

Fully-Integrated Duals Advantage (FIDA) Stakeholder Workgroup

Plan Qualifications / Quality Metrics

Monday, September 24, 2012

9:00 a.m. – 10:15 a.m.

Call summary

On Monday, September 24, 2012, NYSDOH held its second of three FIDA Plan Qualifications/ Quality Metrics Workgroup meeting for stakeholders. Following is a summary of the meeting discussion.

Feedback on previous call summary

NYSDOH asked if any workgroup participants had feedback on the summary of the previous call that was circulated to the group.

- ***Selection of plans to participate in FIDA.*** The group discussed the benefits and drawbacks of using an RFP process to select a limited number of plans to participate in FIDA versus establishing a set of criteria for FIDA plans and allowing any plan that meets the criteria to participate. Eva Eng believed that the number of plans should not be limited through an RFP, as this could potentially disrupt services for members if they had to switch plans. NYSDOH noted that if there was an RFA there would still be a requirement that plans would have to submit successful applications to CMS to participate in Medicare. NYSDOH also noted that there is a State statutory limit of 75 plans in place.

Traci Allen suggested that the workgroup explore the implications of not limiting the plans in the context of the fact that this is a demonstration project. Another participant agreed, stating that because this is a demonstration project and not the open market that consideration should be given regarding limiting the number of participating plans. It could be difficult to track the effectiveness of FIDA if there are too many plans participating.

NYSDOH estimated that 20-30 plans are currently approved for the eight-county FIDA area; however, noted it is difficult to give a definitive number for a variety of reasons (Medicare Advantage plans can change every year because you need to reapply annually, there is consolidation of plans, plans leave the market, overlap between plans that offer both Medicaid LTC and Medicare plans, etc.). A workgroup member informed the group that while there is change every year on the Medicare side it is not

particularly volatile. New York is a high state for non-renewals this year, but it is not currently known if the volatility is upstate or downstate. In any event, the actual number of changing plans is not that high and does not affect that many members. Please see the following chart regarding functioning MLTC plans in the FIDA demonstration area.

<u>County</u>	<u>MLTC Plan</u>
NYC (All Boroughs)	Amerigroup, Centerlight, Homefirst (Elderplan), Elderserve, HHH Choices, Independent Care System, Senior Health Partners, VNS Choice, Wellcare, Fidelis, Senior Whole Health, VillageCare, HIP, ArchCare (Catholic MLTC), United Healthcare, GuildNet
Nassau	Elderserve, GuildNet, Fidelis, VNS Choice, Senior Health Partners, Centerlight, Homefirst (Elderplan), HIP
Suffolk	Elderserve, GuildNet, Fidelis, Centerlight, VNS Choice, HIP
Westchester	Centerlight, Elderserve, Fidelis, Homefirst (Elderplan), HHH Choices, VNS Choice, HIP, GuildNet, HIP

- Passive enrollment.** NYSDOH stated they want every dual eligible individual to have the opportunity to participate in a FIDA plan but will not be requiring that they do so. If a plan has an MLTC or a MAP and not a FIDA option, members will not be passively enrolled in FIDA. Mary Wehrberger stated that she believes that if a plan has a PACE program that the dual have the option to enroll in PACE and not FIDA if the member chooses. Joe Baker and Rose Duhan both supported that concept. A suggestion was made that for FIDA there be a similar process to MLTC auto-assignment. NYSDOH stated that in addition to choice prior to assignment, as in the existing system FIDA will have no lock-in. There is another workgroup that is also addressing enrollment issues.
- Other questions/clarifications.** One participant asked if there were any plans to expand beyond the eight county FIDA area after the demonstration project is over. NYSDOH stated not at the moment, since the current demonstration is a three year project. The goal of the demonstration is to improve care and quality as well as save costs related to unnecessary hospitalizations and institutional services, which will all be evaluated during the demonstration. Another participant asked if there was any sense of what services a plan would provide as part of FIDA that would be beyond State MLTC requirements and Medicare requirements. NYSDOH stated that it was not certain yet, but anticipated there will be some. The three way contract between the plan, NYS, and CMS will ultimately lay out these requirements so plans would have clear information in order to decide whether or not to participate in FIDA.

Level Set

Patient-Centered Care. Carla Williams (NYSDOH) provided an overview of the terms and conditions of MLTC for patient centered planning (relevant section found at the end of this document). It was noted that FIDA is fundamentally not much different but there is additional emphasis on certain components, especially documentation of patient centered care.

Andrew Koski noted that person-centered focus is a whole new way of care planning and asked if there was something plans are doing now to build toward or execute these functions. Mary Wehrberger stated that PACE programs have this established. PACE programs have a very collaborative care planning and management process with patients, especially with engaging family members in care if person is unable (ex. offer the opportunity for telephonic/in-person meetings). PACE programs have established documentation processes as well. Expectations are established in the PACE contract.

Quality Measures. Raina Josberger (NYSDOH) provided an overview of relevant components of the 1115 Waiver and State data sources that can be used to measure quality (OHIP Data Mart, SAAM, bi-annual satisfaction survey, etc.). It was noted that the State data could be used in conjunction with NCQA and/or other measures. The idea would be that the State will compile data for as many measures as possible to minimize burden on plans.

Workgroup members then discussed quality measures related to:

- **Patient's level of involvement/satisfaction with the care planning process.** Leah Farrell mentioned that CARF (formerly the Commission on Accreditation of Rehabilitation Facilities) has a measure that might be worthwhile to consider that assesses the "degree of active participation" of patients in their care. It is unknown how this measure would be assessed. The citation to the quality measure regarding an individual's degree of participation with their person-centered service plan: *Measuring Healthcare Quality for the Dual Eligible Beneficiary Population*, Final Report to HHS, June 2012 - **Appendix H, page 83**. (Source - Commission on Accreditation of Rehabilitation Facilities.) The link to access is:

http://www.qualityforum.org/Setting_Priorities/Partnership/Duals_Workgroup/Dual_Eligible_Beneficiaries_Workgroup.aspx
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- **NCQA.** Joe Baker had a call scheduled with NCQA on September 24 to follow up on the new measures they are releasing January 1, 2013. Joe will ask NCQA if it is OK to circulate to the workgroup an NCQA slide presentation with an outline of the measures.

- **Measures focusing on members transitioning between plans.** Andrew Koski mentioned that this might be beneficial. NYSDOH mentioned that in the MLTC terms and conditions there is a measure for transition of care specific to service hour changes.
- **CAHPS survey.** NYSDOH mentioned that the plan would be to administer a CAHPS or CAHPS -modified survey. It is possible that members (especially if they are in a smaller plan) would get two surveys to complete—a CAHPS survey and a NYSDOH MLTC survey. One participant mentioned that the CAHPS survey is on a contract/organizational level, not a product level. NYSDOH has verified that the CAHPS survey is on a product level.
- **Measures specific to care coordination.** Deb LeBarron stated that since care coordination is an important component of FIDA, the workgroup should closely consider these measures. NYSDOH mentioned that NQF has some relevant measures and asked the workgroup to suggest which ones they would recommend to include. Elisabeth Benjamin mentioned that there was a Medicaid Managed Care workgroup (not MRT-related) run by Foster Gesten at NYS a few years ago where plans weighed in on measures that might be relevant to care coordination and recommended that the workgroup try and obtain the final outcome/summary from that workgroup. NYSDOH said they would follow up to obtain the document.
- **UAS-NY.** Eva Eng asked if the move toward UAS-NY offers any potential to consider different measures or data. NYSDOH mentioned that UAS-NY will be more robust but will take time to evaluate and validate the dataset for use. It will likely be three years until it could be used so it is not really a viable option to change existing measures. UAS-NY has been cross-walked to SAAM so existing measures are assured.
- **Short-term vs. longitudinal measures.** Elisabeth Benjamin suggested that the workgroup consider that some measures are short term while others are long term (e.g., won't evaluate unless someone is in continuous care for a year or more). NYSDOH stated that the measures currently under consideration fall into both categories (e.g., some of the NCQA measures a person must be in continuous care for two years minimum).
- **Number and weighting of measures.** Leah Farrell asked if there was any discussion regarding the number of quality of measures. NYSDOH mentioned that MA has 70+ measures, many of which are CMS core measures for Medicare, and that the workgroup should look at that and provide recommendations. Hany Abdelaal thought the workgroup should consider if there would be any weighting of measures, stating that some of the MA measures were not appropriate to the FIDA population.

Wrap up

- NYSDOH stated they would work to facilitate that the workgroup members get copies of the meeting summaries from the other workgroups, either by email or through the MRT website.
- Another participant mentioned that there was also an MRT-related complex Medicaid beneficiaries meeting run by Foster Gesten in July 2012 and asked that NYSDOH follow up to see if there is any relevant information for the workgroup.