Center for Disability Rights – Center for Independence of the Disabled NY
Community Service Society of NY – Empire Justice Center – Legal Aid Society – Medicare Rights Center
New York Association on Independent Living – Selfhelp Community Services, Inc.

June 30, 2012

Ms. Melanie Bella
Medicare-Medicaid Coordination Office
Centers for Medicare and Medicaid Services (CMS)
7500 Social Security Boulevard
Baltimore, MD 21244

Re: New York State Department of Health's Demonstration to Integrate Care for Dual Eligible Individuals (Draft Proposal for Public Comment, May 31, 2012).
By email submission: NY-MedicareMedicaidCoordination@cms.hhs.gov

Dear Ms. Bella,

Thank you for the opportunity to provide comments on New York State's recently revised demonstration proposal to integrate care for dually eligible beneficiaries (FIDA proposal). We, the undersigned, work in the health, disability and aging communities. We help dually eligible New Yorkers understand their health coverage and how they can obtain needed services.

As New York State notes in its FIDA proposal, dually eligible beneficiaries are more likely to fall below the poverty level and are more likely to be in ill health than beneficiaries enrolled into only Medicare or only Medicaid. We believe that New York's demonstration project offers a unique opportunity to address the numerous and complex problems faced by dually eligible New Yorkers; however, we are also concerned that New York's approach poses significant risks. More specifically, we are concerned that:

- Access and quality of care may be compromised in the name of saving money.
- There may be inadequate provider buy-in resulting in poor quality of care and limited access.
- The move from fee-for-service to insurance based managed care may compromise care by disrupting provider relationships, destabilizing the current safety net and creating a care system based on networks rather than need. There is much talk that the current system "doesn't work," and indeed New York's hospital re-admission rates and hospital infection rates are problematic. But in many important ways the system *does* work – dual eligibles have access to some of the finest medical Centers of Excellence, research and teaching institutions in the nation. Reduced access to these critical providers is a real threat if managed care plans limit their networks.

- New regulations governing FIDA plans may undermine, ignore, or circumvent important beneficiary rights and protections grounded in the Medicare and Medicaid laws and in the State and Federal Constitutions.
- FIDA plans may not be tailored to meet the unique needs of subpopulations being served by subprograms that currently exist in the Medicaid program.
- FIDA programs may have the unintended consequence of incentivizing institutionalization, in contradiction to the State's commitment to the implementation of the Supreme Court's decision in *Olmstead v L.C.*, 527 U.S. 581 (1999).

Overall, we believe that the revised FIDA proposal evidences careful consideration of some of these risks and we are pleased that New York plans to establish working groups to address many of the issues outlined below including, Appeals and Grievances, Financial and Payment Provisions and Quality Metrics. Moreover, we are pleased that New York's proposal to the Centers for Medicare and Medicaid Services (CMS) has evolved considerably from New York's initial proposal; more specifically, scaling back the scope of the demonstration and incorporating a managed fee-for-service model for about half of the affected individuals. The other half will be in capitated plans that raise more concerns. However, we believe further modification is needed before CMS permits this demonstration to move forward.

Promising elements – with concerns and additional protections needed

We commend New York State for incorporating the following elements to help mitigate risks and promote the well-being of dual eligible New Yorkers. We urge CMS to retain these elements in its final demonstration, with additional protections and clarifications.

- **We support the proposal's creation of an independent FIDA participant Ombudsman with broad authority to assist consumers**. Although existing resources and community based organizations should continue to be important advocates, an unbiased ombudsman is needed given the enormous task of shifting dually eligible beneficiaries from fee-for-service into managed care networks and the speed at which the change is proposed to take place. As proposed by New York State, the independent ombudsman will provide information and counseling to beneficiaries regarding FIDA plan coverage and advocate on behalf of aggrieved beneficiaries with the plans. We have four additional suggestions to strengthen the ombudsman's role. First, we recommend the ombudsman's role be expanded to track systemic issues experienced by FIDA plan enrollees. Second, we recommend that the ombudsman be housed in one or more non-profit community-based organizations that have a proven track record of serving dual eligibles. Third, we recommend that each plan be required to appoint a liaison to work with ombudsman staff to resolve problems experienced by enrollees. Fourth, the ombudsman must be equipped to assist beneficiaries in navigating the plan landscape.
- **We support the requirement that every FIDA plan must have a Participant Advisory Committee (PAC) that is open to all beneficiaries and their family representatives**. Requiring the PAC to meet quarterly and providing a forum for beneficiaries and families to voice their

concerns and questions is an important channel for beneficiary engagement. In order to ensure unbiased and prompt reporting of the information shared at these meetings, we suggest that DOH staff attend a sample of PAC meetings on a rotating basis each month, and that all plans provide summaries of the questions and concerns raised at their quarterly PAC meetings to DOH. DOH should publish a consumer friendly summary of PAC reports, including the steps each plan is taking to address beneficiary concerns.

- **We support the lack of an outright FIDA plan lock-in period**. We agree with New York's proposal to allow beneficiaries to leave their FIDA plans at any time. However, we disagree with the state's plan to permit FIDA plan changes and reenrollments only in January and July and recommend that beneficiaries should have the right to continuous open enrollment in FIDA plans. We note that in the current Medicare Advantage program, dual eligible individuals have Special Enrollment Periods to change Medicare Advantage plans on a monthly basis. Duals in New York's demonstration project should not lose this important right.

  As the State acknowledges, this population is more likely to have complex health needs than their peers enrolled in Medicare only or Medicaid only. For that reason, it is important to allow for flexibility in plan choice. At present, dually eligible New Yorkers can see any provider who accepts Medicare and Medicaid, and many choose to use Medicare providers who do not accept Medicaid, paying the coinsurance with their "spend-down" or with a Medigap policy.[1] The shift into insurance-based managed care networks will limit this broad provider access and allowing beneficiaries greater flexibility to switch FIDA plans will help them gain access to different or expanded provider networks as their care needs change. Further, permitting beneficiaries who disenroll from a FIDA plan only a choice of returning to Original Medicare or Medicare Advantage, without the option of switching to a different FIDA plan, defeats the State objective of encouraging care coordination.

- **We support the proposed continuation of benefits pending an appeal.** Aid continuing during the pendency of an appeal is an essential and well-established due process right in the Medicaid program. By allowing beneficiaries to continue to access long-term care, behavioral health services or other long term services for chronic conditions during an appeal, New York State will help ensure that this low income population will not need to pay for their care out of pocket, or more damagingly and likely, to forgo care or be left at risk without necessary long term care. We ask the State to clarify that this right to continued benefits pending appeal exists regardless of whether the plan's reduction or termination of a service is at the end of an "authorization period" for that service, which would require revision of the proposed regulation 18 NYCRR 360-10.8(e)(2) (currently in effect as an emergency regulation).

- **We support the inclusion of individuals with developmental and intellectual disabilities in this demonstration.** According to the New York State Health Foundation's recent report, *Integrating Care for Dual Eligibles in New York: Issues and Options*, 18% of the dually eligible population has

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[1] It should be noted that beneficiaries with the Qualified Medicare Beneficiary (QMB) program cannot be balanced billed for Medicare coinsurances even if they see providers that only accept Medicare and not Medicaid.

a developmental disability.[2] Their inclusion in the demonstration will allow the State to evaluate efforts to improve the quality, coordination, and cost-effectiveness of care received by dually eligible individuals with intellectual and developmental disabilities. Since one of the tenets of the demonstration is coordination across systems, and the State is taking a more holistic view by carving in this population, we believe it is critical that any infrastructure that the State develops (within the demonstration and beyond) must be predicated on individuals' functional needs, and not age or diagnosis. This would support the State's efforts around the Community First Choice Option implementation, which is a community-based Medicaid state plan service that cuts across siloed delivery systems to include hands on assistance, safety monitoring, and cueing for assistance with activities of daily living, instrumental activities of daily living and health related tasks based on functional need.

- **We support the proposal's very limited cost sharing for beneficiaries**. Beneficiaries in FIDA plans would not be responsible for any deductibles, coinsurances, co-payments, financial penalties or any other fees except for Medicare Part D Prescription Drug co-payments, and those receiving Long-Term Services and Supports (LTSS) would be exempt from Part D copayments as well. This protection, as required by CMS, will enable beneficiaries to afford needed health care services.

- **We support the proposal's creation of a separate managed fee-for-service model.** As mentioned we believe that multiple demonstrations are needed in order to evaluation which models improve the care and coordination for beneficiaries. We believe this managed fee-for-service model is an important addition to New York's demonstration proposal. However, in order to assess the success of this model, New York must create targeted metrics that measure the quality of care provided in health homes and beneficiary satisfaction and provide enrollees in the managed fee for service model with access to Ombudsman services.

- **We support the proposal's exclusion of populations participating in alternative coordinated care models.** The FIDA proposal hopes to deliver improved care and coordination and to achieve savings for the State and Federal government. Other models, Health Homes, PACE, ACOs and fee-for service models like enhanced Primary Care Case Management (PCCM), are designed to achieve the same results. The relationship between FIDA plans and these models needs clarification.

    - We agree that participants in ACOs approved before FIDA implementation and PACE programs should be excluded from the demonstration and would urge that participants in the other coordination models listed above be likewise exempted from FIDA enrollment, if FIDA enrollment is not voluntary.

    - The mechanism for identifying dual eligibles enrolled in these other models needs development. Some dual eligibles may be retroactively assigned to ACOs for example,

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[2] Verdier, James, Jenna Libersky, and Jessica Gillooly, *Integrating Care for Dual Eligibles in New York,* New York State Health Foundation, February 2012.

and processes will need to be identified for identifying them, informing them of their excluded status with regard to FIDA enrollment, and making all their options clear to them.

- As described more fully below, we believe that enrollment in FIDA plans should be voluntary. However, if the State adopts passive enrollment, the independent enrollment broker counseling regarding plan choice and enrollment should have the ability not just to provide counseling about these other options but to actually process those enrollments. Otherwise, we are concerned that the ability of other programs, like PACE, to attract enrollees will be unduly restricted.[3]

Elements to be Added/Improved

1) Enrollment

New York currently proposes passive enrollment of beneficiaries into FIDA plans. Under the current proposal, New York would begin passively enrolling dually eligible beneficiaries into health homes in January of 2013 and into FIDA plans in January 2014:

> Phase One in January 2013 –MFFS model -- would passively enroll individuals who have two or more chronic conditions, HIV/AIDS and/or one mental health illness and who do not require more than 120 days of LTSS services or services through an OPWDD or OMH facility into a Health Home – approximately 126,582 New Yorkers across all of New York State.
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> Phase Two in January 2014 – Capitation model -- would passively enroll: (1) those enrolled in mandatory managed long term care (MLTC) – approximately 123,880 people in the target 8-county metropolitan area into FIDA plans, and (2) Full Dual Eligibles age 21 and older who are not residents of an OMF facility and who are receiving services in the OPWDD system anywhere in NYS – about 10,000 people.

Phase One -- Medicaid FFS Health Home Enrollment Concerns

During Phase One New York State proposes to passively enroll approximately 126,582 dually eligible individuals who have two or more chronic conditions, HIV/AIDS and/or one mental health illness and who do not require more than 120 days of LTSS services or services through an OPWDD or OMH facility into a Health Home. The proposed enrollment plan continues with current health home enrollment of non-dually eligible Medicaid recipients with chronic conditions. Eligible duals will be assigned directly to health home networks based on, in priority order (1) higher predictive risk for negative event (2) lower or no ambulatory care connection (3) provider loyalty and (4) geographical factors.

We commend the State for inclusion of a managed fee-for-service model in its revised proposal. We are encouraged to hear that the State has the ability to effectuate plan assignment according to specific

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[3] In order to understand how enrollment brokers will counsel beneficiaries on these programs and/or facilitate enrollment we need additional guidance from CMS. Consequently, we reserve the right to make additional comments in light of forthcoming enrollment guidance.

analytical products, namely an ambulatory connectivity measure and a provider loyalty model. We strongly encourage the State to use these analytical products when enrolling all FIDA eligible duals, as this would greatly limit passive enrollment into plans whose network do not contain a dual beneficiary's specific provider and ease in the transition of dual eligibles who have traditionally used only fee-for-service products. That said, with the very limited information provided in Appendix F we have concerns regarding the criteria currently used by the State in health home assignment and the enrollment and disenrollment processes and procedures after State assignment.

Health home assignment as it currently functions is passive enrollment. Consumers are first made aware of their health home assignment when they receive a welcome notice from their assigned health home. We have specific recommendations regarding minimum requirements for all enrollee notices expressed in section g below.

After initial State assignment and outreach by mail unengaged health home eligible consumers are subject to in-person outreach by health home network subcontractors to effectuate enrollment. This outreach is done without official State guidance and raises questions regarding confidentiality. This is especially true in regards to initial Medicaid member information shared with health home network subcontractors for outreach purposes, prior to gaining patient consent, where the subcontractor may not have treated the patient in the past. Additionally, health homes have limited opportunities for billing for outreach and engagement, which can lead to aggressive enrollment tactics.

Health home eligible members may opt-out of the health home program at anytime. However, we are concerned that eligible members are not properly advised of this fact and/or the proper disenrollment procedures. In fact, though the Health Home Program began passive enrollment in January of 2012, as of April 2012, the Health Home Opt-out Form DOH-5059 was not yet available to health home providers.[4]

Additionally, although health home enrollees will not be restricted to using only providers in the health home's network, it is critical that they are placed into a health home that best fits their needs. The State lists provider loyalty and geographic factors as considerations when assigning a member to a health home. These terms, however, are ambiguous and it is unclear what factors are accounted for in these categories.

Moreover, Appendix F is lacking in important details regarding health home assignment, enrollment and disenrollment processes and procedures. The State must include additional information in the proposal that further explains these processes and at a minimum should issue official guidance, considering beneficiary and advocate input regarding the same.

Phase Two -- FIDA enrollment

We appreciate the State's desire to reach a level of FIDA enrollment that would achieve scale and facilitate a programmatic evaluation. However, we have serious concerns about the State's plan to shift

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[4] New York State Medicaid Update, Special Edition, Volume 28-Number 4, April 2012.

approximately 20 percent of dually eligible New Yorkers into the FIDA plans, and the use of passive enrollment to do so.

a. **As a threshold matter, we question whether passive enrollment of Medicare beneficiaries into private Medicare insurance products is permissible under existing Federal law.[5] We also question whether Section 1115A(d)(1) gives authority to waive dual eligibles' rights as Medicaid beneficiaries under sections 1902(a)(23) and 1932(a)(2)(B) of the Medicaid statute**. These provisions, respectively, establish the right of freedom of choice of provider, and exclude dually eligible New Yorkers from mandatory enrollment in Medicaid managed care.

b. **We recommend that, for at least the first year after implementing the FIDA program, the State employ a voluntary opt-in, rather than passive enrollment with an opt-out, for FIDA plans and alternatives**. This will allow FIDA plans to get their offerings in place and then to attract enrollees by publicizing their strengths. It is premature and risky to shift more than half of New York's dual eligibles to new and untested FIDA plans. FIDA is most like Medicaid Advantage Plus, which is too new and small to test scalability, access, effectiveness.[6] Additionally, the State has not yet undertaken consumer satisfaction and utilization comparison studies of these products. We believe that the State should allow accountable care organizations (ACO's), PACE programs, and health homes to flourish and then evaluate which model is most appropriately scalable and effective. We are pleased to see that PACE program enrollees would be permitted to remain in these programs.

c. **As outlined above, we recommend that the State use existing health home assignment Ambulatory Connectivity Measures and Provider Loyalty Models in FIDA passive enrollment to effectuate thoughtful plan assignment.**

d. If Passive Enrollment is implemented, we have concerns about the State's current proposal to begin enrollment in FIDA plans with the MLTC plan population.

    i. *Phase One*. **We recommend that the State start instead with the approximately 6,600 current Medicaid Advantage (MA) members – rather than MLTC members**. Since the MA members already are accustomed to accessing both Medicare and Medicaid primary care through managed care, they are a more appropriate population to enroll into these new managed care insurance products.

    Additionally, we question the inclusion of ALL 123,880 MLTC members into the capitated model demonstration, while excluding nursing home residents. **Including all MLTC members allows for no control group, and the mammoth size of the enrollment makes this less of a demonstration and more a full-scale change in care delivery on a faster track than is prudent.** Also, the demonstration leaves out current nursing home

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[5] *See*, 42 C.F.R. 431.51.

[6] The program had 1496 enrollees in the 8-county demonstration area as of March 2012. See http://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/.

residents, since they will not yet be in the mandatory MLTC population. Carving out institutionalized dual eligibles creates disincentives for plans to provide community-based services, since they are not at risk for the full cost of nursing home care. While nursing home care is a covered service in the MLTC program, MLTC plans can still avoid the cost of this care because members may disenroll and have Medicaid cover the cost on a FFS basis). We recommend that the number of MLTC enrollees in the demonstration be reduced by at least half, and that a group of nursing home residents participate in the demonstration. This will allow better testing of the effects of care coordination on reducing hospital readmissions from nursing homes.

We are pleased that New York has backed down from a default auto-assignment of MLTC members into FIDA plans operated by the same insurer that operates their MLTC plan. However, we are still concerned that the State anticipates that [for most] the enrollment assistance process would result in enrollment in a FIDA plan that is operated by the individual's current MLTC plan.' Without a detailed explanation of the assignment algorithm, it is impossible to tell whether the default assignment will still be to the FIDA plan run by the MLTC plan's operator. If so, we oppose this and urge individualized plan selection only. By definition, MLTC plans do not include primary medical care, except for the very limited specialties of podiatry, dental care, optometry and audiology. An MLTC member will receive their primary care in 2012 and 2013 through Original Medicare or through their own chosen Medicare Advantage plan – which may *not* be operated by the same parent that operates the MLTC plan. The proposed enrollment protocol that would assign the individual to the FIDA plan operated by the same entity that operates the MLTC plan would have no more than a random chance of ensuring continuity of the member's primary care providers. We urge the State to use the same provider loyalty algorithm to be used for health home assignment to assess the suitability of available FIDA plans.

Furthermore, **MLTC plans do not have Medicare Part D formularies**, and enrollment in a plan which includes all of the beneficiary's drugs with few utilization management tools is essential. The cost sharing protections of the Low Income Subsidy are only effective for Part D drugs covered by the beneficiary's Part D plan. Therefore, if a beneficiary is enrolled into a FIDA plan that does not include prescribed drug, they will face significant out of pocket expenses and/or an unnecessary appeal. Thorough, individualized counseling is needed for efficient enrollment.

The only type of plan match that might minimize disruption of provider relationships would be to match the dual eligible to the FIDA plan that is operated by the same company that operates the individual's Medicare Advantage plan, accompanying prescription medication benefit, *and* the individual's MLTC plan. Since the dual eligible would presumably have found a primary care physician in the MA plan's network, adequate medication coverage in network, and is already receiving long term care services through the MLTC plan, continuity of care would be more probable.

If different companies operate the individual's MLTC and Medicare Advantage plans, or if the individual is not in a Medicare Advantage plan, there should be no automatic assignment to the FIDA plan whose owner happens to operate the MLTC plan; the broker must counsel the individual on the choices, with an individualized inquiry as to whether the member's current physician's or other providers are in this FIDA plan's network.

e. Independent brokers must look holistically at all services and providers the beneficiary accesses before defaulting to an insurance product offered by the same carrier who provides the beneficiary's Medicare or MLTC insurance product, except perhaps in the rare situation where the FIDA plan has the same operator as both the Medicare Advantage, with accompanying drug coverage, and MLTC plan the individual is enrolled in, and the same provider network.

Moreover, through safeguards and counseling, the broker and computerized enrollment systems must prevent combinations of plans that might be detrimental to the beneficiary's access to health services. Beneficiaries will need to be counseled on both FIDA enrollment and FIDA disenrollment options and how their choice may affect their current health care services and access health services they may need in the future. For example, the enrollment broker must ensure that MLTC members who opt out of FIDA enrollment, or who later dis-enroll from a FIDA plan, do not mistakenly enroll in a Medicaid Advantage product, since it would not cover LTSS. We have seen at least one MLTC member enroll in a Medicaid Advantage plan and, as a result, lose 24-hour home care services. The NYC enrollment broker, Maximus, was on notice of this enrollment and allowed it. The Ombudsman's office should be trained on FIDA plan choice and FIDA plan disenrollment, as the office will be an important resource for beneficiaries navigating this new FIDA plan landscape.

Although the plan references the enrollment protocols developed for New York's mandatory Medicaid managed long term care carve-in, which have not yet been fully developed let alone tested, it must be clarified that an enrollment broker would be *required* to work with the beneficiary before enrolling him or her into a FIDA plan.

Enrollment assistance must, at minimum, include:

- **An explanation of the beneficiary's rights to opt out of a FIDA plan and their options for accessing both primary medical care and LTSS – Original Medicare, pioneer ACO, or Medicaid fee-for-service or PACE, MAPlus, or a Medicaid managed long term care product if LTSS are needed.**
- **The opportunity for an individual to register their intention to opt out in advance of receiving enrollment materials.**

- **The limited right to enroll into a FIDA plan during the two annual enrollment periods, as currently proposed.**

- **An online, publicly available plan comparison tool, similar to Medicare's PlanFinder, which a beneficiary, with the assistance of the enrollment counselor or advocate, could use to input their doctors, services and prescriptions and determine which, if any, FIDA plan best suits their particular needs.** Since the CMS PlanFinder already provides information on plan drug formularies, this new FIDA tool could link to PlanFinder for drug information to avoid duplication of effort. However, this separate online tool would be essential to show provider networks, and coordination with CMS would be essential to avoid added confusion for the potential FIDA enrollee or general PlanFinder user. Simply allowing plans to post their evidence of coverage and formulary online without a comparison tool is not acceptable. We ask that CMS prevent enrollment of beneficiaries into FIDA plans until a plan comparison tool is available for beneficiaries to access and use.

- **Information to beneficiaries about other independent sources of counseling, including Community Health Advocates (CHA), the Facilitated Enrollment program for people with disabilities, the FIDA Ombudsman's office, the State Health Insurance Assistance Program (SHIP), local Area Agencies on Aging (AAA), independent living centers, and other organizations with experience with the Medicare or Medicaid program.**

f. **The time allotted for plan selection should be 90 days**, to give adequate time for investigation as to provider networks, as well as counseling from the broker and other sources listed above.

g. **Notices that will be provided to beneficiaries subject to passive enrollment should not be developed by the broker or plan, but by the State with stakeholder input.** The State should convene a workgroup to develop the notices and host beneficiary test groups to elicit suggestions and ensure the notices are understandable. All materials must be made available in alternate formats, designed for a low-vision reader, and be appropriate for a low-literacy audience. Type size, font, contrast, etc. must conform with print publication guidelines http://www.lighthouse.org/accessibility/design/accessible-print-design/making-text-legible. The State should incorporate beneficiary and advocate comments and suggestions, and should ensure that all materials are well translated into languages of all prevalent Limited English Proficiency (LEP) populations, which should be defined as populations of 500 individuals or more in the proposed plan service areas who speak a specific language. In some areas, this may be more languages than the six languages the State proposes. State drafting will guard against notices being produced by entities with a financial stake in enrollment. Moreover, it will prevent enrollment notices from varying between plans.

h. The proposal does not place a limit on the number of FIDA plans a particular insurance carrier can offer. CMS should require **New York to limit the number of FIDA plan insurers and the number of FIDA plan offerings each insurer is permitted to sell.** Ensuring that beneficiaries have a choice of FIDA plans is important; however, equally important is that the choice is meaningful. In our experience working with beneficiaries in the context of Medicare Advantage and Part D, beneficiaries presented with an excessive menu of choices often end up enrolling into plans that do not include their needed services and providers. Duplicative, or nearly duplicative, FIDA plans from the insurer should not be certified as FIDA plans by New York State. We encourage New York to go further and require consistent naming of plans and classify the FIDA as well as Medicaid Advantage and MAPlus plans as is done for Medigap policies, which must be classified into easy-to-compare types.[7] Governing FIDA plans in this way would facilitate 'apple to apples' comparisons. Given the State's unique opportunity to build the FIDA plan benefits and structure from the ground up, a failure to build plan benefit designs that allowed for easy comparisons would be a squandered opportunity.

i. The State notes that Medicare Special Needs Plans (SNPs) are poised to develop additional product lines to provide FIDA plans**. We caution the State against relying on the SNP model for guidance, although SNPs promise coordinated care for beneficiaries, our experience in New York is that the promise is often not realized, in part because this function is not well defined in Federal regulation.** Under current law, SNP networks may include providers who do not accept Medicaid, leaving duals with high and unexpected cost sharing. Although this problem would presumably be resolved with FIDA plans, it is just one of many reasons against using SNP plans as a model for FIDA plans. SNPs often fail to provide beneficiaries with updated and comprehensible explanations of the plan benefits and how to access them. Similarly, because the Medicare regulations specific to SNP plans and sub-regulatory guidance do not provide strong beneficiary protections, we caution the State against incorporating Federal SNP guidance into FIDA plan guidance.

j. We applaud the lack of an outright lock-in period, allowing members to disenroll any time from a FIDA plan. However, we disagree with the state's plan to permit FIDA plan changes and reenrollments only in January and July. We believe restricting choice in this way is a form of lock in. We ask that CMS prevent a demonstration with an outright or modified lock in from moving forward. Since dual eligibles have the right to switch Medicare Advantage and Part D plans once per month, we question whether the State may limit this right for FIDA plans.

If the State does not adopt an open enrollment period, as we suggest, it must provide Special Enrollment Periods (SEPs), similar to those available in the Medicare program. For example, a dual who for the first time needs Medicaid LTSS should have the option of enrolling in FIDA, along with MLTC and MAPlus, since the new service needs would change the considerations of whether or not to enroll in a FIDA or to select a different plan type, as well as considerations for selecting a particular plan. Such an approach would also be consistent with the State-run

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[7] As an example, Fidelis has three dual eligible SNPs – Fidelis Dual Advantage, Fidelis Dual Advantage Plus, and Fidelis Dual Advantage Flex. The latter "flex" plan is NOT a Medicaid Advantage plan contrary to its name – it covers only Medicare services. This confusing use of terms of art must be standardized.

Healthy New York program and the new regulations issued by the U.S. Department of Health and Human Services guiding Exchange enrollment into Qualified Health Plans.

One SEP should allow retroactive disenrollment from a FIDA plan, where enrollment was based on misrepresentations or undue influence in marketing, or where a person with diminished mental capacity enrolled without understanding the consequences and choices and without the plan or broker consulting with the person directing the individual's care. This SEP is necessary where prospective disenrollment, effective the first of the following month, is not sufficient to ameliorate the harm. In such cases, the individual may not realize she has enrolled in a plan and incurs bills from a provider who is out of the plan's network. Retroactive disenrollment, which is now possible in such situations in Medicare Advantage, would at least partly remedy such situations.

Also, members need protection from common disruptions in their Medicaid enrollment due to annual renewal problems, bureaucratic errors and other reasons. The FIDA plan should not be able to disenroll members immediately when these interruptions occur – the plan should receive their capitation rate for an adequate period, and be required to assist the member in resolving the Medicaid enrollment issue. While some of these problems may lessen with state streamlining initiatives in the renewal process, the problems will continue to occur and must be addressed.

2) Network adequacy

a. **We oppose the proposal's minimum provider network standard of two of every provider for each service identified in the plan benefit package.** Appendix E states that the network must meet nothing less than the existing provider network requirements for Medicare and Medicaid and may not be less than two of any provider type. This is inadequate for the proposed possible enrollment of up to 130,000 dual eligibles. Unlike mainstream Medicaid managed care or Medicare Advantage, the MLTC population to be enrolled in FIDA plans not only have, by definition, chronic health conditions, but conditions so severe that they require LTSS. Their primary care physicians will include not only internal medicine or geriatrics specialists but also cardiologists, pulmonologists, neurologists, psychiatrists, orthopedists, and many other specialties. It is critical that there be a maximum patient-to-provider ratio as exists in Medicaid managed care. And with involvement of stakeholders, **New York should determine which services are most needed and most accessed by dually eligible New Yorkers and establish network requirements, which may vary by specialty or service, taking into account other factors such as**:

   i. **Providers must be accepting new FIDA beneficiaries;**

   ii. **State should set a maximum patient load or patient to provider ratio, which may vary based on specialty**. Even if the FIDA plan has two providers available within 30 miles or 30 minutes for each plan service, if a large number of FIDA beneficiaries live within a particular geographic area, such as New York City, this number may not suffice. This safeguard will also help FIDA plans achieve the proposed scheduling times and wait times.

    iii. **A number -- to be determined -- of every provider must meet accessibility standards established by the Americans with Disabilities Act (ADA), and have capacity to serve members with limited English proficiency (LEP) or unique health care needs.**

    iv. **As proposed, all providers must accept the FIDA plan payment, regardless of whether they normally accept Medicare or Medicaid.**

b. Appendix E frames network adequacy standards in terms of appointment waiting times rather than in terms of the patient to provider ratio or number of providers. While waiting time standards are important and should be retained, they are difficult to monitor and are not a substitute for other numerical standards as described above. **Additionally, we recommend periodic "secret shopper" surveys to audit provider availability and compliance with the access metrics specified in the proposal.**

c. The state must conduct a *readiness review* that examines all of the above criteria using a methodology and target measures that have been developed in a transparent stakeholder process–before plans are permitted to "go live."

d. We support the proposal's allowance of access to out-of-network providers at no cost, if the plan's network is unable to meet network adequacy requirements, but the State must clarify when and how and by whom it is determined that the plan is in or out of compliance. **Given the urgent need for time-sensitive care, the beneficiary must be able to go out-of-network without any delay.** Moreover, we propose that members also have the ability to immediately disenroll from the plan and return to fee-for-service Medicaid and Medicare or another FIDA plan.

e. While we are pleased with the new requirement that Plans must report its network capacity to DOH on a quarterly basis, this should be strengthened. The State must specify *how* the FIDA plans will be required to monitor their network capacity. Provider lists must include detailed information on ADA compliance that has been verified and the lists must actually be updated at least quarterly and be made publicly available on the plans' websites, by mail, from the broker, and in other ways. The State must also specify that the plans must determine at regular specified intervals if providers are accepting new patients or have long wait times, and make this information available to beneficiaries in specified ways. Plans must make clear who a beneficiary can contact if they have network adequacy problem, including ADA compliance. The State must also do monitoring to verify the plan's internal capacity monitoring.

f. Transition period for providers as well as service plans. Because many FIDA enrollees will have received their Medicare and Medicaid without network restrictions, it is important that as beneficiaries enter into FIDA plans they are provided with a transition period during which they can access out of network providers without penalty. **We recommend beneficiaries have a six month transition period, not the proposed 60 day period**. Individuals should also be able to extend this period for good cause – if, for example, there is no safe transition to in-network providers possible.

The State must clarify that the FIDA plan is prohibited from applying new utilization management such as prior authorization criteria, step therapy, quantity/frequency limits, medical necessity limitations, etc. during the transition period. For example, if a patient has a prescription that is not in the drug formulary for a participating plan, there must be a mechanism for the new plan to know of previous treatment plans in order to continue them, as was done during the carve-in of the Medicaid pharmacy benefit.

Continuity of treatment should apply to all current treatment plans, and the continuity protection should not be broken because of the end of an authorization period for an on-going service. For example, if a beneficiary was receiving personal care from an MLTC plan that was re-authorized every 6 months, the authorization in place at the beginning of a 6-month transition period would clearly expire in mid-transition period; that expiration should not end the continuity requirement if, in the physician or clinician's opinion, a reauthorization is part of the same treatment. The same should apply to any treatment addition or change that is a reasonable, foreseeable or necessary part of a current treatment plan.

3) Plan payment and performance measures and outcomes

New York's proposal seeks to pursue a capitation model that would pay FIDA plans a risk adjusted per-member-per-month capitated payment in an amount to be determined by DOH and CMS. We are pleased that the State acknowledges the need to provide payments to plans that account for the particularized needs of the plan members. More specifically, we support the FIDA proposal's anticipation of utilizing risk adjustment combined with rate cells or risk corridors or some other reinsurance mechanism to guard against cherry picking.

a. **Payment rates should incentivize best practices. For example, it is vital that plan reimbursements and/or capitation rates, including bonuses and incentives, incentivize community based care over institutionalized and nursing home care.**

We are concerned that although New York expresses support for this concept, commitment to building the appropriate rate framework has not reached a level sufficient to ensure appropriate rate design. While initial discussion indicated a plan for limited risk adjustment in the mandatory Managed Long Term Care program, which we thought insufficient to ensure adequate services for high-need enrollees, more recent statements by officials from the Department of Health indicate that the State may not use any risk adjustment at all in the mandatory MLTC program. Since the FIDA plans are expected to build off of the MLTC plans, experience with risk adjustment in MLTC would seem to be critically important if the State truly intends to include risk adjustment in the negotiated rates for the FIDA plans.

Further, New York's proposal for payments to the FIDA plans contemplates development of financial performance-based incentives only after a year of collecting data and evaluating performance. While the data will undoubtedly inform and improve implementation of rate incentives, we are alarmed at the prospect of no incentives whatsoever while initial data is gathered. We believe incentives could be put in place immediately, and would refer CMS to the consumer advocate proposals to incentivize community based care that were submitted to the State on March 23, 2012, and are posted at http://wnylc.com/health/download/304/. Although these ideas (special rate cells, modified stop loss payments, risk adjustment across plans, robust provider networks) will clearly need refinement and adjustment as the demonstration moves forward, they should be part of New York's reimbursement framework from the start.

In addition, FIDA plan payment rates, particularly in the early years, should compensate plans for successfully achieving full ADA compliance, including architectural changes, purchase of accessible equipment, and training for FIDA plan personnel, providers, and vendors. California's Section 1115 Comprehensive Demonstration Project Waiver includes a provision requiring that plans and providers must be trained in cultural competency to better serve individuals living with disabilities—a similar provision should be included in New York's model.

b. **We appreciate New York's interest in incentivizing high quality care by proposing additional payments be made to FIDA plans that have high *performance measures*. Any measures the State develops should account for the specifics of the dually eligible population.**

Quality measures and performance ratings applied to Medicaid managed care plans for younger and non-disabled adults are not appropriate markers for low income older and disabled adults. New York should consult with organizations that have developed quality measures specifically for this population when developing its performance measures. For example, it should consider adoption of the NIDRR-funded "Assessment of Health Plans and Providers by People with Activity Limitations" instrument based on the Medicaid CAHPS instrument but with phrasing and content areas that are more appropriate to adults with activities limitations or a similar instrument. Data collection should include examination of whether there are disparities in access and outcomes based upon disability, gender, race/ethnicity or other factors.

California's demonstration project includes a provision stating that it will adopt a version of CAHPS designed specifically to reflect the concerns of participants with disabilities. New York should also consult with CMS, as CMS works to further refine its Star ratings program and implement its Medicare Advantage quality bonus payment system. We ask that New York make clear that FIDA plans will not participate in the Federal quality bonus payment program; FIDA plans do not need to receive quality payments from both New York and the Federal government.

The potential Improvement Targets listed by the State as expected Outcomes, which would correlate to performance measures, are not sufficient. (p. 28). They must be expanded to include targets relating to preventing institutionalization, preventing falls and other accidents, maintaining and improving the ability to perform Activities of Daily Living, and other measures that should be developed with stakeholder involvement.

The proposal states, "the FIDA program will be responsible for providing all of the State Plan services and nearly all of the waiver services available through the HCBS Waivers that serve the target population." **We are very pleased that the State is making a concerted effort to incorporate waiver services into the demonstration.** For this population in particular, services such as environmental modifications, independent living skills training (ILST), and home and community support services (HCSS)

– which are all in the proposed services package – are essential to supporting an individual in the community. One of the advantages of a comprehensive benefits package that incorporates waiver services in the demonstration is that it moves the State closer to a cross-silo service delivery system that responds to individual's needs, not diagnosis or age.

The State's plan indicates that FIDA plans will be required to cover all Medicaid and Medicare services, including long term care services and supports and Medicare prescription drug benefits, and other additional services not presently covered by either program.[8] The State has already explicitly listed some of these additional services like transition (moving) assistance. We applaud this effort. **Additionally, we support the State's inclusion of services and supports that are not explicitly listed as expanded services, Medicare services, or Medicaid services, but facilitate care coordination and the health of the beneficiary.**

We are pleased to see the State require FIDA plans to develop *electronic medical records* so that all network providers have access to records for every member. We question whether the State is anticipating and requesting the funding needed to develop the infrastructure, without this capacity, full care coordination will not be possible.

Finally, actuarial support provided by external consultants must be transparent. In order to ensure that community based care is incentivized by the payment rates access to this work and this process is critical. **A minimum medical loss ratio calculation (MLR) should be adopted to ensure that the State's money is spent on providing care to dually eligible New Yorkers, and not the enrichment of plan employees or investors.** We recommend that a standard be adopted that is at least as stringent as the 85% MLR that will apply to Medicare Advantage plans in 2013. Whether or not a minimum MLR is adopted, cost data—as mentioned above—must be reported.

4) Stakeholder and beneficiary engagement

We are pleased to see that the revised demonstration proposal provides additional detail on stakeholder engagement and adds additional tools for beneficiary engagement. Continuing to engage beneficiaries and their advocates, particularly around the development of State and plan memorandums of understanding (MOUs) and enrollment into demonstration programs, is critical.

The State notes that it has been holding weekly meetings with interested stakeholders in which mandatory enrollment of dual eligibles into the MLTC program is discussed. As we noted in earlier comments, these calls are an important tool for disseminating information about implementation, but they do not enable meaningful discussion of the FIDA proposal due to size and the lack of a record of participants or past discussions.

For this reason, we are very pleased to see that the revised proposal would create subcommittees dedicated to addressing specific topics -- this commitment is crucial if stakeholders are to have the opportunity for meaningful input. We would urge the State to construct these groups thoughtfully, with

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[8] Medicare hospice services, out of network family planning services, directly observed therapy for TB, and methadone maintenance treatment are explicitly exempted from these covered services.

attention to size and composition and agenda in advance, in order to avoid large, unstructured meetings that are not efficient or productive.

The revised proposal mentions three topics for subcommittees: integrated appeals and grievances, financial and payment provisions, and quality metrics. We urge the State to add the topic of consumer communications, to encompass both notices and written/electronic materials for outreach and education. The consumer communications subcommittee could also help formulate the participant satisfaction surveys that the State has committed to conduct twice annually. The State should also have a subcommittee on Enrollment and Consumer Navigation, which could critical issues such as choice, network adequacy, continuity of care, and Ombudsman services. Finally we would urge consideration of a subcommittee on Health Homes, to address the fee for service aspect of the program proposal.

The stakeholder subcommittees for the Dual Demonstration should be staffed sufficiently to ensure meaningful development of an overall mission and concrete objectives at the outset and **detailed program updates to ensure level setting at each meeting.** Written materials should accompany oral presentations, and assistance should be provided in interpreting data on program performance and developing recommendations. Finally, task force members should understand the process the State will use for translating their input into program improvements.

The State commits to using focused subcommittees through the period of the MOU negotiations (end of September 2012), which we agree is a critical period for program design (p. 24). Draft MOU provisions should be posted publicly during this period, and the State should provide a period for beneficiaries, advocates, and other stakeholders, as well as the aforementioned task members, to issue comments on the draft provisions.

We would, however, urge the State to maintain the subcommittees beyond September of 2012, as work on the topics they will focus on is unlikely to be completed by that date. Outreach and education, for example, is not scheduled to launch until July of 2013, and many written materials and other consumer communications will be prepared in connection with that date. The subcommittees should disband only when the relevant programmatic features are in place and operating relatively effectively.

The revised proposal catalogues significant amount of outreach to stakeholders via webinars and websites; however, this type of outreach has not been particularly successful in engaging actual beneficiaries from dual eligible communities. We are pleased to see that the State references plans for live educational events once the initiative is underway. These events should be carefully planned in order to increase beneficiary engagement. Outreach about the local meetings must be targeted to reach the dual eligible beneficiaries through community based organizations already engaging with duals, such as independent living centers, HIICAP agencies, managed long term care plans, and other providers.

Additional stakeholder engagement is especially needed for individuals who will be enrolled into health homes. Given that, if approved, beneficiaries will be automatically enrolled into managed fee-for-service health homes beginning January 1, 2013, the State must quickly make available beneficiary-friendly information about health homes. The dedicated mailbox that currently exists for posting questions regarding enrollment, billing and general issues, is inadequate.

We recommend the State hold localized town hall meetings where beneficiaries and family members can ask questions and raise concerns about the health home model. Regarding health homes, beneficiaries need information about the role of the care coordinator, the scope of service coordination available and the difference between a health home network of providers and a private insurance plan's network. To this end, prior to enrollment care managers should reach out to prospective enrollees and explain the health home model, particularly the fact that the enrollee is not restricted to seeing only providers who participate in the health home. If this service cannot be provided by a care coordinator then it should be provided by an enrollment broker.

We also recommend that the State include advocates on their weekly Health Home State Implementation Team meetings, so that advocates and others who work with this population can stay informed about health home implementation and available resources for beneficiaries and their families.

After enrollment, beneficiaries should be educated about the opportunity to participate meaningfully in service assessments and construction of care management teams, and all plans should facilitate access to consumer directed services. We support ongoing solicitation of consumer experience through the requirement for Participant Advisory Committees (PACs) at each plan. We also support the requirement that plans conduct two participant feedback sessions each year and assist with the cost of transportation, and other challenges dual eligible enrollees will fact to attend the meetings.

We are pleased to see that revised proposal commits DOH staff attend a sampling of the participant feedback sessions and would ask that staff likewise attend random PAC meetings to monitor quality and engagement. . DOH should make their summary of the meetings available to beneficiaries and their advocates. Similarly, the annual participant surveys, which we support, should be summarized and made publicly available. This consumer input should prove very valuable to consumer advocates, plans and the State.

In the end, it will be critical for New York to expand its request for demonstration implementation monies to support partnerships with community based providers and advocates who can assist with outreach, navigation, and engagement, and to enable meaningful consumer input on an ongoing basis.

5) Scope of Services and Utilization controls, Appeal rights and grievances

As noted, New York's FIDA proposal will require FIDA plans to cover all Medicare and Medicaid covered services and additional services not presently covered by either program. **In our experience, access to health services in both Medicare and Medicaid is controlled by utilization management and service restrictions like prior authorization or medication step therapy. We recommend that the State allow for a limited utilization of these measures.** In our experience these tools often cause undue delay in receiving a needed service or medication and force beneficiaries into the appeals process unnecessarily.

Moreover, given the FIDA proposal's goal of seamless care coordination between providers, beneficiaries, and the FIDA plans, any question about utilization should be resolved by the provider and the FIDA plan on an individual basis, rather than placing blanket stops on certain services for all FIDA beneficiaries. We recommend that the proposal clarify the role of the care management team in ensuring that receipt of services is not denied or delayed by utilization management or other restrictions.

We were disappointed that the proposal did not provide additional detail on the grievance and appeals process for the demonstration. As noted in our comments to the State, we are encouraged by the elements of the process that are summarized in the proposal, including: single notices, aid continuing for both Medicaid and Medicare benefits pending appeals, and the usage of the most beneficiary friendly timelines for seeking appeals. However, more concrete guidance regarding each of these and other elements of the appeals process is needed. We support the idea of stakeholder involvement in the development of the appeals and grievance process, but it is essential that consumers and consumer advocates are well represented on the workgroup tasked with designing the grievance and appeals process. In addition, stakeholder involvement in the process should not be a substitute for designing a robust system for grievances and appeals. We request that the stakeholder workgroup be tasked with considering the following recommendations:

a. **The demonstration must provide a clear definition of medical necessity.** The contracts and guidance must make clear that plans must provide services using the Medicaid definition of "medical necessity", which is generally more expansive than Medicare, given that Medicaid is a program based on financial need while Medicare is not. Section 365-a of the Social Services Law defines "medical necessity" as:

> "Medical assistance" shall mean payment of part or all of the cost of medically necessary medical, dental and remedial care, services and supplies, as authorized in this title or the regulations of the department, which are necessary to prevent, diagnose, correct or cure conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap and which are furnished an eligible person in accordance with this title and the regulations of the department.

Two examples of services with divergent Medicaid and Medicare criteria are home health services and durable medical equipment (DME). Certified home health agencies commonly conflate the Medicare and Medicaid criteria and use the more restrictive Medicare definition, despite clarification from CMS that certain restrictive eligibility criteria for Medicare home health services do not apply for Medicaid services, for example.[9] Similarly, Medicaid rules prohibit a managed care plan from denying or discouraging a member from submitting a prior approval request for a particular type of medical equipment or device by stating that the

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[9] See, e.g., HCFA Olmstead Update No. 3, HCFA letter to State Medicaid Directors, July 25, 2000 (stating "The 'homebound' requirement is a Medicare requirement that does not apply to the Medicaid program."), posted at http://www.cms.hhs.gov/smdl/downloads/smd072500b.pdf.

requested device does not meet the definition of Durable Medical Equipment (DME), or that the item is "not covered." Since a state Medicaid agency is not permitted to maintain an "exclusive list" of covered DME, there must always be an opportunity to show that the item meets the DME definition.[10]

b. As stated above, the right to a hearing before Medicaid benefits are reduced or terminated, which entails "aid continuing" pending the hearing, is a fundamental due process right. **We are encouraged that the proposal includes this right to aid continuing, but ask the State to confirm that this right to continued benefits pending appeal exists regardless of whether the plan's reduction or termination of a service is at the end of an "authorization period" for that service.** The State recently proposed to amend state regulations governing Medicaid managed care appeals, which would deny the right of aid continuing if the plan's proposed service reduction or termination coincides with the end of an "authorization period." See 18 NYCRR 360-10.8(e)(2) (currently in effect as an emergency regulation). By allowing beneficiaries to continue to access long-term care, behavioral health services or other long-term services for chronic conditions during an appeal, New York State will help ensure that this low income population, whose members cannot pay for their care out of pocket, will not be forced to forgo care or be left at risk without necessary long-term care.[11] Without this protection, the aid continuing right is essentially nonexistent in the context of service terminations or reductions. **We disagree with the recommendation of the Medicare and Medicaid Coordination Office (MMCO), which would result in Medicare benefits being terminated after the initial plan-level determination.[12]** This distinction is arbitrary. Moreover, our experience in Medicare Part D is that the overall plan reversal rate at the Independent Review level is approximately 65 percent.[13] Given this high rate of plan reversal at the Independent Review level, it would unfairly penalize beneficiaries to cut off aid after the initial plan decision. Furthermore, differences in aid continuing between Medicare and Medicare benefits could create confusion and interfere with the stated goal of seamless care provision, as outlined below.

c. Notice content must comport with longstanding state and federal Medicaid requirements. **Notices must include the effective date of the action, explicit reasons for the action, citations to specific regulations, web addresses and phone numbers of the insurer, the independent adjudicator, the Ombudsman's Office, and the State grievance system, along with clear**

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[10] Centers for Medicare and Medicaid Services (CMS), Letter to State Medicaid Directors (Sept. 4, 1998), available at www.cms.hhs.gov/states/letters/smd90498.asp.

[11] As a related matter, authorization periods should be realistic. When a beneficiary has a permanent disabling condition that requires ongoing treatment of a certain type, the authorization period should be annual or six-months, not 90 days, and, for other services, the treating provider should be able to certify a longer authorization period if appropriate. However reasonable the length of the authorization period may be, we reiterate that individuals must be entitled to "aid continuing" if the plan seeks to terminate or reduce long-term services at the end of an authorization period.

[12] CMS, Letter to Organizations Interested in Offering Capitated Financial Alignment Demonstration Plans (Jan. 25 2012), available at: http://www.dhcs.ca.gov/provgovpart/Documents/Duals/Final_CMS_Plan_Guidance.pdf

[13] CMS Fact Sheet Part D Reconsideration Appeals Data, Plan Year 2009, available at: http://www.cms.hhs.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev/Reconsiderations.html

instruction on how to appeal the denial and to request an expedited appeal. Moreover, any oral denial of a particular item or service must be followed up with a written formal denial within 48 hours. This notification must be clear, with the reason the service or item is being denied concisely explained on the first page.

d. A unified appeals process should provide beneficiaries with the more protective due process provisions from the Medicare and Medicaid programs. **The appeals process should lay out a clear appeals pathway for beneficiaries to follow regardless of whether the particularized services are covered by Medicare or Medicaid.** Beneficiaries should not be asked to choose an appeals pathway or to decide whether the service is Medicare or Medicaid covered and then pursue the appropriate Federal or State process. **In any appeals process, it is critical that the beneficiary have no wrong door to exercising appeal rights.**

All FIDA plan internal appeals processes should be identical and New York State should regulate the structure. This will allow for the dissemination of clear and concise information and education about how appeals work for FIDA beneficiaries, rather than referring beneficiaries to their particular FIDA plan. Moreover, it will guard against multiple levels of internal insurer appeals. Insurers should have one bite at the apple before the appeal proceeds to an independent adjudicator. Beneficiaries must be able to contact the plan appeals department and the independent adjudicator.

At all level of appeals the adjudicator should conduct proactive outreach to providers to collect any information that is missing from the beneficiary's appeal or is needed to make a determination of medical necessity. The independent reviewer in the Medicare Part D program conducts this type of outreach. In our experience this outreach guards against rubber stamped denials due to a lack of information. This proactive outreach and coordination seems in keeping with the goals of the FIDA demonstration and should be adopted in New York's FIDA proposal.

e. **We recommend that FIDA enrollees have immediate access to both an internal FIDA plan appeals process and an in person Medicaid fair hearing**, as Medicaid beneficiaries have now. Fair Hearings should be in person as a default, but beneficiaries should have the ability to request a telephonic or video hearing if that is their preference. Homebound beneficiaries should be afforded the rights outlined in *Varshavsky v. Perales*, including the right to a home hearing if they lose a telephone or representative hearing.

f. **The right to conference, which currently exists in the Medicaid fair hearing process, should be preserved in the new FIDA appeals structure.**

g. If FIDA participants will appeal any denied item or service through the State Medicaid appeals channels, which we recommend, State staff will need training and education on Medicare covered services and the Medicare coverage rules that will apply to FIDA plans. State Administrative Law Judges (ALJs) lack practical experience with the Medicare program. **New York's FIDA proposal must explicitly account for the needed training and any additional staffing that may be needed to facilitate this training.**

h. There must also be remedies for beneficiaries who do not have a hearing scheduled timely or do not receive a timely decision. **We recommend lapsed decision timelines trigger a favorable decision for the beneficiary or, at minimum, a delayed plan decision should automatically be forwarded to the next level of appeal.** Presently, in both Medicare and Medicaid, despite firm rules regarding timely decisions, fair hearing requests and request for review by the Medicare Appeals Council extend far beyond their allotted timeline. Presently, Medicaid recipients are being forced to wait months before non-home care hearings are even scheduled. New York must hire appropriate staff to ensure timely decisions and provide concrete remedies for beneficiaries whose decision time has lapsed. Plans could be allowed some filing deadline flexibility but only if the beneficiary is helped, not harmed by this flexibility. Plans must afford members their due process right to access to documents from their medical record to prepare for a hearing, providing a simple way of requesting these documents.

i. Just as aid continuing rights are essential to ensure that this vulnerable population does not go without needed care, beneficiaries should have clear access to an expedited review process for medically urgent care. This could be modeled after the Medicare process, which allows for expedited appeals if a beneficiary's health or life could be endangered by waiting for the regular review timeline. Federal Medicaid regulations also allow for expedited appeals if delay could "jeopardize…the ability to attain, maintain, or regain maximum function." 42 C.F.R. § 438.410(a). Although MMCO has recommended following the 72 hour expedited appeal process in the Medicare Part C program, we recommend the 24 hour timeline governing the initial level of appeal in Medicare Part D.[14] As mentioned above, the current backlog in New York fair hearing requests can make the scheduling of a truly expedited hearing impossible; we reemphasize the need to hire and train the appropriate staff to guard against this outcome.

j. Appeals should be triggered immediately when a service or benefit is denied. 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.

k. We strongly disagree with the MMCO recommendation that the Part D appeal standards remain the same in the demonstration plans; we recommend that the FIDA appeals process for denied medication differ substantially from Medicare Part D. The Part D process, as it currently exists, causes many beneficiaries to experience significant delays in access and suffer negative consequences to their health. As mentioned, in the current appeals standards a denial at the pharmacy counter triggers no due process rights, instead, a beneficiary must go to his or her prescribing physician and request written support to request a coverage determination. Counterintuitively, the physician's prescription does not constitute written support. At this point, beneficiaries have already seen their doctor, been prescribed a medication, and brought the prescription to the pharmacy, only to find that they can neither obtain their needed medication nor immediately initiate the appeals process. This burdensome and opaque appeals

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[14] CMS, Letter to Organizations Interested in Offering Capitated Financial Alignment Demonstration Plans

process is weighed down by excessive paperwork, administrative error, and severely lacks in transparency. Furthermore, beneficiaries, their doctors, and their pharmacists are often unaware of how to challenge the plan's decision. As a result, many bypass the formal appeals process entirely, simply leaving the pharmacy empty-handed and accepting the resulting consequences to their health or, if they can afford to, paying the full cost of the drug out of pocket. For those 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. This Byzantine process allows the plan has three bites at the appeal: the decision at pharmacy counter, the coverage determination and the coverage redetermination. In our experience, this onerous process only deters beneficiaries from pursuing an appeal and confuses beneficiaries, providers and pharmacists. The Part D appeals process is riddled with deficiencies and adoption of the current process for FIDA beneficiaries is ill advised.

6) Monitoring and Oversight

The State indicates that it is currently capable of monitoring the cost, quality and utilization of managed care insurance plans. We are concerned, however, about the proposal's lack of detail in this area, and question whether 10 DOH staff will be sufficient to conduct meaningful monitoring and oversight. 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. CMS must require the State to delineate relevant data measures in more detail and explicitly outline how that data will be collected, analyzed, publicized and acted upon.

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 model. However, even with federal assistance in monitoring the model, DOH will need significant staff resources to arrive upon appropriate data measures for a new initiative such as FIDA, institute the procedures for collecting the data, and analyze and summarize the results for the public.

In terms of identifying the appropriate access and quality matrix for a program such as FIDA, it is imperative that the State not rely exclusively on familiar clinical measures such as avoidable hospitalizations, emergency room use and drug interactions. **We applaud New York for proposing appointment standard requirements and maximum wait times; however, we find the proposal short on critical details about the reporting and oversight of these metrics. Data will also be needed on measures such as:**

- ***Positive social outcomes achieved. Social outcome measures*** include satisfaction with one's ability to participate in the community, employment, pursuit of higher education and other indications of independence;

- ***Broad provider networks***. Duals will need both acute and long-term care from a wide array of specialists and specialized facilities that may not be represented adequately or at all in existing provider networks – accommodations, wait and travel times must be closely monitored and plan provider lists must be kept updated and publicly available;

- ***More accessible provider networks*** Duals will need accessible facilities and the state must develop or obtain the expertise to ensure that capacity is available and that it is improved over the course of FIDA. A study of physical accessibility in primary health care settings in California found that fewer than 10% of offices had accessible medical equipment and that access barriers in bathrooms, examination rooms, and building access had high prevalence access barriers. If people with disabilities cannot receive services in accessible out-patient provider offices it will be impossible for them to receive equally effective health care services in the community, raising Olmstead concerns;

- ***Care integration and coordination.*** The State will need to verify and assess co-location, integrated treatment plans and the effectiveness of multi-disciplinary teams;

- ***Successful beneficiary engagement***. The State must confirm that communications are clear, accurate and effective, ideally through standardization and central development – and that plan outreach and engagement activities are meaningful -, ideally through participation in PAC meetings and collection and publication of PAC reports;

- ***Service utilization & outcomes****.* Widely used quality measure sets do not adequately target the needs of dually eligible beneficiaries- our comments to the State suggested that both social outcomes and tailored clinical measures for treatment of diseases prevalent to the target population are critical to incorporate

It is promising that the DOH is presently receiving Medicare fee-for-service data from CMS, it will be important for the department to build expertise in analyzing Medicare data. The department should also seek information from Medicare Advantage plans operating in the service area.

Another important source of performance data can be gleaned from contractual compliance. It is imperative that the State moves away from reliance on beneficiaries as the primary reporting mechanism for contractual compliance. Both the State and CMS should have an active role in collecting these data points. We again recommend periodic “secret shopper” surveys to audit provider availability and compliance with the access metrics specified in the proposal.

Once the appropriate measures are described and the data collected, it must be analyzed and summarized. DOH must stratify the data by race, ethnicity, primary language, disability and gender in order to identify and address disparities in access and outcomes. DOH must also make information that describes plan performance publicly available in plain language. **Synthesized data should be published in the form of simple comparison charts, report cards or star ratings for beneficiaries and their families.**

The task force structure discussed earlier in these comments will provide an important layer of oversight by soliciting and receiving stakeholder input and the task forces must continue beyond the September expiration date identified by New York. **Actual beneficiaries and their advocates must be task force members and have the opportunity to provide input on their group's agenda.** The task force should receive data relevant to their issue area and assistance with translating the data into recommendations for program improvement.

7) The FIDA Ombudsman program

We are pleased that the State is proposing a Participant Ombudsman (PO) program in conjunction with the FIDA demonstration. We recommend that the State extend this valuable service to individuals in the managed fee-for-service Health Home initiative, which is outlined in the State's final proposal as a major component of the demonstration project. Ultimately, we believe the State should design the PO program with the long-term goal of expanding it to similar populations phasing into managed care.

The State had advanced a sound programmatic framework for the Participant Ombudsman, and we fully support the eleven responsibilities assigned to the program, but would add an additional responsibility – to receive and analyze copies of all cost, payment, quality and other reports in a format to be defined. Such information will augment the individual complaints handled by the Ombudsman and expand the Ombudsman's ability to identify and flag quality and access issues. **Data collected and analyzed by the State should be reported directly to the Ombudsman for this purpose.**

Additionally, we are concerned that the budget of $600K, identified in Appendix O, will be insufficient to serve this population in accordance to the requirements set forth in Appendix H, even without the suggested added responsibility described above. **We believe a budget of $2M is necessary to achieve the scope of work proposed, as evidenced by the staffing requirements below.**

The three person staff referenced in Appendix O could easily account for half of the proposed budget and yet three staff fall short of what will be needed for approximately 300,000 beneficiaries statewide. For this scope of work, staff will be needed to cover phones, handle advanced casework, develop educational materials, conduct outreach, and track relevant policy development. While there could be crossover responsibilities, the limited budget simply will not accommodate the level of expertise required to make the PO successful. For example, if the State envisions the toll free hotline to be live-answer Monday through Friday, 9-5, then there would need to be two to six staff, at a minimum, for that function alone. Again, with a minimum of 10-15 staff and the costs associated with maintaining a website and database, and other responsibilities outlined in the PO proposal, the PO would require $2M.

In addition, in the section that outlines: *How would the PO be organized*, the description under part ii "staffing nature" is not explicit enough. The PO requires individuals to have expertise in case handling and navigation, but also experience in serving individuals who are dually-eligible for Medicare and Medicaid, seniors, and people with disabilities, in particular people with developmental disabilities who are now explicitly rolled into this demonstration. We suggest specific reference to capacity for legal advocacy in addition to expertise in advocating for the populations that will be served by the demonstration. Finally, we recommend that the workforce be distributed regionally to accommodate the diverse populations and, other than the State's recommendation that the "PO could be required to have a physical office in the 8 county demonstration area," this is not addressed in the proposal.

In the section that outlines the PO's responsibilities, part x states that PO will "Conduct Participant education and outreach about rights, access rules and procedures, etc." We believe the PO should also provide education to other entities that provide assistance services and provider services to this population. We urge a requirement for more defined activity, such as "group trainings." This would also impact the budget– the network of community-based organizations that provide counseling and case management services to this population in New York State is vast and extensive resources are needed to train and provide technical assistance to this population.

We support the requirement for plans and Enrollment Brokers to have a "Participant Ombudsman Liaison." We believe there must also be a Participant Ombudsman Liaison at the Department of Health to troubleshoot inevitable program launch issues. **New York should implement a complaint tracking module similar to that utilized by CMS to help resolve individual problems and identify systemic issues and problems.** These functions could be incorporated into the $3.514M State staff budget outlined in Appendix O. The State could explicitly identify this under the already proposed Program Coordinators or Quality Assurance staff.

Under the section that describes how the availability of the PO will be made known to Participants, we believe language should be added to ensure that outreach is conducted to the full spectrum of client assistance services. Key referral sources should be explicitly recognized, with language such as: "Participants may also be referred to the Participant Ombudsman by HIICAP, NY Connects, the LTC Ombudsmen, local legal services, the FIDA Enrollment Broker, NYSDOH, or other consumer assistance programs that serve the population identified in this demonstration." CMS should encourage the State to allocate funding for the increasing number of clients and questions these agencies will field. **Although funding is specifically outlined for the Ombudsman and the Enrollment Broker, it is not outlined for consumer organizations, HIICAP, or NY Connects.**

We are pleased that the State recognizes the need for a Participant Ombudsman program but we strongly believe that in order to make this service viable for the population identified, the State needs to increase the budget. We believe our recommended $2M budget is on par with the other elements' scope of work to budget ratio outlined in the *Implementation Budget Request* in Appendix O, such as the $300K for a consultant to conduct stakeholder engagement or the $5.5M for enrollment broker support services.

8) Access for people with disabilities

The "Rights and Responsibilities" section of the Draft Proposal makes mention of compliance with the Americans with Disabilities Act and gives a couple of examples of specific reasonable accommodations, blending them with other things that it calls "rights." As outlined in earlier sections, New York's FIDA proposal lacks critical details throughout its draft proposal regarding how it will ensure that people with disabilities have an equal opportunity to participate in and benefit from managed care for dually eligible

New Yorkers, whether it be in network adequacy and access, or stakeholder engagement and beneficiary protections, key metrics, or infrastructure and implementation.

The current proposal confines the discussion of obligations pursuant to federal civil rights law to "rights and responsibilities of enrollees. When it gives examples it appears to suggest that rights apply only to enrollees with physical disabilities or hearing or vision-related disabilities. **The proposal should indicate that the enumerate rights apply to individuals with all disabilities, including cognitive or intellectual disabilities and psychiatric disabilities.** ADA obligations apply to program applicants as well as plan enrollees. The State and FIDA plans must address the obligation to achieve equal access more broadly. They must show that they will fulfill their obligation to modify policies, practices and procedures. They must demonstrate a more thorough understanding of reasonable accommodations.

The ADA and federal policy guidance include concepts such as "equal opportunity to participate in and benefit from programs and services," and "equal access." **The State should consider what it must do to ensure equal access for people with disabilities throughout the design of the program—beyond including these concepts in its discussion of rights and responsibilities. It must give examples in its proposal that communicate understanding of the implications of these concepts as well as the concepts of reasonable accommodation.** For example, to ensure "equal access," might be illustrated by indicating that the State will use quality metrics modified to reflect the health needs and concerns of people with disabilities.

Furthermore, the State should demonstrate that it understands that it, FIDA plans and providers have an obligation to modify any policies, practices and procedures that deny equal access to persons with disabilities. Modification may be required to prevent discrimination, for example, a policy that requires enrollees to use a FIDA network vendor even though the vendor's facility is not accessible may be denying individuals with disabilities an opportunity to obtain an equal benefit to those without disabilities.

The State, FIDA plans and providers are required to make reasonable accommodations and should provide examples of these—indicating that the examples are not exclusive. Information about the ADA and its requirements must be made available to applicants as well as plan participants—not only once but on a continuing basis. **The notice that one is entitled to a reasonable accommodation should include language indicating who is covered (referencing ADLs and IADLs) and that help is available in very precise terms.** It should give notice of the right to file an ADA grievance and how to do so. Accommodations can include providing readers, help filling out forms, repeated explanations and extra appointment time to discuss health issues, assistance with administrative procedures like arranging for referrals, flexibility in appointment scheduling, collecting documents or accepting alternate documentation, making phone calls on an individual's behalf, extra appointment time for dressing and undressing, video phone access, etc. these are of course, in addition to requirements related to physical plant and communications technology or interpreter access.

Finally, it is telling that in the non-discrimination provision of the "Rights and Responsibilities" section the draft proposal describes classes of enrollees that must be free of discrimination in accessing care—except for people with disabilities.

In summary, we the undersigned commend the Department of Health for considering some of the critical elements that will ultimately help minimize the risks to dual eligible New Yorkers. However, as outlined above there are many elements of this proposal that need further definition, revision, and explanation before this proposal is approved by CMS. **These revisions and additional explanation will require CMS and the State to work closely with beneficiaries, their advocates and other stakeholders.** Although this would extend the proposal's timeline and delay implementation beyond January 2014 it would help ensure that the demonstration's success We appreciate the need to move the demonstration along quickly, however, given the frailty of this population, we strongly caution the CMS against allowing enrollment before the State assure CMS, dually eligible New Yorkers, and their advocates that integrated care entities with the expertise to care for complex needs are in fact able to meet the needs of the members they will serve.

Again, we appreciate the opportunity to provide these comments to CMS and would be happy to talk with you further as your office continues its review; should you have any questions regarding these comments you may contact Doug Goggin-Callahan at dgoggin-callahan@medicarerights.org or any of the undersigned signatories.

Sincerely,

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