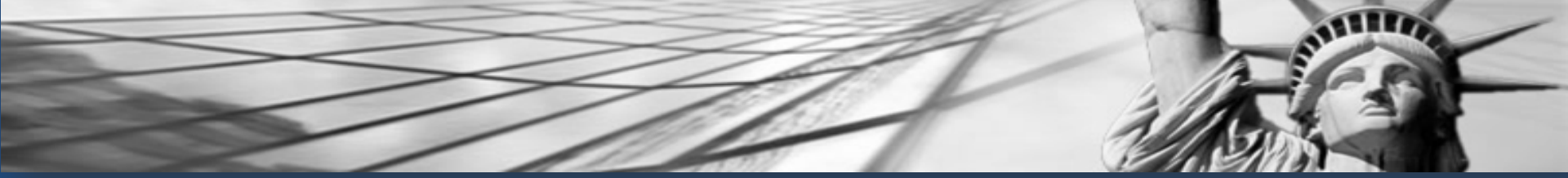

MRT Managed Long Term Care (MLTC) Work Group

Recommendations and Principles

October 27, 2011

Proposed Recommendations

Care Coordination Model (CCM)
Final Draft Principles #1

A CCM must provide or contract for all Medicaid long term care services in the benefit package. CCM will be at risk for the services in the benefit package and rates will be risk adjusted to reflect the population served.

The CCM benefit package includes both community-based and institutional Medicaid covered long term care services and makes consumer directed personal assistance services available for eligible individuals. The CCM is responsible for assessing the need for, arranging and paying for all Medicaid long term care services. The CCM must meet financial solvency standards to assure protection of the members.

(continued)

Care Coordination Model (CCM)
Final Draft Principles #1

The CCM will receive a periodic payment to cover the services in the benefit package to promote the appropriate, efficient and effective use of services for which it is responsible. Payment to the CCM will be based on the functional impairment level and acuity of its members. Risk factors could include functional status, cognitive status, diagnoses, demographics or other measures found to be correlated to increased cost of services. CCM rates shall be actuarially sound and sufficient to support provision of covered long term care services and care coordination and efficient administration. Payments shall incentivize community-based services.

Care Coordination Model (CCM) Final Draft Principles #2

A CCM must include a person-centered care management function that is targeted to the needs of the enrolled population.

Every enrolled plan member must have a care manager or care management team that is responsible for person-centered assessment and reassessment, care plan development and implementation, care plan monitoring, service adjustment, safe discharge and transition planning, and problem solving. The CCM must use Health Information Technology, as feasible, to document, execute and update the plan of care and share information among appropriate staff and providers. The care management function shall address the varying needs of the population. The needs and preferences of the member will guide the intensity and frequency of the care management, encompassing both high-touch and low-touch care management.

Care Coordination Model (CCM) Final Draft Principles #3

A CCM must be involved in care coordination of other services for which it is not at risk.

Transition to fully integrated models of care which include all Medicare and Medicaid services is the goal of NYS over the next three to five years. As an interim approach, the CCM will coordinate care with primary and acute care services and other services not in the CCM service package to promote continuity of care and improve outcomes.

Care Coordination Model (CCM) Final Draft Principles #4

The member and his/her informal supports must drive the development and execution of the care plan.

Eliciting the goals and preferences of members and their informal supports must be a critical component of person-centered care plan development and is essential to promoting quality of life. All members and, where appropriate, a member's representative, shall be given the opportunity to participate in decisions about the type and quantity of service to be provided.

Care Coordination Model (CCM) Final Draft Principles #5

Care coordination is a core CCM function. For benefit package services, CCM members will have a choice of providers.

A CCM must ensure that individualized care coordination is provided to all members, and have adequate capacity to do so. Members will be able to select among a choice of at least two providers (where available) of each benefit package service. CCMs shall have a network that takes into account the cultural and linguistic needs of the population to be enrolled.

There are geographic differences in the availability of service providers and CCMs should not be prevented from operating when market forces (lack of availability or unwillingness to contract) preclude a CCM from offering choice or, perhaps in some instances, a particular service. However, CCM's must have the ability to authorize services from an out-of-network provider if no provider is available in-network that can adequately meet the needs of the member.

Care Coordination Model (CCM) Final Draft Principles #6

A CCM will use a standardized assessment tool to drive care plan development.

CCMs shall use the same standardized assessment tool as other long term care entities (the UAS-NY when available) to be used for initial assessments, scheduled reassessments and other reassessments resulting from a change in condition. The standardized assessment tool must be used to engage the member, the member's physician and informal supports to assure a complete review of member needs.

Care Coordination Model (CCM) Final Draft Principles #7

A CCM will provide services in the most integrated setting appropriate to the needs of qualified members with disabilities.

Consistent with the federal Olmstead decision, CCM care planning shall provide benefit package services in the most integrated setting appropriate to the needs of members with disabilities, include the members in decision-making, address quality of life, and actively support member preferences and decisions in order to improve member satisfaction.

Care Coordination Model (CCM) Final Draft Principles #8

A CCM will be evaluated to determine the extent to which it has achieved anticipated goals and outcomes and to drive quality improvement and payment.

CCMs will submit data to the State, which will be made available publicly, to compare and evaluate entities on an ongoing basis, determine the success of individual CCMs, and create transparency about CCM service delivery. Data will include, but will not be limited to: financial cost reports, provider networks, consumer satisfaction, grievances and appeals, assessment data, care outcomes and encounter data, and disenrollment data (both voluntary and involuntary). The CCM will use its own data and information to develop and conduct quality improvement projects. The Department will track experience of CCMs in relation to quality and costs, and will publish this data annually in a consumer-friendly format on the Department's website.

Care Coordination Model (CCM) Final Draft Principles #9

Existing member rights and protections will be preserved.

Members are entitled to the same rights and protections under CCM as they are under current law and practice, including the Federal and State Law or regulations governing MCOs. CCMs must follow clear criteria established by the Department for involuntary disenrollment and members must be informed about them and the attendant appeals and grievance rights.

Care Coordination Model (CCM) Final Draft Principles #10

A CCM with demonstrated expertise will be able to serve specified population(s).

Some populations have unique needs that can be best addressed by an entity that is skilled in the assessment, care plan development, service networks and monitoring of that group or to address specific medical conditions or illnesses. A CCM shall develop and implement a model of care appropriate to the specific population and use its expertise to serve those members.

Care Coordination Model (CCM) Final Draft Principles #11

Mandatory enrollment into CCMs in any county will not begin until and unless there is adequate capacity and choice for consumers.

Care Coordination Model (CCM) Final Draft Principles #12

Members shall have continuity of care as they transition from other programs.

Consumers already receiving long term care services through another Medicaid program have the right to continue to receive the same type and amount of services after enrollment until the CCM conducts a new assessment and authorizes a new plan of care which includes notice to the member.

Care Coordination Model (CCM)
Final Draft Principles #13

Prospective members will receive sufficient objective information and counseling about their plan choices before enrolling.

Prospective members shall be provided with appropriate materials educating them about their choices and shall have the opportunity to have questions answered before enrollment. Information about plans shall be posted on a website that is accessible to prospective members and the public. This information shall also be included in a printed brochure listing all CCMs in their geographic service area, which shall be sent by the enrollment broker to all prospective members.

Long Term Care Quality Metrics Work Group Recommendations

1. The goal should be to achieve improvement over time and to enable consumers and purchasers to compare CCM performance. This necessitates that the quality measures be transparent and publicly reported.

2. The criteria for determining measures should include that they be measurable, actionable, risk-adjusted, consistent across sectors, parsimonious, and have an impact on care.

Long Term Care Quality Metrics Work Group Recommendations

3. The quality measurement system should cover the following domains:

    - *Reduce utilization associated with nursing home admissions, emergency and urgent care and inpatient admissions.*
    - *Improve quality of life, emotional and behavioral status and preventive care and patient safety*
    - *Care management*
    - *Improve or stabilize functional status*
    - *Ensure continuity of worker and care to fullest extent possible*

4. The MRT Managed Long Term Care Quality Subcommittee should continue to convene to review progress made by SDOH in developing and implementing quality measurement system based on recommendations. Wherever possible, alignment with recommendations of MRT Payment Reform and other workgroups should be achieved.

Fair Hearing Work Group Recommendations

1. Consider the possibility of a targeted increase in resources to handle the move to mandatory enrollment in managed long term care or other care coordination models.

2. Providers should receive notice of fair hearings requested by their clients.

3. Training for ALJs pertaining to state law, rules, and regulations should be evaluated. Consumers and plans should have input to the training.

4. The target timeframe for fair hearing resolution should be within 60 days of the request for the hearing.

5. Regulations should be amended to require documented receipt of written notice of fair hearings to MLTC/CCM administrators of record or legal counsel.

Questions/Open Discussion