State Profile

Summary of Care Coordination Contract Provisions for the Arizona Long-Term Care System (ALTCS)

This summary was prepared for a study of care coordination in managed long-term services and supports programs, conducted by Truven Health Analytics for the AARP Public Policy Institute.[1] Contracts from the following states were included in the study: AZ, CA, DE, FL, HI, IL, KS, MA, MN, NJ, NM, NY, OH, RI, TN, TX, VA, and WI. The full report and contract summaries from the 18 states are available at www.aarp.org/carecoordination. The full report includes a compilation of findings across the states.

Arizona Contract Provisions

Element	Contract Requirement	Summary and Notes
Care Coordination Eligibility and Choice		
1) Which members are eligible for care coordination?	All	All members receive care coordination. The program enrolls three groups of people, all of which must meet institutional level of care requirements: older adults, people with physical disabilities, and people with developmental disabilities.
2) Can eligible members opt out of care coordination?	Not addressed in contract	
3) Can members choose or change care coordinators?	Not addressed in contract	
Care Coordinator Qualifications		
4) Are care coordinators required to have college or nursing degrees?	No	Care coordinator must have one of the following: • Social work degree; • License as a registered nurse; or • A minimum of 2 years' experience in providing case management services to older adults and/or people with physical or developmental disabilities.
5) Are care coordinators required to have experience in long-term services and supports or disability?	No	Two years of experience may be substituted for a degree, but experience is not required.

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Element	Contract Requirement	Summary and Notes
Care Coordinator Qualifications (continued)		
6) Are care coordinators required to receive training?	Yes	Contractor must conduct initial orientation and ongoing training programs for care coordinators. Topics must include case management standards, the ALTCS guiding principles, and subjects relevant to the population served, such as geriatric and/or disability issues, behavioral health, member rights, and quality management role. Specific training is required in identifying behavioral health needs.
Cultural Competency of Care Coordination		
7) Are care coordinators required to speak languages other than English when the other language is used by members?	No	Care coordination must be provided with respect for the member's and family's preferences, interests, needs, culture, language, and belief system. Care coordinators are not required to speak non-English languages.
8) Are translation/interpretation services required when a care coordinator does not speak a member's language?	Yes	Oral interpretation services must be available without cost to all members who need it, regardless of prevalence. Vital written materials must be available in a language when that language is spoken by 5 percent of members. All written materials must be available in a language when that language is spoken by 10 percent of members.
Care Coordinator Assignments, Contact Requirements, and Role		
9) Are care coordinators with certain specialties (e.g., nursing, social work, behavioral health) assigned based on the needs of members?	Yes	Contractor must assign care coordinators to meet the needs of members. Contractor must submit a plan to the State that describes the assignment method.
10) Is in-person contact required and at what frequency?	Yes	Persons receiving community long-term services and supports must be visited every 90 days. Persons in nursing facilities must be visited every 180 days.
11) Is telephonic or other remote contact required?	Yes	Initial contact may be by phone, letter, in person, or other method.
12) Must initial contact with a new member be made within a specified time period?	Yes	Initial contact (by any method) must be made within 7 business days of enrollment. An initial in-person visit is required within 12 business days of enrollment.
13) Is an assessment required at initial enrollment?	Yes	An initial in-person visit is required within 12 business days of enrollment to identify needs and begin the service planning process.
14) Is reassessment required and at what frequency?	Yes	Persons receiving community long-term services and supports must be reassessed every 90 days. Persons in nursing facilities must be reassessed every 180 days.

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Element	Contract Requirement	Summary and Notes
Care Coordinator Assignments, Contact Requirements, and Role (continued)		
15) Does the care coordinator authorize long-term services and supports?	Yes	Care coordinators must authorize services that are medically necessary and cost effective.
16) If the member chooses a participant-directed option, does the care coordinator continue to provide coordination?	Yes	Members who choose to participate in Agency with Choice or Self-Directed Attendant Care options continue to receive care coordination.
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	Care coordinators are responsible for members in transition. Contractor must specify a transition coordinator who has expertise and supports the process for all care coordinators.
18) Does the member have a single point of contact who coordinates across specialized coordinators when needed (e.g., coordinates across long-term services and supports, behavioral, medical specialists)?	Yes	Care coordinator is the single point of contact for the member.
Care Coordination Role with Family Caregivers		
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?	Other	The contract requires more generally that the needs and opinions of family be considered in development of the care plan, and that adequate information and training be provided to assist the member and family in making informed decisions and choices.
20) Does the plan of care address needs of the family caregiver raised during the assessment process?	Not addressed in contract	The contract requires that family input be considered, but does not address whether or not family caregiver needs must be addressed in the plan.
21) Are family caregivers given care coordinator contact information?	Yes	Care coordinator must provide adequate information to, and seek input from, the family.
Care Coordination Information Tools		
22) Does the care coordinator have access to centralized member records?	Not addressed in contract	
23) Does the care coordinator have access to an electronic care coordination program?	Yes	Contractor must submit a plan that describes its care coordination system. Contractor must keep certain aspects of care coordination current in the State's Client Assessment and Tracking System (CATS). Contractors may, but are not required to, enter service authorizations into CATS. If service authorizations are not entered into CATS, the contractor must maintain a uniform services tracking system in each member chart.

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Care Coordination Structures, Policy, and Oversight		
24) Are care coordination caseload ratios required?	Yes	Contractor may not exceed the care coordination caseloads established in the contract. As of 10/1/14, those were: • Community long-term services and supports: 43 • Assisted living: 53 • Nursing facility: 96 If a mixed caseload is assigned, the total weighted value may not exceed 96. Weights for each type of member are specified in the contract.
25) Does state program monitoring include a specific focus on care coordination?	Yes	Contractor must implement a systematic method of monitoring its care coordination program that includes quarterly case file audits submitted to the State.
26) Outcomes measurement: Does the model include an evaluative component, through which the outcomes of the care coordination are periodically measured?	Yes	Contractor must submit annually a care coordination plan that outlines how care coordination standards will be implemented and monitored by the contractor, including a description of the contractor's systematic method of monitoring its care coordination program. The plan must include an evaluation of care coordination from the prior year, to include lessons learned and strategies for improvement.
27) Care coordination entity	Partners permitted	The contract neither requires nor prohibits the contractor from using subcontractors to perform care coordination. All subcontracts must receive prior written approval of the State.

Contract Reviewed: Arizona Long Term Care System (ALTCS) Contract No: YH12-0001 *(contract amendment effective October 1, 2013).*

1 Saucier, P. and B. Burwell. 2015. *Care Coordination in Managed Long-Term Services and Supports.* AARP Public Policy Institute.

July 2015

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