FIDA Demonstration Questions and Answers

SUBJECT	COMMENT	RESPONSIBLE DOH/CMS/ Mercer	RESPONSE
Utilization/Unit Cost Adjustment for Rx Rates	"On page 6, utilization and unit cost adjustment for Rx now covered under Medicare Part are both -9.65%. Is that correct??"	DOH/ Mercer	Yes, this represents a shift of dollars from Medicaid to Medicare for the coverage by Medicare of benzodiazepines and barbituates. We have no reason to believe that this shift would be different for an Existing Enrollee or a Mandatory Enrollee. On average this shift should be very similar for all Dual Eligible members and was applied uniformly across the board to get to the expected reduction.
NHC/Non-NHC Population Costs	"Are the NHC and Non-NHC factors in the chart on page 4 to be applied to the Mandatory population to get the NHC and non-NHC existing population costs? If not, please clarify."	DOH/ Mercer	In the base data for the mandatory population, when a determination could not be provided regarding the NHC and non-NHC population, these factors were used to allocate the costs into the NHC and non-NHC specific rate cells for the mandatory population. The mandatory NHC results were then blended with existing population (which is all NHC) to determine overall FIDA NHC rate. The resulting mandatory non-NHC costs were used to determine the FIDA non-NHC rate.
DSH	As enrollment shifts from Medicare FFS to managed care plans, we strongly believe that CMS should protect hospital DSH funding by carving it out of plan premiums and paying it directly to hospitals, as is done with GME, or require	CMS	We handle DSH in the demonstration in way that mirrors Medicare Advantage policies. Provider payments associated with Medicare DSH are included in the standardized FFS county rates and Medicare Advantage capitation used to determine the Medicare baseline spending under the demonstration. For 2015, CMS is improving the way county rates are established to better reflect the distribution of DSH in FFS across counties. Providers will not separately claim DSH payments for beneficiaries in the demonstration. Beneficiaries in the demonstrations will count toward a hospital's qualification for DSH payments in the same way as other beneficiaries in Medicare managed care. This policy is discussed in the MOU in Appendix 6, I-B. As articulated in
Benefit Package/Rate Incentive	"While excited about the new FIDA program, it is important that we set rates to incentivize plans to participate. If not careful, there could be perverse incentives if the rates/benefit package presented determines that it's more favorable for members to remain in FFS and/or Medicare Advantage SNPs. "	CMS	Under the demonstration, plans must offer the full continuum of Medicare and Medicaid covered items and services to participants, with Medicare covered benefits provided in accordance with 42 CFR Part 422 and 42 CFR Part 423 et seq., and Medicaid covered benefits provided in accordance with the requirements in the approved Medicaid State Plan, including any applicable State Plan Amendments, 1115(a) and 1915(c) waivers. In addition, plans may offer additional benefits that exceed those currently covered by either Medicare or Medicaid. CMS and New York will develop baseline estimates of what the Medicare and Medicaid programs would have spent on behalf of participants absent the demonstration. The savings percentages as established in the MOU will be applied to both the Medicare A/B and Medicaid baseline amounts to establish the rates for the demonstration. The Medicaid MLTC rates will comprise a significant portion of the Medicaid baseline. 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. This methodology, however, will not necessarily match Medicare Advantage reimbursement levels. We assume that the demonstration can achieve lower costs over time, compared to status quo, through improving services to participants, including better care coordination to reduce the utilization of certain high-cost services, better health outcomes and increasing opportunities for community living.

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Supplemental Benefits/Rate Incentive	"DOH must ensure that the rates and benefits afforded to consumers under FIDA will be equal to or greater than the benefits under Medicare Advantage and MLTC."	CMS	Under the demonstration, plans must offer the full continuum of Medicare and Medicaid covered items and services to participants, with Medicare covered benefits provided in accordance with 42 CFR Part 422 and 42 CFR Part 423 et seq., and Medicaid covered benefits provided in accordance with the requirements in the approved Medicaid State Plan, including any applicable State Plan Amendments, 1115(a) and 1915(c) waivers. In addition, plans may offer additional benefits that exceed those currently covered by either Medicare or Medicaid. CMS and New York will develop baseline estimates of what the Medicare and Medicaid programs would have spent on behalf of participants absent the demonstration. The savings percentages as established in the MOU will be applied to both the Medicare A/B and Medicaid baseline amounts to establish the rates for the demonstration. The Medicaid MLTC rates will comprise a significant portion of the Medicaid baseline. 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. This methodology, however, will not necessarily match Medicare Advantage reimbursement levels. We assume that the demonstration can achieve lower costs over time, compared to status quo, through improving services to participants, including better care coordination to reduce the utilization of certain high-cost services, better health outcomes and increasing opportunities for community living.
Wage Parity	The premium adjustment for the Home Care Worker Wage Parity minimum rate of total compensation must reflect the full impact of the payment requirement."	DOH	To the extent that these adjustments are going to be made absent the demonstration they will be incorporated in to the FIDA rates.

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SUBJECT	COMMENT	RESPONSIBLE DOH/CMS/ Mercer	RESPONSE
Tax Treatment in Rates	"We need to understand the treatment of taxes in these rates. Since the demonstration is predicated on saving 1% on "what would have been", I think we need to worry about the HIF and the for-profit tax. With HIF, we had no business in 2013, so they could determine we have no tax liability. But what happens starting 1/1/2015? Will they expect us to eat that tax too? On the for-profit tax, I'm assuming that we'll still have to pay it, even though there is no mention of building it into rates."	CMS	To the extent that costs absent the demonstration include costs associated with such taxes (for example, incorporation of the tax into the development of the Medicaid capitation rates outside of the demonstration and Medicare Advantage bids that comprise a portion of the Medicare A/B rate component), the costs of these taxes are incorporated into the demonstration rates. If the costs associated with any of these or other taxes are not costs the Medicaid or Medicare program would incur absent the demonstration, these costs cannot explicitly be built into the rates as this would violate a key financial tenet of the demonstration (that is, that the demonstration cannot cost more than what either program would have spent absent the demonstration). If a plan participating in the demonstration is a "covered entity" under Section 9010(a) of the Affordable Care Act which establishes the annual Health Insurance Providers Fee, that plan is subject to the fee for its revenue under the demonstration. The demonstration, in and of itself, provides no exemptions from this fee. Exemptions already specified in the law continue to apply.
Shared Savings	Belief that any savings reduction built into the Medicare component of the premium should not exceed 1% over the course of the demonstration. Mechanisms for sharing savings with providers should be developed and made mandatory for plan participation.	CMS	Thank you for the comment. CMS and New York agreed upon the savings percentages as established in the MOU and that there is a reasonable expectation for achieving savings while paying FIDA Plans rates that are adequate to support access to and utilization of medical and non-medical benefits according to Participant needs. In addition, as established in the MOU, if at least one-third of FIDA Plans experience losses in Demonstration Year 1 exceeding 3% of revenue, the savings percentage for Demonstration Year 3 will be reduced to 2.5% from 3%. Consistent with Medicare Advantage policy, CMS does not typically intervene in the negotiation of contracts between private payers and providers, including any requirements regarding sharing savings with providers beyond what is already saved by the state/CMS as a result of application of the savings percentages to the rates FIDA Plans receive. However, the MOU requires the following (which has since been updated by the draft three-way contract): "…by July 1, 2015, FIDA Plans will be required to develop a plan for a fully integrated payment system through which Participating Providers would no longer be paid on a traditional fee-for-service basis but would instead be paid on an alternative basis (e.g., pay for performance, bundled payment). After State approval and no earlier than January 2016, FIDA Plans will be required to implement the approved plans, which will remain in effect throughout the duration of the Demonstration." We believe the demonstration offers an excellent opportunity to develop new ways for providers and plans to better align financing incentives with good outcomes for beneficiaries.

FIDA Demonstration Questions and Answers

SUBJECT	COMMENT	RESPONSIBLE DOH/CMS/ Mercer	RESPONSE
GME	Assuming the FIDA demonstration will adopt the existing CMS policy on direct payment of GME to hospitals for admissions for MA members, and requesting confirmation of this.	CMS	Nothing about the Medicare GME payments will change as a result of the capitated financial alignment model. Medicare provides direct (DGME) and indirect (IME) payments to teaching hospitals for approved GME programs. Because both types of GME payments are calculated using fixed approaches regardless of whether Medicare beneficiaries are in FFS or Medicare Advantage, hospitals will continue to receive all GME payments (DGME and IME) payments in the same manner in which they receive those payments today. Beneficiaries in the demonstration will count toward a hospital's GME payments in the same way as other beneficiaries in Medicare managed care. As a result, Medicare baselines used to determine capitation rates will generally not include amounts related to DGME or operating IME payments.
OPWDD Rates	"We've received a FIDA data book and an OPWDD FIDA Data Book. Are both applicable to these rates released? I don't see any mention of OPWDD in this document."	DOH	No, only the FIDA data book is applicable to the FIDA rates that were released. OPWDD FIDA is progressing on another track.
More Clarification of NHC vs. Non-NHC Rate Development	"In the FIDA Databook, there are no Non-NHC members. On page 3-4 they provide some explanation of how they developed the NHC vs. Non-NHC costs, but I don't understand it. The factors they provided don't make sense to me. Need more clarification."	DOH/ Mercer	In the historical FFS data there is no way to determine a NH certifiable member from a Non NH certifiable member. In order to establish base data for each premium group, adjustments were applied to reflect the estimated acuity of the Nursing Home Certifiable (NHC) and Non-NHC subsets of the MLTC Mandatory Enrollee population relative to the entire MLTC Mandatory Enrollee population. These adjustments were developed based on a study performed by the State of New York's Division of Quality and Evaluation (DQE) whereby clinical and functional assessment data using the Semi-Annual Assessment of member (SAAM) tool was collected on a representative sample of the approximately 60,000 adults residing in NYC that were receiving Medicaid FFS personal care services with assistance from the New York City Human Resource Administration (HRA). The study is available on the NYSDOH website.
COS	"The COS in the data book don't like up with the COSs in this document."	DOH	DOH/ Mercer will provide a cross walk of how the COS in the databook tie to the COS that were utilized for Rate development

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Databook Request	"HPA is requesting a more comprehensive data book be shared with plans to provide transparency into the premium development process and there complex components of the FIDA Rate. HPA is requesting an explanation and data that walks from the base rate to the FIDA rate. In other states, state actuaries have produced a detailed data book that explains the Medicaid portion of the FIDA premium development. Attached is a list of data elements detailed in other states that should be provided to plans."		DOH/Mercer would be happy to discuss requests for additional information and how best to distribute that information to Plans and/or Providers.
Databook Elements Detailed In other States	(A document was attached outlining the elements that were explained and given in detail within other states' similar program implementations): Base data separated by year, rate cell, dollars, units, etc., IBNR factors by COS and population, program changes by COS and each change's calculation, Trends separated by unit cost/utilization, COS, population, historical and prospective, Admin. savings by claims processing and prior authorization, First year savings of 1%, Preliminary rates and Q&A to allow plans to address questions and concerns.		DOH/Mercer would be happy to discuss requests for additional information and how best to distribute any that information to Plans and/or Providers.
Care Management	"The care management component of the rate must reflect the cost of the care management design specific to the FIDA program."	DOH	DOH / Mercer continue to look into the care management requirements for this population and may make adjustment if deemed necessary.

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Data Books	"In general, we'd like for DOH/Mercer to connect the dots between the data books that we've previously received and these rates."	DOH	DOH / Mercer are open to conversations regarding specific crosswalks. However at this time no additional data will be provided.
Periodic Interim Payments (PIP)	Suggestion to require participating plans in FIDA demonstration to offer PIP arrangements to hospitals receiving Medicare FFS PIPs, to avoid the cash flow disruptions that come from reduced PIP payments as enrollment moves from Medicare FFS to managed care.	CMS	Consistent with Medicare Advantage policy, CMS does not typically intervene in the negotiation of contracts between private payers and providers. Therefore, CMS does not intend to require that contracts specify how plans choose to compensate providers regarding PIPs, specifically indicate where they deviate from Medicare policy, or address how plans choose to compensate providers around readmission policies. Nothing, however, would preclude hospitals and plans from incorporating these terms into their contracts.
Medicare Rates	Request for plans that contract with providers using Medicare payment rates be required to clearly specify in provider agreements any areas where they will deviate from Medicare payment policies.	CMS	Consistent with Medicare Advantage policy, CMS does not typically intervene in the negotiation of contracts between private payers and providers.
Readmissions	Suggestion to prohibit plans that utilize the Medicare FFS readmission payment policy from imposing additional readmissions penalties of their own.	CMS	Consistent with Medicare Advantage policy, CMS does not typically intervene in the negotiation of contracts between private payers and providers.

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Pharmacy	"The Coalitions are concerned that the NAMBA is not adequate for the pharmacy costs in NYS. Instead, we recommend that CMS and the State use an average of the counties in the demonstration."	CMS	Under the demonstration, participating plans will not submit bids for Part D. Instead, the Medicare Part D projected baseline for the Part D Direct Subsidy will be set at the NAMBA amount. CMS will estimate an average monthly payment amount for the LICS and Federal reinsurance subsidy amounts which will be 100% cost reconciled after the payment year has ended, as occurs with Part D plans today. CMS and its Office of the Actuary will continue to closely monitor any impacts on the Part D market as the demonstration progresses. To address your concern, CMS performed analysis of the Part D bids specific to plans operating in New York and the analysis showed that the average Part D bids for plans operating in New York are in fact lower, not higher, than the national average. However, CMS is continuing to analyze Part D bid information specific to New York in response to this concern.
Pharmacy/Part D	"Instead of the national average monthly big amount (NAMBA) as the basis for the Part D payment, Medicare Part D average specific to the NY demonstration counties should be used, given the documented higher Part D cost of NY dual eligible Part D compared to the national average."	CMS	Under the demonstration, participating plans will not submit bids for Part D. Instead, the Medicare Part D projected baseline for the Part D Direct Subsidy will be set at the NAMBA amount. CMS will estimate an average monthly payment amount for the LICS and Federal reinsurance subsidy amounts which will be 100% cost reconciled after the payment year has ended, as occurs with Part D plans today. CMS and its Office of the Actuary will continue to closely monitor any impacts on the Part D market as the demonstration progresses. To address your concern, CMS performed analysis of the Part D bids specific to plans operating in New York and the analysis showed that the average Part D bids for plans operating in New York are in fact lower, not higher, than the national average. However, CMS is continuing to analyze Part D bid information specific to New York in response to this concern.
Frailty Factor	"Frailty Factor- Coalitions appreciate both the CMS and the State's consideration of the frailty factor. Given that the population enrolled in FIDA is similar to that enrolled in FIDE-SNPs, we continue to believe that a frailty factor is necessary in order to set adequate rates for this population.	CMS	Capitation rates in the demonstration are required to achieve modest savings relative to what would happen in the absence of the demonstration. Applying the frailty adjuster solely in the demonstration, however, would not be budget neutral. Therefore, the frailty adjuster is not available solely for application the demonstration. However, qualifying Medicare Advantage plans can receive the frailty adjustment in certain circumstances. If a demonstration plan were to qualify for the frailty adjuster in the absence of the demonstration – by meeting the contract requirements to be a FIDE SNP and also having a frailty score that meets the cutoff for FIDE SNPs – then the increased costs associated with the frailty adjustment could be included in a portion of the Medicare Parts A/B capitation rate for the demo, based on the percentage of demonstration Participants who would otherwise be enrolled in Medicare Advantage plans with a frailty adjustment. We would welcome further comments on how to best preserve this intent throughout the demonstration, especially as the number of plans and volume of non-FIDA MA beneficiaries may change over time.

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Frailty Factor	"HPA was pleased that the Centers for Medicare and Medicaid Services (CMS) acknowledged that the NY FIDA population is similar to dual eligible populations that currently receive a Medicare "frailty-factor" risk adjustment. HPA strongly supports this factor adjustment for FIDA participants."	CMS	Capitation rates in the demonstration are required to achieve modest savings relative to what would happen in the absence of the demonstration. Applying the frailty adjuster solely in the demonstration, however, would not be budget neutral. Therefore, the frailty adjuster is not available solely for application the demonstration. However, qualifying Medicare Advantage plans can receive the frailty adjustment in certain circumstances. If a demonstration plan were to qualify for the frailty adjuster in the absence of the demonstration – by meeting the contract requirements to be a FIDE SNP and also having a frailty score that meets the cutoff for FIDE SNPs – then the increased costs associated with the frailty adjustment could be included in a portion of the Medicare Parts A/B capitation rate for the demo, based on the percentage of demonstration Participants who would otherwise be enrolled in Medicare Advantage plans with a frailty adjustment. We would welcome further comments on how to best preserve this intent throughout the demonstration, especially as the number of plans and volume of non-FIDA MA beneficiaries may change over time.
Health Insurer Fee/ Tax	"As much as possible, the full value of the Health Insurer Fee (HIF) should be incorporated into the FIDA premium. This should include both the value of the assessment and the impact of the non-deductible federal income tax on for-profit plans."	CMS	To the extent that costs absent the demonstration include costs associated with such taxes (for example, incorporation of the tax into the development of the Medicaid capitation rates outside of the demonstration and Medicare Advantage bids that comprise a portion of the Medicare A/B rate component), the costs of these taxes are incorporated into the demonstration rates. If the costs associated with any of these or other taxes are not costs the Medicaid or Medicare program would incur absent the demonstration, these costs cannot explicitly be built into the rates as this would violate a key financial tenet of the demonstration (that is, that the demonstration cannot cost more than what either program would have spent absent the demonstration). If a plan participating in the demonstration is a “covered entity” under Section 9010(a) of the Affordable Care Act which establishes the annual Health Insurance Providers Fee, that plan is subject to the fee for its revenue under the demonstration. The demonstration, in and of itself, provides no exemptions from this fee. Exemptions already specified in the law continue to apply.

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Coding Intensity	"The Coalitions are concerned about bringing the entire coding intensity adjustment in year 2. This will require the plans to "improve" risk scores by roughly 5% (for the target population) in year 2, which would be a heavy life. The plans would ask for some additional flexibility on this issue.	CMS	As established in the NY MOU and consistent with CMS' approach across the capitated financial alignment model, CMS will begin applying the prevailing Medicare Advantage coding intensity adjustment to all FIDA Plan Participants beginning in CY 2016. Prior to this – during CY 2014 and CY 2015 – CMS will apply an appropriate coding intensity adjustment based on the proportion of the target population with prior Medicare Advantage or demonstration experience on a county-specific basis as of September 30, 2014. Due to the revised start date for the FIDA Demonstration of October 1, 2014, this means that for both CY 2014 and CY 2015, there will effectively be no downward coding intensity adjustment to the FFS component of the Medicare A/B rate under the demonstration. FIDA Plans will have most Participants enrolled for the majority of CY 2015, and there is a requirement that FIDA Plans assess Participants no later than 60 days of the Participant's enrollment effective date for Participants who are passively enrolled within certain timeframes and for all other Participants no later than 30 days of enrollment of a Participant's effective enrollment date. Thus, we believe applying the full coding intensity adjustment as of CY 2016 is reasonable. However, the contract language gives us flexibility to lower the coding intensity factor in 2016 if the enrollment schedules changes in a way that shifts a significant volume of enrollment until after September 2015.