June 28, 2012

VIA ELECTRONIC MAIL

Ms. Melanie Bella, Director
Medicare-Medicaid Coordination Office
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW
Mail Stop: Room 315-H
Washington, DC 20201

Re: New York Demonstration Proposal to Integrate Care for Dual Eligible Individuals

Dear Ms. Bella:

Thank you for the opportunity to submit comments on New York's recently submitted Demonstration to Integrate Care for Dual Eligible Individuals.

Community Catalyst is a Boston-based national advocacy organization that has been giving consumers a voice in health care reform since 1997. We provide leadership and support to state and local consumer organizations, policymakers and foundations that are working to guarantee access to high quality, affordable health care for everyone. We focus our efforts on helping the most vulnerable consumers, including those that have low incomes, come from communities of color, and/or have difficulty speaking or understanding English.

As we have noted in previous comments, we believe CMS's duals demonstration projects offer unprecedented opportunities to address the numerous and complex problems faced by dual eligibles, and to reduce the costs associated with the medical and long-term supports and services they require. However, we believe they also present real and significant risks.

These new projects will represent a sea change in the way we deliver and pay for care for this vulnerable population, and require careful attention to ensure they meet the needs of the population they aim to serve, especially those of the most medically complex dual eligibles. Our consumer advocate-oriented priorities for the duals demonstration projects *(Dual Eligible Demonstration Projects: Top Ten Priorities for Consumer Advocates)* guided our review of the New York proposal and we hope they will also inform your office's review.

New York's proposal meets many aspects of those priorities, and the state has made significant improvements in response to consumer stakeholder comments. Yet, there remain critical details missing as well as those that ought to be changed in order to meet the needs of

people who are dually eligible. We recommend that CMS require the state to fill in these missing details and make these changes before the demonstration project can move forward. Our comments on the specifics of the proposal follow.

Praiseworthy Design Elements

There is much about the New York demonstration proposal to be commended. We applaud the state's initiative in testing two models, the capitated Fully Integrated Duals Advantage Plans (FIDA), and the managed fee-for-service Health Homes. We believe the following design elements will preserve and enhance the well-being of people enrolled in these programs:

- Requirements for FIDA plans to **establish Participant Advisory Committees** comprised of beneficiaries and family members, and to hold separate public feedback sessions
- Establishment of an **independent consumer ombudsman**
- **Robust person-centered care coordination** in both programs, including consumer choice of a care coordinator in the FIDA plans
- **Broad expansion of covered services** within the FIDA plans, including peer support and recovery services
- Commitment to include a **unified grievance and appeals process using the "best elements" of Medicaid and Medicare**
- Requirements for the program, plans and providers to be **culturally and linguistically competent**

Design Elements of Concern

Despite these commendable design elements, we have many issues of serious concern that we believe must be addressed before the New York demonstration project can permitted to move forward. Below is a quick summary of these concerns, which are discussed at length in our full comments:

- **Passive enrollment** in both programs, and limited options to change FIDA plans
- **Piggy-backing the capitated plans on another major change that is just unfolding –** mandatory managed care for long-term services and supports (LTSS)
- **Inadequate requirements for a provider network** capable of serving the complex needs of dually eligible people
- No requirement for full compliance with the **Americans with Disabilities Act**
- **Insufficient discussion of FIDA financing,** including measures that will discourage the rationing of care
- **Absence of savings estimates with underlying evidence**
- Proposed **quality of care measures that do not focus enough on the population** that will be served

Enrollment

Under the current proposal, New York would begin passively enrolling dually eligible beneficiaries into the FFS Health Homes in January 2013 and the FIDA plans beginning in January 2014. We appreciate the desire to reach a level of enrollment that would allow the programs to achieve scale and facilitate a strong evaluation. However, we strongly recommend that the project employ a voluntary opt-in enrollment process in order to safeguard beneficiaries and ensure full and willing participation by those beneficiaries. The state – on its own and through respected community-based providers – can assist with this process. This is particularly important in the capitated FIDA plans, which include defined provider networks, and which will be enrolling people who were only 12-18 months earlier mandatorily enrolled in managed long-term-services plans. Voluntary opt-in would allow FIDA plans to get networks and procedures in place and then to attract enrollees by publicizing the strengths of those plans.

In the event that the state pursues passive enrollment as outlined in its proposal, there are a number of outstanding issues that must be addressed before CMS allows the project to proceed.

We applaud the state's proposal to launch an outreach and education campaign about the FIDA model in July 2013. However, the proposal does not adequately spell out how the state's enrollment broker will work with individuals to help them select FIDA plans. We recommend the state provide beneficiaries with at least 90 days to make a choice of FIDA plans after they receive specific information about the plans. During these 90 days, we believe the state's enrollment broker should be required to provide extensive choice counseling focused on the factors that the state already identifies as critical: "continued access to providers and services of choice," as well as available qualify data and personal preferences.

We also recommend that this education and counseling be supplemented by assistance from community-based organizations that know the duals populations, such as Community Health Advocates, local Area Agencies on Aging, independent living centers and recovery centers. The state should contract with these organizations as "navigators" to educate potential enrollees about their options and to assist them in selecting a FIDA plan or health home that best serves their individual needs. By using these trusted organizations, the state will help to ensure that consumers make informed choices. Ultimately, we believe this process will increase the number of New York dual eligibles who enroll and, significantly, *remain* in duals demonstration plans.

When beneficiaries do not choose a plan, and the state moves to assign them, we caution against assuming that a FIDA plan that includes the beneficiary's managed LTSS providers is necessarily the best choice. While LTSS are a critical part of the care needs of many duals, medical and prescription drug needs must also be considered.

Finally, we recommend eliminating restrictions on when enrollees can change plans or re-enroll. New York proposes to allow people in FIDA plans to opt out of the program or a specific plan at the end of any month, but would restrict when they may rejoin the program to January 1 and July 1 annually. These restrictions violate the principle of choice: that dually eligible beneficiaries must have the freedom to choose to participate or not and to decide the plan and provider that best meets their needs.

If the state moves ahead with passive enrollment in the Health Homes model, we appreciate their interest in assigning people based on analysis of providers they currently see and locations close to their homes. We think this methodology would work best if coupled with consumer assistance services that make beneficiaries fully aware of their ability to opt out of the health homes or to choose another health home.

Provider networks

We are pleased that New York proposed to require FIDA plans to create provider networks that "meet the broadest of existing applicable Medicare and Medicaid requirements," and that the state plans to impose standards on time, travel and wait times. We also appreciate that the proposal would follow state law that requires coverage of existing providers not in the network for at least a 60-day transition. But we encourage the state to extend that transition period as long as needed by beneficiaries.

We find other proposed measures inadequate, including requiring a choice of only two providers for every service. For services in demand, two providers will be far from enough to serve potentially tens of thousands of beneficiaries.

We believe the following additional steps are required to ensure provider networks include a sufficient number of providers with experience working with the relevant enrollees:

- Maintaining open networks and a commitment to add providers used by new plan members
- Allowing single-case agreements to protect longstanding, beneficial provider relationships and not limiting these to cases in which the network doesn't provide the needed service
- Requiring that all providers be trained on independent living and mental health/substance use disorder recovery approaches.

Within the health homes models, beneficiaries will be able to choose any provider, but the state must ensure that beneficiaries are aware of those choices, and that the health homes themselves have adequate and appropriately trained staff to coordinate the care of their new members.

Long-Term Supports and Services

New York's FIDA proposal is built on its planned move to mandatory managed long-term services and supports, starting next week, for duals needing community-based long-term

services and supports for more than 120 days. These same duals will then be moved into FIDA plans, some of which may grow out of existing LTSS plans. This creates opportunities for integrated plans that truly know how to deliver LTSS well, but it also requires a significant amount of change for tens of thousands of people in a short period of time. In addition, it does not allow much time to resolve any problems in the mandatory managed LTSS system. The health homes demonstration will refer people needing LTSS to the managed LTSS plans as well.

The duals proposal includes little other information about how LTSS will be provided, noting that protocols will follow from the managed LTSS program. We recommend that the state explain how LTSS will be provided in the FIDA program and also that CMS and the state agree to improve the provision of LTSS services for duals as lessons are learned from the LTSS program.

Finally, we commend the inclusion in the proposal of paid family caregiving, as required by New York law, and coverage of personal care assistants, with and without consumer-direction. We urge CMS to require conflict-free long-term care assessments in both the FIDA and Health Homes programs using the Uniform Assessment Tool that the state is finalizing. That tool is designed to examine not only health status but also functional status, mental health, strengths, care needs, and preferences.

Coordination

The New York proposal is commendable for its emphasis on care coordination, interdisciplinary care teams and individualized care plans in both the FIDA and Health Homes models, all with the beneficiary at the center. We appreciate that FIDA plans will be required to provide a choice of care coordinators, but the plan is missing details of what that choice would consist of, and what information beneficiaries would receive to help them with that choice. We also commend the state's requirement that members of each interdisciplinary team must be approved by the beneficiary. For the separate FIDA plans serving people with developmental disabilities, all care coordinators are required to be trained in DD issues. Similarly, for the Health Homes, care managers must have expertise in working with duals, and the proposal states that beneficiaries will play a "central and active role in development and execution of the care plan." These are all excellent provisions. We recommend that the beneficiaries in the Health Homes program also be given a choice of care coordinators.

To strengthen the coordination of LTSS for those beneficiaries that require it, we recommend that the state include an independent LTSS coordinator as part of the care teams, subject to approval by the beneficiary. This will help ensure that the full range of LTSS needs are addressed.

Benefits

We applaud the state for expanding the array of benefits available to FIDA enrollees. Particularly noteworthy are the inclusion of family-based treatment, home visits, independent living skills and training, peer monitoring and personalized recovery services, a full range of

other substance use disorder treatments, moving assistance, non-urgent medical transportation, and "other services" to meet patient needs and preferences. In addition, the care team is responsible for arranging all services in the care plan, whether or not they are covered.

In the Health Homes model, beneficiaries would be eligible for all Medicare and Medicaid fee-for-service care, including peer supports and recovery services, which are critical for this population. In addition, the care manager and care team would be responsible for referring beneficiaries to LTSS services. This will likely enable beneficiaries to have easier access to many important services. We recommend that CMS help the state move forward quickly with its deliberations about adopting the GRACE Team Care model in the Health Homes program. We think the GRACE model would be a helpful addition to the program.

Consumer Engagement

We believe New York has met CMS' requirements for consumer engagement in the planning to date, with hearings, calls and webinars that were well-attended by consumer advocates. However, we are disappointed that New York was able to engage only a few actual beneficiaries. We encourage the state to redouble its efforts to reach out to beneficiaries, and below, we suggest local feedback meetings as one possible strategy.

Going forward, we applaud the state's decision to establish an implementation task force for the FIDA plans with workgroups that will include consumer representatives. We urge CMS to encourage the state to expand those workgroups to cover additional issues, such as enrollment, and to extend them until at least January 2014. In addition, we urge you to require the state to establish similar opportunities for consumer engagement in planning for the Health Homes model, including inviting advocates to participate in the weekly Health Homes implementation team meetings.

We especially commend the decision to establish a participant ombudsman to serve FIDA participants, and urge CMS to provide funding for this function. We recommend that the state expand the ombudsman's role to include Health Homes participants. We also recommend that the office's function include analyzing issues and complaints for patterns that could be addressed through policy change, and reporting these to a designated state official and to the public.

We commend the state for requiring each FIDA plan to have a Participant Advisory Committee open to all beneficiaries, family members and the ombudsman that will review information on quality, enrollment, disenrollment, and grievances and provide an opportunity for feedback to the state. We recommend providing the committees with adequate staffing and other supports, and requiring them to report after each quarterly meeting to the state, the ombudsman, and the public, summaries of concerns raised and discussed.

In addition to requiring each FIDA plan to hold two participant feedback sessions annually, we urge the state to hold neighborhood beneficiary feedback meetings for the FIDA plans and for the Health Homes, conducted in languages spoken by the beneficiaries in that

locality. We are pleased that the state will require plans to help participants with transportation and the costs of attending these meetings. We also commend the state for requiring that plans summarize each session and make the summary public.

Beneficiary Protections

We applaud the state's commitment to a unified grievance and appeals system, drawing on the best of Medicaid and Medicare, and being developed with help from a stakeholder workgroup. We ask CMS to carefully monitor the final form of this appeals system to ensure it is easy for beneficiaries to access and navigate.

We recommend that the state expand the options for choice of providers in the FIDA program, as noted above. We are also concerned about the possible number of FIDA plans and how information about those plans will be provided to beneficiaries. We recommend that information be presented in a uniform and accessible manner, containing information on plan networks and performance.

We commend the state for its commitment to easy-to-read materials for beneficiaries, and to presenting materials in the six most-common languages spoken by beneficiaries, as well as in formats accessible to people with disabilities. We also commend the state for requiring all care sites to be accessible, and urge the state to set up mechanisms to enforce this provision. We also commend the state for requiring the DD FIDA plans to meet requirements of the *Olmstead* decision of the Supreme Court.

But we feel strongly that the state must require all FIDA and Health Homes demonstrations to comply with all state and federal non-discrimination laws, including the Americans with Disabilities Act and the *Olmstead* decision. As part of this requirement, the demonstrations must have a plan for accommodating people with cognitive and psychiatric disabilities.

We note that the state has not spelled out what will constitute "necessary services," which leaves beneficiaries in doubt as to what will be covered. We urge the state to include stakeholders in the development of this definition.

Financing and Payment

The New York proposal offers few details about how the state will determine the capitated per-member-per-month payments (PMPM) that will be made to FIDA plans, stating only that it "anticipates" using rate cells and risk adjustment and may also use risk corridors.

Getting the financing and payment right is critical to assuring FIDA plans have the necessary resources to provide the medical care and the LTSS needed by their members, especially those with complex needs. Without paying close attention to these issues, FIDA plans are likely to receive either windfall profits or devastating losses, results that would undermine the goals of the demonstration program. To avoid these results, New York should:

- Make financing and payment structures transparent

- Ensure that payments do not give providers an incentive for denying or minimizing services and care needed by beneficiaries
- Use payments to incentivize care provided in community-based settings rather than institutional settings. This is particularly important in the FIDA plans, which will not include people currently in nursing homes, an exclusion that could create an incentive for the plans to disenroll people with significant LTSS needs.
- Use a risk adjustment system that includes validated measures of functional status, diagnosis and other relevant socioeconomic and cultural factors such as race, ethnicity, language and gender as well as other social determinants of health such as access to housing, transportation and education

Each of these steps is critical. In addition, we recommend that CMS and the state use risk sharing mechanisms, particularly in the first one to three years of the demonstration project. While progress is being made in developing risk adjustment methodologies that adequately account for the complex needs of individual beneficiaries, they are still at a nascent stage. This elevates the importance of using strategies such as risk-sharing. While we recognize that Medicare has not traditionally used risk-sharing mechanisms, there is precedent in other states for sharing, at the end of each contact year, percentages of gains or losses. For instance, we understand this has been a successful approach for the Massachusetts Senior Care Options program and urge CMS to adopt this structure for this demonstration program.

Finally, we believe that the state should set a minimum medical loss ratio requirement for FIDA plans that is at least equal to the benchmark set for large-group insurance companies by the Affordable Care Act. By limiting administrative expenses to a maximum of 15 percent, the state can assure that as much of the capitated payment as possible will be dedicated to serving members' medical and LTSS needs. This benchmark makes sense particularly in light of the lighter administrative burden placed on FIDA plans under a passive enrollment scenario.

For the Health Homes part of the duals demonstration, the state plans to use a PMPM case management fee based on region and case mix and eventually on functional status, with rates published on the Department of Health's website. CMS has already approved this methodology for the Health Home State Plan that the duals demonstration is building on. We urge CMS to monitor the results of this methodology, and make any modifications necessary to accommodate the specific challenges of the duals beneficiaries.

Savings estimates

We note the absence of any savings estimates in the New York proposal. The state says only that it expects improved quality of life and "reduced acute care encounters" that "will result in savings that should, over time, equal or exceed the expenditures made on providing the care coordination and enhanced array of services."

We expect that the state would be able to provide an estimate of those savings, along with its underlying financial assumptions, prior to CMS approving the project. For example, the public should understand what the state knows about current rates of preventable

hospitalizations, institutionalizations, and emergency room visits and how much the state believes it will need to invest upfront in increased primary care and community-based LTSS in order to meet quality metrics and also to achieve the long-term projected savings.

Quality assessment

Comprehensively assessing the quality of care provided under the duals demonstrations and the outcomes achieved for beneficiaries will be essential to evaluating how successful it has been in improving the lives of the people it seeks to serve. We commend New York for its plans to develop FIDA quality measures well before the demonstration begins, and to engage stakeholders in shaping the measures. The state's initial list of possible "improvement targets" commendably does include patient quality of life, increases in self-directed care, decreases in Medicare skilled nursing home days, and integration of patient feedback on preferences and experiences, but we are concerned that it focuses mostly on medical treatments and outcomes, including many that are not specific to people with mental or physical disabilities.

Among the measures we recommend are those that evaluate data on beneficiaries' experience, including their:

- level of confidence in taking care of themselves, managing problems and getting better health care
- level of involvement in their community
- ability to maintain meaningful relationships
- ability to choose among LTSS options (including home care services, personal care attendants and peer supports)

For the Health Homes model, the proposed benchmarks focus entirely on medical measures, including avoidable hospitalizations and emergency room use, as well as improved outcomes for people with mental health and substance use disorders. While these specific measures are important, and the state also plans to develop a measure on "patient experience," we urge the state to incorporate the above bulleted items in the Health Homes evaluation.

Data gathered on the quality metrics should be analyzed by race, ethnicity, gender, primary language and disability, and shared with the public.

Finally, for the FIDA plans, the state says it will "develop financial performance-based incentives to reward improvements in quality of care," following a year of "collecting and evaluating performance, establishing benchmarks, and developing performance measures." We appreciate the inclusion of these incentives. However, we also encourage the state to consider imposing penalties, in addition to the quality withholding required by CMS, on plans that fail to meet quality targets.

Cultural Competence

New York's proposal includes many provisions that require the programs, plans, providers and the ombudsman operate in a culturally and linguistically competent manner by meeting standards being developed by the state's Medicaid Redesign Health Disparities Workgroup. This is particularly important because of the diverse racial and ethnic breakdown of duals in the Greater New York City area where the FIDA plans will operate.

In particular, we applaud the requirement to make oral interpretation services for the programs available free of charge, and to make all written information available in at least the six most prominent non-English languages. We encourage the state to monitor the need for translation of materials into additional languages.

We also commend the specific requirements for the enrollment broker, who must hire staff to provide translation or interpretation and pay for translator or interpreter help. The ombudsman will likewise "be required to outreach to participants in and provide their assistance in prevalent languages or with the assistance of translation services."

We urge CMS to review the cultural competency requirements as they are developed to ensure they are comprehensive enough to meet the needs of the dually eligible population. We also recommend that the state work to ensure that the definition of cultural competence includes people with mental and physical disabilities.

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In summary, Community Catalyst commends the state of New York for placing such a high priority on improving the lives of dually eligible beneficiaries in the state. While it is evident that the state has taken to heart some of the recommendations from consumer advocates, beneficiaries and community-based service organizations, there is much left to be done before this proposal can be approved.

We urge the state to continue working closely with stakeholders – particularly beneficiaries and their advocates – to address the key issues identified above.

Again, we appreciate the opportunity to provide these comments and would be happy to talk with you further as your office continues its review.

Sincerely,

Alice Dembner
Project Director
Community Catalyst