Financial Alignment Initiative: New York

States participate in the Financial Alignment Initiative, a demonstration program administered by the Centers for Medicare & Medicaid Services, under either a capitated model, a managed fee-for-service model, or an alternative model. The purpose of the demonstration is to test ways to improve care for dually eligible beneficiaries and reduce program costs by aligning financing and coordinating care across Medicaid and Medicare. This fact sheet provides details about New York's demonstration.

TABLE 1. New York's Capitated Model: FIDA-IDD

Demonstration name: Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities (FIDA-IDD)	
Timeline	
MOU signed	November 5, 2015
Opt-in enrollment starts	April 1, 2016
Passive enrollment	No passive enrollment
Scheduled to end	December 31, 2023
Enrollment	
Covered population	Age 21 and older; eligible for Office for Persons with Developmental Disabilities (OPWDD) services; eligible for ICF/IDD level of care and if receiving Section 1915(c) waiver services as an alternative to ICF/IDD placement, enrolled in the Section 1915(c) OPWDD comprehensive waiver; and living in four regions: New York City, Long Island (Nassau and Suffolk counties), Rockland County, and Westchester County
Enrolled (as of January 2022)	1,686
Payment	
Number of participating plans	1
Savings percentage range	0.25–1%
Number of rating categories	2
Other risk mitigation strategies	Risk corridors and enrollment mix adjustment
Benefits	
Expanded benefits	Section 1915(c) OPWDD comprehensive waiver items and services; ICF/IDD services; inpatient mental health over 190-day lifetime limit; intensive psychiatric rehabilitation treatment programs; intensive behavioral health services; individual directed goods and services; transportation; substance use program services; other supportive services the interdisciplinary team determines necessary
Carved out benefits	Hospice

Medicaid and CHIP Payment and Access Commission

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Demonstration name: Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities (FIDA-IDD)	
Required community involvement	Participating plans must contract with an adequate number of community-based LTSS providers to allow participants a choice of at least two providers of each community-based LTSS service with a 15-mile radius or 30 minutes from the participant's ZIP code of residence
Care coordination	
Number of days to complete HRA[1]	Within 30 days of effective enrollment date and must be completed by a registered nurse
Number of days to establish ICP[2]	Within 60 days of completing HRA
Education requirements for care coordinator[3]	Must be a licensed professional such as a registered nurse, licensed social worker, or psychologist and have one year experience working with individuals with IDD. Also, the 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, behavioral health, prescription drugs and DME.
Care coordinator caseload requirements	Not specified
Number of days to maintain continuity of care from previous coverage	Maintain each enrollee's current providers and service levels for at least 90 days after enrollment; 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 no for more than two years; services delivered in an OPWDD certified residence (other than an ICF/IDD) at the time the participant enrolls in the FIDA-IDD program, may continue from the existing residential provider as long as the participant's ICP continues to describe the need for the service
Consumer protections	
Ombudsman	Independent Consumer Advocacy Network

Notes: DME is durable medical equipment. HRA is health risk assessment. ICF/IDD is intermediate care facility for individuals with intellectual and developmental disabilities. ICP is individualized care plan. LTSS is long-term services and supports. MOU is memorandum of understanding.

[1] Plans will also receive the results of the most recent beneficiaries' OPWDD approved assessment to help complete the comprehensive service planning assessment and ICP.

[2] The ICP is referred to as the Life Plan.

[3] The care coordinator is referred to as the care manager.

Sources: CMS 2015, 2016, 2018, 2020, and 2021; ICRC 2022; Community Service Society 2021; and Medicare Payment Advisory Commission (MedPAC) 2018.

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