State Profile

Summary of Care Coordination Contract Provisions for Massachusetts One Care

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.

Massachusetts One Care Contract Provisions

Element	Contract Requirement	Summary and Notes
Care Coordination Eligibility and Choice		
1) Which members are eligible for care coordination?	All	Care coordination is offered to all members. Those with long-term services and supports needs have both a clinical care manager and an independent living-long-term services and supports coordinator (IL-LTSS).
2) Can eligible members opt out of care coordination?	Not addressed in contract	
3) Can members choose or change care coordinators?	Yes	Enrollees must be offered a choice of at least two care coordinators.
Care Coordinator Qualifications		
4) Are care coordinators required to have college or nursing degrees?	Other	Required credentials vary by role. The clinical care manager must be a licensed registered nurse or other licensed professional. The IL-LTSS coordinator must have either a bachelor's degree in social work or human services, *or* at least 2 years' experience working with populations eligible to participate in One Care.
5) Are care coordinators required to have experience in long-term services and supports or disability?	Yes	IL-LTSS coordinators must have experience working with people with disabilities or older people in need of long-term services and supports.

(continued)

AARP Real Possibilities
Public Policy Institute

Element	Contract Requirement	Summary and Notes
Care Coordinator Qualifications (continued)		
6) Are care coordinators required to receive training?	Yes	Training is required and must include person-centered planning, cultural competence, accessibility and accommodations, independent living and recovery, and wellness.
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 second languages.
8) Are translation/interpretation services required when a care coordinator does not speak a member's language?	Yes	Contractor must have the capacity to meet the needs of the linguistic groups in its service area.
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	Persons with complex care needs must be assigned a clinical care manager.
10) Is in-person contact required and at what frequency?	Yes	Comprehensive in-person assessments of members must be conducted annually.
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	Initial contact for a comprehensive assessment is required for each member within 90 days of enrollment.
13) Is an assessment required at initial enrollment?	Yes	A comprehensive assessment is required for each member within 90 days of enrollment.
14) Is reassessment required and at what frequency?	Yes	Reassessment must be conducted annually, or whenever a significant change occurs.
15) Does the care coordinator authorize long-term services and supports?	Not addressed in contract	
16) If the member chooses a participant-directed option, does the care coordinator continue to provide coordination?	Yes	Care coordination model is the same whether the consumer chooses participant-direction or not.
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?	Other	Contractors must assign staff to persons who are in institutions and candidates for discharge, but the staff may be different from the care coordinators.

(continued)

Element	Contract Requirement	Summary and Notes
Care Coordinator Assignments, Contact Requirements, and Role (continued)		
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	The care coordinator employed by the contractor is designated as the single point of contact for the member. Members with long-term services and supports needs may also contact the IL-LTSS coordinator.
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 Comprehensive Assessment must include an assessment of "caregiver needs," but the contract does not require that family caregivers be asked directly about their own needs.
20) Does the plan of care address needs of the family caregiver raised during the assessment process?	Yes	Caregiver needs are required to be addressed in the care planning process.
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?	Yes	All members of the interdisciplinary care team must have access to the Centralized Enrollee Record, including the IL-LTSS coordinator.
23) Does the care coordinator have access to an electronic care coordination program?	Not addressed in the contract	
Care Coordination Structures, Policy, and Oversight		
24) Are care coordination caseload ratios required?	No	Ratios are not required in the contract.
25) Does state program monitoring include a specific focus on care coordination?	Yes	Oversight of care management practices is part of an umbrella requirement for quality management of all covered benefits. Contractors must submit measures related to care coordination.
26) Outcomes measurement: Does the model include an evaluative component, through which the outcomes of the care coordination are periodically measured?	Yes	Contractor, at the request of the State or CMS, must conduct the Home- and Community-Based Services Experience Survey, which includes questions about the care coordination experience.
27) Care coordination entity	Partners mandated	Contractors must contract with Independent Living Centers and Aging Services Access Points (ASAPs) for the IL-LTSS role. Enrollees over the age of 60 must have the option of receiving IL-LTSS coordinator services through an ASAP.

Contract Reviewed: Contract between United States Department of Health and Human Services, Centers for Medicare & Medicaid Services, in Partnership with the Commonwealth of Massachusetts and Commonwealth Care Alliance, Inc., Fallon Community Health Plan and Network Health, LLC *(July 11, 2013).*

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