FINANCIAL ALIGNMENT INITIATIVE

New York Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities (FIDA-IDD) Preliminary Combined First and Second Evaluation Report

Spring 2022

Prepared for
Nancy Chiles Shaffer
Lanlan Xu
Centers for Medicare & Medicaid Services
Center for Medicare & Medicaid Innovation
Mail Stop WB-06-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Submitted by
Angela M. Greene and Zhanlian Feng
RTI International
3040 East Cornwallis Road
P.O. Box 12194
Research Triangle Park, NC 27707-2194
RTI Project Number
0214448.001.007.000.000.006

RTI INTERNATIONAL

FINANCIAL ALIGNMENT INITIATIVE
NEW YORK FULLY INTEGRATED DUALS ADVANTAGE FOR INDIVIDUALS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES (FIDA-IDD)
PRELIMINARY COMBINED FIRST AND SECOND EVALUATION REPORT

By

Muskie School of Public Service, University of Southern Maine

Kimberly I. Snow, MHSA
Elizabeth C. Gattine, JD
Eileen J. Griffin, JD
Louise Olsen, BA

RTI International

Giuseppina Chiri, PhD
Hannah Wright, MSPH
Douglas Fletcher, BS
Matt Toth, MSW, PhD
Noah D'Arcangelo, BA
Amy Kandilov, PhD
Regina Rutledge, PhD
Paul Moore, MA
Sachin Peddada, BA
Nicole Coomer, PhD
Amy E. Chepaitis, PhD
Emily Costilow, MA
Sunnie Hodge, BA
Joyce Wang, MPH
Ira Dave, MSPH
Bayley Weinstein, BS
Guadalupe Suarez, BS
Wayne Anderson, PhD
Edith G. Walsh, PhD

Project Directors: Angela M. Greene, MS, MBA, and Zhanlian Feng, PhD

Federal Project Officers: Nancy Chiles Shaffer, PhD, and Lanlan Xu, PhD

RTI International

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

Spring 2022

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 MMP 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, and our former project officer, Sai Ma. Christopher Klotschkow, Shari Lambert, Valerie Garner, Roxanne Snaauw, and Catherine Boykin provided excellent editing, graphic design, and document preparation.

Contents

Appendices

List of Tables

List of Figures

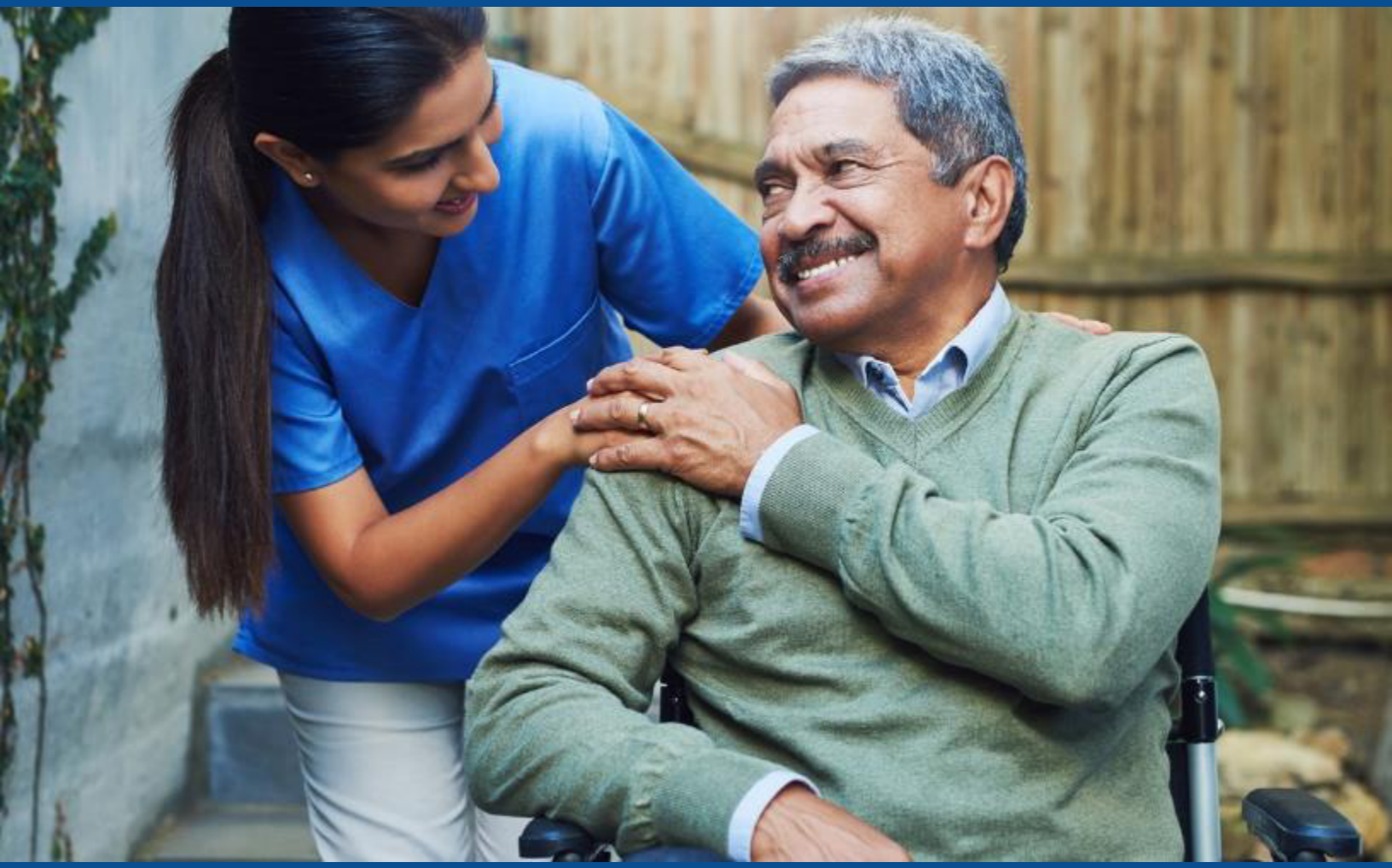
Glossary of Acronyms

CAB	Consumer Advisory Board
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CMS	Centers for Medicare & Medicaid Services
CAS	Coordinated Assessment System
CCO/HH	Care Coordination Organizations/Health Home
CMT	Contract Management Team
CSPA	Comprehensive Service Planning Assessment
CTM	Complaint Tracking Module
DDRO	Developmental Disabilities Regional Office
DinD	Difference-in-differences
DME	Durable medical equipment
DQI	Division of Quality Improvement
EQRO	External Quality Review Organization
FFS	Fee-for-service
FIDA	Fully Integrated Duals Advantage
FIDA-IDD	Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities
HCBS	Home and community-based services
HCC	Hierarchical Condition Category
HEDIS	Healthcare Effectiveness Data and Information Set
IAHO	Integrated Appeals Hearing Office
I AM	It's All About Me assessment tool
ICAN	Independent Consumer Advocacy Network
ICF/IID	Intermediate care facilities for individuals with intellectual disabilities

IDD	Individuals with intellectual and/or developmental disabilities
IDT	Interdisciplinary Team
JAC	Joint Advisory Council
LTSS	Long-term services and supports
MA	Medicare Advantage
MAC	Medicare Appeals Council
MARx	Medicare Advantage and Part D Inquiry System
MFFS	Managed fee-for-service
MMC	Medicaid Managed Care
MMCO	Medicare-Medicaid Coordination Office
MMP	Medicare-Medicaid Plan
MOU	Memorandum of Understanding
MRT	Medicaid Redesign Team
MSC	Medicaid Service Coordinator
NYSDOH	New York State Department of Health
OPWDD	Office of People with Developmental Disabilities
OQPS	Office of Quality and Patient Safety
OTDA	Office of Temporary and Disability Assistance
PAC	Participant Advisory Committee
PCP	Primary care physician or provider
PCSS	Plan of Care Support Services
PHE	Public Health Emergency
PHP	Partners Health Plan
PMPM	Per member per month
POM	Personal Outcome Measure

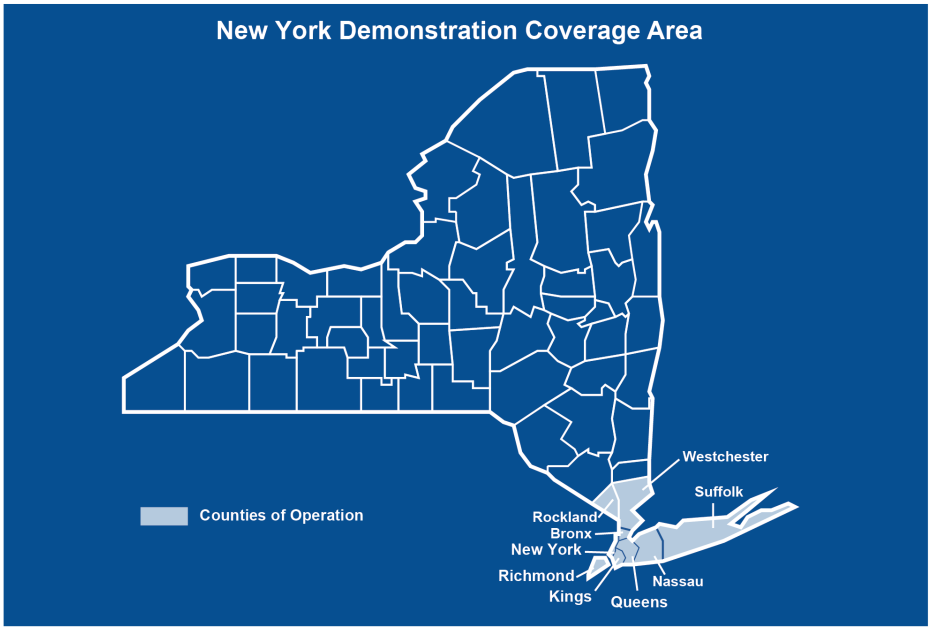
PS	Propensity score
SDRS	State Data Reporting System

Executive Summary



The Medicare-Medicaid Coordination Office and the Innovation Center at the Centers for Medicare & Medicaid Services (CMS) created the Medicare-Medicaid Financial Alignment Initiative (FAI) to test, in partnerships with States, integrated care models for dually eligible beneficiaries.

In April 2016, New York and CMS launched the Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities (FIDA-IDD) demonstration to integrate care for dually eligible beneficiaries with intellectual and/or developmental disabilities. It is the first comprehensive managed care demonstration exclusively serving individuals with IDD in the nation. The demonstration was implemented in nine New York counties: Bronx, Kings, New York, Queens, Richmond, Rockland, Nassau, Suffolk, and Westchester. One Medicare-Medicaid plan (MMP), Partners Health Plan (PHP), qualified to participate in the demonstration. The MMP receives capitated payments from CMS and the State to finance all Medicare and Medicaid services. FIDA-IDD is the second FAI demonstration to operate in New York. The first was the Fully Integrated Duals Advantage (FIDA) demonstration, which operated from 2015 through 2019.



Eligibility for FIDA-IDD is limited to those who are age 21 or older at time of enrollment; eligible for services administered by the Office of People with Developmental Disabilities (OPWDD); entitled to benefits under Medicare Part A, enrolled in Medicare Part B, eligible to enroll in Medicare Part D, and eligible for full Medicaid benefits; in need of the level of care provided by intermediate care facilities for individuals with intellectual disabilities (ICF/IID); residing in the demonstration area; and a U.S. citizen or lawfully present in the United States.

CMS contracted with RTI International to monitor demonstration implementation and to evaluate its impact on beneficiary experience, quality, utilization, and cost. The evaluation includes individual State-specific reports like this one. This combined first and second evaluation report describes implementation of the New York FIDA-IDD demonstration and analysis of the

demonstration's impacts. The report includes findings from qualitative data gathered from April 2016 through December 2020 with key updates from early 2021, and quantitative results for April 2016–December 2018. RTI did not conduct a service utilization impact analysis for this demonstration. Therefore, no service utilization results based on encounter and claims data are included. The cost savings results presented are preliminary because risk corridor payments have not yet been included in the calculations but will be accounted for in updated results in the next report.

Highlights

The State leveraged its experience with the FIDA demonstration to ease roll-out and administration of the FIDA-IDD demonstration. Policies and procedures for enrollment, grievances and appeals, provider training, and care coordination had been refined by the time FIDA-IDD began, leading to a generally smooth start-up for FIDA-IDD. Although enrollment has been lower than what the MMP or the State would prefer, both see low voluntary disenrollment rate and increasing enrollment of the Willowbrook[1] protected class members as indicators of enrollee and advocate satisfaction with the demonstration. An additional success of the demonstration is the increasing use of telehealth strategies beginning in 2018 by the MMP to decrease unnecessary and disruptive emergency department visits and hospitalizations.

Integration of Medicare and Medicaid	The joint CMS-State Contract Management Team (CMT), which is responsible for helping to address issues related to integrating Medicare-Medicaid policies and processes, was successful in its management of the demonstration. In January 2020, CMS approved the State's request to extend the demonstration through the end of 2023.
	Throughout the demonstration period, the State identified the fact that the MMP was developed by IDD providers as one of its strengths. Stakeholders perceived the MMP's care management model as uniquely comprehensive, providing individuals with a level of control over a wide range of detailed choices impacting their everyday lives.

[1] Willowbrook was a State-run institution for individuals with an intellectual disability. Willowbrook closed in 1987. The Willowbrook Permanent Injunction, signed in 1993, defined service standards for class members (OPWDD, n.d.-b).

Eligibility and Enrollment	Because beneficiary participation in FIDA-IDD was opt-in only with no passive enrollment, it has been difficult to increase enrollment.
	A major hospital system refused to participate in the demonstration. CMS, the State, and the MMP said that as a result, some eligible beneficiaries have been reluctant to enroll in FIDA-IDD, particularly if it meant beneficiaries had to change their providers.
	FIDA-IDD enrollment remained a small percentage of eligible beneficiaries but has increased each year of the report period. As of December 2020, 20,396 beneficiaries were eligible for the demonstration and 1,719 were enrolled, for an enrollment rate of 8.4 percent.
Care Coordination	The comprehensive It's All About Me (I AM) assessment tool has been effective at eliciting answers from the IDD population about their social, functional, behavioral, medical, and wellness needs and what can make a difference to their quality of life.
	The MMP's electronic information portal increased communication between providers in real time.
Beneficiary Experience	The MMP used the flexible benefit package in novel ways to meet enrollees' goals as identified through the I AM assessment tool.
	Throughout the demonstration to date, the MMP has used telemedicine to reduce difficult and disruptive trips to the doctor or emergency department. This experience helped the plan meet its members' needs during the COVID-19 public health emergency.

Stakeholder Engagement	The MMP used feedback from the Participant Advisory Council to improve transportation services as well as content for newsletters and social media communications.
Financing and Payment	The MMP had persistent concerns over the adequacy of the Medicare and Medicaid rates to cover the costs of care for members who were older and frailer than expected and to spread fixed costs across its enrollment, which ranged between 3.3 and 8.4 percent of the estimated 20,000 eligible beneficiaries.
	The State saw the MMP's reduction in hospitalizations as a potential source of cost savings for the enrolled population.
Quality of Care	Beginning in 2018, the MMP's pharmacy management program, which reviewed medications across all providers, decreased unnecessary emergency department visits and hospitalizations due to medication management issues.
Demonstration Impact on Cost Savings	As summarized in ***Table ES-1***, relative to the comparison group, the demonstration was associated with increases in Medicare expenditures for all demonstration years and cumulatively throughout the demonstration period.
	The demonstration was not associated with an increase or decrease in Medicaid costs during any demonstration year or cumulatively throughout the demonstration period.

Table ES-1 summarizes the demonstration effects on total Medicare Parts A and B expenditures for all eligible beneficiaries, including both the cumulative effect over the 2-year demonstration period and the annual effect for each demonstration year, as well as the cumulative and annual effect estimates for Medicaid expenditures for the same demonstration period.

Table ES-1
Summary of New York IDD demonstration effects on total Medicare expenditures and on total Medicaid expenditures among all eligible beneficiaries, April 1, 2016–December 31, 2018

Measure	Measurement period	Demonstration effect
Medicare Parts A and B cost	Cumulative (demonstration years 1–2)	Increase[R]
	Demonstration year 1	Increase[R]
	Demonstration year 2	Increase[R]
Medicaid cost	Cumulative (demonstration years 1–2)	NS
	Demonstration year 1	NS
	Demonstration year 2	NS

NS = not statistically significant.
NOTES: Statistical significance is defined at the α = 0.05 level. For numeric estimates of the demonstration's effect on total Medicare expenditures, see ***Figure 2*** in ***Section 10, Demonstration Impact on Cost Savings***. For numeric estimates of the demonstration's effect on total Medicaid expenditures, see ***Figure 3*** in ***Section 10***. Red color-coded shading indicates where the direction of the DinD estimate was unfavorable. To ensure accessibility for text readers and individuals with visual impairment, cells shaded red receive a superscript "R." In the column for "Demonstration effect," an *Increase* or *Decrease* refers to the *relative* change in an outcome for the demonstration group compared to the comparison group, based on the DinD regression estimate of the demonstration effect during the specified measurement period.
SOURCE: RTI analysis of Medicare and Medicaid claims (programs: dd_dy2_cs1480_GLM.log; 30_Regressions.do)

[This page intentionally left blank.]

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) created the Medicare-Medicaid Financial Alignment Initiative (FAI) to test, in partnerships with States, integrated care models for dually eligible beneficiaries. The goal of these demonstrations is to develop person-centered care delivery models integrating the full range of medical care, behavioral health services, and long-term services and supports (LTSS) for dually eligible beneficiaries. The expectation is that integrated delivery models would address the current challenges associated with the lack of coordination of Medicare and Medicaid benefits, financing, and incentives.

The Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities (FIDA-IDD) demonstration is part of New York's larger, ambitious Medicaid reform initiative launched in 2011. Under this initiative, New York set a goal of "Care Management for All" for the New York State Medicaid program, aiming to have all Medicaid beneficiaries enrolled in high-quality, fully integrated care management organizations within 5 years (New York State Department of Health [NYSDOH], n.d.). The key objectives of FIDA-IDD include improving the enrollee experience in accessing care, delivering person-centered care, promoting independence in the community, improving quality, eliminating cost-shifting between Medicare and Medicaid, and achieving cost savings for the State and the Federal government through improvements in care coordination. The demonstration also aims to meet the needs of demonstration enrollees, including their ability to self-direct their own care and live independently in the community (MOU, 2015, p. 4).

FIDA-IDD is the second of two FAI demonstrations in New York. The Fully Integrated Duals Advantage (FIDA) demonstration operated from 2015 through 2019. The FIDA demonstration ended at the conclusion of its 5-year demonstration period, and transitioned to an integrated grievance and appeals demonstration in 2020. The implementation of FIDA-IDD benefited greatly from the State, CMS, and plan experience with the FIDA demonstration. The FIDA-IDD demonstration began on April 16, 2016, and serves adults with intellectual and developmental disabilities who need the level of care provided at an intermediate care facility for individuals with intellectual disabilities (ICF/IID). The Office for People with Developmental Disabilities (OPWDD) is the State entity responsible for overseeing State-administered developmental services for this population. In addition to bringing increased care management to its service population, OPWDD also wanted FIDA-IDD to improve access to primary care physicians and behavioral health providers who are trained and have experience serving individuals with IDD. In 2020, the State requested and received approval from CMS to extend the demonstration through December 31, 2023.

The following are the key demonstration features. We provide additional details in the topic-specific report sections. Also see ***Appendix B*** for a summary of predemonstration and demonstration design features for dually eligible beneficiaries in New York.

Integration of Medicare and Medicaid functions. The FIDA-IDD demonstration integrates several Medicare and Medicaid functions, including development and distribution of marketing materials, enrollment and disenrollment processes, assessment and care planning

processes, appeals process, and contract management functions. We provide further details on the integration of Medicare and Medicaid functions throughout the rest of the report.

Financial model. All Medicare- and Medicaid-covered services in the demonstration are included in capitation payments to the Medicare-Medicaid plan (MMP), except for hospice, methadone maintenance treatment, out-of-network family planning, and directly observed therapy for tuberculosis, which are paid on a fee-for-service (FFS) basis. CMS and the State make separate risk-adjusted, per member per month payments to the FIDA-IDD plan. CMS makes a monthly payment reflecting coverage of Medicare Parts A and B services and a separate amount reflecting Part D services. NYSDOH makes a monthly payment reflecting coverage of Medicaid services (see ***Section 8.1, Rate Methodology***).

Eligible population. Eligibility for FIDA-IDD is limited to those who are age 21 or older at time of enrollment; eligible for services administered by OPWDD; entitled to benefits under Medicare Part A, enrolled in Medicare Part B, eligible to enroll in Medicare Part D, and eligible for full Medicaid benefits; in need of the level of care provided by ICF/IIDs; residing in the demonstration area; and a U.S. citizen or lawfully present in the United States.

FIDA-IDD plan. A single MMP, Partners Health Plan (PHP), is participating in the demonstration. PHP is a provider-based, nonprofit managed care organization that was created to participate in the demonstration. PHP serves individuals with intellectual and/or developmental disabilities (IDD) exclusively through participation in the demonstration and has no other lines of business (PHP, n.d.). To qualify as a FIDA-IDD plan, PHP had to satisfy CMS Model of Care requirements as well as State-specific requirements for a self-directed model of care. To participate in the demonstration, PHP was also required to obtain a Certificate of Authority to operate a managed long-term services and supports (MLTSS) plan from NYSDOH.[2] PHP successfully completed its readiness review, conducted jointly by CMS and New York in January 2016, and entered into the three-way contract with CMS and New York that same month. Although New York had anticipated contracting with more than one MMP, only three plans applied. Applicants were required to have prior experience coordinating care for the IDD populations. Only PHP was able to demonstrate that it could translate its care management experience into a managed care model (see ***Section 3.2, Overview of Integrated Delivery System***).

Geographic coverage. FIDA-IDD is implemented in nine New York counties: Bronx, Kings, New York, Queens, Richmond, Rockland, Nassau, Suffolk, and Westchester.

Care coordination. Under FIDA-IDD, care coordination is provided by a care manager partnered with a service coordinator. The care manager and service coordinator, the enrollee, the enrollee's primary OPWDD provider, and others at the enrollee's request, comprise the Interdisciplinary Team (IDT) (see ***Section 5.1, Care Coordination Model***).

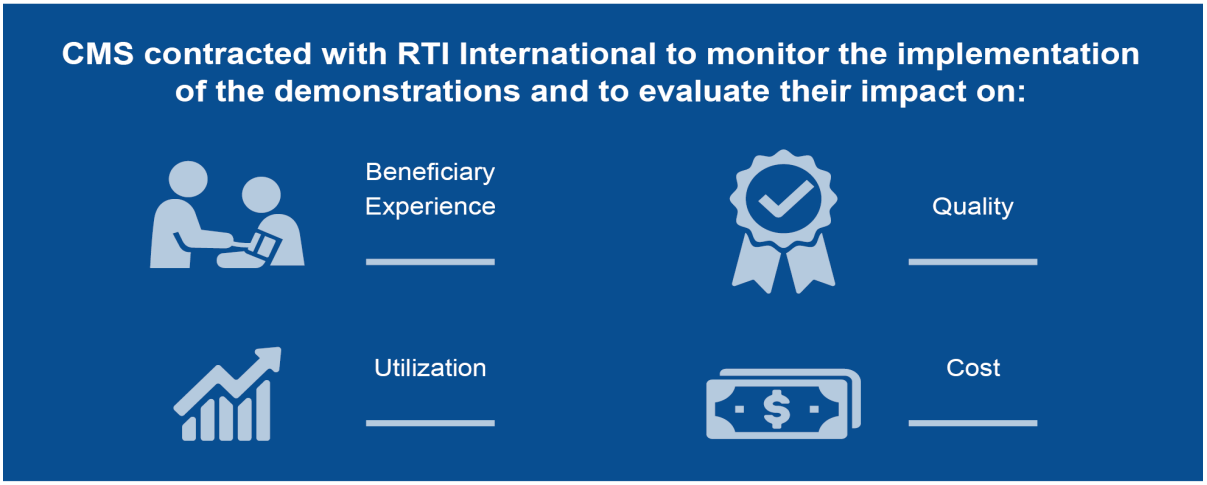
Benefits. FIDA-IDD covers Medicaid State Plan services; services covered under the 1915(c) waiver administered by OPWDD (herein after the OPWDD waiver), including IDD-targeted home and community-based services (HCBS); and Medicare Parts A, B, and D services

[2] An MLTSS plan is a managed care plan that provides Medicaid long-term services and supports to eligible individuals. In New York, these plans are referred to as Managed Long-Term Care plans.

and items (MOU, 2015, pp. 70-74). As in Medicare Advantage (MA), hospice services provided by Medicare-approved hospice providers are reimbursed directly by Medicare and not through the MMP (New York three-way contract, 2018, p. 263). The services authorized under New York's Medicaid Redesign Team (MRT) waiver include targeted home and community-based behavioral health services. See ***Appendix B, Demonstration Design Features,*** for a comparison of predemonstration and demonstration benefits, payment methods, and care coordination strategies.

Stakeholder engagement. Beginning in 2011, OPWDD engaged in an extensive stakeholder process focused on the design of specialized managed care organizations for individuals with IDD. OPWDD also relied on input from the Joint Advisory Council (JAC), a statutorily created statewide advisory council composed of 12 members that include individuals with developmental disabilities, family members, advocates, and service providers[3] (see ***Section 7.1, Stakeholder Engagement***). OPWDD also solicited input from the Consumer Advisory Board (CAB) for Willowbrook class members. (See discussion of Willowbrook class members in ***Section 2.2, Overview of State Context.***) For example, the CAB reviewed the MOU to ensure that the rights of Willowbrook class members, as defined under the permanent injunction, were reflected in the MOU.

1.2 Purpose of this Report



In this report, we analyze implementation of the FIDA-IDD demonstration from its start on April 1, 2016. We include qualitative data through December 2020, with key updates from early 2021. We refer to this time period as "the reporting period" or "the report period" in the qualitative narrative. We describe the New York FIDA-IDD demonstration's key design features; examine the extent to which the demonstration was implemented as planned; identify any modifications to the design; and discuss challenges, successes, and unintended consequences encountered during the period covered by this report. We also include findings or data on the beneficiaries eligible and enrolled, geographic areas covered, care coordination, the beneficiary experience, stakeholder engagement activities.

[3] See New York Mental Hygiene Law, §13.40.

We present quantitative analysis results related to Medicare and Medicaid costs for the demonstration period spanning April 1, 2016, through December 31, 2018. The difference in timeframes between qualitative and quantitative analyses is due to the lag of secondary data used in quantitative analysis. The cost savings results presented are preliminary because risk corridor payments have not yet been included in the calculations but will be accounted for in updated results in the next report. RTI did not conduct a service utilization impact analysis for this demonstration. Therefore, no service utilization results based on encounter and claims data are included.

1.3 Data Sources

We used a wide variety of data sources to inform this report (see below). See ***Appendix A, Data Sources*** for additional details.

SECTION 2

Demonstration Design and State Context

2.1 Changes in Demonstration Design

New York and CMS have made few changes to the original design of the FIDA-IDD demonstration since it was first implemented. One 2018 policy revision clarified when the comprehensive assessment and Life Plan need to be in place. Another change, effective in 2020, expanded the required qualifications for professionals conducting the comprehensive assessments and reassessments from only nurses to also include licensed social workers and psychologists (see ***Section 5.1, Care Coordination Model***). In 2019, CMS and NYSDOH adjusted the appeals process policy that requires providers who file appeals on behalf of enrollees to obtain enrollees' authorization before the plan moves forward with the appeal (see ***Section 6.2, Beneficiary Protections***). As discussed in ***Section 8, Financing and Payment***, in 2017, New York and CMS agreed to continue applying the limit on administrative costs as part of the risk corridor for 2 more years. In 2021, CMS applied a frailty adjustment to the Medicare rate for the plan's 55 and older population.

In response to the COVID-19 public health emergency (PHE), Governor Andrew Cuomo declared a state of emergency on March 7, 2020. NYSDOH leadership and OPWDD quickly stopped visitation and face-to-face meetings for HCBS waiver participants and waiver providers. OPWDD applied for and received an Appendix K Emergency Preparedness and Response waiver for its HCBS providers. The waiver allowed the State to provide retainer payments to community and day habilitation providers. This action enabled these providers to maintain their staff while they were unable to serve enrollees in person. In addition, the Appendix K waiver allowed the MMP to conduct telephonic care coordination meetings with enrollees. The State also relaxed the Medicaid beneficiary recertification requirements, and in 2021, OPWDD said they would ask for a runout period before reinstating the requirements after the PHE ended to ensure the processes were running smoothly.

In early 2021, OPWDD said they were considering continuing some changes they made during the PHE. These included expanding the opportunities for telehealth support of enrollees and providing other options for older enrollees who would like to "retire" from out-of-residence day habilitation activities to other types of in-residence activities. OPWDD gave the example of the MMP arranging for Broadway musical professionals to help enrollees sing together virtually during the PHE.

2.2 Overview of State Context

NYSDOH has had considerable experience with Medicaid managed care, having transitioned most Medicaid beneficiaries into its comprehensive managed care program, Medicaid Managed Care (MMC), and its long-term care population (individuals in need of long-term care for more than 120 days) into one of its MLTSS products. However, with some exceptions, managed care was new to New York's IDD population and developmental services providers because individuals receiving HCBS IDD services had been excluded from MLTSS. Individuals with IDD who receive only Medicaid may, but are not required to, enroll in New York's MMC program, which only covers health benefits. Individuals with IDD who are dually eligible for Medicare and Medicaid and receive their Medicare services on a FFS basis may not enroll in MMC for Medicaid services. Dually eligible individuals with IDD can enroll in MA

Special Needs Plans (called Medicaid Advantage in New York) which cover Medicare services and wraparound Medicaid health benefits, excluding long-term care. Outside the demonstration, all OPWDD services (e.g., HCBS IDD, residential IDD services) are accessed only on a FFS basis.

The "front door" to OPWDD services is through New York's five Developmental Disabilities Regional Offices (DDROs). The DDROs are the primary point of contact for determining eligibility for OPWDD services and for authorization of OPWDD services. The FIDA-IDD demonstration area overlaps with some of the counties in DDRO region 3 and all the counties in DDRO regions 4 and 5. Each of the regions has its own director, under the supervision of OPWDD's deputy commissioner.

In August 2017, New York submitted an amendment to the MRT waiver requesting CMS approval for a two-phase process moving OPWDD services from FFS to managed care. The first phase, authorized under a State plan amendment and beginning July 1, 2018, allowed NYSDOH to implement health homes for individuals with IDD (called Care Coordination Organizations/Health Homes, or CCO/HHs). Responsibility for Medicaid Service Coordination—which is targeted case management and Plan of Care Support Services (PCSS)[4] —was transitioned to the CCO/HHs in this first phase.

In 2018, OPWDD described the movement toward managed care as an important tool to achieve quality and value in the developmental services system that has historically been paid on a FFS basis. OPWDD reiterated one of the goals of the demonstration was to show that "managed care, if well-designed, can serve people with intellectual and developmental disabilities." For individuals dually eligible for Medicare and Medicaid, integrated care is also important. Although OPWDD administers and monitors New York's Medicaid-covered developmental services such as adaptive skill building and community habilitation, there has always been an "enormous hole" in its ability to monitor medical service use, because it did not have access to Medicare data from CMS or Medicaid data from NYSDOH. OPWDD viewed the opportunity to collaborate with CMS and NYSDOH under the demonstration as critical to understanding what is happening on the medical side for most of the population it serves.

Some dually eligible beneficiaries eligible for the demonstration are protected class members under a permanent injunction connected to the Willowbrook State School.[5] The permanent injunction defines standards for case manager qualifications, staffing ratios, and the nature and frequency of case management services for class members. While the FIDA-IDD MOU and three-way contract do not specifically address the Willowbrook permanent injunction, the IDT policy, which governs care management provided to FIDA-IDD enrollees,[6] requires care managers serving Willowbrook class members to coordinate with OPWDD to assure that case management services comply with the permanent injunction (IDT policy, 2018, p. 11). Willowbrook class members are represented by the CAB, a seven-member board providing

[4] PCSS is like Medicaid Service Coordination, except that it is a waiver service designed for individuals who need a less intensive level of monitoring.
[5] As a result of a class action lawsuit, the Willowbrook Consent Decree became effective in 1972 on behalf of Willowbrook residents and their families, referred to as "class members." In 1993, the permanent injunction (court order) was signed which represents the current standard of services for class members.
[6] See ***Section 5, Care Coordination*** for more information about the IDT policy.

representation and advocacy services on an individual basis for all Willowbrook class members, including enrollment decisions into FIDA-IDD.

2.2.1 Federal Implementation Funding

NYSDOH elected not to use Federal implementation funding for its ombudsman program because the program serves many population groups, in addition to those participating in FIDA-IDD. OPWDD used Federal funding through its Balancing Incentive Program to help the developmental services delivery system transition to managed care, specifically by supporting IT system development and care management, which, in turn, supported demonstration implementation.

[This page intentionally left blank.]

SECTION 3

Integration of Medicare and Medicaid

Administration of the FIDA-IDD demonstration benefited greatly from the integrated systems previously developed for the original FIDA demonstration.

FIDA-IDD has served as a steppingstone to fulfill the Medicaid Redesign Team goal of bringing managed care to beneficiaries and providers who were traditionally excluded from it.

Joint management of the demonstration through the Contract Management Team (CMT) has worked well, and technical, policy, and compliance issues have been quickly addressed.

In this section, we provide an overview of the demonstration's management structure and describe the integrated delivery system, the MMP and its provider arrangements, and training and support for the MMP and providers.

3.1 Joint Management of Demonstration

FIDA-IDD is jointly managed by CMS, NYSDOH, and OPWDD. NYSDOH, as the single State Medicaid agency, has lead responsibility for the demonstration. To implement FIDA-IDD, NYSDOH leveraged many components of its existing infrastructure, including its eligibility and enrollment system, enrollment broker, MLTSS certification process, contract management process, claims processing system, quality management capacity, and finance and rate setting capacity. FIDA-IDD also benefited greatly from the integration of systems NYSDOH and CMS built for implementing the FIDA demonstration,[7] and staff who worked on FIDA also assisted with FIDA-IDD. By the time FIDA-IDD began, many implementation issues in the integrated systems had already been resolved.

As the agency responsible for IDD programs, OPWDD has shaped the design and implementation of the demonstration to be responsive to its service population and delivery system. It takes the lead with stakeholder engagement and outreach, reviews marketing materials, troubleshoots enrollment issues, and taps its own quality management capacity to conduct quality monitoring activities specific to the IDD service system, such as the National Core Indicators survey[8] (see ***Section 9.2, Quality Management Structures and Activities***).

At the start of the demonstration, the working relationship between OPWDD and NYSDOH benefited from OPWDD staff who had previously worked for NYSDOH on Medicaid managed care products and understood State Medicaid agency perspective. As the demonstration has progressed, some OPWDD FIDA-IDD staff were pulled away to other OPWDD initiatives such as the launch of the CCO/HH model in 2018. Despite changes in leadership and operations staff at OPWDD and the departure of a key consultant at NYSDOH in 2018 and 2019, staff

[7] The first evaluation report of the FIDA demonstration describes the integrated systems. It can be accessed here: https://innovation.cms.gov/files/reports/fai-ny-firstevalrpt.pdf .
[8] See https://www.nationalcoreindicators.org/ for more information.

members dedicated to FIDA-IDD demonstration operations at each agency reported having adequate support for their work.

The MOU established a Contract Management Team (CMT) to monitor the MMP's performance. Members of the CMT representing CMS include the State leads for MMCO, a representative of CMS' Consortium for Medicaid and Children's Health Operations, and an account manager from the Consortium for Medicare Health Plan Operations (CMHPO) (MOU, 2015, p. 86). OPWDD and NYSDOH CMT membership includes their core FIDA-IDD staff, with ad hoc attendance at meetings by others as needed.

The CMT first convened formally in January 2016 and initially met weekly. The CMT focused on getting the demonstration up and running for the first several months; it subsequently focused more on daily operational matters, and, as of early 2021, met on a biweekly basis.

The CMT also meets with the MMP monthly. These calls focus on outstanding issues or any questions the MMP has and may include discussions about the MMP's provider network, marketing materials, marketing events conducted by the MMP, or contract issues. The CMT regularly reviews the following with the 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.

The CMT also monitors changes in plan leadership and asks the MMP for details on various topics. For example, the MMP provided in-depth information to the CMT on how FIDA-IDD was working for the Willowbrook class members.

OPWDD is often the first point of contact for the MMP and takes responsibility for triaging and sometimes resolving issues before they go to the CMT. OPWDD characterized these as minor issues that do not have large policy implications. For example, OPWDD investigated and addressed enrollment issues arising from eligibility/enrollment data conflicts in New York's Welfare Management System. Some State contractual issues go directly to NYSDOH instead of the CMT.

The CMT has provided a range of technical supports to the MMP. For example, NYSDOH reported helping the plan to submit its Plan Benefit Package (PBP), provider network, and marketing reviews. NYSDOH also reported that the MMP had some deficiencies in its initial PBP, but the MMP addressed them quickly. CMS reported that the CMT had issued some Medicare notices of noncompliance related to marketing materials in the summer of 2017, and in 2018 the CMT asked the MMP to submit a performance improvement plan for improving its provider and pharmacy directory to meet the directory requirements. In 2021, CMS said that

there had not been any major issues in 2020 that warranted a notice of noncompliance, and they had few concerns.

OPWDD staff meet with NYSDOH staff when they have policy issues to resolve, before bringing issues to the CMT. These calls had been weekly at the beginning of the demonstration, but OPWDD reported in 2018 that monthly calls were now sufficient. Throughout the demonstration, OPWDD has expressed appreciation for its CMS partners in managing the demonstration. In 2016 OPWDD described participating in the demonstration as a key opportunity for the State to look at Medicare data to better understand enrollees' medical service use, but in 2018 and 2019 OPWDD also noted that they still had little information about the Medicare side of the demonstration and the impact on Medicare service utilization.

3.2 Overview of Integrated Delivery System

3.2.1 FIDA-IDD Plan

PHP is the only MMP participating in the FIDA-IDD demonstration. The plan was founded by five nonprofit provider groups, representing the regional chapters of The Arc New York and AHRCs[9] (hereafter, Arcs/AHRCs) in the demonstration area. PHP is governed by a board composed of advocates for individuals with IDD, people with managed care expertise, and representatives from the Arcs/AHRCs. OPWDD noted that one of the strengths of PHP is the fact that it was developed by IDD providers. PHP said that its founding providers were motivated to improve coordination of care for persons with IDD, a population that has seen increased life expectancy and subsequent increased frequency of age-related health conditions. OPWDD noted that millions of dollars of private money were invested in the startup of PHP, coming mostly out of the provider community.

Although PHP did not have prior experience operating an MA or MLTSS plan before the launch of FIDA-IDD, PHP's executive team had prior experience with Medicare or Medicaid managed care, either as OPWDD program leaders or as providers. PHP has consistently noted that its combination of people who understand Medicare and Medicaid policy and systems, as well as people who are committed to serving individuals with IDD, has been important to its success.

In the 4 years between New York's original application to implement a demonstration under the FAI and the start of enrollment, PHP was able to pilot its assessment tool and care model. The pilot allowed PHP to refine its care model and care management team as well as develop a relationship with individuals with IDD and their family members. PHP reported that at one point, 1,700 people were participating in the pilot. Stakeholders saw the pilot as having facilitated a smooth implementation of the care model, once FIDA-IDD was launched. They continued to perceive PHP's care management model as uniquely comprehensive and providing individuals with a level of control over a wide range of detailed choices impacting their everyday lives. (See ***Section 5.1, Care Coordination Model,*** for more information on the MMP's care model.)

[9] Arcs and AHRCs are nonprofit provider groups specializing in serving individuals with IDD and are part of a national network of state and local chapters.

3.2.2 Provider Arrangements and Services

Hospital system and physician reluctance to participate in the demonstration has been an ongoing challenge, as eligible beneficiaries with strong ties to specific providers are unwilling to enroll. Several factors contributed to provider resistance to contracting with the MMP.

The MMP noted early in the demonstration that some providers were wary of participating in FIDA-IDD because of negative provider attitudes toward the previous FIDA demonstration, and the plan worked hard to improve these attitudes through provider outreach. The MMP reported, "We don't even say 'FIDA' plan anymore… we actually say 'Managed Care Program.'"[10]

In 2018 the MMP reported having contractual relations with over 15,000 providers and hospital systems. However, throughout the demonstration, the MMP continued to encounter providers who resisted participating in FIDA-IDD, and the nonparticipation of a major hospital system remained one of the plan's biggest challenges. Both OPWDD and CMS reported that this hospital system declined to contract with any new managed care plans, and FIDA-IDD enrollment was not high enough to induce the hospital system to participate. Because it is affiliated with physician associations that serve many potential FIDA-IDD enrollees, many eligible beneficiaries were deterred from enrolling if it meant changing their physician.[11] As OPWDD reported:

There are so many plans now that hospitals are reluctant to take on one more, and particularly if you might [only] get a share of 20 people. To go through all that work and get your legal [team] to approve a contract and set up billing and it's 20 people, they're like, no thanks.

— OPWDD (2018)

In 2019, a hospital system based on Long Island—a key catchment area for the demonstration—stopped participating in the demonstration, creating an additional barrier to enroll eligible beneficiaries in that service area.

From OPWDD's perspective, at least some of the resistance to participate in FIDA-IDD among developmental services providers reflected their reluctance to participate in managed care at all. Although some developmental services providers were large and sophisticated, others were very small, did not use information technology or data, and resisted becoming "medicalized" because of joining managed care. OPWDD continued to believe that the FIDA-IDD demonstration has offered an opportunity for developmental services providers to see how

[10] Provider participation in the FIDA demonstration was low due to what was perceived as burdensome requirements of participating in the IDT and training programs. Details of these challenges and the training requirements originally implemented in the FIDA demonstration can be found in the First Evaluation Report for the New York Fully Integrated Duals Advantage (FIDA).

[11] MMPs participating in the FIDA demonstration experienced a similar challenge with this same hospital system.

integrated care can be effective, and the demonstration could be a steppingstone for the State's eventual transition to managed care for IDD beneficiaries.

To support continuity of care for enrollees with nonparticipating providers, the MMP enters into single case agreements with individual providers. The MMP reported that it has been able to convert many of these single case agreements into contracts, as enrollment has increased. CMS said that the plan used single case agreements strategically to accommodate new enrollees, but it was not the MMP's preferred practice.

OPWDD and the MMP said that it was a challenge to bring dental providers into the network, even when they were paid the Medicaid FFS rate, because people with IDD often require a level of sensitivity in care that the general population does not. OPWDD and the MMP described Medicaid rates for dentists as low. The MMP has been able to leverage its relationships with developmental services providers that run their own Federally Qualified Health Centers to provide dental services.

The MMP typically pays participating developmental services providers on a FFS basis at current Medicaid rates. In 2018–2021, the MMP said it was developing value-based purchasing strategies, but alternative payment methodologies have historically been difficult to arrange with developmental service providers because few measurable outcomes for IDD services are tied to payment. With the expectation that the MMP would enter into value-based purchasing arrangements, the plan worked with its sponsoring organizations and IDD providers on two simultaneous strategies: a shared-savings strategy aimed at reducing unnecessary emergency department use, and an alternative payment methodology where providers would receive a capitated amount for attributed enrollees and would have to meet quality metrics.

In the shared-savings model, clinic providers[12] would receive a share of plan cost savings generated by decreasing unnecessary emergency department (ED) use and hospitalizations (see ***Section 8.2, Financial Impact*** and ***Section 9.2, Quality Management Structures***). The MMP reported in 2021 that IDD providers were incentivized to invest in telemedicine because they could achieve cost savings by avoiding unnecessary ED visits and accompanying enrollees to the hospital.

In the alternative payment methodology, IDD providers would receive a capitation for attributed enrollees and must meet ten quality metrics. Eight of the 10 metrics are pay-for-performance measures and are based on Healthcare Effectiveness Data and Information Set (HEDIS) measures or New York quality withhold measures such as annual wellness visits, flu shots, and hospital admissions related to sepsis. Two of the metrics are newly developed by PHP and are IDD service-specific: (1) transitions to less restrictive settings; and (2) transitions of adults 65+ to retirement-style programming[13] instead of traditional day habilitation activities that may be geared toward a younger population. In 2021, the MMP said the IDD providers would be paid to report data on the IDD quality measures that the plan could use to determine future benchmarks.

[12] OPWDD Article 16 clinics which provide habilitative services to improve or limit disabling conditions, disease, or illness for people with I/DD, https://opwdd.ny.gov/providers/article-16-clinics as accessed April 14, 2021.
[13] OPWDD leadership and PHP used this term to describe day program alternatives for older enrollees who would like to retire from their regular day activities.

3.2.3 MMP Training and Support for Participating Providers

The MMP provided training and guidance on working with individuals with IDD to its vendors such as transportation contractors and pharmacies. For example, they advised vendors that they may have trouble understanding an enrollee's speech, and they need to remain patient or ask if someone else in the home can pick up the phone. The plan did not need to train physicians as much as other providers, because enrollees have typically been able to keep the same physician. The MMP's call center has a hotline that providers can contact at any point with specific questions.

Although the MMP trained residential and nursing facility administrators and other developmental services providers on managed care policies and procedures, the training did not always translate into practice. For example, in 2018 the MMP said that although they trained facility providers to use an enrollee's MMP card—rather than a Medicaid or Medicare card—when taking the enrollee to an appointment, sometimes the wrong card was used. When this happened, the provider was reimbursed incorrectly. The MMP attributed this type of error to the fact that many agencies served only one demonstration enrollee and forgot this exception to their standard practice.

In 2019, the MMP described how they use different types of training to educate developmental services providers, such as meetings in which the MMP's care management team or community outreach group explained enrollees' service plans, continuity of care, and discharge planning procedures. The MMP also hosted a monthly provider education webinar that included a question-and-answer period at the end. The MMP said it reached a few hundred providers per month through the various training opportunities and through phone calls from providers.

3.3 Major Areas of Integration

3.3.1 Integrated Benefits and Enrollment

The three-way contract defines a combined package of Medicare- and Medicaid-covered services. When determining coverage under FIDA-IDD, the MMP must apply the more expansive coverage available under Medicare or Medicaid (New York three-way contract, 2018, p. 52). FIDA-IDD also includes an integrated formulary combining prescription drugs covered under Medicare Part D and Medicaid and certain non-prescription drugs excluded by Medicare Part D (New York three-way contract, 2018, p. 214).

New York and CMS worked together to design integrated enrollment procedures, including integrated enrollment notices and materials for FIDA-IDD enrollees and an integrated enrollment process through New York's enrollment broker. The integrated enrollment process involves the transfer of data files from the enrollment broker to New York's Medicaid enrollment system to confirm Medicaid eligibility, then to CMS's vendor for confirmation of Medicare eligibility, and then to New York's benefit enrollment system before the MMP is notified it has a new enrollee. An enrollee can disenroll by calling New York's enrollment broker, by calling 1-800-MEDICARE, or by enrolling in an MA or Medicare prescription drug plan. To preserve continuity of care, PHP chose to assume financial risk for up to 90 days of

continuing coverage for enrollees who lose their Medicaid eligibility. In ***Section 4, Eligibility and Enrollment,*** we provide more detail on the enrollment process and some of the successes and challenges with enrollment, disenrollment, and the Medicaid recertification process.

3.3.2 Integrated Care Coordination and Care Planning

As discussed in greater detail in ***Section 5, Care Coordination***, Medicare and Medicaid services are integrated through the IDT. The IDT is led by the enrollee's assigned care manager, who can be a nurse, a licensed social worker, or a psychologist. The care manager supports development of a comprehensive Life Plan that addresses the enrollee's medical and psychosocial needs, functional level, behavioral health needs, language, culture and support systems, personal goals, and the individual's preferences. The care manager is paired with a service coordinator who is more likely to be the primary point of contact for the enrollee, contacting providers, scheduling medical appointments, and providing other types of assistance.

The MMP uses a comprehensive service planning assessment tool, the I AM tool, that captures information for functional, medical, behavioral, wellness and prevention domains as well as the enrollee's preferences, strengths, and goals. The results of the assessment are used to develop the Life Plan.

3.3.3 Integrated Quality Management

CMS and NYSDOH have an integrated quality measurement strategy, including core measures collected across all demonstrations under the FAI, New York-specific measures, and quality withhold standards. Quality monitoring is coordinated through the CMT, which jointly monitors plan activities and grievances and appeals, hears reports from the ombudsman program, and identifies emerging trends and issues across plans. See ***Section 9, Quality of Care,*** for more information about quality management.

3.3.4 Integrated Financing

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

3.3.5 Integrated Appeals

New York and CMS developed a unique integrated approach that created a single appeals process for both Medicare and Medicaid appeals (excluding those related to Medicare Part D, which remain outside New York's integrated appeals process). A FIDA-IDD enrollee (or his or her representative) can appeal any action by the MMP to deny or limit authorization of a covered

service.[14] An appeal must first be filed with the MMP. If, on reconsideration, the MMP upholds its original decision, it automatically forwards the appeal to a State-level hearing office, the Integrated Administrative Hearing Office (IAHO) within the New York State Office for Temporary and Disability Assistance, which hears all Medicare- and Medicaid-related appeals. If an enrollee disagrees with the decision at the State level, they may file an appeal at the Federal level with the Medicare Appeals Council.

In addition to streamlining the process, CMS and State appeals policies are also integrated, and the IAHO applies both Medicare and Medicaid statute and regulation when making its ruling. See ***Section 6.2, Beneficiary Protections,*** for more information about the integrated appeals process.

[14] An Action is defined in the three-way contract as a denial or a limited authorization of a requested item or service, or a reduction, suspension, or termination of a previously authorized item or service; denial, in whole or in part, of payment for an item or service; failure to provide items or services in a timely manner; determination that a requested service is not a covered benefit (does not include requests for items or services that are paid for fee-for-service outside the FIDA-IDD Plan); or failure to make a Grievance determination within required time frames (New York three-way contract, p. 5).

SECTION 4

Eligibility and Enrollment

Without passive enrollment, voluntary beneficiary participation in FIDA-IDD may have contributed to low enrollment in the demonstration.

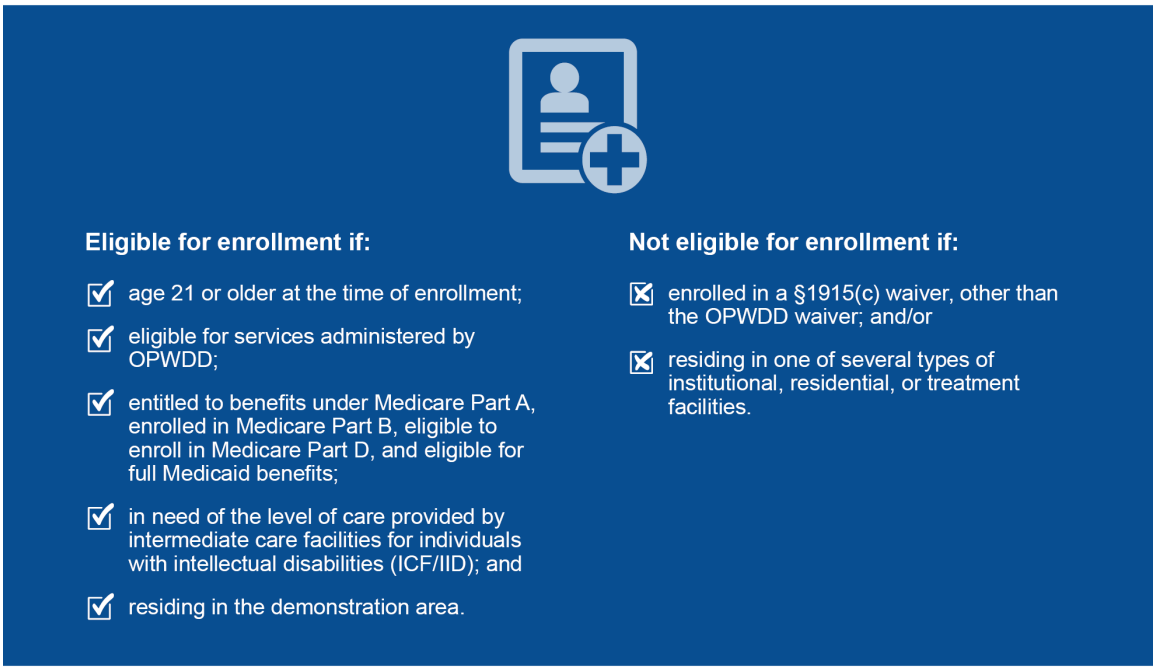
With the refusal of a major hospital system to participate in the demonstration, CMS, the State, and the MMP said eligible beneficiaries have been reluctant to enroll in FIDA-IDD if it meant they had to change their providers.

In this section we provide an overview of the enrollment process for FIDA-IDD. We include eligibility and enrollment data, and discuss the MMP's experiences with reaching enrollees, as well as factors affecting enrollment decisions.

4.1 Eligibility

Figure 1 shows eligibility criteria for the FIDA-IDD demonstration.

Figure 1
Eligibility criteria for passive enrollment in FIDA-IDD



NOTE: Individuals residing in an ICF/IID or an OPWDD-financed group home are eligible for enrollment. However, individuals residing in a developmental center (a large State-operated ICF/IID) must leave the developmental center to be eligible for enrollment.
SOURCE: MOU, pp. 8–9.

4.2 Enrollment

All enrollment transactions are processed through the State-contracted enrollment broker, Maximus, which operates as New York Medicaid Choice for all Medicaid managed care programs in New York. Interested beneficiaries are instructed to call Maximus to learn about enrollment options. Maximus confirms an individual's eligibility for the demonstration and then helps the caller determine whether needed providers are in the MMP's network. The individual can then make the affirmative choice whether to enroll in FIDA-IDD. Transmission of files between Maximus, CMS, New York, and the MMP has gone smoothly with few issues.

Enrollment in the demonstration is on an opt-in basis only, with no use of passive enrollment. The State noted in 2020 that because the process is entirely voluntary, it has been difficult to achieve large increases in enrollment.

An enrollee can disenroll by calling Maximus to request disenrollment; calling 1-800-MEDICARE; enrolling directly in a new MA or Medicare prescription drug plan; or sending a written request to Maximus.

OPWDD used the department's Promoting Relationship and Implementing Safe Environments curriculum to train dedicated call center staff to respond appropriately to individuals who may have language difficulties or cognitive impairments. Additionally, Maximus provided program education and enrollment support at several outreach and marketing events conducted by OPWDD and the MMP. OPWDD described Maximus call center staff as knowledgeable about the FIDA-IDD demonstration and effective in their role of confirming eligibility, describing the demonstration to eligible beneficiaries, and helping individuals find out if their providers (for both medical and IDD services) are in the MMP's network.

New York was able to work with CMS to set a FIDA-IDD enrollment cutoff date of the 20th of the month, for an effective date of the first day of the following month. Enrollment requests that are received after the 20th of the month have an effective date of the first day of the second following month. Enrollees can disenroll up to and on the last day of the month with an effective date of the first day of the next month. OPWDD indicated that the last day of the month disenrollment policy has presented challenges for it and the MMP in ensuring services outside the demonstration are in place for enrollees on the day after they disenroll, a short window of time. Voluntary disenrollment from the demonstration has been low overall, however.

4.2.1 Reaching Enrollees

Eligible beneficiaries learn about FIDA-IDD through program announcement letters, DDROs, the MMP, and marketing and outreach materials and events.

At the start of the demonstration, OPWDD sent FIDA-IDD demonstration announcement letters to eligible beneficiaries in the demonstration area. OPWDD also conducted at least two public meetings each in Nassau County, Suffolk County, and the five boroughs of New York City. It also held joint meetings for Westchester and Rockland counties. The MMP attended these meetings, and representatives from CMS and Maximus attended some of them. OPWDD indicated the meetings were geared toward educating families and individuals about the demonstration, and enrollments were more likely to result from these events than from mailings.

The MMP also conducted marketing events, and staff made presentations for individual families, health fairs, and at other venues. Other strategies included asking provider agencies to host family meetings, asking area independent living centers for permission to make presentations in the facilities to introduce the concept, and conducting home visits for those who did not want to participate in other events. In 2018, CMS noted the MMP's focus on building opt-in enrollment was "impressive," particularly for the first comprehensive managed care product exclusively serving the IDD population. CMS described the MMP as a "trailblazer" because the IDD population historically had been resistant to managed care in New York.

The MMP described the marketing process for FIDA-IDD as very different from that used for mainstream managed care plans because a potential FIDA-IDD enrollee often has a parent or guardian speaking on their behalf. Also, much of the marketing must be conducted on an individual level. The MMP reported in 2018 that it typically took between 60 and 90 days from the initial touchpoint before a family was ready to make the decision to enroll. During that time, the MMP was likely to have several conversations with the family and answer many questions. In 2021, the CMT and MMP said in-person marketing activities were curtailed during the PHE. Prior to the PHE, between 70 and 90 members joined the demonstration each month. Beginning in May 2020, new enrollments numbered between 15 and 30 members per month and, to date, have not rebounded to previous levels (see ***Section 4.3, Eligibility and Enrollment Data***).

Each month during the demonstration, approximately 200 newly eligible people received an informational letter and packet from Maximus. Prior to the PHE, the DDRO's Front Door sessions also provided information about the OPWDD delivery system and available service options, including FIDA-IDD. Most, but not all, people attending these sessions were new to OPWDD services. The MMP participated in these sessions as well, prior to the pandemic.

Most beneficiaries eligible for FIDA-IDD are already receiving OPWDD services. When New York transitioned to the CCO/HH model in 2018, the MMP reported that it marketed FIDA-IDD as another care management option for beneficiaries served by OPWDD, for those who met demonstration eligibility criteria. At the same time, the MMP said that CCOs were marketing themselves as an alternative to the MMP, saying that they were not "managed care" and that beneficiaries could keep their same doctors. The MMP brought this issue to the State, and OPWDD directed the DDROs to clearly identify the MMP as an option for beneficiaries. In 2019, OPWDD said that the 2018 move to CCOs sparked some interest in enrolling in the demonstration among eligible beneficiaries as it signaled the State's continued commitment to moving toward managed care.

4.2.2 Factors Influencing Enrollment Decisions

The MMP encountered several barriers to enrolling beneficiaries, including mistrust of managed care and reluctance to change providers. For the IDD population, OPWDD said that transitioning to managed care can only "move at the speed of trust." OPWDD characterized the IDD population as risk averse and mistrustful of managed care, and that they associated managed care with cuts in services.

This mistrust was reflected in the perspective of representatives from the self-advocate community, who said they had heard from beneficiaries who had enrolled in FIDA-IDD without really understanding how doing so would change their current services. They acknowledged that the MMP had been trying hard to explain the demonstration, but advocates feared that the eligible population still may not have understood their choices and what they mean.

OPWDD, CMS, and the MMP reported that potential enrollees were also reluctant to disrupt their relationships with other types of providers, including medical providers and residential providers. As previously described (see ***Section 3.2, Provider Arrangements and Services)***, a major hospital system refused to participate in FIDA-IDD, limiting the number of physicians serving enrollees. The plan said that its enrollees came into the demonstration with a wide array of providers, often as many as 8 to 10 preferred providers. The MMP reduced disenrollments by attempting to line up all of a beneficiary's providers prior to their enrollment. In 2019, the MMP said it had seen consecutive yearly improvements in its voluntary disenrollment rate.

In 2018, CMS said the MMP encountered obstacles with competing FFS policies when trying to manage the services received by enrollees. For example, the MMP found some duplication of services, such as when beneficiaries received consumer-directed services at the same time they were participating in day habilitation services. Families often relied on the consumer-directed services as a source of income. When the MMP tried to reduce the covered hours of these services while the enrollee was at a day program, families pushed back against the changes, and in some cases, disenrolled the enrollee back into Medicaid FFS to continue getting these payments.

The CAB for the Willowbrook class members[15] has played an important role in influencing enrollment decisions. For Willowbrook class members fully represented by the CAB and for whom no other guardian and family member is available to act on the class member's behalf, the CAB has authority to enroll beneficiaries into FIDA-IDD. A representative for the CAB reported that it has staff members who choose to enroll individuals into FIDA-IDD because they perceive the improvement in care coordination is dramatic. In 2018, more than 10 percent of FIDA-IDD enrollees were Willowbrook class members; in 2019, it had increased to 14 percent.

In 2018, OPWDD revised its regulations to authorize provider agencies to also enroll eligible individuals who have no legal representative or guardian.[16] Prior to this change, agencies were authorized to arrange medical treatment from providers in the FFS system, but they did not have the same authority to enroll an individual into the demonstration. In early 2019, the MMP said this change had increased enrollment. In 2019, OPWDD said that after the initial influx of new enrollees, there were smaller ongoing increases in enrollment of these individuals.

Because the MMP opted to assume financial risk for continuing coverage for 90 days for persons who lose their eligibility for Medicaid, it requested that no one with fewer than 60 days eligibility be enrolled in FIDA-IDD to allow enough time for the MMP to work through the Medicaid recertification. In 2019, the MMP said its experience with the recertification process

[15] See ***Section 2.2, Overview of State Context.***

[16] These regulations, 14 CRR-NY 635-11.4 and 14 CRR-NY 635-11.5, can be found at New York Codes, Rules and Regulations as accessed July 15, 2021.

had improved over time; it was able to identify when an enrollee's Medicaid certification was about to expire, and the service coordinators and care managers worked with the enrollee to complete the paperwork and have them submit it to the New York Human Resources Administration. The MMP said these proactive steps had made the recertification process "pretty seamless." As described in ***Section 2, Changes in Demonstration Design,*** in 2020 the State relaxed the recertification requirements due to the PHE.

4.3 Eligibility and Enrollment Data

As shown in ***Table 1***, the FIDA-IDD enrollment rate remained a small percentage of eligible beneficiaries, but has increased each year of the report period. As of December 2020, 20,396 beneficiaries were eligible for the demonstration and 1,719 were enrolled, for an enrollment rate of 8.4 percent (RTI, SDRS, 2019).

Table 1
FIDA-IDD enrollment

Enrollment indicator	Number of beneficiaries			
	December 2017	December 2018	December 2019	December 2020
Eligibility Beneficiaries eligible to participate in the demonstration as of the end of the month	20,797	21,149	21,715	20,396
Enrollment Beneficiaries currently enrolled in the demonstration at the end of the month	690	1,128	1,475	1,719
Percentage enrolled Percentage of eligible beneficiaries enrolled in the demonstration at the end of the month	3.3%	5.3%	6.8%	8.4%

SOURCE: RTI International: State Data Reporting System (SDRS), 2017, 2018, 2019, and 2020.

[This page intentionally left blank.]

SECTION 5

Care Coordination

The comprehensive I AM assessment tool developed by PHP effectively elicited answers from the IDD population about their social, functional, behavioral, medical, and wellness needs and what can make a difference to their quality of life.

The MMP's electronic information portal increased communication between providers in real-time.

In this section, we provide an overview of the demonstration requirements related to the care coordination function, including assessment processes; use of Interdisciplinary Teams (IDTs) and the development of service plans; delivery of care coordination services; and the role of service coordinators. We also discuss information exchange.

5.1 Care Coordination Model

Under FIDA-IDD, each enrollee is assigned a team, composed of a care manager and a service coordinator, that is responsible for conducting a comprehensive service planning assessment, convening IDT meetings, and developing and implementing a service plan.

Assessment. All beneficiaries receiving OPWDD services are assessed by OPWDD assessment specialists, trained in person-centered practices and interviewing techniques, who perform a comprehensive assessment (using the Coordinated Assessment System, or CAS) to determine medical, developmental, habilitation, and behavioral health services; community-based or facility-based LTSS; and social needs. If an eligible beneficiary chooses to enroll in the demonstration, OPWDD forwards the most recent CAS to the MMP upon enrollment.

The MMP must review and incorporate the CAS results into a second assessment process called the Comprehensive Service Planning Assessment (CSPA), which must be conducted within 30 days of enrollment. The CSPA focuses more specifically on developing an individualized plan. The assessment tool developed by PHP during the pilot prior to the demonstration, called "It's All About Me" (I AM), covers social, functional, medical, behavioral, wellness and prevention domains; caregiver's status and capabilities; and the enrollee's preferences, strengths, and goals. I AM is written in person-first language and is used to determine a recommended list of actions based on the person's current status. Results of the I AM assessment are used as the basis for developing the FIDA-IDD person-centered plan, called the Life Plan, as discussed below (MOU, 2015, p. 24).

The I AM assessment tool was designed using the Council on Quality and Leadership Personal Outcome Measures® (POMs) as a tool for assessing service needs and constructing the service plan.[17] OPWDD described the language used in the tool as eliciting what a person prefers in detail and exemplifying person-centeredness. OPWDD said the tool helps answer the questions, "Who are you as an individual? What's important to you? Every step of the day, what can make the difference to add to your quality of life?" To illustrate that no level of detail was

[17] POMs are a series of 21 indicators used to understand what is important to an individual and identify objective measures of how the individual achieves these goals (CQL, n.d.).

too small, several key informants cited as an example the I AM assessment's question asking the individual about preferred toothpaste brands and shampoo fragrances.

Initially, under the three-way contract the CSPA could be completed only by a registered nurse (New York three-way contract, §§1.34 and 2.6.2, 2016). However, OPWDD reported in 2018 that the MMP found that registered nurses tended to approach the process in a clinical manner and were not looking at the whole person. The MMP asked the State and CMS to change this provision to allow a broader set of licensed professionals to conduct the assessment. Initially, NYSDOH was reluctant to change the requirement because it would make PHP an exception among other MLTSS plans. However, after PHP, CMS and OPWDD discussed the differences between the MLTSS and FIDA-IDD populations and assessment tools, the plan's request was granted. Qualified Intellectual Disabilities Professionals (QIDPs), including licensed social workers and psychologists, were allowed to conduct the assessment (amended three-way contract, §§ 1.31 and 2.6.2, 2018). These licensed professionals must have a broad knowledge of physical and behavioral health care needs and services, and developmental disability needs and services including appropriate support services in the community (IDT Policy, 2018, p. 2).

The first step in conducting assessments is contacting enrollees. To date, because enrollment in the FIDA-IDD demonstration has been opt-in only, the MMP has had little difficulty in reaching enrollees. As shown in ***Table 2***, the percentage of enrollees that the plan was unable to reach within 90 days of enrollment varied initially but remained negligible (0 percent) over the course of the demonstration to date (2016–2020).

Table 2
Percentage of enrollees that the MMP was unable to reach following three attempts, within 90 days of enrollment, 2016–2020

Quarter	Calendar year 2016	Calendar year 2017	Calendar year 2018	Calendar year 2019	Calendar year 2020
Q1	N/A	0.0	0.0	0.0	0.0
Q2	0.0	0.0	0.0	0.0	0.0
Q3	1.3	0.0	0.0	1.0	0.0
Q4	0.0	0.0	0.0	0.0	0.0

MMP = Medicare-Medicaid Plan; N/A = not applicable; Q = quarter.
NOTE: Because the New York FIDA-IDD demonstration began in April 2016, data are not applicable for quarter 1 of 2016.
SOURCE: RTI analysis of MMP-reported data for Core Measure 2.1 as of June 2021. The technical specifications for this measure are in the Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements document.

Table 3 shows that, over the course of the demonstration to date (2016–2020), the percentage of assessments completed within 90 days for all enrollees, was consistently high, ranging from 98.7 to 100 percent. The percentage of assessments completed within 90 days for enrollees willing to participate and who could be reached was also consistently high, at or near 100 percent during this timeframe.

Table 3
Enrollees whose assessments were completed within 90 days of enrollment, 2016–2020

Quarter	Total number of enrollees whose 90th day of enrollment occurred within the reporting period and who were currently enrolled at the end of the reporting period	Percentage of enrollees with assessments completed within 90 days of enrollment[1]	
		All enrollees	All enrollees willing to participate and who could be reached[2]
2016			
Q1	N/A	N/A	N/A
Q2	62	100.0	100.0
Q3	157	98.7	100.0
Q4	149	100.0	100.0
2017			
Q1	99	100.0	100.0
Q2	96	100.0	100.0
Q3	66	100.0	100.0
Q4	82	100.0	100.0
2018			
Q1	95	100.0	100.0
Q2	84	100.0	100.0
Q3	209	99.5	99.5
Q4	106	100.0	100.0
2019			
Q1	118	100.0	100.0
Q2	85	100.0	100.0
Q3	101	99.0	100.0
Q4	134	100.0	100.0
2020			
Q1	173	99.4	100.0
Q2	160	99.4	100.0
Q3	48	100.0	100.0
Q4	58	100.0	100.0

MMP = Medicare-Medicaid Plan; N/A = not applicable; Q = quarter.

[1] The "all enrollees" column presents the percentage of assessments completed for enrollees whose 90th day of enrollment occurred within the reporting period. In the "all enrollees willing to participate and who could be reached" column, the percentages exclude enrollees who were documented as unwilling to participate in an assessment, and enrollees who the MMP was unable to reach following three documented outreach attempts.

[2] The number of enrollees willing to participate and who could be reached cannot be calculated using the corresponding percentages in this table. As indicated in table note 1, RTI used additional data points to calculate these percentages.

NOTE: Because the New York FIDA-IDD demonstration began in April 2016, data are not applicable for quarter 1of 2016.

SOURCE: RTI analysis of MMP-reported data for Core Measure 2.1 as of June 2021. The technical specifications for this measure are in the Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements document.

The MMP must conduct comprehensive reassessments as needed, or at least once annually. The comprehensive reassessment includes elements of the CAS and the CSPA, as well as the enrollee's comprehensive health record (IDT policy, 2018, p. 23). The Life Plan is reviewed twice a year by the IDT, and updates are made directly to the service plan.

Care managers and service coordinators. The MMP pairs each care manager with two service coordinators who share a caseload. For example, one care manager was paired with two service coordinators who each had 30 cases, and the care manager managed the combined 60 cases. Per the three-way contract, the MMP must ensure that the care managers' caseloads are reasonable. Each care manager reports to a regional director. The care manager must be a registered nurse, licensed social worker, or psychologist, and must have the same breadth of knowledge as the QIDPs (IDT policy, 2018, p. 11).

Service coordinator caseloads vary depending on the needs of the individuals served by the care team. For example, the CAB reported in 2018 that the MMP hired and trained service coordinators who work specifically with Willowbrook class members. For Willowbrook class member demonstration enrollees, service coordinators must maintain a client ratio of no greater than 1:20.

The care manager leads and coordinates the IDT, as discussed below. The care manager also conducts the clinical portion of the I AM tool; supports development of the Life Plan and oversees its implementation; and oversees care transitions, including transitions across settings or transitions from nonparticipating to participating providers once the Life Plan is completed for new enrollees (New York three-way contract, 2018, p. 55).

Each FIDA-IDD enrollee is assigned to a care manager who has the appropriate experience and qualifications to address the individual's assigned risk level and individual needs. The enrollee can choose a different care manager or change care managers at any time. Care managers must have at least one telephone contact per month with each enrollee, although more frequent contact may be required by the enrollee's Life Plan.

The service coordinator is also part of the enrollee's care team, under the care manager's supervision. The service coordinator must be a QIDP (discussed earlier in this section). The service coordinator plays a day-to-day role in an enrollee's life: as described by the MMP, this includes setting meetings, reviewing plans, contracting providers, and setting up medical appointments. The service coordinator makes sure Medicaid eligibility is recertified. As the member of the care team with the most frequent enrollee contact, the service coordinator is more likely to be familiar to the enrollee and the first point of contact when an enrollee needs assistance.

With the onset of the PHE in 2020, the MMP suspended in-person care management visits with enrollees, and staff worked remotely to keep plan and care management staff, enrollees and their families safe. Care management staff had weekly and sometimes daily check-in calls with enrollees who lived alone in the community or with aging caregivers and who had comorbidities making them more susceptible to the virus. Service coordinators shared information with enrollees about accessing food stamps, Meals on Wheels, and other local resources. In addition, when day programs were suspended, the MMP temporarily increased

personal care hours for a small number of enrollees who depended on day programs for care and meals. As day programs opened again, personal care hours returned to their previous levels. The State and MMP said the plan's experience with telehealth[18] helped it to adapt quickly to the social distancing requirements of the pandemic.

[The MMP] was reaching out to me about their plans to go remote even before we had completed the planning for the [MLTSS] plans, so they were way ahead, probably a week at least, of anyone else.

— NYSDOH (2021)

The State reported that during the PHE, the MMP did not have a spike in death rates any more than what would be expected in congregate settings, and contrasted this experience with the increased death rates in nursing facilities in New York during the early months of the pandemic. In 2021, the MMP said that 286 enrollees had contracted COVID-19 to date, with two-thirds of the infections occurring in the first wave of the pandemic and peak infections occurring in April 2020. From September 2020 through March 2021, in the second wave of the pandemic, 92 enrollees were infected. The MMP attributed the lower numbers of infections during the second wave to its proactive care coordination and telemedicine program activities.

Table 4 shows that the number of full-time care coordinators (including both care managers and service coordinators) increased over the course of the demonstration (2016–2020). The percentage of care coordinators assigned to care management and conducting assessments decreased slightly, from 43 percent in 2016 to 34 percent in 2020. The caseloads (enrollee loads) for care coordinators increased each year during the demonstration to date. Care coordinator turnover rate increased from 8 percent in 2016 to 24 percent in 2020, with variation among the years. The PHE likely contributed to the higher turnover rate in 2020.

[18] See ***Section 9.2.2, FIDA-IDD MMP Quality Management Structures,*** for more information on PHP's telehealth experience.

Table 4
Care coordination staffing, 2016–2020

Calendar year	Total number of care coordinators (FTE)	Percentage of care coordinators assigned to care management and conducting assessments	Enrollee load per care coordinator assigned to care management and conducting assessments	Turnover rate (%)
2016	35	42.9	28.2	7.9
2017	62	38.7	29.8	18.4
2018	95	33.7	36.8	13.6
2019	97	35.1	45.0	15.7
2020	79	34.2	65.0	24.0

FTE = full time equivalent; MMP= Medicare-Medicaid Plan.
SOURCE: RTI analysis of MMP-reported data for Core Measure 5.1 as of June 2021. The technical specifications for this measure are in the Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements document.

5.2 Care Planning Process

Interdisciplinary Team (IDT). Each enrollee has an individually-tailored IDT, led by the care manager. In addition to the care manager and the service coordinator, the IDT includes the enrollee and the enrollee's designee or representative, if applicable, and the enrollee's primary provider of OPWDD services. In addition, the IDT may include other service providers requested by the enrollee or recommended by other members of the IDT. These optional members might include a behavioral health professional, home care provider, or primary care provider (a physician, primary care extender, or specialist designated as primary care provider). "Participation" in the IDT may include participation in IDT meetings or reviewing and approving the individual's Life Plan within 3 days of delivery (IDT policy, 2018, p. 6).

The IDT is responsible for ensuring integration of the enrollee's medical, behavioral, LTSS, and social needs, as identified through the CSPA. The IDT is required to be person-centered and built on the enrollee's specific preferences and needs (IDT policy, 2018, p. 4). Members are responsible for regularly informing other IDT members about the enrollee's medical, functional, and psychosocial condition, and for remaining alert to pertinent input from other team members, the enrollee, and their representative. IDT members are also required to document changes to the enrollee's condition in their own medical record (IDT policy, 2018, p. 7). Between IDT meetings, the service coordinator is responsible for keeping in contact with IDT members, as part of their regular face-to-face or phone contacts.

The MMP reported that there was no resistance to participating on the IDT from OPWDD service providers because these providers participate in similar activities outside the demonstration for OPWDD waiver services. The plan noted that its experience with convening the IDT would not be as positive if the demonstration required the participation of the primary care provider (PCP) as had been originally required in the FIDA demonstration—PCPs had viewed this requirement as overly burdensome and, as a result, many declined to participate in FIDA altogether.

The MMP said that it is rare for an enrollee to ask a physician or another medical professional to participate in the IDT. However, when asked, PCPs often participate remotely. Whether or not medical professionals participate in the IDT, the care team consults with them as part of the 6-month review of the Life Plan.

The Life Plan. The IDT develops a person-centered service plan, called the Life Plan. The original IDT policy required the Life Plan to be finalized within 60 days of the CSPA, but the policy was revised to require completion within 90 days of the effective date of enrollment, or sooner if circumstances require (IDT policy, 2018, p. 18). The IDT reconvenes at least every 12 months to review the Life Plan, or earlier if there is a triggering event. In addition, the care manager must review the enrollee's Life Plan at least every 6 calendar months from the previous Life Plan review. The Life Plan is tailored to the current and unique psychosocial and medical needs and history of the enrollee, the enrollee's functional level, behavioral health needs, language, culture, and support systems. Each Life Plan must specify several elements, including the enrollee's problems and needs, related interventions, measurable outcomes, and timelines; the enrollee's goals and preferences and how they will be addressed; and all authorized services, including scope and duration. The Life Plan integrates both the POMs and New York's Individualized Protective Oversight Plan[19] requirements.

The Life Plan planning process must be tailored to the enrollee's culture, communication style, physical requirements, and personal preferences. When in-person meetings are not possible, meetings may take place telephonically or by videoconference. The planning process also includes feedback from each IDT member on how well the enrollee's needs and preferences are being met under the current service plan and any suggested changes, the effectiveness of the Life Plan, any issues, and feedback on how well the enrollee is functioning and any suggested interventions for targeted problems. The planning process also includes a discussion of the option to self-direct services.

As shown in ***Table 5*** and ***Table 6***, the MMP was able to complete Life Plans and care plans within the required timeframes during the demonstration to date, 2016–2020. ***Table 5*** shows that overall, the percentage of all enrollees and enrollees documented as willing to complete a care plan and who could be reached increased between 2016 and 2017, ranging from a low of 67.2 percent to a high of 100 percent. ***Table 6*** shows that in 2018 through 2020, the percentage of all enrollees and all enrollees documented as willing to complete a care plan and who could be reached remained consistently high, ranging from 98 to 100 percent.

[19] An Individual Plan for Protective Oversight is a plan that indicates "all key activities that directly impact the health and welfare of the participant and clearly identifies the individual(s) responsible for providing the needed assistance to the participants in the event of an emergency or disaster." https://www.health.ny.gov/facilities/long_term_care/waiver/nhtd_manual/section_05/section_05_c.htm as accessed May 14, 2021.

Table 5
Enrollees with Life Plans completed within 60 days of CSPA completion, 2016–2017

Quarter	Total number of enrollees who had a CSPA completed during the reporting period	Percentage of enrollees with Life Plans completed within 60 days after the completion of the CSPA[1]	
		All enrollees	All enrollees willing to complete a Life Plan and who could be reached[2]
2016			
Q1	N/A	N/A	N/A
Q2	197	70.6	70.9
Q3	131	67.2	67.2
Q4	117	89.7	89.7
2017			
Q1	99	98.0	98.0
Q2	79	96.2	96.2
Q3	62	100.0	100.0
Q4	109	99.1	99.1

CSPA = Comprehensive Service Planning Assessment; MMP = Medicare-Medicaid Plan; N/A = not applicable; Q = quarter.

[1] The "all enrollees" column presents the percentage of Life Plans completed for enrollees who had a CSPA completed during the reporting period. In the "all enrollees willing to participate and who could be reached" column, the percentages exclude enrollees who were documented as unwilling to complete a Life Plan, and enrollees who the MMP was unable to reach following three documented outreach attempts.

[2] The number of enrollees willing to complete a Life Plan and who could be reached cannot be calculated using the corresponding percentages in this table. As indicated in table note 1, RTI used additional data points to calculate these percentages.

NOTES: Because the New York FIDA-IDD demonstration began in April 2016, data are not applicable for quarter 1 of 2016. We present care plan data for 2018 and 2019 in Table E using Core Measure 3.2.

SOURCE: RTI analysis of MMP-reported data for State-specific IDD 1.1 as of January 2021. The technical specifications for this measure are in the Medicare-Medicaid Capitated Financial Alignment Model New York FIDA-IDD-Specific Reporting Requirements document.

Table 6
Enrollees with care plans completed within 90 days of enrollment, 2018–2020

Quarter	Total number of enrollees whose 90th day of enrollment occurred within the reporting period and who were currently enrolled at the end of the reporting period	Percentage of enrollees with care plans completed within 90 days of enrollment[1]	
		All enrollees[2]	All enrollees willing to complete a care plan and who could be reached[2]
2018			
Q1	95	100.0	100.0
Q2	84	100.0	100.0
Q3	209	99.5	99.5
Q4	106	99.1	99.1
2019			
Q1	118	100.0	100.0
Q2	85	100.0	100.0
Q3	101	98.0	99.0
Q4	134	100.0	100.0
2020			
Q1	173	99.4	99.4
Q2	160	99.4	100.0
Q3	48	100.0	100.0
Q4	58	98.3	98.3

MMP = Medicare-Medicaid Plan; Q = quarter.
[1] The "all enrollees" column presents the percentage of care plans completed for enrollees whose 90th day of enrollment occurred within the reporting period. In the "all enrollees willing to participate and who could be reached" column, the percentages exclude enrollees who were documented as unwilling to complete a care plan, and enrollees who the MMP was unable to reach following three documented outreach attempts.
[2] The number of enrollees willing to complete a care plan and who could be reached cannot be calculated using the corresponding percentages in this table. As indicated in table note 1, RTI used additional data points to calculate these percentages.
SOURCE: RTI analysis of MMP-reported data for Core Measure 3.2 as of June 2021. The technical specifications for this measure are in the Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements document.

The percentage of enrollees with at least one documented care goal discussion was consistently 100 percent throughout the course of the demonstration to date (2016–2020), as shown in ***Table 7***.

Table 7
Enrollees with documented discussions of care goals, 2016–2020

Quarter	Total number of enrollees with an initial Life Plan completed	Percentage of enrollees with at least one documented discussion of care goals in the initial Life Plan
2016		
Q1	N/A	N/A
Q2	197	100.0
Q3	147	100.0
Q4	169	100.0
2017		
Q1	122	100.0
Q2	85	100.0
Q3	85	100.0
Q4	106	100.0
2018		
Q1	72	100.0
Q2	132	100.0
Q3	179	100.0
Q4	113	100.0
2019		
Q1	103	100.0
Q2	95	100.0
Q3	81	100.0
Q4	163	100.0
2020		
Q1	160	100.0
Q2	134	100.0
Q3	57	100.0
Q4	58	100.0

MMP = Medicare-Medicaid Plan; N/A = not applicable; Q = quarter.
NOTE: Because the New York FIDA-IDD demonstration began in April 2016, data are not applicable for quarter 1 of 2016.
SOURCE: RTI analysis of MMP-reported data for State-specific IDD 1.2 as of June 2021. The technical specifications for this measure are in the Medicare-Medicaid Capitated Financial Alignment Model New York FIDA-IDD-Specific Reporting Requirements document.

Care coordination at the MMP level. The MMP developed a stratification chart setting minimum standards for the frequency and nature of care team contact with enrollees. Stratification is based on an individual's living situation and health and behavioral needs. In general, for those with a high level of need and for some with a mid-level of need, the service

coordinator has a face-to-face meeting with enrollees at least monthly. Some enrollees characterized as having a low level of need might have quarterly face-to-face meetings. Phone contact might be biweekly or monthly for all members, depending on level of need. OPWDD also noted that the MMP tailored the care model to those who self-direct and prefer a more active role in decision-making without having to meet with a care manager. The PHE curtailed face-to-face meetings with all enrollees in 2020.

In general, services are authorized through the IDT. However, the MMP must work with the regional DDROs to match enrollees with available certified residential services. In 2017, OPWDD worked with the MMP and the three regional DDROs in the demonstration to increase consistency in practice and the MMP's understanding of the process, and to improve communication between the MMP and the DDROs.

The MMP reported in 2018 that the newness of managed care for developmental services providers presented some care coordination challenges. For example, for individuals in a residential facility or an ICF/IID, facility nurses did not routinely contact the plan's care management team when there was a change in the enrollee's condition, a request for service, or a transition. Unlike medical providers, these developmental service providers had been largely carved out of managed care in New York and had no experience with managed care utilization management. In response, the plan conducted trainings for developmental services providers to review MMP policies and procedures (see ***Section 3, Integration of Medicare and Medicaid***).

Care coordination teams encountered challenges scheduling appointments for enrollees when providers did not realize their parent hospital system accepted PHP coverage. To address this issue, the MMP reported in 2020 that it had sent field representatives to doctors' offices to educate providers about the plan.

Continuity of care. Upon enrollment, enrollees may continue to receive services as authorized in their preexisting service plan, maintaining their current providers and service levels for at least 90 days after the effective date of enrollment or until the Life Plan is finalized and implemented, if later (IDT policy, 2018, p. 13). Enrollees may maintain their current ICF/IID or residential providers if the enrollee's Life Plan continues to describe a need for the service (New York three-way contract, 2018, pp. 58–9). Enrollees may maintain current behavioral health service providers (whether in-network or out-of-network for the duration of an episode of care that was ongoing at the time of enrollment, for up to 2 years from the date of demonstration enrollment (New York three-way contract, 2018, p. 59).

5.3 Information Exchange

The MMP must maintain a comprehensive health record to which all members of the IDT have ready access. The IDT is required to have a communication and information sharing plan that allows IDT members access to the enrollee's health information and Life Plan (New York three-way contract, 2018, p. 151). The MMP fulfilled this requirement by developing an integrated system that allows the enrollee, members of the IDT, and providers access to log in and respond to events as they happen.

> *[T]he electronic records system that we built is a huge part of the communication piece. Charting, for example…if the person has a seizure log or a bowel movement chart, etc., this system is taking that communication to the next level because it is in real-time. Instead of the day program calling the evening staff at the group home to ask how the member's night went, they can log in and see this charting and what's going on with the member. … It's really increased communication.*
>
> — MMP (2018)

The integrated system, or portal, also pushes communication to the IDT and to providers. If the care manager makes changes to a Life Plan, the IDT receives an email notifying them of the update. Calls to PHP's 24/7 nurse hotline are also recorded, with notices going to PHP's care team. The MMP reported that although its medical providers had experience with electronic charting and communication tools, developmental services providers had not used the technologies to share information with other providers prior to the demonstration. In 2019, the MMP said that it has had growing success getting developmental services providers to use the portal.

The MMP reported that the integrated system improves plan-level communication as well. For example, if a service coordinator notes having spoken with a parent or guardian about an enrollee's care, a supervisor can access the notes and follow up with the service coordinator about the conversation and any changes or concerns that were raised.

The MMP said that the portal was also used to support telemedicine consultations. It provided a patient profile that a telemedicine provider could use to find out where the individual resided, and information about their health care status and how they accessed services, including ED visits and hospitalizations, and developmental services. Internally, the MMP used the portal to monitor prescriptions. For example, it monitored whether enrollees living in the community had filled a prescription. See ***Section 6, Beneficiary Experience*** and ***Section 9, Quality of Care*** for more details on the MMP's telemedicine and prescription monitoring efforts.

SECTION 6

Beneficiary Experience

The MMP used the flexible benefit package in novel ways to meet enrollees' goals identified through the I AM assessment tool.

Throughout the demonstration to date, the MMP has used telemedicine to reduce difficult and disruptive trips to the doctor or emergency department.

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

In this section, we draw on findings from stakeholder interviews.[20] (See ***Appendix A, Data Sources*** for details about each data source.) We highlight findings on:

- beneficiary satisfaction;
- beneficiary experience with new or expanded benefits, care coordination services, and access to care and quality of services;
- person-centered care and patient engagement;
- personal health outcomes and quality of life;
- the experience of special populations (where information is available); and
- beneficiary protections.

6.1 Impact of the Demonstration on Beneficiaries

In this section we summarize findings from stakeholder interviews reflecting beneficiary experiences with service delivery and quality of life under FIDA-IDD. As noted above, we do not have primary data sources for assessing beneficiary experience from the perspective of the beneficiary.

6.1.1 Overall Satisfaction with and Awareness of FIDA-IDD

Over the course of the demonstration, OPWDD described the continued increasing enrollment of Willowbrook class members as a measure of the demonstration's success. OPWDD characterized the CAB as very cautious in making care choices on behalf of Willowbrook class members and needing to understand how the MMP operates, how the

[20] In the first year of the demonstration, RTI did not conduct focus groups because enrollment was too low. In the second year, RTI obtained a list of enrollees, but large numbers of enrollees on the list lived in the same group home; therefore, we could not conduct the focus groups because of privacy and confidentiality concerns. Also, enrollment in the demonstration was too low as of the date of this report to provide an adequate sample size for beneficiary surveys, e.g., CAHPS.

program works, and how protected class member rights are guaranteed. The CAB also has case managers who closely monitor the care Willowbrook class members receive.

Anything new that starts, I'm very hesitant on where it's going to go, but I have to say, I feel better now after a year and having over 100 people enrolled. I actually feel more confident saying this is a good program. I've actually recommended [that others] enroll their family members.

— Willowbrook Consumer Advisory Board member (2018)

In 2018, a DDRO representative said they had "heard nothing but positive feedback about FIDA-IDD." In 2019–2020, OPWDD and the MMP said they view the low voluntary disenrollment rate as a sign of enrollee satisfaction and an advocacy organization also reported hearing high levels of satisfaction. See ***Section 7.1, Stakeholder Engagement***, for more about the advocacy organization perspective.

6.1.2 Beneficiary Use of New or Expanded Benefits

In addition to all covered services under Medicare Parts A, B, and D, and all New York State Plan services including LTSS, FIDA-IDD covers other supportive services that the IDT determines necessary. CMS and NYSDOH consider this a new benefit under FIDA-IDD to cover items or services that are not traditionally included in Medicare or Medicaid but are necessary and appropriate for the enrollee. The MMP also offers a higher level of care management and service coordination to FIDA-IDD enrollees than is available outside the demonstration.

To ensure that the demonstration's added benefits were available to the large percentage of enrollees in the five New York City boroughs who lived in the community, the MMP used different service coordination strategies. For example, the MMP helped enrollees to transition from one apartment to another and advocated for an enrollee's rights with their landlord. The MMP also worked to find housing for enrollees who were homeless.

In 2019, the plan said it recognized its enrollees may need clinical services like physical, occupational, and speech therapy that are different from the typical population. For example, individuals with IDD may take longer to achieve physical therapy goals than people without IDD, and in some cases, the MMP maintains therapies to prevent regression whereas traditional coverage pays for episodes of care.

CMS credited the MMP's use of the I AM assessment tool to gather information about enrollees' goals and help them achieve those goals. CMS gave the example of the MMP helping an enrollee go to Yankees baseball games. This required a level of coordination above and beyond what is available to individuals in the FFS environment.

6.1.3 Beneficiary Experience with Care Coordination Services

FIDA-IDD's care coordination services appeared to be well-received by beneficiaries over the course of the demonstration to date. In 2019, CMS said that the MMP continued to

perform well on quality measures related to care coordination such as following up with enrollees after hospitalizations. In 2019 and 2021, the State reported findings from the National Core Indicator survey showing a large percentage of responding enrollees saying all their needs were met. The State viewed these findings as evidence that care coordination in the demonstration was working well.

6.1.4 Beneficiary Access to Care and Quality of Services

Access to certain services improved under the demonstration compared to FFS. For example, the CAB, MMP, and State reported in 2018 that the plan was able to arrange durable medical equipment much more quickly than what is possible in the FFS system. Because the IDT authorizes services, the process was quicker and more person-centered than having a provider go through the traditional Medicare and Medicaid service authorization process outside the demonstration. The MMP saw DME as something it can provide to improve an enrollee's quality of life and avoid adverse outcomes, and this flexibility was one of the advantages the demonstration has over FFS. A CAB representative reported that FIDA-IDD enrollees had been able to get wheelchairs within a couple of months whereas going through the traditional Medicaid approval process could take over a year. The plan also reported that under the demonstration, it streamlined access to environmental modifications which can also contribute to an enrollee's quality of life and increased independence.

In 2019, OPWDD said that, as one of the MMP's quality improvement projects, it had increased the number of enrollees using the self-direction benefit[21] from seven enrollees at the beginning of the demonstration to 50. Data reported by the MMP to NYSDOH and CMS' implementation contractor for a State-specific measure (IDD 4.1) indicated that 195 enrollees self-directed their care in 2020.

Not everybody can be in self-direction, but there are pieces of it they can do, and as much integration [that] can occur to expand people's horizons, it's good to make sure that benefit is offered, and [the MMP] has been achieving pretty good success with that.

— OPWDD (2019)

Maintaining access to residential care was challenging in some circumstances. In 2018 and 2019 the MMP and CMS reported that some residential providers had refused to accept enrollees returning after a hospitalization or short-term nursing facility stay because of a change in health status. As a result, some individuals experienced extended stays at a higher level of care than needed. CMS gave an example of a facility refusing to accept an enrollee returning from the hospital after breaking an ankle because the facility said that was a change in health status. In addition to increasing the cost of care, the MMP also noted that extended stays have a negative

[21] The self-direction benefit allows the enrollee to make decisions about what services they have and who provides them, consistent with the enrollee's Life Plan. With assistance from their care manager and others, the enrollee can hire, train, and supervise the people who provide their care.

impact on the individual's quality of life and quality of care. The DDROs, who have a funding and oversight role over residential providers, helped to resolve these cases.

6.1.5 Person-centered Care and Patient Engagement

The MMP reported that its person-centered model enhanced choice of providers for enrollees living in developmental service provider agency certified residential settings.[22] It said that in the FFS system, certified residence staff tended to take individuals to the PCPs affiliated with the residence. In the demonstration, if the enrollee wanted to see a different provider, the MMP care coordinators facilitated the change. This approach may not have been as convenient for the residential staff, however, who were then called upon to take residents to more than one location.

The house staff might drive three people in that house to that one clinic on that Thursday. Now they might have to drive to a second location to another provider. So, it's not making us fast friends in some instances. [But] again, we go back to our model, which is person-centered.

— MMP (2018)

The CAB reported that some nursing facility admissions occurred because some residential developmental services providers refused to assume the risk of serving some individuals with high care needs at home. This makes it challenging for the MMP to provide person-centered care when enrollees would prefer to live in the community, but developmental services providers will not serve them. The CAB suggested OPWDD could be more forceful with these providers to overcome this resistance.

6.1.6 Personal Health Outcomes and Quality of Life

OPWDD identified an enrollee's ability to live the life of their choosing as a valued outcome for FIDA-IDD. Because PHP's I AM assessment was designed using the Council on Quality and Leadership Personal Outcome Measures®, OPWDD can collect data that measures the MMP's ability to achieve those outcomes. See ***Section 9, Quality of Care,*** for more information on the State's methods of ensuring quality, including a person-centered review**.**

The MMP developed several innovations to enhance enrollees' quality of life focusing on individual's interests. For example, early in the demonstration, the MMP developed the "PAL" program which links enrollees with members of the community who share similar interests. In 2021, in response to requests from enrollees and their families for more social opportunities, the MMP developed PAL Social, an online platform, to connect plan enrollees not just with community members, but also with other enrollees around shared interests on a monthly basis.

[22] Development services provider agencies may offer residential options in homes that give enrollees different levels of support suitable for their needs. The Certified Residential Opportunities protocol is used to determine which level is most appropriate. For more information, see https://opwdd.ny.gov/providers/housing.

> *It [the PAL Social activity] could be a dance party, a sewing group, an art theme, allowing our members, especially during the pandemic and social isolation, particularly those in the community, an outlet to interact with other individuals within the community. That has been received positively.*
>
> — MMP (2019)

A CAB representative specifically praised the MMP's creativity in identifying social activities for Willowbrook class member enrollees. The MMP was able to link one enrollee who liked rap music and dancing to a social group for people who dance in their wheelchairs; the CAB representative said, "He absolutely loved it." For an enrollee who liked to play pool, the MMP identified some pool halls that had a set time for him to play and socialize there. The plan also located a dance studio that would support four women with IDD who wanted to dance.

In 2018, the ombudsman described another case in which the demonstration was able to meaningfully improve the quality of life for an enrollee through identifying a need for medical care and facilitating access to that care. The individual's gait had been deteriorating for several years. The enrollee's care manager referred him to have his hip assessed, and the enrollee subsequently had a hip replacement. In addition to "greatly" improving his quality of life, the ombudsman said this intervention was likely to reduce the cost of his care going forward.

In 2021, to improve person-centeredness and quality of life, the MMP and the State also began looking into developing programming for older adults with IDD who would like an alternative to traditional day habilitation services (see ***Section 2, Demonstration Design and State Context***). Also in 2021, the MMP reported it was developing and implementing an alternative payment methodology to reward IDD service providers for improving IDD-specific quality measures which include transitions to less restrictive settings and retirement programming for enrollees over 65 (see ***Section 9, Quality of Care***).

6.1.7 Experience of Subpopulations

In this section we summarize the beneficiary experience for FIDA-IDD subpopulations, including individuals with LTSS or behavioral health needs, and racial, ethnic, or linguistic minorities.

OPWDD did not identify any group as benefiting more from FIDA-IDD than others. However, OPWDD, the MMP, and the CAB noted that certain groups, including enrollees with very high or complex needs, and Willowbrook class members, particularly benefited from enhanced service coordination and care management.

However, OPWDD noted that enrollees who needed less support were still likely to need and get help from the MMP in realizing their goals and self-directing their care. The FIDA-IDD ombudsman (see ***Section 6.2, Beneficiary Protections***) reported that some people joined FIDA-IDD because they hoped the MMP would help them participate in OPWDD's self-direction service option.

In 2021, the MMP reported it had created an additional level of support for enrollees who had past ED visits related to behavioral health. The MMP reached out to those enrollees to ensure they were aware of different supports they could access proactively, and care coordination teams connected enrollees to these supports. The MMP said that for individuals who had been connected to community services, there had been a downward trend in emergency room utilization. The MMP planned to continue supporting these individuals on an ongoing basis to try to push the trends down further.

In 2018, OPWDD noted that FIDA-IDD enrollees were primarily white and non-Hispanic. The next largest group was Hispanic, with a smaller share of persons who were Russian or Chinese. OPWDD reported that the two latter groups often viewed the government – i.e., Medicare and Medicaid—with suspicion, and members of these groups rarely chose to enroll. To counter these suspicions, OPWDD did community outreach through its regional offices, and the MMP conducted public meetings.

6.2 Beneficiary Protections

Enrollees have certain protections under the demonstration. There are several options for them to report grievances or complaints, appeals, and critical incidents and abuse. Beneficiaries also are able to use ombudsman services provided under the demonstration to file and resolve complaints.

6.2.1 Grievances, Appeals, and Critical Incidents

Enrollees have the right to file a grievance with their MMP at any time. A grievance is a complaint or a dispute expressing dissatisfaction with the MMP or a provider, regardless of whether the enrollee is requesting a remedial action. Grievances are resolved at the MMP level.

Table 8 reports the number of grievances or complaints lodged with the MMP according to two data sources: MMP-reported grievances, and those reported to the Complaint Tracking Module (CTM) by the State or through 1-800 Medicare. The average number of MMP-reported grievances remained low throughout the demonstration to date. In 2016, the one complaint reported to the CTM was in the enrollment and disenrollment category.[23] In 2019, most of the four complaints were in the provider-specific category.[24]

[23] This category is defined as "Beneficiary is experiencing an enrollment issue that may require reinstatement or enrollment change".
[24] This category is defined as "Improper, insufficient or delayed claims payment".

Table 8
Grievances or complaints measures and results, 2016–2020

Measure	Reporting period	Results
Average number of MMP-reported grievances or complaints per 1,000 enrollees per quarter	2016	18
	2017	20
Average number of MMP-reported grievances or complaints per 10,000 enrollee months per quarter[1]	2018	39
	2019	41
	2020	40
Number of complaints per year received by the State or 1-800-Medicare and recorded in the CMS Complaint Tracking Module (CTM)[2]	2016	1
	2017	0
	2018	0
	2019	4
	2020	0

CMS = Centers for Medicare & Medicaid Services; MMP = Medicare-Medicaid Plan.
[1] The way that NORC grievance data were analyzed changed in 2018. In 2016 through 2017 data were analyzed per 1,000 enrollees per quarter. Beginning in 2018, data were analyzed per 10,000 enrollee months per quarter.
[2] Data obtained from the Complaints Tracking Module within CMS's health plan management system by RTI.

FIDA-IDD uses the integrated appeals model developed for FIDA.[25] Except for the Medicare Part D appeals process, which remains unchanged, the appeals process is unified for both Medicare and Medicaid appeals at all levels.

At the first level of appeal, a FIDA-IDD enrollee (or their representative) can appeal any action by the MMP to deny or limit authorization of a covered service. An appeal must first be filed with the MMP, which uses a third-party administrator to review appeals.

If, upon reconsideration, the MMP upholds its original decision, the MMP automatically forwards the appeal to the IAHO, which is housed within the Office of Temporary and Disability Assistance (OTDA) (New York three-way contract, 2018, p. 117). The hearing at the IAHO level serves as the integrated second-level appeal for both Medicare and Medicaid, replacing what might otherwise be the bifurcated appeals to CMS's Independent Review Entity for Medicare service coverage decisions and to the OTDA for Medicaid service coverage decisions. To avoid the bifurcation, the IAHO applies both Medicare and Medicaid statute and regulation in making its ruling. The IAHO hears all appeals from the MMP level, whether the claim is only for services that would normally be funded by Medicare, Medicaid, or both.

If an enrollee disagrees with the IAHO's decision, they may file an appeal with the Medicare Appeals Council (MAC),[26] which serves as the integrated third-level appeal for Medicare and Medicaid. The hearing for FIDA-IDD appeals also integrates a third level of appeal at the MAC . In the integrated process, the MAC also applies both Medicare and Medicaid statute and regulation in making its ruling. The MAC hears all appeals from the IAHO,

[25] For a description of the integrated appeals model, see the First Evaluation Report for the FIDA demonstration.
[26] The MAC sits within the Departmental Appeals Board, which is separate from CMS and other operating divisions within the U.S. Department of Health and Human Services.

whether the claim is only for services that would normally be funded by Medicare, Medicaid, or both. Finally, an enrollee whose claim meets a minimum dollar threshold may appeal the MAC's decision in a fourth-level appeal in a Federal district court (New York three-way contract, 2018, p. 119–20).

As shown in ***Table 9***, the average number of MMP-reported appeals remained low over the reporting period. For example (not shown in ***Table 9***), between April 1, 2016, and December 31, 2017, IAHO received only seven appeals for the FIDA-IDD demonstration. Of those, four were withdrawn, two ended in default, and the MMP's decision was reversed in one case. Four of the seven appeals during this time involved the MMP's denial of a high-frequency chest compression device. In 2016, the plan indicated that a vendor had been marketing these devices to enrollees, without reference to whether they were clinically indicated. The MMP reported that inappropriate use of this device was dangerous. In one of these four cases, the MMP's denial was reversed by IAHO because it found that the enrollee's clinical record did meet criteria for use of this device. All the appeals to IAHO involved both Medicare and Medicaid-related claims.

In 2018, the MMP reported some hospital providers were filing appeals on behalf of enrollees for denial of inpatient payment. The MMP and OPWDD noted that individuals with IDD were more likely to be hospitalized following an ED visit than the general population. For example, the MMP said one of its enrollees was hospitalized for a urinary tract infection, despite the enrollee's vital signs being stable. At the time, the process allowed providers to file an appeal on behalf of an enrollee, and if the plan denied it, the appeal would automatically go to the second level at IAHO, at which point the provider would need the enrollee to sign the appeal to move it through the appeals process. This process confused the enrollee who had already been hospitalized and discharged and did not know an appeal had been filed. The MMP believed that these providers were using the process to appeal payment denials for unnecessary hospitalizations and brought the issue to the CMT. In response, CMS and NYSDOH changed the policy to require providers to obtain enrollees' signatures of authorization prior to the plan moving forward with the appeal at the first level. Failure to obtain the authorization results in dismissal of the appeal. In 2020, the CMT said the change resulted in a decrease of these types of appeals.

Table 9
Appeals measures and results, 2016–2020

Measure	Reporting period	Results
Average number of MMP-reported appeals per 1,000 enrollees per quarter	2016	3
	2017	8
Average number of MMP-reported appeals per 10,000 enrollee months per quarter[1]	2018	10
	2019	26
	2020	19

MMP = Medicare-Medicaid Plan.
[1] The way that plan-reported appeals data were analyzed changed in 2018. In 2016 through 2017 data were analyzed per 1,000 enrollees per quarter. Beginning in 2018, data were analyzed per 10,000 enrollee months per quarter.

MMPs are required to report the number of critical incidents and abuse[27] reports for enrollees receiving LTSS to CMS. From 2016 through 2020, the average number of critical incidents and abuse reports per 1,000 enrollees per quarter varied from 7 to 58.

Early in the demonstration, the MMP was reporting all incidents involving enrollees, including any incident that occurred at the provider level that the provider was also reporting separately. OPWDD clarified to the MMP that it should only report incidents that connect to its performance as a plan or in providing care coordination. Providers submit incident reports through New York's Incident Report and Management Application, and incidents involving the MMP would be forwarded to the FIDA-IDD team at OPWDD.

6.2.2 Enrollee Awareness of Beneficiary Rights

There is no direct measure of enrollee awareness of their rights under the demonstration, but the ombudsman program tracks information about the calls it received. The ombudsman program said in 2018 that callers reported finding the ombudsman's number in the enrollee handbook, where it is listed several times. The ombudsman program is also listed as a resource on any letter of service denial or reduction. In 2020, the ombudsman program said that the State and CMS had done "a great job" of making sure information about the ombudsman program and its contact information was "front and center" on communications with enrollees.

6.2.3 Role of Ombudsman

The New York ombudsman program, the Independent Consumer Advocacy Network (ICAN), serves all individuals participating in New York's Medicaid MLTSS programs and a range of other programs. During ICAN's second contract year as ombudsman (2016), it began discussions with the State about adding FIDA-IDD to its scope. ICAN was reluctant to have direct supervisory responsibility over this work, given its lack of in-house expertise working with the IDD population or providers. Instead ICAN amended an existing subcontract with the Center for Independence of the Disabled, who took responsibility for hiring a FIDA-IDD health counselor to be the ombudsman program's primary point of contact for FIDA-IDD.

The FIDA-IDD health counselor started in early March 2016, shortly before enrollment began April 1. All calls to ICAN relating to FIDA-IDD are referred to the FIDA-IDD health counselor. ICAN has trained its entire network on FIDA-IDD so that when someone selects the option from the phone menu, advocates know to redirect FIDA-IDD enrollees to the FIDA-IDD health counselor.

[27] A "critical incident" is any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety, or well-being of a member. Abuse refers to: Willful use of offensive, abusive, or demeaning language by a caretaker that causes mental anguish; knowing, reckless, or intentional acts or failures to act which cause injury or death to an individual or which places that individual at risk of injury or death; rape or sexual assault; corporal punishment or striking of an individual; unauthorized use or the use of excessive force in the placement of bodily restraints on an individual; and use of bodily or chemical restraints on an individual which is not in compliance with federal or state laws and administrative regulations. The definition can be found in the State-specific reporting requirements at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPReportingRequirements

The FIDA-IDD health counselor divides their time between case work and outreach. The volume of cases had been small throughout the demonstration to date and usually involved a mix of pre-enrollment calls and calls from current enrollees. Pre-enrollment calls usually involved people who are considering enrolling but wanted to pose their questions to someone other than the MMP. Current enrollees' calls varied but often related to access and quality of care. For example, ICAN handled concerns about transportation services and about making appointments with providers listed in the directory who claimed to be nonparticipating when the enrollee arrived at the appointment. Calls relating to access may not always have involved a dispute, and the ombudsman program assisted enrollees through the service authorization process:

Sometimes I was able to redescribe or reframe the "no" they were getting [in a way] that was satisfactory to the member. Sometimes I was able to make the case back to the staff what the member really wanted, that the member wasn't successful communicating… I bridge that gap.

— ICAN (2018)

In 2019, ICAN said approximately 40 percent of its FIDA-IDD calls from enrollees related to reductions or denials of service. For comparison, service reductions or denials made up half of the calls from enrollees in New York's other MLTSS programs. The ombudsman program described PHP as being "more tuned in to the population and its needs" than other plans outside of the demonstration. ICAN said that because the demonstration was voluntary, there was not much of an incentive for enrollees having disputes with the MMP to see the resolution process through to the end; enrollees could disenroll back to their previous services outside the demonstration instead. Only a small percentage of ICAN's FIDA-IDD cases have led to complaints or appeals. In 2020, ICAN said the care management model and lower care manager/enrollee ratios had perhaps allowed care managers to take the time to discuss care plans with enrollees, leading to greater understanding of care plan decisions than in other programs. This could explain the lower appeals in FIDA-IDD relative to other MLTSS programs.

ICAN applied a hierarchy to its cases. For urgent matters (e.g., when health and safety appear to be at risk), ICAN would contact the MMP's liaison—who, most often, was the director of care coordination—rather than the designated liaison for complaints. For less urgent matters, ICAN often met with the service coordinator. As described above, some issues were the result of a miscommunication, and ICAN facilitated communication. ICAN may also report complaints to the CTM but reserves that option for "egregious" cases.

Although close to one-half of the MMP's enrollment lived in certified residences, ICAN received few calls from enrollees in these settings. In 2019 and 2021, the ombudsman program described its role of providing information and assisting beneficiaries through disputes as a "complaint-driven system." However, they also noted that approximately one-quarter of FIDA-IDD enrollees were referred to as "non-correspondents," meaning they had no unpaid caregiver such as a family member to advocate on their behalf. With this identified subgroup of enrollees in the demonstration who may have limited capacity to self-advocate, the ombudsman program said it would be useful to have more transparency into how care decisions were made on their

behalf. In 2021, the ombudsman program said that it anticipated the State sharing more program data with the ombudsman under Federal Medicaid managed care regulations, but that it had not yet seen the data.

In 2021, the ombudsman program said it had received approximately 25 FIDA-IDD cases during 2020, one-half of which were related to enrollment questions and the other to enrollee concerns such as changes in visitation policy due to the PHE. Through experience with operating during Hurricane Sandy, the ombudsman program had a business continuity plan in place prior to the PHE. The program had made sure its phone system could work offsite to provide support to beneficiaries who called. Because much of its work took place telephonically prior to the PHE, the shift to remote work went smoothly. However, the ombudsman program did have to educate beneficiaries on digital signing of documents, if enrollees had online access. The slowdown of the US Postal Service made the exchange of hard copy documents much slower as well, sometimes taking weeks.

Throughout the demonstration to date, the FIDA-IDD health counselor conducted education and outreach to educate people about ICAN as a resource if things go wrong or to answer questions about the demonstration. The health counselor attended events, resource fairs, and the MMP's quarterly Participant Advisory Committee meetings (see ***Section 7, Stakeholder Engagement***), and spoke at conferences hosted by a self-advocacy organization. When ICAN identified an opportunity for outreach, it made sure that the MMP and OPWDD were aware, so they could attend if they chose. ICAN distributed a consumer-friendly plain language brochure that described the FIDA-IDD program. The ombudsman program saw itself as providing an independent perspective to help people make an informed choice.

ICAN's contract is with NYSDOH, not OPWDD. However, the CMT, which includes OPWDD representatives, participates in monthly calls with ICAN to address any issues that arise. ICAN reported in 2019 that OPWDD had been very involved and a helpful resource. ICAN acknowledged that having two different State agencies involved made things more complicated, but noted that both NYSDOH and OPWDD successfully worked collaboratively in their partnership with ICAN. For example, when ICAN declined to accept some feedback from the State on its brochure about FIDA-IDD, OPWDD and NYSDOH eventually came to understand that ICAN's role was to be independent. ICAN also noted the value of CMS participation in the CMT, and believed it resulted in increased responsiveness to ICAN's concerns.

As discussed in ***Section 2.2, Overview of State Context***, because its ombudsman program serves a larger population than only FIDA-IDD enrollees, NYSDOH chose not to pursue the CMS funding opportunity that provides support for FAI ombudsman programs.

[This page intentionally left blank.]

SECTION 7

Stakeholder Engagement

The MMP used feedback from the Participant Advisory Committee to improve transportation services and to improve content for newsletters and social media communications.

In this section we describe the approach taken by New York for engaging stakeholders, the mechanisms for soliciting stakeholder feedback, and the impact of those efforts on the demonstration.

7.1 State Role and Approach

OPWDD reported that, beginning in 2011, it engaged in an extensive stakeholder process focused on the design of specialized managed care organizations. This initiative developed the design principles for an earlier model of managed care, which laid the foundation for FIDA-IDD. OPWDD now relies on a Joint Advisory Council (JAC) as its primary mechanism for obtaining feedback on the design and implementation of FIDA-IDD and OPWDD's other efforts to move forward with managed care. By statute, the JAC is chaired by the commissioners for NYSDOH and OPWDD and composed of 12 members that include individuals with developmental disabilities, family members, advocates, and service providers.[28] In practice, OPWDD chairs the JAC.

The JAC is responsible for reviewing all managed care options provided to individuals with IDD and has been meeting quarterly since April 2013. Updates on the development of FIDA-IDD and its design features were presented to the JAC, and JAC's input was solicited. For example, according to OPWDD staff, the JAC was asked for input on developing a tool for assessing network adequacy for FIDA-IDD.

OPWDD also solicited input from the CAB for Willowbrook class members. (See discussion of Willowbrook class members in ***Section 2.2, Overview of State Context***.) In particular, the CAB reviewed the MOU to ensure that the rights of Willowbrook class members, as defined under the permanent injunction, were reflected.

In further effort to obtain stakeholder input. OPWDD conducted a series of outreach and educational activities prior to the start of the demonstration for beneficiaries, family members, providers, and others.

In 2018, OPWDD identified the JAC as its stakeholder group for monitoring the FIDA-IDD implementation. However, OPWDD also noted that the JAC is a statewide group whereas FIDA-IDD is a demonstration in nine downstate counties. Accordingly, OPWDD reported that it was difficult to identify JAC members who could speak knowledgeably about FIDA-IDD's design and implementation. As OPWDD focused on implementing the CCO/HH model, the JAC's attention was further drawn away from FIDA-IDD to center on that initiative.

In 2018, CMS said they had primarily received information from the State, ICAN, and the MMP about how the demonstration was impacting beneficiaries. CMS wanted to get

[28] See New York Mental Hygiene Law, §13.40.

information more directly from stakeholders and people who receive the services, and worked with OPWDD on a beneficiary experience research project. However, the PHE prevented its implementation.

7.2 Participant Advisory Committee

The MMP is required to establish a Participant Advisory Committee (PAC) as part of the demonstration, open to all enrollees, their family representatives or designees, and a representative from the ombudsman program. The PAC must reflect the diversity of the enrollee population. The MMP is required to provide the PAC with information on any updates and proposed changes to the plan, including data on the number and nature of grievances and appeals, information about quality assurance and improvement, and information about enrollments and disenrollments (New York three-way contract, 2018, p. 24). At least 60 percent of the membership of the PAC must be composed of enrollees (New York three-way contract, 2018, p. 105). The PAC must meet in person at least quarterly. In response to the PHE and with the approval of the CMT, the MMP conducted its PAC meetings virtually.

The MMP's PAC members were recruited by its regional directors of its care management teams in the demonstration areas who reached out to active enrollees who had given positive or negative feedback. Representation includes enrollees and family members from all regions of the demonstration area. This group serves as a steering committee to discuss what is working well and suggestions for improvement.

The PAC has helped us form some great opportunities…. In particular, the PAC provided feedback on services (particularly transportation) and helped PHP determine the content for its newsletter and social media communications.

— MMP (2018)

In 2019, the MMP said the PAC had continued to provide valuable feedback on how to improve the plan activities including a suggestion for an enrollee satisfaction survey. As a result, in 2020, the MMP had an external consultant conduct a one-on-one anonymous questionnaire with enrollees to gather more information about how enrollees felt about their services. The plan received positive feedback from respondents and was pleased with the results.

The MMP must also conduct at least two Participant Feedback Sessions each year, where enrollees are invited to voice problems and concerns and to provide positive feedback to the MMP (New York three-way contract, 2018, p. 106). The MMP is required to help with costs, transportation, reasonable accommodations, and other barriers to participation in the sessions. The MMP must allow enrollees to participate in person or remotely. PHP said it received valuable information from the feedback sessions throughout the demonstration, including the suggestion for organizing more social opportunities. This suggestion led to the development of the PAL Social program (see ***Section 6.1.6, Personal Health Outcomes and Quality of Life***). The sessions were held virtually in response to the PHE.

SECTION 8

Financing and Payment

During the reporting period, the MMP had persistent concerns over the adequacy of the Medicare and Medicaid rates to cover the costs of care for a frailer than expected enrollee population and to spread fixed costs across its small membership.

In this section, we describe the demonstration's capitated payment methodology and the financial impact and provider experience associated with those payments.

8.1 Rate Methodology

Consistent with all capitated FAI demonstrations, the FIDA-IDD demonstration tests a new payment methodology with the aim of minimizing cost-shifting, aligning Medicare and Medicaid incentives, promoting independence in the community, supporting the best possible health and functional outcomes for enrollees, and reducing costs to CMS and the State (MOU, 2015, p. 4). All Medicare services and Medicaid-covered services are financed by capitated payments to the MMP, except for hospice and out-of-network family planning, which are paid on an FFS basis. The Medicare and Medicaid contributions represent baseline spending, or the estimated costs if the demonstration had not been implemented. Capitation payments are risk-adjusted, using separate methodologies for Medicare Parts A and B, Medicare Part D, and the Medicaid components of the rate. The demonstration savings rate is applied to baseline spending.

8.1.1 Rating Categories and Risk Adjustments

The Medicare baseline rate for Parts A and B services is a blend of the MA projected payment rates and the Medicare FFS standardized county rates for each year, weighted by the proportion of the eligible population that transitioned from each program into the demonstration. It is adjusted based on the risk profile of each enrollee using the existing MA CMS-Hierarchical Condition Category (HCC) and CMS-HCC end-stage renal disease risk adjustment models. The Medicare Part D baseline is calculated using Part D national average monthly bid amount and is risk-adjusted using the existing Part D prescription drug RxHCC model. The prospective payments for the low-income cost-sharing subsidy and Federal reinsurance amounts are not risk-adjusted (New York three-way contract, 2018, p. 169).

In 2019, the MMP was concerned about the inadequacy of the Medicare rates because they did not include an adjustment for the frailty of its enrollees. The plan said that many of its enrollees who were 55 or older had multiple Activities of Daily Living (ADL) limitations, which would qualify them for a frailty adjustment in a different type of Medicare plan, such as a Fully Integrated Dual Eligible Special Needs Plan. CMS and the MMP discussed the possibility of providing a frailty adjustment in future years, and in 2021, the frailty adjustment was made available to the plan for its 55 and older population. Although the MMP said its younger enrollees also have ADL needs, the Medicare frailty adjustment, which originated in the Program of All-Inclusive Care for the Elderly, is not calibrated for a younger population.

The Medicaid baseline rate was determined by NYSDOH in 2016 and its actuary at the time. There are two age-based rate cells for FIDA-IDD, one for dually eligible adults ages 21 to 50, and one for dually eligible adults aged 50 and older. In March 2018, OPWDD reported that over 500 enrollees (about 60 percent of enrollment at the time) fell into the 50-and-older group.

That grew to 63 percent by June 2019. OPWDD believed the growth of the older age group in the demonstration reflected the increasing life expectancy of people with IDD and included people who had been living at home with aging family members who could no longer provide the needed level of support.

The Medicaid rate was based on the FFS claims history for the eligible population. The rate was based on three major service components: developmental disabilities services; LTSS; and other services (MOU, 2015, pp. 43–4). The developmental disabilities services are the largest component of the baseline costs and are overseen by OPWDD. These included services funded under the State Plan such as ICF/IID, targeted case management, OPWDD-certified specialty clinics, and OPWDD's §1915(c) waiver. Outside of the demonstration, all these services are reimbursed on an FFS basis. The baseline for this component was based on FFS Medicaid spending for FIDA-IDD eligible individuals for the period July 1, 2011, through June 30, 2012 for demonstration year 1 and is updated annually as more current data becomes available.

LTSS, such as personal care, home health care, and adult day care, are authorized in the State Plan and overseen by NYSDOH. Individuals with developmental disabilities were excluded from New York's MLTSS program, so the value of these services was based on the historical FFS expenditures from July 1, 2011, through June 30, 2013, for this population and adjusted to reflect projected experience based on an actuarial analysis for demonstration year 1. This component is updated annually as more current data becomes available.

The third component of the rate—other services—includes traditional health care services such as inpatient/outpatient hospital and physician Medicaid crossover payments, dentists, laboratory, and other Medicaid services. This component also includes mental health and substance use disorder services as authorized in the State Plan and overseen by the Office of Mental Health and Office of Alcoholism and Substance Abuse Services. Although a small number of FIDA-IDD eligible individuals participated in a managed care plan for these services prior to the demonstration, the majority received these services on an FFS basis. The baseline for this component was based on total Medicaid FFS spending for FIDA-IDD eligible individuals from July 1, 2011, through June 30, 2012, for demonstration year 1 and was updated annually as more current data becomes available (MOU, 2015, pp. 43–4).

8.1.2 Savings Percentage

As provided under the three-way contract, aggregate savings percentages have been applied to the baseline spending amounts for the Medicare Parts A and B component and the Medicaid component to compute the capitation payment rates (see ***Table 10***).

Table 10
Savings assumptions built into the capitation payments

Year	Savings percentage
Demonstration year 1 (Apr. 1, 2016–Dec. 31, 2017)	0.25
Demonstration year 2 (Jan. 1–Dec. 31, 2018)	0.5
Demonstration year 3 (Jan. 1–Dec. 31, 2019)	0.75[a]
Demonstration year 4 (Jan. 1–Dec. 31, 2020)	0.75

[a] The savings percentage for demonstration years 3 and 4 has been reduced to 0.75% from the originally planned 1%, per the following three-way contract stipulation: "In the event that PHP experiences losses in demonstration year 1 exceeding 3 percent of revenue, based on at least 12 months of data from demonstration year 1, the savings percentage for demonstration year 3 will be reduced to 0.75 percent. CMS and the State will make such a determination at least 4 months prior to the start of demonstration year 3."
SOURCE: Three-way contract, 2018, p. 168.

Savings percentages were not applied to the Part D component. CMS monitors Part D costs on an ongoing basis, and material changes may be factored into future year savings percentages (New York three-way contract, 2018, p. 168).

8.1.3 Risk Corridors

A risk corridor is a form a risk-sharing between a health plan, Medicare, and Medicaid that protects against financial losses and gains. NYSDOH and CMS set up risk corridors to protect the MMP, CMS, and the State from the impact of possible enrollment bias and uncertainty in rate setting that could result in either under- or overpayment (MOU, 2015, p. 55). For example, if many more beneficiaries with very high costs enrolled in the demonstration than what had been assumed in the rate setting process, the risk corridor would limit the impact on the plan by splitting the share of the losses between the plan, CMS, and the State. Likewise, if the plan experienced excess gains, the savings would be shared.

The three-way contract established risk corridors for demonstration years 1, 2, and 3 (calendar years 2016–17[29], 2018, and 2019), including all Medicare Parts A and B and Medicaid eligible costs. The risk corridor payments are reconciled after application of any risk adjustment methodologies and as if the MMP had received the full quality withhold payment. CMS and New York share losses and recoupments under the risk corridor, in proportion to their contribution to the capitated rates (not including Part D).

The three-way contract establishes three tiers for determining how much of a gain or loss would fall to the MMP and what portion would fall to CMS and New York. For example, in the first year of the demonstration, if the plan experienced between zero and a 1 percent loss or gain, the plan would bear 100 percent of the risk or reward. If the plan experienced a loss or gain between 1 or 2 percent, the plan would bear one-half of the risk or reward, and CMS and the State would share the other half. CMS and the State would share 100 percent of the risk or reward for losses or gains above 2 percent.

[29] The first demonstration year spanned April 1, 2016, through December 31, 2017.

Under the three-way contract, the three tiers are set to increase incrementally each demonstration year, so that the MMP assumes a growing responsibility for losses and gains over the life of the demonstration (New York three-way contract, 2018, p. 171–2). Because of continued low enrollment and the challenges of building substantial enrollment in a voluntary program, in 2018 the MMP raised the issue of continuing the risk corridor beyond the first 3 years of the demonstration. In 2019, CMS said they understood the financial strain on the MMP due to low enrollment; only 6 percent of eligible beneficiaries were enrolled in the demonstration at the end of 2018. At that time, the State was not inclined to continue the corridor, and in 2020, the State's new actuarial firm conducted an analysis of the MMP's services and rates and determined that no changes to the rates, including the extension of the risk corridor, were necessary.

8.2 Financial Impact

8.2.1 Early Implementation Experience

The capitated Medicaid rates for FIDA-IDD were originally based on the assumption that the opt-in enrollment would be evenly divided between people in the community and people in certified residences. Given its previous experience with the pilot program (see ***Section 3.2, Overview of Integrated Delivery System***), the MMP was concerned that the capitation rate would not adequately cover the higher cost of residential individuals. In response to the MMP's concerns, and with data that the plan provided from its pilot program, NYSDOH and the State's actuarial firm adjusted the capitation rate in 2016 to be based on an enrollment mix that was between 50 percent and 75 percent residential enrollees. In addition, NYSDOH talked with CMS about the issue and made a midyear adjustment to the rate based purely on the ratio of community versus residential enrollees. NYSDOH wanted to work with the MMP in the first year to help ensure the rate was adequate to cover the individuals who enrolled. NYSDOH staff noted that the midyear Medicaid rate adjustment was made in June 2016 and was retroactive to the start of the demonstration, April 1, 2016.

We thought that was a pretty good practice [making the midyear adjustment], especially for a startup program, because really what we're talking about here is not necessarily, especially in the first year, PHP's ability to keep people in and out of residence. We're really talking [about] a voluntary selection issue and who just happens to sign up for the plan.

— NYSDOH (2016)

8.2.2 Rate Methodology Design Implications

Encountering higher than expected costs relative to the lower than projected enrollments that threatened its financial viability, the MMP brought the issue to NYSDOH and CMS. After analyzing the rate setting process, NYSDOH and CMS provided substantial financial relief to the plan by extending the limit on administrative expenses as part of the risk corridor. In this section we describe the issues and resolution.

Lower than projected enrollment caused financial strain for the MMP in the demonstration's early years. The MMP originally expected to have 250 enrollees in the first month of the demonstration. The plan projected 150 additional enrollees each month thereafter. Nine months into the demonstration in January 2017, a total of 450 individuals were enrolled in the MMP, representing only 28 percent of the 1,600 enrollees the MMP had projected. In January 2018, a total of 740 beneficiaries were enrolled in the MMP, or 22 percent of the 3,400 originally projected for that point in time.

In a letter dated November 7, 2017, the MMP reported to the State that it was on track to incur a $13 million operating loss related to care coordination and administrative costs for the first demonstration year (April 2016 through December 2017), and it anticipated losing an additional $12 million in 2018, the second year of the demonstration.

The MMP argued that the 2018 allowances for care coordination and administrative expenses were too low, particularly considering the low enrollment. The plan identified several fixed costs that were not reflected in the care coordination rate; the rate only reflected variable costs. It also objected to the fact that the care coordination rate was established using a projected 100,000 eligible beneficiaries rather than the plan's projected enrollment for 2018. Due to these factors, the MMP estimated that it would experience a shortfall of $3.1 million for care coordination services.

The plan pointed out that 72 percent of its administrative expenses are fixed costs. Because of low enrollment, the MMP's administrative cost ratio was 17.7 percent in 2016 and was expected to decrease to 11.7 percent in 2017. At the same time, plan premiums include less than 1 percent for administrative expenses. The MMP projected that it would lose as much as $9 million in 2018 because of the gap in financing for administrative expenses. The MMP also noted that New York's actuary had developed a "best estimate" for administrative costs at 5 percent, which would still result in $4.2 million in unfunded administrative expenses for 2018.

The MMP asked:

(1) that the care coordination costs be based on its projected 2018 enrollment;

(2) for details that support the State's computation of the Medicaid administrative expense ratio;

(3) for an additional 2 percent premium for underwriting gain and reserves;

(4) that the 0.5 percent cost savings attributed to transitioning enrollees from FFS to managed care not be applied to care coordination costs and administrative expenses; and

(5) for a continuation of the 7 percent limit on administrative expenses as part of the risk corridor calculation, rather than eliminating consideration of administrative expenses in the risk corridor calculations for demonstration years 2 and 3.

After analyzing the rate setting process, CMS and NYSDOH approved a continuation of the 7 percent limit on administrative expenses as part of the risk corridor for 2 more years.

Although the plan continued to believe the rates should better reflect administrative costs, the plan leadership appreciated this adjustment. These adjustments reduced the likelihood that the MMP would reach any of the regulatory or capital requirements governing their reserves.

In 2019, CMS completed a preliminary analysis for the interim risk corridor for demonstration year 1. That analysis indicated plan losses of 7.2 percent, and payment of approximately $6 million (across Medicare and Medicaid) due to the MMP. Given the preliminary nature of the analysis, NYSDOH and CMS paid the plan 90 percent of the amounts calculated as due to the MMP and will reconcile any additional amounts due to the plan at final settlement. As part of the interim settlement, CMS paid the MMP $93,012 and NYSDOH paid the MMP $5,353,163 (CMS, 2019b). In 2022, CMS said it paid the MMP an additional $10,864 as its final settlement for demonstration year 1 in September 2020.

In 2019, NYSDOH described the rate setting process as hampered by the State's inability to reimburse the MMP adequately for the extensive care management requirements imposed by the demonstration and noted that the rates for this service had been based on the much lower FFS equivalent. With the implementation of CCO/HHs, the State gained rate experience for this service which will be applied to the demonstration rate setting process in the future.

In addition, the State said it was aware that the administrative component was too low. FIDA-IDD rates had to be budget neutral relative to the cost of those same services in the absence of the demonstration. CMS guidance on the methodology for determining budget neutrality does not consider the resource-intensive startup of the demonstration, when fixed costs are high relative to low enrollment, because these costs would not exist absent the demonstration. Although the MMP said in 2019 that it had experienced adverse selection with enrollees using more personal care and DME than expected, the State maintained that it had adequately accounted for potential adverse selection in the rates and had made adjustments for the plan's actual enrollment.

8.2.3 Cost Experience

The MMP viewed quality improvement as its best cost-saving strategy. By managing care, integrating services, improving discharge planning, avoiding unnecessary ED use, and reducing hospital readmissions, the plan believed it could reduce acute care costs and keep enrollees in the community longer, thus avoiding more costly institutional care. The MMP also made improvements leveraging utilization management activities to minimize duplicative services. The State, CMS, and the MMP noted that the voluntary nature of the demonstration limited some of the traditional managed care methods of achieving costs savings through utilization management.

In 2019, the State said they were looking specifically at the reduction in hospitalizations as a source of cost savings and improved outcomes. The State was pleased with the plan's efforts with hospitals and having its care managers work with them: "So we're seeing good numbers on the inpatient reduction. We're seeing, [compared to] both statewide and nationally, PHP has better numbers."

SECTION 9

Quality of Care

The MMP's pharmacy management program, which reviewed medications across all providers, decreased adverse drug events among enrollees with multiple prescriptions.

The MMP said its telehealth program successfully decreased unnecessary emergency department visits and hospitalizations through providing enrollees and enrollee residences with real-time consultation with IDD-trained emergency medicine physicians.

In this section we provide information on the quality measures, and the quality management structure and activities for the demonstration.

9.1 Quality Measures

The FIDA-IDD demonstration requires that the MMP report standardized quality measures. These measures include:

- A set of core measures specific to all capitated model demonstrations under the FAI that address domains of access, assessment, care coordination, enrollee protection, organization structure and staffing, performance and quality improvement, provider network, and systems and service utilization[30]
- A set of 10 State-specific measures that were selected by OPWDD staff in consultation with CMS after considering feedback from stakeholders. These include a variety of structure, process, and outcome measures spanning a range of service areas including care coordination; long-term care quality; enrollee protections; and utilization. A participant (enrollee)-level[31] file is submitted on an annual basis. The Office of Quality and Patient Safety evaluates measures using the Medicaid Encounter Data System, the OPWDD-approved assessment tool (which will eventually be the CAS), and the participant-level data.

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

The demonstration also uses quality measures required of MA plans, including applicable measures from the Medicare Part C and Part D Reporting Requirements such as appeals and grievances, pharmacy access, payment structures, and medication therapy management.

The MMP is required to submit three additional measure sets as part of the MA requirement:

[30] https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPReportingRequirements.html

[31] New York uses the word "participant" when referring to demonstration enrollees.

- A modified version of the Medicare Advantage and Prescription Drug Plan (MA-PD) Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey that, in addition to the core survey used by Medicare Advantage plans, includes 10 supplemental questions proposed by the RTI Evaluation Team to capture beneficiary experience specific to integration, behavioral health and LTSS;
- The subset of Medicare HEDIS measures, a standard measurement set used extensively by managed care plans, that are required of all MA plans; and
- Selected Health Outcomes Survey measures based on a recurring survey of a random sample of Medicare beneficiaries to assess physical and mental health outcomes.

Data related to these measures, as available, are reported in relevant sections of this report. However, enrollment in the demonstration was too low as of the date of this report to provide an adequate sample size for beneficiary surveys such as CAHPS or HEDIS measures. Future evaluation reports may include these data.

In 2016, OPWDD described how some measures, while consistent with other managed care products in New York, are less relevant for the FIDA-IDD eligible population (e.g., smoking cessation). OPWDD indicated that diabetes, obesity, and employment are more appropriate for the FIDA-IDD population. For OPWDD, the timeliness of assessments and Life Plans are "critical" measures.

FIDA-IDD requires the MMP to use the Council on Quality Leadership's POM interview data (New York three-way contract, 2018, p. 128). OPWDD is collecting this information in the Life Plans that are uploaded from the MMP to OPWDD. OPWDD staff uses this information as part of its person-centered review, described in more detail in ***Section 9.2, Quality Management Structures and Activities***.

9.1.1 Quality Withholds

CMS and NYSDOH withhold a certain percentage of their respective components of the capitation rates (i.e., to the Medicare Parts A and B and Medicaid components; no withhold is applied to the Medicare Part D component). The MMP is eligible to earn back some or all of the withheld amount based on its performance on a set of quality withhold measures. ***Table 11*** describes the performance measure domains for demonstration year 1 and years 2 through 7.[32]

[32] For more information on the specific measures, see MMP Quality Withhold Methodology and Technical Notes.

Table 11
FIDA-IDD quality withhold performance measures domains for demonstration year 1 and demonstration years 2–7

Demonstration Period	Domain
Year 1	Submission of Encounter Data
	Assessments
	Participant Governance Board
	Documentation of Care Goals
	Long Term Care Overall Balance
Years 2–7	Customer Service (DY 3 only)
	Getting Appointments and Care Quickly (DY 3 only)
	Submission of Encounter Data
	Plan All-cause Readmission
	Annual Flu Vaccine
	Follow-up after Hospitalization for Mental Illness
	Controlling Blood Pressure
	Part D Medication Adherence for Diabetes Medications
	ICF-IID Diversion Measure
	Annual Dental Visit (Starting in DY 3)
	Diabetes Care: Blood Sugar Controlled (Starting in DY 5)
	Care for Older Adults: Medication Review (Starting in DY 5)

DY = demonstration year; ICF-IDD = Intermediate Care Facility for Individuals with Intellectual Disabilities.
SOURCE: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPQualityWithholdMethodologyandTechnicalNotes.

The withholds are repaid to the MMP based on the plan's performance relative to established thresholds on the quality withhold measures. The withhold was 1 percent in demonstration year 1, 2 percent in demonstration year 2, and 3 percent in demonstration year 3. For demonstration year 1, which crossed calendar years, the MMP was evaluated to determine whether it met quality withhold requirements at the end of calendar year 2016 and at the end of calendar year 2017. The determination in calendar year 2016 was based solely on those measures that could appropriately be calculated based on the actual enrollment volume in 2016 (New York three-way contract, 2018, p. 175–9). The plan met 100 percent of the measure criteria and received 100 percent of the quality withhold payment for both calendar years included in demonstration year 1 (2016 and 2017) (CMS, n.d.-a). The plan met 75 percent of the measure criteria in demonstration year 2 (calendar year 2018) and received 75 percent of the quality withhold payment (CMS, n.d.-b). The plan met 100 percent of the measure criteria in demonstration year 3 (calendar year 2019) and received 100 percent of the quality withhold payment (CMS, n.d-c.).

9.2 Quality Management Structures and Activities

In this section we describe the components of the FIDA-IDD quality management system, including its interface with CMS, the MMP, and other independent entities, and we describe how well the quality management system is working from various perspectives.

9.2.1 State and CMS Quality Management Structures and Activities

As discussed earlier in this report, the CMT is responsible for monitoring quality and performance measures, reports of enrollee complaints, fiscal operations and financial solvency, network adequacy, and other matters relating to the MMP's ongoing performance. The CMT has had monthly calls with the IAHO to hear about any appeals, and monthly calls with ICAN to hear about any cases the ombudsman program handled or any systemic issues it observed.

The Office of Quality and Patient Safety at NYSDOH is responsible for monitoring quality of care and patient safety across all programs in NYSDOH, including FIDA-IDD and the other Medicaid Managed Care (MMC) programs and initiatives. NYSDOH also has a Quality Strategy for the New York State Medicaid Managed Care Program (NYSDOH, Quality Strategy, October 2015). The document outlines the goals of the managed care program and actions taken by NYSDOH to ensure the quality of care delivered to Medicaid managed care enrollees. The managed care quality strategy is designed and implemented through the mechanisms of measurement and assessment; improvement; redesign; contract compliance and oversight; and enforcement (NYSDOH, October 2015, p. 7). NYSDOH indicated that the quality management activities for FIDA-IDD were very similar to those undertaken for MLTSS, MAP, and Program of All-Inclusive Care for the Elderly.

OPWDD uses a variety of methods to monitor quality and health and safety for all IDD services, including incident reporting, and training and monitoring activities conducted by the Division of Quality Improvement (DQI). DQI is responsible for reviewing all OPWDD service providers and has developed the person-centered review to focus on the person-centered planning process and the content of the Life Plans, the level of communications among IDT members, coordination of health services, individual satisfaction, and other measures of person-centeredness. DQI's goal is to look at the whole person, taking into consideration every service the individual receives, in the way it expects the MMP to do. This ongoing review involves a review of the Life Plan, case notes, and discussions with the enrollee, family members, advocates, and others as applicable. The review also involves searching OPWDD's Incident Report and Management Application for any incident reports submitted on behalf of the enrollee.

OPWDD includes FIDA-IDD enrollees in its National Core Indicators (NCI) survey, which measures State-level performance, with respect to employment, rights, service planning, community inclusion, choice, and health and safety. In early 2020, OPWDD said it has been unable to use all of the information from the NCI surveys as the sample sizes for FIDA-IDD on some measures have been too small to be statistically valid. However, the State shared some information from the NCI with the MMP on the number of enrollees who said they were either satisfied or dissatisfied with elements of their Life Plan such as having opportunities to make friends or being able to choose their care manager. OPWDD discussed the findings with the MMP to identify potential areas for improvement.

9.2.2 FIDA-IDD MMP Quality Management Structure and Activities

The three-way contract sets out quality management requirements specifying that the MMP must have a quality improvement organizational and program structure that meets Federal requirements and National Committee for Quality Assurance Health Plan Accreditation criteria for quality management and improvement (New York three-way contract, 2018, p. 127).

The MMP is also required to use the Home and Community-Based Services Experience Survey in their quality monitoring process. The plan must participate in the review process conducted by the State's External Quality Review Organization (EQRO) (New York three-way contract, 2018, p. 136–8). CMS and NYSDOH also require the MMP to submit data on core and State-specific measures that are detailed in the three-way contract and reporting requirements guidance documents (see ***Section 9.1, Quality Measures***).

The three-way contract specifies that the MMP apply the principles of Continuous Quality Improvement to all aspects of the plan's service delivery system. This includes disseminating evidence-based practice guidelines to its providers and establishing a medical record review process to monitor providers' compliance with policies and procedures, specifications, and appropriateness of care (New York three-way contract, 2018, p. 126–7).

The MMP initiated several quality improvement activities over the demonstration, including efforts to reduce polypharmacy, improve medication management, increase healthy behaviors, improve communication between providers, and expand telehealth to reduce unnecessary trips to the ED.

The plan focused on polypharmacy to ensure that when an individual had 10 or more monthly prescriptions, the prescribers were communicating with each other. In 2018, the MMP described a case of an individual who had been hospitalized frequently; through the medication review, the MMP identified one prescription that had likely caused the hospitalizations. The enrollee had been taking the prescription for 10 years, and although their current primary care physician had not initiated the prescription, they renewed it whenever the pharmacy called. After the review, the medication was stopped, and the individual improved.

The MMP's pharmacy management program also focused on transitions in care and discharge planning to make sure all of an enrollee's providers knew what medications have been prescribed to minimize errors and unnecessary ED visits or hospitalizations. The plan's clinical team leaders (plan nurses and social workers) visited enrollees who had been discharged from the hospital, usually within days of the discharge, to make sure the enrollee understood their discharge plan, that they had the ability to adhere to it, and to make sure a follow-up visit with the enrollee's PCP was scheduled. If there had been medication changes, the visit included a review to check for duplicative drugs, drug interactions, and to make sure the enrollee understood the changes and could access the new medications. In 2019, the MMP noted an added benefit of its focus on care transitions and discharge planning was a decrease the length of stays in hospitals.

Starting in 2018, the MMP implemented a rewards incentive program, "Choose Health," that rewarded enrollees for meeting two out of three preventive health goals, including a flu vaccine, a dental checkup, and a preventive screening. When the goals were accomplished, the

enrollee could select from among four reward options (a tote bag, backpack, t-shirt, or a $10 gift card). The plan received positive feedback on the program during PAC meetings.

In 2019, the MMP began sharing a summary of enrollees' I AM assessments with their PCPs. In 2020, the MMP said the providers appreciated receiving the information on advanced care planning, functional assessments, and medication lists. The providers were asked to review them and send feedback to the MMP about whether they agreed with the information or if they had additional assessment information. The MMP also conducted a "gaps in care" report by provider and by enrollee in 2019, focusing on mammograms, A1C testing, and colorectal cancer screening to improve testing and screening rates. The MMP said it saw improvements between 2018 and 2019 in these areas, which are also HEDIS measures. [33]

The plan piloted a telehealth project in 2018 and expanded it in 2019 to reduce disruptive ED visits and hospital admissions. The MMP reported that IDD providers tended to be overly risk averse and prone to taking beneficiaries to the emergency room for minor issues, particularly when the beneficiary was non-verbal. Both the MMP and OPWDD noted that ED visits for individuals with IDD are more likely to result in a hospital admission than for the general population because EDs often are not equipped or prepared for the complexity of serving individuals with IDD. The MMP said that unnecessary hospitalizations can lead to a downward spiral, especially for people with IDD who are non-verbal or have behavioral health issues exacerbated by the disruption; avoiding these unnecessary stays improves the quality of life for its enrollees.

When people get admitted, there's a significant subset of people that start going downhill and never stop, unfortunately. It becomes the beginning, for lack of a better term, of the end for this group of people.

— MMP representative (2021)

For the telehealth program, the MMP contracted with StationMD, an organization that connected ED doctors who were trained in IDD medical and behavioral health needs with developmental services providers to help determine if a resident required ED care. Developmental services providers had kiosks in their residences to measure blood pressure, pulse oximetry, and temperature of enrollees, and the team of doctors could access this information as well as enrollee's medical records in real-time to determine if emergency care was needed. If an enrollee needed emergency treatment, a team doctor called the receiving ED to alert them and follow up if an admission was warranted. The plan said it had seen a 10 percent decrease in ED visits and a 26 percent reduction in hospital admissions per thousand enrollees between 2018 and 2020 (PHP, 2021).

The MMP reported in 2021 the telehealth program was "in full gear" when the PHE began and offered it to all enrollees in the community and to enrollees in developmental services

[33] We do not provide HEDIS results in this report because enrollment in the demonstration was too low as of the report date to provide an adequate sample size for HEDIS measures.

residences (see ***Section 5, Care Coordination***). The MMP said that even during the PHE, 90 percent of the 537 calls to its telemedicine program resulted in the enrollee being treated in place rather than transferring to the ED.

9.2.3 Independent Quality Management Structures and Activities

New York uses IPRO (a health care assessment and improvement services organization) as the EQRO for its MMC and MLTSS programs. As in MMC and MLTSS, the MMP must choose a quality improvement project. NYSDOH works with the EQRO to review the data available related to the MMP's project, and the EQRO assists the plan in determining which measures it can improve. The MMP can choose from a set of projects that address at least one of the OPWDD Transformation Agenda subject areas, which include the promotion of self-direction; gainful employment and meaningful community engagement; and more integrated living options (New York three-way contract, 2016, p. 135). These projects are in addition to the quality improvement activities initiated by the MMP described in ***Section 9.2.2***.

To date, the MMP has conducted two quality improvement projects (QIPs), one focused on the Transformation Agenda subject area of self-direction. The MMP was able to increase the number of people enrolling in self-direction between 2017 and 2019, but reported to OPWDD that it had difficulties in contracting with enough fiscal intermediaries to accommodate all enrollees who wanted to participate (OPWDD 2021). The other QIP focused on diabetes management, and the MMP reported in 2020 that its A1C diabetes control HEDIS measure improved by 25 percentage points and its blood pressure control measure for enrollees with diabetes increased by 19 percentage points.

ICAN (the ombudsman agency) is also responsible for identifying systemic issues and bringing them to the attention of the CMT. These issues might be identified through case work or through its outreach activities. CMS reported in 2018 that ICAN had not identified any systemic quality issues relating to the MMP. In 2020, when asked about the reasons for the low volume of complaints received for the plan, the ombudsman suggested the care manager ratios may be a contributing factor and that the care managers may have more time to discuss care decisions with demonstration enrollees than those in other programs who have higher caseloads. See ***Section 6.2, Beneficiary Protections***, for more information on the role of the ombudsman.

[This page intentionally left blank.]

SECTION 10

Demonstration Impact on Cost Savings

Our results show increases in gross Medicare Parts A and B costs during the cumulative demonstration period ($34.53 per member per month [PMPM]).

Additionally, our results indicate neither cost increases nor decreases to Medicaid during the cumulative demonstration period.

10.1 Methods Overview

As part of the capitated financial alignment model, New York, CMS, and the MMP entered into a three-way contract to provide services to MMP enrollees. The MMP receives three separate, blended, risk-adjusted prospective capitated payments for Medicare Parts A and B, Medicare Part D, and Medicaid services. The first two payments are from CMS, and the third comes from the State. CMS and New York developed the capitation payment that accounts for the services provided and adjusts the Medicare component for each enrollee using CMS's hierarchical risk adjustment model to account for differences in the characteristics of enrollees. For further information on the rate development and risk adjustment process, see the Memorandum of Understanding and the three-way contract on the Financial Alignment Initiative website.[34]

This section presents the Medicare Parts A and B cost savings analysis for demonstration years 1 to 2 (calendar years April 2016 to December 2018). This section also presents the Medicaid cost savings analysis for demonstration years 1 to 2.

We used an intent-to-treat (ITT) analytic framework that includes beneficiaries eligible for the demonstration rather than only those who enrolled. The ITT framework alleviates concerns of selection bias, supports generalizability of the results among the demonstration eligible population, and mimics the real-world implementation of the demonstration. For this analysis, enrolled beneficiaries account for approximately 5 percent of all eligible beneficiaries (including FFS beneficiaries, MMP enrollees, and MA enrollees) in demonstration year 2. The remaining 95 percent of those in the demonstration group are beneficiaries who are eligible for an MMP but not enrolled (non-enrollees). Results from a separate analysis, using a more restricted definition of MMP enrollees and their comparison group counterparts, are included in ***Appendix D*** (see ***Table D-7***).

To evaluate the demonstration's impact on Medicare costs, RTI performed a DinD analysis of Medicare Parts A and B expenditures that compares demonstration eligible beneficiaries who live in an area where a participating health plan operates—the demonstration

[34] For the MOU, please see https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/NYMOUIDD.pdf For the three-way contract, please see https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/NYFIDA-IDDContract01012018.pdf

group—to those who meet the same eligibility criteria but live outside those operating areas—the comparison group.

To identify the demonstration group, RTI used quarterly files on demonstration eligible beneficiaries submitted by the State of New York. Comparison group beneficiaries were identified through a two-step process. First, we identified comparison areas based on market characteristics. Because of the uniqueness of both the eligibility criteria and the geographic area where the demonstration occurs, the comparison group was constructed using exclusively in-state areas. Second, we applied all available eligibility criteria to beneficiaries in the identified comparison areas. This process is further described in ***Appendix C***. Once the two groups were finalized, we applied propensity score (PS) weighting in the DinD analysis to balance key characteristics between the two groups.

RTI gathered predemonstration and demonstration monthly Medicare expenditure data for both the demonstration and comparison groups from two data sources, as summarized in ***Table 12***. We obtained capitation payments paid to the participating plan during the demonstration period, and payments to the MA plan in the predemonstration and demonstration periods from the CMS Medicare Advantage and Part D Inquiry System (MARx). Part D payments are not included in this analysis. Additionally, this analysis is preliminary as risk corridor payments or recoupments were not included but will be accounted for in updated results for the next report. The capitation payments were the final reconciled payments paid by the Medicare program after taking into account risk score reconciliation and any associated retroactive adjustments in the system at the time of the data pull (October 2021). We also used Medicare FFS claims to calculate expenditures for eligible beneficiaries who were not enrolled in the MMP or MA plan. These FFS claims included all Medicare Parts A and B services.

Table 12
Data sources for monthly Medicare expenditures

Group	Predemonstration period April 1, 2014–March 31, 2016	Demonstration period April 1, 2016–December 31, 2018
Demonstration	Medicare FFS MA capitation	Capitation rate for enrollees MA capitation for non-enrollees Medicare FFS for non-enrollees
Comparison	Medicare FFS MA capitation	Medicare FFS MA capitation

FFS = fee-for-service; MA = Medicare Advantage.

We made several adjustments to the monthly Medicare expenditures to ensure that observed expenditure variations are not due to differences in Medicare payment policies in different areas of the country or the construction of the capitation rates (see ***Appendix D***). ***Table D-1*** in ***Appendix D*** summarizes each adjustment and the application of the adjustments to FFS expenditures or to the capitation rate.

To estimate the effect of the demonstration on Medicare expenditures, we ran a generalized linear model with gamma distribution and log link. This is a commonly used approach in analysis of health care expenditure data. The model controlled for individual

demographic and area-level characteristics (see ***Appendix D***), employed PS weighting, and adjusted for clustering of observations at the county level. The key policy variable of interest in the model was an interaction term measuring the effect of being part of the demonstration eligible group during the demonstration period, which estimates the demonstration's effect on Medicare expenditures.

To evaluate the demonstration's impact on Medicaid costs, RTI performed a DinD analysis of total Medicaid expenditures, using the same demonstration and comparison groups as defined for the Medicare cost savings analysis and the same regression methodology. The outcome of interest was the sum of all Medicaid costs (excluding costs for prescription drugs), both FFS and capitated payments, for the demonstration and comparison groups.[35]

RTI gathered predemonstration and demonstration monthly Medicaid expenditure data for both the demonstration and comparison groups from two types of claims, as summarized in ***Table 13***. We obtained capitation payments paid to the participating plan during the demonstration period and capitated payments to Medicaid managed care plan in the predemonstration and demonstration periods from the Transformed Medicaid Statistical Information System (T-MSIS) Research Identifiable Files (RIFs). We also used Medicaid FFS claims from the T-MSIS RIFs to calculate expenditures for beneficiaries who were not enrolled in the MMP or the Medicaid managed care plan. These FFS claims included all Medicaid services, with the exception of Medicaid claims for prescription drugs.

Table 13
Data sources for monthly Medicaid expenditures

Group	Predemonstration period April 1, 2014–March 31, 2016	Demonstration period April 1, 2016–December 31, 2018
Demonstration	Medicaid FFS Medicaid capitation	Medicaid FFS Medicaid capitation
Comparison	Medicaid FFS Medicaid capitation	Medicaid FFS Medicaid capitation

FFS = fee-for-service

10.2 Demonstration Impact on Medicare Parts A and B Costs

Table 14 shows the magnitude of the DinD estimate of the cumulative demonstration impact on Medicare Parts A and B costs, both in absolute dollar amount and relative to the adjusted mean expenditure level in the comparison group during the demonstration period. The adjusted mean for monthly expenditure increased from the predemonstration period to the demonstration period in both the demonstration and comparison groups. The cumulative DinD estimate of $34.53 PMPM, which amounts to a relative difference of 5.44 percent of the adjusted mean expenditure for the comparison group during the demonstration period, is statistically

[35] Medicaid prescription drug costs only marginally impact the capitation payment received by the MMP.

significant ($p = 0.0138$), suggesting that overall, the FIDA-IDD demonstration was associated with statistically significant increases relative to the comparison group.

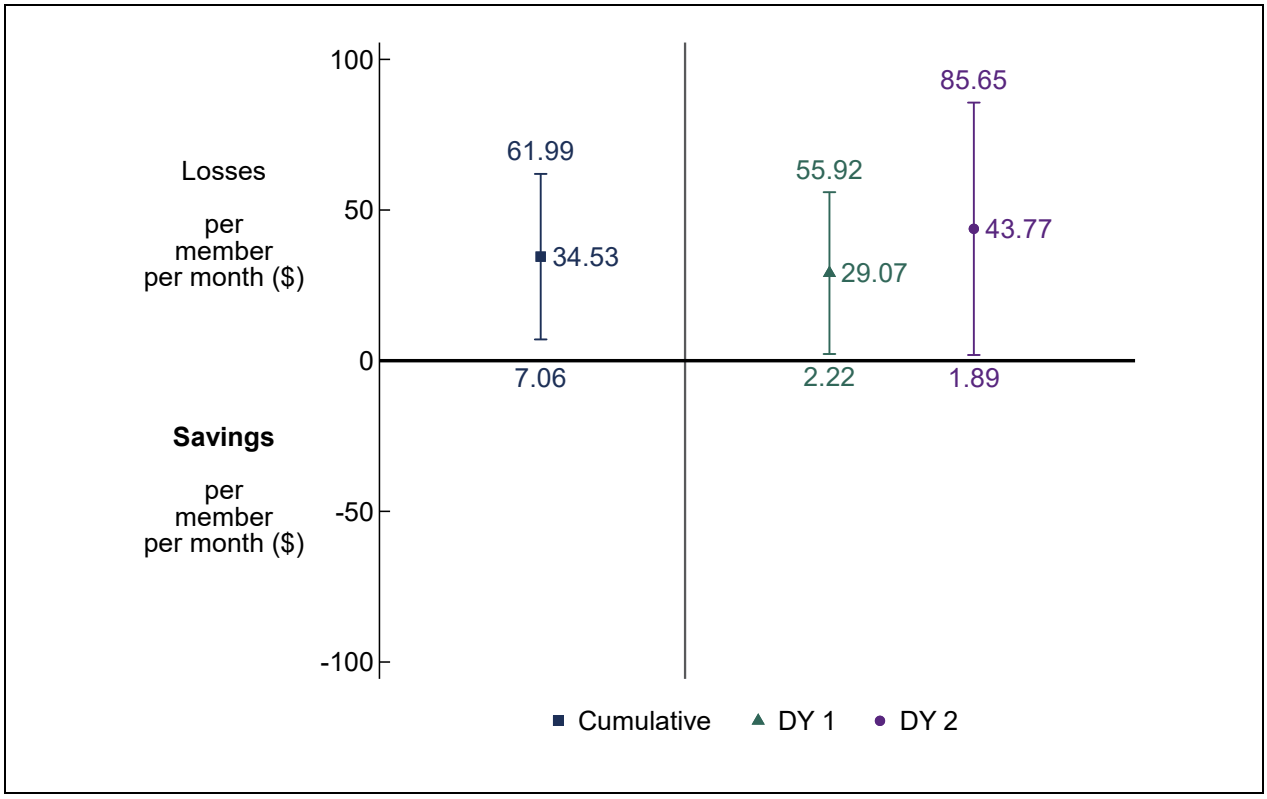
Table 14
Cumulative demonstration impact on Medicare Parts A and B costs for eligible beneficiaries in New York, demonstration years 1–2, April 1, 2016–December 31, 2018

Group	Adjusted mean for predemonstration period ($)	Adjusted mean for demonstration period ($)	Relative difference (%)	Adjusted coefficient DinD ($)	p-value
Demonstration	593.31	635.22	5.44	34.53	0.0138
Comparison	627.98	634.93			

DinD = difference-in-differences.
SOURCE: RTI analysis of Medicare claims (program: dd_dy2_cs1490_Percents.log)

In addition, we estimated the effect of the demonstration in each demonstration year. As shown in ***Figure 2***, the demonstration had a statistically significant effect in all demonstration years (as shown by the confidence intervals not crossing $0), indicating an increase in Medicare costs as a result of the demonstration relative to the comparison group. Note that these estimates rely on the ITT framework, only account for Medicare Parts A and B costs, and use the capitation rate for the MMP rather than the actual amount the plan paid for services. Thus, these estimates are not directly comparable to the financial experience of MMPS as discussed in ***Section 8.2.2, Rate Methodology Design Implications.*** Moreover, as only approximately 5 percent of the eligible population was enrolled in the FIDA-IDD demonstration by demonstration year 2, it is unlikely that any favorable impacts of the demonstration on Medicare costs would be observed.

Figure 2
Cumulative and annual demonstration effects on monthly Medicare Parts A and B costs in New York, demonstration years 1–2, April 1, 2016–December 31, 2018



DY = demonstration year.
NOTE: 95 percent confidence intervals are shown. "Losses"/"**Savings**" indicate increased/decreased costs for eligible beneficiaries in the demonstration group, relative to the comparison group.
SOURCE: RTI analysis of Medicare claims (program: dd_dy2_cs1480_GLM.log)

10.3 Demonstration Impact on Medicaid Costs

Table 15 shows the magnitude of the DinD estimate of the cumulative demonstration impact on Medicaid costs, both in absolute dollar amount and relative to the adjusted mean expenditure level in the comparison group during the demonstration period. Note that the adjusted mean Medicaid costs for the demonstration group in the predemonstration period was $9,938.66, relative to adjusted mean Medicare costs of $593.31 for the same group and period (see ***Table 14***). The adjusted mean monthly expenditure decreased from the predemonstration period to the demonstration period similarly between both the demonstration and comparison groups. The cumulative DinD estimate of –$46.89 PMPM, which amounts to a relative difference of 0.61 percent of the adjusted mean expenditure for the comparison group during the demonstration period, is not statistically significant ($p = 0.9196$). This suggests that overall, the New York FIDA-IDD demonstration was not associated with statistically significant increases or decreases in Medicaid costs relative to the comparison group.

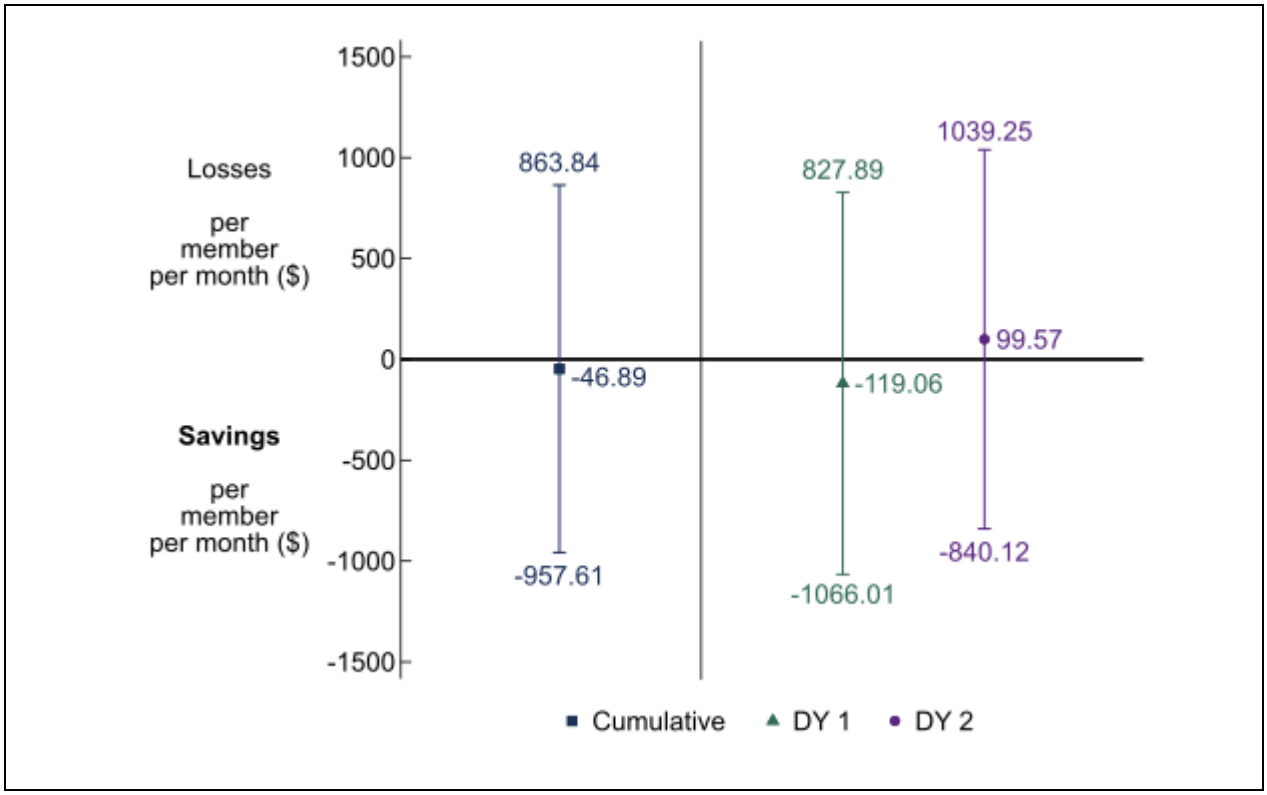
Table 15
Cumulative demonstration impact on Medicaid costs in New York, demonstration years 1–2, April 1, 2016–December 31, 2018

Group	Adjusted mean for predemonstration period ($)	Adjusted mean for demonstration period ($)	Relative difference (%)	Adjusted coefficient DinD ($)	*p*-value
Demonstration	9,938.66	9,339.03	−0.61	−46.89	0.9196
Comparison	8,128.53	7,678.49			

DinD = difference-in-differences.
SOURCE: RTI analysis of Medicaid claims (program: 40_Relative_Difference.do)

In addition, we estimated the effect of the demonstration in each of the 2 demonstration years included in the analysis. As shown in ***Figure 3***, there was no year in which the demonstration had a statistically significant effect (as shown by the confidence intervals crossing $0). Note that these estimates rely on the ITT framework, exclude Medicaid prescription drug costs (which only marginally impact the capitation payment received by the MMP), and are reliant upon the completeness and the correctness of the Medicaid cost data included in the T-MSIS.

Figure 3
Cumulative and annual demonstration effects on monthly Medicaid costs for eligible beneficiaries in New York, demonstration years 1–2, April 1, 2016–December 31, 2018



DY = demonstration year.
NOTE: 95 percent confidence intervals are shown. "Losses"/"**Savings**" indicate increased/decreased costs for eligible beneficiaries in the demonstration group, relative to the comparison group.
SOURCE: RTI analysis of Medicaid claims (program: 30_Regression.do)

[This page intentionally left blank.]

SECTION 11

Conclusions

11.1 Implementation Successes, Challenges, and Lessons Learned

FIDA-IDD successfully launched in April 2016. The demonstration benefited from NYSDOH's early implementation experience with the FIDA demonstration and the integrated infrastructure (e.g., the enrollment process, notices, and integrated appeals) that NYSDOH and CMS had developed for FIDA. In addition, the MMP had already tested its care coordination model during a pilot phase.

The FIDA-IDD care management model and PHP's I AM assessment tool enabled the MMP to provide person-centered care and services that enable enrollees to reach their goals, including social goals such as attending baseball games and dance classes, or playing pool. The MMP increased the number of enrollees who are able to self-direct their own care.

Data from the MMP indicates its pharmacy management program decreased adverse drug events in its membership, and the telehealth program successfully reduced unnecessary ED visits and hospital admissions for enrollees since 2018. The MMP was able to leverage its experience with telehealth in residential settings to expand the service to its enrollees in the community early in the PHE. Through staying in touch with enrollees telephonically, sometimes weekly, or even daily, care managers were able to ensure the needs of enrollees were still being met while social distancing requirements prohibited in-person visits.

OPWDD believed that the complicated nature of the demonstration's design to integrate Medicare and Medicaid services through a managed care plan for a complex population was the biggest challenge faced by the State and the MMP prior to the start of the demonstration. This population was historically carved out of other managed care initiatives. OPWDD noted that PHP bore a large share of the burden and invested substantial private resources into developing tools and systems. The MMP developed a comprehensive assessment that is used to create a very detailed and personalized Life Plan.

Although the mechanics of launching FIDA-IDD appeared to work smoothly, the MMP continued to struggle with low enrollment. Without passive enrollment, enrollees were limited to those who opted into the demonstration. A major hospital system has refused to participate in the demonstration, limiting the plan's ability to attract beneficiaries. The MMP has employed various strategies to increase enrollment. Enrolling Willowbrook class members has been one successful strategy. OPWDD, CMS, and the MMP cited the plan's success with Willowbrook class members as evidence of the demonstration's overall effectiveness at managing care for a complex population. Voluntary disenrollment from FIDA-IDD has been low and was usually tied to reluctance to change providers.

OPWDD leadership believed FIDA-IDD successfully demonstrated that managed care, if well-designed, can serve people with intellectual and developmental disabilities. In 2018, OPWDD began the first of three phases that will transition OPWDD service population to mandatory managed care. OPWDD reported that launching FIDA-IDD prepared it for this transition: "We wouldn't have been where we are now…if we hadn't gone through what has been a very considerable, time-intensive [demonstration] and experiment."

11.2 Demonstration Impact on Cost Savings

The cumulative cost analysis found a statistically significant cost increase to the Medicare program over the 2 demonstration years. The analysis of individual demonstration years also found statistically significant increases in costs to the Medicare program for each individual demonstration year. The cost analyses consider the costs of Medicare Parts A and B through FFS expenditures, and capitation rates paid to the MMP and MA plans. Capitation rates do not provide information on how much the plan paid for services and are based on characteristics of the beneficiary. Thus, capitation rates are not necessarily linked to actual service utilization. Further, the Medicare cost analyses do not consider Part D costs.

There was no evidence of Medicaid cost savings as a result of the New York FIDA-IDD demonstration. The results of the Medicaid cost savings analyses using a DinD regression approach indicate no significant increase or savings in Medicaid costs.

Among FAI demonstrations implemented, New York's FIDA-IDD is unique in having Medicaid as the dominant payer for eligible beneficiaries. This demonstration focuses exclusively on beneficiaries utilizing a significant amount of LTSS relative to other health services, so it is unsurprising that the vast majority of spending for these beneficiaries is Medicaid spending. Comparing monthly Medicaid spending per eligible beneficiary ($9,938.66 from ***Table 14***) to monthly Medicare spending in the pre-demonstration period ($593.31 from ***Table 15***) serves to highlight the importance of Medicaid spending for this population. Although there was a relative increase in Medicare payments in the demonstration, there was no relative change in Medicaid payments. The increase in Medicare payments of $34.53 PBPM should be understood in the context of understanding the proportion of Medicare and Medicaid spending for this population.

11.3 Next Steps

The RTI evaluation team will continue to collect information such as enrollment statistics and updates on key aspects of implementation on a quarterly basis from New York officials through the online State Data Reporting System. We will conduct annual virtual site visit calls with the State and demonstration stakeholders, and quarterly calls with FIDA-IDD State and CMS staff. RTI will conduct additional qualitative and quantitative analyses over the course of the demonstration. The next report will include a qualitative update on demonstration implementation, and quantitative analyses of the demonstration impact on cost measures using additional years of data.

References

Centers for Medicare & Medicaid Services (CMS) and the State of New York (NYS): Memorandum of Understanding (MOU) Between the Centers for Medicare & Medicaid Services (CMS) and New York Regarding a Federal-State Partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Enrollees Who Have Intellectual and Developmental Disabilities. Baltimore, MD. November 5, 2015. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/NYMOUIDD.pdf. As obtained on February 5, 2016.

Centers for Medicare & Medicaid Services (CMS), New York State Department of Health (NYSDOH) and Partners Health Plan (PHP): Contract Between United States Department of Health and Human Services Centers for Medicare and Medicaid Services in Partnership with the State of New York Department of Health and Partners Health Plan. January 14, 2016. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/NewYorkContractIDD.pdf. As obtained on January 13, 2017.

Centers for Medicare & Medicaid Services (CMS) and the State of New York (NYS): FIDA-IDD Demonstration Requirements for Assessment, Service Planning and Authorization, and Ongoing Care Management (IDT Policy). Revised effective January 1, 2018. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/NYFIDA-IDDIDTPolicy01012018.pdf. As obtained on March 23, 2021.

Centers for Medicare & Medicaid Services (CMS): Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements: New York FIDA-IDD-Specific Reporting Requirements (Eff. October 1, 2016). April 13, 2017. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/NYFIDAIDDReportingRequirements041317.pdf. 2017. As obtained on October 29, 2018.

Centers for Medicare & Medicaid Services (CMS), New York State Department of Health (NYSDOH) and Partners Health Plan (PHP): Contract Between United States Department of Health and Human Services Centers for Medicare and Medicaid Services in Partnership with the State of New York Department of Health and Partners Health Plan (Amendment and Restatement). n.d.-b (effective date January 1, 2018). https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/NYFIDA-IDDContract01012018.pdf. As obtained on October 12, 2018.

Centers for Medicare & Medicaid Services (CMS): New York FIDA-IDD Medicare-Medicaid Plan Quality Withhold Analysis Results Demonstration Year 1 (Calendar Years 2016-2017). n.d.-a. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/QualityWithholdResultsReportNYFIDAIDDDY1.pdf. As obtained on November 8, 2021.

Centers for Medicare & Medicaid Services (CMS): New York FIDA-IDD Medicare-Medicaid Plan Quality Withhold Analysis Results Demonstration Year 2 (Calendar Year 2018). n.d.-c. https://www.cms.gov/files/document/qualitywithholdresultsreportnyfidaidddy2.pdf. As obtained on November 8, 2021.

Centers for Medicare & Medicaid Services (CMS): New York FIDA-IDD Medicare-Medicaid Plan Quality Withhold Analysis Results Demonstration Year 3 (Calendar Year 2019). n.d.-d. https://www.cms.gov/files/document/qualitywithholdresultsreportnyfidaidddy3.pdf. As obtained on November 8, 2021.

Centers for Medicare & Medicaid Services (CMS): Medicare-Medicaid Capitated Financial Alignment Model Quality Withhold Technical Notes (DY 2–7): New York FIDA-IDD Specific Measures, Updated October 2, 2020. https://www.cms.gov/files/document/nyfidaiddqualitywithholdguidancedy2-7.pdf. As obtained on February 7, 2022.

Centers for Medicare & Medicaid Services (CMS): Email communication to RTI, received February 9, 2022.

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

New York State Department of Health (NYSDOH): Quality Strategy for the New York State Medicaid Managed Care Program. October 2015. https://www.health.ny.gov/health_care/managed_care/docs/quality_strategy.pdf. As obtained on January 13, 2017.

New York State Office for People with Developmental Disabilities (OPWDD): Beyond Willowbrook. (webpage). n.d.-b. https://opwdd.ny.gov/willowbrook. As obtained on July 16, 2021.

New York State Office for People with Developmental Disabilities (OPWDD): FIDA-IDD Quality Improvement Project, Partners Health Plan: Increase adoption of self-direction (SD) among PHP participants, 1/1/2017-12/31/2019. As obtained on March 23, 2021.

Partners Health Plan (PHP): About Partners Health Plan. (website). https://phpcares.org/our-story/about-partners-health-plan/our-history. n.d. As obtained on January 13, 2017.

Partners Health Plan (PHP): Overview of Admissions, Emergency Room Visits and the Telemedicine Program for 2020. n.d. As obtained on March 26, 2021, from Lila Benayoun at PHP.

RTI International: State Data Reporting System (SDRS). 2017–2019.

Walsh, E., et al.: Measurement, Monitoring, and Evaluation of State Demonstrations to Integrate Care for Dual Eligible Individuals: Aggregate Evaluation Plan. Contract No. HHSM500201000021i TO #3. Waltham, MA. RTI International, December 16, 2013. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/EvalPlanFullReport.pdf. As obtained on May 18, 2021.

[This page intentionally left blank.]

Appendix A

Data Sources

We used the following data sources to prepare this report.

Key informant interviews. The RTI evaluation team conducted in person site visits in New York in 2016 and virtual site visits by phone and Zoom in 2018–2021. The team interviewed the following types of individuals: State policy makers and agency staff, CMS and State contract management team (CMT) members, ombudsman program officials, Medicare-Medicaid plan (MMP) officials, advocates, and other stakeholders

Surveys. Medicare requires all Medicare Advantage (MA) plans, including the FIDA-IDD plan, to conduct an annual assessment of beneficiary experiences using the Medicare Advantage and Prescription Drug Plan Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey instrument. The survey for FIDA-IDD includes the core Medicare CAHPS questions and 10 supplemental questions added by the RTI evaluation team. Enrollment in the demonstration was too low as of the date of this report to provide an adequate sample size for the CAHPS survey.

Demonstration data. The RTI evaluation team reviewed data provided quarterly by New York through the State Data Reporting System (SDRS). 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. This report also uses data for quality measures reported by the FIDA-IDD plan and submitted to CMS' implementation contractor, NORC.[36,37] Data reported to NORC include core quality measures that all Medicare-Medicaid Plans are required to report, as well as State-specific measures that the FIDA-IDD plan is 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.

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] other publicly available materials on the New York FIDA-IDD website and on the OPWDD website.[39]

Conversations with CMS, NYSDOH, and OPWDD officials. To monitor demonstration progress, the RTI evaluation team engages in periodic phone conversations with the New York State Department of Health (NYSDOH), the New York Office for People with Developmental Disabilities (OPWDD) and CMS. These might include discussions about new policy clarifications designed to improve plan performance, quality improvement work group activities, and contract management team actions.

[36] Data are reported for [2016–2020].
[37] The technical specifications for reporting requirements are in the Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements.
[38] https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsinCareCoordination.html
[39] https://opwdd.ny.gov/services-funded-fida-idd-managed-care-program-2020 and https://opwdd.ny.gov/

Complaints and appeals data. Complaint (also referred to as grievance) data are from two sources: (1) complaints from beneficiaries reported by the FIDA-IDD plan to NYSDOH, and reported separately to CMS' implementation contractor, NORC[40], through Core Measure 4.2; and (2) complaints received by NYSDOH or 1-800-Medicare and entered into the CMS electronic Complaint Tracking Module (CTM). The RTI evaluation team also obtains qualitative data on complaints during site visit interviews. Appeals data are generated by the MMP and reported to NYSDOH and NORC, for Core Measure 4.2, and to the New York Integrated Administrative Hearing Office. This report also includes critical incidents and abuse data reported by the FIDA-IDD MMP to NYSDOH and CMS' implementation contractor, NORC.

HEDIS measures. We do not provide HEDIS results in this report because enrollment in the demonstration was too low as of the report date to provide an adequate sample size for HEDIS measures.

Cost savings data. Two primary data sources were used to support the savings analyses, capitation payments and fee-for-service (FFS) Medicare claims. Medicare capitation payments paid to Partners Health Plan (PHP) during the demonstration period were obtained for all MMP enrollees from the CMS Medicare Advantage and Part D Inquiry System (MARx) data. The capitation payments were the final reconciled payments paid by the Medicare program after taking into account risk score reconciliation and any associated retroactive adjustments in the system at the time of the data pull (October 2021). Quality withholds were applied to the capitation payments (quality withholds are not reflected in the MARx data), as well as quality withhold repayments based on data provided by CMS. Risk corridor settlements were not included in this analysis. Capitation payments and FFS Medicare claims were used to calculate expenditures for all comparison group beneficiaries, demonstration group beneficiaries in the baseline period, and demonstration eligible beneficiaries who were not enrolled during the demonstration period. FFS claims included all Medicare Parts A and B services.

Medicaid research identifiable files were used to calculate total Medicaid FFS and Medicaid Managed Care payments among demonstration and comparison group eligible beneficiaries. The source of Medicaid claims data for calendar year 2015 (which includes the first 5 months of the baseline period) was the Medicaid Statistical Information Statistics (MSIS) Medicaid Analytic eXtract (MAX). The source for the Medicaid claims data for calendar years 2016–2018 (which includes the latter 3 months of the baseline period and the two demonstrations periods) was the Transformed Medicaid Statistical Information System (T-MSIS) Analytic Files (TAF).

[40] The technical specifications for reporting requirements are in the Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements document.

Appendix B

Predemonstration and Demonstration Design Features

Key features	Predemonstration	Demonstration[1]
Summary of covered benefits		
Medicare	Medicare Parts A, B, & D	Medicare Parts A, B, & D
Medicaid	Medicaid State Plan, §1115(a) and HCBS waiver services	Medicaid State Plan, §1115(a) and HCBS waiver services
Other		Supplemental benefits, if approved by CMS, DOH, and OPWDD
Payment method (capitated/FFS/MFFS)		
Medicare	FFS or capitated	Capitated
Medicaid (capitated or FFS) Primary/medical	FFS or capitated	Capitated
Behavioral health	FFS or capitated	Capitated
LTSS (excluding HCBS waiver services)	FFS	Capitated
HCBS waiver services	FFS	Capitated
Other (specify)	N/A	
Care coordination/case management		
Care coordination for medical, behavioral health, or LTSS and by whom	MSC, provided by nonprofit agency (TCM service)	Care Manager, employed by or under contract to MMP
Care coordination/case management for HCBS waivers and by whom	MSC, employed by a nonprofit agency (TCM service); or for those with a lower level of need, PCSS coordinator, provided by nonprofit agency (waiver-covered service)	Care Manager, employed by or under contract to MMP
TCM	MSC, provided by nonprofit agency	
Enrollment/assignment		
Enrollment method	N/A	Opt-in enrollment through enrollment broker
Attribution/assignment method	N/A	N/A
Implementation		
Geographic area	N/A	Bronx, King, New York, Queens, Richmond, Rockland, Nassau, Suffolk, and Westchester counties
Phase-in plan	N/A	Notice of option to enroll in March 2016, for coverage to start April 1, 2016
Implementation date	N/A	April 1, 2016

FFS = fee-for-service; HCBS = home and community-based services; LTSS = long-term services and supports; MSC = Medicaid Service Coordinator; MFFS = managed fee-for-service; MMP = Medicare-Medicaid Plan; N/A = not applicable; PCSS = Plan of Care Support Services; OPWDD = Office for People with Developmental Disabilities; TCM = targeted case management.

[1] Information related to the Demonstration in this table is from the MOU, 2015; three-way contract, 2016; and the OPWDD waiver, 2016.

[This page intentionally left blank.]

Appendix C

Comparison Group Methodology for New York FIDA-IDD Demonstration Years 1 & 2

This appendix presents the comparison group selection and assessment results for the Financial Alignment Initiative (FAI) demonstration in the state of New York, the Fully Integrated Duals Advantage Demonstration for Individuals with Intellectual and Developmental Disabilities (FIDA-IDD).

Results for comparison group selection and assessment analyses are prepared for each demonstration year. This Appendix describes the comparison group identification methodology in detail and provides the comparison group results for the first and second demonstration years and two prior predemonstration years for the New York FIDA-IDD demonstration (April 1, 2014–December 31, 2018).

C.1 Demonstration and Comparison Group Characteristics

The FIDA-IDD demonstration area consists of the nine contiguous New York counties of Bronx, Kings, Nassau, New York, Queens, Richmond, Rockland, Suffolk, and Westchester.

Our standard methodology for comparison group identification is to employ a two-part process that entails identifying areas using distance scores to assess the similarity of individual Metropolitan Statistical Areas (MSAs) across the country to the demonstration area at large and estimating a propensity model. However, because the New York demonstration eligibility criteria as well as the area itself is unique in several aspects, in particular New York state's waiver eligibility criteria (described below), we elected to construct a comparison group using in-state areas. Though there were some differences between the in-state comparison group and the greater New York City metropolitan area demonstration group, these were secondary to concerns that we would not successfully be able to identify a comparable comparison group using out-of-state MSAs.

Because the FIDA-IDD demonstration largely uses enrollment in the State's OPWDD waiver or in ICF MR facilities, the comparison group was selected to include participants in the waiver or ICF MR facilities residing in non-demonstration counties in New York. Thus, the comparison area is drawn from 12 non-rural MSAs within the state of New York (Buffalo-Cheektowaga-Niagara Falls; New York-Newark-Jersey City (Dutchess, Putnam, and Orange counties); Albany-Schenectady-Troy; Syracuse; Elmira; Ithaca; Kingston; Binghamton; Watertown-Fort Drum; Utica-Rome; Rochester; and Glens Falls).

Beneficiaries who are ineligible for the demonstration include those who are not enrolled in Medicare Parts A and B; those who are under age 21 at the time of enrollment; and those who, at the time of enrollment, reside in Skilled Nursing Facilities, Developmental Centers, or psychiatric facilities, or receive hospice services. We assess these exclusion criteria on a quarterly basis for the demonstration and comparison group in the predemonstration period and for the comparison group in the demonstration period. We use finder files provided by the State to identify the eligible population for the demonstration group during the demonstration period. We apply these exclusion criteria to the state finder file in the demonstration period to ensure comparability with the comparison group and the demonstration group during the predemonstration period.

Beneficiaries qualified for the demonstration group if they participated for at least one month during the demonstration period. During the 2 baseline years, all beneficiaries meeting the age restriction, dual eligibility criteria, and MSA residency requirements were selected for the demonstration and comparison groups. Further analytic exclusions were performed such as: (1) removing beneficiaries with missing geographic information, (2) removing beneficiaries with zero months of eligibility during each analytic period, (3) removing beneficiaries who moved between the demonstration area and the comparison area any time during the entire study period, (4) removing beneficiaries with missing Hierarchical Condition Code (HCC) risk scores, and (5) removing beneficiaries who died before the beginning of each analytic period. After applying these exclusions, the number of demonstration group beneficiaries remained relatively stable over the 2 predemonstration years and 2 demonstration years, ranging between 19,993 and 22,146 beneficiaries per year. The comparison group remained roughly the same size as the demonstration group, with its yearly count of beneficiaries ranging between 19,423 and 20,775.

MA enrollees are eligible and may opt-in to the New York FIDA-IDD demonstration; this report includes the MA population in the cost savings analysis, described in ***Appendix D***. ***Table C-1*** presents counts and percentages of beneficiaries in the demonstration and comparison groups who were enrolled in MA during each year in the predemonstration and demonstration periods. The prevalence of beneficiaries enrolled in MA per year ranges from 6 to 11 percent in the demonstration group, and from 6 to 10 percent in the comparison group across the study period.

Table C-1
Number and percentage of beneficiaries in the demonstration and comparison groups who were enrolled in Medicare Advantage at any point during each period

Group	Predemonstration year 1	Predemonstration year 2	Demonstration year 1	Demonstration year 2
Demonstration				
Final count of beneficiaries	20,104	20,875	22,273	22,293
Count of beneficiaries with Medicare Advantage	1,265	1,636	2,350	2,524
Percent of beneficiaries with Medicare Advantage (denominator is final count of beneficiaries per period)	6%	8%	11%	11%
Comparison				
Final count of beneficiaries	24,513	24,936	26,194	25,486
Count of beneficiaries with Medicare Advantage	1,461	1,565	2,531	2,286
Percent of beneficiaries with Medicare Advantage (denominator is final count of beneficiaries per period)	6%	6%	10%	9%

C.2 Propensity Score Estimates

RTI's methodology uses propensity scores to examine initial differences between the demonstration and comparison groups in each analysis period and then to weight the data to improve the match between them. The comparability of the two groups is examined with respect to both individual beneficiary characteristics as well as the overall distributions of propensity scores.

A propensity score (PS) is the predicted probability that a beneficiary is a member of the demonstration group conditional on a set of observed variables. Our PS models include a combination of beneficiary-level and region-level characteristics measured at the ZIP code (ZIP Code Tabulation Area) level. Measures of the distance to nearest hospitals and nursing homes were also included.

The logistic regression coefficients and z-values for the covariates included in the propensity model for FIDA-IDD during all predemonstration and demonstration years are shown in ***Table C-2***. For the most recent demonstration year, demonstration year 2, the largest relative differences were that demonstration participants were more likely to be Black, were less likely to be enrolled in another shared savings demonstration, adults in the area were more likely to have a college degree, and tended to live closer to the nearest hospital and nursing home than the beneficiaries in the comparison group. The magnitude of the group differences for all variables prior to PS weighting may also be seen in ***Tables C-3*** through ***C-6***.

C.3 Propensity Score Overlap

The distributions of PSs by group, before and after PS weighting, for each predemonstration and demonstration year are shown in ***Figures C-1*** through ***C-4***. For demonstration year 2, estimated scores for both the demonstration group and comparison group topped out at 0.99. The unweighted comparison group (blue dashed line) is concentrated in the range of propensity scores below 0.20. Inverse probability of treatment weighting pulls the distribution of weighted comparison group propensity scores (red dashed line) closer to that of the demonstration group (solid line).

Any beneficiaries who have estimated propensity scores below the smallest estimated value in the demonstration group are removed from the comparison group. Because of the very broad range of propensity scores found in the FIDA-IDD demonstration data, only 64 beneficiaries were removed from the comparison group in demonstration year 1, and only 122 were removed in demonstration year 2.

Table C-2
Logistic regression estimates for New York FIDA-IDD propensity score models in predemonstration and demonstration periods, April 1, 2014–December 31, 2018

Characteristic	Predemonstration Year 1			Predemonstration Year 2			Demonstration Year 1			Demonstration Year 2		
	Coef.	Std. Error	z-score	Coef.	Std. Error	z-score	Coef.	Std. Error	z-score	Coef.	Std. Error	z-score
Age (years)	−.0073	.0011	−6.6963	−.0088	.0010	−8.4592	−.0098	.0011	−9.3241	−.0102	.0011	−9.6713
Died in year	−.3956	.1105	−3.5797	−.3014	.0999	−3.0177	−1.1554	.0875	−13.2097	−1.6931	.1109	−15.2699
Female (0/1)	.1353	.0282	4.8015	.0761	.0274	2.7751	.0177	.0280	.6329	−.0064	.0288	−.2233
Black (0/1)	.7750	.0381	20.3508	.7525	.0367	20.4874	.7323	.0366	20.0025	.6879	.0368	18.6940
Disability as original reason for entitlement (0/1)	.0041	.0447	.0928	−.0671	.0438	−1.5304	.3284	.0471	6.9740	.1949	.0498	3.9124
ESRD (0/1)	.1050	.2077	.5057	.2857	.2111	1.3533	.1480	.2086	.7094	.0408	.2163	.1888
Share mos. eligible for demonstration during year (prop.)	−.3545	.1098	−3.2280	−.3425	.1022	−3.3528	−1.7939	.0772	−23.2317	−2.0567	.0987	−20.8418
Share mos. Medicare Advantage plan enrolled during year (prop.)	.0744	.0600	1.2388	.2236	.0546	4.0933	−.1488	.0497	−2.9937	−.2326	.0476	−4.8838
HCC risk score	.0671	.0157	4.2661	.0636	.0143	4.4631	−.0158	.0150	−1.0542	.0132	.0167	.7948
Other MDM	−.0503	.0273	−1.8440	−.1211	.0263	−4.6089	−.2500	.0271	−9.2237	−.9262	.0287	−32.2431
% of pop. living in married household	.0130	.0013	10.0000	.0129	.0013	9.6956	.0225	.0014	16.4454	.0205	.0014	14.3648
% of households w/ member >= 60 yrs.	.0360	.0022	16.1676	.0466	.0023	20.4877	.0670	.0022	30.4589	.0701	.0022	31.2320
% of adults with college education	.0441	.0012	36.8087	.0441	.0012	37.7829	.0303	.0011	26.5815	.0307	.0012	25.9875
% of adults with self-care limitation	−.1817	.0110	−16.4489	−.1426	.0104	−13.7461	−.1169	.0107	−10.8818	−.0857	.0111	−7.6871
Distance to nearest hospital (mi.)	−.1889	.0084	−22.5407	−.1645	.0082	−20.1367	−.2132	.0082	−25.8455	−.1917	.0084	−22.9101

(continued)

Table C-2
Logistic regression estimates for New York FIDA-IDD propensity score models in predemonstration and demonstration periods, April 1, 2014–December 31, 2018 (continued)

Characteristic	Predemonstration Year 1			Predemonstration Year 2			Demonstration Year 1			Demonstration Year 2		
	Coef.	Std. Error	z-score	Coef.	Std. Error	z-score	Coef.	Std. Error	z-score	Coef.	Std. Error	z-score
Distance to nearest nursing facility (mi.)	−.6112	.0155	−39.5168	−.6698	.0155	−43.2017	−.7184	.0154	−46.7120	−.7469	.0156	−47.7462
Intercept	−.2849	.1494	−1.9074	−.6211	.1408	−4.4100	−.2362	.1296	−1.8222	.2244	.1476	1.5207

ESRD = end-stage renal disease; HCC = Hierarchical Condition Category; MDM = Master Data Management; MSA = metropolitan statistical area.

Figure C-1
Distribution of beneficiary-level propensity scores in the New York FIDA-IDD demonstration and comparison groups, weighted and unweighted, predemonstration year 1, April 1, 2014–March 31, 2015

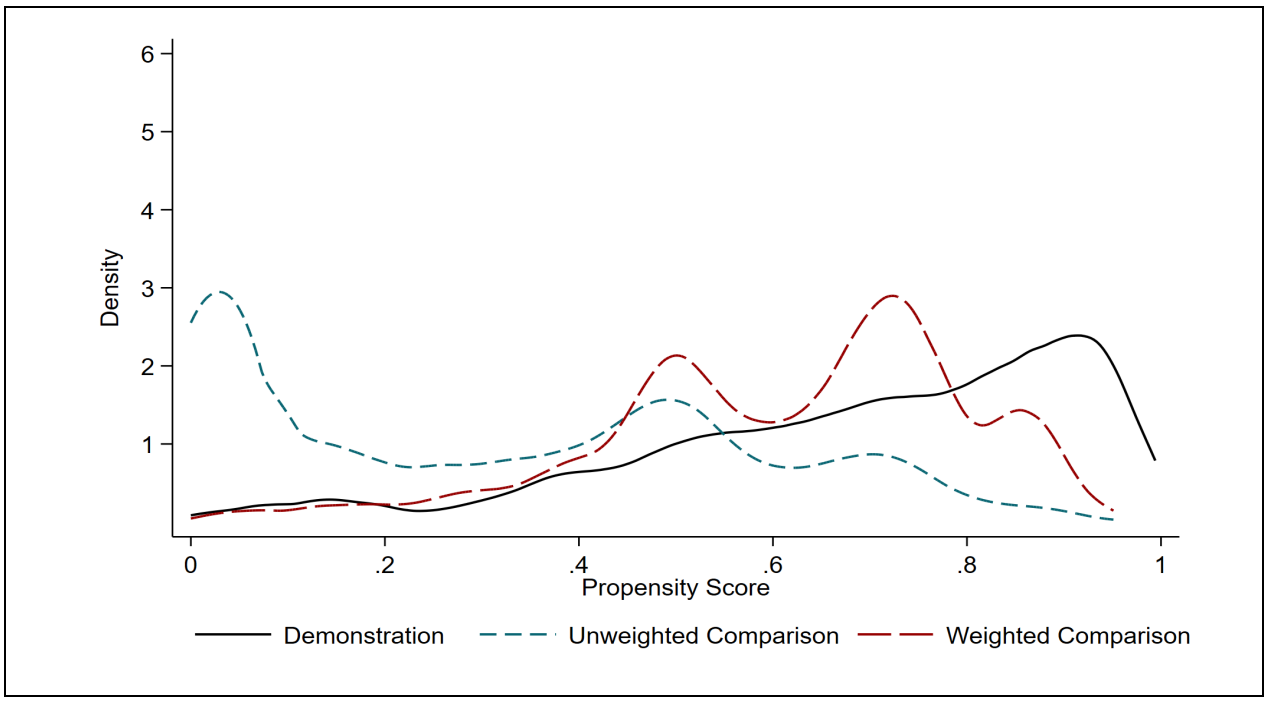


Figure C-2
Distribution of beneficiary-level propensity scores in the New York FIDA-IDD demonstration and comparison groups, weighted and unweighted, predemonstration year 2, April 1, 2015–March 31, 2016

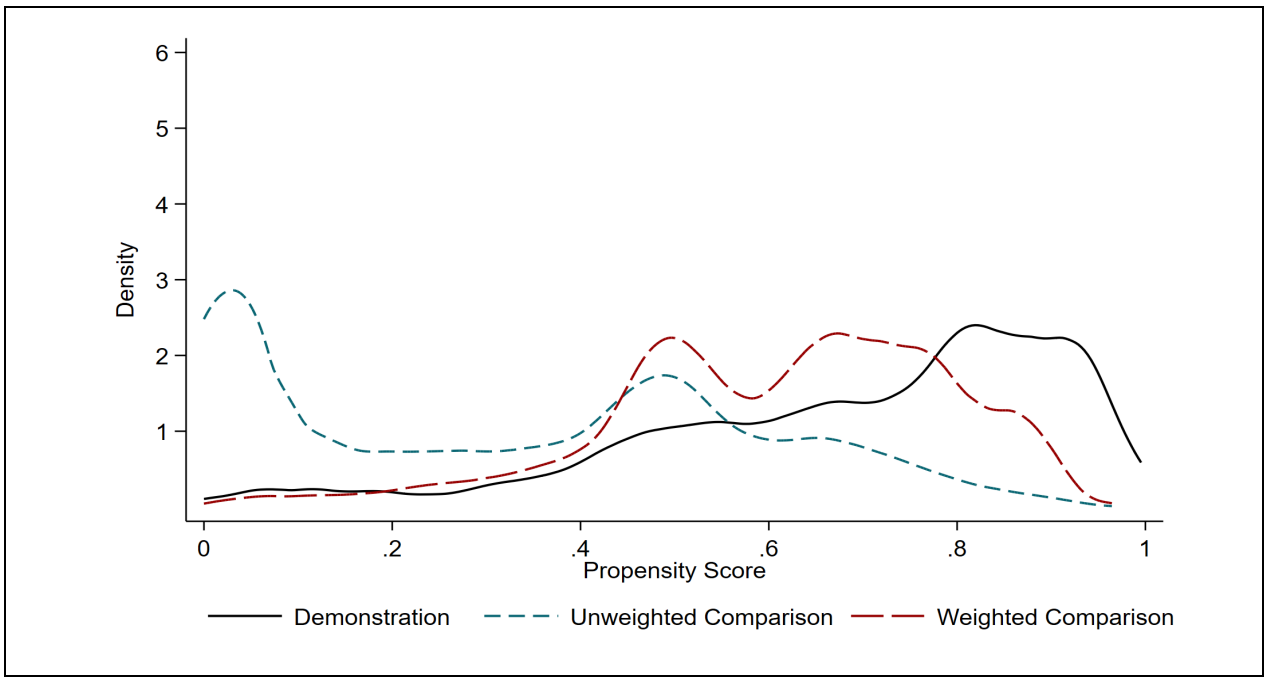


Figure C-3
Distribution of beneficiary-level propensity scores in the New York FIDA-IDD demonstration and comparison groups, weighted and unweighted, demonstration year 1, April 1, 2016–December 31, 2017

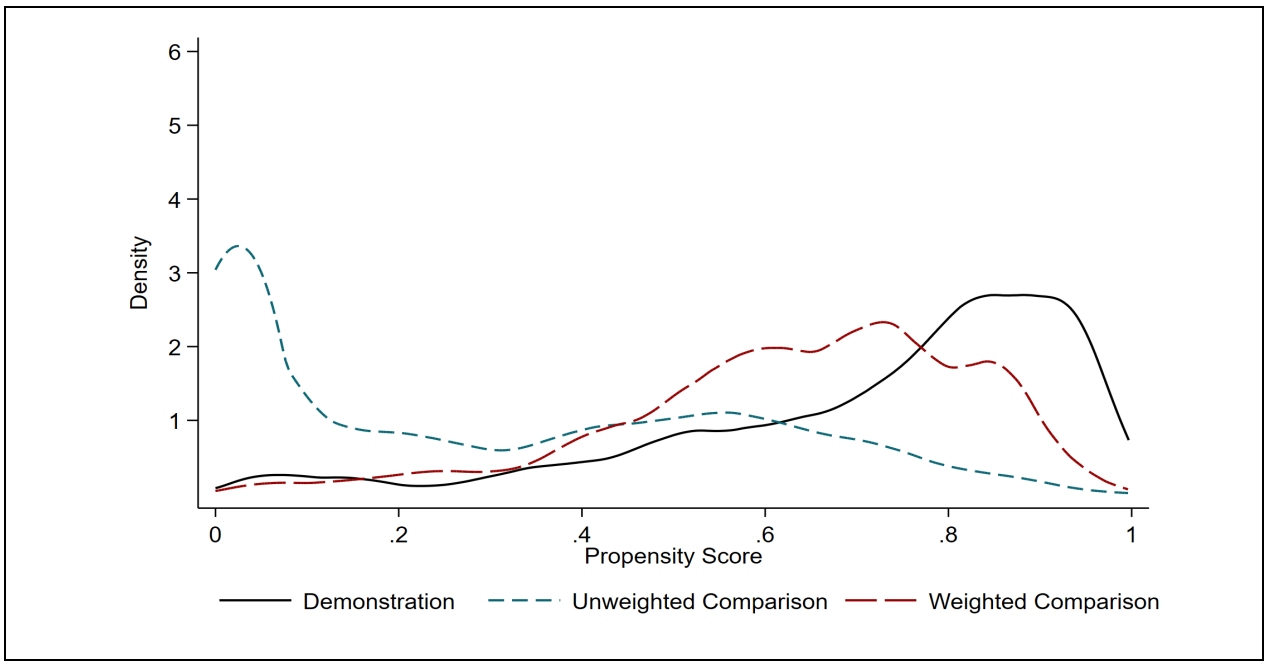
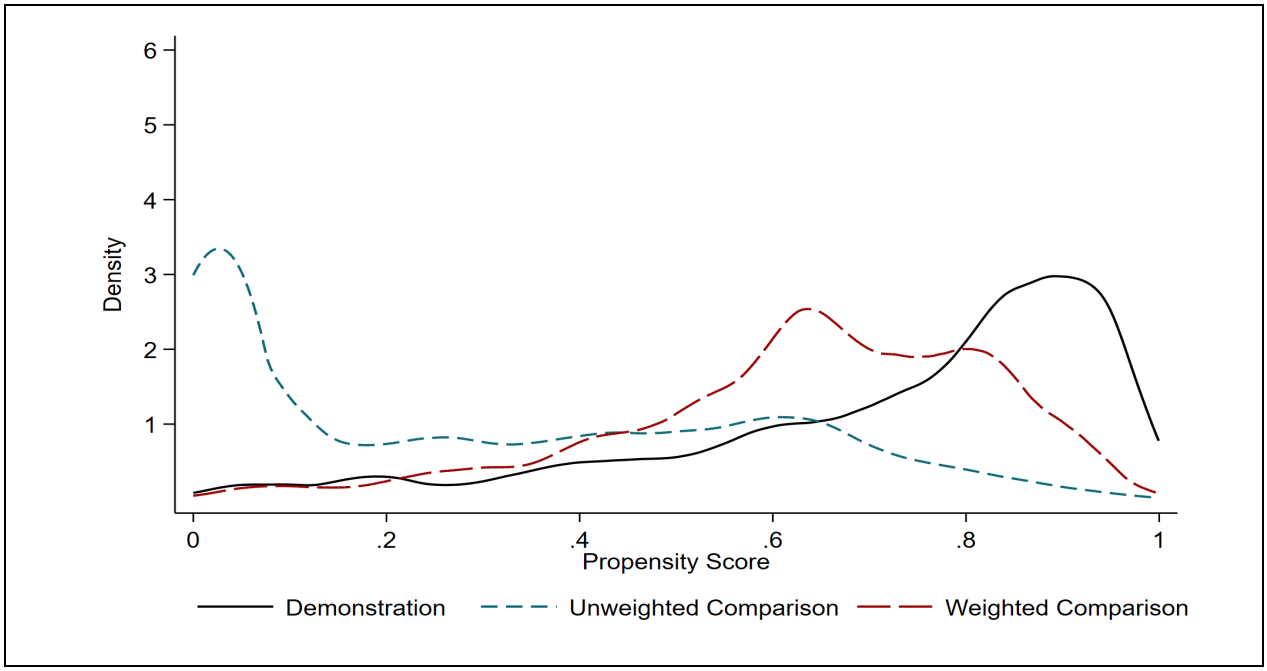


Figure C-4
Distribution of beneficiary-level propensity scores in the New York FIDA-IDD demonstration and comparison groups, weighted and unweighted, demonstration year 2, January 1, 2018–December 31, 2018



C.4 Group Comparability

Covariate balance refers to the extent to which the characteristics used in the propensity score are similar (or "balanced") for the demonstration and comparison groups. Group differences are measured by a standardized difference (the difference in group means divided by the pooled standard deviation of the covariate). An informal standard has developed that groups are considered comparable if the standardized covariate difference is less than 0.10 standard deviations.

The group means and standardized differences for all beneficiary characteristics are shown for each predemonstration and demonstration period in ***Tables C-3*** through ***C-6***. The column of unweighted standardized differences indicates that several of these variables were not balanced prior to weighting, specifically those with unweighted standardized differences exceeding 0.10 in absolute value.

The results of propensity score weighting for New York FIDA-IDD are illustrated in the far-right column (weighted standardized difference) in ***Tables C-3*** through ***C-6***. For demonstration year 2 (the most recent demonstration year for which results are reported), weighting reduced the standardized differences below the threshold level of 0.10 in absolute value for all but three covariates (percent of adults with a college degree and distances to nearest hospital and nursing home) in our model. These weights are used in the impact analyses on cost savings among all eligible beneficiaries.

Table C-3
FIDA-IDD beneficiary covariate means by group before and after weighting by propensity score, predemonstration year 1, April 1, 2014–March 31, 2015

Characteristic	Demonstration group mean	Comparison group mean	PS-weighted comparison group mean	Unweighted standardized difference	Weighted standardized difference
Age	49.539	50.332	48.594	−0.052	0.062
Died	0.014	0.019	0.015	−0.037	−0.002
Female	0.422	0.44	0.43	−0.036	−0.016
Black	0.214	0.102	0.207	0.313	0.018
Disability as original reason for entitlement	0.863	0.849	0.875	0.041	−0.035
ESRD	0.004	0.004	0.004	0.01	−0.003
Share mos. eligible for demonstration during year	0.966	0.969	0.966	−0.028	−0.004
Share mos. Medicare Advantage plan enrolled during year	0.051	0.05	0.059	0.007	−0.032
HCC score	0.959	0.919	0.937	0.045	0.023
Other MDM	0.36	0.363	0.309	−0.005	0.11
% of pop. living in married household	70.357	69.031	68.371	0.092	0.128
% of households w/member >= 60	37.608	38.042	37.937	−0.058	−0.041
% of adults under 65 with college education	37.997	26.172	33.663	0.782	0.271
% of adults under 65 with self-care limitation	2.642	3.265	2.685	−0.37	−0.032
Distance to nearest hospital	2.611	6.042	3.262	−0.968	−0.342
Distance to nearest nursing facility	1.968	4.316	2.295	−0.965	−0.288

ESRD = end-stage renal disease; HCC = Hierarchical Condition Category; MDM = Master Data Management; MSA = metropolitan statistical area; PS = propensity score.

Table C-4
FIDA-IDD beneficiary covariate means by group before and after weighting by propensity score, predemonstration year 2, April 1, 2015–March 31, 2016

Characteristic	Demonstration group mean	Comparison group mean	PS-weighted comparison group mean	Unweighted standardized difference	Weighted standardized difference
Age	49.827	50.196	48.716	−0.024	0.071
Died	0.019	0.022	0.018	−0.022	0.006
Female	0.423	0.438	0.418	−0.031	0.009
Black	0.217	0.103	0.215	0.317	0.006
Disability as original reason for entitlement	0.862	0.859	0.876	0.009	−0.04
ESRD	0.004	0.003	0.004	0.018	−0.003
Share mos. eligible for demonstration during year	0.963	0.965	0.962	−0.019	0.002
Share mos. Medicare Advantage plan enrolled during year	0.064	0.057	0.063	0.033	0.006
HCC score	1.052	1.003	1.02	0.051	0.031
Other MDM	0.381	0.396	0.335	−0.03	0.096
% of pop. living in married household	70.653	68.932	68.709	0.119	0.123
% of households w/member >= 60	38.464	38.717	39.064	−0.034	−0.075
% of adults under 65 with college education	37.694	26.635	34.022	0.741	0.234
% of adults under 65 with self-care limitation	2.724	3.183	2.751	−0.298	−0.019
Distance to nearest hospital	2.633	5.924	3.322	−0.924	−0.36
Distance to nearest nursing facility	1.953	4.255	2.332	−0.939	−0.336

ESRD = end-stage renal disease; HCC = Hierarchical Condition Category; MDM = Master Data Management; MSA = metropolitan statistical area; PS = propensity score.

Table C-5
FIDA-IDD beneficiary covariate means by group before and after weighting by propensity score, demonstration year 1, April 1, 2016–December 31, 2017

Characteristic	Demonstration group mean	Comparison group mean	PS-weighted comparison group mean	Unweighted standardized difference	Weighted standardized difference
Age	47.894	51.233	46.926	−0.213	0.063
Died	0.019	0.037	0.02	−0.114	−0.012
Female	0.409	0.445	0.405	−0.073	0.008
Black	0.234	0.104	0.22	0.353	0.035
Disability as original reason for entitlement	0.91	0.85	0.917	0.186	−0.022
ESRD	0.004	0.004	0.004	0.01	0.003
Share mos. eligible for demonstration during year	0.889	0.943	0.904	−0.268	−0.064
Share mos. Medicare Advantage plan enrolled during year	0.079	0.084	0.07	−0.022	0.035
HCC score	0.93	1.011	0.907	−0.087	0.027
Other MDM	0.346	0.408	0.317	−0.127	0.063
% of pop. living in married household	70.503	69.077	69.096	0.099	0.092
% of households w/member >= 60	40.208	39.992	40.71	0.029	−0.064
% of adults under 65 with college education	38.179	27.901	34.778	0.672	0.215
% of adults under 65 with self-care limitation	2.82	3.122	2.828	−0.202	−0.006
Distance to nearest hospital	2.636	6.598	3.31	−1.064	−0.351
Distance to nearest nursing facility	1.932	4.5	2.362	−1.043	−0.376

ESRD = end-stage renal disease; HCC = Hierarchical Condition Category; MDM = Master Data Management; MSA = metropolitan statistical area; PS = propensity score.

Table C-6
FIDA-IDD beneficiary covariate means by group before and after weighting by propensity score, demonstration year 2, January 1, 2017–December 31, 2018

Characteristic	Demonstration group mean	Comparison group mean	PS-weighted comparison group mean	Unweighted standardized difference	Weighted standardized difference
Age	47.786	50.472	46.986	−0.173	0.053
Died	0.012	0.026	0.013	−0.108	−0.014
Female	0.405	0.436	0.407	−0.063	−0.005
Black	0.236	0.106	0.211	0.352	0.061
Disability as original reason for entitlement	0.916	0.875	0.921	0.135	−0.017
ESRD	0.004	0.003	0.004	0.003	−0.004
Share mos. eligible for demonstration during year	0.923	0.965	0.937	−0.25	−0.072
Share mos. Medicare Advantage plan enrolled during year	0.091	0.081	0.084	0.036	0.024
HCC score	0.902	0.94	0.89	−0.045	0.015
Other MDM	0.221	0.408	0.252	−0.411	−0.073
% of pop. living in married household	70.926	69.943	69.609	0.069	0.088
% of households w/member >= 60	40.95	40.922	41.619	0.004	−0.084
% of adults under 65 with college education	38.713	28.776	35.227	0.651	0.223
% of adults under 65 with self-care limitation	2.88	3.095	2.802	−0.149	0.056
Distance to nearest hospital	2.629	6.559	3.333	−1.049	−0.362
Distance to nearest nursing facility	1.922	4.534	2.391	−1.055	−0.408

ESRD = end-stage renal disease; HCC = Hierarchical Condition Category; MDM = Master Data Management; MSA = metropolitan statistical area; PS = propensity score.

C.5 Enrollee-only Results

We also applied our weighting methodology to the demonstration's enrollee-only population (approximately 5 percent of the eligible demonstration population). We define the enrollee group, along with its comparison group, as follows: (1) the demonstration enrollees are those with at least 3 months of enrollment during the 2-year demonstration period as well as 3 months of eligibility during the 2-year predemonstration period, and (2) the corresponding comparison group beneficiaries are those with at least 3 months of eligibility in both the 2-year demonstration period and the 2-year predemonstration period.

Because demonstration enrollees only constituted about 5 percent of the eligible population, or roughly 1,000 beneficiaries per year, the sample size was too small to yield favorable balance between the demonstration and comparison groups. After PS weighting, the standardized differences of several covariates remained greater than 0.10 in absolute value—four covariates in predemonstration year 1 and six covariates in demonstration year 2. Average age and percent of adults with a college education were the covariates with the highest standardized differences, with values of 0.21 and 0.31, respectively, in demonstration year 2. Although these weights are used in the impact analyses on cost savings among the demonstration enrollee population, results of those analyses should be interpreted with caution due to the differences between the demonstration and comparison groups even after weighting.

C.6 Summary

The New York FIDA-IDD demonstration and comparison groups were initially distinguished by differences in six individual-level covariates as well as four area-level variables during demonstration year 2. After applying PS weights to the eligible population, all but three of these covariate discrepancies were reduced to below the generally accepted threshold for standardized differences. As a result, the weighted FIDA-IDD groups on which the impact analysis among all demonstration eligible beneficiaries is based are adequately balanced with respect to 13 of the 16 variables we consider for comparability. On the other hand, differences remained between the demonstration and comparison groups on which the impact analysis among the demonstration enrollee population is based after weighting, and results of this analysis should be interpreted with caution.

Appendix D

Cost Savings Methodology and Supplemental Tables

D.1 Adjustments to Medicare Expenditures

Several adjustments were made to the monthly Medicare expenditures to ensure that observed expenditures variations are not due to differences in Medicare payment policies in different areas of the country or the construction of the capitation rates. ***Table D-1*** summarizes each adjustment and the application of the adjustments to FFS expenditures or to the capitation rate.

Table D-1
Adjustments to Medicare expenditures variable

Data source	Adjustment description	Reason for adjustment	Adjustment detail
FFS	Indirect Medical Education (IME)	Capitation rates do not include IME.	Do not include IME amount from FFS payments.
FFS	Disproportionate Share Hospital (DSH) Payments and Uncompensated Care Payments (UCP)	The capitation rates reflect DSH and UCP adjustments.	Include DSH and UCP payments in total FFS payment amounts.
FFS	Medicare Sequestration Payment Reductions	Under sequestration Medicare payments were reduced by 2% starting April 1, 2013. Because the predemonstration period includes months prior to April 1, 2013, it is necessary to apply the adjustment to these months of data.	Reduced FFS claim payments incurred before April 2013 by 2%.
Capitation rate (MA and MMP)	Medicare Sequestration Payment Reductions	Under sequestration Medicare payments were reduced by 2% starting April 1, 2013. Sequestration is not reflected in the capitation rates.	Reduced capitation rate by 2%.
Capitation rate (MA)	Bad debt	The Medicare portion of the capitation rate includes an upward adjustment to account for bad debt. Bad debt is not included in the FFS claim payments and therefore needs to be removed from the capitation rate for the savings analysis. (Note: “bad debt” is reflected in the hospital “pass through” payment.)	Reduced capitation rate to account for bad debt load (historical bad debt baseline percentage). This is 0.89% for CY 2014, 0.89% for CY 2015, 0.97% for CY 2016, 0.81% for CY 2017, and 0.82% for 2018.

(continued)

Table D-1 (continued)
Adjustments to Medicare expenditures variable

Data source	Adjustment description	Reason for adjustment	Adjustment detail
Capitation rate (MMP)	Bad debt	The Medicare portion of the capitation rate includes an upward adjustment to account for bad debt. Bad debt is not included in the FFS claim payments and therefore needs to be removed from the capitation rate for the savings analysis. (Note, "bad debt" is reflected in the hospital "pass through" payment.)	This adjustment is not applicable to the NY IDD demonstration, capitation rates are based 100% on FFS.
FFS and capitation rate (MA and MMP)	Average Geographic Adjustments (AGA)	The Medicare portion of the capitation rate reflects the most current hospital wage index and physician geographic practice cost index by county. FFS claims also reflect geographic payment adjustments. To ensure that change over time is not related to differential change in geographic payment adjustments, both the FFS and the capitation rates were "unadjusted" using the appropriate county-specific AGA factor.	Medicare FFS expenditures were divided by the appropriate county-specific 1-year AGA factor for each year. Capitation rates were divided by the appropriate county-specific 5-year AGA factor for each year. Note that the AGA factor applied to the capitated rates for 2014 reflected the 50/50 blend that was applicable to the payment year.
Capitation rate (MA and MMP)	Education user fee	No adjustment needed.	Capitation rates in the MARx database do not reflect the education user fee adjustment (this adjustment is applied at the contract level). Note, education user fees are not applicable in the FFS context and do not cover specific Part A and Part B services. While they result in a small reduction to the capitation payment received by the MMP, we did not account for this reduction in the capitated rate.
Capitation rate (MMP)	Quality withhold	A 1% quality withhold was applied in the first demonstration year, and a 2% quality withhold was applied in the second demonstration year.	Final quality withhold repayments for CY 2016, CY 2017, and 2018 were incorporated into the dependent variable construction.

CY = calendar year; FFS = fee-for-service; MA = Medicare Advantage; MARx = Medicare Advantage and Part D Inquiry System;
MMP = Medicare-Medicaid Plan.

The capitation payments in MARx reflect the savings assumptions applied to the Medicare components of the rate (0.25 percent for the first demonstration year, and 0.5 percent for the second demonstration year), but do not reflect the quality withhold amounts.

No adjustments were made to the Medicaid claims and capitation payment amounts from the MAX and T-MSIS files, beyond winsorizing the monthly total cost of care amounts at the 99th percentile for each State and year.

D.2 Model Covariates

Model covariates included the following variables, which were also included in the comparison group selection process. Variables were included in the model after variance inflation factor testing.

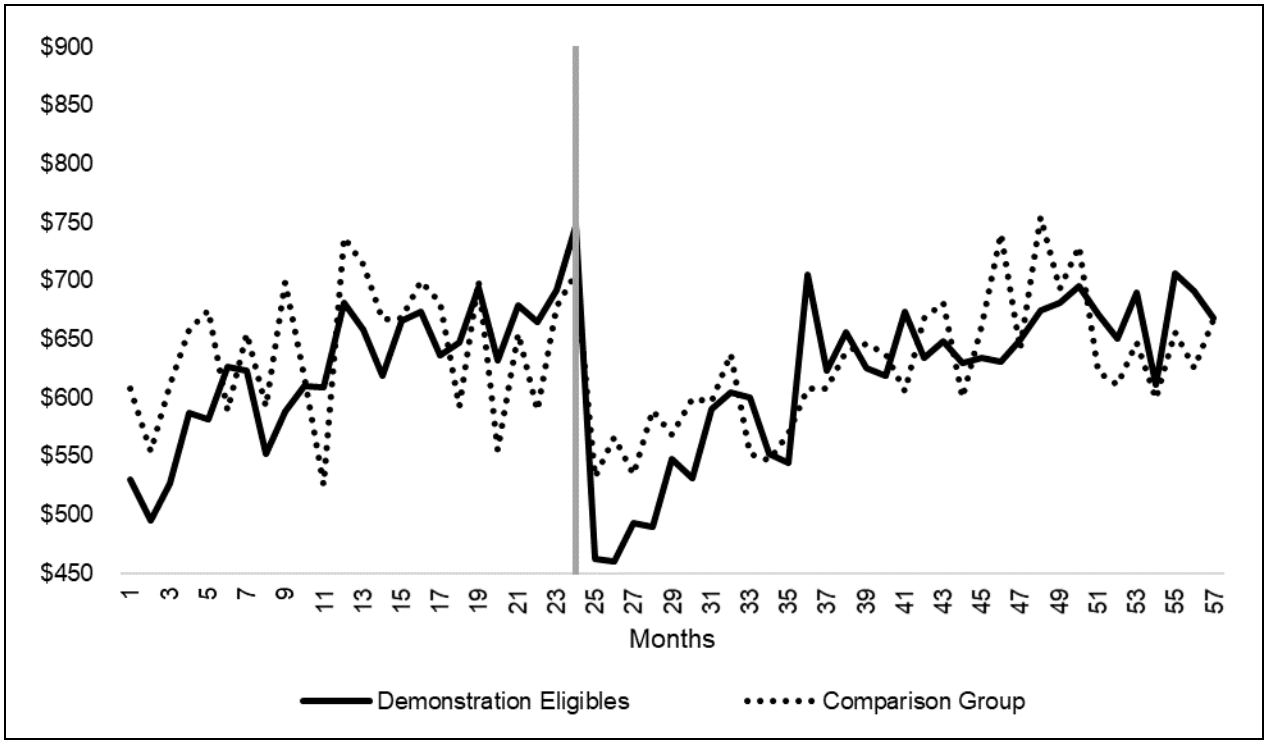
- Demographic variables included in both Medicare and Medicaid models were as follows:
  - Age
  - Sex
  - Race/ethnicity
  - Enrolled in another Medicare shared saving program
  - End-stage renal disease status
  - Disability as reason for Medicare entitlement
  - MA status
- Area-level variables included in both the Medicare and Medicaid models were as follows:
  - MA penetration rate
  - Medicaid spending per dually eligible beneficiary age 19 or older
  - Proportion of dually eligible beneficiaries using
    - Medicaid managed care age 19 or older
  - Percentage of population living in married household
  - Percentage of households with member greater than age 60
  - Percentage of households with member less than age 18
  - Percentage of adults with college degree
  - Unemployment rate
  - Percentage of adults with self-care limitation
  - Distance to nearest hospital
  - Distance to nearest nursing home
- Area-level variables included only in the Medicare model were as follows:
  - Proportion of dually eligible beneficiaries using
    - HCBS age 65 or older

  - Physicians per 1,000 population
- Demographic variables included only in the Medicaid model were as follows:
  - Medicaid eligibility (medically needy, aged, disabled, and missing)

D.3 Medicare Descriptive Results

Once we finalized the adjustments to the dependent variable, we tested a key assumption of a difference-in-differences (DinD) model: parallel trends in the predemonstration period. We plotted the mean monthly Medicare expenditures for both the comparison group and demonstration group, with the PS weights applied. ***Figure D-1*** shows the resulting plot and suggests that there were approximately parallel trends in the predemonstration period.

Figure D-1
Mean monthly Medicare expenditures (weighted), predemonstration and demonstration periods, demonstration and comparison groups, April 2014–December 2018



SOURCE: RTI Analysis of FIDA-IDD demonstration eligible and comparison group Medicare data (program: NYIDD_DY2_1470.log).

The DinD values in ***Tables D-2, and D-3*** represent the overall impact on savings using descriptive statistics. These effects are descriptive in that they are arithmetic combinations of simple means, without controlling for covariates. The change in the demonstration group minus the change in the comparison group is the DinD value. This value would be equal to zero if the differences between predemonstration and the demonstration year were the same for both the demonstration group and the comparison group. A negative value would indicate savings for the demonstration group, and a positive value would indicate losses (additional costs) for the

demonstration group. However, if the DinD confidence interval includes zero, then the value is not statistically significant. These results are only meant to provide a descriptive exploration of the results; the results presented in the ***Section 6*** and ***Table D-6*** represent the most accurate adjusted impact on Medicare costs.

Tables D-2 and D-3 show the mean monthly Medicare expenditures for the demonstration group and comparison group in the predemonstration and each demonstration period, unweighted. The unweighted tables show a decrease in mean monthly Medicare expenditures during demonstration year 1 for the demonstration group, but an increase for the demonstration group in demonstration year 2. Additionally, the unweighted tables show an increase in Medicare expenditures during demonstration years 1–2 for the comparison group. The weighted tables display a different pattern with the comparison group showing a decrease demonstration year 1 but an increase in demonstration year 2 (see ***Tables D-4*** and ***D-5)***. The weighted demonstration group expenditures decrease in demonstration year 1 and increase in demonstration year 2.

Table D-2
Mean monthly Medicare expenditures for demonstration group and comparison group, predemonstration period and demonstration year 1, unweighted

Group	Predemonstration period (Apr 2014–Mar 2016) (95% confidence intervals)	Demonstration year 1 (Apr 2016–Dec 2017) (95% confidence intervals)	Difference (95% confidence intervals)
Demonstration	$626.52 ($558.09, $694.95)	$587.98 ($524.82, $651.14)	−$38.54 ($−76.91, $−0.17)
Comparison	$646.31 ($609.22, $683.41)	$721.64 ($645.78, $797.49)	$75.32 $−11.77, $162.41)
DinD	N/A	N/A	−$113.86 ($−205.49, $−22.22)

DinD = difference-in-differences; N/A = not applicable.
SOURCE: RTI analysis of Medicare claims (program: dd_dy2_cs1500_Tables.log)

Table D-3
Mean monthly Medicare expenditures for demonstration group and comparison group, predemonstration period and demonstration year 2, unweighted

Group	Predemonstration period (Apr 2014–Mar 2016) (95% confidence intervals)	Demonstration year 2 (Jan 2018–Dec 2018) (95% confidence intervals)	Difference (95% confidence intervals)
Demonstration	$626.52 ($558.09, $694.95)	$668.15 ($610.53, $725.76)	$41.63 ($−15.25, $98.51)
Comparison	$646.31 ($609.22, $683.41)	$752.77 ($697.96, $807.57)	$106.45 ($70.53, $142.37)
DinD	N/A	N/A	−$64.82 ($−124.26, $−5.39)

DinD = difference-in-differences; N/A = not applicable.
SOURCE: RTI analysis of Medicare claims (program: dd_dy2_cs1500_Tables.log)

Table D-4
Mean monthly Medicare expenditures for demonstration group and comparison group, predemonstration period and demonstration year 1, weighted

Group	Predemonstration period (Apr 2014–Mar 2016) (95% confidence intervals)	Demonstration year 1 (Apr 2016–Dec 2017) (95% confidence intervals)	Difference (95% confidence intervals)
Demonstration	$626.52 ($558.09, $694.95)	$587.98 ($524.82, $651.14)	−$38.54 ($−76.91, $−0.17)
Comparison	$642.73 ($611.36, $674.11)	$602.95 ($554.17, $651.74)	−$39.78 ($−99.03, $19.47)
DinD	N/A	N/A	$1.24 ($−65.42, $67.90)

DinD = difference-in-differences; N/A = not applicable.
SOURCE: RTI analysis of Medicare claims (program: dd_dy2_cs1500_Tables.log)

Table D-5
Mean monthly Medicare expenditures for demonstration group and comparison group, predemonstration period and demonstration year 2, weighted

Group	Predemonstration period (Apr 2014–Mar 2016) (95% confidence intervals)	Demonstration year 2 (Jan 2018–Dec 2018) (95% confidence intervals)	Difference (95% confidence intervals)
Demonstration	$626.52 ($558.09, $694.95)	$668.15 ($610.53, $725.76)	$41.63 ($−15.25, $98.51)
Comparison	$642.73 ($611.36, $674.11)	$665.25 ($631.01, $699.49)	$22.52 ($−18.60, $63.64)
DinD	N/A	N/A	$19.11 ($−43.50, $81.72)

DinD = difference-in-differences; N/A = not applicable.
SOURCE: RTI analysis of Medicare claims (program: dd_dy2_cs1500_Tables.log)

D.4 Regression Results for Medicare Data

Table D-6 shows the main results from the DinD analysis for demonstration years 1–2 and for the entire demonstration period, controlling for beneficiary demographics and market characteristics. Relative to the comparison group, the demonstration was associated with statistically significant cost increases to the Medicare program during demonstration years 1 through 2. The cumulative impact estimate over both demonstration years was statistically significant suggesting that overall, the demonstration was associated with increases in Medicare costs of $34.53 PMPM.

Table D-6
Cumulative and annual demonstration effects on Medicare Parts A and B costs in New York, demonstration years 1–2, April 1, 2016–December 31, 2018

Period	Adjusted coefficient DinD ($)	*p*-value	95% confidence interval ($)	90% confidence interval ($)
Demonstration Year 1 (April 2016–December 2017)	29.07	0.0338	(2.22, 55.92)	(6.54, 51.6)
Demonstration Year 2 (January 2018–December 2018)	43.77	0.0405	(1.89, 85.65)	(8.62, 78.92)
Cumulative (Demonstration Years 1–2, April 2016–December 2018)	34.53	0.0138	(7.06, 61.99)	(11.47, 57.58)

DinD = difference-in-differences.
SOURCE: RTI analysis of Medicare claims (program: dd_dy2_cs1480_GLM.log)

Table D-7 presents the results from the DinD analysis for the enrollee subgroup. The enrollee subgroup analysis focused on beneficiaries identified as enrolled for at least 3 months in the demonstration period and with at least 3 months of baseline eligibility. Note that a subset of the comparison group developed for the ITT analysis was used in the enrollee subgroup analyses. Comparison group beneficiaries used in the enrollee subgroup analyses were required to have at least 3 months of eligibility in the demonstration period (April 1, 2016–December 31, 2018) and at least 3 months of eligibility in the predemonstration period (April 1, 2014–March 31, 2016), analogous to the criteria for identifying enrollees. The results do not indicate statistically significant additional costs associated with enrollees (at the 95 percent level). This enrollee subgroup analysis is limited by the absence of person-level data on characteristics that potentially would lead an individual in a comparison area to enroll in a similar demonstration, and thus the results should only be considered in the context of this limitation. Additionally, enrollment into the FIDA-IDD demonstration was quite low relative to the size of the eligible population; roughly 5 percent of the eligible population, about 1,000 beneficiaries each year, comprise the enrollee demonstration group. As a result, the PS weights for the enrollee analysis did not ensure balance between the demonstration and comparison group for several covariates. The results of the enrollee analysis should be interpreted only in the context of these limitations.

Table D-7
Cumulative and annual demonstration effects on Medicare Parts A and B costs among enrolled beneficiaries in New York, demonstration years 1–2, April 1, 2016–December 31, 2018

Period	Adjusted coefficient DinD ($)	*p*-value	95% confidence interval ($)	90% confidence interval ($)
Demonstration Year 1 (April 2016–December 2017)	88.15	0.0791	(−10.23, 186.53)	(5.59, 170.71)
Demonstration Year 2 (January 2018–December 2018)	140.00	0.1124	(−32.83, 312.83)	(−5.04, 285.05)
Cumulative (Demonstration Years 1–2, April 2016–December 2018)	108.72	0.0547	(−2.20, 219.64)	(15.63, 201.81)

DinD = difference-in-differences.
SOURCE: RTI analysis of Medicare claims (program: dd_dy2_1510_Enrollee.log)

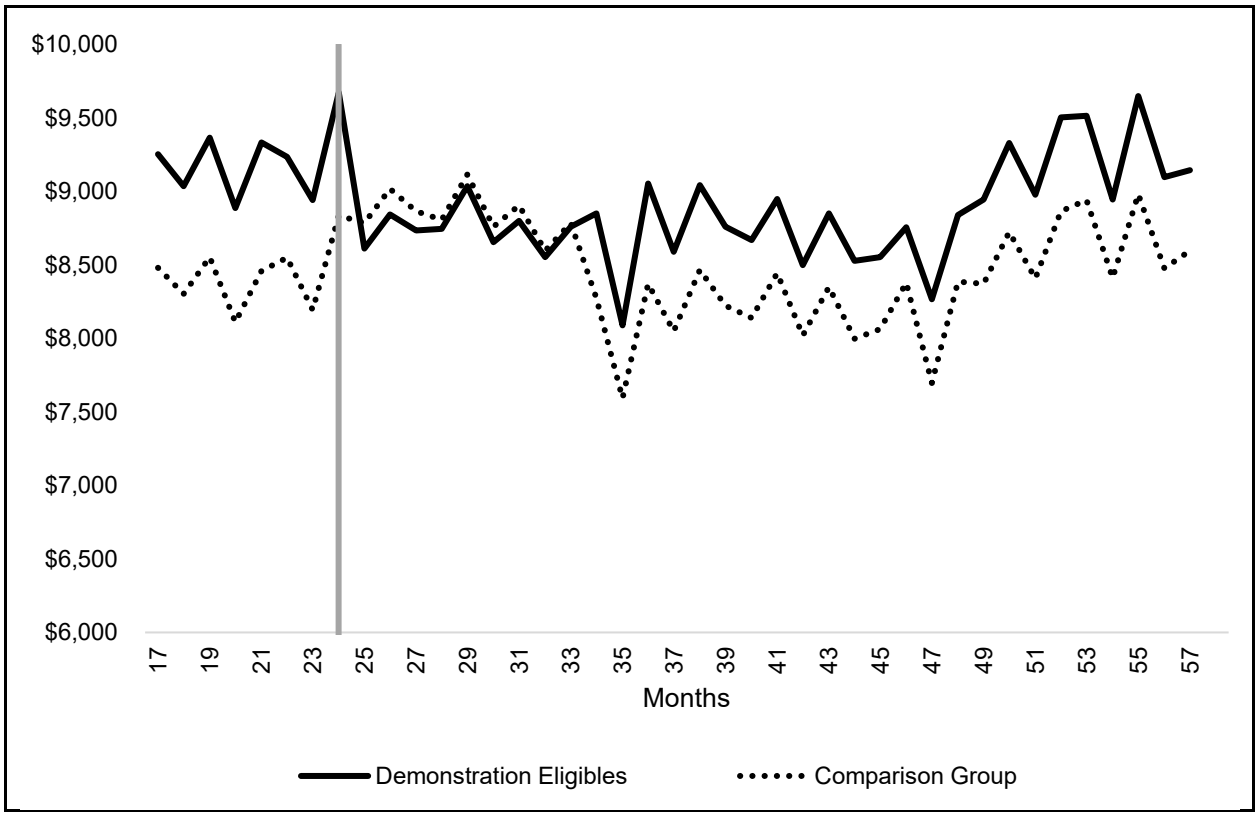
D.5 Medicaid Results

Unless otherwise noted, the Medicaid cost analysis uses the same regression methodology, the same regression covariates, the same comparison group, and the same PS weights as the Medicare cost analysis. Additional regression covariates used only in the Medicaid cost analysis are specified in ***Section D.2***.

Using the Medicaid data, we also tested the parallel trends in the predemonstration period. We plotted the mean monthly Medicaid expenditures for both the comparison group and demonstration group, with the PS weights applied. Monthly Medicaid total cost of care values

were winsorized at the 99th percentile by year and by demonstration/comparison group status. ***Figure D-2*** show the weighted plots, suggesting parallel trends in the predemonstration period. The baseline period for the Medicaid analysis is 8 months (August 2015 to March 2016) instead of 24 months (April 2014 to March 2016) as in the Medicare analysis. This is due to significant cost data irregularities as the state transitioned from MSIS to TMSIS.

Figure D-2
Mean monthly Medicaid expenditures (weighted), predemonstration and demonstration periods, demonstration and comparison groups, August 2015–December 2018



SOURCE: RTI Analysis of FIDA-IDD demonstration eligible and comparison group Medicaid data (program: 60_Trends.do).

Table D-8 shows the Medicaid results from the DinD analysis for demonstration years 1–2 and for the entire demonstration period, controlling for beneficiary demographics and market characteristics. These results use all demonstration eligible beneficiaries—those enrolled in the demonstration and those eligible but not enrolled.

Table D-8
Cumulative and annual demonstration effects on Medicaid costs in New York, demonstration years 1–2, April 1, 2016–December 31, 2018

Period	Adjusted coefficient DinD ($)	p-value	95% confidence interval ($)	90% confidence interval ($)
Demonstration Year 1 (April 2016–December 2017)	−119.06	0.8054	(−1066.01, 827.89)	(−913.76, 675.65)
Demonstration Year 2 (January 2018–December 2018)	99.57	0.8355	(−840.12, 1039.25)	(−689.04, 888.17)
Cumulative (Demonstration Years 1–2, April 2016–December 2018)	−46.89	0.9196	(−957.61, 863.84)	(−811.19, 717.42)

DinD = difference-in-differences.
SOURCE: RTI analysis of Medicaid claims (program: 30_Regression.log)

Note that, because both the demonstration and comparison group were participating in the Medicaid program in New York, there are fewer concerns about differences between the demonstration and comparison groups in Medicaid payments, eligibility, or services covered.