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M E M O R A N D U M

TO: All Members

FROM: Policy Team

DATE: September 4, 2013

SUBJECT: **FIDA MOU Provides Details on Duals Demonstration**

ROUTE TO: CEO, Administrator, Executive Director, CFO

ABSTRACT: A summary of key points in the Memorandum of Understanding entered into by New York State and CMS regarding the state's FIDA Demonstration.

Introduction

On August 26, 2013, the Centers for Medicare and Medicaid Services (CMS) approved New York State's Fully Integrated Dual Advantage (FIDA) demonstration project. The approval came in the form of a Memorandum of Understanding (MOU) between the state and CMS that lays out the major structural pieces of the demonstration. It paves the way for the state to begin enrolling individuals who are eligible for Medicaid and Medicare (dually eligible) and are in need of long term care services into managed long term care plans (i.e., FIDA plans) that integrate Medicare and Medicaid benefits. The demonstration is slated to operate from mid-2014 through 2017 and is expected to serve 170,000 individuals in New York City, Long Island and Westchester County.

FIDA plans will be Medicaid Managed Long Term Care (MLTC) plans that modify their offerings to include Medicare services. The state and CMS have designated 25 MLTC applicants that have met established requirements but will need to go through readiness review and enter into contract with the state and CMS to operate as FIDA plans. Plans will be required to establish provider networks that meet the criteria established in the MOU and organize care in a participant-centered way using an interdisciplinary team selected by the participant. The majority of beneficiaries eligible for FIDA participation are currently enrolled in Medicaid MLTC plans and receiving community-based long term care services and supports. Dually eligible individuals needing nursing home care are also eligible for the demonstration.

As part of Medicaid redesign, the state has made enrollment into Medicaid managed care mandatory in the New York City area. A key feature of FIDA is the authority to automatically ("passively") enroll the dually eligible population into Medicare managed care, something that is not possible without a federal waiver. Individuals will be permitted to opt-out of enrollment into a FIDA plan and will have the option to receive Medicare services on a fee-for-service basis or be enrolled in a non-FIDA Medicare managed care plan. However, consistent with other state Medicaid reform initiatives, they will be required to join or remain enrolled in a Medicaid MLTC plan to receive Medicaid services.

This memo provides an overview of the MOU. A list of key definitions copied from the MOU is provided as Appendix 1 to this memo.

Background

FIDA stems from a federal financial alignment initiative announced in 2011 meant to better align the financing of Medicare and Medicaid programs and integrate primary, acute, behavioral health and long term services and supports for dually eligible enrollees. States were invited to design projects to meet this goal. A number of states responded and descriptions of the various state proposals are available here. By signing the MOU, New York became the seventh state to formalize its participation in the initiative.

The state's original proposal included a plan to serve dually eligible individuals in upstate areas using a managed fee-for-service approach. This part of the proposal was dropped and the state committed to making health homes the primary model for serving this population outside of the 8-county FIDA region. The most current FIDA proposal and addendum focus exclusively on 8 downstate counties – Bronx, Kings, Nassau, New York, Queens, Richmond, Suffolk and Westchester.

DOH conducted a webinar on August 29 to review the MOU. Presentation slides are posted here. Additional materials regarding FIDA are available on the DOH FIDA (also known as MRT Initiative # 101) website. While the MOU outlines the current understanding between New York and CMS, DOH made it clear during the webinar that a number of details are still to be worked out. LeadingAge NY members and/or staff participate in the FIDA workgroups established by DOH. A number of our recommendations are reflected in the MOU.

Eligible Population

The state estimates that there are 170,000 dually eligible individuals eligible for FIDA participation in the 8-county area. Participants must be "full benefit" adult duals. Specifically they must:

1. Be 21 years old or older;
2. Be entitled to benefits under Medicare Part A and enrolled under Parts B and D, and receiving full Medicaid benefits;
3. Reside in a FIDA Demonstration county;
4. Meet one of the following three criteria:
    - Be Nursing Facility Clinically Eligible (NFCE) and be receiving facility-based Long Term Support Services (LTSS); or
    - Be eligible for the Nursing Home Transition and Diversion (NHTD) waiver ; or
    - Require community-based LTSS for more than 120 days.

Individuals receiving services from the Office for People with Developmental Disabilities (OPWDD) or residing in facilities operated by the Office of Mental Health (OMH) are not eligible for the FIDA demonstration. Also excluded are residents of Assisted Living Programs (ALPs), individuals receiving hospice services (at time of enrollment) and those expected to be Medicaid eligible for fewer than six months. PACE participants as well as those enrolled in health homes or Medicare Institutional Special Needs Plans may participate voluntarily in FIDA but will be excluded from passive enrollment. A complete list of exclusions from FIDA and from passive enrollment is found in the MOU and is provided as Appendix 2 to this memo.

Enrollment

Enrollment for eligible individuals into FIDA will proceed on two different timetables: one for those receiving community-based services, the other for those receiving facility-based care. All enrollments and dis-enrollments will be processed by a state-contracted enrollment broker (Maximus) using uniform enrollment, transfer and opt-out materials. Eligible individuals will be able to enroll voluntarily based on the schedules shown below, with passive enrollment scheduled to begin 2-3 months after voluntary enrollees begin receiving services.

Eligible individuals who do not submit a request to enroll in a FIDA plan will be passively enrolled (i.e., auto-assigned) into a plan. Individuals will receive notices at least 60 and 30 days in advance of the passive enrollment date inviting them to select a plan and notifying them of their opt-out rights. The notices will also indicate the plan into which they will be passively enrolled if they do not opt-out or make a plan selection. The initial passive enrollment process will be phased in over a minimum of four months. When selecting the FIDA plan into which to passively enroll an individual the state will use an "intelligent assignment" algorithm that will consider the individual's previous Medicaid managed care enrollment and historic provider utilization.

Individuals may opt out of FIDA prior to passive enrollment or at any time after enrollment. They may also change FIDA plans at any time. Enrollments and dis-enrollments will be effective on the first day of the month following receipt of the request. Individuals opting out of the demonstration may participate in an alternative integrated plan (e.g., PACE or MAP) or may choose to remain in fee-for-service Medicare while complying with mandatory Medicaid managed care enrollment requirements. The MOU also includes a provision requiring the state to ensure that the PACE program is known to eligible individuals as an integrated program alternative to FIDA.

The enrollment start dates shown below are subject to FIDA plans meeting CMS and state requirements.

<u>Individuals receiving Community-Based LTSS</u>

- Voluntary Enrollment: information to eligible individuals starting April 2014, applications accepted starting May 2014, services effective July 2014
- Passive Enrollment: starting in September 2014, phased in over 4 months based on individuals' Medicaid reauthorization dates

<u>Individuals receiving Facility-Based LTSS</u>

- Voluntary Enrollment: information to eligible individuals starting July 2014, applications accepted starting August 2014, services effective October 2014

- Passive Enrollment: starting in January 2015, phased in over 4 months based on individuals' Medicaid reauthorization dates

FIDA Plan Selection

FIDA plans will participate in the demonstration pursuant to a three-way contract with the state and CMS. The designation process is well under way. Twenty-five plans have submitted application materials including their models of care and plan benefit packages. All are state approved MLTC plans which must now complete the CMS-DOH readiness review process that includes desk and site reviews, network validation and systems testing. Plans received a readiness review tool in late August to aid in this process. Along with the requirements of the Medicaid and Medicare programs and those established in the MOU, FIDA plans may be subject to additional requirements included in the three-way contract. DOH has indicated that the opportunity to become a FIDA plan (other than for the 25 plans referenced above) has ended.

Provider Network Adequacy

FIDA plans must adhere to existing applicable network adequacy standards for Medicaid and Medicare services. Services where Medicare and Medicaid may overlap, the standard that offers broader coverage for the participant will apply. Plans must contract with an adequate number of providers to allow participants a choice of at least two providers of each covered community-based service within a 15-mile radius or 30 minute distance from the participant's zip code of residence. For all items and services other than nursing home services, FIDA plans must allow participants to maintain current providers and service levels, including prescription drugs, at the time of enrollment for at least 90 days after enrollment, or until a care assessment has been completed by the FIDA plan, whichever is later.

For existing nursing home residents, FIDA plans must make arrangements with all nursing homes in the Demonstration Area to ensure participants' residency and access to services are not interrupted. For nursing home services that are part of the traditional Medicaid benefit package, FIDA plans will be required to pay non-contracting (i.e., out-of-network) providers the Medicaid fee-for-service (FFS) rate. Under the Demonstration, skilled nursing level care may be provided in a long term care facility without a preceding acute care inpatient stay for individuals enrolled in the Demonstration, when the provision of this level of care is clinically appropriate and can avert the need for an inpatient stay. Participation of nursing facilities in the Demonstration may be subject to quality standards established in the three-way contract.

FIDA plan networks will be confirmed through the readiness review process and monitored on an ongoing basis.

Delivery System and Covered Services

The delivery system outlined in the MOU revolves around person-centered service plans which are developed by the consumer, their informal supports along with an interdisciplinary team. The success of the service plan will be contingent upon the FIDA plans that demonstrate the capacity to provide either directly or through contracts with other providers Medicare and Medicaid services. This network includes medical, drug, behavioral health and community-based or facility-based LTSS providers. In no instances may any FIDA plan have less than two of any provider type necessary to provide covered services. Consumer advocates successfully urged the state to include several services now part of the FIDA benefit package such as home and

community support services, telehealth, respite, palliative care and consumer directed personal assistance services (CDPAS). The full list of FIDA services from the MOU can be found in Appendix 3 to this memo.

Financing

FIDA plans will be required to "develop a plan for a fully integrated payment system through which providers would no longer be paid on a traditional fee-for-service basis but instead be paid on an alternative basis (e.g., pay for performance, bundled payment)". Plans will be required to disclose risk arrangements with their subcontracted providers.

Designated FIDA plans will get a monthly per-enrollee premium from both Medicaid and Medicare with which they will be required to provide all of the services covered by the demonstration (see services section). These premiums will be based on baseline projections of what it would have cost to provide services to the enrolled population absent the FIDA demonstration. These premiums will then be reduced by a savings percentage that will increase each year.

Baseline projections will be calculated for Medicaid, Medicare Parts A, B and D.

Medicaid

Medicaid baseline spending will be primarily based on the capitation (i.e. monthly premium) payments that would be made to MLTC plans to serve this population absent FIDA. This will be blended with historic Medicaid costs (adjusted for inflation) for the FIDA target population served in Medicaid FFS. Adjustments will be made for services that are included in the demonstration but not covered by MLTC premiums.

The state will develop two rate cells: one for individuals requiring 120 or more days of community-based LTSS that do not meet the nursing home level of need standard based on their assessment; the second for those meeting the nursing home level of need standard whether they are actually being cared for in the community or in a nursing home. These amounts will be risk-adjusted using a similar approach as is used to risk adjust current MLTC premiums. Medicaid premiums will be updated annually although DOH will continue to update the baseline calculation to reflect retroactive adjustments to Medicaid payments and will continue to explore the potential need for additional rate cells.

Medicare

Medicare Part A and B baseline spending will be calculated by CMS and its actuaries by blending Medicare Advantage (i.e., Medicare managed care) rates with Medicare FFS standardized county rates. These will be blended based on the proportion of individuals enrolling into FIDA from each payment type. Payments will be adjusted for enrollee acuity by the application of participant risk scores at the time of payment using the existing CMS-HCC methodology.

The baseline will be updated annually consistent with the annual FFS estimates and benchmarks released each year with the annual Medicare Advantage rate announcement. CMS will apply the coding intensity adjustment factor to Medicare Advantage risk scores but in 2014 and 2015 only to the proportion of target population with prior Medicare Advantage experience.

The Medicare Part D baseline for the Part D Direct Subsidy will be set at the Part D national average monthly bid amount for the calendar year. CMS will estimate an average monthly prospective payment amount for the low income subsidy and reinsurance that will be retroactively reconciled. The Part D payment will be risk adjusted using the existing RxHCC methodology.

Adjustments

The Medicaid and Medicare A and B components of the premium will be reduced by a savings percentage that will be:

- 1 percent in demonstration year one (July 2014 – December 2015);
- 1.5 percent in year two (CY 2016);
- 3 percent in year three (CY 2017).

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

Additionally, FIDA plans will be subject to a quality withhold. Plans failing to meet established thresholds on a set of quality measures will be subject to a one percent withhold of the Medicaid and Medicare A and B component of their risk-adjusted rate in year one. The withhold percentage increases to two percent in year two and three percent in year three. The measures which are the basis of the withhold change after year one. These are all listed in Appendix 6 of the MOU.

FIDA plans will be expected to spend 85 percent of premium revenue on expenses directly related to medical claims or care coordination. If this Target Medical Loss Ratio is not met, plans will have to pay CMS and the state the difference between their actual Loss Ratio and 85 percent.

The MOU requires CMS and the state to monitor the financial stability of FIDA plans and provides flexibility to make certain rate adjustments if needed. Additional provisions that FIDA plans may need to comply with may be incorporated into individual plan agreements with the state and CMS.

Participant Protections

The MOU details numerous participant protections and customer services provisions. Participants may opt out of the demonstration or change plans any time that they choose, effective at the beginning of the month. FIDA plans must allow participants to maintain current providers and service levels for at least 90 days from date of enrollment. The state must provide access to enrollment assistance and options counseling to help eligible individuals make enrollment decisions based upon their needs. An integrated grievance and appeals process consolidates the most consumer-favorable elements of the Medicaid and Medicare systems into a single system with one set of notices and procedures.

A newly-added consumer provision is the participant ombudsman (PO). The PO is an independent entity under contract with the state, not the FIDA plan, to help consumers access what they need through the FIDA plan. The PO will support consumer advocacy and focus on principles of community-integration, independent living philosophies and person-centered care in a home and community-based context. In addition all of the participant materials need to be approved by either the state or CMS and is required to be uniform, accessible and understandable (nothing greater than a 6th grade reading level).

The MOU also includes provisions for stakeholder input. The FIDA plans must establish a Participant Advisory Committee (PAC) that meets quarterly and is open to all participants. PAC participants and the PO will participate in the state's ongoing stakeholder meetings. FIDA plans are encouraged to have participants serve on their Board of Directors.

Conclusion

While the MOU presents the most current information about FIDA, continuing dialogue between CMS and New York State as well as the work of DOH-convened topical workgroups may result in changes and clarifications to the information presented above. We will keep members informed of discussions and their implications. In the meantime, if you have questions on FIDA please contact Patrick Cucinelli (pcucinelli@leadingageny.org); Cheryl Udell (cudell@leadingageny.org); Darius Kirstein (dkirstein@leadingageny.org); Dan Heim (dheim@leadingageny.org) or Diane Darbyshire (ddarbyshire@leadingageny.org) or call 518-867-8383.

Appendix 1: Definitions *(From FIDA MOU)*

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

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

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

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

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

CMS – The Centers for Medicare & Medicaid Services.

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

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

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

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

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

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

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

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

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

Enrollment Broker – An independent entity contracted with the State, which is responsible for processing all enrollment and disenrollment transactions. The Enrollment Broker will educate Participants on all potential plan choices and ensure ongoing customer service related to outreach, education, and support for individuals eligible for the Demonstration. The Enrollment Broker will incorporate the option of PACE enrollment into its scripts and protocols.

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

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

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

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

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

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

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

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

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

Interdisciplinary Team (IDT) – The team of individuals that will provide person-centered care coordination and care management to Participants. Each Participant will have an IDT. Each IDT will be comprised, first and foremost, of the Participant and/or his/her designee, the designated care manager, the primary care physician, behavioral health professional, the Participant's home care aide, and other providers either as requested by the Participant or his/her designee or as recommended by the care manager or primary care physician and approved by the

Participant and/or his/her designee. The IDT facilitates timely and thorough coordination between the FIDA Plan, the IDT, the primary care physician, and other providers. The IDT will make coverage determinations. Accordingly, the IDT's decisions serve as service authorizations, may not be modified by the FIDA Plan outside of the IDT, and are appealable by the Participant, their providers, and their representatives. IDT service planning, coverage determinations, care coordination, and care management will be delineated in the Participant's Person-Centered Service Plan and will be based on the assessed needs and articulated preferences of the Participant.

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

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

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

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

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

Medicare-Medicaid Enrollees – For the purposes of this Demonstration, individuals who are entitled to benefits under Medicare Part A, enrolled under Medicare Parts B and D, and receiving full Medicaid benefits.

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

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

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

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

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

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

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

New York State Office of the Medicaid Inspector General – The agency responsible for enhancing the integrity of the New York State Medicaid program by preventing and detecting fraudulent, abusive, and wasteful practices

within the Medicaid program and recovering improperly expended Medicaid funds while promoting high quality patient care.

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

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

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

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

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

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

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

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

Program of All-inclusive Care for the Elderly (PACE) – A capitated benefit for frail elderly authorized by the Balanced Budget Act of 1997 (BBA) that features a comprehensive service delivery system and integrated Medicare and Medicaid financing. PACE is a three-way partnership between the Federal government, the State of New York, and the PACE organization.

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

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

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

Participant Ombudsman (PO) – An independent, conflict-free entity under contract with NYSDOH to provide Participants free assistance in accessing their care, understanding and exercising their rights and responsibilities,

and appealing adverse decisions made by their FIDA Plan. The PO will be accessible to all Participants through telephonic and, where appropriate, in-person access. The PO will provide advice, information, referral and assistance in accessing benefits and assistance in navigating FIDA Plans, providers, or NYSDOH. The PO may participate in FIDA Plan Participant Advisory Committee activities.

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

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

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

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

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

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

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

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

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

Appendix 2: Populations Excluded from FIDA and Passive Enrollment

The following populations are not eligible for the FIDA Demonstration:

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

The following individuals will be excluded from passive enrollment:

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

Appendix 3: Planned FIDA Demonstration Services *(Table 7-A of MOU)*

Abdominal Aortic Aneurism Screening	Health/Wellness Education	Outpatient Rehabilitation (OT, PT, Speech)
Adult Day Health Care	Hearing Services	Outpatient Substance Abuse
AIDS Adult Day Health Care	HIV COBRA Case Management	Outpatient Surgery
Ambulance	HIV Screening	Palliative Care
Ambulatory Surgical Centers	Home and Community Support Services	Pap Smear and Pelvic Exams
Assertive Community Treatment (ACT)	Home Delivered and Congregate Meals	Partial Hospitalization (Medicaid)
Assisted Living Program	Home Health	Partial Hospitalization (Medicare)
Assistive Technology (State Plan and Supplemental to State Plan)	Home Maintenance Services	PCP Office Visits
Bone Mass Measurement	Home Visits by Medical Personnel	Peer-Delivered Services
Cardiac Rehabilitation Services	Immunizations	Peer Mentoring
Cardiovascular Disease Screening	Independent Living Skills and Training	Personal Care Services
Case Management for Seriously and Persistently Mentally Ill	Inpatient Hospital Care (including Substance Abuse and Rehabilitation Services)	Personal Emergency Response Services (PERS)
Cervical and Vaginal Cancer Screening	Inpatient Services during a Non-covered Inpatient Stay	Personalized Recovery Oriented Services (PROS)
Chemotherapy	Inpatient Mental Healthcare	Podiatry
Chiropractic	Inpatient Mental Health over 190-day Lifetime Limit	Positive Behavioral Interventions and Support
Clinical Research Studies	Intensive Psychiatric Rehabilitation Treatment Programs	Private Duty Nursing
Colorectal Screening	Kidney Disease Services	Prostate Cancer Screening
Community Integration Counseling	Mammograms	Prosthetics
Community Transitional Services	Medicaid Pharmacy Benefits as Allowed by State Law	Pulmonary Rehabilitation Services
Comprehensive Medicaid Case Management	Medical Nutrition Therapy	Routine Physical Exam 1/year
Consumer Directed Personal Assistance Services	Medical Social Services	Respite
Continuing Day Treatment	Medicare Cost Sharing	Service Coordination
Day Treatment	Medicare Part D Prescription Drug Benefit as Approved by CMS	Skilled Nursing Facility
Defibrillator (implantable automatic)	Medication Therapy Management	Smoking and Tobacco Cessation
Depression Screening	Mobile Mental Health Treatment	Social and Environmental Supports
Dental	Moving Assistance	Social Day Care
Diabetes Monitoring (Self-Management Training)	Non-Emergency Transportation	Social Day Care Transportation
Diabetes Screening	Nursing Facility (Medicaid)	Specialist Office Visits
Diabetes Supplies	Nutrition (includes Nutritional Counseling and Educational Services)	Structured Day Program
Diagnostic Testing	NYS Office of Mental Health Licensed Community Residences	Substance Abuse Program
Durable Medical Equipment (DME)	Other Supportive Services the Interdisciplinary Team Determines Necessary	Telehealth
Emergency Care	Outpatient Drugs	Urgent Care
Environmental Modifications	Outpatient Hospital Services	Vision Care Services
Family-Based Treatment	Outpatient Mental Health	Wellness Counseling