Okay, good after; well is it good morning or good afternoon? I'm not sure.

It's still morning.

It's still morning. It's a long day. Good morning, everyone. This is Andrew Segal, the Director of the Division of Long Term Care. We have, I see quite a number of people, attendees on the webinar, and we thank those of you who could make it today in person. We're happy you could all gather here today. This is the 4th in a series of meetings that you all know we've been having, in which we hope to continue the conversation and to engage with all the stakeholders on the future of integrated care in New York State and kind of begin envisioning together collaboratively what the best vehicle is to deliver the care that's necessary that's both high in quality and that is cost effective. So as you know we are meeting these sessions to gather feedback from our MLTC, MAP, FIDA and PACE plans as well as providers, members, and stakeholders, and to that end I can say definitively that we've been very very happy with the amount of engagement we've had so far, and we appreciate everyone continuing to engage. Our kick-off meeting in July had about 80 people make the trip to New York to attend in person, and the webinar had 376 callers, so a little bit less today, but we continue to appreciate all the engagement we've had during the meetings and after the meetings as well. We've maintained a pretty high level of participation and a lot of feedback since the last meeting as well. So the whole purpose of this planning process, as you know, is to begin to plan and to prepare for the complexities that we see in the dual population of providing high quality, comprehensive care to our highest cost, highest needs individuals in Medicare and Medicaid, and

we think by having this approach we can really move the needle and create maximum impact on health outcomes, and we've heard a lot of great success stories for this population in other programs, and we think there continues to be a value-based argument for outcomes and for cost efficiency and as well as overall satisfaction, and we're hoping to achieve those in whatever the future vision will be. As you know, managing and coordinating the delivery of care for dual-eligibles has become a central focus of the state. Health of our, because of the federal healthcare reforms too, and I think there's a recognition in all the great work that we do at the state level sharing in the cost savings and with the fed and on the Medicare side in this population which represents, really accounts for a disproportionate share of long-term care costs. It represents some of the most vulnerable folks confronting both economic and health complexities, so continues to be a central focus of the state reform efforts in thinking about next steps and engagement and planning for what the future model looks like. In addition, there are challenges that we are faced in efforts to best serve this population. As you all know and experience every day in the work that you do, and there are some of the topics that we've already covered and we'll continue to talk about, which include retaining sufficient networks statewide, creating and supporting incentives to provide integrated care, offering the highest quality of care that is both _____ and community-based which is something we all strive to do every day in our work, organizing and maintaining necessary resources to deliver care, workforce challenges we all face, and creating quality metrics of performance-based incentives for an integrated product that really are all inclusive and that take into account all aspects of the care model. We really think that, you know, better coordination of care I think should be clear through today's conversation and through this whole stakeholder approach and the amount of time that we put into this that we think better coordination of care and services between Medicare and Medicaid hold significant promise in terms of being able

to improve the lives of millions of New Yorkers, and we've seen that through some of our integrated models already in the state and our FIDA demonstration, and this is, you know, that's paramount as to why we continue to move through this process. So I'd like to thank you all just very much again for being here today and for attending via our webinar or in person. I'd like to welcome all of our managed care plans and participating providers and stakeholders who are here in person or on the phone. I'd also like to thank our partners in integration from CMS: Melissa Sealy, Toby Oliver and Jessica May. Thank you so much for being here, Melissa. And our team from DOH is here today: Joe Shung, Melissa Halperin, Renee Lebrit, Madeline Royale, Patrick Cuccinelli, and Frances _____. And also the folks from the Department of Finance who have come here: Jack Sitera and Ranetta Robison and Ross Boyd. We appreciate you being here today as well. So without further ado, we will proceed with the slide decks. That was next on the agenda? Okay, or the overview of the process?

_____ yeah.

Okay, so today we have our meeting materials. We're gonna further discuss draft language. We have various topics we're gonna cover today, including payment and rate considerations, outreach, education and engagement of participants and providers. We're gonna have a small discussion about MCO plan requirements and qualifications, and then we're going to end with a discussion on enrollment. We will have a followup period for questions, and we will have followup. We expect to have it after the meeting in terms of, you know, getting further feedback from folks. Don't have an opportunity to participate on the phone today? You can always write in to us with our BML and we will continue to evaluate all the input that we receive from today's webinar and on an ongoing basis, and so that will be the process today, and again we thank the Finance folks for being here and having a discussion.

The next spot that we're going through is; thank you, Andrew. Madeline Royale is just going to provide an overview of the session that we had last month, October 16th, and some of the feedback that we received where many people have submitted their questions and further response to the BML. Madeline

Good morning. Can everybody hear me okay? Okay, alright, so we've been getting some really great feedback and we do want to encourage you to continue to submit your written feedback to the Future of Integrated Care BML as this is the platform to get specific suggestions to us and so that we can review and keep an eye on. As you know, with each session, there's a _____ series of questions relative to the topics to be discussed. That was included in the Excel template that we sent out. Topics discussed in our last meeting held October 16th were: Participant Rights and Protections, Marketing Rules and Flexibility, Quality Standards and Measures, and _____ Provider Networks. So for Provider Rights and Protections section, generally commenters agreed with and were supportive of the discussion and draft language that we had distributed for that. However, there was a consistency in suggestions of a more cohesive approach among all parties, including grievance and appeal processes that would include _____ the plan and administrative law judges. Comments also suggested adding language through annual member rights notices that speak to sexual orientation, gender identity, and a statement for people with cognitive limitations to have rights for additional time for their appointments. Stakeholders agreed with requirements maintaining participant advisor committee. However, they would like to see some more flexibility in their plan requirement and suggested perhaps meeting semi-annually. So on to Marketing Rules and Flexibility, comments reflected a response suggesting a more inclusive approach for cultural awareness and diversity to marketing materials. For example, many of you felt as

though marketing materials should be sensitive to cultural or language differences especially those individuals whose language is not, that English was not their primary language. Support of a more united and streamlined state and federal review and approval process for marketing materials, so in other words, we want to see one review by both parties as well as a more defined approval timeline for the process. Last for the marketing section, commenters supported using translation requirements similar to the newly implemented vitals translation requirements, provider primary. With regard to Quality Standards and Measures, commenters recommended that quality assurance requirements be aligned with the requirements of EDP that are already in place. Concerns that were voiced about the high volume of reporting on quality measures encouraged DOH through CMS to develop a set of quality measures that enable plans to focus their efforts on acute, or achieving sustainable quality improvement. There were also recommendations of consolidation to the DOH and CMS measures, and we received several recommendations that enhance administrative efficiencies between Medicare and Medicaid, reporting requirements, 3 of which included standardized QIP and PCIP, integrative reporting processes in CMS and DOH, and consolidation of the DOH and CMS satisfaction surveys. So now this final topic was on Provider Networks, so I just ask, just bear with me a few minutes, as this was by far the most ____. So we asked a series of questions that solicited feedback around language relative to provider network standards, rules around provider choice, access to out of network providers, and travel standards. So there was a consensus that overall agreed with the draft discussion. However, commenters recommended flexibility on minimum network standard requirements based on population being serviced, population size, the county and provider availability. Commenters also recommended inclusion of telehealth services in provider network requirements and greater consistency between Medicaid and Medicare, so requirements around that. Also recommended was implementing a more streamlined provider

network submission, opposed to the separate Medicare and Medicaid submissions, as well as the need for a provider directory and collection requirements currently _____ FIDA. With regard to provider training, commenters questioned that training requirements for providers might turn providers away similar to how it's been with the original provider training requirements in FIDA, and it contributed to a low provider engagement participation in FIDA, so we're looking at that. We were urged to provide regulatory relief for home health agencies when contracting with fully integrated managed care plans, and lastly we were advised that DOH and CMS solicit feedback directly from the provider representatives for their input and the nature of the requirements to complete provider training. So this concludes my summary of the comments from October 16th. We really just thank you all for your thoughtful and insightful comments and just really want to encourage you to continue to submit to the BML. So without further ado, we have _____

We have Jessica on the phone from CMS?

Well, yeah.

Renee and Jack here and Ranetta as well.

Yeah, I guess before I hand it over to Jessica, I'd just like to say you'll notice in the finance section all of our points are ending with question marks, and there's a, that's intentional. We are here today really to hopefully engage the community, providers and plans in a dialog as to what you're seeing in the finance section, what would be helpful, what is difficult, and hopefully we can sort of all work through those issues together and have a meaningful discussion on the matter. I think we can turn it over to Jessica May at CMS first to talk about some of the payment and rate considerations for Medicare.

Great. Hi, everyone. This is Jessica May from CMS. I'm dialing in remotely, so I want to make sure that everyone can hear me alright?

Yep, we can hear you.

Okay, great, thanks. Just as some background, I work at Medicare/Medicaid coordination office at CMS and primarily focus on rate setting and finance issues both related to the financial alignment demonstration as well as more broadly for dual-eligible beneficiaries across Medicare and Medicaid. So on the slide deck you'll see 3 kind of relatively high-level questions that we put together pertaining to the Medicare side of the rates that we wanted to put on the table to get input on this morning. Accompanying, one of the accompanying documents that you should have is a chart that lays out at a high level kind of the rate parameters across Medicare parts A and B, Medicare part D and Medicaid just to kind of put on paper what some of the most significant differences in how we set rates or finance the programs are, since I know a lot of the discussion we've always had on the Medicare side relates to some of the differences. I'm not gonna go through that document line by line, but obviously happy to take any questions that folks have on that, but thought we could get started with kind of, you know, the first question on the slide and kind of talk about that, but obviously any other input on anything related to Medicare rates and financing, please jump in, and Frances and others in the room, I don't know if it would be helpful for folks when they provide input to identify kind of the name and organization just since I don't know who is on, who is there in person in the room.

Gotcha, okay. So anyone that when they have a question or comment, just please make sure you say your name and what agency

you're from or plan or if you're a stakeholder, and so Jessica can know.

Great, that would be helpful. So I'll just kind of start with this first question. This is a very big one, but when we're thinking about how, you know, various options for structuring the Medicare rates, one of the big, one of the big differences between FIDA and what we see in kind of MAP combined with traditional MA plans is kind of how the rates are set, and so in FIDA, CMS sets the rates. There are a number of parameters that we use. It's billed off of Medicare fee-for-service cost and Medicare Advantage rates, but it's a plan set by CMS that is specific to each county. Whereas the more traditional Medicare Advantage structure has benchmarks or projected costs that plans bid against and it's really a plan kind of plan-specific rate versus rates set by CMS. I think that's the first kind of high-level question we wanted to see what folks thoughts are on that kind of general rate-setting parameter and some of the considerations we all should be thinking about in that regard.

So this is David Wagner from Elderplan. We have both a Medicare contract that we do bid on and we have as well a FIDA product, and our MAP product is in our contract with the current bid structure, so I guess we have experience on both sides. I would actually ask a couple of questions before I guess my comments or my suggestion would be, which is first, a bid process takes into account sort of, we have a current state of, or the prior year's costs and information that rolls through for a prior period and then you project out to the bid year based off of those costs. What would be the process or inspire a new program to start bidding? That would be sort of my first question. Second question alongside that would be, is this going to be an exclusive contract the way that FIDA is where you don't have other types of products within? Because when you bid and you have other products within, there's sort of a lot of information that goes

one product within another product and another product, and it all rolls up into a, into 1 bid. If this is 1 product standalone on its own, it might be a little bit different than if you have other products within there. And lastly, if this; I know I posed the question in the past, but I haven't really gotten an answer. Is this going to be a program that is a 3-way contract with the state, or is it a separate 2-step contract the way MAP is where you have a contract with the state and you have a contract with CMS? And I've asked that question because the bid process is one of the plans with CMS and there's no involvement from the DOH side, and I think that actually does play into within the way that the contract is written if we were to go over to a bid process though. I asked a lot of questions in there, but

Sure, and I'll invite others in the room to jump in as well, but I think I have probably some high-level answers to some of those, but I think many of those kinda get at questions that we're still working through as part of the process about figuring out what should this look like? So regarding your first question, at this point at least, I think if we were to envision, if we kind of determined collectively that going in the direction on the Medicare side of bidding and kind of more similar to what happens in traditional Medicare Advantage, just given the infrastructure and the kind of time that it has taken to get that in place more generally for MA, I don't know that we had envisioned kind of a separate setting of benchmarks or a separate bidding process different from what happens in the Medicare Advantage world. I think if we, if there was interest in going in that direction, you know, there's certainly advantages and disadvantages, but advantages in terms of timing and, you know, resources to using or building upon the existing structure. On your second and third questions around whether we were envisioning it being kind of a separate contract or kind of folded in with other contracts that you might hold in the Medicare world, and whether this would be a 3-way

contract like currently exists in FIDA or something more similar to kinda of what happens in the FIDA _____ world where there are separate contracts interstated with CMS, others in the room please weigh in, but my understanding is that's still kind of part of the, part of what we're trying to think through here, and we haven't made a decision on that at this point.

Yeah, but do you see pros and cons? I mean

I do.

Do you want to talk about some of those?

I do. If _____. Like I said, we do the bid process and there, as was said on the phone, there are positives and negatives there, and my recommendation actually would be probably to lean towards the bidding process, because that sort of brings you into really what Medicare Advantage and what's done around the country and what's generally done, but while saying that, I think a 3-way contract complicates it. I really do. I think that the way that FIDA is set up, or I'm sorry, that MAP FIDE SNP is set up right now with separate contracts lends you to be able to go through the bidding process in the traditional Medicare Advantage bidding process way. With the 3-way contract, if there are pieces to the Medicaid side that overlap with the Medicare side, it's gonna be very hard to parse that out, especially if you have it within a contract with other products that might layer themselves in there, which also I think is not a bad idea. I don't think it, right now FIDA is a separate contract because it's a 3-way contract. I think if you had it as a 2 separate contracts with 1 with CMS and 1 with the state, you might be able to, you might be able to bring other products in which actually can help the bidding process in itself. So that would be a recommendation.

_____

Do others have any thoughts about that?

Thank you, David. That's very helpful.

This is Melissa Sealy from CMS. Just to kind of ask for a little bit more clarification, would you, in that _____, would you suggest that there be one, that the future of integrated care products be folded into an existing contract number like you have with your other D-SNP products? Is that _____

Well, not all plans, not all plans have other contracts, but right now, we have a separate contract for FIDA, which if and when FIDA ceases to exist, I would imagine that contract either shuts or closes and then the product, whatever we call future of integrated care, will need to either be layered in to a current contract or get its own contract, but within that own contract, you can make that contract one of two ways. You can make it the way in currently stands, and if by chance, so Elderplan, I can only speak for ourselves. Elderplan has a contract. So we might have the option of taking future of integrated care and putting it into our current contract, but then that would be one complete bid process. I mean, for us to have to do multiple bids, it takes time, it takes administrative costs, it takes a lot of, you know, a lot of pieces to it. There's a lot of pieces to it. So if we had the ability to layer it in, you might want to do it that way. You might not, because there are other pieces that might complicate it when you have a straight Medicare Advantage and you have a D-SNP or you have, you know, other products within your contract. It also lends to, I know this is not a quality compensation, but it does lend itself when you talk about contracts to Stars and what your conditions are on Star basis if you layer it into a current contract with other products and/or you have it has a separate contract because and don't let

other products in. So it's not just a finance question or a bid question. It actually is something that I brought up I think even at the first meeting of this, because it's so basic to know whether this is a 3-way contract, separate contract, if you're going to be bidding or if you're not going to be bidding.

Thanks, and I think there's also in that more impact in the way that _____

Sure, absolutely.

Separately or through one contract.

Sure. That's why it layers to all of those things that was, you know, when you started.

So David, that proposal, are you precluding then the idea for _____?

Not necessarily. I didn't really actually propose anything. I just threw it out there and

I'm sorry to accuse you of that.

As a question to everyone here and to the department, because it really is a very high-level basic question that has to be answered, because as you get into a lot of this, it affects so many different pieces of what we're trying to do here.

Do you see 2 separate contracts _____ or 1 single _____?

Sure, why not. _____ I don't think you're precluded from that.

Or wouldn’t that complicate the delivery of care and the product?

It could. It could, but again, how are you, how are you structuring your monthly payments and with whom?

That’s true.

It’s not just about the contract or the bid. It’s about who are you bundling your payment with and how do you structure the bundle? It doesn’t necessarily preclude you from doing it that way.

But with that, that makes things like streamlining appeals _____ I think it would complicate all the other mechanisms _____ separate contracts.

We do it now with MAP. It doesn’t complicate things at all.

No, you’re right, you’re right.

FIDA is much more complicated than MAP is.

So would folks like to see more of kind of like a road to something that would merit some interest in seeing what this would look like or kinda going down that road of looking at some of the pros and cons at least of, you know, bid not bid, 3-way contract or a 3-way agreement and trying to kind of parse that out? I mean, I’d be interested in hearing what others; I know we may not have the time now where if others don’t feel comfortable on the phone, just hearing from you about kind of what your thoughts are on this, whether you’re kind of in agreement with David or disagree or you have other thoughts about it. I think that would be helpful for us. Yes, Judy?

I think if it's laid out perhaps a different contract process within _____ laid out, I think stakeholders would have more of a, you know, input on which process might make more sense. So if the current process _____, what's the future look like?

Well, you might want to do current process in MAP which is great, current process in FIDA, 3-way contract in another, pros and cons of each, and then try to _____

There is a document that I believe was circulated that sort of lays out _____

Did everyone get this document that we're referring to? The title is, Potential Payment Parameters for discussion purposes only. _____

I'm not sure if there is any particular areas you're looking for elaboration or more detail on, but

Yeah, no, _____. It did teach the; bid versus not bid is a question in here, but it doesn't talk about 3-way contracts versus separate contracts.

Is there another comment in the back?

Yeah. My name is Sherry Wolfe and I'm from a PACE program here in _____. I'm kinda new to the payment and rate setting discussion, but wondering if part of this discussion is looking at or getting more clarification as to the methodology of the Medicare savings piece of how the rate is calculated, giving us a way to prepare for _____.

Hi, this is Jessica May at CMS. I think I heard your question.

So I think that was getting at what we, how we are evaluating or how we would approach kind of the savings that's current built into the FIDA rates, or are you, or kind of on the PACE side? I'm not sure I heard your question fully.

Just looking for sort of a clarification to the methodology used, as they do our rates, but there's that piece of the Medicare savings or sort of claw-back.

Are you referring to _____?

PACE, which is a 3-way contract.

We were having a little conversation over here on the side. The questions we're trying to wave back and forth is administrative _____. We're doing separate bids and 2 separate contracts versus combining things together. I think one of the lessons we've learned from FIDA is there is, we've had a lot of hassles with a lot of the nuances of _____ things that were put in, whether it's reporting, whether we're _____ meetings, whether it was _____ administrative function. So there were certain benefits by having everything streamlined. So I'm not saying bid, no bid. There's advantages of bid that you look to manage your own product a little bit more. You have that advantage there, but the challenge of having more administration versus coming; ultimately, we're trying to come up with plans that will improve outcomes and cost less money. From what I'm hearing through these meetings and even some of _____ processes, we need to find ways to bring overall administrative costs down if we're going to see any sort of savings. So if there's anything that's going to cause more administrative hassles, like I'm hearing a lot of things that sound like great ideas, but there's cost to them. We all want _____ but we don't necessarily need it to get to work.

Unless you have a car and bid, then it’s _____

Sure it is.

Not much.

_____ This is actually a very important point.

But if this is the contract, _____. The bid itself might be _____ extra experience of the product. It still, it’s still you’re separating trying to use a; little bit of a hassle to get the overlapping Medicaid and Medicare benefits, _____ you don’t really have that as much.

You have that right now in MAP. But you did bring up a good point in the fact, I would put this in the positive on the bid side, which is you can create your own product supplemental benefit, and right now, you know, if you meet with a provider or you meet with, you know, a group, all FIDA plans and you get the same benefit, you’re pretty much the same, so what is the, you know, there’s gotta be some type of, or I imagine you would want some type of competitiveness in it so a member actually has something to look at to say oh, what benefits am I getting from this plan? What about this plan? What about this plan? You don’t get that in the current FIDA structure, but in the bid process, you have all these other pieces to it that layer in that give either an advantage to one or maybe not such an advantage in another. It also can lead to a plan being able to deal with its financial bottom line better, because you, if you’re not happy with, you know, where your financial bottom line is one year and its fixed within the bid structure, you eliminate certain benefits, you might not be able to grow as much, you might lose membership, but you can control your bottom line a little bit better than when you don’t have the ability, because FIDA

is, you know _____

But that also makes, that state has to agree that certain benefits are not going to be mandatory.

_____ contract. You look either way. _____ we're gonna have that flexibility to have some of the ability to carve or reduce or _____

_____ it's a severable issue from 2 contracts versus _____

Right, but _____ manage right now, because also like not prohibiting us from doing certain things too.

Right, right.

But that's what, that's what MAP is right now. I mean, we have a; there is a current product that has all of what I'm talking about on the bid side.

But on the bid side, it focuses on the Medicare component and you have to like incorporate the Medicaid. If this is an integrated product, the bid would have to like _____

That's _____ integrated product.

No, I understand, but they don't consider all of the Medicaid products. You have to roll that in.

_____

So I mean, I agree with Steve that it would be administrative _____. Some, I mean, they would obviously have to _____ but

Well, but _____, so David's assertion is there is a bit of flexibility, right, in the bid process where you can control you bottom line cost and you can create kind of

_____

A little bit. And you have product diversification in terms of differentiating from the plan member's perspective, right, but then there's the admin cost, right? So how do we all value the admin cost associated with, you know, that extra bidding process, and does that outweigh any savings that you might be able to generate from managing the bottom line? Do others have thoughts on this?

Well, okay. We also need to encourage the state not to do things like in the past, say well you can't give out extra benefits, and so the plans not only, not only is the floor a little different, but then in some ways the ceiling is a little different so that we're not prohibited from doing a number of activities so that there, the product diversification can be real, actually very real for the consumer.

Okay, so Matt's saying, suggesting that, you know, we should take into consideration what's mandated and what's not, right?

Right, and what's prohibited.

And what's prohibited, okay. I think, my comment is, it was not really specific to the bid. I think even to 3-way contract versus 2 separate contracts, every little component is initiated, is administrative expenses. Whether it means having constant meetings, whether it just focusing and working with contract, with you know 2 separate contracts is the additional burden for each of these. Every

single thing I think the goal here is, I think is we should be looking at applying things to make it easier for the plan, the state, CMS, and the member. _____ simplicity will make things more compact for them as well.

On that note, what becomes clear is that administration simplification is something that folks would like to see, and I think we can have that as an, you know, as we look to, you know, some of the, and maybe it'd be helpful to kind of bucket some of these things that folks really want to keep, you know, I think are part of an ongoing dialog, and that might be one of them, just kind of big headline themes on how we kind of can consider _____ the conversation forward in my mind; that's definitely one of them.

Jessica?

Should we move, are you still there?

Should we move to the next question?

Yes guys, it's Jessica. I can hear folks that are close to the speaker but not everyone in the room, so my apologies.

Okay.

And I think a lot of what we just, what was just addressed, kind of of that second question around supplemental benefits and kind of; there's obviously a lot more _____ at least the current bidding structure works and what the benchmarks are, but that's, you know, that explicit ability as rebate dollars kind of certainly is different in MAP and MA generally right now as compared to FIDA. The last question that we had on our list that we wanted to make sure we had an opportunity to get info on today is one I know has been a

topic of discussion as pertains to FIDA since probably the beginning of the demonstration around risk adjustment and frailty and, you know, if we certainly have another perspective from the plan side about the importance of using the frailty adjustments where possible if we were to stick with kind of the current risk adjustment model, but wanted to make sure that we had an opportunity to get kind of any other input on that issue in particular or risk adjustment more generally before we move on to the Medicaid side of things.

I don’t think you’re obviously gonna hear any perspective from anybody that we don’t think the frailty package should be in there.

(laughter)

But I think you’d get complete agreement in that, but I’m just part of, and I know certain other plans in the room have been part of on a national sort of debate over whether and through our associations on the Medicare side with CMS over the fact that the frailty factor should not be applied the way it’s applied, you know, to a specific product. If a member, doesn’t matter what product they’re in, whether it’s D-SNP or whether it’s, you know, whatever product, if they meet the qualifications for frailty, it should be on a member-by-member basis. If they meet the qualifications for frailty stature, then you should be receiving the plan, should be receiving the frailty factor attached to that member, because in general, risk scores on the Medicare side are member-by-member anyway. So our argument has been through our associations with CMS, and there has been quite a debate on it, that a member if they quality, why if you qualify in MAP, because MAP does have a frailty factor adjustment within the MAP product, to the exact same member in a D-SNP, why are you not eligible for frailty factor? If you’re eligible for frailty, you’re eligible for frailty. _____ same thing, the member is eligible, the plan should receive the _____.

In that discussion with CMS, have you, and I don't know in the weeds of this, but have you had the discussion about where CMS does and doesn't have the legal authority to apply the frailty adjustment?

I don't know about the legal authority to apply it or not to apply it. This is more of a conceptual thought or conversation among it, because there's no question things would have to be changed on it from a legal basis, but it's really conceptually, you know, if a member is eligible in one product, why does the plan have to have that member move into that product so they could receive the frailty factor? If they're eligible, they're eligible.

Yeah, and I think that gets at what, you know, kind of what frailty is intended to reflect and that is kind of the, you know, the residual or what's not explained in terms of anticipated costs by the risk adjustment model. One thing that I just wanted to note that kind of relates to what you just raised but also kind of some of the, you know, broader discussion about the population could be considered as part of kind of moving forward is at least within the current, the current, what's currently available for frailty, and folks that know this from their plans can correct me if I'm wrong, but there needs to be a certain concentration of individuals that meet the frailty criteria within a plan for a plan to kind of meet the level of frailty to add that to payment, so I think that's something to think about in the context of both what you had just raised about an individual kind of level of frailty as well as if there is a material kind of number of more kind of community well that might refer to them individuals that kind of are part of a target population, what that means in terms of a plan's ability to get the frailty adjustment under the current frailty parameters.

I'm pretty sure that the major criteria is over 65 and that you

meet at least, I think it's 4 or 6 ADLs, where if you look at the population that's in FIDA now, that's in MAP or anyone who's gonna quality for a CBLTC service generally is going to qualify for the frailty package. Not always. I might have missed a couple of other qualifications, but those are the major pieces to it.

Yeah, I think it just gets to, kind of looks at the proportion of respondents on each plan that have those ADL limitations and there's a calculation behind that. That has to kind of get to a certain level that exceeds the average level of frailty for PACE plans, and so my only point was if you're, if you have a lot of members or a lot of respondents who don't have ADL limitations, then that kind of can change the calculation and so I think the potential to get frailty.

So basically, you're saying that there's very little gap between the base requirements for them to qualify for the plan and almost any _____ the state requires should be in the frailty fact, should have frailty.

If you include _____, if you include _____ like people who aren't eligible for _____

Yes, but _____, you have to be dual, I mean partial duals _____.

Right, then you also have the under 65 community that was not eligible either. So it's not 100% that matches up, but I'm saying that generally most of the members aren't, if they're in an MLTCP right now are going to be eligible for the frailty factor if they were to choose to go into a product like that.

Okay, but let's go back a second. So you're talking about a _____ definition of frailty factor, but you're, but in essence you're

saying, right, I think we're all saying is that anybody who is in _____ services should, does need an extra boost regarding _____ factor, call it whatever you want, call it the integrated plan boost, whatever you want, they need a boost on their medical, on their Medicare expenses as well. So if you move away from the named frailty factors such as _____ for this discussion, but the problem is that's where; I think what you're saying is that current Medicare rate would not _____ fund this _____ population.

What I'm saying is the reason used when it comes to CMS, you need to work within their parameters _____. Frailty factor is that adjustment, so that's why we just use that term, but to your point 100%. You're right on target. Most of these members are gonna need from the Medicare side a boost to the risks for what the frailty factor adds

But you're missing that half the people who are not getting that boost that need that boost as well, because they are LDSS population.

There was a comment on this that came in from one of the webinar listeners, John Shaw. Is says: The majority of home and community-based services and support time is provided by informal family caregivers. This is a lower cost alternative to paid care. Education and support of the informal caregiver is key to member health. Should this education and support be a formal supplemental benefit considered transparently? At a minimum, access to an informal caregiver versus living alone should be a consideration of risk adjusting for frailty.

What do folks think about that?

CMS _____

(laughter)

I'm sorry. This is Jessica. I'm happy to jump in. I wasn't sure if that's what you were asking though.

Yeah, if you have a comment, go ahead. I was just reading what one of the

Sure.

One of the callers.

So I think the; just as context, the structure we have right now for frailty and for risk adjustment more generally is kind of a regression model where various demographic and health status factors and then ADL limitations are regressed against cost to come up with either risk adjustment or frailty factors that, you know, do the best job of explaining the projected costs for beneficiaries. So there's always certainly opportunity to think about kind of what other factors, you know, might be something that kind of this interest in discussion around consideration of in the risk model. It's just gonna be; we have a challenge of, this is a risk model that we use kind of across the board for every MA beneficiary in the country and whether there's kind of sufficient; one of the questions though is kind of, is there is sufficient and robust enough data on a particular criteria to kind of include in and leave out for the purposes of a regression model _____ risk adjustment _____ too much, but that's just something that we always try to think about when there are some other factors that we might want to explore further in terms of whether they better predict cost in the risk adjustment system.

In terms of just kind of additional benefits, yeah, I think a

lot of that on how the contract, how the contract is structured. In the Medicare Advantage world, when we think about supplemental benefits, there's kind of a very limited defined number of services that fall under that, under kind of the MA regulations, but that's not to say that those are not services that, you know, plan _____ kind of what's the appropriate vehicle and the authority for providing that sort of thing.

I think there might; thank you, Jessica. I think there might be a broader question within this question here, right, online which is, you know, the role of caregiver support in all of our long-term care models, and are there unused home caregiver support, caregiver support that we can better account for in a model going forward, and how do we do that and what role does that play in how, you know, we look at _____ cases and how personal care benefit. I don't know if folks want to explore that in another conversation. That might be something interesting to talk about, or untapped caregiver support.

I'm just not sure how

Not necessarily related to frailty.

No, no, no, forget frailty _____. We're talking so far on the Medicare side. Even that comment was more on the Medicare side. I'm not sure how the caregiver support in any way would adjust up or down the mechanisms for risk score adjustment member by member within the Medicare system. Medicare system risk score adjusts by diagnoses, by submission of data and by certain very specific criteria that creates a buildup of a risk score. You know, if an individual has whatever they, I don't know, whatever factors that they have, I don't see how a caregiver is going to change whether a person has CHF or not, or whatever they might have, that risk adjustment to the Medicare side is not really adjusted by what the caregiver can or cannot do.

Okay. Let's continue to move on. There are bullet points. Jessica, do you want to keep going, or did we cover that already?

I think we kinda covered it.

Covered it, okay.

I think we covered it.

_____ on the Medicaid side now.

Alright, so this first bullet point here _____ so I'm probably setting myself up here, but part of the question here deals with adequacy of our rate structures, and I think, you know, I think when it comes to sort of the medical or the long-term care services support component to the rates, we're using our operating reports and any fee-for-service data, and you know I think you know we have a, we like to think we have a fairly decent handle on that. I think that issue really to come in, you know, program design and structure for administrative and care management components of rates, and you know I think to the extent that we believe that robust care management is actually driving quality and is driving efficiency, obviously it's in the department's best interest to be compensating for that appropriately, so you know the question really becomes then when we're looking at these different program design options, you know what really, what design options really work for the future of integrated care in New York? I think a lot of the care management is really sort of provided by giving people the opportunities to access their long-term care service and support that we think will eventually and should be able to drive savings and efficiencies in the acute care arena, and so I think when we look at our rate structures and we look at, you know, how we have, how we are

bifurcating or not or combining and streamlining the systems and contracts and then reimbursement that sort of becomes a question as to what is the appropriate approach. I know that we spoke earlier, some mentioning about savings, Medicare savings _____. I'm not that familiar with the base _____ program, but I know, you know, we're doing that on the FIDA side and, you know, that is sort of a representation of potential savings through care management of integrated care, but you know where do you put those investment dollars, and how do you see those coming in as savings in order to, you know, essentially fund that care management and administration appropriately?

So do you, are we in this conversation going under the current contracts in place versus what's just been put out there? Because the reimbursement system for that has not really been selfless, so when we talk about what's the next piece of future of integrated, so the Medicaid piece, I would assume we're talking about where we are today in reimbursement.

I think we were talking about what, where we are today and how that could be potentially improved for future integrated products.

But is it the department's idea right now _____ here _____ the program all within one rate, within one rate bill and then

To an extent. The long-term care service and support base has been

By far the most significant piece of rate.

By far the most significant piece, and that's why I'm saying when it comes to the sort of medical components of long-term care service and support specifically, I think there is sort of an

alignment and a structure there. I think of the additional services, I think of the care management, just sort of outside of that and is product dependent of it.

But the care management is all gonna depend on what you require within ratios, because we need to increase our staffing if you track the requirements on ratios. So if you put out there, it's a contract with a ratio, that is not what the current plan has and have to pay for it, and you're gonna have to increase the capitation. So it's currently, right now, I think FIDA is required at 1:100, something like that. _____ what's the requirement?

There aren't any requirements.

_____ no specific ratio, okay. If there is a requirement that for example was just put into the new contract at 1:175 care management ratio, and the average plan out there has an average ratio which is what's calculated in the current rate, have it rolled 2 years forward and rolled within the rate at 1:125, 1:150, whatever the current average is, you're gonna have to pay double for care management if you're gonna layer in a ratio.

And add in the multiple calls now needed, so also actual changes to the needed care management. It seems like there's a little bit if a disconnect between the sort of, you know, we have a larger deficit, we have to sort of start thinking about ways to attack that and then loading on a contract with a lot of new requirements that will have a huge impact on not just care management but administrative as well. When you were giving the updates in the last meeting, you discussed how even some of the requirements for providers were, you know, they have negative impacts _____ on networks, and now even this new contract brings in new requirements for providers about having to take certain preapproved trainings and stuff. I can't even beg

podiatrists to join my plan. Like forget about _____ like oh, and by the way, you have to check these things off, and that is more of an administrative burden in addition to that. Even the discharge planning that's going into this, things like if we needed visits, going to hospitals and that, that's fine, you know, I get why we want to do that, but all of that costs significant dollars, so there's definitely again seems to be this disconnect between the programmatic side and the financial side.

That's why I started with what contracts are we starting. You know, are we starting with the current contract that we're all living and breathing, or this new proposed thing that's going to cost a lot, a lot of additional funding or requirement.

I'm Emily from the Medicare Right Center, and I just wanted to tack onto those things. I think we do need to have a more realistic idea of what it takes to be a care manager in long-term care. Are they even, do they even have enough hours in the day to call everyone that they need to call and manage what they need to manage? And that's something that we hear from, you know, our work _____ with long-term care, and also having a break, a better understanding of the breakdown of what, where risk adjustment comes from would be interesting, considering we just hear from folks about how their care plans aren't completely transparent to that. So if we're relying on care plans and all these, you know, how does it affect the consumer, and it is actually ____ consumer's needs are, I think often needs to be explored further, so that's like a lower-level thing, but as far as care management goes, you know, we definitely need to take a step back and see if we are implementing ratios and all these other things, you know, what should the ratio be, and how much could a person handle if they're working with somebody who needs care, you know, can they adequately do that?

But whatever is implemented has to be paid for. That's the point.

And we're hearing when you were giving the review of all the previous meetings, all I heard was dollar signs, this cost more money, this cost more money, this cost more money, and if we're trying to have this plan _____, the whole point was to bring a vision to then bring down cost, but either you have financial efficiency or you have improved care. It's very hard to get both of them. _____ you know, you don't need that. People can be healthier with good adequate care. Goal here is, goal is to reduce costs _____ costs. The goal is to make everybody healthier. It's just there's a price tag _____, there's a price tag. You can't get both.

I also want to comment that like I agree with everything that's being said with care management, but with regard to some of the benefits that have no limitations, such as transportation, we're not being, the FIDA plans are not being compensated accordingly with the lack of criteria and, you know, limitation. Obviously, we want to keep the participant safe in the community and allow them to access community resources, etc., but you know some of the requests really have, you don't have a leg to stand on when you think about, does this meet the definition of a community _____? I'm all in favor of, you know, getting the member, you know, the psychosocial needs and whatever it is, but it needs to support the care plan in keeping them safe in the community, and clearly, you know, the FIDA plans are not being compensated accordingly.

_____

I just wanted to reiterate just with the commentary section. This is Madeline Royale speaking again. The _____ was an item that came up _____ (coughing) an opportunity for commentary there, so

please do go back to the BML. Any suggestions that you have, and a lot of like the commentary that was presented, this was based on the feedback that we received from you and suggestions that you had as far as what we can do to change or what this program should look like. So you know

I submitted my comments.

Yes.

_____ demonstration year 1, we saw like, I don't want to say abuse, but now that there's more awareness of the fringe benefits within the FIDA product, we're seeing higher utilization. I don't know if it's a direct effect of the DOH marketing campaign, but there's definitely an awareness. I mean, obviously when we have a new member, an existing member, we educate them on the whole package of the benefits.

And these are some of the details that we really would like to see in the comments. You know, we've had some of our regulars who comment and give us, you know, some of this (coughing) _____ to include these types of details so we can take that into consideration as we're moving forward.

And I just wanted to address one

_____ in the back that haven't commented yet.

_____ go ahead.

(laughter)

I just wanted to say, I see this as a value-based payment

discussion too. I mean, you know, you're talking about not being compensated adequately. The savings are supposed to come down the line. So that just points out why the insurance models have not worked for doing what we want to do. I mean, let's face it, you know, you're looking at a premium year or you're looking at somebody who can leave your plan before a premium year is even up, and your savings are down the line, and so all of you are like; I mean, the other thing you can do is try to keep your person and keep them with your plan and keep them healthy and alive with your plan, but yeah, it takes a longer term perspective and this model just doesn't work.

Can I, can I, I want to just sort of clarify what I'm hearing here. I mean, one thing is we're saying that the care management and how that gets paid for and the rate is really largely just a function of what the ratio is, and but I'm hearing, you know, obviously we have other components to it added at benefit, or requirements of the contract, which is _____ and things like that that can obviously complicate that factor, and we're saying also that the care management, you know, isn't even just meeting those ratios isn't necessarily adequate with how many hours are in the day for the care managers to really give the highest quality better care management that they might be looking for, but where I think I do struggle, and I'm interested in hearing input is, you know, those ratios are obviously they're limits, they're, you have to have at least this many care managers. They're not necessarily saying you can't opt to go above, so are we saying that we think in the framework of an integrated product that plans can't stand to garner efficiencies through greater investments in care management above and beyond what the requirements are and, you know, recoup those efficiencies down the line? And we think that it, really that can only drive higher quality but not quality that would turn into efficiencies or savings?

What type of efficiencies? You know, a lot of times I have

these discussions with others in the Department of Health that, you know, using the words driving efficiencies, but tell us what that means. What type of

Hospital, potentially, potentially avoidable complications in hospital admissions. _____ study just presented showing the return _____ because it's all theory and we're at risk for that. I mean, I'm not a clinical person. I'm asking the question of you folks who are in the industry. I mean, so we, you're saying that we don't feel that there is a benefit in terms of efficiency cost.

So that's; what you're talking about is VBP.

Yes.

It's VBP.

Yes, but well, VBP is just that requires a relationship with a provider downstream and contractual relationships.

But in the long run, what you're talking about in way of layering savings is really what driving towards _____ and the different layers of _____, because you have to have the relationship with providers. It's not just gonna be, it's not just happen because a care manager is constantly providing the care management component to reducing the hospitalization, so because no matter what, if the care manager is trying to do their job, if somebody is not in the home with the individual and the individual, something's wrong with them and they're scared or whatever, they're gonna call 9-1-1 while the care manager tries to stop, or tries not to stop but tries to coordinate care, you know, call the physician, call the you know, whatever they're gonna do, they're still gonna call 9-1-1 and have that hospitalization. You need the buy-in of the licensed agency

with the aide training and you need the physician or the PCP to be able to work together all as a group. It's not just the care management component that you're gonna be able to say you have care management and you're gonna be able to drive down hospitalization. It just doesn't work that way.

Yeah, I mean it's care management and administrative costs and technology infrastructure and establishing those lines of communication.

Right, but again let's get back to real numbers, because we're, I'm a finance person. I'm not a clinician either, but if you have a ratio, and I'm not saying that the ratio out there is 1:150 on the average versus 1:175 just to make the numbers even. If you have 50 care managers in a plan and they're at 1:150, you need to double that and have 100 care managers if you're gonna go to 1:175, and each care manager, down state New York is gonna cost close to, if not more than, $100,000. With loaded benefits, it's gonna be more than that. You're talking about a significant increase of cost. How many hospitalizations do you have to reduce to offset that cost? It's not gonna happen. I'm just playing numbers wise. And I'm not saying that it can't be done if you don't drive down possibly some costs, but when you just say efficiencies, you gotta play numbers wise. It's gonna cost more. _____

So budget at the current compensation levels is not worth it economically to do that.

Efficiency, finance and program at the same table _____ because you do really have to do a real analysis of the cost proposals that a program _____ and provide the funding if you want it to have, and that's reality. And given all the statements that I've heard from the Department about budget shortfalls and MLTC being over the

Medicaid global cap, I mean you really have to think of the big picture and whether or not what's being proposed is realistic within that global cap, because that's what the governor _____ concerned about.

Also, we don't have a care manager here. Like if we are gonna have a conversation also about like the tools that care managers need or etc., I think that would be something that's beneficial would be to engage with the care manager and that's also when we're talking about the IDP is exactly what, what you were speaking to is, you know, that they're the collaborators in this system. And then also having worked with the consumer, you know, the care manager is their entry into the plan. Like that really is one of the only people that they're communicating with regularly, so if we're taking about how a plan is successful, we need to, we need to further address what it's like to be a care manager, and I think we need to hear directly from care managers alongside everyone else in the room here that has a higher level finance, you know, proposal, risk factor adjustment _____ (laughter) you know, jargon. We need to have the actual members, employees of the plan that you know do the work and then I think that we can have a better more comprehensive conversation around, you know, what is realistic. Not only what's realistic, but also another thing is, looking at the actual contract, what we're talking about, a care manager has so many responsibilities. Even in MLTC which is partially capitated, it says in the contract that they need to take care of several different factors that that plan doesn't even take, necessarily do. It says that in the contract. So I think that we also need to look at the contract language and go back if we're gonna have a more holistic conversation around care management and what it means to be a person in a plan that's working with a care manager.

And I can tell you, that would be one of my care manager's

biggest complaints is trying to track down things that a plan is not necessarily responsible for but that portion of the coordinated care, trying to talk to a doctor's office has no stake in the game with us per se.

You mean, by not responsible for, you mean not making the actual payment?

We're not making the actual payment, so why would they give us anything to be honest, and my care managers really struggle with that.

Right, and I mean, would you see that as an argument for more integrated, more streamlined benefit design? Or do you think that that's severable?

Yeah. Yeah, no. I mean, I think isn't that sort of the eventual goal of all of this is more of integrated care?

_____

Yeah, I think; this is _____ from Village _____. I think you heard even in prior sessions about plans saying we'd actually prefer to have more control over those elements. Things like mental health services and outpatient treatments, I mean, there are really, if we're really gonna be able to manage the whole individual, we really need to be able to know what's going on in the individual's entire life and not just what we have contract control over.

And if you do that, I mean, then again if; the question is there opportunities to, you know, to drive efficiencies under that framework

That goes back into driving efficiencies. So many years ago, I did a study where we looked at disease management and impact on overall health. So yes, it improves people's health. We reduced hospitalizations, but the cost, administrative cost plus the pharmacy cost to avoid the hospitalizations was more than the reduction in hospitalization. So it was great to make people healthier, but didn't reduce the bottom line. It's once again expectations here.

I also just want to comment also from the care management perspective. Being a clinician, I'm very engaged with the care managers. There are a lot of social issues that the care manager has no control over and they're actually waiting on an external entity to help the member. I know, you know, by reviewing success stories, you can see like the collaboration and the amount of time that the nurses spend with the social workers, a lot of social issues, and I mean, you can't just say, you know, the ratio is 1:100, because each participant

_____

Yeah, they're unique. And I have to tell you within this population in addition to, you know, them being frail, they have a lot of social issues.

I just actually wanted to address one other thing you had said about the medical components rolling forward. That's true, but again talking about layering in additional benefits, and I know you talked about transportation. If you layer CFCO in, you don't have the experience that needs to be put in there as well.

Yeah, that is definitely a challenge for rate setting and, you know, we're aware of that, and we're committing to getting that as accurate as we can. We're obviously working through that, but we appreciated that's a difficult _____.

Can I just say one more thing about care managers?

Okay, I just want to, last one up, because I feel like I might have taken us down a rabbit hole and

(laughter)

I mean, I've worked in health. I'm a government affairs representative, but I sit near the care managers who are always speaking to our members and working closely with them, but the other obligation that they have is significant documentation, so it's not just the relationship with the member, which is critical, but it's their documentation responsibilities. That's an important component which in your calculations, I don't know, you know, if you're thinking about, but I think I would really take that into consideration all of that as you calculate rates.

I mean, I'm curious. Would you consider the documentation like burdensome to a point where it is not helpful and it's driving costs but not necessarily benefits?

_____

Or are you just more concerned to make sure that we're considering that in our budget?

I think we need to consider it in the rate setting process and in the proposals on the program side for ratios and for doubling the monthly contact with members, realizing that the care managers have other responsibilities as well.

Sure, understood, thank you. So I'm gonna move onto the next

issue here, which we were talking about with the adjustment, and I think we were sort of touching on this before where we have done an integration on the Medicaid long-term care product where we have sort of brought together all of the common benefit, basically what is the MLTC partial cap benefit, the long-term care service and support, and under our current models that's sort of what we're risk adjusting on. _____ (coughing) for MAP and FIDA. That doesn't leave room currently for any sort of adjustment for any of the additional Medicaid, or at least under our present model, we don't have any sort of adjustments for the additional Medicaid services, whether they're, you know, additional acute care, pharmacy, _____ or what else do we do, behavioral and substance abuse, and I'm interested in, you know, thoughts. Oh, I guess another issue would also be in, you know, our rate is really, our risk adjustment is really based solely on the community portion of the rate. We are not doing a specific nursing home adjustment. We're using a uniform nursing home rate in our population. So I mean first with a question to sort of the _____ additional benefit, you know, I mean, is that something that people see as something that, you know, our rates aren't adequately compensating or are not fully reflecting those differences in that, or is that more of an issue on the, for the acute care on the managed Medicare side and it's not that relevant on the Medicaid side to a lot of, I don't know, _____ and stuff like that? I'm not really sure how people feel about that, and then also on the nursing home issue and risk, in risk adjustment there.

I think at least our experience on the additional benefit piece, just the additional benefit piece, I haven't seen a need for risk adjustment, because it's small enough, as you said, that in a dual case a lot of it is handled on the Medicare side. If you're a Medicaid only, it might be a little bit of a different story, but if you're just talking about that one component, I don't know necessarily, I think the others might disagree, but it's not, it's

not going to make or break a program whether you risk adjust it or not. Now, if you're talking about PMPM that's you know in total 100, 200,000, whatever the number is, little higher, little lower, to risk adjust it, because one might be at 1.10 and one plan might be on the lower side at 0.9, it's not so significant that you'd necessarily take the time to adjust that small component to it. The nursing home side is a very different story and I was gonna get to how are you handling nursing homes?

I thought you were talking about nursing homes _____

No, no, no, no. No, I'm talking about the additional benefits. Pharmacy, certain additional benefit components that are; you listed them out. Not the nursing homes.

Okay. _____

It's a very very small _____

It was behavioral and substance abuse products and part D pharmacy _____ and additional acute _____

_____

A lot of copays and coinsurance and _____

Yeah, but we don't _____ our population first. I wouldn't even know whether it needs to be adjusted or not.

It's not material. At least for our plan, we have experience with it. On the nursing home side, that's very _____ conversation in and of itself, because as you know, there have been plans that have been pushing, and I think, you know, it's in the general push to have

a separate rate cell for the nursing home component.

Right, sure.

Because the nursing home, the nursing home population and a cost that’s between, between 1 nursing home and another nursing home if we’re going to be required to pay benchmark rates, it is, there’s so much in there.

So I mean, currently what we’re doing in our integrated and our partial product is we’re doing our surveys, right, and we’re going back and we’re adjusting, so mathematically that is sort of currently the equivalent of paying; the timing is obviously different, but mathematically, it’s the equivalent of paying separate rate zones, right? Another point that you’re bringing up has to do with, you know, benchmark rates, and I understand there are all sorts of financing policies, and they’re not really limited to necessarily integrated care, but just in terms of acuity, I mean, do you, or you do see it’s really more about the varying nursing homes as well as to any sort of acuity _____

Well, when you say it’s acuity of that nursing home member, unless you’re just talking about specifically the care management component, the nursing home is taking care of the patient and they’re paying all the costs. That’s on the nursing home side of reimbursement of DOH that really has to deal with that piece of it. We’re not involved with it. We’re required to pay whatever the benchmark rate is. We don’t pay additional whether you have a higher-acuity member or a lower-acuity member in a nursing home.

Unless vets.

What?

Unless you include vets in there. _____

_____ I’m not talking special people. I’m just talking about the

The generic population.

The generic, yeah.

94% of the long-term population in a nursing home. That risk adjustment piece, as you said, it’s sort of being taken care of in a retroactive way. It’s sort of a guess, and if you retroactively change it, then you have to pool to try to offset _____. I think everybody would be a heck of a lot more comfortable with a separate rate style because then you don’t really have to deal with it, but risk adjustment wise, let’s make it; we have to pay what we have to pay _____ benchmark rate.

Can I just pose one other thing? Did always, or there is always some plans say that there’s _____, that there’s some gaps in the risk _____ process. If we’re doing

You’re talking about for the long-term care _____?

_____ community _____ community, but for doing integrated plan, essentially the medical data is being made available, but it makes sense for the state to do a study of integrating the risk score for CMS and see how that would impact the ultimate cost of the Medicaid side as well, whether there’s any difference. _____

_____ looking for correlation _____

_____ or have things, do they, or _____ risks scores and diagnoses to actually increase or decrease the overall risk score. Just _____ out there.

Using acute care data is something

It supplements.

To supplement the UAS in terms of risk, yeah, I mean, I don't know. _____

Can I just jump in there? My question is for Elderplan. So you got into the conversations about a lot of the plans pushing for separate rate cell, the fact that you guys had the same benchmark rate and whatever was in that rate wasn't necessarily your concern, but can you just go a little bit more in detail from the plan perspective about a separate rate cell would address the issue that you have and how that issue, and do you think that issue would be addressed if we suggest tweaking our risk adjustment, an existing risk adjustment?

So let me just first say that I, Elderplan is part of a larger system that has nursing homes within the system, so I'm not again paying the benchmark rate. That's not what I was saying at all. What I'm saying is that plan _____ difference in payment, at least down state New York. I don't know the rates up state. I'm sure they vary tremendously also, can shift probably more than a $100 on a daily basis.

_____

No, no, no. You don't, you, basically you're low is gonna be around 200 to 220 and your high is gonna be 380, 390, so you have a

swing of more than $100, $150, or whatever the number is on a daily basis, so if they plan; now DOH, and I've worked personally directly with Dan on ours specifically, because we had a massive nursing home network and we were having significant population moving into our plan under the nursing homes, and we had to pay that out originally. I'm just talking from our experience. We had a low number. It was readjusted later on. We received back within a material dollar amount or an immaterial dollar amount what we expended, and that's what the whole purpose of it was, but if you had a separate rate cell that was accurately set and a plan bill on a monthly basis that rate cell, I don't, I wouldn't have to wait for that adjustment.

_____

But it _____ significant cash flow _____

_____ which is especially true now where we're transitioning the population, right?

Right, correct.

Theoretically, we would achieve more of a steady state as we go forward.

Correct, but as, but that's gonna take a while.

And that's a separate cost variable.

But wait, wait, I mean, just

I mean, the _____ addressed the number of members that are actually in _____ service, and it doesn't address _____ cost to that amount.

I understand that, but that’s a pool mitigation score, and now you can argue whether pool mitigation methodology is correct or not, and maybe that can be tweaked, but that’s what the pool mitigation is for. But I’m just trying to address the specific question as to whether you risk adjust it or not. It’s not about risk adjusting. Risk adjusting is, is an individual _____ or is the individual sicker, do they have more needs and more spending, more costs, or are we not? And that’s really the nursing home that is paying for those costs on the Medicaid side. On the Medicare side, they go to the hospital, it’s you know whatever _____ service versus if it’s within a dual product or an _____ program or something like that. On the Medicaid side specifically, it’s the nursing home cost that they are paying for those needs or paying whatever we’re required to pay just that top rate, and so you’d probably have to talk to the nursing homes on that side. It’s not use being risk adjusted. It would be the nursing homes, because they, you know, my side, I’m paying what I’m required to pay whether the patient is 100% healthy or whether the patient is really in, you know, really has a lot of _____, so I don’t think risk adjustment is really going to address that, unless the risk adjustment just adjusts for high-costing homes versus low-costing homes. I don’t know how you’d do that _____

_____

Theoretically, from my perspective, take the cost in a day per nursing home, multiply that, add on the care management and admin expenses; that always should get paid. You know, why _____ whether our members end up in more expensive, less expensive homes, 5% withhold and distributing that out is not going to help either situation.

I think we’re getting a little off the integrated topic.

(laughter)

So we have 60 minutes left. We can do 20 more minutes of the last 3 topics. I'm not sure how much further we want to go onto the rate side, Jack. If you want to talk about the last 2 bullets?

Yeah. I mean, I think one thing that's just important to keep in mind too is, you know, where we look ahead for well duals and expansion into the rest of the state, you know, does the idea of incorporating well duals make sense with any of the potential models that we're considering via D-SNPs or a more FIDA-like model or an MA, MAP product, and you know what makes sense in different parts of the state? I'm not sure if anybody has any perspectives on those.

I think all I would ask is that if you start to roll out, like let's say you take something like a FIDA, roll it out across the state, that there is a sort of streamlined process for plans to either move into that product or, you know, that the application process is smooth or easier. That's it. I mean, because if you want to start a FIDA project in Western New York, it's probably better to use what base is already there and that like already have some network or at least have some of the network in place.

And if the goal is for the item on plan qualifications; we'll get into that a little bit later. _____ next few minutes. Now, what we're looking for possibly, and ask the plans what type of experience do you think is necessary for a plan to either be accepted into the future of integrated plan?

Just to address question #3, if you're going to include well duals, I would imagine it has to have a separate rate cell for them, and deal with that within the contract, because the whole, you know,

having a _____ service versus not and what only can come back in recoupment, well that, you gotta deal with that with a separate rate cell because those well duals, you're not gonna have that, so, and that can't be well layered into one. _____ I mean, I would strongly push for separate reimbursement streams on that.

On the last question, if you're _____ the whole state, the question is obviously you mentioned _____ network, some of the other mandates that they come out with will impact how rapidly you can build that network. You have to _____ network providers along with the _____ structure, well that's gonna take that much longer to build the network.

You're saying both pushing forward on _____ at the same time you're pushing forward with integration of state

A VP was an example, but it's really anything. It's just a matter of what's your priority. If your priority is to build the network, then _____ is key. The more pieces you bring into play, then that's going to impact the success.

You're adjusting for the demographics differences, you know, where _____ experience do they have versus mid-state and then down-state. There's all these components are gonna have different reactions to the same product being offered through the market. _____ will make it clearer, but you're not gonna get the _____ that you're looking for, looking to get, so.

I mean, when you look on a Medicare, the Medicare reimbursement, the base rate is adjusted very, you know, _____, so if you look, there are such drastic variations between each county on the Medicare side that I think, you know, up-state would have to, you'd have to really maybe try to align with how Medicare reimburses and make sure

that there's, that that's true alignment.

Alright, thanks. And I know we have 2 items on slide 7 that's related to this too, why Jack is here.

Yeah, I think actually the first issue we've actually touched on quite a bit throughout some of our other topics we were talking about, you know, integrating value-based payments and plan quality into our structure, and then finally, I'm not sure if anybody had any thoughts on reserves, financing requirements for plans under an integrated framework and how that may differentiate from more traditional models or if there are differences between the programs that people find relevant? Well, in the interest of time, I think we can move ahead to some of the other sections.

Okay, thank you, Jack. Thank you, Jessica on the line. And let's move on to the next topic on your agenda which is the outreach education and engagement of the participants and the providers, and Renee Lebrit _____

I think I have a less stressful topic.

(laughter)

So again, we're looking for some feedback with some of the questions that follow this. Like vetting the program, you can't really predict what will need to be changed until there's trends and data that show some of the adjustments that need to be made. So what steps should the state and CMS take to outreach to educate eligible individuals prior to the launch of the program and after?

I mean, I would say that everything on this list of provider training that is standardized across every plan should be done by the

state or CMS. It really doesn't make sense; I mean, all the plans are contracting with the same providers, right? So every time you required a plan to do training, then that provider is going to have to do multiple sessions of training, and anything that takes the provider away from being in the room with patients and getting paid is going to discourage providers from participating in the program. So, I mean, I see things in here, right, that, the participant ombudsman, that doesn't need to be done by each plan. It's the same entity that's doing the same thing for every plan. ADA training, same set of standards. There's quite a few things. I mean, obviously each plan will have some different care management policies and procedures which they have to be responsible for training their provider on their own, but anything that's standardized across all plans should be done by a single entity.

The question was about outreach _____ eligible people for the program. I think what Renee is asking, part of it

Okay. I mean, I think the question; okay, I thought the question included _____

No, no. _____ but does anyone else have thoughts on, I mean there's a lot of things that they, that the state did more recently with the ad campaigns that didn't do at first and, you know, I mean, what are your thoughts on?

Well, I think we, do you know what all the plans _____ most recent efforts around restrictions on advertising and where we thought the challenge was, whether it was the plan or the providers, I don't know if we need to rehash those issues. We would hope that those conversations were learned by the state and they won't be repeated. You know, I don't feel like we need to rehash what is just sort of recent old history. _____ they were targeting the wrong

audience, that the growth wasn’t coming from us. It was coming from other places, and I don’t know if it’s helpful to rehash that conversation here.

I mean, to set up a provider organization with entity that we could solicit feedback at the provider level, I mean, I feel like is very important with regard to provider engagement. They will, because they’re the secret sauce, and if they don’t support it, it will fail. And I think, I mean, the experience that we had _____ is that a lot of the providers had a bad experience with the dual eligible _____ despite our educational efforts and _____

_____ the PCP. It’s very specifically

Yes. I mean, it _____

The physicians have to buy in. If the physicians buy in on day 1, you’re gonna have a program that works. If the physicians don’t buy in, _____ the plan _____. If the

_____

If they’re _____

Yeah, and I think practical application training is very important not just high level, though just to speak for an example, there’s been lots of trainings on value-based payment, but there hasn’t been any sort of like well this is how you actually go about doing it. Yesterday, I spoke at the NYSHFA conference, so with nursing homes, specifically on value-based payment and how to enter into contracts. We have like 6 weeks to get this done, and they were just looking at me like, I don’t know how to do this, where do I get; they asked me where they get their PAH data, like it was, so I get

it, there's a lot of training that went into it, but no one who actually; sometimes you need sort of with things that are brand new like this, like a little bit more of like the, that these are the details, these are the specifics, these are who you're going to reach out to, this is who you can go to for help with, you know, if you have contracting questions or, yeah, and so getting the buy-in is very important in talking about those, like the nitty gritty stuff, not just the overall big picture.

_____ one of the things we didn't talk about here at all today is VBP and the financial parameters around VBP from plans, which is I would assume a big component to what we're gonna have to do in the future of integrated care, and I know what's in the road map, I know what's in the contracts between the state and CMS, but outside of saying you have to do it, the state, we need plans telling over and over again to the state that providers who cannot effectuate change, so a PCP, trying to convince a PCP to take a risk on members hours, it's just not gonna happen. They're not gonna do it, because the risk on their side, they're not gonna take downsizing. They'll take upsize risk, but that's only VBP level 1. To get the VBP level 2, you need upside downside risk, and the providers, whether you're on the PCP side and you're trying to get them to take responsibility for cost of care, you know, shared risk. The day you pull back a dollar from that provider is the day that that relationship is over. The same thing on the licensing agency side, and so we didn't talk about it here, and it's probably not the right, you know, we probably need to talk about that VBP, but if this needs to have VBP level 2 and 3 later in it, plans need to understand the provider training, education needs to be out there to say, this is the way to get to it, because we can't force a provider/employee relationship, and one of the conversations that I've heard, well I actually had a conversation, which is plans are gonna be penalized if they, if in the future, if they don't have VBP level 2 and 3. You could penalize

us all you want, I can't force a provider to sign a downsized _____ contract, and if you're gonna penalize us to the point that we're not gonna be able to make it, then you're just collapsing the program right away, because the plan cannot force the provider to do something.

David, how, I mean, are other folks, you know, when you talk about some of the shortcomings on the FIDA side with the early outreach with the providers, what have plans done to take, or where are your thoughts on how do you create a more robust provider engagement process? And you know, I guess if we're looking forward you know and we're talking about education and what constructs providers _____ within like maybe if it's not directly with the plan within an IPA or an ACO type of arrangement, what are some of the other thoughts about how an education and outreach would look like more ideally knowing what we know now and knowing, having experienced some of the

Honestly, I think DOH needs to sit down with the providers and say, give us feedback. I want to hear from you providers, what will it take for this to work? Because giving them training or your thoughts on it or whatever, they have their own thoughts on it, and if it doesn't work for them, I'm telling you it's gonna end up coming down to us.

_____

But, but, forgetting that piece of it, if you bring the provider community and PCP, IPA, if you talk to them and you say, what is it going to take from us to get you to buy in to this program, way before the program starts, that is, if there are reasonable requests for things that can actually happen and then you bring the plans into it and really have an engagement of a conversation between the

provider community and the plan and the department, and CMS for that matter, that's the way to get this done.

And building on that though, you need to have, you mentioned the IPA, the ACO, each of those are individually grouped, and then you have the small docs, the PCPs, because bottom line, most people don't go to an ACO or an IPA. Most people have their doc that they've had all these years, so if we can carve out those, that population of providers, we're going to have a large population that's not going to enroll in the plan. Though you have the big groups there, but you also have the, you have a stronger presentation of the small doctors, and you're gonna have a challenge doing that, getting them to the table, because most of them are 1 and 2-man shops, but that is probably the most critical component, is getting those individual PCPs to the table, and I'm gonna stress once again, all of these things are gonna cost money. So where is that money gonna be coming from?

I mean, I guess, one of the question; Judy, I just have one quick comment, and that's, my question would be, what are the plans doing to engage? And I hear that a good, you know, we can take that back. Dave, I think that's good to think about. How we do engage the providers in several different forms? But I think we can continue to, in light of the future of integrated care model, think about the best place in a round table to discussion to have that, but I'd like to hear more about what some of the plans again have done to date, you know, first hand from the folks who are here or on the webinar to engage the providers, right, so I want; I know we can take responsibility, but what are you guys doing?

I'll give you 2 different examples and some of our experience. I'll give you 1 on the Medicare side and 1 on the Medicaid side.

Yes, that would be helpful.

So we have risk sharing relationships with a couple of large IPAs, on Medicare side, are not FIDA; well, no we do have FIDA. FIDA is part of this. FIDA, MAP are our Medicare contracts, we have an upsized risk sharing relationship with a; it's upside down then actually, risk sharing relationship with an IPA, a large IPA, where we have a significant number of members throughout all of our product, and we on a monthly basis sit down with them and talk to them about medical management initiatives and different things that we do to try; we have to provide them information, and they then review the information, see why you're having multiple hospitalizations on members, what can they do to stop them, because they're at risk, but they're at risk for the Medicare component. If I layer that in with a MAP product or a FIDA product where I'm, I set for them a budget that they have to achieve better than that, they have an upsize payment, lower than that they have meaning a worse medical loss ratio, they have a downsized risk sharing relationship, if I layer into that the hours of the member and the members have high utilization, everything and anything that they work on on the Medicaid side, on the Medicare side and reduce hospitalizations is gonna be out the window, because the member has high hours and the capitation from Medicaid is not high enough to offset the cost of the high hours, and even if, and these members are the ones who are gonna have hospitalizations, you can bring them down, but the revenue stream is a third, it's a quarter of what it is on the Medicaid side. So if they reduce hospitalization and you're reducing your MLR on the Medicare side, but your revenue stream is, I don't know, $1500 PMPM, $1800 PMPM, but you have high hours that are costing you $8000, $9000 per membership and your capitation is $5000, $4500, everything that they do on the Medicare side is out the window and they're gonna owe us money back for this member having high hours. It's not gonna happen. They're not gonna do it. And so that's where the challenge

comes. On the Medicare side, it works, and we do it, and we've actually had some very successful relationships that way. On the Medicaid side, we've have _____ and we're looking to try, we're getting to a place with a specific license agency, but that license agency also has to it a separate wing of MPs that what we would like to do is to try to pilot a total cost of care relationship with them where they have x amount of members with us in our FIDA and our MAP products and they take total cost of care, which includes the Medicaid hours and it includes the Medicare component, and if their training of their aides and the training of their, within their Medicaid side, the license agency side, can identify early signs of a UTI or excessive, or you know a thing early on, and we can _____ and then send in an NP to go and avoid the hospitalization, and they take the total cost of care into play, they'd be willing to if they reduce, you know, we'll set metrics, they reduce their admit per 1000, they reduce their hospital PMPM, whatever the metrics are, if they're willing to take the responsibility of total cost of care, that would be a model that would work. But most license agencies don't have that other wing to them. Two examples.

That's helpful. I mean, in light of, not to get to sidetracked, of you know the road map and VBP and we did have a boot camp yesterday out in Long Island, in light of the fact if _____ plans have to have in place contracts with _____ engage in those conversations, or I don't want to get too detailed in this meeting about that, but I think it's recognition of the fact that, you know, those conversations should be going on anyway, so I don't know if there are other folks that have comments.

There is a comment from the webinar. It's from Deanna Evanston, the Director of Managed Programs with NYSHFA. She says: Plans have already started sending amendments for VBP level 1 to SNFs. I am working and have reached out to the DOH team, and we are going to do

more education for our providers, but I believe the amendments sent did not and do not allow the provider to have that conversation. It was a take-it-or-leave-it amendment. So that's her comment.

Thank you, Deanna. Appreciate it.

Addressing your comment about what plans are doing, I think the challenge or what you're having in the population, _____ I don't think any of us have even _____ but most of us have only a few members. _____ we had the same issue regarding the VBP. For us to have a conversation with the doctor that only has 1 or 2 members, we don't have the resources for that. So there's the _____ is not reasonable. The only place where it's possible is to have the _____ IPA or by an ACO. Then theoretically you have that possibility, but then you're precluding the entire population that doesn't belong to an ACO, that doesn't belong to an IPA, which is a large part of the population that you're focusing on. So what is the goal here? The goal is to get the part of the population that belongs to the ACOs or the population to the target all of New York State and their needs. So you ask how we're gonna have conversation with the doctor that has 1 or 2 members online? You can't.

Let's just be clear on what you had just said which is due in 6 weeks from now and to address Deanna, the requirement to 12/31/17 is upsize risk only. The provider has no downside risk. Much easier conversation to have with them than when there's _____

And I know you mentioned you know level 2 and level 3, so yeah, we don't want to _____

Right, and with what Deanna is saying, plans are just starting to get these things out, because we have this requirement.

Okay. I just want to be clear, I mean, just because there are _____ conversations, but just because there should be engagement obviously because of meeting level 1 targets by that date, you know, just, I didn't hear a lot of discourse about any engagement _____

Yeah, and I just, I want to add to that though _____ but it's very difficult to have conversations with incomplete data. So we would tell providers along the way like the nursing home providers that you know this is coming, be prepared for it, but we can't tell you a dollar amount attached to it, we can't give you the exact measurement. There's a lot of issues with what members during that specific timeframe actually qualified, and if skilled nursing facilities did not have enough members with any 1 plan, they couldn't use an individual PAH level, which means they have to have aggregated data. I can say that even for myself as of this date, we do not have that data. So how can I send this out without having that yet? So it just, yeah we're having conversations, but it's very difficult for me to keep calling and being like it's coming but I can't do anything yet.

The time restriction too. I mean, we have to get these guys _____. We have to get these contracts approved by DOH before we can even send them out. So it is true there's not a lot of time for us to get this thing done.

And we have _____ money. We haven't been shared the money, so we're supposed to put in a contract with some sort of reimbursement and have the conversation about the reimbursement, and we've been told since the beginning it's coming, but we're being mandated to get these things out, but the state has not been participating in their share of the burden here.

And we can take that back and, at the risk of sounding like a

broken record, you know, I _____ there's a presentation to share on the money portion of that, so that's a whole other conversation I don't want to get on, sidetracked. Okay, well does anyone else have anything to add before we move on on this topic?

Just on this outreach, I think a lot of people raised their eyebrows with the advertising that did go out, but basically it gave members expectations that they were gonna get full live-in and plus all-week social care.

Regarding the advertising _____

By advertising that content, so it was at the _____ was that we were able to give somebody a full-time aide and now we had to also give them social daycare on top of that. That was advertised. That's the exact wording.

You mean the radio ad?

The radio ad that was going out. And it just gives the, it was that we would be able to _____ the person was able to get a full, an aide full-time in their _____ and now _____ from their social needs as well, so I was able to hook them up with _____ social daycare during the week. So just you set the expectations; sorry, you give the impression that you're _____ the max benefit to anybody that's enrolling, and that's unfair to the member, it's unfair to the person assessing the needs and telling them, oh you're not gonna get that. It sounds like a little bit of bait and switch that puts the plan in a very uncomfortable position. So it's a matter of any advertising should be a realistic expectation for the member while still promoting the need or the benefits of the plan that's going out there.

We can take that back. That's good feedback to have in terms of future planning for advertising and for the future integrated products. Yeah, Judy?

I just want to reiterate because some people said that potential members were current enrollees and these products really rely on their PCPs, primary care providers to guide them, and it's really important to provide the most incentive, and we can speak to them and we do. In fact, our participant advisory committee, any time their physicians have a question outside of, you know, we go out and we talk to them about it, but I think for the future, it's really to make it less partisan for them to be engaged. I think initially with FIDA, they didn't know what it was, they didn't understand it, and if the member, potential member went to them about it, they didn't really have a clear concept of how it would impact them as a provider or what their requirements and expectations were. So I think primary care providers are the shortage. They have a lot of members and patients besides the FIDA population to deal with, and we have to make it easy for them to participate in this and give them incentives, and that includes, you know, they need to be paid for their time too. That's really important.

Thank you for that comment. Anyone else? Yes.

Well, at this point, do we want to go any further into the _____ (coughing) education? Do we want to move on to the next topic here?

Why don't we move on?

Okay.

So my name is Melissa Halperin. I'm with the FIDA team. Here what we're pressing forward (mumbling), here what we're putting

forward is really a question to the group and looking for stakeholder feedback as to what factors, _____ in deciding which plans to allow to participate in the future of integrated care in the next integrated care iteration. What we've put together for you are some examples of criteria that other states use in evaluating which plans to allow to participate, and you know they make, in other states, the states require plans to essentially demonstrate their ability to provide the services, to monitor networks, to build networks, to implement in all the various services areas, and there is more showing what's necessary and then the, you know, proposals are evaluated, and so I guess we're looking for some feedback as to whether there are stakeholders who feel that we should be using, you know, a process like this where we're actually considering some more of the factors about the nature of the plans and their ability to meet the needs. So you know looking at these, which we sent out to you, and these come from many different states, but they look at things like their ability to use technology. They look at things like, you know, their policies and procedures, and this is stuff that goes into the bidding process. So I guess we're looking, you know, what factors

This is awfully complicated as opposed to just saying that plans who currently have a similar product, be it FIDA or MAP are the ones who are eligible

PACE, or PACE.

Or PACE, excuse me, correct. As opposed to going through a whole separate process.

I was actually gonna say, and it's probably gonna be an unpopular comment, but plans who stayed in FIDA, stayed for FIDA through 2018, right now there's to my knowledge absolutely no

incentive to stay into 2019, because the product is ending at the end of 2019. We have no idea whether these members are going to, where these members are going to go, so are they gonna roll back into your MTLCP or are they gonna go into this product, if you can even have this product, and so on. From a financial standpoint at least, I can speak to our plan, it's not like we're suggesting making a profit on FIDA. We've been in and we've lost tremendous amounts of money on FIDA over the years, and to me; I'm not saying that it has to be only the FIDA plans that stay in, but at a minimum requirement, I think it should be what just said, which is, does that have experience doing this, and where you were a MAP, FIDA, both, PACE, a plan that has experience with running a dual-integrated plan, I think it's essential. And it also goes to

All the other _____

I think Jason's, you know, wanting of there to be less amount of plans out there and less amounts of; this shouldn't be an open season, anybody can get in.

Right. _____

_____

_____ technology, and you've demonstrated by having _____ all of the other _____ question to them. You can't have the product if you don't have the technology, if you don't have some of the other stuff you're asking for.

So David, are you saying you shouldn't feel as if this is a standalone MLTC and that you have kind of integrated product _____

Tell me why you shouldn't?

Why shouldn’t we?

Why _____

Well, I think the conversation would be different up-state, right? Because I mean

You don’t have the opportunity to _____

You don’t have the opportunity.

_____

I’m talking about those in the down-state

Just down, okay.

5 boroughs, those who have been doing it over and over

(laughter)

If you don’t have the opportunity to be in a FIDA then you don’t have the opportunity to be in a FIDA. MAP is scarce up there, and there are only a few PACE programs. But down-state, there is a tremendous amount of competition and there’s a tremendous amount of plans that all were in for FIDA; oh, let me be in FIDA, let me stick my toe in the water on FIDA, nope I don’t like it, I’m pulling out. I don’t think that those plans should be rewarded with being able to go into _____

So I will not disagree with you all. Just then strictly speaking for the rest of the state, if you have an MLTC-only plan but

you know the market very well, you know the differences there between, you know, down-state, I think you should absolutely be offered the opportunity, especially if you have staff who have experience in PACE programs and that, and why not?

I think part of the reason we have to question this is that we did hear a lot of feedback for FIDA, some of the plans that joined, you know, began participating when the program first started and were only MLTC, and some of them were only Medicare, and there was a big learning curve for those plans on the parts that they were, you know, not experienced in, so that's just part of the reason why we asked the question. I think this is a good conversation. It will be interesting to hear from any people in the room who aren't, you know, with a plan.

Well I would hope the state is not thinking about allowing new entrants into the market, like brand new entrants who have no experience, who have never run this kind of product.

_____ kind of product, on Medicare or Medicaid

Yes.

And _____ in a different state. I mean, these are why we're asking questions. I think that the question, I don't think any, you know, this is just putting it out there. We're trying to get you to think about some of these factors.

I just, I mean, Matt's point is basically that all we're hearing about is we need to drive consolidation, there needs to be consolidation of plans. Opening it up _____

_____ some sort of reward for those that played nicely and

stayed in _____

All I was saying back was, when you said should MLTCs keep DN, I'm just saying that plans who stayed in as Megan just said, there's gotta be something for us. There's gotta be something, and we do have the experience because we've been in, and I just feel very strongly that along with being, you're hearing that it's not up-state

(laughing)

they're not in areas that didn't have the opportunity or only minimally had the opportunity, plans shouldn't be rewarded for not being, no playing along with, not playing, not being a partner with the state and with CMS for this product.

I mean, thank you, David. And I think Matt, we can get to that point, and that might be a future topic. I don't necessarily think we were on any _____ you know lifted any sort of moratorium and have open season on you, tons of new plans coming in.

_____

(laughter)

Consolidation we're seeing in the market.

Are you thinking of plans from other states coming in? Because I know there's a large _____ recently come into New York State, so are we thinking of allowing those entities?

I don't know of any that have proposed that. You know, that's something I guess that we could talk about. I don't think that's the Department's intent here in having a conversation and start looking

at how we can bring interlopers if you will into New York State.

Not only that, but New York State is unique, and you have to be here to understand what that means to be in the market _____

I think we have seen some consolidation of market, right, with some bigger national forces already, you know, but with that, we will go on, but I don't think there is a concerted effort that we're seeing in any situation from on the part of the Department to push those forces in that direction here.

_____ also with the provider, healthcare providers from across the country. If you wanted a non-plan perspective, I would agree with what the gentleman said, that having the experience of running a duals program is critical _____ you can't just convert from an MLTC to a FIDA plan, so I offered that support. I'd also _____ MLTC program is really not a very effective program, and therefore what happens with that program and the providers in it? I don't know, but it's a function of the gentleman over here talking very directly about the integration of the long-term care and acute sides and the primary care physician really can't take risk and responsibility on certain of those healthcare costs, but you need that home and community-based provider to offset those costs in the same way, right? So you mentioned the eyes and ears in the home of the licensed agency aide that has the impact to inform, where in the MLTC program, there's no opportunity to do that.

I wouldn't say it's not effective. I think it's effective in what the MLTCP is, and in the contract that we have, it is an effective program, and I, you're talking about is it an effective program in reducing hospitalization and being an integrated approach with Medicare side and the acute side, and I don't think until more recently where there have this push to try to, I mean the quality

measures are part of the whole, the whole quality that layered into MLTCP. I think that started in 13 or 14, so MLTCP products have been around since 2001. Elderplan has been running since 2001, 2002. I wouldn't say it's an ineffective product, but there hasn't been the approach until the last 3 or 4 years to really try to integrate that Medicare piece of it, and now there is that approach, and so I will go again with saying that I think if you have the opportunity and you run a dual product, you understand really the relationships you have to have with the provider, with the PCP community, with the physician community, and how different and complicated that is as opposed to the, just the licensed agencies _____ for one of those. That's all.

And this report that came out with the report a couple years ago measuring the success of the MLTCP program, so that's worth taking a look at.

Where's our PACE person? I'm sorry I don't remember your name.

Carrie.

Carrie, what about the idea of a partnership? PACE is up-state, and what about the idea of a partnership between MLTC and PACE, due to the fact that PACE is also a provider?

So can you give me an example of what you're saying though?

Well I just thought that _____

(laughter)

We have very seriously explored that. So my background is in PACE, so I mean, that's, I really believe in that integrated model overall, so we have very seriously tried to either acquire or partner

very seriously with a local PACE program and are trying to now do the same with another. It makes perfect sense for the 2 to have some sort of marriage together. It really does. So I think there's a lot of opportunity of something to explore there, so I think it's a good idea.

And one of the things, I mean, we've suggested is that up-state there should probably be some sort of like pilot project and _____ let plans pitch something like that so that they can get some experience before we transition. I mean, obviously if you're targeting a 2020 date, then that may be impossible, but if the roll out for up-state were to be later, we could start now for developing some pilot programs that would give plans a little bit more financial resources to explore some of those things and see what would be practical going forward.

Okay. That's very helpful. I mean, what I'm hearing is that, you know, there's some exclusionary talk, but I think, you know, I wanted everyone to be reassured that this model works good for the entire state. I think there's _____ figure out and for the, other the part of the department too to understand how that fits in the bigger picture of future models, you know future of MLTC, future of MAP _____, what does having 1 integrated model mean if that's the case, and I think that's part of a subject we have to have later, and then how do, well how do you access, right, how do you get in? And I think I hear from David that there's concerns or ideas about some of the pitfalls if you will that we have with so many plans and trying to better understand who brings the best experience to dual integration, and for those up-state who have had _____ like PACE which are tried and true and have been around and expected to continue to be around, so are there opportunities within that for, you know, areas that have had lesser experience with an integrated product?

And at a bare minimum, if the plan does stay around and FIDA through and has, you know, products that is the next product, we should just have some smooth transition there because of the lives of members, it's just gonna, I don't know where they're gonna go.

We hear that, David.

(laughing)

_____ smooth process, that we should have to have that whole, you know, we're moving from a FIDA to this new thing to simplify the application process. It should be the 2-year process that it takes for the MAPs _____. Everything, let's learn what we can from FIDA, the benefits, the _____ benefits _____ experiences. FIDA works better on the enrollment side by having an integrated enrollment. MAPs, the benefits are more aligned with need and doesn't have as many _____ ; all those pieces, but simplify everything and even transitioning to this new plan, let's try to make it easier for the state, make is easier for the plan, easier for the provider.

I have a question for the state. What's, what do you view as the role of Maximus in this whole conversation?

In enrollment. We're gonna talk about that in enrollment.

That's next, okay.

Can I just ask 1 more question? And that is, do folks have any kind of idea why MAP doesn't have greater penetration up-state? Is it just historical or?

_____ penetration down-state also _____

There are only a few hundred up-state.

I mean, there aren't that many. How many MAPs are there up-state?

Yeah, I don't _____

There are not a lot, and there's definitely not; I don't know of any MAP statewide. I don't think there is one.

No, there's not. And I think the counties up-state there, looks like a handful of counties where there's actually a MAP offered I think.

They can probably speak more _____ experience _____ this is not done in enrollment _____

Enrollment on the 20th, enrollment on the 31st day, that's a huge

Barrier.

Issue that has to be dealt with, but FIDA dealt with it. So again, it's the best of both products.

Let's move on to the last topic which is enrollment, slide #10, and I guess let's go to the last bullet. _____ question that came up. There you go, thank you. What do you think about the inclusion of an enrollment broker to handle the enrollment process? And we talked about how to set up, you know, that MAP has their cut off and FIDA does, but what did you want to mention about that?

(mumbling)(laughter)

You're talking about the role of Maximus?

Yeah.

I mean, I think we

Is your preference not to use what

Well, there's definitely a barrier. I mean, it's

I mean, we struggle sometimes, and I don't know if other plans have the same, you know, with our submissions and the delay, and we need to follow up, and you need to call and, you know, you get your reporting and you have a lot of followup or reconciliation that you have to do.

And that's with what product line are you discussing that for?

So we have our MLTC.

Right, _____

We have a FIDA and we have MAP.

And also on the MAP side, we struggle also because of the discrepancy between Medicaid and the Medicare disenrollment dates. You need to make sure if you disenroll with one, you don't lose coverage with the other, that the member knows what if they're going to the pharmacy, it doesn't impact their pharmacy also. So it's really educating the member and being on top of your records, your files, your reconciliation. Everyone has to be all together making sure that this happens so it's, you know, seamless for the member.

I'm sorry. I definitely have an appreciation for the role Maximus plays, because when you're talking of FIDA to MAP, the process is so much more easier, and the member isn't like if they disenroll from MAP, like if you don't coordinate those _____, they're like sitting in limbo, and with FIDA this is effective and they just disenroll and they go back to whatever product they desire.

The FIDA enrollment is much easier than the MAP enrollment, and you're asking Patrick why, or you didn't specifically ask about down-state, but I actually think MAP would grow a lot more if you had easier enrollment structures and structure you have like in FIDA. You'd have much more enrollment, because it's definitely, is a barrier.

Is it timeframes only or is the process?

_____

Able to execute the Medicare and the Medicaid enrollment from there.

It's both, right. Medicaid; the Medicare process on the MAP side is more lengthy, it's more detailed, but it's basically application is much longer than on the FIDA side. _____

(laughter)

_____ you're actually complaining about the MAP product.

No, no.

_____ administration.

No. We're trying to make it better. _____

So I definitely see a good basis for _____. Maybe it's just redesigning MAP to be, to get rid of the administrative burden. Regarding your question on MAP, I'm on FIDA side, so I can't speak for the enrollment side, but just looking at the numbers _____ Maximus, like they 're almost enrolling almost everybody _____ what's happening is the longer time frame now to get members on board for this goes from this point that member is interested, going through Maximus, get through that appointment. Once that's done and they qualify, which they almost always do, then they have to go through each plan's process, in which case _____ members, the plans are not gonna feel that they qualify, then you have to get Maximus to deny or _____ there's a lot of additional hurdles that, on at least from the finance side that I'm seeing with Maximus. I can't speak for enrollment team. They're not represented here, but that's, if we, whatever we could simplify and even potentially reduce the state budget

I will also tell you that if this contract, the new revised one ever goes into place, Maximus is going to have to change all their wording, because there are the requirements of _____ to 90 days of, you know, on disenrollment from a plan, and within the new contract, we're supposed to initiate disenrollment after there's, if there's no paid claim within 30 days of service or whatever it is, you know, services, and you can't, Maximus won't take the disenrollment. It won't take it. So you're gonna be sitting there having to do care management, having to, and what happens if on day 45, the member then starts getting services? I mean, there's such a disconnect, and Maximus if this thing ever went, actually happens, Maximus is going to have to redo everything that they do.

_____ help me better understand that. So you're saying if they haven't had a claim or a service, if they haven't had the actual service in 30 days, contact, or Maximus, right, disenrolls the person; you're saying is not getting processed or?

No, no, no. If you contract

If there's a change in rules in the new contract.

Oh, in the new _____

_____

That thing that's going on right now.

Okay, gotcha.

If that ever went into place.

Understood, okay.

_____ you can have services, and then all of a sudden _____ start services, you've got to enroll them, perform services again, and there, now there's a gap in care, because they have to disenroll them. It's just a lot of things just doesn't make sense.

We're gonna have a big conversation on that contract at some other time.

(laughter)

Can I ask, the _____ in MAP, as long as there are Medicare providers, are there a lot of network restrictions, or

You mean by network restrictions, you mean by off, allowing them in our network?

Yes.

What do you mean by that?

Is it fairly open as long as the individual is a Medicare provider?

On what you want your provider, your provider network to be?

I'm just saying, but I'm just saying in terms of the ease of enrollment.

For the physician or for the

No, for the patient.

I mean, in either product, if they're part of our network, it's, you know, _____ upon enrollment _____

So there's still a network requirement?

Yes.

Yeah, I mean _____

_____

If they don't have an assigned PCP, you're gonna assign them a PCP if that's what they want.

And if my PCP is not in network, why could they not go and enroll on their own?

Right, it's not a network thing.

I mean, we could allow continuity of care if _____ the provider is willing to join the network, but sometimes the provider doesn't like _____ and not willing to join.

It's just that somewhere in the back of my head, I had the idea that it hasn't gone on up-sate because people will, are very reticent to change doctors.

Down-state as well. They're very committed to their doctor.

So you're saying up-state they have their; there's less access to a physician, so what you have when you want to keep it, whereas New York City, if your doctor pushes you off, just run the block.

(laughter)

But that's exactly your point, that's the challenges that were, that David was saying and other people were saying that if you do anything that _____ providers on board, and with so many additional providers, then you're precluding the whole section of the population from joining this. So _____ ACO and IPAs, your precluding a lot of population because they're not gonna _____ correct myself.

Well (laughing)

Alright, so let's just go up to the top, and we've got just a few, and then we'll be finished for the afternoon. Do you think the

new program should be voluntary or mandatory on the Medicaid side for eligible individuals?

_____ also about a lock-in period. I mean, I know Medicare doesn't allow a lock-in, but there have been some experiments with this in other states, I think, but I'm not an expert on that, so it _____ members are also _____ around

_____ has a lock-in.

Which one?

Mainstream.

Mainstream has a lock-in.

Well Mainstream, yeah, but integrated product includes Medicare, so currently there's Medicare rules in there, and I'm wondering if there's creative ways, I mean we struggle with this, and we want members to have choice and we don't want them every 30 days bouncing around and that goes to the whole thing around rates and saving money, and you can't save money _____ or maximize efficiencies if they're only the plan for 3 months.

And we obviously from a plan perspective, we'd like to see some sort of lock-in period, and this, the context of this first bullet was just looking at the Medicaid side, because say a D-SNP you're gonna have the Medicaid, this could be the Medicaid product or, then just looking at on the Medicaid, you're right, there is none allowed _____

It not, right.

So that's we're were just asking about if you think on the, if someone is coming to the state, and on the, if this program is just for on the Medicaid side, do you think it's, do you want to make it voluntary for them to come in, or is it mandatory regardless of what program they select on the Medicare side?

I see what you're saying.

_____

So we know that mandatory enrollment with FIDA was not successful, because everybody wanted to go back to MLTC.

_____

It's passive versus; those were 2 different things.

They were, then that's what I think this question is getting at, or what my question is getting at, and I think we're kind of like splitting hairs on the nuances. If somebody was put into a plan and then they decided they didn't want it because they had other options, so is this question suggesting that folks who could also enroll into MAP or PACE or another integrated product, what does that look like in this, in like the grand scheme of things? I know that those integrated products are not, you know, if we're talking about the entire MLTCP population, which is nearly 200,000 folks, and you're talking about MAP and PACE and the other integrated care is much smaller, but like how, what would the relationship of this enrollment be to these other integrated products? Does that question make sense?

Yeah. Well, I think you gotta decide like what you, if you're gonna keep MAP and FIDA or are you gonna to one integrated product.

I mean, I think PACE is gonna stay in place.

And that's my, yeah, that's my question. It's like, I don't think that we're, we just mentioned that we're not gonna take away PACE, right? So I think, I think, yes?

It would have to be voluntary if you're not gonna take away PACE.

Well, you could require that they enroll in the mandatory, in an integrated product, in an integrated product. It doesn't have to, it could be PACE or

And lock them together _____ push-back like we had in FIDA.

And that's kind of what I'm talking about.

We did something very similar with FIDA, but we had the fall back of a partially capitated plan option, and was then, it's just I think that's kind of where my brain went is, folks are gonna want to know what their options are. Yes?

_____ obviously concerned about is if you have a provider that doesn't want to join the product, and now I'm gonna lose all my, _____ they don't want to joint our network per se, but say they're willing to join a network but not the network, and now I'm gonna lose all my MLTC members to choose only to the one that the provider joins, so my mandatory, you're putting all my membership at risk.

I think part of what the question is asking is what if it were mandatory on the Medicaid side only, but people still could _____ mandatory on the Medicare side, so they would have freedom of choice, and then you would have a product that has a Medicare component, but

your Medicaid piece of it would also be able to work with original Medicare if people wanted to; this is done in other states.

_____

No, I'm trying to understand it. _____ MLTC right now.

Yeah, _____

_____

No, because you have the, I mean, essentially it gives you the ability to hold onto someone when they decide that they want to change their Medicare mind.

Yeah, but that's MLTC then basically, right?

Well no, because it includes a lot more services _____

Okay, well _____

I can't even imagine the complexity from a plan perspective trying to administer something like that.

Yeah _____

You know, there are mechanisms right now, assuming D-SNP, CMS _____ stays the way it is, they have that ability right now, and the other pieces that aren't covered in the wraparound are fee-for-service, right? I mean, how else would they wrap it around? So from a finance perspective, I don't think you're gonna get anybody in the room to say we can administer something like that. But I know, again, we run from that. We run the side. I can't even imagine. As

a matter of fact, because of the disenrollment date change, we have to have a work-around to try to deal with that 11-day gap between a member who loses their Medicare eligibility but still has the wrap-around Medicaid piece for whatever _____. I'm sorry, yes, another month, and we'd have to continue to pay claims, and we've had to put something in place to sort of deal with that situation from a claims perspective, from an eligibility perspective. That's just layering _____

Can I just also say from a care management perspective, it's very hard; we're trying to move forward in integrated care and the care manager is like the gatekeeper. It's gonna be very difficult to coordinate with Medicare doing Medicare planning, and so it's like well we're back to square one, so I just think some care coordination _____ difficult _____

_____

But I think what Alexa is suggesting is that it would be a Medicare/Medicaid plan offered by the state _____, right, so and these are states, other states that are doing this now like New Jersey and Pennsylvania _____ Minnesota and the long-standing _____ and so essentially having, kind of living at the entrance of the D-SNP and the MLTC market so that you've got, you don't have plans that are just offering MLTC or just offering D-SNP, but rather they are offering them together and then trying to do the alignment on the back end, and I definitely recognize the issues with MAP and, you know, _____

How do mandate from on the Medicare side? Like, so, but that's, _____ because I'm not in Minnesota, but like if Medicare rules don't change and a person can stay in Medicare fee-for-service, like how do make 1 product, I just wanted to know how that works, how you manage

your product?

You might be able to look into like, come back to us with some more information on like how this works in other states, and that might be _____

And just to layer another

We can do that, Megan.

Another question on you. Do those states have VBP level?

(laughter)

Level, because I can't imagine having provider relationships where you're at risk from both sides, because we're at risk from both sides if there's certain members drop off of the risk on the Medicare side and still require them to be a VBP 2 _____. I can't even comprehend that, because there's actually level of complexity trying to run _____

I think we can continue to have this conversation if the goal is to have _____. I just want to be mindful of the time, that it's already 2 o'clock. We had a question in the back.

Yeah, and to piggyback off of the suggestion for how this looks in other states, from my perspective, and like what Angela and I are talking about is the way that plans are marketed, and we're talking about marketing and enrollment, Angela has been, you know, repeating, we totally need to have MLTC. So it's like these are your MLTC options and that's how the enrollment works. With this question, in my mind, I'm trying to wrap my head around, you know, how do you talk to somebody that needs long-term care about their options and like

what exactly does that look like, so and now I'm having a better understanding of, you know, you can have fully integrated, yeah.

(inaudible 2:23:29-2:23:44) so I only have the choice of 2 of them because one wasn't very good _____ so I only had 2 options, which no one told me anything about them, so I had _____ find out the information.

And I think it's important that we talk about it from the plan perspective of how this actually looks but then also incorporating, you know, okay, and these are like, I think we, I would benefit from like a clear visual of what options would look like, you know, and how the counseling would work, yeah.

Thank you for that feedback. That's helpful. And we can _____ kind of map this out and maybe that's part of a future meeting that we have. I think we have 1 more bullet point, Joe, and then _____

I think we were gonna _____ wrapping up.

Yeah, let's wrap up this session _____

Okay, so there, what we'll do for the next steps, our next session is in New York City. It's in the same room that we had our first kick-off back on July 20th in New York City. We'll be sending out materials on that. As mentioned before, we are looking through the notes that we take and we review the notes plus all the written comments that we would ask that you send in to us within 10 days. We will send out a reminder for that, and we'll be meeting with CMS to discuss comments between this meeting and the next on December 8th, but we do not anticipate they'll be making any and announce any policy decisions before the completion of _____

Please submit any of your thoughts before November 27th, which is not that far away, so we have to time to consider any thoughts before the next session, as it’s not that far away. Any final words?

Thank you.

Alright, thank you everyone for your time today. We appreciate your participation and are looking forward to seeing you at the next meeting.