One Care
MassHealth+Medicare
Bringing your care together

Care Coordinator & LTS-C
Roles and Responsibilities Overview

Role / Responsibility	Care Coordinator	LTS-C
Area of Expertise	Usually Medical or Nursing background or a community health worker; Expertise in Plan Covered Services / Medical Necessity Guidelines	Usually Social Work or related background; Expertise in Community Resources, LTSS, Peer Services and Health Related Social Needs (or SDOH)
Organizational Affiliation	Part of the Health Plan	Work for Community-Based Organization
One Care member gets the resource through	Automatic with Enrollment	Care Coordinator referral – Member Choice
Care Team Member	**Yes**	**Yes** Can be a more limited role depending on member needs and Care Coordinator
Advocate for Members' Needs	**Yes** From within the Plan	**Yes** Through a Community Provider lens
In Person Visits	**Sometimes** Some Plans offer in-person Care Coordinator visits. All plans offer to do the Individualized Comprehensive Assessment in person. The Assessment is not always done by a Care Coordinator.	**Yes** Most LTS-Cs do in person visits if the member allows. Some Plans do not have LTS-Cs go in person.

Role / Responsibility	Care Coordinator	LTS-C
Conducts Assessments* *Some Care Coordinators and LTS-Cs do their assessments together at a joint home visit	**Sometimes** Plan is responsible for doing the Individualized Comprehensive Assessment and the MDS-HC – annually – Care Coordinator is often involved	**Sometimes** Most plans have LTS-Cs conduct an assessment of members LTSS and community needs
Identifies Resources to Meet Members' Medical and Behavioral Health Needs	**Yes**	**Yes** LTS-C recommends services to Care Coordinator and Member
Identifies Resources for In-Home and Community-Based Services	**Sometimes** When there is no LTS-C on the Care Team	**Yes**
Identifies Resources for Recovery Services	**Yes**	**Yes**
Authority to Authorize Eligibility for Service	**Yes** With Plan Utilization Management Team	**No**
Monitoring LTSS and Community-Based Service Provision	**Sometimes** When there is no LTS-C on the Care Team	**Yes**

*Assessments

The Minimum Data Set-Home Care (MDS-HC) – The MDS-HC assesses key domains of function, health, and service use and is used to ensure accurate rating category assignment. The MDS-HC is conducted in-person by a registered nurse and may be done at the same time as the Comprehensive Assessment.

Comprehensive Assessment – Developed by the health plan, the Comprehensive Assessment is informed by at least one in-person meeting. The Comprehensive Assessment is completed annually and informs the Individualized Care Plan. LTS-Cs may participate in the Comprehensive Assessment.

Long Term Services and Supports (LTSS) Assessments – LTS-Cs conduct an LTSS assessment for most plans when they are assigned to a member. The LTSS assessment informs the types of services and resources they work with the member on.