

Memorandum of Understanding (MOU)

Between

The Centers for Medicare & Medicaid Services (CMS)

And

The State of New York

**Regarding a Federal-State Partnership to Test a Capitated Financial Alignment Model for
Medicare-Medicaid Enrollees Who Have Intellectual and Developmental Disabilities**

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I. STATEMENT OF INITIATIVE

The Centers for Medicare & Medicaid Services (CMS), the State of New York, Department of Health (State / NYSDOH), and the State of New York Office for People with Developmental Disabilities (State / OPWDD) will establish a Federal-State partnership to implement the Medicare-Medicaid Alignment Initiative (Demonstration) to better serve individuals eligible for both Medicare and Medicaid (“Medicare-Medicaid Enrollees”) who have intellectual and developmental disabilities (IDD). This Fully Integrated Duals Advantage Demonstration for Individuals with Intellectual and Developmental Disabilities (FIDA-IDD) shares the general goals and structure of the Fully Integrated Duals Advantage (FIDA) Demonstration, but the two demonstrations are distinct and involve different populations and Medicare-Medicaid Plans. Other important distinctions between the two demonstrations are that the FIDA-IDD Demonstration does not allow for passive enrollment of eligible individuals and includes a benefit package tailored to support individuals with IDD.

As the Single State Medicaid Agency (SMA), NYSDOH is the lead State entity in this agreement and will delegate certain administrative and operational aspects of the Demonstration to OPWDD. The Federal-State partnership will include a Three-way Contract with one Medicare-Medicaid Plan (MMP) approved by CMS offering specialized networks and care management programs designed specifically to serve adults with IDD. This Fully Integrated Duals Advantage Plan for Individuals with Intellectual and Developmental Disabilities (FIDA-IDD Plan) will provide integrated benefits to those Medicare-Medicaid Enrollees who reside in the targeted geographic area and who choose to participate in the Demonstration (Participants).

The Demonstration will begin no earlier than April 1, 2016 and continue until December 31, 2020, unless terminated pursuant to section III.L or continued pursuant to section III.K of this Memorandum of Understanding (MOU). The initiative is testing an innovative payment and service delivery model to alleviate the fragmentation, improve coordination of services, and enhance quality of care for Medicare-Medicaid Enrollees with IDD, and reduce costs for both the State and the Federal government (see Appendix 1 for definitions of terms and acronyms used in this MOU).

The population that will be eligible to participate in the FIDA-IDD Demonstration is limited to "Full Benefit" Medicare-Medicaid Enrollees who are age 21 or older and meet the eligibility criteria outlined herein. Section III.C.1 below provides more information on individuals who are not eligible for the FIDA-IDD Demonstration as well as individuals who are eligible if they disenroll from an existing program.

Under this initiative, the FIDA-IDD Plan will be required to provide for, either directly or through subcontracts, Medicare and Medicaid-Covered Services, as well as additional items and services, under a capitated model of financing. CMS, the State, and the FIDA-IDD Plan will ensure that Participants have access to an adequate network of medical and supportive services, including OPWDD services such as developmental disability, habilitation, prescription drugs and non-prescription drugs, behavioral health, and Community-based Long-Term Services and Supports (LTSS).

CMS and the State have jointly selected and will monitor the FIDA-IDD Plan. As described in section III.A and detailed in Appendices 4 and 5 of this MOU, CMS will implement this initiative under Medicare Parts C and D and demonstration authority for Medicare and State Plan, demonstration, and waiver authority for Medicaid.

Key objectives of the initiative are to improve the Participant experience in accessing care, deliver person-centered care, promote independence in the community, improve quality, eliminate cost shifting between Medicare and Medicaid, and achieve cost savings for the State and Federal government through improvements in care and coordination. CMS and the State expect this model of integrated care and financing to, among other things, improve quality of care and reduce health disparities, meet both health and functional needs, and improve transitions among care settings. Other central goals of this initiative include: meeting Participant needs, providing the opportunity to self-direct care, increasing participant involvement in her or his care, and providing the opportunity for Participants live as independently as possible in the community. CMS and the State expect the FIDA-IDD Plan and providers to focus on personal outcomes and consumer choice as well as follow the principles of wellness and cultural competence to contribute to achieving these goals. This philosophy is focused on helping adults with IDD to live the life they choose.

The initiative will test the effect of an integrated care and payment model on serving both community and institutional populations. Comprehensive contract requirements will specify access, quality, network, financial solvency, and oversight standards. Contract management will focus on performance measurement, including the use of the Council on Quality and Leadership's Personal Outcome Measures, and continuous quality improvement. Except as otherwise specified in this MOU, the FIDA-IDD Plan will be required to comply with all applicable existing laws, rules, and regulations as well as Medicare and Medicaid program specific and evaluation requirements. Details will be further specified in a Three-way Contract to be executed among the FIDA-IDD Plan, the State, and CMS.

As part of this initiative, CMS and the State will test a new Medicare and Medicaid payment methodology designed to support the FIDA-IDD Plan in serving Medicare-Medicaid Enrollees in the Demonstration. This financing approach will minimize cost-shifting, align incentives between Medicare and Medicaid, and support the best possible health and functional outcomes for Participants.

CMS and the State will allow for certain flexibilities that will further the goal of providing a seamless experience for Medicare-Medicaid Enrollees, utilizing a simplified and unified set of rules. Flexibilities will be coupled with specific Participant safeguards which are included in this MOU and will be provided in greater detail in the Three-way Contract. The FIDA-IDD Plan will have full accountability for managing the capitated payment to best meet the needs of Participants. Person-Centered Individualized Service Plans, also known as "Life Plans" (LP), will be developed by Participants, their circles of support, and the Interdisciplinary Team, using a person-centered planning process. CMS and the State expect the FIDA-IDD Plan to achieve savings through better integrated and coordinated care. Subject to CMS and State oversight and as authorized by law, the FIDA-IDD Plan will have significant flexibility to innovate around care delivery and to provide a range of Community-based services as alternatives to or as means to

avoid high-cost services, such as, but not limited to, Facility-based Long-Term Services and Supports, as indicated by the Participants' wishes, needs, and LP.

Preceding the signing of this MOU, the State has undergone necessary planning activities consistent with the CMS standards and conditions for participation, as detailed through supporting documentation provided in Appendix 2. Stakeholder engagement specific to the FIDA-IDD Demonstration was limited while Federal-State discussions were pending. However, the stakeholder engagement did include a robust Participant- and stakeholder- engagement process on the development of specialized managed care programs for individuals with IDD generally and the involvement of two OPWDD Commissioner-led advisory bodies, the Joint Advisory Council and the Transformation Panel. The Joint Advisory Council will focus on FIDA-IDD implementation and quality improvement during the Demonstration.

II. SPECIFIC PURPOSE OF THIS MEMORANDUM OF UNDERSTANDING

This document describes the principles under which CMS and New York State plan to implement and operate the Demonstration. It also outlines the activities CMS and the State plan to conduct in preparation for implementation of the Demonstration.

Following the signing of this MOU and prior to the implementation of the Demonstration, the State and CMS will enter into a Three-way Contract with the selected Plan, which will have also met the Medicare components of the Plan selection process, including submission of a successful Capitated Financial Alignment Application to CMS, and adherence to any annual contract renewal requirements and guidance updates, as specified in Appendix 7. This Three-way Contract will include the additional operational and technical requirements pertinent to the implementation of the Demonstration. The Three-way Contract will set forth the terms and conditions of the Demonstration.

III. DEMONSTRATION DESIGN / OPERATIONAL PLAN

A. DEMONSTRATION AUTHORITY

The following is a summary of the terms and conditions the parties intend to incorporate into the Three-way Contract, as well as those activities the parties intend to conduct prior to entering into the Three-way Contract and initiating the Demonstration. This section and any appendices referenced herein are not intended to create contractual or other legal rights between the parties.

1. Medicare Authority: The Medicare elements of the initiative shall operate according to existing Medicare Parts C and D laws and regulations, as amended or modified, except to the extent these requirements are waived or modified as provided for in Appendix 4. As a term and condition of the initiative, the FIDA-IDD Plan will be required to comply with Medicare Advantage and Medicare Prescription Drug Program requirements in Part C and Part D of Title XVIII of the Social Security Act, 42 CFR Parts 422 and 423, and applicable sub-regulatory

guidance, as amended periodically, except to the extent specified in this MOU, including Appendix 4 and, for waivers of sub-regulatory guidance, the Three-way Contract.

2. **Medicaid Authority:** The Medicaid elements of the initiative shall operate according to existing Medicaid law and regulation and sub-regulatory guidance, including but not limited to the applicable requirements of the Social Security Act Section 1115(a) demonstration, any 1915(a) contract authority, and the OPWDD Comprehensive Waiver under Social Security Act Section 1915(c) which is applicable to those FIDA-IDD Participants who may be enrolled in that Section 1915(c) waiver, as amended or modified, except to the extent waived as provided for in Appendix 5. As a term and condition of the initiative, FIDA-IDD Plan will be required to comply with Medicaid managed care requirements under Title XIX of the Social Security Act and 42 CFR Part 438 et. seq., and applicable sub-regulatory guidance, as amended or modified, except to the extent specified in this MOU, including Appendix 5 and, for waivers of sub-regulatory guidance, the Three-way Contract. All settings and services delivered through providers opting into the network contracted for the FIDA-IDD Demonstration will adhere to the requirements under the Home and Community-based (HCBS) settings rule, in accordance with the State's Statewide Transition Plan, at CFR Part 441.301(c)(1-4), including the requirements for provider-owned and controlled residential settings, person-centered service planning, and any modifications of the additional conditions).

B. CONTRACTING PROCESS

1. **FIDA Plan Procurement Document:** The FIDA-IDD Plan is required to meet the following requirements.

The FIDA-IDD Plan has:

- Achieved a final score of 70 or higher on the Model of Care section of the CMS Capitated Financial Alignment Demonstration application;
- Submitted an acceptable response to the State-specific Model of Care element on "Use of Self-Directed Services" by May 7, 2013; and
- Met all requirements to become a Managed Long Term Care (MLTC) plan and have received a Certificate of Authority to operate a MLTC plan in the State by May 14, 2013.

Prior to implementation of the FIDA-IDD Demonstration, the FIDA-IDD Plan will:

- Participate in and acceptably complete a FIDA-IDD Demonstration readiness review that will be jointly conducted by CMS and the State; and
- Enter into a Three-way Contract with CMS and the State.

CMS required the FIDA-IDD Plan to submit a Capitated Financial Alignment Demonstration application to CMS and meet all of the Medicare components of the FIDA-IDD Plan selection process.

All applicable Medicare Advantage/ Part D requirements and Medicaid managed care requirements will apply, unless otherwise waived, as specified by CMS and the State herein or in the Three-way Contract.

2. FIDA-IDD Plan Selection: The State and CMS received applications to serve as a FIDA-IDD Plan. These applications were reviewed in accordance with the requirements outlined in Appendix 7, and the State and CMS determined that one applicant satisfies all FIDA requirements and can be selected to serve as the FIDA-IDD Plan for the Demonstration.

3. Medicare Waiver Approval: CMS approval of Medicare waivers is reflected in Appendix 4. CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be necessary for purposes of carrying out the model test described in this MOU, in the public interest, or promote the objectives of Title XVIII. CMS will promptly notify the State in writing of the determination and the reasons for the withdrawal, together with the effective date, and, subject to Section 1115A(d)(2) of the Social Security Act, afford the State a reasonable opportunity to request reconsideration of CMS' determination prior to the effective date. Termination and phase out would proceed as described in section III.L of this MOU. If a waiver or expenditure authority is withdrawn, Federal financial participation (FFP) is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including Covered Items and Services and administrative costs of disenrolling Participants.

4. Medicaid Waiver Approval: CMS approval of any new Medicaid waivers pursuant to 1115A or 1915 of the Social Security Act authority and processes is reflected in Appendix 5. CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities for the purpose of this Demonstration would no longer be necessary for purposes of carrying out the model test described in this MOU, in the public interest, or promote the objectives of Title XIX. CMS will promptly notify the State in writing of the determination and the reasons for the withdrawal, together with the effective date, and, subject to Section 1115A(d)(2) of the Social Security Act, afford the State an opportunity to request a hearing to appeal CMS' determination prior to the effective date. Termination and phase out would proceed as described in section III.L of this MOU. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including Covered Items and Services and administrative costs of disenrolling Participants.

5. Readiness Review: CMS and the State, either directly or with contractor support, shall conduct a readiness review of the selected FIDA-IDD Plan. Following the signing of the Three-way Contract, CMS and the State must agree that the FIDA-IDD Plan has passed readiness prior to accepting any enrollment or engaging in any marketing activities. CMS and the State will collaborate in the design and implementation of the readiness review process and requirements. This readiness review shall include an evaluation of the capacity of the potential FIDA-IDD Plan and its ability to meet all program requirements, including having an adequate network that addresses the full range of Participant needs, and the capacity to uphold all Participant safeguards and protections. CMS and the State will conduct a readiness review of the enrollment systems, staffing capacity, and other processes as well as their ability to meet enrollment

requirements. CMS and the State will confirm the readiness of the FIDA Administrative Hearing Unit for reviewing Medicare and Medicaid appeals.

6. **Three-way Contract:** CMS and the State shall develop a single Three-way Contract that both parties agree is administratively effective and ensures coordinated and comprehensive program operation, enforcement, monitoring, and oversight.

C. ENROLLMENT

1. Eligible Populations:

The FIDA-IDD Demonstration will be available to individuals who meet all of the following criteria:

- Age 21 or older at the time of enrollment;
- 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;
- A U.S. citizen or lawfully present in the United States;
- Reside in Bronx, Kings, New York, Queens, Richmond, Rockland, Nassau, Suffolk or Westchester Counties;
- Eligible for OPWDD services in accordance with NYS Mental Hygiene Law 1.03(22); and
- Determined to be eligible for ICF-IID level of care; and
- If receiving Section 1915(c) waiver services as an alternative to ICF-IID placement, enrolled in the Section 1915(c) OPWDD Comprehensive Waiver.

The following populations are not eligible for the FIDA-IDD Demonstration:

- Residents of a New York State Office of Mental Health (OMH) facility;
- Residents of a Skilled Nursing Facility [SNF/Nursing Facility (NF)] and Residents of Developmental Centers. Upon leaving the SNF/NF or Development Center, the person with a developmental disability is then eligible for the FIDA-IDD Demonstration or Medicaid Fee-for-Service.
 - a) A FIDA-IDD Participant who, after enrolling in the FIDA-IDD Demonstration subsequently requires placement in a SNF/NF will remain in the FIDA-IDD Demonstration.
 - b) A FIDA-IDD Participant who after enrolling in the FIDA-IDD Demonstration subsequently remains continuously in a Development Center for more than 90 days will be disenrolled from the FIDA-IDD Demonstration;
- Individuals under the age of 21;
- Residents of psychiatric facilities;

- Individuals expected to be Medicaid eligible for less than six months;
- 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 OMH facility);
- Individuals eligible for the family planning expansion program;
- Residents of alcohol/substance abuse long-term residential treatment programs;
- Individuals eligible for Emergency Medicaid;
- Individuals enrolled in a Section 1915(c) waiver other than the OPWDD Comprehensive Waiver. Individuals enrolled in the following Section 1915(c) waivers programs are not eligible to participate in the FIDA-IDD Demonstration: Traumatic Brain Injury (TBI); Nursing Home Transition and Diversion Waiver; and Long Term Home Health Care Waiver;
- Residents of Assisted Living Programs; and
- Individuals in the Foster Family Care Demonstration.

2. Enrollment and Disenrollment Processes: The State will open enrollment to the eligible population no earlier than April 1, 2016. Eligible individuals will be informed no earlier than March 1, 2016 of the opportunity to opt into the FIDA-IDD Plan for coverage starting no earlier than April 1, 2016. There is no passive enrollment for the FIDA-IDD Demonstration.

All enrollments or disenrollments will be effective the first of the month following the request. Enrollment in or disenrollment from the FIDA-IDD Plan shall be allowed on a month-to-month basis any time during the year, with coverage continuing through the end of the month. CMS and the State will monitor enrollments, disenrollments, and Appeals and Grievances for both evaluation purposes and for compliance with applicable marketing and enrollment laws, regulations, and CMS policies for the purposes of identifying any inappropriate or illegal enrollment, disenrollment, or marketing practices.

If the FIDA-IDD Plan is under the same parent company as any Medicaid Managed Care plan for which the State has terminated or suspended enrollment and marketing activities related to the Medicaid Managed Care plan, the Plan is not permitted to conduct enrollment or marketing activities related to the FIDA-IDD Plan until the Medicaid Managed Care plan deficiencies are resolved or may be disqualified from the Demonstration. Similarly, per January 9, 2013 guidance from CMS, if the FIDA-IDD Plan is under the same parent company as any plan subject to Medicare enrollment and/or marketing sanction as described in 42 CFR Part 422.750 and 42 CFR Part 423.750 at the time CMS and the State seek to execute the Three-way Contract, then the FIDA-IDD Plan will be ineligible to participate.

As mutually agreed upon, and as discussed further in Appendix 7 and the Three-way Contract, CMS, and the State will utilize an independent third party entity (Enrollment Broker) to facilitate all enrollments into the FIDA-IDD Plan. The Enrollment Broker will receive training on the

FIDA-IDD Demonstration and the population it serves and the call center representatives (CSRs) will be required to utilize FIDA-IDD-specific scripts. FIDA-IDD Plan enrollments shall become effective on the same day for both Medicare and Medicaid (the first day of the following month). CMS and the State may establish a later effective date for enrollment requests received late in the calendar month. For those who lose Medicaid eligibility during the month, coverage and Federal financial participation will continue through the end of that month unless the FIDA-IDD Plan chooses to allow a period of deemed continuous eligibility in which case it will continue in accordance with Exhibit 22 of the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance, which discusses an option for deemed continuous eligibility.

3. Uniform Enrollment/Disenrollment Documents: CMS and the State shall jointly develop uniform enrollment and disenrollment notices, forms, and other documents.

4. Outreach and Education: FIDA-IDD Plan outreach and marketing materials will be subject to a single set of marketing rules defined by CMS and the State, as further detailed in Appendix 7.

5. Single Identification Card: CMS and the State shall work with the FIDA-IDD Plan to develop a single identification card that can be used to access all care needs, as further detailed in Appendix 7.

6. Interaction with other Demonstrations: To best ensure continuity of Participant care and provider relationships, CMS will work with the State to address Participant or provider participation in other programs or initiatives, such as Accountable Care Organizations (ACOs). A Participant enrolled in the Demonstration will not be enrolled in, nor have costs attributed to, an ACO or any other shared savings initiative for the purposes of calculating shared Medicare savings under those initiatives.

D. DELIVERY SYSTEMS AND BENEFITS

1. FIDA-IDD Plan Service Capacity: CMS and the State shall contract with the FIDA-IDD Plan that demonstrates the capacity to provide, directly or by subcontracting with other qualified entities, the full continuum of Medicare and Medicaid Covered Items and Services to Participants, in accordance with this MOU and the access and adequacy standards outlined in Appendix 7, CMS guidance, and the Three-way Contract. Medicare covered benefits shall be provided in accordance with 42 CFR Part 422 and 42 CFR Part 423 et seq. Medicaid covered benefits shall be provided in accordance with the requirements in the approved Medicaid State Plan, including any applicable State Plan Amendments, Section 1115(a) demonstration terms and conditions, Section 1915(c) waivers, and in accordance with the requirements specified by the Three-way Contract and this MOU. All settings and services delivered through providers opting into the network contracted for the FIDA-IDD Demonstration will adhere to the requirements under the Home and Community-based settings rule, in accordance with the State's Statewide Transition Plan, at CFR Part 441.301(c)(1-4), including the requirements for provider-owned and controlled residential settings, person-centered service planning, and any modifications of the additional conditions). In accordance with the Three-way Contract and this MOU, CMS and the State may choose to allow for greater flexibility in offering additional benefits that exceed those currently covered by either Medicare or Medicaid, as discussed in Appendix 7. CMS, the State,

and FIDA-IDD Plan will ensure that Participants have access to an adequate network of medical, developmental, habilitation, drug, behavioral health, and Community and Facility-based LTSS providers that are appropriate and capable of addressing the needs of this diverse population, as discussed in more detail in Appendix 7.

2. FIDA-IDD Plan Risk Arrangements: CMS and the State shall require the FIDA-IDD Plan to provide a detailed description of its risk arrangements, if any, with providers under subcontract with the FIDA-IDD Plan. This description shall be made available to FIDA-IDD Plan Participants upon request. It will not be permissible for any incentive arrangements to include any payment or other inducement that serves to withhold, limit, or reduce necessary medical or non-medical items or services to Participants.

For services other than Section 1915(c) Comprehensive OPWDD Waiver Services, the FIDA-IDD Plan is encouraged to implement an alternative payment system through which providers are paid on an alternative basis to traditional fee-for-service as soon as practicable (e.g., pay for performance, bundled payment). To encourage the adoption of these methodologies, the FIDA-IDD Plan is required to develop and submit a plan for developing alternative payment systems addressing the full continuum of covered services, including Section 1915(c) Comprehensive OPWDD Waiver Services, for State and CMS review no later than July 1, 2016. Once a plan is approved, the FIDA-IDD plan must comply with its provisions or seek CMS and State approval of modifications. CMS and the State have the authority to direct the FIDA-IDD plan to make modifications to the alternative payment methodologies as warranted by reporting, grievances, appeals, stakeholder feedback, or other data. These requirements notwithstanding, the FIDA-IDD plan may not implement alternative payment methodologies for Section 1915(c) Comprehensive OPWDD Waiver services earlier than January 1, 2017 or without prior approval of the specific methodologies as described in the plan.

3. FIDA-IDD Plan Financial Solvency- Arrangements: CMS and the State have established a standard for the FIDA-IDD Plan, as articulated in Appendix 7.

E. PARTICIPANT PROTECTIONS, PARTICIPATION, AND CUSTOMER SERVICE

1. Choice of Plan and Providers: Participants will maintain their choice of providers from amongst those that participate in the FIDA-IDD Plan's network. Participants may also exercise the right to disenroll from the FIDA-IDD Plan at any time, effective the first calendar day of the following month. As an alternative to the FIDA-IDD Plan, Participants have the right to choose to receive their Medicare benefits through a Medicare Advantage plan or Medicare Fee-for-Service (FFS) and to receive their Medicaid benefits through Medicaid FFS and any available Medicaid managed care options for which they are eligible.

2. Continuity of Care: CMS and the State will require the FIDA-IDD Plan to ensure that individuals continue to have access to medically necessary items, services, prescription and non-prescription drugs, and medical, developmental disability, habilitation, behavioral health, and Community-based and Facility-based LTSS providers (including OPWDD Service providers) for the transition period as specified in Appendix 7. In addition, during the transition, the FIDA-IDD

Plan will advise Participants and their providers if and when they have received care pursuant to the continuity of care policy that would not otherwise be covered at an in-network level. On an ongoing basis as appropriate, the FIDA-IDD Plan must also contact providers serving Participants who are not already members of its network with information on becoming credentialed as in-network providers. Medicare Part D transition rules and rights will continue as provided for in current law and regulation.

3. Enrollment Assistance and Options Counseling: The State will provide Medicare-Medicaid Participants with independent enrollment assistance and options counseling to help them make an enrollment decision that best meets their needs. The State will contract with the independent Enrollment Broker to ensure ongoing outreach, objective education, and support to individuals eligible for the FIDA-IDD Demonstration.

4. Participant Ombudsman: The State has established a new FIDA Participant Ombudsman. The FIDA Participant Ombudsman will be an independent entity under contract with the State to help Participants and their caregivers/guardians or designees access the care Participants need through the FIDA and FIDA-IDD Demonstrations. CMS will support Participant Ombudsman training on the Demonstrations and their objectives, and CMS, the Administration for Community Living (ACL), and the State will provide ongoing technical assistance to the Participant Ombudsman. The Participant Ombudsman will support individual advocacy and independent systematic oversight for the FIDA and FIDA-IDD Demonstrations, with a focus on compliance with principles of community integration, and person-centered care in the home and community-based care context. The Participant Ombudsman will be responsible for assisting Participants in accessing services through the FIDA and FIDA-IDD Plans and for gathering and reporting data to the State and CMS (via the Contract Management Team) as described in Appendix 7 of this MOU.

5. Person-Centered, Appropriate Care: CMS, the State, and the FIDA-IDD Plan shall ensure that all medically necessary covered benefits are provided to Participants and are provided in a manner that is sensitive to the Participant's functional and cognitive needs, language and culture, allows for involvement of the Participant, Representative and or designees, and is in a care setting appropriate to the Participant's needs, with a preference for the home and the community. CMS, the State, and the FIDA-IDD Plan shall ensure that care is person-centered and can accommodate and support self-direction. The FIDA-IDD Plan shall also ensure that medically necessary Covered Items and Services are provided to Participants, in the least restrictive community setting, and in accordance with the Participant's wishes and the LP.

6. Americans with Disabilities Act (ADA) and Civil Rights Act of 1964: CMS and the State expect FIDA-IDD Plan and provider compliance with the ADA and the Civil Rights Act of 1964 to promote the success of the FIDA-IDD Plan model and support better health outcomes for FIDA-IDD Plan Participants. In particular, CMS and the State recognize that successful person-centered care requires physical access to buildings, services, and equipment and flexibility in scheduling and processes. CMS and the State will require the FIDA-IDD Plan to contract with providers that demonstrate their commitment and ability to accommodate the physical access and flexible scheduling needs of their Participants and have experience and expertise in serving adults with IDD.

CMS and the State also recognize that access includes effective communication. CMS and the State will require the FIDA-IDD Plan and its providers to communicate with the FIDA-IDD Plan Participants in a manner that accommodates their individual needs, including providing interpreters for those who are deaf or hard of hearing, accommodations for Participants with cognitive limitations, and interpreters for those who do not speak English. Also, CMS and the State recognize the importance of staff training on accessibility and accommodation, self-empowerment models, cultural competency, and wellness philosophies. CMS and the State will continue to work with stakeholders, including Participants, to further develop learning opportunities, monitoring mechanisms, and quality measures to ensure that the FIDA-IDD Plan and its providers comply with all requirements of the ADA. Finally, CMS and the State are committed to compliance with the ADA, including application of the Supreme Court's *Olmstead* decision, and agree to ensure, through ongoing surveys and readiness and implementation monitoring, that the FIDA-IDD Plan provides for Participants' long-term services and supports in the most integrated settings.

7. Participant Communications: CMS and the State agree that Participant and prospective Participant materials, in all forms, shall require prior approval by CMS and the State unless CMS and the State agree that one or the other entity is authorized to review and approve such documents on behalf of CMS and the State. CMS and the State will also work to develop pre-approved documents, some of which may be required to be used and some of which may be used at the option of the plan but, in either instance, may be used, under certain circumstances, without additional CMS or State approval. All materials shall be integrated and include, but not be limited to: outreach and education materials; enrollment and disenrollment materials; benefit coverage information; and operational letters for enrollment, disenrollment, claims or service denials, Grievances, appeals, and provider terminations. Such uniform/integrated materials will be required to be accessible and understandable (i.e., no more than a sixth grade reading level) to the Participants that will be enrolled in the FIDA-IDD Plan, their representatives and designees. This includes individuals with disabilities, including but not limited to, those with cognitive and functional limitations, and those with limited English proficiency, in accordance with current Federal guidelines for Medicare and Medicaid. Where Medicare and Medicaid standards differ, the standard providing the greatest access to individuals with disabilities or limited English proficiency will apply.

8. Participant Participation on Governing and Advisory Boards: As part of the Three-way Contract, CMS and the State shall require the FIDA-IDD Plan to obtain Participant and community input on issues of program management and Participant care through a range of approaches. The FIDA-IDD Plan must establish at least one Participant Advisory Committee (PAC) that meets quarterly and is open to all Participants and/or their Representative or designees (e.g., parents, siblings, etc.). PAC members and the Participant Ombudsman will be invited to participate in the State's ongoing stakeholder process. The FIDA-IDD Plan must also establish a process for that PAC to provide input to the FIDA-IDD Plan. The FIDA-IDD Plan must demonstrate that the Participant PAC composition reflects the diversity of the FIDA-IDD Demonstration Participant population, and participation of individuals with disabilities, including Participants, Representatives or designees, within the governance structure of the FIDA-IDD Plan. The FIDA-IDD Plan will also be encouraged to include Participant representation on their

boards of directors. The State will maintain additional processes for ongoing stakeholder participation and public comment, as discussed in Appendix 7.

9. FIDA Plan Customer Service Representatives: CMS and the State shall require the FIDA-IDD Plan to employ or contract with sufficient numbers of customer service representatives who shall answer all inquiries and respond to Participant complaints and concerns. In addition, CMS and the State shall themselves employ or contract with sufficient call center and customer service representatives to address Participant questions and concerns. In New York, this will be done through contracts with the State Enrollment Broker and the Participant Ombudsman. The FIDA-IDD Plan, CMS, and the State shall work to assure the sensitivity, language, and cultural competency of customer service representatives to adequately meet the needs of the Participant population. All services must be culturally and linguistically appropriate and accessible. More detailed information about customer service requirements is included in Appendix 7.

10. Privacy and Security: CMS and the State shall require the FIDA-IDD Plan to ensure the privacy and security of Participant health records and provide for access by Participants to such records in accordance with applicable law. These requirements shall be specified in the Three-way Contract.

11. Integrated Appeals and Grievances: As referenced in section III.F and Appendix 7, Participants will have access to an integrated appeals and grievances process, the details of which are fully outlined in Appendix 7.

12. Cost Sharing for Items and Services: The FIDA-IDD Plan will not charge Medicare premiums, nor assess any cost sharing for Medicare Parts A and B services. The Plan will be permitted to charge Medicare Part D copays to individuals currently eligible to make such payments. Copays charged by the FIDA-IDD Plan must not exceed the lesser of: the applicable amounts for brand and generic drugs established yearly by CMS under the Part D Low Income Subsidy, or the applicable Medicaid copay amounts. This will allow CMS to test whether reducing Participant cost sharing for pharmacy products improves health outcomes and reduces overall health care expenditures through improved medication adherence under the Demonstration. The FIDA-IDD Plan will not assess any cost sharing for Medicaid services, beyond the pharmacy cost sharing described here.

13. No Balance Billing: No Participant may be balance billed by any provider for any reason for Covered Items and Services.

F. INTEGRATED APPEALS AND GRIEVANCES

1. FIDA Plan Grievances and Internal Appeals Processes: CMS and the State agree to utilize a unified set of requirements for FIDA-IDD Plan grievances and internal appeals processes that incorporate relevant Medicare Advantage and Medicaid Managed Care requirements, to create a more Participant-friendly and easily navigable system. This is discussed in further detail in Appendix 7 and will be specified in the Three-way Contract. All FIDA-IDD Plan Grievances and Internal Appeals procedures shall be subject to the review and prior approval of CMS and the State. Medicare Part D appeals and grievances will continue to be managed under existing Part D

rules. CMS and the State will work to continue to coordinate grievances and appeals for all items and services.

2. External Appeals Processes: CMS and the State agree to utilize the streamlined Appeals process outlined in Appendix 7. This will create a more Participant friendly and easily navigable system. Protocols and model notices will be developed to assure coordinated access to the appeals mechanism. This process and these protocols are discussed in further detail in Appendix 7. Part D appeals and grievances will continue to be managed under existing Part D rules. As indicated in Appendix 7, below, CMS and the State will continue to work together and to engage stakeholders to develop an increasingly integrated appeals process that is at least as protective of beneficiary rights and ensures that both Medicare's and Medicaid's coverage policies are accurately applied.

G. ADMINISTRATION AND REPORTING

1. FIDA-IDD Plan Contract Management: As more fully discussed in Appendix 7, CMS and the State agree to designate representatives to serve on a CMS-State Contract Management Team which shall conduct FIDA-IDD Plan contract management activities related to ensuring access, quality, program integrity, program compliance, and financial solvency.

These activities shall include but not be limited to:

- Reviewing and analyzing Health Care Effectiveness Data and Information Set (HEDIS) data, Consumer Assessment of Health Care Providers and Systems (CAHPS) Survey data, Council on Quality and Leadership (CQL) Personal Outcome Measures, Health Outcomes Survey (HOS) data, National Quality Indicator data, and enrollment and disenrollment reports.
- Reviewing any other performance metrics applied for quality withhold or other purposes.
- Reviewing reports of Participant complaints, reviewing compliance with applicable CMS and/or State Medicaid Agency standards, and initiating programmatic changes and/or changes in clinical protocols, as appropriate.
- Reviewing and analyzing reports on the FIDA-IDD Plan's fiscal operations and financial solvency, conducting program integrity studies to monitor fraud, waste, and abuse as may be agreed upon by CMS and the State, and ensuring that the FIDA-IDD Plan takes corrective action, as appropriate.
- Reviewing and analyzing reports on the FIDA-IDD Plan's network adequacy, including the FIDA-IDD Plan's ongoing efforts to replenish their networks and to continually enroll qualified providers.
- Reviewing any other applicable ratings and measures.
- Reviewing reports from the Participant Ombudsman.
- Reviewing direct stakeholder input on both FIDA-IDD Plan-specific and systematic performance.
- Responding to and investigating Participant complaints and quality of care issues.

2. FIDA-IDD Plan Monitoring: CMS and the State will establish procedures for FIDA-IDD Plan monitoring, as described in Appendix 7. Oversight shall generally be conducted in line with the following principles:

- The State and CMS will each retain, yet coordinate, current responsibilities toward the Participant such that Participants maintain access to their benefits across both programs.
- CMS and the State will leverage existing protocols to identify and solve Participant access problems in real-time (e.g. responding to Participant complaints, conducting account management, and analyzing enrollment data).
- Oversight will be coordinated and subject to a unified set of requirements. Oversight will build on areas of expertise and capacity of the State and CMS, leveraging the CMS-State Contract Management Team, as described in Appendix 7.
- Oversight of the FIDA-IDD Plan and providers will be at least as rigorous as existing procedures for Medicare Advantage, Medicare Part D, the State's 1115(a) demonstration, and the State's Medicaid 1915(c) waiver and managed care programs.
- Part D oversight will continue to be a CMS responsibility, with appropriate coordination and communication with the State. The FIDA-IDD Plan will be included in all existing Medicare Advantage and Medicare Part D oversight activities, including (but not limited to) data-driven monitoring, secret shopping, contracted monitoring projects, plan ratings, formulary administration and transition review, and possibly audits.
- Oversight will include a focus on fraud, waste, and abuse.
- CMS and the State will enhance existing mechanisms and develop new mechanisms to foster performance improvement and remove consistently poor performers from the program, leveraging existing CMS tools, such as the Complaints Tracking Module or the Part D Critical Incidence Reporting System, and existing State oversight and tracking tools. Standards for removal on the grounds of poor performance will be articulated in the Three-way Contract.

3. Consolidated Reporting Requirements: CMS and the State shall define and specify in the Three-way Contract a Consolidated Reporting Process for the FIDA-IDD Plan that ensures the provision of the necessary data on diagnosis, HEDIS, and other quality measures, Participant satisfaction and evidence-based measures, and other information as may be beneficial in order to monitor the FIDA-IDD Plan's performance. The FIDA-IDD Plan will be required to meet the encounter reporting requirements that are established for the Demonstration.

4. Accept and Process Data: CMS, or its designated agent(s), and the State shall accept and process uniform person-level Participant Data, for the purposes of program eligibility, payment, and evaluation. Submission of data to the State and CMS must comply with all relevant Federal and State laws and regulations, including, but not limited to, regulations related to HIPAA and to electronic file submissions of patient identifiable information. Such data will be shared by each party with the other party to the extent allowed by law and regulation. This is discussed in more detail in Appendix 7. CMS and the State shall streamline data submissions for the FIDA-IDD Plan wherever practicable.

H. QUALITY MANAGEMENT

1. **Quality Management and Monitoring:** As a model conducted under the authority of Section 1115A of the Social Security Act, the Demonstration and independent evaluation will include and assess quality measures designed to ensure Participants are receiving high quality care. In addition, CMS and the State shall conduct a joint comprehensive performance and quality monitoring process that is at least as rigorous as the Medicare Advantage, Medicare Part D, the State's Section 1115(a) demonstration, and the State's Medicaid Section 1915(c) Comprehensive OPWDD Waiver and managed care programs' requirements. The reporting frequency and monitoring process will be specified in the Three-way Contract. This section of the MOU does not relieve NYSDOH and OPWDD of the oversight responsibilities required under the 1915(c) OPWDD Comprehensive Waiver as outlined in Appendix 5 of this MOU.

2. **External Quality Reviews:** CMS and the State shall coordinate the FIDA-IDD Plan external quality reviews conducted by the Quality Improvement Organization (QIO) and External Quality Review Organization (EQRO).

3. **Determination of Applicable Quality Standards:** CMS and the State shall determine applicable quality standards and monitor the FIDA-IDD Plan's compliance with those standards. These standards are articulated in Appendix 7 and the FIDA-IDD Plan Three-way Contract.

I. FINANCING AND PAYMENT

1. **Rates and Financial Terms:** For each calendar year of the Demonstration, before rates are offered to the FIDA-IDD Plan, CMS shall share with the State the amount of the Medicare portion of the capitated rate, as well as collaborate to establish the data and documentation needed to assure that the Medicaid portion of the capitation rate is consistent with all applicable Federal requirements.

2. **Blended Medicare and Medicaid Payment:** CMS will make separate payments to the FIDA-IDD Plan for the Medicare Parts A/B and Part D components of the rate. The State will make a payment to the FIDA-IDD Plan for the Medicaid component of the rate, as more fully detailed in Appendix 6.

J. EVALUATION

1. **Evaluation Data to be Collected:** CMS and the State have developed processes and protocols, as specified in Appendix 7 and as will be further detailed in the Three-way Contract, for collecting or ensuring the FIDA-IDD Plan or their contractors collect and report to CMS and the State the data needed for evaluation.

2. **Monitoring and Evaluation:** CMS will fund an external, independent evaluation. The Demonstration will be evaluated in accordance with Section 1115A(b)(4) of the Social Security Act. As further detailed in Appendix 7, CMS or its contractor will measure, monitor, and evaluate the overall impact of the Demonstration including the impacts on program expenditures and service utilization changes, including monitoring any shifting of services between medical and non-medical services and between traditional OPWDD Services and other LTSS. The evaluation will include changes in person-level health outcomes, experience of care, and costs by sub-population(s), and changes in patterns of primary, acute, and long-term care and support

services use and expenditures, using principles of rapid-cycle evaluation and feedback. Key aspects and administrative features of the Demonstration, including but not limited to enrollment, marketing, and appeals and grievances will also be examined per qualitative and descriptive methods. The evaluation will consider potential interactions with other demonstrations and initiatives, and seek to isolate the effect of this Demonstration as appropriate. The State will collaborate with CMS or its designated agent during all monitoring and evaluation activities. The State and the FIDA-IDD Plan will submit all data required for the monitoring and evaluation of this Demonstration, according to the data and timeframe requirements listed in the Three-way Contract with the FIDA-IDD Plan. The State and FIDA-IDD Plan will submit both historical data relevant to the evaluation, including MSIS data from the years immediately preceding the Demonstration, and data generated during the Demonstration period.

K. EXTENSION OF AGREEMENT

The State may request an extension of this Demonstration, which will be evaluated consistent with terms specified under Section 1115A(b)(3) of the Social Security Act such as ensuring the Demonstration is improving the quality of care without increasing spending; reducing spending without reducing the quality of care; or improving the quality and care and reducing spending. Any extension request will be subject to CMS approval.

L. MODIFICATION OR TERMINATION OF MOU

The State agrees to provide notice to CMS of any Medicaid State Plan, waiver, or State law or statutory changes that may have an impact on the Demonstration.

1. **Limitations of MOU:** This MOU is not intended to, and does not, create any right or benefit, substantive, contractual or procedural, enforceable at law or in equity, by any party against the United States, its agencies, instrumentalities, or entities, its officers, employees, or agents, or any other person, or against the State, its instrumentalities, officers, employees, contractors or any other agent of the State. Nothing in this MOU may be construed to obligate the parties to any current or future expenditure of resources. This MOU does not obligate any funds by either of the parties. Each party acknowledges that it is entering into this MOU under its own authority.

2. **Modification:** Either CMS or the State may seek to modify, amend, or extend the duration of this MOU per a written request and subject to requirements set forth in Section 1115A(b)(3) of the Social Security Act such as ensuring the Demonstration is improving the quality of care without increasing spending; reducing spending without reducing the quality of care; or improving the quality of care and reducing spending. Any material modification, including extension, shall require written agreement by both parties and a stakeholder engagement process that is consistent with the process required under this Demonstration. At the end of each Demonstration Year, the Director of the Medicare-Medicaid Coordination Office (MMCO) will meet with the State Medicaid Director and the OPWDD Commissioner to discuss the performance of the FIDA-IDD Plan. These parties will review available data, as applicable, including data on enrollment, utilization patterns, health plan expenditures, and risk adjustment to assess whether the FIDA-IDD Plan is meeting the objectives of CMS and the State for this Demonstration, including cost savings. Together, the State and CMS will determine the need to take any performance improvement steps, and will discuss opportunities for

extending the Demonstration for an additional year, subject to Section 1115A of the Social Security Act.

3. **Termination:** CMS or the State may terminate this MOU under the following circumstances:

a. Termination without cause - Except as otherwise permitted below, a termination by CMS or the State for any reason will require that CMS or the State provides a minimum of 90 calendar days' advance notice to the other entity and 60 calendar days' advance notice to Participants and the general public.

b. Termination pursuant to Social Security Act § 1115A(b)(3)(B).

c. Termination for cause - Either CMS or the State may terminate this MOU upon 30 calendar days' advance notice due to a material breach of a provision of this MOU.

d. Termination due to a Change in Law - In addition, CMS or the State may terminate this MOU upon 30 calendar days' advance notice due to a material change in law, or with less or no notice if required by law.

If the Demonstration is terminated as set forth above, CMS shall provide the State with the opportunity to propose and implement a phase-out plan that assures notice and access to ongoing coverage for Participants, and, to the extent that timing permits, adheres to the phase-out plan requirements detailed below. All Participants must be successfully enrolled in a Medicare Part D plan prior to termination of the Demonstration.

4. **Demonstration phase-out.** Termination at the end of the Demonstration must follow the following procedures:

a. Notification – Unless CMS and the State agree to extend the Demonstration, the State must submit a draft phase-out plan to CMS no fewer than five months before the end date of this MOU. Prior to submitting the draft phase-out plan, the State must publish on its website the draft phase-out plan for a 30-day public comment period. The State shall summarize comments received and share such summary with CMS. Both parties must agree to phase-out activities and implement such activities within 14 days of CMS approval of such agreement.

b. Phase-out Plan Requirements - The State must include, at a minimum, in its phase-out plan the process by which it will notify affected Participants, the content of said notices (including information on how Participant appeal rights will continue to operate during the phase-out and any FIDA-IDD Plan transition), the process by which the State will conduct administrative reviews of Medicaid eligibility for the affected Participants, and ensure ongoing coverage for eligible individuals, including plans for enrollment of all Participants in a Medicare Part D plan, as well as any community outreach activities. In addition, such plan must include any ongoing FIDA-IDD Plan and State responsibilities and close-out costs.

c. Phase-out Procedures - The State must comply with all notice requirements found in 42 CFR Parts 431.206, 431.210, and 431.213. In addition, the State must assure all appeal and hearing rights afforded to Participants as outlined in 42 CFR Parts 431.220 and 431.221. If a Participant requests a hearing before the date of action, the State must maintain benefits as required in 42 CFR Part 431.230. If applicable, the State must conduct administrative renewals for all affected Participants in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in the October 1, 2010, State Health Official Letter #10-008.


d. Federal Financial Participation - If the Demonstration is terminated by either party or any relevant waivers are suspended or withdrawn by CMS, Federal Financial Participation shall be limited to normal closeout costs associated with terminating the Demonstration, including Covered Items and Services and administrative costs of disenrolling Participants.

M. SIGNATURES

This MOU is effective on this day forward, _____ through the end of the Demonstration period December 31, 2020. Additionally, the terms of this MOU shall continue to apply to the State and the FI DA Plan as they implement associated phase-out activities beyond the end of the Demonstration period.

In Witness Whereof, CMS and the State of New York have caused this Agreement to be executed by their respective authorized officers:

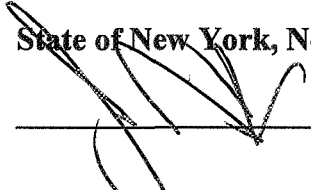
United States Department of Health and Human Services, Centers for Medicare & Medicaid Services:



Date NOV 05 2015

Andy Slavitt
Acting Administrator

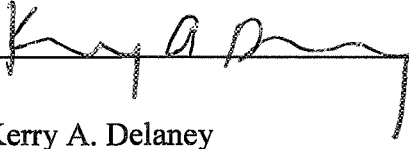
State of New York, New York State Department of Health:



Date 11/2/15

Jason Helgeson
Medicaid Director

State of New York, Office for People with Developmental Disabilities:



Date 10/30/2015

Kerry A. Delaney
Acting Commissioner

Appendix 1: Definitions

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-IDD Plan); or failure to make a grievance determination within required timeframes.

Appeals – A Participant’s request for review of any update to or reauthorization of the Participant’s LP or an Action taken by the FIDA-IDD Plan related to Covered Items or Services.

Care Management –A collaborative process that assists each Participant in accessing services as identified in the Participant’s LP. 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 Participant’s LP. Care management services will assist Participants to obtain needed medical, developmental, habilitation, behavioral health, prescription and non-prescription drugs, Community-based or Facility-based LTSS, social, educational, psychosocial, financial and other services in support of the LP irrespective of whether the needed services are covered under the capitation payment of the Three-way Contract.

Care Manager – A Care Manager must be a licensed professional such as an Registered Nurse (RN), Licensed Social Worker, or Psychologist and have one year experience working with individuals with IDD. A Care Manager is required to have appropriate experience and qualifications commensurate with a Participant’s individual needs (i.e., communication, cognitive, or other barriers) and have knowledge of: physical health; OPWDD Services; appropriate services in the community; frequently used medications and their potential negative side-effects; depression; challenging behaviors; Alzheimer’s’ disease and other disease-related dementias; behavioral health; and issues related to accessing and using durable medical equipment. The FIDA-IDD Plan Care Manager is the IDT lead and facilitates all IDT activities. The Care Manager may request information from the FIDA-IDD Plan’s Utilization Management (UM) staff, such as information about medical necessity, clinical guidelines, or evidence-based best practices. The UM staff, however, may not participate in IDT meetings, and should not be deemed members of the IDT. For each Participant, the FIDA-IDD Plan’s IDT shall consist of the Participant’s Care Manager and specific other persons with relevant expertise and experience appropriate to address the needs of Participants. The Care Manager shall be the point of contact for the Participant or be responsible for assigning and overseeing a point of contact.

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 or ICF/IID care and to enable a person to live as independently as possible.

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 the FIDA-IDD Plan specifying the terms and conditions pursuant to which a participating FIDA-IDD Plan may participate in this Demonstration.

Contract Management Team – A group of CMS, NYSDOH, and OPWDD representatives responsible for overseeing the Three-way Contract for the FIDA-IDD Demonstration.

Covered Services – The set of services required to be offered by the FIDA-IDD Plan.

Council on Quality Leadership’s Personal Outcome Measures –These measures are consistent with self-determination and self-advocacy and are used to promote and monitor person-centered planning. The measures are based on three factors: My Self, My World, and My Dreams and encompass 21 personal outcome measures developed by the Council on Quality and Leadership (CQL).

Cultural Competence – Understanding those values, beliefs, and needs that are associated with an individual’s disability, 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 and developmental services to persons with intellectual and developmental disabilities and/or congenital or acquired disabilities.

Demonstration (also FIDA-IDD Demonstration) – Initiative to better serve individuals eligible for both Medicare and Medicaid (“Medicare-Medicaid Enrollees”) who have intellectual and developmental disabilities.

Designee - An adult that a Participant with capacity to designate has invited to participate in decision making about the Participant’s enrollment and services from the FIDA-IDD Plan.

Developmental Center – OPWDD operated residential treatment facility serving individuals with intellectual and developmental disabilities. These include Brooklyn Developmental Center, Broome Developmental Center, Bernard Fineson Developmental Center, Sunmount Developmental Center, and Valley Ridge Developmental Center.

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

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 that is filed with CMS and/or the State. This is not an Appeal.

Facility-based Long-Term Services and Supports (LTSS) – Facility-based LTSS are a range of medical, social, habilitation 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 or intermediate care facility, ICF-IID (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 Plan.

FIDA-IDD Comprehensive Service Planning Assessment – A systematic evaluation of the Participant’s care and service needs as further described herein. The FIDA-IDD Comprehensive Service Planning Assessment will be conducted using the “It’s All About Me” (IAM) tool. The FIDA-IDD Plan, as part of the care planning process, will complete the IAM, a person-centered assessment written in person-first language which describes the functional status, needs and wishes of a person with IDD across 24 domains and determines a recommended list of actions based on the person’s current status. Among the domains covered by IAM are the following: social, functional, medical, behavioral, wellness and prevention domains, caregiver’s status and capabilities, as well as the Participant’s preferences, strengths, and goals. The FIDA-IDD Plan’s Assessment RN shall use relevant and comprehensive data sources when completing the IAM, including the Participant, Providers, and their caregivers, Representatives, or designees. The IAM results, in addition to the results of the OPWDD Approved Assessment (the Coordinated Assessment System), will be used as the basis for developing the integrated, LP.

Fully-Integrated Duals Advantage Individuals with Intellectual and Developmental Disabilities Plan (FIDA-IDD Plan) – A managed care plan under contract with CMS and the State to provide the fully-integrated Medicare and Medicaid benefits, including OPWDD Covered Items and Services, under the FIDA-IDD Demonstration.

Grievance – In accordance with 42 CFR Part 438.400, grievance means an expression of dissatisfaction about any matter other than an Action A grievance, and is filed and decided at the FIDA-IDD 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) – A 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.

It's All About Me (IAM) Tool – A person-centered assessment used by the FIDA-IDD Plan to complete the Comprehensive Service Planning Assessment. The “It’s All About Me” (IAM) Tool is written in person-first language which describes the functional status, needs and wishes of a person with IDD across 24 domains and determines a recommended list of actions based on the person’s current status. Specifically, the IAM Tool covers the following domains: social, functional, medical, behavioral, wellness and prevention domains, caregiver’s status and capabilities, as well as the Participant’s preferences, strengths, and goals.

Intellectual and Developmental Disabilities (IDD) – A developmental disability as defined in N.Y. Mental Hygiene Law. § 1.03(22).

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

Intermediate Care Facility (ICF-IID) – A residential facility certified by OPWDD as an ICF/IID providing comprehensive and individualized health care and habilitation services to individuals with IDD to promote their functional status and independence. ICF-IID is available only for individuals in need of, and receiving, active treatment (AT) services. AT refers to aggressive, consistent implementation of a program of specialized and generic training, treatment, and health services.

Interdisciplinary Team (IDT) – The team of individuals that will provide person-centered Care Management to Participants. Each Participant will have an IDT. The requirements for the IDT will be articulated in detail in an IDT Policy which will be finalized in conjunction with the Three-way Contract.

Individualized Residential Alternative (IRA) – A facility certified by OPWDD as an IRA. An IRA is identified as a supervised IRA if there are staff onsite or proximately available at all times when persons receiving services are present. An IRA is identified as a supportive IRA if the facility provides practice in independent living under variable amounts of oversight delivered in accordance with the person's needs for such supervision, and staff typically are not onsite nor proximately available at all times when the persons receiving services are present.

Life Plan (LP or Individual Service Plan (ISP) or Plan of Care) – An individualized person-centered care and service plan that is collaboratively developed with the Participant, his or her family/caregivers, and other IDT members to address the full continuum of covered and non-covered physical, behavioral, and long-term services and supports. The LP incorporates the

Participant’s diagnoses, issues, and personal choices and specifies the Covered Items and Services the Participant is authorized to receive as well as the availability and role of informal supports. It includes a written description in the care management record of Participant-specific health care, habilitation, personal goals and valued outcomes to be achieved and the amount, duration, and scope of the Covered Items and Services to be provided to a Participant in order to achieve such goals. The individual LP shall serve as the ISP for members enrolled in the Section 1915(c) OPWDD Comprehensive Waiver and is developed using person-centered practices, is informed by the assessment of the Participant's needs, and is developed by the Participant’s IDT in consultation with the Participant and his/her informal supports. In developing the LP, the FIDA-IDD Plan will use results from the OPWDD Approved Assessment Tool and the IAM Tool.

Effectiveness of the LP is monitored through a process of reassessment with the Participant and a determination as to whether his or her goals are being met and valued outcomes achieved. An interview with the Participant using the Council on Quality and Leadership (CQL) Personal Outcome Measures (POM) by a certified interviewer who is employed by the FIDA – IDD Plan will be completed for a State defined sample. The results of the POM interviews will inform individual planning and organizational quality improvement activity and will be provided to OPWDD for quality oversight data. Non-Covered Items and Services which interrelate with the Covered Items Services identified on the LP and services of informal supports necessary to support the health care and personal goals and effectiveness of the Covered Items and Services should be clearly identified on the LP or elsewhere in the care management record.

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 a comprehensive Medicaid health services plan 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, the FIDA-IDD Plan 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 in Medicare Part B, eligible to enroll in Medicare Part D, and eligible for 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 in collaboration with OPWDD.

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.

New York State Office for People with Developmental Disabilities (OPWDD) – The agency responsible for all services defined as OPWDD Services (see definition below) for persons with developmental disabilities and for collaborating with the NYSDOH and CMS on the administration of the FIDA-IDD Demonstration.

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/OPWDD 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.

OPWDD Approved Assessment Tool – Protocol used by the FIDA-IDD Plan to conduct a Comprehensive Assessment of each Participant’s medical, developmental, habilitation, behavioral health, Community-based or Facility-based LTSS, and social needs completed by the FIDA-IDD Plan IDT. The OPWDD Approved Assessment Tool, which is approved for assessment and reassessment as required for individuals electing to participate in the FIDA-IDD Plan. The IAM Tool results, in addition to the results of the OPWDD Approved Assessment, will be used as the basis for developing the integrated, LP. The OPWDD Approved Assessment Tool will be completed by a Qualified Intellectual Disability Professional (QIDP). The Coordinated Assessment System (CAS) was undergoing validation at the time of the execution of this MOU, and until the validation is complete, the existing tool, (the Developmental Disabilities Planning (DDP2) tool) will be used. For the purpose of this MOU, we reference the “Approved Assessment Tool” as the “OPWDD Approved Assessment Tool.”

Opt-in Enrollment – The process by which eligible individuals actively choose to enroll in the FIDA-IDD Plan.

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.

OPWDD Services – Supports and services operated, certified, authorized or approved by OPWDD that are provided to individuals with intellectual and developmental disabilities and include: services available through the Section 1915(c) OPWDD Comprehensive Waiver, long term therapy services provided by Article 16 clinic treatment facilities, certified by OPWDD; day treatment services certified by OPWDD; and Intermediate Care Facility Services for Individuals with Intellectual Disabilities certified by OPWDD.

Payment Arrangement – An arrangement between the FIDA-IDD Plan and a Skilled Nursing Facility (SNF) provider that describes reimbursement for services in absence of a contract. Note: SNF enrollees cannot opt into the FIDA-IDD Demonstration. However, if a FIDA-IDD Participant requires the services of a SNF, the FIDA-IDD Participant may remain enrolled in the FIDA-IDD Plan and the FIDA-IDD Plan must pay for the service.

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 the FIDA-IDD Plan, including the duration of any month in which their eligibility for the Demonstration ends.

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

Participant Ombudsman (PO) – An independent, conflict-free entity under contract with NYSDOH/OPWDD to provide Participants free assistance in accessing their care, understanding and exercising their rights and responsibilities, and appealing Actions (adverse decisions) made by the FIDA-IDD 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 the FIDA-IDD Plan, providers, or NYSDOH and OPWDD. The PO may participate in the FIDA-IDD 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.

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.

Qualified Intellectual Disability Professional (QIDP) – As defined in 42 CFR 483.430, a QIDP is a professional with at least one year of experience working directly with persons with intellectual disability or other developmental disabilities; and is a doctor of medicine or osteopathy, a registered nurse, or a professional who holds at least a bachelor's degree in a human services field (including, but not limited to: sociology, special education, rehabilitation counseling, and psychology). The QIDP completes the OPWDD Approved Assessment Tool and may participate in IDT meetings.

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, the FIDA-IDD Plan selected to participate in the Demonstration will undergo a readiness review. The readiness review will evaluate the FIDA-IDD 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-IDD 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-IDD Plan's headquarters.

Representative – An organization or adult person authorized under law, to act on behalf of a Participant. 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 – The ability for a Participant and his or her Representative to direct his/her own services through the Self-Direction in the Section 1915(c) OPWDD Comprehensive Waiver or 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.

State – The New York State Department of Health (NYSDOH) is the Single State Medicaid Agency and as such has ultimate authority for the Demonstration. Through a letter of agreement and as described in the Three-way Contract, certain administrative and operational responsibilities are delegated to the New York State Office for People With Developmental Disabilities (OPWDD). Within this MOU, each agency is identified individually where necessary.

Appendix 2: CMS Standards and Conditions and Supporting State Documentation

To participate in the Demonstration, each State submitted a proposal outlining its approach. The proposal had to meet a set of standards and conditions. The table below crosswalks the standards and conditions to their location in the New York proposal. Following the submission of the proposal, CMS asked the State a number of questions when there was ambiguity of whether or not the proposal met the Standards and Conditions. These questions and responses are included in the Addendum to the proposal, which will be posted on CMS' website with the proposal.

Standard/ Condition	Standard/Condition Description	Location in proposal (i.e., page #)
Integration of Benefits	Proposed model ensures the provision and coordination of all necessary Medicare and Medicaid-Covered Items and Services, including primary, acute, prescription drug, behavioral health, and long-term supports and services.	pgs. 3, 6-7, Appendix C
Care Model	Proposed model offers mechanisms for person-centered coordination of care and includes robust and meaningful mechanisms for improving care transitions (e.g., between providers and/or settings) to maximize continuity of care.	pgs. 6-7, 14
Stakeholder Engagement	<p>State can provide evidence of ongoing and meaningful stakeholder engagement during the planning phase and has incorporated such input into its proposal. This will include dates/descriptions of all meetings, workgroups, advisory committees, focus groups, etc. that were held to discuss proposed model with relevant stakeholders. Stakeholders include, but are not limited to, Participants and their families, consumer organizations, Participant advocates, providers, and plans that are relevant to the proposed population and care model.</p> <p>State has also established a plan for continuing to gather and incorporate stakeholder feedback on an ongoing basis for the duration of the Demonstration (i.e., implementation, monitoring, and evaluation), including a process for informing Participants (and their representatives or designees) of the changes related to this Demonstration.</p>	Addendum

Participant Protections	State has identified protections (e.g., enrollment and disenrollment procedures, grievances and appeals, process for ensuring access to and continuity of care, etc.) that would be established, modified, or maintained to ensure Participant health and safety and Participant access to high quality health and supportive services necessary to meet the Participant’s needs. At a minimum, States will be required to:	
	Establish meaningful Participant input processes which may include Participant participation in development and oversight of the model (e.g., participation on FIDA-IDD Plan governing boards and/or establishment of Participant advisory boards) or their caregivers/guardians or designees	pgs. 24-25, Appendices D and L, Addendum
	Develop, in conjunction with CMS, uniform/integrated Participant materials that are accessible and understandable to the Participants who will be enrolled in the plans, including those with disabilities, speech, hearing and vision limitations, and limited English proficiency.	pgs. 22, 24-25, Appendix D, Addendum
	Ensure privacy of Participant health records and provide for access by Participants to such records.	pgs. 14-15, Appendix D
	Ensure that all medically necessary benefits are provided, allow for involvement of representative, caregivers or designees, and in an appropriate setting, including in the home and community.	pgs. 6-7, 15, Appendix D; Addendum
	Ensure access to services in a manner that is sensitive to the Participant’s disability, language, and culture, including customer service representatives that are able to answer Participant questions and respond to complaints/concerns appropriately.	pgs. 34-35, Appendices D and N
	Ensure an adequate and appropriate provider network, as detailed below.	pgs. 13, Appendix E
	Ensure that Participants are meaningfully informed about their care options.	pgs. 11-12, 22, Addendum

	<ul style="list-style-type: none"> · Ensure access to grievance and appeals rights under Medicare and/or Medicaid. 	p. 21, Appendix D
	<ul style="list-style-type: none"> o <i>For Capitated Model</i>, this includes development of a unified set of requirements for FIDA-IDD Plan grievances and internal appeals processes. 	p. 21, Appendix D
State Capacity	State demonstrates that it has the necessary infrastructure/capacity to implement and oversee the proposed model or has demonstrated an ability to build the necessary infrastructure prior to implementation. This includes having necessary staffing resources, an appropriate use of contractors, and the capacity to receive and/or analyze Medicare data.	pgs. 29-30, Appendix F
Network Adequacy	The Demonstration will ensure adequate access to medical, habilitative and supportive service providers that are appropriate for and proficient in addressing the needs of the target population as further described in the MOU template.	pgs. 13, 21, Appendix E
Measurement/ Reporting	State demonstrates that it has the necessary systems in place for oversight and monitoring to ensure continuous quality improvement, including an ability to collect and track data on key metrics related to the model’s quality and cost outcomes for the target population. These metrics may include, but are not limited to Participant experience, access to and quality of all Covered Items and Services (including behavioral health and long term services and supports), utilization, etc., in order to promote Participants receiving high quality care and for purposes of the evaluation.	pgs. 29-30, Appendix F
Data	State has agreed to collect and/or provide data to CMS to inform program management, rate development and evaluation, including but not limited to:	
	<ul style="list-style-type: none"> · Participant level expenditure data and covered benefits for the most recently available three years, including available encounter data in capitated models; 	pgs. 30-31

	<ul style="list-style-type: none"> · Description of any changes to the State Plan that would affect Participants during the demonstration period (e.g., payment rate changes, benefit design, addition or expiration of waivers, etc.); and 	Addendum
	<ul style="list-style-type: none"> · State supplemental payments to providers (e.g., DSH, UPL) during the demonstration period. 	pgs. 30-31
Enrollment	State has identified enrollment targets for proposed Demonstration based on analysis of current target population and has strategies for conducting Participant education and outreach. Enrollment is sufficient to support financial alignment model to ensure a stable, viable, and evaluable program.	pgs. 2, 11, Addendum
Expected Savings	Financial modeling demonstrates that the payment model being tested will achieve meaningful savings while maintaining or improving quality.	pgs. 26-28
Public Notice	State has provided sufficient public notice, including:	
	<ul style="list-style-type: none"> · At least a 30-day public notice process and comment period; 	Addendum
	<ul style="list-style-type: none"> · At least two public meetings prior to submission of a proposal; and 	pgs. 19-20
	<ul style="list-style-type: none"> · Appropriate tribal consultation for any new or changes to existing Medicaid waivers, State Plan Amendments, or Demonstration proposals. 	Addendum
Implementation	State has demonstrated that it has the reasonable ability to meet the following planning and implementation milestones prior to implementation:	
	<ul style="list-style-type: none"> · Meaningful stakeholder engagement. 	Addendum
	<ul style="list-style-type: none"> · Submission and approval of any necessary Medicaid waiver applications and/or State Plan Amendments. 	Addendum
	<ul style="list-style-type: none"> · Receipt of any necessary State legislative or budget authority. 	pgs. 7, 32, Addendum
	<ul style="list-style-type: none"> · Joint procurement process (for capitated models only). 	pg. 7 Addendum

Appendix 3: Details of State Demonstration Area

The Demonstration Area consists of 9 counties: Bronx, Kings, Nassau, New York, Queens, Richmond, Rockland, Suffolk, and Westchester.

The FIDA-IDD Demonstration will begin implementation at the same time in all nine counties with Enrollments beginning no earlier than the effective date of April 1, 2016.

Appendix 4: Medicare Authorities and Waivers

Medicare provisions described below are waived as necessary to allow for implementation of the Demonstration. Except as waived, Medicare Advantage and Medicare Part D provide the statutory authority and regulatory framework for the operation of the Demonstration to the extent that Medicare (versus Medicaid) authority applies. Unless waived, all applicable statutory and regulatory requirements of the Medicare program for Medicare Advantage plans that provide qualified Medicare Part D prescription coverage, including Medicare Parts A, B, C, and D, shall apply to the FIDA-IDD Plan and their sponsoring organizations for the Demonstration period beginning no earlier than April 1, 2016 through December 31, 2020, as well as for periods preceding and following the Demonstration period as applicable to allow for related implementation and close-out activities. Any conforming exceptions to existing Medicare manuals will be noted and reflected in an appendix to the Three-way Contract.

Under the authority at Section 1115A of the Social Security Act, codified at 42 U.S.C. 1315a, the Center for Medicare and Medicaid Innovation is authorized to "...test payment and service delivery models ...to determine the effect of applying such models under [Medicare and Medicaid]" 42 U.S.C. 1315a(b)(1). One of the models listed in Section 1315a(b)(2)(B) that the Center for Medicare and Medicaid Innovation is permitted to test is "[a]llowing States to test and evaluate fully integrating care for dual eligible individuals in the State, including the management and oversight of all funds under the applicable titles with respect to such individuals" § 1315a(b)(2)(B)(x). Section 1315a(d)(1) provides that "The Secretary may waive such requirements of Titles XI and XVIII and of Sections 1902(a)(1), 1902(a)(13), and 1903(m)(2)(A)(iii) [of the Social Security Act] as may be necessary solely for purposes of carrying out this section with respect to testing models described in subsection (b)."

Pursuant to the foregoing authority, CMS will waive the following Statutory and Regulatory requirements:

- Section 1851(a), (c), (e), and (g) of the Social Security Act, and implementing regulations at 42 CFR Part 422, Subpart B, only insofar as such provisions are inconsistent with limiting enrollment in the FIDA-IDD Plan to Medicare-Medicaid Enrollees who are age 21 or older with IDD, and excluding beneficiaries who may meet exclusion criteria specified in section III.C.1.
- Sections 1853, 1854, 1857(e), 1860D-11, 1860D-13, 1860D-14, and 1860D-15 of the Social Security Act, and implementing regulations at 42 CFR Part 422, Subparts F and G, and Part 423, Subparts F and G, only insofar as such provisions are inconsistent with the methodology for determining payments, medical loss ratios and Participant liability under the Demonstration as specified in this MOU, including Appendix 6, which differs as to the method for calculating payment amounts and medical loss ratio requirements, and does not involve the submission of a bid or calculation and payment of premiums, rebates, or quality bonus payments, as provided under Sections 1853, 1854, 1860D-11, 1860D-13, 1860D-14, and 1860D-15, and implementing regulations.

- The provisions regarding deemed approval of marketing materials in Sections 1851(h) and 1860D-1(b)(1)(B)(vi) and implementing regulations at 42 CFR Part 422.2266 and 423.2266, with respect to marketing and Participant communications materials in categories of materials that CMS and the State have agreed will be jointly and prospectively reviewed, such that the materials are not deemed to be approved until both CMS and the State have agreed to approval.
- Sections 1852 (f) and (g) and 1860D-4 implementing regulations at 42 CFR Part 422, Subpart M and 42 CFR Part 423, Subpart M, only insofar as such provisions are inconsistent with the grievance and appeals processes provided for under the Demonstration.
- Section 1860D-14(a)(1)(D) and implementing regulations at 42 CFR Part 423, Subpart P, only insofar as the implicit requirement that cost-sharing for non-institutionalized individuals eligible for the low-income subsidy be greater than \$0, to permit the FIDA Plan to reduce Part D cost sharing below the levels required under Section 1860D-14(a)(1)(D)(ii) and (iii).

Appendix 5: Medicaid Authorities and Waivers

All requirements of the Medicaid program expressed in law and regulation, not expressly waived in this list, shall apply to the Demonstration beginning no earlier than April 1, 2016 through December 31, 2020, as well as for periods preceding and following the Demonstration period as applicable to allow for related implementation and close-out activities. Any conforming exceptions to existing sub-regulatory guidance will be noted and reflected in an appendix to the Three-way Contract.

This Demonstration and the additional authority referenced below are contingent upon CMS approval of a 1915(a) contract authority for voluntary managed care in a limited geographic area and approval of the Section 1915(c) OPWDD Comprehensive Waiver renewal.

Specifically, participation of individuals in the FIDA-IDD Demonstration is contingent upon submission and approval of the documentation for a Section 1915(a) exception to state plan requirements for voluntary managed care. Participation of individuals eligible for the Section 1915(c) OPWDD Comprehensive Waiver is contingent upon the approval of the Section 1915(c) OPWDD Comprehensive Waiver renewal. While the State is rendering services under a temporary extension to the Section 1915(c) OPWDD Comprehensive Waiver, the State is only authorized to render services to the degree and scope in the fifth year of the approved plan. Until the State has an authorized Section 1915(c) OPWDD Comprehensive Waiver, FFP will not be available for services rendered outside of the scope approved in the temporary extension.

The State must meet all requirements of any approved Medicaid 1915(a) contract authority and Section 1915(c) OPWDD Comprehensive Waiver, including, but not limited to, all financial, quality, reporting and monitoring requirements of the waivers, and State financing contained in the State's waiver must be in compliance with Federal requirements. This MOU does not indicate or guarantee CMS approval of the 1915(a) contract authority or Section 1915(c) OPWDD Comprehensive Waiver.

All settings and services delivered through providers opting into the network contracted for the FIDA-IDD Demonstration will adhere to the requirements under the Home and Community-based settings rule in accordance with the State's Statewide Transition Plan, at CFR Part 441.301(c)(1-4), including the requirements for provider-owned and controlled residential settings, person-centered service planning, and any modifications of the additional conditions).

Assessment of actuarial soundness under 42 CFR Part 438.6, in the context of this Demonstration, should consider both Medicare and Medicaid contributions and the opportunities for efficiencies unique to an integrated care program. CMS considers the Medicaid actuarial soundness requirements to be flexible enough to consider efficiencies and savings that may be associated with Medicare. Therefore, CMS does not believe that a waiver of Medicaid actuarial soundness principles is necessary in the context of this Demonstration.

1115A Medicaid Waivers

Under the authority of Section 1115A of the Social Security Act, the following waivers of State Plan requirements contained in Section 1902 and 1903 of the Social Security Act are granted to

enable the State of New York (State) to carry out the FIDA-IDD Demonstration. These authorities shall be in addition to those in the State Plan, the 1915(a) contract authority that will be used in conjunction with this demonstration, the existing Section 1115(a) Partnership Plan demonstration, and Section 1915(c) OPWDD Comprehensive Waiver.

Provisions Related to Contract Requirements - Section 1903(m)(2)(A)(iii) (as implemented in 42 CFR Part 438.6)

- Waiver of contract requirement rules at 42 CFR Part 438.6(a), insofar as its provisions are inconsistent with methods used for prior approval under this Demonstration.

Appendix 6: Payments to FIDA-IDD Plans

CMS and the State will enter into a joint rate-setting process based on the following principles:

- (1) Medicare and Medicaid will each contribute to the total capitation payment consistent with projected baseline spending contributions;
- (2) Demonstration savings percentages assume that the FIDA-IDD Plan is responsible for the full range of services covered under the Demonstration;
- (3) Aggregate savings percentages will be applied equally to the Medicaid and Medicare Parts A and B components; and
- (4) Both CMS and the State will contribute to the methodologies used to develop their respective components of the overall blended rate as summarized in Figure 6-2 and further described below.

Figure 6-1 below outlines how the Demonstration Years will be defined for the purposes of this effort. Rate updates will be effective on January 1st of each calendar year (CY), with changes to savings percentages and quality withholds applicable on a Demonstration Year basis.

Figure 6-1: Demonstration Year Dates

Figure 6-2: Summary of Payment Methodology under the Demonstration

Rate Element	Medicare Parts A and B	Medicare Part D	Medicaid
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Demonstration Year	Calendar Dates
1	April 1, 2016 – December 31, 2017
2	January 1, 2018 – December 31, 2018
3	January 1, 2019 – December 31, 2019
4	January 1, 2020 – December 31, 2020

Rate Element	Medicare Parts A and B	Medicare Part D	Medicaid
<p>Baseline costs for the purposes of setting payment rates</p> <p>Medicare baseline spending will be established prospectively on a calendar year basis for each Demonstration county.</p> <p>Medicaid baseline spending amounts shall be set up front and will be applied in future years unless more recent historical data are available and/or CMS' actuaries and the State determine that a substantial change is necessary to calculate accurate payment rates for the Demonstration.</p>	<p>Blend of Medicare Advantage payments and Medicare standardized fee-for-service projections weighted by where Medicare-Medicaid Enrollees who meet the criteria and who are expected to transition into the Demonstration are enrolled in the prior year. Baseline costs will be calculated as a per member per month (PMPM) standardized cost.</p>	<p>National average monthly bid amount (NAMBA) will be used as the baseline for the direct subsidy portion of Part D spending.</p> <p>Note that additional costs associated with low-income subsidy payments, reinsurance payments, and risk-sharing are included in the Part D baseline for purposes of tracking and evaluating Part D costs but not for purposes of setting payment rates. These amounts will be factored into plan payments as appropriate, but these amounts are subject to reconciliation consistent with Part D reconciliation rules.</p>	<p>Medicaid fee-for-service (FFS) claims that would apply to Medicare-Medicaid Enrollees in the Demonstration Area who choose to enroll in the Demonstration.</p> <p>Baseline historical costs will be calculated as a per member per month (PMPM) and projected to the payment year using trends developed by State actuaries with oversight from CMS.</p> <p>Baseline data will also be adjusted for material program changes that have/are anticipated to occur between the start of the baseline period and the end of the Three-way Contract period.</p>
<p>Responsible for producing data</p>	<p>CMS</p>	<p>CMS</p>	<p>NYSDOH</p>
<p>Savings percentages</p>	<p>Demonstration Year 1: 0.25%</p> <p>Demonstration Year 2: 0.5%</p> <p>Demonstration Year 3: 1%*</p> <p>Demonstration Year 4: 1%*</p>	<p>Not Applicable</p>	<p>Demonstration Year 1: 0.25%</p> <p>Demonstration Year 2: 0.5%</p> <p>Demonstration Year 3: 1%*</p> <p>Demonstration Year 4: 1%*</p>

Rate Element	Medicare Parts A and B	Medicare Part D	Medicaid
Risk Adjustment	Medicare Advantage CMS-HCC Model	Part D RxHCC Model	Rating categories and with risk mitigation described in Section IX.
Quality Withhold	Applied Demonstration Year 1: 1% Demonstration Year 2: 2% Demonstration Year 3: 3% Demonstration Year 4: 3%	Not applied	Applied Demonstration Year 1: 1% Demonstration Year 2: 2% Demonstration Year 3: 3% Demonstration Year 4: 3%
Other Risk Mitigation Provisions	Risk corridors	Existing Part D processes will apply	Risk corridors

* Except as otherwise provided for in Section IX.D.

I. Baseline spending and payment rates for target population in the Demonstration Area

Baseline spending is an estimate of what would have been spent in the payment year had the Demonstration not existed. Medicare baselines will be expressed as standardized (1.0) rates and applicable on a calendar year basis. The baseline costs include three components: Medicaid, Medicare Parts A and B, and Medicare Part D. Payment rates will be determined by applying savings percentages (see section II) to the baseline spending amounts.

A. Medicaid

- i. Prior to implementation of the Demonstration, and subject to CMS approval, the State and its actuaries will be responsible for establishing the baseline spending for Medicaid services that will be included under the Demonstration. The State

and its actuaries will identify the Medicaid baseline costs associated with beneficiaries in the target population for this Demonstration.

- a. Developmental Disabilities Services Component.** The largest component of the Medicaid baseline costs will be for developmental disabilities services overseen by NYS OPWDD. Such services are funded under the State Plan (ICF-IDD, Targeted Case Management, OPWDD-certified specialty Clinic) and OPWDD's Section 1915(c) waiver. All such services are currently limited to FFS reimbursement. The baseline for this component will be based on FFS Medicaid spending for FIDA-IDD-eligible individuals for the period July 1, 2011, through June 30, 2013, for Demonstration Year 1. Baseline Medicaid spending will be updated, as more current data is available, for Demonstration Years 2, 3, and 4. The baseline will take into account historic costs and will be trended forward to the Demonstration period. This component will also be adjusted to reflect the impact of the approval of the 07 Amendment to the Section 1915(c) OPWDD Comprehensive Waiver and the renewal of the Section 1915(c) OPWDD Comprehensive Waiver.
- b. Long Term Support Services Component.** The second component will be long term support services (personal care, home health care, adult day healthcare, skilled nursing facility, etc.) authorized in the State Plan and overseen by NYSDOH. Because individuals with developmental disabilities are presently excluded from enrollment in NYS's Managed Long Term Care (MLTC) plans, the value of these services will be based on the historical FFS expenditures from July 1, 2011 through June 30, 2013 for this population and adjusted to reflect projected experience based on an actuarial analysis for Demonstration Year 1. Baseline Medicaid spending will be updated, as more current data is available, for Demonstration Years 2, 3, and 4.
- c. Other Services Component.** The third component comprises traditional healthcare services (inpatient/outpatient hospital, free-standing clinic, physicians, dentists, and other independent practitioners, medical supplies, durable medical equipment, laboratory, etc., including Medicaid crossover payments). This component will also include mental health and substance abuse services as authorized in the State Plan and overseen by NYS OMH and NYS OASAS.

The vast majority of services in this component are currently funded through the Medicaid FFS program. There are a small number of FIDA-IDD-eligible

individuals who have exercised an option historically to voluntarily enroll in Medicaid managed care plans covering some of these traditional healthcare services. The portion of FIDA-IDD eligible individuals accessing benefits through managed care was determined to be immaterial. Therefore, the baseline for this component may include capitation to the extent the eligible population had participated in Medicaid managed care and their projected costs are anticipated to be materially different from those who did not participate in Medicaid managed care. The baseline for this component will be total Medicaid FFS spending for FIDA-IDD-eligible individuals for such services between July 1, 2011 and June 30, 2013 for Demonstration Year 1. Baseline Medicaid spending will be updated, as more current data is available, for demonstration years 2, 3, and 4. The baseline will take into account historic costs and will be projected forward to the Demonstration period based on an actuarial analysis.

- ii. The State and its actuaries will provide the estimated baseline spending and underlying data for each year of the Demonstration to the CMS contracted actuary, who will validate the estimate of projected costs in Medicaid (absent the Demonstration).
- iii. Medicaid payments for Participants in the Demonstration target population will be determined by applying the annual savings percentages (see section II) to the baseline spending amounts.

The State and its actuaries will continue to update the baseline cost for this Demonstration to reflect changes and/or adjustments that are made to the Medicaid benefits provided to Demonstration Participants. Such changes might consist of FFS rate modifications or State policy changes related to the payment structure of the programs. Except for the regularly scheduled updates that will be effective on January 1 of each calendar year during the Demonstration period, updates to the Medicaid baseline will be allowable only when CMS determines the update would result in a substantial change to the baseline necessary to calculate accurate payment rates for the Demonstration.

B. Medicare Parts A and B:

- i. CMS will develop baseline spending (costs absent the Demonstration) and payment rates for Medicare Parts A and B services using estimates of what Medicare would have spent on behalf of the Participants absent the Demonstration.

- ii. The Medicare baseline rate for Parts A and B services will be a blend of the Medicare Advantage projected payment rates and the Medicare FFS standardized county rates for each year, weighted by the proportion of the target population that will be transitioning from each program into the Demonstration. The Medicare Advantage baseline rates will include costs that would have occurred absent the Demonstration, such as quality bonus payments for applicable Medicare Advantage plans. The standardized county FFS rates reflect projected FFS United States per capita costs (USPCC), adjusted to reflect the historic relationship between the county's FFS per capita costs and the USPCC. CMS calculates these geographic adjustments based on historical FFS claims data. The USPCC includes expenditures for Parts A and B services and the associated bad debt payment, disproportionate share hospital (DSH) payments, amounts related to direct and indirect medical education, and federal administrative costs but excludes hospice services, which are reimbursed through Medicare fee-for-service for Medicare Advantage beneficiaries receiving hospice services. CMS excludes operating indirect medical education and direct graduate medical education payments in establishing standardized county FFS rates, and therefore they will not be factored into the Medicare baseline, consistent with plan payments under Medicare Advantage.

CMS may adjust the Medicare FFS standardized county rates as necessary to calculate accurate payment rates for the Demonstration. To the extent that the published FFS county rates do not conform with current law in effect for Medicare during an applicable payment month, and to the extent that such nonconformance would have a significant fiscal impact on the Demonstration, CMS will update the baseline (and therefore the corresponding payment rate) to calculate and apply an accurate payment rate for such month. Such update may take place retroactively, as needed.

- iii. Medicare Parts A and B payment rates will be determined by applying the annual savings percentages (see section II) to the baseline spending amounts.
- iv. Both baseline rates and payment rates under the Demonstration for Medicare Parts A and B services will be calculated as PMPM standardized amounts for each county participating in the Demonstration for each year. Participant risk scores will be applied to the standardized payment rates at the time of payment.
- v. As needed, CMS may require the State to provide a data file for Participants who would be included in the Demonstration as of a certain date, in order for CMS to more accurately identify the target population to include/exclude in the baseline

spending. CMS will specify the format and layout of the file.

- vi. The Medicare portion of the baseline will be updated annually consistent with the annual FFS estimates and benchmarks released each year with the annual Medicare Advantage rate announcement.
- vii. CMS annually applies a coding intensity adjustment factor to Medicare Advantage risk scores to account for differences in diagnosis coding patterns between the Medicare Advantage and the Original Fee-for-Service Medicare programs. The adjustment for 2016 is 5.41%. The majority of FIDA-IDD Plan Participants will come from Medicare FFS, and 2016 FIDA-IDD Plan risk scores for those individuals will be based solely on prior FFS claims, beyond the control of the FIDA-IDD Plan itself. In calendar years 2016, CMS will apply an appropriate coding intensity adjustment based on the proportion of the target population with prior Medicare Advantage experience on a county-specific basis. In calendar year 2017, CMS will apply an appropriate coding intensity adjustment reflective of all Demonstration enrollees; this will apply the prevailing Medicare Advantage coding intensity adjustment proportional to the anticipated proportion of Demonstration enrollees in CY 2016 with prior Medicare Advantage experience and/or Demonstration experience based on the Demonstration's enrollment phase in as of September 30, 2016. After calendar year 2017, CMS will apply the prevailing Medicare Advantage coding intensity adjustment to all FIDA Plan Participants.

C. Medicare Part D:

- i. The Medicare Part D baseline for the Part D Direct Subsidy will be set at the Part D national average monthly bid amount (NAMBA) for the calendar year. CMS will estimate an average monthly prospective payment amount for the low income cost-sharing subsidy and Federal reinsurance amounts; these payments will be reconciled after the end of each payment year in the same manner as for all Part D sponsors.
- ii. The CY 2016 Part D NAMBA is \$64.66.

II. Aggregate Savings Percentages under the Demonstration

- A. Both parties agree that there is reasonable expectation for achieving savings while paying FIDA Plans capitated rates that are adequate to support access to and utilization of medical and non-medical benefits according to Participant needs.

B. For the State of New York, the savings percentages will be:

- i. Demonstration Year 1: 0.25%
- ii. Demonstration Year 2: 0.5%
- iii. Demonstration Year 3: 1.0%
- iv. Demonstration Year 4: 1.0%

C. Application of the savings percentages is described further in section III and section IX.D of Appendix 6. Rate updates will take place at least annually, as noted in section XI of Appendix 6. However, savings percentages will be calculated and applied based on Demonstration Years.

III. Apply Savings Percentages to Medicare Parts A and B and Medicaid Components of the Integrated Rate

The aggregate savings percentages identified above will be applied to the Medicare A/B and Medicaid components of the rate. Changes to the savings percentages under section II of Appendix 6 would only occur if and when CMS and the State jointly determine the change is necessary to calculate accurate payment rates for the Demonstration.

Savings percentages will not be applied to the Part D component of the rate. CMS will monitor Part D costs closely on an ongoing basis. Any material change in Part D costs relative to the baseline may be factored into future year savings percentages.

IV. Rate Structure for the Medicaid Components of the Rates

The rating categories to be utilized for the Medicaid component of the FIDA IDD Demonstration rates are described below. The State and its actuaries will continue to explore the need for additional rate cells for the target population in the FIDA IDD Demonstration. After execution of this MOU, the State may add additional rate cells, subject to CMS review and approval, on the condition that the addition of new rate cells is budget neutral.

The proposed rate cells are for participants eligible for the Demonstration. The rate cells include the following:

- **Dual Eligible Adults, Age 21 to < 50.** This rate cell will be paid for eligible individuals who are age 21 or older and less than 50. One rate cell for this age group will be determined for the entire Demonstration Area.
- **Dual Eligible Adults, Age 50 and Over.** This rate cell will be paid for eligible individuals who are age 50 and older. One rate cell for this age group will be determined for the entire Demonstration Area.

Within this rate cell structure, participants in institutional settings are combined with those receiving HCBS in order to provide financial incentives to remain in the community. This approach assumes a set portion of enrolled individuals are receiving care in a community setting. Due to the opt-in nature of the Demonstration, there is a risk that more individuals requiring higher levels of care will opt in to the Demonstration than was projected in the assumptions used in rate development. To mitigate this risk to the FIDA-IDD Plan, a risk adjustment process and risk corridors will be utilized. These risk mitigation strategies are described further in Section X.

V. Medicare Risk Adjustment Methodology

- A. The Medicare A/B Demonstration county rate will be risk adjusted based on the risk profile of each enrolled Participant. Except as specified in section I on the coding intensity adjustment factor, the existing CMS-HCC and CMS-HCC ESRD risk adjustment methodology will be utilized for the Demonstration.

- B. The Medicare Part D national average bid will be risk-adjusted in accordance with existing Part D RxHCC methodology.

VI. Quality withhold policy for Medicaid and Medicare A/B components of the integrated, risk-adjusted rate

- A. Under the Demonstration, both payers will withhold a percentage of their respective components of the capitation rate. The withheld amounts will be repaid subject to the FIDA-IDD Plan's performance consistent with established quality thresholds. These thresholds are based on a combination of certain core quality withhold measures (across all Demonstrations under Financial Alignment), as well as State-specified quality measures.

- B. Withhold Measures in Demonstration Year 1.
 - i. Figure 6-3 below identifies core withhold measures for Demonstration Year 1. Together, these measures will be utilized as the basis for the 1% withhold. Additional detail regarding the agreed upon measures will be included in the Three-way Contract, and the methodology for calculating quality withhold payments is described in separate technical guidance.

 - ii. For Demonstration Year One, which crosses calendar years, the FIDA-IDD Plan will be evaluated to determine whether it has met quality withhold requirements at the end of CY 2016 and at the end of CY 2017. The determination in CY 2016 will be based solely on those measures that can appropriately be calculated based on the actual enrollment volume during CY 2016. Consistent with such evaluations, the withheld amounts will be repaid separately for each CY.

Figure 6-3: FIDA-IDD Demonstration Quality Withhold Measures for Demonstration Year One¹

Domain	Measure	Source	CMS Core Withhold Measure	State Specified Measure
Encounter Data	Encounter data submitted accurately and completely in compliance with contract requirements.	CMS/State defined process measure	X	
Assessments	Percent of Participants with initial assessments completed within 90 days of enrollment.	CMS/State defined process measure	X	
Participant Governance Board	Establishment of Participant advisory board or inclusion of Participants on governance board consistent with contract requirements.	CMS/State defined process measure	X	
Customer Service	Percent of best possible score the plan earned on how easy it is to get information and help when needed. <ul style="list-style-type: none"> • In the last 6 months, how often did your health plan's customer service give you the information or help you needed? • In the last 6 months, how often did your health plan's customer service treat you with courtesy and respect? • In the last 6 months, how often were the forms for your health plan easy to fill out? 	AHRQ/CAHPS	X	
Getting Appointments and Care Quickly	Percent of best possible score the plan earned on how quickly Participants get appointments and care <ul style="list-style-type: none"> • In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed? • In the last 6 months, not counting the times when you needed care right away, how often did you get an appointment for your health care at a doctor's office or 	AHRQ/CAHPS	X	

Domain	Measure	Source	CMS Core Withhold Measure	State Specified Measure
	clinic as soon as you thought you needed? • In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?			
Documentation of Care Goals	Percent of Participants with documented discussions of care goals.	CMS/State defined process measure	X	
Long Term Care Overall Balance	Reporting of the percent of Participants who did not reside in a nursing facility for a long stay at the time of enrollment and did not reside in a nursing facility for a long stay during the reporting period.	State defined measure		X

(Note: Part D payments will not be subject to a quality withhold, however FIDA-IDD Plan will be required to adhere to quality reporting requirements that currently exist under Part D.)

C. Withhold Measures in Demonstration Years 2, 3, and 4.

- i. The quality withhold will increase to 2% in Demonstration Year 2 and 3% in Demonstration Year 3 and 4 and will be based on performance in the core Demonstration and State specified measures. Figure 6-4 below identifies the quality withhold measures for Demonstration Years 2, 3, and 4.

Figure 6-4: Quality Withhold Measures for Demonstration Years 2, 3, and 4

Domain	Measure	Source	CMS Core Withhold	State Specified Measure
Encounter Data	Encounter data submitted accurately and completely in compliance with contract requirements.	CMS/State defined process measure	X	
Plan All-cause Readmissions	Percent of Participants discharged from a hospital stay who were readmitted to a hospital within 30 days, either from the same condition as their recent hospital stay or for a different reason.	NCQA/HEDIS	X	
Annual Flu Vaccine	Percent of Participants who got a vaccine (flu shot) prior to flu season.	AHRQ/CAHPS	X	
Follow-up after Hospitalization for Mental Illness	Percentage of discharges for Participants 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner.	NCQA/HEDIS	X	
Screening for Clinical Depression and Follow-up Care	Percentage of Participants ages 18 years and older screened for clinical depression using a standardized tool and follow-up plan documented.	CMS	X	

Reducing the Risk of Falling	Percent of Participants with a problem falling, walking or balancing who discussed it with their doctor and got treatment for it during the year.	NCQA/HEDIS HOS	X	
Controlling Blood Pressure	Percentage of Participants 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) for members 18-59 years of age and 60-85 years of age with diagnosis of diabetes or (150/90) for members 60-85 without a diagnosis of diabetes during the measurement year.	NCQA/HEDIS	X	X
Part D Medication Adherence for Oral Diabetes Medications	Percent of Participants with a prescription for oral diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.	CMS	X	X
Improvement / Stability in Activities of Daily Living (ADL) Functioning	Participants in the FIDA-IDD Demonstration who remained stable or improved in ADL functioning between previous assessment and most recent assessment.	State-specified measure		X
Nursing Facility Diversion Measure	Reporting of the number of nursing home certifiable Participants who lived outside the nursing facility (NF) during the current measurement year as a proportion of the nursing home	State-defined measure		X

	certifiable Participants who lived outside the NF during the previous year.			
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(Note: Part D payments will not be subject to a quality withhold, however the FIDA-IDD Plan will be required to adhere to quality reporting requirements that currently exist under Part D.)

- A. Additional detail regarding the agreed upon measures will be included in the Three-way Contract, and the methodology for calculating quality withhold payments will be described in future technical guidance.

VII. Payments to the FIDA-IDD Plan

- A. CMS will make separate monthly risk-adjusted payments to the FIDA-IDD Plan for the Medicare Parts A and B and Part D components of the rate, based on standardized Demonstration payment rates. Medicare Parts A and B payments and Part D payments will be subject to the same payment adjustments that are made for payments to Medicare Advantage and Part D plans, including but not limited to adjustments for user fees and Medicare Secondary Payer adjustment factors.
- B. The State will make monthly payments to the FIDA-IDD Plan for the Medicaid component of the rate subject to the rate structure specified in Section IV.
- C. The capitated payments from CMS and the State are intended to be adequate to support access to and utilization of Covered Services, according to the FIDA-IDD Participants’ LPs. CMS and the State will jointly monitor access to care and services as well as overall financial viability of the FIDA-IDD Plan accordingly.

VIII. Evaluate and Pay FIDA-IDD Plan Relative to Quality Withhold Requirements

- A. CMS and the State will evaluate FIDA-IDD Plan performance according to the specified metrics required in order to earn back the quality withhold for a given year. CMS and the State will share information as needed to determine whether quality requirements have been met and calculate final payments to each FIDA-IDD Plan from each payer.
- B. Whether or not each FIDA-IDD Plan has met the quality requirements in a given year will be made public, as will relevant quality results of the FIDA-IDD Plan in Demonstration Years 2, 3, and 4.

IX. Reconciliation and Rate Review

- A. **Cost Reconciliation:** Cost reconciliation under Part D will continue as-is under the Demonstration. CMS will monitor Part D costs closely on an ongoing basis. Any material increase in Part D costs relative to the baseline may be factored into future Demonstration Year savings percentages.
- B. **Rate Review Process:** CMS and the State will review the FIDA-IDD Plan's financial reports, encounter data, and other information to assess the ongoing financial stability of the FIDA-IDD Plan and the appropriateness of capitation payments. At any point, the State may request that CMS staff review documentation from specific FIDA-IDD Plan to assess finance related issues.

If deemed necessary, CMS and the State will review available data, as applicable, including data on enrollment, utilization patterns, health plan expenditures, and risk adjustment to assess the appropriateness of capitation rates and identify any potential prospective adjustments that would ensure the rate-setting process is meeting the objective of Medicare and Medicaid jointly financing the costs and sharing in the savings.

- C. **Savings Percentage Adjustment:** In the event that the FIDA IDD Plan experiences losses in Demonstration Year 1 exceeding 3% of revenue in the aggregate in all region in which the Plan participates, the savings percentage for Demonstration Year 3 will be reduced to .75%. CMS and the State will make such a determination at least four months prior to the start of Demonstration Year 3. The annual loss determination will be prior to any payments or recoupments under the risk corridor as described in Section X.B. Annual losses will be calculated as if the FIDA IDD Plan had received the full quality withhold payment and any other offsets except any risk corridor payments or recoupments, as defined in the Three-way Contract.

X. Risk Mitigation Strategies

The State will employ two types of risk mitigation strategies to provide protection to the FIDA-IDD Plan. These strategies are an enrollment mix adjustment process and a risk corridor.

- A. **Enrollment Mix Adjustment:** As noted in Section IV, the Medicaid rate component paid under this Demonstration will reflect a blended rate for all levels of care (institutional and community-based). Individuals' costs depend heavily on their level of care and the initial capitation rates will reflect a blend by level of care based on an estimated membership mix by level of care. Due to the significant unknown elements

around enrollment, the State intends to implement an enrollment mix adjustment. The enrollment mix adjustment will consider the actual enrolled mix of Participants receiving institutional and community-based services against the projected enrollment mix built into the Medicaid component of the capitation rates. The adjustment will modify the Medicaid component of the capitation rate during Demonstration Year 1 within a pre-approved range and mitigate the cost risk presented by a population with higher or lower needs than what was built into the Medicaid component of the capitation rates. The modification will be made once representative enrollment data are available and will apply both retrospectively and prospectively to Demonstration Year 1.

B. Risk Corridor: Risk Corridors will be established for this Demonstration for Demonstration years 1 through 3 as described in this section in order to account for possible enrollment bias and to protect the FIDA-IDD Plan and payors against uncertainty in rate-setting that could result in either overpayment or underpayment. Following Demonstration year 2, CMS and the State will evaluate the need to continue a risk corridor arrangement for Demonstration year 4 based on the assessment of the Plan's financial experience, including Demonstration year 2 risk corridor results.

- i. The Demonstration will utilize a tiered plan-level symmetrical risk corridor to include the combined Medicare A/B and Medicaid components.
- ii. The risk corridors will be reconciled after application of any risk adjustment methodologies (e.g., CMS-HCC). Risk corridors will be reconciled as if the FIDA-Plan had received the full quality withhold payment.
- iii. Process for collecting cost information. CMS and the State will evaluate encounter data, cost data, and Plan financial reports to determine Plan incurred costs of services and care management.
- iv. Risk corridor share. The Medicare and Medicaid contributions to risk corridor payments or recoupments will be in proportion to their contributions to the capitated rates, not including Medicare Part D, with the maximum Medicare payment/recoupment equaling 1% of the risk-adjusted Medicare A/B baseline in Demonstration Year 1, .5% of the risk-adjusted Medicare A/B baseline in Demonstration Year 2, and .25% of the risk-adjusted Medicare A/B baseline in Demonstration Year 3. All

remaining payments once Medicare has reached its maximum obligation shall be treated as Medicaid expenditures eligible for FMAP.

- v. For Demonstration Year 1, risk corridors will consider service and non-medical expenses and administrative costs will be limited to 7% of the FIDA-IDD Plan's costs. For Demonstration Years 2 and 3, administrative costs will be excluded from the risk corridor calculations; care management expenses will not be considered administrative costs.
- vi. Risk corridor tiers: CMS and the State will use the following bands to address potential Plan gains/losses:
 - a. Demonstration Year 1:
 - a. Between 0% and 1.00% gain/loss, the FIDA-IDD Plan would bear 100% of the risk/reward.
 - b. Between 1.00% and 2.00% gain/loss, the FIDA-IDD Plan would bear 50% of the risk/reward; the State and CMS would share in the other 50%, as described in iv above.
 - c. Above 2.00% gain/loss, the State and CMS would share in 100% of the risk/reward, as described in iv above.
 - b. Demonstration Year 2:
 - a. Between 0% and 1.50% gain/loss, the FIDA-IDD Plan would bear 100% of the risk/reward.
 - b. Between 1.50% and 3.00% gain/loss, the FIDA-IDD Plan would bear 50% of the risk/reward; the State and CMS would share in the other 50%, as described in iv above.
 - c. Above 3.00% gain/loss, the State and CMS would share in 100% of the risk/reward, as described in iv above.
 - c. Demonstration Year 3:
 - a. Between 0% and 2% gain/loss, the FIDA-IDD Plan would bear 100% of the risk/reward.
 - b. Between 2% and 3.5% gain/loss, the FIDA-IDD Plan would bear 50% of the risk/reward; the State and CMS would share in the other 50%, as described in iv above.
 - c. Above 3.5% gain/loss, the State and CMS would share in 100% of the risk/reward, as described in iv above.
- vii. Certain expenses, such as taxes and regulatory fees, will be excluded for the purposes of the risk corridor gain/loss calculations.
- viii. Certain offsets, such as reinsurance and third-party liability recoveries,

will be netted out of any expenses prior to the risk corridor gain/loss calculations.

- ix. As part of the Three-way Contract, both Parties intend to develop an approach to considering FIDA-IDD Plan administrative costs to ensure that CMS and the State do not share in any FIDA-IDD Plan losses related to inefficient administrative spending or booking profit margins as an administrative cost, as part of any applicable risk corridor settlement.
- x. The Three-way Contract will include further details on how risk corridors will be operationalized under this Demonstration. To the maximum extent possible, the methodology for calculating any risk corridor payments will conform to prevailing regulatory requirements applicable to the other products offered by the organizations operating a FIDA-IDD Plan.
- xi. Interim and final settlement amounts shall be calculated for each Demonstration Year; however, any Demonstration Year 1 payment will be contingent upon FIDA-IDD Plan participation in Demonstration Year 2, and any Demonstration Year 2 payment will be contingent upon FIDA-IDD Plan participation in Demonstration Year 3, unless otherwise permitted by the State and CMS. Similarly, any Demonstration Year 3 payment will be contingent upon FIDA-IDD Plan participation in Demonstration Year 4.

XI. Payments in Future Years and Mid-Year Rate Adjustments.

- A. Rates will be updated using a similar process for each calendar year. Rate updates will take place on January 1st of each calendar year for the Medicare components of the rates, with changes to the savings percentages applicable on a Demonstration Year basis. Rate updates for the Medicaid component of the rate will take place at least once each year on January 1st and may be more often as necessary if material changes to the program occur or if the financial performance of the FIDA-IDD Plan necessitate a rate change. Changes to the baseline (and therefore to the corresponding payment rate) outside of the annual Medicare Advantage rate announcement and annual Medicaid rate update would occur only if and when CMS and the State jointly determine the change is necessary to calculate accurate payment rates for the Demonstration. For changes solely affecting the Medicare program baseline, CMS will consult with the State prior to making any adjustment, but State concurrence will not be required. Changes may be based on the following factors: shifts in enrollment assumptions; major changes or discrepancies in Federal law and/or State law or policy, compared to assumptions about Federal law and/or State law or policy used in

the development of baseline estimates; and changes in coding intensity. CMS and/or the State will make changes to baseline estimates within 30 days of identification of the need for such changes, and changes will be applied, if necessary on a retrospective basis, to effectuate accurate payment rates for each month. CMS will also evaluate Participant risk scores in Demonstration Year 1 and Demonstration Year 2 to determine whether coding intensity in either or both years supports the need for adjustments to the baseline in Demonstration Year 3. CMS will incorporate such adjustments into the Demonstration Year 3 baseline, as appropriate, on a prospective basis to prevent overpayments due to increased coding intensity.

- B. Changes to the savings percentages would occur if and when CMS and the State jointly determine that changes in Medicare Part D spending have resulted in materially higher or lower savings that need to be recouped through higher or lower savings percentages applied to the Medicare A/B baselines.

Appendix 7: Demonstration Parameters

The purpose of this appendix is to describe the parameters that will govern this Federal-State partnership; the parameters are based upon those articulated by CMS in its January 25, 2012 and March 29, 2012 Health Plan Management System (HPMS) guidance. CMS and the State have further negotiated these parameters, as specified below.

The following sections explain details of the Demonstration design, implementation, and evaluation. Where waivers from current Medicare and Medicaid requirements are required, such waivers are indicated. Further detail on each of these areas will be provided in the Three-way Contract.

I. State of New York Delegation of Administrative Authority and Operational Roles and Responsibilities

The New York State Department of Health (NYSDOH) is the Single State Medicaid Agency (SMA) and as such has oversight responsibility for the supervision of the Medicaid Assistance Program under Title XIX of the Social Security Act. The State Medicaid Director has the final authority for the oversight of all aspects of the Medicaid (MA) program in New York State.

Certain administrative and operational aspects of the FIDA-IDD Demonstration are delegated to the New York State Office for People with Developmental Disabilities (OPWDD) through a letter of agreement with NYSDOH that will identify the respective roles and responsibilities of each agency. This letter of agreement will be reviewed and revised as needed and available to CMS upon request.

The Director of the Division of Long Term Care and the Commissioner of OPWDD will serve as the main points of contact for the Medicare-Medicaid Coordination Office at CMS regarding CMS/New York collaboration in the FIDA-IDD Demonstration. The responsibilities of NYSDOH include oversight of the FIDA-IDD Plan, including Medicaid provider network review and financial oversight of the Demonstration. OPWDD will maintain responsibility for Participant Enrollment, Care Management oversight, and assessment of network adequacy for services under the auspice of OPWDD.

II. Plan or Qualified Entity Selection

To be approved as the FIDA-IDD Plan, the Plan will have to meet all FIDA-IDD Demonstration requirements as outlined in section III.B.1 of this MOU. The FIDA-IDD Plan will also be required to meet the Medicare components of the plan selection process, including submission of a successful Capitated Financial Alignment Application to CMS, and adherence to any annual contract renewal requirements and guidance updates, as specified in Appendix 7.

The selection is contingent on the selected entity passing a CMS and State sponsored readiness review. Upon final selection, the State and CMS will ultimately enter into a Three-way Contract with the selected Plan.

Any future revisions to the final selection will be presented to CMS for prior approval.

III. State Level Enrollment and Disenrollment Operations Requirements

- a. Eligible Populations/Excluded Populations - As described in the body of the MOU.
- b. Enrollment and Disenrollment Processes – Enrollment and disenrollment transactions will be processed by the State Enrollment Broker, consistent with the enrollment effective date requirements outlined in the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance. The State Enrollment Broker will submit enrollment transactions to the CMS Medicare Advantage Prescription Drug (MARx) enrollment system directly or via a third party CMS designates to receive such transactions. CMS will also submit a file to the State Enrollment Broker and the FIDA-IDD Plan identifying individuals who have elected to disenroll from the FIDA-IDD Plan. The State Enrollment Broker and CMS will both share Enrollment and disenrollment transactions with the contracted FIDA-IDD Plan. The contracted FIDA-IDD Plan will have MARx connectivity and comply with all required Medicare Part C and D Enrollment transaction and reply code timelines and will have connectivity with the State Enrollment Broker.
- c. Enrollment Notices – Before they are finalized, Enrollment notices will be made available to the public for comment by both CMS and the State.
- d. Opt-in Enrollment Only - There is no Passive Enrollment for the FIDA-IDD Demonstration. All Enrollment in the FIDA-IDD Demonstration is via Opt-in Enrollment, in which eligible individuals actively choose to enroll in the FIDA-IDD Plan.
- e. Enrollment and Disenrollment Effective Date(s) – All Enrollment effective dates are prospective. Participant-elected Enrollment is effective the first calendar day of the month following the initial receipt of a Participant’s request to enroll. The FIDA-IDD Plan will be required to accept Opt-in Enrollments of eligible individuals no earlier than 30 calendar days prior to the initial effective date of no earlier than April 1, 2016, and begin providing coverage for enrolled individuals no earlier than April 1, 2016. Participant requests to cancel Enrollment will be accepted any time before the Enrollment Effective Date. Requests to disenroll from the FIDA-IDD Plan will be accepted at any point after a Participant’s initial Enrollment occurs and will be effective on the first of the month following receipt of the request. Any time an individual requests to disenroll from the Demonstration, the State will send a letter confirming the disenrollment and providing information on the benefits available to the Participant once they have disenrolled.
- f. No enrollments will be accepted within 6 months of the end of the Demonstration.
- g. The State will provide customer service about the FIDA-IDD Plan and alternative choices for receiving their Medicaid benefits. Medicare resources, including 1-800-Medicare and Medicare.gov, will remain a resource for Medicare Participants; a specialized script for 1-800 Medicare will be developed so that calls related to the FIDA-

IDD Demonstration enrollment will also be referred to the State's Enrollment Broker for customer service and enrollment support.

h. CMS and the State will jointly approve all Demonstration Enrollment notices to ensure complete and accurate information is provided in concert with other Medicare communications, such as the Medicare & You handbook. CMS may also send a jointly-approved notice to individuals, and will coordinate such notice with any State notice(s).

i. State and CMS systems will be reconciled on a timely basis to resolve discrepancies between systems.

IV. State Level Delivery System Requirements

a. State Requirements for Care Management – Care Management services will be available to all FIDA-IDD Demonstration Participants through the FIDA-IDD Plan's Interdisciplinary Team (IDT) model as outlined in the Three-way Contract. The FIDA-IDD Plan will be expected to address the following components as part of their comprehensive Care Management programs. Through the readiness review process, CMS and the State will review FIDA-IDD Plan capacity to deliver Care Management services using the IDT model. CMS and the State will also review and approve the FIDA-IDD Plan's care management systems to ensure that all required components are adequately addressed.

i. Comprehensive Assessment: OPWDD shall provide to the FIDA-IDD Plan the most recent results from the OPWDD Approved Assessment Tool at enrollment. After this initial OPWDD Approved Assessment is provided to the FIDA-IDD Plan, subsequent OPWDD Approved Assessments will be completed by a Qualified Intellectual Disability Professional (QIDP) and will be accessible to each Participant's IDT for any follow-up or clarifying questions regarding the OPWDD Approved Assessment.

Each Participant will receive, and actively participate in, a timely FIDA-IDD Comprehensive Service Planning Assessment of their medical, behavioral health, Community-based and Facility-based long-term services and supports (LTSS), and social needs. The Assessment shall be completed by a RN on staff, or under contract with the FIDA-IDD Plan.

In conducting the FIDA-IDD Comprehensive Service Planning Assessment, the FIDA-IDD Plan RN will use the results of the OPWDD Approved Assessment that are provided to the Plan by OPWDD at enrollment. The FIDA-IDD Comprehensive Service Planning Assessment (the "It's All About Me" or "IAM," tool) covers the following domains: social, functional, medical, behavioral, wellness and prevention domains, caregiver's status and capabilities, as well as the Participant's preferences, strengths, and goals. Upon enrollment into the FIDA-IDD Plan, Participants will receive a FIDA-IDD Comprehensive Service Planning Assessment to be completed no later than 30 calendar days from the individual's Enrollment effective date. This FIDA-IDD Comprehensive Service

Planning Assessment must be performed by a FIDA-IDD Plan staff or contract RN in the location of the Participant's choice.

Once the OPWDD Approved Assessment Tool is validated for such use, the results of the Coordinated Assessment System will be used to confirm the appropriate acuity or risk stratification level for the Participant. The IAM tool will be the basis for developing the integrated LP. The Participant will continue to receive any Community-based or Facility-based LTSS in their existing care plan while the LP is developed and all transition requirements for services, as outlined in the MOU, will apply.

All reassessments (the OPWDD Approved Assessment Tool and the IAM) will be completed by the FIDA-IDD Plan. The FIDA-IDD Plan staff conducting reassessments of the OPWDD Approved Assessment are required to be a QIDP and must complete the approved State curriculum prior to the commencement of reassessments.

The FIDA-IDD Plan must ensure that a comprehensive reassessment process takes place so that the Participant's LP is updated as required. The ongoing reassessment process will occur as follows:

- o As warranted by the Participant's condition but at least annually after the initial assessment completion date;
- o When there is a significant change in the Participant's health status or needs;
- o As requested by the Participant, his/her caregiver, or his/her provider; and based on a Participant's personal outcome measures not being attained.
- o Upon any of the trigger events listed below as expeditiously as possible in accordance with the circumstances and as clinically indicated by the Participant's health status and needs, and in no case more than 30 days after the occurrence of any of the following:
 - A hospital admission that is expected to result in a needed change in the Participant's LP;
 - Transition between care settings;
 - Significant change in functional status;
 - Loss of a caregiver / Representative or designee;
 - Change in diagnosis that is significant enough effect a Participant's life planning or treatment or affects functional status; or

- A request by a member of the IDT who observes a change in functional status including one observed by a member of the IDT.

When a Participant is determined to be likely to require a level of care provided in a nursing facility or an ICF-IID (i.e., nursing home or ICF-IID level of care), the Care Manager and/or IDT informs the Participant and/or his/her Representative of any feasible alternatives and offers the choice of either institutional or home and community-based services.

ii. LP: Within 60 calendar days of the State or contracted entity conducting an initial comprehensive assessment or the FIDA-IDD conducting a reassessment, a LP will be completed for each Participant by the Participant's IDT.

During the reassessment process, a LP will be reviewed and revised, if necessary, within 30 calendar days of the Participant's change in circumstances. Person-centered service planning and care coordination will include establishing and implementing a written LP for the Participant and assisting each Participant to access services called for under the LP. Person-centered service planning includes consideration of the current and unique psychosocial and medical, developmental, and habilitation needs and history of the Participant, as well as the Participant's functional level, behavioral health needs, language, culture, and support systems. Person-centered service planning and documentation of care goals comply with the requirements of the HCBS settings rule in accordance with the State's Statewide Transition Plan, including requirements for modifying a Participant's LP to address a specific, assessed need. Care Management includes referral to and coordination of other necessary medical, social, behavioral health, habilitation, prescription drugs and non-prescription drugs, Community-based or Facility-based LTSS, educational, financial, and other services included in the LP that support the Participant's psychosocial needs irrespective of whether such services are covered by the FIDA-IDD Plan. Person-centered service planning is completed by the Participant and his/her IDT. The LP will contain measureable goals, interventions, and expected outcomes with completion timeframes. The FIDA-IDD Plan will monitor the LP and any gaps in care will be addressed in an integrated manner by the Interdisciplinary Team, including any necessary revisions to the LP.

iii. Interdisciplinary Team (IDT): For each Participant, the FIDA-IDD Plan will support an IDT, led by a Care Manager to ensure the integration of the Participant's medical, developmental, habilitation, behavioral health, Community-based or Facility-based LTSS, and social and protective oversight needs. Each IDT will be comprised, first and foremost, of the Participant and/or his/her Representative and/or designee, the FIDA-IDD Plan Care Manager, the Participant's primary providers of OPWDD Services who have knowledge of the Participant's desired outcomes and service needs, and , the primary care

physician. In addition, the IDT may include, behavioral health professionals, the Participant's home care aide (or a representative caregiver from the Participant's residential services provider [e.g., their IRA or ICF-IID] and/or their day habilitation provider), and other providers either as requested by the Participant or his/her Representative and/or designee or as recommended by the Care Manager or primary care physician and approved by the Participant and/or his/her designee or Representative. FIDA-IDD Plan will ensure that staff team members who are completing care Management activities are operating within their professional scope of practice, appropriate for responding to and meeting the Participant's needs, and complying with the State's licensure/credentialing requirements. The IDT will be person-centered, built on the Participant's specific preferences and needs, and deliver services with transparency, individualization, accessibility, respect, linguistic and cultural competence, and dignity.

Before the initial LP is developed by the IDT, service authorizations may be made by the FIDA-IDD Plan through the utilization management process. After the LP is developed by the IDT, care decisions included therein act as service authorizations. A service authorization may not be modified by the FIDA-IDD Plan except in cases where the Participant (a Provider acting on behalf of the Participant, the Participant's Representative or the Participant's designee) appeals the IDT service authorization. In such a case, the Plan may modify the service authorizations consistent with the Appeal decision. The Participant may appeal any IDT decision, regardless of whether the Participant agreed to the decision. During the meeting, the IDT authorizes both ongoing services in the LP and services that must be adhered to by the FIDA-IDD Plan.

The Care Manager must review the Participant's LP at least every six months from the previous LP review. This LP review must coincide with a meeting with the IDT at least annually (no more than twelve months from the previous IDT meeting). These IDT meetings may occur more frequently, as the IDT must reconvene after a Reassessment, which may be triggered by certain events, as described in this Appendix or if the Participant requests a more frequent meeting.

Between IDT meetings, the FIDA-IDD Plan makes any necessary service authorizations through its utilization management process. In order to ensure that Participants receive timely access to needed services, the FIDA-IDD Plan must authorize any services in line with, or in addition to, the services outlined in the current LP, except as listed in section VII.B and VII.C. Both the IDT and the FIDA-IDD Plan will make coverage determinations, and render service authorizations, with consideration given to clinical guidelines, evidence-based best practices, and medical necessity.

IDT members must operate within their professional scope of practice, appropriate for responding to and meeting the Participant's needs, and complying with the State's licensure/credentialing requirements. Each member of the IDT must meet the applicable State, Federal, or other requirements for his/her

profession. The IDT is highly encouraged to work collaboratively, soliciting input from all members and reaching consensus regarding specific treatment decisions that consider the Participant's specific preferences and needs across multiple domains. Where consensus is not possible, the IDT members should strive for workable compromise. When a care decision is required to be made by a Provider with a certain licensure and/or certification under the applicable laws and regulations of New York State, the ultimate decision always rests with the appropriately licensed and/or certified treating member(s) of the IDT.

1. FIDA-IDD Plan members of the IDT must agree to participate in approved training on the person-centered planning processes, cultural competence, disability, accessibility and accommodations, and wellness principles, along with other required training, as specified by the State. This will include ADA/Olmstead requirements. The FIDA-IDD Plan will offer similar trainings to additional members of the IDT, including primary care providers and specialists, as appropriate.

2. Each Participant will be assigned an IDT with the appropriate experience and qualifications based on a Participant's individual needs (e.g., communication, cognitive, or other barriers). A Participant has the right to choose and change her/his IDT. The FIDA-IDD Plan must ensure that the IDT caseload is reasonable to provide appropriate care coordination and care management.

3. IDT members must have knowledge of developmental disabilities, physical health, aging and loss, appropriate support services in the community, frequently used medications and their potential negative side-effects, depression, challenging behaviors, Alzheimer's disease and other disease-related dementias, behavioral health, and issues related to accessing and using durable medical equipment as appropriate.

- iv. Self-Direction: All Participants have the opportunity to direct their own services through the self-direction options under the Section 1915(c) OPWDD Comprehensive Waiver or the consumer-directed personal assistance option. The FIDA-IDD Plan must inform Participants of this option at initial and annual LP meetings. A FIDA-IDD Plan representative will interview the Participant and his or her Representative to determine if the Participant is a candidate for self-direction. If the Participant wishes to participate in the self-directed program, he or she will be referred to a qualified provider that offers self-direction or provides self-directed community habilitation (both of these options are available under the Section 1915(c) OPWDD Comprehensive Waiver services).

b. Network Adequacy – The following standards will be used for access to all Covered Items and Services except in the event that Medicaid or Medicare standards are more stringent and would provide for increased access to providers:

Each FIDA-IDD Plan’s provider network must meet the existing applicable Medicare and Medicaid provider network requirements. State Medicaid standards shall be utilized for Community-based and Facility-based LTSS, as described below, or for other services for which Medicaid is exclusive, and Medicare standards shall be utilized for pharmacy benefits and for other services for which Medicare is primary, unless applicable Medicaid standards for such services are more favorable to the Participant (i.e., offer broader coverage). Home health and durable medical equipment requirements, as well as any other services for which Medicaid and Medicare overlap, shall be subject to the more favorable to the Participant (i.e., offer broader coverage) of the applicable Medicare and Medicaid standards. Additionally, the provider network must meet all of the following requirements:

i. In no instance may the FIDA-IDD Plan’s network have less than two of any provider type necessary to provide Covered Items and Services.

ii. To the extent reasonable and practical, all providers’ physical sites must be accessible to all Participants as must all providers that deliver services in the Participants’ locations.

iii. The FIDA-IDD Plan must establish and implement mechanisms to ensure that providers comply with the timely access requirements outlined herein, must monitor providers regularly to determine compliance, and must take corrective action if there is a failure to comply.

iv. The following minimum appointment availability standards apply to physical health and behavioral health services:

- 1) For emergency care: immediately upon presentation at a service delivery site.
- 2) For urgent care: within twenty-four (24) hours of request.
- 3) Non-urgent “sick” visit: within forty-eight (48) to seventy-two (72) hours of request, as clinically indicated.
- 4) Routine non-urgent, preventive appointments: within four (4) weeks of request.
- 5) Specialist referrals (not urgent): within two (2) to four (4) weeks of request.
- 6) Pursuant to an emergency or hospital discharge, mental health or substance abuse follow-up visits with a provider (as included in the Benefit Package): within five (5) days of request, or as clinically indicated.
- 7) Non-urgent mental health or substance abuse visits with a provider (as included in the Benefit Package): within two (2) weeks of request.
- 8) Provider visits to make health, mental health, and substance abuse assessments for the purpose of making recommendations regarding a recipient’s ability to perform work within ten (10) days of request.
- 9) Mental Health Clinics must provide a clinical assessment within five (5) days for individuals in the following designated groups:
 - Individuals in receipt of services from a mobile crisis team not currently receiving treatment

- Individuals in domestic violence shelter programs not currently receiving treatment
- Homeless individuals and those present at homeless shelters who are not currently receiving treatment
- Individuals aging out of foster care who are not currently receiving treatment
- Individuals who have been discharged from an inpatient psychiatric facility within the last 60 days who are not currently receiving treatment
- Individuals referred by rape crisis centers
- Individuals referred by the court system.

v. The following minimum access standards apply to Community-based LTSS services:

- For “new to service” Participants (meaning those not already receiving Community-based LTSS), Community-based LTSS service delivery must begin (along with completion of the FIDA-IDD Comprehensive Service Planning Assessment) within 30 calendar days of Enrollment.
- For Participants that are not new to service but transitioning from Medicare and/or Medicaid FFS, the FIDA-IDD Plan must provide continuity of covered Community-based LTSS immediately upon enrollment, as further outlined in the continuity of care/transition policy in this Appendix. The Plan must contract with an adequate number of Community-based LTSS providers to allow Participants a choice of at least two providers of each covered Community-based LTSS service within a 15-mile radius or 30 minutes from the Participant’s ZIP code of residence.

vi. The following minimum access standards apply to Facility-based LTSS services:

- For “new to service” Participants (meaning those not already receiving SNF/NF facility-based LTSS), the FIDA-IDD Plan must enter into contracts or alternatively make payment arrangements with nursing facilities and Developmental Centers as meets the minimum access standards outlined for all providers in this section and as further outlined in the Three-Way Contract.
- Participation of nursing facilities in the Demonstration may be subject to quality standards as articulated in the Three-way Contract.

vii. The FIDA-IDD Plan must provide access to medical services and coverage to Participants through their primary care providers (PCPs) and obstetrics/gynecologists (OB/GYNs,) on a twenty-four (24) hour a day, seven (7) day a week basis. The FIDA-IDD Plan must instruct Participants on what to do to obtain services after business hours and on weekends.

viii. Participants with appointments shall not routinely be made to wait longer than one hour.

ix. FIDA-IDD Plan must have a network that is geographically accessible to Participants in the Demonstration Area.

x. The FIDA-IDD Plan is required to coordinate Participant transportation as defined in the benefit package, including for non-emergent and non-medical needs.

xi. Participants must be assured choice of all providers, including the care coordinator and others that will participate in their IDTs.

xii. Paid family caregiving will be permitted in accordance with 18 NYCRR § 505.14 (h)(2) and as described in the Section 1915(c) OPWDD Comprehensive Waiver.

xiii. The FIDA-IDD Plan is directly responsible for the provision of all other medically necessary Covered Items and Services (regardless of whether access is through a subcontracted behavioral health organization that is accountable to the FIDA-IDD Plan and for which the FIDA-IDD Plan is accountable to the State or directly through the FIDA Plan's network of providers).

xiv. The State has developed transition requirements that specify continuation of existing providers for Covered Items and Services outlined in section V, below.

xv. The State also requires that FIDA-IDD Plan provides and arranges for timely access to all medically necessary items and services covered by Medicare and/or Medicaid. Both the State and CMS will monitor access to services through survey, utilization, and complaints data to assess the need for FIDA-IDD Plan network corrective actions.

CMS and the State will monitor access to care and the prevalence of needs indicated through Participant assessments, and, based on those findings, may require that the FIDA-IDD Plan initiate further network expansion over the course of the Demonstration.

Networks will be subject to confirmation through readiness reviews and on an ongoing basis.

For any covered services for which Medicare requires a more rigorous network adequacy standard than Medicaid (including time, distance, and/or minimum number of providers or facilities), the FIDA-IDD Plan must meet the Medicare requirements. To the extent that Medicaid requires a more rigorous network adequacy standard than Medicare (including time, distance, and/or minimum number of providers or facilities), the FIDA-IDD Plan must meet the Medicaid requirements. Medicare network standards account for the type of service area

(rural, urban, suburban, etc.), travel time, and minimum number of the type of providers, as well as distance in certain circumstances. The State and CMS may grant exceptions to these general rules to account for patterns of care for Participants, but will not do so in a manner that will dilute access to care for Participants. Networks will be subject to confirmation through readiness reviews.

c. Solvency – FIDA-IDD Plan will be required to meet solvency requirements:

i. Consistent with section 1903(m) of the Social Security Act and regulations found at 42 CFR Parts 43, 422.400, and 438.116 as well as applicable State law and regulations; and

ii. FIDA-IDD Plan will be required to meet solvency requirements established in the Three-way Contract.

d. Credentialing and Practitioner Licensure Authorities and Application within Approved Contracts –

i. The FIDA-IDD Plan must adhere to managed care standards at 42 CFR Part 438.214 and 42 CFR Part 422.204, and follow NCQA procedural requirements for standards for credentialing and re-credentialing.

ii. Once approved, in order to minimize administrative burdens on the FIDA-IDD Plan and providers, the FIDA-IDD Plan must employ a single, uniform provider credentialing application that will be developed with the input from the FIDA-IDD Plan and stakeholders, meet Medicare contracting requirements, and be approved by NYSDOH and OPWDD, as applicable.

e. Participant Ombudsman –

NYSDOH will make available to Participants an independent, conflict-free entity to serve as FIDA-IDD Participant Ombudsman (PO). The requirements for the PO will be outlined in the contract between NYSDOH and the PO. The requirements for FIDA-IDD Plan cooperation with the PO will be outlined in the Three-way Contract. The FIDA-IDD Participant Ombudsman will provide Participants free assistance in accessing their care, understanding and exercising their rights and responsibilities, and in appealing adverse decisions made by their FIDA-IDD 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 in navigating the FIDA-IDD Plan, providers, or NYSDOH/OPWDD. The PO may participate in FIDA-IDD Plan Participant Advisory Committee activities. The PO will be required to regularly report on its work to the State and CMS. The FIDA-IDD Plan will be required to notify Participants of the availability of the PO in Enrollment materials, annual notice of grievance and appeal procedures, and all written notices of denial, reduction or termination of a service.

V. Benefits

a. Medical Necessity Determinations – Medically necessary items and services are defined in Appendix 1 as: 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, the FIDA-IDD Plan 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.

i. All care must be provided in accordance and compliance with the ADA, as specified by the Olmstead decision.

ii. The FIDA-IDD Plan must cover all services as outlined in the Three-way Contract and in the State and Federal guidance and may not impose more stringent coverage rules unless explicitly authorized by the Three-way Contract.

b. As a term and condition of this Demonstration, the FIDA-IDD Plan will be required to provide all medically necessary Medicare Parts A, B, and D and Medicaid State Plan and Section 1115(a) and Section 1915(c) OPWDD Comprehensive Waiver items and services. Table 7-A provides a list of Planned FIDA-IDD Demonstration Services. The Planned FIDA-IDD Demonstration Services will be updated to address any changes due to State Plan Amendments, 1115(a) demonstration amendments, and 1915(c) waiver amendments.

Table 7-A: Planned FIDA-IDD Demonstration Services

Abdominal Aortic Aneurism Screening	Medicaid Pharmacy Benefits as Allowed by State Law
Adult Day Health Care	Medical Nutrition Therapy
AIDS Adult Day Health Care	Medication Therapy Management
Ambulance	Medicare Part B Prescription Drugs
Ambulatory Surgical Centers	Medicare Part D Prescription Drug Benefit as Approved by CMS
Assertive Community Treatment (ACT)	Mobile Mental Health Treatment (Medicare)
Assistive Technology	Non-Emergency Transportation
Bone Mass Measurement	Nursing Facility (Medicaid)+
Breast Cancer Screening (Mammograms)	Nutrition (includes Nutritional Counseling and Educational Services)
Cardiac Rehabilitation Services	Obesity Screening and Therapy to Keep Weight Down
Cardiovascular Disease Risk Reduction Visit	Opioid Treatment

(therapy for heart disease)	
Cardiovascular Disease Screening and Testing	OPWDD Certified Outpatient Clinic
Care Management+	Other Health Care Professional Services
Cervical and Vaginal Cancer Screening	Other Supportive Services the Interdisciplinary Team Determines Necessary
Chemotherapy	Outpatient Blood Services
Chiropractic	Outpatient Hospital Services
Colorectal Screening	Outpatient – Medically Supervised Withdrawal- Substance Abuse
*Community Habilitation <ul style="list-style-type: none"> • Agency Purchased • Agency Supported 	Outpatient Mental Health
Consumer Directed Personal Assistance Services	Outpatient Rehabilitation (OT, PT, Speech)
*Day Habilitation <ul style="list-style-type: none"> • Group • Group Supplemental 	Outpatient Substance Abuse Care
Day Treatment (Continuing)	Outpatient Surgery
Day Treatment (Intensive)	Palliative Care
Day Treatment (OPWDD)	Pap Smear & Pelvic Exams
Defibrillator (implantable automatic)	Partial Hospitalization (Medicaid)
Dental	Partial Hospitalization (Medicare)
Depression Screening (Medicare)	Pathways to Employment
Developmental Center+	Personal Care Services
Diabetes Monitoring (Self-Management Training)	Personal Emergency Response Services (PERS)
Diabetes Screening	Personalized Recovery Oriented Services (PROS)
Diabetes Supplies	Podiatry

Diabetic Therapeutic Shoes or Inserts	
Diagnostic Testing	Primary Care Physician
Directly Observed Therapy for Tuberculosis	Pre-Vocational Services
Durable Medical Equipment (DME)	Preventive Services
Emergency Care	Private Duty Nursing
Environmental Modification	Prostate Cancer Screening
Family Planning Services +	Prosthetics
Fiscal Intermediary	Pulmonary Rehabilitation Services
	Remote Access Technology
Freestanding Birth Center Services	*Residential Habilitation <ul style="list-style-type: none"> • Supervised IRA • Supportive IRA Family Care Home
Health/Wellness Education	Respiratory Care Services
Hearing Services	*Respite <ul style="list-style-type: none"> • Free Standing • Hourly <ul style="list-style-type: none"> ○ Agency Purchased ○ Agency Supported
HIV Screening	Routine Physical Exam 1/year
Home Health	*Self Direction (Managed by Fiscal Intermediary) <ul style="list-style-type: none"> • Fiscal Intermediary • Support Brokerage • Live-In-Caregiver • Individual Directed Goods and Services • Community Habilitation • Supported Employment (Intensive & Extended) • Respite Community Transition Services

Home Infusion Bundled Services	Sexually Transmitted Infections (STIs) Screening and Counseling
Home Infusion Supplies and Administration and Medicare Part D Home Infusion Drugs	Skilled Nursing Facility
Home Visits by Medical Personnel	Smoking and Tobacco Cessation
ICF/IID	Specialist Office Visits
Immunizations	Substance Abuse Therapy
Inpatient Hospital Care (including Substance Abuse and Rehabilitation Services)	Support Brokerage
Inpatient Mental Health Care	<ul style="list-style-type: none"> *Supported Employment Intensive <ul style="list-style-type: none"> • One to One <ul style="list-style-type: none"> ○ Agency Purchased ○ Agency Supported • Group *Supported Employment Extended <ul style="list-style-type: none"> • One to One <ul style="list-style-type: none"> ○ Agency Purchased ○ Agency Supported • Group
Inpatient Mental Health over 190-day Lifetime Limit (Medicare)	Telehealth
Inpatient Services during a Non-covered Inpatient Stay	Transportation
Intensive Behavioral Services	Urgent Care
Intensive Psychiatric Rehabilitation Treatment Programs	Vision Care Services
Kidney Disease Services (including End Stage Renal Disease services)	"Welcome to Medicare" Preventive Visit
Mammograms	Wellness Counseling
Medical Social Services	
<p>+</p> <p>Family Planning - In accordance with 42 CFR 431.51(b)(2), a Participant can choose any doctor or clinic that offers family planning services in or out of the Plan's provider network.</p> <p>Nursing Facility (Medicaid) – Benefit available once enrolled in Plan</p> <p>Developmental Center – Benefit available for a maximum of 90 continuous days once enrolled</p>	

in the FIDA-IDD Plan.

Care Management – A benefit provided by the Plan for Participants

c. Other Supportive Services the IDT Determines Necessary – The FIDA-IDD Plan will have discretion to use the capitated payment to enhance Covered Items and Services with additional non-Covered Items and Services where so doing would address a Participant’s needs, as specified in the Participant’s LP and determined by the IDT. The FIDA-IDD Plan will have the flexibility to cover items or services that are not traditionally included as Medicare or Medicaid Covered Items and Services but that are necessary and appropriate for the Participant.

d. Services to be accessed through Medicare or Medicaid Fee-For-Services (FFS) –The following services will be available to FIDA-IDD Demonstration Participants through the Medicare or Medicaid Fee-for-Service program and not through the FIDA-IDD Plan:

(1) Medicare and Medicaid Hospice services

A Participant’s FIDA-IDD Plan IDT will be responsible for coordinating, arranging, and ensuring receipt of these services by the Participant from the Medicare and Medicaid FFS programs as necessary.

e. Election of Medicare Hospice Benefit – As in Medicare Advantage, if, after enrollment, a Participant elects to receive the Medicare hospice benefit, the Participant will remain in the FIDA-IDD Plan, but will obtain the hospice service through the Medicare FFS benefit and the FIDA-IDD Plan would no longer receive Medicare Part C payment for that Participant. Medicare hospice services and all other Original Medicare services would be paid for under Medicare Fee-for-Service. The FIDA-IDD Plan and providers of hospice services would be required to coordinate these services with the rest of the Participant’s care, including with Medicaid and Part D benefits and any additional benefits offered under the FIDA-IDD Plan. The FIDA-IDD Plan would continue to receive Medicare Part D payment, for which no changes would occur. Medicaid services and payments for hospice Participants must comply with the OPWDD Comprehensive Section 1915(c) waiver requirements.

f. Continuity of Care:

(1) For all items and services other than nursing facility services and services provided in a certified residence under the auspice of OPWDD (other than an ICF-IID), the FIDA-IDD Plan 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 the LP has been finalized and implemented, whichever is later. However, a Participant may choose to begin receiving services in accordance with the approved LP prior to the end of this 90 day period. If a Participant is receiving services from a behavioral health provider at the time of enrollment, he or she may continue to get services from that provider until treatment is complete, but not for more than two years. Services delivered in an OPWDD certified residence (other than an ICF-IID) at the time

the Person enrolls in the FIDA-IDD, may continue from the existing residential provider as long as the Participant's LP continues to describe the need for the service. Any reduction, suspension, denial or termination of previously authorized services shall trigger the required notice under 42 CFR Part 438.404 which clearly articulates the Participant's right to file an appeal (either expedited, if warranted, or standard), the right to have authorized service continue pending the appeal, and the right to a fair hearing if the plan renders an adverse determination (either in whole or in part) on the appeal. For nursing facility and ICF/IID services, the FIDA-IDD Plan must allow Participants to maintain current providers for the duration of the Demonstration.

(2) The FIDA-IDD Plan is required to provide or arrange for all medically necessary services provided by the Three-way Contract, whether by sub-contract or by single-case agreement in order to meet the needs of the Participant.

g. Out-of-Network Reimbursement Rules – FIDA-IDD Plan must cover emergent or urgent services provided by out-of-network providers and may authorize other out-of-network services to promote access to continuity of care. For services that are part of the traditional Medicare benefit package, the FIDA-IDD Plan will be required to pay non-contracting providers at least the lesser of the providers' charges or the Medicare FFS rate, regardless of the setting and type of care for authorized out-of-network services. For nursing facility services that are part of the traditional Medicaid benefit package, the FIDA-IDD Plan will be required to pay non-contracting providers the Medicaid FFS rate.

h. 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.

i. For Participants residing in nursing facilities or ICF/IID who wish to move to the community, the FIDA-IDD Plan will refer them to the OPWDD regional office, or the Money Follows the Person (MFP) Program. For Participants who are residents of or who are admitted to nursing facilities and who wish to move or return to the community, the FIDA-IDD Plan has policies to ensure that the IDTs refer these Participants, where appropriate, to the Money Follows the Person (MFP) program within two business days of the Participants (who are residents) receiving a FIDA-IDD Comprehensive Service Planning Assessment and within two business days of a new admission of a Participant. The FIDA-IDD Plan has policies to ensure that the IDT cooperates with the work of the MFP contractor as it relates to the Participant. The FIDA-IDD Plan ensures that all community supports, including housing, are in place prior to the Participant's transition, and providers are knowledgeable and prepared to support the Participant, including interface and coordination with and among clinical services and Community-based LTSS.

VI. Model of Care - The FIDA-IDD Plan (in partnership with contracted providers) will be required to implement an evidence-based model of care (MOC). The FIDA-IDD Plan must meet all CMS MOC standards for Special Needs Plans as well as the self-direction requirements

established by the State. New York's comprehensive Care Management program requirements summarized in section IV of this Appendix will also apply and be outlined in the Three-way Contract and the FIDA-IDD Plan agreement with network providers. CMS' Demonstration plan MOC approval process is based on scoring each of the eleven clinical and non-clinical elements of the MOC. The scoring methodology is divided into three parts: (1) a standard; (2) elements; and (3) factors. These components of the MOC approval methodology are defined below:

(1) Standard: The standard is defined as a MOC that has achieved a score of 70 percent or greater based on NCQA's scoring methodology.

(2) Elements: The MOC has 11 clinical and non-clinical elements, as identified below. The FIDA-IDD Plan submitted a MOU, which was approved by NCQA for a three-year period under the 11-element MOC structure. Each of the 11 elements yielded a score that was totaled and used to determine the final overall score. The 11 MOC elements and the State-specific MOC element (i.e., Self-Direction) are listed below:

- Description of the Plan-specific Target Population;
- Measurable Goals;
- Staff Structure and Care Management Goals;
- Interdisciplinary Care Team;
- Provider Network having Specialized Expertise and Use of Clinical Practice Guidelines and Protocols;
- MOC Training for Personnel and Provider Network;
- Health Risk Assessment;
- Individualized Care Plan;
- Integrated Communication Network;
- Care Management for the Most Vulnerable Subpopulations;
- Performance and Health Outcomes Measurement; and
- Self-Direction (State-specific element):
 - a) Describe how your organization will educate consumers and informal caregivers/guardians or designees on self-directed options
 - b) Describe how your organization will monitor the education efforts
 - c) Describe how your organization will evaluate the self-directed services
 - d) Describe how your organization will monitor and evaluate the percentage of consumers that use the self-directed option.

(3) Factors: Each element is comprised of multiple factors that are outlined in the MOC upload matrix in the Demonstration plan application. The factors for each element are scored using a system from 0 to 4, where 4 is the highest score for a factor. Interested organizations are required to provide a response that addresses every factor within each of the 11 elements. The scores for each factor within a specific element are totaled to provide the overall score for that element out of a total of 160 possible points. Interested organizations must achieve a minimum score of 70 percent to meet the CMS approval standard.

It is CMS's intent for MOC reviews and approvals to be a multi-year process that will allow Demonstration plans to be granted up to a Three-year approval of their MOC based on higher MOC scores above the passing standard. The specific time periods for approvals are as follows:

- Plans that receive a score of eighty-five (85) percent or higher will be granted an approval of the CMS MOC requirement for three (3) years.
- Plans that receive a score in the seventy-five (75) percent to eighty-four (84) percent range will be granted an approval of the CMS MOC requirement for two (2) years.
- Plans that receive a score in the seventy (70) percent to seventy-four (74) percent range will be granted an approval of the CMS MOC requirement for one (1) year.

The FIDA-IDD Plan will be permitted to cure problems with its MOC submission after their initial submissions. The FIDA-IDD Plan with MOCs scoring below 70 percent will have the opportunity to improve their scores based on CMS and State feedback on the elements and factors that need additional work. At the end of the review process, the FIDA-IDD Plan with MOCs that do not meet CMS' standards for approval will not be eligible for selection as the FIDA-IDD Plan.

VII. Prescription and Select Non-Prescription Drugs – The integrated formulary must include any Medicaid-covered prescription drugs and certain non-prescription drugs that are excluded by Medicare Part D. Plans must also cover drugs covered by Medicare Parts A or B. In all respects, unless stated otherwise in this MOU or the Three-way Contract, Part D requirements will continue to apply. Formulary requirements will be fully articulated in the Three-way Contract.

VIII. Grievances – Participants shall be entitled to file internal grievances directly with the FIDA-IDD Plan either orally or in writing. Each FIDA-IDD Plan must track and resolve its grievances according to the integrated Grievance process outlined in the Three-way Contract, or if appropriate, re-route grievances to the coverage decision or appeals processes.

1. Grievance Filing Deadline. All Grievances must be filed within 60 calendar days of the incident or whenever there is dissatisfaction (in the event there is not one specific incident).

2. Acknowledgement of Grievance. The FIDA-IDD Plan must send timely written acknowledgement of receipt of Grievance to the Participant. If a decision is reached before the written acknowledgement is sent, the FIDA-IDD Plan will not send the written acknowledgement.

3. Timeframe for Plan Decision and Notification on Grievance. The FIDA-IDD Plan must respond to a Participant's grievance as fast as the Participant's condition requires, but no later than:

a. Expedited: Paper review – decision and notification within 24 hours (in certain circumstances). For all other circumstances where a standard decision would significantly increase the risk to a Participant’s health, decision and notification within 48 hours after receipt of all necessary information and no more than 7 calendar days from the receipt of the grievance. Certain circumstances requiring a response within 24 hours are defined as:

- i. The complaint involves the FIDA-IDD Plan’s decision to invoke an extension relating to an organization determination.
- ii. The complaint involves the FIDA-IDD Plan’s refusal to grant a Participant’s request for an expedited organization determination under 42 CFR Part 422.570.

b. Standard: Notification of decision within 30 calendar days of the FIDA-IDD Plan receiving the written or oral grievance.

4. Extension. Up to 14-calendar day extension. The FIDA-IDD Plan may extend the 30-calendar day timeframe by up to 14 calendar days if the Participant or provider on the Participant’s behalf (written or verbal) requests the extension or if the FIDA-IDD Plan justifies a need for additional information and documents how the delay is in the interest of the Participant. When the FIDA-IDD Plan extends the deadline, it must immediately notify the Participant in writing of the reasons for the delay.

5. External Grievance. A Participant may file an external grievance through the process outlined in the Three-way Contract.

IX. Appeals — Other than Medicare Part D Appeals, which shall remain unchanged, the below is the approach for an integrated Medicare-Medicaid appeals process. CMS and NYSDOH will work to continue to coordinate Appeals for all services, including those related to Part D. Additional details related to the appeals process will be further delineated in the Three-way Contract.

a. Integrated Appeals Process (IAP):

i. Integrated Notice- FIDA-IDD Demonstration Participants will be notified of all applicable Medicare and Medicaid appeal rights through a single notice specific to the service or item type in question, developed jointly by the State and CMS. All notices shall be integrated and shall communicate the steps in the integrated appeals process identified herein as well as the availability of the Participant Ombudsman to assist with appeals.

ii. Integrated Appeal Process and Time Frames- Time frames for filing an appeal related to benefits will be unified. There are four (4) levels of appeal.

1. Appeal Filing Deadline. Participants, their providers, and their Representatives will have 60 calendar days to file an appeal related to denial or reduction or termination of authorized Medicare or Medicaid benefit coverage. This first level of appeal is an internal appeal, to be

decided by the FIDA-IDD Plan. The appeal must be requested within 60 calendar days of postmark date of notice of Action if there is no request to continue benefits while the appeal decision is pending. A request to continue benefits is valid if an Appeal is requested within 10 business days of the notice's postmark date of the Action or by the intended effective date of the Action, whichever is later, and the Appeal involves the termination or modification of a previously authorized services.

2. Acknowledgement of Appeal. The FIDA-IDD Plan shall be required to send written acknowledgement of appeal to the Participant within 15 calendar days of receipt. If a decision is reached before the written acknowledgement is sent, the FIDA-IDD Plan will not send the written acknowledgement.

3. Timeframe for Plan Decision on Appeal. The FIDA-IDD Plan shall be required to decide the appeal and notify the Participant (and provider, as appropriate) of its decision as follows:

a. Expedited: Paper review unless a Participant requests in-person review - as fast as the Participant's condition requires, but no later than within 72 hours of the receipt of the appeal.

b. Standard: Paper review unless a Participant requests in-person review - as fast as the Participant's condition requires, but no later than 7 calendar days from the date of the receipt of the appeal on Medicaid prescription drug appeals and for other appeals no later than 30 calendar days from the date of the receipt of the appeal.

c. Benefits will continue pending an appeal in accordance with section IX.a.ii.12.

4. Extension. Up to 14-calendar day extension. An extension may be requested by a Participant or provider on a Participant's behalf (written or oral). The FIDA-IDD Plan may also initiate an extension if it can justify need for additional information and if the extension is in the Participant's interest. In all cases, the extension reason must be well-documented, and when the FIDA-IDD Plan requests the extension it must notify the Participant in writing of the reasons for delay and inform the Participant of the right to file an expedited grievance if he or she disagrees with the FIDA-IDD Plan's decision to grant an extension.

5. Notification of Appeal Decision. The FIDA-IDD Plan must make a reasonable effort to provide prompt oral notice to the Participant for expedited appeals and must document those efforts. The FIDA-IDD Plan must send written notice within 2 calendar days of providing oral notice of its decision for standard and expedited appeals.

6. Automatic Administrative Hearing. Any adverse decision by the FIDA-IDD Plan is automatically forwarded to the Integrated Administrative

Hearing Office at the FIDA-IDD Administrative Hearing Unit at the State Office of Temporary and Disability Assistance (OTDA). This step occurs regardless of the amount in controversy (i.e., there will be no amount in controversy minimum imposed but only as to appeals to OTDA). Benefits will continue pending an appeal in accordance with section IX.a.ii.12. The Integrated Administrative Hearing Office role will be further outlined in the Three-way Contract. CMS and NYSDOH will provide the Integrated Administrative Hearing Officers with FIDA-IDD Demonstration specific training. This second level of appeal is external to the FIDA-IDD Plan.

7. Notices of Automatic Administrative Hearing. The FIDA-IDD Plan shall be required to send an Acknowledgement of Automatic Administrative Hearing and Confirmation of Aid Status within 14 calendar days of forwarding the administrative record. . The Integrated Administrative Hearing Office shall provide the Participant with a Notice of Administrative Hearing at least 10 calendar days in advance of the hearing date.

8. Administrative Record for Administrative Hearing. The Integrated Administrative Hearing Office shall create the administrative record at the second level of appeal and allow for requesting and receiving copies of the administrative record in accordance with 42 CFR Part 405.1042.

9. Timeframe for Decision on Administrative Hearing.

a. Standard Timeframe: The Integrated Administrative Hearing Office shall conduct a phone or in-person hearing and render a decision as expeditiously as the Participant's condition requires, but always within 7 calendar days for Medicaid prescription drug coverage matters and for all other matters within 90 calendar days of the date of the Participant's request for an appeal to the FIDA-IDD Plan for the first year of the Demonstration and 62 calendar days of request for the remaining years of the Demonstration.

b. Expedited Timeframe: The Integrated Administrative Hearing Office shall conduct a phone or in-person hearing and notify the Participant (and the provider, as appropriate) of the decision within 72 hours of the forwarding of the FIDA-IDD Plan's appeal decision.

c. Decision: The Integrated Administrative Hearing Officer shall issue a written decision that explains in plain language the rationale for the decision and specifies the next steps in the appeal process, including where to file the appeals, the filing time frames, and other information required by applicable Federal and State requirements. Participants will be notified by the timeframes stated in section II(a)(ii)(9)(a) and (b) of this Appendix.

10. Medicare Appeals Council. If a Participant disagrees with the Integrated Administrative Hearing Officer's decision, the Participant may appeal that decision further to the Medicare Appeals Council, which may overturn the Integrated Administrative Hearing Officer's decision. An adverse Administrative Hearing decision may be appealed to the Medicare Appeals Council within 60 calendar days. This serves as the third level of appeal. These appeals must be filed with the FIDA-IDD Administrative Hearing Unit, which will forward the request for appeal and administrative record to the Medicare Appeals Council in the manner specified in the Three-way Contract. The Medicare Appeals Council will complete a paper review and will issue a decision within 90 calendar days. Benefits will continue pending an appeal in accordance with section IX.a.ii.12. CMS and NYSDOH/OPWDD will provide the Administrative Appeals Judges with FIDA-IDD Demonstration specific information.

11. Federal District Court. An adverse Medicare Appeals Council decision may be appealed to the Federal District Court, which serves as the fourth level of appeal.

12. Continuation of Benefits Pending Appeal. Continuation of benefits for all prior-approved Medicare and Medicaid benefits that are terminated or modified, pending internal FIDA-IDD Plan appeals, Integrated Administrative Hearings Unit, and Medicare Appeals Council must be provided if the original appeal is requested to the FIDA-IDD Plan within 10 calendar days of the notice's postmark date (of the decision that is being appealed) or by the intended effective date of the Action, whichever is later. For benefits to continue pending appeal at the Medicare Appeals Council, the appeal to the Medicare Appeals Council must be requested within 10 calendar days of the postmark date of the Integrated Administrative Hearings Unit decision.

13. Validation of Integrated Administrative Hearing Officer Decisions. As part of the Administration and Oversight activities set forth in this MOU and for purposes of validating that Integrated Administrative Hearing Officer decisions are supported by applicable Medicare law, regulations and coverage criteria, all decisions related to Medicare coverage will also be reviewed by the Part C qualified independent contractor (QIC) for a period of at least one (1) and not to exceed two (2) years. The FIDA-IDD Plan will be responsible for automatically forwarding a complete paper copy of the administrative case file to the Part C QIC. OTDA will be responsible for forwarding a complete paper copy of its decision to designated CMS staff, who will compare the OTDA decision with the QIC decision. The primary purpose of this process is for quality assurance and to provide feedback to OTDA to ensure that cases are adjudicated according to Medicare rules. The Part C QIC's review does not suspend or toll the enrollee's right to request review from the Medicare Appeals Council. CMS reserves the right to make any necessary adjustments to the

appeals process to assure beneficiary access to Medicare items and services. CMS and NYSDOH will evaluate whether and how to continue this quality assurance process in subsequent demonstration years.

X. FIDA-IDD Plan Marketing, Outreach, and Education Activity

As indicated in the CMS “Announcement of Calendar Year (CY) 2013 Medicare Advantage Capitation rates and Medicare Advantage and Part D Payment Policies and Final Call Letter” released on April 2, 2012, CMS Medicare Marketing Guidelines do not apply to marketing done by State governments and marketing materials created by the State do not need to be reviewed or submitted in HPMS. However, CMS and the State agree to work together in the development of these materials, and the State will consult with CMS on the development of the materials.

a. Marketing and Participant Communication Standards for the FIDA-IDD Plan– The FIDA-IDD Plan will be subject to rules governing their marketing and Participant communications as specified under section 1851(h) and 1932(d)(2) of the Social Security Act; 42 CFR Parts 422.111, 422.2260 et. seq., 423.120(b) and (c), 423.128, and 423.2260 et. seq., 438.104; and the Medicare Marketing Guidelines. The State and CMS will work to develop a single consolidated set of marketing rules and requirements and the Three-way Contract will require the FIDA-IDD Plan to comply with any unified set of rules and requirements that are developed. The following exceptions apply:

i. The FIDA-IDD Plan may not market directly to individuals on a one-on-one basis except if the Potential Participant proactively requests a one-on-one appointment and the FIDA-IDD Plan has a documented incoming request for the one-on-one appointment. The FIDA-IDD Plan may provide responses to Participant-initiated requests for information and/or enrollment. The FIDA-IDD Plan may participate in group marketing events and provide general audience materials (such as general circulation brochures and media and billboard advertisements).

CMS and the State will develop a process to mitigate Participant shifting from the FIDA-IDD Plan to other plans operated by the same parent company. At a minimum, the Three-way Contract will identify procedures to provide additional education to Participants that are considering disenrolling from the FIDA-IDD Plan to enroll into a non-FIDA-IDD Plan that may be a part of the same corporate family.

ii. Participant choices regarding enrollment will be honored by CMS and the State.

b. Review and Approval of Marketing and Participant Communications – The FIDA-IDD Plan must receive prior approval of all marketing and Participant communications materials by CMS and/or the State in categories of materials that CMS or the State requires to be prospectively reviewed. In accordance with State rules, the State will conduct prospective review of certain Participant communication materials. FIDA-IDD Plan materials may be designated as eligible for the File & Use process, as described in 42 CFR Parts 422.2262(b) and 423.2262(b), and will therefore be exempt from prospective review and approval by both CMS and the State. CMS and the State may agree to defer to one or the other party for review of certain types of marketing and Participant communications, as agreed in advance by both parties. The FIDA-IDD Plan

must submit all marketing and Participant communication materials, whether prospectively reviewed or not, via the CMS HPMS Marketing Module.

c. Permissible Start Date for FIDA-IDD Plan Marketing Activity – The FIDA-IDD Plan may begin marketing activity, as limited by paragraph (section X(a)(i)) above, no earlier than 90 calendar days prior to the effective date of enrollment for the contract year.

d. CMS and the State will work together to educate individuals about the FIDA-IDD Plan option. CMS and the State will work together to develop single, consolidated notices and marketing materials for use in this Demonstration. Some of these will be models the FIDA-IDD Plan may work from and others will become required documents that the FIDA-IDD Plan will have to use. The Three-way Contract will specify that the FIDA-IDD Plan will be required to use any notices, materials, or other documents that the State and CMS make mandatory.

e. The State’s independent Enrollment Broker will be responsible for educating Participants on all potential plan choices through a variety of mechanisms. Outreach and educational activities may include letters, outreach events, and/or outbound telephone calls and will take into account the prevalence of cognitive impairments, mental illness, limited English proficiency, and low functional literacy. All outreach and educational materials and activities will be reviewed and approved prior to use by both CMS and by the State. The Enrollment Broker will receive training and CSR scripts from the State on the FIDA-IDD Demonstration.

f. Minimum Required Marketing and Participant Communications Materials – At a minimum, the FIDA-IDD Plan will provide current and prospective Participants the following materials. These materials will be subject to the same rules regarding content and timing of Participant receipt as applicable under section 1851(h) of the Social Security Act; 42 CFR Parts 422.111, 422.2260 et. seq., 423.120(b) and (c), 423.128, and 423.2260 et. seq.; and the Medicare Marketing Guidelines. CMS and the State will provide the FIDA-IDD Plan with required templates to use for all of these materials.

i. An Evidence of Coverage (EOC) document that includes information about all State-covered and FIDA-IDD Plan-covered additional benefits, in addition to the required Medicare benefits information. Additional content will be required by the State, including: eligibility requirements for FIDA-IDD Demonstration enrollment; excluded services; Participant rights and responsibilities; services requiring prior authorization; self-referral services; explanation that the FIDA-IDD Plan ID card replaces the Medicare and Medicaid cards; assessment and care planning processes; access and network adequacy requirements; how to access services; how to choose providers; how to access emergency care; the availability of self-directed services and how to begin self-directing services; the right to disenroll from the Demonstration and the procedure for disenrolling; consolidated appeal and grievance rights and processes; non-discrimination requirements; information on Participants’ right to execute advance directives; how to contact the OPWDD regional office for concerns regarding OPWDD services; how to contact the NYSDOH call center for any concerns regarding other Medicaid

services; how to contact the Participant Ombudsman for any assistance; how to access additional information in alternative formats or languages; how to access the FIDA-IDD Plan provider directory; the name of the FIDA-IDD Plan's parent company and any DBA (Doing Business As) that may be used; toll-free Participant services and Care Management and nurse advice 24-hour service lines; and any other content required by State or Federal regulation.

ii. An Annual Notice of Change (ANOC) summarizing all major changes to the FIDA-IDD Plan's covered benefits from one contract year to the next, starting in the second year of the Demonstration.

iii. A Summary of Benefits (SB) containing a concise description of the important aspects of enrolling in the FIDA-IDD Plan, as well as the benefits offered under the FIDA-IDD Plan, including co-payments, applicable conditions and limitations, and any other conditions associated with receipt or use of benefits.

iv. A combined provider and pharmacy directory that includes all providers of Medicare, Medicaid, and additional benefits.

v. A comprehensive integrated formulary that includes Medicare and Medicaid outpatient prescription drugs provided under the FIDA-IDD Plan.

vi. A single identification (ID) card for accessing all Covered Items and Services under the FIDA-IDD Plan.

vii. All Part D required notices, with the exception of the creditable coverage and late enrollment penalty notices required under Chapter 4 of the Prescription Drug Benefit Manual and the LIS Rider required under Chapter 13 of the Prescription Drug Benefit Manual.

f. Notification of Formulary Changes – The requirement at 42 CFR Part 423.120(b)(5) that the FIDA-IDD Plan provides at least 60 calendar days advance notice regarding Part D formulary changes also applies to the FIDA-IDD Plan for outpatient prescription or over-the-counter drugs or products covered under Medicaid or as additional benefits.

XI. Administration and Oversight

a. Oversight Framework

i. Under the Demonstration, there will be a CMS-State Contract Management Team that will ensure access, quality, program integrity, compliance with applicable laws, including but not limited to Emergency Medical Treatment and Active Labor Act (EMTALA) and ADA, and financial solvency, including reviewing and acting on data and reports, conducting studies, and taking corrective action. CMS and the State will require the FIDA-IDD Plan to have a comprehensive plan to detect, correct, prevent, and report fraud, waste, and abuse. The FIDA-IDD Plan must have policies and procedures in place to identify and address fraud, waste, and abuse at both the plan and the third-party levels in the

delivery of FIDA-IDD Demonstration benefits, including prescription drugs, medical care, developmental, habilitation, behavioral health, and Community-based and Facility-based LTSS. In addition, all Medicare Part D requirements and many Medicare Advantage requirements regarding oversight, monitoring, and program integrity will be applied to the FIDA-IDD Plan by CMS in the same way they are currently applied for Prescription Drug Plan (PDP) sponsors and Medicare Advantage organizations.

These responsibilities are not meant to detract from or weaken any current State or CMS oversight responsibilities, including oversight by the Medicare Drug Benefit Group and other relevant CMS groups and divisions, as those responsibilities continue to apply, but rather to assure that such responsibilities are undertaken in a coordinated manner. Neither party shall take a unilateral enforcement action relating to day-to-day oversight without notifying the other party in advance.

b. The Contract Management Team

i. Structure – The Contract Management Team will include representatives from CMS, NYSDOH, and OPWDD, authorized and empowered to represent CMS and the State (including both NYSDOH and OPWDD) about aspects of the Three-way Contract. Generally, the CMS members of the team will include the State Lead from the Medicare Medicaid Coordination Office (MMCO), Regional Office Lead from the Consortium for Medicaid and Children’s Health Operations (CMCHO), and an Account Manager from the Consortium for Health Plan Operations (CMHPO). The precise makeup will include individuals who are knowledgeable about the full range of services and supports utilized by the target population, particularly long-term services and supports.

ii. Reporting – Data reporting to CMS and the State will be coordinated and unified to the extent possible. Specific reporting requirements and processes for the following areas will be detailed in the Three-way Contract.

1. Quality (including HEDIS): Core measures will be articulated in the MOU.
2. Rebalancing from Institutional to HCBS Settings
3. Utilization
4. Encounter Reporting
5. Participant Satisfaction (including CAHPS)
6. Grievances and Appeals
7. Enrollment / Disenrollment Rates
8. Part C and Part D Reporting Requirements, as applicable

9. All required 1115(a) and 1915(c) waiver reporting

10. Participant Ombudsman

c. Oversight and Coordination

The Contract Management Team will be responsible for monitoring of the FIDA-IDD Plan. These responsibilities include, but are not limited to:

- Monitoring compliance with the terms of the Three-way Contract, including issuance of joint notices of non-compliance/enforcement;
- Monitoring compliance with reporting requirements;
- Monitoring compliance with the HCBS settings rule;
- Coordination of periodic audits and surveys of the FIDA-IDD Plan;
- Receipt and response to complaints;
- Reviewing reports from the Participant Ombudsman and coordinating with the Participant Ombudsman as necessary;
- Reviewing direct stakeholder input on both plan-specific and systematic performance;
- Regular meetings with the FIDA-IDD Plan;
- Coordination of requests for assistance from contractors and assignment of appropriate State and CMS staff to provide technical assistance;
- Coordinating review of marketing materials and procedures; and
- Coordinating review of grievances and appeals data, procedures, and materials.

d. Centralized Program –Wide Monitoring, Surveillance, Compliance, and Enforcement

CMS' central office conducts a wide array of data analyses, monitoring studies, and audits on its Medicare Advantage and Part D sponsors. Demonstration contracts will be included in these activities. Demonstration contracts will be treated in the same manner, which includes analysis of their performance based on CMS internal data, active collection of additional information, and CMS issuance of compliance notices, where applicable. The State and Contract Management Team will be informed about these activities and copied on notices but will not take an active part in these ongoing projects or activities.

e. Emergency / Urgent Situations

Both CMS and the OPWDD shall retain discretion to take immediate action where the health, safety, or welfare of any Participant is imperiled or where

significant financial risk is indicated. In such situations, CMS and the State shall notify a member of the Contract Management Team no more than 24 hours from the date of such action, and the Contract Management Team will undertake subsequent action and coordination.

f. FIDA-IDD Plan Call Center Requirements

In addition to current Federal regulatory requirements and CMS guidance requirements for Medicare Advantage plans and Part D plans, the following will be required call center elements:

- FIDA-IDD Plan shall operate a toll-free Participant services telephone line call center. The line will be available nationwide for a minimum of 8am to 8pm Eastern Time, seven days per week.
- Participant service representatives must be available in sufficient numbers to support Participants and meet CMS and State specified standards.
- The FIDA-IDD Plan shall have interpreter services available to call center personnel to answer questions from non-English speaking and limited English proficient current and prospective Participants. Oral interpretation services must be available free-of-charge to all Participants in all non-English languages spoken by Participants.
- The FIDA-IDD Plan must ensure that customer service department representatives shall, upon request, make available to Participants and potential Participants information including, but not limited to, the following:
 - (i) The identity, locations, qualifications, and availability of FIDA-IDD Plan providers;
 - (ii) Participants' rights and responsibilities;
 - (iii) The procedures available to a Participant and/ or provider(s) to challenge or appeal the failure of the FIDA-IDD Plan to provide a requested service and to appeal any adverse Actions (denials);
 - (iv) How to access oral interpretation services and written materials in prevalent languages and alternative, cognitively accessible formats;
 - (v) How to access the Participant Ombudsman, the NYSDOH Participant Call Center, and 1-800-Medicare;
 - (vi) Information on all FIDA-IDD Plan Covered Items and Services and other available services or resources (e.g., State agency services) either directly or through referral or authorization; and
 - (vii) The procedures for a Participant to opt out of the Demonstration.

g. Data System Specifications, Reporting Requirements, and Interoperability

To the maximum extent possible, CMS and the State will collaborate to achieve interoperability among data systems and reporting processes, including:

- Data system description and architecture and performance requirements
- Current information system upgrades and development plans and resource commitments necessary for implementation
- Consolidated reporting requirements
- Encounter reporting
- Reporting data for evaluation and program integrity
- Data Exchange among CMS, State of New York Providers and Contractors, and Health Insurance Exchanges

The FIDA-IDD Plan must maintain a Comprehensive Health Record to which all members of the IDT have swift and easy access. The FIDA-IDD Plan is strongly encouraged to use an electronic health record system that meets the meaningful use provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act. The IDT must have and implement a communications and information sharing plan (as outlined in the IDT Policy) that allows the Participant's health information and LP to be accessible to the IDT. The FIDA Plan is encouraged to join regional health information networks or qualified health information technology (HIT) entities for data exchange and share information with all Providers participating in a LP.

h. Unified Quality Metrics and Reporting

The FIDA-IDD Plan will be required to report measures that examine access and availability, Care Management/transitions, health and well-being, mental and behavioral health, patient/caregiver experience, screening and prevention, and quality of life. This includes a requirement to report Medicare HEDIS, HOS, and CAHPS data, as well as measures related to long-term services and supports. HEDIS, HOS, and CAHPS measures will be reported consistent with Medicare requirements plus any additional Medicaid measures identified by the State. All existing Medicare Part D metrics will be collected as well. The State will supplement quality reporting requirements with additional State-specific measures.

A combined set of core metrics is described below in Table 7-B; more detail on the measures will be provided in the Three-way Contract. CMS and the State will utilize the reported measures in the combined set of core metrics for various purposes, including implementation and ongoing monitoring, assessing plan performance and outcomes, and to allow quality to be evaluated and compared with other plans in the model. A subset of these measures will also be used for calculating the quality withhold payment as addressed in section VI of Appendix 6 in this MOU.

The FIDA-IDD Plan must submit data consistent with requirements established by CMS and/or the State as further described below and in the Three-way Contract. The FIDA-IDD Plan will also be subject to monitoring efforts consistent with the requirements of Medicare Advantage and Medicare Part D, as described in section XI of this Appendix.

Table 7-B: Core Quality Measures under the FIDA-IDD Demonstration

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure	Quality Withholds
1. Antidepressant Medication Management	Percentage of Participants 18 years of age and older who were diagnosed with a new episode of major depression and treated with antidepressant medication, and who remained on an antidepressant medication treatment.	NCQA/HEDIS	X		
2. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	<p>The percentage of adolescent and adult Participants with a new episode of alcohol or other drug (AOD) dependence who received the following.</p> <ul style="list-style-type: none"> • Initiation of AOD Treatment. The percentage of Participants who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis. • Engagement of AOD Treatment. The percentage of Participants who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit. 	NCQA/HEDIS	X		
3. Follow-up After Hospitalization for Mental Illness	Percentage of discharges for Participants 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner.	NCQA/HEDIS	X		X

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure	Quality Withholds
4. Screening for Clinical Depression and Follow-up Care	Percentage of Participants ages 18 years and older screened for clinical depression using a standardized tool and follow-up plan documented.	CMS	X		X
5. Care Transition Record Transmitted to Health Care Professional	Percentage of Participants, regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge.	AMA-PCPI	X		
6. Medication Reconciliation After Discharge from Inpatient Facility	Percent of patients 65 years or older discharged from any inpatient facility and seen within 60 days following discharge by the physician providing on-going care who had a reconciliation of the discharge medications with the current medication list in the medical record documented.	NCQA/HEDIS	X		
7. CAHPS, Health Plan plus supplemental items/questions (TBD). Of particular note are the following:	The percent of the best possible score that the plan earned on how easy it is for Participants to get information from their plan about prescription drug coverage and cost.	AHRQ/CAHPS	X		X

Measure	Description	Measure Steward/Data	CMS Core Measure	State Specified Measure	Quality Withholds
Getting Information about Prescription Drug Coverage and Cost	<p>A. In the last 6 months, how often did your health plan's customer service give you the information or help you needed about prescription drugs?</p> <p>B. In the last 6 months, how often did your plan's customer service staff treat you with courtesy and respect when you tried to get information or help about prescription drugs?</p> <p>C. In the last 6 months, how often did your health plan give you all the information you needed about prescription medication were covered?</p> <p>D. In the last 6 months, how often did your health plan give you all the information you needed about how much you would have to pay for your prescription medicine?</p> <ul style="list-style-type: none"> Using any number from 0 to 10, where 0 is the worst prescription drug plan possible and 10 is the best drug plan possible, what number would you use to rate your health plan for coverage of prescription drugs? 				
Getting Needed Prescription and Non-Prescription Drugs	<p>The percent of best possible score that the plan earned on how easy it is for Participants to get the prescription drugs and non-prescription drugs they need using the plan.</p> <p>A. In the last 6 months, how often was it easy to use your health plan to get the medicines your doctor prescribed?</p> <p>B. In the last six months, how often was it easy to use your health plan to fill a prescription or obtain a non-prescription drug at a local pharmacy?</p>				
Getting	Percent of best possible score the plan earned				

Needed Care	<p>on how easy it is to get needed care, including care from specialists.</p> <p>A. In the last 6 months, how often was it easy to get appointments with specialists?</p> <p>B. In the last 6 months, how often was it easy to get the care, tests, or treatment you needed through your health plan?</p> <p>C. In the last 6 months, how often was it easy to get the care, tests, or treatment you needed through your health plan?</p>				
Getting Appointments and Care Quickly	<p>Percent of best possible score the plan earned on how quickly Participants can get appointments and care.</p> <p>A. In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed?</p> <p>B. In the last 6 months, not counting the times when you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed?</p> <p>C. In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?</p>				

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure	Quality Withholds
Overall Rating of Health Care Quality	<p>Percent of best possible score the plan earned from Participants who rated the overall health care received.</p> <p>A. Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months?</p>				
Overall Rating of Plan	<p>Percent of best possible score the plan earned from Participants who rated the overall plan.</p> <p>A. Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate your health plan?</p>				
8. Part D Call Center – Pharmacy Hold Time	How long pharmacists wait on hold when they call the plan’s pharmacy help desk.	CMS Call Center data	X		
9. Part D Call Center – Foreign Language	Percent of the time that TTY/TDD services and foreign language interpretation were	CMS	X		

Measure					
Interpreter and TTY/TDD Availability	Available when needed by Participants who called the plan's customer service phone number.	Call Center data			
10. Part D Appeals Auto-Forward	<p>How often the plan did not meet Medicare's deadlines for timely appeals decisions.</p> <p>This measure is defined as the rate of cases auto-forwarded to the Independent Review Entity (IRE) because decision timeframes for coverage determinations or redeterminations were exceeded by the plan. This is calculated as: [(Total number of cases auto-forwarded to the IRE) / (Average Medicare Part D enrollment)] * 10,000.</p>	IRE	X		
11. Part D Enrollment Timeliness	The percentage of enrollment requests that the plan transmits to the Medicare program within 7 calendar days of receipt of a completed enrollment request.	Medicare Advantage Prescription Drug System (MARx)	X		
12. Part D Complaints about the Drug Plan	<p>How many complaints Medicare received about the drug plan.</p> <p>For each contract, this rate is calculated as: [(Total number of complaints logged into the CTM for the drug plan regarding any issues) / (Average Contract enrollment)] * 1,000 * 30 / (Number of Days in Period).</p>	CMS CTM data	X		

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure	Quality Withholds
13. Part D Participant Access and Performance Problems	To check on whether Participants are having problems getting access to care and to be sure that plans are following all of Medicare's rules, Medicare conducts audits and other types of reviews. Medicare gives the plan a lower score (from 0 to 100) when it finds problems. The score combines how severe the problems were, how many there were, and how much they affect plan Participants directly. A higher score is better, as it means Medicare found fewer problems.	CMS Administrative data	X		
14. Part D Participants Choosing to Leave the Plan	The percent of Participants who chose to leave the plan in 2013.	CMS Medicare Participant Database Suite of Systems	X		
15. Part D MPF Accuracy	The accuracy of how the Plan Finder data match the PDE data.	CMS PDE data, MPF Pricing Files, HPMS approved formulary extracts, and data from First DataBank and Medispan.	X		

Measure					
16. Part D High Risk Medication	The percent of the Participants who get prescriptions for certain drugs with a high risk of serious side effects, when there may be safer drug choices.	CMS PDE data	X		
17. Part D Diabetes Treatment	Percentage of Medicare Part D Participants who were dispensed a medication for diabetes and a medication for hypertension who were receiving an angiotensin converting enzyme inhibitor (ACEI) or angiotensin receptor blocker (ARB) medication which are recommended for people with diabetes.	CMS PDE data	X		
18. Part D Medication Adherence for Oral Diabetes Medications	Percent of Participants with a prescription for oral diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.	CMS PDE data	X	X	X
19. Part D Medication Adherence for Hypertension (ACEI or ARB)	Percent of Participants with a prescription for a blood pressure medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.	CMS PDE data	X		
20. Part D Medication Adherence for Cholesterol (Statins)	Percent of Participants with a prescription for a cholesterol medication (a statin drug) who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.	CMS PDE data	X		

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure	Quality Withholds
21. Plan Makes Timely Decisions about Appeals	Percent of Participants who got a timely (per timelines in section IX) response when they made a written appeal to the plan about a decision to refuse payment or coverage.	FIDA-IDD Administrative Hearing Unit	X		
22. Part D Appeals Upheld	How often an independent reviewer agrees with the plan's decision to deny or say no to a Participant's Part D appeal. This measure is defined as the percent of IRE confirmations of upholding the plans' Part D decisions. This is calculated as: [(Number of Part D cases upheld) / (Total number of Part D cases reviewed)] * 100.	IRE	X		
23. Non-Part D Appeals Upheld	How often an Integrated Administrative Hearing Officer agrees with the plan's non-Part D decision to deny or say no to a Participant's non-Part D appeal. This measure is defined as the percent of FIDA Administrative Hearing Unit confirmations of upholding the plans' decisions. This is calculated as: [(Number of non-Part D cases upheld) / (Total number of non-Part D reviewed)] * 100.	FIDA Administrative Hearing Unit	X		

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure	Quality Withholds
24. Call Center – Foreign Language Interpreter and TTY/TDD Availability	Percent of the time that the TTY/TDD services and foreign language interpretation were available when needed by Participants who called the plan’s customer service phone number.	CMS Call Center data	X		
25. Percent of High Risk Residents with Pressure Ulcers (Long Stay)	Percentage of all long-stay residents in a nursing facility with an annual, quarterly, significant change or significant correction MDS assessment during the selected quarter (3-month period) who were identified as high risk and who have one or more Stage 2-4 pressure ulcer(s).	NQF endorsed	X		
26. Participant Governance Board	Establishment of Participant advisory board or inclusion of Participants on governance board consistent with contract requirements.	CMS/State defined process measure	X		X
27. Customer Service	Percent of best possible score the plan earned on how easy it is to get information and help when needed. A. In the last 6 months, how often did your health plan’s customer service give you the information or help you needed? B. In the last 6 months, how often did your health plan’s customer service treat you with courtesy and respect? C. In the last 6 months, how often were the forms for your health plan easy to fill out?	AHRQ/CAHPS	X		X

Measure					
28. Assessments	Percent of Participants with initial assessments completed within 90 days of enrollment.	CMS/State defined process measure	X		X
29. Person-Centered Life Plans	Percent of Participants with care plans within 30 days of initial assessment.	CMS/State defined process measure	X	X	
30. Documentation of Care Goals	Percent of Participants with documented discussions of care goals.	CMS/State defined process measure			X
31. Real Time Hospital Admission Notifications	Percent of hospital admission notifications occurring within specified timeframe.	CMS/State defined process measure	X	X	
32. Risk stratification based on LTSS or other factors	Percent of risk stratifications using behavioral health (BH)/LTSS data/indicators.	CMS/State defined process measure	X	X	
33. Discharge follow-up	Percent of Participants with specified timeframe between discharge to first follow-up visit.	CMS/State defined process measure	X		

Measure					
34. Care for Older Adults – Medication Review	Percent of Participants whose doctor or clinical pharmacist has reviewed a list of everything they take (prescription and non-prescription drugs, vitamins, herbal remedies, other supplements) at least once a year.	NCQA/ HEDIS	X		
35. Care for Older Adults – Functional Status Assessment	Percent of Participants whose doctor has done a —functional status assessment to see how well they are doing —activities of daily living (such as dressing, eating, and bathing).	NCQA/HEDIS	X		
36. Care for Older Adults – Pain Screening	Percent of Participants who had a pain screening or pain management plan at least once during the year.	NCQA/HEDIS	X		
37. Diabetes Care –Eye Exam	Percent of Participants with diabetes who had an eye exam to check for damage from diabetes during the year.	NCQA/HEDIS	X		
38. Diabetes Care –Kidney Disease Monitoring	Percent of Participants with diabetes who had a kidney function test during the year.	NCQA/HEDIS	X		
39. Diabetes Care –Blood Sugar Controlled	Percent of Participants with diabetes who had an A-1-C lab test during the year that showed their average blood sugar is under control.	NCQA/HEDIS	X		
40. Rheumatoid Arthritis Management	Percent of Participants with Rheumatoid Arthritis who got one or more prescription(s) for an anti-rheumatic drug.	NCQA/HEDIS	X		

Measure					
41. Reducing the Risk of Falling	Percent of Participants with a problem falling, walking or balancing who discussed it with their doctor and got treatment for it during the year.	NCQA/HEDIS HOS	X		X
42. Plan All-Cause Readmissions	Percent of Participants discharged from a hospital stay who were readmitted to a hospital within 30 days, either from the same condition as their recent hospital stay or for a different reason.	NCQA/HEDIS	X		X
43. Controlling Blood Pressure	Percentage of Participants 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year.	NCQA/HEDIS	X	X	X
44. Comprehensive Medication Review	Percentage of Participants who received a comprehensive medication review (CMR) out of those who were offered a CMR.	Pharmacy Quality Alliance (PQA) Part D Reporting Data	X		
45. Complaints about the Plan	How many complaints Medicare received about the health plan. Rate of complaints about the plan per 1,000 Participants. For each contract, this rate is calculated as: [(Total number of all complaints logged into the CTM) / (Average Contract enrollment)] * 1,000 * 30 / (Number of Days in Period).	CMS CTM data	X		

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure	Quality Withholds
46. Participant Access and Performance Problems	To check on whether members are having problems getting access to care and to be sure that plans are following all of Medicare's rules, Medicare conducts audits and other types of reviews. Medicare gives the plan a lower score (from 0 to 100) when it finds problems. The score combines how severe the problems were, how many there were, and how much they affect plan Participants directly. A higher score is better, as it means Medicare found fewer problems.	CMS Participant database	X		
47. Participants Choosing to Leave the Plan	The percent of Participants who chose to leave the plan in 2014.	CMS	X		
48. Breast Cancer Screening	Percent of female Participants aged 40-69 who had a mammogram during the past 2 years.	NCQA/ HEDIS	X		
49. Colorectal Cancer Screening	Percent of Participants aged 50-75 who had appropriate screening for colon cancer.	NCQA/HEDIS	X		

Measure					
50. Annual Flu Vaccine	Percent of Participants who got a vaccine (flu shot) prior to flu season.	AHRQ/CAHPS Survey data	X		X
51. Improving or Maintaining Mental Health	Percent of all Participants whose mental health was the same or better than expected after two years.	CMS HOS	X		
52. Monitoring Physical Activity	Percent of senior Participants who discussed exercise with their doctor and were advised to start, increase or maintain their physical activity during the year.	HEDIS / HOS	X		
53. Access to Specialists	Proportion of respondents who report that it is always easy to get appointment with specialists.	AHRQ/CAHPS	X		
54. Getting Care Quickly	Composite of access to urgent care.	AHRQ/CAHPS	X		
55. Being Examined on the Examination table	Percentage of respondents who report always being examined on the examination table.	AHRQ/CAHPS	X		
56. Help with Transportation	Composite of getting needed help with transportation.	AHRQ/CAHPS	X		
57. Health Status/Function Status	Percent of Participants who report their health as excellent.	AHRQ/CAHPS	X		

Measure					
58. Self-Direction Participant-level Measure	Percent of Participants, advocates and/or their legal guardians directing their own services through self-direction or the consumer-directed personal assistance option at the plan each Demonstration Year.	State-specified measure		X	
59. Long Term Care Overall Balance Measure	Reporting of the percent of Participants who did not reside in a nursing facility for a long stay at the time of enrollment and did not reside in a nursing facility for a long stay during the reporting period.	State-specified measure		X	X

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure	Quality Withholds
60. Nursing Facility Diversion Measure	Reporting of the number of nursing home certifiable Participants who lived outside the nursing facility (NF) during the current measurement year as a proportion of the nursing home certifiable Participants who lived outside the NF during the previous year.	CMS		X	X

Measure					
61. Long Term Care Rebalancing Measure	<p>Reporting of the number of Participants who were discharged to a community setting from a NF and who did not return to the NF during the current measurement year as a proportion of the number of Participants who resided in a NF during the previous year.</p> <p>Monthly Long Term Care Rebalancing Rate: Numerator: of those Participants in the denominator, those who were discharged to a community setting from a NF and did not return to the NF during the current measurement year.</p> <p><u>Denominator:</u> Participants enrolled in a plan eleven out of twelve months during the current measurement year who resided in a NF for 100 continuous days or more during the previous year and were eligible for Medicaid during the previous year for eleven out of twelve months.</p>	State-specified measure		X	

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Specified Measure	Quality Withholds
	Exclusions: Any Participant with a gap in enrollment of Medicaid eligibility of 30 days during the current measurement year.				
62. Improvement / Stability in Activities of Daily Living (ADL) Functioning	Participants in the FIDA-IDD Demonstration who remained stable or improved in ADL functioning between previous assessment and most recent assessment.	State-specified measure		X	X
63. Participants Referred to OPWDD Regional Office or Money Follows the Person (MFP) Program	Percent of Participants in the FIDA-IDD Demonstration who reside in a nursing facility, wish to return to the community, and were referred to OPWDD Regional Office or the MFP Program.	State-specified measure		X	

XII. Stakeholder Engagement

The State will continue to engage with and incorporate feedback from the public during the implementation and operational phases of the Demonstration. This will be accomplished through an ongoing process of public meetings, monitoring Participant and provider experiences through a variety of means, including surveys, website updates, and data analysis. OPWDD will engage with its Joint Advisory Council to oversee the operation of the FIDA-IDD and the Enrollment processes for individuals choosing to join the Plan. In addition, the State will require that the FIDA-IDD Plan develop meaningful Participant input processes as part of their ongoing operations, as well as systems for measuring and monitoring the quality of service and care delivered to Participants. The State will also develop consumer notices and related materials about the FIDA-IDD Demonstration that are easily understood (i.e., no more than a 6th grade reading level) by persons with limited English proficiency and low functional literacy, and will translate materials into prevalent languages as determined by CMS and the State.

XIII. Evaluation

CMS has contracted with an independent evaluator to measure, monitor, and evaluate the impact of the Financial Alignment models, including the FIDA-IDD Demonstration, on Participant experience of care, quality, utilization, and cost. The evaluator will also explore how the New York initiative operates, how it transforms and evolves over time, and Participants' perspectives and experiences. The key issues targeted by the evaluation will include (but are not limited to):

- Participant health status and outcomes;
- Quality of care provided across care settings;
- Participant access to and utilization of care across care settings;
- Participant satisfaction and experience;
- Administrative and systems changes and efficiencies;
- Participant is supported in the most integrated setting possible;
- Long-term care rebalancing effectiveness; and,
- Overall costs or savings for Medicare and Medicaid.

The evaluator will design a State-specific evaluation plan for the FIDA-IDD Demonstration, and will also conduct a meta-analysis that will look at the State Demonstrations overall. A mixed methods approach will be used to capture quantitative and qualitative information. Qualitative methods will include site visits, qualitative analysis of program data, and collection and analysis of focus group and key informant

interview data. Quantitative analyses will consist of tracking changes in selected utilization, cost, and quality measures over the course of the Demonstration; evaluating the impact of the Demonstration on cost, quality, and utilization measures; and calculating savings attributable to the Demonstration. The evaluator will use a comparison group for the impact analysis. Quarterly reports will provide rapid-cycle monitoring of enrollment, implementation, utilization of services, and costs (pending data availability). The evaluator will also submit New York-specific annual reports that incorporate qualitative and quantitative findings to date, and will submit a final evaluation report at the end of the Demonstration.

The State is required to cooperate, collaborate, and coordinate with CMS and the independent evaluator in all monitoring and evaluation activities. The State and the FIDA-IDD Plan must submit all required data for the monitoring and evaluation of this Demonstration, according to the data and timeframe requirements to be listed in the Three-way Contract. As the independent evaluator is a CMS contractor, the State will submit all data for use by the evaluators without requiring an additional Data Use Agreement (DUA) between the State and the evaluator.

The State will track beneficiaries eligible for the Demonstration, including which beneficiaries choose to enroll or disenroll from the Demonstration, enabling the evaluation to identify differences in outcomes for these groups. The State will need to provide information including but not limited to the following on a quarterly basis to CMS and/or the evaluator:

- Beneficiary-level data identifying beneficiaries eligible and enrolled in the demonstration:
 - o Medicare Beneficiary Claim Account Number (HICN)
 - o MSIS number
 - o Social Security Number
 - o CMS Beneficiary Link Key
 - o Person First and Last Name, Birthdate, and Zip code
 - o Eligibility identification flag - Coded 0 if not identified as eligible for the Demonstration, 1 if identified as eligible for the Demonstration using criteria available in claims or other administrative data, and 2 if identified by criteria from non-administrative data sources
 - o Monthly eligibility indicator - Each monthly eligibility flag variable would be coded 1 if eligible, and zero if not.
 - o Monthly enrollment indicator - Each monthly enrollment flag variable would be coded 1 if enrolled in the Demonstration, and zero if not.

- Summary level data for the State Data Reporting System, including but not limited to:
 - o The number of beneficiaries eligible for the Demonstration, appropriately excluding all individual beneficiaries not eligible for the Demonstration (e.g., individuals under the age of 21, residents of psychiatric facilities, etc.)
 - o The number of beneficiaries enrolled in the Demonstration
 - o The number of beneficiaries who disenroll from the Demonstration

The State will work with the evaluation contractor to determine what Care Management data are available and will share data with the evaluator to support analysis of Care Management utilization patterns. Based on discussions with the evaluation contractor, the State will be asked to provide data potentially including beneficiary-level data, such as HICNs, on beneficiaries receiving Care Management during any given month.

The State will ensure that the evaluator at least annually receives information indicating the primary care provider of record for each Participant. The State will also have the capability to track beneficiary-level data on grievances and appeals that identify the health plan and providers involved.