Fully-Integrated Duals Advantage (FIDA) Stakeholder Workgroup

Navigation / Appeals / Grievances

Friday, September 14, 2012
11:00 a.m. – 12:30 p.m.

Call summary

On Friday September 14, 2012, NYSDOH held its first of three FIDA Navigation/Appeals/ Grievances Workgroup meeting for stakeholders. Following is a summary of the meeting discussion.

Attendees

NYSDOH requested that all meeting attendees that were not on the original attendance list to email Laurie A. Arcuri (laa03@health.state.ny.us) from NYSDOH to indicate participation on the call to ensure that future materials from the workgroup are received.

Overview of FIDA and Workgroup Charge

NYSDOH provided an overview for the workgroup members to the FIDA proposal and the important involvement of stakeholders in shaping the details of the FIDA program as negotiations occur between NYS and CMS. To date, NYSDOH has not received feedback from CMS on the FIDA proposal and have not begun negotiations with CMS; however, NYS is not slated to begin the demonstration until 2014 which leaves ample time for negotiation to occur. At the end of this call summary is a copy of the FIDA overview document that was distributed to workgroup members prior to the call.

NYSDOH has established four stakeholder workgroups as part of the FIDA proposal, each with its own separate charge. The four workgroups are:

- **Finance/Rate Setting.** Charge: to provide feedback related to capitalization; solvency; reserves and rates
- **Outreach/Enrollment/Consumer Engagement.** Charge: to provide feedback related to beneficiary protections, participation and service benefits (including but not limited to): Plan Choice; Continuity of Care; Enrollment Assistance and Options Counseling; Person-Centered Planning; ADA and Civil Rights Protection; Enrollee Communications; Marketing; Education and Enrollment Process
- **Navigation/Appeals/Grievances.** Charge: to provide feedback related to integrated appeals and grievances (including but not limited to): Plan grievances and internal appeals; External Appeals; Enrollment and Disenrollment Processes; Member access and communication supports; Customer service standards; and Member Ombudsman
- **Plan Qualifications/Quality Metrics.** Charge: to provide feedback related to plan selection and quality metrics (including but not limited to): Plan Selection Process; Network Adequacy; requirements for Integrated Services, Assessment, Care Planning

and Management; Credentialing; Model of Care; and Core Demonstration Measures with focus on NCQA/HEDIS/AHRQ/CAHPS/NQF

Review of Known CMS Standards for Navigation/Appeals/Grievances

Since NYSDOH has not received feedback from CMS yet on the FIDA proposal, NYSDOH provided an analysis of the MOU that was created between Massachusetts (MA) and CMS so the workgroup members could see some issues that were raised and provide a structure to target comments. NYSDOH provided some context for the MA MOU, including the following:

- Age group in MA project is 21-64 (versus 21 and older in NYS's proposal)
- Strategy for plan selection in the MA document has been approved by CMS
- MA is providing a full range of services—behavioral, primary, LTC support, and pharmacy
- Pharmacy component is very different between MA and NYS and may not provide a good context to review
- Data system specification/interoperability section is also relevant to consider, given that expectations are higher because of the data exchange requirements of CMS in the demonstration

In addition to the MOU, a three-way contract will be developed between MA, CMS, and Health Plans which could provide another level of detail that the workgroup may want to take into consideration.

Workgroup Discussion

Grievances/Appeals - Process. The goal of FIDA is to have an integrated appeals and grievances process for dual eligible individuals, which means reconciling/marrying the current Medicaid and Medicare processes. One participant asked what was currently done under PACE and Medicaid Advantage Plus (MAP). PACE follows an integrated internal process under federal PACE regulations at 42 CFR Part 460. For External Review, the member is given choice of Medicaid or IRE. In MAP if a service is covered under both, the member is given a choice of processes. If no selection is made, the member is assigned to the more generous process (which is Medicaid). A participant noted that it seems MA took a step toward integration but did not fully integrate. Participants supported taking things "a step further" than MA, as it is important to streamline the processes since members are not familiar with grievance and appeals procedures and do not always have an advocate to work with on their behalf. The group requested a chart that compares key elements of the grievance processes between Medicare and Medicaid.

Medicare Part D. One participant asked if the Medicare Part D grievance/appeals process would continue to be kept separate, as they would like to see prescriptions incorporated into an integrated appeals process. Current grievance/appeals process is burdensome for both members and plans. NYSDOH said that would have to be explored with CMS to see if it was possible.

Aid continuing. Participants noted that the MA MOU appears to have aid continuing during a first level plan appeal, but if a member moves to Medicare independent review committee you lose it. Participants do not want bifurcated process in New York. Further, participants indicated the decision-making timeframe is problematic on Medicaid side and that FIDA should align Medicaid better with the Medicare timeframe. One participant indicated that the Medicare timeframe is reasonable to ensure members have their issues quickly resolved.

External appeals (non-plan appeals). Participants indicated that the Medicare external appeals process works well—if after plan review the plan denies a service, the appeal is forwarded automatically to independent review committee (the same process is contained in the MA MOU). One participant indicated it should be allowed or required that the review entity does a fair amount of outreach to providers, which is particularly beneficial for members who do not have an advocate familiar with the process and documents needed. State independent review was also viewed favorably by workgroup participants. The MA MOU process was viewed as still too complicated and felt that it would need to be further streamlined for New York. Alignment with aid to continuing timing was also indicated as important to ensure that there are not multiple steps and eligibility periods to manage. Participants indicated specific timeframes for resolving issues should to be established and specified. The IRE process works well, which tracks systemic issues and communicates information to plans. Medicare needs an expedited review process with a firm timeframe. A workgroup participant volunteered to send appeals data tracked and reported by Maximus to NYSDOH.

Notifications. Participants indicated that notifications need to be standardized and consistent. Uniform guidelines should be established regarding when notifications need to be communicated and what information they must contain. A participant volunteered to compile the guidelines for Medicare and send to the workgroup. Participants also suggested engaging the workgroups that NYSDOH has previously established to put together Medicaid notices to get their input and any best practices. NYSDOH stated they would explore this option.

Enrollment and disenrollment processes. NYSDOH indicate that they wanted to build on current experience with MAP and PACE. FIDA will still be tied to 1st of the month enrollment, which cannot be changed. One participant stated that for Medicare a member could enroll up to the 31st of the month and be eligible for coverage starting on the 1st of the following month (whereas Medicaid has the 20th of the month as a cutoff), and asked if the Medicaid cutoff could be changed to align with Medicare. Workgroup members would ideally like one process/place for members to enroll in both Medicare and Medicaid (NYSDOH said this is not impossible, but very challenging due to the size and nature of the separate systems). An adequate grace period for disenrollment should be established, some special needs plans (SNPs) have good examples to draw from. NYSDOH requested that a subset of workgroup members propose an optimal enrollment process for the group to work from.

Member access and communications support. The goal of FIDA is to ensure members are fully aware of rights as they navigate through the plan and appeals and grievances process. Participants stated that language (i.e., standards/expectation) regarding uniform notices should

be in the MOU. Participants also stated that it would be desirable to have a single set of guidelines and review process for handbooks and materials. The MA MOU has multiple agencies reviewing materials, which seems cumbersome to workgroup members.

Customer service standards. NYSDOH indicated that FIDA will have member service standards in contracts, starting as its base Medicaid and improve with/integrate Medicare. Participants indicated it would be desirable to include standards regarding customer service representatives (i.e., level of knowledge/expertise they would be expected to have). NYSDOH indicated they would provide the language already in Medicaid contracts to workgroup participants.

Member ombudsman. Participants liked the ombudsman role. Advocates would prefer a non-profit, independent organization to serve in the role. Attention should be paid to how the FIDA ombudsman would or will tie in with other current or planned ombudsmen in the State (LTC, Medicaid, etc.).

Enrollment—passive enrollment. Participants wanted to ensure FIDA did not disrupt existing enrollment, especially Medicare Advantage. One participant wanted to have a "plan finder" capability that possibly would be the responsibility of the enrollment broker to establish. NYSDOH indicated that this would be a separate cost and that additional dollars would have to be requested from the executive budget. Participants wanted to ensure that notification to members about enrollment is consistent. Another participant wanted to establish a way to ensure that members do not inadvertently switch Medicare plans and lose benefits. One possibility was suggested that perhaps FIDA contacts members who make a switch to verify they want to make it and ensure they are aware regarding any loss of benefits that would result.

Next Steps

NYSDOH will provide links to relevant current NYSDOH documents to workgroup participants prior to the next meeting, as well as any information provided by participants. The agenda and any pre-work for the workgroup participants will also be provided prior to the next meeting.

Future session dates and times

Workgroup call #2: Thursday, October 4 from 1-3 pm
Workgroup call #3: Thursday, October 18 from 1-3 pm

Overview

NYSDOH Demonstration Proposal to Integrate Care for Dual Eligible Individuals

Fully- Integrated Duals Advantage (FIDA)

Managed Care Model – Fully-Integrated Dual Advantage (FIDA)

New comprehensive managed care option that is specifically tailored to meet the complex needs of New York's full dual eligibles. Through Fully-Integrated Duals Advantage (FIDA) program, full dual eligibles who require 120 or more days of Long-Term Supports and Services (LTSS) would be provided the entire range of Medicare and Medicaid services as well as an extensive list of LTSS many of which were previously only available in New York State's Home and Community-Based Services Waiver programs.

Through the FIDA program, full dual eligibles would be provided with features such as, but not limited to:

- Seamless access to all physical health, behavioral health, and LTSS;
- A choice of plan and a choice of providers, with choices being facilitated by an independent, conflict-free Enrollment Broker;
- Care planning and care coordination by individualized interdisciplinary teams that are centered around each dual eligible;
- Consumer direction for personal care services;
- An independent, conflict-free, Participant Ombudsman to aid in any questions or problems the Participant has;
- Continuity of care provisions to ensure seamless transition into one's FIDA plan;
- Articulated network adequacy and access standards; and
- New Health Education and Wellness benefit.

Background

Qualifying Plans and Governing Rules

While NYSDOH is building the FIDA program requirements from the program requirements for the MAP program, it will, however, contract with MLTC plans in the demonstration service area that are in operation in 2013, that obtain CMS approval to be a Medicare Advantage Plan for 2014 and that are able to meet the requirements of the FIDA program. The MLTCPs are approved to operate based on the Department's review of their compliance with the MLTC programmatic requirements including a strong care management component, having an adequate contracted network to provide benefit package services, having adequate capitalization and solvency as well as meeting the Public Health Law's requirement for character and competence of the governing body and controlling persons.

For the FIDA OPWDD program, one to three qualifying plans with a history of high-quality care coordination for people with developmental disabilities will be selected to participate. Eligibility to apply to be an OPWDD FIDA plan is further dependent upon the entity being approved to operate as an MLTCP under the authority of NYSDOH during CY 2013. NYSDOH and OPWDD are pursuing state regulatory and legislative changes to support the establishment of specialized MLTCPs in 2013 for this demonstration.

Participating plans will be required to comply with all Medicare Advantage and Medicaid MLTCP requirements except to the extent that NYSDOH has obtained waiver of applicable provisions. FIDA plans will also be required to comply with all applicable New York State laws and regulations, and all additional requirements contained in the three-way contract being developed by CMS and NYSDOH/OPWDD.

Additionally, NYSDOH will pursue a waiver from CMS to permit any PACE plan that is able to meet the FIDA requirements to participate in the FIDA program.

Description of the Target Population

As of December 2010, there were 755,067 dually eligible Medicare/Medicaid recipients in New York State. Many of New York's dual eligibles are vulnerable, disabled, frail adults with chronic medical conditions who are significantly functionally impaired and/or have complex mental health and LTSS needs.

The target population for this demonstration is:

- FIDA - 123,800 full dual eligibles in the **eight counties** of Bronx, Kings, Nassau, New York, Queens, Richmond, Suffolk, and Westchester who: 1) Are age 21 or older; 2) Require community-based long term care services for **more than 120 days**; 3) Are not receiving services through the OPWDD system; and 4) Are not receiving services in an OMH facility.
- FIDA OPWDD – up to 10,000 full dual eligibles **statewide** who: 1) Are age 21 and older and 2) Are receiving services through the OPWDD system; and 3) Are not receiving services in an OMH facility.

Dual eligibles in the 8 county service area	Overall	Individuals receiving LTSS in institutional settings	Individuals receiving LTSS in HCBS settings
Overall total	460,109	54,164	123,880
Individuals age 65+	356,256	49,420	110,102

Individuals under age 65	103,853	4,744	13,778
Individuals with serious mental illness	75,956	20,796	21,112

Geographic Service Area

The FIDA Program will operate in the eight contiguous New York counties of Bronx, Kings, Nassau, New York, Queens, Richmond, Suffolk, and Westchester. 123,880 full dual eligibles who met the enrollment criteria reside in this service area. This service area was selected because it contains extensive provider and plan capacity.

The FIDA OPWDD Program will be available statewide but selected plan(s) will operate in discrete regions of the state based on the network scope and capacity. Up to 10,000 full dual eligibles who receive services through the OPWDD system will participate in this program.