CPRNYDE Comments on FIDA MOU, Requests Participation in “4-Way” Contract

The Coalition to Protect the Rights of New York’s Dually Eligible (CPRNYDE) has sent its formal comments on the new Fully Integrated Duals Advantage (FIDA) demonstration to the Centers for Medicare and Medicaid Services (CMS) and the New York State Department of Health (NYSDOH). The demonstration will be implemented in New York City, Long Island and Westchester County no earlier than July 1, 2014.

In a September 20th, 2013 letter to CMS and NYSDOH, CPRYNDE requests to be involved in ongoing implementation discussions in real time, including the negotiation of the three-way contract between the State, CMS and the FIDA plans, making it a four-way contract (the “Contract”). The organizations that make up CPRNYDE have extensive experience in managed care implementation, particularly as it relates to Managed Long-Term Care (MLTC), and the coalition has worked closely with the State on MLTC implementation. In the letter, CPRNYDE also stated that while the FIDA MOU reflects many lessons learned in MLTC, there are still concerns that issues left unresolved in MLTC will be replicated in FIDA. To that end, CPRNYDE addressed specific concerns with the FIDA MOU and opportunities for improvement in the Contract and subsequent development of guidance and other regulations. Some of these concerns are listed below.

**Integrated Part D Appeals** – We applaud the State and CMS for including aid continuing for all prior-approved Medicare and Medicaid benefits pending appeal. At a minimum, CMS and the State should collapse the multiple levels of Part D plan appeal and ensure that a denial of coverage given at the pharmacy counter is treated as a coverage determination and that the beneficiary is given immediate appeal rights.

**Passive Enrollment** – The MOU refers to an “intelligent assignment” algorithm that will be used for passive enrollment, and will prioritize continuity of providers and/or services. We would like to see the Contract include more detail on how the algorithm works, and also ensure that the algorithm considers Participants’ previous service and provider utilization in both Medicare and Medicaid.

**Participant Ombudsman** – The Contract should allow the Ombudsman to routinely receive and have access to data that the plans report to the State or CMS, and the Ombudsman must have authority to ask questions of the plans about participants regardless of whether a particular participant has provided authorization, and about procedures, systems, and data.

**Continuity of Care** – We recommend that in the Contract, New York adopts at least the 180-day transition period used in other states, as we foresee that the communications and processes that will take place between plans, providers and enrollees will take more time than the 90-day transition period affords.

**Cultural Competency and ADA Compliance** – While the MOU does make some reference to the ADA, the Civil Rights Act of 1964, and the Supreme Court’s *Olmstead* decision, the MOU’s language is very vague in these areas. In the Contract, we’d like to
work with the State, CMS and the FIDA plans to develop more concrete ADA compliance standards.

Transitions Between Care Settings – The contract should provide incentives for plans to assess institutionalized members for discharge to the community and take the steps needed to transition them to the community. We recognize that resources are needed, and that incentives could make a difference.

Networks – The Contract should require plans have contracts with relevant providers in areas known by the State to be in short supply of specific services (i.e. behavioral health services).

Quality – The State should create a reporting system based on the quality measures specified in the MOU as the basis for Quality Withholds.

Read the full letter here.

Minnesota Signs Memorandum of Understanding with CMS

Earlier this month, the Centers for Medicare and Medicaid Services released the Memorandum of Understanding (MOU) for Minnesota’s dual demonstration program. Minnesota’s program—known as Minnesota Senior Health Options program (MSHO)—is unique in its structure. Instead of creating a new fee-for-service or capitated model, Minnesota’s MOU is enhancing the coordination of a program already in existence.

The MSHO program is most analogous to NY’s Medicaid Advantage Plus plans. In Minnesota’s existing MSHO program, plans have two separate contracts. One contract is with the State as a Medicaid managed care organization, and one contract is with CMS as a Medicare Advantage Special Needs Plan for Dual Eligibles (D-SNP). This structure will remain in place, and the MSHO plans will continue to provide the same benefits to their beneficiaries. Due to the limited changes, the demonstration began the day the MOU was released—September 13, 2013. It is planned to continue until December 31, 2016.

The existing MSHO program currently serves approximately 36,000 beneficiaries, and those who are already enrolled will remain in the MSHO plans. Any additional beneficiaries who choose to enroll will be able to do so. The changes to the existing MSHO program through the MOU are extremely limited. However, one of the largest changes is the promotion of Integrated Care System Partnerships (ICSPs). Although it is a little vague how these partnerships will be “promoted,” this provision appears to be a way to encourage MSHO plans to increase care coordination by working with health homes and other integrated care systems. The end goal is to improve coordination between Medicare and Medicaid services, as well as to help beneficiaries remain in the community.

Additionally, the MOU makes two changes to the MSHO program appeals process. First, a new simplified, integrated model notice for appeals will be used. Second, beneficiaries will have 90 days to file an appeal for a Medicare, Medicaid, or Medicare/Medicaid hybrid service. This 90 day period extends the typical Medicare appeal period by 30 days to align it with the Medicaid timeframe. While these changes are both beneficial, they are far from the integrated appeals process that NY has established in its MOU.

Minnesota’s model is much different than other states’ models. Minnesota’s MOU includes no information about cost savings targets or changes in how the plans will be financed, and only makes relatively small changes to an existing program. While the limited changes are focused on increasing care coordination and beneficiary protections, the persistence of separate contracts with both the State and CMS may continue to segregate the Medicare and Medicaid services that beneficiaries receive. Overall, the MOU does not appear to substantially change how dually eligible beneficiaries in Minnesota will receive their health coverage. However, certain aspects of Minnesota’s MOU, such as the ICSPs and the increased appeal timeframe, may be helpful when applied to other states’ demonstrations.
The Federal Long–Term Care Commission Releases Summary of Recommendations

The Federal Long-Term Care Commission, created by Congress after the repeal of the Community Living Assistance Services and Supports Act (CLASS), released a summary of its recommendations to Congress. The Commission was tasked with addressing the country’s need for long-term services and supports.

According to an article published by Kaiser Health News (KHN), the Commission’s recommendations received bipartisan support from nine of the 15 Commissioners and called for supporting criminal background checks for long-term care workers, ensuring that family caregivers are included in care planning, and improving working conditions and opportunities for long-term care workers.

Noticeably missing from the Commission’s recommendations were options for financing long-term care services. Currently, Medicare does not pay for long-term services and supports, and Medicaid only covers those services for people with low incomes or those who have sufficiently spent down their assets in order to qualify. The Commission did not provide any recommendations on how to pay for long-term services and supports, but did recommend that Congress advocate for new models of public payment on the basis of the service, rather than the setting. Access the summary of recommendations here.

CMS Report Compares Long–Term Care Costs for Duals and Non–Duals

The Centers for Medicare & Medicaid Services (CMS) recently released a report comparing the Medicare and Medicaid expenditures of older dual eligible beneficiaries, those who qualify for both programs, with non-dual beneficiaries, based on their long-term care (LTC) use. CMS found that both medical and LTC expenditures were higher for dual eligible beneficiaries than non-duals.

Dual eligibles are among the most vulnerable people served by both the Medicare and Medicaid programs, and they are also some of the most costly. Dual eligibles account for 16 percent of Medicare enrollees, but about 25 percent of total Medicare expenditures. In Medicaid, dual eligibles are even more costly; duals account for 18 percent of Medicaid enrollees and 46 percent of all expenditures. CMS found that in seven states—Arkansas, Florida, Minnesota, New Mexico, Texas, Vermont and Washington—dual eligibles that utilized LTC had more cardiovascular diseases, cancer, dementia, diabetes and developmental disabilities than non-duals. Additionally, both duals and non-duals in LTC had higher total expenditures than beneficiaries that did not utilize LTC.

According to the authors of the CMS report, the results of the study have some policy implications: efforts to address cost controls in the dual eligible population should focus on LTC and improving care coordination, especially as it relates to finding effective ways to address chronic illness. According to the report, managed care may be an opportunity to accomplish those goals, but further research would need to be conducted—older adults enrolled in managed care programs were excluded from this study. Read the CMS report here.
For More Information:

Attend the October 30, 2013 meeting of the Coalition to Protect the Rights of New York’s Dually Eligible. Click here to receive meeting details and call-in information.

See what other states are doing around dual eligibles: visit the National Senior Citizens Law Center (NSCLC) website at Duals Demo Advocacy.

Visit the New York Health Access website for more information on both the demonstration and changes to managed long term care in New York State.

About the Coalition to Protect the Rights of New York’s Dually Eligible (CPRNYDE)

The Coalition to Protect the Rights of New York’s Dually Eligibles (CPRNYDE) is a diverse group of interests, agencies and perspectives working to shape New York’s demonstration project created by the Affordable Care Act to provide quality care for the state’s unique dual eligible population. The coalition’s objectives include: developing standards for appeals, plan and provider selection, quality measurement, reimbursement, benefit design, and compliance with the Americans with Disabilities Act (ADA); supporting the creation of a statewide, independent advocacy entity that strengthens community-based organizations to provide individual assistance and systemic advocacy to dual-elgibles; ensuring timely, real-life information, drawing upon beneficiary experiences, to government agencies, particularly NYSDOH and MMCO, and beneficiary advocates; and educating professionals who serve dually eligible beneficiaries.

CPRNYDE is a part of New York Voices for Better Health, a project to advance care and establish a strong voice for New York’s over 760,000 “dual eligibles”: older and disabled Americans who qualify for both Medicare and Medicaid coverage. Voices for Better Health is a multi-year, $3 million four-state effort funded by The Atlantic Philanthropies and supported nationally by Community Catalyst. It will also seek to institutionalize ways to make dual eligibles active, meaningful and lasting participants in the demonstration projects.