Fully-Integrated Duals Advantage (FIDA) Stakeholder Workgroup

Navigation / Appeals / Grievances

Thursday, October 18, 2012, 1:00 p.m.

On Thursday October 18, 2012, NYSDOH held its third FIDA Navigation/Appeals/Grievances Workgroup meeting for stakeholders. Following is a summary of the meeting discussion.

I. Comments on Previous Call Summary

There were no comments or corrections to the previous call summary.

II. CMS response to questions

NYSDOH reviewed responses provided by CMS to two questions raised in the October 4th meeting related to passive enrollment in MA and the degree of flexibility the state would have in current processes under the FIDA Demonstration. Workgroup participants had no questions.

III. Discussion of Navigation/Appeals/Grievances

Joel Levi from VNSNY provided an overview of the written comments submitted by VNSNY and distributed to the workgroup members. Overall, VNSNY agreed with the approach outlined in the MA MOU.

Doug Goggin-Callahan stated that he was supportive of some of the VNS comments; however, he disagreed with two tracks of appeals at the upper level (Medicare and Medicaid judicial appeal) and also the Part D appeals process.

A summary of the discussion's key points is provided:

- **Internal appeals.** The workgroup had substantial discussion regarding the internal appeals process at the previous workgroup meeting. Doug stated that he was open to talking about not having concurrent internal and external appeals if there are adequate protections for the members. David Silva also stated that he could support keeping the internal appeals process since data supports its effectiveness. David also pointed out that the FIDA care manager can help the member navigate the system and help clear up misunderstandings that normally might go to appeal because of lack of information. NYSDOH stated that there seemed to be consensus in keeping the internal appeals process intact while making improvements.
- **Two tracks of appeals.** Bill Berry stated that he thought that having two tracks of appeals was not more confusing to the beneficiary and gave them improved chances for a favorable outcome. Doug stated that it is easier to have one route because then the beneficiary does not need to know how service is provided (under Medicare, Medicaid, or dual). Further, it

was pointed out that two tracks of appeals could be frustrating for the member, since they would have to undergo a whole other appeals process when one is exhausted ("start all over again").

- **STAR ratings.** There was concern about how participation in FIDA would impact plan's STAR ratings. Karen Eastman mentioned that in a Jan 25 memo from CMS it states that STAR ratings will not be in effect for the demonstration project. Another participant asked how this would be logistically possible, as HEDIS measures are based on the contract level (not product level). Participants were hopeful that STAR issues could be addressed with CMS in the MOU.
- **Part D appeals.** As mentioned in the previous workgroup session, Doug stated that there is a need to incorporate Part D appeals into the FIDA appeals process. Particular issues included making a denial at pharmacy a true denial, collapsing the appeals process to make sure all material is available at time of first appeal (rather than requesting decisions from plans repeatedly), and that plan should call physician directly to determine why a generic is not acceptable (rather than have the written support requirement and the burden on the beneficiary to collect it). A participant agreed with the pharmacy denial; however, suggested that two different pharmacy processes be tested. In addition, the participant felt that these changes will increase appeals because now everything will go to appeal. Regarding Part D, CMS has been pushing plans to look at denials and do physician outreach, which has definitely decreased denials in a positive way.
- **Levels of appeals and hearing types.** Workgroup members discussed two models:
    1. First level: internal appeal; Second level: independent decision maker (IRE, state fair hearing, current state external appeal process, or other entity); Third level: judicial (ALJ)
    2. First level: Internal; Second: IRE; Third: Fair hearing; Fourth: ALJ

  David mentioned that some issues can't be fairly adjudicated with paperwork only, that testimony was needed given the challenges with population and the need to have the opportunity to weigh credibility. Further, David stated that the fair hearing process has precedent and passes legal muster, and is unsure that the IRE would be satisfactory therefore people may proceed to fair hearing anyway. Jeannie Cross requested that NYS review the legality of IRE since a well trained IRE could be beneficial to the process. Cathy Roberts mentioned that logistically Medicare hearings over the phone were very challenging for beneficiaries (harder to look at documentation, follow, etc.) and that it is more adventitious for consumer to be in person rather than by phone. David suggested that if the first level of external appeal is burdensome it is not necessarily a bad thing as it might reduce frivolous lawsuits on the part of members and plans. Rose suggested that the IRE could solve less complex issues and would support its use. Doug stated that integration of the process at the upper levels would be ideal contingent upon adequate training of ALJs in both Medicare and Medicaid issues.
- **Expedited review.** Workgroup members agreed that there should always be an expedited review option. Physician prevails (i.e. physician decides if expedited review is necessary) was discussed as an important feature. Doug stated that there may need to be a separate process to review hospital or SNF discharge because it has to be expedited. A mandatory expedited timeline for these processes was suggested for consideration. A member also

suggested that if a physician requests an expedited appeal that they have access to a phone process and are not required to use regular mail.

NYSDOH asked the workgroup for suggestions regarding what could be put in place at plan level to protect beneficiaries. They included:

- **Standard notices.** In Medicaid there can be variation of notice language from plan to plan—sometimes members get phone calls rather than written notices and if the member does not have documentation they may not be aware of right to appeal. Doug suggested shoring up NYSDOH's model notice of action for Medicaid. A participant suggested including a local advocate's contact information on notices. NYSDOH asked if the ombudsman's information would be sufficient. The participant felt their information would be important too; however, since they will not represent the member during an appeal the local advocate's information would also be useful.
- **Member services staff competency.** Procedures should be established to ensure member services staff are well trained in grievances/appeals processes for members.
- **Simplify marketing materials.** A workgroup member suggested condensing and simplifying materials, especially evidence of coverage information. A suggestion was made that more information could be moved into standard operating procedure rather than marketing materials.

IV. Notices

NYSDOH distributed information to the workgroup regarding a model notices toolkit created by CMS. NYSDOH also noted that there is a workgroup meeting on Thursday Oct 25 that will address marketing materials should anyone be interested in participating (if so contact Laurie A. Arcuri at laa03@health.state.ny.us).

The workgroup discussed the following issues related to notices:

- **Readability Panel.** Jeannie Cross mentioned that Maximus has a readability panel, (which may need to be customized to include the population that FIDA represents), and that NYSDOH should consider forming its own panel to test readability of notices by FIDA beneficiaries and family members.
- **Materials approval process.** Suggestions to streamline the approvals process between Medicare (CMS) and Medicaid (NYS) included aligning timelines in state contracting process with materials review process, creation of model notices, creation of one review entity, simplifying the review process, and reducing the number of entities sending notices to beneficiaries.

V. Summary / Next Steps

NYSDOH thanked the members for participating in the workgroup. Additional materials should be sent to NYSDOH as well as any suggestions going forward. Workgroup members were interested in continuing the workgroup. NYSDOH informed the group that these sessions provided valuable input on issues in advance of negotiation with CMS.