May 29, 2015

Mark Kissinger
Director, Division of Long Term Care
Office of Health Insurance Programs
NYS Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237
(Submitted via email)

Re: Recommendations on the Fully Integrated Duals Advantage (FIDA) Interdisciplinary Team (IDT) Policy Revisions

Dear Mr. Kissinger:

LeadingAge New York has conferred with its managed care plan members and compiled the following comments on the above referenced revisions as found in the Department of Health (DOH) "redline" draft document. Thank you in advance for taking our comments and questions into consideration as you formulate your final policies and implementation strategies.

We recognize that the early indications from the DOH enrollment statistics raise concern over the large percentage of passively enrolled individuals "opting out" of the FIDA program. Anecdotally, one of the areas of concern is the original mandate for the Primary Care Provider (PCP) to participate in IDT meetings and the commensurate concern on the part of Participants that they would have to change PCPs in order to remain enrolled in FIDA. Revising the IDT process to make it more "provider-friendly" may induce fewer individuals to opt-out.

From the managed care organization ("Plan") perspective, the logistics of organizing the IDT meetings and complying with the mandated time frames and attendance requirements are extraordinarily difficult to navigate and have always been a serious concern. From our standpoint, the design of the IDT process would be more in keeping with a PACE-type model with limited enrollment and employed physicians and service providers, rather than a program such as FIDA that is based on the health plan model with potentially thousands of members per plan, large networks of providers, and extensive access to out-of-network services.

Therefore, any measures that can be implemented to allow greater flexibility in the IDT process on the part of both the PCPs and the Plans are highly recommended. We are generally supportive of the proposed revisions to the extent that they allow for a greater degree of flexibility. Specifically, we support the following IDT policy revisions:

- Allowing a surrogate in the form of a physician extender, registered nurse or specialist to represent the PCP at the meetings;

- Allowing for the PCP to review and approve the findings of the Person-Centered Service Plan (PCSP) after the IDT meeting in cases where the PCP or designee was unable to attend;
- Allowing other IDT members to approve the PCSP verbally, electronically or with a wet signature on a separate signature page or the PCSP;
- Allowing for IDT meeting participation by phone or video conferencing;
- Providing greater flexibility in the mandated PCSP completion times for passively enrolled individuals;
- Clarifying in writing that Participants and family member/authorized representative members of the IDT are not required to complete the IDT member training; and
- Defining the circumstances and processes surrounding a Participant's refusal to undergo the comprehensive assessment process.

There are, however, aspects of the IDT process that remain problematic despite these revisions. Fundamental to our concern is that the overall IDT process still remains a significant logistical challenge for the Plans. Additional specific concerns not addressed in the proposed revisions include the following:

- As previously noted, we support the inclusion of additional physician extender designees (Section IV.C). However, we recommend that this revision also include physician assistants, nurse practitioners and registered nurses designated by specialists who are serving as PCPs, and further recommend that in the case of a PCP affiliated with a Federally Qualified Health Center (FQHC), the list of designees include the FQHC licensed practical nurses and medical assistants involved in the Participant's care;
- The proposed process to address the refusal of PCPs to participate in the IDT may not achieve the intended result. FIDA Participants are not likely to be willing to abandon their PCPs, and excluding PCPs from the Plan's network may drive members out of the program. What if a PCP attends some IDT meetings and not others? Perhaps Plans should be authorized to exclude PCPs if they consistently fail to participate, but should not be categorically required to exclude them. In such instances, there should also be provision for the Plan Medical Director to act as a member of the IDT and be authorized to sign off on the PCSP if necessary;
- The acceptable methods of indicating approval of the PCSP in Section VI.F should include the methods set forth in Section XI(C)(PCSP Update/Revision Form) – documented verbal, email or electronic signature, wet signature on a separate page, or wet signature on the PCSP;
- Failure of the Participant to attend the meeting should not preclude the IDT from updating the PCSP as needed. As proposed, if the Participant is absent from the meeting the current PCSP must continue. Here again, this creates the possibility of a discrepancy between the PCSP and the actual care/services the Participant is or should be receiving. The IDT should at a minimum be able to make necessary and obvious changes to the PCSP regardless of the Participant's attendance;
- The mandate for the individual IDT members to "regularly" inform the team of changes in the medical and functional status of the Participant needs to be more clearly defined. As long as changes are made part of the Comprehensive Participant Health Record (CPHR) that should suffice for communications to the IDT. We further believe that the 1-5 business day timeframe for individually contacting all the IDT team members specified in Section IV.F is not realistic, and that any changes to the PCSP should be communicated at the next scheduled IDT meeting;
- The connection between the CPHR and the nursing home or home care plan of care needs to be more clearly defined. Both of these providers are already mandated to maintain detailed medical records. Here again, there is the potential for discrepancies to occur between provider and Plan. This extends to the responsibility for the provision and authorization of services. The fundamental concern being the difference in timing for example in a nursing home updating its care plan versus the IDT updating the PCSP; and
- In a situation in which the Plan was unable to complete an initial assessment due to an inability to locate the Participant after three documented attempts, the policy revisions (Section III.D) require the Plan

honor the PCSP and use its internal utilization management process to authorize service. We recommend that in the case of a newly enrolled Participant lacking a pre-existing PCSP that the Plan be allowed to use the Conflict Free Assessment to develop the PCSP.

We also suggest the following non-substantive edits to the policy:

- In the third paragraph under "Care Manager Responsibilities" (Section V.C), an example is given about authorizing an x-ray service. If the individual in that example was residing in a medical facility –such as a nursing home – the process would be different as the facility would arrange for the service and it may well be provided on-site. To ensure the example is not misinterpreted, we would recommend inserting the words "who lives in the community" after "Participant" in the first sentence; In the third sentence of the first paragraph under "Transition to FIDA PCSP" (Section VI.B), the word "current" should be placed after the word "her." In the final sentence of that same paragraph, the words "a period" should be inserted after "in place for;"
- Under Section IV.C, the sentence should be clarified so that it is clear that the specialist is not a physician extender designee of the PCP;
- Section IV.D should be clarified to state that the designee can substitute for the PCP in the convening of an IDT meeting; and
- Section VI.F should be corrected to be consistent with Section XI.C and allow for provision of verbal and email Participant approval of the PCSC.

As noted, our Plans continue to face significant challenges with the IDT process. Finding convenient meeting times and places; assembling all the necessary participants; tracking and maintaining all the mandated records and notices; and meeting all the mandated timeframes remains a daunting logistical process. LeadingAge NY is supportive of efforts to streamline and simplify the IDT process on behalf of our Plans and providers, and in terms of ensuring the overall success of the FIDA demonstration.

Sincerely,

Patrick Cucinelli, VP for Financial Policy

cc: Rebecca Corso, Deputy Director, Division of Long Term Care
Margaret Willard, Director, Bureau of MLTC
Shanon Vollmer, FIDA Project Director