State Profile

Summary of Care Coordination Contract Provisions for Delaware Diamond State Health Plan Plus

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.

Delaware Contract Provisions

Element	Contract Requirement	Summary and Notes
Care Coordination Eligibility and Choice		
1) Which members are eligible for care coordination?	Subset	Members in nursing facilities, or those receiving community long-term services and supports previously delivered under 1915(c) waiver programs, receive care coordination.
2) Can eligible members opt out of care coordination?	Not addressed in contract	
3) Can members choose or change care coordinators?	Yes	Subject to availability, members may request a change of care coordinator.
Care Coordinator Qualifications		
4) Are care coordinators required to have college or nursing degrees?	No	Care coordinator must have one of the following: • Bachelor's degree in health, human services, social work, or education with one or more years of qualifying experience; • High school degree or equivalent and 3 years of qualifying experience; • RN license; or • LPN with 2 years of qualifying experience with appropriate supervision.

(continued)

AARP Real Possibilities
Public Policy Institute

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	Qualifying experience includes case work practices and policy and the needs of the populations being served.
6) Are care coordinators required to receive training?	Yes	Care coordinators must receive adequate orientation and ongoing training relevant to the populations served that includes classroom instruction and mentoring.
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 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. Written materials must be available in Spanish, and in any other language that is prevalent in the State, as determined through a methodology described by the contractor.
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	Care coordinators assigned to special subpopulations, such as individuals with AIDS or traumatic brain injury, must have experience or training in case management techniques for those populations.
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 must be made within 7 business days of enrollment, and 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 must be made within 7 business days of enrollment.
13) Is an assessment required at initial enrollment?	Yes	An initial in-person visit is required within 10 business days of enrollment to identify needs and develop a service plan, or to review services if already receiving at time of enrollment.
14) Is reassessment required and at what frequency?	Yes	Persons receiving community long-term services and supports or alternative residential services must be reassessed every 90 days. Persons in nursing facilities must be reassessed every 180 days.
15) Does the care coordinator authorize long-term services and supports?	Not addressed in contract	

(continued)

Element	Contract Requirement	Summary and Notes
Care Coordinator Assignments, Contact Requirements, and Role (continued)		
16) If the member chooses a participant-directed option, does the care coordinator continue to provide coordination?	Yes	Care coordinator remains responsible for overall coordination. The member has the option of being referred to a supports broker at a community agency who specializes in helping consumers plan and obtain participant-directed services.
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 coordinator may authorize transitional services and must document them in the service plan and report them to the State.
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.
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 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	
21) Are family caregivers given care coordinator contact information?	Not addressed in contract	
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?	Not addressed in contract	
Care Coordination Structures, Policy, and Oversight		
24) Are care coordination caseload ratios required?	Yes	Care coordination must be provided at a level dictated by the complexity and required needs of the member. Contractors must describe their caseload policy in a plan submitted to the State, not to exceed the following: • Community long-term services and supports, including own home and assisted living: 60 • Nursing facility: 120 • Members in Money Follows the Person program: 30
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.

(continued)

Element	Contract Requirement	Summary and Notes
Care Coordination Structures, Policy, and Oversight (continued)		
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.

Contract Reviewed: Delaware Medicaid Managed Care Program (MMC), DPCI Amendments 4 *(December 22, 2011)* and 5 *(April 2012).*

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

July 2015

601 E Street, NW
Washington DC 20049

Follow us on Twitter @AARPpolicy
on facebook.com/AARPpolicy
www.aarp.org/ppi

For more reports from the Public Policy Institute, visit http://www.aarp.org/ppi/.

AARP® Real Possibilities
Public Policy Institute