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Financial Alignment Initiative New York Fully Integrated Duals Advantage (FIDA) Program First Evaluation Report

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FINANCIAL ALIGNMENT INITIATIVE: NEW YORK FULLY INTEGRATED DUALS ADVANTAGE (FIDA) FIRST EVALUATION REPORT

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Glossary of Acronyms

AAA	Area Agency on Aging
ADL	Activities of daily living
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CCIP	Chronic care improvement project
CMS	Centers for Medicare & Medicaid Services
CMT	Contract Management Team
C-SNP	Chronic Care Special Needs Plan
CTM	Complaint Tracking Module
D-SNP	Dual Eligible Special Needs Plan
FIDA	Fully Integrated Duals Advantage, the name of New York's demonstration
FIDE-SNP	Fully Integrated Dual Eligible Special Needs Plan
HCBS	Home and community-based services
HEDIS	Health Effectiveness Information and Data Set
HIICAP	Health Insurance Information, Counseling and Assistance Program
HMO	Health maintenance organization
HRA	The New York City Human Resources Administration
IAHO	Integrated Appeals Hearing Office
ICAN	Independent Consumer Advocacy Network
IDT	Interdisciplinary team
I-SNP	Institutional Special Needs Plan
LTSS	Long-term services and supports
MA	Medicare Advantage
MAC	Medicare Appeals Council
MAP	Medicaid Advantage Plus

MAPD	Medicare Advantage Prescription Drug plan
MAXIMUS	The enrollment broker for the demonstration
MCO	Managed Care Organization
MFFS	Managed fee-for-service
MLTC	Managed Long Term Care
MLTSS	Managed long-term services and supports
MMCO	Medicare-Medicaid Coordination Office
MMP	Medicare-Medicaid Plan
MOC	Monitoring and oversight coordinator
MOU	Memorandum of Understanding
MRT	Medicaid Redesign Team
NF	Nursing facility
NHTD	Nursing Home Transition and Diversion (waiver)
NYSDOH	New York State Department of Health
OQPS	NYSDOH Office of Quality and Patient Safety
OTC	Over-the-counter
PACE	Program of All-Inclusive Care for the Elderly
PBP	Plan Benefit Package, the set of benefits an MMP offers
PCP	Primary care provider (physician or physician's designee)
PCSP	Person-centered service plan
PMPM	Per member per month
QIP	Quality improvement project
SDRS	State Data Reporting System
SHIP	State Health Insurance Assistance Program
SNP	Special Needs Plan

UAS-NY	Uniform Assessment System for New York
UM	Utilization management
WMS	Welfare Management System, a data system administered by the HRA

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Executive Summary

The Medicare-Medicaid Coordination Office and the Innovation Center at the Centers for Medicare & Medicaid Services (CMS) have created the Medicare-Medicaid Financial Alignment Initiative to test, in partnerships with States, integrated care models for Medicare-Medicaid enrollees. CMS contracted with RTI International to monitor the implementation of the demonstrations and to evaluate beneficiary experience, quality, utilization, and cost. The evaluation will include a final aggregate evaluation report and individual State-specific reports.

New York and CMS launched the Fully Integrated Duals Advantage (FIDA) demonstration on January 1, 2015, to integrate care for Medicare-Medicaid beneficiaries in one of two demonstration regions. Initially, 22 plans were determined to be qualified to operate Medicare-Medicaid Plans (MMPs) in the demonstration. MMPs receive capitated payments from CMS and the State to finance all Medicare and Medicaid services. MMPs also provide care coordination and flexible benefits that vary from plan to plan.

Eligibility for FIDA is limited to those age 21 or older at the time of enrollment; entitled to benefits under Medicare Part A and enrolled in Medicare Parts B and D, and receiving full Medicaid benefits; residing in a FIDA demonstration county; and requiring a nursing facility level of care or 120 days of community-based long-term care. New York's FIDA comprises two regions. Region 1 covers five counties corresponding to the five boroughs of New York City (Bronx, Kings [Brooklyn], New York [Manhattan], Queens, and Richmond [Staten Island]), and Nassau County in Long Island. Enrollment in Region 1 began January 1, 2015. Region 2 covers Westchester and Suffolk counties. Region 2 enrollment was deferred until 2017 and will be discussed in the second evaluation report.[1]

This first evaluation report for the New York demonstration describes implementation of the New York FIDA demonstration and early analysis of the services used by New York demonstration eligible beneficiaries. The report includes findings from qualitative data for the demonstration from its initiation on January 1, 2015, through December 31, 2016, and quantitative results for January 1, 2015 through December 31, 2015. To capture relevant information generated at the conclusion of the demonstration period or immediately afterward, this report also includes updated qualitative information through March 2017. Data sources include key informant interviews, beneficiary focus groups, the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results, Medicare claims data, the MMP encounter data, and other demonstration data.

Highlights

Integration of Medicare and Medicaid

- At the start of the first demonstration year, 21 plans were participating in FIDA. At the start of 2017, 14 plans remained after 4 withdrew or were terminated in demonstration year 1 and 3 withdrew in demonstration year 2. CMS reported that

[1] One plan began enrolling participants in Region 2, starting March 1, 2017, with more plans expected to follow (Telephone conversation with NYSDOH , March 10, 2017).

plan terminations were driven by lower than expected enrollment which did not offset staffing and other operational expenses. CMS reported that participation in FIDA was conditioned on a plan's current certification to provide managed long-term services and supports (MLTSS). However, experience providing MLTSS in New York varied across participating FIDA plans. Predemonstration experience providing Medicare services through a managed care plan also varied—of the 21 FIDA plans participating in the first year of the demonstration, the parent organizations of 14 plans were offering at least one type of Medicare health plan in New York in December 2014 (CMS, 2014b).

Eligibility and Enrollment

- New York conducted passive enrollment starting in April 2015 and ending in October 2015. Of those eligible for passive enrollment, 62 percent opted out. At the end of the passive enrollment period in October 2015, only 8,893, or just 10 percent, of the 88,933 individuals eligible to participate in FIDA that month were enrolled.

- Because beneficiaries were already enrolled in an MLTSS plan, beneficiaries were passively enrolled into the FIDA plan operated by the parent organization operating their MLTSS plan. While beneficiaries were able to retain their LTSS providers, they were less likely to be able to retain their medical providers covered under Medicare. As a result, the transition to FIDA, including passive enrollment, had a disruptive impact on provider relationships for a number of focus group participants; nearly half the focus group participants reported having to find new primary care physicians or specialists.

- The primary factors influencing beneficiaries' enrollment decisions include providers not participating in the MMP networks; providers actively encouraging their patients to opt out; and fear of change among eligible beneficiaries. Many providers declined to participate in FIDA networks because of the perceived burdens of its design, including the formation of new interdisciplinary team and training requirements. In addition, New York offered other choices for persons who were dually eligible for Medicare and Medicaid, including Medicaid Advantage Plus (MAP), under which the same parent company offered both Medicare Advantage and MLTSS.

- In response to low enrollment, New York State Department of Health (NYSDOH) issued a number of reforms aimed at responding to concerns identified by FIDA plans, advocates, providers and beneficiaries. Responding to concerns about the interdisciplinary team and the process for developing the person-centered services plan, NYSDOH significantly revised their requirements to reduce the burden for compliance. NYSDOH also conducted an advertising campaign aimed at explaining that FIDA was reformed and providing information about the benefits of participating in FIDA.

- Most of the reforms and efforts to increase enrollment occurred after passive enrollment ended and have not yielded a significant increase in opt-in enrollment. Although many provider concerns were addressed through reforms implemented at

the end of the first demonstration year, to date it appears these reforms have not successfully repaired FIDA's reputation among providers.

Beneficiary Experience

- Focus group participants described both positive and negative aspects of the care they received through the FIDA demonstration. They reported very different experiences with the care coordination services provided through their FIDA plans and had mixed experiences with access to services.

- With the exception of the Part D appeals process, which remains unchanged, the FIDA appeals process is unified for both Medicare and Medicaid appeals. The first level of appeals beyond the plan level is heard by the Integrated Appeals Hearing Office (IAHO) at the state level, and the second level of appeals is heard by the Medicare Appeals Council at the Federal level. Most stakeholders perceived that New York's integrated appeals process is highly successful.

Financing and Payment

- The Medicaid component of the capitated rate was initially set too low in comparison to NYSDOH's Managed Long Term Care (MLTC) rates, creating a disincentive for FIDA plans to promote their FIDA program; NYSDOH retroactively adjusted the Medicaid rates to provide parity with the MLTC rates.

- CMS was able to adjust the Medicare component of the rates across FIDA and other capitated model demonstrations under the Financial Alignment Initiative demonstrations in 2016, 1 year prior to a risk model update across the Medicare Advantage program. The adjustment offset underprediction in the CMS-Hierarchical Condition Category risk adjustment model for full benefit dual-eligible beneficiaries, and FIDA plans received an increase in their rates due to this change.

Service Utilization

- Only descriptive statistics for eligible demonstration beneficiaries in New York during the demonstration period are presented in this report. The evaluation lacked administrative data on approximately half of the beneficiary characteristics that the State used to exclude beneficiaries from the demonstration, preventing RTI International from creating both a comparison group and a group of predemonstration eligible beneficiaries in the baseline period in New York. Since these two latter groups could not be created, RTI International could not reliably estimate regression-based impact estimates. Therefore, only descriptive statistics are presented for eligible demonstration beneficiaries in New York, and only for the demonstration period. ***Section 1.1.2, What it Covers*** of this report provides a full explanation of this issue.

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1. Overview

1.1 Evaluation Overview

1.1.1 Purpose

The Medicare-Medicaid Coordination Office (MMCO) and the Innovation Center at the Centers for Medicare & Medicaid Services (CMS) have created the Medicare-Medicaid Financial Alignment Initiative to test, in partnerships with States, integrated care models for Medicare-Medicaid enrollees. The goal of these demonstrations is to develop person-centered care delivery models integrating the full range of medical, behavioral health, and long-term services and supports (LTSS) for Medicare-Medicaid enrollees, with the expectation that integrated delivery models would address the current challenges associated with the lack of coordination of Medicare and Medicaid benefits, financing, and incentives.

This report on the New York capitated model demonstration under the Medicare-Medicaid Financial Alignment Initiative, called the Fully Integrated Duals Advantage (FIDA) demonstration, is one of several reports that will be prepared over the next several years to evaluate the demonstration. CMS contracted with RTI International to monitor the implementation of the demonstrations under the Financial Alignment Initiative and to evaluate beneficiary experience, quality, utilization, and cost. The evaluation includes an aggregate final evaluation (Walsh et al., 2013) and individual State-specific evaluation reports.

The goals of the evaluation are to monitor demonstration implementation, evaluate the impact of the demonstration on the beneficiary experience, monitor unintended consequences, and monitor and evaluate the demonstration on a range of outcomes for the eligible population as a whole and for special populations (e.g., people with mental illness and/or substance use disorders, LTSS recipients). To achieve these goals, RTI collects qualitative and quantitative data from New York each quarter; analyzes Medicare and Medicaid enrollment, claims, and encounter data; conducts site visits, beneficiary focus groups, and key informant interviews; and incorporates relevant findings from any beneficiary surveys conducted by other entities. In addition to this report, monitoring and evaluation activities will also be reported in subsequent evaluation reports, and a final aggregate evaluation report for the Financial Alignment Initiative.

1.1.2 What it Covers

This report analyzes implementation of the FIDA demonstration from its initiation on January 1, 2015, through December 31, 2016. For this reporting period, qualitative data and quantitative data based on Medicare claims and Medicare Advantage encounters are included. To capture relevant information generated at the conclusion of the demonstration period or immediately afterward, this report also includes updated qualitative information through March 2017. It describes the New York FIDA demonstration key design features; examines the extent to which the demonstration was implemented as planned; identifies any modifications to the design; and discusses the challenges, successes, and unintended consequences encountered during the period covered by this report. It also includes data on the beneficiaries eligible and enrolled, geographic areas covered, and status of the participating Medicare-Medicaid Plans (hereafter referred to as FIDA plans or MMPs). Finally, the report includes data on care

coordination, the beneficiary experience, stakeholder engagement activities, and, to the extent that data are available, analyses of, quality, utilization, and cost data and a section on special populations served.

This Evaluation Report does not contain regression-based impact analyses on Medicare or Medicaid service use or costs. Instead, it provides only descriptive statistics on Medicare service utilization for the demonstration eligible population in New York during the demonstration period.[2] The use of descriptive statistics is often a starting point for understanding or summarizing the amount of, range, or variation of values among data. Whereas descriptive statistics in this report provide only a snapshot of service use in the demonstration group, the evaluation relies on a difference-in-difference multivariate regression approach to determine any intervention's impact on service utilization, quality, and cost. Regression analysis is used to answer key research questions regarding the intervention by testing the relationship among a set of variables—including sets of variables that "control" for differences across different groups.

Both descriptive statistics and multivariate regression rely on complete and accurate data. Complete data were available only to present descriptive statistics for eligible beneficiaries in New York during the demonstration period. Although nine of the 14 MMPs that were participating at the start of 2017 did report encounter data that was deemed complete and accurate for use in the evaluation, and that RTI's proposed comparison group for New York FIDA met the evaluation's benchmark for acceptability, RTI lacked administrative data on approximately half of the beneficiary characteristics that the State used to exclude beneficiaries from the demonstration. Such data would have been needed to more effectively and completely exclude beneficiaries who otherwise would have met the demonstration's eligibility criteria had the demonstration been implemented in the New York baseline period and also in the proposed comparison group.

As a result of lacking these important data to properly exclude beneficiaries from these groups, RTI found that both service use and cost results in the New York demonstration area greatly differed immediately before and after the demonstration started, preventing a regression-based estimation of demonstration impact. By extension, descriptive statistics could be presented neither for the proposed comparison group nor for the intervention group constructed by the evaluation for the baseline period prior to the demonstration's start date. Therefore, only descriptive statistics are presented in this report, and only for eligible demonstration beneficiaries in New York.

1.1.3 Data Sources

A wide variety of information informed this first Annual Report of the FIDA demonstration. Data sources used to prepare this report include the following:

Key informant interviews. The RTI evaluation team conducted site visits in New York in June 2015 and June 2016. The team interviewed the following types of individuals either during the site visits or during subsequent telephone interviews: State policy makers and staff;

[2] Independently from this evaluation, the State of New York projects Medicaid savings for the first and second demonstration years which align with the contractual savings percentage for those years of 1% and 1.5% respectively. CMS has not validated these estimates.

CMS and State Contract Management Team (CMT) members; representatives speaking for New York City's Health Insurance Information, Counseling and Assistance Program (HIICAP); officials from Independent Consumer Advocacy Network (ICAN), New York's ombudsman program; officials representing six different MMPs; representatives speaking for providers (Federally Qualified Health Centers, adult day health care programs, and nursing facilities); advocates and other stakeholders.

Focus groups. The RTI evaluation team conducted eight focus groups in New York City in June 2016. A total of 22 enrollees and 16 proxies participated in the RTI focus groups. Participants were assigned to groups based on their LTSS and behavioral health services use, race, ethnicity, and primary language. Focus groups were not conducted with beneficiaries who opted out of the demonstration or who disenrolled.

Surveys. Medicare requires all Medicare Advantage plans, including FIDA plans, to conduct an annual assessment of the experiences of beneficiaries using the Medicare Advantage Prescription Drug Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey instrument. The 2016 survey for FIDA plans was conducted in the first half of 2016 and included the core Medicare CAHPS questions and 10 supplemental questions added by the RTI evaluation team. Survey results for a subset of 2016 survey questions are incorporated into this report. Findings are available at the FIDA plan level. The frequency count for some survey questions may be suppressed because too few enrollees responded to the question. Comparisons with findings from all Medicare Advantage plans are available for core CAHPS survey questions.

Demonstration data. The RTI evaluation team reviewed data provided quarterly by New York through the State Data Reporting System (SDRS). These data included eligibility, enrollment, and information reported by New York on its stakeholder engagement process, accomplishments on the integration of services and systems, any changes made in policies and procedures, and a summary of successes and challenges. This report also uses data for quality measures reported by FIDA plans and submitted to CMS's implementation contractor, NORC at the University of Chicago (hereafter referred to as NORC).[3,4] Data reported to NORC include core quality measures that all MMPs are required to report, as well as State-specific measures that FIDA plans are required to report. Due to some reporting inconsistencies across plans in 2015 and 2016, plans occasionally resubmit data for prior demonstration years; therefore, the data included in this report are considered preliminary.

Demonstration policies, contracts, and other materials. This report uses several data sources, including the Memorandum of Understanding (MOU) between the State and CMS (CMS and State of New York, 2013; hereafter, MOU, 2013); the three-way contract (CMS and State of New York, 2014; hereafter, three-way contract, 2014); and State-specific documents, e.g., New York State Department of Health (NYSDOH) policy governing the activities of the

[3] Data are reported for calendar years 2015 and 2016.

[4] The technical specifications for reporting requirements are in the Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements document, which is available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/InformationandGuidanceforPlans.html

interdisciplinary team (IDT), including the original IDT policy (NYSDOH, 2014b; hereafter, IDT policy, 2014) and the final revised IDT policy (NYSDOH, 2015d; hereafter, IDT policy, 2015); Section 1115(a) demonstration terms and conditions; requests for proposals (e.g., for the NYS ombudsman program); state regulations; contract templates for other managed long-term services and supports (MLTSS) programs; financial reports for the plans[5] and other materials, including meeting presentations, minutes, guidance, and reports publicly available on the NYSDOH website (https://www.health.ny.gov/); data reported to RTI through the State Data Reporting System ; and documents on the CMS Medicare-Medicaid Coordination website (CMS, 2016).

Conversations with CMS and NYSDOH officials. To monitor demonstration progress, the RTI evaluation team engages in periodic phone conversations with the NYSDOH and CMS. These might include discussions about new policy clarifications designed to improve plan performance, quality improvement work group activities, and contract management team actions.

Complaints and appeals data. Complaint (also referred to as grievance) data are from two separate sources: (1) complaints from beneficiaries reported by FIDA plans to NYSDOH, and separately to CMS's implementation contractor, NORC; and (2) complaints received by NYSDOH or 1-800-MEDICARE and entered into the CMS electronic Complaint Tracking Module (CTM),[6] including complaints received by ICAN, New York's ombudsman program, and reported to NYSDOH. Appeals data are based on data reported by MMPs to NYSDOH and NORC, for Core Measure 4.2, and New York's Integrated Appeals Hearing Office. Data on critical incidents and abuse reported to NYSDOH and CMS's implementation contractor by FIDA plans are also included in this report.

Although a discussion of the New York MMPs is included, this report presents information primarily at the FIDA demonstration level. It is not intended to assess individual plan performance, but individual plan information is provided where plan-level data are the only data available, or where plan-level data provide additional context.

Service utilization data. Evaluation Report analyses used data from many sources. First, the State provided quarterly finder files containing identifying information on all demonstration eligible beneficiaries in the demonstration period. Second, RTI obtained administrative data on beneficiary demographic, enrollment, and service use characteristics from CMS data systems for only demonstration group members in the demonstration period. Third, these administrative data were merged with Medicare claims and encounter data.

Appendix A provides details on all population definitions and measures and methods used in the analyses; ***Appendix B*** provides a table of predemonstration and demonstration design features for the New York demonstration.

1.2 Model Description and Demonstration Goals

The FIDA demonstration is part of New York's larger, ambitious Medicaid reform initiative launched in 2011. Under this initiative, New York set a goal of "Care Management for

[5] Data are presented for calendar year 2015.
[6] Data are presented for the time period January 2015 through December 2016.

All" for the New York State Medicaid program, aiming to have all Medicaid beneficiaries enrolled in high-quality, fully integrated care management organizations within 5 years (NYSDOH, n.d.-a). Because beneficiaries dually eligible for Medicare and Medicaid accounted for 45 percent of New York State annual Medicaid spending, and 41 percent of Medicare spending, this group was highlighted as an important group to bring into a care management program. The key objectives of FIDA include improving participant experience in accessing care, delivering person-centered care, promoting independence in the community, improving quality, eliminating cost-shifting between Medicare and Medicaid, and achieving cost-savings for New York and the Federal government through improvements in care and coordination (MOU, 2013, p. 1).

Integration of Medicare and Medicaid functions. The FIDA demonstration integrates a number of Medicare and Medicaid functions, including marketing materials, the enrollment and disenrollment processes, the assessment and care planning processes, the appeals process, and contract management functions. More background on integration of Medicare and Medicaid functions is provided in ***Section 2, Integration of Medicare and Medicaid; Section 3, Eligibility and Enrollment; Section 4, Care Coordination; Section 5, Beneficiary Experience; Section 7, Financing and Payment;*** and ***Section 8, Service Utilization***.

Financial model. The demonstration is testing a new payment methodology with the aim of minimizing cost-shifting, aligning Medicare and Medicaid incentives, promoting the best possible health outcomes of enrollees, and reducing costs to CMS and NYSDOH (MOU, 2013, pp. 1–2). All covered services in the demonstration are paid on a capitated basis, with the exception of hospice, methadone maintenance treatment, out-of-network family planning, and directly observed therapy for tuberculosis, which are paid on an FFS basis (three-way contract, 2014, pp. 287–8). CMS and NYSDOH make three separate, risk-adjusted, per member per month (PMPM) payments to FIDA plans. Two separate monthly payments are made by CMS to reflect Medicare Parts A and B services and Part D services. The third monthly PMPM payment is made by NYSDOH and reflects coverage of Medicaid services. ***Section 7, Financing and Payment*** provides more detail on the financial model.

Eligible population. Eligibility for FIDA is limited to those age 21 or older at the time of enrollment; entitled to benefits under Medicare Part A and enrolled in Medicare Parts B and D, and receiving full Medicaid benefits; residing in a FIDA demonstration county; and requiring a nursing facility level of care (e.g., enrolled in the Nursing Home Transition and Diversion §1915(c) waiver) or 120 days of community-based long-term care (MOU, 2013, pp. 6–8, as revised by three-way contract, 2014, p. 186). ***Section 3, Eligibility and Enrollment*** provides more information on eligibility for FIDA.

FIDA plans. As discussed in ***Section 1.4, Overview of State Context***, NYSDOH had already transitioned its LTSS programs into managed care arrangements; by 2012, mandatory enrollment into managed LTSS had been completed. FIDA was designed to build on these existing programs and NYSDOH anticipated that that most beneficiaries would be passively enrolled from one of the MLTSS products offered by the FIDA plan's parent organization. (These other MLTSS products are discussed in greater detail in ***Section 1.4, Overview of State Context***.)

New York did not use a competitive procurement process to select MMPs. FIDA was open to all its MLTSS plans that met FIDA qualification requirements. NYSDOH designed FIDA to build on its existing MLTSS plans so that beneficiaries enrolled in one of its MLTSS plans could be passively enrolled in a FIDA plan operated by the same parent organization. There was no competitive procurement process—FIDA was open to all MLTSS plans that qualified. Specifically, a plan had to meet four qualification requirements to be an MMP. These included (1) receiving a Certificate of Authority to operate as a Managed Long Term Care (MLTC) plan by May 14, 2013; (2) achieving a minimum score on the CMS Capitated Financial Alignment Demonstration Model of Care submission; (3) passing the joint readiness review conducted by CMS and NYSDOH; and (4) entering into a three-way contract with CMS and NYSDOH (MOU, 2013, p. 4). See ***Table 2*** for an overview of managed care penetration in New York City and ***Table 3*** for information about the FIDA plans' prior organizational experience.

Initially, 22 MMPs qualified to participate in FIDA. One plan dropped out before the demonstration began, leaving 21 FIDA plans during the first year of the demonstration. After the first year of the demonstration, 4 more FIDA plans withdrew or were terminated from the demonstration, which left 17 FIDA plans at the start of 2016. By the end of 2016, 3 more MMPs withdrew from FIDA, which left 14 participating plans at the start of 2017. CMS reported that plan terminations were largely driven by lower than expected enrollment in combination with unsustainable operational expenses. ***Section 2.2, Overview of Integrated Delivery System*** provides more background on FIDA plans.

Geographic coverage. New York's FIDA comprises two regions. Region 1 covers five counties corresponding to the five boroughs of New York City (Bronx, Kings [Brooklyn], New York [Manhattan], Queens, and Richmond [Staten Island]), and Nassau County in Long Island Enrollment in Region 1 began January 1, 2015. Region 2 covers Westchester and Suffolk counties. Region 2 enrollment was deferred until 2017 and thus will be reported in the second evaluation report.[7]

Care coordination. FIDA uses an IDT as the platform for coordinating care. The IDT is organized and managed through a care manager. These staff may be employed by a FIDA plan or under contract with the plan. As originally designed, New York modeled the IDT as a "virtual PACE program," using the care model under the Program of All-Inclusive Care for the Elderly (PACE) as the template for defining the requirements for the FIDA IDT. For example, as required under PACE, the original design of FIDA required primary care physicians or their designees to participate in IDT meetings; and the full IDT was to meet in person whenever possible, or by phone or videoconference. ***Section 3, Eligibility and Enrollment*** and ***Section 4, Care Coordination*** provide more detail on the IDT requirements. As discussed in ***Section 2.2, Overview of Integrated Delivery System,*** requirements were met with resistance from providers and were logistically challenging for FIDA plans. As a result, New York modified the IDT requirements in December 2015, at the end of the first demonstration year. These modifications, along with others to the demonstration design, are discussed in more detail in ***Section 4, Care Coordination***.

[7] One plan began enrolling participants in Region 2, starting March 1, 2017, with more plans expected to follow (Telephone conversation with NYSDOH representatives, March 10, 2017).

Benefits. FIDA offers a combined set of Medicare and Medicaid benefits as part of a single benefits package. Covered services include the following:

- All New York Medicaid State Plan services (including LTSS, but excluding intermediate care facility for persons with intellectual or developmental disabilities [ICF/IDD] services, out-of-network family planning services, methadone management treatment program, and directly observed therapy for tuberculosis disease (three-way contract, 2014, pp. 249, 287–88)

- A set of HCBS equivalent to those available under New York's Nursing Home Transition and Diversion (NHTD) HCBS waiver: respite, service coordination, assistive technology, community integration counseling, community transitional services, congregate and home-delivered meals, environmental modifications, home and community support services, home visits by medical personnel, independent living skills training, moving assistance services, nutritional counseling/education services, peer mentoring, positive and behavioral interventions and supports, respiratory therapy, structured day program, wellness counseling (three-way contract, 2014, pp. 249, 251–2). These services are not available outside of FIDA except through enrollment in the NHTD waiver.

- Services, drugs, and equipment covered under Medicare Parts A, B, and D (three-way contract, 2014, p. 249).

- Other supportive services the IDT determines necessary (three-way contract, 2014, p. 251).

Stakeholder engagement. New York designed its demonstration in collaboration with advocates and plans. As the FIDA demonstration moved from the design phase to the implementation phase, the stakeholder engagement process became bifurcated, with NYSDOH and CMS meeting with the plans separately. Representatives for the Medicare Rights Center serve as lead for the advocates and meet monthly with NYSDOH and CMS. See ***Section 6, Stakeholder Engagement*** for more on stakeholder engagement.

1.3 Changes in Demonstration Design

The early design of FIDA was an important (but not the only) factor contributing to a challenging demonstration launch. Most significantly, plans and providers perceived that the requirements related to the IDT planning process, as originally designed, were overly burdensome. Beneficiaries also had very high opt-out rates and voluntary disenrollments. FIDA rates paid to the plans were not comparable to those paid under New York's other programs, and FIDA plans had limitations on their ability to market FIDA to persons enrolled in their other MLTSS products. (See ***Section 1.4, Overview of State Context*** for more about New York's other MLTSS programs, ***Section 3.2, Enrollment Process*** for more about enrollment, and ***Section 7.1, Rate Methodology*** for more on the rate methodology.) Lastly, plans perceived dashboard reporting requirements to be burdensome and duplicative of other reporting requirements.

NYSDOH responded by making some significant modifications to FIDA's design. Most of these changes were effective December 2015, at the end of the first demonstration year; New

York and CMS continue to address concerns identified by plans, providers and advocates. ***Table 1*** summarizes the most significant modifications made by NYSDOH to date.

Table 1
Select changes in demonstration design

Original design	New design
IDT policy	
• Participation required for primary care provider (PCP) (physician or physician's designee); and nursing facility representative and behavioral health provider if enrollee receiving services from those types of providers. • IDT members required to meet in real time, in person or by phone or videoconference. Wet signatures of IDT members required. • The IDT authorizes those services included in the signed person-centered service plan The FIDA Plan may not disallow any service or treatment authorized in the PCSP. • IDT members required to complete web-based training program.	• Participation of PCP and others at enrollee's choice. PCP may review and sign person-centered service plan, without attending IDT meeting. • Care manager can meet separately with IDT members. Alternative methods of approval accepted. • The IDT authorizes those services included in the signed person-centered service plan, except the FIDA plan authorizes services when outside the scope of practice of IDT members. • Training program optional for IDT members.
Marketing	
• FIDA plans not allowed to market directly to potential enrollees through unsolicited contact. • FIDA plans not allowed to submit enrollment requests to the enrollment broker, as allowed for MLTC.	• FIDA plans allowed to make outbound calls to market FIDA to individuals enrolled in one of their other products (MLTC, PACE, or Medicaid Advantage Plus [MAP]). With prior approval from CMS and NYSDOH, FIDA plans are also allowed to send FIDA educational materials to members who opted out. • FIDA plans allowed to submit enrollment requests for those new to service • FIDA plans are allowed to make warm transfers of potential participants to enrollment broker, except FIDA plans are allowed to stay on the line with potential participant and enrollment broker.
Rates	
• FIDA Medicaid rates were developed using different methodology than that used for MLTC program, and compared unfavorably. • FIDA quality incentives based on withhold from rates, while MLTC quality incentive was separately financed and additive to rates.	• Medicaid rates were revised to be consistent with MLTC rate setting methodology. • An adjustment was made to the FIDA rates to compensate for the different methods used for financing of quality incentives for MLTC.
Reporting requirements	
• Biweekly and monthly dashboard reporting required from FIDA Plans to the CMT.	• No longer required.

CMS = Centers for Medicare & Medicaid Services; CMT = Contract Management Team; FIDA = Fully Integrated Duals Advantage demonstration; IDT = interdisciplinary team; MLTC = Managed Long Term Care plan; NYSDOH = New York State Department of Health; PACE = Program of All-Inclusive Care for the Elderly; PCSP = person-centered service plan.

SOURCES: IDT policy, 2014; IDT policy, 2015; NYSDOH, 2015e.

Given the significance of the changes, one NYSDOH key informant described 2016 as the first demonstration year of the newly designed FIDA, rather than FIDA's second demonstration year. However, the attempt to give FIDA a fresh start in 2016 was undermined by the damage to the FIDA brand resulting from the demonstration's rocky start in 2015. ***Section 2.2, Overview of Integrated Delivery System,*** provides more background on this topic. NYSDOH, CMS, and some FIDA plans reported that even with the reforms, it has been difficult to overcome the first impressions formed in 2015. As discussed in ***Section 3, Eligibility and Enrollment***, these and other challenges have helped to keep FIDA enrollment low, in spite of the effort to reform FIDA. This document incorporates information about implementation challenges but focuses primarily on the FIDA demonstration as it is currently designed.

1.4 Overview of State Context

1.4.1 Transition to Mandatory Enrollment in MLTSS

Prior to the launch of FIDA, New York already had multiple Medicaid managed care products, including Mainstream Managed Care,[8] Medicaid Advantage,[9] MLTC, Medicaid Advantage Plus (MAP),[10] and PACE. New York's MLTC is a partially capitated program covering Medicaid-funded long-term care services, originally launched in 1998. New York transitioned to mandatory enrollment into MLTC 2 years prior to the launch of FIDA.

By January 2013, mandatory enrollment in MLTC for the FIDA demonstration regions had been completed (NYSDOH, 2015b). Advocates report that mandatory enrollment in MLTC was disruptive and upsetting for many LTSS users. Advocates believe these earlier experiences caused enrollees to fear enrolling into FIDA and contributed to the high number of opt-outs and disenrollments from FIDA in early 2015.

As an alternative to mandatory enrollment in MLTC, persons dually eligible for Medicare and Medicaid had the option of enrolling in one of two programs designed for Medicare-Medicaid enrollees—a PACE program and a MAP program (CMS, 2014a). New York launched these programs in 2006 and 2007. Starting in 2015, voluntary enrollment in the FIDA demonstration became another alternative to mandatory enrollment in MLTC. The FIDA program was in competition with these other MLTSS plans and often suffered in comparison, in

[8] Mainstream Medicaid provides comprehensive health coverage to New York Medicaid beneficiaries; some beneficiaries are exempted, and some, including FIDA enrollees, are excluded.

[9] Medicaid Advantage provides Medicaid-funded "wraparound" benefits to persons dually eligible for Medicare and Medicaid but not enrolled in one of New York's MLTSS programs. These wraparound benefits include new services covered under New York's Medicaid program that are not covered under Medicare or provide expanded coverage for certain Medicare services. For example, Medicaid Advantage covers Medicare cost sharing, inpatient mental health services over that allowed under Medicare, non-Medicare covered home health services, hearing and vision services, and non-emergency medical transportation.

[10] Medicaid Advantage Plus covers the LTSS services covered under MLTC with the wraparound services covered under Medicaid Advantage (see note 8). The MAP program allows Medicare-Medicaid beneficiaries to enroll in an MLTC plan and Medicare Advantage plan operated by the same parent organization. MAP is similar to and aligned with Fully Integrated Dual Eligible Special Need Plans (FIDE-SNPs). In New York, stakeholders sometimes refer to FIDE-SNPs as MAP.

the eyes of both plans and providers. See ***Section 2.2, Overview of Integrated Delivery System; Section 3.2, Enrollment Process;*** and ***Section 7.2, Financial Impact***.

Table 2 provides predemonstration enrollment data by demonstration county for New York's existing Medicaid managed care programs (Mainstream Managed Care, Medicaid Advantage) and MLTSS programs (MLTC, MAP, and PACE), as well as market penetration rates for Medicare Advantage in the same counties.

Table 2
Predemonstration enrollment[1] in Medicaid Managed Care products and Medicare Advantage (December 2014) by county[2]

	Medicaid Managed Care		Medicaid MLTSS Programs			Medicare Advantage	
County	Mainstream Medicaid	Medicaid Advantage	Partial Cap	Medicaid Advantage Plus	PACE	Enrollment	Penetration
All New York City counties	2,685,783	6,256	109,190	5,621	3,541	493,746	41%
Bronx	621,858	-	-	-	-	98,525	53%
Kings	938,384	-	-	-	-	135,593	40%
New York	315,738	-	-	-	-	88,854	34%
Queens	717,042	-	-	-	-	138,977	43%
Richmond	92,761	-	-	-	-	31,797	40%
Other demonstration counties							
Nassau	173,250	295	4,677	173	56	57,590	24%
Suffolk	201,865	61	,3141	112	85	55,490	21%
Westchester	134,946	274	2,946	10	223	37,952	23%
Total	3,195,844	6,886	119,954	5,916	3,905	644,778	35%

[1] Includes beneficiaries both eligible for Medicaid only and those dually eligible for Medicare and Medicaid.

[2] County level data is not available for the counties comprising New York City for Medicaid MLTSS programs.

SOURCES: NYSDOH, 2014c; CMS, 2014c.

1.4.2 Multiple Reform Initiatives

At the time of FIDA's launch, New York was in the midst of an ambitious and comprehensive period of payment and delivery system reform: a "blizzard of initiatives," according to one NYSDOH informant. Since 2012, New York implemented mandatory MLTSS; launched health homes; continued implementing a Delivery System Reform Incentive Payment program and a second-round State Innovation Model Test Award. Also, the State reformed its behavioral health services and delivery system. In 2016, it launched FIDA-IDD, a Financial Alignment Initiative demonstration for adults with intellectual disabilities. New York continues to work toward transitioning traumatic brain injury and its nursing home transition and diversion §1915(c) waiver programs into managed care. New York has also implemented a Money Follows the Person demonstration, a Balancing Incentive Program, and other reforms related to

LTSS. As discussed in ***Section 2, Integration of Medicare and Medicaid***, plans perceived that the "blizzard" of State-led reform, in addition to numerous other reform initiatives led by CMS, contributed to "reform fatigue" among providers and created further resistance to participating in FIDA, a relatively small initiative.

1.4.3 Federal Financial Support

As announced in September 2013, the State received Federal implementation funding support in the amount of $6.8 million for the first 12 months of implementation and an additional $6.2 million for the second 12 months. Activities supported under that grant include building enrollment broker capacity and developing enrollment materials; a multifaceted outreach campaign for potential enrollees; stakeholder workgroups; actuarial analysis and rate-setting support; staffing for demonstration management and oversight; and operationalization of the integrated appeals process (CMS, 2013b). Key informants from NYSDOH identified these funds as critical for funding the supports needed for implementation.

The State chose not to request funding for the ombudsman program serving FIDA enrollees. Instead, NYSDOH has contracted with an ombudsman to serve all of its managed long-term care programs, including FIDA, MLTC, MAP, PACE, and LTSS available through mainstream Medicaid managed care plans.

In 2014, New York also received $695,572 in funding from CMS and the Administration for Community Living for its State Health Insurance Assistance Program (SHIP) to provide options counseling to Medicare-Medicaid enrollees (CMS, 2018).This funding was granted to the State Office for Aging,, which contracted with the SHIP (known as a Health Insurance Information, Counseling and Assistance Program in New York) serving New York City. See ***Section 3.2, Enrollment Process*** for more information about the options counseling program for FIDA.

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2. Integration of Medicare and Medicaid

Highlights

- At the start of the first demonstration year, 21 plans were participating in the Fully Integrated Duals Advantage (FIDA) demonstration. At the start of 2017, 14 plans remained after three withdrew and one was terminated in demonstration year 1, and three withdrew in demonstration year 2. Exiting plans were not interviewed for this evaluation; however, CMS indicated that plans withdrew because enrollment was lower than expected relative to staffing and operational expenses.
- A number of plans encouraged New York State Department of Health (NYSDOH) to decline the opportunity to extend the demonstration beyond 2017, suggesting that New York instead incorporate many of FIDA's features into New York's existing Medicaid Advantage Plus (MAP) program. New York chose to extend and committed to engaging stakeholders in designing an integrated care model for implementation after the demonstration.
- Many providers declined to participate in FIDA plan networks because of the perceived burden of the demonstration design. Although many provider concerns were addressed through reforms implemented at the end of the first demonstration year, to date it appears these reforms have not successfully repaired FIDA's reputation among providers.
- The large number of participating FIDA plans created logistical challenges during the launch and early implementation of FIDA. In spite of this, NYSDOH and CMS created an effective Contract Management Team (CMT) to coordinate communication and provide plans with technical assistance.
- Aligning Federal and State policies and systems was challenging and slowed by the review and approval processes within both New York State and CMS.

This section provides an overview of the management structure that was created to oversee the implementation of the demonstration and discusses in greater detail the organization, geographic coverage areas, and enrollment experience of the 22 FIDA plans that were originally selected to integrate and deliver the FIDA, and the remaining 14 plans in place after the first 2 years of the demonstration. It also provides a general description of the other functions (e.g., care coordination, eligibility, enrollment, quality management, and financing) that the NYSDOH, CMS, and the plans had to coordinate or integrate as part of the implementation of the demonstration. Later sections provide more in-depth discussion of the implementation successes and challenges associated with the integration of these functions.

2.1 Joint Management of Demonstration

A key component of the joint management of the FIDA demonstration is the CMS-State CMT. The CMT is responsible for monitoring overall FIDA plan compliance, having regular meetings with the FIDA plans, and responding to external grievances (three-way contract, 2014,

pp. 183–85). This section describes the CMT and the way its role and activities have evolved since the beginning of the CMT.

Together, CMS and New York's teams comprise the CMT. CMS's team is led by two project officers from the Medicare-Medicaid Coordination Office (MMCO). In addition, the CMT includes regional staff, including staff from the Consortium of Medicare Health Plans Operations (CMHPO) and the Consortium of Medicaid and Children's Health Operations (CMCHO). New York's team includes staff from New York's Division of Long Term Care, which is part of the Office of Health Insurance Programs and the New York Medicaid program. The Director of the Division of Long Term Care, with the assistance of the Director of the Bureau of Managed Long Term Care, provides leadership for the FIDA demonstration. Funding for FIDA demonstration staff was provided by CMS, and members responsible for the day-to-day operation of the FIDA program were hired as contractors. Over time, FIDA has experienced turnover for both FIDA leadership and program staff. By August 2016 leadership for NYSDOH's Division of Long Term Care and the Bureau of Managed Long Term Care had completely turned over. NYSDOH indicated that some turnover among program staff can be attributed to uncertainty about New York's ongoing commitment to financing FIDA staff and uncertain pathways for transitioning contracted staff to permanent state employee positions. The number of program staff members was reduced over time; original staffing configurations were based on expectations of higher FIDA enrollment than occurred.

In New York, the CMT is functionally divided into two groups: CMT-Operational (CMTO) and CMT-Management (CMTM). The CMTO is responsible for monitoring plan performance and the CMTM is responsible for making cross-cutting policy decisions and resolving issues that emerge from the CMTO.

2.1.1 The Role and Composition of the CMTO

A plan-level CMT is assigned to each FIDA plan and is responsible for monitoring the performance of that plan. For NYSDOH, each CMTO includes a monitoring and oversight coordinator (MOC). The MOC has a role comparable to that of the contract managers responsible for monitoring the MLTC and MAP plans. NYSDOH's MOC sets the agenda for CMT meetings with the FIDA plan, hosts the meetings, and conducts follow-up activities.

Each CMTO includes an account manager and account analyst from CMS. These representatives are part of CMHPO. The CMS account manager is responsible for overseeing Medicare Advantage and Part D plans. The analyst is responsible for marketing review and anything involving case work, including complaints logged in CMS's Complaint Tracking Module (CTM). In addition to these CMS staff members, the CMTO includes one of MMCO's two project officers assigned to the FIDA demonstration, and a representative from CMCHO.

In the early phases of implementation, each plan-level CMT met by phone biweekly to discuss the plan's performance, including timely completion of assessments, the status of interdisciplinary team (IDT) meetings, service plans, provider trainings, grievances and appeals, and a number of other measures. NYSDOH officials explained that, at the start of the demonstration, the biweekly calls also involved providing plan-specific technical assistance, responding to questions about enrollment, reporting, implementation of the IDT, technical details

regarding enrolling providers, marketing, and other issues. Over time, CMTO meetings with the plans moved to a monthly schedule, with more emphasis on hearing about how the plan is working for beneficiaries.

Staff from across the CMTOs also meet to share information and issues gathered at the plan level. In this way, the CMTO has been able to surface cross-cutting operational issues and develop consistent responses across all FIDA plans. The CMTO also hears a regular update on each individual FIDA plan from the MOC assigned to that plan, allowing the CMTO to identify trends across FIDA plans. The CMTO monitors the FIDA plans' timely resolution of the complaints that have been logged in the CTM. The CMTO also reviews and discusses the grievances that come in through NYSDOH's enrollment broker. In the summer of 2015, during the early months of the demonstration, the CMTOs also conducted site visits with FIDA plans. These visits provided CMT members an opportunity to hear from the FIDA plans' marketing teams and the different provider groups they have targeted, listen to an IDT call, and see how the different departments within a FIDA plan worked together.

2.1.2 The Role and Composition of the CMTM

CMS reported that not all other demonstration states needed a separate CMTM. However, the CMTM has been active in New York as a separate forum for cross-cutting policy issues across the large number of FIDA plans. CMS takes the lead in initiating the agendas for CMTM calls, which tend to focus on addressing policy questions about the FIDA plans. In some cases, the CMTM addresses questions by clarifying policy when it has not been articulated clearly enough. In some cases, the CMTM consults CMS or NYSDOH to address cross-cutting policy questions that affect more than one FIDA plan.

In the early phases of implementation, the CMTM had two separate management meetings, one with NYSDOH and MMCO project officers and a second that included NYSDOH, MMCO, and others from CMS. In the second year of the demonstration, those meetings have been consolidated. For NYSDOH, CMTM meetings include FIDA leadership and program staff and, depending on the topic, one or more MOC may also participate. For CMS, the MMCO project officers participate and bring others from CMS in as necessary. The meetings are weekly and supplemented by ad hoc calls when needed.

2.2 Overview of Integrated Delivery System

2.2.1 FIDA Plans

FIDA Plan Qualifications

NYSDOH designed FIDA to build on the MLTC and MAP plans so that beneficiaries enrolled in either of those plans could be passively enrolled in a FIDA plan operated by the same parent organization. As a result, there was no competitive procurement process—FIDA was open to all MLTC and MAP plans that qualified.

The readiness review for each FIDA plan involved a review of policies and procedures, plan systems, the provider network, and a site visit. The high number of FIDA plans created unique challenges for implementing the FIDA plan readiness reviews. The readiness reviews

were conducted starting in September 2013, several months before the template 3-year contract was finalized in July 2014, and almost a year before the final three-way contract was signed in October 2014. The timing of the readiness review was driven largely by the number of FIDA plans participating in FIDA.

The early start of the readiness reviews created some challenges. For example, at the time the readiness reviews began, a number of elements in the review were identified as "pending" because some policies were still being developed. Most significantly, the IDT policy was not finalized until June 2014. It is believed that this delay created some duplicative steps in the readiness review process. For example, CMS reported that some plans submitted documentation to comply with the pending IDT policy, only to have to resubmit it after the IDT policy was finalized At least one FIDA plan also noted that developing the provider network so long before program implementation meant early efforts at provider outreach and education had faded from memory for many providers, causing many providers to be unfamiliar with FIDA and its requirements by the time enrollment began.

Participating FIDA Plans

Initially, 22 FIDA plans qualified to participate in FIDA. Of these, one plan[11] chose to voluntarily withdraw from FIDA before the demonstration began. Four FIDA plans[12] exited at the end of 2015, leaving 17 plans participating during the second demonstration year, 2016. At the end of 2016 three more plans[13] withdrew, leaving 14 plans participating in 2017, the third year of the demonstration. CMS reported that plan terminations were driven by lower than expected enrollment which did not offset staffing and other operational expenses. One plan was terminated at the direction of CMS because it failed to submit its Plan Benefit Package (PBP)[14] by the statutory deadline.

The original 21 FIDA plans had a diverse history. Several were "home grown" managed long-term services and supports (MLTSS) plans, branching off from provider-based organizations to participate in New York's MLTSS programs. Others were product lines offered by more traditional managed care organizations, with more of a focus on coverage for medical care. ***Table 3*** presents the FIDA plans prior organizational experience.

As ***Table 3*** illustrates, although participation in FIDA was conditioned on a plan's current participation as an MLTC plan, the size of MLTC enrollment varied significantly across plans. Several FIDA plans entered the market with the implementation of mandatory enrollment in 2012, while others date back to the voluntary MLTC program that began in 1998. Some FIDA plans also had past experience operating as other types of Medicare health plans (e.g., a Medicare Advantage Prescription Drug [MAPD] plan, a Medicare Prescription Drug Plan [PDP], a Special Needs Plan [SNP], or a PACE program). Of the 21 FIDA plans participating in the first year of the demonstration, the parent organizations of 14 plans were offering at least one type of Medicare health plan in New York in December 2014 (CMS, 2014b). As ***Table 3*** shows, even

[11] Montefiore HMO LLC.

[12] HealthPlus Amerigroup FIDA Plan, Arch Care Community Advantage FIDA Plan, Emblem Health Dual Assurance FIDA Plan, and Integra FIDA Plan.

[13] AlphaCare Signature FIDA Plan, CenterLight Healthcare FIDA Plan and WellCare Advocate Complete FIDA.

[14] The PBP is the set of benefits the MMP offers. The MMP is required to submit timely the PBP to CMS for benefit analysis, marketing and beneficiary communication purposes.

among those with Medicare Advantage experience, there was wide variation in the number of beneficiaries enrolled in their Medicare Advantage plans, with one plan having fewer than 20 enrollees and two others having more than 100,000.

Table 3
FIDA plans' prior organizational experience

Organization name	FIDA plan name	National chain	Nonprofit	Other plans offered through parent company	Enrollment in demonstration area December 2014 [1]			Medicare Advantage enrollment December 2014
					MLTC	MAP	PACE	
Aetna Better Health of New York	Aetna Better Health FIDA Plan	Yes	No	MLTC; MAPD	2,950	N/A	N/A	15,603
AgeWell New York, LLC	AgeWell New York FIDA	No	No	MLTC; MAPD; I-SNP; D-SNP	3,978	N/A	N/A	N/A
AlphaCare of New York, Inc.	AlphaCare Signature FIDA Plan	No[2]	No	MLTC; MAPD; D-SNP; I-SNP	1,433	N/A	N/A	1,082
Amerigroup New York, LLC	HealthPlus Amerigroup FIDA Plan	Yes	No	Medicaid MCO; MLTC; MA; MAP; MAPD	2,897	7	N/A	11,024
ArchCare Community Life	ArchCare Community Advantage FIDA Plan	No	Yes	MLTC; I-SNP; PACE	1,903	N/A	333	1,576
CenterLight Healthcare, Inc.	CenterLight Healthcare FIDA Plan	No	Yes	MLTC; I-SNP; D-SNP; PACE	7,410	N/A	2,985	967
Centers Plan for Healthy Living, LLC	FIDA Care Complete	No	No	MLTC; MAPD	1,940	N/A	N/A	<20
Elderplan, Inc. (aka HomeFirst)	Elderplan FIDA Total Care	No	Yes	MLTC; D-SNP with LTC; D-SNP; I-SNP; C-SNP (Diabetes); MAPD	10,157	814	N/A	13,961
ElderServe Health, Inc.	RiverSpring FIDA Plan	No	Yes	MLTC	10,414	N/A	N/A	N/A
Fidelis Care of NY (NYS Catholic Health Plan)	Fidelis Care FIDA Plan	No	Yes	Medicaid MCO; MLTC; MAP; MAPD; D-SNP	7,302	80	N/A	27,028
GuildNet, Inc.	GuildNet Gold Plus FIDA Plan	No	Yes	MLTC; D-SNP	14,513	726	N/A	714
Managed Health (Healthfirst) (aka Senior Health Partners)	Healthfirst AbsoluteCare FIDA Plan	No	Yes	Medicaid MCO; MLTC; MAPD; D-SNP; I-SNP	14,220	3,368	N/A	124,015

(continued)

Table 3 (continued)
FIDA plans' prior organizational experience

Organization name	FIDA plan name	National chain	Nonprofit	Other plans offered through parent company	Enrollment in demonstration area December 2014[1]			Medicare Advantage enrollment December 2014
					MLTC	MAP	PACE	
Health Insurance Plan of Greater New York (HIP)	EmblemHealth Dual Assurance FIDA Plan	No	No	Medicaid MCO; MLTC; MAPD	1,337	656	N/A	113,625
Independence Care Systems, Inc.	ICS Community Care Plus FIDA MMP	No	Yes	MLTC	5,328	N/A	N/A	N/A
Integra MLTC Inc.	Integra FIDA Plan	No	Yes	MLTC	2,191	N/A	N/A	N/A
MetroPlus Health Plan	MetroPlus FIDA Plan	No	Yes	Medicaid MCO; MLTC; MA; D-SNP; C-SNP (HIV/AIDS); MAPD	810	N/A	N/A	8,559
NorthShore-LIJ Health System, Inc.	North Shore-LIJ FIDA LiveWell	No	No	MLTC	1,443	N/A	N/A	N/A
Senior Whole Health of New York, Inc.	SWH Whole Health FIDA	No	No	MLTC; MAP; D-SNP	1,764	53	N/A	41
VillageCare MAX	VillageCare MAX Full Advantage FIDA Plan	No	Yes	MLTC	3,517	N/A	N/A	N/A
VNSNY Choice	VNSNY Choice FIDA Complete	No	Yes	MLTC; MAPD; C-SNP (HIV)	16,289	212	N/A	19,109
WellCare of NY, Inc.	WellCare Advocate Complete FIDA	Yes	No	Medicaid MCO; MLTC; MAPD; D-SNP	6,336	N/A	N/A	51,971

N/A = not applicable; C-SNP = Chronic Care Special Needs Plan; D-SNP = Dual Eligible Special Needs Plan; I-SNP = Institutional Special Needs Plan; MA = Medicare Advantage; MAP = Medicaid Advantage Plus; MAPD = Medicare Advantage Prescription Drug Plan; Medicaid MCO = Mainstream Managed Care Organization; MLTC = Managed Long Term Care; PACE = Program of All-inclusive Care for the Elderly.

[1] For the purpose of this table, the demonstration area includes Region 1 (the five counties of New York City and Nassau County) and Region 2 (Westchester and Suffolk Counties).

[2] Magellan Health Services, Inc. owns 65 percent of this plan.

NOTE: Includes the 21 plans that participated in FIDA during the first demonstration year.

SOURCES: RTI International, 2015; NYSDOH, 2014c; CMS, 2014b.

The variation in prior experience is reflected in the variation in enrollment in the different Medicaid and Medicare plans before the start of the demonstration. As indicated in ***Table 3***, as of December 2014, the parent companies of some plans had no enrollees in a Medicare Advantage plan, whereas others had more than 100,000 in New York State.

Factors including the size of the parent organization and prior experience with Medicaid and Medicare were perceived to influence how easily a plan transitioned to FIDA:

- **Size of parent organization.** NYSDOH indicated that the size of the FIDA plan's parent organization and the expertise and resources available to it seemed to influence the FIDA plan's ability to make certain adjustments or solve certain types of problems quickly. However, NYSDOH also noted that some larger FIDA plans with multiple lines of business may have difficulty making adjustments if they use a vendor that does not keep the lines of business separate.

- **Prior Medicare and Medicaid experience.** NYSDOH observed that FIDA plans with both Medicare and Medicaid experience tended to adapt more quickly to FIDA requirements. This observation was reinforced through interviews with FIDA plans; of the four plans interviewed during the June 2015 site visit, the one with the fewest complaints about the FIDA enrollment process was also the FIDA plan with the largest MAP enrollment. (See ***Section 3, Eligibility and Enrollment*** for more on enrollment.) Another FIDA plan with no prior experience with Medicare reported that developing all of the marketing materials and complying with Medicare's marketing rules was a major challenge.

Based on the very small sample of FIDA plans interviewed, there is some indication that FIDA plans are likely to attract different types of beneficiaries, based on the organizational history, philosophy, and professional disciplines associated with that plan. For example, one FIDA plan had a history of providing services to persons with chronic conditions and visual impairment; this FIDA plan reported having a very elderly, high-need population. Another FIDA plan embraced an independent living philosophy and reported that its beneficiaries tended to value self-direction, with a corresponding resistance to the high level of involvement represented by the IDT.

FIDA plans are not required to operate in all of the demonstration counties. However, multiple plans participate in each county. During the second demonstration year, 8 of 17 participating FIDA plans served all six counties in Region 1; 2 served five of the six counties; and 6 served four of the six counties. Richmond County (Staten Island) and Nassau County on Long Island had the fewest Medicare-Medicaid Plans (MMPs) in their service areas: 10 and 11, respectively (NYSDOH, 2015c). ***Table 4*** indicates which counties were served by each FIDA plan at the beginning of the second demonstration year.

Table 4
FIDA plan by county participation, 2016

FIDA plan	County					
	Bronx	Kings (Brooklyn)	New York (Manhattan)	Queens	Richmond (Staten Island)	Nassau (Long Island)
Aetna Better Health FIDA Plan		x	x	x		x
AgeWell New York FIDA	x	x	x	x		x
AlphaCare Signature FIDA Plan	x	x	x	x		
CenterLight Healthcare FIDA Plan	x	x	x	x	x	x
FIDA Care Complete	x	x	x	x	x	
Elderplan FIDA Total Care	x	x	x	x	x	x
RiverSpring FIDA Plan	x	x	x	x	x	x
Fidelis Care FIDA Plan	x	x	x	x	x	x
GuildNet Gold Plus FIDA Plan	x	x	x	x	x	x
Healthfirst AbsoluteCare FIDA Plan	x	x	x	x	x	x
ICS Community Care Plus FIDA MMP	x	x	x	x		
MetroPlus FIDA Plan	x	x	x	x		
North Shore-LIJ FIDA LiveWell		x	x	x	x	x
SWH Whole Health FIDA	X	x	x	x		
VillageCare MAX Full Advantage FIDA Plan	X	x	x	x		
VNSNY Choice FIDA Complete	X	x	x	x	x	x
WellCare Advocate Complete FIDA	X	x	x	x	x	x

NOTE: Omits the four plans that did not participate after the first demonstration year (Integra FIDA Plan, HealthPlus Amerigroup FIDA Plan, Arch Care Community Advantage FIDA Plan and Emblem Health Dual Assurance FIDA Plan).

SOURCE: NYSDOH, 2016c.

Level of Commitment to the FIDA Demonstration

In general, the FIDA plans interviewed in the early months of the demonstration identified the ability to integrate Medicaid and Medicare services as an important advance in their ability to serve their members. One FIDA plan acknowledged another important motivation was its desire to preserve its membership enrolled in its MLTC program; a plan choosing not to participate in FIDA ran the risk of seeing their members passively enrolled into a FIDA plan operated by a different organization.

While FIDA plans may have had some motivation to participate in FIDA, key informants for NYSDOH speculate that some plans hedged their bets on committing fully to FIDA. For example, NYSDOH speculated that some plans limited their marketing activities due to uncertainty about the FIDA Medicaid rates. As described more fully in ***Section 7, Financing and Payment***, information about Medicaid final rates for the FIDA demonstration was not available prior to the start of the demonstration, and the draft rates that were published were not in parity with those available under MLTC. NYSDOH theorized that this uncertainty may have undermined the FIDA plans' incentive to market FIDA to providers and their MLTC enrollees.

Also, CMS speculated that at least one FIDA plan was sending negative messages about FIDA to its MLTC members and to providers.

Regardless of FIDA plans' initial commitment, the high beneficiary opt-out rate early in the demonstration and the perceived administrative burden associated with FIDA prompted frustration and concern among the plans interviewed in June 2015. For example, FIDA was perceived to have significantly more reporting requirements than MLTC or MAP. Plans also reported that trying to schedule IDT meetings with providers was challenging and time-consuming for their staff. Although the reforms implemented in December 2015 responded to many of the concerns, they were not implemented until after the final phase of passive enrollment, after the majority of eligible beneficiaries had opted out or disenrolled.

In 2016, NYSDOH believed the reforms and revised rates helped to stabilize FIDA enrollment. However, without passive enrollment, increasing enrollment depends on Medicare-Medicaid enrollees choosing to opt in. Opt-in enrollments were not sufficient to offset voluntary and involuntary disenrollments. As a result, enrollment declined 29 percent (a decrease from a total of 6,542 enrollees to 4,672) from its peak in the third quarter of 2015, the quarter before the reforms were implemented, and the fourth quarter of 2016. In general, the decline in enrollment was fairly consistent across plans, with one notable exception—one plan almost doubled its enrollment through a significant marketing effort. ***Table 5*** shows the change in enrollment by FIDA plan from January 2016, the quarter after reforms were implemented, to December 2016, the end of the fourth quarter of 2016.

At the end of 2015, four plans were no longer participating in FIDA.[15] Three more exited at the end of 2016. In July 2016, CMS extended an offer to all States participating in the Financial Alignment Initiative to extend the demonstration period by 2 years; New York extended its demonstration period 2 years beyond the planned end date of December 2017. This invitation prompted correspondence on behalf of the New York Coalition of Managed Long Term Care and PACE plans expressing the Coalition's preference that FIDA not be extended.[16] The letter identified a number of features of the FIDA program that the Coalition would like to incorporate into the MAP program but expressed the Coalition's concern that FIDA is not the appropriate vehicle for integrating care for Medicare-Medicaid enrollees:

> …[S]ince its inception, FIDA has faced significant design and implementation challenges and has suffered from lack of provider engagement and support, decreasing participation by managed care plans, significant concerns about rate sufficiency, and low enrollment. While the Department has made efforts to remedy these issues and the plans have done their best to enroll members, these financial and operational issues persist for many plans (Fiori and Lytle, September 9, 2016).

[15] One plan was disqualified from continued participation because it failed to submit its Plan Benefit Package on time, a requirement under Medicare.

[16] The Coalition describes itself as representing 21 managed care organizations that provide coverage for the overwhelming majority of MLTC, PACE and FIDA enrollees (New York Coalition of Managed Long Term Care and PACE Plans, January 26, 2016, p. 2).

The Coalition's position was countered by a letter from another plan suggesting that many of the early challenges associated with FIDA had been addressed and the demonstrations under the Financial Alignment Initiative have broader regulatory authority for implementing the integrated features that work well under FIDA (Surpin, September 12, 2016). The better path forward, according to this plan, would be to rebrand FIDA and eliminate competition between FIDA and the MAP program.

Table 5
Change in enrollment by FIDA plan, Jan. to Dec. 2016

FIDA plan	Total enrollment Jan. 2016	Total enrollment Dec. 2016	Percent change
Aetna Better Health FIDA Plan	66	45	−32
AgeWell New York FIDA	53	39	−26
AlphaCare Signature FIDA Plan[1]	44	32	−27
CenterLight Healthcare FIDA Plan[1]	215	108	−50
FIDA Care Complete	37	23	−38
Elderplan FIDA Total Care	304	311	2
RiverSpring FIDA Plan	15	†	N/A
Fidelis Care FIDA Plan	379	300	−21
GuildNet Gold Plus FIDA Plan	923	779	−16
Healthfirst AbsoluteCare FIDA Plan	1,237	990	−20
ICS Community Care Plus FIDA MMP	189	154	−19
MetroPlus FIDA Plan	183	170	−7
North Shore-LIJ FIDA LiveWell	29	26	−10
SWH Whole Health FIDA	63	122	94
VillageCare MAX Full Advantage FIDA Plan	34	24	−29
VNSNY Choice FIDA Complete	2,264	1,723	−24
WellCare Advocate Complete FIDA[1]	207	128	−38

N/A = not applicable.

[1] Exited the FIDA demonstration at the end of 2016.

† Indicates enrollment of 10 or fewer.

NOTE: Four plans did not participate after the first demonstration year, ending December 2015: Integra FIDA Plan, HealthPlus Amerigroup FIDA Plan, Arch Care Community Advantage FIDA Plan and Emblem Health Dual Assurance FIDA Plan.

SOURCES: NYSDOH, 2016a; and Integrated Care Resource Center, 2017.

In the end, NYSDOH decided to extend the demonstration; however, it did not make that announcement until November 9, 2016. CMS speculates that NYSDOH's delay in committing to the extension contributed to the plans' uncertainty about NYSDOH's commitment to FIDA and may have undermined the value of the advertising campaign (conducted in the second half of 2016, as discussed in ***Section 3, Eligibility and Enrollment***) as an opportunity for FIDA plans to build their enrollment.

2.2.2 Provider Arrangements and Services

FIDA plans are required to establish networks of participating providers that meet Medicare and Medicaid accessibility standards. The three-way contract requires a FIDA plan to have a network that is adequate to ensure access to medical, behavioral health, pharmacy, and both community-based and facility LTSS to meet the needs of the population, including physical, communication, and geographic access (three-way contract, 2014, p. 74). Plans were required to demonstrate compliance with network adequacy requirements at the county level as part of the readiness review.

Many plans were able to leverage their provider networks from their existing managed care products to build their provider network for FIDA. However, one plan reported that some plans without prior history administering a Medicare product encountered some challenges contracting with medical providers. In addition, some large health systems did not want to contract with plans with only a small number of enrollees, creating a barrier to FIDA participation for those whose physicians were part of those health systems.

Because New York's Medicare-Medicaid beneficiaries were already enrolled in one of New York's MLTSS programs, NYSDOH had to decide whether passive enrollment would prioritize the continuity of a beneficiary's LTSS provider relationships financed through the Medicaid-funded MLTSS program or the beneficiary's relationship to its medical providers under Medicare. NYSDOH believed that it was most important to minimize disruption to LTSS provider relationships:

> [Passive enrollment] was based on the MLTC. It was not based on their Medicare provider or behavioral health…We talked about that, "What should we be assuming are the most important services these individuals would want to keep constant or consistent?" We said it would be the MLTC. … It's their home health aides, the person who comes in every day to make sure they can get of bed.

NYSDOH also assumed that, if a new enrollee's Medicare providers were not already in network, the FIDA plans could contract with those providers in anticipation of passive enrollment or during the 90-day continuity of care period following enrollment. Based on these assumptions, NYSDOH designed FIDA to build on the MLTSS programs: beneficiaries enrolled in an MLTC or MAP plan would be passively enrolled into a FIDA plan operated by the same parent organization. Although CMS had data use agreements with NYSDOH dating back to 2011, NYSDOH reported that it did not use the Medicare data to inform passive enrollment decisions in the demonstration, citing difficulty with using the data. Some FIDA plans reported that they were not able to contract with providers in advance of passive enrollment, to ensure that a new enrollee's providers were in their network. Some FIDA plans reported not having advance information about new enrollees' medical providers. For example, one plan reported that it often had information about the primary care provider for those enrollees that had been previously enrolled in their MLTC plan and it also had contracts with a majority of providers in the service area. However, this plan found that it often did not discover until the care planning process that it did not have contracts with the specialist or subspecialists that the FIDA enrollee used; some of these specialists (e.g., a cardiologist or an endocrinologist) played the primary role in managing the beneficiary's care.

Without advance information on an enrollee's current providers, the FIDA plans could not begin recruiting those providers until they had conducted intake with the enrollees and confirmed whether the beneficiary's providers were already enrolled. Because some FIDA plans were confused about marketing restrictions, they were not certain about when they were permitted to initiate contact with the beneficiary to start the conversation about whether their providers were in network. Also, given the high opt-out rate, one plan reported choosing to wait until the first day of enrollment before conducting a welcome call, to avoid initiating contact with persons who were likely to opt out.

When FIDA plans did try to recruit physicians, many physicians refused to participate in FIDA because of the perceived burden. Although FIDA offered a 90-day continuity-of-care period under which the FIDA plan could pay providers, many providers refused to accept payment from FIDA. The primary focus of provider concerns about FIDA related to the original design of the IDT, discussed in more detail in ***Section 4, Care Coordination***. One FIDA plan reported:

> Once the physicians heard about the IDT process and the time it was going to take them away from their practice and/or billing of patients, they would speak to the members and say 'I simply don't have time for it.'

In addition to resistance to the IDT, NYSDOH's attempt to incorporate Medicaid policy into CMS's template for the Plan Benefit Package (PBP) unintentionally resulted in a misunderstanding among plans that every service required prior authorization. NYSDOH reported that the PBP template was designed for Medicare plans and limited NYSDOH's ability to incorporate Medicaid policy:

> Our intention was always that if you're going to require authorization then the IDT should be the entity that authorizes the services but…we ended up putting it forward in a way that the plans could only interpret as every service required authorization….That was a barrier that I think accidentally got put in place that we've now removed by allowing a lot more flexibility in the PBP document for the plans to specify which services they want to require prior authorization for.

In particular, plans were originally directed to enter a note in the PBP's notes field indicating that "These services must be authorized as specified in the NYSDOH IDT Policy" (NYSDOH, 2016b).

As a result, in the first year of the demonstration, providers were required to request authorization for everything, which made some providers feel micromanaged, especially when compared to their experience with MAP or Medicare Advantage. NYSDOH clarified the authorization process to be similar across MAP and FIDA plans in the spring of 2016. In particular, plans specified that no prior authorization was required for certain specialty services, or they elect to require prior authorization.

NYSDOH, CMS, and FIDA plans identified a number of other provider concerns as barriers to provider participation; some providers were reluctant to participate in managed care in general and some perceived the provider training requirements as too onerous (see ***Section 2.2.3,***

Training and Support for Plans and Providers). In addition, NYSDOH and FIDA plans cited reform fatigue as another major factor that discouraged provider participation, particularly because FIDA is a relatively small initiative compared with other reform activities in New York, such as Delivery System Reform Incentive Payment (DSRIP).

Although the IDT policy was significantly revised in December 2015 and other changes have been made to address provider concerns (see ***Section 4, Care Coordination***), FIDA's negative reputation among providers continued to be a problem, as one NYSDOH official described during the 2016 site visit:

> One of the [MMP] medical directors said to us "It's sort of tough to have a second-time go-round of your first impression of the program." That's what they're working on right now.... I think it is the physicians driving this [low enrollment] for not joining the plans…it's still the physicians.

For those providers participating in FIDA, some FIDA plans describe examples of physicians willing to actively engage in the IDT. In the words of one plan:

> The PCPs that are engaged, they share a wealth of information and there's a flow of clinical information to get that participant on track for the right level of services to avoid an admission…And they're also addressing behavioral health…and social services, which can impact someone's quality of life.

This plan noted that this level of engagement is the exception, not the rule, and speculated that those physicians most willing to engage had fewer FIDA members on their panel. This plan acknowledged that its provider reimbursement model does not pay for physician services without an office visit and did not reward physicians for a higher level of engagement.[17]

Representatives for other types of providers reported that the FIDA plans do not make an effort to include them on the IDT. For example, according to one key informant, some nursing facilities reported that they are rarely invited to participate in IDT meetings. Because the IDT policy requires that the composition of the IDT be defined by the enrollee, it is possible that some providers are not included because the enrollee chose not to include them.

2.2.3 Training and Support for Plans and Providers

During the early phases of implementation, the CMT served as the primary vehicle for providing technical assistance to the plans through separate calls with each FIDA plan and weekly calls with all FIDA plans. These calls were used to provide trainings to the MMPs as needed and to ensure that the MMPs were given consistent answers to similar questions that have come up from different MMPs. In the early phases of implementation, the CMT also published a series of Frequently Asked Questions (FAQs) covering a range of demonstration-related topics.

[17] As part of its DSRIP program, NYSDOH is requiring its Medicaid managed care organizations to transition their fee-for-service provider contracts to value-based arrangements; the three-way contracts also required FIDA plans to submit plans for this transition in early in the demonstration (three-way contract, 2014, p. 90). However, low enrollment in FIDA and provider resistance to participating in FIDA has left FIDA plans with little leverage to negotiate with their providers, resulting in deferral of this requirement.

The FAQs focused on start-up or short-term operational issues, including how to reconcile or integrate Medicare and Medicaid processes and policies relating to grievances and appeals, encounter data, marketing, enrollment, and other topics. The FAQs also addressed the technical complexities of the enrollment process, including the flow of enrollment files among NYSDOH and its enrollment broker, CMS and its vendors, and the FIDA plans. The CMT's support was well received by the FIDA plans as a reflection of how hard NYSDOH and CMS were working to respond to questions and clarify policies.

To ensure that providers have similar training and knowledge of the demonstration, its features, and the issues related to the Medicare-Medicaid eligible population, CMS and its contractor, the Lewin Group, worked together with the FIDA plans and beneficiary advocates to create a mandatory, web-based training program for FIDA providers (CMS, n.d.).[18] Initially, all providers normally credentialed by the FIDA plans and responsible for the care of FIDA enrollees were required to take the training, as were clinical leadership and compliance and administrative staff within a provider organization, and any member of an IDT (NYSDOH, 2015f, p. 2). The training was designed to satisfy the training requirements for all FIDA plans, saving providers from taking multiple trainings and the plans from producing multiple training curricula. To respond to provider concerns about the burden associated with participating in FIDA, the training requirements were made optional in December 2015 (NYSDOH 2015e, p. 1).

2.3 Major Areas of Integration

2.3.1 Integrated Benefits and Enrollment

The three-way contract defines a combined package of Medicare and Medicaid covered services. New York's Medicaid program covers some services that "wraparound" Medicare covered services, including non-Medicare inpatient mental health services, skilled nursing facility services, durable medical equipment, and home health. When determining coverage under FIDA, FIDA plans must apply the more favorable of the current Medicare and NYSDOH coverage rules (three-way contract, 2014, p. 249). FIDA also includes an integrated formulary combining prescription drugs covered under Medicare Part D and Medicaid and certain non-prescription drugs excluded by Part D (three-way contract, 2014, p. 249).

New York and CMS worked together to design integrated enrollment procedures, including integrated enrollment notices and materials for FIDA members and an integrated enrollment process through New York's enrollment broker. The integrated enrollment process involves the transfer of data files from the enrollment broker to New York's Medicaid enrollment system to confirm Medicaid eligibility, then to CMS's vendor for confirming Medicare eligibility, and then to New York's benefit enrollment system before the FIDA plan is notified it has a new enrollee. The process of disenrollment is less integrated, requiring the beneficiary to call both 1-800-MEDICARE, to reenroll in a Medicare plan, and MAXIMUS, to reenroll in a Medicaid plan. ***Section 3, Eligibility and Enrollment*** provides more detail on the

[18] Training modules addressed cultural competency; how to identify and support persons with behavioral health needs and diagnoses; and how to promote reasonable accommodations and support effective interactions for persons with disabilities. The training program also provided an overview of FIDA and supplemental training on the IDT, training that was originally required for IDT members.

enrollment process and some of the challenges that have been encountered with enrollment, disenrollment, and the Medicaid recertification process.

2.3.2 Integrated Care Coordination and Care Planning

As discussed in greater detail in ***Section 4, Care Coordination***, Medicare and Medicaid services are integrated through the FIDA plan's care manager and the IDT. The IDT develops a single person-centered service plan (PCSP) that is required to address all the enrollee's care and service needs, whether or not they are provided by the FIDA plan. The FIDA plan is accountable for sharing clinical and treatment plan information.

2.3.3 Integrated Quality Management

CMS and NYSDOH have an integrated quality measurement strategy, including core measures collected across all demonstrations, New York-specific measures, and quality withhold standards. Quality monitoring is coordinated through the CMT, which jointly monitors plan activities and grievances and appeals, hears reports from the ombudsman, and identifies emerging trends and issues across plans. Although early in the process, New York's External Quality Review Organization is expected to coordinate their Medicaid quality activities with the quality improvement activities on the Medicare side. See ***Section 9, Quality of Care*** for more information about quality management.

2.3.4 Integrated Financing

CMS and NYSDOH make three separate, risk-adjusted, per member per month (PMPM) payments to FIDA plans. CMS makes a monthly payment reflecting coverage of Medicare Parts A and B services and a separate amount reflecting Part D services. NYSDOH makes a monthly payment reflecting coverage of Medicaid services. CMS and NYSDOH withhold a certain percentage of their respective components of the capitation rates (i.e., to the Medicare Parts A and B and Medicaid components; no withhold is applied to the Part D component). The withhold will be repaid to the FIDA plans subject to each MMP's performance relative to the quality thresholds established in the three-way contract. See ***Section 7, Financing and Payment*** for more information about financing and payment.

2.3.5 Integrated Appeals

New York and CMS have developed a unique integrated appeals process that creates a single appeals process for both Medicare and Medicaid appeals (excluding those related to Part D, which remain outside New York's integrated appeals process). A FIDA enrollee (or his or her representative) can appeal any "action" by the FIDA plan to deny or limit authorization of a covered service. An appeal must first be filed with the FIDA plan. If, on reconsideration, the plan upholds its original decision, it automatically forwards the appeal to a State-level hearing office, which hears all Medicare- and Medicaid-related appeals. If an enrollee disagrees with the decision at the State level, he or she may file an appeal at the Federal level. In addition to streamlining the process, FIDA also integrates CMS and State appeals policies. See ***Section 5.2, Impact of the Demonstration on Beneficiaries*** for more information about the integrated appeals process.

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3. Eligibility and Enrollment

Highlights

- New York conducted passive enrollment starting in April 2015 and ending in October 2015. Of those eligible for passive enrollment, 62 percent opted out. At the end of the passive enrollment period in October 2015, only 8,893, or just 10 percent, of the 88,933 individuals eligible to participate in the Fully Integrated Duals Advantage (FIDA) demonstration that month were enrolled.
- Passive enrollment required transferring enrollment files from the enrollment broker to CMS to confirm eligibility for Medicare, then to New York State to confirm eligibility for Medicaid, and then to the FIDA plan to confirm enrollment. In the early stages of the demonstration, the timing and accuracy of these data transfers created challenges for FIDA plans.
- The primary factors influencing beneficiaries' enrollment decisions include: providers not participating in the demonstration; providers actively encouraging their patients to opt out; and fear of change among eligible beneficiaries.
- In response to low enrollment, New York State Department of Health (NYSDOH) issued a number of reforms aimed at responding to concerns identified by FIDA plans, advocates, providers and beneficiaries. NYSDOH also conducted an advertising campaign aimed at explaining that FIDA was reformed and providing information about the benefits of participating in FIDA.
- Most of the reforms and efforts to increase enrollment occurred after passive enrollment ended and have not yielded a significant increase in opt-in enrollment.

3.1 Introduction

This section provides an overview of the enrollment process for FIDA. Currently, Medicare-Medicaid beneficiaries can opt in to FIDA and, at any time, disenroll from a plan or opt out of the demonstration. Initially, beneficiaries were passively enrolled in phases over the first several months of the demonstration. This section describes the passive enrollment process, the challenges encountered in the early stages of the demonstration and the opt-in enrollment process currently used. Specifically, the complexities of integrating the Medicare and Medicaid eligibility and enrollment systems are addressed. Finally, data on those enrolled and those who opted out are presented.

3.2 Enrollment Process

3.2.1 Eligibility

Eligibility for FIDA is based on the following criteria: age 21 or older at the time of enrollment; entitled to or enrolled in Medicare Part A, enrolled in Medicare Part B, eligible to enroll in Medicare Part D, and receiving full Medicaid benefits; and residing in a FIDA demonstration county. Additionally, beneficiaries must meet one of the following criteria: clinically eligible for nursing facility services and receiving facility-based long-term services and supports (LTSS); eligible for the Nursing Home Transition & Diversion (NHTD) §1915(c) waiver; or require community-based long term care services for more than 120 days. Assessments to identify an individual's need for 120 days or more of community-based long-term care services must be conducted in compliance with New York's §1115(a) waiver. (MOU, 2013, pp. 6–8, as revised by three-way contract, 2014, p. 186 and State-specific Enrollment Appendix 5, 2016, Section 2, p. 2).

Initially, persons residing in a nursing facility were excluded from enrollment into FIDA. However, starting in February 2015, New York began transitioning nursing facility services to Medicaid managed care. Under the transition plan, starting February 1, 2015, persons residing in one of five counties in the demonstration area (Bronx, Kings, New York, Queens, and Richmond) and newly needing nursing facility services were required to enroll in one of New York's MLTSS programs: MLTC, MAP, or FIDA. The sixth county in the demonstration area (Nassau) was part of the second phase in this transition process, starting April 1, 2015. Finally, starting October 1, 2015, persons already residing in a nursing facility before February 1, 2015, may opt in to FIDA or another MLTSS program, if they choose to. Otherwise, nursing facility services provided to those already in a nursing facility before that date are reimbursed on a fee-for-service basis (NYSDOH, 2015a, p. 2).

3.2.2 Phases of Enrollment

As proposed, NYSDOH planned to begin implementation of FIDA starting in January 2014 (NYSDOH, 2012a). When the Memorandum of Understanding (MOU) was signed, the earliest start date was pushed to July 1, 2014. Following completion of the readiness review for the FIDA plans, the start date for opt-in enrollment was moved to January 1, 2015 (NYSDOH, n.d.-b).

In advance of the January 1, 2015, start date, in December 2014 NYSDOH issued a program announcement letter to all individuals eligible to enroll in FIDA. NYSDOH also issued 90-, 60-, and 30-day passive enrollment notices to individuals slated to be passively enrolled. Those notices described the FIDA demonstration and beneficiaries' options for enrolling in or opting out of the demonstration.

NYSDOH originally scheduled passive enrollment in five waves starting on April 1, 2015, and divided the eligible beneficiaries based on their Medicaid Eligibility Authorization renewal date and their birth month (three-way contract, 2014, pp. 188–90).

Table 6 shows the schedule of passive enrollment phases. Because New York was experiencing a high rate of opt-outs, NYSDOH delayed the third phase of passive enrollment,

scheduled for June 1, to provide time to investigate the reasons for the opt-outs and evaluate whether to continue the demonstration. Ultimately, NYSDOH decided to continue with the demonstration and resumed passive enrollment on July 1. NYSDOH conducted a sixth wave of passive enrollment effective on October 1, 2015, but then suspended the process in response to the continued high opt-out rate.

Table 6
Region 1 enrollment schedule

Phase	Effective date of enrollment
Phase 1	April 1, 2015
Phase 2	May 1, 2015
Phase 3	July 1, 2015[a]
Phase 4	August 1, 2015
Phase 5	September 1, 2015
Phase 6	October 1, 2015

[a] Phase 3 was originally planned to begin June 1, but NYSDOH paused passive enrollment for a month while it evaluated the cause of the high opt-out rate.

3.2.3 Passive Enrollment Experience

Notices

In December 2014, NYSDOH sent beneficiaries a letter announcing the FIDA demonstration and the opportunity to opt in. Beginning in January 2015, beneficiaries who were scheduled to be passively enrolled were also sent letters describing the demonstration, the name of the FIDA plan the beneficiary was to be enrolled in, and how to opt out of the demonstration.

While NYSDOH initially required plans to translate all documents into six languages (Spanish, Chinese, Russian, Italian, Haitian-Creole, and Korean), NYSDOH later discovered that many of the demonstration announcement letters sent to eligible beneficiaries were in the wrong language. MAXIMUS, which sends the notices to beneficiaries, receives information on the language spoken by beneficiaries from Human Resources Administration (HRA) through the Welfare Management System (WMS). During the 2015 evaluation site visit, FIDA plans said they heard from their MLTC members that they had received a letter in the wrong language. At that 2015 site visit, one FIDA plan voiced frustration: "Members start getting material 60 days, then 30 days, then big packets of material…they [can't] really read it because it wasn't translated…to hear that MAXIMUS hasn't translated any of its letters, it becomes frustrating." CMS representatives said they have also encouraged MAXIMUS and State agencies to adopt a "standing request" process for beneficiaries to ask for information in a preferred language once, similar to the requirement FIDA plans have.

At the start of the demonstration, if a beneficiary called a FIDA plan to enroll, the Medicare-Medicaid Plan (MMP) was required to set up a three-way call between the MMP, beneficiary, and the enrollment broker and "warmly transfer" the beneficiary to the enrollment broker to begin the enrollment process (three-way contract, 2014, p. 45). NYSDOH and CMS

revised the enrollment policy in December 2015 to allow FIDA plans to remain on the phone to provide additional insights when potential FIDA enrollees speak with MAXIMUS about their enrollment options, if the plan's participation is permitted by the beneficiary.

Enrollment

During April and May 2015, the first 2 months of passive enrollment, over half of those eligible for passive enrollment opted out of the demonstration. This pattern continued after NYSDOH resumed passive enrollment in July 2015. By the time the passive enrollment period ended in October 2015, NYSDOH reported that 62 percent of those eligible for passive enrollment had opted out before they could be enrolled and another 12 percent had disenrolled. At the end of the passive enrollment period, only 8,893 out of 88,933 individuals eligible to participate in FIDA in October 2015—just 10 percent—were enrolled. Following this last phase of passive enrollment, beneficiaries must actively enroll in the demonstration if they would like to participate.[19]

NYSDOH, FIDA plans, and the ombudsman indicated that the initial announcement notice sent in December 2014 caused much concern and anxiety among potential enrollees. Plans said that their MLTC care managers received calls from participants asking "What is happening to me?" or "What does this mean?" FIDA plans reported being confused about what they could say about FIDA to beneficiaries without running afoul of marketing rules, and chose to err on the side of caution. The ombudsman experienced a much greater call volume about the demonstration in December 2014, a month before FIDA's start date, than NYSDOH had anticipated.

Plans reported that many beneficiaries were not aware that they have been passively enrolled until the plan reached out with a welcome call. Plans reported that some members of their Participant Advisory Council reported being surprised to learn they had been passively enrolled; the spouse of one member indicated her husband could not read. Some FIDA plans believed some of the confusion is attributed to the enrollment notices, which are perceived to be too long, confusing, or not in the correct language.

In focus groups conducted by the RTI evaluation team, some participants described their enrollment into FIDA as the "insurance changed" and the change was "out of their control."

Advocates interviewed during the first site visit questioned whether passive enrollment is appropriate for the Medicare-Medicaid beneficiaries eligible for FIDA, given the medical fragility of the population and the complexity of the process.

3.2.4 Integration of Medicare and Medicaid Enrollment Systems

Enrollment Broker

The enrollment process is integrated through MAXIMUS, a single, State-contracted enrollment broker which operates as New York Medicaid Choice. MAXIMUS handles all enrollment transactions for FIDA. If beneficiaries call Medicare's customer service line, 1-800-

[19] Some beneficiaries covered under a plan exiting from FIDA have been passively transitioned to another FIDA plan.

MEDICARE, with questions about the FIDA demonstration or to enroll, customer service provides general information on the FIDA demonstration and suggests a call to MAXIMUS if additional information is required. When a beneficiary calls MAXIMUS with questions about FIDA, MAXIMUS first identifies whether the beneficiary is actually eligible to participate. If eligibility is confirmed, MAXIMUS then provides information about the different Medicaid options available.

During the passive enrollment phase, beneficiaries could opt out of FIDA at any time prior to the effective date of enrollment by calling either 1-800-MEDICARE or MAXIMUS and making the affirmative choice not to participate in the demonstration. Those beneficiaries enrolled in FIDA may disenroll by enrolling in another Medicare health or Part D or PACE plan; calling 1-800-MEDICARE; calling MAXIMUS; or submitting a signed written request to MAXIMUS to disenroll. The disenrollment process is not fully integrated. Call center staff at 1-800-MEDICARE will help the beneficiary to choose a Medicare product (e.g., Original Medicare with a Part D Plan, Medicare Advantage) (CMS, 2013a) and then refer him or her to MAXIMUS for assistance in choosing a Medicaid product. Similarly, a beneficiary calling MAXIMUS will receive help choosing a Medicaid product for long-term services and supports (LTSS); if the beneficiary chooses a partial MLTC plan (and not MAP or PACE), he or she is then referred to 1-800-MEDICARE for assistance in choosing a Medicare product. If beneficiaries do not contact 1-800-MEDICARE, they will be returned to Medicare fee-for-service (CMS, 2013a).

Both the State and CMS reported that, in the interest of allowing similar enrollment capabilities for the MLTC, MAP, and FIDA, NYSDOH now allows plans to use the same process for enrolling beneficiaries who are new to service—rather than referring the individual to MAXIMUS, the FIDA plan may now submit a "U-File" to MAXIMUS, and if MAXIMUS confirms that the beneficiary is eligible for the demonstration, MAXIMUS processes the enrollment and sends a letter to the beneficiary confirming the enrollment. CMS staff noted that the U-File process is seldom used.

Enrollment and Disenrollment Data File Transfers

To effectuate enrollment into FIDA, MAXIMUS sends a daily batch file of enrollment requests to the CMS Medicare Advantage and Prescription Drug system (MARx) then processes the transaction. CMS sends a Daily Transaction Reply Report (DTRR) with the accepted and rejected transactions to both MAXIMUS and the MMP impacted by the change. MAXIMUS then sends a batch file of all the acceptances to the New York electronic Medicaid enrollment system, eMedNY. If the transactions are approved at the eMedNY level, they are then sent to the New York State benefits enrollment system, the WMS. At that point, the beneficiaries are officially enrolled in FIDA.

The timing and accuracy of data transfers created problems for the MMPs, beneficiaries, and providers in the first several months of the demonstration. One MMP described cases in which a beneficiary was scheduled for passive enrollment, called MAXIMUS, and actively opted in 1 month prior to the passive enrollment date. In cases like this, the MMP said the data file from CMS showed that the person was enrolled, but the file from MAXIMUS still showed the person will be enrolled at a later date. The MMP was not sure whether the person was actually

enrolled at the time services were delivered. However, State informants indicated that, with the suspension of passive enrollment, data transfer issues have not been as common a complaint.

> An unanticipated complication in the integrated enrollment process involves the New York City HRA, the agency that recertifies Medicaid eligibility. Like all Medicaid beneficiaries, FIDA members must be recertified as eligible for Medicaid on an annual basis. HRA recertifies eligibility for Medicaid for all beneficiaries in the New York City area. NYSDOH has learned that HRA has the capacity to execute enrollment and disenrollment from FIDA plans within the WMS.
>
> The HRA does not have the authority to reactivate a member's Medicare plan enrollment. If a member is disenrolled from FIDA because of a lapse in Medicaid eligibility, the member is automatically placed in fee-for-service Medicare with a Part D plan. When HRA recertifies for Medicaid eligibility and "erases" the disenrollment from the FIDA plan and does not notify Medicare, any claims that occur during the time when the beneficiary was disenrolled must be retroactively adjusted by CMS once MAXIMUS determines the member really is in the FIDA plan again.

The majority of FIDA plans have elected to offer a 90-day period of deemed continuous eligibility for beneficiaries who have not been recertified in time. Those enrolled in a FIDA plan electing this option stay enrolled while the recertification is processed, reducing the potential for disrupted enrollment.

3.2.5 Contacting and Locating Enrollees

Because FIDA was built on existing MLTSS programs, most new FIDA enrollees were already enrolled in an MLTC or MAP operated by the FIDA plan's parent company. As a result, very few could not be reached within 90 days of enrollment. As indicated in ***Table 7***, the percentage of enrollees that FIDA plans were unable to reach within 90 days of enrollment ranged from 0.4 percent at its lowest to 2.4 percent at its highest.

Table 7
Percentage of enrollees that FIDA plans were unable to reach following three attempts, within 90 days of enrollment

Quarter	Calendar year 2015	Calendar year 2016
Q1	0.4%	2.7%
Q2	1.5%	1.3%
Q3	1.4%	0.0%
Q4	1.3%	1.3%

NOTES: Arch Care Community Advantage, Emblem Health Dual Assurance, HealthPlus Amerigroup, and Integra FIDA plans withdrew after 2015. Data for Arch Care Community Advantage were included through Quarter 3 2015. Data for Emblem Health Dual Assurance, HealthPlus Amerigroup, and Integra were included through Quarter 4 2015.

SOURCE: RTI analysis of MMP reported data for Core Measure 2.1, as of September 2018. The technical specifications for this measure are in the Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements document, which is available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/InformationandGuidanceforPlans.html.

3.2.6 Factors Influencing Enrollment Decisions

Overall, enrollment in FIDA has been much lower than NYSDOH expected, primarily as a result of beneficiaries choosing to opt out of the demonstration. At the start of the demonstration, key informants at NYSDOH, FIDA plans, advocates, and the ombudsman identified several reasons for the high opt-out and disenrollment rate. Some but not all of these concerns were consistent with the survey conducted by MAXIMUS, New York's enrollment broker, which asked beneficiaries their reason for opting out of FIDA prior to being passively enrolled in the program (see ***Table 8***).

Table 8
Reasons for opting out of enrollment in FIDA, year to date December 19, 2015

Opt-out reason	Number	Percent
Satisfied with current services	18,657	39.68
Do not want to make any changes/Don't like change	15,859	33.73
Don't want to change PCP	3,654	7.77
Want to keep separate cards	1,989	4.23
PCP/Specialist does not accept FIDA	1,793	3.81
Don't want to change specialist/dentist	1,150	2.45
FIDA cancellation	1,102	2.34
Don't want to lose any benefits	754	1.60
I'm being advised to opt out	586	1.25
FIDA plan did not provide an Over-the-Counter card[1]	466	0.99
Don't want to give up my Medicare card	220	0.47
Refused to provide an opt-out reason	196	0.42
I have a union/employer-sponsored benefit	168	0.36
No difference between the MLTC to FIDA	123	0.26
I'm being advised to opt out by provider	97	0.21
I'm being advised to opt out by plan	90	0.19
Called 1-800-MEDICARE to opt out	79	0.17
I'm being advised to opt-out by home health agency	40	0.09

FIDA = New York Fully Integrated Duals Advantage program; MLTC = Managed Long-Term Care plan.

[1] See ***Section 5.2.2, Beneficiary Experience with New or Expanded Benefits*** for more information about the Over-the-Counter (OTC) card.

SOURCE: MAXIMUS, 2015.

Fear of Change and "too much, too soon"

Advocates, NYSDOH, and FIDA plans indicated that many beneficiaries were afraid to enroll in FIDA, having only recently transitioned to the MLTC program in 2012. There was a sense among advocates that beneficiaries did not want to join FIDA because they had just gotten used to MLTC and did not want to change anything about how they currently received services. One FIDA plan noted that its disenrollment survey revealed that most choosing to disenroll were not aware they were being passively enrolled in FIDA: "…what they said to us was, 'It just left a bad taste in my mouth. I knew nothing about it and my plan changed, and I didn't know why.'" NYSDOH and Independent Consumer Advocacy Network key informants reported that there is a feeling among beneficiaries that they should wait and see how it works for others before joining themselves.

This rationale is supported by MAXIMUS' survey, with the majority (73 percent) of respondents saying they were satisfied with current services or did not want to change.

Provider not In-Network

Although FIDA was intended to preserve the relationships between beneficiaries and their LTSS providers, beneficiaries' relationships to their medical providers also proved to be an important factor in influencing beneficiary enrollment. Many beneficiaries who learned that an important provider was not part of their FIDA plan opted out before being passively enrolled, or they disenrolled after enrollment. As discussed in ***Section 2, Integration of Medicare and Medicaid***, many providers refused to participate in FIDA because it was perceived to be overly burdensome or because they distrusted managed care.

According to one MMP, once enrollees realize that their doctor is not participating, "all bets are off." Plans reported that many beneficiaries with complex needs are reluctant to disrupt long-standing relationships with providers who know them and understand their care needs. NYSDOH officials also speculated that language barriers may explain loyalty to providers who do not join a FIDA plan. NYSDOH reported that 57 percent of FIDA-eligible beneficiaries speak a language other than English; a beneficiary may be reluctant to part with a provider able to speak the same language, if that provider does not participate in FIDA.

According to the enrollment broker's survey of those opting out, a total of 14 percent identified interference with a provider relationship as the reason they did not want to participate in FIDA.

Active Discouragement by Providers

Second, as discussed in ***Section 2, Integration of Medicare and Medicaid*****,** some providers were actively encouraging their patients to opt out of FIDA, because they perceived FIDA to be too burdensome. There was also a general perception that a number of providers, particularly providers identified as Russian, were resistant to managed care and refused to participate. Provider resistance extended to accepting any payment under FIDA: Although FIDA plans were required to honor an individual's preexisting service plan for the first 90 days of enrollment, some providers still refused to provide care to patients who had enrolled in FIDA. One FIDA plan reported members visiting a doctor's office and being turned away because the provider did not participate in FIDA:

> It's a real challenge when we're the advocate and the woman at the front desk says to a member "You can't see the doctor today." We get that repeatedly: "We ran your number, we're not in network." You can say it's continuity of care and the first 90 days. That person says no.

According to the enrollment broker's survey of those opting out, less than 1 percent said they were opting out because a plan or provider was encouraging them to.

Interdisciplinary Teams (IDTs)

FIDA plans reported that the original design of the IDT had deterred some beneficiaries from enrolling in FIDA. The requirements of the IDT policy apply to every member, regardless of the member's needs or preferences. One FIDA plan expressed concern that the original design of the IDT model ran counter to the independent living philosophy of self-determination. The informant reported that several beneficiaries enrolled in the MMP's other MLTSS product resisted enrolling in FIDA because the IDT model did not allow them to choose a less intensive level of involvement for the IDT; according to these key informants, some beneficiaries see themselves as capable of managing their own care and do not need a care manager's help. Informants reported that a number of potential enrollees were dissuaded from enrolling in FIDA because they saw the IDT as too intrusive and an invasion of privacy, noting in particular that members of the Chinese community were more inclined to see the role of and communication across the IDT as an invasion of privacy.

This concern was not explicitly captured in the survey of opt outs conducted by the enrollment broker.

3.2.7 Activities to Increase Enrollment

NYSDOH and CMS have employed several strategies to increase enrollment. They conducted multiple outreach activities to both providers and beneficiaries. Beginning in June 2015, NYSDOH and CMS conducted trainings for providers and FIDA plans to present information on the benefits of FIDA and discuss collaboration between providers and MMPs. NYSDOH also made edits to the call center scripts used by MAXIMUS, mailed letters to 43,000 eligible beneficiaries who had not yet made a decision to opt in to the demonstration, mailed FIDA marketing letters to 8,200 Medicare and Medicaid providers, and continued to conduct FIDA outreach through the ombudsman program.[20]

In the second half of 2016, NYSDOH rolled out an ad campaign funded by a CMS grant that targeted potential enrollees and providers to educate them on the benefits of FIDA. The campaign involved radio and print advertisements, posters on bus shelters, newsstands, and phone kiosks near hospitals in target ZIP codes; a digital presence on websites and search engines; brochures and pamphlets placed in provider offices; and a collection of FIDA

[20] Unfortunately, state informants report that the letters sent to beneficiaries were printed in the beneficiary's language on record in the WMS, not the language on record in the UAS-NY (phone conversation with NYSDOH, September 9, 2016). NYSDOH had identified WMS data on the beneficiary's language as inaccurate or incomplete but were unable to correct this problem.

promotional giveaway items such as pens, notepads and magnifying glasses that FIDA plans could distribute at their discretion.

As reported by the State to RTI in late 2015 and late 2016, since November 2015, the number of members per month who have voluntarily disenrolled has been decreasing. However, the number of newly enrolled members per month has not yet kept pace with the voluntary disenrollments, or the involuntary disenrollments of members who died or moved out of the service area. While the ad campaign ran throughout the fall of 2016, there was not an appreciable uptick in enrollment during that time.

The New York State Office for the Aging also received funding from CMS and the Administration for Community Living to support outreach and benefits counseling through its Health Insurance Information, Counseling and Assistance Program (HIICAP), New York's State Health Insurance Assistance Program. Unfortunately, New York experienced delays getting a contract in place, delaying full implementation of this initiative. Because of these delays, HIICAP was not able to begin outreach until October 2015, after the passive enrollment phase was completed. HIICAP has targeted its outreach at senior centers, naturally occurring retirement communities, social day programs and caregiver agencies; by May 2016, they had conducted more than 120 presentations to 4,500 people. HIICAP reported that they encountered resistance from case managers at the senior centers who question the value of FIDA.

3.3 Summary Data

The efforts of NYSDOH and CMS to increase enrollment have not successfully altered the initial trajectory for FIDA. Enrollment continues to be only a fraction of the number of persons eligible to participate. As of December 2016, approximately 4,672 beneficiaries were enrolled in the FIDA demonstration, representing about 4.4 percent of the eligible population.

See ***Table 9*** for demonstration enrollments in the first eight quarters of the demonstration period.

Table 9
Demonstration enrollment by quarter, January 1, 2015–December 31, 2016

Quarter	Beneficiaries eligible to enroll in FIDA	FIDA enrollment	Percent	Percent change
Q1	76,339	640	0.8	N/A
Q2	80,595	3,797	4.7	493
Q3	85,444	6,542	7.7	72
Q4	89,007	6,199	7.0	−5
Q5	94,276	5,577	6.0	−10
Q6	99,053	5,229	5.3	−6
Q7	102,015	4,941	4.8	−6
Q8	106,386	4,672	4.4	−5

N/A = not applicable.

SOURCES: Data reported by the State to RTI through the State Data Reporting System, 2015 and 2016.

4. Care Coordination

Highlights

- Initially, New York State Department of Health (NYSDOH) modeled its care model after that of the Program of All-Inclusive Care for the Elderly (PACE), requiring comprehensive and integrated care planning with mandatory, real-time primary care provider participation in the interdisciplinary team (IDT) meetings and person-centered service planning process.
- At the end of 2015, NYSDOH reformed the FIDA care model design to address provider and plan concerns about the IDT, service plan documentation, and other features under the original design.
- The IDT effectively authorizes those Fully Integrated Duals Advantage (FIDA) demonstration services included in the Person-Centered Service Plan (PCSP), as long as the services included in the plan are within the scope of practice of IDT members. The FIDA plan cannot overturn the IDT's service authorization.
- Beneficiaries reported mixed experiences with their care manager and the IDT process.

4.1 Care Coordination Model

This section provides an overview of the demonstration requirements related to the care coordination function, including assessment processes; use of IDTs and the development of the PCSPs; delivery of care coordination services; and the role of care managers. The experiences of FIDA Medicare-Medicaid Plans (MMPs) are included in this section as is the care coordination of long-term services and supports (LTSS) and behavioral health services and data exchange.

4.1.1 Assessment

Under the current IDT policy, a comprehensive assessment of enrollees must be completed in a timely manner so that the PCSP can be completed and implemented within 90 days of enrollment (IDT policy, 2015, p. 2). For individuals enrolling from a Managed Long Term Care (MLTC) plan operated by the FIDA plan, the assessment must be completed within 6 months of the enrollee's last MLTC assessment.

The assessment is conducted using the Uniform Assessment System for New York (UAS-NY) tool. The assessment captures a range of domains, including social, functional, medical, behavioral, wellness and prevention domains, caregiver status and capabilities, as well as enrollee preferences, strengths, and goals (IDT policy, 2015, p. 1). The assessment must be performed by a registered nurse, employed by or under contract to the FIDA plan (IDT policy, 2015, p. 1) and completed in the individual's home, hospital, nursing facility or any other setting (IDT policy, 2015, p. 2). A comprehensive reassessment must occur at least once every 6

months, no more than 30 days after a request, and as expeditiously as possible after certain "trigger" events (IDT policy, 2015, p. 15).

In general, FIDA plans have been able to complete the assessment within 90 days for almost all enrollees, with the 90-day assessment completion rates among all enrollees consistently at 90 percent or greater). Among enrollees documented as reachable or willing to participate, timely assessment completion rates were consistently greater than 93 percent. High rates of assessment completion might be explained by the fact that most of the FIDA enrollees were previously enrolled in an MLTC plan and the contact information for these individuals was thus readily available. ***Table 10*** shows the number and percent of enrollees whose assessment was completed within 90 days of enrollment.

Table 10
Enrollees whose assessment was completed within 90 days of enrollment

Quarter	Total number of enrollees whose 90th day of enrollment occurred within the reporting period	Assessment completed within 90 days of enrollment %	
		All enrollees	All enrollees documented as reachable and willing to participate
2015			
Q1	230	99.1	99.6
Q2	2,090	92.6	95.9
Q3	2,623	92.6	96.3
Q4	2,848	91.0	93.5
2016			
Q1	377	90.7	95.8
Q2	157	95.5	97.4
Q3	121	98.3	98.3
Q4	159	96.9	98.1

NOTES: Arch Care Community Advantage, Emblem Health Dual Assurance, HealthPlus Amerigroup, and Integra FIDA plans withdrew after 2015. Data for Arch Care Community Advantage were included through Quarter 3 2015. Data for Emblem Health Dual Assurance, HealthPlus Amerigroup, and Integra were included through Quarter 4 2015.

SOURCE: RTI analysis of MMP reported data for Core Measure 2.1, provided to RTI as of September 2018. The technical specifications for this measure are in the Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements document, which is available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/InformationandGuidanceforPlans.html.

4.1.2 Care Planning Process

Interdisciplinary Team

For the original design of the care model, NYSDOH intended FIDA to be a "virtual PACE program," modeling the IDT after the model of integrated care provided through the PACE. As originally designed, the participation of certain providers on the IDT was required, including the enrollee's primary care provider (PCP) or a designee from the PCP's practice with clinical experience and knowledge of the enrollee's needs and the enrollee's behavioral health professional and nursing facility provider, if the enrollee is receiving services from those types of

providers. At the enrollee's option, the IDT could also include the enrollee's home care aide and others (IDT policy, 2014, p. 3). As discussed in ***Section 3.2, Enrollment Process,*** providers perceived that the original design of the IDT process was overly burdensome, resulting in a number of reforms implemented in December 2015. Under these reforms, the IDT was required to include only the FIDA enrollee or the enrollee's authorized representative and the FIDA plan's care manager, (IDT policy, 2015, p. 3). At the enrollee's choice, the care manager may invite others to participate on the IDT, including the enrollee's designee and any of the enrollee's providers (IDT policy, 2015, p. 3). The FIDA plan's utilization management (UM) staff may not participate in IDT meetings, although a care manager may request information about medical necessity, clinical guidelines, evidence-based best practices and other information, from UM staff (IDT policy, 2015, p. 4).

IDT meetings are facilitated by the care manager. Members of the IDT are required to operate within their scope of practice; care decisions rest with the provider with the license or certification required for that care decision. If no one with the required credentials is participating on the IDT, the FIDA plan's UM staff will make the care decision (IDT policy, 2015, p. 4).

The IDT effectively authorizes those FIDA services included in the PCSP, as long as the services included in the plan are within the scope of practice of IDT members (IDT policy, 2015, p. 8). The FIDA plan may not disallow any service or treatment authorized in the PCSP. One FIDA plan sees this role for the IDT as a great asset not available in the MLTC program: "It takes out such big speed bumps and staff loves it, members love it." This plan explained the IDT can simply authorize a mobility device as a covered service, avoiding an otherwise long and complicated process of obtaining Medicare or Medicaid approval. Another FIDA plan expressed concerns about giving the IDT authority to authorize services, suggesting it fosters inconsistency across enrollees and creates the potential for bad decisions:

> So you have a member asking for a motorized wheelchair. Maybe they have balance or vision issues. That clinician, the care manager, knows that a scooter…is not a safe vehicle for that member. The physician really doesn't want to be bothered… "Give them what they want." The daughter says, "I want my mother…to have whatever she wants." The aide says "This is a really good gig. I don't want to go against that member so I think she should have what she wants." So, if it [is] majority rules…that's making a bad clinical decision and purchasing perhaps a fairly costly piece of equipment inappropriately…. That's not appropriate healthcare. I think there's a reason to have some consistency in decision-making and some standards.

Person-Centered Service Plan

Assessment results are used as the basis for developing the integrated PCSP (IDT policy, 2015, p. 1). The assessment must be completed in time for the PCSP to be developed and implemented within 90 days of enrollment (IDT policy, 2015, p. 2); the IDT must create the PCSP within 30 days of completing the assessment (IDT policy, 2015, p. 7). The PCSP must be reviewed every 6 months, or sooner, based on a triggering event (IDT policy, 2015, p. 16).

The IDT policy identifies the elements to be included in the PCSP, including the enrollee's goals and preferences, needs, specified interventions, a communications plan, and other elements (IDT policy, 2015, p. 10). The PCSP must address all care and service needs of the participant, whether or not the services are provided by the FIDA plan.

The original IDT policy required an enrollee's "wet signature" on the plan. Other members of the IDT could sign off with a wet signature, an electronic signature, or with a confirming e-mail (IDT policy, 2014, p. 20). The PCSP was not considered complete until all the signatures are received.

FIDA plans reported that obtaining the required signatures and sign-offs on these forms had become an administrative challenge, especially within the required time frames. One FIDA plan noted the challenge of getting members to sign their PCSP: "A lot of members have been told by their family 'Don't open any letters, don't read any letters, don't sign any letters because you're not sure what you're signing.'" The FIDA plan rules were modified such that plans may now obtain the IDT members' approval verbally, by e-mail or electronically, or by a wet signature on the PCSP itself or a signature page to be attached to the PCSP (IDT policy, 2015, p. 9).

The initial design of FIDA created some challenges for plans when it came to timely completion of the PCSP. Plans reported great difficulty scheduling timely IDT meetings around PCP involvement; obtaining signatures and sign-offs further delayed the ability of plans to meet deadlines for timely completion of the PCSP; these challenges are reflected in the number of PCSPs completed quarterly. ***Table 11*** presents the total number and percentage of enrollees with a completed PCSP each quarter for quarters 1 to 3 in 2015. From the first to third quarters in 2015, the percent of PCSPs completed within 30 days of initial assessment decreased, with a slight increase from 37 to 17 to 23 percent of all enrollees and 38 to 18 to 24 percent of enrollees documented as reachable and willing to participate.

Table 11
Members with person-centered service plans completed Q1–Q3, 2015

Quarter	Total number of enrollees who had an assessment completed or whose 90th day of enrollment occurred within the reporting period	Care plan completed within 30 days of initial assessment, percent	
		All enrollees	All enrollees documented as reachable and willing to participate
2015			
Q1	782	36.8	38.0
Q2	3,046	17.1	18.2
Q3	3,368	22.6	23.7

NOTES: Arch Care Community Advantage, Emblem Health Dual Assurance, HealthPlus Amerigroup, and Integra FIDA plans withdrew after 2015. Data for Arch Care Community Advantage were included through Quarter 3 2015. Data for Emblem Health Dual Assurance, HealthPlus Amerigroup, and Integra were included through Quarter 4 2015.

SOURCE: RTI analysis of MMP reported data for New York State-Specific Measure 2.1, as of November 2017. The technical specifications for this measure are in the Medicare-Medicaid Capitated Financial Alignment Model New York FIDA-Specific Reporting Requirements document, which is available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/InformationandGuidanceforPlans.html.

In December 2015, NYSDOH reformed its IDT policy, making it easier for plans to implement PCSPs timely. It also changed the reporting requirements for timely completion of the PCSP starting in October, the start of fourth quarter of 2015. Also, the passive enrollment period for the fourth quarter of 2015 ended during this time frame, which reduced the number of PCSPs to be completed. As a result, the FIDA plans' ability to report timely completion of PCSPs for all enrollees improved substantially from 32 to 83 percent between the fourth quarter of 2015 and the fourth quarter of 2016. Among enrollees documented as reachable and willing to participate, the percentage of enrollees with a care plan completed ranged from 33 to 89 percent between the fourth quarter of 2015 and the third quarter of 2016. ***Table12*** presents the total number and percentage of enrollees with a completed PCSP each quarter, from quarter 4 in 2015 to quarter 4 in 2016.

Table 12
Members with person-centered service plans completed, Q4 2015–Q4 2016

Quarter	Total number of enrollees who had an assessment completed or whose 90th day of enrollment occurred within the reporting period	Care plan completed within 90 days of enrollment, percent	
		All enrollees	All enrollees documented as reachable and willing to participate
2015			
Q4	3,198	32.5	33.2
2016			
Q1	390	67.7	70.2
Q2	167	78.4	81.4
Q3	126	88.1	89.5
Q4	168	83.3	85.4

NOTES: Arch Care Community Advantage, Emblem Health Dual Assurance, HealthPlus Amerigroup, and Integra FIDA plans withdrew after 2015. Data for Arch Care Community Advantage were included through Quarter 3 2015. Data for Emblem Health Dual Assurance, HealthPlus Amerigroup, and Integra were included through Quarter 4 2015.

SOURCE: RTI analysis of MMP reported data for New York State-Specific Measure 2.1, as of September 2018. The technical specifications for this measure are in the Medicare-Medicaid Capitated Financial Alignment Model New York FIDA-Specific Reporting Requirements document, which is available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/InformationandGuidanceforPlans.html.

Table 13 presents the total number and percentage of members with care plans with at least one documented discussion of care goals in the initial care plan. Among enrollees with a care plan, the proportion of members with at least one documented discussion of care goals remained at or above 87.5 percent over the course of the demonstration. This percentage peaked in the first and third quarters of 2016 at 99.5 percent.

Table 13
Members with care plans with at least one documented discussion of care goals in the initial care plan

Quarter	Total number of members with a care plan completed	Members with at least one documented discussion of care goals in the care plan
2015		
Q1	483	98.1%
Q2	1,086	91.3%
Q3	1,281	87.5%
Q4	974	96.4%
2016		
Q1	937	99.5%
Q2	256	98.0%
Q3	423	99.5%
Q4	207	96.1%

NOTES: Arch Care Community Advantage, Emblem Health Dual Assurance, HealthPlus Amerigroup, and Integra FIDA plans withdrew after 2015. Data for Arch Care Community Advantage were included through Quarter 3 2015. Data for Emblem Health Dual Assurance, HealthPlus Amerigroup, and Integra were included through Quarter 4 2015.

SOURCE: RTI analysis of MMP reported data for New York State-Specific Measure 2.2, as of September 2018. The technical specifications for this measure are in the Medicare-Medicaid Capitated Financial Alignment Model New York FIDA-Specific Reporting Requirements document, which is available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/InformationandGuidanceforPlans.html.

Care Coordination at the Plan Level

Each enrollee has an assigned care manager. The care manager may be an employee or under contract to the FIDA plan and must have the appropriate experience and qualifications to address the enrollee's assigned risk level and individual needs (IDT policy, 2015, p. 6). Care managers are not required to possess a specific educational degree but must have knowledge in certain areas, including physical health, community support services, commonly prescribed medications and their side effects, behavioral health, and the use of durable medical equipment (three-way contract, 2014, p. 56). An enrollee with an existing MLTC plan care manager may request to work with the same care manager under FIDA, and the FIDA plan must honor that request if feasible (IDT policy, 2015, p. 5). Otherwise, the FIDA plan assigns each enrollee a care manager with the appropriate knowledge to meet the enrollee's needs and risk level. An enrollee has the right to choose a different care manager at any time (IDT policy, 2015, p. 6).

The care manager is responsible for ensuring that the IDT fulfills its responsibilities and assisting it in doing so. The care manager is responsible for notifying the IDT of any "trigger" events that may necessitate reconsideration of the PCSP, such as hospitalizations, transitions between care settings, or changes in functional status (IDT policy, 2014, p. 6).

Table14 presents data on care coordination staffing for FIDA plans in 2015 and 2016. The number of care managers employed by FIDA plans decreased from 467 to 150 between 2015 and 2016. The percentage of care managers assigned to care management and conducting assessments increased from 69 to 85 percent, and member load per care manager increased from 20 to 38 between 2015 and 2016. During this time frame, the turnover rate decreased from 17 percent to 14 percent.

Table 14
Care coordination staffing

Calendar year	Total number of care managers (FTE)	Percentage of care managers assigned to care management and conducting assessments	Member load per care manager assigned to care management and conducting assessments	Turnover rate
2015	467	69.0	20.4	17.1%
2016	150	84.7	38.4	14.0%

NOTES: Arch Care Community Advantage, Emblem Health Dual Assurance, HealthPlus Amerigroup, and Integra FIDA plans withdrew after 2015. Data for these plans were included for 2015.

SOURCE: RTI analysis of MMP reported data for Core Measure 5.1, as of September 2018. The technical specifications for this measure are in the Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements document, which is available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/InformationandGuidanceforPlans.html.

The four FIDA plans interviewed by the evaluation team during 2016 and 2017 site visits had different strategies for configuring their care management teams. One FIDA plan with low enrollment originally designed its care management so that staff served a mix of FIDA enrollees and beneficiaries enrolled in other products, and then changed its model to have one specialized team focused exclusively on FIDA. A larger plan had care managers dedicated to FIDA enrollees. The two remaining plans, one with large and the other small enrollment, had their care managers cover a mixed caseload of FIDA and other products.

One plan described the difference between the care management provided under its other products and the care management it provides under FIDA. This plan has created a new staff position to support care managers, the "FIDA liaison," who is responsible for providing the care manager and the IDT with information on Medicare service utilization, hospital admissions and discharges, and other information typically not available for the MLTC program, and less formally accessible under its MAP program.

4.2 Information Exchange

FIDA plans are not required to use any particular electronic or other system for facilitating care management. However, the care manager on behalf of the FIDA plan must maintain a single, comprehensive health record for each enrollee, separate from the PCSP. At a minimum, the comprehensive health record must contain specific documentation of all care and services rendered to the participant by providers, and must be made available to all IDT members (IDT policy, 2015, p. 14). Under the three-way contract, FIDA plans are "strongly encouraged"

to use an electronic health record system that meets Federal "meaningful use" provisions and to join regional health information networks or qualified health information technology entities for data exchange and information sharing with all providers involved in implementing a PCSP (three-way contract, 2014, p. 179). In practice, some FIDA plans provide electronic access to a comprehensive record. The majority of plans distribute the PCSP to IDT members in paper form.

5. Beneficiary Experience

Highlights

- Focus group participants described both positive and negative aspects of the care they received through the Fully Integrated Duals Advantage (FIDA) demonstration. They reported very different experiences with the care coordination services provided through their FIDA plans and had mixed experiences with access to services.
- The transition to FIDA had a disruptive impact on provider relationships for a number of focus group participants; nearly half the focus group participants reported having to find new primary care physicians or specialists.
- Some focus group participants reported being asked about their care goals and working with the care manager to develop a plan to achieve those goals; others felt excluded from the planning process, or left to themselves to figure out how to achieve their goals.
- Several focus group participants indicated that their health had improved, though not all attributed it to FIDA.
- With the exception of the Part D appeals process, which remains unchanged, the FIDA appeals process is unified for both Medicare and Medicaid appeals. NYSDOH, CMS, plans, and other key stakeholders perceive that the integrated appeals process has been successful.

5.1 Introduction

Improving the experience of beneficiaries who access Medicare- and Medicaid-covered services is one of the main goals of the demonstrations under the Financial Alignment Initiative. Many aspects of FIDA are designed expressly with this goal in mind, including emphases on working closely with beneficiaries to develop person-centered service plans, delivering all Medicare and Medicaid services through a single plan, providing access to new and flexible services, and aligning Medicare and Medicaid processes.

This section highlights findings from various sources that indicate the levels of beneficiary satisfaction with FIDA overall, FIDA benefits, medical and specialty services, care coordination services, access to care and quality of care, person-centered care and patient engagement, and personal health outcomes and quality of life. For beneficiary experience, we draw on findings from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey and RTI focus groups and stakeholder interviews. Please see ***Section 1.1.3***, ***Data Sources*** for details about each data source. This section also provides information on beneficiary protections, data related to complaints and appeals, and critical incident and abuse reports. The section includes information, where available, on the experience of special populations.

5.2 Impact of the Demonstration on Beneficiaries

This section summarizes the findings of focus groups, beneficiary surveys, and stakeholder interviews reflecting beneficiary experiences with service delivery and quality of life under FIDA. Beneficiary experiences related to the early enrollment process, including experiences of beneficiaries who chose to opt in, opt out, or who were passively enrolled, are discussed as part of ***Section 3, Eligibility and Enrollment***.

5.2.1 Overall Satisfaction with FIDA

Focus group participants described both positive and negative aspects of the care they received through the FIDA demonstration. Participants' favorable comments about FIDA included having all their services covered under one plan, the absence of co-pays, and the responsiveness of services. In the words of one focus group participant: "Since FIDA's come into play, everything has been wonderful. Because now there's a responsibility." Another focus group participant was grateful for the speed of service: "[B]efore it would take a long time, a week or two weeks, to set something up. Now it's just days." Unfavorable comments about the FIDA demonstration were often related to having access to needed providers through the plan's provider network, the quality and reliability of home care and transportation services, and the lack of responsiveness of the FIDA plan. Some FIDA plans noted that they experience similar complaints for their other MLTSS programs.

Data from the CAHPS survey is consistent with the mixed findings from the focus groups. ***Table 15*** presents beneficiary satisfaction data from the 2016 CAHPS survey. In 2016, the two FIDA plans, GuildNet and VNS Choice, participating in the CAHPS survey[21] had 49 and 51 percent of respondents rate their health plan as a 9 or 10 (10 being best). The national average for all Medicare Advantage (MA) contracts in the same year was 61 percent and for all Medicare-Medicaid Plan (MMP) contracts, 59 percent. In 2016, 52 and 58 percent of respondents participating in an MMP rated the drug plan with a 9 or 10, respectively, which was lower than the percentage of national MA contract respondents and national MMP contract respondents who gave these same ratings (61 percent). Only one plan had data in 2016 on the percent of respondents who said they were always treated with courtesy and respect (71 percent). The national average in 2016 for all MA contracts was 79 percent, and the national average for MMP contracts was 75 percent.

We provide national benchmarks from MA plans where available, understanding that MA enrollees and demonstration enrollees may have different health and sociographic characteristics which would affect the results. There are differences in the populations served by the FIDA demonstration and the MA population, including health and socioeconomic characteristics that must be considered in the comparison of the demonstration to the national MA contracts.

[21] Only two New York FIDA MMPs, GuildNet Gold Plus FIDA Plan (GuildNet) and VNSNY Choice FIDA Complete (VNS) had sufficient enrollment to participate in the 2016 CAHPS.

Table 15
Beneficiary overall satisfaction, 2016

CAHPS survey item	National distribution—All MA contracts	National distribution—All MMP contracts	GuildNet	VNS Choice
Percent rating health plan 9 or 10 on scale of 0 (worst) to 10 (best)	61 (N=142,984)	59 (N=9,765)	51 (N=141)	49 (N=439)
Percent rating drug plan 9 or 10 on scale of 0 (worst) to 10 (best)	61 (N=132,613)	61 (N=9,617)	58 (N=145)	52 (N=412)
Percent reporting being "always" treated with courtesy and respect	79 (N=43,077)	75 (N=3,719)	—	71 (N=211)

— = data not available; MA = Medicare Advantage; MMP = Medicare-Medicaid Plan.

SOURCE: CAHPS data for 2016.

5.2.2 Beneficiary Experience with New or Expanded Benefits

FIDA does not cover new benefits or services not already available through Medicaid or Medicare, except that FIDA expands the scope of transportation services to cover transportation services for nonmedical events or services (e.g., religious services, community activities, or the grocery store).[22] In addition, FIDA enrollees may not be charged co-payments for FIDA services. Focus group participants identified the enhanced transportation services and not having co-payments as reasons they were interested in participating in FIDA. However, unlike other MLTSS programs, a much broader range of Medicaid services may be accessed through FIDA. For example, eligible FIDA enrollees have access to home and community-based services under New York's 1915(c) Nursing Home Diversion and Transition waiver; these services are not available under MLTC or MAP.

While focus group participants valued access to nonmedical transportation, others expressed their frustration with the delivery of these services. In the words of one participant, "every time [I request transportation for] something nonmedical, I want to reach through the phone and choke the life out of them" because the transportation company says it only provides medical transportation.

In addition to covered services, the FIDA plans, with the approval of New York State Department of Health (NYSDOH) and CMS, may offer supplemental benefits. Over-the-counter (OTC) drug benefits are a popular supplemental benefit offered through many MA health plans. Some FIDA plans also offer the OTC benefit. However, in FIDA OTC benefits are subject to more restrictions than those typically offered by an MA plan, causing confusion. For example, in order to comply with rules governing the Federal drug rebate program, New York requires beneficiaries to obtain the equivalent of a prescription in order to receive this benefit. Some focus group participants viewed the OTC as an important benefit but reported that they see it as more limited than what they had before under MA. In particular, some focus group participants indicated that their OTC covered fewer items than what had previously been covered and often

[22] Under New York's other managed long-term services and supports (MLTSS) programs, beneficiaries have access to emergency and nonemergency medical transportation services to access needed medical care.

covered a limited set of options (e.g., creams with fragrance but none without). The perceived limitations of the FIDA OTC card can be partly attributed to beneficiary confusion—"supplemental" items covered under a Medicare Advantage plan are not covered under FIDA's OTC card because they are already a covered FIDA benefit and, under Federal law, are not eligible to be a "supplemental" benefit covered under an OTC card.

5.2.3 Beneficiary Experience with Medical and Specialty Services

The transition to FIDA had a disruptive impact on provider relationships for a number of focus group participants, nearly half of whom reported having to find new primary care physicians or specialists. Many participants did not learn that their providers did not accept FIDA until they arrived at a scheduled appointment. While some participants successfully found replacements, others reported that finding a new provider was a long and difficult process. One focus group participant reported the following:

> We have been going through the ringer the last 6 months trying to find [my mother, a FIDA enrollee] a cardiologist that will accept the insurance…. Online, [her plan gives] you a list of all these doctors, only to find out…they no longer take the insurance. I've also had that problem trying to find her a dentist [and] an eye doctor. … [I]t's just been a real horror because they don't seem to be keeping their information up to date, especially online where you'd think it could be quickly corrected.

For the two FIDA plans participating in the CAHPS survey, 70 and 84 percent of plan respondents reported they had the same doctor before enrolling in the health plan[23] (see ***Table 16***).

Table 16
Beneficiary experience with medical services (including specialists), 2016

CAHPS survey item	GuildNet	VNS Choice
Percent reporting that they had the same doctor before enrolling in the MMP	84 (N=44)	70 (N=179)

MMP = Medicare-Medicaid Plan.

SOURCE: RTI Supplemental CAHPS data for 2016.

5.2.4 Beneficiary Experience with Care Coordination Services

Focus group participants reported very different experiences with the care coordination services provided through their FIDA plans. Some reported having very positive experiences; as one participant said, "I would stay [with FIDA] because I got a great team that work[s] with me, that understands me." A number of participants were frustrated by their lack of direct contact with their care manager. In the words of one focus group participant: "I think I have a [care manager], but I don't have a direct contact to that person. If I need to speak to that person, I've got to go through a million people to get to them. …I would like to be able to contact the

[23] The respondents represented a very small proportion of those enrolled in each plan.

coordinator or case manager or whatever that title is if I have a specific concern." Another focus group participant reported that communication between providers was better, "…but I don't think it's because of FIDA. …I think it's because of my legwork and putting together a good group of doctors."

The mixed results of the focus group findings are supported by the results of the CAHPS survey for the two plans participating. Fewer than half of respondents (47 percent) from GuildNet, one FIDA plan, and only 26 percent from VNS Choice, the other FIDA plan, reported that they had anyone from their health plan, doctor's office, or clinic help them coordinate their care among doctors or other health providers. Compared to national averages, both plans had similar levels of respondents reporting they always got the information they needed from their health plan. In 2016, 49 and 54 percent of respondents from VNS Choice and GuildNet plans respectively reported this and the national average for MA contracts was 55 percent and for all MMP contracts, 52 percent. Only one plan, VNS Choice, had a sample size large enough to report the percent of respondents who were very satisfied with the help they received coordinating care (32 percent) (see ***Table 17***).

Table 17
Beneficiary experience with care coordination, 2016

CAHPS survey item	National distribution—All MA contracts	National distribution—All MMP contracts	GuildNet	VNS Choice
Percent who had anyone from their health plan, doctor's office, or clinic help them coordinate their care among doctors or other health providers	N/A	N/A	26 (N=43)	47 (N=168)
Of those who used care coordination, the percent who were "very satisfied" with the help from the MMP or doctor's office in coordinating their care	N/A	N/A	#	32 (N=76)
Percent reporting that health plan "always" gave them information they needed	55 (N=42,677)	52 (N=3,669)	54 (N=63)	49 (N=204)

= sample size of 10 or fewer not presented; MA = Medicare Advantage; MMP = Medicare-Medicaid Plan.; N/A = not applicable.

SOURCES: RTI Supplemental CAHPS data for 2016 and CAHPS data for 2016.

5.2.5 Beneficiary Access to Care and Quality of Services

Focus group participants had mixed experiences with access to services. While some participants reported no problems, others mentioned difficulties finding a provider willing to accept FIDA insurance.

Only one FIDA plan had data to report on the percent of respondents who said they needed any treatment or counseling for a personal or family problem (11 percent). Of those who needed treatment or counseling, 61 percent of respondents were usually or always able to easily get the treatment or counseling (see ***Table 18***).

Table 18
Beneficiary experience with access to services, 2016

CAHPS survey item	GuildNet	VNS Choice
Percent who needed any treatment or counseling for a personal or family problem	#	11 (N=176)
Of those who reported needing it, percent who report it is "usually" or "always" easy to get the treatment or counseling they needed through their health plan	#	61 (N=18)

= sample size of 10 or few not presented.

SOURCE: RTI Supplemental CAHPS data for 2016.

In addition to medical services, beneficiaries also had mixed experiences with other services and benefits. Several focus group participants described difficulties in obtaining the right diabetic and other medical supplies. Others were pleased with the quality of the supplies.

While some focus group participants were pleased with the quality of their home care aides, others expressed dissatisfaction. For example, some complained about aides not doing their job, being poorly trained or disrespectful, or being in poor health or too elderly to provide the needed care. Key informants for NYSDOH and the FIDA plans interviewed in June 2016 indicated that home care aides were a common source of enrollee grievances, although that type of grievance is common in New York's other MLTSS programs. CMS reported that MMPs address these issues on a case-by-case basis as enrollee grievances arise.

Finally, focus group participants described both positive and negative experiences with transportation services. A few participants mentioned the coverage of non-medical transportation as an added benefit obtained through FIDA. Some issues identified by some focus group participants included not being able to reach the transportation services on Sunday, having to reschedule medical appointments because transportation services were not available, and having to call the FIDA plan because the transportation service was not answering the phone. Key informants for all four plans interviewed in June 2016 identified transportation services as one of the primary sources of enrollee grievances. Grievances related to transportation services are common to New York's other MLTSS programs.

5.2.6 Person-Centered Care and Patient Engagement

Again, focus group participants reported widely different experiences with their FIDA plans' focus on person-centered care and patient engagement. While some reported being asked about their care goals and working with their care manager to develop a plan to achieve those goals, others felt excluded from the planning process, or left to themselves to figure out how to achieve their goals:

> For me, my case manager often asks me, "Where do you see yourself in a year?" And I told her moving out in my own apartment and moving out on my own. …and just living a normal life. …No, no [care manager isn't helping]. Actually, I have a few people from when I went to college that are still there that know a lot about that. So they kind of helped me get the ball rolling on that.

Another participant reported: "I don't feel I'm part of a team. …In my heart, yes, I feel I have a say…but am I consulted, no. But yes, they tell me what to do and if you react to it, fine. If you don't, fine."

5.2.7 Personal Health Outcomes and Quality of Life

The impact of FIDA on the health, well-being and quality of life of participants is unclear. Several focus group participants indicated that their health had improved, though not all attributed it to FIDA. For example, one focus group participant reported: "[Mom's health has] improved, yes. [Even at 92.] Yes, because she's getting even more health services." Others said their health and quality of life had stayed the same. One participant said that his care team was more attentive, while another said his plan had changed and rotated everybody around and the staff are more stressed. As a counterpoint, one focus group participant reported a positive experience with her mother's FIDA plan:

> [Someone from FIDA plan] gives me a list of like, "What do you think are some of the things that you perceive your mom can do?" Because, remember, she can't do anything for herself. So I say to her I'd really like to see if we can get her moving…. She says, well, let's get the physical therapist. So we come up with a plan together, a care plan.

Beneficiary experiences with their physicians appears to be positive, based on the response for two FIDA plans. As shown in ***Table 19***, in 2016, 95 and 98 percent of VNS Choice and GuildNet plan respondents reported that their personal doctor understands how their health problems affect their day-to-day lives.

Table 19
Beneficiary experience with personal health outcomes, 2016

CAHPS survey item	GuildNet	VNS Choice
Percent reporting that their personal doctor understands how any health problems they have affect their day-to-day lives	98 (N=45)	95 (N=173)

SOURCE: RTI Supplemental CAHPS data for 2016.

5.2.8 Experience of Special Populations

This section summarizes the beneficiary experience for FIDA plan special populations, including individuals with long-term services and supports (LTSS) or behavioral health needs, and racial/ethnic or linguistic minorities.

During the June 2016 site visits, key informants from NYSDOH and the FIDA plans did not have a basis for distinguishing beneficiary experiences among subpopulations. Most participants in the two Spanish-speaking focus groups did not feel that language barriers at FIDA plans or providers were a significant problem. Some noted that they had found Spanish-speaking providers. However, some participants did note that they sometimes received information from plans in the wrong language. See ***Section 3, Eligibility and Enrollment*** for discussion of the role New York's Welfare Management System plays in collecting inaccurate or incomplete

information about an enrollee's primary language. African American focus group participants did not explicitly identify their race as having an impact on the care they received through FIDA.

Table 20 presents 2016 CAHPS data on several survey measures describing the experiences of special populations, such as MMP enrollees who use home health care or assistance. Because eligibility for the FIDA demonstration is limited to persons requiring a nursing facility level of care or 120 days of community-based long-term care, it is not surprising that most (90 and 91 percent) respondents from the VNS Choice and GuildNet plans, respectively, needed someone to come into their home to give them home health care or assistance. Plans had 88 and 92 percent of respondents who said it was usually or always easy to get personal care or aide assistance at home. There was a difference in plans in the percent of respondents who needed special medical equipment (39 and 56 percent). Only one plan had enough data in 2016 to report the percent of respondents who said it was usually or always easy for them to get or replace special medical equipment (51 percent).

Table 20
Beneficiary experience among special populations, 2016

CAHPS survey item	GuildNet	VNS Choice
Percent who needed someone to come into their home to give them home health care or assistance	91 (N=44)	90 (N=176)
Percent who reported it is "usually" or "always" easy to get personal care or aide assistance at home through their care plan	88 (N=40)	92 (N=155)
Percent who had a health problem for which they needed special medical equipment, such as a cane, wheelchair, or oxygen equipment	39 (N=44)	56 (N=174)
Of those who reported needing it, percent who reported it is "usually" or "always" easy to get or replace the medical equipment they needed through their health plan	#	51 (N=91)

= sample size of 10 or fewer not presented.

SOURCE: RTI Supplemental CAHPS data for 2016.

5.2.9 Beneficiary Protections

The FIDA demonstration offers a number of beneficiary protections. FIDA enrollees may file a grievance with their FIDA plan, and they have the right to file a grievance with CMS or with NYSDOH.[24] FIDA enrollees may also file appeals from a FIDA plan's adverse coverage decision. An appeal might include a denial, reduction, or termination of service, or another type of adverse coverage determination.

In the FIDA demonstration, New York has integrated the appeals process.[25] If the plan's decision is wholly or partially adverse to the enrollee, the FIDA plan automatically forwards the

[24] A grievance is an expression of dissatisfaction, perhaps arising from the inability to get an appointment with a primary care provider (PCP) or specialist, or excessive wait time to get an appointment, or other concerns. The term "complaint" and "grievance" are used interchangeably in New York (three-way contract, 2014, p. 9).

[25] For appeals outside of FIDA's integrated appeals process, the process is bifurcated for appeals involving both Medicare and Medicaid claims—for Medicare-related services, the beneficiary follows the Medicare appeals

appeal to New York's Integrated Administrative Hearing Officer (IAHO), within New York's Office of Temporary and Disability Assistance (OTDA). The IAHO hears the second level of appeal, applying both Medicare and Medicaid coverage rules. If the FIDA enrollee disagrees with the IAHO's decision, the next level of appeal is the Medicare Appeals Council (MAC), which also applies both Medicare and Medicaid coverage rules. An adverse decision by the MAC may be appealed to U.S. District Court. NYSDOH, CMS, MAC, IAHO, FIDA plans, and other key stakeholders perceive that the integrated appeals process has been successful.

As a quality check on the IAHO's application of Medicare regulations, FIDA plans have been required to forward appeals involving Medicare-related services to the Medicare Independent Review Entity (IRE) for a non-binding review of the appeals decided by the IAHO.[26] For assistance with grievances and appeals, beneficiaries are referred to the ombudsman program for New York's Managed Long-Term Care (MLTC) programs, the Independent Consumer Advocacy Network (ICAN), and to New York's local State Health Insurance Assistance Program, called the Health Insurance Information, Counseling and Assistance Program.

This section summarizes the types of beneficiary complaints and appeals received about FIDA. Data are received from each of the following sources: (1) data reported by MMPs on complaints made directly to them[27]; (2) data reported on the CTM for complaints received by NYSDOH and1-800-Medicare[28]; (3) data reported by New York's Integrated Administrative Hearing Officer (IAHO); (4) data reported by ICAN, New York's ombudsman for all of its managed long-term services and supports (MLTSS) programs[29]; and (5) qualitative information collected by the evaluation team. Reporting periods vary across these sources.

The number of MMP-reported complaints per 1,000 enrollees in the demonstration was highest in the first quarter (Quarter 1, 2015); in subsequent quarters of 2015 there was a period of decline, which was followed by a general increase from Quarter 4 of 2015 through 2016.[30, 31] In the first demonstration year (2015), half of the 18 complaints filed with 1-800-MEDICARE were

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process through the IRE; for Medicaid-related services, the beneficiary follows the appeal process for Medicaid services through the State's administrative hearing process. Because Medicaid is the secondary payer for services that are both Medicare- and Medicaid-related (e.g., home health or durable medical equipment), the appeal must be pursued first as a Medicare appeal, with the appeal to Medicaid following if Medicare coverage is denied or only partially covers the claim. (New York also files appeals on behalf of beneficiaries, to recover the Medicare share for services that are covered under both Medicare and Medicaid.)

[26] In July 2017, NYSDOH reported that it had recently learned that the IRE had identified no inconsistencies from this review, although the number of Medicare appeals have been limited.

[27] MMP Reported Data provided to RTI by CMS

[28] Data obtained from the Complaints Tracking Module (CTM) within HPMS by RTI

[29] Information obtained by RTI during site visits

[30] Data are preliminary and have not been reconciled. 2016 data do not include the following FIDA plans due to withdrawal from the demonstration: HealthPlus Amerigroup, Arch Care Community Advantage, Emblem Health Dual Assurance and Integra.

[31] SOURCE: RTI analysis of MMP reported data for Core Measure 4.2, as of September 2018. The technical specifications for this measure are in the Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements document, which is available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/InformationandGuidanceforPlans.html.

related to beneficiary enrollment and disenrollment. In 2016, of the 14 complaints filed with 1-800-MEDICARE, 3 were related to beneficiary enrollment; 7 were in areas relating to legal and administrative issues (plan providing poor customer service and difficulties acquiring materials in alternative formats). In 2016, beneficiaries also reported complaints related to benefits, access, and quality of care (data not shown).[32]

FIDA plans are required to report on the number of critical incident and abuse reports among members receiving LTSS.[33] The number of critical incident and abuse reports per 1,000 members receiving LTSS gradually increased over each quarter of the demonstration, reaching a high of 4.26 reports per 1,000 members receiving LTSS in Quarter 3 of 2016 (data not shown).[34]

The total number of plan-level appeals per 1,000 enrollees increased through the demonstration years (2015–2016) to a high of 57.1 in the third quarter of 2016.[35] With the exception of the first two quarters of the demonstration, a strong majority, more than 70 percent of appeals per quarter, resulted in fully favorable outcomes for the beneficiary (data not shown). In 2015 and 2016, 89 appeals were received by the IAHO; the highest number of appeals, 42 (47 percent), were related to Medicaid Personal Care Services, with 15 (36 percent) of these appeals overturned and 11 (26 percent) withdrawn (data not shown).[36]

ICAN reported that during the passive enrollment phase (April to October 2015), it handled a large volume of cases predominantly related to enrollment into FIDA. But, by the 2016 site visit, only a small portion of ICAN's cases were related to FIDA. Based on the data

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[32] SOURCE: RTI calculations from the CMS Complaint Tracking Module, covering January 2015- December 2016. Information current as of May 31, 2017.

[33] Reporting requirements define "critical incident" as "any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety, or well-being of a member." Abuse refers to (1) willful use of offensive, abusive, or demeaning language by a caretaker that causes mental anguish; (2) knowing, reckless, or intentional acts or failures to act that cause injury or death to an individual or which places that individual at risk of injury or death; (3) rape or sexual assault; (4) corporal punishment or striking of an individual; (5) unauthorized use or the use of excessive force in the placement of bodily restraints on an individual; and (6) use of bodily or chemical restraints on an individual that is not in compliance with Federal or State laws and administrative regulations. Reporting requirements are available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/NYFIDAReportingRequirements041317.pdf.

[34] SOURCE: RTI analysis of MMP reported data for NY Measure 4.1, as of September 2018. The technical specifications for this measure are in the Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements document, which is available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/InformationandGuidanceforPlans.html. This measure is based on the number of enrollees receiving LTSS at any point in the quarter; this number may be greater than the number of enrollees enrolled at the end of a quarter.

[35] Data are preliminary and have not been reconciled. 2016 data do not include the following FIDA plans due to withdrawal from the demonstration: HealthPlus Amerigroup, Arch Care Community Advantage, Emblem Health Dual Assurance and Integra.
SOURCE: RTI analysis of MMP reported data for Core Measure 4.2, as of September 2018. The technical specifications for this measure are in the Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements document, which is available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/InformationandGuidanceforPlans.html.

[36] SOURCE: RTI analysis of Integrated Appeals Status Report obtained from CMS.

ICAN collects, ICAN representatives perceived FIDA enrollees to be less likely to experience reductions, discontinuance, or denials of services compared to those enrolled in MLTC. ICAN submits complaints potentially involving a rule violation to both NYSDOH and CMS's CTM. ICAN has found that FIDA plans tend to respond quickly to ICAN when a complaint is submitted into the CTM, because they are required to resolve complaints entered in the CTM timely. ICAN noted that the CMS staff monitoring the CTM typically receive so few complaints about FIDA or MMPs that CMS staff tend to be unfamiliar with FIDA and are not helpful. ICAN makes sure that Medicare-Medicaid Coordination Office staff are made aware when ICAN submits a complaint to the CTM.

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6. Stakeholder Engagement

Highlights

- New York State Department of Health (NYSDOH) receives input on the Fully Integrated Duals Advantage (FIDA) demonstration primarily from advocates and FIDA plans. Engaging beneficiaries and providers is challenging.
- Advocates played an important role in designing key features of the FIDA demonstration, including the integrated appeals process and the provider training.
- Initially, during the design phase, advocates and plans participated in joint stakeholder meetings. As the FIDA plans moved to the implementation phase, NYSDOH began meeting with the plans separately. The Medicare Rights Center serves as the primary point of contact for New York's coalition of advocates.

6.1 Overview

This section describes the approach taken by New York for engaging stakeholders, the mechanisms for soliciting stakeholder feedback, and the impact of those efforts on the demonstration.

6.2 Organization and Support

6.2.1 State Role and Approach

During the proposal development process, NYSDOH conducted a series of stakeholder outreach activities, including two public meetings, two webinars, and two rounds of public comment on its proposal (proposal, 2012, p. 19). NYSDOH also held five webinars in 2013 and 2014. As part of New York's larger Medicaid Redesign Team (MRT) effort, NYSDOH created a Managed Long Term Care Implementation work group and a Managed Care Policy and Planning work group for stakeholders that have included updates about and discussions of FIDA (proposal, 2012, p. 19; NYSDOH, n.d.-a). NYSDOH also convened stakeholder work groups on specific FIDA implementation topics: Plan Qualifications and Quality Metrics; Navigation/Appeals/Grievances; Outreach, Enrollment, and Consumer Engagement; and Finance and Reimbursement. Those groups each met three times in fall 2012 (NYSDOH, n.d.-c).

Although NYSDOH has employed a variety of strategies to incorporate the voice of beneficiaries in the design and implementation of FIDA, key informants for NYSDOH acknowledge that their stakeholder engagement strategies rely primarily on advocates (who may themselves be beneficiaries) rather than directly engaging with beneficiaries. NYSDOH has successfully cultivated strong lines of communication with advocates and has relied heavily on advocates as surrogates for beneficiaries. To supplement the voice of advocates, NYSDOH collects enrollment and disenrollment surveys.

NYSDOH also acknowledges that it has been difficult to bring providers to the table. Provider associations in New York are fragmented, making it difficult to identify stakeholders who can speak on behalf of any group of providers. In the words of one provider association representative, "Providers truthfully are stretched very thin. There's a lot going on in New York in terms of healthcare reform. There's a lot of different types of work groups going on and so many different programs and plans and strategies going on all at the same time." In spite of these challenges, NYSDOH reported that it has conducted provider outreach through written communication; meetings with provider associations, independent practice associations, and other stakeholder groups; and by hosting provider events and conducting quarterly webinars.

NYSDOH reported that stakeholders, particularly advocates for beneficiaries, played an influential role in the design of FIDA, including the design and direction of the interdisciplinary team (IDT), the integrated appeals process, the design of FIDA notices, and the Americans with Disabilities Act attestation requirement.

NYSDOH uses its MRT listserv and informational webinars to provide updates and solicit input from the public. Information is also available on NYSDOH's website.

6.2.2 Advisory Committee

New York's Medicaid program, the Office of Health Insurance Programs (OHIP), continues to host a monthly Medicaid managed care work group that serves as the structure for ongoing input into FIDA. As a standing agenda item, this group hears updates on the FIDA demonstration and the Managed Long Term Care program. NYSDOH reports that over time, presentations before this group have become more about information sharing, rather than dialogue.

NYSDOH has other informal avenues for receiving input and questions from advocates. CMS and NYSDOH meet biweekly with the policy director for the Medicare Rights Center, who serves as the primary point of contact for the Steering Committee for the Coalition to Protect the Rights of New York's Dually Eligible (CPRNYDE). In addition, through the design process, NYSDOH has built relationships with advocates so that often when questions or issues arise, an advocate will contact a NYSDOH staff member directly. The CPRNYDE comprises a wide range of advocates, including the Empire Justice Center, the Center for the Independence of the Disabled, and the New York Legal Assistance Group.

As part of monthly Contract Management Team meetings, NYSDOH meets separately with the plans.[37] Initially, these meetings focused on the details of implementing FIDA, but over time they have evolved primarily into opportunities for the CMT to share information with the plans.

[37] In the early stages of implementation these meetings were biweekly.

7. Financing and Payment

Highlights

- The Medicaid component of the capitated rate was initially set too low in comparison to the Managed Long Term Care (MLTC) rates of the New York State Department of Health (NYSDOH), creating a disincentive for Fully Integrated Duals Advantage (FIDA) plans to promote their FIDA program; NYSDOH retroactively adjusted the Medicaid rates to provide parity with the MLTC rates.
- Delays in finalizing the Medicaid component of the capitated rate created uncertainty among the FIDA plans, adding to FIDA plans' disincentive to actively promote their FIDA programs.
- In fiscal year 2016, NYSDOH adjusted the Medicaid portion of the rates every quarter to account for changes in program and policy, including the mandatory enrollment of nursing facility residents into managed care.
- Because FIDA plans enroll a more frail population, CMS is considering applying a frailty adjustment to the Medicare rates for the FIDA demonstration; New York's FIDA demonstration would be the only demonstration for which this adjustment would be made, given the unique target population of this demonstration. CMS was able to adjust the Medicare component of the rates across all Financial Alignment Initiative demonstrations in 2016 to offset underprediction in the CMS-Hierarchical Condition Category (HCC) risk-adjustment model for full benefit dual-eligible beneficiaries, and FIDA plans received an increase in their rates due to this change.

7.1 Rate Methodology

The demonstration is testing a new payment methodology with the aim of minimizing cost-shifting, aligning Medicare and Medicaid incentives, promoting the best possible health and outcomes of enrollees, and reducing costs to CMS and NYSDOH (MOU, 2013, pp. 1–2). All covered services in the demonstration are paid on a capitated basis, with the exception of hospice, methadone maintenance treatment, out-of-network family planning, and directly observed therapy for tuberculosis, which are paid on a fee-for-service basis. CMS and NYSDOH make three separate, risk-adjusted, per member per month (PMPM) payments to FIDA plans. CMS makes a monthly payment reflecting coverage of Medicare Parts A and B services and a separate amount reflecting Part D services. NYSDOH makes a monthly payment reflecting coverage of Medicaid services. This section describes the rate methodology of the demonstration and findings relevant to early implementation.

7.1.1 Rating Categories and Risk Adjustments

The baseline for the Medicare Parts A and B component of the rate is a blend of the Medicare fee-for-service standardized county rates and the Medicare Advantage rates for that

year or projected for that year. It is risk adjusted based on the risk profile of each enrollee using the existing Medicare Advantage CMS-HCC and CMS-HCC end-stage renal disease risk-adjustment models. For 2015 and 2016, the rate is also being adjusted to offset the Medicare Advantage coding intensity adjustment factor to reflect the proportion of enrollees in 2015 and 2016 who were previously in Medicare FFS and for whom risk scores would be based solely on FFS experience (three-way contract, 2014, p. 203). The Medicare Part D baseline is calculated using the Part D national average monthly bid amount and is risk adjusted using the existing Part D prescription drug RxHCC model. The prospective payments for the low-income cost-sharing subsidy and Federal reinsurance amounts are not risk adjusted (three-way contract, 2014, p. 204). The baseline for the Medicare Parts A and B component of the rate also incorporates increased payments to reflect the Medicare frailty adjustment that would have been made for beneficiaries eligible for FIDA, had they remained in a Medicare Advantage plan.

The baseline for the Medicaid component of the rate is a blend of the Managed Long Term Care (MLTC) plan capitation rate (for LTC services) and a projection of fee-for-service spending NYSDOH would have incurred absent the demonstration for other Medicaid-covered services (MOU, 2013, pp. 43–4). Rate categories were contemplated in the MOU, but the final payment methodology uses a single rate cell (FIDA CY 2015 Rate Report, 2014, p. 2). The rate includes a prospective risk adjustment based on functional assessment. In 2016, NYSDOH was also updating the rates quarterly to reflect FIDA's transition to mandatory enrollment for new-to-service nursing home residents.

The Medicaid rates during the first 3 months of the demonstration were rates developed independently of MLTC and were not risk adjusted (January 1, 2015, through March 31, 2015). For the next 6 months of the demonstration (April 1, 2015, through September 30, 2015), NYSDOH indicated that rates were risk adjusted using a methodology similar to that applied in the MLTC program and using a relative risk score created based on functional assessments of members. When the demonstration started, New York was transitioning from using the Semi-Annual Assessment of Members to the Uniform Assessment System (UAS-NY), and risk scores were based on a blend of those assessments. Currently, a risk score is determined for each FIDA plan enrollee based on submission of the UAS-NY and an adjustment for enrollees in nursing facilities who are now mandatorily enrolled in MLTC. The enrollee scores are aggregated, and an overall risk score for each Medicare-Medicaid Plan (MMP) is calculated. The "raw" MMP-level scores are compared across MMPs and converted into relative scores to ensure rate parity between the MLTC and FIDA programs. The final PMPM paid to the MMP is the product of the baseline and the relative risk score (FIDA CY 2015 Rate Report, 2014, p. 9). State informants indicated in site visit interviews in 2016 that the rates would be adjusted quarterly during the year to account for changes in the enrolled population that would include more nursing facility residents, but that in future years, the rates should be more stable.

7.1.2 Savings Percentage

In computing the capitation payment rates, aggregate savings percentages are applied to the baseline spending amounts for the Medicare Parts A and B component and the Medicaid component as shown in ***Table 21***.

Table 21
Savings assumptions built into the capitation payments

Year	Savings percentage
Demonstration year 1 (Jan. 1–Dec. 31, 2015)	1
Demonstration year 2 (Jan. 1–Dec. 31, 2016)	1.5
Demonstration year 3 (Jan. 1–Dec. 31, 2017)	2.5[a]

[a] Because more than one-third of FIDA plans experienced losses in demonstration year 1 exceeding 3 percent of revenue, the savings percentage for demonstration year 3 was reduced from 3 percent to 2.5 percent.

SOURCE: Three-way contract, 2014.

FIDA plans have an incentive to keep administrative spending low relative to spending on care for their enrollees. To ensure adequate MMP spending on services, the three-way contract requires MMPs to refund the difference to CMS and NYSDOH if the medical loss ratio drops below 85 percent. CMS and NYSDOH will share the amount proportionally to their share of the total FIDA payment rate (three-way contract, 2014, pp. 37–8). The medical loss ratio is calculated by dividing benefit expenditures (including expenditures on all covered items and services, any services or items purchased in lieu of costlier covered services and items, and personnel costs associated with case manager and the medical director providing services to FIDA participants) by the total capitation payments paid by CMS and NYSDOH.

Savings percentages are not applied to the Part D component. CMS monitors Part D costs on an ongoing basis, and material changes may be factored into future-year savings percentages (three-way contract, 2014, p. 203).

7.1.3 Quality Withholds

CMS and NYSDOH withhold a certain percentage of their respective components of the capitation rates (i.e., to the Medicare Parts A and B and Medicaid components; no withhold is applied to the Part D component). The withhold is repaid to the FIDA plans subject to each MMP's performance relative to established quality thresholds. The withhold is 1 percent in demonstration year 1, 2 percent in demonstration year 2, and 3 percent in demonstration year 3. A determination of whether the MMP meets the quality withhold requirements is made public (three-way contract, 2014, pp. 207–8). Because more than one-third of FIDA plans experienced losses in demonstration year 1 exceeding 3 percent of revenue, the savings percentage for demonstration year 3 was reduced from 3 percent to 2.5 percent as required in the three-way contract (three-way contract, 2014, p. 207).

7.1.4 Risk Corridors

The overall FIDA payment methodology does not include risk mitigation strategies used in some other State demonstrations under the Financial Alignment Initiative, such as risk corridors or risk pools (but the standard Part D risk corridor applies to the FIDA plan's Part D experience).

7.2 Financial Impact

7.2.1 Early Implementation Experience

Stakeholders from both NYSDOH and CMS indicated in site visit interviews that MMPs had concerns about the adequacy of the rates throughout 2015. On the Medicare side, FIDA plans advocated for a frailty adjustment comparable to that which applies to PACE and FIDE-SNPs. CMS informants said that MMPs that also offered MAP plans (which are a Medicare FIDE-SNP paired with a Medicaid managed long-term service supports [MLTSS] plan) were concerned that while MAP and FIDA serve the same population, only MAP had a frailty adjustment; CMS informants suggested the disparity could be preventing some MMPs from fully supporting their FIDA product and creating an incentive for plans to promote enrollment into their MAP product. In late fall 2015, CMS met individually with some of the plans to understand their concerns about the frailty adjustment and also heard from some of them that the FIDA rates undercompensated them for Part D costs. Stakeholders from CMS indicated they were unable to provide a mechanism to apply a frailty adjustment to the FIDA plans, but they were able to provide a payment adjustment to MMPs across all demonstrations under the Financial Alignment Initiative by increasing the fee-for-service component of the calendar year 2016 Medicare Parts A and B baseline rate, to better align FIDA plan payments with Medicare fee-for-service costs and offset underprediction in the risk adjustment model.[38]

CMS stated that they had asked the New York MMP plan associations to tell their plans to take a "procedural step" to let CMS know they are still interested in pursuing the application of a frailty adjustment to the Medicare rates; CMS is considering this adjustment only for the FIDA demonstration, given the frailty of the population enrolled in FIDA plans. CMS representatives also indicated that they have been analyzing the Part D data, which they say may merit some adjustments to the Part D rate for calendar year 2017.[39]

Although the Medicaid component of the FIDA rates are based partly on the MLTC rates, the FIDA rates were developed by New York's State Actuary, while the MLTC rates were developed by NYSDOH. As a result, there was variation in the method for developing the rates, including the assumptions used, the timing of rate adjustments, and the costs that could be included. The original resulting FIDA rates were well below comparable MLTC rates. NYSDOH worked with CMS to update the Medicaid component of the rate to achieve parity with the MLTC plan payment rate retroactively to April 1, 2015. State informants indicated that with the adjustments to the Medicaid rates over the course of the demonstration, the plans seem more satisfied with their rates.

While both the Medicare and Medicaid rate components have been adjusted during the demonstration, the initial Medicaid rate was not finalized at the start of the demonstration. NYSDOH did publish a draft rate effective January 1, 2015, but it quickly became clear that the

[38] https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/PartABPaymenttoMMPs111215.pdf as accessed on March 15, 2017.

[39] CMS reported that, for calendar years 2017 and 2018 it has allowed the FIDA plans to attest to the anticipated amount it will spend for the Part D Long Income Cost Sharing Subsidy and reinsurance, to change the amount paid to the plan prospectively; total reimbursement is not changed because all costs are reconciled.

rates were lower than those for MLTC. Key informants at NYSDOH described reluctance on the part of the MMPs to market the FIDA product and reach out to potential enrollees and providers because of their uncertainty about the rate.

With continued low enrollment rates, it has been difficult for plans to achieve economies of scale for the IDT process and other care coordination requirements, translation costs of member materials (which were much higher for FIDA than MLTC and MAP due to different requirements), printing provider directories in the first year of implementation, and other administrative costs associated with being a FIDA plan.

7.2.2 Rate Methodology Design Implications

In New York, the FIDA demonstration competes against other MLTSS and Medicare Advantage products. Disparity in the Medicaid rate across FIDA and MLTC and MAP is perceived to have undermined the incentive for FIDA plans to promote FIDA. Similarly, because Medicare rates do not include the frailty adjustment, FIDA plans believed Medicare rates failed to take into account the true costs associated with serving persons dually eligible for Medicare and Medicaid. Although NYSDOH eventually aligned its FIDA rates with its other MLTSS products, and CMS partially addressed plan concerns for Medicare rates, it is possible that the disparity in rates played a role in undermining FIDA's successful launch in the early days of the demonstration.

7.2.3 Cost Experience

Only three FIDA plans reported a net gain during the first year of the demonstration year; most plans experienced losses, with some of the smaller plans losing two to three times their revenue.

For most plans, the largest portion of expenditures are attributed to home and community-based services, personal care services, and home health. Other common sources of expenditures include inpatient services, skilled nursing facility services, and Part D pharmacy. ***Table 22*** provides detail on how FIDA plan expenditures were distributed across service categories in the first year of the demonstration.

Table 22
Percent service spend by category, January 1, 2015–December 31, 2015

Category	Aetna Better Health	AgeWell	AlphaCare	ArchCare	CenterLight	Centers Plan	Elderplan	ElderServe	Emblem Health	Fidelis
Adult/Social Day Care	0.48	0.00	1.49	0.00	2.66	2.56	0.16	0.97	0.00	0.43
Assisted Living	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Dental Services	0.00	0.23	0.19	0.00	0.19	0.15	0.22	0.00	0.20	0.08
Diagnostic Testing Services	0.00	0.00	0.78	1.60	0.08	0.48	0.46	0.00	1.40	1.42
Durable Medical Equipment	1.93	1.11	1.35	0.25	1.25	2.14	0.94	0.00	0.00	0.00
Home and Community-Based Services/Personal Care/Home Health	76.09	0.86	72.79	30.76	61.75	54.87	56.42	0.00	5.06	0.35
Hospital Outpatient	0.00	0.00	0.47	0.21	0.11	0.26	0.00	2.36	0.92	1.23
Inpatient	0.00	0.00	8.28	0.00	7.85	16.42	14.32	8.96	17.40	13.10
Inpatient Mental Health and Substance Abuse	0.00	0.00	0.00	0.00	0.00	0.41	0.42	0.00	0.12	0.08
Other	7.99	9.31	2.16	5.54	4.43	4.61	11.41	67.01	56.93	63.44
Outpatient	0.00	0.00	2.01	0.00	0.00	0.81	0.76	0.00	0.92	0.45
Outpatient Mental Health and Substance Abuse	0.00	0.00	0.12	0.00	0.00	0.03	0.02	1.38	3.74	0.01
Outpatient Surgery and Rehab Services	0.06	65.82	0.29	0.00	0.00	0.48	2.74	0.00	0.11	0.17
Primary Care Providers	0.00	8.32	0.98	0.18	0.19	2.43	0.25	0.00	2.11	1.80
Pharmacy—Non-Part D	0.25	12.54	0.02	0.00	0.22	1.30	0.72	0.02	0.12	0.07
Pharmacy—Part D	9.03	0.00	3.57	13.76	7.90	1.74	2.18	7.99	1.38	10.62
Skilled Nursing Facility	4.04	0.00	2.64	47.59	9.08	8.43	7.75	8.52	8.68	5.24
Transportation Services	0.13	1.52	2.74	0.00	4.23	2.84	1.13	2.78	0.84	1.51
Vision Services	0.00	0.09	0.13	0.11	0.06	0.04	0.09	0.02	0.06	0.00
Total	100.00	99.80	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00

(continued)

Table 22 (continued)
Percent service spend by category, January 1, 2015, to December 31, 2015

	GuildNet	Health First Health Plan	Health Plus Amerigroup	Integra	MetroPlus Health Plan	NorthShore	Senior Whole Health of NY	Village Care	VNS NY Choice	Well Care
Adult/Social Day Care	0.01	1.10	0.37	1.04	0.41	1.60	1.94	1.56	0.56	0.00
Assisted Living	2.21	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Dental Services	0.21	0.00	0.06	0.59	0.05	0.25	0.02	0.16	0.07	0.17
Diagnostic Testing Services	0.80	1.22	0.68	0.86	1.33	0.68	0.40	2.40	0.75	0.61
Durable Medical Equipment	0.00	1.77	1.42	0.00	0.96	1.86	2.73	1.02	0.35	1.06
Home and Community Based Services/Personal Care/Home Health	0.31	61.84	59.70	55.02	50.99	62.34	60.24	51.96	58.21	50.54
Hospital Outpatient	1.11	0.53	0.74	0.04	0.26	0.41	0.43	0.42	0.26	0.81
Inpatient	12.60	14.80	14.50	14.83	12.30	7.56	9.06	16.07	14.24	18.02
Inpatient Mental Health and Substance Abuse	0.00	0.28	0.13	0.00	0.41	0.00	0.00	0.00	0.55	0.41
Other	64.37	4.51	4.80	1.69	7.74	1.09	2.32	1.83	3.40	13.47
Outpatient	0.64	1.32	1.22	0.00	0.77	0.16	0.04	0.00	0.22	0.59
Outpatient- Mental Health and Substance Abuse	0.04	0.42	0.00	2.81	4.65	0.03	0.08	0.77	0.12	0.35
Outpatient Surgery and Rehab Services	0.08	0.55	0.25	0.22	0.31	0.08	0.11	0.30	0.14	0.06
Primary Care Providers	0.25	1.98	1.21	0.01	2.92	0.56	6.01	3.87	0.70	1.42
Pharmacy-Non-Part D	0.15	0.71	11.27	0.00	14.79	0.05	6.98	0.33	0.95	0.27
Pharmacy-Part D	9.96	0.09	0.00	10.82	0.00	9.22	0.00	4.80	10.87	7.24
Skilled Nursing Facility	4.59	5.90	3.13	10.03	1.88	12.59	8.21	12.11	7.11	3.74
Transportation Services	2.42	2.96	0.52	1.92	0.00	1.41	1.40	2.38	1.50	1.24
Vision Services	0.26	0.02	0.02	0.11	0.21	0.09	0.01	0.03	0.01	0.00
Total	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00

SOURCE: FIDA plan submissions to NYSDOH as of May 2016.

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8. Service Utilization

Highlight

- Only descriptive statistics for eligible demonstration beneficiaries in New York during the demonstration period are presented in this report. The evaluation lacked administrative data on approximately one-half of the beneficiary characteristics that the State used to exclude beneficiaries from the demonstration, preventing RTI from creating both a comparison group and a group of predemonstration eligible beneficiaries in the baseline period in New York. Since these two latter groups could not be created, RTI could not reliably estimate regression-based impact estimates. Therefore, only descriptive statistics are presented for demonstration eligible beneficiaries in New York, and only for the demonstration period. This issue is described in full in ***Section 1.1.2, What it Covers*** of this Evaluation Report.

The purpose of the analyses in this section is to understand health care service use in the New York demonstration group during demonstration year 1 (calendar year 2015) using descriptive analyses. These descriptive results do not reflect the impact of the demonstration, but serve to provide an understanding the relative levels of service use on the service utilization measures analyzed.

Utilization data were analyzed for only nine of the 14 MMPs that were participating at the start of 2017: GuildNet, Fidelis, Independence Care System, Managed Health, Elderplan, VNS Choice, Senior Whole Health of New York, MetroPlus Health Plan, and Aetna Better Health of New York. The remaining MMPs had enrollments of approximately 50 members or less, so were not included in this First Evaluation Report. As noted in ***Section 3.3, Summary Data***, enrollment in FIDA has not exceeded 8 percent of those beneficiaries eligible to enroll.

8.1 Overview of Benefits and Services

The three-way contract defines a combined package of Medicare and Medicaid covered services. With minor exceptions, the demonstration covers all New York Medicaid State Plan services (including LTSS) and a set of services equivalent to those covered under New York's HCBS waiver for this population group. Some of these services "wraparound" Medicare covered services, including non-Medicare inpatient mental health services, skilled nursing facility services, durable medical equipment, and home health.

8.2 Summary of Descriptive Analysis Methodology

The population analyzed in this section includes all New York beneficiaries who met demonstration eligibility criteria, including those in the nine MMPs that were participating at the start of 2017. For context, in New York, only approximately 15 percent of eligible beneficiaries in demonstration year 1 whose utilization was analyzed in this section were enrolled in the demonstration. Please see ***Section 3.2, Enrollment Process*** for details on demonstration eligibility.

Appendix A contains a detailed description of the evaluation design, data used, and measure definitions. We examined 12 Medicare service utilization measures and six RTI quality of care measures. The results reflect the underlying experience of the demonstration group in the demonstration period. Data are analyzed for the first demonstration year (January 1, 2015–December 31, 2015).

8.3 Descriptive Statistics on the Demonstration Eligible Population

Tables are presented for the overall demonstration eligible population in New York (***Tables 23*** and ***24***), followed by tables on New York demonstration eligible beneficiaries who were enrollees and non-enrollees (***Tables 25*** and ***26***). These tables present results on the average percentage of demonstration eligible beneficiaries using selected Medicare service types during the months in which they met demonstration eligibility criteria in the demonstration period. In addition, average counts of service use are presented across all such eligible months, and for the subset of these months in which eligible beneficiaries were users of each respective service type. Data is shown for the demonstration period for only New York eligible beneficiaries.

Descriptive results are presented for 12 service settings: inpatient, inpatient psychiatric, inpatient non-psychiatric, emergency department visits not leading to admission, emergency department psychiatric visits, observation stays, skilled nursing facility, hospice, primary care, outpatient as well as independent physical, speech, and occupational therapy, and other hospital outpatient services. In addition, six quality measures representing specific utilization types of interest are presented: 30-day all-cause risk-standardized readmission rate; preventable emergency room visits; rate of 30-day follow-up after hospitalization for mental illness; ambulatory care sensitive condition overall composite rate (Agency for Healthcare Research and Quality [AHRQ] Prevention Quality Indicator [PQI] #90); ambulatory care sensitive condition chronic composite rate (AHRQ PQI #92); and depression screening rate.

Table 23
Proportion and utilization for institutional and non-institutional services for the New York demonstration eligible beneficiaries

Measures by setting	Demonstration year 1
Number of demonstration beneficiaries	91,423
Institutional setting	
Inpatient admissions[1]	
% with use	4.1
Utilization per 1,000 user months	1,106.5
Utilization per 1,000 eligible months	45.9

(continued)

Table 23 (continued)
Proportion and utilization for institutional and non-institutional services for the New York demonstration eligible beneficiaries

Measures by setting	Demonstration year 1
Inpatient psychiatric	
% with use	0.1
Utilization per 1,000 user months	1,070.2
Utilization per 1,000 eligible months	0.7
Inpatient non-psychiatric	
% with use	4.1
Utilization per 1,000 user months	1,103.8
Utilization per 1,000 eligible months	45.1
Emergency department use (non-admit)	
% with use	3.8
Utilization per 1,000 user months	1,183.2
Utilization per 1,000 eligible months	45.5
Emergency department use (psychiatric)	
% with use	0.1
Utilization per 1,000 user months	1,191.2
Utilization per 1,000 eligible months	1.7
Observation stays	
% with use	0.3
Utilization per 1,000 user months	1,091.1
Utilization per 1,000 eligible months	2.8
Skilled nursing facility	
% with use	1.0
Utilization per 1,000 user months	1,087.2
Utilization per 1,000 eligible months	10.8
Hospice	
% with use	0.4
Utilization per 1,000 user months	1,024.3
Utilization per 1,000 eligible months	3.8
Non-institutional setting	
Primary care E&M visits	
% with use	67.4
Utilization per 1,000 user months	2,435.4
Utilization per 1,000 eligible months	1,641.2

(continued)

Table 23 (continued)
Proportion and utilization for institutional and non-institutional services for the New York demonstration eligible beneficiaries

Measures by setting	Demonstration year 1
Outpatient therapy (PT, OT, ST)	
% with use	1.2
Utilization per 1,000 user months	13,291.6
Utilization per 1,000 eligible months	165.2
Independent therapy (PT, OT, ST)	
% with use	8.6
Utilization per 1,000 user months	17,821.2
Utilization per 1,000 eligible months	1,529.8
Other hospital outpatient services	
% with use	21.7
Utilization per 1,000 user months	—
Utilization per 1,000 eligible months	—

— = data not available. E&M = evaluation and management; OT = occupational therapy, PT = physical therapy, ST = speech therapy.

[1] Includes acute admissions, inpatient rehabilitation, and long-term care hospital admissions.

SOURCE: RTI International analysis of Medicare data.

Table 24
Quality of care and care coordination outcomes for demonstration eligible beneficiaries for the New York demonstration

Quality and care coordination measures	Demonstration year 1
30-day all-cause risk-standardized readmission rate (%)	19.0
Preventable ER visits per eligible months	0.024
Rate of 30-day follow up after hospitalization for mental illness (%)	49.5
Ambulatory care-sensitive condition admissions per eligible months—overall composite (AHRQ PQI #90)	0.010
Ambulatory care-sensitive condition admissions per eligible months—chronic composite (AHRQ PQI #92)	0.007
Screening for clinical depression per eligible months	0.006

AHRQ PQI =Agency for Healthcare Research and Quality Prevention Quality Indicator; ER = emergency room.

SOURCE: RTI International analysis of Medicare data.

8.4 Service Use for Enrollee and Non-Enrollee Populations

To provide insights into the utilization experience over time, ***Tables 25*** and ***26*** present descriptive statistics for the enrolled population, compared to those demonstration eligible beneficiaries who were not enrolled, for each service.

The only clear differences in utilization between enrollees and non-enrollee outcomes were that the former had fewer primary care E&M visits and lower use of independent therapy (***Table 25***). As for the quality of care and care coordination measures, enrollees appeared to have a lower rate of 30-day follow up after hospitalization for mental illness, lower rate of ACSC admissions (both chronic and overall), and a lower rate of screening for clinical depression than non-enrollees (***Table 26***).

Table 25
Proportion and utilization for institutional and non-institutional services for the New York demonstration enrollees and non-enrollees

Measures by setting	Group	Demonstration year 1
Number of enrollees		13,840
Number of non-enrollees		77,583
Institutional setting		
Inpatient admissions[1]	Enrollees	
% with use		3.99
Utilization per 1,000 user months		1,083.57
Utilization per 1,000 eligible months		43.20
Inpatient admissions[1]	Non-enrollees	
% with use		4.10
Utilization per 1,000 user months		1,108.76
Utilization per 1,000 eligible months		45.41
Inpatient psychiatric	Enrollees	
% with use		0.04
Utilization per 1,000 user months		1,130.43
Utilization per 1,000 eligible months		0.50
Inpatient psychiatric	Non-enrollees	
% with use		0.07
Utilization per 1,000 user months		1,067.13
Utilization per 1,000 eligible months		0.76
Inpatient non-psychiatric	Enrollees	
% with use		3.95
Utilization per 1,000 user months		1,079.52
Utilization per 1,000 eligible months		42.65

(continued)

Table 25 (continued)
Proportion and utilization for institutional and non-institutional services for the New York demonstration enrollees and non-enrollees

Measures by setting	Group	Demonstration year 1
Inpatient non-psychiatric	Non-enrollees	
% with use		4.03
Utilization per 1,000 user months		1,106.06
Utilization per 1,000 eligible months		44.62
Emergency department use (non-admit)	Enrollees	
% with use		3.26
Utilization per 1,000 user months		1,226.32
Utilization per 1,000 eligible months		39.93
Emergency department use (non-admit)	Non-enrollees	
% with use		3.80
Utilization per 1,000 user months		1,183.80
Utilization per 1,000 eligible months		44.97
Emergency department use (psychiatric)	Enrollees	
% with use		0.10
Utilization per 1,000 user months		1,264.15
Utilization per 1,000 eligible months		1.28
Emergency department use (psychiatric)	Non-enrollees	
% with use		0.14
Utilization per 1,000 user months		1,199.32
Utilization per 1,000 eligible months		1.71
Observation stays	Enrollees	
% with use		0.21
Utilization per 1,000 user months		1,245.45
Utilization per 1,000 eligible months		2.61
Observation stays	Non-enrollees	
% with use		0.26
Utilization per 1,000 user months		1,087.54
Utilization per 1,000 eligible months		2.78
Skilled nursing facility	Enrollees	
% with use		1.76
Utilization per 1,000 user months		1,112.31
Utilization per 1,000 eligible months		19.61

(continued)

Table 25 (continued)
Proportion and utilization for institutional and non-institutional services for the New York demonstration enrollees and non-enrollees

Measures by setting	Group	Demonstration year 1
Skilled nursing facility	Non-enrollees	
% with use		0.94
Utilization per 1,000 user months		1,086.80
Utilization per 1,000 eligible months		10.23
Hospice	Enrollees	
% with use		0.56
Utilization per 1,000 user months		1,057.63
Utilization per 1,000 eligible months		5.94
Hospice	Non-enrollees	
% with use		0.35
Utilization per 1,000 user months		1,022.84
Utilization per 1,000 eligible months		3.60
Non-institutional setting		
Primary care E&M visits	Enrollees	
% with use		51.89
Utilization per 1,000 user months		2,477.95
Utilization per 1,000 eligible months		1,285.70
Primary care E&M visits	Non-enrollees	
% with use		69.29
Utilization per 1,000 user months		2,455.26
Utilization per 1,000 eligible months		1,701.19
Outpatient Therapy (PT, OT, ST)	Enrollees	
% with use		0.83
Utilization per 1,000 user months		6,734.55
Utilization per 1,000 eligible months		56.03
Outpatient therapy (PT, OT, ST)	Non-enrollees	
% with use		1.25
Utilization per 1,000 user months		13,266.52
Utilization per 1,000 eligible months		166.31
Independent therapy (PT, OT, ST)	Enrollees	
% with use		2.80
Utilization per 1,000 user months		15,075.46
Utilization per 1,000 eligible months		422.22
Independent therapy (PT, OT, ST)	Non-enrollees	
% with use		9.43
Utilization per 1,000 user months		17,983.12
Utilization per 1,000 eligible months		1,696.44

(continued)

Table 25 (continued)
Proportion and utilization for institutional and non-institutional services for the New York demonstration enrollees and non-enrollees

Measures by setting	Group	Demonstration year 1
Other hospital outpatient services	Enrollees	
% with use		16.34
Utilization per 1,000 user months		—
Utilization per 1,000 eligible months		—
Other hospital outpatient services	Non-enrollees	
% with use		21.97
Utilization per 1,000 user months		—
Utilization per 1,000 eligible months		—

— = data not available. E&M = evaluation and management; OT = occupational therapy; PT = physical therapy; ST = speech therapy.

[1] Includes acute admissions, inpatient rehabilitation, and long-term care hospital admissions.

SOURCE: RTI International analysis of Medicare data.

Table 26
Quality of care and care coordination outcomes for enrollees and non-enrollees for the New York demonstration

Quality and care coordination measures	Group	Demonstration year 1
30-day all-cause risk-standardized readmission rate (%)	Enrollees	17.5
	Non-enrollees	19.3
Preventable ER visits per eligible months	Enrollees	0.020
	Non-enrollees	0.023
Rate of 30-day follow up after hospitalization for mental illness (%)	Enrollees	35.3
	Non-enrollees	52.1
Ambulatory care-sensitive condition admissions per eligible months—overall composite (AHRQ PQI # 90)	Enrollees	0.004
	Non-enrollees	0.009
Ambulatory care-sensitive condition admissions per eligible months—chronic composite (AHRQ PQI # 92)	Enrollees	0.002
	Non-enrollees	0.007
Screening for clinical depression per eligible months	Enrollees	0.002
	Non-enrollees	0.006

AHRQ PQI =Agency for Healthcare Research and Quality Prevention Quality Indicator; ER = emergency room.

SOURCE: RTI International analysis of Medicare data.

8.4.1 Service Use by Demographic Characteristics of Eligible Beneficiaries

To examine any differences in racial and ethnic groups, ***Figures 1, 2,*** and ***3*** provide month-level results for five settings of interest: inpatient admissions, emergency department

(non-admit), primary care E&M visits, outpatient therapy (physical therapy [PT], occupational therapy [OT], and speech therapy [ST]), and hospice. Results across these five settings are displayed using three measures: percentage with any use of the respective service, counts per 1,000 demonstration eligible beneficiaries, and counts per 1,000 eligible beneficiaries with any use of the respective service.

Figure 1 presents the percentage of use of selected Medicare services. Asians had the lowest use in all service settings except primary care E&M visits, for which Blacks had the lowest and Whites had the highest. Hispanics had the highest hospice admissions, and Blacks and Hispanics had the highest emergency department visits.

Regarding counts of services used among users of each respective service, as presented in ***Figure 2***, the counts of primary care E&M visits, hospice admissions, emergency department visits, and inpatients admissions were all similar across all racial and ethnic groups. Counts of outpatient therapy visits, on the other hand, were notably lower among Hispanics compared to the other groups; Whites and Asians had the highest counts.

Figure 3 presents counts of services across all demonstration eligible beneficiaries regardless of having any use of the respective services. Trends for utilization across all service settings were broadly similar to those displayed in ***Figure 1***.

Figure 1
Percent with use of selected Medicare services

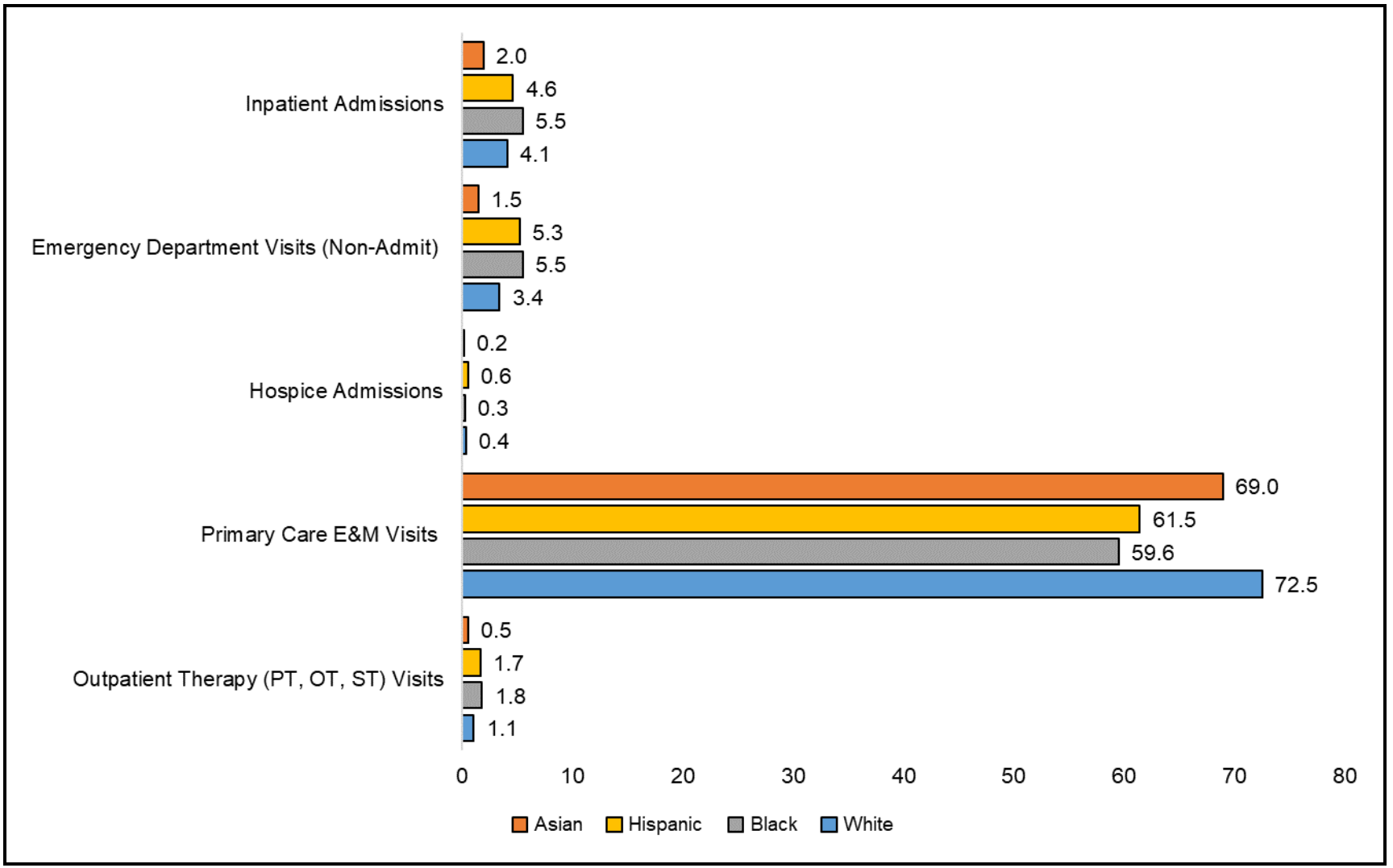


Figure 2
Service use among all demonstration eligible beneficiaries with use of service per 1,000 user months

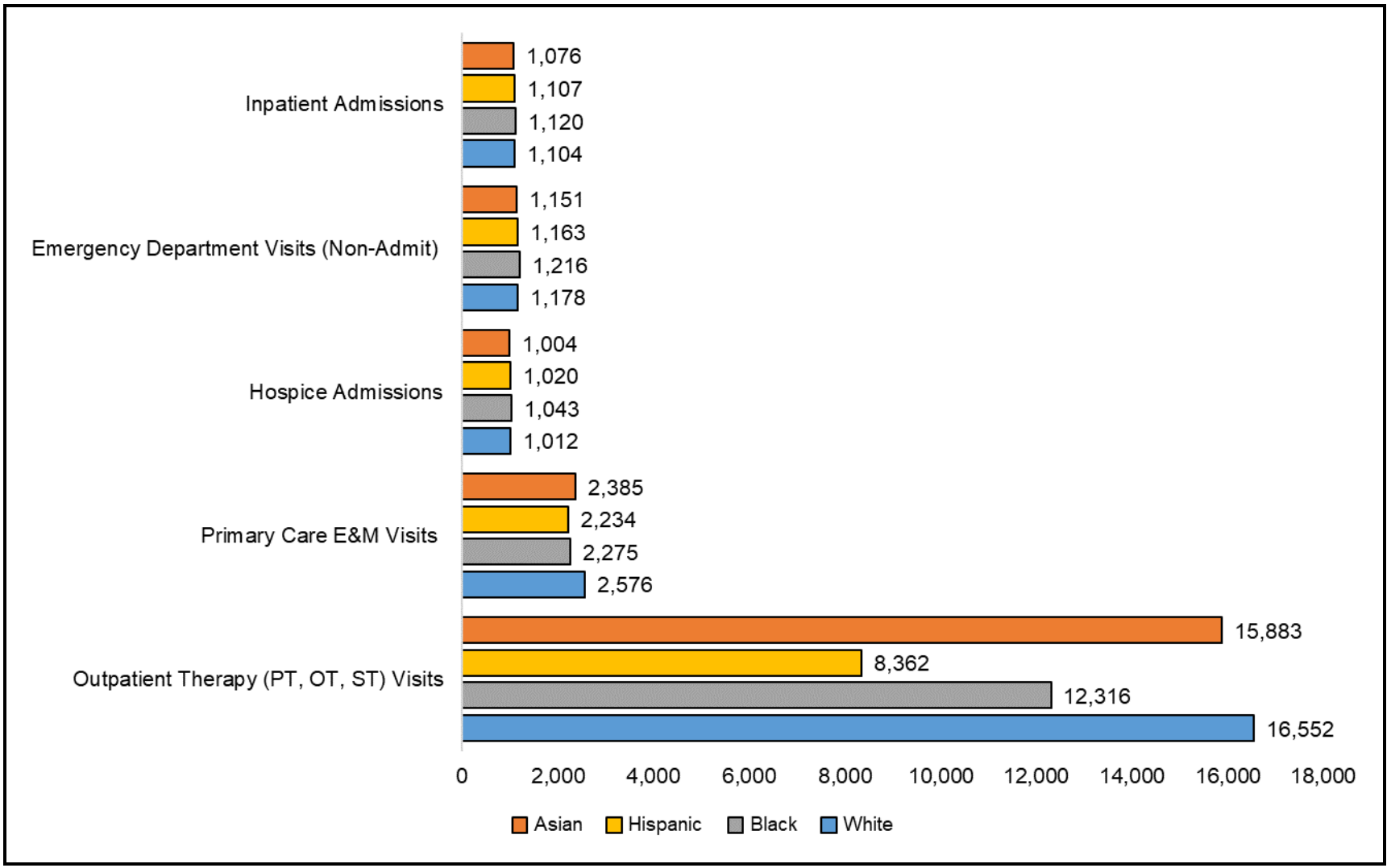
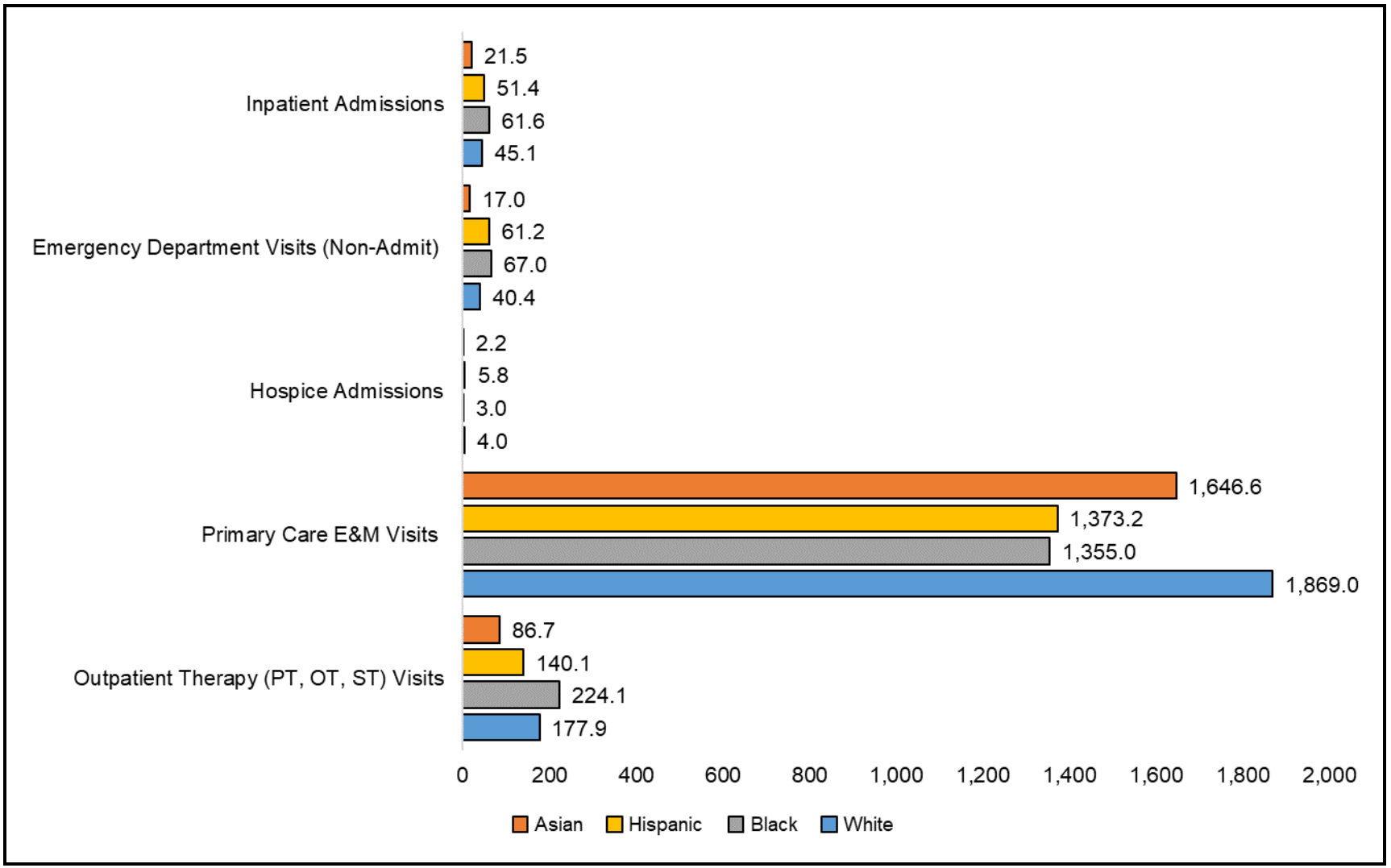


Figure 3
Service use among all demonstration eligible beneficiaries per 1,000 eligible months



9. Quality of Care

Highlights

- New York State Department of Health (NYSDOH) coordinates its quality management of the Fully Integrated Duals Advantage (FIDA) demonstration with both CMS and its other Managed Long Term Services and Supports (MLTSS programs), Managed Long Term Care (MLTC) and Medicaid Advantage Plus (MAP).
- The majority of FIDA plans performed better than the Medicare Advantage mean on four out of nine HEDIS measures reviewed by RTI. For the remaining measures, a majority of the FIDA plans did not perform better than the Medicare Advantage mean.
- Six out of the nine FIDA plans reported more outpatient visits per 1,000 members than the Medicare HMO benchmark value and seven out of nine plans reported fewer emergency department visits than the Medicare HMO benchmark value, which are favorable results.

9.1 Quality Measures

The FIDA demonstration requires that FIDA plans report standardized quality measures. These measures include the following:

- A set of core measures specific to all capitated model demonstrations under the Financial Alignment Initiative that address domains of access, assessment, care coordination, enrollee protection, organization structure and staffing, performance and quality improvement, provider network, and systems and service utilization.[40]

- A set of State-specific measures that were selected by NYSDOH staff in consultation with CMS after considering feedback from stakeholders. NYSDOH captures information about falls among nursing facility residents, self-direction, improvement or stability of enrollee functional abilities, and measures of whether the FIDA plans are shifting the balance of services away from long term nursing facility use.

CMS and the State use reporting and performance data on several of the core and State-specific measures to determine what portion of the capitation rates retained by CMS and the State as a "quality withhold" will be repaid to the MMPs.

The demonstration also utilizes quality measures required of Medicare Advantage plans, including applicable measures from the Part C and Part D Reporting Requirements such as

[40] Core reporting requirements for Medicare-Medicaid Plans may be accessed at CMS's Financial Alignment Initiative website providing *Information and Guidance for Plans:* https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/InformationandGuidanceforPlans.html.

appeals and grievances, pharmacy access, payment structures, and medication therapy management

FIDA plans are required to submit three additional measure sets as part of the Medicare Advantage requirement:

- A modified version of the Medicare Advantage Prescription Drug (MA-PD) Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey that, in addition to the core survey used by Medicare Advantage plans, includes 10 supplemental questions proposed by the RTI Evaluation Team to capture beneficiary experience specific to integration, behavioral health and long-term services and supports (see ***Section 5, Beneficiary Experience*** for CAHPS findings).

- The subset of Medicare Healthcare Effectiveness Data and Information Set (HEDIS) measures, a standard measurement set used extensively by managed care plans, that are required of all Medicare Advantage plans.

- Selected Health Outcomes Survey (HOS) measures based on a recurring survey of a random sample of Medicare beneficiaries to assess physical and mental health outcomes (three-way contract, 2014).

Data related to these measures are reported in relevant sections of this report.

With the original launch, FIDA plans were required to submit dashboard measures for the Contract Management Team (CMT) to monitor implementation. These measures were submitted on a monthly basis and overlapped with other reporting requirements. As part of the reforms in December 2015, dashboard reporting was eliminated. FIDA plans cited this as an improvement, although at least one plan also questioned the "value added" by FIDA's other reporting requirements, relative to those required under MAP. In addition, this plan noted that it is not always easy to implement changes in metrics, if it requires new ways of capturing data. One FIDA plan, participating in multiple demonstrations under the Financial Alignment Initiative was concerned that the measures vary across states, creating reporting challenges and potentially undermining the ability to compare performance across States.

At the time of the June 2016 site visit, plans had only recently submitted their first participant-level files to NYSDOH. At that time, a key informant for NYSDOH reported that those plans with prior experience with New York's mainstream managed care product were already familiar with New York's participant-level file and did not have a problem with reporting. At that time, the Office of Quality and Patient Safety (OQPS) was continuing to work with other FIDA plans to correct problems with the submission.

9.2 Quality Management Structures and Activities

This section examines the components of the quality management system for FIDA, including its interface with CMS, FIDA plans, and other independent entities, and describes how well the quality management system is working from various perspectives.

9.2.1 State and CMS Quality Management Structures and Activities

As discussed in ***Section 2.1, Joint Management of Demonstration***, the CMT integrates certain monitoring functions for assuring the quality of plan performance. In addition to jointly monitoring plan activities, the CMT monitors complaints, grievances, and appeals; hears reports from the ombudsman; and identifies emerging trends and issues across plans.

Internal to NYSDOH, the OQPS is responsible for monitoring quality of care and patient safety across all programs in NYSDOH, including FIDA and the other Medicaid managed care programs and initiatives. NYSDOH has had years of experience with quality measurement, starting with mainstream managed care plans and using HEDIS measures, and evolving to include quality measurement for nursing facilities and NYSDOH's MLTC programs. NYSDOH also has a Quality Strategy for the New York State Medicaid Managed Care Program (NYSDOH, 2014d). The document outlines the goals of the managed care program and actions taken by NYSDOH to ensure the quality of care delivered to Medicaid managed care enrollees. The managed care quality strategy is designed and implemented through the mechanisms of measurement and assessment; improvement; delivery system transformation/redesign; contract compliance and oversight; and enforcement (NYSDOH, 2014d, p. 7).

The quality management activities of the OQPS for FIDA are very similar to those undertaken for MLTC, MAP, and the Program of All-inclusive Care for the Elderly. The OQPS works with the program teams to clarify policy and procedures and ensure the data collected reflects those policies and procedures, and ensure the measures used capture what the team wants to measure.

9.2.2 FIDA Medicare-Medicaid Plan Quality Management Structure and Activities

The three-way contract specifies that FIDA plans apply the principles of Continuous Quality Improvement to all aspects of the FIDA plan's service delivery system. This includes disseminating evidence-based practice guidelines to its providers and establishing a medical record review process to monitor providers' compliance with policies and procedures, specifications, and appropriateness of care (three-way contract, 2014, pp. 146–8).

Plans varied in their strategies for monitoring provider quality. One plan reported that it will be developing provider profiles to identify gaps in care. This plan also conducts annual on-site visits and will be conducting provider record audits. This plan also plans to add the Americans with Disabilities Act (ADA) Plus standards into its provider directory; ADA Plus uses 25 additional standards, in addition to the minimum required for ADA compliance, to assess the accessibility of a provider's office.

FIDA plans must conduct a quality improvement project (QIP) each year (three-way contract, 2014, p. 156–7). Among the four plans interviewed in June 2016, two were conducting QIPs focused on fall prevention and two were focused on advanced directives. FIDA plans must also conduct a chronic care improvement project (CCIP); NYSDOH and CMS selected the topic area of diabetes for the CCIP. Among the four plans interviewed in June 2016, two were focusing their CCIP on medication adherence, and one was focusing on patient education. The fourth was implementing two interventions, one focused on medication adherence and the other on reporting to providers on gaps in care for their patients.

FIDA plans reported mixed success in collecting actionable feedback from their Participant Advisory Committees (PACs). One plan reported that members of their PAC focus primarily on wanting more personal care hours. However, one plan learned through its PAC that some of the dental providers in its network had offices that were not accessible for persons in wheelchairs. This plan used the ADA attestation form to conduct site visits to ensure that bathrooms, the reception area, and exam rooms are accessible for persons in a wheelchair and that procedures can be performed while a person is in a wheelchair. Another plan reported that the PAC gives it a better understanding of the experiences of the participant and their caregiver and has helped to identify process improvement activities.

9.2.3 Independent Quality Management Structures and Activities

The Independent Consumer Advocacy Network (ICAN), New York's ombudsman, is responsible for identifying emerging trends based on the calls it receives and the types of cases it handles. Data are collected from all of ICAN's partnering agencies, and the specialists work with ICAN to identify trends. ICAN reported having biweekly or monthly calls with NYSDOH, depending on the volume of cases. CMS participates in calls with ICAN on a monthly basis.[41] During this call, ICAN reports on the types of complaints it is receiving, the issues it is tracking and, with the permission of the enrollee, ICAN and NYSDOH review and discuss specific case examples. ICAN also submits a monthly activity report that includes cases opened or closed, broken down by subcontractor, plan type, and plan name.

NYSDOH uses IPRO as the External Quality Review Organization (EQRO) for Medicaid managed care programs. For NYSDOH's other Medicaid managed care programs, the EQRO helps plans identify measures they can improve and reviews the data connected to a plan's quality improvement project. NYSDOH has folded FIDA into the EQRO's responsibilities. However, at the time of the 2016 site visit, IPRO had not begun working with the data from the FIDA demonstration yet. IPRO is expected to coordinate their quality activities with quality improvement on the Medicare side.

9.3 Results for Selected Quality Measures

9.3.1 HEDIS Quality Measures Reported for New York's FIDA Plans

Ten Medicare HEDIS measures for Medicare-Medicaid Plan (MMP) enrollees are reported in ***Table 27***. RTI identified these measures for reporting in this Evaluation Report after reviewing the list of measures we previously identified in RTI's Aggregate Evaluation Plan as well as the available HEDIS data on these measures for completeness, reasonability, and sample size; 2015 calendar year data were available for the nine FIDA plans for which RTI is reporting quantitative results. Detailed descriptions of the measures can be found in the RTI Aggregate Evaluation Plan.[42] Results were reported for measures where the sample size was greater than 30 beneficiaries. Five HEDIS measures are not reported because the sample size for the measure was too low to report (annual monitoring for members on digoxin, antidepressant medication

[41] ICAN provides ombudsman services to all of New York's MLTSS programs; FIDA comprises a small fraction of the cases handled by ICAN.

[42] https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/EvalPlanFullReport.pdf

management, disease modifying antirheumatic drug therapy in rheumatoid arthritis, follow-up after hospitalization for mental illness, and initiation and engagement of alcohol and other drug dependence treatment). In addition to reporting the results for each FIDA plan, the mean value for Medicare Advantage plans for each measure is provided for comparison.

We provide national benchmarks from Medicare Advantage plans, where available, understanding that Medicare Advantage enrollees and demonstration enrollees may have different health and sociographic characteristics that would affect the results. Unlike Medicare Advantage plans, New York FIDA plans exclusively serve dual eligible beneficiaries who have LTSS needs. Previous studies on Medicare Advantage health plan performance reveal poorer quality ratings for plans serving a higher proportion of dual eligible beneficiaries and beneficiaries with disabilities. HEDIS measure performance, in particular, is slightly worse among plans active in areas with lower incomes and populations with a higher proportion of minorities (Office of the Assistant Secretary for Planning and Evaluation, 2016). Benchmarks should be considered with that limitation in mind. These findings on HEDIS measure performance for New York FIDA plans represent the early experience in the demonstration and are likely to change over time as FIDA plans gain more experience working with enrollees. Monitoring trends over time in plan performance may be more important than the comparison to the national Medicare Advantage plans given the population differences. Several years of HEDIS results are likely needed to know how well FIDA plans perform relative to each other and whether they perform above or below any potential benchmark.

HEDIS results greatly varied across the nine FIDA plans. Aetna and Senior Whole Health of New York did not report data on any HEDIS measure, and Elderplan and Independence Care System reported only data on one HEDIS measure **(**adults' access to preventive/ambulatory health services). The remaining five plans reported some but not all HEDIS data. Therefore, for most measures, the results reported below are frequently comparing five or fewer plans at most.

For each measure, results across plans vary, and there was not a consistent trend across measures for one FIDA plan compared to others. For four measures reported (adult body-mass index assessment, adults' access to preventive/ambulatory health services, ambulatory care, and plan all-cause readmissions), a majority of the plans that have reported data performed better than the national Medicare health maintenance organization (HMO) benchmark value. Six out of the nine plans also reported more outpatient visits per 1,000 members than the Medicare HMO benchmark value, which is desirable. Seven out of nine plans reported fewer emergency department visits than the Medicare HMO benchmark value, which is also desirable. For one measure (annual monitoring for patients on persistent medications), three plans performed better than the Medicare HMO benchmark value.

On specific measures for comprehensive diabetes care, FIDA plans had uneven performance, with a majority of plans having better performance on administering a hemoglobin A1c (HbA1c) level test, retinal eye exam, and providing medical attention for nephropathy; and a majority having poorer performance on the control of HbA1c level (both those with good and bad control) and blood pressure control.

For the remaining measures, the majority of plans performed below the benchmark value for blood pressure control and just below the benchmark for colorectal cancer screening.

Table 27
Selected HEDIS measures for New York FIDA plans, 2015

Measure	National Medicare Advantage Plan mean	Aetna Better Health	Elderplan	GuildNet	HealthFirst Health Plan (Managed Health)	Independence Care System	MetroPlus Health Plan	NY State Catholic Health Plan (Fidelis)	Senior Whole Health of NY	VNS NY Choice
Adult BMI assessment	93.0%	N/A	N/A	N/A	94.0%	N/A	95.9%	N/A	N/A	N/A
Adults' access to preventive/ambulatory health services	94.7%	N/A	96.7%	100.0%	99.7%	80.0	99.1%	96.8%	N/A	98.0%
Annual monitoring for patients on persistent medications										
Annual monitoring for members on angiotensin-converting–enzyme (ACE) inhibitors or angiotensin-receptor blockers (ARBs)	92.6%	N/A	N/A	N/A	95.2%	N/A	100.0%	97.6%	N/A	N/A
Annual monitoring for members on digoxin	57.4%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Annual monitoring for members on diuretics	92.9%	N/A	N/A	N/A	97.0%	N/A	100.0%	N/A	N/A	N/A
Total rate of members on persistent medications receiving annual monitoring	91.9%	N/A	N/A	N/A	95.7%	N/A	100.0%	98.5%	N/A	NA
Blood pressure control[1]	67.6%	N/A	N/A	32.3%	56.4%	N/A	59.3%	64.7%	N/A	N/A
Breast cancer screening	72.3%	N/A	N/A	N/A	78.9%	N/A	N/A	N/A	N/A	N/A

(continued)

Table 27 (continued)
Selected HEDIS measures for New York FIDA plans, 2015

Measure	National Medicare Advantage Plan mean	Aetna Better Health	Elderplan	GuildNet	HealthFirst Health Plan (Managed Health)	Independence Care System	MetroPlus Health Plan	NY State Catholic Health Plan (Fidelis)	Senior Whole Health of NY	VNS NY Choice
Care of older adults										
Advance care planning	N/A	N/A	N/A	23.7%	N/A	N/A	N/A	N/A	N/A	14.3%
Medication review	N/A	N/A	N/A	40.9%	N/A	N/A	N/A	N/A	N/A	31.0%
Functional status assessment	N/A	N/A	N/A	37.7%	N/A	N/A	N/A	N/A	N/A	100.0%
Pain assessment	N/A	N/A	N/A	40.0%	N/A	N/A	N/A	N/A	N/A	100.0%
Colorectal cancer screening	66.7%	N/A	N/A	N/A	65.9%	N/A	66.0%	N/A	N/A	N/A
Comprehensive diabetes care										
Received hemoglobin A1c (HbA1c) testing	93.1%	N/A	N/A	93.3%	93.8%	N/A	100.0%	N/A	N/A	N/A
Poor control of HbA1c level (>9.0%) (higher is worse)	28.4%	N/A	N/A	40.0%	31.8%	N/A	23.1%	N/A	N/A	N/A
Good control of HbA1c level (<8.0%)	61.8%	N/A	N/A	50.0%	55.0%	N/A	71.8%	N/A	N/A	N/A
Received eye exam (retinal)	68.3%	N/A	N/A	46.7%	76.7%	N/A	76.9%	N/A	N/A	N/A
Received medical attention for nephropathy	95.5%	N/A	N/A	100.0%	95.4%	N/A	100.0%	N/A	N/A	N/A
Blood pressure control (<140/90 mm Hg)	60.9%	N/A	N/A	43.4%	58.9%	N/A	59.0%	N/A	N/A	N/A

(continued)

Table 27 (continued)
Selected HEDIS measures for New York FIDA plans, 2015

Measure	National Medicare Advantage Plan mean	Aetna Better Health	Elderplan	GuildNet	HealthFirst Health Plan (Managed Health)	Independence Care System	MetroPlus Health Plan	NY State Catholic Health Plan (Fidelis)	Senior Whole Health of NY	VNS NY Choice
Plan all-cause readmissions (average adjusted probability total) (higher is worse)	17.3%	N/A	N/A	11.3%	N/A	N/A	11.4%	15.2%	N/A	N/A
Ambulatory care (per 1,000 members) outpatient visits	9,161.2	5,490.2	13,498.78	11,174.52	7,163.7	2,862.04	21,1137.1	14,346.7	11,603.31	10,743.18
Emergency department visits	607.8	235.29	927.58	535.45	435.14	257.33	539.12	532.95	595.04	623.73

N/A = not available, or the number of enrollees in the plan's provided HEDIS data available for inclusion in the measure was less than 30, and therefore not reported per RTI's decision rule for addressing low sample size.

NOTES: Data for fall risk management, physical activity in older adults, and management of urinary incontinence in older adults are not available for CY 2015. Medicare HMO benchmark values were not available for all measures (e.g., care of older adults measures). Data for which the final sample size was <30 were determined too small to present; in cases where final sample size was unavailable, RTI used eligible population to make this determination. Detailed descriptions of HEDIS measures presented can be found in the RTI Aggregate Evaluation Plan: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/EvalPlanFullReport.pdf

[1] The following criteria were used to determine adequate blood pressure control: less than 140/90 mm Hg for members 18–59 years of age; diagnosis of diabetes and <140/90 mm Hg for members 60–85 years of age; no diagnosis of diabetes and <150/90 mm Hg for members 60–85 years of age.

SOURCE: RTI analysis of 2015 HEDIS measures.

10. Conclusions

10.1 Implementation Successes, Challenges, and Lessons Learned

The FIDA demonstration has several innovations that elicited largely favorable reviews from stakeholders. Most notably, New York's integrated appeals process is perceived to be highly successful by plans, advocates, NYSDOH, CMS, New York's State-level Integrated Appeals Hearing Office (IAHO), and the Federal government's Medicare Appeals Council (MAC). The integrated appeals system streamlines the resolution of appeals. To date, the findings of the IAHO and the MAC have been noncontroversial and the relationship between the IAHO and the MAC is mutually respectful.

The FIDA demonstration also combines the interdisciplinary team (IDT) responsibility for care management with authority over utilization management (with some exceptions), streamlining the care planning process and service authorization process: When the IDT (acting within the scope of practice for its members) agrees that a service is necessary, it is authorized and is not subject to the FIDA plan's review. Not all FIDA plans see this design feature as favorable; however, others see this as a much more natural and effective way to ensure an individual receives the services needed.

In spite of these and other strengths, the FIDA demonstration continues to be challenged by low enrollment; smaller plans are particularly challenged to manage costs, and many plans have experienced losses. Low enrollment is the result of many factors including the context in which FIDA was implemented, some features of its design, and the result of the implementation process.

10.1.1 Context for Implementation

Regardless of how it designed the demonstration, New York would have encountered a number of environmental factors impeding FIDA's success. First, most of those eligible to enroll in FIDA had only recently completed mandatory enrollment into Managed Long Term Care (MLTC). Advocates reported that the transition to mandatory enrollment had been disruptive and frightening for many of New York's long-term services and supports (LTSS) users, predisposing many FIDA-eligible beneficiaries to resist any change potentially disrupting services or provider relationships.

The fact that most eligible beneficiaries were already enrolled in a partially capitated managed LTSS product also meant that they had already developed a relationship with an MLTSS plan and that plan's network of LTSS providers. Rather than starting fresh, most eligible beneficiaries "rolled over" from their MLTC plan into the FIDA product operated by the same parent organization, creating some uncertainty about whether that beneficiary's other providers would be in network. If beneficiaries had enrolled in FIDA from fee-for-service, it might have been easier to match beneficiaries with plans already having all their key providers in network.

The existence of other MLTSS and D-SNP products also created competition for FIDA, making it difficult for FIDA's more ambitious design features to succeed—to the degree that rates for FIDA were lower or FIDA imposed more requirements on the plans or providers than

Medicaid Advantage Plus (MAP) or MLTC, plans and providers would have an incentive to favor MAP or MLTC over FIDA.

In spite of the density of the population in the demonstration area, many providers resist participating in managed care, particularly among certain demographic groups or in certain geographic areas. In addition, some important large hospital systems have limited the number of new managed care contracts they enter into, effectively precluding the participation of the hospital system's network of physicians.

FIDA was implemented in the midst of a number of ambitious reforms. Because it was relatively small in comparison to other reform initiatives, FIDA had difficulty competing for the attention of both NYSDOH leadership and the provider community.

10.1.2 The Design of FIDA

As discussed previously, a number of design features associated with New York's care model generated a great deal of resistance among providers and plans. For example, requiring all members of the IDT to meet in real time created logistical challenges for the FIDA plans and resentment among providers. These and other features, including requiring FIDA plans to obtain "wet" signatures on the person-centered service plan (PCSP) and requiring providers to participate in a comprehensive training program, damaged FIDA's "brand" among providers and made MAP and MLTC relatively more appealing. Uneven stakeholder participation in the design of FIDA did not provide an opportunity to test the underlying assumptions behind the IDT design with providers and beneficiaries.

NYSDOH also chose to allow all MLTC plans to participate in FIDA. As discussed next, the large number of plans contributed to some of the logistical challenges associated with implementation. NYSDOH anticipated more active engagement from plans, conducting outreach and education to their members and providers. However, at least some plans participated in FIDA to make sure their MLTC and MAP enrollees were not diverted to a FIDA program operated by another plan.

10.1.3 Implementation of FIDA

The launch of the FIDA demonstration was a major undertaking for NYSDOH and CMS. Key personnel for both agencies were able to create an effective working relationship. However, in spite of these efforts, many key decisions were delayed by bureaucratic processes and many key systems had not been tested before passive enrollment began. In particular, at the time that passive enrollment began, the enrollment process was untested and the Medicaid rates were not final. NYSDOH and CMS assumed that the FIDA plans were conducting member and provider outreach and education, whereas the FIDA plans assumed that NYSDOH and CMS were conducting member and provider outreach and education. In addition, the contract to create the ombudsman program was not signed until a month before opt-in enrollment began, and the contract with New York's Health Insurance Information, Counseling and Assistance Program to conduct outreach and benefits counseling was not signed until after the passive enrollment phase was over.

Although NYSDOH and CMS acted relatively quickly to make midcourse corrections, the passive enrollment process was over before those changes could be finalized and implemented. In retrospect, NYSDOH would conduct enrollment at a much slower pace, and would ensure that key systems were in place.

10.1.4 Midcourse Corrections

Since December 2015, NYSDOH and CMS have implemented numerous reforms to respond to the concerns raised by plans and providers; they have conducted an advertising campaign and outreach. However, these efforts have not successfully altered the initial trajectory for FIDA. Enrollment continues to be only a fraction of the number of persons eligible to participate.

10.1.5 Beneficiary Experience

In general, FIDA's benefit design was well-received by focus group participants, who made favorable comments about having all their services covered under one plan and no copays. However, focus group participants reported they needed to switch primary care providers. In addition, many focus group participants were confused by the over-the-counter (OTC) drug benefit—a highly valued benefit—and believed that the OTC card was more limited under FIDA. Perhaps the most troubling findings relate to the quality of care management services. As indicated by New York State leadership, care management was meant to be the centerpiece of FIDA, and "Care Management for All" is a top priority under New York's Medicaid Redesign initiative. However, the focus group and survey findings call into question the quality of care management services provided under FIDA. Although it is difficult to know if these findings apply generally to FIDA as a whole, they at least raise questions about consistency.

10.2 Preliminary Service Utilization Findings

This evaluation report included descriptive analysis results for the demonstration group in the demonstration period, and also a comparison of MMP enrollees versus nonenrollees in New York. No testing was performed between the enrollee and nonenrollee groups. The results reflect the underlying experience of these beneficiaries as opposed to the effect of the demonstration.

10.3 Next Steps

The RTI evaluation team will continue to collect information on a quarterly basis from New York State officials through the online State Data Reporting System, covering enrollment statistics and updates on key aspects of implementation. The RTI evaluation team will continue conducting quarterly calls with the New York State and CMS staff and will request the results of any evaluation activities conducted by NYSDOH or other entities, such as results from the Consumer Assessment of Healthcare Providers and Systems and State-specific demonstration measures the plans are required to report to CMS. RTI will conduct additional site visits and qualitative research activities as needed over the course of the demonstration.

The next report will include a qualitative update on demonstration implementation, descriptive analyses of quality and utilization measures, and multivariate analyses of cost data for those eligible for the demonstration and for an out-of-State comparison group. As noted

previously, New York requested an extension from CMS to continue the demonstration, which will provide further opportunities to evaluate the demonstration's performance.

References

Centers for Medicare & Medicaid Services (CMS): Funding to Support Options Counseling for Medicare-Medicaid Enrollees. (webpage). Updated January 4, 2018. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FundingtoSupportOptionsCounselingforMedicare-MedicaidEnrollees-.html. 2018. As obtained on February 13, 2018.

Centers for Medicare & Medicaid Services (CMS): Fully Integrated Duals Advantage: Provider Training. (webpage). https://fida.resourcesforintegratedcare.com/my.policy . n.d. As obtained on September 1, 2015.

Centers for Medicare & Medicaid Services (CMS): Medicare-Medicaid Plan Enrollment and Disenrollment Guidance. June 14, 2013. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMPFinalEnrollGuidance.pdf. 2013a. As obtained on July 19, 2015.

Centers for Medicare & Medicaid Services (CMS): Implementation Support for State Demonstrations. (webpage). Updated December 19, 2013. http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/ImplementationSupportforState Demonstrations.html. 2013b. As obtained on August 29, 2015.

Centers for Medicare & Medicaid Services (CMS): Managed Care in New York. August 2014. https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/downloads/new-york-mcp.pdf. 2014a. As obtained on September 6, 2015.

Centers for Medicare & Medicaid Services (CMS): Monthly Enrollment by Plan – December 2014. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Monthly-Enrollment-by-Plan-Items/Monthly-Enrollment-by-Plan-2014-12.html?DLPage=1&DLSort=1&DLSortDir=descending. 2014b. As obtained on August 24, 2015.

Centers for Medicare & Medicaid Services (CMS): Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements: New York FIDA-Specific Reporting Requirements. Effective October 1, 2015. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignment Initiative/Downloads/FinalCY2015CoreReportingRequirementsNY010716.pdf. As obtained on September 17, 2017.

Centers for Medicare & Medicaid Services (CMS) and the State of New York: Memorandum of Understanding (MOU) Between The Centers for Medicare & Medicaid Services And The State of New York Regarding a Federal-State Partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Enrollees. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/NYMOU.pdf. August 26, 2013.

Centers for Medicare & Medicaid Services (CMS) and the State of New York: Contract Between United States Department of Health and Human Services Centers for Medicare & Medicaid Services In Partnership with State of New York, Department of Health. https://www.health.ny.gov/health_care/medicaid/redesign/docs/final_three_way_contract_generic.pdf. July 3, 2014.

Coalition of New York State Managed Long Term Care and PACE Plans: Testimony of The Coalition of New York State Managed Long Term Care and PACE Plans on the Governor's Proposed 2016-2017 Health and Medicaid Budget. January 26, 2016. https://nyassembly.gov/2016budget/testimony/20160125_health/20160125-Health-Lytle.pdf. As obtained July 2, 2017.

Anthony J. Fiori and James W. Lytle: Letter on behalf of Coalition of New York State Managed Long Term Care and PACE Plans in regard to the Future of FIDA. September 9, 2016.

Fully Integrated Duals Advantage CY 2015 Rate Report. November 5, 2014. As obtained on June 15, 2015, by email from Melissa Seeley at CMS.

Integrated Care Resource Center: Monthly Enrollment in Medicare-Medicaid Plans by Plan and by State, May 2016 to May 2017. May 2017. http://www.integratedcareresourcecenter.com/PDFs/MMP_Enroll_by_State_May_2017.pdf. As obtained May 28, 2017.

MAXIMUS: FIDA Weekly Activity Summary, Summary for Week Ending 12/19/15.

New York State Department of Health (NYSDOH): A Plan to Transform the Empire State's Medicaid Program: Multi-Year Action Plan. https://www.health.ny.gov/health_care/medicaid/redesign/docs/mrtfinalreport.pdf. n.d.-a. As obtained May 29, 2017.

New York State Department of Health (NYSDOH): FIDA Demonstration Revised Enrollment Schedule. n.d.-b. As obtained on October 16, 2014, from Kevin Malone at CMS.

New York State Department of Health (NYSDOH): MRT 101 - Develop initiatives to integrate and manage care for eligible duals. (webpage). https://www.health.ny.gov/health_care/medicaid/redesign/mrt_101.htm. n.d.-c. As obtained on July 19, 2015.

New York State Department of Health (NYSDOH): Nursing Home Transition and Diversion Waiver: Program Manual. https://www.health.ny.gov/facilities/long_term_care/waiver/nhtd_manual/nhtd_program_manual_with_forms.pdf. 2008. As obtained on September 6, 2015.

New York State Department of Health (NYSDOH): New York State's Demonstration to Integrate Care for Dual Eligible Individuals. Final proposal. Albany, NY. May 25, 2012. https://www.health.ny.gov/facilities/long_term_care/docs/2012-05-25_final_proposal.pdf. 2012a. As obtained on July 19, 2015.

New York State Department of Health (NYSDOH): Medicaid Advantage Plus (MAP) Model Contract. https://www.health.ny.gov/health_care/medicaid/redesign/docs/mrt90_medicaid_adv_plus_model_contract.pdf. 2012b. As obtained on August 22, 2015.

New York State Department of Health (NYSDOH): Managed Long Term Care Partial Capitation Contract. https://www.health.ny.gov/health_care/medicaid/redesign/docs/mrt90_partial_capitation_contract.pdf. 2012c. As obtained on August 22, 2015.

New York State Department of Health (NYSDOH): Managed Long-Term Care and Fully Integrated Duals Advantage Ombudsman Program Request for Applications. February 28, 2014. https://www.health.ny.gov/funding/rfa/inactive/1312200945/1312200945.pdf. 2014a. As obtained on July 19, 2015.

New York State Department of Health (NYSDOH): FIDA Demonstration Requirements for Assessment, Service Planning and Authorization, and Ongoing Care Management. June 5, 2014. 2014b.

New York State Department of Health (NYSDOH): Managed Long Term Care Enrollment by Plan, County and Program. December 2014. https://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/2014/docs/en12_14.pdf. 2014c. As obtained on January 19, 2015.

New York State Department of Health (NYSDOH): Quality Strategy for the New York State Medicaid Managed Care Program. https://www.health.ny.gov/health_care/managed_care/docs/quality_strategy.pdf. July 13, 2014. 2014d. As obtained on July 13, 2015.

New York State Department of Health (NYSDOH): Transition of Nursing Home Benefit and Population into Managed Care: Implementation. February 2015. https://www.health.ny.gov/health_care/medicaid/redesign/docs/nursing_home_transition_final_policy_paper.pdf. 2015a. As obtained May 29, 2017.

New York State Department of Health (NYSDOH): MRT Listserv Update. July 27, 2015. 2015b.

New York State Department of Health (NYSDOH): FIDA Plans by Region. December 2015. https://www.health.ny.gov/health_care/medicaid/redesign/fida_plans_by_region.htm. 2015c. As obtained May 28, 2017.

New York State Department of Health (NYSDOH): FIDA Demonstration Requirements for Assessment, Service Planning and Authorization, and Ongoing Care Management. Revised December 9, 2015. https://www.health.ny.gov/health_care/medicaid/redesign/fida/docs/2015-12-09_rev_idt_policy.pdf. 2015d. As obtained July 2, 2017.

New York State Department of Health (NYSDOH): FIDA: New Flexibility Offered. December 9, 2015. https://www.health.ny.gov/health_care/medicaid/redesign/fida/docs/2015-12-09_fida_reform_summary.pdf. 2015e. As obtained June 27, 2017.

New York State Department of Health (NYSDOH): Provider Training Q&A. March 30, 2015. https://www.health.ny.gov/health_care/medicaid/redesign/docs/provider_training_qa.pdf. 2015f. As obtained on July 7, 2015.

New York State Department of Health (NYSDOH): FIDA Enrollment by Plan. January 2016. https://www.health.ny.gov/health_care/medicaid/redesign/fida/2016-1-29_fida_trends.htm. 2016a. As obtained on July 2, 2017.

New York State Department of Health (NYSDOH): PBP Guidance for FIDA Plans. January 26, 2016. 2016b. As obtained January 17, 2018.

Rick Surpin, President, Independence Care System: Letter to Mark Kissinger and Andrew Segal in regard to the Future of FIDA. September 12, 2016.

RTI International: Evaluation team review and analysis of monthly enrollment in parent organization's Medicare Advantage, Cost, and Demo plans in New York State as of December 2014. Compiled using data from https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Monthly-Enrollment-by-Plan-Items/Monthly-Enrollment-by-Plan-2014-12.html?DLPage=1&DLSort=1&DLSortDir=descending. 2015. As obtained on February 26, 2015.

Walsh, E. G., Anderson, W., Greene, A. M., et al.: Measurement, Monitoring, and Evaluation of State Demonstrations to Integrate Care for Dual Eligible Individuals: Aggregate Evaluation Plan. Contract No. HHSM500201000021i TO#3. Waltham, MA. RTI International. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/EvalPlanFullReport.pdf. 2013. As obtained on December 4, 2014.

Appendix A:
Analysis Methodology

A.1 Methodology

We briefly describe the overall evaluation design, the data used, and the populations and measures analyzed.

A.1.1 Evaluation Design

RTI International customarily uses an intent-to-treat (ITT) approach for the impact analyses conducted for the evaluation, comparing the eligible population under each State demonstration with a similar population that is not affected by the demonstration (i.e., a comparison group). ITT refers to an evaluation design in which all Medicare-Medicaid enrollees eligible for the demonstration constitute the evaluation sample, regardless of whether they actively participated in demonstration models. Thus, under the ITT framework, analyses include all beneficiaries eligible for the demonstration, including those who are eligible but are not contacted by the State or participating providers to enroll in the demonstration or care model; those who enroll but do not engage with the care model; and a group of similar eligible individuals in the comparison group.

As discussed in ***Section 1.1.2, What it Covers,*** RTI lacked administrative data on approximately half of the beneficiary characteristics that the State used to exclude beneficiaries from the demonstration. Such data would have been needed to more effectively and completely exclude beneficiaries who otherwise would have met the demonstration's eligibility criteria had the demonstration been implemented in the New York baseline period and also in the proposed comparison group. Therefore, RTI was not able to create a comparison group, or the predemonstration period group in New York, and therefore not able to conduct impact analyses. Instead, RTI used the data that were complete, including MMP encounter data, to report descriptive statistics for eligible New York demonstration beneficiaries in the demonstration period, and also for the enrollee and nonenrollee groups.

A.1.2 Data

Evaluation Report analyses used data from several sources. First, the State provided quarterly finder files containing identifying information on all demonstration eligible beneficiaries in the demonstration period. Second, RTI obtained administrative data on beneficiary demographic, enrollment, and service use characteristics from CMS data systems for demonstration group members. Third, these administrative data were merged with Medicare claims and encounter data on utilization of Medicare services.

A.1.3 Populations and Services Analyzed

The populations analyzed in the report include all demonstration eligible beneficiaries; demonstration enrollees; demonstration nonenrollees; and demographic groups (race/ethnicity).

For all demonstration eligible beneficiaries and service types analyzed, we provide estimates of three access to care and utilization measures: the percent of demonstration eligible beneficiaries with any use of a service, and counts of service use for all eligible beneficiaries and users of the respective service.

The 12 service settings analyzed include both institutional (inpatient, inpatient psychiatric, inpatient non-psychiatric, emergency department visits not leading to admission, emergency department psychiatric visits, observation stays, skilled nursing facility, and hospice) and community settings (primary care, outpatient as well as independent physical, speech, and occupational therapy, and other hospital outpatient services).

In addition, six quality measures representing specific utilization types of interest are presented: 30-day all-cause risk-standardized readmission rate; preventable emergency room visits; rate of 30-day follow-up after hospitalization for mental illness; ambulatory care sensitive condition overall composite rate (Agency for Healthcare Research and Quality [AHRQ] Prevention Quality Indicator [PQI] #90); ambulatory care sensitive condition chronic composite rate (AHRQ PQI #92); and depression screening rate.

The analyses were conducted for the first demonstration period (January 1, 2015 to December 31, 2015) for only the demonstration group in the demonstration period.

A.1.4 Detailed Population Definitions

Demonstration eligible beneficiaries. Beneficiaries are identified in a given month if they were a Medicare-Medicaid enrollee and met any other specific demonstration eligibility criteria. Beneficiaries in the demonstration period are identified from quarterly State finder files

Additional special populations were identified for the analyses as follows:

- **Enrollees.** A beneficiary was defined as an enrollee if they were enrolled in the demonstration during the demonstration period.

- **Race/Ethnicity.** Race/ethnicity was defined as a categorical variable where beneficiaries were categorized as *White*, *Black*, *Hispanic*, or *Asian*.

A*.1.5 Detailed Utilization and Expenditure Measure Definitions*

For any health care service type, the methodology for estimating average monthly utilization and the percentage of users takes into account differences in the number of eligibility months across beneficiaries. Because full-benefit dual eligibility status for the demonstration can vary by month over time for any individual, the methodology used determines dual eligibility status for the demonstration for each person on a monthly basis during a predemonstration or demonstration period. That is, an individual can meet the demonstration's eligibility criteria for up to 12 months during the observation year. The methodology adds the total months of full-benefit dual eligibility for the demonstration across the population of interest and uses it in the denominator in the measures in ***Section 8, Service Utilization***, creating average monthly utilization information for each service type. The methodology effectively produces average

monthly use statistics for each year that account for variation in the number of dual eligible beneficiaries in each month of the observation year.

The utilization measures below were calculated as the aggregate sum of the unit of measurement (e.g., counts) divided by the aggregated number of eligible member months [and user months] within each group (*g*) where group is defined as the New York demonstration year 1.

We calculated the average number of services per 1,000 eligible months and per 1,000 user months by beneficiary group (*g*). We defined *user month* as an eligible month where the number of units of utilization used [for a given service] was greater than zero during the month. The average yearly utilization outcomes are measured as:

$$Y_g = \frac{\Sigma_{ig} Z_{ig}}{\left(\frac{1}{1{,}000}\right) * \Sigma_{ig} n_{ig}}$$

Where

Y_g = average count of the number services used [for a given service] per eligible or user month within group *g*.

Z_{ig} = the total units of utilization [for a given service] for individual *i* in group *g*.

n_{ig} = the total number of $\frac{1}{1{,}000}$ eligible/user months for individual *i* in group *g*.

The denominator above is scaled by such that the result is interpreted in terms of average monthly utilization per 1,000 eligible beneficiaries. This presentation is preferable, compared with per eligible, because some of the services are used less frequently and would result in small estimates.

The average percentage of users [of a given service] per eligible month during the predemonstration or demonstration year is measured as follows:

$$U = \frac{\Sigma_{ig} X_{ig}}{\Sigma_{ig} n_{ig}} \quad \text{x } 100$$

Where

U_{ig} = average percentage of users [for a particular service] in a given month among beneficiaries in group *g*.

X_{ig} = the total number of eligible months of service use for an individual *i* in group *g*.

n_{ig} = the total number of eligible or user months for an individual *i* in group *g*.

A.1.6 Quality of Care and Care Coordination Measures

Similar to the utilization measures, for the appendix tables of descriptive statistics, the quality of care and care coordination measures were calculated as the aggregated sum of the numerator divided by the aggregated sum of the denominator for each respective outcome within each beneficiary group, except for the average 30-day all-cause risk standardized readmission rate and the 30-day followup after hospitalization for mental illness, which are reported as percentages.

Average 30-day all-cause risk standardized readmission rate (percent) was calculated as follows:

$$30 - Risk\ Standardized\ Readmission\ = \frac{\left(\frac{\Sigma_{ig} x_{ig}}{\Sigma_{ig} \mathrm{n}_{ig}} X\ C\right)}{Prob_g}$$

Where

C = the national average of 30-day readmission rate, .238.

x_{ig} = the total number of readmissions for individual *i* in group *g*.

n_{ig} = the total number of hospital admissions for individual *i* in group *g*.

$Prob_g$ = the annual average adjusted probability of readmission for individuals in group *g*. The average adjusted probability equals:

Average adjusted probability of readmission	
Demonstration group	**Average adjusted probability of readmission**
Demonstration year 1	
New York	0.190

Rate of 30-day follow-up in a physician or outpatient setting after hospitalization for mental illness (percent) was calculated as follows:

$$MHFU\ = \frac{\Sigma_{ig} x_{ig}}{\Sigma_{ig} \mathrm{n}_{ig}} * 100$$

Where

MHFU = the average rate of 30-day follow-up care after hospitalization for a mental illness (percent) for individual*s in* group *g*.

x_{ig} = the total number of discharges from a hospital stay for mental health that had a follow-up for mental health within 30 days of discharge for individual *i* in group *g*.

n_{ig} = the total number of discharges from a hospital stay for mental health for individual *i* in group *g*.

Average ambulatory care sensitive condition admissions per eligible beneficiary, overall and chronic composite (PQI #90 and PQI #92) was calculated as follows:

$$ACSC_{ig} = \frac{\Sigma_{ig} x_{ig}}{\Sigma_{ig} \mathrm{n}_{ig}}$$

Where

$ACSC_g$ = the average number of ambulatory care sensitive condition admissions per eligible month for overall/chronic composites for individuals in group *g*.

x_{ig} = the total number of discharges that meet the criteria for AHRQ PQI #90 [or PQI #92] for individual *i* in group *g*.

n_{ig} = the total number of eligible months for individual *i* in group *g*.

Preventable ER visits per eligible month was calculated as follows:

$$ER_{ig} = \frac{\Sigma_{ig} x_{ig}}{\Sigma_{ig} \mathrm{n}_{ig}}$$

Where

ER_g = the average number of preventable ER visits per eligible month for individuals in group *g*.

x_{ig} = the total number ER visits that are considered preventable based in the diagnosis for individual *i* in group *g*.

n_{ig} = the total number of eligible months for individual *i* in group *g*.

Average number of beneficiaries per eligible month who received depression screening during the observation year was calculated as follows:

$$D_g = \frac{\Sigma_{ig} x_{ig}}{\Sigma_{ig} \mathrm{n}_{ig}}$$

Where

D_g = the average number of beneficiaries per eligible month who received depression screening in group *g*.

x_{ig} = the total number eligible beneficiaries age 65+ who ever received depression screening in group *g*.

n_{ig} = the total number of eligible months among beneficiaries in group *g*.

Average rate of beneficiaries per positive depression screening who received a follow-up plan during the observation year was calculated as follows:

$$PD_g = \frac{\Sigma_{ig} x_{ig}}{\Sigma_{ig} \mathrm{n}_{ig}}$$

Where

PD_g = the average number of beneficiaries per positive depression screening who received a follow-up plan among beneficiaries in group *g*.

x_{ig} = the total number beneficiaries who received a positive depression screen and a follow up plan in group *g*.

n_{ig} = the total number of beneficiaries who received a positive depression screen in group *g*.

Appendix B:
Summary of Predemonstration and Demonstration Design Features for Medicare and Medicaid Beneficiaries in New York

Table B-1
Summary of predemonstration and demonstration design features

Key features	Predemonstration	Demonstration[1]
Summary of covered benefits		
Medicare	Medicare Parts A, B, and D	Medicare Parts A, B, and D
Medicaid	Medicaid State Plan services; HCBS waiver services; nursing facility services	Medicaid State Plan services, HCBS-equivalent waiver services,[2] nursing facility services, and supplemental benefits (at the MMPs' discretion and with State and CMS approval)
Payment method		
Medicare	FFS or capitated	Capitated
Medicaid (capitated or FFS)		
Primary/medical	FFS for MLTC Capitated for MAP and PACE	Capitated
Behavioral health	FFS for MLTC or MAP Capitated for PACE	Capitated
LTSS (excluding HCBS waiver services)	Capitated	Capitated
HCBS waiver services	FFS for MLTC and MAP Capitated for PACE	Capitated
Other (specify)	N/A	N/A
Care coordination/case management		
Care coordination for medical, behavioral health, or LTSS and by whom	Medical care coordination through Medicaid Advantage Plus plans, Medicare Advantage plans, or PACE, if applicable; Behavioral health—no care coordination; LTSS—care coordination by MLTC plans for those needing 120 days or more of LTSS; Nursing facility residents: no care coordination unless enrolled in MLTC plan.	FIDA plans are responsible for person-centered care coordination and care management through use of interdisciplinary teams.

(continued)

Table B-1 (continued)
Summary of predemonstration and demonstration design features

Key features	Predemonstration	Demonstration[1]
Care coordination/case management for HCBS waivers and by whom	Care coordination is a covered service under the NHTD 1915(c) waiver and may be provided by a qualified professional through a health and human services agency.	FIDA plans are responsible for person-centered care coordination and care management through use of interdisciplinary care teams.
TCM	N/A	N/A
Rehabilitation option services	Range of psychiatric rehabilitation services provided through programs licensed or certified by New York State Office of Mental Health.	Range of psychiatric rehabilitation services provided through programs licensed or certified by New York State Office of Mental Health managed through FIDA.
Clinical, integrated, or intensive care management	N/A	FIDA plans are responsible for person-centered care coordination and care management through use of interdisciplinary care teams.
Enrollment/assignment		
Enrollment method	People aged 21 and older needing 120 days or more of community-based LTSS are required to enroll in an MLTC plan; may elect to enroll in a MAP plan or PACE as an alternative.	Enrollees have an opportunity to select a FIDA plan. During the passive enrollment phase and for transitions from non-renewing plans, those who did not select a FIDA plan or opt out were be passively enrolled. Those who opt out of the FIDA demonstration will remain with their MLTC plan for Medicaid-covered community-based and facility-based LTSS, and receive Medicare services through FFS or through a Medicare Advantage plan. Part D benefits are also accessed through a managed care plan or through a standalone Part D plan. Individuals may disenroll from their FIDA plan at any time, effective on the first day of the following month.
Attribution/assignment method	N/A	Based on parent company of MLTC plan unless not previously enrolled in MLTC.
Implementation		
Geographic area	N/A	Region/Phase 1: Bronx, Kings, New York, Queens, Richmond, Nassau. Region/Phase 2: Suffolk, and Westchester counties.

(continued)

Table B-1 (continued)
Summary of predemonstration and demonstration design features

Key features	Predemonstration	Demonstration[1]
Phase-in plan	N/A	Enrollment will be phased in. Community-based and facility-based populations were eligible for opt-in enrollment effective January 1, 2015. In Region 1, passive enrollment for community-based populations occurred in monthly waves from April through October 2015, except for June. Passive enrollment for facility-based populations new to custodial status as of February 1, 2015. Enrollment in Region 2 began in 2017.
Implementation date	N/A	January 1, 2015

FFS = fee for service; FIDA = Fully Integrated Duals Advantage; HCBS = home and community-based services; LTSS = long-term services and supports; MAP = Medicaid Advantage Plus; MFFS = managed fee for service; MLTC = Managed Long Term Care; MMP = Medicare-Medicaid Plan; N/A = not applicable; NHTD = Nursing Home Transition and Diversion; PACE = Program of All-inclusive Care for the Elderly; TCM = targeted case management.

[1] Information related to the demonstration in this table is from the Memorandum of Understanding between CMS and The State of New York (MOU, 2013). Information related to predemonstration services is derived from NYSDOH 2008, 2012a, 2012b, and 2012c. Information relating to predemonstration services document minimum standards defined in contracts or rules; actual practice may vary by plan.

[2] FIDA covers a range of HCBS waiver services otherwise only available to persons participating under New York's Nursing Home Transition and Diversion or Traumatic Brain Injury HCBS waivers. These additional services include community integration counseling; community transitional services; environmental modifications; home visits by medical personnel; independent living skills, training, and development services; and moving assistance.