LeadingAge New York

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Mark Kissinger
Director, Division of Long Term Care
Office of Health Insurance Programs
New York State Department of Health
Empire State Plaza, Corning Tower, 14th floor
Albany, New York 12237

RE: Comments on Conflict Free Case Management

Dear Mr. Kissinger:

Thank you for your recent invitation to LeadingAge New York to present comments on Conflict Free Case Management (CFCM) in the context of the Balancing Incentive Program (BIP) initiative and the transition to managed long term care (MLTC). On behalf of our MLTC plan and home and community-based services (HCBS) members, we offer the recommendations outlined below. Our recommendations represent a consensus of opinion developed by a joint workgroup of our HCBS and MLTC plan providers.

At the outset, we believe it is important to stress that up until this point, the MLTC plans have been fulfilling the role of determining clinical eligibility for Medicaid-covered HCBS. They have been doing so with several "firewalls" and other procedural processes in place to ensure members' freedom of choice, health and welfare and to reduce any potential conflicts. Safeguards in the current system include grievance and fair hearing processes that ensure enrollees have avenues to pursue in the event of a disagreement with the plan of care. The variety of MLTC plans available, the newly established ombudsman and the ability of enrollees to change plans also represent important safeguards. Finally, the quality reporting mechanisms and enrollee satisfaction surveys help to ensure that MLTC plans remain responsive to the needs of each individual. Bearing this in mind, we do not believe that an extensive added layer of regulatory/policy requirements and oversight is warranted. Any new CFCM process should be designed to augment procedures or contracts already in place such as Care Management Administrative Services (CMAS) agreements.

Our recommendations on CFCM are as follows:

Recommendation # 1 – Independent Assessment Entity: The Department should issue a Request for Applications (RFA) and enter into a contracting arrangement with an independent entity or entities (e.g., IPRO, CMAS agreements contractors, regional long-term care assessment center, etc.) to perform clinical eligibility determinations or re-determinations. The contracted entity or entities should have the necessary clinical competence to demonstrate an understanding of the complexities of delivering HCBS to a diverse patient population.

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It is also critical that the independent entity is able to complete the UAS-NY in a manner that is consistent with generally accepted standards of clinical practice. Regardless of the initial UAS-NY being completed by the contracted entity, the MLTC plans as the risk-bearing entities will still need to perform their own assessments for actual care planning and care delivery. It is important that there be some reasonable assurance of consistency between the two assessments. To monitor for such consistency, the independent entity could also perform a third party review of the assessments to ensure accuracy. The state contracting out this monitoring component will provide an additional layer of oversight. The state could implement any corrective action if discrepancies are noted.

Recommendation # 2 – Financial Support for Added Assessments: There is no way around the fact that implementation of an additional layer of clinical eligibility determination or re-determination will entail added costs. These costs should be offset from the added federal financial participation awarded through BIP. In all probability some independent entity will have to be contracted with to perform these clinical determinations, and this added cost should **not** be borne by the MLTC plans.

Recommendation #3 – Minimize Inconvenience to Enrollees: As alluded to in the recommendations above, there is the potential of enrollees being subjected to multiple assessments in a relatively short period of time. With an estimate of about 2 hours for completing the first UAS-NY, it is important to consider minimizing the burden on the enrollee of undergoing multiple assessments. We understand the critical nature of UAS-NY implementation and role this new assessment will play in the overall BIP initiative. However, if some abbreviated version of UAS-NY could be implemented as a screening tool, this would help in minimizing the burden on enrollees.

Recommendation #4 – Plans Maintain Responsibility for Care Planning and Delivery: The basic concept behind the current Medicaid restructuring is to move away from the current State-run fee-for-service system and place responsibility for coordinating care and controlling costs onto the risk-bearing entities (i.e., the MLTC plans). In order for this to work, the MLTC plans must maintain ultimate responsibility for determining the plan of care and delivering the services, even if a plan may utilize a subcontractor to perform any of these functions.

Therefore, it is critical that the independent entity's role be limited solely to determining clinical eligibility for Medicaid coverage. The plans must be allowed to conduct their own assessments in order to fulfill their role as the care managers. To do otherwise would undermine the ability of the MLTC plans to manage the care of their enrollees. Here again, it is important to remember that other safeguards and firewalls exist to protect the rights of the enrollee.

Recommendation #5 – Flexibility for Rural and Other Special Needs Areas: The federal CFCM guidelines themselves acknowledge the need for flexibility in developing processes for rural areas. New York's proposed work plan should reflect the fact that in rural areas, it may not be feasible or advisable to implement CFCM as outlined above. For example, if reaching the enrollee involves travel over long distances, it probably makes more sense to simply have the MLTC plan combine the initial assessment with the care planning assessment. Likewise, with certain populations (e.g., behavioral health clients), it may be advisable to minimize the number of assessments performed. Our state work plan should reflect the same flexibility found in the federal guidelines. Once again, where flexibility is

called for in the initial assessment process, other safeguards and firewalls should be sufficient to ensure the enrollee is receiving proper services.

Recommendation #6 – Minimize Administrative Complexity and Preserve Timeliness: It is inevitable that implementing this separate assessment process will produce an added layer of requirements for the enrollment process. With this in mind, efforts are needed to ensure that the final process is as simple and streamlined as possible. We have already offered some recommendations in this area including: 1.) flexibility for rural areas; 2.) limiting the role of the independent assessor to Medicaid clinical eligibility only; and 3.) developing a simplified screening tool.

In addition, the entity(ies) tasked with performing this function must be able to prove that they have the capability to quickly and efficiently conduct assessments, without unnecessarily slowing down the enrollment process. It may be advisable to have properly trained hospital discharge personnel conduct the initial screen in order to facilitate orderly patient flow and avoid a potential increase in alternate level of care days. As plans seek to expand enrollment in MLTC and remain responsive to enrollees' needs, assessment delays could be very detrimental to the process. It should also be clear that the screen is only necessary for new Medicaid enrollees. Current plan members who may need hospitalizations, for example, should not be subject to screening.

On behalf of both our HCBS and MLTC plan members, thanks again for the opportunity to present our recommendations. As always, LeadingAge NY staff stand ready to work with the Department on implementation of BIP and related initiatives.

Sincerely,

Daniel J. Heim
Executive Vice President