

Memorandum of Understanding (MOU)

Between

The Centers for Medicare & Medicaid Services (CMS)

And

The State of New York

**Regarding a Federal-State Partnership to Test a Capitated Financial Alignment Model for
Medicare-Medicaid Enrollees**

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I. STATEMENT OF INITIATIVE

The Centers for Medicare & Medicaid Services (CMS) and the State of New York, Department of Health (State / NYSDOH) will establish a Federal-State partnership to implement the Medicare-Medicaid Alignment Initiative (Demonstration) to better serve individuals eligible for both Medicare and Medicaid (“Medicare-Medicaid Enrollees”). The Federal-State partnership will include a Three-way Contract with Fully Integrated Duals Advantage (FIDA) Plans, which are Medicare-Medicaid Plans (MMPs) that will provide integrated benefits to those Medicare-Medicaid Enrollees who reside in the targeted geographic area and who choose to participate in the Demonstration (Participants).

The Demonstration will begin no earlier than July 1, 2014 and continue until December 31, 2017, unless terminated pursuant to section III.L or continued pursuant to section III.K of this Memorandum of Understanding (MOU). The initiative is testing an innovative payment and service delivery model to alleviate the fragmentation and improve coordination of services for Medicare-Medicaid Enrollees, enhance quality of care, and reduce costs for both the State and the Federal government. (See Appendix 1 for definitions of terms and acronyms used in this MOU.)

The population that will be eligible to participate in the FIDA Demonstration is limited to "Full Benefit" Medicare-Medicaid Enrollees who are age 21 or older and meet the eligibility criteria outlined herein. Section III.C.1 below provides more information on individuals who are not eligible for the FIDA Demonstration as well as individuals who are eligible if they disenroll from an existing program.

Under this initiative, FIDA Plans will be required to provide for, either directly or through subcontracts, Medicare and Medicaid-covered services, as well as additional items and services, under a capitated model of financing. CMS, the State, and the FIDA Plans will ensure that Participants have access to an adequate network of medical and supportive services.

CMS and the State shall jointly select and monitor the FIDA Plans. As described in section III.A and detailed in Appendices 4 and 5, CMS will implement this initiative under Medicare Parts C and D and demonstration authority for Medicare and State Plan, demonstration, and waiver authority for Medicaid.

Key objectives of the initiative are to improve the Participant experience in accessing care, deliver person-centered care, promote independence in the community, improve quality, eliminate cost shifting between Medicare and Medicaid, and achieve cost savings for the State and Federal government through improvements in care and coordination. CMS and the State expect this model of integrated care and financing to, among other things, improve quality of care and reduce health disparities, meet both health and functional needs, and improve transitions

among care settings. Meeting Participant needs, including the ability to self-direct care, be involved in one's care, and live independently in the community, are central goals of this initiative. CMS and the State expect FIDA Plan and provider implementation of the independent living and recovery philosophy, wellness principles, and cultural competence to contribute to achieving these goals.

The initiative will test the effect of an integrated care and payment model on serving both community and institutional populations. In order to accomplish these objectives, comprehensive contract requirements will specify access, quality, network, financial solvency, and oversight standards. Contract management will focus on performance measurement and continuous quality improvement. Except as otherwise specified in this MOU, FIDA Plans will be required to comply with all applicable existing Medicare and Medicaid laws, rules, and regulations as well as program specific and evaluation requirements, except as modified by this MOU. This will be further specified in a Three-way Contract to be executed among the FIDA Plans, the State, and CMS.

As part of this initiative, CMS and the State will test a new Medicare and Medicaid payment methodology designed to support FIDA Plans in serving Medicare-Medicaid Enrollees in the Demonstration. This financing approach will minimize cost-shifting, align incentives between Medicare and Medicaid, and support the best possible health and functional outcomes for Participants.

CMS and the State will allow for certain flexibilities that will further the goal of providing a seamless experience for Medicare-Medicaid Enrollees, utilizing a simplified and unified set of rules. Flexibilities will be coupled with specific Participant safeguards and will be included in this MOU and the Three-way Contract. FIDA Plans will have full accountability for managing the capitated payment to best meet the needs of Participants. Person-Centered Service Plans will be developed by Participants, their caregivers, and Interdisciplinary Team, using a person-centered planning process. CMS and the State expect FIDA Plans to achieve savings through better integrated and coordinated care. Subject to CMS and State oversight, FIDA Plans will have significant flexibility to innovate around care delivery and to provide a range of community-based services as alternatives to or means to avoid high-cost services if indicated by the Participants' wishes, needs, and Person-Centered Service Plan.

Preceding the signing of this MOU, the State has undergone necessary planning activities consistent with the CMS standards and conditions for participation, as detailed through supporting documentation provided in Appendix 2. This includes a robust Participant- and stakeholder- engagement process.

II. SPECIFIC PURPOSE OF THIS MEMORANDUM OF UNDERSTANDING

This document details the principles under which CMS and New York plan to implement and operate the Demonstration. It also outlines the activities CMS and the State plan to conduct in preparation for implementation of the Demonstration. The parties will execute a Three-way Contract with FIDA Plans setting forth the terms and conditions of the Demonstration. Further detail about FIDA Plan responsibilities will be included in and appended to the Three-way Contract.

Following the signing of this MOU and prior to the implementation of the Demonstration, the State and CMS will ultimately enter into Three-way Contracts with selected plans, which will have also met the Medicare components of the Plan selection process, including submission of a successful Capitated Financial Alignment Application to CMS, and adherence to any annual contract renewal requirements and guidance updates, as specified in Appendix 7. These Three-way Contracts will include the additional operational and technical requirements pertinent to the implementation of the Demonstration.

III. DEMONSTRATION DESIGN / OPERATIONAL PLAN

A. DEMONSTRATION AUTHORITY

The following is a summary of the terms and conditions the parties intend to incorporate into the Three-way Contracts, as well as those activities the parties intend to conduct prior to entering into the Three-way Contracts and initiating the Demonstration. This section and any appendices referenced herein are not intended to create contractual or other legal rights between the parties.

- 1. Medicare Authority:** The Medicare elements of the initiative shall operate according to existing Medicare Parts C and D laws and regulations, as amended or modified, except to the extent these requirements are waived or modified as provided for in Appendix 4. As a term and condition of the initiative, FIDA Plans will be required to comply with Medicare Advantage and Medicare Prescription Drug Program requirements in Part C and Part D of Title XVIII of the Social Security Act, and 42 CFR Parts 422 and 423, and applicable sub-regulatory guidance, as amended from time to time, except to the extent specified in this MOU, including Appendix 4 and, for waivers of sub-regulatory guidance, the Three-way Contract.

2. **Medicaid Authority:** The Medicaid elements of the initiative shall operate according to existing Medicaid law and regulation and sub-regulatory guidance, including but not limited to all requirements of the Section 1115(a) demonstration and the 1915(c) waivers applicable to those FIDA Participants that may be enrolled in a 1915(c) waiver, as amended or modified, except to the extent waived as provided for in Appendix 5. As a term and condition of the initiative, FIDA Plans will be required to comply with Medicaid managed care requirements under Title XIX of the Social Security Act and 42 CFR Part 438 et. seq., and applicable sub-regulatory guidance, as amended or modified, except to the extent specified in this MOU, including Appendix 5 and, for waivers of sub-regulatory guidance, the Three-way Contract.

B. CONTRACTING PROCESS

1. **FIDA Plan Procurement Document:** FIDA Plans are required to meet the following requirements:
 - Achieve a final score of 70 or higher on the Model of Care section of the CMS Capitated Financial Alignment Demonstration application;
 - Submit an acceptable response to the State specific Model of Care element on “Use of Self-Directed Services” by May 7, 2013;
 - Meet all requirements to become a Managed Long Term Care (MLTC) plan and have received a Certificate of Authority to operate a MLTC plan in the State by May 14, 2013;
 - Participate in and acceptably complete a FIDA Demonstration readiness review that will be jointly conducted by CMS and the State; and
 - Enter into a Three-way Contract with CMS and the State.

As articulated in the January 9, 2013 guidance from CMS, FIDA Plans are also required to submit a Capitated Financial Alignment Demonstration application to CMS and meet all of the Medicare components of the FIDA Plan selection process.

All applicable Medicare Advantage/ Part D requirements and Medicaid managed care requirements will apply, unless otherwise waived, as specified by CMS and the State herein or in the Three-way Contract.

2. **FIDA Plan Selection:** The State and CMS will review applications for FIDA Plans, in accordance with the requirements outlined in Appendix 7, and will determine which applications satisfy all FIDA requirements and can be selected to serve as a FIDA Plan for the Demonstration.

- 3. Medicare Waiver Approval:** CMS approval of Medicare waivers is reflected in Appendix 4. CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of Title XVIII. CMS will promptly notify the State in writing of the determination and the reasons for the withdrawal, together with the effective date, and, subject to Section 1115A(d)(2) of the Social Security Act, afford the State a reasonable opportunity to request reconsideration of CMS' determination prior to the effective date. Termination and phase out would proceed as described in section III.L of this MOU. If a waiver or expenditure authority is withdrawn, Federal financial participation (FFP) is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including covered services and administrative costs of disenrolling Participants.
- 4. Medicaid Waiver Approval:** CMS approval of any new Medicaid waivers pursuant to Sections 1115, 1115A, or 1915 of the Social Security Act authority and processes is reflected in Appendix 5. CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities for the purpose of this Demonstration would no longer be in the public interest or promote the objectives of Title XIX. CMS will promptly notify the State in writing of the determination and the reasons for the withdrawal, together with the effective date, and, subject to Section 1115A(d)(2) of the Social Security Act, afford the State an opportunity to request a hearing to appeal CMS' determination prior to the effective date. Termination and phase out would proceed as described in section III.L of this MOU. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including covered services and administrative costs of disenrolling Participants.
- 5. Readiness Review:** CMS and the State, either directly or with contractor support, shall conduct a readiness review of each selected FIDA Plan. Following the signing of the Three-way Contract, CMS and the State must agree that an FIDA Plan has passed readiness prior to that FIDA Plan accepting any enrollment. CMS and the State will collaborate in the design and implementation of the readiness review process and requirements. This readiness review shall include an evaluation of the capacity of each potential FIDA Plan and its ability to meet all program requirements, including having an adequate network that addresses the full range of Participant needs, and the capacity to uphold all Participant safeguards and protections. CMS and the State will conduct a readiness review of the enrollment systems, staffing capacity, and processes and their ability to meet enrollment requirements. CMS and the State will also conduct a readiness review of the FIDA Administrative Hearing Unit staffing,

training, and data systems to confirm its ability to meet requirements for reviewing Medicare and Medicaid appeals.

- 6. Three-way Contract:** CMS and the State shall develop a single Three-way Contract and contract negotiation process that both parties agree is administratively effective and ensures coordinated and comprehensive program operation, enforcement, monitoring, and oversight.

C. ENROLLMENT

1. Eligible Populations:

The FIDA Demonstration will be available to individuals who meet all of the following criteria:

- Age 21 or older at the time of enrollment;
- Entitled to benefits under Medicare Part A and enrolled under Medicare Parts B and D, and receiving full Medicaid benefits; and
- Reside in a FIDA Demonstration county.

Individuals must also meet one of the three following criteria:

- Are Nursing Facility Clinically Eligible and receiving facility-based long-term services and supports (LTSS), which are subsequently referred to as individuals eligible for facility-based LTSS. These individuals are eligible contingent upon submission and approval of an amendment to the existing Partnership Plan demonstration under Social Security Act Section 1115(a);
- Are eligible for the Nursing Home Transition & Diversion (NHTD) 1915(c) waiver contingent upon submission and approval of an amendment to the existing Partnership Plan demonstration under Social Security Act Section 1115(a) and an amendment to the NHTD Section 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 shall be conducted in accordance with Special Term and Condition 28 of the Partnership Plan Demonstration under Social Security Act Section 1115(a).

The following populations are not eligible for the FIDA Demonstration:

- Residents of a New York State Office of Mental Health (OMH) facility;
- Those receiving services from the New York State Office for People with Developmental Disabilities (OPWDD) system;
- Individuals under the age of 21;
- Residents of psychiatric facilities;
- Individuals expected to be Medicaid eligible for less than six months;
- Individuals eligible for Medicaid benefits only with respect to tuberculosis-related services;
- Individuals with a "county of fiscal responsibility" code 99 in MMIS (individuals eligible only for breast and cervical cancer services);
- Individuals receiving hospice services (at time of enrollment);
- Individuals with a "county of fiscal responsibility" code of 97 (individuals residing in a State Office of Mental Health facility);
- Individuals with a "county of fiscal responsibility" code of 98 (individuals in an OPWDD facility or treatment center);
- Individuals eligible for the family planning expansion program;
- Individuals under 65 years of age (screened and require treatment) in the Centers for Disease Control and Prevention breast and/or cervical cancer early detection program and need treatment for breast or cervical cancer, and are not otherwise covered under creditable health coverage;
- Residents of intermediate care facilities for individuals with intellectual/developmental disabilities (ICF/IIDD);
- Individuals who could otherwise reside in an ICF/IIDD, but choose not to;
- Residents of alcohol/substance abuse long-term residential treatment programs;
- Individuals eligible for Emergency Medicaid;
- Individuals in the OPWDD Home- and Community-Based Services (OPWDD HCBS) section 1915(c) waiver program;
- Individuals in the following section 1915(c) waiver program: Traumatic Brain Injury (TBI);

- Residents of Assisted Living Programs; and
- Individuals in the Foster Family Care Demonstration.

The following individuals will be excluded from passive enrollment:

- Native Americans but they may opt in to the Demonstration at any time;
- Individuals who are eligible for the Medicaid buy-in for the working disabled and are nursing home certifiable;
- Aliessa Court Ordered Individuals;
- Individuals enrolled in PACE;
- Individuals enrolled in a Medicare Advantage Special Needs Plan for institutionalized individuals;
- Individuals enrolled in Health Homes;
- Individuals assigned to a CMS Accountable Care Organization (ACO) as of the point in time they would otherwise be included in the passive enrollment phase;
- Individuals participating in the CMS Independence at Home demonstration; and
- Individuals enrolled in Employer or Union Sponsored coverage for employees or retirees.

- 2. Enrollment and Disenrollment Processes:** NYSDOH will open enrollment to the community-based LTSS eligible population no earlier than July 1, 2014 and will open enrollment to the facility-based LTSS eligible population no earlier than October 1, 2014.
- a. Eligible community-based LTSS individuals will be informed no earlier than April 1, 2014 of the opportunity to opt into a FIDA Plan for coverage starting no earlier than July 1, 2014. Beginning no earlier than July 1 2014, eligible community-based LTSS individuals will be notified of the State's plan for passive enrollment, which would begin no earlier than September 1, 2014. Specifically, they will be notified of their right to select among contracted FIDA Plans no fewer than sixty (60) days prior to their assigned effective date of enrollment and will have the opportunity to opt out until the last day of the month prior to the effective date of enrollment. When an eligible individual has not made an active choice, his/her enrollment into a FIDA Plan will be conducted using a seamless, passive enrollment process that provides the opportunity for Participants to opt out or disenroll from the FIDA Plan at any time. Prior to the effective date of their enrollment, individuals who would be passively enrolled will have the opportunity to opt out and will receive sufficient notice and information with which to do so, as further detailed in Appendix 7.

- b. Eligible facility-based LTSS individuals will be informed no earlier than July 1, 2014 of the opportunity to opt into a FIDA Plan for coverage starting October 1, 2014. Beginning in October 2014, eligible facility-based LTSS individuals will be notified of the State's plan for passive enrollment, which would begin no earlier than January 1, 2015. Specifically, they will be notified of their right to select among contracted FIDA Plans no fewer than sixty (60) days prior to their assigned effective date of enrollment and will have the opportunity to opt out until the last day of the month prior to the effective date of enrollment. When an eligible individual has not made an active choice, his/her enrollment into an FIDA Plan will be conducted using a seamless, passive enrollment process that provides the opportunity for Participants to opt into or disenroll from the FIDA Plan at any time. Prior to the effective date of their enrollment, individuals who would be passively enrolled will have the opportunity to opt out and will receive sufficient notice and information with which to do so, as further detailed in Appendix 7.

Disenrollment from FIDA Plans and transfers between FIDA Plans shall be allowed on a month-to-month basis any time during the year; however, coverage for these individuals will continue through the end of the month. CMS and the State will monitor enrollments and disenrollments for both evaluation purposes and for compliance with applicable marketing and enrollment laws, regulations, and CMS policies, for the purposes of identifying any inappropriate or illegal marketing practices. As part of this analysis, CMS and the State will monitor any unusual shifts in enrollment by individuals identified for passive enrollment into a particular FIDA Plan to a Medicare Advantage plan operated by the same parent organization. If those shifts appear to be due to inappropriate or illegal marketing practices, CMS and the State may discontinue further passive enrollment into an FIDA Plan. Any illegal marketing practices will be referred to appropriate agencies for investigation.

CMS and the State will also monitor any enrollments or disenrollments based on beneficiary health needs. Any FIDA Plans under the same parent company as any Medicaid Managed Care plan for which the State has terminated or suspended enrollment and marketing activities related to the Medicaid Managed Care plan are not permitted to conduct enrollment or marketing activities related to the FIDA Plan until the Medicaid Managed Care plan deficiencies are resolved or may be disqualified from the Demonstration. Per January 9, 2013 guidance from CMS, any FIDA Plan under Medicare enrollment and/or marketing sanction will be ineligible to participate if it is under sanction as described in 42 CFR Part 422.750 and 42 CFR Part 423.750 at the time CMS and the State seek to execute the Three-way Contract. Also as articulated in the January 9, 2013 guidance from CMS, any FIDA Plan that is an outlier in the CMS past performance analysis for Contract Year (CY) 2014

and/or has a Consistently Low Performing Icon on the Medicare Plan Finder will be ineligible to receive passive enrollment until it is no longer considered by CMS to be a past performance outlier and/or no longer has a Consistently Low Performing Icon on Medicare Plan Finder.

As mutually agreed upon, and as discussed further in Appendix 7 and the Three-way Contract, CMS and the State will utilize an independent third party entity (Enrollment Broker) to facilitate all enrollment into the FIDA Plans. FIDA Plan enrollments, including enrollment from one FIDA Plan to a different FIDA Plan, and opt-outs shall become effective on the same day for both Medicare and Medicaid (the first day of the following month). For those who lose Medicaid eligibility during the month, coverage and Federal financial participation will continue through the end of that month. Persons receiving OPWDD services will not be passively enrolled into a FIDA Plan.

3. **Uniform Enrollment/Disenrollment Documents:** CMS and the State shall develop uniform enrollment and disenrollment forms and other documents.
4. **Outreach and Education:** FIDA Plan outreach and marketing materials will be subject to a single set of marketing rules defined by CMS and the State, as further detailed in Appendix 7.
5. **Single Identification Card:** CMS and the State shall work with FIDA Plans to develop a single identification card that can be used to access all care needs, as further detailed in Appendix 7.
6. **Interaction with other Demonstrations:** To best ensure continuity of Participant care and provider relationships, CMS will work with the State to address Participant or provider participation in other programs or initiatives, such as Accountable Care Organizations (ACOs). A Participant enrolled in the Demonstration will not be enrolled in, or have costs attributed to, an ACO or any other shared savings initiative for the purposes of calculating shared Medicare savings under those initiatives.

D. DELIVERY SYSTEMS AND BENEFITS

1. **FIDA Plan Service Capacity:** CMS and the State shall contract with FIDA Plans that demonstrate the capacity to provide, directly or by subcontracting with other qualified entities, the full continuum of Medicare and Medicaid covered items and services to Participants, in accordance with this MOU and the access and adequacy standards outlined in Appendix 7, CMS guidance, and the Three-way Contract. Medicare covered benefits shall

be provided in accordance with 42 CFR Part 422 and 42 CFR Part 423 et seq. Medicaid covered benefits shall be provided in accordance with the requirements in the approved Medicaid State Plan, including any applicable State Plan Amendments, 1115(a) and 1915(c) waivers, and in accordance with the requirements specified by the Three-way Contract and this MOU. In accordance with the Three-way Contract and this MOU, CMS and the State may choose to allow for greater flexibility in offering additional benefits that exceed those currently covered by either Medicare or Medicaid, as discussed in Appendix 7. CMS, the State, and FIDA Plans will ensure that Participants have access to an adequate network of medical, drug, behavioral health, and community-based or facility-based LTSS providers that are appropriate and capable of addressing the needs of this diverse population, as discussed in more detail in Appendix 7.

- 2. FIDA Plan Risk Arrangements:** CMS and the State shall require each FIDA Plan to provide a detailed description of its risk arrangements with providers under subcontract with the FIDA Plan. This description shall be made available to FIDA Plan Participants upon request. It will not be permissible for any incentive arrangements to include any payment or other inducement that serves to withhold, limit, or reduce necessary medical or non-medical items or services to Participants. By December 1, 2014, FIDA Plans will be required to develop a plan for a fully integrated payment system through which providers would no longer be paid on a traditional fee-for-service basis but would instead be paid on an alternative basis (e.g., pay for performance, bundled payment). After State approval and no earlier than January 2015, FIDA Plans will be required to implement the approved plans, which will remain in effect throughout the duration of the Demonstration.
- 3. FIDA Plan Financial Solvency Arrangements:** CMS and the State have established a standard for all FIDA Plans, as articulated in Appendix 7.

E. PARTICIPANT PROTECTIONS, PARTICIPATION, AND CUSTOMER SERVICE

- 1. Choice of Plans and Providers:** As referenced in section III.C.2, Participants will maintain their choice of plans and providers, and may exercise that choice at any time, effective the first calendar day of the following month. This includes the right to choose an alternative integrated package of Medicare and Medicaid services through 1) a different FIDA Plan, 2) a Medicaid Advantage Plus plan, or 3) a PACE plan. Likewise, Participants have the right to choose a combination of 1) a Medicare Advantage plan, Medicaid Fee-For-Service (FFS) and an MLTC plan or 2) Medicare Fee-For-Service (FFS), Medicaid FFS, an MLTC plan and a Prescription Drug Plan to receive the full array of Medicare and Medicaid services outside of an integrated product.

- 2. Continuity of Care:** CMS and the State will require FIDA Plans to ensure that individuals continue to have access to medically necessary items, services, prescription and non-prescription drugs, and medical, behavioral health, and community-based and facility-based LTSS providers for the transition period as specified in Appendix 7. In addition, during the transition FIDA Plans will advise Participants and providers if and when they have received care that would not otherwise be covered at an in-network level. On an ongoing basis, and as appropriate, FIDA Plans must also contact providers not already members of their network with information on becoming credentialed as in-network providers. Part D transition rules and rights will continue as provided for in current law and regulation.
- 3. Enrollment Assistance and Options Counseling:** As referenced in section III.C.2 and Appendix 7, the State will provide Medicaid-Medicare Participants with independent enrollment assistance and options counseling to help them make an enrollment decision that best meets their needs. The State will work with the independent Enrollment Broker to ensure ongoing outreach, education and support to individuals eligible for the FIDA Demonstration.
- 4. Participant Ombudsman:** The State is creating a new FIDA Participant Ombudsman. The FIDA Participant Ombudsman will be an independent entity under contract with the State to help Participants and their caregivers access the care Participants need through the FIDA Demonstration. CMS will support Participant Ombudsman training on the Demonstration and its objectives, and CMS, the Administration for Community Living (ACL), and the State will provide ongoing technical assistance to the Participant Ombudsman. The Participant Ombudsman will support individual advocacy and independent systematic oversight for the FIDA Demonstration, with a focus on compliance with principles of community integration, independent living, and person-centered care in the home and community-based care context. The Participant Ombudsman will be responsible for assisting Participants in accessing services through the FIDA Plans and for gathering and reporting data to the State and CMS (via the Contract Management Team) as described in Appendix 7 of this MOU.
- 5. Person-Centered, Appropriate Care:** CMS, the State, and FIDA Plans shall ensure that all medically necessary covered benefits are provided to Participants and are provided in a manner that is sensitive to the Participant's functional and cognitive needs, language and culture, allows for involvement of the Participant and caregivers, and is in a care setting appropriate to the Participant's needs, with a preference for the home and the community. CMS, the State, and FIDA Plans shall ensure that care is person-centered and can accommodate and support self-direction. FIDA Plans shall also ensure that medically necessary covered services are provided to Participants, in the least restrictive community setting, and in accordance with the Participant's wishes and Person-Centered Service Plan.

- 6. Americans with Disabilities Act (ADA) and Civil Rights Act of 1964:** CMS and NYSDOH expect FIDA Plan and provider compliance with the ADA and the Civil Rights Act of 1964 to promote the success of the FIDA Plan model and support better health outcomes for FIDA Plan Participants. In particular, CMS and NYSDOH recognize that successful person-centered care requires physical access to buildings, services, and equipment and flexibility in scheduling and processes. NYSDOH and CMS will require FIDA Plans to contract with providers that demonstrate their commitment and ability to accommodate the physical access and flexible scheduling needs of their Participants. NYSDOH and CMS also recognize that access includes effective communication. NYSDOH and CMS will require FIDA Plans and their providers to communicate with their Participants in a manner that accommodates their individual needs, including providing interpreters for those who are deaf or hard of hearing, accommodations for Participants with cognitive limitations, and interpreters for those who do not speak English. Also, CMS and NYSDOH recognize the importance of staff training on accessibility and accommodation, independent living and recovery models, cultural competency, and wellness philosophies. CMS and NYSDOH will continue to work with stakeholders, including Participants, to further develop learning opportunities, monitoring mechanisms, and quality measures to ensure that FIDA Plans and their providers comply with all requirements of the ADA. Finally, CMS and NYSDOH are committed to compliance with the ADA, including application of the Supreme Court's *Olmstead* decision, and agree to ensure, through ongoing surveys and readiness and implementation monitoring, that FIDA Plans provide for Participants' long-term services and supports in care settings appropriate to their needs.
- 7. Participant Communications:** CMS and the State agree that Participant and prospective Participant materials, in all forms, shall require prior approval by CMS and the State unless CMS and the State agree that one or the other entity is authorized to review and approve such documents on behalf of CMS and the State. CMS and the State will also work to develop pre-approved documents some of which may be required to be used and some of which may be used at the option of the plan but, in either instance, may be used, under certain circumstances, without additional CMS or State approval. All materials shall be integrated and include, but not be limited to: outreach and education materials; enrollment and disenrollment materials; benefit coverage information; and operational letters for enrollment, disenrollment, claims or service denials, complaints, internal appeals, external appeals, and provider terminations. Such uniform/integrated materials will be required to be accessible and understandable (i.e., no more than a 6th grade reading level) to the Participants that will be enrolled in the FIDA Plans, and their caregivers. This includes individuals with disabilities, including but not limited to, those with cognitive and functional limitations, and those with limited English proficiency, in accordance with current Federal guidelines for Medicare and Medicaid. Where Medicare and Medicaid standards differ, the standard

providing the greatest access to individuals with disabilities or limited English proficiency will apply.

- 8. Participant Participation on Governing and Advisory Boards:** As part of the Three-way Contract, CMS and the State shall require FIDA Plans to obtain Participant and community input on issues of program management and Participant care through a range of approaches. The FIDA Plan must establish at least one Participant Advisory Committee (PAC) that meets quarterly and is open to all Participants. PAC members and the Participant Ombudsman will be invited to participate in the State's ongoing stakeholder process. The FIDA Plan must also establish a process for that PAC to provide input to the FIDA Plan. The FIDA Plan must demonstrate that the Participant PAC composition reflects the diversity of the FIDA Demonstration Participant population, and participation of individuals with disabilities, including Participants, within the governance structure of the FIDA Plan. FIDA Plans will also be encouraged to include Participant representation on their boards of directors. The State will maintain additional processes for ongoing stakeholder participation and public comment, as discussed in Appendix 7.
- 9. FIDA Plan Customer Service Representatives:** CMS and the State shall require FIDA Plans to employ or contract with sufficient numbers of customer service representatives who shall answer all inquiries and respond to Participant complaints and concerns. In addition, CMS and the State shall themselves employ or contract with sufficient call center and customer service representatives to address Participant questions and concerns. In New York, this will be done through contracts with the Enrollment Broker and the Participant Ombudsman. FIDA Plans, CMS, and the State shall work to assure the language and cultural competency of customer service representatives to adequately meet the needs of the Participant population. All services must be culturally and linguistically appropriate and accessible. More detailed information about customer service requirements is included in Appendix 7.
- 10. Privacy and Security:** CMS and the State shall require all FIDA Plans to ensure privacy and security of Participant health records and provide for access by Participants to such records. These requirements shall be specified in the Three-way Contract.
- 11. Integrated Appeals and Grievances:** As referenced in section III.F and Appendix 7, Participants will have access to an integrated appeals and grievance process, the details of which are fully outlined in Appendix 7.
- 12. No Cost Sharing for Items and Services:** FIDA Plans will not charge Medicare Parts C or D premiums, nor assess any cost sharing for Medicare Parts A and B services. All Participants are currently eligible for \$0 Part D co-pays in accordance with Section 1860D-

14(a)(1)(D)(i) of the Social Security Act and 42 CFR Part 423.782(a)(ii). FIDA Plans will not assess any cost sharing for Medicare Part D or NYSDOH services.

- 13. No Balance Billing:** No Participant may be balance billed by any provider for any reason for covered services.

F. INTEGRATED APPEALS AND GRIEVANCES

- 1. FIDA Plan Grievances and Internal Appeals Processes:** CMS and the State agree to utilize a unified set of requirements for FIDA Plan grievances and internal appeals processes that incorporate relevant Medicare Advantage and Medicaid Managed Care requirements, to create a more Participant-friendly and easily navigable system. This is discussed in further detail in Appendix 7 and will be specified in the Three-way Contract. All FIDA Plan Grievances and Internal Appeals procedures shall be subject to the review and prior approval of CMS and the State. Part D appeals and grievances will continue to be managed under existing Part D rules, and Medicaid non-Part D pharmacy appeals will be managed by NYSDOH. CMS and NYSDOH will work to continue to coordinate grievances and appeals for all items and services.
- 2. External Appeals Processes:** CMS and the State agree to utilize the streamlined Appeals process outlined in Appendix 7. This will create a more Participant friendly and easily navigable system. Protocols and model notices will be developed to assure coordinated access to the appeals mechanism. This process and these protocols are discussed in further detail in Appendix 7. Part D appeals and grievances will continue to be managed under existing Part D rules. As indicated in Appendix 7, below, CMS and the State will continue to work together and to engage stakeholders to develop an increasingly integrated appeals process that is at least as protective of beneficiary rights and ensures that both Medicare's and Medicaid's coverage policies are accurately applied.

G. ADMINISTRATION AND REPORTING

- 1. FIDA Plan Contract Management:** As more fully discussed in Appendix 7, CMS and the State agree to designate representatives to serve on a CMS-State Contract Management Team which shall conduct FIDA Plan contract management activities related to ensuring access, quality, program integrity, program compliance, and financial solvency.

These activities shall include but not be limited to:

- Reviewing and analyzing Health Care Effectiveness Data and Information Set (HEDIS) data, Consumer Assessment of Health Care Providers and Systems (CAHPS) Survey data, Health Outcomes Survey (HOS) data, and enrollment and disenrollment reports.
- Reviewing any other performance metrics applied for quality withhold or other purposes.
- Reviewing reports of Participant complaints, reviewing compliance with applicable CMS and/or State Medicaid Agency standards, and initiating programmatic changes and/or changes in clinical protocols, as appropriate.
- Reviewing and analyzing reports on FIDA Plans' fiscal operations and financial solvency, conducting program integrity studies to monitor fraud, waste, and abuse as may be agreed upon by CMS and the State, and ensuring that FIDA Plans take corrective action, as appropriate.
- Reviewing and analyzing reports on FIDA Plans' network adequacy, including the FIDA Plans' ongoing efforts to replenish their networks and to continually enroll qualified providers.
- Reviewing any other applicable ratings and measures.
- Reviewing reports from the Participant Ombudsman.
- Reviewing direct stakeholder input on both FIDA Plan-specific and systematic performance.
- Responding to and investigating Participant complaints and quality of care issues.

2. FIDA Plan Monitoring: CMS and the State will establish procedures for FIDA Plan monitoring, as described in Appendix 7. Oversight shall generally be conducted in line with the following principles:

- The State and CMS will each retain, yet coordinate, current responsibilities toward the Participant such that Participants maintain access to their benefits across both programs.
- CMS and the State will leverage existing protocols (for example, in responding to Participant complaints, conducting account management, and analyzing enrollment data) to identify and solve Participant access problems in real-time.
- Oversight will be coordinated and subject to a unified set of requirements. Oversight will build on areas of expertise and capacity of the State and CMS, leveraging the CMS-State Contract Management Team, as described in Appendix 7.
- Oversight of the FIDA Plans and providers will be at least as rigorous as existing procedures for Medicare Advantage, Part D, the State's 1115(a) demonstration, and the State's Medicaid 1915(c) waiver and managed care programs.

- Part D oversight will continue to be a CMS responsibility, with appropriate coordination and communication with the State. Demonstration Plans will be included in all existing Medicare Advantage and Part D oversight activities, including (but not limited to) data-driven monitoring, secret shopping, contracted monitoring projects, plan ratings, formulary administration and transition review, and possibly audits.
 - Oversight will also include, but is not limited to, a focus on fraud, waste, and abuse.
 - CMS and the State will enhance existing mechanisms and develop new mechanisms to foster performance improvement and remove consistently poor performers from the program, leveraging existing CMS tools, such as the Complaints Tracking Module or the Part D Critical Incidence Reporting System, and existing State oversight and tracking tools. Standards for removal on the grounds of poor performance will be articulated in the Three-way Contract.
- 3. Consolidated Reporting Requirements:** CMS and the State shall define and specify in the Three-way Contract a Consolidated Reporting Process for FIDA Plans that ensures the provision of the necessary data on diagnosis, HEDIS and other quality measures, Participant satisfaction and evidence-based measures, and other information as may be beneficial in order to monitor each FIDA Plan’s performance. FIDA Plans will be required to meet the encounter reporting requirements that are established for the Demonstration.
- 4. Accept and Process Data:** CMS, or its designated agent(s), and the State shall accept and process uniform person-level Participant Data, for the purposes of program eligibility, payment, and evaluation. Submission of data to the State and CMS must comply with all relevant Federal and State laws and regulations, including, but not limited to, regulations related to HIPAA and to electronic file submissions of patient identifiable information. Such data will be shared by each party with the other party to the extent allowed by law and regulation. This is discussed in more detail in Appendix 7. CMS and the State shall streamline data submissions for FIDA Plans wherever practicable.

H. QUALITY MANAGEMENT

- 1. Quality Management and Monitoring:** As a model conducted under the authority of Section 1115A of the Social Security Act, the Demonstration and independent evaluation will include and assess quality measures designed to ensure Participants are receiving high quality care. In addition, CMS and the State shall conduct a joint comprehensive

performance and quality monitoring process that is at least as rigorous as the Medicare Advantage, Part D, the State's 1115(a) demonstration, and the State's Medicaid 1915(c) waiver and managed care programs' requirements. The reporting frequency and monitoring process will be specified in the Three-way Contract.

2. **External Quality Reviews:** CMS and the State shall coordinate the FIDA Plan external quality reviews conducted by the Quality Improvement Organization (QIO) and External Quality Review Organization (EQRO).
3. **Determination of Applicable Quality Standards:** CMS and the State shall determine applicable quality standards and monitor the FIDA Plans' compliance with those standards. These standards are articulated in Appendix 7 and the FIDA Plan Three-way Contract.

I. FINANCING AND PAYMENT

1. **Rates and Financial Terms:** For each calendar year of the Demonstration, before rates are offered to FIDA Plans, CMS shall share with the State the amount of the Medicare portion of the capitated rate, as well as collaborate to establish the data and documentation needed to assure that the Medicaid portion of the capitation rate is consistent with all applicable Federal requirements.
2. **Blended Medicare and Medicaid Payment:** CMS will make separate payments to the FIDA Plans for the Medicare A/B and Part D components of the rate. The State will make a payment to the FIDA Plans for the Medicaid component of the rate, as more fully detailed in Appendix 6.

J. EVALUATION

1. **Evaluation Data to be Collected:** CMS and the State have developed processes and protocols, as specified in Appendix 7 and as will be further detailed in the Three-way Contract, for collecting or ensuring the FIDA Plans or their contractors collect and report to CMS and the State the data needed for evaluation.
2. **Monitoring and Evaluation:** CMS will fund an external evaluation. The Demonstration will be evaluated in accordance with Section 1115A(b)(4) of the Social Security Act. As further detailed in Appendix 7, CMS or its contractor will measure, monitor, and evaluate the overall impact of the Demonstration including the impacts on program expenditures and service utilization changes, including monitoring any shifting of services between medical and non-medical services. The evaluation will include changes in person-level health

outcomes, experience of care, and costs by sub-population(s), and changes in patterns of primary, acute, and long-term care and support services use and expenditures, using principles of rapid-cycle evaluation and feedback. Key aspects and administrative features of the Demonstration, including but not limited to enrollment, marketing, and appeals and grievances will also be examined per qualitative and descriptive methods. The evaluation will consider potential interactions with other demonstrations and initiatives, and seek to isolate the effect of this Demonstration as appropriate. The State will collaborate with CMS or its designated agent during all monitoring and evaluation activities. The State and FIDA Plans will submit all data required for the monitoring and evaluation of this Demonstration, according to the data and timeframe requirements listed in the Three-way Contract with FIDA Plans. The State and FIDA Plans will submit both historical data relevant to the evaluation, including MSIS data from the years immediately preceding the Demonstration, and data generated during the Demonstration period.

K. EXTENSION OF AGREEMENT

The State may request an extension of this Demonstration, which will be evaluated consistent with terms specified under Section 1115A(b)(3) of the Social Security Act such as ensuring the Demonstration is improving the quality of care without increasing spending; reducing spending without reducing the quality of care; or improving the quality and care and reducing spending. Any extension request will be subject to CMS approval.

L. MODIFICATION OR TERMINATION OF MOU

The State agrees to provide notice to CMS of any State Plan or waiver changes that may have an impact on the Demonstration.

- 1. Limitations of MOU:** This MOU is not intended to, and does not, create any right or benefit, substantive, contractual or procedural, enforceable at law or in equity, by any party against the United States, its agencies, instrumentalities, or entities, its officers, employees, or agents, or any other person. Nothing in this MOU may be construed to obligate the parties to any current or future expenditure of resources. This MOU does not obligate any funds by either of the parties. Each party acknowledges that it is entering into this MOU under its own authority.
- 2. Modification:** Either CMS or the State may seek to modify or amend this MOU per a written request and subject to requirements set forth in Section 1115A(b)(3) of the Social Security Act such as ensuring the Demonstration is improving the quality of care without increasing spending; reducing spending without reducing the quality of care; or improving the quality

and care and reducing spending. Any material modification shall require written agreement by both parties and a stakeholder engagement process that is consistent with the process required under this Demonstration.

3. Termination: CMS and the State may terminate this MOU under the following circumstances:

- a. Termination without cause - Except as otherwise permitted below, a termination by CMS or the State for any reason will require that CMS or the State provides a minimum of 90 days advance notice to the other entity and 60 days advance notice is given to Participants and the general public.
- b. Termination pursuant to Social Security Act § 1115A(b)(3)(B).
- c. Termination for cause - Either CMS or the State may terminate this MOU upon 30 days' notice due to a material breach of a provision of this MOU.
- d. Termination due to a Change in Law - In addition, CMS or the State may terminate this MOU upon 30 days' notice due to a material change in law, or with less or no notice if required by law.

If the Demonstration is terminated as set forth above, CMS shall provide the State with the opportunity to propose and implement a phase-out plan that assures notice and access to ongoing coverage for Participants, and, to the extent that timing permits, adheres to the phase-out plan requirements detailed below. All Participants must be successfully enrolled in a Part D plan prior to termination of the Demonstration.

4. Demonstration phase-out. Termination at the end of the Demonstration must follow the following procedures:

- a. Notification – Unless CMS and the State agree to extend the Demonstration, the State must submit a draft phase-out plan to CMS no less than 5 months before the end date of this MOU. After CMS review, the State must publish on its website the draft phase-out plan for a 30-day public comment period. The State shall summarize comments received and share such summary with CMS. Once the phase-out plan is agreed to by CMS, the phase-out activities must begin within 14 days.
- b. Phase-out Plan Requirements - The State must include, at a minimum, in its phase-out plan the process by which it will notify affected Participants, the content of said notices (including information on how Participant appeal rights will continue to operate during the phase-out and any FIDA Plan transition), the process by which the

State will conduct administrative reviews of Medicaid eligibility for the affected Participants, and ensure ongoing coverage for eligible individuals, including plans for enrollment of all Participants in a Part D plan, as well as any community outreach activities. In addition, such plan must include any ongoing FIDA Plan and State responsibilities and close-out costs.

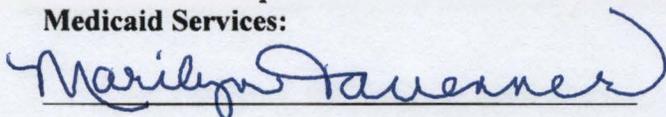
- c. Phase-out Procedures - The State must comply with all notice requirements found in 42 CFR Parts 431.206, 431.210, and 431.213. In addition, the State must assure all appeal and hearing rights afforded to Participants as outlined in 42 CFR Parts 431.220 and 431.221. If a Participant requests a hearing before the date of action, the State must maintain benefits as required in 42 CFR Part 431.230. If applicable, the State must conduct administrative renewals for all affected Participants in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in the October 1, 2010, State Health Official Letter #10-008.
- d. FFP - If the Demonstration is terminated by either party or any relevant waivers are suspended or withdrawn by CMS, FFP shall be limited to normal closeout costs associated with terminating the Demonstration including covered services and administrative costs of disenrolling Participants.

M. SIGNATURES

This MOU is effective on this day forward August 26, 2013 through the end of the Demonstration period December 31, 2017. Additionally, the terms of this MOU shall continue to apply to the State and FIDA Plans as they implement associated phase-out activities beyond the end of the Demonstration period.

In Witness Whereof, CMS and the State of New York have caused this Agreement to be executed by their respective authorized officers:

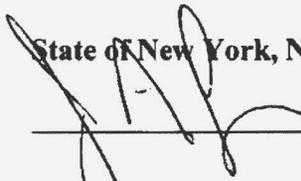
United States Department of Health and Human Services, Centers for Medicare & Medicaid Services:



Marilyn Tavenner
Administrator

August 26, 2013

State of New York, New York State Department of Health:



Jason Helgeson
Medicaid Director

August 26, 2013

Appendix 1: Definitions

Action – A denial or a limited authorization of a requested item or service or a reduction, suspension, or termination of a previously authorized item or service; denial, in whole or in part, of payment for an item or service; failure to provide items or services in a timely manner; determination that a requested service is not a covered benefit (does not include requests for items or services that are paid for fee-for-service outside the FIDA Plan); or failure to make a grievance determination within required timeframes.

Appeals – A Participant’s request for review of an Action taken by a FIDA Plan related to items or services.

Care Manager – An appropriately qualified professional who is the FIDA Plan’s designated accountable point of contact for each Participant’s care coordination and care management services. The care manager is the primary individual responsible for conducting, directing, or delegating care management duties, as needed. Responsibilities include: facilitating Interdisciplinary Team (IDT) activities and communication; facilitating assessment of needs; ensuring and assisting in developing, implementing and monitoring the Person-Centered Service Plan; and serving as the lead of the IDT.

Care Management – A collaborative process that assists each Participant in accessing services as identified in the Participant’s Person-Centered Service Plan. The care management process assesses, plans, implements, coordinates, monitors, and evaluates the options and services (both Medicare and Medicaid) required to meet a Participant’s needs across the continuum of care. It is characterized by advocacy, communication, and resource management to promote quality, cost effective, positive outcomes. The care management process also provides referral and coordination of other services in support of the Patient-Centered Service Plan. Care management services will assist Participants to obtain needed medical, behavioral health, prescription and non-prescription drugs, community-based or facility-based LTSS, social, educational, psychosocial, financial and other services in support of the Person-Centered Service Plan irrespective of whether the needed services are covered under the capitation payment of the Three-way Contract.

Center for Medicare and Medicaid Innovation (Innovation Center) – Established by Section 3021 of the Affordable Care Act, the Innovation Center was established to test innovative payment and service delivery models to reduce program expenditures under Medicare and Medicaid while preserving or enhancing the quality of care furnished to individuals under such titles.

CMS – The Centers for Medicare & Medicaid Services.

Community-based Long-Term Services and Supports (LTSS) – Community-based LTSS are a range of medical, habilitation, rehabilitation, home care, or social services a person needs over months or years in order to improve or maintain function or health which are provided in the person’s home or community-based setting such as assisted-living facilities. These home and community-based services are designed to meet an individual's needs as an alternative to long term nursing facility care and to enable a person to live as independently as possible.

Consolidated Laws of New York – Contains all New York statutes of a general and permanent nature passed by the New York State Legislature and signed by the governor.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) – Participant survey tool developed and maintained by the Agency for Healthcare Research and Quality to support and promote the assessment of consumers’ experiences with health care.

Contract – Also referred to as the Three-way Contract, this is the participation agreement that CMS and the State have with a FIDA Plan specifying the terms and conditions pursuant to which a participating FIDA Plan may participate in this Demonstration.

Contract Management Team – A group of CMS and NYSDOH representatives responsible for overseeing the Three-way Contract.

Covered Services - The set of services required to be offered by the FIDA Plans.

Cultural Competence – Understanding those values, beliefs, and needs that are associated with an individual’s age, gender identity, sexual orientation, and/or racial, ethnic, or religious backgrounds. Cultural Competence also includes a set of competencies which are required to ensure appropriate, culturally sensitive health care to persons with congenital or acquired disabilities.

Demonstration (also FIDA Demonstration) – Medicare-Medicaid Alignment Initiative to better serve individuals eligible for both Medicare and Medicaid (“Medicare-Medicaid Enrollees”).

Enrollment – The processes by which an individual who is eligible for the Demonstration is enrolled in a FIDA Plan.

Enrollment Broker – An independent entity contracted with the State, which is responsible for processing all enrollment and disenrollment transactions. The Enrollment Broker will educate Participants on all potential plan choices and ensure ongoing customer service related to

outreach, education, and support for individuals eligible for the Demonstration. The Enrollment Broker will incorporate the option of PACE enrollment into its scripts and protocols.

External Quality Review Organization (EQRO) – An independent entity that contracts with the State and evaluates the access, timeliness, and quality of care delivered by managed care organizations to their Medicaid enrollees.

External Grievance – A grievance with an adverse decision at the FIDA Plan level that is filed with CMS and/or the State.

Facility-based Long-Term Services and Supports (LTSS) – Facility-based LTSS are a range of medical, social, or rehabilitation services a person needs over months or years in order to improve or maintain function or health which are provided in a long term care facility such as a nursing home (not including Assisted Living Residences).

FIDA Administrative Hearing Unit – The unit within the New York State Office of Temporary and Disability Assistance which reviews adverse decisions made by FIDA Plans.

Fully-Integrated Duals Advantage Plan (FIDA Plan) – A managed care plan under contract with CMS and the State to provide the fully-integrated Medicare and Medicaid benefits under the FIDA Demonstration.

Grievance – In accordance with 42 CFR Part 438.400, grievance means an expression of dissatisfaction about any matter other than an “adverse action.” A grievance is filed and decided at the FIDA Plan level. (Possible subjects for grievances include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Participant’s rights).

Healthcare Effectiveness Data and Information Set (HEDIS) – Tool developed and maintained by the National Committee for Quality Assurance that is used by health plans to measure performance on dimensions of care and service in order to maintain and/or improve quality.

Health Outcomes Survey (HOS) – Participant survey used by the Centers for Medicare & Medicaid Services to gather valid and reliable health status data in Medicare managed care for use in quality improvement activities, plan accountability, public reporting, and improving health.

Integrated Administrative Hearing Officer – An Administrative Law Judge (ALJ) of the

FIDA Administrative Hearing Unit.

Interdisciplinary Team (IDT) – The team of individuals that will provide person-centered care coordination and care management to Participants. Each Participant will have an IDT. Each IDT will be comprised, first and foremost, of the Participant and/or his/her designee, the designated care manager, the primary care physician, behavioral health professional, the Participant’s home care aide, and other providers either as requested by the Participant or his/her designee or as recommended by the care manager or primary care physician and approved by the Participant and/or his/her designee. The IDT facilitates timely and thorough coordination between the FIDA Plan, the IDT, the primary care physician, and other providers. The IDT will make coverage determinations. Accordingly, the IDT’s decisions serve as service authorizations, may not be modified by the FIDA Plan outside of the IDT, and are appealable by the Participant, their providers, and their representatives. IDT service planning, coverage determinations, care coordination, and care management will be delineated in the Participant’s Person-Centered Service Plan and will be based on the assessed needs and articulated preferences of the Participant.

Managed Long Term Care Program – The NYSDOH long term managed care program that contracts with Medicaid Advantage Plus plans, Partially Capitated Managed Long Term Care (MLTC) plans, and Program of All-inclusive Care for the Elderly plans (PACE) to provide managed community-based or facility-based LTSS to eligible consumers.

Medicaid Advantage Plus Program – The partially-integrated Medicare and Medicaid managed care program for Medicare-Medicaid Enrollees who require community-based or facility-based LTSS.

Medicaid Managed Care Plan – A health maintenance organization (“HMO”) or prepaid health service plan (“PHSP”) certified under Article 44 of the State Public Health Law that is under contract with NYSDOH to provide most of the Medicaid services in New York.

Medically Necessary – Those items and services necessary to prevent, diagnose, correct, or cure conditions in the Participant that cause acute suffering, endanger life, result in illness or infirmity, interfere with such Participant’s capacity for normal activity, or threaten some significant handicap. Notwithstanding this definition, FIDA Plans will provide coverage in accordance with the more favorable of the current Medicare and NYSDOH coverage rules, as outlined in NYSDOH and Federal rules and coverage guidelines.

Medicare-Medicaid Coordination Office – Formally the Federal Coordinated Health Care Office, established by Section 2602 of the Affordable Care Act.

Medicare-Medicaid Enrollees – For the purposes of this Demonstration, individuals who are

entitled to benefits under Medicare Part A, enrolled under Medicare Parts B and D, and receiving full Medicaid benefits.

Medicaid – The program of medical assistance benefits under Title XIX of the Social Security Act and various demonstrations and waivers thereof.

Medicaid Waiver – Generally, a waiver of existing law authorized under Section 1115(a), 1115A, or 1915 of the Social Security Act. A Section 1115(a) waiver is also referred to as a demonstration.

Medicare – Title XVIII of the Social Security Act, the Federal health insurance program for people age 65 or older, people under 65 with certain disabilities, and people with End-Stage Renal Disease (ESRD) or Amyotrophic Lateral Sclerosis (ALS).

Medicare Waiver – Generally, a waiver of existing law authorized under Section 1115A of the Social Security Act.

New York State Department of Health (NYSDOH) – The agency responsible for administering the Medicaid program in the State of New York and the terms of this Demonstration.

New York State Office of Mental Health (OMH) – The agency responsible for operating psychiatric centers across the State and regulating, certifying, and overseeing more than 4,500 programs, which are operated by local governments and nonprofit agencies. These programs include various inpatient and outpatient programs, emergency, community support, residential and family care programs.

New York State Office of Temporary and Disability Assistance (OTDA) – The agency responsible for conducting State Medicaid fair hearings and supervising programs that provide assistance and support to eligible families and individuals.

New York State Office of the Medicaid Inspector General – The agency responsible for enhancing the integrity of the New York State Medicaid program by preventing and detecting fraudulent, abusive, and wasteful practices within the Medicaid program and recovering improperly expended Medicaid funds while promoting high quality patient care.

Nursing Facility Clinically Eligible – A standard of eligibility for care in a nursing facility, based on an individual's care needs and functional, cognitive, and medical status as determined upon completion of the NYSDOH Approved Assessment Tool.

Nursing Home Transition & Diversion 1915(c) Waiver – Social Security Act Section 1915(c) waiver that gives New York State the Medicaid authority to provide home and community-based services to certain medically needy individuals. These services enable these individuals to live at home or in the community with appropriate supports rather than in a nursing facility.

NYSDOH Approved Assessment Tool – Protocol used by the FIDA Plans to conduct a comprehensive assessment of each Participant’s medical, behavioral health, community-based or facility-based LTSS, and social needs completed by the FIDA Plan IDT. Assessment domains will include, but not be limited to, the following: social, functional, medical, behavioral, wellness and prevention domains, caregiver status and capabilities, as well as the Participants’ preferences, strengths, and goals. The State anticipates that the Uniform Assessment System – New York (UAS-NY) will be the basis for the tool used to conduct these assessments for Participants.

Other Supportive Services the IDT Determines Necessary – Additional supportive services or items determined by the Participant’s IDT to be necessary for the Participant. This is meant to cover items or services that are not traditionally included in the Medicare or Medicaid programs but that are necessary and appropriate for the Participant.

Opt Out – A process by which an eligible individual can choose not to participate in the Demonstration and receive his/her Medicare benefits through Fee for Service (FFS) Medicare and a standalone Part D plan; Program of All-inclusive Care for the Elderly (PACE); or Medicare Advantage.

OPWDD – New York State Office for People with Developmental Disabilities (OPWDD).

OPWDD Services – Services include: long term therapy services provided by Article 16 clinic treatment facilities, certified by OPWDD under 14 NYCRR, Part 679 or provided by Article 28 Diagnostic & Treatment Centers explicitly certified by NYSDOH as serving primarily persons with developmental disabilities; day treatment services provided in an intermediate care facility (ICF) or comparable facility and certified by OPWDD under 14 NYCRR, Part 690; Comprehensive Medicaid Case Management services; and home and community based waiver program services for people with developmental disabilities.

Payment Arrangement – An arrangement between a FIDA Plan and a nursing facility provider that describes reimbursement for services in absence of a contract.

Program of All-inclusive Care for the Elderly (PACE) – A capitated benefit for frail elderly authorized by the Balanced Budget Act of 1997 (BBA) that features a comprehensive service

delivery system and integrated Medicare and Medicaid financing. PACE is a three-way partnership between the Federal government, the State of New York, and the PACE organization.

Partially Capitated MLTC Plan – A managed care plan that provides Medicaid community-based or facility-based LTSS to both Medicare-Medicaid Enrollees and individuals who qualify only for Medicaid.

Participant – Individuals enrolled in a FIDA Plan, including the duration of any month in which their eligibility for the Demonstration ends.

Participant Communications – Materials designed to communicate to Participants FIDA Plan benefits, policies, processes and/or Participant rights.

Participant Ombudsman (PO) – An independent, conflict-free entity under contract with NYSDOH to provide Participants free assistance in accessing their care, understanding and exercising their rights and responsibilities, and appealing adverse decisions made by their FIDA Plan. The PO will be accessible to all Participants through telephonic and, where appropriate, in-person access. The PO will provide advice, information, referral and assistance in accessing benefits and assistance in navigating FIDA Plans, providers, or NYSDOH. The PO may participate in FIDA Plan Participant Advisory Committee activities.

Partnership Plan – Social Security Act Section 1115(a) waiver that provides New York State the Medicaid authority to enroll Medicaid enrollees and Medicare-Medicaid Enrollees in a Medicaid MLTC plan.

Passive Enrollment – An enrollment process through which an eligible individual is enrolled by the State (or its vendor) into a FIDA Plan, following a minimum 60-day advance notification that includes the opportunity to decline enrollment into a FIDA Plan or make another enrollment decision prior to the effective date.

Person-Centered Service Plan (or Plan of Care) – A written description in the care management record of Participant-specific health care goals to be achieved and the amount, duration, and scope of the covered services to be provided to a Participant in order to achieve such goals. The individual Person-Centered Service Plan is based on assessment of the Participant's health care needs and developed by the IDT in consultation with the Participant and his/her informal supports. The FIDA Plan will use the NYSDOH Approved Assessment Tool and include consideration of the current and unique psycho-social and medical needs and history of the Participant, as well as the Participant's functional level and support systems and clinical and non-clinical needs. The comprehensive assessment identifies services to be provided or arranged to meet the identified needs and includes goals, interventions, and expected outcomes.

Effectiveness of the Person-Centered Service Plan is monitored through reassessment and a determination as to whether the health care goals are being met. Non-covered services which interrelate with the covered services identified on the Person-Centered Service Plan and services of informal supports necessary to support the health care goals and effectiveness of the covered services should be clearly identified on the Person-Centered Service Plan or elsewhere in the care management record.

Privacy – Requirements established in the Health Insurance Portability and Accountability Act of 1996, and implementing regulations, Medicaid regulations, including 42 CFR Parts 431.300 through 431.307, as well as relevant New York privacy laws.

Quality Improvement Organization (QIO) – A statewide organization that contracts with CMS to evaluate the appropriateness, effectiveness, and quality of care provided to Medicare Participants.

Readiness Review – Prior to entering into a Three-way Contract with the State and CMS, each FIDA Plan selected to participate in the Demonstration will undergo a readiness review. The readiness review will evaluate each FIDA Plan's ability to comply with the Demonstration requirements, including but not limited to: the ability to quickly and accurately process claims and enrollment information, accept and transition new Participants, and provide adequate access to all Medicare- and Medicaid-covered medically necessary services. CMS and the State will use the results to inform their decision of whether the FIDA Plan is ready to participate in the Demonstration. At a minimum, each readiness review will include a desk review and potentially a site visit to the FIDA Plan's headquarters.

Representative – Representative means an individual appointed by a Participant or other party, or authorized under State or other applicable law, to act on behalf of a Participant or other party involved in the grievance or appeal. Unless otherwise stated in this subpart, the representative will have all the rights and responsibilities of a Participant or party in filing a grievance, and in obtaining an organization determination or in dealing with any of the levels of the appeals process.

Self-Direction (also Consumer Direction) – The ability for a Participant to direct his/her own services through the consumer-directed personal assistance option.

Solvency – Standards for requirements on cash flow, net worth, cash reserves, working capital requirements, insolvency protection and reserves established by the State and agreed to by CMS.

State – The State of New York.

Appendix 2: CMS Standards and Conditions and Supporting State Documentation

To participate in the Demonstration, each State submitted a proposal outlining its approach. The proposal had to meet a set of standards and conditions. The table below crosswalks the standards and conditions to their location in the New York proposal. Following the submission of the proposal, CMS asked the State a number of questions when there was ambiguity of whether or not the proposal met the Standards and Conditions. These questions and responses are included in the Addendum to the proposal, which will be posted on CMS' website with the proposal.

Standard/ Condition	Standard/Condition Description	Location in proposal (i.e., page #)
Integration of Benefits	Proposed model ensures the provision and coordination of all necessary Medicare and Medicaid-covered services, including primary, acute, prescription drug, behavioral health, and long-term supports and services.	pgs. 3, 11, 15-17; Appendix C; Addendum
Care Model	Proposed model offers mechanisms for person-centered coordination of care and includes robust and meaningful mechanisms for improving care transitions (e.g., between providers and/or settings) to maximize continuity of care.	pgs. 4-8, 10-12, 13-19
Stakeholder Engagement	State can provide evidence of ongoing and meaningful stakeholder engagement during the planning phase and has incorporated such input into its proposal. This will include dates/descriptions of all meetings, workgroups, advisory committees, focus groups, etc. that were held to discuss proposed model with relevant stakeholders. Stakeholders include, but are not limited to, Participants and their families, consumer organizations, Participant advocates, providers, and plans that are relevant to the proposed population and care model.	pgs. 19-20

	State has also established a plan for continuing to gather and incorporate stakeholder feedback on an ongoing basis for the duration of the Demonstration (i.e., implementation, monitoring, and evaluation), including a process for informing Participants (and their representatives) of the changes related to this initiative.	pgs. 24-25; Appendix L
Participant Protections	State has identified protections (e.g., enrollment and disenrollment procedures, grievances and appeals, process for ensuring access to and continuity of care, etc.) that would be established, modified, or maintained to ensure Participant health and safety and Participant access to high quality health and supportive services necessary to meet the Participant's needs. At a minimum, States will be required to:	
	· Establish meaningful Participant input processes which may include Participant participation in development and oversight of the model (e.g., participation on FIDA Plan governing boards and/or establishment of Participant advisory boards).	pgs. 24-25; Appendices D and L
	· Develop, in conjunction with CMS, uniform/integrated Participant materials that are accessible and understandable to the Participants who will be enrolled in the plans, including those with disabilities, speech, hearing and vision limitations, and limited English proficiency.	pgs. 22, 24-25; Appendix D; Addendum
	· Ensure privacy of Participant health records and provide for access by Participants to such records.	pgs. 14-15; Appendix D
	· Ensure that all medically necessary benefits are provided, allow for involvement of caregivers, and in an appropriate setting, including in the home and community.	pgs. 6-7, 14; Appendix D; Addendum
	· Ensure access to services in a manner that is sensitive to the Participant's language and culture, including customer service representatives that are able to answer Participant questions and respond to complaints/concerns appropriately.	pgs. 34-35; Appendices D and N

	<ul style="list-style-type: none"> · Ensure an adequate and appropriate provider network, as detailed below. 	pgs. 7, 13-14, Appendix E; Addendum
	<ul style="list-style-type: none"> · Ensure that Participants are meaningfully informed about their care options. 	pgs. 14, 22
	<ul style="list-style-type: none"> · Ensure access to grievance and appeals rights under Medicare and/or Medicaid. 	p. 21; Appendix D
	<ul style="list-style-type: none"> o <i>For Capitated Model</i>, this includes development of a unified set of requirements for FIDA Plan complaints and internal appeals processes. 	p. 21; Appendix D
State Capacity	State demonstrates that it has the necessary infrastructure/capacity to implement and oversee the proposed model or has demonstrated an ability to build the necessary infrastructure prior to implementation. This includes having necessary staffing resources, an appropriate use of contractors, and the capacity to receive and/or analyze Medicare data.	pgs. 29-30; Appendix F; Addendum
Network Adequacy	The Demonstration will ensure adequate access to medical and supportive service providers that are appropriate for and proficient in addressing the needs of the target population as further described in the MOU template.	pgs. 13, 21; Appendix E; Addendum
Measurement/Reporting	State demonstrates that it has the necessary systems in place for oversight and monitoring to ensure continuous quality improvement, including an ability to collect and track data on key metrics related to the model's quality and cost outcomes for the target population. These metrics may include, but are not limited to Participant experience, access to and quality of all covered services (including behavioral health and long term services and supports), utilization, etc., in order to promote Participants receiving high quality care and for purposes of the evaluation.	pgs. 29-30, Appendix F

Data	State has agreed to collect and/or provide data to CMS to inform program management, rate development and evaluation, including but not limited to:	
	· Participant level expenditure data and covered benefits for the most recently available three years, including available encounter data in capitated models;	pgs. 30-31
	· Description of any changes to the State Plan that would affect Participants during this three-year period (e.g., payment rate changes, benefit design, addition or expiration of waivers, etc.); and	pgs. 30-31
	· State supplemental payments to providers (e.g., DSH, UPL) during the three-year period.	pgs. 30-31
Enrollment	State has identified enrollment targets for proposed Demonstration based on analysis of current target population and has strategies for conducting Participant education and outreach. Enrollment is sufficient to support financial alignment model to ensure a stable, viable, and evaluable program.	pgs. 2-3, 9-10; Addendum
Expected Savings	Financial modeling demonstrates that the payment model being tested will achieve meaningful savings while maintaining or improving quality.	pgs. 26-28
Public Notice	State has provided sufficient public notice, including:	
	· At least a 30-day public notice process and comment period;	p. 20
	· At least two public meetings prior to submission of a proposal; and	pgs. 19-20
	· Appropriate tribal consultation for any new or changes to existing Medicaid waivers, State Plan Amendments, or Demonstration proposals.	Addendum

Implementation	State has demonstrated that it has the reasonable ability to meet the following planning and implementation milestones prior to implementation:	
	· Meaningful stakeholder engagement.	pgs., 19-20; Appendix L
	· Submission and approval of any necessary Medicaid waiver applications and/or State Plan Amendments.	Addendum
	· Receipt of any necessary State legislative or budget authority.	pgs. 31-32; Appendix L; Addendum
	· Joint procurement process (for capitated models only).	p. 7; Appendix L; Addendum
	· Participant outreach/notification of enrollment processes, etc.	pgs. 22, 24-25; Appendix L; Addendum

Appendix 3: Details of State Demonstration Area

The Demonstration Area consists of 8 counties: Bronx, Kings, Nassau, New York, Queens, Richmond, Suffolk, and Westchester.

Appendix 4: Medicare Authorities and Waivers

Medicare provisions described below are waived as necessary to allow for implementation of the Demonstration. Except as waived, Medicare Advantage and Medicare Part D provide the authority and statutory and regulatory framework for the operation of the Demonstration to the extent that Medicare (versus Medicaid) authority applies. Unless waived, all applicable statutory and regulatory requirements of the Medicare program for Medicare Advantage plans that provide qualified Medicare Part D prescription coverage, including Medicare Parts A, B, C, and D, shall apply to FIDA Plans and their sponsoring organizations for the Demonstration period beginning no earlier than July 1, 2014 through December 31, 2017, as well as for periods preceding and following the Demonstration period as applicable to allow for related implementation and close-out activities. Any conforming exceptions to existing Medicare manuals will be noted and reflected in an appendix to the Three-way Contracts.

Under the authority at Section 1115A of the Social Security Act, codified at 42 U.S.C. 1315a, the Center for Medicare and Medicaid Innovation is authorized to "...test payment and service delivery models ...to determine the effect of applying such models under [Medicare and Medicaid]." 42 U.S.C. 1315a(b)(1). One of the models listed in Section 1315a(b)(2)(B) that the Center for Medicare and Medicaid Innovation is permitted to test is "[a]llowing States to test and evaluate fully integrating care for dual eligible individuals in the State, including the management and oversight of all funds under the applicable titles with respect to such individuals." § 1315a(b)(2)(B)(x). Section 1315a(d)(1) provides that "The Secretary may waive such requirements of Titles XI and XVIII and of Sections 1902(a)(1), 1902(a)(13), and 1903(m)(2)(A)(iii) [of the Social Security Act] as may be necessary solely for purposes of carrying out this section with respect to testing models described in subsection (b)."

Pursuant to the foregoing authority, CMS will waive the following Statutory and Regulatory requirements:

- Section 1851(a), (c), (e), and (g) of the Social Security Act, and implementing regulations at 42 CFR Part 422, Subpart B, only insofar as such provisions are inconsistent with (1) limiting enrollment in FIDA Plans to Medicare-Medicaid Enrollees who are age 21 or older, including Medicare-Medicaid Enrollees who may have End-Stage Renal Disease, and excluding beneficiaries who may meet exclusion criteria specified in section III.C.1, and (2) the passive enrollment process provided for under the Demonstration.

- Sections 1853, 1854, 1857(e), 1860D-11, 1860D-13, 1860D-14, and 1860D-15 of the Social Security Act, and implementing regulations at 42 CFR Part 422, Subparts F and G, and Part 423, Subparts F and G, only insofar as such provisions are inconsistent with the methodology for determining payments, medical loss ratios and Participant liability under the Demonstration as specified in this MOU, including Appendix 6, which differs as to the method for calculating payment amounts and medical loss ratio requirements, and does not involve the submission of a bid or calculation and payment of premiums, rebates, or quality bonus payments, as provided under Sections 1853, 1854, 1860D-11, 1860D-13, 1860D-14, and 1860D-15, and implementing regulations.
- The provisions regarding deemed approval of marketing materials in Sections 1851(h) and 1860D-1(b)(1)(B)(vi) and implementing regulations at 42 CFR Part 422.2266 and 423.2266, with respect to marketing and Participant communications materials in categories of materials that CMS and the State have agreed will be jointly and prospectively reviewed, such that the materials are not deemed to be approved until both CMS and the State have agreed to approval.
- Sections 1852 (f) and (g) and 1860D-4 and implementing regulations at 42 CFR Part 422, Subpart M and 42 CFR Part 423, Subpart M, only insofar as such provisions are inconsistent with the grievance and appeals processes provided for under the Demonstration.
- Section 1860D-14(a)(1)(D) and implementing regulations at 42 CFR Part 423, Subpart P, only insofar as the implicit requirement that cost-sharing for non-institutionalized individuals eligible for the low-income subsidy be greater than \$0, to permit FIDA Plans to reduce Part D cost sharing below the levels required under Section 1860D-14(a)(1)(D)(ii) and (iii).

Appendix 5: Medicaid Authorities and Waivers

All requirements of the Medicaid program expressed in law and regulation, not expressly waived in this list, shall apply to the Demonstration beginning no earlier than July 1, 2014 through December 31, 2017, as well as for periods preceding and following the Demonstration period as applicable to allow for related implementation and close-out activities. Any conforming exceptions to existing sub-regulatory guidance will be noted and reflected in an appendix to the Three-way Contracts.

This Demonstration and the additional authority referenced below are contingent upon CMS-approved amendments to Social Security Act Section 1115(a) and the Nursing Facility Transition & Diversion (NHTD) 1915(c) waiver. Specifically, participation of individuals who are Nursing Facility Clinically Eligible and receiving facility-based LTSS is contingent upon submission and approval of an amendment to the existing Partnership Plan demonstration under Section 1115(a). Participation of individuals eligible for the NHTD 1915(c) waiver is contingent upon submission and approval of an amendment to the existing Partnership Plan demonstration under Section 1115(a) and an amendment to the NHTD Section 1915(c) waiver, which shall include a transition plan and phase-in and phase-out schedule and meeting other requirements in the Section 1915(c) technical guide. The State must meet all requirements of any approved Medicaid waiver authority as expressed in the terms of the Section 1115(a) demonstration and Section 1915(c) waiver, including, but not limited to, all financial, quality, reporting and monitoring requirements of the demonstration and waiver, and State financing contained in the State's waiver must be in compliance with Federal requirements. This MOU does not indicate or guarantee CMS approval of the amendments to the Section 1115(a) demonstration or Section 1915(c) waiver. If the necessary Section 1115(a) amendment is approved, Title XIX savings attributable to the FIDA Demonstration may not be added to budget neutrality savings under the State's existing Partnership Plan demonstration under Section 1115(a). When the State's Section 1115(a) demonstration is considered for renewal and at the end of the FIDA Demonstration under this MOU, CMS' Office of the Actuary will estimate and certify actual Title XIX savings to date under the FIDA Demonstration attributable to populations and services provided under Section 1115(a). This amount will be subtracted from the Section 1115(a) budget neutrality savings approved for the renewal.

Assessment of actuarial soundness under 42 CFR Part 438.6, in the context of this Demonstration, should consider both Medicare and Medicaid contributions and the opportunities for efficiencies unique to an integrated care program. CMS considers the Medicaid actuarial soundness requirements to be flexible enough to consider efficiencies and savings that may be associated with Medicare. Therefore, CMS does not believe that a waiver of Medicaid actuarial soundness principles is necessary in the context of this Demonstration.

1115A Medicaid Waivers

Under the authority of Section 1115A of the Social Security Act, the following waivers of State Plan requirements contained in Section 1902 and 1903 of the Social Security Act are granted to enable the State of New York (State) to carry out the Demonstration. These authorities shall be in addition to those in the State Plan, the existing 1115(a) Partnership Plan demonstration, and pending amendments to the 1115(a) Partnership Plan demonstration and NHTD 1915(c) waiver.

Provisions Related to Contract Requirements - Section 1903(m)(2)(A)(iii) (as implemented in 42 CFR Part 438.6)

- Waiver of contract requirement rules at 42 CFR Part 438.6(a), insofar as its provisions are inconsistent with methods used for prior approval under this Demonstration.

Appendix 6: Payments to FIDA Plans

CMS and the State will enter into a joint rate-setting process based on the following principles:

- (1) Medicare and Medicaid will each contribute to the total capitation payment consistent with projected baseline spending contributions;
- (2) Demonstration savings percentages assume that FIDA Plans are responsible for the full range of services covered under the Demonstration;
- (3) Aggregate savings percentages will be applied equally to the Medicaid and Medicare Parts A and B components; and
- (4) Both CMS and the State will contribute to the methodologies used to develop their respective components of the overall blended rate as summarized in Figure 6-2 and further described below.

Figure 6-1 below outlines how the Demonstration Years will be defined for the purposes of this effort. Rate updates will be effective on January 1st of each calendar year (CY), with changes to savings percentages and quality withholds applicable on a Demonstration Year basis.

Figure 6-1: Demonstration Year Dates

Demonstration Year	Calendar Dates
1	July 1, 2014 – December 31, 2015
2	January 1, 2016 – December 31, 2016
3	January 1, 2017 – December 31, 2017

Figure 6-2: Summary of Payment Methodology under the Demonstration

	Medicare Parts A and B	Medicare Part D	Medicaid
<p>Baseline costs for the purposes of setting payment rates</p> <p>Medicare baseline spending will be established prospectively on a calendar year basis for each Demonstration county.</p> <p>Medicaid baseline spending amounts shall be set up front and will be applied in future years unless more recent historical data are available and/or CMS' actuaries and the State determine that a substantial change is necessary to calculate accurate payment rates for the Demonstration.</p>	<p>Blend of Medicare Advantage payments and Medicare standardized fee-for-service projections weighted by where Medicare-Medicaid Enrollees who meet the criteria and who are expected to transition into the Demonstration are enrolled in the prior year. Baseline costs will be calculated as a per member per month (PMPM) standardized cost.</p>	<p>National average monthly bid amount (NAMBA) will be used as the baseline for the direct subsidy portion of Part D spending.</p> <p>Note that additional costs associated with low-income subsidy payments, reinsurance payments, and risk-sharing are included in the Part D baseline for purposes of tracking and evaluating Part D costs but not for purposes of setting payment rates. These amounts will be factored into plan payments as appropriate, but these amounts are subject to reconciliation consistent with Part D reconciliation rules.</p>	<p>Blend of Medicaid capitation rates and fee-for-service (FFS) claims that would apply to Medicare-Medicaid Enrollees in the Demonstration Area who choose to enroll in the Demonstration.</p> <p>Baseline costs will be calculated as a per member per month (PMPM) and trended using trends to the payment year developed by State actuaries with oversight from CMS.</p>
Responsible for producing data	CMS	CMS	NYSDOH
Savings percentages	<p>Savings percentages:</p> <p>Demonstration Year 1: 1%</p> <p>Demonstration Year 2: 1.5%</p> <p>Demonstration Year 3: 3%</p>	Not Applicable	<p>Savings percentages:</p> <p>Demonstration Year 1: 1%</p> <p>Demonstration Year 2: 1.5%</p> <p>Demonstration Year 3: 3%</p>

Risk adjustment	Medicare Advantage CMS-HCC Model	Part D RxHCC Model	Risk adjustment methodology similar to the model that is currently used to risk adjust Managed Long Term Care (MLTC) program capitation rates.
Quality withhold	Applied Demonstration Year 1: 1% Demonstration Year 2: 2% Demonstration Year 3: 3%	Not applied	Applied Demonstration Year 1: 1% Demonstration Year 2: 2% Demonstration Year 3: 3%
Other payment provisions	Medical Loss Ratio (MLR)	Existing Part D processes will apply	MLR

I. Baseline spending and payment rates for target population in the Demonstration Area

Baseline spending is an estimate of what would have been spent in the payment year had the Demonstration not existed. Medicare baselines will be expressed as standardized (1.0) rates and applicable on a calendar year basis. The baseline costs include three components: Medicaid, Medicare Parts A and B, and Medicare Part D. Payment rates will be determined by applying savings percentages (see section II) to the baseline spending amounts.

A. Medicaid:

- a. Prior to implementation of the Demonstration, and subject to CMS approval, the State and its actuaries will be responsible for establishing the baseline spending for Medicaid services that will be included under the Demonstration. The State and its actuaries will identify the Medicaid costs associated with beneficiaries in the target population for this Demonstration.
 - i. The largest component of the Medicaid baseline costs will be based on MLTC capitation payments that would be in effect in absence of the Demonstration.
 - ii. For any services excluded from the MLTC rate but included in this Demonstration, or for any population not otherwise eligible for MLTC, the Medicaid baseline will include an estimate of the cost of providing such

benefits on a FFS basis. The Medicaid baseline will not include the cost of services not provided in the Demonstration nor other supportive services the IDT determines necessary (as defined in Appendix 1). These baseline Medicaid costs will be based on FFS data for calendar years 2010 through 2013, as available at the point of rate-setting for each year. The baseline will take into account historic costs and will be trended forward to the Demonstration period.

- b. The State and its actuaries will provide the estimated baseline spending and underlying data for each year of the Demonstration to the CMS contracted actuary, who will validate the estimate of projected costs in Medicaid (absent the Demonstration).
- c. Medicaid payments for Participants in the Demonstration target population will be determined by applying the annual savings percentages (see section II) to the baseline spending amounts.

The State and its actuaries will continue to update the baseline cost for this Demonstration to reflect changes and/or adjustments that are made to the MLTC capitation payment and the Medicaid benefits provided on a FFS basis outside of the Demonstration. Such changes might consist of FFS rate modifications, changes to the MLTC, PACE, or Medicaid Advantage Plus capitations payments, or State policy changes related to the payment structure of the programs. Except for the regularly scheduled updates that will be effective on January 1 of each calendar year during the Demonstration period, updates to the Medicaid baseline will be allowable only when CMS determines the update would result in a substantial change to the baseline necessary to calculate accurate payment rates for the Demonstration.

B. Medicare Parts A and B:

- a. CMS will develop baseline spending (costs absent the Demonstration) and payment rates for Medicare Parts A and B services using estimates of what Medicare would have spent on behalf of the Participants absent the Demonstration.
- b. The Medicare baseline rate for Parts A and B services will be a blend of the Medicare Advantage projected payment rates and the Medicare FFS standardized county rates for each year, weighted by the proportion of the target population that will be transitioning from each program into the Demonstration. The Medicare Advantage baseline rates will include costs that would have occurred absent the Demonstration, such as quality bonus payments for applicable Medicare Advantage plans. The standardized county FFS rates reflect projected

FFS United States per capita costs (USPCC), adjusted to reflect the historic relationship between the county's FFS per capita costs and the USPCC. CMS calculates these geographic adjustments based on historical FFS claims data. The USPCC includes expenditures for Parts A and B services and the associated bad debt payment, disproportionate share hospital (DSH) payments, amounts related to direct and indirect medical education, and federal administrative costs but excludes hospice services, which are reimbursed through Medicare fee-for-service for Medicare Advantage beneficiaries receiving hospice services. CMS excludes operating indirect medical education and direct graduate medical education payments in establishing standardized county FFS rates, and therefore they will not be factored into the Medicare baseline, consistent with plan payments under Medicare Advantage.

CMS may adjust the Medicare FFS standardized county rates as necessary to calculate accurate payment rates for the Demonstration. To the extent that the published FFS county rates do not conform with current law in effect for Medicare during an applicable payment month, and to the extent that such nonconformance would have a significant fiscal impact on the Demonstration, CMS will update the baseline (and therefore the corresponding payment rate) to calculate and apply an accurate payment rate for such month. Such update may take place retroactively, as needed.

- c. Medicare Parts A and B payment rates will be determined by applying the annual savings percentages (see section II) to the baseline spending amounts.
- d. Both baseline rates and payment rates under the Demonstration for Medicare Parts A and B services will be calculated as PMPM standardized amounts for each county participating in the Demonstration for each year. Participant risk scores will be applied to the standardized payment rates at the time of payment.
- e. As needed, CMS may require the State to provide a data file for Participants who would be included in the Demonstration as of a certain date, in order for CMS to more accurately identify the target population to include/exclude in the baseline spending. CMS will specify the format and layout of the file.
- f. The Medicare portion of the baseline will be updated annually consistent with the annual FFS estimates and benchmarks released each year with the annual Medicare Advantage rate announcement.
- g. CMS annually applies a coding intensity adjustment factor to Medicare Advantage risk scores to account for differences in diagnosis coding patterns between the Medicare Advantage and the Original Fee-for-Service Medicare programs. The adjustment for 2014 is 4.91%. The majority of FIDA Plan Participants will come from Medicare FFS, and 2014 FIDA Plan risk scores for those individuals will be based solely on prior FFS claims, beyond the control of

the FIDA Plans themselves. In calendar years 2014 and 2015, CMS will apply an appropriate coding intensity adjustment based on the proportion of the target population with prior Medicare Advantage experience on a county-specific basis. After calendar year 2015, CMS will apply the prevailing Medicare Advantage coding intensity adjustment to all FIDA Plan Participants.

C. Medicare Part D:

- a. The Medicare Part D baseline for the Part D Direct Subsidy will be set at the Part D national average monthly bid amount (NAMBA) for the calendar year. CMS will estimate an average monthly prospective payment amount for the low income cost-sharing subsidy and Federal reinsurance amounts; these payments will be reconciled after the end of each payment year in the same manner as for all Part D sponsors.

The CY 2014 Part D NAMBA is \$75.88.

II. Aggregate Savings Percentages under the Demonstration

- A. Both parties agree that there is reasonable expectation for achieving savings while paying FIDA Plans capitated rates that are adequate to support access to and utilization of medical and non-medical benefits according to Participant needs.
- B. For the State of New York, the savings percentages will be:
 - a. Demonstration Year 1: 1%
 - b. Demonstration Year 2: 1.5%
 - c. Demonstration Year 3: 3%

Application of the savings percentages is described further in section III and section IX.D of Appendix 6. Rate updates will take place at least annually, as noted in section X of Appendix 6. However, savings percentages will be calculated and applied based on Demonstration Years.

III. Apply Savings Percentages to Medicare Parts A and B and Medicaid Components of the Integrated Rate

Savings percentages identified above will be applied to the Medicare Parts A and B and Medicaid components of the rate. Changes to the savings percentages under section II of Appendix 6 would only occur if and when CMS and the State jointly determine the change is necessary to calculate accurate payment rates for the Demonstration.

Savings percentages will not be applied to the Part D component of the rate. CMS will monitor

Part D costs closely on an ongoing basis. Any material change in Part D costs relative to the baseline may be factored into future year savings percentages.

IV. Rate Structure and Risk Adjustment Methodology for Medicaid Components of the Rates

The rating categories to be utilized for the Medicaid component of the FIDA Demonstration rates in the Demonstration are described below. The State and its actuaries will continue to explore the need for additional rate cells for the target population in the FIDA Demonstration. After execution of this MOU, the State may add additional rate cells, subject to CMS review and approval, on the condition that the addition of new rate cells is budget neutral.

The proposed rate cells are for Participants eligible for the Demonstration. The rate cells include the following:

- **Community Non-Nursing Home Certifiable**. This rate cell will be paid for individuals who require more than 120 days of community-based long term care support services, but who do not meet a Nursing Home Level of Care (NHLOC) standard as defined by the NYSDOH Approved Assessment Tool. One rate cell for nursing home non-certifiable individuals will be determined for the entire Demonstration Area.
- **Nursing Home Certifiable**. The nursing home certifiable rate cell will be paid for individuals who meet the standard of NHLOC as defined by the NYSDOH Approved Assessment Tool. Using the NYSDOH Approved Assessment Tool, the NHLOC designation will be made by FIDA Plans with NYSDOH review and audits of the assessments. NYSDOH and the New York State Office of the Medicaid Inspector General will jointly develop an audit plan, which is subject to CMS approval. One rate cell for nursing home certifiable individuals will be determined for the entire Demonstration Area.

Each rate cell defined above will be risk adjusted for each FIDA Plan by comparing each FIDA Plan's relative risk for each rate cell to the regional average risk. The regional average for the purpose of this Demonstration will be the entire Demonstration Area.

The risk adjustment methodology for each rate cell will be substantially similar to the model that the State currently uses to risk adjust MLTC capitation rates in the 1115(a) waiver program. Specifically, the State and its actuaries will utilize historical functional status and diagnostic data, in conjunction with MLTC plan encounter data and Medicaid FFS data to identify appropriate predictors of variation in Medicaid costs for FIDA Demonstration Participants and develop a risk adjustment model. As is the case in the MLTC program, the model will be subjected to a rigorous validation process before being finalized and a Summary of Methods document will be produced for stakeholder review and ultimately CMS approval. Please see the document entitled, *Medicaid MLTC Risk-Adjusted Rates, Summary of Methods for April 1, 2012 Implementation (Version 1.0)*, for more details about this methodology.

Functional status and diagnostic data reported through the NYSDOH Approved Assessment Tool for FIDA Demonstration Participants will then be used to develop risk scores for FIDA Demonstration Participants, and the scores for each FIDA Plan's Participants will be aggregated to determine raw plan scores. Prior to application, raw plan scores will be used to determine relative plan scores in order to ensure budget neutrality. Each FIDA Plan's final Medicaid capitation rate will be determined by multiplying their relative plan score by the base Medicaid capitation rate.

The State and CMS will explore options to mitigate the risk to FIDA Plans receiving a disproportionate share of high cost individuals. This may include the State mandating a minimum level of reinsurance that each FIDA Plan must maintain. This risk mitigation approach will be finalized no later than the approval of an amendment to the existing Partnership Plan demonstration under Social Security Act Section 1115(a).

V. Medicare Risk Adjustment Methodology

- A. The Medicare A/B Demonstration county rate will be risk adjusted based on the risk profile of each enrolled Participant. Except as specified in section I on the coding intensity adjustment factor, the existing CMS-HCC and CMS-HCC ESRD risk adjustment methodology will be utilized for the Demonstration.
- B. The Medicare Part D national average bid will be risk-adjusted in accordance with existing Part D RxHCC methodology.

VI. Quality withhold policy for Medicaid and Medicare A/B components of the integrated, risk-adjusted rate

- A. Under the Demonstration, both payers will withhold a percentage of their respective components of the capitation rate. The withheld amounts will be repaid subject to the FIDA Plans' performance consistent with established quality thresholds. These thresholds are based on a combination of certain core quality withhold measures (across all Demonstrations under Financial Alignment), as well as State-specified quality measures.
- B. Withhold Measures in Demonstration Year 1.
 - a. Figure 6-3 below identifies core withhold measures for Demonstration Year 1. Together, these measures will be utilized as the basis for the 1% withhold. Additional detail regarding the agreed upon measures will be included in the Three-way Contract.

Figure 6-3: FIDA Demonstration Quality Withhold Measures for Demonstration Year One¹

Domain	Measure	Source	CMS Core Withhold Measure	State Specified Measure
Encounter Data	Encounter data submitted accurately and completely in compliance with contract requirements.	CMS/State defined process measure	X	
Assessments	Percent of Participants with initial assessments completed within 30 days of enrollment.	CMS/State defined process measure	X	
Participant Governance Board	Establishment of Participant advisory board or inclusion of Participants on governance board consistent with contract requirements.	CMS/State defined process measure	X	
Customer Service	Percent of best possible score the plan earned on how easy it is to get information and help when needed. <ul style="list-style-type: none"> In the last 6 months, how often did your health plan's customer service give you the information or help you needed? In the last 6 months, how often did your health plan's customer service treat you with courtesy and respect? In the last 6 months, how often were the forms for your health plan easy to fill out? 	AHRQ/CAHPS	X	
Getting Appointments and Care Quickly	Percent of best possible score the plan earned on how quickly Participants get appointments and care <ul style="list-style-type: none"> In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed? In the last 6 months, not counting the times when you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed? 	AHRQ/CAHPS	X	

	<ul style="list-style-type: none"> In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time? 			
Documentation of Care Goals	Percent of Participants with documented discussions of care goals.	CMS/State defined process measure		X
Nursing Facility Diversion Measure	<p>Reporting of the number of nursing home certifiable Participants who lived outside the nursing facility (NF) during the current measurement year as a proportion of the nursing home certifiable Participants who lived outside the NF during the previous year.</p> <p><u>Nursing Facility Diversion Rate:</u> <u>Numerator:</u> Of those Participants in the denominator, those who did not reside in a NF for more than 100 continuous days during the current measurement year. <u>Denominator:</u> Nursing home certifiable Participants enrolled in a plan eleven out of twelve months during the current measurement year, did not reside for more than 100 continuous days in a NF during the previous year, and were eligible for Medicaid during the previous year for eleven out of twelve months. <u>Exclusions:</u> Any nursing home certifiable Participant with a gap in enrollment of Medicaid eligibility of 30 days during the current measurement year.</p>	State-defined measure		X

C. Withhold Measures in Demonstration Years 2 and 3.

- a. The quality withhold will increase to 2% in Demonstration Year 2 and 3% in Demonstration Year 3 and will be based on performance in the core Demonstration and State specified measures. Figure 6-4 below identifies the quality withhold measures for Demonstration Years 2 and 3.

Figure 6-4: Quality Withhold Measures for Demonstration Years 2 and 3

Domain	Measure	Source	CMS Core Withhold Measure	State Specified Measure
Plan All-cause Readmissions	Percent of Participants discharged from a hospital stay who were readmitted to a hospital within 30 days, either from the same condition as their recent hospital stay or for a different reason.	NCQA/HEDIS	X	
Annual Flu Vaccine	Percent of Participants who got a vaccine (flu shot) prior to flu season.	AHRQ/CAHPS	X	
Follow-up after Hospitalization for Mental Illness	Percentage of discharges for Participants 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner.	NCQA/HEDIS	X	
Screening for Clinical Depression and Follow-up Care	Percentage of Participants ages 18 years and older screened for clinical depression using a standardized tool and follow-up plan documented.	CMS	X	
Reducing the Risk of Falling	Percent of Participants with a problem falling, walking or balancing who discussed it with their doctor and got treatment for it during the year.	NCQA/HEDIS HOS	X	
Controlling Blood Pressure	Percentage of Participants 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year.	NCQA/HEDIS	X	X
Part D Medication Adherence for Oral Diabetes Medications	Percent of Participants with a prescription for oral diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.	CMS	X	X
Improvement/Stability in Activities of Daily Living (ADL)	Participants in the FIDA Demonstration who remained stable or improved in ADL functioning between previous assessment and most recent assessment.	State-defined measure		X

Functioning				
Nursing Facility Diversion Measure	<p>Reporting of the number of nursing home certifiable Participants who lived outside the nursing facility (NF) during the current measurement year as a proportion of the nursing home certifiable Participants who lived outside the NF during the previous year.</p> <p><u>Nursing Facility Diversion Rate:</u> <u>Numerator:</u> Of those Participants in the denominator, those who did not reside in a NF for more than 100 continuous days during the current measurement year. <u>Denominator:</u> Nursing home certifiable Participants enrolled in a plan eleven out of twelve months during the current measurement year, did not reside for more than 100 continuous days in a NF during the previous year, and were eligible for Medicaid during the previous year for eleven out of twelve months. <u>Exclusions:</u> Any nursing home certifiable Participants with a gap in enrollment of Medicaid eligibility of 30 days during the current measurement year.</p>	State-defined measure		X

(Note: Part D payments will not be subject to a quality withhold, however FIDA Plans will be required to adhere to quality reporting requirements that currently exist under Part D.)

- b. Additional detail regarding the agreed upon measures will be included in the Three-way Contract.

VII. Payments to FIDA Plans

- A. CMS will make separate monthly risk-adjusted payments to the FIDA Plans for the Medicare Parts A and B and Part D components of the rate, based on standardized Demonstration payment rates. Medicare Parts A and B payments and Part D payments will be subject to the same payment adjustments that are made for payments to Medicare Advantage and Part D plans, including but not limited to adjustments for user fees and Medicare Secondary Payer adjustment factors.
- B. The State will make monthly risk-adjusted payments to FIDA Plans for the Medicaid component of the rate subject to the rate structure specified in Section IV.
- C. The capitated payments from CMS and the State are intended to be adequate to support access to and utilization of covered services, according to Participant Person-Centered Service Plans. CMS and the State will jointly monitor access to care and overall financial viability of Plans accordingly.

VIII. Evaluate and Pay FIDA Plans Relative to Quality Withhold Requirements

- A. CMS and the State will evaluate FIDA Plan performance according to the specified metrics required in order to earn back the quality withhold for a given year. CMS and the State will share information as needed to determine whether quality requirements have been met and calculate final payments to each FIDA Plan from each payer.
- B. Whether or not each FIDA Plan has met the quality requirements in a given year will be made public, as will relevant quality results of FIDA Plans in Demonstration Years 2 and 3.

IX. Medical Loss Ratio, Reconciliation, and Rate Review

- A. **Medical Loss Ratio:** FIDA Plans will be required each year to meet a Target Medical Loss Ratio (TMLR) threshold of 85 percent, which regulates the minimum amount of revenue that must be used for expenses either directly related to medical claims or care coordination. If the Medical Loss Ratio (MLR) calculated annually is less than the TMLR, the FIDA Plan shall remit to CMS and the State an amount equal to the difference between the calculated MLR and the TMLR (expressed as a percentage) multiplied by the revenue received during the coverage year. Any collected remittances would be distributed proportionally back to the Medicare and Medicaid programs.

The Three-way Contract will include additional specifications on the MLR. To the maximum extent possible, the methodology for calculating the MLR will conform to prevailing Federal regulatory requirements applicable to other Medicare products offered

by organizations operating FIDA Plans.

- B. **Cost Reconciliation:** Cost reconciliation under Part D will continue as-is under the Demonstration. CMS will monitor Part D costs closely on an ongoing basis. Any material increase in Part D costs relative to the baseline may be factored into future Demonstration Year savings percentages.
- C. **Rate Review Process:** CMS and the State will review FIDA Plan financial reports, encounter data, and other information to assess the ongoing financial stability of the FIDA Plans and the appropriateness of capitation payments. At any point, the State may request that CMS staff review documentation from specific FIDA Plans to assess finance related issues.

If deemed necessary, CMS and the State will review available data, as applicable, including data on enrollment, utilization patterns, health plan expenditures, and risk adjustment to assess the appropriateness of capitation rates and identify any potential prospective adjustments that would ensure the rate-setting process is meeting the objective of Medicare and Medicaid jointly financing the costs and sharing in the savings.

- D. **Savings Percentage Adjustment:** In the event that at least one-third of FIDA Plans experience losses in Demonstration Year 1 exceeding 3% of revenue, based on at least 15 months of data from Demonstration Year 1, the savings percentage for Demonstration Year 3 will be reduced to 2.5%. CMS and the State will make such a determination at least four months prior to the start of Demonstration Year 3.

X. Payments in Future Years and Mid-Year Rate Adjustments.

- A. Rates will be updated using a similar process for each year. Rate updates will take place on January 1st of each calendar year for the Medicare components of the rates, with changes to the savings percentages applicable on a Demonstration Year basis. Rate updates for the Medicaid component of the rate will take place at least once each New York State fiscal year and may be more often as necessary to match adjustments made to the Medicaid capitation rates in the contracts that support the 1115(a) waiver program (i.e., MLTC program) that would apply for beneficiaries in the target population who do not enroll in this Demonstration. Changes to the baseline (and therefore to the corresponding payment rate) outside of the annual Medicare Advantage rate announcement would occur only if and when CMS and the State jointly determine the change is necessary to calculate accurate payment rates for the Demonstration. For changes solely affecting the Medicare program baseline, CMS will consult with the State prior to making any adjustment, but State concurrence will not be required. Changes may be based on the following factors: shifts in enrollment assumptions; major changes or discrepancies in Federal law and/or State law or policy, compared to assumptions about Federal law and/or State law or policy used in the development of baseline estimates; and

changes in coding intensity. CMS and/or the State will make changes to baseline estimates within 30 days of identification of the need for such changes, and changes will be applied, if necessary on a retrospective basis, to effectuate accurate payment rates for each month. CMS will also evaluate Participant risk scores in Demonstration Year 1 and Demonstration Year 2 to determine whether coding intensity in either or both years supports the need for adjustments to the baseline in Demonstration Year 3. CMS will incorporate such adjustments into the Demonstration Year 3 baseline, as appropriate, on a prospective basis to prevent overpayments due to increased coding intensity.

- B. Changes to the savings percentages would occur if and when CMS and the State jointly determine that changes in Part D spending have resulted in materially higher or lower savings that need to be recouped through higher or lower savings percentages applied to the Medicare A/B baselines.

Appendix 7: Demonstration Parameters

The purpose of this appendix is to describe the parameters that will govern this Federal-State partnership; the parameters are based upon those articulated by CMS in its January 25, 2012 and March 29, 2012 Health Plan Management System (HPMS) guidance. CMS and the State have further negotiated these parameters, as specified below.

The following sections explain details of the Demonstration design, implementation, and evaluation. Where waivers from current Medicare and Medicaid requirements are required, such waivers are indicated. Further detail on each of these areas will be provided in the Three-way Contract.

I. State of New York Delegation of Administrative Authority and Operational Roles and Responsibilities

The New York State Department of Health (NYSDOH) is the single State agency for the Medicaid program. The Medicaid Director oversees Medicaid operations and will be involved with implementing and monitoring the Demonstration. The Demonstration will benefit from the direct and ongoing involvement of staff and programs across NYSDOH as described below.

Overall responsibility for development of the FIDA Demonstration model and implementation plan rests with the Medicaid Director, who will chair the FIDA Management Team. The Director of the Division of Long Term Care will serve as the main point of contact for the Medicare-Medicaid Coordination Office at CMS regarding CMS/New York collaboration in the FIDA Demonstration.

II. Plan or Qualified Entity Selection

To be approved as a FIDA Plan, MLTC program and Mainstream Managed Care plans will have to apply and will have to meet all FIDA Demonstration requirements as outlined in section III.B.1 of this MOU. FIDA Plans will also be required to meet the Medicare components of the plan selection process, including submission of a successful Capitated Financial Alignment Application to CMS, and adherence to any annual contract renewal requirements and guidance updates, as specified in Appendix 7.

These selections are contingent on the selected entities passing a CMS and State sponsored readiness review. Upon final selection, the State and CMS will ultimately enter into a Three-way Contract with selected plans.

Any future revisions to the final selections will be presented to CMS for prior approval.

III. State Level Enrollment Operations Requirements

- a. Eligible Populations/Excluded Populations - As described in the body of the MOU.
- b. Enrollment and Disenrollment Processes – Enrollment and disenrollment transactions will be processed through the State Enrollment Broker. NYSDOH (or its vendor) will submit enrollment transactions to the CMS Medicare Advantage Prescription Drug (MARx) enrollment system directly or via a third party CMS designates to receive such transactions. CMS will also submit a file to NYSDOH identifying individuals who have elected to disenroll from a FIDA Plan, opt out of passive enrollment, or have enrolled in or have selected another type of available Medicare coverage that is not a FIDA Plan. NYSDOH will share enrollment, disenrollment, and opt-out transactions with contracted FIDA Plans.
- c. Uniform Enrollment / Transfer and Opt-Out Letter and Forms – Before they are finalized, letters and forms will be made available to stakeholders for comment by both CMS and the State.
- d. Enrollment Effective Date(s) – All enrollment effective dates are prospective. Participant-elected enrollment is effective the first day of the month following the initial receipt of a Participant’s request to enroll or, for passive enrollment, the first day of the month following the month in which the Participant is eligible, as applicable for an individual Participant. Passive enrollment is effective no sooner than 60 days after Participant notification of the right to select a FIDA Plan and the option to decline passive enrollment.
 - i. FIDA Plans will be required to accept opt-in enrollments of eligible community-based LTSS individuals no earlier than 60-days prior to the initial effective date of no earlier than July 1, 2014, and begin providing coverage for opt-in enrolled individuals no earlier than July 1, 2014. FIDA Plans will be required to accept opt-in enrollments of eligible facility-based LTSS individuals no earlier than 60-days prior to the initial effective date

of no earlier than October 1, 2014, and begin providing coverage for opt-in enrolled individuals no earlier than October 1, 2014.

- ii. No earlier than September 1, 2014, the State will begin to conduct passive enrollment for those eligible community-based LTSS Participants who have not submitted a request to enroll in a FIDA Plan. No earlier than January 1, 2015, the State will begin to conduct passive enrollment for those eligible facility-based LTSS Participants who have not submitted a request to enroll in a FIDA Plan. The effective dates above are subject to FIDA Plans meeting CMS and State requirements including Plans' capacity to accept new Participants.
- iii. Phase-in Process. Once passive enrollment is initiated for each group per III.d.ii above, it will be phased in over a minimum of a four-month period and will take into account how close Participants are to their Medicaid redetermination date.
- iv. The State will provide notice of the option to select a FIDA Plan at least 60 days prior to the effective date of passive enrollment and will accept opt-out requests through the last day of the month prior to the effective date of enrollment. This notice will explain the Participant's options, including the option to decline passive enrollment into the FIDA Plan, or once enrolled, to request prospective disenrollment from the Demonstration.
- v. Thirty days prior to the passive enrollment effective date, a second notice will be provided to Participants who have not responded to the initial notice. The notice will include the name of the FIDA Plan into which the Participant would be enrolled unless he/she selects another plan or opts out of the Demonstration. New York will proceed with passive enrollment into the identified FIDA Plan for Participants who do not make a different choice as described in the "Phase-in Process" above.
- vi. Requests to disenroll from a FIDA Plan or enroll in a different FIDA Plan will be accepted at any point after a Participant's initial enrollment occurs and is effective on the first of the month following receipt of the request. Any time an individual requests to opt out of passive enrollment or disenroll from the Demonstration, the State will send a letter confirming the opt-out and providing information on the benefits available to the Participant once they have opted out or disenrolled.

vii. Participants who otherwise are included in Medicare reassignment effective January 1 of a given year or from their current Medicare Prescription Drug Plan (PDP) or terminating Medicare Advantage Prescription Drug Plan (MA-PD) to another PDP, will not be eligible for passive enrollment that same year. For example:

1. Those reassigned to a new PDP effective January 1, 2014, will be eligible for passive enrollment into an FIDA Plan effective no earlier than January 1, 2015.

The State and CMS must agree in writing to any changes to the enrollment effective dates. CMS will provide identifying information to the State about eligible Participants no later than 120 days prior to the date of the first passive enrollment period.

- e. No enrollments will be accepted within 6 months (or less) of the end of the Demonstration.
- f. Notification of FIDA Plan selection and enrollment options will be provided by the State to each Participant no fewer than 60 calendar days prior to the effective date of the proposed enrollment.
- g. Passive enrollment activity will be coordinated with CMS activities such as Annual Reassignment and daily auto-assignment for individuals with the Part D Low Income Subsidy.
- h. The State will develop an “intelligent assignment” algorithm for passive enrollment (e.g. that prioritizes continuity of providers and/or services). The algorithm will consider Participants’ previous Medicaid managed care enrollment and historic provider utilization.
- i. The State will provide customer service, including mechanisms to counsel Participants notified of passive enrollment and to receive and communicate Participant choice of opt out to CMS via transactions to CMS’ MARx system. Participants will also be provided a notice upon the completion of the opt-out process. Medicare resources, including 1-800-Medicare, will remain a resource for Medicare Participants; calls related to FIDA Demonstration enrollment will be referred to the State’s Enrollment Broker for customer service and enrollment support.
- j. CMS and the State will jointly approve all Demonstration notices to ensure complete and accurate information is provided in concert with other Medicare

communications, such as the Medicare & You handbook. CMS may also send a jointly-approved notice to individuals, and will coordinate such notice with any State notice(s).

- k. State and CMS systems will be reconciled on a timely basis to resolve discrepancies between systems.
- l. PACE information – The State will ensure that the PACE program is known to eligible individuals as an integrated program alternative to FIDA Demonstration enrollment. The option of PACE enrollment will be specified in outreach and educational materials about the FIDA Demonstration and will be incorporated into the Enrollment Broker scripts and protocols.

IV. State Level Delivery System Requirements

- a. State Requirements for Care Management – Care management services will be available to all FIDA Demonstration Participants through the FIDA Plan’s Interdisciplinary Team (IDT) model as outlined in the Three-way Contract. FIDA Plans will be expected to address the following components as part of their comprehensive care management programs. Through the readiness review process, CMS and the State will review FIDA Plan capacity to deliver care management services using the IDT model. The CMS and the State will also review and approve the FIDA Plans’ care management programs to ensure that all required components are adequately addressed.
 - i. Comprehensive Assessment: Each Participant shall receive, and be an active participant in, a timely comprehensive assessment of medical, behavioral health, community-based or facility-based LTSS, and social needs completed by the FIDA Plan care management team. The FIDA Plan will use the NYSDOH Approved Assessment Tool to conduct the assessment. Assessment domains will include, but not be limited to, the following: social, functional, medical, behavioral, wellness and prevention domains, caregiver status and capabilities, as well as the Participants’ preferences, strengths, and goals. Relevant and comprehensive data sources, including the Participant, providers, and family/caregivers, shall be used by the FIDA Plans. Results of the assessment will be used to confirm the appropriate acuity or risk stratification level for the Participant and as the basis for developing the integrated, Person-Centered Service Plan. The Participant will continue to receive any community-based or facility-based LTSS in their existing

care plan during this time period and all transition requirements for services, as outlined in the MOU, will be adhered to.

Upon enrollment in the FIDA Demonstration, all Participants will receive a comprehensive assessment to be completed no later than 30 days from the individual's enrollment date. This initial assessment and all reassessments must be performed by a Registered Nurse (RN) in the individual's home, which includes an assisted living facility or nursing facility, using the NYSDOH Approved Assessment Tool. The FIDA Plan must ensure that a comprehensive reassessment and a Person-Centered Service Plan update are performed:

- As warranted by the Participant's condition but at least every six (6) months after the initial assessment completion date;
- When there is a change in the Participant's health status or needs;
- As requested by the Participant, his/her caregiver, or his/her provider; and
- Upon any of the following trigger events:
 - A hospital admission;
 - Transition between care settings;
 - Change in functional status;
 - Loss of a caregiver;
 - Change in diagnosis;
 - As requested by a member of the IDT who observes a change that requires further investigation.

When a Participant is determined to be likely to require a level of care provided in a nursing facility (i.e., nursing home level of care), the care manager and/or IDT informs the Participant and/or his/her representative of any feasible alternatives and offers the choice of either institutional or home and community-based services.

- ii. Person-Centered Service Plan: Within 30 days of the FIDA Plan conducting a comprehensive assessment, a Person-Centered Service

Plan will be completed for each Participant by the Participant's IDT. For comprehensive reassessments, a Person-Centered Service Plan will be reviewed and revised, if necessary, within 30 days of the reassessment. Person-centered service planning and care management will include establishing and implementing a written Person-Centered Service Plan for the Participant and assisting each Participant to access services called for under the Person-Centered Service Plan. Person-centered service planning includes consideration of the current and unique psychosocial and medical needs and history of the Participant, as well as the Participant's functional level, behavioral health needs, language, culture, and support systems. Care management includes referral to and coordination of other necessary medical, social, behavioral health, prescription drugs and non-prescription drugs, community-based or facility-based LTSS, educational, financial and other services of the Person-Centered Service Plan that support the Participant's psychosocial needs irrespective of whether such services are covered by the FIDA Plan. Person centered service planning is completed by the Participant and his/her IDT. Person-Centered Service Plans will contain measureable goals, interventions, and expected outcomes with completion timeframes. The FIDA Plans will monitor the Person-Centered Service Plans and any gaps in care will be addressed in an integrated manner by the Interdisciplinary Team, including any necessary revisions to the Person-Centered Service Plan.

- iii. Interdisciplinary Team (IDT): For each Participant, FIDA Plans will support an IDT, led by a care manager to ensure the integration of the Participant's medical, behavioral health, substance use, community-based or facility-based LTSS, and social needs. Each IDT will be comprised, first and foremost, of the Participant and/or his/her designee, the designated care manager, the primary care physician, behavioral health professional, the Participant's home care aide, and other providers either as requested by the Participant or his/her designee or as recommended by the care manager or primary care physician and approved by the Participant and/or his/her designee. FIDA Plans will ensure that staff team members who are completing care management activities are operating within their professional scope of practice, appropriate for responding to and meeting the Participant's needs, and complying with the State's licensure/credentialing requirements. The

IDT will be person-centered, built on the Participant's specific preferences and needs, and deliver services with transparency, individualization, accessibility, respect, linguistic and cultural competence, and dignity. The IDT's decisions serve as service authorizations, may not be modified by the FIDA Plan outside of the IDT, and are appealable by the Participant, their providers, and their representatives. IDT service planning, coverage determinations, care coordination, and care management will be delineated in the Participant's Person-Centered Service Plan and will be based on the assessed needs and articulated preferences of the Participant.

1. FIDA Plan members of the team must agree to participate in approved training on the person-centered planning processes, cultural competence, disability, accessibility and accommodations, independent living and recovery, and wellness principles, along with other required training, as specified by the State. This will include *ADA/Olmstead* requirements. FIDA Plans will offer similar trainings to additional members of the team: primary care providers and specialists, as appropriate.
2. Each Participant will be assigned a care manager with the appropriate experience and qualifications based on a Participant's individual needs (e.g., communication, cognitive, or other barriers). A Participant has the right to choose and change her/his care manager. The FIDA Plan must ensure that the care manager's caseload is reasonable to provide appropriate care coordination and care management.
3. Care managers must have knowledge of physical health, aging and loss, appropriate support services in the community, frequently used medications and their potential negative side-effects, depression, challenging behaviors, Alzheimer's disease and other disease-related dementias, behavioral health, and issues related to accessing and using durable medical equipment as appropriate.
4. FIDA Plan will ensure that when Participants are in a hospital awaiting discharge because of a need for community-based services or nursing facility placement authorization, IDTs shall provide any prior authorizations within 48 hours of readiness for

discharge to ensure that delays do not adversely affect discharge planning at the hospital or service delivery.

- iv. **Self-Direction:** All Participants have the opportunity to direct their own services through the consumer-directed personal assistance option. FIDA Plans must inform Participants of this option at initial and annual care planning meetings. The Three-way Contract will outline the FIDA Plan requirements for offering and providing self-direction.
- b. **Network Adequacy** – The following standards will be used for access to all covered services except in the event that Medicaid or Medicare standards are more stringent and would provide for increased access to providers:

Each FIDA Plan's provider network must meet the existing applicable Medicare and Medicaid provider network requirements. State Medicaid standards shall be utilized for community-based and facility-based LTSS, as described below, or for other services for which Medicaid is exclusive, and Medicare standards shall be utilized for pharmacy benefits and for other services for which Medicare is primary, unless applicable Medicaid standards for such services are more favorable to the Participant (i.e., offer broader coverage). Home health and durable medical equipment requirements, as well as any other services for which Medicaid and Medicare may overlap, shall be subject to the more favorable to the Participant (i.e., offer broader coverage) of the applicable Medicare and Medicaid standards. Additionally, the provider network must meet all of the following requirements:

- i. In no instance may any FIDA Plan's network have less than two of any provider type necessary to provide covered services.
- ii. All providers' physical sites must be accessible to all Participants as must all providers that deliver services in the Participants' locations.
- iii. FIDA Plans must establish and implement mechanisms to ensure that providers comply with the timely access requirements outlined herein, must monitor providers regularly to determine compliance, and must take corrective action if there is a failure to comply.
- iv. The following minimum appointment availability standards apply to physical health and behavioral health services:

- 1) For emergency care: immediately upon presentation at a service delivery site.
 - 2) For urgent care: within twenty-four (24) hours of request.
 - 3) Non-urgent “sick” visit: within forty-eight (48) to seventy-two (72) hours of request, as clinically indicated.
 - 4) Routine non-urgent, preventive appointments: within four (4) weeks of request.
 - 5) Specialist referrals (not urgent): within two (2) to four (4) weeks of request.
 - 6) Pursuant to an emergency or hospital discharge, mental health or substance abuse follow-up visits with a provider (as included in the Benefit Package): within five (5) days of request, or as clinically indicated.
 - 7) Non-urgent mental health or substance abuse visits with a provider (as included in the Benefit Package): within two (2) weeks of request.
 - 8) Provider visits to make health, mental health, and substance abuse assessments for the purpose of making recommendations regarding a recipient’s ability to perform work within ten (10) days of request.
 - 9) Mental Health Clinics must provide a clinical assessment within five (5) days for individuals in the following designated groups:
 - Individuals in receipt of services from a mobile crisis team not currently receiving treatment
 - Individuals in domestic violence shelter programs not currently receiving treatment
 - Homeless individuals and those present at homeless shelters who are not currently receiving treatment
 - Individuals aging out of foster care who are not currently receiving treatment
 - Individuals who have been discharged from an inpatient psychiatric facility within the last 60 days who are not currently receiving treatment
 - Individuals referred by rape crisis centers
 - Individuals referred by the court system.
- v. The following minimum access standards apply to community-based LTSS services:
- For “new to service” Participants (meaning those not already receiving community-based LTSS), community-based LTSS service delivery must begin (along with completion of the comprehensive assessment) within 30 days of enrollment.
 - For Participants that are not new to service but transitioning from a MLTC plan, from another plan, or from Medicare and/or Medicaid FFS, FIDA Plans must provide continuity of community-based LTSS immediately upon enrollment, as further outlined in the continuity of

care/transition policy. Plans must contract with an adequate number of community-based LTSS providers to allow Participants a choice of at least two providers of each covered community-based LTSS service within a 15-mile radius or 30 minutes from the Participant's ZIP code of residence.

- vi. The following minimum access standards apply to facility-based LTSS services:
 - For “new to service” Participants (meaning those not already receiving facility-based LTSS), FIDA Plans must enter into contracts or make payment arrangements with nursing facilities as meets the minimum access standards outlined for all providers in this section and as further outlined in the Three-Way Contract.
 - For Participants that are not new to services but are transitioning from a MLTC plan, from another FIDA Plan, or from Medicare and/or Medicaid FFS, FIDA Plans must either enter into contracts or make other payment arrangements with all nursing facilities in the Demonstration Area to ensure Participants' residency and access to services are not interrupted.
 - Participation of nursing facilities in the Demonstration may be subject to quality standards as articulated in the Three-way Contract.
- vii. Each FIDA Plan must provide access to medical services and coverage to Participants through their primary care providers (PCPs) and obstetrics/gynecologists (OB/GYNs,) on a twenty-four (24) hour a day, seven (7) day a week basis. The FIDA Plan must instruct Participants on what to do to obtain services after business hours and on weekends.
- viii. Participants with appointments shall not routinely be made to wait longer than one hour.
- ix. FIDA Plans must have a network that is geographically accessible to Participants in the Demonstration Area.
- x. FIDA Plans are required to coordinate Participant transportation, including for non-emergent and non-medical needs.
- xi. Participants must be assured choice of all providers, including the care coordinator and others that will participate in their interdisciplinary teams.
- xii. Paid family caregiving will be permitted in accordance with 18 NYCRR § 505.14 (h)(2).

- xiii. FIDA Plans are directly responsible for the provision of all other medically necessary covered items and services (regardless of whether access is through a subcontracted behavioral health organization that is accountable to the FIDA Plan and for which the FIDA Plan is accountable to NYSDOH, or directly through the FIDA Plan's network of providers).
- xiv. The State has developed transition requirements that specify continuation of existing providers for covered services outlined in section V, below.
- xv. The State also requires that FIDA Plans provide and arrange for timely access to all medically necessary services covered by Medicare and/or Medicaid. Both the State and CMS will monitor access to services through survey, utilization, and complaints data to assess the need for FIDA Plan network corrective actions. The State will conduct reviews of FIDA Plans to ensure compliance with network adequacy standards.
- xvi. The State and CMS will finalize the standards, based on administrative data and stakeholder input. CMS and the State will monitor access to care and the prevalence of needs indicated through Participant assessments, and, based on those findings, may require that FIDA Plans initiate further network expansion over the course of the Demonstration.

Networks will be subject to confirmation through readiness reviews and on an ongoing basis.

For any covered services for which Medicare requires a more rigorous network adequacy standard than Medicaid (including time, distance, and/or minimum number of providers or facilities), the FIDA Plan must meet the Medicare requirements. To the extent that Medicaid requires a more rigorous network adequacy standard than Medicare (including time, distance, and/or minimum number of providers or facilities), the FIDA Plan must meet the Medicaid requirements.

Medicare network standards account for the type of service area (rural, urban, suburban, etc.), travel time, and minimum number of the type of providers, as well as distance in certain circumstances. The State and CMS may grant exceptions to these general rules to account for patterns of care for Participants, but will not do so in a manner that will dilute access to care for Participants. Networks will be subject to confirmation through readiness reviews.

- c. Solvency – FIDA Plans will be required to meet solvency requirements:

- i. Consistent with section 1903(m) of the Social Security Act and regulations found at 42 CFR Parts 43, 422.400, and 438.116 as well as applicable State law and regulations; and
 - ii. FIDA Plans will be required to meet solvency requirements established in the Three-way Contract.
 - d. Credentialing and Practitioner Licensure Authorities and Application within Approved Contracts –
 - i. FIDA Plans must adhere to managed care standards at 42 CFR Part 438.214 and 42 CFR Part 422.204, and must be accredited by NCQA and follow NCQA procedural requirements for standards for credentialing and re-credentialing.
 - ii. In order to minimize administrative burdens on FIDA Plans and providers, FIDA Plans must employ a single, uniform provider credentialing application that will be developed with the input from FIDA Plans and stakeholders, meet Medicare contracting requirements, and be approved by NYSDOH.
 - e. Participant Ombudsman –

NYSDOH will make available to Participants an independent, conflict-free entity to serve as FIDA Participant Ombudsman (PO). The requirements for the PO will be outlined in the contract between NYSDOH and the PO. The requirements for FIDA Plan cooperation with the PO will be outlined in the Three-way Contract. The FIDA Participant Ombudsman will provide Participants free assistance in accessing their care, understanding and exercising their rights and responsibilities, and in appealing adverse decisions made by their FIDA Plan. The PO will be accessible to all Participants through telephonic and, where appropriate, in-person access. The PO will provide advice, information, referral and assistance in accessing benefits and in navigating the FIDA Plans, providers, or NYSDOH. The PO may participate in FIDA Plan Participant Advisory Committee activities. The PO will be required to regularly report on its work to the State and CMS. FIDA Plans will be required to notify Participants of the availability of the PO in enrollment materials, annual notice of grievance and appeal procedures, and all written notices of denial, reduction or termination of a service.

V. Benefits

- a. Medical Necessity Determinations – Medically necessary items and services are defined in Appendix 1 as: those items and services necessary to prevent, diagnose, correct, or cure conditions in the Participant that cause acute suffering, endanger life, result in illness or infirmity, interfere with such Participant’s capacity for normal activity, or threaten some significant handicap. Notwithstanding this definition, FIDA Plans will provide coverage in accordance with the more favorable of the current Medicare and NYSDOH coverage rules, as outlined in NYSDOH and Federal rules and coverage guidelines.
 - i. All care must be provided in accordance and compliance with the ADA, as specified by the *Olmstead* decision.
 - ii. The FIDA Plan must cover all services as outlined in the Three-way Contract and in the State and Federal guidance and may not impose more stringent coverage rules unless explicitly authorized by the Three-way Contract.
- b. As a term and condition of this Demonstration, the FIDA Plans will be required to provide all medically necessary Medicare Parts A, B, and D and Medicaid State Plan and 1115(a) and 1915(c) waiver items and services. Table 7-A provides a list of Planned FIDA Demonstration Services. The Planned FIDA Demonstration Services will be updated to address any changes due to State Plan Amendments, 1115(a) demonstration amendments, and 1915(c) waiver amendments.

Table 7-A: Planned FIDA Demonstration Services

Abdominal Aortic Aneurism Screening	Mammograms
Adult Day Health Care	Medicaid Pharmacy Benefits as Allowed by State Law
AIDS Adult Day Health Care	Medical Nutrition Therapy
Ambulance	Medical Social Services
Ambulatory Surgical Centers	Medicare Cost Sharing
Assertive Community Treatment (ACT)	Medicare Part D Prescription Drug Benefit as Approved by CMS
Assisted Living Program	Medication Therapy Management
Assistive Technology (State Plan and Supplemental to State Plan)	Mobile Mental Health Treatment
Bone Mass Measurement	Moving Assistance
Cardiac Rehabilitation Services	Non-Emergency Transportation
Cardiovascular Disease Screening	Nursing Facility (Medicaid)
Case Management for Seriously and Persistently Mentally Ill	Nutrition (includes Nutritional Counseling and Educational Services)
Cervical and Vaginal Cancer Screening	NYS Office of Mental Health Licensed Community Residences

Chemotherapy	Other Supportive Services the Interdisciplinary Team Determines Necessary
Chiropractic	Outpatient Drugs
Clinical Research Studies	Outpatient Hospital Services
Colorectal Screening	Outpatient Mental Health
Community Integration Counseling	Outpatient Rehabilitation (OT, PT, Speech)
Community Transitional Services	Outpatient Substance Abuse
Comprehensive Medicaid Case Management	Outpatient Surgery
Consumer Directed Personal Assistance Services	Palliative Care
Continuing Day Treatment	Pap Smear and Pelvic Exams
Day Treatment	Partial Hospitalization (Medicaid)
Defibrillator (implantable automatic)	Partial Hospitalization (Medicare)
Depression Screening	PCP Office Visits
Dental	Peer-Delivered Services
Diabetes Monitoring (Self-Management Training)	Peer Mentoring
Diabetes Screening	Personal Care Services
Diabetes Supplies	Personal Emergency Response Services (PERS)
Diagnostic Testing	Personalized Recovery Oriented Services (PROS)
Durable Medical Equipment (DME)	Podiatry
Emergency Care	Positive Behavioral Interventions and Support
Environmental Modifications	Private Duty Nursing
Family-Based Treatment	Prostate Cancer Screening
Health/Wellness Education	Prosthetics
Hearing Services	Pulmonary Rehabilitation Services
HIV COBRA Case Management	Routine Physical Exam 1/year
HIV Screening	Respite
Home and Community Support Services	Service Coordination
Home Delivered and Congregate Meals	Skilled Nursing Facility
Home Health	Smoking and Tobacco Cessation
Home Maintenance Services	Social and Environmental Supports
Home Visits by Medical Personnel	Social Day Care
Immunizations	Social Day Care Transportation
Independent Living Skills and Training	Specialist Office Visits
Inpatient Hospital Care (including Substance Abuse and Rehabilitation Services)	Structured Day Program
Inpatient Services during a Non-covered Inpatient Stay	Substance Abuse Program
Inpatient Mental Healthcare	Telehealth
Inpatient Mental Health over 190-day Lifetime Limit	Urgent Care
Intensive Psychiatric Rehabilitation Treatment Programs	Vision Care Services
Kidney Disease Services	Wellness Counseling

- c. Other Supportive Services the IDT Determines Necessary – FIDA Plans will have discretion to use the capitated payment to enhance covered services with additional non-covered services or items where so doing would address a Participant’s needs, as specified in the Participant’s Person-Centered Service Plan

and determined by the IDT. The FIDA Plans will have the flexibility to cover items or services that are not traditionally included as Medicare or Medicaid covered services but that are necessary and appropriate for the Participant.

- d. Services to be accessed through Medicare or Medicaid Fee-For-Services (FFS) – The following services will be available to FIDA Demonstration Participants through the Medicare or Medicaid Fee-for-Service program and not through the FIDA Plan:
 - (1) Medicare and Medicaid Hospice services;
 - (2) Out of Network Family Planning services;
 - (3) Directly Observed Therapy for Tuberculosis; and
 - (4) Methadone Maintenance Treatment.

A Participant's FIDA Plan IDT will be responsible for coordinating, arranging, and ensuring receipt of these services by the Participant from the Medicare and Medicaid FFS programs when called for in a Participant's Person-Centered Service Plan.

- e. Election of Medicare Hospice Benefit – As in Medicare Advantage, if, after enrollment, a Participant elects to receive the Medicare hospice benefit, the Participant will remain in the FIDA Plan, but will obtain the hospice service through the Medicare FFS benefit and the FIDA Plan would no longer receive Medicare Part C payment for that Participant. Medicare hospice services and all other Original Medicare services would be paid for under Medicare fee-for-service. FIDA Plans and providers of hospice services would be required to coordinate these services with the rest of the Participant's care, including with Medicaid and Part D benefits and any additional benefits offered under the FIDA Plans. FIDA Plans would continue to receive Medicare Part D payment, for which no changes would occur. Medicaid services and payments for hospice Participants must comply with the FIDA Demonstration Medicaid 1915(b) waiver requirements.
- f. Continuity of Care
 - i. For all items and services other than nursing facility services, FIDA Plans must allow Participants to maintain current providers and service levels, including prescription drugs, at the time of enrollment for at least 90 days after enrollment, or until a care assessment has been completed by the FIDA Plan, whichever is later. Any reduction, suspension, denial or termination of previously authorized services shall trigger the required

notice under 42 CFR Part 438.404 which clearly articulates the Participant's right to file an appeal (either expedited, if warranted, or standard), the right to have authorized service continue pending the appeal, and the right to a fair hearing if the plan renders an adverse determination (either in whole or in part) on the appeal. For nursing facility services, FIDA Plans must allow Participants to maintain current providers for the duration of the Demonstration.

- ii. FIDA Plans are required to provide or arrange for all medically necessary services provided by the Three-way Contract, whether by sub-contract or by single-case agreement in order to meet the needs of the Participant.
- g. Out-of-Network Reimbursement Rules – FIDA Plans must cover emergent or urgent services provided by out-of-network providers and may authorize other out-of-network services to promote access to continuity of care. For services that are part of the traditional Medicare benefit package, FIDA Plans will be required to pay non-contracting providers at least the lesser of the providers' charges or the Medicare FFS rate, regardless of the setting and type of care for authorized out-of-network services. For nursing facility services that are part of the traditional Medicaid benefit package, FIDA Plans will be required to pay non-contracting providers the Medicaid FFS rate.
- h. Under the Demonstration, skilled nursing level care may be provided in a long term care facility without a preceding acute care inpatient stay for individuals enrolled in the Demonstration, when the provision of this level of care is clinically appropriate and can avert the need for an inpatient stay.
- i. For Participants residing in nursing facilities who wish to move to the community, the FIDA Plan will refer them to preadmission screening teams or the Money Follows the Person Program. The FIDA Plan ensures that all community supports, including housing, are in place prior to the Participant's transition, and providers are knowledgeable and prepared to support the Participant, including interface and coordination with and among clinical services and community-based LTSS.

VI. Model of Care- All FIDA Plans (in partnership with contracted providers) will be required to implement an evidence-based model of care (MOC). FIDA Plans must meet all CMS MOC standards for Special Needs Plans as well as the self-direction requirements established by the State. New York's comprehensive care management program requirements summarized in section IV will also apply and be outlined in the

Three-way Contract and the FIDA Plan provider agreement. CMS' Demonstration plan MOC approval process is based on scoring each of the eleven clinical and non-clinical elements of the MOC. The scoring methodology is divided into three parts: (1) a standard; (2) elements; and (3) factors. These components of the MOC approval methodology are defined below:

- (1) Standard: The standard is defined as a MOC that has achieved a score of 70 percent or greater based on NCQA's scoring methodology.
- (2) Elements: The MOC has 11 clinical and non-clinical elements, as identified below, and each element will have a score that will be totaled and used to determine the final overall score. The 11 MOC elements and the State-specific MOC element (i.e., Self-Direction) are listed below:
 - Description of the Plan-specific Target Population;
 - Measurable Goals;
 - Staff Structure and Care Management Goals;
 - Interdisciplinary Care Team;
 - Provider Network having Specialized Expertise and Use of Clinical Practice Guidelines and Protocols;
 - MOC Training for Personnel and Provider Network;
 - Health Risk Assessment;
 - Individualized Care Plan;
 - Integrated Communication Network;
 - Care Management for the Most Vulnerable Subpopulations;
 - Performance and Health Outcomes Measurement; and
 - Self-Direction (State-specific element):
 - a) Describe how your organization will educate consumers and informal caregivers on self-directed (consumer-directed) options
 - b) Describe how your organization will monitor the education efforts
 - c) Describe how your organization will evaluate the self-directed (consumer-directed) services
 - d) Describe how your organization will monitor and evaluate the percentage of consumers that use the self-directed (consumer-directed) option.
- (3) Factors: Each element is comprised of multiple factors that are outlined in the MOC upload matrix in the Demonstration plan application. The factors for each element are scored using a system from 0 to 4, where 4 is the highest score for a factor. Interested organizations are required to provide a response that addresses every factor within each

of the 11 elements. The scores for each factor within a specific element are totaled to provide the overall score for that element out of a total of 160 possible points. Interested organizations must achieve a minimum score of 70 percent to meet the CMS approval standard.

It is CMS's intent for MOC reviews and approvals to be a multi-year process that will allow Demonstration plans to be granted up to a three-year approval of their MOC based on higher MOC scores above the passing standard. The specific time periods for approvals are as follows:

- Plans that receive a score of eighty-five (85) percent or higher will be granted an approval of the CMS MOC requirement for three (3) years.
- Plans that receive a score in the seventy-five (75) percent to eighty-four (84) percent range will be granted an approval of the CMS MOC requirement for two (2) years.
- Plans that receive a score in the seventy (70) percent to seventy-four (74) percent range will be granted an approval of the CMS MOC requirement for one (1) year.

FIDA Plans will be permitted to cure problems with their MOC submissions after their initial submissions. FIDA Plans with MOCs scoring below 70 percent will have the opportunity to improve their scores based on CMS and State feedback on the elements and factors that need additional work. At the end of the review process, FIDA Plans with MOCs that do not meet CMS' standards for approval will not be eligible for selection as FIDA Plans.

VII. Prescription and Select Non-Prescription Drugs – The integrated formulary must include any Medicaid-covered prescription drugs and certain non-prescription drugs that are excluded by Medicare Part D. Plans must also cover drugs covered by Medicare Parts A or B. In all respects, unless stated otherwise in this MOU or the Three-way Contract, Part D requirements will continue to apply. Formulary requirements will be fully articulated in the Three-way Contract.

VIII. Grievances – Participants shall be entitled to file internal grievances directly with the FIDA Plan either orally or in writing. Each FIDA Plan must track and resolve its grievances according to applicable Medicare and Medicaid rules, or if appropriate, re-route grievances to the coverage decision or appeals processes.

1. **Grievance Filing Deadline.** All grievances must be filed within 60 calendar days of the incident or whenever there is dissatisfaction (in the event there is not one specific incident). Expedited grievance must be filed within 60 calendar days of the date of the coverage decision and must include physician certificate of need.
2. **Acknowledgement of Grievance.** The FIDA Plan must send written acknowledgement of the grievance to the Participant within 15 business days of receipt. If a decision is reached before the written acknowledgement is sent, the FIDA Plan will not send the written acknowledgement.
3. **Timeframe for Plan Decision and Notification on Grievance.** A FIDA Plan must respond to a Participant's grievance as fast as the Participant's condition requires, but no later than:
 - a. Expedited: Paper review – decision and notification within 24 hours (in certain circumstances). For all other circumstances where a standard decision would significantly increase the risk to a Participant's health, decision and notification within 48 hours after receipt of all necessary information and no more than 7 calendar days from the receipt of the grievance. Certain circumstances requiring a response within 24 hours are defined as:
 - i. The complaint involves a FIDA Plan's decision to invoke an extension relating to an organization determination.
 - ii. The complaint involves a FIDA Plan's refusal to grant a Participant's request for an expedited organization determination under 42 CFR Part 422.570.
 - b. Standard: Notification of decision within 30 calendar days of the FIDA Plan receiving the written or oral grievance.
4. **Extension.** Up to 14-calendar day extension. The FIDA Plan may extend the 30 calendar day timeframe by up to 14 calendar days if the Participant or provider on the Participant's behalf (written or verbal) requests the extension or if the FIDA Plan justifies a need for additional information and documents how the delay is in the interest of the Participant. When the FIDA Plan extends the deadline, it must immediately notify the Participant in writing of the reasons for the delay.
5. **Notification of Grievance Decision.** The FIDA Plan must notify the Participant of the decision by phone for expedited grievances and provide written notice of the decision within 3 business days of decision (expedited and standard).
6. **External Grievance.** A Participant may file an external grievance through the process outlined in the Three-way Contract.

IX. Appeals — Other than Medicare Part D appeals, which shall remain unchanged, the below is the approach for an integrated Medicare-Medicaid appeals process. CMS and NYSDOH will work to continue to coordinate grievances and appeals for all services, including those related to Part D. Additional details related to the appeals process will be further delineated in the Three-way Contract.

a. Integrated/Unified Appeals Process:

- i. Integrated Notice- FIDA Demonstration Participants will be notified of all applicable Medicare and Medicaid appeal rights through a single notice specific to the service or item type in question, developed jointly by the State and CMS. All notices shall be integrated and shall communicate the steps in the integrated appeals process identified herein as well as the availability of the Participant Ombudsman to assist with appeals.
- ii. Integrated Appeal Process and Time Frames- Time frames for filing appeal related to benefits will be unified. There are four (4) levels of appeal.
 1. **Appeal Filing Deadline.** Participants, their providers, and their representatives will have 60 calendar days to file an appeal related to denial or reduction or termination of authorized Medicare or Medicaid benefit coverage. This first level of appeal is an internal appeal, to be decided by the FIDA Plan. The appeal must be requested within 60 calendar days of postmark date of notice of Action if there is no request to continue benefits while the appeal decision is pending. If there is a request to continue benefits while the appeal decision is pending and the appeal involves the termination or modification of a previously authorized service, the appeal must be requested within 10 calendar days of the notice's postmark date or by the intended effective date of the Action, whichever is later.
 2. **Acknowledgement of Appeal.** The FIDA Plan shall be required to send written acknowledgement of appeal to the Participant within 15 calendar days of receipt. If a decision is reached before the written acknowledgement is sent, the FIDA Plan will not send the written acknowledgement.
 3. **Timeframe for Plan Decision on Appeal.** The FIDA Plan shall be required to decide the appeal and notify the Participant (and

provider, as appropriate) of its decision as fast as the Participant's condition requires, but:

- a. Expedited: Paper review unless a Participant requests in-person review - as fast as the Participant's condition requires, but no later than within 72 hours of the receipt of the appeal.
- b. Standard: Paper review unless a Participant requests in-person review - as fast as the Participant's condition requires, but no later than 7 calendar days from the date of the receipt of the appeal on Medicaid prescription drug appeals and no later than 30 calendar days from the date of the receipt of the appeal.

Benefits will continue pending an appeal in accordance with section IX.a.ii.12.

4. **Extension.** Up to 14-calendar day extension. An extension may be requested by a Participant or provider on a Participant's behalf (written or oral). The FIDA Plan may also initiate an extension if it can justify need for additional information and if the extension is in the Participant's interest. In all cases, the extension reason must be well-documented, and when the FIDA Plan requests the extension it must notify the Participant in writing of the reasons for delay and inform the Participant of the right to file an expedited grievance if he or she disagrees with the FIDA Plan's decision to grant an extension.
5. **Notification of Appeal Decision.** The FIDA Plan must make a reasonable effort to provide prompt oral notice to the Participant for expedited appeals and must document those efforts. The FIDA Plan must send written notice within 2 calendar days of providing oral notice of its decision for standard and expedited appeals.
6. **Automatic Administrative Hearing.** Any adverse decision by the FIDA Plan is automatically forwarded to the Integrated Administrative Hearing Officer at the FIDA Administrative Hearing Unit at the State Office of Temporary and Disability Assistance (OTDA). This step occurs regardless of the amount in controversy (i.e., there will be no amount in controversy minimum imposed). Benefits will continue pending an appeal in accordance with section IX.a.ii.12. The Integrated Administrative Hearing Officer role will be jointly developed by NYSDOH and CMS. CMS and NYSDOH will provide the Integrated Administrative Hearing Officers with

FIDA Demonstration specific training. This second level of appeal is external to the FIDA Plan. OTDA serving as the FIDA Administrative Hearing Unit is subject to CMS and NYSDOH joint review of OTDA readiness, including use of contractor support.

7. **Notices of Automatic Administrative Hearing.** The FIDA Plan shall be required to send an Acknowledgement of Automatic Administrative Hearing and Confirmation of Aid Status within 14 calendar days of forwarding the administrative record. The Integrated Administrative Hearing Officer shall provide the Participant with a Notice of Administrative Hearing at least 10 calendar days in advance of the hearing date.
8. **Administrative Record for Administrative Hearing.** The Integrated Administrative Hearing Officer shall create the administrative record at the second level of appeal and allow for requesting and receiving copies of the administrative record in accordance with 42 CFR Part 405.1042.
9. **Timeframe for Decision on Administrative Hearing.**
 - a. **Standard Timeframe:** The Integrated Administrative Hearing Officer shall conduct a phone or in-person hearing and render a decision as expeditiously as the Participant's condition requires, but always within 7 calendar days for Medicaid prescription drug coverage matters and for all other matters within 90 calendar days of request for the first year of the Demonstration and 30 calendar days of request for the 2nd and 3rd year of the Demonstration.
 - b. **Expedited Timeframe:** The Integrated Administrative Hearing Officer shall conduct a phone or in-person hearing notify the Participant (and the provider, as appropriate) of the decision within 72 hours of the forwarding of the FIDA Plan's appeal decision.
 - c. **Decision:** The Integrated Administrative Hearing Officer shall issue a written decision that explains in plain language the rationale for the decision and specifies the next steps in the appeal process, including where to file the appeals, the filing time frames, and other information required by

applicable Federal and State requirements. Participants will be notified by the timeframes stated in section II(a)(ii)(9)(a) and (b) of this Appendix.

10. **Medicare Appeals Council.** If a Participant disagrees with the Integrated Administrative Hearing Officer's decision, the Participant may appeal that decision further to the Medicare Appeals Council, which may overturn the Integrated Administrative Hearing Officer's decision. An adverse Administrative Hearing decision may be appealed to the Medicare Appeals Council within 60 calendar days. This serves as the third level of appeal. These appeals must be filed with the FIDA Administrative Hearing Unit, which will forward the request for appeal and administrative record to the Medicare Appeals Council in the manner specified in the Three-way Contract. The Medicare Appeals Council will complete a paper review and will issue a decision within 90 calendar days. Benefits will continue pending an appeal in accordance with section IX.a.ii.12. CMS and NYSDOH will provide the Administrative Appeals Judges with FIDA Demonstration specific training.
11. **Federal District Court.** An adverse Medicare Appeals Council decision may be appealed to the Federal District Court, which serves as the fourth level of appeal.
12. **Continuation of Benefits Pending Appeal.** Continuation of benefits for all prior-approved Medicare and Medicaid benefits that are terminated or modified, pending internal FIDA Plan appeals, Integrated Administrative Hearings, and Medicare Appeals Council must be provided if the original appeal is requested to the FIDA Plan within 10 calendar days of the notice's postmark date (of the decision that is being appealed) or by the intended effective date of the Action, whichever is later.
13. **Validation of Integrated Administrative Hearing Officer Decisions.** As part of the Administration and Oversight activities set forth in this MOU and for purposes of validating that Integrated Administrative Hearing Officer decisions are supported by applicable Medicare law, regulations and coverage criteria, all decisions related to Medicare coverage will be reviewed by the

Part C qualified independent contractor (QIC) for a period not to exceed one (1) year. OTDA will be responsible for forwarding a complete paper copy of the administrative case file to the Part C QIC within two (2) days of the Integrated Administrative Hearing Officer's decision. The primary purpose of the Part C QIC's review is for quality assurance and to provide feedback to OTDA to ensure that cases are adjudicated according to Medicare rules. The Part C QIC's review does not suspend or toll the enrollee's right to request review from the Medicare Appeals Council. CMS reserves the right to make any necessary adjustments to the appeals process to assure beneficiary access to Medicare items and services.

X. FIDA Plan Marketing, Outreach, and Education Activity

As indicated in the CMS "Announcement of Calendar Year (CY) 2013 Medicare Advantage Capitation rates and Medicare Advantage and Part D Payment Policies and Final Call Letter" released on April 2, 2012, CMS Medicare Marketing Guidelines do not apply to marketing done by State governments and marketing materials created by the State do not need to be reviewed or submitted in HPMS. However, CMS and the State agree to work together in the development of these materials, and the State will consult with CMS on the development of the materials.

- a. Marketing and Participant Communication Standards for FIDA Plans – FIDA Plans will be subject to rules governing their marketing and Participant communications as specified under section 1851(h) and 1932(d)(2) of the Social Security Act; 42 CFR Parts 422.111, 422.2260 et. seq., 423.120(b) and (c), 423.128, and 423.2260 et. seq., 438.104; and the Medicare Marketing Guidelines (Chapter 3 of the Medicare Managed Care Manual and Chapter 2 of the Prescription Drug Benefit Manual). The State and CMS will work to develop a single consolidated set of marketing rules and requirements and the Three-way Contract will require FIDA Plans to comply with any unified set of rules and requirements that are developed. The following exceptions apply:
 - i. FIDA Plans may not market directly to individuals on a one-on-one basis but may provide responses to Participant-initiated requests for information and/or enrollment. FIDA Plans may participate in group

marketing events and provide general audience materials (such as general circulation brochures and media and billboard advertisements).

- ii. CMS and the State will develop a process to mitigate Participant shifting from FIDA Plans to other plans operated by the same parent company. At a minimum, the Three-way Contract will identify procedures to provide additional education to Participants that are considering opting out of an FIDA Plan for a non-FIDA Plan that may be a part of the same corporate family. Participant choices regarding enrollment will be honored by CMS and the State.
- b. Review and Approval of Marketing and Participant Communications – FIDA Plans must receive prior approval of all marketing and Participant communications materials by CMS and/or the State in categories of materials that CMS or the State requires to be prospectively reviewed. In accordance with State rules, the State will conduct prospective review of certain Participant communication materials. FIDA Plan materials may be designated as eligible for the File & Use process, as described in 42 CFR Parts 422.2262(b) and 423.2262(b), and will therefore be exempt from prospective review and approval by both CMS and the State. CMS and the State may agree to defer to one or the other party for review of certain types of marketing and Participant communications, as agreed in advance by both parties. FIDA Plans must submit all marketing and Participant communication materials, whether prospectively reviewed or not, via the CMS HPMS Marketing Module.
 - c. Permissible Start Date for FIDA Plan Marketing Activity – FIDA Plans may begin marketing activity, as limited by paragraph (section X(a)(i)) above, no earlier than 45 days prior to the effective date of enrollment for the contract year.
 - d. CMS and the State will work together to educate individuals about their FIDA Plan options. CMS and the State will work together to develop single, consolidated notices and marketing materials for use in this Demonstration. Some of these will be models FIDA Plans may work from and others will become required documents that FIDA Plans will have to use. The Three-way Contract will specify that the FIDA Plans will be required to use any notices, materials, or other documents that the State and CMS make mandatory.
 - e. The State's independent Enrollment Broker will be responsible for educating Participants on all potential plan choices through a variety of mechanisms.

Outreach and educational activities may include letters, outreach events, and/or outbound telephone calls and will take into account the prevalence of cognitive impairments, mental illness, limited English proficiency, and low functional literacy.

- f. Minimum Required Marketing and Participant Communications Materials – At a minimum, FIDA Plans will provide current and prospective Participants the following materials. These materials will be subject to the same rules regarding content and timing of Participant receipt as applicable under section 1851(h) of the Social Security Act; 42 CFR Parts 422.111, 422.2260 et. seq., 423.120(b) and (c), 423.128, and 423.2260 et. seq.; and the Medicare Marketing Guidelines (Chapter 3 of the Medicare Managed Care Manual and Chapter 2 of the Prescription Drug Benefit Manual). FIDA Plans will use a Demonstration-specific Summary of Benefits.
 - i. An Evidence of Coverage (EOC) document that includes information about all State-covered and FIDA Plan-covered additional benefits, in addition to the required Medicare benefits information. Additional content will be required by the State, including: eligibility requirements for FIDA Demonstration enrollment; excluded services; Participant rights and responsibilities; services requiring prior authorization; self-referral services; explanation that the FIDA Plan ID card replaces the Medicare and Medicaid cards; assessment and care planning processes; access and network adequacy requirements; how to access services; how to choose providers; how to access emergency care; the availability of self-directed services and how to begin self-directing services; the right to change FIDA Plans and the procedure for requesting a change; the right to disenroll from the Demonstration and the procedure for disenrolling; consolidated appeal and grievance rights and processes; non-discrimination requirements; information on Participants' right to execute advance directives; how to contact the NYSDOH call center for any concerns; how to contact the Participant Ombudsman for any assistance; how to access additional information in alternative formats or languages; how to access the FIDA Plan provider directory; the name of the FIDA Plan's parent company and any DBA (Doing Business As) that may be used; toll-free Participant services and care management and nurse advice 24-hour service lines; and any other content required by State or Federal regulation.

- ii. An Annual Notice of Change (ANOC) summarizing all major changes to the FIDA Plan's covered benefits from one contract year to the next, starting in the second year of the Demonstration.
 - iii. A Summary of Benefits (SB) containing a concise description of the important aspects of enrolling in the FIDA Plan, as well as the benefits offered under the FIDA Plan, including co-payments, applicable conditions and limitations, and any other conditions associated with receipt or use of benefits.
 - iv. A combined provider and pharmacy directory that includes all providers of Medicare, Medicaid, and additional benefits.
 - v. A comprehensive integrated formulary that includes Medicare and Medicaid outpatient prescription drugs provided under the FIDA Plan.
 - vi. A single identification (ID) card for accessing all covered services under the FIDA Plan.
 - vii. All Part D required notices, with the exception of the creditable coverage and late enrollment penalty notices required under Chapter 4 of the Prescription Drug Benefit Manual and the LIS Rider required under Chapter 13 of the Prescription Drug Benefit Manual.
- f. Notification of Formulary Changes – The requirement at 42 CFR Part 423.120(b)(5) that FIDA Plans provide at least 60 days advance notice regarding Part D formulary changes also applies to FIDA Plans for outpatient prescription or over-the-counter drugs or products covered under Medicaid or as additional benefits.

XI. Administration and Oversight

- a. Oversight Framework
 - i. Under the Demonstration, there will be a CMS-State Contract Management Team that will ensure access, quality, program integrity, compliance with applicable laws, including but not limited to Emergency Medical Treatment and Active Labor Act (EMTALA) and ADA, and financial solvency, including reviewing and acting on data and reports, conducting studies, and taking corrective action. CMS and the State will require FIDA Plans to have a comprehensive plan to detect, correct,

prevent, and report fraud, waste, and abuse. FIDA Plans must have policies and procedures in place to identify and address fraud, waste, and abuse at both the plan and the third-party levels in the delivery of FIDA Demonstration benefits, including prescription drugs, medical care, behavioral health, and community-based and facility-based LTSS. In addition, all Part D requirements and many Medicare Advantage requirements regarding oversight, monitoring, and program integrity will be applied to FIDA Plans by CMS in the same way they are currently applied for Prescription Drug Plan (PDP) sponsors and Medicare Advantage organizations.

These responsibilities are not meant to detract from or weaken any current State or CMS oversight responsibilities, including oversight by the Medicare Drug Benefit Group and other relevant CMS groups and divisions, as those responsibilities continue to apply, but rather to assure that such responsibilities are undertaken in a coordinated manner. Neither party shall take a unilateral enforcement action relating to day-to-day oversight without notifying the other party in advance.

b. The Contract Management Team

- i. Structure – The Contract Management Team will include representatives from CMS and the State, authorized and empowered to represent CMS and the State about aspects of the Three-way Contract. Generally, the CMS members of the team will include the State Lead from the Medicare Medicaid Coordination Office (MMCO), Regional Office Lead from the Consortium for Medicaid and Children’s Health Operations (CMCHO), and an Account Manager from the Consortium for Health Plan Operations (CMHPO). The precise makeup will include individuals who are knowledgeable about the full range of services and supports utilized by the target population, particularly long-term services and supports.
- ii. Reporting – Data reporting to CMS and the State will be coordinated and unified to the extent possible. Specific reporting requirements and processes for the following areas will be detailed in the Three-way Contract.
 1. Quality (including HEDIS): Core measures will be articulated in the MOU.

2. Rebalancing from Institutional to HCBS Settings
3. Utilization
4. Encounter Reporting
5. Participant Satisfaction (including CAHPS)
6. Complaints and Appeals
7. Enrollment / Disenrollment Rates
8. Part C and Part D Reporting Requirements, as negotiated and applicable
9. All required 1115(a) and 1915(c) waiver reporting
10. Participant Ombudsman

c. Oversight and Coordination

The Contract Management Team will be responsible for monitoring of each FIDA Plan. These responsibilities include, but are not limited to:

- Monitoring compliance with the terms of the Three-way Contract, including issuance of joint notices of non-compliance/enforcement;
- Coordination of periodic audits and surveys of the FIDA Plan;
- Receipt and response to complaints;
- Review reports from the Participant Ombudsman;
- Reviewing direct stakeholder input on both plan-specific and systematic performance;
- Regular meetings with each FIDA Plan;
- Coordination of requests for assistance from contractors and assignment of appropriate State and CMS staff to provide technical assistance;
- Coordinate review of marketing materials and procedures; and

- Coordinate review of grievance and appeals data, procedures, and materials.

d. Centralized Program –Wide Monitoring, Surveillance, Compliance, and Enforcement

CMS' central office conducts a wide array of data analyses, monitoring studies, and audits. Demonstration contracts will be included in these activities, just as all Medicare Advantage and Part D organizations will be included. Demonstration contracts will be treated in the same manner, which includes analysis of their performance based on CMS internal data, active collection of additional information, and CMS issuance of compliance notices, where applicable. The State and Contract Management Team will be informed about these activities and copied on notices but will not take an active part in these ongoing projects or activities.

e. Emergency / Urgent Situations

Both CMS and the State shall retain discretion to take immediate action where the health, safety, or welfare of any Participant is imperiled or where significant financial risk is indicated. In such situations, CMS and the State shall notify a member of the Contract Management Team no more than 24 hours from the date of such action, and the Contract Management Team will undertake subsequent action and coordination.

f. FIDA Plan Call Center Requirements

In addition to current Federal regulatory requirements and CMS guidance requirements for Medicare Advantage plans and Part D plans, the following will be required call center elements:

- FIDA Plans shall operate a toll-free Participant services telephone line call center. The line will be available nationwide for a minimum of 8am to 8pm Eastern Time, seven days per week.
- Operators must be available in sufficient numbers to support Participants and meet CMS and State specified standards.
- Oral interpretation services must be available free-of-charge to all Participants in all non-English languages spoken by Participants.
- Plans must ensure that customer service department representatives shall, upon request, make available to Participants and potential

Participants information including, but not limited to, the following:

- The identity, locations, qualifications, and availability of providers;
- Participants' rights and responsibilities;
- The procedures available to a Participant and/ or provider(s) to challenge or appeal the failure of the contractor to provide a requested service and to appeal any adverse Actions (denials);
- How to access oral interpretation services and written materials in prevalent languages and alternative, cognitively accessible formats;
- How to access the Participant Ombudsman, the NYSDOH Participant Call Center, and 1-800-Medicare;
- Information on all FIDA Plan covered services and other available services or resources (e.g., State agency services) either directly or through referral or authorization; and
- The procedures for a Participant to change FIDA Plans or to opt out of the Demonstration.

g. Data System Specifications, Reporting Requirements, and Interoperability

- i. Data system description and architecture and performance requirements
- ii. Current information system upgrades and development plans and resource commitments necessary for implementation
- iii. Consolidated reporting requirements
- iv. Encounter reporting
- v. Reporting data for evaluation and program integrity
- vi. Data Exchange among CMS, State of New York Providers and Contractors, and Health Insurance Exchanges

FIDA Plans will be encouraged to use an electronic health record system that

meets the Meaningful Use provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act and allows the Participant's health information and Patient-Centered Service Plan to be accessible to the IDT. If an IDT provider does not have such a system, the provider will submit a plan to the FIDA Plan for when and how it will meet the requirement, as further specified in the Three-way Contract. FIDA Plans will also be required to commit to joining regional health information networks or qualified health information technology (HIT) entities for data exchange and share information with all providers participating in a Person-Centered Service Plan.

h. Unified Quality Metrics and Reporting

FIDA Plans will be required to report measures that examine access and availability, care coordination/transitions, health and well-being, mental and behavioral health, patient/caregiver experience, screening and prevention, and quality of life. This includes a requirement to report Medicare HEDIS, HOS, and CAHPS data, as well as measures related to long-term services and supports. HEDIS, HOS, and CAHPS measures will be reported consistent with Medicare requirements plus any additional Medicaid measures identified by the State. All existing Part D metrics will be collected as well. The State will supplement quality reporting requirements with additional State-specific measures.

A combined set of core metrics is described below in Table 7-B; more detail on the measures will be provided in the Three-way Contract. CMS and the State will utilize the reported measures in the combined set of core metrics for various purposes, including implementation and ongoing monitoring, assessing plan performance and outcomes, and to allow quality to be evaluated and compared with other plans in the model. A subset of these measures will also be used for calculating the quality withhold payment as addressed in section VI of Appendix 6 in this MOU.

In addition, CMS and the State may apply progressive monetary sanctions tied to premium payments for not meeting minimum performance standards, as would be specified by CMS and the State in the Three-way Contract. Table 7-B specifies the CMS Core Quality Measures and the State quality measures.

FIDA Plans must submit data consistent with requirements established by CMS and/or the State as further described below and in the Three-way Contract. FIDA Plans will also be subject to monitoring efforts consistent with the requirements of Medicare Advantage and Part D, as described in section XI of this Appendix.

Table 7-B: Core Quality Measures under the FIDA Demonstration

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure	Quality Withholds
1. Antidepressant Medication Management	Percentage of Participants 18 years of age and older who were diagnosed with a new episode of major depression and treated with antidepressant medication, and who remained on an antidepressant medication treatment.	NCQA/HEDIS	X		
2. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	<p>The percentage of adolescent and adult Participants with a new episode of alcohol or other drug (AOD) dependence who received the following.</p> <ul style="list-style-type: none"> • Initiation of AOD Treatment. The percentage of Participants who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis. • Engagement of AOD Treatment. The percentage of Participants who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit. 	NCQA/HEDIS	X		
3. Follow-up After Hospitalization for Mental Illness	Percentage of discharges for Participants 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial	NCQA/HEDIS	X		X

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure	Quality Withholds
	hospitalization with a mental health practitioner.				
4. Screening for Clinical Depression and Follow-up Care	Percentage of Participants ages 18 years and older screened for clinical depression using a standardized tool and follow-up plan documented.	CMS	X		X
5. SNP 6: Coordination of Medicare and Medicaid Benefits	<p>The organization coordinates Medicare and Medicaid benefits and services for Participants.</p> <p>Element A: Coordination of Benefits for Dual Eligible Participants</p> <p>Element B: Administrative Coordination of D-SNPs</p> <p>Element C: Administrative Coordination for Chronic Condition and Institutional Benefit Packages (May not be applicable for demos)</p> <p>Element D: Service Coordination</p> <p>Element E: Network Adequacy Assessment</p>	NCQA/ SNP Structure & Process Measures	X		
6. Care Transition Record Transmitted to Health Care Professional	Percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge.	AMA-PCPI	X		

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure	Quality Withholds
7. Medication Reconciliation After Discharge from Inpatient Facility	Percent of patients 65 years or older discharged from any inpatient facility and seen within 60 days following discharge by the physician providing on-going care who had a reconciliation of the discharge medications with the current medication list in the medical record documented.	NCQA/HEDIS	X		
8. SNP 4: Care Transitions	<p>The organization manages the process of care transitions, identifies problems that could cause transitions and where possible prevents unplanned transitions.</p> <p>Element A: Managing Transitions Element B: Supporting Participants through Transitions Element C: Analyzing Performance Element D: Identifying Unplanned Transitions Element E; Analyzing Transitions Element F: Reducing Transitions</p>	NCQA/ SNP Structure & Process Measures	X		
9. CAHPS, Health Plan plus supplemental items/questions (TBD). Of particular note are the following:		AHRQ/CAHPS	X		X

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure	Quality Withholds
Getting Information about Prescription Drug Coverage and Cost	<p>The percent of the best possible score that the plan earned on how easy it is for Participants to get information from their plan about prescription drug coverage and cost.</p> <p>A. In the last 6 months, how often did your health plan's customer service give you the information or help you needed about prescription drugs?</p> <p>B. In the last 6 months, how often did your plan's customer service staff treat you with courtesy and respect when you tried to get information or help about prescription drugs?</p> <p>C. In the last 6 months, how often did your health plan give you all the information you needed about prescription medication were covered?</p> <p>D. In the last 6 months, how often did your health plan give you all the information you needed about how much you would have to pay for your prescription medicine?</p>				
Rating of Plan for Coverage of Prescription Drugs	<p>The percent of the best possible score that the plan earned from Participants who rated the plan for its coverage of prescription drugs.</p>				

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure	Quality Withholds
Getting Needed Prescription and Non-Prescription Drugs	<ul style="list-style-type: none"> • Using any number from 0 to 10, where 0 is the worst prescription drug plan possible and 10 is the best drug plan possible, what number would you use to rate your health plan for coverage of prescription drugs? <p>The percent of best possible score that the plan earned on how easy it is for Participants to get the prescription drugs and non-prescription drugs they need using the plan.</p> <p>A. In the last 6 months, how often was it easy to use your health plan to get the medicines your doctor prescribed?</p> <p>B. In the last six months, how often was it easy to use your health plan to fill a prescription or obtain a non-prescription drug at a local pharmacy?</p>				
Getting Needed Care	<p>Percent of best possible score the plan earned on how easy it is to get needed care, including care from specialists.</p> <p>A. In the last 6 months, how often was it</p>				

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure	Quality Withholds
Getting Appointments and Care Quickly	<p>easy to get appointments with specialists? B. In the last 6 months, how often was it easy to get the care, tests, or treatment you needed through your health plan? C. In the last 6 months, how often was it easy to get the care, tests, or treatment you needed through your health plan?</p> <p>Percent of best possible score the plan earned on how quickly Participants can get appointments and care.</p> <p>A. In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed? B. In the last 6 months, not counting the times when you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed? C. In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?</p>				

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure	Quality Withholds
Overall Rating of Health Care Quality	<p>Percent of best possible score the plan earned from Participants who rated the overall health care received.</p> <ul style="list-style-type: none"> Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months? 				
Overall Rating of Plan	<p>Percent of best possible score the plan earned from Participants who rated the overall plan.</p> <ul style="list-style-type: none"> Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate your health plan? 				
10. Part D Call Center – Pharmacy Hold Time	How long pharmacists wait on hold when they call the plan’s pharmacy help desk.	CMS Call Center data	X		
11. Part D Call Center – Foreign Language	Percent of the time that TTY/TDD services and foreign language interpretation were	CMS	X		

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure	Quality Withholds
Interpreter and TTY/TDD Availability	available when needed by Participants who called the plan's customer service phone number.	Call Center data			
12. Part D Appeals Auto-Forward	<p>How often the plan did not meet Medicare's deadlines for timely appeals decisions.</p> <p>This measure is defined as the rate of cases auto-forwarded to the Independent Review Entity (IRE) because decision timeframes for coverage determinations or redeterminations were exceeded by the plan. This is calculated as: [(Total number of cases auto-forwarded to the IRE) / (Average Medicare Part D enrollment)] * 10,000.</p>	IRE	X		
13. Part D Enrollment Timeliness	The percentage of enrollment requests that the plan transmits to the Medicare program within 7 calendar days of receipt of a completed enrollment request.	Medicare Advantage Prescription Drug System (MARx)	X		
14. Part D Complaints about the Drug Plan	<p>How many complaints Medicare received about the drug plan.</p> <p>For each contract, this rate is calculated as: [(Total number of complaints logged into the CTM for the drug plan regarding any issues) / (Average Contract enrollment)] * 1,000 * 30 / (Number of Days in Period).</p>	CMS CTM data	X		

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure	Quality Withholds
15. Part D Participant Access and Performance Problems	To check on whether Participants are having problems getting access to care and to be sure that plans are following all of Medicare's rules, Medicare conducts audits and other types of reviews. Medicare gives the plan a lower score (from 0 to 100) when it finds problems. The score combines how severe the problems were, how many there were, and how much they affect plan Participants directly. A higher score is better, as it means Medicare found fewer problems.	CMS Administrative data	X		
16. Part D Participants Choosing to Leave the Plan	The percent of Participants who chose to leave the plan in 2013.	CMS Medicare Participant Database Suite of Systems	X		
17. Part D MPF Accuracy	The accuracy of how the Plan Finder data match the PDE data.	CMS PDE data, MPF Pricing Files, HPMS approved formulary extracts, and data from First DataBank and	X		

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure	Quality Withholds
		Medispan			
18. Part D High Risk Medication	The percent of the Participants who get prescriptions for certain drugs with a high risk of serious side effects, when there may be safer drug choices.	CMS PDE data	X		
19. Part D Diabetes Treatment	Percentage of Medicare Part D Participants who were dispensed a medication for diabetes and a medication for hypertension who were receiving an angiotensin converting enzyme inhibitor (ACEI) or angiotensin receptor blocker (ARB) medication which are recommended for people with diabetes.	CMS PDE data	X		
20. Part D Medication Adherence for Oral Diabetes Medications	Percent of Participants with a prescription for oral diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.	CMS PDE data	X	X	X
21. Part D Medication Adherence for Hypertension (ACEI or ARB)	Percent of Participants with a prescription for a blood pressure medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.	CMS PDE data	X		
22. Part D Medication Adherence for Cholesterol (Statins)	Percent of Participants with a prescription for a cholesterol medication (a statin drug) who fill their prescription often enough to cover	CMS PDE data	X		

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure	Quality Withholds
	80% or more of the time they are supposed to be taking the medication.				
23. Plan Makes Timely Decisions about Appeals	Percent of Participants who got a timely (per timelines in section IX) response when they made a written appeal to the plan about a decision to refuse payment or coverage.	FIDA Administrative Hearing Unit	X		
24. Part D Appeals Upheld	<p>How often an independent reviewer agrees with the plan's decision to deny or say no to a Participant's Part D appeal.</p> <p>This measure is defined as the percent of IRE confirmations of upholding the plans' Part D decisions. This is calculated as: [(Number of Part D cases upheld) / (Total number of Part D cases reviewed)] * 100.</p>	IRE	X		
25. Non-Part D Appeals Upheld	<p>How often an Integrated Administrative Hearing Officer agrees with the plan's non-Part D decision to deny or say no to a Participant's non-Part D appeal.</p> <p>This measure is defined as the percent of FIDA Administrative Hearing Unit confirmations of upholding the plans' decisions. This is calculated as: [(Number of non-Part D cases upheld) / (Total number of</p>	FIDA Administrative Hearing Unit	X		

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure	Quality Withholds
	non-Part D cases reviewed)] * 100.				
26. Call Center – Foreign Language Interpreter and TTY/TDD Availability	Percent of the time that the TTY/TDD services and foreign language interpretation were available when needed by Participants who called the plan’s customer service phone number.	CMS Call Center data	X		
27. Percent of High Risk Residents with Pressure Ulcers (Long Stay)	Percentage of all long-stay residents in a nursing facility with an annual, quarterly, significant change or significant correction MDS assessment during the selected quarter (3-month period) who were identified as high risk and who have one or more Stage 2-4 pressure ulcer(s).	NQF endorsed	X		
28. Participant Governance Board	Establishment of Participant advisory board or inclusion of Participants on governance board consistent with contract requirements.	CMS/State defined process measure	X		X
29. Customer Service	Percent of best possible score the plan earned on how easy it is to get information and help when needed. A. In the last 6 months, how often did your health plan’s customer service give you the information or help you needed? B. In the last 6 months, how often did your health plan’s customer service treat you with	AHRQ/CAHPS	X		X

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure	Quality Withholds
	courtesy and respect? C. In the last 6 months, how often were the forms for your health plan easy to fill out?				
30. Assessments	Percent of Participants with initial assessments completed within 30 days of enrollment.	CMS/State defined process measure	X		X
31. Person-Centered Service Plan	Percent of Participants with care plans within 30 days of initial assessment.	CMS/State defined process measure	X	X	
32. Documentation of Care Goals	Percent of Participants with documented discussions of care goals.	CMS/State defined process measure			X
33. Real Time Hospital Admission Notifications	Percent of hospital admission notifications occurring within specified timeframe.	CMS/State defined process measure	X	X	
34. Risk stratification based on LTSS or other factors	Percent of risk stratifications using behavioral health (BH)/LTSS data/indicators.	CMS/State defined process measure	X	X	
35. Discharge follow - up	Percent of Participants with specified timeframe between discharge to first follow-up visit.	CMS/State defined process measure	X		

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure	Quality Withholds
36. Care for Older Adults – Medication Review	Percent of Participants whose doctor or clinical pharmacist has reviewed a list of everything they take (prescription and non-prescription drugs, vitamins, herbal remedies, other supplements) at least once a year.	NCQA/ HEDIS	X		
37. Care for Older Adults – Functional Status Assessment	Percent of Participants whose doctor has done a —functional status assessment to see how well they are doing —activities of daily living (such as dressing, eating, and bathing).	NCQA/HEDIS	X		
38. Care for Older Adults – Pain Screening	Percent of Participants who had a pain screening or pain management plan at least once during the year.	NCQA/HEDIS	X		
39. Diabetes Care – Eye Exam	Percent of Participants with diabetes who had an eye exam to check for damage from diabetes during the year.	NCQA/HEDIS	X		
40. Diabetes Care – Kidney Disease Monitoring	Percent of Participants with diabetes who had a kidney function test during the year.	NCQA/HEDIS	X		
41. Diabetes Care – Blood Sugar Controlled	Percent of Participants with diabetes who had an A-1-C lab test during the year that showed their average blood sugar is under control.	NCQA/HEDIS	X		
42. Rheumatoid Arthritis Management	Percent of Participants with Rheumatoid Arthritis who got one or more prescription(s) for an anti-rheumatic drug.	NCQA/HEDIS	X		

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure	Quality Withholds
43. Reducing the Risk of Falling	Percent of Participants with a problem falling, walking or balancing who discussed it with their doctor and got treatment for it during the year.	NCQA/HEDIS HOS	X		X
44. Plan All-Cause Readmissions	Percent of Participants discharged from a hospital stay who were readmitted to a hospital within 30 days, either from the same condition as their recent hospital stay or for a different reason.	NCQA/HEDIS	X		X
45. Controlling Blood Pressure	Percentage of Participants 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year.	NCQA/HEDIS	X	X	X
46. Comprehensive medication review	Percentage of Participants who received a comprehensive medication review (CMR) out of those who were offered a CMR.	Pharmacy Quality Alliance (PQA) Part D Reporting Data	X		
47. Complaints about the Plan	How many complaints Medicare received about the health plan. Rate of complaints about the plan per 1,000 Participants. For each contract, this rate is calculated as: [(Total number of all complaints logged into the CTM) / (Average	CMS CTM data	X		

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure	Quality Withholds
	Contract enrollment)] * 1,000 * 30 / (Number of Days in Period).				
48. Participant Access and Performance Problems	To check on whether members are having problems getting access to care and to be sure that plans are following all of Medicare's rules, Medicare conducts audits and other types of reviews. Medicare gives the plan a lower score (from 0 to 100) when it finds problems. The score combines how severe the problems were, how many there were, and how much they affect plan Participants directly. A higher score is better, as it means Medicare found fewer problems.	CMS Participant database	X		
49. Participants Choosing to Leave the Plan	The percent of Participants who chose to leave the plan in 2014.	CMS	X		
50. Breast Cancer Screening	Percent of female Participants aged 40-69 who had a mammogram during the past 2 years.	NCQA/ HEDIS	X		
51. Colorectal Cancer Screening	Percent of Participants aged 50-75 who had appropriate screening for colon cancer.	NCQA/HEDIS	X		
52. Cardiovascular Care – Cholesterol Screening	Percent of Participants with heart disease who have had a test for —bad (LDL) cholesterol within the past year.	NCQA/HEDIS	X		
53. Diabetes Care –	Percent of Participants with diabetes who	NCQA/HEDIS	X		

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure	Quality Withholds
Cholesterol Screening	have had a test for —bad (LDL) cholesterol within the past year.				
54. Annual Flu Vaccine	Percent of Participants who got a vaccine (flu shot) prior to flu season.	AHRQ/CAHPS Survey data	X		X
55. Improving or Maintaining Mental Health	Percent of all Participants whose mental health was the same or better than expected after two years.	CMS HOS	X		
56. Monitoring Physical Activity	Percent of senior Participants who discussed exercise with their doctor and were advised to start, increase or maintain their physical activity during the year.	HEDIS / HOS	X		
57. Access to Primary Care Doctor Visits	Percent of all Participants who saw their primary care doctor during the year.	HEDIS	X		
58. Access to Specialists	Proportion of respondents who report that it is always easy to get appointment with specialists.	AHRQ/CAHPS	X		
59. Getting Care Quickly	Composite of access to urgent care.	AHRQ/CAHPS	X		
60. Being Examined on the Examination table	Percentage of respondents who report always being examined on the examination table.	AHRQ/CAHPS	X		
61. Help with Transportation	Composite of getting needed help with transportation.	AHRQ/CAHPS	X		
62. Health Status/Function Status	Percent of Participants who report their health as excellent.	AHRQ/CAHPS	X		

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure	Quality Withholds
63. Percent of Residents Experiencing One or More Falls with a Major Injury	This measure is based on data from all non-admission MDS 3.0 assessments of long-stay nursing facility residents which may be annual, quarterly, significant change, significant correction, or discharge assessment. It reports the percent of residents who experienced one or more falls with major injury (e.g., bone fractures, joint dislocations, closed head injuries with altered consciousness, and subdural hematoma) in the last year (12-month period). The measure is based on MDS 3.0 item J1900C, which indicates whether any falls that occurred were associated with major injury.	NQF/CMS		X	
64. Self-direction Participant-level Measure	Percent of Participants directing their own services through the consumer-directed personal assistance option at the plan each Demonstration Year.	State-specified measure		X	
65. Long Term Care Overall Balance Measure	Reporting of the number of Participants who did not reside in a nursing facility (NF) as a proportion of the total number of Participants in a plan. <u>Numerator:</u> Of those Participants in the denominator, those who did not reside for more than 100 continuous days in a NF during the current measurement year.	State-specified measure		X	

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure	Quality Withholds
	<p><u>Denominator:</u> Participants in a plan eleven out of twelve months during the current measurement year.</p> <p><u>Exclusions:</u> Any Participant with a gap in enrollment of Medicaid eligibility of 30 days during the current measurement year.</p>				
66. Nursing Facility Diversion Measure	<p>Reporting of the number of nursing home certifiable Participants who lived outside the nursing facility (NF) during the current measurement year as a proportion of the nursing home certifiable Participants who lived outside the NF during the previous year.</p> <p><u>Nursing Facility Diversion Rate:</u> <u>Numerator:</u> Of those Participants in the denominator, those who did not reside in a NF for more than 100 continuous days during the current measurement year. <u>Denominator:</u> Nursing home certifiable Participants enrolled in a plan eleven out of twelve months during the current measurement year, did not reside for more than 100 continuous days in a NF during the previous year, and were eligible for Medicaid</p>	State-specified measure		X	X

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure	Quality Withholds
	<p>during the previous year for eleven out of twelve months.</p> <p><u>Exclusions:</u> Any nursing home certifiable Participant with a gap in enrollment of Medicaid eligibility of 30 days during the current measurement year.</p>				
67. Long Term Care Rebalancing Measure	<p>Reporting of the number of Participants who were discharged to a community setting from a NF and who did not return to the NF during the current measurement year as a proportion of the number of Participants who resided in a NF during the previous year.</p> <p>Monthly Long Term Care Rebalancing Rate: Numerator: of those Participants in the denominator, those who were discharged to a community setting from a NF and did not return to the NF during the current measurement year.</p> <p><u>Denominator:</u> Participants enrolled in a plan eleven out of twelve months during the current measurement year who resided in a NF for 100 continuous days or more during the previous year and were eligible for Medicaid during the previous year for eleven out of twelve months.</p>	State-specified measure		X	

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure	Quality Withholds
	<u>Exclusions:</u> Any Participant with a gap in enrollment of Medicaid eligibility of 30 days during the current measurement year.				
68. Improvement / Stability in Activities of Daily Living (ADL) Functioning	Participants in the FIDA Demonstration who remained stable or improved in ADL functioning between previous assessment and most recent assessment.	State-specified measure		X	X
69. Participants Referred to Preadmission Screening Teams or Money Follows the Person (MFP) Program	Percent of Participants in the FIDA Demonstration who reside in a nursing facility, wish to return to the community, and were referred to preadmission screening teams or the MFP Program.	State-specified measure		X	

XII. Stakeholder Engagement

The State will continue to engage with and incorporate feedback from stakeholders during the implementation and operational phases of the Demonstration. This will be accomplished through an ongoing process of public meetings, monitoring Participant and provider experiences through a variety of means, including surveys, website updates, and data analysis. In addition, the State will require that FIDA Plans develop meaningful Participant input processes as part of their ongoing operations, as well as systems for measuring and monitoring the quality of service and care delivered to Participants. The State will also develop consumer notices and related materials about the FIDA Demonstration that are easily understood (i.e., no more than a 6th grade reading level) by persons with limited English proficiency and low functional literacy, and will translate materials into prevalent languages as determined by CMS and the State.

XIII. Evaluation

CMS has contracted with an independent evaluator to measure, monitor, and evaluate the impact of the Financial Alignment models, including the New York capitated Demonstration, on Participant experience of care, quality, utilization, and cost. The evaluator will also explore how the New York initiative operates, how it transforms and evolves over time, and Participants' perspectives and experiences. The key issues targeted by the evaluation will include (but are not limited to):

- Participant health status and outcomes;
- Quality of care provided across care settings;
- Participant access to and utilization of care across care settings;
- Participant satisfaction and experience;
- Administrative and systems changes and efficiencies;
- Long-term care rebalancing effectiveness; and,
- Overall costs or savings for Medicare and Medicaid.

The evaluator will design a State-specific evaluation plan for the New York Demonstration, and will also conduct a meta-analysis that will look at the state Demonstrations overall. A mixed methods approach will be used to capture quantitative

and qualitative information. Qualitative methods will include site visits, qualitative analysis of program data, and collection and analysis of focus group and key informant interview data. Quantitative analyses will consist of tracking changes in selected utilization, cost, and quality measures over the course of the Demonstration; evaluating the impact of the Demonstration on cost, quality, and utilization measures; and calculating savings attributable to the Demonstration. The evaluator will use a comparison group for the impact analysis. Quarterly reports will provide rapid-cycle monitoring of enrollment, implementation, utilization of services, and costs (pending data availability). The evaluator will also submit New York-specific annual reports that incorporate qualitative and quantitative findings to date, and will submit a final evaluation report at the end of the Demonstration.

The State is required to cooperate, collaborate, and coordinate with CMS and the independent evaluator in all monitoring and evaluation activities. The State and FIDA Plans must submit all required data for the monitoring and evaluation of this Demonstration, according to the data and timeframe requirements to be listed in the Three-way Contract.

The State will track beneficiaries eligible for the Demonstration, including which beneficiaries choose to enroll, disenroll from, or opt out of passive enrollment into the Demonstration, enabling the evaluation to identify differences in outcomes for these groups. The State will need to provide information including but not limited to the following on a quarterly basis to CMS and/or the evaluator:

- Beneficiary-level data identifying beneficiaries eligible and enrolled in the demonstration:
 - Medicare Beneficiary Claim Account Number (HICN)
 - MSIS number
 - Social Security Number
 - CMS Beneficiary Link Key
 - Person First and Last Name, Birthdate, and Zip code
 - Eligibility identification flag - Coded 0 if not identified as eligible for the Demonstration, 1 if identified as eligible for the Demonstration using criteria available in claims or other administrative data, and 2 if identified by criteria from non-administrative data sources
 - Monthly eligibility indicator - Each monthly eligibility flag variable would be coded 1 if eligible, and zero if not.
 - Monthly enrollment indicator - Each monthly enrollment flag variable would be coded 1 if enrolled in the Demonstration, and zero if not.

- Summary level data for the State Data Reporting System, including but not limited to:
 - The number of beneficiaries eligible for the Demonstration, appropriately excluding all individual beneficiaries *not* eligible for the Demonstration (e.g., individuals under the age of 21, residents of psychiatric facilities, individuals in the Traumatic Brain Injury 1915(c) waiver program, etc.)
 - The number of beneficiaries enrolled in the Demonstration
 - The number of beneficiaries who opt out of passive enrollment into the Demonstration
 - The number of beneficiaries who disenroll from the Demonstration
 - The number of plans participating in the Demonstration

The State will work with the evaluation contractor to determine what care coordination/case management data are available and will share data with the evaluator to support analysis of care coordination utilization patterns. Based on discussions with the evaluation contractor, the State will be asked to provide data potentially including beneficiary-level data, such as HICNs, on beneficiaries receiving care coordination during any given month.

The State will ensure that the evaluator at least annually receives information indicating the primary care provider of record for each Participant. The State will also have the capability to track beneficiary-level data on grievances and appeals that identify the health plan and providers involved.