LeadingAge New York
formerly NYAHSA

COMMENTS ON NEW YORK STATE DEPARTMENT OF HEALTH'S DEMONSTRATION TO INTEGRATE CARE FOR DUAL ELIGIBLE INDIVIDUALS REVISED DRAFT PROPOSAL DATED MAY 3, 2012

Introduction

LeadingAge New York appreciates the opportunity to comment on the *New York State Department of Health's Demonstration to Integrate Care for Dual Eligible Individuals* proposal. This initiative holds great promise to improve the care experiences of dual eligible recipients, improve population health and save state and federal dollars. Among the benefits of the approach is the prospect of alleviating misalignments between Medicare and Medicaid benefits and administrative rules governing access to these services, and the opportunity to coordinate services across the physical health, mental health and behavioral health domains through both capitated and managed fee-for-service (MFFS) approaches.

We appreciate that DOH has revised the proposal based on stakeholder feedback, but note that little time was given to learn about and truly understand the changes and their potential impact on the system and the people served by it. In particular, the public outreach efforts noted in the proposal did not allow for a full understanding of the intent behind adding the MFFS approach and the corresponding changes to the population targeted for enrollment in the capitated model. While much education has taken place on health homes, the state's current plans surrounding enrollment of chronically ill recipients of long term care services in health homes are not well understood.

Furthermore, this initiative would be planned and implemented at a time of dramatic changes in long term and post-acute care in New York State. While this demonstration builds upon the health home initiative and mandatory enrollment into managed long term care (MLTC) plans, those initiatives are not yet fully realized and we have yet to appreciate all the consequences of each. In fact, there remain many unanswered questions that could greatly impact both the service delivery system and the consumers it serves. It becomes difficult, then, to anticipate the consequences and potential ripple effects of all of these initiatives taken together. We urge the state to make every effort to ensure that the many Medicaid Redesign Team initiatives can work together, and monitor closely the impacts these reforms have on consumers, providers and plans.

LeadingAge NY offers the following preliminary input to help ensure that that this demonstration is implemented in a manner that achieves maximum benefit for all. We offer our comments based on our current understanding of the proposal, but believe that more time, information and forums are necessary to provide ample opportunities for fully-informed and meaningful stakeholder input.

General Observations

- To ensure that FIDA plans and their provider networks can effectively function and that enrollees can experience seamless services, significant program differences between Medicaid and Medicare need to be reconciled, standardized, streamlined or otherwise addressed using a "best of breed" approach. These differences are apparent in the areas of eligibility criteria, coverage requirements, enrollment processes, benefits, billing systems and provider networks. The three-way contract among CMS, the

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state and health plans is intended to test administrative, benefit and enrollment flexibilities that will further the goal of providing a seamless experience for Medicare-Medicaid enrollees utilizing a simplified and unified set of rules. We hope that New York will maximize the opportunity to do so that is provided by the demonstration.

- Under "Relation to Existing Programs," the draft proposal indicates that there will be no changes to the PACE programs in connection with the FIDA demonstration. Since PACE is an established fully integrated model of care for duals, efforts aimed at better aligning Medicare and Medicaid requirements and processes for FIDA plans should extend to PACE programs.
- Fourteen other states are conducting these demonstrations. We encourage DOH to closely monitor the plans and activities of the other states, and to consider adopting promising practices from the other demonstrations.

Target Populations

- The introduction indicates that full dual eligibles are the target population. How will partial duals be addressed, particularly the Qualified Medicare Beneficiaries with full Medicaid (QMB Plus), the Specified Low-Income Medicare Beneficiaries with full Medicaid (SLMB Plus) and Medicaid-only dual eligibles? These individuals have access to full Medicaid benefits.
- The target population for the MFFS component is consistent with the first wave of enrollees in the state's health homes program, and is limited to individuals requiring less than 120 days of long term care (LTC) services. DOH has indicated that the second wave of health home implementation would target the LTC population through the MLTC structure and a care management network of nursing homes and non-institutional providers. Does the state contemplate amending this proposal to integrate a LTC health home model when and if program features are developed?
- How will program designs, including covered services and capitation payments, be adjusted to reflect the availability of benefits through the Veteran's Health Administration and Supplemental Security Income? Are there other public or private benefits that would have a bearing on FIDA and health home services and capitation payments and, if so, how will they be taken into account? Will individuals who have employer sponsored Medicare coverage simply be exempted from passive enrollment, or will they be excluded from enrolling?
- Are the four population groups identified on page 9 excluded from enrolling in FIDA, or exempted from passive enrollment?
- Will non-mandatory duals (i.e., non-full duals) be permitted to voluntarily enroll in a FIDA plan within the eight-county area?
- Dual eligibles are more likely to have Alzheimer's disease, other cognitive impairments and mental disorders than other recipients. How will the enrollment processes take into account the decision-making capacity of such individuals?
- With regard to the OPWDD FIDA plan, how will DOH ensure that consumers are adequately informed of their options in order to make a choice about plan participation? How will the enrollment process take into account the decision-making capacity of these individuals?
- The percentages of total duals enrolled in FIDA and health homes cited on page 31 seem to be reversed, with a larger absolute number of health home members than FIDA enrollees identified in the write-up.

Enrollment/Disenrollment/Service Continuity

- The CMS July 8, 2011 State Medicaid Directors Letter indicates that transfers from one participating plan to another shall be allowed on a month-to-month basis any time in the year throughout the entire duration of the initiative. However, page 11 of the draft indicates that plan transfers are only permitted in January and July of each year. Please explain the discrepancy.
- The fact that only a very small number of dual-eligible recipients participated in the state's feedback session, even with financial incentives available, is telling. The individuals who are targeted for enrollment in FIDA are the least likely to understand the initiative and what it means for them. This may be a reason for the historically low rates of voluntary enrollment in dual-capitated plans. DOH has to put considerable efforts into ensuring that communication to consumers and their designated representatives is informative and clear. This is likely to be a confusing initiative, and people need to understand their options, rights and responsibilities.
- The proposed continuity of care policy provides for up to 60 days of services from existing providers upon transition into a FIDA plan, and leaves open the possibility that this timeframe could be extended to 90 days. If there is a possibility that more than 60 days would elapse until the plan performs a comprehensive assessment of the enrollee and arranges for all of the services, the continuity of care requirement should be extended to 90 days or more. While the draft indicates that not many participants will need to avail themselves of this policy, the fact is that specific services are being added, as is the Medicare benefit if the individual was previously in traditional Medicare.
- It sounds as though individuals enrolled in PACE will not be approached to enroll in a FIDA program, and PACE will not be offered as an option under the FIDA initiative. We argue that PACE should be presented as an option, as it is a long standing program that has successfully provided integrated care for the dual-eligible population.
- Members of current Medicaid Advantage Programs (MAPs) and PACE programs that are deemed to be FIDAs should be automatically considered to be FIDA members. Since those members have already chosen enrollment in a managed Medicare (and Medicaid) program, there should be no reason for triggering a Medicare opt-out or transition period. This recommendation is consistent with DOH's "conversion in place" strategy and ensures continuity of care by the same provider network already used by each member, while expanding the benefit package for each member. Further, it reduces the potential confusion to the consumer, who has the right to change providers if they so choose.
- Dual-capitated plans have been around for several years in New York, but haven't achieved the type of enrollment the state had wanted. DOH should attempt to understand the reasons for this to determine any barriers that may need to be overcome to ensure that large numbers of dual eligibles who are passively enrolled elect to disenroll from the Medicare managed aspect of their plan.
- In addition to taking their medications, enrollees should be expected to adhere to treatment protocols and avail themselves of preventative medicine and education on lifestyle choices.

Plan Establishment/Development

- There is concern as to whether Medicaid-only MLTCs will be able to evolve into dually-capitated plans in the timeframes outlined. We recommend that the state work closely with CMS to ensure that administrative processes can move quickly to enable these plans to evolve, and that DOH work with new applicants as well as existing plans to ensure their ability to evolve.
- All MAPs and PACE programs within the demonstration area that have demonstrated quality and capacity for enrolling and delivering care to the targeted population should be deemed as FIDAs. For

example, a MAP could be considered to meet quality and capacity standards if its Medicare Advantage lines have achieved three stars in each of the past three years and that has enrolled and served at least 200 individuals for the past two years.

- FIDA plans should be given the option of serving Zip Code-delimited areas within the service area counties and not be required to serve entire counties. This would allow plans to develop models of care for specific populations within the target group and to construct networks of providers familiar with and to these populations. It also would enable the construction of networks whose providers can deliver care within the timeframes and proximities set forth in the application. We also believe allowing Zip Code-delimited service areas would enhance care coordination and provider accountability and engagement.
- Can a FIDA plan subcontract with an existing single capitation plan such as an MLTC or SNP to provide care coordination or other FIDA services?

Covered and Excluded Services

- Under "Proposed Benefit Design," Medicare and Medicaid hospice services are excluded from the FIDA benefit package. New York State has been a leader in, and currently has initiatives underway aimed at, expanding access to and awareness of hospice and palliative care. With the growing emphasis on advance directives and the higher mortality rate of this population, the decision as to whether to include hospice and palliative care services in the FIDA benefit structure is an important one that should be further considered.
- Will FIDA plans be required to have a choice of two Health Homes in their network, or will they be required to contract with any willing health home in their service area? Will all FIDA enrollees be required to enroll in a health home?
- The Health Home summary included in the Executive Summary indicates that health homes are responsible for coordinating Medicare benefits and Medicaid State Plan benefits. Are waiver services (e.g., 1915(c)) also coordinated for health home members?
- How does this demonstration dovetail with the multi-payer statewide patient centered medical home (PCMH) initiative? Will certain duals be targeted for enrollment in PCMH versus FIDA and health homes?
- We are pleased to see the Assisted Living Program included as a FIDA benefit package service. Clarifications will be needed as to which services can be reimbursed with capitated Medicaid dollars versus those which are covered under the SSI benefit.
- We are pleased to see that several services were added to the listing of FIDA covered benefits including community integration counseling, depression screening, environmental modifications, health homes, other supportive services and service coordination. However, we question the rationale for eliminating "assistive technology" from the list of covered FIDA services. We also recommend the inclusion of respite.
- Are vehicle modifications allowed under the environmental modification service?
- We agree on the merits of including transportation to social day care in the benefit. If there are any other types of non-emergency transportation related to other covered FIDA benefits, these should also be included in the benefit package.
- DOH should provide greater clarity regarding how certain "services" are defined. For example:
    - One of the additional services listed in Appendix B is "OMH Licensed CRs." Does DOH intend for FIDAs to provide health and medical care to persons residing in OMH Community Residences or for FIDAs to also pay for the housing services?

- Another of the additional services listed in Appendix B is "Telehealth." Does DOH intend for FIDAs to contract with two or more telehealth equipment vendors or, for example, would contracting with two or more Certified Home Health Agencies that utilize telehealth suffice? How is telehealth defined for this purpose?

Expectations of Plans

- Under "Network Adequacy and Access" and Appendix D, how will the time and travel distance standards be determined and measured (i.e., based on navigation/directions or actual travel times)?
- How do the other access and adequacy standards identified on page 12 and Appendix D compare to standards included in Medicare Advantage plans and Medicaid managed care plans? Are they more or less stringent and, if so, what is the basis for the difference?
- Will DOH prescribe the specific evidence-based practices that FIDA plans use, or will plans be given the authority to identify and implement recognized practices that they determine will best meet the needs of their enrollees?
- CMS and the state will establish a standard for all participating FIDA plans to demonstrate financial solvency that could reflect the requirements for Medicare Advantage plans, Medicaid managed care organizations, PACE providers or some other solvency standard. There should be a proper alignment between plan expectations and capitation payments to ensure that FIDA plans can maintain solvency based on the selected requirements.
- We believe that technology is crucial to redesigning and improving health care, and would like to see every provider be in a position to implement interoperable health information technology and electronic health records. Unfortunately, many providers can afford that investment. We are concerned, thus, about the new technology requirements for the capitated and MFFS approaches. The reality is that subcontractors will also need to implement certain technologies in order for the requirements to have the desired impact. Hearing that the state has only limited HEAL-NY funds which may be available to assist in achieving this requirement is inadequate. If the state is unwilling or unable to invest more into this initiative, it should be removed as a requirement.
- We appreciate that DOH added a list (Appendix H) of potential improvement targets for FIDA programs that somewhat reflect the recommendations of the MRT MLTC-Waiver Redesign Workgroup's quality metrics subcommittee. However, the targets listed in Appendix H do not fully reflect the subcommittee's/workgroup's recommendation that "[t]he criteria for determining measures should include that they be measurable, actionable, risk-adjusted, consistent across sectors, parsimonious, and have an impact on care." Therefore, we recommend that Appendix H be revised to include the subcommittee's recommended criteria (quoted above) and to reflect the parsimonious "starter set" of NCQF quality measures for dual eligibles (issued after the subcommittee met) plus measures of skilled nursing facility admissions and use of advance directives.

Disputes and Feedback

- Currently, the MLTC, MAP and MA programs all have different grievance and appeals processes that are confusing for participants, plans and adjudicators alike. The draft proposal indicates that an integrated and consumer friendly grievance process will be incorporated. We urge that the FIDA grievance and appeals process contain the following elements:
    - The timeframe to submit and appeal should be integrated with the Medicare timeframe (i.e., 60 days);

  - The timeframe to respond to a claim payment denial appeal should be integrated with the Medicare timeframe (i.e., 60 days);
  - The timeframe to respond to a grievance should be integrated with the DOH timeframe of 45 days; and
  - The timeframe to respond to an expedited appeal should be integrated with the DOH timeframe of 3 business days.
- While the draft proposal includes grievance, appeal and ombudsman protections for enrollees, it should also include dispute resolution processes for providers. Invariably, there will be disagreements and concerns that will not be sufficiently and timely resolved through contractual mechanisms.
- We recommend that FIDAs be required to provide DOH/CMS with a plan for regularly gathering participant feedback through multiple routes. For example, patient satisfaction surveys, MA-CAHPS, teleconferences, and Participant Advisory Committee meetings are all valid options. While in-person, small group sessions may be appropriate for some participants, they could be onerous for the homebound and certain other dual eligible enrollees.

Financing and Payment

- FIDA plan rates should be specified to be actuarially sound and timely adjusted, and must take into consideration the addition of benefits not now covered by MAPs (e.g., those specified in Appendix B). Risk adjustment should be at the member level, based on the Medicare system. The rate methodology should be specified *prior* to plans submitting letters of intent to seek participation in the demonstration.
- Capitated payments should be sufficient in amount to ensure that expectations can be imposed on FIDAs to make reasonable payments to service providers. Historically, Medicaid fee-for-service reimbursements to LTC providers have been at below-cost levels, and these providers have relied on Medicare payments to subsidize these underpayments. If these payments are reduced under FIDA, they could easily lead to service disruptions.
- We recommend that FIDAs be required to pay out-of-network providers the Medicare fee-for-service rate during the transition period.
- It is inappropriate to include performance-based incentives given the current inadequate state of MA SNP performance measurement. Going forward, we recommend adopting the approach proposed by the Measure Applications Partnership of the National Quality Forum for dual eligibles and phasing the Partnership's proposed "starter set" measures in during the course of the three-year demonstration.
- With regard to participant cost sharing (page 22), it is unclear whether FIDA enrollees will be subject to Medicaid spousal impoverishment budgeting if they are being served in a nursing home or Medicaid 1915(c) waiver program. This is an issue with mandatory MLTC enrollment more broadly. If spousal budgeting is not conferred on these individuals, it may affect their ability and/or that of their spouses to live independently in the community.

Expected Outcomes

- Data on service utilization, beneficiary experience, quality and cost outcomes should be made available to FIDA plans and their network providers to facilitate monitoring and evaluation of plan and provider performance.
- Improvement targets for FIDA plans should readily align with quality measures being implemented for New York's Medicaid program more generally.

- How will demonstration savings be measured? Will there be control groups used for comparison to FIDA enrollees?

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