LeadingAge™ New York

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Via E-Mail

Re: Comments on "Building for the Future: Managed Long Term Care Programs in New York"

Dear Messrs. Helgerson and Kissinger:

I am writing on behalf of LeadingAge New York to offer comments on the Department of Health's draft white paper entitled, "Building for the Future: Managed Long Term Care Programs in New York."

We appreciate and share the Department's commitment to strengthening the partially-capitated Managed Long Term Care (MLTC) and Fully-Integrated Duals Advantage (FIDA) programs, and we support many of the proposals advanced by the white paper. We wish to stress, however, that the strength and stability of these programs rests in large part on the adequacy of their premiums to cover the expenses (administrative, care management, and medical) associated with serving a vulnerable population with multiple comorbidities and functional limitations. Notably, at the same time that New York's various managed long term care programs have been undergoing rapid growth and frequent changes in policies and requirements, rate updates across all products have been subject to extended delays. FIDA rates have not been finalized, and questions have been raised about the adequacy of the rates in relation to the acuity and frailty of the beneficiaries. We will be following up with you on rate issues and will focus this letter on programmatic proposals to improve the programs.

MLTC Plus Product

The white paper proposes the creation of an MLTC Plus product that would offer behavioral health benefits, a primary care coordination benefit, quality incentives for primary care practitioners, and rigorous protocols for transitions from hospitals to the community. We understand that MLTC plans would be selected to offer the MLTC Plus product based on an application process that would entail

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close collaboration with a DSRIP performing provider system (PPS). The MLTC Plus plans would be expected to participate in value-based payment arrangements with the DSRIP PPS providers.

We support the concept of creating a stronger connection between MLTC plans and primary care practitioners and understand the rationale for adding behavioral health services to the MLTC benefit package. Our members also share the Department's commitment to assuring coordinated care at transitions between health care settings. However, we have the following concerns and recommendations in relation to the MLTC Plus proposal:

- ***Diversion of Resources from Existing Programs and Added Consumer Confusion:***

Consumers and providers are currently confronting a bewildering array of managed care products, including MLTC, Medicare Advantage, Dual Eligible Special Needs Plans (D-SNPs), Institutional Special Needs Plans (I-SNPs), FIDA, Medicaid Advantage, Medicaid Advantage Plus, and PACE. The addition of a new MLTC Plus product to this menu of managed care plans is likely to add to the confusion. The creation of a new MLTC Plus product may contribute to provider billing problems, drive up administrative costs for plan and providers, and have unintended impacts on FIDA enrollment.

We recommend that the Department and CMS focus resources on strengthening the existing MLTC program rather than focusing on the design and launch of another product. If the Department and other stakeholders determine that the MLTC benefit package should be expanded, then the new benefits should be added to the existing product, rather than to a new product, and made available to all plans.

- ***Need for advance notice and timely implementation of adequate rates:***

If the Department moves forward with new benefits or a new MLTC Plus product, the rates would have to accommodate new services, possibly a new population of behavioral health waiver participants, and new care management and administrative investments to address the needs of the new members and their providers. Plans will be reluctant to assume these new responsibilities, without advance knowledge of the rates they will be paid. As you know, serious concerns have been raised about the adequacy of the rates in the existing program. Further, the approval process for new MLTC, PACE and FIDA rates has been subject to lengthy delays. MLTC plans are currently operating under 2014 rates, which have yet to be adjusted for the federal share of various pool distributions. PACE plans are still awaiting approval of their 2013 rates, and MAP plans are still waiting for approval of 2012 and 2013 rates. Similarly, as noted above, FIDA rates have not yet been finalized and plans are operating under draft rates. The delays and uncertainty surrounding rates are untenable, particularly in the context of rapid change in the enrolled population, when investment in infrastructure, staffing and expansion is needed.

- ***Many physician practices serving small numbers of MLTC members:***

MLTC plans are working daily to coordinate care among a variety of providers, including the long-term care providers in plan networks and the primary care practitioners, hospitals and others whose services are not included in the MLTC benefit package. It is challenging for MLTC plans to engage with and influence providers of services that are excluded from the benefit package, given the lack of a payer relationship. We appreciate the Department's effort to address that problem, but we question whether the proposed primary care bonus payments will be effective. It is important to recognize that MLTC members may be dispersed among hundreds or even thousands of primary care practices, with each

practice serving only a handful of members. It may be difficult to offer a care coordination bonus large enough to interest these practices, given the small numbers of MLTC Plus members they are likely to serve.

- ***Unintended effects of PPS alignment and selective implementation of the new product:***

The Department's proposal to authorize the MLTC Plus product in selected regions based on PPS/MLTC collaborations raises concerns about attribution of beneficiaries and unintended competitive impacts. Currently, the DSRIP attribution methodology takes in to account nursing home and primary care practitioner loyalty. It does not recognize home care agency loyalty or MLTC enrollment. Since MLTC beneficiaries tend to be dual eligibles, their primary care practitioners may not be enrolled in the Medicaid program and may not be participating in a PPS. As a result, MLTC beneficiaries may currently be unattributed or, in regions with more than one PPS, they may be scattered among different PPSs. It may be difficult for an MLTC to focus resources on projects with one PPS when only a small portion of its beneficiaries are receiving services from that PPS's providers.

Furthermore, the proposal to authorize only a subset of MLTC plans to offer the MLTC Plus product may create a competitive advantage for selected plans. This may have the unintended consequence of depleting the enrollment of the plans that were not selected, even though their quality and networks might be equal to, or better than, the selected plans. As noted above, we recommend that all plans be eligible to offer the enhanced benefit package.

- ***Possible duplication of care management activities:***

The MLTC Plus product would entail close collaborations with DSRIP PPSs and presumably Health Homes. As the PPSs roll out their DSRIP projects, beneficiaries may be assigned to care managers, care coordinators, or health coaches in connection with those projects.[1] A beneficiary with a serious mental illness may also have a Health Home care manager. MLTC plans and long-term/post-acute care (LTPAC) providers are beginning to experience the effects of the multiple care coordination/care management initiatives that have been implemented to reduce fragmentation in health care delivery. For example, a dually-eligible MLTC beneficiary, who is assigned a care manager through his/her managed care plan, may also have a care coordinator through a patient-centered medical home or accountable care organization, and a hospital-sponsored care transition coach for post-acute care. At best, these overlapping roles, while well-intentioned, raise questions about the added value of each layer of care management or coordination. At worst, they can lead to duplicative or conflicting instructions to beneficiaries and their providers, uncertainty about the scope of care management responsibility, and a lack of accountability.

MLTC plans recommend that MLTC care managers be given primary responsibility for the beneficiaries enrolled in MLTC. Unlike a number of other titles that bear care management responsibilities, care

[1] A recent report issued by the Center for Health Workforce Studies, HANYS, and GNYHA explored the overlapping functions and educational requirements of these titles. "2015 Nursing and Allied Professionals Survey Report: Exploring Emergent Healthcare Workforce Titles and Functions, " available at: http://www.hanys.org/workforce/survey/reports/2015_nursing_allied_workforce_survey_report.pdf?utm_source=e-lert&utm_medium=e-mail&utm_term=magnetmail_hanys&utm_content=LINK%20CHECK&utm_campaign=mmansfie@hanys.org

managers with MLTC plans are required to be nurses or social workers. Moreover, MLTC plans are required to coordinate care across a broad range of social, supportive and medical services and have experience in doing so.

- ***Addition of behavioral health HCBS services requires careful consideration:***

The addition of these benefits will require the investment of additional resources in network development, modifications to claims adjudication systems to accommodate new codes, and provider and beneficiary education. Before proceeding with additional services, the Department should (i) determine whether there is a need for the HARP HCBS benefits among the existing MLTC population and the impact, if any, of this initiative on the composition of MLTC enrollment; (ii) complete the HARP transition with the mainstream plans so that MLTC plans can learn from their experience; and (ii) model the necessary rate adjustments in consultation with the plans.

- ***Proscriptive care transition protocols and exclusion of nursing home transitions:***

Many of our members are engaged in interventions to improve transitions from hospitals to nursing homes and community-based settings and from nursing homes to home. They recognize the importance of warm hand-offs, health information exchange, patient and family engagement, and active follow-up, including home visits. The proposed care transition protocols for the MLTC Plus product, however, are too proscriptive and fail to acknowledge that post-discharge care must be tailored to the needs of the individual. Furthermore, because some post-acute services, such as nursing visits, would ordinarily be covered by Medicare, if medically-necessary, the implementation and source of funds for this proposal will be complex.

In addition, while the white paper speaks to engaging nursing homes in the care transition protocols at a later date, it is important to recognize that nursing homes are currently involved in a variety of care transitions, including admitting residents from hospitals for post-acute and long-term stays and discharging residents to home care. As the State works to reduce avoidable hospitalizations regardless of payer, nursing homes should be included in its policy initiatives.

- ***Readiness for value-based payment:***

Our members recognize the importance of value-based payment (VBP) to achieving the Triple Aim and the State's DSRIP goals. However, it is important to be realistic about the challenges associated with VBP in the long-term care sector. It is difficult to reduce spending and manage utilization within the MLTC benefit package due to the intensive needs of the members, extensive fixed costs borne by LTPAC providers, continuity of care policies, and fair hearing rights. While savings is available from avoided hospitalizations, those costs (and savings) are borne by Medicare, and a reduction in acute care expenses is likely to lead to an increase in Medicaid-funded long-term care expenses. Finally, the success of VBP arrangements relies heavily on data and analytics and health information exchange. Unfortunately, there has been little public investment in information technology and health information exchange in the LTPAC sector. As a result, many LTPAC providers lack the infrastructure necessary to succeed in a VBP environment.

FIDA

We appreciate the Department's attention to the disappointing enrollment figures in the FIDA program and welcome its proposal to initiate a FIDA marketing campaign. We support the proposals in the white paper to permit direct enrollment by plans, to allow plans to create their own marketing comparison tools, and to eliminate the licensure requirement for FIDA marketing representatives. We also support permitting plans to market multiple lines of business in their FIDA plan marketing materials.

We have the following comments and recommendations regarding the other proposals:

- ***Freezing MLTC enrollment in organizations that do not attain 25 percent enrollment in fully-capitated products:***

We oppose this proposal as it is likely to be counterproductive. It will reduce the managed care choices available to consumers and cut off new MLTC enrollees as a potential source of FIDA enrollment. It will also penalize organizations based on circumstances that are entirely beyond their control. The organizations that operate FIDA plans have invested millions of dollars in FIDA and want the program to succeed, but have been hindered by marketing restrictions and requirements, physician resistance, and consumer satisfaction with their existing care. In part, the slow growth of FIDA speaks to the success of the MLTC program. Plans should not be penalized for what amounts to high levels of consumer satisfaction with their existing plan.

- ***Optional Interdisciplinary Team (IDT) process with incentives and penalties:***

We share the interest of the Department and consumer representatives in a person-centered, team-based approach to care planning and management. However, the IDT, as currently conceived, raises insurmountable implementation challenges and has engendered resentment on the part of both providers and consumers. We recommend replacing the highly prescriptive IDT framework with a more flexible and feasible approach. Under this new approach, within broad parameters defined by the Department in consultation with the plans, plans would be permitted to design their own person-centered, interdisciplinary care management models. The composition, format and location of care planning and management meetings would be based on the needs and preferences of the beneficiary. Typically, a meeting would be convened upon enrollment and upon a major change in health status or needs. If providers are not available to participate in a meeting or conference call, the FIDA care manager would be permitted to gather input from relevant providers and report on it at the meeting. Additional funding to compensate providers for time spent in care planning and management meetings would be helpful to encourage their participation.

If the IDT structure is to be retained, we would support the proposal to make the IDT optional for beneficiaries. However, the Department's proposed bonus and penalty plan is likely to result in unnecessary pressure on plans and consumers, without addressing the underlying problem.

- ***Semi-annual passive enrollment in FIDA:***

To date, the passive enrollment process has not succeeded in generating acceptable levels of enrollment. It is our understanding that the current process is confusing and anxiety-provoking for beneficiaries. Before it is extended any further, the Department should launch the proposed marketing campaign and

implement the proposed revisions in the marketing rules. We are hopeful that these initiatives will stimulate enrollment and eliminate the need for further passive enrollment. Further, as indicated by the Department at the Long Term Care Forum, if semi-annual passive enrollment is implemented, it should not apply to beneficiaries who have already opted out of FIDA.

- ***Intelligent assignment to match beneficiaries with plans based on PCP and home health relationships:***

To the extent that passive enrollment is continued, it should proceed after the marketing campaign and be coupled with additional provider and consumer education. We support the concept of intelligent assignment based on the beneficiary's provider, as well as plan, relationships. However, it is important to recognize that beneficiaries often prioritize their relationship with their home care aides over other provider relationships.

- ***Behavioral health HCBS services covered under the HARP program:***

As noted above, the addition of these benefits will require the investment of additional resources in network development, modifications to claims adjudication systems to accommodate new codes, and provider and beneficiary education. Before proceeding with these additional services, the Department should (i) finalize FIDA rates under the existing benefit package and stabilize the program; (ii) determine whether FIDA beneficiaries need the HARP HCBS benefits; (iii) complete the HARP transition with the mainstream plans so that FIDA plans can learn from their experience; and (iv) model the necessary rate adjustments in consultation with the plans.

- ***"Over the Counter" drug card:***

An Over the Counter (OTC) drug card may be an appealing benefit for beneficiaries and may encourage enrollment. However, it should not be a required benefit. Moreover, an OTC card would be an effective incentive only to the extent that the FIDA card is aligned with the OTC cards available through Medicare Advantage and Part D. We understand that State Medicaid requirements related to the collection of rebates prevent this alignment. The State should explore making the necessary changes to its rebate policy to permit this initiative.

- ***Enrollment of dual eligibles who do not require long term care services:***

We recognize that the "well dual" population represents a sizeable pool of prospective members. However, we are concerned about adding a new category of beneficiaries when the rates for the existing FIDA population have not been finalized. Before a new population is added, the existing FIDA program should be stabilized with final rates, the new population should be clearly defined, and new rates should be modeled and approved in consultation with the plans.

- ***Offering Medicaid long-term care beneficiaries FIDA enrollment as their "first choice" upon enrollment in Medicare:***

Because the mechanism for implementing this proposal is unclear, we are not prepared to comment on it in detail. However, to the extent that the goal is to promote enrollment in fully-integrated, Medicare/Medicaid plans, beneficiaries should also be offered other fully-integrated options, including PACE and MAP.

- ***Provider Training***

In an effort to encourage physician participation in FIDA networks, we support the relaxation of provider training requirements. Specifically, provider training should be voluntary, and the State should explore accreditation to offer continuing medical education credits for participation. Any required training should be reduced to a single web-based program not to exceed an hour in duration.

- ***Translation requirements***

Existing FIDA requirements entail translation of multiple, lengthy documents into six languages, regardless of the prevalence of those languages among the prospective or enrolled population. They also require mailing of hard copies of the translations to members, whether or not they are wanted or needed. We support the alignment of FIDA translation requirements with MLTC prevalent language requirements. We also recommend targeted mailings of translated documents, based on member needs and preferences. To the extent that member documents are required to include certain standard statements in multiple languages, we request that the Department provide those translations.

Thank you for your consideration of these issues and the opportunity to offer comments. We would appreciate the opportunity to meet with you to discuss these issues further.

Sincerely yours,

Karen Lipson
Executive Vice President for Innovation Strategies

cc: Rebecca Corso
Margaret Willard