November 27, 2013

Ms. Melissa Seeley
Centers for Medicare and Medicaid Services (CMS)
7500 Security Blvd.
Baltimore, Maryland 21214

Mr. Mark Kissinger
New York State Department of Health
Empire State Plaza, Corning Tower, 14th Floor
Albany, New York 11237

Re: Priorities for the Fully Integrated Dual Advantage program contract

Dear Ms. Seeley and Mr. Kissinger,

Thank you for your continued commitment to engaging consumer stakeholders as the Fully Integrated Dual Advantage (FIDA) program is implemented. We appreciate the Medicare-Medicaid Coordination Office's (MMCO) and New York State Department of Health's (State) efforts to develop high-quality programs aimed at improving the care provided to individuals dually eligible for Medicare and Medicaid benefits. The Coalition to Protect the Rights of New York's Dually Eligible (CPRNYDE) represents many of the consumer stakeholder groups that have been assisting dually eligible individuals access healthcare services, including those provided by Medicare Advantage (MA) and Medicare Part D, mainstream Medicaid managed care and mandatory managed long term care (MLTC).

As MMCO works with the State to develop a "three-way" contract between CMS, the State and the private health plans set to offer FIDA policies, a contract that would presumably outline more details of the FIDA program, we would like to provide our priorities for this contract, based on our knowledge of the consumer experience in managed care here in New York. Dually eligible individuals have long trusted our organizations to help them navigate the oftentimes confusing healthcare system, and we are pleased to be able to provide input based on our extensive experience working with this population throughout the state.

We appreciate that both MMCO and the State have taken many of our comments into consideration and has incorporated our input into the Memorandum of Understanding (MOU) and readiness review tool. However, we still have some concerns about the implementation of the FIDA demonstration. Unfortunately, without seeing a draft of the contract, we are unable to provide comments that are specific to what MMCO and the State have already put together. However, we anticipate submitting more thorough comments once a draft of the contract has been released. As you know, we have provided input to MMCO and the State regarding many of our concerns about FIDA, but in this letter we address the areas where we feel it is imperative,

for the sake of the consumer, for MMCO, the State and private plans to include sufficient detail and consumer protections in the contract:

Integrated Appeals

We applaud the State and CMS for the MOU's inclusion of an integrated appeals process for Medicare and Medicaid. We advocated for an integrated process, and we were pleased to have the support from private plans and the State. We also applaud the State and CMS for including aid continuing for all prior- approved Medicare and Medicaid benefits pending appeal. We are encouraged by language in the MOU that alludes to continued discussion about including Medicare Part D as part of the integrated FIDA appeals process.

The Part D process, as it currently exists, causes many beneficiaries to experience significant delays in access and suffer negative consequences to their health. In the current appeals standards, a denial at the pharmacy counter triggers no due process rights. Instead, a beneficiary must request written support from his or her prescribing physician to request a coverage determination. As a result, many bypass the formal appeals process entirely, in many cases leaving the pharmacy empty-handed and accepting the resulting consequences to their health. For those beneficiaries who do request a coverage determination, it is only after this coverage determination is made that the beneficiary has any appeal rights. The beneficiary must appeal to the plan once again, and request a coverage redetermination. In our experience, the current process is burdensome and deters beneficiaries from pursuing an appeal.

In the contract, the unified appeals process in FIDA should integrate all Medicare and Medicaid denials, including denied medications. At a minimum, CMS and the State should collapse the multiple levels of the Part D plan appeals process in the contract and ensure both that a denial of coverage given at the pharmacy counter is treated as a coverage determination, and that the beneficiary is given immediate appeal rights. This would be an improvement from the current structure, which requires the beneficiary to ask the health plan for a separate coverage determination before the appeal can begin.

Continuity of Care (Transition Periods, Passive Enrollment and Self-direction)

<u>Transition Periods:</u>

Plans should be required to allow Participants to maintain their current providers for the duration of FIDA. While the provisions outlined in the MOU are very strong for Participants who live in nursing homes, the care continuity for non-nursing-home residents is not as robust. The

MOU allows consumers to continue to receive services from non-network providers for up to 90 days upon enrolling and transitioning into FIDA. In the Virginia and Illinois MOUs, the transition period is 180 days, and California allows a 180-day transition period for Medicare services and up to one year for Medicaid services.[1] While we recognize that New York already safeguarded transition in the switch to MLTC, we recommend that in the Contract New York adopt at least the 180-day transition period for authorizations for services that have already transitioned to MLTC and for any services that have not. We make this recommendation as we foresee that the communications and processes that will take place between plans, providers and enrollees will take more time than the 90-day transition period affords.

Passive Enrollment:

The MOU refers to an "intelligent assignment" algorithm that will be used for passive enrollment, and will prioritize continuity of providers and/or services. While we see this as a positive application of the algorithm, we would like to see the Contract include more detail on how the algorithm works, and also ensure that the algorithm considers not only Participants' previous Medicaid managed care enrollment and historic provider utilization, but their previous Medicare service and provider utilization as well.

Self-direction:

The FIDA MOU is very strong in the application of the consumer's right to self-direction; however, we would like to see specific contract provisions related to the provisions outlined in the Governor's Olmstead Plan, which highlights that consumer direction services be offered as the first option in managed care settings.

Care Coordination

We are pleased the MOU outlines that plans must support an Interdisciplinary Team (IDT) for each Participant, and that the determinations of the IDT are binding service authorizations. However, we are concerned that the IDT does not include the Registered Nurse who performs the Participant's initial plan assessment and subsequent reassessments. Additionally, the IDT is responsible for completing each Participant's Person-Centered Service Plan, but the MOU does not mention how the assessment will be used to inform the development of the Person-

[1]See, e.g. Incentives for Community-Based Services and Supports in Medicaid Managed Long Term Care: Consumer Advocate Recommendations for New York State (March 2012) posted at http://wnylc.com/health/download/304/. This paper cites examples used or proposed in other states. Also, see New York's 2012 Managed Long Term Care Report: An Incomplete Picture (Coalition to Protect the Rights of New York'sDuallyEligible,April2013) posted at http://www.wnylc.com/health/download/401/

Centered Service Plan. The contract should stipulate that the nurse who performs the original assessment be available to the IDT to answer specific questions about the enrollee's health status. Additionally, if FIDA Plans are required to use UASNY to assess for long-term care services, then how will conflicts between the UASNY and the determination of the IDT be reconciled? We request that the IDT be given specific authority to override the mechanical application of UASNY where that is necessary to effectuate the Person-Centered Service Plan. Further, language should be included in the Contract, or in subsequent guidance and regulations, that would require FIDA Plans to assess each Participant's need for modification of policies and procedures and for reasonable accommodations in order to access services.

As outlined in our extensive comments on the draft plan readiness review tool, we support the requirement that plans must conduct assessments in the assisted living facility or nursing home if that is the Participant's home. The Contract should require that plans also conduct the assessments in a hospital or rehabilitation facility if the client is temporarily receiving care in such facilities. In MLTC, we have seen plans refuse to assess prospective members in these settings, thus delaying their ability to return home with the necessary home care services in place.

We are also concerned that, while a care manager has the important responsibility of leading the IDT and can recommend that other providers are added to the IDT, the MOU does not stipulate the level of licensure or credentialing necessary for someone to be considered a care manager. The MOU refers to a care manager's "appropriate experience and qualifications based on a Participant's individual needs," but this language is very vague. With MLTC, we have seen a wide disparity in reported care-manager-to-member ratios, perhaps reflecting differences among plans in what staff are considered care managers. NYSDOH should outline specific qualifications of the care manager, including licensure and credentialing requirements and necessary training, in the contract. Enrollment/assessment nurses should specifically be excluded from consideration as care managers.

Finally, while we applaud the imposition of these mandates for person-centered care management and use of IDT, we are concerned that there is no particular financial incentive for FIDA Plans to robustly implement them. We would welcome a method of rate modification based upon measurable indicators of the quality of plans' interdisciplinary care planning, such as care-manager-to-member ratio, member surveys, frequency of IDT meetings, and consistency of encounter data with specific care plans.

Participant Ombudsman

We advocated for the inclusion of an independent, conflict-free entity to serve as an ombudsman in FIDA, and we are pleased that the Participant Ombudsman has been included as

part of the MOU. In the Contract, we look forward to seeing more detail regarding how the Participant Ombudsman will work with FIDA Plans.

CPRNYDE recommends that the Contract provide the Ombudsman with the opportunity to address program issues and facilitate systematic advocacy to ensure timely and adequate access to all services and supports a beneficiary is eligible to receive. The Ombudsman should be allowed to routinely receive and have access to data that the plans report to the State or CMS. The Ombudsman must have the authority to ask questions of the plans about participants, regardless of whether a particular participant has provided authorization, procedures, systems, and data. This will enable an Ombudsman to investigate systemic issues and not only troubleshoot individual cases. The program should include technical assistance, consumer education, community training on obtaining Medicaid and Medicare services and coordination, supports, and protection of due process rights. In addition, the program should provide advice and assistance in preparing and filing complains, grievances and appeals of complaints or grievances, including preparation of documents and guidance for self-advocacy.

It is critical that the Ombudsman program is developed and implemented effectively. As Managed Care is rolled out in New York, individuals will require expert assistance as they adjust to mandatory enrollment. CPRNYDE is uniquely qualified to help with the development of this program. To help safeguard vulnerable populations and ensure the success of the program, we request the opportunity to work with the State to help develop the requirements of the Participant Ombudsman.

ADA Compliance and Independent Evaluation

While the MOU does make some reference to the ADA, the Civil Rights Act of 1964, and the Supreme Court's *Olmstead* decision, the MOU's language is very vague in these areas. For instance, the MOU requires FIDA Plans to contract with providers that demonstrate "commitment and ability" to accommodate the "physical access and flexible scheduling needs" of participants and "effective communication." But, the MOU stops short of requiring providers to actually be accessible and provide reasonable accommodations.

In the Contract, we would like to see more concrete guidance on ADA compliance standards, materials and training requirements. The contract could better reflect the references to the Americans with Disabilities Act and disability literacy contained in the Readiness Review.

Additionally, we recommend that the State conduct independent evaluations of FIDA Plans' ADA compliance, including auditing plan practices and provider listings. There is evidence of physical, communications and programmatic inaccessibility of provider sites and self-reporting of accessibility has been found to be inaccurate. The State should contract with independent living

centers to conduct site audits of plan and provider sites; there is a precedent for this as the State is currently engaging with independent living centers in evaluation of accessibility of mammography providers.

Rates

We applaud the State for recognizing that high need cases, such as those who require split-shift or 24/7 personal care or consumer directed personal cases, could require additional financial incentives to avoid institutional placement. We support the State's vision, as expressed in its October 2013 Olmstead Plan, to transition 10 percent of all nursing facility residents back into the community within the next five years, and we appreciate the direction the State is moving with respect to high risk pools for plans and quality incentives tied to community care.

We are very concerned, however, that even as the State commits to rebalancing community and institutional spending, it is seriously considering creating a nursing home specific rate cell within the MLTC program, which serves as the platform for FIDA. This approach could seriously diminish, if not completely erase, any incentive MLTC Plans have to care for high needs members in the community as opposed to institutions. Although the State proposes to delay availability of the enhanced rate for 1-3 months following institutionalization (and extend the higher rate for 1-3 months following discharge for individuals transitioning back to the community), plans will be hard pressed to ignore the opportunity to receive higher compensation for high needs members whose care in the community costs as much, if not more, than care in a nursing home

The State proposes to utilize the nursing home rate for two years, in order to stabilize funding for plans and nursing home providers and gather data on the costs of high needs members in the community. We question whether such a rate would achieve the desired stabilizing effect, given that nursing home rates vary widely currently, and whether stabilization is as critical as some believe, given the trend toward nursing home providers becoming MLTC plans. We recognize the State's need to accumulate more data, given the difficulties the State has experienced with collecting encounter data on community care from private plans in the recent past. However, we feel strongly that one year should be the maximum period allowed for the nursing home rate, given the damaging incentives it creates for plans to favor nursing home care over community care for high need members.

In addition, we urge CMS and the State to create a high-needs community rate cell, supported by a specific nursing facility transitional rate, in order to counter-balance the nursing home rate and create an ongoing incentive to deinstitutionalize nursing home residents. The high-needs community rate cell would apply to assistance provided to individuals receiving 12 or more hours of long-term services and supports (LTSS) per day. The specific nursing facility transitional

rate would be an add-on that plans would qualify for when an individual is transitioned out of a nursing facility. This rate would also require plans to perform the necessary outreach into nursing facilities to identify individuals for transition, maximizing the reach and use of the funds. Under the specific nursing facility transition rate, plans would receive increased payments for three months while the consumer is still in the nursing facility, in addition to the first six months after he/she has moved into the community.

We believe that the community rate cell (coupled with the transitional funding) has distinct advantages over a high needs risk pool, whose size would be directly proportional to reductions in the base rate, making it more difficult for all plans to serve higher need members, particularly if they do not anticipate recoveries from the "first come, first served" quality pool. We welcome the opportunity to provide further information regarding our proposal for a community rate cell, including strategies for addressing data gaps in the short term and targeting new resources to maintain budget neutrality.

Transitions Between Care Settings

The sole requirement for FIDA Plans to assist members who want to transition to the community from nursing homes is a referral to Pre-Admission Screening and Resident Review (PASRR) evaluations or the Money Follows the Person (MFP) program. This is inadequate to further the goal of promoting community-based long-term care. PASRR evaluates solely persons known to have or suspected of having Mental Illness (MI), Traumatic Brain Injury (TBI), or dual diagnoses of MI with TBI or Developmental Disabilities (DD). While this screening is required and helpful, it will not screen people who do not have these diagnoses for possible discharge into the community. Nor is the MFP program sufficient—while it is a worthwhile program, it has very limited capacity to assess potential for transition to community living to all institutionalized members of FIDA Plans. Also, we understand that this program is being diverted to the DD population, so will be even less of a resource.

Since FIDA Plans are responsible for assessing and authorizing a wide range of community-based long- term care services, and for providing person-centered case management, we recommend that the FIDA Plans be required to do essentially what the MFP contractors do, as well as assess eligibility for all community-based long-term care services *and* for identifying, applying for and securing housing options where needed. Similarly, FIDA Plans must be required to do more than track the number of members wanting to move to the community. They should also report the number of residents the plan independently assessed for potential discharge and eligibility for community-based care, and the number of residents discharged, with the length of time from initial assessment for discharge to actual discharge to the community, and the reasons why members could not be discharged (i.e. lack of affordable and accessible housing).

Additionally, the contract should provide incentives—whether carrot or stick or a combination—for plans to assess institutionalized members for discharge to the community and take the steps needed to transition them to the community. We recognize that resources are needed—a reason why MFP and the Nursing Home Transition & Diversion Waiver have not been as successful in New York as hoped— and that incentives could make a difference. We have also recommended some of these incentives to the State in the context of MLTC.

Networks

The Contract should require FIDA Plans to have contracts with relevant providers in areas known by the State to be in short supply of specific services (i.e. behavioral health services) and/or specify their plans for assisting participants with accessing out of network care for these services. Also, the Contract should stipulate that plan contracts with providers not only ensure "non-discrimination," but also set forth the affirmative obligation of providers to reasonably accommodate all participants with disabilities. Accessibility survey information about building and office entrances, waiting rooms, exam rooms, restrooms and medical equipment should be noted in the FIDA plan directory for each provider. Finally, the Contract should require plans to update online provider directories and search functionality on a frequent (i.e., weekly) basis.

Quality

The Contract should not provide FIDA Plans the authority to develop their own quality measures. Instead, the State should create a reporting system based on the quality measures specified in the MOU as the basis for Quality Withholds. Many national organizations have compiled recommendations for monitoring quality in LTSS, given that traditional outcome measures through HEDIS and other protocols focus on primary and acute care.[2]The Contract should also stipulate that FIDA Plan reports must include a process for documenting and tracking that participants are advised of their ADA-related rights, reasonable accommodations are being made, and any inquiries, complaints and appeals related to those rights.

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[2]See, e.g. *Identifying and Selecting Long-Term Services and Supports Outcome Measures,* (Disability Rights Education and Defense Fund (DREDF) and Natl. Senior Citizens Law Center, January 2013), posted at *http://www.nsclc.org/wp-content/uploads/2013/02/Guide-LTSS-Outcome-Measures-Final.pdf; Medicaid Long- Term Services and Supports: Key Considerations for Successful Transitions from Fee-for-Service to Capitated Managed Care Programs (Kaiser Commission, April 2013), posted at http://kaiserfamilyfoundation.files.wordpress.com/2013/05/8433.pdf.*

Plan Marketing

We are pleased to see that CMS and the State will monitor enrollments and disenrollments for compliance with applicable marketing and enrollment laws, for the purposes of identifying any inappropriate or illegal marketing practices. We are also pleased that CMS and NYSDOH will monitor unusual shifts in enrollment into particular FIDA Plans or Medicare Advantage Plans operated by the same parent organization.

We recommend that in the contract, CMS and the State are required to monitor all enrollments into FIDA Plans, whether passive or based on individuals opting in, for inappropriate or illegal marketing practices. CMS and the State should discontinue passive and opt-in enrollments into FIDA Plans that use inappropriate or illegal marketing practices. The contract should also stipulate that marketing rules for FIDA Plans should be at least as stringent as those used in the Medicare Advantage and Part D programs.

We also recommend that the contract should include the creation of an online, publicly available plan comparison tool, similar to Medicare's Plan Finder, which an individual, with the assistance of the enrollment counselor or advocate, could use to input his or her doctors, services and prescriptions and determine which, if any, FIDA Plan best suits his or her particular needs.

Thank you again for your continued engagement with consumer stakeholders on FIDA implementation and for the opportunity to provide these comments for your consideration. We would be more than willing to discuss our comments with you further as MMCO and the State continue to develop the contract. Should you have any questions regarding these comments, you pay contact Krystal Knight at kknight@medicarerights.org.

Sincerely,

The Coalition to Protect the Rights of New York's Dually Eligible.