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New and Updated Information on Care Management Administrative Services (CMAS)

Speakers

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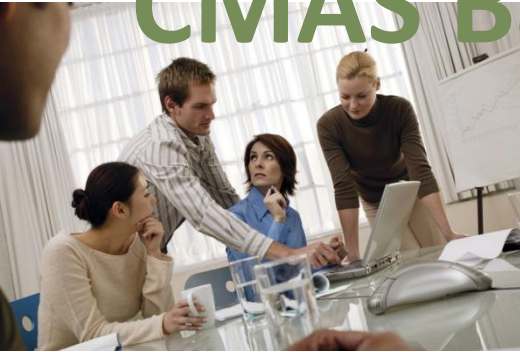


Agenda

- Introduction
- History of the Care Management Administrative Services (CMAS) agreement;
- What providers are eligible to enter into this agreement;
- What are the critical components of the agreement;
- Review of the three documents promulgated by DOH to guide the CMAS agreement; and
- Issues that you need to consider when entering into a CMAS agreement.
- Attachments
- Questions and Answers



CMAS Background



Introduction

This is a **new** opportunity for certain providers to enter into an agreement with Managed Long Term Care plans to provide care management services.

History

Spring/Summer 2012

- Facilitate contracting between managed care plans and Certified Home Health Agencies (CHHAs), Long Term Home Health Care Programs (LTHHCPs) and Licensed Home Care Services Agencies (LHCSAs) for services to managed care members
- Management Service Agreements (MSAs) – Part 98 - sole agreement clause
- New Agreement Developed – blend of a MSA and provider agreement



CMAS Background, Cont.

History


Fall/Winter 2012

- Draft CMAS language developed by Associations and Plans
 - Published November 30, 2012
 - Revised December 27, 2012 and January 2, 2013






Who is the Administrator

- An administrator means any entity performing Technical and Administrative Services as defined herein for the provision of Care Management Services on behalf of an MCO.
 - CMAS Standard Clauses, page 1
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What is Care Management Services

- “Care Management Services” means the delegation by the MCO of the process that assists enrollees to access necessary covered services as identified in the Care Plan.
 - It also provides referral and coordination of other services in support of the Care Plan.
 - Care Management Services assists Enrollees to obtain needed medical, social, educational, psychosocial, financial and other services in support of the Care Plan irrespective of whether the needed services are covered under the capitation payment to the MCO.
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“Care Plan/Person Centered Service Plan”

- is a written description in the care management record of member-specific health care goals to be achieved and the amount, duration and scope of the covered services to be provided to an Enrollee in order to achieve such goals.
 - The person centered individual service plan is based on assessment of the member's health care needs and developed in consultation with the member and his/her informal supports.
 - The plan includes consideration of the current and unique psycho-social and medical needs and history of the enrollee, as well as the person's functional level and support systems.
 - Effectiveness of the person centered service plan is monitored through reassessment and a determination as to whether the health care goals are being met.
 - Non-covered services which interrelate with the covered services identified on the plan and services of informal supports necessary to support the health care goals and effectiveness of the covered services should be clearly identified on the person centered service plan or elsewhere in the care management record.
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Questions?

Q & A