Care Coordination

a high-level

Overview

DSHS ALTSA HCS

1/2025

The Power of Communication

Purpose

Care Coordination:

- is the proactive collaboration between Apple Health Medicare Connect Dual Special Need Plans (DSNP) and the Long-term care (LTC) system that increases client/beneficiary ability to return to and remain in the community, with the right support in place.
- helps avoid unnecessary inpatient stays or health complications.
- leads to more efficient and timely transitions of care, support whole person health and achieve better integration of services at the local level.

Care Coordination Team

- Medicare Advantage DSNPs
- Managed Care Organizations (MCO)
- Long Term Care case management system that includes:
  - Area Agencies on Aging (AAA)
  - Home and Community Services (HCS)

All entities work together as a team in the coordination of care will lead to:

- More efficient and timely transitions of care
- Support whole person health
- Achieve better integration of services at the local level

When and How to Engage with System Partners

Medicare Advantage (MA) Plans and the LTC system should coordinate with each other as they become aware of a client who would benefit from cross-system coordination.

MA Plans and LTC system can initiate coordination via email or through established biweekly care coordination meetings. HCA/AAAs can find the contact list of the MA health plans on the ALTSA Intranet

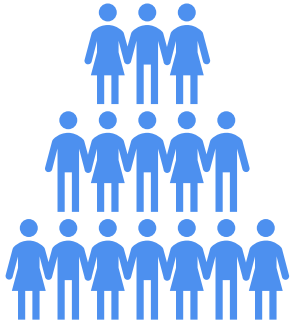
MA plans may find the HCS/AAA case manager listed in PRISM if the individual has LTSS authorized services

Successful Collaboration

- Individuals are responsible for achieving successful transitions of care and to include care and/or case management.
- We should be well versed on the services available to clients/beneficiaries and how to access them.
- While we cannot all be experts in all things, we can partner across the delivery systems to address gaps in care and achieve more efficient and cost-effective service delivery.

Success Stories through Collaborative Care Coordination

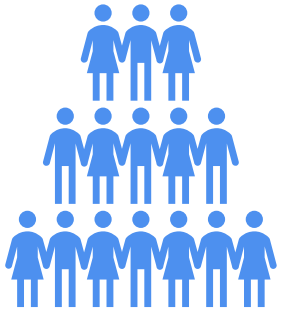
Successful Care Coordination between the Medicare Advantage D-SNP, the hospital, the Community Choice Guide (CCG) and, Housing



Outcome of this staffing→

The D-SNP provider identified special benefits they were able to offer to the client transitioning to in home to include: 252 home delivered meals, 6 home visits per year, grocery assistance, transportation up to 60 per year to medical/pharmacy visits and provided the client with a glucometer providing educational phone support for diabetes management.

Successful Care Coordination between the BHSO and MA DSNP



Outcome of this collaboration→

Example of client who is on a 180-day Involuntary Treatments Act (ITA), due to the client's complex behavioral needs and challenge to find placement. The BHSO provider and the MA DSNP worked together on placement search, splitting the search by county, coordinating with the HCS Case Manager(CM). The Managed Care Organization (MCO) was also looking at availability of long-term civil commitment beds.

Understanding our Roles and Responsibilities around Care Coordination and Who Does What

Area Agency on Aging: role in care coordination

Information and Assistance (no wrong door access to local community services and supports)

Case management of Medicaid LTC clients served in their home.

Conduct ongoing functional assessments for LTC and service plans

Assist with transition to LTC services or settings

Case management for other programs like supportive housing, state funded family caregiver support programs, Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA)

Some AAAs have special programs like Health Homes or care transitions

Contract Medicaid LTC providers

Other social support services (local expertise) e.g.:

- Transportation
- Nutrition Services – congregate or home delivered meals
- Family Care Giver Support
- Information and Assistance
- Environmental modifications

Home & Community Services(HCS): role in care coordination

- Initial eligibility determination for referrals to the Medicaid LTC system.
- Financial eligibility determination for some Medicaid clients
- Conduct person centered initial and ongoing functional assessment and service plan
- Residential and SNF case management
- Assist with referrals as identified in the functional assessment
- Assist with transitions of care from inpatient to community LTC and from different LTC settings.
- Authorize Medicaid LTC services
- Contract LTC residential settings and services

Medicare Advantage (MA) Dual Special Needs Plans (DSNPs):role in care coordination

Responsible to conduct an Initial Health Risk Assessment and offer care management services if indicated.

Assist with transition planning and responsible to locate and assist with scheduling post discharge appointments with providers

Coordination with the BHSO (behavioral health plan) as appropriate

Reviews/approves authorization requests for Durable Medical Equipment (DME)

Timely Prior Authorizations for medically necessary care like SNF, Home Health or other care

Track in-patient stays and identify opportunities for early intervention, assist with transitions

Responsibility for Medicare-covered benefits and to coordinate Medicare benefits and services

Offer Supplemental Benefits (vary depending on the plan) could include:

- Transportation
- PERS
- Transitional Meals
- Utilities, Over the Counter (vitamins, basic supplies), and Healthy Food Card

Not sure how to initiate care coordination or, need further support?

Regional Support is available to: MA Plans, MCOs, HCA CMs, AAAs, BHSOs

Region	Location	Contact
Region 1	North Central, Spokane, Greater Columbia and Klickitat County	Sarah Rogala Managed Care Systems Consultant sarah.rogala2@dshs.wa.gov
Region 2	North Sound, King County	Laura Botero Managed Care Systems Consultant laura.botero@dshs.wa.gov
Region 3	Salish, Thurston-Mason, Pierce, Great Rivers, Clark and Skamania	Genevieve Boyle Managed Care Systems Consultant genevieve.boyle@dshs.wa.gov

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Thank you