On October 27, 2011, the Medicaid Redesign Team's ("MRT") Managed Long Term Care Implementation and Waiver Redesign ("MLTC") work group held its third and final meeting. Work group co-chair Carol Raphael presided over the meeting and stated that the group's goal is to redesign a flagship long term care system in New York that is affordable, that represents quality, and that will pave the way for other states. She further advised the group that the goal for the day was to reach agreement on all of the recommendations that will be put forth by the group to the full Medicaid Redesign Team for consideration at its November 1 meeting. Ms. Raphael acknowledged some of the concerns that have been voiced by work group members, most notably that the recommendations did not emerge as everyone on the team would have written them. However, she said that she hopes the final recommendations represent some common ground for all members based on all of the different perspectives individuals bring to the table. She also recognized several members' concerns that the proposed draft recommendations are too general and do not offer sufficient detail. In response, she noted that many of the final outcomes based on this group's work will depend on the actual implementation process – a process that this group cannot control. Finally, she acknowledged that this group's charge is more difficult than the charge given to some other groups because the MLTC group faces very real challenges to programs that already exist rather than simply facing challenges to implementing aspirational programs. Work group members in attendance at this meeting included:

- Michael Birnbaum – Vice President, United Hospital Fund
- Courtney Burke – Commissioner, Office of People with Developmental Disabilities
- Jo-Ann A. Costantino – CEO, The Eddy
- Doug Goggin-Callahan – NYS Policy Director, Medicare Rights Center
- George Gresham – President, 1199-SEIU
- Mary Harper – Executive Deputy Commissioner, Medical Insurance & Community Services Administration, New York City Human Resources Administration
- Joseph M. Healy, Jr. PhD – CEO, Comprehensive Care Management Corp.
- Mark Lane – President & CEO, NYS Catholic Health Plan, Inc., Fidelis Care New York
- David McNally – New York Manager of Government Relations and Advocacy, AARP
- Betty Mullin-DiProsa – President & CEO, St. Ann's Community
- Carol Rodat – New York Policy Director, PHI
- M. Kate Rolf – President and CEO, VNA of Syracuse
- Marilyn Saviola – Director of Advocacy, Independence Care System
- Melanie Shaw, JD- Executive Director, New York Association on Independent Living (NYAIL)
- Kathleen Shure – Senior Vice President, Managed Care & Insurance Expansion, Greater New York Hospital Association

Eli Feldman, the MLTC work group's other co-chair, expressed the pivotal importance of this particular meeting and voiced his satisfaction at the way the group has come together to compose recommendations regarding such a difficult problem in a very short timeframe. He then laid out the structure for the day's meeting: Mark Kissinger from DOH will summarize the text of each recommendation and then the group will discuss each one in depth and analyze the significant amount of written commentary that has

been received from stakeholders. Finally, the group will take a vote on each of the three sets of recommendations as a whole (the draft CCM principles, the quality recommendations, and the fair hearing recommendations).

Draft CCM Principles

Mark Kissinger, Deputy Commissioner of the New York State Department of Health ("DOH"), provided a brief overview of the thirteen draft CCM principles. He noted that the only principle containing changes from the version released on the MRT's website was principle number two, relating to technology. The words "as feasible" were inserted so that the principle now reads: "The CCM must use Health Information Technology, as feasible, to document, execute and update the plan of care and share information among appropriate staff providers." After wrapping up this review, the group embarked on a discussion of each individual CCM principle. The principles numbered two, four, six, nine, and ten generated no comments or discussion and will be published in the group's final recommendations with no changes. The full comments of each work group member are reproduced at the end of this memorandum. In summary, the group will make the following changes to the list of CCM principles:

- ***Principle One*** – *A CCM must provide for or contract for all Medicaid long term care services in the benefit package. CCM will be at risk for the services in the benefit package and rates will be risk adjusted to reflect the population served.*
    - The group will convene a special subgroup on Friday, October 28 to amend this principle. The subgroup will add language intended to make it easier for smaller entities to meet the reserve requirements by instituting a phase-in and ramp-up provision. The subgroup will also add language that specifically delineates integrated consumer directed care models as acceptable within the CCM principles.
- ***Principle Five*** – *Care coordination is a core CCM function. For benefit package services, CCM members will have a choice of providers.*
    - The work group will attempt to sharpen the language in this principle to clearly differentiate it from the guidelines put forth in principle number eleven.
- ***Principle Eleven*** – *Mandatory enrollment into CCM's in any county will not begin until and unless there is adequate capacity and choice for consumers.*
    - Language will be added to this principle to institute a phase-in of reserve requirements in order to keep this principle in line with principle number one.
- ***Principle Twelve*** – *Members shall have continuity of care as they transition from other programs.*
    - The language of this principle will be amended to require that a notice of the right to appeal be sent to plan members when the level of service is decreased after certain medical assessments.
- ***Principle Thirteen*** – *Prospective members will receive sufficient objective information and counseling about their plan choices before enrolling.*
    - This principle will be amended to include a reference to the recommendations put forth by the MRT's Streamlining work group. This will advise plan members of the availability of an independent third party for conflict-free counseling.

CCM Principle Conclusions

After all of the principles had been debated, the group took a preliminary vote to gauge the general consensus on the current format. The members voted on the entire package rather than on each principle, and the vote yielded twelve in favor, one against, and two abstentions. It should be noted that most of the individuals who voted in favor of the principles did so with the caveat that because significant changes are still to be made to the principles, they wished to be able to withdraw or reverse their votes once a completed version of the principles is available for inspection.

Quality and Fair Hearing Principles

There was very little discussion of these principles. The group noted that its goal is to create long term care quality metrics that achieve significant improvements over time and enable consumers to compare CCM performance. The group was in agreement on the criteria that should be considered and voted unanimously to approve these principles for inclusion in the work group's final recommendations to the full MRT.

Fair Hearing Principles

There was almost no discussion of these principles at this meeting. Marilyn Saviola said that the committee had some conceptual disagreements that still need to be addressed but nonetheless, those in attendance voted unanimously in favor of approving these principles for inclusion in the work group's final recommendations.

Discussion of Draft CCM Principles

Principle Number One

A CCM must provide or contract for all Medicaid long term care services in the benefit package. CCM's will be at risk for the services in the benefit package and rates will be risk adjusted to reflect the population served.

The group spent nearly an hour and a half discussing this first proposal and work group members vehemently expressed their differing opinions. The final outcome of this discussion was that a separate sub-group would be convened on Friday, October 28 in order to amend this principle to include consumer directed care models. Comments from the members of the work group are below.

Mark Lane wished to discuss the requirement that CCM's meet "financial solvency standards." He said that this term is too vague – which standards does the group intend to hold CCM's to: DOH, DFS, or other net worth/reserve requirements? He advocated for a change to the language to clarify that the standards are to be "consistent with all other entities." **Mark Kissinger** advised the group that this particular point is still a work in progress at DOH and that guidelines should be available sometime in mid-November.

Jo-Ann Constantino next spoke about the general approach put forth in this recommendation, expressing concern that it still appeared to be a single model approach and that such an approach has the potential to negate all of the benefits existing long term care programs have come to provide. She supported the written language submitted by several associations that suggests a preamble explicitly allowing and supporting multiple models. Ms. Constantino believes that this model is far too heavily insurance based and that it will disenfranchise many entities that have the capacity and experience necessary to elevate to a new level of care delivery. **David McNally** agreed and also advocated for a preamble in the document stating that the group does not intend to identify managed care insurance models as the only option. He emphasized that it is essential to put the member into the driver's seat and to allow that person to choose from several available models and options. **Marilyn Saviola** also agreed and stated her belief that if MLTC organizations are still required to have a certain level of contingency reserves, then the playing field will never be level. She also reemphasized the importance of consumer choice.

The work group co-chairs then tried to capture the issues identified within this principle. **Carol Raphael** noted the key components discussed: 1) that CCM's should be responsible for all components of long term care services; 2) there must be a risk-based system; and 3) that payment will be risk-adjusted based on a number of variables. Raphaeil asked the group what modifications could be made to this principle that would address the work group's concerns and ensure that provider based models are allowed – but still make them provider models that cover a bundle of services and also assume risk? **Eli Feldman** stated that there are currently provider based models in the marketplace and asked the group to attempt to devise a way that providers could operate with full risk, yet maintain a reserve arrangement that is not insurance based.

Jo-Ann Constantino responded to this by stating that providers simply cannot assume full risk because there is not a large enough population base to draw from, especially outside New York City. She believes it is troublesome that the group is still addressing the issues related to financial risk and thinks that smaller organizations will be unable to meet any of the requirements put forth by the State. She also urged the group to give the language proposed by the associations genuine consideration.

Kate Rolf advised the group that she received a letter from Senator Valesky stating that the group is interpreting the legislature's intent incorrectly. Senator Valesky wrote in the letter that the Legislature's intent was to include non-insurance based models within these CCM principles.

Eli Feldman again posed the question to the group: He asked how we can devise a capitated model that properly accounts for and allocates risk. He then said that if a group takes on full capitation and full risk, then for the sake of the clients financial safety, the group needs to have an insurance net available.

Betty Mullin-DiProsa then asked why DOH and the work group are so concerned about these issues and reserve requirements. She noted that home health care agencies are currently serving over 30,000 people in New York and asked whether the

State has run into issues with these organizations becoming financially insolvent and consequently harming consumers and patients (and Mr. Kissinger responded in the negative). Finally, she said she does not understand the drive to eliminate options currently available to consumers and move to a single insurance-based model.

Valencia Lloyd (DOH) responded that DOH wishes to move away from "risk" and fee for service models and wishes to contract for an array of services instead. DOH would like the entity to be responsible for a large array of services, meaning that DOH must ensure that sufficient reserves are available to keep plans solvent. She further advised that it is not the model that is being questioned, but instead how the model operates. If there are ways to support the risk, she advised that DOH would have no problem supporting other models, but DOH has not seen that other models will be effective to date. **Mark Kissinger** also said that we need to remember that we are discussing all MLTC services – both in and outpatient.

Based on these comments, **Michael Birnbaum** said that if this is the approach DOH means to take, the group needs to work on resolving a lack of clarity in the principles' language. Specifically, he said that the language appears quite clear that we intend to exclude everyone other than insurance based models and the work group needs to resolve this to be in accord with its intent.

Kathy Shure then suggested that the group develop a reserve level that starts lower and then in some way transitions to the full amount in order to allow providers to enter the marketplace with an opportunity grow and build the necessary capital within a finite amount period of time. This would help to level the playing field for new providers as they attempt to enter the market. This idea was quite popular with other group members. **Carol Rodat** supported it, but also noted that carrying some reserve requirement is essential. She stated that she has seen workforces dramatically affected by bankruptcy and believe that we need significant oversight of payment plans and other similar arrangements. **Joseph Healy and Marilyn Saviola** also agreed and reminded the group to remain cognizant of the continuity principle they all committed to. Mr. Healy believes that the first issue the group must attack is financing – until that is solved, he said it will be very difficult to move away from the system as it exists today. **Betty Mullin-DiProsa** also agreed with these comments and suggested that the group investigate the critical mass required to sustain a company. In her estimation, knowing this would ensure effective and efficient operation of many of these programs

Mark Lane stated that there is no way to talk about risk without also addressing financial solvency. He suggested that the group insert language requiring CCM's to meet the same solvency standards applicable under risk bearing capitated models. He also noted that the letter submitted by the associations restated the group's requirement that "financial models must meet DOH requirements." Mr. Lane asked Mark Kissinger what exactly these requirements are and Mr. Kissinger responded that his depends largely upon the provider type.

The group then decided that it would amend the language to insert what Kathy Shure attempted to capture. Carol Raphael began a discussion of how the group might enable

smaller entities to enter the market while remaining on solid financial ground. She stated that New York already has a viable and effective consumer directed care program and has managed to put the necessary elements together for thousands of people. She polled the group to determine if a separate subgroup should be put together to look into how to implement a consumer directed care model. The response was favorable among the members and it was decided that a special subgroup would convene on Friday, October 28 to address this particular issue. In closing the discussion on this topic, Jo-Ann Constantino reminded the group of the concerns she noted at the outset – it is essential that there are alternative models available to consumers.

Principle Number Three

> *A CCM must be involved in care coordination of other services for which it is not at risk.*

Mark Lane asked the group what it expects a CCM to do to coordinate primary and acute care services. Carol Raphael cited reducing unnecessary admissions and enhanced emergency care as areas CCM's should target, but another issue to address is what is expected of these organizations and how it will be measured. Finally, Kathy Shure asked how CCM's will intersect with home care models.

Mark Kissinger responded to these questions, stating that DOH has not landed on exactly how to measure and monitor CCMs' services, but the issue is being looked at by DOH staff members and guidelines will be provided in the near future. The same is essentially true for interactions between CCM's and home care agencies – DOH has not arrived at a decision on how the different programs will work together, but it hopes to put forth some guidance on this issue shortly.

Principle Number Five

> *Care coordination is a core CCM function. For benefit package services, CCM members will have a choice of providers.*

Tom Holt wished to address how out of network services are to be treated under this principle. Specifically, he was concerned about coverage for out of state services, when appropriate services are not available within the network. (These comments were submitted in written form as Mr. Holt was unable to attend the meeting in person.) Valencia Lloyd answered that such services would need to be covered by the plan: if a plan has an inadequate network, it would be required to allow its members to use providers within the service area. If the service area is close to the New York border and appropriate services happen to fall outside state lines, they will need to be covered by the plan.

David McNally expressed concern about principle numbers five and eleven conflicting with each other. In his opinion, they say essentially opposite things. Valencia Lloyd again responded and said that principle number five refers to the threshold number of

providers in a CCM's network, while principle number eleven refers to the mandatory versus voluntary distinction for CCM's.

The group concluded that it would try to sharpen the language of this principle in order to emphasize the distinctions between it and principle number eleven.

Principle Number Seven

> *A CCM will provide services in the most integrated setting appropriate to the needs of qualified members with disabilities.*

Melanie Shaw expressed concern regarding how a plan will be responsible for complying with the State's position as it relates to the Supreme Court's Olmstead decision – i.e. how will the State hold plans responsible for implementing this decision in all that they do? Mark Kissinger responded that this is an implementation issue that the State has taken the responsibility for to date. DOH will provide guidance for both existing programs as well as start-up CCM's in the near future.

Principle Number Eight

> *A CCM will be evaluated to determine the extent to which it has achieved anticipated goals and outcomes and to drive quality improvement and payment.*

Work group member Tom Holt asked how character and competency will be reviewed for CCM's. Mark Kissinger answered this question by stating that it will be policed in the same fashion that it is for all other entities DOH is responsible for overseeing.

Principle Number Eleven

> *Mandatory enrollment into CCM's in any county will not begin until and unless there is adequate capacity and choice for consumers.*

Kate Rolf expressed concern for CCM's serving the Upstate New York regions, noting that these are the geographic areas where a plan for phasing in the new program and its reserve requirements will be essential. Eli Feldman responded that this is an area should be addressed by the subgroup created to revise principle number one (at the meeting to be held Friday, October 28). Joseph Healy noted that this will be an issue downstate as well: it is not feasible to think that 30,000 individuals can migrate into a new program when it becomes active on April 1, 2012.

Principle Number Twelve

> *Members shall have continuity of care as they transition from other programs.*

Doug Goggin-Callahan asked that this principle be updated to include a requirement that a notice be sent to the plan member after an assessment is conducted. He asked that this notice specifically lay out the right to appeal and the process for doing so if the level of service is reduced based on the results of the assessment (including fair hearing rights and notice requirements etc.). The group agreed with this request and will add the notice requirement along with timeframes for appeals to the principles.

Principle Number Thirteen

> *Prospective members will receive sufficient objective information and counseling about their plan choices before enrolling.*

David McNally spoke about the importance of conflict-free counseling, noting that it is a hallmark that helps put the consumer into the driver's seat. He asked that a provision be inserted advising consumers of the availability of such counseling and also asked the group how it intends to locate the funds to create a program such as this one. Carol Raphael responded to these concerns by stating that the principle will be revised to insert a reference to the MRT Streamlining work group's principles that clearly explain the counseling programs available to consumers. The issue of funding such a program was left open. This concluded the discussion of the draft CCM principles.