

APPENDIX C: Care Management Agencies Minimum Qualifications

1. The CMA/OHCDS provider must be from a local government, private nonprofit or for-profit organization, able to provide social and health care management services to Medi-Cal-eligible persons of any age and who are certifiable for nursing facility care. (A private nonprofit agency must have certification from the State of California, Office of Secretary of State or a letter from the Department of the Treasury, Internal Revenue Service classifying the administrative agency as a private nonprofit agency.)
2. The CMA/OHCDS providers must be able to provide home and community-based services at a cost in the aggregate lower than nursing facility care, with the cost effectiveness achieved by coordinating the delivery of services to clients from various sources. Sources include Medi-Cal (traditional, non-waived services), Medicare, the Older Americans Act, the Americans with Disabilities Act, the Rehabilitation Act of 1973, the Lanterman Developmental Disabilities Act, Supplemental Security Income/State Supplemental Payments, In-Home Supportive Services, housing assistance agencies, and other local programs.
3. The CMA/OHCDS providers must be capable of providing waiver services directly or through vendor agreements with local providers for services which include (family and participant training, home modifications, chore and personal care assistance, respite care, transportation, meal services, protective services, communication services, care management, transitional care management, skilled nursing, nursing supervision and habilitation).
4. The CMA/OHCDS providers must ensure provider rates are sufficient to maintain an adequate provider network to meet the needs of its participants, monitor delivery and quality of services and changes in participants' health and functional status; have overall responsibility for the operation of the local CMA; and must be able to plan, organize, and direct all administrative and program activities across all waiver providers in accordance with the contract with DHCS, all standards and requirements as published in the CMA Manual, and policy directives issued by DHCS.
5. The CMA/OHCDS providers must maintain a management information system (MIS) with the capability to collect and track participant and service data, provide required waiver reports, and enable the provider to bill NF/AH expenditures through the State Medi-Cal claims payment system. The MIS must also be able to support the care management process which involves conducting and documenting assessments and reassessments; developing and updating care plans and tracking outcomes; making and documenting service arrangements; and monitoring service delivery and other recording-keeping requirements as published in the CMA contract and manual.
6. The CMA/OHCDS providers must have local community knowledge and experience in establishing and maintaining effective working relationships with community-based organizations, private nonprofit organizations, service providers, managed care organizations,

skilled nursing facilities, hospitals, housing authorities, and government entities; utilize its knowledge and experience to maximize and coordinate all community resources to meet the care and service needs of the participants.

7. The CMA/OHCDS providers must assist in navigating the disability system under state and federally funded programs, and demonstrate care management and institutional transitions experience related to serving a population that includes either a significant number of frail, physically disabled participants and/or a similar population. This includes: knowledge and experience in outreach activities, Medi-Cal eligibility enrollment and disenrollment procedures for managed care and NF/AH, assessments and reassessments including level-of-care and medical necessity requirements, care planning, transitional care planning, case conferencing, and service delivery including participant monitoring and follow-up activities.
8. The CMA/OHCDS providers must ensure consumer representation on issues related to participant care, access to services, provider and family training, care management and person-centered care planning, and quality of care issues. This may be achieved by including at least one consumer representative on their governing board to help ensure that the target population's needs are being met and any concerns are being heard.