Building for the Future
Managed Long Term Care Programs in New York

Consistent with the Medicaid Redesign Team's goal of "Care Management for All", New York's long term care program has evolved from primarily a fee-for-service delivery system into one in which the majority of individuals requiring more than 120 days of community based long term care must enroll into Managed Long Term Care (MLTC). Nearly 150,000 people have successfully transitioned into MLTC programs of all types.

Although the successful completion of statewide implementation only recently occurred, we have several years of experience with mandatory enrollment. We are taking the opportunity to assess the partially capitated program and are looking to build upon the successes of MLTC and create an enhanced model for the future. The proposed model enhancements discussed in the attached white paper would allow for the creation of community partnerships to better align the program with DSRIP goals, including value based payments, integrating behavioral health services into the model, and enhancing care transitions. In the absence of mandatory fully integrated care (Medicare and Medicaid), we believe this enhanced model will allow MLTC participants enrolled in a partially capitated program to receive services in a way that promotes integration between Medicare and Medicaid providers, thereby enhancing care for participants.

In addition, the New York State Department of Health's (NYSDOH) Office of Health Insurance Programs (OHIP) recognizes that there must be better alignment and coordination of Medicaid and Medicare services and our goal is to continue to increase the number of people receiving services through fully integrated MLTC plans. In addition to the models that have been operating for a number of years (PACE and MAP), NYSDOH, in partnership with the Centers for Medicare and Medicaid Services (CMS), is in the process of rolling out the Fully Integrated Duals Advantage (FIDA) demonstration program, which is an innovative approach to achieving this goal.

Although OHIP is implementing a passive enrollment process, this integrated model of care is a voluntary program and as such, the State has experienced low enrollment levels during the early stages of the program. Throughout the development of the FIDA, OHIP committed to continually reviewing the program design and to consider making modifications to the program to support its success. In addition to looking to the future of FIDA, the attached white paper proposes areas for design modification, including making additional changes to the IDT policy, modifying the network requirements, enhancing or eliminating services from the benefit package, providing bonus payments for primary care participation in the IDT, as well as others.

These papers are **draft proposals** that are intended to begin a discussion with stakeholders on how we can work together to build MLTC programs for the future that best meet the needs of individuals in need of long term care.

The Future of Managed Long Term Care in New York

Introduction

New York is transforming its health care delivery system, and is quickly becoming a national model for high-quality, cost-effective health care. The New York State Department of Health (NYSDOH) embraces the vision for health care system redesign, which provides a three-part "Triple Aim" goal for delivery reform:

- Better care experience
- Better health outcomes
- Lower health care costs

The Division of Long Term Care (DLTC) has been at the forefront of these developments for years, and proposes the Managed Long Term Care Plus (MLTC Plus) initiative.

Under this initiative, the Office of Health Insurance Programs (OHIP) will expand benefit packages for selected MLTC partial capitation plans and enhance provider coordination through targeted incentive payments and new care management protocols. The MLTC Plus initiative will complement and enhance the State's Delivery System Reform Incentive Payment program (DSRIP), and OHIP will work closely with plans and providers to develop and discover the most effective protocols and incentives. When ready, we will expand the most successful elements of the MLTC initiative statewide by leveraging the existing MLTC infrastructure and resources.

This document is intended as the starting point for collaboration between stakeholders and DLTC for this important stage of the long term care delivery system transformation. To this end, it provides a brief history of MLTC in New York State and outlines a vision for the future.

A Brief History of Managed Long Term Care in New York

In New York State, managed long term care (MLTC) provides an array of services for individuals who are disabled or with chronic ailments who seek to remain safely in their homes while receiving needed care. With a focus on serving a dually eligible Medicaid and Medicare population, MLTC plans provide services that include medical care, personal care and social services. MLTC has expanded greatly since its outset, and is currently a very effective system of care for enrollees in need of extended services.

PACE Plans

Under the Laws of 1984, New York State authorized the first "Chronic Care Demonstration Program." This provided Beth Abraham Hospital the opportunity to begin concept development, leading to operations as one of the original ten Program of All-Inclusive Care for the Elderly (PACE) Demonstrations in the nation. Comprehensive Care Management (now known as CenterLight Health Care) began operations in the Bronx, and has since grown to become one of the largest PACE Organizations in the nation. Subsequently, Chapter 530 of the Laws of 1988 provided Rochester General Hospital the opportunity to develop the second demonstration, and Independent Living for Seniors (now known as ElderONE) joined Comprehensive Care Management as one of the original ten PACE demonstrations. The Centers for Medicare and Medicaid Services (CMS) originally provided demonstration authority to develop ten PACE Demonstrations, and later expanded that authority to twenty. Chapter 597 of the Laws of 1994 and Chapter 81 of the Laws of 1995 led to the development of two additional PACE

organizations in New York. Loretto: Independent Living Services (now known as PACE CNY) and Senior Care Connections (known as Eddy SeniorCare) first began operations as a Medicaid-only "prePACE" model, and later moved to the full risk coverage of all Medicare / Medicaid services PACE Demonstrations. Today we have 8 PACE plans serving over 5,500 individuals.

Partial Capitation Plans

Chapter 39 of the Laws of 1997 authorized development of a fifth entity under the Chronic Care Demonstration. Independence Care System (ICS) began operations as a Medicaid partially capitated model, with a unique focus of serving the adult disabled population.

Sponsored by Robert Wood Johnson Foundation, funding was received from the Commonwealth Fund in 1994 which allowed New York State to issue a Request for Proposals soliciting entities to participate in the Evaluated Medicaid Long Term Care capitation program. This provided an opportunity for entities to present an innovative concept design, while keeping with the basic premise of a partially capitated Medicaid-only model. Five entities were selected through this RFP, launching the operation of VNS CHOICE, CO-OP Care Plan, Senior Network Health, Partners in Community Care, and Health Partners of NY.

In 1997, Chapter 659 of the Laws of 1997(also known as the Long Term Care Integration and Finance Act) provided plan sponsors with some flexibility in developing models of delivery to better assist in providing services to maintain individuals in the community. The legislation also consolidated the original operating and approved demonstrations under the authority of Public Health Law Article 4403-f. Additional expansion was provided for eight plans, four designated by the Assembly Speaker and four by the Senate President Pro Tem. In subsequent years, legislative authority provided for designation of an additional ten plans.

Medicaid Advantage Plus (MAP)

In 2006, the concept for a new integrated Medicaid / Medicare MLTC plan was developed. Medicaid Advantage Plus (MAP) provided a comprehensive benefit package for dully eligible persons over 18 years of age. This model was designed to allow the Medicaid program to benefit from savings that had only accrued to Medicare under the Partial Capitation model, and it is more flexible than PACE, allowing enrollees more choice in selecting their providers. Currently we have 8 plans with over 6,000 enrollees.

Medicaid Redesign Team (MRT)

Shortly after entering office in January of 2011, Governor Andrew Cuomo established Medicaid redesign as a priority, and created the "Medicaid Redesign Team" (MRT) to lead this ambitious initiative. MRT was charged with advising the NYSDOH on re-creation of the Medicaid landscape, and over 350 recommendations for reform were proposed. MRT #90 was designed to transition the fee-for-service utilization of community based long term care services into MLTC plans, supporting the "Care Management for All" initiative. These initiatives created increased interest in both the development of new MLTC plans and expansion of existing plans, and fostered a period of rapid growth.

Recent History

In 2012, New York received approval from CMS to begin the mandatory enrollment of dual eligibles into MLTC plans. Individuals in need of community based term care services for over 120 days, age 21 or older, were directed to MLTC plans.

The rollout of mandatory enrollment began in September of 2012 in the borough of Manhattan, and was then phased in through the remainder of New York City. In January 2013, mandatory enrollment was initiated in Nassau, Suffolk and Westchester counties. Further expansion across the state was implemented as plan capacity grew. By the end of 2014, mandatory MLTC enrollment had been implemented in the majority of counties in New York. Statewide capacity was approved by CMS in mid-June 2015 and achieved by July 2015. Today, MLTC mandatory enrollment is active in all counties in New York, giving any eligible resident the ability to join a long term care plan in order to better manage their individual care needs. (See Attachment 1, *Tables 1 and 2*)

Current Status

As the rollout of new Managed Long Term Care plans reached completion, it has provided the opportunity for plans to mature, and establish deeper relationships with their provider networks. This has occurred at a time when the provider systems across the state are undergoing fundamental changes. These changes, many of which are directly tied to the State's DSRIP program and the concurrent move to value based payment, aim to rearrange the delivery system and health care markets in order to realign market incentives to promote value and improve the quality of health care delivery.

The Department of Health is committed to helping this transformation. To complement these changes, and to better establish relationships with their network providers, MLTC plans will discover new ways of arranging for the payment of care and develop new protocols that align with the changes in workflow that providers are undergoing.

The Department has started implementing the transition of Behavioral Health benefits into the Mainstream Managed Care product, and is now looking toward opportunities to enhance the Managed Long Term Care product to better align with the DSRIP goals and objectives.

A Look to the Future: Consider Developing Managed Long Term Care "Plus"

It is widely accepted that access to primary health care translates into better health outcomes. Individuals who regularly visit a primary care physician are more likely to receive preventive health services, experience improved management of chronic health and behavioral health conditions, and have a decreased likelihood of premature death. Rehospitalization is a frequent, costly, and sometimes life-threatening event that is significantly associated with gaps in primary care and in follow-up.

One idea OHIP is considering is develop a MLTC Plus program. This would include enhancing MLTC plans' ability to strengthen relationships between physicians and their patient-enrollees so that rates of avoidable hospitalizations and readmissions will be reduced. Providing incentives to develop strong care coordination and robust follow-up planning would also improve outcomes for patients, and thus reduce costs overall.

An MLTC Plus program would incorporate a three-pronged approach. The first is the enhancement and integration of the services offered to this MLTC population to include primary and preventive care and incorporate a specific focus on Behavioral Health services, which include mental health services and substance use disorder services. The second element provides quality incentives for demonstrated achievement of certain primary care delivery metrics. A third element focuses on improving transition of care from hospital to community, decreasing adverse events in the MLTC population and reducing avoidable re-hospitalization. These proposals seek ultimately to provide a more comprehensive set of benefits for MLTC enrollees, with the goals of aligning with DSRIP and achieving the Triple Aim.

The proposed initiatives are directed toward enhancing the partial capitation model of managed long term care.

The partial capitation model has been targeted for this initial set of enhancement proposals because the existing model has already been implemented statewide. Other managed long term care product lines have been developed, but are comparatively limited to certain geographic areas of the state. In addition, partial capitation plans have the largest enrollment of all MLTC plans (Attachment 1, Table 2), and as Medicare is not a component, using partial capitation plans precludes the added complexities found in modifying other product lines that include a Medicare component.

Connection to DSRIP

An MLTC Plus partial capitation model initiative would complement and leverage improvements being realized through DSRIP. The aim of DSRIP is to fundamentally restructure the health care delivery system by reinvesting in the Medicaid program, with the primary goal of reducing avoidable hospital use by 25% over five years. Avoidable hospital use encompasses not only avoidable hospital readmissions, but also inpatient admissions and emergency department visits that could have been avoided if the patient had received adequate preventive care services. This goal has also been woven into the concepts being proposed.

A noteworthy, recurring theme among DSRIP project plans is the integration of behavioral health services with primary medical care. All 25 of the DSRIP Performing Providers Systems chose to implement such a project. Furthermore, a number of MLTC plans have made formal ties with Performing Provider System (PPS) networks in support of the projects chosen for implementation by the various PPSs. This existing association can be capitalized upon in promoting the goals of MLTC Plus initiatives, particularly for the proposal to integrate behavioral health into the MLTC benefit package (Proposal 1).

Payment reform is another key feature of DSRIP. The proposed MLTC Plus initiative would align payment policies with quality goals, rather than incentivizing volume over value (Proposal 2). Plans would contract with groups of providers to deliver integrated, seamless care for all the covered care needs of this subpopulation. As described in detail in the CMS-approved NYS Medicaid VBP Roadmap, prevention, care coordination, and optimal patient outcomes will be rewarded, while avoidable admissions, fragmentation and provider-centric care will be disincentivized. It is expected that after five years of the DSRIP program, 90 percent of payments from managed care organizations to providers will be in value based arrangements. MLTC Plus would include quality monitoring and performance measurement, aligning the incentives for the plans with the incentives that will be embedded in the contracts of these plans and the providers. In the NYS Roadmap, Level 1 value based payments refers to shared

savings without downside risk, which would be the minimum expectation. This is consistent with Medicare's roadmap toward value based payments.

DSRIP also promotes community-level collaborations. These collaborations involve close interaction with community-based organizations, care management agencies and other entities to promote an individual's success in treatment by keeping them as integrated as possible in the community in which they live. Managed Long Term Care plans are already well-positioned in this arena and will play an instrumental role in the success of individual DSRIP projects, as well as the proposed MLTC Plus, bringing MLTC plans more deeply into alignment with the transformation of health care. Proposal 3 aims to capitalize on this existing capability and develop it further, particularly through the implementation of strengthened Care Transitions from hospital to community.

Concept Design Goals

Implementation of the MLTC Plus initiative is proposed to encompass the development of three distinct project concepts that could ultimately merge to create the strengthened delivery model:

- create opportunities for MLTC plans to partner with Primary Care Physicians to achieve improved health outcomes with fewer avoidable hospitalizations,

- align the quality initiatives of the plan with the value based arrangements of DSRIP, and

- expand the MLTC partial capitation benefit package to include Behavioral Health services (Mental Health and Substance Use Disorder services).

See Attachment 1 for relevant background data.

Three components are presented for consideration.

Component 1: Integration of New Services

The design of the MLTC partial capitation plan is focused on a strong care management model with the goal of keeping enrollees living safely in the community with the support and services of the plan. The primary focus of the benefit package is home care, though it also includes Adult Day Health Care, Audiology, Optometry, Dental, Durable Medical Equipment, Non-Emergency Transportation, and Social / Environmental Supports. The remainder of traditional Medicaid services are fee-for-service.

The MLTC Plus proposal would enhance the MLTC partial capitation benefit package, adding primary care and preventive health services. The initiative would also add behavioral health services traditionally provided through the New York State Office of Mental Health's Home and Community-Based Services (HCBS) Waiver program and the more recent Health and Recovery Plans (HARPs).

Currently, these behavioral health service are unavailable through MLTC partial plans. HCBS Waiver recipients must first disenroll from the Waiver program before they may enroll in an MLTC plan, thereby losing access to the Waiver's specialized services, and dual eligible individuals may not enroll in HARPs. Yet the addition of these services into MLTC, which are designed to integrate medical and behavioral health care to keep individuals in the community

and out of institutions, is very much in line with the current mission of MLTC. These new services would bring added value to the MLTC population and their addition is a logical extension of the MLTC program's person-centered approach to care. This expands upon the basic, perhaps outdated, understanding of MLTC benefit design, while allowing MLTC partial capitation plans to operate within their current authority.

The integration of new benefits would be accomplished in a manner similar to the inclusion of behavioral health services into the Mainstream Managed Care (MMC) benefit package. The suite of behavioral health services being added to MMC will be carefully analyzed to determine that each additional, specific service does not exceed the design parameters of the MLTC operating authority specified in Public Health Law Article 4403-f.

Component 2: Primary Care Delivery - Quality Incentives

The MLTC Plus would encourage MLTC plans to enter into supplementary arrangements with Medicaid and Medicare-enrolled primary care physicians who provide medical oversight to their enrollees. The proposed initiative would establish a mechanism to incentivize high-level, patient-centered care and increase the quality of care coordination services to plan enrollees.

MLTC plans would determine the strength and quality of an enrollee's relationship with his/her primary care physician by establishing metrics that capture, but are not limited to, the following parameters:

- Physician response to community-based nurse within two hours for urgent issues

- Physician response to community-based nurse within 24 hours for non-urgent issues

- Physician provides office or home visits to the enrollee a minimum of four times annually

- Physician returns signed orders within seven business days

- Physician achieves a satisfactory score on an annual Patient Satisfaction Survey in terms of the following:
    - Enrollee wait time
    - Responsiveness to enrollee needs
    - Clear communication of enrollee's health issues, treatments, options, etc.

- Physician provides timely and appropriate interventions, avoiding unnecessary hospitalizations

- Physician provides follow-up visits to enrollee within one week of hospital discharge

Reimbursement for successful performance as demonstrated via these and other measurements could result in a bonus payment paid by the MLTC plan to physicians for those MLTC enrollees in the physician's panel. The bonus could be an amount reflective of the physician's successful satisfaction of the MLTC plan's quality metrics per active member per calendar year. This reimbursement strategy would also be closely aligned with DSRIP, which rewards quality outcomes via a Pay-for-Performance strategy.

Component 3: Care Transitions from Hospital to Community

To strengthen the ability of MLTC enrollees to successfully maintain their independence in the community, it is important to focus on ending fragmentation of care across both chronic and acute episodes. To improve health outcomes and promote quality of care, the common thread across all episodes of care must be the enrollee. Weaving all transitions of care into a seamless pattern, regardless of site of the delivery, is a key intervention that all MLTC plans would provide.

Successful, person-centered, transitions require optimal two-way communications between hospital discharge planners, primary care physicians/hospitalists, medical specialists, pharmacists, and the MLTC plan. In order to promote seamless care transitions and improve quality of care, decrease adverse events and prevent re-hospitalization, MLTC plans would be required to create specific requirements for care managers/transition specialists to achieve coordinated transitions by acting as the fulcrum of all activities related to the provision of care in the community. While this current proposal is focused on in-patient hospitalizations, it is anticipated that the scope will expand to include emergency department visits and 23-hour crisis observations. The goal of this focused transition for the hospitalized enrollee may be achieved by requiring the care manager/transition coordinator to:

- communicate with a hospital discharge planner 48-72 hours prior to discharge;

- review information related to the admission, including diagnosis, treatments, testing, imaging, additions/changes to medications etc.;

- conduct outreach to a Certified Home health Agency (CHHA) provider based on hospital discharge plans, if appropriate, based on the care plan;

- communicate with enrollee to discuss impending discharge and MLTC services available in the community;

- answer any questions, share telephone contact information and set up a home visit within 48 hours of hospital discharge to review plans for follow-up appointments or testing;

- conduct two (2) follow-up telephone calls with the enrollee (or family, as appropriate) within 10 days of discharge to assure that the enrollee's needs are being met; and

- address any outstanding questions from the enrollee or family member.

Additionally, we are proposing that daily nursing visits should be made for five (5) days post-discharge to prevent rehospitalizations enrollees at-risk based on diagnoses (whether related to the current hospital event or existing chronic conditions) including, but not limited to:

- Asthma
- Cellulitis
- Congestive Heart Failure
- Urinary Tract Infections

During this critical five-day transition period, the MLTC plan would authorize wrap-around nursing above and beyond any skilled CHHA visits for dual eligibles to assure that the enrollee has daily nursing visits. The CHHA and MLTC plan must establish clear communication pathways in order for the enrollee to receive optimal benefit from these visits.

As the nursing home population has begun to transition to MLTC, we will also look toward initiatives to extend these care concepts to transitions between nursing homes and hospitals.

Managed Long Term Care Plus: Additional Considerations

MLTC Operating Authority (PHL § 4403-f)

DLTC is committed to making this transformation within the current MLTC legal authority. MLTC plans certified by the Department under Section 4403-f of the Public Health Law may provide health and long term care services. These services include, but are "not limited to home and community-based and institution-based long term care and ancillary services (that shall include medical supplies and nutritional supplements) that are necessary to meet the needs of persons whom the plan is authorized to enroll." In addition, the plan may cover "primary care and acute care if so authorized."

While not comprehensive, the authority to provide services under Section 4403-f extends beyond strictly "long term care" services, and allows plans to offer other services necessary to meet enrollees' needs. This is best illustrated by the current model MLTC partial capitation benefit package, which includes audiology, optometry, and dental. Although these are general services, important for all, they are nonetheless widely recognized as being especially important to the health and wellbeing of the MLTC population. Removing these services from the benefit package would seriously limit access and would significantly impact the health of MLTC enrollees.

Traditionally, MLTC benefit packages have not included behavioral health services. This is in large part because it was assumed that the long term care and behavioral health services populations were distinct, and that behavioral health services did not have general application. That understanding has changed drastically, however, as the relevance and general importance of behavioral health services has become better understood. It is now clear that behavioral health is a much bigger part of overall health than previously known. This is especially true for the MLTC population—individuals with functional limitations or chronic illnesses who require assistance with routine daily activities such as bathing, dressing, preparing meals, and administering medications.

The evolution of our clinical understanding about the importance of behavioral health services, both generally and specifically for the MLTC population, provides the basis for the inclusion of certain behavioral health services. As individual services are evaluated for inclusion in the benefit package as part of the MLTC Plus initiative, OHIP will ensure that they meet this standard, enabling MLTC plans certified under Section 4403-f to continue operating within the bounds of their existing authority.

9

MLTC Plus Initiative Scope

A key to success for the MLTC Plus initiative would be defining an appropriate scope for the initial phase. DLTC would select a number of MLTC partial capitation plans and providers for purposes, to help identify and develop the best ways for MLTC plans to support delivery system reform. In conjunction with DLTC, these partners would help implement and evaluate the DSRIP supportive activities.

To be successful, the MLTC Plus scope must be manageable enough so that DLTC and partners can quickly implement and analyze protocols, incentive arrangements, and other suggested supportive activities. However, it must also be broad and diverse enough to test and assess the complexities inherent to delivery system reform. And it must be representative enough so that successes are replicable in other markets across the state, in areas with a different stakeholders.

There are three critical elements to determining the initiative's scope. The first is choosing the appropriate location. DLTC is looking for areas with a high intersection between the DSRIP attributed patient populations and MLTC partial capitation plan membership. Ideally the initiative would be large enough so that it can replicate some of the complexities of the overall health care system. However, it is likely more important to ensure a high level of intersection, so that MLTC partial capitation plans and providers are better able to form cooperative relationships and fulfil initiative objectives.

The System Transformation, Clinical Improvement, and Population-wide DSRIP projects form a second element of this determination. While many of these projects include aspects that are relevant to the care of the MLTC population, only some of those projects were chosen by a significant percentage of the PPSs that sent in DSRIP applications. Projects like 2.b.iv[1] and 3.a.i,[2] which were chosen by all or almost all of the applicants, provide an opportunity to standardize MLTC plans' DSRIP-supportive activities. This should allow successful arrangements between MLTC plans and providers to be replicated in other areas of the state and in various market types.

The third element is the identification of appropriate partners and OHIP encourages the interest of all MLTC partial capitation plans. Partners must be willing to form value based and alternative payment arrangements and to engage in additional activities that will potentially impact plan and provider administrative loads. OHIP is committed to maintaining a robust health care delivery system, however MLTC Plus partners must be willing to expose relevant portions of their organizations to risks associated with new or untested arrangements.

As OHIP determines the basic parameters of MLTC Plus, we would select willing partners and solicit their input in forming the operational framework of the initiative. This framework would consist of the process and procedures used to select particular DSRIP support projects and determine appropriate compensation. Through this framework, DLTC and the partners would select the initial sets of enhancement protocols, incentive payments, and other DSRIP supportive activities. If multiple locations and sets of partners are chosen for the initiative, DLTC would allow for variance in the projects that are selected for initial implementation. These projects would build on the proposals already set forth in the DSRIP applications received by the Department and any new projects developed in concert with the partners.

---

[1] Care transitions intervention model to reduce 30 day readmissions for chronic health conditions

[2] Integration of primary care and behavioral health services

MLTC Plus would strengthen the role of Managed Long Term Care Plans in promoting enrollee health and well-being by incentivizing quality outcomes and integrating behavioral health and other services into the MLTC partial capitation model. Through the implementation of these arrangements in the MLTC Plus initiative areas, successful local projects would be studied and scaled statewide as appropriate, across the MLTC partial capitation plan infrastructure. In this way, MLTC Plus would promote the "Triple Aim" and ensure delivery system reform.

Attachment 1
Relevant Background Data

Of the nearly 148,000 unique, 2013-2014 MLTC enrollees, over 90% of whom were Dually-Eligible (Medicare / Medicaid), there was an 88% match of Medicaid IDs with the NY SPARCS database, indicating good correlation (*see Table 3*). Use of SPARCS data enables a view of those admissions/visits paid for entirely by Medicare, and which would not appear in the Medicaid claims database. As also noted in Table 3, 50% of these MLTC enrollees were admitted and discharged from the hospital at least once during 2013-14, and 41% were discharged from the emergency department (ED) in this same timeframe.

Of the over 43,000 MLTC enrollees who were enrolled in MLTC in 2014 and were also hospitalized in 2014, 45% had 2 or more discharges and 3.7% had more than 5 hospitalizations (*see Table 4*). Additionally, of those nearly 36,000 2014 MLTC enrollees evaluated in the emergency department in 2014, 40% had 2 or more visits to the ED and nearly 4% of those discharged from the ED had more than 5 ED visits (*see Table 5*). These members with multiple hospitalizations or ED visits present opportunities for interventions or system changes to improve their health, for creation of alternatives for primary and preventive care other than the hospital or emergency room, and for avoidance of over-utilization of emergency services.

Further information about members' diagnoses contributing to the high utilization of hospital and ED services would help inform potential interventions to improve MLTC enrollees' health. In addition, comparison of utilization of an age-matched, non-MLTC general population to MLTC enrollees would help us better understand the scale of difference for utilization of these acute health care services between the two populations.

Table 1. Managed Long Term Care Enrollment by Plan Type / Area of state

Managed Long Term Care Enrollment[*]			
Plan Type	**New York City**	**Rest of State**	**TOTAL**
Partial Capitation	106,815	21,483	128,298
PACE	3,406	2,110	5,516
Medicaid Advantage Plus	5,677	421	6,098
TOTAL	**115,898**	**24,014**	**139,912**

*as of 8/1/2015

Table 2. MLTC Plans currently enrolling participants, by Plan Type / Area of state

MLTC Plans Actively Enrolling Participants[*]			
Plan Type	**New York City**	**Rest of State**	**TOTAL**
Partial Capitation	24	8	32
PACE	2	6	8
Medicaid Advantage Plus	8	0	8
TOTAL	34	14	48

*as of 8/1/2015

Table 3. Summary of Matching MLTC members with SPARCS inpatient and Emergency Department (ED) discharge files.

MLTC Members	**Number**	**Percent**
Total (counts by unique MBR ID; enrolled in 2013 & 2014)	147,553	100.00%
Matched to SPARCS (Inpatient & ED; discharge year: 2009-2015)	129,493	87.80%
Found in SPARCS inpatient discharge files during 2013-2014	73,031	49.50%
Found in SPARCS ED discharge files during 2013-2014	60,589	41.06%

Table 4. MLTC members who utilized the hospital inpatient care during 2013-2014.

MLTC Members	Discharge 2013		Discharge 2014	
	N	Rate	N	Rate
Members Enrolled in 2013 (N = 138,952)	**47,119**	**33.9%**	**42,408** [a]	**30.5%**
Number of SPARCS inpatient discharges: 1	24,099	51.1%	22,538	53.1%
2-5	20,846	44.2%	17,981	42.4%
>5	2,174	4.6%	1,889	4.5%
Members Enrolled in 2014 (N = 132,703)	**42,529** [b]	**32.0%**	**43,517**	**32.8%**
Number of SPARCS inpatient discharges: 1	23,538	55.3%	23,916	55.0%
2-5	17,423	41.0%	17,979	41.3%
>5	1,568	3.7%	1,622	3.7%

[a] – 40,232 (95%) out of 42,408 MLTC members also enrolled in 2014
[b] – 38,843 (91%) out of 42,529 MLTC members also enrolled in 2013

Table 5. MLTC members who utilized the Emergency Department (ED) outpatient care during 2013-2014.

MLTC Members	Discharge 2013		Discharge 2014	
	N	Rate	N	Rate
Members Enrolled in 2013 (N = 138,952)	**38,275**	**27.5%**	**35,050** [a]	**25.2%**
Number of SPARCS ED visits: 1	22,004	57.5%	20,446	58.3%
2-5	14,600	38.1%	13,033	37.2%
>5	1,671	4.4%	1,571	4.5%
Members Enrolled in 2014 (N = 132,703)	**36,405** [b]	**27.4%**	**35,961**	**27.1%**
Number of SPARCS ED visits: 1	21,626	59.4%	21,769	60.5%
2-5	13,413	36.8%	12,862	35.8%
>5	1,366	3.8%	1,330	3.7%

[a] – 33,089 (94%) out of 35,050 MLTC members also enrolled in 2014
[b] – 33,575 (92%) out of 36,405 MLTC members also enrolled in 2013

The Future of Fully Integrated Duals Advantage Program (FIDA)

Introduction

Dual eligible beneficiaries are among the poorest and sickest of those covered by either Medicare or Medicaid and, subsequently, they account for a disproportionate share of spending in both programs. Yet unfortunately their care is disjointed, with little to no coordination.[3] State and federal agencies, managed care organizations and advocates all agree that the misalignment between Medicare and Medicaid must be addressed. The varying rules, overlapping benefits and conflicting financial incentives between the two programs greatly affect the nearly 10 million beneficiaries nationwide who are dually eligible for both programs.[4]
In an effort to address these issues, New York and 11 other states have partnered with the Centers for Medicare and Medicaid Services (CMS) to align the two programs. This is being accomplished through three year demonstration models which aim to address both the financial arrangements between CMS, providers and the states, as well as the lack of integration between the primary, acute, behavioral health and long term services and supports (LTSS) used by the dual-eligible beneficiaries.[5]

History of Dual Integration

Prior to the implementation of the demonstration models referenced above, the nation and New York State's history with dual integration is a longstanding one. Beginning with the Program of All-Inclusive Care for the Elderly (PACE), and followed by other programs such as Medicaid Advantage (MA), Medicaid Advantage Plus (MAP), and Dual Eligible Special Needs Plans (D-SNPs). Each program provides all the care and services covered by both Medicare and Medicaid. However, their origins and levels of success vary.

Program of All-Inclusive Care for the Elderly (PACE)

The PACE model can be traced back as far as the early 1970s when a San Francisco community recognized that elderly immigrants had a pressing need for long term care services. From there, support of the PACE model continued to grow with a total of 114 PACE programs operating in 32 states as of 2015.[6] New York State (NYS) operates 8 PACE programs, serving over 5,500 beneficiaries.

---

[3] http://kff.org/medicaid/fact-sheet/state-demonstration-proposals-to-integrate-care-and-align-financing-for-dual-eligible-beneficiaries/
https://kaiserfamilyfoundation.files.wordpress.com/2014/07/8426-06-financial-alignment-demonstrations-for-dual-eligible-beneficiaries-compared.pdf

[4] http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2014/02/12/states-meld-medicare-and-medicaid

[5] http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsinCareCoordination.html

[6] http://www.npaonline.org/website/article.asp?id=12#History

Medicaid Advantage (MA)/Medicaid Advantage Plus (MAP)

NYS implemented their MA and MAP programs in 2006 and 2007, respectively. They offer Medicare and Medicaid benefits through Medicare plans that contract with NYS. The MA and MAP models of care are similar, but the MAP model requires more intensive case management. As of June 2015:

- MA is offered in 26 upstate counties and New York City, to approximately 9,200 beneficiaries.
- MAP is offered in 8 upstate counties and New York City, to over 6,000 beneficiaries.[7]

D-SNP

D-SNPs began in 2006. They are required by federal law to have contracts with the states in which they are offered, and they are available to beneficiaries in all Medicaid eligibility categories. As of 2015, there are 41 D-SNPs in New York State, serving 186,752 members.

The Need for Integration Continues

Integration of services for dual-eligible beneficiaries is known to improve both participant satisfaction and their overall health outcomes. When a patient's needs and preferences are understood and shared between each treating provider, adverse prescription interactions and duplication of services would likely be reduced.[8]

While the undertaking of integration is far from simple, the long term benefits provide a strong incentive. For example, some sources estimate that up to 40% of hospitalizations of low-income nursing home residents could be avoided if there was better, more integrated care for this population which, in turn, should result in lower costs for both federal and state governments. [9] In addition, with the increase in the number of Americans over age 65 and Medicaid expansion through the Affordable Care Act, the dual-eligible population is expected to continue to rise. Therefore, there is undoubtedly a need to continue integration efforts for the dual population.

Fully Integrated Duals Advantage (FIDA) Demonstration

Each state's development of its integrated programs has looked very different based on the unique qualities of each state's long term care infrastructure. As such, it is difficult to compare financial alignment demonstrations to each other. New York, unlike most other demonstration states, had a pre-existing mandatory managed long term care (MLTC) structure. New York's FIDA program is one of four MLTC options in New York.

The FIDA program is intended to meet the Medicaid Redesign Team's "Triple Aim" of providing better care to consumers, achieving better health outcomes and to reducing the cost of care. While building off of New York's existing MLTC models, FIDA was designed to enhance what is

---

[7] https://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/

[8] http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=70

[9] http://www.fiercehealthfinance.com/story/states-look-cut-costs-treating-dual-eligibles/2014-02-16

offered under existing models by providing more services (such as behavioral health services and home and community-based waiver services), along with a more intensive participant-centered care coordination model. The model assumes that this enhanced approach will result in better health outcomes as well as result in cost savings.

To be eligible for FIDA, individuals must be: 1) age 21 and over; 2) in need of at least 120 days of community-based long term care or nursing facility clinically eligible and receiving benefits in a nursing facility; 3) receiving full Medicaid benefits; and 4) entitled to benefits under Medicare Part A and enrolled in Parts B and D. There are certain populations that are excluded from enrolling or from passive enrollment into FIDA, which is outlined in the 3-way contract.

Opt-in enrollment into FIDA became effective on January 1, 2015 and passive enrollment became effective in April 2015. The current geographic location of the FIDA demonstration is the 5 boroughs of NYC and Nassau County. This is known as Region 1. Region 2 (Westchester and Suffolk Counties) are slated to begin accepting enrollments on or around January 1, 2016. CMS has also presented an optional two year extension period, for which New York has requested approval. The current demonstration runs January 1, 2015 through December 31, 2017, and if approved, could go through 2019.

Nearly all of the individuals who have enrolled into FIDA came from an existing MLTC plan. As of September 2015, over 7,000 people were enrolled in FIDA. This number will continue to increase through continued opt-in enrollment, passive enrollments scheduled to occur on October 1, 2015 and later, as well as through the implementation of opt-in and passive enrollment in Region 2.

Based on feedback that we have received from consumers, plans and providers to date, individuals enrolled in FIDA are being served successfully and participants are satisfied with the program. However, enrollment into FIDA has not reached expected levels. Anecdotally, this can be attributed to the following:

- Potential participants do not want to change programs because they may be:

  - fearful that they will lose their current providers;

  - unclear on how FIDA could benefit them above and beyond what they are getting in their current MLTC program;

  - satisfied with their MLTC Plan;

  - cautious of making any change in their healthcare coverage.

- Plans have not committed to the model and have not made sufficient efforts toward marketing the program to potential participants.

- Providers were not educated early enough to support the program and encourage their patients to enroll, which has instead resulted in providers encouraging patients to opt out.

- Medicare providers may be unwilling to work with managed care plans because they are reluctant to change the way they are paid, since many are working with Medicare fee-for-service.

- The interdisciplinary team (IDT) model is perceived to be onerous on providers and, as such, providers do not want to participate.

- Plans are not opening their networks to providers that are working with FIDA participants, especially Medicare providers.

- Rate uncertainty.

- Provider training requirements are onerous.

Although the FIDA program is still early in its inception, NYS wants to take the opportunity to work with stakeholders on the design to determine what the future of the program will look like.

Proposed Program Changes to Increase Enrollment into FIDA

The FIDA program is still in its infancy, so there is not enough data on the success of the program in terms of participant outcomes. However, anecdotal reports indicate that the IDT is effective and that individuals in FIDA are satisfied with the program. However, the goal is to increase enrollment in FIDA to ensure that more people can receive fully integrated care. To achieve this, we have several recommendations that could provide more flexibility in the program design and that should appeal to participants, providers and plans.

IDT

The IDT is a critical component of the FIDA model, as it provides an intensive care coordination process that makes the participant the center of the care planning process. It offers an opportunity for participants and their providers to work collaboratively in making decisions about participants' care. This collaborative approach toward care planning can lead to better outcomes for participants because they are more invested in the process. OHIP believes that the IDT model is an important element of the program that plans, providers and participants will come to value with time and experience. Thus, we recommend several incentives to promote the IDT element of the program while also increasing flexibility for the plans, providers and participants:

- The first option for modifying the FIDA program is to make the IDT optional for participants. Individuals who join FIDA would be offered the informed option of having an IDT or a care manager to coordinate their care. All plans would have to continue to have both the traditional managed care service authorization process as well as the IDT option available.

  To incentivize utilization of the IDT model over traditional care management, OHIP would develop a bonus pool in which FIDA plans would receive bonus payments for utilization of the IDT model. These bonus payments would be designed so that plans would have to achieve a minimum threshold of 25 percent utilization of the IDT model. Anything below 25 percent would result in plans receiving a reduction in future capitation payments Plans would receive a bonus payment from a pool of funds for the percentage of their long term care membership that utilizes the IDT model above 25 percent. Above

the 25 percent, plans could receive bonus payments that progressively increase based on percentage of IDT utilization.

- To address the concern that some physicians may not be willing to be on the IDT, OHIP also proposes to create a primary care provider incentive pool in which funding could be provided to plans, who would pass to physicians, for participation in IDT meetings.

- To incentivize consumer participation in the IDT, the program could also allow for participants to receive small incentives (e.g., a grocery store gift card) each time he/she participates in an IDT meeting.

Marketing

Marketing has been a challenge for the program thus far. Complex and changing rules – reflecting both Medicare and Medicaid requirements - added to plan confusion and impacted the amount and nature of early marketing. This may have contributed to reduced enrollment into their plans. We propose to offer additional flexibility in the rules governing consumer marketing, including the following:

- Allow Plans to provide a comparison between their MLTC programs. Currently, Plans can only use a comparison tool that is provided by CMS/OHIP.

- Eliminate the requirement that a licensed marketing representative be the only person that can describe the FIDA plan to potential consumers.

- Explore additional areas of flexibility within the current Medicare rules.

In addition, OHIP is prepared to invest funds and resources to develop and implement a FIDA marketing campaign. Plans, advocates and providers support for increased enrollment is key to a successful effort.

Enrollment

Unlike in Medicare Advantage, FIDA Plans are unable to directly enroll individuals into the program and unable to assist callers in navigating the enrollment process with the Enrollment Broker. OHIP would allow the FIDA plans to enroll directly into their plans as is allowed in Medicare Advantage.

Another element to enrollment that we propose modifying is intelligent assignment to better match the primary care and home health provider history of the FIDA member.

Another change we are considering is that in order to incentivize plans to enroll individuals into integrated care, we propose requiring companies participating in the FIDA Program to achieve 25% integrated care across all LTSS members by December of 2016. As part of this effort, we are proposing to freeze new MLTC partial plan enrollment to MLTC partial plans of a company that has a FIDA plan but does not have at least 25 percent of their total LTSS members (MLTC Program Participants) enrolled in an integrated plan (whether FIDA, MAP or PACE) by December 2016.

In addition, to increase enrollment into the FIDA program, we propose to take the following expansion measures:

- Implement at least semi-annual passive enrollment into FIDA.

- Individuals on Medicaid will be offered FIDA as their first choice upon enrollment into Medicare when they turn age 65 and are in need of long term care services. Enrollees will have the option of opting out of FIDA and enrolling in an MLTC plan, but FIDA will be the primary choice.

- Expand enrollment to the dual population not in need of 120 days of long term services and supports (well duals), which would include the rollout of a passive enrollment process for this population.

Services

The FIDA program already has a more robust service package than any other managed care plan. For example, in addition to the Medicaid benefits offered through MLTC and Medicare benefits, the program includes the State Plan Health and Recovery Plan (HARP) services as well as the services otherwise offered only to participants of the Nursing Home Transition and Diversion (NHTD) and Traumatic Brain Injury (TBI) 1915c waiver programs.

We also propose to also add the following services:

- Consistent with the MLTC partial plan proposal outlined above, FIDA could add the HARP HCBS services to the benefit package.

- Require that all plans offer an "Over the Counter" drug card.

- Evaluate the addition or elimination of other services that plans, providers, and participants recommend. One service that plans have raised as an issue is non-medical transportation.

Networks

FIDA is a person centered model, yet we have found that many opt outs have occurred because potential participants were afraid that they would lose their current Medicare providers if they join because they are not in the network. We propose to add an "any willing primary care provider" requirement to the program whereby FIDA plans must allow any qualified primary care provider who is willing to accept the terms of the managed care plan to join their network and provide services to FIDA participants.

The Future of FIDA

The goal of the proposed changes described above is to strengthen the FIDA program by providing flexibility and incentives that will drive growth in the program without sacrificing quality to participants. OHIP is committed to continuing to work closely with CMS and stakeholders to shape the program to ensure its future success.