



## **Improving Care Coordination for Members of Long-Term Service and Supports**

Findings from the Cal MediConnect Best Practices Meeting

Department of Health Care Services

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## **Improving Care Coordination for Members with Long-Term Services and Supports**

The Cal MediConnect (CMC) program was developed to better serve dual eligible beneficiaries – those enrolled in both Medicare and Medi-Cal. A particular focus of CMC – as well as the broader Coordinated Care Initiative (CCI) – is to better integrate long-term services and supports (LTSS) for these beneficiaries. Several years into the program, evaluation findings indicate that, while CMC has provided a valuable new pathway for serving dual eligibles, more work can be done to connect members to LTSS services and to better integrate and coordinate those services with the more traditional medical benefits that health plans offer. As one of several initiatives to address this ongoing challenge, during the spring of 2018, the CMC plans participated in a best practices process to examine their own internal operations and share learnings with each other.

### **Care Coordination and LTSS in Cal MediConnect**

In the fee-for-service system, it can be easy for beneficiaries in need of services to fall through the cracks. The CMC care coordination system was specifically designed to help health plans proactively identify and meet members' needs, first through data-driven risk stratification, then the Health Risk Assessment (HRA) process, then the development and implementation of the care plan by the care team and member.

CMC members start the care coordination process by completing a HRA in person, over the phone, or by mail through the CMC health plan. The HRA is designed to assess the beneficiary's health risk by asking them about social determinants, functional capacity, medical conditions, and behavioral health conditions. The CMC plans use the HRA to identify what level of care coordination beneficiaries may need, further assessments, or referrals to services.

Based on the HRA results, and in consultation with the beneficiary, the plans develop individualized care plans (ICPs), create interdisciplinary care teams (ICTs), and assign members to a care manager. (Note: The term care manager in this paper refers to anyone who performs care coordination activities, and may include care coordinators, care managers, case managers, etc.).

The care manager is usually the point of contact for the entire ICT – composed of providers (including clinicians and LTSS providers), family/caregivers, and community-based organizations – that is charged with integrating services and providing clients with holistic care. The ICP is a person-centered document that prioritizes the member's health goals in the context of their overall needs. Within the plan, the care manager and the member agree upon what

measurable objectives must be met in order to accomplish the goals in a timely manner. The plan should be reviewed and approved by the member and updated no less than annually.

One of the most significant services the CMC plans provide is connecting beneficiaries to LTSS, if needed, that will help improve their health status. The HRA includes screening questions that are intended to streamline the LTSS referral process and are standard across all CMC plans. If a member needs LTSS, their care manager from the CMC health plan will initiate the referral process and work with the plan to arrange for and cover the cost of the services. Arranging for LTSS is an example of a measurable goal that can be included in the ICP. It is important to note that if clients already have access to LTSS, joining CMC will not interrupt these services. The primary LTSS covered by CMC plans are:

- **Community Based Adult Services (CBAS)** offers centers for older adults and/or adults with disabilities to participate in day treatment programs that help them maintain optimal capacity for self-care. Participants receive personal care education, physical, occupational and speech therapies, and nutrition counseling.
- **In-Home Supportive Services (IHSS)** is a program that offers clients a caretaker that comes to the client's home and assists them with bathing, dressing, housecleaning, laundry, and medication management.<sup>1</sup>
- **Multipurpose Senior Services Program (MSSP)** sites provide social and health care management for elderly clients who are certified for placement in a nursing facility but wish to remain in the community. Staff from these sites assist with activities such as making homes more handicap accessible and connecting clients to community resources.
- **Long Term Care (LTC) Facilities** provide both medical and personal care to people who are unable to manage independently in the community and therefore live at these facilities.

This paper largely focuses on how CMC plans are helping connect members to home and community-based LTSS services, although the best practices groups also had productive conversation about helping better serve members residing in long-term care facilities.

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<sup>1</sup> The IHSS benefit was integrated into managed care in CCI counties until January 1, 2018, when it reverted to a fee-for-service benefit. This ended the program funding changes implemented under CCI and IHSS was no longer included in capitation rates for plans, but the program continued operating as before. Plans and counties were encouraged to collaborate on care coordination, but funding to support county coordination was ended.

## Survey Findings and Efforts to Improve Access to LTSS

Integration of LTSS services was a primary objective of the CMC program – helping redirect beneficiaries from LTC settings back into their communities by providing home and community-based services (HCBS). Working with the CMC plans to combine medical benefits with LTSS and enhanced care coordination services within a single health plan was designed to create a financial incentive for ensuring that beneficiaries receive the LTSS services that help them stay healthy and reduce avoidable acute care utilization.

However, a 2017 survey of CMC members found that there is more work to do to ensure that members receive care coordination and needed LTSS. Based on a [2017 survey of CMC members](#), 58 percent of CMC members reported that they did not have a care manager. Of participants who reported having a care manager, 28 percent said that having a care manager had improved their care. For beneficiaries receiving LTSS services, 41 percent said they could use more assistance with personal care and/or routine needs. Twenty-six percent of members with IHSS reported that the CMC plan helped them increase the number of caretaker hours they were receiving.

As a result of these evaluation findings and as a part of a comprehensive effort to continuously improve the CMC program, the Department of Health Care Services (DHCS) and its partners – the Centers for Medicare & Medicaid Services (CMS) and the CMC plans – have taken several steps to improve access to and coordination of LTSS services, including:

- Enhanced LTSS Referral and Utilization Data Reporting: While DHCS and CMS have always required some reporting around ICT and ICP, reporting requirements for CMC plans expanded to include additional metrics on CPO services and CBAS, MSSP, and IHSS referrals and utilization.
- Standardized HRA LTSS Referral Questions: DHCS convened a workgroup of stakeholders, including agency staff, health plans, providers, and others, to recommend standardized HRA questions designed to identify whether beneficiaries are facing a risk factor for needing LTSS supports. The intent is to use the questions as a screening mechanism to determine if members needed additional assessments or referrals to LTSS services.

DHCS and CMS selected the care coordination topic for an in-depth best practices process to check in with the plans on their approach to providing care coordination to members with LTSS and to foster shared learning across the CMC plans and demonstration counties. DHCS developed a series of questions for the plans to answer in order to better understand plans' internal care coordination practices and used the responses to facilitate one-on-one

conversations with the CMC plans during their contract management team meetings in February and March of 2018. The findings from those conversations informed the development of the agenda for an in-person best practices meeting in May. The combined lessons learned are reflected in this document.

## **Identifying LTSS Needs**

### *Health Risk Assessments*

Starting in January 2018, all CMC plans were required to use ten standardized Health Risk Assessment questions designed to help identify new members who could benefit from LTSS. The questions, developed by the workgroup described above, covered topics from activities of daily living to financial insecurity, loneliness, and caregiver stress, to give the plans a holistic view of the member's non-medical needs.

All plans are required to attempt to conduct an HRA for every new member – within 45 days for members identified as high risk, and 90 days for low-risk members. Plans must also revisit the HRA every year to identify any changes in a member's status. All plans reported that they had implemented the new HRA LTSS questions, with some plans fully integrating the questions into the HRA and others asking the questions as an addendum.

Based on plan responses to our survey in February 2018, below are the CMC plans' best practices for asking, recording, and following up when HRA responses, assessments, or internal or external referrals indicate a need for LTSS services.

### *HRA Standardized Referral Questions Implementation*

A key area of interest for the best practices process was around how the plans are using these new HRA questions and the care coordination process overall to identify and meet the need for LTSS among members. Plans varied widely in how they conduct the HRAs – some plans contracted out to a dedicated vendor, others delegated the responsibility to physician practice groups (known as PPGs, including medical groups and independent physician associations, or IPAs), and some kept the process in-house at the plan level. Keeping the full HRA process in-house seemed to enable plans to more easily adopt the new questions and share the members' answers with their providers and care team, so that the member can quickly begin receiving needed services. At least one plan currently contracting the HRA out to a vendor reported that it has plans to bring it in-house in the near future.

### Identifying LTSS Needs Outside of the HRA

Plans acknowledged that while the HRA provides useful information, it isn't the only – or even always the best – way to identify members who could benefit from LTSS services. For example, plans have faced challenges locating members for their initial HRA, and then while they contact their members on an annual basis, any change in a member's status should trigger a reassessment of their needs. As such, mechanisms in addition to the HRA may be needed in order to most effectively identify LTSS needs.

CMC plans reported a range of ways they identify LTSS needs in addition to the HRA process:

- **Internal Referrals:** The plans have developed systems to solicit referrals from internal departments including: providers, member services, behavioral health, utilization management, discharge planning, and long-term care diversion.
  - Utilization management is a key way that plans are looking to use data analysis to better understand when members may have a new need for LTSS or other plan supports. Many plans reported that they work to connect with members who are in the hospital or emergency department, as they are highly likely to need support transitioning back into their home and/or community.
  - While plans reported using data mining to identify members who may need LTSS or other supports, they also reported that it was not always effective. For example, there may be members who may need LTSS supports but do not interact regularly with the health system (particularly hospitals) and may be harder to proactively identify.
- **External Referrals:** Plans allow members, caregivers, SNFs, CBOs, and other programs (e.g. Whole Person Care) to refer members to LTSS services through an accessible phone line, a dedicated email address, and other avenues.

### **Connecting Members to Services**

The following are several best practices in plan operations to turn HRA responses into referrals:

- **Leverage Technology to Make Data Accessible:** Some plans reported integrating their HRA responses directly into their electronic health records (EHRs), care management software systems, or provider portals as quickly as possible to make them easily available to the member's entire care team.
- **Ensure Necessary Follow-Up:**

- Some plan care management systems automatically trigger alerts to care managers or flags in member files if there is follow-up needed from the HRA responses.
- Other plans stratify members based on HRA responses, LTSS need, and historical usage data to determine when and how they will reach out to members for follow-up.
- Many plans assign a (usually clinical) care manager to fully review a member's answers to the HRA questions and make referrals to the appropriate services based on the answers. (HRAs are often conducted by non-clinical staff who are not qualified to direct this type of follow-up.)
  - Plans vary in the timeliness of their follow-up actions from three to 30 business days.
  - Plans reported they immediately follow-up with members if their answers indicate an imminent safety concern.
- Post-HRA Assessments: Plans reported that the HRA questions were effective at screening and identifying members for follow-up but could not always take the place of more complete and targeted assessments.
  - Some HRA responses trigger a dementia assessment or a more complete LTSS needs assessment.
  - Some plans have care managers or other staff (e.g. social workers) conduct home visits.
  - An identification of insufficient caregiver support usually triggers a referral to IHSS or custodial care.

### Monitoring Referrals and Availability of LTSS Services

All plans reported internal policies and procedures for making referrals to LTSS and other community services, based on the results of the member's HRA, other assessments, or triggers. Plans reported having care managers track and follow-up on referrals quickly – within five business days – more quickly for those with immediate need and have care managers constantly update the member's ICP with information regarding referrals.

Another best practice identified was to include the LTSS referrals in the EHR or care management software. This can allow plans to use automatic reminders for care managers or providers to trigger follow-up. This type of system can be especially effective for plans working with delegated entities, to ensure all providers have access to up-to-date information.

Best practices for following up on LTSS referrals differed somewhat by the type of LTSS service:

- IHSS referrals:
  - When IHSS stopped being a managed care benefit and returned to being a fee-for-service benefit, plans and counties have faced some difficulties in maintaining close care coordination, including when plans refer members for new or additional IHSS hours. At least one plan reported that while they had previously been able to work closely with the counties to reduce the application processing times for members from four to six months to four to six weeks, the wait time is increasing again.
  - As a best practice, many plans had care managers tracking IHSS referrals by contacting members following the referral to ensure they have heard from the Department of Social Services (DSS). If the member already has an informal caregiver such as a family member, the care manager can help the member formalize that caregiver through the IHSS program, so they can be paid for their work.
  - Plans reported continuing to have their care managers develop a relationship with the IHSS case manager and maintain communication in order to keep the member's ICP up-to-date.
- CBAS Referrals:
  - Several plans reported having their care managers familiarize themselves with the CBAS centers in their counties, particularly which CBAS centers tend to offer specific services or serve specific communities. This helped ensure that the care managers would refer members to the CBAS center that best fit their need, not just the closest facility. This was particularly important in Los Angeles County. As an example, some CBAS centers offer services like acupuncture, or offer their services predominantly in Chinese or Spanish or other non-English languages.
  - To ensure the referral was a success and the member is receiving needed services, the care manager should also be in direct contact with the CBAS center to ensure that the member is attending appointments and to coordinate care accordingly.
- MSSP Referrals: The primary challenge with referrals to the MSSP program is that each site usually has a waiting list. As a best practice, some plans are providing bridging services to members on waitlists to help meet any immediate needs.

## Care Coordination Infrastructure

Cal MediConnect plans have each developed different internal care coordination infrastructures. Some plans delegate primary care coordination to their delegated entities, some delegate medical care coordination but retain coordination for LTSS and other social services, and some plans hold all care coordination at the plan level. Care coordination around LTSS services was one of few services that nearly every plan maintained at the plan level, and did not delegate.

Additionally, how plans provide tailored care coordination to their members with LTSS also varies. No model seemed to be a single best practice, as each model has benefits and limitations in serving members.

- Dedicated LTSS Care Coordination: Some plans have specific units dedicated to serving members who have LTSS needs. These specialists often provide a “wrap” to the traditional (medical) care coordination model that is typical of health plans. This can ensure that members with LTSS needs have a care manager who is very familiar with these programs and understands how to help the member navigate them. However, it can also create an added level of complexity and need to “coordinate the coordinators.”
- Integrated LTSS Care Coordination: Some plans categorize members with LTSS needs alongside medically complex members in their high-level care coordination programs. While the care managers are usually cross-trained in LTSS programs, they are not necessarily specialists. The benefit is that this model can help ensure members have a single care manager responsible for comprehensively managing their full medical and LTSS needs.
- Intensive Care Coordination Programs: Some plans also provide targeted care management for members during transitions or during specific episodes of high needs. Some plans provide care management teams that are specific to members during hospitalizations or transitions from the hospital to the community. Other plans contract with vendors who provide short-term, on-site care management in a member’s home. Often combined with home health services, these care managers work with members for up to six months to see them through a specific episode of care, while CMC plan care managers provide monthly telephonic follow-up. These care managers need to be well versed in the types of LTSS services that can help members during or after these episodes.

Within any care coordination infrastructure, there are some best practices to help ensure plans are meeting the needs of their members with LTSS:

- Have a general care manager (non-clinical) conduct initial follow-up and a licensed clinical social worker (LCSW) or LTSS trained care manager provide follow-up on LTSS needs.
- Integrate the care manager into the ICT, and ensure referrals are reflected in the ICP.
- Assign the non-clinical care manager (e.g. public programs specialist) to call the member to close the loop and verify that they understand available services and are receiving them based on referrals.
- Reach out to members when they enroll in the CMC plan to identify the need for LTSS referrals and ask whether or not the member has a caregiver. If they do, the caregiver's name is noted in the member's file. The care manager should contact members to provide information on LTSS benefits and assist with the application process, providing extra help in applying for IHSS.
- Develop an LTC Custodial team for members receiving LTC in nursing facilities.

### **Training and Education**

As plans were new to many of the LTSS services at the start of CMC, they have had to implement trainings for their staff, delegated entities, and providers to ensure all actors understand what resources are available for members.

- Trainings for Plan Staff and Providers:
  - Plans must train a wide variety of actors on LTSS services, including care coordination staff, providers, delegated plans, community partners, and vendors.
    - Plans should plan to provide training upon hiring and on an ongoing basis as needed. Staff often need refreshers and frequent turnover requires continuous training opportunities.
    - It can be helpful to have a LCSW with public programs experience play a role in the training, as they can offer a non-medical perspective.
    - It is important to train care managers to serve high needs populations. For example, dementia training is required for at least some care managers and many plans have participated in a dementia training initiative developed by Alzheimer's Greater Los Angeles.
    - Plans should conduct LTSS-specific trainings for all delegated entities, whether they hold the risk for LTSS services and care coordination or not. This will help ensure that delegated entities understand the resources available for their members and can help them access those services.

- Provider email blasts and newsletters are an effective mechanism to provide training updates as needed. Plans can also develop LTSS informational materials for providers to display in their offices.
  - Trainings should include: who is eligible, how to identify LTSS needs (and recognize when they may be urgent), how to connect members with LTSS services, as well as resources in the community such as food, transportation, caregiver support, utilities, housing, etc.
    - In-service and orientation days at LTSS provider facilities can give staff the best understanding of how LTSS providers support their members.
      - For example, plans reported having care managers shadow staff at CBAS centers. This type of approach requires working closely with the LTSS providers to ensure they understand what type of information will be most helpful for the plan staff to make the training effective. With this type of hands-on experience, plan care managers and staff can better explain the benefits of the LTSS service to their members.
    - Care managers need to be trained on how to facilitate referrals for LTSS services, including:
      - Helping members navigate the IHSS assessment and application process;
      - Meeting members needs while they are on MSSP waiting lists; and
      - Connecting members with the most culturally appropriate CBAS center.
- Understand Available Community Resources: The CCI and CMC required health plans to understand and interact with a broader array of LTSS providers as well as a range of community organizations that help support dual eligibles in California. One area of focus for the best practices process was on how the CMC plans were ensuring their staff understood what community resources are available for their members and how best to connect them with those resources.
  - One best practice is for plans to dedicate a staff member to cataloguing CBOs in the community and making those resources accessible to the care managers and members who need them. However, this type of catalogue needs to be regularly updated.

## **Working with LTSS Partners**

One of the best ways health plans can serve their members with LTSS services is by developing meaningful partnerships with LTSS providers to ensure members are having their needs met and care coordinated.

### **Preventing Unnecessary Hospitalizations and Emergency Department Visits**

Several plans reported working closely with various LTSS providers to try to prevent unnecessary hospitalizations and ED visits (a requirement of the CMC program). Plans would often mine their data to see if certain CBAS centers or LTC facilities had a high percentage of members who were visiting the hospital or ED, and then work with those providers to identify and address the causes. Plans reported that actions as simple as sharing a facility's rate of hospitalizations or ED visits compared to competitor facilities' rates could often prompt improvement.

### **Coordinating with Care Managers**

Members at CBAS centers and in the MSSP program have dedicated care managers as a part of those LTSS services. By building relationships with these care managers, plans can improve care delivery and coordination between the LTSS provider, plan care manager, and other plan providers.

The IHSS carve-out has created some challenges to coordinating care between plans and IHSS providers and county social workers. Most counties have not signed new memorandums of understanding (MOUs) with the CMC plans to share data, and, without dedicated funding, many county IHSS social workers are not participating in CMC care teams. Rebuilding these relationships could significantly improve care coordination for members with IHSS.

### **Working with Long-Term Care Facilities**

A key goal of the CMC program is to provide plans with the financial incentive to transition members out of LTC nursing facilities and into the community using HCBS, including the LTSS programs.

The CCI and CMC represent the first-time health plans have had the responsibility and risk for long-term nursing facility stays, a Medi-Cal benefit. Under the initiative, plans have worked to develop relationships with their LTC facilities and report it is a priority to try to identify

members who may benefit from returning to the community, as well as to identify members in those facilities who may benefit from increased care coordination.

However, plans also report that it can be difficult to work with the LTC facilities, which range in sophistication and quality. As mentioned above, plans have worked to identify LTC facilities where members may be experiencing higher rates of unnecessary hospitalizations and ED visits, and then work with those facilities to reduce that utilization.

- **Member Transitions Require Intensive Care Management:** To transition a beneficiary from an LTC facility back into the community requires intensive care management and partnership between the facility and plan. Here are some identified best practices:
  - Plans need to educate facilities about the HCBS services that are available to help members live independently, and this education is often a continuous process.
  - It is helpful to dedicate a team to LTC utilization review and case management to identify LTC members soon after admission who could return to the community, assess barriers, and educate about LTSS and care management available to support transition back to the community.
  - Plans should designate care managers to work with LTC members who are transitioning back to the community and be their primary point of contact.
  - LTC transitions always include an IDT meeting at the LTC facility and ensure frequent communication.
  - While the California Community Transitions Project (CCT) can be a helpful resource, the CMC plans also need to dedicate resources to support and move transitions forward.

### **Ongoing Challenges and Next Steps**

Despite the CMC plans' concerted efforts to improve care coordination for members with LTSS, there are several remaining challenges, including some systemic issues:

- **Coordination Challenges:**
  - Arranging complex care coordination and sustained LTSS for those without support system, with a cognitive impairment, and/or with behavioral health issues can be difficult to set up and maintain, even with specialists trained in serving these populations.
  - Limited provider participation and challenges developing integrated care teams across medical, LTSS, and social services that agree on defined goals, work together, and meet regularly.

- Overlap and duplication of care coordination efforts. Multiple assessments and care planning are required for each LTSS program and the health plan. Members express confusion and frustration about duplication of assessments and multiple contacts from care managers.
- Ongoing difficulties coordinating with the county IHSS programs due to the carve-out and lack of new MOUs between plans and counties. This has created delays for beneficiaries navigating the process to be assessed for IHSS hours and limits the information available to county social workers and plan care managers in seeking to coordinate care for the beneficiary.
- Resources Challenges:
  - Limited availability of community resources and housing. This can limit the ability to transition members out of LTC facilities and into the community.
  - Limited number of MSSP slots leads to long waiting lists. While the transition of the MSSP program to a plan benefit will hopefully alleviate this issue in the CCI counties, many CMC plans could do more to support members with needs while they are on MSSP waitlists.

This best practices process revealed that the CMC plans are working to improve access to LTSS services, as well as coordination for members receiving those services. Plans have developed various approaches to care coordination for members with LTSS services based on their overall approach to care coordination and model of care for their members. DHCS will continue to collect and analyze data regarding CMC members' utilization of LTSS services and continue to work with plans to reinforce the need to support these members in accessing these critical services.