Fully Integrated Duals Advantage (FIDA)
Provider Outreach and Education Event – January 27, 2016

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Learning Objectives:

By the end of this activity, learners should be able to:

1. Recognize what the Fully Integrated Duals Advantage (FIDA) program is and how it operates (including benefit package, eligibility criteria, enrollment process);
2. Identify the roles and responsibilities of providers and how they are paid under FIDA;
3. Identify the benefits of integrated care and the Interdisciplinary Team (IDT) for beneficiaries and providers; and
4. Identify the how the IDT works and specific examples of how integrated care and the IDTs have helped beneficiaries.

What is FIDA?

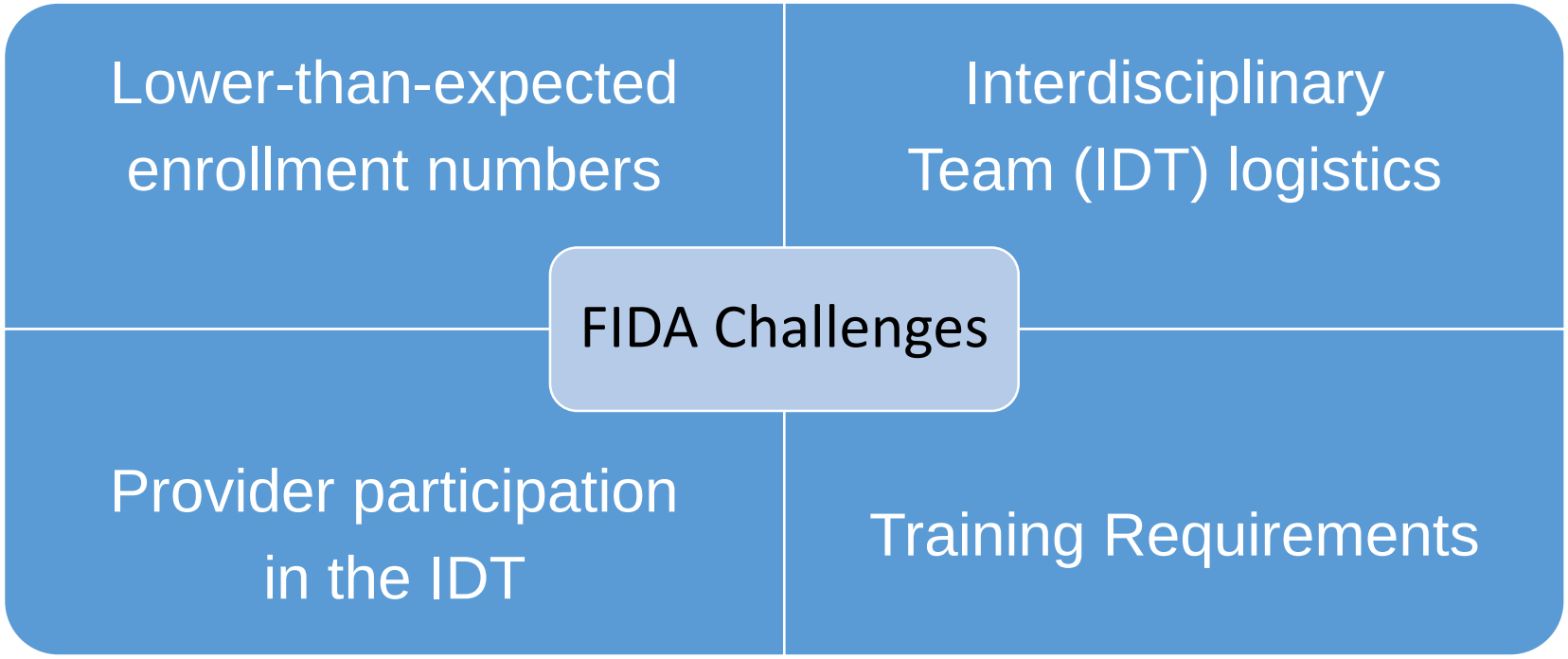
- The Fully Integrated Duals Advantage (FIDA) program is a partnership between the Centers for Medicare and Medicaid Services (CMS) and the New York State Department of Health (DOH).
- Through FIDA, certain dual-eligible individuals (Medicaid and Medicare) will be enrolled into fully integrated managed care plans.
- FIDA is operational in New York City and Nassau County and the Demonstration period runs from January 2015 to December 2017. Timing of Westchester and Suffolk Counties are to be determined, but it will be some time after mid 2016.
- There are 17 FIDA Plans in New York City and Nassau County.

FIDA Plans Available

FIDA Plan Name	FIDA Plan Name
Aetna Better Health FIDA Plan	Healthfirst AbsoluteCare FIDA Plan
AgeWell New York FIDA	ICS Community Care Plus FIDA MMP
AlphaCare Signature FIDA Plan	MetroPlus FIDA Plan
CenterLight Healthcare FIDA Plan	North Shore-LIJ FIDA LiveWell
Elderplan FIDA Total Care	RiverSpring FIDA Plan
FIDA Care Complete	SWH Whole Health FIDA
Fidelis Care FIDA Plan	VillageCareMAX Full Advantage FIDA Plan
GuildNet Gold Plus FIDA Plan	VNSNY Choice FIDA Complete
	WellCare Advocate Complete FIDA

FIDA Reforms

- DOH and CMS recognized that there were challenges related to the program:



FIDA Reforms

- As a result, DOH hosted a Long Term Care forum on the future of FIDA and Managed Long Term Care (MLTC). Over 530 people participated.
  - o The whitepaper and slides are available on the MRT website at: https://www.health.ny.gov/health_care/medicaid/redesign/
- DOH collaborated with CMS, Participants, Plans, providers, and stakeholders to enhance the ease and value of FIDA and reformed the program with specific attention to improved flexibility for the Participant, Plans, and providers.
  - o A summary document of the reforms and a revised IDT Policy were released on December 9, 2015, and posted to the FIDA MRT 101 website: https://www.health.ny.gov/health_care/medicaid/redesign/mrt_101.htm
  - o DOH and CMS are revising other materials such as the Participant Handbook, the Marketing Guidance, and the Three-way contract.

FIDA Reforms

- At the core, FIDA remains true to its original key components:
  - **Fully integrated** delivery of Medicaid and Medicare services
  - **Person-centered care** that promotes independence in the community
  - **Improved quality** through care coordination
  - **High quality, cost-effective** health care

IDT Flexibility

- **The Participant's right to choose the make-up of the IDT:**
  - The IDT can be small, consisting of just a Care Manager and Participant, or broader, with a variety of members (from the original IDT list) based on the Participant's choice.
- Provider participation in an IDT is adjustable, depending on member availability, items being discussed in a given meeting, or the needs, wishes, and goals of the Participant.
- Primary Care Providers may review and sign off on a completed Person-Centered Service Plan (PCSP) without attending IDT meetings.
- IDT members may meet at different times. The Care Manager may separately meet with different IDT members in developing the PCSP.

IDT Flexibility

- Plans have authorization over any medically necessary services included in the PCSP that are outside of the scope of practice of IDT members.
- IDT training will be encouraged, but not mandatory.
- Plans have more flexibility in how and when the IDT members communicate with one another.
- Plans retain responsibility for effective and efficient information sharing among providers (including non-IDT participants), including any PCSP revisions.

Flexibility for Participants

- We heard from Participants that they had an issue with the amount of assessments they experienced when transitioning from an existing MLTC plan to FIDA. As a result, the following changes were made to the timing of assessments:
  - Plans may use the existing MLTC schedule for completion of a Participant's Uniform Assessment System (UAS) if the Participant is transferring from a sister MLTC/PACE/MAP plan; i.e., each FIDA Participant transferring from a sister plan need not complete a new assessment until six months from the date of their last MLTC assessment.
    - The FIDA Plan must contact the Participant and review any available medical record and claims history from the pre-enrollment period to determine changes in health status, health event, or needs that would trigger an updated UAS.
    - If an updated UAS is required, it will be conducted within six months of the last UAS, and create the PCSP within 90 days following the enrollment effective date.
  - All other Participants have a PCSP deadline of 90 days from the enrollment effective date.

Participant Satisfaction

- DOH/CMS and the Contract Management Team (CMT) will evaluate the Participant's satisfaction with the FIDA Plan’s IDT delivery and operations.
- FIDA Plans must meet Medicare-Medicaid Plan Model of Care (MOC) elements and consistently update MOCs to reflect changes to the IDT Policy.
- The CMT will assess a Plan’s IDT performance against specific data collected.

Participant Satisfaction

- DOH and CMS will look at existing reporting measures to assure Participant satisfaction. The data collected includes:

In the last six months, did anyone from the Participant's health plan, doctor's office, or clinic help coordinate care among these doctors or other health providers?	How satisfied is the Participant with the help in coordinating care in the last year?	What is the number of nursing home certifiable Participants who lived outside the nursing facility during the current measurement year as a proportion to those during the previous year?	Has the required follow-up after hospitalization for mental illness occurred?

Participant Satisfaction

- DOH and CMS will also review the existing reporting measures based on percentages of the following:

Participants discharged from a hospital who were readmitted within 30 days, either for the same condition as their recent hospital stay or for a different reason.	Participants who saw their primary care doctor during the year.	Participants in the FIDA Demonstration who reside in a nursing facility, wish to return to the community, and were referred to preadmission screening teams or the Money Follows the Person Program.	Patients 65 years or older discharged from any inpatient facility and seen within 60 days following discharge by the physician providing on-going care, who had a reconciliation of the discharge medications with the current medication list in the medical record documented.

Flexibility In Marketing

- Plans now have authorization to do the following:
  - o Market multiple lines of business more easily.
  - o Provide a written or verbal comparison among their MLTC (Partial, PACE, MAP) and FIDA products.
  - o Send, with prior approval from DOH/CMS, FIDA educational materials (e.g., one-page letters, newsletters, etc.) to participants who have opted out.
  - o Conduct outbound FIDA marketing calls to individuals enrolled in any other Medicaid or Medicare product line with the Plan or company.
  - o Conduct promotional activities and make nominal gifts at the Medicare Marketing Guidelines levels ($15).

Flexibility in Enrollment

- Plans are allowed to submit enrollment requests to Maximus (consistent with MLTC procedure). NY Medicaid Choice (NYMC) will process the enrollment and send letters, which include Independent Consumer Advocacy Network (ICAN) contact information, to an individual that:
  - confirms the Participant's enrollment in FIDA;
  - articulates that choice counseling is available through NYMC and
  - informs the Participant of the option to switch or disenroll from a FIDA Plan at any time.
- Plans are allowed to remain on the phone with prospective Participants when they call NYMC.

Clarification on Provider ADA Attestation

- The following clarification was given related to the Provider ADA Attestation Form requirements:
  - No provider should be terminated from a FIDA Plan network for not answering in the affirmative to elements on the form.
  - The form is to help Participants identify which providers offer specified accessibility features.
  - Completion or non-completion of the form, or responding in the affirmative to elements included does not alter existing obligations to comply with the ADA.
  - FIDA Plans must maintain a complete and accurate provider directory, including information collected by the form. Plans have discretion on how to address provider refusals to complete the form.

FIDA Eligibility Remains the Same

- Eligible individuals:
  - Are age 21 or older at time of enrollment;
  - Are entitled to benefits under Medicare Part A, enrolled under Part B, eligible to enroll in Part D, and receiving full Medicaid benefits;
  - Reside in New York City or Nassau County; and
  - Must meet one of the following:
    - Require more than 120 days of community-based long term care; or
    - Are Nursing Facility Clinically Eligible and receiving facility-based long term services and supports (LTSS); or
    - Are eligible for the Nursing Home Transition and Diversion Waiver program.

FIDA Enrollment

- There are two types of enrollment:
  - **Opt-in Enrollment,** which is initiated by an individual.
  - **Passive Enrollment,** which is enrollment by the State, is suspended until further notice, except in limited circumstances.
- **Participants may opt out of or enroll in FIDA at <u>any time</u>.**
  - Those who opt out or disenroll will continue to receive Medicaid services through the MLTC plan and have a choice of Original Medicare or Medicare Advantage and a prescription drug plan.
- Region 2 (Suffolk and Westchester Counties) will not start until after mid-2016.

Why Should Individuals Join FIDA?

An FIDA Participant will have:

- The services and supports needed to remain independent and living in the community.
- A person-centered care plan and Interdisciplinary Team (IDT) comprised of members that the Participant has chosen.
- Full Medicare and Medicaid coverage, long term care services, behavioral health services, Part D and Medicaid drugs, and additional benefits from an integrated managed care plan.
- A Care Manager who can schedule doctor's appointments, help him or her get medicine and access other services.
- One process for all Medicare and Medicaid appeals (except for Part D appeals).
- The right to file an appeal for any Medicare or Medicaid service (except for Part D) through one appeals process.
- Help navigating the Managed Long Term Care system or the appeals process through the Ombudsman Program, ICAN.

Why Should Providers Participate in FIDA?

- Helps you ensure your patient gets all the care and support needed to live safely at home (including appropriate number of home health aide hours), and may help avoid hospitalization and nursing home stays.
- Provides extra support coordinating care for your patient through a Care Manager. The Care Manager does not replace the role of a physician. The Care Manager will document any changes to the care plan, and notify you of any other services your patient receives.
- Offers you the opportunity to work collaboratively with other providers as part of a care team to develop a single care plan to address your patient's needs.
- Simplifies the claims process because you can bill FIDA Plans for both Medicare and Medicaid services.

Out-of-Network Rules Remain the Same

- Out-Of-Network (OON) rules:
  - The Plan or the IDT can approve a provider who is OON, when necessary, to meet the needs of the Participant.
  - Participants must have access to all providers, including non-participating providers, all authorized services, and pre-existing service plans, including prescription drugs, for at least 90 days or until the care plan is finalized and implemented, whichever is later.
  - Plans must provide OON providers with information on how to apply to become participating provider.

Payments

- FIDA Plans receive payments for Medicare Parts A/B and Part D from CMS and Medicaid payment from the State in a capitated payment.
- Payment rates to Plans are based on estimates of what Medicare and Medicaid would have spent on enrollees in absence of FIDA.
- Plans receive a monthly integrated capitation payment and providers bill the FIDA Plan directly for all services rather than Medicare or MLTC.
- Balance billing of Participants is prohibited.
- Unless a contract between a provider and health plan specifies otherwise, there is no need for a provider to differentiate whether the services are covered through Medicare or Medicaid.

Payments

- One of the challenges we heard raised by providers was related to Medicare capitation payment. As a result:
  - CMS has committed to reviewing its payment of health plans participating in the demonstration in addition to increasing rates for 2016 to offset the CMS-HCC risk adjustment model's under prediction of costs for full benefit dual eligible beneficiaries.
  - CMS is conducting additional analysis of the Part D bids.
  - CMS is open to reconsidering the assumptions used in determining the adjustment for CY 2016 based on revised projections of enrollment and recent experience in the demonstration.

Payments to Non-Participating Providers

- For covered items and services that are part of traditional Medicare (i.e., Medicare Fee-For-Service [FFS] benefit package:
  - o FIDA Plans pay at least the lesser of the providers' charges or the Medicare FFS rate, regardless of the setting and type of care for authorized OON services.
- For nursing facility services that are part of traditional Medicaid benefit package:
  - o FIDA Plans pay the Medicaid FFS rate for three years after NH transition to managed care became mandatory in a county (NYC 2/1/15; Nassau 4/1/15).
- For covered items and services that are part of the traditional Medicaid benefit package:
  - o FIDA Plans shall pay any State Office of Mental Health or State Office of Alcoholism and Substance Abuse Services licensed or certified Provider of behavioral health services at least the applicable Medicaid FFS rate for a period of not more than two years.

Continuity of Care Remains the Same

- FIDA Plans must allow Participants to maintain current providers – even if not in a Plan's network – and service levels, including prescription drugs, for at least 90 days or until a PCSP is finalized and implemented, whichever is later.
- Exceptions to 90-Day Continuity of Care:
  - Existing behavioral health service providers must be maintained for up to 24 months;
  - For nursing facility services, Plans must allow Participants to maintain current providers for the duration of the Demonstration; or
  - If the IDT or FIDA Plan approves the Participant to see an out-of-network provider.

Role of ICAN Remains the Same

- The Ombudsman, known as the Independent Consumer Advocacy Network (ICAN), remains a resource for Participants.
- ICAN provides individuals free assistance in accessing care, filing grievances, appealing adverse decisions, and understanding and exercising rights and responsibilities.
- ICAN can be reached by calling **1-844-614-8800** or online at **www.icannys.org.**

Next Moves

- DOH and CMS remain committed to the FIDA Program and will monitor the changes in 2016 and make additional changes if needed.

- DOH recognizes that there must be better coordination of Medicaid and Medicare services and our goal is to continue to increase the number of people receiving services through fully integrated Managed Long Term Care plans (e.g., FIDA, partial MLTC, Medicaid Advantage Plus, and PACE).

Questions?

More Information

General Information:
www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/

FIDA Reforms and Revised IDT Policy:
https://www.health.ny.gov/health_care/medicaid/redesign/mrt_101.htm

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