NYAHSA | New York Association of Homes & Services for the Aging

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M E M O R A N D U M

TO: All Members

FROM: Dan Heim, Senior Vice President
Cheryl Udell, Policy Analyst

DATE: August 17, 2011

SUBJECT: **MRT MLTC Implementation and Waiver Redesign Workgroup Meeting**

ROUTE TO: Administrator/Program Director

ABSTRACT: MRT Managed Care Workgroup discusses care coordination guidelines.

Introduction

At the second meeting of the Medicaid Redesign Team (MRT) Managed Long Term Care (MLTC) Implementation and Waiver Redesign Workgroup yesterday, the Department of Health (DOH) unveiled a draft version of the much-awaited Care Coordination Model (CCM) principles for discussion. NYAHSA attended the meeting.

Meeting Summary

Workgroup co-chair Carol Raphael clarified that the goal of the meeting was to arrive at a consensus on the draft CCM principles, which are intended to be used to develop CCM guidelines. Under the 2011-12 state budget legislation, beginning April 1, 2012 all adult Medicaid recipients who need 120+ days of home and community-based services will be required to enroll in an MLTC plan or a CCM as defined by DOH.

The workgroup discussed each principle and raised several points throughout the meeting:

- Concern that the principles suggest a capitated, insurance model like MLTC that may not be workable in some areas of the state and for many providers;
- The need to carefully define the benefit package, with questions on whether to include a nursing home component and other services;
- Clarifying the level of responsibility for arranging for and coordinating services not included in the benefit package;

- Developing more than just one care coordination model rather than a "one size fits all" approach;
- Ensuring an adequate capacity of service providers;
- Adhering to a person-centered approach and including consumer direction;
- Complying with the Olmstead decision;
- Fair hearing rights and consumer protections;
- Rules around enrollment and voluntary/involuntary disenrollment;
- Utilizing a standardized assessment tool with different populations and whether the UAS-NY would be robust enough;
- Developing contracts with providers that are consistent with the guiding principles;
- Clarifying whether care coordination is a service or administrative cost;
- Risk-adjusting payments to reflect the needs of the population,
- Need for transition as capacity is being developed; and
- Ensuring DOH has the infrastructure in place before April 1, 2012 to monitor and provide oversight of CCMs.

Following discussion on each of the principles, workgroup members made general comments. Some members indicated that if the CCM is driven by financial considerations rather than quality measures and a person-centered approach, the model will fail. Other members said that while the workgroup may agree on refined principles, the "devil" will be in the operational details.

The meeting concluded with outlining next steps:

- Using feedback from the meeting to revise and add to the principles;
- Circulating the revised principles via e-mail for additional comment;
- Holding a meeting in Brooklyn on September 19 to obtain public input (and possibly an additional public meeting Upstate);
- Holding the next workgroup meeting on September 28; and
- Convening 3 subcommittees of the workgroup to focus on: (1) quality; (2) fair hearings; and (3) the role of local social services districts in Medicaid eligibility and enrollment. The subcommittees would be comprised of workgroup members and outside representatives.

Conclusion

NYAHSA will be following up on this discussion, as well as a recent meeting we had with DOH on legislation intended to enhance the long term home health care program so it can function as a CCM. We are working with the Association's Community Based Services Cabinet, the Adult Day Health Care Council and our association partners to promote existing, time-tested coordinated care models as viable options alongside MLTCs. We will continue to keep members posted on our work.

The draft care coordination principles that were reviewed at yesterday's meeting are reproduced below. Please click here to obtain other materials and audio recordings of the meetings of this workgroup. Contact Cheryl Udell with any questions or comments at cudell@nyahsa.org or 518-867-8383, ext. 151.

Attachment

Draft Care Coordination Model (CCM) Principles

1. A CCM must provide or contract for all Medicaid long term care services in the benefit package.

The CCM service package includes both community-based and institutional Medicaid covered long term care services. The CCM is responsible for assessing the need for, arranging and paying for all Medicaid long term care services.

2. A CCM must be financially at risk for the services in the benefit package.

The CCM will receive a periodic payment to cover the services in the benefit package to promote the appropriate and efficient use of services for which it is responsible.

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

Every individual must have a care manager or care management team that is responsible for assessment and reassessment, care plan development and implementation, care plan monitoring, service adjustment and problem solving. The care management function should address the varying needs of the population and should encompass high-touch/low-touch as dictated by the needs of the member and informal supports/caregivers.

4. A CCM must be involved in care management 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 years. As an interim approach, the CCM must be responsible for care managing primary and acute care services and other services not in the CCM service package to promote continuity of care.

5. CCM care management must involve the individual and informal supports in the development and execution of the care plan to extent desired by the individual.

Eliciting and adhering to the wishes and preferences of individuals and their informal supports is a critical component of care plan development. Members with capacity should be given the opportunity to participate in decisions about the type and quantity of service to be provided.

6. CCM members will have a choice of providers for all benefit package services.

Members should be able to select among several providers of each service. CCMs should have a network that takes into account the cultural and linguistic needs of the population to be enrolled. However, 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. Members should have the ability to receive services from an out-of-network provider if no provider is available in-network that can adequately meet the needs of the member.

7. CCM will use a standardized assessment tool to drive care plan development. Data should be submitted to NYS.

CCMs should 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. Data submitted to the State will be available to compare and evaluate entities to create transparency about CCM service delivery.

8. CCM care planning will seek to provide services in the most integrated setting appropriate to the needs of qualified individuals with disabilities.

Consistent with the federal Olmstead decision, care planning should seek to provide care in the best setting to match the needs of members, engage the members in decision-making and address quality of life.

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

Data will be submitted and evaluated on an ongoing basis to determine the success of the CCM. Data will include, but not be limited to: financial reports, provider networks, consumer satisfaction, grievances and appeals, care outcomes and encounter data. The CCM will use its own data and information to develop and conduct quality improvement projects.

10. CCM rates will be risk adjusted to reflect the population served.

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 should be actuarially sound and sufficient to support provision of covered long term care services and care coordination.

11. CCM will provide adequate consumer protections for members.

Members must be entitled to and be informed of their rights as members of the CCM. This includes the right to make complaints about the care and services provided, to have requests for services addressed timely and to appeal decisions by the CCM. Members should have the right to disenroll from the CCM on a month to month basis and join another provider of service.

12. A CCM 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 and monitoring of that group or to address specific medical conditions or illnesses. A CCM should be able to develop and use its expertise to serve specific populations.