

On Monday, September 19, 2011, the Managed Long Term Care Implementation and Waiver Redesign Work Group ("MLTC" Work Group) held a public hearing to solicit comment on the development and implementation of the proposed managed long term care and coordinated care model (CCM) principles. A list of the individuals who provided comments is attached.

The following MLTC Work Group members were in attendance:

Carol Raphael, Co-Chair of the MLTC Work Group, and President & CEO of the Visiting Nurse Service of New York;

Eli Feldman, Co-Chair of the MLTC Work Group, and President & CEO of the Metropolitan Jewish Health System and the Chairman of the Continuing Care Leadership Coalition;

Mary Harper, the Executive Deputy Commissioner of the NYC Human Resources Administration, Medical Insurance & Community Services Administration;

Michael Birnbaum, Vice President, United Hospital Fund;

Heather Bates, filling in for Doug Goggin-Callahan, NYS Policy Director, Medicare Rights Center;

Joseph M. Healy, Jr. PhD, Chief Executive Officer, Comprehensive Care;

David McNally, New York Manager of Government Relations and Advocacy; AARP

M. Kate Rolf, President and CEO, Visiting Nurse Association of Western New York;

Melanie Shaw, the Executive Director, New York Association on Independent Living (NYAIL).

Marilyn Saviola, Director of Advocacy, Independence Care System

Also in attendance were Jim Introne from the Governor's Office and Mark Kissinger from the New York State Department of Health (DOH).

There were 27 individuals who provided comment. Unlike prior MRT public hearings, where speakers were required to limit their comments to two minutes, individuals were allotted 5 minutes to speak.

Comments were provided by a wide array of long term care plans, providers, and consumers, including representatives from the following organizations:

New York Association of Homes and Services for the Aged (NYASHA);

Adult Day Health Care Council (ADHCC);

New York State Adult Day Care Services (NYSADCS);

Various Long Term Home Health Care (LTHHC) providers and trade organizations, including representatives from the New York State Association of Health Care Providers (NYSHCP), the Home Care Association of New York State (HCA), and the Continuing Care Leadership Coalition (CCLC);

MLTC and PACE programs;

Consumer advocacy organizations, including representatives from ICS, Consumer Directed Communities, and Westchester Disabled on the Move;

Personal Care Providers (Sunnyside Community Services);
HIV/AIDS SNPs;
Health insurance information exchange organizations; and
Home care workers (one worker provided comments, accompanied by the Greater New York Hospital Association (GNYHA)).

A summary of the comments is provided below.

I. Public Comments

A prevalent theme of the day was the near-uniform insistence that the Work Group revise its draft CCM principles to make them broader, clearer, and more flexible. However, the Work Group lamented that no one had actually offered any tangible revisions as they had hoped. This came as a disappointment to many of the members since the purpose of the meeting was to obtain specific revisions to the language of the CCM principles.

Long Term Home Health Care Programs

As anticipated, many LTHHC providers and trade organizations attended the forum to plead their case for the inclusion of the LTHHC model as a CCM, and if not, to at least revise the current principles to provide the flexibility needed for existing LTHHC providers to transition to MLTC (e.g., relaxing the reserve requirements). Representatives from Jewish Home Life Care, Flushing Manor, Metropolitan Jewish Long Term Home Care, St. Nicks Alliance, and Isabella Geriatric Center all strongly advocated that the LTHHC program continue to be a viable model. In addition, they called for expanding payment options to include episodic and bundled rates, which would allow for financial risk sharing by providers.

Lisa Riccoboni, the Director of Patient Services at Flushing Manor, noted that the proposed CCM principles are a “one size fits all approach” that exclude programs with proven track records of providing quality, cost-efficient care. She mentioned that there was “no way” her organization could meet the reserves requirement under the proposed principles, and questioned why there was a need to change the care coordination model when “they’ve demonstrated the cost effectiveness of [LTHHC] over the last 30 years?” Similar statements were made by Laura Redemski for Jewish Home Life Care and Michael Rochford, the Executive Director of St. Nicks Alliance. Sandra Shaw, the Director of Patient Services for Metropolitan Jewish Long Term Home Care, requested that changes be made to the CCM principles that would allow her organization—and those like it—to make a smooth transition to MLTC.

Scott Amerhein, the President of the Continuing Care Leadership Coalition, recommended that provisions be established that would allow LTHHC programs to continue serving residents and take on new residents until they are able to achieve status as a CCM. Mr. Amerhein indicated that this is critical since these programs number more than 100 and provide services for more than 30,000 individuals.

Christie Johnson, the President of the NYSHCP, and Al Cardillo, the Executive Vice President of Policy and Program Services at the HCA, offered a joint presentation, beginning with Ms. Johnson, who noted that her providers accept that change is necessary and are willing to embrace the change, but that given the enormous diversity in home care provider types, the CCM cannot simply adopt a “one size fits all approach”. Ms. Johnson stressed that the Work Group cannot lose sight of the fact that its decisions have far reaching consequences and will directly impact consumer choice and continuity of care.

Mr. Cardillo indicated that their chief request was that the CCM criteria be revised so there is explicit language to accommodate models other than the MLTC model. Citing that the LTHHC model has a long history of effectiveness with respect to cost management, and is the only program that is statutorily designated to be a care coordination program, he indicated that he has been working with the legislature to add some legislative refinement to the program, and to make the structure “more in compliment” with the proposed CCMs and other models of MLTC.

Eli Feldman asked Mr. Cardillo why LTHHC providers could not accept sub-capitation from a MLTC plan that takes on risk and has sufficient reserves? Mr. Cardillo responded that they envision an option that would permit this, but at the same time feel that if a LTHHC provider wants to be a CCM for the consumer, than this ought to be an option as well. He further noted that if the only acceptable form of payment is capitation-based payment from insurers, then this would eliminate a lot of LTHHC entities.

Jim Introne asked Mr. Cardillo if he could provide suggested revisions or a restatement of the CCM principles. Mr. Cardillo offered one example where the language surrounding risk sharing seemed very broad (mentioning that an entity may receive periodic payments for services delivered) though fails to specify what payment options are actually permitted. Mr. Cardillo said it would be important to clarify if capitation is the only acceptable payment option or if episodic or bundled payments are likewise acceptable. He further noted that his providers are concerned that the proposals steer Care Coordination Models nearly completely toward the insurance side, though he knows from past conversations with DOH and the Governor’s office that there is willingness for provider based options.

Mr. Introne asked Mr. Cardillo to modify the principles “in a way that you think they need to be modified”, and return them to the Work Group for consideration.

Myrna Sandbrand, the Director of the LTHHCP at Family Care Certified Services, asked the Work Group to push back the timeline for the mandatory enrollment into MLTC. She explained that a lot of LTHHC providers are not in a position to become MLTCPs and will need time to negotiate with existing MLTCPs or otherwise plan their next move.

Adult Day Health Care

Supporters of NYS’ ADHC centers argued that ADHC can provide a “one stop shop for

MLTCPs”, and suggested that the State make regulatory changes to unbundle reimbursement rates and allow ADHC centers to run a health and social model that provides meals and personal care in addition to medical services. The ADHC could then contract with a MLTCP to provide basic services (care planning, therapeutic recreation, meals, etc.), and would allow residents to move seamlessly between congregate levels of care as needed. This suggestion was offered by Christine Fitzpatrick, the Executive Director of the ADHCC, who further indicated that of the 13,500 individuals ADHC centers currently serve, 75% are dual eligibles.

Comments were also provided by Christopher Nadeau, the Vice President of NYADS. Mr. Nadeau offered two points on the proposed CCM principles. First, he expressed his concern that the assessment tool for MLTC is too narrow in choice and excludes other cost-effective services. He also noted that the principles need to adopt uniform assessment standards and should further incentivize plans that focus on providing care in the least restrictive setting possible.

In addition, Mr. Nadeu raised the issue of avoiding potential conflicts of interest in instances where an MLTCP is both the agent that assesses levels of care, authorizes services, and serves as the provider of care for consumers. He requested that additional safeguards be instituted so assessment and authorization determinations are made in a conflict-free manner when an MLTCP finds itself simultaneously in the “gatekeeper and provider role”. Dave McNally from AARP responded that he shared Mr. Nadeu’s concern.

MLTC Plans and PACE Plans

The lone MLTC plan representative, Tony Fiori, lauded the care provided by current MLTC programs, and indicated that the State would create an “uneven playing field” if it allowed for care coordination models with insufficient financial reserves. This would also create problems for consumers, he added, since “reserves ensure that enrollees can receive the services they need”.

Consumers

Consumer Advocates criticized the process as being provider and plan driven with little attention paid to the needs of consumers. Many also urged the panel to exclude consumer directed programs from MLTC, such as Anthony Caputo of Consumer Directed Communities (CDC), a Consumer Directed Program.

Mr. Caputo explained that consumer directed programs, such as his own, are able to provide cost effective care thanks to the home care exemption under the Nurse Practice Act. He noted, as an example, that if Work Group member Marilyn Saviola, herself an enrollee of a Consumer Directed Program, relied on services to be performed by a nurse, the cost of her care to the State would be substantially higher than it is now. In fact, he continued, the true cost savings of the program are even greater when you consider that CDC provides its employees with not only jobs, but also health insurance.

Mr. Caputo noted that many of CDC's employees would otherwise receive public assistance and be enrolled in Medicaid if they were not employed by CDC.

Mr. Caputo further commented that the self-directed disabled individual is a consumer, not a patient, and is fully capable of determining their own care. He called the draft models "paternalistic" and the Work Group's attempt to mesh Consumer Directed Programs with the MLTC model "an insult to all those individuals who struggle for independence in their daily lives". He concluded that the Consumer Directed Model must be excluded from MLTC.

Similarly, Mel Tanzman of Westchester Disabled on the Move indicated that the majority of individuals in the long term care system are self-directing, and should therefore be able to control their own life, and not have it controlled for them by a managed care plan. He criticized the MRT process for its lack of transparency, calling it dominated by "providers and managed care plans", and likened it to a "train barreling down without breaks". Citing his own experience on various Work Groups or subcommittees thereof, he indicated that there have not been enough meetings and time spent discussing critical issues before recommendations have been submitted.

Valerie Bogart, from Self-Help Community Services, argued that care should be self-directed whenever possible, with the individual or his or her representative in charge of their own plan of care. Ms. Bogart also recommended that the State develop a uniform assessment standard and further urged that existing treatment plans remain intact after the individual enrolls in a new Plan. Eli Feldman asked if this would be necessary, even if independent oversight was established to review any determination that resulted in a reduction in services, such as, an automatic, independent IPRO medical review upon enrollment. Ms. Bogart responded in the affirmative, explaining that if there is no change in a person's condition, but nevertheless a change in the individual's care assessment, then any reduction in care would constitute a violation of the patient's rights.

Several consumers of ICS, a nonprofit Medicaid managed long-term care plan in New York City that serves 1,400 Medicaid and nursing home-eligible adults with physical disabilities or chronic illnesses, asked the panel if their current services are going to be disrupted. Mark Kissinger indicated that there are no plans to change their program at all, and any questions they may have may be directed toward their case manager.

Heidi Siegfried, the Health Policy Director at Center for Independence of the Disabled, NY, said that people should be in charge of their own care, and that such care should be fully involved and in the most integrated setting possible. She also noted that the State should ensure that Administrative Law Judges are properly trained, and that there be a disincentive for institutionalizing care.

HIV/AIDS Advocates

HIV/AIDS advocates proposed eliminated the fee-for-service model for Aids Adult Health Care Services (distinct from Adult Day Health Care), and recommended that the Aids Adult Health

Care Service model should be folded into the rate for SNPs. Under this proposal, articulated by Paul Vitale, the President and CEO of the Samaritan Project, individuals needing 120 hours or more of services would be enrolled in HIV SNPs. They also strongly advocated that HIV SNPs be kept completely out of MLTC.

Mr. Vitale explained that the State must determine a new payment system for services that are presently carved out of Medicaid Managed Care (including Aids Adult Healthcare Services). Citing its successes in dramatically lowering costs, Mr. Vitale noted that HIV SNPs could successfully accommodate those individuals currently enrolled in Aids Adult Health Care Services while providing high quality care at significantly lower costs.

Charles King, the President and CEO of Housing Works, the nation's largest community based organization, who also serves as the President of AIDS Adult Day Health Care Services, which represents 14 out of the 15 AIDS Adult Day Health Care Services in the city, reiterated Mr. Vitale's requested that the AIDS Adult Day Health Care rate be folded into the SNP rate. Mr. King explained that consumers with AIDS are generally plagued by other issues, including homelessness, incarceration, and mental illness. He noted that AIDS Adult Day Health Care is very different from Adult Day Health Care, as AIDS Adult Day Health Care is rarely an alternative to nursing home care, but rather, is an alternative to living on the streets or incarceration. AIDS Adult Day Health Care provides respite to people dealing with multiple complex issues and is markedly different from Adult Day Health Care Services, he noted, and in light of this, he requested that it not be considering a long term care provider, but that their rates be folded into the SNP rate. Mr. King announced that his organization was confident of their worth under the SNP rate and believe they could dramatically improve the outcomes of individuals with HIV and other co-morbid conditions.

Jim Introne asked Mr. King about whether the AIDS Adult Day Health Care services provide nursing home services as a covered benefit? Mr. King responded that his organization currently only covers short term nursing, but would be happy to discuss an "all-in" plan and to be both a SNP and an MLTC plan. He also noted that his organization would be happy to be a BHO as well.

Personal Care Providers

Andrea Thomas, of Sunnyside Community Services, a nonprofit personal care provider, asked that the Work Group respect the community based perspective, and remain mindful of their position during the transition.

Health Information Exchange

Irene Koch, the executive director of the Brooklyn Health Information Exchange, expressed that she was there to discuss how health information exchanges can support the care coordination goals of the Work Group. She noted that the exchange enables providers and care givers to share key data, which would help streamline transfers of care during the MLTC implementation phase. She also noted that the health information

exchange can track patients and quality metrics through registries, and supports many federal health care initiatives, including health homes, CMS' electronic record program, and the ACO program. She did note, however, that significant work is needed to educate providers on the healthcare information exchange, but believed the time and investment to be worthwhile, as the goals of the MRT and this Workgroup can be advanced through the exchange. She also noted that funding is needed to build interfaces and manage work flows.

Medicaid Redesign Team: Managed Long Term Care Implementation and Waiver Redesign Work Group

Public Hearing Testimony, September 19, 2011

1. Patrick Cucinelli
2. Christine Fitzpatrick
3. Margaret Chin
4. Laura Radensky
5. Tracey Sokoloff
6. Andrea Thompson
7. Christopher Nadeau
8. Christine Johnson
9. Al Cardillo
10. Valerie Bogart
11. Mary Ellen Morici
12. Mel Tanzman
13. Azzlee Blackwood
14. Scott Amrhein
15. Lisa Ricaboni
16. Paul Vitale
17. Tom Mori
18. Michelle Branker
19. Anthony Caputo
20. Anthony Trocchia
21. Heidi Siegfried
22. Audrey Shaw
23. Margaret Rodriguez
24. Irene Koch
25. Charles King
26. Michael Rodford
27. Pam Guigli

More information on this Work Group and MRT initiatives is available at:
http://www.health.ny.gov/health_care/medicaid/redesign/