MRT Managed Long Term Care Implementation and Waiver Redesign Work Group

# Care Coordination Model (CCM) Principles

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NEW YORK state department of HEALTH

# CCM Principle #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.

# CCM Principle #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.

# CCM Principle #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.

# CCM Principle #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.

# CCM Principle #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.

# CCM Principle #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.

# CCM Principle #7

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

# CCM Principle #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.

# CCM Principle #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.

# CCM Principle #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.

# CCM Principle #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.

# CCM Principle #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.