FIDA Reforms
FREQUENTLY ASKED QUESTIONS

1. Are the slides from the 12/22/15 FIDA Update webinar available?
   A. Yes, the slides are posted on MRT 101 website at https://www.health.ny.gov/health_care/medicaid/redesign/docs/2015-12-22_fida.pdf

2. As of what date did passive enrollment in FIDA stop?
   A. The last phase of passive enrollment occurred in January 2016.

3. Primary Care Providers (PCP) may review and sign off on a completed Person-Centered Service Plan (PCSP) without attending IDT meetings. With that said, any PCP that reviews and signs off on a PCSP does not require IDT training, correct?
   A. Yes, that is correct, Plans are required to encourage training for providers but training is no longer mandatory. Please see the list of reforms and the revised IDT Policy available on the MRT 101 website.

4. Will any of these changes need to be reflected in the Participant Handbook?
   A. Yes, DOH and CMS are revising the Participant Handbook Chapters 1, 3, 4, 8, and 12. Templates will be distributed to all FIDA Plans along with instructions for using an Errata sheet for existing Participants and updating the entire Participant Handbook.

5. Will FIDA become mandatory?
   A. No, FIDA remains a voluntary program for certain eligible individuals residing in New York City and Nassau County.

6. Do you anticipate a need for any statutory changes associated with these program updates?
   A. No, DOH does not envision a need for statutory changes to the FIDA Program. The FIDA policy materials will be updated accordingly.

7. Are patients with Medicaid exception code H9 eligible for FIDA?
   A. No, an individual with a H9 code would not be eligible for FIDA. The H9 code relates to an individual eligible for HARP. An individual is not eligible for FIDA if eligible for or enrolled in HARP.

8. Will the State allow any new FIDA plans to join the program?
   A. No, the State is not considering allowing new plans to join FIDA.

9. Can a person still opt out of FIDA?
   A. Future passive enrollment is suspended until further notice. However, an individual may opt out of FIDA at any time. People who have already opted out can join at any time.

10. How will the new patient satisfaction measures be collected?

A. DOH and CMS will assess the performance of the FIDA Plan´s Interdisciplinary Team (IDT) model against ten existing reporting measures, and FIDA Plans will collect data for these measures as described in the Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements, New York-Specific Reporting Requirements, and CAHPS survey.

Measures CMS/DOH will track to assess participant satisfaction with IDT, per December 9, 2015 FIDA Reforms	
Measure Included in December 9, 2015 FIDA Reforms	***Existing Reporting Requirement***
In the last six months, did anyone from the Participant's health plan, doctor's office, or clinic help coordinate care among these doctors or other health providers?	Measure #OHP3 from CAHPS survey*
How satisfied is the Participant with the help in coordinating care in the last 12 months?	Measure #OHP5 from CAHPS survey*
What is the percentage of Participants discharged from a hospital who were readmitted within 30 days, either for the same condition as their recent hospital stay or for a different reason?	NCQA / HEDIS Plan All-Cause Readmissions
What is the percentage of patients 65 years or older discharged from any inpatient facility and seen within 60 days following discharge by the physician providing on-going care, who had a reconciliation of the discharge medications with the current medication list in the medical record documented?	NCQA / HEDIS, including NY Participant Level Files. The description has changed since the FIDA contract was effectuated. The current description is: "The percentage of discharges from January 1–December 1 of the measurement year for members 18 years of age and older for whom medications were reconciled on or within 30 days of discharge".
What is the total percentage of all Participants who saw their primary care doctor during the year?	Adults' Access to Preventive/Ambulatory Health Services (AAP) HEDIS measure, which captures "The percentage of members 20 years and older who had an ambulatory or preventive care visit."
What is the percentage of Participants in the FIDA Demonstration who reside in a nursing facility (NF), wish to return to the community, and were referred to preadmission screening teams or the Money Follows the Person Program?	This measure was included in the FIDA contract but has since been removed. FIDA Plans are not reporting on this measure.
What is the number of nursing home-certifiable Participants who lived outside the NF during the current measurement year as a proportion to those during the previous year?	Core 9.2 Nursing Facility (NF) Diversion
Follow-up required after Hospitalization for Mental Illness.	Follow-Up After Hospitalization for Mental Illness (FUH) HEDIS measure
Additional Measures DOH/CMS Will Track for Assessing IDT (not included in December 9, 2015 FIDA Reforms)	***Existing Reporting Requirement***
NY 2.3 Participants with first follow-up visit within 30 days of hospital discharge	NY 2.3
Core 3.1 Members, regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted within 24 hours of discharge to the facility or primary care provider or other health care professional designated for follow-up care. (modified from NQF #0648)	Core 3.1
*Not all FIDA Plans are required to conduct the CAHPS survey. Please see the October 9, 2015 HPMS Memo, "UPDATED: Reporting Requirements for 2016 HEDIS®, HOS and CAHPS® Measures, Adding Two Asthma Measures to Table 2".	

11. Are FIDA plans required to pay government rates for behavioral health services?
    A. Yes.

12. Are FIDA plans required to pay government rates for behavioral health services other than Article 31 clinic services; for example, PROS, ACT, Community Residences?
    A. Yes.

13. With regard to ACT billing for FIDA, would the claims use an 837I with the rate code and procedure code/modifier combination reported on the OMH Coding Taxonomy sheet?
    A. Yes.

14. FIDA plans are required to incorporate Part 820 Residential Addiction Services into the network of contracted programs. If such programs are not available, what are plans obligated to do?
    A. OASAS recognizes that Part 820 Residential Addiction Services are not yet available. As such programs become available, FIDA plans must incorporate them into the networks. If such programs are not yet available, plans are not held to the Part 820 contracting requirement.

15. For this population, isn't six months a rather long time to go between assessments when one moves from one plan to another?
    A. Please see the timing of the Comprehensive Assessment as outlined in the IDT Policy. The Policy states, "For these Participants with a pre-FIDA assessment, FIDA Plans must contact Participants and review any available medical record and claims history of that Participant to ensure that there are no changes in the Participant´s health status and needs that would trigger the necessity for an updated assessment. All other Participants must be assessed in a timely manner so that their PCSP can be developed and implemented within 90 days following their effective date of enrollment. The FIDA Plan must also perform the UAS at any time upon the request of the Participant."

16. Can you further clarify if a UAS is needed with every hospitalization or just significant changes to the Participant's condition?
    A. Yes, a FIDA plan must ensure that a Comprehensive Reassessment is performed as expeditiously as possible in accordance with the circumstances and as clinically indicated by the Participant´s health status and needs, and in no case more than 30 days after a trigger event, which includes a hospitalization. Please see the IDT Policy for the timing of Comprehensive Reassessments.

17. How are you handling participants who require 24-hour care? Are there standards regarding what requirements need to be met for someone to receive 24-hour care?
    A. Any eligible individual may participate in the FIDA program, including those that need 24-hour care. FIDA plans must meet the needs of the Participants that are enrolled, including providing 24-hour, community-based care where a comprehensive assessment identifies this as a need.

18. Will FIDA plans be negotiating rates with out-of-network providers?
    A. Yes, but there parameters for out-of-network provider rates. In particular:
        a. For covered items and services that are part of traditional Medicare (i.e., Medicare Fee-For-Service [FFS] benefit package: FIDA Plans pay at least the lesser of the providers' charges or the Medicare FFS rate, regardless of the setting and type of care for authorized OON services.
        b. For nursing facility services that are part of traditional Medicaid benefit package: FIDA Plans pay the Medicaid FFS rate for three years after NH transition to managed care became mandatory in a county (NYC 2/1/15; Nassau 4/1/15).

19. What are the reporting expectations for FIDA?
    A. Please see the reporting requirements outlined in the Three-way Contract, which is available on the FIDA MRT 101 website: https://www.health.ny.gov/health_care/medicaid/redesign/docs/final_three_way_contract_generic.pdf

20. Is there an authorization needed for billing a FIDA plan?
    A. Not all services require prior authorization. The State's requirements around which services require prior authorization are outlined in the Three-Way Contract and in the state's Plan Benefit Package Guidance to plans. Plans have limited discretion in determining which services require authorization. Plans must make information available to providers about which services require prior authorization and which do not.

21. Do you see FIDA plans reimbursing for telemedicine in the near future?
    A. Telehealth is already one of the FIDA covered services. The FIDA plans are already required to reimburse providers for this service as this is already a Medicaid state plan service. FIDA Plans must pay providers for this service according to the fee schedule they agreed on in their contract with the plan.

22. When will plans receive a revised contract reflecting these changes?
    A. In early 2016, the State and CMS will be revising the Three-way Contract to reflect these changes.

23. Will the State or CMS be marketing FIDA?
    A. Yes, the State intends to market the FIDA program in 2016. Also, FIDA plans should be marketing the program as well.

24. Can plans market to senior citizen organizations, church groups, etc.?
    A. Yes. Please see *Final CY 2016 Marketing Guidance for New York's Medicare-Medicaid Plans* [FIDA plans]. The guidance was revised on March 22, 2016.

25. Can the plans be on the phone to assist participants with opting out?
    Yes, FIDA Plans are allowed to stay on the phone with participants when they call Maximus.

26. What happens to Medicaid when a FIDA Participant changes his/her Medicare coverage?
    A. The individual will be transitioned to a MLTC partial plan.

27. Are participants required to pay Part B premiums?
    A. NYSDOH has clarified that the Part B Premium must still be paid by FIDA members not otherwise eligible for Medicare savings program.

28. Will DOH and CMS offer incentives to plans and providers to increase membership?
    A. No, the State and CMS will not be providing additional financial incentives to plans or providers above and beyond the programmatic reforms effective as of December 9, 2016 and the increase to the fee-for-service component of the CY 2016 Medicare Parts A/B baseline rate for FIDA.