CARE COORDINATION: CONTRACT EXAMPLES

Below are a few examples of contract language, which highlight the varying approaches to care coordination in MLTSS programs.

- The first example is from the Massachusetts Senior Care Options contract, which highlights three different topics and approaches: (1) requiring a subcontract with a traditional care coordination agency, specifically with a group in the MA aging network, (2) providing a detailed description of the care integration and coordination expectations of the contractors, and (3) expecting care coordination to go beyond covered services.

- The second example is from the Minnesota Senior Health Options (MSHO) contract where the provisions for care coordination reflect the program's design as a fully integrated Medicare and Medicaid product.

- The third example is from New York and highlights the state's specific requirements for coordinating care for services and supports that are beyond those covered in the MLTSS program.

- The final example is from Wisconsin's Family Care contract with MCOs, which requires coordination of formal, informal, health, and LTSS, regardless of whether or not those services and supports are included in the Family Care program. Contract language is also included that shows that WI expects care coordination to be member centered and a team responsibility.

Massachusetts Senior Care Options

From MassHealth Senior Care Options, Attachment A, Contract for Senior Care Organizations, Section 2.4 Care Management and Integration.

5. Geriatric Support Services Coordinator (GSSC)
The Contractor must establish its own written qualifications for a GSSC and provide a GSSC through a contract with one or more of the ASAPs [Aging Services Access Point] designated by the Executive Office of Elder Affairs that operate in the Contractor's Service Area. If more than one ASAP is operating in the Contractor's Service Area, the Contractor may:

- Contract with all of the ASAPs; or

- Contract with a lead- ASAP to coordinate all the GSSC work in the Contractor's Service Area…

6. Integration and Coordination of Services

The Contractor must ensure effective linkages of clinical and management information systems among all Providers in the Provider Network, including clinical Subcontractors (that is, acute, specialty, behavioral health, and long term care Providers). The Contractor must ensure that the PCP or the PCT integrates and coordinates services including, but not limited to:

a. An Individualized Plan of Care for each Enrollee, signed by the Enrollee or the Enrollee's representative, developed by the PCP or, if applicable, the PCT, and the periodic review and modification of this treatment plan by the PCP or PCT;
b. Written protocols for generating or receiving referrals and for recording and tracking the results of referrals;
c. Written protocols for providing or arranging for second opinions, whether in or out of network;
d. Written protocols for sharing clinical and Individualized Plan of Care information, including management of medications;
e. Written protocols for determining conditions and circumstances under which specialty services will be provided appropriately and without undue delay to Enrollees who do not have established Complex Care Needs (for example, GSSC and specialty physician services);
f. Written protocols for tracking and coordination of Enrollee transfers from one setting to another...and ensuring continued provision of necessary services; and
g. Written protocols for obtaining and sharing individual medical and care planning information among the Enrollee's caregivers in the Provider Network, and with CMS and EOHHS for quality management and program evaluation purposes…

12. Coordinating Services with Federal, State, and Community Agencies

a. The Contractor must implement a systematic process for coordinating care and creating linkages for services for its Enrollees with organizations not providing Covered Services including, but not limited to:
    1) State agencies (for example, the Executive Office of Elder Affairs, the Department of Public Health, the Department of Mental Retardation, and the Department of Mental Health);
    2) Social service agencies (such as the Councils on Aging) and services (such as housing, food delivery, and nonmedical transportation);
    3) Consumer, civic, and religious organizations; and
    4) Federal agencies (for example, the Department of Veterans Affairs, Housing and Urban Development, and the Social Security Administration).
b. The systematic process and associated linkages must provide for:
    1) Sharing information and generating, receiving, and tracking referrals;
    2) Obtaining consent from Enrollees to share individual Enrollee medical information where necessary; and
    3) Ongoing coordination efforts...

(Excerpt from definitions)

Aging Services Access Point (ASAP) - an entity organized under Massachusetts General Law (M.G.L.) c.19 §4B that contracts with the Executive Office of Elder Affairs to manage the Home Care Program in Massachusetts and that performs case management, screening, and authorization activities for certain long term care services.

Minnesota Senior Health Options

From Minnesota Senior Health Options, Article 6.1.3.

The MCO must provide Care Coordination/Case Management services that are designed to ensure access and integrate the delivery of all Medicare and Medicaid preventive, primary, acute, post acute, rehabilitation, and long term care services, including State Plan Home Care Services under section 6.1.14, and Elderly Waiver services to MSHO Enrollees. The MCO shall also coordinate the services it furnishes to its Enrollees with the services an Enrollee receives from any other MCO. The MCO shall develop and maintain written descriptions as provided in section 3.4.2(C), and policies and procedures for operation of the Care Coordination/Case Management system in accordance with this section that shall be made available as part of an EQRO review, and for CMS EW waiver reviews.

> (A) *MSHO Care Coordination Components.* The Care Coordination system must be designed to ensure communication and coordination of an Enrollee's care across the Medicare and Medicaid network Provider types and settings, to ensure smooth transitions for Enrollees who move among various settings in which care may be provided over time, and to strive to facilitate and maximize the level of Enrollee self- determination and Enrollee choice of services, Providers and living arrangements. The Care Coordination system should provide each Enrollee with a primary contact person who will assist the Enrollee in simplifying access to services and information. The system must be designed to promote and assure service accessibility, attention to individual needs, continuity of care, comprehensive and coordinated service delivery, culturally appropriate care and fiscal and professional accountability.

New York Medicaid Advantage Plus

From New York Medicaid Advantage Plus, Section 10.15.

10.15 Coordination of Services

a) The Contractor shall coordinate care for Enrollees with: i) the court system (for court ordered evaluations and treatment); ii) specialized providers of health care for the

homeless, and other providers of services for victims of domestic violence; iii) family planning clinics, community health centers, migrant health centers, rural health centers and prenatal care providers; iv) WIC; v) programs funded through the Ryan White CARE Act; vi) other pertinent entities that provide services out of network; vii) local governmental units responsible for public health, mental health, mental retardation or Chemical Dependence Services; and viii) specialized providers of long term care for people with developmental disabilities.

b) Coordination may involve contracts or linkage agreements (if entities are willing to enter into such an agreement), or other mechanisms to ensure coordinated care for Enrollees, such as protocols for reciprocal referral and communication of data and clinical information on Enrollees.

Wisconsin Family Care

From Wisconsin Department of Health Services, Division of Long Term Care, Article V.

B. Interdisciplinary Team Composition

The interdisciplinary team (IDT) is the vehicle for providing member-centered care management. The full IDT always includes the member and other people specified by the member, as well as IDT staff. Throughout this article the term "IDT staff" refers to the social service coordinator, registered nurse and any other staff who are assigned or contracted by the MCO to participate in the IDT and is meant to distinguish those staff from the full IDT.

C. Member-Centered Planning Process

Member-centered planning is an ongoing process and the member-centered plan (MCP) needs to reflect the frequent changes experienced in members' lives. Member-centered planning will continue to evolve to reflect the growing relationship of mutual trust and understanding between the member and IDT staff and to adapt to changes in the member's outcomes and health status. Member-centered planning includes all the following processes.

1. *Comprehensive Assessment*

    a. Purpose

        i. The member is central to the comprehensive assessment process.

        ii. The purpose of the comprehensive assessment is to provide a unique description of the member to assist the IDT staff, the member, a service provider or other authorized party to have a clear understanding of the member and the services and items necessary to support the member's individual outcomes, needs and preferences.

        iii. The comprehensive assessment is essential in order for IDT staff to comprehensively identify the member's outcomes, strengths, needs for support, preferences, informal supports, and ongoing clinical or functional

conditions that require long-term care, a course of treatment or regular care monitoring…

Member-Centered Planning

a. Purpose

i. Member-centered planning is a process through which the IDT identifies appropriate and adequate services and supports to be authorized, provided and/or coordinated by the MCO.

ii. Member-centered planning results in a member-centered plan (MCP) which identifies all services and supports whether paid, provided or coordinated, formal or informal, that are consistent with the information collected in the comprehensive assessment and are:

a) Sufficient to assure the member's health, safety and wellbeing;

b) Consistent with the nature and severity of the member's disability or frailty; and

c) Satisfactory to the member in supporting the member's outcomes…

E. Providing, Arranging, Coordinating and Monitoring Services

1. *Providing and Arranging for Services*

The IDT staff is formally designated as being primarily responsible for coordinating the member's overall long-term care and health care. In accordance with the MCP, the IDT staff shall authorize, provide, arrange for or coordinate services in the benefit package in a timely manner.

2. *Coordination with Other Services*

Coordination of services includes ensuring that the formal and informal support services are involved appropriately and in accordance with the member's preferences. The IDT staff shall ensure coordination of long-term care services with health care services received by the member as well as other services available from community organizations and other social programs.

This includes but is not limited to assisting members to access social programs when they are unable to do so themselves and if requested providing information to a member about how to choose a Medicare Part D Prescription Drug Plan.