DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

State Demonstrations Group

October 13, 2016

Jason Helgerson
Director, Office of Health Insurance Programs
New York State Department of Health
Empire State Plaza
Corning Tower (OCP – 1211)
Albany, NY 12237

Dear Mr. Helgerson:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) is granting a temporary extension of New York's Partnership Plan section 1115 demonstration (Project No. 11-W-00114/2). The temporary extension is effective through November 15, 2016. The extension period will give CMS and New York the opportunity to have more detailed discussions of the issues involved in the longer extension of the demonstration.

The demonstration will continue to operate under all other current Special Terms and Conditions (STCs) and waiver and expenditure authorities. The per-member-per month (PMPM) costs approved for the last demonstration year will be used to determine budget neutrality through this temporary extension period.

Your project officer, Deborah Steinbach, will contact you to facilitate these discussions. Ms. Steinbach can be reached by phone at (410) 786-7404, or by e-mail at Deborah.Steinbach@cms.hhs.gov, should you need to contact her. We look forward to continuing to work with you and your staff on your 1115 demonstration extension.

Sincerely,

/s/

Eliot Fishman
Director

cc:
Michael Melendez, Associate Regional Administrator, CMS Region II New York

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
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State Demonstrations Group

September 7, 2016

Jason Helgerson
Director, Office of Health Insurance Programs
New York State Department of Health
Empire State Plaza
Corning Tower (OCP – 1211)
Albany, NY 12237

Dear Mr. Helgerson:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) is granting a temporary extension of New York's Partnership Plan section 1115 demonstration (Project No. 11-W-00114/2). The temporary extension is effective through October 15, 2016. The extension period will give CMS and New York the opportunity to have more detailed discussions of the issues involved in the longer extension of the demonstration.

The demonstration will continue to operate under all other current Special Terms and Conditions (STCs) and waiver and expenditure authorities. The per-member-per month (PMPM) costs approved for the last demonstration year will be used to determine budget neutrality through this temporary extension period.

Your project officer, Deborah Steinbach, will contact you to facilitate these discussions. Ms. Steinbach can be reached by phone at (410) 786-7404, or by e-mail at Deborah.Steinbach@cms.hhs.gov, should you need to contact her. We look forward to continuing to work with you and your staff on your 1115 demonstration extension.

Sincerely,

/s/

Eliot Fishman
Director

cc:
Michael Melendez, Associate Regional Administrator, CMS Region II New York

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

State Demonstrations Group

August 4, 2016

Jason Helgerson
Director, Office of Health Insurance Programs
New York State Department of Health
Empire State Plaza
Corning Tower (OCP – 1211)
Albany, NY 12237

Dear Mr. Helgerson:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) is granting a temporary extension of New York's Partnership Plan section 1115 demonstration (Project No. 11-W-00114/2). The temporary extension is effective through September 15, 2016. The extension period will give CMS and New York the opportunity to have more detailed discussions of the issues involved in the longer extension of the demonstration.

The demonstration will continue to operate under all other current Special Terms and Conditions (STCs) and waiver and expenditure authorities. The per-member-per month (PMPM) costs approved for the last demonstration year will be used to determine budget neutrality through this temporary extension period.

Your project officer, Deborah Steinbach, will contact you to facilitate these discussions. Ms. Steinbach can be reached by phone at (410) 786-7404, or by e-mail at Deborah.Steinbach@cms.hhs.gov, should you need to contact her. We look forward to continuing to work with you and your staff on your 1115 demonstration extension.

Sincerely,

/s/

Eliot Fishman
Director

cc:
Michael Melendez, Associate Regional Administrator, CMS Region II New York

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

State Demonstrations Group

July 13, 2016

Jason Helgerson
Director, Office of Health Insurance Programs
New York State Department of Health
Empire State Plaza
Corning Tower (OCP – 1211)
Albany, NY 12237

Dear Mr. Helgerson:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) is granting a temporary extension of New York's Partnership Plan section 1115 demonstration (Project No. 11-W-00114/2). The temporary extension is effective through August 15, 2016. The extension period will give CMS and New York the opportunity to have more detailed discussions of the issues involved in the longer extension of the demonstration.

The demonstration will continue to operate under all other current Special Terms and Conditions (STCs) and waiver and expenditure authorities. The per-member-per month (PMPM) costs approved for the last demonstration year will be used to determine budget neutrality through this temporary extension period.

Your project officer, Deborah Steinbach, will contact you to facilitate these discussions. Ms. Steinbach can be reached by phone at (410) 786-7404, or by e-mail at Deborah.Steinbach@cms.hhs.gov, should you need to contact her. We look forward to continuing to work with you and your staff on your 1115 demonstration extension.

Sincerely,

/s/

Eliot Fishman
Director

cc:
Michael Melendez, Associate Regional Administrator, CMS Region II New York

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

State Demonstrations Group

June 14, 2016

Jason Helgerson
Director
Office of Health Insurance Programs
New York State Department of Health
Empire State Plaza
Corning Tower (OCP – 1211)
Albany, NY 12237

Dear Mr. Helgerson:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) is granting a temporary extension of New York's Partnership Plan section 1115 demonstration (Project No. 11-W-00114/2). The temporary extension is effective through July 15, 2016.

The extension period will give CMS and New York the opportunity to have more detailed discussions of the issues involved in the longer extension of the demonstration, including discussions related to CMS' review of New York's budget neutrality.

The demonstration will continue to operate under all other current Special Terms and Conditions (STCs) and waiver and expenditure authorities. The per-member-per month (PMPM) costs approved for the last demonstration year will be used to determine budget neutrality through this temporary extension period.

Your project officer, Deborah Steinbach, will contact you to facilitate these discussions. Ms. Steinbach can be reached by phone at (410) 786-7404, or by e-mail at Deborah.Steinbach@cms.hhs.gov, should you need to contact her. We look forward to continuing to work with you and your staff on your 1115 demonstration extension.

Sincerely,

/s/

Eliot Fishman
Director

cc: Michael Melendez, Associate Regional Administrator, CMS Region II New York

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

State Demonstrations Group

May 25, 2016

Jason Helgerson
Director
Office of Health Insurance Programs
New York State Department of Health
Empire State Plaza
Corning Tower (OCP – 1211)
Albany, NY 12237

Dear Mr. Helgerson:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) is granting a temporary extension of New York's Partnership Plan section 1115 demonstration (Project No. 11-W-00114/2). The temporary extension is effective through June 15, 2016.

The extension period will give CMS and New York the opportunity to have more detailed discussions of the issues involved in the longer extension of the demonstration, including discussions related to CMS' review of New York's budget neutrality.

The demonstration will continue to operate under all other current Special Terms and Conditions (STCs) and waiver and expenditure authorities. The per-member-per month (PMPM) costs approved for the last demonstration year will be used to determine budget neutrality through this temporary extension period.

Your project officer, Deborah Steinbach, will contact you to facilitate these discussions. Ms. Steinbach can be reached by phone at (410) 786-7404, or by e-mail at Deborah.Steinbach@cms.hhs.gov, should you need to contact her. We look forward to continuing to work with you and your staff on your 1115 demonstration extension.

Sincerely,

/s/

Eliot Fishman
Director

cc: Michael Melendez, Associate Regional Administrator, CMS Region II New York

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

State Demonstrations Group

May 25, 2016

Jason Helgerson
Director
Office of Health Insurance Programs
New York State Department of Health
Empire State Plaza
Corning Tower (OCP – 1211)
Albany, NY 12237

Dear Mr. Helgerson:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) is granting a temporary extension of New York's Partnership Plan section 1115 demonstration (Project No. 11-W-00114/2). The temporary extension is effective through June 15, 2016.

The extension period will give CMS and New York the opportunity to have more detailed discussions of the issues involved in the longer extension of the demonstration, including discussions related to CMS' review of New York's budget neutrality.

The demonstration will continue to operate under all other current Special Terms and Conditions (STCs) and waiver and expenditure authorities. The per-member-per month (PMPM) costs approved for the last demonstration year will be used to determine budget neutrality through this temporary extension period.

Your project officer, Deborah Steinbach, will contact you to facilitate these discussions. Ms. Steinbach can be reached by phone at (410) 786-7404, or by e-mail at Deborah.Steinbach@cms.hhs.gov, should you need to contact her. We look forward to continuing to work with you and your staff on your 1115 demonstration extension.

Sincerely,

/s/

Eliot Fishman
Director

cc: Michael Melendez, Associate Regional Administrator, CMS Region II New York

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

State Demonstrations Group

March 31, 2016

Jason Helgerson
Director
Office of Health Insurance Programs
New York State Department of Health
Empire State Plaza
Corning Tower (OCP – 1211)
Albany, NY 12237

Dear Mr. Helgerson:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) is granting a temporary extension of New York's Partnership Plan section 1115 demonstration (Project No. 11-W-00114/2). The temporary extension is effective through April 30, 2016.

The extension period will give CMS and New York the opportunity to have more detailed discussions of the issues involved in the longer extension of the demonstration, including discussions related to CMS' review of New York's budget neutrality.

The demonstration will continue to operate under all other current Special Terms and Conditions (STCs) and waiver and expenditure authorities. The per-member-per month (PMPM) costs approved for the last demonstration year will be used to determine budget neutrality through this temporary extension period.

Your project officer, Deborah Steinbach, will contact you to facilitate these discussions. Ms. Steinbach can be reached by phone at (410) 786-7404, or by e-mail at Deborah.Steinbach@cms.hhs.gov, should you need to contact her. We look forward to continuing to work with you and your staff on your 1115 demonstration extension.

Sincerely,

/s/

Eliot Fishman
Director

cc: Michael Melendez, Associate Regional Administrator, CMS Region II New York

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

State Demonstrations Group

February 24, 2016

Jason Helgerson
Director
Office of Health Insurance Programs
New York State Department of Health
Empire State Plaza
Corning Tower (OCP – 1211)
Albany, NY 12237

Dear Mr. Helgerson:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) is granting a temporary extension of New York's Partnership Plan section 1115 demonstration (Project No. 11-W-00114/2). The temporary extension is effective through March 31, 2016.

The extension period will give CMS and New York the opportunity to have more detailed discussions of the issues involved in the longer extension of the demonstration, including discussions related to CMS' review of New York's budget neutrality.

The demonstration will continue to operate under all other current Special Terms and Conditions (STCs) and waiver and expenditure authorities. The per-member-per month (PMPM) costs approved for the last demonstration year will be used to determine budget neutrality through this temporary extension period.

Your project officer, Deborah Steinbach, will contact you to facilitate these discussions. Ms. Steinbach can be reached by phone at (410) 786-7404, or by e-mail at Deborah.Steinbach@cms.hhs.gov, should you need to contact her. We look forward to continuing to work with you and your staff on your 1115 demonstration extension.

Sincerely,

/s/

Eliot Fishman
Director

cc: Michael Melendez, Associate Regional Administrator, CMS Region II New York

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

State Demonstrations Group

November 23, 2015

Jason Helgerson
Director
Office of Health Insurance Programs
New York State Department of Health
Empire State Plaza
Corning Tower (OCP – 1211)
Albany, NY 12237

Dear Mr. Helgerson:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) is granting a temporary extension of New York's Partnership Plan section 1115 demonstration (Project No. 11-W-00114/2). The temporary extension is effective through February 29, 2016.

The extension period will give CMS and New York the opportunity to have detailed discussions of the issues involved in the extension of the demonstration, including discussions related to CMS' review of New York's budget neutrality.

The demonstration will continue to operate under all other current Special Terms and Conditions (STCs) and waiver and expenditure authorities. The per-member-per month (PMPM) costs approved for the last demonstration year will be used to determine budget neutrality through this temporary extension period.

Your project officer, Deborah Steinbach, will contact you to facilitate these discussions. Ms. Steinbach can be reached by phone at (410) 786-7404, or by e-mail at Deborah.Steinbach@cms.hhs.gov, should you need to contact her. We look forward to continuing to work with you and your staff on your 1115 demonstration extension.

Sincerely,

/s/

Eliot Fishman
Director

cc: Michael Melendez, Associate Regional Administrator, CMS Region II New York

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

State Demonstrations Group

September 30, 2015

Jason Helgerson
Director
Office of Health Insurance Programs
New York State Department of Health
Empire State Plaza
Corning Tower (OCP – 1211)
Albany, NY 12237

Dear Mr. Helgerson:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) is granting a temporary extension of New York's Partnership Plan section 1115 demonstration (Project No. 11-W-00114/2). The temporary extension is effective through December 31, 2015.

The extension period will give CMS and New York the opportunity to have more detailed discussions of the issues involved in the longer extension of the demonstration, including discussions related to CMS' review of New York's budget neutrality.

The demonstration will continue to operate under all other current Special Terms and Conditions (STCs) and waiver and expenditure authorities. The per-member-per month (PMPM) costs approved for the last demonstration year will be used to determine budget neutrality through this temporary extension period.

Your project officer, Deborah Steinbach, will contact you to facilitate these discussions. Ms. Steinbach can be reached by phone at (410) 786-7404, or by e-mail at Deborah.Steinbach@cms.hhs.gov, should you need to contact her. We look forward to continuing to work with you and your staff on your 1115 demonstration extension.

Sincerely,

/s/

Eliot Fishman
Director

cc: Michael Melendez, Associate Regional Administrator, CMS Region II New York

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

JUL 29 2015

Mr. Jason Helgerson
Director
Office of Health Insurance Programs
New York State Department of Health
Empire State Plaza
Corning Tower (OCP – 1211)
Albany, NY 12237

Dear Mr. Helgerson:

The Centers for Medicare & Medicaid Services (CMS) is approving New York's request to amend its Medicaid demonstration, entitled New York Partnership Plan, Project Number 11-W-00114/2, originally approved by CMS on July 15, 1997.

This amendment provides a waiver of section 1902(a)(10)(B) of the Social Security Act (the Act) for New York to establish Health and Recovery Plans (HARPs) and provide an option for coordinated care and additional home and community based services (HCBS) for populations diagnosed with severe mental illness and substance use disorders. Effective August 1, 2015, and once fee for service rates for the HARPs HCBS services are approved, New York will be permitted to commence enrollment into HARPs. Current enrollees in New York's Mainstream Medicaid Managed Care program will be reviewed for HARPs eligibility, and if eligible, will be passively enrolled. Individuals may opt out within 90 days of passive enrollment. New enrollees, upon being determined eligible for Medicaid, will be given an assessment for severe mental illness or substance use disorder. When individuals are no longer eligible, they will be offered a choice of Mainstream Medicaid Managed Care plan to continue receiving Medicaid benefits.

With this amendment, CMS is also revising current waivers of 1902(a)(1) and 1902(a)(23)(A) of the Act. These revised authorities will permit New York to geographically phase in HARPs enrollment and restrict choice of provider to those who furnish services under HARPs plans.

CMS is also approving new expenditure authorities to effectuate eligibility flexibilities for the Adult Group. New York is permitted to implement the following features:

- Seamless enrollment of adults who receive Temporary Assistance for Needy Families (TANF) into Medicaid,
- Extension of continuous eligibility for members of the Adult Group who turn 65 during their coverage period and
- Extension of temporary coverage for members of the Adult Group who experience a coverage gap before entering the health insurance Marketplace.

Also, CMS is granting the state's request to extend its expenditure authority for its Advance Premium Tax Credit program that provides support to individuals who have transitioned from Medicaid under the demonstration to the health insurance Marketplace.

At this time, CMS is not approving a waiver of section 1902(a)(27) and 1902(a)(32) to allow individuals to self-direct their HCBS expenditures to providers who do not have a provider agreement with the state Medicaid agency. CMS will continue to work with New York on its pilot proposal that necessitates these new waiver authorities and may approve under a subsequent amendment to the 1115 demonstration.

CMS' approval of this amendment is conditioned upon compliance with the enclosed list of waiver and expenditure authorities and Special Terms and Conditions (STCs) defining the nature, character and extent of anticipated federal involvement in the project. The award is subject to our receiving your written acknowledgement of the award and acceptance of these STCs within 30 days of the date of this letter.

Your project officer for this demonstration is Ms. Jessica Woodard. She is available to answer any questions concerning your section 1115 demonstration. Ms. Woodard's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
Mail Stop: S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-9249
Facsimile: (410) 786-8534
Email: Jessica.Woodard@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Woodard and to Mr. Michael Melendez, Associate Regional Administrator for the Division of Medicaid and Children's Health Operations. Mr. Melendez's contact information is as follows:

Mr. Michael Melendez
Associate Regional Administrator
Division of Medicaid and Children's Health Operations
26 Federal Plaza
New York, NY 10278
Telephone: (212) 616-2430
Email: Michael.Melendez@cms.hhs.gov

If you have questions regarding this approval, please contact Mr. Eliot Fishman, Director, State Demonstrations Group, Center for Medicaid & CHIP Services, at (410) 786-5647.

Sincerely,

Andrew M. Slavitt
Acting Administrator

Enclosures

cc: Michael Melendez, Associate Regional Administrator, CMS New York

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

Children and Adults Health Programs Group

March 31, 2015

Jason Helgerson
Director
Office of Health Insurance Programs
New York State Department of Health
Empire State Plaza
Corning Tower (OCP – 1211)
Albany, NY 12237

Dear Mr. Helgerson:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) is granting a temporary extension of New York's Partnership Plan section 1115 demonstration (Project No. 11-W-00114/2). The temporary extension is effective through April 30, 2015.

The extension period will give CMS and New York the opportunity to have more detailed discussions of the issues involved in the longer extension of the demonstration. For example, there would be more time to engage in discussions related to CMS' review of New York's budget neutrality.

Please note that while some waiver and expenditure authorities will continue into the temporary extension period, other authorities will expire. The following will expire as of March 31, 2015:

- Expenditure authority to receive federal financial participation for payments to providers from the Interim Access Assurance Fund (IAAF).

The demonstration will continue to operate under all other current Special Terms and Conditions (STCs) and waiver and expenditure authorities. The per-member-per month (PMPM) costs approved for the last demonstration year will be used to determine budget neutrality through this temporary extension period.

Your project officer, Jessica Woodard, will contact you to facilitate these discussions. Ms. Woodard can be reached at (410) 786-9249 of Jessica.Woodard@cms.hhs.gov should you need to contact her. We look forward to continuing to work with you and your staff on your 1115 demonstration extension.

Sincerely,

/s/

Eliot Fishman
Director

cc: Michael Melendez, Associate Regional Administrator, CMS Region II New York

CENTERS FOR MEDICARE & MEDICAID SERVICES

SECTION 1115 OF THE SOCIAL SECURITY ACT MEDICAID DEMONSTRATION

NEW YORK PARTNERSHIP PLAN

WAIVER NUMBER 11-W-00114/2

CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER AUTHORITY

NUMBER: 11-W-00114/2

TITLE: Partnership Plan Medicaid Section 1115 Demonstration

AWARDEE: New York State Department of Health

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived in this list, shall apply to the demonstration, beginning April 14, 2014.

The following waivers shall enable New York to implement the approved Special Terms and Conditions (STCs) for the New York Partnership Plan Medicaid section 1115 demonstration.

1. **Statewideness** **Section 1902(a)(1)**

To permit New York to geographically phase in the Managed Long Term Care (MLTC) program and the Health and Recovery Plans (HARPs) and to phase in behavioral health (BH) home and community based services (HCBS) into HIV Special Needs Plans(SNPs). To permit New York to geographically phase in long term nursing home benefits into managed care.

2. **Income Comparability** **Section 1902(a)(17)**

To enable New York to apply a more liberal income standard for individuals who are deinstitutionalized and receive home and community-based services (HCBS) through the managed long term care program than for other individuals receiving community-based long term care.

3. **Service Comparability (Amount, Duration & Scope)** **Section 1902(a)(10)(B)**

To enable New York to provide HCBS behavioral health services, whether furnished as a state plan benefit or as a demonstration benefit, to targeted populations that may not be consistent with the targeting authorized under the approved state plan, in amount, duration and scope that exceeds those available to eligible individuals not in those targeted populations.

4. **Freedom of Choice** **Section 1902(a)(23)(A)**

To the extent necessary to enable New York to require beneficiaries to enroll in managed care plans, including the Mainstream Medicaid Managed Care (MMMC), and MLTC and HARPs programs in order to obtain benefits offered by those plans. Beneficiaries shall retain freedom of choice of family planning providers.

5. **Payments to Providers Under the State Plan** **Sections 1902(a)(13)(A) and 1902(a)(30)(A)**

To the extent necessary to permit the state to elect to reduce supplemental payments to institutional providers otherwise authorized under the approved state plan in order to prioritize funding for delivery system reform incentive payments.

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY LIST

NUMBER: 11-W-00114/2

TITLE: Partnership Plan Medicaid Section 1115 Demonstration

AWARDEE: New York State Department of Health

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by New York for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period beginning April 14, 2014, until the ending date specified for each authority, be regarded as expenditures under the state's title XIX plan.

The following expenditure authorities shall enable New York to implement the approved Special Terms and Conditions (STCs) for the New York Partnership Plan Medicaid section 1115 demonstration. The authorities also promote the objectives of title XIX in the following ways:

- Expenditure authorities 1, 2, 4, 5, 6, 9 and 10 help increase efficiency and quality of care through initiatives to transform service delivery networks;
- Expenditure authorities 1, 2, 3, 4 and 8 help increase overall coverage of low-income individuals in the state;
- Expenditure authorities 2, 6 and 7 help improve health outcomes for Medicaid and other low-income populations in the state; and,
- Expenditure authorities 9 and 10 help stabilize, strengthen, and increase access to providers and provider network availability to serve Medicaid low-income populations in the state.

1. **Demonstration-Eligible Populations.** Expenditures for healthcare related costs for the following populations that are not otherwise eligible under the Medicaid state plan.

    a. Demonstration Population 9 (HCBS Expansion). Medically needy individuals who are receiving HCBS, and who are medically needy after application of community spouse and spousal impoverishment eligibility and post-eligibility rules consistent with section 1924 of the Act.

    b. Demonstration Population 10 (Individuals Moved from Institutional Settings to Community Settings for Long Term Care Services). Expenditures for health care related costs for individuals moved from institutional nursing facility settings to community settings for long term services and supports who would not otherwise be eligible based on income, but whose income does not exceed a more liberal income standard, and who receive services through the managed long term care program under the demonstration.

    c. Demonstration Population 11 (Temporary Assistance for Needy Families (TANF) Recipients). Expenditures for health care related costs for low-income adults enrolled

in TANF. These individuals are exempt from receiving a MAGI determination in accordance with §1902(e)(14)(D)(i)(I) of the Act.

2. **Twelve-Month Continuous Eligibility Period**. Expenditures for health care related costs for individuals who have been determined eligible under groups specified in Table 1 of STC 4 in Section IV for continued benefits during any periods within a twelve month eligibility period when these individuals would be found ineligible if subject to redetermination. This authority includes providing continuous coverage for the Adult Group determined financially eligible using Modified Adjusted Gross Income (MAGI) based eligibility methods. For expenditures related to the Adult Group, specifically, the state shall make a downward adjustment of 2.6 percent in claimed expenditures for federal matching at the enhanced federal matching rate and will instead claim those expenditures at the regular matching rate.

3. **Transitional Coverage for Members of the Adult Group Turning 65.** Expenditures for health care related costs for individuals under the state plan who are in the Adult Group upon turning 65. Coverage for these individuals will continue until the end of their respective continuous eligibility period. Expenditures for individuals receiving continued coverage will be claimed at the regular match rate. (End Date: January 1, 2016)

4. **Transitional Coverage to the Marketplace.** Expenditures for health care related costs for individuals under the state plan who experience a coverage gap before a file transfer is completed from the Medicaid agency to the Marketplace. This population will receive continued benefits for no longer than 30 days until coverage under the Marketplace is effective. Expenditures for individuals receiving this coverage will be claimed at the regular matching rate. (End Date: June 30, 2016)

5. **Facilitated Enrollment Services.** Expenditures for enrollment assistance services provided by managed care organizations (MCOs), the costs for which are included in the claimed MCO capitation rates.

6. **Demonstration Services for Behavioral Health Provided under MMMC**. Expenditures for provision of residential and outpatient addiction services, crisis intervention and licensed behavioral health practitioner services to MMMC enrollees only and are not provided under the state plan.

7. **Targeted HCBS Behavioral Health Services.** Expenditures for the provision of HCBS behavioral health services under Health and Recovery Plans (HARPs) and HIV SNPs that are not otherwise available under the approved state plan.

8. **Designated State Health Programs Funding**. Expenditures for the designated state health program specified in STC 12 in Section VII which provides premium subsidies to FHPlus individuals and new applicants between 133 percent and 150 percent FPL who have coverage through the Marketplace. (End Date: December 31, 2015)

9. **Designated State Health Programs Funding**. Expenditures for the designated state health program specified in STC 15 in Section VIII of the STCs, not to exceed $345.4 million in FFP through March 31, 2016.

10. **Delivery System Reform Incentive Payment (DSRIP) Program**. Expenditures for incentive payments and planning grant payments for the DSRIP program specified in STC 1 – 40 in Section VIII of the STCs, not to exceed $1,007.8 million of FFP through March 31, 2016.

CENTERS FOR MEDICARE & MEDICAID SERVICES

SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-00114/2

TITLE: Partnership Plan Medicaid Section 1115 Demonstration

AWARDEE: New York State Department of Health

I. PREFACE

The STCs have been arranged into the following subject areas:

I. Preface
II. Program Description and Objectives
III. General Program Requirements
IV. Populations Affected by and Eligible Under the Demonstration
V. Demonstration Benefits and Enrollment
VI. Delivery Systems
VII. Delivery System Reform Program Description and Objectives
VIII. General Reporting Requirements
IX. General Financial Requirements
X. Monitoring Budget Neutrality
XI. Evaluation of the Demonstration

Additionally, attachments have been included to provide supplementary information and guidance for specific STCs.

II. PROGRAM DESCRIPTION AND OBJECTIVES

The state's goal in implementing the Partnership Plan section 1115(a) demonstration is to improve access to health services and outcomes for low-income New Yorkers by:

- Improving access to health care for the Medicaid population;
- Improving the quality of health services delivered;
- Expanding access to family planning services; and
- Expanding coverage with resources generated through managed care efficiencies to additional low-income New Yorkers.

The demonstration is designed to permit New York to use a managed care delivery system to deliver benefits to Medicaid recipients, create efficiencies in the Medicaid program, and enable the extension of coverage to certain individuals who would otherwise be without health insurance. It was approved in 1997 to enroll most Medicaid recipients into managed care organizations (MCOs) (Medicaid managed care program). As part of the demonstration's renewal in 2006, authority to require some disabled and aged populations to

enroll in mandatory managed care was transferred to a new demonstration, the Federal-State Health Reform Partnership (F-SHRP). Effective April 1, 2014, this authority was restored to this demonstration as F-SHRP was phased out.

In 2001 the Family Health Plus (FHPlus) program was implemented as an amendment to the demonstration, providing comprehensive health coverage to low-income uninsured adults, with and without dependent children, who have income greater than Medicaid state plan eligibility standards. FHPlus was further amended in 2007 to implement an employer-sponsored health insurance (ESHI) component. Individuals eligible for FHPlus who have access to cost-effective ESHI are required to enroll in that coverage, with FHPlus providing any wrap-around services necessary to ensure that enrollees get all FHPlus benefits. FHPlus expires on December 31, 2013 and will become a state-only program, but federal matching funding for state expenditures for FHPlus will continue to be available as a designated state health program through December 31, 2014.

In 2002 the demonstration was expanded to incorporate a family planning benefit under which family planning and family planning-related services are provided to women losing Medicaid eligibility and to certain other adults of childbearing age (family planning expansion program). The family planning expansion program expires on December 31, 2013 and becomes a state plan benefit.

In 2010 the Home and Community Based Services Expansion program (HCBS expansion program) was added to the demonstration. It provides cost-effective home and community based services to certain adults with significant medical needs as an alternative to institutional care in a nursing facility. The benefits and program structure mirrors those of existing section 1915(c) waiver programs, and strives to provide quality services for individuals in the community, ensure the well-being and safety of the participants and increase opportunities for self-advocacy and self-reliance.

As part of the 2011 extension, the state was authorized to develop and implement two new initiatives designed to improve the quality of care rendered to Partnership Plan recipients. The first, the Hospital-Medical Home (H-MH) project, will provide funding and performance incentives to hospital teaching programs in order to improve the coordination, continuity and quality of care for individuals receiving primary care in outpatient hospital settings. By the end of the demonstration extension period, the hospital teaching programs which receive grants under the H-MH project will have received certification by the National Committee for Quality Assurance as patient-centered medical homes and implemented additional improvements in patient safety and quality outcomes.

The second 2011 initiative was intended to reduce the rate of preventable readmissions within the Medicaid population, with the related longer-term goal of developing reimbursement policies that provide incentives to help people stay out of the hospital. Under the Potentially Preventable Readmissions (PPR) project, the state will provide funding, on a competitive basis, to hospitals and/or collaborations or hospitals and other providers for the purpose of developing and implementing strategies to reduce the rate of PPRs for the Medicaid population. Projects will target readmissions related to both medical and

behavioral health conditions.

Finally, in 2011 CMS began providing matching funding for the state's program to address clinic uncompensated care through its Indigent Care Pool. Prior to this extension period, the state funded (with state dollars only) this program which provides formula-based grants to voluntary, non-profit and publicly-sponsored Diagnostic and Treatment Centers (D&TCs) for services delivered to the uninsured throughout the state.

In 2012, New York added to the demonstration an initiative to improve service delivery and coordination of long term care services and supports for individuals through a managed care model. Under the Managed Long Term Care (MLTC) program, eligible individuals in need of more than 120 days of community-based long term care are enrolled with managed care providers to receive long term services and supports as well as other ancillary services. Other covered services are available on a fee-for-service basis to the extent that New York has not exercised its option to include the individual in the Mainstream Medicaid Managed Care Program (MMMC). Enrollment in MLTC was phased in geographically and by group.

The state's goal specific to managed long term care (MLTC) are as follows:

- Expanding access to managed long term care for Medicaid enrollees who are in need of long term services and supports (LTSS);
- Improving patient safety and quality of care for enrollees in MLTC plans;
- Reduce preventable inpatient and nursing home admissions; and
- Improve satisfaction, safety and quality of life.

In April 2013 New York had three amendments approved. The first amendment was a continuation of the state's goal for transitioning more Medicaid beneficiaries into managed care. Under this amendment, the Long Term Home Health Care Program (LTHHCP) participants began transitioning, on a geographic basis, from New York's 1915(c) waiver into the 1115 demonstration and into managed care. Second, this amendment eliminated the exclusion from MMMC of, both foster care children placed by local social service agencies and individuals participating in the Medicaid buy-in program for the working disabled.

Additionally the April 2013 amendment approved expenditure authority for New York to claim FFP for expenditures made for certain designated state health program beginning April 1, 2013 through March 31, 2014. During this period, the state was also required to submit several deliverables to demonstrate that the state was successful in its efforts to transform its health system for individuals with developmental disabilities.

A December 2013 amendment was approved to ensure that the demonstration made changes that were necessary in order to coordinate its programs with the Medicaid expansion and other changes made under the Affordable Care Act (ACA) implementation beginning January 1, 2014.

Effective April 1, 2014 CMS approved an amendment to extend several authorities that expired in calendar year 2014. As part of the amendment CMS extended authorities related

to the transitioning of parents into state plan coverage and other authorities that provide administrative ease to the state's programs and continuing to provide services to vulnerable population, i.e. HCBS Expansion program and individuals moved from institutional settings into community based settings.

Also effective April 1, 2014, the Federal-State Health Reform Partnership (F-SHRP) demonstration phased out and populations receiving managed care of managed long term care in the 14 counties that encompassed the F-SHRP demonstration were moved into the Partnership Plan demonstration.

The amendment approved on April 14, 2014 allows New York to take the first steps toward a major delivery system reform to be supported by a Delivery System Reform Incentive Payment (DSRIP) program. We have reached agreement on the basic structure of Medicaid funding for New York State's longer-term transformation efforts, which aim to significantly improve care, change how public and safety net providers are organized, and reform how Medicaid pays for health services. This amendment to the Partnership Plan demonstration will provide for an Interim Access Assurance Fund (IAAF) to ensure that sufficient numbers and types of providers are available in the community to participate in the transformation activities contemplated by the DSRIP Program. The DSRIP program will incentivize providers through additional payments beginning contingent on the 5-year renewal of the demonstration in 2015.

On December 31, 2014, CMS amended Partnership Plan to enable New York to extend long term nursing facility services to enrollees of New York's MMMC and MLTC populations, thereby removing patients in residential health care facilities (RHCF) at the time of enrollment into MMMC who are classified as permanent and recent residents of RHCF at time of enrollment into MLTC. As part of the agreement, the state also instituted an independent long term services and support (LTSS) assessment process via an enrollment broker and implemented its Independent Consumer Support Program in areas of the state where services and enrollment were being instituted. The demonstration was also temporarily extended until March 31, 2015.

In August 2015 CMS approved New York's request to implement Health and Recovery Plans (HARPs) to integrate physical, behavioral health and HCBS for Medicaid enrollees with diagnosed severe mental illness (SMI) and/or substance use disorder (SUD) to receive services in their own homes and communities. Under the demonstration, HARPs are a separate coverage product that is targeted to Medicaid enrollees that meet need-based criteria for SMI and/or SUD established by the state. HIV SNP plans under MMMC will also offer BH HCBS services to eligible individuals meeting targeting, risk, and functional needs criteria. All MMMC plans will offer BH benefits in integrated plans including four new demonstration services.

The demonstration is also amended to effectuate eligibility flexibilities for the Adult Group, including allowing adults enrolled in TANF to be enrolled as a demonstration population, without a MAGI determination, extension of continuous eligibility for members of the Adult Group who turn 65 during their continuous eligibility period and temporary coverage for

members of the Adult Group who are determined eligible to receive coverage through the Marketplace.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statues**. The state must comply with all applicable federal statues relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid Law, Regulation and Policy.** All requirements of the Medicaid program expressed in law, regulation and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), must apply to the demonstration.

3. **Changes in Medicaid Law, Regulation and Policy**. The state must, within the timeframes specified in law, regulation or policy statement, come into compliance with any changes in federal law, regulation or policy affecting the Medicaid program that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable.

4. **Impact on Demonstration of Changes in Federal Law, Regulation and Policy.**

   a. To the extent that a change in federal law, regulation or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph.

   b. If mandated changes in the federal law require state legislation, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

5. **State Plan Amendments**. The state will not be required to submit title XIX state plan amendments for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid state plan is affected by a change to the demonstration, a conforming amendment to the state plan may be required, except as otherwise noted in these STCs. The state is required to submit new or revised title XIX state plan amendments for state plan services received by demonstration participants except for services provided through waiver or expenditure authority.

6. **Changes Subject to the Amendment Process.** Changes related to program design, eligibility, enrollment, expansion of program benefits, sources of non-federal share of funding and budget neutrality must be submitted to CMS as amendments to the demonstration. All amendments require are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Social Security Act (the Act). The state must not implement changes to these elements without prior approval by CMS. Amendments to the demonstration are not retroactive, and FFP will not be available for changes to the demonstration that have not been approved through the amendment process outlined in STC 7 of this section.

7. **Amendment Process**. Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. Amendment requests must include, but are not limited to, the following:

    a. An explanation of the public process used by the state, consistent with the requirements of STC 14 of this section, to reach a decision regarding the requested amendment;

    b. A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by eligibility group/EG) the impact of the amendment;

    c. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and

    d. If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.

8. **Extension of the Demonstration**.

    a. Should the state intend to request an extension of the demonstration under section 1115(a), 1115(e), or 1115(f), the state must submit an extension request no later than 6 months prior to the expiration date of the demonstration. The chief executive officer of the state must submit to CMS either a demonstration extension request or a phase-out plan consistent with the requirements of STC 9 of this section.

    b. Compliance with Transparency Requirements of 42 CFR 431.412. Effective April 27, 2012, as part of the demonstration extension requests, the state must provide documentation of compliance with the transparency requirements of 42 CFR 431.412 and the public notice and tribal consultation requirements outlined in STC 14 of this section regarding Public Notice, Tribal Consultation and Consultation with Interested Parties.

9. **Demonstration Phase-Out.** The state may suspend or terminate this demonstration in whole, or in part, consistent with the following requirements:

   a. **Notification of Suspension or Termination**: The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and phase-out plan. The state must submit its notification letter and a draft phase-out plan to CMS no less than 4 months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft phase-out plan to CMS, the state must publish on its website the draft phase-out plan for 30 day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation state plan amendment. Once the 30 day public comment period has ended, the state must provide a summary of each public comment received, the state's response to the comment, and the way the state incorporated the received comment into a revised phase-out plan.

      CMS must approve the phase-out plan prior to the implementation of the phase-out activities. There must be a 14 day period between CMS approval and the phase-out plan implementation of phase-out activities.

   b. **Phase-Out Plan Requirements**: The state must include, at a minimum, in its phase out plan its process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and any community outreach activities.

   c. **Phase-Out Procedures**: The state must comply with all notice requirements found in 42 CFR § 431.206, § 431. 210 and § 431.213. In addition, the state must ensure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR § 431.220 and § 431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR § 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine whether they qualify for Medicaid eligibility under a different eligibility category as discussed in the October 1, 2011 State Health Official Letter #10-008.

   d. **Federal Financial Participation (FFP):** If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.

10. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate the demonstration, subject to adequate public notice, (in whole or in part) at any time before the date of expiration, whenever it determines following a hearing that the state has materially failed to comply with the terms of the project. CMS will promptly notify the state in writing of the determination and the reasons for the suspension or termination, together with the effective date.

11. **Finding of Non-Compliance**. The state does not relinquish its rights to challenge CMS findings that the state materially failed to comply.

12. **Withdrawal of Waiver Authority**. 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 in the public interest or promote the objectives of title XIX of the Act. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver of expenditure authority, including services and administrative costs of disenrolling participants.

13. **Adequacy of Infrastructure**. The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; monitoring and oversight of managed care plans providing long term services and supports and HCBS, including quality and enrollment processes; and reporting on financial and other demonstration components.

14. **Public Notice, Tribal Consultation and Consultation with Interested Parties**. The state must comply with the state Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The state must also comply with the tribal consultation requirements in section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009 and the tribal consultation requirements contained in the state's approved state plan, when the state proposes any program changes to the demonstration, including (but not limited to) those referenced in STC 6 of this section.

    In states with federally recognized Indian tribes, consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 letter or the consultation process in the state approved Medicaid state plan, if that process is specifically applicable to consulting with tribal governments on waivers (42 CFR § 431.408(b)(2)).

15. **Transformed Medicaid Statistical Information Systems (T-MSIS) Requirements**. The state shall comply with all data reporting requirements under Section 1903(r) of the Act, including but not limited to Transformed Medicaid Statistical Information Systems Requirements. More information on T-MSIS is available in the August 23, 2013 State Medicaid Director Letter. On August 23, 2013, a State Medicaid Director Letter entitled, "Transformed Medicaid Statistical Information System (T-MSIS) Data", was released. It states that all States are expected to demonstrate operational readiness to submit T-MSIS files, transition to T-MSIS, and submit timely T-MSIS data by July 1, 2014. Among other purposes, these data can support monitoring and evaluation of the Medicaid program in New York against which the premium assistance demonstration will be compared.

    Should the MMIS fail to maintain and produce all federally required program management data and information, including the required T-MSIS, eligibility, provider, and managed care

encounter data, in accordance with requirements in the State Medicaid Manual Part 11, FFP may be suspended or disallowed as provided for in federal regulations at 42 CFR 433 Subpart C, and 45 CFR Part 95.

16. The state must have processes in place to ensure that there is no duplication of federal funding for any aspect of the demonstration.

IV. POPULATIONS AFFECTED BY AND ELIGIBILITY UNDER THE DEMONSTRATION

1. Demonstration Components. The Partnership Plan includes four distinct components, each of which affects different populations, some of which are eligible under the state plan and some of which are eligible only as an expansion population under the demonstration.

a. Mainstream Medicaid Managed Care Program (MMMC). This component provides Medicaid state plan and demonstration benefits through a managed care delivery system comprised of managed care organizations (MCOs) and primary care case management (PCCM) arrangements to most recipients eligible under the state plan. (See Attachment A for a listing of MMMC benefits) All state plan eligibility determination rules apply to these individuals.

Specifically the state has authority to expand mandatory enrollment in mainstream managed care to all individuals identified in Table 2 (except those otherwise excluded or exempted as outlined in STC 9 of this section. When the state intends to expand mandatory managed care enrollment to additional counties, it must notify CMS 90 days prior to the effective date of the expansion and submit a revised assessment of the demonstration's budget neutrality agreement, which reflects the projected impact of the expansion for the remainder of the demonstration approval period.

b. Managed Long Term Care (MLTC). This component provides a limited set of Medicaid state plan benefits including long term services and supports through a managed care delivery system to individuals eligible through the state plan who require more than 120 days of community based long term care services. See Attachment B for a listing of MLTC services.

Services not provided through the MLTC program are provided on a fee-for-service basis. The state has authority to expand mandatory enrollment into MLTC to all individuals identified in Table 3 (except those otherwise excluded or exempted as outlined in STC 10 of this section) with initial mandatory enrollment starting in any county in New York city and then expanding statewide based on the enrollment plan outlined in Attachment F. When the state intends to expand into a new county outside of New York City, it must notify CMS 90 days prior to the effective date of the expansion and submit a revised assessment of the demonstration's budget neutrality agreement along with all other required materials as outlined in STC 6 in Section V.

c. Home and Community Based Services Expansion Program (HCBS Expansion). This component provides home and community based services similar to those provided under the state's section 1915(c) HCBS waivers (Long Term Home Health Care Program/LTHHCP, Nursing Home Transition and Diversion Program/NHTD, and Traumatic Brain Injury Program/TBI) to certain medically needy individuals. These services enable these individuals to live at home with appropriate supports rather than in a nursing facility. See Attachment C for HCBS Expansion services.

d. Health and Recovery Plans (HARPs): This component provides integrated Medicaid covered services for, and includes, services specifically to address the needs of individuals with a serious mental illness (SMI) and substance use disorder (SUDs) conditions under the demonstration. Members enrolled in the Health and Recovery Plans described below will not be enrolled in mainstream MCOs (they are distinct lines of business) but the same entity may offer both products. Within the HARPs, a benefit package of behavioral health home and community based services (BH HCBS) is provided, in addition to the existing mainstream benefit package. See attachment D for a listing of BH HCBS services.

2. Individuals Eligible under the Medicaid State Plan (State Plan Eligibles). Mandatory and optional Medicaid state plan populations derive their eligibility through the Medicaid state plan and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid state plan, except as expressly waived and as further described in these STCs.

3. Individuals Not Otherwise Eligible under the Medicaid State Plan. Individuals made eligible under this demonstration by virtue of the expenditure authorities expressly granted include those in the HCBS Expansion component of the demonstration and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid state plan, except as specified as not applicable in the expenditure authorities for this demonstration.

4. Continuous Eligibility Period.

a. Duration. The state is authorized to provide a 12 month continuous eligibility period to the groups of individuals specified in Table 1, regardless of the delivery system through which they receive Medicaid benefits. Once the state begins exercising this authority, each newly eligible individual's 12 month period shall begin at the initial determination of eligibility; for those individuals who are re-determined eligible consistent with Medicaid state plan rules, the 12-month period begins at that point. At each annual eligibility redetermination thereafter, if an individual is re-determined eligible under the Medicaid state plan the individual is guaranteed a subsequent 12 month continuous eligibility period. 12 month continuous eligibility is also authorized for the new adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.

b. Exceptions. Notwithstanding subparagraph (a), if any other following circumstances occur during an individual's 12 month continuous eligibility period, the individual's Medicaid eligibility shall be terminated, suspended or re-determined:

i. The individual cannot be located.
ii. The individual is no longer a New York State resident.
iii. The individual requests termination of eligibility.
iv. The individual dies.
v. The individual fails to provide, or cooperate in obtaining a Social Security Number, if otherwise required.
vi. The individual provided an incorrect or fraudulent Social Security Number.
vii. The individual was determined eligible for Medicaid in error.
viii. The individual is receiving treatment in a setting where Medicaid eligibility is not available (e.g. institution for mental disease).
ix. The individual is receiving care, services or other supplies under a section 1915 waiver.
x. The individual was previously otherwise qualified for emergency medical assistance benefits only, based on immigration status, but is no longer qualified because the emergency has been resolved.
xi. The individual fails to provide the documentation of citizenship or immigration status required under federal law.
xii. The individual is incarcerated.
xiii. The individual turns 65 years of age and is no longer eligible for the Adult Group (beginning January 1, 2016)[1].

Table 1: Groups Eligible for a 12 Month Continuous Eligibility Period

State Plan Mandatory and Optional Groups	Statutory or Regulatory Reference Reference
Pregnant Women	42 CFR 435.116
Adult Group	42 CFR 435.119
Parents or other caretaker relatives	42 CFR 435.110
Members of low income families, except for children	1931 and 1925

5. Individuals enrolled in MMMC. Table 2 below lists the groups of individuals who receive Medicaid benefits through the mainstream Medicaid managed care component of the demonstration, as well as the relevant expenditure reporting category (demonstration population) for each.

Table 2: Mainstream Medicaid Managed Care Program

State Plan Mandatory and Optional Groups	CFR Reference	Expenditure and Eligibility Group Reporting
Pregnant Women	42 CFR 435.116	Demonstration Population 2
Infants and Children under age 19	42 CFR 435.118	Demonstration Population 1
Adult Group	42 CFR 435.119	

[1] Individuals enrolled in Medicaid under the Adult Group who turn 65 years of age, upon receipt of Medicare, will be seamlessly disenrolled from MMMC and continue receiving Medicaid on a fee for service basis. MMIS will indicate that Medicaid is last payer of any fee for service claims for these individuals.

Children with adoption assistance, foster care or guardianship under title IV-E	42 CFR 435.145	Demonstration Population 1
Parents and other Caretaker Relatives	42 CFR 435.110	Demonstration Population 2

6. **Individuals enrolled in MLTC**. Table 3 below lists the groups of individuals who may be enrolled in the Managed Long Term Care component of the demonstration as well as the relevant expenditure reporting category (demonstration population) for each. To be eligible, all individuals in this program must need more than 120 days of community based long term care services and for MAP and PACE have a nursing home level of care.

Table 3: Managed Long Term Care Program

State Plan Mandatory and Optional Groups	FPL and/or Other Qualifying Criteria	Expenditure and Eligibility Group Reporting
Optional Adults aged 65 or older	42 CFR 435.210	Demonstration Population 11/MLTC Adults 65 and above – Duals
Optional Adults/children blind or disabled	42 CFR 435.230	Demonstration Population 10/MLTC Adults 18 through 64 – Duals
Optional Adults	Income at or below the monthly income standard, or with spend down to monthly income standard	Demonstration Population 11/MLTC Adults 65 and above - Duals
Adults/children aged 18 through 64 blind and disabled	Income at or below the monthly income standard, or with spend down to monthly income standard	Demonstration Population 10/MLTC Adults 18 through 64 – Duals
Aged 18 through 64 Medicaid Buy In for Working People with Disabilities	Income up to 250% of FPL	Demonstration Population 10/MLTC Adults 18 through 64 – Duals
Parents and Caretaker Relatives 21 through 64	Income at or below the monthly income standard, or with spend down to monthly income standard	Demonstration Population 10/MLTC Adults 18 through 64 – Duals
Children aged 18 through 20	Income at or below the monthly income standard or with spend down	Demonstration Population 10/MLTC Adults 18 through 64 – Duals
Pregnant Women	Income up to 200% of FPL	Demonstration Population 10/MLTC Adults 18 through 64 – Duals
Poverty Level Children Aged 18 through 20	Income up to 133% of FPL	Demonstration Population 10/MLTC Adults 18 through 64 – Duals
Foster Children Aged 18	In foster care on the date of	Demonstration Population

through 20	18th birthday	10/MLTC Adults 18 through 64 – Duals
Individuals Moved from Institutional Settings to Community Settings for Long Term Care Services	Income based on higher income standard to community settings for long term services and supports pursuant to STC 8 of this section	Demonstration Population 10 and 11/MLTC Adults 18 through 64 and MLTC Adults 65 and above

7. **Individuals enrolled in HCBS Expansion Program.** This group, identified as Demonstration Population 9/HCBS Expansion, includes married medically needy individuals:

   a. Who meet a nursing home level of care;

   b. Whose spouse lives in the community; and

   c. Who would be income-eligible for Medicaid services in the community but for the application of the spousal impoverishment eligibility and post-eligibility rules of section 1924 of the Act.

8. **Individuals Moved from Institutional Settings to Community Settings for Long Term Services and Supports.** Individuals discharged from a nursing facility who enroll into the MLTC program in order to receive community based long term services and supports or who move from an adult home as defined in subdivision twenty-five of section two of the social services law, to the community and, if applicable, enroll into the MLTC program, are eligible based on a special income standard. Spousal impoverishment rules shall not apply to this population. The special income standard will be determined by utilizing the average Housing and Urban Development (HUD) Fair Market Rent (FMR) dollar amounts for each of the seven regions in the state, and subtracting from that average, 30 percent of the Medicaid income level (as calculated for a household of one) that is considered available for housing. The seven regions of the state include: Central, Northeastern, Western, Northern Metropolitan, New York City, Long Island and Rochester.

   The state shall work with Nursing Home Administrators, nursing home discharge planning staff, family members and the MLTC health plans to identify individuals who may qualify for the housing disregard as they are able to be discharged from a nursing facility back into the community and enrolled into the MLTC program. Spousal impoverishment rules shall apply to individuals who have a spouse living in the community who enroll into the MLTC program.

   Enrollees receiving community based long term services and supports must be provided with nursing facility coverage through managed care, if nursing facility care is needed for 120 days or less and there is an expectation that the enrollee will return to community based settings. During the short term nursing facility stay, the state must retain the enrollees' community maintenance needs allowance. In addition, the state will ensure that the MLTC

Managed Care Organizations (MCOs) work with individuals, their families, nursing home administrators, and discharge planners to help plan for the individual's move back into the community, as well as to help plan for the individual's medical care once he/she has successfully moved into his/her home. For dually eligible enrollees, the MCO is responsible for implementing and monitoring the plan of care between Medicare and Medicaid. The MCO must assure the services are available to the enrollee.

9. **Individuals eligible to be enrolled in HARPs**. Medicaid adult beneficiaries age 21 or over eligible for Medicaid furnished in MMMC under the demonstration who are diagnosed with SMI and/or serious SUD and meet risk factors specified by:

   a. a review of current MMMC utilization,

   b. a diagnosis specified by New York's Office of Mental Health (OMH),

   c. an SUD diagnosis by New Yrok's Office of Alcoholism and Substance Abuse Services (OASAS), and includes but is not limited to, receiving a "moderate" score of the Community Mental Health Assessment Suite of the International Resident Assessment Instrument (interRAI).

10. **Exclusions and Exemptions from MMMC**. Notwithstanding the eligibility criteria in STC 1 of this section, certain individuals cannot receive benefits through the MMMC program (i.e. excluded), while others may request an exemption from receiving benefits through the MMMC program (i.e. exempted). Tables 4 and 5 list those individuals either excluded or exempted from MMMC.

Table 4: Individuals Excluded from MMMC

Individuals who become eligible for Medicaid only after spending down a portion of their income
Residents of state psychiatric facilities and residents of Residential Treatment Facilities for Children and Youth
Participants in capitated long term care demonstration projects
Medicaid eligible infants living with incarcerated mothers
Individuals with access to comprehensive private health insurance if cost effective
Foster care children in the placement of a voluntary agency
Certified blind or disabled children living or expected to live separate and apart from their parents for 30 days or more
Individuals expected to be Medicaid eligible for less than 6 months (except for pregnant women)
Individuals receiving hospice services (at time of enrollment)
Individuals with a "county of fiscal responsibility" code of 97, except for individuals in OMH family care who other than their residence in district 97 would be eligible to enroll in MMMC.
Individuals with a "county of responsibility" code of 98 (Individuals in an Office for People with Developmental Disabilities/OPWDD facility or treatment center)
Youth in the care and custody of the commissioner of the Office of Family & Children Services
Individuals who are under 65 years of age (screened and require treatment) in the Centers for Disease Control and Prevention breast, cervical, colorectal or prostate cancer, and who are not

otherwise covered under creditable health coverage
Individuals who are eligible for Emergency Medicaid

Table 5: Individuals who may be exempted from MMMC

Individuals with chronic medical conditions who have been under active treatment for at least 6 months with a sub-specialist who is not a network provider for any Medicaid MCO in the service area or whose request has been approved by the New York State Department of Health Medical Director because of unusually severe chronic care needs. Exemption is limited to six months
Individuals designated as participating in OPWDD-sponsored programs
Individuals already scheduled for a major surgical procedure (within 30 days of scheduled enrollment) with a provider who is not a participant in the network of any Medicaid MCO in the service area. Exemption is limited to six months
Individuals with a developmental or physical disability receiving services through a Medicaid home and community based services (HCBS) waiver authorized under section 1915(c) of the Act
Child and Youth residents of alcohol/substance abuse long term residential treatment programs
Native Americans
Individuals with a "county of fiscal responsibility code of 98" (OPWDD) in Medicaid Management Information System/MMIS) in counties where program features are approved by the state and operational at the local district level to permit these individuals to voluntarily enroll

11. Exclusions and Exemptions from MLTC. Notwithstanding the eligibility criteria in STC 1 of this section, certain individuals cannot receive benefits through the MLTC program (i.e. excluded while others may request an exemption from receiving benefits through the MLTC program (i.e. exempted). Tables 6 and 7 list those individuals either excluded or exempted from MLTC.

Table 6: Individuals excluded from MLTC

Residents of psychiatric facilities
Individuals expected to be Medicaid eligible for less than six months
Individuals eligible for Medicaid benefits only with respect to tuberculosis-related services
Individuals with a "county of fiscal responsibility" code 99 in MMIS (Individuals eligible only for breast and cervical cancer services)
Individuals receiving hospice services (at time of enrollment)
Individuals with a "county of fiscal responsibility " code of 97 (Individuals residing in a state Office of Mental Health facility)
Individuals with a "county of fiscal responsibility" code of 98 (Individuals in an OPWDD facility or treatment center)
Individuals who are under 65 years of age (screened and require treatment) in the Centers for Disease Control and Prevention breast, cervical, colorectal and/or prostate early detection program and need treatment for breast, cervical, colorectal or prostate cancer and who are not otherwise covered under creditable health coverage
Residents of intermediate care facilities for the mentally retarded (ICF/MR)
Individuals who could otherwise reside in an ICF/MF, but choose not to
Residents of alcohol/substance abuse long term residential treatment programs
Individuals eligible for Emergency Medicaid
Individuals in the Office for People with Developmental Disabilities Home and Community

Based Services (OPWDD HCBS) section 1915(c) waiver program
Individuals in the following section 1915(c) waiver programs: Traumatic Brain Injury (TBI), Nursing Home Transition & Diversion (NHTD), and Long Term Home Health Care Program (LTHHCP) in certain counties[2] (see Attachment F)
Residents of Assisted Living Programs
Individuals in receipt of Limited Licensed Home Care Services
Individuals in the Foster Family Care Demonstration

Table 7: Individuals who may be exempted from MLTC

Individuals aged 18 through 20 who are nursing home certifiable and require more than 120 days of community based long term care services
Native Americans
Individuals who are eligible for the Medicaid buy in for the working disabled and are nursing home certifiable
Aliessa Court Ordered Individuals

12. Exclusions from HARPs[3]. Individuals who are in other delivery systems including FFS, dual eligibles, FIDA, and MLTC will not be eligible for HARP enrollment.

13. Population-Specific Program Requirements.

a. MMMC Enrollment of Individuals Living with HIV. The state is authorized to require individuals living with HIV to receive benefits through MMMC. Once the state begins implementing MMMC enrollment in a particular district, individuals living with HIV will have 30 days in which to select a health plan. If no selection is made, the individual will be auto-assigned to an MCO. Individuals living with HIV who are enrolled in an MCO (voluntarily or by default) may request transfer to an HIV Special Needs Plan (SNP) at any time if one or more HIV SNPs are in operation in the individual's district. Further, transfers between HIV SNPs will be permitted at any time. Individuals in HIV SNPs will be eligible for BH HCBS services if meeting the targeting, risk and functional needs requirements for BH HCBS services. HIV SNPs will meet all requirements of MMMC plans providing LTSS as well as HARP plans relating to HCBS service delivery.

b. Restricted Recipient Programs. The state may require individuals participating in a restricted recipient program administered under 42 CFR §431.54(e) to enroll in MMMC. Furthermore, MCOs may establish and administer restricted recipient programs, through which they identify individuals that have utilized Medicaid services at a frequency or amount that is not medically necessary, as determined in accordance with utilization guidelines established by the state, and restrict them for a reasonable period of time to

2 New York is using a phased in approach to transition LTHHCP individuals into the MLTC program. There are six phases (see Attachment F).

[3] Upon implementation of DISCOs, individuals enrolled in Medicaid under a DISCO will be excluded from HARP eligibility.

obtain Medicaid services from designated providers only. The state must adhere to the following terms and conditions in this regard.

i. Restricted recipient programs operated by MCOs must adhere to the requirements in 42 CFR §431.54(e)(1) through (3), including the right to a hearing conducted by the state.

ii. The state must require MCOs to report to the state whenever they want to place a new person in a restricted recipient program. The state must maintain summary statistics on the numbers of individuals placed in restricted recipient programs, and the reasons for those placements, and must provide the information to CMS upon request.

c. Managed care enrollment of individuals using long term services and supports under the Demonstration. The state is authorized to require certain individuals using long term services and supports to enroll in either mainstream managed care or managed long term care as identified in STC 1 of this section. Enrollment in HARPs is optional. In addition, the populations that are exempted from mandatory enrollment, based on the exemption lists in STCs 10 and 11 of this section may also elect to enroll in managed care plans. Once these individuals begin to enroll in managed care, the state will be required to provide the following protections for the population[4].

i. Person Centered Service Planning. The state, through its contracts with its MCOs and/or Prepaid Inpatient Health Plans (PIHPs), will require that all individuals utilizing long term services and supports will have a person centered individual service plan maintained at the MCO or PIHP. Person centered planning includes consideration of the current and unique psycho-social and medical needs and history of the enrollee, as well as the person's functional level, and support systems.

A. The state must establish minimum guidelines regarding the person centered plan (PCP) that will be reflected in MCO/PIHP contracts. These must include at a minimum, a description of:

1. The qualification for individuals who will develop the PCP;

2. Types of assessments;

3. How enrollees are informed of the services available to them; and

4. The MCOs' responsibilities for implementing and monitoring the PCP.

B. The MCO/PIHP contract shall require the use of a person centered and directed planning process intended to identify the strengths, capacities and preferences of the enrollee, as well as to identify an enrollee's long term care needs and the resources available to meet those needs, and to provide access to additional care

4 All beneficiary protections apply to MMMC, MLTC and HARPs, unless otherwise noted in Section V

options as specified by the contract. The person centered plan is developed by the participant with the assistance of the MCO/PIHP, provider and those individuals the participant chooses to include. The plan includes the services and supports that the participant needs.

C. The MCO/PIHP contract shall require that service plans must address all enrollees' assessed needs (including health and safety risk factors) and personal goals, taking into account an emphasis on services begin delivered in home and community based settings.

D. The MCO/PIHP contract shall require that a process is in place that permits the participants to request a change to the person centered plan if the participant's circumstances necessitate a change. The MCO contract shall require that all service plans are updated and/or revised at least annually or when warranted by changes in the enrollee's needs.

E. The MCO/PIHP shall ensure that meetings related to the enrollee's person centered plan will be held at a location, date and time convenient to the enrollee and his/her invited participants.

F. The MCO/PIHP contract shall require development of a backup plan to ensure that needed assistance will be provided in the event that the regular services and supports identified in the individual service plan are temporarily unavailable. The backup plan may include other individual assistance or services.

G. The MCO/PIHP contract shall require that services be delivered in accordance with the service plan, including the type, scope, amount, duration, and frequency.

H. The MCO/PIHP contract shall require that enrollees receiving long term services and supports have a choice of provider, where applicable, which has the capacity to serve that individual within the network. The MCO/PIHP must contract with at least two providers in each county in its service area for each covered service in the benefit package unless the county has an insufficient number of providers licensed, certified, or available in that county.

I. The MCO/PIHP contract shall require policies and procedures for the MCO/PIHP to monitor appropriate implementation of the individual service plans, including the qualifications of individuals developing service plans, types of assessments conducted and the method for how enrollees are notified of available services.

ii. Verification of MLTC Plan Enrollment. The state shall implement a process for MLTC plans, network and non-network providers for the state to confirm enrollment of enrollees who do not have a card or go to the wrong provider before developing a person-centered service plan.

iii. Health and Welfare of Enrollees. The state through its contracts with its MCOs/PIHPs shall ensure a system is in place to identify, address, and seek to prevent instances of abuse, neglect, and exploitation of its enrollees on a continuous basis. This should include provisions such as critical incident monitoring and reporting to the state, investigations of any incident including, but not limited to, wrongful death, restraints, or medication errors that resulted in an injury. In each quarterly report, the state will provide information regarding any such incidents by plan. The state will also ensure that children and adults receiving MLTC are afforded linkages to child and/or adult protective services through all service entities, including the MCOs/PIHPs.

iv. Maintaining Accurate Beneficiary Address. New York will complete return mail tracking for enrollment notification mailings. The state will use information gained from returned mail to make additional outreach attempt through other methods (phone, email, analysis of prior claims, etc.).

v. Network of Qualified Providers. The provider credentialing criteria described at 42 CFR § 438.214 must apply to providers of long-term services and supports. If the MCO's/PIHP's credentialing policies and procedures do not address non-licensed/non-certified providers, the MCO/PIHP shall create alternative mechanisms to ensure the health and safety of its enrollees. To the extent possible, the MCO/PIHP shall incorporate criminal background checks, reviewing abuse registries as well as any other mechanism the state includes within the MCO/PIHP contract.

d. MLTC enrollment. Including the protections afforded individuals in subparagraph (c) of STC 11 of this section, the following requirements apply to MLTC plan enrollment:

i. Transition of Care Period: Initial transition into MLTC from fee-for-service. Each enrollee who is receiving community-based long-term services and supports that qualifies for MLTC must continue to receive services under the enrollee's pre-existing service plan for at least 90 days after enrollment, or until a care assessment has been completed by the MCO/PIHP, whichever is later. Any reduction, suspension, denial or termination of previously authorized services shall trigger the required notice under 42 CFR § 438.404 which clearly articulates the enrollee'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 initial implementation of the auto-assigned population, the plans must submit data for state review on a monthly basis reporting instances when the plan has issued a notice of action that involves a reduction of split shift or live-in services or when the plan is reducing hours by 25 percent or more. The plan will also report the number of appeals and fair hearings requested regarding these reductions. The state shall ensure through its contracts that if an enrollee is to change from one MCO/PIHP to another, the MCO/PIHPs will communicate with one another to ensure a smooth transition and provide the new MCO/PIHP with the individual's current service plan.

ii. Marketing Oversight.

A. The state shall require each MCO/PIHPs through its contracts to meet 42 CFR §438.104, and state marketing guidelines which prohibit cold calls, use of government logos and other standards.

B. All materials used to market the MCO/PIHP shall be prior approved by the state.

C. The state shall require through its contracts that each MCO/PIHP provide all individuals who were not referred to the plan by the enrollment broker with information (in a format determined by the state) describing managed long term care, a list of available plans and contact information to reach the enrollment broker for questions or other assistance. The plan shall report the number of individuals receiving these materials to the state on a quarterly basis pursuant to STC 4 in Section IX.

e. Demonstration Participant Protections. The state will ensure that adults in LTSS in MLTC programs are afforded linkages to adult protective services through all service entities, including the MCO's/PIHP's. The state will ensure that these linkages are in place before, during, and after the transition to MLTC as applicable.

f. Non-duplication of Payment. MLTC Programs will not duplicate services included in an enrollee's Individualized Education Program under the Individuals with Disabilities Education Act, or services provided under the Rehabilitation Act of 1973.

V. DEMONSTRATION BENEFITS AND ENROLLMENT

1. Demonstration Benefits and Cost Sharing. The following benefits are provided to individuals eligible for the Medicaid managed care components of the demonstration:

a. Mainstream Medicaid Managed Care (MMMC). State plan and demonstration benefits delivered through MCOs or, in certain districts, primary care case management arrangements, with the exception of certain services carved out of the MMMC contract and delivered directly by the state on a fee-for-service basis. All MMMC benefits (regardless of delivery method), as well as the co- payments charged to MMMC recipients, are listed in Attachment A. In addition to state plan benefits, there are four demonstration services for individuals in MMMC only provided to enrollees in MMMC under the demonstration. An additional 1115 demonstration amendment will be submitted to CMS prior to incorporating the behavioral health state plan services and demonstration services for populations under age 21.

b. Managed Long Term Care. State plan benefits delivered through MCOs or, in certain districts, prepaid inpatient health plans, with the exception of certain services carved out of the MLTC contract and delivered directly by the state on a fee-for-service basis. All MLTC benefits are listed in Attachment B.

c. Health and Recovery Plans (HARPs). State plan and demonstration benefits that are identical to MMMC with an additional component that provides HCBS for SMI and SUD needs will be provided by the HARPs.. Nursing facility services will not be provided by HARPs. There are no co-payments for HARP services. All BH HCBS benefits are listed in Attachment D. HCBS for HARPs recipients meeting targeting, risk and need-based functional criteria are only provided under the demonstration. The state must update the Medicaid state plan for rehabilitation and other mental health and substance use disorder services as identified through a companion letter to TN 10-38 as well as substance use disorder demonstration services not described in the current state plan. HIV SNPs will also provide BH HCBS benefits to individuals meeting targeting, risk and needs-based criteria. All reimbursement for BH HCBS in HARPs and HIV SNPs will be non-risk.

2. **HARPs Services Tiers.** HARPs recipients will receive HCBS services under the following tier structure in accordance with their person-centered services plan.

   a. Tier 1 HCBS services –
      i. Peer supports
      ii. Employment supports
      iii. Education supports.
   b. Tier 2 HCBS services – All HCBS services, including Tier 1 services. These services are provided to individuals whose medical need surpasses the need for Tier 1 services.
   c. Crisis respite - Crisis respite services under the HARPs are available to all HARPs enrollees, regardless of the tiers from which they receive services.
      i. Intensive crisis respite
      ii. Short term crisis respite in a dedicated facility
      iii. Short term crisis respite in a non-dedicated facility

   HARP enrollees are permitted to appeal any service denial decisions.

3. **HARPs Services Utilization Thresholds.** The following thresholds will apply to HARPs enrollees. The state will track and report overall utilization to ensure cost containment as well as compile sufficient fee for service data to submit HARPs capitation rates to CMS for approval.
   a. Tier 1 - $8,000 per person, per 12 month period threshold. Up to $10,000 in services are permitted.
   b. Tier 2 - $16,000 per person, per 12 month period threshold. Up to $20,000 in services are permitted.
   c. Crisis Respite – 7 days per service, up to 21 days per 12 month period.

   If a HARP enrollee exceeds any threshold for clinical reasons, the enrollee's HARP must contact the HARP medical director from New York OMH or OASAS and get approval for specific dollar increases above the thresholds.

4. **Alternative Benefit Plan**. The Affordable Care Act Low-Income Adult Group will receive benefits provided through the state's approved Alternative Benefit Plan (ABP) SPA.

5. **Home and Community Settings Characteristics.** Beneficiaries receiving Medicaid HCBS and LTSS services furnished through the 1115 demonstration, including individuals who receive services under the demonstration's HCBS Expansion program must receive services in residential and non-residential settings located in the community, which meet CMS standards for HCBS settings as articulated in current 1915(c) policy, including regulations at 42 CFR §441.301. Individuals who receive BH HCBS described under HARPs (STC 1(d) in Section IV) and HIV SNPs must also reside in and receive HCB services in settings that fully comply with 42 CFR 441.301 as detailed in the New York Statewide Transition Plan amended no later than August 31, 2015 to include the services identified in this amendment that are HCBS. This amended Statewide Transition Plan must meet CMS approval for these settings to be funded beyond November 30, 2015. A full list of home and community based qualities are provided in Attachment C.

6. **Inmates of a Public Institution.** Medicaid eligible individuals who are inmates of a public institution and admitted as inpatients to medical institutions listed at 42 CFR 441.11(c) are eligible for Medicaid funding for medically necessary services, as described under the state's Medicaid plan, and provided by a certified provider that maintains compliance with federal requirements.

7. **Option for Consumer Directed Personal Assistance Program**. Enrollees shall have the option to elect self-direction of Personal Assistance under the MMMC program. The state shall ensure through its contracts with the MCOs/PIHPs that enrollees are afforded the option to select self-direction and enrollees are informed of CDPAP as a voluntary option to its members. Individuals who select self-direction must have the opportunity to have choice and control over how services are provided and who provides the service.

    a. **Information and Assistance in Support of Participant Direction**. The state/MCO shall have a support system that provides participants with information, training, counseling, and assistance, as needed or desired by each participant, to assist the participant to effectively direct and manage their self-directed services. Participants shall be informed about self-directed care, including feasible alternatives, before electing the self-direction option.

    b. **Participant Direction by Representative.** The participant who self-directs the personal care service may appoint a volunteer designated representative to assist with or perform employer responsibilities to the extent approved by the participant. Services may be directed by a legal representative of the participant. Consumer-directed services may be directed by a non-legal representative freely chosen by the participant. A person who serves as a representative of a participant for the purpose of directing services cannot serve as a provider of personal attendant services for that participant.

c. Participant Employer Authority. The participant (or the participant's representative) must have decision-making authority over workers who provide personal care services.

i. Participant. The participant (or the participant's representative) provides training, supervision and oversight to the worker who provides services. A Fiscal/Employer Agent that follows IRS and local tax code laws functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law.

ii. Decision-Making Authorities. The participants exercise the following decision making authorities: Recruit staff, hire staff , verify staff's ability to perform identified tasks, schedule staff, evaluate staff performance, verify time worked by staff and approve time sheets, and discharge staff.

d. Disenrollment from Self-Direction. A participant may voluntarily disenroll from the self-directed option at any time and return to a traditional service delivery system through the MMMC or MLTC program. To the extent possible, the member shall provide his/her intent to withdraw from participant direction. A participant may also be involuntarily disenrolled from the self-directed option for cause, if continued participation in the consumer-directed services option would not permit the participant's health, safety, or welfare needs to be met, or the participant demonstrates the inability to self-direct by consistently demonstrating a lack of ability to carry out the tasks needed to self-direct services, or if there is fraudulent use of funds such as substantial evidence that a participant has falsified documents related to participant-directed services. If a participant is terminated voluntarily or involuntarily from the self-directed service delivery option, the MCO/PIHP must transition the participant to the traditional agency direction option and must have safeguards in place to ensure continuity of services.

e. Payment for services will be made following the service being rendered and only upon receipt of an acceptable receipt, invoice or signed and approved timesheet, as applicable.

f. Appeals. The following actions shall be considered adverse action under both 42 CFR 431 subpart E and 42 CFR 438 subpart F:

i. A reduction, suspension or termination of authorized CDPAP services;
ii. A denial of a request to change Consumer Directed Personal Assistance Program services.

8. Adding Services to the MMMC and/or MLTC plan benefit package. At any point in time the state intends to add to either the MMMC or MLTC plan benefit package currently authorized state plan or demonstration services that have been provided on a fee-for-service basis, the state must provide CMS the following information, with at least 30 days' notice prior to the inclusion of the benefit, either in writing or as identified on the agenda for the monthly calls referenced in STC 3 in Section IX:

a. A description of the benefit being added to the MCO/PIHP's benefit package;

b. A detailed description of the state's oversight of the MCO/PIHPs readiness to administer the benefit including: readiness and implementation of activities, which may include onsite reviews, phone meetings and desk audits reviewing policies and procedures for new services, data sharing to allow plans to create services plans as appropriate, process to communicate the change to enrollees, MCO/PIHP network development to include providers of that service and any other activity performed by the state to ensure plan readiness.

c. Information concerning the changes being made to the MMMC and/or MLTC contract provisions and capitation payment rates in accordance with STC 2 in Section VI.

CMS reserves the right to delay implementation of the benefit transition until such time as appropriate documentation is provided showing evidence of MCO/PIHP readiness. In addition, new services that are not currently authorized under the state plan or demonstration may be added only through approved amendments to the state plan or demonstration.

CMS will notify the state of concerns within 15 days. If no comments are received, the state may proceed with the scheduled benefit transition.

9. Expanding MLTC enrollment. Any time the state is ready to expand mandatory MLTC plan enrollment into a new geographic area for populations approved for managed care through an amendment, the state must provide CMS notification at least 90 days prior to the expansion. Such notification will include:

a. A list of the counties that will have approved populations moving to mandatory enrollment;

b. A list of MCO/PIHPs with an approved state certificate of authority to operate in those counties demonstrating that enrollees will be afforded choice of plan within the new geographic area;

c. Confirmation that the MCO/PIHPs in the new geographic area have met the network requirements in STC 10 in Section VI for each MCO/PIHP.

The state must also apply the requirements of STC 5 of this section when applicable to the MLTC population or geographic area being added to the MLTC program.

CMS reserves the right to delay implementation of the geographic expansion until such time as notification documentation is provided.

CMS will notify the state of concerns within 15 days. If no comments are received, the state may proceed with the scheduled geographic expansion.

10. Assurances during expansion of MLTC enrollment, HARPs enrollment and expansion of LTSS for MMMC recipients including HIV SNPs. The assurances below pertain to future MLTC expansions and provision of LTSS for MMMC recipients (where applicable)

authorized under this demonstration. To provide and demonstrate smooth transitions for beneficiaries, the state must:

a. Send sample notification letters. Existing Medicaid providers must receive sample beneficiary notification letters via widely distributed methods (mail, email, provider website, etc.) so that providers are informed of the information received by enrollees regarding their managed care transition.

b. Provide continued comprehensive outreach, including educational tours for enrollees and providers. The educational tour should educate enrollees and providers on the MLTC plan enrollment options, rights and responsibilities and other important program elements. The state must provide webinars, meeting plans, and send notices through outreach and other social media (e.g. state's website). The enrollment broker, choice counseling entities, ombudsman and any group providing enrollment support must participate.

c. Operate a call center independent of the MLTC, and MMMC and HARP plans for the duration of the demonstration. This entity must be able to help enrollees in making independent decisions about plan choice and be able to document complaints about the plans. During the first 60 days of implementation the state must review all call center response statistics to ensure all contracted plans are meeting requirements in their contracts. After the first 60 days, if all entities are consistently meeting contractual requirements the state can lessen the review of call center statistics, but no more than 120 days should elapse between reviews.

d. Review the outcomes of the auto-assignment algorithm to ensure that MLTC and MMMC plans with more limited networks do not receive, are the same or larger number of enrollees, as plans with larger networks.

e. The state shall require MCO/PIHPs to maintain the current worker/recipient relationship for no less than 90 days.

11. Assessment of LTSS needs under MLTC, MMMC and Behavioral Health under HARPs and HIV SNPs. The state shall begin implementation of an independent and conflict-free LTSS needs assessment system for newly eligible Medicaid recipients, as applicable. After implementation has begun, MLTC plans will not complete any LTSS needs assessments for individuals requesting such services prior to enrollment in a plan. Non-dually eligible individuals requesting LTSS will be assessed for criteria necessitating enrollment in MLTC or an alternate waiver program. An independent LTSS assessment system must be in place in any geographic location where MLTC or, LTSS in MMMC will be mandated or where HARPs are an option. It should be noted that LTSS assessments in for skilled nursing facility services in MMMC and behavioral health assessments for HARPs and HIV SNPs will be conflict free prior to implementation and geographic phase in.

The following requirements apply until the state implements an independent LTSS assessment process:

a. MLTC plans conduct the initial assessment for an individual's need for LTSS using a standardized assessment tool designated by the state and conduct the assessment in a timely manner, but not to exceed 30 days of a referral or initial contact.

b. The state shall ensure the Semi-Annual Assessment of Members (SAAM) tool (or successor tool designated by the state) to determine if the individual has a need for LTSS. Other assessment tools may be used as appropriate in addition to the SAAM, if approved by the state. The state shall take corrective action against MLTC plans that do not meet this 30 day requirement.

c. The MCO/PIHP shall complete a re-assessment at least annually, or when an enrollee reports a change.

d. New Medicaid applicants must be provided the results of their assessment and educated on the steps in the Medicaid eligibility determination, including denial and fair hearing procedures. Current eligibles must be provided information regarding choice of MLTC plan.

e. The state shall require each MCO/PIHP, through its contracts, to report to the enrollment broker the names of all individuals for whom an assessment is completed. If the individual has not been referred by the enrollment broker, the MCO/PIHP shall report the date of initial contact by the individual and the date of the assessment to determine compliance with the 30-day requirement.

f. The state shall review a sample of the MLTC plan LTSS assessments every six months, either through the External Quality Review Organization (EQRO) of by the state, to verify the correct determinations were made.

12. Operation of the HCBS Expansion Program. The individuals eligible for this component of the demonstration will receive the same HCBS as those individuals determined eligible for and enrolled in the state's Long Term Home Health Care Program (LTHHCP), Nursing Home Transition and Diversion Program (NHTDP) and Traumatic Brain Injury Program (TBIP) authorized under section 1915(c) of the Act. The specific benefits provided to participants in this program are listed in Attachment C.

The state will operate the HCBS Expansion program in a manner consistent with approved LTHHCP, NHTDP and TBIP 1915(c) waiver programs and must comply with all administrative, operational, quality improvement and reporting requirements contained therein. The state shall provide enrollment and financial information about the individuals enrolled in the HCBS Expansion program as requested by CMS.

13. **Facilitated Enrollment**. Facilitated enrollers, which may include MCOs, health care providers, community-based organizations, and other entities under state contract, will engage in those activities described in 42 CFR § 435.904(d)(2), as permitted by 42 CFR § 435.904(e)(3)(ii), within the following parameters:

    a. Facilitated enrollers will provide program information to applicants and interested individuals as described in 42 CFR §435.905(a).

    b. Facilitated enrollers must afford any interested individual the opportunity to apply for Medicaid without delay as required by 42 CFR §435.906.

    c. If an interested individual applies for Medicaid by completing the information required under 42 CFR §435.907(a) and (b) and 42 CFR §435.910(a) and signing a Medicaid application, that application must be transmitted to the LDSS for determination of eligibility.

    d. The protocols for facilitated enrollment practices between the LTSS and the facilitated enrollers must:

        i. Ensure that choice counseling activities are closely monitored to minimize adverse risk selection; and
        ii. Specify that determinations of Medicaid eligibility are made solely by the LTSS.

12. **Passive Enrollment**. For any component that requires passive enrollment of potential enrollees, individuals must have the ability to "opt out." Beneficiaries in an MMMC with a HARP line of business will be passively enrolled with the ability to opt-out within the first 90 days following passive enrollment and return to their original MCO. Following that 90 day opt out period, HARP enrollees may not change plans again until the annual enrollment period for that plan. HARP eligible beneficiaries in an MMMC without a HARP line of business will be allowed to voluntarily enroll in a HARP. The beneficiary must be given the choice of another MCO and the current MCO must assist the beneficiary to make the change. The state will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria. When a beneficiary opts out of the HARPs and into a MMMC, care must be coordinated during the transition between physical and behavioral health, to best meet the needs of the beneficiary. The MCO and the HARP must work together to transition the beneficiary.

VI. DELIVERY SYSTEMS

1. **Contracts**. Procurement and the subsequent final contracts developed to implement selective contracting by the state with any provider group shall be subject to CMS approval prior to implementation. Payments under contracts with public agencies, that are not competitively bid in a process involving multiple bidders, shall not exceed the documented costs incurred in furnishing covered services to eligible individuals (or a reasonable estimate with an adjustment factor no greater than the annual change in the consumer price index).

2. **Managed Care Contracts**. No FFP is available for activities covered under contracts and/or modifications to existing contracts that are subject to 42 CFR 438 requirements prior to CMS approval of model contract language. The state shall submit any supporting documentation deemed necessary by CMS. The state must provide CMS with a minimum of 45 days to review and approve changes. CMS reserves the right, as a corrective action, to withhold FFP (either partial or full) for the demonstration, until the contract compliance requirement is met.

3. **Managed Care Data Requirements**. All managed care organizations shall maintain an information system that collects, analyzes, integrates and reports data as set forth at 42 CFR §438.242. This system shall include encounter data that can be reported in a standardized format. Encounter data requirements shall include the following:

    a. **Encounter Data (Health Plan Responsibilities).** The health plan must collect, maintain, validate and submit data for services furnished to enrollees as stipulated by the state in its contracts with the health plans.

    b. **Encounter Data (State Responsibilities).** The state shall, in addition, develop mechanisms for the collection, reporting, and analysis of these, as well as a process to validate that each plan's encounter data are timely, complete and accurate. The state will take appropriate actions to identify and correct deficiencies identified in the collection of encounter data. The state shall have contractual provisions in place to impose financial penalties if accurate data are not submitted in a timely fashion. Additionally, the state shall contract with its EQRO to validate encounter data through medical record review.

    c. **Encounter Data Validation Study for New Capitated Managed Care Plans.** If the state contracts with new managed care organizations, the state shall conduct a validation study 18 months after the effective date of the contract to determine completeness and accuracy of encounter data. The initial study shall include validation through a sample of medical records of demonstration enrollees.

    d. **Submission of Encounter Data to CMS.** The state shall submit encounter data to the Medicaid Statistical Information System (MSIS) and when required T-MSIS (Transformed MSIS) as is consistent with federal law and per STC 15 in Section III. The state must assure that encounter data maintained at managed care organizations can be linked with eligibility files maintained at the state.

4. **Interpretation Services and Culturally Competent Care**. The MCOs and other entities acting on behalf of the state Medicaid agency (including, but not limited to enrollment brokers) must have interpretation services and provide care that is consistent with the individual's culture. MCOs must conduct analyses to determine any gaps in access to these services and will expand its workforce accordingly. The MCOs may also require the use of remote video and voice technology when necessary.

5. **Managed Care Benefit Packages**. Individuals enrolled in managed care plans under the demonstration must receive from the managed care program the benefits as identified in Attachments A through D, respectively. As noted in plan readiness and contract

requirements, the state must require that, for enrollees in receipt of LTSS, each MCO/PIHP coordinate, as appropriate, needed state plan services that are excluded from the managed care delivery system but available through a fee-for-service delivery system, and must also assure coordination with services not included in the established benefit package. Plans will be at risk for any Medicaid covered service that is currently delivered. BH HCBS in HARPs and HIV SNPs will be non-risk for the initial years in accordance with STC 1 of section V. If the MCO network is unable to provide necessary medical services covered under the contract to a particular enrollee, the MCO will be required to cover these services out of network for the enrollee. The costs of room and board may not be covered and cannot be included when determining the MCO payment rates.

6. **Managed Care Rates Transition for HARPs**. While working towards a managed care capitated rate for HARPs, the state may not proceed with implementation in a region until it has approved HCBS fee for service rates for such region. The state must submit HARP capitation rates to CMS for approval no later than December 31, 2018. Should the state not have the ability to submit proposed rates, it must request a temporary extension to continue using the most recently approved rates.

7. **Managed Care Rate Transition for Skilled Nursing Facilities (SNF).** For 2 years after a county has transitioned from FFS to managed care for SNF services, plans will be required to pay contracted nursing homes either the existing FFS rate or a negotiated rate which allows the nursing home and the plan to engage in other financing arrangements. MLTC and MMMC plans will be reimbursed with an actuarial sound rate in compliance with 42 CFR 438.6. The rate must be calculated to promote community integration by creating a blended institutional/Home and Community Based Services (HCBS) rate structure. For calendar year 2016, the state shall submit an actuarial certification to CMS for approval that contains the following modifications:

   a. MLTC transition rates must be phased out.
   b. An HCBS 'rate cohort" for MMC plans must be included.
   c. Documentation must be submitted identifying the unique and cumulative impact of the various capitation rate withholds that are funding the funds.
   d. Documentation must be submitted assessing gaps in rate-setting for MLTC plans that necessitate funds to mitigate risks.

8. **Behavioral Health Services Furnished by MMMCs, HIV SNPs, and HARPs**. To the extent that an MCO is not able to meet the requirements for the management of the specialty behavioral health services, the MCO must contract with a managed care behavioral health organization to manage those services for enrollees. If the MCO network is unable to provide necessary medical services covered under the contract to a particular enrollee, the MCO will be required to cover these services out of network for the enrollee. This includes up to a two year period following the carve-in of behavioral health services into managed care during which time the MCO will reimburse OMH ambulatory licensed and OASAS certified providers the FFS fee schedule to ensure continuity of care. After 90 days, the MCO may apply utilization review criteria to individuals under the care of non-participating providers. Plans will be required to authorize services and reimburse providers whether the behavioral health provider is contracted with the health plans or an out of network provider.

If the health plan does not offer a HARP line of business, that plan's HARP-eligible enrollees will be offered a choice of plans with a HARP by the state's enrollment broker. For SUD services and the delivery system changes associated with the new demonstration services and resulting state plan amendments including changes under the CMS Innovation Accelerator Program (IAP), the state may require the MCOs through their contracts, as approved by CMS, to adopt system-wide changes and rates, also approved by CMS, to ensure that the innovations are adopted in a consistent manner statewide.

9. **Independent Consumer Support Program.** To support the beneficiary's experience receiving and applying to receive long term services and supports in a managed care environment, the state shall create and maintain a permanent independent consumer support program to assist beneficiaries in understanding the coverage model and in the resolution of problems regarding services, coverage, access and rights.

   a. Organizational Structure. The Independent Consumer Support Program shall operate independently from any Partnership Plan MCO. Additionally, to the extent possible, the program shall also operate independently of the state Medicaid agency.

   b. Accessibility. The services of the Independent Consumer Support Program shall be available to all Medicaid beneficiaries enrolled in Partnership Plan who are in need of LTSS (institutional, residential and community based) and must be accessible through multiple entryways (e.g., phone, internet, office) and also provide outreach in the same manner as appropriate.

   c. *Functions*. The Independent Consumer Support Program shall assist beneficiaries to navigate and access covered LTSS, including the following activities:

      i. offer beneficiaries support in the pre-enrollment state, such as unbiased health plan choice counseling and general program-related information.

      ii. serve as an access point for complaints and concerns about health plan enrollment, access to services and other related matters.

      iii. help enrollees understand the fair hearing, grievance and appeal rights and processes within the health plan and at the state level, and assist them through the process if needed/requested.

      iv. conduct trainings with Partnership Plan MCO and providers on community-based resources and supports that can be linked with covered plan benefits.

   d. Staffing. The Independent Consumer Support Program must employ individuals who are knowledgeable about the state's Medicaid programs; beneficiary protections and rights under Medicaid managed care arrangements; and the health and service needs of persons with complex needs, including those with a chronic condition, disability, and cognitive or behavioral needs.

e. Data Collection and Reporting. The Independent Consumer Support Program shall track the volume and nature of beneficiary contacts and the resolution of such contacts on a schedule and manner determined by the state, but no less frequently than quarterly.

f. Geographic expansion of MLTC and LTSS in MMMC. In any geographic location where the state is mandating MLTC or LTSS in MMMC, the state must have the Independent Consumer Support Program in place at least 30 days prior to enrollment procedures for that geographic location.

10. **Revision of the State Quality Strategy**. The state must update its comprehensive Quality Strategy to reflect all managed care plans (MCO/PIHPs) operating under MMMC including HIV SNPs, MLTC and HARP programs proposed through this demonstration and submit to CMS for approval of the most recent amendment within 90 days of approval of the most recent amendment. The state must obtain the input of recipients and other stakeholders in the development of its revised comprehensive Quality Strategy and make the Strategy available for public comment. The state must revise the strategy whenever significant changes are made, including changes through this demonstration. Pursuant to STC 5 in Section IX, the state must also provide CMS with annual reporting on the implementation and effectiveness of the updated comprehensive quality strategy, as it impacts the demonstration. The CQS must also address the following elements:

    a. The state's goals for improvement, identified through claims and encounter data, quality metrics and expenditure data. The goals should align with the three part aim but should be more specific in identifying specific pathways for the state to achieve these goals.
    b. The specific quality metrics for measuring improvement in the goals. The metrics should be aligned with the Medicaid and CHIP adult and child core measures, and should also align with other existing Medicare and Medicaid federal measure sets where possible.
    c. Metrics should be measured at the following levels of aggregation: the state Medicaid agency, each managed care entity, and each direct health services provider. The state will work with CMS to further define what types of metrics will be measured for direct service providers.
    d. The specific methodology for determining benchmark and target performance on these metrics for each aggregated level identified above (state, plan and provider).
    e. MLTSS essential elements as defined in the May 21, 2013 CMS Information Bulletin to its MMMC quality reporting system (QARR).
    f. The specific methodology for determining ongoing compliance with HCBS settings qualities.

11. **Required Components of the State Quality Strategy**. The revised comprehensive Quality Strategy shall meet all the requirements of 42 CFR 438 Subpart D. The quality strategy must include components relating to managed long term services and supports. The Quality strategy must address the following regarding the population utilizing long term services and supports: level of care assessments, service planning, and health and welfare of enrollees.

12. **Required Monitoring Activities by the State and/or EQRO.** The state's EQR process for the mainstream managed care and MLTC plans shall meet all the requirements of 42 CFR

438 Subpart E. In addition, the state, or its EQRO shall monitor and annually evaluate the MCO/PIHPs performance on specific new requirements under mandatory enrollment of individuals utilizing long term services and supports. The state shall provide an update of the processes used to monitor the following activities as well as the outcomes of the monitoring activities within the annual report in STC 5 in Section IX. The new requirements include, but are not limited to the following:

a. MLTC Plan Eligibility Assessments. To ensure that approved instruments are being used and applied appropriately and as necessary, and to ensure that individuals being served with LTSS meet the MLTCplan eligibility requirements for plan enrollment. The state will also monitor assessments conducted by the plan where individuals are deemed ineligible for enrollment in an MLTC plan.

b. Service Plans. To ensure that MCOs/PIHPs are appropriately creating and implementing service plans based on enrollee's identified needs.

c. MCO/PIHP credentialing and/or verification policies. To ensure that LTSS services are provided by qualified providers.

d. Health and welfare of enrollees. To ensure that the MCO/PIHP, on an ongoing basis, identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation.

13. Access to Care, Network Adequacy and Coordination of Care Requirements for Long Term Services and Supports (LTSS). The state shall set specific requirements for MCO/PIHPs to follow regarding providers of LTSS, consistent with 42 CFR 438 Part D. These requirements shall be outlined within each MCO/PIHP contract. These standards should take into consideration individuals with special health care needs, out of network requirements if a provider is not available within the specific access standard, ensuring choice of provider with capacity to serve individuals, time/distance standards for providers who do not travel to the individual's home, and physical accessibility of covered services. The MLTC or mainstream managed care plan is not permitted to set these standards.

14. Demonstrating Network Adequacy. Annually, each MCO/PIHP must provide adequate assurances that it has sufficient capacity to serve the expected enrollment in its service area and offers an adequate coverage of benefits as described in Attachment A and B for the anticipated number of enrollees in the service area.

a. The state must verify these assurances by reviewing demographic, utilization and enrollment data for enrollees in the demonstration as well as:

i. The number and types of providers available to provide covered services to the demonstration population;
ii. The number of network providers accepting the new demonstration population; and
iii. The geographic location of providers and demonstration populations, as shown through GeoAccess, similar software or other appropriate methods.

b. The state must submit the documentation required in subparagraphs (i) – (iii) above to CMS with each annual report.

c. Enrollees and their representatives must be provided with reference documents to maintain information about available providers and services in their plans.

15. Advisory Committee as required in 42 CFR 438. The state must maintain for the duration of the demonstration a managed care advisory group comprised of individuals and interested parties appointed pursuant to state law by the Legislature and Governor. To the extent possible, the state will attempt to appoint individuals qualified to speak on behalf of seniors and persons with disabilities who are impacted by the demonstration's use of managed care, including individuals with developmental disabilities, regarding the impact and effective implementation of these changes on individuals receiving LTSS.

16. Health Services to Native Americans Populations. The plan currently in place for patient management and coordination of services for Medicaid-eligible Native Americans developed in consultation with the Indian tribes and/or representatives from the Indian health programs located in participating counties shall continue in force for this extension period.

VII. DELIVERY SYSTEM REFORM PROGRAM DESCRIPTION AND OBJECTIVES

1. Medicaid Redesign Team (MRT)

a. BACKGROUND

The purpose of this demonstration amendment is to describe a structure under which the federal government will provide up to $8 billion in new federal funds for all Medicaid Redesign Team (MRT) activities including delivery system reform in the waiver, managed care programming and state plan amendment (SPA) activities. The purpose of one component of MRT, the Delivery System Reform Incentive Payment (DSRIP) program, is to provide incentives for Medicaid providers to create and sustain an integrated, high performing health care delivery system that can effectively and efficiently meet the needs of Medicaid beneficiaries and low income uninsured individuals in their local communities by improving care, improving health and reducing costs. Up to $6.42 billion of the new MRT funding is available for DSRIP payments to providers. An additional $500 million in temporary, time limited, funding is available from an Interim Access Assurance Fund (IAAF) for payments to providers to protect against degradation of current access to key health care services in the near term. And, up to $1.08 billion in federal funding for non-DSRIP Medicaid Redesign purposes, with specific uses of that funding still to be discussed and finalized.

Only initial funding of this structure is authorized in 2014; continued authority for operations and funding must be authorized upon renewal of the overall Partnership Plan demonstration, and is contingent on satisfactory initial implementation.

The DSRIP program is focused on the following goals: (1) safety net system transformation at both the system and state level; (2) accountability for reducing avoidable hospital use and

improvements in other health and public health measures at both the system and state level; and (3) efforts to ensure sustainability of delivery system transformation through leveraging managed care payment reform.

i. Safety Net System Transformation. The DSRIP funds provider incentive payments to reward safety net providers when they undertake projects designed to transform the systems of care that support Medicaid beneficiaries and low income uninsured by addressing three key elements, which must be reflected in all DSRIP projects proposed by safety net providers participating in DSRIP (referred to as "Performing Provider Systems"). DSRIP projects will be designed to meet and be responsive to community needs while ensuring overall transformation objectives are met. As such, all projects must include the following elements, whose core components and associated outcome measures are further described in the DSRIP Strategies Menu and Metrics (Attachment J):

A. Element 1: Appropriate Infrastructure. The DSRIP will further the evolution of infrastructure and care processes to meet the needs of their communities in a more appropriate, effective and responsive fashion to meet key functional goals. This will include changes in the workforce. Infrastructure evolution must support the broader goals of DSRIP, and key outcomes reflect the kinds of infrastructure to be supported under DSRIP. Appropriate infrastructure should ensure access to care, particularly to outpatient resources as well as effective care integration. In support of linking settings, the transforming infrastructure should place more emphasis on outpatient settings. Also, critical services such as care coordination may need to be expanded to meet the broad needs of the population served.

Indicators related to this objective are included in the System Transformation Milestones (Domain 2) described in more detail in DSRIP Strategies Menu and Metrics (Attachment J). Because many of these indicators are difficult to benchmark, the state will be accountable for ensuring that these indicators are moving overall in the right directions across all systems as part of the statewide accountability described in STC 14 (f) of this section.

B. Element 2: Integration across settings. The DSRIP will further the transformation of patient care systems to create strong links between different settings in which care is provided, including inpatient and outpatient settings, institutional and community based settings, and importantly behavioral and physical health providers. The goal will be to coordinate and provide care for patients across the spectrum of settings in order to promote health and better outcomes, particularly for populations at risk, while also managing total cost of care. The DSRIP will fund projects that include new and expanded care coordination programs, other evidence based, data driven interventions and programs focused on key health and cost drivers and opportunities for providers to share information and learn from each other.

Key outcomes to be measured are expected to reflect this ongoing transformation.

Integration across settings will create alignments between providers. The DSRIP will include restructuring payments to better reward providers for improved outcomes and lower costs.

Indicators related to this objective are included in the Clinical Improvement Milestones (Domain 3) described in more detail in DSRIP Strategies Menu and Metrics (Attachment J). Each system will be accountable for these indicators, and in addition, because the state should also work to support this goal, the state will also be accountable for statewide performance on these outcomes as described in STC 14(g) of this section.

C. **Element 3: Assuming responsibility for a defined population.** The DSRIP projects will be designed in ways that promote integrated systems assuming responsibility for the overall health needs of a population of Medicaid beneficiaries and low income uninsured people, not simply responding to the patients that arrive at the doors of a hospital. The state will approve a defined population for each DSRIP project based on geographic and member service loyalty factors, as described in DSRIP Program Funding and Mechanics Protocol (Attachment I). Safety net providers may propose to develop integrated systems that target the individuals served by a set of aligned community-based providers, or more ambitious systems to tackle accountability for an entire geographic population. Patient and beneficiary engagement through tools including community needs assessment and responsiveness to public health needs will be an important element of all DSRIP projects.

Each indicator used to determine DSRIP awards should reflect a population, rather than the patients enrolled in a particular intervention. In addition, DSRIP performing provider systems will be required to report on progress on priorities related to the Prevention Agenda as included in the Population-wide Strategy Implementation Milestones (Domain 4) described in more detail in DSRIP Strategies Menu and Metrics (Attachment J).

D. **Element 4: Procedures to reduce avoidable hospital use: guidepost for statewide reform.** New York has identified a statewide goal of reducing avoidable hospital use and improving outcomes in other key health and public health measures. Effectively reducing avoidable hospital use requires alignment of outpatient and inpatient settings, requires systems that can take responsibility for a population, and requires investments in key infrastructure--and so this is a guidepost that can ensure that these transformations are aligned with our shared goals of better health, and better care at lower cost.

Consistent with the fact that this is an integral guidepost to system transformation, key improvement outcomes for avoidable hospital use and improvements in other health and public health measures will be included for each project, and the state will be held accountable for these measures as part of the statewide accountability described in STC 14 (f) of this section.

E. Element 5: State managed care contracting reforms to establish and promote DSRIP objectives. The state must also ensure that its managed care payment systems recognize, encourage and reward positive system transformation. To fully accomplish DSRIP goals and ensure sustainability of the initiatives supported by this demonstration, as a condition of receiving DSRIP project funding, the state shall develop and execute payment arrangements and accountability mechanisms with its managed care contractors. These payment and accountability changes, described further in STC 39 of this section, must be reflected in the state's approved state plan and managed care contracts, and are funded through the approved state plan (without separate DSRIP funding). These changes are a condition for overall DSRIP project funding to be released.

This goal will also be monitored as part of the statewide accountability test described in STC 14(f) of this section and will be tracked not at a DSRIP project level, but at the state level. The state must ensure state payments to managed care plans reflect and promote the establishment and continuation of integrated service delivery systems and procedures to reduce avoidable hospital use and ensure improvements in other health and public health measures.

ii. State and Provider Accountability. Overall DSRIP project funding is available up to the amounts specified in the special terms and conditions. Such funding is subject to the Performing Provider System meeting ongoing milestones established pursuant to this demonstration, and the state meeting overall state milestones as described in the STCs and DSRIP Program Funding and Mechanics Protocol (Attachment I). In addition, statewide achievement of performance goals and targets must be achieved and maintained for full access to the funding level as specified in the STCs. Specific reductions from statewide funds are taken from the state starting in Year 3 accordance with STC 14 (h) of this section if these targets are not achieved.

Individual projects are awarded based on the merit of the proposal itself, its support of the overall DSRIP goals, and the projected breadth and depth of the impact on Medicaid beneficiaries. Public transparency, a process that allows for community input, and independent expert evaluation are critical to the approval and funding levels for each project.

It should be noted that federal funding for DSRIP activities is limited in any phase of the demonstration period to the amounts set forth in this demonstration authority, subject to all of the reductions based on milestones, even if the state expenditures exceed the amount for which federal funding is available.

b. Interim Access Assurance Fund (IAAF). Temporary, time limited, funding is available from an IAAF to protect against degradation of current access to key health care services in the near term. The IAAF is available to provide supplemental payments that exceed upper payment limits, DSH limitations, or state plan payments, to ensure that current trusted and viable Medicaid safety net providers, according to criteria established by the

state consistent with these STCs, can fully participate in the DSRIP, transformation without unproductive disruption. The IAAF is authorized as a separate funding structure from the DSRIP program to support the ultimate achievement of DSRIP goals. To the extent available funds are not expended in this time-limited IAAF, they are available for the DSRIP program itself. In addition, a separate fund is authorized to make DSRIP project design grants to providers. The IAAF and the design grant funds are both part of the overall DSRIP total funding.

i. Interim Access Assurance Fund. To protect against degradation of current access to key health care services, limit unproductive disruption, and avoid gaps in the health delivery system, New York is authorized to make payments for the financial support of selected Medicaid providers.

A. Limit on FFP. New York may expend up to $500 million in FFP for Interim Access Assurance payments for the period from the date of approval of the IAAF expenditure authority until December 31, 2014. Contingent upon renewal of the demonstration, the authority could be extended until March 31, 2015. To the extent available funds are not expended in this time-limited IAAF, they are available for the DSRIP program itself.

B. Funding. The non-federal share of IAAF payments may be funded by state general revenue funds and transfers from units of local government that are compliant with section 1903(w) of the Act. Any IAAF payments must remain with the provider receiving the payment to be used for health care related purposes, and may not be transferred back to any unit of government, directly or indirectly, or redirected for other purposes. The IAAF payments received by providers cannot be used for the non-federal share of any expenditures claimed under a federally-supported grant.

ii. Interim Access Assurance Fund Requirements.

A. The state will make all decisions regarding the distribution of IAAF payments to ensure that sufficient numbers and types of providers are available to Medicaid beneficiaries in the geographic area to provide access to care for Medicaid and uninsured individuals while the state embarks on its transformation path. The IAAF payments shall be limited to providers that serve significant numbers of Medicaid individuals, and that the state determines have financial hardship in the form of financial losses or low margins. In determining the qualifications of a safety net provider for this program and the level of funding to be made available, the state will take into consideration both whether the funding is necessary (based on current financial and other information on community need and services) to provide access to Medicaid and uninsured individuals. The state will also seek to ensure that IAAF payments supplement but do not replace other funding sources.

B. Before issuing any payments to providers, the state must post on its Website a list of qualifications that providers must meet to receive payments under this section,

provide an opportunity for public comment for at least 14 days, and consider such comments. On the day the proposed qualifications list is posted, the state must provide to CMS the URL where the list can be found. The state must take the public comments into account when qualifying providers and distributing funds from this account.

C. Following the end of the public comment period in (ii), the state will initiate an open application period of at least 14 days duration for providers to submit applications.

D. If a provider otherwise meeting the qualifications of this section is also receiving funds through the state's vital access program, or any other supplemental payment program for which the federal government provides matching funds, or Medicaid disproportionate share hospital payments, the state must assure CMS of non-duplication. As part of the reporting requirements described in (iii) below, the state assures that the payment information for the IAAF will be maintained, as the reporting information is subject to CMS audit. A provider may receive both funding through this special fund and a planning grant as part of the DSRIP program.

iii. Reporting.

A. Within 10 days of initiating payments under this section to a provider, the state must submit a report to CMS that states the total amount of the payment or payments, the amount of FFP that the state will claim, the source of the non-Federal share of the payments, and documentation of the needs and purposes of the funds to assure CMS of non-duplication. The state should document all other Medicaid payments (e.g. base, supplemental, VAP, DSH) the provider receives to demonstrate that existing payments are not sufficient to meet financial needs of the providers.

B. In each quarterly progress report, the state will include a summary of all payments under this section made during the preceding quarter, including all information required in (A), and attach copies all reports submitted under (A) for payments made during the quarter.

C. When reporting payments under this section on the CMS-64, the state must include in Form CMS-64 Narrative a table that lists all payments by date, provider, and amount (broken down by source), and a reference to the quarterly progress report(s) where the payments and all of their required supporting documentation is presented.

iv. IAAF payments. The IAAF payments are not direct reimbursement for expenditures or payments for services. Payments from the IAAF are not considered patient care revenue, and shall not be offset against disproportionate share hospital expenditures or other Medicaid expenditures that are related to the cost of patient care (including

stepped down costs of administration of such care) as defined under these STCs, and/or under the state plan.

c. Delivery System Reform Incentive Payment (DSRIP) Fund. The terms and conditions in Section c apply to the State's exercise of Expenditure Authority 9: Expenditures Related to the Delivery System Reform Incentive Payment (DSRIP) Fund. These requirements are further elaborated by Attachment I, "NY DSRIP Program Funding and Mechanics Protocol," Attachment J "NY DSRIP Strategies Menu and Metrics," and Attachment K "DSRIP Operational Protocol." For purposes of this section, the DSRIP program will have its own demonstration years (DY) and any reference to DY is in reference to the DSRIP portion of the Partnership Plan demonstration and not the entire Partnership Plan demonstration. DSRIP funding for demonstration year DY 1 through DY 5 is contingent on renewal of the demonstration no later than December 31, 2014 and the revision of Attachments I, J and K based on the pre-implementation activities described in this section.

As described further below, DSRIP funding is available to *Performing Provider Systems* that consist of *safety net providers* whose *project plans* are approved and funded through the process described in these STCs and who meet particular *milestones* described in their approved DSRIP *project plans*. DSRIP project plans are based on the evidenced-based *projects* specified in the DSRIP Strategies Menu and Metrics (Attachment J) and are further developed by Performing Provider Systems to be directly responsive to the needs and characteristics of the low-income communities that they serve and to achieve the transformation objectives furthered by this demonstration.

2. Safety Net Definition: The definition of safety net provider for hospitals will be based on the environment in which the performing provider system operates. Below is the safety net definition:

a. A hospital must meet the following criteria to participate in a performing provider system:

i. Must be either a public hospital, Critical Access Hospital or Sole Community Hospital, or

ii. Must pass two tests:
A. At least 35 percent of all patient volume in their outpatient lines of business must be associated with Medicaid, uninsured and Dual Eligible individuals.
B. At least 30 percent of inpatient treatment must be associated with Medicaid, uninsured and Dual Eligible individuals; or

iii. Must serve at least 30 percent of all Medicaid, uninsured and Dual Eligible members in the proposed county or multi-county community. The state will use Medicaid claims and encounter data as well as other sources to verify this claim. The state reserves the right to increase this percentage on a case by case basis so as to ensure that the needs of each community's Medicaid members are met.

b. Non-hospital based providers, not participating as part of a state-designated health home, must have at least 35 percent of all patient volume in their primary lines of business and must be associated with Medicaid, uninsured and Dual Eligible individuals.

c. Vital Access Provider Exception: The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval. Three allowed reasons for granting an exception are:

i. A community will not be served without granting the exception because no other eligible provider is willing or capable of serving the community.

ii. Any hospital is uniquely qualified to serve based on services provided, financial viability, relationships within the community, and/or clear track record of success in reducing avoidable hospital use.

iii. Any state-designated health home or group of health homes.

d. Non-qualifying providers can participate in Performing Providers Systems. However, non-qualifying providers are eligible to receive DSRIP payments totaling no more than 5 percent of a project's total valuation. CMS can approve payments above this amount if it is deemed in the best interest of Medicaid members attributed to the Performing Provider System.

3. **Performing Provider Systems.** The safety net providers that are funded to participate in a DSRIP project are called "Performing Provider Systems." Performing Provider Systems that complete project milestones and measures as specified in Attachment J, "DSRIP Strategies Menu and Metrics", are the only entities that are eligible to receive DSRIP incentive payments.

4. **Two DSRIP Pools**. Performing Provider Systems will be able to apply for funding from one of two DSRIP pools: Public Hospital Transformation Fund and Safety Net Performance Provider System Transformation Fund.

a. The Public Hospital Transformation Fund will be open to applicants led by a major public hospital system. The public hospital systems allowed to participate in this pool include:

i. Health and Hospitals Corporation of New York City
ii. State University of New York Medical Centers
iii. Nassau University Medical Center
iv. Westchester County Medical Center
v. Erie County Medical Center

b. The Safety Net Performance Provider System Transformation Fund would be available to all other DSRIP eligible providers.

c. Allocation of funds between the two pools will be determined after applications have been submitted, based on the valuation of applications submitted to each pool. The valuation framework is described in STC 9 of this section and will be further specified in the Program Funding and Mechanics Protocol.

d. There is also a Performance Pool within the two DSRIP pools, as described in the Program Funding and Mechanics Protocol (Attachment I).

5. **Coalitions and Attributed Population**. Major public general hospitals and other safety net providers are strongly required to form coalitions that apply collectively as a single Performing Provider System. Coalitions will be evaluated on performance on DSRIP milestones collectively as a single Performing Provider System. Coalitions are subject to the following conditions in addition to the requirements specified in the Program Funding and Mechanics Protocol:

   a. Coalitions must designate a lead coalition provider who will be held responsible under the DSRIP for ensuring that the coalition meets all requirements of Performing Provider Systems, including reporting to the state and CMS.

   b. Coalitions must establish a clear business relationship between the component providers, including a joint budget and funding distribution plan that specifies in advance the methodology for distributing funding to participating providers. The funding distribution plan must comply with all applicable laws and regulations, including, but not limited to, the following federal fraud and abuse authorities: the anti-kickback statute (sections 1128B(b)(1) and (2) of the Act); the physician self-referral prohibition (section 1903(s) of the Act); the gainsharing civil monetary penalty (CMP) provisions (sections 1128A(b)(1) and (2) of the Act); and the beneficiary inducement CMP (section 1128A(a)(5) of the Act). CMS approval of a DSRIP plan does not alter the responsibility of Performing Provider Systems to comply with all federal fraud and abuse requirements of the Medicaid program.

   c. Each Performing Providers System must, in the aggregate, identify a proposed population for DSRIP. The proposed population will be aligned with the population attribution methodology specified in the Program Funding and Mechanics Protocol. The attribution methodology will assure non-duplication of members between DSRIP Performing Providers Systems.

   d. Each coalition must have a data agreement in place to share and manage data on system-wide performance.

6. **Objectives**. Performing Provider Systems will design and implement projects that aim to achieve each of the following objectives or sub-parts of objectives, which are elaborated further in the DSRIP Strategies Menu and Metrics (Attachment J). To put in the context of

the overall three objectives below, each performing provider system is responsible for project activity that addresses the first two objectives, for a defined population as specified in the third objective.

a. The creation of appropriate infrastructure and care processes based on community need, in order to promote efficiency of operations and support prevention and early intervention.

b. The integration of settings through the cooperation of inpatient and outpatient, institutional and community based providers, in coordinating and providing care for patients across the spectrum of settings in order to promote health and better outcomes, particularly for populations at risk, while managing total cost of care.

c. Population health management as described in the attribution section of the Program Funding and Mechanics Protocol.

7. **Project Milestones.** Progress towards achieving the goals specified above will be assessed by specific milestones for each project, which are measured by particular metrics that are further defined in the DSRIP Strategies Menu and Metrics (Attachment J). These milestones are organized into the following domains:

a. *Project progress milestones (Domain 1).* Investments in technology, tools, and human resources that will strengthen the ability of the Performing Provider Systems to serve target populations and pursue DSRIP project goals. Performance in this domain is measured by a common set of project progress milestones, which will include milestones related to the monitoring of project spending and post-DSRIP sustainability. This includes at least semi-annual reports on project progress specific to the performing provider system's DSRIP project and its Medicaid and uninsured patient population.

b. *System transformation milestones (Domain 2).* As described further in the Project Menu, this includes outcomes that reflect the four subparts of the goal on system transformation, including measures of inpatient/ outpatient balance, increased primary care/community-based services utilization, and rates of global capitation, partial capitation and bundled payment of providers by Medicaid managed care plans, and measures for patient engagement.

c. *Clinical improvement milestones (Domain 3):* As described further in the Project Menu, this domain includes metrics that reflect improved quality of care for Medicaid beneficiaries; including the goal of reducing avoidable hospital use and improvements in other health and public health measures. Payment for performance on these outcome milestones will be based on an objective demonstration of improvement over a baseline, using a valid, standardized method. Systems that are already high performers on these metrics, with the exception of avoidable hospitalization metrics, before initiation of projects must either explore alternative projects or align with lower performing providers such that the system as a whole has adequate room for improvement (as defined in DSRIP Program Funding and Mechanics Protocol (Attachment I).

d. *Population-wide Strategy Implementation Milestones (Domain 4).* DSRIP Performing Provider Systems will be responsible for reporting on progress on strategies they have chosen related to the Prevention Agenda as identified in DSRIP Strategies Menu and Metrics (Attachment J) for relevant populations as identified in DSRIP Program Funding and Mechanics Protocol (Attachment I) and as approved in their project plan.

8. DSRIP Project Plan Performing Provider Systems must develop a DSRIP project plan that is based on one or more of the projects specified in the DSRIP Strategies Menu and Metrics (Attachment J) and complies with all requirements specified in the DSRIP Program Funding and Mechanics Protocol. Performing Provider Systems should develop DSRIP project plans, while leveraging community needs, including allowing community engagement during planning, to sufficiently address the delivery system transformation achievement that is expected from their projects. DSRIP project plans will be provided in a structured format developed by the state and approved by CMS and must be tracked by the state over the duration and close out of the program. DSRIP project plans must be approved by the state and may be subject to additional review by CMS, DSRIP project plans must include the following elements:

a. *Rationale for Project Selection.*

i. Each DSRIP project plan must identify the target populations, program(s), and specific milestones for the proposed project, which must be chosen from the options described in the approved DSRIP Strategies Menu and Metrics.

ii. Goals of the project plan should be aligned with each of the objectives as described in STC 6 of this section.

iii. Milestones should be organized as described above in STC 7 of this section reflecting the three overall goals and subparts for each goal as necessary.

iv. The project plan must describe the need being addressed and the starting point (including baseline data consistent with the agreement between CMS and the state) of the performing provider system related to the project. The starting point of the project plan must be after April 1, 2015.

v. Based on the starting point the performing provider system must describe its 5-year expected outcome for each of the domains described in STC 7 of this section. Supporting evidence for the potential for the interventions to achieve these changes should be provided in support of this 5 year projection for achievement in the goals of this DSRIP.

vi. The DSRIP Project Plan shall include a description of the processes used by the Performing Provider System to engage and reach out to stakeholders, including a plan for ongoing engagement with the public, based on the process described in the Operational Protocol (Attachment K).

vii. Performing Provider Systems must demonstrate how the project will transform the delivery system for the target population and do so in a manner that is aligned with the central goals of DSRIP, and in a manner that will be sustainable after DY5. The projects must implement new, or significantly enhance existing health care initiatives; to this end, providers must identify the CMS and HHS funded delivery system reform initiatives in which they currently participate or in which they have participated in the previous five years, and explain how their proposed DSRIP activities are not duplicative of activities that are already or have recently been funded.

viii. The plan must include an approach to rapid cycle evaluation that informs the system in a timely fashion of its progress, how that information will be consumed by the system to drive transformation and who will be accountable for results, including the organizational structure and process to oversee and manage this process. The plan must also indicate how it will tie into the state's requirement to report to CMS on a rapid cycle basis.

ix. The plan must contain a comprehensive workforce strategy. This strategy will identify all workforce implications – including employment levels, wages and benefits, and distribution of skills – and present a plan for how workers will be trained and deployed to meet patient needs in the new delivery system. Applicants will need to include workers and their representatives in the planning and implementation of their workforce strategy.

b. *Description of Project Activities.*

i. Each project must feature strategies from all domains described in STC 7 of this section and the DSRIP Strategies Menu and Metrics.

ii. For each domain of a project, there must be at least one associated outcome metric that must be reported in all years, years 1 through 5. The initially submitted DSRIP project plan must include baseline data on all measures, should demonstrate the ability to provide valid data and provide benchmarks for each measure. Baseline measurements should be based on the most recently available baseline data, as agreed to by CMS and the state.

c. *Justification of Project Funding.*

i. The DSRIP project plan shall include a detailed project specific budget as provided for in DSRIP Program Funding and Mechanics Protocol (Attachment I) and a description of the performing provider system or provider coalition's overall approach to valuing the project. Project valuations will be subject to a standardized analysis by the state as described below and further specified in the Program Funding and Mechanics Protocol.

ii. DSRIP project plans shall include any information necessary to describe and detail

mechanisms for the state to properly receive intergovernmental transfer payments (as applicable and further described in the program funding and mechanics protocol).

9. Project Valuation. DSRIP payments are earned for meeting the performance milestones (as specified in each approved DSRIP project plan). The value of funding for each milestone and for DSRIP projects overall should be proportionate to and its potential benefit to the health and health care of Medicaid beneficiaries and low income uninsured individuals, as further explained in the Program Funding and Mechanics Protocol (Attachment I).

a. *Maximum project valuation*. As described further in the Program Funding and Mechanics Protocol, a maximum valuation for each project on the project menu shall be calculated based on the following valuation components as specified in the Program Funding and Mechanics Protocol (Attachment I).

i. Index score of transformation potential. The state will use a standardized index to score each project on the project menu, based on its anticipated delivery system transformation. This index will include factors of anticipated transformation, such as potential for achieving the goals of DSRIP outlined in STC 6 of this section, expected cost savings, potential to reduce preventable events, capacity of the project to directly affect Medicaid and uninsured beneficiaries and robustness of evidence base. The index scoring process is described in the DSRIP Program and Funding and Mechanics Protocol and will be available for public comment in accordance with STC 10 of this section.

ii. Valuation benchmark. The project index score will be multiplied by a valuation benchmark in combination with the components below for all DSRIP projects in order to determine the maximum valuation for the project, as specified in the Program Funding and Mechanics Protocol (Attachment I). The valuation benchmark should be externally justified based on evidence for the value and scope of similar system transformations and delivery system reforms, and may not be based on the total statewide limit on DSRIP funding described in STC 14 of this section. By no later than 15 days after the public comment period for initial DSRIP applications, the state will establish a state-wide valuation benchmark based on its assessment of the cost of similar delivery reforms. This value will be expressed in a per member per month (PMPM) format and may not exceed $15 PMPM, calculated multiplying paragraphs (iii)(B) and (C) below.

iii. DSRIP Project Plan Application Score. Based on the Performing Provider System's application, each project plan will receive a score based on the following:

A. The fidelity to the project description, and likelihood of achieving improvement by using that project.
B. Number of beneficiaries attributed to each performing provider's project plan.
C. Number of DSRIP months that will be paid for under the DSRIP project plan.

b. *Progress milestones and outcome milestones.* A DSRIP project's total valuation will be distributed across the milestones described in the DSRIP project plan, according to the specifications described in the Program Funding and Mechanics Protocol (Attachment I). An increasing proportion of DSRIP funding will be allocated to performance on outcome milestones each year, as described in DSRIP Program Funding and Mechanics Protocol (Attachment I).

c. *Performance based payments*. Performing Provider Systems may not receive payment for metrics achieved prior to the baseline period set by CMS and the State in accordance with these STCs and the funding and mechanics protocol and achievement of all milestones is subject to audit by CMS, the state, and the state's independent assessor described in STC 10 of this section. The state shall also monitor and report proper execution of project valuations and funds distribution as part of the implementation monitoring reporting required under STC 12 of this section. In addition to meeting performance milestones, the state and performing providers must comply with the financial and reporting requirements for DSRIP payments specified in STC 13 of this section and any additional requirements specified in the Program Funding and Mechanics Protocol (Attachment I).

10. Pre-implementation activities. In order to authorize DSRIP funding for DY 1 to 5, the state must meet the following implementation milestones according to the timeline outlined in these STCs and must successfully renew the demonstration according to the process outlined in STC 8 in Section III. Failure to complete these requirements will result in a state penalty, as described in paragraph (vi) below.

a. *Project Design Grants*. During calendar year 2014, the state may provide allotted amounts to providers for DSRIP Design Grants from a designated Design Grant Fund. These grants will enable providers to develop specific and comprehensive DSRIP Project Plans. New York may expend up to $100 million in FFP for the grant payments from the Design Grant Fund. Unspent funds will be carried over to DSRIP. DSRIP Project Design Grant payments count against the total amounts allowed for DSRIP under the demonstration.

i. Submitting a proposal for a DSRIP Project Design Grant. Providers and coalitions must submit a DSRIP design proposal as an application for a design. The state will review proposals and award design grants at any time during the pre-implementation activities.

ii. Use of Design Grant Funds. The providers and coalitions that receive DSRIP project design grants must use their grant funds to prepare a DSRIP project plan to prepare the provider's application for a DSRIP award. Providers and coalitions that receive DSRIP project design grants must submit a DSRIP application.

b. *Public comment period.* The state must engage the public and all affected stakeholders (including community stakeholders, Medicaid beneficiaries, physician groups, hospitals, and health plans) by publishing the development of the DSRIP Program Funding and

Mechanics Protocol and DSRIP Strategies Menu and Metrics (Attachments I and J), including all relevant background material, and providing a public comment period that will be no less than 30 days that includes submission of comments through electronic means as well as public meetings across the State.

c. *Allowable changes to DSRIP protocols.* The state must post the public comments received and any technical modifications the state makes to the DSRIP Program Funding and Mechanics Protocol and DSRIP Strategies Menu and Metrics (Attachments I and J). Only changes to the protocol and menu that are related to the public comments will be allowed and incorporated into final protocols for DY 1 to DY 5. The state will submit the final protocols and menu and CMS will review and take action on the changes (ie. approve, deny or request further information or modification) no later than 30 days after the state's submission.

d. *Baseline data on DSRIP measures.* The state must use existing data accumulated prior to implementation to identify performance goals for performing providers. The state must identify high performance levels for all anticipated measures in order to ensure that providers select projects that can have the most meaningful impact on the Medicaid population, and may not select projects for which they are already high performers, with the exception of projects specifically focused on avoidable hospitalization.

e. *Procurement of entities to assist in the administration and evaluation of DSRIP*. The state will identify independent entities with expertise in delivery system improvement, including an independent assessor, an independent evaluator and any other an administrative costs. The independent entities will work in cooperation with one another to do the following:

i. Independent Assessor: Conduct a transparent review of all proposed DSRIP project plans and make project approval recommendations to the state.

ii. Independent Evaluator: Assist with the continuous quality improvement activities.

iii. Administrative Costs: Administrative costs the state incurs associated with the management of DSRIP reports and other data.

A. The state must describe the functions of each independent entity and their relationship with the state as part of its Operational Protocol (Attachment K)

B. The state may elect to require IGTs to be used to fund the non-federal share of the administrative activities, as permitted under the state plan.

C. Spending on the independent entities and other administrative cost associated within the DSRIP fund is classified as a state administrative activity of operating the state plan as affected by this demonstration. The state must ensure that all administrative costs for the independent entities are proper and efficient for the administration of the DSRIP Fund.

f. *Submit evaluation plan*. The state must submit an evaluation plan for DSRIP consistent

with the requirements of STC 19 of this section no later than 120 days after award of the DSRIP program and must identify an independent evaluator. The evaluation plan, including the budget and adequacy of approach to meet the scale and rigor of the requirements of STC 21 of this section, is subject to CMS approval.

g. *Update comprehensive quality strategy*. The state must update its comprehensive quality strategy, defined in Section VI, to ensure the investment in DSRIP programs will complement and be supported by the state's managed care quality activities and other quality improvements in the state, including the state's Medicaid Redesign Team and Health Homes initiatives.

h. *DSRIP Operational Protocol.* The state shall submit for CMS approval a draft operational protocol for approving, overseeing, and evaluating DSRIP project grants no later than 90 days after the award of the Demonstration. The protocol is subject to CMS approval. The State shall provide the final protocol within 30 days of receipt of CMS comments. If CMS finds that the final protocol adequately accommodates its comments, then CMS will approve the final protocol within 30 days. This protocol will become an appendix to Attachment K of these STCs.

i. The Operational Protocol, including required baseline and ongoing data reporting, independent assessor protocols, performing provider requirements, and monitoring/evaluation criteria shall align with the CMS approved evaluation design and the monitoring requirements in STC 34 of this section.

ii. The state shall make the necessary arrangements to assure that the data needed from the Performing Provider Systems, and data needed from other sources, are available as required by the CMS approved monitoring protocol.

iii. The Operational Protocol and reports shall be posted on the state Medicaid website within 30 days of CMS approval.

i. *CMS Oversight of Pre-implementation Activities*. CMS reserves the right to provide oversight over the state's pre-implementation activities in order to document late submissions and missed deliverables without notice of a delay from the state. Notice of delay from of any deliverable must be received by CMS no less than 10 days before the due date of the deliverable. As part of CMS' review of the state's deliverables, CMS will assess completeness based on listed deliverable requirements in the STCs.

11. DSRIP proposal and project plan review. In accordance with the schedule outlined in these STCs and the process described further in the Program Funding and Mechanics Protocol (Attachment I), the state and the assigned independent assessor must review and approve DSRIP project plans in order to authorize DSRIP funding for DY 1, DY 2, and DY 3 and must conduct ongoing reviews of DSRIP project plans as part of a mid-point assessment in order to authorize DSRIP funding for DY 4 and DY 5. The state is responsible for conducting these reviews for compliance with approved protocols. CMS reserves the right to review projects in which the state did not accept the finding of the independent assessor or

other outlier projects, as specified in the Program Funding and Mechanics Protocol (Attachment I).

a. *Review tool.* The state will develop a standardized review tool that the independent assessor will use to review DSRIP project plans and ensure compliance with these STCs and associated protocols. The review tool will be available for public comment for a 30 day period according to the timeframe specified in the Program Funding and Mechanics Protocol (Attachment I). The review tool will define the relevant factors, assign weights to each factor, and include a scoring for each factor. Each factor will address the anticipated impact of the project on the Medicaid and uninsured populations consistent with the overall purpose of the DSRIP program.

b. *Role of the Independent assessor*. An independent assessor will review project proposals using the state's review tool and consider anticipated project performance. The independent assessor shall make recommendations to the state regarding approvals, denials or recommended changes to project plans to make them approvable. This entity (or another entity identified by the state) will also assist with the mid-point assessment and any other ongoing reviews of DSRIP project plan.

c. *Public comment.* Project proposals will be public documents and subject to public comment. The public will have no less than30 days from the date of project posting to submit comments for specific project proposals, according to the process described in the Operational Protocol (Attachment K). After the comment period for the projects closes, a method for which the public can continue to comment must remain available, to obtain feedback on the ongoing implementation of the projects. The state must periodically compile comments received over the life of the demonstration and ensure that responses to comments are provided and released for public view.

d. *Mid-point assessment.* During DY 3, the state's independent assessor shall assess project performance to determine whether DSRIP project plans merit continued funding and provide recommendations to the state. If the state decides to discontinue specific projects, the project funds may be made available for expanding successful project plans in DY 4 and DY 5, as described in the Program Funding and Mechanics Protocol (Attachment I).

12. Monitoring. With the assistance of the independent assessor, the state will be actively involved in ongoing monitoring of DSRIP projects, including but not limited to the following activities.

a. *Review of milestone achievement.* At least two times per year, Performing Provider Systems seeking payment under the DSRIP program shall submit reports to the state demonstrating progress on each of their projects as measured by project-specific milestones and metrics achieved during the reporting period. The reports shall be submitted using the standardized reporting form approved by the state and CMS. Based on the reports, the state will calculate the incentive payments for the progress achieved according to the approved DSRIP project plan. The Performing Provider System shall

have available for review by New York or CMS, upon request, all supporting data and back-up documentation. These reports will serve as the basis for authorizing incentive payments to Performing Provider Systems for achievement of DSRIP milestones.

b. *Quarterly DSRIP Operational Protocol Report.* The state shall provide quarterly updates to CMS and the public on the operation of the DSRIP program. The reports shall provide sufficient information for CMS to understand implementation progress of the demonstration and whether there has been progress toward the goals of the demonstration. The reports will document key operational and other challenges, to what they attribute the challenges and how the challenges are being addressed, as well as key achievements and to what conditions and efforts they attribute the successes.

c. *Learning collaboratives*. With funding available through this demonstration, the state will support regular learning collaboratives regionally and at the state level, which will be a required activity for all Performing Provider Systems, and may be organized either geographically, by the goals of the DSRIP, or by the specific DSRIP projects as described in the DSRIP Strategies Menu and Metrics (Attachment J). Learning collaboratives are forums for Performing Provider Systems to share best practices and get assistance with implementing their DSRIP projects. Learning collaboratives should primarily be focused on learning (through exchange of ideas at the front lines) rather than teaching (i.e. large conferences), but the state should organize at least one face-to-face statewide collaborative meeting a year. Learning collaboratives should be supported by a web site to help providers share ideas and simple data over time (which should not need to be developed from scratch). In addition, the collaboratives should be supported by individuals (regional "innovator agents") with training in quality improvement who can travel from site to site in the network to rapidly answer practical questions about implementation and harvest good ideas and practices that they systematically spread to others.

d. *Rapid cycle evaluation.* In addition to the comprehensive evaluation of DSRIP described in STC 22 of this section, the state will be responsible for compiling data on DSRIP performance after each milestone reporting period and summarizing DSRIP performance to-date for CMS in its quarterly reports. Summaries of DSRIP performance must also be made available to the public on the state's website along with a mechanism for the public to provide comments.

e. *Additional progress milestones for at risk projects.* Based on the information contained in the Performing Provider System's semiannual report or other monitoring and evaluation information collected, the state or CMS may identify particular projects as being "at risk" of not successfully completing its DSRIP project in a manner that will result in meaningful delivery system transformation. The state or CMS may require these projects to meet additional progress milestones in order to receive DSRIP funding in a subsequent semi-annual reporting period. Projects that remain "at risk" are likely to be discontinued at the midpoint assessment, described in STC 11 of this section.

f. *Annual discussion and site visits*. In addition to regular monitoring calls, the State shall

on an annual basis present to and participate in a discussion with CMS on implementation progress of the demonstration including progress toward the goals, and key challenges, achievements and lessons learned. The state, the independent assessor, and CMS will conduct annual site visits of a subset of Performing Providers to ensure continued compliance with DSRIP requirements.

g. *Application, review, oversight, and monitoring database*. The state will ensure that there is a well maintained and structured database, containing as data elements all parts and aspects of Performing Provider Systems' DSRIP project plans including the elements discussed in paragraph 8; independent assessor, state, and CMS review comments and scores; project planning, process, improvement, outcome, and population health milestones, with indicators of their required timing, incentive payment valuation, and whether or not they were achieved; and any other data elements required for the oversight of DSRIP. Along with the database, the state will develop software applications that will support:

i. Electronic submission of project plans by Performing Provider Systems;

ii. Public comment on project plans;

iii. Review of project plans by the independent assessor, state, and other independent participants in project plan review and scoring;

iv. Electronic submission by Performing Provider Systems of their performance data;

v. Generation of reports, containing (at a minimum) the elements in STC 36 of this section, that can be submitted to CMS to document and support amounts claimed for DSRIP payments on the CMS-64;

vi. Summaries of DSRIP project plans submissions, scoring, approval/denial, milestone achievement, and payments that can be accessed by the public;

vii. Database queries, and export all or a portion of the data to Excel, SAS, or other software platforms; and

viii. On-line access rights for CMS.

13. Financial Requirements applying to DSRIP payments generally.

a. The non-Federal share of Fund payments to providers may be funded by state general revenue funds, and transfers from units of local government consistent with federal law. Any DSRIP payment must remain with the provider specified in the DSRIP project plan, and may not be transferred back to any unit of government, including public hospitals, either directly or indirectly. In the case of coalitions that are performing DSRIP projects collectively, the DSRIP funding will flow to the participating providers and/or the coalition coordinating entity according to the methodology specified in the DSRIP

project plan but may not be transferred between coalition providers.

b. The state must inform CMS of the funding of all DSRIP payments to providers through a quarterly payment report to be submitted to CMS within 60 days after the end of each quarter, as required under STC 36 of this section. This report must identify the funding sources associated with each type of payment received by each provider. This report must identify and fully disclose all the underlying primary and secondary funding sources of the non-Federal share (including health care related taxes, intergovernmental transfers, general revenue appropriations, and any other mechanism) for each type of payment received by each provider.

c. The state will ensure that any lack of adequate funds from local sources will not result in lowering the amount, duration, scope or quality of Medicaid services available under the state plan or this demonstration. The preceding sentence is not intended to preclude the state from modifying the Medicaid benefit through the state plan amendment process.

d. The state may not claim FFP for DSRIP Payments until both the state and CMS have concluded that the performing providers have met the performance indicated for each payment. Performing providers' reports must contain sufficient data and documentation to allow the state and CMS to determine if the performing provider has fully met the specified metric, and performing providers must have available for review by the state or CMS, upon request, all supporting data and back-up documentation. FFP will be available only for payments related to activities listed in an approved DSRIP project plan.

e. Each quarter the State makes DSRIP Payments or IAAF payments and claims FFP, appropriate supporting documentation will be made available for CMS to determine the appropriate amount of the payments. Supporting documentation may include, but is not limited to, summary electronic records containing all relevant data fields such as Payee, Program Name, Program ID, Amount, Payment Date, Liability Date, Warrant/Check Number, and Fund Source. Documentation regarding the Funds revenue source for payments will also identify all other funds transferred to such fund making the payment. This documentation should be used to support claims made for FFP for DSRIP Payments that are made on the CMS-64.9 Waiver forms.

f. DSRIP Payments are not direct reimbursement for expenditures or payments for services. Payments from the DSRIP Fund are intended to support and reward performing providers for improvements in their delivery systems that support the simultaneous pursuit of improving the experience of care, improving the health of populations, and reducing per capita costs of health care. Payments from the DSRIP Fund are not considered patient care revenue, and shall not be offset against disproportionate share hospital expenditures or other Medicaid expenditures that are related to the cost of patient care (including stepped down costs of administration of such care) as defined under these Special Terms and Conditions, and/or under the State Plan.

14. Limits on Federal Financial Participation.

a. Use of FFP. The state will receive up to a total of $8 billion FFP to support MRT activities: $6.92 billion for DSRIP, $500 million of which will be for the IAAF, and the remaining amount to be allocated by the state for remaining MRT activities (with no more than $1.08 billion for such other activities).

b. MRT Cap. The State can claim FFP for MRT expenditures in each DSRIP Year up to the limits shown in the table below. Each DSRIP Project Plan must specify the DSRIP Year to which each milestone pertains; all incentive payments associated with meeting the milestone must count against the annual limit for the DSRIP Year identified. The state or its contractor shall monitor and report proper execution of project valuations and funds distribution as part of the implementation monitoring and reporting required under STC 35 of this section.

c. One-year DSRIP funding carry-over. If a performing provider system does not fully achieve a metric in Domains 2, 3 or 4 that was specified in its approved DSRIP project plan for completion in a particular DSRIP year, the performing provider system must report on the missed metrics in the given DSRIP year. Performing Provider Systems that do not meet annual milestones for a given metric will not be eligible to receive incentive payments for the missed metrics in that given DSRIP year. Any funding that would have been allocated to the performing provider system during that DSRIP year will be placed in the performance pool fund to be redistributed to Performing Provider Systems that have exceeded their set performance benchmarks for that DSRIP year. When a performing provider system does not meet its DSRIP year performance metrics, the missed metrics milestone will be recalibrated based on the procedures in DSRIP Program Funding and Mechanics Protocol (Attachment I) for the next DSRIP year and the performing provider system will be eligible to receive payments from the DSRIP payment pool for that next year if it reaches the recalibrated milestone in that next DSRIP year.

d. Fund Allocations According to MRT Demonstration Year

(Federal Financial Participation in Millions)

	Year-0	**Year-1**	**Year-2**	**Year-3**	**Year-4**	**Year-5**	**Total**
Sources of Funding							
Public Hospital IGT Transfers (Supports DSRIP IGT Funding for Public Performing Provider Transformation Fund, Safety Net Performance Provider System Transformation Fund,	$512.0	$878.1	$933.0	$1,481.8	$1,317.1	$878.1	$6,000.0

DSRIP, State Plan and Managed Care Services)							
State Appropriated Funds	$188.0	$345.4	$476.6	$467.8	$343.5	$178.7	$2,000.0
Total Sources of Funding	**$700.0**	**$1,223.5**	**$1,409.5**	**$1,949.6**	**$1,660.6**	**$1,056.8**	**$8,000.0**
Uses of Funding							
DSRIP Expenditures	$620.0	$1,007.8	$1,070.7	$1,700.6	$1,511.6	$1,007.8	$6,918.5
Interim Access Assurance Fund (IAAF)	$500.0	$0.0	$0.0	$0.0	$0.0	$0.0	$500.0
Planning Payments	$70.0	$0.0	$0.0	$0.0	$0.0	$0.0	$70.0
Performance Payments	$0.0	$957.8	$1,020.7	$1,650.6	$1,461.6	$957.8	$6,048.5
Administration	$50.0	$50.0	$50.0	$50.0	$50.0	$50.0	$300.0
Health Homes	$80.0	$66.7	$43.9	$0.0	$0.0	$0.0	$190.6
MC Programming	$0.0	$149.0	$294.9	$249.0	$149.0	$49.0	$890.9
Health Workforce MLTC Strategy	$0.0	$49.0	$49.0	$49.0	$49.0	$49.0	$245.0
HCBS Services	$0.0	$100.0	$245.9	$200.0	$100.0	$0.0	$645.9
Total Uses of Funding	**$700.0**	**$1,223.5**	**$1,409.5**	**$1,949.6**	**$1,660.6**	**$1,056.8**	**$8,000.0**

**Includes costs associated with State based planning in Year-0.*
**New York State may spend up to 5% of annual costs on Administration.*

e. Notwithstanding the limits in STC 1.a and 14.a, to the extent that the state elects to limit supplemental payments to an institutional provider class otherwise authorized under its state plan in any state fiscal year during which the DSRIP demonstration is in effect, an amount equal to the federal share of the amount not paid to such providers, up to $600 million may be added to the overall MRT and DSRIP limits on federal funding. This election will be available only to the extent that the state does not increase the authorized levels of such supplemental payments, or initiate new supplemental payments, during the authorized demonstration period. The state must develop and use a tracking spreadsheet (following a format approved by CMS) to ensure that the amounts of the DSRIP increase do not exceed the amount of authorized but unpaid supplemental payments.

f. Statewide accountability. Beginning in DSRIP Year 3, the limits on DSHP funding and on total DSRIP payments described in paragraph (a) above may be reduced based on

statewide performance, according to the process described in the Program Funding and Mechanics Protocol.

g. Statewide performance will be assessed on a pass or fail basis, for a set of 4 milestones.

i. Statewide performance on universal set of delivery system improvement metrics (as defined in Attachment J). Metrics for delivery system reform will be determined at a statewide level. Each metric will be calculated to reflect the performance of the entire state. Each of these statewide metrics will be assigned a direction for improving and worsening. This milestone will be considered passed in any given year if more metrics in these domains are improving on a statewide level than are worsening, as compared to the prior year as well as compared to initial baseline performance.

ii. A composite measure of success of projects statewide on project-specific and population wide quality metrics. This test is intended to reflect the success of every project in achieving the goals that have been assigned to each project, including pay for reporting for certain outcome measures as specified in DSRIP Strategies Menu and Metrics (Attachment J). As described in DSRIP Program Funding and Mechanics Protocol (Attachment I), each metric that determines project level incentive payments for each project will be determined at the project level to be meeting the improvement standards. This statewide milestone will be considered passed in any given year if the number of metrics for each project that trigger award as the improvement standards in DSRIP Program Funding and Mechanics Protocol (Attachment I) are greater than the number of metrics for each project that fail to trigger an award as per the improvement standard in DSRIP Program Funding and Mechanics Protocol (Attachment I).

iii. Growth in statewide total Medicaid spending, including MRT spending, that is at or below the target trend rate (Measure applies in DY4 and DY5). The per member per month (PMPM) amounts will be adjusted to exclude growth in federal funding associated with the Affordable Care Act. The state will not be penalized if it uses these higher FMAP rates generated by the Affordable Care Act to reinvest in its Medicaid program.

Growth in statewide total inpatient and emergency room spending that is at or below the target trend rate (Measure applies in DY 3, DY 4 and DY 5).

Both of the above measures will be measured on a PMPM basis in the most recent state fiscal year from the state fiscal year that immediately precedes it, with applicable spending including both federal and non-federal shares combined. Per member per month spending in each measure is determined by dividing statewide total spending by the number of person-months of Medicaid eligibility in the state for the state fiscal year. The most recent state fiscal year is the last state fiscal year ending prior to the start of the DSRIP Year. For total Medicaid spending, the target trend rate is the ten-year average rate for the long-term medical component of the

Consumer Price Index (as used to determine the state's Medicaid Global Spending Cap for that year), for DYs 4 and 5 only. For inpatient and emergency room spending the target trend rate is the ten-year average rate for the long-term medical component of the Consumer Price Index (as used to determine the state's Medicaid Global Spending Cap for that year) minus 1 percentage points for DY 3 and 2 percentage points for DYs 4 and 5.

iv. Implementation of the managed care plan, including targets agreed upon by CMS and the state after receipt of the managed care contracting plan in STC 39 of this section related to reimbursement of plans and providers consistent with DSRIP objectives and measures. These targets will include one associated with the degree to which plans move away from traditional fee for service payments to payment approaches rewarding value.

h. The state must pass all four milestones to avoid DSRIP reductions. If the state fails on any of the 4 milestones, the amount of the potential reduction is set as follows:

The state must pass 50 percent of the inpatient/emergency room spending reduction goals to avoid DSHP penalties. This will be the sole test for any DSHP penalty. The amount of the potential reduction is set as follows:

	DSRIP Year 3	DSRIP Year 4	DSRIP Year 5
DSHP Penalty	$23.39 million (5 percent)	$34.35 million (10 percent)	$35.74 million (20 percent)
DSRIP Penalty	$74.09 million (5 percent)	$131.71 million (10 percent)	$175.62 million (20 percent)

If DSRIP and DSHP penalties are applied, the state reduce funds in an equal distribution of projects, and will not affect the high performance fund.

15. Designated State Health Programs (DSHP). The state may claim FFP for certain DSHP expenditures, following procedures and subject to limits as described below.

a. Limit on FFP for DSHP. The amount of FFP that the state may receive for DSHP may not exceed the limit described below. If upon review, the amount of FFP received by the state is found to have exceeded the applicable limit, the excess must be returned to CMS as a negative adjustment to claimed expenditures on the CMS-64.

$ millions

Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Total
188.0	345.4	476.6	467.8	343.5	178.7	2,000

The FFP limit for 2014 is the lowest of the following amounts:

i. $188 million,

ii. The combined non-Federal share of IAAF Payments, DSRIP Project Design Grant payments and DSRIP administrative costs in 2014, and

iii. The federal share of total matchable DSHP expenditures in 2014 as outlined below.

b. DSHP List 1. The state may claim FFP in support of DSRIP for List 1 DSHP expenditures made after March 31, 2014. The state may not claim FFP until after the date on which CMS has approved a DSHP Claiming Protocol for the specific DSHP.

i. Health Care Reform Act programs

A. AIDS Drug Assistance
B. Tobacco Use Prevention and Control
C. Health Workforce Retraining

ii. State Office on Aging programs
A. Community Services for the Elderly
B. Expanded In-Home Services to the Elderly

iii. Office of Children and Family Services: Committees on Special Education direct care programs

iv. State Department of Health, Early Intervention Program Services

c. DSHP List 2. The state may claim FFP in support of DSRIP for List 2 DSHP expenditures made after December 31, 2014. The state may not claim FFP until after the date on which CMS has approved a DSHP Claiming Protocol for the specific DSHP

i. Homeless Health Services

ii. Childhood Lead Poisoning Primary Prevention

iii. Healthy Neighborhoods Program

iv. Cancer Services Programs

v. Obesity and Diabetes Programs

vi. TB Treatment, Detection and Prevention

vii. TB Directly Observed Therapy

viii. General Public Health Work

ix. Newborn Screening Programs

d. DSHP List 3. The state may claim FFP in support of DSRIP for List 3 DSHP expenditures not used for DD Transformation. The state may not claim FFP until after the **date** on which CMS has approved a DSHP Claiming Protocol for the specific DSHP

i. Office of Mental Health

A. Licensed Outpatient Programs
B. Care Management
C. Emergency Programs
D. Rehabilitation Services
E. Residential (Non-Treatment)
F. Community Support Programs

ii. Office for People with Developmental Disabilities

A. Day Training
B. Family Support Services
C. Jervis Clinic
D. Intermediate Care Facilities
E. HCBS Residential
F. Supported Work (SEMP)
G. Day Habilitation
H. Service Coordination/Plan of Care Support
I. Pre-vocational Services
J. Waiver Respite
K. Clinics - Article 16

iii. Office of Alcoholism and Substance Abuse Services

A. Outpatient and Methadone Programs
B. Prevention and Program Support Services

e. DSHP Claiming Protocol. The state will develop a CMS-approved DSHP claiming protocol with which the state will be required to comply in order to draw down DSHP funds for DSRIP. State expenditures for the DSHP listed above must be documented in accordance with the protocols. The state is not eligible to receive FFP until an applicable protocol is approved by CMS. Once approved by CMS, the protocol becomes Attachment L of these STCs, and thereafter may be changed or updated with CMS approval. Changes and updates are to be applied prospectively. For each DSHP, the protocol must contain the following information:

i. The sources of non-federal share revenue, full expenditures and rates.

ii. Program performance measures, baseline performance measure values, and improvement goals. (CMS may, at its option, approve the DSHP Claiming Protocol for a DSHP without this feature.)

iii. Procedures to ensure that FFP is not provided for any of the following types of expenditures:

A. Grant funding to test new models of care
B. Construction costs (bricks and mortar)
C. Room and board expenditures
D. Animal shelters and vaccines
E. School based programs for children
F. Unspecified projects
G. Debt relief and restructuring
H. Costs to close facilities
I. HIT/HIE expenditures
J. Services provided to undocumented individuals
K. Sheltered workshops
L. Research expenditures
M. Rent and utility subsidies normally funded by the United State Department of Housing and Urban Development
N. Prisons, correctional facilities, and services provided to individuals who are civilly committed and unable to leave
O. Revolving capital fund
P. Expenditures made to meet a maintenance of effort requirement for any federal grant program
Q. Administrative costs
R. Cost of services for which payment was made by Medicaid or CHIP (including from managed care plans)
S. Cost of services for which payment was made by Medicare or Medicare Advantage
T. Funds from other federal grants
U. Needle-exchange programs

f. DSHP Claiming Process.

i. Documentation of each designated state health program's expenditures, as specified in the DSHP Protocol, must be clearly outlined in the state's supporting work papers and be made available to CMS.

ii. In order to assure CMS that Medicaid funds are used for allowable expenditures, the state will be required to document through an Accounting and Voucher system its request for DSHP payments. The vouchers will be detailed in the services being requested for payment by the state and will be attached to DSHP support.

iii. Federal funds must be claimed within two years following the calendar quarter in which the state disburses expenditures for the DSHP.

iv. Federal funds are not available expenditures disbursed before April 1, 2014, or for

services rendered prior to April 1, 2014.

v. Federal funds are not available for expenditures disbursed after December 31, 2014, or for services rendered after December 31, 2014.

vi. Sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. To the extent that federal funds from any federal programs are received for the DSHP listed above, they shall not be used as a source of non-federal share.

vii. The administrative costs associated with the DSHP listed above, and any others subsequently added by amendment to the demonstration, shall not be included in any way as demonstration and/or other Medicaid expenditures.

viii. Any changes to the DSHP listed above shall be considered an amendment to the demonstration and processed in accordance with STC 7 in Section III.

g. Reporting DSHP Payments. The state will report all expenditures for DSHP payments to the programs listed above on the forms CMS-64.9 Waiver and/or 64.9P Waiver under the waiver name "DSRIP DSHP" (if in support of DSRIP) or "IAAF DSHP" (if in support of Interim Access Assurance Fund payments) as well as on the appropriate forms CMS-64.9I and CMS-64PI.

16. Budget Neutrality Review. In conjunction with any demonstration renewal beyond December 31, 2014, CMS reserves the right to modify the budget neutrality agreement consistent with budget neutrality policy.

17. Improved Management Controls. The state and CMS agree that, in conjunction with any Partnership Plan demonstration renewal beyond December 31, 2014, the state will undertake additional activities and steps to strengthen internal controls, compliance with federal and state Medicaid requirements and financial reporting to ensure proper claiming of federal match for the Medicaid program, and to self-identify and initiate timely corrective action on problems and issues. To support the development of these additional special terms and conditions, the state will provide a report to CMS by October 1, 2014, outlining its assessment of current strengths and weaknesses of the state's system of internal and financial management controls (taking into account any audit findings from federal or state oversight agencies including the HHS Office of Inspector General, the state Office of Inspector General, and CMS); the steps the state proposes to take to strengthen compliance, documentation and transparency; and the expected path for resolution of any outstanding deferrals or disallowances initiated by CMS as of the date of this amendment.

18. DSRIP Transparency. During the 30 day public comment period for the DSRIP Program Funding and Mechanics protocol (Attachment I), DSRIP Strategies Menu and Metrics (Attachment J), the state must have conducted at least two public hearings regarding the state's DSRIP amendment approval. The state must utilize teleconferencing or web capabilities for at least one of the public hearings to ensure statewide accessibility. The two

public hearings must be held on separate dates and in separate locations, and must afford the public an opportunity to provide comments. Once the state develops its standardized review tool the independent assessor will use for the DSRIP project plans, the tool must also be posted for public comment for 30 days.

a. Administrative Record. CMS will maintain, and publish on its public Web site, an administrative record that may include, but is not limited to the following:

i. The demonstration application from the state.
ii. Written public comments sent to the CMS and any CMS responses.
iii. If an application is approved, the final special terms and conditions, waivers, expenditure authorities, and award letter sent to the state.
iv. If an application is denied, the disapproval letter sent to the state.
v. The state acceptance letter, as applicable.
vi. Specific requirements related to the approved and agreed upon terms and conditions, such as implementation reviews, evaluation design, quarterly progress reports, annual reports, and interim and/or final evaluation reports.
vii. Notice of the demonstration's suspension or termination, if applicable.

b. CMS will provide sufficient documentation to address substantive issues relating to the approval documentation that should comprehensively set forth the basis, purpose, and conditions for the approved demonstration.

19. Submission of Draft Evaluation Design. The state shall submit a draft DSRIP evaluation design to CMS no later than 120 days after the award of the demonstration, including, but not limited to data that the state proposes to be used to evaluate DSRIP. The state must employ aggressive state-level standards that align with its managed care evaluation approach.

20. Submission of Final Evaluation Design. The state shall provide the Final Evaluation Design within 30 days of receipt of CMS comments of the Draft Evaluation Design. If CMS finds that the Final Evaluation Design adequately accommodates its comments, then CMS will approve the Final Evaluation Design and the final evaluation plan will be included as Attachment M of these STCs.

21. Evaluation Requirements. The state shall engage the public in the development of its evaluation design. The evaluation design shall incorporate an interim and summative evaluation and will discuss the following requirements as they pertain to each:

a. The scientific rigor of the analysis;
b. A discussion of the goals, objectives and specific hypotheses that are to be tested;
c. Specific performance and outcomes measures used to evaluate the demonstration's impact;
d. How the analysis will support a determination of cost effectiveness;
e. Data strategy including sources of data, sampling methodology, and how data will be obtained;
f. The unique contributions and interactions of other initiatives; and

g. How the evaluation and reporting will develop and be maintained.

The demonstration evaluation will meet the prevailing standards of scientific and academic rigor, as appropriate and feasible for each aspect of the evaluation, including standards for the evaluation design, conduct, and interpretation and reporting of findings. The demonstration evaluation will use the best available data; use controls and adjustments for and reporting of the limitations of data and their effects on results; and discuss the generalizability of results.

The state shall acquire an independent entity to conduct the evaluation. The evaluation design shall discuss the state's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications the entity must possess, how the state will assure no conflict of interest, and a budget for evaluation activities.

22. Evaluation Design. The Evaluation Design shall include the following core components to be approved by CMS:

a. Research questions and hypotheses: This includes a statement of the specific research questions and testable hypotheses that address the goals of the demonstration, including:

i. safety net system transformation at both the system and state level;

ii. accountability for reducing avoidable hospital use and improvements in other health an public health measures at both the system and state level and

iii. efforts to ensure sustainability of transformation of/in the managed care environment at the state level.

The research questions will be examined using appropriate comparison groups and studied in a time series.

b. The design will include a description of the quantitative and qualitative study design (e.g., cohort, controlled before-and-after studies, interrupted time series, case-control, etc.), including a rationale for the design selected. The discussion will include a proposed baseline and approach to comparison. The discussion will include approach to benchmarking, and should consider applicability of national and state standards. The application of sensitivity analyses as appropriate shall be considered.

c. Performance Measures: This includes identification, for each hypothesis, of quantitative and/or qualitative process and/or outcome measures that adequately assess the effectiveness of the Demonstration in terms of cost of services and total costs of care, change in delivery of care from inpatient to outpatient, quality improvement, and transformation of incentive arrangements under managed care. Nationally recognized measures should be used where appropriate. Measures will be clearly stated and described, with the numerator and dominator clearly defined. To the extent possible, the state will incorporate comparisons to national data and/or measure sets. A broad set of metrics will be selected. To the extent possible, metrics will be pulled from nationally recognized metrics such as from the National Quality

Forum, Center for Medicare and Medicaid Innovation, meaningful use under HIT, and the Medicaid Core Adult sets, for which there is sufficient experience and baseline population data to make the metrics a meaningful evaluation of the New York Medicaid system.

d. Data Collection: This discussion shall include: A description of the data sources; the frequency and timing of data collection; and the method of data collection. The following shall be considered and included as appropriate:

i. Medicaid encounter and claims data in TMSIS,
ii. Enrollment data,
iii. EHR data, where available
iv. Semiannual financial and other reporting data
v. Managed care contracting data
vi. Consumer and provider surveys, and
vii. Other data needed to support performance measurement

e. Assurances Needed to Obtain Data: The design report will discuss the state's arrangements to assure needed data to support the evaluation design are available

f. Data Analysis: This includes a detailed discussion of the method of data evaluation, including appropriate statistical methods that will allow for the effects of the Demonstration to be isolated from other initiatives occurring in the state. The level of analysis may be at the beneficiary, provider, health plan and program level, as appropriate, and shall include population and intervention-specific stratifications, for further depth and to glean potential non-equivalent effects on different sub-groups. Sensitivity analyses shall be used when appropriate. Qualitative analysis methods shall also be described, if applicable.

g. Timeline: This includes a timeline for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables.

h. Evaluator: This includes a discussion of the state's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess; how the state will assure no conflict of interest, and a budget for evaluation activities.

23. Interim Evaluation Report. The state is required to submit a draft Interim Evaluation Report 90 days following completion of DY 4 of the demonstration. The Interim Evaluation Report shall include the same core components as identified in STC 24 of this section for the Summative Evaluation Report and should be in accordance with the CMS approved evaluation design. CMS will provide comments within 60 days of receipt of the draft Interim Evaluation Report. The state shall submit the final Interim Evaluation Report within 30 days after receipt of CMS' comments.

24. Summative Evaluation Report. The Summative Evaluation Report will include analysis

of data from DY 5. The state is required to submit a preliminary summative report in 180 days of the expiration of the demonstration including documentation of outstanding assessments due to data lags to complete the summative evaluation. Within 360 days of the end for DY 5, the state shall submit a draft of the final summative evaluation report to CMS. CMS will provide comments on the draft within 60 days of draft receipt. The state should respond to comments and submit the Final Summative Evaluation Report within 30 days.

25. The Final Summative Evaluation Report shall include the following core components:

a. Executive Summary. This includes a concise summary of the goals of the Demonstration; the evaluation questions and hypotheses tested; and key findings including whether the evaluators find the demonstration to be budget neutral and cost effective, and policy implications.

b. Demonstration Description. This includes a description of the Demonstration programmatic goals and strategies, particularly how they relate to budget neutrality and cost effectiveness.

c. Study Design. This includes a discussion of the evaluation design employed including research questions and hypotheses; type of study design; impacted populations and stakeholders; data sources; and data collection; analysis techniques, including controls or adjustments for differences in comparison groups, controls for other interventions in the state and any sensitivity analyses, and limitations of the study.

d. Discussion of Findings and Conclusions. This includes a summary of the key findings and outcomes, particularly a discussion of cost effectiveness, as well as implementation successes, challenges, and lessons learned.

e. Policy Implications. This includes an interpretation of the conclusions; the impact of the demonstration within the health delivery system in the state; the implications for state and federal health policy; and the potential for successful demonstration strategies to be replicated in other state Medicaid programs.

f. Interactions with Other State Initiatives. This includes a discussion of this demonstration within an overall Medicaid context and long range planning, and includes interrelations of the demonstration with other aspects of the state's Medicaid program, and interactions with other Medicaid waiver sand other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid.

26. State Presentations for CMS. The state will present to and participate in a discussion with CMS on the final design plan at post approval. The state will present on its interim evaluation report that is described to in STC 23 of this section. The state will present on its summative evaluation in conjunction with STC 24 of this section.

27. Public Access. The state shall post the final approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report on the State Medicaid website within 30 days of approval by CMS.

28. CMS Notification. For a period of 24 months following CMS approval of the Summative Evaluation Report, CMS will be notified prior to the public release or presentation of these reports and related journal articles, by the state, contractor or any other third party. Prior to release of these reports, articles and other documents, CMS will be provided a copy including press materials. CMS will be given 30 days to review and comment on journal articles before they are released. CMS may choose to decline some or all of these notifications and reviews.

29. Electronic Submission of Reports. The state shall submit all required plans and reports using the process stipulated by CMS, if applicable.

30. Cooperation with Federal Evaluators. Should CMS undertake an evaluation of the demonstration or any component of the demonstration, or an evaluation that is isolating the effects of DSRIP, the state and its evaluation contractor shall cooperate fully with CMS and its contractors. This includes, but is not limited to, submitting any required data to CMS or the contractor in a timely manner and at no cost to CMS or the contractor.

31. Cooperation with Federal Learning Collaboration Efforts. The state will cooperate with improvement and learning collaboration efforts by CMS.

32. Evaluation Budget. A budget for the evaluation shall be provided with the evaluation design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses, and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the design is not sufficiently developed.

33. Deferral for Failure to Provide Summative Evaluation Reports on Time. The state agrees that when draft and final Interim and Summative Evaluation Reports are due, CMS may issue deferrals in the amount of $5,000,000 if they are not submitted on time to CMS or are found by CMS not to be consistent with the evaluation design as approved by CMS.

34. DSRIP Implementation Monitoring. The state must ensure that they are operating its DSRIP program according to the requirements of the governing STCs. In order to demonstrate adequate implementation monitoring towards the completion of these requirements, the state will submit the following:

a. DSRIP monitoring activities, in STC 35 of this section as a part of the operational protocol in STC 10 (h) of this section indicating how the state will monitor compliance with demonstration requirements in the implementation of this

demonstration, including monitoring and performance reporting templates. Monitoring and performance templates are subject to review and approval by CMS.

b. Data usage agreements demonstrating the availability of required data to support the monitoring of implementation.

c. Quarterly Report Framework indicating what metrics and data will be available to submit a quarterly report consistent with STC 36 of this section.

35. DSRIP Monitoring Activities. As part of the state's Operational Protocol described in STC 10 (h) of this section and Attachment K, the state will submit its plans for how it will meet the DSRIP STCs through internal monitoring activities. The monitoring plans should provide, at a minimum, the following information:

a. The monitoring activities aligned with the DSRIP deliverables as well as the CMS evaluation design to ensure that entities participating in the DSRIP process are accountable for the necessary product and results for the demonstration.

b. The state shall make the necessary arrangements to assure that the data needed from the performing providers, coalitions, administrative activities, independent assessor and independent evaluator that are involved in the process for DSRIP deliverables, measurement and reporting are available as required by the CMS approved monitoring protocol.

c. The state shall identify areas within the state's internal DSRIP process where corrective action, or assessment of fiscal or non-fiscal penalties may be imposed for the entities described in STC 10(e) of this section, should the state's internal DSRIP process or any CMS monitored process not be administered in accordance with state or federal guidelines.

d. The monitoring protocol and reports shall be posted on the state Medicaid website within 30 days of submission to CMS.

36. DSRIP Quarterly Progress Reports. The state must submit progress reports in the format specified by CMS, no later than 60-days following the end of each quarter along with the Operational Protocol Report described above. The first DSRIP quarterly reports will be due by August 30, 2014. The intent of these reports is to present the state's analysis and the status of the various operational areas in reaching the three goals of the DSRIP activities. These quarterly reports, using the quarterly report guideline outlined in Attachment L, must include, but are not limited to the following reporting elements:

a. Summary of quarterly expenditures related to IAAF, DSRIP Project Design Grant, and the DSRIP Fund;
b. Summary of all public engagement activities, including, but not limited to the activities required by CMS;
c. Summary of activities associated with the IAAF, DSRIP Project Design Grant, and

the DSRIP Fund. This shall include, but is not limited to, reporting requirements in STC 3 of this section and Attachment K, the Operational Protocol:

i. Provide updates on state activities, such as changes to state policy and procedures, to support the administration of the IAAF, DSRIP Project Design Grant and the DSRIP Fund;
ii. Provide updates on provider progress towards the pre-defined set of activities and associated milestones that collectively aim towards addressing the state's goals;
iii. Provide summary of state's analysis of DSRIP Project Design;
iv. Provide summary of state analysis of barriers and obstacles in meeting milestones;
v. Provide summary of activities that have been achieved through the DSRIP Fund; and
vi. Provide summary of transformation and clinical improvement milestones and that have been achieved.

d. Summary of activities and/or outcomes that the state and MCOs have taken in the development of and subsequent approval of the Managed Care DSRIP plan; and

e. Evaluation activities and interim findings.

The state may comment and submit a revised Attachment L no later than 30 days after approval of these STCs. CMS will approve necessary changes and update the attachment as necessary. Any subsequent changes to Attachment L must be submitted to CMS prior the end of the reporting period in which the change to the Quarterly Report would take place.

37. Annual Onsite with CMS. In addition to regular monitoring calls, the state shall on an annual basis present to and participate in a discussion with CMS on implementation progress of the demonstration including progress toward the goals, and key challenges, achievements and lessons learned.

38. Rapid Cycle Assessments. The state shall specify for CMS approval a set of performance and outcome metrics and network characteristics, including their specifications, reporting cycles, level of reporting (e.g., the state, health plan and provider level, and segmentation by population) to support rapid cycle assessment in trends under premium assistance and Medicaid fee-for-service, and for monitoring and evaluation of the demonstration.

39. Medicaid Managed Care DSRIP Contracting Plan. In recognition that the DSRIP investments represented in this waiver must be recognized and supported by the state's managed care plans as a core component of long term sustainability, and will over time improve the ability of plans to coordinate care and efficiently deliver high quality services to Medicaid beneficiaries through comprehensive payment reform, strengthened provider networks and care coordination, the state must take steps to plan for and reflect the impact of DSRIP in managed care contracts and rate-setting approaches. Prior to the state submitting contracts and rates for approval for the April 1, 2015 to March 31, 2016

contract cycle, the state must submit a roadmap for how they will amend contract terms and reflect new provider capacities and efficiencies in managed care rate-setting. Recognizing the need to formulate this plan to align with the stages of DSRIP, this should be a multi-year plan, and necessarily be flexible to properly reflect future DSRIP progress and accomplishments. This plan must be approved by CMS before the state may claim FFP for managed care contracts for the 2015 state fiscal year. The state shall update and submit the Managed Care DSRIP plan annually on the same cycle and with the same terms, until the end of this demonstration period and its next renewal period. Progress on the Managed Care DSRIP plan will also be included in the quarterly DSRIP report. The Managed Care DSRIP plan should address the following:

a. What approaches MCOs will use to reimburse providers to encourage practices consistent with DSRIP objectives and metrics, including how the state will plan and implement its stated goal of 90% of managed care payments to providers using value-based payment methodologies.
b. How and when plans' currents contracts will be amended to include the collection and reporting of DSRIP objectives and measures.
c. How the DSRIP objectives and measures will impact the administrative load for MCOs, particularly insofar as plans are providing additional technical assistance and support to providers in support of DSRIP goals, or themselves carrying out programs or activities for workforce development or expansion of provider capacity. The state should also discuss how these efforts, to the extent carried out by plans, avoid duplication with DSRIP funding or other state funding; and how they differ from any services or administrative functions already accounted for in capitation rates.
d. How alternative payment systems deployed by MCOs will reward performance consistent with DSRIP objectives and measures.
e. How the state will assure that providers participating in and demonstrating successful performance through DSRIP will be included in provider networks.
f. How managed care rates will reflect changes in case mix, utilization, cost of care and enrollee health made possible by DSRIP, including how up to date data on these matters will be incorporated into capitation rate development.
g. How actuarially-sound rates will be developed, taking into account any specific expectations or tasks associated with DSRIP that the plans will undertake, and how the state will use benchmark measures (e.g., MLR) to ensure that payments are sound and appropriate. How plans will be measured based on utilization and quality in a manner consistent with DSRIP objectives and measures, including incorporating DSRIP objectives into their annual utilization and quality management plans submitted for state review and approval by January 31 of each calendar year.
h. How the state will use DSRIP measures and objectives in their contracting strategy approach for managed care plans, including reform.

40. New York MRT-DSRIP Deliverables Schedule.

Due Date/Submission Date	Activity/Deliverable
April 14, 2014	CMS approves STCs and DSRIP Attachments

	New York posts the DSRIP Funding and Mechanics Protocol and the DSRIP Strategies Menu and Metrics for public comment for 30 days
	New York posts IAAF Qualifications and Application on for public comment for 14 days;
	14 day IAAF application period begins once comment period closes
	IAAF awards can be distributed after 14 day application period closes
	State has 10 days to submit its first report for IAAF payments (STC 1(b)(iii)(A) of this section)
	State will make baseline data for DSRIP measures available
	State submits its proposed independent assess statement of work (SOW) for its independent assessor contract procurement
May 1, 2014	State must accept DSRIP STCs or offer technical corrections, including for the DSRIP Operational Protocol and the Quarterly Reporting formats
	State has 10 days to submit changes to the DSRIP Funding and Mechanics Protocol and the DSRIP Strategies Menu and Metrics once public comment period closes
	CMS will review changes to the DSRIP Funding and Mechanics Protocol and DSRIP Strategies Menu and Metrics and take action no later than 30 days after state submits changes
	State accepts DSRIP Design Grant applications and make Design Grant awards
	State posts DSRIP Project Plan Review Tool that independent assessor will use to score submitted DSRIP Project Plan applications for 30 days
August 1, 2014	State submits draft DSRIP evaluation design
August 30, 2014	State submits its first quarterly report, including its operational report (STCs 35 & 36)
October 1, 2014	State submits its Improved Management Controls report to CMS
	State accepts DSRIP Project Plan applications

	State will perform initial review of submitted DSRIP Project Plan applications
	Independent assessor will perform full review of DSRIP project plan applications
	Independent assessor will post reviewed DSRIP Project Plan applications for public comment for 30 days
New York Partnership Plan Renewal Period – January 1, 2015	
	Independent assessor approval recommendations made public
	State Distributes DSRIP Project Plan awards for approved performing provider systems
Quarterly Deliverables – Quarterly Report and Operational Report	
August 30, 2014	
November 30, 2014	
February 28, 2015	
May 30, 2015	

*__Note__: Activities/Deliverables without a specific Due Date/Submission Date could occur at any time during the timeframes with dates certain, for example the public comment period for the DSRIP Funding and Mechanics Protocol could occur any time after April 14, 2014, based on the state's discretion, so long as the activities are completed and related deliverables are submitted. Should the state renew the demonstration, the quarterly reporting will continue during the renewal period.

IX. GENERAL REPORTING REQUIREMENTS

1. **General Financial Requirements**. The state must comply with all general financial requirements set forth in Section X.

2. **Reporting Requirements Related to Budget Neutrality**. The state must comply with all reporting requirements for monitoring budget neutrality set forth in section XI.

3. **Monthly Calls**. CMS shall schedule monthly conference calls with the state. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration. Areas to be addressed include, but are not limited to, MCO operations (such as contract amendments and rate certifications), transition and implementation activities, health care delivery, the FHP-PAP program, enrollment of individuals using LTSS and non-LTSS users broken out by duals and non-duals, cost sharing, quality of care, access, family planning issues, benefits, audits, lawsuits, financial reporting and budget neutrality issues, MCO financial performance that is relevant to the demonstration, progress on evaluations, state legislative developments, services being added to the MMMC including HIV SNPs, MLTC or HARPs plan benefit package pursuant to Section V, and any demonstration amendments, concept papers, or state plan amendments the state is considering submitting. CMS shall update the state on any amendments or concept papers under review, as well as federal policies and issues that may affect any aspect of the demonstration. The state and CMS shall jointly develop the agenda for the calls.

4. **Quarterly Operational Reports**. The state must submit progress reports in accordance with the guidelines in Attachment E taking into consideration the requirements in STC 7 of this section, no later than 60 days following the end of each quarter (December, March, and June of each demonstration year). The state may combine the quarterly report due for the quarter ending September with the annual report in STC 5 of this section. The intent of these reports is to present the state's analysis and the status of the various operational areas. In addition to the guidelines for quarterly reporting in Attachment E, the state's report shall also include the following:

    a. Beneficiary choice of plans and capacity of plans participating in the HIV SNP, MMC and MLTC, HARPs or Fully Integrated Duals Advantage (FIDA), including the number of beneficiaries who made an affirmative choice.
    b. LTSS Assessment statistics in accordance with the requirements of STC 8 in Section V, including corrective actions against MCOs/PIHPs that do not meet the 30 day assessment requirement.
    c. Total enrollment in each MCO by month. Data should reflect a rolling 12 month period.
    d. Total beneficiaries who chose to opt out of HARP, their reason for opting out and the number who decide to voluntarily enroll or re-enroll.
    e. Activities related to choice counseling including efforts to improve health literacy and the methods used to obtain public input, e.g. recipient focus groups, etc.
    f. Progress toward compliance with T-MSIS requirements.
    g. Status of managed care plan performance, initiatives and activities as measured by HEDIS, CAHPs and other quality metrics.

5. **Annual Report.** The state must submit an annual report documenting accomplishments, project status, quantitative and case study findings, interim evaluation findings, utilization data, and policy and administrative difficulties in the operation of the demonstration. The state must submit this report no later than 90 days following the end of each demonstration year. Additionally, the annual report must include:

    a. A summary of the elements included within each quarterly report;

    b. An update on the progress related to the quality strategy as required STC 9 in Section VI, including:

        i. Outcomes of care, quality of care, cost of care and access to care for demonstration populations;
        ii. The results of beneficiary satisfaction survey, grievances and appeals;

    c. The status of the evaluation required in Section XII and information regarding progress in achieving demonstration evaluation criteria including the results/impact of any demonstration programmatic area defined by CMS that is unique to the demonstration design or evaluation hypotheses;

d. An aggregated enrollment report showing the total number of individuals enrolled in each plan;

e. A listing of the new geographic areas the state has expanded MLTC to;

f. A list of the benefits added to the managed care benefit package;

g. An updated transition plan which shows the intended transition and timeline for any new benefits and/or populations into the demonstration;

h. Network adequacy reporting as required in STC 13 of Section VI;

i. State efforts related to the collection and verification of encounter data and utilization data, including the required transition to T-MSIS, encounter data validation activities and outcomes conducted by the EQRO.

j. Any other topics of mutual interest between CMS and the state related to the demonstration; and

k. Any other information the state believes pertinent to the demonstration, such as:

i. Any policy or administrative difficulties that may impact the demonstration,
ii. Any state legislative developments that may impact the demonstration,
iii. The status of the health care delivery system under the demonstration with respect to issues and/or complaints identified by beneficiaries,
iv. The impact of the demonstration in providing insurance coverage to beneficiaries and uninsured population,
v. The existence or results of any audits, investigations or lawsuits that impact the demonstration,
vi. The financial performance of the demonstration (budget neutrality), and
vii. A summary of the annual post-award forum, including all public comments received regarding the process of the demonstration project.

6. Transition Plan. On or before July 1, 2012, and consistent with guidance provided by CMS, the state is required to prepare, and incrementally revise, a Transition Plan consistent with the provisions of the Affordable Care Act (ACA) for individuals enrolled in the demonstration, including how the state plans to coordinate the transition of these individuals to a coverage option available under the ACA without interruption in coverage to the maximum extent possible. The plan must include the required elements and milestones described in paragraphs (a)-(e) outlined below. In addition, the Plan will include a schedule of implementation activities that the state will use to operationalize the Transition Plan. For any elements and milestones that remain under development as of July 1, 2012, the state will include in the Transition Plan a description of the status and anticipated completion date.

a. Seamless Transitions. Consistent with the provisions of the ACA, the Transition Plan will include details on how the state plans to obtain and review any additional

information needed from each individual to determine eligibility under all eligibility groups, and coordinate the transition of individuals enrolled in the demonstration (by FPL) (or newly applying for Medicaid) to a coverage option available under the ACA without interruption in coverage to the maximum extent possible. Specifically, the state must:

i. Determine eligibility under all January 1, 2014, eligibility groups for which the state is required or has opted to provide medical assistance, including the group described in §1902(a)(10)(A)(i)(VIII) for individuals under age 65 and regardless of disability status with income at or below 133 percent of the FPL;
ii. Identify demonstration populations not eligible for coverage under the ACA and explain what coverage options and benefits these individuals will have effective January 1, 2014;
iii. implement a process for considering, reviewing and making preliminary determinations under all January 1, 2014 eligibility groups for new applicants for Medicaid eligibility;
iv. Conduct an analysis that identifies populations in the demonstration that may not be eligible for or affected by the ACA and the authorities the state identifies that may be necessary to continue coverage for these individuals; and
v. Develop a modified adjusted gross income (MAGI) calculation for program integrity.

b. Access to Care and Provider Payments.

i. Provider Participation. The state must identify the criteria that will be used for reviewing provider participation in (e.g., demonstrated data collection and reporting capacity) and means of securing provider agreements for the transition.
ii. Adequate Provider Supply. The state must provide the process that will be used to assure adequate provider supply for the state plan and demonstration populations affected by the demonstration on December 31, 2013. The analysis should address delivery system infrastructure/capacity, provider capacity, utilization patterns and requirements (i.e., prior authorization), current levels of system integration, and other information necessary to determine the current state of the of service delivery. The report must separately address each of the following provider types:

A. Primary care providers,
B. Mental health services,
C. Substance use services and
D. Dental.

iii. Provider Payments. The state will establish and implement the necessary processes for ensuring accurate encounter payments to providers entitled to the prospective payment services (PPS) rate (e.g., certain FQHCs and RHCs) or the all-inclusive rate (e.g., certain Indian Health providers).

c. System Development or Remediation. The Transition Plan for the demonstration is expected to expedite the state's readiness for compliance with the requirements of the

Affordable Care Act and other federal legislation. System milestones that must be tested for implementation on or before January 1, 2014 include: Replacing manual administrative controls with automotive processes to support a smooth interface among coverage and delivery system options that is seamless to beneficiaries.

d. Progress Updates. After submitting the initial Transition Plan for CMS approval, the state must include progress updates in each quarterly and annual report. The Transition Plan shall be revised as needed.

e. Implementation.

i. By October 1, 2013, the state must begin to implement a simplified, streamlined process for transitioning eligible enrollees in the demonstration to Medicaid, the Exchange or other coverage options in 2014. In transitioning these individuals from coverage under the waiver to coverage under the state plan, the state will not require these individuals to submit a new application.

ii. On or before December 31, 2013, the state must provide notice to the individual of the eligibility determination using a process that minimizes demands on the enrollees.

7. Reporting Requirements Related to Individuals using Long Term Services and Supports. In each quarterly report required by Section IX, the state shall report:

a. Any critical incidents reported within the quarter and the resulting investigations as appropriate;

b. The number and types of grievance and appeals for this population filed and/or resolved within the reporting quarter for this population;

c. The total number of assessments for enrollment performed by the plans, with the number of individuals who did not qualify to enroll in an MLTC plan;

d. The number of individuals referred to an MLTC plan that received an assessment within 30 days;

e. The number of people who were not referred by the enrollment broker and contacted the plan directly and were provided MLTC materials;

f. Rebalancing efforts performed by the MLTC plans and mainstream plans once the benefit is added. Rebalancing reporting should include, but is not limited to the total number of individuals transitioning in and out of a nursing facility within the quarter.

g. Total number of complaints, grievances and appeals by type of issue with a listing of the top 5 reasons for the event.

8. Final Evaluation Report. The state shall submit a Final Evaluation Report pursuant to the requirements of section 1115 of the Act.

X. GENERAL FINANCIAL REQUIREMENTS

1. **Quarterly Expenditure Reports**. The state must provide quarterly expenditure reports using Form CMS-64 to separately report total expenditures for services provided under the Medicaid program, including those provided through the demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS shall provide FFP for allowable demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Section XI.

2. **Reporting Expenditures under the Demonstration**. The following describes the reporting of expenditures under the demonstration:

   a. In order to track expenditures under this demonstration, New York must report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System, following routine CMS-64 reporting instructions outlined in Section 2500 of the State Medicaid Manual. All demonstration expenditures must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the DY in which services were rendered or for which capitation payments were made).

   b. DY reporting shall be consistent with the following time periods:

Demonstration Year	Time Period
1	10/1/1997 - 9/30/1998
2	10/1/1998 - 9/30/1999
3	10/1/1999 - 9/30/2000
4	10/1/2000 - 9/30/2001
5	10/1/2001 - 3/30/2003
6	04/1/2003 - 9/30/2004
7	10/1/2004 - 9/30/2005
8	10/1/2005 - 9/30/2006
9	10/1/2006 - 09/30/2007
10	10/1/2007 - 09/30/2008
11	10/1/2008 - 09/30/2009
12	10/1/2009 - 09/30/2010
13	10/1/2010 - 09/30/2011
14	10/1/2011 - 09/30/2012
15	10/1/2012 - 09/30/2013
16	10/1/2013 – 7/31/2015

c. Demonstration expenditures will be correctly reported on Forms CMS-64.9 Waiver. Quarterly cost settlements and pharmaceutical rebates relevant to the demonstration will be allocated to the demonstration populations specified in subparagraph (g) and offset against current quarter waiver expenditures. Demonstration expenditures net of these cost settlement offsets will be reported on Form CMS-64.9 Waiver. Amounts offset will be identifiable in the state's supporting work papers and made available to CMS.

i. Allocation of cost settlements. The state will calculate the percentage of Medicaid expenditures for each demonstration eligibility group to expenditures for all Medicaid population groups from a DataMart file produced for the latest completed federal fiscal year. Quarterly recoveries will be allocated to the eligibility groups based on those percentages. These percentages will be updated annually to reflect the most recent completed federal fiscal year.

ii. Allocation of pharmacy rebates. The state will calculate the percentage of pharmacy expenditures for each demonstration eligibility group to pharmacy expenditures for all population groups from a DataMart file produced for the latest completed federal fiscal year. Rebates will be allocated to the eligibility groups based on those percentages. These percentages will be updated annually to reflect the most recent completed federal fiscal year.

d. For the HCBS Expansion component of the demonstration, the state shall report only the home and community based services expenditures for Demonstration Population 9 on line 19A on Forms CMS-64.9 Waiver and/or 64.9P.

e. For each DY, fourteen separate waiver Forms CMS-64.9 Waiver and/or 64.9P Waiver must be completed, using the waiver name noted below in brackets, to report expenditures for the following demonstration populations and services.

i. Demonstration Population 1 - Temporary Assistance to Needy Families (TANF) child under age 1 through age 20 required to enroll in managed care in any county. [TANF Child]

ii. Demonstration Population 2 - TANF Adults aged 21 through 64 required to enroll in managed care in any county. [TANF Adult]

iii. Demonstration Population 3 - Disabled Adults and Children 0 through 64 voluntarily enrolled in managed care. [SSI 0 through 64]

iv. Demonstration Population 4 – Disabled Adults and Children 0-64 required to enroll in managed care.

v. Demonstration Population 5 – Disabled Adults 65+ voluntarily enrolled in managed care.

vi. Demonstration Population 6 – Disabled Adults 65+ required to enroll in managed care.

vii. Demonstration Population 7 – Non Duals 18-64

viii. Demonstration Population 8 – Non Duals 65+

ix. Demonstration Population 9 - Home and Community-Based Services Expansion participants [HCBS Expansion]

x. Demonstration Population 10 – Individuals Moved From Institutional Settings to Community Settings for Long Term Care Services

xi. Demonstration Population 11 - MLTC Adults age 18 through 64 - Duals [MLTC Adults 18 -64]

xii. Demonstration Population 12 - MLTC Adults age 65 and above - Duals [MLTC Adults 65+]

xiii. Demonstration Services – Expenditures for services provided by designated state health programs for which state revenue will be used to fund New York's DSRIP program. [DSHP for DSRIP]

xiv. Demonstration Services – Expenditures for payments to New York that provide project funding and incentive payments to Performing Provider Systems under DSRIP.

xv. Demonstration Services 7 - Designated State Health Program for expenditures made for the period January 1, 2014 through December 31, 2015 for the state-funded Marketplace subsidy program who purchases health care coverage in the Marketplace. [DSHP – APTC]

xvi. Demonstration Services 8 – Expenditures made for BH HCBS services for individuals enrolled in HARP and HIV SNPs. [BH HCBS] *Note: expenditures under this MEG will be claimed in the manner necessary to ensure the correct claiming of FMAP for all populations. For example, BH HCBS services for the adult expansion groups will be claimed at the FMAP rate at STC 6 of section XI.*

xvii. Demonstration Services 9 – Expenditures made for provision of residential and outpatient addiction services, crisis intervention and licensed behavioral health practitioner services to MMMC enrollees only and are not provided under the state plan.

3. **Expenditures Subject to the Budget Neutrality Agreement.** For purposes of this section, the term "expenditures subject to the budget neutrality agreement" must include all Medicaid expenditures in STC 2(e) of this section for individuals who are enrolled in this demonstration (with the exception of the populations identified in subparagraphs iii, iv, and ix), as well as the demonstration services described in subparagraphs x through xiii, subject to limitations enumerated in this paragraph. All expenditures that are subject to the budget neutrality agreement are considered demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and/or 64.9P Waiver.

4. **Mandated Increase in Physician Payment Rates in 2013 and 2014**. Section 1202 of the Health Care and Education Reconciliation Act of 2010 (Pub. Law 110-152) requires state Medicaid programs to reimburse physicians for primary care services at rates that are no less than what Medicare pays, for services furnished in 2013 and 2014, with the Federal Government paying 100 percent of the increase. The entire amount of this increase will be excluded from the budget neutrality test for this demonstration. The specifics of separate reporting of these expenditures will be described in guidance to be issued by CMS at a later date.

5. **Administrative Costs**. Administrative costs will not be included in the budget neutrality limit, but the state must separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver.

6. **Claiming Period**. All claims for expenditures subject to the budget neutrality cap (including any cost settlements) must be made within 2 years after the calendar quarter in which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the state must continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

7. **Reporting Member Months**. The following describes the reporting of member months for demonstration populations:

   a. For the purpose of calculating the budget neutrality expenditure cap and for other purposes, the state must provide to CMS, as part of the quarterly report required under STC 4 in Section IX, the actual number of eligible member months for the demonstration populations defined in STC 1 of this section, for months prior to or including the ending date indicated in STC 2(e) of this section for each demonstration population. The state must submit a statement accompanying the quarterly report, which certifies the accuracy of this information.

   To permit full recognition of "in-process" eligibility, reported counts of member months may be subject to revisions after the end of each quarter. Member month counts may be revised retrospectively for up to 2 years as needed.

   b. The term "eligible member months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes 3 eligible member months to the total. Two individuals who are eligible for 2 months each contribute 2 eligible member months, for a total of 4 eligible member months.

   c. For the purposes of this demonstration, the term "demonstration eligibles" excludes unqualified aliens and refers to the demonstration populations described in STC 2 of this section. Beginning in DY 9, "demonstration eligibles" excludes Demonstration Populations 3 and 4, subject to STC 3(b) of this section, as well as portions of Demonstration Populations 1 and 2, as specified in STC 3(a – b) of this section. Demonstration Services 8 will have duplicate expenditures of member months in other demonstration populations and the state will ensure that duplicate member months will be omitted from any official tallies under the demonstration.

8. **Standard Medicaid Funding Process**. The standard Medicaid funding process must be used during the demonstration. New York must estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure

cap and separately report these expenditures by quarter for each federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments and State and Local Administration Costs. CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state. As part of the state's amendment to introduce eligibility flexibilities that seamlessly enroll adult TANF recipients into Medicaid, extend Adult Group coverage to individuals who turn 65 for a limited period and provide Medicaid during a temporary Marketplace coverage gap, the state will work with CMS to determine the best method to reconcile actual member months and actual expenditures for individuals in affected populations to ensure appropriate FMAP is claimed.

9. **Extent of FFP for the Demonstration**. Subject to CMS approval of the source(s) of the non- federal share of funding, CMS shall provide FFP at the applicable federal matching rates for the demonstration as a whole as outlined below, subject to the limits described in section XI:

    a. Administrative costs, including those associated with the administration of the demonstration.

    b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan and waiver authorities.

    c. Net expenditures and prior period adjustments, made under approved expenditure authorities granted through section 1115(a)(2) of the Act, with dates of service during the operation of the demonstration.

10. **Sources of Non-Federal Share**. The state certifies that the non-federal share of funds for the demonstration is state/local monies. The state further certifies that such funds shall not be used to match for any other federal grant or contract, except as permitted by law. All sources of non- federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

    a. CMS may review the sources of non-federal share of funding for the demonstration at any time. The state agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.

    b. Any amendments that impact the financial status of the program shall require the state to provide information to CMS regarding all sources of the non-federal share of funding.

11. **State Certification of Funding Conditions**. The state must certify that the following conditions for the non-federal share of demonstration expenditures are met:

a. Units of government, including governmentally operated health care providers, may certify that state or local tax dollars have been expended as the non-federal share of funds under the demonstration.

b. To the extent the state utilizes certified public expenditures (CPEs) as the funding mechanism for the title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the state would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.

c. To the extent the state utilizes CPEs as the funding mechanism to claim federal match for payments under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the state the amount of such tax revenue (state or local) used to satisfy demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the state's claim for federal match.

d. The state may use intergovernmental transfers to the extent that such funds are derived from state or local tax revenues and are transferred by units of government within the state. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of title XIX payments.

e. Under all circumstances, health care providers must retain 100 percent of the claimed expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) exist between health care providers and state and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes (including health care provider-related taxes), fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

12. **Monitoring the Demonstration**. The state will provide CMS with information to effectively monitor the demonstration, upon request, in a reasonable time frame.

XI. MONITORING BUDGET NEUTRATLITY

1. **Limit on Title XIX Funding**. The state shall be subject to a limit on the amount of federal title XIX funding that the state may receive on selected Medicaid expenditures during the period of approval of the demonstration. The limit is determined by using a per capita cost method, and budget neutrality expenditure caps are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. The data supplied by the state to CMS to set the annual limits is subject to review and audit, and, if found to be inaccurate, will result in a modified budget neutrality expenditure limit.

2. **Risk**. New York shall be at risk for the per capita cost (as determined by the method described below) for demonstration eligibles under this budget neutrality agreement, but not

for the number of demonstration eligibles in each of the groups. By providing FFP for all demonstration eligibles, New York shall not be at risk for changing economic conditions that impact enrollment levels. However, by placing New York at risk for the per capita costs for demonstration eligibles under this agreement, CMS assures that federal demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no demonstration.

3. **Demonstration Populations Used to Calculate Budget Neutrality Expenditure Limit.** The following demonstration populations are used to calculate the budget neutrality expenditure limit subject to the limitations outlined in STC 4 of this section and are incorporated into the following eligibility groups (EGs):

   a. Eligibility Group 1 – TANF Children under age 1 through 20 required to enroll in managed care in the counties subject to mandatory managed care enrollment as of October 1, 2006 (Demonstration Population 1)

   b. Eligibility Group 2 – TANF Adults aged 21 through 64 required to enroll in managed care in the counties subject to mandatory managed care enrollment as of October 1, 2006 (Demonstration Population 2).

   c. Eligibility Group 3 - Disabled Adults and Children 0 through 64 (Demonstration Population 3).

   d. Eligibility Group 4 - Aged or Disabled Adults (Demonstration Population 4)

   e. Eligibility Group 5 – MLTC adults age 18 through 64 – Duals (Demonstration Population 10).

   f. Eligibility Group 6 – MLTC Adults age 65 and above – Duals (Demonstration Population 11).

4. **Budget Neutrality Expenditure Limit**. The following describes the method for calculating the budget neutrality expenditure limit for the demonstration:

   a. For each year of the budget neutrality agreement, an annual budget neutrality expenditure limit is calculated for each EG described in STC 3 of this section as follows:

      i. An annual EG estimate must be calculated as a product of the number of eligible member months reported by the state in accordance with the requirements outlined in STC 3 of this section, for each EG, times the appropriate estimated per member per month (PMPM) costs from the table in subparagraph (iii) below. Should EGs 3 and 4 be incorporated into the budget neutrality expenditure limit, as outlined in this STC, the PMPM costs may be revised.

      ii. The PMPM costs in subparagraph (iii) below are net of any premiums paid by demonstration eligible.

iii. The PMPM costs for the calculation of the annual budget neutrality expenditure limit for the eligibility groups subject to the budget neutrality agreement under this demonstration are specified below.

A. To reflect the additional demonstration year that was authorized through temporary extension (DY 12), the PMPM cost for each EG in DY 11 has been increased by the appropriate growth rate from the prior extension period. These figures are displayed below.

Eligibility Group	**DY 11 (10/1/08 –**	**Trend Rate**	**DY 12 (10/1/09 –**
TANF Children under age 1 through 20	$549.19	6.7%	$585.99
TANF Adults 21through 64	$751.73	6.6%	$801.34

B. For the current extension period, the PMPM costs for each EG in DY 12 has been increased by the appropriate growth rate included in the President's federal fiscal year 2011 budget for DYs 13 through 16, as outlined below. In addition, because the Family Planning Expansion Adults are going to be treated as a "hypothetical state plan population" beginning in DY 13, a PMPM cost was constructed based on state expenditures in DY 10, and increased by the rate of growth in the medical care component of the Consumer Price Index between 2004 and 2008. Because DYs 16 and 17 combined are less than 12 months in duration, they are assigned the PMPM costs equal to what would have been calculated for the full year starting October 1, 2013 and ending September 30, 2014. The FHPlus Adults with Children and Family Planning Expansion Adults groups will end on December 31, 2013, so no PMPM is defined for those groups for DY 17. The budget neutrality expenditure limit will end March 31, 2014; expenditures made after that date for DSHP must be offset by accumulated savings from DYs 1 through 18.

Eligibility Group	DY 12 (10/1/09 – 9/30/10)`	Trend Rate	DY 13 (10/1/10 – 9/30/11)	DY 14 (10/1/11 – 9/30/12)	DY 15 (10/1/12 – 9/30/13)	DY 16 (10/1/13 – 7/31/15)
TANF Children under age 1 through 20	$585.99	6.6%	$624.67	$665.90	$709.85	$756.70
TANF Adults 21 through 64	$801.34	6.4%	$852.63	$907.20	$965.26	$1027.04
	[redacted]					
MLTC Adults 18through 64 - Dual	[redacted]	1.19%	[redacted]	$4009.38	$4057.09	$4105.37
MLTC Adults 65	[redacted]	3.23%	[redacted]	$4742.15	$4895.32	$5053.44

and above - Dual	[redacted]		[redacted]			

iv. The annual budget neutrality expenditure limit for the demonstration as a whole is the sum of the project annual expenditure limits for each EG calculated in subparagraph (i) above.

b. The overall budget neutrality expenditure limit for the demonstration period is the sum of the annual budget neutrality expenditure limits calculated in subparagraph (a)(iv) above for each year. The federal share of the overall budget neutrality expenditure limit represents the maximum amount of FFP that the state may receive for expenditures on behalf of demonstration populations and expenditures described in Section X during the demonstration period.

5. Monitoring of New Adult Group Spending and Opportunity to Adjust Projections. For each demonstration year, a separate annual budget limit for the new adult group will be calculated as the product of the trended monthly per person cost times the actual number of eligible/member months as reported to CMS by the state under the guidelines set forth in Section X. The per capita cost estimates for the new adult group are listed in the table below.

MEG	DY 16 – PMPM
New Adult Group	$722.57

a. If the state's experience of the take up rate for the new adult group and other factors that affect the costs of this population indicates that the new adult group PMPM limit described above may underestimate the actual costs of medical assistance for the new adult group, the state has the opportunity to submit an adjustment to the PMPM limit, along with detailed expenditure data to justify this, for CMS review without submitting an amendment pursuant to Section II. In order to ensure timely adjustments to the PMPM limit for a demonstration year, the revised projection for DY 16 must be submitted to CMS by no later than October 1, 2014.

b. The budget limit for the new adult group is calculated by taking the PMPM cost projections for the above group in each demonstration year, times the number of eligible member months for that group and demonstration year, and adding the products together across demonstration years. The federal share of the budget neutrality cap is obtained by multiplying total computable budget neutrality cap by the federal share.

c. The state will not be allowed to obtain budget neutrality "savings" from this population.

d. If total FFP reported by the state for the new adult group should exceed the federal share of FFP for the budget limit for the new adult group by more than 3 percent following each demonstration year, the state must submit a corrective action plan to CMS for approval.

6. **Calculating the Federal Medical Assistance Percentage (FMAP) for Continuous Eligibility for the Adult Group.** CMS anticipates that states that adopt continuous eligibility for adults would experience a 2 percent increase in enrollment. Based on this estimate, CMS has determined that 97.4 percent of the member months for newly eligibility in the Adult Group will be made at the enhanced FMAP rate and 2.6 percent will be matched at the regular FMAP rate.

7. **State Reporting for the FMAP Adjustment.** Newly eligible individuals in the Adult Group shall be claimed at the enhanced FMAP rate. The state must make an adjustment in the CMS-64W that accounts for the proportion of member months in which beneficiaries are enrolled due to continuous eligibility and could have been disenrolled due to excess income in absence of continuous eligibility (i.e. 2.6 percent). For the purposes of budget neutrality, the members for the adult group within the 2.6 percent of the population described in this STC will be treated as a hypothetical population. The state is not subject to use their budget neutrality savings towards providing continuous eligibility for this population.

8. **Future Adjustments to the Budget Neutrality Expenditure Limit**. CMS reserves the right to adjust the budget neutrality expenditure limit to be consistent with enforcement of impermissible provider payments, health care related taxes, new federal statutes, or policy interpretations implemented through letters, memoranda, or regulations with respect to the provision of services covered under the Partnership Plan.

9. **Enforcement of Budget Neutrality.** CMS shall enforce budget neutrality over the life of the demonstration rather than on an annual basis. DY 16c expenditures, which will consist only of DSHP expenditures in support of the H-MH and PPR demonstrations, will be included in the budget neutrality test for the demonstration. The state may receive FFP for these expenditures to the extent that sufficient accumulated budget neutrality savings are available from prior DYs.

10. **Exceeding Budget Neutrality**. If at the end of this demonstration period the overall budget neutrality expenditure limit has been exceeded, the excess federal funds must be returned to CMS. If the demonstration is terminated prior to the end of the budget neutrality agreement, an evaluation of this provision shall be based on the time elapsed through the termination date.

XII. EVALUATION OF THE DEMONSTRATION

1. The evaluation design must include a discussion of the goals and objectives set forth in Section II of these STCs, and develop evaluation questions specific to the changes implemented in the demonstration during the extension period.

    a. The evaluation questions should include, but are not limited to:

        i. To what extent has the provisions of continuous eligibility affected the stability and continuity of coverage and care to adults? How has the implementation of the Statewide Enrollment Center impacted “churning” by demonstration participants?

ii. A quantitative and qualitative assessment of the effectiveness of the provider and enrollee education and outreach efforts, as well as plan oversight and compliance monitoring, in minimizing the impact of the transition of individuals living with HIV into mandatory Medicaid managed care.

iii. To what extent has the mandatory enrollment of individuals living with HIV into MMC impacted their perceptions of care (fee-for-service vs. Safety Net Population/SNP vs. mainstream)?

iv. Has the required enrollment of individuals living with HIV into Medicaid managed care (either mainstream plans or HIV SNPs) impacted quality outcomes, which in earlier studies showed that these individuals enrolled in managed care on a voluntary basis received better quality care than in fee-for-service?

v. An assessment of the successes and failures, along with recommendations for improvement, of the HIV SNP program.

vi. Has the state's H-MH demonstration resulted in demonstrable improvements in the quality of care received by demonstration participants?

vii. To what extent has the H-MH demonstration produced replicable residency program design features that enhance training in medical home concepts?

viii. How has the H-MH demonstration helped the selected facilities improve both their systemic and quality performance under each initiative implemented by the selected facilities?

ix. How have the results of the PPR demonstration program informed changes in reimbursement policies that provide incentives to help people stay out of the hospital?

x. How has the PPR demonstration program improved quality and cost savings at selected facilities? To what extent are the interventions tested both replicable and sustainable?

xi. How has the additional funding provided under the Clinic Uncompensated Care program increased the use of patient-centered medical homes and electronic medical records?

xii. How have the results of the Marketplace Subsidy Program for enrollment in a QHP, using childless adults who are not eligible to receive a subsidy as a comparison group, expanded access to health insurance coverage?

b. The evaluation questions for MLTC goals should include, but are not limited to:

i. How has enrollment in MLTC plans increased over the length of the demonstration?

ii. What are the demographic characteristics of the MLTC population? Are they changing over time?

iii. What are the functional and cognitive deficits of the MLTC population? Are they changing over time?

iv. Are the statewide and plan-specific overall functional indices decreasing or staying the same overtime?

v. Are the average cognitive and plan specific attributes decreasing or staying the same over time?

vi. Are the individuals care plans consistent with the functional and cognitive abilities of the enrollees? This evaluation question will be included as there is sufficient data

available in 2014 to provide accurate measures. NYS will address this question in the Final Evaluation Plan.

vii. Access to care: To what extent are enrollees able to receive timely access to personal, home care and other services such as dental care, optometry and audiology?

viii. Quality of care: Are enrollees accessing necessary services such as flu shots and dental care?

ix. Patient Safety: Are enrollees managing their medications? What are the fall rates and how are they changing over time?

x. Satisfaction: What are the levels of satisfaction with access to, and perceived timeliness and quality of network providers?

xi. Costs: What are the PMPM costs of the population?

The draft design must discuss the outcome measures that will be used in evaluating the impact of the demonstration during the period of approval, particularly among the target population. It must discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the demonstration shall be isolated from other initiatives occurring in the state.

c. No later than 120 days after approval of the amendment to include BH services in MMMC and BH HCBS services in HIV SNPs and HARPS, the state must submit to CMS a draft evaluation design addendum describing how the state will evaluate HARPs and BH integration in MMMC. At a minimum, the evaluation of BH integration must examine the impact of HARPs and HIV SNPs on use of care and health outcomes for individuals eligible to receive BH HCBS benefits, the factors associated with individuals electing to or declining to enroll in HARPs, the cost effectiveness of HARPs, and the consequences of targeting availability of BH HCBS to a more narrowly defined population than the criteria in the state plan.

2. Evaluation Implementation. The state shall implement the final evaluation design and submit its progress in each of the quarterly and annual progress reports.

3. Interim Evaluation Report. The state must submit an interim evaluation report as part of the state's request for any future renewal of the demonstration.

4. Final Evaluation Report. The state must submit draft final evaluation reports according to the following schedule.

a. By July 31, 2014 the state must submit to CMS a draft final evaluation report, presenting findings from all evaluation activities. Findings from the evaluations of the H-MH and PPR demonstrations may be preliminary findings. CMS shall provide comments within 60 days after receipt of the report. The state shall submit the final evaluation report within 60 days after receipt of CMS comments.

b. By April 30, 2015 the state must submit to CMS a draft final evaluation report on the evaluations of the H-MH and PPR demonstrations. CMS shall provide comments within

60 days after receipt of the report. The state shall submit the final evaluation report within 60 days after receipt of CMS comments.

5. **Cooperation with CMS Evaluators**. Should CMS conduct an independent evaluation of any component of the demonstration, the state will cooperate fully with CMS or the independent evaluator selected by CMS. The state will submit the required data to the contractor or CMS.

ATTACHMENT A

Mainstream Medicaid Managed Care Benefits

Inpatient and outpatient hospital services
Clinic services including Rural Health Clinic and Federally Qualified Health Center services
Laboratory and X-ray services
Home health services
Early Periodic Screening, Diagnosis, and Treatment services (for individuals under age 21 only)
Family planning services and supplies
Physicians services including nurse practitioners and nurse midwife services
Dental services
Physical and occupational therapy
Speech, hearing, and language therapy
Prescription drugs, over-the-counter drugs, and medical supplies
Durable Medical Equipment (DME), including prosthetic and orthotic devices, hearing aids, and prescription shoes
Vision care services, including eyeglasses
Intermediate Care Facilities for the Mentally Retarded (ICF/MR)
Nursing facility services (Not covered in HARPs)
Personal care services
Medical Social Services for persons transitioning from the LTHHCP who received the service under the LTHHCP (non-state plan service)
Home Delivered Meals for persons transitioning from the LTHHCP who received the service under the LTHHCP (non-state plan service)
Case management services
Hospice care services
TB-related services
Inpatient and outpatient behavioral health services (mental health and chemical dependence services)
Emergency medical services, including emergency transportation
Adult day care
Personal Emergency Response Services (PERS)
Renal dialysis
Home and Community Based Services waivers (HCBS)
Care at Home Program (OPWDD)
Non–emergency transportation
Experimental or investigational treatment (covered on a case-by-case basis)
Health Home Care Coordination and Management

Service	Co-pay
Non-preferred brand-name prescription drugs	$3

Preferred brand-name prescription drugs	$1
Generic prescription drugs	$1

Note: One co-pay is charged for each new prescription and each refill. No co-payment for drugs to treat mental illness (psychotropic) and tuberculosis.

The state plan and demonstration behavioral health benefits below are being included in the MMMC plans for adults age 21 and over according to the implementation phase in. A separate amendment will be submitted for children under age 21 to include these benefits and HCBS services in MMMC.

State Plan Inpatient and Outpatient Behavioral Health Services in MMMCs for individuals 21 and older, excluding rehabilitation services for residents of community residences
Clinic: Medically supervised outpatient withdrawal
Clinic: OASAS outpatient and opioid treatment program (OTP) services
Rehabilitation: OASAS outpatient rehabilitation programs
Clinic: Outpatient clinic services (OMH services)
Outpatient Hospital: Comprehensive psychiatric emergency program including Extended Observation Bed (EOB)
Clinic: Continuing day treatment
Clinic: Partial hospitalization
Rehabilitation: Personalized Recovery Oriented Services
Rehabilitation: Intensive Psychiatric Treatment
Rehabilitation: Assertive Community Treatment
Targeted Case Management (being phased out) including Instensive case management/supportive case management
Inpatient Hospital: Medically Managed detoxification (hospital based)
Inpatient Hospital: Medically supervised inpatient detoxification
Inpatient hospital: Inpatient treatment
Inpatient Hospital: Inpatient psychiatric services
Rehabilitation: Services for residents of community residences *Note: these services are currently excluded from the behavioral health integration. will be phased into MMMC via contract amendments at a later date.*

Demonstration-Only Behavioral Health and SUD Services
Residential addiction services
Outpatient addiction Services
Crisis Intervention
Licensed Behavioral Health Practitioner Services

ATTACHMENT B
Managed Long Term Care Benefits

Home Health Care*
Medical Social Services
Adult Day Health Care
Personal Care
Durable Medical Equipment**
Non-emergent Transportation
Podiatry
Dental
Optometry/Eyeglasses
Outpatient Rehabilitation PT, OT, SP
Audiology/Hearing Aids
Respiratory Therapy
Private Duty Nursing
Nutrition
Skilled Nursing Facilities
Social Day Care
Home Delivered/Congregate Meals
Social and Environmental Supports
PERS (Personal Emergency Response Service)

*Home Care including Nursing, Home Health Aide, Physical Therapy (PT), Occupational Therapy (OT), Speech Pathology (SP)

**DME including Medical/Surgical, Hearing Aid Batteries, Prosthetic, Orthotics and Orthopedic Footwear

ATTACHMENT C

Home and Community-Based Services Expansion Program Benefits

All HCBS Expansion program participants may not receive all benefits listed below. An individual participant's access to the benefits below may vary based on the individual's similarity to an individual determined eligible for and enrolled in the LTHHC, NHTD, or TBI 1915(c) waiver program.

Assistive Technology (including personal emergency response system)
Community Integration Counseling and Services
Community Transition Services
Congregate/Home Delivered Meals
Environmental Modifications
Home and Community Support Services
Home Maintenance
Home Visits by Medical Personnel
Independent Living Skills Training
Intensive Behavioral Programs
Medical Social Services
Moving Assistance
Nutritional Counseling/Education
Peer Mentoring
Positive Behavioral Interventions
Respiratory Therapy
Respite Care/Services
Service Coordination
Social Day Care (including transportation)
Structured Day Program
Substance Abuse Programs
Transportation
Wellness Counseling Services

Home and community-based services (HCBS) must be provided in a setting that includes the following qualities:
The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

- The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.
- Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.
- Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
- Facilitates individual choice regarding services and supports, and who provides them.
- In a provider-owned or controlled residential setting, in addition to the qualities specified above, the following additional conditions must be met:

    1. The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.
    2. Each individual has privacy in their sleeping or living unit:

        - Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.
        - Individuals sharing units have a choice of roommates in that setting.
        - Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.

    3. Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time.
    4. Individuals are able to have visitors of their choosing at any time.
    5. The setting is physically accessible to the individual.
    6. Any modification of the additional conditions specified in items 1 through 4 above, must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:

        - Identify a specific and individualized assessed need.
        - Document the positive interventions and supports used prior to any modifications to the person-centered service plan.
        - Document less intrusive methods of meeting the need that have been tried but did not work.

- Include a clear description of the condition that is directly proportionate to the specific assessed need.
- Include regular collection and review of data to measure the ongoing effectiveness of the modification.
- Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
- Include the informed consent of the individual.
- Include an assurance that interventions and supports will cause no harm to the individual.

Settings That are Not Home and Community-Based:

For 1115 demonstrations that furnish HCBS services, settings that are not home and community-based are defined at §441.301(c)(5) as follows:

- A nursing facility;
- An institution for mental diseases;
- An intermediate care facility for individuals with intellectual disabilities;
- A hospital; or
- Any other locations that have qualities of an institutional setting, as determined by the Secretary.

ATTACHMENT D – BH HCBS in HARPS and HIV SNPs

Behavioral Health HCBS
HCBS Assessment • HCBS Eligibility Brief Assessment • HCBS Full Assessment
Rehabilitation • Psychosocial Rehabilitation • Community Psychiatric Support and Treatment (CPST)
Empowerment Services-Peer Supports
Habilitation Services
Respite • Short-term Crisis Respite • Intensive Crisis Respite
Non-medical transportation
Family Support and Training
Employment Supports • Pre-vocational • Transitional Employment • Intensive Supported Employment • On-going Supported Employment
Education Support Services

*HCBS settings must adhere to the same HCBS setting qualities as listed in Attachment C.

ATTACHMENT E

Quarterly Operational Report Format

Under Section IX STC 4, the state is required to submit quarterly reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter (except for the report due for the quarter ending on September 30 of each demonstration year, which can be incorporated into the annual report required under Section IX).

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the state. A complete quarterly progress report must include an updated budget neutrality monitoring workbook.

NARRATIVE REPORT FORMAT: Title

Partnership Plan

Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:

Introduction:

Information describing the goal of the demonstration, what it does, and key dates of approval /operation. (This should be the same for each report.)

Enrollment Information:

Please complete the following table that outlines all enrollment activity under the demonstration. The state should indicate "N/A" where appropriate. If there was no activity under a particular enrollment category, the state should indicate that by "0". Please note any changes in enrollment that fluctuate 10 percent or more over the previous quarter as well as the same quarter in the prior demonstration year.

Enrollment Counts

Note: Enrollment counts should be person counts, not participant months

Demonstration Populations (as hard coded in the CMS-64)	**Current Enrollees** (to date)	**No. Voluntary Disenrolled in current Quarter**	**No. Involuntary Disenrolled in current Quarter**
Population 1 – TANF Child under age 1 through age 20 in mandatory MC counties			

Population 2 - TANF Adults aged 21 through 64 in mandatory MC counties as of 10/1/06			
Adult Group in MMMC			
Population 9 – HCBS Expansion participants			
Population 10 – MLTC Adults 18 through 64 - Duals			
Population 11 – MLTC Adults age 65 and above - Duals			

Total enrollment in each MCO by month

Voluntary Disenrollments:

- Cumulative Number of Voluntary Disenrollments within Current Demonstration Year
  - Number of Opt-outs for all HARP enrollees and reasons
  - Number of Voluntary enrollments into HARPs
  - Number of re-enrollments into HARPs
- Reasons for Voluntary Disenrollments

Involuntary Disenrollments:

- Cumulative Number of Involuntary Disenrollments within Current Demonstration Year
- Reasons for Involuntary Disenrollments

Enrollment Information for Specific Sub-populations:

- Enrollees in the HCBS Expansion program
  - Enrollees in the HIV SNP
  - Enrollees in the HARPs

Program Operations

Outreach/Innovative Activities: Summarize outreach activities and/or promising practices for the current quarter.

Operational/Policy Developments/Issues: Identify all significant program developments/issues/problems that have occurred in the current quarter, including, but not limited to, approval and contracting with new plans, benefit changes, and legislative activity. Also include any anticipated activities or program changes related to health care delivery, benefits, enrollment, grievances, quality of care, access, and other operational issues.

Update on Progress and Activities related to Quality Demonstrations and Clinic Uncompensated Care Funding: Identify all activities relating to the implementation of these programs, including but not limited to:

- Release of solicitations and selection of awardees for the quality demonstrations;
- An explanation of grants, contracts or other financial arrangements entered into for purposes of implementing the quality demonstrations of this demonstration; and
- Progress of grantees in meeting the milestones identified in these STCs and any award documents.

Consumer Issues: A summary of the types of complaints or problems consumers identified about the program in the current quarter. Include any trends discovered, the resolution of complaints, and any actions taken or to be taken to prevent other occurrences, this should be broken out to show the number of LTSS complaints vs. all other categories identified. Also discuss feedback, issues or concerns received from the Medicaid Managed Care Advisory Review Panel (MMCARP), advocates and county officials.

Quality Assurance/Monitoring Activity: Identify any quality assurance/monitoring activity in current quarter.

Managed Long Term Care Program: Identify all significant program developments, issues, or problems that have occurred in the current quarter.

Home and Community-Based Services Expansion Program: For the quarter ending March 31 each year, attach a copy of the CMS-372 report completed in accordance with Appendix A of the approved Long-Term Home Health Care, the Nursing Home Transition and Diversion, and the Traumatic Brain Injury 1915(c) waivers.

Demonstration Evaluation: Discuss progress of evaluation implementation.

Financial/Budget Neutrality Developments/Issues: Provide information on:

- Quality demonstration and clinic uncompensated care expenditures – to whom and when
- Designated State Health Programs – amount of FFP claimed for the quarter

Enclosures/Attachments: Identify by title any attachments along with a brief description of what information the document contains.

State Contact(s): Identify individuals by name, title, mailing address, phone, fax, and email address that CMS may contact should any questions arise.

Date Submitted to CMS:

ATTACHMENT F – RESERVED

ATTACHMENT G

Mandatory Managed Long Term Care/Care Coordination Model (CCM)

Mandatory Population: Dual eligible, age 21 and over, receiving community based long term care services for over 120 days, excluding the following:

- **Long Term Home Health Care Program (in certain counties, see timeline below);**
- **Nursing Home Transition and Diversion waiver participants;**
- **Traumatic Brain Injury waiver participants;**
- **Nursing home residents;**
- **Assisted Living Program participants; and**
- **Dual eligible that do not require community based long term care services.**

Voluntary Population: Dual eligible, age 18 through 20, in need of community based long term care services for over 120 days and assessed as nursing home eligible. Non-dual eligible age 18 and older assessed as nursing home eligible and in need of community based long term care services for over 120 days.

The following requires CMS approval to initiate and reflects the enrollment of the mandatory population only.

Phase I and II: New York City and the suburbs

July 1, 2012 - Any new dual eligible case new to service, fitting the mandatory definition in any New York City County will be identified for enrollment and referred to the Enrollment Broker for action.

- Enrollment Broker will provide with educational material, a list of plans/CCMs, and answer questions and provide assistance contacting a plan if requested.
- Plan/CCM will conduct assessment to determine if eligible for community based long term care.
- Plan/CCM transmits enrollment to Enrollment Broker.

In addition, the following identifies the enrollment plan for cases already receiving care. Enrollment will be phased in by service type by borough by zip code in batches. People will be given 60 days to choose a plan according to the following schedule.

July 1, 2012: Begin personal care cases in New York County

August 1, 2012: Continue personal care cases in New York County

September, 2012: Continue personal care cases in New York County and begin personal care in Bronx County; and begin consumer directed personal assistance program cases in New York and Bronx counties

October, 2012: Continue personal care and consumer directed personal assistance program cases in New York and Bronx counties and begin Kings County

November, 2012: Continue personal care and consumer directed personal assistance program cases in New York, Bronx and Kings Counties

December, 2012: Continue personal care and consumer directed personal assistance program cases in New York, Bronx and Kings Counties and begin Queens and Richmond counties

January, 2013: Continue personal care and consumer directed personal assistance program citywide.

February, 2013 (and until all people in service are enrolled): Personal care, consumer directed personal assistance program, citywide.

March, 2013: Personal care, consumer directed personal assistance program, adult day health care, home health care over 120 days citywide.

March, 2013: Personal care, consumer directed personal assistance program, adult day health care, home health care over 120 days in Nassau, Suffolk and Westchester counties

April, 2013: Personal care, consumer directed personal assistance program, adult day health care, home health care over 120 days and long-term home health care program citywide.

April, 2013: Personal care, consumer directed personal assistance program, adult day health care, home health care over 120 days and long-term home health care program in Nassau, Suffolk and Westchester Counties

Phase III: Rockland and Orange Counties

Dually eligible community based long term care service recipients in these additional counties as capacity is established. June 2013

Phase IV: Albany, Erie, Onondaga and Monroe Counties

Dually eligible community based long term care service recipients in these additional counties as capacity is established. Anticipated Fall 2013

Phase V: Other Counties with capacity.

Dually eligible community based long term care service recipients in these additional counties as capacity is established. Anticipated Spring 2014

Phase VI:

Previously excluded dual eligible groups contingent upon development of appropriate program models:

- Nursing Home Transition and Diversion waiver participants;
- Traumatic Brain Injury waiver participants;
- Nursing home residents;
- Assisted Living Program participants;
- Dual eligible that do not require community based long term care services.

CENTERS FOR MEDICARE & MEDICAID SERVICES

SECTION 1115 OF THE SOCIAL SECURITY ACT MEDICAID DEMONSTRATION

NEW YORK PARTNERSHIP PLAN

WAIVER NUMBER 11-W-00114/2

CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER AUTHORITY

NUMBER: 11-W-00114/2

TITLE: Partnership Plan Medicaid Section 1115 Demonstration

AWARDEE: New York State Department of Health

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived in this list, shall apply to the demonstration, beginning April 14, 2014 through December 31, 2014.

The following waivers shall enable New York to implement the approved Special Terms and Conditions (STCs) for the New York Partnership Plan Medicaid section 1115 demonstration.

1. **Statewideness** **Section 1902(a)(1)**

To permit the exclusion of some residents of some counties in New York from participation in Mandatory Mainstream Managed Care (MMMC) and Managed Long Term Care (MLTC) under this demonstration.

2. **Income Comparability** **Section 1902(a)(17)**

To enable New York to apply a more liberal income standard for individuals who are deinstitutionalized and receive home and community-based services (HCBS) through the managed long term care program than for other individuals receiving community-based long term care.

3. **Freedom of Choice** **Section 1902(a)(23)(A)**

To the extent necessary to enable New York to require beneficiaries to enroll in managed care plans, to the extent of the services furnished through the MMMC and MLTC programs. Beneficiaries shall retain freedom of choice of family planning providers.

4. **Payments to Providers Under the State Plan** **Sections 1902(a)(13)(A) and 1902(a)(30)(A)**

To the extent necessary to permit the state to elect to reduce supplemental payments to institutional providers otherwise authorized under the approved state plan in order to prioritize funding for delivery system reform incentive payments.

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY LIST

NUMBER: 11-W-00114/2

TITLE: Partnership Plan Medicaid Section 1115 Demonstration

AWARDEE: New York State Department of Health

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by New York for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period beginning April 14, 2014, until the ending date specified for each authority, be regarded as expenditures under the state's title XIX plan.

The following expenditure authorities shall enable New York to implement the approved Special Terms and Conditions (STCs) for the New York Partnership Plan Medicaid Section 1115 demonstration.

1. **Demonstration-Eligible Populations.** Expenditures for healthcare related costs for the following populations that are not otherwise eligible under the Medicaid state plan. (End Date: December 31, 2014).

    - Demonstration Population 9 (HCBS Expansion). Medically needy individuals who are receiving HCBS, and who are medically needy after application of community spouse and spousal impoverishment eligibility and post-eligibility rules under 1924 of the Act are applied.

    - Demonstration Population 10 (Individuals Moved from Institutional Settings to Community Settings for Long Term Care Services). Expenditures for health care related costs for individuals moved from institutional nursing facility settings to community settings for long term services and supports who would not otherwise be eligible based on income, but whose income does not exceed a more liberal income standard, and who receive services through the managed long term care program under the demonstration.

2. **Twelve-Month Continuous Eligibility Period**. Expenditures for health care related costs for individuals who have been determined eligible under groups specified in Table 1 of STC 4 in Section IV for continued benefits during any periods within a twelve month eligibility period when these individuals would be found ineligible if subject to redetermination (End Date: December 31, 2014)

3. Twelve-Month Continuous Eligibility Period. Expenditures for health care related costs for individuals in the new adult population determined eligible under the Modified Adjusted Gross Income (MAGI) methodology. This population will receive continued benefits during any period within a twelve month eligibility period when these individuals would be found ineligible if subject to redetermination. To reflect that only the regular matching rate is

available for these demonstration expenditures, the state shall, make a downward adjustment of 2.6 percent in claimed expenditures for federal matching at the enhanced federal matching rate and will instead claim those expenditures at the regular matching rate.

4. **Facilitated Enrollment Services.** Expenditures for enrollment assistance services provided by organizations that do not meet the requirements of Section 1903(b)(4) of the Act, as interpreted by 42 CFR 438.810(b)(1) and (2). Inasmuch as these services may be rendered by MCOs and therefore included in the MCOs' capitation payments, no expenditures other than these payments may be submitted for FFP. (End Date: December 31, 2014)

5. **Designated State Health Programs Funding**. Expenditures for the designated state health programs specified in STC 12 in Section VII which provide health care services to low-income or uninsured New Yorkers in an amount not to exceed $531.2 million of the demonstration period, including $186.2 million for direct funding for an indigent care pool. (End Date: December 31, 2014.)

6. **Designated State Health Programs Funding**. Expenditures for the designated state health program specified in STC 12 in Section VII which provides transitional Family Health Plus (FHPlus) benefits to parents and caretaker relatives with incomes up to 150 percent of the federal poverty level (FPL). This authority expires December 31, 2014.

7. **Designated State Health Programs Funding**. Expenditures for the designated state health program specified in STC 12 in Section VII which provides premium subsidies to FHPlus individuals and new applicants between 133 percent and 150 percent FPL who have coverage through the Marketplace. This authority expires December 31, 2014.

8. **Designated State Health Programs Funding**. Expenditures for the designated state health program specified in STC 15 in Section VIII of the STCs, not to exceed $188 million in FFP in calendar year 2014.

9. **Delivery System Reform Incentive Payment (DSRIP) Program**. Expenditures for incentive payments and planning grant payments for the DSRIP program specified in STC 1 – 40 in Section VIII of the STCs, not to exceed $120 million of FFP in calendar year 2014.

10. **Interim Access Assurance Fund (IAAF).** Expenditures for payments to providers from the IAAF specified in STC 1 in Section VIII of the STCs, not to exceed $500 million in FFP in calendar year 2014.

CENTERS FOR MEDICARE & MEDICAID SERVICES

SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-00114/2

TITLE: Partnership Plan Medicaid Section 1115 Demonstration

AWARDEE: New York State Department of Health

I. PREFACE

The STCs have been arranged into the following subject areas:

I. Preface
II. Program Description and Objectives
III. General Program Requirements
IV. Populations Affected by and Eligible Under the Demonstration
V. Demonstration Benefits and Enrollment
VI. Delivery Systems
VII. Quality Demonstration Programs and Clinic Uncompensated Care Funding
VIII. Delivery System Reform Program Description and Objectives
IX. General Reporting Requirements
X. General Financial Requirements
XI. Monitoring Budget Neutrality
XII. Evaluation of the Demonstration
XIII. Schedule of State Deliverables for the Demonstration Extension

Additionally, attachments have been included to provide supplementary information and guidance for specific STCs.

II. PROGRAM DESCRIPTION AND OBJECTIVES

The state's goal in implementing the Partnership Plan section 1115(a) demonstration is to improve access to health services and outcomes for low-income New Yorkers by:

- Improving access to health care for the Medicaid population;
- Improving the quality of health services delivered;
- Expanding access to family planning services; and
- Expanding coverage with resources generated through managed care efficiencies to additional low-income New Yorkers.

The demonstration is designed to use a managed care delivery system to deliver benefits to Medicaid recipients, create efficiencies in the Medicaid program, and enable the extension of coverage to certain individuals who would otherwise be without health insurance. It was approved in 1997 to enroll most Medicaid recipients into managed care organizations

(MCOs) (Medicaid managed care program). As part of the demonstration's renewal in 2006, authority to require some disabled and aged populations to enroll in mandatory managed care was transferred to a new demonstration, the Federal-State Health Reform Partnership (F-SHRP). Effective April 1, 2014, this authority was restored to this demonstration as F-SHRP was phased out.

In 2001 the Family Health Plus (FHPlus) program was implemented as an amendment to the demonstration, providing comprehensive health coverage to low-income uninsured adults, with and without dependent children, who have income greater than Medicaid state plan eligibility standards. FHPlus was further amended in 2007 to implement an employer-sponsored health insurance (ESHI) component. Individuals eligible for FHPlus who have access to cost-effective ESHI are required to enroll in that coverage, with FHPlus providing any wrap-around services necessary to ensure that enrollees get all FHPlus benefits. FHPlus expires on December 31, 2013 and will become a state-only program, but federal matching funding for state expenditures for FHPlus will continue to be available as a designated state health program through December 31, 2014..

In 2002 the demonstration was expanded to incorporate a family planning benefit under which family planning and family planning-related services are provided to women losing Medicaid eligibility and to certain other adults of childbearing age (family planning expansion program). The family planning expansion program expires on December 31, 2013 and becomes a state plan benefit.

In 2010 the Home and Community Based Services Expansion program (HCBS expansion program) was added to the demonstration. It provides cost-effective home and community based services to certain adults with significant medical needs as an alternative to institutional care in a nursing facility. The benefits and program structure mirrors those of existing section 1915(c) waiver programs, and strives to provide quality services for individuals in the community, ensure the well-being and safety of the participants and increase opportunities for self-advocacy and self-reliance.

As part of the 2011 extension, the state was authorized to develop and implement two new initiatives designed to improve the quality of care rendered to Partnership Plan recipients. The first, the Hospital-Medical Home (H-MH) project, will provide funding and performance incentives to hospital teaching programs in order to improve the coordination, continuity and quality of care for individuals receiving primary care in outpatient hospital settings. By the end of the demonstration extension period, the hospital teaching programs which receive grants under the H-MH project will have received certification by the National Committee for Quality Assurance as patient-centered medical homes and implemented additional improvements in patient safety and quality outcomes.

The second 2011 initiative was intended to reduce the rate of preventable readmissions within the Medicaid population, with the related longer-term goal of developing reimbursement policies that provide incentives to help people stay out of the hospital. Under the Potentially Preventable Readmissions (PPR) project, the state will provide funding, on a competitive basis, to hospitals and/or collaborations or hospitals and other providers for the

purpose of developing and implementing strategies to reduce the rate of PPRs for the Medicaid population. Projects will target readmissions related to both medical and behavioral health conditions.

Finally, in 2011 CMS began providing matching funding for the state's program to address clinic uncompensated care through its Indigent Care Pool. Prior to this extension period, the state funded (with state dollars only) this program which provides formula-based grants to voluntary, non-profit and publicly-sponsored Diagnostic and Treatment Centers (D&TCs) for services delivered to the uninsured throughout the state.

In 2012, New York added to the demonstration an initiative to improve service delivery and coordination of long term care services and supports for individuals through a managed care model. Under the Managed Long Term Care (MLTC) program, eligible individuals in need of more than 120 days of community-based long term care are enrolled with managed care providers to receive long term services and supports as well as other ancillary services. Other covered services are available on a fee-for-service basis to the extent that New York has not exercised its option to include the individual in the Mainstream Medicaid Managed Care Program (MMMC). Enrollment in MLTC was phased in geographically and by group.

The state's goal specific to managed long term care (MLTC) are as follows:

- Expanding access to managed long term care for Medicaid enrollees who are in need of long term services and supports (LTSS);
- Improving patient safety and quality of care for enrollees in MLTC plans;
- Reduce preventable inpatient and nursing home admissions; and
- Improve satisfaction, safety and quality of life.

In April 2013 New York had three amendments approved. The first amendment was a continuation of the state's goal for transitioning more Medicaid beneficiaries into managed care. Under this amendment, the Long Term Home Health Care Program (LTHHCP) participants were transitioned from New York's 1915(c) waiver into the 1115 demonstration and into managed care. Second, this amendment eliminated the exclusion from MMMC of, both foster care children placed by local social service agencies and individuals participating in the Medicaid buy-in program for the working disabled.

Additionally the April 2013 amendment approved expenditure authority for New York to claim FFP for expenditures made for certain designated state health program beginning April 1, 2013 through March 31, 2014. During this period, the state was also required to submit several deliverables to demonstrate that the state was successful in its efforts to transform its health system for individuals with developmental disabilities.

A December 2013 amendment was approved to ensure that the demonstration made changes that were necessary in order to coordinate its programs with the Medicaid expansion and other changes made under the Affordable Care Act (ACA) implementation beginning January 1, 2014.

Effective April 1, 2014 CMS approved an amendment to extend several authorities that expired in calendar year 2014. As part of the amendment CMS extended authorities related to the transitioning of parents into state plan coverage and other authorities that provide administrative ease to the state's programs and continuing to provide services to vulnerable population, i.e. HCBS Expansion program and individuals moved from institutional settings into community based settings.

Also effective April 1, 2014, the Federal-State Health Reform Partnership (F-SHRP) demonstration phased out and populations receiving managed care of managed long term care in the 14 counties that encompassed the F-SHRP demonstration were moved into the Partnership Plan demonstration.

The amendment approved on April 14, 2014 allows New York to take the first steps toward a major delivery system reform to be supported by a Delivery System Reform Incentive Payment (DSRIP) program. We have reached agreement on the basic structure of Medicaid funding for New York State's longer-term transformation efforts, which aim to significantly improve care, change how public and safety net providers are organized, and reform how Medicaid pays for health services. This amendment to the Partnership Plan demonstration will provide for an Interim Access Assurance Fund (IAAF) to ensure that sufficient numbers and types of providers are available in the community to participate in the transformation activities contemplated by the DSRIP Program. The DSRIP program will incentivize providers through additional payments beginning contingent on the 5-year renewal of the demonstration in 2015.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statues**. The state must comply with all applicable federal statues relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid Law, Regulation and Policy.** All requirements of the Medicaid program expressed in law, regulation and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), must apply to the demonstration.

3. **Changes in Medicaid Law, Regulation and Policy**. The state must, within the timeframes specified in law, regulation or policy statement, come into compliance with any changes in federal law, regulation or policy affecting the Medicaid program that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable.

4. **Impact on Demonstration of Changes in Federal Law, Regulation and Policy.**

    a. To the extent that a change in federal law, regulation or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this

demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph.

b. If mandated changes in the federal law require state legislation, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

5. **State Plan Amendments**. The state will not be required to submit title XIX state plan amendments for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid state plan is affected by a change to the demonstration, a conforming amendment to the state plan may be required, except as otherwise noted in these STCs.

6. **Changes Subject to the Amendment Process.** Changes related to program design, eligibility, enrollment, expansion of program benefits, sources of non-federal share of funding and budget neutrality must be submitted to CMS as amendments to the demonstration. All amendments are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Social Security Act (the Act). The state must not implement changes to these elements without prior approval by CMS. Amendments to the demonstration are not retroactive, and FFP will not be available for changes to the demonstration that have not been approved through the amendment process outlined in STC 7 of this section.

7. **Amendment Process**. Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. Amendment requests must include, but are not limited to, the following:

   a. An explanation of the public process used by the state, consistent with the requirements of STC 14 of this section, to reach a decision regarding the requested amendment;

   b. A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by eligibility group/EG) the impact of the amendment;

   c. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and

d. If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.

8. Extension of the Demonstration.

a. Should the state intend to request an extension of the demonstration under section 1115(a), 1115(e), or 1115(f), the state must submit an extension request no later than 6 months prior to the expiration date of the demonstration. The chief executive officer of the state must submit to CMS either a demonstration extension request or a phase-out plan consistent with the requirements of STC 9 of this section.

b. Compliance with Transparency Requirements of 42 CFR 431.412. Effective April 27, 2012, as part of the demonstration extension requests, the state must provide documentation of compliance with the transparency requirements of 42 CFR 431.412 and the public notice and tribal consultation requirements outlined in STC 14 of this section regarding Public Notice, Tribal Consultation and Consultation with Interested Parties.

9. Demonstration Phase-Out. The state may suspend or terminate this demonstration in whole, or in part, consistent with the following requirements:

a. Notification of Suspension or Termination: The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and phase-out plan. The state must submit its notification letter and a draft phase-out plan to CMS no less than 4 months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft phase-out plan to CMS, the state must publish on its website the draft phase-out plan for 30 day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation state plan amendment. Once the 30 day public comment period has ended, the state must provide a summary of each public comment received, the state's response to the comment, and the way the state incorporated the received comment into a revised phase-out plan.

CMS must approve the phase-out plan prior to the implementation of the phase-out activities. There must be a 14 day period between CMS approval and the phase-out plan implementation of phase-out activities.

b. Phase-Out Plan Requirements: The state must include, at a minimum, in its phase out plan its process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and any community outreach activities.

c. Phase-Out Procedures: The state must comply with all notice requirements found in 42 CFR § 431.206, § 431. 210 and § 431.213. In addition, the state must ensure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR § 431.220 and § 431.221. If a demonstration participant requests a hearing before the date

of action, the state must maintain benefits as required in 42 CFR § 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine whether they qualify for Medicaid eligibility under a different eligibility category as discussed in the October 1, 2011 State Health Official Letter #10-008.

d. Federal Financial Participation (FFP): If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.

10. CMS Right to Terminate or Suspend. CMS may suspend or terminate the demonstration, subject to adequate public notice, (in whole or in part) at any time before the date of expiration, whenever it determines following a hearing that the state has materially failed to comply with the terms of the project. CMS will promptly notify the state in writing of the determination and the reasons for the suspension or termination, together with the effective date.

11. Finding of Non-Compliance. The state does not relinquish its rights to challenge CMS findings that the state materially failed to comply.

12. Withdrawal of Waiver Authority. 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 in the public interest or promote the objectives of title XIX of the Act. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver of expenditure authority, including services and administrative costs of disenrolling participants.

13. Adequacy of Infrastructure. The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; monitoring and oversight of managed care plans providing long term services and supports including quality and enrollment processes; and reporting on financial and other demonstration components.

14. Public Notice, Tribal Consultation and Consultation with Interested Parties. The state must comply with the state Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The state must also comply with the tribal consultation requirements in section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009 and the tribal consultation requirements contained in the state's approved state plan, when the state proposes any program changes to the demonstration, including (but not limited to) those referenced in STC 6 of this section.

In states with federally recognized Indian tribes, consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 letter or the consultation process in the state approved Medicaid state plan, if that process is specifically applicable to consulting with tribal governments on waivers (42 CFR § 431.408(b)(2)).

15. **Transformed Medicaid Statistical Information Systems (T-MSIS) Requirements**. The state shall comply with all data reporting requirements under Section 1903(r) of the Act, including but not limited to Transformed Medicaid Statistical Information Systems Requirements. More information on T-MSIS is available in the August 23, 2013 State Medicaid Director Letter. On August 23, 2013, a State Medicaid Director Letter entitled, "Transformed Medicaid Statistical Information System (T-MSIS) Data", was released. It states that all States are expected to demonstrate operational readiness to submit T-MSIS files, transition to T-MSIS, and submit timely T-MSIS data by July 1, 2014. Among other purposes, these data can support monitoring and evaluation of the Medicaid program in New York against which the premium assistance demonstration will be compared.

    Should the MMIS fail to maintain and produce all federally required program management data and information, including the required T-MSIS, eligibility, provider, and managed care encounter data, in accordance with requirements in the State Medicaid Manual Part 11, FFP may be suspended or disallowed as provided for in federal regulations at 42 CFR 433 Subpart C, and 45 CFR Part 95.

IV. POPULATIONS AFFECTED BY AND ELIGIBILITY UNDER THE DEMONSTRATION

1. **Demonstration Components.** The Partnership Plan includes five distinct components, each of which affects different populations, some of which are eligible under the state plan and some of which are eligible only as an expansion population under the demonstration.

    a. **Mainstream Medicaid Managed Care Program (MMMC).** This component provides Medicaid state plan benefits through a managed care delivery system comprised of managed care organizations (MCOs) and primary care case management (PCCM) arrangements to most recipients eligible under the state plan. All state plan eligibility determination rules apply to these individuals.

        Specifically the state has authority to expand mandatory enrollment in mainstream managed care to all individuals identified in Table 2 (except those otherwise excluded or exempted as outlined in STC 9 of this section. When the state intends to expand mandatory managed care enrollment to additional counties, it must notify CMS 90 days prior to the effective date of the expansion and submit a revised assessment of the demonstration's budget neutrality agreement, which reflects the projected impact of the expansion for the remainder of the demonstration approval period.

    b. **Managed Long Term Care (MLTC**). This component provides a limited set of Medicaid state plan benefits including long term services and supports through a

managed care delivery system to individuals eligible through the state plan who require more than 120 days of community based long term care services.

Services not provided through the MLTC program are provided on a fee-for-service basis. The state has authority to expand mandatory enrollment into MLTC to all individuals identified in Table 3 (except those otherwise excluded or exempted as outlined in STC 10 of this section) with initial mandatory enrollment starting in any county in New York city and then expanding statewide based on the enrollment plan outlined in Attachment F. When the state intends to expand into a new county outside of New York City, it must notify CMS 90 days prior to the effective date of the expansion and submit a revised assessment of the demonstration's budget neutrality agreement along with all other required materials as outlined in STC 6 in Section V.

c. Home and Community Based Services Expansion Program (HCBS Expansion). This component provides home and community based services to those provided under three of the state's section 1915(c) HCBS waivers (Long Term Home Health Care Program/LTHHCP, Nursing Home Transition and Diversion Program/NHTD, and Traumatic Brain Injury Program/TBI) to certain medically needy individuals. These services enable these individuals to live at home with appropriate supports rather than in a nursing facility.

2. Individuals Eligible under the Medicaid State Plan (State Plan Eligibles). Mandatory and optional Medicaid state plan populations derive their eligibility through the Medicaid state plan and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid state plan, except as expressly waived and as further described in these STCs.

3. Individuals Not Otherwise Eligible under the Medicaid State Plan. Individuals made eligible under this demonstration by virtue of the expenditure authorities expressly granted include those in the HCBS Expansion component of the demonstration and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid state plan, except as specified as not applicable in the expenditure authorities for this demonstration.

4. Continuous Eligibility Period.

a. Duration. The state is authorized to provide a 12 month continuous eligibility period to the groups of individuals specified in Table 1, regardless of the delivery system through which they receive Medicaid benefits. Once the state begins exercising this authority, each newly eligible individual's 12 month period shall begin at the initial determination of eligibility; for those individuals who are redetermined eligible consistent with Medicaid state plan rules, the 12-month period begins at that point. At each annual eligibility redetermination thereafter, if an individual is redetermined eligible under the Medicaid state plan the individual is guaranteed a subsequent 12 month continuous eligibility period. 12 month continuous eligibility is also authorized for the new adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.

b. Exceptions. Notwithstanding subparagraph (a), if any other following circumstances occur during an individual's 12 month continuous eligibility period, the individual's Medicaid eligibility shall be terminated:

i. The individual cannot be located.
ii. The individual is no longer a New York State resident.
iii. The individual requests termination of eligibility.
iv. The individual dies.
v. The individual fails to provide, or cooperate in obtaining a Social Security Number, if otherwise required.
vi. The individual provided an incorrect or fraudulent Social Security Number.
vii. The individual was determined eligible for Medicaid in error.
viii. The individual is receiving treatment in a setting where Medicaid eligibility is not available (e.g. institution for mental disease).
ix. The individual is in receipt of long term care services.
x. The individual is receiving care, services or other supplies under a section 1915 waiver.
xi. The individual was previously otherwise qualified for emergency medical assistance benefits only, based on immigration status, but is no longer qualified because the emergency has been resolved.
xii. The individual fails to provide the documentation of citizenship or immigration status required under federal law.
xiii. The individual is incarcerated.

Table 1: Groups Eligible for a 12 Month Continuous Eligibility Period

State Plan Mandatory and Optional Groups	Statutory Reference (Social Security Act(
Pregnant women aged 19 or older	1902(a)(10)(A)(i)(III) or (IV); and 1902(a)(10)(A)(ii)(I) and (II)
Children aged 19 or 20	1902(a)(10)(A)(ii)(I) and (II)
Parents or other caretaker relatives aged 19 or older	1902(a)(10)(A)(ii)(I) and (II)
Members of low income families, except for children	1931 and 1925
Medically needy pregnant women, children and parents/caretaker relatives	Without spend down under 1902(a)(10)(C)(i)(III)

5. Individuals enrolled in MMMC. Table 2 below lists the groups of individuals who receive Medicaid benefits through the Medicaid managed care component of the demonstration, as well as the relevant expenditure reporting category (demonstration population) for each.

Table 2: Mainstream Medicaid Managed Care Program

State Plan Mandatory and Optional Groups	FPL and/or Other Qualifying Criteria	Expenditure and Eligibility Group Reporting
Pregnant Women	Income up to 200% of FPL	Demonstration Population 2/Temporary Assistance to Needy Families (TANF) Adult

Children under age 1	Income up to 200% of FPL	Demonstration Population 1/TANF Child
Children 1 through 5	Income up to 133% of the FPL	Demonstration Population 1/TANF Child
Children 6 through 18	Income up to 133% of FPL	Demonstration Population 1/TANF Child
Children 19 through 20	Income at or below the monthly income standard (determined annually)	Demonstration Population 1/TANF Child
Foster Children Aged 0 through 20, (IV-E Foster Children and non IV-E Foster Children)	Categorically Medicaid Eligible, Disregard all Income	Demonstration Population 1/TANF Child
The New Adult Group (effective January 1, 2014)	Income up to 133% of FPL	New Adult Group
Parents and Caretaker Relatives	Income at or below the monthly income standard (determined annually)	Demonstration Population 2/TANF Adult

6. **Individuals enrolled in MLTC**. Table 3 below lists the groups of individuals who may be enrolled in the Managed Long Term Care component of the demonstration as well as the relevant expenditure reporting category (demonstration population) for each. To be eligible, all individuals in this program must need more than 120 days of community based long term care services and for MAP and PACE have a nursing home level of care.

Table 3: Managed Long Term Care Program

State Plan Mandatory and Optional Groups	FPL and/or Other Qualifying Criteria	Expenditure and Eligibility Group Reporting
Adults aged 65 and older	Income at or below SSI level	Demonstration Population 11/MLTC Adults 65 and above – Duals
Adults/children aged 19 through 64	Income at or below SSI level	Demonstration Population 10/MLTC Adults 18 through 64 – Duals
Adults aged 65 and older	Income at or below the monthly income standard, or with spend down to monthly income standard	Demonstration Population 11/MLTC Adults 65 and above - Duals
Adults/children aged 18 through 64 blind and disabled	Income at or below the monthly income standard, or with spend down to monthly income standard	Demonstration Population 10/MLTC Adults 18 through 64 – Duals
Aged 18 through 64 Medicaid Buy In for Working People with Disabilities	Income up to 250% of FPL	Demonstration Population 10/MLTC Adults 18 through 64 – Duals
Parents and Caretaker	Income at or below the	Demonstration Population

Relatives 21 through 64	monthly income standard, or with spend down to monthly income standard	10/MLTC Adults 18 through 64 – Duals
Children aged 18 through 20	Income at or below the monthly income standard or with spend down	Demonstration Population 10/MLTC Adults 18 through 64 – Duals
Pregnant Women	Income up to 200% of FPL	Demonstration Population 10/MLTC Adults 18 through 64 – Duals
Poverty Level Children Aged 18 through 20	Income up to 133% of FPL	Demonstration Population 10/MLTC Adults 18 through 64 – Duals
Foster Children Aged 18 through 20	In foster care on the date of 18th birthday	Demonstration Population 10/MLTC Adults 18 through 64 – Duals
Individuals Moved from Institutional Settings to Community Settings for Long Term Care Services	Income based on higher income standard to community settings for long term services and supports pursuant to STC 8 of this section	Demonstration Population 10 and 11/MLTC Adults 18 through 64 and MLTC Adults 65 and above

7. **Individuals enrolled in HCBS Expansion Program.** This group, identified as Demonstration Population 9/HCBS Expansion, includes married medically needy individuals:

   a. Who meet a nursing home level of care;

   b. Whose spouse lives in the community; and

   c. Who could receive services in the community but for the application of the spousal impoverishment eligibility and post-eligibility rules of section 1924 of the Act.

8. **Individuals Moved from Institutional Settings to Community Settings for Long Term Services and Supports.** Individuals discharged from a nursing facility who enroll into the MLTC program in order to receive community based long term services and supports or who move from an adult home as defined in subdivision twenty-five of section two of the social services law, to the community and, if applicable, enroll into the MLTC program, are eligible based on a special income standard. Spousal impoverishment rules shall not apply to this population. The special income standard will be determined by utilizing the average Housing and Urban Development (HUD) Fair Market Rent (FMR) dollar amounts for each of the seven regions in the state, and subtracting from that average, 30 percent of the Medicaid income level (as calculated for a household of one) that is considered available for housing. The seven regions of the state include: Central, Northeaster, Western, Northern Metropolitan, New York City, Long Island and Rochester.

The state shall work with Nursing Home Administrators, nursing home discharge planning staff, family members and the MLTC health plans to identify individuals who may qualify for the housing disregard as they are able to be discharged from a nursing facility back into the community and enrolled into the MLTC program. Spousal impoverishment rules shall apply to individuals who have a spouse living in the community who enroll into the MLTC program.

Enrollees receiving community based long term services and supports must be provided with nursing facility coverage through managed care, if nursing facility care is needed for 120 days or less and there is an expectation that the enrollee will return to community based settings. During the short term nursing facility stay, the state must retain the enrollees' community maintenance needs allowance. In addition, the state will ensure that the MLTC Managed Care Organizations (MCOs) work with individuals, their families, nursing home administrators, and discharge planners to help plan for the individual's move back into the community, as well as to help plan for the individual's medical care once he/she has successfully moved into his/her home. For dually eligible enrollees, the MCO is responsible for implementing and monitoring the plan of care between Medicare and Medicaid. The MCO must assure the services are available to the enrollee.

9. **Exclusions and Exemptions from MMMC**. Notwithstanding the eligibility criteria in STC 1 of this section, certain individuals cannot receive benefits through the MMMC program (i.e. excluded), while others may request an exemption from receiving benefits through the MMMC program (i.e. exempted). Tables 4 and 5 list those individuals either excluded or exempted from MMMC.

Table 4: Individuals Excluded from MMMC

Individuals who become eligible for Medicaid only after spending down a portion of their income
Residents of state psychiatric facilities or residents of state-certified or voluntary treatment facilities for children and youth
Patients in residential health care facilities (RHCF) at time of enrollment and residents in an RHCF who are classified as permanent
Participants in capitated long term care demonstration projects
Medicaid eligible infants living with incarcerated mothers
Individuals with access to comprehensive private health insurance if cost effective
Foster care children in the placement of a voluntary agency
Certified blind or disabled children living or expected to live separate and apart from their parents for 30 days or more
Individuals expected to be Medicaid eligible for less than 6 months (except for pregnant women)
Individuals receiving hospice services (at time of enrollment)
Individuals with a "county of fiscal responsibility" code of 97 (Individuals residing in a state Office of Mental Health facility)
Individuals with a "county of responsibility" code of 98 (Individuals in an Office for People with Developmental Disabilities/OPWDD facility or treatment center)
Youth in the care and custody of the commissioner of the Office of Family & Children Services
Individuals who are under 65 years of age (screened and require treatment) in the Centers for

Disease Control and Prevention breast, cervical, colorectal or prostate cancer, and who are not otherwise covered under creditable health coverage
Individuals who are eligible for Emergency Medicaid

Table 5: Individuals who may be exempted from MMMC

Individuals with chronic medical conditions who have been under active treatment for at least 6 months with a sub-specialist who is not a network provider for any Medicaid MCO in the service area or whose request has been approved by the New York State Department of Health Medical Director because of unusually severe chronic care needs. Exemption is limited to six months
Individuals designated as participating in OPWDD-sponsored programs
Individuals already scheduled for a major surgical procedure (within 30 days of scheduled enrollment) with a provider who is not a participant in the network of any Medicaid MCO in the service area. Exemption is limited to six months
Individuals with a developmental or physical disability receiving services through a Medicaid home and community based services (HCBS) waiver authorized under section 1915(c) of the Act
Residents of alcohol/substance abuse long term residential treatment programs
Native Americans
Individuals with a "county of fiscal responsibility code of 98" (OPWDD) in Medicaid Management Information System/MMIS) in counties where program features are approved by the state and operational at the local district level to permit these individuals to voluntarily enroll

10. Exclusions and Exemptions from MLTC. Notwithstanding the eligibility criteria in STC 1 of this section, certain individuals cannot receive benefits through the MLTC program (i.e. excluded while others may request an exemption from receiving benefits through the MLTC program (i.e. exempted). Tables 8 and 9 list those individuals either excluded or exempted from MLTC.

Table 6: Individuals excluded from MLTC

Residents of psychiatric facilities
Residents of residential health care facilities (RHCF) at time of enrollment
Individuals expected to be Medicaid eligible for less than six months
Individuals eligible for Medicaid benefits only with respect to tuberculosis-related services
Individuals with a "county of fiscal responsibility" code 99 in MMIS (Individuals eligible only for breast and cervical cancer services)
Individuals receiving hospice services (at time of enrollment)
Individuals with a "county of fiscal responsibility " code of 97 (Individuals residing in a state Office of Mental Health facility)
Individuals with a "county of fiscal responsibility" code of 98 (Individuals in an OPWDD facility or treatment center)
Individuals who are under 65 years of age (screened and require treatment) in the Centers for Disease Control and Prevention breast, cervical, colorectal and/or prostate early detection program and need treatment for breast, cervical, colorectal or prostate cancer and who are not otherwise covered under creditable health coverage
Residents of intermediate care facilities for the mentally retarded (ICF/MR)
Individuals who could otherwise reside in an ICF/MF, but choose not to
Residents of alcohol/substance abuse long term residential treatment programs

Individuals eligible for Emergency Medicaid
Individuals in the Office for People with Developmental Disabilities Home and Community Based Services (OPWDD HCBS) section 1915(c) waiver program
Individuals in the following section 1915(c) waiver programs: Traumatic Brain Injury (TBI), Nursing Home Transition & Diversion (NHTD), and Long Term Home Health Care Program (LTHHCP) in certain counties1 (see Attachment F)
Residents of Assisted Living Programs
Individuals in receipt of Limited Licensed Home Care Services
Individuals in the Foster Family Care Demonstration

Table 7: Individuals who may be exempted from MLTC

Individuals aged 18 through 20 who are nursing home certifiable and require more than 120 days of community based long term care services
Native Americans
Individuals who are eligible for the Medicaid buy in for the working disabled and are nursing home certifiable
Aliessa Court Ordered Individuals

11. Population-Specific Program Requirements.

a. MMMC Enrollment of Individuals Living with HIV. The state is authorized to require individuals living with HIV to receive benefits through MMMC. Once the state begins implementing MMMC enrollment in a particular district, individuals living with HIV will have 30 days in which to select a health plan. If no selection is made, the individual will be auto-assigned to an MCO. Individuals living with HIV who are enrolled in an MCO (voluntarily or by default) may request transfer to an HIV Special Needs Plan (SNP) at any time if one or more HIV SNPs are in operation in the individual's district. Further, transfers between HIV SNPs will be permitted at any time.

b. Restricted Recipient Programs. The state may require individuals participating in a restricted recipient program administered under 42 CFR §431.54(e) to enroll in MMMC. Furthermore, MCOs may establish and administer restricted recipient programs, through which they identify individuals that have utilized Medicaid services at a frequency or amount that is not medically necessary, as determined in accordance with utilization guidelines established by the state, and restrict them for a reasonable period of time to obtain Medicaid services from designated providers only. The state must adhere to the following terms and conditions in this regard.

i. Restricted recipient programs operated by MCOs must adhere to the requirements in 42 CFR §431.54(e)(1) through (3), including the right to a hearing conducted by the state.

1 New York is using a phased in approach to transition LTHHCP individuals into the MLTC program. There are six phases (see Attachment F).

ii. The state must require MCOs to report to the state whenever they want to place a new person in a restricted recipient program. The state must maintain summary statistics on the numbers of individuals placed in restricted recipient programs, and the reasons for those placements, and must provide the information to CMS upon request.

c. Managed care enrollment of individuals using long term services and supports for MMMC and MLTC. The state is authorized to require certain individuals using long term services and supports to enroll in either mainstream managed care or managed long term care as identified in STC 1 of this section. In addition, the populations that are exempted from mandatory enrollment, based on the exemption lists in STCs 9 and 10 of this section may also elect to enroll in managed care plans. Once these individuals begin to enroll in managed care, the state will be required to provide the following protections for the population2.

i. Person Centered Service Planning. The state, through its contracts with its MCOs and/or Prepaid Inpatient Health Plans (PIHPs), will require that all individuals utilizing long term services and supports will have a person centered individual service plan maintained at the MCO or PIHP. Person centered planning includes consideration of the current and unique psycho-social and medical needs and history of the enrollee, as well as the person's functional level, and support systems.

A. The state must establish minimum guidelines regarding the person centered plan (PCP) that will be reflected in MCO/PIHP contracts. These must include at a minimum, a description of:

1. The qualification for individuals who will develop the PCP;

2. Types of assessments;

3. How enrollees are informed of the services available to them; and

4. The MCOs' responsibilities for implementing and monitoring the PCP.

B. The MCO/PIHP contract shall require the use of a person centered and directed planning process intended to identify the strengths, capacities and preferences of the enrollee, as well as to identify an enrollee's long term care needs and the resources available to meet those needs, and to provide access to additional care options as specified by the contract. The person centered plan is developed by the participant with the assistance of the MCO/PIHP, provider and those individuals the participant chooses to include. The plan includes the services and supports that the participant needs.

C. The MCO/PIHP contract shall require that service plans must address all enrollees' assessed needs (including health and safety risk factors) and personal

2 All beneficiary protections apply to both MMMC and MLTC, unless otherwise noted in Section V

goals, taking into account an emphasis on services being delivered in home and community based settings.

D. The MCO/PIHP contract shall require that a process is in place that permits the participants to request a change to the person centered plan if the participant's circumstances necessitate a change. The MCO contract shall require that all service plans are updated and/or revised at least annually or when warranted by changes in the enrollee's needs.

E. The MCO/PIHP shall ensure that meetings related to the enrollee's person centered plan will be held at a location, date and time convenient to the enrollee and his/her invited participants.

F. The MCO/PIHP contract shall require development of a backup plan to ensure that needed assistance will be provided in the event that the regular services and supports identified in the individual service plan are temporarily unavailable. The backup plan may include other individual assistance or services.

G. The MCO/PIHP contract shall require that services be delivered in accordance with the service plan, including the type, scope, amount and frequency.

H. The MCO/PIHP contract shall require that enrollees receiving long term services and supports have a choice of provider, where applicable, which has the capacity to serve that individual within the network. The MCO/PIHP must contract with at least two providers in each county in its service area for each covered service in the benefit package unless the county has an insufficient number of providers licensed, certified, or available in that county.

I. The MCO/PIHP contract shall require policies and procedures for the MCO/PIHP to monitor appropriate implementation of the individual service plans, including the qualifications of individuals developing service plans, types of assessments conducted and the method for how enrollees are notified of available services.

ii. Verification of MLTC Plan Enrollment. The state shall implement a process for MLTC plans, network and non-network providers for the state to confirm enrollment of enrollees who do not have a card or go to the wrong provider before developing a person-centered service plan.

iii. Health and Welfare of Enrollees. The state through its contracts with its MCOs/PIHPs shall ensure a system is in place to identify, address, and seek to prevent instances of abuse, neglect, and exploitation of its enrollees on a continuous basis. This should include provisions such as critical incident monitoring and reporting to the state, investigations of any incident including, but not limited to, wrongful death, restraints, or medication errors that resulted in an injury. In each quarterly report, the state will provide information regarding any such incidents by plan. The state will also ensure

that children and adults receiving MLTC are afforded linkages to child and/or adult protective services through all service entities, including the MCOs/PIHPs.

iv. Maintaining Accurate Beneficiary Address. New York will complete return mail tracking for enrollment notification mailings. The state will use information gained from returned mail to make additional outreach attempt through other methods (phone, email, analysis of prior claims, etc.).

v. Independent Consumer Support Program. To support the beneficiary's experience receiving and applying to receive long term services and supports in a managed care environment, the state shall create and maintain a permanent independent consumer support program to assist beneficiaries in understanding the coverage model and in the resolution of problems regarding services, coverage, access and rights.

vi. Core Elements of the Independent Consumer Support Program.

A. *Organizational Structure.* The Independent Consumer Support Program shall operate independently from any Partnership Plan MCO. Additionally, to the extent possible, the program shall also operate independently of the Department of Human Services. The organizational structure of the program shall support its transparent and collaborative operation with beneficiaries, MCOs, and state government.

B. *Accessibility.* The services of the Independent Consumer Support Program are available to all Medicaid beneficiaries enrolled in Partnership Plan who are in need of LTSS (institutional, residential and community based). The Independent Consumer Support Program must be accessible through multiple entryways (e.g., phone, internet, office) and must reach out to beneficiaries and/or authorized representatives through various means (mail, phone, in person), as appropriate.

C. *Functions*. The Independent Consumer Support Program assists beneficiaries to navigate and access covered LTSS. Where an individual is enrolling in a new delivery system, the services of this program help individuals understand their choices and resolve problems and concerns that may arise between the individual and a provider/payer. The following list encompasses the program's scope of activity.

1. The program shall offer beneficiaries support in the pre-enrollment state, such as unbiased health plan choice counseling and general program-related information.

2. The program shall serve as an access point for complaints and concerns about health plan enrollment, access to services and other related matters.

3. The program shall help enrollees understand the fair hearing, grievance and appeal rights and processes within the health plan and at the state level, and assist them through the process if needed/requested.

4. The program shall conduct trainings with Partnership Plan MCO as well as providers on community-based resources and supports that can be linked with covered plan benefits.

D. *Staffing*. The Independent Consumer Support Program must employ individuals who are knowledgeable about the state's Medicaid programs; beneficiary protections and rights under Medicaid managed care arrangements; and the health and service needs of persons with complex needs, including those with a chronic condition, disability, and cognitive or behavioral needs. In addition, the Independent Consumer Support Program shall ensure that its services are delivered in a culturally competent manner and are accessible to individuals with limited English proficiency.

E. *Data Collection and Reporting*. The Independent Consumer Support Program shall track the volume and nature of beneficiary contacts and the resolution of such contacts on a schedule and manner determined by the state, but no less frequently than quarterly. This information will inform the state of any provider or contractor issues and support the reporting requirements to CMS.

vii. Independent Consumer Support Program Plan. The state shall submit a plan to CMS describing the structure and operation of the Independent Consumer Support Program that aligns with the core elements provided in this STC no later than January 1, 2014.

viii. Network of Qualified Providers. The provider credentialing criteria described at 42 CFR § 438.214 must apply to providers of long-term services and supports. If the MCO's/PIHP's credentialing policies and procedures do not address non-licensed/non-certified providers, the MCO/PIHP shall create alternative mechanisms to ensure the health and safety of its enrollees. To the extent possible, the MCO/PIHP shall incorporate criminal background checks, reviewing abuse registries as well as any other mechanism the state includes within the MCO/PIHP contract.

d. MLTC enrollment. Including the protections afforded individuals in subparagraph (c) of STC 11 of this section, the following requirements apply to MLTC plan enrollment:

i. Transition of Care Period: Initial transition into MLTC from fee-for-service. Each enrollee who is receiving community-based long-term services and supports that qualifies for MLTC must continue to receive services under the enrollee's pre-existing service plan for at least 90 days after enrollment, or until a care assessment has been completed by the MCO/PIHP, whichever is later. Any reduction, suspension, denial or termination of previously authorized services shall trigger the required notice under 42 CFR § 438.404 which clearly articulates the enrollee'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 initial implementation of the auto-assigned population, the plans must submit data for state review on a monthly basis reporting instances when the plan has issued a notice of action that involves a reduction of split shift or live-in services or when the plan is reducing hours by 25 percent or more. The plan will also report the number of appeals and fair hearings requested regarding these reductions. The state shall ensure through its contracts that if an enrollee is to change from one MCO/PIHP to another, the MCO/PIHPs will communicate with one another to ensure a smooth transition and provide the new MCO/PIHP with the individual's current service plan.

ii. Assessment of LTSS Need. The following requirements apply until the state implements an independent and conflict-free long-term services and supports (LTSS) assessment process (as required by subparagraph (iii) of this STC).

A. MLTC plans conduct the initial assessment for an individual's need for LTSS using a standardized assessment tool designated by the state. The following requirements apply to the activities that must be undertaken by a MLTC plan as it assesses individuals for need for LTSS.

1. The state shall ensure all individuals requesting LTSS are assessed in a timely manner.

a. The state shall ensure the Semi-Annual Assessment of Members (SAAM) tool (or successor tool designated by the state) to determine if the individual has a need for LTSS.

b. In addition to the SAAM tool, the MCO/PIHP may use other assessment tools as appropriate. The state must review and approve all other assessment tools used by the MCO/PIHP.

2. The state must ensure through its contracts that each MCO/PIHP must complete the initial assessment in the individual's home of all individuals referred to or requesting enrollment in an MLTC plan within 30 days of that referral or initial contract. MCO/PIHP compliance with this standard shall be reported to CMS in the quarterly reports required under STC 4 in Section IX. The state shall take corrective action against MLTC plans that do not meet this 30 day requirement.

a. The MCO/PIHP shall complete a re-assessment at least annually, or when an enrollee's needs change.

b. If the assessed individual is not already a Medicaid recipient, the MCO/PIHP shall:

1. Provide the individual with the results of the assessment.

2. If the assessment indicates that the individual meets the criteria for LTSS, explain that the results of the assessment will be forwarded to the individual's county social services office for a formal Medicaid eligibility determination.

3. If the assessment indicates that the individuals do not meet the criteria for LTSS, explain that the results of the assessment do not indicate that the individual is eligible for Medicaid and provide a written notice to the individuals that they have the right (consistent with 42 CFR §435.906) to request a formal Medicaid eligibility determination from the county social services office.

c. If the assessed individual is already a Medicaid recipient, the MCO/PIHP shall:

1. Provide the recipient with the results of the assessment.

2. If the assessment indicates that the recipient meets the criteria for LTSS, explain that the individual is eligible for enrollment in an MLTC.

3. Provide the recipient with information about all the MLTC plans in which the recipient can enroll.

3. The state shall require each MCO/PIHP, through its contract, to report to the enrollment broker the names of all individuals for whom an assessment is completed. If the individual has not been referred by the enrollment broker, the MCO/PIHP shall report the date of initial contact by the individual and the date of the assessment to determine compliance with the 30-day requirement.

4. The state shall use this information to determine if individuals have been assessed incorrectly.

B. The state shall review a sample of the MLTC plan LTSS assessments every six months, either through the External Quality Review Organization (EQRO) or by the state, to verify the correct determinations were made.

C. The state must submit to CMS for review and comment, and subsequently approval of the written notice required in subparagraph (d)(ii)(A)(2) no later than May 31, 2013.

iii. Transformation of LTSS Needs Assessment. The state shall begin implementation of an independent and conflict-free LTSS needs assessment system for newly eligible Medicaid recipients, as applicable, no later than December 1, 2014. After that implementation has begun, MLTC plans will not complete any LTSS needs assessments for individuals requesting such services prior to the enrollment in the plan. Non-dually eligible individuals requesting LTSS will be assessed to see if they meet the criteria to be enrolled in a MLTC plan or alternate waiver program prior to being told their enrollment options. In order to achieve this milestone, the state must:

A. Submit to CMS an initial plan for implementing this transformation by December 31, 2013.

B. Submit to CMS a final plan with specific action items and timeframes by May 31, 2014.

C. Report progress on the plan in each quarterly report required under STC 4 in Section IX.

iv. Marketing Oversight.

A. The state shall require each MCO/PIHPs through its contracts to meet 42 CFR §438.104, and state marketing guidelines which prohibit cold calls, use of government logos and other standards.

B. All materials used to market the MCO/PIHP shall be prior approved by the state.

C. The state shall require through its contracts that each MCO/PIHP provide all individuals who were not referred to the plan by the enrollment broker with information (in a format determined by the state) describing managed long term care, a list of available plans and contact information to reach the enrollment broker for questions or other assistance. The plan shall report the number of individuals receiving these materials to the state on a quarterly basis pursuant to STC 4 in Section IX.

e. Demonstration Participant Protections. The state will ensure that adults in LTSS in MLTC programs are afforded linkages to adult protective services through all service entities, including the MCO's/PIHP's. The state will ensure that these linkages are in place before, during, and after the transition to MLTC as applicable.

f. Non-duplication of Payment. MLTC Programs will not duplicate services included in an enrollee's Individualized Education Program under the Individuals with Disabilities Education Act, or services provided under the Rehabilitation Act of 1973.

V. DEMONSTRATION BENEFITS AND ENROLLMENT

1. Demonstration Benefits and Cost Sharing. The following benefits are provided to individuals eligible for the Medicaid managed care components of the demonstration:

a. Mainstream Medicaid Managed Care (MMMC). State plan benefits delivered through MCOs or, in certain districts, primary care case management arrangements, with the exception of certain services carved out of the MMMC contract and delivered directly by the state on a fee-for-service basis. All MMMC benefits (regardless of delivery method), as well as the co- payments charged to MMMC recipients, are listed in Attachment A.

b. Managed Long Term Care. State plan benefits delivered through MCOs or, in certain districts, prepaid inpatient health plans, with the exception of certain services carved out

of the MLTC contract and delivered directly by the state on a fee-for-service basis. All MLTC benefits are listed in Attachment B.

2. **Alternative Benefit Plan**. The Affordable Care Act Low-Income Adult Group will receive benefits provided through the state's approved Alternative Benefit Plan (ABP) SPA.

3. **Home and Community Settings Characteristics.** MLTC enrollees, including individuals who receive services under the demonstration's HCBS Expansion program described in STC 1(c) in Section IV, must receive services in residential settings located in the community, which meet CMS standards for HCBS settings as articulated in current 1915(c) policy and as modified by subsequent regulatory changes, in accordance with the plan submitted by the state (required in Attachment G). This plan shall be due no later than December 31, 2013. Residential settings include characteristics such as providing full access to facilities such as kitchen and cooking facilities, small dining areas, convenient privacy for visitors and easy access to resources and activities in the community. A full list of home and community based characteristics are provided in Attachment C.

4. **Option for Consumer Directed Personal Assistance Program**. Enrollees shall have the option to elect self-direction. The state shall ensure through its contracts with the MCOs/PIHPs that enrollees are afforded the option to select self-direction and enrollees are informed of CDPAP as a voluntary option to its members. Individuals who select self-direction must have the opportunity to have choice and control over how services are provided and who provides the service.

   a. **Information and Assistance in Support of Participant Direction**. The state/MCO shall have a support system that provides participants with information, training, counseling, and assistance, as needed or desired by each participant, to assist the participant to effectively direct and manage their self-directed services. Participants shall be informed about self-directed care, including feasible alternatives, before electing the self-direction option.

   b. **Participant Direction by Representative.** The participant who self-directs the personal care service may appoint a volunteer designated representative to assist with or perform employer responsibilities to the extent approved by the participant. Services may be directed by a legal representative of the participant. Consumer-directed services may be directed by a non-legal representative freely chosen by the participant. A person who serves as a representative of a participant for the purpose of directing services cannot serve as a provider of personal attendant services for that participant.

   c. **Participant Employer Authority**. The participant (or the participant's representative) must have decision-making authority over workers who provide personal care services.

      i. Participant. The participant (or the participant's representative) provides training, supervision and oversight to the worker who provides services. A Fiscal/Employer Agent that follows IRS and local tax code laws functions as the participant's agent in

performing payroll and other employer responsibilities that are required by federal and state law.

ii. Decision-Making Authorities. The participants exercise the following decision making authorities: Recruit staff, hire staff , verify staff's ability to perform identified tasks, schedule staff, evaluate staff performance, verify time worked by staff and approve time sheets, and discharge staff.

d. Disenrollment from Self-Direction. A participant may voluntarily disenroll from the self-directed option at any time and return to a traditional service delivery system through the MMMC or MLTC program. To the extent possible, the member shall provide his/her intent to withdraw from participant direction. A participant may also be involuntarily disenrolled from the self-directed option for cause, if continued participation in the consumer-directed services option would not permit the participant's health, safety, or welfare needs to be met, or the participant demonstrates the inability to self-direct by consistently demonstrating a lack of ability to carry out the tasks needed to self-direct services, or if there is fraudulent use of funds such as substantial evidence that a participant has falsified documents related to participant-directed services. If a participant is terminated voluntarily or involuntarily from the self-directed service delivery option, the MCO/PIHP must transition the participant to the traditional agency direction option and must have safeguards in place to ensure continuity of services.

e. Appeals. The following actions shall be considered adverse action under both 42 CFR 431 subpart E and 42 CFR 438 subpart F:

i. A reduction, suspension or termination of authorized CDPAP services;
ii. A denial of a request to change Consumer Directed Personal Assistance Program services.

5. Adding Services to the MMMC and/or MLTC plan benefit package. At any point in time the state intends to add to either the MMMC or MLTC plan benefit package currently authorized state plan or demonstration services that have been provided on a fee-for-service basis, the state must provide CMS the following information, with at least 30 days' notice prior to the inclusion of the benefit, either in writing or as identified on the agenda for the monthly calls referenced in STC 3 in Section IX:

a. A description of the benefit being added to the MCO/PIHP's benefit package;

b. A detailed description of the state's oversight of the MCO/PIHPs readiness to administer the benefit including: readiness and implementation of activities, which may include onsite reviews, phone meetings and desk audits reviewing policies and procedures for new services, data sharing to allow plans to create services plans as appropriate, process to communicate the change to enrollees, MCO/PIHP network development to include providers of that service and any other activity performed by the state to ensure plan readiness.

c. Information concerning the changes being made to the MMMC and/or MLTC contract provisions and capitation payment rates in accordance with STC 2 in Section VI.

CMS reserves the right to delay implementation of the benefit transition until such time as appropriate documentation is provided showing evidence of MCO/PIHP readiness. In addition, new services that are not currently authorized under the state plan or demonstration may be added only through approved amendments to the state plan or demonstration.

CMS will notify the state of concerns within 15 days. If no comments are received, the state may proceed with the scheduled benefit transition.

6. **Expanding MLTC enrollment**. Any time the state is ready to expand mandatory MLTC plan enrollment into a new geographic area for populations approved for managed care through an amendment, the state must provide CMS notification at least 90 days prior to the expansion. Such notification will include:

   a. A list of the counties that will have approved populations moving to mandatory enrollment;

   b. A list of MCO/PIHPs with an approved state certificate of authority to operate in those counties demonstrating that enrollees will be afforded choice of plan within the new geographic area;

   c. Confirmation that the MCO/PIHPs in the new geographic area have met the network requirements in STC 10 in Section VI for each MCO/PIHP.

   The state must also apply the requirements of STC 5 of this section when applicable to the MLTC population or geographic area being added to the MLTC program.

   CMS reserves the right to delay implementation of the geographic expansion until such time as notification documentation is provided.

   CMS will notify the state of concerns within 15 days. If no comments are received, the state may proceed with the scheduled geographic expansion.

7. **Assurances during expansion of MLTC enrollment.** The assurances below pertain to future MLTC expansions authorized under this demonstration. To provide and demonstrate smooth transitions for beneficiaries, the state must:

   a. Send sample notification letters. Existing Medicaid providers must receive sample beneficiary notification letters via widely distributed methods (mail, email, provider website, etc.) so that providers are informed of the information received by enrollees regarding their managed care transition.

   b. Provide educational tours for enrollees and providers. The educational tour should educate enrollees and providers on the MLTC plan enrollment options, rights and responsibilities and other important program elements. The state must provide webinars, meeting plans, and send notices through outreach and other social media (e.g. state's

website).The enrollment broker, choice counseling entities, ombudsman and any group providing enrollment support must participate.

c. Operate a call center independent of the MLTC plans for the duration of the demonstration. This entity must be able to help enrollees in making independent decisions about plan choice and be able to document complaints about the plans. During the first 60 days of implementation the state must review all call center response statistics to ensure all contracted plans are meeting requirements in their contracts. After the first 60 days, if all entities are consistently meeting contractual requirements the state can lessen the review of call center statistics, but no more than 120 days should elapse between reviews.

d. Review the outcomes of the auto-assignment algorithm to ensure that MLTC plans with more limited networks do not receive, are the same or larger number of enrollees, as plans with larger networks.

e. The state shall require MCO/PIHPs to maintain the current worker/recipient relationship for no less than 90 days.

8. **Operation of the HCBS Expansion Program**. The individuals eligible for this component of the demonstration will receive the same HCBS as those individuals determined eligible for and enrolled in the state's Long Term Home Health Care Program (LTHHCP), Nursing Home Transition and Diversion Program (NHTDP) and Traumatic Brain Injury Program (TBIP) authorized under section 1915(c) of the Act. The specific benefits provided to participants in this program are listed in Attachment C.

   The state will operate the HCBS Expansion program in a manner consistent with approved LTHHCP, NHTDP and TBIP 1915(c) waiver programs and must comply with all administrative, operational, quality improvement and reporting requirements contained therein. The state shall provide enrollment and financial information about the individuals enrolled in the HCBS Expansion program as requested by CMS.

9. **Facilitated Enrollment**. Facilitated enrollers, which may include MCOs, health care providers, community-based organizations, and other entities under state contract, will engage in those activities described in 42 CFR § 435.904(d)(2), as permitted by 42 CFR § 435.904(e)(3)(ii), within the following parameters:

   a. Facilitated enrollers will provide program information to applicants and interested individuals as described in 42 CFR §435.905(a).

   b. Facilitated enrollers must afford any interested individual the opportunity to apply for Medicaid without delay as required by 42 CFR §435.906.

   c. If an interested individual applies for Medicaid by completing the information required under 42 CFR §435.907(a) and (b) and 42 CFR §435.910(a) and signing a Medicaid

application, that application must be transmitted to the LDSS for determination of eligibility.

d. The protocols for facilitated enrollment practices between the LTSS and the facilitated enrollers must:

i. Ensure that choice counseling activities are closely monitored to minimize adverse risk selection; and
ii. Specify that determinations of Medicaid eligibility are made solely by the LTSS.

VI. DELIVERY SYSTEMS

1. **Contracts**. Procurement and the subsequent final contracts developed to implement selective contracting by the state with any provider group shall be subject to CMS approval prior to implementation. Payments under contracts with public agencies, that are not competitively bid in a process involving multiple bidders, shall not exceed the documented costs incurred in furnishing covered services to eligible individuals (or a reasonable estimate with an adjustment factor no greater than the annual change in the consumer price index).

2. **Managed Care Contracts**. No FFP is available for activities covered under contracts and/or modifications to existing contracts that are subject to 42 CFR 438 requirements prior to CMS approval of model contract language. The state shall submit any supporting documentation deemed necessary by CMS. The state must provide CMS with a minimum of 45 days to review and approve changes. CMS reserves the right, as a corrective action, to withhold FFP (either partial or full) for the demonstration, until the contract compliance requirement is met.

3. **Managed Care Data Requirements**. All managed care organizations shall maintain an information system that collects, analyzes, integrates and reports data as set forth at 42 CFR §438.242. This system shall include encounter data that can be reported in a standardized format. Encounter data requirements shall include the following:

   a. Encounter Data (Health Plan Responsibilities). The health plan must collect, maintain, validate and submit data for services furnished to enrollees as stipulated by the state in its contracts with the health plans.

   b. Encounter Data (State Responsibilities). The state shall, in addition, develop mechanisms for the collection, reporting, and analysis of these, as well as a process to validate that each plan's encounter data are timely, complete and accurate. The state will take appropriate actions to identify and correct deficiencies identified in the collection of encounter data. The state shall have contractual provisions in place to impose financial penalties if accurate data are not submitted in a timely fashion. Additionally, the state shall contract with its EQRO to validate encounter data through medical record review.

   c. Encounter Data Validation Study for New Capitated Managed Care Plans. If the state contracts with new managed care organizations, the state shall conduct a validation study 18 months after the effective date of the contract to determine completeness and

accuracy of encounter data. The initial study shall include validation through a sample of medical records of demonstration enrollees.

d. Submission of Encounter Data to CMS. The state shall submit encounter data to the Medicaid Statistical Information System (MSIS) and when required T-MSIS (Transformed MSIS) as is consistent with federal law and per STC 15 in Section III. The state must assure that encounter data maintained at managed care organizations can be linked with eligibility files maintained at the state.

4. **Interpretation Services and Culturally Competent Care**. The MCOs must have interpretation services and provide care that is consistent with the individual's culture. MCOs must conduct analyses to determine any gaps in access to these services and will expand its workforce accordingly. The MCOs may also require the use of remote video and voice technology when necessary.

5. **Managed Care Benefit Package**. Individuals enrolled in either MMMC or MLTC must receive from the managed care program the benefits as identified in Attachments A or B, as appropriate. As noted in plan readiness and contract requirements, the state must require that, for enrollees in receipt of LTSS, each MCO/PIHP coordinate, as appropriate, needed state plan services that are excluded from the managed care delivery system but available through a fee-for-service delivery system, and must also assure coordination with services not included in the established benefit package.

6. **Revision of the State Quality Strategy**. The state must update its comprehensive Quality Strategy to reflect all managed care plans (MCO/PIHPs) operating under MMMC and MLTC programs proposed through this demonstration and submit to CMS for approval of the most recent amendment within 90 days of approval of the most recent amendment. The state must obtain the input of recipients and other stakeholders in the development of its revised comprehensive Quality Strategy and make the Strategy available for public comment. The state must revise the strategy whenever significant changes are made, including changes through this demonstration. Pursuant to STC 5 in Section IX, the state must also provide CMS with annual reporting on the implementation and effectiveness of the updated comprehensive quality strategy, as it impacts the demonstration. The CQS must also address the following elements:
   - **a.** The state's goals for improvement, identified through claims and encounter data, quality metrics and expenditure data. The goals should align with the three part aim but should be more specific in identifying specific pathways for the state to achieve these goals.
   - **b.** The specific quality metrics for measuring improvement in the goals. The metrics should be aligned with the Medicaid and CHIP adult and child core measures, and should also align with other existing Medicare and Medicaid federal measure sets where possible.
   - **c.** Metrics should be measured at the following levels of aggregation: the state Medicaid agency, each managed care entity, and each direct health services provider. The state will work with CMS to further define what types of metrics will be measured for direct service providers.
   - **d.** The specific methodology for determining benchmark and target performance on these metrics for each aggregated level identified above (state, plan and provider).

7. **Required Components of the State Quality Strategy**. The revised comprehensive Quality Strategy shall meet all the requirements of 42 CFR 438 Subpart D. The quality strategy must include components relating to managed long term services and supports. The Quality strategy must address the following regarding the population utilizing long term services and supports: level of care assessments, service planning, and health and welfare of enrollees. The state should also incorporate performance measures for outcomes related to quality of life and community integration related to health system transformation for individuals with developmental disabilities.

8. **Required Monitoring Activities by the State and/or EQRO.** The state's EQR process for the mainstream managed care and MLTC plans shall meet all the requirements of 42 CFR 438 Subpart E. In addition, the state, or its EQRO shall monitor and annually evaluate the MCO/PIHPs performance on specific new requirements under mandatory enrollment of individuals utilizing long term services and supports. The state shall provide an update of the processes used to monitor the following activities as well as the outcomes of the monitoring activities within the annual report in STC 5 in Section IX. The new requirements include, but are not limited to the following:

    a. **MLTC Plan Eligibility Assessments.** To ensure that approved instruments are being used and applied appropriately and as necessary, and to ensure that individuals being served with LTSS meet the MLTC plan eligibility requirements for plan enrollment. The state will also monitor assessments conducted by the plan where individuals are deemed ineligible for enrollment in an MLTC plan.

    b. **Service Plans.** To ensure that MCOs/PIHPs are appropriately creating and implementing service plans based on enrollee's identified needs.

    c. **MCO/PIHP credentialing and/or verification policies.** To ensure that LTSS services are provided by qualified providers.

    d. **Health and welfare of enrollees.** To ensure that the MCO/PIHP, on an ongoing basis, identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation.

9. **Access to Care, Network Adequacy and Coordination of Care Requirements for Long Term Services and Supports (LTSS)**. The state shall set specific requirements for MCO/PIHPs to follow regarding providers of LTSS, consistent with 42 CFR 438 Part D. These requirements shall be outlined within each MCO/PIHP contract. These standards should take into consideration individuals with special health care needs, out of network requirements if a provider is not available within the specific access standard, ensuring choice of provider with capacity to serve individuals, time/distance standards for providers who do not travel to the individual's home, and physical accessibility of covered services. The MLTC or mainstream managed care plan is not permitted to set these standards.

10. **Demonstrating Network Adequacy**. Annually, each MCO/PIHP must provide adequate assurances that it has sufficient capacity to serve the expected enrollment in its service area

and offers an adequate coverage of benefits as described in Attachment A and B for the anticipated number of enrollees in the service area.

a. The state must verify these assurances by reviewing demographic, utilization and enrollment data for enrollees in the demonstration as well as:

i. The number and types of providers available to provide covered services to the demonstration population;
ii. The number of network providers accepting the new demonstration population; and
iii. The geographic location of providers and demonstration populations, as shown through GeoAccess, similar software or other appropriate methods.

b. The state must submit the documentation required in subparagraphs (i) – (iii) above to CMS with each annual report.

c. Enrollees and their representatives must be provided with reference documents to maintain information about available providers and services in their plans.

11. Advisory Committee as required in 42 CFR 438. The state must maintain for the duration of the demonstration a managed care advisory group comprised of individuals and interested parties appointed pursuant to state law by the Legislature and Governor. To the extent possible, the state will attempt to appoint individuals qualified to speak on behalf of seniors and persons with disabilities who are impacted by the demonstration's use of managed care, including individuals with developmental disabilities, regarding the impact and effective implementation of these changes on individuals receiving LTSS.

12. Health Services to Native Americans Populations. The plan currently in place for patient management and coordination of services for Medicaid-eligible Native Americans developed in consultation with the Indian tribes and/or representatives from the Indian health programs located in participating counties shall continue in force for this extension period.

VII. QUALITY DEMONSTRATION PROGRAMS AND CLINIC UNCOMPENSATED CARE FUNDING

1. Hospital-Medical Home (H-MH) Demonstration. The purpose of this demonstration is to improve the coordination, continuity, and quality of care for individuals receiving primary care in hospital outpatient departments operated by teaching hospitals, as well as other primary care settings used by teaching hospitals to train resident physicians. The demonstration will be instrumental in influencing the next generation of practitioners in the important concepts of patient- centered medical homes. Training sites, in particular, due to the structural discontinuity imposed by rotating residents and attending physicians' schedules, present a significant opportunity to improve patient experience and care through residency redesign.

During this extension period, entities that serve as clinical training sites for primary care residents will work toward transforming their delivery system consistent with the National

Committee on Quality Assurance (NCQA) requirements for medical home recognition under its Physician Practice Connections® - Patient-Centered Medical Home™ program (PPC®PCMH™) and the "Joint Principles" for medical home development articulated by primary care professional associations.

In addition, hospitals which receive funding under this demonstration shall be required to implement a number of patient safety and systemic quality improvement projects.

2. **H-MH Demonstration Eligibility and Selection.** All teaching institutions in New York State will be eligible to participate in the H-MH demonstration. However, because the state does not intend to use a public competitive process to select awardees, the selection criteria for the H-MH demonstration will include for each:

   a. The extent to which the hospital has existing arrangements with training sites in the community (such as federal qualified health centers) to provide clinical experience to its primary care residents;

   b. An attestation as to their willingness and commitment to accomplish all milestones outlined in STC 3 of this section, including achieving NCQA PPC®PCMH™ Level 2 recognition or above (in accordance with the standards applicable at the time that recognition is awarded) by the end of the second year of the demonstration;

   c. An agreement to track and report the clinical performance metrics required in STC 4 of this section; and

   d. An agreement to implement both the system improvement and patient safety initiatives consistent with STC 5 and 6 of this section.

   To ensure that a mix of both academic medical centers and community teaching hospitals receive awards under the H-MH demonstration, the Department must submit its recommendations (along with proposed award amounts) to CMS for review before making final awards. An institution that already has achieved at least PPC®-PCMHTM Level 2 recognition under an earlier set of NCQA standards may participate if its goal is to renew or upgrade its recognition under later, more stringent NCQA standards.

3. **H-MH Milestones related to achievement of National Committee for Quality Assurance (NCQA) PPC®PCMH™ for all awardees**. The key milestone for receiving demonstration funding will be the achievement of NCQA PPC®-PCMHTM Level 2 or Level 3 recognition within 2 years from the start date of the program. The state will receive from NCQA a monthly 'roster' of practices, which have achieved NCQA PPC®-PCMHTM Level 2 or Level 3 recognition. In the interim, programs must demonstrate the achievement of the following milestones throughout the duration of the project:

   a. A detailed work plan after award. Each awardee must submit a redesign strategy and detailed work plan to the state that documents how funds will be used for the following approved purposes: consultation services for practice re-design; staff development

activities to support 'team' design to assuring continuity of care for patients; activities associated with curriculum changes; workforce retraining and retooling, and NCQA certification costs. The work plan must also:

i. Indicate the clinical performance metrics that will be used (as discussed in STC 4 of this section), and provide baseline rates for each measure,
ii. Describe how the awardee will implement the H-MH System Improvement Initiatives described in STC 5 of this section, and
iii. Indicate which H-MH Quality and Safety Improvement Projects that the awardee will undertake, along with associated milestones.

b. Baseline assessment within six months. Each awardee must submit a formal baseline assessment to the state (using the NCQA tool or one developed by a primary care professional organization) that compares current practice with NCQA standards, along with a revised work plan and timeline.

c. Interim report at the end of year 1. Each awardee must submit to the state a report of interim progress in meeting the first year milestones and goals identified through the baseline assessment tool with revised plan as appropriate.

d. MH recognition. Each awardee must achieve NCQA PPC®-PCMHTM Level 2 or Level 3 recognition, using 2011 standards, by the end of year 2.

4. H-MH clinical performance metrics for years 2 and 3. Each awardee must develop at least five clinical performance metrics which shall be consistent with the standardized measures used by the New York State Department of Health in its Quality Assurance Reporting Requirements (QARR) system and/or meaningful use measures and relevant to the population being served, for internal practice measurement and improvement. Baseline and yearly rates for each measure must be submitted in the annual progress report.

5. H-MH System Improvement Initiatives. Each awardee's project work plan and subsequent progress reports must incorporate the awardee's strategy for accomplishing the implemented initiatives as well as the milestones to measure success.

a. Each awardee must implement an initiative to restructure operations to enhance patient's continuity of care experience in conjunction with developing a patient centered medical home. Awardees shall extend the ambulatory, continuity training experience of residents within the limits of residency requirements from the Residency Review Committee of the Accreditation Council for Graduate Medical Education. This could be accomplished by increasing the number of continuity training sites, expanding sites beyond the hospital environment (if the program is based in a hospital), increasing resident time in ambulatory settings, or other activities or combinations of approaches. These sites would also be required to provide care consistent with medical home requirements and achieve formal recognition within two years of program start date. The project work plan must include:

i. A method for objective measurement of progress which may include number of new continuity sites, percent increase in ambulatory training experience for residents;
ii. How these activities will support core activities of medical home transformation; and
iii. How these restructuring changes will be sustained following the termination of the demonstration.

b. Further, each awardee must select at least one of the following four initiatives to implement during the grant award period:

i. Care Transitions/Medication Reconciliation Programs. Hospital awardees may be ideally suited to coordinate care between inpatient and outpatient settings given that they are frequently the same providers of care. This initiative would allow programs to develop a better 'bridge' for this transition, particularly with respect to medication reconciliation and management but also for outpatient primary and specialty care follow up. While the methods and staffing used to improve coordination could vary, all proposals must incorporate the evidence-based components of effective medication reconciliation. Programs would be required to:

A. Develop a registry of patients who have participated (directly through contact/outreach or indirectly through shared electronic information or medication lists) in medication reconciliation. The registry must contain sufficient unique identifiers to enable linkage to Medicaid claims data and be completed by the end of Year 1.
B. Participate as needed (sharing lists), with the Department, in periodic evaluation of readmissions and other utilization and quality metrics for patients receiving care transition/medication reconciliation services, including the tracking of quarterly progress, either on pilot unit or hospital wide.
C. Develop standardized clinical protocols for communication with patients/families during and post-discharge and care transition processes focused on most common causes of avoidable readmissions.
D. Develop integrated information systems between hospital inpatient and outpatient sites to enable improved continuity and follow up care.
E. Create system to identify patients at highest risk of subsequent avoidable hospitalization and create a patient stratification approach to allocation of resources to facilitate community linkages, including primary and specialty care services.

ii. Integration of Physical-Behavioral Health Care. Medicaid has a large number of members with co-existing physical and mental health/substance abuse co-morbidities. Optimal care requires integration of services and providers so that care is coordinated and appropriate for the well-being of the entire person, not just for a single condition. There are many barriers between behavioral and physical health care including different providers, varying locations, multiple agencies, confidentiality rules and regulations, historic lack of communication between providers, and more. This initiative will require training programs to find ways to integrate care for their

patients with behavioral health conditions within the medical home. The project work plan must include details on:

A. A strategy for integration which includes a means of improving referrals to behavioral health providers, enhanced communication with mental health/substance abuse providers, process for obtaining appropriate consents for sharing personal health information, and procedures for coordinated case management (particularly for cases in which patients may have more than one provider).

B. Developing a linkage to the Office of Mental Health Psychiatric Services and Clinical Knowledge Enhancement System (PSYKES) project, which provides data and recommendations for potential problems of polypharmacy and metabolic syndrome exacerbation for Medicaid members using Medicaid databases within the first year of the program start date. The linkage will require creating systems to receive, and act on, reports generated by PSYKES. The linkage must be completed by the end of Year 1.

C. Developing training for primary care clinicians in behavioral health care with particular focus on integrating depression screening and pain management with appropriate treatment modalities and referral.

D. Assessing demand and capacity to provide co-located services or other approaches to decrease wait times and improve access to behavioral health services.

iii. Improved Access and Coordination between Primary and Specialty Care. There is a tremendous opportunity to promote access and coordination between primary and specialty providers who are both providing care within the same delivery system, often in close physical proximity. Despite that opportunity, there are many examples in which the level of coordination is suboptimal, having the greatest adverse impact on those patients with more advanced, chronic diseases.

A. Programs will be required to put into place systems that would facilitate the ready access to specialty care when appropriate, with improved bilateral communication between primary and specialty care providers/clinics through transparent, standardized, referral processes. Specific goals include improving timely access to specialists, completed referral forms with required clinical information and reason(s) for referral, timely response of findings/recommendations from the specialist and higher rates of satisfaction on the part of providers and patients with respect to specialty care services.

B. Programs will be required to generate measures of access and coordination. These measures should be incorporated into a baseline assessment and annual evaluations and include patient and provider experiences related to wait times, follow up with primary care provider after specialty visit (as appropriate), delayed or rejected referrals, patient/provider satisfaction.

C. Identify gaps in care and coordination for specialty services including collection of baseline data on wait times and appointment backlogs; survey primary care providers and specialists regarding the referral process and access and develop improvement plan based on findings with at least quarterly data collection, which will consider expansion of selected specialists, training of primary care providers in provision of select low level specialty care, inclusion of specialists in team care, protocols for primary-specialty care co-management.

iv. Enhance Interpretation Services and Culturally Competent Care.

A. Programs will conduct an analysis to determine gaps in access to language services, and implement language access policies and procedures.
B. Programs may expand workforce within interpreter services by hiring, training, and/or certifying interpreters, or determining other methods for increasing patients' access to appropriate language services.
C. Programs may include use of remote video and voice technology for instantaneous qualified health care interpretations.
D. Develop programs to improve staff cultural competence and awareness through evidence based training.
E. Develop capacity to generate prescription labels in patient's primary language with easy to understand instructions.

6. H-MH Quality and Safety Improvement Projects (QSIP). In addition, each awardee shall implement at least two of the six Quality and Safety Improvement Projects outlined in this STC.

These QSIPs will include interventions that have been demonstrated to produce measurable and significant results across different types of hospital settings, including in safety net hospitals; have a strong evidence base, meaning interventions that have been endorsed by a major national quality organization, with reasonably strong evidence established in the peer reviewed literature, including within the safety net; and are meaningful to hospital patients.

An awardee is precluded from choosing any QSIP for which it has achieved top performance for at least 4 consecutive quarters, in aggregate in all process and outcomes measures within the intervention, where "top performance" is defined as being in the Top Quartile. Each QSIP below has specific measures that an awardee must include; however, awardees may include additional milestones to enable the implementation of the measures specified for the intervention.

Milestones for the QSIPs can include infrastructure, redesign, implementation of evidence-based processes, and measurement and achievement of evidence-based outcomes. Awardees must include for each year a milestone for reporting the data on each QSIP to the Department. Improvement Targets will be determined based on the progress an awardee has already made on the improvement project pursuant to baseline data collected as of January 1, 2012. The 3-year end goals for each measure will be to move from one performance band to

the next, except in the case of hospitals that are in the Top Band where the goal will be to move into the Top Quartile. Hospitals will be placed in one of 3 bands based on baseline performance as compared to state or national data on hospital performance, including safety net hospital performance, as follows:

a. "Lower band" performers, as defined as the bottom one-third (1-33 percentile) of hospitals will target moving into the middle-third performance band;
b. "Middle band" performers, as defined as the middle third (34-64 percentile) of hospitals, will target moving into the top performance band; and
c. "Top band" performers, as defined as the top third (66-100 percentile) of hospitals, will target moving into the top quartile.

Hospitals that have achieved performance in the top quartile will be expected to maintain or exceed top performance.

d. Severe Sepsis Detection and Management

i. Elements

A. Implement the Sepsis Resuscitation Bundle: to be completed within 6 hours for patients with severe sepsis, septic shock, and/or lactate > 4mmol/L (36mg/dl).
B. Implement the Sepsis Management Bundle: to be completed within 24 hours for patients with severe sepsis, septic shock, and/or lactate > 4 mmol/L (36 mg/dl).
C. Make the elements of the Sepsis Bundles more reliable.

ii. Key Measures

A. Percent compliance with four elements of the Sepsis Resuscitation Bundle, as measured by percent of hospitalization with sepsis, severe sepsis or septic shock and/or an infection and organ dysfunction where targeted elements of the Sepsis Resuscitation Bundle were completed.

B. Sepsis mortality

e. Central-Line-Associated Bloodstream Infection (CLABSI) Infection Prevention

i. Elements

A. Implement the central line bundle.

B. Make the process for delivery all bundle elements more reliable.

ii. Key Measures

A. Compliance with Central Line Bundle

B. Central Line Bloodstream Infections

f. Surgical Complications Core Processes (SCIP)

i. Elements

A. Surgical site infection prevention

B. Beta blockers continuation

C. Venous Thromboembolism (VTE) prophylaxix

ii. Key Measures

A. SCIP Composite Process Measure:

1. **SCIP-Inf-2**: Prophylactic antibiotic selection for surgical patients.

2. **SCIP-Inf-3**: Prophylactic antibiotics discontinued within 24 hours after surgery end time/48 hours for cardiac patients.

3. **SCIP-Inf-4:** Cardiac surgery patients with controlled 6 a.m. postoperative serum glucose.

4. **SCIP-Inf-6**: Surgery patients with appropriate hair removal.

5. **SCIP-Inf-9**: Urinary catheter removed on postoperative day 1 (POD 1) or postoperative day 2 (POD 2) with day of surgery being day zero.

6. **SCIP-Card- 2**: Surgery patients on a beta-blocker prior to arrival who received a beta-blocker during the perioperative period.

7. **SCIP-VTE-1**: Surgery patients with recommended venous thromboembolism prophylaxis orderedSCIP-VTE-2: Surgery patients who received appropriate venous thromboembolism prophylaxis within 24 hours prior to surgery to 24 hours after surgery.

B. Rate of surgical site infection for Class 1 and 2 wounds within 30 days of surgery.

g. Venous Thromboembolism (VTE) Prevention and Treatment

i. Element – Provide appropriate VTE Prophylaxis, including pharmaceutical and mechanical approaches based on national guidelines

ii. Key Measures

A. VTE Discharge Instructions

B. VTE Prophylaxis

h. Neonatal Intensive Care Unit (NICU) Safety and Quality

i. Elements

A. Participation in Vermont Oxford Network (VON) quality/safety measurement and improvement activities or New York State Obstetric and Neonatal Quality Collaborative (NYSONQC) sponsored Neonatal Enteral Nutrition Project and Statewide Collaborative to decrease NICU central line associated bloodstream infections.
B. Assess current areas of need for performance improvement based on relative performance of hospital NICU to VON benchmarks and/or state level performance.
C. Develop improvement projects (at least 2 which may include, but is not limited to, enteral nutrition or central line projects above) focusing on areas of greatest need making use of VON network quality improvement strategies and/or other evidence based care bundles.

ii. Key Measures. Use of appropriate metrics for quality, safety, morbidity, complications, and risk adjusted mortality based on improvement project, including but not limited to:

A. Nosocomial sepsis rates (per 1000 patient days) from NYS NICU Module;
B. Central line associated bloodstream infection rates per 1000 central line days using the NYS hospital acquired infection data reporting system;
C. Maintenance checklist use per total number of days of central line use; and
D. Percent infants discharged from NICU at less than 10th percentile weight born <31 weeks gestation.

i. Avoidable Preterm Births: Reducing Elective Delivery Prior to 39 Weeks Gestation.

i. Elements. Use of evidence based interventions for evaluation, measurement, and improvement of preventable preterm births using findings from NICHQ/CMS Neonatal Outcomes Improvement Project and/or California Toolkit to Transform Maternity Care:

A. Identification and treatment of chronic medical conditions and high risk behaviors
B. Early identification of mothers at high risk for preterm delivery
C. Use of antenatal steroids in appropriate patients
D. Reducing elective inductions/cesarean sections without appropriate medical or obstetric indication

ii. Key Measures

A. Percent of scheduled inductions at 36(0/7) to 38(6/7) weeks without medical or obstetrical indication documented of all scheduled deliveries
B. Percent of scheduled inductions at 36(0/7) to 38(6/7) weeks without medical or obstetrical indication documented of all scheduled inductions
C. Percent of scheduled C-sections at 36(0/7) to 38(6/7) weeks without medical or obstetrical indication documented of all scheduled deliveries
D. Percent of scheduled C-sections at 36(0/7) to 38(6/7) weeks without medical or obstetrical indication documented of all scheduled C-sections
E. Percent of all scheduled deliveries at 36(0/7) to 38(6/7) weeks without medical or obstetrical indication documented of all scheduled deliveries
F. Percent of infants born at 36(0/7) to 38(6/7) weeks gestation by scheduled delivery who went to neonatal intensive care unit
G. Percent of mothers informed about risks and benefits of scheduled deliveries 36(0/7) to 38(6/7) weeks gestation documented in the medical record
H. Percent scheduled deliveries at 36(0/7) to 38(6/7) weeks that have documentation in the medical record of meeting optimal criteria of gestational age assessment
I. IHI Elective Induction Bundle Elements: Percentage of times that all four of the following elements are in place:

1. gestational age >/= 39 weeks
2. monitor fetal heart rate for reassurance of fetal status
3. pelvic exam: assess to determine dilation, effacement, station, cervical position and consistency, and fetal presentation
4. monitor and manage hyperstimulation (tachysystole).

7. H-MH Funding Distribution. Awardees will receive demonstration funds based on the number of Medicaid recipients served and the number of primary care residents trained. Eighty percent of an awardee's funds will be based on Medicaid patient volume and twenty percent will be based on primary care residents trained in that facility. The formula will be proportionally allocated using these criteria. Facilities will not be included if they do not satisfy the requirements for one of the supplemental program initiatives. Full or partial funding is contingent on achieving each year's goals. In no instance will an awardee receive funding beyond year 2 unless the awardee has achieved NCQA PPC®-PCMHTM Level 2 or Level 3 recognition.

a. Year 1 Funds. Each awardee will receive one-fourth of the first year's funding amount upon award. The remaining first year payment will be issued once the awardee has documented that the applicable first-year program milestones (as stipulated in STC 3 (a), (b), and (c) in this section) have been met. If the first year milestones are not met by the end of year 1, the awardee will forfeit the remaining funding for that year but would be allowed to continue to work toward meeting the milestones and eligible for subsequent year funding.
b. Year 2 Funds. Each awardee will receive one-fourth of the second year's funding amount upon completion of the applicable year one milestones. Upon achieving NCQA PPC®-PCMHTM Level 2 or Level 3 accreditation, the remainder of the second year's funds will be made available, provided all other requirements for Quality Service

Improvement Programs (QSIP) projects are up to date. If an awardee does not achieve accreditation by the end of year two or, for a hospital awardee, make progress on the additional initiatives that are required as a condition of funding, the remainder of year two funding will be forfeited.

c. Year 3 Funds. Third year funding will be provided only to awardees that have achieved NCQA PPC®-PCMHTM Level 2 or Level 3 recognition and, for hospital awardees, meet the applicable milestones for the additional initiatives as stipulated in the hospital's approved work plan. Awardees will receive one-fourth of the funding amount at the start of the year and the remainder after submission of the third year milestones.

8. H-MH Reporting.

a. The state shall include updates on activities related to the H-MH demonstration in the quarterly operational reports required under STC 4 in Section IX including updated expenditure projections reflecting the expected pace of disbursements under the demonstration.

b. The state shall provide an assessment of the H-MH demonstration by summarizing each awardee's activities during the demonstration year in each annual report required under STC 5 in Section IX.

c. The state shall include an assessment of the success of the H-MH demonstration in the evaluation required by STC 1 in Section XII including the milestones in STC 3(c) in this section, the hospital improvement projects in STC 2(d) in this section as well as the outcome measures for each supplemental program initiative implemented by the awardees.

9. Potentially Preventable Readmissions (PPR) Demonstration. The purpose of this demonstration is to test strategies for reducing the rate of preventable readmission within the Medicaid population, with the related longer-term goal of developing reimbursement policies that provide incentives to help people stay out of the hospital. It is intended to assist hospitals with reducing the rate of PPRs in advance of the implementation of the Hospital Readmissions Reduction Program (authorized by section 3025 of the Patient Protection and Affordable Care Act) on October 1, 2012. Beginning with FFY 2012, hospitals will face reductions in Medicare payments if they have readmission rates higher than what would be expected for specific conditions.

Hospitals will be asked to devise unique strategies that target each hospital's particular experiences, strengths, weaknesses and patient profile. Projects will focus on improved quality and cost savings and will include reporting and evaluation components to ensure that the projects are replicable and sustainable. Activities will include a review of policies and operational procedures that may be contributing to high rates of avoidable readmissions; reengineering the discharge planning process; and appropriate management of post-hospital/transition care; coordination with outpatient and post-discharge providers, including institutions and community providers, to address transitional care needs.

a. Eligibility. All hospitals in the state will be eligible to participate in the PPR demonstration.

b. Selection. The state will develop and issue a Request for Grant Application (RGA). Awards will be made based on the published criteria in the RGA, and funding will be made available over the demonstration extension period as specified in the RGA. The RGA shall also include requirements for evaluating the success of the implemented strategies

c. Reporting.

i. Once grantees are in place, the state shall include in the quarterly operational report under STC 4 in Section IX, the following information:

A. A summary of the interventional strategies each grantee intends to implement.
B. Baseline assessment of each grantee's readmission rate.
C. Interim assessments (as data is available) of each grantee's success in reducing PPRs.
D. Updated expenditure projections reflecting the expected pace of disbursements under the demonstration.

ii. The state shall provide a progress report in the implementation of the PPR demonstration in each annual report required under STC 5 in Section IX.

10. Clinic Uncompensated Care Funding. The state shall provide grants to voluntary, non-profit and publicly-sponsored Diagnostic and Treatment Centers (D&TCs) for services delivered to the uninsured throughout the state through an Indigent Care Pool (ICP).

a. Eligibility. In order to receive ICP funds, each facility must provide a comprehensive range of primary health care of mental health care services, have at least 5 percent of their visits providing services to uninsured individuals and have a process to collect payments from third-party payers.

b. Reporting.

i. The state shall include updates on activities related to ICP grants in each quarterly operational report required under STC 4 in Section IX, including the extent to which actual expenditures for the grants are consistent with projections.

ii. The state shall also include the following information on each facility which received a grant in the annual report required in STC 5 in Section IX.

A. The total amount of ICP funds awarded.

B. The total amount of funding that each clinic received from other federal agencies, including but not limited to, the Health Resources and Services Administration and the Substance Abuse and Mental Health Services Administration.

C. The extent to which the clinic participates in any medical home initiative, including a summary of the initiative.

D. The extent to which the clinic has implemented certified electronic health records (EHRs) for its patients.

E. The number of providers practicing predominantly within a Federally Qualified Health Center (FQHC) grantee who are meaningful users of certified EHRs consistent with 42 CFR §495.6.

11. Funding for Quality Demonstrations and Clinic Uncompensated Care. Federal funds will be used to pay the full cost of these programs. Accordingly, Federal Financial Participation (FFP) will be available for state funds for the Indigent Care Pool (beginning August 1, 2011 and ending December 31, 2014) and the Designated State Health Programs (DSHP) described in STC 11 of this section (beginning August 1, 2011 and ending December 31, 2014), as certified on each quarterly CMS Form 64 expenditure reports.

a. Limitations on FFP.

i. FFP is limited to no more than $531.2 million over the demonstration extension period as follows:

A. $325 million for the H-MH demonstration;
B. $20 million for the PPR demonstration; and
C. $186.2 million for the ICP, but only to the extent that the state appropriates and expends at least $186.2 million over the extension period. Otherwise, FFP for the ICP may be no more than one-half of total ICP spending (both federal and state funds).

ii. The state shall be eligible to receive FFP over the demonstration period for its own expenditures for:

A. The Indigent Care Pool (for ICP expenditures made between August 1, 2011 and December 31, 2014); and
B. DSHP (for DSHP expenditures made between August 1, 2011 and December 31, 2014).

b. Reporting.

i. Updated expenditure projections shall be provided by the state in each quarterly operational report required under STC 4 in Section IX.
ii. Expenditure Reporting for the H-MH demonstration. DSHP expenditures used to draw down federal funds for the H-MH demonstration shall be reported on the CMS-64 under waiver name MH Demo – DSHP.

iii. Expenditure Reporting for the PPR demonstration. DSHP expenditures used to draw down federal funds for the PPR demonstration shall be reported on the CMS-64 under waiver name PPR Demo – DSHP.

iv. Expenditure Reporting for Clinic Uncompensated Care.

A. The state's own expenditures for ICP grants shall be reported on the CMS-64 under waiver name ICP – Direct.

B. DSHP expenditures used to draw down federal funds for Clinic Uncompensated Care shall be reported on the CMS-64 under waiver name ICP – DSHP.

c. Reconciliation and Recoupment. By the end of the demonstration extension period, if the amount of DSHP claimed over the demonstration period results in the state receiving FFP in an amount greater than what the state actually expended for quality demonstrations and clinic uncompensated care, the state must return to CMS federal funds in an amount that equals the difference between claimed DSHP and actual state expenditures made for these initiatives.

i. As part of the annual report required under STC 5 in Section IX, the state will report both DSHP claims and expenditures to date for the quality demonstrations and clinic uncompensated care.

ii. The reported claims and expenditures will be reconciled at the end of the demonstration with the state's CMS-64 submissions

iii. Any repayment required under this subparagraph will be accomplished by the state making an adjustment for its excessive claim for FFP on the CMS-64 by entering an amount in line 10(b) of the Summary sheet equal to the amount that equals the difference between claimed DSHP and actual expenditures made for these initiatives during the extension period.

12. Designated State Health Programs. Subject to the conditions outlined in STC 12 of this section, FFP may be claimed for expenditures made for the following designated state health programs beginning August 1, 2011 through December 31, 2014. Designated state health program funding described in paragraphs (m) and (n) below begins January 1, 2014.

a. Homeless Health Services
b. HIV-Related Risk Reduction
c. Childhood Lead Poisoning Primary Prevention
d. Healthy Neighborhoods Program
e. Local Health Department Lead Poisoning Prevention Programs
f. Cancer Services Programs
g. Obesity and Diabetes Programs
h. TB Treatment, Detection and Prevention
i. TB Directly Observed Therapy
j. Tobacco Control
k. General Public Health Work
l. Newborn Screening Programs

m. The state may claim as allowable expenditures under the demonstration the payments made through its state-funded program to provide subsidies for parents and caretaker relatives with incomes above 133 percent of the FPL through 150 percent of the FPL who purchase health insurance through the Marketplace. Subsidies will be provided on behalf of individuals who: (1) are not Medicaid eligible but who are parents or caretaker relatives of individuals under the age of 21; (2) are eligible for the advance premium tax credit (APTC); and (3) whose income is above 133 percent of the FPL through 150 percent of the FPL. Federal financial participation for the premium assistance portion of QHP subsidies for citizens and eligible qualified aliens will be provided through the Designated State Health Programs pursuant to this STC. Authority to claim federal matching for this program will end on December 31, 2014.

n. The state may claim as allowable expenditures under the demonstration, the payments made through its state-funded program to provide FHPlus benefits to parents and caretaker relatives with incomes up to and including 150 percent of the FPL who are no longer eligible under the demonstration. Authority to claim federal matching for this program will end on December 31, 2014.

13. Designated State Health Programs (DSHP) Claiming Process.

a. Documentation of each DSHP's expenditures must be clearly outlined in the state's supporting work papers and be made available to CMS.

b. Federal funds must be claimed within two years after the calendar quarter in which the state disburses expenditures for the DSHPs in STC 12 of this section. Claims may not be submitted for state expenditures disbursed after December 31, 2014.

c. Sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. To the extent that federal funds from any federal programs are received for the DSHPs listed in STC 12 of this section, they shall not be used as a source of non-federal share.

d. The administrative costs associated with DSHPs in STC 12 of this section and any others subsequently added by amendment to the demonstration shall not be included in any way as demonstration and/or other Medicaid expenditures.

e. Any changes to the DSHPs listed in STC 12 of this section shall be considered an amendment to the demonstration and processed in accordance with STC 7 in Section III.

VIII. DELIVERY SYSTEM REFORM PROGRAM DESCRIPTION AND OBJECTIVES

1. Medicaid Redesign Team (MRT)

a. BACKGROUND

The purpose of this demonstration amendment is to describe a structure under which the federal government will provide up to $8 billion in new federal funds for all Medicaid Redesign Team (MRT) activities including delivery system reform in the waiver, managed care programming and state plan amendment (SPA) activities. The purpose of one component of MRT, the

Delivery System Reform Incentive Payment (DSRIP) program, is to provide incentives for Medicaid providers to create and sustain an integrated, high performing health care delivery system that can effectively and efficiently meet the needs of Medicaid beneficiaries and low income uninsured individuals in their local communities by improving care, improving health and reducing costs. Up to $6.42 billion of the new MRT funding is available for DSRIP payments to providers. An additional $500 million in temporary, time limited, funding is available from an Interim Access Assurance Fund (IAAF) for payments to providers to protect against degradation of current access to key health care services in the near term. And, up to $1.08 billion in federal funding for non-DSRIP Medicaid Redesign purposes, with specific uses of that funding still to be discussed and finalized.

Only initial funding of this structure is authorized in 2014; continued authority for operations and funding must be authorized upon renewal of the overall Partnership Plan demonstration, and is contingent on satisfactory initial implementation.

The DSRIP program is focused on the following goals: (1) safety net system transformation at both the system and state level; (2) accountability for reducing avoidable hospital use and improvements in other health and public health measures at both the system and state level; and (3) efforts to ensure sustainability of delivery system transformation through leveraging managed care payment reform.

i. Safety Net System Transformation. The DSRIP funds provider incentive payments to reward safety net providers when they undertake projects designed to transform the systems of care that support Medicaid beneficiaries and low income uninsured by addressing three key elements, which must be reflected in all DSRIP projects proposed by safety net providers participating in DSRIP (referred to as "Performing Provider Systems"). DSRIP projects will be designed to meet and be responsive to community needs while ensuring overall transformation objectives are met. As such, all projects must include the following elements, whose core components and associated outcome measures are further described in the DSRIP Strategies Menu and Metrics (Attachment J):

A. Element 1: Appropriate Infrastructure. The DSRIP will further the evolution of infrastructure and care processes to meet the needs of their communities in a more appropriate, effective and responsive fashion to meet key functional goals. This will include changes in the workforce. Infrastructure evolution must support the broader goals of DSRIP, and key outcomes reflect the kinds of infrastructure to be supported under DSRIP. Appropriate infrastructure should ensure access to care, particularly to outpatient resources as well as effective care integration. In support of linking settings, the transforming infrastructure should place more emphasis on outpatient settings. Also, critical services such as care coordination may need to be expanded to meet the broad needs of the population served.

Indicators related to this objective are included in the System Transformation Milestones (Domain 2) described in more detail in DSRIP Strategies Menu and Metrics (Attachment J). Because many of these indicators are difficult to benchmark, the state will be

accountable for ensuring that these indicators are moving overall in the right directions across all systems as part of the statewide accountability described in STC 14 (f) of this section.

B. Element 2: Integration across settings. The DSRIP will further the transformation of patient care systems to create strong links between different settings in which care is provided, including inpatient and outpatient settings, institutional and community based settings, and importantly behavioral and physical health providers. The goal will be to coordinate and provide care for patients across the spectrum of settings in order to promote health and better outcomes, particularly for populations at risk, while also managing total cost of care. The DSRIP will fund projects that include new and expanded care coordination programs, other evidence based, data driven interventions and programs focused on key health and cost drivers and opportunities for providers to share information and learn from each other.

Key outcomes to be measured are expected to reflect this ongoing transformation. Integration across settings will create alignments between providers. The DSRIP will include restructuring payments to better reward providers for improved outcomes and lower costs.

Indicators related to this objective are included in the Clinical Improvement Milestones (Domain 3) described in more detail in DSRIP Strategies Menu and Metrics (Attachment J). Each system will be accountable for these indicators, and in addition, because the state should also work to support this goal, the state will also be accountable for statewide performance on these outcomes as described in STC 14(g) of this section.

C. Element 3: Assuming responsibility for a defined population. The DSRIP projects will be designed in ways that promote integrated systems assuming responsibility for the overall health needs of a population of Medicaid beneficiaries and low income uninsured people, not simply responding to the patients that arrive at the doors of a hospital. The state will approve a defined population for each DSRIP project based on geographic and member service loyalty factors, as described in DSRIP Program Funding and Mechanics Protocol (Attachment I). Safety net providers may propose to develop integrated systems that target the individuals served by a set of aligned community-based providers, or more ambitious systems to tackle accountability for an entire geographic population. Patient and beneficiary engagement through tools including community needs assessment and responsiveness to public health needs will be an important element of all DSRIP projects.

Each indicator used to determine DSRIP awards should reflect a population, rather than the patients enrolled in a particular intervention. In addition, DSRIP performing provider systems will be required to report on progress on priorities related to the Prevention Agenda as included in the Population-wide Strategy

Implementation Milestones (Domain 4) described in more detail in DSRIP Strategies Menu and Metrics (Attachment J).

D. Element 4: Procedures to reduce avoidable hospital use: guidepost for statewide reform. New York has identified a statewide goal of reducing avoidable hospital use and improving outcomes in other key health and public health measures. Effectively reducing avoidable hospital use requires alignment of outpatient and inpatient settings, requires systems that can take responsibility for a population, and requires investments in key infrastructure--and so this is a guidepost that can ensure that these transformations are aligned with our shared goals of better health, and better care at lower cost.

Consistent with the fact that this is an integral guidepost to system transformation, key improvement outcomes for avoidable hospital use and improvements in other health and public health measures will be included for each project, and the state will be held accountable for these measures as part of the statewide accountability described in STC 14 (f) of this section.

E. Element 5: State managed care contracting reforms to establish and promote DSRIP objectives. The state must also ensure that its managed care payment systems recognize, encourage and reward positive system transformation. To fully accomplish DSRIP goals and ensure sustainability of the initiatives supported by this demonstration, as a condition of receiving DSRIP project funding, the state shall develop and execute payment arrangements and accountability mechanisms with its managed care contractors. These payment and accountability changes, described further in STC 39 of this section, must be reflected in the state's approved state plan and managed care contracts, and are funded through the approved state plan (without separate DSRIP funding). These changes are a condition for overall DSRIP project funding to be released.

This goal will also be monitored as part of the statewide accountability test described in STC 14(f) of this section and will be tracked not at a DSRIP project level, but at the state level. The state must ensure state payments to managed care plans reflect and promote the establishment and continuation of integrated service delivery systems and procedures to reduce avoidable hospital use and ensure improvements in other health and public health measures.

ii. State and Provider Accountability. Overall DSRIP project funding is available up to the amounts specified in the special terms and conditions. Such funding is subject to the Performing Provider System meeting ongoing milestones established pursuant to this demonstration, and the state meeting overall state milestones as described in the STCs and DSRIP Program Funding and Mechanics Protocol (Attachment I). In addition, statewide achievement of performance goals and targets must be achieved and maintained for full access to the funding level as specified in the STCs. Specific reductions from statewide funds are taken from the state starting in Year 3 accordance with STC 14 (h) of this section if these targets are not achieved.

Individual projects are awarded based on the merit of the proposal itself, its support of the overall DSRIP goals, and the projected breadth and depth of the impact on Medicaid beneficiaries. Public transparency, a process that allows for community input, and independent expert evaluation are critical to the approval and funding levels for each project.

It should be noted that federal funding for DSRIP activities is limited in any phase of the demonstration period to the amounts set forth in this demonstration authority, subject to all of the reductions based on milestones, even if the state expenditures exceed the amount for which federal funding is available.

b. Interim Access Assurance Fund (IAAF). Temporary, time limited, funding is available from an IAAF to protect against degradation of current access to key health care services in the near term. The IAAF is available to provide supplemental payments that exceed upper payment limits, DSH limitations, or state plan payments, to ensure that current trusted and viable Medicaid safety net providers, according to criteria established by the state consistent with these STCs, can fully participate in the DSRIP, transformation without unproductive disruption. The IAAF is authorized as a separate funding structure from the DSRIP program to support the ultimate achievement of DSRIP goals. To the extent available funds are not expended in this time-limited IAAF, they are available for the DSRIP program itself. In addition, a separate fund is authorized to make DSRIP project design grants to providers. The IAAF and the design grant funds are both part of the overall DSRIP total funding.

i. Interim Access Assurance Fund. To protect against degradation of current access to key health care services, limit unproductive disruption, and avoid gaps in the health delivery system, New York is authorized to make payments for the financial support of selected Medicaid providers.

A. Limit on FFP. New York may expend up to $500 million in FFP for Interim Access Assurance payments for the period from the date of approval of the IAAF expenditure authority until December 31, 2014. Contingent upon renewal of the demonstration, the authority could be extended until March 31, 2015. To the extent available funds are not expended in this time-limited IAAF, they are available for the DSRIP program itself.

B. Funding. The non-federal share of IAAF payments may be funded by state general revenue funds and transfers from units of local government that are compliant with section 1903(w) of the Act. Any IAAF payments must remain with the provider receiving the payment to be used for health care related purposes, and may not be transferred back to any unit of government, directly or indirectly, or redirected for other purposes. The IAAF payments received by providers cannot be used for the non-federal share of any expenditures claimed under a federally-supported grant.

ii. Interim Access Assurance Fund Requirements.

A. The state will make all decisions regarding the distribution of IAAF payments to ensure that sufficient numbers and types of providers are available to Medicaid beneficiaries in the geographic area to provide access to care for Medicaid and uninsured individuals while the state embarks on its transformation path. The IAAF payments shall be limited to providers that serve significant numbers of Medicaid individuals, and that the state determines have financial hardship in the form of financial losses or low margins. In determining the qualifications of a safety net provider for this program and the level of funding to be made available, the state will take into consideration both whether the funding is necessary (based on current financial and other information on community need and services) to provide access to Medicaid and uninsured individuals. The state will also seek to ensure that IAAF payments supplement but do not replace other funding sources.

B. Before issuing any payments to providers, the state must post on its Website a list of qualifications that providers must meet to receive payments under this section, provide an opportunity for public comment for at least 14 days, and consider such comments. On the day the proposed qualifications list is posted, the state must provide to CMS the URL where the list can be found. The state must take the public comments into account when qualifying providers and distributing funds from this account.

C. Following the end of the public comment period in (ii), the state will initiate an open application period of at least 14 days duration for providers to submit applications.

D. If a provider otherwise meeting the qualifications of this section is also receiving funds through the state's vital access program, or any other supplemental payment program for which the federal government provides matching funds, or Medicaid disproportionate share hospital payments, the state must assure CMS of non-duplication. As part of the reporting requirements described in (iii) below, the state assures that the payment information for the IAAF will be maintained, as the reporting information is subject to CMS audit. A provider may receive both funding through this special fund and a planning grant as part of the DSRIP program.

iii. Reporting.

A. Within 10 days of initiating payments under this section to a provider, the state must submit a report to CMS that states the total amount of the payment or payments, the amount of FFP that the state will claim, the source of the non-Federal share of the payments, and documentation of the needs and purposes of the funds to assure CMS of non-duplication. The state should document all other Medicaid payments (e.g. base, supplemental, VAP, DSH) the provider receives to demonstrate that existing payments are not sufficient to meet financial needs of

the providers.

B. In each quarterly progress report, the state will include a summary of all payments under this section made during the preceding quarter, including all information required in (A), and attach copies all reports submitted under (A) for payments made during the quarter.

C. When reporting payments under this section on the CMS-64, the state must include in Form CMS-64 Narrative a table that lists all payments by date, provider, and amount (broken down by source), and a reference to the quarterly progress report(s) where the payments and all of their required supporting documentation is presented.

iv. IAAF payments. The IAAF payments are not direct reimbursement for expenditures or payments for services. Payments from the IAAF are not considered patient care revenue, and shall not be offset against disproportionate share hospital expenditures or other Medicaid expenditures that are related to the cost of patient care (including stepped down costs of administration of such care) as defined under these STCs, and/or under the state plan.

c. Delivery System Reform Incentive Payment (DSRIP) Fund. The terms and conditions in Section c apply to the State's exercise of Expenditure Authority 9: Expenditures Related to the Delivery System Reform Incentive Payment (DSRIP) Fund. These requirements are further elaborated by Attachment I, "NY DSRIP Program Funding and Mechanics Protocol," Attachment J "NY DSRIP Strategies Menu and Metrics," and Attachment K "DSRIP Operational Protocol." For purposes of this section, the DSRIP program will have its own demonstration years (DY) and any reference to DY is in reference to the DSRIP portion of the Partnership Plan demonstration and not the entire Partnership Plan demonstration. DSRIP funding for demonstration year DY 1 through DY 5 is contingent on renewal of the demonstration no later than December 31, 2014 and the revision of Attachments I, J and K based on the pre-implementation activities described in this section.

As described further below, DSRIP funding is available to *Performing Provider Systems* that consist of *safety net providers* whose *project plans* are approved and funded through the process described in these STCs and who meet particular *milestones* described in their approved DSRIP *project plans*. DSRIP project plans are based on the evidenced-based *projects* specified in the DSRIP Strategies Menu and Metrics (Attachment J) and are further developed by Performing Provider Systems to be directly responsive to the needs and characteristics of the low-income communities that they serve and to achieve the transformation objectives furthered by this demonstration.

2. Safety Net Definition: The definition of safety net provider for hospitals will be based on the environment in which the performing provider system operates. Below is the safety net definition:

a. A hospital must meet the following criteria to participate in a performing provider system:

i. Must be either a public hospital, Critical Access Hospital or Sole Community Hospital, or

ii. Must pass two tests:
A. At least 35 percent of all patient volume in their outpatient lines of business must be associated with Medicaid, uninsured and Dual Eligible individuals.
B. At least 30 percent of inpatient treatment must be associated with Medicaid, uninsured and Dual Eligible individuals; or

iii. Must serve at least 30 percent of all Medicaid, uninsured and Dual Eligible members in the proposed county or multi-county community. The state will use Medicaid claims and encounter data as well as other sources to verify this claim. The state reserves the right to increase this percentage on a case by case basis so as to ensure that the needs of each community's Medicaid members are met.

b. Non-hospital based providers, not participating as part of a state-designated health home, must have at least 35 percent of all patient volume in their primary lines of business associated with Medicaid, uninsured and Dual Eligible individuals.

c. Vital Access Provider Exception: The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval. Three allowed reasons for granting an exception are:

i. A community will not be served without granting the exception because no other eligible provider is willing or capable of serving the community.

ii. Any hospital is uniquely qualified to serve based on services provided, financial viability, relationships within the community, and/or clear track record of success in reducing avoidable hospital use.

iii. Any state-designated health home or group of health homes.

d. Non-qualifying providers can participate in Performing Providers Systems. However, non-qualifying providers are eligible to receive DSRIP payments totaling no more than 5 percent of a project's total valuation. CMS can approve payments above this amount if it is deemed in the best interest of Medicaid members attributed to the Performing Provider System.

3. Performing Provider Systems. The safety net providers that are funded to participate in a DSRIP project are called "Performing Provider Systems." Performing Provider Systems that complete project milestones and measures as specified in Attachment J, "DSRIP Strategies

Menu and Metrics", are the only entities that are eligible to receive DSRIP incentive payments.

4. **Two DSRIP Pools**. Performing Provider Systems will be able to apply for funding from one of two DSRIP pools: Public Hospital Transformation Fund and Safety Net Performance Provider System Transformation Fund.

   a. The Public Hospital Transformation Fund will be open to applicants led by a major public hospital system. The public hospital systems allowed to participate in this pool include:

   i. Health and Hospitals Corporation of New York City
   ii. State University of New York Medical Centers
   iii. Nassau University Medical Center
   iv. Westchester County Medical Center
   v. Erie County Medical Center

   b. The Safety Net Performance Provider System Transformation Fund would be available to all other DSRIP eligible providers.

   c. Allocation of funds between the two pools will be determined after applications have been submitted, based on the valuation of applications submitted to each pool. The valuation framework is described in STC 9 of this section and will be further specified in the Program Funding and Mechanics Protocol.

   d. There is also a Performance Pool within the two DSRIP pools, as described in the Program Funding and Mechanics Protocol (Attachment I).

5. **Coalitions and Attributed Population**. Major public general hospitals and other safety net providers are strongly required to form coalitions that apply collectively as a single Performing Provider System. Coalitions will be evaluated on performance on DSRIP milestones collectively as a single Performing Provider System. Coalitions are subject to the following conditions in addition to the requirements specified in the Program Funding and Mechanics Protocol:

   a. Coalitions must designate a lead coalition provider who will be held responsible under the DSRIP for ensuring that the coalition meets all requirements of Performing Provider Systems, including reporting to the state and CMS.

   b. Coalitions must establish a clear business relationship between the component providers, including a joint budget and funding distribution plan that specifies in advance the methodology for distributing funding to participating providers. The funding distribution plan must comply with all applicable laws and regulations, including, but not limited to, the following federal fraud and abuse authorities: the anti-kickback statute (sections 1128B(b)(1) and (2) of the Act); the physician self-referral prohibition (section 1903(s) of the Act); the gainsharing civil monetary penalty (CMP) provisions (sections 1128A(b)(1)

and (2) of the Act); and the beneficiary inducement CMP (section 1128A(a)(5) of the Act). CMS approval of a DSRIP plan does not alter the responsibility of Performing Provider Systems to comply with all federal fraud and abuse requirements of the Medicaid program.

c. Each Performing Providers System must, in the aggregate, identify a proposed population for DSRIP. The proposed population will be aligned with the population attribution methodology specified in the Program Funding and Mechanics Protocol. The attribution methodology will assure non-duplication of members between DSRIP Performing Providers Systems.

d. Each coalition must have a data agreement in place to share and manage data on system-wide performance.

6. Objectives. Performing Provider Systems will design and implement projects that aim to achieve each of the following objectives or sub-parts of objectives, which are elaborated further in the DSRIP Strategies Menu and Metrics (Attachment J). To put in the context of the overall three objectives below, each performing provider system is responsible for project activity that addresses the first two objectives, for a defined population as specified in the third objective.

a. The creation of appropriate infrastructure and care processes based on community need, in order to promote efficiency of operations and support prevention and early intervention.

b. The integration of settings through the cooperation of inpatient and outpatient, institutional and community based providers, in coordinating and providing care for patients across the spectrum of settings in order to promote health and better outcomes, particularly for populations at risk, while managing total cost of care.

c. Population health management as described in the attribution section of the Program Funding and Mechanics Protocol.

7. Project Milestones. Progress towards achieving the goals specified above will be assessed by specific milestones for each project, which are measured by particular metrics that are further defined in the DSRIP Strategies Menu and Metrics (Attachment J). These milestones are organized into the following domains:

a. *Project progress milestones (Domain 1).* Investments in technology, tools, and human resources that will strengthen the ability of the Performing Provider Systems to serve target populations and pursue DSRIP project goals. Performance in this domain is measured by a common set of project progress milestones, which will include milestones related to the monitoring of project spending and post-DSRIP sustainability. This includes at least semi-annual reports on project progress specific to the performing provider system's DSRIP project and its Medicaid and uninsured patient population.

b. *System transformation milestones (Domain 2).* As described further in the Project Menu, this includes outcomes that reflect the four subparts of the goal on system transformation, including measures of inpatient/ outpatient balance, increased primary care/community-based services utilization, and rates of global capitation, partial capitation and bundled payment of providers by Medicaid managed care plans, and measures for patient engagement.

c. *Clinical improvement milestones (Domain 3):* As described further in the Project Menu, this domain includes metrics that reflect improved quality of care for Medicaid beneficiaries; including the goal of reducing avoidable hospital use and improvements in other health and public health measures. Payment for performance on these outcome milestones will be based on an objective demonstration of improvement over a baseline, using a valid, standardized method. Systems that are already high performers on these metrics, with the exception of avoidable hospitalization metrics, before initiation of projects must either explore alternative projects or align with lower performing providers such that the system as a whole has adequate room for improvement (as defined in DSRIP Program Funding and Mechanics Protocol (Attachment I).

d. *Population-wide Strategy Implementation Milestones (Domain 4).* DSRIP Performing Provider Systems will be responsible for reporting on progress on strategies they have chosen related to the Prevention Agenda as identified in DSRIP Strategies Menu and Metrics (Attachment J) for relevant populations as identified in DSRIP Program Funding and Mechanics Protocol (Attachment I) and as approved in their project plan.

8. DSRIP Project Plan Performing Provider Systems must develop a DSRIP project plan that is based on one or more of the projects specified in the DSRIP Strategies Menu and Metrics (Attachment J) and complies with all requirements specified in the DSRIP Program Funding and Mechanics Protocol. Performing Provider Systems should develop DSRIP project plans, while leveraging community needs, including allowing community engagement during planning, to sufficiently address the delivery system transformation achievement that is expected from their projects. DSRIP project plans will be provided in a structured format developed by the state and approved by CMS and must be tracked by the state over the duration and close out of the program. DSRIP project plans must be approved by the state and may be subject to additional review by CMS, DSRIP project plans must include the following elements:

a. *Rationale for Project Selection.*

i. Each DSRIP project plan must identify the target populations, program(s), and specific milestones for the proposed project, which must be chosen from the options described in the approved DSRIP Strategies Menu and Metrics.

ii. Goals of the project plan should be aligned with each of the objectives as described in STC 6 of this section.

iii. Milestones should be organized as described above in STC 7 of this section reflecting

the three overall goals and subparts for each goal as necessary.

iv. The project plan must describe the need being addressed and the starting point (including baseline data consistent with the agreement between CMS and the state) of the performing provider system related to the project. The starting point of the project plan must be after April 1, 2015.

v. Based on the starting point the performing provider system must describe its 5-year expected outcome for each of the domains described in STC 7 of this section. Supporting evidence for the potential for the interventions to achieve these changes should be provided in support of this 5 year projection for achievement in the goals of this DSRIP.

vi. The DSRIP Project Plan shall include a description of the processes used by the Performing Provider System to engage and reach out to stakeholders, including a plan for ongoing engagement with the public, based on the process described in the Operational Protocol (Attachment K).

vii. Performing Provider Systems must demonstrate how the project will transform the delivery system for the target population and do so in a manner that is aligned with the central goals of DSRIP, and in a manner that will be sustainable after DY5. The projects must implement new, or significantly enhance existing health care initiatives; to this end, providers must identify the CMS and HHS funded delivery system reform initiatives in which they currently participate or in which they have participated in the previous five years, and explain how their proposed DSRIP activities are not duplicative of activities that are already or have recently been funded.

viii. The plan must include an approach to rapid cycle evaluation that informs the system in a timely fashion of its progress, how that information will be consumed by the system to drive transformation and who will be accountable for results, including the organizational structure and process to oversee and manage this process. The plan must also indicate how it will tie into the state's requirement to report to CMS on a rapid cycle basis.

ix. The plan must contain a comprehensive workforce strategy. This strategy will identify all workforce implications – including employment levels, wages and benefits, and distribution of skills – and present a plan for how workers will be trained and deployed to meet patient needs in the new delivery system. Applicants will need to include workers and their representatives in the planning and implementation of their workforce strategy.

b. *Description of Project Activities.*

i. Each project must feature strategies from all domains described in STC 7 of this section and the DSRIP Strategies Menu and Metrics.

ii. For each domain of a project, there must be at least one associated outcome metric that must be reported in all years, years 1 through 5. The initially submitted DSRIP project plan must include baseline data on all measures, should demonstrate the ability to provide valid data and provide benchmarks for each measure. Baseline measurements should be based on the most recently available baseline data, as agreed to by CMS and the state.

c. *Justification of Project Funding.*

i. The DSRIP project plan shall include a detailed project specific budget as provided for in DSRIP Program Funding and Mechanics Protocol (Attachment I) and a description of the performing provider system or provider coalition's overall approach to valuing the project. Project valuations will be subject to a standardized analysis by the state as described below and further specified in the Program Funding and Mechanics Protocol.

ii. DSRIP project plans shall include any information necessary to describe and detail mechanisms for the state to properly receive intergovernmental transfer payments (as applicable and further described in the program funding and mechanics protocol).

9. Project Valuation. DSRIP payments are earned for meeting the performance milestones (as specified in each approved DSRIP project plan). The value of funding for each milestone and for DSRIP projects overall should be proportionate to and its potential benefit to the health and health care of Medicaid beneficiaries and low income uninsured individuals, as further explained in the Program Funding and Mechanics Protocol (Attachment I).

a. *Maximum project valuation*. As described further in the Program Funding and Mechanics Protocol, a maximum valuation for each project on the project menu shall be calculated based on the following valuation components as specified in the Program Funding and Mechanics Protocol (Attachment I).

i. Index score of transformation potential. The state will use a standardized index to score each project on the project menu, based on its anticipated delivery system transformation. This index will include factors of anticipated transformation, such as potential for achieving the goals of DSRIP outlined in STC 6 of this section, expected cost savings, potential to reduce preventable events, capacity of the project to directly affect Medicaid and uninsured beneficiaries and robustness of evidence base. The index scoring process is described in the DSRIP Program and Funding and Mechanics Protocol and will be available for public comment in accordance with STC 10 of this section.

ii. Valuation benchmark. The project index score will be multiplied by a valuation benchmark in combination with the components below for all DSRIP projects in order to determine the maximum valuation for the project, as specified in the Program Funding and Mechanics Protocol (Attachment I). The valuation benchmark should be externally justified based on evidence for the value and scope of similar system

transformations and delivery system reforms, and may not be based on the total statewide limit on DSRIP funding described in STC 14 of this section. By no later than 15 days after the public comment period for initial DSRIP applications, the state will establish a state-wide valuation benchmark based on its assessment of the cost of similar delivery reforms. This value will be expressed in a per member per month (PMPM) format and may not exceed $15 PMPM, calculated multiplying paragraphs (iii)(B) and (C) below.

iii. DSRIP Project Plan Application Score. Based on the Performing Provider System's application, each project plan will receive a score based on the following:

A. The fidelity to the project description, and likelihood of achieving improvement by using that project.
B. Number of beneficiaries attributed to each performing provider's project plan.
C. Number of DSRIP months that will be paid for under the DSRIP project plan.

b. *Progress milestones and outcome milestones.* A DSRIP project's total valuation will be distributed across the milestones described in the DSRIP project plan, according to the specifications described in the Program Funding and Mechanics Protocol (Attachment I). An increasing proportion of DSRIP funding will be allocated to performance on outcome milestones each year, as described in DSRIP Program Funding and Mechanics Protocol (Attachment I).

c. *Performance based payments*. Performing Provider Systems may not receive payment for metrics achieved prior to the baseline period set by CMS and the State in accordance with these STCs and the funding and mechanics protocol and achievement of all milestones is subject to audit by CMS, the state, and the state's independent assessor described in STC 10 of this section. The state shall also monitor and report proper execution of project valuations and funds distribution as part of the implementation monitoring reporting required under STC 12 of this section. In addition to meeting performance milestones, the state and performing providers must comply with the financial and reporting requirements for DSRIP payments specified in STC 13 of this section and any additional requirements specified in the Program Funding and Mechanics Protocol (Attachment I).

10. Pre-implementation activities. In order to authorize DSRIP funding for DY 1 to 5, the state must meet the following implementation milestones according to the timeline outlined in these STCs and must successfully renew the demonstration according to the process outlined in STC 8 in Section III. Failure to complete these requirements will result in a state penalty, as described in paragraph (vi) below.

a. *Project Design Grants*. During calendar year 2014, the state may provide allotted amounts to providers for DSRIP Design Grants from a designated Design Grant Fund. These grants will enable providers to develop specific and comprehensive DSRIP Project Plans. New York may expend up to $100 million in FFP for the grant payments from the

Design Grant Fund. Unspent funds will be carried over to DSRIP. DSRIP Project Design Grant payments count against the total amounts allowed for DSRIP under the demonstration.

i. Submitting a proposal for a DSRIP Project Design Grant. Providers and coalitions must submit a DSRIP design proposal as an application for a design. The state will review proposals and award design grants at any time during the pre-implementation activities.

ii. Use of Design Grant Funds. The providers and coalitions that receive DSRIP project design grants must use their grant funds to prepare a DSRIP project plan to prepare the provider's application for a DSRIP award. Providers and coalitions that receive DSRIP project design grants must submit a DSRIP application.

b. *Public comment period.* The state must engage the public and all affected stakeholders (including community stakeholders, Medicaid beneficiaries, physician groups, hospitals, and health plans) by publishing the development of the DSRIP Program Funding and Mechanics Protocol and DSRIP Strategies Menu and Metrics (Attachments I and J), including all relevant background material, and providing a public comment period that will be no less than 30 days that includes submission of comments through electronic means as well as public meetings across the State.

c. *Allowable changes to DSRIP protocols.* The state must post the public comments received and any technical modifications the state makes to the DSRIP Program Funding and Mechanics Protocol and DSRIP Strategies Menu and Metrics (Attachments I and J). Only changes to the protocol and menu that are related to the public comments will be allowed and incorporated into final protocols for DY 1 to DY 5. The state will submit the final protocols and menu and CMS will review and take action on the changes (ie. approve, deny or request further information or modification) no later than 30 days after the state's submission.

d. *Baseline data on DSRIP measures.* The state must use existing data accumulated prior to implementation to identify performance goals for performing providers. The state must identify high performance levels for all anticipated measures in order to ensure that providers select projects that can have the most meaningful impact on the Medicaid population, and may not select projects for which they are already high performers, with the exception of projects specifically focused on avoidable hospitalization.

e. *Procurement of entities to assist in the administration and evaluation of DSRIP.* The state will identify independent entities with expertise in delivery system improvement, including an independent assessor, an independent evaluator and any other an administrative costs. The independent entities will work in cooperation with one another to do the following:

i. Independent Assessor: Conduct a transparent review of all proposed DSRIP project plans and make project approval recommendations to the state.

ii. Independent Evaluator: Assist with the continuous quality improvement activities.

iii. Administrative Costs: Administrative costs the state incurs associated with the management of DSRIP reports and other data.

A. The state must describe the functions of each independent entity and their relationship with the state as part of its Operational Protocol (Attachment K)

B. The state may elect to require IGTs to be used to fund the non-federal share of the administrative activities, as permitted under the state plan.

C. Spending on the independent entities and other administrative cost associated within the DSRIP fund is classified as a state administrative activity of operating the state plan as affected by this demonstration. The state must ensure that all administrative costs for the independent entities are proper and efficient for the administration of the DSRIP Fund.

f. *Submit evaluation plan*. The state must submit an evaluation plan for DSRIP consistent with the requirements of STC 19 of this section no later than 120 days after award of the DSRIP program and must identify an independent evaluator. The evaluation plan, including the budget and adequacy of approach to meet the scale and rigor of the requirements of STC 21 of this section, is subject to CMS approval.

g. *Update comprehensive quality strategy*. The state must update its comprehensive quality strategy, defined in Section VI, to ensure the investment in DSRIP programs will complement and be supported by the state's managed care quality activities and other quality improvements in the state, including the state's Medicaid Redesign Team and Health Homes initiatives.

h. *DSRIP Operational Protocol.* The state shall submit for CMS approval a draft operational protocol for approving, overseeing, and evaluating DSRIP project grants no later than 90 days after the award of the Demonstration. The protocol is subject to CMS approval. The State shall provide the final protocol within 30 days of receipt of CMS comments. If CMS finds that the final protocol adequately accommodates its comments, then CMS will approve the final protocol within 30 days. This protocol will become an appendix to Attachment K of these STCs.

i. The Operational Protocol, including required baseline and ongoing data reporting, independent assessor protocols, performing provider requirements, and monitoring/evaluation criteria shall align with the CMS approved evaluation design and the monitoring requirements in STC 34 of this section.

ii. The state shall make the necessary arrangements to assure that the data needed from the Performing Provider Systems, and data needed from other sources, are available as required by the CMS approved monitoring protocol.

iii. The Operational Protocol and reports shall be posted on the state Medicaid website within 30 days of CMS approval.

i. *CMS Oversight of Pre-implementation Activities*. CMS reserves the right to provide oversight over the state's pre-implementation activities in order to document late submissions and missed deliverables without notice of a delay from the state. Notice of delay from of any deliverable must be received by CMS no less than 10 days before the due date of the deliverable. As part of CMS' review of the state's deliverables, CMS will assess completeness based on listed deliverable requirements in the STCs.

11. DSRIP proposal and project plan review. In accordance with the schedule outlined in these STCs and the process described further in the Program Funding and Mechanics Protocol (Attachment I), the state and the assigned independent assessor must review and approve DSRIP project plans in order to authorize DSRIP funding for DY 1, DY 2, and DY 3 and must conduct ongoing reviews of DSRIP project plans as part of a mid-point assessment in order to authorize DSRIP funding for DY 4 and DY 5. The state is responsible for conducting these reviews for compliance with approved protocols. CMS reserves the right to review projects in which the state did not accept the finding of the independent assessor or other outlier projects, as specified in the Program Funding and Mechanics Protocol (Attachment I).

a. *Review tool.* The state will develop a standardized review tool that the independent assessor will use to review DSRIP project plans and ensure compliance with these STCs and associated protocols. The review tool will be available for public comment for a 30 day period according to the timeframe specified in the Program Funding and Mechanics Protocol (Attachment I). The review tool will define the relevant factors, assign weights to each factor, and include a scoring for each factor. Each factor will address the anticipated impact of the project on the Medicaid and uninsured populations consistent with the overall purpose of the DSRIP program.

b. *Role of the Independent assessor*. An independent assessor will review project proposals using the state's review tool and consider anticipated project performance. The independent assessor shall make recommendations to the state regarding approvals, denials or recommended changes to project plans to make them approvable. This entity (or another entity identified by the state) will also assist with the mid-point assessment and any other ongoing reviews of DSRIP project plan.

c. *Public comment.* Project proposals will be public documents and subject to public comment. The public will have no less than30 days from the date of project posting to submit comments for specific project proposals, according to the process described in the Operational Protocol (Attachment K). After the comment period for the projects closes, a method for which the public can continue to comment must remain available, to obtain feedback on the ongoing implementation of the projects. The state must periodically compile comments received over the life of the demonstration and ensure that responses to comments are provided and released for public view.

d. *Mid-point assessment.* During DY 3, the state's independent assessor shall assess project performance to determine whether DSRIP project plans merit continued funding and

provide recommendations to the state. If the state decides to discontinue specific projects, the project funds may be made available for expanding successful project plans in DY 4 and DY 5, as described in the Program Funding and Mechanics Protocol (Attachment I).

12. Monitoring. With the assistance of the independent assessor, the state will be actively involved in ongoing monitoring of DSRIP projects, including but not limited to the following activities.

a. *Review of milestone achievement.* At least two times per year, Performing Provider Systems seeking payment under the DSRIP program shall submit reports to the state demonstrating progress on each of their projects as measured by project-specific milestones and metrics achieved during the reporting period. The reports shall be submitted using the standardized reporting form approved by the state and CMS. Based on the reports, the state will calculate the incentive payments for the progress achieved according to the approved DSRIP project plan. The Performing Provider System shall have available for review by New York or CMS, upon request, all supporting data and back-up documentation. These reports will serve as the basis for authorizing incentive payments to Performing Provider Systems for achievement of DSRIP milestones.

b. *Quarterly DSRIP Operational Protocol Report.* The state shall provide quarterly updates to CMS and the public on the operation of the DSRIP program. The reports shall provide sufficient information for CMS to understand implementation progress of the demonstration and whether there has been progress toward the goals of the demonstration. The reports will document key operational and other challenges, to what they attribute the challenges and how the challenges are being addressed, as well as key achievements and to what conditions and efforts they attribute the successes.

c. *Learning collaboratives*. With funding available through this demonstration, the state will support regular learning collaboratives regionally and at the state level, which will be a required activity for all Performing Provider Systems, and may be organized either geographically, by the goals of the DSRIP, or by the specific DSRIP projects as described in the DSRIP Strategies Menu and Metrics (Attachment J). Learning collaboratives are forums for Performing Provider Systems to share best practices and get assistance with implementing their DSRIP projects. Learning collaboratives should primarily be focused on learning (through exchange of ideas at the front lines) rather than teaching (i.e. large conferences), but the state should organize at least one face-to-face statewide collaborative meeting a year. Learning collaboratives should be supported by a web site to help providers share ideas and simple data over time (which should not need to be developed from scratch). In addition, the collaboratives should be supported by individuals (regional "innovator agents") with training in quality improvement who can travel from site to site in the network to rapidly answer practical questions about implementation and harvest good ideas and practices that they systematically spread to others.

d. *Rapid cycle evaluation.* In addition to the comprehensive evaluation of DSRIP described

in STC 22 of this section, the state will be responsible for compiling data on DSRIP performance after each milestone reporting period and summarizing DSRIP performance to-date for CMS in its quarterly reports. Summaries of DSRIP performance must also be made available to the public on the state's website along with a mechanism for the public to provide comments.

e. *Additional progress milestones for at risk projects.* Based on the information contained in the Performing Provider System's semiannual report or other monitoring and evaluation information collected, the state or CMS may identify particular projects as being "at risk" of not successfully completing its DSRIP project in a manner that will result in meaningful delivery system transformation. The state or CMS may require these projects to meet additional progress milestones in order to receive DSRIP funding in a subsequent semi-annual reporting period. Projects that remain "at risk" are likely to be discontinued at the midpoint assessment, described in STC 11 of this section.

f. *Annual discussion and site visits*. In addition to regular monitoring calls, the State shall on an annual basis present to and participate in a discussion with CMS on implementation progress of the demonstration including progress toward the goals, and key challenges, achievements and lessons learned. The state, the independent assessor, and CMS will conduct annual site visits of a subset of Performing Providers to ensure continued compliance with DSRIP requirements.

g. *Application, review, oversight, and monitoring database*. The state will ensure that there is a well maintained and structured database, containing as data elements all parts and aspects of Performing Provider Systems' DSRIP project plans including the elements discussed in paragraph 8; independent assessor, state, and CMS review comments and scores; project planning, process, improvement, outcome, and population health milestones, with indicators of their required timing, incentive payment valuation, and whether or not they were achieved; and any other data elements required for the oversight of DSRIP. Along with the database, the state will develop software applications that will support:

i. Electronic submission of project plans by Performing Provider Systems;

ii. Public comment on project plans;

iii. Review of project plans by the independent assessor, state, and other independent participants in project plan review and scoring;

iv. Electronic submission by Performing Provider Systems of their performance data;

v. Generation of reports, containing (at a minimum) the elements in STC 36 of this section, that can be submitted to CMS to document and support amounts claimed for DSRIP payments on the CMS-64;

vi. Summaries of DSRIP project plans submissions, scoring, approval/denial, milestone

achievement, and payments that can be accessed by the public;

vii. Database queries, and export all or a portion of the data to Excel, SAS, or other software platforms; and

viii. On-line access rights for CMS.

13. Financial Requirements applying to DSRIP payments generally.

a. The non-Federal share of Fund payments to providers may be funded by state general revenue funds, and transfers from units of local government consistent with federal law. Any DSRIP payment must remain with the provider specified in the DSRIP project plan, and may not be transferred back to any unit of government, including public hospitals, either directly or indirectly. In the case of coalitions that are performing DSRIP projects collectively, the DSRIP funding will flow to the participating providers and/or the coalition coordinating entity according to the methodology specified in the DSRIP project plan but may not be transferred between coalition providers.

b. The state must inform CMS of the funding of all DSRIP payments to providers through a quarterly payment report to be submitted to CMS within 60 days after the end of each quarter, as required under STC 36 of this section. This report must identify the funding sources associated with each type of payment received by each provider. This report must identify and fully disclose all the underlying primary and secondary funding sources of the non-Federal share (including health care related taxes, intergovernmental transfers, general revenue appropriations, and any other mechanism) for each type of payment received by each provider.

c. The state will ensure that any lack of adequate funds from local sources will not result in lowering the amount, duration, scope or quality of Medicaid services available under the state plan or this demonstration. The preceding sentence is not intended to preclude the state from modifying the Medicaid benefit through the state plan amendment process.

d. The state may not claim FFP for DSRIP Payments until both the state and CMS have concluded that the performing providers have met the performance indicated for each payment. Performing providers' reports must contain sufficient data and documentation to allow the state and CMS to determine if the performing provider has fully met the specified metric, and performing providers must have available for review by the state or CMS, upon request, all supporting data and back-up documentation. FFP will be available only for payments related to activities listed in an approved DSRIP project plan.

e. Each quarter the State makes DSRIP Payments or IAAF payments and claims FFP, appropriate supporting documentation will be made available for CMS to determine the appropriate amount of the payments. Supporting documentation may include, but is not limited to, summary electronic records containing all relevant data fields such as Payee, Program Name, Program ID, Amount, Payment Date, Liability Date, Warrant/Check Number, and Fund Source. Documentation regarding the Funds revenue source for

payments will also identify all other funds transferred to such fund making the payment. This documentation should be used to support claims made for FFP for DSRIP Payments that are made on the CMS-64.9 Waiver forms.

f. DSRIP Payments are not direct reimbursement for expenditures or payments for services. Payments from the DSRIP Fund are intended to support and reward performing providers for improvements in their delivery systems that support the simultaneous pursuit of improving the experience of care, improving the health of populations, and reducing per capita costs of health care. Payments from the DSRIP Fund are not considered patient care revenue, and shall not be offset against disproportionate share hospital expenditures or other Medicaid expenditures that are related to the cost of patient care (including stepped down costs of administration of such care) as defined under these Special Terms and Conditions, and/or under the State Plan.

14. Limits on Federal Financial Participation.

a. Use of FFP. The state will receive up to a total of $8 billion FFP to support MRT activities: $6.92 billion for DSRIP, $500 million of which will be for the IAAF, and the remaining amount to be allocated by the state for remaining MRT activities (with no more than $1.08 billion for such other activities).

b. MRT Cap. The State can claim FFP for MRT expenditures in each DSRIP Year up to the limits shown in the table below. Each DSRIP Project Plan must specify the DSRIP Year to which each milestone pertains; all incentive payments associated with meeting the milestone must count against the annual limit for the DSRIP Year identified. The state or its contractor shall monitor and report proper execution of project valuations and funds distribution as part of the implementation monitoring and reporting required under STC 35 of this section.

c. One-year DSRIP funding carry-over. If a performing provider system does not fully achieve a metric in Domains 2, 3 or 4 that was specified in its approved DSRIP project plan for completion in a particular DSRIP year, the performing provider system must report on the missed metrics in the given DSRIP year. Performing Provider Systems that do not meet annual milestones for a given metric will not be eligible to receive incentive payments for the missed metrics in that given DSRIP year. Any funding that would have been allocated to the performing provider system during that DSRIP year will be placed in the performance pool fund to be redistributed to Performing Provider Systems that have exceeded their set performance benchmarks for that DSRIP year. When a performing provider system does not meet its DSRIP year performance metrics, the missed metrics milestone will be recalibrated based on the procedures in DSRIP Program Funding and Mechanics Protocol (Attachment I) for the next DSRIP year and the performing provider system will be eligible to receive payments from the DSRIP payment pool for that next year if it reaches the recalibrated milestone in that next DSRIP year.

d. Fund Allocations According to MRT Demonstration Year

($ millions)

	Year-0	Year-1	Year-2	Year-3	Year-4	Year-5	Total
Sources of Funding							
Public Hospital IGT Transfers (Supports DSRIP IGT Funding for Public Performing Provider Transformation Fund, Safety Net Performance Provider System Transformation Fund, DSRIP, State Plan and Managed Care Services)	$512.0	$878.1	$933.0	$1,481.8	$1,317.1	$878.1	$6,000.0
State Appropriated Funds	$188.0	$345.4	$476.6	$467.8	$343.5	$178.7	$2,000.0
Total Sources of Funding	**$700.0**	**$1,223.5**	**$1,409.5**	**$1,949.6**	**$1,660.6**	**$1,056.8**	**$8,000.0**
Uses of Funding							
DSRIP Expenditures	$620.0	$1,007.8	$1,070.7	$1,700.6	$1,511.6	$1,007.8	$6,918.5
Interim Access Assurance Fund (IAAF)	$500.0	$0.0	$0.0	$0.0	$0.0	$0.0	$500.0
Planning Payments	$70.0	$0.0	$0.0	$0.0	$0.0	$0.0	$70.0
Performance Payments	$0.0	$957.8	$1,020.7	$1,650.6	$1,461.6	$957.8	$6,048.5
Administration	$50.0	$50.0	$50.0	$50.0	$50.0	$50.0	$300.0
Health Homes	$80.0	$66.7	$43.9	$0.0	$0.0	$0.0	$190.6
MC Programming	$0.0	$149.0	$294.9	$249.0	$149.0	$49.0	$890.9
Health Workforce MLTC Strategy	$0.0	$49.0	$49.0	$49.0	$49.0	$49.0	$245.0
1915i Services	$0.0	$100.0	$245.9	$200.0	$100.0	$0.0	$645.9
Total Uses of Funding	**$700.0**	**$1,223.5**	**$1,409.5**	**$1,949.6**	**$1,660.6**	**$1,056.8**	**$8,000.0**

**Includes costs associated with State based planning in Year-0.*
**New York State may spend up to 5% of annual costs on Administration.*

e. Notwithstanding the limits in STC 1.a and 14.a, to the extent that the state elects to limit supplemental payments to an institutional provider class otherwise authorized under its state plan in any state fiscal year during which the DSRIP demonstration is in effect, an amount equal to the federal share of the amount not paid to such providers, up to $600 million may be added to the overall MRT and DSRIP limits on federal funding. This election will be available only to the extent that the state does not increase the authorized levels of such supplemental payments, or initiate new supplemental payments, during the authorized demonstration period. The state must develop and use a tracking spreadsheet (following a format approved by CMS) to ensure that the amounts of the DSRIP increase

do not exceed the amount of authorized but unpaid supplemental payments.

f. Statewide accountability. Beginning in DSRIP Year 3, the limits on DSHP funding and on total DSRIP payments described in paragraph (a) above may be reduced based on statewide performance, according to the process described in the Program Funding and Mechanics Protocol.

g. Statewide performance will be assessed on a pass or fail basis, for a set of 4 milestones.

i. Statewide performance on universal set of delivery system improvement metrics (as defined in Attachment J). Metrics for delivery system reform will be determined at a statewide level. Each metric will be calculated to reflect the performance of the entire state. Each of these statewide metrics will be assigned a direction for improving and worsening. This milestone will be considered passed in any given year if more metrics in these domains are improving on a statewide level than are worsening, as compared to the prior year as well as compared to initial baseline performance.

ii. A composite measure of success of projects statewide on project-specific and population wide quality metrics. This test is intended to reflect the success of every project in achieving the goals that have been assigned to each project, including pay for reporting for certain outcome measures as specified in DSRIP Strategies Menu and Metrics (Attachment J). As described in DSRIP Program Funding and Mechanics Protocol (Attachment I), each metric that determines project level incentive payments for each project will be determined at the project level to be meeting the improvement standards. This statewide milestone will be considered passed in any given year if the number of metrics for each project that trigger award as the improvement standards in DSRIP Program Funding and Mechanics Protocol (Attachment I) are greater than the number of metrics for each project that fail to trigger an award as per the improvement standard in DSRIP Program Funding and Mechanics Protocol (Attachment I).

iii. Growth in statewide total Medicaid spending, including MRT spending, that is at or below the target trend rate (Measure applies in DY4 and DY5). The per member per month (PMPM) amounts will be adjusted to exclude growth in federal funding associated with the Affordable Care Act. The state will not be penalized if it uses these higher FMAP rates generated by the Affordable Care Act to reinvest in its Medicaid program.

Growth in statewide total inpatient and emergency room spending that is at or below the target trend rate (Measure applies in DY 3, DY 4 and DY 5).

Both of the above measures will be measured on a PMPM basis in the most recent state fiscal year from the state fiscal year that immediately precedes it, with applicable spending including both federal and non-federal shares combined. Per member per month spending in each measure is determined by dividing statewide total spending by the number of person-months of Medicaid eligibility in the state for

the state fiscal year. The most recent state fiscal year is the last state fiscal year ending prior to the start of the DSRIP Year. For total Medicaid spending, the target trend rate is the ten-year average rate for the long-term medical component of the Consumer Price Index (as used to determine the state's Medicaid Global Spending Cap for that year), for DYs 4 and 5 only. For inpatient and emergency room spending the target trend rate is the ten-year average rate for the long-term medical component of the Consumer Price Index (as used to determine the state's Medicaid Global Spending Cap for that year) minus 1 percentage points for DY 3 and 2 percentage points for DYs 4 and 5.

iv. Implementation of the managed care plan, including targets agreed upon by CMS and the state after receipt of the managed care contracting plan in STC 39 of this section related to reimbursement of plans and providers consistent with DSRIP objectives and measures. These targets will include one associated with the degree to which plans move away from traditional fee for service payments to payment approaches rewarding value.

h. The state must pass all four milestones to avoid DSRIP reductions. If the state fails on any of the 4 milestones, the amount of the potential reduction is set as follows:

The state must pass 50 percent of the inpatient/emergency room spending reduction goals to avoid DSHP penalties. This will be the sole test for any DSHP penalty. The amount of the potential reduction is set as follows:

	DSRIP Year 3	DSRIP Year 4	DSRIP Year 5
DSHP Penalty	$23.39 million (5 percent)	$34.35 million (10 percent)	$35.74 million (20 percent)
DSRIP Penalty	$74.09 million (5 percent)	$131.71 million (10 percent)	$175.62 million (20 percent)

If DSRIP and DSHP penalties are applied, the state reduce funds in an equal distribution of projects, and will not affect the high performance fund.

15. Designated State Health Programs (DSHP). The state may claim FFP for certain DSHP expenditures, following procedures and subject to limits as described below.

a. Limit on FFP for DSHP. The amount of FFP that the state may receive for DSHP may not exceed the limit described below. If upon review, the amount of FFP received by the state is found to have exceeded the applicable limit, the excess must be returned to CMS as a negative adjustment to claimed expenditures on the CMS-64.

$ millions

Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Total
188.0	345.4	476.6	467.8	343.5	178.7	2,000

The FFP limit for 2014 is the lowest of the following amounts:

i. $188 million,

ii. The combined non-Federal share of IAAF Payments, DSRIP Project Design Grant payments and DSRIP administrative costs in 2014, and

iii. The federal share of total matchable DSHP expenditures in 2014 as outlined below.

b. DSHP List 1. The state may claim FFP in support of DSRIP for List 1 DSHP expenditures made after March 31, 2014. The state may not claim FFP until after the date on which CMS has approved a DSHP Claiming Protocol for the specific DSHP.

i. Health Care Reform Act programs

A. AIDS Drug Assistance
B. Tobacco Use Prevention and Control
C. Health Workforce Retraining

ii. State Office on Aging programs
A. Community Services for the Elderly
B. Expanded In-Home Services to the Elderly

iii. Office of Children and Family Services: Committees on Special Education direct care programs

iv. State Department of Health, Early Intervention Program Services

c. DSHP List 2. The state may claim FFP in support of DSRIP for List 2 DSHP expenditures made after December 31, 2014. The state may not claim FFP until after the date on which CMS has approved a DSHP Claiming Protocol for the specific DSHP

i. Homeless Health Services

ii. Childhood Lead Poisoning Primary Prevention

iii. Healthy Neighborhoods Program

iv. Cancer Services Programs

v. Obesity and Diabetes Programs

vi. TB Treatment, Detection and Prevention

vii. TB Directly Observed Therapy

viii. General Public Health Work

ix. Newborn Screening Programs

d. DSHP List 3. The state may claim FFP in support of DSRIP for List 3 DSHP expenditures not used for DD Transformation. The state may not claim FFP until after the **date** on which CMS has approved a DSHP Claiming Protocol for the specific DSHP

i. Office of Mental Health

A. Licensed Outpatient Programs
B. Care Management
C. Emergency Programs
D. Rehabilitation Services
E. Residential (Non-Treatment)
F. Community Support Programs

ii. Office for People with Developmental Disabilities

A. Day Training
B. Family Support Services
C. Jervis Clinic
D. Intermediate Care Facilities
E. HCBS Residential
F. Supported Work (SEMP)
G. Day Habilitation
H. Service Coordination/Plan of Care Support
I. Pre-vocational Services
J. Waiver Respite
K. Clinics - Article 16

iii. Office of Alcoholism and Substance Abuse Services

A. Outpatient and Methadone Programs
B. Prevention and Program Support Services

e. DSHP Claiming Protocol. The state will develop a CMS-approved DSHP claiming protocol with which the state will be required to comply in order to draw down DSHP funds for DSRIP. State expenditures for the DSHP listed above must be documented in accordance with the protocols. The state is not eligible to receive FFP until an applicable protocol is approved by CMS. Once approved by CMS, the protocol becomes Attachment L of these STCs, and thereafter may be changed or updated with CMS approval. Changes and updates are to be applied prospectively. For each DSHP, the protocol must contain the following information:

i. The sources of non-federal share revenue, full expenditures and rates.

ii. Program performance measures, baseline performance measure values, and improvement goals. (CMS may, at its option, approve the DSHP Claiming Protocol

for a DSHP without this feature.)

iii. Procedures to ensure that FFP is not provided for any of the following types of expenditures:

A. Grant funding to test new models of care
B. Construction costs (bricks and mortar)
C. Room and board expenditures
D. Animal shelters and vaccines
E. School based programs for children
F. Unspecified projects
G. Debt relief and restructuring
H. Costs to close facilities
I. HIT/HIE expenditures
J. Services provided to undocumented individuals
K. Sheltered workshops
L. Research expenditures
M. Rent and utility subsidies normally funded by the United State Department of Housing and Urban Development
N. Prisons, correctional facilities, and services provided to individuals who are civilly committed and unable to leave
O. Revolving capital fund
P. Expenditures made to meet a maintenance of effort requirement for any federal grant program
Q. Administrative costs
R. Cost of services for which payment was made by Medicaid or CHIP (including from managed care plans)
S. Cost of services for which payment was made by Medicare or Medicare Advantage
T. Funds from other federal grants

f. DSHP Claiming Process.

i. Documentation of each designated state health program's expenditures, as specified in the DSHP Protocol, must be clearly outlined in the state's supporting work papers and be made available to CMS.

ii. In order to assure CMS that Medicaid funds are used for allowable expenditures, the state will be required to document through an Accounting and Voucher system its request for DSHP payments. The vouchers will be detailed in the services being requested for payment by the state and will be attached to DSHP support.

iii. Federal funds must be claimed within two years following the calendar quarter in which the state disburses expenditures for the DSHP.

iv. Federal funds are not available expenditures disbursed before April 1, 2014, or for

services rendered prior to April 1, 2014.

v. Federal funds are not available for expenditures disbursed after December 31, 2014, or for services rendered after December 31, 2014.

vi. Sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. To the extent that federal funds from any federal programs are received for the DSHP listed above, they shall not be used as a source of non-federal share.

vii. The administrative costs associated with the DSHP listed above, and any others subsequently added by amendment to the demonstration, shall not be included in any way as demonstration and/or other Medicaid expenditures.

viii. Any changes to the DSHP listed above shall be considered an amendment to the demonstration and processed in accordance with STC 7 in Section III.

g. Reporting DSHP Payments. The state will report all expenditures for DSHP payments to the programs listed above on the forms CMS-64.9 Waiver and/or 64.9P Waiver under the waiver name "DSRIP DSHP" (if in support of DSRIP) or "IAAF DSHP" (if in support of Interim Access Assurance Fund payments) as well as on the appropriate forms CMS-64.9I and CMS-64PI.

16. Budget Neutrality Review. In conjunction with any demonstration renewal beyond December 31, 2014, CMS reserves the right to modify the budget neutrality agreement consistent with budget neutrality policy.

17. Improved Management Controls. The state and CMS agree that, in conjunction with any Partnership Plan demonstration renewal beyond December 31, 2014, the state will undertake additional activities and steps to strengthen internal controls, compliance with federal and state Medicaid requirements and financial reporting to ensure proper claiming of federal match for the Medicaid program, and to self-identify and initiate timely corrective action on problems and issues. To support the development of these additional special terms and conditions, the state will provide a report to CMS by October 1, 2014, outlining its assessment of current strengths and weaknesses of the state's system of internal and financial management controls (taking into account any audit findings from federal or state oversight agencies including the HHS Office of Inspector General, the state Office of Inspector General, and CMS); the steps the state proposes to take to strengthen compliance, documentation and transparency; and the expected path for resolution of any outstanding deferrals or disallowances initiated by CMS as of the date of this amendment.

18. DSRIP Transparency. During the 30 day public comment period for the DSRIP Program Funding and Mechanics protocol (Attachment I), DSRIP Strategies Menu and Metrics (Attachment J), the state must have conducted at least two public hearings regarding the state's DSRIP amendment approval. The state must utilize teleconferencing or web capabilities for at least one of the public hearings to ensure statewide accessibility. The two public hearings must be held on separate dates and in separate locations, and must afford the

public an opportunity to provide comments. Once the state develops its standardized review tool the independent assessor will use for the DSRIP project plans, the tool must also be posted for public comment for 30 days.

a. Administrative Record. CMS will maintain, and publish on its public Web site, an administrative record that may include, but is not limited to the following:

i. The demonstration application from the state.
ii. Written public comments sent to the CMS and any CMS responses.
iii. If an application is approved, the final special terms and conditions, waivers, expenditure authorities, and award letter sent to the state.
iv. If an application is denied, the disapproval letter sent to the state.
v. The state acceptance letter, as applicable.
vi. Specific requirements related to the approved and agreed upon terms and conditions, such as implementation reviews, evaluation design, quarterly progress reports, annual reports, and interim and/or final evaluation reports.
vii. Notice of the demonstration's suspension or termination, if applicable.

b. CMS will provide sufficient documentation to address substantive issues relating to the approval documentation that should comprehensively set forth the basis, purpose, and conditions for the approved demonstration.

19. Submission of Draft Evaluation Design. The state shall submit a draft DSRIP evaluation design to CMS no later than 120 days after the award of the demonstration, including, but not limited to data that the state proposes to be used to evaluate DSRIP. The state must employ aggressive state-level standards that align with its managed care evaluation approach.

20. Submission of Final Evaluation Design. The state shall provide the Final Evaluation Design within 30 days of receipt of CMS comments of the Draft Evaluation Design. If CMS finds that the Final Evaluation Design adequately accommodates its comments, then CMS will approve the Final Evaluation Design and the final evaluation plan will be included as Attachment M of these STCs.

21. Evaluation Requirements. The state shall engage the public in the development of its evaluation design. The evaluation design shall incorporate an interim and summative evaluation and will discuss the following requirements as they pertain to each:

a. The scientific rigor of the analysis;
b. A discussion of the goals, objectives and specific hypotheses that are to be tested;
c. Specific performance and outcomes measures used to evaluate the demonstration's impact;
d. How the analysis will support a determination of cost effectiveness;
e. Data strategy including sources of data, sampling methodology, and how data will be obtained;
f. The unique contributions and interactions of other initiatives; and
g. How the evaluation and reporting will develop and be maintained.

The demonstration evaluation will meet the prevailing standards of scientific and academic rigor, as appropriate and feasible for each aspect of the evaluation, including standards for the evaluation design, conduct, and interpretation and reporting of findings. The demonstration evaluation will use the best available data; use controls and adjustments for and reporting of the limitations of data and their effects on results; and discuss the generalizability of results.

The state shall acquire an independent entity to conduct the evaluation. The evaluation design shall discuss the state's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications the entity must possess, how the state will assure no conflict of interest, and a budget for evaluation activities.

22. Evaluation Design. The Evaluation Design shall include the following core components to be approved by CMS:

a. Research questions and hypotheses: This includes a statement of the specific research questions and testable hypotheses that address the goals of the demonstration, including:

i. safety net system transformation at both the system and state level;

ii. accountability for reducing avoidable hospital use and improvements in other health an public health measures at both the system and state level and

iii. efforts to ensure sustainability of transformation of/in the managed care environment at the state level.

The research questions will be examined using appropriate comparison groups and studied in a time series.

b. The design will include a description of the quantitative and qualitative study design (e.g., cohort, controlled before-and-after studies, interrupted time series, case-control, etc.), including a rationale for the design selected. The discussion will include a proposed baseline and approach to comparison. The discussion will include approach to benchmarking, and should consider applicability of national and state standards. The application of sensitivity analyses as appropriate shall be considered.

c. Performance Measures: This includes identification, for each hypothesis, of quantitative and/or qualitative process and/or outcome measures that adequately assess the effectiveness of the Demonstration in terms of cost of services and total costs of care, change in delivery of care from inpatient to outpatient, quality improvement, and transformation of incentive arrangements under managed care. Nationally recognized measures should be used where appropriate. Measures will be clearly stated and described, with the numerator and dominator clearly defined. To the extent possible, the state will incorporate comparisons to national data and/or measure sets. A broad set of metrics will be selected. To the extent possible, metrics will be pulled from nationally recognized metrics such as from the National Quality Forum, Center for Medicare and Medicaid Innovation, meaningful use under HIT, and the Medicaid Core Adult sets, for which there is sufficient experience and

baseline population data to make the metrics a meaningful evaluation of the New York Medicaid system.

d. Data Collection: This discussion shall include: A description of the data sources; the frequency and timing of data collection; and the method of data collection. The following shall be considered and included as appropriate:

i. Medicaid encounter and claims data in TMSIS,
ii. Enrollment data,
iii. EHR data, where available
iv. Semiannual financial and other reporting data
v. Managed care contracting data
vi. Consumer and provider surveys, and
vii. Other data needed to support performance measurement

e. Assurances Needed to Obtain Data: The design report will discuss the state's arrangements to assure needed data to support the evaluation design are available

f. Data Analysis: This includes a detailed discussion of the method of data evaluation, including appropriate statistical methods that will allow for the effects of the Demonstration to be isolated from other initiatives occurring in the state. The level of analysis may be at the beneficiary, provider, health plan and program level, as appropriate, and shall include population and intervention-specific stratifications, for further depth and to glean potential non-equivalent effects on different sub-groups. Sensitivity analyses shall be used when appropriate. Qualitative analysis methods shall also be described, if applicable.

g. Timeline: This includes a timeline for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables.

h. Evaluator: This includes a discussion of the state's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess; how the state will assure no conflict of interest, and a budget for evaluation activities.

23. Interim Evaluation Report. The state is required to submit a draft Interim Evaluation Report 90 days following completion of DY 4 of the demonstration. The Interim Evaluation Report shall include the same core components as identified in STC 24 of this section for the Summative Evaluation Report and should be in accordance with the CMS approved evaluation design. CMS will provide comments within 60 days of receipt of the draft Interim Evaluation Report. The state shall submit the final Interim Evaluation Report within 30 days after receipt of CMS' comments.

24. Summative Evaluation Report. The Summative Evaluation Report will include analysis of data from DY 5. The state is required to submit a preliminary summative report in 180 days of the expiration of the demonstration including documentation of outstanding

assessments due to data lags to complete the summative evaluation. Within 360 days of the end for DY 5, the state shall submit a draft of the final summative evaluation report to CMS. CMS will provide comments on the draft within 60 days of draft receipt. The state should respond to comments and submit the Final Summative Evaluation Report within 30 days.

25. The Final Summative Evaluation Report shall include the following core components:

a. Executive Summary. This includes a concise summary of the goals of the Demonstration; the evaluation questions and hypotheses tested; and key findings including whether the evaluators find the demonstration to be budget neutral and cost effective, and policy implications.

b. Demonstration Description. This includes a description of the Demonstration programmatic goals and strategies, particularly how they relate to budget neutrality and cost effectiveness.

c. Study Design. This includes a discussion of the evaluation design employed including research questions and hypotheses; type of study design; impacted populations and stakeholders; data sources; and data collection; analysis techniques, including controls or adjustments for differences in comparison groups, controls for other interventions in the state and any sensitivity analyses, and limitations of the study.

d. Discussion of Findings and Conclusions. This includes a summary of the key findings and outcomes, particularly a discussion of cost effectiveness, as well as implementation successes, challenges, and lessons learned.

e. Policy Implications. This includes an interpretation of the conclusions; the impact of the demonstration within the health delivery system in the state; the implications for state and federal health policy; and the potential for successful demonstration strategies to be replicated in other state Medicaid programs.

f. Interactions with Other State Initiatives. This includes a discussion of this demonstration within an overall Medicaid context and long range planning, and includes interrelations of the demonstration with other aspects of the state's Medicaid program, and interactions with other Medicaid waiver sand other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid.

26. State Presentations for CMS. The state will present to and participate in a discussion with CMS on the final design plan at post approval. The state will present on its interim evaluation report that is described to in STC 23 of this section. The state will present on its summative evaluation in conjunction with STC 24 of this section.

27. Public Access. The state shall post the final approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report on the State Medicaid website

within 30 days of approval by CMS.

28. **CMS Notification**. For a period of 24 months following CMS approval of the Summative Evaluation Report, CMS will be notified prior to the public release or presentation of these reports and related journal articles, by the state, contractor or any other third party. Prior to release of these reports, articles and other documents, CMS will be provided a copy including press materials. CMS will be given 30 days to review and comment on journal articles before they are released. CMS may choose to decline some or all of these notifications and reviews.

29. **Electronic Submission of Reports.** The state shall submit all required plans and reports using the process stipulated by CMS, if applicable.

30. **Cooperation with Federal Evaluators**. Should CMS undertake an evaluation of the demonstration or any component of the demonstration, or an evaluation that is isolating the effects of DSRIP, the state and its evaluation contractor shall cooperate fully with CMS and its contractors. This includes, but is not limited to, submitting any required data to CMS or the contractor in a timely manner and at no cost to CMS or the contractor.

31. **Cooperation with Federal Learning Collaboration Efforts.** The state will cooperate with improvement and learning collaboration efforts by CMS.

32. **Evaluation Budget.** A budget for the evaluation shall be provided with the evaluation design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses, and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the design is not sufficiently developed.

33. **Deferral for Failure to Provide Summative Evaluation Reports on Time.** The state agrees that when draft and final Interim and Summative Evaluation Reports are due, CMS may issue deferrals in the amount of $5,000,000 if they are not submitted on time to CMS or are found by CMS not to be consistent with the evaluation design as approved by CMS.

34. **DSRIP Implementation Monitoring.** The state must ensure that they are operating its DSRIP program according to the requirements of the governing STCs. In order to demonstrate adequate implementation monitoring towards the completion of these requirements, the state will submit the following:

    a. DSRIP monitoring activities, in STC 35 of this section as a part of the operational protocol in STC 10 (h) of this section indicating how the state will monitor compliance with demonstration requirements in the implementation of this demonstration, including monitoring and performance reporting templates. Monitoring and performance templates are subject to review and approval by CMS.

b. Data usage agreements demonstrating the availability of required data to support the monitoring of implementation.

c. Quarterly Report Framework indicating what metrics and data will be available to submit a quarterly report consistent with STC 36 of this section.

35. DSRIP Monitoring Activities. As part of the state's Operational Protocol described in STC 10 (h) of this section and Attachment K, the state will submit its plans for how it will meet the DSRIP STCs through internal monitoring activities. The monitoring plans should provide, at a minimum, the following information:

a. The monitoring activities aligned with the DSRIP deliverables as well as the CMS evaluation design to ensure that entities participating in the DSRIP process are accountable for the necessary product and results for the demonstration.

b. The state shall make the necessary arrangements to assure that the data needed from the performing providers, coalitions, administrative activities, independent assessor and independent evaluator that are involved in the process for DSRIP deliverables, measurement and reporting are available as required by the CMS approved monitoring protocol.

c. The state shall identify areas within the state's internal DSRIP process where corrective action, or assessment of fiscal or non-fiscal penalties may be imposed for the entities described in STC 10(e) of this section, should the state's internal DSRIP process or any CMS monitored process not be administered in accordance with state or federal guidelines.

d. The monitoring protocol and reports shall be posted on the state Medicaid website within 30 days of submission to CMS.

36. DSRIP Quarterly Progress Reports. The state must submit progress reports in the format specified by CMS, no later than 60-days following the end of each quarter along with the Operational Protocol Report described above. The first DSRIP quarterly reports will be due by August 30, 2014. The intent of these reports is to present the state's analysis and the status of the various operational areas in reaching the three goals of the DSRIP activities. These quarterly reports, using the quarterly report guideline outlined in Attachment L, must include, but are not limited to the following reporting elements:

a. Summary of quarterly expenditures related to IAAF, DSRIP Project Design Grant, and the DSRIP Fund;
b. Summary of all public engagement activities, including, but not limited to the activities required by CMS;
c. Summary of activities associated with the IAAF, DSRIP Project Design Grant, and the DSRIP Fund. This shall include, but is not limited to, reporting requirements in STC 3 of this section and Attachment K, the Operational Protocol:

i. Provide updates on state activities, such as changes to state policy and procedures, to support the administration of the IAAF, DSRIP Project Design Grant and the DSRIP Fund;
ii. Provide updates on provider progress towards the pre-defined set of activities and associated milestones that collectively aim towards addressing the state's goals;
iii. Provide summary of state's analysis of DSRIP Project Design;
iv. Provide summary of state analysis of barriers and obstacles in meeting milestones;
v. Provide summary of activities that have been achieved through the DSRIP Fund; and
vi. Provide summary of transformation and clinical improvement milestones and that have been achieved.

d. Summary of activities and/or outcomes that the state and MCOs have taken in the development of and subsequent approval of the Managed Care DSRIP plan; and

e. Evaluation activities and interim findings.

The state may comment and submit a revised Attachment L no later than 30 days after approval of these STCs. CMS will approve necessary changes and update the attachment as necessary. Any subsequent changes to Attachment L must be submitted to CMS prior the end of the reporting period in which the change to the Quarterly Report would take place.

37. Annual Onsite with CMS. In addition to regular monitoring calls, the state shall on an annual basis present to and participate in a discussion with CMS on implementation progress of the demonstration including progress toward the goals, and key challenges, achievements and lessons learned.

38. Rapid Cycle Assessments. The state shall specify for CMS approval a set of performance and outcome metrics and network characteristics, including their specifications, reporting cycles, level of reporting (e.g., the state, health plan and provider level, and segmentation by population) to support rapid cycle assessment in trends under premium assistance and Medicaid fee-for-service, and for monitoring and evaluation of the demonstration.

39. Medicaid Managed Care DSRIP Contracting Plan. In recognition that the DSRIP investments represented in this waiver must be recognized and supported by the state's managed care plans as a core component of long term sustainability, and will over time improve the ability of plans to coordinate care and efficiently deliver high quality services to Medicaid beneficiaries through comprehensive payment reform, strengthened provider networks and care coordination, the state must take steps to plan for and reflect the impact of DSRIP in managed care contracts and rate-setting approaches. Prior to the state submitting contracts and rates for approval for the April 1, 2015 to March 31, 2016 contract cycle, the state must submit a roadmap for how they will amend contract terms and reflect new provider capacities and efficiencies in managed care rate-setting.

Recognizing the need to formulate this plan to align with the stages of DSRIP, this should be a multi-year plan, and necessarily be flexible to properly reflect future DSRIP progress and accomplishments. This plan must be approved by CMS before the state may claim FFP for managed care contracts for the 2015 state fiscal year. The state shall update and submit the Managed Care DSRIP plan annually on the same cycle and with the same terms, until the end of this demonstration period and its next renewal period. Progress on the Managed Care DSRIP plan will also be included in the quarterly DSRIP report. The Managed Care DSRIP plan should address the following:

a. What approaches MCOs will use to reimburse providers to encourage practices consistent with DSRIP objectives and metrics, including how the state will plan and implement its stated goal of 90% of managed care payments to providers using value-based payment methodologies.
b. How and when plans' currents contracts will be amended to include the collection and reporting of DSRIP objectives and measures.
c. How the DSRIP objectives and measures will impact the administrative load for MCOs, particularly insofar as plans are providing additional technical assistance and support to providers in support of DSRIP goals, or themselves carrying out programs or activities for workforce development or expansion of provider capacity. The state should also discuss how these efforts, to the extent carried out by plans, avoid duplication with DSRIP funding or other state funding; and how they differ from any services or administrative functions already accounted for in capitation rates.
d. How alternative payment systems deployed by MCOs will reward performance consistent with DSRIP objectives and measures.
e. How the state will assure that providers participating in and demonstrating successful performance through DSRIP will be included in provider networks.
f. How managed care rates will reflect changes in case mix, utilization, cost of care and enrollee health made possible by DSRIP, including how up to date data on these matters will be incorporated into capitation rate development.
g. How actuarially-sound rates will be developed, taking into account any specific expectations or tasks associated with DSRIP that the plans will undertake, and how the state will use benchmark measures (e.g., MLR) to ensure that payments are sound and appropriate. How plans will be measured based on utilization and quality in a manner consistent with DSRIP objectives and measures, including incorporating DSRIP objectives into their annual utilization and quality management plans submitted for state review and approval by January 31 of each calendar year.
h. How the state will use DSRIP measures and objectives in their contracting strategy approach for managed care plans, including reform.

40. New York MRT-DSRIP Deliverables Schedule.

Due Date/Submission Date	Activity/Deliverable
April 14, 2014	CMS approves STCs and DSRIP Attachments
	New York posts the DSRIP Funding and Mechanics Protocol and the DSRIP

	Strategies Menu and Metrics for public comment for 30 days
	New York posts IAAF Qualifications and Application on for public comment for 14 days;
	14 day IAAF application period begins once comment period closes
	IAAF awards can be distributed after 14 day application period closes
	State has 10 days to submit its first report for IAAF payments (STC 1(b)(iii)(A) of this section)
	State will make baseline data for DSRIP measures available
	State submits its proposed independent assess statement of work (SOW) for its independent assessor contract procurement
May 1, 2014	State must accept DSRIP STCs or offer technical corrections, including for the DSRIP Operational Protocol and the Quarterly Reporting formats
	State has 10 days to submit changes to the DSRIP Funding and Mechanics Protocol and the DSRIP Strategies Menu and Metrics once public comment period closes
	CMS will review changes to the DSRIP Funding and Mechanics Protocol and DSRIP Strategies Menu and Metrics and take action no later than 30 days after state submits changes
	State accepts DSRIP Design Grant applications and make Design Grant awards
	State posts DSRIP Project Plan Review Tool that independent assessor will use to score submitted DSRIP Project Plan applications for 30 days
August 1, 2014	State submits draft DSRIP evaluation design
August 30, 2014	State submits its first quarterly report, including its operational report (STCs 35 & 36)
October 1, 2014	State submits its Improved Management Controls report to CMS
	State accepts DSRIP Project Plan applications
	State will perform initial review of submitted DSRIP Project Plan applications

	Independent assessor will perform full review of DSRIP project plan applications
	Independent assessor will post reviewed DSRIP Project Plan applications for public comment for 30 days
New York Partnership Plan Renewal Period – January 1, 2015	
	Independent assessor approval recommendations made public
	State Distributes DSRIP Project Plan awards for approved performing provider systems
Quarterly Deliverables – Quarterly Report and Operational Report	
August 30, 2014	
November 30, 2014	
February 28, 2015	
May 30, 2015	

*__Note__: Activities/Deliverables without a specific Due Date/Submission Date could occur at any time during the timeframes with dates certain, for example the public comment period for the DSRIP Funding and Mechanics Protocol could occur any time after April 14, 2014, based on the state's discretion, so long as the activities are completed and related deliverables are submitted. Should the state renew the demonstration, the quarterly reporting will continue during the renewal period.

IX. GENERAL REPORTING REQUIREMENTS

1. **General Financial Requirements**. The state must comply with all general financial requirements set forth in Section X.

2. **Reporting Requirements Related to Budget Neutrality**. The state must comply with all reporting requirements for monitoring budget neutrality set forth in section XI.

3. **Monthly Calls**. CMS shall schedule monthly conference calls with the state. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration. Areas to be addressed include, but are not limited to, MCO operations (such as contract amendments and rate certifications), transition and implementation activities, health care delivery, the FHP-PAP program, enrollment of individuals using LTSS and non-LTSS users broken out by duals and non-duals, cost sharing, quality of care, access, family planning issues, benefits, audits, lawsuits, financial reporting and budget neutrality issues, MCO financial performance that is relevant to the demonstration, progress on evaluations, state legislative developments, services being added to the MMMC and/or MLTC plan benefit package pursuant to Section V, and any demonstration amendments, concept papers, or state plan amendments the state is considering submitting. CMS shall update the state on any amendments or concept papers under review, as well as federal policies and issues that may affect any aspect of the demonstration. The state and CMS shall jointly develop the agenda for the calls.

4. **Quarterly Operational Reports**. The state must submit progress reports in accordance with the guidelines in Attachment D taking into consideration the requirements in STC 7 of this section, no later than 60 days following the end of each quarter (December, March, and June

of each demonstration year). The state may combine the quarterly report due for the quarter ending September with the annual report in STC 5 of this section. The intent of these reports is to present the state's analysis and the status of the various operational areas. In addition to the guidelines for quarterly reporting in Attachment D, the state's report shall also include the following:

a. Beneficiary choice of plans and capacity of plans participating in the HIV SNP, MMC and MLTC or Fully Integrated Duals Advantage (FIDA), including the number of beneficiaries who made an affirmative choice.
b. Total enrollment in each MCO by month. Data should reflect a rolling 12 month period.
c. Activities related to choice counseling including efforts to improve health literacy and the methods used to obtain public input, e.g. recipient focus groups, etc.
d. Progress toward compliance with T-MSIS requirements.
e. Status of managed care plan performance, initiatives and activities as measured by HEDIS, CAHPs and other quality metrics.

5. Annual Report. The state must submit an annual report documenting accomplishments, project status, quantitative and case study findings, interim evaluation findings, utilization data, and policy and administrative difficulties in the operation of the demonstration. The state must submit this report no later than 90 days following the end of each demonstration year. Additionally, the annual report must include:

a. A summary of the elements included within each quarterly report;

b. An update on the progress related to the quality strategy as required STC 6 in Section VI, including:

i. Outcomes of care, quality of care, cost of care and access to care for demonstration populations;
ii. The results of beneficiary satisfaction survey, grievances and appeals;

c. The status of the evaluation required in Section XII and information regarding progress in achieving demonstration evaluation criteria including the results/impact of any demonstration programmatic area defined by CMS that is unique to the demonstration design or evaluation hypotheses;

d. An aggregated enrollment report showing the total number of individuals enrolled in each plan;

e. A summary of the use of self-directed service delivery options in the state at the time when those benefits are included in the demonstration;

f. A listing of the new geographic areas the state has expanded MLTC to;

g. A list of the benefits added to the managed care benefit package;

h. An updated transition plan which shows the intended transition and timeline for any new benefits and/or populations into the demonstration;

i. Network adequacy reporting as required in Section VI;

j. State efforts related to the collection and verification of encounter data and utilization data, including the required transition to T-MSIS, encounter data validation activities and outcomes conducted by the EQRO.

k. Any other topics of mutual interest between CMS and the state related to the demonstration; and

l. Any other information the state believes pertinent to the demonstration, such as:

i. Any policy or administrative difficulties that may impact the demonstration,
ii. Any state legislative developments that may impact the demonstration,
iii. The status of the health care delivery system under the demonstration with respect to issues and/or complaints identified by beneficiaries,
iv. The impact of the demonstration in providing insurance coverage to beneficiaries and uninsured population,
v. The existence or results of any audits, investigations or lawsuits that impact the demonstration,
vi. The financial performance of the demonstration (budget neutrality), and
vii. A summary of the annual post-award forum, including all public comments received regarding the process of the demonstration project.

6. Transition Plan. On or before July 1, 2012, and consistent with guidance provided by CMS, the state is required to prepare, and incrementally revise, a Transition Plan consistent with the provisions of the Affordable Care Act (ACA) for individuals enrolled in the demonstration, including how the state plans to coordinate the transition of these individuals to a coverage option available under the ACA without interruption in coverage to the maximum extent possible. The plan must include the required elements and milestones described in paragraphs (a)-(e) outlined below. In addition, the Plan will include a schedule of implementation activities that the state will use to operationalize the Transition Plan. For any elements and milestones that remain under development as of July 1, 2012, the state will include in the Transition Plan a description of the status and anticipated completion date.

a. Seamless Transitions. Consistent with the provisions of the ACA, the Transition Plan will include details on how the state plans to obtain and review any additional information needed from each individual to determine eligibility under all eligibility groups, and coordinate the transition of individuals enrolled in the demonstration (by FPL) (or newly applying for Medicaid) to a coverage option available under the ACA without interruption in coverage to the maximum extent possible. Specifically, the state must:

i. Determine eligibility under all January 1, 2014, eligibility groups for which the state is required or has opted to provide medical assistance, including the group described in §1902(a)(10)(A)(i)(VIII) for individuals under age 65 and regardless of disability status with income at or below 133 percent of the FPL;

ii. Identify demonstration populations not eligible for coverage under the ACA and explain what coverage options and benefits these individuals will have effective January 1, 2014;

iii. implement a process for considering, reviewing and making preliminary determinations under all January 1, 2014 eligibility groups for new applicants for Medicaid eligibility;

iv. Conduct an analysis that identifies populations in the demonstration that may not be eligible for or affected by the ACA and the authorities the state identifies that may be necessary to continue coverage for these individuals; and

v. Develop a modified adjusted gross income (MAGI) calculation for program integrity.

b. Access to Care and Provider Payments.

i. Provider Participation. The state must identify the criteria that will be used for reviewing provider participation in (e.g., demonstrated data collection and reporting capacity) and means of securing provider agreements for the transition.

ii. Adequate Provider Supply. The state must provide the process that will be used to assure adequate provider supply for the state plan and demonstration populations affected by the demonstration on December 31, 2013. The analysis should address delivery system infrastructure/capacity, provider capacity, utilization patterns and requirements (i.e., prior authorization), current levels of system integration, and other information necessary to determine the current state of the of service delivery. The report must separately address each of the following provider types:

A. Primary care providers,
B. Mental health services,
C. Substance use services and
D. Dental.

iii. Provider Payments. The state will establish and implement the necessary processes for ensuring accurate encounter payments to providers entitled to the prospective payment services (PPS) rate (e.g., certain FQHCs and RHCs) or the all-inclusive rate (e.g., certain Indian Health providers).

c. System Development or Remediation. The Transition Plan for the demonstration is expected to expedite the state's readiness for compliance with the requirements of the Affordable Care Act and other federal legislation. System milestones that must be tested for implementation on or before January 1, 2014 include: Replacing manual administrative controls with automotive processes to support a smooth interface among coverage and delivery system options that is seamless to beneficiaries.

d. Progress Updates. After submitting the initial Transition Plan for CMS approval, the state must include progress updates in each quarterly and annual report. The Transition Plan shall be revised as needed.

e. Implementation.

i. By October 1, 2013, the state must begin to implement a simplified, streamlined process for transitioning eligible enrollees in the demonstration to Medicaid, the Exchange or other coverage options in 2014. In transitioning these individuals from coverage under the waiver to coverage under the state plan, the state will not require these individuals to submit a new application.

ii. On or before December 31, 2013, the state must provide notice to the individual of the eligibility determination using a process that minimizes demands on the enrollees.

7. Reporting Requirements Related to Individuals using Long Term Services and Supports. In each quarterly report required by Section IX, the state shall report:

a. Any critical incidents reported within the quarter and the resulting investigations as appropriate;

b. The number and types of grievance and appeals for this population filed and/or resolved within the reporting quarter for this population;

c. The total number of assessments for enrollment performed by the plans, with the number of individuals who did not qualify to enroll in an MLTC plan;

d. The number of individuals referred to an MLTC plan that received an assessment within 30 days;

e. The number of people who were not referred by the enrollment broker and contacted the plan directly and were provided MLTC materials;

f. Rebalancing efforts performed by the MLTC plans and mainstream plans once the benefit is added. Rebalancing reporting should include, but is not limited to the total number of individuals transitioning in and out of a nursing facility within the quarter.

g. Total number of complaints, grievances and appeals by type of issue with a listing of the top 5 reasons for the event.

8. Final Evaluation Report. The state shall submit a Final Evaluation Report pursuant to the requirements of section 1115 of the Act.

X. GENERAL FINANCIAL REQUIREMENTS

1. Quarterly Expenditure Reports. The state must provide quarterly expenditure reports using Form CMS-64 to separately report total expenditures for services provided under the

Medicaid program, including those provided through the demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS shall provide FFP for allowable demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Section XI.

2. **Reporting Expenditures under the Demonstration**. The following describes the reporting of expenditures under the demonstration:

   a. In order to track expenditures under this demonstration, New York must report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System, following routine CMS-64 reporting instructions outlined in Section 2500 of the State Medicaid Manual. All demonstration expenditures must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the DY in which services were rendered or for which capitation payments were made).

   b. DY reporting shall be consistent with the following time periods:

Demonstration Year	Time Period
1	10/1/1997 - 9/30/1998
2	10/1/1998 - 9/30/1999
3	10/1/1999 - 9/30/2000
4	10/1/2000 - 9/30/2001
5	10/1/2001 - 3/30/2003
6	04/1/2003 - 9/30/2004
7	10/1/2004 - 9/30/2005
8	10/1/2005 - 9/30/2006
9	10/1/2006 - 09/30/2007
10	10/1/2007 - 09/30/2008
11	10/1/2008 - 09/30/2009
12	10/1/2009 - 09/30/2010
13	10/1/2010 - 09/30/2011
14	10/1/2011 - 09/30/2012
15	10/1/2012 - 09/30/2013
16	10/1/2013 – 12/31/2013
17	1/1/2014 – 3/31/2014
18	4/1/2014 – 12/31/2014

c. Demonstration expenditures will be correctly reported on Forms CMS-64.9 Waiver. Quarterly cost settlements and pharmaceutical rebates relevant to the demonstration will be allocated to the demonstration populations specified in subparagraph (g) and offset against current quarter waiver expenditures. Demonstration expenditures net of these cost settlement offsets will be reported on Form CMS-64.9 Waiver. Amounts offset will be identifiable in the state's supporting work papers and made available to CMS.

i. Allocation of cost settlements. The state will calculate the percentage of Medicaid expenditures for each demonstration eligibility group to expenditures for all Medicaid population groups from a DataMart file produced for the latest completed federal fiscal year. Quarterly recoveries will be allocated to the eligibility groups based on those percentages. These percentages will be updated annually to reflect the most recent completed federal fiscal year.

ii. Allocation of pharmacy rebates. The state will calculate the percentage of pharmacy expenditures for each demonstration eligibility group to pharmacy expenditures for all population groups from a DataMart file produced for the latest completed federal fiscal year. Rebates will be allocated to the eligibility groups based on those percentages. These percentages will be updated annually to reflect the most recent completed federal fiscal year.

d. For the HCBS Expansion component of the demonstration, the state shall report only the home and community based services expenditures for Demonstration Population 9 on line 19A on Forms CMS-64.9 Waiver and/or 64.9P.

e. For each DY, fourteen separate waiver Forms CMS-64.9 Waiver and/or 64.9P Waiver must be completed, using the waiver name noted below in brackets, to report expenditures for the following demonstration populations and services.

i. Demonstration Population 1 - Temporary Assistance to Needy Families (TANF) child under age 1 through age 20 required to enroll in managed care in any county, for expenditures associated with dates of service on or before December 31, 2014. [TANF Child]

ii. Demonstration Population 2 - TANF Adults aged 21 through 64 required to enroll in managed care in any county, for expenditures associated with dates of service on or before December 31, 2014. [TANF Adult]

iii. Demonstration Population 3 - Disabled Adults and Children 0 through 64, for expenditures associated with dates of service on or before December 31, 2014 [SSI 0 through 64]

iv. Demonstration Population 4 - Aged or Disabled Adults, for expenditures associated with dates of service on or before December 31, 2014 [SSI 65+]

v. Demonstration Population 9 - Home and Community-Based Services Expansion participants, for expenditures associated with dates of service on or before December 31, 2014 [HCBS Expansion]

vi. Demonstration Population 10 - MLTC Adults age 18 through 64 - Duals [MLTC Adults 18 -64]

vii. Demonstration Population 11 - MLTC Adults age 65 and above - Duals [MLTC Adults 65+]

viii. Demonstration Services 1 - State Indigent Care Pool (ICP) Direct Expenditures, for expenditures made on or before December 31, 2014 [ICP-Direct]

ix. Demonstration Services 2 - Designated State Health Programs to Support Clinic Uncompensated Care Funding, for expenditures made on or before December 31, 2014 [ICP – DSHP]

x. Demonstration Services 3 - Designated State Health Programs to Support Medical Home Demonstration, for expenditures made on or before December 31, 2014 [DSHP - HMH Demo]

xi. Demonstration Services 4 - Designated State Health Programs to Support Potentially Preventable Readmission Demonstration, for expenditures made on or before December 31, 2014 [DSHP - PPR Demo]

xii. Demonstration Services 5 - Designated State Health Programs for expenditures made for the period of April 1, 2013 through March 31, 2014 in conjunction with deliverables associated with health system transformation for individuals with developmental disabilities. [DSHP - DD]

xiii. Demonstration Services 6 - Designated State Health Programs for expenditures made for the period January 1, 2014 through December 31, 2014 for the orderly close out of FHPlus adults with children. [DSHP – FHPlus]

xiv. Demonstration Services 7 - Designated State Health Program for expenditures made for the period January 1, 2014 through December 31, 2014 for the state-funded Marketplace subsidy program who purchases health care coverage in the Marketplace. [DSHP – APTC]

3. **Expenditures Subject to the Budget Neutrality Agreement.** For purposes of this section, the term "expenditures subject to the budget neutrality agreement" must include all Medicaid expenditures in STC 2(e) of this section for individuals who are enrolled in this demonstration (with the exception of the populations identified in subparagraphs iii, iv, and ix), as well as the demonstration services described in subparagraphs x through xiii, subject to limitations enumerated in this paragraph. All expenditures that are subject to the budget neutrality agreement are considered demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and/or 64.9P Waiver.

4. **Mandated Increase in Physician Payment Rates in 2013 and 2014**. Section 1202 of the Health Care and Education Reconciliation Act of 2010 (Pub. Law 110-152) requires state Medicaid programs to reimburse physicians for primary care services at rates that are no less than what Medicare pays, for services furnished in 2013 and 2014, with the Federal Government paying 100 percent of the increase. The entire amount of this increase will be excluded from the budget neutrality test for this demonstration. The specifics of separate reporting of these expenditures will be described in guidance to be issued by CMS at a later date.

5. **Administrative Costs**. Administrative costs will not be included in the budget neutrality limit, but the state must separately track and report additional administrative costs that are

directly attributable to the demonstration. All administrative costs must be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver.

6. **Claiming Period**. All claims for expenditures subject to the budget neutrality cap (including any cost settlements) must be made within 2 years after the calendar quarter in which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the state must continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

7. **Reporting Member Months**. The following describes the reporting of member months for demonstration populations:

   a. For the purpose of calculating the budget neutrality expenditure cap and for other purposes, the state must provide to CMS, as part of the quarterly report required under STC 4 in Section IX, the actual number of eligible member months for the demonstration populations defined in STC 1 of this section, for months prior to or including the ending date indicated in STC 2(e) of this section for each demonstration population. The state must submit a statement accompanying the quarterly report, which certifies the accuracy of this information.

   To permit full recognition of "in-process" eligibility, reported counts of member months may be subject to revisions after the end of each quarter. Member month counts may be revised retrospectively for up to 2 years as needed.

   b. The term "eligible member months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes 3 eligible member months to the total. Two individuals who are eligible for 2 months each contribute 2 eligible member months, for a total of 4 eligible member months.

   c. For the purposes of this demonstration, the term "demonstration eligibles" excludes unqualified aliens and refers to the demonstration populations described in STC 2 of this section. Beginning in DY 9, "demonstration eligibles" excludes Demonstration Populations 3 and 4, subject to STC 3(b) of this section, as well as portions of Demonstration Populations 1 and 2, as specified in STC 3(a – b) of this section.

8. **Standard Medicaid Funding Process**. The standard Medicaid funding process must be used during the demonstration. New York must estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure cap and separately report these expenditures by quarter for each federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments and State and Local Administration Costs. CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form CMS-

64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

9. **Extent of FFP for the Demonstration**. Subject to CMS approval of the source(s) of the non- federal share of funding, CMS shall provide FFP at the applicable federal matching rates for the demonstration as a whole as outlined below, subject to the limits described in section XI:

   a. Administrative costs, including those associated with the administration of the demonstration.

   b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan and waiver authorities.

   c. Net expenditures and prior period adjustments, made under approved expenditure authorities granted through section 1115(a)(2) of the Act, with dates of service during the operation of the demonstration.

10. **Sources of Non-Federal Share**. The state certifies that the non-federal share of funds for the demonstration is state/local monies. The state further certifies that such funds shall not be used to match for any other federal grant or contract, except as permitted by law. All sources of non- federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

    a. CMS may review the sources of non-federal share of funding for the demonstration at any time. The state agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.

    b. Any amendments that impact the financial status of the program shall require the state to provide information to CMS regarding all sources of the non-federal share of funding.

11. **State Certification of Funding Conditions**. The state must certify that the following conditions for the non-federal share of demonstration expenditures are met:

    a. Units of government, including governmentally operated health care providers, may certify that state or local tax dollars have been expended as the non-federal share of funds under the demonstration.

    b. To the extent the state utilizes certified public expenditures (CPEs) as the funding mechanism for the title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the state would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.

c. To the extent the state utilizes CPEs as the funding mechanism to claim federal match for payments under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the state the amount of such tax revenue (state or local) used to satisfy demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the state's claim for federal match.

d. The state may use intergovernmental transfers to the extent that such funds are derived from state or local tax revenues and are transferred by units of government within the state. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of title XIX payments.

e. Under all circumstances, health care providers must retain 100 percent of the claimed expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) exist between health care providers and state and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes (including health care provider-related taxes), fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

12. **Monitoring the Demonstration**. The state will provide CMS with information to effectively monitor the demonstration, upon request, in a reasonable time frame.

XI. MONITORING BUDGET NEUTRATLITY

1. **Limit on Title XIX Funding**. The state shall be subject to a limit on the amount of federal title XIX funding that the state may receive on selected Medicaid expenditures during the period of approval of the demonstration. The limit is determined by using a per capita cost method, and budget neutrality expenditure caps are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. The data supplied by the state to CMS to set the annual limits is subject to review and audit, and, if found to be inaccurate, will result in a modified budget neutrality expenditure limit.

2. **Risk**. New York shall be at risk for the per capita cost (as determined by the method described below) for demonstration eligibles under this budget neutrality agreement, but not for the number of demonstration eligibles in each of the groups. By providing FFP for all demonstration eligibles, New York shall not be at risk for changing economic conditions that impact enrollment levels. However, by placing New York at risk for the per capita costs for demonstration eligibles under this agreement, CMS assures that federal demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no demonstration.

3. **Demonstration Populations Used to Calculate Budget Neutrality Expenditure Limit.** The following demonstration populations are used to calculate the budget neutrality

expenditure limit subject to the limitations outlined in STC 3 of Section X and are incorporated into the following eligibility groups (EGs):

a. Eligibility Group 1 – TANF Children under age 1 through 20 required to enroll in managed care in the counties subject to mandatory managed care enrollment as of October 1, 2006 (Demonstration Population 1)

b. Eligibility Group 2 – TANF Adults aged 21 through 64 required to enroll in managed care in the counties subject to mandatory managed care enrollment as of October 1, 2006 (Demonstration Population 2).

c. Eligibility Group 5 – MLTC adults age 18 through 64 – Duals (Demonstration Population 10).

d. Eligibility Group 6 – MLTC Adults age 65 and above – Duals (Demonstration Population 11).

Note: Demonstration Populations 3 and 4 are no longer part of the calculation of the budget neutrality expenditure cap under this demonstration, but under demonstration 11-W-000234/2, the Federal-State Health Reform Partnership. Demonstration Population 8 has been moved to the state plan.

4. Budget Neutrality Expenditure Limit. The following describes the method for calculating the budget neutrality expenditure limit for the demonstration:

a. For each year of the budget neutrality agreement, an annual budget neutrality expenditure limit is calculated for each EG described in STC 3 of this section as follows:

i. An annual EG estimate must be calculated as a product of the number of eligible member months reported by the state in accordance with the requirements outlined in STC 3 of Section X, for each EG, times the appropriate estimated per member per month (PMPM) costs from the table in subparagraph (iii) below. Should EGs 3 and 4 be incorporated into the budget neutrality expenditure limit, as outlined in this STC, the PMPM costs may be revised.

ii. The PMPM costs in subparagraph (iii) below are net of any premiums paid by demonstration eligible.

iii. The PMPM costs for the calculation of the annual budget neutrality expenditure limit for the eligibility groups subject to the budget neutrality agreement under this demonstration are specified below.

A. To reflect the additional demonstration year that was authorized through temporary extension (DY 12), the PMPM cost for each EG in DY 11 has been

increased by the appropriate growth rate from the prior extension period. These figures are displayed below.

Eligibility Group	DY 11 (10/1/08 –	Trend Rate	DY 12 (10/1/09 –
TANF Children under age 1 through 20	$549.19	6.7%	$585.99
TANF Adults 21through 64	$751.73	6.6%	$801.34

B. For the current extension period, the PMPM costs for each EG in DY 12 has been increased by the appropriate growth rate included in the President's federal fiscal year 2011 budget for DYs 13 through 16, as outlined below. In addition, because the Family Planning Expansion Adults are going to be treated as a "hypothetical state plan population" beginning in DY 13, a PMPM cost was constructed based on state expenditures in DY 10, and increased by the rate of growth in the medical care component of the Consumer Price Index between 2004 and 2008. Because DYs 16 and 17 combined are less than 12 months in duration, they are assigned the PMPM costs equal to what would have been calculated for the full year starting October 1, 2013 and ending September 30, 2014. The FHPlus Adults with Children and Family Planning Expansion Adults groups will end on December 31, 2013, so no PMPM is defined for those groups for DY 17. The budget neutrality expenditure limit will end March 31, 2014; expenditures made after that date for DSHP must be offset by accumulated savings from DYs 1 through 18.

Eligibility Group	DY 12 (10/1/09 – 9/30/10)`	Trend Rate	DY 13 (10/1/10 – 9/30/11)	DY 14 (10/1/11 – 9/30/12)	DY 15 (10/1/12 – 9/30/13)	DY 16 (10/1/13 – 12/31/13)	DY 17 (1/1/14 – 3/31/14)	DY 18 (4/1/14 – 12/31/14)
TANF Children under age 1 through 20	$585.99	6.6%	$624.67	$665.90	$709.85	$756.70	$756.70	$756.70
TANF Adults 21 through 64	$801.34	6.4%	$852.63	$907.20	$965.26	$1027.04	$1027.04	$1027.04
MLTC Adults 18through 64 - Dual		1.19%		$4009.38	$4057.09	$4105.37	$4105.37	$4105.37
MLTC Adults 65 and above - Dual		3.23%		$4742.15	$4895.32	$5053.44	$5053.44	$5053.44

iv. The annual budget neutrality expenditure limit for the demonstration as a whole is the sum of the project annual expenditure limits for each EG calculated in subparagraph (i) above.

b. The overall budget neutrality expenditure limit for the demonstration period is the sum of the annual budget neutrality expenditure limits calculated in subparagraph (a)(iv) above for each year. The federal share of the overall budget neutrality expenditure limit represents the maximum amount of FFP that the state may receive for expenditures on behalf of demonstration populations and expenditures described in Section X during the demonstration period.

5. Monitoring of New Adult Group Spending and Opportunity to Adjust Projections. For each demonstration year, a separate annual budget limit for the new adult group will be calculated as the product of the trended monthly per person cost times the actual number of eligible/member months as reported to CMS by the state under the guidelines set forth in Section X. The per capita cost estimates for the new adult group are listed in the table below.

MEG	DY 17 – PMPM
New Adult Group	$722.57

a. If the state's experience of the take up rate for the new adult group and other factors that affect the costs of this population indicates that the new adult group PMPM limit described above may underestimate the actual costs of medical assistance for the new adult group, the state has the opportunity to submit an adjustment to the PMPM limit, along with detailed expenditure data to justify this, for CMS review without submitting an amendment pursuant to Section II. In order to ensure timely adjustments to the PMPM limit for a demonstration year, the revised projection for DY 17 must be submitted to CMS by no later than October 1, 2014.

b. The budget limit for the new adult group is calculated by taking the PMPM cost projections for the above group in each demonstration year, times the number of eligible member months for that group and demonstration year, and adding the products together across demonstration years. The federal share of the budget neutrality cap is obtained by multiplying total computable budget neutrality cap by the federal share.

c. The state will not be allowed to obtain budget neutrality "savings" from this population.

d. If total FFP reported by the state for the new adult group should exceed the federal share of FFP for the budget limit for the new adult group by more than 3 percent following each demonstration year, the state must submit a corrective action plan to CMS for approval.

6. Calculating the Federal Medical Assistance Percentage (FMAP) for Continuous Eligibility for the Adult Group. CMS anticipates that states that adopt continuous eligibility for adults would experience a 2 percent increase in enrollment. Based on this estimate, CMS has determined that 97.4 percent of the member months for newly eligibility in the Adult Group will be matched at the enhanced FMAP rate and 2.6 percent will be matched at the regular FMAP rate.

7. State Reporting for the FMAP Adjustment. Newly eligible individuals in the Adult Group shall be claimed at the enhanced FMAP rate. The state must make an adjustment in the CMS-64W that accounts for the proportion of member months in which beneficiaries are enrolled due to continuous eligibility and could have been disenrolled due to excess income in absence of continuous eligibility (i.e. 2.6 percent). For the purposes of budget neutrality, the members for the adult group within the 2.6 percent of the population described in this STC will be treated as a hypothetical population. The state is not subject to use their budget neutrality savings towards providing continuous eligibility for this population.

8. Future Adjustments to the Budget Neutrality Expenditure Limit. CMS reserves the right to adjust the budget neutrality expenditure limit to be consistent with enforcement of impermissible provider payments, health care related taxes, new federal statutes, or policy interpretations implemented through letters, memoranda, or regulations with respect to the provision of services covered under the Partnership Plan.

9. Enforcement of Budget Neutrality. CMS shall enforce budget neutrality over the life of the demonstration rather than on an annual basis. DY 18 expenditures, which will consist only of DSHP expenditures in support of the H-MH and PPR demonstrations, will be included in the budget neutrality test for the demonstration. The state may receive FFP for these expenditures to the extent that sufficient accumulated budget neutrality savings are available from prior DYs.

10. Exceeding Budget Neutrality. If at the end of this demonstration period the overall budget neutrality expenditure limit has been exceeded, the excess federal funds must be returned to CMS. If the demonstration is terminated prior to the end of the budget neutrality agreement, an evaluation of this provision shall be based on the time elapsed through the termination date.

XII. EVALUATION OF THE DEMONSTRATION

1. The evaluation design must include a discussion of the goals and objectives set forth ins Section II of these STCs, and develop evaluation questions specific to the changes implemented in the demonstration during the extension period.

a. The evaluation questions should include, but are not limited to:

i. To what extent has the provisions of continuous eligibility affected the stability and continuity of coverage and care to adults? How has the implementation of the Statewide Enrollment Center impacted "churning" by demonstration participants?

ii. A quantitative and qualitative assessment of the effectiveness of the provider and enrollee education and outreach efforts, as well as plan oversight and compliance monitoring, in minimizing the impact of the transition of individuals living with HIV into mandatory Medicaid managed care.

iii. To what extent has the mandatory enrollment of individuals living with HIV into MMC impacted their perceptions of care (fee-for-service vs. Safety Net Population/SNP vs. mainstream)?

iv. Has the required enrollment of individuals living with HIV into Medicaid managed care (either mainstream plans or HIV SNPs) impacted quality outcomes, which in earlier studies showed that these individuals enrolled in managed care on a voluntary basis received better quality care than in fee-for-service?

v. An assessment of the successes and failures, along with recommendations for improvement, of the HIV SNP program.

vi. Has the state's H-MH demonstration resulted in demonstrable improvements in the quality of care received by demonstration participants?

vii. To what extent has the H-MH demonstration produced replicable residency program design features that enhance training in medical home concepts?

viii. How has the H-MH demonstration helped the selected facilities improve both their systemic and quality performance under each initiative implemented by the selected facilities?

ix. How have the results of the PPR demonstration program informed changes in reimbursement policies that provide incentives to help people stay out of the hospital?

x. How has the PPR demonstration program improved quality and cost savings at selected facilities? To what extent are the interventions tested both replicable and sustainable?

xi. How has the additional funding provided under the Clinic Uncompensated Care program increased the use of patient-centered medical homes and electronic medical records?

xii. How have the results of the Marketplace Subsidy Program for enrollment in a QHP, using childless adults who are not eligible to receive a subsidy as a comparison group, expanded access to health insurance coverage?

b. The evaluation questions for MLTC goals should include, but are not limited to:

i. How has enrollment in MLTC plans increased over the length of the demonstration?

ii. What are the demographic characteristics of the MLTC population? Are they changing over time?

iii. What are the functional and cognitive deficits of the MLTC population? Are they changing over time?

iv. Are the statewide and plan-specific overall functional indices decreasing or staying the same overtime?

v. Are the average cognitive and plan specific attributes decreasing or staying the same over time?

vi. Are the individuals care plans consistent with the functional and cognitive abilities of the enrollees? This evaluation question will be included as there is sufficient data available in 2014 to provide accurate measures. NYS will address this question in the Final Evaluation Plan.

vii. Access to care: To what extent are enrollees able to receive timely access to personal, home care and other services such as dental care, optometry and audiology?

viii. Quality of care: Are enrollees accessing necessary services such as flu shots and dental care?

ix. Patient Safety: Are enrollees managing their medications? What are the fall rates and how are they changing over time?

x. Satisfaction: What are the levels of satisfaction with access to, and perceived timeliness and quality of network providers?

xi. Costs: What are the PMPM costs of the population?

The draft design must discuss the outcome measures that will be used in evaluating the impact of the demonstration during the period of approval, particularly among the target population. It must discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the demonstration shall be isolated from other initiatives occurring in the state.

c. The state must submit to CMS for approval a draft evaluation design no later than July 1, 2013.

2. **Evaluation Implementation**. The state shall implement the final evaluation design and submit its progress in each of the quarterly and annual progress reports.

3. **Interim Evaluation Report**. The state must submit an interim evaluation report as part of the state's request for any future renewal of the demonstration.

4. **Final Evaluation Report**. The state must submit draft final evaluation reports according to the following schedule.

   a. By July 31, 2014 the state must submit to CMS a draft final evaluation report, presenting findings from all evaluation activities. Findings from the evaluations of the H-MH and PPR demonstrations may be preliminary findings. CMS shall provide comments within 60 days after receipt of the report. The state shall submit the final evaluation report within 60 days after receipt of CMS comments.

   b. By April 30, 2015 the state must submit to CMS a draft final evaluation report on the evaluations of the H-MH and PPR demonstrations. CMS shall provide comments within 60 days after receipt of the report. The state shall submit the final evaluation report within 60 days after receipt of CMS comments.

5. **Cooperation with CMS Evaluators**. Should CMS conduct an independent evaluation of any component of the demonstration, the state will cooperate fully with CMS or the independent evaluator selected by CMS. The state will submit the required data to the contractor or CMS.

XIII. SCHEDULE OF STATE DELIVERABLES FOR THE DEMONSTRATION EXTENSION PERIOD

Date - Specific	Deliverable	Reference

07/1/2013	Submit Draft Evaluation Plan	STC 1 in Section XII
	Deliverable	Reference
Annual	By January 1st - Annual Report	STC 5 in Section IX
Quarterly		
	Quarterly Operational Reports	STC 4 in Section IX
	Quarterly Expenditure Reports	STC 1 in Section X
	Eligible Member Months	STC 7 in Section X

ATTACHMENT A

Mainstream Medicaid Managed Care Benefits

Inpatient and outpatient hospital services
Clinic services including Rural Health Clinic and Federally Qualified Health Center services
Laboratory and X-ray services
Home health services
Early Periodic Screening, Diagnosis, and Treatment services (for individuals under age 21 only)
Family planning services and supplies
Physicians services including nurse practitioners and nurse midwife services
Dental services
Physical and occupational therapy
Speech, hearing, and language therapy
Prescription drugs, over-the-counter drugs, and medical supplies
Durable Medical Equipment (DME), including prosthetic and orthotic devices, hearing aids, and prescription shoes
Vision care services, including eyeglasses
Intermediate Care Facilities for the Mentally Retarded (ICF/MR)
Nursing facility services
Personal care services
Medical Social Services for persons transitioning from the LTHHCP who received the service under the LTHHCP (non-state plan service)
Home Delivered Meals for persons transitioning from the LTHHCP who received the service under the LTHHCP (non-state plan service)
Case management services
Hospice care services
TB-related services
Inpatient and outpatient behavioral health services (mental health and chemical dependence services)
Emergency medical services, including emergency transportation
Adult day care
Personal Emergency Response Services (PERS)
Renal dialysis
Home and Community Based Services waivers (HCBS)
Care at Home Program (OPWDD)
Non–emergency transportation
Experimental or investigational treatment (covered on a case-by-case basis)

Service	Co-pay

Non-preferred brand-name prescription drugs	$3
Preferred brand-name prescription drugs	$1
Generic prescription drugs	$1

Note: One co-pay is charged for each new prescription and each refill. No co-payment for drugs to treat mental illness (psychotropic) and tuberculosis.

ATTACHMENT B

Managed Long Term Care Benefits

Home Health Care*
Medical Social Services
Adult Day Health Care
Personal Care
Durable Medical Equipment**
Non-emergent Transportation
Podiatry
Dental
Optometry/Eyeglasses
Outpatient Rehabilitation PT, OT, SP
Audiology/Hearing Aids
Respiratory Therapy
Private Duty Nursing
Nutrition
Skilled Nursing Facilities
Social Day Care
Home Delivered/Congregate Meals
Social and Environmental Supports
PERS (Personal Emergency Response Service)

*Home Care including Nursing, Home Health Aide, Physical Therapy (PT), Occupational Therapy (OT), Speech Pathology (SP)

**DME including Medical/Surgical, Hearing Aid Batteries, Prosthetic, Orthotics and Orthopedic Footwear

ATTACHMENT C

Home and Community-Based Services Expansion Program Benefits

All HCBS Expansion program participants may not receive all benefits listed below. An individual participant's access to the benefits below may vary based on the individual's similarity to an individual determined eligible for and enrolled in the LTHHC, NHTD, or TBI 1915(c) waiver program.

Assistive Technology (including personal emergency response system)
Community Integration Counseling and Services
Community Transition Services
Congregate/Home Delivered Meals
Environmental Modifications
Home and Community Support Services
Home Maintenance
Home Visits by Medical Personnel
Independent Living Skills Training
Intensive Behavioral Programs
Medical Social Services
Moving Assistance
Nutritional Counseling/Education
Peer Mentoring
Positive Behavioral Interventions
Respiratory Therapy
Respite Care/Services
Service Coordination
Social Day Care (including transportation)
Structured Day Program
Substance Abuse Programs
Transportation
Wellness Counseling Services

Home and community-based services (HCBS) must be provided in a setting that has home-like characteristics and not in institutionalized settings, unless an enrollee is in need of short term respite care. Below are the required home and community characteristics that must be in place for HCBS and other long-term services and supports programs:

- Private or semi-private bedrooms including decisions associated with sharing a bedroom.
- Full access to facilities in a home, such as kitchen and cooking facilities and small dining areas.
- All participants must be given an option to receive HCBS in more than one residential setting appropriate to their needs.
- Private or semi-private bathrooms that include provisions for privacy.
- Common living areas and shared common space for interaction between participants, their guests and other residents.
- Enrollees must have access to food storage or a food pantry area at all times.
- Enrollees must be provided with an opportunity to make decisions about their day to day activities including visitors, when and what to eat, in their home and in the community.
- Enrollees will be treated with respect, choose to wear their own clothing, have private space for their personal items, have privacy to visit with friends, family, be able to use a telephone with privacy, choose how and when to spend their free time, have easy access to resources and activities of their choosing in the community.

In provider owned or controlled residential settings, the following additional conditions will be provided to members:

- Privacy in sleeping or living unit.
- Units have lockable entrance doors, with appropriate staff having keys to doors.
- Enrollees share units only at the enrollee's choice.
- Enrollees have freedom to furnish and decorate sleeping or living units.
- The setting is physically accessible to the enrollee.

HCBS LTSS are not provided in institution-like settings except when such settings are employed to furnish short-term respite to individuals.

ATTACHMENT D

Quarterly Operational Report Format

Under Section IX, the state is required to submit quarterly reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter (except for the report due for the quarter ending on September 30 of each demonstration year, which can be incorporated into the annual report required under Section IX).

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the state. A complete quarterly progress report must include an updated budget neutrality monitoring workbook.

NARRATIVE REPORT FORMAT: Title

Partnership Plan

Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:

Introduction:

Information describing the goal of the demonstration, what it does, and key dates of approval /operation. (This should be the same for each report.)

Enrollment Information:

Please complete the following table that outlines all enrollment activity under the demonstration. The state should indicate "N/A" where appropriate. If there was no activity under a particular enrollment category, the state should indicate that by "0". Please note any changes in enrollment that fluctuate 10 percent or more over the previous quarter as well as the same quarter in the prior demonstration year.

Enrollment Counts

Note: Enrollment counts should be person counts, not participant months

Demonstration Populations (as hard coded in the CMS-64)	**Current Enrollees** (to date)	**No. Voluntary Disenrolled in current Quarter**	**No. Involuntary Disenrolled in current Quarter**

Population 1 – TANF Child under age 1 through age 20 in mandatory MC counties			
Population 2 - TANF Adults aged 21 through 64 in mandatory MC counties as of 10/1/06			
Adult Group in MMMC			
Population 9 – HCBS Expansion participants			
Population 10 – MLTC Adults 18 through 64 - Duals			
Population 11 – MLTC Adults age 65 and above - Duals			

Voluntary Disenrollments:

- Cumulative Number of Voluntary Disenrollments within Current Demonstration Year
- Reasons for Voluntary Disenrollments

Involuntary Disenrollments:

- Cumulative Number of Involuntary Disenrollments within Current Demonstration Year
- Reasons for Involuntary Disenrollments

Enrollment Information for Specific Sub-populations:

- Enrollees in the HCBS Expansion program

Program Operations

Outreach/Innovative Activities: Summarize outreach activities and/or promising practices for the current quarter.

Operational/Policy Developments/Issues: Identify all significant program developments/issues/problems that have occurred in the current quarter, including, but not limited to, approval and contracting with new plans, benefit changes, and legislative activity. Also include any anticipated activities or program changes related to health care delivery, benefits, enrollment, grievances, quality of care, access, and other operational issues.

Update on Progress and Activities related to Quality Demonstrations and Clinic Uncompensated Care Funding: Identify all activities relating to the implementation of these programs, including but not limited to:

- Release of solicitations and selection of awardees for the quality demonstrations;

- An explanation of grants, contracts or other financial arrangements entered into for purposes of implementing the quality demonstrations of this demonstration; and
- Progress of grantees in meeting the milestones identified in these STCs and any award documents.

Consumer Issues: A summary of the types of complaints or problems consumers identified about the program in the current quarter. Include any trends discovered, the resolution of complaints, and any actions taken or to be taken to prevent other occurrences, this should be broken out to show the number of LTSS complaints vs. all other categories identified. Also discuss feedback, issues or concerns received from the Medicaid Managed Care Advisory Review Panel (MMCARP), advocates and county officials.

Quality Assurance/Monitoring Activity: Identify any quality assurance/monitoring activity in current quarter.

Managed Long Term Care Program: Identify all significant program developments, issues, or problems that have occurred in the current quarter.

Home and Community-Based Services Expansion Program: For the quarter ending March 31 each year, attach a copy of the CMS-372 report completed in accordance with Appendix A of the approved Long-Term Home Health Care, the Nursing Home Transition and Diversion, and the Traumatic Brain Injury 1915(c) waivers.

Demonstration Evaluation: Discuss progress of evaluation implementation.

Financial/Budget Neutrality Developments/Issues: Provide information on:

- Quality demonstration and clinic uncompensated care expenditures – to whom and when
- Designated State Health Programs – amount of FFP claimed for the quarter

Enclosures/Attachments: Identify by title any attachments along with a brief description of what information the document contains.

State Contact(s): Identify individuals by name, title, mailing address, phone, fax, and email address that CMS may contact should any questions arise.

Date Submitted to CMS:

ATTACHMENT E

Expiration Dates for Demonstration Components

The following table shows the expiration dates for the various components of the demonstration.

Demonstration Components	Expiration Date
Facilitated Enrollment Services Twelve Month Continuous Eligibility Period Home and Community-Based Services Expansion Program Individuals Moved from Institutional Settings to Community Settings for Long Term Care Services Designated State Health Programs associated with health System Transformation for Individuals with Developmental Disabilities	December 31, 2014
Designated State Health Program that provides transitional Family Health Plus benefits to parents and caretaker relatives with incomes up to 150 percent of the FPL.	December 31, 2014
Hospital-Medicaid Home Demonstration Potentially Preventable Re-Hospitalization Demonstration Designated State Health Programs associated with H-MH and PPR Demonstrations	December 31, 2014

ATTACHMENT F

Mandatory Managed Long Term Care/Care Coordination Model (CCM)

Mandatory Population: Dual eligible, age 21 and over, receiving community based long term care services for over 120 days, excluding the following:

- **Long Term Home Health Care Program (in certain counties, see timeline below);**
- **Nursing Home Transition and Diversion waiver participants;**
- **Traumatic Brain Injury waiver participants;**
- **Nursing home residents;**
- **Assisted Living Program participants; and**
- **Dual eligible that do not require community based long term care services.**

Voluntary Population: Dual eligible, age 18 through 20, in need of community based long term care services for over 120 days and assessed as nursing home eligible. Non-dual eligible age 18 and older assessed as nursing home eligible and in need of community based long term care services for over 120 days.

The following requires CMS approval to initiate and reflects the enrollment of the mandatory population only.

Phase I and II: New York City and the suburbs

July 1, 2012 - Any new dual eligible case new to service, fitting the mandatory definition in any New York City County will be identified for enrollment and referred to the Enrollment Broker for action.

- Enrollment Broker will provide with educational material, a list of plans/CCMs, and answer questions and provide assistance contacting a plan if requested.
- Plan/CCM will conduct assessment to determine if eligible for community based long term care.
- Plan/CCM transmits enrollment to Enrollment Broker.

In addition, the following identifies the enrollment plan for cases already receiving care. Enrollment will be phased in by service type by borough by zip code in batches. People will be given 60 days to choose a plan according to the following schedule.

July 1, 2012: Begin personal care cases in New York County

August 1, 2012: Continue personal care cases in New York County

September, 2012: Continue personal care cases in New York County and begin personal care in Bronx County; and begin consumer directed personal assistance program cases in New York and Bronx counties

October, 2012: Continue personal care and consumer directed personal assistance program cases in New York and Bronx counties and begin Kings County

November, 2012: Continue personal care and consumer directed personal assistance program cases in New York, Bronx and Kings Counties

December, 2012: Continue personal care and consumer directed personal assistance program cases in New York, Bronx and Kings Counties and begin Queens and Richmond counties

January, 2013: Continue personal care and consumer directed personal assistance program citywide.

February, 2013 (and until all people in service are enrolled): Personal care, consumer directed personal assistance program, citywide.

March, 2013: Personal care, consumer directed personal assistance program, adult day health care, home health care over 120 days citywide.

March, 2013: Personal care, consumer directed personal assistance program, adult day health care, home health care over 120 days in Nassau, Suffolk and Westchester counties

April, 2013: Personal care, consumer directed personal assistance program, adult day health care, home health care over 120 days and long-term home health care program citywide.

April, 2013: Personal care, consumer directed personal assistance program, adult day health care, home health care over 120 days and long-term home health care program in Nassau, Suffolk and Westchester Counties

Phase III: Rockland and Orange Counties

Dually eligible community based long term care service recipients in these additional counties as capacity is established. June 2013

Phase IV: Albany, Erie, Onondaga and Monroe Counties

Dually eligible community based long term care service recipients in these additional counties as capacity is established. Anticipated Fall 2013

Phase V: Other Counties with capacity.

Dually eligible community based long term care service recipients in these additional counties as capacity is established. Anticipated Spring 2014

Phase VI:

Previously excluded dual eligible groups contingent upon development of appropriate program models:

- Nursing Home Transition and Diversion waiver participants;
- Traumatic Brain Injury waiver participants;
- Nursing home residents;
- Assisted Living Program participants;
- Dual eligible that do not require community based long term care services.

ATTACHMENT G

Reimbursement and Claiming Protocol for New York Designated State Health Programs Expenditures and Determination of Allowable DSHP Costs Per Waiver 11-W-00-0014/2

To support the goals of health system transformation, the State may claim Federal Financial Participation (FFP) for the State programs, subject to the a maximum capped amount of $250 million in FFP and restrictions, described in the Special Terms and Conditions (STCs) # 66 of New York's Partnership Plan Medicaid Section 1115 Demonstration Waiver #11-W-00-0014/2 for the Approval Period April 1, 2013 through March 31, 2014. STC # 66 Paragraph b requires the State to develop a CMS approved protocol for claiming Designated State Health Program (DSHP) expenditures. The State shall claim DSHP expenditures in accordance with the protocol set forth in this appendix up to the maximum capped amount of $250 million in FFP for the period April 1, 2013 through March 31, 2014.

The general claiming process applicable to all net deficit funded programs is set forth in Sections I through IV. Addition detail describing specific steps is in Section V (Net Deficit Program Details).

I. State Documentation of Expenditures for Net Deficit Funded Programs

Documentation provided by the State to CMS for quarterly DSHP expenditures will include the following:

- The agency;
- The program;

  Provider

- Net deficit payment amount;
- Voucher/contract information;
- Provider costs, and
- Net adjusted deficits.

II. Off-Sets: In accordance with STC 66(b)(ii) DSHP expenditures submitted to CMS will not include payment for:

- Medicaid funded costs and other Federal aid;
- Room and board/IMD;

- Services to undocumented individuals;

- Research;

- Rent and utility subsidies to individuals;

- Forensics

- Other funding (e.g. insurance and local aid).

For each off-set the State will indicate the page, line and column reference from the consolidated fiscal report (CFR).

To assure DSHP expenditures do not include coverage of services to undocumented individuals, the State will reduce each service provider's reported program costs by 10 percent unless a more detailed accounting of actual costs for these individuals is provided that is acceptable to CMS.

III. Net Deficits Payments

New York may claim expenditures to purchase DSHP services furnished for the period April 1, 2013 through March 31, 2014. Expenditures for payments to service providers shall not exceed the lesser of (1) the full value of the actual net deficit payment or (2) the provider's reported adjusted net deficit. For each DSHP, service providers will have their revenues and expenses identified using New York's Consolidated Fiscal Reporting System. Under this system, each service provider is required to file a CFR to document expenses and revenues in a uniform process for each program they have contracted to provide. The CFR serves as the year end cost report and will be used to document provider deficits. Where applicable, New York will reduce each service provider's reported expenses to remove the cost of any applicable offset listed in Section II. Net deficits will be recomputed using the adjusted expenses to determine each providers adjusted net deficit.

Upon the availability of the Final CFR, the State will compare DSHP expenditures to each provider's reported adjusted net deficits. Based on this comparison, the State shall adjusts its claim as necessary to assure its does not include any payments that exceeded a service provider's adjusted net deficits. Federal share on any identified overpayments will be refunded by the State making an adjustment on the CMS-64 report by entering an amount in line 10(b) of the Summary Sheet.

All applicable CFRs used for claiming and final expenditure reconciliation (Final - Closeout) will have complied with New York State Consolidated Fiscal Reporting and Claiming Manual: Appendix AA – Audit Guidelines that mandate audited providers financial statements and CFRs be reasonably assured and free from material misstatement.

OASAS - By the definition of net deficit financing, OASAS funds are only used after all revenue sources (including Medicaid) are offset against the approved budget/expenses. In the programs OASAS is claiming under DSHP, there are no room and board costs for individuals and no research funds. The claim is based the net budget minus Federal SAPT Bloc Grant Funding used minus a 10 percent off-set for undocumented immigrants (unless a more detailed accounting of actual costs for these individuals is provided that is acceptable to CMS).

Interim Payments:

OASAS - Advance payments are made on a quarterly basis based on the Budget of Record at the time the payment is made. Within 1 year after the close of a contract year, the advance payments made are reconciled with actual approved costs as submitted in the CFR and future payments are adjusted accordingly.

OPWDD and OMH - Similar to OASAS, advance payments are made per the term of approved contract and reconciled based on the submission of the CFR with future payments adjusted if necessary ,

IV. Documentation of State Expenditures for Designated State Health Programs

In claiming DSHP expenditures , New York State will provide CMS with a summary excel sheet by agency, program and provider in an orderly format so that CMS may review and test underlying supporting documentation as detailed in this Section.

A. For all eligible DSHPs claimed New York State will have available for CMS to test as desired behind each NYS DOH-4103 Claim:

   i. Direct control payment sheets for all providers
   ii. Identifying contract number, provider name & code (agency code?), budget period
   iii. Program
   iv. Voucher number
   v. Voucher amount
   vi. Total amount paid to date
   vii. State financial system voucher entry

B. At a timeframe of no less than nine months following receipt of the Final CFR, for the claiming year ending March 31, 2014 New York State will conduct a Final Analysis which will include the following for CMS to review as desired:

   i. For each contract, provider and eligible DSHP program claimed, electronic worksheets will be available and include the following:

      1) Variance in amounts between the State's paid claim amount, against both actual expenditures and net deficit funding amount identified within the Final CFR.

2) Based on the Final CFR, a rollup of all programs, units of services provided and number of employees or full time equivalents (FTEs) per program.

NOTE: Since Supported Housing Rental Assistance (6050) and Supported Housing Community Services (6060) are considered one program upon closeout, there will be a discreet closeout presentation separating the program expenditures against the budgeted and paid amounts for each. The State will provide detail similar to subsection A of this section to ensure that no payment is made for this program.

Documentation of expenditures for each DSHP must be clearly outlined in the state's supporting work papers and be made available to CMS in accordance with this claiming protocol.

The State will use its voucher and accounting system to identify the amount it expended to purchase services from each service provider under each program during the period April 1, 2013 – March 31, 2014.

Statewide Financial System (SFS):

SFS is the State's accounting system, the 'book-of-record' for New York State. Each agency enters vouchers into SFS. The Office of the State Comptroller (OSC) reviews, approves and then processes the payments. The OSC process includes budget checks against appropriations/segregations to ensure appropriate authority for the expenditures has been provided by the NYS Division of the Budget through a certificate of approval process that is built into SFS.

OASAS enters vouchers individually by provider into SFS. Individual control sheets are manually maintained in excel to track payments by program components and make adjustments to the Budget of Record as needed.

OMH enters vouchers into SFS through a secure bulk-load file protocol. The bulk-load files create the commensurate entries into the SFS system to generate payments to providers/counties. Once approved and processed, the transaction information is then put into a pre-programmed extract file that is bulk-loaded into OMH's Aid to Localities Financial System (ALFS). Information from the file is loaded into ALFS populating all the relevant payment information into assigned data tables.

OPWDD utilizes the Statewide Financial System (SFS) to process contracts and vouchers for the review, approval and payment by the Office of the State Comptroller (OSC). When NYS transitioned to SFS, OPWDD established unique program codes within SFS for all programs to track expenditure patterns. SFS budget checks the transaction to insure sufficient resources are available within the segregation/appropriation authority established through an approval process with the Division of the Budget and the State Comptroller.

Consolidated Fiscal Report (CFR):

The CFR is a uniform cost reporting platform which is required to be completed by all service providers/counties receiving funding.

The CFR is used as both a "year-end cost report" and a "year-end claiming document". The year-end cost report includes the Core schedules and Supplemental schedules which are used to set reimbursement rates and financial analysis of program costs. The cost reporting schedules are completed using a consistent reporting methodology in order for the data to be comparable between providers, regions and programs. The consistent methodology includes; using accrual accounting, including the depreciation of equipment and property, and using the ratio value method to allocate agency administration costs. The year-end claiming document includes the Consolidated Claim Report (CCR) which is used to report expenses and revenues for providers receiving State Aid funding through a direct contract with the State Agency and/or through a local contract with a county Local Government Unit (LGU). Providers are also required to file their program budgets utilizing the Consolidated Budget Report (CBR) portion of the CFR. The CBR is the same reporting platform and schedules found in the CFR.

The CFR represents the keystone of the fiscal monitoring processes by requiring the use of independent CPAs to perform comprehensive reviews of the providers' accounting records and to certify their financial reports. A "Full CFR" requires certification by an independent auditor and a copy of the providers' certified financial statements. Further, the certified CFR documents include detailed expenses (by program) to ensure that expenditures have actually been incurred and that they are accurate and related to the contracted program services.

Importantly, the CFR includes staffing reports for personal costs which represent the vast majority of the expenses for the provision of mental health services and, independent CPA's review provider's payroll and accounting records as part of the CFR submission process. While performing CFR Desk Audits, analysts may request that providers submit additional documentation including "other than personal service costs" where large dollar expenditures have been claimed in the CFR (e.g., equipment purchases) and they occasionally identify other significant concerns with the underlying operations of the provider (e.g., the potential misuse of government funds). In the case of the latter, any identified issues are immediately referred to the each agency's Bureau of Audit or the Counsel's Office for further investigation.

OASAS Only Systems

State Aid Auditing and Reporting System (SABRS):

For OASAS payments SABRS is used to maintain and update, as necessary, the Budget of Record (BOR). When quarterly or other payments are made, the latest BOR is reviewed by the Claims Unit to calculate the next payment due. These payment calculations are made manually via control sheets established for each provider breaking down the budget and project payment by each program type and funding source (State and/or Federal). It should be noted that OASAS utilizes mid-year claims for Calendar Year Providers & Counties.

OMH Only Systems

Aid to Localities Financial System (ALFS):
ALFS is an OMH budgeting, financial and contracting management system that tracks $1.3B from the development of the NYS Enacted Budget through the contract reconciliation process. ALFS tracks the authorization of over 100 funding streams for 113 program types that are operated by over 800 not-for-profit providers and all 62 NYS counties. The system provides Internal Controls through a variety of programmed "checks and balances" and there are user id and date/time stamps saved for every transaction in ALFS. Budgetary checks are hard coded into ALFS to ensure sufficient funds are available to make payments. ALFS also provides linkage to Spending Plan Guidelines via the OMH website which governs the allowable uses of State funds for various fund and program codes. Using ALFS has eliminated paperwork for central office, field office and county users with the system issuing electronic authorizations, payment information, county planning documents, and provider budget and claiming information.

ALFS interfaces with the following systems:

- IAMF (Interagency Master File)
- MHPD (Mental Health Provider Directory)
- CONCERTS (OMH Licensing database)
- CFRS (Consolidated Financial Report System); and
- SFS (Statewide Financial System) and OSC Master Vendor File (VendRep)

The County Allocation Tracker (CAT) is a budgeting function imbedded in ALFS and allows counties to file their budgets with the State electronically. These budgets must to conform to the funding level authorized for the County and are reviewed by OMH Field Office fiscal staff through a series of automated and manual budget checks. The budget checks are linked to the programmatic and fiscal requirements outlined in the Spending Plan Guidelines issued annually. Counties are allowed to revise their CAT allocations throughout the current fiscal year and OMH Field Office fiscal staff is required to review, run budget checks and approve the revised CAT. If a county fails to complete a CAT, they can be subjected to a withholding of their State Aid. Providers paid by counties directly are required to use the CBR which is submitted to the county. However, providers are still required to submit a CFR directly to the State through the CFR system. OMH uses the CAT to cross-check both reported county and provider spending submitted in the CFR against provider CBRs and county CATs .

V. Net Deficit Program Details

A. Office of Alcoholism and Substance Abuse Services

State Agency: Office of Alcoholism and Substance Abuse Services
Program Group: Outpatient and Methadone Programs

Program Codes:
Methadone-to-Abstinence (0605)
Methadone Maintenance (2050)
Keep Units (2150)
Outpatient Chemical Dependence for Youth (0140)
Medically Supervised Outpatient (3520)
Enhanced Medically Supervised Outpatient (3528)
Outpatient Rehabilitation Services (3530)

Funding Sources:
Mental Hygiene Program Fund
General Fund

For each program in this program group, the State will perform the following steps to determine the amount of the DSHP expenditure eligible.

1. Process to identify value of applicable offsets - The 10 percent undocumented immigrant off-set is applied (unless a more detailed accounting of actual costs for these individuals is provided that is acceptable to CMS) after the State's net deficit payment is calculated (Budget minus other revenue (including Medicaid) minus State payment using SAPT Bloc Grant funds.

2. Process to identify program net deficit payments - Budget minus other revenue (including Medicaid) minus State payment using SAPT Bloc Grant funds.

Brief Description:

Chemical dependence outpatient services assist individuals who suffer from chemical abuse or dependence and the family members and/or significant others. Outpatient services may be delivered at different levels of intensity responsive to the severity of the problems presented by the client and include medication assisted treatment such as methadone and buprenorphine. These services may be provided in a free standing setting, or may be co-located in a variety of other health and human service settings. Sponsorship may be voluntary, proprietary or county operated.

0140 - Outpatient Chemical Dependence for Youth - Such programs serve youth between the ages 12 and 1 8 by providing a drug-free setting supporting abstinence from alcohol and/or other substances of abuse. Active treatment is rendered through multi- disciplinary clinical services designed to assist the youth in achieving and maintaining an abstinent lifestyle and to serve youth whose normal adolescent development, in one or more major life areas, has been impaired as a result of the use of alcohol and /or other substances by a parent or significant other.

0605 - Methadone-to-Abstinence – Outpatient Opioid treatment programs (OTPs) where medication assisted treatment is delivered on an ambulatory basis in gradually decreasing doses to the point of abstinence, followed by continued drug-free treatment.

2050 - Methadone Maintenance – Outpatient Opioid treatment programs (OTPs) where medication assisted treatment is delivered primarily on an ambulatory basis, with most programs located in either a community or hospital setting. Medication is administered daily at a stabilized dose over an extended period of time.

2150 - KEEP Units – Outpatient – Methadone Opioid treatment programs (OTPs) where medicated assisted treatment is delivered on an ambulatory basis. KEEP is an interim (not more than 180 days) protocol that provides intensive medical and support services in order to evaluate the long-term treatment needs of patients.

3520 & 3528 - Medically Supervised Outpatient & Enhanced Medically Supervised Outpatient - These programs assist individuals who suffer from chemical abuse or dependence and their family members and/or significant others through group and individual counseling; education about, orientation to, and opportunity for participation in, relevant and available self-help groups; alcohol and substance abuse disease awareness and relapse prevention; HIV and other communicable diseases, education, risk assessment, supportive counseling and referral; and family treatment. In addition, social and health care services, skill development in accessing community services, activity therapies, information and education about nutritional requirements, and vocational and educational evaluation must be available either directly or through written agreements. Procedures are provided according to an individualized assessment and treatment plan. This service mandates that medical staff be part of the multi-disciplinary team and the designation of a Medical Director, which provides for medical oversight and involvement in the provision of outpatient services. These services are Medicaid eligible providing other standards pertaining to fee-for-service Medicaid are met.

3530 - Outpatient Rehabilitation Services - This service level is designed to serve more chronic individuals who have inadequate support systems, and either have substantial deficits in functional skills or have health care needs requiring attention or monitoring by health care staff. These programs provide social and health care services, skill development in accessing community services, activity therapies, information and education about nutritional requirements, and vocational and educational evaluation. Clients initially receive these procedures five days a week for at least four hours per day. There is a richer staff to client ratio for these services compared to other outpatient levels and these services are required to have a half-time staff person qualified in providing recreation and/or occupation al services as assistant or registered nurse. Like half-time nurse practitioner, physician medically supervised outpatient, outpatient rehabilitation services, mandate that medical staff be part of the multi-disciplinary team and the designation of a Medical Director, which provides for medical oversight and involvement in the provision of outpatient services. These services are Medicaid eligible providing other standards pertaining to fee-for-service Medicaid are met.

The length of stay and the intensity of services as measured by frequency and duration of visits vary from one category of outpatient services to another and intensity will vary during the course of treatment within a specific category. In general, persons are engaged in

outpatient treatment up to a year and visits are more frequent earlier in the treatment process becoming less frequent as treatment progresses.

Eligible Population:

Individuals who come to the program are assessed as to whether the service is clinically appropriate. In the most recent year for which data is available, over 56,000 individuals were served in outpatient programs and over 10,000 in methadone programs. Any NYS resident is eligible with no income limitation. The universe of potential individuals is extrapolated from a Needs estimate based on geographic region which compares estimated need versus available capacity.

State Agency: Office of Alcoholism and Substance Abuse Services
Program Group: Prevention and Program Support Services
Program Codes:
Primary Prevention Services (5220)
Other Prevention Services (5550)

Funding Sources:
Mental Hygiene Program Fund
General Fund

Brief Description:

5520 – Primary Prevention Services - Primary Prevention is defined as a collaborative and community focused process to prevent or delay substance use and abuse in individuals, families and communities. Prevention service approaches include education, environmental strategies, community capacity building, positive alternatives and information dissemination. The selection of prevention service activities within these service approaches is based on a community needs assessment that identifies levels of substance use, its consequences, elevated risk factors and decreased protective factors. Prevention counseling and early intervention activities with individuals, families and groups are not included as Primary Prevention Services. Individuals who are diagnosable for substance abuse or dependence are not served with Primary Prevention Services.

5550 - Other Prevention Services- Other Prevention service approaches funded by OASAS include Prevention Counseling and Early Intervention. Prevention Counseling is an OASAS certified service designed to assess and improve the levels of youth and family risk and protective factors to prevent or reduce substance use, problem gambling and the negative consequences of such behaviors. Prevention Counseling is offered to IOM selected youth who are considered at highest risk for developing substance abuse or gambling problems. Early intervention is offered to IOM Indicated individuals who have already begun to exhibit substance use or gambling behaviors but do not meet the DSM-IV criteria of substance abuse or dependence or problem gambling. Individuals may require referral for assessment and treatment with more intensive services.

These services are designed to improve individual and family risk and protective factors, while others target the community and school environment as a whole. Services include school-based classroom programs using multi-session curricula to increase family and youth understanding of the consequences of substance abuse, improve drug and other problem behavior attitudes and teach drug refusal and other social skills; strategies developed to target environmental factors to improve substance use regulations and policies, increase compliance with regulations and policies to reduce availability of alcohol, tobacco and other substances; and change social norms regarding substance abuse. The evidence-based models delivered by many OASAS providers have been estimated to reduce public costs by $8 to $56 for every $1 of program cost.

Eligible Population:

The majority of services under this program are geared towards school-aged individuals and their parents (guardians), although there are no eligibility requirements. In the most recent year for which data is available, over 460,000 participants received prevention services.

B. Office of Mental Health

For each program in this program group, the State must perform the following steps to determine the amount of the DSHP expenditure eligible for FFP under STC #66. The payments and associated claimed expenditures for the following programs must be commensurate with actual program service delivered.

For DSHP eligible expenditures related to services provided on behalf of the State by local providers and counties.

Step 1 – **Identify all expenditures potentially eligible for DSHP claim in the Aid to Localities Financial System (ALFS) for the designated time period:** State identifies all expenditures from the Office of Mental Health Aid to Localities Financial System (ALFS) that fall within the liability date period of April 1, 2013 through March 31, 2014 as required in STC# 66. These payments are initiated in the OMH ALFS, reviewed and approved by OMH staff at appropriate levels and bulk-loaded into the NYS Statewide Financial System (SFS). The NY State Office of the State Comptroller (OSC) has internal checks and approvals built into SFS to ensure payments are authorized and conform to State appropriation authority at appropriate levels. Once reviewed, OSC releases payment to providers/counties. SFS and ALFS will be used to document actual payments to providers/counties for DSHP eligible services provided on behalf of the State and can be used to track State appropriation authority for the expenditures.

Step 2 – C**ollapse multiple payments (expenditure data) into single line for each provider and/or county and align/compare with the CBR/CAT budget data for each provider and/or county to facilitate offset of DSHP ineligible expenditures:** State matches all payments made to providers and/or counties with the service provider budgets (Consolidated Budget Report within the Consolidated Fiscal Report for providers and the County Allocation Tracker (CAT) in the ALFS for counties) for the April 1, 2013 to March

31, 2014 time period to be later compared against actual expenditures reported on a prior year Consolidated Fiscal Report (CFR) (utilizing both main CFR claiming schedules: the DMH 2 CFR schedule displays the fund code specific detail portion of a claim and the DMH 3 CFR schedule displays the program summary level detail of a claim). The State utilizes program, fund and account codes from the SFS and ALFS to match disbursements with reported/budgeted expenditures on the CBR/CAT. (Separate table(s) that crosswalk SFS, ALFS, CFR, CBR and CAT coding (including program and fund codes) will be supplied as an attachment to the final claim submission. The tables will also indicate any other program code/fund code exclusions that are referenced in Steps below).

Step 2a—Compile CBR/CATS data for each provider/county identified in Step 2 and match up against prior year's provider/county CFR expenditure data compiled in Step 2: In order to determine the amount of the initial claim, the State compiles budgets (CBR and/or CAT) submitted by providers and/or counties identifying the specific program/fund codes for all CFR expenditures. All State identified prior year CFR expenditures are matched and verified by provider, program and fund codes to the CBR/CAT budgets for the April 1, 2013 to March 31, 2014 time period. NOTE: For Counties the CAT will serve as the summary reference, but prior year CFR claims data will be used as a proxy to determine allocation of funding across program and fund codes.

Step 2b – Compiled CBR/CAT budget data is adjusted to eliminate DSHP ineligible programs and services: Once the expenditure data has been matched and verified in Step 2a, the State offsets all non-eligible DSHP expenditures based on the provider/county submitted CBR/CAT budget as follows:

1) Medicaid and any other Federal funding (Medicaid expenditures are not in the disbursement data because NYS State Share is paid by the NYS Dept. of Health)

    a. (CBR, schedule DMH-2, lines 14-24);
    b. DMH-2, line 14: Participant Fees
    c. DMH-2, line 15: SSI & SSA;
    d. DMH-2, line 16: Home Relief/Public Assistance;
    e. DMH-2, line 17: Medicaid;
    f. DMH-2, line 18: Medicare;
    g. DMH-2, line 19: Other Third Parties;
    h. DMH-2, line 20: OPWDD Residential Room and Board/NYS OPTS (not relevant for OMH);
    i. DMH-2, line 21: Transportation, Medicaid;
    j. DMH-2, line 22: Transportation, Other;
    k. DMH-2, line 23: Sales: Contract Total;
    l. DMH-2, line 24: Federal Grants.

2) Third Party revenue (CBR, schedule DMH-2, lines 29 and 48); DMH-2, line 29: Other Revenue; DMH-2, line 48: Non-Funded.

3) Research (There is no local funding for research or research related programs)

4) Forensics (Fund Code 039J) reported on schedule DMH-3;

5) Room & board (CBR, schedule DMH-2, line 28, by program code for residential programs); DMH-2, line 28: Net Deficit Funding

6) Rent & Utilities (There are no rent or utility subsidies to individuals outside of the 6050 and 6060 – Supported Housing Program);

7) Other Exclusions (identified by program and funding code combinations) that are not DSHP eligible. (Separate table(s) that crosswalk SFS, ALFS, CFR, CBR and CAT coding (including program and fund codes) will be supplied as an attachment to the final claim submission. The tables will also indicate all other program code/fund code exclusions that are not already referenced above).

8) Undocumented individuals – a 10 percent bottom-line reduction to account for undocumented individuals (unless a more detailed accounting of actual costs for these individuals is provided that is acceptable to CMS) per CMS' request.

Step 2c—OMH compiles all prior year CFR expenditure data for providers/counties identified in Step 1-2. OMH will claim the lesser of the CBR/CAT budgeted expenditure calculated from Steps 2a-2b OR the prior year's providers/counties CFR reported claim as calculated from Steps 2c – 2d below: State compiles certified CFR information found in the DMH-2 and DMH-3 CFR claiming schedules for all providers/Counties identified in Step 2A for the April 1, 2013 through March 31, 2014 time period consistent with STC# 66. All reported prior year CFR expenditures are matched and verified by provider, program and fund codes.

Step 2d – Compiled prior year's providers/counties CFR expenditure data from Step 2c is adjusted to eliminate DSHP ineligible programs and services: State offsets non-eligible DSHP expenditures from reported CFR expenditures as follows:

1) Medicaid and any other Federal funding (Medicaid expenditures are not in the disbursement data because NYS State Share is paid by the NYS Dept. of Health)

    a. (CBR, schedule DMH-2, lines 14-24);
    b. DMH-2, line 14: Participant Fees
    c. DMH-2, line 15: SSI & SSA;
    d. DMH-2, line 16: Home Relief/Public Assistance;
    e. DMH-2, line 17: Medicaid;
    f. DMH-2, line 18: Medicare;
    g. DMH-2, line 19: Other Third Parties;
    h. DMH-2, line 20: OPWDD Residential Room and Board/NYS OPTS (not relevant for OMH);
    i. DMH-2, line 21: Transportation, Medicaid;

j. DMH-2, line 22: Transportation, Other;
k. DMH-2, line 23: Sales: Contract Total;
l. DMH-2, line 24: Federal Grants.

2) Third Party revenue (CBR, schedule DMH-2, lines 29 and 48); DMH-2, line 29: Other Revenue; DMH-2, line 48: Non-Funded.

3) Research (There is no local funding for research or research related programs)

4) Forensics (Fund Code 039J) reported on schedule DMH-3;

5) Room & board (CBR, schedule DMH-2, line 28, by program code for residential programs); DMH-2, line 28: Net Deficit Funding

6) Rent & Utilities (There are no rent or utility subsidies to individuals outside of the 6050 and 6060 – Supported Housing Program);

7) Other Exclusions (identified by program and funding code combinations) that are not DSHP eligible. (Separate table(s) that crosswalk SFS, ALFS, CFR, CBR and CAT coding (including program and fund codes) will be supplied as an attachment to the final claim submission. The tables will also indicate all other program code/fund code exclusions that are not already referenced above).

8) Undocumented individuals – a 10 percent bottom-line reduction to account for undocumented individuals (unless a more detailed accounting of actual costs for these individuals is provided that is acceptable to CMS) per CMS' request.

Step 2e—Compare adjusted CBR/CAT budgeted expenditures from 2a – 2b to adjusted prior year providers/counties CFR claims from Steps 2c -2d. OMH will claim the lesser of the calculated from Steps 2a-2b OR the prior year's providers/counties CFR reported claim as calculated from Steps 2c – d.

Step 3 – The state submits an initial claim for the adjusted CBR/CAT budgeted expenditures from Steps 2a-2b or the adjusted prior year's providers/counties CFR claim calculated in Step 2c-2d, whichever is less. The claim must be submitted in accordance with STC #66 and the individual DSHP program as allowed by Waiver 11-W-00-0014/2.

The State attests expenditures used are correct and verifiable as DSHP allowable. The State further attests state fund only funds expended per STC #66 are used for DSHP allowable program services. (Separate table(s) that crosswalk SFS, URC and Program coding will be provided as an attachment to the final claim submission).

Step 4 – Final analysis of submitted claims to determine DSHP eligibility and submission of an adjusted/final claim to CMS: No less than nine months following the receipt of the Final CFR, for the claiming year ending March 31, 2014, OMH will conduct a

final analysis of the CFR claims submitted by the providers/counties identified in the initial claim.

Step 4a - OMH will compile final CFR expenditure data for all providers/counties included in the initial claim submitted to CMS as determined in Step 3.

Step 4b – Compiled final CFR expenditure data from Step 4a is adjusted to eliminate DSHP ineligible programs and services: State offsets non-eligible DSHP expenditures from reported CFR expenditures as follows:

1) Medicaid and any other Federal funding (Medicaid expenditures are not in the disbursement data because NYS State Share is paid by the NYS Dept. of Health)

    a. (CBR, schedule DMH-2, lines 14-24);
    b. DMH-2, line 14: Participant Fees
    c. DMH-2, line 15: SSI & SSA;
    d. DMH-2, line 16: Home Relief/Public Assistance;
    e. DMH-2, line 17: Medicaid;
    f. DMH-2, line 18: Medicare;
    g. DMH-2, line 19: Other Third Parties;
    h. DMH-2, line 20: OPWDD Residential Room and Board/NYS OPTS (not relevant for OMH);
    i. DMH-2, line 21: Transportation, Medicaid;
    j. DMH-2, line 22: Transportation, Other;
    k. DMH-2, line 23: Sales: Contract Total;
    l. DMH-2, line 24: Federal Grants.

2) Third Party revenue (CBR, schedule DMH-2, lines 29 and 48); DMH-2, line 29: Other Revenue; DMH-2, line 48: Non-Funded.

3) Research (There is no local funding for research or research related programs)

4) Forensics (Fund Code 039J) reported on schedule DMH-3;

5) Room & board (CBR, schedule DMH-2, line 28, by program code for residential programs); DMH-2, line 28: Net Deficit Funding

6) Rent & Utilities (There are no rent or utility subsidies to individuals outside of the 6050 and 6060 – Supported Housing Program);

7) Other Exclusions (identified by program and funding code combinations) that are not DSHP eligible. (Separate table(s) that crosswalk SFS, ALFS, CFR, CBR and CAT coding (including program and fund codes) will be supplied as an attachment to the final claim submission. The tables will also indicate all other program code/fund code exclusions that are not already referenced above).

8) Undocumented individuals – a 10 percent bottom-line reduction to account for undocumented individuals (unless a more detailed accounting of actual costs for these individuals is provided that is acceptable to CMS) per CMS' request.

Step 4c— Compare initial Claim submitted to CMS (from Step 3) to final CFR claims compiled and adjusted for exclusions in Steps 4a-4c. State compiles the actual disbursements included in the initial claim (Step 3) by provider/locality from 4/1/13 through 3/31/14 and matches against the compiled CFR reported expenditures (after exclusions in Step 4b) for the same time period. State identifies the difference between the amount claimed for DSHP and the final certified CFR claim submitted by the provider. The State submits a final adjusted claim to CMS with agreed upon back-up materials.

OMH Source Data:

Statewide Financial System (SFS): is the State's accounting system, the 'book-of-record' for New York State. OMH enters vouchers into SFS through a secure bulk-load file protocol. The bulk-load files create the commensurate entries into the SFS system to generate payments to providers/counties.

Aid To Localities Financial System (ALFS): An OMH budgeting, financial and contracting management system that tracks $1.3B from the development of the NYS Enacted Budget through the contract reconciliation process. Expenditures data is populated from bulk-load files received from SFS daily.

Consolidated Fiscal Report (CFR): The Consolidated Fiscal Report (CFR) is a uniform cost reporting platform which is required to be completed by all service providers/counties receiving OMH funding.

OMH Program Groups:

State Agency: Office of Mental Health
Program Group: Licensed Outpatient Programs
Program Codes:
Continuing Day Treatment (CDT) (1310)
Clinic Treatment (2100)
Clinic-Plus (0790)
Day Treatment services for children and adolescents (0200)
Partial Hospitalization (2200)
Intensive Psychiatric Rehabilitation and Treatment (IPRT) (2320)
Funding sources: State Appropriations

Brief Description:

Outpatient funds are used to provide treatment designed to reduce symptoms, improve functioning and ensure ongoing support for individuals experiencing serious and persistent mental illness and ensure that their basic needs are met. This program has a focus on improving an individual's quality of life in the community and reducing the need for inpatient care through the provision of community based treatment services.

Some of the specific services provided by the Outpatient program include: (1) Continuing Day Treatment (CDT) (1310), which provides active treatment and rehabilitation designed to maintain or enhance current levels of functioning and skills, to maintain community living and to foster development of self-awareness and self-esteem; (2) Clinic Treatment (2100), which provides assessment and treatment planning, health screening and referral, discharge planning, verbal therapy, medication therapy, medication education, symptom management, and psychiatric rehabilitation readiness determination; (3) Clinic-Plus (0790), which represents an enhancement of traditional clinic services such that the Clinic-Plus programs adopt a public health approach which enables earlier identification of children with emotional disturbance as well as earlier intervention; (4) Child and Family Clinic-Plus Outreach and Screening Services, which takes a broad-based approach to identify children and adolescents with emotional disturbances and to intervene at the earliest possible opportunity; (4) Day Treatment services for children and adolescents(0200), which provide intensive, non-residential services, including a blend of mental health and special education provided in a fully integrated service; (5) Partial Hospitalization (2200), which provides treatment to stabilize and ameliorate acute symptoms, serve as an alternative to inpatient hospitalization, and reduce the length of a hospital stay within a medically supervised program; and (6) Intensive Psychiatric Rehabilitation and Treatment (IPRT)(2320), which is designed to assist a patient in forming and achieving mutually agreed-upon goals in living, learning, working and social environments; to intervene with psychiatric rehabilitation technologies to overcome functional disabilities; and to improve environmental supports.

Eligible Population:

Programs serve adults and/or children diagnosed with a Serious Mental Illness or Serious Emotional Disturbance. In the most recent year for which data is available, the Outpatient program served approximately 111,200 clients, excluding Medicaid and Medicare clients.

State Agency: Office of Mental Health
Program Group: Care Management
Program Codes:
Intensive Case Management (ICM) (1810)
Supportive Case Management (SCM) (6810)
Blended Case Management (BCM) (0820)
Adult Home Case Management (6820)
Residential Treatment Facility (RTF) Transition Coordinators (2880)
Transition Management (TM) Services (1970)
Non-Medicaid Care Coordination activities (2720)
Funding sources: State Appropriations

Brief Description:

Care Management funds are used to coordinate services for individuals experiencing serious and persistent mental illness and ensure that their basic needs are met. Care managers play a major role in identifying, engaging in services, advocating for, and helping clients to find their way through complex health care and social services systems; they also provide on-site crisis intervention and skills teaching when other services are not available. These services, which include some specialized care management for the elderly, are an essential support for many individuals currently living in community settings. Care management is aimed at linking the individuals to the service system and coordinating the various services necessary for successful outcomes. The objective of care management in a mental health system is continuity of care. Services provided may include linking, monitoring and case-specific advocacy.

Some of the specific services provided by the Care Management program include: (1) Health Home Care Management, which provides coordinated, comprehensive medical and behavioral health care to Medicaid-enrolled adults with chronic conditions through care management and integration that assures access to appropriate services, improves health outcomes, reduces preventable hospitalizations and emergency room visits, promotes use of health information technology (HIT), and avoids unnecessary care; (2) Intensive Case Management (ICM) (1810), where case workers assist recipients to develop and maintain viable living, working and social situations in their communities through intensive interaction with the participants; (3) Supportive Case Management (SCM) (6810); which is a variant of the ICM program, is designed to provide services to individuals who require less support than provided under ICM; (4) Blended Case Management (BCM) (0820); which facilitates a team approach to case management services by combining the caseloads of multiple Intensive Case Managers and/or Supportive Case Managers; (4) Adult Home Case Management(6820), which promotes optimal health and wellness by implementing a person-centered approach to service delivery and ensuring linkages to and coordination of essential community resources; (5) Residential Treatment Facility (RTF) Transition Coordinators (2880), which exist within each RTF to ensure family engagement as well as timely, successful discharges of children and adolescents; (6) Transition Management (TM) Services(1970) (discharge planning); which provide support for improved community service linkages and timely filing of Medicaid applications for seriously and persistently mentally ill (SPMI) consumers being released from local correctional facilities; and (7) Non-Medicaid Care Coordination activities (2720), which are aimed at linking the consumer to the service system and at coordinating the various services in order to achieve a successful outcome.

Eligible Population:

Programs serve adults and/or children diagnosed with a Serious Mental Illness or Serious Emotional Disturbance. In the most recent year for which data is available, the Care Management program served approximately 25,200 clients, excluding Medicaid and Medicare clients.

State Agency: Office of Mental Health

Program Group: Emergency Programs
Program Codes:
Respite Services (0650)
Crisis intervention services (2680)
Crisis Residence (0910)
Crisis Respite Beds (1600)
Home-Based Crisis Intervention (HBCI) (3040)
Funding Sources: State Appropriations

Brief Description:

The Emergency program provides emergency safety net services for individuals with mental illness including crisis services, intervention and outreach. Funds support emergency safety net services for individuals who would otherwise be at risk of hospitalization or more costly Medicaid services requiring increased Federal Financial Participation, which is consistent with Olmstead. All programs serve individuals who are indigent, uninsured or underinsured. As the Medicaid portion of this program is largely budgeted within DOH, the OMH budget includes a higher proportion of non-Medicaid expenses.

Some of the specific services provided by the Emergency program include: (1) Comprehensive Psychiatric Emergency Program (CPEP); which is designed to directly provide or ensure the provision of a full range of psychiatric emergency services, including: crisis intervention, extended observation beds in the hospital, crisis outreach services, and crisis residence; (2) Respite Services (0650); which are temporary services (not beds) provided by trained staff in the consumer's place of residence or other temporary housing arrangement; (3) Crisis intervention services (2680); which provide screening, assessment, stabilization, triage, and/or referral to an appropriate program or programs; (4) Crisis Residence (0910), which is a licensed residential, 24 hours/day, time-limited stabilization service, which provides for acute symptom reduction and the restoration of an individual's condition to a pre-crisis level of functioning; (5) Crisis Respite Beds (1600), which are dedicated beds within a larger licensed service, which provide a homelike environment with room, board and supervision in cases where individuals must be removed temporarily from their usual residence; and (6) Home-Based Crisis Intervention (HBCI)(3040), which is a clinically oriented program with support services by a MSW or Psychiatric Consultant which provides short-term, intensive in-home crisis intervention services to a family in crisis due to the imminent risk of their child being admitted to a psychiatric hospital.

Eligible Population:

Programs serve adults and/or children diagnosed with a Serious Mental Illness or Serious Emotional Disturbance. In the most recent year for which data is available, the Emergency program served approximately 80,200 clients, excluding Medicaid and Medicare clients.

State Agency: Office of Mental Health
Program Group: Rehabilitation Services
Program Codes:

Personalized Recovery-Oriented Services (PROS) (9340)
Treatment Congregate (6070)
Treatment Apartment Based Residential Program (7070)
Children and Youth (C&Y) Community Residences (7050)
Teaching Family Homes (4040)
Funding Sources: State Appropriations

Brief Description:

The Rehabilitation Services program provides an array of services designed to promote the recovery of individuals with severe and persistent mental illness through the integration of treatment, support, and rehabilitation; with a focus on improving an individual's quality of life in the community and reducing the need for inpatient care through the provision of community based treatment services.

Some of the specific services provided by the Rehabilitation Services program include: (1) Personalized Recovery-Oriented Services (PROS) (9340), which is a comprehensive service which integrates treatment, support and rehabilitation in a manner that facilitates the individual's recovery, including improving functioning, reducing inpatient utilization, reducing emergency services, reducing contact with the criminal justice system, increasing employment, attaining higher levels of education and securing preferred housing; (2) Treatment Congregate (6070), which is a group-living designed residential program which focuses on intensive goal-oriented interventions necessary to address the specific functional and behavioral deficits which prevent residents from accessing generic housing; (3) Treatment Apartment based residential program(7070), which focuses on intensive goal-oriented interventions necessary to address the specific functional and behavioral deficits which prevent residents from accessing generic housing; (4) Children and Youth (C&Y) Community Residences(7050), which provide a supervised, therapeutic environment for six to eight children or adolescents, between the ages of 5 and 18 years, that includes structured daily living activities, problem solving skills development, a behavior management system and caring consistent adult interactions; and (5) Teaching Family Homes(4040), in which specially trained parents live and work with four children and youth with serious emotional disturbances in a home-like setting, where the teaching parents are responsible for the social education of the children and the implementation of a service plan developed in conjunction with the family and clinical service provider.

Eligible Population:

Programs serve adults and/or children diagnosed with a Serious Mental Illness or Serious Emotional Disturbance. In the most recent year for which data is available, the Rehabilitation Services program served approximately 500 clients, excluding Medicaid and Medicare clients.

State Agency: Office of Mental Health
Program Group: Residential (Non-Treatment)
Program Codes:

Congregate Support programs (6080)
Community Residence/Single-Room Occupancy (CR-SRO) programs (8050)
Supported/Single-Room Occupancy (SP-SRO) programs (5070)
Support Apartment programs (7080)
Supported Housing Community Services (6080, 6060, 6050)
Funding Sources: State Appropriations

Brief Description:

Some of the specific services provided by the Residential (Non-Treatment) program include: (1) Congregate Support programs (6080), which are single-site residential programs that provide support designed to improve or maintain an individual's ability to live as independently as possible and eventually access generic housing; (2) Community Residence/Single-Room Occupancy (CR-SRO) programs (8050), which provide service-enriched, licensed, extended-stay housing with on-site services for individuals who want private living units, but who have minimal self-maintenance and socialization skills (3) Supported/Single-Room Occupancy (SP-SRO) programs (5070), which provide long-term or permanent housing in settings where residents can access the support services they require to live successfully in the community; (4) Support Apartment programs (7080), which provide support designed to improve or maintain an individual's ability to live as independently as possible, and eventually access generic housing; and (5) Supported Housing Community Services(6080, 6060, 6050), which assist individuals in locating and securing housing of their choice and in accessing the supports necessary to live successfully in the community through assistance with choosing housing, roommates, and furniture; providing financial assistance with purchasing apartment furnishings; assistance with resolving roommate or landlord issues; and linking residents to a comprehensive community support system of case management, mental health and general health supports.

Eligible Population:

Programs serve adults and/or children diagnosed with a serious mental illness or serious emotional disturbance. In the most recent year for which data is available, the Residential (Non-Treatment) program served approximately 9,400 clients, excluding Medicaid and Medicare clients.

State Agency: Office of Mental Health
Program Group: Community Support Programs
Program Codes:
Advocacy/support services (1760)
Psychosocial Club (0770)
Drop in Centers (1770)
Self-Help (2770)
Outreach services (0690)
On-site Rehabilitation (0320)
Multicultural Initiatives (3990)
Supported Education (5340)

MICA Networks (5990)
Geriatric Demo Gatekeeper (1410)
Geriatric Demo Physical Health-Mental Health Integration (1420)
Transportation (0670)
Recreation (0610)
Transitional Employment Placement (TEP) (0380)
Enclave in Industry (1340)
Assisted Competitive Employment (ACE) (1380)
Affirmative business/Industry (2340)
Work program (3340)
Ongoing Integrated Supported Employment Services (2340)
Family Support Services (1650)
School-based mental health (1510)
Coordinated Children's Services Initiative (CCSI) (2990)
Vocational and Educational Services (Children and Family) (1320)
Home-based family treatment (1980)
Homeless placement services (1960)
Recovery centers (2750)
Day Training (XX48)
Mobile Mental Health Teams (MMHTs) (XX86)
The Client Worker program (3429)
Funding Sources: State Appropriations

Brief Description:

The Community Support program includes a wide range of community mental health services, which provide services for individuals in community settings who are considered severely and persistently mentally ill. Funds support non-residential safety net services for individuals who would otherwise be at risk of out of home placement or hospitalization and increased Federal Financial Participation for more costly Medicaid services, which is consistent with Olmstead. The Community Support program provides treatment to help reduce symptoms, improve functioning, and provide ongoing support while maintaining adults in the community.

Some of the specific services provided by the Community Support program include: (1) Advocacy/support services (1760); (2) Psychosocial Club (0770); (3) Drop in Centers(1770); (4) Self-Help (2770); (5) Outreach services (0690); (6) On-site Rehabilitation (0320); (7) Multicultural Initiatives (3990); (8) Supported Education (5340); (9) MICA Networks(5990); (10) Geriatric Demo Gatekeeper(1410); (11) Geriatric Demo Physical Health-Mental Health Integration(1420); (12) Transportation (0670); (13) Recreation (0610); (14) Transitional Employment Placement (TEP) (0380); (15) Enclave in Industry (1340); (16) Assisted Competitive Employment (ACE) (1380); (17) Affirmative business/Industry (2340); (18) Work program (3340); (19) Ongoing Integrated Supported Employment Services(2340); (20) Family Support Services (1650); (21) School-based mental health (1510); (22) Coordinated Children's Services Initiative (CCSI) (2990); (23) Vocational and Educational Services (Children and Family) (1320); (24) Home-based family treatment

(1980); (25) Homeless placement services (1960); (26) Recovery centers (2750); (27) Day Training (XX48); (28) Mobile Mental Health Teams (MMHTs) (XX86); and the (29) Client Worker program (3429). Program descriptions for listed programs are available in Appendix F of the New York State Consolidated Fiscal Reporting and Claiming Manual.

Eligible Population:

Programs serve adults and/or children diagnosed with a Serious Mental Illness or Serious Emotional Disturbance. In the most recent year for which data is available, the Community Support program served approximately 121,400 clients, excluding Medicaid and Medicare clients.

C. Office for People with Developmental Disabilities

State Agency: Office for People with Developmental Disabilities
Program: Day Training
Program Code: 0330
Funding Sources: State Appropriations

Brief Description:

A program or planned combination of services provided to developmentally disabled persons whose level of disability is not so severe as to require more intensive services but whose functional behavior deficits limit their ability to function independently. The goal of day training programs is to provide program interventions that will assist developmentally disabled persons in the acquisitions of knowledge and skills that will enable them to improve their personal, social, and vocational skills and their ability to function independently. Day training also includes programs consisting of specialized developmental services that are operated with the goal of providing developmentally disabled persons with habilitation and social skills which will enable the individual to maintain gains made in other programs or to gain entry to a level of programming requiring more independent functioning such as supported employment or if possible, competitive employment.

Eligible Population:

Eligible individuals are those with developmental disabilities as defined by Mental Hygiene Law and who benefit from day training services consistent with their individual service plan.

State Agency: Office for People with Developmental Disabilities
Program: Family Support Services
Program Code: 0150
Funding Sources: State Appropriations

Brief Description:

The purpose of Family Support Services (FSS) is to enable families to provide in-home care to their family members with a developmental disability. Crisis intervention services help prevent emergency admissions to Medicaid-funded community homes or institutional facilities. Consistent with the *Olmstead* decision, these services also enable families to continue to care for a family member with a developmental disability in the least restrictive environment, at home. In addition to these critical services, FSS also provides non-Medicaid funded services, such as training to family members, information and referral services, support groups, recreation, transportation, and other in-home services for individuals with and without Medicaid. These supports also help individuals to stay with their families and do so at a very modest cost of care compared to living in a Medicaid-funded community home.

Specific services available to FSS participants include:

- Behavior Management: Planned, systematic application of the methods and findings of behavior science with the intent of altering observable behaviors, including increasing, decreasing, extending, restricting, teaching and maintaining behaviors.

- Respite (Overnight/Day/Evening): These services provide the family with temporary relief from the care of a person with a developmental disability in order to permit the caregivers to be absent during overnight to conduct business, deal with an emergency or pursue a leisure activity. This service may be provided in or out of the home.

- Family Reimbursement/Cash Subsidy: Services and goods which are not funded through other sources can be purchased through family reimbursement or cash subsidy. For family reimbursement services, the family and provider agency or Developmental Disabilities Regional Office (DDSR) agree to a plan for purchase of services and goods, the family makes the purchase, provides a receipt and is reimbursed. For cash subsidy services, the family and provider agency or DDRO agree to a plan for purchase of services and goods and then the family is given a set amount of funding to make the purchase. After the services and goods are purchased, the family must provide receipts in order to receive additional family reimbursements or cash subsidy services.

- Other: At times a family or an individual may need a unique service, which is not included in the group of services listed, including:

    - Financial and Life Planning Assistance**:** Financial assistance services assist families in accessing necessary assistance from generic and OPWDD funding, benefits, entitlements, and other sources. Life planning assistance services assist a family to develop a plan, with input from the individual with a developmental disability, as possible, and with assistance from professionals, which will provide the family with some assurance about future life options available to the individual with a developmental disability and selection of these options.

    - Service Access Assistance: Contact with the individual, family member or primary care giver and service providers on a regular basis to assist with planning and

accessing services and supports. Service access assistance can include assessment of service needs, planning and coordination, linkage and referral, follow-up, monitoring and advocacy.

- Free-Standing Respite: These services provide temporary room, board and supervision of an individual with a developmental disability in an out-of-home setting, or supervision in the natural home, when the family member or primary care giver is absent or needs relief.

- Counseling: Face-to-face, individual, group, or family counseling or therapy in a planned, structured session intended to help an individual or family gain insight, resolve problems, develop alternate behaviors or address other issues of concern. This includes counseling provided over the telephone with individuals or with their families.

- Training: Training and education activities offered to the parents, siblings and care givers, designed to augment or improve their knowledge of, and ability to promote the development of their family member, and to aid in their ability to care for their family member at home. Training in activities of daily living which enable individuals to increase their level of independence and improve the quality of their lives.

- Vacation/Day/Sleep Away Camp: Vacation is a scheduled period of time away from the daily routine usually spent on recreational and leisure activities. Camps are licensed through the Department of Health. Camps, usually operated in the summer, provide for the physical and social needs of campers and offer recreation and leisure activities.

- Recreation (Day/Evening): A planned program of social, recreational and leisure activities which are enjoyable and often include opportunities to interact with and participate as part of a community. Recreation offers children and adults the chance to play, experience good times, and identify and pursue activities in which they are interested. It promotes development of a wide range of skills and helps create balance and well-being.

- Home Care: Services provided by a Home Care Agency licensed through the Department of Health. Employment of a Home Care Agency staff person in an individual's place of residence to aid in carrying out housekeeping functions in order to assist the individual in reaching identified goals, offer assistance and relief to a caregiver or family member, or provide a temporary substitute for a care giver or family member.

- Information/Referral/Outreach: Information and referral services provide information on programs and services for individuals and their families. Linkages can be made to diagnostic, residential, habilitative, educational, vocational, medical, and recreational services, and to entitlement programs such as Medicaid SSI. Includes activities undertaken to ensure the individual's use of a service or acceptance in a program and may include accompanying the individual. Outreach services identify unserved or underserved individuals with developmental disabilities or their families who are eligible

to use all appropriate services offered through OPWDD generic and specialized services delivery systems.

- Transportation: Provides an individual and/or family member with the proper mode of transportation to and from his/her residence and programs and services.

- Items Purchased, Rented or Leased:

  - Special Adaptive Equipment: Any item, product or piece of equipment that can be used by persons with disabilities to maintain or improve their functional abilities. Such equipment might include: bathtub lifts, transfer boards, modified eating utensils, communication devices, adapted toys or accessible vans. Includes assistive technology services to help a person know about, acquire and use the appropriate adaptive equipment, e.g., demonstration, assessment, funding, training, maintenance, and repairs.

  - Environmental Modification: Environmental modification services provide assistance to families with the removal of barriers which limit accessibility and remodeling to enhance the independent or assisted functioning of individuals with developmental disabilities within their home. Such services include the installation of ramps, lifts or grab bars, widening of doorways, kitchen and bathroom cabinetwork, and counter or appliance changes (e.g., special sink handles).

  - Supplies: Can include the following:

    - Medication expenses such as cost of prescription and nonprescription substances which are necessary as a result of the individual's disability. Must have a receipt from the pharmacy. (Note: For those eligible, costs of prescription drugs are reimbursable through Medicaid.)

    - Continence products (e.g., diapers, wipes): products generally of a disposable nature, used to assist in caring for the individual, who, due to the disability, has a continence problem. Examples include diapers, wipes, chucks, draw sheets, and other bed linens. Must have a receipt of purchase.

    - Special clothing: the cost for extra clothing required for an individual with night time incontinence, or for an individual whose garments wear out quickly due to abnormal movement patterns resulting from a disability. Can include specially designed clothing for individuals with physical disabilities, and medically prescribed articles for which other funding is not available (e.g., orthopedic shoes, helmets for head protection). Must have a receipt of purchase.

    - Special dietary needs: food and supplements cost for special diets prescribed by a physician. The need for dietary supplements must be directly related to the

individual's disability and must not be reimbursable through other funding sources. Must have a receipt of purchase.

- Other: There are a number of supply items needed to properly maintain persons with disabilities but are too numerous and varied to categorize. These items might include things such as batteries, program supplies, or other items reasonably related to the care of the family member with a disability. Must have a receipt of purchase.

Eligible Population:

Eligible individuals are those with developmental disabilities as defined by Mental Hygiene Law and who live in a home environment with their primary caregiver(s). Supports and services are provided to children and families caring for a child or adult family member with developmental disabilities in an effort to maintain the family member at home and strengthen the family's care giving capacity.

ATTACHMENT H

(Reserved for Future Use)

Attachment I - NY DSRIP Program Funding and Mechanics Protocol

I. Preface

a. Delivery System Reform Incentive Payment Fund

On April 14, 2014, the Centers for Medicare and Medicaid Services (CMS) approved New York's request for an amendment to the New York's Partnership Plan section 1115(a) Medicaid demonstration extension (hereinafter "demonstration") authorizing the creation of a Delivery System Reform Incentive Payment (DSRIP) Fund. This demonstration is currently approved through December 31, 2014. DSRIP Funds will not be made available after December 31, 2014 unless the state's demonstration renewal is approved by CMS.

Section IX of the Special Terms and Conditions (STC) describes the general rules and requirements of the Delivery System Reform Incentive Payment (DSRIP) Fund.

b. DSRIP Strategies Menu and Metrics and Program Funding and Mechanics Protocol

The DSRIP requirements specified in the STCs are supplemented by two attachments to the STCs. The Program Funding and Mechanics Protocol (this document, Attachment I) describes the State and CMS review process for DSRIP project plans, incentive payment methodologies, reporting requirements, and penalties for missed milestones. The DSRIP Strategies Menu and Metrics (Attachment J) details the specific delivery system improvement activities that are eligible for DSRIP funding.

This version of the DSRIP Program Funding and Mechanics Protocol is approved April 14, 2014. In accordance with STC 10.b in section IX, the state may submit modifications to this protocol for CMS review and approval in response to comments received during the post-award comment period and as necessary to implement needed changes to the program as approved by CMS.

II. DSRIP Performing Provider Systems

The entities that are responsible for performing a DSRIP project are called "Performing Provider Systems." Performing Provider Systems must meet all requirements described in the STCs, including the safety net definition described in STC 2 is section IX. This section provides more detail about the specific criteria that performing provider systems must meet in order to receive DSRIP funding and the process that the state will follow to assure that performing provider systems meet these standards.

The state will determine the types of providers eligible to participate as a Performing Provider System, as described in paragraph (a) below. All providers are required to form coalitions of providers that participate in DSRIP as a single Performing Provider System, as described in paragraph (b) below. Coalitions must specify their outpatient beneficiary population based on the attribution model described in paragraph (c) below.

a. Assessment of Safety Net Provider Status

The state will use data from DSH audits and other available information to make an assessment of which providers in the state could be eligible for DSRIP funding, consistent with STC 2 in section IX. This list of providers will be submitted to CMS and will be publicly available on the state's website. Performing Provider Systems are expected to continue serving a high proportion of Medicaid and uninsured patients throughout the duration of the demonstration, and significant deviation from these standards will be cause to discontinue DSRIP funding for the Performing Provider System after the mid-point assessment.

b. Coalitions

Eligible major public general hospitals and other safety net providers are encouraged to form coalitions that apply collectively as a single Performing Provider System. The state will review each of the proposed Performing Provider Systems and may require additional connectivity to additional medical, behavioral health, long term care, developmental disabilities or social service providers as required to build a comprehensive regional performance network. Coalitions will be evaluated on performance on DSRIP milestones collectively as a single Performing Provider System. Coalitions are subject to the following conditions:

i. Coalitions must designate a lead coalition provider who is primarily responsible for ensuring that the coalition meets all requirements of performing provider systems, including reporting to the state and CMS. In the process of formally approving each Performing Provider System, the state shall articulate a set of standards that each lead entity must follow including specific rules on project oversight, performance payment distribution and other required legal and operational obligations of the lead entity.
ii. Coalitions must establish a clear business relationship between the component providers, including a joint budget and funding distribution plan that specifies in advance the methodology for distributing funding to participating providers. The funding distribution plan must comply with all applicable laws and regulations, including, without limitation, the following federal fraud and abuse authorities: the anti-kickback statute (sections 1128B(b)(1) and (2) of the Act); the physician self-referral prohibition (section 1903(s) of the Act); the gainsharing civil monetary penalty (CMP) provisions (sections 1128A(b)(1) and (2) of the Act); and the beneficiary

inducement CMP (section 1128A(a)(5) of the Act). CMS approval of a DSRIP plan does not alter the responsibility of Performing Provider Systems to comply with all federal fraud and abuse requirements of the Medicaid program.

iii. Coalitions must have a plan for reporting, decision-making, change management, and dispute resolution on performance and incentive payments.

iv. Each coalition must in the aggregate meet the minimum outpatient beneficiary requirements specified in paragraph (d) below.

v. For coalitions that involve public hospitals that are providing Intergovernmental Transfer (IGT) funding for a project, the public entity providing IGT funding will generally be the lead coalition provider for the Performing Provider System that is directly using the IGT match. Private safety net providers can also service as coalition leads as provided in paragraph (d) below.

vi. Each coalition must have a data agreement in place to share and manage patient level data on system-wide performance consistent with all relevant HIPAA rules and regulations.

c. DSRIP Beneficiary Attribution Method

The goal of DSRIP is to have each Performing Provider System responsible for most or all Medicaid beneficiaries in the given geography or medical market area. It is expected that most of the Medicaid beneficiaries (including dually eligible members) in the state will be attributed to a Performing Provider System. The possible exceptions are beneficiaries that are primarily being served by providers not participating in any Performing Provider System in the region. However, given the comprehensive nature of DSRIP, it is expected that each approved Performing Provider System will include all of the major providers of Medicaid services in their region, greatly reducing the number of beneficiaries not attributed to any Performing Provider System. A beneficiary will only be attributed to one Performing Provider System, based on the methodology described below.

Performing Provider Systems must include a proposed target population, including a specific geography for the overall performing provider effort. Each Performing Provider System will be approved for a specific geography, consisting of one or more counties, based on their application and the state's review. This specific geography will be utilized to form a service area for the purpose of attribution. Utilizing the proposed geography, for each DSRIP Project Plan submitted by a given Performing Provider System, the department will identify the Medicaid and uninsured beneficiaries' population (if applicable) that will be attributed to that system prospectively at the start of each measurement year. This prospective attribution denominator for DY 1 will be used in valuation for payment purposes without any adjustments applied, except at the midpoint evaluation as specified in section VI.d. The attributed members will be the collective focus for all projects.

Matching Goal - The aim of the attribution process is to help assign a DSRIP participants to the best Performing Provider System based on the recipient's current utilization patterns, including assigned care management and primary care provider as well as the geographical appropriateness of that system. This means beneficiaries will be assigned to Performing Provider Systems, in

their region, which include the providers most responsible for their care (as determined based on visits to primary service types -including PCP - as described below). The attribution logic will test for a plurality of visits within the Performing Provider System. Plurality, for DSRIP purposes, means a greater proportion of services as measured in qualifying visits within the Performing Provider System than from services outside the Performing Provider System.

Two Forms of Attribution:

DSRIP Attribution will come in two forms. The first form of attribution will be to initially assign a given cohort of patients to each Performing Provider System. This will be a 1 to 1 match between a Performing Provider System and each attributable Medicaid and uninsured member (uninsured members will be attached at the aggregate county level based on census data). This first form of attribution will be called *Attribution for Initial Valuation*. The second form of attribution will be for performance measurement purposes and will be done at the conclusion of each measurement year to create an appropriate group of members for DSRIP performance measurement purposes – this form of Attribution will be called *Attribution for Performance Measurement*.

Attribution for Initial Valuation:

This initial attribution is done for two basic purposes. The first purpose is to create a number of Medicaid and uninsured lives for use in the calculation of potential performance awards as part of the DSRIP valuation process. The second purpose is to create an initial group of Medicaid members only for initial performance benchmark development. Attribution for Initial Valuation will follow a logic flow based first on 1) the type of PPS and then 2) the population subcategory the given Medicaid member falls into.

PPS Type and Attribution*:*

Three PPS Types will be recognized for the purpose of attribution:

1) Single PPS in a Region;
2) Multi PPS in Region –Public Hospital Led/Involved; and
3) Multi PPS – Non Public Hospital Involved.

Single PPS in a Region - If a PPS is the only PPS approved by the state in a defined region then all the Medicaid members receiving services in that region will be attributed to that single PPS. As previously promised by the State, the single PPS in a region will also receive all the non-utilizing Medicaid members (i.e., members enrolled in Medicaid but not receiving any Medicaid paid services) residing in their approved region in their attribution. In addition, the single PPS will receive all the uninsured residing in their approved region if they agree to do the 11th DSRIP project targeted to the uninsured.

Multi PPS in Region - Public Hospital Led/Involved – If a PPS that includes a major public hospital in their network (as lead, co-lead, or network partner) is approved in a region where there is at least one other approved PPS, then the public led/involved PPS will receive all

utilizing Medicaid members (with the exception of some low utilizing Medicaid members – see below) that get most of their services from the PPS network through the loyalty assignment methodology described below. This public led/involved PPS will also be given the first opportunity to develop an 11th project specifically designed to serve the uninsured in its region. If this public led/involved PPS opts to do that 11th project, they will then also have all the uninsured members residing in their approved region attributed to their PPS for initial valuation. This public led/involved PPS will also receive (for attribution for payment purposes and again only if they do the 11th project) a cohort of non-utilizing and low use Medicaid members in the region. Low use members are those that meet a state definition of lower use designed to target members with use patterns that appear to not be coordinated by PCP or care manager during the attribution period (e.g., ED visits with no evidence of PCP access, Inpatient visits with no primary care etc.). All of these low use members may however be included in the attribution denominators for measurement purposes (and baseline data) based on their current access patterns. This cohort of non-utilizing and low utilizing members will be utilized in attribution and valuation for all Public hospital Led/Involved PPSs and any non-public PPSs approved to do the 11th project as discussed below. This non-utilizing and low utilizing cohort will be determined at the conclusion of the DSRIP application review.

Multi PPS – Non Public Involved – If the PPS is approved in a region that contains at least one other PPSs approved for all or part of their approved region (Multi PPS) and this region does not include a major public hospital as a major partner in their network, then this non-public involved PPS will receive attribution of utilizing Medicaid members that get most of their services from their PPS network in the loyalty assignment methodology described below. This Multi-PPS (non-public) type is only eligible to receive uninsured and a cohort of low/non-utilizing Medicaid members under one of two scenarios – 1) there is no public PPS in the region or 2) there is a public PPS in the region but the public PPS has opted not to do the 11th project. If scenario 1 or 2 materializes, the Non Public PPS(s) would then have the option to elect to pursue the 11th project. If the non-public PPS(s) decides to pursue the 11th project, they will then be eligible to receive uninsured and a cohort of low/non-utilizing Medicaid members in their attribution. If a public led/involved PPS is approved in the region and that public PPS opts not to do the 11th project, then the non-Public involved PPS(s) in the region will be offered an opportunity to do so. If the non-public PPS(s) selects the 11th project, under such circumstances then they will be assigned the uninsured members residing in their approved PPS region in the attribution for initial valuation based on the percentage of Medicaid members assigned to the PPSs in the region (e.g., if a given Non Public PPS has 60 percent of the region's Medicaid population attributed then they will get 60 percent of the uninsured members). So, if no public led PPS exists in the region or the public declines to do the 11th project, the uninsured members will be divided between any Non-public PPS(s) (once the opt to do the 11th project) based on the percentage of Medicaid members assigned to the PPSs in the region. Also, the cohort of the low/non utilizing Medicaid population will be attributed to the any Non-public PPS(s) using the same method as the uninsured are distributed; again they will be assigned this population only if they opt to do the 11th project.

Attribution for Payment Logic based on PPS Type:

PPS Type	Medicaid Regular[1] Utilizers Attribution	Medicaid Non/Low Utilizers Attribution	Uninsured Attribution
Single PPS in Region	All in the defined region	All in the defined region	All in the defined region if the PPS opts for the 11th project.
Multi PPS in Region - Public Led/Involved	Based on attribution loyalty logic	Cohort in the defined region if the PPS opts for the 11th project	All in defined region if PPS opts for 11th project
Multi PPS – Non Public Involved	Based on attribution loyalty logic	None - unless no public PPS in the region or the public PPS opts not to do the 11th project. In addition, this PPS would need to do the 11th project and Non/Low attribution will then be based on PPS MA attribution percentage in region.	None - unless no public PPS in the region or the public PPS opts not to do the 11th project. In addition, this PPS would need to do the 11th project and uninsured attribution will then be based on PPS MA attribution percentage in region.

Attribution Logic – Loyalty Based Attribution for Regions with Multiple PPS

Utilizing Medicaid Members will be attributed first based on what population subcategory they belong to and second based on the attribution loyalty logic that has been specifically designed for that given subpopulation by the state.

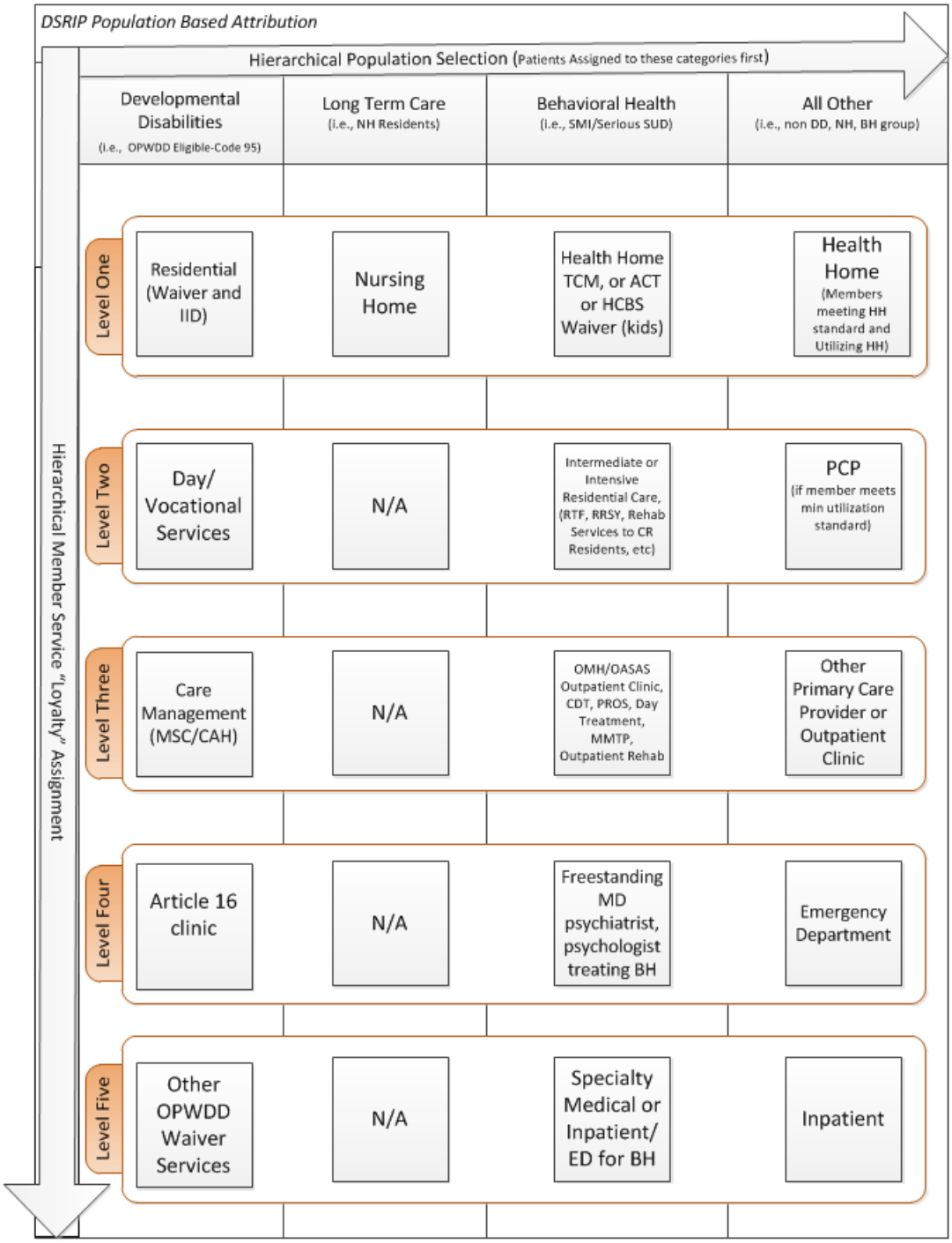
Four mutually exclusive population subcategory groupings have been set up for DSRIP purposes:

- Developmental Disabilities (OPWDD Service Eligible – Code 95)
- Long Term Care (Only NH residents)
- Behavioral Health (SMI/Serious SUD)
- All Other

Medicaid members will be placed into one of these population subcategories based on a mutually exclusive hierarchy in the order presented above. In other words, the logic will first look for evidence of Developmental Disabilities and if none exists then evidence of Long Term Care and if none exists then Behavioral Health and if none exists then the member will be assigned to All Other. So, for example, if the member meets criteria for developmental disabilities and long term care they will be assigned to development disabilities as that is first in the hierarchy. Similarly, if a member does not meet criteria for developmental disabilities but does meet criteria for both long term care and behavioral health they will be assigned to long term care.

After a member is assigned to a population subcategory they will then been assigned to a PPS based on a loyalty algorithm that is specific to their population subcategory. For instance, if they have been assigned to the behavioral health subcategory the algorithm will check first for care management/health home connectivity and if none exists go on to look for residential connectivity and then ambulatory and so on in hierarchical order.

The following graphic helps to illustrate the overall process.



It should be noted that the majority of members will be attributed from within the "All other" category above. It is estimated that over 80 percent of Medicaid members will be attributed from within that category. Further, while some members in the All Other category with multiple chronic illness will be attributed based on their health home care management agency, clearly most of the All Other members are going to be attributed to a DSRIP network based on their health plan assigned PCP as most patients are in health plans and many of those members are

utilizing their assigned PCP. If a non-health home member in the "All Other" is not utilizing the assigned PCP they will then be attributed based upon the primary care provider or clinic that they see most often for ambulatory care. If no ambulatory care exists they will then be attributed based upon emergency department and then inpatient use if necessary. *Irrespective of the final attribution, each PPS will be required to make ongoing efforts to work with health plans and providers to align care management, PCP and specialty services for all attributed members in such a way to fully leverage existing positive clinical relationships.*

The results of the preliminary attribution process above will be shared with the Medicaid Managed Care organizations for their enrolled members. The MCOs will review the state's attribution logic/results and suggest any needed changes based on more current member utilization information including more recent PCP assignment or specialty service access. In advance of this attribution process the state will share the DSRIP Performing Provider System network with the plan to identify any network alignment gaps that may exist so that the DSRIP Performing Provider System and the MCOs can work together to align service delivery and plan contracted networks as appropriate.

PPS Networks and Attribution - Once the Performing Provider System network of service providers is finalized the each Performing Provider System service network will be loaded into the attribution system for recipient loyalty to be assigned based on visit counts to the overall Performing Provider System network in each of the above hierarchical population subcategories. Once the initial attribution is calculated for the purposes of setting DSRIP project values, the performing provider system network may only be changed with a DSRIP plan modification (as described in section X.a below). For each of these population subcategories, the algorithm will check the services provided by each provider and accumulate these visits to the Performing Provider System the given provider is partnered with. If a recipient is currently outside the Performing Provider System geographic area, the visits are excluded (e.g. recipient traveling from upstate to NYC for special surgery). Each Performing Provider System associated with the matched provider accumulates the total number of visits for each service/provider combination. Adjustments to attribution based on known variables (e.g, recent changes to the recipient's address) may be made by the state with MCO input if deemed necessary by data. After all visits against all providers are tallied up for a given service type, the methodology finds the Performing Provider System with the highest number of visits for the recipient in each service loyalty level as appropriate. If a single provider is in more than one PPS network (e.g, PCP) then the tie breaking method below may be employed for final matching purposes. This overall process will be designed to ensure that the Performing Provider System that is the best fit for the recipient is chosen.

Finalizing Match and Ties - If more than one Performing Provider System has the highest number of visits based on the highest priority service loyalty types noted, the methodology re-runs the above logic across all Medicaid service types. This process could break a tie if additional visits in other service types cause one Performing Provider System to accumulate more visits. So for instance, Nursing Home residents that are in nursing homes with connectivity to multiple PPSs may be placed based on their utilization of hospital or other services. If, however, this still results in a tie, the methodology will place the recipient in a separate bucket to be assigned at the end of the process. Recipients who have no predominant demonstrated

provider utilization pattern will be assigned to a PPS based on a special logic. If the member is not matched from within the Developmental Disabilities, Long Term Care or Behavioral Health population subcategories the Performing Provider System in their geographic region will be chosen by first looking to see if the beneficiary has any primary care provider (PCP) assigned by a Medicaid health plan; if the beneficiary has an assigned PCP the beneficiary will be matched to the Performing Provider System that has that PCP in their network (a method will be developed to address PCPs that are in more than one Performing Provider System). For all population subcategories, if the beneficiary cannot be matched by PCP, then the beneficiary will be assigned to the Performing Provider System with the most beneficiaries already assigned (by the visit attribution method) in their specific zip code or other relevant geographic area. Except for beneficiaries who are explicitly excluded because they receive the majority of their services (more than 50%) at providers that are not participating in DSRIP, all beneficiaries will be attributed.

Attribution for Performance Measurement Purposes

Although the patient populations targeted for Performing Provider System measurement are determined as of January 1 (or other date specified) of the measurement year for valuation purposes, patient attribution for Performing Provider System quality measurement for domain 2 and 3 metrics will be defined as of the measurement period. This is consistent with the CMS Medicare Shared Savings Program (MSSP), where there is an initial, prospective attribution at the start of the measurement year to determine the populations to be included and a final attribution at the end of the year for evaluation and measurement. Each patient will be assigned to only one PPS for measurement purposes. The patient population attributed for valuation will form the basis for quality measurement for all population-based measures (see Metric Specification guide) with the appropriate criteria applied for each measure. For episodic-based measures (see Metric Specification guide), the initial population attributed to each PPS will be limited to only those members seen for that episode of care within the PPS network during the measurement period. Episode of care refers here to all care provided over a period of time (as defined in the measurement specifications) for a specific condition (e.g. Diabetes - all diabetes care received in a defined time period for those members; HIV- all HIV care received in a defined time period for those members). Since PPS networks are non-binding and members can chose to receive care outside of network, it is necessary to protect patient confidentiality for certain highly sensitive medical conditions, as well as, ensure medical records are available to the PPS network for all hybrid measures. For institutional-based measures (see Metric Specification guide) the population for quality measurement will represent the population within that facility.

d. Minimum Outpatient Service Level

Performing Provider Systems must have a minimum of 5,000 attributed Medicaid beneficiaries a year in outpatient settings.

e. Performing Provider System Relation to IGT Entities

Intergovernmental transfer (IGT) entities are entities that are eligible to contribute allowable governmental funds or other non-federal funds for use by the state for the non-federal share of DSRIP payments for a Performing Provider System. They include government-owned Hospitals and other government entities such as counties.

The non-federal share of DSRIP payments to providers will be funded through the use of intergovernmental transfers (IGTs) from government owned or operated major public hospitals or their sponsoring government entity or other affiliated governmental entity, consistent with applicable federal law and regulations. Such IGTs will not be represented on any financial statement by the public hospital as a cost of patient care, overhead, tax, or administrative cost; instead it shall be reflected as a transfer to the state government. For purposes of this section, the major public hospital or their affiliated government or governmental entity are deemed to be one and the same.

No portion of a DSRIP payment paid to a Private Performing Provider system may be redirected to the public entity that is supplying IGTs to finance the non-federal share of such payments. Also, no private provider that is included in a coalition of providers that includes public providers can transfer DSRIP funds to those public providers. Nothing herein precludes or restricts such private provider from making payments to a public provider for services performed or provided by the public provider including DSRIP related services.

The state encourages public and private providers to collaborate where appropriate and will work with Performing Provider Systems to clarify the flow of IGT funding to avoid impermissible provider donations.

III. Projects, Metrics, and Metric Targets

a. Projects

Performing provider systems will design and implement at least five and no more than 10 DSRIP projects, selected from the Strategies Menu and Metrics (Attachment J). Each project will be based on a particular strategy from Attachment J and will be developed to be responsive to community needs and the goal of system transformation, as defined by the objectives in STC 6 in section IX.

All the DSRIP projects for a Performing Provider System will be part of the Performing Provider System's overall DSRIP Project Plan.

There are projects described in Attachment J that are grouped into different strategies, such as behavioral health, within each Domain (System Transformation Projects (Domain 2), Clinical Improvement Projects (Domain 3), and Population-wide Projects (Domain 4). For each strategy, there is a set of metrics that the performing provider system will be responsible for if they do any one of the projects within that strategy.

As described in Attachment J, Performing Provider Systems will select at least two system

transformation projects (including one project to create integrated delivery systems as well as another project from either the care coordination or connecting settings strategies list), two clinical improvement projects (including a behavioral health project), and one population-wide project. The selection of all projects must be based on the community needs assessment of the baseline data and as the target population selected by the performing provider system. Performing Provider Systems may choose additional projects as appropriate.

b. Metrics

In order to measure progress towards achieving each objective, each project must include metrics in all four of the following domains. Performing Provider Systems will report on these metrics in their semi-annual reports (described in VI.a below) and will receive DSRIP payment for achievement of these milestones (based on the mechanism described in VII.a below).

i. Overall project progress metrics (Domain 1)
ii. System transformation metrics (Domain 2)
iii. Clinical improvement metrics (Domain 3)
iv. Population-wide metrics (Domain 4)

Performing Provider Systems that exceed their metrics and achieve high performance by exceeding a preset higher benchmark for reducing avoidable hospitalizations or for meeting certain higher performance targets for their assigned behavioral health population will be eligible for additional DSRIP funds from the high performance fund, described in paragraph VIII.b. below.

The Strategies Menu and Metrics (Attachment J) describes the specific metrics that will be used to assess performance under each domain and specifies which metrics are pay-for-reporting and which are pay-for-performance. Additional measure specifications, including the process for addressing small n issues is described in the Metric Specification Guide supplement to Attachment J.

As described in STC 12.e. in section IX, the state or CMS may add domain 1 metrics to a project prospectively in order to address implementation concerns with at risk projects.

c. Metric Targets

All performing provider systems must have a target for all pay-for-performance metrics, which will be used to determine whether or not the performance target for the metric was achieved. Performance targets should be based on the higher of top decile of performance for state or national data, or an alternative method approved by CMS. NY DSRIP goals for metrics may be based on NYS Medicaid results (preferred source) or national data where possible and on DSRIP DY1 results for metrics where state or national data are unavailable.
Annual improvement targets for Performing Provider System metrics will be established using the methodology of reducing the gap to the goal by 10%. The Performing Provider System baseline data will be established as soon as complete data is available for the baseline period (as specified in the Metric Specification Guide supplement to Attachment J) and will be used as the foundation to determine the gap to goal to set the improvement target.

For example if the baseline data for a measure is 52 percent and the goal is 90 percent, the gap to the goal is 38. The target for the project's first year of performance would be 3.8 percent increase in the result (target 55.8 percent). Each subsequent year would continue to be set with a target using the most recent year's data. For example, should a PPS meet or exceed the first year's target of 55.8 percent, the next annual target would be 10 percent of the new gap to the goal. This will account for smaller gains in subsequent years as performance improves toward the goal or measurement ceiling.

The PPS will know the annual performance target to be achieved at the beginning of the current DY and the method for determining the annual performance target will remain the same throughout the DSRIP years.

In general, Performing Provider System that achieve their target for the DY will be considered to have reached the annual milestone for the metric, and Performing Provider System that achieve 20 percent gap to goal or the 90th percentile of the statewide performance for the high performance metrics listed in Attachment J may be eligible for additional payment for high performance. If more frequent reporting (more than annual) of metric results are required for projects, the reported results for payment should be based on a standard twelve month period.

IV. DSRIP Project Plan Requirements

a. Project Plan Development Process

The proposed project plans should be developed in collaboration with community stakeholders and responsive to community needs. Performing Provider Systems have the option to seek DSRIP design grants described in STC 10 in section IX.

According to a timeline developed by the state and CMS that aligns with the DSRIP deliverables schedule outlined in STC 40 in section IX, Performing Provider Systems must submit a final DSRIP Project Plan to the state for review with a complete budget and all other items described below, consistent with the requirements in STC 8 in section IX.

It is expected that the transformational nature of the activities to be undertaken in these projects will require a strict adherence to disciplined project management. The DSRIP Project Plan must provide evidence that the Performing Provider Systems has a clear understanding of the needs of the service area (based on objective data specific to the service area as well as community input), that the project will address these needs in a significant manner, that the Performing Provider System understands the metrics that will need to be monitored and the methodology that will be used to do such, and that the Performing Provider System has internal and/or external resources that will be available for project management and the required rapid cycle improvements inherently needed in these projects.

b. Organization of DSRIP Project Plan

DSRIP Project Plans must be submitted in a structured format agreed upon by the state and CMS. At a minimum, the plan shall include the following sections:

Attachment I - NY DSRIP Program Funding and Mechanics Protocol

1) **DSRIP Face Sheet**
   This face sheet will list the documents included within the package and include the applicant's name and a brief (no more than 1000 word) executive summary of the submitted project.
2) **Provider Demographics** including:
   a) Name, Address, Senior level person responsible for the DSRIP project and to whom all correspondence should be addressed
   b) The name of providers and their identification numbers participating in the project plan, including the lead provider in the case of a coalition.
   c) Definition of service area (according to the specifications in the DSRIP Strategies Menu and Metrics) and a discussion of how the providers in the coalition relate to (or inform) the service area definition. As further described in the DSRIP Strategies Menu and Metrics, Performing Provider Systems are accountable for improving the quality of care for all Medicaid and low-income uninsured beneficiaries in their service area as defined in the DSRIP Member Attribution Method above.
   d) Identification as a safety net provider with documentation supporting that identification as described in paragraph II.a above.
   e) Current patient population including demographic information, payer mix to document qualification as described in paragraph II.c above.
3) **Identification of Provider Overarching Goals:** The Performing provider system will need to identify its goals for the project, as well as how the project contributes to achieving the overall goals (defined in STC 1 in section IX) to create and sustain an integrated, high performing health care delivery system that can effectively and efficiently meet the needs of Medicaid beneficiaries in their local communities by improving care, improving health and reducing costs. More specifically, the Performing provider system should demonstrate how the project will engage in system transformation (including linking across settings, ensuring appropriate capacity, and taking responsibility for a population), as demonstrated by achievement of avoidable events [including addressing behavioral health]. The Performing provider system will need to demonstrate that it has a governance strategy that ensures that participating providers work together as a "system" and not as a series of loosely aligned providers nominally committed to the same goal. Plans to progressively move from a loosely organized network of affiliated entities to an actual Integrated Delivery System must be evident in the goals.

   The Performing provider system will need to provide objective data-driven evidence that this is a relevant goal for the Performing provider system and its service area. The performing provider system must demonstrate that all relevant Domain 3 metrics for the projects selected align with community needs and that these areas have room for improvement. With the exception of behavioral health Domain 3 measures, for which the following will not apply, if the Performing provider system's performance on the most recent available data (as specified in the Metric Specification Guide supplement to Attachment J) for the majority of any chosen Domain 3 metric set is within 10 percentage points or 1.5 standard deviations to the high performance goal described in section III.c above (whichever is greater) , the project would not be approved.

4) **Identification of Provider Project to meet identified goals,** including brief rationale for project choice and summary (including citations) of existing evidence showing that project can lead to improvement on goals of project. Logic models such as driver diagrams may be helpful to demonstrate how the elements of the project all contribute to the central goals. Further information will be provided in the detailed assessment provided in (5) and must include all relevant domains outlined in the Strategies Menu and Metrics.
5) **Performance Assessment**
   a) Current community health needs (population demographics, types and numbers of providers and services, cost profile, designation as Health Professional Shortage Area, mortality and morbidity statistics, and health disparities): Population demographics should include those who are institutionalized as well as those involved in the criminal justice systems. The assessment will include a discussion of a designated list of public health concerns determined by the state, including behavioral health. The selection of these concerns should be supported by baseline data on current performance on targeted health indicators and quality metrics. A review of the social determinates of health and assessment of disabilities consistent with Olmstead should also be included in such community assessment. Needs assessment should include a review of non-English languages spoken in the Performing Provider System catchment area to guide development of multi-language outreach and education material.
   b) Evidence of regional planning including names of partners involved in the proposed project (in addition to any coalition members in the Performing Provider System in accordance with the process described in paragraph II.b above) Detailed analysis of issues causing poor performance in the project area. These must include assessment of patient co-morbidities, patient characteristics, social system support, system capacity for primary care and disease management, and institutional issues such as finances, confounders to health care system improvement including fragmentation of services, competition, and assessment of regional planning issues.
   c) Comprehensive workforce strategy - this strategy will identify all workforce implications – including employment levels, wages and benefits, and distribution of skills – and present a plan for how workers will be trained and deployed to meet patient needs in the new delivery system based on the performance assessment of community health needs, and how the strengths of current workforce will be leveraged to the maximum degree possible under current state law and regulations.
   d) Review of Financial stability – A complete review of the financial condition of all financially challenged safety net and public providers in the performing provider system.
   e) Evidence of public input into the project including consumer engagement. This should include documentation of collaboration with local departments of public health, public stakeholders and consumers. In addition, the provider will need to document how there will be ongoing engagement with the community stakeholders, including active participation in any regional health planning activities currently underway in their community. Applicants will need to include workers and their representatives in the planning and implementation of their overall project with particular emphasis on the comprehensive workforce strategy. The Performing

Provider System must specifically include evidence of consumer engagement in their needs assessment and planning process. The state may require Performing Provider Systems to maintain a website including contact information, overview of public comment opportunities, results of public processes, application materials, and required reporting.

6) **Work Plan Development:** In this section the provider will provide an initial high-level work plan in a state-approved format using the domains of milestones identified in the DSRIP Strategies Menu and Metrics.

   i. Project progress milestones (Domain 1)
   ii. System transformation and financial stability milestones (Domain 2)
   iii. Clinical improvement milestones (Domain 3)
   iv. Population-wide Milestones (Domain 4)

   The Performing Provider System will need to document their plans to address and implement the project including each of the confounders identified in the Performance Assessment section. This should include resources available to complete the project. The time frame for the work plan will be five years. It is expected that no more than the first two years will be utilized to implement major system changes related to the project. In addition, it is expected that improvements in outcome metrics will begin to occur in that first two year period.
7) **Rapid cycle evaluation:** The plan must include an approach to rapid cycle evaluation that informs the system of progress in a timely fashion, and how that information will be consumed by the system to drive transformation and who will be accountable for results, including the organizational structure and process to oversee and manage this process. The plan must also indicate how it will tie into the state's requirement to report to CMS on a rapid cycle basis.
8) **Establishment of Milestones and Metrics:** A section of the work plan must provide documentation of the monitoring strategy for the project including significant milestones and associated metrics, as specified in the DSRIP Strategies Menu and Metrics.
9) **Budget:** Performing Provider Systems must provide a detailed budget for all 5 years of their DSRIP project. For Performing Provider Systems that were awarded HEAL grants, a detailed budget report along with a description of the similarities or differences must be included.
10) **Governance:** The plan must include a detailed description of how the system will be governed and how it will evolve into a highly effective Integrated Delivery System. A clear corporate structure will be necessary and all providers that participate in the project will need to commit to the project for the life of the waiver. Weak governance plans that do not demonstrate a strong commitment to the success of the project will be rejected. Strong centralized project control will be encouraged especially for projects that require the greatest degree of transformation. The governance model should review the Performing Provider System's need to pursue any state certificate of public advantage (COPA) and Accountable Care Organization (ACO) opportunities. Coalitions must define the members of the coalition and submit all supporting information about coalition governance including the business relationship, as

described in Section II.b. The governance plan must address how the performing provider system proposes to address the management of lower performing members within the Performing Provider System network. This plan must include progressive sanctions prior to any action to remove a member from the performing provider system. The governance plan must also include a process by which the Performing Provider System will progressively advance from a group of affiliated providers to a high performing Integrated Delivery System. The state may provide governance template information for Performing Provider Systems to utilize in the development of their governance models and plans.

11) **Data sharing and confidentiality**: Metrics will be collected in a uniform and valid fashion across all members of a Performing Provider System. The plan must include provisions for appropriate data sharing arrangements that permit this and appropriately address all privacy protections contained in federal law including HIPAA and New York Law.
12) **Expectation of Sustainability:** Performing Provider Systems are asked to explain how the outcomes of this project will be sustained at the end of DSRIP and how gains can be continued after the conclusion of the project period. This should include a financial forecast of expected savings related to the implementation.
13) **Legal Compliance –** Performing Provider Systems must comply with all relevant laws and regulations including compliance with Civil Rights Law and specifically all laws governing non-discrimination.
14) **Signed Attestations*:***
The Performing Provider System will submit a description of any initiatives that the provider is participating in that are funded by the U.S. Department of Health and Human Services and any other relevant delivery system reform initiative currently in place. The Performing Provider System will, by signature, attest that the submitted DSRIP project is not a duplication of a project from these other funded projects and does not duplicate the deliverables required by the former project (s). It should be noted if this project is built on one of these other projects or represents an enhancement of such a project that may be permissible, but it must be clearly identified as such in the DSRIP project plan.

The provider will submit an attestation statement documenting that the information provided in this document is accurate at the time of submission and that the provider, if accepted into the DSRIP, will cooperate fully with the state in the implementation and monitoring of this project and participate in the required learning collaboratives related to this project.

If the Performing Provider System is receiving funds from the Public DSRIP pool it will also provide a description of the IGT source identified for the project and attest that this IGT derives from local, public funds.

V. Project Valuation

The DSRIP project and application valuations will be calculated by the state (with assistance from the independent assessor) according to the methodology described below.

A maximum valuation for each DSRIP application is calculated based on the formula described in Section A below. Once the overall application value is determined, the value for the individual metrics of the DSRIP project plan is determined based on the distribution method described in Section B below. Project values are subject to monitoring by the state and CMS, as described in Section C below, and Performing Provider Systems may receive less than valuation described in their DSRIP plan if they do not meet metrics and/or if DSRIP funding is reduced because of the statewide penalty (described in Section IX.d below)

As a reminder, Performing Provider Systems are to submit a Project Plan with a minimum of 5 projects and (in most cases) a maximum of 10 projects for scoring purposes. In certain instance, a performing Provider System may be eligible to pursue a project plan containing 11 projects. Please see below for project selection requirements per domain.

- Domain 2 Projects - Applicants must select at least two projects from this domain (one of which must be from sub-list *A* and one of which must be from sub-list *B* **or** *C*) but can submit up to 4 projects from Domain 2 for scoring purposes
    - For eligible Performing Provider Systems pursuing 11 projects in their plan, they are allowed to select up to 5 projects from Domain 2 for scoring purposes. Domain 2 project selection must follow the same requirements listed above, but in these instances, there will also be the option for these systems to add project 2.d.i.
- Domain 3– Applicants must select at least two projects from this domain (one of which must be *A. Behavioral Health*), but can submit up to 4 projects from Domain 3 for scoring purposes
- Domain 4 – Applicants must select at least one project from this domain, but can submit up to 2 projects from Domain 4 for scoring purposes.

a. Valuation for DSRIP Application

The maximum DSRIP project and application valuation will follow a five-step process.

1. The first step assigns each project in the Strategy Menu (Attachment J) a *project index score* which is a ratio out of a total of 60 possible points of each project (X/60 = project index score).
2. The second step creates a *project PMPM* by multiplying the project index score by the state's valuation benchmark. The valuation benchmark is pre-set by the state and varies based upon the number of projects proposed by an applicant.
3. The third step determines the *plan application score* for the performing provider's application based on a total of 100 points possible for each application (X/100 = Application Score)
4. In the fourth step, the *maximum project value* is calculated by multiplying the project PMPM, the plan application score, the number of beneficiaries attributed to the project, and the duration of the DSRIP project (see example below).

5. Once the maximum project values have been determined, the *maximum application value* for a Performing Provider System is calculated by adding together each of the maximum project values for a given Performing Provider System's application.

The maximum application value represents the highest possible financial allocation a Performing Provider System can receive for their Project Plan over the duration of their participation in the DSRIP program. Performing Provider Systems may receive less than their maximum allocation if they do not meet metrics and/ or if DSRIP funding is reduced because of the statewide penalty (described in Section IX below).).

Step 1: Calculating Project Index Score

The value of a single project is expressed as an index score (see below). Project index scores are based upon a grading rubric that evaluated the project's ability to transform the health care system. The State has assigned an index score to each project based on the grading rubric and the given project's relative value to the other projects in the state's menu. For application planning, index scores for each project are available to providers in the DSRIP Project Toolkit. These values have been made available to applicants in advance for their application submission.

The formula for the index score for each project on the menu consists of the following elements:

a. Potential for achieving DSRIP goal of system transformation, including the three objectives, as described in STC 6 in section IX (Score 1 (lowest) – 30 (highest))
b. Potential for achieving DSRIP goal of reducing preventable events, as described in STC 1a in section IX (Score 1– 10)
c. Scope of project and capacity of project to directly affect Medicaid and uninsured population (1-10)
d. Potential Cost Savings to the Medicaid Program (1-5)
e. Robustness of evidence base (1-5)

Adding up the scores for each element for a given project will give each project an index score of X/60. The project index score (out of the 60 possible points) will be expressed in decimal form for calculation purposes.

Step 2: Calculating Project PMPM

Each project will be assigned a valuation benchmark based on the number of projects proposed in the application as described in Table 1 below.

By no later than 15 days after the public comment period for initial DSRIP applications, the state will establish a state-wide valuation benchmark based on its assessment of the cost of

similar delivery reforms. This value will be expressed in a per member per month (PMPM) format and may not exceed $15 PMPM, as described in STC 9 in section IX.

For the purposes of the example described later in this section, an initial $8 PMPM valuation benchmark is used in Table 1 below. However, because projects serving more beneficiaries will have synergistic properties and economies of scale that will lower a project's per member per month cost, the final valuation benchmark will be set based on the overall scope of applications received. Table 1 (below) will be updated to reflect the final valuation benchmark developed by the state in accordance with CMS's guidelines.

Because additional projects will have synergistic properties, from leveraging shared infrastructure and resources, the valuation benchmark is discounted as follows for Performing Provider Systems selecting multiple projects. Although the project PMPM levels drop with the inclusion of additional projects, the overall Performing Project System valuation will generally increase (depending on the value of the actual projects selected) as more projects are added to the overall PPS effort. If the valuation benchmark is adjusted based on the process described above, the relative discount factor for additional projects beyond will remain the same.

Table 1. Valuation benchmark table (PMPMs may be revised according to the schedule described above, subject to the standards described in STC 9 in section IX)

Number of projects	Valuation Benchmark
5 (minimum)	$8.00
6	$7.20
7	$6.80
8	$6.65
9	$6.50
10	$6.50
11 (only for eligible PPS)	$6.50

The valuation benchmark is then multiplied by the project index score to create a project PMPM for each project.

Step 3: Plan Application Score

Based on their submitted application, each project plan will receive a score based on the fidelity to the project description, and likelihood of achieving improvement by using that project. This plan application score will be used as a variable in calculating the maximum project value.

Each plan application score will be expressed as a score out of 100, which will drive the percent of the maximum project valuation for each project that will be allocated to that individual project plan. The plan application score (out of the 100) will be expressed in decimal form when calculating the maximum application valuation. The state will develop a rubric for the individual plan application score in collaboration with CMS. This rubric must include an assessment of whether each proposed project is sufficiently different from other DSRIP projects selected (and other existing projects being funded by other sources) so as to ensure that the Performing Provider System does not receive double-credit for performing similar activities.

Performing Provider Systems eligible for and approved to deliver project 2.d.i ("the 11th project") will be awarded an application bonus to reflect the extra effort needed to address the project's target population. The total Project Plan application score, including the 11th Project Application bonus points, can't exceed 100 points (i.e.: If an application score, before the addition of the bonus points, is a 95- then the maximum bonus added to that PPS application would be 5 point for a total score of 100). Applications will also be scored based on an applicant's commitment to developing a capability to responsibly receive risk-based payments from managed care plans through the DSRIP project period.

Step 4: Calculating Maximum Project Value

The number of beneficiaries attributed to the project (based on the attribution method described in Section III above) and the anticipated duration (expressed in months) of the applicant's participation in DSRIP program will also be used to calculate the maximum value for each project as follows.

Maximum Project Value = [Project PMPM] x [# of Beneficiaries] x [Plan Application Score] x [DSRIP Project Duration]

Step 5: Calculating Maximum Application Value

Once the Maximum Project Value for each of the projects in the Performing Provider System application is calculated, the maximum project values for each of the project are then added together to provide the Maximum Application Value for the DSRIP application.

Example: Putting it all together - Below is a simple example of the DSRIP valuation calculation:

For illustration purposes, a Performing Provider System submits six projects in their application. Two projects are from Domain Two; Creating an Integrated Delivery System, and Expand Access to Primary Care , and three projects from Domain Three; Integration of Behavioral Health in Primary care, Development of Evidence Based Medicine Adherence programs, and

HIV Services Transformation and one project from Domain Four; Evidence Based Strategies to Prevent Substance Abuse and Other Mental/Behavioral Disorders. Scoring steps are included below but all numbers are for illustration purposes only and do not reflect on the actual values that the example projects will receive.

Step 1: Calculating Project Index Scores (for illustration purposes) Project Index Scores

- Project 1: Creating an Integrated Delivery System 56/60=.93
- Project 2:Create a Medical Village (Hospital) 54/60=.9
- Project 3: Integration of Behavioral Health in Primary care 39/60=.65
- Project 4: Evidence Based Medicine Adherence 29/60=.48
- Project 5: HIV Services Transformation 28/60=.47
- Project 6: Strategies to Prevent SUD and BH Disorders 20/60=.33

Step 2: Calculating Project PMPM (numbers below are for illustration only):

Since there are six projects in this example application, the valuation benchmark is $7.20 (for a six project application - from the table in step 2 above). Each of the Project Index Scores (from Step 1) are then multiplied by Valuation Benchmark to compute the individual Project PMPMs.

[Project Index Score] X [Valuation Benchmark] =Project PMPM (see table below)

	Project Index Score	Valuation Benchmark	Project PMPM
Project 1	0.93	$7.20	$6.70
Project 2	0.9	$7.20	$6.48
Project 3	0.65	$7.20	$4.68
Project 4	0.48	$7.20	$3.46
Project 5	0.47	$7.20	$3.38
Project 6	0.33	$7.20	$2.38

Step 3: Calculating Plan Application Score

Performing Provider System submits a six project Performing Provider System application and receives a plan application score of 85/100. As part of the 15 point reduction from a perfect score, the Performing Provider System received a reduction because the Performing Provider System selected two projects that share the same metric set.

Step 4 and 5: Calculating Maximum Project Value and Maximum Application Valuation

The attribution assessment completed by the provider in their application (and subsequently verified by the State's attribution method and independent assessors) shows 100,000 beneficiaries are expected to be served by the applicant's DSRIP project.

As a result, the maximum application value is calculated as $138,108,000, as illustrated below.

	Project PMPM	**# of Beneficiaries**	**Project Plan Application Score**	**# of DSRIP Months**	**Maximum Project Value**
Project 1	$6.70	100,000	0.85	60	$34,170,000
Project 2	$6.48	100,000	0.85	60	$33,048,000
Project 3	$4.68	100,000	0.85	60	$23,868,000
Project 4	$3.46	100,000	0.85	60	$17,646,000
Project 5	$3.38	100,000	0.85	60	$17,238,000
Project 6	$2.38	100,000	0.85	60	$12,138,000
			Maximum Application Valuation		**$138,108,000**

b. Metric valuation

Once the overall project valuation is set, incentive payment values will be calculated for each metric/milestone domain in the DSRIP project plan by multiplying the total valuation of the project in a given year by the milestone percentages specified below.

Metric/Milestone Domains	Performance Payment*	Year 1 (CY 15)	Year 2 (CY 16)	Year 3 (CY 17)	Year 4 (CY 18)	Year 5 (CY 19)
Project progress milestones (Domain 1)	P4R/ P4P	80%	60%	40%	20%	0%
System Transformation and Financial Stability Milestones (Domain 2)	P4P	0%	0%	20%	35%	50%
	P4R	10%	10%	5%	5%	5%
Clinical Improvement Milestones (Domain 3)	P4P	0%	15%	25%	30%	35%
	P4R	5%	10%	5%	5%	5%
Population health Outcome Milestones (Domain 4)	P4R	5%	5%	5%	5%	5%

** P4P is pay for performance; P4R is pay for reporting.*

Within each metric/milestone domain and pay-for-performance/ pay-for-reporting grouping, the value for each metric/milestone will be equally divided between all metrics in a given grouping per the process that follows.

Providers will receive DSRIP payments based on achievement of reporting milestones (P4R) and/or performance targets for metrics (P4P) for a given project during a performance period. Within each project, the value for achieving each performance target/milestone is the same (evenly weighted) and will be calculated as "meeting" or "not meeting" the performance target/milestone. The points given for reaching a specified performance target/milestone will be called an Achievement value and will be calculated as a 0 or 1 value. If a performance target or reporting milestone is met, the Performing Provider System will receive an AV of 1 for that performance target/milestone in that reporting period. If the Performing Provider System does not meet its milestone or performance target, the Performing Provider System will receive an AV of 0 for that reporting period. This will be done across every project in every domain. Performing Provider System improvement targets will be established annually using the baseline data for DY 1 and then annually thereafter for DY2-5. High level performance targets will be provided by the State using results from managed care reporting data in DY1 and using results from DSRIP projects in DY2-DY5 as described in metric targets in Section III c. The Achievement value for P4P metrics will be established by comparing the Performing Provider System result for the reporting period with the improvement target for the Performing Provider System. If the Performing Provider System meets the improvement target for the metric, the Performing Provider System will receive an AV of 1. If the Performing Provider System result also meets a high performance threshold, there may be additional payment through High Performance fund, which is not included in this part of the payment calculation.

AVs will then be grouped into either a pay-for-reporting (P4R) or a pay-for-performance (P4P) bucket for each domain. The P4P and P4R AVs in each domain will be summed to determine the Total Achievement Value (TAV) for the domain. A Percentage Achievement Value (PAV) will then be calculated by dividing the TAV by the maximum AV (the total number of metrics) for P4P and P4R in each domain. The PAV will demonstrate the percentage of achieved metrics within the P4R and P4P metrics for each domain for that reporting period.

Example: A Performing Provider System has a project in year one with a project level valuation of $100,000 for year one. If the Performing Provider System achieves two out of five of its metrics/milestones for that project it would receive 40 percent of the $100,000 or $40,000. The metrics/milestone value would be assigned AV and PAVs as follows:

Metric/Milestone	***Achievement***	***AV***
Milestone 1	*Achieved*	*1*
Milestone 2	*Achieved*	*1*
Milestone 3	*Not Achieved*	*0*
Milestone 4	*Not Achieved*	*0*
Milestone 5	*Not Achieved*	*0*
	TAV	*2*
	PAV 2/5	*40%*

The PAV will be used to determine the level of the total payment the provider has earned for that reporting period based upon the performance payment distribution provided under the metric valuation. The level of payment for a provider within a domain will be proportionate to the PAV allocated to that domain. Additionally, the Performing Provider System will be eligible for bonus payments by reaching separate high performance targets described in Section III and Attachment J.

c. Project Value Monitoring

Performing Provider Systems will be required to develop budgets and report on DSRIP project spending throughout the demonstration. As described in paragraph VI.c below, CMS reserves the right to review project values to ensure that the project value index, the population denominator, and the overall project valuation are calculated correctly.

VI. DSRIP Project Plan Review Process

a. Overview of Review Responsibilities

Each Performing Provider System that elects to participate in the DSRIP program must submit a DSRIP Plan in accordance with the DSRIP Plan guidelines outlined in section IV of this Project Funding and Mechanics protocol, Attachment J: DSRIP Strategies Menu and Metrics, and the demonstration's Special Terms and Conditions. Performing Provider Systems are expected to provide accurate information in their DSRIP plans and respond to the state and CMS's requests for additional information and/or plan revisions in accordance with the timelines specified.

The state is responsible for reviewing all DSRIP plans using a CMS-approved checklist and other review process requirements described below. The state's review will be supplemented by

an independent assessment of DSRIP plans and a public engagement period, which should inform the state's decision of whether to approve a DSRIP plan.

CMS will monitor the state's review process and approve projects in accordance with section VI.c. below.

All Performing Provider Systems will be subject to addition review during the mid-point assessment, at which point the state may require DSRIP plan modifications and may terminate some DSRIP projects, based on the feedback from the independent assessor, the public engagement process and the state's own assessment of project performance. CMS will also monitor this mid-point assessment review process and make determinations in accordance with V.d

b. State-level Review Process

i. *DSRIP plan review checklist*

On or before September 1, 2014, the state will submit the state's approach and review criteria for reviewing DSRIP Project Plans, as well as a draft DSRIP Plan Initial Review Checklist that will be used in the state's initial review of DSRIP Plans to CMS.

CMS and the state will work collaboratively to refine the criteria, approach, and DSRIP Plan Checklist to support a robust review process and compelling justification for approval of each project. The state (with support from the independent assessor) will apply the CMS approved review process to ensure that DSRIP Plans are thoroughly and consistently reviewed.

At a minimum, the DSRIP Plan Checklist shall include the following criteria:

A. The plan is in the prescribed format and contains all required elements described herein and is consistent with special terms and conditions.
B. The plan conforms to the requirements for Domains 1, 2, 3, and 4 as described herein, as well as in Attachment J: DSRIP Strategies Menu and Metrics
C. The plan clearly identifies goals, milestones, metrics, and expected results.
D. The description of the project is coherent and comprehensive and includes a logic model clearly representing the relationship between the goals, the interventions and the measures of progress and outcome.
E. The project selection is grounded in a demonstrated need for improvement at the time that the project is submitted and is sufficiently comprehensive to meaningfully contribute to the CMS three part aim for better care for individuals, better health for the population, lower costs through improvement (i.e. Triple Aim), and while at the same time charting a path towards future sustainability.
F. The likelihood for success of this intervention is based on, where available, accurate and robust citations to the evidence base.
G. The plan includes an approach to rapid cycle evaluation that informs the system of progress in a timely fashion, and how that information will be consumed by the system to drive transformation and who will be accountable for results, including the organizational structure and process to oversee and manage this process. The plan must also indicate how it will tie into the state's requirement to report to CMS on a rapid cycle basis.

H. The plan includes a detailed description of project governance. Included in the description will detailed accounting of how decisions will be made and what corporate structure will be used throughout the life of the project. A clear description of the powers granted to the project's corporate entity by participating providers must be described as well as what the governance plan is beyond the waiver period. The governance plan must address how the Performing Provider System will address management of lower performing providers in the Performing Provider System network.
I. The goals are mapped to a robust and appropriate set of research hypotheses to support the evaluation.
J. There is a coherent discussion of the Performing Provider System's participation in a learning collaborative that is strongly associated with the project and demonstrates a commitment to collaborative learning that is designed to accelerate progress and mid-course correction to achieve the goals of the project and to make significant improvement in the outcome measures specified.
K. The amount and distribution of funding is in accordance with Section V of this protocol "Project Valuation."
L. The plan, project, milestones, and metrics are consistent with the overall goals of the DSRIP program.
M. The plan where necessary includes specific goals, projects, milestones and metrics focused on directly and aggressively addressing any provider financial stability issues.

ii. Independent assessment and public engagement process

The state must identify an independent entity ("independent assessor") to conduct an impartial review of all submitted DSRIP plans. The independent assessor will first conduct an initial screen of DSRIP plans to ensure that they meet the minimum submission requirements.

The independent assessor will notify the Performing Provider System in writing of any initial questions or concerns identified with the provider's submitted DSRIP Plan and provide an opportunity for Performing Provider Systems to address these concerns.

After determining which DSRIP plans meet the minimum submission criteria, the independent assessor will convene a panel of relevant experts and public stakeholders to assist with the scoring of projects, in a manner similar to a federal grant review process. The independent assessor will ensure that standards are followed to prevent conflict of interest in the panel scoring process.

iii. Consumer Education Campaign

The state will conduct a statewide consumer education campaign through a competitively selected contractor with a proven track record in conducting large public education campaigns. The consumer education campaign will focus on development of educational materials and marketing efforts to help educate Medicaid and uninsured members about the benefits of the DSRIP program and the services available through local Performing Providers Systems. Campaign materials will be developed in multiple languages.

iv. State assessment

According to a timeline developed by the state and CMS that aligns with the DSRIP deliverables schedule outlined in STC 40 in section IX, the state will make its official, initial determination on each timely submitted DSRIP Plan based on the findings of the independent assessor and the outside review panel. Any deviations from the independent assessor's recommendations should be clearly explained to CMS.

The state will notify the provider system in writing that the plan has been approved and submitted to CMS.

During the state review process, including by the independent assessor and before the state notifies the provider system of an approval, the state will make adjustments to these reviews to accommodate any systemic gaps that CMS identifies in its review of a sample of plans as provided in VI.c. Any revisions to the reviews will be applied to all plans.

c. CMS Monitoring Process

In addition to approving the review protocol, CMS will review a sample of plans reviewed by the independent assessor and by the state to determine whether the protocol was followed, will identify any systematic gaps between the protocol and the actual reviews, and will provide such findings to the state to address these gaps in reviews by the independent assessor and by the state. CMS reserves the right to do a second sampling following notification by the state that the review processes were revised and after the independent assessor and the state complete additional reviews. Assuming that CMS finds that the reviews are consistent with the review protocol, CMS will accept the state's recommendations for approval with the following possible exceptions which will be applied at CMS's discretion:

i. The state's decision about approval is not consistent with the independent assessor
ii. The plan is an outlier in the valuation schema
iii. There is evidence in the plan, or exogenous information made available to CMS that calls into question for the independent assessor or the state of funding duplication
iv. There is evidence in the plan, or exogenous information made available to CMS calls into question whether the project is new or significantly expanded or enhanced from a project already underway.

CMS will complete its review according to a timeline developed by the state and CMS that aligns with the DSRIP deliverables schedule outlined in STC 40 in section IX. CMS reserves the right to conditionally approve plans, and to allow modifications to plans to resolve issues it identifies in its review provided that the modifications are made to the plan and found acceptable by CMS according to the timeline provided by CMS.

d. Mid-point Assessment

The state's mid-point assessment review will be developed in collaboration with CMS. All DSRIP plans initially approved by the state must be re-approved by the state in accordance with the CMS approved review protocol in order to continue receiving DSRIP funding in DY 4 and 5.

The state will use and independent assessor and public engagement process similar to the process used for the initial approval of projects, described in paragraph b.ii above.

The state will submit to CMS for approval, on or before October 1, 2016, draft mid-point assessment review criteria, a description of its approach to review, and a draft DSRIP Plan Mid-point Assessment Checklist that will reflect the approved criteria and will be used in the assessment. CMS and the state will work collaboratively to refine the criteria, approach, and DSRIP Plan Checklist. The state will apply these criteria to ensure that DSRIP projects are thoroughly and consistently reviewed. Where possible, the state will notify providers in advance of the mid-point assessment if providers need to make changes in order to comply with the approved review criteria.

During DY 3, the independent assessor will work with the state to conduct a transparent mid-point assessment of all DSRIP projects using CMS-approved criteria. This review will provide an opportunity to modify projects and/or metrics in consideration of learning and new evidence. The independent assessor will conduct a focused review of certain high-risk projects identified by the state, CMS or the independent entity based on information provided for all projects in the provider's monitoring reports.

The mid-point assessment review will, at a minimum, include an assessment of the following elements:

i. Compliance with the approved DSRIP project plan, including the elements described in the project narrative;
ii. Compliance with the required core components for projects described in the DSRIP Strategies Menu and Metrics, including continuous quality improvement activities;
iii. Non-duplication of Federal funds;
iv. An analysis and summary of relevant data on performance on metrics and indicators to this point in time;
v. The benefit of the project to the Medicaid and uninsured population and to the health outcomes of all patients served by the project (examples include number of readmissions, potentially preventable admissions, or adverse events that will be prevented by the project);
vi. An assessment of project governance including recommendations for how governance can be improved to ensure success. The composition of the performing provider system network from the start of the project until the midpoint will be reviewed. Adherence to required policies regarding management of lower performing providers in the network will be reviewed with a special focus on any action with regard to removing lower performing members prior to DY 4 and 5. (Note: Modifying coalition members requires a plan modification);
vii. The opportunity to continue to improve the project by applying any lessons learned or best practices that can increase the likelihood of the project advancing the three part aim; and
viii. Assessment of current financial viability of all providers participating on the DSRIP project.

Based on the recommendations by the independent assessor, the state or CMS may require prospective plan modifications that would be effective for DYs 4 and 5, including adjustments to project metrics or valuation. Significant changes to the number of Medicaid beneficiaries attributed to a Performing Provider System will require adjustments to the project valuation.

The state will review all modifications resulting from the mid-point assessment prior to CMS review and consideration, consistent with the process for review of plan modifications, described in section X. Future DSRIP payment for a provider may be withheld until the necessary changes as identified by the mid-point assessment are submitted (and all other requirements for DSRIP payment are met).

VII. Reporting Requirements and Ongoing Monitoring

Performance management and assessment of DSRIP will occur throughout its duration and will take several forms. Each area of assessment is interrelated to ensure a continuous cycle of quality improvement and shared learning. The final project work plans will provide the basis for monitoring each project.

1. Ongoing provider-level evaluations will occur on a regular basis, as described below, and seek to provide timely and actionable feedback on the initiative's progress, in terms of infrastructure changes, implementation activities and outcomes. The formative evaluation, or performance management, will track and report regularly on actions, performance on objective attainment and overall progress towards achieving a health care system based on the improving health, improving care, and reducing costs, and progress toward achieving the primary goals of DSRIP, to reduce avoidable hospitalization and seek improvements in other health and public health measures by transforming systems.
2. Learning collaboratives will be implemented to seek peer-to-peer (provider-to-provider) and community stakeholder input on project level development of action plans, implementation approaches and project assessment. New York will be responsible for leading the collaborative approach to ensure effective sharing of information (e.g. best practices, case studies, challenges, results). The schedule for the collaboratives meeting will be shared with CMS.
3. On a quarterly basis, the state will publish on its website project-by-project status updates which will show available data that reflects each strategy's progress on metrics and indicators, as relative to pre-approved targets.
4. A mid-point assessment (end of the third year) will be completed by an independent assessor. The midpoint assessment which will provide independent quantitative analysis of DSRIP planning and implementation through December 2016, as well as timely qualitative research findings which will provide context for reports on provider's progress in planning and implementing selected DSRIP programs. The qualitative findings will contribute to understanding implementation issues which go beyond the quantitative analyses. In addition, the qualitative analysis will inform and sharpen analytic plans for the summative evaluation. The mid-point assessment will be submitted by the end of June 2017.
5. In addition to monitoring, an interim and final summative statewide evaluation of DSRIP will be completed by the independent evaluator to examine the effect of DSRIP activities on achieving the State goals of (1) safety net system transformation

at both the system and state level; (2) accountability for reducing avoidable hospital use and improvements in other health and public health measures at both the system and state level; and (3) efforts to ensure sustainability of delivery system transformation through leveraging managed care payment reform. The data and findings of the mid-point assessment will be among the information used by the independent evaluator for the interim evaluation. Among other things, the interim evaluation will provide broad learning both within the state and across the nation. Part of this interim evaluation will examine issues overlapping with ongoing provider-level evaluations, and part of this effort will examine questions overlapping with the final evaluation.

a. Semi-annual Reporting on Project Achievement

Two times per year, Performing Provider Systems seeking payment under the DSRIP program shall submit reports to the state demonstrating progress on each of their projects as measured by the milestones and metrics described in their approved DSRIP plan. The reports shall be submitted using the standardized reporting form approved by the state and CMS. Based on the reports, the state will calculate the incentive payments for the progress achieved in accordance with Section VII "Disbursement of DSRIP Funds". The Performing Provider System shall have available for review by the state or CMS, upon request, all supporting data and back-up documentation. These reports will be due as indicated below after the end of each reporting period:

- Reporting period of January 1 through June 30: the reporting and request for payment is due July 31.
- Reporting period of June 30 through December 31: the reporting and request for payment is due January 31.

These reports will serve as the basis for authorizing incentive payments to Performing Provider Systems for achievement of DSRIP milestones. The state shall have 30 days to review and approve or request additional information regarding the data reported for each milestone/metric and measure. If additional information is requested, the Performing Provider System shall respond to the request within 15 days and the state shall have an additional 15 days to review, approve, or deny the request for payment, based on the data provided. The state shall schedule the payment transaction for each Performing Provider System within 30 days following state approval of the Performing Provider System's semi-annual report.

As part of CMS's monitoring of DSRIP payments, CMS reserves the right to review a sample of the Performing Provider System Reports and withhold or defer FFP if DSRIP milestones have not been met.

Note: Because many domain 2, 3, and 4 metrics are annual measures, these annual measures will only be available to be reported once a year for purposes of authorizing and determining incentive payments.

b. State Monitoring Reports

The state, or its designee, will conduct robust monitoring and assessment of all submitted reports, Performing Provider System progress, challenges and completion no less

frequently than quarterly, and as appropriate in order to monitor DSRIP implementation and activities.

Upon this review, an analysis will be made regarding:

- the extent of progress each Performing Provider System is making towards meeting each milestone
- the specific activities that appear to be driving measureable change
- the key implementation challenges, including governance issues, associated with specific activities designed to drive improvement
- the identification of adjustments to the DSRIP program, and/or projectsas observed through the analysis of submitted provider-level data and/or onsite findings as they occur

Comparative analysis and findings will be performed and summarized into actionable reports that provide the right level of information to various project stakeholders to help facilitate learning at the Performing Provider System level, as well as the DSRIP program level. The reports will be used to drive peer-to-peer discussion regarding opportunities for improvement and methods for course correction through the use of the Learning Collaborative. The results of these assessments will be disseminated to the independent DSRIP evaluation contractor and CMS. This information is expected to inform the DSRIP evaluation during both the mid-point and summative evaluations to understand key factors related to the performance and progression of the DSRIP program to date.

The state, or its designee, will take effective action, as needed, to remedy a finding to promote fulfillment of the DSRIP goals. This may include providing feedback to the health care industry at-large, or individual project participants if significant issues are observed.

i. Operational Report

An operational report at the project level will be the primary report to manage and report DSRIP performance. The operational report will have the functionality to report on project-level data related to Performing Provider Systems performing the same project. This report will also include an Executive Summary which will be used by CMS, senior state officials and the public as a means of following the overall progress of the DSRIP demonstration. This report will include the following data elements:

1. Identification of participating providers
2. Completion factor of providers, by provider
3. Dashboard of project-specific measure results, aggregated at project, plan, regional and state levels
4. Summary of applied interventions
5. Summary of pilot models
6. Summary of reported challenges
7. Summary of reported successes
8. Update on governance
9. Noted best practices

10. Summary of approved payments (compared to the valuation in the DSRIP project plan), which should reconcile to the DSRIP funding reported on the CMS-64

This report will be used to inform and direct the Learning Collaboratives. It will be used to ensure consistent analysis on key implementation activities across Performing Provider Systems and act as a platform for discussion during monthly conference calls and quarterly in-person collaboration meetings. This report may be utilized by the Performing Provider System project personnel as a primary tool to aid routine collaboration among Performing Provider Systems implementing the same project. This level of reporting may also show progress of the learning process itself by tracking the frequency of meetings by activity and participation in order to confirm that the learning collaborative activity is being fulfilled by the Performing Provider System.

It will be the responsibility of each project participant to ensure effective diffusion of learning amongst Performing Provider Systems who have selected the same project focus area. This includes discussing the types of innovations, strategies and Plan-Do-Study-Act (PDSA) cycles that have been implemented throughout the demonstration.

ii. Consumer Level Report

A consumer level report will have the functionality to report on high-level geographic and project-specific data elements in order to understand which providers in their area are driving to improve quality and the area of focus for that Performing Provider System. The report may include:

1. County-level map that indicates all New York hospitals
2. County-level map that indicates all participating hospitals and participating outpatient providers

This report may also have drill-down functionality to learn summary detail about the objective, methodology, current performance, and expected results of each Performing Provider System.

c. Learning Collaboratives

One facet of the DSRIP program is the development of the Learning Collaborative. The purpose of the Learning Collaborative is to promote and support a continuous environment of learning and sharing based on data transparency within the New York healthcare industry in an effort to bring meaningful improvement to the landscape of healthcare in New York.

The Learning Collaborative will be managed by the state and/or its independent assessor through both virtual and in-person collaboration that both builds relationships as well as facilitates project analysis and measurement. The Learning Collaborative will be designed to promote and/or perform the following:

1. Sharing of DSRIP project development including data, challenges, and proposed solutions based on the Performing Provider Systems' quarterly progress reports
2. Collaborating based on shared ability and experience
3. Identifying key project personnel

4. Identification of best practices
5. Provide updates on DSRIP program and outcomes
6. Track and produce a "Frequently Asked Questions" document
7. Encourage the principles of continuous quality improvement cycles

There will be multiple collaboratives developed based on the number and type of projects chosen by Performing Provider Systems. Each learning Collaborative will include key personnel from the Performing Provider Systems and selected members of the stakeholder community including provider association representation. For each collaborative, the state will designate personnel to be responsible for guiding and facilitating the Learning Collaborative.

An online, web-based tool will be utilized in order to effectively manage the collection and the dissemination of information related to the DSRIP and projects. A key component of the online tool will be a reporting feature that allows tiered-level reporting that conveys key information to the various levels of stakeholder groups interested in learning and tracking performance of the DSRIP program. This tool will act as a repository with reporting capability for various audiences including that of the general public, the Department, CMS, and the healthcare industry.

The tool will deliver data in ways that can be 1) easily interpreted by various stakeholders, 2) promote self-evaluation, and 3) promote the diffusion of effective intervention models.

d. Program Evaluation

As described in STC 10.e. in section IX, the state will identify an independent evaluator to provide an interim and summative evaluation. The interim evaluation will consider among other things the findings of the mid-point assessment conducted by the independent assessor. The evaluations must be in accordance with the evaluation STCs 19-30 in section IX and as approved by CMS through the evaluation design phase provided in STC 20 in section IX.

The interim evaluation will be due one year prior to the expiration of the demonstration and will include data from DY 1, 2, and 3. The final, summative evaluation will be completed by the end of March 2020.

The interim and summative evaluation will meet all standards of leading academic institutions and academic peer review, as appropriate for both aspects of the DSRIP program evaluation, including standards for the evaluation design, conduct, interpretation, and reporting of findings.

e. Overall Data Standards

The state will collect data from providers often as is practical in order to ensure that project impact is being viewed in as “real time” a fashion as possible. Collecting and analyzing data in this fashion will allow for rapid, life-cycle improvement which is an essential element of the DSRIP project plan.

Since managed care is an important component of the state's quality improvement strategy, the state will implement a provider/plan data portal that will allow access to appropriately permissioned patient and provider specific data in the Medicaid Data Warehouse. Role based access to this portal will allow providers and their partnering health plans access to current Medicaid claims and encounters data and eventually real time EMR and care management data provided through connectivity with local regional health organizations (RHIOs). Faster access to more real time clinical and managed care data will be particularly relevant to this project and is also the rationale for using state-measured health plans metrics or Quality Assurance Reporting Requirements (QARR) as a major data source for this project. In addition, providers and their partnering health plans will have access to the analytical capabilities of 3M and Salient suite of performance tools through the portal. This will allow DSRIP providers and the health plans to partner with the state to measure case mix adjusted avoidable hospitalization metrics at the local level using standardized definitions and eventually with more real time updates. More information on DSRIP performance and the portal will be posted on the state's DSRIP website.

The state will use the Quality Committee, established in 2013 to assist NYSDOH on quality measurement and improvement that will be responsible for supporting the clinical performance improvement cycle of DSRIP activities. The Quality Committee includes representatives from various sectors of healthcare including hospitals, nursing homes, managed care plans, provider organizations and consumer representation. Additional members will be added specifically to reflect DSRIP including representatives from local governmental units and additional consumer representation. The current charge of the Committee is to provide NYSDOH with expertise in various sectors of health care quality, assist on proposed quality improvement goals and provide guidance on measuring and reporting quality information to the public. The Quality Committee will serve as an advisory group for DSRIP offering expertise in health care quality measures, clinical measurement and clinical data used in performance improvement initiatives.

Final decision-making authority will be retained by the state and CMS, although all recommendations of the committee will be considered by the state and CMS.

Specifically, the Quality Committee will provide feedback to the state regarding:

i. Development of attribution models
ii. Selection of metrics
iii. Selection of the high performance target goals including the behavioral health high performance avoidable hospitalization threshold for bonus payment purposes.

Data and metrics that form the basis of incentive payments in DSRIP should have a high degree of accuracy and validity. Consistent with current requirements for MCO and PIHPs under 438.242, the state must ensure, through its contracts with the Performing provider systems, that each Performing provider system receiving payments under DSRIP maintains (or participates in) a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of this DSRIP. The state must require that each Performing provider system ensure that data received from providers within the system is accurate and complete by ensuring that Performing Provider Systems have appropriate data agreements in place (as described in section IV.b) and verifying the accuracy and timeliness of reported data (including such data that contributes to chart review metrics), screening the data for completeness, logic, and consistency.

To the degree that the data and metrics are generated and obtained via managed care systems already subject to 438.242, no additional validation of the data is required.

For data and metrics reported in systems not subject to 438.242, these agreements between the state and Performing provider systems should also be accompanied by validation process performed by the independent assessor to ensure that the processes are generally valid and accurate. Penalties will be applied to Performing provider systems that are not reporting data that are valid and accurate as described.

VIII. DSRIP Funding Limits

a. Statewide limit on DSRIP Funding

Total DSRIP Fund expenditures are limited as specified in STC 14 in section IX. In addition to this limit, DSRIP Fund expenditures cannot exceed the lesser of the aggregate valuation of DSRIP projects as adjusted to include DSRIP planning funding and funds allocated to the High Performance Fund. Allowable expenditures are further limited by the availability of non-federal funding (through proper IGT or other funding), and provider performance on DSRIP milestones and metrics.

b. Public Hospital and Safety Net Provider Performance Provider System Transformation Funds

All Performing Provider Systems with approved DSRIP Project Plans will be eligible to apply for funding from one of two DSRIP pools. The first, Public Hospital Transformation Fund, will be open to applicants led by a major public hospital system. The public hospital systems allowed to participate in this fund include:

i. Health and Hospital Corporation of New York City
ii. State University of New York Medical Centers
iii. Nassau University Medical Center
iv. Westchester County Medical Center
v. Erie County Medical Center

The second fund Safety Net Performance Provider System Transformation Fund, would be available to all other DSRIP eligible providers.

Allocation of funds between the two pools will be determined after applications have been submitted, based on the valuation of applications submitted to each pool.

c. High performance fund

A portion of the Public Hospital Transformation Fund and Safety Net Performance Provider System Transformation Fund will be set aside to reward high performing systems according to the process specified below. The high performance fund will be made up of the following funds:

1. For DY 2-5, up to 10 percent of the total DSRIP funds set aside for the high performance fund
2. Target Funds that are forfeited from providers that do not achieve project milestones and metrics, less any prior year appealed forfeited funds where the

appeal was settled in the current demonstration year in favor of the Performing Provider System.

The total amount of funding allocated for the high performance fund shall be distributed to qualifying providers based on meeting a specific set of Domain 2 and 3 metrics identified as a high performance metrics by the state with input from the quality and measures committee. The metrics for the high performance fund are specified in Attachment J.

Additional funds will be set aside within each fund for performing provider systems reaching stretch/ bonus level targets (set by the state with input from the quality and measures committee) for significant improvement in avoidable hospitalization reduction for their attributed behavioral health population.

IX. Disbursement of DSRIP Funds

a. Total Available DSRIP Incentive Payments for a Project based on Project Valuation

Aggregate incentive payments available over the 5 year demonstration period to a Performing Provider System will be based on the project valuation approved by the state, subject to the limits set forth in section V above

b. Payment Based on Milestone Achievement for DY 1 – DY 5

Incentive payments are calculated separately for each project. The amount of the incentive funding paid to a provider will be based on the amount of progress made within specific milestones and the valuation of those milestones.

Half of the incentive funding for Domain 1 in DY 1 will be awarded for approval of the DSRIP plan. Fifteen percent will be paid upon the delivery of an acceptable first semiannual report. Fifteen percent will be paid upon the delivery of an acceptable second semiannual report.
For each metric, the provider will include in the required DSRIP provider report the progress made in completing each metric along with sufficient supporting documentation. Progress for a given metric will be categorized as fully achieved or not achieved. If a provider has previously reported progress in a domain and received partial funding after the first semi-annual reporting period, only the additional amount is eligible for funding in the second semi-annual reporting period.

c. Payments from the High Performance Fund

Performing Provider Systems who have achieved performance improvement beyond the stated target improvement value in their approved DSRIP project plan will be eligible for additional payment from the DSRIP high performance fund, not to exceed 30 percent of their DSRIP project value.
A half of the high performance fund will be available for tier 1 payments, and half will be available for tier 2 payments which will be distributed as follows:

- Higher performing participating providers whose performance closes the gap between their current performance and the high performance level by 20 percent shall receive Tier 1 level reward payments.

- Higher performing participating providers whose performance meets or exceeds the high performance level (90th percentile of statewide performance) shall receive Tier 2 level reward payments.

High performance fund payments shall be adjusted based on Medicaid and indigent population size served by the project being implemented by the provider. The percentages above may be adjusted up or down by the State for each metric as appropriate to account for volume of demand on the high performance fund.

The state, working with the quality committee, will set a high performance threshold for the measures described in attachment J specifically avoidable hospitalizations for the entire attributed population and separate high performance targets (physical and behavioral metrics) for the behavioral health population subset. High Performance payments will be based on attaining 20 percent gap to goal or the 90th percentile of statewide performance on the high performance metrics listed in attachment J.

d. Accountability for state performance

As described in STC 14 in section IX, providers and the state are accountable for statewide performance. DSRIP funding for providers may be reduced based on poor performance statewide described below.

If any of the four milestones below are not met, then DSRIP payments to providers will be reduced by the amount specified in STC 14 in section IX. DSRIP payment reductions will be applied proportionately to all DSRIP Performing Provider Systems based on the valuation of their DSRIP project plans. DSRIP reductions will not be applied to the DSRIP high performance fund payments.

Achievement of the statewide milestones is calculated as follows:

1. ***Statewide performance on universal set of delivery system improvement metrics.*** The core set of delivery system improvement metrics in domain 2 of attachment J will be assigned a direction for improving or worsening and will be calculated to reflect the performance of the entire state. This milestone will be considered passed in any given year if more metrics in this domain are improving on a statewide level than are worsening (i.e. the performance level is the same or better, no error bar applied), as compared to the prior year as well as compared to initial baseline performance (DY 1).

2. ***A composite measure of success of projects statewide on project-specific and population-wide quality metrics.*** The number of metrics met by each Performing Provider System in a given year based on the project-specific improvement standards specified in their approved DSRIP project plan will be added together to determine the composite success of all DSRIP projects. For the purposes of this addition, pay for reporting measures will only be counted once in the aggregate for each domain. This statewide milestone will be considered passed in any given year if the number of metrics met by all Performing Provider Systems in the aggregate is greater than the number of metrics that were not met.

3. ***Growth in statewide total Medicaid spending that is at or below the target trend rate.*** As

further described in STC 14 in section IX, statewide performance on this milestone will be considered passed if the state improves on the following two metrics on a per member per month (PMPM) basis, comparing the most recent state fiscal year to the year that immediately precedes it:

a. Growth in statewide total inpatient and emergency room spending that is at or below the target trend rate (Measure applies in DSRIP Year3, DSRIP Year 4 and DSRIP Year 5).

b. Growth in statewide total Medicaid spending that is at or below the target trend rate (measure applies in DSRIP Year 4 and DSRIP Year 5). PMPM amounts will be adjusted to exclude growth in federal funding associated with the Affordable Care Act. The state will not be penalized if it uses these higher FMAP rates generated by the ACA to reinvest in its Medicaid program.

For total Medicaid spending, the target trend rate is the ten-year average rate for the long-term medical component of the Consumer Price Index (as used to determine the state's Medicaid Global Spending Cap for that year), for DSRIP Years 4 and 5 only. For inpatient and emergency room spending the target trend rate is the ten-year average rate for the long-term medical component of the Consumer Price Index (as used to determine the state's Medicaid Global Spending Cap for that year) minus 1 percentage points for DSRIP Year 3 and 2 percentage points for DSRIP Years 4 and 5.

4. ***Implementation of the managed care plan.*** This milestone will be measured by targets agreed upon by CMS and the state after receipt of the managed care strategy plan in STC 39 in section IX related to reimbursement of plans and providers consistent with DSRIP objectives and measures. These targets will include one associated with the degree to which plans move away from traditional fee for service payments to payment approaches rewarding value.

e. Intergovernmental Transfer Process

The state will calculate the nonfederal share amount to be transferred by an IGT Entity in order to draw the federal funding for the incentive payments related to the milestone achievement that is reported by the Performing Provider System and approved by the IGT Entity and the State. Within 14 days after notification by the state of the identified nonfederal share amount, the IGT Entity will make an intergovernmental transfer of funds. The state will draw the federal funding and pay both the nonfederal and federal shares of the incentive payment to the Performing Provider System. If the IGT is made within the appropriate 14-day timeframe, the incentive payment will be disbursed within 30 days. The total computable incentive payment must remain with the Performing Provider System.

X. DSRIP Project Plan Modifications

a. Modifying Existing Project Plans in Limited Circumstances

No more than once a year, Performing Provider Systems may submit proposed modifications to an approved DSRIP project plan for state and CMS review. These modifications may not decrease the scope of the project unless they also propose to decrease the project's valuation.

Removal of any Performing Provider System member organization requires a proposed modification and removal of any such lower performing member must follow the required governance procedures including progressive sanction requirements.

The state and CMS will follow the same review process described in section VI above, except that the independent assessor will not be expected to convene review panels.

b. Reinvestment of Unused DSRIP Funds in DY4 and DY5

Unused DSRIP funding for DY 4 and 5 (including funding allocated to projects that were terminated as part of the midpoint assessment) may be directed towards further replicating high performing DSRIP projects that have proven to be particularly successful and can be implemented elsewhere (in approved Performing Provider System' that are not currently employing such projects) and achieve results within two years. The state will develop its methodology for expanding successful projects and submit this to CMS in DY 2 for review and approval before the midpoint assessment is completed in DY 3.

Attachment J - NY DSRIP Strategies Menu and Metrics

Preface

a. Delivery System Reform Incentive Payment Fund

On April 14, 2014, the Centers for Medicare and Medicaid Services (CMS) approved New York's request for an amendment to the New York's Partnership Plan section 1115(a) Medicaid demonstration extension (hereinafter "demonstration") authorizing the creation of a Delivery System Reform Incentive Payment (DSRIP) Fund. This demonstration is currently approved through December 31, 2014. DSRIP Funds will not be made available after December 31, 2014 unless the state's demonstration renewal is approved by CMS.

Section IX of the Special Terms and Conditions (STC) describes the general rules and requirements of the Delivery System Reform Incentive Payment (DSRIP) Fund.

b. DSRIP Strategies Menu and Metrics and Program Funding and Mechanics Protocol

The DSRIP requirements specified in the STCs are supplemented by two attachments to the STCs. The Program Funding and Mechanics Protocol (Attachment I) describes the State and CMS review process for DSRIP project plans, incentive payment methodologies, reporting requirements, and penalties for missed milestones. The DSRIP Strategies Menu and Metrics (this attachment, Attachment J) details the specific delivery system improvement projects and metrics that are eligible for DSRIP funding. The projects are listed in Part I and the metrics are listed in Part II. Additional information is provided in two additional documents as described below.

This version of the DSRIP Strategies Menu and Metrics is approved April 14, 2014. In accordance with STC 10.b, the state may submit modifications to this protocol for CMS review and approval in response to comments received during the post-award comment period and as necessary to implement needed changes to the program as approved by CMS.

c. Supporting operational guides

This attachment will be supplemented by two additional operational guides developed by the state and approved by CMS, which will assist performing provider systems in developing and implementing their projects and will be used in the state's review of the approvability and the valuation of DSRIP projects.

First, the state will develop a ***Project Toolkit*** that will describe the core components of each DSRIP project listed on the DSRIP project menu below (Part I). This supplement will also describe how DSRIP projects are distinct from each other and the state's rationale for selecting each project (i.e. the evidence base for the project and its relation to community needs for the Medicaid and uninsured population). The core components and other elements of the project description will be used as part of the DSRIP plan checklist (described in section V of Attachment I). To assist providers in valuing projects, this supplement will also include the index score of transformation/ health care improvement potential determined by the state (according to the process described in section IV.c. of Attachment I).

Second, the state will develop a ***Metric Specification Guide*** that provides additional information on the metrics described in the metrics list below (Part II). Specifically, the state will specify the data source for each measure (specifically whether the measure is collected by the state or providers), the measure steward for each metric (if applicable), the National Quality Forum reference number (if applicable), and the high performance level for each pay-for-performance metric. The high performance level for each metric will be used to establish outcome targets for all pay-for-performance measures, as described in Attachment I.

Part I – Projects Menu

Each Performing Provider System will employ multiple projects both to transform health care delivery as well as to address the broad needs of the population that the performing provider system serves. These projects described in Attachment J are grouped into different strategies, such as behavioral health, within each Domain (System Transformation Projects (Domain 2), Clinical Improvement Projects (Domain 3), and Population-wide Projects (Domain 4). For each strategy, there is a set of metrics that the performing provider system will be responsible for if they do any one of the projects within that strategy.

Each project selected by a Performing Provider System will be developed into a specific set of focused milestones and metrics that will be part of the Performing Provider System's DSRIP project plan. Project selection will be driven by the mandatory community needs assessment, and the rationale and starting point for each project must be described in the DSRIP project plan, as described in Attachment I.

DSRIP project plans must include a minimum of five projects (at least two system transformation projects, two clinical improvement projects, and one population-wide project). As described further in Attachment I, a maximum of 11 projects will be considered for project valuation scoring purposes. Additional projects can be included in the application, but they will not affect the project valuation.

Domain 2: System Transformation Projects

All DSRIP plans must include at least two of the following projects based on their community needs assessment. At least one of those projects must be from sub-list A and one of these projects must be from sub-list B or C, as described below. Performing Provider Systems can submit up to 4 projects from Domain 2 for valuation scoring purposes. For eligible Performing Provider Systems pursuing 11 projects in their plan, they will be allowed to select up to 5 projects (the fifth project being project 2.d.i) from Domain 2 for scoring purposes (as described in attachment I).

A. Create Integrated Delivery Systems (required)

- 2.a.i Create Integrated Delivery Systems that are focused on Evidence-Based Medicine / Population Health Management
- 2.a.ii Increase certification of primary care practitioners with PCMH certification and/or Advanced Primary Care Models (as developed under the New York State Health Innovation Plan (SHIP))
- 2.a.iii Health Home At-Risk Intervention Program: Proactive management of higher risk patients not currently eligible for Health Homes through access to high quality primary care and support services.
- 2.a.iv Create a medical village using existing hospital infrastructure
- 2.a.v Create a medical village/alternative housing using existing nursing home

B. Implementation of Care Coordination and Transitional Care Programs

2.b.i Ambulatory Intensive Care Units (ICUs)
2.b.ii Development of co-located of primary care services in the emergency department (ED)
2.b.iii ED care triage for at-risk populations
2.b.iv Care transitions intervention model to reduce 30 day readmissions for chronic health conditions
2.b.v Care transitions intervention for skilled nursing facility (SNF) residents
2.b.vi Transitional supportive housing services
2.b.vii Implementing the INTERACT project (inpatient transfer avoidance program for SNF)
2.b.viii Hospital-Home Care Collaboration Solutions
2.b.ix Implementation of observational programs in hospitals

C. Connecting Settings

2.c.i. Development of community-based health navigation services
2.c.ii Expand usage of telemedicine in underserved areas to provide access to otherwise scarce services

D. Utilizing Patient Activation to Expand Access to Community Based Care for Special Populations

2.d.i Implementation of Patient Activation Activities to Engage, Educate and Integrate the uninsured and low/non-utilizing Medicaid populations into Community Based Care

Domain 3: Clinical Improvement Projects

All DSRIP plans must include at least two projects from this domain, based on their community needs assessment. At least one of those projects must be a behavioral health project from sub-list A, as described below. Performing Provider Systems can submit up to 4 projects from Domain 3 for valuation scoring purposes (as described in Attachment I).

A. Behavioral Health (required)

3.a.i Integration of primary care and behavioral health services
3.a.ii Behavioral health community crisis stabilization services
3.a.iii. Implementation of evidence-based medication adherence program (MAP) in community based sites for behavioral health medication compliance
3.a.iv Development of Withdrawal Management (e.g., ambulatory detoxification, ancillary withdrawal services) capabilities and appropriate enhanced abstinence services within community-based addiction treatment programs
3.a.v Behavioral Interventions Paradigm (BIP) in Nursing Homes

B. Cardiovascular Health

Note: Performing provider systems selecting cardiovascular health projects will be expected to utilize strategies contained in the Million Hearts campaign as appropriate (http://millionhearts.hhs.gov/index.html).

3.b.i	Evidence-based strategies for disease management in high risk/affected populations (adult only)
3.b.ii	Implementation of evidence-based strategies in the community to address chronic disease -- primary and secondary prevention projects (adult only)

C. Diabetes Care

3.c.i	Evidence-based strategies for disease management in high risk/affected populations (adults only)
3.c.ii	Implementation of evidence-based strategies in the community to address chronic disease – primary and secondary prevention projects (adults only)

D. Asthma

3.d.i	Development of evidence-based medication adherence programs (MAP) in community settings –asthma medication
3.d.ii	Expansion of asthma home-based self-management program
3d.iii	Implementation of evidence-based medicine guidelines for asthma management

E. HIV/AIDS

3.e.i	Comprehensive Strategy to decrease HIV/AIDS transmission to reduce avoidable hospitalizations – development of a Center of Excellence for management of HIV/AIDS

F. Perinatal Care

3.f.i	Increase support programs for maternal & child health (including high risk pregnancies) (Example: Nurse-Family Partnership)

G. Palliative Care

3.g.i	Integration of palliative care into the PCMH Model
3.g.ii	Integration of palliative care into nursing homes

H. Renal Care

3.h.i	Specialized Medical Home from Chronic Renal Failure

Domain 4: Population-wide Projects

The following represent priorities in the State's Prevention Agenda with health care delivery sector projects to influence population-wide health (available at : http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/index.htm). The alignment of these projects with the New York State Prevention Agenda (including focus areas, etc.) is described further in the Project Description Supplement.

All DSRIP plans must include at least one project from this domain, based on their community needs assessment. Performing Provider Systems can submit up to 2 projects from Domain 4 for valuation scoring purposes (as described in Attachment I).

A. Promote Mental Health and Prevent Substance Abuse (MHSA)

4.a.i	Promote mental, emotional and behavioral (MEB) well-being in communities
4.a.ii.	Prevent Substance Abuse and other Mental Emotional Behavioral Disorders
4.a.iii.	Strengthen Mental Health and Substance Abuse Infrastructure across Systems

B. Prevent Chronic Diseases

4.b.i.	Promote tobacco use cessation, especially among low SES populations and those with poor mental health
4.b.ii.	Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings (Note: This project targets chronic diseases that are not included in domain 3., such as cancer)

C. Prevent HIV and STDs

4.c.i	Decrease HIV morbidity
4.c.ii	Increase early access to, and retention in, HIV care
4.c.iii	Decrease STD morbidity

4.c.iv Decrease HIV and STD disparities

D. Promote Healthy Women, Infants and Children

4.d.i Reduce premature births

II. Metrics

The domains of metrics here are intended to provide specificity to the overall intent to promote system transformation, using measures of system transformation as well as including avoidable events as a marker for positive transformation. Items associated with pay for reporting or pay for performance are described in requirements for all domains as well.

An overview of the metric domains from the funding and mechanics protocol is below:

i. Overall project progress metrics (Domain 1)
ii. System transformation metrics (Domain 2)
iii. Clinical improvement metrics (Domain 3)
iv. Population-wide project implementation metrics (Domain 4)

All DSRIP plans must include all core metrics in Domain 1, all metrics in Domain 2, and all core metrics in Domain 4. DSRIP plans must also include the behavioral health metrics in Domain 3.a. and strategy-specific metrics based on the Domain 3 and 4 projects selected, as further described in the Project Toolkit. The state or CMS will add project-specific Domain 1 metrics to DSRIP project plans as necessary to address concerns with "at risk" projects, based on input from the independent assessor. Behavioral health metrics are included because those diagnoses are highly correlated with avoidable events.

A subset of these metrics related to avoidable hospitalizations, behavioral health and cardiovascular disease will also be part of the high performance fund, described in attachment I and as noted below: These latter markers align with the nationwide Million Hearts Initiative on cardiac outcomes, in order to tackle the leading cause of mortality in New York State.

Metric	Domain reference
Avoidable ED Visits (All Population)	2.a
Avoidable Re-hospitalizations (All Population)	2.a
Avoidable ED Visits (BH Population)	3.a
Avoidable Re-hospitalizations (BH Population)	3.a
Follow-up for Hospitalization for Mental Illness	3.a
Antidepressant Medication Management	3.a

Diabetes Monitoring for People with Diabetes and Schizophrenia	3.a
Cardiovascular Monitoring for People with CVD and Schizophrenia	3.a
Controlling Hypertension (NQF 0018)	3.b.
Tobacco Cessation (NQF 0027) (component on discussing smoking and tobacco use cessation strategies)	3.b.

Where possible, the state will make drillable data available for PPSs to be able to better understand the impact of disparities on the PPSs and improvements seen in specific populations through these projects. Because of small population size and lack of standards for comparison, the state will not be able to provide meaningful state wide metrics for each population segment.

Domain 1. Overall Project Progress Metrics

Domain 1 metrics assess overall implementation of all DSRIP projects (regardless of whether the project was developed from a project selected from Domain 2, 3, or 4 listed above). All

Core Domain 1 Metrics (for all providers):

1. Semi-annual reports (pay for reporting), which will include:
    a. Project narrative on status and challenges
    b. Information on project spending/budget and any other financial information requested by the state, including financial sustainability of system and projects.
    c. Documentation on the number of beneficiaries served through the projects
    d. Update on project governance
    e. Update on workforce strategy implementation
    f. Percent of providers that are reporting relevant DSRIP project data
    g. Description of steps taken by the system to prepare for non-FFS reimbursement systems (including an update on any on-going negotiations with Medicaid managed care plans)
    h. Engagement in learning collaboratives

2. Approval of DSRIP Plan (DY 1 only)

3. Workforce milestones (P4P/ P4R, as specified in the Metrics Specification Guide)
    - Percent Complete of System's preapproved Workforce Plan Number of health care workers retrained/redeployed vs. # eligible based on system service changes
    - Net change in number of new MDs hired – PCP; specialty
    - Net change in number of new mid-levels providers hired (RPA, NP, NM)

- Net change in number of other mid-level providers hired

4. System Integration milestones (P4P/ P4R, as specified in the Metrics Specification Guide)
    - Percent complete of preapproved system integration plan in the PPS project plan
    - For HH population, % in O/E; % in Active Care Management; % with Care Plan

Additional project-specific Domain 1 metrics:

5. Additional project-specific metrics, established by the state or CMS for a particular project, especially "at risk" projects. (Pay for performance, i.e. achievement of corrective action as specified by the state or CMS for "at risk" projects) The state's independent assessor will develop a rubric for assessing semi-annual reports, workforce milestones, and system integration milestones to identify at risk projects.

Domain 2. System Transformation Metrics

All Domain 2 metrics are pay-for-reporting in DY 1 and 2. As described below, some metrics become pay-for-performance in DY 3-5. All of these metrics will be assessed on a statewide level as part of the statewide Domain 2 performance test described in STC 14.g.i in section IX, with the exception of the Medicaid spending metric and the provider reimbursement metric and (which are included as part of other statewide accountability tests described in STC 14.g.iii and 14.g.iv in section IX respectively).

Domain 2 – System Transformation Metrics						
				DSRIP Year 2		**DSRIP Years 3 - 5**
State-wide Measure	**Measure Name**	**Measure Steward**		**Pay for Reporting/Pay for Performance**		**Pay for Reporting/Pay for Performance**
A. Create Integrated Delivery System						
Potentially Avoidable Services						
X	Potentially Avoidable Emergency Room Visits	3M		Reporting		Performance
X	Potentially Avoidable Readmissions	3M		Reporting		Performance
X	PQI Suite – Composite of all measures	AHRQ		Reporting		Performance
X	PDI Suite – Composite of all measures	AHRQ		Reporting		Performance
Provider Reimbursement						
	Percent of total Medicaid provider reimbursement received through sub-capitation or other forms of non-FFS reimbursement			Reporting		Reporting
System Integration						
X	Percent of Eligible Providers with participating agreements with RHIO's; meeting MU Criteria and able to participate in bidirectional exchange			Reporting		Reporting
Primary Care						
X	Percent of PCP meeting PCMH (NCQA)/ Advance Primary Care (SHIP)			Reporting		Reporting
X	CAHPS Measures including usual source of care Patient Loyalty (Is doctor/clinic named the place you usually go for care? How long have you gone to this doctor/clinic for care?)	AHRQ		Reporting		Performance
Access to Care						
X	HEDIS Access/Availability of Care; Use of Services	NCQA		Reporting		Performance

Domain 2 – System Transformation Metrics						
X	CAHPS Measures: - Getting Care Quickly (routine and urgent care appointments as soon as member thought needed) - Getting Care Needed (access to specialists and getting care member thought needed) - Access to Information After Hours - Wait Time (days between call for appointment and getting appoint for urgent care)	AHRQ		Reporting		Performance
Medicaid Spending for Projects Defined Population on a PMPM Basis						
	Medicaid spending on ER and Inpatient Services			Reporting		Reporting
	Medicaid spending on PC and community based behavioral health care			Reporting		Reporting
B. Implementation of care coordination and transitional care programs						
Performing Provider Systems will be required to meet all of the above metrics with the addition of the following:						
Care Transitions						
	H-CAHPS – Care Transition Metrics	AHRQ		Reporting		Performance
X	CAHPS Measures – Care Coordination with provider up-to-date about care received from other providers	AHRQ		Reporting		Performance
C. Connecting Settings						
Performing Provider Systems will be required to meet all of the above metrics for A and B.						
D, Utilizing Patient Activation to Expand Access to Community Based Care for Special Populations						
	Interval Change in Patient Activation Measure® (PAM®) –Percent of members measured at Level 3 or 4 on the PAM® utilizing at least 13 item version. (Done separately for each population – UI and NU/LU)	**Insignia Health**		**Reporting**		**Performance**
	Use of primary and preventive care services-- Percent of attributed Medicaid members with no claims history for primary care and preventive services in measurement year compared to same in baseline year (For NU and LU Medicaid Members)	**NYS**		**Reporting**		**Performance**
	Emergency department use by uninsured persons as measured by percent of Emergency Medicaid emergency department claims compared to same in baseline year. (Uninsured only)	**NYS**		**Reporting**		**Performance**
	CG-CAHPS done by PPS documenting the uninsured population experience with the health care system	**AHRQ**		**Reporting**		**Performance**

Domain 3. Clinical Improvement Metrics

All Domain 3 metrics are pay-for-reporting in DY 1. As described below, some metrics continue as pay-for-reporting in DY 2-3 but become pay-for-performance in DY 4-5. In general, provider systems will include all metrics associated with the project selected, unless otherwise specified below.

Domain 3 – Clinical Improvement Metrics								
						DSRIP Years 2 – 3		**DSRIP Years 4 - 5**
	Measure Name	**Measure Steward**	**NQF#**	**Source**	**Measure Type**	**Pay for Reporting/Pay for Performance**		**Pay for Reporting/Pay for Performance**
A. Behavioral Health (Required) – All behavioral health projects will use the same metrics except for SNF programs implementing the BIP in Nursing Homes project. These providers will include the additional behavioral health measures below in A-2.								
	PPV (for persons with BH diagnosis)	3M		Claims	Outcome	Performance		Performance
	Antidepressant Medication Management	NCQA	0105	Claims	Process	Performance		Performance
	Diabetes Monitoring for People with Diabetes and Schizophrenia	NCQA	1934	Claims	Process	Performance		Performance
	Diabetes Screening for People with Schizophrenia./BPD Using Antipsychotic Med.	NCQA	1932	Claims	Process	Performance		Performance
	Cardiovascular Monitoring for People with CVD and Schizophrenia.	NCQA	1933	Claims	Process	Performance		Performance
	Follow-up care for Children Prescribed ADHD Medications	NCQA	0103	Claims	Process	Reporting		Performance
	Follow-up after hospitalization for Mental Illness	NCQA	0576	Claims	Process	Performance		Performance
	Screening for Clinical Depression and follow-up	CMA	0418	Medical Record	Process	Reporting		Performance
	Adherence to Antipsychotic Medications for People with Schizophrenia	NCQA	1879	Claims	Process	Performance		Performance
	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)	NCQA	0004	Claims	Process	Performance		Performance
A – 2. Additional behavioral health measures for provider systems implementing the Behavioral Interventions Paradigm (BIP) in Nursing Homes project								
	PPR for SNF patients	3M		Claims	Outcome	Performance		Performance
	Percent of Long Stay Residents who have Depressive Symptoms	CMS		MDS 3.0	Process	Performance		Performance
B. Cardiovascular Disease								

Domain 3 – Clinical Improvement Metrics								
						DSRIP Years 2 – 3		**DSRIP Years 4 - 5**
	Measure Name	**Measure Steward**	**NQF#**	**Source**	**Measure Type**	**Pay for Reporting/Pay for Performance**		**Pay for Reporting/Pay for Performance**
	PQI # 7 (HTN)	AHRQ		Claims	Outcome	Performance		Performance
	PQI # 13 (Angina without procedure)	AHRQ		Claims	Outcome	Performance		Performance
	Cholesterol Management for Patients with CV Conditions	NCQA		Medical Record	Outcome	Reporting		Performance
	Controlling High Blood Pressure (Provider responsible for medical record reporting)	NCQA	0018	Medical Record	Outcome	Reporting		Performance
	Aspirin Discussion and Use	CAHPS		Survey	Process	Reporting		Performance
	Medical Assistance with Smoking Cessation	NCQA	0027	Survey	Process	Reporting		Performance
	Flu Shots for Adults Ages 50 – 64	NCQA	0039	Survey	Process	Reporting		Performance
	Health Literacy Items (includes understanding of instructions to manage chronic condition, ability to carry out the instructions and instruction about when to return to the doctor if condition gets worse	CAHPS		Survey	Process	Reporting		Performance
C. Diabetes Mellitus								
	PQI # 1 (DM Short term complications)	AHRQ	0274	Claims	Outcome	Performance		Performance
	Comprehensive Diabetes screening (HbA1c, lipid profile, dilated eye exam, nephropathy)	NCQA		Medical Record	Process	Reporting		Performance
	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	NCQA	0059	Medical Record	Outcome	Reporting		Performance
	Comprehensive diabetes care - LDL-c control (<100mg/dL)	NCQA	0064	Medical Record	Outcome	Reporting		Performance
	Medical Assistance with Smoking Cessation	NCQA	0027	Survey	Process	Reporting		Performance
	Flu Shots for Adults Ages 50 – 64	NCQA	0039	Survey	Process	Reporting		Performance
	Health Literacy Items (includes	CAHPS		Survey	Process	Reporting		Performance

Domain 3 – Clinical Improvement Metrics								
						DSRIP Years 2 – 3		**DSRIP Years 4 - 5**
	Measure Name	**Measure Steward**	**NQF#**	**Source**	**Measure Type**	**Pay for Reporting/Pay for Performance**		**Pay for Reporting/Pay for Performance**
	understanding of instructions to manage chronic condition, ability to carry out the instructions and instruction about when to return to the doctor if condition gets worse)							
D. Asthma								
	PQI # 15 Adult Asthma	AHRQ	0283	Claims	Outcome	Performance		Performance
	PDI # 14 Pediatric Asthma	AHRQ	0638	Claims	Outcome	Performance		Performance
	Asthma Medication Ratio	NCQA	1800	Claims	Process	Performance		Performance
	Medication Management for People with Asthma	NCQA	1799	Claims	Process	Performance		Performance
E. HIV/AIDS								
	HIV/AIDS Comprehensive Care : Engaged in Care	NYS		Claims	Process	Performance		Performance
	HIV/AIDS Comprehensive Care : Viral Load Monitoring	NYS		Claims	Process	Performance		Performance
	HIV/AIDS Comprehensive Care : Syphilis Screening	NYS		Claims	Process	Performance		Performance
	Cervical Cancer Screening	NCQA	0032	Claims	Process	Reporting		Performance
	Chlamydia Screening	NCQA	0033	Claims	Process	Performance		Performance
	Medical Assistance with Smoking Cessation	NCQA/	0027	Survey	Process	Reporting		Performance
	Viral Load Suppression	HRSA	2082	Medical Record	Outcome	Reporting		Performance
F. Perinatal Care								
	PQI # 9 Low Birth Weight	AHRQ	0278	Claims	Outcome	Performance		Performance
	Prenatal and Postpartum Care—Timeliness and Postpartum Visits	NCQA	1517	Medical Record	Process	Reporting		Performance
	Frequency of Ongoing Prenatal Care	NCQA	1391	Medical Record	Process	Reporting		Performance
	Well Care Visits in the first 15 months	NCQA	1392	Claims	Process	Reporting		Performance

Domain 3 – Clinical Improvement Metrics								
						DSRIP Years 2 – 3		**DSRIP Years 4 - 5**
	Measure Name	**Measure Steward**	**NQF#**	**Source**	**Measure Type**	**Pay for Reporting/Pay for Performance**		**Pay for Reporting/Pay for Performance**
	Childhood Immunization Status	NCQA	0038	Medical Record	Process	Reporting		Performance
	Lead Screening in Children	NCQA		Medical Record	Process	Reporting		Performance
	PC-01 Early Elective Deliveries	Joint Commission	0469	Medical Record	Process	Reporting		Reporting
G. Palliative Care – All projects will use the same metric set.								
	Risk-Adjusted percentage of members who remained stable or demonstrated improvement in pain.	NYS		UAS	Process	Reporting		Performance
	Risk-Adjusted percentage of members who had severe or more intense daily pain	NYS		UAS	Process	Reporting		Performance
	Risk-adjusted percentage of members whose pain was not controlled.	NYS		UAS	Process	Reporting		Performance
	Advanced Directives – Talked about Appointing for Health Decisions	NYS		UAS	Process	Reporting		Performance
	Depressive feelings - percentage of members who experienced some depression feeling	NYS		UAS	Process	Reporting		Performance
H. Renal Care								
	Comprehensive Diabetes screening (HbA1c, lipid profile, dilated eye exam, nephropathy)	NCQA		Medical Record	Process	Reporting		Performance
	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	NCQA	0059	Medical Record	Outcome	Reporting		Performance
	Comprehensive diabetes care - LDL-c control (<100mg/dL)	NCQA	0064	Medical Record	Outcome	Reporting		Performance
	Annual Monitoring for Patients on Persistent Medications – ACE/ARB	NCQA		Claims	Process	Reporting		Performance
	Controlling High Blood Pressure	NCQA	0018	Medical Record	Outcome	Reporting		Performance

Domain 3 – Clinical Improvement Metrics								
						DSRIP Years 2 – 3		**DSRIP Years 4 - 5**
	Measure Name	**Measure Steward**	**NQF#**	**Source**	**Measure Type**	**Pay for Reporting/Pay for Performance**		**Pay for Reporting/Pay for Performance**
	Flu vaccine 18-64	NCQA	0039			Reporting		Performance
	Medical Assistance with Smoking and Tobacco Use Cessation	NCQA	0027			Reporting		Performance

Domain 4. Population-Wide Metrics

This domain includes pay-for-reporting for relevant measures from the New York State Prevention Agenda related to the Domain 4 projects selected. All Domain 4 metrics will be measured by a geographical area denominator of all New York State residents that New York State has already developed for the Prevention Agenda. Some metrics are not collected on an annual basis but will be reported on their usual collection cycle. For example, the BRFSS is done biannually.

The metrics that are part of the New York State Prevention Agenda are available here: http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/index.htm and will be further described in the metric specification guide.

		Source	Geographic Granularity
Improve Health Status and Reduce Health Disparities (required for all projects)			
1.	Percentage of premature death (before age 65 years)	NYS NYSDOH Vital Statistics	State, County
2.	***Ratio of Black non-Hispanics to White non-Hispanics***		
3.	***Ratio of Hispanics to White non-Hispanics***		
4.	Age-adjusted preventable hospitalizations rate per 10,000 - Aged 18+ years	SPARCS	Statewide Region County
5.	***Ratio of Black non-Hispanics to White non-Hispanics***		
6.	***Ratio of Hispanics to White non-Hispanics***		
7.	Percentage of adults with health insurance - Aged 18-64 years	US Census	
8.	Age-adjusted percentage of adults who have a regular health care provider - Aged 18+ years	BRFSS	Statewide NYC/ROS County
Promote Mental Health and Prevention Substance Abuse			
66.	Age-adjusted percentage of adults with poor mental health for 14 or more days in the last month	BRFSS	Statewide NYC/ROS County

67.	Age-adjusted percentage of adult binge drinking during the past month	BRFSS	Statewide NYC/ROS County
68.	Age-adjusted suicide death rate per 100,000	NYS NYSDOH Vital Statistics	State, county
Prevent Chronic Diseases			
21.	Percentage of adults who are obese	BRFSS	Statewide NYC/ROS County
22.	Percentage of children and adolescents who are obese	BRFSS	Statewide NYC/ROS County
23.	Percentage of cigarette smoking among adults	BRFSS	Statewide NYC/ROS County
24.	Percentage of adults who receive a colorectal cancer screening based on the most recent guidelines - Aged 50-75 years	BRFSS	Statewide
25.	Asthma emergency department visit rate per 10,000	SPARCS	Statewide Region County
26.	Asthma emergency department visit rate per 10,000 - Aged 0-4 years	SPARCS	Statewide Region County
27.	Age-adjusted heart attack hospitalization rate per 10,000	SPARCS	Statewide Region County
28.	Rate of hospitalizations for short-term complications of diabetes per 10,000 - Aged 6-17 years	SPARCS	Statewide Region County
29.	Rate of hospitalizations for short-term complications of diabetes per 10,000 -	SPARCS	Statewide

	Aged 18+ years		Region County
Prevent HIV/STDs			
33.	Newly diagnosed HIV case rate per 100,000	NYS HIV Surveillance System	
34.	***Difference in rates (Black and White) of new HIV diagnoses***		
35.	***Difference in rates (Hispanic and White) of new HIV diagnoses***		
36.	Gonorrhea case rate per 100,000 women - Aged 15-44 years	NYS STD Surveillance System	
37.	Gonorrhea case rate per 100,000 men - Aged 15-44 years	NYS STD Surveillance System	
38.	Chlamydia case rate per 100,000 women - Aged 15-44 years	NYS STD Surveillance System	
39.	Primary and secondary syphilis case rate per 100,000 males	NYS STD Surveillance System	
40.	Primary and secondary syphilis case rate per 100,000 females	NYS STD Surveillance System	
Promote Healthy Women, Infants, and Children			
41.	Percentage of preterm births	NYS NYSDOH Vital Statistics	State, County
42.	***Ratio of Black non-Hispanics to White non-Hispanics***		
43.	***Ratio of Hispanics to White non-Hispanics***		
44.	***Ratio of Medicaid births to non-Medicaid births***		

45.	Percentage of infants exclusively breastfed in the hospital	NYS NYSDOH Vital Statistics	State, County
46.	***Ratio of Black non-Hispanics to White non-Hispanics***		
47.	***Ratio of Hispanics to White non-Hispanics***		
48.	***Ratio of Medicaid births to non-Medicaid births***		
49.	Maternal mortality rate per 100,000 births	NYS NYSDOH Vital Statistics	State, County
54.	Percentage of children with any kind of health insurance - Aged under 19 years	U.S. Census Bureau, Small Area Health Insurance Estimates	State, County
56.	***Ratio of low-income children to non-low income children***		
57.	Adolescent pregnancy rate per 1,000 females - Aged 15-17 years	NYS NYSDOH Vital Statistics	State, County
58.	***Ratio of Black non-Hispanics to White non-Hispanics***		
59.	***Ratio of Hispanics to White non-Hispanics***		
60.	Percentage of unintended pregnancy among live births	Pregnancy Risk Assessment Monitoring System	State
61.	***Ratio of Black non-Hispanics to White non-Hispanics***		
62.	***Ratio of Hispanics to White non-Hispanics***		
63.	***Ratio of Medicaid births to non-Medicaid births***		
64.	Percentage of women with health coverage - Aged 18-64 years	U.S. Census Bureau Small Area Health	State, County

		Insurance Estimates	
65.	Percentage of live births that occur within 24 months of a previous pregnancy	NYS NYSDOH Vital Statistics	State, county