State Profile

Summary of Care Coordination Contract Provisions for the Ohio MyCare 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.

Ohio 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 risk-stratification process, through which individuals are assigned to one of five risk-stratification levels: intensive, high, medium, low, and monitoring. Each contractor establishes the criteria and thresholds used for each risk level. Contractor assigns a care coordinator who is the accountable point of contact for a member. A member receiving home- and community-based services also is assigned a waiver service coordinator at an Area Agency on Aging, which provides the coordinator as a subcontractor to the health plan. A member who receives services through a Medicaid Behavioral Health Home can elect to receive care coordination through the health home, which provides the coordination as a delegated provider within the health plan's network.
2) Can eligible members opt out of care coordination?	Other	Care coordination must be offered to all members. Members receiving home- and community-based services must receive care coordination. Others may opt out of care coordination.
3) Can members choose or change care coordinators?	Yes	Contractor must have a process in place that enables a member to request a change of care coordinator.

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Element	Contract Requirement	Summary and Notes
Care Coordinator Qualifications		
4) Are care coordinators required to have college or nursing degrees?	No	Contract requires contractors to ensure that staff who are completing care management functions are operating within professional scope of practice, are appropriate for responding to beneficiaries' needs, and follow state licensure/credentialing requirements.
5) Are care coordinators required to have experience in long-term services and supports or disability?	Yes	Care coordinators for members receiving home- and community-based services waiver services must have experience in long-term services and supports/disability.
6) Are care coordinators required to receive training?	Yes	Care coordinators must participate in professional training sessions on an annual basis on numerous topics, including person-centered planning, self-direction, cultural and disability competence, communication, accessibility and accommodations, independent living and recovery, wellness principles, Americans with Disabilities Act/Olmstead requirements, and other topics as specified by the state.
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	
8) Are translation/interpretation services required when a care coordinator does not speak a member's language?	Yes	If required by the member, translation services must be provided at no cost to the member.
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 is responsible for ensuring that staff who are completing care coordination functions are appropriate for responding to members' needs.
10) Is in-person contact required and at what frequency?	Yes	Minimum in-person contact schedule is prescribed for each of the five risk-stratification levels, but more contact should be provided if needed by the member. Contact requirements are more frequent during a member's initial 6 months of enrollment and then decline to the following minimums: • Monitoring risk level: annual • Low risk level: semiannual • Medium risk level: quarterly • High risk level: every other month • Intensive level: monthly

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Element	Contract Requirement	Summary and Notes
Care Coordinator Assignments, Contact Requirements, and Role (continued)		
11) Is telephonic or other remote contact required?	Yes	Telephone contact supplements in-person visits and also varies by the risk-stratification level of the member. After the first 6 months of an individual's enrollment, members must receive the following minimums: • Monitoring risk level: semiannual • Low risk level: quarterly • Medium risk level: monthly • High risk level: monthly • Intensive level: as needed between visits
12) Must initial contact with a new member be made within a specified time period?	Yes	Initial contact is required in accordance with the contact schedule that applies to a member's first 6 months of enrollment, which varies by risk-stratification level.
13) Is an assessment required at initial enrollment?	Yes	Assessments are required for all newly enrolled members, and the time frame varies by the risk-stratification level of the member. Members in the monitoring and low risk levels must be assessed within 75 days, those in the medium risk level must be assessed within 60 days, and those in the high and intensive risk levels must be assessed within 15 days.
14) Is reassessment required and at what frequency?	Yes	Reassessments must be conducted annually, and updates to the assessment must be made as needed.
15) Does the care coordinator authorize long-term services and supports?	Other	A waiver service coordinator develops the waiver services plan with the member. Each contractor establishes its own process for approving services and may empower qualified waiver service coordinators or care coordinators to authorize services.
16) If the member chooses a participant-directed option, does the care coordinator continue to provide coordination?	Yes	Contractor must promote self-direction to members enrolled in waiver services, and remains responsible for coordination of services when members choose self-direction.
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	In order for a member to access the Ohio Home Choice Program, the care coordinator must refer the member (if agreed to by member) to the Ohio Home Choice Program. The care coordinator works with the home choice transition coordinator to perform the required activities to support a successful transition. Services provided by the home choice transition coordinator cannot be duplicative of those already provided by the care coordinator.
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	All members have a care coordinator who is the accountable point of contact and responsible for overall coordination. The care coordinator is supported by a trans-disciplinary care team, which comprises the waiver service coordinator, providers, the beneficiary, family members, caregivers, and other parties as needed.

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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?	Other	The contract requires more generally that caregiver status and capabilities be determined as part of the assessment process. These domains are also evaluated and considered in the development and implementation of the waiver service plan.
20) Does the plan of care address needs of the family caregiver raised during the assessment process?	Yes	Yes, if needs are identified as part of assessment process.
21) Are family caregivers given care coordinator contact information?	Yes	Care manager contact information is documented in the care plan, which is given to the member's family caregivers with the consent of the member.
Care Coordination Information Tools		
22) Does the care coordinator have access to centralized member records?	Yes	Contractor must use information technology systems and processes to integrate multiple data elements into a single, centralized, comprehensive record for each member.
23) Does the care coordinator have access to an electronic care coordination program?	Yes	Contractor must have a care management system that captures, at a minimum, results of the assessment, the content of the integrated care plan, and member/provider contact notes.
Care Coordination Structures, Policy, and Oversight		
24) Are care coordination caseload ratios required?	Yes	Caseload ranges are mandated and vary by the risk-stratification level of the member as follows: • Intensive risk: 1:25–1:50 • High risk: 1:51–1:75 • Medium risk: 1:76–1:100 • Low risk: 1:101–1:250 • Monitoring risk: 1:251–1:350
25) Does state program monitoring include a specific focus on care coordination?	Yes	Contractor must submit a description of the care coordination model, assessment tools, staffing model, care plan templates, etc., for review and approval by the State. Contractors must submit electronic care coordination data as specified by the State, including performance measures related to care coordination. Documentation submitted by contractors, as well as care coordination records, are subject to review and audit by the State and/or the external quality review organization.
26) Outcomes measurement: Does the model include an evaluative component, through which the outcomes of the care coordination are periodically measured?	Yes	Contractors are required to conduct evaluations of their care coordination systems with regard to health outcomes, consumer satisfaction, quality of life, independent living status, functional status, hospital and emergency rates, preventable admissions, etc. Results must be produced for the overall program and by each stratification level. Results must be made available to the State upon request.

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Element	Contract Requirement	Summary and Notes
Care Coordination Structures, Policy, and Oversight (continued)		
27) Care coordination entity	Partners mandated	Contractors are accountable for the provision of comprehensive care coordination services to all beneficiaries enrolled in the plan, and may delegate any or all parts of care coordination. For members who are enrolled in certified Medicaid Behavioral Health Homes, the contractor must allow those members to receive care coordination directly from the health home. For members who are 60 or older receiving home and community-based services, a waiver service coordinator role must be subcontracted to Area Agencies on Aging and a second qualified entity. For members under the age of 60, contractors may provide waiver service coordination directly, or subcontract to an entity with experience in disability services, including an Area Agency on Aging.

Contract Reviewed: Contract between United States Department of Health and Human Services Centers for Medicare & Medicaid Services, in Partnership with the State of Ohio Department of Medicaid and [name of contractor] *(February 11, 2014). Also reviewed:* MyCare Ohio Plan Provider Agreement, *rev. January 2015.*

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

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