David Silva

From: Mark L. Kissinger <mlk15@health.state.ny.us>
Sent: Monday, May 05, 2014 6:54 PM
To: David Silva
Cc: Shanon D Vollmer
Subject: Re: NYLAG Comments on FIDA Three-Way Contracts

Thanks David
We will review

Sent from my iPhone

On May 5, 2014, at 5:35 PM, "David Silva" <DSilva@nylag.org> wrote:

> Dear Mark,
>
> Please find attached NYLAG's first two pages of comments on the three-way contract. We of course adopt and reiterate all comments from CPRNYDE. I hope we will have a chance to provide further comment. Thanks and let me know if you have any questions.
>
> Regards,
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> David
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> _____
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> <NYLAG Comments on 3-way contract.pdf>

NEW YORK LEGAL ASSISTANCE GROUP

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COMMENTS OF NYLAG IN RESPONSE TO DRAFT FIDA THREE-WAY CONTRACT

Appeals / Grievances

The definition of the term "Action" should be broadened to include failure to voluntarily disenroll a member, failure of the plan to successfully empanel the IDT within a specified period of time, failure of the IDT to issue a decision within a specified period of time, and failure to provide or pay for an already-authorized item or service. ¶ 1.5 at pp. 5-6.

Interdisciplinary Care Team

Decisionmaking by IDT

Nowhere in the IDT policy or contact is a decisionmaking priciple specified for the IDT. Does the IDT decide on service authorizations by taking a vote? Does the care manager have veto power? Must consensus be reached? While various stakeholders will surely have different positions on these alternatives, the current policy provides no guidance and thus plans will improvise. We do not take a position on which principle is most advantageous for consumers; our comment is simply that some principle must be specified to prevent confusion.

Quorum in IDT

Does plan initially determine list of participants in a member's IDT, and then thereafter all listed members must be involved for IDT to be empowered to make decisions? Can there be ad hoc absences or substitutions to the IDT? How many members of the IDT must be "present" for its decision to be valid?

Scope of IDT

Contract contemplates that IDT approval would be required for all services that require prior authorization. However, we are concerned that for certain services the IDT process will unnecessarily encumber the authorization for time-sensitive services. There are certain prior authorization services which are historically approved promptly upon application of the treating physician, without a lengthy and collaborative process (e.g., prescription drugs). For some services, social/cultural/environmental factors are less relevant to appropriateness, so the involvement of other participants of the IDT besides the PCP makes less sense. We urge that the contract enable a more streamlined, less intensive process for time-sensitive, purely medical services. ¶ 1.90 at pp. 18-19; ¶ 2.9.4.2 at pp.125-126.

Enrollment / Disenrollment

We applaud DOH/CMS for defining the opt-in enrollment date to be the first day of the month following the receipt by the enrollment broker of a timely enrollment transaction. This will provide further protection against a gap between enrollment and commencement of services, a problem that has been widespread with MLTC. ¶ 2.3.1.3 at p. 49.

We also applaud the clause broadly prohibiting discrimination in enrollment by FIDA plans, particularly inclusion of income status, physical or mental condition or disability, expected health status, or need for health care services. ¶ 2.3.1.6 at p. 50. However, we encourage you

to also prohibit enrollment discrimination based on availability/willingness of family or other informal supports to shoulder a portion of the plan of care. Again, this is a problem that has been widespread with MLTC.

We are pleased to see the requirement for a direct telephone transfer of members requesting disenrollment to the enrollment broker to effectuate the disenrollment. ¶ 2.3.2.1.1 at p. 53. In the unlikely event that consumers are displeased with their FIDA plan, and they contact their plan rather than contacting the enrollment broker or Ombudsman, it is essential that the plan be prohibited from discouraging them to disenroll, and indeed has an affirmative duty to assist them in doing so.

We are also pleased to see that involuntary disenrollments are to be approved by the Contract Management Team consisting of CMS and DOH staff. ¶ 2.3.2.8.1 at p. 55. However, we request that the contract specifically stipulate that determinations of the CMT to affirm a plan's request for involuntary disenrollment be appealable at a Medicaid fair hearing.

Continuity of Care

As we have recommended in the past, we reiterate that DOH should require plans to continue covering services from non-participating providers for 180 days post-enrollment, as Virginia, Illinois, and California have done. ¶ 2.6.6.1.1 at p. 79.

Minimum Access Standards

Although we are glad that minimum access standards are spelled out precisely in the contract, we feel the timeline for community-based LTSS is too lenient. For New to Service participants, the services might not commence until 30 days from enrollment. ¶ 2.7.1.8.5.1 at p. 94. This is unacceptable for applicants who have already waited two months since applying for Medicaid, are likely already in need of services, and for whom their plan has already collected a month's capitation. A more reasonable timeline would be 7 days.

We have numerous additional comments which cannot possibly be fit into two pages. Our final comment is that this process of releasing a 300-page contract and providing a week and two pages to comment falls far short of the transparency and stakeholder engagement that has thus far been the refrain of CMS' and DOH's ambitions for FIDA. We hope that there will be further opportunities for meaningful comment.

Very Truly Yours,

David Silva, Esq.
Assistant Director, Evelyn Frank Legal Resources Program