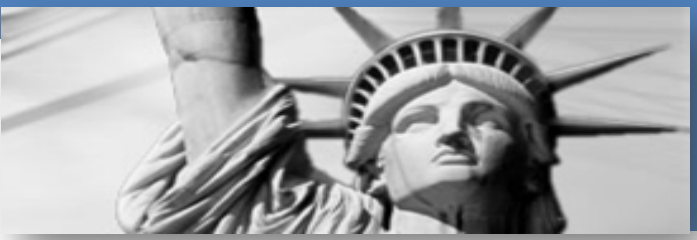

NEW YORK state department of HEALTH

Redesigning THE MEDICAID PROGRAM

New York Medicaid Redesign Fully Integrated Duals Advantage Program

Finance Workgroup

November 15, 2012

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Agenda

- Introductions
- Finance Work Group Goals
- Research Basis for Fully-Integrated Care Plans
- National Overview of LTC Dual Integration Demonstration
- CMS Requirements for Dual Integration
- CMS Capitated Methodology
- NYS Data on Medicare-Medicaid Enrollees
- NYS FIDA Demonstration Proposal
- Proposals from Other States
- Next Steps

FIDA Finance Work Group

FIDA Finance Work Group Goals

- In March 2011, NYSDOH received a planning grant from CMS to develop a demonstration proposal around integrated care for individuals eligible for Medicaid and Medicare (Dual Eligibles)
- The Department established several stakeholder work groups to address various aspects of the demonstration (i.e., finance, outreach, appeals and plan selection/quality).
- The Finance Work Group was created to:
  1) Discuss integrated premium development and options for Medicaid rate setting;
  2) Identify potential issues that require further discussion with CMS; and
  3) Formulate steps that can be taken from a finance and reimbursement perspective to ensure that plans, providers and members are ready for the transition to managed care.

Research Basis for Fully-Integrated Care Plans

- Thomson Reuters (2011) conducted an assessment of the research literature on duals in four areas:

  - *Fully Integrated Care Plans Serving Medicare-Medicaid Enrollees*
    - ✓ Reviewed studies relating to 4 managed care plans (i.e., MA Senior Care Options, MN Disability Health Options, MN Senior Health Care Options and WI Family Partnership)
    - ✓ Found that health care outcomes, including satisfaction were similar or slightly better for dual enrollees in fully-integrated plans

  - *Managed Long Term Care Services and Supports*
    - ✓ Examined 9 relevant research studies
    - ✓ Found mixed results in trying to assess impact of MLTSS potentially due to diversity in types of programs, divergent outcome measures, older data and weak research design making it difficult to draw definitive conclusions.

  - *Program of All-Inclusive Care for the Elderly (PACE)*
    - ✓ Assessed 10 studies on PACE programs
    - ✓ Studies show some evidence of decreased Medicare costs and inpatient use, reduced mortality risk and higher self-reported quality.

  - *On-Site Primary Care Providers in Nursing Facilities*
    - ✓ Utilized 2 studies for Evercare model and primary care demonstration project
    - ✓ While reduction in use emergency services and risk of hospitalization was observed, conclusions about cost effectiveness were mixed.

Research Basis for Fully-Integrated Care Plans

- Additional Research:
  - *Spending Differences Associated with the Medicare Physician Group Practice Demonstration* (Colla, et al., 2012) – www.commonwealthfund.org/

    Major Findings:
    - ✓ PGPD achieved significant annual per capita savings for dual eligibles; however similar savings levels were not achieved for other Medicaid beneficiaries.
    - ✓ Significant savings across home health care and acute care (reduced hospitalizations also reported).
    - ✓ Decreased Medical and surgical readmissions within 30 days for duals

  - *Best Bets for Reducing Medicare Costs for Dual Eligible Beneficiaries: Assessing the Evidence* (Brown & Mann, 2012) – www.kff.org/medicare/upload/8353.pdf

    Major Findings:
    - ✓ Results were achieved with interventions that were targeted at specific subgroups of duals and tailored to each individual's needs.
    - ✓ While studies are inconclusive regarding cost savings, there may be potential for net Medicare savings if net capitation rates are below local Medicare FFS costs
    - ✓ Strong evidence to support reductions in hospitalizations and costs as a result of interventions targeted at duals residing in nursing homes
    - ✓ Care coordination programs targeting full benefit duals who live in the community with multiple and/or severe chronic conditions (but not requiring LTSS) may provide best opportunity for savings
    - ✓ Duals in relatively good health with no more than one chronic condition (not requiring LTSS) may benefit from programs that help coordinate coverage across Medicare and Medicaid programs.

Research Basis for Fully-Integrated Care Plans

- Other resources:
  - *Medicare-Medicaid Enrollee State Profile: The National Summary* www.integratedcareresourcecenter.com/icmstateprofiles.aspx
  - *Medicare-Medicaid Enrollee State Profile: New York -* www.integratedcareresourcecenter.net/PDFs/StateProfileNY.pdf

National Overview of LTC Dual Integration Demonstration

- Based on 2008 data, an estimated 9.2 million individuals nationally are eligible for both Medicare and Medicaid
- Duals comprise relatively small share of Medicare and Medicaid population, but account for disproportionate share of spending (totaling $300 billion across programs):
  - Medicare - 21% of FFS population; 36% of spending (2006)
  - Medicaid - 15% of population; 40% of spending (2007)
- Section 2602 of Affordable Care Act (ACA) enacted to improve quality, reduce costs and enhance beneficiary experience
  - New York and fourteen other states (CA, CO, CT, MA, MI, MN, NC, OK, OR, SC, TN, VT, WA, WI) selected to design new models that integrate care for dual eligible individuals
  - In addition to the 15 states awarded design contracts, another 10 states are working with CMS to pursue a Financial Alignment Demonstration to integrate care for duals. These states are: AZ, HI, IA, ID, IL, MO, OH, RI, TX, and VA.

CMS Federal Requirements for Dual Integration

CMS Requirements for Dual Integration

- Purpose of Demonstration Program:
  - Ensure individuals have full access to services and benefits
  - Improve coordination between federal government and states
  - Develop innovative and integrated models of care
  - Incentivize programmatic alignment between Medicare and Medicaid for: care management, FFS benefits, prescription drugs, cost sharing, enrollment and appeals.
  - Eliminate financial misalignments that lead to poor quality and cost shifting through capitated and managed fee-for-service (FFS) models.

- Additional benefits:
  - Improved state access to Medicare data for care coordination, including timely availability of A (inpatient), B (medical) and D (prescription drug) data.
  - More accurate data on dual population including geographic variation and potentially avoidable hospitalizations.

CMS Capitated Rate Methodology

- Capitated model utilizes joint rate-setting process
  - Medicare and Medicaid will coordinate in setting payment levels
  - Both payers will prospectively share in savings achievable through the demonstrations
  - Model relies on baseline spending estimates determined for target population
    - Baseline is the estimate of what would have been spent in the payment year had demonstration not existed
    - Established prospectively on a year-by-year basis

- Payment structure:
  - CMS will make separate payments to health plans for the Medicare A/B and Part D components of the rate
  - State will make a payment to health plans for the Medicaid component of the rate

Components of CMS Rate Methodology - Medicaid

- Baseline Spending Target:
  - ✓ Medicaid methodology will vary State to State
  - ✓ State and its actuaries are responsible for providing historical costs data to CMS's contracted actuaries
  - ✓ CMS' contracted actuaries (with guidance from CMS) will validate data and project baseline costs absent the demonstration.
  - ✓ Takes into account historic costs and includes consideration of Medicaid managed care plan level payment (if State currently serves dual enrollees through capitated managed care) as well as FFS costs.
    - New York to determine how MAP and other programs factor into baseline estimates.
- Risk Adjustment Methodology:
  - ✓ Medicaid to be risk adjusted by methodology proposed by each State and agreed to by CMS.
    - New York will likely use Clinical Risk Groups (CRGs) or the risk method currently applied for MLTC.

Components of CMS Rate Methodology - Medicare

- Baseline Spending Target:
  - ✓ Medicare methodology will be consistent across all States participating in the initiative
  - ✓ CMS to calculate baseline spending (absent demonstration) and develop estimate of cost for Medicare A and B services.
    - For Medicare FFS beneficiaries, baseline costs = CY 2014 Medicare Advantage standardized FFS county rates (Note: CY 2013 rates are applicable for State demonstrations being implemented in calendar year 2013).
    - For Medicare Advantage beneficiaries, baseline reflects MA plan payments including Part C rebates
    - Each county baseline will be a weighted average of these FFS and MA costs based on expected proportion of enrollment from FFS and MA
  - ✓ Rates are standardized (reflecting risk of an average 1.0 population)
  - ✓ Medicare Part D (for Part D Direct Subsidy) will be set at the Part D national average monthly bid amount for the payment year
    - Bid amount is weighted average of the standardized bid amounts for each prescription drug plan and is released by CMS in August of each year
    - CMS will estimate average monthly payment for low-income cost sharing and Federal reinsurance subsidy amounts (payments will be fully reconciled).

- Risk Adjustment Methodology:
  - ✓ Applied to Medicare A/B and Part D Direct Subsidy components based on CMS-HCC and RxHCC risk models, respectively, representing the risk profile of each enrollee.

Shared Savings Target Methodology

- Aggregate Savings Target:
  - ✓ Savings target based on CMS modeling.
    - Both modeling and input from States and other stakeholders will inform the selection of the target.
  - ✓ Varies by state and will be specified in each state's MOU (e.g., 1% in Year 1; 3% in Year 2; 5% in Year 3).
- Integrated Rate Savings Target:
  - ✓ To be applied to Medicare A/B and Medicaid components (excludes Part D)
    - Allows both payers to proportionally share in contribution to the capitation rate and savings achieved through demonstration regardless of underlying utilization patterns (e.g., whether savings accrued by reducing hospitalizations where Medicare is primary or by nursing facility placements where Medicaid is primary, both payers will benefit)

Quality Adjustment

- Quality Withhold:
  - ✓ Applies to Medicaid and Medicare A/B components of rate.
  - ✓ CMS and states will withhold a portion of the capitation payments that participating health plans can earn back if they meet certain quality thresholds.
  - ✓ Threshold measures to be combination of certain core quality measures, determined by State and CMS as part of MOU discussion process
    - CMS expects the core quality measures to be consistent across all demonstrations under the Financial Alignment Initiative
    - Each State will work with CMS as part of its MOU discussions to develop the State-specific performance measures.
    - For more information on core quality measures, please see pages 48-50 of the Massachusetts MOU at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MassMOU.pdf.
  - ✓ In Year 1, encounter reporting may be utilized as basis for 1% withhold, plus any addition State/CMS requirements
  - ✓ Withhold expected to increase (e.g., 2% in Year 2; 3% in Year 3)
  - ✓ Part D payments not subject to quality withhold

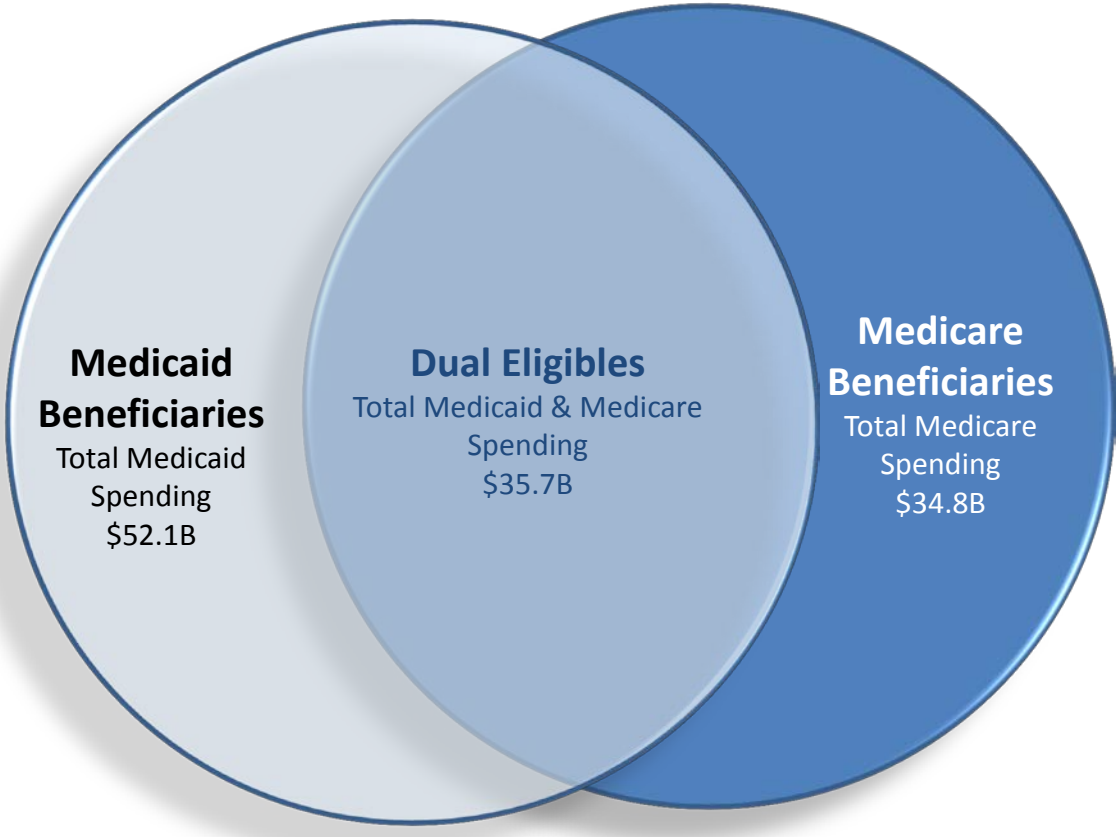
- Quality Withhold Payments:
  - ✓ CMS and State to assess plan performance and calculate payments.

New York State Data on Medicare-Medicaid Enrollees

All Dual Eligible Recipients (820,000 approx.)*

Comprises 38% of Medicaid Spending ($19.8B)

Comprises 46% of Medicare Spending ($15.9B)



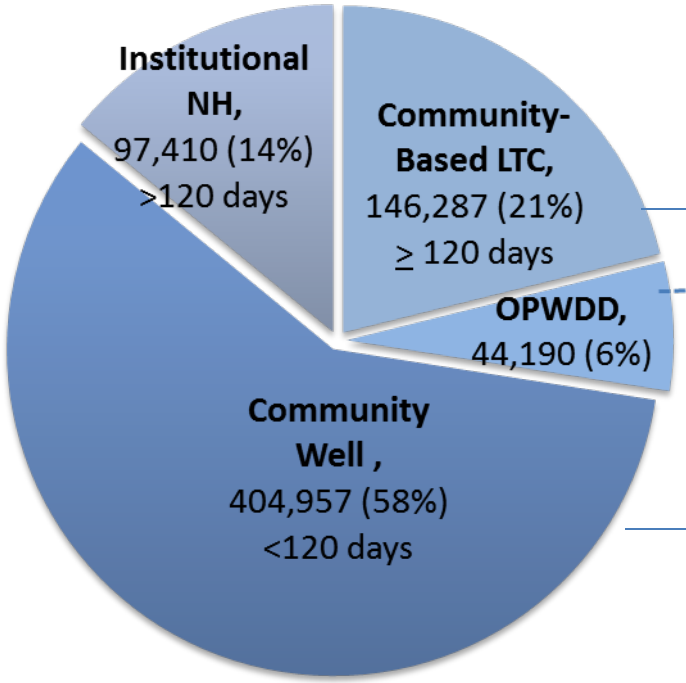
Dual Eligibles – Total Medicaid and Medicare Spending ($ in Billions)

Program	Population[1]	$
Medicaid	*Dual, Full*	*19.4*
	Dual, Partial	*0.4*
	Total	19.8
Medicare	*Dual, Full–Part A/B*	*7.9*
	Dual, Partial–Part A/B	*2.3*
	All Duals–Part C	*2.1*
	All Duals–Part D	*3.6*
	Total	15.9

[1]*Full Benefit Dual* = Enrollee has met financial and categorical requirements for Medicaid and is enrolled in Medicare Part A and/or Part B; *Partial Benefit Dual*= Enrollee not eligible for full Medicaid benefits, but state Medicaid Program "buys in" and pays Medicare Part A and/or Part B premium.

Sources: Medicaid – United Hospital Fund (2010) data net administration costs. Medicare –Kaiser (2009) data trended by Medicare market basket to 2010. Medicaid Duals-NYS DOH Data Mart (2010). Medicare Duals – Part A/B- National Claims History Database; Part C-Kaiser (2011) benchmark data detrended to 2010; Part D-Based on 2013 estimated PMPMs detrended to 2010. *Reflects annual basis versus enrollment in a given month.

Full-Benefit Dual Eligible Recipients Population Cohort (700,000 approx.)*



N = 692,844 Dual Enrollees

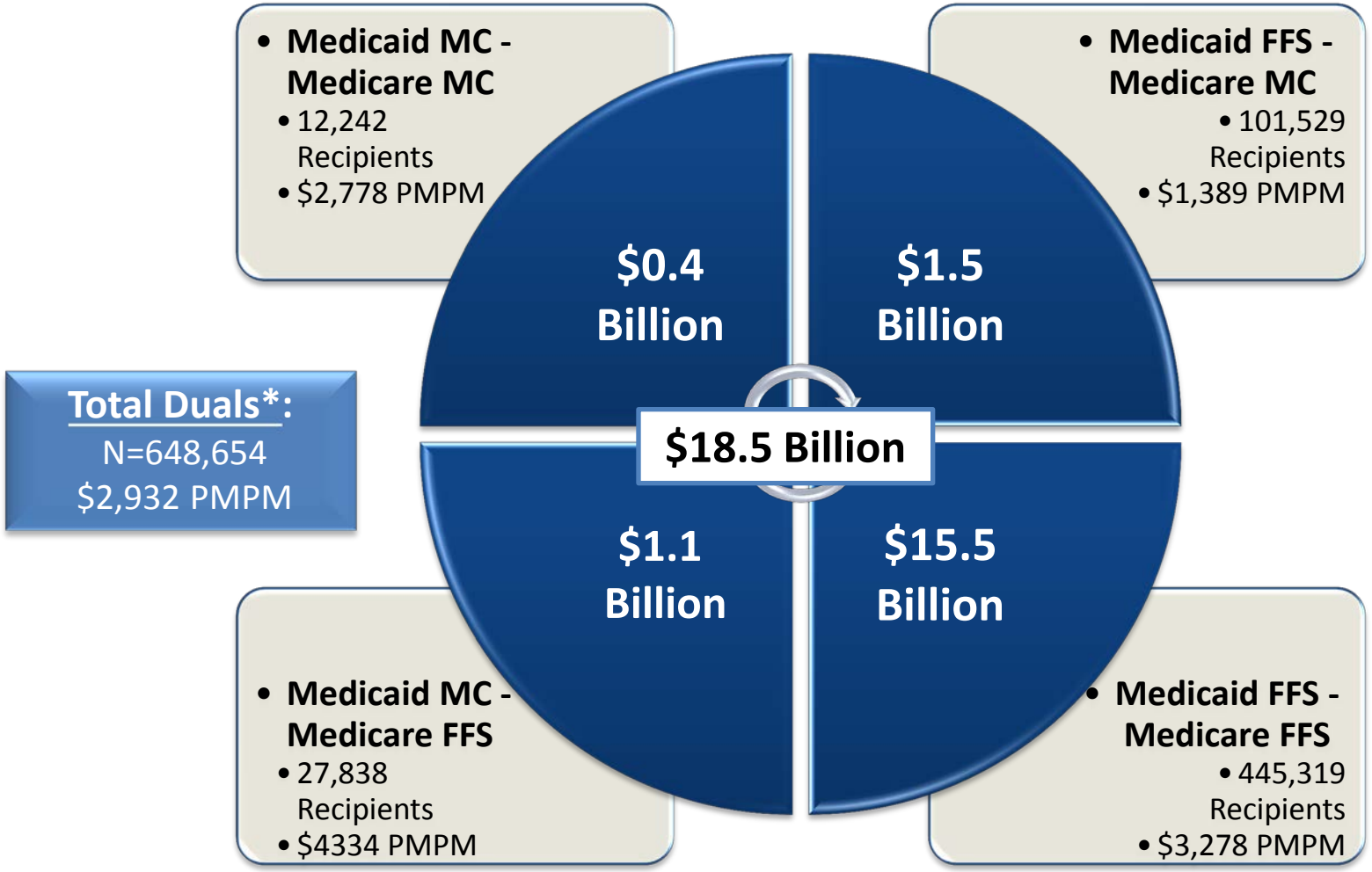
FIDA Demo – Capitated Approach (8 Counties NYC – January 1, 2014)	
FIDA – Primary	123,880
FIDA – OPWDD	Up to 10,000

FIDA Demo – Managed FFS (Statewide – January 1, 2013)	
FIDA – Health Homes	126,582
MH/Substance Abuse	65,365
Other Chronic Medical	61,217

*Estimated statewide dual eligible population aged 21 and over (excluding individuals residing in OMH facilities).

Dual Eligible Participation in Managed Care

(All Full Benefit Duals excluding OPWDD Cohort)



*Total includes 61,726 dual enrollees (which are not reflected in any of the four quadrants) that have had some MC or FFS experience during the year ($1.4B; $2,345 PMPM) ; all full-benefit duals excluding OPWDD comprises $19.9 billion in expenditures.

Full-Benefit Dual Eligible Recipients Population Cohort (700,000 approx.)*

Population	Member Months	Medicaid $	Medicare $	Total	Total PMPM
Institutional – NH	1,006,147	$5,695,115,759	$1,835,235,425	$7,530,351,185	$7,484
Community –Based LTC	1,639,374	$5,683,607,363	$2,661,299,331	$8,344,906,694	$5,090
OPWDD	517,506	$4,521,383,716	$272,818,618	$4,794,202,335	$9,264
Community Well	4,141,923	$1,104,714,346	$2,919,032,042	$4,023,746,388	$972
Total	**7,304,923**	**$17,004,821,184**	**$7,688,385,416**	**$24,693,206,602**	**$3,380**

*Reflects Medicare Part A and B only.

Community-Based LTC Cohort

Dual Eligible Recipients by Category of Service

COS	Recipients	Medicaid $	Medicare $	Total $	PMPM $
Inpatient	57,833	115,070,134	1,243,565,704	1,358,635,837	829
SNF	13,850	43,925,162	180,617,594	224,542,756	137
Hospice	2,731	4,274,284	26,146,362	30,420,646	19
Non-ER HOPD	74,817	51,354,093	112,836,819	164,190,912	100
ER (HOPD)	39,515	2,963,721	21,899,290	24,863,011	15
FS Clinic	22,867	45,976,937	88,482,912	134,459,848	82
Home Health Care	71,739	1,777,985,127	220,648,732	1,998,633,859	1,219
Physician/Specialist	126,325	42,298,233	497,808,014	540,106,247	329
DME	96,675	66,211,854	82,380,069	148,591,923	91
Pharmacy	116,302	56,594,189	---	56,594,189	35
Capitation	41,425	1,182,771,609	---	1,182,771,609	721
Personal Care	54,350	1,682,541,484	---	1,682,541,484	1,026
Waiver Services	2,645	94,165,270	---	94,165,270	57
ALP/Adult Day Care	15,180	294,780,308	---	294,780,308	180
Case Mgmt.	2,084	8,637,716	---	8,637,716	5
Other Services	125,856	214,057,243	186,913,836	400,971,079	244
Total	**146,287**	**$ 5,683,607,363**	**$ 2,661,299,331**	**$ 8,344,906,694**	**$ 5,090**

OPWDD Cohort

Dual Eligible Recipients by Category of Service

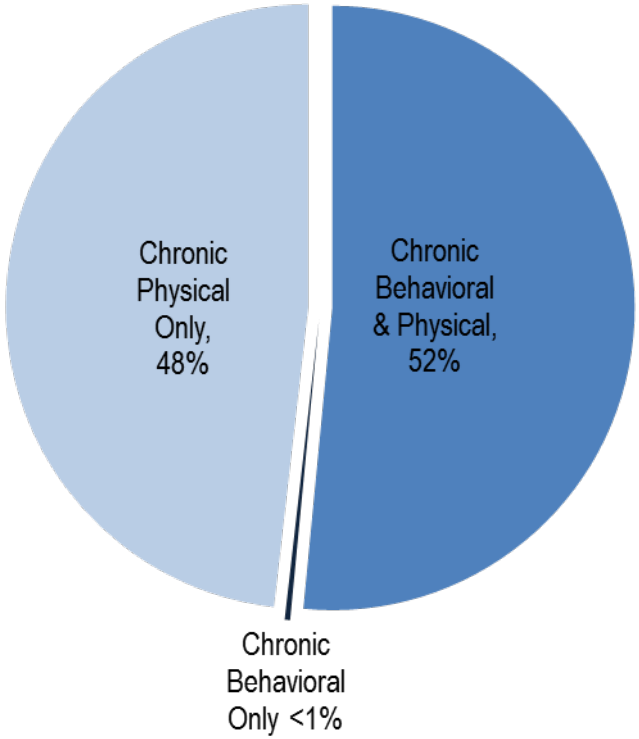
COS	Recipients	Medicaid $	Medicare $	Total $	PMPM $
Inpatient	6,684	11,013,787	119,102,465	130,116,252	251
SNF	1,149	13,624,194	12,187,934	25,812,128	50
Hospice	206	2,203,145	2,502,688	4,705,833	9
Non-ER HOPD	33,766	14,271,995	26,105,995	40,377,990	78
ER (HOPD)	14,989	703,161	7,910,779	8,613,940	17
FS Clinic	28,926	85,384,666	4,500,672	89,885,338	174
Home Health Care	2,294	21,872,470	3,859,838	25,732,308	50
Physician/Specialist	41,699	6,335,314	57,855,281	64,190,595	124
DME	16,856	6,988,151	16,646,781	23,634,932	46
Pharmacy	24,890	9,731,622	---	9,731,622	19
Capitation	501	2,380,982	---	2,380,982	5
Personal Care	1,962	58,187,914	---	58,187,914	112
Waiver Services	35,216	3,319,948,511	---	3,319,948,511	6,415
ICFDD	5,447	806,512,206	---	806,512,206	1,558
ALP/Adult Day Care	1,121	26,296,448	---	26,296,448	51
Case Mgmt.	38,250	104,429,144	---	104,429,144	202
Other Services	41,083	31,500,006	22,146,187	53,646,192	104
Total	**44,190**	**$ 4,521,383,716**	**$ 272,818,618**	**$ 4,794,202,335**	**$ 9,264**

Base Health Status and Severity of Illness

(Unique Beneficiaries and Percent of Total Cohort)

	Severity of Illness Level								
Base Health Status	0	1	2	3	4	5	6	Grand Total	Pct
Healthy/Acute	2,888							2,888	2%
	100%							100%	
Minor Condition		854	389	270	178			1,691	1%
		51%	23%	16%	11%			100%	
Single Chronic		7,660	3,112	1,300	288	521	25	12,906	7%
		59%	24%	10%	2%	4%	0%	100%	
Pairs Chronic		18,824	18,263	19,832	21,043	18,492	2,657	99,111	52%
		19%	18%	20%	21%	19%	3%	100%	
Triples Chronic		2,644	5,270	19,155	9,624	11,209	4,727	52,629	28%
		5%	10%	36%	18%	21%	9%	100%	
Malignancies		50	433	1,612	4,082	1,833		8,010	4%
		1%	5%	20%	51%	23%		100%	
Catastrophic		218	1,978	2,223	1,905	940	3,831	11,095	6%
		2%	18%	20%	17%	8%	35%	100%	
HIV / AIDS			410	531	865	549		2,355	1%
			17%	23%	37%	23%		100%	
Grand Total	2,888	30,250	29,855	44,923	37,985	33,544	11,240	190,685	100%
Pct	2%	16%	16%	24%	20%	18%	6%	100%	

Prevalence of Chronic Health Conditions (Top 20)



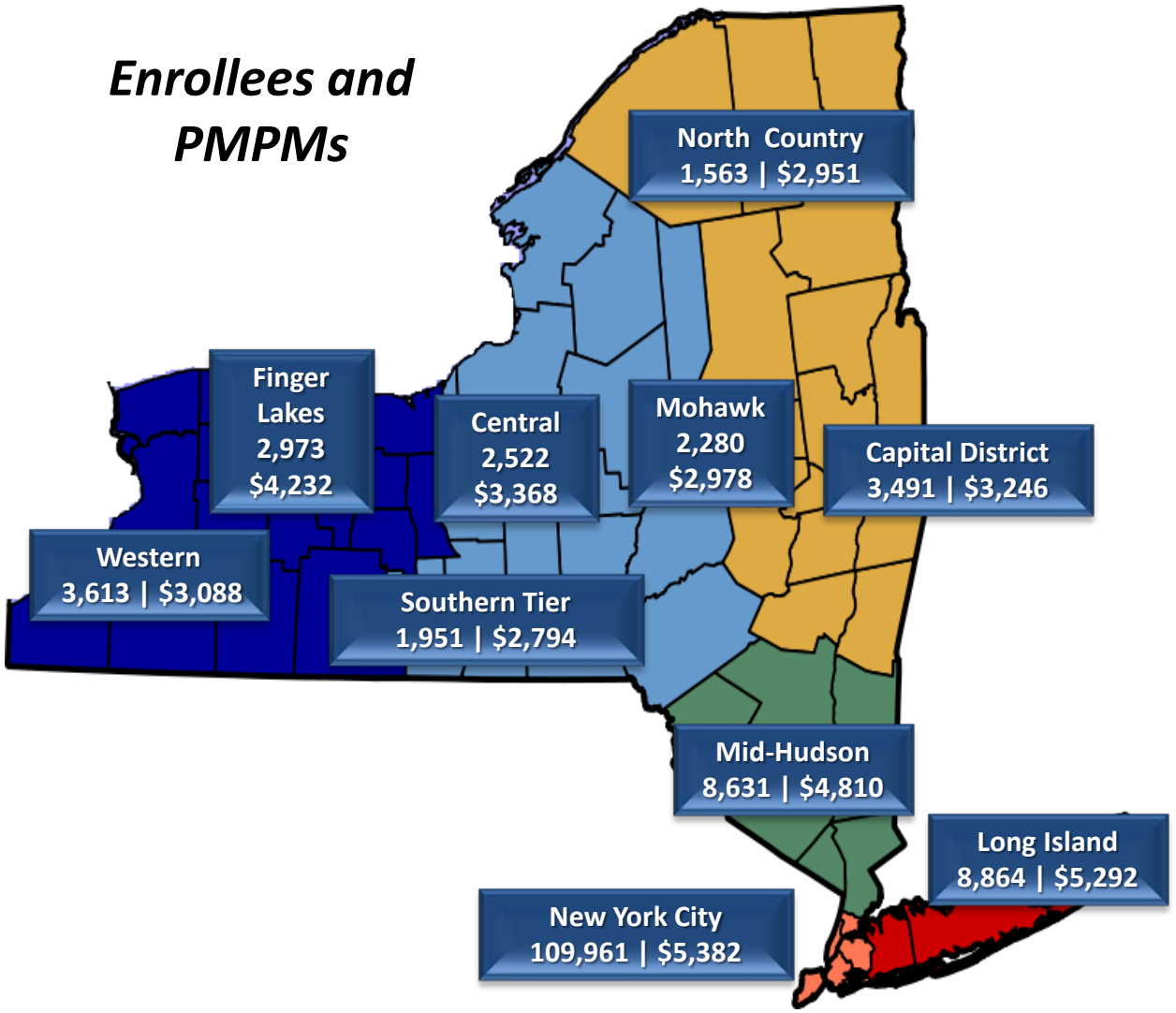
Episode Disease Condition	Unique Beneficiary	Percent Total Cohort
Hypertension	144,862	76.0
Hyperlipidemia	116,310	61.0
Chronic Joint and Musculoskeletal Diagnoses - Minor	78,980	41.4
Diabetes	71,735	37.6
Osteoarthritis	62,439	32.7
Depression	57,945	30.4
Coronary Atherosclerosis	50,565	26.5
Chronic Gastrointestinal Diagnoses - Minor	42,090	22.1
Angina and Ischemic Heart Disease	41,158	21.6
Congestive Heart Failure	40,218	21.1
Peripheral Vascular Disease	39,185	20.5
Chronic Thyroid Disease	38,267	20.1
Osteoporosis	38,154	20.0
Schizophrenia	38,127	20.0
Chronic Endocrine, Nutritional, Fluid, Electrolyte and Immune Diagnoses - Moderate	35,310	18.5
Alzheimer's Disease and Other Dementias	35,217	18.5
Chronic Stress and Anxiety Diagnoses	33,725	17.7
Mild / Moderate Mental Retardation	33,569	17.6
Asthma	33,174	17.4
Chronic Genitourinary Diagnoses	32,206	16.9

Community –Based LTC Cohort

Total Spending for Dual Eligibles by Region (146,300 approx.)

Region:	Medicaid (in Millions)	Medicare (in Millions)
Capital District	78.6	45.4
Central	60.1	30.9
Finger Lakes	101.0	39.3
Long Island	318.1	179.3
Mid-Hudson	281.3	168.5
Mohawk Valley	41.5	32.4
New York City	4,661.1	2,052.2
North Country	25.7	24.4
Other	16.2	9.9
Southern Tier	29.8	28.7
Western	70.2	50.3
Statewide	**5,683.6**	**2,661.3**

Enrollees and PMPMs



*Data Source: Medicaid - NYS DOH Data Mart (2010); Medicare – National Claims History and Baseline Assessment File (2010)

Total Spending for Dual Eligibles – Downstate Area (8 Counties)

Region	Duals	Member Months	Medicaid ($)	Medicare ($)	Total	PMPM ($)
LI-Nassau	4,875	52,231	179,951,948	98,027,282	277,979,230	5,322
LI-Suffolk	3,989	41,755	138,147,219	81,283,188	219,430,407	5,255
NYC-Bronx	17,567	198,409	671,525,854	293,233,511	964,759,365	4,862
NYC-Kings	45,616	521,384	2,088,285,960	943,203,704	3,031,489,664	5,814
NYC-NY	21,288	241,849	890,336,129	361,634,164	1,251,970,293	5,177
NYC-Queens	21,539	243,490	860,911,762	384,985,031	1,245,896,793	5,117
NYC-Richmond	3,075	34,132	115,518,515	54,696,260	170,214,776	4,987
NYC-Unknown	876	8,093	34,586,309	14,401,103	48,987,412	6,053
Westchester	3,992	43,159	151,956,095	81,089,398	233,045,493	5,400
Total	**122,817**	**1,384,502**	**5,131,219,792**	**2,312,553,641**	**7,443,773,433**	**5,377**

Total Spending for Dual Eligibles – Downstate Area (8 Counties)

Region	Duals	Member Months	Medicaid ($)	Medicare ($)	Total	PMPM ($)
LI-Nassau	2,374	27,887	15,423,857	261,903,853	277,327,710	9.945
LI-Suffolk	2,749	32,191	17,213,075	266,251,966	283,465,041	8,806
NYC-Bronx	1,124	12,892	6,879,624	68,097,816	74,977,441	5,816
NYC-Kings	2,581	30,006	19,605,630	219,270,101	283,875,731	7,961
NYC-NY	2,309	27,034	16,829,962	280,940,458	297,770,420	11,015
NYC-Queens	1,717	19,984	9,336,045	122,860,699	132,196,744	6,615
NYC-Richmond	660	7,621	4,181,373	57,678,917	61,860,290	8,117
NYC-Unknown	456	5,394	3,262,439	66,705,301	69,967,740	12,971
Westchester	1,400	16,428	9,441,155	158,117,993	167,559,149	10,200
Total	**15,370**	**179,437**	**1,501,827,105**	**102,173,160**	**1,604,000,265**	**8,939**

Data Cube

- Consists of interface to access and select data
- Application links to data cube to retrieve information from summary data set
- Availability of data contingent on addressing key issues:
  - ✓ Security
  - ✓ Data Sharing Agreement
  - ✓ HIPAA (Data aggregation required/non-identifiable health information)

New York State Fully Integrated Duals Advantage (FIDA) Demonstration

New York State FIDA Demonstration

2013

- January 1st: Health Home FIDA Demonstration
- Statewide implementation for 126,000 individuals
- Targeted toward Medicaid-Medicare enrollees with complex chronic medical, behavioral and long term care needs (less than 120 days).

2014

- January 1st: Community-Based LTC and OPWDD FIDA Demonstration
- Phase-In for dual enrollees aged 21-64 requiring services for 120 days or more.
- Implementation designated for eight counties: Bronx, Kings, Nassau, New York, Queens, Richmond, Suffolk and Westchester
- Primary FIDA Demonstration provides comprehensive package of services to 123,880 individuals receiving long term care services and supports in the community.
- OPWDD FIDA Demonstration includes up to 10,000 individuals with intellectual and developmental disabilities.

2015

- December 31st: Conclusion of 3-Year Federal Demonstration for Health Home FIDA (subject to approval by CMS)

2016

- December 31st: Conclusion of 3-Year Federal Demonstration for Community-Based LTC and OPWDD FIDA (subject to approval by CMS)

Proposed Target Population for Primary FIDA

- All Full Dual Eligibles in 8 County Service Area
  - Age 21 and Over
  - Not receiving services through OPWDD
  - Not receiving services in an OMH Facility
  - Not participating in Bronx Health Access Network Pioneer ACO

NYS Proposed Dual Integration Model

- Program benefits include, but are not limited to:
  - ✓ Care planning and coordination
  - ✓ Consumer direction for personal care services
  - ✓ Continuity of care provisions to ensure seamless transition to a FIDA plan
  - ✓ Articulated network adequacy and access standards
- Goal to improve health outcomes and reduce avoidable hospitalizations, health care costs and reliance on long term care facilities

Proposed Enrollment Process

- Phase 1 – January 2014
  - In Fall of 2013, the independent Enrollment Broker will contact full dual MLTCP recipients of community-based care and inform them of intention to enroll them into the Fully-Integrated Duals Advantage Program
    - Dual eligibles will be informed that they will be enrolled into a FIDA plan offered by their MLTCP plan sponsor, if available, or will be contacted to be counseled through a choice of FIDA plan
- Phase 2 – January 2015
  - In Fall of 2014, the independent Enrollment Broker will contact remaining full dual eligibles and inform them of intention to enroll them into the Fully-Integrated Duals Advantage Program
    - Dual eligibles will be informed that they will be enrolled into a FIDA plan offered by their Medicaid Advantage or Medicaid Advantage plan or will be contacted to be counseled through a choice of FIDA plan

Proposed Care Model and Covered Benefits

- Fully-Integrated Dual Advantage program
  - Capitated managed care program that provides comprehensive array of Medicare, Medicaid, and supplemental services – including:
    - All physical healthcare
    - All behavioral healthcare
    - Pharmacy
    - All LTSS services currently available through Medicaid Advantage Plus (MAP) program
    - Additional services currently only available through HCBS Waivers (e.g., NHTD, LTHHCP and TBI waivers)
    - Additional supplemental services not currently required in NYSDOH managed care plans

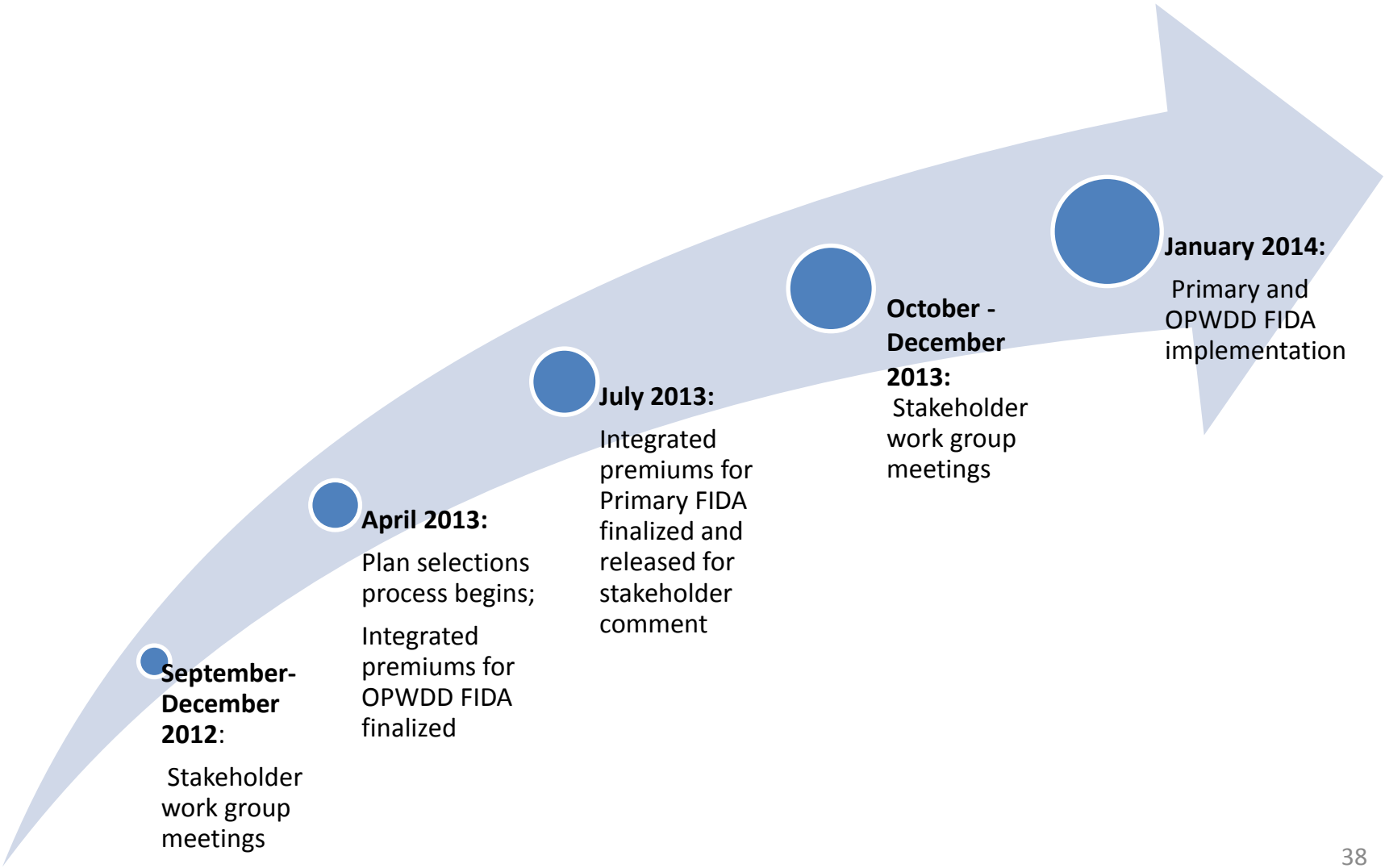
FIDA Benefit Package

Additional Covered Services (Beyond MAP coverage)

AIDS Adult Day Health Care
Assertive Community Treatment (ACT)
Assisted Living Program
Assistive Technology
Case Management for Seriously and Persistently Mentally Ill
Community Transitional Services
Comprehensive Medicaid Case Management
Consumer Directed Personal Assistance Services
Continuing Day Treatment
Day Treatment
Family-Based Treatment
Health and Wellness Education
HIV COBRA Case Management
Home and Community Support
Home Visits by Medical Personnel

Independent Living Skills and Training
Intensive Psychiatric Rehabilitation Treatment Programs
Medicaid Pharmacy Benefits -per State Law
Moving Assistance
OMH Licensed CRs*
Partial Hospitalizations
Personalized Recovery Oriented Services
Positive Behavioral Interventions and Support
Social Day Care Transportation
Structured Day Program
Substance Abuse Program
Telehealth
Wellness Counseling

NYS FIDA Rate Setting Milestones



LTC Dual Integration Proposals from Other States

LTC Dual Integration – Summary of State Proposals (2011)

State	Target Population	Pilot Area	Description
CA	150,000 full benefit duals within 24 months	8 Counties	DHCS to implement initial pilots; At least one pilot to be managed by County Organized Health System (COHS) and piloted within CA's Two-Plan County Model. Enrollees receive full range of Medicare services. Part A and B premiums currently paid by State would not be included in pilots.
CO	Voluntary participation of at least 30,000 duals	Statewide	Proposes dual enrollment into CO's Accountable Care Collaborative, a hybrid primary care medical home and accountable care organization.
CT	Up to 120,000 full and partial benefit duals 65+ in nursing homes and community (includes duals in Home Care Program for Elders HCBS waiver)	Statewide	Utilizes Integrated Care Organizations (ICOs) for single point of accountability offering duals a health home and featuring partnerships among multiple provider types. State proposes to establish risk-adjusted global budgets to assess ICO's effectiveness in managing costs.
MA	110,000 full dual eligible adults 21-64	Statewide	MassHealth will assume operational responsibility and will combine funding for duals at the State level and procure contracts with entities that integrate care and service delivery.
MI	All dually eligible individuals up to 220,050	Statewide with phase-in	Duals will be enrolled within Health Home model with ability to opt out. MI proposes to contract with entities to administer program under an acuity-based capitation arrangement. Initial shared risk between state and contracted entities, with full risk transferred to contractors. Financing arrangement between Medicaid and Medicare ranging from full risk to State to shared risk/savings model.

LTC Dual Integration – Summary of State Proposals (2011)

State	Target Population	Pilot Area	Description
MN	107,000 full benefit duals - 48,500 seniors and 5,800 aged 18-64 with disabilities enrolled in managed care; 53,000 with disabilities in FFS	Statewide	Consists of implementation of Health Care Homes (HCH) and provider level payment systems such as accountable care organizations (ACOs) and Total Cost of Care payment models.
NC	All dual eligibles up to 176,000	Statewide	Builds on existing Community Care of North Carolina (CCNC) program. Approximately 110,000 duals are currently participating in CCNC's primary medical home model. CCNC works with Medicare Healthcare Quality (MHCQ) Demonstration and Multi-Payer Advanced Primary Care Practice (MA PCP) Demonstration.
OK	2,200 duals in Phase 1; Statewide expansion in Phases 2 and 3	Phase 1 – Tulsa Region	Three phase/concept approach: (1) Accountable Care Organization (ACO) for high cost duals; (2) State operated benefit plan and network which combines funding streams for all duals including those with behavior health needs; and (3) Expansion of state's PACE program to target duals in need of nursing level of care.
OR	59,000 full benefit duals	Statewide	Proposes global budget for providing care coordination/best practices. Contracts would require person-centered plans for duals with acute care needs as well as phase in health homes.
SC	68,000 individuals aged 65 and over	TBD	Integrated care model using Health Home option outlined in the Affordable Care Act. Integrated Care Workgroup to design the model and develop implementation plan.

LTC Dual Integration – Summary of State Proposals (2011)

State	Target Population	Pilot Area	Description
TN	All full benefit duals up to 137,000	Statewide	TennCare proposes to expand its managed care service package to include Medicare Part A and B services. TennCare service are provide by Managed Care Organizations (MCOs) and enrollees in every part of the state have their choice of two MCOs.
VT	All dual eligibles up to 21,379	Statewide	State would expand its Advanced Primary Care Practices and add case management with its existing Blueprint community health teams to link services for duals.
WA	115,000 full benefit duals	Statewide (Certain Pilot Counties for Financing Initiative)	Over 20,000 duals would be eligible for the health home managed fee-for-service demonstration, which will operate in the majority of the State, with the exception of three counties where the State is pursuing the capitated Financial Alignment Demonstration. Multi-phased implementation to include: (1) Chronic Care Management expansion for high risk/high cost duals; (2) transition to managed care for low risk/low cost duals; (3) integrated financing pilots; and (4) fully integrated delivery and financing system for all duals.
WI	15,000 full benefit duals	TBD	CMS and the State will develop risk-adjusted capitation payments for Integrated Care Organizations to provide integrated benefits to individuals who are in a long-term Medicaid nursing home stay. The ICO would managed all Medicare-Medicaid benefits for dual eligible individuals through enhanced care coordination.

Source: Design Contract Concepts submitted to CMS (2011).

LTC Dual Integration – Summary of State Proposals

- Kaiser Report (August 2011) – "Proposed Models to Integrate Medicare and Medicaid Benefits for Dual Eligibles" available at: http://www.kff.org/medicaid/upload/8215.pdf

- Kaiser Report (October 2012) – "State Demonstrations to Integrate Care and Align Financing for Dual Eligible Beneficiaries: A Review of 26 Proposals Submitted to CMS" available at: http://www.kff.org/medicaid/upload/8369.pdf

- Individual state reports available at: http://cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateDemonstrationstoIntegrateCareforDualEligibleIndividuals.html

Next Steps

Next Steps for Finance Workgroup

- Formulate list of issues and questions to discuss with CMS and submit to the Department of Health
- Areas may include:
  - ✓ Programmatic Concerns
  - ✓ Funding Streams
  - ✓ Rate Calculation and Payment Issues
  - ✓ Plan Capacity
  - ✓ Development of Quality Metrics
  - ✓ Performance Appraisal

Upcoming Meetings:

- **TBD: November 2012**
- **TBD: December 2012**

Resources for additional information on New York State's FIDA Demonstration (MRT Proposals 90 and 101)

- Please visit our website:
  http://www.health.ny.gov/health_care/medicaid/redesign/supplemental_info_mrt_proposals.htm

- Please feel free to submit any comments or inquiries to the following email address:

  mltcworkgroup@health.state.ny.us