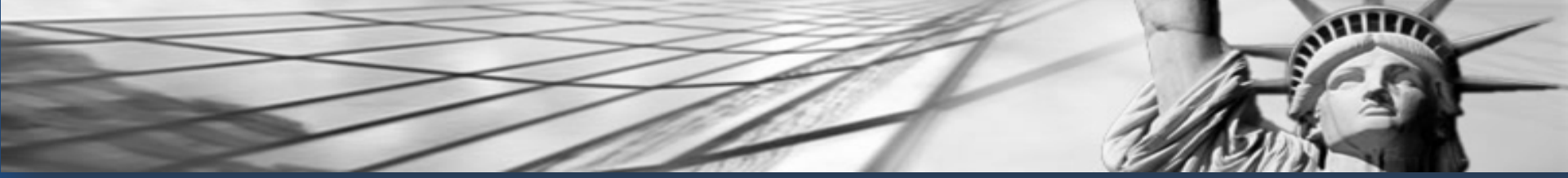

Care Coordination Model (CCM) Guidelines

Care Coordination Model (CCM) Guidelines

- 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.

- These guidelines are based on the principles developed by the Managed Long Term Care and Waiver Redesign Workgroup during period August to November of 2011 and adopted by the Medicaid Redesign Team on November 1, 2011.

Overview

- Provides or contracts for all Medicaid long term care services.
- At risk for the services in the benefit package and rates will be risk adjusted to reflect the population served.
- 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.

Overview

- Payment to the CCM will be based on the functional impairment level and acuity of its members.
- Rates will be actuarially sound and sufficient to support provision of covered services, efficient administration and will incentivize community-based services.
- Demonstrate the capabilities and requirements required by state law (Section 4403-f (7) (b) of the Public Health Law).

Eligible Applicants

- Any entity that meets the operational and financial requirements for a CCM
- Must be a separate legal entity established to operate the CCM (or already have an Article 44 COA)
- Requirements for filing a certificate of incorporation or articles of organization are outlined in 10NYCRR 98-1.4 and 98-1.5(a).
- 10NYCRR 98-1.11(j) details the requirements for delegated functions within management contracts. The delegated functions include claims payment. Management contracts must meet the Management Contract Guidelines (available from DOH)

Care Coordination Model Application

- Will be available on the Department of Health's website – after answers to questions are incorporated

Basic Requirements to be addressed by application as required in 4403-f(3)

- 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;
- enrollment process which shall ensure that enrollment in the plan is informed.
- 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;
- sufficient management systems capacity and the ability to efficiently process payment for covered services;

Care Coordination Model Application

- readiness and capability to maximize reimbursement of and coordinate services under Medicaid and all other applicable benefits,
- readiness and capability to arrange and manage covered services and coordinate non-covered services which could include primary, specialty, and acute care services reimbursed under Medicare
- willingness and capability of taking all steps necessary to secure and integrate any potential sources of funding for services provided
- 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; if individuals were in receipt of such services prior to enrollment CCM must contract with agencies currently providing such services to promote continuity of care.
- financially responsible and may be expected to meet its obligations to its enrolled members.

Care Coordination Model Application

- Department will acknowledge applications upon receipt.
- Applicants will be notified in writing of any questions and/or 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

- 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)

Target Population and Service Area

- Applicant must describe the size and characteristics of the target population in the proposed service area.
- Applicant 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.
- Applicant 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.).

Benefit Package

- Responsible for assessing its members for the following services, care planning for them, and arranging and monitoring the services for continued appropriateness and adequacy:
  - 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

Benefit Package

- *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 rate includes all Medicare cost sharing for the services that are noted.

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.

Benefit Package

- In order to allow the CCM to develop a more comprehensive benefit package while building enrollment the following benefits must be added 12 months after receiving a certificate of authority:
  - Podiatry
  - Dentistry
  - Optometry/Eyeglasses
  - Audiology/Hearing Aids
  - *Outpatient therapies

Network capacity for these services must be demonstrated to the Department prior to the beginning of Year 2

Network Development and Prompt Payment

- Applicants 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. 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.

Network Development and Prompt Payment

- 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.

- 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 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
- 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.

Care Management and Care Coordination

- Consistent with the federal Olmstead decision, 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
  - actively support members preferences and decisions in order to improve member satisfaction.
- Coordinate care with primary, acute, behavioral and other services that are not in the CCM benefit package to promote continuity of care:
  - assuring that transitions between service settings are made smoothly,
  - new or changed physician orders requiring other providers are acted upon
  - referrals are made and followed-up on for non-benefit package services.

Care Management and Care Coordination

- Detailed description of the proposed care management model and how the applicant will provide care management to its members.

- If applicant defines a unique or specialized population then it must demonstrate that it 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 Enrollment/Disenrollment

- Department approval required on all marketing material prior to use.
- Activities must be conducted consistent with the marketing requirements in 10NYCRR 98-1.19, 42 CFR 438.104 and CCM contract requirements.
- Must process referrals and requests for enrollment as they are received without consideration to the amount of service an individual may require.
- May not discriminate against an applicant on the basis of health status or need for health care services.

Marketing Enrollment/Disenrollment

- Must use the standardized assessment tool required by the Department to determine if the member applicant is eligible for CCM enrollment and to serve as part of the basis for care plan development.
- Assessment must be conducted by a Registered Nurse. CCM may use other tools as part of its assessment.
- Must determine if the member applicant has current providers of benefit package services and provide information to potential enrollees about the 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

- 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.
- 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.
- Must adhere to the requirements regarding internal grievances and appeals processes and have written policies and procedures approved by the Department.

Member Rights and Protections

- 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.
- 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

- Must include a health information system consistent with the requirements of 42 CFR 438.242
- Department approved written quality plan for ongoing assessment, implementation and evaluation of overall quality of care and services.
- Must have board level accountability for overall oversight of program activities.
- The plan must reflect the requirements of the CCM contract.

Rates

- PMPM payment to cover the services in the benefit package to promote the appropriate, efficient and effective use of services for which it is responsible
- Based on the functional impairment level and acuity of its members. The factors used to risk adjust rates may include functional status, cognitive status, diagnoses, demographics or other measures found to be correlated to increased cost of services.
- 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

- 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.
- Demonstrate that its net worth will meet the reserve requirements for the first three years of operations.
- Identify the source of initial capital.

(continued)

Financial Requirements: *Capital Requirements*

- 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.
- Plans sponsored by or affiliated with larger health systems may be capitalized by subordinated debt in the form of a Surplus Note.

Financial Requirements:
Required Initial Capital Calculation

CCM applicants will be required to submit projected revenue and expense statements for the first 3 years of operations.

EXAMPLE

(*New entity with no other Mainstream or MLTC lines of business*)

- Applicant's Projected Med. Expenses 12 months after financial breakeven : $21,284,562
- Required Initial Capital Escrow for CCM's is equal to 3% of projected Medical Expenses from above: $21,284,562 X .03 = $638,537
- Projected Pre-operational Expenses: $267,974
- Projected cumulative losses to break even: $1,062,865
- Required Initial Capital is equal to the sum of the three items above: **$1,969,376**

Financial Requirements:
Regulatory Reserve Requirements

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

(continued)

Financial Requirements:
Regulatory Reserve Requirements

- 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 the calendar 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.

Financial Requirements: *Reserve Requirements*

Required reserves are calculated based upon the 3 year revenue and expense projections submitted by the applicant.

EXAMPLE (New Entity no other lines of business)

Year 1 Escrow: $21,284,562 X 3% = $638,537

Year 2 Escrow: $23,965,379 X 4% = $958,615

Year 3 Escrow: $37,048,658 X 5% = $1,852,433

The Contingent Reserve is calculated on December 31st of each year. Applicant's year 1 projected premium revenue is $7,674,404

Year 1 Contingent Reserve: $7,674,404 X 5% = $383,720

Year 2 Contingent Reserve: $7,674,404 X 5% = $383,720

Year 3 Contingent Reserve: $29,735,607 X 5% = $1,486,780

Financial Requirements:
Minimum Net Worth Requirement

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

EXAMPLE: (New Entity no other lines of business)

	Year 1	Year 2	Year 3
Escrow	$638,537	$958,615	$1,852,433
Contingent Res.	$383,720	$383,720	$1,486,780
Minimum Net Worth	**$638,537**	**$958,615**	**$1,852,433**

Reporting

- **Annual and Quarterly Financial Statements**
  - Medicaid Managed Care Operating Reports
    - Member Months, Revenue and Expense (Gross and PMPM), Balance Sheet, Cost and Utilization Data
    - Reports and Certifications are filed electronically
      - CEO and CFO must certify by the MMCOR filing date
    - Immediately following issuance of the COA, plans need to obtain access to the NYSDOH Health Commerce System (HCS) by contacting the Commerce Accounts Management Unit (CAMU) at **1-866-529-1890.**

Reporting (continued)

- **Other Financial Reports**
  - Certified Audited Financial Statements
    - Due by April 1 of each year
- **Encounter Data**
  - Following issuance of the COA, plans need to contact the Provider Network – MEDS Compliance Data Unit at **OMCMEDS@health.state.ny.us** or **(518) 486-9012.**

Reporting (continued)

- Responsible for annual, quarterly and ongoing reporting to the Department, reporting requirements will be include:
  - Grievance and appeals reports
  - Fraud and abuse reports
  - Performance improvement projects
  - Enrollee health and functional status
  - Provider network

Applicable Laws and Regulations

- Where there are direct conflicts the guidelines will govern:
  - State:
    - Public Health Law
      - Article 44 - Health Maintenance Organizations (especially Section 4403-f)
      - 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
  - Federal:
    - 42CFR Part 438
      - Managed Care Organizations

Questions and Answers

Q: If a LTHHCP or CHHA sponsors a CCM, can it apply to cover a region larger than that approved for the LTHHCP or CHHA?

A: A CCM can apply for a service area that is larger than that of the CHHA or LTHHCP. However the CCM must either:

- *Have a network of contracted home care providers that are approved to serve the additional counties, or*
- *Obtain a service area expansion for the CHHA or LTHHCP*

Questions and Answers

Q: The CCM Guidelines shows five services that must be included in the benefit package by the beginning of Year 2. Could we initiate them in Year 1 instead? If so, how is the capitation affected?

A: A CCM may offer the complete benefit package in Year 1. The capitation payment would be adjusted to include all services.

Questions and Answers

Q: Are there benefit limits for the CCM for services such as vision and home delivered meals?

A: For benefits such as vision, a CCM must provide benefits that are no less restrictive than the fee for service Medicaid program. Refer to the Medicaid provider manuals on the DOH website for details.

For social and environmental supports such as meals, the CCM will have service authorization criteria (approved by DOH) that identify how medical necessity will be determined.

Questions and Answers

Q: Is there a data book available to assist in determining expected costs for Year 1?

A: Yes, regional average costs are available and will be posted to the DOH website with the CCM application.

Questions and Answers

Q: Are there standard care management models and assessment tools (in addition to SAAM) that are available for us to use?

A: It is the CCM's responsibility to research and evaluate care management models and assessment tools that are appropriate for the intended target population.

Questions?

Please send them to:

mltcworkgroup@health.state.ny.us