MEMORANDUM

TO: LeadingAge New York Members

FROM: Karen Lipson

DATE: September 28, 2015

RE: Summary of NYS Department of Health White Paper on Future of Managed Long Term Care and FIDA

The Department of Health (DOH) has released a draft white paper on the future of its Managed Long Term Care (MLTC) and the Fully-Integrated Duals Advantage (FIDA) programs. The paper was disseminated to stimulate discussion and elicit recommendations at tomorrow's DOH Long Term Care Forum. The following summarizes key components of the white paper:

MLTC Plus Proposal

The paper proposes to strengthen the partially-capitated MLTC program by creating an "MLTC Plus" model. MLTC Plus is intended to address the fragmentation and cost-shifting that can result from the segregation of Medicare and Medicaid benefits. Specifically, the MLTC Plus model would:

- Add primary and preventive care and behavioral health services to the MLTC benefit package;
- Provide quality incentives for demonstrated achievement of certain primary care metrics.
- Require certain protocols at transitions from the hospital to the community, in order to reduce avoidable re-hospitalizations.
- Apply the value-based payment reforms set forth in the NYS Roadmap, requiring plans to measure provider performance and reward them for optimal patient outcomes through payment arrangements that, at a minimum, involve shared savings.

The paper appears to envision limiting the MLTC Plus product initially to selected plans in limited geographic areas. Regions would be chosen based on overlap between the DSRIP-attributed patient population and MLTC enrollment and based on the applicable Performing Provider System's (PPS's) selection of projects relevant to the MLTC population.

New Benefits

The paper does not elaborate on the scope or financing of the primary and preventive care benefits that would be added to the MLTC Plus benefit package. However, it envisions "supplementary arrangements with Medicaid- and Medicare-enrolled primary care physicians" (PCPs) to incentivize "high-level, patient-centered care and increase the quality of care coordination services to plan enrollees." Physicians would be evaluated and rewarded through bonus payments based on their performance on the following metrics:

- Response to community-based nurse within two hours for urgent issues and within 24 hours for non-urgent issues;

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- Office or home visits to the member at least four times annually;
- Submission of signed orders within seven business days;
- Satisfactory score on an annual Patient Satisfaction Survey in relation to:
    - Enrollee wait time
    - Responsiveness to enrollee needs
    - Communication of enrollee's health issues, treatments, options;
- Timely and appropriate interventions to avoid unnecessary hospitalizations; and
- Follow-up visits to the member within one week of hospital discharge.

The behavioral health benefits to be integrated would include home and community-based waiver services currently available through the Office of Mental Health's Medicaid waiver and the newly-developed Health and Recovery Plans (HARPS).

Care Transitions

The paper proposes to improve transitions from acute care to community settings in MLTC Plus by imposing specific post-discharge protocols on MLTC Plus care managers and community-based providers. While the proposal focuses on community-based, post-discharge care after inpatient admissions, DOH envisions expanding it to include discharges from the emergency department and 23-hour crisis observation and discharges to nursing homes. Under this proposal, care managers would be required 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;
- Conduct outreach to a certified home health agency (CHHA), if appropriate, based on the care plan;
- Communicate with the enrollee to discuss the 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 discharge to review plans for follow-up appointments or testing;
- Conduct two 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;
- Address any outstanding questions from the enrollee or family member; and
- Authorize daily nursing visits for five days post-discharge based on diagnosis (whether or not related to the hospital admission), including, but not limited to:
    - Asthma
    - Cellulitis
    - Congestive Heart Failure
    - Urinary Tract Infections.

The draft paper posits that the MLTC Plus model will improve outcomes for MLTC members by driving closer relationships with PCPs, integrating behavioral health with long-term care services, and strengthening care transitions.

FIDA Proposals

The paper sets forth a series of proposals intended to increase enrollment in FIDA plans (i.e., fully-capitated plans that cover both Medicare and Medicaid benefits). Launched in January 2015, the FIDA program operates in New York City and Nassau County and is expected to expand to include Westchester and Suffolk Counties. The paper acknowledges that beneficiaries are opting out of FIDA at high rates and cites several reasons including:

- Beneficiaries are fearful that they will lose access to current providers and unclear on the advantages of FIDA in comparison with MLTC enrollment;
- Plans have not, in DOH's opinion, committed to the model and made sufficient marketing investments;
- Providers, according to DOH, encourage patients to opt out because:
    - They are accustomed to Medicare fee-for service reimbursement and are reluctant to change the way they are paid; and
    - The interdisciplinary team (IDT) model and provider training requirements are perceived to be onerous;
- FIDA plan rates are uncertain; and
- Plans are not, in DOH's opinion, opening their networks to providers that are working with FIDA participants, especially Medicare providers.

Significantly, to address low enrollment, DOH proposes to expand the population eligible for FIDA to include dual eligibles who do not need long term care and to extend passive enrollment to this population. In addition, it proposes changes in enrollment procedures and new penalties for low enrollment in fully-capitated plans; an IDT consumer opt-out along with incentives and penalties to support IDT participation; added flexibility in marketing rules; additional benefits; and an "any willing PCP requirement.

Enrollment Proposals

The paper's proposal to expand the eligible FIDA population to include dual eligibles who do not require 120 days of long term care would significantly expand the targeted market for FIDA. In addition, to this expansion, the paper proposes a combination of changes in the enrollment process and penalties for low enrollment. Specifically, it proposes to freeze enrollment in MLTC plans operated by organizations that also operate FIDA plans, if the organization does not attain 25 percent enrollment in its fully-capitated products (i.e., FIDA, PACE and MAP) by December 2016. It also proposes the following changes in enrollment procedures:

- Direct enrollment by plans, in addition to enrollment through the Department's enrollment broker;
- Intelligent assignment to match beneficiaries with plans based on PCP and home health relationships;
- Implementing semi-annual passive enrollment in FIDA;

- Offering Medicaid beneficiaries FIDA enrollment as their "first choice" upon enrollment in Medicare at age 65, if they are in need of long term care services.

IDT Proposals

The paper attempts to mitigate the deterrent effect of the IDT on physician participation, by affording beneficiaries the right to opt-out of the IDT process. However, this opt-out would be accompanied by incentives and penalties to support IDT participation. FIDA plans would receive bonus payments from a bonus pool for utilization of the IDT model above a minimum threshold of 25 percent. IDT participation below 25 percent would result in a reduction in future capitation payments. In addition, a primary care provider incentive pool would provide funding for plans to reward physicians who participate in IDT meetings. The program could also provide small incentives (e.g., a grocery store gift card) to consumers who participate in IDT meetings.

Marketing Proposals

The paper proposes to provide additional flexibility in consumer marketing, including:

- Allowing plans to create their own tool comparing their managed care products. Currently, plans may only use a comparison tool that is provided by CMS/OHIP.
- Eliminating the requirement that only licensed marketing representatives may describe the FIDA plan to potential consumers.

The Department indicates in the paper that it is prepared to develop and implement a FIDA marketing campaign.

Benefit Changes

The paper proposes to make the following changes in the FIDA benefit package:

- Add the behavioral health HCBS services covered under the HARP program;
- Require that all plans offer an "Over the Counter" drug card.
- Evaluate the addition or elimination of other services, including non-medical transportation.

PCP Participation

To address the concern attributed to Medicare beneficiaries that they will lose access to existing PCPs if they join a FIDA plan, the paper proposes an "any willing primary care provider" requirement . Under this proposal, FIDA plans would be required to permit any qualified PCP, who is willing to accept the terms of the plan, to join their network.

Please contact Karen Lipson, klipson@leadingageny.org, and Dan Heim, dheim@leadingageny.org, with your comments on these proposals.