State Profile

Summary of Care Coordination Contract Provisions for California MediConnect

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.

California Contract Provisions

Element	Contract Requirement	Summary and Notes
Care Coordination Eligibility and Choice		
1) Which members are eligible for care coordination?	All	Contractor must offer care coordination to all members and must have a system for identifying members who need it, based on a health risk assessment (HRA). All members must also have access to an Interdisciplinary Care Team (ICT) as needed. An ICT includes the primary care provider, care coordinator, and others as needed.
2) Can eligible members opt out of care coordination?	Yes	Members may choose not to participate in care coordination or the ICT process. The ICT may continue to coordinate care without the member's direct participation.
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	The contract does not specify degrees. It states that care coordination is "performed by nurses, social workers, primary care providers, if appropriate, other medical, behavioral health, or long-term services and supports professionals, and health plan care coordinators, as applicable."

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Element	Contract Requirement	Summary and Notes
Care Coordinator Qualifications (continued)		
5) Are care coordinators required to have experience in long-term services and supports or disability?	Yes	All care coordinators must have the appropriate experience and qualifications, based on members' needs. In addition, contractor must have specially designated care coordination staff trained in dementia care management and specially designated staff trained in the Multi-Purpose Senior Services Program (MSSP).
6) Are care coordinators required to receive training?	Yes	Contractor must provide training for ICT members (which includes the care coordinator) initially and on an annual basis. Required training topics include person-centered planning processes; linguistic, cultural, and cognitive competence; accessibility and accommodations; independent living and recovery and wellness principles; information about long-term services and supports programs, eligibility for long-term services and supports services, and program limitations; core concepts of the Olmstead Decision; and others.
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	Members have a right to receive medical and non-medical care from a team that meets the beneficiary's needs, in a manner that is sensitive to the beneficiary's language and culture.
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. Certain written materials must be available in all threshold languages, as defined by the State.
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 have a process for assigning a care coordinator with the appropriate experience and qualifications based on the member's assigned risk level and individual needs.
10) Is in-person contact required and at what frequency?	Not addressed in contract	
11) Is telephonic or other remote contact required?	Not addressed in contract	
12) Must initial contact with a new member be made within a specified time period?	Yes	Members who have been stratified as "higher risk" must receive an HRA within 45 days of enrollment. Members stratified as "lower risk" must receive an HRA within 90 days.
13) Is an assessment required at initial enrollment?	Yes	All members must receive an HRA, which serves as a starting point for development of an individualized care plan.
14) Is reassessment required and at what frequency?	Yes	Reassessment must be conducted annually or whenever significant changes indicate a need.

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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	Contractor must ensure that an authorized care coordinator is available 24 hours a day for timely authorization of covered services.
16) If the member chooses a participant-directed option, does the care coordinator continue to provide coordination?	Yes	Care coordinator is still responsible for overall coordination, and a social worker from the county In-Home Supportive Services (IHSS) program participates on the ICT. (IHSS is California's self-directed personal care program.)
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	Contractor must develop and implement processes for coordination of care for nursing facility residents, including care transition plans and programs to move members back into the community.
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)?	Not addressed in contract	
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	For all members, the required initial and annual HRA process must identify the participation of caregivers. Participation of caregivers must be encouraged, but the care coordinator must follow member's direction about the level of caregiver involvement. Contractor must have specially designated care coordination staff trained in dementia care, including caregiver stress and its management, and community resources for caregivers.
20) Does the plan of care address needs of the family caregiver raised during the assessment process?	Other	Participation of caregivers must be encouraged, but the care coordinator must follow member's direction about the level of caregiver involvement. Caregiver training and support are available services under the Community-Based Adult Services (CBAS) program. CBAS is one of the long-term services and supports programs for which the contractor is responsible.
21) Are family caregivers given care coordinator contact information?	Yes	Participation of caregivers must be encouraged, but the care coordinator must follow member's direction about the level of caregiver involvement.
Care Coordination Information Tools		
22) Does the care coordinator have access to centralized member records?	Yes	Contractor must have a documented process for coordinating the exchange of information among all ICT members.
23) Does the care coordinator have access to an electronic care coordination program?	Not addressed in contract	

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Care Coordination Structures, Policy, and Oversight		
24) Are care coordination caseload ratios required?	No	Caseload ratios are not specified.
25) Does state program monitoring include a specific focus on care coordination?	Yes	The contract specifies coordination-related measures that must be reported to the State. The State and Centers for Medicare and Medicaid Services are authorized under the contract to conduct audits and site visits to ensure compliance in any area.
26) Outcomes measurement: Does the model include an evaluative component, through which the outcomes of the care coordination are periodically measured?	Yes	Contractor must conduct an annual review, analysis, and evaluation of the effectiveness of the care management program processes and identify actions to be implemented to improve the quality of care and delivery of services.
27) Care coordination entity	Partners mandated	Contractor must coordinate care collaboratively in certain long-term services and supports programs that have become the contractor's responsibility, as follows: MSSP: Contractor must coordinate and work collaboratively with MSSP providers on care coordination activities in this 1915(c) waiver program. MSSP coordinators must be included on the ICTs as appropriate. IHSS Program: Contractor must coordinate with county agencies that administer this consumer-directed personal care assistant program, to facilitate participation of county social workers on ICTs as appropriate. The roles and responsibilities of the contractor and county must be articulated in a memorandum of understanding. Contractor may delegate care coordination to subcontracted health plans, health systems, and practices, but remains accountable for the function and must monitor it.

Contract Reviewed: Contract between United States Department of Health and Human Services Centers for Medicare & Medicaid Services in Partnership with California Department of Health Care Services and [name of contractor] *(not dated).*

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

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