266 West 37th Street, 3rd Floor
New York, NY 10018
212.869.3850/Fax: 212.869.3532

Proposal for New York State FIDA Replacement-Future of Integrated Care[i]

May 2018

Joe Baker
President
jbaker@medicarerights.org

Beth Shyken-Rothbart
Senior Counsel, Client Services
bshyken@medicarerights.org

I. Introduction

New York State has recognized and continues to recognize the need to address the future of integrated care for New Yorkers who have both Medicare and Medicaid. The state's efforts to create and design a financial alignment demonstration, the Fully Integrated Duals Advantage (FIDA) program, shows the recognition of the need to improve dual eligibles' health care outcomes. However, the FIDA program is set to expire by 2020. Therefore, New York State is once again exploring options for supporting integrated care for New York's dual eligible population. The New York State Department of Health (NYSDOH) Division of Long-Term Care with the Centers for Medicare and Medicaid Services (CMS) held a series of stakeholder meetings in fall 2017 during which providers, health plans, consumer advocates, and consumers and their caregivers were invited to contribute to the conversation about planning for New York's future of integrated care. Medicare Rights Center actively participated in these stakeholder meetings and submitted comments when requested.

Like New York State, Medicare Rights also recognizes this need for better integration of care for New York's dual eligible population. In addition to participating in the above mentioned stakeholder meetings, Medicare Rights has also separately engaged with stakeholders in an effort to increase stakeholder voices in this current conversation about the future of integrated care in New York. The federal government is also exploring ways to integrate care for dual eligibles. For instance, the recently passed Bipartisan Budget Act of 2018 (BBA of 2018) permanently authorized Dual Special Needs Plans (D-SNPs), which are Medicare Advantage plans for people who are dually eligible for Medicare and Medicaid. In particular, the BBA of 2018 also included changes to D-SNPs that require increased integration. Furthermore, CMS issued a request for stakeholder input on (1) the design of an integrated Medicare-Medicaid appeals approach for D-SNPs, and (2) the establishment of minimum state contract requirements for D-SNPs. Medicare Rights submitted comments informed by experiences assisting Medicare beneficiaries, their family members, and health care professionals in general, and by our work with dually eligible New Yorkers and the programs that serve them in particular – including FIDA and D-SNPs.

Based on experiences assisting individuals with Medicare and Medicaid and our involvement in the design and implementation of the FIDA program for New York's dual eligible population with long-term care needs, Medicare Rights

Center hereby presents its proposal to implement a fully integrated care model for New York's dual eligible population. This proposal incorporates input from the consumer advocate community, dually eligible New Yorkers, providers, and health plans. While this proposal contains many recommendations for a new integrated care model, we and other consumer advocates should have further opportunity to provide comment as NYSDOH develops and publicly releases its new proposal to replace FIDA.

Medicare Rights supports the right of Medicare beneficiaries to choose the most appropriate delivery of their Medicare benefits and heath care that best meets their needs. Therefore, it is important for beneficiaries to have the option to choose whether to receive Fee-for-Service Medicare or to receive their Medicare benefits through a private plan. In the event that a beneficiary opts to receive their Medicare benefits through a private plan they should be presented with a meaningful choice of high quality plans.

In the context of dual eligibles and in particular those who are in need of long-term services and supports (LTSS), New York State requires most dual eligibles who are in need of greater than 120 days of long-term care to receive this care through a managed long-term care plan (MLTC). However, these dual eligible New Yorkers still retain the right to receive Fee-for-Service Medicare for most of their health care needs, even though they must receive some of their Medicaid services, such as LTSS, from an MLTC plan.

While this proposal for a fully integrated care model discusses managed care options, as other options do not seem to be currently under consideration by NYSDOH and CMS, Medicare Rights believes, given our experience in working with dual eligibles, that managed care plans may not be the best option for all of them. Therefore, we insist that Fee-for-Service Medicare, as well as any new managed care plan, continue to be available to dual eligibles, allowing them and their caregivers to continue to select the best option to meet their health needs.

There are potential benefits of managed care for dual eligibles, such as: reducing care fragmentation, delivering person-centered and community-based care, and improving health outcomes.[ii] By aligning Medicare and Medicaid's financing and delivery of services, the hope is that quality of care can be stabilized or improved, confusion can be minimized for beneficiaries, and costs can be lowered. Some studies have shown that states utilizing Medicare and Medicaid integrated care initiatives report fewer emergency

department admissions, shorter hospital stays, increased preventive care utilization, and lower readmission rates.

There have been other key lessons learned from states' efforts to integrate care for dually eligible beneficiaries. Lessons learned across multiple financial alignment demonstrations include the importance of providing ongoing, targeted beneficiary engagement; engaging providers so they understand and are trained in care philosophies and models relevant to these populations; being flexible with program requirements to the extent possible; and setting sufficient reimbursement rates. These lessons include direct experiences from New York's FIDA program and are reflected in this proposal. Many of the benefits and protections in FIDA are recommended to be included in the new model. In addition, observations and experiences in New York's larger managed care sector have informed this proposal, as well as RTI International's (the CMS contracted evaluator for FIDA) early findings on the FIDA demonstration.

Another key lesson, based on experiences from the FIDA demonstration, is that dual eligibles and their caregivers need and seek out independent assistance understanding, navigating, and accessing health care from the state's ombudsman program, the Independent Consumer Advocacy Network (ICAN). The creation of ICAN has allowed the program to serve approximately 15,000 New Yorkers who by definition are frail, vulnerable, and may also have cognitive and language issues.[iii] ICAN should continue to serve as the state's ombudsman program for people with Medicaid LTSS and additionally serve as the ombudsman to support those who choose to enroll in the new, fully integrated care model.

II. Background

A. Proposed Model of Care

According to the MEDPAC-MACPAC January 2018 Data Book, individuals who are dually eligible for Medicare and Medicaid are poorer and sicker than the rest of the Medicare population.[iv] The CMS Medicare-Medicaid Coordination Office (MMCO) reports that there are close to 726,000 full dual eligibles in New York and almost 147,000 partial dual eligibles.[v] [vi] A full dual eligible is a person who has Medicare and full Medicaid benefits, which includes Medicaid paying for the Medicare Part B premium and the Part A premium, if applicable. A partial dual eligible is a person who has Medicare and does not have full Medicaid benefits, but rather qualifies to have

Medicaid pay the Medicare Part B premium, Part A premium, if applicable, and may pay Medicare cost-sharing.[vii]

The New York State Department of Health (NYSDOH) reports that, as of April 2018 approximately 237,000 of the over 725,000 full dual eligible New Yorkers are enrolled in a variety of managed care products specifically for full dual eligibles.[viii] These managed care products include: partial capitation Managed Long-Term Care (MLTC) plans, Program of All-Inclusive Care for the Elderly (PACE), Medicaid Advantage (MA), Medicaid Advantage Plus (MAP), FIDA, and Fully Integrated Duals Advantage for individuals with Intellectual and Developmental Disabilities (FIDA-IDD). However, with the exception of those enrolled in the state's PACE program and the state's FIDA programs, most of these full dual eligible New Yorkers are not enrolled in a managed care plan that truly coordinates and integrates their Medicare and Medicaid services. There are over 200,000 New Yorkers enrolled in D-SNPs, and this number includes both full and partial dual eligibles. Currently, there is very little integration or coordination of Medicare and Medicaid services provided in D-SNPs that are offered in New York.

The MA and MAP plans as well as the partially capitated MLTC plans all include some promised elements of integration or coordination. However, beneficiaries enrolled in these plans often experience fragmented care and often find the plans lack the resources or initiative to assist them with coordinating their care. Therefore, these full dual eligible low-income, sick New Yorkers often face challenges accessing needed care, which may result in avoidable hospitalization, duplication of services, and subpar health outcomes.

Some full dual eligible New Yorkers may have up to five sources of health coverage to navigate in order to access necessary care and services. For example, a full dual eligible with a Medicaid MLTC plan may also have a Medicare Advantage with Prescription Drug plan, or a full dual eligible who has Fee-for-Service Medicare may have a Medigap plan, a Part D prescription drug plan, and retiree coverage, in addition to their Medicaid MLTC plan. Navigating multiple plans to access care can be burdensome and inefficient. NYSDOH identified the multiple challenges a dual eligible may face when having multiple health plans or coverage:

- Care is not coordinated;
- Coverage rules and procedures differ under each program;

- Written information comes from multiple sources with no single comprehensive description of the sum total of benefits, procedures, or rights and responsibilities applicable to dual eligibles;
- Processes for grievances and appeals differ as to notices relating to both coverage determinations and grievances and appeals;
- Responsibility for delivering necessary services is divided between different programs, making it hard to know where to go when problems present;
- Providers are challenged to understand how the different coverages interact and how to proceed when they conflict; and
- Providers across programs have little or no established mechanisms through which to communicate. [ix]

Based on our experience working with New York dual eligibles, many have cobbled together integrated high quality care through Fee-for-Service Medicare. Working with their primary care physician or other health care providers, these beneficiaries achieve a level of coordination to access services and care that is not readily replicable in other managed care plans or other integrated programs. However, other duals struggle with navigating their multiple plans or sources of coverage and face challenges in trying to coordinate all of their services. Consequently, a managed fully integrated plan may be a good option for these New York full dual eligibles to best access care that meets their health care needs.

Unfortunately, the managed care plan landscape is confusing, as noted above, for all duals, their caregivers, and providers. There is currently an array of plans, such as D-SNPs, MA, MAP, MLTC, PACE, and FIDA, from which duals can choose, and there is no roadmap for consumers or their advocates to understand when they can or should transition to another plan to access certain services or another level of care coordination. To the average consumer, many of these plans seem to offer similar services according to the plan's claims (i.e., almost all types of plans tout their ability to offer care coordination).Therefore, when consumers truly need care coordination, they are sometimes disappointed that the type of plan they have chosen does not actually have the resources to provide them with that care. And, if their particular plan does not offer a plan type that does offer care coordination, the plan might not inform the consumer of options available through other plan sponsors.

Regardless of how New York moves ahead with an integrated care model, there must be a simplification of plan offerings for dual eligibles. And there must be clear guidance for consumers, providers, and plans themselves about what types of plans might be suitable for consumers as their health care needs change over time. Thousands of dual eligibles are left to navigate bifurcated coverage with little, if any, assistance coordinating their care all while suffering from chronic illnesses, increased frailty as they age or health declines, or struggling with challenges associated with being of low income.

Further, the new integrated care model for New York's full benefit dually eligible population should have a single set of comprehensive benefits that include a range of services: physician, hospital, prescription drug, behavioral health, and long-term care services. Each beneficiary should have an individualized care plan created with and coordinated by an interdisciplinary team of health providers and have the opportunity to inform their own care plan. Ideally integrated care should be delivered in lower-cost community settings, which is consistent with most beneficiaries' preferences. The integrated care model has the potential to ensure that each dual eligible New Yorker receives all of their necessary services in the least restrictive environment possible and through an integrated program that is based on addressing needs of the whole person using a person-centered care approach.

B. Target Population

We recommend that the target population for this new integrated model of care should include all full dual eligibles, those with LTSS needs, and those without LTSS who may or may not later require LTSS. The model should be offered statewide in all counties. We recommend that the model align with goals articulated by MMCO. A fully integrated product should further MMCO goals, such as improving quality and access to care for dual eligibles, simplifying processes, and eliminating regulatory conflicts and cost-shifting that occurs between the Medicare and Medicaid programs. While dual eligibles have varied levels of need, it is certain that any dual eligible likely has experienced challenges due to receiving fragmented care from the Medicare and Medicaid programs. New York has the opportunity to create a product offering available to all full dual eligibles, who are in need of assistance accessing their health care. Creating an integrated product for all

New York full dual eligibles is a means for New York to be a leader in the efforts currently being undertaken by MMCO.

III. Care Model Overview

A. Proposed Delivery System

1. Geographic Service Area

The new integrated care model should operate statewide. All full dual eligible New Yorkers should have the option to participate in an integrated care model that may lessen the challenges that result from having to navigate two different health insurance programs, Medicare and Medicaid. However, the new model will likely need to roll-out in phases in order to ensure that all counties are adequately prepared in terms of Participant (hereafter "Participant" refers to an enrollee in the new integrated care model) access and choice, network adequacy, provider education and outreach, and beneficiary education and outreach. Assuming a phased roll-out is necessary, counties with existing dual products such as FIDA or MAP may be better equipped to roll out earlier than counties that have few or no dual product offerings. RTI findings on successes and challenges in New York's financial alignment demonstrations concluded that it was more difficult for Medicare-Medicaid Plans (MMPs) to implement Medicare benefits if they had not offered a Medicare product prior to their participation in FIDA.[x]

Throughout the FIDA demonstration, upstate advocates and beneficiaries often expressed the desire to have a FIDA plan in their area. While some areas of the state may not be equipped to operate an integrated product immediately, we recommend that creative options to provide integrated care be encouraged and explored by working with local area hospitals, facilities, and providers, in addition to plans.

If New York chooses not to roll out this program statewide, then NYSDOH should create measures that may allow for and support expansion of the program statewide.

2. Enrollment Method

Enrollment into the new integrated model should be voluntary for all dual eligibles at the time the new model rolls out in their county. Beneficiary outreach should promote informed choice and education prior to voluntarily opting in to the new model. This will allow beneficiaries and their family members the

opportunity to learn what the new integrated care model offers and will allow them to identify whether it is the right product for them. Seamless conversion should not be utilized in the first year of the new integrated care model. We recommend that no earlier than year two of the new integrated model, individuals who become full dual eligibles may be subject to seamless conversion into the new integrated model if they are currently enrolled in a Medicaid Managed Care (MMC) plan that has approval authority from CMS to seamlessly enroll their members into their dual product upon Medicare eligibility.[xi] In addition, in the event of seamless conversion, provider networks in the fully integrated care plans should be substantially identical to the network in the MMC plan. MMC plans should identify and contact beneficiaries at least 90 days prior to enrollment to ensure that the enrollment meets beneficiary needs. The beneficiary must affirmatively opt in through an independent enrollment broker.

All individuals who enroll in the new integrated model, whether voluntarily or by opting for seamless conversion, should be entitled to continuity of care rights upon enrollment. Beneficiaries should have the right to continuous open enrollment into the new integrated model, similar to their rights in the current Medicare Advantage program, where dual eligibles currently have Special Enrollment Periods to change Medicare Advantage plans on a monthly basis.[xii] Dual eligibles in New York must continue to have this important right and there should be no lock-in period for the new integrated model.

Passive enrollment should not be used to enroll beneficiaries into the new integrated care model. Passive enrollment infringes on a beneficiary's statutory right to choose either traditional Fee-for-Service Medicare or a managed care plan, such as a Medicare Advantage product, PACE, or FIDA. Experience from the financial alignment demonstrations, and especially FIDA, shows that passive enrollment is not effective or efficient since there were rapid disenrollments once beneficiaries discovered they were passively enrolled.[xiii] In New York, while the FIDA Memorandum of Understanding (Appendix 7) indicated the use of intelligent assignment so that beneficiaries' passive enrollment would allow them to continue seeing their providers, beneficiary experience proved otherwise. Based on Medicare Rights' interactions with beneficiaries, many of those passively enrolled into FIDA actively disenrolled once they realized they were unable to see their longtime providers. Other demonstrations had a similar experience.

Passive enrollment into an unfamiliar product leads to uncertainty and risks about one's care and access to care. It prevents low-income, vulnerable individuals from actively choosing their health care coverage and may result in enrollment in a plan that does not best meet their needs. We recommend that efforts to stimulate enrollment occur through robust outreach and education about the new integrated care model in order for informed dually eligible individuals to be able to exercise their right to choose the best option for their health care needs.

3. Network Adequacy and Access

Participants of the new integrated care model must have timely access to all necessary providers. All new integrated care model plans should meet the broadest of the existing applicable Medicare and Medicaid provider network requirements.[xiv] In addition, the new integrated care model plans should comply with CMS Medicare Advantage Network Adequacy criteria.[xv] A maximum patient-to-provider ratio, as exists in MMC, should be identified for new integrated care models. With the involvement of stakeholders, New York should determine which services are most needed and most accessed by dually eligible New Yorkers. The state should then establish network requirements, which may vary by specialty or service but also take into account other factors, such as: providers accepting new patients, a maximum patient load, or patient to provider ratio which is based on specialty, a determined number of every type of provider who meet accessibility standards established by the American Disabilities Act (ADA), and capacity to serve members with limited English proficiency (LEP) or unique health care needs. Access to out-of-network providers at no cost to Participants should be available to all Participants if it is determined that a plan's network is unable to meet the Participant's needs. Plans then should be required to enter single case agreements in these circumstances. Plans should ensure that Participants can access out-of-network providers without any delay.

Finally, Participants should be clearly informed about access to out-of-network providers. Often beneficiaries are not aware of this option and will delay, or unnecessarily limit, seeing appropriate providers.

In addition, Participants should be educated on the wait-time limits and maximum travel and distance requirements. Participants are often unaware of these requirements and have significant wait times to see providers and for transportation to providers. Plan communications around network adequacy

must be accurate and current to truly allow Participants to access necessary providers. Strong oversight of network adequacy must be incorporated into the integrated care model in accordance with the GAO report recommendations for enhanced oversight of Medicare Advantage plan network adequacy.[xvi]

If network adequacy and access are not carefully designed and monitored, then Participants will suffer consequences of delays and lack of appropriate care.

4. Care Coordination

The integrated model must provide effective and efficient person-centered care coordination and care management for all Participants. This should be accomplished through an Interdisciplinary Team (IDT) approach and each IDT should have a point-person who will facilitate information sharing amongst the IDT members and also serve as the Participant's designated care manager. The IDT members should include the primary care physician and/or specialist providers of the Participant's choice, in addition to the Participant and/or their designee. For example, the IDT might be comprised of the Participant and/or their designee; designated care manager; primary care physician; behavioral health professional; Participant's home care aide; and other providers either requested by the Participant or their designee, or as recommended by the care manager or primary care physician and approved by the Participant and/or their designee. The inclusion of these providers will allow for thorough care coordination to occur. All IDT provider members should be compensated for their participation. In addition, IDT members should have a direct method of communication with the Participant's IDT care manager in order for the Participant's needs to be addressed timely and efficiently.

The care manager is an integral component of the new integrated care model having both the role of coordinating the IDT and the Participants' services. Each IDT care manager must have an appropriate caseload to ensure that the Participant receives all necessary services and assistance in a timely manner. Therefore, we recommend that plans be required to adhere to specific care manager-to-member ratios that may vary based on Participants' level of need. For example a care manager that supports Participants with lower needs might have a larger caseload than a care manager that supports Participants with high needs. Care manager-to-member ratios and a cap on care managers' caseloads, at a minimum, should be developed based on current care

manager and plan member experiences and with expert input from appropriate professionals such as social workers and geriatricians.

Furthermore, care mangers must be properly trained to address all needs of the Participants they support. Current MLTC members report that their care managers often do not know how to help them access particular services such as durable medical equipment and the member is only given a list of suppliers to call rather than be assisted through the process. MLTC members also state that care managers are quick to respond to a request by stating that they cannot help with particular issues, especially anything related to Medicare even when the MLTC plan is the secondary payer. Therefore, care manager responsibilities should be clearly outlined and known by care managers in order to avoid current MLTC members' experience of care managers frequently shifting responsibilities or refusing to provide assistance. In the new integrated care model Participants should feel supported and cared for by their care managers and should be able to develop a trusting, reliable relationship as they experience robust care coordination.

The IDT care planning should allow Participants to receive person-centered, culturally competent care that supports self-direction and is provided in the least restrictive setting. The integrated care plan should facilitate and accommodate the Participant's or their designee's involvement in all care planning activities. Participants and/or their designee should be meaningfully engaged in the service planning process, including the development of care plans that reflect the Participant's values, needs, and desired quality of care and life. Participants and their caregivers should always have the most updated version of their current care plan. All Participants should have access to ICAN, the independent participant ombudsman, to help them exercise their rights and express wishes in and around the care planning process. Plans should be required to allow participants' authorized representatives, including ICAN counselors, to communicate with plan staff and participate in the care planning process.

The framework for the IDT and care coordination should be clearly diagrammed and outlined for all stakeholders, but in particular it is very important that Participants are aware of what care coordination should look like, how it operates, how to access it, and what to expect. According to the CAHPS Survey on enrollee experiences in the Medicare-Medicaid financial alignment demonstrations, only 35 percent of survey respondents recalled receiving help from their health plan and/or providers in coordinating their care.[xvii] The RTI

report suggests that Participants in duals demonstrations may lack understanding about the care planning process, which results in little to no involvement. However, RTI also reported that once Participants become familiar with their assigned care coordinators and establish a personal relationship with them, then the Participants appreciate the support and learn to ask for assistance with accessing and coordinating services and care.

It is essential that the new integrated care model include efficient, effective care coordination and management and that NYSDOH oversight ensures that this robust care management occurs for all Participants. Without it, the integrated care model will likely fail to assist and promote improved health outcomes for dual eligibles.

5. Integrated Data

NYSDOH and CMS should create a shared data system in order for the new integrated care plans, providers, and Participants to access health records, claims, service authorizations, and care plans. ICAN and community-based organizations working with Participants, when granted permission, should also be able to access the shared data system. The creation and use of a shared data system that allows authorized users to access health plan records could improve communication between providers, health plans, and Participants. Provider access to health plan records could result in less duplication of services and reduced expenditures if a provider is able to know what other tests and services were previously ordered. It could also lessen Participants and/or their representatives' confusion about a Participant's services or plan of care. Allowing for access to integrated data could strengthen and improve the IDT care planning and service authorization process. It would also reduce the amount of phone time and phone calls that providers, care managers, advocates, caregivers, and Participants often experience when trying to access information from a health plan or provider.

Access to health records is a frequent hurdle to assisting patients, servicing health plan members, or advocating on behalf of a health plan member. The RTI FIDA evaluation reported that providers faced challenges accessing patient records from health plans.[xviii] Providers also stated that access to data and information was an obstacle to participating in FIDA IDT meetings and in prescribing certain services. An example of one type of shared data system is being used by Ohio's financial alignment demonstration, My Care Ohio. My Care Ohio has incorporated a cloud-based electronic care management

system that grants access to all participating providers and delegated care management entities. My Care Ohio participants can also access their own portal to input information and communicate with care managers.[xix]

The new integrated care model should be developed with strong, careful consideration of how to provide and ensure access to integrated data that will further the goals of an integrated product that offers coordinated, person-centered care.

B. Proposed Benefit Design

1. Supplemental Benefits and Support Services

a. Interdisciplinary Care Team (IDT)

Each Participant's care should be planned, arranged, and authorized by an individualized, person-centered care planning team, the IDT. As mentioned previously, the IDT should consist of various providers and the Participant and/or their designee and be coordinated by the Participant's care manager. In addition to authorizing services, the IDT should create and update Participant care plans. Participants' medical, functional, and social needs should be fully assessed upon enrollment and reassessments should occur at least every six months and more frequently if there is a change in the Participant's condition, thus requiring involvement by the IDT.

Provider participation in the IDT should be a billable claim and reimbursement rates should account for time spent on IDT involvement. Physicians should retain the flexibility to assign another provider on their staff to serve on the IDT (e.g., nurse practitioner or a physician assistant). IDT members should have a direct line of communication with the Participant's care manager who also serves as the IDT point-person. No provider should have to access a phone tree to reach the Participant's care manager.

Use of the IDT model in PACE has proved successful; however, much was learned through the use of the IDT in the FIDA program. FIDA's initial IDT policy required revision and a more flexible IDT became more realistic and accessible for plans, providers, and FIDA members, yet FIDA plans still reported difficulties engaging primary care physicians.[xx] The RTI FIDA evaluation reported that lack of provider reimbursement contributed to the participation difficulties. It is in the Participant's and plan's best interest to have their providers participate in the

IDT, and the new integrated model must include provider reimbursement and flexibility that will allow for and encourage provider participation in the IDT.

b. Person-Centered Service Planning Approach

The new integrated care model can best address the necessary care needs of full dual eligibles through a person-centered approach. The integrated care model should create a care planning approach that balances complex care needs with individual daily living goals. Person-centered care allows for coordination with acute medical care and behavioral health. Plans should be required to carry out person-centered care as defined in the *Journal of the American Geriatric Society*: "Person-centered care means that individuals' values and preferences are elicited and, once expressed, guide all aspects of their health care, supporting their realistic health and life goals." [xxi]

The IDT, which includes the Participant, should create the care plan, which should integrate medical services and home-community based services and be built around a Participant's goals, not just their medical problems. The person-centered planning approach should include core elements such as 1) care supported by an IDT with the Participant at the center; 2) a personalized, goal-oriented care plan based on a Participant's values and preferences, with goals regularly reviewed; 3) a primary contact, such as the care manager, on the IDT that is responsible for coordination and communication; 4) care coordination among all health care and supportive services with continual information sharing; 5) education and training on person-centered care for providers and other individuals involved in the care; and 6) ongoing feedback to assess outcomes and well-being for continuous quality improvement.[xxii]

The PACE program has been successfully using the person-centered service planning approach and should be considered as an essential best practice to include in the new integrated care model. Person-centered care planning is also used and required in Medicaid Home and Community-Based Services (HCBS).[xxiii]

IV. Engagement and Beneficiary Protections

A. Provider Engagement

Provider education is just as important as enrollee outreach for ensuring a successful integrated care model and a smooth programmatic rollout. There should be targeted provider outreach that both explains the purpose of the new integrated care model as well as addresses providers' practical concerns. The provider outreach should focus on contracting details and include clear explanations of available benefits and any new billing practices and procedures, which must be consistent across all plans. Prior to the roll-out, providers should receive comprehensive yet concise educational information about the new integrated care model by mail, webinar, and trainings. Providers should have the opportunity to respond to materials to ensure that the new integrated care model design is appropriately structured to allow their patients to benefit. Additionally, providers should be required to participate in the informational and educational sessions related to the new integrated care model. However, participation must be easy for providers and should take into consideration provider's daily practices as well as previous methods that successfully achieved provider participation.

Once the new program has rolled out, providers should be surveyed every six months to inform NYSDOH on how the new model is working for providers and their patients. As mentioned above, surveys must be easily accessible for providers and should be created for completion that can occur as part of providers' regular daily practice. Survey results should be publically available within two months of the conclusion of each survey.

We urge NYSDOH to ensure early provider engagement in the new integrated care model. Lack of provider familiarity with FIDA and understanding of the program largely contributed to the low enrollments and high opt-out rates. Therefore, it is essential that providers be involved in and educated about the integrated care model because they are often the first person that a beneficiary consults about whether they should join a new health plan. Strong provider engagement will lend itself to a strong integrated care program.

B. Stakeholder Engagement

The Future of Integrated Care stakeholder meetings that were held in fall 2017 should continue in order to gather stakeholder ideas and feedback, and NYSDOH should identify how previous stakeholder meeting conversations and comments are being incorporated into the new integrated care model. NYSDOH should develop task forces to engage stakeholders as the new integrated care model proceeds. The task forces should be targeted to address

specific concerns such as: Quality Assurance; Monitoring and Oversight; Finance and Incentives; Enrollment; and Consumer Communication and Outreach. Task forces should be sufficiently staffed to ensure meaningful development of an overall mission and concrete objectives at the outset. NYSDOH staff should regularly inform task force members about how and when their input is incorporated into the new integrated care model.

Stakeholders should also have the opportunity to comment on draft materials outlining the new integrated care model, including the contract, and these materials should be made publicly available. We recommend that the new integrated care model be governed by a three-way contract that includes NYSDOH, CMS, and the plans. A three-way contract will allow for necessary oversight and collaboration between NYSDOH, CMS, and the plan in order to create a truly comprehensive, integrated care model that meets the health care needs of New York's dual eligibles.

Advocates who were invited to comment on the FIDA three-way contract and FIDA materials (i.e., notices and Member Handbook) should be involved in the same way again. Advocates' feedback was incorporated to strengthen the design and implementation of FIDA and its offerings. Once the model rolls-out, NYSDOH should hold quarterly stakeholder meetings to gather input and feedback about the new integrated care model. These quarterly stakeholder meetings could also be used by NYSDOH to provide updates and share information about topics such as, but not limited to, enrollment, plan performance, appeals data, and provider and Participant satisfaction survey results.

Lastly, NYSDOH and CMS should publicly share the data that has been collected throughout the FIDA demonstration, as well as from the MAP, PACE, and D-SNP programs, to inform the stakeholders' process. This should include aggregated UAS-NY assessment data, encounter data, enrollment data, grievance and appeal statistics, and quality measures. It is impossible for stakeholders to agree on which aspects of these programs worked and which didn't if they do not have a shared set of empirical facts from which to operate. These data should be regularly published online for the new integrated program, so that stakeholders can monitor plan performance and provide informed feedback to NYSDOH and CMS.

C. Beneficiary Engagement

A beneficiary engagement plan should be created in partnership with community-based providers and advocates, including ICAN. The beneficiary engagement plan should also be informed by NYSDOH holding localized town hall meetings where beneficiaries and family members can ask questions and raise concerns about the new integrated care model program design. The beneficiary engagement plan should include an outreach and education campaign, including written materials, live trainings and presentations, and electronic media activities, to ensure that the eligible population, their caregivers, their providers, and the advocates are well informed and well prepared for the roll-out of the new integrated care model and aware of the benefits offered in the new integrated model. NYSDOH should engage beneficiaries to test readability and comprehension of these materials and materials should be altered based on beneficiaries' feedback.

Informational notices and updates should be shared with the eligible population prior to the roll-out, which will at a minimum include information on eligibility, how to enroll, benefits offered, and rights and protections in the new integrated care model. Information must be available in alternate formats, designed for a low-vision reader and be appropriate for a low-literacy audience. Type size, font, contrast, and other features must conform with print publication guidelines and materials should be available in the six most common languages. The ICAN helpline number should be included on all written or electronic communication about the new integrated care program.

Beneficiaries enrolled in new integrated care plans should have the opportunity to engage with their plan and NYSDOH. Participant satisfaction and quality surveys should be conducted every six months. Surveys should be conducted by an independent entity such as ICAN. Survey results should be made publicly available and shared at quarterly stakeholder meetings.

All plans should be required to hold at least two Participant Feedback Sessions in their service areas each year. At these sessions, Participants should be invited to raise problems and concerns, and provide positive feedback as well. Plans should be required to assist Participants with the costs, transportation, and other challenges of attending these in-person Participant Feedback Sessions. NYSDOH should be required to attend a sampling of these events each year. Plans should be required to summarize each session and make the summary available to Participants and the public.

New York regulation requires each managed care plan to either have member representation on its board of directors or to have an advisory council of plan members to provide feedback to the plan.[xxiv] Each integrated care plan should be required to have a Participant Advisory Committee (PAC) that should be open to all Participants and family representatives as well as ICAN representatives. Plans should have quarterly PAC meetings and NYSDOH and Regional CMS staff should attend at least one PAC meeting hosted by each plan per year. Plans should be required to assist Participants with costs, transportation, and other challenges attending all of these meetings.

At each quarterly PAC meeting, plans are expected to share any updates or proposed changes; information about the number and nature of grievances and appeals; information about quality assurance and improvement; information about enrollments and disenrollments; and Participant satisfaction survey results. PAC meetings should be a forum for Participants to voice questions and concerns regarding all topics related to service delivery and quality of life as well as provide any input and feedback on topics raised by the plan.

While some FIDA plans believed that the PAC meetings in FIDA were not productive due to low Participant attendance, it is important that these forums continue in order to allow Participants in the new integrated care model to be at the table with their plan. In addition, because the proposed integrated care model should be an available option for all full dual eligibles, there will likely be a greater number of well-duals enrolled who may be able to participate.

All Participants and beneficiaries inquiring about or seeking enrollment into a new fully integrated care plan should have access to ICAN.

D. Beneficiary Protections

1. Continuity of Care

NYSDOH created continuity of care protections for the FIDA model and should incorporate similar and better continuity of care protections in the new integrated care model.[xxv] While FIDA allowed for 90 days of continuity of care, the new integrated care model should allow for six months of continuity of care rights. Participants should be able to continue to see their established providers and complete any ongoing courses of treatment during the first six months of transition into a new integrated care plan, in the event that these providers are not in the plan network. The plan should allow Participants who are receiving

behavioral health services to maintain current behavioral health service providers for the current episode of care for a period not to exceed two years from the date of enrollment in the plan. NYSDOH should also require that all care plans and prescription medication authorizations last for six months of transition to the new integrated plan.

Therefore, only after a Participant's first six months in the new integrated care plan can that plan reduce, suspend, deny, or terminate a service. Any reduction, suspension, denial, or termination of a previously authorized service will trigger the plan to issue notice required under 42 CFR § 438.404, and the Participant must be informed of their appeal rights and right to aid continuing.[xxvi]

Continuity of care rights must be built into the new integrated care model. Most of the dual eligible population has critical health needs and disruptions in their care and access to services can be detrimental, potentially causing avoidable hospitalizations and visits to emergency departments. The integrated care model's continuity of care rights should apply when enrolling in a plan or transferring to another integrated care plan, whether it is a voluntary or involuntary transfer. It is further recommended that continuity of care rights also apply when a Participant is disenrolling from a new integrated care plan and enrolling into another type of product. Continuity of care rights will allow for New York's dually eligible population to receive and access continuous care as needed to maintain or improve health outcomes.

2. Grievance and Appeals Process

Medicare Rights recommends that the new integrated care model adopt the FIDA Medicare-Medicaid integrated grievance and appeals process ("FIDA appeals process"). NYSDOH successfully created and implemented the FIDA Appeals Process and it has proved to be effective for all to use.

States and federal government entities look to the FIDA Appeals Process as a model of innovation for improving access to care for dual eligibles. Under FIDA, Participants, caregivers, plans, and advocates have all witnessed and experienced the benefits of the integrated appeals process. It is much easier to understand and proceed with an appeal using the integrated appeals process. MACPAC has also noted the benefits of an integrated appeals process for dual eligibles and heard firsthand that New York beneficiaries, providers, health plans, and other stakeholders support the single integrated appeals process.[xxvii]

In addition, the move toward an integrated appeals and grievance process for dual eligible beneficiaries enrolled in dual products was included in the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2018 in the context of D-SNPs. The Act became law as part of the BBA of 2018, and it requires that procedures for unified grievances and appeals procedures be in place for D-SNPs by April 1, 2020.[xxviii] Therefore, it would be a step in the wrong direction to not include an integrated appeals process in the new integrated care model.

The integrated care model should continue to auto-forward unfavorable and partially unfavorable appeals to the next appeal levels with aid continuing for the duration of the entire appeals process.

In addition, the new integrated care model's fully integrated appeals process should also include Medicare Part D prescription drug appeals. Currently, Medicare Part D beneficiaries who are denied a medication at the pharmacy must still take multiple steps to get a plan determination in order to appeal the denial, leading to potentially harmful delays. The Part D appeals process is weighed down by excessive paperwork and administrative error, and severely lacks transparency. Beneficiaries, their prescribers, and their pharmacists are often unaware of how to challenge the plan's decision. As a result, many beneficiaries bypass the formal appeals process entirely, simply leaving the pharmacy empty-handed and accepting the resulting consequences to their health, or paying the full cost of the drug out of pocket, if they can afford to do so.

For the beneficiaries who do request a coverage determination, it is only after this coverage determination is made that the beneficiary has any appeal rights. However, rather than appealing to an independent entity, the beneficiary once again makes an appeal to the plan. The current Part D appeals process allows the plan to have three opportunities at the appeal: the decision at the pharmacy counter, the coverage determination, and the coverage redetermination. From experience, this process often deters beneficiaries from pursuing an appeal and confuses beneficiaries, prescribers, and pharmacists. The Part D appeals process is riddled with deficiencies and adoption of the current process for the new integrated care model would be ill advised.

3. Enrollment Assistance

NYSDOH should continue utilizing an independent enrollment broker to assist Participants in making their initial enrollment decisions as well as any additional enrollment or disenrollment decisions. The enrollment broker should be conflict-free and well-equipped to understand and explain the new integrated care model and other service delivery options, including PACE. The independent enrollment broker should have a plan comparison tool similar to Medicare's PlanFinder, which will allow the enrollment counselor to assist the beneficiary by inputting their providers, services, and prescriptions to help determine which, if any, new integrated care plan best suits the beneficiary's particular needs. The enrollment broker should provide oral and written information on enrollment rights, including but not limited to the rights and procedures involved in making an enrollment or disenrollment choice and the availability of ICAN to also help the Participant. The independent enrollment broker should also be able to provide information, based on the caller's needs, about other independent sources of counseling, such as Community Health Advocates (CHA); the Facilitated Enrollment for the Aged, Blind, and Disabled Program (FE-ABD); the State Health Insurance Assistance Program (SHIP); local Area Agencies on Aging (AAA); independent living centers; and other organizations with experience with the Medicare and/or Medicaid programs.

4. Ombudsman Access

The Independent Consumer Advocacy Network (ICAN) should serve as the Participant ombudsman for all Participants in the new, fully integrated care model. ICAN should continue to operate in its current scope and provide information and counseling to beneficiaries and advocates on behalf of aggrieved beneficiaries. ICAN's scope should expand to include all Participants in the new, fully integrated care model, including dual eligibles that are not receiving any LTSS. All Participants should have access to free assistance from ICAN and be provided assistance with accessing care; understanding and exercising their rights; appealing adverse decisions made by their plans; and referral and direct assistance/representation in dealing with plans, providers, CMS, and/or NYSDOH. ICAN should track systemic issues experienced by Participants in the new, fully integrated care model. The ICAN Helpline should be included on all plan and NYSDOH notices. NYSDOH has recognized the need for ICAN's assistance by the number of cases ICAN handles and anticipates its growth.[xxix] Therefore, ICAN is not just the logical choice to serve as the Participant ombudsman but is the necessary choice due to its successful

structure and in-depth experience assisting New York's dually eligible population.

V. Financing

The new, fully integrated care model must incorporate financing that allows for the program to succeed and for Participants to receive high quality coordinated care that meets all of their health care needs and goals. Medicare and Medicaid, as two separate programs, have conflicting financial incentives. Therefore, the integrated care model should attempt to align the financial incentives and properly incentivize the plans to provide high quality person-centered care. Integrated care plan rates should allow for robust care management services and provide appropriate compensation for services, such as coordinating a person's medical appointments and health services and supplies. Care managers should be supported, provided the necessary tools to efficiently succeed, and engaged in plan feedback and evaluation of the person-centered care management system. Payment rates must also be adequate to reimburse providers for IDT participation to ensure robust care coordination and care management.

The integrated care model should use a rate-setting methodology that rewards plans for serving New York's vulnerable dual eligible population and should incentivize home and community-based services over institutionalization wherever possible. NYSDOH should look to financial alignment demonstrations in states such as California and Massachusetts that used multiple rating categories to determine the rate plans would receive.[xxx] For example, California used four rating categories that were thoroughly defined: a) institutionalized; b) HCBS high; c) HCBS low; and d) community well. It is important that NYSDOH consider multiple rate categories because this proposed integrated care model includes full benefit dual eligibles who are not receiving LTSS and therefore it is crucial that the rate-setting methodology be transparent in order to prevent cherry-picking by plans. For instance, the integrated care model should include the development of a high-needs community rate cell to ensure that plans are correctly compensated and incentivized to allow for Participants to remain healthy and in their homes. Protections must be in place to prevent incentivizing plans to institutionalize Participants.

Payment should be aligned with quality measures that address what matters most to Participants: promoting care to be delivered in a person-centered manner. The quality measures used to reward high-performing plans should be well-tested, comprehensive, and outcomes-based. The measures also should be designed and adjusted in order to not dis-incentivize enrollment of high risk-high needs beneficiaries. The quality measures used to adjust payment rates should be publically available in an easy to understand format. Scores and results should be presented regularly to Participants in a meaningful way.

Payment rates that reward real savings achieved through the reduction of inefficiencies and increased value must be developed without incentivizing gamesmanship or inappropriate care reductions. Any shared savings or cost reduction incentives must be closely monitored for inappropriate reductions in Participants' needed services. In addition, any value-based purchasing or value-based insurance design must have appropriate consumer protections and safeguards.

VI. Monitoring and Oversight of Managed Care Plans

Monitoring and oversight are critical in order to inform program modifications and corrective actions; identify and address health disparities; and educate enrollees so that potential barriers to accessing needed care can be avoided through careful and informed choice of plans. In a three-way contract between DOH, CMS, and plans, both CMS and DOH should have the authority to issue corrective action plans; impose enrollment and marketing sanctions; levy monetary penalties; and if necessary, terminate plan contracts. Both federal and state investigative bodies should have the authority to monitor and investigate the new integrated care model. In addition, there should be rigorous monitoring for discriminatory practices or other unintended consequences of the payment rates and financing. Methods should be in place to evaluate the efficacy of the model and its effects on care quality and patient satisfaction.

There should be strong oversight of care management and care coordination, which are key components of the new care model. Oversight of care management and care coordination are essential because they are at the core of ensuring that Participants are receiving assistance accessing necessary care that aligns with their plan of care and benefitting from a fully integrated care model. In MLTC and even in FIDA some participants experience poor care

coordination and care management, which results in untimely access to necessary services and supplies. Lack of care management and coordination have also resulted in individual providers taking on the role of care manager, coordinating services for their patients thus duplicating efforts and wasting state dollars. Therefore, the new integrated care model must have complete and thorough oversight of the person-centered care management process. CMS' role in providing sufficient oversight was highlighted by a GAO report recommending that additional oversight by CMS was needed in previous demonstration projects in order to determine whether care coordination is being provided to dual eligibles. GAO recommended that CMS develop new comparable measures that are aligned with existing measures in order to strengthen the oversight of care coordination.[xxxi] NYSDOH should adhere to applicable recommendations in the GAO report, and it should constantly monitor plans and be in frequent communication with plans about the plan's regular execution of care management and care coordination for Participants.

Quality measures must address complex characteristics of dual eligibles (i.e., use of LTSS, functional decline, frailty, and multiple coexisting conditions) and address critical indicators of quality improvement. As stated previously, there must be measures that capture care coordination as well as outcomes for when enrollees have different goals. The quality indicators should provide continuous feedback to program improvement efforts.[xxxii] The measures should also address use of effective care, costs of care, and Participant experiences.

Transparency of the monitoring and oversight of the integrated care plans must exist in order to inform all stakeholders about the delivery of services and compliance with state and federally imposed requirements. There should also be transparency in the creation and design of quality measures. Quality measures should align with quality measures in other health system transformation initiatives. Health care providers have expressed that the myriad of new health care models and quality initiatives challenge their attention and resources (and that of their administrators).

VII. Targeted Outcomes

The new integrated care model should allow for full dual eligible New Yorkers to have a better quality of life by eliminating fragmented care. The person-centered care planning approach along with the robust care coordination

should facilitate meeting Participant's goals, which should lead to improving health and quality of life or maintaining it. Quality of care and the Participant and their family's/caregivers' experiences with care should also improve. By avoiding duplication of services through careful care management and avoiding frequent hospitalizations and emergency department services, the integrated care model should provide a better quality of life for each Participant and could reduce the overall cost of care.

Endnotes

[i] This proposal was created and modeled off of the New York State Department of Health's Demonstration to Integrate Care for Dual Eligibles, Final Proposal (May 2012). Some ideas and language from the 2012 proposal are incorporated in this proposal.

[ii]Center for Health Care Strategies, Inc. and Manatt, "Strengthening Medicaid Long Term Services and Supports in an Evolving Policy Environment: A Toolkit for States." (December 2017), available at: https://www.chcs.org/media/Strengthening-LTSS-Toolkit_120717.pdf

[iii] New York State Department of Health Office of Health Insurance Programs, "MRT 'Boo-Yah' Report." (March 2018), available at: https://www.health.ny.gov/health_care/medicaid/redesign/progress_updates/docs/2018-03-15_boo-yah_rep.pdf

[iv] MEDPAC-MACPAC, "Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid." (January 2018), see exhibit.7 page 34 and exhibit 4 page 37: http://medpac.gov/docs/default-source/data-book/jan18_medpac_macpac_dualsdatabook_sec.pdf?sfvrsn=0. Eighteen percent of dual eligibles report being in poor health, as compared with six percent of non-dual Medicare beneficiaries. Dual eligibles are more likely to be institutionalized than non-dual eligibles (21 percent vs. 5 percent). They account for 20 percent of the Medicare population but 34 percent of Medicare spending; they account for 15 percent of all Medicaid beneficiaries but 32 percent of all Medicaid spending

[v] Medicare-Medicaid Coordination Office, "Monthly Enrollment Snapshots." (March 2017 data-updated quarterly), available at" https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Analytics.html

[vi] MedPAC, "Report to Congress: Medicare and the Health Care Delivery System, Chapter 9 Issues affecting dual eligible beneficiaries: CMS's financial alignment demonstration and the Medicare Savings Programs." (June 2016), available at: http://www.medpac.gov/docs/default-source/reports/chapter-9-issues-affecting-dual-eligible-beneficiaries-cms-s-financial-alignment-demonstration-and-t.pdf?sfvrsn=0. The Medicare Payment Advisory Commission report to Congress on issues facing dual eligibles includes information about the dual eligible population. Dual eligibles are more likely than other Medicare beneficiaries to have three or more chronic conditions or be diagnosed with mental illness. Dual eligibles also likely have more need for assistance in performing activities of daily living (ADLs), such as bathing, toileting and getting dressed. About 23 percent of full-benefit dual eligibles over age 65 are diagnosed with Alzheimer's disease. The health care needs and costs for dual eligibles are high and are expected to increase as the baby boomers age.

[vii] Congressional Budget Office, "Glossary of Terms Related to Dual-Eligible Beneficiaries of Medicare and Medicaid." (January 2013), available at: https://www.cbo.gov/publication/44309

[viii] Medicaid Managed Care Enrollment Reports available at: https://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/ (This does not include dual eligibles enrolled in Dual Special Needs Plans.)

[ix] New York State Department of Health, "New York State Department of Health's Demonstration to Integrate Care for Dual Eligibles Final Proposal." (May 2012), pages 5-6

[x] RTI International, "Early Findings on Care Coordination in Capitated Medicare-Medicaid Plans under the Financial Alignment Initiative." (March 2017), page 14, available at: https://innovation.cms.gov/Files/reports/fai-carecoordination-issuebrief.pdf .

[xi] Medicare Managed Care Manual (MMCM) Chapter 2, Sec. 40.1.4 available at: CY 2018 MA Enrollment and Disenrollment Guidance 6-15-17

[xii] While under the Final Part C and Part D Rule the continuous SEP available to dual eligibles will be lessened to once per calendar quarter for the first nine months of the year beginning in 2019, we recommend a continuous monthly SEP be available to New York's full dual eligible population.

[xiii] Grabowski. "Passive Enrollment of Dual-Eligible Beneficiaries Into Medicare And Medicaid Managed Care Has Not Met Expectations." (May 2017), available at: Passive Enrollment of Dual-Eligible Beneficiaries Into Medicare And Medicaid Managed Care Has Not Met Expectations. MedPac, "Issues affecting dual eligible beneficiaries: CMS's financial alignment demonstration and the Medicare Savings Program." (June 2016), page 278, available at: Issues affecting dual eligible beneficiaries: CMS's financial alignment demonstration and the Medicare Savings Program

[xiv] 42 C.F.R. §§ 422.112, 423.120, and 438.206

[xv] Center for Medicare & Medicaid Services (CMS), "Medicare Advantage Network Adequacy Criteria Guidance." (January 2017), available at: https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/MA_Network_Adequacy_Criteria_Guidance_Document_1-10-17.pdf

[xvi] United States Government Accountability Office (GAO), "Medicare Advantage: Actions Needed to Enhance CMS Oversight of Provider Network Adequacy." (August 2015), available at http://www.gao.gov/assets/680/672236.pdf

[xvii] CMS, "Enrollee Experiences in the Medicare-Medicaid Financial Alignment Initiative: Results through the 2017 CAHPS Surveys." (December 2017), available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/FAICAHPSResultsDec2017.pdf

[xviii] RTI International, "Early Findings on Care Coordination in Capitated Medicare-Medicaid Plans under the Financial Alignment Initiative." (March 2017), page 24, available at: https://innovation.cms.gov/Files/reports/fai-carecoordination-issuebrief.pdf

[xix] Center for Health Care Strategies, Inc., "Improving Services for Medicare-Medicaid Enrollees: What's Top-of-Mind for Health Plans?" (August 2015), available at: https://www.chcs.org/improving-services-medicare-medicaid-enrollees-whats-top-mind-health-plans/

[xx] RTI International, "Early Findings on Care Coordination in Capitated Medicare-Medicaid Plans under the Financial Alignment Initiative." (March 2017), pages 23-24, available at: https://innovation.cms.gov/Files/reports/fai-carecoordination-issuebrief.pdf

[xxi] Journal of the American Geriatrics Society, "Person-Centered Care: A Definition and Essential Elements, The American Geriatrics Society Expert Panel on Person-Centered Care." (January 2016), available at: https://onlinelibrary.wiley.com/doi/pdf/10.1111/jgs.13866

[xxii] The SCAN Foundation, "Panel: Getting Person-Centered to Get Results." (June 2016), available at: http://www.thescanfoundation.org/learn-more-about-person-centered-care

[xxiii] 42 C.F.R. § 441.540. In New York person-centered care planning is required for individuals with OPWDD funded HCBS waiver services, 14 NYCRR 636-1.

[xxiv] 10 NYCRR 98-1.1(g).

[xxv] FIDA three-way contract, Section 2.6.6 Continuity of Care, p. 62-63.

[xxvi] Pursuant to requirements in 42 CFR §438.420, NYS Social Services Law §365–a(8), and 18 NYCRR §360–10.8, Medicaid Managed Care (MMC) enrollees may receive continuation of benefits, known as Aid Continuing (AC), under certain circumstances. Enrollees must meet filing requirements identified in 42 CFR §438.420.

[xxvii] Medicaid and CHIP Payment and Access Commission (MACPAC), "Integrating Appeals Processes for Dually Eligible Beneficiaries." (January 2018), available at: https://www.macpac.gov/wp-content/uploads/2018/01/Integrating-Appeals-Processes-for-Dually-Eligible-Beneficiaries.pdf

[xxviii] Bipartisan Budget Act of 2018, Pub. L. 115-123 (2018). The Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act was passed and signed on February 9, 2018. See Sec. 50311.

[xxix] New York State Department of Health Office of Health Insurance Programs, "MRT 'Boo-Yah!' Report." (March 2018), available at: https://www.health.ny.gov/health_care/medicaid/redesign/progress_updates/docs/2018-03-15_boo-yah_rep.pdf

[xxx] MACPAC, “Financial Alignment Initiative for Beneficiaries Dually Eligible for Medicaid and Medicare.” (January 2018), available at: https://www.macpac.gov/wp-content/uploads/2015/09/Financial-Alignment-Initiative-for-Beneficiaries-Dually-Eligible-for-Medicaid-and-Medicare-1.pdf

[xxxi] GAO Report to Congressional Requesters, “Medicare and Medicaid: Additional Oversight Needed of CMS’s Demonstration to Coordinate the Care of Dual-Eligible Beneficiaries.” (December 2015), available at: https://www.gao.gov/assets/680/674340.pdf

[xxxii] National Committee for Quality Assurance (NCQA), “Integrated Care for People with Medicare and Medicaid: A Roadmap for Quality.” (March 2013), available at: https://www.thescanfoundation.org/sites/default/files/ncqa-integrated_care_for_people_medicare_medicaid-3-6-13.pdf