FINANCIAL ALIGNMENT INITIATIVE

New York Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities: Preliminary Third Evaluation Report

October 2023

Prepared for

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FINANCIAL ALIGNMENT INITIATIVE
NEW YORK FULLY INTEGRATED DUALS ADVANTAGE FOR INDIVIDUALS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES: PRELIMINARY THIRD EVALUATION REPORT

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Glossary of Acronyms

ARPA	American Rescue Plan Act of 2021
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CAS	Coordinated Assessment System
CCO/HH	Care Coordination Organization/Health Home
CMS	Centers for Medicare & Medicaid Services
CMT	Contract Management Team
CSPA	Comprehensive Service Planning Assessment
CTM	Complaint Tracking Module
DinD	Difference-in-differences
D-SNP	Dual Eligible Special Needs Plan
FFS	Fee-for-service
HCBS	Home and community-based services
HCC	Hierarchical Condition Category
HEDIS	Healthcare Effectiveness Data and Information Set
IAM	It's All About Me assessment tool
ICF/IID	Intermediate Care Facility for Individuals with Intellectual Disabilities
IDD	Intellectual and developmental disabilities
IDT	Interdisciplinary Team
ITT	Intent-to-treat
LTSS	Long-term services and supports
MA	Medicare Advantage
MAC	Medicare Appeals Council
MARx	Medicare Advantage Prescription Drug System
MAXIMUS	The enrollment broker for the FIDA-IDD demonstration

MMCO	Medicare-Medicaid Coordination Office
MMC	New York's Medicaid Managed Care program
MMP	Medicare-Medicaid Plan
MOU	Memorandum of Understanding
OAH	New York's Office of Administrative Hearings
OPWDD	New York's Office for People with Developmental Disabilities
OTDA	New York's Office of Temporary Disability Assistance
PAC	Participant Advisory Council
PCP	Primary care physician or provider
PHE	Public Health Emergency
PHP	Partners Health Plan
PMPM	Per member per month
PS	Propensity score
T-MSIS	Transformed Medicaid Statistical Information System
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.

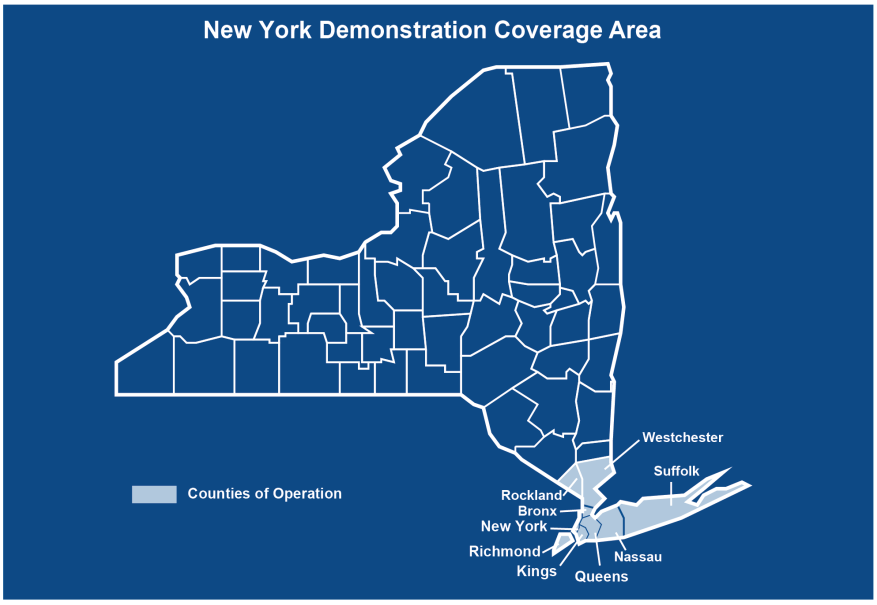
In April 2016, New York and CMS launched the Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities (FIDA-IDD) demonstration to integrate care for dually eligible beneficiaries with intellectual and/or developmental disabilities. It is the first comprehensive managed care demonstration exclusively serving individuals with IDD in the nation. The demonstration has been implemented in nine New York counties: Bronx, Kings, New York, Queens, Richmond, Rockland, Nassau, Suffolk, and Westchester (see ***New York Demonstration Coverage Area***). A single 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.

The New York FIDA-IDD demonstration

was launched in 2016 in nine downstate counties and was the first comprehensive managed care demonstration exclusively serving individuals with intellectual and developmental disabilities (IDD) in the nation. Due at least in part to a lack of provider participation, less than 8 percent of eligible beneficiaries enrolled. Beneficiaries who did enroll reported high levels of satisfaction, especially with care coordination and the ease of obtaining durable medical equipment. The Medicare-Medicaid Plan's (MMP) assessment and care coordination model provided person-centered care planning that identified goals and helped to achieve them, improving enrollees' quality of life. The MMP successfully used telehealth and care coordination to reduce unnecessary trips to the emergency department.

The low enrollment and enrollment of a frailer than expected population led to financial challenges for the MMP. The MMP was unable to spread start-up and administrative costs over a broad enrollment base, and expenditures for personal care and Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) services outstripped the capitation rate paid to the plan.

Overall, the demonstration had no impact on Medicare or Medicaid expenditures among all eligible beneficiaries over the first 4 demonstration years.



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 for People with Developmental Disabilities; 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 (ICFs) for individuals with intellectual disabilities

(ICF/IID);[1] 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 preliminary third evaluation report for the New York FIDA-IDD demonstration describes its implementation and includes an analysis of the demonstration's impacts on select outcomes. We include qualitative evaluation information for calendar years 2021 and 2022, and quantitative results for April 2016 – December 2020. Demonstration year 1 includes April 2016 through December 2017. Subsequent demonstration years—demonstration years 2, 3, and 4—include full single calendar years.

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 Medicare cost savings results presented are preliminary because risk corridor payments in demonstration years 2 through 4 are not yet finalized and thus have not been included in the calculations.

Highlights

Integration of Medicare and Medicaid	CMS and the State worked together in jointly managing and providing oversight of demonstration activities through monthly meetings with the MMP.
Eligibility and Enrollment	The continued lack of participation by major hospital systems in the demonstration's service area discouraged eligible beneficiaries from enrolling. The MMP was unable to increase enrollment above 8 percent of eligible beneficiaries throughout the reporting period.
	Aging family caregivers described the FIDA-IDD demonstration as an attractive option to provide care for their demonstration-eligible loved ones when the family members were unable to continue their care managing activities.
Care Coordination	The MMP was able to successfully implement the care model for enrollees, and nearly every enrollee had assessments and discussions of care goals throughout the reporting period.

[1] This eligibility category includes both community dwelling individuals with this level of need and individuals in ICFs.

Stakeholder Engagement	The COVID-19 public health emergency curtailed stakeholder engagement activities that would have occurred during the reporting period
Financing and Payment	The State issued a Statement of Deficiency to the plan in 2021 because its net worth fell $35 million below contractually obligated levels.[2]
	The MMP tried streamlining administrative functions to help its financial standing but ultimately attributed its losses on inadequate Medicaid rates that did not reflect its experience. The State attributed the plan's losses to inadequate service utilization management.
Quality of Care	Throughout the reporting period, neither CMS nor the State had any concerns of note about the quality of care provided by the MMP.
	In 2021, the MMP automated the gaps-in-care reports sent to enrollees' providers and care managers that indicated if preventive screenings or chronic disease management measures were missing. If there was an identified gap, the care manager would reach out to the provider and enrollee to schedule the needed service.
	PHP improved performance over time on measures for blood pressure control, controlling HbA1c levels (blood glucose measure), medication review (one of the Care for Older Adults measures), and plan all-cause readmissions for enrollees ages 18-64 and 65+.
Beneficiary Experience	The State, CMS, and the MMP viewed the continued low disenrollment rate as an indicator of enrollee satisfaction with the demonstration.

[2] Since then, the MMP has developed a plan of correction to improve its financial position.

Beneficiary Experience (continued)	In 15 interviews with enrollees and/or their family members, most reported that they were very satisfied with the MMP and appreciated care management services and the speed of getting durable medical equipment.
	Some enrollees and beneficiary advocates noted that the MMP's network had providers that were not geographically accessible and would require lengthy transports.
Demonstration Impact on Cost Savings	As summarized in ***Table ES-1***, the demonstration shows no impact on Medicare expenditures over the first 4 demonstration years relative to the comparison group.[3]
	The demonstration was also not associated with any change in Medicaid costs over the first 4 demonstration years, relative to the comparison group (***Table ES-1***).[4]

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 four-year demonstration period and the annual effect for each demonstration year, as well as the cumulative and annual effects on Medicaid expenditures for the same demonstration period.

Table ES-1
Summary of New York demonstration effects on total Medicare and Medicaid expenditures among all eligible beneficiaries, April 1, 2016–December 31, 2020

Measure	Measurement period	Demonstration effect
Medicare Parts A and B cost	Cumulative (demonstration years 1–4)	NS
	Demonstration year 1	NS
	Demonstration year 2	NS
	Demonstration year 3	NS
	Demonstration year 4	NS

(continued)

[3] Final Medicare risk corridor payments were incorporated into the analysis, but risk corridor payments for demonstration years 2–4 were not yet final.
[4] The final and interim risk corridor payments were not included in the Medicaid cost analysis. These payments were large (see ***Table 3-7, Section 3, Update on Demonstration Implementation***) and would reduce any estimated savings or increase any estimated losses.

Table ES-1 (continued)
Summary of New York demonstration effects on total Medicare and Medicaid expenditures among all eligible beneficiaries, April 1, 2016–December 31, 2020

Measure	Measurement period	Demonstration effect
Medicaid cost	Cumulative (demonstration years 1–4)	NS
	Demonstration year 1	NS
	Demonstration year 2	NS
	Demonstration year 3	NS
	Demonstration year 4	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 expenditures, see ***Figure 5-1*** (Medicare) and ***Figure 5-2*** (Medicaid) in ***Section 5, Demonstration Impact on Cost Savings***.
SOURCE: RTI analysis of Medicare and Medicaid claims.

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 New York Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities (FIDA-IDD) demonstration began on April 16, 2016. Under FIDA-IDD, eligible beneficiaries enroll in a capitated Medicare-Medicaid Plan (MMP) that covers all services available under Medicare and Medicaid, as well as care coordination and flexible benefits. 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. An interdisciplinary team (IDT) made up of the enrollee, care manager responsible for assessment and planning, service coordinator, and others of the enrollee's choosing develops a plan of care that integrates the enrollee's medical, behavioral, long-term supports and services (LTSS), and social needs.

The demonstration was originally scheduled to end on December 31, 2020. In 2020, the State requested and received approval from CMS to extend the demonstration through December 31, 2023 (New York three-way contract, 2016; amended New York three-way contract 2020).[5] The Combined First and Second Evaluation Report includes extensive background information and demonstration implementation information for 2016 through 2020.

1.2 Purpose of this Report

CMS contracted with RTI International to monitor implementation of the demonstrations under the FAI and to evaluate their impact on beneficiary experience, quality, utilization, and cost. In this report we include qualitative evaluation information for calendar year 2021 (demonstration year 5), with relevant updates through mid-2022. We provide updates to the previous evaluation report in key areas, including enrollment, care coordination, beneficiary experience, and stakeholder engagement activities, and discuss the challenges, successes, and emerging issues identified during the reporting period.

We present quantitative analysis results on costs for the period spanning April 2016, through December 2020 (the first 4 demonstration years). The difference in timeframes between qualitative and quantitative analyses is due to the longer lag of secondary data used in quantitative analysis. Demonstration year 1 includes April 2016 through December 2017. Subsequent demonstration years—demonstration years 2, 3, and 4—include full calendar years.

[5] In 2022, as part of the contract year 2023 Medicare Advantage and Part D rulemaking process, capitated model states were given an opportunity to extend their demonstrations (no later than December 31, 2025) in order to convert their MMPs into integrated Dual Eligible Special Needs Plans (D-SNPs) and contingent upon submitting to CMS a transition plan by October 1, 2022. As of September 2023, the New York FIDA-IDD demonstration has been extended through December 31, 2024.

1.3 Data Sources

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

SECTION 2

Demonstration Design and State Context

2.1 Changes in Demonstration Design

FIDA-IDD is a capitated model demonstration that operates in nine New York counties: Bronx, Kings, New York, Queens, Richmond, Rockland, Nassau, Suffolk, and Westchester. The design of the demonstration is described in the Combined First and Second Evaluation Report. The New York State Department of Health (NYSDOH) elected not to use Federal implementation funds for the demonstration.[6] Instead, New York's Office for People with Developmental Disabilities (OPWDD) used Federal funding through its Balancing Incentive Program to help the developmental disabilities services delivery system transition to managed care, specifically by supporting IT system development and care management, which, in turn, supported demonstration implementation.

Implementation Effectiveness: Fidelity

Now that the Financial Alignment Initiative demonstrations have been in place for several years, we have identified several measures as indicators of implementation effectiveness or success, based on the standard implementation science approach, that we believe are useful for this evaluation. The four measures are: (1) fidelity of the demonstration to the original design, (2) demonstration reach, (3) implementation dose, and (4) the State's and CMS' reflections on demonstration effectiveness. We discuss each of these measures in this report, starting with fidelity.

Implementation fidelity can be considered as the degree to which an intervention is implemented as originally designed, even if adaptations to the strategy become necessary. For States, plans, and other stakeholders, including policy-makers, it is helpful to reflect on the changes to the demonstration model that were made as implementation unfolded, and the impact of those changes. These findings can inform design or implementation of future models.

As seen in ***Table 2-1***, the FIDA-IDD demonstration has been implemented with a high degree of fidelity to the original design.

The New York three-way contract was amended in 2018 and 2020 for operational aspects of the demonstration including when the comprehensive assessment and Life Plan (the demonstration's person-centered plan) need to be in place, and the qualifications of the professionals conducting the assessment (see ***Section 3.3, Care Coordination***). These changes did not materially change the design of the demonstration. 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 through 2019. In 2021, CMS agreed to apply a frailty adjustment to the Medicare rate for the plan's 55 and older population.[7]

Table 2-1 illustrates the major changes to key FIDA-IDD demonstration characteristics from its start in early 2016 to early 2022.

[6] Only States that were awarded original design grants from CMS were then also eligible for Federal funds to support planning and funds to support implementation.

[7] In 2023, CMS, the State, and PHP executed a three-way contract amendment to reinstate the risk corridor retroactive to 2020 and extend it through 2022 (see ***Section 3.5, Financing and Payment***).

Table 2-1
Key changes to New York FIDA-IDD over the course of the demonstration (March 2016 through early 2022)

Key demonstration feature	Changes to the original demonstration design
Timeline	FIDA-IDD was extended through December 31, 2023.[1]
Eligibility	No changes.
Geography/ Number of participating MMPs	No changes.
Services/Carve-outs	No changes specific to the demonstration.
Payment structure	Beginning in 2021, CMS applied a frailty adjustment to the Medicare rate for the plan's 55 and older population. Effective January 1, 2021, the risk corridor was reinstated retroactively to 2020 and extended through 2022.

CMS = Centers for Medicare & Medicaid Services; FIDA-IDD = Fully Integrated Duals Advantage-Intellectual and Developmental Disabilities; MMP = Medicare-Medicaid plan

[1] As of September 2023, the New York FIDA-IDD demonstration has been extended through December 31, 2024.

2.2 Overview of State Context

With some exceptions, prior to the demonstration, managed care was new to New York's IDD population and developmental disabilities services providers because individuals receiving home and community-based services (HCBS) IDD services had been excluded from the State's managed LTSS (MLTSS) plans. Individuals with IDD who receive only Medicaid may, but are not required to, enroll in New York's Medicaid Managed Care (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 fee-for-service (FFS) basis may not enroll in MMC for Medicaid services. Dually eligible beneficiaries with IDD who do not need LTSS can enroll in Special Needs Plans[8] that cover Medicare services and wraparound Medicaid health benefits. Outside of the demonstration, all OPWDD services (e.g., HCBS IDD, residential IDD services) are accessed only on a FFS basis.

Beginning on July 1, 2018, under a State plan amendment, CMS allowed NYSDOH to implement health homes for individuals with IDD (called Care Coordination Organizations/Health Homes, or CCO/HHs) in what was intended to be a first step toward transitioning all developmental disability services to a managed care model. OPWDD envisioned that the CCO/HHs and the FIDA-IDD demonstration would lead to the development and implementation of a specialized provider-led model of managed care for people with IDD. However, service system upheaval brought on by the Public Health Emergency (PHE) in 2020 and State budgetary constraints caused OPWDD to pause development of managed care. The OPWDD Strategic Plan, 2023–2027 (OPWDD, 2022) describes future efforts to continue

[8] In 2022, New York replaced its Medicare Advantage Special Needs Plan model for people without LTSS needs, previously called "Medicaid Advantage plans" in New York, with "IB-Dual," the Integrated Benefits for Dually-Eligible Enrollees Program. IB-Dual is a D-SNP plan and MMC plan under the same parent company.

exploring managed care and other delivery models for people with IDD that build upon the State's broader efforts to promote integrated care for dually eligible individuals.

Some dually eligible beneficiaries eligible for the demonstration are protected class members under a permanent injunction connected to the Willowbrook State School.[9] 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,[10] requires care managers serving Willowbrook class members to coordinate with OPWDD to ensure that case management services comply with the permanent injunction (IDT policy, 2018, p. 11). Willowbrook class members are represented by the Consumer Advisory Board (CAB), a seven-member board providing representation and advocacy services on an individual basis for all Willowbrook class members, including enrollment decisions into FIDA-IDD. This report includes perspectives from CAB representatives on how the demonstration impacted Willowbrook class members.

[9] 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.
[10] See ***Section 3.3, Care Coordination*** for more information about the IDT policy.

SECTION 3

Update on Demonstration Implementation

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

3.1 Integration of Medicare and Medicaid

Despite turnover among CMS and State staff, the Contract Management Team (CMT) continued to function well in joint efforts to manage the demonstration through monthly meetings with the MMP.

The MMP submitted its value-based shared savings contract for clinic providers for State approval, but it was unable to implement an alternative payment methodology for developmental services providers who wished to maintain their FFS payment rates.

As discussed in the Combined First and Second Evaluation Report, PHP is the only MMP participating in the FIDA-IDD demonstration. As a small, specialized plan in a well-developed managed care market, the MMP had difficulties in growing its network to be more attractive to potential enrollees. In this section we provide updates on joint management activities and demonstration integration structures.

3.1.1 Joint Management of the Demonstration

New York and CMS jointly managed the demonstration through the Contract Management Team (CMT). In late 2021 and early 2022, two CMT members—one from CMS and one from OPWDD—who had worked on the demonstration since the beginning left the management team. A second original CMS member left in fall 2022. New staff from CMS and OPWDD were added, and the CMT continued to function well, holding monthly meetings with the MMP to review performance data and discuss current priorities.

Throughout the demonstration, the CMT had minimal concerns about PHP's ability to meet performance benchmarks in care assessments, planning, and coordination. During 2021 and early 2022, the PHE was a primary topic of discussion, but later in 2022 the CMT began to discuss quality measures including Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) data[11] to ensure that the MMP's financial problems (see below) were not impacting quality of care for enrollees.

In 2021, the State alerted CMS that PHP was experiencing significant financial issues putting it below the State requirement for cash reserves. This resulted in a Statement of Deficiency issued by the State to PHP requiring the plan to submit a Plan of Correction (see ***Section 3.5, Financing and Payment***).

[11] We do not provide CAHPS results in this report because enrollment in the demonstration was too low as of the report date to provide adequate sample sizes for CAHPS measures. Although the data are not included in this report, the CMT can discuss CAHPS measures with the MMP during monthly calls.

In late 2019, PHP entered into a business associate agreement with a CCO/HH to streamline some of its administrative functions such as claims processing and vendor oversight. In 2022 the CMT was concerned that the plan would also share care coordination services with the CCO/HH which would be a departure from the demonstration's care coordination model. CMS noted that, to date, the plan was using the CCO/HH to achieve administrative cost savings and the CCO/HH was not meeting directly with enrollees to coordinate care. The CMT planned to continue to monitor these activities.

3.1.2 Integrated Delivery System

FIDA-IDD Plan

PHP is the only MMP participating in the FIDA-IDD demonstration. The plan continued to have challenges in 2021 and 2022 in contracting with three major hospital systems, limiting its network of providers. OPWDD, CMS, and PHP said that PHP's low enrollment made it difficult to engage with the large systems in the demonstration area. Lack of provider participation was a key reason for beneficiary reluctance to enroll in the demonstration (see ***Section 3.2, Eligibility and Enrollment***).

In 2020 and 2021, the MMP wanted to expand its footprint into additional counties to increase enrollment and improve its finances. However, in 2021, the State was not convinced the plan was in a financially stable enough position to approve adding more counties. In 2022, the ombudsman program and the CAB also questioned whether a larger service area would lead to increased enrollment if key health systems were not a part of the plan's network. CMS noted that unlike a large corporate MMP, the plan had limited capacity to support an expanded line of business while establishing it in a new area. The plan had difficulty enrolling members in urban areas, and it was not clear that expanding into more geographically dispersed areas would have helped.

Despite PHP's financial position, CMS and the State continued to be impressed by the MMP's dedication to improving its enrollees' lives, describing the plan as a great partner that really cared about the demonstration population. During the reporting period, the plan continued its use of telehealth in residential settings to reduce unnecessary and disruptive emergency department use and hospitalizations, as well as to provide virtual social opportunities for enrollees. It was also developing telehealth behavioral services to help enrollees access behavioral health services more quickly than if they had to wait for an in-person appointment.

Value-based Payment Arrangements

In 2021, PHP was developing a shared savings value-based payment strategy for clinic providers and an alternative payment methodology for developmental services providers. In 2022, the MMP reported that it had submitted its shared savings contract to the State for approval but that it was still awaiting signatures. It noted the delay appeared to be due to staffing issues at the State level and not to any specific issue with the plan's proposal.

The plan designed an alternative payment methodology employing a capitated payment and sharing savings with developmental services providers who met quality metrics for attributed enrollees. However, the plan said that developmental services providers were ultimately

unwilling to change from their current FFS payment to an at-risk arrangement. The plan said that although it shared how providers could use data to identify trends and patterns to improve enrollee outcomes, it acknowledged that not all developmental services providers were comfortable with or had the capacity to use the data, with some providers still using paper charts.

3.2 Eligibility and Enrollment

Enrollment remained flat during the reporting period, and the PHE curtailed the plan's outreach efforts.

The lack of participation by major hospital systems continued to be a primary factor influencing eligible beneficiaries' choices to enroll.

The State, enrollees and enrollee guardians saw the FIDA-IDD demonstration as an attractive option when guardians such as aging parents or other family members could no longer provide the level of care coordination needed by their demonstration eligible adult children or siblings.

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

3.2.1 Enrollment Summary

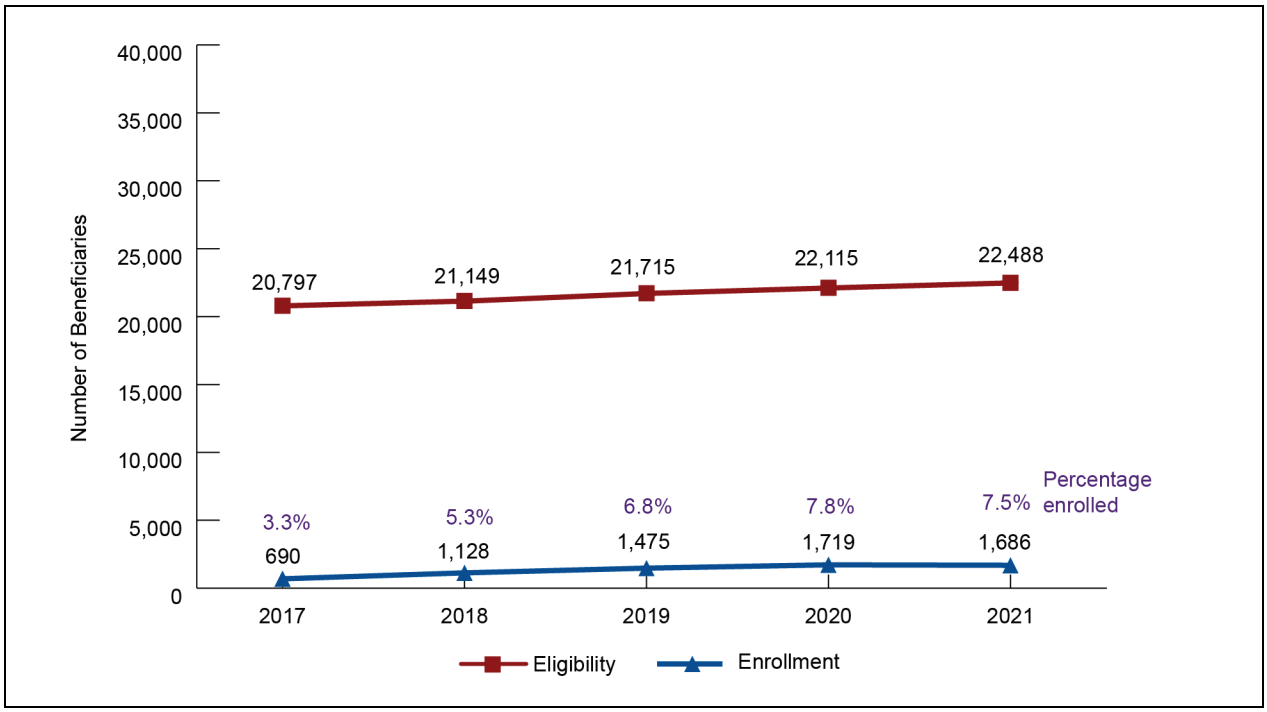
There were no changes in the eligibility requirements for the demonstration during 2021–2022. The number of beneficiaries eligible for the demonstration increased modestly by 8.4 percent from 2017 to 2021 (20,737 to 22,488). The percentage of eligible beneficiaries enrolled remained low throughout the demonstration and ranged between a low of 3.3 percent in 2017 and a high of 7.8 percent in 2020 (see ***Figure 3-1***).

Implementation Effectiveness: Reach

"Reach" is an individual-level measure of participation and refers to the percentage of persons who are affected by a policy, program or initiative. To measure this in the FAI, we examine the percentage of eligible beneficiaries who are enrolled in the demonstration.

Figure 3-1 shows that eligibility slightly increased over time and that enrollment remained less than 8 percent, showing limited reach of the reach of the demonstration.

Figure 3-1
New York FIDA-IDD demonstration enrollment and eligibility at the end of each calendar year, 2017–2021



FFS = Fee-for service; SDRS = State Data Reporting System.
NOTE: Enrollment and eligibility are reported as of December each year. Enrollment and eligibility data reported in the SDRS may not match the finder file data used for quantitative analyses, because of the timing for completion and submitting the finder file versus the SDRS. The definition of eligibility used here, and also in ***Section 5, Demonstration Impact on Cost Savings***, includes FFS and Medicare Advantage populations.
SOURCE: SDRS data for 2017–2021. The SDRS items used to collect eligibility and enrollment were: "Total number of beneficiaries who are eligible to participate in the demonstration" and "Total number of beneficiaries who are enrolled in the demonstration, as of the end of the given month."

3.2.2 Outreach and Options Counseling

The PHE continued to hamper PHP's enrollment efforts in 2021 and 2022. Early in the demonstration, PHP primarily used face-to-face meetings with potential enrollees and their families to market the plan and confirm whether a beneficiary's providers were in its network. Social distancing requirements during the PHE prevented the plan from this face-to-face marketing strategy, and as a result, enrollment remained flat in 2021 and 2022, with the small number of new enrollees being offset by voluntary and involuntary disenrollment.

3.2.3 Factors Influencing Beneficiary Enrollment Decisions

The primary factor influencing beneficiary enrollment decisions continued to be whether their providers were in PHP's network. As described earlier in this section, PHP had difficulty contracting with large hospital systems, and eligible beneficiaries were reluctant to join the demonstration if their specialty providers were not in the network. The plan, State, CMS, and beneficiary advocates reported in 2022 that the absence of one particular hospital system contributed to the plan's continued low enrollment. In 2022 beneficiary interviews, most

demonstration enrollees said they were able to keep their original providers with one saying they would not have joined if they had had to change.

A second contributing factor in enrollment decisions throughout the demonstration appeared to have been the age of enrollees' caregivers. In 2022, OPWDD said that at marketing events prior to the PHE, there was a higher-than-expected number of older family members wanting to enroll their adult children or siblings. The State suggested that the demonstration, with its integrated care model providing for all Medicare and Medicaid services and an assigned care manager, was particularly attractive to older adults who were no longer able to provide the level of care their family members required. In interviews with enrollees and their guardians, respondents valued the care management provided by the MMP. See ***Section 4, Beneficiary Experience*** for more detail.

> *Having [the MMP] there, I know he's getting the best care 24/7. It relieves me of the pressure that I would have to go out and find somebody to do something. It's a complete care package.*
>
> —Non-Hispanic Male Family Member, New York (2022)

3.3 Care Coordination

The MMP was able to conduct assessments and discuss care goals with nearly all enrollees throughout the demonstration to date.

Care coordination is a core element of the FIDA-IDD demonstration, intended to improve enrollee experience in accessing care, ensure care is person-centered, and promote independence in the community. To accomplish these goals, PHP assigns enrollees a care coordination team, composed of a care manager and a service coordinator. The care manager conducts a comprehensive service planning assessment, leads IDT meetings, supports the development of a service plan and oversees its implementation. The service coordinator assists with implementing the plan including setting up meetings and making medical appointments. The design of FIDA-IDD's care coordination model is more fully described in the Combined First and Second Evaluation Report. In this section we highlight major findings on key components and processes of the FIDA-IDD care coordination model: assessment, care planning, and care coordination.

3.3.1 Assessments

All beneficiaries receiving OPWDD services are assessed by OPWDD assessment specialists who are trained in person-centered practices and interviewing techniques and 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. PHP uses the "It's All About Me" (IAM) assessment tool[12] for the and the results form the basis of the FIDA-IDD person-centered plan, call the Life Plan. PHP shares a summary of the IAM assessment with an enrollee's primary care provider, so they know about the enrollee's functional assessment responses, advanced care planning, and medications.

Because enrollment in the FIDA-IDD demonstration has been opt-in only, the MMP has had little difficulty in obtaining correct contact information for and reaching enrollees, evidenced by the negligible percentage of enrollees it was unable to reach within 90 days to date (2016-2021) (see ***Table 3-1***).

Implementation Effectiveness: Dose

Earlier in this report, we discussed "reach," which measures the percentage of persons who receive or are affected by or participate in a *policy, program or initiative*. "Dose" is a measure of implementation effectiveness that refers to the amount of, exposure to, or uptake of an *intervention* provided to a target population within a program or initiative. In the FAI, the main intervention is care coordination.

Because we do not have a direct measure of how many enrollees receive care coordination, we use a proxy measure for dose: the percentage of enrollees that MMPs were not able to reach or locate. This measure gives a sense of how many enrollees were not able to make a choice to engage in care coordination—without connecting with care coordinators, enrollees could not have completed CSPAs, care plans or identify care goals (these activities are discussed later in this section).

Table 3-1 shows that excluding the first year, this measure was at or near zero percent over the course of the demonstration to date, suggesting that the virtually all enrollees were able to receive care coordination.

Table 3-1
Percentage of members that the New York FIDA-IDD MMP was unable to reach following three attempts, within 90 days of enrollment, 2016–2021

Quarter	Calendar year					
	2016	2017	2018	2019	2020	2021
Q1	N/A	0.0	0.0	0.0	0.0	0.0
Q2	0.0	0.0	0.0	0.0	0.0	0.0
Q3	1.3	0.0	0.0	1.0	0.0	0.0
Q4	0.0	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 January 2023. The technical specifications for this measure are in the Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements document.

[12] See the Combined First and Second Evaluation Report for more details on the I AM tool.

Enrollee familiarity with OPWDD assessments likely contributed to their willingness to participate in the CSPA process, and the plan continued to have high rates of completed assessments within 90 days of enrollment ranging from 95.2 to 100.0 percent (see ***Table 3-2***).

Table 3-2
New York FIDA-IDD members whose assessments were completed within 90 days of enrollment, 2016–2021

Quarter	Total number of members whose 90th day of enrollment occurred within the reporting period and who were currently enrolled at the end of the reporting period	Percentage of members with assessments completed within 90 days of enrollment[1]	
		All members	All members 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

(continued)

Table 3-2 (continued)
New York FIDA-IDD members whose assessments were completed within 90 days of enrollment, 2016–2021

Quarter	Total number of members whose 90th day of enrollment occurred within the reporting period and who were currently enrolled at the end of the reporting period	Percentage of members with assessments completed within 90 days of enrollment[1]	
		All members	All members willing to participate and who could be reached[2]
2021			
Q1	36	100.0	100.0
Q2	20	100.0	100.0
Q3	23	100.0	100.0
Q4	21	95.2	100.0

MMP = Medicare-Medicaid Plan; N/A = not applicable; Q = quarter.
[1] The "all members" column presents the percentage of assessments completed for members whose 90th day of enrollment occurred within the reporting period. In the "all members willing to participate and who could be reached" column, the percentages exclude members who were documented as unwilling to participate in an assessment, and members who the MMP was unable to reach following three documented outreach attempts.
[2] The number of members 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 1 of 2016.
SOURCE: RTI analysis of MMP-reported data for Core Measure 2.1 as of January 2023. The technical specifications for this measure are in the Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements document.

3.3.2 Care Planning

Care planning is implemented via a Life Plan and demonstration policy requires the MMP to finalize the Life Plan within 90 days of the effective date of enrollment, or sooner if circumstances require (IDT policy, 2018, p. 6). The IDT develops the Life Plan which is tailored to each enrollee and must specify the enrollee's problems and needs, related interventions, measurable outcomes, and timelines; enrollee goals and preferences and how they will be addressed; and all authorized services including scope and duration.

PHP reported on Life Plan and care plan completion using two different measures during the demonstration. From 2014 through 2017, the plan used a State-specific measure. ***Table 3-3*** shows that for all enrollees and all enrollees willing to complete a Life Plan and who could be reached, the percentage with Life Plans completed within 60 days after completion of the CSPA increased from 2016 to 2017, with percentages at almost 100 percent in late 2017.

Table 3-3
New York FIDA-IDD members with Life Plans completed within 60 days of CSPA completion, 2016–2017

Quarter	Total number of members who had a CSPA completed during the reporting period	Percentage of members with Life Plans completed within 60 days after completion of the CSPA[1]	
		All members	All members 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 members" column presents the percentage of Life Plans completed for members who had a CSPA completed during the reporting period. In the "all members willing to complete a Life Plan and who could be reached" column, the percentages exclude members who were documented as unwilling to complete a Life Plan and members who the MMP was unable to reach following three documented outreach attempts.

[2] The number of members 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.

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 Measure IDD 1.1 as of January 2023. The technical specifications for this measure are in the Medicare-Medicaid Capitated Financial Alignment Model New York FIDA-IDD-Specific Reporting Requirements document.

As of 2018, the MMP reported on Life Plan completion using a newly introduced core measure that applies across all FAI demonstrations. This measure refers to Life Plans as "care plans." As shown in ***Table 3-4***, the percentage of all enrollees with Life Plans (care plans) completed within 90 days of enrollment remained above 95 percent in 2018 through 2021. Among enrollees willing to participate and who could be reached, Life Plan (care plan) completion rates were also consistently high, at or near 100 percent during this timeframe. The plan maintained its high completion through the PHE through using telehealth.

Table 3-4
New York FIDA-IDD members with care plans completed within 90 days of enrollment, 2018–2021

Quarter	Total number of members whose 90th day of enrollment occurred within the reporting period and who were currently enrolled at the end of the reporting period	Percentage of members with care plans completed within 90 days of enrollment[1]	
		All members	All members 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	109	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
2021			
Q1	36	100.0	100.0
Q2	20	95.0	100.0
Q3	23	100.0	100.0
Q4	21	95.2	100.0

MMP = Medicare-Medicaid Plan; Q = quarter.
[1] The "all members" column presents the percentage of care plans completed for members whose 90th day of enrollment occurred within the reporting period. In the "all members willing to complete a care plan and who could be reached" column, the percentages exclude members who were documented as unwilling to complete a care plan and members who the MMP was unable to reach following three documented outreach attempts.
[2] The number of members 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 January 2023. The technical specifications for this measure are in the Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements document.

In beneficiary interviews in 2022, nearly all enrollees we spoke to described participating in the Life Plan process to talk about their goals, and most described being part of a care team. ***Table 3-5*** shows that the MMP's percent of enrollees with at least one documented discussion of care goals in the initial Life Plan was consistently 100 percent throughout 2016–2021.

Table 3-5
New York FIDA-IDD members with documented discussions of care goals, 2016–2021

Quarter	Total number of members with an initial Life Plan completed	Percentage of members 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
2021		
Q1	26	100.0
Q2	20	100.0
Q3	20	100.0
Q4	22	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 Measure IDD 1.2 as of January 2023. The technical specifications for this measure are in the Medicare-Medicaid Capitated Financial Alignment Model New York FIDA-IDD-Specific Reporting Requirements document.

3.3.3 Care Coordination Capacity

PHP reported that recruiting care coordinators (including both care managers and service coordinators) in the Long Island and Manhattan areas was especially difficult in 2021 and early 2022. In spring 2022, the plan was seeing more qualified candidates applying for the role, and the shortages were not as concerning, although the Long Island area continued to have some staffing challenges. PHP said it had been able to maintain its service levels during the staffing shortage, and the State said it was not worried about the plan's ability to provide care coordination.

As shown in ***Table 3-6***, the number of care coordinators varied over the course of the demonstration to date (2016–2021). The percentage of care coordinators assigned to care management and conducting assessments increased noticeably from 33 to 43 percent in earlier years, to 88.1 percent in 2021. The enrollee load (case load) increased each year from 2016 through 2020 before decreasing from 65.0 in 2020 to 29.1 in 2021. The turnover rate increased overall, with a low of 7.9 percent in 2016 and a high of 24.0 percent in 2020. There was variation across the years.

Table 3-6
Care coordination staffing at the New York FIDA-IDD MMP, 2016–2021

Calendar year	Total number of care coordinators (FTE)	Percentage of care coordinators assigned to care management and conducting assessments	Member load per care coordinator assigned to care management and conducting assessments	Turnover rate (%)
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
2021	67	88.1	29.1	17.3

FTE= full time equivalent; MMP = Medicare-Medicaid Plan.
SOURCE: RTI analysis of MMP-reported data for Core Measure 5.1 as of January 2023. The technical specifications for this measure are in the Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements document.

3.4 Stakeholder Engagement

The PHE prevented the State from conducting stakeholder engagement activities and hampered the MMP's ability to increase participation in its Participant Advisory Council.

In this section we describe stakeholder engagement activities during 2021 and early 2022, and the impact of those efforts on the demonstration.

During the reporting period, OPWDD reported that it had not conducted recent stakeholder engagement activities for the demonstration due to the PHE.

The MMP noted that the same members, often self-advocates who live independently, tended to participate in Participant Advisory Council (PAC) meetings. The plan had a strategic goal to broaden member participation, but it acknowledged that because the PAC meetings were held virtually due to the PHE quarantine restrictions, it was difficult for enrollees who need assistance from family members or residence staff to use a computer to participate.

3.5 Financing and Payment

CMS and the State reinstated the risk corridor retroactively to 2020 and extended it through 2022.

The MMP's cash reserves fell below the State-required level in 2021, triggering a need for a Plan of Correction.

The MMP attributed its financial losses to inadequate Medicaid rates and delayed risk corridor and quality withhold payments from the State. New York attributed the losses to the plan's inadequate service utilization management.

In this section we provide a summary of changes to the financing and payment for New York FIDA-IDD during 2021 and early 2022, including the disbursement of funds available through the American Rescue Plan Act of 2021 (ARPA) to demonstration providers, the extension of the risk corridor through 2022, and PHP's ability to maintain its required cash reserves.

3.5.1 Capitation Rates

As of May 2022, the State had not finalized the 2021 rates for the demonstration and was in the process of developing the 2022 rates.

During the PHE, the State received funds to support home and community-based providers under ARPA Section 9817.[13] The State had wanted to share these funds directly with demonstration providers as it would have for FFS providers, but CMS said that would conflict with how payments were authorized to demonstration providers under the 1115 waiver. [14] Because agencies providing services to demonstration enrollees also provide services to the general OPWDD service population, the State developed a process to calculate the percentage of a provider's clients that were demonstration enrollees, attribute a portion of the provider's ARPA-funded payment for those enrollees, inform the plan to make the payment to the provider, and then adjust the plan's capitation rate accordingly for the payment. The State planned to

[13] See American Rescue Plan of 2021, Section 9817.

[14] Payments to fee-for-service HCBS providers included bonuses supporting worker longevity, retention, vaccination, and working during the PHE ("heroes" pay).

adjust the 2021 rates to include bonuses for worker longevity and working through the PHE and adjust the 2022 rates to include worker retention and vaccination bonuses.

Risk Corridors

The demonstration design included the use of risk corridors to share losses or savings in the first three years of the demonstration, and were calculated separately for the Medicare and Medicaid capitation rates. The risk corridors were designed to protect the MMP from shortfalls brought on by high costs during the demonstration's start-up period (called "shared losses"). They also protected CMS and the State from overpaying if the MMP's costs were lower than projected (called "shared savings"). CMS and the State had declined to extend the risk corridors beyond 2019 as discussed in the previous evaluation report. During this reporting period, the MMP and the State favored the reinstatement of the risk corridor but for different reasons.

The MMP maintained that the capitation rates inadequately reflected its experience, especially for personal care services, and that the risk corridor should continue beyond 2019 to guard against excessive losses. The State's contracted actuary conducted an analysis of PHP's Medicaid service utilization and rates in 2019 and determined the rates were adequate and an extension of the risk corridor was unwarranted at the time. Although the MMP had also said the Medicare rates were inadequate, the plan did not share any supporting analysis or documentation for CMS consideration.

By contrast, in late 2021, the State said it saw an opportunity to share savings through reinstituting the risk corridor for 2022. The State maintained that, as service utilization had declined under the PHE, reinstating the risk corridor would allow the State to recoup some of the capitation that was unspent on services. However, CMS saw reinstituting the risk corridor for CY 2022 as a way to respond to PHP's financial challenges. Ordinarily, CMS prohibits retroactive risk mitigation techniques, but due to an emergency provision under the Section 1115 authority, New York sought to reinstate the risk corridors for 2020 and 2021 as well. An amendment to the three-way contract reflecting the retroactive reinstatement of the risk corridor to 2020 and extending it through 2022 was approved in March 2023, with an effective date of January 1, 2021.

Quality Withhold Percentages

CMS and the State withhold part of their respective capitation payments pending analysis of MMP performance on a set of CMS core and State-specific quality measures. For demonstration year 4 (2020) and demonstration year 5 (2021), the plan qualified for the quality withhold adjustment due to an extreme and uncontrollable circumstance, based on the COVID-19 PHE in 2020 (CMS, n.d.-a) and Hurricane Ida in 2021 (CMS, n.d.-c). As a result, the plan received 100 percent of its withheld amounts for both years, based solely on full reporting of applicable quality withhold measures. For more details about the quality withhold measures and plan performance, see ***Section 3.6, Quality of Care***.

Savings Percentage

Capitation payments to the MMP include a discount relative to Medicare and Medicaid baseline rates, referred to as the 'aggregate savings percentage'. The aggregate savings percentage for the demonstration, which is applied equally to Medicare Parts A and B and

Medicaid baseline spending amounts, increased gradually over the first 3 years of the demonstration to 0.75 percent. The August 2020 contract amendment continued the 0.75 percentage through demonstration year 7 (2023) (CMS, 2020).

MMP and State Concerns about Rates and Financing

PHP continued to experience financial instability in 2021 and 2022 , and PHP and the State suggested different explanations including inadequate rates, inefficient use of lower cost services, contractually required reserves, and delayed risk corridor payments. For example, PHP continued to have concerns about the adequacy of the Medicaid rates, especially for personal care services and ICF/IID care. The State said it had hoped that the MMP's approach to care planning would entail an efficient use of funds—if the plan were able to provide care more efficiently through care planning and management strategies, it would be able to achieve savings on the capitation. Because the rates were based on the FFS costs absent the demonstration and the plan continued to suggest the rates for personal care were not high enough, the State said it appeared the plan was simply providing more personal care to enrollees than outside the demonstration and not achieving cost savings somewhere else such as through reductions in higher cost services or administrative savings.

During the report period, the MMP said enrollees in ICF/IIDs had been driving a $20 million deficit in its bottom line and that its capitation rate was inadequate to cover this high-cost service. The State acknowledged that these facilities tend to serve beneficiaries with high service needs and that State-operated ICF/IIDs, in particular, are often a provider of last resort. Although enrollees in State-operated facilities were a small portion of enrollees in ICF/IIDs, the State also acknowledged having lagged in establishing reimbursement rates for State-operated providers by several years because it uses a methodology based on a reconciliation of actual costs to achieve the highest possible federal match for the dollars that the State spends on that service. Although the State projects forward what the reimbursement will be and includes it in the capitation rate, the final reimbursement rate for the providers is retroactively adjusted to reflect the actual cost.

The FFS rate parity described in the three-way contract (CMS, 2016, p. 63) required the MMP to pay the State-operated ICF/IIDs the State-established rates, which changed retroactively. Thus, PHP was paid the capitation rate with the estimated ICF/IID rate, but subsequently contended that the State had not accounted for retroactive FFS rate updates for that level of care in their capitation rate. In response, the plan delayed paying the State-operated facilities until a resolution was reached, and the State delayed making significant risk corridor and quality withhold payments. However, at the time of this report, the plan and the State have resolved this discrepancy. The State agreed to execute payment owed to the plan for the calendar year 2018 interim risk corridor and the calendar year 2019 quality incentive withhold. The plan agreed to remit full payment for services rendered by State-operated providers and facilities, but to date, it had not yet done so.

In addition to having enrollees with high service costs, the risk corridor and quality withhold payment delays contributed to the MMP's poor financial situation. In 2021, the NYSDOH Division of Health Plan Contracting and Oversight (DHPCO) issued a Statement of Deficiency to PHP because the plan reported a net worth of minus $24.5 million. By contract, the State requires the plan to have a net worth of almost $11 million. Therefore, PHP was short by approximately $35 million to comply with its contract. PHP submitted a Plan of Correction

outlining program initiatives and streamlined administrative functions it believed would put the plan on better financial footing in 2022. When DHPCO reviewed the plan's financial status in 2022, the plan showed a deficit of approximately $21 million.

PHP and the State differed in the amount the plan was owed. PHP reported in 2022 that the State owed it close to $50 million from multiple years of risk corridor settlements and quality withhold payments. The State said it owed the plan approximately $25 million. However, the State also said that even if the plan received that amount, it would still be out of compliance with its contractually required $11 million in reserve. It is unclear if the State's figure included quality withhold payments. The final amounts of risk corridor payments from Medicare and Medicaid for demonstration years 2 and 3 were unavailable at the time of this report; preliminary amounts are in ***Table 3-7.***

Table 3-7
Risk corridor payment amounts paid to the MMP, demonstration years 1–3

Demonstration Year	Medicare Risk Corridor Payment	Medicaid Risk Corridor Payment
DY1	$103,876 [1]	$5,628,380 [1]
DY2	$55,401 [2]	$5,846,910 [2]
DY3	$39,398 [2]	$17,239,279 [2]

DY = demonstration year.
[1] Final total amount for Medicare was later corrected to $103,586, but the number in the table was the one used in analysis; final total amount for Medicaid was later corrected to $5,656,590.
[2] Interim payment.
SOURCE: CMS, n.d.-b

3.6 Quality of Care

The MMP met 78 percent of the quality withhold measures for the demonstration in CY2021, and due to an extreme and uncontrollable circumstance, Hurricane Ida, CMS and the State determined the MMP could receive 100 percent of the withheld amount. CMS and the State had few concerns about quality of care throughout the demonstration to date.

The MMP automated gaps-in-care reports to providers and care managers to ensure enrollees received scheduled preventive and chronic disease management services.

The MMP improved performance over time on measures for blood pressure control, controlling HbA1c levels (blood glucose measure), medication review (one of the Care for Older Adults measures), and plan all-cause readmissions for enrollees ages 18-64 and 65+.

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

3.6.1 Quality Measures

MMPs are required to report performance on a combination of CMS core and State-specific quality metrics, described in the Combined First and Second Evaluation Report. There were no changes in quality measures during 2020–2021. A subset of the quality measures are designated as quality withhold measures. Both CMS and the State withhold a portion of their respective components of the capitation rate, and MMPs can earn back some or all of their withheld payments based on meeting the benchmarks or gap closure targets (as applicable) for the quality withhold measures.[15]

For 2020, all FAI MMPs were eligible for the quality withhold adjustment due to an extreme and uncontrollable circumstance, specifically the COVID-19 PHE. As a result, PHP received 100 percent of the withhold amount, based solely on complete reporting of all applicable quality withhold measures. One measure, annual flu vaccine, was designated as not applicable, because MMPs were not required to report 2020 CAHPS survey results due to the PHE. For 2021, the plan met 78 percent of the quality withhold measures. CMS and the State determined that the MMP was again eligible for a quality withhold adjustment due to an extreme and uncontrollable circumstance during CY 2021, specifically Hurricane Ida. Therefore, the MMP received 100 percent of the withheld amount based on complete measure reporting, irrespective of measure performance.[16]

The State monitored the Medicaid dental care quality withhold measure and noticed a drop in 2020 across all Medicaid managed care plans including PHP, likely due to dental offices being closed during the PHE. Throughout the demonstration to date, neither CMS nor the State had concerns over the quality of care provided by the MMP.

3.6.2 Quality Management Activities

The State's External Quality Review Organization conducted the required Medicaid managed care compliance review of the MMP for the full set of standards in 2020-2021. The results of that review were not available when this report was written. PHP's Quality Improvement Projects (QIPs) during the reporting period focused on dental care visits and improving blood pressure control and blood sugar control. The plan said the PHE had made getting dental care more difficult, and it was trying to ensure that enrollees were able to get their regular dental visits (see ***Section 4, Beneficiary Experience***).

[15] MMPs can earn a "met" designation for a measure by meeting the benchmark set by CMS or the State. For some measures, MMPs can also earn a "met" by closing the gap between its prior year performance and the benchmark by a stipulated improvement percentage (typically 10 percent) (CMS, n.d.). https://www.cms.gov/files/document/qualitywithholdresultsreportnyfidaidddy4.pdf

[16] For more information about the quality withhold methodology, refer to the Medicare-Medicaid Capitated Financial Alignment Model Core Quality Withhold Technical Notes and the New York FIDA-IDD Quality Withhold Measure Technical Notes available at: Quality Withhold Methodology.

In addition to the QIPs, PHP worked on ensuring enrollees were getting regular preventive care screenings and chronic disease management services by automating the sharing of a gaps-in-care report with providers and care managers. If an enrollee was missing a preventive care or chronic disease management service such as blood sugar testing, the care manager reached out to them and their providers to assist with getting the visits scheduled. The plan also started sharing Healthix alerts with providers to ensure they were aware when an enrollee was admitted to and discharged from the hospital in order to improve on quality measures around readmissions.[17] In 2022, the plan was looking into education programs around preventing falls, which were a major cause of emergency department use and inpatient admissions, and prevention of sepsis.

3.6.3 HEDIS Quality Measures Reported for Partners Health Plan

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

Four of the 13 Medicare HEDIS measures for MMP enrollees that RTI analyzes are reported in ***Figures 3-2*** through ***3–6,*** with results on all 13 measures appearing in ***Table B-1*** in ***Appendix B.*** RTI identified these measures in its Aggregate Evaluation Plan based on their historic completeness, reasonability, and sample size. The 2017–2021 HEDIS data were available for Partners Health Plan. In response to the PHE, in 2020, CMS did not require Medicare plans (including MMPs) to submit HEDIS data covering the 2019 measurement year. In 2021, Medicare plans (including MMPs) resumed normal reporting for measurement year 2020.

Detailed descriptions of selected HEDIS measures can be found in the RTI Aggregate Evaluation Plan. Results reported in ***Figures 3-2*** through ***3–6*** show Partners Health Plan's 2017 through 2021 HEDIS performance data on measures for blood pressure control, good control of hemoglobin A1c (HbA1c) levels (< 8.0 percent), medication review (one of the Care for Older Adults measures), and plan all-cause readmissions (ages 18–64 and ages 65+).[18]

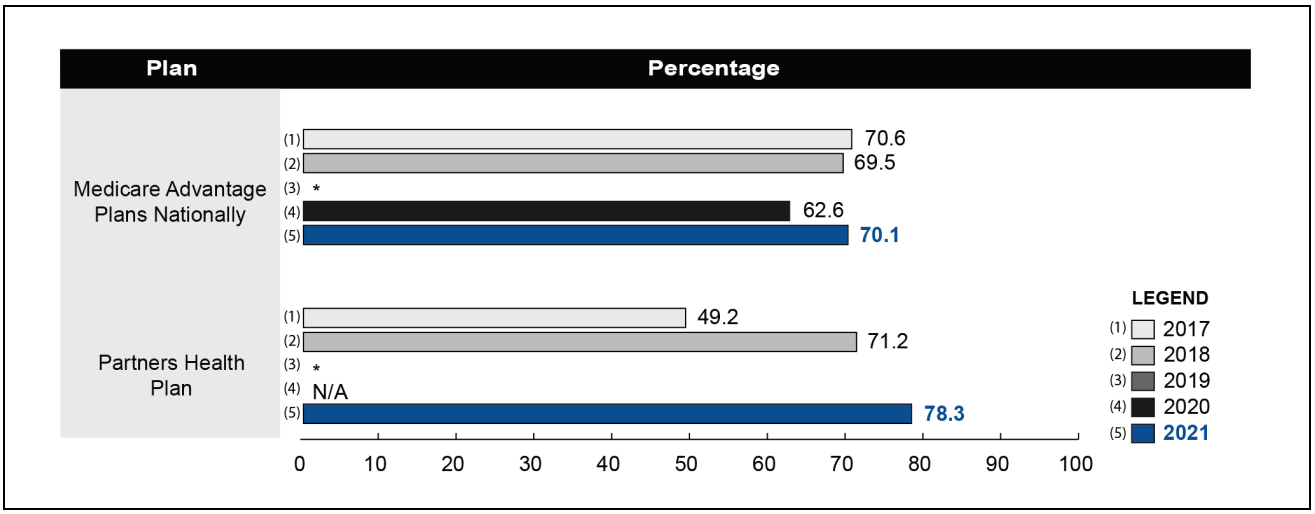
Although monitoring trends in MMP performance is the primary focus of our HEDIS analysis, the figures and appendix table also compare MMP performance to national Medicare Advantage plan means for reference when available. We provide the national Medicare Advantage plan means with the understanding that Medicare Advantage enrollees and demonstration enrollees may have different health and sociodemographic characteristics, which would affect results. Previous studies on health plan performance reveal poorer-quality ratings for plans serving a higher proportion of dually eligible beneficiaries and beneficiaries with disabilities. Additionally, HEDIS measure performance, in particular, is slightly worse among Medicare plans serving areas with lower income and populations with higher proportions of

[17] Healthix is a public health information exchange serving New York City and Long Island.
[18] These are hospital readmissions.

minorities (ASPE, 2016). Comparisons to national Medicare Advantage plan means should be considered with these limitations in mind.

As shown in ***Figure 3-2***, Partners Health Plan performance on blood pressure control increased between 2017 and 2021, with the most pronounced increase between 2017 and 2018.

Figure 3-2
Blood pressure control,[1] 2017–2021: Reported performance rates for Partners Health Plan



* = data not available; HEDIS = Healthcare Effectiveness Data and Information Set; MMP = Medicare-Medicaid Plan; N/A = not applicable, where the number of enrollees in the MMP's provided HEDIS data available for inclusion in the measure was less than 30, and therefore not reported per RTI's decision rule for addressing low sample size.

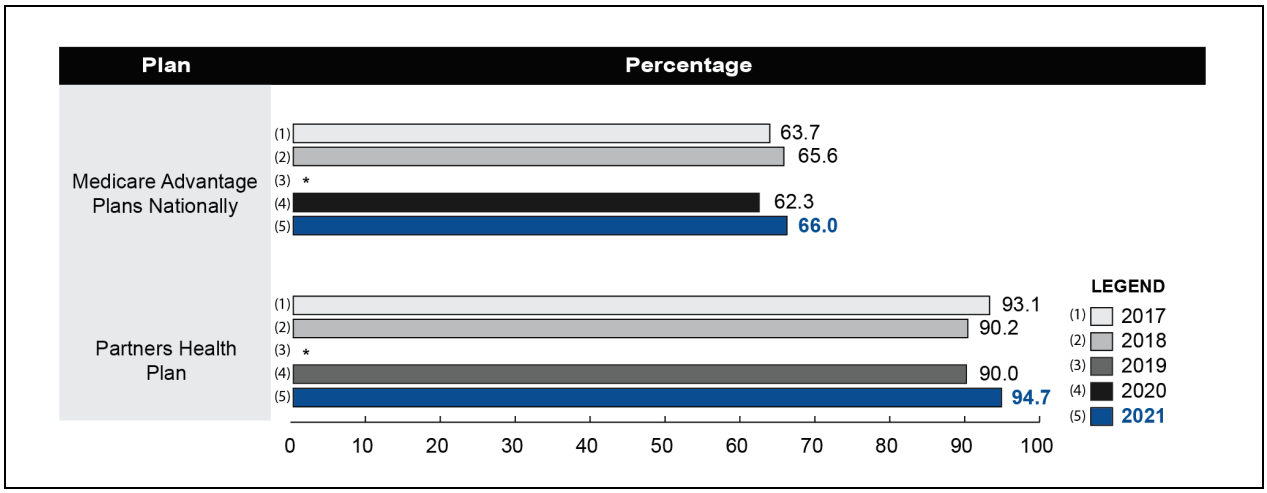
[1] The following criteria were used to determine adequate blood pressure control: less than 140/90 mm Hg for enrollees 18–59 years of age; diagnosis of diabetes and <140/90 mm Hg for enrollees 60–85 years of age; no diagnosis of diabetes and <150/90 mm Hg for enrollees 60–85 years of age.

NOTE: In response to the COVID-19 Public Health Emergency, CMS did not require Medicare Advantage plans (including MMPs) to submit HEDIS data covering the 2019 measurement year.

SOURCE: RTI analysis of 2017 through 2021 HEDIS measures.

As shown in ***Figure 3-3***, Partners Health Plan performance on controlling HbA1c levels (< 8.0 percent) increased between 2017 and 2021, with percentages remaining above 90 percent.

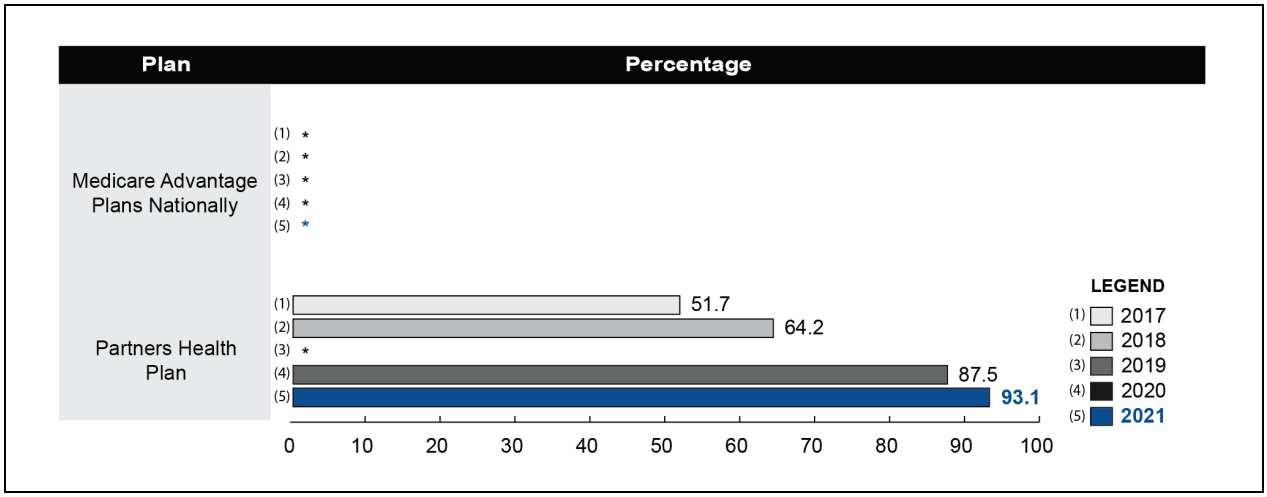
Figure 3-3
Good control of HbA1c level (<8.0%), 2017–2021: Reported performance rates for Partners Health Plan



* = data not available; HEDIS = Healthcare Effectiveness Data and Information Set; MMP = Medicare-Medicaid Plan.
NOTE: In response to the COVID-19 Public Health Emergency, CMS did not require Medicare Advantage plans (including MMPs) to submit HEDIS data covering the 2019 measurement year.
SOURCE: RTI analysis of 2017 through 2021 HEDIS measures.

Figure 3-4 shows that, for medication review (one of the Care for Older Adults measures), Partners Health Plan reported substantial year over year increases from 2017 to 2021. Non-SNP MA plans do not report the Care for Older Adults measures, so a national MA plan mean is not available.

Figure 3-4
Medication review (one of the Care for Older Adults measures), 2017–2021: Reported performance rates for Partners Health Plan

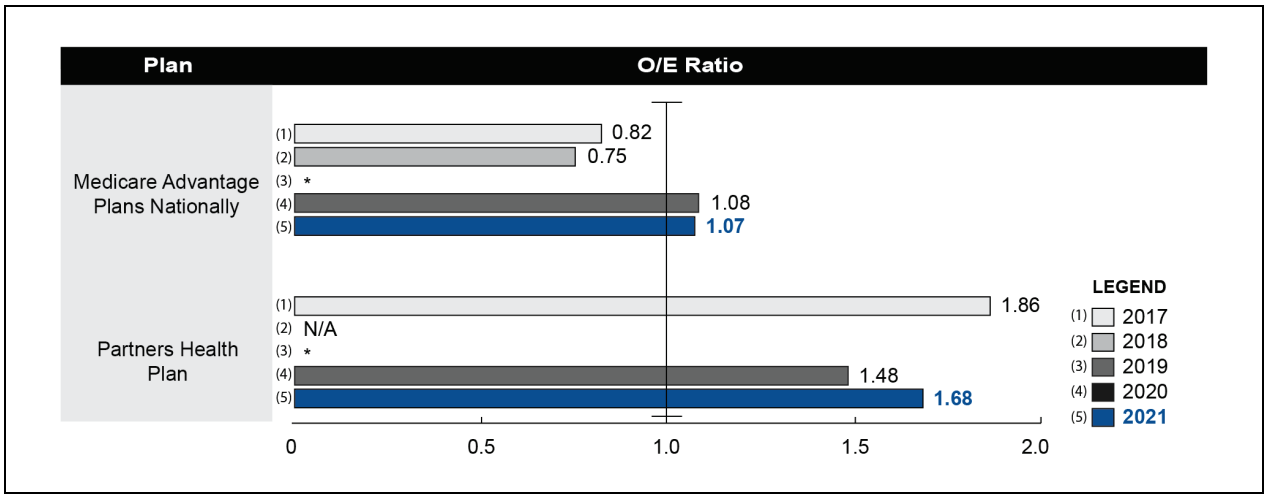


* = data not available; HEDIS = Healthcare Effectiveness Data and Information Set; MMP = Medicare-Medicaid Plan.
NOTE: In response to the COVID-19 Public Health Emergency, CMS did not require Medicare Advantage plans (including MMPs) to submit HEDIS data covering the 2019 measurement year.
SOURCE: RTI analysis of 2017 through 2021 HEDIS measures.

Plan all-cause readmissions for enrollees ages 18–64 and 65+ are reported in ***Figure 3-5*** and ***Figure 3-6***, respectively, as an observed-to-expected ratio, whereby an MMP's observed readmission rate is compared with its expected readmission rate given its beneficiary case mix. A value below 1.0 (shown by the vertical line at $x = 1$ in the figure below) is favorable and indicates that the MMP had fewer readmissions than expected for its populations based on case mix.

Figure 3-5 shows that Partners Health Plan reported higher than expected readmission rates for enrollees ages 18–64 for all years where data were available and sample size requirements were met. Similarly, ***Figure 3-6*** shows that, where data were available and sample size requirements were met, Partners Health Plan reported higher than expected readmission rates for enrollees ages 65+.

Figure 3-5
Plan all-cause readmissions, ages 18–64, 2017–2021: Reported observed-to-expected ratios for Partners Health Plan

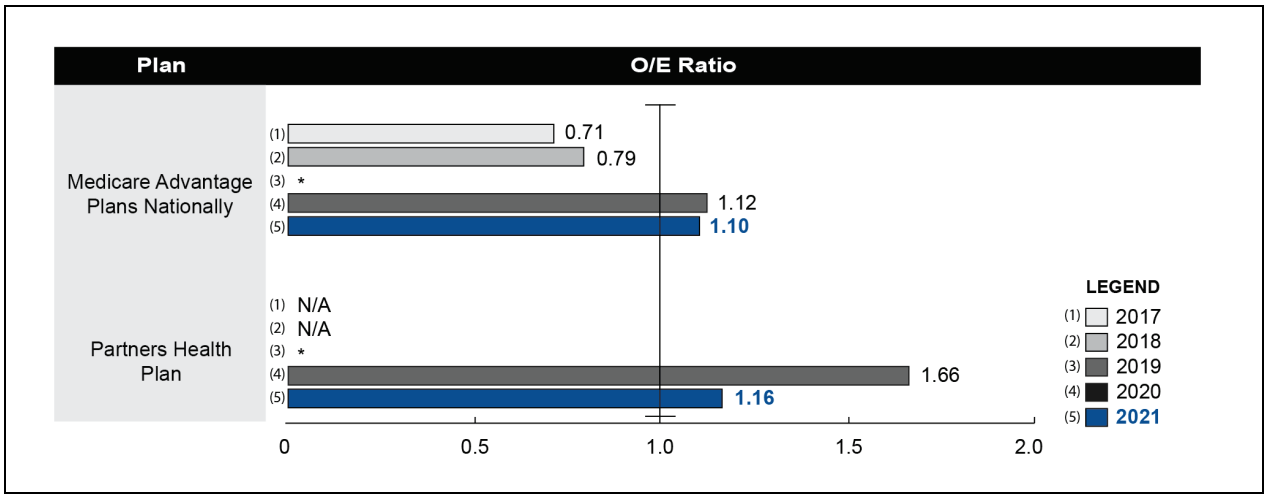


* = data not available; HEDIS = Healthcare Effectiveness Data and Information Set; MMP = Medicare-Medicaid Plan; N/A = not applicable, where the number of enrollees in the MMP's provided HEDIS data available for inclusion in the measure was less than 30, and therefore not reported per RTI's decision rule for addressing low sample size.

NOTE: In response to the COVID-19 Public Health Emergency, CMS did not require Medicare Advantage plans (including MMPs) to submit HEDIS data covering the 2019 measurement year.

SOURCE: RTI analysis of 2017 through 2021 HEDIS measures

Figure 3-6
Plan all-cause readmissions, ages 65+, 2017–2021: Reported observed-to-expected ratios for Partners Health Plan



* = data not available; HEDIS = Healthcare Effectiveness Data and Information Set; MMP = Medicare-Medicaid Plan; N/A = not applicable, where the number of enrollees in the MMP's provided HEDIS data available for inclusion in the measure was less than 30, and therefore not reported per RTI's decision rule for addressing low sample size.

NOTE: In response to the COVID-19 Public Health Emergency, CMS did not require Medicare Advantage plans (including MMPs) to submit HEDIS data covering the 2019 measurement year.

SOURCE: RTI analysis of 2017 through 2021 HEDIS measures.

SECTION 4

Beneficiary Experience

Overall satisfaction with the demonstration was high, as shown by low voluntary disenrollment rates and beneficiary interviews.

Enrollees had faster access to durable medical equipment in the demonstration, but some said some network providers were too far away to be accessible.

One of the main goals of the demonstration under the FAI is to improve the beneficiary experience accessing Medicare and Medicaid services. In this section we highlight beneficiary experience with FIDA-IDD, and provide information on beneficiary protections, data related to complaints and appeals, and critical incident and abuse reports. For beneficiary experience, we draw on interviews with enrollees or their family members conducted by RTI in 2022. See ***Appendix A*** for a full description of these data sources.[19]

4.1 Impact of the Demonstration on Beneficiaries

4.1.1 Overall Satisfaction with the Demonstration

During the reporting period, the State and PHP continued to view the low disenrollment rate as an indicator of enrollee satisfaction with the plan.

The people that are involved, they tend to come in, they stay long-term. A little bit of fluctuation here and there, but it's been a very stable number for a long time. So, it seems like the folks involved with it are, to a large extent, enjoying it and happy with the services they're getting.

—OPWDD (2022)

In 2022 we conducted individual interviews with 15 New York FIDA-IDD enrollees or their caregivers to ask about their experience with the demonstration. Twelve out of 15 participants said they were "very satisfied" with the demonstration. Enrollees and family members cited having access to needed care and care managers who proactively reached out to them and genuinely cared about them as reasons for their high satisfaction.

When I call, they handle it as a priority, and her case manager always takes care of everything. I never have to follow up on anything, it just gets done.

—Individual Beneficiary Family Member Interview Participant(2022)

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[19] 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.

4.1.2 Experience with Care Coordination

All enrollees and family members interviewed said they knew who their care manager was and how to reach them. Although most said they called their care manager's direct line, a few primarily used email. Most interviewees said their care managers responded to them quickly, usually within 24 hours, but one said the care manager would try to transfer them to another department. The frequency of contact with care managers ranged from once a week (one individual) to twice a year (two individuals) with most saying they spoke monthly or more often, enough to meet their needs. One participant said they would have preferred more frequent contact and more assistance obtaining services. Several beneficiaries said they felt listened to and respected by their care team including their care manager and service coordinator. Nearly all described participating in the LifePlan process to talk about enrollee goals.

You know, prior to enrolling in PHP, I was kind of, not very happy. I wasn't doing too well, but, now I have some goals. I want to work toward some plans for my future. And that's always a really good feeling. I just feel better as a person, I guess.

—Individual Beneficiary Interview Participant (2022)

Family members and enrollees said they often arranged for their own services rather than having the service coordinator do it, but several described being able to call the service coordinator if they needed help with finding services or making appointments. Two individuals had asked their service coordinators for assistance with getting different housing such as an individual apartment, consumer-directed personal care services, and work support but had not had their needs met and had been told that services were not available in their area. One individual was contemplating switching service coordinators.

4.1.3 Quality and Access to Care

PHP said its biggest challenge in providing care coordination in 2021 and early 2022 was the lack of available services due to the PHE. There were many day habilitation programs that either closed or switched to virtual programming. As the PHE began to ease in 2022, the plan noted that while some day habilitation providers were opening back up, others were not.

In interviews, most enrollees and family members said they were happy with their access to and choice of providers. Most were satisfied with the care they received and thought it was high quality. Two individuals said the plan needed more PCPs, dentists, behavioral health providers, and job coaches. These respondents said that although some needed providers were in the plan's network, they were located too far away, one noting that there were more participating dentists on Long Island compared to Manhattan where the respondent lived. Beneficiary advocates also noted that some providers were too far away for some enrollees to reach easily, sometimes requiring at least hour-long transportation. For many FIDA-IDD enrollees, lengthy transports are physically and behaviorally very demanding. When transports are too long or cumbersome, some FIDA-IDD enrollees may be too exhausted to participate in the scheduled appointment. In 2022, the MMP said it was developing an approach to mobile service delivery

that would meet members where they live rather than have residence staff transporting members to services such as dental care, immunizations, and diabetes bloodwork monitoring.[20]

Many of the interview participants, beneficiary advocates, and the Ombudsman said that accessing durable medical equipment was easier and faster than it was before enrolling. Enrollees and advocates viewed quicker access to new equipment like motorized wheelchairs and walkers as well as speedier repairs of equipment as crucial to maintaining or increasing enrollees' inclusion in their communities.

> *It might take a couple of years to get a walker under Medicare or Medicaid. [Now] it takes an email to my [MMP] care coordinator.*
>
> —Individual Beneficiary Interview Participant (2022)

4.2 Beneficiary Protections

4.2.1 Grievances, Appeals and Complaints

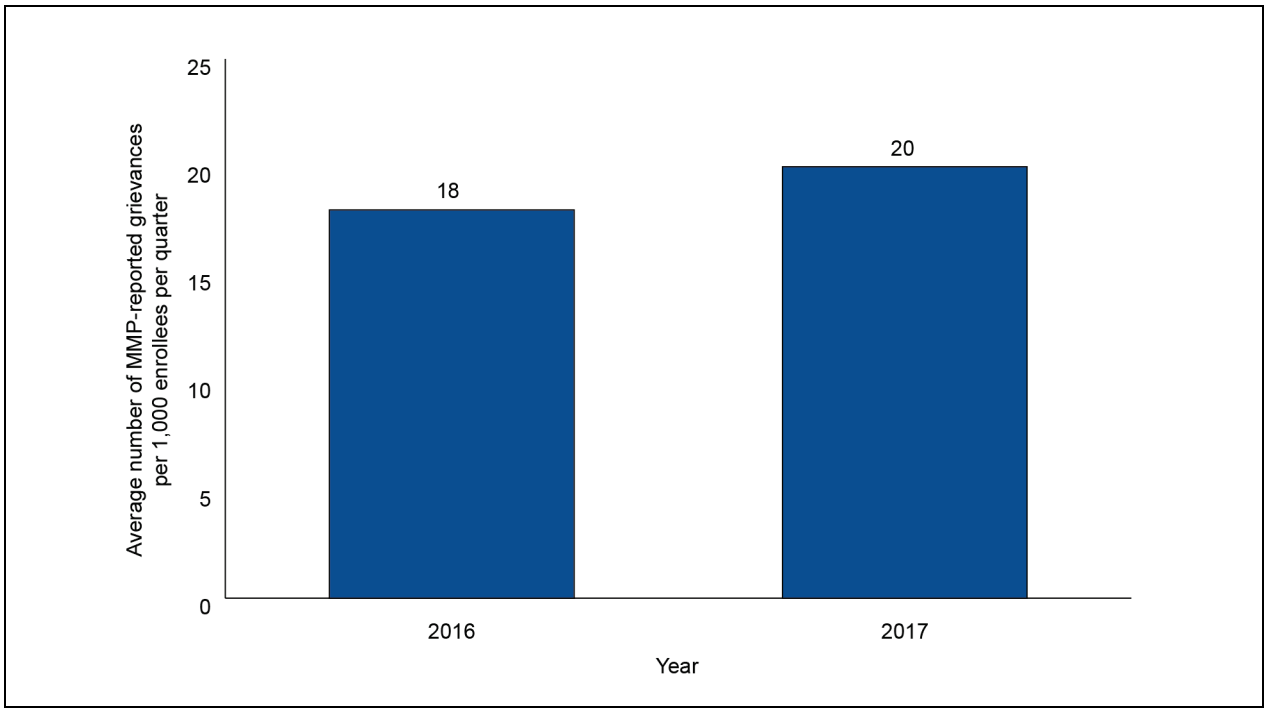
Enrollees have certain protections under the demonstration. There are several options for them to report grievances or complaints, appeals, and critical incidents and abuse. Ombudsman services are available under the demonstration to assist enrollees with filing and resolving complaints, as well as to provide information about the process. Over the reporting period, the ombudsman program continued to help enrollees with complaints, grievances, and appeals, although it no longer represents them in the appeals process due to a new federal regulation[21] implemented in 2019 governing beneficiary support programs. Due to competing demands for State staff time during the PHE, the State stopped holding monthly calls with the ombudsman program in 2020. As of 2022, the calls had not been reinstated, and the ombudsman program said that it thought the calls would have been a valuable opportunity to share information with the State about policies or procedures that impact all enrollees, not just those with a complaint or grievance.

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.

MMPs are required to track and report grievance data. Because the way that plan-reported grievance data were analyzed changed in 2018, we report separate data from two periods (2016–2017 and 2018–2021). In 2016 and 2017, data were analyzed per 1,000 enrollees per quarter. Beginning in 2018, data were analyzed per 10,000 enrollee months per quarter. As shown in ***Figure 4-1***, the average number of MMP-reported grievances per 1,000 enrollees per quarter remained low in 2016 and 2017.

[20] In 2023, PHP implemented mobile service delivery for dental services and immunizations.
[21] CFR Title 42, Chapter IV, subchapter C, Section 438.71

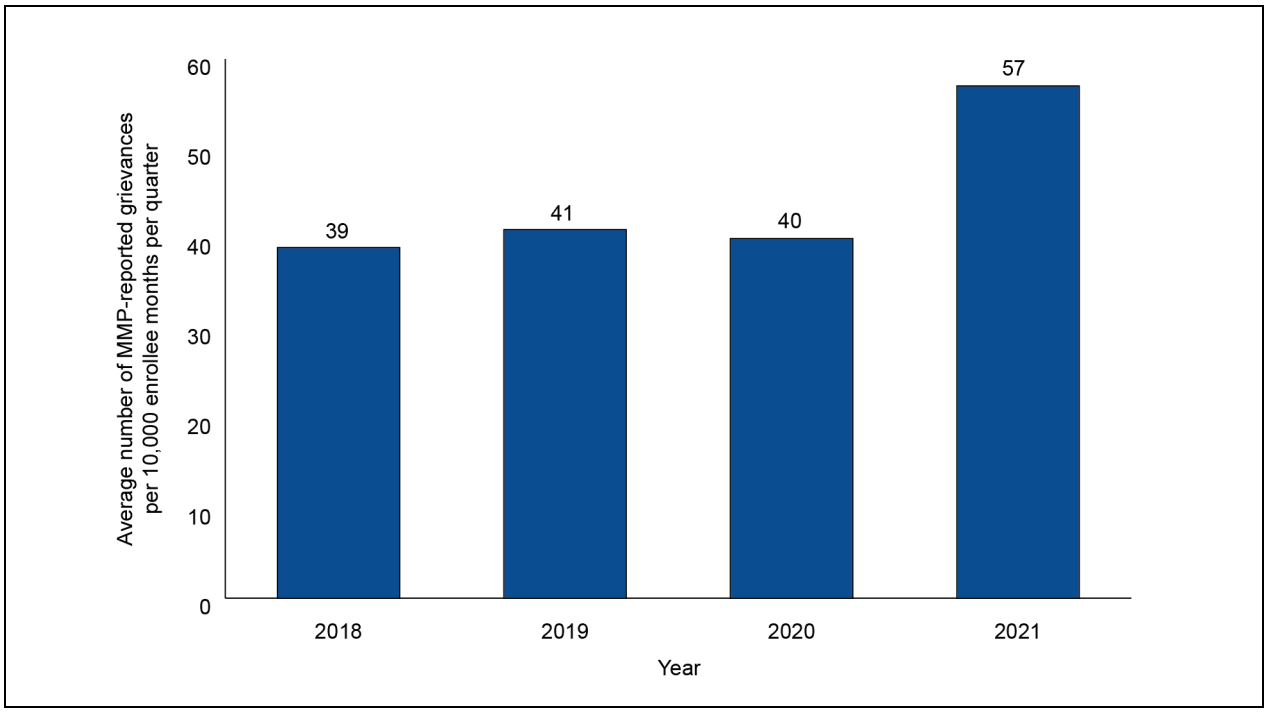
Figure 4-1
New York FIDA-IDD average number of MMP-reported grievances per 1,000 enrollees per quarter, 2016–2017



MMP = Medicare-Medicaid Plan.

As shown in ***Figure 4-2***, the average number of MMP-reported grievances per 10,000 enrollee months per quarter generally increased from a low of 39 in 2018 to a high of 58 in 2021.

Figure 4-2
New York FIDA-IDD average number of MMP-reported grievances per 10,000 enrollee months per quarter, 2018–2021



MMP = Medicare-Medicaid Plan.

Total complaints reported to the Complaint Tracking Module (CTM) by NYSDOH or through 1-800-Medicare remained very low from 2016 through 2021, ranging from zero to four each year. The highest number of complaints over the course of the demonstration to date were in the provider specific[22] category followed by complaints in the enrollment and disenrollment[23] category.

Enrollees also have the right to appeal the MMP's decision to deny, terminate, suspend, or reduce services. The first level of appeal is filed directly with the MMP.

FIDA-IDD uses the integrated appeals model developed for FIDA.[24] 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 plan to deny or limit authorization of a covered service. An appeal must first be filed with the plan, which uses a third-party administrator to review appeals.

[22] This category is defined as "claims payment, or network contracting issue."
[23] This category is defined as "Beneficiary is experiencing an enrollment issue that may require reinstatement or enrollment change."
[24] For a description of the integrated appeals model, see the First Evaluation Report for the FIDA demonstration.

If, upon reconsideration, the MMP upholds its original decision, the plan automatically forwards the appeal to the Office of Administrative Hearings (OAH), which is housed within the Office of Temporary and Disability Assistance (OTDA).The hearing at the OAH level serves as the integrated second-level appeal for both Medicare and Medicaid, replacing what might otherwise be the divided process of appealing to CMS's Independent Review Entity for Medicare service coverage decisions and to the OTDA for Medicaid service coverage decisions. To avoid the division, the OAH applies both Medicare and Medicaid statute and regulation in making its ruling.

If an enrollee disagrees with the OAH's decision, they may file an appeal with the Medicare Appeals Council (MAC),[25] which serves as the integrated third-level appeal for Medicare and Medicaid. The MAC hears all appeals from the OAH, 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[26] may appeal the MAC's decision in a fourth-level appeal in a Federal district court.

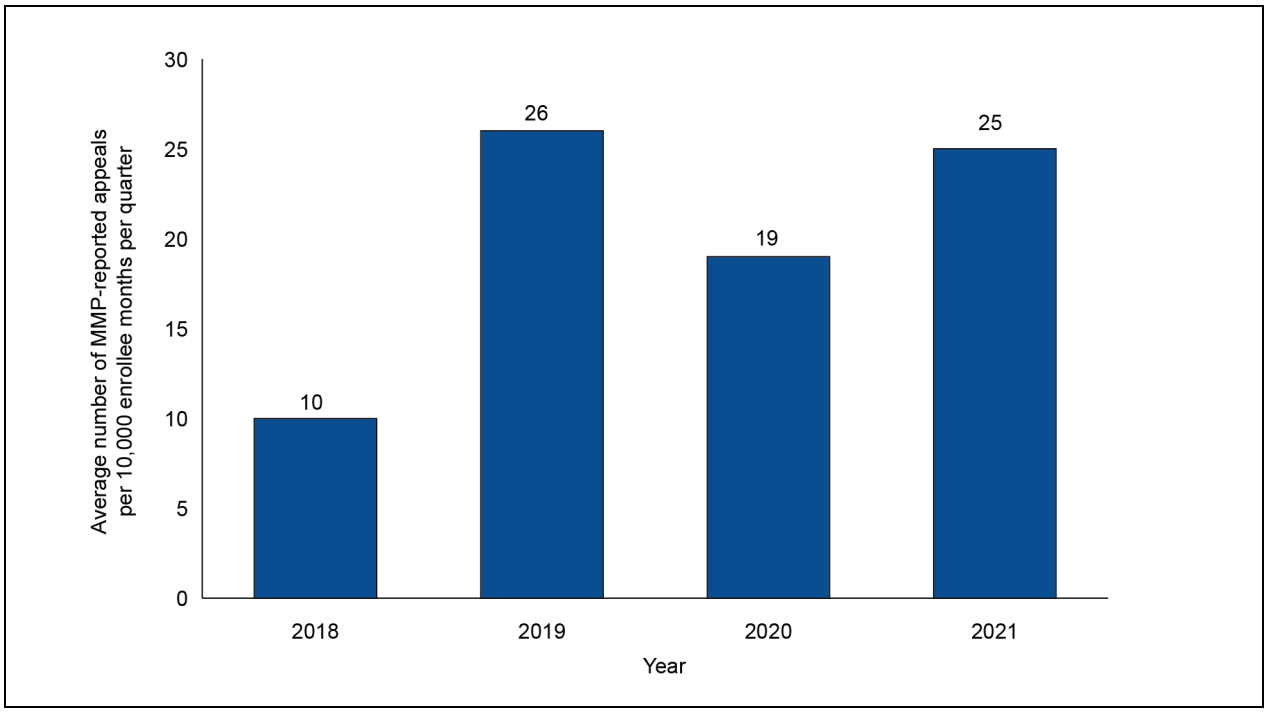
Because the way that plan-reported appeals data were analyzed changed in 2018, we report separate data from two periods (2016–2017 and 2018–2021). In 2016 and 2017, data were analyzed per 1,000 enrollees per quarter. Beginning in 2018, data were analyzed per 10,000 enrollee months per quarter. From 2016 through 2017 the average number of MMP-reported appeals per 1,000 enrollees per quarter remained very low (ranging from three to eight) (data not shown).

As shown in ***Figure 4-3,*** the average number of MMP-reported appeals per 10,000 enrollee months per quarter varied from 10 to 26 from 2018 through 2021.

[25] 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.

[26] The threshold for the amount in controversy (AIC) for judicial review can change each year and is based on the percentage increase over the initial threshold amount of $1,000 established in 2003. In 2023, the AIC threshold was $1,850, an 85% increase over the 2003 amount.

Figure 4-3
New York FIDA-IDD average number of MMP-reported appeals per 10,000 enrollee months per quarter, 2018–2021



MMP = Medicare-Medicaid Plan.

SECTION 5

Demonstration Impact on Cost Savings

The demonstration had no impact on Medicare expenditures over the first 4 demonstration years, relative to the comparison group.

The demonstration had no impact on total Medicaid expenditures over the first 4 demonstration years, relative to the comparison group, although large risk corridor payments were not incorporated into the Medicaid analysis.

5.1 Methods Overview

As part of the capitated financial alignment model, New York, CMS, and MMPs entered into a three-way contract to provide services to MMP enrollees. MMPs receive three separate risk-adjusted prospective capitated payments. The first two payments are from the Medicare program for Medicare Parts A and B, and Medicare Part D, and the third comes from the State for Medicaid services. To develop the Medicare Parts A and B capitated rate, CMS combined the Medicare FFS standardized county rates and the Medicare Advantage projected payment rates. Each component contributed to the final rate proportionally to the target population that would be enrolled in each program absent the demonstration.[27] CMS 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 FAI website.[28]

This section presents the Medicare Parts A and B and Medicaid cost savings analyses for demonstration years 1 to 4 (April 2016 to December 2020). 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 only approximately 8 percent of all eligible beneficiaries (including FFS beneficiaries, MMP enrollees, and MA enrollees) in demonstration year 4.[29] The remaining 92 percent of those in the demonstration group are beneficiaries who are eligible for the MMP but not enrolled (non-enrollees). Descriptive results for the entire eligible population are provided in ***Appendix D*** (see ***Tables D-4 to D-11***). 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-14***). The results of this analysis of the more restricted definition of MMP enrollees indicated that there was a statistically significant increase in cost for each demonstration year as well as cumulatively over the entire demonstration.

[27] Joint Rate Setting Process for the Financial Alignment Initiative's Capitated Model (cms.gov)
[28] For the MOU, 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 (original), see https://www.cms.gov/files/document/nyfidaiddcontractamendment.pdf.
[29] The enrollment percentages reported in this section may be different than what was reported in ***Section 3.2, Eligibility and Enrollment***, because of the timing for completion and submitting the finder file versus the SDRS.

To evaluate the cost implications of the demonstration, RTI performed a difference-in-differences (DinD) regression analysis of Medicare Parts A and B expenditures that compares demonstration eligible beneficiaries who live in an area where the participating health plan operates—the demonstration group—to those who meet the same eligibility criteria but live outside those operating areas—the comparison group. The comparison group is a population of in-State dually eligible beneficiaries who are also enrolled in a MLTSS program. Propensity weights balance the characteristics of the demonstration group and the comparison group (see ***Appendix C*** for details).

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. Although finalized Medicare risk corridor payments in DY1 were incorporated into the Medicare payments, the finalized Medicaid risk corridor payments were not incorporated into the Medicaid payments.

5.2 Demonstration Impact on Medicare Parts A and B Costs

Table 5-1 shows the magnitude of the DinD estimate of the cumulative demonstration impact on Medicare Parts A and B cost, both in absolute dollar amount and relative to the adjusted mean expenditure level in the comparison group during the demonstration period covered in this report. The adjusted mean for monthly expenditures increased from the predemonstration period to the demonstration period in both the demonstration and comparison groups, though it increased by a larger amount in the demonstration group than in the comparison group.

The cumulative DinD estimate of $11.48 per member per month (PMPM), which amounts to a relative difference of 1.67 percent of the adjusted mean expenditure for the comparison group during the demonstration period, is not statistically significant (p = 0.5409). This suggests that overall, the New York demonstration was not associated with a statistically significant increase or decrease relative to the comparison group.

Table 5-1
Cumulative demonstration impact on monthly Medicare Parts A and B costs in New York, demonstration years 1–4, April 1, 2016–December 31, 2020

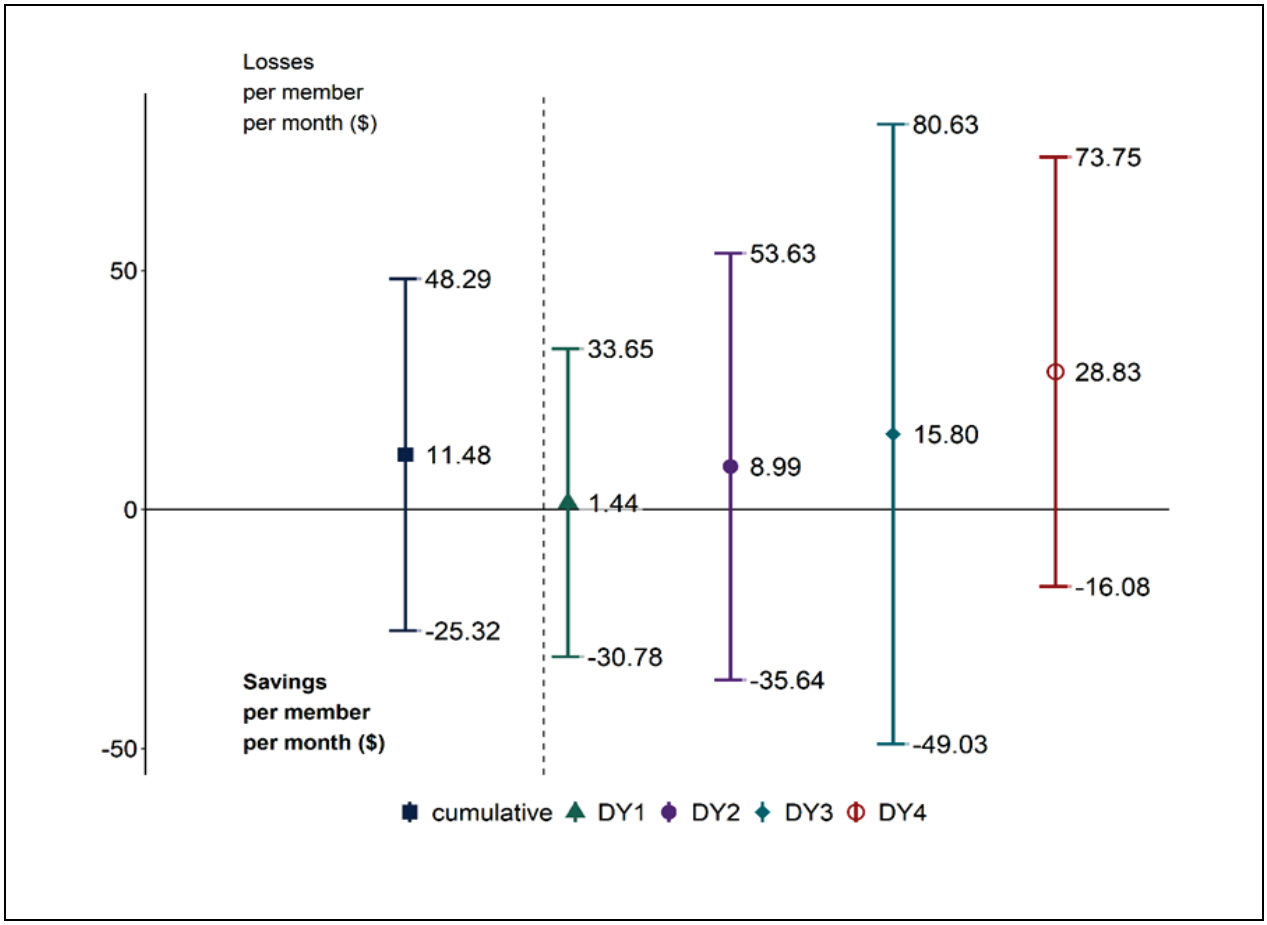
Group	Adjusted mean for predemonstration period ($)	Adjusted mean for demonstration period ($)	Adjusted coefficient DinD ($)	Relative difference (%)	*p*-value
Demonstration	646.65	667.54	11.48	1.67	0.5409
Comparison	677.25	686.07			

DinD = difference-in-differences.
SOURCE: RTI analysis of Medicare claims.

In addition, we estimated the effect of the demonstration in each demonstration year. As shown in ***Figure 5-1***, the demonstration had no statistically significant effect on Medicare costs

in demonstration years 1 through 4 (as shown by the confidence intervals crossing $0). Note that these estimates are based on the ITT analytic framework, only account for Medicare Parts A and B cost, and use the capitation rate for the MMP rather than the actual amount the plan paid for services.

Figure 5-1
Cumulative and annual demonstration effects on monthly Medicare Parts A and B costs in New York, demonstration years 1–4, April 1, 2016–December 31, 2020



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.

Relative to the analysis presented in the Combined First and Second New York Evaluation Report, the results in this report are slightly different. The analysis in the current report included beneficiaries with hospice and nursing home use in the demonstration and comparison groups, conditional on having at least one quarter of demonstration eligibility without those services. We applied a similar criterion to the demonstration group during the

demonstration period, but further refined the sample to only include observations identified by the state as eligible for the demonstration during the demonstration period.[30]

As a result of these refinements, beneficiary months included in this report were less expensive in the demonstration group during the demonstration period, compared to those observed previously. Thus, the relative increase in spending from the predemonstration to the demonstration period among those in the demonstration group was less steep on average than the increase observed in the Combined First and Second New York Evaluation Report. Specifically, the estimated difference-in-difference impact decreased from a statistically significant increase of $34.53 PMPM across demonstration years 1 and 2 (in the prior report) to an insignificant impact of $11.48 PMPM across demonstration years 1 through 4 (in ***Figure 5-1***).

To better understand these results, we conducted additional descriptive analyses. The details of these analyses are provided in ***Appendix E*** along with an interpretation and discussion of the results. In the first analysis we compared MMP rates with the expected FFS expenditures that would have otherwise occurred for the enrolled population, in demonstration years 1 and 4. The extent to which the MMP capitated payment rates are set higher or lower relative to what CMS would have paid under traditional FFS Medicare could affect the impact estimates.

Overall, we found that MMP rates are lower than enrollees' anticipated FFS experience in both demonstration year 1 and demonstration year 4 (see ***Tables E-2*** and ***E-3*** in ***Appendix E***). We also conducted an analysis of spending and hierarchical condition category (HCC) characteristics among the enrolled population during the predemonstration period. We found that enrollees had higher costs and were less healthy during the predemonstration period than the demonstration eligible but never enrolled population (see ***Figures E-1*** and ***E-2*** in ***Appendix E***). Both the MMP rates and the fact that the demonstration was attractive to a sicker population would indicate potential for savings. However, the large eligible but not enrolled population likely drives the Medicare cost savings estimates, given that only 8 percent of the demonstration group is actually enrolled.

5.3 Demonstration Impact on Medicaid Costs

Table 5-2 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. The comparison group is a population of in-state dually eligible beneficiaries who are also enrolled in a MLTSS program. Propensity weights balance the characteristics of the demonstration group and the comparison group (see ***Appendix D***).

The adjusted mean monthly expenditures declined from the predemonstration period to the demonstration period in both the demonstration group and the comparison group, with a

[30] The application of State-defined eligibility criteria for the demonstration group in the demonstration period derived from the State-provided finder file (see ***Appendix D)*** may introduce positive bias as it relates to the hospice eligibility criteria. Appling the State-defined eligibility criteria removes a greater percent of hospice users in the demonstration group in the demonstration period than during the predemonstration period. Thus, the beneficiary months included in this analysis are less expensive in the demonstration group during the demonstration period than in the predemonstration period.

larger decrease in the demonstration group. The cumulative DinD estimate is -$79.85 PMPM, which amounts to a relative difference of -1.01 percent, which is not statistically significant (p=0.8459). 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.

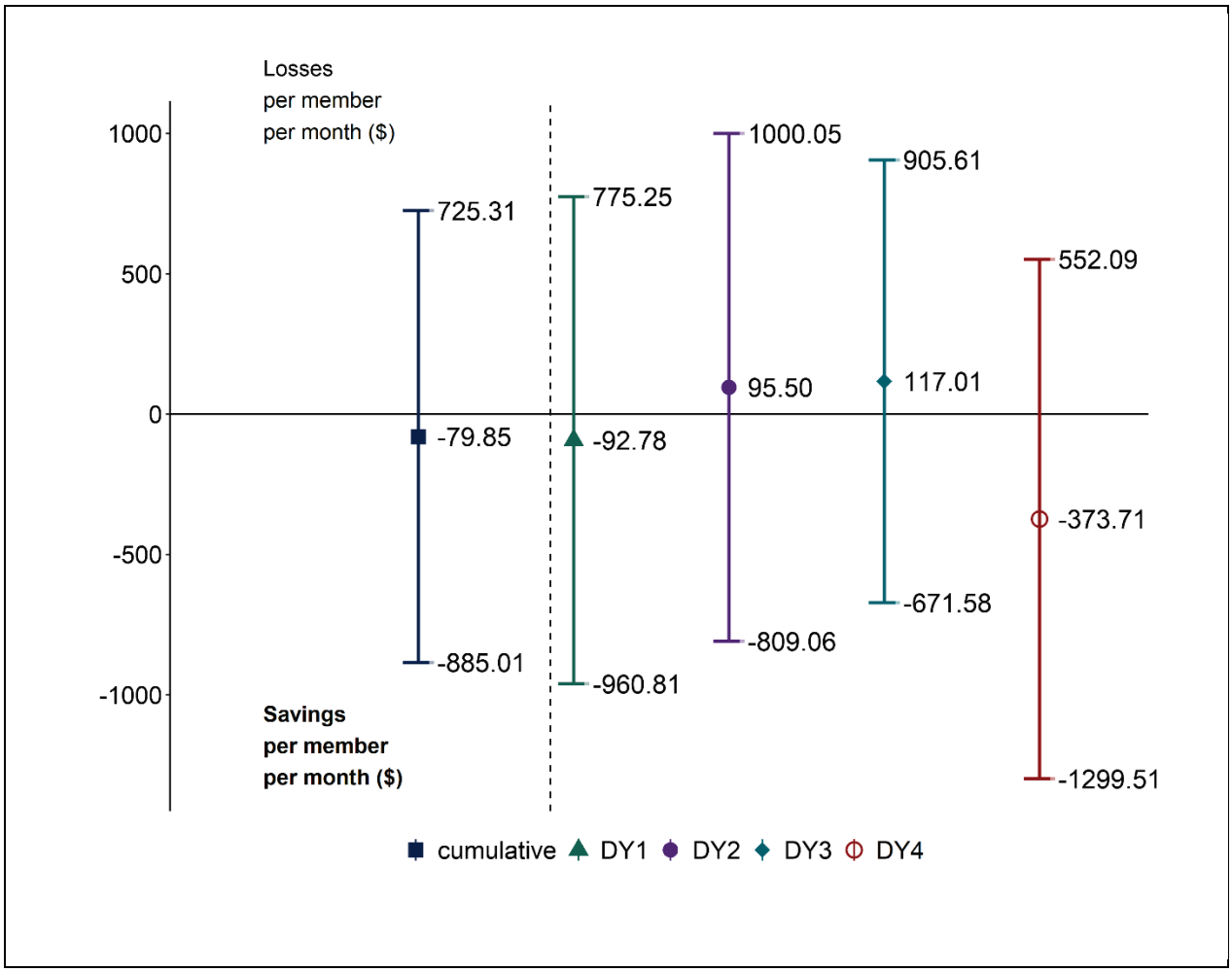
Table 5-2
Cumulative demonstration effect on Medicaid costs for eligible beneficiaries in New York, demonstration years 1–4, April 1, 2016–December 31, 2020

Group	Adjusted mean for predemonstration period ($)	Adjusted mean for demonstration period ($)	Adjusted coefficient DinD ($)	Relative difference (%)	*p*-value
Demonstration	8,997.34	8,756.37	−79.85	−1.01%	0.8459
Comparison	8,075.96	7,928.71			

DinD = difference-in-differences.
SOURCE: RTI analysis of Medicaid claims.

In addition, we estimated the effect of the demonstration in each of the 4 demonstration years included. As shown in ***Figure 5-2***, the demonstration had no statistically significant effect in any demonstration year (as shown by the confidence intervals spanning $0). There was no increase or decrease in Medicaid costs associated with the demonstration relative to the comparison group in any of those years. Note that these estimates are based on the ITT analytic framework, exclude Medicaid prescription drug costs, and are reliant upon the completeness and the correctness of the Medicaid cost data included in the T-MSIS. In addition, large risk corridor payments from the State to the MMP are not incorporated into this analysis of Medicaid costs, which would reduce any savings estimated (see ***Section D.6, Medicaid Regression Results*** in ***Appendix D*** for additional details).

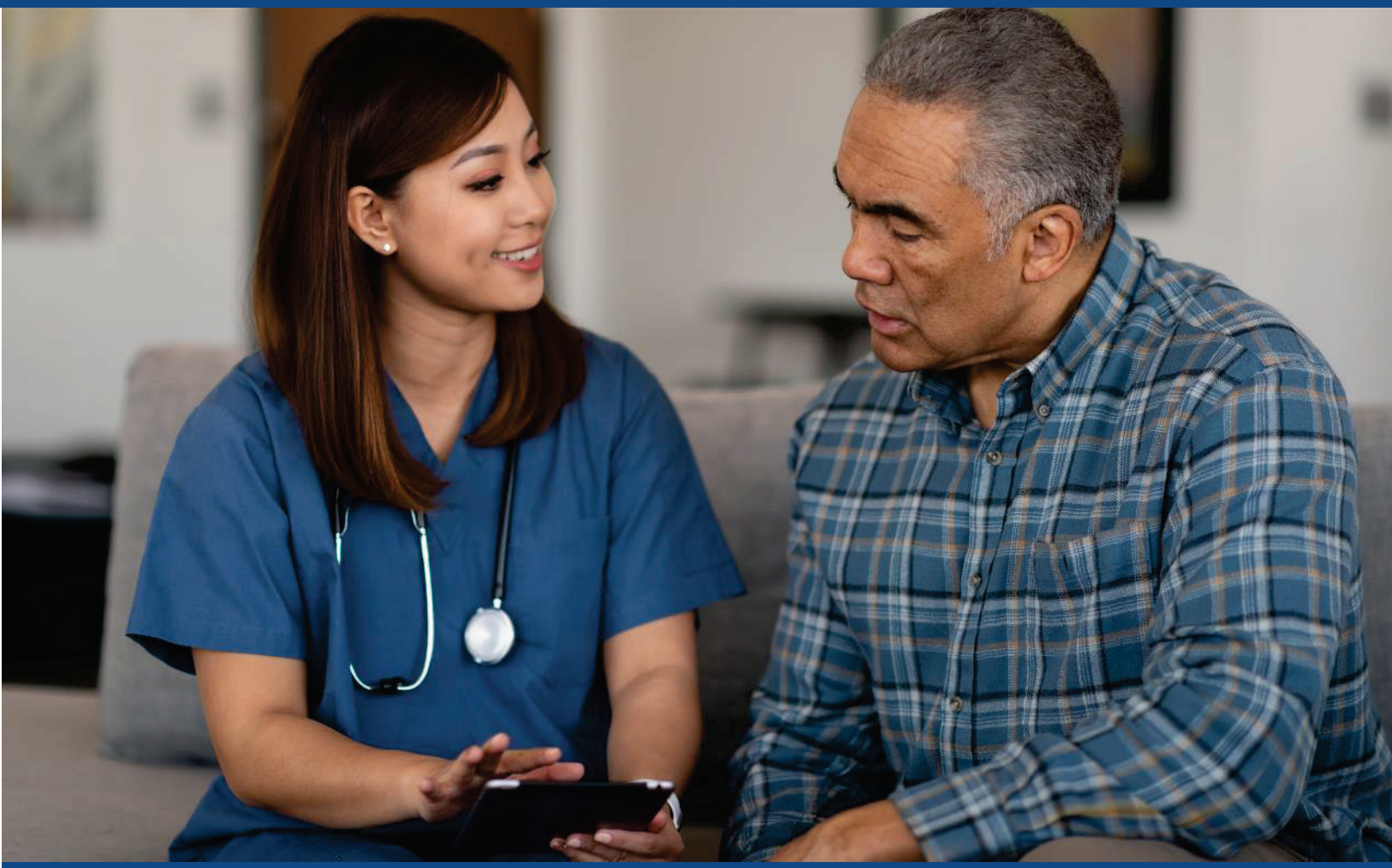
Figure 5-2
Cumulative and annual demonstration effects on monthly Medicaid costs for eligible beneficiaries in New York, demonstration years 1–4, April 1, 2016–December 31, 2020



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.

SECTION 6

Conclusions



6.1 Implementation Successes, Challenges, and Lessons Learned

The FIDA-IDD demonstration was implemented with good fidelity to the model. Throughout the demonstration, the State, CMS, plan, ombudsman program, and beneficiary advocates supported the integration of Medicare and Medicaid as a model of care particularly beneficial to the IDD population. The State viewed coordinating developmental services—including residential care—with primary, acute, and behavioral health care as a way to improve the enrollee experience in accessing care, deliver person-centered care, promote independence in the community, and improve service quality. During the reporting period, the State and CMS extended the demonstration through December 31, 2023,[31] and continued to support the demonstration's care management model. At the time of this report, the State was working with CMS on a potential integrated D-SNP model for the eligible population.

The demonstration achieved an effective "dose" of care coordination, with nearly all enrollees experiencing the assessment and care planning process. Although some enrollees and family members continued to arrange for their own services, the MMP's care management strategy helped enrollees identify and achieve goals. The plan used its experience with care coordination and telehealth to respond quickly to the PHE, and the State noted that the plan was able to achieve faster uptakes in vaccinations than outside the demonstration.

The State and CMS thought PHP's implementation of the care model, with the IAM assessment tool and team of a care manager and service coordinator, was very successful in identifying and responding to enrollee's service needs and goals. The State, CMS, and advocates viewed the plan's dedication to the IDD population as key to its ability to meet the needs of enrollees.

Although enrollment was much lower than expected or desired, enrollees tended to remain in the demonstration, and the MMP, State, and CMS viewed this as a signal of enrollee satisfaction. Most enrollees and their families who were interviewed for the evaluation described high levels of satisfaction, especially with care coordination, the speed and efficiency of obtaining durable medical equipment, and feeling as if their care coordinators genuinely cared for them.

State officials had been surprised by how many aging parents attended marketing events to enroll their adult children. The FIDA-IDD demonstration appeared to provide these older family caregivers with peace of mind that a dedicated team would help organize, arrange, and monitor all aspects of their adult children or siblings' needs for health and behavioral services, LTSS including developmental services, and social opportunities that encouraged inclusion in the community. The integrated model of care may have been particularly attractive to older adults without other family members able to take over care coordination tasks.

Despite the strength of the care model as implemented by PHP, support from the State, CMS, and other stakeholders, and high enrollee satisfaction, the demonstration had poor implementation effectiveness in that it failed to reach most of the eligible beneficiaries for which it was designed, primarily due to the lack of participating providers. The eligible population

[31] As of September 2023, the New York FIDA-IDD demonstration has been extended through December 31, 2024.

required an extensive network to meet their needs for highly specialized care, and the State acknowledged that a plan would have difficulty bringing in a large hospital system unless the plan negotiated a reimbursement rate favorable to it. A large plan with tens of thousands of enrollees might be able to negotiate such a rate and be financially viable, but a small plan with fewer than 2,000 enrollees likely could not. Without a deep network of specialty providers as well as generalists, dentists, and others with ability to serve individuals who may have significant communication and behavioral challenges, drawing more beneficiaries into the demonstration was not feasible.

The low enrollment challenged PHP's ability to spread administrative costs and offset higher-cost enrollees with enrollees with less intense service needs. Opt-in only enrollment also challenged the plan's ability to make changes to enrollees' service plans—if they did not agree with a change, they could always go back to FFS. The MMP was put in the position of learning about enrollee needs, preferences, and goals, developing a person-centered plan of care to meet those needs, and not having the ability to implement a plan of care that would be perceived as a service limit or reduction.

In reflecting on whether the demonstration has been successful overall, OPWDD acknowledged that it was very difficult to establish an all-voluntary plan for a population historically resistant to managed care. When asked if passive enrollment could ever be an option for this population, neither the State nor CMS thought it would be viable. CMS noted that unlike other FAI demonstrations, the beneficiaries eligible for FIDA-IDD have such widely varied functional and communication levels and strong connections to multiple providers that large-scale passive enrollment would be difficult; it could lead to unintended breaks in service if enrollees' providers were not in the plan's network. Despite these challenges, enrollees benefited from the care coordination that they received through the demonstration.

In addition to low enrollment, an older, frailer than expected enrollee base, a higher proportion of enrollees living in residential settings than anticipated, and the MMP's limited ability to use utilization management techniques to achieve cost savings, the plan's ongoing significant financial shortfall on the Medicaid side was also impacted by capitation rates that did not reflect the experience of the plan. CMS and State officials acknowledged shortcomings in the Medicaid rate setting process developed for the demonstration and suggested adjustments or additional rate cells for special populations might have mitigated some of the financial strain experienced by the plan. Ultimately, implementing a managed care model which required a FFS rate parity for providers presented fiscal challenges, and the State and CMS, although still supportive of the care model and of PHP as a partner, did not see how the demonstration, as designed, could be sustainable without significant changes to rate development.

6.2 Demonstration Impact on Medicare and Medicaid Costs

The cumulative cost analysis found no statistically significant impact on the Medicare program over the first 4 demonstration years evaluated. The analysis of individual demonstration years also found no statistically significant impact on the Medicare program during any of the 4 demonstration years. The cost analyses consider the costs of Medicare Parts A and B through FFS expenditures, and capitation rates paid to MMP plans 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 linked to actual service utilization.

Similarly, the cumulative cost analysis found no statistically significant impact on the Medicaid program over the 4 demonstration years, or on any of the individual demonstration years. However, the Medicaid cost analysis focused on Medicaid expenditures reported in the T-MSIS data. Medicaid risk corridor payments, which were not reported in the T-MSIS data and not included in our analyses, were large (see ***Table 3-7*** in ***Section 3, Update on Demonstration Implementation***). With no cost savings and substantial Medicaid risk corridor payments from the State to the MMP, it is likely the demonstration resulted in losses to the Medicaid program.

An assumption as part of the ITT study design is that enrollment in the demonstration will be large enough to statistically observe a change in the monthly average PMPM, relative to the comparison group. In New York FIDA-IDD, enrollment was only approximately 8 percent of the eligible demonstration population. Although the Medicare capitated rates seem to have been set lower than what a risk standardized FFS rate would be (see ***Table E–1*** in ***Appendix E***), the spending experience of the eligible but not enrolled population may have obscured any relative changes in spending among the enrolled population. Moreover, ***Figures E–1*** through ***E–3*** in ***Appendix E*** show that demonstration enrollees were more expensive, sicker, and had higher mortality, relative the eligible non-enrolled group, which resulted in higher monthly spending for the enrolled population from the predemonstration to the demonstration periods (see ***Figure E–1*** in ***Appendix E***). Both the MMP rates and the fact that the demonstration was attractive to a sicker population would indicate potential for savings. However, the large eligible but not enrolled population drives the Medicare cost savings estimates, given that less than 10 percent of the demonstration group is actually enrolled.

Although we did not conduct an assessment of the Medicaid MMP rates, the large Medicaid risk corridor payments from the State to the MMP suggest that either the Medicaid rates were set too low given the composition of the enrolled population (more frail than originally anticipated), or the MMP was not successful in achieving cost efficiencies or a combination of both.

6.3 Summary

New York FIDA-IDD was launched in 2016 in nine downstate counties and was implemented with a high degree of fidelity to the model design. It was the first comprehensive managed care demonstration exclusively serving individuals with IDD in the nation. A single MMP provided enrollees with access to an integrated package of Medicare and Medicaid covered benefits coordinated by a two-person care team. By coordinating enrollees' developmental services, including residential services, with their primary, acute, and behavioral care, the State sought to provide person-centered care that improved enrollee access to care, promoted independence, and improved quality of services for a population that historically had been excluded from Medicaid managed care. Enrollment in FIDA-IDD was on an opt-in basis throughout the demonstration.

The MMP was founded by a consortium of developmental services providers, and this background bolstered its ability to serve FIDA-IDD enrollees, many of whom had complex

medical and behavioral conditions. The MMP's comprehensive assessment tool elicited detailed information about enrollee care goals and preferences as well as quality of life goals such as learning to dance or attending baseball games. Enrollees generally remained in the demonstration and reported a high level of satisfaction with care coordination and the ease and speed of obtaining durable medical equipment. However, most eligible beneficiaries chose not to enroll in the FIDA-IDD, primarily due to the lack of a large health system's participation. Eligible beneficiaries had long-standing relationships with multiple specialty providers affiliated with the large health system and were reluctant to change providers to enroll in the demonstration.

Over the course of the demonstration, the MMP was able to coordinate developmental services with primary and acute care using telehealth strategies. In 2018, to reduce unnecessary trips to the emergency department which, for the IDD population, can be extremely disruptive and lead to poor outcomes, residential service providers were provided kiosks in their residences to measure blood pressure, pulse oximetry, and temperature of enrollees. A team of IDD-trained emergency medicine physicians could access this information as well as an 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 emergency department to alert them and follow up if an admission was warranted. The MMP leveraged its experience with telehealth during the PHE and was able to continue to provide care coordination virtually to enrollees, leading to a higher uptake in vaccinations among enrollees than those outside the demonstration.

The low enrollment rate, and enrollment of a frailer than expected population, led to financial challenges for the MMP. The plan was unable to spread start-up and administrative costs over a broad enrollment base, and expenditures for personal care and ICF-IID services outstripped the Medicaid capitation rate paid to the plan. Because enrollment was on an opt-in basis, the plan was limited in how it could use utilization management strategies to rein in costs as enrollees could disenroll if they disagreed with the MMP's service plan. Delayed payment of substantial risk corridor payments from the State also impacted the plan's financial health and its ability to meet contractually required reserves.

The demonstration had no impact on Medicare or Medicaid expenditures over the first 4 demonstration years. Factors other than demonstration effectiveness, such as the large eligible but not enrolled population (about 92 percent), may have contributed to this cost finding.

NYSDOH and OPWDD are developing a plan for the IDD population after the demonstration ends and are working with CMS to consider the viability of a FIDE-SNP model. FIDA-IDD demonstrated the importance of having a broad network of major health system providers to serve the IDD population. Without their participation, a FIDE-SNP may experience similar low enrollment as in the demonstration.

References

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 February 24, 2023.

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 February 24, 2023.

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 effective August 1, 2020. https://www.cms.gov/files/document/nyfidaiddcontractamendment.pdf. As obtained on February 24, 2023.

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 February 24, 2023.

Centers for Medicare & Medicaid Services (CMS) and the State of New York (NYS): FIDAIDD 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 February 24, 2023.

Centers for Medicare & Medicaid Services (CMS): New York FIDA-IDD Medicare-Medicaid Plan Quality Withhold Analysis Results Demonstration Year 4 (Calendar Year 2020). n.d.-a. https://www.cms.gov/files/document/qualitywithholdresultsreportnyfidaidddy4.pdf. As obtained February 23, 2023.

Centers for Medicare & Medicaid Services (CMS): IDD DY1-3 Risk Corridor Payment Summary. n.d.-b. As obtained October 3, 2022, from Susannah Woodman at CMS/CMMI.

Centers for Medicare & Medicaid Services (CMS): New York FIDA-IDD Medicare-Medicaid Plan Quality Withhold Analysis Results Demonstration Year 5 (Calendar Year 2021). n.d.-c. https://www.cms.gov/files/document/qualitywithholdresultsreportnyfidaidddy4.pdf. As obtained April 13, 2023.

New York State Office for People with Developmental Disabilities (OPWDD) 2022: 2023-2027 Strategic Plan. https://opwdd.ny.gov/statewide-comprehensive-507-plan. As obtained February 24, 2023.

Appendix A

Data Sources

We used the following data sources to prepare this report.

Key informant interviews. The RTI evaluation team conducted virtual site visits in New York in 2021 and 2022. The team interviewed the following individuals: Medicare-Medicaid plan (MMP), State, and CMS officials; the ombudsman program; and beneficiary advocates. To monitor demonstration progress, the RTI evaluation team engaged 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 included discussions about new policy clarifications designed to improve plan performance, quality improvement workgroup activities, and CMT actions.

Beneficiary interviews. RTI conducted 15 individual interviews with beneficiaries enrolled in the Fully Integrated Duals Advantage Demonstration for Individuals with Intellectual and Developmental Disabilities (FIDA-IDD) in New York or their family members. We interviewed four beneficiaries and 11 family members. The interviews took place between October 2023 and November 2022. All of the interviews were conducted in English.

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 FIDA-IDD demonstration was too low in 2016 through 2018 to conduct the CAHPS survey. In 2019 and 2021, the survey was conducted, but there were not sufficient data for the survey measures that the RTI evaluation team typically includes in the evaluation reports. In response to the COVID-19 public health emergency, CMS did not require MA plans (including MMPs) to collect CAHPS data for 2020. The CMT has access to all of the CAHPS data for 2019 and 2021 and uses those results for quality improvement processes.

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 Medicare-Medicaid Plans and submitted to CMS' implementation contractor, NORC.[32,33] Data reported to NORC include core quality measures that all Medicare-Medicaid Plans are required to report, as well as State-specific measures that New York FIDA-IDD plans are required to report. Due to reporting inconsistencies, plans occasionally resubmit data for prior demonstration years; therefore, the data included in this report are considered preliminary.

Demonstration policies, contracts, and other materials. The RTI evaluation team reviewed a wide range of demonstration documents, including demonstration and State-specific

[32] Data are reported for 2014–2021.

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

information on the CMS website;[34] and other publicly available materials on the New York OPWDD[35] and NYSDOH websites.[36]

Complaints and appeals data. Complaint (also referred to as grievance) data are from three separate sources: (1) complaints from beneficiaries reported by MMPs to NYSDOH, and reported separately to CMS' implementation contractor, NORC[37], through Core Measure 4.2; (2) complaints received by NYSDOH or 1-800-Medicare and entered into the CMS electronic Complaint Tracking Module; and (3) qualitative data obtained by RTI on complaints. Appeals data are generated by MMPs and reported to NYSDOH and NORC, for Core Measure 4.2, and to the Medicare Independent Review Entity. This report also includes critical incidents and abuse data reported by Partners Health Plan (PHP) to NYSDOH and NORC.

HEDIS measures. For the Financial Alignment Initiative (FAI) evaluation, we report on a subset of Medicare Healthcare Effectiveness Data and Information Set (HEDIS) measures, a standard measurement set used extensively by managed care plans, that are required of all MA plans.

Medicare and Medicaid cost 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 the MMP during the demonstration period were obtained for all demonstration enrollees from 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 2022). RTI applied quality withholds to the capitation payments (quality withholds are not reflected in the MARx data), as well as quality withhold repayments and risk corridor payments or recoupments based on data provided by CMS. Capitation payments and FFS Medicare claims were used to calculate expenditures for all comparison group beneficiaries, demonstration beneficiaries in the predemonstration period, and demonstration eligible beneficiaries who were not enrolled during the demonstration period. FFS claims included all Medicare Parts A and B services. For a comprehensive list of adjustments please refer to ***Table D-1*** in ***Appendix D***.

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 years 2014–2015 (which includes the predemonstration period and the first 9 months of the first demonstration period) was the Medicaid Statistical Information Statistics (MSIS) Medicaid Analytic eXtract (MAX). The source for the Medicaid claims data for calendar years 2016–2019 (which includes the remainder of the demonstration period) was the Transformed Medicaid Statistical Information System (T-MSIS) Analytic Files (TAF).

[34] https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsinCareCoordination.html
[35] https://opwdd.ny.gov/
[36] https://www.health.ny.gov/
[37] The technical specifications for reporting requirements are in the Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements document.

Appendix B

New York FIDA-IDD MMP Performance on Select HEDIS Quality Measures for 2017–2021

Table B-1 provides 2017 through 2021 HEDIS performance data for the New York FIDA-IDD MMP. Using correlation coefficients that were 0.9 and above, or −0.9 and below, we have applied green and red shading to indicate where MMP performance over time for a given measure was steadily improving or worsening; green indicates a favorable trend, and red indicates an unfavorable one. We did not perform any testing for statistical significance for differences across years because of the limited data available. For measures without green or red shading, year-over-year MMP performance remained relatively stable between 2017 and 2021.

Partners Health Plan improved performance over time on measures for colorectal cancer screening, medication review (Care for Older Adults submeasure), maintaining good HbA1c levels (<8.0%) (Comprehensive Diabetes Care submeasure), but worsened performance over time on measures for breast cancer screening and receiving eye exams (retinal) (Comprehensive Diabetes Care submeasure).

Table B-1
New York FIDA-IDD MMP performance on select HEDIS quality measures for 2017–2021[1]

Measure	National MA Plan mean	Partners Health Plan			
	(2021)	(2017)	(2018)	(2020)	(2021)
Adults' access to preventive/ambulatory health services	94.2	99.1	98.3	97.8	98.5
Adult BMI assessment[2]	N/A	N/A	77.1	—	—
Blood pressure control[3]	70.1	49.2	71.2	N/A	78.3
Breast cancer screening	68.3	N/A	76.4 R	67.0 R	65.0 R
Colorectal cancer screening	68.6	N/A	66.1 G	73.8 G	76.5 G
Disease modifying anti-rheumatic drug therapy in rheumatoid arthritis[4]	N/A	N/A	N/A	N/A	—
Follow-up after hospitalization for mental illness (30 days)[5]	48.7	N/A	N/A	N/A	N/A
Antidepressant medication management					
Effective acute phase treatment[6]	79.5	N/A	N/A	N/A	N/A
Effective continuation phase treatment[7]	64.5	N/A	N/A	N/A	N/A
Care for older adults					
Advance care planning	N/A	7.7	6.9	52.0	64.3
Medication review	N/A	51.7 G	64.2 G	87.5 G	93.1 G
Functional status assessment	N/A	14.3	22.6	61.4	51.1
Pain assessment	N/A	46.2	45.9	50.8	57.1
Comprehensive diabetes care					
Received Hemoglobin A1c (HbA1c) testing	93.7	93.1	90.2	90.0	94.7
Poor control of HbA1c level (>9.0%) (higher is worse)	24.1	72.4	46.4	45.7	24.2
Good control of HbA1c level (<8.0%)	66.0	27.6 G	50.0 G	52.4 G	73.4 G
Received eye exam (retinal)	70.7	82.8 R	82.1 R	71.9 R	69.7 R
Received medical attention for nephropathy	94.9	84.5	92.0	88.1	85.3
Blood pressure control (<140/90 mm Hg)	67.4	48.3	67.9	71.9	74.6

(continued)

Table B-1 (continued)
New York FIDA-IDD MMP performance on select HEDIS quality measures for 2017–2021[1]

Measure	National MA Plan mean	Partners Health Plan			
	(2021)	(2017)	(2018)	(2020)	(2021)
Initiation and engagement of alcohol and other drug (AOD) dependence treatment					
Initiation of AOD treatment [8]	33.7	N/A	N/A	N/A	N/A
Engagement of AOD treatment [9]	5.4	N/A	N/A	N/A	N/A
Plan all-cause readmissions (Observed-to-expected ratio[10])					
Age 18-64	1.07	1.86	N/A	1.48	1.68
Age 65+	1.10	N/A	N/A	1.66	1.16
Ambulatory care (per 1,000 members[11])					
Outpatient visits	N/A	20,191.7	21,221.9	—	—
Emergency department visits (higher is worse)	N/A	673.2	763.1	—	—

(continued)

Table B-1 (continued)
New York FIDA-IDD MMP performance on select HEDIS quality measures for 2017–2021[1]

— = not available, where the plan did not provide HEDIS data for this measure; AOD = alcohol and other drug; BMI = body mass index; HEDIS = Healthcare Effectiveness Data and Information Set; MA = Medicare Advantage; MMP = Medicare-Medicaid Plan; N/A = not applicable, where MA plans do not report such data, or where the number of enrollees in the MMP's HEDIS data available for inclusion in the measure was less than 30, and therefore not reported per RTI's decision rule for addressing low sample size.

[1] In response to the COVID-19 Public Health Emergency, CMS did not require Medicare plans (including MMPs) to submit HEDIS data covering the 2019 measurement year. Therefore, we omitted a column for the 2019 measurement year.

[2] Adult BMI assessment was retired from HEDIS in 2020. Therefore, MMPs did not provide HEDIS data for this measure for measurement years 2020 and 2021.

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

[4] Disease modifying anti-rheumatic drug therapy in rheumatoid arthritis measure was retired from HEDIS in 2021. Therefore, MMPs did not provide HEDIS data for this measure for the 2021 measurement year.

[5] NCQA implemented a significant specification change with HEDIS 2017, disallowing same-day follow-up visits. National benchmarks fell from HEDIS 2017 to HEDIS 2018.

[6] Represents the percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks).

[7] Represents the percentage of members who remained on an antidepressant medication for at least 180 days (6 months.

[8] Represents percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis

[9] Represents the percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit

[10] Plan all-cause readmissions are reported as an observed-to-expected ratio. A value below 1.0 is favorable and indicates that MMPs had fewer readmissions than expected for their populations based on case mix.

[11] Measures for Outpatient visits and Emergency department visits (both within Ambulatory Care per 1,000 members) were retired from HEDIS in 2019. Therefore, MMPs did not provide HEDIS data for these measures for measurement years 2020 and 2021.

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

SOURCE: RTI analysis of 2017 through 2021 HEDIS measures.

Appendix C

Comparison Group Methodology for New York FIDA-IDD Demonstration Years 3 & 4

This appendix presents the comparison group selection and assessment results for the New York FIDA-IDD demonstration.

Results for comparison group selection and assessment analyses are prepared for each demonstration year. The evaluation report for the first and second demonstration years and 2 prior predemonstration years of the New York FIDA-IDD demonstration was publicly released in June 2022. This appendix describes the comparison group identification methodology and results in detail for the third and fourth performance years for the New York FIDA-IDD demonstration (January 1, 2019–December 31, 2020) and notes any major changes since the previous evaluation report. Results for the third demonstration year are nearly identical to those for the fourth demonstration year and are omitted to conserve space.

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. Because the FIDA-IDD demonstration largely uses enrollment in the State's OPWDD waiver or in ICF/IID facilities, the comparison group was selected to include participants in the waiver or ICF/IID facilities residing in non-demonstration counties in New York. Thus, the comparison area is drawn from 12 non-rural metropolitan statistical areas (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). These geographic areas have not changed since the Combined First and Second Evaluation Report.

Beneficiaries who are ineligible for the demonstration include those younger than 21, not enrolled in Medicare Part A and Part B, or reside in a Skilled Nursing Facility, Developmental Center, or psychiatric facility, or receive hospice services at the time of enrollment. 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. Finder files provided by the State are used to identify the eligible population for the demonstration group during the demonstration period, to which exclusion criteria are applied in order to ensure comparability with the comparison group and the demonstration group during the predemonstration period.

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*** displays the number and percentage of beneficiaries who were in MA during each predemonstration and demonstration period. The prevalence of beneficiaries ever enrolled in MA ranges from 13.8 to 16.4 percent in the demonstration group, and from 14.5 to 16.9 percent in the comparison group across the study period.

Table C-1
Number and percentage of beneficiaries in the New York FIDA-IDD demonstration and comparison groups enrolled in Medicare Advantage at any point during each period

Group	Pre-demonstration year 1	Pre-demonstration year 2	DY 1	DY 2	DY 3	DY 4
Demonstration						
Initial count of beneficiaries	239,301	255,615	456,725	262,771	267,187	270,479
Count of beneficiaries with Medicare Advantage	32,991	39,265	73,910	43,074	42,562	42,526
Percentage of beneficiaries with Medicare Advantage	13.8%	15.4%	16.2%	16.4%	15.9%	15.7%
Comparison						
Initial count of beneficiaries	231,584	250,715	435,640	241,877	240,120	235,449
Count of beneficiaries with Medicare Advantage	33,587	38,913	73,715	36,741	36,182	34,510
Percentage of beneficiaries with Medicare Advantage	14.5%	15.5%	16.9%	15.2%	15.1%	14.7%

DY= Demonstration Year

Further analytic exclusions were performed in both the comparison and demonstration groups 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 Category (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 (which include both those enrolled in the MMP and those who are eligible but not enrolled) remained stable over the two predemonstration periods and four demonstration periods, ranging between 20,010 and 22,549 beneficiaries per year. The number of beneficiaries in the comparison group ranged between 19,308 and 20,900 during the predemonstration and demonstration years.

C.2 Propensity Score Estimates

RTI's methodology examines initial differences between the demonstration and comparison groups in each analysis period to produce propensity scores, a rating of how likely a beneficiary is to be part of the demonstration group based on certain characteristics. Specifically, 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. Weights are calculated based on these scores and applied to the

data to improve comparability between the two groups. Comparability is evaluated in terms of individual beneficiary characteristics and the overall distributions of PSs.

The logistic regression coefficients and z-values for the covariates included in the propensity model for New York FIDA-IDD demonstration year 4 are shown in ***Table C-2***, and the magnitudes of the group differences for all variables prior to and after PS weighting are shown in ***Table C-3***. The largest relative differences are that demonstration participants were more likely to be Black, less likely to be enrolled in another shared savings demonstration, and tended to live in areas of higher education, a greater percent of married households, greater percent of household members 60 years and older, and closer to a hospital and nursing home than the beneficiaries in the comparison group. These logistic regression findings are very similar to those for demonstration year 3.

C.3 Propensity Score Overlap

The distributions of propensity scores by group for demonstration year 4 are shown in ***Figure C-1*** before and after propensity score weighting. Estimated scores for both the demonstration and comparison group topped out at around 0.99. Unweighted propensity scores for the comparison group (dashed line) are concentrated in the range below 0.10. Inverse probability of treatment weighting pulls the distribution of weighted comparison group propensity scores (dotted line) closer to that of the demonstration group (solid line).

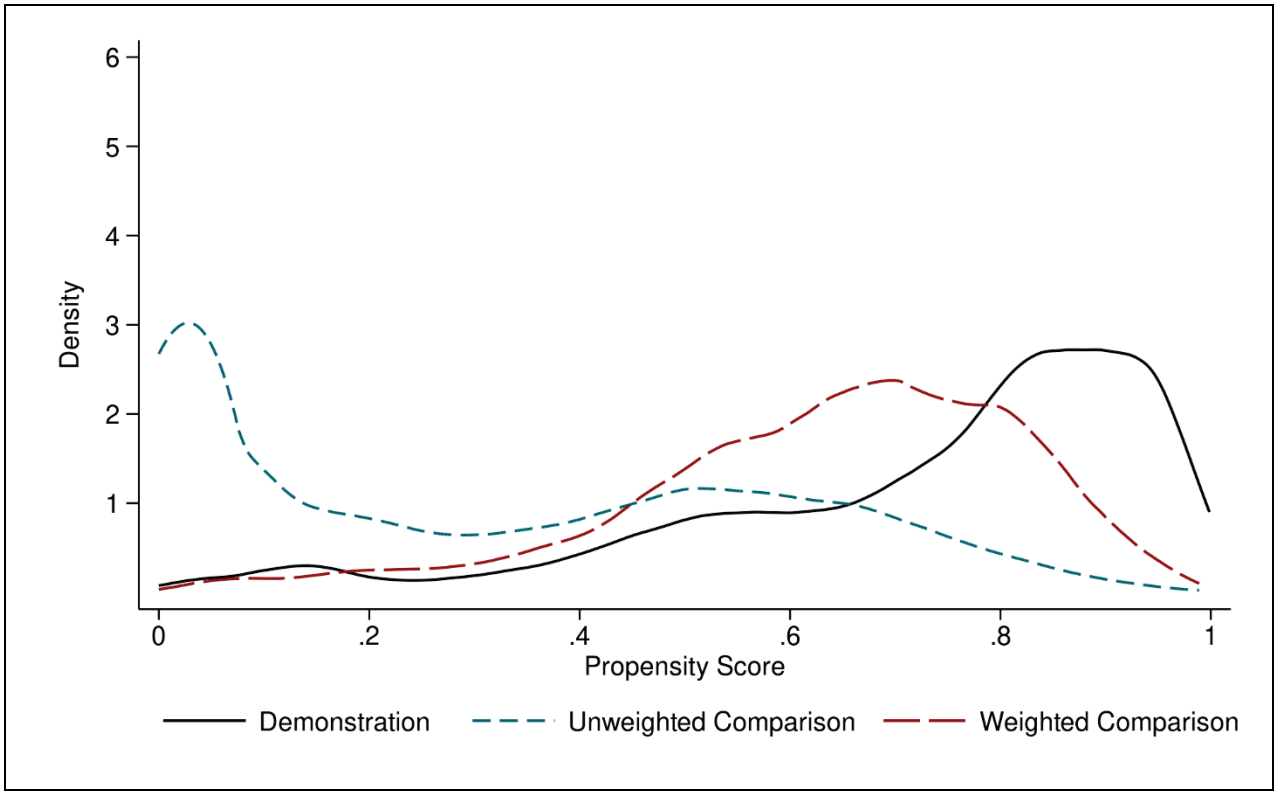
Any beneficiaries who have estimated propensity scores below the smallest estimated value in the demonstration group are removed from the comparison group. This resulted in the removal of only 50 and 24 beneficiaries from the comparison group in demonstration years 3 and 4, respectively.

Table C-2
Logistic regression estimates for New York FIDA-IDD propensity score models in demonstration year 4, January 1, 2020–December 31, 2020

Characteristic	Demonstration Year 4		
	Coef.	Standard error	z-score
Age (years)	−0.0126	0.0010	−12.46
Died during year (0/1)	−1.3956	0.1070	−13.04
Female (0/1)	−0.1210	0.0272	−4.45
Black (0/1)	0.7222	0.0361	20.01
Disability as original reason for entitlement (0/1)	0.0829	0.0516	1.61
ESRD (0/1)	−0.0103	0.2278	−0.05
Share of months eligible during year	−2.7534	0.1333	−20.66
Share of months Medicare Advantage plan enrollment during year	−0.2628	0.0427	−6.16
HCC risk score	0.0037	0.0180	0.21
Other MDM participation (0/1)	−0.2779	0.0276	−10.07
% of pop. living in married household	0.0199	0.0015	13.37
% of households w/member >= 60 yrs.	0.0693	0.0019	35.85
% of adults with college education	0.0337	0.0011	29.58
% of adults with self-care limitation	0.0029	0.0098	0.30
Distance to nearest hospital (mi.)	−0.1816	0.0081	−22.29
Distance to nearest nursing facility (mi.)	−0.7320	0.0154	−47.40
Intercept	0.5463	0.1724	3.17

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

Figure C-1
Distribution of beneficiary-level propensity scores in the New York FIDA-IDD demonstration and comparison groups, weighted and unweighted, January 1, 2020–December 31, 2020



C.4 Group Comparability

Covariate balance refers to the extent to which the characteristics used in the PS are similar (or "balanced") between 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 been developed such that groups are considered comparable if the standardized covariate difference is less than 0.10 standard deviations.

Table C-3
New York FIDA-IDD dually eligible beneficiary covariate means by group before and after weighting by propensity score—demonstration year 4: January 1, 2020–December 31, 2020

Characteristic	Demonstration group mean	Comparison group mean	PS-weighted comparison group mean	Unweighted standardized difference	Weighted standardized difference
Age (years)	47.254	49.950	46.809	0.173	0.029
Died during year (%)	2.603	2.917	2.622	0.019	0.001
Female (%)	39.909	43.317	38.890	0.069	0.021
Black (%)	23.788	10.706	21.688	0.352	0.050
Disability as original reason for entitlement (%)	92.368	89.088	92.927	0.113	0.021
ESRD (%)	0.306	0.293	0.317	0.002	0.002
Share of months eligible during year	0.937	0.976	0.956	0.257	0.110
Share of months Medicare Advantage plan enrollment during year	0.107	0.111	0.110	0.016	0.010
HCC score	0.859	0.885	0.854	0.036	0.006
Other MDM participation (%)	32.884	42.828	40.564	0.206	0.160
% of pop. living in married household	71.265	70.352	71.136	0.066	0.009
% of households w/ member >= 60	42.532	42.418	42.786	0.014	0.029
% of adults with college education	40.710	30.615	38.012	0.618	0.159
% of adults with self-care limitation	2.878	3.105	2.711	0.138	0.112
Distance to nearest hospital (mi.)	2.626	6.482	3.359	1.039	0.374
Distance to nearest nursing facility (mi.)	1.930	4.487	2.411	1.058	0.423

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

The group means and standardized differences for all beneficiary characteristics are shown for demonstration year 4 in ***Table C-3***. The column of unweighted standardized differences indicates that several of these variables were not balanced prior to weighting. Nine variables had unweighted standardized differences exceeding 0.10 in absolute value: age, percent Black, percent with disability as original reason for entitlement, share of months eligible during the year, percent participating in other Medicare shared savings programs (other MDM), percent of adults with a college education, percent of adults with self-care limitation, and the distances (in miles) to the nearest hospital and nursing facility.

The results of PS weighting for New York FIDA-IDD demonstration year 4 are illustrated in the far-right column (weighted standardized differences) in ***Table C-3***. Propensity weighting reduced the standardized differences below the threshold level of 0.10 in absolute value for all but six of the covariates in our model. Four of these covariates have standardized differences below 0.20, while two—distance to the nearest hospital and distance to the nearest nursing facility—have standardized differences closer to 0.40, a value which indicates moderate incomparability. The New York FIDA-IDD demonstration is comprised of counties in and around New York City and finding in-state comparison areas with a similar urban concentration and characteristics is not possible. That said, both demonstration and comparison group eligible beneficiaries are subject to the same State policies and comparing the means of these two covariates among the demonstration group with those among the weighted comparison group shows little substantive difference. That is, a distance of 2.6 miles to the nearest hospital (demonstration group) is likely not meaningfully different than a distance of 3.4 miles (weighted comparison group). Thus, despite the moderately high standardized differences for these two covariates, the samples are relatively well balanced. We found similar results for demonstration year 3.

C.5 Enrollee-only Results

We also applied our weighting methodology to the demonstration's enrollee-only population (approximately 6.7 percent of the eligible demonstration population in demonstration year 4 or roughly 1,500 beneficiaries) to produce weights for use in the impact analyses on cost savings among the demonstration enrollee 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 4-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 4-year demonstration period and the 2-year predemonstration period.

As was the case among all eligible beneficiaries, the unweighted values of several covariates differed substantially between the demonstration and comparison group among enrollees in demonstration year 4. After weighting, the standardized differences of all but five covariates (age, percent of population living in a married household, percent of adults with a college education, distance to nearest hospital, and distance to nearest nursing facility) were reduced to less than 0.10 in absolute value. The differences in means between the demonstration group and weighted comparison group for the remaining five covariates are likely not meaningful for the cost savings analysis presented in this report.

C.6 Summary

The New York FIDA-IDD demonstration and comparison groups were initially distinguished by differences in five individual-level covariates and four area-level variables. However, PS weighting successfully reduced all but six covariate discrepancies to below the generally accepted threshold for standardized differences of 0.10 and all but four to below 0.20. Differences in means for the remaining two covariates with standardized differences greater than 0.20—distances to nearest hospital and nearest nursing facility—are likely not meaningful for

the cost savings analysis. As a result, the weighted New York FIDA-IDD groups are adequately balanced. Further analysis of the enrollee group yielded similar results to the main analysis on the all-eligible population presented in this appendix.

Appendix D

Cost Savings Methodology and Supplemental Tables

D.1 Cost Savings Methodology

To identify the demonstration group, RTI used quarterly files on demonstration eligible beneficiaries submitted by New York. Because FIDA-IDD demonstration eligibility uses enrollment in the State's OPWDD waiver or ICF/IID facilities, comparison group beneficiaries were selected from participants in the waiver or ICF/IID facilities in non-demonstration counties in New York. Selection criteria for both the demonstration and comparison groups are further described in ***Appendix C***. Once both groups were identified, we applied propensity score (PS) weighting in difference-in-differences (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 D-1***. We obtained capitation payments paid to the MMP during the demonstration period, and payments to MA plans in the predemonstration and demonstration periods from the CMS Medicare Advantage and Part D Inquiry System (MARx). Part D payments were not included in this analysis. 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 2022). We also used Medicare FFS claims to calculate expenditures for eligible beneficiaries who were not enrolled in an MMP or MA plan. These FFS claims included all Medicare Parts A and B services.

Table D-1
Data sources for monthly Medicare expenditures

Group	Predemonstration period April 1, 2014–March 31, 2016	Demonstration period April 1, 2016–December 31, 2020
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.

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, 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 demonstrations effect on Medicare expenditures.

D.1.1 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-2*** summarizes each adjustment and the application of the adjustments to FFS expenditures or to the capitation rate.

Table D-2
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, 0.82% for CY 2018, 0.84% for CY 2019, and 0.81% for CY 2020.
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.)	Reduced blended capitation rate to account for bad debt load (historical bad debt baseline percentage). This is 0.97% for CY 2016, 0.81% for CY 2017, 0.82% for CY 2018, 0.84% for CY 2019, and 0.81% for CY 2020. Since there was no bad debt extra load in the MMP rates, no further adjustments were applied.

(continued)

Table D-2 (continued)
Adjustments to Medicare expenditures variable

Data source	Adjustment description	Reason for adjustment	Adjustment detail
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 MMPs, 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, 2% was applied in the second demonstration year, and a 3% quality withhold was applied in the third and fourth demonstration years but was not reflected in the capitation rate used in the analysis.	Final quality withhold repayments for CY 2015, CY 2016, CY 2017, CY 2018, CY 2019, and CY 2020 were incorporated into the dependent variable construction.
Capitation rate (MMP)	Risk Corridor	Risk corridor payment or recoupments are based on reconciliation after application of high-cost risk pool or risk adjustment methodologies.	Final risk corridor payments and recoupments were incorporated into the dependent variable construction for demonstration year 1. Interim risk corridor payments were not incorporated.

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, 0.50 percent for the second demonstration year, and 0.75 percent for the third and fourth demonstration years), but do not reflect the quality withhold amounts.

For the Medicaid analysis, no adjustments were made to the 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 separately for the demonstration group and the comparison group, and within those groups separately for each year.

To prevent introducing bias into the Medicaid cost analysis, we do not apply the final risk corridor payments to the Medicaid cost outcomes calculated from the T-MSIS claims data, although we do discuss these risk corridor payments in a descriptive table (see ***Table 3-7*** in ***Section 3, Update on Demonstration Implementation***). We do not have access to data for the comparison group or for the eligible but not enrolled portion of the demonstration group that would provide similar risk corridor payments or other adjustments not accounted for in the T-MSIS claims.

D.1.2 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:
  - Age
  - Sex
  - Race/ethnicity
  - Enrolled in another Medicare shared saving program
  - End-stage renal disease status
  - Disability as reason for Medicare entitlement
  - MA status
  - Medicare Secondary Payer (MSP)
- Area-level variables included in both the Medicare and Medicaid savings models were:
  - MA penetration rate
  - Medicaid spending per dually eligible beneficiary age 19 or older
  - Proportion of dually eligible beneficiaries using
    - home and community-based services (HCBS) age 65 or older
    - Medicaid managed care age 19 or older
  - Physicians per 1,000 population
  - 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
  - Pandemic vulnerability index (for analyses including 2020 data)
- Demographic variables included only in the Medicaid model were:
  - Medicaid eligibility (medically needy, aged, disabled, and missing)

D.1.3 Populations Analyzed

The population analyzed for the Cost Savings outcome include all demonstration eligible beneficiaries, as well as demonstration enrollees. ***Table D-3*** presents descriptive statistics of select characteristics for four population subgroups in demonstration year 4: all demonstration eligible beneficiaries, the comparison group, all MMP enrollees, and all non-MMP enrollees.

The most prevalent age group among all groups was age 64 and younger (ranging from 76.1 to 86.2 percent). All four groups were predominantly White (ranging from 57.8 to 72.4 percent) with African American being the next highest percentage (ranging from 21.7 to 25.7). Among the comparison population, there was a relatively lower percentage of Hispanics (1.3 percent) relative to the other groups (range 6.7 to 7.3 percent), and of Asians (0.7 percent) relative to other groups (range from 2.0 percent to 2.6 percent).

Across all groups, a larger proportion of beneficiaries were male (58.5 to 61.1 percent), had disability as the primary reason for Medicare entitlement (88.2 to 92.9 percent).

The HCC score is a measure of the predicted relative annual cost of a Medicare beneficiary based on the diagnosis codes present in recent Medicare claims. Beneficiaries with a score of 1 are predicted to have average cost in terms of annual Medicare expenditures. Beneficiaries with HCC scores less than 1 are predicted to have below average costs, whereas those with scores of 2 are predicted to have twice the average annual cost. Average HCC scores ranged between 0.85 and 0.97 among all groups.

Table D-3
Characteristics of eligible beneficiaries in New York in demonstration year 4 by group

Characteristics	Demonstration group	Comparison group	Demonstration group, enrollees	Demonstration group, non-enrollees
Weighted number of eligible beneficiaries	22,549	19,438	1,806	20,743
Demographic characteristics				
Age				
64 and younger	85.2	86.2	76.1	85.9
65 to 74	11.4	9.8	17.1	10.9
75 and older	3.5	4.0	6.8	3.2
Female				
No	60.1	61.1	58.5	60.2
Yes	39.9	38.9	41.5	39.8
Race/ethnicity				
White	57.9	72.4	58.8	57.8
African American	23.8	21.7	25.7	23.6
Hispanic	7.2	1.3	6.7	7.3
Asian	2.5	0.7	2.0	2.6
Other	8.6	4.0	6.8	8.7
Disability as reason for original Medicare entitlement				
No	7.6	7.1	11.8	7.3
Yes	92.4	92.9	88.2	92.7
ESRD status				
No	99.7	99.7	99.9	99.7
Yes	0.3	0.3	0.1	0.3
MSA				
No	0.0	0.0	0.0	0.0
Yes	100.0	100.0	100.0	100.0
Participating in Shared Savings Program				
No	67.1	61.3	99.9	64.3
Yes	32.9	38.7	0.1	35.7
HCC score	0.9	0.9	1.0	0.8

(continued)

Table D-3 (continued)
Characteristics of eligible beneficiaries in New York in demonstration year 4 by group

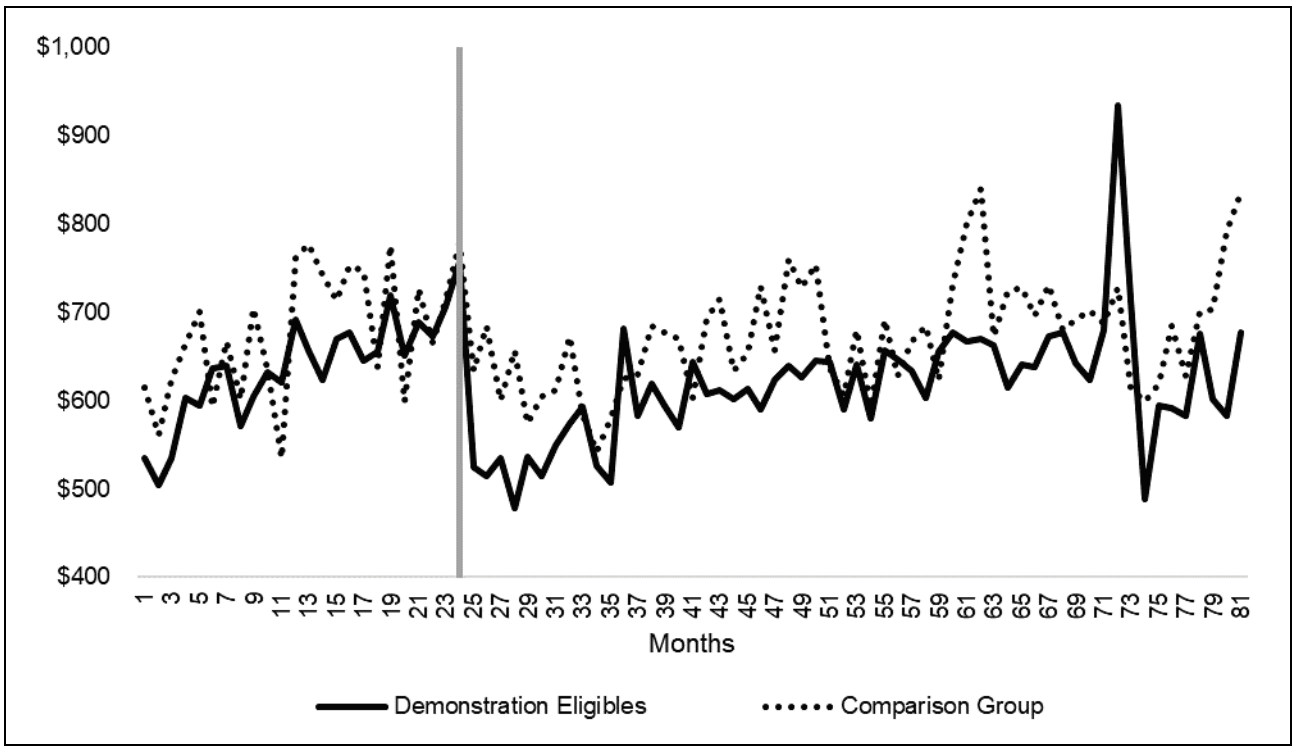
Characteristics	Demonstration group	Comparison group	Demonstration group, enrollees	Demonstration group, non-enrollees
Market characteristics				
Medicare spending per dually eligible beneficiary, ages 19+ ($)	21,784	14,754	21,785	21,784
MA penetration rate	0.3	0.4	0.3	0.3
Medicaid-to-Medicare fee index (FFS)	0.6	0.6	0.6	0.6
Medicaid spending per dually eligible beneficiary, ages 19+ ($)	25,390	23,258	25,391	25,390
Fraction of dually eligible beneficiaries using NF, ages 65+	0.1	0.4	0.1	0.1
Fraction of dually eligible beneficiaries using HCBS, ages 65+	0.0	0.0	0.0	0.0
Fraction of dually eligible beneficiaries using personal care, ages 19+	0.1	0.1	0.1	0.1
Fraction of dually eligible beneficiaries with Medicaid managed care, ages 19+	0.0	0.0	0.0	0.0
Population per square mile, all ages	5,981	829	5,982	5,981
Patient care physicians per 1,000 population	0.9	0.8	0.9	0.9
Area characteristics				
% of pop in Medicare Advantage	10.3	10.6	NA	11.0
% of pop. living in married households	71.3	71.1	72.3	71.2
% of adults with college education	40.7	38.0	47.5	40.1
% of adults with self-care limitations	2.9	2.7	2.7	2.9
% of adults unemployed	5.6	5.2	5.5	5.6
% of household with individuals younger than 18	30.7	24.1	29.3	30.8
% of household with individuals older than 60	42.5	42.8	40.8	42.7
Distance to nearest hospital	2.6	3.7	2.3	2.7
Distance to nearest nursing facility	1.9	2.4	1.8	1.9
Pandemic Vulnerability Index	0.5	0.5	0.5	0.5

ESRD = end-stage renal disease; FFS = fee-for-service; HCBS = home and community-based services; HCC = Hierarchical Condition Category; MA = Medicare Advantage; MSA = metropolitan statistical area, NF = nursing facility.
NOTE: Analysis conducted on demonstration eligible FFS population and Medicare-Medicaid Plan enrollees.
SOURCE: RTI Analysis of New York demonstration eligible and comparison group Medicare data.

D.2 Medicare Descriptive Results

Once we finalized the adjustments to the dependent variable, we tested a key assumption of a 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 parallel trends in the predemonstration period. The steep rise in month 72 is very likely attributed to additional costs associated with the COVID-19 public health emergency.

Figure D-1
Mean monthly Medicare expenditures (weighted), predemonstration and demonstration periods, New York demonstration and comparison group, April 2014–December 2020



SOURCE: RTI Analysis of New York demonstration eligible and comparison group Medicare data.

The DinD values in ***Tables D-4*** through ***D-11*** 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 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 ***Section 5, Demonstration Impact on Cost Savings*** and ***Table D-12*** represent the most accurate adjusted impact on Medicare costs.

Tables D-4 through ***D-7*** 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 years 1 and 2 for the demonstration group, but an increase for the demonstration group in demonstration years 3 and 4. Additionally, the unweighted tables show an increase in Medicare expenditures during demonstration years 1–4 for the comparison group. The weighted tables display a different pattern with the comparison group showing a decrease in demonstration years 1 and 2 and an increase in demonstration years 3 and 4. The weighted demonstration group expenditures show the same pattern, with larger decreases than the comparison group in demonstration years 1 and 2 and smaller increases than the comparison group in demonstration years 3 and 4 (***Tables D-8*** through ***D-11***).

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

Group	Predemonstration period (April 2014–March 2016) (95% confidence intervals)	Demonstration year 1 (April 2016–December 2017) (95% confidence intervals)	Difference (95% confidence intervals)
Demonstration	$638.61 ($569.91, $707.32)	$571.16 ($510.16, $632.16)	−$67.45 (−$109.62, −$25.28)
Comparison	$666.27 ($632.76, $699.79)	$741.18 ($667.03, $815.33)	$74.91 (−$7.36, $157.18)
DinD	N/A	N/A	−$142.36 (−$232.61, −$52.11)

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

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

Group	Predemonstration period (April 2014–March 2016) (95% confidence intervals)	Demonstration year 2 (January 2018–December 2018) (95% confidence intervals)	Difference (95% confidence intervals)
Demonstration	$638.61 ($569.91, $707.32)	$626.28 ($575.48, $677.09)	−$12.33 (−$66.98, $42.32)
Comparison	$666.27 ($632.76, $699.79)	$754.58 ($699.17, $809.98)	$88.30 ($47.55, $129.06)
DinD	N/A	N/A	−$100.63 (−$165.08, −$36.19)

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

Table D-6
Mean monthly Medicare expenditures for New York demonstration group and comparison group, predemonstration period and demonstration year 3, unweighted

Group	Predemonstration period (April 2014–March 2016) (95% confidence intervals)	Demonstration year 3 (January 2019–December 2019) (95% confidence intervals)	Difference (95% confidence intervals)
Demonstration	$638.61 ($569.91, $707.32)	$651.86 ($591.95, $711.78)	$13.25 (−$58.35, $84.85)
Comparison	$666.27 ($632.76, $699.79)	$793.68 ($733.90, $853.45)	$127.41 ($84.17, $170.64)
DinD	N/A	N/A	−$114.16 (−$192.44, −$35.88)

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

Table D-7
Mean monthly Medicare expenditures for New York demonstration group and comparison group, predemonstration period and demonstration year 4, unweighted

Group	Predemonstration period (April 2014–March 2016) (95% confidence intervals)	Demonstration year 4 (January 2020–December 2020) (95% confidence intervals)	Difference (95% confidence intervals)
Demonstration	$638.61 ($569.91, $707.32)	$645.27 ($582.58, $707.95)	$6.65 (−$51.50, $64.81)
Comparison	$666.27 ($632.76, $699.79)	$786.73 ($727.17, $846.29)	$120.46 ($79.02, $161.90)
DinD	N/A	N/A	−$113.81 (−$181.02, −$46.59)

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

Table D-8
Mean monthly Medicare expenditures for New York demonstration group and comparison group, predemonstration period and demonstration year 1, weighted

Group	Predemonstration period (April 2014–March 2016) (95% confidence intervals)	Demonstration year 1 (April 2016–December 2017) (95% confidence intervals)	Difference (95% confidence intervals)
Demonstration	$638.61 ($569.91, $707.32)	$571.16 ($510.16, $632.16)	−$67.45 (−$109.62, −$25.28)
Comparison	$680.43 ($656.65, $704.21)	$634.88 ($589.94, $679.82)	−$45.55 (−$102.54, $11.44)
DinD	N/A	N/A	−$21.90 (−$90.20, $46.39)

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

Table D-9
Mean monthly Medicare expenditures for New York demonstration group and comparison group, predemonstration period and demonstration year 2, weighted

Group	Predemonstration period (April 2014–March 2016) (95% confidence intervals)	Demonstration year 2 (January 2018–December 2018) (95% confidence intervals)	Difference (95% confidence intervals)
Demonstration	$638.61 ($569.91, $707.32)	$626.28 ($575.48, $677.09)	−$12.33 (−$66.98, $42.32)
Comparison	$680.43 ($656.65, $704.21)	$677.15 ($634.81, $719.49)	−$3.28 (−$51.45, $44.89)
DinD	N/A	N/A	−$9.05 (−$78.58, $60.48)

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

Table D-10
Mean monthly Medicare expenditures for New York demonstration group and comparison group, predemonstration period and demonstration year 3, weighted

Group	Predemonstration period (April 2014–March 2016) (95% confidence intervals)	Demonstration year 3 (Jan 2019–December 2019) (95% confidence intervals)	Difference (95% confidence intervals)
Demonstration	$638.61 ($569.91, $707.32)	$651.86 ($591.95, $711.78)	$13.25 (−$58.35, $84.85)
Comparison	$680.43 ($656.65, $704.21)	$716.81 ($641.18, $792.44)	$36.38 (−$48.15, $120.92)
DinD	N/A	N/A	−$23.13 (−$129.38, $83.12)

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

Table D-11
Mean monthly Medicare expenditures for New York demonstration group and comparison group, predemonstration period and demonstration year 4, weighted

Group	Predemonstration period (April 2014–March 2016) (95% confidence intervals)	Demonstration year 4 (January 2020–December 2020) (95% confidence intervals)	Difference (95% confidence intervals)
Demonstration	$638.61 ($569.91, $707.32)	$645.27 ($582.58, $707.95)	$6.65 (−$51.50, $64.81)
Comparison	$680.43 ($656.65, $704.21)	$691.16 ($634.95, $747.36)	$10.73 (−$57.31, $78.76)
DinD	N/A	N/A	−$4.07 (−$89.92, $81.78)

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

D.3 Medicare Regression Results

Table D-12 shows the main results from the Medicare DinD analysis for demonstration years 1–4 and for the entire demonstration period, controlling for beneficiary demographics and market characteristics. Relative to the comparison group, the demonstration was not associated with statistically significant increases in Medicare costs during demonstration years 1 through 4. The cumulative impact estimate over all 4 demonstration years was not statistically significant suggesting that overall, the demonstration was not associated with increases in Medicare costs.

Table D-12
Cumulative and annual demonstration effects on Medicare Parts A and B costs in New York, demonstration years 1–4, April 1, 2016–December 31, 2020

Period	Adjusted coefficient DinD ($)	*p*-value	95% confidence interval ($)	90% confidence interval ($)
Demonstration Year 1 (April 2016–December 2017)	1.44	0.9304	(−30.78, 33.65)	(−25.60, 28.47)
Demonstration Year 2 (January 2018–December 2018)	8.99	0.6929	(−35.64, 53.63)	(−28.47, 46.46)
Demonstration Year 3 (January 2019–December 2019)	15.80	0.6329	(−49.03, 80.63)	(−38.61, 70.21)
Demonstration Year 4 (January 2020–December 2020)	28.83	0.2083	(−16.08, 73.75)	(−8.86, 66.53)
Cumulative (Demonstration Years 1–4, April 2016–December 2020)	11.48	0.5409	(−25.32, 48.29)	(−19.40, 42.37)

DinD = difference-in-differences.
SOURCE: RTI analysis of Medicare claims.

Table D-13 provides an illustrative example of the generalized linear model output for each covariate on mean monthly Medicare expenditures across the entire demonstration period.

Table D-13
Generalized linear model results on monthly Medicare expenditures, New York
(n = 3,197,253 person months)

Independent variables	Coefficient	Standard error	z-value	*p*-value
Demonstration group	−0.0462	0.0346	−1.34	0.181
Post period	0.0129	0.0238	0.54	0.587
Interaction of post period x demonstration group	0.0189	0.0313	0.60	0.546
Age (continuous)	0.0245	0.0018	13.87	0.000
Asian	−0.3030	0.0703	−4.31	0.000
Black	0.0255	0.1097	0.23	0.816
Female	0.0148	0.0436	0.34	0.735
Hispanic	−0.0834	0.0322	−2.59	0.009
Other race/ethnicity	−0.1532	0.0377	−4.07	0.000
Disability as reason for Medicare entitlement	−0.0941	0.0476	−1.98	0.048
End-stage renal disease	2.2802	0.0857	26.61	0.000
Participation in other Shared Savings Program	0.1332	0.0247	5.39	0.000
Medicare Advantage status	0.4010	0.0498	8.05	0.000
Medicare Secondary Payer	−0.5943	0.0865	−6.87	0.000
Patient care physicians per 1,000 population	−0.4579	0.2756	−1.66	0.097
Fraction of duals with Medicaid managed care, ages 19+	4.1334	1.6012	2.58	0.010
Medicare Advantage penetration rate	0.2750	0.1621	1.70	0.090
Medicaid spending per dually eligible beneficiary	0.0000	0.0000	−0.39	0.697
Fraction of duals using HCBS, ages 65+	−0.7634	0.6884	−1.11	0.267
Percent of adults with college education	0.0030	0.0014	2.17	0.030
Percent of adults with self-care limitation	0.0299	0.0115	2.61	0.009
Percent of households with individuals older than 60	−0.0031	0.0019	−1.66	0.098
Percent of households with individuals younger than 18	−0.0021	0.0023	−0.90	0.369
Percent of population married	0.0020	0.0011	1.78	0.074
Percent of adults who are unemployed	−0.0029	0.0042	−0.70	0.485
Distance to nearest hospital	0.0256	0.0135	1.90	0.057
Distance to nearest nursing facility	−0.0090	0.0139	−0.65	0.516
Pandemic Vulnerability Index	0.0355	0.0403	0.88	0.379
Intercept	5.3872	0.2898	18.59	0.000

FFS = fee-for-service; HCBS = home and community-based services.
SOURCE: RTI analysis of Medicare claims.

Table D-14 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, and that separate PS weights were calculated. 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, 2020) 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 indicate statistically significant additional costs associated with enrollees. 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.

Table D-14
Cumulative and annual demonstration effects on Medicare Parts A and B costs among enrolled beneficiaries in New York, demonstration years 1–4, April 1, 2016–December 31, 2020

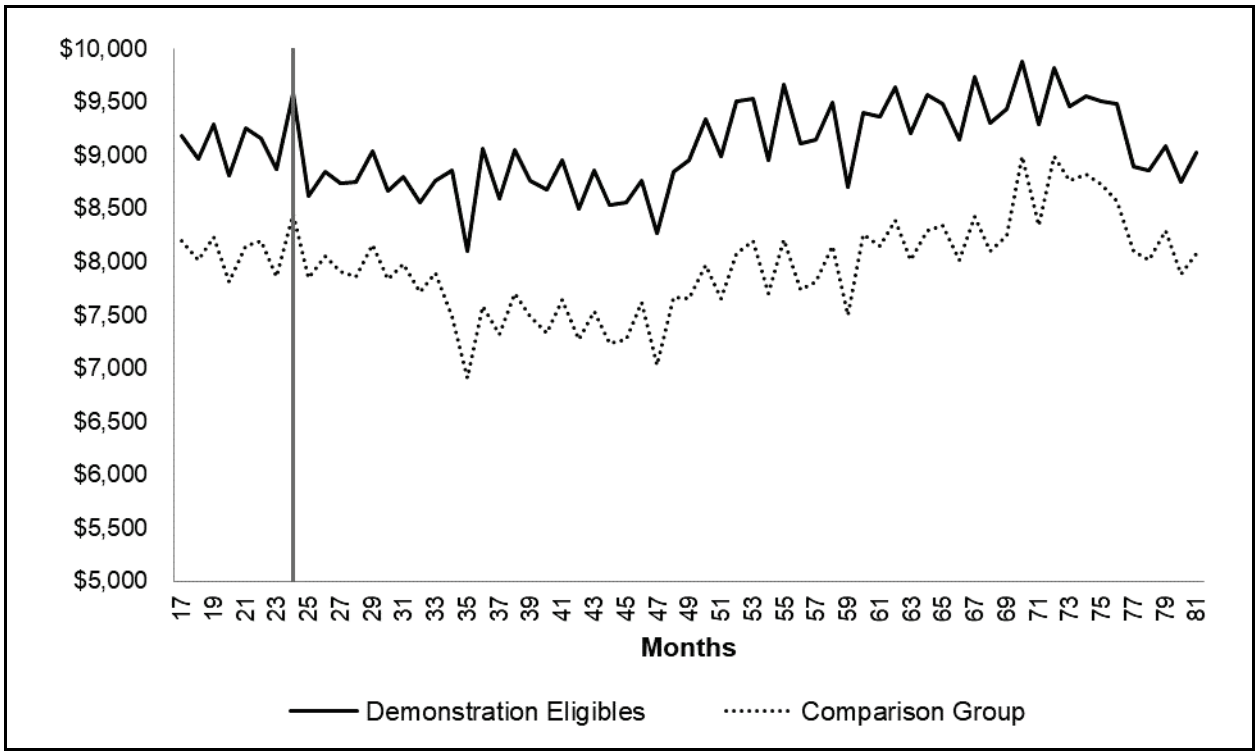
Period	Adjusted coefficient DinD ($)	*p*-value	95% confidence interval ($)	90% confidence interval ($)
Demonstration Year 1 (April 2016–December 2017)	124.08	0.0022	(44.83, 203.33)	(57.57, 190.59)
Demonstration Year 2 (January 2018–December 2018)	221.17	0.0025	(77.85, 364.50)	(100.89, 341.46)
Demonstration Year 3 (January 2019–December 2019)	304.03	0.0003	(139.81, 468.26)	(166.21, 441.85)
Demonstration Year 4 (January 2020–December 2020)	318.44	0.0001	(154.03, 482.85)	(180.46, 456.42)
Cumulative (Demonstration Years 1–4, April 2016–December 2020)	222.90	0.0001	(111.10, 334.71)	(129.08, 316.73)

DinD = difference-in-differences.
SOURCE: RTI analysis of Medicare claims.

D.5 Medicaid Descriptive Results

Using the Medicaid data, we also tested for 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 by year and by demonstration/comparison group status. ***Figure D-2*** shows 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 T-MSIS.

Figure D-2
Mean monthly Medicaid expenditures (weighted), predemonstration and demonstration periods, New York demonstration and comparison groups, August 2015–December 2020



SOURCE: RTI Analysis of New York FIDA-IDD demonstration eligible and comparison group Medicaid data.

The DinD values in ***Tables D-15*** through ***D-22*** represent the overall impact on Medicaid 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 in mean monthly costs between the 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 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 ***Section 5, Demonstration Impact on Cost Savings*** and ***Table D-23*** represent the most accurate adjusted impact on Medicaid costs.

Tables D-15 through ***D-18*** show the mean monthly Medicaid expenditures for the demonstration group and comparison group in the predemonstration and each demonstration period, unweighted. The unweighted tables show that monthly Medicaid expenditures for the demonstration group decreased between the predemonstration period and the first demonstration year, increased in demonstration years 2 relative to the first demonstration year, but still remaining lower than the predemonstration period. Medicaid expenditures in demonstration year

3 were higher than in predemonstration period, then they decreased slightly between demonstration years 3 and 4.

However, in the comparison group, Medicaid expenditures increased in all years. The unweighted DinD estimate is negative and statistically significant in demonstration years 1, 3, and 4. However, this relationship does not continue when the weights are applied to the Medicaid expenditures. The weighted tables display wider confidence intervals which span zero, suggesting that when comparison group characteristics are taken into account, there is no statistically significant relationship between the FIDA-IDD demonstration and Medicaid costs in the demonstration group, relative to the comparison group (***Tables D-19*** through ***D-22***).

Table D-15
Mean monthly Medicaid expenditures for New York demonstration group and comparison group, predemonstration period and demonstration year 1, unweighted

Group	Predemonstration period (August 2015–March 2016) (95% confidence intervals)	Demonstration year 1 (April 2016–December 2017) (95% confidence intervals)	Difference (95% confidence intervals)
Demonstration	$9,141.20 ($8,179.47, $10,102.94)	$8,729.63 ($7,750.79, $9,708.47)	−$411.58 (−$702.69, −$120.47)
Comparison	$8,269.56 ($7,050.70, $9,488.42)	$8,429.44 ($7,055.91, $9,802.98)	$159.88 (−$67.34, $387.10)
DinD	N/A	N/A	−$571.46 (−$918.46, −$224.45)

DinD = difference-in-differences; N/A = not applicable.
SOURCE: RTI analysis of Medicaid claims.

Table D-16
Mean monthly Medicaid expenditures for New York demonstration group and comparison group, predemonstration period and demonstration year 2, unweighted

Group	Predemonstration period (August 2015–March 2016) (95% confidence intervals)	Demonstration year 2 (January 2018–December 2018) (95% confidence intervals)	Difference (95% confidence intervals)
Demonstration	$9,141.20 ($8,179.47, $10,102.94)	$9,089.01 ($8,056.35, $10,121.68)	−$52.19 (−$460.59, $356.21)
Comparison	$8,269.56 ($7,050.70, $9,488.42)	$8,493.53 ($7,362.53, $9,624.54)	$223.97 ($66.69, $381.25)
DinD	N/A	N/A	−$276.16 (−$682.16, $129.83)

DinD = difference-in-differences; N/A = not applicable.
SOURCE: RTI analysis of Medicaid claims.

Table D-17
Mean monthly Medicaid expenditures for New York demonstration group and comparison group, predemonstration period and demonstration year 3, unweighted

Group	Predemonstration period (August 2015–March 2016) (95% confidence intervals)	Demonstration year 3 (January 2019–December 2019) (95% confidence intervals)	Difference (95% confidence intervals)
Demonstration	$9,141.20 ($8,179.47, $10,102.94)	$9,378.01 ($8,056.35, $10,121.68)	$236.81 (−$76.11, $549.73)
Comparison	$8,269.56 ($7,050.70, $9,488.42)	$8,850.01 ($7,585.96, $10,114.05)	$580.44 ($443.99, $716.90)
DinD	N/A	N/A	−$343.63 (−$660.18, −$27.09)

DinD = difference-in-differences; N/A = not applicable.
SOURCE: RTI analysis of Medicaid claims.

Table D-18
Mean monthly Medicaid expenditures for New York demonstration group and comparison group, predemonstration period and demonstration year 4, unweighted

Group	Predemonstration period (August 2015–March 2016) (95% confidence intervals)	Demonstration year 4 (January 2020–December 2020) (95% confidence intervals)	Difference (95% confidence intervals)
Demonstration	$9,141.20 ($8,179.47, $10,102.94)	$9,300.58 ($8,305.57, $10,295.58)	$159.37 (−$105.74, $424.49)
Comparison	$8,269.56 ($7,050.70, $9,488.42)	$9,417.36 ($7,822.37, $11,012.35)	$1,147.80 ($745.43, $1,550.17)
DinD	N/A	N/A	−$988.42 (−$1,454.54, −$522.31)

DinD = difference-in-differences; N/A = not applicable.
SOURCE: RTI analysis of Medicaid claims.

Table D-19
Mean monthly Medicaid expenditures for New York demonstration group and comparison group, predemonstration period and demonstration year 1, weighted

Group	Predemonstration period (August 2015–March 2016) (95% confidence intervals)	Demonstration year 1 (Apr 2016–December 2017) (95% confidence intervals)	Difference (95% confidence intervals)
Demonstration	$9,141.20 ($8,179.47, $10,102.94)	$8,729.63 ($7,750.79, $9,708.47)	−$411.58 (−$702.69, −$120.47)
Comparison	$8,115.21 ($6,757.14, $9,473.28)	$7,614.68 ($6,631.38, $8,597.99)	−$500.53 (−$1,650.84, $649.78)
DinD	N/A	N/A	$88.95 (−$1,085.14, $1,263.04)

DinD = difference-in-differences; N/A = not applicable.
SOURCE: RTI analysis of Medicaid claims.

Table D-20
Mean monthly Medicaid expenditures for New York demonstration group and comparison group, predemonstration period and demonstration year 2, weighted

Group	Predemonstration period (August 2015–March 2016) (95% confidence intervals)	Demonstration year 2 (January2018–December 2018) (95% confidence intervals)	Difference (95% confidence intervals)
Demonstration	$9,141.20 ($8,179.47, $10,102.94)	$9,089.01 ($8,056.35, $10,121.68)	−$52.19 (−$460.59, $356.21)
Comparison	$8,115.21 ($6,757.14, $9,473.28)	$7,783.82 ($6,917.65, $8,649.99)	−$331.39 (−$1,481.63, $818.85)
DinD	N/A	N/A	$279.20 (−$926.86, $1,485.26)

DinD = difference-in-differences; N/A = not applicable.
SOURCE: RTI analysis of Medicaid claims.

Table D-21
Mean monthly Medicaid expenditures for New York demonstration group and comparison group, predemonstration period and demonstration year 3, weighted

Group	Predemonstration period (August 2015–March 2016) (95% confidence intervals)	Demonstration year 3 (January 2019–December 2019) (95% confidence intervals)	Difference (95% confidence intervals)
Demonstration	$9,141.20 ($8,179.47, $10,102.94)	$9,378.01 ($8,407.10, $10,348.93)	$236.81 (−$76.11, $549.73)
Comparison	$8,115.21 ($6,757.14, $9,473.28)	$8,160.01 ($7,224.75, $9,095.27)	$44.80 (−$1,002.73, $1,092.34)
DinD	N/A	N/A	$192.01 (−$883.14, $1,267.15)

DinD = difference-in-differences; N/A = not applicable.
SOURCE: RTI analysis of Medicaid claims.

Table D-22
Mean monthly Medicaid expenditures for New York demonstration group and comparison group, predemonstration period and demonstration year 4, weighted

Group	Predemonstration period (August 2015–March 2016) (95% confidence intervals)	Demonstration year 4 (January 2020–December 2020) (95% confidence intervals)	Difference (95% confidence intervals)
Demonstration	$9,141.20 ($8,179.47, $10,102.94)	$9,300.58 ($8,305.57, $10,295.58)	$159.37 (−$105.74, $424.49)
Comparison	$8,115.21 ($6,757.14, $9,473.28)	$8,466.14 ($7,302.28, $9,630.00)	$350.93 (−$727.98, $1,429.84)
DinD	N/A	N/A	−$191.55 (−$1,286.20, $903.09)

DinD = difference-in-differences; N/A = not applicable.
SOURCE: RTI analysis of Medicaid claims.

D.6 Medicaid Regression Results

Table D-23 shows the Medicaid results from the DinD analysis for demonstration years 1–4 and for the entire demonstration period, controlling for beneficiary demographics and market characteristics.

Table D-23
Cumulative and annual demonstration effects on Medicaid costs in New York, demonstration years 1–4, April 1, 2016–December 31, 2020

Period	Adjusted coefficient DinD ($)	p-value	95% confidence interval ($)	90% confidence interval ($)
Demonstration Year 1 (April 2016–December 2017)	−92.78	0.8341	(−960.81, 775.25)	(−821.26, 635.70)
Demonstration Year 2 (January 2018–December 2018)	95.50	0.8361	(−809.06, 1,000.05)	(−663.63, 854.62)
Demonstration Year 3 (January 2019–December 2019)	117.01	0.7712	(−671.58, 905.61)	(−544.80, 778.83)
Demonstration Year 4 (January 2020–December 2020)	−373.71	0.4289	(−1,299.51, 552.09)	(−1,150.66, 403.25)
Cumulative (Demonstration Years 1–4, April 2016–December 2020)	−79.85	0.8459	(−885.01, 725.31)	(−755.56, 595.86)

DinD = difference-in-differences.
SOURCE: RTI analysis of Medicaid claims.

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. While the difference-in-differences results indicate that the demonstration had no impact on Medicaid expenditures, it is important to note that these results do not account for the risk corridor payments made from the State to the MMP. Risk corridors payments for the MMP are reported for 3 of 4 demonstration years (see ***Table 3-7*** in ***Section 3, Update on Demonstration Implementation***). The risk corridor payments in demonstration year 1 are final, whereas the risk corridor payments in demonstration years 2 and 3 are interim and may increase or decrease before being finalized.

Appendix E

Supplemental Analysis

E.1 Cost Savings Supplemental Analyses

The FAI mandated that certain savings percentages be applied to the MMP capitated rate to ensure that the demonstration would result in a decrease in Medicare spending. However, our findings from an impact analysis indicate that the demonstration resulted in no impact on Medicare costs among overall eligible beneficiaries in the demonstration group, relative to the comparison group, from demonstration year 1 to demonstration year 4, despite the application of savings percentages in the capitation rate for MMP enrollees. To better understand these results, we conducted four analyses:

1. We calculated and compared a normalized county-based FFS standardized rate with the actual MMP rate to determine whether the MMP capitated rate was set higher than what would otherwise have been spent in Medicare FFS.[38] Specifically, using observed FFS expenditure data available from CMS, we calculated FFS county rates by taking county-level per capita costs and dividing it by the average risk score for each county.[39] In this way, we obtained a county-level rate for a person whose risk is 1.0 that can be used for comparison with the MMP rate. If the MMP rates were set higher than what would have been observed under FFS, then this would help explain in part why the New York demonstration resulted in increased Medicare costs. By contrast, if the rates were set lower than what would have been observed under FFS, then this would help explain decreases in Medicare costs.

2. We compared the predemonstration spending history among those who enrolled in demonstration year 1 and those who were enrolled but not eligible (ENE). If enrolled beneficiaries are less expensive than those who never enrolled during the predemonstration period, then this would provide evidence of favorable selection into the enrolled group.

3. We compared the predemonstration risk score profiles among those who enrolled in demonstration year 1 and those who were ENE. If enrolled beneficiaries have lower average risk scores than those who never enrolled during the predemonstration period, then this would provide evidence of favorable selection into the enrolled group.

4. We conducted a cross-sectional analysis of mortality rates among enrolled beneficiaries and eligible but not enrolled beneficiaries during the entire study period. If enrolled beneficiaries have a lower rate of mortality than those not enrolled, than this would provide evidence of favorable selection into the enrolled group.

[38] The analysis is focused on FFS as over 95 percent of the beneficiaries who enrolled were previously in FFS.
[39] FFS Data (2015–2021). Available at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/FFS-Data.

E.1.1 Rate-setting comparison

Table E-1 provides an example of how RTI calculated the normalized county rate using observed FFS Parts A and B expenditures for Bronx County, New York. First, using observed FFS expenditure data available from CMS, we summed Part A and Part B per capita costs and then we divided the amount by the county-level risk score. [40]

Table E-1
Example of RTI normalized county rate calculations for 2017 (demonstration year 1), Bronx County, New York

County	Part A total per capita[1]	Part B total per capita[1]	Part A + Part B	Risk score[2]	RTI normalized FFS rate
Bronx, NY	706.34	436.14	1,142.48	1.12316	1,017.19

FFS = fee-for-service.
[1] FFS17.xlsx file found in the download titled *FFS DATA 2017 (ZIP)* from FFS Data (2015-2021) | CMS.
[2] Medicare FFS County 2023 Web.xlsx files found in the download titled *FFS DATA 2020 (ZIP)* from FFS Data (2015-2021) | CMS.

Table E-2
Comparison of MMP rates to observed FFS spending in New York, 2017 (demonstration year 1)

County	Enrollment (bene-months)[1]	Percent enrollment (of total eligible bene-months)[1]	RTI normalized FFS rate	Final MMP rate after application of 0.25% savings	MMP rate as % of RTI Normalized FFS rate
	A	B	C	D	E
Bronx	309	4.7%	1,017.19	976.00	96.0%
Kings	499	7.6%	927.39	880.06	94.9%
Nassau	2,641	40.1%	977.79	941.84	96.3%
New York	491	7.5%	957.42	872.16	91.1%
Queens	329	5.0%	913.67	870.40	95.3%
Richmond	129	2.0%	929.40	914.37	98.4%
Rockland	431	6.5%	934.21	945.04	101.2%
Suffolk	1,114	16.9%	1,000.06	945.66	94.6%
Westchester	643	9.8%	925.73	934.58	101.0%
Weighted Average[2]	—	—	965.98	929.61	96.3%
Total	6,586	—	—	—	—

FFS = fee-for-service; MMP = Medicare-Medicaid Plan. — = Not applicable
[1] As reflected in RTI's DinD impact analysis sample.
[2] Numbers in column A are used as the weights.

[40] Note that because the Part A total per capita costs in the actuary file includes both Part A only beneficiaries and those with both Part A and Part B, we raised the RTI rate by 3 percent to reflect the exclusion of Part A only beneficiaries in managed care (see ***column C***, ***Tables E-2*** and ***E-3***).

Table E-3
Comparison of MMP rates to observed FFS spending in New York, 2020 (demonstration year 4)

County	Enrollment (bene-months)[1]	Percent enrollment (of total eligible bene-months)[1]	RTI normalized FFS rate	Final MMP rate after application of 0.75% savings	MMP rate as % of RTI Normalized FFS rate
	A	B	C	D	E
Bronx	2,127	11.0%	1,188.91	956.02	80.4%
Kings	2,185	11.3%	1,021.65	909.61	89.0%
Nassau	4,318	22.3%	1,015.61	1,010.32	99.5%
New York	4,345	22.4%	1,024.58	935.39	91.3%
Queens	1,696	8.7%	1,013.10	899.38	88.8%
Richmond	757	3.9%	964.77	960.16	99.5%
Rockland	988	5.1%	947.54	1,020.96	107.7%
Suffolk	1,928	9.9%	1,039.58	1,055.22	101.5%
Westchester	1,047	5.4%	949.50	985.74	103.8%
Weighted Average[2]	—	—	1,030.45	968.24	94.3%
Total	19,391	—	—	—	—

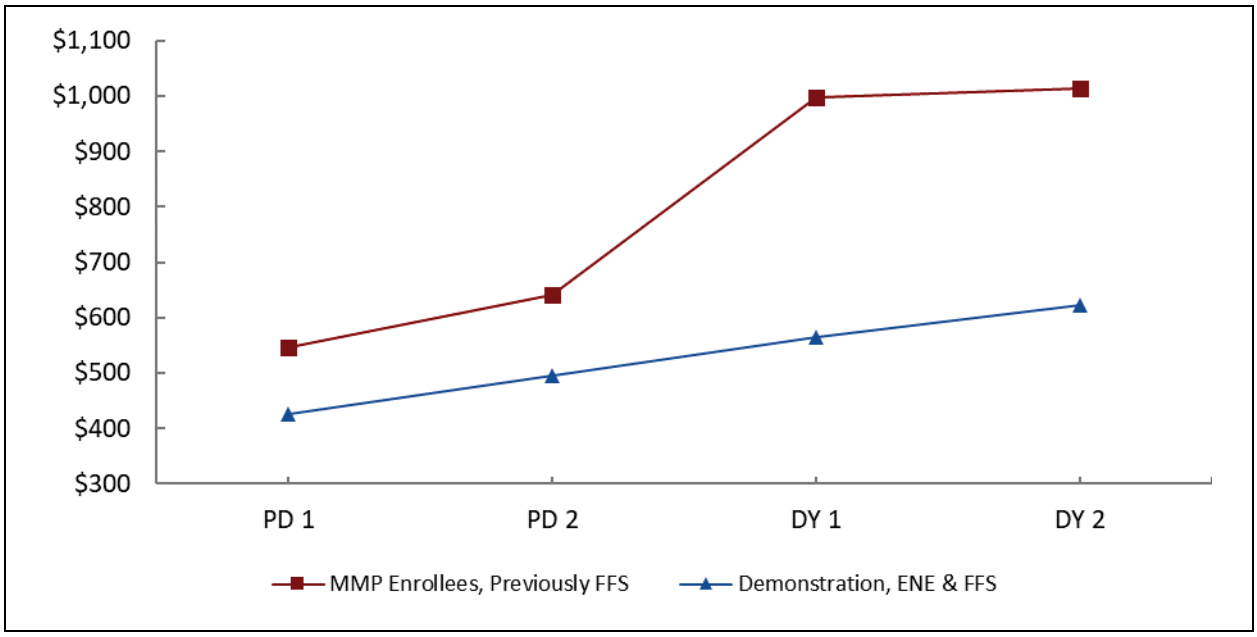
FFS = fee-for-service; MMP = Medicare-Medicaid Plan. — = Not applicable.
[1] As reflected in RTI's DinD impact analysis sample.
[2] Numbers in column A are used as the weights.

On a composite basis, the MMP capitation rates are lower than the RTI normalized FFS rate (overall, the weighted average MMP rate is 96.3 percent of the RTI FFS rate in demonstration year 1, and 94.3 percent in demonstration year 4). With the exception of two counties, all of the MMP rates are lower than the RTI normalized FFS rate demonstration year 1 (***Table E-2***, column E). The number of counties with MMP rates lower than the RTI normalized FFS rate decreased in demonstration year 4, with three counties having rates higher than the RTI normalized FFS rate (***Table E-3***, column E). While there is potential for Medicare cost savings where the MMP capitation rates are lower than the normalized FFS rates, the large ENE population may be driving the Medicare cost savings estimates, given that only 8% of the demonstration group is actually enrolled.

E.1.2 Pre-enrollment Cohort Analysis

Our analysis of predemonstration trends found that FFS beneficiaries with higher predemonstration FFS expenditures were more likely to enroll in an MMP plan. ***Figure E-1*** illustrates that the demonstration year 1 enrolled population was more costly during the predemonstration period than its ENE counterpart. Additionally, ***Figure E-2*** indicates that risk scores for enrollees were higher than the average risk scores of the ENEs, which corresponds to enrollees' greater spending relative to the ENE group. Combined, these findings do not provide evidence of favorable selection into the MMPs at the start of the demonstration; rather they indicate that the demonstration treated more vulnerable individuals.

Figure E-1
Average Medicare Parts A and B costs PMPM among demonstration year 1 enrolled and ENE cohorts in New York

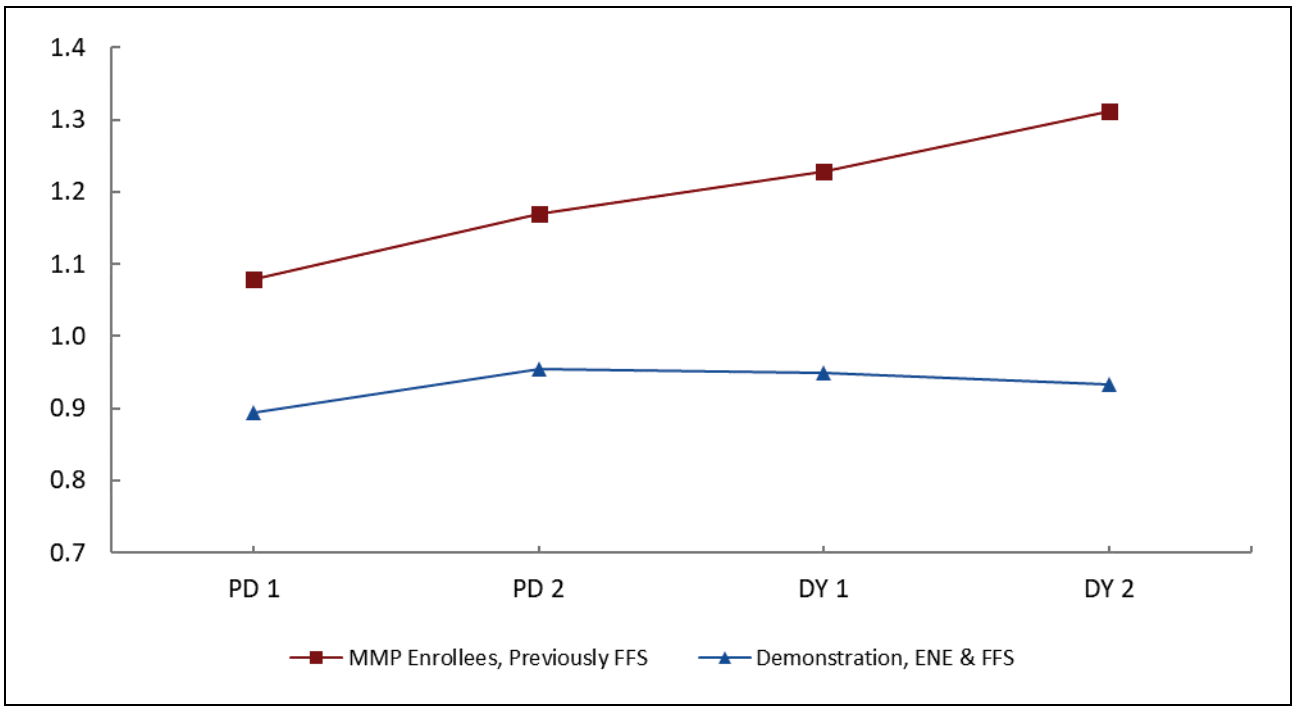


DY = demonstration year; ENE= eligible not enrolled; FFS = fee-for-service; MMP = Medicare-Medicaid Plan; PDY = predemonstration year; PMPM = per member per month.
NOTES: The number of observations for DY 2 represents a subset of DY 1 enrollees. PDY 1 is from April 2014 through March 2015; PDY 2 is from April 2015 through March 2016; DY 1 is from April 2016 through December 2017; DY 2 is from January 2018 through December 2018.
SOURCE: RTI analysis of New York pre-enrollment trends.

Finally, although the factors described here are at play for the enrollee population, the FFS eligible but not enrolled beneficiaries are not affected by the savings percentages built into the MMP capitated rates. The analysis of the demonstration's impact on Medicare costs used an ITT approach that included all eligible beneficiaries, not only those enrolled in an MMP, to alleviate concerns about selection bias in enrollment that could not be replicated in the comparison group. The eligible but not enrolled population was substantially larger than the enrolled population (which was about 8 percent[41]). As such, the spending among the eligible but not enrolled may be driving the overall results. Moreover, Medicare spending in the comparison group changed at about the same rate and similar direction as the demonstration group, further reinforcing the finding of no statistical difference in Medicare expenditures reported in ***Section 5, Demonstration Impact on Cost Savings***.

[41] The enrollment percentages reported in the section may be different than what was reported in ***Section 3.2, Eligibility and Enrollment,*** because of the timing for completion and submitting the finder file versus the SDRS.

Figure E-2
Average risk score among demonstration year 1 enrolled and ENE cohorts in New York



DY = demonstration year; ENE= eligible not enrolled; FFS = fee-for-service; MMP = Medicare-Medicaid Plan; PDY = predemonstration year; PMPM = per member per month.
NOTE: PDY 1 is from April 2014 through March 2015; PDY 2 is from April 2015 through March 2016; DY 1 is from April 2016 through December 2017; DY 2 is from January 2018 through December 2018.
SOURCE: RTI analysis of New York pre-enrollment trends.

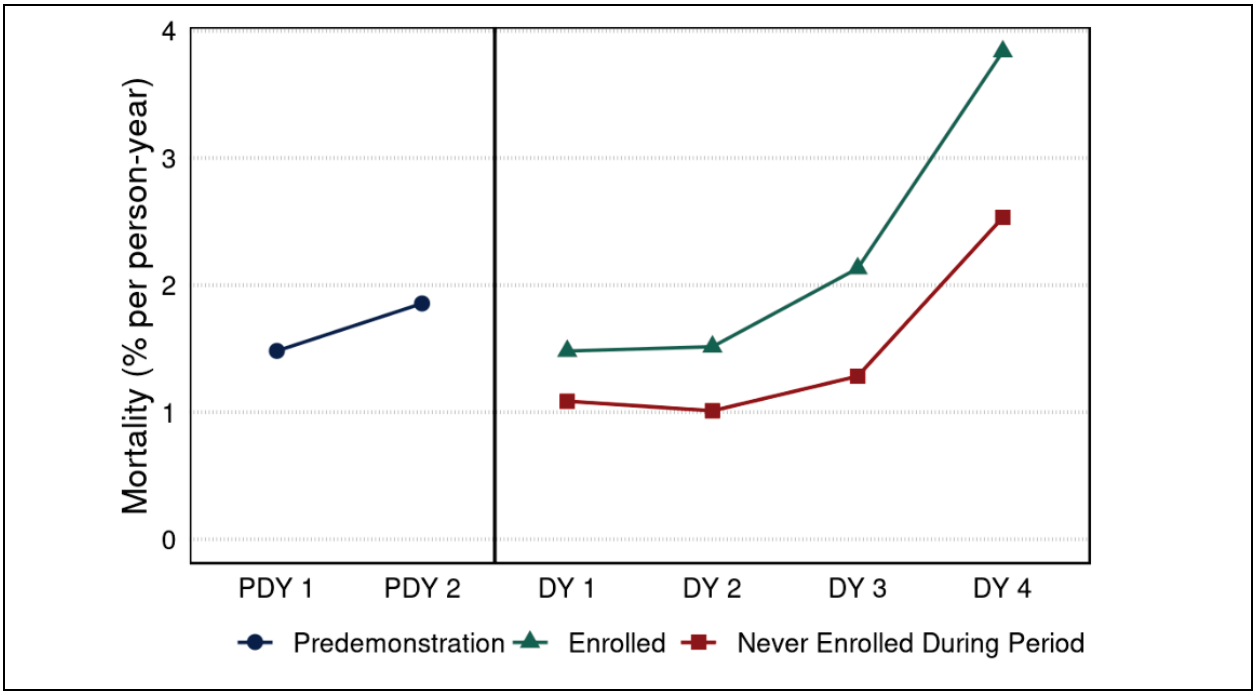
E.1.3 Mortality Analysis

This descriptive analysis examines mortality rates to provide additional insight into differences in health characteristics between enrolled and non-enrolled beneficiaries in the demonstration group. These differences can help understand the DinD results described in ***Section 5, Demonstration Impact on Cost Savings.*** A lower mortality rate observed among the enrolled population, relative to the demonstration eligible but not enrolled population, could suggest favorable selection into demonstration enrollment and lower the likelihood of observing favorable demonstration effects. Demonstration group eligible beneficiaries are categorized into three groups: predemonstration, enrolled during a demonstration period, and never enrolled during a demonstration period**.** Enrollment categories are based on period-level indicators, so the same beneficiary's observations may be categorized differently over time based on enrollment during a given period. ***Figure E-3*** and ***Table E-4*** show the annualized mortality rate for each group, defined as the number of beneficiaries who died during a given period divided by the number of person-years (months alive divided by 12) during the period.

- Beneficiaries who enrolled in MMPs during the demonstration period had a higher mortality rate than the demonstration eligible non-enrolled during the demonstration period.

- These findings are consistent with the pre-enrollment description of HCC scores and FFS PMPM among enrollees and eligible non-enrollees (see ***Figure E-1 and Figure E-2***) suggesting the MMP enrolled sicker and more expensive beneficiaries, relative to the eligible population that did not enroll. These findings are also consistent with the descriptive results showing that enrollees were older than ENEs (see ***Table D-3*** in ***Appendix D***).

Figure E-3
Mortality rate among enrolled and not enrolled in New York, April 1, 2014–December 31, 2020



PDY = predemonstration year; DY = demonstration year.
NOTES: Mortality rates are not easily interpretable during the first demonstration year due to increased demonstration enrollment through the first demonstration year. Beneficiaries who enroll late in DY 1 are included in the mortality rate's denominator for the entire period, whereas the non-enrolled group does not select for beneficiaries who survive longer. By DY 2, the mortality rate is more comparable between the enrolled and non-enrolled beneficiaries.

Table E-4
Monthly percent of beneficiaries who died during the predemonstration and demonstration periods in New York, April 1, 2014–December 31, 2020

Period	Predemonstration		Demonstration: Enrolled		Demonstration: Eligible not enrolled	
	N	Died (%)	N	Died (%)	N	Died (%)
PDY 1	238,861	1.48	—	—	—	—
PDY 2	254,782	1.86	—	—	—	—
DY 1	—	—	17,013	1.48	444,118	1.09
DY 2	—	—	14,257	1.52	248,063	1.01
DY 3	—	—	18,578	2.13	247,834	1.28
DY 4	—	—	21,259	3.84	245,881	2.50

— = Not applicable.
DY = demonstration year; PDY = predemonstration year.
NOTE: The N includes the number of alive months during the year among demonstration eligible beneficiaries. Mortality rates are reported as percentages per beneficiary-year.
SOURCE: RTI analysis of Medicare enrollment data.