



FIDA Update and MOU Discussion

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Meeting Agenda

- Welcome/Introductions
- FIDA Update:
 - Memorandum of Understanding (MOU) Review
 - Implementation Funding
 - Ombudsman Funding
 - Readiness Reviews
 - Three-Way Contracts
- Comments/Questions



Memorandum of Understanding (MOU)

- The Memorandum of Understanding between CMS and NYSDOH was signed on August 26, 2013
- Demonstration is approved and implementation will proceed in accordance with the terms of the MOU – running from July 2014 through December 2017
- Through this Demo, NYSDOH and CMS are testing the delivery of fully integrated items and services through a capitated managed care model



MOU - Some Highlights

- Comprehensive service package
- Broad medical necessity definition applies to all services
- Interdisciplinary Team (IDT) authorizes virtually all services
- Integrated Grievance & Appeals (G&A) processes
- Participant Ombudsman



MOU - Start Dates

- Individuals receiving Community-Based LTSS
 - Voluntary Enrollment – Effective July 2014
 - Passive Enrollment – Effective September 2014
- Individuals receiving Facility-Based LTSS
 - Voluntary Enrollment – Effective October 2014
 - Passive Enrollment – Effective January 2015

Passive enrollment will occur over several months and will be phased based on how much time individuals have left on their eligibility authorizations



MOU - Enrollment and Disenrollment

- Eligible populations will be given time for voluntary enrollment prior to passive enrollment
- Participants may opt-out of passive enrollment before the date on which their passive enrollment is scheduled to occur
- Participants may disenroll (after enrollment) in any month
- Enrollments and Disenrollments run through the Enrollment Broker – Maximus

FIDA Plans have NO role in enrollment



MOU - Eligibility

- Eligible Populations:
 - Age 21 or older;
 - Entitled to benefits under Part A and enrolled under Parts B and D, and receiving full Medicaid benefits; and
 - Reside in a FIDA Demonstration county.

- Must also meet one of the following three:
 - Are Nursing Facility Clinically Eligible (NFCE) and receiving facility-based Long Term Support Services (LTSS);
 - Are eligible for the Nursing Home Transition and Diversion (NHTD) waiver ; or
 - Require community-based LTSS for more than 120 days.



MOU - Eligibility

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;
- 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;



MOU - Eligibility

The following individuals are not eligible for FIDA:

- 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;
- 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.



MOU - Eligibility

- The following individuals ARE eligible for FIDA but will not be passively enrolled:
 - Native Americans but they may opt into the Demonstration at any time;
 - Those eligible for the Medicaid buy-in for the working disabled and are nursing home certifiable;
 - Aliessa Court Ordered Individuals;
 - Those enrolled in PACE;
 - Those enrolled in a Medicare Advantage Special Needs Plan for institutionalized individuals;
 - Those enrolled in Health Homes;
 - Those assigned to a CMS Accountable Care Organization (ACO) as of the time they would otherwise be included in the passive enrollment phase;
 - Those participating in the CMS Independence at Home (IAH) demo; and
 - Those enrolled in Employer or Union Sponsored coverage for employees or retirees.



MOU - Choice

- Choice –
 - Participants have the right to choose:
 - Whether to participate
 - Plans
 - Providers (all, including care manager)
 - Members of IDT
 - Self-directed Care



MOU - Service Planning and Care Management

- Comprehensive Assessment must be conducted within 30 days of enrollment
 - Conducted by an RN in the individual's home
 - Conducted using a state approved assessment instrument
 - Assessment to be used as basis for the Person-Centered Services Plan (PCSP)
- Re-assessment (and PCSP update) must be completed:
 - As warranted 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;
 - 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.



MOU - Service Planning and Care Management

- Person-Centered Service Planning
 - Assessment and Service Planning to be completed by an Interdisciplinary Team (IDT), which will be comprised of:
 - Participant and/or his/her designee;
 - Designated care manager;
 - Primary care physician;
 - Behavioral health professional;
 - Participant's home care aide; 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.
 - The IDT makes coverage determinations which may not be modified by the FIDA Plan outside of the IDT and are appealable by the Participant.



MOU - Service Planning and Care Management

- IDT service planning, care coordination and care management
 - Will be based on the assessed needs and articulated preferences of the Participant.
 - Will assist each Participant in obtaining needed medical, behavioral health, prescription and non-prescription drugs, community-based or facility-based LTSS, social, educational, psychosocial, financial and other services in support of the PCSP irrespective of whether the needed services are covered under the capitation payment.

- Consumer Direction is included in the covered services and in the service planning process.



MOU - Cost to Participant

- Cost
 - There are no costs for services.
 - No Part D and Medicaid drug co-pays.
 - Balance Billing is prohibited.
 - Some Participants may have applicable spend-down/NAMI for Medicaid.



MOU - Continuity of Care

- Continuity of Care
 - Participants have access to all providers, all authorized services, and preexisting service plans for 90 days or until a comprehensive assessment has been completed and a service plan is developed – except for participants who reside in nursing homes at the time of passive enrollment.
 - 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.



MOU - Network Adequacy and Access

- 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).



MOU - Network Adequacy and Access

- 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;
 - All providers' physical sites must be 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.



MOU - 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 FIDA PO in enrollment materials, annual notice of Grievance and Appeal procedures, and all written notices of denial, reduction or termination of a Service.



MOU – Participant Participation and Involvement

- Plans are required to obtain Participant and community input through:
 - At least one Participant Advisory Committee (PAC) that meets quarterly and is open to all Participants:
 - PAC members and the Participant Ombudsman will be invited to participate in the State’s ongoing stakeholder process.
 - Plans must also establish a process for that PAC to provide input to the Plan.
 - PAC composition must reflect the diversity of the FIDA Participant population.
 - Plans will also be encouraged to include Participant representation on their boards of directors.
 - NYSDOH will have a process for ongoing stakeholder participation and public comment.



MOU - Covered Benefits

- Covered Benefits –
 - Covered Benefits include those currently covered by Medicaid, Medicare and Home and Community Based Waiver Services (see MOU for complete list).
 - Medically Necessary –
 - Those items and services necessary to prevent, diagnose, correct, or cure conditions in the Participant that cause acute suffering, endanger life, result in illness or infirmity, interfere with such Participant's capacity for normal activity, or threaten some significant handicap Notwithstanding this definition, FIDA Plans will provide coverage in accordance with the more favorable of the current Medicare and NYSDOH coverage rules, as outlined in NYSDOH and Federal rules and coverage guidelines.
 - FIDA plans 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.



MOU - Grievances and Appeals (G&A)

- Integrated G&A Processes
 - 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 systems for FIDA.
- Integrated G&A Notices
 - Notification of **all** applicable Medicare and Medicaid appeal rights will be provided through a single notice specific to the service or item type in question, developed jointly by the State and CMS.
 - 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.



MOU - Grievances and Appeals

- Grievance Process
 - File within 60 days.
 - Plan must send written acknowledgment 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 process outlined in the Three-way Contract.



MOU - Grievances and Appeals

- Four (4) Levels of Integrated Appeals:

- **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 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.



MOU - Grievances and Appeals

2. Integrated Administrative Hearing.

- Adverse appeal decisions made by plans are **automatically** forwarded to the Integrated Administrative Hearing Officer (IAHO) at the Office of Temporary and Disability Assistance (OTDA).
- Benefits will continue pending appeal if filed with the FIDA Plan within 10 days of receipt of the notice of termination/reduction in services.
- Acknowledgment within 14 days . The IAHO must provide a Notice of Administrative Hearing at least 10 days in advance of the hearing.
- 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.



MOU - Grievances and Appeals

3. 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.

4. Federal District Court.

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



MOU - Grievances and Appeals

- Other 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 (QIC) for a period not to exceed one (1) 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.



MOU - Quality

- **Quality Metrics**
 - **MOU contains Quality Measures that CMS and the state will require.**
 - **Some of these will be used for the quality withholds**
 - **In addition, CMS and the State may apply progressive monetary sanctions tied to premium payments for not meeting minimum performance standards, as will be specified by CMS and the State in the Three-way Contract.**



MOU - Integrated Materials

- The State and CMS are developing single consolidated set of
 - Marketing rules and requirements and model document
 - Enrollment rules and requirements and model documents
 - Appeal notices
- The three-way contract will require FIDA plans to comply with any unified set of rules and requirements that are developed.



MOU - Plan Selection

- Plan Selection Steps completed
 - Plans had to submit their applications in February 21, 2013
 - Plans had to submit their models of care as well
 - Plans had to be approved by the state as MLTCP plans by May 14, 2013
 - Plans had to submit their Plan Benefit Packages into HPMS in June 2013
- Plan Selection Steps to complete
 - At present there are 25 plans, all of which must successfully satisfy the readiness requirements and get through the readiness review steps (described in more detail later in this presentation)



MOU - Financial

- Plan Risk Arrangements
 - Plans will be required to provide a detailed description of its risk arrangements with providers under subcontract with the FIDA Plan
 - Incentive arrangements can't include any payment or other inducement that serves to withhold, limit, or reduce necessary medical or non-medical items or services to Participants.
 - By 12/1/14, Plans must develop a plan for a fully integrated payment system through which providers would not be paid FFS but would be paid on an alternative basis (e.g., pay for performance, bundled payment).
 - After State approval and no earlier than January 2015, FIDA Plans will be required to implement the approved plans, which will remain in effect throughout the duration of the Demonstration.
- Solvency
 - Plans have to meet state and federal solvency requirements



MOU - Financial

- Proposed rate cells:
 - **Community Non-Nursing Home Certifiable**. Rate cell for individuals who require more than 120 days of community-based LTSS, but who do not meet a Nursing Home Level of Care (NHLOC) standard as defined by the NYSDOH Approved Assessment Tool. One rate cell for nursing home non-certifiable (NHC) individuals will be determined for the entire Demonstration Area.
 - **Nursing Home Certifiable**. Rate cell for individuals who meet the standard of NHLOC as defined by the NYSDOH Approved Assessment Tool. One rate cell for NHC individuals will be determined for the entire Demonstration region.
- Each rate cell will be risk adjusted by FIDA Plan by comparing each FIDA Plan's relative risk for each rate cell to the regional average risk. The regional average will be the entire Demonstration Area.



MOU - Financial

	Savings Percentages	
Year**	Medicare Part A and B	Medicaid
1	1%	1%
2	1.5%	1.5%
3	3%*	3%*
	Quality Withhold	
Year	Medicare Part A and B	Medicaid
1	1%	1%
2	2%	2%
3	3%	3%

***Trigger:** In the event that at least one-third of FIDA Plans experience losses in Demonstration Year 1 exceeding 3% of revenue, based on at least 15 months of data from Demonstration Year 1, the savings percentage for Demonstration Year 3 will be reduced to 2.5%. CMS and the State will make such a determination at least four months prior to the start of Demonstration Year 3.

****Demonstration year calendar dates:**

Year 1: July 1, 2014 – December 31, 2015

Year 2: January 1, 2016 – December 31, 2016

Year 3: January 1, 2017 – December 31, 2017

MOU - Financial

- **Medical Loss Ratio:** FIDA Plans will be required each year to meet a Target Medical Loss Ratio (TMLR) threshold of 85 percent, which regulates the minimum amount of revenue that must be used for expenses either directly related to medical claims or care coordination. If the Medical Loss Ratio (MLR) calculated annually is less than the TMLR, the FIDA Plan shall remit to CMS and the State an amount equal to the difference between the calculated MLR and the TMLR (expressed as a percentage) multiplied by the revenue received during the coverage year. Any collected remittances would be distributed proportionally back to the Medicare and Medicaid programs.
 - CMS and the State will work together with Plans and Plan Associations to further define what expenses can be used to meet the Target Medical Loss Ratio Requirement



MOU - Financial

Quality Withhold Measures for Year 1:	Quality Withhold Measures for Years 2 and 3:
<ul style="list-style-type: none">• Encounter Data• Assessments• Participant Governance Board• Customer Service• Getting Appointments and Care Quickly• Documentation of Care Goals• Nursing Facility Diversion Measure	<ul style="list-style-type: none">• Plan All-cause Readmissions• Annual Flu Vaccine• Follow-up after Hospitalization for Mental Illness• Screening for Clinical Depression and Follow-up Care• Reducing the Risk of Falling• Controlling Blood Pressure• Part D Medication Adherence for Oral Diabetes Medications• Improvement/Stability in Activities of Daily Living (ADL) Functioning• Nursing Facility Diversion Measure



Update - FIDA Implementation Funding

- CMS Implementation Support
 - In January, NYSDOH applied for Implementation Funding through Centers for Medicare and Medicaid Services (CMS)
 - Ongoing discussions with CMS about application as MOU has been in development
 - NYSDOH expects to have implementation funding awarded soon



Update - Participant Ombudsman Funding

- CMS Opportunity to Request Funding for Participant Ombudsman Program
- On August 5, 2013, NYSDOH applied for Ombudsman Program Funding through Centers for Medicare and Medicaid Services (CMS)
 - CMS Decisions expected by September 13, 2013
 - Immediately thereafter, Phase 1 planning begins for 6 months
 - Phase 2 implementation of Participant Ombudsman Program begins in March 2014 to be trained and staffed by FIDA start date of 7/1/14



Update - Readiness Review

- A draft of the readiness review tool was distributed to plans on 8/27/13 and CMS had a call with plans to go over the tool on 8/28/13.
- The readiness review process has several steps
 1. **Desk Review**
 - a. This process is currently underway. Plans submitted their Plan Benefit Packages through HPMS in June.
 - b. Plans will receive notices of deficiencies and an opportunity to correct.
 2. **Site Review**
 3. **Network Validation**
 4. **Systems Testing**
 5. **Pre-enrollment validation (last chance to further correct any outstanding desk review deficiencies)**



Update - Three-Way Contracts

- Are now being developed – some other state’s models are online and offer a good sense of what will be in ours
- Will be signed after the readiness review process is completed

DOH Milestones Through December 2013

Key Milestones

- Stakeholder meeting
- Notice of Implementation and Ombudsman Funding Awards
- Hire FIDA program staff
- Complete Readiness Review processes
- RFA for Ombudsman
- Start developing participant outreach and education campaign including notices
- Develop quality assurance instructions and parameters
- Develop operations, policies, draft notices, and uniform written materials on consolidated appeals and grievances processes
- Develop provider and plan education and training plan



Next Steps

- Await CMS Implementation and Ombudsman Funding
- Complete Readiness Review Steps
- Complete Three-Way Contract development Process
- Reconvene with Stakeholders in November



Questions?



We want to hear from you!

FIDA e-mail:

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MRT website:

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