

Selected Provisions from Integrated Care RFPs and Contracts: Care Coordination

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As states develop initiatives to better integrate care for Medicare-Medicaid enrollees (individuals dually eligible for Medicare and Medicaid), care coordination provisions will be among the most critical elements to include in requests for proposals (RFPs) and three-way contracts between the Centers for Medicare & Medicaid Services (CMS), state Medicaid agencies, and health plans. Historically, services for Medicare-Medicaid enrollees have been financed separately by the Medicare and Medicaid programs through a combination of fee-for-service and managed care models. As a result, service delivery for this population has been largely uncoordinated and has failed to maximize the benefits and financial resources of both programs – often resulting in potentially avoidable high-cost episodes of care.

Development of new RFPs and contracts provides significant opportunities for Medicare and state Medicaid agencies to enhance the coordination of services delivered to Medicare-Medicaid enrollees through the integration of financing and benefits at the health plan level. However, it will be important for RFPs and contracts to articulate clearly the expectations for health plans to ensure that service delivery for Medicare-Medicaid enrollees is truly coordinated across providers and settings of care and includes all covered Medicare and Medicaid benefits and services. The text box on the next page (CMS Guidance on Care Coordination Protections in Medicare Medicaid Demonstrations) provides additional information on these CMS requirements.

A number of states with experience serving complex populations have taken significant steps in their current Medicaid managed care contracts to require health plans to better integrate Medicare and Medicaid services and to coordinate services for their enrollees. Arizona, Massachusetts, Minnesota, Tennessee, and Texas have managed care contracts that offer examples of care coordination provisions and language that states may consider including in their RFPs and contracts.

IN BRIEF: States pursuing the capitated financial alignment model to integrate care for Medicare-Medicaid enrollees may need to develop requests for proposals (RFPs) to select health plans to participate in their financial alignment demonstration. They must also develop three-way contracts with the Centers for Medicare & Medicaid Services and participating health plans that will govern the demonstrations. Care coordination provisions will be an integral part of these RFPs and contracts.

This technical assistance tool covers a number of key issues in the development of RFPs and contract provisions related to care coordination in five states—Arizona, Massachusetts, Minnesota, Tennessee, and Texas. It highlights variations across states and provides examples of how five states with managed care experience have addressed the following:

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Guide to this Technical Assistance Tool

The RFPs/contracts in the five states deal with these topics in different ways and at different levels of detail. This tool highlights examples of how the five states dealt with these issues that may be useful models for other states. It is not intended to be a comprehensive inventory. It draws from both RFPs and contracts, since states often incorporate detailed RFP provisions into their managed care contracts.

Each section of this tool includes a summary of key contract requirements, notes where those requirements can be found in the contracts, and excerpts actual contract language in “Sample Contract Language” text boxes. Links to the RFPs or contracts are provided below. States are encouraged to use these contracts for reference and adapt the sample language to their own context, programs, and goals.

- **Arizona:** Arizona Long Term Care System (ALTCS) Elderly & Physically Disabled (E/PD) Contract for Contractors, http://www.azahcccs.gov/commercial/Downloads/Solicitations/BiddersLibrary/YH12-0001/General/General_SectionA_F_YH12-0001_1_31_11FINALCLEAN.pdf.
- **Arizona:** Arizona Marketing Outreach and Incentives Policy, <http://www.azahcccs.gov/shared/Downloads/ACOM/ACOM.pdf>.
- **Massachusetts:** Massachusetts Senior Care Options Contract for Senior Care Organizations http://www.chcs.org/usr_doc/2010_contract.pdf.
- **Minnesota:** Minnesota Senior Care Plus Services Contract, http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_156513.
- **Tennessee:** Contractor Risk Agreement State of Tennessee, <http://www.tn.gov/tenncare/forms/middletnmco.pdf>.
- **Texas:** Texas Health and Human Services Contract General Terms and Conditions, <http://www.hhsc.state.tx.us/medicaid/STARPLUSExpansionContract.pdf>.
- **Texas:** Texas Uniform Managed Care Manual (UMCM), <http://www.hhsc.state.tx.us/medicaid/umcm>.

Two of the states included in this technical assistance tool – Arizona and Massachusetts – conducted health plan procurements during the past year that are not reviewed here. The RFPs for those procurements can be found at these links:

- **Arizona:** AHCCCS Acute Care/Children’s Rehabilitative Services RFP, issued November 1, 2012, awarded March 22, 2013, <http://www.azahcccs.gov/commercial/Purchasing/bidderslibrary/YH14-0001.aspx>.
- **Massachusetts:** Duals Demonstration Request for Responses From Integrated Care Organizations, issued June 18, 2012, awarded November 2, 2012, <http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/120730-duals-demo-rfr.pdf>.

CMS Guidance on Care Coordination in Medicare-Medicaid Demonstrations

CMS has outlined for states and interested health plans the requirements and provisions related to care coordination that CMS expects will be included the demonstrations. The current guidance is on the Medicare-Medicaid Coordination Office (MMCO) web site at this link: <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsinCareCoordination.html>. See in particular:

- Medicare-Medicaid Financial Alignment Demonstrations – Standards & Conditions (January 2012)
- Capitated Financial Alignment Model Plan Guidance (January 25, 2012)
- Guidance for Organizations Interested in Participating as Medicare-Medicaid Plans in States Seeking to Implement Capitated Financial Alignment Demonstrations in 2014 (January 9, 2013)

Additional resources on care coordination are on the Integrated Care Resource Center web site at: <http://www.integratedcareresourcecenter.com/icmcaremanagement.aspx>.

Care Coordination Provisions in Existing Requests for Proposals/Contracts

While there are significant similarities in these RFPs and contracts, these five states each use different terms to refer to care coordination, and the way they define the concept may differ based on program design, history, and context. Notably, states have adopted different approaches in the development and delivery of care coordination services based on a host of factors including variation in the scope of services covered, the amount of resources available, and historical relationships between state agencies, non-profit support agencies, plans and providers. The RFP and contract language cited in this document is for illustration purposes only. The intent is to identify issues that may be relevant in the design of RFPs and contract provisions and to provide examples of how several states with extensive managed care experience have addressed those issues. States should take into account relevant differences between the programs they are developing and those in the five states covered in this technical assistance tool as they consider these care coordination provisions. Most notably, the managed care programs in Arizona, Massachusetts, and Minnesota include both Medicaid and Medicare services, while those in Tennessee and Texas include only Medicaid services.

Brief summaries of the care coordination models in the five states are provided below and an overview of the major features of the Medicaid managed care programs in the five states appears in Appendix 1.

- **Arizona:** The Arizona Long-Term Care System (ALTCS) uses “case managers” employed by the health plans to coordinate acute care, behavioral health care and LTSS for Medicaid-only beneficiaries requiring nursing home level of care and beneficiaries dually eligible for Medicare and Medicaid.
- **Massachusetts:** The state’s Senior Care Options (SCO) program for Medicare-Medicaid enrollees and Medicaid-only beneficiaries age 65 and over uses a physician-led multidisciplinary team to coordinate acute care services and long-term services and supports (LTSS) for beneficiaries. Health plans contract with community organizations already assisting beneficiaries with LTSS to include a Geriatric Support Services Coordinator (GSSC) on the multidisciplinary team.
- **Minnesota:** Minnesota Senior Health Options (MSHO), the managed care program providing integrated Medicare and Medicaid services for Medicare-Medicaid enrollees 65 years and older, uses a care coordinator system developed by health plans to coordinate acute and LTSS services for beneficiaries. The system includes assignment of a single point of contact to coordinate services across Medicare and Medicaid. This point of contact can be a primary care provider (PCP) who functions as a certified medical home.
- **Tennessee:** CHOICES, the state’s program for beneficiaries who qualify for Medicaid long-term care and meet nursing home level of care, uses either a single person or team-based coordination system (based on health plan design) to coordinate Medicaid acute care services and LTSS. Care coordinators are employed by the health plans.
- **Texas:** STAR+PLUS, the state’s program for SSI/disabled Medicaid beneficiaries, including those dually eligible for Medicare and Medicaid, uses “service coordinators” who work with the member’s PCP to integrate acute care, LTSS, and behavioral health services.

1. Definition of Care Coordination

All states require care coordination for certain types of enrollees (e.g., older adults), though some states like Massachusetts and Tennessee define care coordination as a set of processes that plans must carry out rather than defining it as a separate benefit. Other states like Arizona and Minnesota define a distinct care coordination benefit and provide detailed descriptions of responsibilities. While states may use different terms for care coordination and may define it somewhat differently, the benefit typically includes a common set of activities including member assessment, monitoring of service delivery, and communication across providers and settings of care (more detail available in Responsibilities and Qualification of a Care Coordinator). Arizona and Minnesota use the term “case management” and care coordination interchangeably. In Tennessee, by contrast, “case management” refers to services provided on top of care coordination for enrollees with complex conditions such as co-morbid physical and behavioral health conditions.

State Definitions of Care Coordination

- **Arizona:** Uses the term *case management* and defines it as “the process through which appropriate and cost effective medical, medically-related social services, and behavioral health services are identified, planned, obtained and monitored for individuals eligible for ALTCS services.” (TN, Sec. D.16)
- **Massachusetts:** Defines care coordination *services in terms* of processes and mandates that health plans ensure that the primary care provider or primary care team maintains written protocols for referrals, second opinions, and sharing of patient information including adherence to individualized care plans and patient medical records. (MA, Sec. 2.4(A)(6))
- **Minnesota:** Uses *care coordination* and *case management* interchangeably to mean the assignment of an individual who coordinates the provision of all Medicare and Medicaid health and “long-term care” services for enrollees in the MSHO and MSC+ programs. (MN, Sec. 2.16, 2.20)
- **Tennessee:** Within its description of *service coordination*, the state provides a detailed list of care coordination processes including coordinating among relevant providers of primary care, behavioral health, and LTSS, assessing quality and appropriateness of services furnished, monitoring member medical and behavioral health conditions, providing discharge planning, and tracking preventive service screening (TN, Sec. 2.9) This care coordination is provided to all CHOICES enrollees. In addition, the state requires contracted health plans to maintain a voluntary case management program for enrollees who are high risk or have unique, chronic, or complex needs (for example, members with co-morbid physical health and behavioral health conditions). Case management includes member assessments and development and implementation of an individualized care plan. Health plans must ensure that case management activities are integrated with CHOICES care coordination processes and functions. (TN, Sec. 2.9.5)
- **Texas:** Uses the term *service coordination* and defines the term as a specialized care management service that includes identification of physical, mental health and LTSS needs, development of a Service Plan to address needs, assistance to ensure timely and coordinated access to providers, and coordination with social and other services delivered outside of covered health plan services. (TX, Article 2, Attachment A)

Coordination between Medical and Social Services

Most states also require contracted health plans to coordinate with various relevant state and social service agencies such as Area Agencies on Aging (AAAs). States vary with regard to what is defined as a social service, but examples include housing, food delivery, and nonmedical transportation in Massachusetts; income assistance in Tennessee; and assessments of medical barriers to employment and social security disability determination in Minnesota.

- **Massachusetts:** Massachusetts requires health plans to implement “a systematic process for coordinating care and creating linkages” with state agencies (e.g., Executive Office of Elder Affairs) and social service agencies (e.g., Councils on Aging) for services such as housing, food delivery, and nonmedical transportation. (MA, Sec. 2.4.12(a)) The systematic process and linkages must allow for sharing information, tracking referrals, obtaining enrollee consent to share medical information, and ongoing coordination efforts such as regularly scheduled meetings. (MA, Sec. 2.4.12(b))
- **Minnesota:** Requires coordination of medical and social service needs which may involve working with “Local Agency social service staff or with various community resources in the county” (MN, Sec. 6.1.5)
- **Tennessee:** Care coordination for individuals who qualify for Medicaid “long-term care” and meet a nursing home level of care includes assessing enrollee status, identifying medical and social needs, and ensuring coordination across settings of care. (TN, Sec. 2.9.6)
- **Texas:** Contracted health plans must have “a systematic process to coordinate Non-capitated Services” and involve community organizations that are important to the health and wellbeing of members. (TX, Sec. 8.1.13, Attachment B-1) Service coordinators work with members and providers to develop a

Service Plan that is coordinated with community support systems such as Independent Living Centers, AAAs, and Mental Retardation Authorities. (TX, Sec. 4.04.1, Attachment A)

Sample Contract Language: Coordination between Medical and Social Services

Tennessee (Section 2.9.6.1.3)

“The Contractor shall use care coordination as the continuous process of: (1) assessing a member’s physical, behavioral, functional, and psycho-social needs; (2) identifying the physical health, behavioral health, and long-term care services and other social support services and assistance (e.g., housing, or income assistance) that are necessary to meet identified needs; (3) ensuring timely access to and provision, coordination and monitoring of physical health, behavioral health, and long-term care services needed to help the member maintain or improve his or her physical or behavioral health status or functional abilities and maximize independence; and (4) facilitating access to other social support services and assistance needed in order to ensure the member’s health, safety and welfare, and as applicable, to delay or prevent the need for more expensive institutional placement.”

Care Coordination across Medicare and Medicaid Benefits

All five states specifically require coordination of Medicare and Medicaid services for individuals who are dually eligible even if, as in Texas and Tennessee, Medicare services are not included in health plans’ capitated benefit package.

- **Minnesota:** Requires coordination of all Medicare and Medicaid “preventive, primary, acute, post acute, rehabilitation and long term care services,” including references to other programs offered by the state. (MN Sec. 6.1.3) The state requires contracted health plans to “promote the continued integration of Medicare and Medicaid benefits.” (MN, Sec. 3.7.2)
- **Tennessee:** Requires health plan’s care coordinator or care coordination team to coordinate with Medicare payers, Medicare Advantage plans, and Medicare providers as appropriate to coordinate the benefits of members who are dually eligible for Medicare and Medicaid (TN, Sec. 2.9.6.9.5)
- **Texas:** Requires contracted health plans to also contract with CMS as an operating Medicare Advantage Dual Special Needs Plan to coordinate care for dual eligibles. (TX, Sec. 8.1.34.8, Attachment B-1)

2. Responsibilities and Qualifications of a Care Coordinator

Typically, care coordinators are required to carry out a common set of activities including assessment of member health and social support needs, development of an individualized care plan to address member needs, arrangement and monitoring of the delivery of services in the care plan, and communication with providers across systems and settings of care. Most states provide minimum qualifications for the care coordinator position, but qualifications are fairly broad, ranging from a bachelor’s degree in social work to medical degrees. Each of the states also includes fairly detailed descriptions of the responsibilities of a care coordinator that spell out these activities.

Position Qualifications

- **Arizona:** Requires health plans to have two types of positions on staff: (1) the “Medical Management Coordinator” (MMC), who must be an Arizona-licensed registered nurse, physician, or physician’s assistant if making medical necessity decisions or have a Master’s degree in health services, health care administration, or business administration if not required to make medical necessity determinations. (AZ, Sec. D25); and (2) case managers to manage and coordinate enrollee services. Case managers must be a degreed social worker, licensed registered nurse, or a person with a minimum of two years’ experience in providing case management to persons who are elderly and/or persons with physical or developmental disabilities. (AZ, Sec. D16)

- **Minnesota:** Requires the MSHOs care coordinator to be a social worker, public health nurse, registered nurse, physician assistant, nurse practitioner, or physician. (MN, Sec. 2.16)
- **Tennessee:** Directs MCOs to establish qualifications for a care coordinator but also requires the care coordinator to be, at minimum, an RN or LPN or have a bachelor’s degree in social work, nursing or other health care profession. (TN, Sec. 2.9.6.11)
- **Texas:** Requires “service coordinators” to be experienced in meeting the needs of people with disabilities, old and young, and vulnerable populations. Service coordinators must have an undergraduate or graduate degree in social work or a related field, or be a registered nurse, licensed vocational nurse, advanced nurse practitioner, or a physician assistant. (TX, Sec. 4.04.1, Attachment A) They are considered “key HMO Personnel.” (TX, Sec 4.04.1, Attachment A)

Responsibilities of a Care Coordinator

- **Massachusetts:** Requires “linkages” of clinical and management information systems among all providers including primary care providers, members of the primary care team, specialty, behavioral health and providers of LTSS. Primary care providers or primary care teams are responsible for integrating and coordinating services through activities such as developing and modifying a Plan of Care, tracking referrals, tracking and coordinating transfers between settings of care, and sharing medical and care planning information among providers. (MA, Sec. 2.4(A)(6))
- **Minnesota:** MSHO care coordinator coordinates the provision of Medicare and Medicaid health and long-term care services as well as the services of different health and social service professionals across various settings of care. (MN, Sec. 2.16) More specifically, the MSHO care coordinator is responsible for creating and implementing a care plan that involves arranging an initial assessment, facilitating annual physician visits for preventive and primary care, arranging and coordinating support services, ensuring informed consent for all services, coordinating with other local agencies, educating the member about good health care practices, and assisting with identification of providers. (MN, Sec. 6.1.3)
- **Tennessee:** Requires health plans to provide care coordinators responsible for coordinating among PCPs, specialists, behavioral health providers, and long-term care providers; performing preventive health case management services, monitoring ongoing medical or behavioral health conditions, coordinating hospital and/or institutional discharge planning; and authorizing services provided by non-contract providers. Other responsibilities vary by type of enrollee (e.g., which public programs they qualify for). (TN, Sec. 2.9.1)
- **Texas:** Requires service coordinators to work with the enrollee’s primary care physician, regardless of whether the physician is in the plan’s network, to coordinate all services, including acute, long term care, behavioral health, and services not covered under the plans’ capitation. The coordinator must actively involve all providers serving the enrollee. (TX, Sec. 8.1.34, Attachment B-1) The service coordinator must work with relevant providers to develop a single Service Plan. (TX, Sec. 4.04.1(c), Attachment A)

Sample Contract Language: Responsibilities of a Care Coordinator

Minnesota (Section 6.1.3(A)(2)(d))

“The MCO shall ensure that the care coordinator works in partnership with the Enrollee and/or authorized family members, responsible parties or guardians and the primary care physician, and in consultation with any specialists caring for the Enrollee. The care coordinator shall cooperate with the Enrollee in developing, coordinating and, in some instances, providing supports and services identified in the Enrollee’s Care Plan and obtaining consent to the medical treatment or service. Care Coordination is provided at a level of involvement based on the needs and choices made by the Enrollee and/or authorized family members or guardian, and as appropriate to implement and monitor the Care Plan.”

3. Assignment of a Care Coordinator

The states reviewed handle assignments care coordinators to enrollees differently. Some explicitly required assignment to all enrollees (e.g., Minnesota) while others assign only upon enrollee request (e.g., Texas).

- **Minnesota:** Requires assignment of a coordinator to all MSHO enrollees. (MN, Sec. 2.16)
- **Tennessee:** Requires contracted health plans to provide care coordination to all enrollees who qualify for Medicaid long-term care and meet a nursing home level of care (TN, Sec. 2.9.6) and to assign each of these enrollees with a “specific care coordinator.” (TN, Sec. 2.9.6.4.3) Enrollees in the home- and community-based services program also must be assigned a care coordinator to assure integration with medical services, including extensive requirements relating to the provision of services. (TN, Sec. 2.9.6)
- **Texas:** Requires contracted health plans to provide a “service coordinator” to enrollees who request one and to other individuals when the health plan determines one is required through enrollee assessment. Health plans must ensure that each member has a PCP who is responsible for clinical direction and who, with the service coordinator, integrates acute care, long-term care, and behavioral health services. (TX, Sec. 8.1.34, Attachment B-1) In addition, health plans must develop and maintain a system and procedures for identifying enrollees with special health care needs (MSHCN), must contact enrollees identified through a pre-screening process and make a determination as to whether an enrollee is a MSHCN. (TX, Sec. 8.1.13, Attachment B-1)

4. Structure of Care Team

State requirements vary relating to the use of care teams. While Massachusetts includes specific requirements, Tennessee does not require the use of care teams but sets minimum requirements for those that utilize them.

Use of and Members of Care Teams

- **Massachusetts:** Requires plans to establish care teams around a geriatric model of care. The primary care team must consist of a primary care physician working with a geriatric support services coordinator (GSSC), a nurse practitioner, registered nurse, or physician’s assistant, all of whom must have experience in geriatric practice. The team may be expanded to include other professionals at the request of the primary care physician. (MA, Definitions) Plans must contract with external GSSCs through an Aging Services Access Point (ASAP), which is an Area Agency on Aging or other type of organization operating under contract with the Executive Office of Elder Affairs. (MA, Definitions) The GSSCs are responsible for initial and ongoing assessments of the health and functional status of the enrollee, including making determinations related to long-term care and community-based care, coordinating and authorizing long-term care and support services, and monitoring and evaluating functional outcomes. (MA, Sec. 2.4(A)(5))
- **Minnesota:** Although the state does not specify the use of a care team, if the plan does utilize a care team, it must include a care coordinator and others with expertise and experience in the performance of care coordination services, including the development of a care plan. (MN, Sec. 6.1.5)
- **Tennessee:** Does not require plans to use care coordination teams, but if they are used, they must include a care coordinator, and other persons with “relevant expertise and experience” who are assigned to support the coordinator. (TN, Sec. 1) The care coordination teams “are discrete entities within the [health plans’] organizational structure dedicated to fulfilling care coordination functions.” (TN, Sec. 2.9.6.4.4)
- **Texas:** Health plans must assure that members with special health care needs (MSHCN) have access to interdisciplinary care teams and that they have access to PCPs with experience in serving MSHCN. (TX, Sec. 8.1.13, Attachment B-1)

5. Development of Care Plans

All five states include requirements related to developing care plans. States include detail on who should develop the care plan and how it should be developed. Notably, many of the states emphasize a person-centered approach by requiring that enrollees, their families, or representatives be included in the care plan development process.

Responsible Party for Developing Care Plan

- **Arizona:** The case manager is required to develop an individualized care plan. The contract contains detailed requirements regarding the development of the plan and factors that should be taken into consideration. Case managers are also required to conduct overall functional status and medical status reviews, and to review and update the care plan periodically. (AZ, Sec. D16, definition of case management services)
- **Massachusetts:** The primary care physician or primary care team is required to develop an individualized care plan for each enrollee. (MA, 2.4(A)(6))
- **Tennessee:** The case management team is required to develop an individualized care plan as part of case management services, which are voluntary. (TN, Sec. 2.9.5)
- **Texas:** The service coordinator is responsible for developing a seamless package of care that ensures primary, acute care, and LTSS needs are met through a “single, understandable, rational plan”. (TX, Sec. 4.04.1)

Person-Centered Approach

- **Arizona:** Requires the case manager to make “every effort” to foster a member-centered approach and to respect member/family self-determination. Members/family/significant others must be a part of the development of the care plan with the case manager. (AZ, Sec. D16)
- **Minnesota:** Requires that the care plan be developed in consultation with the enrollee, health care professionals, and family. (MN, Sec. 2.18, 6.1.5)
- **Texas:** Indicates that the plan must be developed through a thorough assessment of the enrollees’ needs and developed in cooperation with enrollees, their families or representatives. (TX, Sec. 8.1.13, Attachment B-1) The plan should promote self-determination. (TX, Sec. 4.04.1) Plans must identify and train members or their family members to coordinate their own care to the extent they are capable and willing. (TX, Sec. 8.1.34, Attachment A)

Sample Contract Language: Person-Centered Approach

Arizona (Section D.16)

“The case manager will make every effort to foster a member-centered approach and respect maximum member/family self-determination while promoting the values of dignity, independence, individuality, privacy, and choice. The involvement of the member and the member’s family in strengths and needs identification and in decision making is a basic tenet of case management practice. Care plan development is a shared responsibility with the member/family/significant others input seen as key to the success of the plan. The member/family/significant others are partners with the case managers in the development of the plan with the case manager in a facilitating mode.”

6. Reimbursement for Care Coordination

States reviewed typically do not specify reimbursement for care coordination services. Instead, these services are included in a capitated rate. However, Massachusetts requires plans to subcontract with LTSS coordinators and Minnesota allows PCPs who are certified Health Care Homes to serve in the care coordinator role. These two states provide examples of contract language for reimbursement for care coordination services.

- **Massachusetts:** Requires plans to contract with external GSSCs, and requires reimbursement for services, but provides flexibility in the reimbursement relationship between plans and ASAPs (e.g. FFS, capitation, partial capitation). If reimbursement-related issues arise, health plans must collaborate with state agencies overseeing plans and ASAPs to explore options before terminating contracts. (MA, Sec. 2.4(A)(5))
- **Minnesota:** Requires a managed care organization to pay a care coordination fee to providers who are certified as Health Care Homes. The fee schedule must be based on criteria developed by the state. Contracted health plans may operate an alternative comprehensive payment system, but the alternative must also meet state criteria. (MN, Sec. 4.25)

Sample Contract Language: Reimbursement for Care Coordination

Minnesota (Section 4.25)

“The MCO shall pay a care coordination fee to Providers for qualified Enrollees of a certified Health Care Home within the MCO Provider network, unless the MCO is using an alternative comprehensive payment arrangement. The fee schedule for Health Care Homes must be stratified according to the stratification criteria developed by the STATE, pursuant to Minnesota Statutes § 256B.0751 et seq. In addition, (1) The MCO will consider Medicare status, and any additional resources that may be available when determining Health Care Home care coordination rates for Dual Eligible Enrollees; and (2) If a clinic or clinician is a certified Health Care Home but the MCO has an alternative comprehensive payment arrangement that is inclusive of care coordination and tied to outcome measures related to patient health, patient experience and cost effectiveness with that clinic or clinician, upon documentation of the alternative comprehensive payment arrangement and its proposed performance and outcome measures, the STATE will provide a variance from the stratified fee schedule in 4.25(A) above and from any additional Health Care Home care coordination fee. See section 3.4.2(K)(2) for documentation of the comprehensive alternative payment arrangement. The MCO is not required to pay both a Health Care Home care coordination fee and a fee based on a more comprehensive payment arrangement.”

7. Caseload Requirements

A few states include language related to caseload requirements for care coordinators, though the states range in the level of detail provided. While Arizona specifies a precise caseload ratio, Minnesota requires health plans to develop ratios based on certain criteria, and Texas requires health plans to monitor the coordinators' workload.

- **Arizona:** Requires “adequate” staffing and includes a formula for determining case loads. Caseloads must not exceed a weighted value of 96 enrollees per case manager with some variation based on the type of individual the case manager is responsible for. (AZ, Sec. D16)
- **Minnesota:** Requires health plans to establish criteria for care coordinator caseload ratios. Criteria to develop ratios include need for translation, case mix, need for high intensity acute care coordination, mental health status, travel time, and lack of family or informal supports. (MN, Sec. 6.1.3(A)(5))
- **Texas:** Requires contracted health plans to monitor service coordinator workload to make sure all functions are performed in a timely manner. (TX, Sec. 4.04.1, Attachment A)

8. Transition to New Providers Requirements

Tennessee and Texas include language related to assisting enrollees with their transition between providers. This may occur as individuals are enrolled into new health plans or as providers leave health plan networks. The goal is to maintain continuity of care for enrollees.

- **Tennessee:** Requires contracted health plans to “actively” assist enrollees with chronic or acute medical or behavioral health conditions and enrollees receiving long-term care services in transitioning to another provider when the current provider terminates participation with the plan. (TN, Sec. 2.9.4)
- **Texas:** Requires health plans to provide a transition plan for new enrollees that are already receiving LTSS at the time of enrollment. The transition plan must ensure continuous care for the enrollee as the enrollee is transferred into the health plan’s network and must pay existing providers up to six (6) months until the health plan has completed enrollee assessments and new care plans. (TX, Sec. 8.1.34.4)

Sample Contract Language: Transition to New Providers Requirements

Tennessee (Section 2.9.4.1)

“The Contractor shall actively assist members with chronic or acute medical or behavioral health conditions, members who are receiving long-term care services, and members who are pregnant in transitioning to another provider when a provider currently providing their long-term care services, or currently providing prenatal services has terminated participation with the Contractor. For CHOICES members, this assistance shall be provided by the member’s care coordinator/care coordination team.”

9. Use of Centralized Enrollee Record

Some states require a contracted health plan to develop and implement a single centralized record for each enrollee that can be accessed by members of the care team.

- **Arizona:** The case manager, used by health plans to manage enrollee care, is required to conduct initial and periodic service reviews with each member and track status in an electronic system (the Client Assessment and Tracking System). (AZ, Sec. D16)
- **Massachusetts:** Requires contracted health plans to maintain a “single, centralized, comprehensive” record that documents members’ medical, functional, and social status. The contract includes a detailed list of all the types of data relating to these three areas in the member record. (MA, Sec. 2.4(A)(8))

Appendix 1: Major Features of Programs for Medicare-Medicaid Enrollees in Selected States

State	Program Name and Start Date	Population Covered	Total Number of Full Benefit Medicare-Medicaid Enrollees in the State (2009) ^a	Number of Medicare-Medicaid Enrollees in Integrated Plans/Programs ^b	Number and Name of Plans ^c	Benefits Covered	Geography	Medicaid Enrollment
Arizona	Arizona Health Care Cost Containment System (AHCCCS) (1982)	All Medicaid beneficiaries, including duals	126,826	32,816 (1/2012)	8: APIPA, Bridgeway, CareFirst, Health Choice, Maricopa Health Plan, Mercy Care, Phoenix Health Plan, University Family Care	Acute care	Statewide	Mandatory
	Arizona Long-Term Care System (ALTCS) (1989)	All Medicaid beneficiaries needing nursing home level of care, including duals		6,466 (1/2012)	3: Mercy Care, Bridgeway, Evercare Select	Acute and LTSS	Statewide	Mandatory
Massachusetts	Senior Care Options (SCO) (2004)	Duals and Medicaid-only beneficiaries age 65+	253,025	24,175 (4/2013)	5: Commonwealth Care Alliance, Evercare, NaviCare, Senior Whole Health, Tufts Health Plan	Acute and LTSS	Statewide	Voluntary
	PACE	Age 55+ and needing nursing home level of care		2,562 (7/2011)	6: Elder Service Plan (4 plans), Summit Elder Care, Uphams Elder Service Plan	Acute and LTSS	Boston area	Voluntary
Minnesota	Minnesota Senior Health Options (MSHO) (1997)	All Medicaid beneficiaries age 65+, including duals	141,141	35,573 (3/2013) Includes non-duals	8: Blue Plus, Health Partners, Itasca Medical Care, Medica, Metropolitan Health Plan, Prime West, South Country Health Alliance, UCare	Acute and LTSS	Statewide	Voluntary
	Minnesota Senior Care Plus (MSC+) (2005)	Medicaid beneficiaries age 65+, including duals; duals get Medicare through FFS		12,917 (3/2013) Includes non-duals	8 (same as MSHO)	Acute and LTSS	Statewide	Mandatory (alternative to MSHO)
	Special Needs Basic Care (SNBC) (2008)	All Medicaid beneficiaries age 18-64 with physical disabilities, including duals		37,634 (3/2013) Includes non-duals	5: South Country Health Alliance, Medica, Metropolitan Health Plan, PrimeWest Health, UCare	Acute and most (but not all) LTSS	Statewide	Voluntary
Tennessee	TennCare CHOICES (2010)	Age 65+ or 21+, in nursing facility, needing nursing home level of care, or at risk of institutionalization	191,279	None	3: United Healthcare Community Plan, BlueCare, Amerigroup	Medicaid acute and LTSS	Statewide	Mandatory

State	Program Name and Start Date	Population Covered	Total Number of Full Benefit Medicare-Medicaid Enrollees in the State (2009) ^a	Number of Medicare-Medicaid Enrollees in Integrated Plans/Programs ^b	Number and Name of Plans ^c	Benefits Covered	Geography	Medicaid Enrollment
	PACE	Age 55+ and needing nursing home level of care		317 (7/2010)	1: Alexian Brothers	Acute and LTSS	Selected counties	Voluntary
Texas	STAR+PLUS (1998)	SSI/disabled Medicaid beneficiaries not in nursing facilities, including full duals	394,205	43,000 (2010)	5: Amerigroup, Molina, Superior Health Plan, HealthSpring, United Healthcare Community Plan	Medicaid acute and LTSS; Medicare services provided separately	Selected counties	Mandatory
	PACE	Age 55+ and needing nursing home level of care		984 (7/2011)	3: Bienvivir Senior Health Service, Jan Werner Adult Day Care Center, La Paloma	Acute and LTSS	Selected counties	Voluntary

NOTE: Appendix 1 prepared by J. Libersky and J. Verdier, Mathematica Policy Research. Main source: J. Verdier, J. Libersky, and J. Gillooly. "Integrating Care for Dual Eligibles in New York: Issues and Options." New York, NY: NYS Health Foundation, February 2012.

a. Number of Full Benefit Dual Eligibles, as confirmed by the Medicare Enrollment Database from Medicaid Analytic eXtract (MAX) 2009 Validation reports.

b. Number of duals enrolled in PACE programs is from CMS Managed Care Program Summary Report, July 1, 2011. Numbers enrolled in other integrated plans/programs are from Mathematica analysis of May 2012 state Financial Alignment Demonstration proposals, state web sites, and CMS SNP Comprehensive Reports.

c. Mathematica analysis of contracted plans. Number of plans is current as of May 2013.

ABOUT THE INTEGRATED CARE RESOURCE CENTER

The ***Integrated Care Resource Center*** is a national initiative of the Centers for Medicare & Medicaid Services to help states improve the quality and cost-effectiveness of care for Medicare-Medicaid enrollees and other high-need, high-cost Medicaid beneficiaries. The state technical assistance activities provided within the ***Integrated Care Resource Center*** are coordinated by Mathematica Policy Research and the Center for Health Care Strategies. For more information, visit www.integratedcaresourcecenter.com.

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