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# Helping your Patients Understand the Fully Integrated Duals Advantage (FIDA) Program

# Medicare Rights Center

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- ❖ The Medicare Rights Center is a national, nonprofit consumer service organization that works to ensure access to affordable health care for older adults and people with disabilities through:
  - Counseling and advocacy
  - Educational programs
  - Public policy initiatives

# What we will learn

- ❖ **FIDA: A program for people with both Medicare and Medicaid who need certain types of care. FIDA offers a way to get Medicare and Medicaid services from one private plan.**
- ❖ The difference between FIDA and Managed Long Term Care (MLTC)
- ❖ How FIDA helps dually eligible patients with long term care needs
- ❖ How providers may be affected by the FIDA program after patients enroll
- ❖ Who is eligible and who is not eligible for FIDA
- ❖ What people must do to enroll and what they must do if they do not want to enroll in a FIDA plan
- ❖ What FIDA covers
- ❖ How you can help your patients make the right plan choices
- ❖ How continuity of care is protected under FIDA
- ❖ How providers can help patients should they need to appeal

# MLTC and FIDA: What's the difference?

## MLTC

- Only covers Medicaid long term care, dental, vision, and podiatric services
- Does not affect Medicare coverage
- Is **mandatory** for most long term care populations

## FIDA

- Covers all health care services and items, including physician services and prescription drugs
- Provides both Medicare and Medicaid benefits
- Is **optional**

# How FIDA could improve health and quality of life

## ❖ Simpler for patients

- ~100,000 patients eligible for FIDA in New York City and Nassau
- Patients in FIDA are able to get all care through one health plan – this means one ID card for most services

## ❖ Better overall care coordination for patients

- Patients in FIDA have more individualized care plans and better supports to stay safely in their care setting of choice

## ❖ Better communication among providers, caregivers, and patients

- Everyone involved in the patient's care is aware of care plan and who to contact with questions or problems

# Why might patients opt in to FIDA?

- ❖ Eligible patients are particularly vulnerable to problems arising from a lack of care coordination, such as higher hospital admissions rates and higher risk of medication interactions
- ❖ **Benefits of FIDA**
  - One card and one plan for all health care services
  - One care manager ensures access to all care needs
  - Interdisciplinary team (IDT) helps manage care to ensure that coordinated care is delivered
  - Plan may offer services that aren't traditionally available through Medicare or Medicaid coverage
  - Can switch between FIDA plans or switch back to an MLTC plan up to once per month
  - All care decisions are appealable by patient or representative

# Potential benefits of provider participation in FIDA

- ❖ FIDA systems and structures add tools for improving care coordination for vulnerable populations
- ❖ FIDA is a demonstration project starting on a small scale, and provider feedback now will be important for improving this and future models
- ❖ FIDA participation may open up additional business opportunities and deepen relationships with managed care plans
- ❖ In the long-run, FIDA hopes to save providers time
  - FIDA intends to increase health care access, coordination, and understanding for beneficiaries, thereby decreasing avoidable hospitalizations and urgent care

# How are providers paid by FIDA plans?

- ❖ Each plan has their own claims submission process
- ❖ Plans must pay all approved electronic claims within 30 days of receipt and paper claims within 45 days of receipt
- ❖ Each plan must distribute a Participating Provider Manual to the providers that are in their plan's network with information containing:
  - Provider billing and reporting practices
  - Claims and Encounter submission processes
- ❖ Plans must develop a plan for a fully integrated payment system through which Participating Providers would no longer be paid on a traditional fee-for-service basis but would receive a form of alternative payment such as bundled payment or value-based payment from plans
  - This bundled payment structure will begin in 2016



# How do I become a FIDA provider?

- ❖ If you work with a hospital or facility, you should not have to contract with a plan yourself
  - Speak to an administrator to find out the plans with which your facility contracts
- ❖ If your patient is enrolled in FIDA and you are not yet contracted with his/her plan, a FIDA care manager (affiliated with plan) will call to ask you to join the plan
  - You will then be certified via New York State's training portal and be invited to participate in an Interdisciplinary Care Team (IDT) meeting.
- ❖ If you work independently but have not heard from a FIDA care manager, survey your patients to find out the plans with which they are enrolled
  - If patients do not know, use number on their Medicare card to check their coverage by entering them into [www.medicare.gov/find-a-plan](http://www.medicare.gov/find-a-plan)



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# FIDA Eligibility and Enrollment

# Four FIDA eligibility criteria

**To be eligible for FIDA, a patient must meet all of the following:**

<b>1) Be dually eligible</b>	Have both Medicare and full Medicaid
<b>2) Be at least 21 years old</b>	
<b>3) Receive 120+ days of community-based long term care, or require permanent nursing home care</b>	Long term care = Ongoing care needed to help perform everyday activities. Can include care in the community or in a facility. Examples include but are not limited to: <ul style="list-style-type: none"><li>•Home health care</li><li>•Nursing home care</li><li>•Medical adult day health care</li></ul>
<b>4) Live in a county in New York State where FIDA has been rolled out</b>	Downstate: New York City (5 boroughs) and Nassau County

# Exclusions from FIDA

- ❖ The following groups are not allowed to enroll in FIDA plans:
  - People under 21
  - Office of Mental Health (OMH) facility residents
  - Beneficiaries who receive Office for People with Developmental Disabilities (OPWDD) services
  - Psychiatric facility residents
  - Individuals expected to be Medicaid-eligible for less than six months
  - Individuals eligible for Emergency Medicaid
  - Individuals receiving hospice services before FIDA rollout
  - Residents of or people who qualify to reside in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)
  - Residents of alcohol/substance abuse long term residential treatment programs
  - Individuals in the Traumatic Brain Injury (TBI) waiver program
  - Residents of Assisted Living Programs
  - Individuals in the Foster Family Care demonstration

# FIDA enrollment

- ❖ FIDA start date = January 1, 2015
- ❖ To be FIDA-eligible, must meet all four criteria
- ❖ Enrollment into FIDA is **optional**
- ❖ Patients are automatically (**passively**) enrolled if they do not opt in or opt out
- ❖ Patients can switch into, out of, or between FIDA plans up to once per month
- ❖ New York Medicaid Choice (aka Maximus)
  - 888-401-6582
  - <http://www.nymedicaidchoice.com/>

# FIDA enrollment

- ❖ Opt in = actively enroll in FIDA through New York Medicaid Choice
  - If enrollment occurs **before** noon on the 20<sup>th</sup> of the month, plan effective date is 1<sup>st</sup> of the month after enrollment
  - If enrollment occurs **after** noon on the 20<sup>th</sup> of the month, effective date is first of the month after next
  - See next slide for more information
- ❖ Opt out = contact New York Medicaid Choice or 800-Medicare to decline FIDA enrollment
  - Patients choosing to opt out should do so before passive enrollment to avoid coverage disruptions
  - Also possible to enroll in FIDA and later opt out
    - Will go back to Medicare/Medicaid/MLTC coverage on the 1<sup>st</sup> of the month after disenrollment (if disenrolled before noon on the 20<sup>th</sup>)

# FIDA passive enrollment

## ❖ Phases of passive enrollment:

- Region I: Bronx, Kings, Nassau, New York, Queens, and Richmond counties
  - Opt-in starting January 1, 2015
  - **Passive enrollment** starting April 1, 2015
- Region II: Westchester and Suffolk counties – **on hold until further notice**

## ❖ FIDA-eligible patients receive three notices before their passive enrollment

- 90-day, 60-day, and 30-day notices
- Notices remind people to choose a plan that best meets their needs, or to opt out before passive enrollment
- If beneficiaries are already in an MLTC plan, they will be passively enrolled into the FIDA offering of the insurance company that currently provides their MLTC coverage

December 2014

<Barcode> <Letter Code>  
<Name>  
<Address>  
<City>, <State>, <Zip>

**Important information about a new program that can  
change the way you get your Medicare and Medicaid  
services**

Dear [MemberName; B-3]:

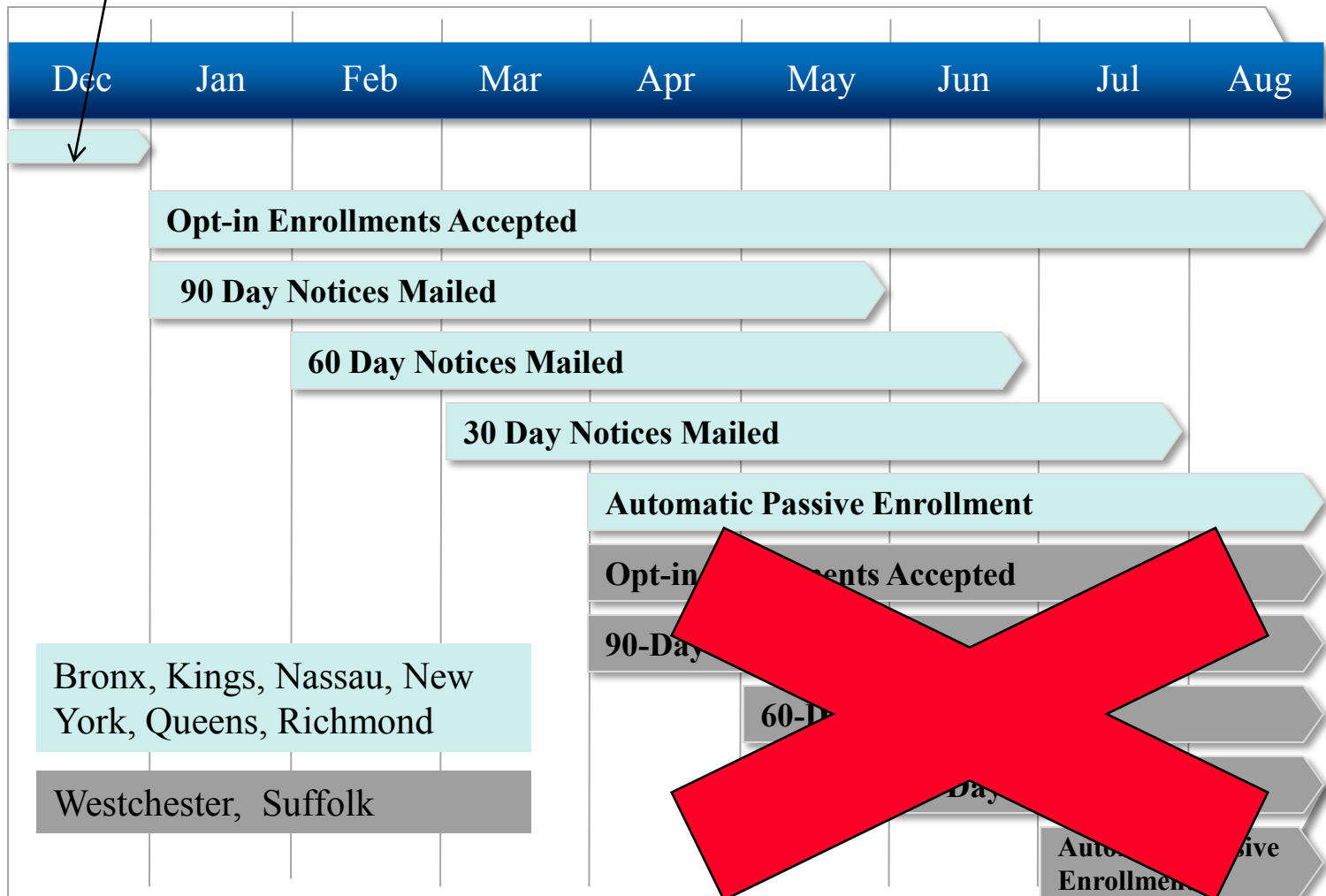
[MedicaidCIN; B-16]

Do you have Medicare and Medicaid? The New York State Department of Health has a new program that can make it easier for you to get your care. It is called Fully Integrated Duals Advantage (FIDA)



# FIDA enrollment timeline

Program Announcement Letter Mailed



# Nursing home enrollment

- ❖ Permanent nursing home residents before February 1, 2015 continue to be covered by fee-for-service Medicaid
  - Do not have to enroll in MLTC
  - Not going to be passively enrolled in FIDA
- ❖ New permanent nursing home residents who qualify for full Medicaid and Medicare (moved to nursing homes after February 1, 2015) have to take an MLTC plan
- ❖ New permanent nursing home residents (moved to nursing homes after February 1, 2015) will be passively enrolled into FIDA **on or after August 1, 2015**
  - Definitive dates not yet scheduled
- ❖ All permanent nursing home residents have the option to opt into FIDA after October 1, 2015

# Exceptions to passive enrollment

- ❖ The following groups are excluded from passive enrollment into FIDA, but may choose to opt in:
  - Native Americans
  - Nursing home-eligible people who qualify for the Medicaid buy-in for the working disabled
  - Aliessa court-ordered individuals
  - PACE plan enrollees
  - Special Needs Plan for institutionalized individuals enrollees
  - Health Home enrollees
  - Those who are Accountable Care Organization (ACO) members when passive enrollment phase begins
  - Individuals participating in the CMS Independence at Home demonstration
  - Individuals enrolled in employer- or union-sponsored coverage for employees or retirees

# Opt-out pros and cons

Those who opt out of FIDA continue to receive benefits through separate channels, as before FIDA.

Opt-Out Pros	Opt-Out Cons
Can stay with fee-for-service Medicare and acute care Medicaid, which do not have provider networks	Separate benefit cards for different areas of coverage, meaning a patient could have up to 5 different types of insurance
Can keep current Part D plan	Limited care coordination offered: patients and caregivers must navigate different areas of coverage themselves
Can switch between MLTC plans or switch to FIDA up to once per month	Patients who meet all four criteria must at least have an MLTC plan

# Opt-in pros and cons

Those who opt into FIDA and those who are passively enrolled receive benefits through one plan.

Pros	Cons
One card and one plan for all health care services	Limited to a network of providers and pharmacies for all drugs and services – may have to stop using providers who are not in plan's network
Interdisciplinary team (IDT) helps manage care to ensure that coordinated care is delivered	Patients who disagree with IDT decisions need to appeal to the plan
Optional: Can switch between FIDA plans or switch back to an MLTC plan up to once per month	



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# FIDA Coverage

# FIDA coverage

- ❖ FIDA plans cover all services a dual eligible patient is entitled to including:
  - Medicare coverage
  - Medicaid coverage
  - Long term care coverage
  - Drug coverage
- ❖ There are no costs for covered benefits from in-network providers
  - Cost sharing is illegal and balance billing is illegal
- ❖ FIDA patients must stay within a network of doctors and hospitals
- ❖ This rule applies to all Medicare and Medicaid services except:
  - Patients already in nursing homes can stay in current nursing homes regardless of plan networks
  - Patients receiving behavioral health services can keep current behavioral health providers for 2 years after they join a FIDA plan if treatment began before they transitioned into FIDA

# Continuation of care protections

- ❖ New FIDA plan members continue to receive the same services from existing providers for at least 90 days after coverage start date or until a Person-Centered Service Plan (PCSP) has been completed by the FIDA plan, whichever is later
  - Eases patient's transition to new network of providers
  - Eases patient's transition to new drug coverage
  - Allows FIDA plans time to contract with patient's current providers and schedule IDT meetings
- ❖ FIDA plan has 60 days to assess the care needs of people who are passively enrolled and 30 days for all other enrollees



# Person-Centered Service Plan

- ❖ “A written description in the care management record of Participant-specific health care goals to be achieved and the amount, duration, and scope of the covered services” (FIDA Memorandum of Understanding)
- ❖ Developed by IDT
- ❖ Must be completed within 30 days of a care needs assessment or reassessment
- ❖ Patient preferences must be included
- ❖ The FIDA plan must monitor and address any gaps in care in the PCSP
  - Must call for updates when necessary

# Interdisciplinary Team (IDT)

- ❖ Ensures the integration and coordination of patient's health care through the Person-Centered Service Plan and ongoing support
  - IDT must authorize most care services
- ❖ Each FIDA plan member has their own IDT led by a plan-employed care manager. Other IDT members include:
  - FIDA patient (if they are able and willing)
  - FIDA patient's caregivers or representatives (if applicable)
  - Primary care physician
  - RN who performed the care needs assessment (if member approves)
  - Behavioral health specialists (if applicable)
  - Home care aide (if applicable)
  - Nursing home representative (if applicable)
  - Other specialists or health providers (if member approves)

# Interdisciplinary Team (IDT)

- ❖ Except for emergency and urgent care, patient should consult with IDT before using a Specialist if not noted in PCSP
- ❖ FIDA plan cannot change IDT decisions
- ❖ Patient can appeal any IDT decisions, including PCSP decisions
- ❖ IDT authorizes any other health care service needs that may arise (also appealable)
- ❖ IDT can supplement covered services with non-covered services or items if the PCSP indicates non-covered services are needed (plan then pays for these services)

# IDT time commitment

- ❖ FIDA plan's care manager organizes IDT meetings
- ❖ IDTs must meet every 6 months, or every time there is a change in a patient's care need
  - For example, if a patient is hospitalized with a stroke or heart attack, the IDT is convened even if 6 months have not passed
- ❖ Providers can participate in IDT meetings telephonically
- ❖ Providers can send representatives to take their place telephonically or in person at an IDT meeting
- ❖ Some FIDA plans reimburse providers for time spent participating in IDT meetings



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# FIDA Choices

# Helping patients choose FIDA plans

When helping your patients consider FIDA plans:

- 1) Tell them which plans you or your facility contract with so they can choose a plan that has you in its network

If you are not sure which plans your facility contracts with, speak to an administrator

- 2) Tell them to make a list of their other providers, including doctors, nurse practitioners, long term care providers, pharmacists
- 3) Tell them to list the prescription drugs they take
- 4) Tell them to call the plans you participate with and ensure their other providers are in network and their drugs are covered

**FIDA patients must choose providers, hospitals, facilities, and pharmacies that are in plan's network.**

# Choices after a beneficiary is passively enrolled

- ❖ If patient wants to remain in FIDA, encourage:
  - A conversation with you and other providers about new coverage
  - Confirmation with home health care agency or adult day care program that they accept FIDA plan
  - Creating a list of current providers and prescription drugs to make sure they are in network and covered (see slide 29)
- ❖ FIDA plan has 60 days to perform the initial assessment and create PCSP
- ❖ Patients can prepare for assessment by making a list of prescription drugs, providers, and current health care needs and issues
- ❖ **Remember:** Patients can switch between FIDA plans or switch back to an MLTC plan up to once per month

# Choices after a beneficiary is passively enrolled

- ❖ If patient wants to switch coverage back to pre-FIDA coverage:
  - Remind them of 90 days of continuous coverage
    - If they disenroll within that timeframe, services should not be disrupted
  - Patient should call **NY Medicaid Choice (855-600-3432)** to disenroll from FIDA
    - Request confirmation of disenrollment from NY Medicaid Choice representative and what date that disenrollment is effective
  - Patient should specify which MLTC plan they want to be enrolled in—whether their pre-FIDA MLTC plan, or a different one
    - Confirm what date that enrollment is effective
  - Patient should call 800-Medicare to confirm new Medicare coverage, including Part D coverage
  - Make patients aware that they may have to be re-assessed for coverage needs by MLTC plan
    - Patient should contact MLTC care manager about reassessment





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# Helping Patients Appeal

# Who can file an appeal?

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- ❖ Patient
- ❖ Friend or family member
- ❖ Provider
  - Providers can request an appeal on behalf of a FIDA patient by filling out the sections of the denial notice
  - If a patient needs someone to represent them at their hearing, representative and patient must sign an Appointment of Representative Form available from the plan

# Levels of FIDA appeal

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## ❖ Four levels of appeal:

- 1) Initial appeal to FIDA plan
- 2) Appeal to FIDA Administrative Hearing Unit at the New York State Office for Temporary and Disability Assistance (OTDA)
- 3) Appeal to federal Medicare Appeals Council (MAC)
- 4) Appeal to federal district court

# Medicare and Medicaid drug appeals

- ❖ **Medicaid drug appeals:** process is part of the FIDA integrated appeals process (aid continuing applies – see slide 39)
  - Applies to drugs that are covered by Medicaid but not Medicare
- ❖ **Medicare drug appeals:** Process is not part of the FIDA integrated appeals process (aid continuing does not apply)
  - Medicare Part D appeals process applies to Part D drugs
    - To learn more about the Part D appeals process visit [www.medicareinteractive.org](http://www.medicareinteractive.org)

# When to file an appeal

- ❖ When patient receives a notice that contains decision/s that they or you disagree with
- ❖ For example:
  - Integrated Coverage Determination Notice
    - Issued when the Person-Centered Care Plan is created or updated and changes have been made to the care the patient received under the old PCSP
    - Issued each time care requested by the patient or provider is denied
    - Issued each time that care ends or is reduced

# Integrated Coverage Determination Notice

- ❖ FIDA plan must give the patient written notice of any denials, terminations, reductions
- ❖ Notice must be translated for individuals who speak Spanish, Chinese, Russian, Italian, Haitian-Creole, Korean
- ❖ Notices must list contact info for the **Independent Consumer Advocacy Network (ICAN: 844-614-8800)** and explain:
  - Denial, reduction, or termination and reasons for decision
  - Citation to the regulations
  - Right to file an appeal
  - How to file an appeal
  - How and when to request an expedited appeal

# Aid continuing

- ❖ Coverage for a service/item being terminated/reduced continues while an appeal is pending = **aid continuing**
  - Applies through the MAC level of appeal
    - **Does not apply to Part D drug appeals**
- ❖ Your patient or their representative must file an appeal verbally or in writing within 10 days of the postmark date or by the intended effective date of the denial, reduction, termination (whichever is later) to get automatic aid continuing
  - If your patient does not need aid continuing, they or a representative can file an appeal verbally or in writing within 60 calendar days of the postmark date on the denial notice
- ❖ Even if denial is upheld, your patient should not be charged for aid continuing

# Strengthening an appeal

- ❖ Prescribing physician is important to the appeals process
  - Must provide statement of medical necessity and work closely with appeals advocate and/or patient
- ❖ Persistence is key
  - Some plans rubber stamp denials (especially if the drug is expensive), and appeals often win at the independent review level without any additional information



# What we learned

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- ❖ Difference between MLTC and FIDA
- ❖ How FIDA hopes to improve care coordination
- ❖ Why providers should participate
- ❖ Patient eligibility
- ❖ Patient enrollment
- ❖ FIDA benefits, rights, and coverage
- ❖ How you can help patients make the right choice
- ❖ Helping patients appeal IDT denials

# Where to find information

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## ❖ **New York Medicaid Choice**

- 855-600-3432
- <http://www.nymedicaidchoice.com/>
- Patients can contact to enroll in or switch FIDA or MLTC plans

## ❖ **Independent Consumer Advocacy Network (ICAN)**

- 844-614-8800
- <http://www.icannys.org>
- Patients can contact with any problems or concerns about MLTC or FIDA