State Profile

Summary of Care Coordination Contract Provisions for New Mexico Centennial 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.

New Mexico Contract Provisions

Element	Contract Requirement	Summary and Notes
Care Coordination Eligibility and Choice		
1) Which members are eligible for care coordination?	All	All members receive some level of care coordination, based on the results of a health-risk assessment (HRA). Level 1 is minimal coordination provided to members with no significant health risks. If the HRA indicates risk, a comprehensive needs assessment is completed, and members are categorized for Level 2 or Level 3 care coordination, depending on risk level. For example: Members needing assistance with two or more activities of daily living (ADL) or instrumental activities of daily living (IADLs) and living in the community are categorized as Level 2 if low risk, and Level 3 if medium to high risk.
2) Can eligible members opt out of care coordination?	Yes	Members can elect to opt out of care coordination, but are strongly encouraged to participate.
3) Can members choose or change care coordinators?	Yes	To the extent available, contractor must honor members' requests to change care coordinator.
Care Coordinator Qualifications		
4) Are care coordinators required to have college or nursing degrees?	Yes	Care coordinators who perform comprehensive assessments must have bachelor's degrees in nursing, social work, or other health care profession.
5) Are care coordinators required to have experience in long-term services and supports or disability?	Yes	Care coordinators must have relevant experience. Care coordinators with self-directing members must have experience with self-direction.

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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 training for new care coordinators and annual training on several topics outlined in the contract. Contractors should use trainers from New Mexico Tribes as appropriate, though not all Native Americans are required to utilize managed-care services for certain types of Medicaid coverage.
Cultural Competency of Care Coordination		
7) Are care coordinators required to speak languages other than English when the other language is used by members?	Yes	Contractor must recruit and train a diverse staff that is representative of member demographics. All staff are required to take cultural competency training.
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 a language when that language is spoken by 5 percent of members, except for Native American languages that do not have a written form, or for which the State has not received permission from the Tribe to use the language.
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 submit an annual plan that describes its method for assigning care coordinators in a manner that meets the needs of the population. In most cases, the member will be assigned to a care coordinator who specializes in the member's identified needs or an additional care coordinator will be assigned to co-manage the member's specific need.
10) Is in-person contact required and at what frequency?	Yes	The care coordinator must have in-person meetings at the following minimum frequency: • Level 2 members: twice a year • Level 3 members: quarterly
11) Is telephonic or other remote contact required?	Yes	Care coordinator must have as much contact as needed to meet the member's needs, but no less than the following: • Level 2 members: quarterly phone contact • Level 3 members: monthly phone contact
12) Must initial contact with a new member be made within a specified time period?	Yes	The HRA must be completed within 10 days of enrollment, and may be in person or by phone.
13) Is an assessment required at initial enrollment?	Yes	The HRA must be completed within 10 days of enrollment for all members, and may be in person or by phone. As indicated by the HRA, each member categorized as Level 2 or Level 3 must have a comprehensive needs assessment scheduled within 14 calendar days and completed within 30 calendar days of the HRA.

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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 occur at least annually, or more frequently if needed or if requested by the member, primary care provider, or other provider.
15) Does the care coordinator authorize long-term services and supports?	No	Care coordinator does not authorize any long-term services and supports or related services.
16) If the member chooses a participant-directed option, does the care coordinator continue to provide coordination?	Yes	Care coordinator must inform and educate the member regarding all aspects of the Self-Directed Community benefit and if chosen, assist the member in implementing the option.
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	For members who are candidates for transition (based on several possible indicators), the care coordinator must complete a transition plan.
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	Level 2 and Level 3 members must all be assigned to specific care coordinators who serve as their points 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?	Not addressed in contract	
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?	Yes	Care coordinators must provide information about their role to all members, providers, and any authorized caregivers and encourage communication.
Care Coordination Information Tools		
22) Does the care coordinator have access to centralized member records?	Yes	Contractor must be able to identify unique members across information systems and link/merge information at the member level.
23) Does the care coordinator have access to an electronic care coordination program?	Yes	Contractor must 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	Maximum caseloads are as follows: • Level 2 members: 75 • Level 3 members: 50 • Self-directing members: 40 Contractor is expected to reduce these maximums as needed to accommodate travel for care coordinators in frontier areas.
25) Does state program monitoring include a specific focus on care coordination?	Yes	Contractor must submit several quarterly reports to the State, including care coordination, transitions, level of care, long-term services and supports provided, and care coordination caseloads and staffing ratios.
26) Outcomes measurement: Does the model include an evaluative component, through which the outcomes of the care coordination are periodically measured?	Yes	Contractor must have a comprehensive system for monitoring care coordination, remediating issues, identifying systemic problems and strategies for addressing them, and measuring success of the program.
27) Care coordination entity	Partners mandated	Contractors are directed to use several types of local entities as part of their care coordination capacity, including the Indian Health Service, Tribal health providers, Urban Indian providers, patient-centered medical homes, health homes, core service agencies, and community health workers.

Contract Reviewed: Medicaid Managed Care Services Agreement among New Mexico Human Services Department, New Mexico Behavioral Health Purchasing Collaborative, and Molina Healthcare of New Mexico *(PSC 13-630-8000-0022) (to provide Centennial Care services beginning on January 1, 2014).*

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

July 2015

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