

Care Coordination Model Guidelines

Overview

A Care Coordination Model (CCM) is an entity that provides or contracts for all Medicaid long term care services. The CCM will be at risk for the services in the benefit package and rates will be risk adjusted to reflect the population served.

Under state law, the CCM will be among the options available (in addition to Managed Long Term Care Plans (MLTCPs) to enroll dual-eligible individuals age 21 and older who require community-based long term care services for more than 120 days.

The CCM benefit package includes both community-based and institutional Medicaid covered long term care services and will make consumer directed personal assistance services available for eligible individuals in July of 2012.

Care management is a key function of the CCM. The CCM must ensure that individualized, person-centered care management is provided to all members. Care coordination for services not in the benefit package, including primary care, acute care and behavioral health to promote continuity of care and improve outcomes is also a hallmark of the CCM.

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. The factors used to risk adjust CCM rates may include functional status, cognitive status, diagnoses, demographics or other measures found to be correlated to increased cost of services.

The CCM rates will be actuarially sound and sufficient to support provision of covered long term care services and care coordination and efficient administration and will incentivize community-based services.

CCMs are required by state law (Section 4403-f (7) (b) of the Public Health Law) to demonstrate the same capabilities and requirements as MLTCPs and therefore many of the guidelines for CCMs will parallel those for MLTCPs.

The development of CCMs reflects the direction of the New York State Medicaid program to provide care management to all populations. The transition to fully integrated approaches that manage primary, acute and long term care services of enrollees will assure quality of care by eliminating unnecessary hospitalizations, institutional placements and emergency visits. Applicants for CCMs should consider the capacity to evolve to full integration of Medicare and Medicaid within three to five years. Certified home health care agencies and long term home health programs as currently configured are not CCMs, however, they may apply to receive such designation pursuant to these

guidelines. In addition, it is the intention of the Department of Health to allow long term home health care programs to contract with CCMs.

Eligible Applicants

Any entity that meets the operational and financial requirements for a CCM may apply. However, there must be a separate legal entity established to operate the CCM. It may not be a department or unit of another entity. Requirements for filing a certificate of incorporation or articles of organization are outlined in 10NYCRR 98-1.4 and 98-1.5(a).

The CCM is subject to 10NYCRR 98-1.11(j) which details the requirements for delegated functions within management contracts. The delegated functions include claims payment. Management contracts must meet the Management Contract Guidelines which are available from DOH upon request.

Care Coordination Model Application

A proposed CCM must submit the Certification Application for Care Coordination Models which will be available on the Department of Health's website. The application articulates what information is needed.

Pursuant to the Public Health Law, a CCM must meet the requirements specified in Section 4403-f (3) (a) - (i) of the Public Health Law. To be approved as a CCM, the applicant must demonstrate the following:

- (a) that it will have in place acceptable quality-assurance mechanisms, grievance procedures, mechanisms to protect the rights of enrollees and case management services to ensure continuity, quality, appropriateness and coordination of care;
- (b) that it will include an enrollment process which shall ensure that enrollment in the plan is informed. The application shall describe the disenrollment process, which shall provide that an otherwise eligible enrollee shall not be involuntarily disenrolled on the basis of health status;
- (c) satisfactory evidence of the character and competence of the proposed operators and reasonable assurance that the applicant will provide high quality services to an enrolled population;
- (d) sufficient management systems capacity to meet the requirements of this section and the ability to efficiently process payment for covered services;
- (e) readiness and capability to maximize reimbursement of and coordinate services reimbursed pursuant to title XVIII of the federal social security act and all other applicable benefits, with such benefit coordination including, but not limited to, measures to support sound clinical decisions, reduce administrative complexity,

coordinate access to services, maximize benefits available pursuant to such title and ensure that necessary care is provided;

(f) readiness and capability to arrange and manage covered services and coordinate non-covered services which could include primary, specialty, and acute care services reimbursed pursuant to title XIX of the federal social security act;

(g) willingness and capability of taking, or cooperating in, all steps necessary to secure and integrate any potential sources of funding for services provided by the managed long term care plan, including, but not limited to, funding available under titles XVI, XVIII, XIX and XX of the federal social security act, the federal older Americans act of nineteen hundred sixty-five, as amended, or any successor provisions subject to approval of the director of the state office for aging, and through financing options such as those authorized pursuant to section three hundred sixty-seven-f of the social services law;

(h) that the contractual arrangements for providers of health and long term care services in the benefit package are sufficient to ensure the availability and accessibility of such services to the proposed enrolled population consistent with guidelines established by the commissioner; with respect to individuals in receipt of such services prior to enrollment, such guidelines shall require the managed long term care plan to contract with agencies currently providing such services, in order to promote continuity of care. In addition, such guidelines shall require managed long term care plans to offer and cover consumer directed personal assistance services for eligible individuals who elect such services pursuant to section three hundred sixty-five-f of the social services law; and

(i) that the applicant is financially responsible and may be expected to meet its obligations to its enrolled members.

The Department will acknowledge applications upon receipt. The applicant will be notified in writing of questions and deficiencies. Applicants that successfully meet the requirements for a Certificate of Authority will need to complete additional programmatic requirements, particularly those related to necessary policies and procedures before a Readiness Review can be completed. A contract between the Department and CCM must be executed and approved by the Office of the State Comptroller before the CCM may begin to enroll members.

Target Population and Service Area

The CCM target population is comprised of the following people:

- Age 21 and older
- Dually eligible for Medicare and Medicaid (The member may have a spend down)

- Is assessed as needing community-based long term care services (CBLTC) for more than 120 days (CBLTC includes home health care, personal care, adult day health care, private duty nursing).

The CCM application must describe the size and characteristics of the target population in the proposed service area.

A CCM may propose to serve a specialized population (based on specific diagnoses or conditions). The network and care management model of care must specify how the needs of the specialized population will be addressed.

A proposed CCM service area may include one or more counties. A CCM will not be approved to serve an area smaller than a county (e.g. certain zip codes, towns etc.).

Services Covered by the CCM Benefit Package

A CCM will begin operations with a partially capitated Medicaid benefit package. However, transition to fully integrated models of care which include all Medicare and Medicaid services is the goal of New York State over the next three to five years. This transition will include CCMs.

The following are the services that are included in the CCM benefit package for which the CCM will need to have an adequate network of providers. The CCM is responsible for assessing its members for these services, care planning for them, and arranging and monitoring the services for continued appropriateness and adequacy.

The CCM rate includes all Medicare cost sharing for the services that are noted with an asterisk. Members have freedom of choice for Medicare service providers although the CCM may encourage the member to use network providers. If a non-network Medicare provider is selected, the CCM must pay the Medicare share of cost to that provider.

- Home Health Care
- Nursing
- Home Health Aide
- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Medical Social Services
- Personal Emergency Response System
- Private Duty Nursing
- Respiratory therapy
- Nutritional counseling
- *DME including medical supplies, hearing aid batteries, prosthetics, orthotics and orthopedic footwear (as medically necessary by State law)

Adult Day Health Care
Personal Care
*Nursing Home
Non-emergent transportation
Home delivered meals
Social Day Care
Social and environmental supports

The CCM must add the following benefits 12 months after receiving a certificate of authority. Network capacity for these services must be demonstrated to the Department:

Podiatry
Dentistry
Optometry/Eyeglasses
Audiology/Hearing Aids
*Outpatient therapies

CCM Network Development and Prompt Payment

The CCM must have a choice of at least two providers in each county for each benefit package service. The Department acknowledges that some counties do not have sufficient available resources to meet this requirement for some services (e.g. social day care). Lack of availability does not preclude a CCM network from being approved. In instances where there is a lack of willingness to contract with the CCM, documentation should be submitted demonstrating the efforts made to meet the network requirements. The network must take into account the cultural and linguistic needs of the proposed population (including any specialized group) to be enrolled and be geographically accessible to the population. The format for submitting the network is included in the CCM Certificate of Authority application.

The contracting guidelines, standard clauses and submission forms are on the DOH website at:

http://www.health.ny.gov/health_care/managed_care/hmoipa/hmo_ipa.htm

Model contract templates may be submitted to DOH for review and approval as to form before the COA approval so that they may be used in network development.

A complete, contracted network must be demonstrated and attested to before the COA can be approved.

Other network requirements:

- CCMs must comply with Section 3224-a of the State Insurance Law pertaining to prompt payment to providers of covered services.

- CCMs must comply with Section 3614-c of the Public Health Law pertaining to home care worker parity.

Care Management and Care Coordination

Every enrolled CCM 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 care management function must address the varying needs of the population to be enrolled. 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.

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, must be given the opportunity to participate in decisions about the type and quantity of service to be provided.

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

The CCM must coordinate care with primary, acute, behavioral and other services that are not in the CCM benefit package to promote continuity of care. This includes, but is not limited to, assuring that transitions between service settings are made smoothly, new or changed physician orders requiring other providers are acted upon and referrals are made and followed-up on for non-benefit package services.

The CCM application requires submission of a detailed description of the proposed care management model and how the applicant will provide care management to its members.

A CCM that proposes to service a unique or specialized population must demonstrate that is skilled in the assessment, care plan development, and monitoring of that population and that it has a service network that is able to meet those specialized needs.

Other requirements:

- CCMs must have a plan for compliance with the federal Americans with Disabilities Act of 1973 (Section 504). Guidelines for compliance plan development are available on the Department website at:

http://www.health.ny.gov/health_care/managed_care/pdf/appendixj.pdf

Marketing and Enrollment/Disenrollment

A CCM must obtain Department approval on all marketing material prior to use. Marketing activities must be conducted consistent with the marketing requirements in 10NYCRR 98-1.19, 42 CFR 438.104 and CCM contract requirements.

A CCM must process referrals and requests for enrollment as they are received without consideration to the amount of service an individual may require. A CCM may not discriminate against an applicant on the basis of health status or need for health care services.

The CCM must use the standardized assessment tool required by the Department (currently the Semi-Annual Assessment of Members – SAAM) to determine if the applicant is eligible for CCM enrollment and to serve as part of the basis for care plan development. The assessment tool must be used to engage the member, the member's physician and informal supports to assure complete review of members needs. The SAAM assessment must be conducted by a Registered Nurse. The CCM may use other tools in addition to SAAM or the Department's required assessment tool as part of its assessment.

As part of the initial intake process, the CCM must determine if the applicant has current providers of benefit package services and provide information to potential enrollees about the CCM network of providers. Individuals already receiving long term care services through another Medicaid program have the right to continue to receive the same type and amount of services until the CCM conducts a new assessment, authorizes a new plan of care and providers notice to the member including appeal rights.

Member Rights and Protections

CCM members are entitled to the same rights and protections as they are under current law and practice, including federal and state law or regulations. CCMs must follow clear criteria established by the Department for involuntary disenrollment of members. Members must be informed about these rights and protections including the attendant fair hearing rights.

Each member must be provided a CCM handbook that describes the CCM, the benefit package services, the network of providers, how to access services, the eligibility criteria, grievance and appeal process, disenrollment process and criteria for involuntary disenrollment.

The CCM must adhere to the requirements regarding internal grievances and appeals processes and have written policies and procedures approved by the Department. The requirements are detailed in the CCM contract.

CCM members are entitled to the member rights detailed in the CCM contract. These rights must be communicated to applicants and members in a written format.

In addition, the CCM must adopt and maintain arrangements, satisfactory to the Department, to protect members from incurring liability for payment of any fees that are the legal obligation of the CCM.

Quality Assurance and Performance Improvement Program

A CCM must have a quality assurance and performance improvement program which includes a health information system consistent with the requirements of 42 CFR 438.242 and a Department approved written quality plan for ongoing assessment, implementation and evaluation of overall quality of care and services.

The quality plan must have board level accountability for overall oversight of program activities. The plan must reflect the requirements of the CCM contract.

Rates

The CCM will receive a per member per month payment to cover the services in the benefit package to promote the appropriate, efficient and effective use of services for which it is responsible. This capitated payment to the CCM will be based on the functional impairment level and acuity of its members. The factors used to risk adjust CCM rates may include functional status, cognitive status, diagnoses, demographics or other measures found to be correlated to increased cost of services.

The CCM rates will be actuarially sound and sufficient to support provision of covered long term care services and care coordination and efficient administration and will incentivize community-based services.

Financial Requirements

Capital Requirements for CCMs

CCMs must have initial capital sufficient to comply with the Health Department's Regulation Part 98-1.11 escrow and contingent reserve requirements on an ongoing basis. Estimated minimum start-up capital must be sufficient to fund pre-operational expenses, cumulative operating losses sustained through the time the break-even point is reached plus 3% of medical expenses for the 12 month period after reaching financial break-even and provide additional resources to cover unanticipated losses. The CCM must also demonstrate that it will maintain a net worth that meets the reserve requirements for the first three years of operations.

CCMs must identify the source of initial capital. If the source of capital is a subordinated loan, then the loan must be in the form of a Surplus Note (Surplus Notes are

issued in accordance with SSAP No. 41. The proposed loan document must be submitted to the Department of Health for review and approval.

When determining the total initial capital needed at start-up only liquid assets are counted (excludes buildings, furniture, fixtures and equipment).

Pledges and/or donations receivable will not be counted towards start-up capital.

Reserve Requirements

All CCMs are subject to the reserve and escrow requirements in 10NYCRR §98-1.11(e) and (f) with the exception of the initial 2 years of operations as described below.

CCMs must maintain an escrow account, in the form of a trust account approved by the Department of Financial Services. The funding of the Escrow account requirement can be phased in over two years from the date the CCM initially commences operations. At the date of opening the escrow account must be equal to 3% of projected expenditures for medical expenses care services for the first calendar year of operations and will be calculated as follows for subsequent years:

Year 2: 4% of projected medical expenses

Year 3 and for subsequent years: 5% of projected medical expenses

CCMs must maintain a reserve, to be designated as the contingent reserve, which must be equal to 5% of its annual net premium income at the end of year. The contingent reserve is used to cover unanticipated losses that might inhibit the ability of the CCM to pay member service claim obligations to providers.

Minimum Net Worth Requirement

The CCM must maintain a minimum net worth equal to the greater of the escrow requirement or the contingent reserve.

Reporting

CCMs will be responsible for annual, quarterly and ongoing reporting to the Department. Details of the reporting requirements will be included in the CCM contract but include:

- Annual financial statements
- Quarterly financial statements
- Other financial reports
- Encounter data
- Grievance and appeals reports
- Fraud and abuse reports

- Performance improvement projects
- Enrollee health and functional status (currently the Semi-Annual Assessment of Members)
- Provider network

Applicable laws and regulations

In addition to the guidelines above, the following are a list of relevant laws and regulations pertaining to CCMs. Where there are direct conflicts the guidelines will govern.

New York State

Public Health Law

Article 44 - Health Maintenance Organizations

Especially Section 4403-f - Managed Long Term Care Plans

Article 49 – Certification of Agents and Utilization Review Process

Article 29-B and 29-C – Advance Directives

Insurance Law

Section 3224-a (Prompt pay)

10NYCRR

Part 98-1 - Health Maintenance Organizations

Part 98-2 - External Appeals of Adverse Determinations

CCM Contract Provisions – Currently under development.

See: http://www.health.ny.gov/health_care/managed_care/mltc/pdf/mltc_contract.pdf for an example.

Federal

42CFR Part 438

Managed Care Organizations