New York State Fully Integrated Duals Advantage (FIDA) Demonstration Overview

- In August 2013, a Memorandum of Understanding (MOU) was signed between the Centers for Medicare and Medicaid Services (CMS) and NYSDOH.
- The FIDA Demonstration period is from January 2015 through December 2017.
- To be a FIDA Plan, a plan must be approved as an MLTC plan, be approved as a Medicare Advantage (with prescription drug) plan, and meet all the FIDA requirements.
- Currently, 22 Plans are going through the readiness review process. In early November, Plans will be notified if they are found ready to participate. This is based on many elements such as systems, staffing, network adequacy, marketing, and training.
- Plans have signed a three-way contract with CMS and NYSDOH which is contingent on passing the readiness review process.

FIDA Eligibility:

- Age 21 years of age or older;
- Entitled to benefits under Medicare Part A and enrolled under Part B and D and receiving full Medicaid benefits;
- Living in 1 of the 8 demonstration counties: NYC, Long Island, Westchester
- Also had to Fit 1 of 3 criteria:
    - Require community-based LTSS for more than 120 days,
    - Are Nursing Facility Clinically Eligible and receiving facility-based LTSS, or
    - Are eligible for the Nursing Home Transition Diversion Waiver program.

Implementation:

- There will be 2 Regions that are phased in at different times due to network adequacy issues.
- **Region I**: Bronx, Kings, New York, Queens, Richmond, and Nassau will begin with voluntary enrollment in January 2015 and passive enrollment beginning April 2015.
- **Region II**: Suffolk and Westchester will begin voluntary enrollment in April 2015 and passive enrollment in July 2015.

Key Aspects of FIDA

- Interdisciplinary Team is a defining concept of the FIDA program
    - Modeled on the PACE program except members of the IDT are not employed by the Plans.
    - FIDA Plans are required to use an Interdisciplinary Team (IDT) approach.
    - The IDT, led by an accountable care manager, will ensure integration of the Participant's medical, behavioral health, community-based or facility-based long term services and supports (LTSS), and social needs.
    - The IDT will be based on a Participant's specific preferences and needs, and deliver services with respect to linguistic and cultural competence, and dignity.

- IDT Composition:
  - **Participant** or, in the case of incapacity, an authorized representative
  - Participant's **designee(s),** if desired by the Participant
  - **Primary Care Provider** (PCP) or a designee with clinical experience from the PCP's practice who has knowledge of the Participant's needs
  - **Behavioral Health Professional**, if there is one, or a designee with clinical experience from the professional's behavioral health practice who has knowledge of Participant's needs
  - **FIDA Plan Care Manager**
  - 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
  - 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
- The IDT as a whole is responsible for making coverage determinations as part of service planning.
- All service plans developed by the IDT act as authorizations for those items and services contained within.
- UM has a limited role in FIDA. For example, UM cannot be a member of the IDT.
- Service authorizations may be made by the FIDA Plan through the UM process before the initial care plan is developed by the IDT.
- In between IDT meetings, any additional services the Participant needs that are not already addressed by the current care plan are subject to the Plan's UM process for coverage decisions.

- Integrated Grievances and Appeals (G &A)
  - 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 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 an appeal on behalf of a Participant.
  - 4 levels of appeals:
    - Plan
    - Integrated Administrative Hearings Office
    - Medicare Appeals Council
    - Federal District Court