State Profile

Summary of Care Coordination Contract Provisions for Virginia Commonwealth Coordinated 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.

Virginia Contract Provisions

Element	Contract Requirement	Summary and Notes
Care Coordination Eligibility and Choice		
1) Which members are eligible for care coordination?	All	
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	Care coordinators must either have a bachelor's degree or be a registered nurse (RN) with at least 1 year of experience working as an RN.
5) Are care coordinators required to have experience in long-term services and supports or disability?	Yes	Care coordinators must have demonstrated ability to communicate with members who have complex medical needs and may have communication barriers, and also must have experience navigating resources and computer systems to access information.

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Element	Contract Requirement	Summary and Notes
Care Coordinator Qualifications (continued)		
6) Are care coordinators required to receive training?	Yes	Care coordinators must have training initially and annually on person-centered planning processes, cultural competence, accessibility and accommodations, independent living and recovery, Americans with Disabilities Act/Olmstead requirements, and wellness principles, along with other required training, 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?	No	Care coordinator must develop a culturally competent plan of care tailored to the member's needs and preferences, but is not required to be proficient in the language of the member.
8) Are translation/interpretation services required when a care coordinator does not speak a member's language?	Yes	Contractor must notify members that oral interpretation is available for any language at no cost to members, and that translations of written information are available in prevalent languages. A prevalent language is one used by at least 5 percent of members.
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	The initial assessment must be conducted face-to-face within 30 days of enrollment for home- and community-based services members, and within 60 days for nursing facility members. Additional in-person contacts must be made as appropriate, but are not specified.
11) Is telephonic or other remote contact required?	No	Contact must be made as needed to meet the needs of the member, but frequency is not specified.
12) Must initial contact with a new member be made within a specified time period?	Yes	Contractor must provide an orientation to members within 30 calendar days of enrollment.
13) Is an assessment required at initial enrollment?	Yes	All new members must receive a health risk assessment within the following time frames: • 30 days for home- and community-based services waiver members; • 60 days for nursing facility members and other vulnerable members; and • 90 days for all other members.
14) Is reassessment required and at what frequency?	Yes	Nursing facility members must be reassessed in accordance with Minimum Data Set guidelines (quarterly updates). All other members must be reassessed annually or whenever the member has a significant change.
15) Does the care coordinator authorize long-term services and supports?	Not addressed in contract	

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Element	Contract Requirement	Summary and Notes
Care Coordinator Assignments, Contact Requirements, and Role (continued)		
16) If the member chooses a participant-directed option, does the care coordinator continue to provide coordination?	Yes	Care coordinator continues to coordinate the overall plan of care and must work with the fiscal/employer agent and other parties as needed to delineate the roles and responsibilities of the parties.
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?	No	Care coordinator may make a referral to the Money Follows the Person (MFP) Program. If the individual enrolls in MFP, he or she will be disenrolled from the managed long-term services and supports program.
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	Care coordinator must act as a single point of contact for both the member and the Interdisciplinary Care Team (ICT).
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, with the permission of the member, family caregivers should be involved in the planning process and provide information relevant to the member's needs.
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	The ICT must maintain the member record, including but not limited to appropriate and timely entries about the care provided, diagnoses determined, medications prescribed, and treatment plans developed for each member.
23) Does the care coordinator have access to an electronic care coordination program?	Not addressed in contract	
Care Coordination Structures, Policy, and Oversight		
24) Are care coordination caseload ratios required?	No	Contractor must maintain staffing levels necessary to perform its responsibilities and meet the needs of members.
25) Does state program monitoring include a specific focus on care coordination?	Yes	Contractor must submit measures to the State, several of which include components of care coordination, such as timely assessments and plans of care and coordination of benefits. The State may conduct audits at its discretion.

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Element	Contract Requirement	Summary and Notes
Care Coordination Structures, Policy, and Oversight (continued)		
26) Outcomes measurement: Does the model include an evaluative component, through which the outcomes of the care coordination are periodically measured?	Other	Contractor must have an internal monitoring and performance improvement system, but care coordination is not specified as an area for evaluation.
27) Care coordination entity	Partners mandated	In general, contractor may employ or contract for care managers and other staff. In addition, the following relationships are required: • Contractor must contract with behavioral health homes for members with serious and persistent mental illness; • Contractor must contract with local entities that currently perform case management for certain members with intellectual disabilities, mental illness, or substance abuse; • Contractor may contract with other community entities, including adult day care centers and nursing facilities.

Contract Reviewed: Contract between United States Department of Health and Human Services Centers for Medicare & Medicaid Services in Partnership with the Commonwealth of Virginia Department of Medical Assistance Services and [name of contractor] *(December 4, 2013).*

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

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