Re: New York State Department of Health ("NYSDOH" or "the State") memo on nursing facility transition into managed care, including long and short term rate setting goals and strategies

Dear Mr. Ulberg and Mr. DeMatteo,

Thank you for continuing to engage consumers in discussions surrounding the development of rates in the Managed Long Term Care (MLTC) and Fully Integrated Duals Advantage (FIDA) programs. As you know from several conversations with the Coalition to Protect the Rights of New York’s Dually Eligible (CPRNYDE), we believe the development of a nursing facility rate cell, which may provide certain plans a financial incentive to institutionalize consumers, is incongruent with the State’s Olmstead plan\(^1\), which commits New York State to transitioning ten percent of long term stay nursing facility residents to the community over the next five years. And it is our understanding, based on our own conversations with the agency, that the Centers for Medicare and Medicaid Services (CMS) will not consider any rate proposal from the State that incentivizes nursing facility placements, regardless of whether or not we as consumer advocates are supportive. We understand that the State has limited time to develop a rate for the MLTC program, which will also serve as the basis for rates in FIDA. As such, we are committed to working hand-in-hand with the State, the Plans, and the nursing facilities to swiftly develop a rate proposal that is fair and balanced for all stakeholders, that is aligned with the State’s Olmstead plan, and will receive the approval of CMS. We also encourage the State to look to the ways other states, including Massachusetts, have created community-based rate cells in a way that garnered CMS approval.

We have talked extensively amongst ourselves over the last day and a half trying to arrive at a point where we could support the proposal; however, we have come to the conclusion that we have no choice but to remain in opposition to the State’s current proposal to create a nursing facility rate cell and two risk pools. The two risk pools do not contain adequate beneficiary protections, and under this proposal, Plans would not know in advance whether their aggregate service mix met the threshold to qualify for a payment under the risk pool, nor would they receive the payment until many months after they had provided the services or transitioned the members out of the nursing

The use of a nursing facility rate cell is also very problematic in that it has the potential to create a financial incentive for Plans to place consumers into nursing facilities.

Since March 2012, before MLTC was mandatory for nursing facility residents, CPRNYDE has advocated for modifications to the pure risk-adjusted rate-setting method in order to counterbalance the intrinsic bias toward institutionalization. In response to those previous recommendations, we had heard from the State that its risk-adjustment method was very robust and incorporated multiple factors to properly gauge the Plans’ assumption of medical risk. Accordingly, we were told no rate cells, reinsurance, or stop-loss payments were appropriate.

In the 21 months since then, we have seen many examples of what we believe are MLTC plans responding to the incentives built into their rates: avoiding enrollment of high-need members, placing high-need members in nursing facilities, and disenrolling members once they are in nursing facilities. We understand and are sympathetic to the Plans’ opposition to the use of a blended rate during the transition of nursing facility residents from Fee-For-Service Medicaid (FFS Medicaid) into a managed care environment and their fear that the blended rate will only compound the inadequacies of the current system by failing to adequately capture both high-need community rates and nursing facility rates, instead of just the high need community rates. While we agree that a blended rate has significant potential problems, we view it as preferable to a nursing facility rate cell since it is blind with regard to setting, particularly as it relates to consumers at the extreme high end of the cost continuum.

Therefore, in an effort to incentivize community-based care and mitigate the adverse financial effects Plans may experience due to the transition of nursing facility residents from FFS Medicaid into MLTC and FIDA, we recommend that the State create a rate cell based on whether or not a consumer has high needs in the community. In addition to this rate cell, we propose that the State create a nursing facility transition pool that would help to appropriately reimburse plans that transition consumers out of institutions and back into the community. This would be supplemented by payments to community-based peer organizations that would help work to identify and assist nursing facility residents in transitioning to the community.

We recognize that identifying and successfully transitioning someone from a nursing facility to the community is labor intensive and expensive. Therefore, the State should create a financial incentive for plans to transition consumers out of nursing facilities, and to prevent institutionalization of consumers who are in the community, if they are able to live at home with community-based LTSS. The transition pool would recognize the increased costs that go along with the transition by

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providing plans with increased capitation payments for the three months before a consumer has transitioned into the community and is still in the nursing facility, in addition to the nine months after a consumer has moved into the community. It is our position that this rate structure would help Plans adjust to the movement of the nursing facility population into managed care while also incentivizing community-based care, thus helping the State reach its goals as outlined in its Olmstead plan.

Other states have utilized community-based rate cells in their demonstrations. In particular, Massachusetts has developed a rate structure that includes three separate tiers of community-based rates: a tier for high community need, a tier for high behavioral health needs in the community, and a third cell for community-based members that do not necessarily have high needs. Massachusetts is just one example of a set of rate cells that CMS approved and that could serve as a model for how New York State could develop community-based rates in MLTC and FIDA.

Rather than losing limited time by developing and resubmitting a proposal to CMS that contains a nursing facility rate cell incentivizing nursing facility placements, a proposal CMS would reject, we propose that the State should consider a different set of rate modifications that provides a strong incentive toward community-based care, while also helping to insulate the plans from disproportionate medical risk. Given the information we have, we feel this is a strong compromise.

Sincerely,

The Coalition to Protect the Rights of New York’s Dually Eligible

cc:    Mark Kissinger, NYSDOH
       Melissa Seeley, CMS

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