spg SACHS POLICY GROUP
60 East 42nd Street, Suite 1762
New York, NY 10165
Phone: 212 827 0660
Fax: 212 827 0667

Update on MLTC and FIDA

OVERVIEW

On September 29th, the Office of Health Insurance Programs (OHIP) and the Centers for Medicare & Medicaid Services (CMS) held a forum on the future of long-term care services in New York, which outlined a proposal to create an enhanced managed long-term care (MLTC) initiative called MLTC Plus as well as some planned changes to the Fully Integrated Duals Advantage (FIDA) demonstration. The State has released a white paper (available here) on these proposals.

The State is accepting public comments on this document through October 9th. Comments should be sent by email to mltcworkgroup@health.ny.gov with subject line "LTC Forum."

MLTC PLUS

Under MLTC Plus, plans would offer an enhanced MLTC Plus product. Such plans would:

- Incorporate primary care and behavioral health (BH) services into their benefit packages;
- Make quality incentive payments for primary care services, aligned with the value-based payments in the Delivery System Reform Incentive Payment (DSRIP) program; and
- Employ care managers and transition specialists to actively coordinate all activities related to transitions from hospitals back to the community.

The State intends to implement this initiative under the existing MLTC legislative framework, which it considers to permit the inclusion of primary care and BH services. It has not yet determined the scope of the project, including geographic areas, the number of participating plans, and other such considerations, but intends to solicit input from willing partners to help develop the operational framework.

Expanded Benefit Package

The MLTC Plus benefit package would expand on the MLTC benefit to include:

- Primary care services;
- Preventive services; and
- BH services, including mental health and substance use services. This may include Office of Mental Health (OMH) Home and Community-Based Services (HCBS) waiver services and Health and Recovery Plan (HARP) services.

OHIP will review individual services for inclusion to ensure that they meet the existing criteria in Section 4403-f of the Public Health Law, which permits MLTC plans to offer "ancillary services" required to meet the needs of enrollees.

Quality Incentives for Primary Care

In the MLTC Plus program, plans would be encouraged to enter quality-based incentive relationships with primary care physicians (PCPs). Plans would establish metrics to determine whether physicians respond quickly, reliably, and effectively to enrollees. These might include:

- A minimum number of annual visits;

- Maximum thresholds for response times;
- Timely follow-up visits;
- Minimum scoring on patient satisfaction surveys; and
- Other metrics to be determined.

MLTC Plus plans might then pay PCPs a per-member, per-year bonus based on performance on these metrics.

Coordination of Care Transitions

MLTC Plus plans would require care managers and/or transition specialists to be the single point of contact responsible for coordinating transitions from the hospital to the community. Coordinators would be required to:

- Communicate with hospital discharge planners before a discharge;
- Review all information related to the admission;
- Reach out to a certified home health agency (CHHA) provider, as needed;
- Communicate with the enrollee to discuss the discharge and post-discharge care;
- Set up a home visit within 48 hours to review follow-up plans; and
- Make at least two follow-up calls to the enrollee within 10 days.

Furthermore, based on the diagnosis, coordinators would arrange for daily nursing visits to be made to the enrollee for five days after discharge, in order to prevent readmissions. These visits would be wrap-around services, on top of any existing CHHA services, which will require coordination between the plan and the CHHA. Relevant diagnoses might include:

- Asthma;
- Cellulitis;
- Congestive heart failure;
- Urinary tract infections; and
- Other at-risk diagnoses.

Although this program would initially cover only inpatient admissions, the State intends to expand it to cover emergency department (ED) visits and 23-hour crisis observations, and, as the MLTC benefit expands to cover nursing home residents, transitions from hospitals to nursing homes.

CHANGES TO THE FIDA DEMONSTRATION

Due to low enrollment, the State proposes to modify the FIDA program in the following areas:

- Making interdisciplinary team (IDT) care coordination optional;
- Increasing flexibility in marketing rules and providing funds for a marketing campaign;
- Changing enrollment processes and incentives;
- Expanding the FIDA service package; and
- Requiring FIDA plans to accept any willing primary care provider into the network.

Optional IDT

The State proposes to require all FIDA plans to allow enrollees to choose whether they would prefer IDT care coordination or a traditional care manager. OHIP would incentivize use of the IDT model by:

- Making bonus payments to plans with greater than 25 percent IDT utilization (and penalties to plans with lower utilization);
- Creating an incentive pool to allow plans to pass through incentives to physicians to participate in IDT meetings; and
- Allowing plans to incentivize enrollees with small gifts for participation in IDT meetings.

Marketing

The State proposes to allow plans to provide their own comparison tool between MLTC programs and to use non-licensed personnel to describe the FIDA program to enrollees, and will explore whether further flexibility is available. It will also provide funds and resources for a marketing campaign.

Enrollment

The State proposes to improve plans' flexibility and increase their incentives to enroll consumers:

- Plans would be allowed to directly enroll consumers into FIDA plans, rather than proceeding through the statewide enrollment broker.
- Insurers who offer FIDA plans would be required to have 25 percent of their total LTSS population enrolled in integrated dual-eligible plans. Such plans include the FIDA, Medicaid Advantage Plus (MAP), and Program of All-Inclusive Care for the Elderly (PACE) programs. Insurers not meeting the target by December 2016 would face a freeze of enrollment into their partial MLTC plans.

The State would also change its own enrollment processes as follows:

- Dual-eligible individuals who need fewer than 120 days of LTSS would be eligible for, and passively enrolled into, FIDA plans;
- Medicaid enrollees who turn 65 and who need LTSS would be offered FIDA plans as their first choice upon enrollment into Medicare;
- The State would conduct passive enrollment on a semi-annual (or more frequent) basis; and
- OHIP would modify the passive assignment model to be based more on enrollees' primary care and home health history.

Service Package

Consistent with the MLTC Plus proposal, the State would add HARP HCBS services to the benefit package, and require that all plans offer an over-the-counter drug benefit. The State is also open to adding or removing services, such as non-medical transportation, based on stakeholder feedback.

Provider Network

In order to address concerns that enrollees' existing primary care providers might not be in-network, the State proposes to institute an "any willing primary care provider" requirement. All FIDA plans would be required to include in their provider networks any qualified PCP willing to accept the plan's terms.