December 13, 2013

Mr. Mark Kissinger
New York State Department of Health
Empire State Plaza, Corning Tower, 14th Floor
Albany, New York 11237

Re: Draft FIDA Demonstration Requirements for Assessment, Service Planning, and Ongoing Care Management

Dear Mr. Kissinger,

We are pleased to see that the State has created a draft of requirements for assessment, service planning, and ongoing care management in the Fully Integrated Dual Advantage (FIDA) program. We appreciate the New York State Department of Health's (State) efforts to create a truly coordinated care system in FIDA that will allow Participants better access to the services they need. The Coalition to Protect the Rights of New York's Dually Eligible (CPRNYDE) has always supported the development of an Interdisciplinary Team (IDT) for each Participant, and we'd like to thank the State for incorporating our previous comments into the draft policies and procedures. Specifically, the draft policies and procedures include the Registered Nurse (RN) who completes the Participant's assessment as a member of the IDT as approved by the Participant. Further, the draft polices and procedures require plans to perform the initial assessment not only in the individual's home, but also in the hospital, acute care facility, assisted living facility or nursing facility. In Managed Long-Term Care (MLTC), we have seen plans refuse to assess prospective members in these settings, thus delaying their ability to return home with the necessary home care services. We are pleased that this will not be an issue in FIDA, and we would like to see similar requirements implemented in MLTC.

There are several sections of the draft policies and procedures that have the potential to have very positive effects on a Participant's ability to access needed services. However, we do have some concerns with portions of the document, and we would like the State to provide clarification in other areas. As such, we are submitting the following comments on the draft requirements and look forward to further engaging the State as these requirements are developed:

Comprehensive Assessment

We are pleased that the State plans to require FIDA Plans to perform the initial assessment not only in the individual's home, but also in the hospital, acute care facility, assisted living facility or

nursing facility. As such, we recommend that the RN who performs the initial assessment has an understanding of Long-Term Services and Supports (LTSS) and independent living and recovery philosophies.

We would like the State to provide more information on the reasons why passively enrolled individuals may wait up to 60 days to receive a comprehensive assessment upon being enrolled into a FIDA plan, while all other individuals enrolled into the FIDA Demonstration will receive a comprehensive assessment no later than 30 days from their enrollment effective dates.

Interdisciplinary Team

We applaud the State for including the FIDA Plan RN as a member of the IDT as approved by the Participant. We also believe it is reasonable that the draft policies and procedures allow either the Primary Care Provider (PCP) or a designee with clinical experience from the PCP's practice and who has knowledge of the needs of the Participant to serve on the IDT. However, we believe the Participant should be the lead of the IDT if they want to and have the capability to do so. In addition, a Participant should be able to assign a care giver/family member to participate on the IDT in his or her stead, should that be the Participant's desire.

We also support the State's inclusion of training for FIDA Plan staff members who are members of the IDT. In addition to trainings on the person-centered planning processes, cultural competence, disability, accessibility and accommodations, independent living and recovery, and wellness principles, the State should also require training on self-direction and principles of gerontology and geriatric case management. The IDT should also provide education and support to Participants over the age of 60 to include services offered through the Area Agency on Aging.

The policies and procedures should outline how conflicts among IDT members are reconciled. Presumably, the Care Manager would have final decision-making authority. However, it would be more appropriate that conflicts are automatically escalated to a supervisor in cases of disagreement among IDT members. Participants and their designated family members/caregivers should also be provided with updated contact information for all members of the IDT.

Care Manager

We support the State's requirement that each FIDA Participant is assigned a FIDA Plan staff or contract Care Manager. However, a particular maximum Participant-to-Care Manger ratio should be specified. Other state's demonstrations have included additional guidance that may be helpful to the State in determining this ratio. Arizona requires "adequate" staffing and includes a formula for determining caseloads. Caseloads must not exceed a weighted value of 96

enrollees per case manager with some variation based on the type of individual the case manager is responsible for.[1] Similarly, Minnesota requires health plans to establish criteria for care coordinator caseload ratios. Criteria to develop ratios include need for translation, case mix, need for high intensity acute care coordination, mental health status, travel time, and lack of family or informal supports.[2]

We are still concerned that the FIDA Plan Care manager leads the IDT and can recommend that other providers be added to the IDT without the draft policies and procedures stipulating the level of licensure or credentialing necessary for someone to be considered a Care Manager. The draft policies and procedures refer to a Care Manager's knowledge base, and while that language is more specific than what was stipulated in the FIDA Memorandum of Understanding (MOU), the policies and procedures fall short of outlining specific qualifications of the Care Manager, including licensure and credentialing requirements and necessary education.

Other states, including Arizona, Minnesota, Tennessee and Texas, have stricter requirements for individuals serving as Care Managers or related positions in their managed care programs. [3] For example, Arizona requires health plans to have two types of positions on staff: Medicare Management Coordinators (MMCs) and Case Managers. The MMC must be an Arizona-licensed registered nurse, physician, or physician assistant if making medical necessity decisions, or have a Master's degree in health services, health care administration, or business administration if not required to make medical necessity determinations. Case Managers, which manage and coordinate enrollee services, must be degreed social workers, licensed registered nurses, or persons with a minimum of two years' experience in providing case management to persons who are elderly and/or persons with physical and/or developmental disabilities. Minnesota, which is also implementing a financial alignment demonstration, requires the Minnesota Seniors Health Options care coordinator to be a social worker, public health nurse, registered nurse, physician assistant, nurse practitioner, or physician. Similarly, New York should create specific qualifications for the FIDA Care Manager.

Initial Service Plan

We agree that the Participant should continue to receive any community-based or facility-based LTSS in their preexisting service plan during the transition to the FIDA Plan. This should include any transition from one FIDA Plan to another. Additionally, the Participant should continue to

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[1] Integrated Care Resource Center, "Selected Provisions from Integrated Care RFPs and Contracts: Care Coordination (AZ, Sec. D16)," (July 2013), available at http://www.chcs.org/usr_doc/ICRC_Care_Coordination_FINAL_7_29_13.pdf

[2] Integrated Care Resource Center, "Selected Provisions from Integrated Care RFPs and Contracts: Care Coordination

[2] Integrated Care Resource Center, "Selected Provisions from Integrated Care RFPs and Contracts: Care Coordination (MN, Sec. 6.1.3(A)(5))," (July 2013), available at http://www.chcs.org/usr_doc/ICRC_Care_Coordination_FINAL_7_29_13.pdf

[3] Integrated Care Resource Center, "Selected Provisions from Integrated Care RFPs and Contracts: Care Coordination," (July 2013), available at http://www.chcs.org/usr_doc/ICRC_Care_Coordination_FINAL_7_29_13.pdf

receive not only the LTSS in their preexisting service plan, but also any other healthcare services included therein. Also, the Person-Centered Service Plan (PCSP) should contain a specific description of reasonable accommodations and modifications of policies and procedures that must be made by the plan and providers.

We also agree that the Participant should have the right to appeal any changes to his or her PCSP. However, the policies and procedures are not clear in regards to how a Participant may initiate this appeal. Will Participants receive a notice with denial instructions upon the IDT's completion of a new PCSP? How does the Participant appeal if he or she disagrees with the other IDT members in the event the disagreement has not resulted in a change to the PCSP? More details regarding the Participant's rights to appeal are needed. It is our understanding that the issuance of the PCSP is subject to internal appeal to the extent it involves an action by the plan (i.e., approval, denial, reduction, discontinuance of covered services). To the extent it does not involve 'action' by the plan, the PCSP should be subject to filing of a grievance.

Additionally, does the Care Manager assist the Participant with the appeals process? And in the even that the Participant has a complaint about or grievance with a member of the IDT, including the Care Manager, how does the Participant go about filing that complaint or grievance? The policies and procedures should clearly outline the process for filing a grievance or complaint against a member of the IDT, as well as the consequences the IDT member will face as a result.

We agree with the State that the Participant must sign a written refusal to participate in the service planning meeting confirming that he/she is choosing not to attend and that his/her non-attendance is not a result of the IDT failing to accommodate the Participant's needs and scheduled. This written refusal should be a standardized form that is consistent across all FIDA Plans.

Care Management

We oppose requiring IDT involvement for routine medical treatment. It can take a long time to get all these people to call back and weigh in. Authorization for routine medical care in FIDA should be no more restrictive than it is in Medicare Advantage, with retroactive notification of IDT. The Centers for Medicare and Medicaid Services (CMS) stipulates in the managed care manual "Medicare Advantage Organizations may not implement utilization management protocols that create inappropriate barriers to needed care."[4] Requiring all the IDT members to weigh in for any and every routine medical treatment is going to create a barrier to care. In

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[4] Centers for Medicare and Medicaid Services, "Medicare Managed Care Manual: Chapter 4: Benefits and Beneficiary Protections (110.1)," available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf

addition, requirements for authorizing as needed, occasional, periodic, or episodic health care services should be no more restrictive than in Medicare Advantage.

We appreciate that the draft policies and procedures require IDT members to have access to the Participant's medical record. However, the medical record should also be available to the Participant, as he/she should be considered a member of the IDT.

Also the draft policies and procedures do not delineate the entity that monitors the IDT. What are the checks and balances in place to ensure that the IDT is coordinating the Participant's care? How is the IDT made accountable to the Participant? And should a Participant be less than satisfied with care management under the IDT or Care Manager, the policies and procedures should outline how the Participant can go about requesting a new IDT or Care Manager from the FIDA Plan. The Participant should also receive this information in writing, and in a format that is most accommodating to the Participant. In addition, in the event that the Care Manager must step down from his/her role necessitating the appointment of a new Care Manager, this information should be clearly communicated to the Participant by introducing the new Care Manager in person, if possible, or at the very least in writing.

With regards to ongoing communication within the IDT, we understand that FIDA Plans need flexibility in determining their own documented internal procedures governing the exchange of information between IDT members, providers, and Participants and their caregivers. We also support FIDA Plans' flexibility, especially the flexibility to meet Participants' individual needs. However, to the extent that forms and policies can be standardized, we encourage the State to do so. This will alleviate confusion on the part of the Participant in the event that he/she needs to change FIDA Plans.

Comprehensive Reassessment/ Service Plan Revisions and Updates

We are pleased that the draft policies and procedures allow the Participant to request a comprehensive reassessment. However, there are no details outlining how the Participant is to go about making this request, and the policies and procedures should include this information. The Participant should receive information from the Care Manager on how to request a comprehensive reassessment.

Thank you again for your continued engagement with consumer stakeholders on FIDA implementation and for the opportunity to provide these comments for your consideration. Should you have any questions regarding these comments, you pay contact Krystal Knight at kknight@medicarerights.org.

Sincerely,

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