Fully Integrated Duals Advantage (FIDA) Demonstration

Frequently Asked Questions (FAQs) September 2013

These FAQs respond to questions that are not addressed in other Fully Integrated Duals Advantage (FIDA) Demonstration materials posted on the MRT website, such as posted webinars, presentations and proposals. Please read these FAQs in conjunction with the other posted materials.

General Questions

Q1. Where is this presentation on the MRT website?

A1. The presentation can be found on the MRT website (http: //www.health.ny.gov/health_care/medicaid/redesign/) under the FIDA summary of the "Key MRT Initiatives" section.

Q2. What is the status of the OPWDD FIDA?

A2. The Office for Persons with Developmental Disabilities (OPWDD) will work with the Centers for Medicare & Medicaid Services (CMS) on a separate MOU. While a specific submission date has yet been determined, information pertaining to this program will be posted on the OPWDD and MRT websites as it becomes available.

Q3. Is the MOU available to review?

A3. Yes, the final Memorandum of Understanding (MOU) between the Centers for Medicare& Medicaid Services (CMS) and the State of New York regarding a Federal-State partnership to test a capitated financial alignment model for Medicare-Medicaid enrollees can be found on the CMS website (http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/NYMOU.pdf).

Q4. What is the timeline for release of rates?

A4. The State is currently working with CMS and both sets of actuaries to establish rates; the timeline is anticipated to be released in the near future.

Q5. Which Managed Care Organizations are participating / providing care in the FIDA Demonstration?

A5. The New York State Department of Health (NYSDOH) and CMS are currently working with 25 plans. To be selected as a FIDA Plan, these plans must successfully satisfy the readiness requirements and enter into a Three-way Contract with NYSDOH and CMS prior to being finally approved for participation in the FIDA Demonstration.

Q6. Approximately when does DOH plan to announce which plans have met all requirements and will be participating in the FIDA Demonstration?

A6. NYSDOH will announce which plans have met all requirements and will be participating in the FIDA Demonstration upon completion of the Readiness Review (which includes a desk review, site review, network validation, systems testing, and pre-enrollment validation). We currently anticipate that this announcement will be made in the second quarter of CY 2014. In the interim, NYSDOH and CMS are working with the following plans:

- Aetna
- Agewell
- AlphaCare
- Amerigroup
- Amida
- Catholic Managed Long Term Care, Inc. (Archcare)
- Centerlight
- Centers Plan for Healthy Living
- Elderplan (Homefirst)
- Elderserve
- Fidelis Care of NY (NYS Catholic Health Plan)
- GuildNet
- Healthfirst (Managed Health, Inc.)
- HHH Choices
- HIP
- Independence Care Systems
- Integra
- MetroPlus
- Montefiore
- North Shore LIJ Health Plan, Inc.
- Senior Whole Health
- United Healthcare
- VillageCare MAX
- VNYSNY Choice
- Wellcare

Q7. Can a Participant insist on fee for service?

A7. No. Participants do not determine whether a fee-for-service rate or a capitated rate is applied to services. These rates are determined by the FIDA Plans and providers.

Q8. Can you post the Readiness Review Tool on the MRT website?

A8. A preliminary draft of the Readiness Review Tool has been shared with plans for their review and comment and will be posted on MRT and CMS websites when it is finalized.

Q9. Is there a required Participant to ombudsman ratio?

A9. The Ombudsman Request for Application is under development but we do not anticipate that it will include a predetermined Participant to ombudsman ratio.

Q10. What will be the requirements/background for someone to be an ombudsman?

A10. The Participant Ombudsman (PO) will be an independent, conflict-free entity under contract with NYSDOH to provide Participants free assistance in accessing their care, understanding and exercising their rights and responsibilities, and appealing adverse decisions made by their FIDA Plan. The PO will provide advice, information, referral and

assistance in accessing benefits and assistance in navigating FIDA Plans, providers, or NYSDOH. The requirements for the PO will be outlined in the contract between NYSDOH and the PO. Also, the Request for Applications (RFA) for the Ombudsman program will be released shortly and will be available on the NYSDOH website.

Q11. When is NYS planning on submitting the Nursing Home Transition & Diversion waiver amendment?

A11. The Nursing Home Transition and Diversion (NHTD) waiver amendment is currently under internal review and will be submitted to CMS upon completion. DOH maintains information on the NHTD waiver program at http://www.health.ny.gov/facilities/long_term_care/#nhtd_waiver.

Q12. If a current NHTD waiver consumer opts out of FIDA, will they have the option to continue to receive services under the NHTD waiver?

A12. This issue is currently being deliberated; how the NHTD waiver will work in conjunction with the implementation of the FIDA Demonstration remains a work in progress and we are open to ideas and options.

Q13. How will behavioral health treatment be delivered to FIDA Participants?

A13. Behavioral Health services are included in the covered services provided by the FIDA Plan and, thus, will be delivered through the FIDA Demonstration's provider network. Within 30 days of the FIDA Plan conducting a comprehensive assessment, a Person-Centered Service Plan will be completed for each Participant by the Participant's Interdisciplinary Team (IDT). Person-centered service planning includes consideration of the current and unique psychosocial and medical needs and history of the Participant, as well as the Participant's functional level, behavioral health needs, language, culture, and support systems. Care management includes referral to and coordination of other necessary medical, social, behavioral health, prescription drugs and non-prescription drugs, community-based or facility-based LTSS, educational, financial and other services of the Person-Centered Service Plan that support the Participant's psychosocial needs irrespective of whether such services are covered by the FIDA Plan. Person-centered service planning is completed by the Participant and his/her IDT.

Q14. Can you clarify what is meant by 'provider accessibility'? Is this wheelchair access?

A14. New York State regulation at 10 NYCRR § 98-1.6(f) requires the availability and accessibility of health care services to Medicaid enrollees. Public programs and services, when viewed in their entirety, must be readily accessible to and useable by individuals with disabilities. This standard includes physical access, non-discrimination in policies and procedures and communication. Communications with individuals with disabilities are required to be as effective as communications with others. In the event that full physical accessibility is not readily available for people with disabilities, a Compliance Plan will describe the steps or actions the FIDA Plan will take to assure accessibility to services equivalent to those offered at the inaccessible facilities.

Q15. What is a "nursing facility diversion measure"?

A15. This measure reports the number of nursing home certifiable Participants who lived outside the nursing facility (NF) during the current measurement year as a proportion of the nursing home certifiable Participants who lived outside the NF during the previous year.

Q16. Can you provide a list of all the other participating states?

A16. A list of all states that have entered into MOUs with CMS can be found here: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsinCareCoordination.html.

Enrollment Questions

Q1. How will eligibility of new entrants be assessed?

A1. The process to identify an individual's need for 120 days or more of community-based long term care services shall be conducted in accordance with Special Term and Condition 28 of the Partnership Plan Demonstration under Social Security Act Section 1115(a).

Q2. Is the "intelligent assignment" algorithm based on historic Medicare or Medicaid reimbursed providers (or both)?

A2. The State's intelligent assignment algorithm is in the process of being developed. . However, we anticipate that the algorithm for passive enrollment (e.g. that prioritizes continuity of providers and/or services) will consider Participants' previous Medicaid managed long term care enrollment and historic provider utilization.

Q3. With respect to passive enrollment, will the algorithm assigning a person who is already enrolled in a Medicare Advantage Plan and MLTCP give preference to the Medicare Advantage relationship or to the MLTCP relationship?

A3. The intelligent assignment algorithm is still in development.

Q4. Are Medicaid Advantage Plan (MAP) participants excluded from passive enrollment?

A4. No. The following individuals will be excluded from passive enrollment:

- Native Americans but they may opt in to the FIDA Demonstration at any time;
- Individuals who are eligible for the Medicaid buy-in for the working disabled and are nursing home certifiable;
- Aliessa Court Ordered Individuals;
- Individuals enrolled in PACE;
- Individuals enrolled in a Medicare Advantage Special Needs Plan for institutionalized individuals;
- Individuals enrolled in Health Homes;
- Individuals assigned to a CMS Accountable Care Organization (ACO) as of the point in time they would otherwise be included in the passive enrollment phase;
- Individuals participating in the CMS Independence at Home demonstration; and
- Individuals enrolled in Employer or Union Sponsored coverage for employees or retirees.

Q5. For opt-in enrollment, are assessments done before or after enrollment?

A5. Upon enrollment in the FIDA Demonstration, all Participants will receive a comprehensive assessment to be completed no later than 30 days from the individual's enrollment date. This initial assessment and all reassessments must be performed by a Registered Nurse (RN) in-person with the Participant in the Participant's home (which may be a nursing home or assisted living). Initial assessments may be completed while a new Participant is admitted to a hospital, acute care facility, skilled nursing facility, etc., instead of waiting for the Participant to be discharged to their home; however, the Participant will need to be reassessed upon transfer of care setting back to his/her home. Assessments will be completed using the NYSDOH Approved Assessment Tool.

Q6. Are social workers allowed to complete assessments?

A6. No. Only registered nurses (RNs) are allowed to complete assessments, under the terms and conditions of the MOU.

Q7. When will FIDA Plan processing of voluntary enrollments for those receiving community LTSS begin?

A7. Eligible community-based LTSS individuals will be informed no earlier than April 1, 2014 of the opportunity to opt into a FIDA Plan for coverage starting no earlier than July 1, 2014. Beginning no earlier than July 1, 2014, eligible community-based LTSS individuals will be notified of the State's plan for passive enrollment, which would begin no earlier than September 1, 2014. Specifically, they will be notified of their right to select among contracted FIDA Plans no fewer than sixty (60) days prior to their assigned effective date of enrollment and will have the opportunity to opt out until the last day of the month prior to the effective date of enrollment. When an eligible individual has not made an active choice, his/her enrollment into a FIDA Plan will be conducted using a passive enrollment process that provides the opportunity for Participants to opt out or disenroll from the FIDA Plan at any time. Prior to the effective date of their enrollment, individuals who would be passively enrolled will have the opportunity to opt out and will receive sufficient notice and information with which to do so, as further detailed in Appendix 7 of the MOU.

Q8. Assisted Living Program (ALP) residents are excluded, however the Table 7-A list of FIDA Demonstration services includes ALP. Please clarify.

A8. While residents in Assisted Living Programs (ALPs) are expressly excluded from participation in the FIDA Demonstration, ALP can be provided as a service to new Participants as part of a FIDA Plan. The intersection of the ALP program and Managed Care is complex, and the State is pursuing ongoing examination of how to best deal with this issue.

Q9. Assisted Living Program (ALP) residents are excluded, however the Table 7-A list of FIDA Demonstration services includes ALP. Please clarify.

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Q10. Will the FIDA Plans get a file with all the members at once or will it roll out in increments?

A10. Enrollment and disenrollment transactions will be processed through the State Enrollment Broker. NYSDOH (or its vendor) will submit enrollment transactions to the CMS Medicare Advantage Prescription Drug (MARx) enrollment system directly or via a third-party CMS designates to receive such transactions. CMS will also submit a file to NYSDOH identifying individuals who have elected to disenroll from a FIDA Plan, opt out of passive enrollment, or have enrolled in or have selected another type of available Medicare coverage that is not a FIDA Plan. NYSDOH will share enrollment, disenrollment, and opt-out transactions with contracted FIDA Plans. Once passive enrollment is initiated, it will be phased in over a minimum of a four-month period and will take into account how close Participants are to their Medicaid redetermination date. More detail on the enrollment process will be forthcoming.

Contracting/Credentialing Questions

Q1. Regarding the use of the uniform provider credentialing application, will a Plan's existing network be grandfathered in?

A1. No. A FIDA Plan's existing network would not be grandfathered in. We will provide more information regarding the uniform provider credentialing application in the future.

Q2. When will the Three-way Contract be finalized?

A2. It is anticipated that the Three-way Contract will be available in the first quarter of CY 2014.

Q3. If one is a provider do we need to create FIDA related agreements right away?

A3. The State strongly encourages providers to work closely with the FIDA Plans as they set up their provider networks to understand the nuances of the FIDA Demonstration so that agreements can be developed and completed in a timely manner.

Q4. Are you saying that the FIDA Plans need to contract with every nursing facility in the service area?

A4. All FIDA Plans must enter into contracts or make other payment arrangements with all nursing facilities in the Demonstration Area to ensure Participants' residency and access to services are not interrupted.

Q5. What criteria will be used to determine "nursing home certifiable" FIDA members?

A5. This issue will be discussed further and resolved during development of the Three-way Contract.

Q6. The MOU states that FIDA Plans must enter into contracts or payment arrangements with all nursing facilities in the FIDA Demonstration Area and that participation of nursing facilities may be subject to quality standards. Will FIDA Plans have to contract with nursing facilities that don't meet the standards?

A6. This issue will be discussed further and resolved during development of the Three-way Contract.

Appeals Questions

Q1. Can you talk more about the four levels of appeals, particularly the 2nd, 3rd, and 4th levels? Will the State contract with current Independent Review Organizations to perform this function, or will the State and Federal levels be performed by in-house state and Federal employees?

A1. The grievance and appeals process takes the most consumer-favorable elements of the Medicare and Medicaid grievance and appeals systems and incorporates them into consolidated, integrated systems for the FIDA Demonstration. There are four (4) Levels of Integrated Appeals: 1) Plan-Level Appeal; 2) Integrated Administrative Hearing; 3) Medicare Appeals Council; and 4) Federal District Court. Participants may also file for an Article 78, which is currently available. The second level of appeal will be conducted by the FIDA Administrative Hearing Unit at the State Office of Temporary and Disability Assistance (OTDA). The third and fourth levels are conducted by Federal staff. Additional details on these four levels are found on pp. 24-26 of the 8-29-13 FIDA Demonstration webinar presentation, located at:
http://www.health.ny.gov/health_care/medicaid/redesign/mrt_101.htm

Q2. With respect to the integrated appeals process outlined on pages 76-80 of the MOU, it appears that only one 14-calendar day extension may be requested by the Participant or the FIDA Plan. Is that correct?

A2. The integrated grievance and appeals process includes an extension up to 14-calendar days. An extension may be requested by a Participant or provider on a Participant's behalf (written or oral). The FIDA Plan may also initiate an extension if it can justify need for additional information and if the extension is in the Participant's interest. In all cases, the extension reason must be well-documented, and when the FIDA Plan requests the extension it must notify the Participant in writing of the reasons for delay and inform the Participant of the right to file an expedited grievance if he or she disagrees with the FIDA Plan's decision to grant an extension.

Q3. Is the up to 14-day extension applicable to grievances?

A3. Yes. Page 75 of the MOU indicates that FIDA Plans may extend the 30 calendar day timeframe by up to 14 calendar days, if the Participant or provider on the Participant's behalf requests the extension or if the FIDA Plan justifies a need for additional information and documents how the delay is in the interest of the Participant. When the FIDA Plan extends the deadline, it must immediately notify the Participant in writing of the reasons for the delay.

Fiscal Questions

Q1. Does the prohibition of Fee-For-Service compensation apply to all providers or only those for whom a risk arrangement exists?

A1. The prohibition on Fee-For-Service (FFS) compensation applies to all providers, consistent with the intent of the FIDA Demonstration to move away from a Fee-For-Service model. By December 1, 2014, FIDA Plans will be required to develop a plan for an alternative arrangement with all providers to move away from a FFS compensation model. 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 FIDA Demonstration.

Q2. If a NHTD waiver consumer currently receives NHTD housing and is enrolled into FIDA, will they continue to receive the NHTD housing funding?

A2. One of the recommendations of the Affordable Housing MRT workgroup is to continue the NHTD subsidies in some form for those eligible individuals. It is the State's intent to continue to housing vouchers for certain individuals. The exact specifications have not been developed yet. Funding would be outside the capitation payments for the FIDA Demonstration.

Q3. What are the state and Federal solvency requirements?

A3. CMS and the State have established a standard for all FIDA Plans, as articulated in Appendix 7 (p. 56) of the MOU. FIDA Plans will be required to meet solvency requirements consistent with section 1903(m) of the Social Security Act and regulations found at 42 CFR Parts 43, 422.400, and 438.116 as well as applicable State law and regulations; and as established in the Three-way Contract. A specific document outlining solvency requirements is nearing completion and will be posted on the MRT website.

Q4. What was the rationale for the 3% savings target for Demonstration Year 3?

A4. The 3% savings target was the result of a negotiated agreement between the State and the Federal governments. Research has shown that coordination of care services, especially for duals in Long-Term Care, may result in some savings to both the Medicare and Medicaid programs.

Q5. Will there be a separate rate cell for nursing home-certifiable members living in a nursing home (vs. in the community)?

A5. No. Page 47 of the MOU outlines two proposed rate cells for Participants eligible for the FIDA Demonstration—one rate cell for community non-nursing home certifiable Participants and one rate cell for nursing home certifiable Participants. The nursing home certifiable rate cell will be paid for individuals who meet the standard of NHLOC, as defined by the NYSDOH Approved Assessment Tool, regardless of whether an individual resides in the community or a nursing facility. Using the NYSDOH Approved Assessment Tool, the NHLOC designation will be made by FIDA Plans with NYSDOH review and audits of the assessments. NYSDOH and the New York State Office of the Medicaid Inspector General will jointly develop an audit plan, which is subject to CMS approval. One rate cell for nursing home certifiable individuals will be determined for the entire FIDA Demonstration Area.

Q6. Can you elaborate on what constitutes marketing practices that, as specified in the MOU, is restricted to no earlier than 45 days prior to the effective date of enrollment?

A6. No. The State is still defining what marketing practices are. However, we note that the starting point for definition of marketing under the FIDA Demonstration is the definition as provided in 42 CFR 422.2260 and 42 CFR 423.2260 and in the Medicare Marketing Guidelines. We will provide additional information related to this topic as it is finalized.

Quality Metrics/Readiness Review Questions

Q1. What will the metrics reporting process look like? What will be the provider responsibilities to the FIDA Plan for reporting quality metrics?

A1. FIDA Plans will be required to report measures that examine access and availability, care coordination/transitions, health and well-being, mental and behavioral health, patient/caregiver experience, screening and prevention, and quality of life. This includes a requirement to report Medicare HEDIS, HOS, and CAHPS data, as well as measures related to long-term services and supports. HEDIS, HOS, and CAHPS measures will be reported consistent with Medicare requirements plus any additional Medicaid measures identified by the State. All existing Part D metrics will be collected as well. The State will supplement quality reporting requirements with additional State-specific measures. A combined set of core metrics is described in Table 7-B of the MOU; more detail on the measures will be provided in the Three-way Contract. CMS and the State will utilize the reported measures in the combined set of core metrics for various purposes, including implementation and ongoing monitoring, assessing plan performance and outcomes, and to allow quality to be evaluated and compared with other plans in the model. A subset of these measures will also be used for calculating the quality withhold payment as addressed in section VI of Appendix 6 in the MOU.

Q2. Have you decided on the NYS Approved Assessment Tool?

A2. The Uniform Assessment System – New York (UAS-NY) will be the basis for the tool used to conduct these assessments for Participants. Assessment domains will 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.

Q3. Do we need to use the NYS Approved Assessment Tool for all the events that require reassessment such as "change in diagnosis"?

A3. Yes. The NYSDOH Approved Assessment Tool establishes the protocol used by the FIDA Plans to conduct a comprehensive assessment of each Participant's medical, behavioral health, community-based or facility-based LTSS, and social needs. As stated on page 61 of the MOU, a comprehensive re-assessment and Person-Centered Service Plan update will be performed as warranted by the Participant's condition but:

a. At least every six (6) months after the initial assessment completion date;

b. When there is a change in the Participant's health status or needs;

c. As requested by the Participant, his/her caregiver, or his/her provider; and

d. Upon any of the following trigger events:

i. A hospital admission;
ii. Transition between care settings;
iii. Change in functional status;
iv. Loss of a caregiver;
v. Change in diagnosis;
vi. As requested by a member of the IDT who observes a change that requires further investigation.

Q4. Will the quality metric on nursing home diversion rates only include community-based members?

A4. Yes. The Nursing Facility Diversion Measure reports the number of nursing home certifiable Participants who lived outside the nursing facility during the current measurement year as a proportion of the nursing home certifiable Participants who lived outside the nursing facility during the previous year.

Q5. Will FIDA OPWDD Plans Go Through Readiness with FIDA Plans?

A5. The Office for Persons with Developmental Disabilities (OPWDD) will submit a separate FIDA MOU and related documents to the Centers for Medicare & Medicaid Services (CMS). CMS and NYSDOH will conduct a separate readiness review process for FIDA OPWDD Plans. Information pertaining to the FIDA OPWDD Demonstration and readiness review requirements will be available on the OPWDD website.