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Health Pulse

State to end FIDA program for dual eligible beneficiaries

The state is abandoning an insurance product meant to provide integrated care for dual Medicare and Medicaid beneficiaries and better manage their health care costs.

Its Fully Integrated Duals Advantage program will end Dec. 31, and the 2,700 members enrolled in the program can pick a new plan. But if they do nothing by Dec. 20, they will be moved into a comparable Medicaid Advantage Plus product offered by their insurer on Jan. 1.

Members would then receive benefits through the Medicaid Advantage Plus plan and a Medicare Advantage Dual Eligible Special Needs Plan offered by the same company.

The transition to MAP "offers an opportunity for participants to continue receiving integrated care and care coordination for their Medicare and Medicaid benefits," the state Department of Health wrote in its phase-out plan.

The six insurers remaining in FIDA that are taking part in the transition are Centers Plan, Elderplan, Healthfirst, RiverSpring, Senior Whole Health and VNSNY Choice.

The state had big plans for FIDA when it initially projected about 118,000 residents in New York City, Long Island and Westchester County would be enrolled in the program in 2014. FIDA wraps a person's Medicare and Medicaid benefits into one plan and one membership card. It also assigned members to a care team that includes their doctor, care manager and other providers.

The program was focused on better managing the health care costs of people who are dually eligible for Medicare and Medicaid, who tend to visit the hospital more frequently and require more expensive care. The per-person average monthly cost for a dually-eligible beneficiary was $2,532, or three times the cost Medicare paid for Medicare-only members, according to a national study cited by the Citizens Budget Commission.

But burdensome regulations hobbled the program early on. Doctors were wary and in some cases counseled patients to opt out of the state's automatic enrollment process. Restrictions also were placed on how insurers could market it. By late 2015 about 60,000 people had opted out, and around 7,500 were enrolled across 17 insurers.

Even after easing marketing rules for insurers and conducting outreach to doctors, the plans failed to gain traction and the state Department of Health did not ask the Centers for Medicare and Medicaid Services to extend the program beyond Dec. 31.

Patient advocates are now advising members to make sure their preferred doctors are in their new plan's network and their drugs are included on the plan's formulary.

The Medicaid plans that accept former FIDA enrollees are required to continue providing services under the member's existing care plan either for 120 days after enrollment or until the insurer conducts an assessment and the member agrees on the new care plan, whichever comes first.

"Dual eligibles in need of long term care have faced numerous changes including the closures of many MLTC plans," said Rebecca Novick, director of the health law unit at the Legal Aid Society. "With all of these transitions, we have seen many clients for whom it worked seamlessly but others who have received misinformation from plans and faced disruptions in care. In addition to responding to complaints received, this is an opportunity for additional oversight by DOH to make sure no one loses care without due process."