On Wednesday, September 28, 2011, the Medicaid Redesign Team ("MRT") held its fourth meeting of the Managed Long Term Care Implementation and Waiver Redesign Work Group ("MLTC" Work Group) at the NYS DOH-Metropolitan Regional Office in New York City. A copy of the meeting's agenda, as well as the materials presented, is attached.

The purpose of the meeting was to further consider the Care Coordination Model (CCM) principles intended to guide DOH in the development of the CCMs to be used in the mandatory enrollment of persons in need of community-based long term care services.

The meeting began with co-chairs Carol Raphael and Eli Feldman welcoming the work group members and reviewing the meeting agenda. Most MLTC work group members were in attendance. Mark Kissinger and Vallencia Lloyd from the Department of Health (DOH) were also present, as well as, Jim Introne from the Governor's Office.

I. Status Update – Mark Kissinger

Mark provided the below update on MLTC applications and enrollment growth:

**Managed Long Term Care Enrollment Growth - 2011**

| Plan Type | Number of Plans | January, 2011 Census | August, 2011 Census | % Change During 2011 |
|---|---|---|---|---|
| Partially Capitated | 14 | 29,043 | 33,303 | 14.7% |
| Program of All Inclusive Care for the Elderly | 7 | 3,559 | 3,733 | 4.9% |
| Medicaid Advantage Plus | 8 | 1,207 | 1,515 | 25.5% |
| Total | 23* | 33,809 | 38,551 | 14.0% |

*Some plans offer more than one product (both a partial and a MAP, for example). Therefore the number of plans offering Managed Long Term Care is less than the number of products.

**Pending MLTC Applications as of September 28, 2011**

| Type of Application/Plan | Partially Capitated | PACE | Medicaid Advantage Plus | Total |
|---|---|---|---|---|
| New MLTC Applications | 2 | 1 | | 3 |
| | | | | |
| Service Area Expansion for Operational MLTC Plan* | 11 | | 2 | 13 |
| | | | | |
| Operational MLTC Adding a Line of Business | 2 | | 1 | 3 |
| | | | | |
| Total | 15 | 1 | 3 | 19 |

II. Reports

A. Fair Hearing Work Group Minutes – Eli Feldman

III. Mr. Feldman provided an overview of the fair hearing process and noted that the subcommittee meeting was very constructive with considerable participation by members, ALJ and DOH participation. Consensus was reached by the subcommittee on the need for more ALJ training and the need for a standardized process to ensure that people's needs are met in the transition from Fee-For-Service (FFS) to managed MLTC. There was a request by ALJs for enhanced staffing and a better education on State laws, regulations and rules pertaining to managed long term care program changes. The subcommittee determined that there was a need for uniform ALJ training and a need for the fair hearing process to expedite appeals. Finally, whether there could be a role for IPRO in conjunction to ALJs with regard to MLTC plans was discussed, but no consensus was reached. Alan Morse noted that ALJs are not clinicians and therefore, it is difficult for them to make a clinical judgment without a clinical background placing them in an untenable position. Alan further stated that a judge will be more likely to listen to an impartial arbitrator such as IPRO when Plans seek to reduce costs and restrain services and enrollees seek to maximize their benefits.

B. Quality Work Group Minutes – Carol Raphael

Ms. Raphael reported that this subcommittee's focus is to recommend criteria for "quality" measures for MLTC Plans. She noted that these measures have to be "actionable" and must impact overall care. The measures must capture consumer preferences; assess quality of life in a setting where people don't reside; and recognize that work force continuity impacts quality. The committee reviewed the "SAM" assessment instrument, but Marilyn Saviola noted that this tool did not capture consumer elements.

It was reported that IPRO currently surveys member satisfaction of Plans every four years, but with services being provided through managed care, IPRO will begin doing surveys every two years. The most recent survey indicates that 91 percent of Plan members would recommend their Plan to another person and 85 percent of members view their Plan as "good or excellent". The survey indicated that Members are not satisfied with dental services.

In addition, the seven domains to quality measures embedded into the Health Home application submitted to CMS, according to Pat Roohan are the following:

- Decreases in nursing home admissions
- Decreases in urgent care visits
- Reductions in inpatient admissions
- Improvements to quality of life
- Mental health status
- Improvements in preventative care and Patient safety

- Satisfaction and Timeliness of care management

The need to have an early alert warning system for when quality is a problem was expressed. Mr. McNally of AARP suggested the Work Group review the quality measures of other states including Minnesota. Mr. Birnbaum of the United Hospital Fund (UHF) noted that in 2-3 weeks UHF will be issuing their draft report on quality measures which Mr. Introne stated he would be interested in reading.

C. Public Hearing – Mark Kissinger

Mr. Kissinger provided a brief overview of the public hearing held on September on Monday September 19th to solicit comment on the development and implementation of the proposed Managed Long term Care Coordination Model (CCM) principles. Twentyseven people gave testimony on the future of the consumer directed, Long term home health program (LTHHCP), and the Adult Day Program. Mr. Kissinger noted that the Work Group was slightly frustrated that no one had actually offered any tangible revisions to the Care Coordination Model (CCM) principles. Co-chair Eli Feldman expressed disappointment that there was no feedback to the CCM principles since that was the stated purpose of the meeting and encouraged people to submit written comments. Jo-Ann Costantino questioned whether any amendments to the CCM principles had been received from Al Cardillo of HCA as he had promised to do at the hearing. Ms. Raphael acknowledged that Mr. Cardillo had advanced to the Department amendments to the CCM principles and promised to distribute the document to the work group.

D. Review of Work Group Other Subcommittee – Carol Raphael

The subcommittee formed by members of the Program Streamlining work group and members of this work group (MLTC) focused on the overarching principle that Medicaid recipients who need long term care should share in all the eligibility and enrollment simplification, streamlining and automation, to the extent allowed by federal law that will be developed and implemented for Medicaid recipients who need health care services. The subcommittee recommended the following:

- Centralize and automate eligibility processes for Medicare Savings Programs by January 2014;
- Direct State investment in an Asset Verification System (AVS) to permit the electronic verification of assets for determining eligibility;
- Automate spend down by linking eMedNY to WMS and using provider billing to track spend down similarly to an insurance deductible.

E. Mainstream Consumer Protections – Vallencia Lloyd

Vallencia Lloyd of the DOH presented the attached powerpoint on consumer rights in managed care. Presently, 31 percent of New Yorkers are enrolled in a managed care plan. In NYS, consumers have the right to information about health plans, access to needed care, and the right to complain, grieve and appeal. Service authorizations, retrospective

reviews, action appeals, notices and fair hearings are all provided by NYS. Fair hearings are issued when a reduction, denial or termination of treatment occurs and a notice is issued in a timely manner. The DOH and SID jointly administer an independent review if an external appeal is granted which affords providers and consumers an independent review. In 2010, 1070 external appeals were filed, with 39 percent being fully or partially reversed. The DOH provides a managed care hotline to help providers and enrollees with their complaints. In 2010, 916 complaints were filed with the majority of complaints centered on billing disputes, denials of clinical treatment and access to referrals. Of these 916 complaints, 25 percent were substantiated.

The enrollment process for Medicaid managed care begins with education on Plan options and then allowing consumers the option of a Plan in the County. Maximus maintains a toll free number to assist with education and questions from consumers. The consumer has 30 days to choose a Plan. If no choice is made the employee will be autoassigned in a Plan using the current AA algorithm. The enrollee can switch Plans within the first 90 days for any reason, but is locked into a Plan for the next 9 months unless there is a good cause for switching. The recipient can choose a Primary Care Provider (PCP) from the Plan. If no PCP is chosen then one is assigned.

IV. Federal Waivers Overview – Vallencia Lloyd

Ms. Lloyd provided an overview of the State's existing 1115 waiver noting that section 1115 of the Social Security Act provides States' broad flexibility to test new ideas of policy merit. Demonstrations must be "budget neutral" over the life of the project, meaning they cannot be expected to cost the Federal government more than it would cost without the waiver. The 1115 waiver is the vehicle used by NYS to require the SSI population be enrolled in managed care and will be the vehicle used for mandatory MLTC expansion.

V. Finalize Principles – James Introne

The balance of the meeting was dedicated to a discussion of the CCM principles. The work group discussed each principle with members offering comments on each principle. Consensus was reached on a number of the principles; however, hotly debated and still unresolved are the core issues of whether the payment methods for the care coordination model would be limited to insurance models and what scope of services are subject to risk and care coordination responsibility.

Some members argued that the payment model should be limited only to insurance based capitation while others argued for the inclusion of provider based risk bearing models as provided through LTHHCP enhancement legislation. This approach, advanced by Jo-Ann Costantino and Joe Healy, would provide for risk bearing under an episodic payment where LTHHCPs would directly serve as CCMs.

Mr. Introne emphasized that the goal of the work group was to recommend policy within the framework of a fiscal imperative. Mr. Introne appeared open to provider based models, but did not indicate which type of provider based payment method or which type of provider

would be acceptable to the State.

One issue raised in the discussion centered on the ability of LTHHCPs and MLTC plans to partner through contract. Some work group members argued that current restrictions preclude contractual relationships. DOH noted that they will change any law, regulations or waiver provision necessary to implement the agreed upon CCM principles.

Other work group members argued that LTHHCPs should have the authority to function as a CCM equivalent to a MLTC. Mr. McNally of AARP questioned whether the principles, as drafted, were open to consumer options or limited to a sole program.

Scope of services was also debated with sharp contrasts by members in the necessary level of services and flexibility in CCM responsibilities. Mr. Introne stated that all long term care services must be covered.

The Co-Chairs requested that a subgroup of members revise the CCM principles. Due to the ongoing CCM revisions the work group determined there was a need for an additional meeting which is scheduled for October 27th.

It is anticipated that final CCM principles will be completed and posted by November 15, 2011 as required by the budget legislation.

Redesigning
THE MEDICAID PROGRAM

# Medicaid Redesign Team Work Group
## Managed Long Term

*90 Church Street*
*New York, New York*

*September 28, 2011*

## MEETING AGENDA

---

WELCOME
*Co-Chairs*

STATUS UPDATE
*Mark Kissinger*

REPORTS
*Fair Hearing Workgroup Minutes - Eli Feldman*
*Quality Workgroup Minutes - Carol Raphael*
*Public Hearing - Mark Kissinger*
*Review of Work Groups other Subcommittee - Carol Raphael*

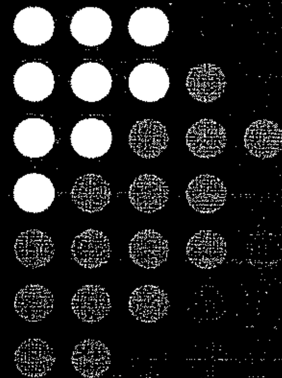
MAINSTREAM CONSUMER PROTECTIONS
*Vallencia Lloyd*

FEDERAL WAIVERS OVERVIEW
*Vallencia Lloyd*

FINALIZE PRINCIPLES
*James Introne*

DISCUSS NEXT STEPS

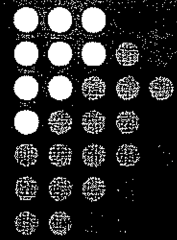
# MRT Managed Long Term Care Workgroup

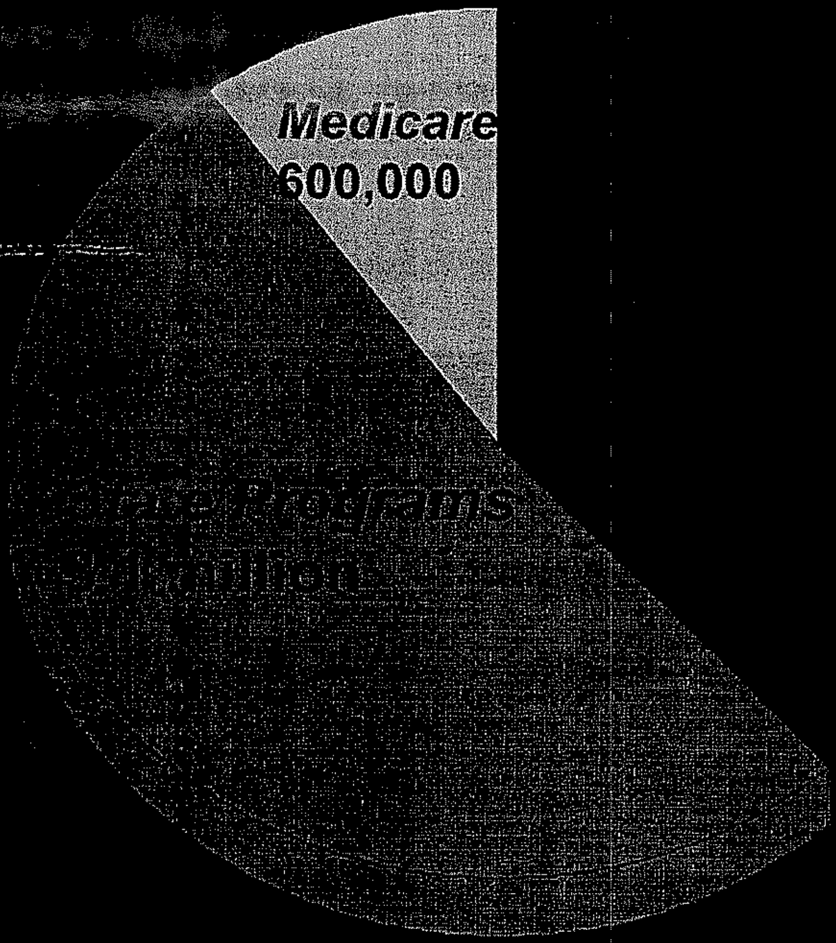


Consumer Rights in Managed Care

September 28, 2011

# Nearly 31% of New Yorkers are enrolled in a managed care plan

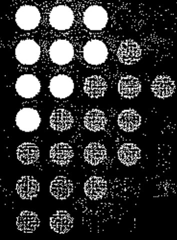





- 2.3 million commercial enrollees receive coverage through their employer or purchase it directly
- 3.1 million enrollees of state health insurance programs including Medicaid Managed Care, Family Health Plus and Child Health Plus
- 600,000 Medicare beneficiaries

# NYS Consumer Rights

## PHL §§ 4403, 4408, 4902, 4903, & 4904



- Right to information about Health Plans
  - Benefit description
  - Referral and authorization requirements
  - Provider network
- Access to Needed Care
  - Right to out of network care
  - Prudent layperson emergency care
  - Transitional care
  - Access to specialty care & specialty care centers
- Right to complain, grieve and appeal
  - Notification of denials of treatment and grievance outcomes
  - Clinical rationale for the denial
  - Appeal of denials & timeframes for responding
  - If appeal timeframes not met, the denial is reversed

# Service Authorizations

- New, review and notice in
  - Expedited, 3 bd from request
  - Standard, 3 bd from all info and no more than 14 days from request
- Concurrent, review and notice in
  - Expedited, 1 bd from all info and no more than 3 business days from request
  - Standard, 1 bd from all info and no more than 14 days from request
  - Home health care following inpatient admission on Friday or day before holiday, 72 hours after all info, no more than 3 bd of request
- All may be extended up to 14 days if:
  - plan needs more info and in member's best interest to extend
  - Enrollee or provider requests extension
- Verbal and written notice made to enrollee and provider

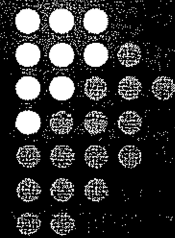
# Retrospective Review

- Review and determine 30 days after all information
- Claim denials noticed on day of denial
- Written notice to provider and enrollee
  - Notice only provider for certain administrative issues: duplicate claim, unbundling of global codes, up-coding, in excess of contracted rate, etc
- Cannot deny prior authorized service on retrospective review unless information that changes decision was not shared with MCO
- Cannot deny claim for prior authorized service unless at time of claim:
  - not eligible for coverage
  - Untimely claim submission
  - benefit exhausted
  - Confirmed fraud or abuse
  - Authorization based on inaccurate or incomplete information

# Action Appeals

- No less than 60 business days to file
- Plan determines in:
  - Expedited, 2 bd of all info and no more than 3 bd from appeal
  - Standard, no later than 30 days from appeal
- All may be extended up to 14 days if:
  - plan needs more info and in member's best interest to extend
  - Enrollee or provider requests extension
- Notice to enrollee and provider:
  - Expedited verbal notice at time of decision, written in 24 hours.
  - Standard written notice within 2 business days of decision.

# Notices



- Notice whether approved or denied
- Written adverse determination content includes
  - Reason
  - clinical rationale in terms specific enough to judge basis for appeal
  - Internal plan appeal rights and time frames
  - Fair hearing rights and form
  - External appeal rights, if applicable
  - Right to complain to DOH
  - Translations, formats for special needs, and assistance with appeal process available from plan

# Fair Hearings

Issued When:

- Reduction, Denial, or Termination of Treatment
- Notice issued by plans when action is taken
- Notices must be issued 10 days in advance of action for aid continuing.
- Denial of an exclusion/exemption

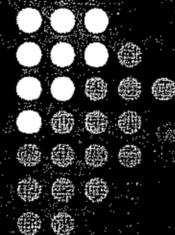
# Fair Hearings

- Enrollee will have right to aid to continue if
  - Fair hearing is filed timely
  - Involves termination, reduction, suspension of previously authorized service
  - Service ordered by provider
  - Original authorization has not expired
- If requested, services continue until
  - Enrollee withdraws fair hearing
  - Fair hearing decision
  - Original service authorization expires

42 CFR 438.420

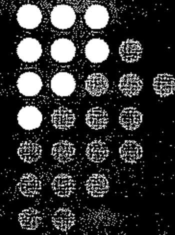
# External Appeal affords providers and consumers an independent review

**PHL Article 49 Title 2**



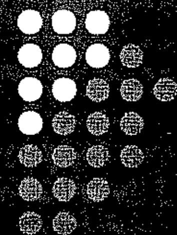
- Jointly administered by SDOH and SID
- Decisions made by independent agents
- Appeals available for denials based on:
  - Medical necessity
  - Experimental treatment for life threatening or disabling condition
  - Out-of-network service materially different from service in network
- 1070 external appeals filed in 2010
  - 413 (39%) fully or partially reversed

## DOH Managed Care Hot Line available to assist providers and enrollees



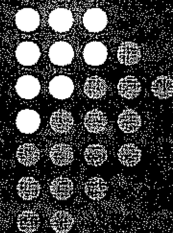
- Call 1-800-206-8125 with complaints relating to:
  - Quality of care
  - Plan operations
  - Any issue of dissatisfaction
  - Questions about Medicaid fair hearing rights
- 916 complaints filed in 2010
  - 25% substantiated
  - Major areas of complaints were:
    - Billing disputes
    - Denial of clinical treatment
    - Access to referrals

# Medicaid Managed Care Enrollment Process

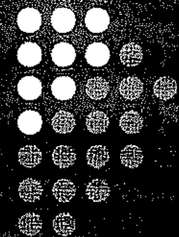


- Provides Education on plan options
  - FE's trained to educate and assist in choice
  - Maximus has toll free # to assist with education and questions
- Consumers have choice of a managed care plan operating in the county
- Consumers have the right to apply for exclusions and exemptions

# Medicaid Managed Care Enrollment Process



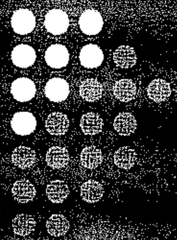
- New applications
  - Medicaid/FHPlus Application amended to strengthen choosing on application
- Choice must be made during the application process, section I
  - If eligible for exemption/exclusion, must self identify
  - If no choice is made or exemption/exclusion request, auto-assignment will occur using current AA algorithm



# Medicaid Managed Care Enrollment Process

- Newly targeted for mandatory enrollment
  - New populations being added through expansions
  - Recipients in new mandatory counties during phase-in
- Notice and materials sent to potential enrollee
  - Allows for 30 days to choose plan
    - Enrollment education packet will be sent
    - Plan choice can be by mail, phone, or in person
  - If plan not chosen, current AA algorithm followed

# Plan Enrollment



- **Guarantee**
  - Enrollee receives MCO benefit for six months from enrollment eff. date if eligibility lost
- **Lock-in**
  - First 90 days – switch plans for any reason
  - Next nine months – locked in unless good cause
- **PCP choice**
  - Recipient can choose a PCP from Plan
  - If a PCP is not chosen, one is assigned
- **Fair Hearings**
  - If exemption/exclusion denied (A/C if applicable)

## Managed Long Term Care Enrollment Growth - 2011

| Plan Type | Number of Plans | January, 2011 Census | August, 2011 Census | % Change During 2011 |
|---|---|---|---|---|
| Partially Capitated | 14 | 29,043 | 33,303 | 14.7% |
| Program of All Inclusive Care for the Elderly | 7 | 3,559 | 3,733 | 4.9% |
| Medicaid Advantage Plus | 8 | 1,207 | 1,515 | 25.5% |
| Total | 23* | 33,809 | 38,551 | 14.0% |

*Some plans offer more than one product (both a partial and a MAP, for example). Therefore the number of plans offering Managed Long Term Care is less than the number of products.

## Pending MLTC Applications as of September 28, 2011

| Type of Application/Plan | Partially Capitated | PACE | Medicaid Advantage Plus | Total |
|---|---|---|---|---|
| New MLTC Applications | 2 | 1 | | 3 |
| | | | | |
| Service Area Expansion for Operational MLTC Plan* | 11 | | 2 | 13 |
| | | | | |
| Operational MLTC Adding a Line of Business | 2 | | 1 | 3 |
| | | | | |
| Total | 15 | 1 | 3 | 19 |

*Several plans have submitted more than one application for service area expansions (different counties in each application).

## New York State's Section 1115 Waiver Demonstration Programs

Section 1115 of the Social Security Act provides the Secretary of Health and Human Services broad authority to authorize experimental, pilot, or demonstration projects likely to assist in promoting the objectives of the Medicaid statute. Flexibility under Section 1115 is sufficiently broad to allow states to test substantially new ideas of policy merit. These projects are intended to demonstrate and evaluate a policy or approach that has not been demonstrated on a widespread basis. Some states expand eligibility to individuals not otherwise eligible under the Medicaid program, provide services that are not typically covered, or use innovative service delivery systems.

There are two types of Medicaid authority that may be requested under Section 1115:

- Section 1115(a)(1) – allows the Secretary to waive provisions of section 1902 to operate demonstration programs (Statewideness, Freedom of Choice and Medicaid Eligibility and Quality Control), and
- Section 1115(a)(2) – allows the Secretary to provide Federal financial participation for costs that otherwise cannot be matched under Section 1903.

Projects are generally approved to operate for a five-year period, and states may submit renewal requests to continue the project for additional periods of time. Demonstrations must be "budget neutral" over the life of the project, meaning they cannot be expected to cost the Federal government more than it would cost without the waiver.

A. <u>The Partnership Plan</u>

The State's goal in implementing the Partnership Plan is to improve the health status of low-income New Yorkers by:

- improving access to health care for the Medicaid population;
- improving the quality of health services delivered; and
- expanding coverage to additional low income New Yorkers with resources generated through managed care efficiencies.

The Partnership Plan Section 1115 Demonstration uses a managed care delivery system to create efficiencies in the Medicaid program and enable the extension of coverage to certain individuals who would otherwise be without health insurance. The initial Partnership Plan demonstration was approved in 1997 to enroll most Safety Net and TANF Medicaid beneficiaries into managed care organizations (Medicaid managed care program), either on a mandatory or voluntary basis, and to provide 24 months of family planning services, only, to women losing Medicaid eligibility after giving birth. In 2001, accrued savings under the Partnership Plan allowed the State to implement the Family Health Plus (FHPlus) program under an amendment to the demonstration. FHPlus provides comprehensive health coverage to low-income uninsured adults, with and without children, who have income and/or assets greater than Medicaid eligibility

standards. In 2002, the demonstration was further amended to provide family planning services to certain adults of childbearing age (family planning expansion program).

Since then, mandatory enrollment has been extended to additional populations. Beginning in 2005, mandatory enrollment of SSI-eligible individuals began in New York City, and was completed statewide as of December 2008. Medicaid beneficiaries with both SSI and serious mental illness began enrolling in 2007. The SSI population was shifted to the F-SHRP waiver in 2006 (see below). Mandatory enrollment of the HIV/AIDS population was extended to beneficiaries in New York City in September 2010. Medicaid Redesign Team initiatives will eliminate most excluded and exempt populations over the next three years.

As of April 2011, 2.9 million individuals are enrolled in the Medicaid managed care program and over 400,000 are enrolled in the FHPlus program.

Budget Neutrality is a requirement of Section 1115 waivers and limits federal funding to the amount that would have occurred absent of the waiver. The analysis compares without-waiver expenditure limits to with-waiver expenditures. The without-waiver amount is an estimated amount for persons eligible for the waiver using the initial PMPMs trended forward by trends included in the terms and conditions times the eligibles. The with-waiver amount is equal to the actual expenditures for eligibles. The cost before the waiver (without-waiver) must also be greater than the with-waiver to have budget neutrality. As there is no allowance for expenditures for Safety Net or FHPlus members without children, these must be funded with the savings. All persons eligible for the waiver are included in the budget neutrality formula whether or not they are enrolled in managed care. Budget neutrality is calculated over the entire demonstration, not for each year of the demonstration. The current savings for the Partnership Plan waiver is $51B (estimated through 12/31/13, the expiration date of the proposed extension). However, this amount is overstated since CMS requires the amounts to match the CMS64 which understates the with-waiver amounts because it uses some time frames with little or no lag.

B. <u>Federal-State Health Reform Partnership (F-SHRP)</u>

The goal of F-SHRP is to promote the efficient operation of the State's health care system by: reducing excess capacity in the acute care system; shifting emphasis in long-term care from institutional-based to community-based settings; expanding the adoption of advanced health information technology, including e-prescribing, electronic medical records and regional health information organizations; and, improving ambulatory and primary care provision.

Under F-SHRP, the federal government will invest up to $1.5 billion in agreed upon reform initiatives. The federal investment in these reforms is conditioned upon the F-SHRP waiver generating federal savings sufficient to offset the federal investment and the State meeting certain performance milestones, including:

- Increasing fraud and abuse recoveries to 1.5% of the State's FFY 2005 total Medicaid expenditures by the end of the Demonstration:
- Implementing a preferred drug program for the entire Medicaid program;
- Implementing an employer-sponsored insurance program;
- Implementing a single point of entry system for long term care service assessment; and
- Implementing the Medicaid cost containment and reform initiatives.

Much of the savings associated with F-SHRP reforms will accrue over the long term. To generate short term savings to invest in health care reform initiatives, the federal government agreed to count savings generated through: decreased hospital utilization resulting from eliminating excess acute care capacity; and, expansion of mandatory Medicaid managed care enrollment to the SSI and SSI-related population statewide and to individuals in 14 upstate New York counties. The Budget Neutrality savings for the F-SHRP waiver is $18B (estimated through 3/31/14, the expiration date of the extension).

Federal funds flow to the State as federal match on expenditures for Designated State Health Programs (DSHPs), which include certain HCRA programs (e.g., Healthy New York, ADAP, Tobacco Prevention, Telemedicine demonstration, pay for performance) as well as health care programs administered by other State agencies, such as SOFA, OMH, OPWDD, OASAS and OCFS. DSHPs are not Medicaid programs and would not ordinarily qualify for federal match. The State is eligible for 50% federal match on DSHP expenditures up to $300 million per year. After incurring DSHP expenditures, the State may draw down the federal matching funds only as it is ready to expend the same amount of State funds on reform initiatives. Federal funding is limited to $300 million per year, must be used for reform expenditures in that year, and may not be rolled over into subsequent years. On March 31, 2011, the State received federal approvals for an extension of the F-SHRP waiver through 3/31/14 to permit the State to continue its health care system restructuring activities and to benefit from the temporary increase in its FMAP rate under the American Recovery and Reinvestment Act.