State Profile

Summary of Care Coordination Contract Provisions for Massachusetts Senior Care Options

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 Senior Care Options Contract Provisions

Element	Contract Requirement	Summary and Notes
Care Coordination Eligibility and Choice		
1) Which members are eligible for care coordination?	Other	Care coordination is provided by a primary care physician or a primary care team (PCT) to all members with complex care needs. Persons with long-term services and supports needs are also assigned a geriatric social services coordinator (GSSC). The GSSC is part of the PCT.
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?	Yes	GSSC must be a licensed social worker in Massachusetts (which requires a degree) *or* have a bachelor's degree with 2 years of professional experience.
5) Are care coordinators required to have experience in long-term services and supports or disability?	Yes	GSSC must have continuing education units in geriatric practice or 2 years of professional experience in the care of persons over the age of 65, with at least 1 year involving work in a medical setting.

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Element	Contract Requirement	Summary and Notes
Care Coordinator Qualifications (continued)		
6) Are care coordinators required to receive training?	Yes	GSSC must have annual continuing education units in geriatric practice.
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	Contractor must be responsive to linguistic, cultural, ethnic, or other unique needs of members, but 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	Both oral and written materials must be provided to members as needed.
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?	Not addressed in contract	
10) Is in-person contact required and at what frequency?	Yes	For members with complex care needs, the assessment process must include an in-home component.
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 member assessment and orientation must be conducted within 30 days of enrollment.
13) Is an assessment required at initial enrollment?	Yes	The initial assessment must be scheduled within 5 business days of the effective date of enrollment and conducted no later than 30 calendar days after the member's choice of PCP has been made.
14) Is reassessment required and at what frequency?	Yes	Reassessments must be conducted: • Every 6 months; *or* • When the member requires complex care, at least quarterly; *or* • Whenever a member experiences a major change.
15) Does the care coordinator authorize long-term services and supports?	Other	Care coordinator executes authorizations made by the PCT.
16) If the member chooses a participant-directed option, does the care coordinator continue to provide coordination?	Not addressed in contract	
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 have written protocols for tracking and coordinating transitions of all types.

(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	Formally, the PCT is the point of contact for the member. The care coordinator is a member of the team and may act as 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	In the quality management section of the contract, contractors are required to conduct a survey or focus group of family members to assess the contractor's performance in supporting family members and significant others. Also, contractor must implement a Management of Dementia initiative, which includes educational programming for significant caregivers.
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?	Yes	Centralized Enrollee Record must be accessible to all members of the PCT.
23) Does the care coordinator have access to an electronic care coordination program?	Yes	Contractor must ensure effective linkages of clinical and care management information.
Care Coordination Structures, Policy, and Oversight		
24) Are care coordination caseload ratios required?	No	The contract does not specify ratios.
25) Does state program monitoring include a specific focus on care coordination?	Not addressed in contract	
26) Outcomes measurement: Does the model include an evaluative component, through which the outcomes of the care coordination are periodically measured?	Other	Contractor must conduct annual surveys of members, which may include questions on care coordination.
27) Care coordination entity	Partners mandated	Contractors must contract with Aging Services Access Points for GSSC services.

Contract Reviewed: MassHealth Senior Care Options Attachment A: Contract for Senior Care Organizations *(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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