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Fully Integrated Duals Advantage (FIDA) Training

New York State Department of Health
Office of Health Insurance Programs
Division of Long-Term Care

What is FIDA?

- The Fully Integrated Duals Advantage (FIDA) program.
- A managed care program that combines and offers all Medicare and Medicaid services through one program.
- A partnership between the Centers for Medicare and Medicaid Services (CMS) and NYSDOH.
- FIDA is operational in New York City and Nassau County and the demonstration period runs from January 2015 to December 2019. Westchester and Suffolk County started recently in 2017 with plans starting on a rolling basis.
 - The FIDA program is being offered by 14 Health Plans, although not all plans operate in all counties. The Plans have executed a three-way contract with NYSDOH and CMS after completing a readiness-review process.

FIDA Training Agenda

- Topics of discussion will include:
 - Eligibility
 - Covered Services and Continuity of Care
 - The Interdisciplinary Team (IDT) and Care Management Systems
 - Integrated Grievance and Appeals Process
 - Enrollment and Disenrollment
 - ICAN Ombudsman





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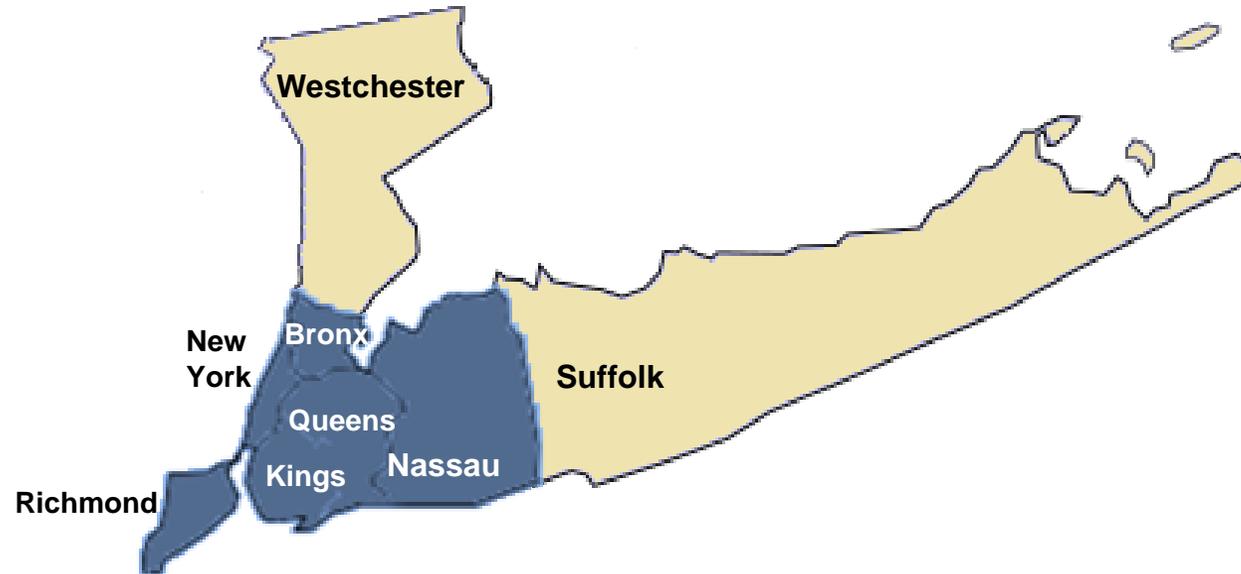
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FIDA Eligibility

Who is Eligible for FIDA?

Participants must be:

- 21 or older;
- Entitled to benefits under Medicare Part A, enrolled in Medicare Part B, and eligible for Medicare Part D;
- Receiving full Medicaid benefits; and;
- Be a resident of a demonstration county: **Bronx, Kings, New York, Queens, Richmond, Westchester, Nassau, and Suffolk.**



And meet one of the following three criteria:

- Require community-based LTSS for more than 120 days,
- Are eligible for the Nursing Home Transition and Diversion Waiver program, **or**
- Are Nursing Facility clinically eligible and receiving facility-based LTSS.

Who is Not Eligible for FIDA?

Individuals who are:

- With a "county of fiscal responsibility" code 97, 98, or 99.
- Residents of Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDD) program.
- Eligible to live in an ICF/IIDD, but choose not to.
- In alcohol/substance abuse long-term residential treatment program residents.
- Eligible for Emergency Medicaid.
- In the New York State Office for People With Developmental Disabilities (OPWDD) Home and Community Based Services (HCBS) waiver program.
- In the Traumatic Brain Injury (TBI) waiver program.
- In the Foster Family Care Demonstration.
- Residents of a New York State Office of Mental Health (OMH) facility or a psychiatric facility.
- Residents in an Assisted Living Program.
- Receiving services from the OPWDD system.
- Authorized for only Medicaid eligibility for less than six months.
- Eligible for Medicaid benefits only for tuberculosis-related services.
- Under 65 (screened and require treatment) in the Centers for Disease Control and Prevention Breast or Cervical Cancer Early Detection program and need treatment for breast or cervical cancer, and are not otherwise covered under creditable health coverage.
- Receiving hospice services (at time of enrollment).
- Eligible for the family planning expansion program.





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FIDA Covered Services and Continuity of Care

FIDA Covered Items and Services

- FIDA Plans are required to provide medically necessary covered items and services.
- The “medical necessity” definition includes the more favorable of the current Medicare and NYSDOH coverage rules, as outlined in NYSDOH and Federal rules and coverage guidelines.
- FIDA coverage includes items and services currently covered by:
 - Medicare, including Part D drugs
 - Medicaid, including medications
 - Medicaid HCBS Waivers and other Long term care services
 - Other services added to the Demonstration

FIDA Covered Items and Services

Abdominal Aortic Aneurism Screening
 Adult Day Health Care
 AIDS Adult Day Health Care
 Ambulance
 Ambulatory Surgical Centers
 Assertive Community Treatment (ACT)
 Assisted Living Program
 Assistive Technology (State Plan and Supplemental to State Plan)
 Bone Mass Measurement
 Breast Cancer Screening (Mammograms)
 Cardiac Rehabilitation Services
 Cardiovascular Disease Risk Reduction Visit (therapy for heart disease)
 Cardiovascular Disease Screening and Testing
 Care Management (Service Coordination)
 Cervical and Vaginal Cancer Screening
 Chemotherapy
 Chiropractic
 Colorectal Screening
 Community Integration Counseling
 Community Transitional Services
 Comprehensive Psychiatric Emergency Programs (CPEP)
 Consumer Directed Personal Assistance Services
 Continuing Day Treatment
 Crisis Intervention Services
 Defibrillator (implantable automatic)
 Dental
 Depression Screening
 Diabetes Monitoring (Self)
 Diabetes Supplies
 Diabetic Therapeutic Shoes or Inserts
 Diagnostic Testing
 Durable Medical Equipment (DME)
 Emergency Care
 Environmental Modifications
 Family Planning Services
 HCSS
 Health/Wellness Education
 Hearing Services
 HIV Screening
 Home Delivery and Congregate meals
 Home Health
 Home Infusion Bundled Services
 Home Infusion Supplies and Administration and Medicare Part D Home Infusion Drugs
 Home Maintenance Services
 Home Visits by Medical Personnel
 Immunizations
 Independent Living Skills and Training
 Inpatient Hospital Care (including Substance Abuse and Rehabilitation Services)
 Inpatient Mental Healthcare
 Inpatient Mental Health over 190-day Lifetime Limit
 Intensive Psychiatric Rehabilitation Treatment Programs
 Inpatient Services during a Non-covered Inpatient Stay
 Kidney Disease Services (including ESRD services)
 Mammograms
 Medicaid Pharmacy Benefits as Allowed by State Law



FIDA Covered Items and Services

Medical Nutrition Therapy
 Medicare Part B Prescription Drugs
 Medicare Part D Prescription Drug Benefit as Approved by CMS
 Medication Therapy Management
 Mobile Mental Health Treatment
 Moving Assistance
 Non-Emergency Transportation
 Nursing Facility (Medicaid)
 Nursing Hotline
 Nutrition (includes Nutritional Counseling and Educational Services)
 New York State Office of Mental Health Licensed Community Residences
 Obesity Screening and Therapy to Keep Weight Down
 Opioid Treatment Services – Substance Abuse
 Other Health Care Professional Services
 Other Supportive Services the Interdisciplinary Team Determines Necessary
 Outpatient Blood Services
 Outpatient Hospital Services
 Outpatient – Medically Supervised Withdrawal- Substance Abuse
 Outpatient Mental Health
 Outpatient Rehabilitation (OT, PT, Speech)
 Outpatient Substance Abuse
 Outpatient Surgery
 Palliative Care
 Pap Smear and Pelvic Exams
 Partial Hospitalization (Medicaid)
 Partial Hospitalization (Medicare)
 PCP Office Visits
 Peer-Delivered Services
 Peer Mentoring

Personal Care Services
 Personal Emergency Response Services (PERS)
 Personalized Recovery Oriented Services (PROS)
 Podiatry
 Positive Behavioral Interventions and Support
 Preventive Services
 Private Duty Nursing
 Prostate Cancer Screening
 Prosthetics
 Pulmonary Rehabilitation Services
 Residential Addiction Services
 Respiratory Care Services
 Respite
 Routine Physical Exam 1/year
 Sexually Transmitted Infections (STIs) Screening and Counseling
 Skilled Nursing Facility
 Smoking and Tobacco Cessation
 Social and Environmental Supports
 Social Day Care
 Social Day Care Transportation
 Specialist Office Visits
 Structured Day Program
 Substance Abuse Program
 Telehealth
 Transportation
 Urgent Care
 Vision Care Services
 “Welcome to Medicare” Preventive Visit
 Wellness Counseling



FIDA Costs and Payment Processes

- There are no FIDA-specific costs to Participants, including no Medicare Part D or Medicaid drug co-payments/co-insurance, no premiums, and no deductibles for any covered items or services. A Participant may still have eligibility-related costs such as spend-down or net monthly income payments.
- Balance billing of Participants is prohibited: cannot bill participants for covered items and services.
- FIDA Plans will receive a monthly integrated (Medicare or Medicaid) capitation payment.
- Participating Providers will bill FIDA Plans for services and cannot bill Medicaid or Medicare.

Continuity of Care for Participants

- Upon Enrollment:
 - Participants have access to all providers, including Non-Participating Providers, all authorized services and their pre-existing service plans – including prescription drugs, **for at least 90 days**; or until the Person Centered Service Plan (PCSP) is finalized and implemented, whichever is later.
 - Participants can stay in their current Nursing Home for the duration of the demonstration.
 - All FIDA Plans must have contracts or payment arrangements with all nursing homes, so that FIDA enrollees who are already in a nursing home can stay at that same nursing home for the duration of the demonstration.
 - The FIDA Plan must allow Participants receiving Behavioral Health Services to maintain their current Providers, whether Participating or Non-Participating, for the current Episode of Care but not exceed two years from the effective date of enrollment. This requirement applies only to Episodes of Care that were ongoing during the transition period from Medicaid Fee-For-Service (FFS) to enrollment in a FIDA Plan.



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FIDA Interdisciplinary Team (IDT) and Care Management System

FIDA Comprehensive Assessment

- Each Participant will actively participate in a Comprehensive Assessment of their medical, Behavioral Health, LTSS, and social needs.
- This is for care-planning purposes and not a functional eligibility assessment.
- The Comprehensive Assessment must cover at least social, functional, medical, behavioral, wellness, and prevention domains; caregiver status and capabilities; and the Participants' preferences, strengths, and goals.
- The Comprehensive Assessment shall be completed by an RN on staff, or under contract with, the FIDA Plan.
- The Comprehensive Assessment must be performed in the individual's home, Hospital, Nursing Facility, or any other setting using the Uniform Assessment System for NY (UAS-NY).



FIDA Comprehensive Assessment

- The initial Comprehensive Assessment must be completed no later than:
 - In time so that a Person-Centered Service Plan can be completed within 90 days; or
 - Within 6 months of any MLTC Assessment for Participants who transfer to FIDA from MLTC.
- The results of the Comprehensive Assessment will confirm the Participant's acuity and be the basis for developing the PCSP.
- The PCSP, created by the IDT, outlines the services the person will receive during the period covered by the PCSP.

FIDA Comprehensive Reassessment

- A Comprehensive Reassessment must be performed at least once every six months; within 30 days of a request by a Participant, Designee, Authorized Representative, or Provider; and as soon as possible – no more than 30 days – after any of these trigger events:
- A change in health status or needs of the Participant due to:
 - A Hospital admission;
 - Transition between care settings;
 - Change in functional status;
 - Loss of a caregiver;
 - Change in diagnosis; or
- As requested by a member of the IDT who observes a change in functional status.



FIDA Care Coordination and the IDT

A Participant's IDT must be made up of:

- The **Participant** or, in the case of incapacity, an authorized representative; and
- The **FIDA Plan Care Manager**;

At the Participant's choosing, the IDT may also include:

- The Participant's **designee(s)**, if desired by the Participant;
- A **Primary Care Provider** (PCP) or a designee with clinical experience from the PCP's practice who has knowledge of the Participant's needs;
- A **Behavioral Health Professional**, if there is one, or a designee with clinical experience from the professional's Behavioral Health practice who has knowledge of the Participant's needs;
- The Participant's **Home Care Aide(s)**, or a designee with clinical experience from the home care agency who has knowledge of the Participant's needs;
- The Participant's **Nursing Facility Representative**, who is a clinical professional, if receiving Nursing Facility care; and
- **Other Providers** either as requested by the Participant or designee; or as recommended by the IDT.
- The **RN** who completed the Participant's Assessment, if approved by the Participant or designee.

Person-Centered Service Planning (PCSP) Requirements

- The Participant is the center of the PCSP process.
- The PCSP must:
 - Be tailored to the Participant's culture, communication style, physical requirements, and personal preferences.
 - Contain measureable goals, interventions, and expected outcomes with completion timeframes.
 - Consider the Participant's functional level, the psychosocial, medical and Behavioral Health needs, as well as the language, culture, and support systems.
 - Be completed so that the initial PCSP can be completed within 30 days of enrollment and must be revised within 30 days of any Comprehensive Reassessment.



How Services Are Authorized

- Service authorizations may be made by the FIDA Plan through the Utilization Management (UM) process before the initial PCSP is developed by the IDT.
- After the PCSP is developed by the IDT, care decisions contain therein act as service authorizations for six months or the duration of the care plan.
- In between IDT meetings, any additional services the Participant needs that are not already addressed by the current PCSP are subject to the Plan's UM process for coverage decisions.
- Service authorizations made by the IDT may not be modified by the FIDA Plan. Note: Service authorizations may be modified pursuant to the decision of a Participant appeal.
- The Participant may appeal any IDT decision, regardless of whether the Participant agreed at the time of the IDT meeting.



Covered Items or Services with No Authorization Required

Participants may directly obtain these items and services without review, prior authorization, or approval by either the plan or the IDT:

- Emergency or urgently needed care.
- Out-of-Network Dialysis when the participant is out of service area.
- Family planning and Women's Health specialists services.
- Prescription drugs on the formulary, that do not require prior authorization or that are not on the formulary but for which a refill request is made for an existing prescription within the 90-day transitional period.
- Other Preventive Services.
- Supplemental Education, Wellness, and Health Management Services.
- **Dental Services through Article 28 Clinics Operated by Academic Dental Centers.**
- Vision Services through Article 28 clinics that provide optometry services and are affiliated with the College of Optometry of the State University of New York to obtain covered optometry services.
- Participants who are eligible to receive services from a participating Indian health care provider; Indian Health Service (IHS); and Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) provider; covered services provided by that I/T/U provider, as long as that provider has the capacity.
- Primary Care Doctor visits.
- Immunizations.
- Palliative Care.
- Public health agency facilities for Tuberculosis (TB) Screening, Diagnosis and Treatment; including Directly Observed Therapy (TB/DOT).
- Cardiac Rehabilitation, first course of treatment (a physician or RN authorization for subsequent courses of treatment).



Covered Items and Services that must be authorized by a specialist

- The following items and services must be authorized by the indicated specialist and cannot be authorized by the IDT or the FIDA Plan. (These items and services do not need to be included in the PCSP.)
 - Preventive Dental X-Rays – These require Dentist authorization.
 - Comprehensive Dental – These services require Dentist authorization.
 - Eye Wear – These require Optometrist or ophthalmologist authorization.
 - Hearing Aids – These require Audiologist authorization.





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FIDA Integrated Grievance and Appeal Processes

Highlights of the Integrated Grievance and Appeal (G&A) Process created for FIDA

- The G&A process incorporates the most consumer-favorable elements of the Medicare and Medicaid grievance and appeals systems into a consolidated, integrated system for Participants.
- All notices are consolidated and are being jointly developed by CMS and NYSDOH.
- All notices must communicate the steps in the integrated appeals process, as well as the availability of the Participant Ombudsman to assist with appeals.
- Providers can file on behalf of a Participant, but do not have a FIDA-specific right to appeal Plan payment decisions.
- There are four levels of appeal.



FIDA Integrated Grievance Process

- A grievance is a specific or generalized complaint about the plan, a provider, etc., not a mechanism for challenging a plan's coverage decision, and must be filed within 60 days.
- Plan must send written acknowledgement 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 seven days from 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 1-800 Medicare. The NYSDOH/CMS Contract Management Team will review.

FIDA Integrated Appeal Process

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 seven days on Medicaid prescription drug appeals and 30 days from the date of the receipt of the appeal.
- An extension of up to 14 days 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 two business days of decision for all appeals.

FIDA Integrated Appeal Process

Level 2 Appeal. Integrated Administrative Hearing:

- Adverse appeal decisions made by Plans are forwarded to the Integrated Administrative Hearing Office (IAHO) at the Office of Temporary and Disability Assistance (OTDA) within two days.
 - Benefits will continue, pending appeal, if the first level appeal was filed with the FIDA Plan within 10 days of receipt of the notice of termination or 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 seven days for Medicaid prescription drug-coverage matters. For all other matters, a decision must come within 90 days of the request during the first year of FIDA and 62 days of request during the second and third years.
- The IAHO must issue a written explanation of the decision and specify the next steps in the appeal process – including where to file a third level appeal, time frames, and other applicable requirements.

FIDA Integrated Appeal Process

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.

FIDA Integrated Appeal Process

- Who can use the integrated appeal process?
 - Participants and Authorized Representatives filing on behalf of a Participant,
 - Participating Providers and Non-Participating Providers who are appealing on behalf of a Participant,and
 - Non-Participating Providers appealing on their own behalf.
 - This is new as of 11/29/16.





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FIDA Enrollment and Disenrollment

FIDA Enrollment

Types of enrollment:

Opt-In Enrollment, which is initiated by an individual.

- Enrollment requests can be made to NY Medicaid Choice or to a Plan directly.

Passive Enrollment, is enrollment by the state, which the individual can decline by opting out.

- There is none scheduled at this time.

FIDA Enrollment

- All enrollments (Opt-In and Passive) are processed through NYMC. Consumers can request enrollment through the Plans and the Plans can submit these to NYMC but, NYMC has to complete the steps to process all enrollments into FIDA.
- **NY Medicaid Choice** will:
 - Provide individuals and their families with information and education about FIDA Plans.
 - Provide counseling and assistance.
 - Check which FIDA Plans a person's doctors or other Providers work with.
 - Confirm whether a plan covers current medications.
 - Check to see if certain items or services are covered in FIDA (i.e. home care)
 - Direct callers to additional resources if necessary (e.g. HRA)
 - Enroll individuals into a FIDA Plan.



14 FIDA Plans

Aetna Better Health FIDA Plan

AgeWell New York FIDA

CenterLight Healthcare FIDA Plan

Elderplan FIDA Total Care

Fidelis Care FIDA Plan

GuildNet Gold Plus FIDA Plan

Healthfirst AbsoluteCare FIDA Plan

ICS Community Care Plus FIDA MMP

MetroPlus FIDA Plan

North Shore-LIJ FIDA LiveWell

RiverSpring FIDA Plan

SWH Whole Health FIDA

VillageCareMAX Full Advantage FIDA Plan

VNSNY Choice FIDA Complete



Disenrollment

- Individuals may disenroll from FIDA at any time.
- Technically, disenrollments may be accomplished by:
 - Contacting NY Medicaid Choice (NYMC)
 - Contacting 1-800-Medicare to enroll into another plan
 - Directly enrolling into a Medicare Advantage plan
- It would be best, however, for consumers to be directed to NYMC so that they can be educated about MLTC options
- FIDA Plans cannot accept disenrollment requests



Involuntary Disenrollment

- **Required Involuntary Disenrollments**—The State **must** disenroll a Participant in the following cases:
 - Participant moves out of the service area;
 - Participant is temporarily absent from the plan service in excess of six months;
 - Participant loses entitlement to either Medicare Part A or Part B;
 - Participant loses Medicaid eligibility or other FIDA eligibility;
 - Participant dies;
 - FIDA Plan Contract termination or service area reduction; or
 - Participant materially misrepresents information to the FIDA Plan regarding reimbursement for third-party coverage.



Involuntary Disenrollment

- **Discretionary Involuntary Disenrollments –**
 - Participant engages in conduct or behavior that seriously impairs the Plan's ability to furnish Covered Items and Services to either the Participant or other Participants.
 - Participant provides fraudulent information on an enrollment form or the Participant willfully misuses or permits another person to misuse the Participant's ID card.
 - Participant knowingly fails to complete and submit any necessary consent or release allowing the FIDA Plan and/or Providers to access necessary health care and service information.



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ICAN Ombudsman

Participant Ombudsman – ICAN

- The Participant Ombudsman program, known as the **Independent Consumer Advocacy Network (ICAN)**, was launched on December 1, 2014.
- The program provides FIDA Participants with direct assistance in navigating their coverage, but in understanding and exercising their rights and responsibilities.
- ICAN also serves MLTC and Medicaid Managed Care (MMC) enrollees who receive LTSS.
- Currently, the call center receives calls from the **entire** state.
- The first several ICAN locations, in which people can get in-person assistance, opened in each of the New York City boroughs and in Nassau and Suffolk counties.
- All Participant materials include information about ICAN.
- The network can be reached by calling **1-844-614-8800** or online at: www.icannys.org.





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Summary and Questions

How Would an Individual Learn about FIDA?

- Providers
- Marketing from Plans
- Maximus - Both NY Medicaid and CFEEC
- Word of Mouth
- HIICAP and NY Connects
- Advertising by State
- You



Why Should an Individual Join FIDA?

- Receive full Medicare and Medicaid coverage, long term care, Part D and Medicaid drugs, and additional benefits from a single, integrated managed care plan. In other words, FIDA covers all the benefits that the individual may receive through their managed long term care (MLTC) plan, Original Medicare or their Medicare Advantage plan, and their Part D plan.
- IDT Process for Service Planning and Care Coordination
- FIDA covers additional services most of which are **not** currently available through MLTC plans, for example Mobile mental health treatment and Peer mentoring
- Some FIDA Plans offer supplemental benefits, such as monthly Over-the-Counter (OTC) allowances and annual vision exams.
- Have a 90-day continuity of care period to be able to adjust to the program. This means they will be able to receive all of their benefits as they are now for at least 90 days after their enrollment effective date. If they receive behavioral care, their continuity of care period will be 2 years.



Why Should an Individual Join FIDA?

- Pay NO deductibles, premiums, or copayments/coinsurance to the plan.
- Need NO referrals to see specialists.
- Have a Care Manager who can schedule doctor's appointments, arrange transportation and help them get their medicine.
- Be able to add their caregivers to their care team to help them make decisions regarding their care and understand the goals of their care plans.
- Use one phone number to call the plan for all questions regarding their benefits.
- Use one ID card to receive *all* of their benefits.
- Have access to the ICAN Ombudsman if they have a problem with their plan.
- Have the right to leave FIDA at any time and for any reason.



Contact Us:

If you have questions related to:

FIDA email: FIDA@health.ny.gov

FIDA program website:

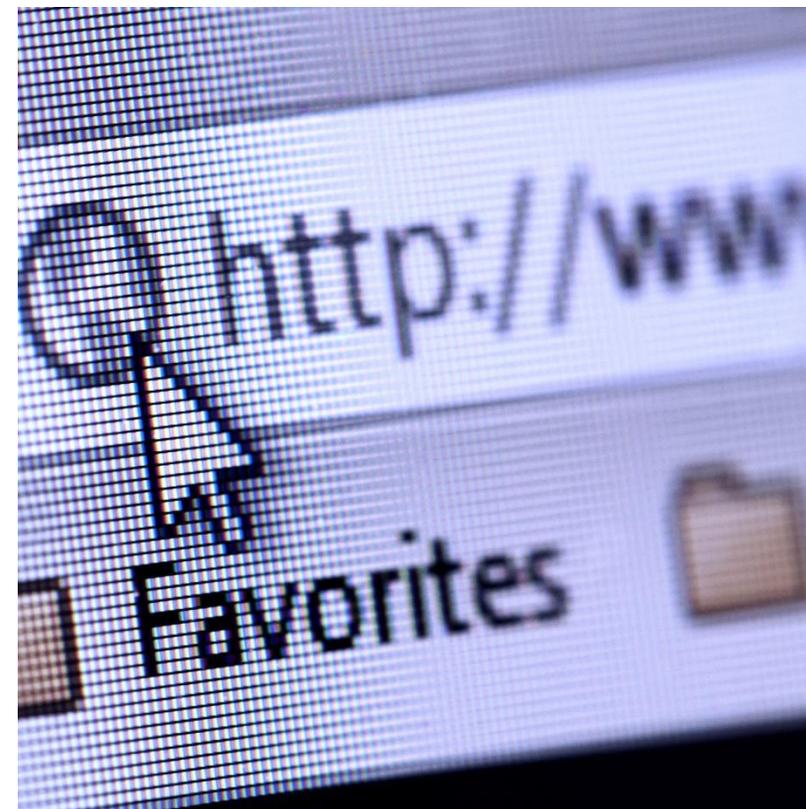
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