FIDA Update

Mark Kissinger, Director, Division of Long Term Care
Rebecca Corso, Acting Deputy Director
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FIDA Stakeholder Meeting Agenda

- Welcome and Introductions
- FIDA Update
  - Eligibility
  - Enrollment Process
  - Covered Benefits
  - Continuity of Care
  - Network Adequacy
  - Interdisciplinary Team Approach
  - Grievances & Appeals
- Status and Next Steps
- Comments/Questions

FIDA Update

- A key component of "care management for all" is the Fully Integrated Dual Advantage (FIDA) demonstration project.
- Through this effort certain dually eligible individuals (Medicaid and Medicare) will be enrolled into fully-integrated managed care products.
- The Memorandum of Understanding (MOU) between CMS and DOH was signed on August 26, 2013.
- The FIDA Demonstration period is from July 2014 through December 2017.

FIDA Eligibility

- FIDA Eligible Populations:
  - Age 21 or older;
  - Entitled to benefits under Medicare Part A and enrolled under Parts B and D, and receiving full Medicaid benefits; and
  - Reside in a FIDA Demonstration County: Bronx, Kings, New York, Queens, Richmond, Nassau, Suffolk and Westchester Counties
- Must also meet one the following three criteria:
  - Are Nursing Facility clinically eligible and receiving facility-based long term support services;
  - Are eligible for the Nursing Home Transition and Diversion Waiver (NHTD); or
  - Require community-based Long Term Supports and Services (LTSS) for more than 120 days.

Populations Not FIDA Eligible

The following individuals are not eligible for FIDA:

- Residents of an OMH facility;
- People receiving services from the OPWDD system;
- Individuals under the age of 21;
- Residents of psychiatric facilities;
- Individuals expected to be Medicaid eligible for less than six months;
- Individuals eligible for Medicaid benefits only with respect to tuberculosis related services;

Populations Not FIDA Eligible

- Individuals with a "county of fiscal responsibility"
- Code 99 (Individuals eligible only for breast and cervical cancer services);
- Code 97 (Individuals residing in a state Office of Mental Health facility);
- Code 98 (Individuals in an OPWDD facility or treatment center);
- Individuals receiving hospice services (at time of enrollment);
- Individuals eligible for the family planning expansion program;
- Individuals under 65 (screened and require treatment) in the Centers for Disease Control and Prevention breast and/or cervical cancer early detection program and need treatment for breast or cervical cancer, and are not otherwise covered under creditable health coverage;

Populations Not FIDA Eligible

The following individuals are not eligible for FIDA:

- Residents of ICF/IIDD;
- Individuals who could otherwise reside in an ICF/IIDD, but choose not to;
- Residents of alcohol/substance abuse long-term residential treatment programs;
- Individuals eligible for Emergency Medicaid;
- Individuals in the OPWDD HCBS waiver program;
- Individuals in the Traumatic Brain Injury (TBI) waiver program;
- Residents of Assisted Living Programs; and
- Individuals in the Foster Family Care Demonstration.

Enrollment Process

FIDA Enrollment Process:

- In July 2014, begin accepting voluntary enrollments for individuals in need of community-based long-term care services greater than 120 days.
- In September 2014, begin process of passive enrollment for individuals in need of community-based long-term care services greater than 120 days.
- In October 2014, begin accepting voluntary enrollment for dual eligible individuals in nursing homes.

Enrollment Process

- In January 2015, begin process of passive enrollment notification for dual eligible individuals in nursing homes.
- Each phase of passive enrollment will occur over several months and will be phased based on how much time individuals have left on their eligibility authorizations. The phase in approach is under development.
- Eligible individuals can opt-out of passive enrollment.
- Enrollment broker (Maximus) will provide enrollment counseling and assistance.
- FIDA Plans do not have a role in enrollment process or eligibility determinations.

Update from the MOU:

  - New dual eligible individuals will be enrolled into FIDA. Individuals will have to opt out of FIDA to join a MLTCP or FFS Medicare program.

FIDA Covered Benefits

Proposed Covered Benefits:

- The medical necessity definition includes the most favorable elements of the Medicaid and Medicare definition.
- Covered Services include services covered by the existing Medicare and Medicaid programs in New York in addition to Home and Community-Based waiver services and wellness programs.
- IDT will have discretion to supplement covered services with non-covered services or items where so doing would address a Participant's needs, as specified in the Participant's Person-Centered Service Plan.

Covered Benefits

Cost:

- There are no costs for covered benefits or services to Participants who enroll in FIDA.
- No Part D and Medicaid drug co-pays.
- Balance billing is prohibited.

Continuity Of Care

Continuity of Care:

- Participants have access to all providers, all authorized services, and preexisting service plans including prescription drugs for 90 days or until the Person Centered Service Plan is finalized and implemented, which is later. Participants can maintain their existing Nursing Home provider for the duration of the demonstration.

- All FIDA Plans must have contracts or payment arrangements with all nursing homes such that nursing home residents who are passively enrolled are afforded access to that nursing home for the duration of the demonstration.

Update from the MOU:

  - The FIDA Plan shall allow Participants who are receiving Behavioral Health Services to maintain current Behavioral Health Service providers for the current episode of care. This requirement will be in place for the first 24 months of the contract and applies only to episodes of care that were ongoing during the transition period from FFS to FIDA.

Network Adequacy

- Networks must meet the existing applicable Medicare and Medicaid provider network requirements.

- Network Adequacy standards listed in Appendix 7 of the MOU apply to community-based and facility-based LTSS or other services for which Medicaid is exclusive, and Medicare standards apply to pharmacy benefits and for other services for which Medicare is primary, unless applicable Medicare or Medicaid standards for such services are more favorable to the Participant (i.e., offer broader coverage).

Update from the MOU:

  - Plans have submitted their networks for review and ADA Attestations are due on January 31, 2014.

Network Adequacy

Highlights of the Network Adequacy standards listed in Appendix 7 of the MOU. Networks:

- Have at least 2 of every provider type necessary to provide covered services in FIDA region;
- All providers' physical sites must be ADA accessible;
- Must meet minimum appointment availability standards;
- Must have an adequate number of community-based LTSS providers to allow Participants a choice of at least two providers of each covered community-based LTSS service within a 15-mile radius or 30 minutes from the Participant's ZIP code of residence; and
- Ensure that Participants with appointments shall not routinely be made to wait longer than one hour.

Changes in the IDT Process from the MOU

- After feedback from Plans and Advocates we have revised the IDT policy as follows:
  - RN who performed the assessment may be a member of the IDT if approved by the Participant.
  - The FIDA Plan care manager is the lead of the IDT.
  - Timing of assessments has changed to 60 days for current MLTC dual eligibles and 30 days for new to service
  - A single uniform credentialing application will begin in year 2 of the Demonstration (January 2016).

Comprehensive Assessment

- Each Participant shall receive, and be an active participant in, a comprehensive assessment of medical, behavioral health, community-based or facility-based LTSS, and social needs.
- Participants will receive a comprehensive assessment to be completed no later than:
  - 60 days from the individual's enrollment effective date for the first five months of passive enrollment for both populations.
  - 30 days from the individuals enrollment effective date for all other enrollees.
- The assessment shall be completed by an RN who is on staff or under contract with the FIDA Plan and must be performed in the individual's home, hospital, acute care facility, assisted living facility or nursing facility, using the NYSDOH Approved Assessment Tool (which will be the Uniform Assessment System, UAS-NY).
- Assessment domains must include, but not be limited to, the following: social, functional, medical, behavioral, wellness and prevention domains, caregiver status and capabilities, as well as the Participants' preferences, strengths, and goals.
- Results of the assessment will be used to confirm the acuity for the Participant and as the basis for developing the integrated, Person-Centered Service Plan (PCSP).

Timing of Comprehensive Reassessments

The FIDA Plan must ensure that a comprehensive reassessment is performed:

- As warranted by the Participant's condition but at least every six (6) months after the initial assessment completion date;
- When there is a change in the Participant's health status or needs;
- As requested by the Participant, his/her caregiver, or his/her provider; and
- Upon any of the following trigger events:
  - A hospital admission;
  - Transition between care settings;
  - Change in functional status;
  - Loss of a caregiver;
  - Change in diagnosis;
  - As requested by a member of the IDT who observes a change that requires further investigation.

Interdisciplinary Team (IDT)

- FIDA Plans are required to use an Interdisciplinary Team (IDT) approach to provide each Participant with an individualized comprehensive care planning process in order to maximize and maintain every Participant's functional potential and quality of life.
- For each Participant, an IDT, led by an accountable care manager, will ensure the integration of the Participant's medical, behavioral health, substance use, community-based or facility-based LTSS, and social needs.
- The IDT will be person-centered, built on the Participant's specific preferences and needs, and deliver services with transparency, individualization, accessibility, respect, linguistic and cultural competence, and dignity.
- The IDT's decisions serve as service authorizations, may not be modified by the FIDA Plan outside of the IDT, and are appealable by the Participant, their providers, and their representatives.
- The IDT authorizes both ongoing service plan care and services as well as "as-needed", occasional, periodic, or episodic health care service needs that may arise.

IDT and Participant Involvement

- IDT is participant-centered and process cannot occur in a person-centered fashion without Participant involvement.
- IDT meetings involve and include the Participant and accommodate the schedule of participants.
- Participants may refuse to participate but the refusal must be documented.
- IDT is not required to yield to/approve every participant request.
- The Participant has the right to appeal the PCSP and other service determinations, regardless of whether he/she voiced objection to the plan at the time of the IDT meeting.

IDT Composition

- Participant;
- Participant's designee(s);
- Primary Care Physician (PCP) or designee with clinical experience from the PCPs practice who has knowledge of the needs of the Participant;
- Behavioral Health Professional, if there is one;
- FIDA Plan care manager;
- Participant's home care aide, if receiving home care;
- Participant's nursing facility representative, if receiving nursing facility care; and
- Additional individuals, including:
  - Other providers either as requested by the Participant or his/her designee; or as recommended by the IDT members as necessary for adequate care planning and approved by the Participant and/or his/her designee; or
  - The RN who completed the Participant's assessment, if approved by the Participant and/or his/her designee.

IDT Responsibilities

- Patient Centered Service Plan (PCSP) Development and Updates;
- Education and Support to Participant;
- Coordination of Services;
- Ongoing Communication; and
- Care Management, including PCSP Implementation and Oversight.

IDT and Care Management

- The IDT lead is the accountable care manager (FIDA Plan staff or contract).
- To the extent they are able, Participants must participate in care planning. Participants must be asked to express their preferences about care, and these must be respected and incorporated into care decisions, as appropriate.
- **The IDT must make clinically sound care, evidence-based decisions which are based on medically necessity**.
- Decisions must be made jointly by all IDT members, but when this is not possible, a decision approved by the majority will carry.
- The IDT must keep a record that documents how Participants and families are included in the service planning process, even if they refuse to meet with the IDT.

IDT Care Management Requirements

- Ensure that the Participant obtains the services identified in the PCSP.
- Document service delivery in a record accessible to all IDT members.
- Communicate and share information with other IDT members.
- Approve "as needed, occasional, periodic or episodic services" which includes all covered services that require authorization but are not required to be in the PCSP:
    - Services that cannot wait a day may be authorized by one of the healthcare professionals on the IDT, with subsequent notice to the other IDT members.
    - Services that can wait a day, must not be provided until the IDT has been notified and given a chance to weigh in before services start.
    - These services do not need to be included in the PCSP unless they become ongoing services.

Patient Centered Service Plan (PCSP)

- Conceptually, the PCSP must include all services that the IDT can be expected to know will be/are needed or to predict will be needed:
  - A list of these will be outlined in the three way contract between CMS, the State and the FIDA Plan. We reviewed our entire covered services list and determined which were services that could be known or predicted at the time of a PCSP meeting.
  - Other services can also be included in the PCSP to the extent known or predicted, this list is just the ones that must be addressed in each PCSP.
- Very few services require authorization by someone other than the IDT. For example, hearing aids are approved by an audiologist.
- Some services require no authorization at all. For example, emergency care or urgent care to name a few.

Patient Centered Service Planning Requirements

- A PCSP must be completed within 30 days of the assessment and must be revised within 30 days of any reassessment.
- PCSP will be based on the assessed needs and articulated preferences of the Participant.
- Initial PCSP must be completed after a meeting of the IDT (in-person or telephonic).
- The IDT policy, as outlined in the Three Way contract indicates what needs to be discussed during the planning meetings and what should be specified in the PCSP.
- FIDA Plan must have a standardized PCSP form it expects all IDTs to complete in the PCSP process.

Implementation of the PCSP

- The FIDA Plan has a process to:
  - Monitor the PCSP to identify any gaps in care;
  - Address any gaps in an integrated manner through the IDT, including any necessary revisions to the PCSP;
  - Update the PCSP in the time frames outlined;
  - Ensure that the Participant receives any necessary assistance and accommodations to prepare for and fully participate in the care planning process.

Integrated Grievances and Appeals (G & A) Process

- The G&A process takes the most consumer-favorable elements of the Medicare and Medicaid grievance and appeals systems and incorporates them into consolidated, integrated G&A system for FIDA Participants.
- Notification of all applicable Medicare and Medicaid appeal rights will be provided through a single notice, developed jointly by CMS and the State, specific to the service or item type in question.
- All notices will be integrated and shall communicate the steps in the integrated appeals process as well as the availability of the Participant Ombudsman to assist with appeals.

4 Levels of Appeals Process

- Level 1 – Appeals to Plans
- Level 2 – Integrated Administrative Hearing
- Level 3 – Medicare Appeals Council
- Level 4 – Federal District Court

Grievances & Appeals Process

Grievance Process:

- File within 60 days.
- Plan must send written acknowledgement of grievance within 15 business days of receipt.
- Grievance must be decided as fast as Participant's condition requires, but no more than:
  - Expedited: Within 24 hours (in certain circumstances). For all other expedited circumstances, within 48 hours after receipt of all necessary information but no more than 7 days from the receipt of the grievance.
  - Standard: Notification of decision within 30 days of the FIDA Plan receiving the written or oral grievance.
- A Participant may file an external grievance through the 1-800 Medicare and the DOH/CMS Contract Management Team will review.

4 Levels of Appeals

Level 1. Plan-Level Appeal:

- File within 60 days or within 10 days for aid to continue.
- Plan sends written acknowledgement of appeal to the Participant within 15 days of receipt.
- Decision as fast as the Participant's condition requires, but:
  - Expedited: No later than within 72 hours of the receipt of the appeal.
  - Standard: No later than 7 days on Medicaid prescription drug appeals and 30 days from the date of the receipt of the appeal.
- Up to 14 day extension may be requested by a Participant or provider on a Participant's behalf (written or verbal) or the FIDA Plan, if can justify.
- The FIDA Plan must make a reasonable effort to document and give oral notice to the Participant for expedited appeals and must send written notice within 2 business days of decision for all appeals.

4 Levels of Appeals

Level 2 Appeal. Integrated Administrative Hearing:

- Adverse appeal decisions made by plans are **automatically** forwarded to the Integrated Administrative Hearing Office (IAHO) at the Office of Temporary and Disability Assistance (OTDA) within 2 days.
- Benefits will continue pending appeal if filed with the FIDA Plan within 10 days of receipt of the notice of termination/reduction in services.
- Acknowledgement within 14 days. OTDA must provide confirmation of the appeal and schedule the administrative hearing taking into account the Participant's availability.
- Decision on Administrative Hearing:
  - Expedited: Within 72 hours of in-person or phone hearing.
  - Standard: As expeditiously as the Participant's condition requires after an in-person or phone hearing, but within 7 days for Medicaid prescription drug coverage matters and for all other matters 90 days of request for the first year of FIDA and 30 days of request for the 2nd and 3rd year of FIDA.
- The IAHO has to issue a written decision that explains the rationale for the decision and specifies the next steps in the appeal process, including where to file the appeals, the filing time frames and other applicable appeal requirements.

4 Levels of Appeals

Level 3 Appeal. Medicare Appeals Council:

- An adverse Administrative Hearing decision may be appealed to the Medicare Appeals Council within 60 days. The Medicare Appeals Council will complete a paper review and will issue a decision within 90 days.

Level 4 Appeal. Federal District Court:

- An adverse Medicare Appeals Council decision may be appealed to the Federal District Court.

Other Appeals Features

Continuation of Benefits Pending Appeal.

- Continuation of benefits for all prior-approved Medicare and Medicaid benefits that are terminated or modified, pending internal FIDA appeals, Integrated Administrative Hearings, and Medicare Appeals Council must be provided if the original appeal is requested to the FIDA Plan within 10 days from the date of the decision that is being appealed.

Validation of Integrated Administrative Hearing Officer Decisions.

- All decisions related to Medicare coverage will be reviewed by the Part C qualified independent contractor for a period not to exceed one year. The primary purpose of the Part C QIC's review is for quality assurance and to provide feedback to OTDA to ensure that cases are adjudicated according to Medicare rules.

Participant Ombudsman

Participant Ombudsman (PO):

- An independent, conflict-free entity that will provide Participants free assistance in accessing care, understanding and exercising rights and responsibilities, and appealing adverse decisions.
- Will provide advice, information, referral and direct assistance and representation in dealing with the FIDA plans, providers, or NYSDOH.
- Will be required to regularly report on its work to the State.
- FIDA Plans will be required to notify Participants of the availability of the PO in enrollment materials, annual notice of Grievance and Appeal procedures, and all written notices of denial, reduction or termination of a Service.
- RFA to be released in early 2014.

Rate Development

- DOH/ CMS released a Draft Rate document and are working on developing responses to the questions received as a result of the release.
- DOH/ CMS/ Mercer are working on the more finite issues related in the rate development.
  - Upon finalization of these issues, a time will be scheduled to meet with plans and representatives to discuss these results in further detail.
- DOH and Mercer are working to incorporate any potential changes as into the premium.
  - Time will be set up to meet with plans and representatives to review any changes to the Medicaid and Medicare rates.

FIDA Status

- 23 Plans are currently going through the Readiness Review Process:
  - Desk Reviews began in October and are ongoing.
  - In-Person site reviews start next week through the end of January
  - Systems Testing in February
- Networks were submitted on December 27 and are under review. Plans will have the opportunity to cure deficiencies.
- Provider ADA Attestation forms due January 31, 2014.
- Development of the Three Way contract has begun and will continue over the next several months. Anticipated final contract in March 2014.
- Rate development is underway.
- Development of Plan marketing materials is underway.

Next Steps

- Finalize enrollment process.
- DOH and CMS to develop Participant outreach and education campaign including notices.
- Develop quality assurance instructions and parameters.
- Develop policies, draft notices, and uniform written materials on consolidated appeals and grievances processes.
- Develop Provider and Plan education and training materials.

Next Steps

Questions?

Contact us:

Questions and/or comments:

FIDA e-mail: FIDA@health.state.ny.us

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