

Fully-Integrated Duals Advantage (FIDA) Stakeholder Workgroup

Outreach / Enrollment / Consumer Engagement

Thursday, October 25, 2012

1:00 p.m. – 3:00 p.m.

Call summary

On Thursday October 25, 2012, NYSDOH held the third and final FIDA Outreach/ Enrollment/ Consumer Engagement Workgroup meeting for stakeholders. Following is a summary of the meeting discussion.

I. Review of October 9, 2012 Meeting Summary

Participants had no feedback on the previous meeting summary.

II. Discussion of Market Material Comparison

Karl Dehm from VNSNY Choice created and shared with the group a document comparing the marketing guidelines between Medicare Advantage and Medicaid MLTC (PDF provided as part of meeting materials). Karl summarized the differences stating that the bottom line is that both the State and CMS have vibrant requirements around marketing, and that there are a number of features in place to make sure consumers are protected. The workgroup discussed this issue, summarized as follows.

- **Plan's ability to receive referrals.** The workgroup discussed the difference between plan's ability to receive referrals for new members. In summary, CMS has a strong prohibition on any provider "steering" a patient to a plan; however, the provider may give his/her patients info about the plans he/she is affiliated with and may suggest that a plan may have benefits that fit with a patient's needs. This type of referrals is generally permitted in Medicaid. MLTC plans frequently target outreach to providers and community organizations so that they can refer patients to the plan.

Positive aspects to the ability to accept referrals included that the patients are more likely to be homebound, more likely to take advice from providers, enables continuity of care, and that providers are more familiar with the patient needs and so can theoretically make informed suggestions. Drawbacks included that the patient would not necessarily get the full spectrum of benefits from the provider (not just that their provider is covered), that it would preserve the plan hierarchy by steering members into plans largely based on marketing ("whoever gets to them first"), and does not enable the patient's ability to make an informed choice about all plan options to select which plan is best for them.

A workgroup participant stated that the issue should be focused more on how the patient learns about the plan, noting that it is a challenge if an individual learns about the plan based on marketing alone. Karl Dehm stated that plans are required to provide a host of information before a person enrolls (e.g. consumer guide, formulary). Workgroup members indicated the need for an independent organization to be able to provide plan options to individuals, noting that an advocacy organization and/or ombudsman with counselors trained in plan options would be better positioned. Other members noted that most people do not get information regarding plans from an independent organization (e.g. Maximus), rather from family members, providers, etc. Another Workgroup participant mentioned that there are relevant issues outlined as part of MRT that are still unresolved that may be applicable to FIDA (NYSDOH stated that marketing is part of the MRT 90 work plan and that is still ongoing).

- **Passive vs. voluntary enrollment.** A number of issues were discussed regarding passive versus voluntary enrollment. Anthony Fiori stated that if the enrollment process is too robust/ cumbersome that people will not enroll, based on experience with moving from MLTC into MAP. Provider availability and choice were concerns for multiple workgroup members. Members were unsure that higher cost providers currently available through Medicare FFS in New York City will contract with FIDA plans, which would affect continuity and choice. It was suggested that if FIDA uses auto-assignment it should be made as “intelligent” as possible. If passive enrollment is used there must be protections for continuity. In order to optimize individual choice and control, David Silva suggested that there be a voluntary enrollment period before passive enrollment starts in order to maximize the number of opt-ins, as well as establishing a period (90 days) where individuals could continue going to out of network providers and still have the option to opt-out. Ideally, however, David believed that all enrollment should be voluntary (no passive enrollment). One workgroup member noted that passive enrollment is complicated by the fact that FIDA has qualified eligibility (120+ days of care), unlike Medicare where everyone is eligible after a certain point. Overall the workgroup members agreed that there should be one approach and a single process for enrollment to ensure that FIDA is the default plan for eligible individuals.
- **MAPs and FIDA.** Workgroup members discussed MAP as it relates to passive enrollment into FIDA. The issue was raised that if there is passive enrollment the MAPs will not have many members left. It was pointed out that if a MAP or MLTC has a FIDA, the member will automatically get passively enrolled but could still dis-enroll if they chose. If a MAP does not have a plan, members would be “thoughtfully” enrolled in a FIDA plan through a broker. Not all MAP members would be eligible for FIDA. David suggested considering carving out MAP from passive enrollment (but can opt in if they want) because members are already in a fully integrated plan. It was noted that MAP plans would likely convert into FIDAs or offer a FIDA plan option. Participants discussed what would happen at the end of the demonstration—would a plan start the MAP again if FIDA was not continued? If FIDA continues beyond the demonstration the state could allow MAP to sunset and then roll everyone into FIDA in the future. It was

acknowledged that multiple models (MAP, FIDA, etc.) can be challenging to manage, but having multiple models gives opportunity for comparison.

III. Discussion of Patient Bill of Rights

NYSDOH asked the workgroup to discuss if Medicare and Medicaid rights be put out to members in integrated materials. David stated that it would be a good idea to have single, simplified materials whenever possible. Workgroup members noted that the bill of rights does not “operationalize” well (i.e. does not easily translate into action for the member) and suggestions were made to provide a better explanation regarding how the consumer could take action if their rights are not being met (e.g. putting information for whom to contact if specific rights are in question). The workgroup discussed the issue regarding how to ensure that a consumer is not misdirected regarding the difference between grievance and appeals and their respective processes. Valerie Bogart stated that the plan Care Managers (CMs) have a significant role in this process since that is likely the first person a member will contact. CMs must be well trained regarding how to counsel the person regarding if their issue merits a grievance, appeal, or something else. Further, barriers should not be in place such as how in some MLTCs a member can call to orally create an appeal but it also must be confirmed in writing as well, which adds a high level of inconvenience for the member for multiple reasons.

Karl Dehm voiced a concern about creating another document because of the volume of materials a member receives. Workgroup members suggested a need for a separate workgroup dedicated to member handbook issues because the handbook “must be improved” for consumers.

IV. 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, mentioning that they would like to build some consensus on issues addressed by the group, or at minimum identify those areas that do and do not have consensus and why. NYSDOH informed the group that these sessions provided valuable input on issues in advance of negotiation with CMS. NYSDOH welcomes input directly in the meantime.