

_____ looked at network adequacy, participant's protection, marketing and outreach, quality standards, rates and contracts, and NCO qualifications, so it's been a very robust dialog, and that will continue today about, with our, you know, our agenda, which we plan to cover geographic scope again, consolidation of existing programs, and opportunities there within, and Medicare integration and transition process, so you know to date we have received a lot of valuable feedback from statements and questions that have come up both during in-person meetings as well as afterwards with the followup comment period by all the attendees, and we are going through a really, you know, robust process to strategically examine all the questions and the issues that have been brought to our attention and deciding, you know, what the next steps will be. So we're, just so folks know, after this meeting, we're intending to allow for an additional comment period, and that will include all topics covered through all of the sessions. Feel free to reach out to us, not just on topics covered in this session, but we're happy to take questions about topics covered in other sessions, and I think that will really give folks another opportunity to provide written feedback. You know, I know we have trouble right now with the webinar. This is being reported from folks, so hopefully folks will have an opportunity to either listen to the session that they couldn't join today or provide additional feedback. We are setting the due date for all additional comments as of January 12, 2018. I think that's what we're all driving to, but I know this time of year, and I know there are a couple other _____ priorities going on right now, so I don't want folks to feel overwhelmed by that date. We can always reexamine that date if that becomes necessary, but you know it might be best just to send in your comments quickly in terms of reactions, because I think folks typically know, have when fresh in their mind probably have all the questions, so that would be helpful.

So again, thank you all for attending. We'd like to welcome all of our managed care plans, all the participating providers and advocates and all the rest of the stakeholders and trades. I'd also like to thank folks at _____ joining us for these meetings. They've been terrific in really shepherding this process along and really their involvement has been so beneficial in partnering, you know, to look at the future here of integrated care. So thank you to _____ and Alex Krause from the Integrated Care Resource Center, or if I said that wrong _____ Alex Kress.

Cruz.

Cruz. I'm sorry, Alex yes, who will be speaking today I believe, right? And so we're very excited to have Alex here. And then our team from _____, Kirk Dobson, Alyssa Halperin, Madeline Royale, Patrick Genelli, _____ and Frances Ness, who organizes the webinars, and then Renee Lebrit, who was not able to be here today.

So thank you everyone. I'm gonna turn it over now to Erin _____, who is gonna review kind of the agenda for the day and then lead us through the next topic.

Welcome everybody and thanks to Andrew. I also wanted to thank Andrew for giving us all the support that he's given us through this process and allowing us to assemble this _____ and helping us to get this whole _____ together and also (inaudible 03:45-03:50) so we'll attack right into the overview of the process. I see a lot of faces in this room who have been here every single meeting, so those of you have been here, you (inaudible 03:57-4:00) but we will start with the meeting materials. You should all see that prior to this meeting, we sent out a packet of information which has drafted discussion language which sometimes can look like a contract. We wanted to make sure that they're never really proposed contracts. These are just discussion language, something for you to react to and give us your thoughts on. So that packet went out to everybody I think you should

have gotten yesterday, maybe day before. In the last few days that packet went out, so everybody should have that packet with you to be looking at while we're going through this, and it is on the 4 topics that we have reserved for discussion at this meeting. It's not meant to be all-encompassing, this language that we've put together for any specific program. We created it really as a means of gathering input from all stakeholders, whether you're providers or payers or advocates, and we are gonna cover the 4 topics today that are set forth in the packet of materials, one of which is geographic scope, which we covered, I believe, in the first of our topic series, and we thought it was important enough that now we've gone through the whole series and gained some feedback that we kinda touch on it again and see if perceptions have changed as we've gone through the series. All comments are welcome today as always, but we do ask that you try to limit your comments to the topic we're covering at the time, because while we want to hear everything, we want to also make sure that we're able to accurately gather comments when we put out materials for what was discussed and what was said, and also it helps us if we run into any time issues; it helps us to stay on track and make sure we're covering everything that we want, especially since this is the last session _____. We will be taking comments from the webinar as well as from the room. We do have webinar _____. Can they hear us?

I'm not sure, _____recording.

Okay, just in case webinar folks are there, we'll take the questions, and if not, it could go pretty quickly today. We do ask that you come forward, yes, to the microphone. Do we have a microphone today for comments, or are we

Oh, look at that. We have a podium for it today. So, that's

great. So it does help in case we do have some webinar people and also because we are preparing transcripts of these if you do step to the microphone _____ say your questions, and then we can capture everything for the transcript _____ for historic value for what was said (inaudible 06:42-06:47) helpful. We do ask for followup comments in case you don't want to come to the microphone today, or if you think of your comment or question after the meeting. We do have a _____ that we would like for you to use _____ and it is futureofintegratedcare@health.ny.gov. That helps us to track all the comments and make sure that we in a coordinated way get responses back. We do take all of those comments that come in both here and through the _____ and we put them all together in a template and then we can go over them with CMS. We can form any decisions that we are eventually going to make based on them, and we will also post them once the transcripts and everything _____ posted on our website. (inaudible 7:43-7:50). I guess I just covered it all. The last point was that we are going _____ CMS as always after every one of these series, we meet with CMS and we review all the comments. This one being the last one, we are gonna give a little more time. We want to know if that January 12th date works for everyone. We don't want to rush it, but we _____ forever also. So, we want to give a quick review of sessions 1, 2, 3, and 4, this being session 5. So our first session was in July was the kickoff for this stakeholder process. As cold as it is today, I think we were in this room, right? We were, weren't we right here?

Yeah.

And it was so hot that day I remember. I'm missing that a little bit right now. _____ presented on the value and importance of planning for the future in integrated care in your state following the _____. Lindsay Barnett from the Medicare/Medicaid Coordination Office and CMS was there that day, and she also offered a status update on the Medicare and Medicaid Financial Alignment Initiative so

_____ refresh are all available through our website, and _____ from Mathematics Policy Research and _____ from the Center _____ from the Center For Healthcare Strategy had presented on other state approaches to integrating Medicare and Medicaid _____ beneficiaries and the implications for (inaudible 9:20-9:23). Those materials are available there. Following that July meeting, we sent out a survey to the stakeholder group requesting information on formatting for the followup stakeholder process. Based on that survey and on the facts that we received during preliminary meetings, we scheduled 4 subsequent sessions, and we alternated based on the survey results. We alternated between _____. So session 2 was in Albany and it was on September 7th. Those topics were covered that day were the target population, covered services, care coordination and care management elements and _____. For session 3, we held that one in October, October 16th, and we returned to New York City for that one. This time, that time, we sent out some discussion draft language beforehand for reaction and to solicit feedback, and we covered the topics of network adequacy and access, participant rights to protection, marketing rules and flexibility and quality standard _____. Last month, we went back to Albany, and we held session 4 on November 16th. We had that day our colleagues from the Department of Health Division of Finance and Rate Setting, and they, so Jack Hera and Ranetta Robinson came that day, and Jeff _____ from CMS, and they sat on the panel to address payment in rate consideration, outreach education and engagement of participants and providers _____ plan requirement qualifications and _____. So we can dive right into our topics today, starting with the revisit to geographic scope, and I will turn it over to Madeline Royale and Patrick Crusinelli from the Department of Health.

(inaudible 11:21-11:27) Hello everyone. For purposes of this discussion, we will be, Patrick and I will be laying out a visual of the products that currently exist throughout New York State. The packet that, can everyone hear me okay? _____ the packet that; is

that better? Okay. The packet that Erin _____ referenced may look a little bit different than what we've typically seen for a contract language. It is actually an outline of Medicare or Medicaid Secure Advantage and _____ products, which will align with the _____ that are coming to us to follow. Patrick _____ will give a high level of review of what _____ in the packets here.

If I could just, one thing, let me know (inaudible 12:20-12:23). It did not escape our notice, Madeline, that (inaudible 12:24-12:34)

_____ the next slide that you'll see is very colorful and warm and that's not as cold as we'll get to warmth in New York State _____ so the _____ New York State Department of Health managed long term care plans by county. So if you'll take a look throughout the state, we have partial throughout that's outlined in the purple here. If you go over to the 5 boroughs, you see we have partial space maps by the _____ then over to the western region of the county, you have sporadically throughout. Those are highlighted in blue the _____ and partial, and some little pieces of orange here partial _____ so we really wanted to highlight where some of the dual products are throughout New York State. This map does not contain the Medicare Advantage or the SNP. We're actually gonna go to the next slide. So now this map here, this is the Medicare Advantage enrollment percentage and number of contracts per county, which we found this map to be very interesting. As you'll see throughout the state highlighted is the orange. We have a consistent about 20-49% enrolled in the Medicare Advantage _____ and then here on the western side, you have this little pocket here of over 50% of enrollment _____, and then in the Bronx, there's the state of the 50% over here, also highlighted up there _____. So Patrick will take us through a high level; oops, I'm sorry. In the bottom tier there is where under 20% enrolled in the Medicare Advantage. So Patrick will take us through our high level

When we get to the questions, I think it might be interesting to talk about what (inaudible 14:47-14:51) counties out there in Western New York. Anyone here from Western New York? _____ you don't get Western New York _____. There is a very prominent _____ Medicare HMO preferred care out there (inaudible 15:10-15:17) So anyway, you have with your handouts _____ data on Medicare Advantage _____ and it's divided (inaudible 15:25-15:32) and I think even this was that those areas of the state or those programs that have been successful in terms of reaching out _____ integrated Medicare product are _____ you might see most successful at in terms of integrating with Medicare and Medicaid. Actually, that came out _____ theme at the last session where we were talking about finance. (inaudible 15:53-16:06) but if you look at that little area of Western New York, that actually gets pretty close to that high in California. Among our neighboring states, we (inaudible 16:15-16:27) the vast majority of our Medicare Advantage (inaudible 16:30-16:34). Now the information that's on this map (inaudible 16:38-16:43) you can see that New York state comes in overall at 38-48% Medicare Advantage enrollment among eligible providers, and then there's this very, there's just variations on _____ data. _____ table 4 having the largest number of contracts (inaudible 17:00-17:04) and the lowest number of contracts in Livingston County which is somewhere around here and with _____ contracts. Any questions so far?

(inaudible 17:15-17:43)

The question is, do we look at income distribution _____ where we have the high rate of HMO penetration? That's an excellent point. That's something _____ take a look at.

And that is part of what we want to discuss before we move on from this map is, you know, any feedback that you may have or thoughts that you may have that _____ to this variant in the Medicare

Advantage distribution throughout New York State. So we'll open the floor if anybody has any other ideas.

You've got a couple of maps in the package. Then you've got a section (inaudible 18:20-19:11)

Just for purposes of the WebEx and just to make sure that everyone can hear, we just ask that you come up to use the microphone and also introduce yourself when you come to provide commentary or ask any questions just so everyone can hear.

So then you've got (inaudible 19:28-19:41) then you see that the vast majority of people are in a dual eligible SNP. You also have the vast majority of Medicare _____ are in non-special needs plans (inaudible 19:52-20:22)

This map gives the number of contracts in various areas of the state.

(inaudible 20:28-20:35)

Then you've got a couple more charts. Table 5 is your Medicare (inaudible 20:41-20:51) enrollment in the state, and bottom of the list you have _____ plans for healthy living (inaudible 20:57-21:32) Erie County, and that drops down to below, it's actually 0% in Thompson County, and we have 4 or 5 counties in the state that have no _____. Any questions (inaudible 21:49-21:55)

So we did pull some questions, and feel free to either respond to _____ for those that are on the WebEx. Looking at our geographic scope here throughout New York State, one of the questions we have is: Which geographic areas should be included as we move forward with the future of integrated care?

We've had prior conversations in these meetings where people felt like something like a statewide _____ program like you _____. I don't know if people still feel, have any strong feelings about that?

(inaudible 22:48-23:23) on the map, there is a large number of Medicare Advantage plans already available _____ county _____ and maybe that's the way, so maybe that's the foundation (inaudible 23:33-23:39).

That's why we felt it was important to present the Medicare Advantage information.

Thank you. Next question is: If all areas should be included; I'm sorry, _____.

(inaudible 23:57-25:41)

That's a really great point, and it should come up as we discuss provider education and the route that we should take with that, and like Erin _____ mentioned prior, we will be going back through all of the feedback and commentary that we had discussing further movement with CMS and just how to pull this together. It actually leads us into our next question, which is: If all areas should be included, should all begin at the same time? And if not, what timeline? And I think your point is we should stagger

I think that there have been (inaudible 26:17-26:35)

I think you make a very good point, and I would really encourage you to actually if you wouldn't mind sending that to _____ as well, your comment. We were taking it down and recording, but _____

(inaudible 26:46-27:32)

Any other questions or responses to those questions? And lastly, we have: What preparatory steps are necessary to build for 2020 in all geographic areas?

I think from what has been stated already, we do hear that there should be a lot of provider education and to make sure that it is even throughout the state to give everybody a fair playing realm.

(inaudible 28:04-29:20)

Oh, you make a great point there. Just one question for you: What would you suggest or how do you think it would be, would be the best route to begin to engage the providers for?

(inaudible 29:36-35:00)

Thank you for that feedback. We will absolutely _____ this all back together, meeting together internally with various departments with CMS _____ a lot of the commentary and feedback _____. Are there any other questions with geographic scope before we move on in the webinar?

Hi, I'm Frederick _____, Director of _____ Medicare _____.
(inaudible 35:37-36:01)

Okay, thank you.

Yeah, we'll definitely take a look at that.

I'm sorry. Your name again?

Frederick _____

Frederick Hardy was saying that we should take a look at Kaiser Permanente and that, and some of the _____ affects some of the networks and the provider enrollment.

Kaiser _____

The Kaiser Family Foundation. Okay, so you would just say that that is a crucial piece that we should take a look into as far as correlating the network and network accuracy _____. Any other comments or questions? Okay, _____ move on to the next

In the spirit of the season, though, we are looking at the, I guess the ghost of integrated care future, and hopefully it'll be a friendly area _____

(laughing)

(inaudible 37:12-37:28)

Up next is Alyssa.

Actually, I'm gonna turn it over pretty quickly to Alex Cruz, but as she speaks and talks to us about what's happening in other states and around the country with integrated care and platforms for integration, I just ask that you think of some of these questions, because we're gonna come back to them when she's done. So, you know, should the state request permission to continue using the existing MMP demonstration authority _____? Please ask CMS if there is a way that we _____ using this. Should we ask CMS for authority to pursue a completely new and different demonstration? Should we ask CMS for authority to, demonstration authority to carry forward some of the flexibility of FIDA into, you know, a new and different platform that

doesn't require wholesale demonstration authority to implement? Should we as a state use D-SNP or a FIDE SNP plus Medicaid plan as the model for integration moving forward? What are the considerations that, you know, going to any of those decisions? So just please keep those in mind and then I will come back and see what, what feedback folks may have. And now I'd like to introduce Alex Cruz from DHCS and the Integrated Care Resource Center, and

I'm really glad to be here today and want to point out that I threw my coffee cup away (inaudible 39:05-39:14) and I didn't know the rule before I came in, but it is nice to be with all of you today and talk to you a little bit about one mechanism that states around the country are using to advance integration that I know, you know, exists in New York State but varies state to state, you know, how much the D-SNP platform is leveraged, but I will be talking about that in the next probably 20 minutes or so, and I'm looking forward to answering questions that folks might have. Most of the information I'll present is somewhat high level when it comes to how D-SNP works. There's probably folks in the room who obviously operate these products and know a lot about the way that D-SNPs exist and operate in certain states, relations to other programs, so we will be welcoming, you know, having some conversation that you might want to add, and I also wanted to point out that there are a lot of different options _____ advancing Medicare and Medicaid alignment, and I won't be talking about, you know, one of those which I know is relevant in New York State and across the country _____. I may be referencing in the presentation how D-SNPs relate or compare to regular Medicare Advantage plans or to the FIDA program, but I just want to point out that we understand the value and import of the PACE program. So moving on, let me show you the agenda of what I'll cover real quick, and this is the Integrated Care Resource Center, I should say, you may be familiar with this, my colleague, Jim _____ and former colleague, Mary Phillips, presented at the meeting in July,

worked with states around the country in the Medicare/Medicaid Coordination Office on technical assistance _____ materials like some of those that have been shared with you in the materials for the meeting today _____. So the agenda, I'm just gonna go back 1 slide and just indicate that I'll cover a little bit about the history and the purpose of D-SNP and what that landscape looks like nationally and the opportunities for states to use this model for Medicare and Medicaid alignment and then talk just a little bit about comparisons between the D-SNP model of other Medicare Advantage options as well as like the contracting basis. What is the requirement _____ D-SNP that states can use? And then last but not least will share some information with you about a model in New Jersey that is actually the furthest _____ I would say go on the D-SNP platform in terms of alignment, so want to just share that in for comparison. That might be helpful _____ New York State. So moving on to the first actually content slide.

_____ So the history in terms of D-SNP, the D-SNP acronym that I just used obviously stands for Dual Eligible Specials Needs Plans, and these are plans that were authorized back in 2003, began operating under the Medicare Advantage Program in 2006, so we've got a little over 10 years of history of the plan being in the marketplace, and they are a type of Medicare Advantage prescription drug plan or a type of Medicare Advantage plan. They're similar to Medicare Advantage prescription drug plan in that they have to meet all the same requirements. They have to provide all of the Medicare part A, part B and C benefits, and they, the uniqueness of this particular plan type is that they are only permitted to enroll _____ and they have to have certain requirements that are met that I will go through in a little bit more detail later, but one of them includes having a very distinct model of care _____ model that is tailored to _____ that Andrew was pointing out earlier _____. There have been _____ and will show you a slide of what that looks like in this model, and there's now over 2 million dual-eligible enrollees in

these products in 41 states, and in New York State what that looks like is the data that you just saw, but you know 230,000 individuals approximately in D-SNP statewide depending upon _____ map shot, and there was about 200,000 downstate and just 30,000 upstate. So the last thing just to share here for folks that may not be familiar of special needs plans. There's actually 3 types under the Medicare Advantage Program. There's D-SNP which are chronic conditions, special needs plans, and there are institutional SNPs or I-SNPs, and of those types of Medicare products, nationally about half of the individuals in them are really eligible, but there's not the same requirements. They can serve, you know, non-dually-eligible Medicare beneficiaries.

So moving on to the next slide, this one is a map that shows where D-SNP enrollment is concentrated nationally, and it actually distinguishes between in; the color changed a little bit on us, I think, but between the highest D-SNP enrollment in some of these brown states. There's about 12 states that are shaded in brown and the rest are yellow. Those are states that actually generally have a higher level of integration in their D-SNP programs, some linkages between their D-SNP and state Medicaid programs, so there's actually higher enrollment in those states, and then it may also correlate to just higher enrollment in Medicare Advantage Products in general in those states as well, and Florida is an example of a state like that, and then, and California as well. And then there, just you know a point here that's I think helpful to be made early on _____ talking about, you know, Dual-Eligible Special Needs Plans and bringing that into this conversation, which is that outside of the Financial Alignment Initiative or the FIDA program as an example in New York, this really is, you're thinking about how to conserve, you know, the maximum number of dual-eligible in an integrated system of care. You know, where would you effectively try to move those individuals to in New York State that did not know _____ model or the Financial Alignment Initiative, or if you're a state that's looking at, you

know what comes next and what options exist _____, D-SNP offers the greatest potential to serve the largest number of dual-eligible. So the, I think that's probably it on this slide, and we'll move, we'll do the next one.

So this is just a quick picture of growth. I think it represents a couple things about Dual-Eligible Special Needs Plans. One, that it's a relatively stable platform under the Medicare Advantage program. It's been around for 10 years. During that time, the enrollment and the actual obvious number of _____ has been pretty steady. There was a change in about 2012, 2013 when there were some new requirements added for D-SNP and we saw kind of a change in the number of D-SNPs that were operating nationally, but there's a lot of potential here. There, current Dual-Eligible Special Needs Plan products under the Medicare Program is authorized to continue for 2018 and it actually has time after time been reauthorized, and it is the understanding at this point, although there is, you know, legislative activity that has to happen at the federal level, is that this product continues to be reauthorized.

So the next slide is, covers the level of integration of Medicare Advantage Plans that we're talking about today. This isn't all of the Medicare Advantage Plan types but the ones that are leveraged for integration being D-SNPs and MSP as well as a comparison of the D-SNP and the MSP model to a regular Medicare Advantage Plan, and I just wanted to share at a high level that when you're looking at a standard Medicare Advantage C, there is actually, right, no specific requirement to coordinate across the Medicare and the Medicaid program. So individuals that may need, you know, if there is a high concentration of Medicare Advantage enrollees, they may be in these products, and they may also be in a Medicaid product. There's not the same level of requirements to be D-SNP and MSP models. The other thing that's interesting to point out here is just thinking about relevance to New York State is that there's a

pretty thoughtful rate design in the MAP program, and I think there's variety of plans under MAP that may or may not have, operate different types of Medicare Advantage products, D-SNP or Medicare Advantage plans, and if someone was in a standard MAP plan with a Medicare Advantage Product, you don't have the same requirements.

I'm not going into the difference between the _____ slides, because I have a slide in just a little bit that will compare in more detail those 2 models. So we can just do the next slide if that sounds good.

So we're gonna talk a little bit about comparison to other platforms and opportunities to contract with D-SNP from the state's perspective. So we can move on to the next slide. So this is just, you know, integration basics, some of what we talked about. Again, some that may not be new to many of you, but Medicare Advantage D-SNP provides all Medicare benefits. They have a responsibility to coordinate or arrange for Medicaid benefits. They may or may not actually _____ provide those. They have a separate contract between the state and CMS, and a number of states, an increasing number of states are actually linking the companion _____ Medicaid plan to a D-SNP offering, and you'll see that in real steps when I talk about _____ a little bit, but the linkage between managed _____ and a Dual-Eligible Special Needs Plan for a number of states has provided, you know, the greatest potential for integration of benefits and _____. There is a subset of Dual-Eligible Special Needs Plans which are referred to as FIDE SNPs, and there are of course FIDE SNPs operating in New York State, and they are fully integrated Dual-Eligible Special Needs Plans. They are plans that have requested a special designation from CMS because they achieve a higher level of alignment in both benefit integration but also in some areas that might matter let's say to a beneficiary, which is perhaps integrated through this fiscal process at the plan level or integrated with carryover, have some level for a FIDE SNP of alignment administratively from this new program in addition to integrations benefits, and then they by virtue

of being designated as a FIDE SNP, there's an opportunity for that plan to see if they would qualify for a relative small but not insignificant Medicare payment which is referred to as a _____ adjustment to reflect the _____ that are enrolled in the FIDE SNP and it is the most integrated D-SNP option.

So moving on to the next slide, I alluded to this earlier, but in January of 2013, there was a requirement that was implemented, and this was for Dual-Eligible Special Needs Plans, and it was something that provided new opportunities for states basically that they have to have, to operate D-SNPs have to have a contract with the state in which it wants to operate. So these are referred to I think in New York State as Coordination of Benefits Agreements. Nationally, sometimes they're referred to as D-SNP contracts or NIPA agreements, but NIPA was the legislation that basically said if you want to operate a D-SNP, sit down, talk to the state that you're going to be operating in, establish a contract, show us that contract, and then we'll give you, you know, a stamp to continue operating as this plan type. And the basic requirements for D-SNP I think are interesting to point out that even now as D-SNPs have worked with their state partners to establish this Coordination of Benefits Agreement or NIPA contract, they're pretty basic requirements that are the bar, right, that _____. There are things like the signing of the contracts, what service area is covered? Which populations are going to be involved?

What is the level of benefits that might be included under the D-SNP? Things like, a few other requirements, of course, but you know are you gonna verify eligibility for Medicaid before you enroll in D-SNP? So these are not, you know, the kinds of things you probably think about when you think about the FIDE program and some of the _____ requirements which are released, you know, built around how do you actually better coordinate the _____ program, and for beneficiaries these are just kind of making sure the minimum levels that there's the conversations between states and then it's really up to states to then decide, you know, how do you do the Coordination of

Benefits Agreement to leverage the recruitment model and level of integration that _____ varies considerably across states.

So is there anything else I think I wanted to cover here? I think, you know, just that there's a trend naturally for states to go beyond those minimum NIPA requirements. There are opportunities to achieve administrative, clinical, financial integration through these D-SNP contracts that a lot of states have taken. So if we move to talk a little bit about this comparison of Dual-Eligible Special Needs Plan model and the Medicare/Medicaid plan, you'll get a sense looking at this that there's a lot of words, really tiny small words on the slide, but there is I think just a couple, you know, high-level things to point out. One is that through these 2 plan types, there is similarity in the first 2 categories, so you have an opportunity through both of these to have involvement between the states, the plans, and you know through the MFP model you've got a 3-way contract that brings CMS into the picture. The D-SNPs have the contract _____ talks about. If you look at covered benefits, there's really an opportunity under both of these platforms to fully integrate care, and you can decide you know at what level would someone who's involved in a D-SNP or an MFP, what benefits would go into that with the Medicaid side. There's similarity there. Where you get into I think some more significant _____ models is, we're gonna start with the bottom first, but is you know the opportunity for Medicare and Medicaid alignment. The _____ model has, right, extensive, you know, joint federal oversight, integrated financing and payment for the plan, actually uses an integrated enrollment mechanism so that someone who is negotiating the Medicaid and the Medicare program can go into the MFP product in one enrollment process instead of _____ and it actually has, you know, marketing templates _____ is one example, but joint marketing templates, review of materials between the state and the federal partners and just a lot more administrative alignment can be achieved in the MFP platform, but it doesn't mean, right, that you can't achieve a good

degree of Medicare and Medicaid alignment to D-SNP. There's opportunities I think that are driven in part by the states, the health plans working together to figure out, you know, what that alignment would look like. And then the other thing I think to point out is _____ that is separate contract between states and D-SNP and CMS and the D-SNPs is that, you know, the level of financial integration is different, but from a plan perspective, our experience working with states and talking to plans that operate both products is you can achieve, right, a similar level of financial integration at the plan level, because they may be getting some separate payments under a D-SNP and the payment may be more integrated under an MFP model, but there's a plan level financial incentive under both models responsible for Medicare and Medicaid service delivery and hopefully working with providers within those networks and working with care coordination models that are established, you know, figure out how to maximize delivery of those benefits for the best service of beneficiaries but also to hopefully provide services in, you know, the right setting, provide _____ services to a hospitalization or _____, all of those things that are pretty important to the beneficiary.

The last thing I guess to point out from here is that there's differences and of course things like, you know, quality rating system applicability under the Medicare D-SNP model, the stars rating that applies to Medicare Advantage Plans applies to those products, and so it's one set of quality metrics and incentives that are built into the Medicare Advantage Stars Program. Under the MMPs, there is very specific quality _____ and different quality incentives that are built in, so that is probably more than folks ever care to know about the differences between the MFPs and the D-SNP model, but _____ want to be able to support your conversations _____.

The last slide that I'm going to cover really just talks about a model in New Jersey that may be of interest, which is leveraging the

platform to deliver full integration, and the person who oversees the D-SNP program in New Jersey likes to refer to this as essentially a fully integrated option for full benefit dual-eligibles in New Jersey. If someone is a full-benefit dual-eligible and they're negotiating either Medicaid _____ Medicare enrollment system, this is just a choice, right, if they want to obtain fully integrated care, and it's basically built on the alignment that I was talking about earlier between Medicaid offerings and the D-SNPs, so what New Jersey has done to create that option for duals is they actually offer an MLTSS plan under their Medicaid program. They established and launched the Managed Long-Term Services and Supports in 2014, and they limit their D-SNP enrollment in New Jersey to couple things: 1) full benefit dual eligibles, but they also limit the enrollment to individuals who want to be in an integrated product, so D-SNPs in New Jersey are required to operate a Medicaid Managed Care Plan, and then they're also required to operate D-SNPs, and in order to obtain the Medicaid contracts, the state actually; I'm sorry for getting turned around, but in order to operate the Medicaid contracts, the state actually requires that the health plans that are contracted in New Jersey, makes sure that they have approval to operate a D-SNP, and their service areas for their D-SNP and their Medicaid plan have to align. So they kind of go through an approval process, operates the Medicaid plan, whatever the footprint that looks like for that plan, they have the same geographic footprint for their D-SNP, and that way there is a fully integrated option for people in _____. There are a few other things to point out here, and of course I'm happy to take questions, but New Jersey actually asks all D-SNPs to request designation from CMS for FIDE SNP so that there is not _____ obtain that _____ factor payment, and then they also have pretty robust care coordination administrative alignment requirements. They assign individuals on the Medicaid side, select a D-SNP for Medicare to the New Jersey Medicaid plan that matches that D-SNP, so they've basically built some alignment into their state's assignment process for Medicaid what it is in New Jersey a mandatory Medicaid managed

care, and then they do a lot of work, and New Jersey is not unique in this, but they do a lot of work to educate beneficiaries that this option exists and work to that from the plan type but also from the state planning and coordinating with different programs, including their state health insurance program.

And I think, you know, just a couple other things, which is that there's a fair amount, I think, of similarity again between the MFP platform and the D-SNP model, but one of the things that we just like to point out in programs like this is that it takes some time, right, to develop this _____ from the state side to understand the complexities of Medicare, the _____ models and figure out, you know, how do you basically improve the alignment for a beneficiary? And New Jersey has been operating, I think, you know, integrated products since about 2012. They actually started some D-SNP integration efforts before they got MLTSS program, and today that's kind of paid off for them. They have about a quarter of the state's dual eligible population enrolled in FIDE SNP. They get pretty positive feedback from beneficiaries and folks that they appreciate, right, those options seem available. Since they limit the enrollment for full benefit dual eligible which could include _____ but also includes individuals who are full benefit dual eligible, otherwise eligible for all the benefits under Medicaid but maybe you know at a little bit higher income level than _____. They work with the plans to make sure that there are zero cost share D-SNPs so that from a beneficiary's perspective, there _____ no cost sharing in the model.

So they've had a good experience with it, and you know are neighbors to New York State, so hopefully it's helpful to know a little bit about their model.

So I think the last thing to just point out is there's a couple of appendix slides here if you move on through. One is, the first 2 slides are the details of the minimum requirement for D-SNP contracts. I think the coordination of benefits New York State, this

is coordination of benefits agreement New York State today actually cover the minimum requirements but don't _____ go I think far beyond them, although there's potential that some of those D-SNPs for different reasons are operating more integrated plans. The actual agreement between the D-SNPs and the states, I think, achieves all these minimum requirements but don't go past them currently, so _____ in what those look like. So the next slide is the rest of the minimum requirements, and then the last slide is just some additional resources _____. So I'm happy to take questions if folks have any.

Yes, and I guess if you can go up to the mic and let us know who you are and where you're from, that would be wonderful.

(inaudible 1:03:48-1:04:05)

No, it's a good question, and you know the short answer is, I think there's a variety of variation in the level of integration that occurs when MAP plans that I'd love for someone else to answer that better than I can probably.

Some are, some are D-SNP _____

Some are Medicare Advantage plans and _____. And the requirement in New York with MAP; I think New York, New Mexico is just like a better state where there's a requirement to operate some type of Medicare Advantage Plan, and there is then the potential that someone can be enrolled, right, in the same parent organization, but not all of them are D-SNPs or at that level perhaps of integration.

One other question (inaudible 1:04:50-1:04:55)

Yes, so I think (inaudible 1:05:01-1:05:11)

It's almost that, but we'll flip it back and forth and around. The basic requirement is, all the full benefit dual eligibles in New

Jersey with you know minimal exceptions are required to ____.

There's authority in New Jersey to enroll that population into mandatory Medicaid managed care, including for MLTSS, so once someone is enrolled on the Medicaid side and makes that choice, they have the option. They're not required to enroll in D-SNP since they can't, you know, require that. They have an option to basically either be in the stand-alone Medicaid managed care options and the MLTSS plan or choose to enroll in D-SNP on the Medicare side, so they have the freedom for different Medicare Advantage options.

Hi. (inaudible 1:06:06-1:06:59)

Yeah. You know, it's data that I think is available or data that the state; I know there were some ____ conversations about looking ____ geographic scope in different ways, but I would guess if ____ something that states look at, you could also look at the number of D-SNPs in the state that are zero cost share or not, and I'm not sure what that ____ looks like in New York State.

(inaudible 1:07:22-1:09:27)

That's a helpful comment. I think folks probably agree. I think we have _____. Welcome.

Hi, Frederick ____ again. (inaudible 1:09:38-1:10:44)

You're, just to clarify things that we understood that the number of ____ improvement your saying is under the ____ model.

There's improvement in integration ____, right, and it makes me think about one particular thing that I do think of interest is as ____ launch the financial alignment ____ model, there has been this corresponding effort on the part of the Medicare/Medicaid coordination ____ CMS brought the CMS, Centers for Medicare, to look incrementally, right, at how you can improve the alignment of

materials, so there's new things like an integrated summary of benefits that's available for D-SNPs, and I can't, you know, predict the future _____, but I think there's just this ongoing initiative to take some of the things that you can take from the financial alignment model and the improvement particularly administratively that would be of benefit to beneficiaries and bring those over to the D-SNP model, again incrementally sometimes limited by the fact that _____ level of Medicare flexibility or authority under the D-SNP models _____

(inaudible 1:12:02-1:12:36)

We're discussing whether the, sorry; my question, my question was _____ in New York we have this _____ challenges in enrollment (inaudible 1:12:45-1:13:17)

Sure. So the first question, it's; they're good questions and not necessarily the simplest in like in answers. I think one, in terms of the enrollment time period, New Jersey and other states make I think their decisions about how they can do the most with the D-SNP model to coordinate enrollment, and one of the ways that they think about and states have done is to follow the Medicare contracting cycle and the Medicare calendar, so basically mirror the open enrollment period on the Medicaid side with the Medicare Advantage open enrollment period. It's basically a dual eligible, they have the option to enroll _____ D-SNP every month because they have a little bit more flexibility in the Medicare Advantage enrollment process, but from a state side, the time when dual eligibles, you know, would make the most moves and think about their choices is during that Medicare Advantage open enrollment period. So that kind of addresses from the beneficiary's perspective, you know, where there's an alignment effort that states have done is just usually to follow the _____ cycle. See, the other one is; I'm sorry.

Yeah, so duals are all here, but if you actually look at data in terms of dual eligible _____ from Medicare Advantage products, they, people in Medicare dual or not dual tend to make their choices when they are given information that says you need to make a choice by this time frame, which is during Medicare Advantage open enrollment period, so there are states that have aligned with that cycle for their Medicaid plans, and that doesn't answer your question, I think, about what's more of a fiscal issue from a state's side which is, and a state _____, right, is if you have to be _____ make a decision by the 20th of the month under Medicaid, but under Medicare you have until the end of the month, that can create, you know, a little bit of confusion. _____ something that happens _____ in the MAP model.

It sounds like your questions, would that make sense to happen or not happen, right, in a D-SNP model? New Jersey does coordination of care health plans, and I think that whatever their particular policy or system approaches are from a Medicaid enrollment system, they try to align those dates and give the person the same timeframe to make the choice, but I think there's implications from the state's side in terms of, right, like why is there a cutoff _____ Yeah, that's a really good question. I think the second question, right, which is more around what's better or worse with the _____ contract for 3-way contract, and I can't answer that question from the plan side, but I would think that it's an interesting question to pose, you know, to health plans _____ plan side does to basically, you know, operate under both of those parameters would have thoughts there. I can say that I often think more about like what's in the contract, and you know the 3-way contract model has a lot that the state and federal partners have sat down and thought about, make it work together in that contract, and I think there's a little bit more effort that has to go into when the state is developing their _____ contracts, right, what's in the Medicare Advantage contract, but more importantly like what are the additional state requirements that we want to add in?

And so really I think one of the biggest differences I see is having a very deliberate D-SNP model in thinking about what the parameters are in contracts that would achieve, you know, hopefully a level of integration that stakeholders and the states _____. I don't _____ like a clear, clear benefit of either contract. It's more what _____

(inaudible 1:17:16-1:17:22)

States that are not operating in the financial alignment initiative cannot _____ contract, so that's a good additional clarification. So you can only have a 3-way contract with the MFP model. D-SNPs can't have a 3-way contract currently.

(inaudible 1:17:36-1:19:11)

So related to the _____ care requirement, you know, I am not _____ New Jersey contract. I don't know, 4 or 500 pages, but I don't know specifically. I know they have _____ care requirements through their MLTSS program, and their responsibility in their D-SNP contracts is for, right, what are the parameters around the _____ of Medicaid benefits, and so they actually unify their NIPA agreement with their Medicaid contracts, and so we can definitely go back and look at those and actually share those with you. I'd be very happy to do that, but I would think that they are pretty standard to what states typically do in Medicare managed care. I think often times _____ it might be a little bit different. I know within the MFP model in California as an example, they actually extend it, right, some of their _____ care requirements, so I think that's a state-by-state decision, but the other question about movement, which I think was what you're asking, right, is how often people move or how much that can change? I participate in quarterly meetings, right, through New Jersey where they often share data on enrollment, you know, where this program has been, and it's been a steady growth of enrollment in their D-SNP programs. It's at the 26,000 mark currently, and I, my

understanding from them is that there is not a lot of _____ enrolled, who dis-enroll actively by choice, and this is after, right, your initial period of enrollment, what _____ established in that model.

They tend to have, I think there has been some examination of data in New Jersey right now, but I'm not sure that they've disseminated _____ but, so looking at things like _____ my understanding, you know, anecdotally, is that _____ numbers and what that looks like.

(inaudible 1:21:04-1:21:33)

There's a couple of things that, you know, _____ helpful from other states, which is, one is that there, some states have used their NIPA or Coordination of Benefits Agreements to put some parameters around some type of marketing that they'd like D-SNPs to do in the state, and if they market to _____, and the other thing is that New Jersey has I think a total of 5 D-SNPs operating in the state, so the number of Medicare Advantage products in the state might obviously, you know, impact as well. So _____ hopefully that's helpful. And I don't see anyone else at the microphone. I haven't looked at a list _____ checking on time, but really appreciate all of your questions and will be here if anyone has any followup questions.

Okay, _____ that was great. We've heard a lot of feedback so far on this, and we're behind our schedule, so I'm going to encourage folks who have additional thoughts on what platforms you would like to see the state using for integration, to include that in the comments that you submit in writing using the comment pathway and _____ January, so there's more time to do that, and then we can move along to our next topic and _____

Thank you. We're just gonna talk for the next few minutes about _____ consolidation of these programs. When we kicked off our meeting here in July, we had a slide there talking about managed care

products available in the state of New York _____ about 7 different programs, and today we wanted just to gather some input from the audience. You know, we have these programs that are available for the membership for dually eligible, and does anyone have a sense that, you know, there may be a better way to _____ members in the plan if they didn't have as many choices? And if that's something because we think that New York State a little further than some of the other states in the country on the platforms of managed care for dually eligible. You know, you look at some of the things that New Jersey was doing _____ so they were trying to make these other arrangements to get up to a level that the MFP is _____ months of the program so far. We have 24, so we did make some changes 2 years ago to the program, and so we just want _____ overall the consolidation of the existing programs, do we want to consider making any changes to that? And when Andrew kicked off the call-back in July, we said that we would consider that. You know, we don't know what's gonna happen in 2 years. We may have a different landscape of what products are available for this population that we're all serving, but I just wanted to kind of open it up to you, what everyone feels if they think that their program, if they've _____ something, how that's going to impact the rest of the _____ product that we have?

(inaudible 1:25:08-1:28:42)

Jeff, what was the question again?

(inaudible 1:28:44-1:31:18)

We've had some comments come in about the integrated program and even from today in the audience, and I remember reading in the comments, which _____ like we like the idea of the integrated model, but we don't support when the plan _____ to the next step, so I think that's something that, you know, we continue to hear about those

integrated models we like but maybe that portion of _____ comments coming in as well.

(inaudible 1:31:56-1:33:18)

Any other thoughts on consolidation _____? I kept some of the information on comments coming in, some of them today; do we think that we have enough integrated programs here in the state of New York? _____ handful that we mentioned. Any other way we want to look at that? _____

I'll put that down.

(inaudible 1:33:46-1:34:26)

Okay, it looks like it's 1:25, so why don't we move on to the last topic _____ transition.

Alright, I'm pinch hitting for Renee who unfortunately is under the weather, unable to join us today. We're gonna talk a little bit about considerations for transition, and obviously as they develop the plan moving forward and work with CMS and all of you, you'll know what that is. Once decisions are made, there would be more discussion about transitions, but at a high level, we just want to start to at least capture some thoughts you have in terms of what transaction that when transition process and protections we would want to make sure we incorporate into, you know, the move to the future of integrated care. How will we move consumers to the new model? How will we ensure a seamless transition? What kinds of pieces do you feel are most important that you want to make sure get built into the design of the future of integrated care as it's being built and ensure that it's a seamless transition, you know, and that

we've accounted for everything? So what we're actually going to do is, since we're getting tired and probably hungry, I'm gonna write your thoughts on the, on this easel, and Madeline is going to give everyone a Post-it, and as we get towards the end of the conversation, we're gonna ask you to come up and put your blank Post-it next to which consideration you think is most critical as we move forward in terms of transition. So if it's not _____ here and it's not _____ plan, throw them at me. Everyone, you know, get up. You can move a little if you want. We can keep you awake until _____ does the wrap-up, and I will take thoughts as to what you think are most important considerations for the transition. So, don't push getting to the microphone. _____ in my handwriting.

(inaudible 1:36:37-1:37:23)

Is that it? Did I get it?

Early _____

Just a second.

Hi, Rebecca _____ Society. I think you had a similar point that I really really want to emphasize how traumatic these kinds of _____ the care that people's lives and in their homes and _____ are for people and have been _____ really want to push whether it's _____ sun setting (inaudible 1:37:57-1:45:17)

So you're saying more flexible?

I think that they go together. I think they _____. I just think that we're, when we talk about what they are that the plans have an ability _____ of the department that says _____. Having to transfer the members over to independent broker, we weren't really getting I think some of the questions resolved, and so a lot of _____

other things happen. _____

(inaudible 1:46:04-1:46:53)

Anyone need another Post-it? _____ you really want to put Post-its on?

Since we're talking about the (inaudible 1:47:08-1:49:40)

If you could be quiet, we have one other to add.

Yes, so be loud.

(inaudible 1:49:49-1:51:38)

Well, thank you for playing, and I'm gonna turn it back over to Erin _____.

That was really helpful. That's interesting to look at how many, you know, where all the stickies went and how many people are; it's not how I would have predicted it went, so that was really helpful. So we'll finish up with additional discussion and comments based on the time we have left, as we were going to, and see if there was any additional comments or thoughts that anyone wanted to raise on topics we haven't already covered over the 5 sessions. So since our time is probably getting a little short here, we'll say that if you have ideas for future topics, we aren't gonna have any more of these series, but we could send topics out that we haven't covered in a different way if we think there are any and if we can't shoe horn it into what we already covered. You can send those into BML futureofintegratedcare@health.ny.gov. The followup comments, as we said, are requested from you. What we're going to do, as we've done

after some of the past meetings, is send out one comment monthly. I think it's an Excel spreadsheet that allows you to send your comments to us. The purpose of this is not for you to read the comments that you've already sent in, but it's for new comments. It helps us gather them in a more organized fashion so that we can post _____ online for everyone to look at and so that we can review them with CMS as we move forward. Submit those also to our BML, and our target date right now is January 12th. If that becomes unworkable, if you think that there's more time needed, please let us know also by email through the BML. So for our next step, we are keeping those comments. There's no need to resubmit any of the comments that you've already submitted. We will review with CMS and we'll communicate what the next steps are. We have taken some pretty thorough notes today and in all of the other sessions, and we'll be reviewing all of those plus all of the written comments and questions that have been submitted through the webinar and to the BML, and we will decide on the next steps and communicate those in the same way that we've been communicating to all of you _____.

Last slide in the deck is just again all of the information which is of course the future of integrated care BML and a link to our website where we post these helpful information, and because I'm Erin _____ and I can never have a _____ on there and because _____ play such an important role in the future of integrated care and all care in New York, here's our _____ BML if you have any questions, and there is a link to our website where _____ materials are posted.

Remember that in that Medicaid _____ library, we have if you scroll down with the libraries getting bigger, we have a specific MLTC chapter to open up and find all of those materials there. Any last questions, comments, concerns, Carl?

(inaudible 1:54:57-1:55:09)

We don't have a specific enough timeline today to really

communicate, because I wouldn't want to be wishy-washy and waffle back on it, but we are going to be coming up with that sort of information in the general timeline and sending that out, some materials through, you know, the same way that we've done here.

(inaudible 1:55:24-1:56:30)

So yeah, any specific ideas that you want to map out for our consideration, you can also send in to that BML. That would be really helpful. You could also send it directly to me, but it's always better to come through the BML, because then it doesn't have a chance of getting lost in my in-box, not that anything ever gets lost in my in-box. Alright, well thank you all so much for participation in this. We'll be reaching out with the next steps. Thank you.