity for care coordination, and in any case must have expertise sufficient to oversee the delegated entity’s care coordination practices and ensure that they comply with the state and federal

FIGURE 3  
Delegated Model



requirements. The Delegated model is not very common and generally is found in states with highly evolved managed care arrangements—such as California and Minnesota—and the payment is usually subcapitation. In the Minnesota market, a variation includes delegation to large residential services providers that have added primary care and care coordination capacity to an array of continuing care options that include independent apartments, assisted living, and nursing facilities.

More recently, with the advent of Medicaid Health Homes under the Affordable Care Act, a few MLTSS programs include delegation of care coordination to behavioral health homes for members with serious mental illness. These may be located at PCP offices or community mental health centers.

The perceived advantage of the delegated model is that a member may experience more seamless coordination, since the care coordinator is typically located with a key provider, such as the PCP mental health provider or assisted-living provider. The perceived disadvantage is that the care coordinator may become “captured” by the provider and find it difficult to advocate for the member when the member and provider disagree on a course of action.

This section has described three broad models of care coordination found in MLTSS programs in 18 states. The next section examines more specific characteristics of care coordination found in the contract specifications of those programs.

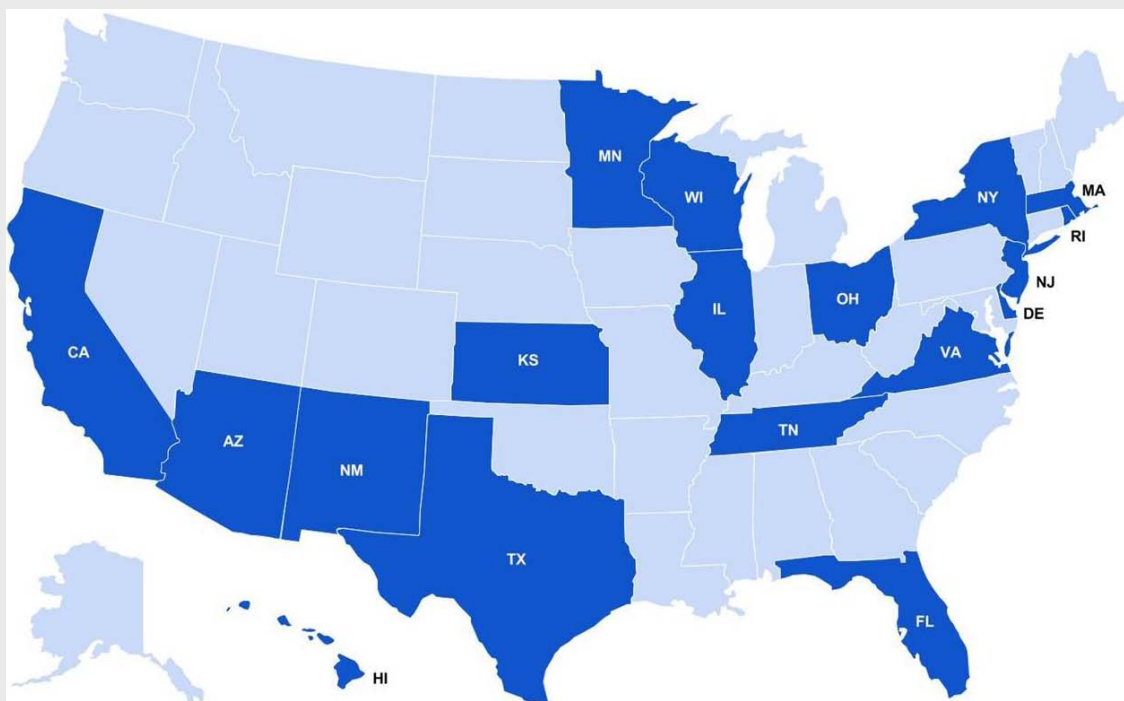
### 3. Characteristics of Care Coordination in MLTSS

The care coordination specifications of MLTSS contracts in 18 states were reviewed for content in seven topic areas (figure 4). We found a range of requirements in all areas. In part, this reflects the variation in populations served across programs, which includes the full range of people with nursing facility level-of-care needs to people with no current LTSS needs. It also reflects differences in contracting philosophy and practices across the states. This section provides highlights of the contract study findings. A compilation of findings across states is provided in appendix A, and detailed findings by state are available on the AARP website at <http://www.aarp.org/carecoordination>.

#### WHO GETS CARE COORDINATION AND WHAT CHOICES DO THEY HAVE?

A majority of contracts (13) require that all members receive, or at least be offered, care coordination. Some of these programs exclusively serve people whose needs are certified at the nursing facility level of care, a group for whom care coordination is required. Other programs serve a broader group based on Supplemental Security Income (SSI) and SSI-related eligibility criteria. Programs encompassing the broader range of needs typically stratify members into at least three risk groups (low, medium, and high) and specify additional requirements (such as contact requirements and caseloads) by risk group. For example, the contract may require that someone in the low-risk group be contacted by a care coordinator at least annually, while

FIGURE 4  
18 States with Managed LTSS Programs for Older People and Adults with Physical Disabilities in 2014



someone in the high-risk group be contacted at least monthly. Some contracts specify risk group assignment criteria, whereas others require contractors to develop their own risk stratification systems and submit them to the state for review.

Although contracts emphasize consumer choice and preferences in the service planning process, most (10) do not address whether members can opt out of care coordination altogether. Among those contracts that do address this issue, four explicitly allow members to opt out and two do not. States may have concerns that including such language would create a loophole that contractors could exploit to reduce the number of people receiving care coordination, though the reason for the absence of such language is unclear.

### **WHAT QUALIFICATIONS DO CARE COORDINATORS HAVE?**

About half the contracts (9) require at least nursing or bachelor's degrees for all care coordinators. Another six contracts allow experience to be substituted for degrees, and four contracts require degrees for some but not all care coordinators, depending on the role they play or the subpopulation they serve. Nursing and social work are the most common types of degrees cited. Others often mentioned are human services, sociology, psychology, and mental health services.

About half the contracts (10) specifically require experience in LTSS or disability. Eighteen contracts require care coordinators to be trained initially and at regular intervals. Common mandated training topics include: characteristics and needs of the populations served; behavioral health; Preadmission Screening and Resident Review (PASRR) requirements; person-centered planning; consumer-directed services; and respect for cultural, spiritual, and ethnic beliefs of others.

### **WHAT TYPE OF CONTACT MUST CARE COORDINATORS HAVE WITH MEMBERS?**

Virtually all contracts (18) set standards for when initial contact with new members must be made, ranging from 3 days to 90 days from the date of enrollment. Several contracts allow the

initial contact to be made by phone, for purposes of setting up an in-person visit for the initial assessment to be conducted. Several contracts vary the initial contact standard by risk group, allowing more time to contact members at lower risk.<sup>4</sup> Some contracts allow more time in the first year of the contract, acknowledging the challenge of contacting an entire membership in the opening weeks of a new program.

An initial needs assessment is also required in 18 contracts. Some programs enrolling people with a broader range of needs (from low to high risk) require an initial health risk assessment, which may be conducted by phone or through data analysis, followed by an in-person comprehensive assessment for all members found to be at the higher risk levels. Typically, anyone certified at the nursing facility level of care is considered to be in the high-risk category and receives a comprehensive, in-person assessment. All contracts require reassessments. Ten require them at least annually, and nine require them quarterly or semiannually. All contracts specify that more frequent reassessment be made as the needs of the member change.

Most contracts (17) specify minimum levels of in-person contact that must be made and vary the standard by risk group. Thirteen contracts specify quarterly in-person contact for some or all members, with other contracts requiring semiannual or annual contact.

### **WHAT IS THE CARE COORDINATOR'S ROLE WHEN MEMBERS PARTICIPATE IN NURSING HOME TRANSITION PROGRAMS OR SELF-DIRECT THEIR LTSS?**

Most MLTSS states also have Money Follows the Person, or similar programs, to help people transition out of nursing facilities into community settings. Most contracts (16) require the contractor to interface with or help administer these programs. Care coordinators are expected to participate in transition planning and continue to coordinate overall care while a member is in the transition process. The care coordinator refers members to specialty transition support providers and incorporates

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4 For a more detailed discussion of Ohio's risk-stratification approach, see: Ensslin, B. and S. Barth. November 2014. "Risk Stratification to Inform Care Management for Medicare-Medicaid Enrollees: State Strategies." Center for Health Care Strategies, Technical Assistance Brief.

them into the service plan. A few contracts require the contractor to have a specialist in community reintegration available to all care coordinators as a resource.

Similarly, the care coordinator is required to continue overseeing the service plan when members self-direct their personal assistance services. Fourteen contracts specify an ongoing role for the care coordinator that includes monitoring the services, interfacing with the fiscal/employer agent (F/EA) as needed, and periodically assessing whether the member wishes to continue self-directing his or her services.

### WHAT CASELOADS DO THEY HAVE?

Eight contracts specify caseload ratios, four do not specify them but require contractors to submit their proposed caseload ratios for approval, and seven do not address caseload. Contracts that include caseload ratios vary them by risk group, and several provide caseload weighting formulas that must be applied when care coordinators have mixed caseloads. Maximum caseload ratios for the high-risk groups range from 30 to 60, and for lower risk groups, from 75 to 600.

### WHAT TOOLS DO THEY USE?

Most contracts (17) require information systems that can draw from multiple sources for member-level information, including claims, assessments, and service plans. A few specifically require a centralized member record that can be accessed at any time by plan staff.

*“The Contractor’s system shall be able to electronically track, store, and share timely end-to-end data necessary to complete MLTSS Care Management processes for Members receiving long-term services and supports, including but not limited to, system alerts for changes related to MLTSS status, clinical and financial eligibility status, Plan of Care, service utilization, and other pertinent data needed by the Care Manager.”*

—New Jersey Contract

*“The Contractor shall ensure adequate staffing to meet case management requirements. The Contractor’s case management plan shall also describe their methodology for assigning and monitoring case management caseloads. Each case manager’s caseload may not exceed a weighted value of 96. . . . The following formula represents the standard maximum allowable per case manager.*

- *For institutionalized members, a weighted value of 0.8 is assigned. Case managers may have up to 120 institutionalized members ( $120 \times 0.8=96$ )*
- *For HCBS (own home), a weighted value of 2.0 is assigned. Case managers may have up to 48 HCBS members ( $48 \times 2.0=96$ )*
- *For Assisted Living Facility (ALF) members, a weighted value of 1.6 is assigned. Case managers may have up to 60 ALF members ( $60 \times 1.6=96$ ).*
- *For Acute Care Only members, a weighted value of 1.0 is assigned. Case managers may have up to 96 Acute Care Only members ( $96 \times 1.0=96$ ).*
- *If a mixed caseload is assigned, there can be no more than a weighted value of 96.”*

—Arizona Contract



### **HOW IS CARE COORDINATION MONITORED, ASSESSED, AND IMPROVED?**

Care coordination is specifically mentioned as an area for state monitoring in 18 contracts. In most cases, this includes care coordination reports or measures that contractors must submit at least annually. Most contracts also specify care coordination as an area in which the state, the U.S. Centers for Medicare & Medicaid Services (CMS), the External Quality Review Organization, or other state agent may audit through desk audits, on-site audits, or both.

Fifteen contracts specify that the contractor must evaluate its care coordination function in an ongoing manner and report its findings to the state at least annually. Typically, the contractor must report what it found and what changes it has made to improve any shortcomings.

### **HOW ARE FAMILY CAREGIVERS INCORPORATED INTO THE PROCESS?**

The importance of family caregivers is often acknowledged in contracts, though most provide little specificity about their role in the care coordination process. Fifteen contracts mention family caregivers in the context of needs assessment, usually as a source of information that should be sought out by the care coordinator with consent of the member, and sometimes as someone whose training needs should be assessed by the care coordinator. In three contracts, family caregiver training is a covered benefit and is to be included in the service plan when needed. Nine contracts include provisions for providing care coordinator contact information to family

*“The CONTRACTOR shall submit a quarterly Care Coordination Report to assess the CONTRACTOR’s performance and timeliness associated with the care coordination process. The report shall present data separately for Members new to the care coordination process and those Members who are receiving ongoing care coordination. The report shall include, at a minimum, information regarding: (i) number of HRAs [health risk assessments] completed; (ii) number of HRAs completed within contract timeframes; (iii) compliance with timeframes associated with assignment of initial risk level; (iv) compliance rates regarding completion of comprehensive needs assessments; (v) compliance with face to face and telephonic visit standards; and (vi) number of Members assigned to each care coordination level.”*

–New Mexico Contract

caregivers, when the member consents or when the family caregiver is the legal representative.

One state (Tennessee) recently added language about caregivers that is the most explicit to date. At initial enrollment of a member and at least annually thereafter, the contract requires that the caregiver’s role in the life of the member be determined, the caregiver’s health and well-being be assessed, and training and other needs be identified.

*“At a minimum, for members in CHOICES Groups 2 and 3, the caregiver assessment shall include: (1) an overall assessment of the family member(s) and/or caregiver(s) providing services to the member to determine the willingness and ability of the family member(s) or caregiver(s) to contribute effectively to the needs of the member, including employment status and schedule, and other care-giving responsibilities; (2) an assessment of the caregiver’s own health and well-being, including medical, behavioral, or physical limitations as it relates to the caregiver’s ability to support the member; (3) an assessment of the caregiver’s level of stress related to care-giving responsibilities and any feelings of being overwhelmed; (4) identification of the caregiver’s needs for training in knowledge and skills in assisting the person needing care; and (5) identification of any service and support needs to be better prepared for their care-giving role.”*

–Tennessee Contract

## 4. Case Studies

The prior section presented findings of a review of MLTSS contracts in 18 states. This section takes a deeper look at two of those states, Illinois and Ohio. Ohio mandated that its MLTSS contractors share certain care coordination functions with Area Agencies on Aging, whereas Illinois did not require, but allowed, its contractors to enter into partnerships.

### CASE STUDY 1: ILLINOIS

#### **The Community Care Alliance of Illinois (CCAI)**

The Community Care Alliance of Illinois (CCAI) was formed in 2012 in response to the Illinois Medicaid Program's plan to enroll 50 percent of Medicaid beneficiaries into risk-based care coordination programs by 2015. Family Health Network (FHN), which has been offering managed health care services to children and parents in the Illinois Medicaid program since 1995, established CCAI as a wholly owned subsidiary. A group of safety net hospitals in the greater Chicago area created FHN. Both FHN and CCAI are not-for-profit organizations, recognized by Illinois Medicaid as Managed Care Community Networks (MCCNs). Illinois providers must own, operate, or govern MCCNs. They are intended to be local, provider-based alternatives to health maintenance organizations (HMOs) but perform essentially the same managed care functions for the Medicaid program as HMOs and operate at full financial risk.

CCAI shares network development, contracting, finance, communications, member services, information systems, and data analysis capacity with FHN but otherwise operates as a free-standing entity with its own board of directors and model of care. CCAI is focused exclusively on serving people with disabilities and older people,

as reflected in its mission: *The Community Care Alliance of Illinois is a health plan dedicated to consumer-directed, community-based innovative health services specializing in the care of seniors and people with disabilities.*

CCAI went live in April 2013 in the Rockford region (about 90 miles northwest of Chicago) with its Medicaid Integrated Care Program (ICP) plan. It expanded to Chicago in March 2014, and to the rest of Cook County and surrounding counties (known as the "Collar Counties") in May 2014. As of June 2014, CCAI had just over 8,700 ICP members in nine counties.

Effective January 1, 2014, CCAI also began operating two Medicare Advantage plans, one open to all Medicare beneficiaries and one open to dually eligible Medicare-Medicaid beneficiaries. Combined enrollment in the two plans was just over 700 as of August 2014. CCAI had applied to become a contractor in Illinois's Medicare-Medicaid Alignment initiative but was not selected.

#### **The Illinois Integrated Care Program (ICP)**

The ICP began in 2011 with two plans (Aetna and Illinicare, a local division of Centene) in suburban Cook and the Collar Counties. Goals were to improve the quality of care and services and save the State money.<sup>5</sup> The target population was adults with disabilities (19 years and over) and older adults (60 years and over). Dually eligible Medicare-Medicaid beneficiaries were excluded, in anticipation of the State's separate Financial Alignment Initiative.<sup>6</sup>

The program's services were offered in phases, with the initial package excluding LTSS. Service Package I included primary, acute, behavioral, pharmacy, and other medical services. From

5 Heller, T. et al. May 2014. *An Independent Evaluation of the Integrated Care Program: Findings from the Baseline through Year Two (FY13)*. Institute on Disability and Human Development, University of Illinois at Chicago. Accessed August 8, 2014, at <https://www2.illinois.gov/hfs/SiteCollectionDocuments/ICPFinalReportFY13.pdf>.

6 The ICP and Financial Alignment Initiative are both part of a larger effort in Illinois to enroll beneficiaries from all population groups into some form of coordinated care. For more information, see: <http://www2.illinois.gov/hfs/publicinvolvement/cc/Pages/default.aspx>. Accessed August 8, 2014.

February through August 2013, Service Package II was phased into the program. Service Package II includes all institutional and community-based LTSS except HCBS waiver services for people with developmental disabilities. It includes five existing HCBS waiver programs operated through three State agencies (table 1). Service Package III, which will add HCBS waiver and other services for people with developmental disabilities, has not been offered to date.

**TABLE 1**  
**HCBS Waiver Programs Included in the ICP as of February 2013**

Program	Operating State Agency
Persons who are Elderly HCBS Waiver	Department on Aging
Persons with a Brain Injury HCBS Waiver	Department of Human Services, Division of Rehabilitation Services
Persons with Disabilities HCBS Waiver	Department of Human Services, Division of Rehabilitation Services
Persons with HIV/AIDS HCBS Waiver	Department of Human Services, Division of Rehabilitation Services
Supportive Living Program HCBS Waiver	Department of Healthcare and Family Services

Source: Compiled by Truven Health Analytics.

As the State added Service Package II to the program, it also expanded the number of contractors and mandatory enrollment regions. It was during this period that CCAI became a contractor, intending to begin in its home base of Chicago, where it already had an extensive provider network. However, after initially planning to begin the rollout of Service Package II in Chicago, the State decided instead to start in the Rockford region, so CCAI developed a network, hired care coordinators, and enrolled its first ICP member in Rockford in 2013. In 2014, CCAI expanded to suburban Cook County, the

Collar Counties, and Chicago as the State rolled out Service Package II in those areas.

As of June 2014, ICP had a total of 14 contractors with a combined enrollment of just under 100,000.<sup>7</sup> CCAI is one of three plans competing for members in the Rockford region, one of six in suburban Cook County and the Collar Counties, and one of nine in Chicago. CCAI does not participate in the remaining ICP regions to the west and south of Chicago (Central, Metro East, and Quad Cities). Total enrollment for each plan is shown in table 2. Two national HMOs, Aetna and IlliniCare (the local Centene plan), were the first to offer ICP plans in 2011 and are significantly larger than plans that were added subsequently, with nearly 30,000 members each. CCAI and Meridian Health Plan are nearly tied for third-largest enrollment, at about 8,700 each, leading a middle tier of five plans with enrollment between 3,000 and 9,000. The remaining seven plans have fewer than 2,000 members each.

**TABLE 2**  
**Illinois ICP Enrollment as of June 2014**

Plan	Enrollment
Aetna Better Health Inc.	29,578
IlliniCare Health Plan Inc. (Centene)	29,803
Meridian Health Plan Inc.	8,732
Community Care Alliance of Illinois	8,704
Health Alliance Connect	5,299
Molina Healthcare of ILL	5,225
Blue Cross/Blue Shield of Illinois	3,328
EntireCare	1,797
Together4Health	1,754
Be Well	1,673
My Health Care Coordination	1,294
Cigna HealthSpring of Illinois	1,116
Precedence	902
Humana Health Plan	641
<b>TOTAL</b>	<b>99,846</b>

Source: Illinois Department of Healthcare and Family Services Managed Care Enrollment.

7 Illinois Department of Healthcare and Family Services Managed Care Enrollment. Accessed July 26, 2014, at <http://www2.illinois.gov/hfs/PublicInvolvement/cc/Pages/default.aspx>.

## Shifting Roles for the Original HCBS Care Coordination Agencies

As shown earlier in table 1, five HCBS waiver programs have been folded into the ICP. Care coordination in the fee-for-service versions of those programs varies by waiver, and the role played by the traditional agencies in the ICP varies by plan. The State has clearly made the ICP plans responsible for care coordination of their members and has given the plans discretion as to whether they partner with the historic waiver providers.

### *HCBS Waiver for Older Persons*

Before the implementation of the ICP, the Department on Aging designated Care Coordination Units (CCUs) to act as central access points for aging services, provide care coordination, and monitor services provided through the Persons who are Elderly HCBS Waiver. One CCU per geographic area was chosen through a competitive procurement process to serve as the central access point for older adults who need LTSS. CCUs perform determination of need assessments to qualify applicants for waiver or other programs, and provide care coordination, which includes developing service plans, arranging for services to be delivered, and monitoring delivery. Many CCUs are also designated as Adult Protective Services providers, a role that was recently expanded to include both older adults and younger adults 18–59 years of age. In addition to providing care coordination services for Medicaid-eligible HCBS waiver recipients, CCUs also provide comparable services to people enrolled in Illinois' Community Care Program (CCP), which provides HCBS services to people not financially eligible for Medicaid. CCP services are still means-tested, but higher asset limits apply, and participants with higher incomes are required to share in the cost of services. The state-funded CCP is equal in size to the Medicaid-funded HCBS counterpart. CCUs will continue to provide care coordination services to people enrolled in the non-Medicaid program.

CCUs are typically senior centers and other social services agencies, such as Aging Care Connections, Catholic Charities, Lutheran Services, and the Visiting Nurses Association. Area Agencies on Aging do not perform care

coordination. They distribute Older Americans Act (OAA) funds to CCUs and engage in planning activities under the OAA.

In regions where enrollment in the ICP is now mandatory, CCUs continue to act as a central access point for older adults seeking services, perform determination of need assessments, coordinate OAA services, and operate Adult Protective Services. They also continue to provide care coordination services for people who are not participating in ICP or the Financial Alignment Initiative.

For ICP enrollees, the CCUs' traditional care coordination role is neither protected nor prohibited by state policy, but the ICP contractors have become responsible for the function. ICP contractors are free to enter into subcontracts with CCUs or not, and a wide variety of business relationships are emerging in the ICP regions. The two largest plans have chosen to retain the full care coordination function internally. At least three plans in the middle tier of enrollment (Meridian, CCAI, and Molina) have entered into contracts with CCUs to supplement the care coordination performed by the plans. Services being purchased by the plans include outreach to new enrollees who are difficult to find (e.g., listed address and phone number are no longer current); conducting the in-person contacts mandated by their state contract; conducting comprehensive assessments and service plans; and providing transition services for people discharged from hospitals. One plan (Blue Cross/Blue Shield of Illinois) is subcontracting with CCUs for comprehensive care coordination services, including medical coordination as needed—an arrangement that expands the CCU's traditional function beyond LTSS into medical management.

To streamline contracting between ICP contractors and CCUs, a group of CCUs has reactivated a separate statewide nonprofit organization, the Coordinated Care Alliance (CCA).<sup>8</sup> CCA negotiates master contracts for its members, manages referrals and billing, and facilitates consistent practice across its members. Members pay an administrative fee to support CCA's functions. An ICP contractor needs to negotiate only one

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8 CCA was founded in the 1980s in response to an early wave of managed care in Illinois, but its initial efforts to partner with managed care organizations did not materialize.

agreement with CCA that covers all of the CCUs in the ICP contractor's service area.

It is too early to know whether the CCA or individual CCUs will navigate the transition successfully. The experience promises to offer valuable lessons for other states that intend to let the market determine how traditional care coordination entities are involved in MLTSS programs.

#### ***Persons with a Brain Injury HCBS Waiver and Persons with Disabilities HCBS Waiver***

In the fee-for-service version of these programs, the Department of Human Services, Division of Rehabilitation Services (DHS-DRS), provides care coordination directly through state workers in regional offices. The care coordination function for waiver participants who enroll in ICP is transferred from the State to the ICP contractors. DHS-DRS retains the determination of need process.

The DHS-DRS waivers include an option for participant-directed personal assistant services, and this option extends to the ICP program. In both the traditional and ICP versions of this waiver, DHS-DRS retains the role of coemployer with self-directing participants, performing payroll and related functions. When an ICP member self-directs services, the ICP contractor pays DHS-DRS for personal assistant services delivered, and DHS-DRS pays the assistants.

#### ***Persons with HIV/AIDS HCBS Waiver***

DHS-DRS contracts with the AIDS Foundation to manage the HIV/AIDS Waiver program in Chicago, where most HIV/AIDS Waiver participants live. The AIDS Foundation also receives federal Ryan White funding through the Illinois Department of Public Health, and 12 other funding streams from federal, state, and local sources. The AIDS Foundation has braided these funding streams to contract with 60 agencies for about 150 care coordinators in the Chicago area. About 60 of the care coordinators serve waiver participants. The AIDS Foundation performs determination of need assessments, trains and certifies care coordinators, and ensures that contracted agencies meet waiver standards.

In ICP regions, the ICP contractors become responsible for care coordination of waiver participants. ICP care coordinators are required to have a minimum of 20 hours of training in waiver programs, including the HIV/AIDS program. The AIDS Foundation retains the determination of need assessment process. No other care coordination role is prescribed for the AIDS Foundation or its network of care coordination agencies.

As of May 2014, when ICP was beginning to roll out in Chicago, although the AIDS Foundation had been approached by some ICP contractors to conduct training, it had not been able to negotiate subcontracts for care coordination.

#### ***Supportive Living Program HCBS Waiver***

The Department of Healthcare and Family Services operates this waiver, which serves adults with disabilities and older adults. Determination of need assessments are conducted by CCUs for older adults, and by DHS-DRS for adults with disabilities. Care coordination is less intensive in this program and is provided as needed by the supportive living facility where the participant resides. The facility receives a flat monthly rate for the package of services provided under this waiver, which includes any needed coordination.

For ICP members, the ICP contractor becomes responsible for care coordination. ICP contractors may delegate parts of the responsibility to the facilities. For example, CCAI conducts an initial face-to-face health risk assessment with new members and annual reassessments, and coordinates with the facility, which conducts quarterly assessments and handles day-to-day coordination needs of residents.

CCUs and DHS-DRS continue to conduct determination of need assessments for ICP members in this waiver.

#### ***CCAI's Care Coordination Model***

The ICP contract between the State and plans has several pages of specifications related to how care coordination must be performed, but at the same time, it gives plans discretion to develop unique care coordination models.<sup>9</sup> CCAI has some of its

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<sup>9</sup> See pages 45–52 of the contract, *Furnishing Health Services in an Integrated Care Program by a Managed Care Organization (2010-24-005-KA4)*, accessed July 26, 2014, at [http://www2.illinois.gov/hfs/sitecollectiondocuments/icp\\_aetna\\_022013.pdf](http://www2.illinois.gov/hfs/sitecollectiondocuments/icp_aetna_022013.pdf).

care coordinators located at a central office. It also has decentralized care coordinators housed in Anchor Homes, which are fully accessible provider locations throughout their service areas, typically medical centers or federally qualified health centers. As of July 2014, CCAI had six Anchor Homes in the greater Chicago region and two in the Rockford region. Each Anchor Home offers a primary care practitioner, which may be a doctor or nurse practitioner; a nurse care coordinator; and an LTSS coordinator with at least a bachelor's degree in social work, counseling, or human services. Together, the group constitutes the Primary Care Team. Table 3 describes CCAI's approach to meeting several ICP contract requirements.

### **ICP Impacts on Care Coordination in Illinois**

The implementation of the ICP has had a major impact on how care coordination is provided to people with LTSS needs in the community. Before ICP was implemented, CCUs—nonprofit social service agencies funded by the Illinois Department on Aging—provided LTSS care coordination services for older adults. Either state agencies or other local nonprofit organizations provided care coordination for younger populations.

The State has remained neutral as to whether its ICP contractors choose to structure care coordination as an internal function within the managed care entity or as a subcontracted function purchased from community organizations. Most ICP contractors have done both, creating internal capacity and subcontracting with traditional care coordination entities for selected aspects of the care coordination function, such as locating members who are difficult to find, conducting in-home visits, and developing service plans. The two largest contractors have chosen to perform the entire function internally. One contractor has chosen to subcontract for the entire service coordination function for most members.

CCAI is a midtier nonprofit start-up contractor serving Rockford, Chicago, suburban Cook County, and the Collar Counties. It developed its own unique internal model of care coordination

based in Anchor Homes, supplemented by subcontracts with traditional care coordination entities. Each of CCAI's Anchor Homes includes a team comprising a nurse practitioner, nurse, and social services professional who coordinate care for CCAI members assigned to that Anchor Home. This model allows the team to address both the medical and social needs of CCAI members in a collaborative framework. Contacts with members, either by phone or in person, are conducted by whichever team member is most appropriate to the member's health care status and social service needs, or by a community agency subcontracted to perform certain activities collaboratively with the CCAI team. Team members with whom we met were relatively positive about the team-based model, while acknowledging that roles and responsibilities within the team, and team communications, continue to evolve.

We conducted this case study about a year after the initial inclusion of LTSS into ICP, and just as the Financial Alignment Initiative began to roll out. CCUs had recently activated the CCA to provide greater administrative efficiency in the negotiation of contracts and present a united front in that process. Individual CCUs were undergoing changes in their business strategies and exploring new ways to meet the needs of the marketplace in a managed care environment.

Regardless of the payment and delivery model adopted by the state of Illinois, the overall demand for services to support people with LTSS needs in community-based settings will continue to grow. What the ultimate impact on care coordination will be remains to be seen. However, the State has contracted with the University of Illinois Chicago to evaluate the ICP.<sup>10</sup> At the consumer level, the question is whether care will become more integrated, improving both experience and outcomes. At the community organization level, the question is whether traditional community organizations will successfully adapt to new roles, and whether managed care organizations and community organizations can forge successful collaborative partnerships.

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10 For evaluation results reported to date, see: Heller, T. et al., op. cit.

**TABLE 3**  
**CCAI's Approach to Care Coordination in the ICP**

	Summary of Contract Requirement	Summary of CCAI's Approach
<b>Who gets care coordination?</b>	Plans are required to offer care coordination to: 1) all members receiving HCBS waiver services; 2) any member who needs it, based on the plan's risk stratification system; and 3) any member who requests it.	New members who are participating in any of the five HCBS waivers are assigned care coordinators. In addition, attempts are made to reach all new members to assess needs and offer care coordinators.
<b>On what basis are care coordinators assigned to individual members?</b>	The contract specifies that plans must assign a care coordinator "who has the experience most appropriate to support the Enrollee."	<p>CCAI assigns care coordinators based on several member criteria, including:</p> <ul style="list-style-type: none"> <li>• affiliation with Anchor Health Home,</li> <li>• waiver program participation,</li> <li>• hospitalization,</li> <li>• emergency department use,</li> <li>• other high-need indicators.</li> </ul> <p>When people choose CCAI, the State's enrollment broker helps them make a PCP selection within CCAI's network, or assigns them to one if no selection is made. First, if the assigned PCP is associated with an Anchor Home, the member is assigned to that Anchor Home. The Primary Care Team at the assigned Anchor Home assigns a registered nurse (RN) coordinator if the member's needs are primarily medical, and an LTSS coordinator if they are primarily LTSS-related. The LTSS coordinator and RN coordinator consult with each other and with the PCP as needed. Additional specialized resources may be offered as dictated by member needs. For example, members with significant psychiatric disabilities may be referred to a CCAI vendor that has specialized expertise in supporting individuals with serious mental illness.</p>
<b>What qualifications must care coordinators have?</b>	Acceptable qualifications include professional licensure as an RN, licensed practical nurse (LPN), social worker, or counselor, or a bachelor's degree in related fields. Qualifications vary by waiver population served. Some waivers allow experience or certification in lieu of degrees or licenses.	CCAI's nurse care coordinators are all RNs. LTSS coordinators must have a minimum of a bachelor's degree in social work, counseling, or human services, and most have master's degrees. CCAI seeks staff with experience in case management or care coordination at community agencies or managed care organizations.
<b>What training is required for care coordinators?</b>	A minimum of 20 hours of in-service training is required initially and annually. Topics must be specific to the HCBS waiver population served.	CCAI provides 4 weeks of training to all new care coordinators, which includes classroom instruction and assignment to a mentor who is already working in the field. Every care coordinator also receives at least 20 hours of training per year once employed.
<b>Is proficiency in languages required?</b>	Proficiency in a second language is not required, but the contractor must provide oral interpretation free of charge to members who need it.	CCAI has Spanish- and Polish-speaking care coordinators. There is also a demand for Hindi, which CCAI hopes to meet directly in the future. When a care coordinator does not know a member's language, he or she can use an interpretation service.
<b>How much contact is required?</b>	In-person contact is required for most HCBS waiver populations, and the standard varies by population, ranging from 1 in-person contact per month for members receiving HIV/AIDS Waiver services to 1 in-person contact every 90 days for members receiving Elderly or Persons with Disabilities Waiver services.	CCAI has adopted the ICP minimum requirements as their minimum requirements, which are in-person contact every 90 days for Elderly and Disabled Waivers, monthly face-to-face for HIV/AIDS Waiver, monthly contact for Brain Injury Waiver, and annual contact for the Supportive Living Waiver. (The Brain Injury and Supportive Living Waivers do not require that the contact be face-to-face.)

TABLE 3 CONTINUED

	Summary of Contract Requirement	Summary of CCAI's Approach
<b>How are initial and subsequent service plans implemented?</b>	The existing waiver service plans of new members must be honored for at least 90 days, after which the contractor may develop a new service plan based on its assessment of need. Needs must be reassessed at least annually, or more often based on member needs.	CCAI accesses the existing service plans online from a state system. CCAI may increase services, but may not decrease them for 90 days. Its internal policy is to allow existing service plans to remain for 6 months. Within the first 90 days, it completes an assessment to determine if any changes should be considered.
<b>What must contractors do in regard to family caregivers?</b>	Plans must provide family caregivers an opportunity to provide input into the service plan and must consider caregiver qualifications when assessing the risks associated with the service plan.	With the consent of members, care coordinators try to engage family members as much as possible, in order to determine what level of caregiving is being provided, whether that can continue, and whether respite or training are needed. The level of involvement by caregivers varies considerably, depending largely on the wishes of the member.
<b>What information tools must contractors have?</b>	Plans are required to have information systems in place that integrate clinical information, assessments, and care plan.	CCAI care coordinators have access to the emergency medical record at the Anchor Home, and maintain assessments and care plans in a system provided by CCAI's parent company. Care coordinators must consult these information sources separately and integrate information manually.
<b>Are caseload ratios mandated?</b>	<p>The maximum caseload is specified by risk level as follows:</p> <ul style="list-style-type: none"> <li>Participants of Brain Injury Waiver or HIV/AIDS Waiver: 30</li> <li>High-risk members: 75</li> <li>Moderate-risk members: 150</li> <li>Low-risk members: 600</li> </ul> <p>Plans must use specified weighting for care coordinators with mixed caseloads.</p>	CCAI care coordinators have mixed caseloads that average about 100 active members each. Total caseload, with inactive members, averages about 130. An inactive member may be one who has opted out of care coordination, or who cannot be reached.
<b>Where are care coordinators located?</b>	Location of care coordinators is not specified in the contract, but contact requirements include in-person visits.	The majority of care coordinators are assigned to work at specific Anchor Homes, with the rest assigned to the plan's central location or from their homes.
<b>Who employs the care coordinators?</b>	The contract does not specify that the plan must employ care coordinators. The plans may contract for them or employ them.	Nurse care coordinators and LTSS coordinators are employed by CCAI and accountable to CCAI managers. Anchor Homes employ the PCPs.
<b>What relationship does the plan have with traditional care coordination agencies?</b>	The traditional agencies continue to conduct the determination of need assessments, and DHS-DRS continues to act as coemployer for members who choose self-direction, so at a minimum, plans need to refer members for determination of need and establish a vendor relationship with DHS-DRS for self-directing members. No other relationship is specified in the contract.	<p>CCAI is working with the Coordinated Care Alliance (CCA) to purchase the following services from Care Coordination Units (CCUs): finding new enrollees who are difficult to find, conducting face-to-face contacts as required by the various waiver programs, and monitoring and assisting with service plan implementation.</p> <p>For self-directing members, CCAI pays DHS-DRS as the fiscal employer agent, and DHS-DRS pays the personal assistants.</p> <p>CCAI has had discussions with the AIDS Foundation about having the AIDS Foundation conduct the minimum contacts for members in the HIV/AIDS Waiver.</p>



## CASE STUDY 2: OHIO

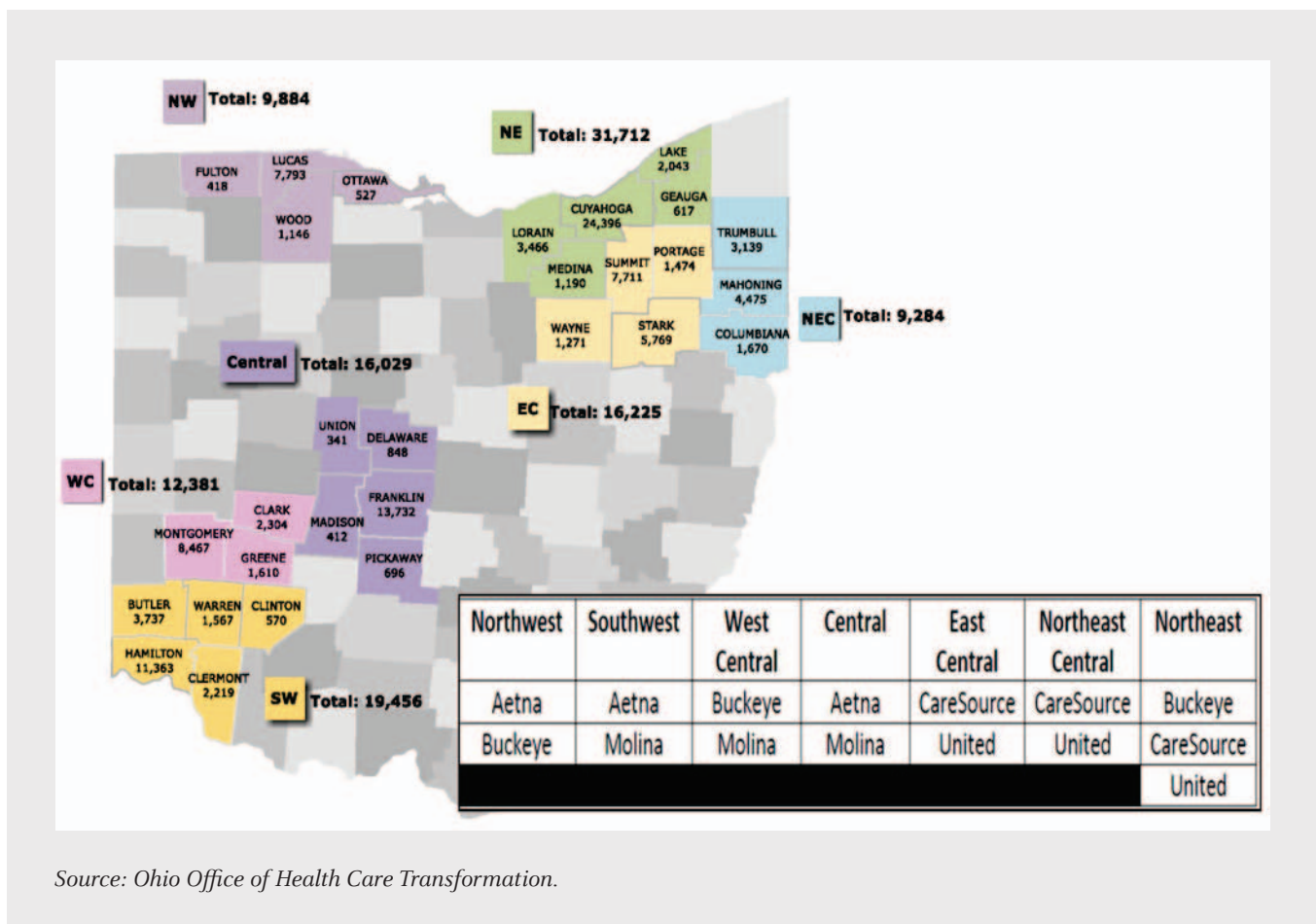
### The MyCare Ohio Program

*MyCare Ohio* is the state’s demonstration program under the Financial Alignment Initiative sponsored by the Medicare-Medicaid Coordination Office at CMS. *MyCare Ohio* uses a fully capitated model for “full benefit” Medicare-Medicaid Enrollees (MMEs) who are 18 years of age or older. Health plans participating in the *MyCare Ohio* Program receive Medicare and Medicaid capitation payments to provide comprehensive Medicare and Medicaid benefits to all MMEs who choose to receive dual coverage through the demonstration program. The purpose of *MyCare Ohio* is to demonstrate the impact of fully integrated care coordination models on improving quality and reducing costs for those who are dually eligible for Medicare and Medicaid.

In 2012, the State and CMS jointly selected five health plans to participate in the demonstration program through a competitive procurement process. The State decided to implement the demonstration in seven distinct regions of the State comprising most of Ohio’s metropolitan areas (figure 5). In each of the seven regions, two health plans compete for enrollment, with the exception of the Cleveland metropolitan area, where three health plans are participating in the demonstration program.

Beginning on May 1, 2014, MMEs residing in the seven demonstration regions were required to enroll in *MyCare Ohio* for their Medicaid benefits, and they could choose to enroll (opt in) for Medicare. People who did not actively enroll in a plan were automatically assigned to one of the plans in their region for Medicaid benefits. Automatic assignment to plans was about evenly divided across competing plans. Once assigned to

FIGURE 5  
Regions and Participating Plans: *MyCare Ohio* Program



a plan, MMEs who are enrolled for both Medicaid and Medicare are allowed to switch plans on a monthly basis. Those who opted out for their Medicare benefits were allowed to switch plans during the first 90 days of enrollment, and annually during an open enrollment period.

At the time of our site visit in November 2014, over 100,000 people had been enrolled in the *MyCare Ohio* demonstration for at least their Medicaid benefits, and members had received letters from the State communicating information about the upcoming Medicare passive enrollment process (table 4).

### Changing Role of the Area Agencies on Aging

Ohio’s original HCBS waiver program for people 60 and older is known as PASSPORT. Under the PASSPORT program, the AAAs have traditionally provided case management services to HCBS waiver participants, developed and managed the PASSPORT provider network, processed claims from PASSPORT providers, and provided quality oversight for the program.<sup>11</sup> Before *MyCare*, the PASSPORT program provided HCBS to over 33,000 participants, mostly MMEs, and had an annual budget exceeding \$500 million. AAAs play a

role in administering the State’s much smaller Assisted Living Waiver program. Some AAAs also administer county-based services for older people that are supported by local tax revenues (referred to as levy programs). Some AAAs have partnered with local hospitals and other providers to implement transition programs from hospitals to home-based services. The AAAs also serve as the “front door” to the LTSS system in Ohio through Aging and Disability Resource Centers (ADRCs) and conduct level of care assessments to determine if applicants qualify for nursing facility and HCBS alternatives. Finally, the AAAs carry out many additional functions under the federal OAA. Thus, Ohio’s AAAs have historically had a major role in the management and delivery of alternative HCBS to people over the age of 60 in Ohio.

The target population for *MyCare* includes MMEs currently served in the State’s HCBS waiver programs, including PASSPORT and the Assisted Living Waiver. *MyCare* includes a new HCBS waiver program that combines the features of PASSPORT, Assisted Living, and other traditional HCBS waivers. When an HCBS waiver participant enrolls in *MyCare*, they are disenrolled from the traditional HCBS waiver and enrolled in the new *MyCare* waiver. At that point, the *MyCare* plan takes on primary

**TABLE 4**  
**MyCare Ohio Members by Plan and Region as of October 30, 2014**

Region	Counties	Health Plans	Number of Enrollees
Northeast	Lorain, Cuyahoga, Lake, Medina, Geauga	Buckeye	4,440
		CareSource	14,559
		United	8,879
Northeast Central	Trumbull, Mahoning, Columbiana	CareSource	4,233
		United	3,795
Northwest	Fulton, Lucas, Wood, Ottawa	Aetna	4,182
		Buckeye	3,958
Southwest	Butler, Warren, Clinton, Hamilton, Clermont	Aetna	8,994
		Molina	7,631
East Central	Wayne, Summit, Stark, Portage	CareSource	8,281
		United	6,304
Central	Franklin, Union, Delaware, Madison, Pickaway	Aetna	7,479
		Molina	6,295
West Central	Montgomery, Clark, Greene	Buckeye	6,795
		Molina	4,516
<b>TOTAL</b>			<b>100,341</b>

Source: Ohio Office of Health Care Transformation.

11 For PASSPORT members who are not dually eligible for Medicare and Medicaid, and therefore not eligible for participation in the *MyCare Ohio* program, the AAAs continue to perform the traditional care management responsibilities that they conducted before the implementation of *MyCare Ohio*.

responsibility for the management of all Medicaid benefits, including HCBS waiver services. The AAAs remain involved in administering HCBS services to *MyCare* members, but as subcontractors to the *MyCare* plans. This has required the AAAs to make significant changes in their programs and business practices, which are described in greater detail below.<sup>12</sup> From the perspective of AAAs and other stakeholders, implementation of *MyCare* has been a significant challenge, with many operational problems yet to be resolved at the time of our visit.

### Care Coordination in *MyCare*<sup>13</sup>

Care coordination requirements in the *MyCare Ohio* contract are relatively detailed compared with other states' MLTSS contracts.<sup>14</sup> The requirements are intended to promote a care coordination approach that is "person-centered, promotes the beneficiary's ability to live independently and comprehensively coordinate the full set of Medicare and Medicaid benefits across the continuum of care including medical, behavioral, LTSS, and social needs."<sup>15</sup>

Ohio requires *MyCare* plans to develop a risk-stratification framework for their members, which is then used in part to determine care coordination intensity levels. The State does not prescribe a specific risk-stratification methodology, but does require the plans to identify at least three levels of risk.<sup>16</sup> *MyCare* plans must also conduct a comprehensive assessment of each member within a specified time period from the point of initial enrollment, depending on risk level, and at least annually thereafter, or more often if needed. The comprehensive assessment must lead to the development of an individual care plan, the contents of which are specified in considerable detail in the contract.

Every *MyCare Ohio* member must be assigned a care manager. Degrees are not specified, but care managers must have "the appropriate experience and qualifications based on the beneficiary's needs."<sup>17</sup> The contract specifies minimum care coordination staffing ratios (number of members per care manager) and contact schedules for each risk-stratification level. For example, plan members assigned to the highest (Intensive) risk level must be visited at least twice in the first month of enrollment, and have an in-person visit at least monthly thereafter. The majority of care managers employed by the plans we visited were licensed nurses who worked out of their homes. Caseload assignments take geographical location into account to minimize travel times for the care managers. Care managers generally have mixed caseloads that include HCBS waiver members, nursing home residents, and people living in the community who do not need LTSS services.

Some plans use behavioral health specialists as care managers for members with significant mental health needs, or delegate the care coordination function to behavioral health homes for members already associated with those health homes.

*MyCare* plans must also assign an HCBS waiver service coordinator to any member who is receiving HCBS waiver services. The waiver service coordinator does not replace the care manager, but becomes a member of the transdisciplinary team that focuses on the waiver services plan. Initially, *MyCare* plans were required to contract exclusively with AAAs to perform the waiver services coordination function for members 60 years of age and older, thereby ensuring that members who had been participating in the PASSPORT waiver program continued to receive waiver service coordination

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12 Note that the impact on Ohio's AAAs is limited to the metropolitan areas in which the *MyCare* program has been implemented. AAAs operating in regions outside the demonstration continue to operate the PASSPORT program in its traditional manner (see figure 5).

13 Ohio uses the term "care management" to describe what we have universally called "care coordination" in this brief.

14 Contract between United States Department of Health and Human Services Centers for Medicare & Medicaid Services, in Partnership with the State of Ohio Department of Medicaid and [name of contractor]. February 11, 2014.

15 Ibid.

16 For a more detailed discussion of Ohio's risk-stratification approach, see: Ensslin, B., op. cit.

17 Contract, op. cit.

through the AAAs during the transition phase. Subcontracted responsibilities include conducting assessments, developing the HCBS waiver service plan, putting the service plan into operation once approved, conducting reassessments as needed, maintaining ongoing contact with *MyCare Ohio* members to identify and resolve issues, and coordinating with other community resources to meet member needs. This exclusive subcontracting arrangement ended on January 1, 2015, when *MyCare* plans were required to offer members 60 and older a second option for HCBS waiver service coordination. AAAs remain the default option if the *MyCare* member does not select a waiver service coordinator, but all *MyCare* members are now offered two choices for waiver service coordination. *MyCare* plans cannot offer themselves as the second option.

For members under 60 receiving HCBS waiver services, *MyCare* plans have more flexibility. Waiver members under 60 must also be assigned waiver service coordinators, but the plans can provide the function directly or subcontract it to AAAs or to any other qualified vendor. Plans were utilizing all three of these options (internal, AAAs, and other vendor) at the time of our visit.

The waiver service coordination function in *MyCare Ohio* resembles the function performed by the AAAs under the PASSPORT program, with some significant exceptions. Under *MyCare Ohio*, plans conduct all provider network management and claims processing. In the PASSPORT program, AAAs manage the LTSS provider network. Under *MyCare*, the AAAs do not have final approval over the members' care plans, although several plans had delegated significant authority to the AAAs to adjust care plans to each member's needs. Also, under PASSPORT, AAAs used their own assessment tools and information systems, while under *MyCare*, the AAAs were required to use the plans' assessment tools and automated case management systems for ongoing operations. AAA waiver service coordinators also have new responsibilities under *MyCare* related to their participation on the transdisciplinary team. They must coordinate their functions with the plans' own care managers, and meet the plans' data reporting requirements. They also must participate in the plans' quality management processes to the extent those processes apply to HCBS waiver services.

### **Variation across *MyCare* Plans**

The State included relatively specific requirements for care coordination in its contracts with *MyCare* plans, but the plans retain a fair amount of discretion in regard to how they structure and operate the care coordination function. The resulting variation is apparent across plans.

One major difference across *MyCare* plans is how much of the care coordination function they subcontract. For older people receiving HCBS waiver services, two plans had decided to subcontract most care coordination functions to the AAAs, including conducting all required member contacts. The same two plans also decided to subcontract with AAAs to provide care coordination for HCBS waiver participants who are under 60 years old, a group the plans could have served directly under the terms of the contract. Two other plans took a different approach, retaining as much of the care coordination function in-house as permissible under the contract. For adults over the age of 60 receiving HCBS, these plans contracted with the AAAs strictly for the waiver service coordination and maintained their own direct contact with members through their internal care managers, for example. For *MyCare Ohio* members under 60, these two plans retained the entire care coordination function within their plans.

Plans also differ in the degree of authority they delegate to the AAAs to approve changes in service plans. All *MyCare* plans retain overall authority to approve HCBS waiver services, but some plans allow waiver service coordinators to make increases in service plans valued up to \$250 or more, whereas other plans require all changes to be approved before implementation.

Another difference is the depth of member information shared by the plans with the AAAs. In all cases, AAAs must use the plans' information systems, accessed via web portals. Some plans allow AAAs to see only HCBS waiver service-related information, whereas others allow access to certain medical information, such as diagnoses and prescriptions. Receipt by the AAAs of aggregate reports on HCBS service recipients also varied considerably by plan.

### **MyCare Impacts on Care Coordination in Ohio**

In *MyCare*, all members are eligible for care coordination, whether or not they receive LTSS. Intensity of care coordination varies based on the risk-stratification level assigned by the plan. Members with the lowest needs are contacted and their needs assessed at least annually, while those with the most intensive needs have in-person contact every month. This represents an expansion of care coordination beyond those with existing LTSS needs or chronic conditions. *MyCare* also broadened the care coordination function beyond LTSS to reach all Medicaid and Medicare services. The objective is to detect needs earlier and engage all members more proactively in health promotion. With the program still in its infancy, more time is needed to assess if the strategy will be successful in improving health, enhancing the consumer's experience, and reducing Medicare and Medicaid costs.

*MyCare Ohio* has already had an impact on the infrastructure that had been built up over many years to provide care coordination for people with LTSS needs. The State recognized the value of that infrastructure by requiring health plans to form business relationships with AAAs, which had provided case management in traditional HCBS waiver programs. This enabled MMEs in the State's traditional HCBS waiver programs (PASSPORT, Assisted Living, and others) to continue receiving waiver service coordination from AAAs as they transitioned to the *MyCare* waiver.

AAAs were ensured a continuing role in waiver service coordination, but they have had to make significant adjustments to their program and business practices, including the following:

- To protect their proprietary information and practices, the plans require the AAAs to dedicate specific waiver service coordinators to their *MyCare* plans, and to establish firewalls between the dedicated staff of the various *MyCare* plans. So, for example, some waiver service coordinators work exclusively under a Molina subcontract, while others in the same AAA work exclusively under an Aetna subcontract. The AAAs have had to segment their business into separate, dedicated staffs and limit communication that may occur between those staffs. If a *MyCare* waiver participant switches from one plan to the other, the waiver service coordinator must change, despite being employed by the same AAA.
- Plans vary in the care coordination functions they subcontract to the AAAs, so the role varies between groups within the AAA. For example, one plan contracts for the AAA to conduct all member contacts, while another contracts only for quarterly contacts. This places a training and compliance burden on the AAAs, which must ensure that the specific requirements of each individual subcontract with the *MyCare* plans are met.
- Waiver service coordinators in the traditional programs can act on service plans with internal approval at the AAA level, whereas waiver service coordinators working in *MyCare* must often seek approval from the plans to alter service plans. The need for external approvals has to some degree hampered the ability of waiver service coordinators to respond rapidly to consumers' changing service needs.
- *MyCare* also altered the AAAs' relationships with LTSS providers. In the traditional waiver programs, AAAs maintain, pay, and oversee the provider network. Now the plans perform those functions for *MyCare*, while the AAAs continue to monitor the provider network for the traditional programs. The providers now must interact with additional payers, and for the AAAs, the cost of maintaining a provider network must be spread out across a decreased revenue base. They are no longer paid to maintain the provider network in the *MyCare* program, but must still maintain a network for their non-*MyCare* programs.
- AAAs have also been forced to adapt in order to take advantage of the new market provided by *MyCare*. For example, with support from the federal CMS Community Transitions Program, some AAAs have developed considerable expertise in transitioning MMEs from the hospital back into the community, thereby reducing hospital readmissions by providing timely and targeted community supports. As grant funding winds down for the federal demonstration, the *MyCare* plans are a natural customer for transition services.

The AAAs have successfully sold the service to some of the plans, but it required an ability to price the service appropriately and negotiate with the plans for a role that extends beyond waiver service coordination. Some of the plans have also contracted with AAAs for waiver participants under the age of 60, a group with distinct needs, which has required AAAs to hire more staff with expertise in physical disability and behavioral health.

Depending on the nature of the subcontract with the AAA, waiver participants may have more or less awareness that, in most cases, they now have two coordinators—the care manager at the health plan and the waiver service coordinator at the AAA. The plans and AAAs appear to have adopted a “no wrong person” approach, in which the person who receives the request from the

member takes responsibility for coordinating with the other, rather than redirecting the member. This is an area likely to be refined over time as relationships evolve and business practices respond to the changing market environment.

Since the *MyCare Ohio* program is still in its relatively early stages of implementation, it is too early to make any kind of evaluative assessment of the care coordination model that the program employs. From the perspective of the AAAs, advocates, and other stakeholders, the transition to *MyCare* has been rough, and the process for fixing systemic issues has not been clear. It is clearly a model that is evolving, as the plans and the AAAs continue to work out how they can work together effectively to provide a high-quality product to Medicare-Medicaid members.

## 5. Conclusions

Care coordination is changing significantly as states implement MLTSS programs. Organizations that provided case management in the traditional fee-for-service system, such as AAAs in Ohio and CCUs in Illinois, have faced significant challenges in adapting their business models to succeed in the new environment. Developments include the following.

- **Care coordination is being defined more broadly than traditional case management.** It generally includes comprehensive coordination of all services and informal supports received, including health and social services. It also reaches more people, with most MLTSS programs requiring that all members receive some level of care coordination, with intensity determined through a risk-stratification system.
- **Three care coordination models have emerged in MLTSS programs: In-House, Shared Functions, and Delegated.** States give contractors varying degrees of discretion to implement unique care coordination structures, and many variations of the three models have emerged. In the In-House model, MLTSS contractors (usually health plans) build capacity inside their organizations and conduct care coordination directly. In the Shared Functions model, MLTSS contractors partner with external organizations, such as AAAs, Independent Living Centers, tribal organizations, or health homes, to provide certain aspects of care coordination. In the Delegated model, the plan delegates the entire function to a subcontracted health system or other entity that takes full responsibility for all aspects of care coordination. All three models are known to exist within single MLTSS programs, and even within a single health plan. For example, a health plan may use the Delegated model for members already associated with a continuing care system, a Shared Functions model for members receiving HCBS waiver services through an AAA, and an In-House model for all other members.
- **Whether mandated or not, many collaborative Shared Functions arrangements are emerging.** Some states require MLTSS contractors to implement Shared Functions models with traditional case management organizations, while others leave the decision to the contractors. Shared Functions arrangements exist in both of the case study programs. The relationships were mandated in Ohio and emerged in response to market pressures in Illinois.
- **Shared Functions models have preserved a role for traditional case management organizations and tapped into their expertise, but they have also created challenges.** For example, the approach has in some places led to members being assigned two different care coordinators, one from the traditional organization and one from the managed care contractor. Significant effort must go into role delineation and ensuring a seamless experience for the member. Information sharing is proving to be a significant challenge. Concerns about proprietary information and the security of protected health information (PHI) have been barriers to the free flow of information between MLTSS contractors and their community partners.
- **Care coordination specifications vary considerably across states.** In addition to deciding whether to mandate relationships with traditional case management organizations, states face several key choices in specifying care coordination requirements. These include eligibility for care coordination, minimum qualifications of care coordinators, minimum frequency of contact with members, and whether to specify the maximum number of members who may be assigned to one care coordinator. The direction taken by a state appears to be related to contracting

philosophy, advocacy on the part of various types of stakeholders, and the level of detail that was historically specified in traditional programs.

- **The shift by states from fee-for-service models to managed care models for LTSS is having a major impact on the traditional case management infrastructure for HCBS.** In response, some case management providers are re-engineering their practices and business models to become more competitive in the new market environment. For example, some are expanding their health care capacity by hiring more nurses to work in teams with their social workers. Others are engaging with hospitals to implement protocols for successfully transitioning people from the hospital into community settings. Some have

accepted per-person-per-month payments for care coordination and other services, a significant shift from grant-based or fee-for-service payments.

Care coordination for people with LTSS needs is evolving significantly as states move to MLTSS. Federal and state policy, market forces, and available infrastructure are all influencing the models of care. The comparable impact of these models on consumer health, experience, and cost is not known, but the immediate impact on traditional LTSS systems is clear. Given that care coordinators are, and will remain, a critical point of contact for consumers who use LTSS, a greater understanding of the relative effectiveness of emerging models is an issue of high policy priority.



## Appendix A: Compilation of MLTSS Care Coordination Contract Specifications across States

The following table compiles the results of the contract analysis across the 19 contracts in 18 states. (One state, Massachusetts, has separate contracts for each of its two MLTSS programs.)

Detailed tables for each contract analyzed are available on the AARP website at <http://www.aarp.org/carecoordination>. The individual tables include descriptions of how the elements are addressed, including, for example, the caseload ratios when ratios are required, the frequency of contact required, and so on.

The state abbreviations in the table refer to contracts for the following programs:

<b>AZ</b>	Arizona Long-Term Care System
<b>CA</b>	California MediConnect
<b>DE</b>	Delaware Diamond State Health Plan Plus
<b>FL</b>	Florida Long-Term Care Managed Care Program
<b>HI</b>	Hawaii QUEST Expanded Access
<b>IL</b>	Illinois Integrated Care Program
<b>KS</b>	Kansas KanCare
<b>MA-ONE</b>	Massachusetts One Care
<b>MA-SCO</b>	Massachusetts Senior Care Options
<b>MN</b>	Minnesota Senior Health Options and Senior Care Plus (both programs use the same contract)
<b>NJ</b>	New Jersey FamilyCare MLTSS Program
<b>NM</b>	New Mexico Centennial Care
<b>NY</b>	New York Managed Long-Term Care Partial Capitation Program
<b>OH</b>	Ohio MyCare
<b>RI</b>	Rhode Island Medicaid Managed Integrated Adult Care Services in the Rhody Health Options Program
<b>TN</b>	Tennessee TennCare CHOICES
<b>TX</b>	Texas STAR+PLUS
<b>VA</b>	Virginia Commonwealth Coordinated Care
<b>WI</b>	Wisconsin Family Care and Family Care Partnership (both programs use the same contract)

Meaning of Findings in the table:

**Yes** The contract includes the requirement.

**No** The contract addresses the topic but does not require it.

**Other** The contract addresses the topic but not in a way that allows a yes or no response.

**Not Addressed** The contract does not address the topic. It may be addressed in other state policy or guidance but is not found in the contract.

Because Massachusetts has two distinct contracts for each of its MLTSS programs, the following abbreviations are used:

**MA-One** Massachusetts OneCare

**MA-SCO** Massachusetts Senior Care Options

## Compilation of Findings

Element	Finding	States
<b>CARE COORDINATION ELIGIBILITY AND CHOICE</b>		
1) Which members are eligible for care coordination?	All members	AZ, CA, FL, HI, MA-One, MN, NJ, NM, NY, OH, TN, VA, WI
	Subset of members	DE, RI
	Other	IL, MA-SCO, TX
	Not addressed	KS
2) Can eligible members opt out of care coordination?	Yes	CA, NM, RI, TX
	No	NY, WI
	Other	IL, OH, TN
	Not addressed	AZ, DE, FL, HI, KS, MA-One, MA-SCO, MN, NJ, VA
3) Can members choose or change care coordinators?	Yes	DE, HI, KS, MA-One, MN, NJ, NM, OH, TN, WI
	Not addressed	AZ, CA, FL, IL, MA-SCO, NY, RI, TX, VA
<b>CARE COORDINATOR QUALIFICATIONS</b>		
4) Are care coordinators required to have college or nursing degrees?	Yes	MA-SCO, NJ, NM, NY, RI, TN, TX, VA, WI
	No	AZ, CA, DE, FL, KS, OH
	Other	HI, IL, MA-One, MN
5) Are care coordinators required to have experience in long-term services and supports or disability?	Yes	CA, DE, FL, MA-One, MA-SCO, NM, OH, TX, WI, VA
	No	AZ, IL, KS, MN, NJ, NY, RI, TN
	Other	HI
6) Are care coordinators required to receive training?	Yes	AZ, CA, DE, FL, HI, IL, KS, MA-One, MA-SCO, MN, NJ, NM, NY, OH, TN, TX, VA, WI
	Not addressed	RI
<b>CULTURAL COMPETENCY OF CARE COORDINATION</b>		
7) Are care coordinators required to speak languages other than English when the other language is used by members?	Yes	MN, NM
	No	AZ, CA, DE, FL, HI, IL, KS, MA-One, MA-SCO, NJ, NY, OH, RI, TN, TX, VA, WI
8) Are translation/ interpretation services required when a care coordinator does not speak a member's language?	Yes	AZ, CA, DE, FL, HI, IL, KS, MA-One, MA-SCO, MN, NJ, NM, NY, OH, RI, TN, TX, VA, WI
<b>CARE COORDINATOR ASSIGNMENTS, CONTACT REQUIREMENTS, AND ROLE</b>		
9) Are care coordinators with certain specialties (e.g., nursing, social work, behavioral health) assigned based on the needs of members?	Yes	AZ, CA, DE, FL, IL, MA-One, NJ, NM, NY, OH, RI, TN, TX
	Other	WI
	Not addressed	HI, KS, MA-SCO, MN, VA
10) Is in-person contact required?	Yes	AZ, DE, FL, HI, IL, MA-One, MA-SCO, MN, NJ, NM, NY, OH, RI, TN, TX, VA, WI
	Not addressed	CA, KS
11) Is telephonic or other remote contact required?	Yes	AZ, DE, FL, HI, IL, NM, OH, RI, TN, TX, WI
	No	VA
	Not addressed	CA, KS, MA-One, MA-SCO, MN, NJ, NY
12) Must initial contact with a new member be made within a specified time period?	Yes	AZ, CA, DE, FL, HI, IL, KS, MA-One, MA-SCO, MN, NJ, NM, OH, RI, TN, TX, VA, WI
	Not addressed	NY
13) Is an assessment required at initial enrollment?	Yes	AZ, CA, DE, FL, HI, IL, KS, MA-One, MA-SCO, MN, NJ, NM, NY, OH, RI, TN, VA, WI
	Other	TX
14) Is reassessment required?	Yes	AZ, CA, DE, FL, HI, IL, KS, MA-One, MA-SCO, MN, NJ, NM, NY, OH, RI, TN, TX, VA, WI

Element	Finding	States
15) Does the care coordinator authorize long-term services and supports?	Yes	AZ, CA, NJ, TN, TX
	No	NM
	Other	MA-SCO, OH, WI, RI
	Not addressed	DE, FL, HI, IL, KS, MA-One, MN, NY, VA
16) If the member chooses a participant-directed option, does the care coordinator continue to provide coordination?	Yes	AZ, CA, DE, HI, IL, KS, MA-One, MN, NJ, NM, OH, TN, TX, VA
	Other	FL, RI, WI
	Not addressed	MA-SCO, NY
17) Does the care coordinator play a role when members use a transition program such as Money Follows the Person to move out of institutional settings?	Yes	AZ, CA, DE, FL, HI, IL, KS, MA-SCO, MN, NJ, NM, OH, RI, TN, TX, WI
	No	VA
	Other	MA-One
	Not addressed	NY
18) Does the member have a single point of contact who coordinates across specialized coordinators when needed (e.g., coordinates across LTSS, behavioral, medical specialists)?	Yes	AZ, DE, FL, IL, MA-One, MA-SCO, MN, NJ, NM, OH, RI, TN, TX, VA
	Not addressed	CA, HI, KS, NY, WI
<b>CARE COORDINATION ROLE WITH FAMILY CAREGIVERS</b>		
19) Are family caregivers asked directly about: (a) their own health and well-being, (b) level of stress and feelings of being overwhelmed, (c) need for training in assisting the member, and (d) any additional services or supports needed to better carry out their roles?	Yes	TN
	Other	AZ, CA, DE, FL, HI, IL, MA-One, MA-SCO, MN, NJ, OH, RI, VA, WI
	Not addressed	KS, NM, NY, TX
20) Does the plan of care address needs of the family caregiver raised during the assessment process?	Yes	MA-One, OH, TN, WI
	Other	CA, FL, HI, KS, NJ, RI
	Not addressed	AZ, DE, IL, MA-SCO, MN, NM, NY, TX, VA
21) Are family caregivers given care coordinator contact info?	Yes	AZ, CA, FL, MN, NM, OH, RI, TN, WI
	Not addressed	DE, HI, IL, KS, MA-One, MA-SCO, NJ, NY, TX, VA
<b>CARE COORDINATION INFORMATION TOOLS</b>		
22) Does the care coordinator have access to centralized member records?	Yes	CA, FL, HI, IL, KS, MA-One, MA-SCO, MN, NJ, NM, NY, OH, RI, TN, TX, VA, WI
	Not addressed	AZ, DE
23) Does the care coordinator have access to an electronic care coordination program?	Yes	AZ, IL, KS, MA-SCO, MN, NJ, NM, NY, OH, TN, TX
	Not addressed	CA, DE, FL, HI, MA-One, RI, VA, WI
<b>CARE COORDINATION STRUCTURES, POLICY, AND OVERSIGHT</b>		
24) Are care coordination caseload ratios required?	Yes	AZ, DE, FL, HI, IL, NJ, NM, OH, TN
	No	CA, KS, MA-One, MA-SCO, NY, VA, WI
	Other	MN, RI, TX
25) Does state program monitoring include a specific focus on care coordination?	Yes	AZ, CA, DE, FL, HI, IL, KS, MA-One, MN, NJ, NM, NY, OH, RI, TN, TX, VA, WI
	Not addressed	MA-SCO
26) Outcomes measurement: does the model include an evaluative component, through which the outcomes of the care coordination are periodically measured?	Yes	AZ, CA, DE, FL, HI, KS, MA-One, MN, NJ, NM, NY, OH, RI, TN, WI
	Other	IL, MA-SCO, TX, VA
27) Care coordination entity	Partners mandated	CA, MA-One, MA-SCO, NM, OH, VA
	Partners permitted	AZ, DE, FL, HI, IL, KS, MN, NJ, NY, RI, TN, TX, WI

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