FINANCIAL ALIGNMENT INITIATIVE

New York FIDA Combined Second and Third Evaluation Report

Spring 2021

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FINANCIAL ALIGNMENT INITIATIVE
NEW YORK FIDA
COMBINED SECOND AND THIRD EVALUATION REPORT

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CMS Contract No. HHSM-500-2014-00037i TO#7

Spring 2021

This project was funded by the Centers for Medicare & Medicaid Services under contract no. HHSM-500-2014-00037i TO #7. The statements contained in this report are solely those of the authors and do not necessarily reflect the views or policies of the Centers for Medicare & Medicaid Services. RTI assumes responsibility for the accuracy and completeness of the information contained in this report.

Acknowledgments

We would like to thank the State officials who contributed information reflected in this evaluation report through interviews during site visits and quarterly telephone calls. We also thank the Medicare-Medicaid enrollees, managed care plan staff, consumer advocates, and other stakeholders who also answered our questions about their experience and perspectives on the demonstrations. We gratefully acknowledge the many contributions of CMS staff, especially our project officers, Nancy Chiles Shaffer and Lanlan Xu, our former project officers, Sai Ma and Daniel Lehman, and Thomas Shaffer. We also thank other staff at the University of Southern Maine, especially Elizabeth Gattine, who helped to gather information, produce tables, and ensure quality for this report. We thank Amarilys Bernacet and Amy Chepaitis for their careful review of and feedback on this report. Christopher Klotschkow, Catherine Boykin, Roxanne Snaauw, Shari Lambert, and Valerie Garner provided excellent editing, document preparation, and graphic design.

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Glossary of Acronyms

CAHPS	Consumer Assessment of Healthcare Providers and Systems
CMS	Centers for Medicare & Medicaid Services
CMT	Contract Management Team
CTM	Complaint Tracking Module
D-SNP	Dual Eligible Special Needs Plan
DSRIP	Delivery System Reform Incentive Payment
FFS	Fee-for-service
FIDA	Fully Integrated Duals Advantage
FIDA-IDD	Fully Integrated Duals Advantage for Individuals with Intellectual and/or Developmental Disabilities
FIDE-SNP	Fully Integrated Dual Eligible Special Needs Plan
HCBS	Home and community-based services
HEDIS	Healthcare Effectiveness Data and Information Set
ICAN	Independent Consumer Advocacy Network
IAHO	Integrated Administrative Hearing Office
IDT	Interdisciplinary Team
LTSS	Long-term services and supports
MA	Medicare Advantage
MAC	Medicare Appeals Council
MAP	Medicaid Advantage Plus
MARx	Medicare Advantage Prescription Drug System
MAXIMUS	The enrollment broker for the FIDA demonstration
MLTC	Managed long-term care
MMCO	Medicare-Medicaid Coordination Office

MMP	Medicare-Medicaid Plan
MOU	Memorandum of Understanding
OTDA	Office of Temporary and Disability Assistance
PACE	Program of All-Inclusive Care for the Elderly
PCP	Primary care physician or provider
PCSP	Person-Centered Service Plan
SDRS	State Data Reporting System
UAS	Uniform Assessment System

Executive Summary

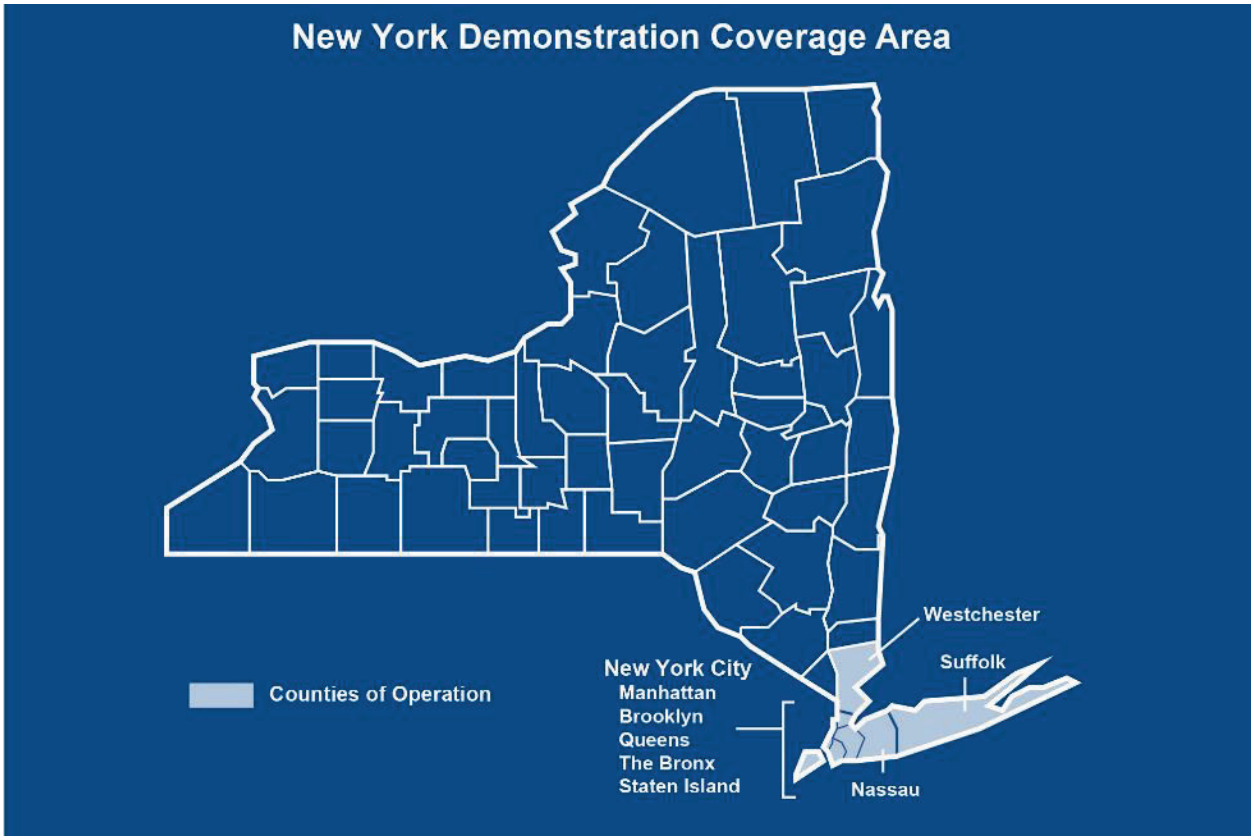
The Medicare-Medicaid Coordination Office and the Innovation Center at the Centers for Medicare & Medicaid Services (CMS) have created the Medicare-Medicaid Financial Alignment Initiative (FAI) to test, in partnerships with States, integrated care models for Medicare-Medicaid enrollees. New York and CMS launched the Fully Integrated Duals Advantage (FIDA) demonstration on January 1, 2015, to integrate care for Medicare-Medicaid beneficiaries in the greater New York City area. The demonstration ended on December 31, 2019. Initially, twenty-one Medicare-Medicaid Plans (MMPs) participated in the demonstration. In the final year, six MMPs remained. MMPs received capitated payments from CMS and the State to finance all Medicare and Medicaid services. MMPs also provided care coordination and flexible benefits that varied from plan to plan.

Eligibility for FIDA was limited to those age 21 or older at the time of enrollment who:

- are entitled to benefits under Medicare Part A and enrolled in Medicare Parts B and D
- receive full Medicaid benefits
- reside in a FIDA demonstration county
- require a nursing facility level of care or 120 days of community-based long-term care.

FIDA encompassed two regions. Region 1 covered five counties corresponding to the five boroughs of New York City (Bronx, Kings [Brooklyn], New York [Manhattan], Queens, and Richmond [Staten Island]), and Nassau County in Long Island. Region 2 covered Westchester and Suffolk counties. Enrollment in Region 1 began January 1, 2015. Enrollment in Region 2 began in March 2017. The demonstration ceased accepting new enrollments effective June 1, 2019.

Stakeholders supported the demonstration's elements of streamlined care planning and service authorization processes, and its integrated appeals process allowing a single path to appeal both Medicare and Medicaid service decisions. However, due to a combination of design choices, environmental factors, and early implementation missteps, a large number of potential enrollees and providers opted out of participation.



Although New York and CMS addressed many of the issues, FIDA was plagued by its early negative reputation and declining enrollment throughout the life of the demonstration. Out of over 100,000 eligible beneficiaries, enrollment peaked in October 2015 at 8,833[1] and declined to 2,320 as of December 2019.[2]

Beginning in the summer of 2017, the State and CMS held several stakeholder meetings to discuss the future of integrated care in New York, including the role of the FIDA demonstration. As a result of those forums and other discussions with MMPs and stakeholders in 2018, New York and CMS decided that the FIDA demonstration would conclude at the end of 2019. New York and CMS worked together on continuing the demonstration waiver authority only for the integrated appeals process developed under FIDA and applying it to Medicaid Advantage Plus (MAP) plans, a type of New York Medicaid managed long-term care plan aligned with a Medicare Advantage plan that provides both Medicare and Medicaid services.

CMS contracted with RTI International to monitor the implementation of the FAI demonstrations and to evaluate their impact on beneficiary experience, quality, utilization, and cost. The evaluation includes individual State-specific reports.

[1] RTI International: State Data Reporting System (SDRS). 2015–2017.
[2] NYSDOH: https://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/. As obtained on March 16, 2020.

In this evaluation report for the New York FIDA demonstration, we describe demonstration implementation activity from 2017 through 2019, and the considerable planning activity during the final demonstration years to create an option to seamlessly transition FIDA enrollees into existing MAP plans aligned with Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs) under the same MMP parent organization.[3] We include findings from qualitative data for 2017–2019. Using qualitative data gathered throughout the demonstration (2015–2019), we also present overall demonstration successes, challenges, and lessons learned at the end of the report. We used a variety of data sources to prepare this report (see ***Appendix A***).

[3] FIDA enrollees had the option to transition into MAP-participating D-SNP plans or to choose either a different Medicare Advantage plan or Medicare fee-for-service as well as a different Medicaid managed long term care plan. There is no fee-for-service option for Medicaid LTSS in New York for beneficiaries eligible for the FIDA demonstration, with the exception of 1915(c) Nursing Home Transition and Diversion waiver services. New York plans to move these waiver services to managed care in 2022. For more information on the different types of MLTSS options in New York, please see the First Evaluation Report.

This evaluation report does not contain descriptive statistics or regression-based impact analyses on Medicare and Medicaid service use or costs. RTI lacked administrative data on approximately one-half of the beneficiary characteristics that the State used to determine whether beneficiaries met demonstration eligibility criteria. Such data would have been needed for RTI to more effectively exclude from the evaluation analysis all beneficiaries who would not have met the State's eligibility criteria had the demonstration been implemented in the New York baseline period and also in the comparison group. As a result, RTI decided that the data available to the evaluation were not sufficient to construct a comparison group or identify potential demonstration eligible beneficiaries in the predemonstration period in New York State.

Highlights

Integration of Medicare and Medicaid	At the demonstration's end, CMS and New York allowed FIDA plans to transition enrollees who had not already chosen another option into sister MAP-participating D-SNP plans.
	The successful integrated appeals process developed under FIDA will continue after the demonstration ends and will be available to enrollees of certain MAP-participating D-SNPs.
Eligibility and Enrollment	Of the 21 original participating FIDA plans, 14 remained in 2017. Four plans exited after 2017, and four more exited after 2018, leaving six plans participating in 2019, the final year.
	Enrollment in the demonstration was low from the start and continued to decline from 2017 through 2019.
Care Coordination	MMPs continued to support the care coordination model as an effective approach for reducing fragmentation of care.
	During 2017 through 2019, most primary care providers did not participate in the Interdisciplinary Team (IDT) as envisioned. A plan that paid providers for their time had more success in engaging them in the IDT.

Beneficiary Experience	Most 2017 focus group participants expressed overall satisfaction with FIDA. They felt that FIDA had improved their access to needed medical and specialty services, as well as their quality of health, life, and independence. Most also said their care management was effective.
	Findings from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys (2016–2019) showed FIDA member satisfaction generally increased over time and was similar to Medicare Advantage and MMP enrollee satisfaction nationwide.
	Over the course of the demonstration, the number of member appeals heard by the Integrated Administrative Hearing Office (IAHO), the State entity responsible for reviewing second-level appeals, remained low.
Quality of Care	CMS and the New York State Department of Health (NYSDOH) did not report any major quality issues related to FIDA MMPs between 2017 and 2019.
	Low enrollment in the demonstration prevented many (but not all) MMPs from reporting on Healthcare Effectiveness Data and Information Set (HEDIS) measures.

FIDA Demonstration Successes, Challenges, and Lessons Learned	
	The FIDA demonstration successfully streamlined the appeals process for enrollees through integrating appeals at the plan level and automatically forwarding adverse plan decisions to a State office (IAHO) that determined the outcome by applying both Federal Medicare and State Medicaid policy.
	The original extensive provider training requirements and IDT policy requiring real-time meeting participation contributed significantly to provider and beneficiary decisions not to participate in the demonstration. The State and CMS noted that getting provider buy-in and input early on would be key to the success of future programs.
	FIDA never recovered from its early negative reputation among providers, which led to low provider participation and in turn, unwillingness of beneficiaries to participate in the demonstration.
	The lack of rate parity between FIDA and other established programs competing for the same dually eligible enrollees created incentives for MMPs not to promote the FIDA product.

SECTION 1

Demonstration and Evaluation Overview

1.1 Demonstration Description and Goals

The Medicare-Medicaid Coordination Office (MMCO) and the Innovation Center at the Centers for Medicare & Medicaid Services (CMS) have created the Medicare-Medicaid FAI to test, in partnerships with States, integrated care models for Medicare-Medicaid enrollees. New York implemented two demonstrations with CMS, one of which was the FIDA demonstration that operated January 2015 through December 2019.[4]

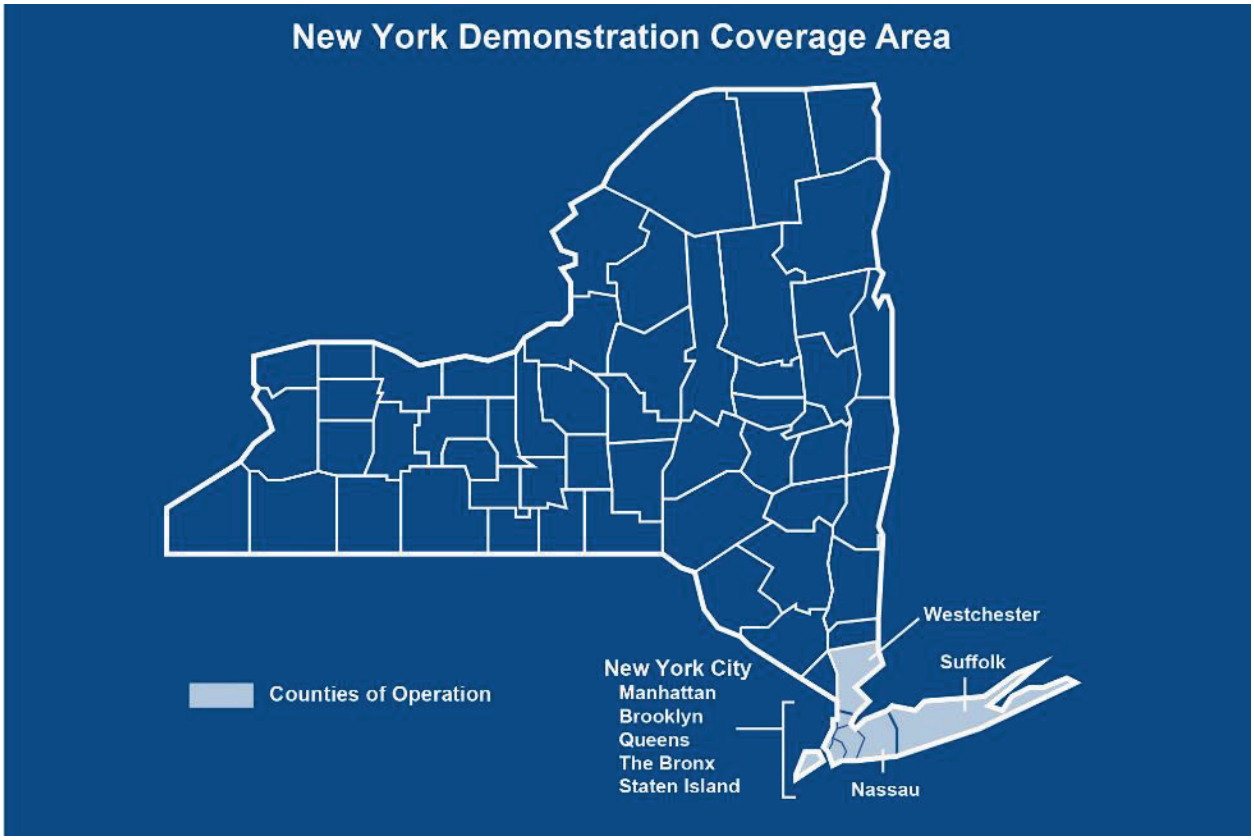
In the FIDA demonstration, qualified MMPs offered a combined set of Medicare and Medicaid benefits integrated through an IDT and care planning process. The MMPs received capitated payments from CMS and the State to finance Medicare and Medicaid services.

Eligibility for FIDA was limited to those age 21 or older at the time of enrollment who:

- were entitled to benefits under Medicare Part A and enrolled in Medicare Parts B and D,
- received full Medicaid benefits,
- resided in a FIDA demonstration county, and
- required a nursing facility level of care or 120 days of community-based long-term care.

The FIDA demonstration was active in two regions. Region 1 covered five counties corresponding to the five boroughs of New York City (Bronx, Kings [Brooklyn], New York [Manhattan], Queens, and Richmond [Staten Island]), as well as Nassau County on Long Island. Enrollment in Region 1 began January 1, 2015. Region 2 covered Westchester and Suffolk counties. Enrollment in Region 2 began in March 2017, but because an MMP withdrew from the demonstration as of January 1, 2019, no FIDA plans were available in Suffolk County during the final year.

[4] The other demonstration, the Fully Integrated Duals Advantage for Individuals with Intellectual and/or Developmental Disabilities (FIDA-IDD), started in April 2016 and, as of this report, will continue through December 2023. This report covers only the FIDA demonstration.



FIDA covered all services available under Medicare Parts A, B, and D, and all New York Medicaid State Plan services, including long-term services and supports (LTSS).[5] However, unlike the State's other Medicaid managed LTSS programs (see ***Section 2.2, Overview of State Context***), a much broader range of Medicaid services could be accessed through FIDA, including home and community-based services (HCBS) under New York's 1915(c) Nursing Home Transition and Diversion waiver.[6]

FIDA also covered other supportive services not traditionally included in Medicare or Medicaid that the member's IDT determined necessary and appropriate. CMS and the NYSDOH, the lead State agency for demonstration implementation, considered this a new benefit under FIDA. The First Evaluation Report includes extensive background information about the demonstration.

1.2 Purpose of This Report

CMS contracted with RTI International to monitor the implementation of the demonstrations under the FAI and to evaluate their impact on beneficiary experience, quality,

[5] There are some exclusions, such as ICF/IDD services. Please see the First Evaluation Report for a detailed list of excluded services.

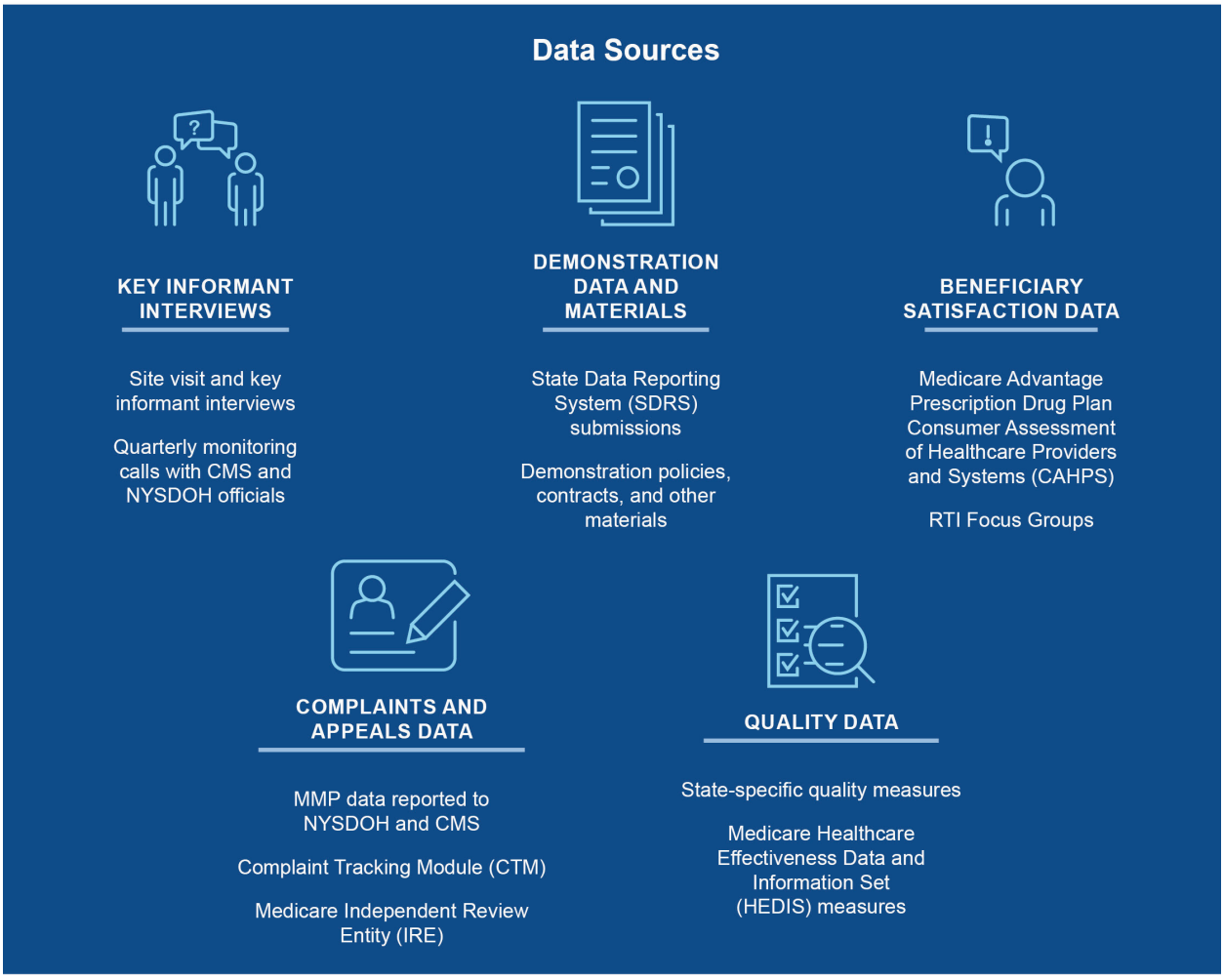
[6] In addition, unlike the other New York managed LTSS programs, FIDA covered transportation for medical and nonmedical events or services (e.g., religious services, community activities, or the grocery store).

utilization, and cost. In this evaluation report, we include qualitative information for calendar years 2017 through 2019, the third through fifth demonstration years.

We provide updates to the previous evaluation report in key areas, including enrollment, care coordination, beneficiary experience, and stakeholder engagement activities. We also describe the considerable planning activity during the demonstration's final 2 years to create a seamless transition for FIDA enrollees into existing MAP plans aligned with Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs) under the same MMP parent organization. Because the demonstration ended in December 2019, we also present overall demonstration successes, challenges, and lessons learned at the end of the report.

1.3 Data Sources

We used a variety of data sources to prepare this report (see below). See ***Appendix A*** for additional detail on data sources.



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SECTION 2

Demonstration Design and State Context

2.1 Changes in Demonstration Design

During the launch of the FIDA demonstration, MMPs identified some design features that deterred provider and beneficiary participation in the demonstration, or placed a heavy burden on the MMPs. As a result, during the early phase of the demonstration, many beneficiaries chose to opt out of FIDA before they could be passively enrolled. In addition, many of those who were passively enrolled chose to disenroll.[7]

To respond to those concerns, in 2015, CMS and NYSDOH made a number of changes to the demonstration design. Most importantly, they significantly relaxed the Interdisciplinary Team (IDT) requirements. For example, they made primary care provider participation optional and ceased requiring the full IDT to meet simultaneously. In addition, CMS and NYSDOH:

- made the extensive provider training requirements for all FIDA-participating providers voluntary,
- modified or clarified marketing restrictions,
- adjusted rates to create more parity with competing products, and
- reduced reporting requirements.[8]

Most of these changes were effective December 2015, at the end of the first demonstration year, and are discussed in the First Evaluation Report.

After 2015, CMS and NYSDOH made other changes to ease MMP administrative burden. These included relaxing translation requirements for enrollee documents, clarifying prior authorization requirements to align with the IDT policy changes, and permitting remote participation of enrollees in an MMP's Participant Feedback Session. The three-way contract was amended effective January 1, 2018, to formalize these changes, including those made in December 2015. The amended contract also added a 2-year extension to the demonstration, for a new end date of December 31, 2019 (NYSDOH, 2018b).

2.2 Overview of State Context

In addition to FIDA, New York offers three managed LTSS products:

1. The Managed Long Term Care (MLTC) program is a partially capitated program covering Medicaid-funded long-term care services, launched in 1998 as a voluntary program and made mandatory in 2012.

2. The MAP program allows dually eligible beneficiaries to enroll in an MLTC plan and Medicare Advantage Dual Eligible Special Needs plan (D-SNP) operated by the same parent company. MAP covers nearly all the Medicaid benefits available in FIDA,

[7] At the start of the demonstration, there were many challenges with the passive enrollment process, as detailed in the First Evaluation Report.
[8] See ***Table 1*** of the First Evaluation Report for more information about changes to demonstration design.

though it does not cover as many behavioral health services or the HCBS waiver services available under FIDA.[9]

3. New York also offers a Program of All-Inclusive Care for the Elderly (PACE).

Throughout implementation, due to rate parity issues and similar target populations, FIDA MMPs competed with the MLTC,MAP, and PACE programs (see ***Section 3.5, Financing and Payment***). ***Table 1*** shows the enrollment of these alternative programs predemonstration and at the end of the demonstration, relative to FIDA.

Table 1
Enrollment in managed LTSS programs operating in the FIDA demonstration area, December 2014 and 2019

Year	MLTC	MAP	PACE	FIDA
Enrollment, December 2014	119,954	5,916	3,905	N/A
Enrollment, December 2019	213,313	17,582	5,734	2,320

N/A = not applicable.
SOURCE: NYSDOH Medicaid Managed Care Enrollment Reports, December 2014 and December 2019 available at https://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/. As obtained July 20, 2020.

FIDA also was one of many concurrent Medicaid Reform initiatives in New York. Most significantly, New York operates a Delivery System Reform Incentive Payment (DSRIP) program under its Medicaid Redesign Team (MRT) §1115(a) waiver. Under DSRIP, New York supports 25 Performing Provider Systems (PPSs) made up of hospitals, providers, and community-based organizations, with the goal of promoting collaboration to improve quality and reduce avoidable hospital use.

Although providers could participate in both DSRIP and FIDA, the initiatives had different reporting requirements, creating a burden for providers to participate in both. DSRIP competed with FIDA for providers because providers had a more direct financial incentive to participate in PPSs through shared savings than if they contracted with a FIDA plan. The State was able to support value-based payments to the PPSs under DSRIP over a 5-year period (2015–2020) by using $8 billion in Federal savings generated by MRT activities. Such funds were not available to providers under FIDA. For more information on these competing factors, see the First Evaluation Report.

NYSDOH received Federal implementation funding support for FIDA in the amount of $6.8 million for the first 12 months of implementation and an additional $6.2 million for the second 12 months. The State chose not to request funding for the Ombudsman program serving FIDA enrollees because the Ombudsman also serves individuals covered under New York's other managed LTSS programs and its Medicaid Health and Recovery Programs. Accepting Federal funding for the Ombudsman program would have decreased the State's flexibility in

[9] See First Evaluation Report, page 9.

designing the program to serve multiple Medicaid LTSS populations. In 2014, New York received $695,572 in funding from CMS and the Administration for Community Living for its State Health Insurance Assistance Program (SHIP) to provide options counseling to Medicare-Medicaid enrollees. However, the contract with SHIP was not in place until October 2015, 9 months after the start of the demonstration.

In 2016, most MMPs voiced continued concern about low demonstration enrollment and urged the State not to pursue a demonstration extension when the option arose.[10] However, the State hoped extending the demonstration by 2 years would give FIDA a chance to recover from its rocky start. According to CMS, the State also wanted to see if a 2016 advertising campaign would result in increased enrollment. The State went forward with the extension through December 2019. To respond to MMP concerns, beginning in the second half of 2017, CMS and NYSDOH held a series of forums with key stakeholders to discuss the future of integrated care, each focused on key design elements for a model of integrated care.[11] The State said that given the lack of support from providers and plans for FIDA, they were surprised to hear during these forums how much providers and plans still wanted an integrated program. CMS said that the extension also gave CMS, the State, and MMPs time to plan for a smooth transition at demonstration end.

Fundamentally, people like the FIDA model, but they don't like the name or recognize that FIDA is it. They want everything integrated, streamlined marketing, dual info that is easier for the consumer. Every design feature that they like is in the existing FIDA model.

— State Official (2017)

Conversations between the State, CMS, and stakeholders about potential integrated options continued through 2018, though they slowed because of changes in NYSDOH staff and leadership in late 2017 and into 2018. These changes included the appointment of a new Medicaid Director and Director and Deputy Director of the Division of Long Term Care, key figures in Medicaid policy and planning.

In 2019, after continued analysis and discussion, NYSDOH and CMS decided to allow MMPs to transition their remaining enrollees at the end of the demonstration, who had not already made another choice at the end of the demonstration, to MAP plans aligned with a Fully Integrated Dual Eligible Special Needs Plan under the same parent organization. These entities are referred to as MAP-participating D-SNP plans. See ***Sections 3.2.4, Transition Enrollment Activities,*** and ***5.1, Post-FIDA Transition Planning***, for descriptions of the development of the post-FIDA enrollment activities and transition plan.

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[10] A coalition of plans representing a majority of FIDA enrollees sent a letter to NYSDOH recommending against an extension. One plan wrote a counter letter in favor.

[11] Transcripts and recordings from each of the meetings can be found on NYSDOH's *Planning for the Future of Integrated Care in New York State* webpage located at: https://www.health.ny.gov/health_care/medicaid/redesign/future/. Accessed April 23, 2020.

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SECTION 3

Update on Demonstration Implementation

In this section, we provide updates on important aspects of the demonstration that have occurred since the First Evaluation Report. This includes updates on integration efforts, enrollment, care coordination activities, stakeholder engagement activities, financing and payment, and quality management strategies.

3.1 Integration of Medicare and Medicaid

Prior experience with Medicare managed care and MLTC was associated with MMP longevity in the demonstration.

3.1.1 Joint Management Activities

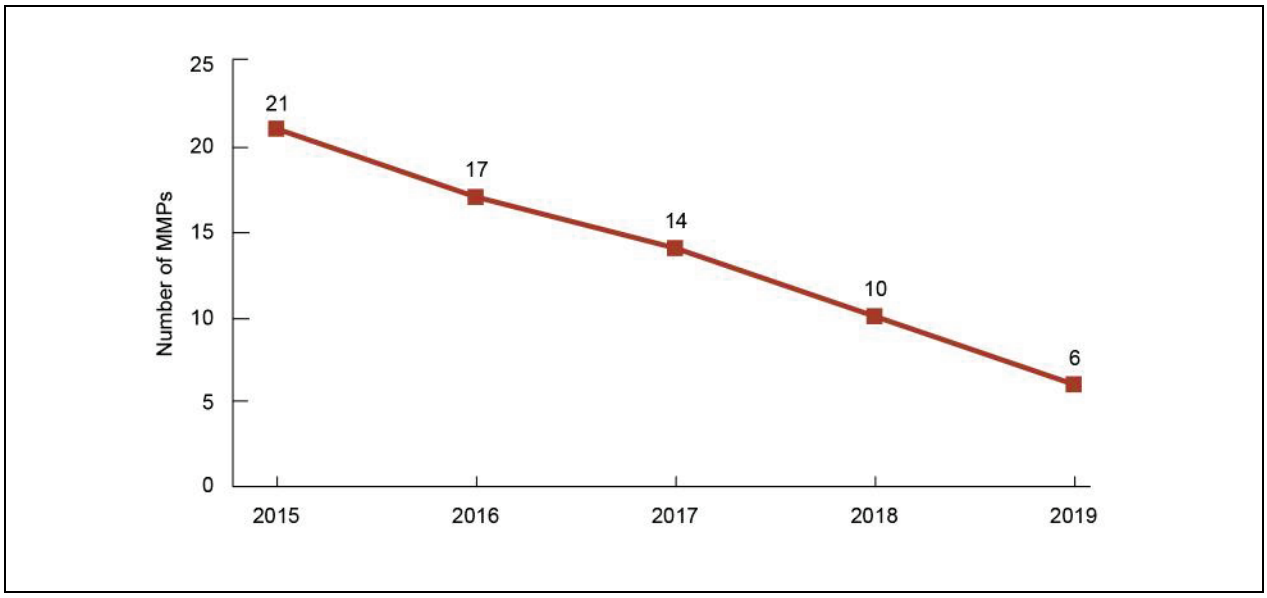
Joint management of the demonstration by CMS and the State through the Contract Management Team (CMT) continued throughout the demonstration. CMT-Operational calls, with all of the plans participating, occurred once a month, and CMT-Management calls with each plan occurred once a week until September 2019, after which they were held twice a week during the transition process (see ***Section 5, Demonstration End and Transition Planning***).

During each year's interviews (2017–2019) MMCO staff said they continued to have less engagement from CMS Medicare and Medicaid account managers than they had hoped. Although most of the questions that came up during CMT calls fell under MMCO purview, a CMS account manager might have been able to answer some questions more quickly. CMS noted that State participation on the CMT calls also was not as regular as it had been in previous years. The contract termination of a key FIDA consultant in 2018, leaving only one State staff member dedicated to FIDA operations, likely contributed to this change. However, CMS, NYSDOH, and the MMPs generally viewed the CMT as effective.

3.1.2 FIDA MMPs

Over the course of the demonstration, MMPs exited FIDA at a steady pace. Of the original 21 participating FIDA plans, only 6 plans remained in 2019, the final year (see ***Figure 1***). Based on the information gathered in NYSDOH, CMS, and MMPs interviews, possible reasons for the decision to exit include, alone or in combination: low enrollment (see ***Section 3.2, Eligibility and Enrollment***), the administrative burden associated with the care model (see ***Section 3.3, Care Coordination***) and reporting; or the financing and rate methodology for FIDA (see ***Section 3.5, Financing and Payment***).

Figure 1
The number of MMPs participating in the FIDA demonstration by year



During the reporting period, MMPs acknowledged that many of their concerns about the FIDA demonstration had been addressed through the design changes implemented in 2015 or later. However, they continued to perceive that FIDA was burdened by:

- its early negative reputation, which deterred provider participation and beneficiary enrollment;
- rates that compared poorly to MAP and MLTC; and
- a higher level of administrative costs associated with the care model, reporting, and beneficiary protections.[12]

Impact of Prior MA and MLTC Experience on MMP Longevity in FIDA

Prior experience operating Medicare managed care and Medicaid MLTC products appears to have had some relationship to an MMP's continued participation in FIDA and its share of FIDA enrollees. Of the 21 MMPs that participated in FIDA at its launch, eight were already operating large Medicare Advantage plans (defined here as having more than 10,000 enrollees). Of the 13 plans with lower Medicare Advantage enrollment levels, 11 also had lower enrollments in their MLTC products; 9 of these dropped out of the demonstration. [13]

The State allowed all qualifying MLTC plans to participate in the demonstration instead of going through a competitive procurement process. Based on the attrition of MMPs with less

[12] For example, although NYSDOH had relaxed the requirements for translating beneficiary materials and providing paper copies of provider directories, one MMP still saw the cost of producing beneficiary materials as excessive, given the size of the program.
[13] For more detail on the prior experience of the MMPs, please refer to ***Table 3*** in the First Evaluation Report.

MA and MLTC experience, especially in the original 3-year demonstration period, these plans were not able to make FIDA a viable product. No plans with small pre-demonstration MA enrollments, and fewer than one-half of plans with small pre-demonstration MLTC enrollment, chose to participate during the extension period, 2018–2019.

The three MMPs with substantial prior experience in both Medicare Advantage and MLTC accounted for 93 percent of FIDA enrollment at the start of the final demonstration year (2019). These plans also had other advantages to explain their longevity in the demonstration: a larger pool of MLTC enrollees to transition to FIDA, established Medicare and Medicaid provider networks, and larger organizations able to absorb administrative costs and losses associated with launching their FIDA plans.

3.2 Eligibility and Enrollment

FIDA enrollment continued its steady decline from 2017 through 2019, with only a small percent of eligible beneficiaries participating in the demonstration.

CMS and NYSDOH successfully developed and implemented a transition process to passively enroll remaining FIDA enrollees into MAP-participating D-SNP plans, aimed at minimizing disruptions in care.

In this section we provide updates in eligibility and enrollment processes, including integration of eligibility systems, enrollment methods, and outreach. We also outline significant events affecting enrollment patterns during the timeframe covered by this report.

3.2.1 Implementation Enrollment Activities

Enrollment continued its steady decline during FIDA's last 3 years, from 4,744 in January 2017[14] to 2,320 at the end of the demonstration in December 2019.[15] There were no changes in demonstration eligibility criteria during this time, and enrollment continued on an opt-in only basis. In accordance with the three-way contract (CMS 2018a), the demonstration ceased accepting new enrollments on May 20, 2019, with an effective date of June 1, 2019.

In 2017, CMS and NYSDOH developed a strategy to facilitate passively enrolling FIDA enrollees of non-renewing plans into one of the remaining plans in the same region for the new plan year by using an "intelligent assignment" process based on enrollees' current providers. This allowed enrollees to remain enrolled in the integrated FIDA demonstration when their plan ended its demonstration participation, without having to take any action. CMS shared enrollee contact information with the MMPs so that the exiting MMPs could share enrollees' care plans with the receiving MMPs.

[14] RTI, SDRS, 2017.
[15] NYSDOH: https://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/. As obtained on March 16, 2020.

CMS tracked transfer of care plans between FIDA plans to ensure this had happened. NYSDOH also required the exiting plans to provide updates on their enrollees' Medicaid eligibility recertification to minimize disruptions when the enrollees were passively enrolled into new plans. Additionally, NYSDOH decided not to passively enroll enrollees who had not been Medicaid certified by mid-December prior to the start of 2018 and 2019. CMS and the State noted that these measures created a smoother passive enrollment process for non-renewing plans in 2018 and 2019 than in previous years.

In 2018, CMS noted that the plans had not conducted many marketing and outreach activities during the year. With the end of the demonstration in sight, there was little incentive for plans to try to increase their enrollment. MMPs in 2018 confirmed that they had not put much effort into marketing and outreach and that they expected their enrollment to remain flat in 2019. One plan said it averaged between 5 and 10 new enrollments per month, usually from enrollees who had seen a billboard or bus shelter sign and decided to enroll. The plan also said that it averaged around 30 disenrollments per month, usually due to member deaths.

MMPs said providers and beneficiaries did not understand the full benefit of the FIDA demonstration. In 2018, one MMP voiced frustration with the 2016 NYSDOH-sponsored advertising campaign that did not give information about how the demonstration compared to MLTC in terms of enhanced care management of Medicaid and Medicare benefits. Beneficiary reluctance to change from a plan that already met their needs, without understanding what additional benefits they might receive under FIDA, also contributed to low enrollments according to the MMPs.

From 2015 through 2017, enrollment only ranged from 3.2 percent to 7.7 percent of eligible beneficiaries (see ***Table 2***).[16] After a peak in late 2015, enrollment steadily declined.

Table 2
Demonstration enrollment, last month of quarter: January 1, 2015–December 31, 2017

Quarter	Beneficiaries eligible to enroll in FIDA	FIDA enrollment	Enrollment as a Percent of eligible beneficiaries	Percent change in enrollment
2015				
Q1	76,339	640	0.8	N/A
Q2	80,595	3,797	4.7	493
Q3	85,444	6,542	7.7	72
Q4[a]	89,007	6,199	7.0	−5

(continued)

[16] Although States may consider enrollees receiving comprehensive benefits in other Medicare products (e.g., Medicare Advantage) eligible to opt in, the RTI evaluation does not consider these enrollees eligible for the demonstration while they are enrolled in another product.

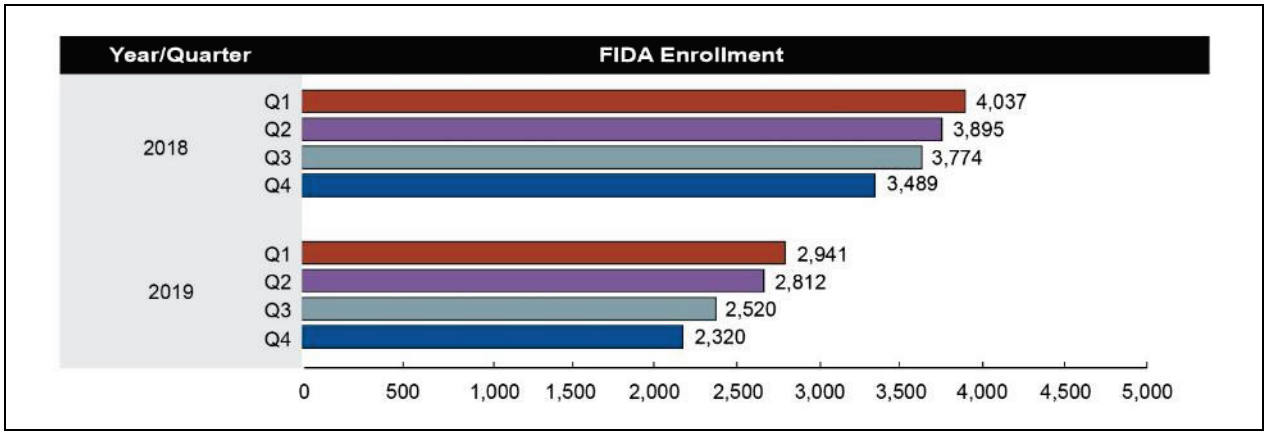
Table 2
Demonstration enrollment, last month of quarter: January 1, 2015–December 31, 2017 (continued)

Quarter	Beneficiaries eligible to enroll in FIDA	FIDA enrollment	Enrollment as a Percent of eligible beneficiaries	Percent change in enrollment
2016				
Q1	94,276	5,577	6.0	−10
Q2	99,053	5,229	5.3	−6
Q3	102,015	4,941	4.8	−6
Q4	106,386	4,672	4.4	−5
2017				
Q1	113,572	4,477	3.9	−4
Q2	120,281	4,423	3.7	−1
Q3	118,728	4,252	3.6	−4
Q4	128,046	4,158	3.2	−2

FIDA = Fully Integrated Duals Advantage; N/A = not applicable.
[a] Passive enrollment ended in Quarter, 2015.
SOURCE: RTI International: State Data Reporting System (SDRS). 2015–2017.

In 2018 and 2019, the final demonstration years, enrollment continued to decline (see ***Figure 2***).[17]

Figure 2
Demonstration enrollment, last month of quarter, January 1, 2018–December 31, 2019



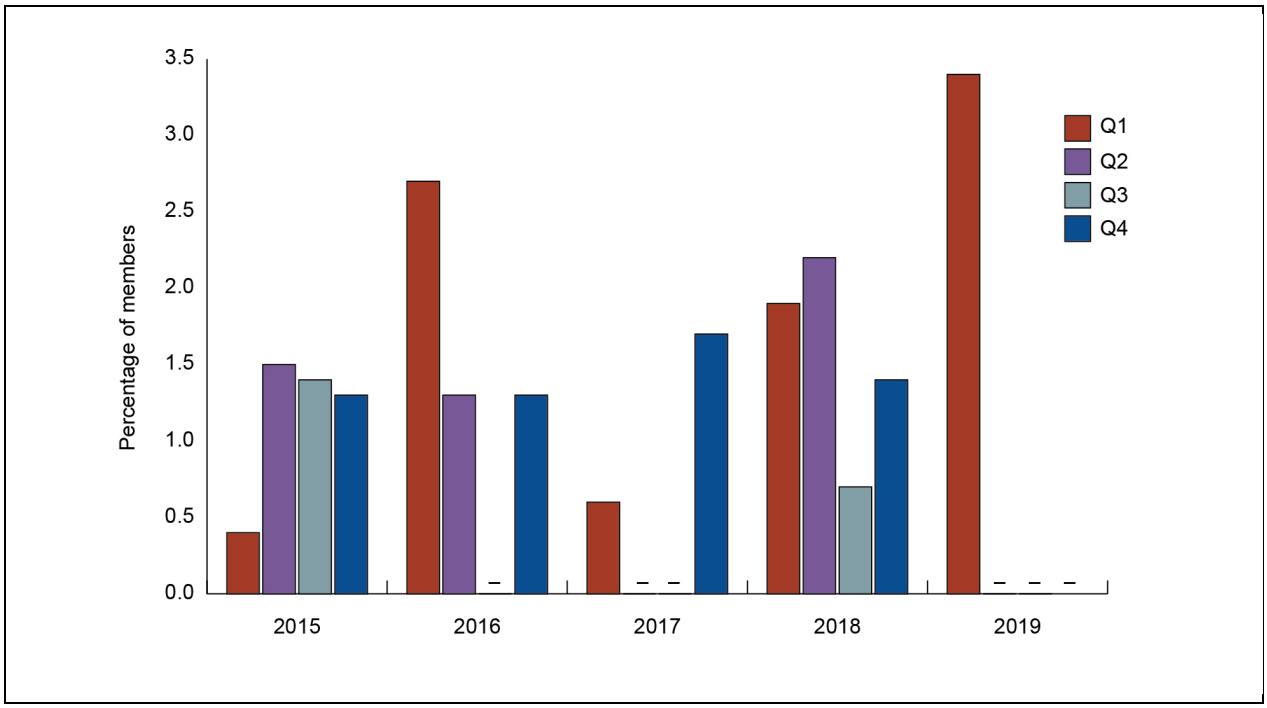
SOURCE: NYSDOH Medicaid Managed Care Enrollment Reports, 2018–2019, https://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/. Accessed March 16, 2020.

[17] New York did not submit SDRS data beyond 2017. Eligibility data are not available for these years.

3.2.2 Locating Beneficiaries

Locating beneficiaries within 90 days of enrollment was not a major challenge in FIDA. Most FIDA enrollees had been members of MMPs' sister MLTC plans prior to joining FIDA, so MMPs had access to current enrollee contact information. As indicated in ***Figure 3***, the percentage of enrollees who could not be reached within 90 days of enrollment was consistently very low throughout the demonstration (2015–2019), ranging from 0.0 percent in several quarters to 3.4 percent in quarter 1 of 2019.

Figure 3
Percentage of members that New York FIDA plans were unable to reach following three attempts, within 90 days of enrollment, 2015–2019



– = data are not available. Q = quarter.
NOTES: In quarter 4, 2019, the MMPs reported 0 for each data element because there were no new enrollees that met measure criteria. Some plans dropped out of the demonstration. Data for Arch Care Community Advantage, Emblem Health Dual Assurance, HealthPlus Amerigroup, and Integra FIDA plans are not included for 2016 and forward. Data for Aetna Better Health, Inc., Independence Care System, Inc., New York State Catholic Health Plan, Inc., and North Shore L-J Health Plan, Inc. are not included for 2018 and 2019. Data for GuildNet, Inc., AgeWell New York, LLC, MetroPlus Health Plan, and Village Senior Services Corporation are not included for 2019.
SOURCE: RTI analysis of MMP-reported data for Core Measure 2.1 as of July 2020. The technical specifications for this measure are in the Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements document.

3.2.3 Waiver of Changes to Enrollment Lock-in Policy

CMS created new lock-in policies allowing Medicare Advantage (MA) plans to limit member changes in enrollment to once per quarter, starting in 2019. Given that new enrollments to FIDA were to cease in June 2019, NYSDOH used a Medicare waiver to keep the

disenrollment policy on a monthly basis rather than changing the policy just for the last several months of the demonstration.

Throughout the demonstration, MMPs voiced concerns about the administrative and financial burden of not being able to lock enrollees into their membership for longer than a month at a time. At the beginning of the demonstration, MMPs increased their staff to accommodate thousands of passively enrolled members, only to have most members disenroll within a short period of time. Even after passive enrollment stopped in 2015, MMPs described enrolling a member, sending out member materials, and conducting an assessment, only to have the member disenroll the next month. Had FIDA continued beyond 2019, with a change in MA policy, the State had the option to lock in enrollees on a quarterly basis.

3.2.4 Transition Enrollment Activities

MMP Marketing Activities

In 2019, key informants said communication about the end of FIDA from the MMPs to enrollees and other stakeholders throughout the year enabled a smoother transition, compared to the demonstration rollout in 2015.[18] In spring 2019, MMPs asked CMS and NYSDOH for permission to discuss available options with their enrollees; in previous years, MMPs had been prohibited from directly marketing their alternative products to FIDA enrollees. CMS and NYSDOH allowed MMPs to talk with their enrollees about their 2019 sister plan options in spring and summer 2019, using approved scripts. Only two plans pursued these early outreach activities. All MMPs had to wait until October 2019 to begin marketing the 2020 plan options to their enrollees. While some FIDA enrollees voluntarily chose the alternative products before the end of the demonstration, most were passively enrolled into sister MAP-participating D-SNP plans. In 2019, the State and MMPs said the ability to speak with enrollees about the upcoming changes several months in advance of the passive enrollment effective date eased the transition.

Passive Enrollment into MAP-participating D-SNPs

To further ease the transition and limit negative effects on beneficiaries at the demonstration's end, in 2019 CMS and NYSDOH developed a passive enrollment process into MAP-participating D-SNPs for FIDA enrollees who had not already chosen other products earlier in the year. As a first step, CMS and NYSDOH conducted analyses to ensure that the benefits available under MAP-participating D-SNP plans were comparable to FIDA benefits.

On the Medicaid side, FIDA covered additional services not available in MAP plans such as palliative care, structured day programs, social day care, transportation, and home maintenance. NYSDOH analyzed utilization of these additional services in 2016 and 2017 and found they accounted for less than 0.02 percent of the per member per month capitation in each year. NYSDOH concluded the Medicaid benefit packages under FIDA and MAP were sufficiently similar because the extra benefits available under FIDA were rarely used.

[18] The roll-out of the demonstration caused significant disruptions in enrollees' relationships with their Medicare providers. For more information on this and other challenges related to passive enrollment, see the First Evaluation Report.

On the Medicare side, CMS analyzed the networks and benefits available in the MAP-participating D-SNP plans. To receive enrollees through passive enrollment, a FIDA plan's sister MAP-participating D-SNP plan had to meet the following Medicare criteria:

- Existing Medicare providers for the FIDA plan and MAP-participating D-SNP had to be comparable;
- Medicare benefits between the FIDA plan and MAP-participating D-SNP had to be similar;
- Premium and cost-sharing between the FIDA plan and MAP-participating D-SNP had to be similar; and
- Medicare payment for the MAP-participating D-SNP had to be less than or equal to the Medicare fee-for-service rate.

Using these criteria, CMS concluded that 96 percent of FIDA enrollees would be eligible for passive enrollment into a MAP-participating D-SNP product.

The transitional passive enrollment process presented some policy and operational challenges. Under the demonstration, MAXIMUS, the State's Medicaid enrollment broker, provided an integrated enrollment process by administering both Medicare and Medicaid enrollment transactions, and also handled annual passive enrollment transactions for non-renewing MMPs.

Outside of the demonstration, MAXIMUS did not have the authority to passively enroll FIDA enrollees into MAP-participating D-SNPs. Therefore, the enrollment process reverted to the pre-demonstration divided procedure: the MMPs sent the State a list of enrollees, to determine their eligibility for passive enrollment into a D-SNP owned by the same parent organization. The State sent the list to Maximus to confirm enrollee eligibility. After confirmation, the State sent the list to the sister D-SNP plans which then submitted the enrollment transactions to CMS. After the Medicare transactions were completed, MAXIMUS then administered the Medicaid enrollment transaction for the State. Data transfer issues between the plans and CMS resulted in missed transaction deadlines, but CMS resolved them before the January 1, 2020 effective date.

Similar to the process developed for non-renewing MMPs in previous years (discussed earlier in this section), CMS and NYSDOH asked the FIDA MMPs to transfer the medical records and care plans of their enrollees who chose to enroll in competing products, including MLTC or MAP products, instead of being passively enrolled into a sister MAP-participating D-SNP under the same MMP parent organization. CMS and the State worked with the MMPs and MAXIMUS to make sure that the receiving plans had the information necessary to avoid any gaps in the enrollees' records and care.

3.3 Care Coordination

CMS, NYSDOH, and MMPs held favorable views of the FIDA care coordination model and service authorization through the Person-Centered Service Plan (PCSP).

MMPs varied in their implementation of the care model: some conducted face-to-face meetings with enrollees as envisioned in the three-way contract, whereas others conducted telephonic meetings.

Engaging primary care providers in the IDT continued to challenge MMPs.

In this section we provide a summary of the FIDA care coordination model. We highlight the status of and major accomplishments in key care coordination components and processes: assessment, care planning, and information exchange.

3.3.1 FIDA Care Coordination Model

Over the last 3 years of the demonstration, the State, CMS, and the MMPs held favorable views of the care coordination model of the IDT with a care manager[19] coordinating both Medicaid and Medicare benefits for enrollees. MMPs felt that the care coordination model successfully decreased fragmentation of services. Although MMPs generally supported the care model, some noted that FIDA imposed a higher administrative burden than MLTC or MAP programs. For example, one MMP said its MAP care managers provide the same level of service but are not required to have a formal IDT meeting to generate a Person-Centered Service Plan (PCSP), as is required for FIDA.

Assessment

The percentage of all enrollees, as well as enrollees who were willing to participate and could be reached, with an assessment completed within 90 days of enrollment remained high throughout the demonstration (2015–2019), ranging from 90.7 percent to 99.3 percent (see ***Table 3***).

[19] In the FIDA demonstration, "care manager" is used instead of "care coordinator."

Table 3
Members whose assessments were completed within 90 days of enrollment, 2015–2019

Quarter	Total number of members whose 90th day of enrollment occurred within the reporting period and who were currently enrolled at the end of the reporting period	Percentage of assessments completed within 90 days of enrollment	
		All members	All members willing to participate and who could be reached
2015			
Q1	230	99.1	99.6
Q2	2,090	92.6	95.9
Q3	2,623	92.6	96.3
Q4	2,848	91.0	93.5
2016			
Q1	377	90.7	95.8
Q2	157	95.5	97.4
Q3	121	98.3	98.3
Q4	159	96.9	98.1
2017			
Q1	334	98.2	99.4
Q2	176	99.4	100.0
Q3	405	98.5	98.5
Q4	173	98.3	100.0
2018			
Q1	521	95.8	98.0
Q2	135	97.0	100.0
Q3	138	99.3	100.0
Q4	142	97.9	99.3
2019			
Q1	385	96.4	100.0
Q2	65	98.5	100.0
Q3	37	97.3	100.0
Q4	0	N/A	N/A

N/A = data are not applicable. Q = quarter.
NOTES: In quarter 4, 2019, the MMPs reported 0 for each data element because there were no new enrollees that met measure criteria. Some plans dropped out of the demonstration. Data for Emblem Health Dual Assurance, HealthPlus Amerigroup New York LLC, and Integra MLTC, Inc. FIDA plans are not included for 2016 and forward. Data for Aetna Better Health, Inc., Independence Care System, Inc., New York State Catholic Health Plan, Inc., and North Shore L-J Health Plan, Inc. are not included for 2018 and 2019. Data for GuildNet, Inc., AgeWell New York LLC, MetroPlus Health Plan, Inc., and Village Senior Services Corporation are not included for 2019.
SOURCE: RTI analysis of MMP-reported data for Core Measure 2.1 as of July 2020. The technical specifications for this measure are in the Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements document.

IDT Meetings and Care Management

In 2017, CMS and NYSDOH said they had envisioned FIDA care managers conducting IDT meetings with their enrollees in person but acknowledged that MMPs varied in how they implemented this model. During the reporting period (2017–2019), some MMPs said they conducted IDT meetings by telephone, and others conducted them in person. Ombudsman representatives in 2017 described variation in how plans appeared to execute the model with some MMPs fully embracing it and others appearing to do minimal coordination.

Although there was variation in how MMPs conducted IDT meetings, in 2017–2019 the Ombudsman office and beneficiary advocates characterized FIDA care managers, in general, as different from MLTC and MAP care managers. The Ombudsman office suggested FIDA care managers could respond more quickly to changes in enrollees' needs compared to their MLTC and MAP counterparts. The Ombudsman office noted that FIDA care managers had lower turnover and more accessibility for enrollees, compared to MLTC and MAP care managers, and that FIDA care managers' smaller caseload potentially explained their higher level of responsiveness.

In 2019, beneficiary advocates attributed an increased level of coordination and integration to the single capitated payment in the FIDA model and the explicit role of care managers to manage all LTSS, primary, acute and behavioral health services. With a single payment covering all Medicare and Medicaid services, MMPs had a financial incentive to manage all aspects of their enrollees' care to maximize their ability to stay healthy in the community and minimize avoidable high-cost care. Care managers from multiple MMPs said their ability to coordinate both acute care and LTSS services enabled them to more effectively manage their enrollees' care needs compared to MLTC products. In 2018 and 2019, MMPs and advocates saw care coordination under FIDA as particularly effective for frail enrollees.

As the number of participating plans decreased each year of the demonstration, the total number of care managers decreased , from 467 in 2015 to 47 in 2019 (see ***Table 4***). From 2015 to 2019, the care manager turnover rate varied, with a low of 12 percent in 2016 and a high of 27 percent in 2017. Overall, average caseloads increased after a low of 20 in 2015 to highs of approximately 70 in 2017 and 2018, with 2019 slightly lower, at 52.

Table 4
Care coordination staffing, 2015–2019

Calendar year	Total number of participating plans	Total number of care coordinators (FTE)	Percentage of care coordinators assigned to care management and conducting assessments	Member load per care coordinator assigned to care management and conducting assessments	Turnover rate (%)
2015	21	467	69.0	20.4	14.6
2016	17	150	84.7	38.4	12.3
2017	14	81	75.3	71.5	27.0
2018	10	56	85.7	70.3	26.3
2019	6	47	93.6	52.5	24.2

FTE = full time equivalent.
NOTES: Some plans dropped out of the demonstration. Data for Emblem Health Dual Assurance, HealthPlus Amerigroup New York LLC, and Integra MLTC, Inc. FIDA plans are not included for 2016 and forward. Data for Aetna Better Health, Inc., Independence Care System, Inc., New York State Catholic Health Plan, Inc., and North Shore L-J Health Plan, Inc. are not included for 2018 and 2019. Data for GuildNet, Inc., AgeWell New York LLC, MetroPlus Health Plan, Inc., and Village Senior Services Corporation are not included for 2019.
SOURCE: RTI analysis of MMP-reported data for Core Measure 5.1 as of July 2020. The technical specifications for this measure are in the Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements document.

Person-Centered Service Plan (PCSP)

From 2017 through 2019, MMPs reported that service authorizations under FIDA were simpler than under other products.[20] The PCSP produced by the IDT amounted to an authorization of services as long as the services were within the scope of practice of the professionals participating in the IDT.[21] For example, the care manager was able to authorize the number of hours of homecare provided based on the assessment and consultation with the care team. In the MLTC program, care management and utilization management were separate, and decisions about homecare hours were made by utilization management.

[20] As discussed in the First Evaluation Report, in the early phases of FIDA implementation some MMPs were confused about service authorization requirements under FIDA and mistakenly imposed unnecessarily burdensome prior authorization requirements on providers. NYSDOH issued guidance to clarify prior authorization requirements going forward (NYSDOH, 2016).
[21] If a physician did not take part in the IDT, medical services requiring physician approval were authorized through the MMP's utilization management process.

Table 5 shows that the percentage of all enrollees that had a PCSP completed within 30 days of initial assessment or reassessment varied from 17.1 to 36.8 percent for the three quarters in 2015 during which this measure was active. The percentage of enrollees with a completed PCSP who were not documented as unwilling to complete a PCSP or unreachable varied within a similar range. This State-specific measure changed in quarter 4 of 2015; see ***Tables 6*** and *7*.

Table 5
Members with PCSPs completed within 30 days of initial assessment and each reassessment, quarters 1 through 3, 2015

Quarter	Total number of members with an initial assessment or reassessment completed during the reporting period	Percentage of PCSPs completed within 30 days of initial assessment or reassessment	
		All members	All members not documented as unwilling to complete a PCSP or unreachable
2015			
Q1	782	36.8	38.0
Q2	3,046	17.1	18.2
Q3	3,368	22.6	23.7

PCSP = Person-Centered Service Plan; Q = quarter.
NOTES: Data presented for Quarters 1–3, 2015, reflect the number of members with PCSPs completed within 30 days of initial assessment or reassessment. The State measure NY 2.1 changed in quarter 4 of 2015. See Tables 6 and 7.
SOURCE: RTI analysis of MMP-reported data for State-specific measure NY 2.1 as of July 2020. The technical specifications for this measure are in the Medicare-Medicaid Capitated Financial Alignment Model New York FIDA-Specific Reporting Requirements document.

Table 6 shows that the percentage of all enrollees that had a PCSP completed within 90 days of enrollment varied greatly, from 32.5 to 91.5 percent, with most percentages close to the higher end of the range beginning in late 2016. The percentage of enrollees with a completed PCSP who were not documented as unwilling to complete a PCSP or unreachable followed a similar pattern, increasing after a low of 33.2 percent in late 2015 to noticeably higher percentages beginning in 2016, with all percentages in the 90 percent range in 2017. This State-specific measure was retired in quarter 1 of 2018; PSCP data were thereafter (in 2018 and 2019) reported under a core measure (see ***Table 7***).

Table 6
Members with a PCSP completed within 90 days of enrollment, 2015–2017

Quarter	Total number of members whose 90th day of enrollment occurred within the reporting period	Percentage of members with a PCSP completed within 90 days of enrollment	
		All members	All members not documented as unwilling to complete a PCSP or unreachable
2015			
Q4	3,198	32.5	33.2
2016			
Q1	390	67.7	70.2
Q2	167	78.4	81.4
Q3	126	88.1	89.5
Q4	168	83.3	85.4
2017			
Q1	343	91.5	92.9
Q2	187	90.4	93.9
Q3	426	88.7	90.0
Q4	185	91.4	93.4

PCSP = Person-Centered Service Plan; Q = quarter.
NOTES: Data for Arch Care Community Advantage, Emblem Health Dual Assurance, HealthPlus Amerigroup, and Integra FIDA plans are not included for 2016 and 2017. These plans dropped out of the demonstration. The State-specific measure NY 2.1 was retired in quarter 1 of 2018; PSCP data for 2018 and 2019 are presented in Table 7 as the Core Measure 3.2.
SOURCE: RTI analysis of MMP-reported data for State-specific measure NY 2.1 as of July 2020. The technical specifications for this measure are in the Medicare-Medicaid Capitated Financial Alignment Model New York FIDA-Specific Reporting Requirements document.

Table 7 shows the percentage of all enrollees that had a PCSP completed within 90 days of enrollment remained high, ranging from 89.1 to 97.3 percent. The percentage of enrollees with a completed PCSP who were not documented as unwilling to complete a care plan or unreachable remained high as well, ranging from 91.9 to 100.0 percent. We report data for this core measure beginning in 2018 because the New York FIDA-specific measure NY 2.1 was retired in January 2018.

Table 7
Members with a care plan completed within 90 days of enrollment, 2018–2019

Quarter	Total number of members whose 90th day of enrollment occurred within the reporting period and who were currently enrolled at the end of the reporting period	Percentage of members with a care plan completed within 90 days of enrollment	
		All members	All members not documented as unwilling to complete a care plan or unreachable
2018			
Q1	521	89.1	91.9
Q2	135	91.9	94.7
Q3	138	92.8	94.1
Q4	142	92.3	96.3
2019			
Q1	385	96.6	96.9
Q2	65	96.9	98.4
Q3	37	97.3	100.0
Q4	0	N/A	N/A

N/A = data are not applicable. Q = quarter.
NOTES: In quarter 4, 2019, the MMPs reported 0 for each data element because there were no new enrollees that met measure criteria. Data for Aetna Better Health, Inc., Independence Care System, Inc., New York State Catholic Health Plan, Inc., and North Shore L-J Health Plan, Inc. are not included for 2018 and 2019. Data for GuildNet, Inc., AgeWell New York LLC, MetroPlus Health Plan, Inc., and Village Senior Services Corporation are not included for 2019.
SOURCE: RTI analysis of MMP-reported data for Core Measure 3.2 as of July 2020. The technical specifications for this measure are in the Medicare-Medicaid Capitated Financial Alignment Model New York FIDA-Specific Reporting Requirements document.

As shown in ***Table 8***, the percentage of enrollees with at least one documented discussion of care goals remained high throughout the demonstration with a low of 87.5 percent in late 2015 and the majority of other values close to or equal to 100.

Table 8
Members with documented discussion of care goals, 2015–2019

Calendar year	Total number of members with an initial PCSP completed	Percentage of members with at least one documented discussion of care goals in the initial PCSP
2015		
Q1	483	98.1
Q2	1,086	91.3
Q3	1,281	87.5
Q4	974	96.4
2016		
Q1	937	99.5
Q2	256	98.0
Q3	423	99.5
Q4	207	96.1
2017		
Q1	365	99.2
Q2	246	100.0
Q3	331	98.8
Q4	219	97.7
2018		
Q1	449	95.8
Q2	170	99.4
Q3	166	98.8
Q4	147	98.6
2019		
Q1	336	99.4
Q2	72	98.6
Q3	10	100.0
Q4	0	N/A

N/A = data are not applicable. PCSP = Person-Centered Service Plan; Q = quarter.
NOTES: There were no initial PCSPs completed in quarter 4, 2019, so the MMPs reported 0 for this data element. Some plans dropped out of the demonstration. Data for Emblem Health Dual Assurance, HealthPlus Amerigroup New York LLC, and Integra MLTC, Inc. FIDA plans are not included for 2016 and forward. Data for Aetna Better Health, Inc., Independence Care System, Inc., New York State Catholic Health Plan, Inc., and North Shore L-J Health Plan, Inc. are not included for 2018 and 2019. Data for GuildNet, Inc., AgeWell New York LLC, MetroPlus Health Plan, Inc., and Village Senior Services Corporation are not included for 2019.
SOURCE: RTI analysis of MMP-reported data for State-specific Measure NY 2.2 as of July 2020. The technical specifications for this measure are in the Medicare-Medicaid Capitated Financial Alignment Model New York FIDA-Specific Reporting Requirements document.

Provider Engagement and Communication

Although IDTs were intended as a vehicle to ensure provider involvement in care planning and interdisciplinary communication, they had mixed success. Most of the MMPs interviewed from 2017 through 2019 had difficulties engaging PCPs in IDT meetings, even after the IDT provider requirements were relaxed. For example, an MMP in 2019 said that while it was able to contact PCPs quickly to address specific issues, most PCPs did not welcome having a regular update call. An exception was an MMP in 2018 that paid PCPs a "medical management fee." This plan's PCPs more regularly participated in IDT meetings, usually via telephone; the care manager was able to offer a billing code allowing providers to bill for every 15 minutes they spent with the MMP's care manager in IDT meetings and other care management calls. The fee also covered the nurse's (or physician's) review of the PCSP to compensate for this time as well.

One MMP in 2019 said that through the IDT, behavioral health providers, nurse practitioners and home care attendants were able to give input into the care plan, even if a PCP was too busy to join the IDT. Three other MMPs reported that FIDA did not have a direct impact on how providers communicated with each other and the MMP. One MMP said its parent company's robust Health Information Exchange facilitated communication between providers and was available through all of its plans, not just the FIDA plan. The three-way contract strongly encouraged MMPs to use electronic health records (EHR) to facilitate information exchange, but in 2019, the State said it did not regularly ask if plans were using EHRs. The State noted that although larger plans might have the resources to implement an EHR, smaller ones likely would not.

3.3.2 Transition Care Coordination Activities

As the demonstration was winding down, MMPs considered aspects of FIDA that they thought worked well for the plans and their enrollees. In 2019, some MMPs reported trying to maintain the FIDA enrollees' care managers in the transition to MAP-participating D-SNP plans. Another MMP said it was exploring how to incorporate the PCSP into its MAP plans.

[T]he freedom to tailor the care plan goals and what's important to the member is something we would like to carry over.

— MMP (2019)

Another plan said it was going to maintain the IDT in their MAP-participating D-SNP in order to preserve the collaboration between disciplines.

3.4 Stakeholder Engagement

Most Participant Advisory Committee activity was devoted to resolving individual member issues rather than robustly engaging with enrollees in MMP policy development and direction.

A few MMPs changed policies and procedures based on member feedback.

In this section we describe stakeholder engagement activities during the period of this report and the impact of those efforts on the demonstration.

3.4.1 Medicare Rights Center

Throughout the demonstration, NYSDOH and CMS engaged with stakeholders through the Coalition to Protect the Rights of New York's Dually Eligible (CPRNYDE), a group of beneficiary advocacy organizations, including the Medicare Rights Center (MRC). The MRC was the primary point of contact between NYSDOH, CMS, and the CPRNYDE.[22] In 2018, the MRC said there had not been as much engagement with the State, CMS, or plans as earlier in the demonstration, and they met monthly instead of weekly because there were fewer issues to discuss. However, in 2019, MRC representatives were involved in discussions regarding beneficiary rights during the post-FIDA transition process described later in this section.

3.4.2 MMP Participant Advisory Committees

The demonstration required MMPs to convene Participant Advisory Committees (PACs) at least quarterly. In 2018, CMS and NYSDOH formally revised contract requirements to permit MMPs to allow remote enrollee participation to increase meeting accessibility, especially for frail enrollees. In 2017–2019, with some exceptions, MMPs reported struggling to attract participants to meetings. Most of the MMPs said that five to 10 people attended their PAC meetings, and that discussions tended to center on individual enrollees' issues.

However, a few MMPs changed elements of their operations because of feedback received through PACs. One MMP changed vendors of incontinence supplies after PAC members brought in examples of poor quality supplies. When its enrollees complained about the length of the care management phone call, another plan streamlined the call by revising a script. Another MMP changed its over-the-counter (OTC) card benefit amount to renew quarterly instead of monthly because PAC members said that certain items were too expensive for a monthly OTC amount but could be purchased by spreading the benefit amount over 3 months. One MMP in 2019 was so supportive of the PAC model that it shared information about it with its national organization. This MMP was also using the PAC model in its MAP and MLTC products.

[22] See the First Evaluation Report for more information on stakeholder engagement in the design of FIDA.

3.4.3 Transition Stakeholder Engagement Activities

MRC provided comments to the State and CMS after each "Future of Integrated Care" meeting held in 2017, but MRC representatives in 2018 said there was little follow up, and the State seemed already committed to moving forward with a D-SNP model. In 2019, however, an MRC representative noted that the MRC appreciated State and CMS efforts to engage with consumer advocates during the phase-out process. MRC successfully advocated for strong transition rights including a provision for 6 months of continuity of care for FIDA enrollees as they moved to new plans. MRC also identified areas of improvement in the phase-out notices that the State and FIDA Plans sent to FIDA enrollees which NYSDOH and CMS were able to incorporate into the notice. See ***Section 2.2, Overview of State Context,*** and ***Section 5.1, Post-FIDA Transition Activities,*** for more discussion of the 2017 Future of Integrated Care meetings.

3.5 Financing and Payment

CMS and NYSDOH tried to improve the parity in rates between FIDA and competing MLTC and MAP products during the last 3 years of the demonstration.

Financial concerns were a factor in MMP decisions to stop participating prior to the demonstration's scheduled end date.

In this section, we outline changes in financing and payment since 2016 (demonstration year 2) and relevant findings relating to these changes.

3.5.1 Improvements in Rate Comparability

In the early phases of implementation, FIDA Medicaid rates had been developed using a different methodology than that used for the MLTC and MAP program.[23] The inconsistency in rates created an incentive for MMPs to keep their enrollees in MLTC. This issue was identified early in the implementation phases and NYSDOH made some corrections to address it. (See the First Evaluation Report for more information.)

In 2017, some MMPs agreed that adjustments to Medicaid rates had made FIDA payments more comparable to those under MLTC and MAP. However, one MMP noted that the MLTC and MAP have a different, and more favorable, methodology for mitigating risk associated with high-cost, high-need patients. In addition to risk corridors, the MLTC and MAP programs also use what this MMP characterized as "reinsurance" to reduce the impact of outliers: the managed care organizations contribute to a risk pool that is distributed to the MLTCs and MAPs in proportion to their share of high-cost, high-risk enrollees. In the absence of this risk mitigation mechanism, this MMP believed a few high-cost, high-need patients could have a big impact on an MMP with low enrollment.

[23] The FIDA rates had been developed using an actuarial firm, while MLTC rates had been developed by NYSDOH.

In late 2017, NYSDOH reformed its Medicaid rate setting methodology again, to simplify and create greater consistency across its MLTC, MAP, and FIDA programs. The new methodology used a uniform base rate for medical expenses that were common across these programs and adjusted the base rate for acuity for each program, and then for each plan. The changes better reflected the higher acuity of FIDA enrollees and their use of nonmedical expenses including care management. However, in 2018, the State said that despite efforts to align FIDA rates with the competing products, "we were still asking plans to deliver a richer benefit with more administrative duties and care management duties, and not giving them any additional dollars for it."

MMPs also identified an important bias in the Medicare rate setting methodology. Under an MA plan that is aligned with a MAP plan and operates as a FIDE-SNP, rates for plans that meet eligibility criteria are adjusted based on a "frailty factor" that reflects predicted Medicare expenditures based on the functional status of the population. MA plan payments for many FIDE-SNPs under New York's MAP program include the frailty factors, but the Medicare rates under FIDA did not.

As of 2015, CMS adjusted upwards the MMP Medicare Parts A and B baseline rates to reflect the Medicare frailty adjustment that would have been paid to MA plans in the absence of the demonstration. Although the adjustment was not the same as a plan-specific frailty adjustment available to Medicare Advantage MAP plans, it was a material adjustment to the FIDA rates, unique to the FIDA demonstration. Effective in 2019, qualifying FIDA MMPs were eligible to receive the frailty adjustment. However, in 2019, the CMT said that, due to a technical issue, the payment system was programmed to recognize PACE and D-SNPs, not FIDA plans, and payment to MMPs was delayed.

3.5.2 MMP Cash Flow Issues and Cost Savings

In 2017, CMS, NYSDOH, and the MMPs recognized that the built-in cost savings of the FIDA rate setting process created cash flow problems for the MMPs, given their high start-up costs and low enrollment. The built-in aggregate savings percentages applied to the baseline Medicaid and Medicare Parts A and B costs, started at 1 percent in 2015 and increased annually through 2017 to 2.5 percent.[24] This saving percentage was intended to allow both payers to proportionally share in demonstration savings, regardless of underlying service use patterns.

However, in 2017 the built-in savings percentage, coupled with the quality withhold amounts of 3 percent of the capitation payment (see ***Section 3.6, Quality of Care***), resulted in the MMPs having a combined 5.5 percent lower capitation payment until they met the annual quality targets to receive the withheld amount. The built-in savings percentage was originally projected to increase to 3 percent in 2018 and 2019. In response to MMP cash flow concerns, CMS and NYSDOH held the savings percentage at 2.5 percent for the final 2 years of the demonstration (see ***Table 9***).

[24] The original aggregate saving percentage in demonstration year 3 (2017) was 3 percent, but due to more than one-third of FIDA MMPs experiencing losses greater than 3 percent in the first demonstration year, the aggregate savings percentage was reduced to 2.5 percent for year 3. Please see the First Evaluation Report for more information on aggregate savings percentage assumptions in the rate setting process.

Table 9
Percent of capitation payment reduced by built-in savings and quality withholds, by demonstration year

Measure	2015	2016	2017	2018	2019
Built-in cost savings percent applied to capitation payment	1	1.5	2.5	Projected: 3 Actual: 2.5	Projected: 3 Actual: 2.5
Quality withhold percent applied to the capitation payment	1	2	3	3	3
Sum of cost savings and quality withhold percentage of capitation payment	2	3.5	5.5	Projected: 6 Actual: 5.5	Projected: 6 Actual: 5.5

Three of the four MMPs interviewed in 2018 said it was difficult to realize any cost savings in the FIDA program. Another plan said that because so many enrollees with lower utilization disenrolled due to provider network issues, the plan became a catchment for the oldest and sickest enrollees with high utilization of home care services. This plan also said HCBS such as supervision of Activities of Daily Living[25] available in FIDA contributed to high costs, as many of its enrollees with cognitive impairment used this benefit.

Remember, this is an older senior population with multiple chronic conditions. It's unlikely they're going to return to good health at any point… they just have intense medical needs.

— MMP (2018)

Despite CMS and NYSDOH efforts to create greater parity in the FIDA rates and reduce MMP cash flow issues, financial concerns were a factor in MMPs' decisions to leave the demonstration early. In 2018, NYSDOH said that low enrollment prevented plans from spreading costs across their membership.

[25] Definitions of FIDA covered services including home and community-based services can be found in the three-way contract, pp. 236–68.

3.6 Quality of Care

The FIDA demonstration did not experience systemic issues relating to quality of care, and most MMPs received between 75 percent and 100 percent of their quality withhold payments in 2015–2019.

2018 HEDIS data were limited for several FIDA MMPs. However, relative to MA, most plans that met the sample size threshold for reporting performed favorably on HEDIS measures related to adults' access to preventive/ambulatory health services, antidepressant medication management – effective continuation phase treatment, and medical attention for nephropathy (within measures of diabetes control).

Where plans met the sample size criteria for reporting and data were available, year-over-year MMP performance remained relatively stable between 2015 and 2018.

In this section we provide information on the quality management structure and activities of the demonstration as well as results of HEDIS measures, a standard measurement set used extensively by managed care plans that are required of all MA plans.

3.6.1 Contract Management Team Quality Oversight

The CMT monitored the quality and performance of each MMP. In addition to monitoring CAHPS and HEDIS measures, NYSDOH and CMS regularly reviewed the following with each MMP:

- data from the CMS implementation contractor;
- the timeliness of IDT meetings, assessments, and reassessments;
- appeals;
- relevant reports from the Ombudsman;
- Medicare notices of noncompliance; and
- complaints and grievances.

In 2017, in response to findings from a CMT review of Integrated Care Denial Notices (ICDN), the CMT drafted a technical assistance document for the MMPs. Plans were advised on the three-way contract requirements of the ICDNs, such as requirements to:

- use the appropriate model of ICDN for different circumstances,
- use language easily understood by a layperson,
- provide a clinical rationale for denying a service, and
- obtain information from providers.

In 2018 , the CMT found no systemic issues impacting quality of care in the FIDA demonstration, but a few MMPs were required to submit performance improvement plans (PIP) for issues such as having a backlog of care plans that had not been completed, having poor quality care plans, not having a follow-up visit within 30 days after a hospital discharge, and issues related to the 2018 provider and pharmacy directory. The CMT issued one MMP a warning letter requiring it to submit a business plan explaining how it was going to fix an issue with processing appeals. Subsequent reviews by the CMT showed the MMP resolved the issue.

The CMT reviewed complaints, grievances, and appeals with MMPs monthly throughout the 2015–2019 implementation period, and discussed trends with the plans. Transportation and home care aides continued to be perennial sources of complaints, but these are common complaints in MLTC and MAP products, too. The MMPs and Ombudsman said the types of FIDA complaints were similar to those in MLTC and MAP products. For more information on the grievance and appeals process, see ***Section 4.2.1, Grievances and Appeals***.

3.6.2 Quality Measurement and Improvement

Like all MLTC plans in New York, FIDA MMPs submitted data from the State's standardized assessment tool, the Uniform Assessment System Community Health Assessment, to NYSDOH's Office of Quality and Patient Safety (OQPS) (NYSDOH, 2019). OQPS produces annual MLTC reports based on the measures. Some of the measures are descriptive, such as a count of how many enrollees were living alone. OQPS calculates statistical significance for other measures and compares them to the statewide average.

The MLTC reports also includes performance-over-time measures using two assessments for the same person conducted between 6 to 13 months apart. OQPS looks for stability or improvement over time and compares plans to the statewide average. The most recent MLTC report available at the time of this evaluation report was from 2018.[26] Three of the 10 MMPs participating in 2018 did not have a large enough sample size to report on all measures. For those MMPs with large enough enrollments, FIDA plans appeared comparable to the statewide averages on most measures (NYSDOH, 2018c).

As part of a streamlining process taking place across all FAI demonstrations, CMS handed responsibility to review the Medicare-related Quality Improvement Projects (QIPs) for FIDA to OQPS in January 2018. This aligned with CMS' broader QIP policy for MA plans that were no longer required to submit QIPs for CMS review. In 2018, OQPS said they were able to fold the QIP review into their well-established PIP review process with their External Quality Review Organization, iPRO. Although it did not encounter any issues with the process of incorporating the QIP reviews, OQPS noted that there were added costs to the State for the extra work.

[26] Annual New York Managed Long Term Care Reports can be found here: https://www.health.ny.gov/health_care/managed_care/mltc/reports.htm. As obtained on April 2, 2020.

3.6.3 Quality Improvement at the MMPs

During the reporting period, MMPs explained that their QIPs focused on a range of topics, including:

- falls prevention,
- emergency visits,
- advanced directives,
- depression management,
- diabetes management, and
- avoidable hospitalizations.

In 2017, one MMP reported improvements resulting from its QIPs, including a 13 percent reduction in falls. In 2019, one MMP worked on increasing enrollees' use of advanced directives because the plan's lawyers deemed many of the enrollees' forms invalid due to missing signatures or other issues. This plan's care managers were able to work with enrollees to increase the number of valid directives.

MMPs reported using HEDIS measures to monitor quality of their providers. One MMP in 2018 said that because its network was large but its FIDA enrollment was small, it grouped like-type members or like-type clinical issues together in order to give meaningful feedback to its providers on how they were doing. Another MMP in 2019 was surprised how difficult it was to get some of their enrollees to adhere to the health care service and screening recommendations that comprise the HEDIS measures. The plan's care managers educated enrollees about the value of vaccinations and cancer screenings and enlisted providers to encourage healthy behaviors.

3.6.4 Quality Withhold Payments

CMS and the State withhold a percentage of MMP capitation payments pending the achievement of quality targets. In June of 2018, CMS published the results of the quality withhold analyses covering the first 2 demonstration years (calendar years 2015 and 2016) (CMS 2018b; CMS 2018c). For 2015, when 21 MMPs were in the demonstration:

- 16 MMPs had 100 percent of the withhold payment returned after meeting at least 80 percent of the measure criteria
- Four received 75 percent of their withholds for meeting between 60 and 79 percent of the criteria
- One received 50 percent of its withhold payment for meeting between 40 and 59 percent of the criteria.

In 2016, when 17 plans were in the demonstration:

- Seven received 100 percent of their withhold payment
- Nine received 75 percent of their payment

- One plan received 25 percent of its payment for meeting between 20 and 39 percent of the criteria.

In August 2019, CMS published the results of the quality withhold analysis covering the third demonstration year, which covered calendar year 2017. Plans that terminated on or before January 1, 2019, were not eligible for a quality withhold payment. The amount that each terminated plan would have received was pooled and added to the amounts earned by the six MMPs still participating in the FIDA demonstration on January 1, 2019. For 2017, four of the six plans remaining in 2019 had 100 percent of the withhold payment returned after meeting at least 80 percent of the measure criteria. The other two received 75 percent of their withholds for meeting between 60 and 79 percent of the criteria (CMS 2018d). For 2018, three of the six plans remaining in 2019 had 100 percent of the withhold payment returned, and three plans had 75 percent of the withhold payment returned (CMS, 2020).

3.6.5 HEDIS Quality Measures Reported for FIDA Demonstration Plans

MMPs are required to report HEDIS data to CMS and the States. HEDIS is a measure set developed and maintained by the National Committee for Quality Assurance. It is used by the vast majority of commercial, Medicare, and Medicaid health plans to measure performance on dimensions of care and service in order to maintain and/or improve quality. In the FAI, MMPs report data on a subset of HEDIS measures that are required of all MA plans.

Thirteen Medicare HEDIS measures for MMP enrollees are reported in ***Figures 4–7*** and ***Tables B-1a–B-1c*** in ***Appendix B***. RTI selected this subset of available measures identified in RTI's Aggregate Evaluation Plan as well as the available HEDIS data on these measures for completeness, reasonability, and sample size; at least some 2018 calendar year data were available for all 10 FIDA MMPs, although three MMPs had sample sizes below 30 for almost all measures, which allowed reporting for only the two Ambulatory Care measures. Detailed descriptions of the measures can be found in the RTI Aggregate Evaluation Plan.[27] Results reported in ***Figures 4–7*** compare the 10 plans, with the exception of some measures where sample size was less than 30 beneficiaries, or where national MA plan mean data were not available for comparison, as with submeasures related to care of older adults.

We provide national MA plan means, where available, understanding that MA enrollees and demonstration enrollees may have different health and sociographic characteristics that would affect the results. Previous studies on health plan performance reveal poorer quality ratings for plans serving a higher proportion of dual eligible beneficiaries and beneficiaries with disabilities. To be eligible for FIDA, a member needs to require nursing facility level of care or 120 days of community-based long-term care. These eligibility requirements render FIDA enrollees as frailer and with a greater disability prevalence than their MA counterparts. Additionally, HEDIS measure performance, in particular, is slightly worse among plans active in areas with lower income and populations with a higher proportion of minorities (ASPE, 2016).

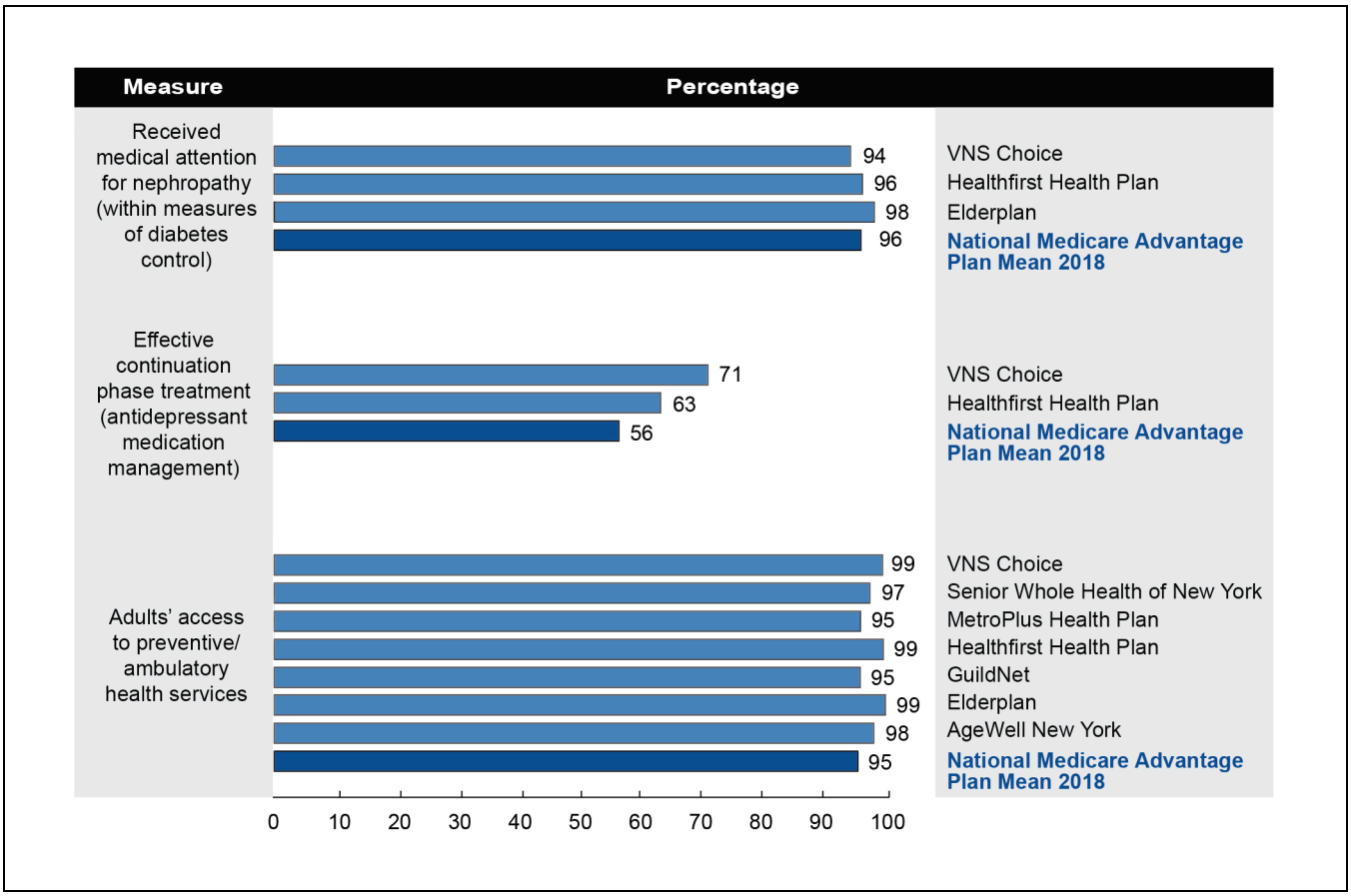
National MA plan means should be considered with these limitations in mind. Monitoring trends over time in MMP performance may be more important than the comparison

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

to the national MA plans given the population differences. Several years of HEDIS results are likely needed to know how well MMPs perform relative to each other and whether they perform above or below any potential benchmark.

The MMPs represented in the figures in this section are those that met the sample size thresholds for HEDIS measures. As shown in ***Figure 4***, most MMPs meeting the sample size threshold for reporting performed better than the respective national MA plan mean in calendar year 2018 for measures of adults' access to preventive/ambulatory health services, antidepressant medication management (effective continuation phase treatment), and medical attention for nephropathy (within measures of diabetes control).

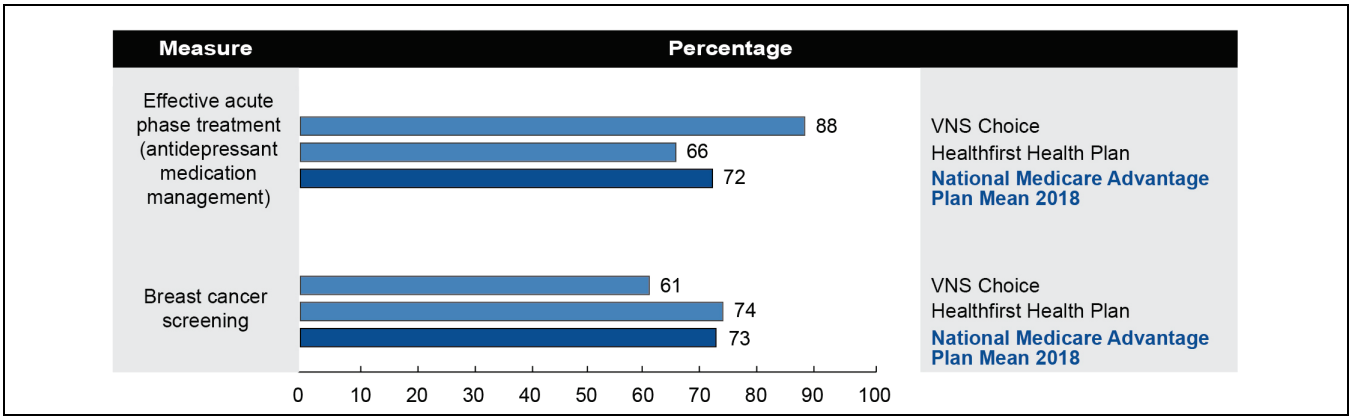
Figure 4
HEDIS measures[1] where most MMPs outperformed the National MA plan mean, calendar year 2018



[1] Reported performance rates for New York FIDA MMPs that satisfied sample size requirements.

Figure 5 shows that for another two measures (antidepressant medication management—effective acute phase treatment and breast cancer screening) performance was mixed, with about half of the MMPs that met the sample size threshold for reporting outperforming the respective national MA plan mean, and the other half not.

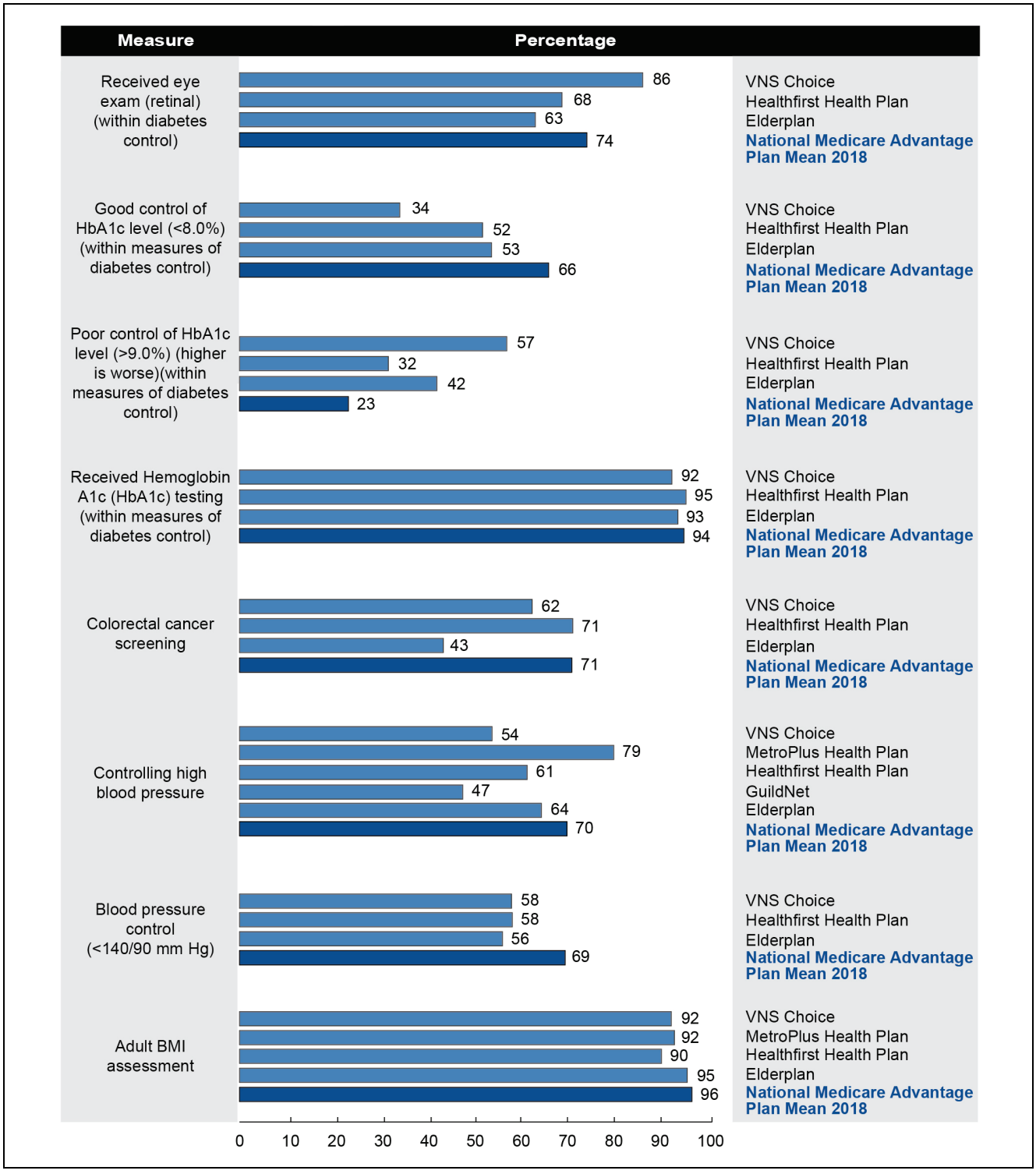
Figure 5
HEDIS measures[1] where MMP performance varied in comparison to the National MA plan mean, calendar year 2018



[1] Reported performance rates for New York FIDA MMPs that satisfied sample size requirements.

Figure 6 shows that for another eight measures, most MMPs that met the sample size threshold for reporting performed worse than the respective national MA plan means. Five of these measures were sub measures of Comprehensive Diabetes Care (HbA1c testing, control of HbA1c levels (poor and good), blood pressure control, and retinal eye exams).

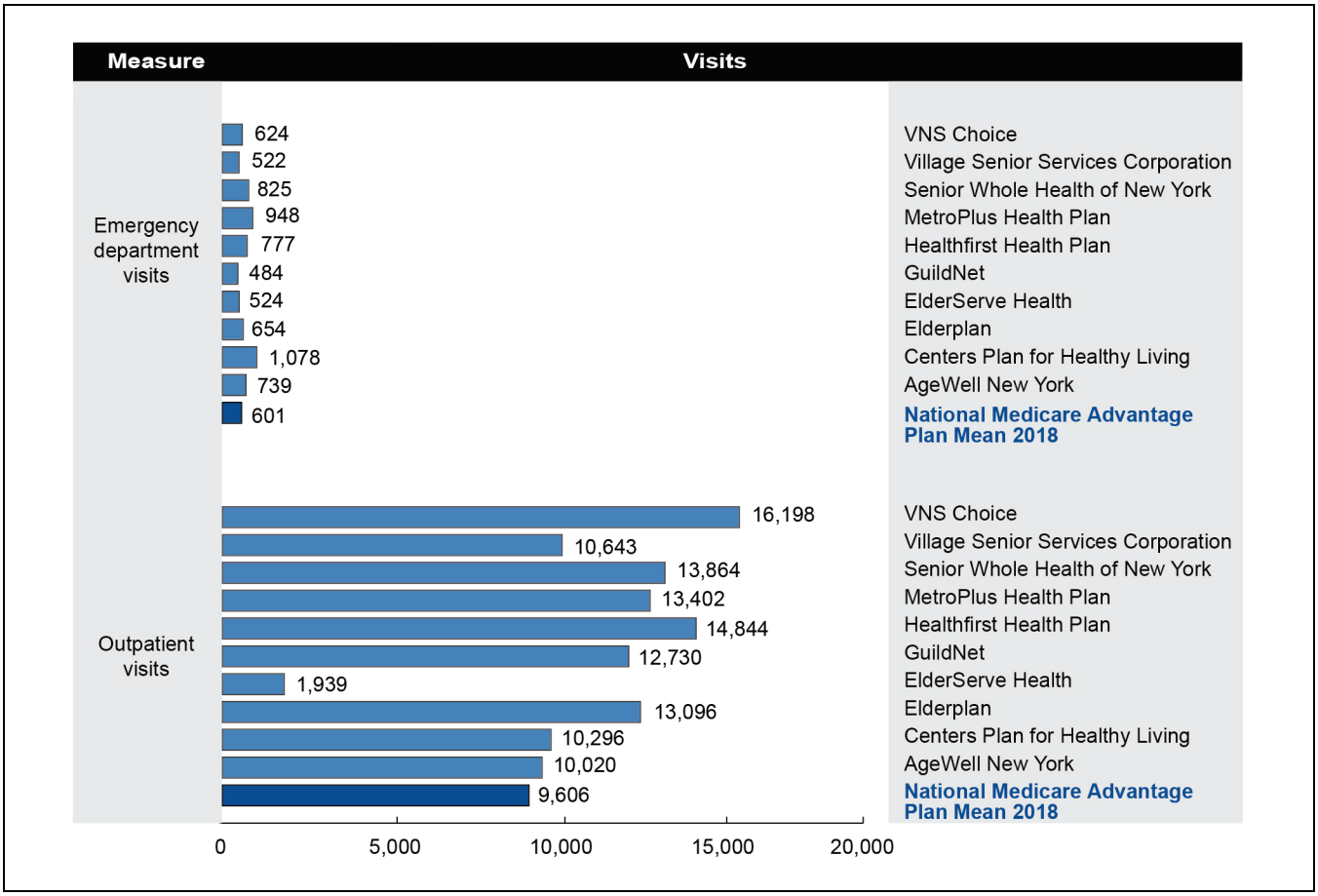
Figure 6
HEDIS measures[1] where most MMPs performed below the National MA plan mean, calendar year 2018



[1] Reported performance rates for New York FIDA MMPs that satisfied sample size requirements.

And as shown in ***Figure 7***, for measures of ambulatory care per 1,000 members (outpatient and emergency department [ED] visits), 9 out of 10 MMPs reported more outpatient visits than the respective national MA plan mean, which is desirable if MMPs are working to lower more expensive institutional use. However, 7 out of 10 MMPs reported a higher number of ED visits per 1,000 members than the respective national MA plan mean, which is undesirable.

Figure 7
Ambulatory care per 1,000 members[1]: MMP versus MA performance, calendar year 2018



[1] Reported as visit counts per 1,000 New York FIDA MMP members.

SECTION 4

Beneficiary Experience

CAHPS survey findings showed FIDA enrollee satisfaction generally increased over time, and enrollees' experience with care coordination was similar to that of MA plans and MMPs nationwide.

Most 2017 focus group participants were satisfied with FIDA, and described a higher level of satisfaction with FIDA than with their previous plans.

The successful integrated grievance and appeals process developed in FIDA will be continued in the MAP program under a 4-year §1115(A) demonstration.

4.1 Impact of the Demonstration on Beneficiaries

Improving the beneficiary experience of accessing Medicare and Medicaid services is one of the main goals of the demonstration. In this section we highlight beneficiary experience with FIDA and provide information on beneficiary protections, data related to complaints and appeals, and critical incident and abuse reports. We also include information on the experience of special populations.

For beneficiary experience, we draw on findings from the CAHPS survey, RTI focus groups, and stakeholder interviews. See ***Appendix A*** for a full description of these data sources.

We provide national benchmarks from MA plans, where available, understanding that there are differences in the populations served by the FIDA demonstration and the MA population, including health and socioeconomic characteristics that must be considered in the comparison of the demonstration to the national MA contracts. Note that only three FIDA MMPs had enough respondents to report CAHPS results in 2016–2019.

4.1.1 Beneficiary Overall Satisfaction

Most 2017 RTI focus group participants expressed overall satisfaction with FIDA and reported a higher level of satisfaction with FIDA than with their previous plans.

With FIDA, it's like I'm in control now.

— Focus group participant (2017)

Positive aspects of FIDA mentioned by participants included having Medicare and Medicaid services under one program and feeling that they were active participants in their care decisions.

…the reason I chose FIDA is I won't have to deal with Medicare and Medicaid separately. So it's combined and it's in one place and it's really easy. I don't want to deal with multiple people.

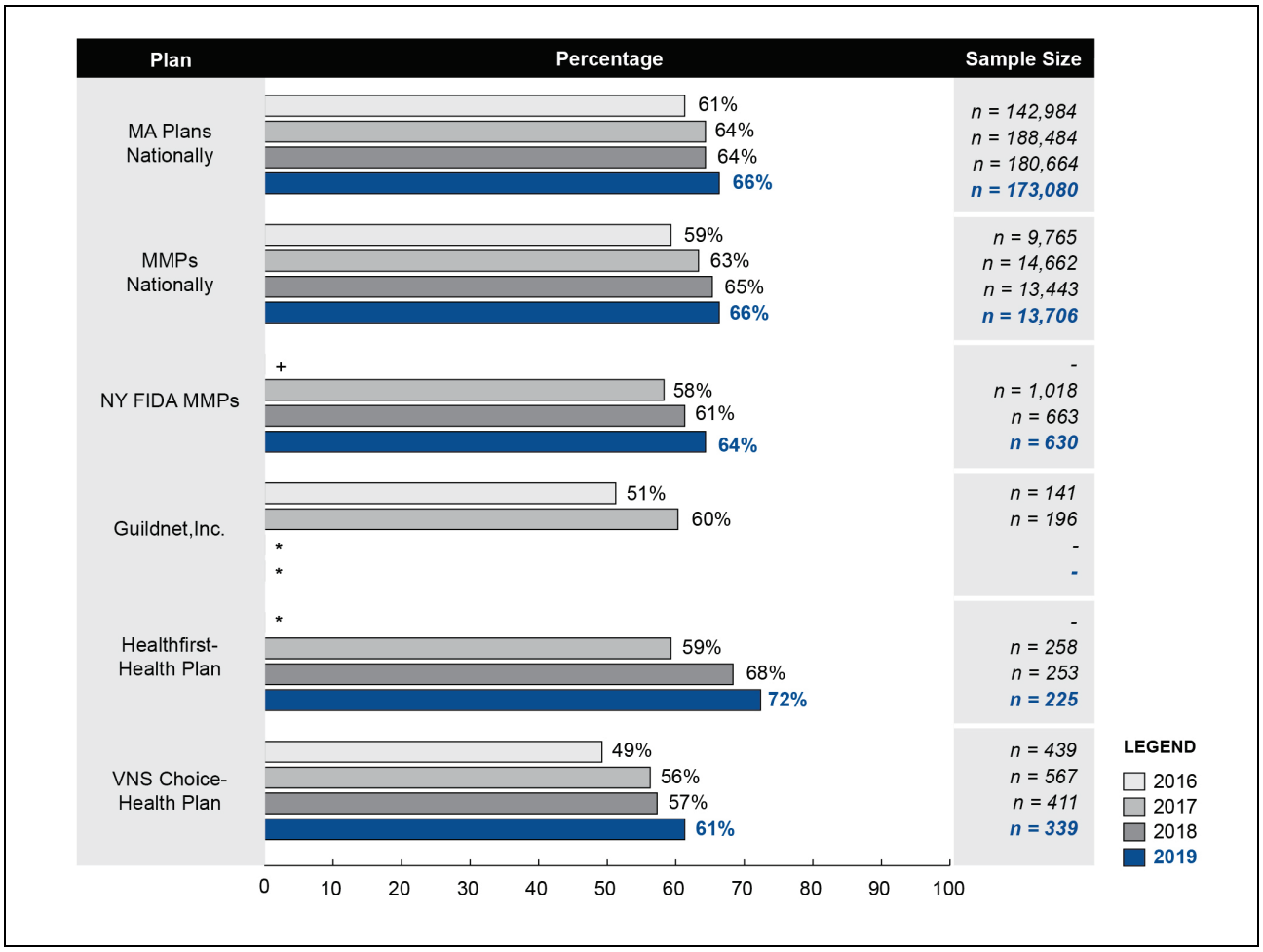
— Focus group participant (2017)

I have a voice in the services I receive…. They actually listen to me. And if I say no, they let it be no. I really enjoy that part, having some kind of say in my care.

— Focus group participant (2017)

CAHPS survey data in ***Figure 8*** show similar levels of satisfaction among respondents as was heard in the focus groups. For each of the plans reporting data for 2016–2019, the percentage of CAHPS respondents who rated their health plan as a 9 or 10 increased during that timeframe. Satisfaction with FIDA health plans slightly trailed satisfaction with MMPs in other States and MA plans nationally.

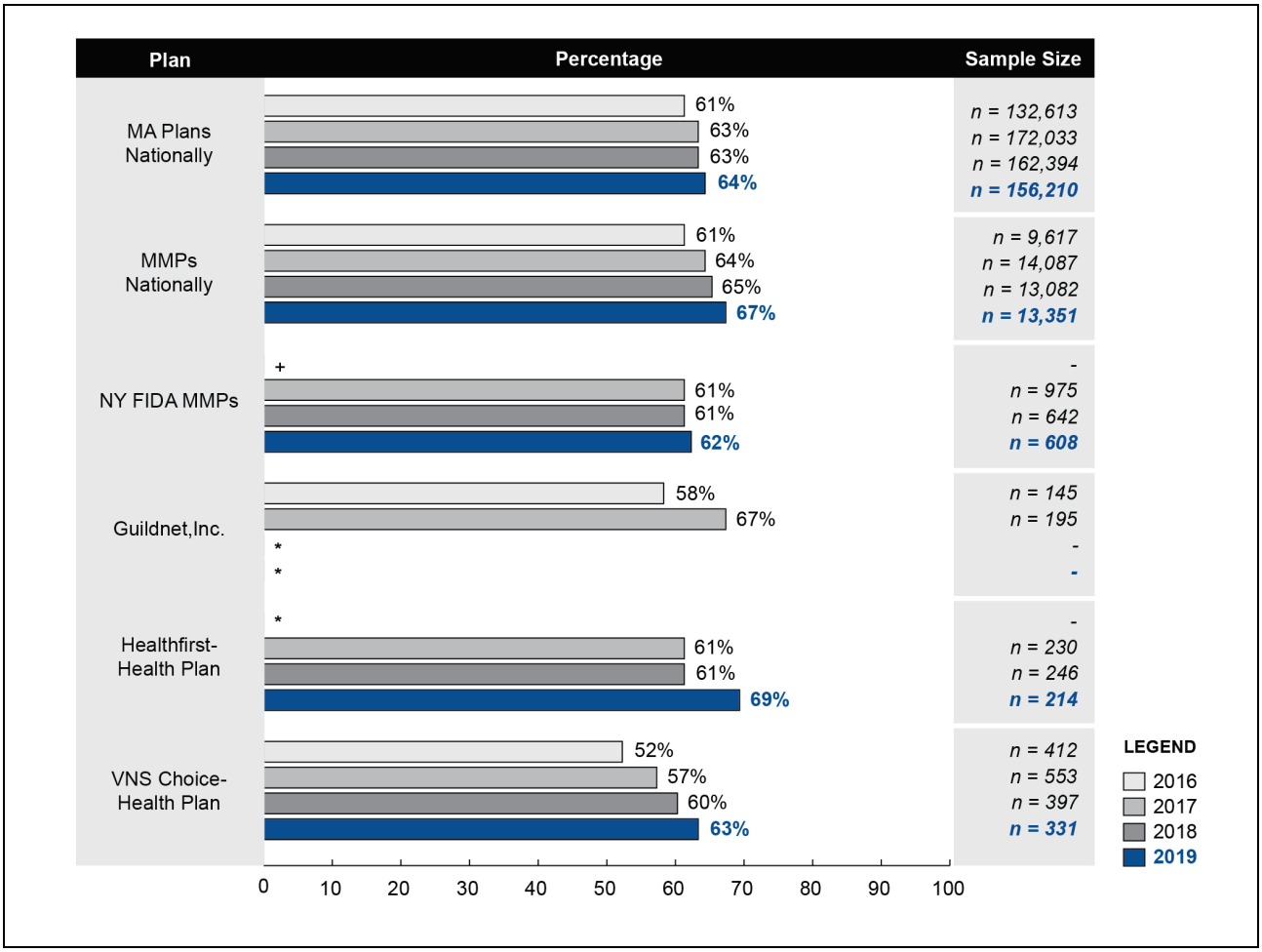
Figure 8
Beneficiary overall satisfaction, 2016–2019: Percent of beneficiaries rating their health plan as a 9 or 10



* = data not available; + = 2016 data for NY FIDA MMPs do not appear in the chart because reporting of State-level MMP distribution began in 2017. MA = Medicare Advantage; MMP = Medicare-Medicaid Plan.
NOTE: Although other MMPs participated in some years of the demonstration, Healthfirst Health Plan, GuildNet, Inc., and VNS Choice were the participating MMPs between 2016 and 2019.
SOURCE: CAHPS data for 2016–2019. This item was case mix adjusted. The CAHPS question used for this item was: "Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?"

Satisfaction with FIDA MMP prescription drug plans slightly trailed satisfaction with MMPs in other States and MA plans nationally. From 2016 to 2019, the percentage of CAHPS respondents who rated their prescription drug plan as a 9 or 10 increased for all three MMPs in the years they reported data (***Figure 9***).

Figure 9
Beneficiary overall satisfaction, 2016–2019: Percentage of beneficiaries rating their prescription drug plan as a 9 or 10



* = data not available; + = 2016 data for NY FIDA MMPs do not appear in the chart because reporting of State-level MMP distribution began in 2017. MA = Medicare Advantage; MMP = Medicare-Medicaid Plan.
NOTE: Although other MMPs participated in some years of the demonstration, Healthfirst Health Plan, GuildNet, Inc., and VNS Choice were the participating MMPs between 2016 and 2019.
SOURCE: CAHPS data for 2016–2019. This item was case mix adjusted. The CAHPS question used for this item was: "Using any number from 0 to 10, where 0 is the worst prescription drug plan possible and 10 is the best prescription drug plan possible, what number would you use to rate your prescription drug plan?"

MMP Communication with Enrollees

Many notices sent by FIDA MMPs were required by the State or CMS, but the number received by enrollees appeared to cause them some concern. For example, FIDA enrollees requiring ongoing LTSS received Explanation of Benefits statements on a regular basis, but many 2017 focus group participants described the volume of mail as "overwhelming" and said that "it all has to be dealt with carefully."

I get reams and reams of paper that at the end I owe zero. You read through… and it goes on and on forever. And you don't dare throw it out…. I wish I didn't get so much.

— Focus group participant (2017)

Focus group participants feared potentially missing some crucial bit of information that they might have to respond to.

I have so many newsletters from [my FIDA MMP], and I'm like, 'Which one do I read first? What's important?'

— Focus group participant (2017)

4.1.2 Beneficiary Experience With Care Coordination

Several 2017 RTI focus group participants described their care management services very positively.

It felt like as soon as I got on that plan, everything in my life just fell into place… I didn't have to do a whole lot of talking and calling people…. Everybody is communicating now.

—Focus group participant (2017)

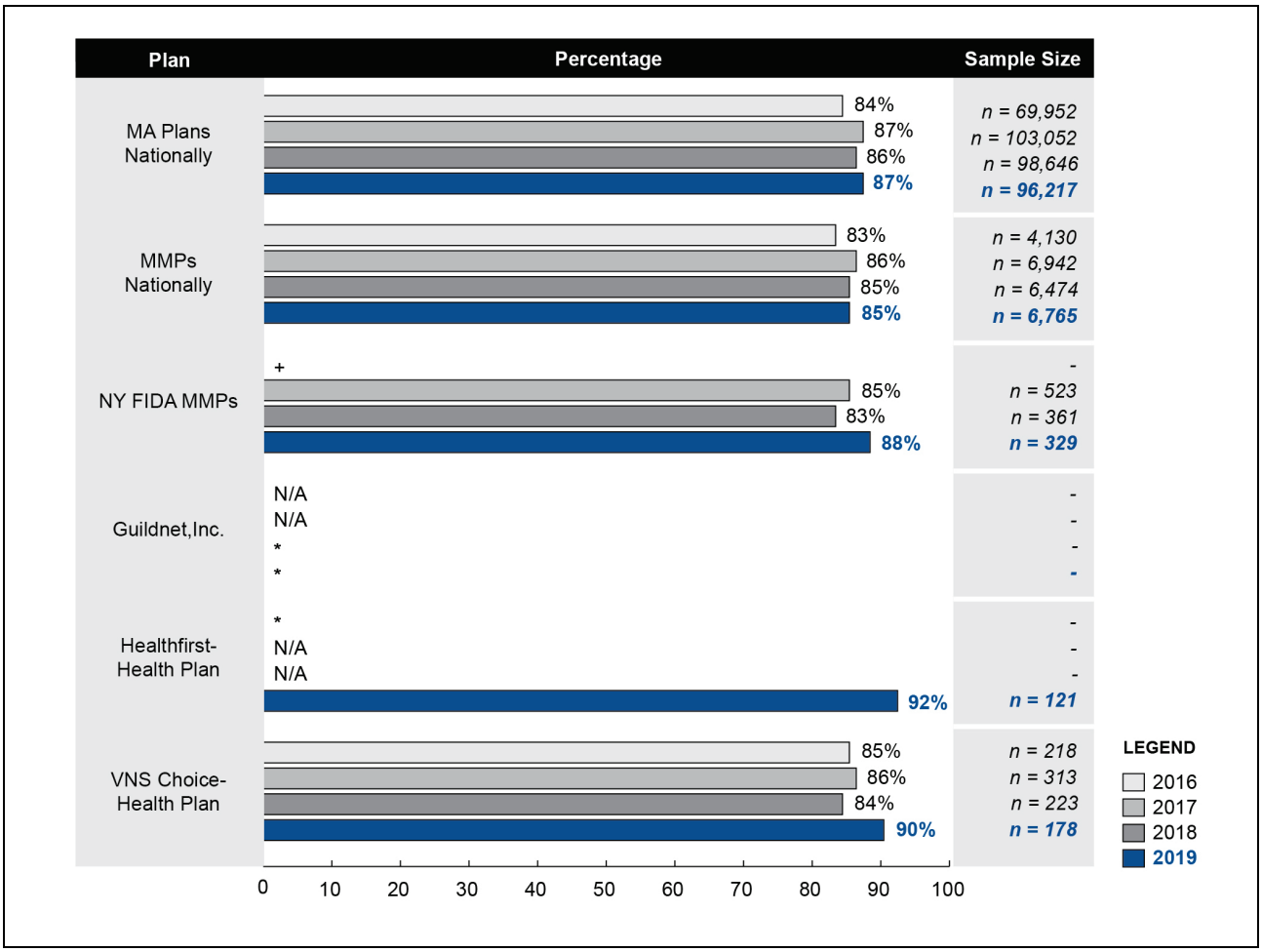
My nurse care manager, she's the one that lets me know everything. I can discuss anything with her, and then she'll collaborate with everybody else and get back to me.

— Focus group participant (2017)

Many 2017 RTI focus group participants made a distinction between using their FIDA MMP care manager and their home care agency for help with their home care attendants. When asked whom they call if they need assistance with their home care service, many responded as this person did: "[W]e go through an agency that provides the health care, the health care aide, and that's a separate agency from the long-term care company, which is [FIDA MMP]."

From 2016 through 2019, for the two FIDA MMPs that reported data for this item, the percentage of CAHPS respondents who reported that in the past 6 months their personal doctors were usually or always informed about care from specialists was similar to the national MMP averages (see ***Figure 10***).

Figure 10
Beneficiary experience with care coordination, 2016–2019: Percentage of beneficiaries reporting that in the past 6 months their personal doctors were usually or always informed about care received from specialists



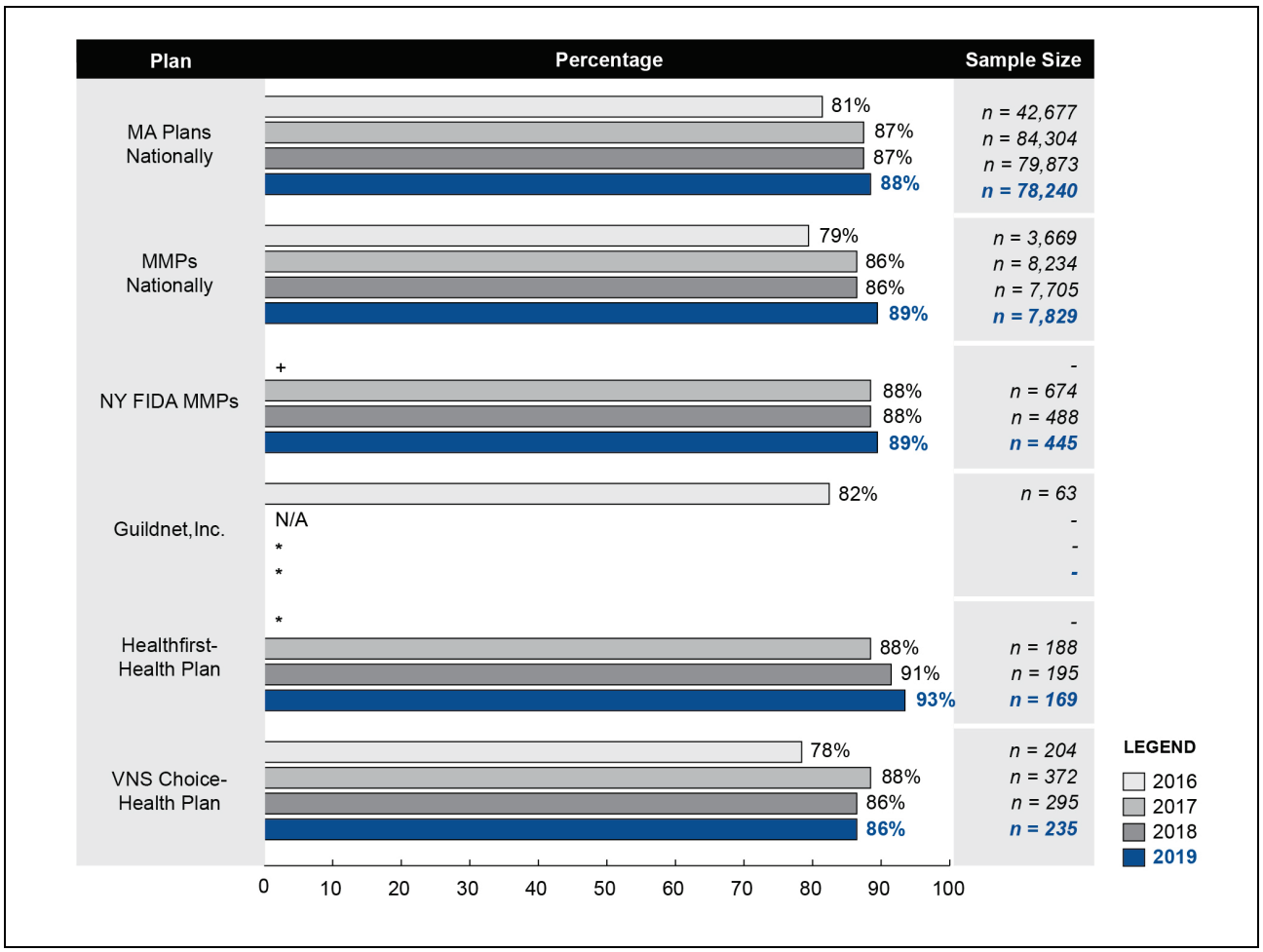
* = data not available; + = 2016 data for NY FIDA MMPs do not appear in the chart because reporting of State-level MMP distribution began in 2017. MA = Medicare Advantage; MMP = Medicare-Medicaid Plan; NA = either there were too few beneficiaries who responded to the question to allow reporting or the score had low reliability.

NOTE: Although other MMPs participated in some years of the demonstration, Healthfirst Health Plan, GuildNet, Inc., and VNS Choice were the participating MMPs between 2016 and 2019.

SOURCE: CAHPS data for 2016–2019. This item was case mix adjusted. The CAHPS question used for this item was: "In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from specialists?"

The percentage of CAHPS respondents in 2016–2019 who reported that their health plan usually or always gave them information was similar to MA and MMPs nationally for the FIDA MMPs that reported data (see ***Figure 11***).

Figure 11
Beneficiary experience with care coordination, 2016–2019: Percentage of beneficiaries reporting that their health plan usually or always gave them information they needed



* = data not available; + = 2016 data for NY FIDA MMPs do not appear in the chart because reporting of State-level MMP distribution began in 2017. MA = Medicare Advantage; MMP = Medicare-Medicaid Plan; NA = either there were too few beneficiaries who responded to the question to allow reporting or the score had low reliability.

NOTE: Although other MMPs participated in some years of the demonstration, Healthfirst Health Plan, GuildNet, Inc., and VNS Choice were the participating MMPs between 2016 and 2019.

SOURCE: CAHPS data for 2016–2019. This item was case mix adjusted. The CAHPS question used for this item was: "In the last 6 months, how often did your health plan's customer service give you the information or help you needed?"

4.1.3 Quality of and Access to Care

Focus group participants in 2017 were happy with the FIDA transportation benefit for nonmedical trips.

They take me grocery shopping. They'll take you to church. They'll take you up the block to the park, and you can call them when you're ready to go home.

— Focus group participant (2017)

However, throughout the demonstration, CMS, NYSDOH, and MMPs said complaints about transportation reliability were common. Several focus group participants described their transportation services as having been better prior to FIDA because they previously had a choice of transportation providers. Under their FIDA plan, these participants had to use a specific company. Some participants said they had missed appointments because the drivers were late. Others were left at provider offices and had to call family members to pick them up, or they had to take other transportation such as a bus or cab.

Enrollee experience with home care assistance varied. Several focus group participants said they were pleased that their hours of home care assistance increased under FIDA. They were satisfied with their aides, saying they have been "wonderful." Others described frustration with their home care attendants being "lazy" and not being well trained.

They (home care attendants) need more training in just basic (cooking)—you don't have to be a gourmet chef.

— Focus group participant (2017)

As previously noted, many participants who were disappointed with their attendants said they called the home health agencies directly, rather than contacting their FIDA care manager for assistance.

Some focus group participants were concerned about turnover among home care attendants. Some felt that the visiting nurses should "at least stay with a person for a few months… to know your case and your medical problems."

They come and they go, and there's nothing you can do about that. They come and they go. They get better work or they get fired.

– Focus group participant (2017)

4.1.4 Special Populations

In 2017–2019, site visit key informants could not identify particular racial or ethnic subgroups that benefitted more or less from participating in FIDA. One MMP in 2019 said enrollees with behavioral health needs particularly benefitted from having in-home behavioral health visiting nurse practitioners meet with the enrollees and participate in the IDT, and the care managers were able to coordinate those services along with LTSS, acute care, and primary care. Other MMPs also said that medically frail enrollees benefitted from FIDA's care model and integration of benefits. In general, enrollment in FIDA was too low to identify distinct patterns in special populations.

4.2 Beneficiary Protections

In this section, we summarize grievance (complaint) and appeals data received from:

- data reported by MMPs on complaints made directly to them;[28]
- data submitted to the Complaints Tracking Module (CTM) for complaints received by NYSDOH and 1-800-Medicare;[29]
- data reported by the Integrated Administrative Hearing Office (IAHO),[30] a second-level review of appeals; and
- qualitative information collected by the evaluation team. We also include findings from the Independent Consumer Advocacy Network (ICAN), the Ombudsman serving the demonstration.

4.2.1 Grievances and Appeals

Grievances/Complaints

FIDA enrollees were entitled to file a grievance with an MMP. A grievance is defined as an expression of dissatisfaction with any matter other than an adverse service determination. Grievances were resolved at the MMP level.

MMPs have reported grievances in two different ways since the demonstration began. From 2015 through 2017, MMPs reported total grievances per 1,000 enrollees. The number of MMP-reported grievances per 1,000 enrollees fluctuated during this period, with both the low (16.3 grievances per 1,000 enrollees) and high (44.1 grievances per 1,000 enrollees) in 2015. Effective January 2018, the reporting requirements were modified so that plans reported total grievances per 10,000 enrollee months. From 2018 through 2019, the total number of reported grievances per 10,000 enrollee months ranged between a high of 4,548.0 in quarter 3 of 2018 and a low of 864.7 in quarter 1 of 2019. This range may be a result of only six plans reporting in 2019 versus 10 in 2018.

[28] MMP Reported Data provided to RTI by CMS.
[29] Data obtained from the Complaints Tracking Module (CTM) within HPMS by RTI.
[30] Data provided to RTI by CMS.

The number of complaints reported to the CTM decreased from 2015–2019, from a high of 18 in 2015 to a low of 8 in 2019. The highest number of complaints were in four categories:

- enrollment and disenrollment for 2015 and 2017;
- *Plan Lead Legal and Administrative*[31] for 2016;
- *Provider Specific*[32] for 2018; and
- benefits, access, and quality of care categories for 2019.

Integrated Appeals Process

An enrollee was entitled to appeal a service determination made by the IDT or the MMP. The first level of appeal was heard by the MMP. If the first-level appeal resulted in an adverse outcome for the enrollee, the appeal was automatically forwarded to a second level of appeal. As described in the First Evaluation Report, NYSDOH and CMS integrated the Medicare and Medicaid second-level appeals process so that all second-level appeals were heard by the IAHO within New York's Office of Temporary and Disability Assistance (OTDA). When CMS agreed to support the State's request to have the IAHO review both Medicare and Medicaid second-level appeals, CMS required its Independent Review Entity (IRE) to review the State's Medicare decisions. Although the IRE review would not override OTDA decisions, CMS had never before allowed a State to make Medicare appeals decisions and wanted to ensure the State was making decisions consistent with those the IRE would make. In 2017, CMS was satisfied with IAHO Medicare decisions and dropped this parallel review process by the IRE.

If the outcome at the IAHO level was adverse, the enrollee could appeal to the Medicare Appeals Council (MAC); from there, the final level of appeal was to the Federal courts. No FIDA appeal was ever taken to the Federal court. Benefits were continued while the appeal was heard as long as the enrollee had filed the appeal within required time limits.

In 2019, CMS, NYSDOH, MMPs, advocates, and the Ombudsman described FIDA's integrated appeals process as a major success of the demonstration. CMS highlighted the fact that the IAHO was able to apply both Medicare and Medicaid policy so effectively in its adjudication of appeals that only three appeals went to the third level, the MAC, over the entire 5 years of the demonstration.

As with grievances, MMPs have reported appeals in two ways since the demonstration began. From 2015 through 2017, MMPs reported total appeals per 1,000 enrollees. The number of MMP-reported appeals per 1,000 enrollees fluctuated during this period, with a low of 2.4 in quarter 2 of 2015 and a high of 57.1 in quarter 3 of 2016. Effective January 2018, the reporting requirements were modified so that plans reported total appeals per 10,000 enrollee months. From 2018 through 2019, the total number of MMP-reported appeals per 10,000 enrollee months fluctuated, with a high of 1,786.6 in quarter 4 of 2018 and a low of 402.8 in quarter 1 of 2019.

[31] This category includes complaints about customer service and difficulties getting materials in alternative formats.
[32] This category includes complaints about improper, insufficient, or delayed claims payments.

The IAHO received 445 appeals submitted by enrollees or on their behalf from 2015 through 2019. Fifty-one percent of submitted appeals were withdrawn or ended in default. Of the 219 appeals heard by the IAHO, 95 were reversed in favor of the member, 37 were affirmed for the MMP, and 77 were settled through stipulation. Most of the 219 appeals (78.1 percent) involved only Medicaid policy, and 21.9 percent involved both Medicare and Medicaid policy. The IAHO reported appeals cases and status data to CMS and NYSDOH on a biweekly basis, and CMS, NYSDOH, IAHO, and the MAC discussed these data on monthly calls.

In 2018 and 2019, the integrated appeals process had wide support from many stakeholders to continue for Medicare-Medicaid beneficiaries after the demonstration ended. To expand the integrated process to the MAP-participating D-SNP plans, CMS and NYSDOH are implementing a 4-year §1115(A) demonstration initiative that began January 1, 2020.

Critical Incidents

FIDA plans were required to report to CMS' implementation contractor on the numbers of critical incidents and abuse reports for enrollees receiving LTSS. The number of reports per 1,000 members varied but remained relatively low during the demonstration (2015–2019), from a low of 0.0 reports per 1,000 members in quarter 1 of 2015 to a high of 10.1 reports per 1,000 members in quarter 4 of 2019.

4.2.2 The Ombudsman

As described in ***Section 2.2, Overview of State Context***, ICAN is the Ombudsman for all of New York's managed LTSS. In 2017–2019, ICAN representatives said FIDA accounted for a small percentage of the cases handled by the Ombudsman program in the demonstration area. ICAN most commonly helped FIDA enrollees with issues related to access to services, understanding of health insurance, and enrollment, similar to the types of cases it handles for MLTC.

In 2017–2019, ICAN reported that calling and participating in IDT meetings on behalf of enrollees can be a successful model to resolve service authorization disputes. ICAN's participation helped the MMPs to implement the IDT as envisioned by the FIDA model in which the enrollee has a voice in care planning. The Ombudsman compared the IDT and FIDA care management to care planning under MLTC where the MLTC care coordinator says to the member, "This is what we're going to do." The presence of the Ombudsman at the IDT meeting encouraged a two-way conversation about authorizing services that made sense for the enrollee's needs.

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SECTION 5

Demonstration End and Transition Planning

The State and CMS decided MAP-participating D-SNPs would best offer integrated care after the demonstration.

The integrated appeals process and integrated marketing materials developed under FIDA will continue for MAP-participating D-SNPs.

5.1 Post-FIDA Transition Planning

The State and CMS focused much of their attention in 2017 through 2019, and particularly in 2018 and 2019, on whether, and in what form, design elements of the demonstration's integrated delivery system could be continued. As described in ***Section 2.2, Overview of State Context***, CMS and NYSDOH held five meetings in the second half of 2017 to gather information from stakeholders about what worked and what did not during the demonstration.

MMPs favored the MAP program over FIDA because of rate adjustments based on enrollees' level of frailty available in MAP (see ***Section 3.5, Financing and Payment***), and less burdensome reporting and care model requirements. Key FIDA elements that had broad support among stakeholders included:

- the integrated appeals process,
- integrated marketing materials,
- joint review of marketing materials by CMS and NYSDOH,
- a single enrollment broker, and
- joint contract management by the State and CMS.

CMS proposed building off of the D-SNP model to allow the State to incorporate popular FIDA elements under a continuation of the §1115(A) demonstration waiver.[33] Ultimately, the State and CMS decided existing MAP-participating D-SNP plans would be the best vehicle to offer integrated care to Medicare-Medicaid beneficiaries. All six FIDA MMPs remaining in 2019 offered these types of plans. See ***Section 3.2, Eligibility and Enrollment,*** for information on the passive enrollment process for transitioning FIDA enrollees to these plans.

Two FIDA features are preserved in the MAP-participating D-SNP plans. MAP-participating D-SNPs and the aligned D-SNPs will have the integrated appeals process implemented under the FIDA demonstration (see ***Section 4.2, Beneficiary Protections***). CMS and NYSDOH also developed integrated marketing materials for the new plans. However, they were not complete in time for some of the plans to use them to market their 2020 products.

[33] §3021 of the Patient Protection and Affordable Care Act of 2019; §1115(a) of the Social Security Act.

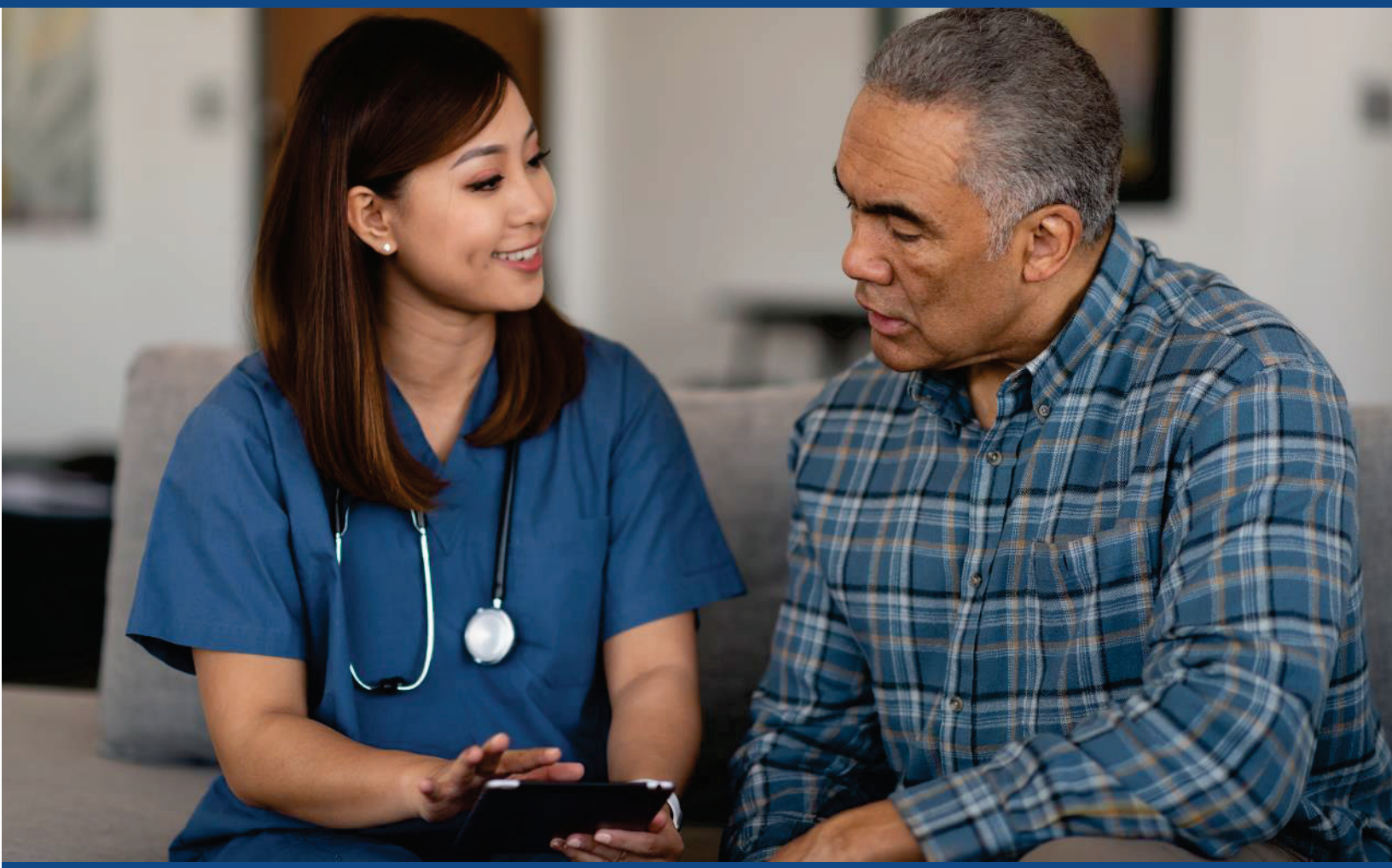
CMS and the State determined it would not be possible to continue the joint review of marketing materials outside the §1115(A) demonstration authority. Using a single enrollment broker would have required major changes to the State's enrollment systems changes; and CMS and NYSDOH already have separate contract management processes for MAPs and D-SNPs and will continue them for MAP-participating D-SNPs. However, CMS and NYSDOH will conduct joint monitoring of the integrated appeals and grievances demonstration through monthly calls with CMS, NYSDOH, IAHO, and MAC staff, as well as quarterly calls between CMS, NYSDOH, and the MAP plans.

5.2 Contract Management Team Transition Activities

In mid-September 2019, at the request of NYSDOH, the CMT started having calls every other week with all of the FIDA plans to have regular contact throughout the transition process. During these calls, MMPs raised concerns about the timing of scheduled assessments and their impact on enrollees. All FIDA, MLTC, and MAP plans use the Uniform Assessment System (UAS) to evaluate Medicaid beneficiaries' needs for LTSS, on at least an annual basis. MAP policy requires assessments within 90 days of enrollment. However, for FIDA enrollees whose UAS reassessment was due in December 2019, this would have meant two comprehensive assessments within a short period of time, once in December and again within 90 days of enrolling in MAP. To address these concerns, CMS and the State gave the MMPs flexibility to move the December 2019 UAS reassessments to early 2020 after the enrollees had moved to their new MAP plans. As described in ***Section 3.2, Eligibility and Enrollment***, FIDA MMPs were required to transfer enrollee care plans to enrollees' new MAP plans.

SECTION 6

Conclusions



6.1 Successes

6.1.1 Integrated Appeals Process

The most successful element of the FIDA demonstration was the integrated appeals process, as evidenced by the broad support for it which led to its continuation for a much larger group of dual eligible beneficiaries. FIDA enrollees benefitted from the way Medicare and Medicaid protections were combined, including the automatic forwarding of appeals to a second-level review, borrowed from Medicare, and the automatic continuation of benefits during the appeals process and live hearing at the second level, borrowed from New York's Medicaid program.

The development and implementation of the integrated appeals process required a leap of faith by CMS to allow the IAHO housed in the NYSDOH OTDA to apply Medicare policy to appeals decisions, and the State had to commit staff resources from OTDA to an unfamiliar process.

We are essentially delegating the responsibility that is statutorily invested in Medicare to…a State agency that has no experience with this.

— CMS (2015)

CMS's Medicare IRE concurrent review of the IAHO decisions early in the demonstration acted as a safeguard to ensure the IAHO applied Medicare policy properly and gave CMS confidence in the State's ability to manage the process, ending the need for concurrent review after 2016.

6.1.2 Care Management Model

Although provider resistance to participating in the IDT prevented the care management model from being fully implemented as designed, MMPs, enrollees, and advocates viewed the model favorably. MMPs identified certain features of the FIDA care model as particularly valuable in addressing the enrollee as a whole person. For example, the IDT could authorize services within the scope of practice of the professionals participating in the IDT, making it easier for the IDT to be responsive and flexible. MMPs said the care model reduced service fragmentation, especially for frail enrollees. Paying PCPs to participate in IDT meetings was a successful way to engage them.

Plans able to submit CAHPS data showed FIDA members' satisfaction with their MMP increased over time, and satisfaction with care coordination was similar to MA plans and MMPs nationally. Focus group participants in 2017 reported that they valued having Medicare and Medicaid services under one program and feeling that they were active participants in their care decisions. MMPs reported that the benefits of the FIDA model were most significant for those with the greatest need for assistance.

6.1.3 Transition to End the FIDA Demonstration

The development and implementation of a transition plan to preserve elements of FIDA and minimize disruptions in care after the demonstration ended was a key success in 2019. Although it was not without delays and challenges, CMS described the transition as having gone relatively smoothly. The State echoed this assessment.

There were some hiccups but at the same time we have to keep in mind the scope of what we were doing. We were completely ending a demonstration and then moving beneficiaries in a way that we had never done before.

— CMS (2019)

So, it was a little bit different process, but working with MAXIMUS [the enrollment broker] was very good [as well as] MMCO…. Everyone knew what steps we had to follow to make it a smooth transition.

— State official (2019)

6.2 Challenges

6.2.1 Early Negative Reputation

Even after the 2015 changes to the IDT policy, provider training requirements, and passive enrollment, and the advertising campaign targeted at providers in 2016, FIDA continued to suffer from a lack of provider participation and subsequent member disenrollments and opt-outs. Neither the State, nor CMS, nor the MMPs were able to communicate the benefits of integrated, coordinated services for Medicare-Medicaid beneficiaries sufficiently enough to counteract provider and beneficiary reluctance to participate. Ultimately, although stakeholders supported many of its features, the FIDA demonstration never recovered from its early negative reputation.

6.2.2 Passive Enrollment from Managed Long-Term Care to FIDA

Although not described in detail in this report, the passive enrollment process presented a major challenge to the demonstration. Eligible beneficiaries were passively enrolled into FIDA only in the first year, but the experience had a negative impact on the demonstration with lasting effects.[34] Basing the FIDA passive enrollment process on members' MLTC plans essentially broke the relationship with enrollees' Medicare providers because, unlike in MAP, most MLTC program enrollees were not in a sister plan for Medicare services. The State's difficult experience with rolling out mandatory Medicaid MLTC in 2012 may have erroneously led NYSDOH officials to prioritize beneficiary relationships with home care attendants over medical providers. Although staff turnover is common in the home care attendant workforce,

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[34] Please see ***Section 3.2, Enrollment Process***, of the First Evaluation Report for additional detail.

beneficiaries with chronic conditions often have built long-term relationships with their medical providers. Preserving these relationships was more important to beneficiaries than preserving their relationships with home care attendants.

6.2.3 Varying Medicare Advantage and Managed Long-Term Care Experience Among MMPs

Allowing all plans that met demonstration qualification requirements to participate resulted in several MMPs with little or no previous experience with Medicare managed care. In general, MMPs without previous experience with Medicare policy and providers had greater difficulty building their networks and complying with unfamiliar regulations, and they tended to leave the demonstration early. Had the FIDA demonstration restricted participation to plans that had both MLTC and MA experience, MMP provider networks may have had fewer issues.

6.2.4 Rate Setting in a Competitive Managed Care Environment

The rate setting process for Medicare and Medicaid components did not account for New York's competitive managed care environment. A lack of rate parity, combined with extra requirements imposed by the demonstration, made FIDA less attractive than MAP or MLTC products for plans to market to similar members. Although not as extensive or seamless as FIDA, integration of Medicare and Medicaid benefits was available to MAP plan members, but many MAP plans received a favorable frailty rate adjustment in the Medicare component and MMPs did not. With FIDA's lower Medicaid component relative to MLTC at the beginning of the demonstration, plans had incentives to steer enrollees back to their sister MLTC or MAP plans.

6.3 Lessons Learned

When asked about lessons learned from the demonstration, NYSDOH and CMS emphasized that getting providers to buy into the program from the beginning is crucial. Whereas FIDA envisioned PCPs as key members of the IDT, providers saw participation as a burden on their time rather than as a benefit for enrollees. In 2019, the four MMPs interviewed said that, given their experience, they would make the same decision to participate in the demonstration. However, one MMP said it would have strong reservations about participating and advised other States to learn from FIDA's challenges, especially in requiring physician participation in an IDT.

The State and CMS have already applied some of the lessons learned from FIDA in developing a transition process for Medicaid enrollees in managed care products who become eligible for Medicare. When these enrollees become newly eligible for Medicare, they will be allowed to be automatically enrolled into their Medicaid managed care plan's sister MA plan, similar to a MAP plan but without LTSS. This preserves existing provider relationships and retains members in managed care instead of disenrolling them into Medicare FFS. The State hopes that keeping these newly dual eligible beneficiaries in managed care will encourage the plans to keep the enrollees healthy in the community, and perhaps delay future needs for long-term care.

Although FIDA ended in December 2019, the State continues its focus on better integrating care for Medicare-Medicaid beneficiaries. NYSDOH has asked CMS to extend the

FIDA-IDD demonstration currently serving dual eligible enrollees with intellectual and developmental disabilities. The integrated appeals process is expanding to the larger population of Medicare-Medicaid beneficiaries.

We have to take what we learned and move it to the next program.

— State official (2019)

6.4 Next Steps

As previously noted, the demonstration ended on December 31, 2019. RTI will next evaluate and report on the integrated appeals process that has expanded to Medicare-Medicaid beneficiaries in MAP-participating D-SNP plans in New York under the 4-year §1115(A) demonstration initiative beginning January 1, 2020.

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Appendix A

Data Sources

We used the following data sources to prepare this report.

Key informant interviews: The RTI evaluation team conducted annual site visits in New York in 2017 through 2019. In 2017, the team interviewed the following individuals: NYSDOH leadership, and program staff; representatives of four MMPs, advocates, the Ombudsman, the New York State Office for the Aging, and the New York City Health Insurance Information, Counseling and Assistance Program. Three of the MMPs interviewed had been interviewed during at least one previous site visit.

In 2018 and 2019, the team interviewed the same representatives from NYSDOH and CMS, with the exception of leadership in 2019; representatives from four MMPs; advocates; and the Ombudsman. Three of the four MMPs in both 2018 and 2019 had been interviewed during at least one previous site visit. Over the course of the demonstration, the evaluation team interviewed 9 of the 21 MMPs that participated in the demonstration.

To monitor demonstration progress, the RTI evaluation team engaged in periodic phone conversations with the NYSDOH and CMS. These included discussions about new policy clarifications designed to improve plan performance, quality improvement activities, and contract management team actions.

Focus groups. The RTI evaluation team conducted eight focus groups in New York City in May 2017. Two focus groups were held for Spanish speaking enrollees, two for Black enrollees, two for enrollees with LTSS needs, and two for a mix of enrollees. A total of 30 FIDA enrollees participated in the focus groups.

Demonstration data. The RTI evaluation team reviewed data provided quarterly by New York through the State Data Reporting System (SDRS) during the first three years (2015–2017) of the demonstration. These reports include eligibility, enrollment, opt-out, and disenrollment data, and information reported by New York on its integrated delivery system, care coordination, benefits and services, quality management, stakeholder engagement, financing and payment, and a summary of successes and challenges. In the absence of available 2018-2019 SDRS data, the RTI evaluation team reviewed 2018 and 2019 monthly enrollment data posted on the NYSDOH website.[35] This evaluation report also uses data for quality measures reported by FIDA plans and submitted to CMS' implementation contractor, NORC.[36,37] Data reported to NORC include core quality measures that all MMPs are required to report, as well as State-specific measures that FIDA plans are required to report. Due to reporting inconsistencies, plans occasionally resubmit data for prior demonstration years; therefore, the data included in this report are considered preliminary.

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[35] https://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/. As obtained on March 16, 2020.

[36] Data are reported for 2015–2019.

[37] The technical specifications for reporting requirements are in the Medicare-Medicaid Capitated Financial Alignment Model Core and New York FIDA-Specific Reporting Requirements documents, which are available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPReportingRequirements. As obtained on September 11, 2020.

Demonstration policies, contracts, and other materials. The RTI evaluation team reviewed a wide range of demonstration documents, including demonstration and State-specific information on the CMS website[38]; and other publicly available materials on the New York FIDA website.[39]

Beneficiary satisfaction surveys. Medicare requires all MA plans, including FIDA plans, to conduct an annual assessment of beneficiary experiences using the Medicare Advantage and Prescription Drug Plan CAHPS survey instrument.[40] The CAHPS surveys for FIDA MMPs included the core Medicare CAHPS questions. This report includes survey results for a subset of the 2016–2019 survey questions. Findings are available at the MMP level. The frequency count for some survey questions is suppressed because too few enrollees responded to the question. Comparisons with findings from all MA plans are available for core CAHPS survey questions.

Complaints and appeals data. Complaint (also referred to as grievance) data are from three separate sources: (1) complaints from beneficiaries reported by FIDA plans to NYSDOH, and separately to CMS' implementation contractor, NORC, through Core Measure 4.2; (2) complaints received by NYSDOH or 1-800-Medicare and entered into the CMS electronic CTM; and (3) qualitative data obtained by RTI on complaints. Appeals data are generated by MMPs and reported to NYSDOH and NORC. This report also includes critical incidents and abuse data reported by FIDA MMPs to NYSDOH and NORC. This report also includes data on second-level appeals reported by New York's IAHO, as provided by CMS, for 2015 through 2019.

HEDIS measures. We report on a subset of Medicare HEDIS measures, a standard measurement set used extensively by managed care plans, which are required of all MA plans.

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[38] https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsinCareCoordination. As obtained on April 20, 2020.

[39] https://www.health.ny.gov/health_care/medicaid/redesign/fida/. As obtained on March 4, 2020.

[40] The CAHPS requirement applies to MA plans, including FIDA MMPs, with enrollment of 600 or more as of July 1 of the year prior to the measurement year. Most FIDA plans did not have adequate enrollment to participate. Only three FIDA MMPs ever participated in CAHPS.

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Appendix B

New York FIDA MMP Performance on Select HEDIS Quality Measures, 2015–2018

Tables B-1a through ***B-1c*** provide 2015 through 2018 HEDIS performance data for MMPs. These tables illustrate where MMP performance across demonstration years was steadily improving or worsening, and if these trends were favorable or unfavorable. Using correlation coefficients that were 0.9 and above, or −0.9 and below, we apply green and red shading to indicate where MMP performance over time for a given measure was steadily improving or worsening; green indicates a favorable trend, where red indicates an unfavorable one. No testing for statistical significance for differences across years is performed because of the limited data available. For measures without green or red shading, year over year MMP performance remained relatively stable between 2015 and 2018.

Table B-1a
New York FIDA Demonstration Plan Performance on Select HEDIS Quality Measures for 2015–2018 by MMP

Measure	National MA Plan Mean	AgeWell New York				Centers Plan for Healthy Living				ElderPlan			
	2018	2015	2016	2017	2018	2015	2016	2017	2018	2015	2016	2017	2018
Adults' access to preventive/ambulatory health services	95.0	N/A	94.1	N/A	97.6	N/A	N/A	N/A	N/A	N/A	100.0	100.0	99.5
Adult BMI assessment	96.0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	83.7	95.0
Controlling high blood pressure[1]	69.5	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	50.0	50.5	64.1
Breast cancer screening	72.7	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Colorectal cancer screening	70.5	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	40.8	43.2
Disease modifying anti-rheumatic drug therapy in rheumatoid arthritis	77.8	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Follow-up after hospitalization for mental illness (30 days)	47.9	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Antidepressant medication management													
Effective acute phase treatment[2]	72.1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Effective continuation phase treatment[3]	56.1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Care for older adults													
Advance care planning	N/A	—	46.9	N/A	100.0	—	N/A	N/A	N/A	N/A	31.1[G]	38.9[G]	53.1[G]
Medication review	N/A	—	71.9	N/A	96.5	—	N/A	N/A	N/A	N/A	60.3[G]	70.9[G]	78.1[G]
Functional status assessment	N/A	—	96.9	N/A	100.0	—	N/A	N/A	N/A	N/A	98.1	100.0	96.6
Pain assessment	N/A	—	100.0	N/A	100.0	—	N/A	N/A	N/A	N/A	98.6	100.0	97.2

(continued)

Table B-1a (continued)
New York FIDA Demonstration Plan Performance on Select HEDIS Quality Measures for 2015–2018 by MMP

Measure	National MA Plan Mean	AgeWell New York				Centers Plan for Healthy Living				ElderPlan			
	2018	2015	2016	2017	2018	2015	2016	2017	2018	2015	2016	2017	2018
Comprehensive diabetes care													
Received Hemoglobin A1c (HbA1c) testing	94.3	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	94.7	97.9	93.0
Poor control of HbA1c level (>9.0%) (higher is worse)	23.1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	44.7	57.5	41.9
Good control of HbA1c level (<8.0%)	65.6	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	44.7	38.3	53.5
Received eye exam (retinal)	73.7	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	57.9	48.9	62.8
Received medical attention for nephropathy	95.5	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	97.4	95.7	97.7
Blood pressure control (<140/90 mm Hg)	69.1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	52.6[G]	53.2[G]	55.8[G]
Initiation and engagement of alcohol and other drug (AOD) dependence treatment													
Initiation of AOD treatment [4]	33.6	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Engagement of AOD treatment [5]	4.5	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Plan all-cause readmissions (Observed-to-expected ratio)[6]													
Age 18-64	0.75	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Age 65+	0.71	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Ambulatory care (per 1,000 members)													
Outpatient visits (higher is better)	9,606.0	3,105.3[G]	6,552.3[G]	9,587.8[G]	10,019.6[G]	7,010.2	12,334.4	9,295.8	10,295.7	13,498.8	12,108.8	12,284.8	13,095.8
Emergency department visits (higher is worse)	600.8	447.4[R]	451.9[R]	696.7[R]	738.7[R]	520.4	780.2	1,140.9	1,078.3	927.6	723.0	647.9	653.5

(continued)

Table B-1a (continued)
New York FIDA Demonstration Plan Performance on Select HEDIS Quality Measures for 2015–2018 by MMP

BMI = body mass index; N/A = not applicable, where MA plans do not report such data or not applicable, where the number of enrollees in the demonstration plan's provided HEDIS data available for inclusion in the measure was less than 30, and therefore not reported per RTI's decision rule for addressing low sample size. — = not available, where the plan did not provide HEDIS data for this measure.

[1] The following criteria were used to determine adequate blood pressure control: less than 140/90 mm Hg for members 18–59 years of age; diagnosis of diabetes and <140/90 mm Hg for members 60–85 years of age; no diagnosis of diabetes and <150/90 mm Hg for members 60–85 years of age.
[2] Represents the percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks).
[3] Represents the percentage of members who remained on an antidepressant medication for at least 180 days (6 months).
[4] Represents percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.
[5] Represents the percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.
[6] Plan all-cause readmissions are reported as an observed-to-expected ratio. A value below 1.0 is favorable and indicates that plans had fewer readmissions than expected for their populations based on case mix.

NOTES: Green and red color-coded shading indicates where performance over time for a given measure was steadily improving or worsening; green indicates a favorable trend, where red indicates an unfavorable one. To ensure accessibility for text readers and individuals with sight disabilities, cells shaded green or red receive, respectively, a superscript "G" or "R". Detailed descriptions of HEDIS measures presented can be found in the RTI Aggregate Evaluation Plan.
SOURCE: RTI analysis of 2015 through 2018 HEDIS measures.

Table B-1b
New York FIDA Demonstration Plan Performance on Select HEDIS Quality Measures for 2015–2018 by MMP

Measure	National MA Plan Mean	ElderServe Health				GuildNet				Healthfirst Health Plan			
	2018	2015	2016	2017	2018	2015	2016	2017	2018	2015	2016	2017	2018
Adults' access to preventive/ambulatory health services	95.0	N/A	N/A	N/A	N/A	100.0	94.0	95.5	95.4	99.7	98.6	98.8	99.2
Adult BMI assessment	96.0	N/A	N/A	N/A	N/A	N/A	74.0	84.4	N/A	94.0	97.3	92.2	89.6
Controlling high blood pressure[1]	69.5	N/A	N/A	N/A	N/A	32.3	61.8	56.4	47.4	56.4	61.2	62.3	61.0
Breast cancer screening	72.7	N/A	N/A	N/A	N/A	N/A	N/A	37.3	N/A	78.9	74.6	63.9	73.9
Colorectal cancer screening	70.5	N/A	N/A	N/A	N/A	N/A	44.9	31.0	N/A	65.9	66.9	62.9	70.7
Disease modifying anti-rheumatic drug therapy in rheumatoid arthritis	77.8	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Follow-up after hospitalization for mental illness (30 days)	47.9	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Antidepressant medication management													
Effective acute phase treatment[2]	72.1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	51.6	N/A	65.7
Effective continuation phase treatment[3]	56.1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	41.9	N/A	62.9
Care for older adults													
Advance care planning	N/A	—	—	N/A	N/A	23.7	35.3	56.7	46.5	—	91.7	97.6	98.1
Medication review	N/A	—	—	N/A	N/A	40.9	71.8	81.3	65.3	—	79.8	84.4	78.1
Functional status assessment	N/A	—	—	N/A	N/A	37.7	67.6	76.6	62.4	—	94.2[G]	98.8[G]	99.3[G]
Pain assessment	N/A	—	—	N/A	N/A	40.0	66.7	82.2	68.5	—	96.1[G]	99.0[G]	99.8[G]

(continued)

Table B-1b (continued)
New York FIDA Demonstration Plan Performance on Select HEDIS Quality Measures for 2015–2018 by MMP

Measure	National MA Plan Mean	ElderServe Health				GuildNet				Healthfirst Health Plan			
	2018	2015	2016	2017	2018	2015	2016	2017	2018	2015	2016	2017	2018
Comprehensive diabetes care													
Received Hemoglobin A1c (HbA1c) testing	94.3	N/A	N/A	N/A	N/A	93.3	86.6	95.3	N/A	93.8	93.5	95.6	94.7
Poor control of HbA1c level (>9.0%) (higher is worse)	23.1	N/A	N/A	N/A	N/A	40.0	45.1	38.8	N/A	31.8	36.4	35.2	31.6
Good control of HbA1c level (<8.0%)	65.6	N/A	N/A	N/A	N/A	50.0	50.0	56.5	N/A	55.0[G]	53.8[G]	52.2[G]	51.6[G]
Received eye exam (retinal)	73.7	N/A	N/A	N/A	N/A	46.7	45.1	68.2	N/A	76.7	65.8	64.8	68.4
Received medical attention for nephropathy	95.5	N/A	N/A	N/A	N/A	100.0	91.5	96.5	N/A	95.4	94.0	97.5	95.8
Blood pressure control (<140/90 mm Hg)	69.1	N/A	N/A	N/A	N/A	43.4[G]	67.1[G]	72.9[G]	N/A	58.9	56.5	60.4	57.9
Initiation and engagement of alcohol and other drug (AOD) dependence treatment													
Initiation of AOD treatment [4]	33.6	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Engagement of AOD treatment [5]	4.5	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Plan all-cause readmissions (Observed-to-expected ratio)[6]													
Age 18-64	0.75	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	-	N/A	N/A	N/A
Age 65+	0.71	N/A	N/A	N/A	N/A	N/A	1.0	N/A	N/A	-	1.1	N/A	0.9
Ambulatory care (per 1,000 members) (counts)													
Outpatient visits (higher is better)	9,606.0	1,700.3	864.9	1,815.1	1,938.9	11,174.5[G]	11,793.9[G]	12,462.1[G]	12,730.1[G]	7,163.7	14,057.7	15,407.92	14,843.9
Emergency department visits (higher is worse)	600.8	196.2	648.7	201.7	524.0	535.5	858.4	587.2	484.2	435.1	1,230.8	793.7	776.6

(continued)

Table B-1b (continued)
New York FIDA Demonstration Plan Performance on Select HEDIS Quality Measures for 2015–2018 by MMP

BMI = body mass index; N/A = not applicable, where MA plans do not report such data or not applicable, where the number of enrollees in the demonstration plan's provided HEDIS data available for inclusion in the measure was less than 30, and therefore not reported per RTI's decision rule for addressing low sample size. — = not available, where the plan did not provide HEDIS data for this measure.

[1] The following criteria were used to determine adequate blood pressure control: less than 140/90 mm Hg for members 18–59 years of age; diagnosis of diabetes and <140/90 mm Hg for members 60–85 years of age; no diagnosis of diabetes and <150/90 mm Hg for members 60–85 years of age.
[2] Represents the percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks).
[3] Represents the percentage of members who remained on an antidepressant medication for at least 180 days (6 months).
[4] Represents percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.
[5] Represents the percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.
[6] Plan all-cause readmissions are reported as an observed-to-expected ratio. A value below 1.0 is favorable and indicates that plans had fewer readmissions than expected for their populations based on case mix.

NOTES: Green and red color-coded shading indicates where performance over time for a given measure was steadily improving or worsening; green indicates a favorable trend, where red indicates an unfavorable one. To ensure accessibility for text readers and individuals with sight disabilities, cells shaded green or red receive, respectively, a superscript "G" or "R". Detailed descriptions of HEDIS measures presented can be found in the RTI Aggregate Evaluation Plan.
SOURCE: RTI analysis of 2015 through 2018 HEDIS measures.

Table B-1c
New York FIDA Demonstration Plan Performance on Select HEDIS Quality Measures for 2015–2018 by MMP

Measure	National MA Plan Mean	MetroPlus Health Plan				Senior Whole Health of New York				Village Senior Services Corporation				VNS Choice			
	2018	2015	2016	2017	2018	2015	2016	2017	2018	2015	2016	2017	2018	2015	2016	2017	2018
Adults' access to preventive/ambulatory health services	95.0	99.1	100.0	98.7	95.5	N/A	97.7	97.9	97.0	N/A	N/A	N/A	N/A	98.0	97.9	99.4	99.0
Adult BMI assessment	96.0	95.9	97.9	98.6	92.3	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	76.8[G]	81.5[G]	91.6[G]
Controlling high blood pressure[1]	69.5	59.3	71.2	66.7	79.4	N/A	N/A	15.9	N/A	N/A	N/A	N/A	N/A	N/A	41.1	36.7	53.6
Breast cancer screening	72.7	N/A	N/A	89.5	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	62.0	59.0	61.1
Colorectal cancer screening	70.5	66.0	62.2	82.8	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	55.2	55.1	62.1
Disease modifying anti-rheumatic drug therapy in rheumatoid arthritis	77.8	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	54.8	N/A	N/A
Follow-up after hospitalization for mental illness (30 days)	47.9	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Antidepressant medication management																	
Effective acute phase treatment[2]	72.1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	64.6[G]	75.6[G]	88.2[G]
Effective continuation phase treatment[3]	56.1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	64.6	70.7	70.6
Care for older adults																	
Advance care planning	N/A	—	81.5	92.2	92.0	—	9.3	71.3	63.3	—	N/A	N/A	N/A	14.3	21.0	53.5	41.9
Medication review	N/A	—	89.1	93.8	93.1	—	14.0	70.1	61.1	—	N/A	N/A	N/A	31.0[G]	47.0[G]	66.9[G]	75.2[G]
Functional status assessment	N/A	—	90.8	95.3	92.0	—	11.6	67.8	63.3	—	N/A	N/A	N/A	100.0	91.0	95.6	99.5
Pain assessment	N/A	—	89.9	97.7	93.1	—	9.3	69.0	65.6	—	N/A	N/A	N/A	100.0	92.0	96.1	99.5

(continued)

Table B-1c (continued)
New York FIDA Demonstration Plan Performance on Select HEDIS Quality Measures for 2015–2018 by MMP

Measure	National MA Plan Mean	MetroPlus Health Plan				Senior Whole Health of New York				Village Senior Services Corporation				VNS Choice			
	2018	2015	2016	2017	2018	2015	2016	2017	2018	2015	2016	2017	2018	2015	2016	2017	2018
Comprehensive diabetes care																	
Received Hemoglobin A1c (HbA1c) testing	94.3	100.0	100.0	97.9	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	93.4	89.6	91.8
Poor control of HbA1c level (>9.0%) (higher is worse)	23.1	23.1	35.9	23.4	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	67.7	67.8	56.7
Good control of HbA1c level (<8.0%)	65.6	71.8	53.9	61.7	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	28.8	24.6	34.0
Received eye exam (retinal)	73.7	76.9	69.2	70.2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	62.8	85.8	85.6
Received medical attention for nephropathy	95.5	100.0	92.3	95.7	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	93.8	95.6	93.8
Blood pressure control (<140/90 mm Hg)	69.1	59.0[G]	64.1[G]	66.0[G]	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	50.9	50.3	57.7
Initiation and engagement of alcohol and other drug (AOD) dependence treatment																	
Initiation of AOD treatment[4]	33.6	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	55.9	N/A	N/A
Engagement of AOD treatment[5]	4.5	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	5.9	N/A	N/A
Plan all-cause readmissions (Observed-to-expected ratio)[6]																	
Age 18–64	0.75	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Age 65+	0.71	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1.1[G]	0.9[G]	0.6[G]
Ambulatory care (per 1,000 members) (counts)																	
Outpatient visits (higher is better)	9,606.0	21,137.1	26,690.8	14,577.4	13,402.1	11,603.3	13,652.7	13,940.6	13,863.7	8,907.2	12,117.3	10,218.3	10,643.5	10,743.2[G]	13,132.7[G]	15,630.1[G]	16,197.6[G]
Emergency department visits (higher is worse)	600.8	539.1[R]	756.2[R]	831.4[R]	948.5[R]	595.0	467.1	581.5	825.1	463.9	1,250.8	1,048.0	521.7	623.7	609.6	669.5	624.4

BMI = body mass index; N/A = not applicable, where MA plans do not report such data or not applicable, where the number of enrollees in the demonstration plan's provided HEDIS data available for inclusion in the measure was less than 30, and therefore not reported per RTI's decision rule for addressing low sample size. — = not available, where the plan did not provide HEDIS data for this measure.

(continued)

Table B-1c (continued)
New York FIDA Demonstration Plan Performance on Select HEDIS Quality Measures for 2015–2018 by MMP

[1] The following criteria were used to determine adequate blood pressure control: less than 140/90 mm Hg for members 18–59 years of age; diagnosis of diabetes and <140/90 mm Hg for members 60–85 years of age; no diagnosis of diabetes and <150/90 mm Hg for members 60–85 years of age.
[2] Represents the percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks).
[3] Represents the percentage of members who remained on an antidepressant medication for at least 180 days (6 months).
[4] Represents percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.
[5] Represents the percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.
[6] Plan all-cause readmissions are reported as an observed-to-expected ratio. A value below 1.0 is favorable and indicates that plans had fewer readmissions than expected for their populations based on case mix.

NOTES: Green and red color-coded shading indicates where performance over time for a given measure was steadily improving or worsening; green indicates a favorable trend, where red indicates an unfavorable one. To ensure accessibility for text readers and individuals with sight disabilities, cells shaded green or red receive, respectively, a superscript “G” or “R”. Detailed descriptions of HEDIS measures presented can be found in the RTI Aggregate Evaluation Plan.
SOURCE: RTI analysis of 2015 through 2018 HEDIS measures.