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

September 23, 2013

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

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

Dear Mr. Kissinger and Ms. Seeley,

As New York moves forward with the implementation of the Fully Integrated Duals Advantage (FIDA) program, we look forward to continued consumer stakeholder engagement, and we request that the Coalition to Protect the Rights of New York's Dually Eligible (CPRNYDE) be involved in ongoing implementation discussions in real time, including the negotiation of the Contract between the State, CMS and the FIDA plans, making it a four-way contract (the "Contract"). The organizations that make up CPRNYDE have extensive experience in managed care implementation, particularly as it relates to Managed Long-Term Care (MLTC), and the coalition has worked closely with the State on MLTC implementation. As such, it is imperative that CPRNYDE be an equal partner in the Contract negotiations going forward. While the FIDA MOU reflects many lessons learned in MLTC, we are concerned that issues left unresolved in MLTC will be replicated in FIDA. To that end, we have assembled the following comments that address our specific concerns with the FIDA MOU and opportunities for improvement in the Contract and subsequent development of guidance and other regulations. These comments are not the extent of our input, but rather an indication of where our priorities lie as FIDA implementation moves forward.

Also, please refer to our comments on New York's draft plan readiness review tool, which we have previously shared with both of you; many of our MOU comments that appear in this letter are pulled from the extensive comments we provided on the draft tool. We anticipate these concerns will be addressed to some extent in the Contract, which is why we are requesting a seat at the table for these negotiations. Our comments on the MOU, as well as our previous comments on the draft plan readiness review, demonstrate the reason why we should be engaged in these discussions—our comments are comprehensive and constructive and prove that just like the State and CMS, consumer advocates are committed to a FIDA program that coordinates high-quality care for dual eligible beneficiaries.

Integrated Part D 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. At a minimum, CMS and the State should collapse the multiple levels of the Part D plan appeals process and ensure 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 and Passive Enrollment)

Transition Periods:

The care continuity provisions outlined in the MOU are very strong for Participants who live in nursing homes, and we agree that plans should be required to allow Participants to maintain their current providers for the duration of FIDA. However, as compared to other states, 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] We recommend that in the Contract, New York adopts at least the 180-day transition period used in other states, 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.

Care Coordination

We are pleased the MOU outlines that plans must support an Interdisciplinary Team (IDT) for each Participant. 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-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 plans to 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.

We are also concerned that a care manager leads the IDT, and can recommend that other providers are added to the IDT, but 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. Specific qualifications of the care manager, including licensure and credentialing requirements and necessary training, should be outlined in the Contract.

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. The Contract should allow the Ombudsman to routinely receive and have access to data that the plans report to the State or CMS, and the Ombudsman must have authority to ask questions of the plans about participants regardless of whether a particular participant has provided authorization, and about procedures, systems, and data. This is necessary for the Ombudsman to investigate systemic issues and not only troubleshoot individual cases. As this entity will be made available to all FIDA Participants, we expect the opportunity to develop the requirements for the Participant Ombudsman with the State, CMS and the FIDA plans in real time.

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 could require additional financial incentives to avoid placement in an institution and taking the necessary steps to create a high-risk pool for those recipients who require split-shift or 24/7 community-based care. The MOU establishes that capitation rates will utilize the capitated rates from MLTC as the benchmark for the Medicaid component of the rate. It is unclear as to whether the new pools will be in place in time for inclusion in the FIDA benchmark capitation. If the envisioned pools are to be successful, the transition must occur in a manner that allows them to also be incorporated into the FIDA program.

Cultural Competency and ADA Compliance

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, but the MOU stops short of requiring providers to actually be accommodating. In the Contract, we'd like to work with the State, CMS and the FIDA plans to develop more concrete ADA compliance standards. Additionally, we recommend that the State should conduct evaluations of FIDA plans' ADA compliance, including auditing provider listings.

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.[1]

[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

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. Finally, the Contract should require plans to update online provider directories and search functionality on a monthly 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.

Sincerely,

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

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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's Dually Eligible, April 2013)*, posted at http://www.wnylc.com/health/download/401/

[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*.