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M E M O R A N D U M

TO: All Members

FROM: Diane Darbyshire, Senior Policy Analyst

DATE: June 1, 2012

SUBJECT: **Dual Eligibles Proposal Submitted to CMS**

ROUTE TO: CEOs, CFOs, Administrators

ABSTRACT: Final proposal incorporates minor changes, some positive.

Introduction

The Department of Health (DOH) submitted a final proposal to the Centers for Medicare and Medicaid Services (CMS) for a demonstration to integrate care for dual eligibles. LeadingAge New York actively participated in the public education sessions on the proposal, and submitted substantial comments on the prior drafts of the proposal. While DOH's final draft does not differ significantly from the most recent version, we are pleased to see several of our suggestions incorporated. To view the final proposal, click here.

Notable changes in this final proposal include:

- the Managed Fee for Service Health Homes approach will start January 2013, rather than July 1, 2012;
- DOH will pursue a waiver to include PACE programs in the Fully Integrated Duals Advantage (FIDA) program, and the enrollment broker will provide information about PACE as an option;

- FIDA plans will be able to phase-in the information technology requirements; and,
- specific information about quality measures and targets is provided.

While this is the final proposal, there remains opportunity to provide feedback. CMS will provide the opportunity for public comment, and DOH will initiate regular meetings with interested stakeholders to gather ideas and feedback on how to operationalize key components of its FIDA demonstration plan. Subcommittees will be formed to address specific topics, such as Integrated Appeals and Grievance Process and Procedures, Financial and Payment Provisions, and Quality Metrics. DOH also intends to have an ongoing dialogue with stakeholders in the implementation of the different initiatives.

The following outlines significant points to the proposal which may be of interest.

Fully Integrated Duals Advantage Approach

FIDA builds upon the mandatory enrollment of Medicaid-eligible individuals requiring 120 days or more of home and community based services into managed long term care (MLTC) options, by passively enrolling them into Medicare managed plans as well. For the purposes of FIDA, these plans will integrate the Medicaid and Medicare services, and will have additional requirements and options. Implementation will take place in the New York City area, as well as Long Island and Westchester, starting January 2014.

It should be noted that there will be up to three FIDA plans specifically designed to serve the developmentally disabled population. The regional area is not confined to the downstate area described above.

PACE
LeadingAge New York is pleased to see that DOH will pursue a waiver from CMS to permit any Program for All-inclusive Care for the Elderly (PACE) plan that is able to meet the FIDA requirements to participate in the FIDA program. The waiver would allow PACE plans to serve a broader population (e.g., individuals less than 55 years of age, ability of PACE to work with community primary care physicians for individuals who may not necessarily need to attend a PACE Center). The enrollment broker will also provide information about PACE to individuals when counseling about their options. However, LeadingAge New York is concerned that the demonstration, as originally proposed, would inadvertently discourage people from enrolling in the long-standing dual capitation option.

Medicaid MLTC
DOH explicitly stated that while the FIDA program requirements are based on the Medicaid Advantage Program (MAP), the state will contract with Managed Long Term Care (MLTC) plans in the demonstration service areas that are in operation in 2013, that obtain CMS approval to be a Medicare Advantage Plan for 2014 and that are able to meet the requirements of the FIDA program.

Medicaid Advantage and Medicaid Advantage Plus
It is anticipated that many of the Medicaid Advantage and Medicaid Advantage Plus plans (the

Medicare Advantage Special Needs Plans that also provide Medicaid) will transition to or will develop additional product lines through which to provide FIDA plans. Otherwise, these plans will continue to exist and will serve those full dual eligibles that opt-out or at some point choose to disenroll from the FIDA program.

Changing Plans
DOH clarified that re-enrolling into the FIDA program once one has opted out or changing from one FIDA plan to another will only be permitted in January and July of each year.

Adequacy of Network
Plans will be required to report its network of contracted providers to DOH quarterly. Participant experiences with network adequacy and access will be captured in the Participant Feedback Process, through data collected by the Participant Ombudsman and complaints to the Department.

Continuity of Care
DOH is exploring extending the timeframe for which an individual new to a plan can continue to see their established providers, and complete any ongoing courses of treatment from 60 days to 90 days - this will require statutory change. Additionally, DOH will require that all care plans and prescription medication authorizations last for at least the first 60 days of transition, or 90 days if the timeframe can be extended to 90 days.

Enhanced Network Adequacy and Provider Access Requirements
Participants will have access to a provider network that offers a choice of each provider type and that establishes provider access rules that limit wait times, appointment times and travel/distance times. Specifically, it limits wait times to one hour, establishes appointment scheduling times that ensure timely access to routine, urgent and specialist care, or requires networks to be sufficient to ensure that participants need not travel more than thirty miles or thirty minutes to access any provider within the network. Despite the good intention of these requirements, LeadingAge New York is concerned about feasibility.

Payment to Participating FIDA Plans
FIDA plans will receive per-member-per-month capitated payments in an amount to be determined jointly by CMS and DOH. DOH anticipates the inclusion of risk adjustment and rate cells (possibly also risk corridors) in the negotiated rate. Financial performance-based incentives will also be developed to reward improvements in quality of care received by participants. Any such payments will be implemented following a year of collecting and evaluating performance, establishing benchmarks and developing performance measures. These financial incentives would be paid in addition to the capitation rates.

Integrated Records and Information Technology
Another area of concern in the last proposal was the extensive technology requirements for the FIDA plans. While LeadingAge New York believes that technology will be essential in the true coordination and integration of care, there has been limited funding available to assist the larger provider community to make the investments needed to have such systems in place. In addition, implementation of some technologies has been met with resistance, and lack of standardization

has slowed implementation. While FIDA plans may meet the requirements, they will be limited in their usefulness if other providers that they contract with have not been able to take the steps to exchange information electronically. For these reasons, LeadingAge New York is pleased to see a relaxing of the requirements outlined in the prior draft of the proposal, allowing for FIDAs to submit a plan to implement the changes if they are not able to meet the requirements by the deadline. It should also be noted that DOH stated there may be a small amount of money made available in a future HEAL grant initiative to fund these initiatives.

According to the proposal, FIDA plans must have structured information systems, policies, procedures and practice to create, document, execute, update and share information with all of the participant's providers. Plans will be required to indicate how they will use and require all providers to use single integrated electronic participant health and services records, and the information technology tools available through the plan for accessing, updating and sharing information on health history, demographics, care plans, goals, care plan adherence, care gap alerts, clinical referrals, claims information, lab results, provider/enrollee communications, contact logs, progress notes, consultations, physicians orders and encounters. They must have a systematic process to follow up on tests, treatments, services and referrals, which is incorporated into the participant's plan of care.

At a minimum, by January 1, 2015, all FIDA plans must:

- Have structured interoperable health information technology systems, policies, procedures and practices to support the creation, documentation, execution and ongoing management of a plan of care for every patient.
- Use an electronic health record system that qualifies under the Meaningful Use provisions of the HITECH Act, which allows the patient's health information and plan of care to be accessible to the interdisciplinary team of providers. If the provider does not currently have such a system, they will provide a plan for when and how they will implement it.
- Comply with the current and future version of the Statewide Policy Guidance (http://health.ny.gov/technology/statewide_policy_guidance.htm), which includes common information policies, standards and technical approaches governing health information exchange.
- Commit to joining regional health information networks or qualified health IT entities for data exchange, and includes a commitment to share information with all providers participating in a care plan. RHIOs/QE (Qualified Entities) provides policy and technical services required for health information exchange through the Statewide Health Information Network of New York (SHIN-NY).
- Support the use of evidence based clinical decision making tools, consensus guidelines and best practices to achieve optimal outcomes and cost avoidance.

Potential Improvement Targets

DOH is considering improvement targets for all FIDA plans and will seek stakeholder input on

both the targets and metrics shortly. Areas under consideration are outlined in Appendix I of the proposal, and include items like reducing the number of medications, lowering use of emergency departments, hospitals and nursing homes, reducing readmissions to hospitals, etc.

Managed Fee for Service Health Home Approach

The Managed Fee for Service approach builds upon the health home initiative, and is planned to go statewide in January 2013 for certain populations and people with multiple chronic conditions. There will be at least two health homes in each geographic region (as practicable).

The proposal provides details on how eligible individuals will be assigned to a health home provider based on existing relationships with health care providers or other care delivery system relationships, geography, and/or qualifying condition. The individual would be able to select a different health home, however, or opt-out of the demonstration.

Referrals

Community providers will call the State to find out if a dual member is already assigned to a health home, and if so, which one. When the identified member has not been assigned to a health home, the referring entity will contact the designated health home appropriate for the member, and that health home will add that member to the tracking their tracking file. Individuals with no service utilization are randomly assigned to a health home. A Referral Work Group chaired by a Managed Care Plan and Health Home is being established to develop clinical guidelines and procedures to assist providers in making referrals.

Improvement Targets

Health homes must meet a number of evidence-based quality measures based on outcomes from health care services. As outcomes are demonstrated, health homes will selectively refer to care managers who are meeting or exceeding standards.

DOH proposes to utilize both the Medicaid and Medicare shared savings models supported by care management payments to create incentives to improve coordination of care.

Appendix J of the proposal provides information on the Goals and Quality Measures for health homes. Improvement targets will be developed around:

- potentially avoidable inpatient admissions and preventable emergency room visits;
- utilization of mental health services, improving outcomes for persons with mental illness and/or substance use disorders;
- improving disease-related care for chronic conditions; and,
- improving preventive care.

In addition, a quality measure will be developed to evaluate the dual patient experience of care experience.

Participant Involvement in Care Planning

FIDA plans and health home providers must facilitate and accommodate the participant's or

his/her designee's involvement in all care planning activities. All participants will have access to the independent Participant Ombudsman to help them exercise their rights and express their wishes in and around the care planning process.

Transitioning from a Health Home to a FIDA

In the geographic region where FIDAs are being implemented, the health home care manager will contact the FIDA program to assess the appropriateness of transitioning the member into a FIDA.

Conclusion

LeadingAge New York is pleased to see the inclusion of several of the association's suggestions included in the final proposal, and will follow the implementation of these initiatives closely. Members are encouraged to keep LeadingAge New York informed of their experiences, concerns and questions so the association can advocate appropriately.

If you have any questions about the contents of this document, contact Diane Darbyshire at ddarbyshire@leadingageny.org, or 518-867-8828.