State Profile

Summary of Care Coordination Contract Provisions for the New York Managed Long-Term Care Partial Capitation Program

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 York 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 this program have long-term services and supports needs, and all are eligible for care coordination.
2) Can eligible members opt out of care coordination?	No	In order to qualify for the program, a person must require care coordination, and it must be provided to all members.
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	Contractor describes care coordinators as "health care professionals" and provides the following examples: physicians, nurses, social workers, and therapists.
5) Are care coordinators required to have experience in long-term services and supports or disability?	No	Experience requirements are not specified in the contract.
6) Are care coordinators required to receive training?	Yes	The contract specifies training for staff to ensure compliance and to address sensitivity and attitudinal barriers related to disability.

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Element	Contract Requirement	Summary and Notes
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 prevalent language in the contractor's service area, defined as 5 percent or more of the population.
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 assign care coordinators to meet the needs of members.
10) Is in-person contact required and at what frequency?	Yes	The contract requires an in-person comprehensive assessment of need every 6 months.
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?	Not addressed in contract	
13) Is an assessment required at initial enrollment?	Yes	Care coordinator is responsible for assessment at initial enrollment of the member.
14) Is reassessment required and at what frequency?	Yes	A reassessment must be conducted when the member needs it or at least every 6 months.
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?	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?	Not addressed in contract	
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)?	Not addressed in contract	

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Element	Contract Requirement	Summary and Notes
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 info?	Not addressed in contract	
Care Coordination Information Tools		
22) Does the care coordinator have access to centralized member records?	Yes	Contractor's care management system must provide access to clinical and service plan information.
23) Does the care coordinator have access to an electronic care coordination program?	Yes	Contractor's care management system must include automated information systems.
Care Coordination Structures, Policy, and Oversight		
24) Are care coordination caseload ratios required?	No	Contract does not mandate ratios.
25) Does state program monitoring include a specific focus on care coordination?	Yes	Contractor must maintain care management records and make them available to the State with 2 business days' notice.
26) Outcomes measurement: Does the model include an evaluative component, through which the outcomes of the care coordination are periodically measured?	Yes	Contractor is required to have a quality management process to review the effectiveness of care coordination functions, including assessment, service planning, monitoring, etc.
27) Care coordination entity	Partners permitted	The contract neither requires nor prohibits the contractor from using subcontractors to perform care coordination.

Contract Reviewed: Managed Long-Term Care Partial Capitation Contract *(January 1, 2012–December 31, 2014).*

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

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