Frequently Asked Questions for New York Providers

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Introduction to FIDA

1) What is the Fully Integrated Duals Advantage (FIDA) demonstration?

The Fully Integrated Duals Advantage (FIDA) demonstration program offers an optional new way for beneficiaries to receive their Medicare and Medicaid benefits all together from one managed care plan. Patients who qualify for MLTC and live in certain areas of New York State typically qualify to enroll in a FIDA plan. The goal of this demonstration is to provide beneficiaries with more coordinated insurance that makes it easier for to access the care they need and deserve.

2) What is Medicaid Managed Long Term Care (MLTC)?

Medicaid Managed Long Term Care (MLTC) is a program that provides coverage for Medicaid long term care benefits. If an individual is dually eligible for Medicare and Medicaid and receives ongoing long term care services, they are most likely be required to enroll in—or have already been enrolled in—an MLTC plan in order to receive their Medicaid long term care benefits (see next question for more information). MLTC services are delivered through private managed care plans, and these plans do **not** affect how patients receive their Medicare benefits.

3) What is the difference between MLTC and FIDA?

There are two key differences between MLTC and FIDA. First and most importantly, MLTC plans only provide members' (sometimes known as participants) Medicaid long term care benefits. They do not affect how members receive their Medicare benefits or other Medicaid benefits. On the other hand, FIDA plans provide all of members' Medicaid **and** Medicare benefits.

Second, if a beneficiary qualifies for an MLTC plan, it is typically mandatory for them to enroll in one. If they qualify for a FIDA plan, they can choose whether they want to enroll in one or opt out of the demonstration. Remember that they are automatically enrolled in a FIDA plan if they do not actively choose a FIDA plan or actively choose to opt out of the demonstration.

Eligibility and Enrollment

4) Who is eligible for a FIDA plan?

Patients are eligible for a FIDA plan if they:

- Have **both** full Medicare and full Medicaid;
- Need 4 months (120 days) or more of long term care services provided in the community, or require permanent nursing home care;
- Are age 21 or older; **and**
- Live in the FIDA demonstration area (see question 5).

Keep in mind that enrolling in a FIDA plan is optional. Patients can choose to continue to receive their health care coverage in the same way they are now. However, if they qualify for the FIDA demonstration and do not make an active choice either to enroll in a plan or opt out of the demonstration, they are automatically (passively) enrolled in a FIDA plan. Most FIDA-eligible patients are passively enrolled in a FIDA plan if they do not make an active choice.

Patients can choose to enroll in a FIDA plan but cannot be passively enrolled if they meet the eligibility criteria listed above and:

- Are enrolled in a PACE plan;
- Are enrolled in a Medicare Advantage Special Needs Plan (SNP) for institutionalized patients;
- Are enrolled in the Nursing Home Transition and Diversion (NHTD) waiver program;

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- Have employer or union sponsored coverage for employees or retirees; or
- Are assigned to a CMS Accountable Care Organization (ACO).

Patients are **not** eligible for FIDA if they are:

- In the Traumatic Brain Injury (TBI) or Office for People with Developmental Disabilities (OPWDD) waivers;
- Receiving hospice care;
- In the Assisted Living Program;
- Under the age of 21;
- Receiving services from the Office for People with Developmental Disabilities (OPWDD); or
- A resident of a psychiatric facility.

5) Where is FIDA happening?

FIDA is happening in New York's downstate counties (listed below). FIDA is not rolling out in any county other than the ones listed below, so beneficiaries who live outside of these counties are not eligible to enroll.

- New York City (five counties)
    - New York
    - Kings
    - Queens
    - Richmond
    - Bronx

- Long Island
    - Nassau County

Suffolk and Westchester counties were scheduled to be a part of the FIDA rollout in mid-2015, but FIDA is on hold in both of those counties until further notice.

6) When is FIDA happening?

Beneficiaries who live in New York City or Nassau County were able to choose to enroll in a FIDA plan beginning January 1, 2015. Those who are eligible and did not choose a plan, or actively chose not to enroll in a plan (opt out), began to be automatically enrolled in FIDA plans on April 1, 2015. Automatic enrollment of eligible beneficiaries receiving community-based long term care services (e.g., home health care) continues through the Summer and Fall of 2015. Beneficiaries who have been passively enrolled still have the option to opt out of the demonstration (see question 8). Permanent nursing home residents are enrolled using a different timeline (see question 22).

7) What are a beneficiary's enrollment options?

FIDA-eligible beneficiaries have a few options, including:

- Actively choose a FIDA plan to enroll in (see question 8);
- Actively choose not to enroll in a FIDA plan, also known as opting out (see question 8); **or**
- Do nothing and be automatically enrolled (also known as passively enrolled) in a FIDA plan.

Remember, beneficiaries are **not** required to enroll in a FIDA plan. Additionally, it is best for beneficiaries to actively choose a FIDA plan or actively opt out when FIDA is launched in their county. If they do nothing, the plan they are automatically enrolled in may not be the plan that best fits their needs.

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Beneficiaries who opt out of FIDA continue to receive their health care coverage as they do now. This means they go back to receiving their long term care services through their former MLTC plan. If they choose to enroll in a FIDA plan or are automatically enrolled in a FIDA plan, they begin to receive all of their Medicare and Medicaid benefits through their new FIDA plan.

8) How do beneficiaries enroll in a FIDA plan or opt out of the FIDA demonstration?

To enroll in a FIDA plan, a beneficiary should call New York Medicaid Choice. New York Medicaid Choice's number is 855-600-FIDA (855-600-3432) and website is www.nymedicaidchoice.com. Keep in mind that New York Medicaid Choice has a different number for the FIDA demonstration than for the MLTC program.

To opt out of the FIDA demonstration, a beneficiary should either call New York Medicaid choice at 855-600-FIDA (855-600-3432) or 800-Medicare. New York Medicaid Choice or Medicare walks them through that process.

New York Medicaid Choice helps beneficiaries compare FIDA plan options and enroll in the plan they choose. See question 10 to learn more tips for beneficiaries to use to choose the plan that is best for them. When a beneficiary chooses a plan, coverage begins the first of the following month if enrollment occurs before noon on the 20th of the month. If it occurs after that, coverage begins the first of the month, two months later. For example, if a beneficiary enrolls in a plan on February 15th, their coverage begins on March 1st. If they enroll in a plan on February 22nd, their coverage begins on April 1st.

Keep in mind that beneficiaries can switch their FIDA plan or choose to opt out of FIDA at any time during the year. If a beneficiary enrolls in a FIDA plan and later chooses to opt out of FIDA, they are able to choose how they would like to receive their Medicare coverage (through Original Medicare or a Medicare Advantage plan). In most cases, they are able to go back to receiving their health coverage in the same way as before. However, if a beneficiary was in the Nursing Home Transition and Diversion Waiver (NHTD) before they enrolled in a FIDA plan, they have to reapply for the NHTD program.

9) If a beneficiary is automatically (passively) enrolled in a FIDA plan, how is their plan chosen for them?

Beneficiaries who do not actively choose a FIDA plan or actively opt out of the FIDA demonstration are automatically (passively) enrolled into a FIDA plan. If a beneficiary already had an MLTC plan and the same company offers a FIDA plan, they are enrolled in that company's FIDA plan. However, the providers and pharmacies they use **may not** be in their new FIDA plan's network, so they should not rely on passive enrollment to ensure that all of their coverage needs are met.

The FIDA plan they are automatically enrolled in sends them enrollment materials 30 days (one month) before the date they are automatically enrolled. However, they still have the opportunity to actively enroll in a different plan or actively opt out of the FIDA program up to the day before they are passively enrolled. Once they are passively enrolled, they can choose to switch plans or opt out of the program up to once per month.

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Coverage and Choices

10) If a beneficiary chooses to enroll in a FIDA plan, how do they choose the plan that is best for them?

To find the best FIDA plan for them, a beneficiary should follow the steps below. Remember, they can switch their plan or opt out of the FIDA demonstration at any time during the year.

- Beneficiaries should make a list of all of the health providers they use (primary care doctors, specialists, long term care agencies, and any others), the drugs they take, and the pharmacies they use.
- Beneficiaries should call New York Medicaid Choice at 855-600-FIDA (855-600-3432).
- Beneficiaries should look tell Medicaid Choice which health providers they use, drugs they take, and pharmacies they use. Medicaid Choice helps the beneficiary find a plan that includes all or most of their health providers, drugs, and pharmacies.
    - Beneficiaries should look for a plan that includes all or most of their health care providers. If a provider is not in the FIDA plan's network, they may have to switch to a different provider that is in-network to avoid paying out of pocket for their care.
    - Beneficiaries should also look for a FIDA plan that includes all of the prescription drugs they take on its list of covered drugs (formulary). If their drugs are not on the formulary, they may have to switch to a different drug or pay out of pocket for their drug.
    - Finally, beneficiaries should look for a plan that includes the pharmacies they use as in-network pharmacies. They may have to pay the full cost of their drugs if they go to a pharmacy that is out-of-network.

New York Medicaid Choice helps beneficiaries sort through their FIDA plan options. New York Medicaid Choice enrolls beneficiaries in the plan they choose. See question 8 for more information about when coverage begins.

11) If a beneficiary enrolls in a FIDA plan, are they able to get the same level of care as before?

FIDA does not change the amount or type of care a beneficiary is eligible to receive. Additionally, if they enroll in a FIDA plan, they should be able to receive the same amount of care from the same providers for a transition period of 90 days (3 months) or when their care plan is complete, whichever is longer.

There are additional protections if a beneficiary is in a nursing home or has a mental health provider. If they are in a nursing home at the time they enroll in a FIDA plan, the nursing home stay and care continues to be covered for as long as they need it, even if the nursing home is not in network. Additionally, if they are receiving mental health care, the care from that provider continues to be covered for two years, or for as long as the health episode requiring the care lasts, whichever is shorter.

Once a beneficiary enrolls in a FIDA plan, the plan sends a nurse to conduct a care assessment. Based on the assessment, the IDT determines a new care plan. The beneficiary should receive a copy of the care plan that lists the services the IDT feels they should receive. If they do not agree with the care plan, they can file an appeal (see question 24). Remember, they can also switch to a different plan or opt out up to once per month at any time during the year.

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12) What assessments are conducted to determine FIDA enrollees' care needs?

An individual must first be certified to need 120+ days of community-based long term care before they can enroll in a FIDA plan (see question 4). Later in 2015, certain permanent nursing home residents will be eligible (see question 22). When an individual requests ongoing long term care services, the Conflict-Free Evaluation and Enrollment Center (CFEEC) sends a nurse to the individual's home to assess whether they need 120+ days of long term care. To schedule an evaluation, an individual can call the CFEEC at 855-222-8350.

Once the beneficiary has enrolled in a FIDA plan, they receive a comprehensive assessment. This assessment is used by the IDT (see question 14) to create the Person-Centered Service Plan (PCSP). The comprehensive assessment is conducted by a nurse at the plan and must include social, functional, medical, behavioral, wellness and prevention domains, caregiver status and capabilities, as well as the members' preferences, strengths, and goals. The nurse should get information from the beneficiary, the beneficiary's health care providers, and the beneficiary's family members and caregivers when completing the assessment. If the beneficiary actively enrolled in a FIDA plan, the assessment should be completed within 30 days of enrollment. For beneficiaries that were automatically (passively) enrolled in a FIDA plan, the assessment should be completed within 60 days of enrollment.

The IDT uses the assessment to create the PCSP, which outlines all of the care that a member needs. The PCSP should be completed within 30 days of the assessment. The PCSP should be updated as often as needed, with a minimum of every six months. If there are any changes in a member's health status, the PCSP needs to be updated. The IDT is authorizing coverage for all care outlined in the PCSP. If a member requires additional care that is not outlined in the PCSP, the plan can authorize it as needed. Certain services are not in the PCSP and always require plan pre-authorization, such as dental and vision services. Any coverage decisions made by the IDT or by the plan can be appealed (see question 24).

Benefits for Patients and Providers

13) What benefits are provided by a FIDA plan?

FIDA plans provide all of a beneficiary's Medicare and Medicaid benefits. These include Medicare health benefits and Medicare prescription drug benefits, as well as all Medicaid health benefits, long term care benefits, and prescription drug benefits. For the benefits that FIDA covers, there is no cost sharing (the beneficiary does not have any costs). In addition to the existing benefits, FIDA provides a new benefit called the Interdisciplinary Care Team (IDT).

14) What is the IDT?

The IDT is a group of professionals and family members who develop a member's plan of care (known as the Person-Centered Service Plan or PCSP), which outlines the care a member should receive and how they should receive it. A plan of care should address all of a member's social, functional, medical, behavioral, wellness and prevention domains, caregiver status and capabilities, as well as the member's preferences, strengths, and goals. The IDT also provides ongoing coordination of care and helps to decide if the plan covers a beneficiary's care. The IDT includes:

- The member, if they choose to be a part of it;
- The member's caregiver(s) or family member(s), if the member chooses to have them be a part of it;

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- The member's care manager, the professional who is the contact/representative from the FIDA plan and who leads the IDT and helps coordinate the member's care;
- The member's primary care doctor or a representative of the primary care doctor (e.g., a nurse practitioner);
- The member's behavioral health provider or representative, if the member has one;
- The member's home care aide(s) or a representative from the home care agency, if the member receives home care;
- A representative from the member's nursing home, if the member receives care in this setting; and
- Anyone else the member wants to have on their IDT.

The IDT must meet at least every six months to reassess the member's needs, but may decide to meet more often if the member's medical needs change. Also, a nurse must provide a comprehensive reassessment within 30 days if the member, their provider, or their care manager requests one. The member should also get reassessed within 30 days if any of the following occur:

- The member has a hospital stay
- The member is moving care settings
- The member's ability to function changes
- The member loses their caregiver
- The member is diagnosed with a new condition or their condition changes.

15) What are the potential benefits of FIDA for providers?

FIDA promises to increase care coordination for patients, which also has benefits for providers, including increasing meaningful communication between:

- Providers and insurance companies
- Providers, patients, and caregivers
- Providers who care for the same patient
  And
- Support offered to provider by the FIDA member's care manager, helping reduce the provider's workload and need to check in with patients about all aspects of care.

Removing communications barriers increases the speed and precision of patient care and decision-making. It is hoped that greater coordination leads to patients requiring fewer doctors visits and fewer hospitalizations, saving providers time in the long run.

16) What are IDT meeting requirements for providers?

Providers must attend a patient's IDT meetings but **can do so telephonically.** Providers can also send a representative to attend an IDT meeting for them (telephonically or in person). Some FIDA plans are reimbursing providers/ representatives for time spent attending IDT meetings. Physicians, Physician's Assistants, and Nurse Practitioners should the IDT meeting to share their experiences working with the patient, discuss the patients' diagnoses, prescribed medications, etc. Social services providers should share the services the consumer is currently receiving and other discussed/potential needs. Long term care providers and home health aides should do the same. All discussions should happen within the context that the PCSP reflects the beneficiary's needs and goals for care improvement. The provider serving as the patient's primary care provider for the purposes of the IDT meeting (this person can be a Physician's Assistant, Nurse Practitioner, or specialist) must sign off on the PCSP.

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Payment for Providers

17) How are providers and facilities paid under the FIDA demonstration?

FIDA plans must develop a plan for a fully integrated payment system through which participating providers are no longer paid on a traditional fee-for-service basis but instead receive a bundled payment from plans. This bundled payment structure begins in 2016.

Similar to Medicare Advantage plan reimbursement, each FIDA plan has its own claims submission process. Plans must pay all approved electronic claims within 30 days of receipt and paper claims within 45 days of receipt.

There is no need to bill multiple parties (e.g., NYS Medicaid, other health plans for cost sharing) as the FIDA Plan pays providers in full. Each Plan must distribute a Participating Provider Manual (updated annually) to the providers in their Plan's network by with information containing provider billing practices and claims submission processes.

Plans must develop a plan for a fully integrated payment system as an alternative to the traditional fee-for-service method by July 1, 2015 (pay for performance, bundled payment, etc.). The alternative payment system goes into effect no earlier than January 2016.

18) How are providers notified about participation in FIDA?

This depends on 1) whether the provider is part of an umbrella network, like a hospital system; 2) whether the provider already participates in plan networks; and 3) whether the provider has FIDA patients.

- Providers who work at hospitals or facilities do not have to contract with plans directly. Instead, speak to a hospital or facility administrator to find out which FIDA plans your facility accepts.
- Providers who are not affiliated with an umbrella system but who do participate in the networks of Medicare Advantage and/or MLTC offerings from insurance companies that also provide FIDA offerings should be contacted by the plan to join the network of their FIDA offering.
- Providers who are not affiliated with an umbrella system but who do see patients that join FIDA plans are contacted by those plans and given the steps to join that plan's network.

Providers in all three categories are given the steps to become a FIDA plan's in-network provider. The first step for all providers is to take a FIDA training course provided by New York State Department of Health. To learn more about the training click here or visit the Medicaid Redesign section of www.health.ny.gov.

If you work independently of a hospital system, know you have patients who qualify for FIDA, but have not heard from a FIDA plan about joining their network, 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/enrollment/check-enrollment.aspx

19) During the 90 days of continuous coverage, does an out-of-network provider need authorization to accept out-of-network payments from FIDA plans?

The FIDA plan should contact each provider the patient sees during this period, 1) sending him or her an authorization form so they can accept payments from plans with which they are not affiliated and 2) encouraging the provider to become part of the FIDA plan so that the patient can continue to see

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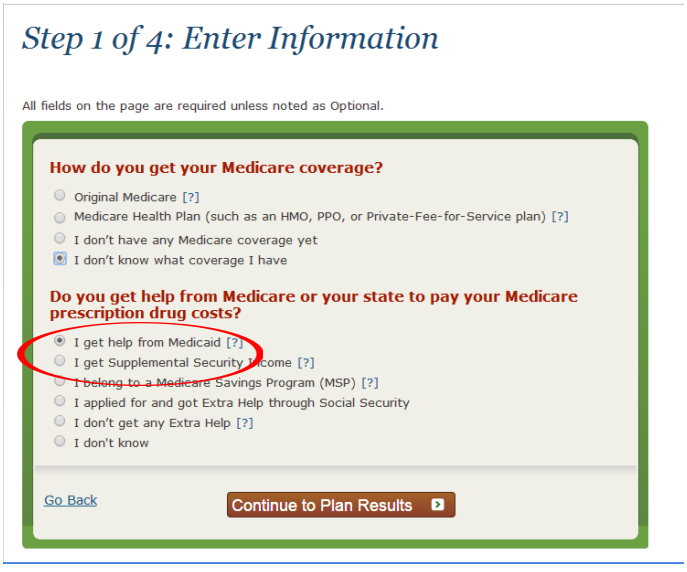
him or her beyond the 90-day transition period. See question 18 for more about becoming a FIDA provider.

Tips for Providers

20) Do FIDA plans post their formularies so that providers can discuss drug options with patients?

Yes, the best place to find whether a FIDA plan works for a specific patient is the Medicare Plan Finder Tool (www.medicare.gov/find-a-plan). Please see a step-by-step tutorial of how to use the Plan Finder to find a plan that covers all of your patient's drugs below.

Enter patient's information in the **Personalized search** box. If you are doing a general search, enter appropriate zip code into the **General search** box. Select **Find Plans.**



To find FIDA-specific plan information, fill out the first question's radio buttons as appropriate, then always select the **I get help from Medicaid** radio button in answer to the second question. Select **Continue to Plan Results.**

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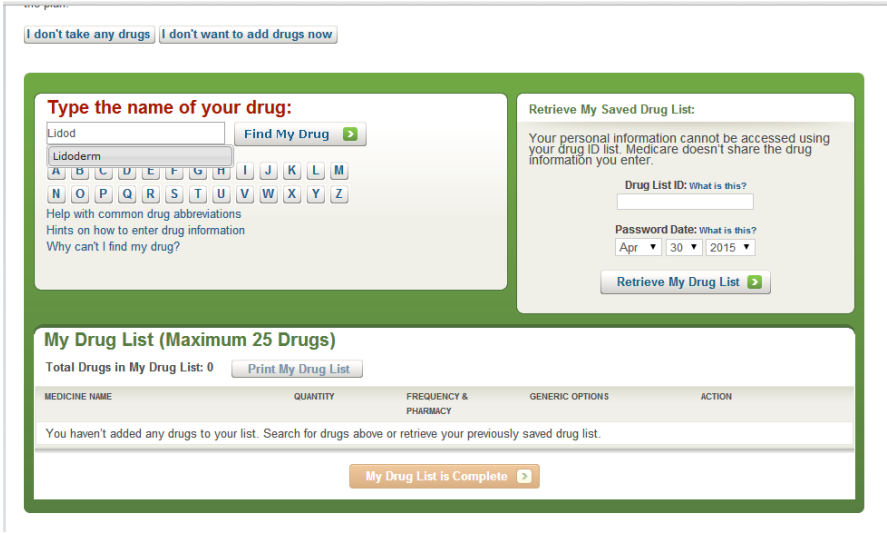
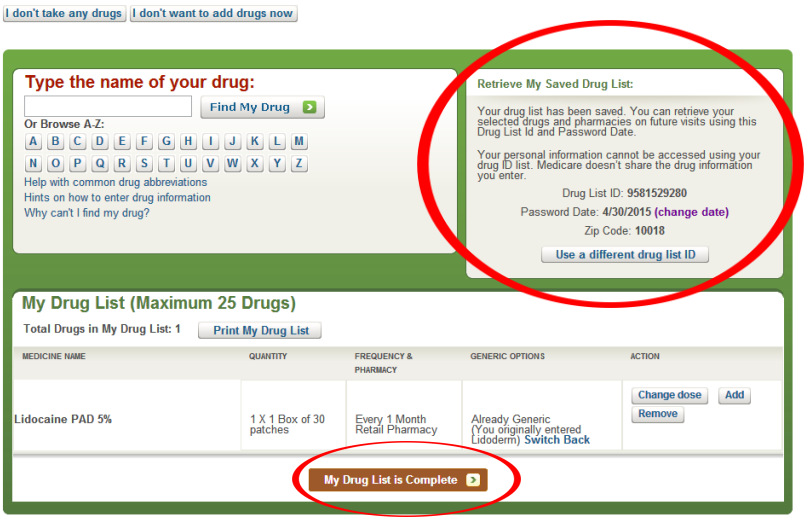


If you are doing a specific search for a patient, enter their drugs in the drug selector tool. The patient's plan results change based on their specific needs. If you are not doing a specific search, select **I don't want to add drugs now.**



If you are doing a specific search for a patient, save their Drug List ID and Password Date before selecting **My Drug List is Complete.**

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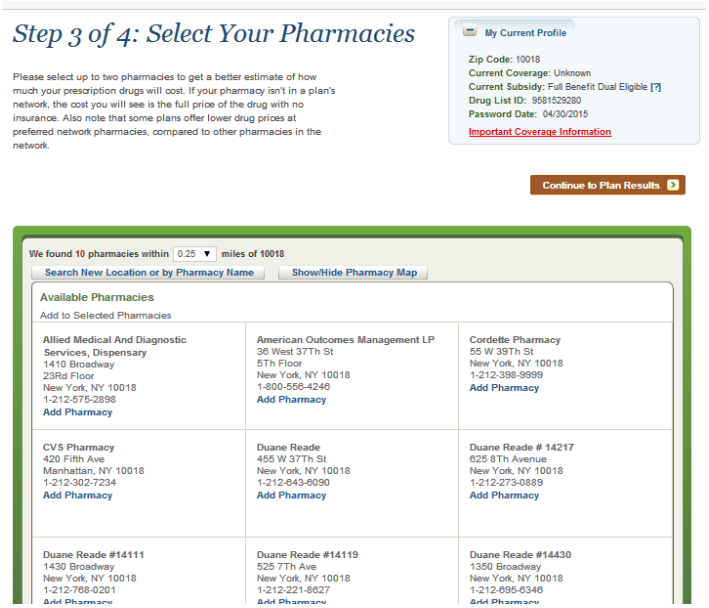
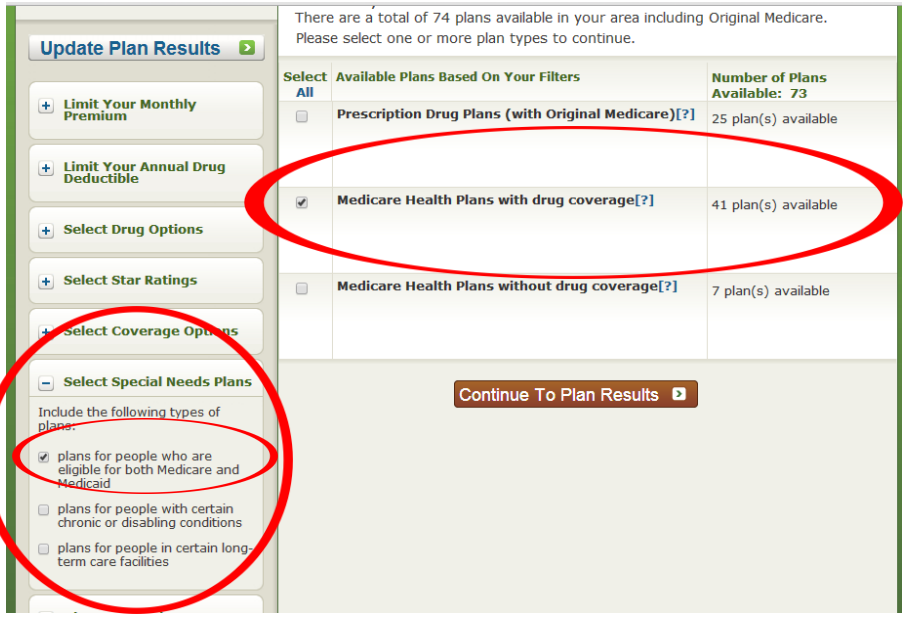


If you are doing a specific search for a patient, select the pharmacy or pharmacies they use. You may select up to two pharmacies. Select **Continue to Plan Results.** If you are not doing a specific search for a patient, the Plan Finder tool skips this page automatically.



On the **Refine your Plan Results** page, open **Select Special Needs Plans** in the left-hand column. Within the dropdown, select **plans for people who are eligible for both Medicare and Medicaid.** Finally, in the middle of the page, select **Medicare Health Plans with drug coverage.** Select **Continue to Plan Results.**

A list of relevant FIDA plans is generated based on the medications and pharmacies selected earlier.

21) Do FIDA plans post their networks so providers can discuss provider options with patients?

Yes, FIDA plan websites post networks and formularies. Each plan's website can be found below.

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Plan Name	Plan Website
Aetna Better Health FIDA	http://www.aetnabetterhealth.com/ny/members/fida/
AgeWell New York FIDA	http://www.agewellnewyork.com/join-a-plan/fully-integrated-duals-advantage-fida/
AlphaCare Signature FIDA	http://www.alphacare.com/ac-plans/fida.aspx
ArchCare Community Advantage FIDA	https://www.archcare.org/health-plans/archcare-community-advantage
CenterLight Healthcare FIDA	http://www.centerlighthealthcare.org/fida/
Centers Plan for Healthy Living - FIDA Care Complete	http://www.centersplan.com/fida/home/
Elderplan FIDA Total Care	http://elderplanfida.org/
EmblemHealth Dual Assurance FIDA	http://www.emblemhealth.com/Our-Plans/FIDA/Plans/2014-FIDA-Plan/EmblemHealth-FIDA.aspx#phcontent_1_plan_description
Fidelis Care FIDA	http://www.fideliscare.org/en-us/products/fullyintegrateddualsadvantage(fida)(medicare-medicaidplan[mmp]).aspx
GuildNet Gold Plus FIDA	http://www.lighthouseguild.org/health-plans/guildnet-gold-plus-fida-plan
Healthfirst AbsoluteCare FIDA	http://healthfirst.org/health-insurance/absolutecare/
HealthPlus Amerigroup FIDA	https://www.myamerigroup.com/fida/Pages/aboutus.aspx
ICS Community Care Plus FIDA	http://www.icsny.org/care-plus/
Integra FIDA	http://www.integraplan.org/fida/
MetroPlus FIDA	http://www.metroplus.org/get-health-insurance/health-plans/fida?xx=xz&lang=en-US
North Shore-LIJ FIDA LiveWell	http://nslijhealthplans2.stage.bluespiremarketing.net/fidalivewell/
RiverSpring FIDA - ElderServe	http://www.riverspringfida.org/
SWH Whole Health FIDA	http://www.seniorwholehealth.com/home/members-new-york/swh-whole-health-fully-integrated-duals-advantage-fida/welcome-members.html
VillageCareMAX Full Advantage FIDA	http://www.villagecaremax.org/fida/
VNSNY Choice FIDA Complete	https://www.vnsnychoice.org/for-our-members/member-materials
WellCare Advocate Complete FIDA	https://fida.wellcareny.com/member/default

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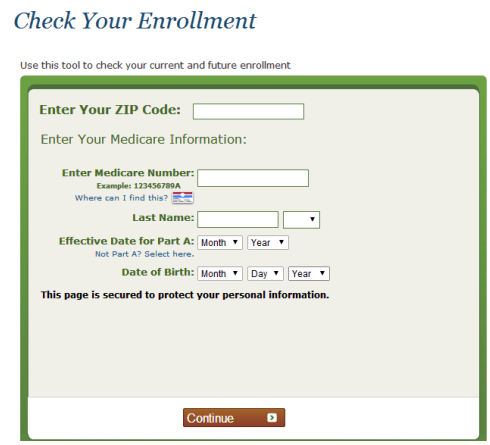
22) How do I know what sort of coverage a patient has?

Confirm the beneficiary's current enrollment and coming month's enrollment via:

- The Medicare Check Your Enrollment Tool (https://www.medicare.gov/find-a-plan/enrollment/check-enrollment.aspx). Input the beneficiary's Medicare information in this tool. Their current coverage generates on the next page.



- New York Medicaid Choice (855-600-3432)
- 800-Medicare (800-633-4227)

FIDA and Nursing Home Residents

23) How does FIDA affect permanent nursing home residents?

People who are nursing home residents before February 1, 2015, are covered by fee-for-service Medicaid and do not have to enroll in MLTC. These patients are not going to be passively enrolled into FIDA. New nursing home residents (moved to nursing homes after February 1, 2015) have to take an MLTC plan. New nursing home residents (moved to nursing homes after February 1, 2015) can opt into FIDA after October 1,2015. Passive enrollment for new nursing home residents will take place, but it is not yet scheduled.

For additional details on permanent nursing home residents and New York State duals demonstrations please click here or visit the Medicaid Redesign section of www.health.ny.gov.

24) How does FIDA affect short-term nursing home residents?

Patients who receive short-term nursing home or skilled nursing facility care may be subject to the FIDA enrollment timeline outlined in question 4 if they meet all the FIDA eligibility criteria outlined in question 2. In other words, if a short-term nursing patient is otherwise eligible for FIDA, they should be passively enrolled in 2015.

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FIDA Appeals and Grievances

25) What can beneficiaries do if they disagree with their FIDA plan's or IDT's care decision?

If a beneficiary disagrees with their FIDA plan's or IDT's care decision, they should appeal. An appeal is a formal request for the FIDA plan to reconsider its care decision. If a plan or IDT denies, reduces, or ends a member's care, the individual has the right to appeal. The plan must provide members written notice of its decision and their appeal and grievance rights whenever the IDT develops or updates their plan of care, or the plan or IDT makes a decision regarding care that is not included in the plan of care. The bullet points below review the steps to appeal. See question 26 for more information about filing a grievance, which is a formal complaint to the plan.

It is important to know that, if a member starts their appeal within 10 days of receiving notice of the plan's decision, or by the day their care was supposed to be reduced or ended, they can continue receiving the same amount of care during the appeals process, which is also known as aid continuing. As long as the member continues to meet appeal deadlines, the care continues to be covered through the Medicare Appeals Council (MAC) level of appeal. If a member meets these requirements, the plan cannot charge them for care they received during the appeal, even if they lose the appeal.

Additionally, keep in mind that members continue to use the existing Medicare Part D appeal process for most prescription drugs. Members also continue to use the same Medicare appeals process when they disagree with a hospital discharge. Visit www.medicareinteractive.org to learn more about these Medicare appeal processes. The following process is only if a member is appealing a coverage decision about their non-prescription and non-hospital health services:

- The member receives a written notice of their appeal and grievance rights when their plan or IDT denies, reduces, or ends their care.

- The member should follow the instructions on the notice to file an appeal with their plan within 60 days. For standard appeals, the plan should make a decision within 30 days. For expedited appeals, the plan should make a decision within 72 hours (3 days). Expedited appeals can be filed if the member believes they need the care right away.
    - Reminder: If the member appeals within 10 days of receiving the denial, the plan must continue care during the appeal.
- If the appeal is approved by the plan, the member's care is covered. If it is denied, the appeal is automatically be sent to the FIDA Administrative Hearing Unit at the New York State Office for Temporary and Disability Assistance (OTDA). The OTDA should issue a decision within 90 days for standard appeals and 72 hours for expedited appeals.
- If the appeal is approved by the OTDA, the member's care is covered. If it is denied, the member can choose to continue to the next level by filing an appeal with the Medicare Appeals Council (MAC) within 60 days of the OTDA denial. The MAC should issue a decision within 90 days.
- If the appeal is still unsuccessful, the member can file an appeal with the Federal District Court. There is no timeframe for the District Court to make its decision.

If a member's appeal is denied, the scheduled change in their care occurs. If the appeal is approved, the member can receive the amount/type of care that was requested.

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26) If a patient with FIDA is admitted to a Medicare Part A-covered skilled nursing facility (SNF) and at some point no longer needs skilled care so is dropped from skilled to custodial care, do they retain their right to appeal to the Quality Improvement Organization (QIO)?

Discharge appeals for FIDA members follow Medicare appeals regulations and timelines; they are not part of the FIDA integrated appeals process. This means hospitals must provide the **Important Message from Medicare** to FIDA patients before discharge. This document explains patient rights and lists next steps in discharge appeals.

FIDA members should follow instructions in their **Important Message from Medicare** and request review by the Quality Improvement Organization (QIO). This request must be made by noon of the first business day after receipt of notice. QIO has one business day to make a decision about the hospital discharge.

If the FIDA members misses this deadline, they can file an oral or written request for an expedited, 72-hour FIDA plan appeal. QIO makes a decision within one business day after receipt of the request, records, and any other information needed to make the decision. If QIO overturns the FIDA plan's decision, the plan must pay for the remainder of the hospital stay.

Some dually eligible individuals whose Medicare-covered services are being terminated or reduced can still receive Medicaid-covered care. For example, a beneficiary whose SNF care is being terminated because they no longer have a skilled need can receive Medicaid-covered non-skilled care in the same (or similar) facility. In this case, the FIDA member may not need to appeal the reduction/termination in care, since the Medicaid part of their FIDA benefit covers the needed custodial/non-skilled care. Beneficiaries should only appeal to continue Medicare-covered services. Beneficiaries in inpatient settings (or their caregivers) should be in regular contact with their FIDA plan's care manager to make sure that appropriate care is being provided and that is covered.

27) How do members file a complaint (grievance) with their FIDA plan?

A grievance is an official complaint that FIDA members file with their plan. It is **not an appeal** and is not a request to get care covered. Instead, it is a complaint about something the plan has said or done. Members can file a grievance over the phone or in writing.

- Members must file a grievance within 60 days of the incident they are filing about. They can file a grievance through their care coordinator, by calling the plan using the number on their FIDA card, or by sending a letter to their FIDA plan.
    - Make sure the member includes as much information as they can about the incident(s) they are filing the grievance about.

- The plan must respond to the grievance within 30 days of receiving the grievance.
    - However, if the member or their health care provider believes they need a quicker decision to avoid serious harm to the member's health or ability to function, an expedited grievance can be filed. For an expedited grievance, the FIDA plan must usually make a decision within 48 hours of receiving all information, and no more than 7 days in total.

If a member is filing a grievance, they may also want to file a complaint with Medicare by calling 800-Medicare and asking to file a complaint in the complaints tracking module (CTM). Members can also file grievances and complaints by contacting the Independent Consumer Advocacy Network (ICAN) at 844-614-8800.

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28) Where should FIDA members go if they have questions about or problems with their plan?

There are a few different resources for members, depending on their question or problem:

- The FIDA plan provides them with a care manager. Their care manager should be able to answer their questions about plan benefits and network. If they do not know who their care manager is, they should call the number on their FIDA card.
- All members can always contact the FIDA/MLTC Ombudsman in New York State called the Independent Consumer Advocacy Network (ICAN) at 844-614-8800.
- If members have a question about switching or enrolling in an FIDA plan, they should call New York Medicaid Choice at 855-600-FIDA (855-600-3432) or go to www.nymedicaidchoice.com.
- If members have a complaint about their FIDA plan, they can call the New York State Department of Health Complaint Hotline at 866-712-7197.
    - They can also file a grievance with their FIDA plan, which is a formal complaint about an FIDA plan's actions or decisions (see question 26). In some cases, they may want to file both an appeal and a grievance.
- They can also file a complaint about their FIDA plan with Medicare by calling 800-Medicare.

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