Highlights of New York's Memorandum of Understanding with CMS
For the New York Demonstration to Integrate Care for Dual Eligible Beneficiaries,
Fully Integrated Duals Advantage (FIDA)

Scope

- Individuals eligible for the FIDA demonstration include full benefit Medicare-Medicaid enrollees aged 21 and older who must meet one of the following three criteria: Nursing Facility Clinically Eligible and receiving facility-based long-term services and supports (LTSS); eligible for the Nursing Home Transition & Diversion (NHTD) 1915(c) waiver, and; require community-based long-term care services for more than 120 days.
- Excluded populations from this demonstration include, but are not limited to the following: residents of a New York State Office of Mental Health facility, individuals receiving services from the New York State Office for People with Developmental Disabilities system, residents of psychiatric facilities, individuals receiving hospice services, residents of immediate care facilities for individuals with intellectual/developmental disabilities, and individuals in the Traumatic Brain Injury 1915(c) waiver. A full list of excluded populations is found on Page 7 of the MOU.
- Individuals excluded from passive enrollment include, but are not limited to the following: Native Americans (who may opt-in at any time); individuals enrolled in Program for All-Inclusive Care for the Elderly (PACE); individuals enrolled in a Medicare Advantage Special Needs Plan for institutionalized individuals (I-SNPs); individuals enrolled in Health Homes; individuals assigned to a CMS Accountable Care Organization (ACO), and; individuals participating in the CMS Independence at Home demonstration.
- The demonstration will be implemented in eight counties of the State – Bronx, Kings, New York, Queens, Richmond, Suffolk, and Westchester – and will run from July 1, 2014 to December 31, 2017.

Contracting and Rates

- CMS and the State will enter into a joint rate-setting process as described in Appendix 6 of the MOU.
- CMS will develop baseline spending (costs absent the demonstration) and payment rates for Medicare Parts A and B services using estimates of what Medicare would have spent on behalf of the participants absent the demonstration using a blend of Medicare Advantage projected payment rates and Medicare Fee-for-Service (FFS) standardized county rates. The Medicare Part D baseline for the Part D Direct Subsidy will be set at the Part D national average monthly bid amount (NAMBA) for the calendar year.
- Subject to CMS approval, the State and its actuaries will determined the baseline spending for Medicaid services under the demonstration based on historical State data and trends rates. Medicaid actuarial soundness principles will apply to payments to health plans.
- Rates for each demonstration year will incorporate projected savings as follows: Year 1, 1%; Year 2, 1.5%; and Year 3, 3%.
- CMS-HCC risk adjustment methodology will be applied to the Medicare Part A/B portion of the rate and Part D RxHCC will be applied to the Part D portion. The Medicaid portion of the blended rate paid to health plans will include a rate cell structure risk adjustment.
- Because most FIDA participants will come from Medicare FFS, in calendar years 2014 and 2015, CMS will apply an appropriate coding intensity adjustment based on the proportion of the target population with prior Medicare Advantage experience on a county-specific basis. After calendar year 2015, CMS will apply the prevailing Medicare Advantage coding intensity adjustment to all FIDA plan participants.
- FIDA plans will be required each year to meet a Target Medical Loss Ratio (TMLR) threshold of 85 percent. If the Medical Loss Ratio (MLR) calculated annually is less than the TMLR, the FIDA plan shall remit to CMS and the State an amount equal to the difference between the calculated MLR and the TMLR (expressed as a percentage) multiplied by the revenue received during the coverage year.

Enrollment

- Passive enrollment is effective no sooner than 60 days after participant notification of the right to select a FIDA plan and the option to not participate in the demonstration. The State will execute the passive enrollment process in phases for eligible community-based LTSS individuals, facility-based LTSS individuals, and the NHTD waiver population.
- Requests to disenroll from a FIDA plan or enroll in a different FIDA plan will be accepted at any point after a participant's initial enrollment occurs and is effective on the first of the month following receipt of the request. Any time an individual requests to opt out of passive enrollment or disenroll from the demonstration, the State will send a letter confirming the opt-out and providing information on the benefits available to the participant once they have opted out or disenrolled.
- Participants will maintain their choice of plans and providers, including the right to choose an alternative integrated package of Medicare and Medicaid services through 1) a different FIDA Plan, 2) a Medicaid Advantage Plus plan, or 3) a PACE plan. Likewise, Participants have the right to choose a combination of 1) a Medicare Advantage plan, Medicaid Fee-For-Service (FFS) and a Managed Long Term Care (MLTC) plan or 2) Medicare Fee-For-Service (FFS), Medicaid FFS, an MLTC plan and a Prescription Drug Plan to receive the full array of Medicare and Medicaid services outside of an integrated product.

Consumer Protections

- CMS, the State, and FIDA plans shall ensure that all medically necessary covered benefits are provided to participants and are provided in a manner that is sensitive to the participant's functional and cognitive needs, language and culture, allows for involvement of the participant and caregivers, and is in a care setting appropriate to the participant's needs, with a preference for the home and the community.

- The State and CMS will require FIDA plans and their providers to communicate with their participants in a manner that accommodates their individual needs, including providing interpreters for those who are deaf or hard of hearing, accommodations for participants with cognitive limitations, and interpreters for those who do not speak English.
- The State will provide Medicaid-Medicare participants with independent enrollment assistance and options counseling to help them make an enrollment decision that best meets their needs. The State will work with an independent Enrollment Broker to ensure ongoing outreach, education, and support to individuals eligible for the FIDA demonstration.
- The State will create a new FIDA Participant Ombudsman. The FIDA Participant Ombudsman will be an independent entity under contract with the State to help participants and their caregivers access the care participants need through the FIDA demonstration.
- CMS and the State agree to utilize a unified set of requirements for FIDA plan grievances and internal appeals processes that incorporate relevant Medicare Advantage and Medicaid Managed Care requirements, to create a more participant-friendly and easily navigable system, except Part D appeals and grievances will continue to be managed by CMS as proscribed under existing Part D rules.
- Quality withhold measures will be applied to the demonstration for Medicare Parts A and B and Medicaid. The percentage withhold will be 1%, 2%, and 3% in each of the three demonstration years, respectively.

Care Model and Assessments

- All FIDA plans (in partnership with contracted providers) will be required to implement an evidence-based model of care (MOC). FIDA plans must meet all CMS MOC standards for Special Needs Plans as well as the self-direction requirements established by the State, as well as any other State requirements.
- FIDA plans will ensure the provision and coordination of all necessary Medicare and Medicaid-covered services, including primary, acute, prescription drug, behavioral health, and long-term supports and services. CMS, the State, and FIDA plans shall ensure that care is person-centered and can accommodate and support self-direction. Care management services will be available to all FIDA demonstration participants through the FIDA plan's Interdisciplinary Team (IDT) model.
- FIDA plans shall also ensure that medically necessary covered services are provided to participants, in the least restrictive community setting, and in accordance with the participant's wishes and their Person-Centered Service Plan. Person-Centered Service Plans will be developed by participants, their caregivers, and their Interdisciplinary Team, using a person-centered planning process.
- Upon enrollment in the FIDA demonstration, all participants will receive a comprehensive assessment to be completed no later than 30 days from the individual's enrollment date. This initial assessment and all reassessments must be performed by a Registered Nurse (RN) in the individual's home, which includes an assisted living facility or nursing facility, using the State Approved Assessment Tool. Within 30 days of the FIDA plan conducting a comprehensive assessment, a Person-Centered Service Plan will be completed for each participant by the participant's IDT.
- For each participant, FIDA plans will support an IDT, led by a care manager to ensure the integration of the participant's medical, behavioral health, substance use, community-based or facility-based LTSS, and social needs.

Continuity of Care

- For all items and services other than nursing facility services, FIDA plans must allow participants to maintain current providers and service levels, including prescription drugs, at the time of enrollment for at least 90 days after enrollment, or until a care assessment has been completed by the FIDA plan, whichever is later. For nursing facility services, FIDA plans must allow participants to maintain current providers for the duration of the demonstration.
- FIDA plans will advise participants and providers if and when they have received care that would not otherwise be covered at an in-network level. On an ongoing basis, and as appropriate, FIDA plans must also contact providers not already members of their network with information on becoming credentialed as in-network providers. FIDA plans must cover emergent or urgent services provided by out-of-network providers and may authorize other out-of-network services to promote access to continuity of care.
- FIDA plans are required to provide or arrange for all medically necessary services provided by the three-way contract, whether by sub-contract or by single-case agreement in order to meet the needs of the participant.

Evaluation

- CMS has contracted with an independent evaluator to measure, monitor, and evaluate the impact of the financial alignment models, including the New York capitated demonstration, on participant experience of care, quality, utilization, and cost. The evaluator will also explore how the New York initiative operates, how it transforms and evolves over time, and participants' perspectives and experiences.
- The State is required to cooperate, collaborate, and coordinate with CMS and the independent evaluator in all monitoring and evaluation activities. The State and FIDA plans must submit all required data for the monitoring and evaluation of this demonstration, according to the data and timeframe requirements to be listed in the three-way contract.