Redesigning
THE MEDICAID PROGRAM

NEW YORK STATE DEPARTMENT OF HEALTH

Medicaid Redesign Team (MRT)

Managed Long Term Care Implementation and Waiver Redesign Work Group

FINAL RECOMMENDATIONS

Medicaid Redesign Team
Managed Long Term Care Implementation and Waiver Redesign Work Group
Final Recommendations – October 28, 2011

WORK GROUP CHARGE:

- Advise DOH on the development of care coordination models (which may include Long Term Home Health Care Programs) to be used in the mandatory enrollment of persons in need of community-based long term care services.
- Review processes to ensure that sufficient patient protections exist. Promulgate guidelines for network development and contractual arrangements which are sufficient to ensure the availability, accessibility and continuity of services.
- Discuss ways to promote access to services and supports in homes and communities, so individuals may avoid nursing home placement and hospital stays.

WORK GROUP MEMBERSHIP:

The members of the Managed Long Term Care Implementation and Waiver Redesign Work Group were selected by co-chairs and MRT members Eli Feldman and Carol Raphael.

- **Co-chair: Eli Feldman,** President & CEO, Metropolitan Jewish Health System and Chairman, Continuing Care Leadership Coalition
- **Co-chair: Carol Raphael,** President & CEO, Visiting Nurse Service of New York
- **Michael Birnbaum,** Vice President, United Hospital Fund
- **Courtney Burke,** Commissioner, Office of People with Developmental Disabilities
- **Jo-Ann A. Costantino,** Chief Executive Officer, The Eddy
- **Doug Goggin-Callahan,** NYS Policy Director, Medicare Rights Center
- **George Gresham,** President, 1199-SEIU
- **Mary Harper,** Executive Deputy Commissioner, Medical Insurance & Community Services Administration, New York City Human Resources Administration
- **Joseph M. Healy, Jr. PhD,** Chief Executive Officer, Comprehensive Care Management Corp.
- **Tom Holt,** President & CEO, Lutheran Social Services
- **Mark Lane,** President & CEO, New York State Catholic Health Plan, Inc., Fidelis Care New York

-continued-

- **David McNally,** New York Manager of Government Relations and Advocacy, AARP
- **Alan R. Morse, JD, PhD,** President & CEO, The Jewish Guild for the Blind, GuildNet, Inc.
- **Betty Mullin-DiProsa,** President & CEO, St. Ann's Community
- **Carol Rodat,** New York Policy Director, PHI
- **M. Kate Rolf,** President and CEO, VNA of Syracuse
- **Marilyn Saviola,** Director of Advocacy, Independence Care System
- **Melanie Shaw, JD,** Executive Director, New York Association on Independent Living (NYAIL)
- **Kathleen Shure,** Senior Vice President, Managed Care & Insurance Expansion, Greater New York Hospital Association

MEETING DATES AND FOCUS:

- **July 8, 2011** – The first meeting of the Work Group reviewed the charge and background material on the MRT recommendations; the status of the managed long term care program and certain 1915 (c) waivers. In addition, data was reviewed related to current expenditures and demographics on current participants in FFS and managed long term care. Jim Verdier from Mathematica Policy Research provided a presentation on Dual Initiatives in Other States. A comprehensive discussion was undertaken on the following questions so that care coordination model principles and guidelines can be created:
    - What long term care services should be included in the benefit package?
    - What requirements should there be for plans/models in regard to size, expertise, network, financial viability, etc.?
    - What should be the essential ingredients in care coordination?
    - Which approaches to care coordination and management would have the most beneficial impact on beneficiaries, service use and Medicaid expenditures?
    - How can we ensure consumer rights and protections?
    - How do we improve the care and outcomes of the target population?
    - How should monitoring of performance and outcomes be conducted?
    - What should payment model be to ensure clear accountability for good outcomes for a target population?
    - Is there any feasible accountability model that is not full risk that will enable full integration down the road?
    - What should the future be of current non-capitated care coordination models?
    - How can we best transition from current long term care system to new plans and models including incorporating consumer directed care?
    - How should we best approach the dual eligible population, i.e., to ensure integration and coordination?
    - How can we ensure needed capacity?
    - How do we accommodate regional variation?

- **August 16, 2011** – The members worked to review the initial Care Coordination Model (CCM) Principles that would be applied to the development of models of care. There were twelve principles discussed and each member had the opportunity to provide comments and recommend modifications to the principles. As a result, principles were modified and reissued to members for comment prior to being released to the public for review.

- The proposed CCM principles were the basis for the public hearing that took place on September 19, 2011 at the NYC College of Technology.

- **September 28, 2011** – The members received an update on MLTC applications; reports from the Fair Hearing and Quality Metrics Subcommittees; an overview of the testimony presented at the MLTC Public Hearing; a presentation of recommendations identified by the Program Streamlining and State/Local Responsibilities Work Group; presentations on consumer protections in mainstream Medicaid managed care plans and an overview of the 1115 waiver process. The Work Group then spent significant time to complete the CCM Principles. At the end of the meeting the Co-Chairs requested that a subgroup of members take the opportunity to revise the CCM Principles so that they can be finalized. As a result of the ongoing revisions the Work Group determined a need for another meeting beyond the October 20th deadline which is scheduled for October 27th. It is anticipated that final recommendations will be made on the CCM Principles so that DOH staff can complete guidelines by November 15, 2011.

- **October 27, 2011** – The members completed their review of the Care Coordination Principles and made revisions resulting in the adoption of the set of principles by majority vote. Two members abstained and one member voted no. Members also reviewed and revised the Quality and Fair Hearing Subcommittee reports. All members supported the inclusion of those sets of revised recommendations. In addition, the members identified consumer direction as an integral part of the Care Coordination Model Principles and Managed Long Term Care and therefore recommend establishment of a separate work group.

Outside Experts Consulted with:

Jim Verdier from Mathematica Policy Research provided a presentation on Dual Initiatives in Other States for the first Work Group meeting.

Two subcommittees were established that included the participation of individuals beyond the membership of the Work Group. The subcommittees covered two critical areas: Long Term Care Quality Metrics (meetings held on 9/13/11 and 10/20/11) and Fair Hearings (meeting held on 8/31/11).

LONG TERM CARE QUALITY METRICS SUBCOMMITTEE

Work Group Participants and Interested Parties: Carol Raphael (Chair); Michael Birbaum; Kevin Finnegan; Joe Healy; Bryan Marcou-O'Malley; Marilyn Saviola; Helen Schaub; Melvyn Tanzman; Courtney Burke; Jo-Ann Costantino; Betty Mullin-DiProsa; Leah Farrell; David McNally; Mary Kate Rolf; Mary Ellen Connington; Kathryn Haslanger; and Andrew Segal, who served as Secretary of the meeting. DOH Staff: Mark Kissinger; Carla Williams; Linda Gowdy; and Patrick Roohan

Subcommittee charge: Identify measures that advance quality in a redesigned long-term care system. The Subcommittee considered the following:

- How to make measures relevant to consumers and capture consumer choice and preference.
- How to capture quality of life, which involves maintenance of function, prevention of decline, as well as improvement.
- Overview of the SAAM tool and consumer surveys of current managed long term care plans.
- Quality Measurement System that will be embedded in the health home application.
- Uniform Assessment System –NY (UAS-NY) which will be web-based and replace the SAAM for home and community based programs including managed long term care and care coordination models.
- Quality measures being considered by the National Quality Forum (NQF) Post-Acute/Long-Term Care Work Group. The NQF Work Group agreed after studying the field that the 4 priority areas of measurement in a long-term care system are:
    - Function (patient factors such as ADLs, IADLs, and stage of illness);
    - Goal Attainment (e.g. improvement, maintenance, palliation);
    - Care Coordination (dual eligible individuals in a long-term care system experience multiple settings of care and providers); and
    - Cost/Access (specifically addressing the issue of cost-shifting)

A substantial amount of time was also focused on the principles and criteria that should guide the development of quality measures and improvement systems. It was recommended that quality measures must be measurable, actionable, risk-adjusted, and consistent across sectors, and have an impact on care.

FAIR HEARING SUBCOMMITTEE

Work Group members and interested parties: Eli S. Feldman, Valerie Bogard, Evelyn Frank, Mark Lane, Alan Morse, J.D., Ph.D., Chris Palmieri, Marilyn Saviola, Melanie Shaw, J.D., Meghan Shineman, Zeynep Sumer, Roxanne Tena-Nelson, Mark Ustin (representing James Lytle.) DOH staff: Mark L. Kissinger, Carla Williams, Linda Gowdy, Vallencia Lloyd, Jane McCluskey, James Deering, Dan Tarantino, Karen Meier. Office of Temporary Disability Assistance (OTDA): Maria Vidal, Hank Pedicone, Dan Bloodstein, Inez Haettenshwiller and Dave Amiraian.

Subcommittee charge: Discuss how the fair hearing process intersects with and impacts on and MRT initiatives.

The Subcommittee considered the following:

- The decision in *Shakhnes v. Doar*, requiring final Administrative Law Judge (ALJ) rulings within 90 days for Medicaid-funded home care applicants and recipients, should – and so far has – improved the timeliness of decisions. OTDA noted that *Shakhnes* affects only a small class of recipients and has been appealed.
- Attention needs to be paid to voluntary enrollments as well as mandatory enrollment.
- Standardized process to ensure that people's needs are met in the transition from the current fee-for-service system to mandatory managed long-term care.

The Subcommittee discussed the following recommendations:

- The MLTC Implementation & Waiver Redesign Work Group and the MRT, as a whole, should consider the possibility of a targeted increase in resources to handle the move to mandatory enrollment in managed long term care or other care coordination models. OTDA was asked for data related to the current number of ALJs and their current caseload. That data request is still outstanding.
- Providers should receive notice of fair hearings requested by their clients; plans should make clear to members who their plan is in order to facilitate this.
- Training for ALJs pertaining to state law, rules, and regulations pertaining to managed long term care and care coordination models should be evaluated and enhanced. Consumers and plans should have input to the training.
- Consumers requested the right to have a fair hearing resolved within 60 days of the request for the hearing. OTDA should be provided the resources if needed after an analysis of current work process to schedule hearings within 21 days of a request and to issue decisions within 60 days.
- Regulations should be amended to require documented receipt of written notice of fair hearings to MLTC/CCM administrators of record or legal counsel whose enrollees are exercising fair hearing rights.

Other issues that were not agreed upon:

- To expedite the Appeals and Fair Hearing Process, where there is disagreement over the initial proposed MLTC/CCM Plan of Care, either by the consumer or the MLTC/CCM, either should have the right to ask for an independent clinical assessment by an independent external organization. If the assessment conflicts with the proposed PoC, the MLTC/CCM has 5 days in which to agree with and/or propose an alternative PoC. If the consumer decides not to accept the result of the assessment and/or the PoC, s/he may file for a fair hearing within 5 days of reviewing the new PoC. Agreement could not be reached on the two assessments being presumptive evidence of the needed plan of care when reviewed by the ALJ.

WORK GROUP SUMMARY OF RECOMMENDATIONS:

RECOMMENDATION 1: Preamble and Principles for Care Coordination Models

Preamble: These principles will inform guidelines for the development of Care Coordination Models (CCM). The resulting guidelines will allow for flexibility in model design while protecting the consumer. In addition a reasonable phase-in period for providers and consumers is necessary during implementation of the major changes advanced by the Medicaid Redesign Team.

Individuals who need long term care should have access to Medicaid enrollment and eligibility assistance. To assure consistency with other MRT activities, the Work Group supports the Program Streamlining and State/Local Responsibilities Work Group Recommendations related to Long Term Care and Enrollment.

Principle #1

A CCM must provide or contract for all Medicaid long term care services in the benefit package. CCM will be at risk for the services in the benefit package and rates will be risk adjusted to reflect the population served.

The CCM benefit package includes both community-based and institutional Medicaid covered long term care services and makes consumer directed personal assistance services available for eligible individuals. The CCM is responsible for assessing the need for, arranging and paying for all Medicaid long term care services. The CCM must meet financial solvency standards to assure protection of the members, such standards shall include a phase-in period.

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. Risk factors could include functional status, cognitive status, diagnoses, demographics or other measures found to be correlated to increased cost of services. CCM rates shall be actuarially sound and sufficient to support provision of covered long term care services and care coordination and efficient administration. Payments shall incentivize community-based services.

Principle #2

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

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 CCM must use Health Information Technology, as feasible, to document, execute and update the plan of care and share information among appropriate staff and providers. The care management function shall address the varying needs of the population. 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.

Principle #3

A CCM must be involved in care coordination 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 to five years. As an interim approach, the CCM will coordinate care with primary and acute care services and other services not in the CCM service package to promote continuity of care and improve outcomes.

Principle #4

The member and his/her informal supports must drive the development and execution of the care plan.

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

Principle #5

Care coordination is a core CCM function. For benefit package services, CCM members will have a choice of providers.

A CCM must ensure that individualized care coordination is provided to all members, and have adequate capacity to do so. Within the CCM, members will be able to select among a choice of at least two providers (where available) of each benefit package service. CCMs shall have a network that takes into account the cultural and linguistic needs of the population to be enrolled.

There are geographic differences in the availability of service providers and CCMs should not be prevented from operating when market forces (lack of availability or unwillingness to contract) preclude a CCM network from offering choice or, perhaps in some instances, a particular service. However, CCM's must have the ability to authorize services from an out-of-network provider if no provider is available in-network that can adequately meet the needs of the member.

Principle #6

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

CCMs shall 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. The standardized assessment tool must be used to engage the member, the member's physician and informal supports to assure a complete review of member needs.

Principle #7

A CCM will provide services in the most integrated setting appropriate to the needs of qualified members with disabilities.

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

Principle #8

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

CCMs will submit data to the State, which will be made available publicly, to compare and evaluate entities on an ongoing basis, determine the success of individual CCMs, and create transparency about CCM service delivery. Data will include, but will not be limited to: financial cost reports, provider networks, consumer satisfaction, grievances and appeals, assessment data, care outcomes and encounter data, and disenrollment data (both voluntary and involuntary). The CCM will use its own data and information to develop and conduct quality improvement projects. The Department will track experience of CCMs in relation to quality and costs, and will publish this data annually in a consumer-friendly format on the Department's website.

Principle #9

Existing member rights and protections will be preserved.

Members are entitled to the same rights and protections under CCM as they are under current law and practice, including the Federal and State Law or regulations governing MCOs. CCMs must follow clear criteria established by the Department for involuntary disenrollment and members must be informed about them and the attendant appeals and grievance rights.

Principle #10

A CCM with demonstrated expertise 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, service networks and monitoring of that group or to address specific medical conditions or illnesses. A CCM shall develop and implement a model of care appropriate to the specific population and use its expertise to serve those members.

Principle #11

Mandatory enrollment into CCMs in any county will not begin until and unless there is adequate capacity and choice for consumers and opportunity for appropriate transition of the existing service system in the county.

The Department of Health shall review existing long term care programs and seek to remove barriers that may prevent contracting with a CCM.

Principle #12

Members shall have continuity of care as they transition from other programs.

Consumers 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 provides notice to the member including appeal rights.

Principle #13

Prospective members will receive sufficient objective information and counseling about their choices before enrolling.

Prospective members shall be provided with appropriate materials educating them about their choices and shall have the opportunity to have questions answered before enrollment. Information about options shall be posted on a website that is accessible to prospective members and the public. This information shall also be included in a printed brochure listing all CCMs in their geographic service area, which shall be sent by the enrollment broker to all prospective members.

RECOMMENDATION 2: Quality Measures

1. The goal should be to achieve improvement over time and to enable consumers and purchasers to compare CCM performance. This necessitates that the quality measures be transparent and publicly reported.
2. The criteria for determining measures should include that they be measurable, actionable, risk-adjusted, consistent across sectors, parsimonious, and have an impact on care.
3. The quality measurement system should cover the following domains:
    - *Reduce inappropriate utilization associated with nursing home admissions, emergency and urgent care and inpatient admissions;*
    - *Improve quality of life, emotional and behavioral status and preventive care and patient safety;*
    - *Improve care management;*
    - *Improve or stabilize functional status;*
    - *Ensure continuity of worker and care to fullest extent possible.*
4. The MRT Managed Long Term Care Quality Subcommittee should continue to convene to review progress made by SDOH in developing and implementing quality measurement system based on recommendations. Wherever possible, alignment with recommendations of MRT Payment Reform and other work groups should be achieved.

RECOMMENDATION 3: Fair Hearing

1. Consider the possibility of a targeted increase in resources to handle the move to mandatory enrollment in managed long term care or other care coordination models.
2. Providers should receive notice of fair hearings requested by their clients.
3. Ongoing training for ALJs pertaining to state law, rules, and regulations should be evaluated. Consumers and plans should have input and access to the training.
4. The target timeframe for fair hearing resolution should be within 60 days of the request for the hearing.
5. Regulations should be amended to require documented receipt of written notice of fair hearings to CCM administrators of record or legal counsel.

RECOMMENDATION 4: Consumer Direction

Establish a work group to advise the Department on the integration of self directed program models, including the consumer directed personal assistance program (CDPAP), into CCMs and Managed Long Term Care.

Redesigning
THE MEDICAID PROGRAM

Medicaid Redesign Team
Managed Long Term Care Implementation and Waiver Redesign Work Group
Final Recommendations – October 28, 2011

Recommendation Number: 1

Recommendation Short Name: Care Coordination Principles

Program Area: Long Term Care

Implementation Complexity: High

Implementation Timeline: Short-Term

Required Approvals:

- ☑ Administrative Action
- ☐ Statutory Change
- ☑ State Plan Amendment
- ☑ Federal Waiver

Proposal Description: Preamble and Principles for Care Coordination Models

Preamble: These principles will inform guidelines for the development of Care Coordination Models (CCM). The resulting guidelines will allow for flexibility in model design while protecting the consumer. In addition a reasonable phase-in period for providers and consumers is necessary during implementation of the major changes advanced by the Medicaid Redesign Team.

Individuals who need long term care should have access to Medicaid enrollment and eligibility assistance. To assure consistency with other MRT activities, the Work Group supports the Program Streamlining and State/Local Responsibilities Work Group Recommendations related to Long Term Care and Enrollment.

Principle #1

A CCM must provide or contract for all Medicaid long term care services in the benefit package. CCM will be at risk for the services in the benefit package and rates will be risk adjusted to reflect the population served.

The CCM benefit package includes both community-based and institutional Medicaid covered long term care services and makes consumer directed personal assistance services available for eligible individuals. The CCM is responsible for assessing the need for, arranging and paying for all Medicaid long term care services. The CCM must meet financial solvency standards to assure protection of the members, such standards shall include a phase-in period.

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. Risk factors could include functional status, cognitive status, diagnoses, demographics or other measures found to be correlated to increased cost of services. CCM rates shall be actuarially sound and sufficient to support provision of covered long term care services and care coordination and efficient administration. Payments shall incentivize community-based services.

Principle #2

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

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 CCM must use Health Information Technology, as feasible, to document, execute and update the plan of care and share information among appropriate staff and providers. The care management function shall address the varying needs of the population. 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.

Principle #3

A CCM must be involved in care coordination 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 to five years. As an interim approach, the CCM will coordinate care with primary and acute care services and other services not in the CCM service package to promote continuity of care and improve outcomes.

Principle #4

The member and his/her informal supports must drive the development and execution of the care plan.

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

Principle #5

Care coordination is a core CCM function. For benefit package services, CCM members will have a choice of providers.

A CCM must ensure that individualized care coordination is provided to all members, and have adequate capacity to do so. Within the CCM, members will be able to select among a choice of at least two providers (where available) of each benefit package service. CCMs shall have a network that takes into account the cultural and linguistic needs of the population to be enrolled.

There are geographic differences in the availability of service providers and CCMs should not be prevented from operating when market forces (lack of availability or unwillingness to contract) preclude a CCM network from offering choice or, perhaps in some instances, a particular service. However, CCM's must have the ability to authorize services from an out-of-network provider if no provider is available in-network that can adequately meet the needs of the member.

Principle #6

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

CCMs shall 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. The standardized assessment tool must be used to engage the member, the member's physician and informal supports to assure a complete review of member needs.

Principle #7

A CCM will provide services in the most integrated setting appropriate to the needs of qualified members with disabilities.

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

Principle #8

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

CCMs will submit data to the State, which will be made available publicly, to compare and evaluate entities on an ongoing basis, determine the success of individual CCMs, and create transparency about CCM service delivery. Data will include, but will not be limited to: financial cost reports, provider networks, consumer satisfaction, grievances and appeals, assessment data, care outcomes and encounter data, and disenrollment data (both voluntary and involuntary). The CCM will use its own data and information to develop and conduct quality improvement projects. The Department will track experience of CCMs in relation to quality and costs, and will publish this data annually in a consumer-friendly format on the Department's website.

Principle #9

Existing member rights and protections will be preserved.

Members are entitled to the same rights and protections under CCM as they are under current law and practice, including the Federal and State Law or regulations governing MCOs. CCMs must follow clear criteria established by the Department for involuntary disenrollment and members must be informed about them and the attendant appeals and grievance rights.

Principle #10

A CCM with demonstrated expertise 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, service networks and monitoring of that group or to address specific medical conditions or illnesses. A CCM shall develop and implement a model of care appropriate to the specific population and use its expertise to serve those members.

Principle #11

Mandatory enrollment into CCMs in any county will not begin until and unless there is adequate capacity and choice for consumers and opportunity for appropriate transition of the existing service system in the county.

The Department of Health shall review existing long term care programs and seek to remove barriers that may prevent contracting with a CCM.

Principle #12

Members shall have continuity of care as they transition from other programs.

Consumers 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 provides notice to the member including appeal rights.

Principle #13

Prospective members will receive sufficient objective information and counseling about their choices before enrolling.

Prospective members shall be provided with appropriate materials educating them about their choices and shall have the opportunity to have questions answered before enrollment. Information about options shall be posted on a website that is accessible to prospective members and the public. This information shall also be included in a printed brochure listing all CCMs in their geographic service area, which shall be sent by the enrollment broker to all prospective members.

Financial Impact: None

Health Disparities Impact:
Expansion of care management models of all types is expected to reduce disparities.

Benefits of Recommendation:
Provides a framework from which required guidelines can be developed.

Concerns with Recommendation: Transition period and consumer choice.

Impacted Stakeholders: All Medicaid long term care consumers; MLTC; LTHHCP; home care industry, managed care industry.

Medicaid Redesign Team
Managed Long Term Care Implementation and Waiver Redesign Work Group
Final Recommendations – October 28, 2011

Recommendation Number: 2

Recommendation Short Name: Quality Measures

Program Area: Long Term Care

Implementation Complexity: High

Implementation Timeline: Short-Term

Required Approvals: ☑ **Administrative Action** ☐ **Statutory Change** ☐ **State Plan Amendment** ☐ **Federal Waiver**

Proposal Description: Quality Measures

1. The goal should be to achieve improvement over time and to enable consumers and purchasers to compare CCM performance. This necessitates that the quality measures be transparent and publicly reported.

2. The criteria for determining measures should include that they be measurable, actionable, risk-adjusted, consistent across sectors, parsimonious, and have an impact on care.

3. The quality measurement system should cover the following domains:

    - *Reduce inappropriate utilization associated with nursing home admissions, emergency and urgent care and inpatient admissions.*
    - *Improve quality of life, emotional and behavioral status and preventive care and patient safety*
    - *Improve care management*
    - *Improve or stabilize functional status*
    - *Ensure continuity of worker and care to fullest extent possible*

4. The MRT Managed Long Term Care Quality Subcommittee should continue to convene to review progress made by SDOH in developing and implementing quality measurement system based on recommendations. Wherever possible, alignment with recommendations of MRT Payment Reform and other workgroups should be achieved.

Financial Impact: None

Health Disparities Impact:
Expansion of care management models of all types is expected to reduce disparities.

Benefits of Recommendation:
To measure and compare service delivery for consumers and payors.

Concerns with Recommendation:
Potential reporting burden and need for consistency with other initiatives.

Impacted Stakeholders:
All Medicaid long term care consumers; MLTC; LTHHCP; home care industry, managed care industry.

Medicaid Redesign Team
Managed Long Term Care Implementation and Waiver Redesign Work Group
Final Recommendations – October 28, 2011

Recommendation Number: 3

Recommendation Short Name: Fair Hearing

Program Area: Long Term Care

Implementation Complexity: High

Implementation Timeline: Short-Term

Required Approvals: ☑ Administrative Action ☐ Statutory Change ☐ State Plan Amendment ☐ Federal Waiver

Proposal Description: Fair Hearing

1. Consider the possibility of a targeted increase in resources to handle the move to mandatory enrollment in managed long term care or other care coordination models.
2. Providers should receive notice of fair hearings requested by their clients.
3. Ongoing training for ALJs pertaining to state law, rules, and regulations should be evaluated. Consumers and plans should have input and access to the training.
4. The target timeframe for fair hearing resolution should be within 60 days of the request for the hearing.
5. Regulations should be amended to require documented receipt of written notice of fair hearings to CCM administrators of record or legal counsel.

Financial Impact: To be determined

Health Disparities Impact: Not applicable

Benefits of Recommendation:
Improved fair hearing process.

Concerns with Recommendation:
Some Work Group members felt the recommendations did not address all of the issues impacting consumers and providers.

Impacted Stakeholders:
All Medicaid long term care consumers; MLTC; LTHHCP; home care industry, managed care industry.