September 9, 2011

Jason Helgerson, Deputy Commissioner
Office of Health Insurance Programs
NYS Department of Health
14th Floor, Corning Tower
Empire State Plaza
Albany, New York 12237

Mark Kissinger, Deputy Commissioner
Office of Long Term Care
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Eli Feldman, Co-Chair
Carol Raphael, Co-Chair
MRT Workgroup on Managed LTC Implementation and Waiver Redesign
c/o NYS Department of Health
14th Floor, Corning Tower
Empire State Plaza
Albany, New York 12237

Dear Mr. Helgerson, Mr. Kissinger, Mr. Feldman and Ms. Raphael:

We write on behalf of New York State's health care community to respectfully submit comments and requested changes to the State Department of Health's (DOH) draft care coordination principles presented at the August 16 meeting of the MRT Workgroup on Managed Long Term Care Implementation and Waiver Redesign.

The design and implications of these criteria are of an utmost serious nature for patients, providers and communities. Recognizing the profound undertaking by the Department and observing the statutory requirement for the input of the home and community-based services sector, as the associations representing the totality and balance of the long term health care sector, we submit the following comments. The intent of these comments is to assist New York State and the MRT Workgroup in developing a thoughtful transition for the individuals receiving essential home and community-based services.

- The health care community requests revision of the draft principles relating to financial risk and service package requirements of the Care Coordination Model (CCM) options.

Contrary to the intent of the Legislature and to the availability of more than a sole program option for consumers and for the infrastructure, the draft principles are skewed to a narrow, one-size-fits-all form for what are supposed to be CCM *options*.
With regard to financial risk, the principles essentially limit consumers and program options to a single program structure. Such limitation is unnecessary and undermines the goal of providing options for consumers. Other successful, foundational models of care coordination and service integration are already operational, deeply rooted, accessible and perform well throughout New York State. In addition, these models also demonstrate excellent care coordination expertise. The draft principles would deny the Long Term Home Health Care Program (LTHHCP), which is specifically referenced in the statute, and other, newly evolving, innovative options that are not a direct capitation or insurance-type nature. Doing so ignores federally-backed, viable methods of risk-sharing (such as episodic payment, bundling and other) that are provider-based, and that avoid the rigidity, limitation and restrictions (including the extremely limiting financial reserve requirements) of an insurance based system.

The health care community requests that the care coordination principles be revised to be explicitly inclusive of these non risk-sharing options, including the LTHHCP in particular.

We note that legislation (S.5853/A.8522) sponsored by the Senate and Assembly Health Chairs, Senator Kemp Hannon and Assemblyman Richard Gottfried, which is being strongly advocated industry-wide by providers, philanthropies and the State Society on Aging, would in fact convert the state's payment methodology for LTHHCP to a global/episodic system and consolidate the care management/care coordination within that system. The health care community continues to urge your engagement in quickly achieving agreement on this legislation and requests the revision of the care coordination principles to accommodate the provisions of this bill and the LTHHCP.

- The scope of services requirements articulated in the draft principles, both for the provision and coordination of services by a CCM, warrant flexibility similar to and consistent with the inclusive methods of risk-sharing described above. Such flexibility in services and in the methods of risk-sharing is a vital inclusion to these principles.

  The singular "MLTC package-approach" to the service package/coordination portion of the principles may imprudently restrict, impair or fundamentally preclude, existing, innovative and highly desired models of care coordination (i.e., LTHHCP, ACOs, Health Homes, Adult Day Health Care and others).

  The health care community requests that the guidelines be revised to permit the requisite flexibility for the service package and care coordination responsibilities to be inclusive of multiple CCM options, and explicitly LTHHCP as the one specific option to MLTC cited in the statute.

- Principles requiring "a choice of providers" should provide consumers a choice *between* CCMs and CCM/MLTC options as may be available in each service area.

The health care community asks that the principles be clear and explicit on the choice of options.

- Language for the principles requiring consumer choice *within* a CCM or MLTC option need to be revised and made explicit to be realistic, practicable and financially sound in accordance with the consumer's needs and the CCM/MLTC's capacity/resources of the community. The references in the draft principles to "out-of-network" services should be removed.

  The health care community asks that the language pertaining to CCM and service provider choice be revised accordingly. We request the opportunity and would be pleased to work with the Department and/or the Workgroup in fashioning the language in this regard.

- We support principles of consumer (and their informal supports') input into the entire care assessment, planning and provision process, and that the outcome should be consistent with person-centered care principles and with Olmstead for care in the most appropriate and integrated setting for the consumer.

- The health care community strongly endorses the principle requiring the use of a uniform assessment system. However, the language should explicitly indicate this new system's purpose of accurately ascertaining the person's health, social and environmental needs, replacing all other state assessment tools (so as not to add, duplicate or compound current paperwork or documentation burdens on health personnel), and should coincide with the federal OASIS tool as much as possible in order to avoid duplication. The uniform assessment tool should also be used for providing data access to providers in addition to providing data access to the state.

  The health care community requests the incorporation of explicit language to address these assessment concerns and recommendations.

- The health care community supports the draft principle providing for the reporting of data and ongoing evaluation relating to the success of the CCM and to create transparency about the CCM service delivery. The health care community requests, however, that language be revised to clearly reflect that:

  - requested data be reasonable and efficient for CCMs to compile;
  - it not unduly add to CCM's (and especially to health practitioners') administrative burden;
  - it replace other data requirements that are currently applied to MLTCs or CCMs;
  - evaluation be conducted with the input and engagement of CCMs and respective state associations;
  - evaluation results be made available to CCMs; and

- any data made available publicly be appropriate and fair for disclosure and be representative of the true experience of the CCM/consumer population.

- The health care community concurs with the draft principle that payments be actuarially sound, sufficient to support provision of covered long term care services and care coordination and efficient administration, and aligned with the needs of the consumers served. We are concerned however and request that the accurate costs and cost-variables (such as presence or absence of family, remote nature of rural patients or unique service issues relating to urban patients, unique issues of special needs populations or households that present care/cost consequences) be duly considered and factored into the payment methodology. This will also be particularly important for patients with a mental health diagnosis and/or developmental disabilities, whose cost of care may exceed that of their peers with similar clinical and functional abilities.

- The health care community supports the draft principle to ensure the maintenance of and adherence to due process rights for consumers. Commensurate costs or obligations upon the CCM resulting from due process proceedings (e.g., fair hearing decisions, aid continuing, etc.,) however must be reflected in the payment and regulatory accommodations for the CCM.

  The health care community requests the opportunity and would be pleased to work with the Department and the Workgroup's Subcommittee on Fair Hearings and Appeals to craft the appropriate language and criteria to ensure consumer due process and commensurate CCM payment/regulatory consideration.

- The health care community concurs with the draft principle that CCMs be able to develop and utilize expertise to serve specific populations with unique needs. Again, this will be particularly important for patients with mental health and/or developmental disabilities who are currently served by Special Needs CHHAs and other providers with this expertise.

  The language of the current draft principle appears "permissive" and to avoid particular criteria or mandates. The health care community supports this permissive approach but believes that further provisions are necessary to ensure that the payment and regulatory provisions for CCMs are commensurate, appropriate and enabling of this goal.

- The health community asserts the critical need for and requests the inclusion of principle language addressing transition issues/needs for the system, patients and providers. Principle language should be included which provides for the necessary steps, parameters and protections to ensure the appropriate implementation of MLTC, CCM and mandatory enrollment policies, with particular regard to: the continuity of care to consumers; stability of providers and overall home and community-based care infrastructure; appropriate timetable for transition of patients (mindful of the needs of the patients, current providers and CCMs); appropriate timetables for current models, including LTHHCPs, that will act as CCMs and for the approval of other, new models of CCM;

assurances that mandatory enrollment into MLTCs or CCMs will not be imposed in an area that lacks capacity in that area; as well as other critical factors.

We respectfully request your consideration of this input on behalf of the home and community-based long term care services community. We will be pleased to meet and work with the Department and the Workgroup to craft language changes on all of the issues and recommendations addressed herein, and commit our full resources to working with the Administration to implement this transformational policy change in New York State, while ensuring patient access to high-quality and cost-effective home and community-based care.

Please contact our offices with any questions or next steps in the follow-up process.

Thank you.

Sincerely,

Joanne Cunningham
President, HCA

Christine Johnston
President, HCP

Daniel Heim
Executive Vice President
NYAHSA

Christine M. Fitzpatrick
Executive Director, Adult Day Health Care Council

cc: James Introne, Deputy Secretary for Health
Nirav Shah, MD, Commissioner of Health
Hon. Dean Skelos, Senate Majority Leader
Hon. Sheldon Silver, Speaker of the Assembly
Hon. Kemp Hannon, Chair, Senate Health Committee
Hon. Richard Gottfried, Chair, Assembly Health Committee
Hon. Catharine Young, Chair, Legislative Commission on Rural Resources
Hon. Aileen Gunther, Vice Chair, Legislative Commission on Rural Resources
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