New York State Department of Health's Demonstration to Integrate Care for Dual Eligible Individuals

Draft Proposal
For Public Comment
March 22, 2012

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NYSDOH Demonstration Proposal to Integrate Care for Dual Eligible Individuals

Executive Summary

The New York State Department of Health (NYSDOH) proposes to develop a managed care program that fully integrates all Medicare and Medicaid physical healthcare, behavioral healthcare, and long-term supports and services.

NYSDOH's fully-integrated managed care program would be called FIDA, the Fully-Integrated Duals Advantage program. FIDA would provide a comprehensive package of services to all dual eligibles in the eight NY counties of Bronx, Kings, Nassau, New York, Queens, Richmond, Suffolk, and Westchester. Enrollment would be phased, with dual eligibles who are enrolled in NY's mandatory Medicaid Managed Long Term Care Program being passively enrolled for January 2014 and all remaining full dual eligibles in the service area being passively enrolled for January 2015.

NYSDOH is poised for success in this endeavor. A 2011 state law requires NYSDOH to enroll certain dual eligibles who are age 21 or older and who require more than 120 days of community-based long-term supports and services into NYSDOH's Managed Long Term Care Program (MLTCP). Those eligible are being enrolled in phases, with Phase 1 beginning this summer in New York City. By January 2013, the mandatory MLTCP will be expanded geographically to cover the 8 counties proposed as the FIDA service area. In the months that follow, NYSDOH will bring additional counties into mandatory MLTCP as counties are determined to have the capacity to meet the requirements of the program.

The legislative mandate to enroll dual eligibles into MLTCP nicely positions NYSDOH for this demonstration. Additionally, MLTCP provides an excellent platform from which to develop the FIDA program. As MLTCP plans are managed care plans that are delivering all Medicaid long-term supports and services and a significant proportion of these either are integrated Medicare and Medicaid plans at present or are well-positioned to offer integrated plans[1], transitioning MLTCP enrollees into the FIDA plans may occur with the least possible disruption in access to care.

Target Population	Full Dual Eligibles, Age 21 and older, who are not residents of an OMH facility, and who are not receiving services from the OPWDD system
Total Number of Full Benefit Medicare-Medicaid Enrollees Statewide	755,067
Total Number of	460,109

[1] When enrolled in NYSDOH's mandatory Medicaid Managed Long Term Care program, dual eligibles will have a choice of whether to receive their care through a fully-integrated PACE program, a fully-integrated Medicaid Advantage Plus program, or a partially-capitated managed long term care plan. More than half of the state's partially-capitated managed long term care plans are owned by parent organizations that operate Medicare Advantage plans in NY suggesting a good likelihood of easy conversion.

Beneficiaries Eligible for Demonstration	
Geographic Service Area	Bronx, Kings, New York, Queens, Richmond, Nassau, Suffolk, and Westchester
Summary of Covered Benefits	All Medicare Part A, B, and D benefits, all Medicaid State Plan benefits, HCBS benefits and supplemental benefits as described in Appendix B
Financing Model	The capitated model outlined in the July 8, 2011 SMD letter.
Summary of Stakeholder Engagement/Input	Focus Groups and Individual Interviews – 12/14/11 -12/16/11 MLTC Stakeholder Conference Calls – 1/26/12, 2/2/12, 2/9/12, 2/16/12, 2/23/12, 3/1/12, 3/8/12, and 3/15/12 Solicitation of Public Input – 3/6/12 Stakeholder Webinar Discussions – 3/13/12 and 3/15/12
Proposed Implementation Date(s)	The target population would be enrolled in phases with those who are currently enrolled in the mandatory MLTC Program being enrolled January 2014 and all others being enrolled January 2015.

A. Introduction

With years of experience designing care models for New Yorkers, NYSDOH hereby presents its proposal to implement a demonstration through which it would offer a new comprehensive managed care option that is specifically tailored to meet the complex needs of New York's full dual eligibles. Through this new Fully-Integrated Duals Advantage (FIDA) program, full dual eligibles would be provided the entire range of Medicare and Medicaid services as well as an extensive list of Long-Term Supports and Services (LTSS) many of which were previously only available in New York State's Home and Community-Based Services Waiver programs.

Through the FIDA program, full dual eligibles would be provided with features such as, but not limited to:

- Seamless access to all physical health, behavioral health, and LTSS;
- A choice of plan and a choice of providers, with choices being facilitated by an independent, conflict-free Enrollment Broker;
- Care planning and care coordination by individualized interdisciplinary teams that are centered around each dual eligible;
- Consumer direction for personal care services;
- An independent, conflict-free, Participant Ombudsman to aid in any questions or problems the Participant has;
- Continuity of care provisions to ensure seamless transition into one's FIDA plan;
- Articulated network adequacy and access standards; and
- New Health Education and Wellness benefit including many supports for achieving personal best health.

B. Background

i. Proposed Model of Care

According to the Medicare Payment Advisory Committee's June 2010 Data Book[2], individuals who are dually eligible for Medicare and Medicaid are poorer and sicker than the rest of the Medicare population. Fifty-one percent have incomes under the poverty level, as compared with 8% of non-dual Medicare Participants. Twenty percent of dual eligibles report being in poor health whereas only 7% of non-dual Medicare Participants report being in poor health. Dual eligibles are more likely to be institutionalized – 19% of duals are institutionalized compared with 3% of non-dual Medicare Participants. And, dual eligibles have a greater incidence of cognitive impairments, mental disorders, diabetes, pulmonary disease, stroke and Alzheimer's disease. They account for 16% of the Medicare population but 27% of Medicare spending; they account for 15% of the state's Medicaid population but 45% of its Medicaid spending.[3]

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[2] Medicare Payment Advisory Commission, "A Data Book: Healthcare Spending and the Medicare Program (June 2010)", Chapter 3, available at http://www.medpac.gov/chapters/Jun10DataBookSec3.pdf.

[3] These figures are based on 2007 data provided in this December 2010 Kaiser Commission on Medicaid and the Uninsured report "Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2007", available at: http://www.kff.org/medicaid/upload/7846-02.pdf

New York State has over 750,000 full dual eligibles enrolled in its Medicaid program. These full dual eligibles vary considerably not only in their care needs but also in how they access care and what care coordination or care management services are or are not available to assist them in accessing care.

Despite their high cost and their greater care needs, the care of dual eligibles is largely uncoordinated and significantly fragmented.[4] With the exception of those dual eligibles over 55 who participate in the state's Program of All-Inclusive Care for the Elderly (PACE) program or those that participate in a Medicaid Advantage or Medicaid Advantage Plus (MAP) program, the majority of New York's dual eligible adults receive their Medicaid physical health (PH) benefits from the Medicaid Fee-For-Service program. These dual eligibles receive their Medicaid behavioral health (BH) benefits from Medicaid Fee-For-Service. Some dual eligibles participate in the partially-capitated Managed Long Term Care Plans while others participate in and receive community-based LTSS through the Personal Care Services Program or one of the state's 1915(c) HCBS Waiver Programs.

Dual eligibles receive their Medicare healthcare services through Traditional Medicare or through Medicare Advantage (MA). And, they may receive their Medicare Part D through a Medicare Prescription Drug Plan or through a MA plan. Some with Traditional Medicare may even retain a Medigap policy (despite the lack of need given their Medicaid coverage and despite the amount of monthly expenditure the dual eligible unnecessarily makes to pay for this duplicative coverage). It is also the case that some dual eligibles are eligible for healthcare or long-term care through the Veterans Health Administration.

The number and nature of programs or plans each individual dual eligible may have is staggering and provides strong support for the need for integration. Under the status quo, a given full dual eligible may have half a dozen separate sources of coverage. This highly fragmented array of different coverages leads to access challenges for dual eligibles, some of which include that:

- Care is not coordinated;
- Coverage rules and procedures differ under each program;
- Written information comes from multiple sources with no single comprehensive description of the sum total of benefits, procedures, or rights and responsibilities applicable to dual eligibles;
- Processes for grievances and appeals differ, as do notices relating to both coverage determinations and grievances and appeals;
- Responsibility for delivering necessary services is divided between different programs, making it hard to know where to go when problems present;
- Providers are challenged to understand how the different coverages interact and how to proceed when they conflict; and

[4] Medicare Payment Advisory Commission, Report to the Congress "Medicare and the Healthcare Delivery System (June 2011)", Chapter 5, available at http://www.medpac.gov/documents/Jun11_EntireReport.pdf.

- Providers across programs have little or no established mechanisms through which to communicate.

When dual eligible individuals struggle to access their necessary care through the fragmented elements of the existing system, they are likely to go without some portion of their necessary care. This often leads to decline in health status that can eventually result in more costly interventions. Because improved access to care can mean better quality of care and quality of life to Participants and can improve efficiencies to the state, it is imperative that streamlined, seamless access to a broad array of services be developed.

Perhaps it would be less challenging to navigate the patchwork of a system if dual eligibles were provided person-centered care planning and coordination that addressed the entire array of physical health, behavioral health, LTSS, and supplemental services they might need or wish to access. Unfortunately, there is presently no comprehensive care coordination spanning all services provided by all coverages available to all dual eligibles.

NYSDOH is determined to develop a comprehensive integrated program through which care is seamlessly delivered and well-coordinated. Integrating all Medicare and Medicaid physical health, behavioral health, long-term care, and transportation services significantly reduces the number of separate sources of coverage a dual eligible may have to one primary source, his/her FIDA plan (with the limited exception of individuals who are also eligible to receive Veterans Administration healthcare benefits).

Through the State Demonstration to Integrate Care for Dual Eligible Individuals, NYSDOH has designed a capitated managed care program that fully integrates all Medicare and Medicaid physical healthcare, behavioral healthcare, and LTSS. The Fully-Integrated Duals Advantage (FIDA) program would provide a comprehensive package of services to all dual eligibles in the eight NY counties of Bronx, Kings, Nassau, New York, Queens, Richmond, Suffolk, and Westchester. Enrollment would be phased, with dual eligibles who are enrolled in NY's mandatory Medicaid Managed Long Term Care Program as of fall of 2013 being passively enrolled into the FIDA Program for January 2014. All remaining full dual eligibles in the service area would be passively enrolled for January 2015.

In its voluntary Medicaid Advantage program, the NYSDOH has made significant steps towards providing streamlined, seamless access to physical healthcare. Through its voluntary MAP program, the NYSDOH has made significant steps towards providing streamlined, seamless access to physical healthcare and LTSS. NYSDOH will build its FIDA program off of the requirements of the MAP program. While the MAP program requirements establish the foundation for the development of the new fully-integrated program, NYSDOH is significantly enhancing the benefit package provided through the MAP program for its new fully-integrated program (as further described in Section C. and Appendix B).

NYSDOH believes that its proposed person-centered care planning, coupled with a multi-disciplinary care coordination approach and the availability of enhanced community-based services, will provide the demonstration's dual eligibles with an improved quality of life and reduced acute care encounters. This will not only prevent or delay health declines but will result in savings that should account for the expenditures made on providing the care coordination and enhanced community-based services.

Qualifying Plans and Governing Rules:

While NYSDOH is building the demonstration requirements off of the program requirements for the MAP program, it will, however, contract with any Medicare Advantage Dual Eligible Special Needs Plans that have experience serving New York's Medicare/Medicaid dual eligibles and that are able to meet the requirements of the new fully-integrated program.

Participating plans will be required to comply with all Medicare Advantage Dual Eligible Special Needs Plan requirements and all Medicaid Managed Care regulations, except to the extent that NYSDOH has obtained waiver of applicable provisions. At this time, NYSDOH envisions seeking exception to the applicable Medicare and Medicaid rules for purposes of providing an integrated appeal process and to the applicable Medicare enrollment rules to allow for passively enrolling the eligible population into plans and for limiting the frequency of enrollment into the FIDA program and plan changes within the FIDA program. FIDA plans will also be required to comply with all applicable New York State laws and regulations, and all additional requirements contained in the three-way contract being developed by CMS and NYSDOH.

ii. Description of the Target Population

As of December 2010, there were 460,109 dually eligible Medicare/Medicaid recipients in New York State. Many of New York's dual eligibles are vulnerable, disabled, frail adults with chronic medical conditions who are significantly functionally impaired and/or have complex mental health and LTSS needs.

The target population for this demonstration is all those full dual eligibles in the eight counties of Bronx, Kings, Nassau, New York, Queens, Richmond, Suffolk, and Westchester who:

- Are age 21 or older;
- Are not receiving services through the OPWDD system;
- Are not receiving services in an OMH facility; and
- Are not attributed to the Bronx Health Access Network Pioneer ACO.

The demonstration is focused on this geographic subsection of the state and will cover 460,109 full dual eligibles, although enrollment will occur in two phases as described in Section C.i.2.

	Overall	Individuals receiving LTSS in institutional settings	Individuals receiving LTSS in HCBS settings
Overall total	460,109	54,164	123,880
Individuals age 65+	356,256	49,420	110,102
Individuals under age 65	103,853	4,744	13,778
Individuals with serious mental illness	75,956	20,796	21,112
Other (as necessary—please describe)			

C. Care Model Overview

i. Proposed Delivery System

1. Geographic Service Area

The FIDA Program will operate in the eight contiguous New York counties of Bronx, Kings, Nassau, New York, Queens, Richmond, Suffolk, and Westchester. 460,109 full dual eligibles reside in this service area. This service area was selected because it contains extensive provider and plan capacity, which should be more than sufficient to successfully implement the demonstration in a way that guarantees seamless Participant access as well as Participant choice.

2. Enrollment Method

Dual eligible individuals in the service area will be passively enrolled into the FIDA Program. Enrollment will occur in two phases.

A 2011 state law requires NYSDOH to enroll all dual eligibles who are age 21 or older and who require more than 120 days of community-based LTSS into NYSDOH's MLTCP. Those eligible are being enrolled in phases, with Phase 1 beginning this summer in New York City. Because NYSDOH wishes to avoid disruption in access to long-term care services NYSDOH will build its fully-integrated Medicaid Duals Advantage program off of the mandatory Medicaid MLTCP. NYSDOH believes this holds the least possibility of disruption in access to care because so many of the MLTCP plans either are integrated Medicare and Medicaid plans or are well-positioned to offer an integrated Medicare and Medicaid plan.[5]

[5] When enrolled in NYSDOH's mandatory Medicaid Managed Long Term Care program, dual eligibles will have a choice of whether to receive their care through a fully-integrated PACE program, a fully-integrated Medicaid Advantage Plus program, or a partially-capitated managed long term care plan. More than half of the state's partially-capitated managed long term care plans are owned by parent organizations that operate Medicare Advantage plans in NY suggesting a good likelihood of easy conversion.

Participants will not be locked in to their choice of FIDA plan and can disenroll at any time after enrollment. Re-enrollment after one has opted out or plan changes within the FIDA program, however, will be limited. Re-enrolling into the FIDA program once one has opted out or changing from one FIDA plan to another will only be permitted in January and July of each year.

a. Phase One Passive Enrollment

In January 2014, those dual eligibles in the eight county service area of Bronx, Kings, Nassau, New York, Queens, Richmond, Suffolk, and Westchester who are receiving community-based LTSS and are enrolled in NY's mandatory Medicaid Managed Long Term Care (MLTC) program will be passively enrolled into a Fully-Integrated Duals Advantage (FIDA) plan. Of this population, PACE enrollees would not be passively enrolled into a FIDA plan. They would be permitted to elect enrollment into a FIDA plan but, enrollment would not be mandated for them. NYSDOH will work with CMS to identify dual eligibles that have employer sponsored Medicare coverage and to determine how NYSDOH might avoid passively enrolling these individuals.

Those full dual eligible MLTC Participants who are enrolled in a MAP plan or a partially-capitated plan would be enrolled into the FIDA program with the assistance of an Enrollment Broker. Enrollment protocols will be established as are included in the logic for the MLTCP mandatory enrollment plan selection process. Accordingly, the Enrollment Broker would work to enroll these individuals first into a FIDA plan that is operated by an individual's current MLTC plan. NYSDOH believes that this would limit the likelihood of service or access disruption. In the event that an eligible MLTC Participant's MLTC plan has not also been approved to offer a FIDA plan, the Enrollment Broker will thoughtfully assist the individual to determine the best FIDA plan in which to enroll the individual based on the individual's existing relationships with service providers and his/her preferences.

Full dual eligible MLTC Participants who are passively enrolled can decline the FIDA plan enrollment or choose enrollment into a different FIDA plan. If they opt out of passive enrollment, these individuals will remain in their MLTC plan and will receive their Medicare services through the Traditional Medicare or Medicare Advantage plan choices they have previously made.

b. Phase Two Passive Enrollment

In January 2015, all other full dual eligible individuals who are part of the target population and who reside in the service area will be passively enrolled into a Fully-Integrated Duals Advantage (FIDA) plan. NYSDOH will work with CMS to identify dual eligibles that have employer sponsored Medicare coverage and to determine how NYSDOH might avoid passively enrolling these individuals.

i) Full Dual Eligible Individuals Participating in Medicaid Advantage as of Fall 2014

Those full dual eligibles who are enrolled in a Medicaid Advantage plan would be enrolled into a FIDA plan with the assistance of an Enrollment Broker. As with passive

enrollment for phase one, enrollment protocols would be employed to help prevent disrupting access or care. Thus, the Enrollment Broker would first endeavor to enroll these individuals into a FIDA plan that is operated by the individual's current Medicaid Advantage Plan Sponsor, if one is available. In the event that an eligible full dual eligible individual's Medicaid Advantage plan has not been approved to offer a FIDA plan, the Enrollment Broker will thoughtfully assist the individual to determine the best FIDA plan in which to enroll the individual based on the individual's existing relationships with service providers and his/her articulated plan preferences.

Full dual eligible Medicaid Advantage Participants who are passively enrolled can decline the FIDA plan enrollment or choose to enroll in a different FIDA plan. If they opt out of passive enrollment, these individuals will remain in their Medicaid Advantage plan and will receive their Medicaid and Medicare services through the Medicaid Advantage plan they had previously chosen.

ii) Full Dual Eligible Individuals Participating in Medicaid FFS in Fall 2014

Those full dual eligibles that are enrolled in NY's Medicaid Fee-For-Service program would be enrolled into a FIDA plan with the assistance of an Enrollment Broker. The Enrollment Broker will use established enrollment protocols to thoughtfully assist the individual to determine the best FIDA plan in which to enroll the individual based on the individual's existing relationships with service providers and his/her articulated plan preferences.

Full dual eligible individuals who receive their Medicaid through the Medicaid FFS program who are passively enrolled can decline the FIDA plan enrollment or choose to enroll in a different FIDA plan. Consistent with Governor Cuomo's proposal of "care management for all", NYSDOH will be implementing a phased plan to transition all dual eligibles to managed care, a process anticipated to begin its first phase of enrollment in 2015. As a result, if a dual eligible who was in Medicaid FFS in fall of 2014 chooses to opt out of passive enrollment, these individuals will be enrolled in a Medicaid managed care plan of their choice (which may include a Medicaid Advantage plan) or will be assigned to a Medicaid managed care plan (excluding Medicaid Advantage plans) by the Enrollment Broker, using the established enrollment protocols Unless they choose to enroll in a Medicaid Advantage plan, these individuals will receive their Medicare services through the Traditional Medicare or Medicare Advantage plan choices they have previously made.

3. Network Adequacy and Access

It is imperative that Participants have timely access to all necessary providers. For this reason, NYSDOH proposes to require a choice of at least two of every provider for each service identified in the plan benefit package. It is also for this reason that NYSDOH will require that plans ensure that their provider networks meet time and travel distance standards of no greater than thirty minutes and thirty miles. Waiting times at provider's offices cannot exceed one hour. Additionally, appointment standard requirements will be established such that:

- Emergency care must be available immediately;
- Urgent care must be available within 24 hours of request;
- Sick visits must be available within 24-72 hours of request;
- Routine, non-urgent preventive appointments must be available within 4 weeks of request; and
- Non-urgent specialist visits must be available within 2-4 weeks of request.

Detailed Access and Adequacy Standards are outlined in Appendix D.

Providers will need to meet all applicable licensure and provider certification requirements in the Medicare and Medicaid programs and will be bound not to balance bill any Participant.

In the event that a FIDA plan network is unable to meet any of the applicable network adequacy requirements, the plan will have to allow access to out-of-network providers at no cost to the Participants and until such time as the plan is capable of providing in-network access in accordance with the requirements.

Transitions into the FIDA program will be eased by requirements that ongoing courses of treatment with out-of-network providers be permitted to continue for up to 60 days during the initial transition into a Participant's new FIDA plan.

Plans will be required to report all providers of covered services to NYSDOH on a quarterly basis. Participant experiences with network adequacy and access will be captured in the Participant Feedback Process, described in Section D.iii. below and through data collected by the Participant Ombudsman.

4. Care Coordination

The FIDA program will provide person-centered care coordination and care management to all Participants. This will be accomplished through the use of interdisciplinary teams comprised, first and foremost, of the Participant and/or his/her designee, the designated care manager, the primary care physician, behavioral health professional, and other providers either as requested by the Participant or his/her designee or as recommended by the care manager or primary care physician and approved by the Participant and/or his/her designee. Care planning will be based on the assessed needs and articulated preferences of the Participant.

The FIDA plan must both facilitate and accommodate the Participant's or his/her designee's involvement in all care planning activities. All Participants will have access to the independent Participant Ombudsman to help them exercise their rights and express their wishes in and around the care planning process.

ii. Proposed Benefit Design

The FIDA plans will provide all covered services through fully capitated, managed care plans within which each Participant's care is planned, arranged, and authorized by an individualized, person-centered care planning team. Participants will

have input into their care planning team, the care planning process, the content of the care plan, and the nature of care delivery.

FIDA plans will provide all services covered by Medicare Part A, B, and D, virtually all Medicaid State Plan physical health, behavioral health, and LTSS, and an array of additional LTSS and Health and Wellness services not presently covered by the traditional Medicare or Medicaid programs. A complete list of covered services can be found at Appendix B.

Four services will continue to be provided through the Medicare or Medicaid Fee-for-Service programs, however, a Participant's interdisciplinary care coordination team within his/her FIDA plan will be responsible for arranging and ensuring receipt of these services when they are called for in a Participant's care plan. These four services are:

- Medicare Hospice services,
- Out of Network Family Planning services,
- Directly Observed Therapy for Tuberculosis, and
- Methadone Maintenance Treatment.

FIDA plans are directly responsible for the provision of all other covered services (regardless of whether access is through a subcontracted behavioral health organization that is accountable to the FIDA plan and for which the FIDA plan is accountable to NYSDOH, or directly through the plan's network of providers).

1. Supplemental Benefits and Support Services

The FIDA program will provide full dual eligibles with a comprehensive array of Medicare and Medicaid physical health, behavioral health, LTSS, and supplemental benefits. Covered services include those that have never been previously available from one source. Service delivery will be streamlined and access to FIDA covered services will be seamless.

The FIDA program will provide the services outlined in Appendix B. This includes the provision of the following services that have not previously been made available through any of the New York State Medicaid Advantage integrated programs:

- AIDS Adult Day Health Care
- Assertive Community Treatment (ACT)
- Assisted Living Program
- Assistive Technology (supplement to State Plan AT)
- Case Management for Seriously and Persistently Mentally Ill (sponsored by state or local mental health units)
- Community Transitional Services
- Comprehensive Medicaid Case Management
- Consumer Directed Personal Assistance Services
- Continuing Day Treatment
- Day Treatment
- Family-Based Treatment

- Health and Wellness Education[6]
- Health Home services
- HIV COBRA Case Management
- Home Visits by Medical Personnel
- Independent Living Skills and Training
- Intensive Psychiatric Rehabilitation Treatment Programs
- Medicaid Pharmacy Benefits as allowed by State Law (select drug categories excluded from the Medicare Part D benefit)
- Moving Assistance
- OMH Licensed CRs
- Partial Hospitalizations
- Personalized Recovery Oriented Services (PROS)
- Positive Behavioral Interventions and Support
- Social Day Care Transportation
- Structured Day Program
- Substance Abuse Program
- Telehealth
- Wellness Counseling

iii. Use of Evidence-Based Practices

All FIDA plans will be expected to develop and employ mechanisms to ensure that service delivery is evidence-based and that best practices are followed in care planning and service delivery. Plans will have to demonstrate how they will ensure that their providers are following best-evidence clinical guidelines through decision support tools and other means to inform and prompt providers about treatment options. Plans will have to identify how they will employ systems to identify and track patients in ways that provide patient-specific and population based support, reminders, data and analysis, and provider feedback.

All plans will be required to demonstrate how they will educate their providers and clinical staff about evidence-based best practices and how they will support their providers and clinical staff (through training or consultations) in following evidence-based practices. Providers and their practices will be required to provide services in accordance with established evidence-based clinical practice guidelines appropriate for the dual eligibles they serve. And, plans will be required to demonstrate how they will hold their providers to evidence-based practices specific to their practice areas.

[6] This new benefit will include: 1) classes, support groups, and workshops, 2) educational materials and resources, and 3) website, email, and mobile phone application communications on topics including, but not limited to heart attack and stroke prevention, asthma, living with chronic conditions, back care, stress management, healthy eating and weight management, oral hygiene, and osteoporosis. This benefit also includes annual preventive care reminders and caregiver resources.

iv. Relation to Existing Programs and Other New Initiatives

1. Relation to Existing Waivers and State Plan Services

The creation of the FIDA program option does not eliminate or interfere with the existing Medicaid Waivers and State plan services that are available to the target population. The FIDA program will be responsible for providing all of the State Plan services and nearly all of the waiver services available through the HCBS Waivers that serve the target population. Eligible individuals that opt-out of enrollment or at some point choose to disenroll may receive state plan services through the non-fully-integrated Medicaid system.

2. Existing managed long-term care programs

The FIDA program is being built upon the framework established in the managed long-term care program's program. The MLTC system will continue to exist and will serve those who are not full dual eligibles as well as those full dual eligibles that opt-out or at some point choose to disenroll from the FIDA program.

3. Existing Specialty Behavioral Health Plans

These do not exist at this time. Some are in development and are anticipated to be in effect during the demonstration. The FIDA program will not interfere with these specialty behavioral health plans, nor will these specialty behavioral health plans interfere with FIDA operations.

4. Existing Integrated Programs via Medicare Advantage Special Need Plans (SNPs) or PACE programs

The FIDA program is being built upon the framework established in the managed long-term care program. It is anticipated that many of the Medicaid Advantage and Medicaid Advantage Plus plans (the Medicare Advantage Special Needs Plans that also provide Medicaid) will transition or will develop additional product lines through which to provide FIDA plans. Otherwise, these plans will continue to exist and will serve those full dual eligibles that opt-out or at some point choose to disenroll from the FIDA program.

The PACE programs will not be changed by the creation of the new FIDA program and their dual eligible enrollees will not be passively enrolled into the demonstration. These programs will continue to exist and will serve those full dual eligibles that opt-out or at some point choose to disenroll from the FIDA program, as well as those Medicaid-only, Medicare-only and private pay individuals as they may currently serve.

5. Other State payment/delivery efforts underway

There are no other State payment/delivery efforts underway at this time.

6. Other CMS payment/delivery initiatives or demonstrations

The goals of this Demonstration align significantly with the goals of several other CMS payment/delivery initiatives or demonstrations.

A new Medicaid state plan option allows states to develop "health home" services for certain Medicaid recipients. The Affordable Care Act authorized a temporary 90% federal match rate (FMAP) for states implementing health home services. Health homes are designed to be person-centered systems of care that facilitate access to and coordination of the full array of primary and acute physical health services, behavioral health care, and long-term community-based services and supports. The health home model of service delivery expands on the traditional medical home models that many states have developed in their Medicaid programs, by building additional linkages and enhancing coordination and integration of medical and behavioral health care to better meet the needs of people with multiple chronic illnesses. The model aims to improve health care quality and clinical outcomes as well as the patient care experience, while also reducing per capita costs through more cost-effective care. New York has submitted and received CMS approval of a State Plan Amendment to provide health home services to Medicaid participants with chronic conditions, as outlined in the State Plan Amendment.

The Health Homes initiative is wholly consistent with the aims of the integrated care demonstration that NYSDOH is herein proposing to undertake. The Health Homes initiative encourages significant focus on care management and this will enhance the care coordination capabilities of the FIDA plans. Health Homes assignment will be addressed within the FIDA plans and care coordination and service delivery will be provided in concert with the health home care coordination and service delivery activities and features.

The Pioneer Accountable Care Organization (ACO) Model is a CMS Innovation Center initiative. In December 2011, CMS announced 32 organizations that were selected to participate in this model. Through this model, the Pioneer ACO sites will help test the effectiveness of particular payment arrangements in providing beneficiaries with a better care experience through Accountable Care Organizations (ACO), while also reducing Medicare costs. One of the 32 organizations that were selected is the Bronx Health Access Network. This organization is located within the eight county service area for the FIDA program. Participants in this Pioneer ACO will be excluded from eligibility for the FIDA program.

New York is one of eight states that were awarded multi-payer advanced primary care practice demonstration grants. New York is implementing the Multi-payer Advanced Primary Care Demonstration (MAPCP) by adding Medicare as a payer to the pre-existing Adirondack Medical Home Multipayor Demonstration Program (ADK demonstration). The ADK demonstration is a regional initiative in northeastern New York State that began in 2005 as a collaboration among local providers seeking to strengthen the region's beleaguered primary care system, with a specific focus on recruiting and retaining primary care physicians practicing in rural/frontier communities. The regional ADK demonstration is limited to practices in Clinton, Essex, Franklin,

Hamilton, and Washington counties and will not overlap at all with this demonstration's service area. The experience and lessons learned from the MAPCP demonstration will be considered as NYSDOH evaluates geographic expansion decisions following the end of this demonstration.

Last summer, CMS announced a new initiative to help states improve the quality of care for people in nursing homes. This demonstration to reduce preventable hospitalizations among nursing home residents will focus on reducing preventable inpatient hospitalizations among nursing home residents by providing these individuals with the treatment they need without having to unnecessarily go to a hospital. In January 2012, CMS announced that it will competitively select and partner with independent organizations that will provide enhanced clinical services to people in approximately 150 nursing homes. The intervention will be targeted to nursing facilities with high hospitalization rates and a high concentration of residents who are eligible for both the Medicare and Medicaid programs. It is not yet known whether providers within the eight county service area for this demonstration will be involved in the new demonstration to reduce preventable hospitalizations among nursing home residents.

D. Stakeholder Engagement and Beneficiary Protections

i. Stakeholder Engagement During the Model Design

NYSDOH has been engaging stakeholders since early 2011 through the Medicaid Redesign Team. The Medicaid Redesign Team (MRT) was created by Governor Andrew Cuomo in January 2011. Work Groups were created around many important subject areas, including a Managed Long Term Care Implementation and Waiver Redesign Work Group, a Behavioral Health Reform Work Group, and a Health Disparities Work Group.

Since January, 2012, NYSDOH has engaged stakeholders in weekly calls around MLTC. Every Thursday morning, more than 100 stakeholders join in a 90 minute call to discuss Managed Long Term Care Implementation which includes the mandatory enrollment of dual eligibles into the MLTC Program.

In the fall of 2011, Thomson Reuters (through funding from CMS) helped NYSDOH to schedule focus groups and personal interviews with dual eligibles who receive community-based LTSS in three regions of the state. NYSDOH invited 1,100 dual eligibles to participate. Financial incentives were offered in exchange for participation. While only 8 individuals attended, the small size provided an extraordinary level of participation by each attendee and an incredible breadth of discussion.

On March 6, 2012, NYSDOH published a request for public input.[7] It was posted on the MRT website, available to anyone with internet access. More than 1860 notices of this request were sent out to interested stakeholders (between 1300 on the MRT e-

[7] The solicitation for public input can be found here: http://www.health.ny.gov/health_care/medicaid/redesign/solicitation_for_public_comment.htm

mail list, 204 Facebook followers, and 359 Twitter followers). Not only did the notices request input, they also urged stakeholder groups to forward the input request on to their own networks so that additional stakeholders might be reached. Also on March 6, 2012, NYSDOH published a brief concept paper describing the proposed demonstration on its Medicaid Redesign Team website.[8]

On March 13, 2012 and March 15, 2012, NYSDOH conducted stakeholder webinars during which NYSDOH explained the design elements of its preliminary proposal and captured feedback. Approximately 200 stakeholders participated in these webinars and 98 substantive questions or comments were received during the two sessions.

ii. New or Modified Participant Protections

A broad array of Participant protections will be included in the FIDA program.

Continuity of Care

Participants will be provided with continuity of care protections that allow them to continue to see their established providers and complete any ongoing courses of treatment during the first 60 days of transition into the new FIDA plan, in the event that these providers are not already part of the FIDA plan network. It is not anticipated that many Participants will need to avail themselves of this continuity of care protection, as a significant number of Participants are expected to be passively enrolled into a FIDA plan that belongs to and has nothing less than the same provider network as that Plan Sponsor's MLTC or Medicaid Advantage plan out of which the Participants will be passively enrolled. Others will be enrolled with the assistance of the independent Enrollment Broker which will be charged with facilitating choices that minimize disruption in access to existing providers.

Enhanced Network adequacy and provider access requirements

Participants will have access to a provider network that offers a choice of each provider type and that establishes provider access rules that limit wait times, appointment times, and travel/distance times. While MAP already guarantees a right to a choice of each provider type, it does not presently limit wait times to one hour, establish appointment scheduling times that ensure timely access to routine, urgent, and specialist care, or require networks to be sufficient to ensure that Participants need not travel more than thirty miles or thirty minutes to access any provider within the network. These modifications to existing protections aid in access and help ensure that Participants can timely obtain the care they need.

Grievance and Appeal Process

NYSDOH proposes to provide a fully-integrated Medicare and Medicaid grievance and appeal process that includes the most consumer-friendly elements of the Medicare and Medicaid grievance and appeal processes. NYSDOH is committed to offering the best elements of both systems. The specifics of this fully-integrated

[8] The proposal concept paper can be found here: http://www.health.ny.gov/health_care/medicaid/redesign/overview_of_ny_demonstration.htm

grievance and appeal process are under discussion with CMS, however a model of NYSDOH's preferred integrated approach to Grievances and Appeals will be included as Appendix F in the draft submitted to CMS on April 26, 2012.. Key elements include single notices, continuing benefits pending appeal, and the employment of the most Participant favorable timeframes for filing appeals and receiving decisions.

Rights and Responsibilities

Participants will be provided with all the federal rights reflected in the Medicare Advantage, Medicaid Managed Care, and HCBS Waiver programs. They will also be provided with all state rights reflected in the NYS managed care laws and regulations. A comprehensive list consolidating all these rights in a single statement along with Participant responsibilities is provided in Appendix C.

Participant Ombudsmen

If provided funding by CMS for NYSDOH's Demonstration Implementation Funding Request, NYSDOH will make available to Participants an independent, conflict-free entity to serve as FIDA Participant Ombudsman. The FIDA Participant Ombudsman will provide Participants with free assistance in accessing their care, understanding and exercising their rights and responsibilities, and in appealing adverse decisions made by their plan. The FIDA Participant Ombudsman will be accessible to all Participants through telephonic and, where appropriate, in-person access. The Participant Ombudsman will provide advice, information, referral and direct assistance/representation in dealing with the FIDA plans, providers, or NYSDOH. The FIDA Ombudsman shall provide Participants with assistance with problems such as the following:

- Understanding benefits, coverage or access rules and procedures, and Participant rights and responsibilities;
- Exercising rights and responsibilities;
- Accessing covered benefits;
- Addressing providers who balance bill;
- Challenging plan denial, reduction or termination of service decisions;
- Raising and resolving quality of care and quality of life issues; and
- Ensuring the right to privacy, consumer direction, and decision-making.

FIDA plans will be required to notify Participants of the availability of the FIDA Ombudsman in enrollment materials, annual notice of Grievance and Appeal procedures, and all written notices of denial, reduction or termination of a Service.

Enrollment Assistance

NYSDOH will utilize an independent Enrollment Broker to assist Participants in making both their initial enrollment decisions as well as any additional enrollment or disenrollment decisions. The Enrollment Broker will be scripted, conflict-free, and well-equipped to understand and explain both FIDA and other service delivery options, including PACE. The Enrollment Broker will be resourced with enrollment protocols and logic to help ensure that Participants are assisted with enrolling into their choice of plans from amongst those that best meet their needs and preferences.

Integrated Information

One key current challenge for dual eligibles is the absence of a single source of information explaining the scope of coverage and how to access services. The FIDA program will provide a single set of informative materials, streamlining all marketing materials and all Participant notices so that all information will be comprehensive and will flow from one integrated source.

Costs

Providers will be expressly prohibited from billing Participants for the cost of covered services. Participants shall not be charged any coinsurance, co-payments, deductibles, financial penalties, or any other amount in full or part, with the exception of Medicare Part D Prescription Drug co-payments, if the individual does not receive LTSS. Those Participants who receive either community-based or institutionally-based LTSS will not be charged for any Medicare Part D Prescription Drug co-payments. NAMI and Spend-Down costs are ones for which eligible Participants will be required to pay, however, as these are costs relating to eligibility and are not plan costs. They will, however, be paid directly to the FIDA plan.

iii. Ongoing Stakeholder Feedback

NYSDOH will gather Stakeholder feedback, during implementation and throughout the demonstration, through quarterly stakeholder meetings. During implementation, these meetings will provide an opportunity for NYSDOH to provide updates and to receive input into such things as final design decisions or model Participant notices. During the demonstration, these meetings will provide an opportunity for NYSDOH to provide updates and to receive feedback into how the program is serving Participants.

Information and updates will be shared with the eligible population prior to enrollment through written notices, plan communications, newsletters, and electronic communications. These will be available in prevalent languages for LEP individuals and in alternative formats for individuals with disabilities. Beginning in July of 2013, NYSDOH will launch an outreach and education campaign including written materials, live trainings and presentations, and electronic media activities to ensure that the eligible population, their caregivers, their providers, and the advocates are all well-informed and well-prepared for the roll-out of the demonstration. These will be available in prevalent languages for LEP individuals and in alternative formats for individuals with disabilities.

During the demonstration, NYSDOH will conduct quality surveys on all Participants annually. NYSDOH presently conducts similar Participant surveys on a biannual basis. NYSDOH will provide an opportunity for Participants to complete these annual quality surveys either in writing (in all prevalent languages or through alternative formats) or via the telephone (with the use of interpretation services for Participants who so require).

All plans will be required to conduct at least two Participant Feedback Sessions in their service areas each year. At these, Participants will be invited to raise problems and concerns and to provide positive feedback as well. Plans will be required to assist Participants with the costs, transportation, and other challenges of attending these in-person Participant Feedback Sessions.

NY's managed care law currently requires each managed care plan to either have Participant representation on its board of directors or to have an advisory committee of Participants to provide feedback to the plan.[9] Under the demonstration, each plan will be required to have a Participant Advisory Committee (PAC). Each PAC will be open to all Participants and family representatives as well as the demonstration's Participant Ombudsman.

Each PAC will meet quarterly. At these meetings, the plan would be expected to share any updates or proposed changes as well as information about the number and nature of grievances and appeals, information about quality assurance and improvement, information about enrollments and disenrollments, and more. The PAC members would be invited to voice questions and concerns about topics including but not limited to quality of life and service delivery and would be encouraged to provide input and feedback into topics raised by the plan.

At all times during the demonstration, Participants may access the Participant Ombudsman for assistance. Through the Participant Ombudsman's report to NYSDOH, the Participant experience will be shared, providing yet another means of capturing feedback. Additionally, at all times during the demonstration, Participants may access NYSDOH through its toll-free participant assistance number (1-866-712-7197).

E. Financing and Payment

i. State-level payment reforms and Selected Financial Alignment Model

NYSDOH proposes to conduct a demonstration using the capitated model described in the July 8, 2011 State Medicaid Director Letter.

NYSDOH is in the process of making or exploring multiple state-level payment reforms. This includes a shift toward episodic payment for CHHA and pricing for nursing homes. It also includes a phasing in of risk adjusted payment rates for the MLTCP with rates that will be based on the new Uniform Assessment tool (the UAS) instead of the current Semi-Annual Assessment of Members (SAAM). NYSDOH is also in the process of implementing payment reports that include implementation of rate cells and development of risk corridors.

In the FIDA program, NYSDOH would anticipate employing rate cells and risk adjustment. NYSDOH might also utilize risk corridors.

[9] 10 NYCRR 98-1.11(g)

ii. Payment to Participating Plans

Plans will receive per-member-per-month capitated payments in an amount to be determined jointly by CMS and NYSDOH. NYSDOH anticipates the inclusion of risk adjustment and rate cells (possibly also risk corridors) in the negotiated rate. Additionally, NYSDOH will develop financial performance-based incentives to reward improvements in quality of care received by Participants. Any such payments will be implemented following a year of collecting and evaluating performance, establishing benchmarks, and developing performance measures. These financial incentives would be paid in addition to the capitation rates paid by CMS and NYSDOH.

F. Expected Outcomes

i. NYSDOH Capacity for Monitoring, Collecting, and Tracking Data on Key Metrics

NYSDOH has limited staff designated for monitoring, collecting, and tracking data such as would be needed on key metrics related to the demonstration's quality and cost outcomes for the target population. NYSDOH will utilize a portion of its implementation budget for both staff and systems that will facilitate thorough monitoring, collecting, and tracking around such elements as beneficiary experience, access to care, and utilization of services in order to insure that beneficiaries receive high quality care and for the purposes of evaluation. NYSDOH will simultaneously implement Medicaid Redesign Team recommendations around presenting data on key metrics in a meaningful way for Participants to use in making plan selections.

ii. Potential Improvement Targets

NYSDOH is considering establishing improvement targets around: potentially avoidable hospitalizations, 30-day readmission rates, quality of life, use of advance directives, reduction in pressure ulcers, and heart attack and stroke prevention activities.

iii. Expected Impact of Proposed Demonstration on Medicare and Medicaid Costs

New York's Medicaid program was the most costly of any state in the country in 2008. And, while only 15% of its Medicaid enrollees in 2007 were dual eligibles, they were responsible for 45% of all state Medicaid expenditures. The annual expenditures for dual eligibles who receive LTSS in New York were $23,447, more than twice the national average of $10,840, in 2007. Acute care costs for this population were also extremely high at $30,384, nearly twice the national average of $15,459. New York's Medicaid payments for acute care services and beneficiary cost sharing not covered by Medicare were approximately 70% above the national average, while Medicaid payments for Medicare Part A and B premiums were closer to the national average. While most of the Medicaid costs for services to dual eligibles were exceedingly above the national average, Medicare costs were far below national averages in nursing home care, home health services, durable medical equipment, and hospice services. It is

believed that the relatively low Medicare expenditures may be a result of overreliance on Medicaid covered services.

NYSDOH believes that person-centered care planning, coupled with a multi-disciplinary care coordination approach and the availability of enhanced community-based and Health and Wellness services will provide its dual eligibles with an improved quality of life and will result in reduced acute care encounters. This will not only prevent or delay health declines but will result in savings that should, over time, equal or exceed the expenditures made on providing the care coordination and enhanced array of services.

G. Infrastructure and Implementation

i. NYSDOH Infrastructure/Capacity to Implement and Oversee the Demonstration

Oversight of the New York State Medicaid Program resides with the Department of Health (NYSDOH). Within NYSDOH, is the Office of Health Insurance Programs (OHIP) which administers programs that deliver needed care and services to dual eligibles. The OHIP administers the MLTCP, including program design, licensure, certification and surveillance, rate setting and quality oversight. It also has oversight responsibility for assisted living facilities, community-based services and other services. OHIP addresses matters related to Medicaid beneficiaries, developing new budget proposals and implementing new legislation. In addition to OHIP, there are several state agencies that serve large numbers of the dually eligible such as the Office of Mental Health (OMH) which provides care to thousands of dually eligible through its network of outpatient clinics across the state.

Since 1995, NYSDOH has been designing, developing and implementing managed care models for various populations. Each new program takes into consideration the needs of the targeted membership and develops requirements that foster appropriate care such as: comprehensive provider networks, easy access to care and adequate financing and administrative infrastructure.

NYSDOH has the infrastructure but not sufficient staff to begin implementation of the demonstration. Staff within various Divisions of the Office of Health Insurance Programs (OHIP) will take on most of the responsibility for the demonstration. This demonstration will be administered by the Division of Long Term Care within OHIP. Within DLTC, the Bureau of Managed Long Term Care will be assigned the responsibility to implement the demonstration. The Division of Quality and Evaluation (DQE) in OHIP will be responsible for all data analysis. The OHIP administrative office will be responsible for the execution of subcontracts. Contract staff will need to be brought in to fulfill critical components of implementation.

Key NYSDOH project staff includes:

- Mr. Mark Kissinger, Director, Division of Long Term Care will be responsible for the oversight of the demonstration.

- Ms. Linda Gowdy, Director, Bureau of Managed Long Term Care, will be responsible for day to day administration of the demonstration. She will supervise the demonstration program coordinator and program administrator and will managed the work of all subcontractors funded under this demonstration. Ms. Gowdy has over 25 years of professional experience working in NYSDOH primarily on programs designed to support the health needs of the low income elderly.
- 1 Staff Person to serve as Program Manager that will be responsible for implementation of the demonstration.
- 3 Staff Persons to serve as Program Coordinators that will be responsible to resolve program and Participant issues.
- 2 Staff Persons to serve as Contract Coordinators that will be responsible for oversight of the contracts between NYSDOH and the FIDA plans. They will work with assigned plans to ensure compliance with contract requirements.
- 1 Staff Person to serve as Quality Manager, to oversee and manage reporting on quality management with individual plans and across the program.
- 3 Staff Persons to serve as Hearing Officers, to add capacity at the Hearings unit for processing appeals for dual eligibles related to the Demonstration.
- Mr. Patrick Roohan, Director, Division of Quality and Evaluation (DQE) will be responsible for all analytic work related to this demonstration. Mr. Roohan has over 25 years experience in conducting and overseeing health services research in NYSDOH. He and his staff will be responsible for receiving, housing, linking and protecting confidential Medicare data as well as overseeing analysis of the linked Medicaid/Medicare data file.
- 3 Staff Persons for Quality Measurement and Evaluation to conduct and analyze short-cycle and longer-cycle quality measurement and state evaluation activities, development and deployment of survey tools, costs of accessing, transferring, and analyzing data and other quality data, and report infrastructure development.
- Ms. Mary Beth Conroy, Director, Financial Research and Analysis Unit, within DQE will be the lead analyst assigned to create a linked Medicaid and Medicare file for purposes of analysis. Ms. Conroy has over 20 years of experience in health services research and financial analysis and is the lead on risk adjustment payment methodologies for managed care and managed long-term care.
- 2 Staff Persons to serve as Analytic Lead and Data Analysts who will be responsible for monitoring, collecting, and tracking data around key metrics. They will also aggregate, analyze, and report on encounter data, quality data, financial data for quality control and other purposes. They will also be responsible for extrapolating key information from the Medicare data that has recently been made available to NYSDOH.
- 10 Staff Persons to conduct monitoring and oversight of the program.

External Consultants

NYSDOH will procure consultants to assist in the implementation of the demonstration. Proposed contractors for this project include:

- Actuarial Support – A consultant firm experienced in working with New York State will be hired to assure the actuarial soundness of rates for the demonstration, analytical support during procurement, and development or purchase of risk adjustment tools.

- Analytic Support – A consulting firm with experience in working with dual eligibles will be hired to respond to questions and support NYSDOH activities around data, policies and procedures.

- Stakeholder Engagement – While NYSDOH staff and other state agency staff will be organizing and involved in gathering stakeholder input, it is necessary to hire a consultant group who can assist in scheduling and moderating meetings, developing communications tools, including website content for updates, and can organize larger forums, including scheduling and securing meeting space. The consultant will be responsible synthesizing the recommendations that emanate from all stakeholder discussions.

- Enrollment Broker – A contractor will be used to serve as Enrollment Broker to assist new enrollees and existing Participants with making plan choices.

- Participant Ombudsman – A contractor will be used to serve as the Participant Ombudsman to provide information and advocacy services to FIDA program Participants.

Current Analytic Capability

The Division of Quality and Evaluation, within the Office of Health Insurance Programs, has had the lead responsibility for evaluating the care provided to publicly funded insurance individuals, in both fee-for-service and managed care delivery systems, for over fifteen years. The Division is charged with collecting and analyzing data from various sources and for assuring data integrity. Through the use of standardized, as well as NYS-specific measures, NYSDOH has been able to monitor the cost, quality and utilization and describe successes and challenges in delivering care to populations at high risk of poor outcomes, describe the experiences of publicly insured individuals in various care settings (ambulatory, inpatient and long-term care) and promote quality improvement across the delivery system. Specifically related to any analysis of the under 65 dual population, staff in the DQE has done a comprehensive evaluation of the cost, quality and utilization of the non-dual SSI population in both managed care and fee-for-service Medicaid using both claims and encounter data.

The Division is staffed with a team of clinicians, programmers and analysts and has a long and successful history of linking Medicaid data with data from other sources, such as Vital Records and hospital discharge data and then using the linked files for analysis. Examples of ongoing and successful linkages include: 1) linking Medicaid birth data with data from Vital Statistics birth files to monitor trends among low income

women who give birth and 2) linking hospital discharge data with Medicaid data and using software designed to identify potentially preventable hospitalizations and preventable readmissions. Results from matched data file analysis are then sent to health plans and providers for purposes of sharing information and promoting quality improvement. We have used an iterative process, similar to the ones we have used for other linking exercises, for matching Medicare and Medicaid files to develop a linked database. The division has also overseen the administration of satisfaction with care surveys including the dual eligible population and validates encounter data submitted by MLTCP plans.

NYSDOH has established data-sharing agreements with CMS regarding the shared use of Medicare fee-for-service data for dually eligible Medicare recipients who reside in New York. NYSDOH is now receiving, housing, and analyzing the Medicare data that has been linked. This data set is being used primarily for research purposes and for obtaining a better understanding of the health service needs of the population. CMS has indicated that pharmacy data could be provided in "real time" which would aid in helping plans identify early care management needs, risk stratifying the population and developing actuarially sound capitation rates. Medicaid eligibility claims and encounter data will be used to link to the Medicare data.

Linked Medicare data is used to measure preventable inpatient events including preventable admissions (PQIs preventive quality indicators), potentially preventable readmissions (PPRs), and potentially preventable complications (PPCs). Well coordinated comprehensive primary care will help reduce these preventable events, and using these metrics will help improve quality and potentially reduce costs. The linked dataset helps NYS evaluate the quality of the care for dually eligible individuals by having the ability to calculate national performance measures including select HEDIS measures.

While NYSDOH has extensive analytic capacity as an agency, dedicated analysts will be required for this demonstration.

ii. Medicaid and/or Medicare Rules to be Waived

NYSDOH is identifying any waivers or other federal authority that would be needed for the provision of services not presently covered under the State Plan. NYSDOH anticipates needing a new 1915(a) waiver to provide this managed care program.

iii. Description of Expansion Plans

The roll-out of mandatory enrollment into the MLTCP throughout the state will lay the groundwork for and determine the capacity for future expansion of the FIDA program. Focusing on the eight contiguous New York City counties allows NYSDOH to develop, analyze, evaluate, and modify the FIDA program before expansion. It is anticipated, however, that by 2017, there should be infrastructure in place in several other service areas to permit expansion beyond the demonstration service area.

iv. Overall Implementation Strategy and Anticipated Timeline

Timeframe	Key Activities/Milestones	Responsible Parties
March 22, 2012	Post for Public Comment	DOH
March 22, 2012	Ongoing Stakeholder Feedback and Public Comment Process	DOH and Stakeholders
April 20, 2012	Deadline for Public Comment	DOH
April 26, 2012	Final Submission to CMS	DOH
May 4	CMS issues public notice of proposal in the Federal Register	CMS
May 4 – Jun. 4	CMS accepts public comments, shares with DOH	CMS
May 4 – Jun. 11	CMS/State review of public comments	CMS and DOH
June 2012	Stakeholder Implementation Meeting	DOH and Stakeholders
Jun. 4 – Aug. 30	MOU negotiations	CMS and DOH
June 2012	DOH Finalizes Quality Measures and Expected Outcomes	DOH
September 2, 2012	MOU Negotiations Complete	CMS and DOH
September 12, 2012	MOU signed by CMS and State	CMS and DOH
September 2012	Receive Implementation Funds from CMS	DOH
September 2012	Stakeholder Implementation Meeting	DOH and Stakeholders
September 15, 2012	Begin Systems Change Process	DOH
October 2012	Pursue Legislative Changes and Budget Appropriations	DOH
December 2012	Stakeholder Implementation Meeting	DOH and Stakeholders
March 2013	Stakeholder Implementation Meeting	DOH and Stakeholders
April 2013	Begin Plan Selection Process	DOH
June 2013	Stakeholder Implementation Meeting	DOH and Stakeholders

June 2013	Plan review	CMS and DOH
June – September 2013	Three-way contract documents finalized	CMS and DOH
July 2013 - ongoing	Consumer Education and Outreach Campaign	DOH
July 30, 2013	Final Plan Selection completed	CMS and DOH
August – September 20, 2013	Readiness reviews	CMS and DOH
August 15 – September 30, 2013	Plans finalize policies, procedures	Plans, CMS and DOH
September 20, 2013	Three-way contracts signed	Plans, CMS and DOH
September 2013	Stakeholder Implementation Meeting	DOH and Stakeholders
No later than October 1, 2013	Beneficiary notification	DOH
October 1, 2013 - ongoing	Opt out beneficiaries enrolled in alternative option(s)	DOH
December 2013	Stakeholder Implementation Meeting	DOH and Stakeholders

H. Feasibility and Sustainability

i. Potential Implementation Barriers or Challenges

Statewide restrictions on hiring could pose a barrier to successful implementation and serves as the reason that NYSDOH is requesting its implementation funds to be provided as a grant. NYSDOH is also evaluating the extent to which undertaking Affordable Care Act opportunities, such as the Balancing Incentive Payments Program or the Community First Choice Option would impact implementation.

ii. Necessary Statutory or Regulatory Changes

NYSDOH anticipates that it will need state statutory authority to implement the FIDA program.

iii. New State Funding or Contracting

NYSDOH anticipates that it will need state budget authority to proceed with implementing the FIDA program.

iv. Scalability and Replicability

The FIDA Demonstration will include over 60% of New York State's dual eligibles. The scalability and replicability of the demonstration's managed care model is tied to the network capacity in the other areas of the state. The state is rolling-out the

mandatory enrollment into its MLTCP throughout the state during the demonstration period and these activities will lay the groundwork for and determine the capacity for future expansion of the FIDA program. It is anticipated, however, that by 2017, there should be infrastructure in place in other service areas to permit the expansion.

v. Letters of Support

Letters of Support will be included as Appendix G in the draft submitted to CMS on April 26, 2012.

I. CMS Implementation Support—Budget Request

NYSDOH will request implementation support (in an amount to be identified in the draft submitted to CMS). Implementation funds will be used to enable NYSDOH to offer an Independent Enrollment Broker and an Independent Ombudsman to help Participants. These funds will also be used to enable NYSDOH to hire sufficient staff to analyze data, oversee implementation, undertake implementation activities, conduct plan surveillance and evaluation, assist in enrollment, and provide information and assistance to Participants.

Specifically, NYSDOH seeks funding for the following:

- **Program staff:** An amount to be determined for dedicated contract staff to manage the program, including
  - 1 Program Manager – to oversee daily program operation
  - 2 Analytic Lead and Data Analysts – to aggregate, analyze, and report on encounter data, quality data, financial data for quality control and other purposes
  - 3 Program Coordinators – to work to resolve program and Participant issues
  - 2 Contract Coordinators - to work with assigned plans to ensure compliance with contract requirements
  - 1 Quality Manager – to oversee and manage reporting on quality management with individual plans and across the program
  - 3 Hearing Officers – to add capacity at the Hearings unit for processing appeals for dual eligibles related to the Demonstration
- **Quality and Evaluation Staff:** An amount to be determined for the cost of 3 contract staff for Quality Measurement and Evaluation: Resources to conduct and analyze short-cycle and longer-cycle quality measurement and state evaluation activities, development and deployment of survey tools, costs of accessing, transferring, and analyzing data and other quality data, and report infrastructure development.
- **Systems Changes:** An amount to be determined for IT system changes that will support Participant enrollments, encounter data collection and analysis, develop customized cubes and queries, federal reporting, financial analysis, new assignment plans, modifications to the capitation payment system, and transferring eligibility and enrollment data between systems, including sharing information with plans and CMS.

- **Actuarial analysis and rate setting:** An amount to be determined for actuarial support for rate development and analysis, analytical support during procurement, and development or purchase of risk adjustment tools.
- **Enrollment Broker Support:** An amount to be determined for Enrollment Broker support including, but not limited to production and mailing of marketing and program information materials, including communications about enrollment, resources to conduct targeted and broad outreach/marketing for Participants and providers, and regular stakeholder meetings (quarterly during implementation).
- **Enrollment Broker Customer Service**: An amount to be determined for Support for Participants during enrollment processes, including enrollment process customer communications capacity, hands-on assistance to Participants evaluating their enrollment choices, informational materials to Participants and those assisting with decision support, and coordination with Medicare enrollment processes.
- **Staff Travel and Mileage**: An amount to be determined for resources for out-of-state travel for key project staff, such as to technical assistance meetings or to meet with CMS, and for mileage reimbursements for staff travel to meetings around the state.
- **Monitoring and Oversight**: An amount to be determined for the cost of 10 field and central office staff to conduct monitoring and oversight of the program.
- **Stakeholder Engagement**: An amount to be determined for ongoing Stakeholder Engagement – While NYSDOH staff and other state agency staff will be organizing and involved in gathering stakeholder input, it is necessary to hire a consultant group who can assist in scheduling and moderating meetings, developing communications tools, including website content for updates, and can organize larger forums, including scheduling and securing meeting space. The consultant will be responsible for development of a report synthesizing the recommendations that emanate from the stakeholder discussions.
- **Participant Ombudsman:** An amount to be determined for the new Participant Ombudsman as described herein.

A proposed budget will be included as Appendix E in the draft submitted to CMS on April 26, 2012.

J. Additional Documentation

Not applicable.

K. Interaction with Other HHS/CMS Initiatives

Partnership for Patients:

The Partnership for Patients strives to improve the safety of healthcare by reducing preventable injuries in hospitals by 40% and cutting hospital readmissions by 20%. NYSDOH has a long-standing history of commitment to these goals. This demonstration will fully align with this HHS initiative. Providing safer care to patients while hospitalized and better care transitions out of the hospital setting are essential elements of the NYSDOH care delivery philosophy and will likewise be integral components of the new FIDA program.

In 2008, nearly 15% of all initial hospital stays in New York resulted in a readmission within 30 days.[10] These readmissions, which amounted to nearly 274,000 hospital stays in 2008, cost the state $3.7 billion and made up 16% of total hospital costs. Readmissions for complications or infections cost New York State $1.3 billion, accounting for nearly 6% of total hospital costs. More than half of readmissions and readmission costs were attributable to patients aged 65 or older.

In 2010, the NY legislature enacted provision 2807-c(35) under Article 28 of the Public Health Law and in 2011 the NYSDOH adopted new regulations at NYCRR 86-1.37 requiring a reduction in readmission rates and modifying payment provisions to create an incentive to reduce preventable readmissions. Under the payment provisions, the occurrence of preventable readmissions prompts a lower reimbursement rate for hospitals than does the absence of preventable readmissions. In accordance with its adopted policy positions supporting the importance of reducing preventable readmissions, NYSDOH is committed to including efforts around reducing readmissions in the FIDA program and believes its payment provisions create incentives for providers to accomplish this. NYSDOH will develop quality measures on reduction of readmission rates and pay for performance payments for significant success in reducing of readmission rates. Reducing readmission rates is currently a Performance Improvement Project for ten Medicaid managed care plans.

At the heart of efforts to reduce preventable readmissions is evidence-based research supporting the need to improve the nature of transitions across care settings. How one leaves a hospital and how prepared one is with tools, resources, supports, follow-up appointments, and other interventions can significantly decrease the likelihood of readmission. For this reason, all FIDA plans will be required to have and implement policies and procedures that will ensure successful care transitions.

FIDA plans will be expected to implement interventions such as:

- Pre-discharge coordination and patient education;
- Early post-discharge contact of at-risk patients and facilitation of PCP follow-up;

[10] "Reducing Hospital Readmissions in New York State: A Simulation Analysis of Alternative Payment Incentives", September 2011, NYS Health Foundation, available here: http://www.nyshealthfoundation.org/userfiles/NYSHF_Mathematica%20Final_v5.pdf

- Care transition models such as Project RED or the Coleman model;
- Participant post-discharge disease/case management;
- Enhanced care coordination for primary care and behavioral health;
- Behavioral health and physical health integration;
- Patient education and self-management initiatives;
- Medication management; and
- Targeted early home care (in person or 'virtual').

Not only will all FIDA plans have to develop and implement protocols to reduce preventable readmissions including improvement in transitions across care settings, but they will have to institute strategies designed to reduce preventable injuries during hospitalizations. This not only aligns with the Partnership for Patients but is also required in NY state law. In accordance with 2807-c(35) under Article 28 of the Public Health Law, NYSDOH recently adopted regulations at NYCCRR 86-1.42 that establish a payment policy to incentivize reductions in preventable injuries. This provision articulates multiple preventable injuries that, should they occur, will not be eligible for reimbursement. Under this provision, NYSDOH denies reimbursement for hospital acquired conditions, which are avoidable hospital complications and medical errors that are identifiable, preventable, and serious in their consequences to patients.

HHS Action Plan to Reduce Racial and Ethnic Health Disparities

Remediating racial and ethnic health disparities is an established priority for NYSDOH. In January 2011, when Governor Andrew Cuomo created the Medicaid Redesign Team to find ways to reform and improve the New York State Medicaid program, work groups were developed around the most critical areas in need of reform. Work groups were created around such topics as Affordable Housing, Behavioral Health Reform, Managed Long Term Care Implementation and Waiver Redesign, and Health Disparities. The Health Disparities Work Group was charged with advising NYSDOH on initiatives, including establishment of reimbursement rates, to support providers' efforts to offer culturally competent care and undertake measures to address health disparities based on race, ethnicity, gender, age, disability, sexual orientation and gender expression. It was also charged with advising NYSDOH about incorporating interpretation and translation services to patients with limited English proficiency and who are hearing impaired.

The Health Disparities Work Group met throughout 2011 and, in October 2011, issued its final report and recommendations[11]. Of the fourteen recommendations presented by the Work Group, NYSDOH is already in the process of implementing six, with plans to implement the remaining recommendations in the near years ahead. The Work Group recommendations currently being implemented system-wide include:

- Implementing and expanding data collection standards required by the Affordable Care Act by including detailed reporting on race and ethnicity,

[11] Medicaid Redesign Team Health Disparities Work Group Final Recommendations – October 20, 2011 http://www.health.ny.gov/health_care/medicaid/redesign/docs/health_disparities_report.pdf

gender identity, the six disability questions used in the 2011 American Community Survey (ACS), and housing status. NYSDOH will also begin providing funding to support data analyses and research to facilitate NYSDOH work with internal and external partners to promote programs and policies that address health disparities, to improve quality and promote appropriate and effective utilization of services including the integration and analysis of data to better identify, and to understand and address health disparities.

- Adjusting Medicaid rates for hospital inpatient and outpatient departments, hospital emergency departments, diagnostic & treatment centers, and federally-qualified health centers to include reimbursement for the costs of interpretation services for patients with LEP and communication services for people who are deaf or hard of hearing.

- Initiating requirements for all chain pharmacies to provide translation and interpretation services for LEP patients, that standardized prescription labels be required to ensure understanding and comprehension especially by LEP individuals and that prescription pads be modified to allow prescribers to indicate if a patient is LEP, and if so, to note their preferred language.

- Integrating hepatitis care, treatment and supportive services into primary care settings including community health centers, HIV primary care clinics and substance use treatment programs.

- Promoting and addressing health care needs of persons with chemical dependency including allowing medical providers to prescribe syringes to prevent disease transmission; allowing harm reduction therapy as an appropriate and reimbursable treatment modality in OASAS facilities and by authorizing NYSDOH AIDS Institute Syringe Exchange providers to be reimbursed by Medicaid for harm reduction services provided to Medicaid eligible individuals.

Not only will FIDA plans be required to comply with requirements adopted in concert with these Health Disparities Work Group recommendations as they are enacted, but, the FIDA plans will also be required to adopt and implement policies ensuring culturally competent care coordination and service delivery, making oral interpretation services for any Participant that so requires, and making all written information available in prevalent languages. FIDA plan polices must reflect the extension of these obligations to all participating providers and contractors.

Both the Enrollment Broker and the Participant Ombudsman will be held to similar requirements. The Enrollment Broker will be required to employ staff members to provide translation or interpretation functions; pay for direct translator/interpreter assistance; and translate outreach materials into other languages. The Participant

Ombudsman will be required to outreach to Participants in and provide their assistance in prevalent languages or with the assistance of translation services.

Million Hearts Campaign

The FIDA demonstration aligns well with the Million Hearts initiative to prevent one million heart attacks and strokes over the next five years by promoting the "ABCS" of clinical prevention (appropriate aspirin therapy, blood pressure control, cholesterol control, and smoking cessation) as well as healthier lifestyles and communities. Additionally, with the addition of a broad array of Health Education and Wellness services as covered services under the FIDA program, direct attention will now be given to ensuring that health education around symptoms, prevention, and detection of cardiac disease that has not previously been provided under NYSDOH Medicaid programs. Additionally, NYSDOH is establishing improvement targets specifically on education around prevention of heart attacks and stroke and may also develop performance incentives around this measure.

Appendix A
GLOSSARY AND ACRONYMS

Fully-Integrated Duals Advantage Program - The fully-integrated Medicare and Medicaid managed care program for full dual eligibles in the eight county area of Bronx, Kings, Nassau, New York, Queens, Richmond, Suffolk, and Westchester that would be created under this demonstration.

Managed Long Term Care Program – The NYSDOH managed care program that contracts with Medicaid Advantage Plus plans, Partially Capitated Managed Long Term Care plans, PACE plans, and Care Coordination Model plans to provide managed LTSS to eligible consumers.

Medicaid Advantage Program – The partially-integrated Medicare and Medicaid managed care program for full dual eligibles who do not require LTSS.

Medicaid Advantage Plus Program – The partially-integrated Medicare and Medicaid managed care program for full dual eligibles who do not require LTSS.

Medicaid Redesign Team – A group of stakeholders that have been appointed and tasked by Governor Cuomo to find ways to reduce costs and increase quality and efficiency in the Medicaid program.

Participant – A full dual eligible individual who is enrolled in a FIDA plan.

Program of All-Inclusive Care for the Elderly (PACE) – The fully-integrated Medicare and Medicaid managed care program built around an enhanced adult day care center that is available in select service areas of New York State.

Partially Capitated MLTC Plan – A managed care plan that provides Medicaid LTSS only to both dual eligibles and individuals who qualify only for Medicaid.

Acronyms:
FIDA – Fully-Integrated Duals Advantage
LEP – Limited English Proficiency
LTSS – Long-Term Supports and Services
MAP – Medicaid Advantage Plus
MLTCP – Managed Long Term Care Program
MRT – Medicaid Redesign Team
NYSDOH – New York State Department of Health
PACE – Program of All-Inclusive Care for the Elderly

APPENDIX B - Covered Services and Excluded Services

This chart lists those services presently covered by the existing integrated Medicare and Medicaid programs in New York alongside those additional services that will be added in the creation of the FIDA program.

Service Name	Medicaid Advantage Plus (MAP) Covered Service that will be Covered and Coordinated by FIDA Plan	Additional Services (not covered by MAP Plans) that will be Covered and Coordinated by FIDA Plan	ALL FIDA Plan Covered Services
Abdominal Aortic Aneurism Screening	Yes		Yes
Adult Day Health Care	Yes		Yes
AIDS Adult Day Health Care		Yes	Yes
Ambulance	Yes		Yes
Assertive Community Treatment (ACT)		Yes	Yes
Assisted Living Program		Yes	Yes
Assistive Technology (supplement to State Plan AT)		Yes	Yes
Bone Mass Measurement	Yes		Yes
Cardiac Rehabilitation Services	Yes		Yes
Cardiovascular Disease Screening			
Case Management for Seriously and Persistently Mentally Ill		Yes	Yes
Chiropractic	Yes		Yes
Colorectal Screening	Yes		Yes
Community Transitional Services		Yes	Yes
Comprehensive Medicaid Case Management		Yes	Yes

Consumer Directed Personal Assistance Services		**Yes**	**Yes**
Continuing Day Treatment		**Yes**	**Yes**
Day Treatment		**Yes**	**Yes**
Dental	**Yes**		**Yes**
Diabetes Monitoring	**Yes**		**Yes**
Diabetes Screening	**Yes**		**Yes**
Diagnostic Testing	**Yes**		**Yes**
Durable Medical Equipment (DME)	**Yes**		**Yes**
Emergency Care	**Yes**		**Yes**
Family-Based Treatment		**Yes**	**Yes**
Health/Wellness Education[12]	**Yes**		**Yes**
Health Homes			**Yes**
Hearing Services	**Yes**		**Yes**
HIV COBRA Case Management		**Yes**	**Yes**
HIV Screening	**Yes**		**Yes**
Home Delivered and Congregate Meals	**Yes**		**Yes**
Home Health	**Yes**		**Yes**
Home Visits by Medical Personnel		**Yes**	**Yes**
Immunizations	**Yes**		**Yes**
Independent Living Skills and Training (CONFIRM)		**Yes**	**Yes**

[12] Health and Wellness Education for Participants and their caregivers includes i) the provision of: 1) classes, support groups, and workshops, 2) educational materials and resources, and 3) website, email, or mobile application communications; ii) at no cost to the Participant; iii) on topics including, but not limited to heart attack and stroke prevention, asthma, living with chronic conditions, back care, stress management, healthy eating and weight management, oral hygiene, and osteoporosis. This benefit also includes annual preventive care reminders and caregiver resources.

Inpatient Hospital Care (Including Substance Abuse and Rehabilitation Services)	Yes		Yes
Inpatient Services during a non-covered inpatient stay	Yes		Yes
Inpatient Mental Healthcare	Yes		Yes
Inpatient Mental Health Over 190-Day Lifetime Limit		Yes	Yes
Intensive Psychiatric Rehabilitation Treatment Programs		Yes	Yes
Kidney Disease Services			
Mammograms	Yes		Yes
Medicaid Pharmacy Benefits as allowed by State Law		Yes	Yes
Medical Nutrition Therapy	Yes		Yes
Medical Social Services	Yes		Yes
Medicare Cost Sharing:	Yes		Yes
Medicare Part D Prescription Drug Benefit as Approved by CMS	Yes		Yes
Moving Assistance		Yes	Yes
Non-Emergency Transportation	Yes		Yes
Nutrition	Yes		Yes
OMH Licensed CRs		Yes	Yes
Other Additional Part C Benefit	Yes		Yes
Outpatient Drugs	Yes		Yes
Outpatient Hospital Services			
Outpatient Mental Health	Yes		Yes
Outpatient Rehabilitation (OT, PT, Speech)	Yes		Yes

Outpatient Substance Abuse	Yes		Yes
Outpatient Surgery	Yes		Yes
Pap Smear and Pelvic Exams	Yes		Yes
Partial Hospitalization (Medicaid)		Yes	Yes
Partial Hospitalizations (Medicare)	Yes		Yes
PCP Office Visits	Yes		Yes
Personal Care Services	Yes		Yes
Personal Emergency Response Services (PERS)	Yes		Yes
Personalized Recovery Oriented Services (PROS)		Yes	Yes
Podiatry	Yes		Yes
Positive Behavioral Interventions and Support		Yes	Yes
Private Duty Nursing	Yes		Yes
Prostate Cancer Screening	Yes		Yes
Prosthetics	Yes		Yes
Pulmonary Rehabilitation Services	Yes		Yes
Routine Physical Exam 1/year	Yes		Yes
Skilled Nursing Facility	Yes		Yes
Smoking and Tobacco Cessation	Yes		Yes
Social and Environmental Supports	Yes		Yes
Social Day Care	Yes		Yes
Social Day Care Transportation		Yes	Yes
Specialist Office Visits	Yes		Yes

Structured Day Program		**Yes**	**Yes**
Substance Abuse Program		**Yes**	**Yes**
Telehealth		**Yes**	**Yes**
Urgent Care	**Yes**		**Yes**
Vision Care Services	**Yes**		**Yes**
Wellness Counseling		**Yes**	**Yes**

Four services will continue to be provided through the Medicare or Medicaid Fee-for-Service programs, however, a Participant's interdisciplinary care coordination team within his/her FIDA plan will be responsible for arranging and ensuring receipt of these when called for in a Participant's care plan. These are:

- Medicare Hospice services,
- Out of Network Family Planning services,
- Directly Observed Therapy for Tuberculosis, and
- Methadone Maintenance Treatment.

Appendix C
Rights and Responsibilities

Each FIDA plan must have, maintain, and implement written policies and procedures regarding Participant rights which fulfill the requirements of 42 CFR 438.100 and all applicable Federal and State law and regulation. The FIDA plan's policies and procedures must require that neither the Contractor nor its Participating Providers adversely regard a Participant who exercises his/her rights as described herein. The FIDA plan's policies and procedures must require the plan's employees and subcontractors to comply with and protect Participant rights. If a Participant lacks capacity to exercise these rights, the rights shall be exercised by an individual, guardian or entity legally authorized to represent the Participant.

Specifically, Participants have the following rights:

i) To receive medically necessary care;
ii) To receive timely access to care and services;
iii) To request and receive written and oral information about the plan, its providers, its benefits and services and the Participants rights and responsibilities in a manner the Participant understands. This includes the right to receive materials and/or assistance in a foreign language and in alternate formats, if necessary.
iv) To be provided qualified interpreters, free of charge, if a Participant needs interpreters during appointments with providers and when talking to his/her plan;
v) To be treated with consideration, respect and full recognition of his or her dignity and individuality;
vi) To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation;
vii) Not to be neglected, intimidated, physically or verbally abused, mistreated or exploited;
viii) To get care without regard to sex, race, health status, color, age, national origin, sexual orientation, marital status or religion;
ix) To be told where, when and how to get the services the Participant needs, including how to get covered benefits from out-of-network providers if they are not available in the plan network;
x) To complain to NYSDOH or the Local Department of Social Services; and, the Right to use the New York State Fair Hearing System and/or a New York State External Appeal, where appropriate;
xi) To be advised in writing of the availability of the NYSDOH toll-free hotline, the telephone number, the hours of its operation and that the purpose of the hotline is to receive complaints or answer questions about home care agencies.
xii) To appoint someone to speak for him/her about the care he/she needs.
xiii) To be informed of all rights, and the right to exercise such rights, in writing prior to the effective date of coverage;
xiv) To participate in his/her care planning and participate in any discussions around changes to the plan of care, if/when they are warranted;

xv) To recommend changes in policies and services to agency personnel, NYSDOH or any outside representative of the patient's choice;

xvi) To have telephone access to a medical professional from the plan 24/7 in order to obtain any needed emergency or urgent care or assistance;

xvii) To access care without facing physical barriers. This includes the right to be able to get in and out of a care provider's office, including barrier-free access for Participants with disabilities or other conditions limiting mobility, in accordance with the Americans with Disabilities Act;

xviii) To see a specialist and request to have a specialist serve as primary care physician;

xix) To talk with and receive information from providers on all conditions and all available treatment options and alternatives, regardless of cost, and to have these presented in a manner the Participant understands. This includes the right to be told about any risks involved in treatment options and about whether any proposed medical care or treatment is part of a research experiment.

xx) To choose whether to accept or refuse care and treatment, after being fully informed of the options and the risks involved. This includes the right to say yes or no to the care recommended by providers, the right to leave a hospital or other medical facility, even if against medical advice, and to stop taking a prescribed medication.

xxi) To receive a written explanation if services or care were denied, without have to request a written explanation.

xxii) To have privacy in care, conversations with providers, and medical records such that:

- Medical and other records and discussions with providers will be kept private and confidential;
- Participant gets to approve or refuse to allow the release of identifiable medical or personal information, except when the release is required by law
- Participant may request that any communication that contained protected health information from the plan be sent by alternative means or to an alternative address;
- Participant is provided a copy of the plan's Privacy Practices, without having to request the same;
- Participant may request and receive a copy of his or her medical records and request that they be amended or corrected, as specified in 45 CFR 164.524 and 164.526., if the privacy rule, as set forth in 45 CFR 160 and 164, A and E, applies; and
- Participant may request information on how his/her health and other personal information has been released by the plan;

xxiii) To seek and receive information and assistance from the independent, conflict free Participant Ombudsman;

xxiv) To make decisions about providers and coverage, which includes the right to choose and change providers within the plan network and to choose and change coverage (including how one receives his/her Medicare and/or Medicaid coverage);

xxv) To be informed at the time of enrollment of the right to make an "advance directive" – giving instructions about what is to be done if the Participant is not able to make medical decisions for him/herself - and to have the plan and its providers honor it; and

xxvi) To access information about the plan, its network of providers, and your covered services including:

- information about the plan's financial condition, its performance rating, how it compares to other plans, the number of appeals made by Participants;
- information about the qualifications of the providers and how they are paid; and
- information about the rules and restrictions on covered services.

FIDA Participants have the following responsibilities:

- To try to understand covered services and the rules around getting covered services;
- To tell providers that they are enrolled in a FIDA plan and show their FIDA plan ID card;
- To treat Providers and employees of the plan with respect;
- To communicate problems immediately to the plan;
- To accept help from the plan's employees without regard to race, religion, color, age, sex, national origin, or disability of the employee or Contractor;
- To keep appointments or notify the interdisciplinary team if an appointment cannot be kept;
- To supply accurate and complete information to the plan's employees;
- To actively participate in Care Plan development and implementation;
- To notify the state and the plan of any changes in income and assets. Assets include bank accounts, cash in hand, certificates of deposit, stocks, life insurance policies, and any other assets;
- To ask questions and request further information regarding anything not understood;
- To use the plan's designated providers for services included in the benefit package;
- To notify the plan of any change in address or lengthy absence from the area;
- To comply with all policies of the plan as noted in the Participant Handbook;
- To take prescribed medicines;
- If sick or injured, to call their doctors or care coordinators for direction right away;
- In case of emergency, to call 911; and
- If Emergency Services are required out of the service area, to notify the plan as soon as possible.

Appendix D
Provider Network Access and Adequacy Standards

FIDA plans must establish and implement mechanisms to ensure that Participating Providers comply with timely access requirements, monitor regularly to determine compliance and take corrective action if there is a failure to comply.

The following minimum appointment availability standards apply:

1) For emergency care: immediately upon presentation at a service delivery site.
2) For urgent care: within twenty-four (24) hours of request.
3) Non-urgent "sick" visit: within forty-eight (48) to seventy-two (72) hours of request, as clinically indicated.
4) Routine non-urgent, preventive appointments: within four (4) weeks of request.
5) Specialist referrals (not urgent): within two (2) to four (4) weeks of request.
6) Pursuant to an emergency or hospital discharge, mental health or substance abuse follow-up visits with a Participating Provider (as included in the Benefit Package): within five (5) days of request, or as clinically indicated.
7) Non-urgent mental health or substance abuse visits with a Participating Provider (as included in the Benefit Package): within two (2) weeks of request.
8) Provider visits to make health, mental health and substance abuse assessments for the purpose of making recommendations regarding a recipient's ability to perform work within ten (10) days of request.

Each FIDA plan must provide access to medical services and coverage to Participants, either directly or through their PCPs and OB/GYNs, on a twenty-four (24) hour a day, seven (7) day a week basis. The plan must instruct Participants on what to do to obtain services after business hours and on weekends.

Participants with appointments shall not routinely be made to wait longer than one hour.

FIDA plans must have a network that is geographically accessible to the population to be served.

1) Travel time/distance to primary care sites shall not exceed thirty (30) minutes from the Participant's residence in metropolitan areas or thirty (30) minutes/thirty (30) miles from the Participant's residence in non-metropolitan areas.
2) Participants may, at their discretion, select participating PCPs located farther from their homes as long as they are able to arrange and pay for transportation to the PCP themselves.

Travel time/distance to specialty care, hospitals, mental health, lab and x-ray providers shall not exceed thirty (30) minutes/thirty (30) miles from the Participant's residence.

Plans are required to coordinate Participant transportation.

Appendix E

Implementation Budget Request

Will be included in final draft.

Appendix F

NYSDOH's Preferred Approach to Integrated Grievances and Appeals

Will be included in final draft.

Appendix G

Letters of Support

Will be included in final draft.