State Profile

Summary of Care Coordination Contract Provisions for the New Jersey FamilyCare, MLTSS Program[1]

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.[2] 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.

New Jersey Contract Provisions

Element	Contract Requirement	Summary and Notes
Care Coordination Eligibility and Choice		
1) Which members are eligible for care coordination?	All	All members in the managed long-term services and supports (MLTSS) program 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	Contractor must have a process for receiving and acting on requests for new care coordinators.
Care Coordinator Qualifications		
4) Are care coordinators required to have college or nursing degrees?	Yes	Care coordinators must have a degree and be licensed as a social worker or registered nurse, or have a bachelor's degree in a health-related or behavioral science field, with a minimum of 1 year paid professional experience working directly with older people or people with physical disabilities in an institutional or community setting.
5) Are care coordinators required to have experience in long-term services and supports or disability?	No	Long-term services and supports/disability experience is not required, though knowledge *or* experience is required in the needs and service delivery system for all populations in the care coordinator's caseload.

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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 provide initial and ongoing training for care coordinators in topics such as person-centered service planning, long-term services and supports benefits, provider network, community resources, cultural competency, behavioral health, consumer direction, and Preadmission Screening and Resident Review (PASRR) process.
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 in a culturally relevant manner, and cultural competency is a required training topic. 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 must be available without cost to all members who need it, regardless of prevalence. Translated written materials must be available for any group that meets a threshold of 5 percent of members or 200 members, whichever is greater.
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 ensure that the care coordination provided meets the needs of individual members.
10) Is in-person contact required and at what frequency?	Yes	In-person contact requirements vary by setting, as follows: • At least every 180 calendar days for members in non-pediatric nursing facilities or community alternative residential settings; and • At least every 90 calendar days for members residing in community settings or pediatric nursing facilities. In addition, the care coordinator must conduct an on-site visit within 3 business days following a member's discharge to a home- and community-based services setting.
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	Within 5 business days of the effective date of a new member's enrollment, the contractor must initiate contact to establish a time for a face-to-face visit. The face-to-face visit must be completed within 10 calendar days of enrollment.
13) Is an assessment required at initial enrollment?	Yes	Contractor must review the assessment conducted by the State's level-of-care assessment system, complete the initial face-to-face visit, and develop an individualized plan of care.

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Element	Contract Requirement	Summary and Notes
Care Coordinator Assignments, Contact Requirements, and Role (continued)		
14) Is reassessment required and at what frequency?	Yes	Reassessment must be conducted at least annually, or whenever the needs of a member change.
15) Does the care coordinator authorize long-term services and supports?	Yes	Care coordinators authorize long-term services and supports services within the cost-effectiveness limits established by the State.
16) If the member chooses a participant-directed option, does the care coordinator continue to provide coordination?	Yes	Contractor's care coordinator remains responsible for overall coordination and must ensure that the care coordinator's functions do not duplicate the functions performed by the fiscal/employer agent, which manages payroll, tax, and program compliance functions.
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 leads the interdisciplinary team process, which includes assessing transitional service needs, authorizing and procuring assessed transitional services, and coordinating the development of the transition plan. The care coordinator must coordinate with the State's designated transition office as part of the planning process.
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	Contractor must ensure that, upon a member's entry into the MLTSS program, the care coordinator assumes primary responsibility for coordination of all the member's physical health, behavioral health, and long-term services and supports needs.
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	Care coordinator must ensure that, with the member's permission, caregivers are involved in developing the plan of care.
20) Does the plan of care address needs of the family caregiver raised during the assessment process?	Other	Caregiver training is a covered service and can be included in the plan of care when needed. Other caregiver needs are not addressed in the 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	Contractor must maintain an electronic system that can receive and index member-level information from multiple sources, including the State's level-of-care assessment system.
23) Does the care coordinator have access to an electronic care coordination program?	Yes	Contractor must develop and maintain an electronic case management system.

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Element	Contract Requirement	Summary and Notes
Care Coordination Structures, Policy, and Oversight		
24) Are care coordination caseload ratios required?	Yes	Care coordinator caseloads may not exceed a weighted average of 120. Maximum varies by setting, as follows: • Nursing facility: 240 • Community alternative residential setting: 120 • Home- and community-based services: 60
25) Does state program monitoring include a specific focus on care coordination?	Yes	Contractor must monitor the care coordination process on an ongoing basis and make regular reports to the State and/or external quality review organization, including several care coordination–related measures. The State may conduct on-site audits at its discretion.
26) Outcomes measurement: Does the model include an evaluative component, through which the outcomes of the care coordination are periodically measured?	Yes	An evaluation of the Contractor's Managed Long-Term Services and Supports Care Management Plan from the previous year shall be included in an annual submission of a comprehensive written Managed Long-Term Services and Supports Care Management Program Description, highlighting 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. If subcontractors are proposed, the contractor must submit its proposed subcontract and oversight plan to the State for review and approval prior to implementing the services of the subcontractor.

Contract Reviewed: Contract between State of New Jersey Department of Human Services, Division of Medical Assistance and Health Services, and [name of contractor] *(July 2014, v.2, accepted).*

1 New Jersey refers to care coordinators as care managers.

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

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601 E Street, NW
Washington DC 20049

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