Mandatory Managed Long Term Care

Consumer Response To

Recommendations And Guidelines Of

The NY State Medicaid Redesign Team's

Managed Long Term Care Implementation And Waiver Work Group

And

Their State Implementation

Brief For Policy Makers

March, 2012

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Introduction

Purpose Of This Brief

The purpose of this brief is to share the concerns and views of the Long Term Care Community Coalition, a statewide coalition of civic, professional and consumer groups working to improve long term care, on mandatory managed long term care. The brief provides an analysis of the recommendations and guidelines of the Medicaid Redesign Team (MRT) and their implementation. In addition, we have a list of consumer recommendations we would like to see implemented. We hope that by providing a consumer-oriented perspective this brief will be useful to you. As the MRT recommendations are implemented in state law and policy we hope that you will use this as a resource to make sure that plan members receive appropriate care and that state money is used wisely and efficiently. As the state moves forward in its implementation of these changes we will update this brief. It will be available on our webpage dedicated to this issue (http://www.ltccc.org/MandatoryManagedCare.shtml). If you are interested in receiving future updates directly please email us at info@ltccc.org.

New York State Requests Waiver to Make Major Changes in Medicaid

As you know, New York State has embarked on a major redesign of the Medicaid program.

Governor Cuomo commissioned the MRT to implement cost savings initiatives while maintaining the provision of needed care. The MRT voted to implement seventy-nine (79) proposals which focus on program changes and implementation of new initiatives. Legislative changes were enacted in the State's 2011-2012 Budget allowing the State to proceed with obtaining the necessary approvals to implement the various proposals. One of these changes was to mandate enrollment in Managed Long Term Care for Medicaid recipients over age 21 who need home and community based services for more than 120 days. Persons subject to mandatory enrollment will be assigned to a plan if don't select one within 60 days of the date on which they are given a choice of plans.

Medicaid Redesign Team

In Phase 1, the MRT developed a package of reform proposals that achieved the Governor's Medicaid budget target, introduced significant structural reforms to reduce costs, and achieved the savings without any cuts to eligibility.

In Phase 2, the MRT was directed to create a coordinated plan to ensure that the program can function within a multi-year spending limit and improve program quality. Work groups focusing on specific issues were created to develop recommendations for the full MRT.

The Work Group focusing on mandatory managed long term care was the Managed Long Term Care Implementation and Waiver Redesign Work Group.

Managed Long Term Care Implementation and Waiver Redesign Work Group

The mission of this group is to advise DOH on the development of care coordination models to be used in the mandatory enrollment of persons in need of community-based long term care services. Below are the recommendations and guidelines of this group and an analysis by LTCCC.

Recommendations of MRT[1] and Analysis

Recommendation 1: Care Coordination Models (CCM) Principles[2]

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

   Analysis: The inclusion of nursing home care in the services may be positive or negative for consumers. By including nursing home care and putting the plan at risk for the cost of that care, more people may be kept in the community for their care if the plan feels that it would be less expensive to do so. However, it is possible that for those individuals needing 24 hour care, a plan may find it would be cheaper to put someone in a nursing home and may have an incentive to do so.

2. ***A CCM must include a person-centered care management function that is targeted to the needs of the enrolled population.*** Every enrolled CCM member must have a care manager or care management team that is responsible for person-centered assessment and reassessment, care plan development and implementation, care plan monitoring, service adjustment, safe discharge and

[1] http://www.health.ny.gov/health_care/medicaid/redesign/docs/mltc_implement_waiver_rpt.pdf. Medicaid Redesign Team (MRT), Managed Long Term Care Implementation and Waiver Redesign Work Group Final Recommendations.
[2] The recommendations listed below are taken directly from the report.

transition planning, and problem solving. The CCM must use Health Information Technology, as feasible, to document, execute and update the plan of care and share information among appropriate staff and providers. The care management function shall address the varying needs of the population. The needs and preferences of the member will guide the intensity and frequency of the care management, encompassing both high-touch and low-touch care management.

Analysis: This sounds very good. However there are no requirements for care managers such as required experience or education and no required ratio of managers to members.

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

   Analysis: This is very important. Until all Medicare and Medicaid services are included in the plans, this coordination is crucial.

4. ***The member and his/her informal supports must drive the development and execution of the care plan.*** They shall be given the opportunity to participate in decisions about the type and quantity of service to be provided.

   Analysis: What this means in practice is unclear. Need some specifics such as: making sure care management meetings are held when informal supports are available; a clarification of "driving the plan;" having an opportunity is not the same as driving the plan.

5. ***Care coordination is a core CCM function. For benefit package services, CCM members will have a choice of providers.*** Within the CCM, members will be able to select among a choice of at least two providers (where available) of each benefit package service. CCMs shall have a network that takes into account the cultural and linguistic needs of the population to be enrolled and be geographically accessible to the population. There are geographic differences in the availability of service providers and CCMs should not be prevented from operating when market forces (lack of availability or unwillingness to contract) preclude a CCM network from offering choice or, perhaps in some instances, a particular service. However, CCM's must have the ability to authorize services from an out-of-network provider if no provider is available in-network that can adequately meet the needs of the member.

   Analysis: It is not clear if a choice of two providers, especially nursing homes, will be enough to provide consumers with real choice. A nursing home might be where they will spend the rest of their lives. Also, it is unclear how , without specific rules, the network will take into account cultural and linguistic needs. In addition, the last

point, that CCMs should not be prevented from operating when market forces preclude a CCM from offering choices, seems to undermine this recommendation.

6. ***A CCM will use a standardized assessment tool to drive care plan development which must be conducted by a Registered Nurse.***

   Analysis: This is an excellent recommendation. If members change plans their assessments can be sent to the new plan and the Department of Health can better monitor assessments when they are standardized.

7. ***A CCM will provide services in the most integrated setting appropriate to the needs of qualified members with disabilities.*** Consistent with the Supreme Court's *Olmstead* decision, CCM care planning shall provide benefit package services in the most integrated setting appropriate to the needs of members with disabilities, include the members in decision-making, address quality of life, and actively support member preferences and decisions in order to improve member satisfaction.

   Analysis: It is unclear what will happen if consumer/informal support disagree with plan's decision. Will the plan be permitted to discharge the client?

8. ***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.*** CCMs will submit data to the State, which will be made available publicly, to compare and evaluate entities on an ongoing basis, determine the success of individual CCMs, and create transparency about CCM service delivery. Data will include, but will not be limited to: financial cost reports, provider networks, consumer satisfaction, grievances and appeals, assessment data, care outcomes and encounter data, and disenrollment data (both voluntary and involuntary). The CCM will use its own data and information to develop and conduct quality improvement projects. DOH will track experience of CCMs in relation to quality and costs, and will publish this data annually in a consumer-friendly format on DOH's website. Must have board level accountability for overall oversight of program activities.

   Analysis: Although the list of data is excellent (it includes real quality outcomes), it is unclear if DOH has the resources needed to effectively monitor quality.

9. ***Existing member rights and protections will be preserved.*** Members are entitled to the same rights and protections under CCM as they are under current law and practice, including the Federal and State Law or regulations governing Managed Care Organizations (MCO). CCMs must follow clear criteria established by the

Department for involuntary disenrollment and members must be informed about them and the attendant appeals and grievance rights.

Analysis: This is very important. Again, will DOH have the resources to monitor?

10. ***A CCM with demonstrated expertise will be able to serve specified population(s).*** If applicant defines a unique or specialized population then it must demonstrate that it is skilled in the assessment, care plan development, and monitoring of that population and that it has a service network that is able to meet those specialized needs.

    Analysis: This is a good recommendation; however the criteria for judging must be analyzed to make sure they are valid.

11. ***Mandatory enrollment into CCMs in any county will not begin until and unless there is adequate capacity and choice for consumers and opportunity for appropriate transition of the existing service system in the county.***

    Analysis: Good recommendation, but recommendation #5 (above): that "CCMs should not be prevented from operating when market forces (lack of availability or unwillingness to contract) preclude a CCM network from offering choice or, perhaps in some instances, a particular service," seems to undermine this recommendation.

12. ***Members shall have continuity of care as they transition from other programs.*** Consumers already receiving long term care services through another Medicaid program have the right to continue to receive the same type and amount of services until the CCM conducts a new assessment authorizing a new plan of care and provides notice to the member including appeal rights.

    Analysis: This is very important. Again, will DOH have the resources to monitor?

13. ***Prospective members will receive sufficient objective information and counseling about their choices before enrolling.*** Prospective members shall be provided with appropriate materials educating them about their choices and shall have the opportunity to have questions answered before enrollment. Information about options shall be posted on a website that is accessible to prospective members and the public. This information shall also be included in a printed brochure listing all CCMs in their geographic service area, which shall be sent by the enrollment broker to all prospective members.

    Analysis: Very important recommendation. In addition to sending such information to prospective members, the information should also be sent to places where people needing long term care might congregate: senior citizen centers,

churches, synagogues, mosques, libraries, etc… in order to help the those who might need this in the future understand the issues.

Recommendation 2: Quality Measures

The goal should be to achieve improvement over time and to enable consumers and purchasers to compare CCM performance. This necessitates that the quality measures be transparent and publicly reported. The criteria for determining measures should include that they be measurable, actionable, risk-adjusted, consistent across sectors, parsimonious, and have an impact on care. The quality measurement system should cover the following domains:

- Reduce inappropriate utilization associated with nursing home admissions, emergency and urgent care and inpatient admissions;
- Improve quality of life, emotional and behavioral status, preventive care and patient safety;
- Improve care management;
- Improve or stabilize functional status; and
- Ensure continuity of worker and care to fullest extent possible.

The MRT Managed Long Term Care Quality Subcommittee should continue to convene to review progress made by DOH in developing and implementing quality measurement system based on recommendations. Wherever possible, alignment with recommendations of MRT Payment Reform and other work groups should be achieved.

Analysis: Excellent criteria, however, the problem of monitoring the reporting and the quality outcomes will be difficult for DOH with its present staffing levels. In addition, the use of the word "parsimonious" is troubling. Although we do not want to burden the plans, we do want to make sure the criteria for choosing measures are not too few to be meaningful.

Recommendation 3: Fair Hearings

- Consider the possibility of a targeted increase in resources to handle the move to mandatory enrollment in managed long term care or other care coordination models.
- Providers should receive notice of fair hearings requested by their clients.
- Ongoing training for ALJs pertaining to state law, rules, and regulations should be evaluated. Consumers and plans should have input and access to the training.
- The target timeframe for fair hearing resolution should be within 60 days of the request for the hearing.

- Regulations should be amended to require documented receipt of written notice of fair hearings to CCM administrators of record or legal counsel.

Analysis: These are excellent recommendations. It is important however, to make sure that the member is able to continue receiving services pending a hearing.

Recommendation 4: Consumer Direction

Establish a work group to advise the Department on the integration of self directed program models, including the consumer directed personal assistance program (CDPAP), into CCMs and Managed Long Term Care.

Analysis: This group must include consumers and their representatives in large numbers.

State Implementation

The state has been holding weekly meetings[3] of the MLTC Implementation Advisory Group which includes all stakeholders. LTCCC has been participating in these meetings.

Enrollment Plans

The state, once it gets approval from CMS, will implement an enrollment plan. Expecting to enroll over 2000 people a month, the state will begin with New York City residents, moving to the rest of the state over this and next year.

The state has contracted with the Maximus Company as the independent broker for this program. Maximus is developing, with DOH, materials to be sent to eligible consumers.[4]

Maximus expects to send out announcement letters, enrollment letters, follow up letters 30 days and 45 days after enrollment letter, auto-enrollment letters, if necessary, 60 days after the enrollment letter, enrollment packets describing who must join a plan, plan features and services, how to choose, rights and responsibilities, how to change plans, how to make grievances and fair hearing overviews and they are pilot testing all the material. Consumers will be asked to enroll over the phone rather than fill out a form.

[3] See, http://www.health.ny.gov/health_care/medicaid/redesign/mtg_materials_mltc_implem_advisory_grp.htm for materials given to this group and for summaries of meetings.
[4] See, http://www.health.ny.gov/health_care/medicaid/redesign/docs/2012-02-08-presentation.pdf for a presentation of plans for these materials.

Quality Measurements[5]

The suggested list of indicators is long and comprehensive. They are based upon the data collected in the Semi-Annual Assessment of Members (SAMM)[6] and a member experience of care survey. SAAM is based on the Outcome and Assessment Information Set (OASIS-B), and is used to establish clinical eligibility for the MLTC program and assist health providers in care planning and outcomes monitoring. Measures are categorized as Current Status and Performance; Performance over Time; and Satisfaction with the Experience of Care. The indicators include both current status and performance and performance over time in overall functioning and activities of daily living; incontinence and neurological/emotional/behavioral status; and member satisfaction.

LTCCC Recommendations

General Recommendations

1. New York State is trying to make major changes in too short a time and with too few resources. There must be additional resources given to DOH to permit its staff to conduct meaningful monitoring of plan requirements and client outcomes.
2. Although there has been much transparency of the process, not enough consumer representatives have been included on the original work groups. Any additional work groups must have a larger percentage of consumers or their representatives. While the weekly meetings, by telephone, have permitted all stakeholders to give their opinion and learn up to date information, consumer suggestions must be accepted.

[5] See, http://www.health.ny.gov/health_care/medicaid/redesign/docs/list_mltc_rpt_measures.pdf for a detailed list of all indicators.
[6] See, http://www.health.ny.gov/health_care/managed_care/mltc/pdf/mltc_SAAM_ver_2_1_5.pdf for a copy of SAAM.

Specific Recommendations

1. The state should not begin implementing mandatory managed long term care enrollment until much more education has been conducted. In addition to sending information to potential plan members, educational sessions should be held throughout the state. A comprehensive education plan should be developed with public/consumer input. The plan should include a robust, user-friendly web resource. Developed information should be widely disseminated, not only to prospective members.
2. The state should not begin implementing mandatory managed long term care enrollment until plans are in place and meeting all requirements.
3. The state should not begin implementing mandatory managed long term care enrollment until DOH has added the needed staff to monitor plan compliance and member care.
4. Since the care management function is the heart of the plan, there must be requirements surrounding this function such as:
   a. Educational and experience requirements and
   b. Ratio of numbers of care managers to clients related to acuity.
5. There need to be specific requirements related to how the member and his/her informal supports will "drive" the development and execution of the care plan. If there are disagreements, how will they be handled?
6. There must be more than a choice of two providers, especially for nursing home care.
7. There must be specific rules related to how the plan will take into account cultural and linguistic needs.
8. The State must ensure that a member has the due process right to continue receiving services unchanged, as “aid continuing” pending a hearing, before a plan reduces or terminates services that were previously authorized by the plan or by the prior-approval procedure for the services that the individual previously received before mandatory MLTC enrollment.