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

May 19, 2013

Mr. Mark Kissinger
New York State Department of Health
Empire State Plaza, Corning Tower, 14th Floor
Albany, New York 12237

Re: New York's proposed addendum to the demonstration for dually eligible beneficiaries

Dear Mr. Kissinger,

We write regarding the Department of Health's (DOH) April 18, 2013 addendum to the demonstration proposal to integrated care for New York's dually eligible beneficiaries. We are encouraged to see a revised implementation timeline for the fully integrated dual advantage (FIDA) program that provides beneficiaries with a longer voluntary enrollment period, although we continue to oppose passive enrollment generally. Regarding the proposed expansion of the FIDA program to include dually eligible beneficiaries who require facility-based long term care, we appreciate that adding this population to the demonstration is an opportunity to build in measures to further incentivize community-based care. However, the expansion must include safeguards that ensure that beneficiaries in nursing homes do not experience disruptions in service that would threaten their health and safety and that enrollees facing transitions into nursing homes have meaningful choices among providers.

The extension of the voluntary enrollment period in FIDA

We applaud New York's decision to extend the voluntary enrollment period for FIDA eligible beneficiaries to six months—the longest voluntary enrollment period of any state pursing a demonstration for dually eligible beneficiaries.[1] We continue to believe the demonstrations should not utilize passive enrollment, particularly in the early years of the demonstration when FIDA plans are building capacity and expertise, and thus urge a voluntary enrollment period of at least one year. In no event should any beneficiaries be auto-enrolled into plans before the state has developed *and* implemented a robust plan readiness review. Potential enrollees in FIDA are among the most vulnerable of all Medicaid or Medicare recipients. Many will have very little ability to navigate a capitated environment or advocate on their own behalf. Before any beneficiary is enrolled into a FIDA plan the State must ensure FIDA plans have met the standards of the readiness review.

Additionally, beneficiaries should be passively enrolled into the FIDA plan that offers them the greatest continuity of care, taking into account all of the potential enrollees' care needs. As we noted in earlier

[1] FIDA enrollment for beneficiaries with 120 days or more of community-based long term care begins in January 2014 and beneficiaries are passively enrolled beginning in July 2014. FIDA enrollment for beneficiaries that require facility-based long term care begins July 2014 and beneficiaries are passively enrolled beginning in January 2015.

comments, we do not believe that beneficiaries should be automatically enrolled into the FIDA plan offered by their current managed long term care (MLTC) plan.[2] Instead, DOH should develop an intelligent assignment system which pays ample attention to allowing beneficiaries to keep a majority of their current providers, and takes into consideration their health care and medication needs. To do otherwise places vulnerable individuals at risk of an interruption in care, which could compromise their wellness.

The inclusion of beneficiaries receiving facility-based long term care in the FIDA demonstration

If beneficiaries in nursing facilities are included in the FIDA demonstration, DOH will need to take a number of additional steps to ensure that facility residents have meaningful choices, including the choice to receive care in the community whenever possible. DOH will need to build incentives for community based care as opposed to institutional care into the rates, and guard against providers steering beneficiaries into preferred health plans, as well as inappropriately restricting provider choice through limited networks.

Provider Steering. We applaud DOH for requiring FIDA plans to enter into contracts or make other payment arrangements with all nursing facilities in the FIDA demonstration service area. We agree that, if nursing facility residents are moved into FIDA plans, this requirement will decrease disruption in service, and help more beneficiaries remain in their current nursing facility. However, in the absence of a requirement for nursing facilities to contract with every FIDA plan there is a risk that the nursing facilities may steer beneficiaries to preferred health plans and create a de facto network that results in limited choice for beneficiaries. DOH must guard against incentives which could lead to inappropriate marketing, abuses of payment arrangements, and inadequate nursing facility networks.

An incentive exists for nursing facilities to leverage their members to obtain better rates. For example, by contracting with only one or two plans and creating payment arrangements with others, nursing facilities have a bargaining chip to negotiate higher rates with the one or two plans with which they contract. A related concern is that nursing facilities will actively encourage residents to join FIDA plans that make higher payments to the facility. Although much of this activity is prohibited under Medicare and Medicaid marketing guidance, oversight from DOH will be required to ensure that beneficiaries are not being steered by nursing facilities, and are making informed and voluntary enrollment choices.

Plan networks. Allowing for payment arrangements between nursing facilities and all FIDA plans will help current residents remain in their facility even if the facility does not formally contract with the FIDA plan. Too much flexibility in this regard may have unwanted consequences, however, since FIDA plans may have inadequate nursing facility networks if facilities contract with only a few FIDA plans and otherwise have case-by-case payment arrangements. Beneficiaries must have a choice between a number of high quality options that will meet their needs when faced with a transition into a nursing facility. To address this concern, DOH could require plans to formally contract with a certain number of facilities in the service area that have a four or five star quality rating on Medicare's Nursing Home Compare tool.

[2] CPRNYDE Steering Committee comments on New York's demonstration to integrated care for dually eligible beneficiaries, June 2012, available at: http://www.medicarerights.org/pdf/CMS-Comments-NYSDOH-Demonstration-Duals-Care-Integration-June-2012.pdf.

We are concerned that, without adequate nursing facility networks, dually eligible beneficiaries—particularly those with the need for the most specialized services—may have to disenroll into the fee-for-service program to find a facility that meets their needs. Although the fee-for-service program may be the best option for some beneficiaries, the beneficiary should make that choice, not be forced into a choice due to a lack of adequate in network facilities in FIDA plans. Moreover, this type of forced choice shifts the cost of providing nursing facility care from the FIDA plan to the State.

Incentivizing Community-Based Care. DOH should establish a tiered rate structure with a rate cell specifically dedicated to the small group of highest-need individuals. This tiered rate structure should financially incentivize community-based care over facility-based care. We encourage New York to look to Illinois; the Illinois memorandum of understanding (MOU) creates a four tiered rate structure for beneficiaries in nursing facilities, beneficiaries in qualifying home and community based services (HCBS) waiver programs, beneficiaries moving from a nursing facility to an HCBS waiver program, and beneficiaries in the community (who are not in an HCBS waiver program).[3] The MOU notes that this rate structure was designed to "align the payment with risk while incentivizing movement from the nursing facility to home and community based care. The method to accomplish this includes both incentives and penalties." [4] DOH should develop a similar rate structure in conjunction with stakeholders through the existing financing workgroup.

In the alternative, DOH could consider the establishment of stop-loss payments for community-based care for high-need individuals, as opposed to stop loss payments for nursing facility care. In the context of MLTC and FIDA, it is important to incentivize home and community-based services by establishing stop-loss payments in order to prevent even short-term stays in nursing facilities. This would serve to prevent FIDA beneficiaries from being permanently institutionalized as a result of a short-term stays that could cause them to lose their homes. It would also prevent short term stays from becoming long term placements simply as a result of mental and physical deconditioning due to beneficiaries being taken out of their known environment.

FIDA plan contracts should include performance measures that incentivize community-based care and ensure timely provision of appropriate and needed services. Performance measures should have a targeted value. For example, nursing facility utilization should be benchmarked against industry accepted standards—not simply reported. Data should be reported and then publicly reported by DOH in a standard manner that provides for an easy comparison across FIDA plans. In addition, there must be sanctions for FIDA plans that fall below benchmarked standards as well as requirements for corrective actions. Finally, FIDA plan contracts should include the performance measures that capture: nursing facility diversion and transitions, community-first default, consumer directed personal assistance, quality of care and quality of life measures, assistive technology devices and services, expeditious actions for enrollment, access, and initiation of services.[5]

The concerns and recommendations we articulated in earlier comments related to enrollment, independent counseling and assistance, continuity of care, and incentivizing community-based care apply to beneficiaries in nursing facilities. Beneficiaries in FIDA plans need culturally and linguistically

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[3] MOU between the State of Illinois and the Centers for Medicare & Medicaid Services (CMS), available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/ILMOU.pdf.

[4] *Id.* at 43.

[5] *Incentives for Community-Based Services and Supports in Medicaid Managed Long Term Care: Consumer Advocates Recommendations for New York*, March 2012, available at: http://wnylc.com/health/download/304/.

appropriate notices, access to independent enrollment counseling, and continued access to their existing providers regardless of the setting in which they are receiving care . We refer DOH and the Medicare-Medicaid Coordination Office (MMCO) to our earlier comments for more specific recommendations on these critical elements of the demonstration.[6]

If you have any questions or wish to discuss these comments in more detail, please do not hesitate to reach out to Doug Goggin-Callahan by phone 212.204.6275 or by email dgoggin-callahan@medicarerights.org.

Center for Independence of the Disabled, New York
BWICA Educational Fund
Community Service Society
Directions in Independent Living
Empire Justice Center
Legal Aid Society
Long Term Care Community Coalition
Medicare Rights Center
New York Association on Independent Living
New York Legal Assistance Group
Southern Tier Independence Center
Statewide Senior Action Council

Cc: Melissa Seeley, Medicare-Medicaid Coordination Office

[6] CPRNYDE Steering Committee comments on New York's demonstration to integrated care for dually eligible beneficiaries, June 2012, available at: http://www.medicarerights.org/pdf/CMS-Comments-NYSDOH-Demonstration-Duals-Care-Integration-June-2012.pdf.