NEW YORK
state department of
HEALTH

Nirav R. Shah, M.D., M.P.H.
Commissioner

Sue Kelly
Executive Deputy Commissioner

August 29, 2013

Ms. Jessica Woodard
Project Officer
Division of State Demonstrations and Waivers
Centers for Medicaid, CHIP and Survey & Certification, CMS
MS S2-01-16, 7500 Security Blvd.
Baltimore, Maryland 21244-1850

Dear Ms. Woodard:

Enclosed is the New York State Department of Health's 2013 third quarter Quarterly Report for the Section 1115 Partnership Plan, covering the period April 1, 2013 through June 30, 2013.

Sincerely,

[redacted]

Gregory S. Allen, Director
Division of Program Development & Management
Office of Health Insurance Programs

Enclosure
cc: M. Melendez

Partnership Plan
Section 1115 Quarterly
Demonstration Year: 15 (10/1/2012 – 9/30/2013)
Federal Fiscal Quarter: 3 (04-01-2013 – 06/30/2013)

I. Introduction

On September 29, 2006, the Centers for Medicare and Medicaid Services (CMS) approved an extension of New York's 1115 waiver, known as the Partnership Plan, for the period beginning October 1, 2006 and ending September 30, 2010. CMS subsequently approved a series of short term extensions while negotiations continued on renewing the waiver into 2014. On July 29, 2011, CMS approved a renewal of the Partnership Plan for the period 8/1/11 through 12/31/14, with some waiver components expiring earlier to reflect implementation of the Affordable Care Act (ACA). CMS approved three waiver amendments on September 30, 2011, March 30, 2012 and August 31, 2012 incorporating changes resulting from recommendations of the Governor's Medicaid Redesign Team.

II. Enrollment

Third Quarter

Demonstration Populations (as hard coded in the CMS 64)	Current Enrollees (to date)	# Voluntary Disenrolled in Current Quarter	# Involuntary Disenrolled in Current Quarter
Population 1 – TANF Child under 1 through 20 in mandatory counties as of 10/1/06	1,660,021	25,042	66,408
Population 2 - TANF Adults aged 21 through 64 in mandatory counties as of 10/1/06	492,214	10,394	22,835
Population 3 – Safety Net Adults	836,190	19,496	26,451
Population 4 – Family Health Plus Adults with children	335,165	6,172	20,917
Population 5 – Family Health Plus Adults without children	93,083	1,977	6,781

Explanation of Populations:

- Population 1 - TANF enrolled in the 14 mandatory counties prior to 10/1/06 and all TANF outside of the 14 mandatory counties - aged 1 through 20
- Population 2 - TANF enrolled in the 14 mandatory counties prior to 10/1/06 and all TANF outside of the 14 mandatory counties - aged 21 through 64
- Population 3 - Safety Net Adults
- Population 4 - Family Health Plus Adults with Children
- Population 5 - Family Health Plus Adults without Children

Voluntary Disenrollments	
Total # Voluntary Disenrollments in Current Demonstration Year[1]	**177,581**

Reasons for voluntary disenrollments include: enrollment in another plan; approved enrollee request to qualify as either exempt or excluded; relocation to residence outside county of enrollment; and, Local Department of Social Services (LDSS) approval to disenroll based upon appropriate cause.

Involuntary Disenrollments	
Total # Involuntary Disenrollments in Current Demonstration Year[1]	**454,684**

Reasons for involuntary disenrollments include: loss of Medicaid eligibility; eligibility transfers between Family Health Plus (FHPlus) and Medicaid; inappropriate enrollment and death.

III. Outreach/Innovative Activities

The New York State Department of Health (the Department), Maximus and the local departments of social services (LDSS) continue to provide education and outreach in the areas of enrollment and health plan selection to Medicaid eligible individuals that are not enrolled in managed care.

A. Progress of Mandatory Managed Care Expansion

As of November 2012, mandatory Medicaid managed care programs are operating in all counties of the state, including New York City. During this quarter, staff continued to provide technical support to both county staff and providers in all counties. The counties opting to utilize the assistance of the enrollment broker also received support from Maximus staff.

B. New York City (NYC) Outreach Activities

The total Medicaid eligible population in NYC is approximately 3.1 million. Currently, 2.2 million are enrolled in a managed care plan, including eligible SSI recipients.

The Medicaid Redesign Team (MRT) changes implemented during the reporting period had a significant impact on the work of New York Medicaid Choice (NYMC).

[1] Demonstration year to date: 10/01/2012 – 03/3012013

NYMC Field Customer Services Representatives (FCSRs) were assigned to cover 5 HIV/AIDS Services Administration (HASA) sites, 13 Medicaid offices and 17 Job Centers. The Education and Enrollment Driven Referral (EED) process was responsible for 82% of the total consumers engaged by NYMC in the last quarter.

The overall activities at Medicaid offices remained constant averaging 14 consumers per work session. A work session covers a half day of work activities.

A total of 2,702 presentations were scheduled by NYMC. Of these, 619 or 23% of the total scheduled presentations were observed by the Contract Monitoring Unit (CMU).

C. New York State (outside of NYC) Outreach Activities

The Department hosted three Medicaid Managed Care Coalition meetings to provide information on the following systems and program changes:

- MRT #1458, including expansion of managed care enrollment to include: Long Term Home Health Care Program (LTHHCP) recipients, and children in foster care placed in the community directly by the LDSS; and expansion of benefits to include medical social services and home delivered meals.
- Enrollment center progress on the Health Care Eligibility and Assessment Renewal Tool (HEART tool). The HEART tool is used by the Enrollment Center to do Medicaid eligibility renewals.

Several Medicaid updates were published and Managed Care Technical Advisory Group conference calls were held to update the counties on changes to the program as a result of the MRT roll-out.

IV. Operational/Policy Developments/Issues

A. Partnership Plan Waiver Amendments

The Department finalized and received CMS approval of the Special Terms and Conditions (STCs) for enrollment of individuals in the Long Term Home Health Care Program (LTHHCP), 1915(c) waiver program offering home based care to individuals who would otherwise be admitted to a nursing home. Dually eligible LTHHCP participants over age 21 are required to enroll in a MLTC plan based on a phase-in schedule approved by CMS. Dually eligible LTHHCP participants aged 18 through 20 may choose to enroll in a MLTC plan approved to enroll individuals aged 18 and older, and dually eligible individuals aged 21 and under and non-duals of any age may voluntarily enroll in a MMMC plan.

CMS granted the Department authorization for MMMC enrollment of individuals in foster care who are placed in the community directly by LDSS. This does not extend to individuals in foster care in a waiver program, those placed through a contracted agency, or those housed in an institution. In addition, the Department received CMS authorization for managed care enrollment of individuals eligible through the Medicaid Buy-In for Working People with Disabilities (MBI-WPD) program.

B. Health Plans

1. Changes to Certificates of Authority:

There were no changes to Certificates of Authority this quarter.

2. Routine surveillance activity for the quarter included operational surveys for the following plans:

   - Amida Care, Inc. Survey was conducted May 21, 2013 to May 24, 2013. A Statement of Deficiency was issued. A plan of correction has not yet been received.

   - UnitedHealthcare of New York, Inc. Survey was conducted on April 22, 2013. No deficiencies were cited.

   - HealthFirst PHSP, Inc. Survey was conducted April 17, 2013 to April 18, 2013. No deficiencies were cited.

   - Metro Plus Health Plan, Inc. and Metro Plus Health Plan SNP, Inc. Surveys were conducted June 17, 2013 to June 21, 2013. Statements of Deficiency are pending.

3. Routine provider directory surveys were conducted for health plans in the first half of 2013 with the following results. Where deficiencies were found, plans were required to provide plans of corrections:

   - The following plans received a Statement of Deficiency as a result of the Provider Directory Survey:
     Amerigroup New York, LLC.
     Amida Care, Inc.
     HealthFirst PHSP, Inc.
     Health Insurance Plan of Greater New York.
     Hudson Health Plan, Inc.
     Independent Health Association, Inc.
     Metro Plus Health Plan, Inc.
     Metro Plus Health Plan SNP, Inc.
     MVP Health Plan, Inc.
     Neighborhood Health Providers, Inc.
     New York State Catholic Health Plan, Inc.
     UnitedHealthcare of New York, Inc.
     VNS Choice
     Wellcare of New York, Inc.

   Beginning in the second quarter of 2011, the Department delegated the member services survey to its agent, IPRO. No problems were found with access to health plan telephone lines.

C. Fiscal Year (FY) 2013 State Budget Changes to Medicaid

Under the FY 2013 New York state budget, all previously existing exclusions or exemptions from mandatory enrollment into Medicaid managed care were eliminated. The Commissioner of Health was given the discretion to mandate enrollment of new populations into managed care once rates and benefits are in place. Two additional capitated programs were created within the Medicaid program: Fully Integrated Duals

Advantage plans (FIDAs), and Developmental Disability Individual Support and Care Coordination Organizations (DISCOs). The budget also provides the Commissioner of Health with the authority to include additional services in the Medicaid managed care plan benefit package.

D. Waiver Deliverables

1. Family Health Plus Buy-in Program

Development Activities

The United Federation of Teachers (UFT) contracted with New York State and the NYS Office of Children and Family Services to provide all 25,000 of its child care providers with access to health insurance through the FHPlus Employer Buy-In program. UFT has partnered with the Health Insurance Plan of New York to provide a network of services to their members. The child care workers are licensed and registered home child care providers in New York City and provide services to low-income families. During this quarter, a total of 1219 unsubsidized UFT members were enrolled in the FHPlus Buy-In program. For child care workers who are eligible for Medicaid or FHPlus, the premium is paid through the state.

FidelisCare, present in almost all counties within the state, is seeking to contract with a vendor, U.S. Fire and Unified Life, to provide family planning services so that FidelisCare can participate in the FHPlus Employer Buy-in program. As a Catholic health plan, FidelisCare does not provide these services. U.S. Fire and Unified Life is working with the state to complete the necessary steps to be approved as a vendor for family planning with FidelisCare for the FHPlus Employer Buy-In program.

The Department continues to receive inquiries from small employers about the FHPlus Buy-in Program. However, many of these inquiries are from counties where there is no health insurance plan participation and no additional enrollments have been made.

Information on the FHPlus Employer Buy-in program for both managed care plans and potential employers is available on the Department website at: **http://www.nyhealth.gov/health_care/managed_care/family_health_plus_employer_buy-in/index.htm.**

2. Family Health Plus Premium Assistance Program

The FHPlus Premium Assistance Program (PAP), for individuals who are eligible for FHPlus and have access to cost effective health insurance went into effect on January 1, 2008. Total enrollment as of June 30, 2013 is 3,077 individuals.

Enrollment in ESHI Through FHPlus PAP	New Enrollment 04/01/13-06/30/13	Total Enrollment June 30, 2013
FHPlus Adults with children	64	750
FHPlus Adults without children	281	2,327
Total	**345**	**3,077**

Age group for reporting Quarter 4/01/13-6/30/13	Number of Enrollees
19-44	2,590
45-64	487

3. Medicaid Eligibility Quality Control Plan (MEQC)

- MEQC 2008 – Appropriateness of Applications Forwarded to LDSS Offices by Enrollment Facilitators:

  Review activities were transitioned to the Department review staff for completion because the project agreement that supported this review expired. During the reporting period, the Department continued to compile the review results and draft a final summary.

- MEQC 2009 – Review of Medicaid Eligibility Determinations and Redeterminations for Single and Childless Couple Individuals Determined Ineligible for Temporary Assistance:

  The Pacific Health Policy Group (PHPG), the contractor hired to assist the Department with multiple MEQC reviews, continued to follow up with state program and system staff to establish the proper protocols for generating the universes of cases that meet the review requirements. Availability from the Department's system staff continues to be limited because of other system priorities (i.e., system work related to ACA and the Marketplace). System staff involvement was deemed necessary because the universe specifications for this review are more complicated than usual. Several multi-step edit processes are needed to accurately identify the universes of cases from which to pull the review samples.

  Based on discussions with regional CMS staff, PHPG began exploring the feasibility of using another approach that would rely less on system staff. If feasible, the revised approach will likely require numerous staff hours to manually evaluate and remove the cases that don't fit the project criteria (i.e., mimicking the multi-step programming processes).

- MEQC 2010 – Review of Medicaid Eligibility Determinations and Redeterminations for Persons Identified as Having a Disability:

  Despite issues that continued to emerge while attempting to identify the proper universes of cases, the Department and PHPG continued to work together to successfully develop, test and implement the programming specifications. A letter kicking off the review was issued to the various district offices on April 2, 2013. PHPG has requested copies of the appropriate case record information and the review process has begun. It is expected that initial, peer, supervisory and quality assurance reviews will be complete on or around October 15, 2013 so that final feedback from the districts can be collected on or around November 29, 2013.

- MEQC 2011 – Review of Medicaid Self Employment Calculations

Review results were finalized and a summary report was issued to the regional CMS office on June 28, 2013.

- MEQC 2012 – Review of Medicaid Income Calculations and Verifications

  Initial, peer, supervisory and quality assurance reviews have been completed. PHPG is in the process of gathering final feedback from the district involved in the review before issuing a draft report for review by the Department. It is expected that the final summary report will be issued on or about July 31, 2013.

- MEQC 2013 – Review of Documentation Used to Assess Immigration Status and Coding

  The Department and PHPG are in the process of developing the programming specifications needed to draw the universe of cases from the Department's data warehouse system. The testing and modification processes are expected to continue through the next quarter.

E. State Health Access Program Grant (SHAP)

As previously reported, there will be no new Health Research and Services Administrations (HRSA) appropriations to support SHAP-funded programs for years three through five; this decision affected all SHAP states. The Department received approval to use unexpended SHAP funds. SHAP funds are currently being used, in part, to help support Enrollment Center operations. The Enrollment Center began operations on June 13, 2011, and consolidated the FHPlus, Medicaid, and Child Health Plus (CHPlus) call centers. The Enrollment Center is also processing certain upstate renewals, and is preparing to expand processing to include a subset of NYC Premium Assistance cases as well as statewide presumptive eligibility Family Planning Benefit Program (FPBP) applications.

F. Benefit Changes/Other Program Changes

Home Delivered Meals and Medical Social Services: Effective April 1, 2013, these two services were added to the Medicaid managed care benefit package for enrollees who have transitioned to a MMMC plan from the Long Term Home Health Care Program (LTHHCP) and were receiving home delivered meals under the LTHHCP. This addition to the benefit package will prevent the loss of access to this service for LTHHCP participants upon MMMC enrollment and may reduce the risk of failure for these specific enrollees to remain in the community.

Pharmacy Network for Specialty Drugs: Effective April 1, 2013, managed care organizations (MCO) must permit each enrollee to fill any mail order covered prescription at any mail order or non-mail order retail pharmacy in the MCO's network. If the MCO has designated a specific pharmacy or pharmacies for filling prescriptions for a particular drug or drugs, the enrollee may fill such prescriptions at any other pharmacy in the MCO's network provided that the pharmacy agrees to a comparable price of the pharmacy designated by the MCO.

Adult Day Health Care (ADHC) and AIDS Adult Day Health Care (AIDS ADHC): The Department is awaiting authorization from CMS regarding the addition of ADHC and

AIDS ADHC to the Medicaid managed care benefit package. These programs are designed to assist individuals to live more independently in the community or to eliminate the need for residential health care services. Individuals currently in receipt of these services will receive 90 days of transitional care with the current care plan, or until the MCO authorizes an alternate care plan, whichever is later.

Directly Observed Therapy for Tuberculosis (TB/DOT): The Department is awaiting CMS approval to include TB/DOT in the Medicaid managed care benefit package. TB/DOT is the direct observation of oral ingestion of TB medications to assure patient compliance with the physician's prescribed medication regimen, and to monitor effectiveness of the prescribed treatment. Previously MCOs included medications for the treatment of tuberculosis, and this initiative adds the direct observation to ensure medications are appropriately ingested.

G. Twelve Month Continuous Coverage

In 2007, revisions were made to Chapter 58 of the New York State Social Services Law to provide continuous coverage for certain Medicaid beneficiaries and FHPlus enrollees for a period of twelve months from the date of initial eligibility and subsequent redetermination of eligibility. This proposal will provide stability and continuity of coverage and care to adults in the same way that it has for children on Medicaid. Twelve months continuous coverage for adults will be implemented January 1, 2014 with the implementation of the New York Marketplace.

H. Federally Qualified Health Services (FQHC) Lawsuit

CHCANYS, et al vs NYS Dept of Health -- a mixed decision was rendered by Judge Carter of the US District Court, Southern District of NY in February, 2013. The Court dismissed four of six of plaintiffs' causes of action and directed the Department to make changes in reimbursement policy/procedures in connection with the remaining two causes of action. Plaintiffs have filed an appeal with regard to those causes of action dismissed by the Court and the Department has filed a cross-appeal with regard to the Court's decision concerning the other two causes of action.

I. Managed Long Term Care Program

CMS provided approval for the mandatory enrollment of dual eligible recipients, 21 years of age or older receiving more than 120 days of community based long term care services, into a Managed Long Term Care Plan (MLTCP) on August 31, 2012. The initiative offers three (3) models of MLTCPs: partially capitated; the Program of All-Inclusive Care for the Elderly (PACE); and, Medicaid Advantage Plus (MAP). Both PACE and MAP include Medicare and Medicaid covered services in the benefit package and require the participant to be nursing home eligible; partially capitated plans include only Medicaid covered benefits. Recipients must choose a plan to receive services. If no choice is made, the recipient is enrolled into a partially capitated plan.

The mandatory enrollment process began in New York County in June 2012 with announcement letters notifying recipients of fee for service personal care services (of at least 120 days and 120 days of Medicaid eligibility) that the Medicaid program was changing, the recipients then received a mandatory notice and materials to start the choice period. Recipients eligible were given sixty (60) days to choose a plan. The enrollment process has followed the enrollment plan submitted with the Partnership Plan amendment, by New York City borough (Bronx, Brooklyn, Queens and Staten Island)

through December 2012. The population seeking services is now directed by Health Resources Administration (HRA) case workers to New York Medicaid Choice (NYMC), the New York State enrollment broker, which provides information and counseling to consumers, facilitates enrollment, educates plans and supports the state with data gathering.

All MLTCP models provide a person-centered plan of care, integration of health care, environmental and social services and a supportive transition from the previous, fragmented, FFS process to coordinated managed care.

1. Accomplishments

   - Mandatory enrollment process initiated and continuing in all five boroughs. Due to the length of the prior authorization and Medicaid eligibility periods, additional cohorts from all NYC counties will continue to be identified for the enrollment process; the anticipated time frame to transition all personal care cases in the five boroughs is June 2013.

   - Expanded the scope of the mandatory enrollment initiative by incorporating additional benefits into the MLTC benefit package. Recipients receiving services through the Consumer Directed Personal Care Program can now receive that benefit through a MLTCP and are included in the mandatory enrollment population. This was made effective in November of 2012. (See separate section below).

   - Completed systemic process to identify recipients receiving Private Duty Nursing (PDN) and/or Adult Day Health Care services and include these consumers in the mandatory enrollment cohort. A systemic process to identify recipients receiving Certified Home Health Agency (CHHA) services is in development. The LTHHCP population can be identified and will be transitioned when CMS approval is received.

   - Expanded MLTCP availability by approving 23 service area expansions, 9 new lines of business for operational MLTCPs, and 85 new certificates of authority for new partially capitated plans.

   - Developed, in consultation with local officials and NYMC, processes for Nassau, Suffolk and Westchester local social services districts to commence notification to participants in January 2013.

   - Established a standardized process for MLTCPs to enter into agreements with entities for the provision of Care Management Services. The three documents developed and issued to plans, Care Management Administrative Services Contract Statement and Certification, Standard Clauses for Care Management Administrative Services Contract, and Care Management Administrative Services Contract Guidelines for MLTC Plans, allow MLTCPs to establish this relationship in an expedited manner. Care management is the foundation of the managed long term care process.

   - New York's Enrollment Broker, NYMC conducted the MLTC Post Enrollment Outreach Survey which contains specific questions specifically designed to measure the rate at which consumers are able to maintain their relationship with their personal care aide or home attendant. For the period ending December

2012, 957 surveys were completed and found that 86% of the respondents are receiving services from the same home attendant (personal care) agency.

- Expanded the scope of the transition of community based services to include Certified Home Health Agency care, Private Duty Nursing and Adult Day Health Care services in mandatory counties beginning in February 2013.
- Expanded the geographic transition region to include Nassau, Suffolk and Westchester counties in February 2013 with CMS approval.
- Continued to develop reporting mechanisms with Enrollment Broker and Computer Sciences Corporation to assure information is gathered as required as transition moves forward.
- Expanded Department's complaint hotline staffing and developed and implemented a new standardized database for tracking complaints and resolution.
- Additional education was developed and shared with MLTC Plans addressing Consumer Directed Personal Assistance Services and its use.
- Entered into discussion to initiate a Member Services survey of all MLTC Plans on a semi-annual basis by the State's contractor to assure information shared with potential enrollees is accurate and helpful.
- Developed, with the Enrollment Broker, training for local social services in the transition process, identifying the districts ongoing role during the transition, establish clear communication mechanisms with MLTC plans, SDOH and stakeholders to ease transitions, addressing potential systemic issues and ensure informed choice by stakeholders and enrollees.

2. Significant Program Developments

- Initial mandatory enrollment process completed in NYC.
- Mandatory initiative moving into Nassau, Suffolk and Westchester counties.
- Continued incorporation of community based LTSS into the MLTC benefit package – CDPAP, PDN, Adult Day Health Care (ADHC), and CHHA.
- Expanded MLTCP capacity in all mandatory counties and building capacity for future counties.
- Continuity of care assured through transition period.
- Monitoring of network capacity, delivery systems and coordination of care.
- Development of data gathering systems to meet terms and conditions reporting requirements.
- Development and submission of waiver amendments for the 1915 c LTHHCP.
- Created study protocol with External Quality Review Organization (EQRO) to review auto-assigned cases to meet reporting requirement related to transition of care.

- Developed and expanded information available to participants selecting plans to include a Consumer Guide for Plans in NYC based on assessment data submitted. This Consumer Guide is also being developed for other regions of the state.

- Established mechanism for ongoing policy directives to MLTCs for clarification and consistency in MLTC transitions and ongoing implementation and expansion.

- Improvement to network reporting guidelines for all MLTCs.

- Initiated training for use of the mandatory Uniform Assessment System for New York State which will replace the Semi Annual Assesment of Members tool previously utilized by MLTC assessors.

- Developed Guidelines for MLTC plans and the State's Enrollment Broker on Involuntary Disenrollment to assure appropriate notice and ongoing care as needed to support health and safety of enrollees in the community.

- Further clarified the definition of community based long term care services to address Medicaid recipients in need of housekeeping services.

3. Issues and Problems

Hurricane Sandy had a devastating impact on New York State's health resources and the aftermath of the storm continues to affect health care needs and outcomes.

- It was necessary to pause the implementation and processing of auto-assignments in New York City during November due to disruptions caused by Hurricane Sandy. This resulted in delays in issuing announcement and mandatory enrollment notices to targeted consumers during November; however schedules were back on track by December of 2013.

- NYMC, the Department enrollment broker, had to redeploy systems and resources due to storm damage at their main facility.

- The Department's ability to systemically identify certain transition populations was delayed.

- In response to various allegations of improprieties relating to utilization of Social Day Care in MLTC, SDOH, the Attorney General's Office and the Office of the Medicaid Inspector General are cooperating in ongoing audits and investigations. Focused activities are being expanded on an ongoing basis as issues are identified.

4. Summary of Self Directed Options

To minimize disruption and promote continuity for members receiving Consumer Directed Personal Assistance Service (CDPAS) a policy for the transition of CDPAS into MLTC and the MCO benefit package was created. Self-direction gives individuals and families greater control over the services they receive, how they receive them and who provides them and a clear direction to both the MLTC plans and MCOs supports its success.

This policy document was created in conjunction with a CDPAS Workgroup reflective of numerous stakeholders that met a number of times to discuss issues and develop policies for this new benefit:

- **Contracting During the Transition Period** For the period October 1 2012-September 30, 2013 (Transition Period), Health Plans are required to contract with FIs that currently have a contract or MOU with a LDSS and currently provide fiscal intermediary services to the health plan's member(s). The rate of payment must be at least the FFS rate of payment provided for in the contract or MOU between the FI and the LDSS. The MLTC/MCO is not required to contract with FIs unwilling to accept the applicable Medicaid FFS rate as long as the MLTC/MCO maintains two (2) FIs for each county. To adequately meet the needs of members who are newly assessed and considered eligible to receive CDPAS, the MLTC/MCO may also include in the MLTC/MCO's network FIs that do not have a contract or MOU with the LDSS.

- **Consumer Continuity of Care and Choice During the Transition Period** The Department provided a list of FIs currently providing FI services to FFS and MCO's enrolled members. To promote and maintain consumer choice, members may, during the Transition Period, change to any FI in the county that has a contract with the MCO.

  If, at the time of transition, an FI serves less than five (5) members in a county, MLTC/MCOs may encourage the members to use an alternative FI to minimize the number of FIs an MLTC/ MCO must have under contract. However, during the transition period, the expectation is that a member is not required to transition to a different consumer directed personal assistant due to the lack of an MLTC/MCO/FI contract. MLTC/ MCOs are prohibited from coercing or threatening the member or the worker to change FIs.

- **Network Adequacy During the Transition Period** An MLTC/ MCO that does not have members participating in CDPAS in a particular LDSS must have at least two (2) FI contracts. This will ensure that members will have the option to participate in CDPAS.

- **FI Contracting and Network Adequacy After the Transition Period** Beginning October 1, 2013, MLTC/MCOs may contract with two (2) FIs to cover members in multiple counties.

- **Model FI Contract and Department of Health Review** The Department supports the use of the MLTC/MCO/FI model contract developed by the parties. However, each MLTC/MCO/FI may negotiate the terms of the model contract, except that no agreement may contain provisions that would be considered management functions under 10 NYCRR 98-1.11 or a provider agreement per 10 NYCRR 98-1 and the Provider Contract Guidelines without the express written approval of the Department. The MCO were required to submit to the Department the name(s) of the contracted FIs for each county prior to October 1, 2012 and the fourth quarter of each year thereafter, or upon request of the Department.

- **Acknowledgement of the Roles and Responsibilities of the Consumer/Designated Representative** Each member prior to receiving CDPAS must sign a consumer acknowledgement of the roles and responsibilities

of the MLTC/MCO and the member. The Department has provided a sample acknowledgment form with the minimum requirements for its use by the MLTC/MCO.

- Transition of Consumer Direct Services continues throughout the mandatory counties.

- Department is preparing guidelines to share with all MLTCs regarding Consumer direct Services to supplement existing educational materials shared previously.

5. Required Quarterly Reporting

   - **Critical incidents:** The most significant critical incident for the reporting period was Hurricane Sandy. In order to assure ongoing connection to members the Department required Plans: to provide working phone numbers available 24/7 and alternate working email addresses; to make member service representatives available beyond office hours; to perform outreach to members to assess their safety and location; and to authorize out of network coverage for services to assure that members could continue services in alternative locations due to evacuations. In addition NYMC had to make adjustments due to being evacuated from their workplace such as shifting consumer representative phone lines, delaying mandatory mailings, and creating alternate access to systems. During recovery, Plans, the Department, the HRA and NYMC have continued to identify issues (i.e. mailing addresses; out of service area members) to assure ongoing continuity. Also during this time the Department, in partnership with NYMC is developing the critical incident reporting structure. Due to Hurricane Sandy, additional time is needed to complete the system.

     The system continues to be refined at this time, with an anticipated completion date of Fall 2013.

     No critical incidents have come to the attention of the Department this quarter. We continue to work on a formal electronic structure that will be in place next quarter.

   - **Grievance and appeals:** The number and types of grievance and appeals for this population filed and/or resolved within the reporting quarter:

Period: 10/01/12 - 12/31/12			
Grievances			
Total for this period:		**Resolved**	**Resolved %**
# Same Day	2294	2294	100%
# Standard/Expedited	564	219	39%
Total for this period:	2858	2513	88%

Appeals	
Total appeals filed for this period:	
Total for this period:	221

Period: 01/01/13 – 03/31/2013			
Grievances			
Total for this period:		**Resolved**	**Resolved %**
# Same Day	2712	2712	100%
# Standard/Expedited	730	689	94%
Total for this period:	3442	3401	99%

Appeals	
Total appeals filed for this period:	
Total for this period:	407

Period: 04/01/13 – 06/30/2013			
Grievances			
Total for this period:		**Resolved**	**Resolved %**
# Same Day	3427	3427	100%
# Standard/Expedited	751	715	95%
Total for this period:	4178	4142	99%

Appeals	
Total appeals filed for this period:	
Total for this period:	413

- **Assessments for enrollment:** The total number of assessments for enrollment performed by the plans is 15,382, with 721 individuals who did not qualify to enroll in an MLTC plan.

- **Referrals and 30 days assessment:** This was the first quarter for Plans to report to the enrollment broker (New York Medicaid Choice) the number of individuals they received referral on from outside NYMC and the time frame in which assessments were completed. The establishment of the reporting system and training of Plans to assure data completeness and quality is an ongoing effort. This quarter there were 1,604 reported referrals with 1,362 dates of assessment within the 30 day time frame. This represents an 85% rate of assessment completion based on data elements submitted. The remaining 242 reported referrals had errors in the data that resulted in an inability to calculate a date for assessment. NYMC is reaching out to plans to improve the data reporting. The State will review the finalized data to determine if actions need to be taken.

- **Consistency of reporting has improved over the last quarter of 2012, but data discrepancies indicate that continued education and refining instructions is necessary.** Raw data shows total assessments conducted by MLTC plans during the period is 3,491. Of those, only 1,598 were conducted within the 30 day time frame, 1,899 were not. This represents less than 50% compliance with the base timeframes, however non compliance is appears to be isolated to certain plans. The State's enrollment broker NYMC has provided additional education regarding reporting and a steady improvement in quality and

timelines is apparent. The Department issued notification that effective next quarter (July) plan specific remedial actions will be taken as indicated.

- **Referrals outside enrollment broker:** 6,580 people were not referred by the enrollment broker and contacted the plan directly and were provided MLTC materials.

- **Referrals outside enrollment broker (consumers who were referred but did not qualify for the 30 day age calculation because of bad dates in date field):** 158 people were not referred by the enrollment broker and contacted the plan directly and were provided MLTC materials.

- **Rebalancing efforts:** Due to delay in reporting of the current assessment data from SAAM (Semi-Annual Assessment of Members), the following data reflects activities prior to implementation of mandatory enrollment. This is statewide data for managed long term care plans, therefore a subset of individuals enrolled during that period (1,108 out of 58,846).

  For the January – June 2012 reporting period, the MLTC population had 1,108 people admitted to a nursing home during the same time period.

  For the 1,108 people, percent break out by reason(s):

Therapy/Rehab	59
Respite	4
Permanent Placement	34
Unsafe home	5.7
Other	2.9

For July - December 2012. There were 1,227 nursing home admissions (out of 78,269). Admitted to a nursing home during this time period:

Therapy/Rehab	62
Respite	3.7
Permanent Placement	30
Unsafe home	6.4
Other	3

- **Total complaints, grievances/appeals by type of issue:**

Reason for Grievance	Total
Dissatisfaction with quality of home care (other than lateness or absences)	581
# Same Day	385
# Standard	194
# Expedited	2
Home care aides late/absent on scheduled day of service	179
# Same Day	139
# Standard	40
# Expedited	0
Dissatisfaction with quality of day care	14
# Same Day	7
# Standard	5
# Expedited	2
Dissatisfaction with quality of other covered services	188
# Same Day	123
# Standard	64
# Expedited	1
Dissatisfaction with transportation	2761
# Same Day	2516
# Standard	245
# Expedited	0
Travel time to services too long	10
# Same Day	8
# Standard	2
# Expedited	0
Wait too long to get appointment or service	25
# Same Day	20
# Standard	5
# Expedited	0
Waiting time too long in provider's office	4
# Same Day	4
# Standard	0
# Expedited	0
Dissatisfaction with care management	106
# Same Day	69

Reason for Grievance	Total
# Standard	37
# Expedited	0
Dissatisfaction with member services and plan operations	35
# Same Day	14
# Standard	21
# Expedited	0
Dissatisfied with choice of providers in network	18
# Same Day	12
# Standard	6
# Expedited	0
Misinformed about plan benefits or rules by marketing or other plan staff	3
# Same Day	0
# Standard	3
# Expedited	0
Language translation services not available	2
# Same Day	1
# Standard	1
# Expedited	
Hearing/vision needs not accommodated	3
# Same Day	1
# Standard	2
# Expedited	0
Disenrollment issues	18
# Same Day	3
# Standard	15
# Expedited	0
Enrollment issues	7
# Same Day	3
# Standard	4
# Expedited	0
Plan staff rude or abusive	9
# Same Day	3
# Standard	6
# Expedited	0
Provider staff rude or abusive	24
# Same Day	11

Reason for Grievance	Total
# Standard	13
# Expedited	0
Violation of other enrollee rights	3
# Same Day	2
# Standard	1
# Expedited	0
Denial of expedited appeal	1
# Same Day	0
# Standard	1
# Expedited	0
Other:	187
# Same Day	106
# Standard	81
# Expedited	0
Total for this period:	4178
# Same Day	3427
# Standard	746
# Expedited	5

Reason for Appeal	Total
Denial or limited authorization of service including amount, type or level of service	**252**
# of Standard Filed	242
# of Expedited Filed	10
Reduction, suspension or termination of previously authorized service	96
# of Standard Filed	96
# of Expedited Filed	0
Denial in whole or part of payment for service	65
# of Standard Filed	65
# of Expedited Filed	0
Other	0
# of Standard Filed	0
# of Expedited Filed	0
Total appeals filed for this period:	413
# of Standard Filed	403
# of Expedited Filed	10

Fraud & Abuse Complaints Reported in Quarter	10

Reason for Complaints	Total
Billing provider questions on coverage or payer	42
Dissatisfaction with quality of home care	13
Care not adequate to support client in home	10
Difficulty obtaining DME	9

V. Financial, Budget Neutrality Development/Issues

A. Quarterly Expenditure Report Using CMS-64

See Attachment 1. NYS Partnership Plan Projected 1115 Waiver Budget Neutrality Impact.

B. Designated State Health Programs

There was no expenditure activity for Designated State Health Programs during the quarter.

C. Hospital Demonstration and Clinic Uncompensated Care

The Department processed Clinic Uncompensated Care distributions in the amount of $34,165,504, $17,082,754 FFP, during the quarter ended March 31, 2012.

The Department processed Clinic Uncompensated Care distributions in the amount of $9,196,209, $4,598,105 FFP, during the quarter ended June 30, 2012.

The Department processed Clinic Uncompensated Care distributions in the amount of $1,790,919, $895,459 FFP, during the quarter ended September 30, 2012.

Cumulative distributions to date total $45,152,632, $22,576,316 FFP.

The Department processed Clinic Uncompensated Care distributions in the amount of $79,428,341, $39,714,171 FFP, during the quarter ended December 31, 2012.

The Department processed Clinic Uncompensated Care distributions in the amount of $28,385,795, $14,192,898 FFP, during the quarter ended March 31, 2013.

Cumulative disbursements to date total $152,966,768, $76,483,387 FFP.

At this time, there are no further updates available. Upon receipt, the updated information will be submitted.

VI. Update on Progress Activities Related to Quality Demonstrations and Clinic Uncompensated Care Funding

Hospital-Medical Home Demonstration

A. Program Accomplishments:

- Met with selected hospital teams to address revision issues and challenges to finalize work plans and to support, educate and clarify demonstration program requirements;
- Finalized and launched the quarterly and annual reporting tool for hospitals to begin;
- Developed a user guide and technical guide for use with the reporting tool
- Developed an instruction manual with technical specifications for medication reconciliation registry;
- Trained reviewers for quarterly reporting in criteria for hospitals work plans, including Care Transition & Medication Reconciliation, Integration of Physical-Behavioral Health Care, Improved Access Between Primary and Specialty Care, Enhanced Interpretation Services and Culturally Competent Care, Severe Sepsis Detection, Central Line-Associated Bloodstream Infection (CLABSI) Prevention, Venous Thromboembolism Prevention and Treatment, and Surgical Complications Core Processes;
- Met with the NYS DOH Perinatal Quality Collaborative to determine the requirements for quarterly reporting and developed a review process for the Avoidable Preterm Births and Neonatal Intensive Care Unit Safety and Quality inpatient projects; and
- Designed a Resident Survey to be distributed in early July assessing primary care resident understanding of, and attitudes toward PCMH and continuity clinic fidelity to PCMH clinic principles.

B. Program Status:

During the third quarter, the New York State Department of Health (NYSDOH) review team worked with hospitals to finalize work plans revisions, assisting hospitals in the complicated work of measure development and revising project details that met standards set by the Special Terms and Conditions. Hospitals' work plan revisions were completed and sent to IPRO for insertion into the final work plan and measure grid. Hospitals continued to prepare and implement planned actions as written in the work plan and revisions as work began on January 1, 2013.

The system redesign that began during the second quarter to support hospitals work plans continued during this third quarter and was coordinated with the electronic reporting tool that is completed. The two are to be interrelated and

going forward will allow hospitals to have interchangeable access to both the work plan and the reporting tool.

C. Administrative and Policy Challenges:

Outpatient sites were not well equipped to collect standardized measure data due to changing electronic record systems, lack of experience and understanding on the part of clinicians on carrying out formal reporting, as well as evolving clinical guidelines and measure definitions. Now that sites are anticipating reporting on the measures they have selected, many have discovered the need for a better understanding of measure development and have sought NYSDOH assistance to revise their measure definitions and data collection plans. We are meeting this challenge with the development of systems for allowing those changes while not imposing on the quarterly review process.

D. Planned Actions for the Next Quarter:

- Hold a Question & Answer conference call on the Reporting Tool;
- Review the quarterly data submissions from the Hospitals;
- Begin conducting site visits to learn about the accomplishments, changes and challenges hospitals are facing during this Demonstration Program;
- Plan the Annual In-Person Meeting for Hospitals;
- Plan project oriented Best Practice Presentations to facilitate collaboration between hospitals
- Administer Resident Survey

Potentially Preventable Readmissions Demonstration

No change at this time.

VII. Consumer Issues

A. Complaints

Medicaid managed care plans reported **4464** complaints/action appeals this quarter, a decrease of **8%** from the previous quarter. Of these complaints/appeals, **669** were FHPlus complaints/appeals. The most frequent category of complaint/appeal was balance billing disputes, accounting for **33%** of the total. There were **61** complaints/appeals reported by the HIV special needs plans (SNPs). The majority of these complaints (**10**) were in the category of reimbursement/billing. The Department directly received **147** Medicaid managed care complaints and **2** FHPlus complaints this quarter.

The top five most frequent categories of complaints were as follows:
33% Balance Billing
13% Reimbursement/Billing Issues
9% Difficulty Obtaining Emergency Services

8% Non-Medical Provider MCO Services
8% Dissatisfaction with quality of care

Beginning in 2013, complaint categories were updated to allow reporting for disputes involving new benefits and long term care services and supports.

This quarter, mainstream Medicaid managed care plans reported the following complaints and action appeals regarding long term services and supports. The Department did not identify any overall trends impacting enrollees' access to services:

Long Term Services and Supports	Number of Complaints/Action Appeals Reported
Consumer Directed Personal Assistant	0
Home Health Care	7
Non-Permanent Residential Health Care Facility	0
Personal Care Services	14
Personal Emergency Response System	0
Private Duty Nursing	0
Total	21

B. Medicaid Managed Care Advisory Review Panel (MMCARP) Meetings

No MMCARP meetings occurred during this quarter.

C. Managed Care Policy and Planning Meetings

Managed Care Policy and Planning meetings were held on April 18, May 16 and June 20, 2013. The April meeting included presentations on: updates on MMC and FHPlus rates; 2012 Quality Incentive payments; stop-loss advance; response to plan association and Milliman letter regarding administrative and CRG adjustments; primary care rate increase (PCRI); managed care efficiency adjustments; MLTC risk corridor calculation; uniform assessment tool; FIDA update; update on new populations and benefits; patient centered medical home.

The May meeting included: updates on MMC and FHPlus rates; MLTC rates, transition rates and timing; reserves; FIDA update; implementation of elective C-section and Percutaneous Coronary Intervention (angioplasty) initiatives; Behavorial Health Organization (BHO) presentation; mental health/pharmacy workgroup update; and a presentation by food and nutrition services agency, God's Love We Deliver.

Presentations at the June meeting included: MEDS/MMCOR report; mainstream April 2013 rates; PCRI; stop-loss/risk pools; an update on MLTC rates/risk corridor settlement; update on FIDA; update on BHO; Hepatitis C; a discussion of the standardized pharmacy prior authorization form; and a presentation on the New York City school-located vaccination program

VIII. Quality Assurance/Monitoring

A. Quality Measurements

1. All seventeen Medicaid plans submitted care management data for members identified for or enrolled in care management services during 2012. There were 128,554 members either identified or enrolled in care management during 2012 which is largely consistent with the year prior. The data includes information on the volume of members, intake and enrollment process measures as well as some information about the volume of services and length of enrollment in the programs. This information will be shared with plan-specific reports in the third quarter and the following tables provide examples of what will be included in the report.

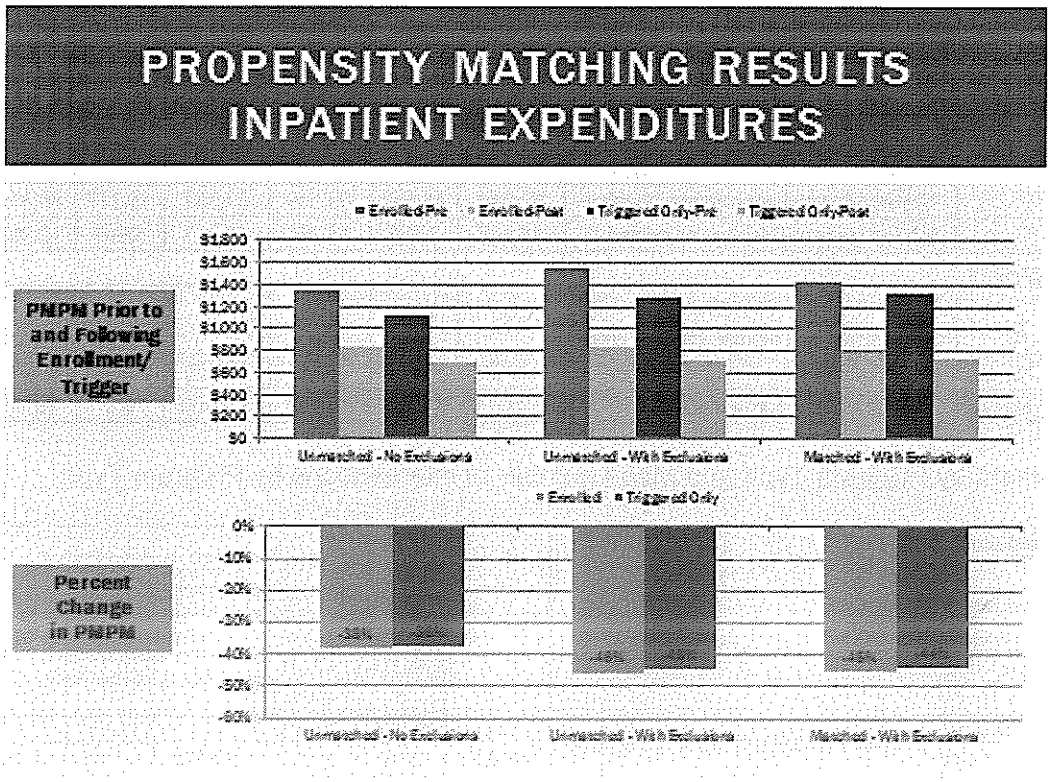
Volume involved in Care Management

		2011 Statewide Result			2012 Statewide Result		
Measure	**Definition**	**Denom**	**Num**	**% 2011**	**Denom**	**Num**	**% 2012**
Identifying for Case Management							
Trigger Rate	Number triggered /Number enrolled in	3,504,720	111,285	3.2%	3,892,252	128,554	3.3%
Contact Rate	Number contacted /Number triggered	111,285	52,064	46.8%	128,554	57,582	44.8%
Appropriateness Rate	Number deemed appropriate /Number	52,064	48,668	93.5%	57,582	46,217	80.3%
Refusal Rate	Number refused /Number contacted &	48,668	7,398	15.2%	46,217	5,967	12.9%
Enrolling in Case Management							
Total Number Enrolled	Members who were contacted, deemed appropriate, and did not refuse to enter		**Min**	**Max**		**Min**	**Max**
...Annually	Total number enrolled in CM in the	41,020	96	13,035	39,552	111	11,580
...Monthly Average	Total number enrolled in CM / 12	3,418.3	8.0	1,086.3	3,296.0	9.3	965.0

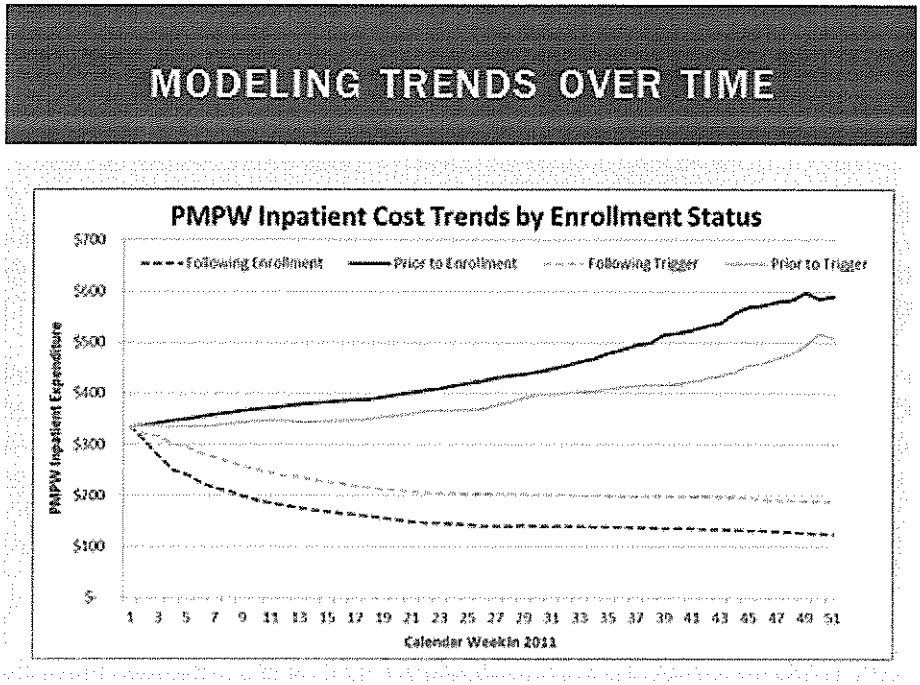
Enrollment by Program Type and Mean number of interventions by Program Type

Provision of Case Management							
CM Program Type....							
Behavioral Health	Percent Enrolled in Program (of all CM enrollees)	41,020	2,925	7.1%	39,552	4,177	10.6%
Catastrophic			2,776	6.8%		3,653	9.2%
Chronic Adult			19,315	47.1%		10,300	26.0%
Health Home			6	0.0%		0	0.0%
High Risk OB			9,583	23.4%		13,041	33.0%
HIV/AIDS			808	2.0%		1,585	4.0%
Oncology			160	0.4%		83	0.2%
Pediatrics			4,088	10.0%		2,696	6.8%
Provider-based			22	0.1%		8	0.0%
Utilization-based			1,321	3.2%		4,009	10.1%
Missing/Invalid/Not Reported			16	0.0%		0	0.0%
...By Total Interventions Received		**Denom**		**Mean**	**Denom**		**Mean**
Behavioral Health	Mean Number of Total Interventions (for members in that program type)	2,925		3.0	4,177		5.6
Catastrophic		2,776		4.7	3,653		5.9
Chronic Adult		19,315		4.5	10,300		6.6
Health Home		6		4.7	0		0.0
High Risk OB		9,583		4.1	13,041		4.7
HIV/AIDS		808		4.3	1,585		7.6
Oncology		160		12.6	83		9.0
Pediatrics		4,088		3.1	2,696		5.4
Provider-based		22		1.9	8		3.1
Utilization-based		1,321		4.3	4,009		3.8
Missing/Invalid/Not Reported		16		3.1	0		0.0

2. In addition to process measures, we are continuing to analyze the impact of care management on costs and utilization. Analyses were done using propensity matched groups of those enrolled in care management and those who were identified for care management, but did not enroll. Analyses are continuing to be developed, but preliminary results indicate that the inpatient and ER costs decreased by a higher percentage for the enrolled group than those identified for care management, but did not enroll.



3. Similarly, preliminary analyses of cost trends over time to determine the impact on cost using a time series approach have indicated there may be a greater decrease in costs for inpatient services for those enrolled in care management than those who were identified, but did not enroll.



B. Managed Long Term Care

Member Satisfaction Survey

In February 2013, the Managed Long Term Care satisfaction survey was released to a random sample of members from each plan. Members with six months or more of continuous enrollment were targeted within the 25 MLTC plans. The survey was concluded on June 30, 2013 and the response rate was 27%. The survey data is currently being analyzed and the results will be publicly available in a report on the Department's web site and select measures will be available by plan in the 2013 Managed Long-Term Care Report and the regional consumer guides this fall.
http://devweb.health.ny.gov/health_care/managed_care/mltc/consumer_guides/index

Transitions of Care focused clinical study

The expansion of the Medicaid Section 1115 Demonstration requires NYS to conduct a validation audit to determine MLTC compliance with the requirement that an initial assessment be completed within 30 days of referral and to assess the continuity of care during the transition of care period. NYSDOH, with its external quality review agent, IPRO, initiated this study in February 2013 to assess both the timeliness and the continuity of care

components. Nineteen MLTC plans were sent random samples of auto-assigned and mandatory enrolled members and were required to submit documentation to IPRO for review by the end of March. IPRO is continuing to review the plan submitted records and will be completing their reviews and summarizing the findings within the next month.

UAS-NY Transition

On May 13, 2013, the Division of Long Term Care announced a 90-day delay in the implementation of the Uniform Assessment System for New York (UAS-NY) for Managed Long Term Care (MLTC) Plans and their respective provider networks. The UAS-NY is a web-based software application that will provide a comprehensive assessment system to evaluate individuals' health status, strengths, care needs, and preferences to guide the development of individualized long-term care service plans. This delay is intended to provide additional time for MLTC plans to ensure that their staff and providers within their provider networks are prepared to successfully transition to using the UAS-NY.

C. Quality Improvement Activities

External Quality Review

Approval was obtained to extend the current External Quality Review contract with the Island Peer Review Organization (IPRO) for an additional 12 month period. The contract extension will run from April 1, 2013 through March 31, 2014.

A Request for Proposals is currently being prepared to solicit bids for a five year contract to conduct Medicaid managed care external quality review (EQR) as per the Balanced Budget Act of 1997 and CMS published EQR regulations. The new contract will be in effect April 1, 2014.

Health plans participated in a variety of quality improvement activities including performance improvement projects, and special studies.

Performance Improvement Projects (PIPs)

The Department's external quality review organization, Island Peer Review Organization (IPRO), assisted managed care plans with completing the Performance Improvement Projects (PIPs). For the 2011 – 2012 study period, two collaborative PIP projects are in progress: 1) Eliminating Disparities in Asthma Care (EDAC) which involved six Medicaid managed care plans in the Brooklyn, NY service area and 2) Reducing Potentially Preventable Readmissions (PPR) which has 10 health plans from across the state participating. Both PIP projects have concluded and final reports are being written by the plans.

For 2013-2014, a collaborative PIP includes two parts: 1) implementing interventions to improve care in diabetes prevention and management, smoking cessation and hypertension management, and 2) testing the effectiveness of patient incentives on improving health behaviors and outcomes in the above-noted clinical areas. Plans have submitted proposals describing their proposed interventions. The interventions have been reviewed by the Department and IRPO and discussed and refined with the plans. During the quarter, the plans began to implement their interventions for improvement and for the testing of patient incentives through Diabetes Prevention Programs.

D. Quality Outcomes Evaluation

Selective Contracting

Staff continues to work with hospital representatives concerning the Department's policy regarding Medicaid reimbursement for breast cancer surgery and hospital eligibility for the performance of such surgery. In addition, staff continues to maintain an updated database of CMS centers certified to perform bariatric surgery and field questions regarding the Department's policy that only CMS certified bariatric centers may be reimbursed for bariatric surgical services provided for Medicaid recipients.

Quality Outcomes Evaluation

- Potentially Preventable Hospitalizations
  Staff has received data for hospital inpatient claims for the year 2012. Data preparation has begun to clean and format the data. Once prepared, the following indicators will be added to the file: Potentially Preventable Readmissions (PPRs), Potentially Preventable Complications (PPC) and Prevention Quality Indicators (PQIs). These indicators are necessary for many of the quality incentives conducted by the Department.

- Prevention Quality Indicators for Managed Care Plans
  Staff has received data for Medicaid encounters during calendar year 2012. Once the file is prepared and the Prevention Quality Indicators have been identified, the data will be analyzed and the health plans will be ranked. This measure will be added to the Managed Care Quality Incentive released this fall.

- Nursing Home Quality Improvement
  Staff has released the first year report using benchmark data and conducted webinars on the methodology and results of the quality pool. Staff continues to work with nursing home representatives to answer questions about the quality pool. Data for calendar year 2012 has been received and staff is starting to conduct analyses for the potentially avoidable hospitalization measure to be included in the quality pool to be released this fall.

- Managed Long-Term Care Quality Incentive
  Staff is finalizing the analysis plan for the risk adjustment methodology for the potentially avoidable hospitalization measure in this incentive. Data for the calendar year 2012 has been received and staff is starting to conduct analyses for the potentially avoidable hospitalization measure to be included in this quality incentive and the MLTC annual report.

Asthma Disparities Grant

Eliminating Disparities in Asthma Care (EDAC) Grant activities this quarter were focused on the following: posting the Executive Summary and results of the EDAC Collaborative survey to the IHI Extranet; calculating and posting the Group III Suite of Measures for measurement period 10; and beginning to analyze data in accordance with the EDAC evaluation plan.

The Group III Suite of Measures includes 5 measures stratified by race/ethnicity and health plan. Those 5 measures are: 1) two or more chronic maintenance asthma visits (CMAV); 2) at least one emergency department visit with a primary diagnosis of asthma (ED); 3) at least one hospitalization with a primary diagnosis of asthma (IP); 4) at least one filled prescription for a long-term asthma controller medication filled within 30 days of their last asthma outpatient visit (LTC); and 5) the ratio of asthma controller medications to all asthma medications filled being higher than 0.5 (RACM). The trend data for the EDAC Group III measures indicate that CMAV rates, stratified by race/ethnicity, are on a general downward trend (72.1 when work started in the practices in May 2011 and 65.9 in January of 2013) but seem to be stabilizing for Blacks and Hispanics. Hispanics in Central Brooklyn had the

highest rate for this measure (70.9) in the last measurement period (2/2012-1/2013). The ED rate, after going down, has begun to increase for Hispanics in Central Brooklyn, while the rate for Blacks has stabilized. This increase may be due in part to seasonal variation as the same increase is seen around the same time of year in the previous year. IP rates have decreased across all race/ethnic groups, with a modest increase in the winter likely due to seasonal variation. The RACM has gone down from 64.8 to 51.8 for all race/ethnic groups, with Hispanics decreasing the least (63.7-54.0). The LTC rate overall has been fairly stable from May 2011 to January 2013, although the rate for Blacks has decreased from 72.1 to 56.9 from May 2011 to January 2013. When the Group III Suite of Measures is stratified by health plan, little variation is noted.

IX. Family Planning Expansion Program

Family Planning Benefit Program Enrollment Summary
Third Quarter FFY 2013 (April 1, 2013 – June 30, 2013)

	Female	Male	Total
New Enrollees This Quarter	7,850	2.082	9,932
Total Enrollees This Quarter	38,321	8,765	47,086
Enrollees Using Services This Quarter	11,918	254	12,172
Cumulative Enrollment Since 7/01/11	87,790	24375	112,165
Enrollees Using Services Since 7/01/11	43,133	1,660	44,793
Continuous Enrollment Since 7/01/11	4,048	358	4,406

Source of Data: DOH/OMM Audit, Fiscal and Program Planning Data Mart (Report Date: 01-June-2013)

Family Planning Benefit Program Utilization by Category of Service
Third Quarter FFY 2013 (April 1, 2013 – June 30, 2013)

TOTAL Medicaid Eligibles	**47,086**
TOTAL Medicaid Recipients	**12,172**
TOTAL Medicaid Expenditures	**2,376,183**
TOTAL Medicaid Eligible Months	**119,471**
AVERAGE Expenditures per Eligible	**50**
AVERAGE Months per Eligible	**2.5**
PMPM	**20**

Categories of Service (COS)	COS Dollars	COS PMPM	COS Dollars per Recipient	COS Claims / Days		COS Claims / Days per Recipient	COS Recipients
Physician	17,497	0.15	75	627	Claims	3	232
Dentist	262	0.00	262	1	Claims	1	1
Nursing	129	0.00	26	6	Claims	1	5
OPD Clinic (hospital outpatient)	36,902	0.31	277	154	Claims	1	133
FS Clinic (D&T center)	1,278,670	10.70	248	6,073	Claims	1	5,147
Inpatient	7,104	0.06	1,184	0	Days	0	6

Categories of Service (COS)	COS Dollars	COS PMPM	COS Dollars per Recipient	COS Claims / Days		COS Claims / Days per Recipient	COS Recipients
Pharmacy	916,653	7.67	119	14,834	Claims	2	7,733
Laboratory	46,245	0.39	45	2,138	Claims	2	1,017
Transportation	3,000	0.03	188	69	Claims	4	16
CTHP	997	0.01	55	22	Claims	1	18
DME and Hearing Aid	138	0.00	35	13	Claims	3	4
Referred Ambulatory	66,668	0.56	93	1,092	Claims	2	715

source of Data: DOH/OMM Audit, Fiscal and Program Planning Data Mart, (Report Date: 01-June-2013)

X. Transition Plan Updates

Attachment 2 contains the Department's updated Transition Plan indicating how New York State will transition enrollees to a coverage option under the Affordable Care Act, as required by the Section 1115 Partnership Plan demonstration.

XI. Other

Medicaid Managed Care/Family Health Plus/HIV SNP Model Contract

On June 21, 2013, the Department received CMS approval of the October 1, 2012 amendment to the Medicaid Managed Care/Family Health Plus/HIV SNP Model Contract. This amendment modifies the previously approved August 1, 2011 version of the model contract and includes contract language changes related to implementation of various Medicaid Redesign Team initiatives, other programmatic changes and a one-year extension of the contract through February 28, 2014. The contract amendment was sent to MCOs for signature on June 27, 2013.

Attachments

Mark Bertozzi
Director of Bureau of Administration
One Commerce Plaza
Albany, NY 12237
Phone: 518-473-5876
Fax: 518-473-5508
Submitted on: December 31, 2012

ATTACHMENT 1

New York State Partnership Plan
Projected 1115 Waiver Budget Neutrality Impact Through December 2013
DY10 0708 21 Month Lag

Budget Neutrality Cap (Without Waiver)	DY 1 - 8 (10/1/97 - 9/30/06) Projected	DY 9 (10/1/06-9/30/07) Actual	DY 10 (10/1/07-9/30/08) Actual	DY 11 (10/1/08-9/30/09) Actual	DY 12 (10/1/09-9/30/10) Actual	DY 13A 10/1/10-3/31/11) Actual
Demostration Group 1 - TANF Children under age 1 through 20		$8,641,454,877	$9,086,365,132	$9,861,957,505	$11,197,206,500	$6,105,699,488
Demonstration Group 2 - TANF Adults 21-64		$3,045,582,094	$3,217,134,170	$3,723,180,372	$4,511,421,595	$2,467,348,368
Demonstration Group 6 - FHP Adults w/Children		$1,691,957,919	$1,813,935,485	$1,759,689,505	$1,878,516,641	$1,043,047,420
Demonstration Group 8 - Family Planning Expansion						
Demonstration Group 10 - MLTC Adult Age 18-64 Duals						
Demonstration Group 11 - MLTC age 65+ Duals						
W/O Waiver Total	$144,639,878,523	$13,378,994,889	$14,117,434,787	$15,344,827,382	$17,587,144,736	$9,616,095,275

Budget Neutrality Cap (With Waiver)	DY 1 - 8 (10/1/97 - 9/30/06) Projected	DY 9 (10/1/06-9/30/07) Actual	DY 10 (10/1/07-9/30/08) Actual	DY 11 (10/1/08-9/30/09) Actual	DY 12 (10/1/09-9/30/10) Actual	DY 13A 10/1/10-3/31/11) Actual
Demostration Group 1 - TANF Children under age 1 through 20		$4,006,367,977	$4,412,472,964	$3,033,275,859	$4,144,199,750	$1,827,792,863
Demonstration Group 2 - TANF Adults 21-64		$2,062,992,139	$2,222,230,858	$1,826,307,957	$2,619,299,634	$1,159,889,284
Demonstration Group 5 - Safety Net Adults		$3,017,805,826	$3,213,033,028	$2,638,577,654	$4,024,374,518	$1,864,361,807
Demonstration Group 6 - FHP Adults w/Children up tp 150%		$813,927,831	$884,575,928	$868,666,366	$963,020,020	$502,539,894
Demonstration Group 7 - FHP Adults without Children up to 100%		$587,725,574	$566,489,543	$399,823,417	$313,222,949	$155,882,395
Demonstration Group 7A - FHP Adults without Children @ 160%		$0	$0	$0	$0	$0
Demonstration Group 8 - Family Planning Expansion		$10,471,785	$10,598,020	$5,726,583	$9,839,735	$4,164,485
Demonstration Group 9 - Home and Community Based Expansion (HCBS)		N/A	N/A	N/A	N/A	N/A
Demonstration Group 10 - MLTC Adult Age 18-64 Duals						
Demonstration Group 11 - MLTC age 65+ Duals						
Demonstration Population 1: State Indigent Care Pool Direct Expenditures (ICP-Direct)						
Demonstration Population 2: Designated State Health Programs to Support Clinic Uncompensated Care Funding (ICP - DSHP)						
Demonstration Population 3: Designated State Health Programs to Support Medical Home Demonstration (DSHP - HMH Demo)						
Demonstration Population 4: Designated State Health Programs to Support Potentially Preventable Readmission Demonstration (DSHP - PPR Demo)						
Demonstration Population 5: Designated State Health Programs (Various)						
With Waiver Total	$123,931,127,812	$10,499,291,132	$11,309,400,341	$8,772,377,836	$12,073,956,605	$5,514,630,728
Expenditures (Over)/Under Cap	$20,708,750,711	$2,879,703,758	$2,808,034,445	$6,572,449,546	$5,513,188,131	$4,101,464,547

New York State Partnership Plan
Projected 1115 Waiver Budget Neutrality Impact Through December 2013
DY10 0708 21 Month Lag

Budget Neutrality Cap (Without Waiver)	DY 13B (4/1/11-9/30/11) Projected	DY 14 (10/1/11-9/30/12) Projected	DY 15 (10/1/12-9/30/13) Projected	DY 16 (10/1/13-12/31/13) Projected	BIPA Extension (10/1/06 - 12/31/13) Projected	DY 1 - DY 16
Demostration Group 1 - TANF Children under age 1 through 20	$6,124,850,620	$13,425,919,749	$14,841,351,076	$7,943,771,145	$87,228,576,093	
Demonstration Group 2 - TANF Adults 21-64	$2,443,271,375	$5,369,945,414	$5,930,750,009	$3,168,610,456	$33,877,243,854	
Demonstration Group 6 - FHP Adults w/Children	$1,055,415,331	$2,341,067,454	$2,632,237,613	$724,658,042	$14,940,525,410	
Demonstration Group 8 - Family Planning Expansion	$5,140,241	$10,702,271	$1,856,551	$0	$17,699,062	
Demonstration Group 10 - MLTC Adult Age 18-64 Duals		$247,394,784	$1,027,336,330	$260,284,563	$1,535,015,677	
Demonstration Group 11 - MLTC age 65+ Duals		$2,554,212,091	$10,820,566,375	$2,796,750,566	$16,171,529,032	
W/O Waiver Total	**$9,628,677,568**	**$23,949,241,763**	**$35,254,097,954**	**$14,894,074,774**	**$153,770,589,127**	**$298,410,467,650**

Budget Neutrality Cap (With Waiver)	DY 13B (4/1/11-9/30/11) Projected	DY 14 (10/1/11-9/30/12) Projected	DY 15 (10/1/12-9/30/13) Projected	DY 16 (10/1/13-12/31/13) Projected	BIPA Extension (10/1/06 - 12/31/13) Projected	DY 1 - DY 16
Demostration Group 1 - TANF Children under age 1 through 20	$2,939,950,571	$6,308,398,240	$6,952,064,209	$3,538,354,107	$37,162,876,540	
Demonstration Group 2 - TANF Adults 21-64	$1,689,556,014	$3,600,327,984	$3,971,420,054	$2,002,396,978	$21,154,420,902	
Demonstration Group 5 - Safety Net Adults	$3,223,555,684	$7,909,780,921	$9,461,009,489	$2,551,560,477	$37,904,059,404	
Demonstration Group 6 - FHP Adults w/Children up tp 150%	$500,350,859	$1,114,110,571	$1,247,419,773	$342,014,780	$7,236,626,022	
Demonstration Group 7 - FHP Adults without Children up to 100%	$163,167,013	$341,142,857	$387,671,617	$107,268,049	$3,022,393,415	
Demonstration Group 7A - FHP Adults without Children @ 160%	$0	$0	$0	$0	$0	
Demonstration Group 8 - Family Planning Expansion	$5,460,394	$11,576,340	$2,045,425	$0	$59,882,767	
Demonstration Group 9 - Home and Community Based Expansion (HCBS)	$3,699,108	$3,699,108	$3,699,108	$924,777	$12,022,101	
Demonstration Group 10 - MLTC Adult Age 18-64 Duals		$249,276,515	$999,765,437	$249,927,129	$1,498,969,081	
Demonstration Group 11 - MLTC age 65+ Duals		$2,561,508,288	$10,403,512,554	$2,629,869,736	$15,594,890,578	
Demonstration Population 1: State Indigent Care Pool Direct Expenditures (ICP-Direct)	$2,600,000	$14,650,000	$13,700,000	$3,400,000	$34,350,000	
Demonstration Population 2: Designated State Health Programs to Support Clinic Uncompensated Care Funding (ICP - DSHP)	$2,600,000	$14,650,000	$13,700,000	$3,400,000	$34,350,000	
Demonstration Population 3: Designated State Health Programs to Support Medical Home Demonstration (DSHP - HMH Demo)	$0	$133,400,000	$133,300,000	$33,300,000	$300,000,000	
Demonstration Population 4: Designated State Health Programs to Support Potentially Preventable Readmission Demonstration (DSHP - PPR Demo)	$0	$5,000,000	$6,700,000	$1,600,000	$13,300,000	
Demonstration Population 5: Designated State Health Programs (Various)					$0	
With Waiver Total	**$8,530,939,644**	**$22,267,520,825**	**$33,596,007,666**	**$11,464,016,033**	**$124,028,140,809**	**$247,959,268,621**
Expenditures (Over)/Under Cap	**$1,097,737,924**	**$1,681,720,938**	**$1,658,090,288**	**$3,430,058,741**	**$29,742,448,318**	**$50,451,199,029**

Attachment 2

New York State

Partnership Plan Medicaid Section 1115 Demonstration

Transition Report

I. Introduction

On September 29, 2006, the Centers for Medicare and Medicaid Services (CMS) approved an extension of New York's 1115 waiver, known as the Partnership Plan, for the period beginning October 1, 2006 and ending September 30, 2010. CMS subsequently approved a series of short term extensions while negotiations continued on renewing the waiver into 2014. On July 29, 2011, CMS approved a renewal of the Partnership Plan for the period August 1, 2011, through December 31, 2014, with some waiver components expiring earlier to reflect implementation of the Affordable Care Act (ACA).

On January 1, 2014, New York will have made considerable progress in implementing the ACA. Specifically, New York will have expanded coverage, made changes to access to care, and reforms to the payment and delivery system. The ACA expands Medicaid eligibility for individuals under the age of 65, with income at or below 133 percent of the Federal Poverty Level (FPL). In New York State, some of these individuals are currently eligible under New York's Partnership Plan 1115 Waiver.

II. Transition Plan

Nearly 90 percent of individuals currently covered under New York's Partnership Plan 1115 waiver will transition to a State Plan eligibility group with coverage through an Alternative Benefit Plan as a result of the Medicaid expansion authorized by the ACA and adopted by New York. For most enrollees in Family Health Plus, the transition to Medicaid using MAGI eligibility rules will occur at renewal. Ideally, the State would choose to switch coverage for the waiver population from Family Health Plus to Medicaid on January 1, 2014. However, this is not possible for all enrollees because not enough information is known to the system about parent/caretaker enrollees to automatically switch them to a MAGI budget on January 1, 2014.

New York intends to stop accepting new applications for Family Health Plus after December 31, 2013. Anyone who submits an application prior to or on that date and are found eligible, will be enrolled in Family Health Plus for 12 months. Effective January 1, 2014, new applications will be evaluated using MAGI eligibility rules, and if eligible, applicants will be enrolled in Medicaid under an Alternative Benefit Plan. New York has chosen the Medicaid State Plan benefit (without institutional long-term care) as its Alternative Benefit Plan and will be submitting a SPA for Secretary Approval as soon as the SPA templates are available from CMS.

Family Health Plus single and childless couples will have their coverage changed to the Alternative Benefit Plan effective January 1, 2014. Family Health Plus parents and caretaker relatives with income up to 138% FPL will transition to the Alternative Benefit Plan as they renew, effective April 1, 2014. Family Health Plus parents and caretaker

relatives with income over 138% FPL to 150% FPL will transition to a qualified health plan, however the State will pay the enrollee's share of the premium, this does not include the individual's cost sharing.

Using existing rules, individuals renewing coverage from October 1, 2013 through March 31, 2014, if determined eligible, will enroll in the current plan under the waiver (e.g. Family Health Plus or Medicaid) for twelve months but no longer than through December 31, 2014 for Family Health Plus. Individuals determined ineligible from October 1, 2013 through March 31, 2014, will be sent a notice referring the person to apply for coverage through the Marketplace.

New York is building a new eligibility system that automates the MAGI eligibility rules for Medicaid, CHIP, and Advance Premium Tax Credits. The State anticipates over one million individuals are eligible to obtain coverage during the open enrollment period that begins October 1, 2013, and even more may apply. Given the complexity of the system build, the short time for adequately testing all the eligibility permutations and the data services available through the Federal Hub, and the reality that rules and interfaces will continue to be built 3-6 months after open enrollment, New York has decided to mitigate risk by maintaining current Medicaid enrollees in the legacy system until the State is confident it has the automation and system stability to transition over three million current enrollees without a disruption in coverage. New York is prioritizing the ability to provide coverage on January 1, 2014 to the newly eligible populations while doing no harm to current Medicaid enrollees.

To maintain stability in coverage for the over three million Medicaid enrollees whose eligibility will be determined under MAGI, the current legacy system will be modified to calculate budgets using MAGI rules to the maximum extent possible. Effective April 1, 2014, local districts will be able to determine MAGI eligibility using the current legacy system for those individuals renewing coverage. Local districts will continue to renew existing enrollees using MAGI rules in the legacy system for at least six months or until the new eligibility system is fully automated and is stable enough to handle the transition of over 3 million current recipients. The legacy logic will include:

- No longer counting child support as income
- Not applying income disregards/deductions
- Increased federal poverty levels to comply with ACA income levels
- New AID categories for claiming
- Revised client notices

The current renewal form will be used.

New applications submitted to local departments of social services from October 2013 through December 2013, will have eligibility determined under existing rules in the legacy system and, if eligible, individuals will be enrolled for 12 months of coverage. Individuals that are not eligible due to income will be instructed to reapply through the Marketplace. Applications submitted to the Marketplace from October 2013 through December 2013, will be determined using MAGI rules and if determined eligible,

coverage will be effective January 1, 2014. Applications submitted on or after January 1, 2014, will have eligibility determined through the Marketplace under the ACA rules. Individuals who have medical bills or are in need of coverage in the three month period prior to January 1, 2014, will be referred to the local department of social services for a determination of eligibility for payment/reimbursement of medical bills.

Although New York will transition individuals from the waiver to coverage under the ACA, the State intends to maintain the authority included in the waiver to mandatorily enroll individuals into managed care in counties **other than** Allegany, Cortland, Duchess, Fulton, Montgomery, Putnam, Orange, Otsego, Schenectady, Seneca, Sullivan, Ulster, Washington and Yates.

Table 1: Individuals Enrolled in Medicaid Managed Care

Current State Plan Mandatory and Option Groups	Current FPL and/or other qualifying criteria
Pregnant women	Income up to 200%
Children under age 1	Income up to 200%
Children 1 through 5	Income up to 133%
Children 6 through 18	Income up to 133%
Children 19-20	Income at or below the monthly income standard
Parents and caretaker relatives	Income at or below the monthly income standard

A. Seamless Transitions

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, regardless of disability status with income at or below 133 percent of the FPL;**

The following chart outlines the current waiver population, current coverage, and the coverage options for individuals between 133% FPL and 150% FPL currently enrolled in Family Health Plus. These options include transitioning Family Health Plus enrollees to Advanced Premium Tax Credits. Regardless of which options are available in 2014, all populations will have eligibility determined under the ACA.

Table 2: Groups Transitioning from Demonstration to ACA

Demonstration Eligible Group	Current Federal Poverty Level	Current Coverage	2014 Coverage
Adults who were recipients of or eligible for Safety Net Cash Assistance but are otherwise ineligible for Medicaid (Single individuals and Childless Couples) [s. 2001(a)(1) and (2)]	Income based on Statewide standard of need, approximately 0%-78% FPL	Medicaid	0% ≤ 133% Benchmark
Adults who were recipients of or eligible for Safety Net Cash Assistance but are otherwise ineligible for Medicaid (Single individuals and Childless Couples) [s. 2001(a)(1) and (2)]	Income above the Medicaid income standard but at or below gross 100% FPL	Family Health Plus	0% ≤133% Benchmark
Children 19 and 20 years old [s. 2001(a)(1) and (2)]	Income above the Medicaid income standard but at or below gross 150% FPL*	Family Health Plus	0% ≤ 133% Standard coverage > 133% ≤150% Standard coverage >150% APTC
Parents and caretaker relatives of a child under the age of 21 (who could otherwise be eligible under section 1931 of the Medicaid State Plan) [s. 2001(a)(1) and (2)]	Income above the Medicaid income standard but at or below gross 150% FPL*	Family Health Plus	0% ≤ 133% Benchmark > 133%≤150% State will pay enrollee's share of APTC premiums and seek federal participation as a designated state health program >150% APTC (no state assistance)

*The current Partnership Plan 1115 approved NYS comparing income to 160% FPL, but this has not been implemented.

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;

All populations currently covered under the waiver will have coverage options under the ACA. In addition, New York plans to implement 12-months of continuous coverage for adults in conjunction with the implementation of the ACA.

In 2007, revisions were made to Chapter 58 of the New York State Social Services Law to provide a 12-month continuous eligibility period to the groups of individuals specified in Table 2, 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 the Medicaid State plan, 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.

This proposal will provide stability and continuity of coverage and care to adults in the same way that it has for children on Medicaid. Authority for this population's eligibility during the 12 month continuous eligibility period is only in the 1115 waiver and therefore, individuals during this period would be eligible for expanded Medicaid levels and benchmark under ACA, and are also subject to continuous coverage. The Department is in the process of exploring the necessary system and program changes and anticipates implementing in January 2014.

Table 3: Groups Eligible for a 12-Month Continuous Eligibility Period

State Plan Mandatory and Optional Groups	Statutory Reference
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

iii. Implement a process for considering, reviewing, and making preliminarily determinations under all January 1, 2014 eligibility groups for new applicants for Medicaid eligibility;

- Local departments of social services will process new applications for Medicaid using current eligibility rules through December 31, 2013.
- New applications submitted to the Marketplace from October 2013 through December 2013, will have eligibility determined through the Marketplace under ACA rules and, if eligible, enrollment will be effective January 1, 2014. The acceptance notice will inform individuals who have medical bills or are in need of coverage prior to January 1, 2014 to apply at the LDSS. Applicants will be informed of this process online so they may go directly to the LDSS rather than apply through the Marketplace before January 1, 2014.
- Beginning January 1, 2014, new applications will go through the Marketplace and will be processed through the new integrated eligibility system.

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;

Nearly all of the populations covered under the waiver will be covered under the ACA and those populations who are subject to continuous coverage will also have it applied under the waiver.

Parents/caretakers with MAGI income between 138% and 150% of FPL will no longer be eligible for a Medicaid waiver category, but will be eligible for a tax credit under the ACA provided they do not have access to affordable coverage. The State will be seeking authority through an amendment to the Partnership Plan waiver, for federal financial participation for an affordability wrap for those individuals who would have been eligible for Family Health Plus prior to January 1, 2014 and who are now able to purchase Qualified Health Plans. The goal is to mitigate the increased costs for these individuals as they move from the Medicaid waiver to the QHP. The State intends to implement an affordability wrap to pay the premium for the Qualified Health Plan for individuals in this income group who purchase a silver plan. 19 and 20 year olds who are living with parents with MAGI income between 138% and 150% of the FPL will no longer be eligible for a Medicaid waiver category, but will be eligible for Medicaid under MOE requirements.

v. Develop a modified adjusted gross income (MAGI) calculation for program eligibility.

New York is developing a new eligibility system that will automate program eligibility based on the MAGI eligibility rules as defined by CMS. All applications submitted to the Marketplace after January 1, 2014 will be processed using the MAGI eligibility rules in the new system.

As described above, to maintain stability in coverage for the over three million Medicaid enrollees whose eligibility will be determined under MAGI, the current legacy system will be modified to calculate budgets using MAGI rules to the maximum extent possible. Effective April 1, 2014, local districts will be able to determine MAGI eligibility using the current legacy system for individuals renewing coverage. Local districts will continue to renew existing enrollees using MAGI rules in the legacy system for at least six months, or, until the new eligibility system is fully automated and is stable enough to handle the transition of over three million current recipients.

New York opted for CMS to develop a modified adjusted gross income (MAGI) equivalency level for converting existing net eligibility levels to MAGI eligibility levels. New York received preliminary results, but is waiting for the re-run results for children along with the weighted averages for the separate applicant and beneficiary results.

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;

The service delivery network for a Managed Care Organization ("MCO") is county specific and is comprised of primary, specialty and ancillary providers as well as related institutions consistent with the benefit package. Each county network must include at least one hospital, one inpatient and outpatient mental health facility as well as at least one substance abuse inpatient and outpatient facility. This applies to HMOs participating in government programs and those that have exclusive commercial membership.

The behavioral health network is required to have both individual providers, outpatient facilities and inpatient facilities. The facilities must include mental health and substance abuse services. In the case of outpatient mental health, at least one facility in the county must be licensed by the Office of Mental Hygiene pursuant to Article 31 of the Mental Hygiene Law, or be a facility operated by the Office of Mental Hygiene. The mental health inpatient facility can be either a psychiatric center under the jurisdiction of the Office of Mental Hygiene, or, a unit or part of a hospital operating under Article 28 of the Public Health Law.

The provision of alcohol and substance abuse services must also be provided in an outpatient facility and an inpatient facility. These facilities must have the capacity to provide substance abuse treatments. The inpatient facilities must have the capacity to provide detoxification and rehabilitation services.

In addition to the above, Medicaid networks must also include traditional Medicaid providers, i.e., presumptive eligibility providers, Designated AIDS Centers and Federally Qualified Health Centers (FQHCs), where available.

With the implementation of the homeless population into Medicaid managed care, we also require the MCO to contract with available federally qualified 330 H providers in every county they are available in.

On April 1, 2013, the Long Term Home Health Care Program and non-agency foster care children living in the community in the upstate counties were transitioned into Medicaid managed care. As a result, additional provider network requirements were made. In the Long Term Home Health Care Program, MCOs were required to contract with certified home health care agencies, nursing homes and hospitals that provided the Long Term Home Health Care Program.

The addition of the non-agency foster care children required MCOs to augment their provider network where necessary to include fee for service health care providers who have traditionally treated this population. We also strongly encouraged MCOs to contract with specific specialty health care providers for intake and ongoing comprehensive assessments for children in foster care.

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 MCO is required to have the full array of contracted providers in each county. However, in rural counties, this may not be possible due to a lack of resources within the county. When there is a lack of a provider type in a county the MCOs may contract with providers in adjacent counties, or service area, to fulfill the network requirements. In some cases where counties border neighboring states and the normal access and referral pattern for obtaining medical services in those areas is to go across state boundaries, MCOs may request approval to augment their networks by adding those out of state providers. Attachment 1 provides a listing of the core provider types for all lines of business.

In addition to the full array of required health care providers, the network must include sufficient numbers of each provider type, be geographically distributed and ensure choice of primary and specialty care providers. The Public Health Law requires the MCO member a choice of at least three geographically accessible primary care providers. It is the department's policy that MCOs are required to contract minimally with two of each required specialist provider types per county. However, additional providers may be required based on enrollment and to ensure geographic accessibility.

The Department of Health has developed time and distance standards for provider networks to which MCOs are required to adhere. For all Medicaid, HIV Special Needs Plans, and Child Health Plus health products, the time and distance standard is as follows:

- metropolitan areas - 30 minutes by public transportation;

- non-Metropolitan areas - 30 minutes or 30 miles by public transportation or by car;
- in rural areas transportation requirements may exceed these standards if justified.

The provider networks for the Medicaid, HIV Special Needs Plans, and Child Health Plus managed care products are reviewed on a quarterly basis. The Department of Health maintains a database and MCOs are required to submit their networks electronically at schedule dates. The submitted data goes through an editing process to ensure the data contains all required information prior to accepting the network. Prior to a network analysis the information is matched against state and federal disciplinary files to remove providers unauthorized from participation in government programs. Subsequently, the network is analyzed for the presence of core provider types and sufficient numbers of providers to ensure choice of primary and specialty providers.

The first part of the review is an electronic analysis based upon program parameters established by the Department to determine if each county has an adequate number of the required core providers. The second part of the analysis is a manual review of reports that are produced. Examples of these reports include whether there are a sufficient number of providers in the county to provide a choice of primary and specialty providers and a comparison of providers not contracting with a specific MCO but who have contracts with other MCOs in the same county. The reports are then summarized and MCOs are notified of any access issues identified within their certified areas of operation. MCOs are required to review the summaries and report back to the Department. The Department will then have MCOs sign an attestation that members may obtain services on an out of network basis to the nearest provider, but not greater than 30 minutes or 30 miles from the members' residence. This attestation remains in place until the MCO is able to successfully address the noted provider inadequacy.

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);**

The State will pay the PPS rate through the eMedNY FFS system for eligible Medicaid enrollees. For enrollees in Medicaid managed care, the State will make supplemental payments to eligible FQHC/RHC's to make up the difference between the PPS rate and the average managed care payment.

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: i. Replacing manual administrative controls with automated processes to help support a**

smooth interface among coverage and delivery system options that is seamless to beneficiaries;

New York is working to simplify and align both our rules and processes in accordance with the ACA requirements, and to automate MAGI eligibility determinations and verifications to the maximum extent practicable, and to promote a more seamless customer experience.

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;

The State will provide quarterly and annual reports.

E. **Implementation**

i. By July 1, 2013, the State must begin to implement a simplified, streamlined process for transitioning eligible enrollees in the Demonstration to Medicaid, the Marketplace, 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;

As described above, New York will transition eligible childless adult enrollees in the Demonstration to Medicaid on January 1, 2014. Parents/caretakers will be transitioned at their renewal beginning April, 2014 to either Medicaid or QHP coverage.

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;

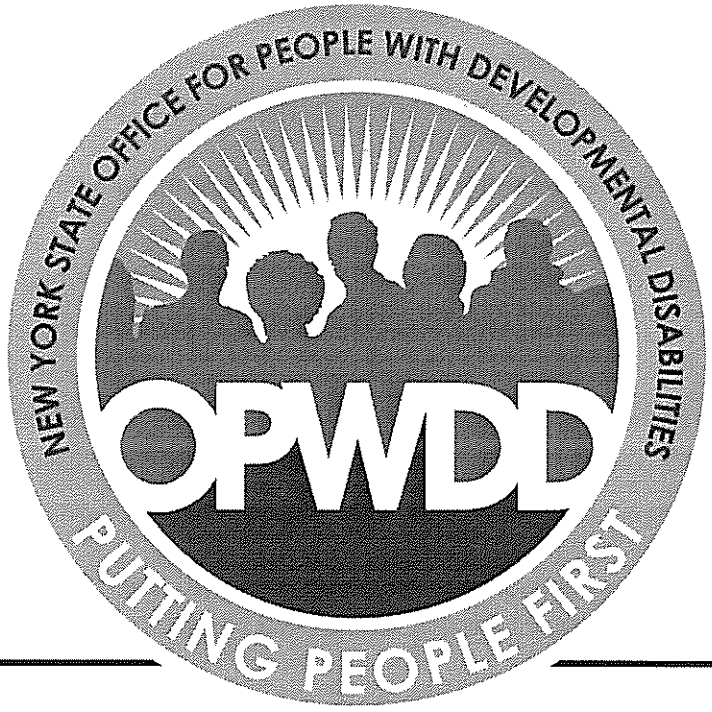
New York plans to provide appropriate notices that minimize demands on enrollees to the maximum extent possible.

Attachment 1

Core Provider Types for All Lines of Business.

NOTE: Data will be provided when it becomes available

ATTACHMENT 3



Transformation Agreement

July 1, 2013

Progress Update and Quarterly Report

Submission to the Centers for Medicare and Medicaid Standards

Table of Contents

Introduction..... 1

Residential Transitions and Supportive Housing..... 1

Expanding Supportive Housing Options..... 2

Increasing Supported Employment Services and Competitive Employment 3

Data Collection..... 3

Building the Employment Pipeline and Supporting Retention 4

Ending New Enrollments in Workshops 5

Increasing Self-Direction 7

Self Direction Education to Beneficiaries 7

Beneficiaries with Developmental Disabilities who currently Self-Direct Their Services 8

Appendices

1. Increasing the Availability of Community Housing Options For People with Intellectual and Developmental Disabilities 9
2. Supported Employment Baseline E-mail to CMS 16
3. June 26, 2013 No new enrollments into Sheltered Workshops Letter to Providers 17
4. OPWDD Employment Transformation Questions and Answers 18

Introduction

In accordance with the Health System Transformation for Individuals with Developmental Disabilities Agreement as defined in the Standards Terms and Conditions of New York State's Partnership Plan Medicaid Section 1115 Demonstration, this document reports to the Centers for Medicare and Medicaid Services (CMS) the completion of the July 1, 2013 Transformation Deliverable Schedule which includes progress and quarterly updates in the following areas:

- Transition information for specific residents of Finger Lakes and Taconic Intermediate Care Facilities (ICF) including residential settings;
- Progress for increasing availability of supportive housing options and the number of new housing units available to persons being transitioned from ICFs and meeting HCBS standards;
- Progress toward increasing the number of individuals engaged in competitive employment and the number of individuals remaining in sheltered workshops; and
- The number of participant self-direction training/education sessions conducted and the number of self-direction enrollees.

Please note that the additional July 1, 2013 deliverables have been or will be submitted to CMS under the cover of the New York State Department of Health no later than July 1. These documents include:

- New York State Department of Health's amended comprehensive Quality Strategy incorporating the changes resulting from the Developmental Disabilities Transformation revisions (Sent to CMS on June 25, 2013)
- Developmental Disabilities Transformation DRAFT Evaluation Plan (Sent to CMS on June 25, 2013)
- 1915 c People First Waiver Fiscal Amendment (to be submitted on 7/1 or 7/2 when the Portal is available following system maintenance.)

Residential Transitions and Supportive Housing

Residential Transitions and Supportive Housing
(from CMS Special Terms and Conditions, Attachment H)

a. By January 1, 2014, New York will transition a total of 148 residents from the Finger Lakes and Taconic ICFs in accordance with the following milestones:
i. 7 residents will be transitioned prior to July 1, 2013

d. New York will provide quarterly updates on the progress for increasing the availability of supportive housing options, including "non-traditional housing models" such as the "Home of Your Own", Family Care, Shared Living, Customized Residential Options, and AFI. Each quarterly update will include the number of new housing units that are available to persons being transitioned from ICFs, and meet CMS standards for HCBS settings.

Since April 1, 2013, OPWDD has assisted eight individuals to transition from the Finger Lakes and Taconic campus based ICFs to community settings meeting the Home and Community Based Services settings standards.

Individuals Assisted to Transition to Community Settings April 1 – June 30, 2013					
Name	Date	Certified Capacity	Certification Type	Meets HCBS Standards	MFP Compliant
JS	5/20/2013	13	Supervised IRA	Yes	No
LB	5/28/2013	6	Supervised IRA	Yes	No
MD	6/17/2013	13	Supervised IRA	Yes	No
RK	6/28/2013	4	Supervised IRA	Yes	Yes
DC	6/28/2013	4	Supervised IRA	Yes	Yes
TS	6/28/2013	4	Supervised IRA	Yes	Yes
CL	5/20/2013	8	Supervised IRA	Yes	No
BC	4/23/2013	6	Supervised IRA	Yes	No

OPWDD has already expressed its intent to downsize all campus-based institutional settings within four years from a current census of just under 1,000 persons located at multiple settings statewide, to a census of just 150 persons residing at only two remaining campus locations. Further, these remaining settings will be considered for use as transitional, short-term treatment and stabilization settings only.

Presently, just over 6,100 people live in community-based Intermediate Care Facilities (ICF's) statewide. A detailed analysis of all of the existing residential settings has been compiled, along with demographic data related to individuals in ICFs. Preliminary recommendations for reducing the number of individuals being supported in institutional settings, and expanding the number of individuals who reside in integrated settings, with associated timeframes, are under development. This information is being assembled and summarized into both regional and statewide formats which will form the basis of specific transformational action plans. These two elements will allow for a pre and post-transformation view of OPWDD's system of residential supports. Based on CMS feedback and further analysis as needed, OPWDD will finalize the plan by October 1, 2013.

Expanding Supportive Housing Options

To increase the availability of supportive housing options, OPWDD is actively engaged in maintaining existing partners in the housing industry and cultivating new partners. It is also necessary to educate, train and provide technical assistance to public and private sectors, administrators in the human services industry, front line workers and others. Appendix 1 provides a summary of OPWDD's current activity and progress in developing new supportive housing opportunities; ongoing efforts to maintain and create new partners in the housing industry; and education, training and technical assistance efforts. Each quarter hereafter, OPWDD will report progress in identifying additional supportive housing opportunities for individuals with developmental disabilities from this baseline of partnerships and education.

Number of new housing units developed April 1- June 30, 2013	
New Home Owners	1
Available Supportive Housing Units	62

Increasing Supported Employment Services and Competitive Employment

Supported Employment Services and Competitive Employment
(from CMS Special Terms and Conditions, Attachment H)

a. *By May 31, 2013, New York must provide CMS with a baseline count of the number of enrollees receiving supported employment services and the number of enrollees engaged in competitive employment for the most recent period for which data is available. Thereafter, the state must provide CMS with a quarterly report documenting the state's progress toward the agreed-upon goal of increasing the number of persons engaged in competitive employment, through Supported Employment, by 700 persons above the previous 12 month enrollment, with no exceptions for attrition during the period of April 1, 2013 and March 31, 2014. Given the expected fluctuations triggered by school timelines (e.g. graduations), New York will increase the number of persons in competitive employment by no less than 250 persons by October 1, 2013, with no exceptions for attrition. Only integrated gainful employment at minimum wage or higher will be considered competitive employment. The quarterly report also must include a description of activities the state has undertaken during the quarter to increase the number of demonstration participants engaged in competitive employment.*
b. *Effective July 1, 2013, New York will no longer permit new admissions to sheltered workshops. The state will report the number of enrollees that remain in sheltered workshops in each quarterly report as required under paragraph 62.*

OPWDD is using the following strategies to increase the number of individuals engaged in competitive employment:

Data Collection

There are 172 agencies that provide supported employment services. During this reporting period, OPWDD reviewed the rosters of each of these agencies to verify the number of people who were enrolled in supported employment services and the number of people who were competitively employed in an integrated setting earning at least minimum wage. In addition, OPWDD gathered data on the number youth exiting high school who may be OPWDD eligible and likely to apply to New York State Education Department's Adult Career and Continuing Education Services – Vocational Rehabilitation (ACCES-VR) for intensive supported employment services.

During this quarter, OPWDD established a baseline for the number of people receiving supported employment services and working in the community. After adjusting for inaccuracies that were initially captured in previously reported data, there were 8,773 individuals with developmental disabilities enrolled in supported employment services and of these individuals, 5,822 are competitively employed in an integrated setting and earning at least minimum wage as of March 31, 2013. This was provided to CMS on 5/31 as required in the Transformation Agreement (see Appendix 2).

Building the Employment Pipeline and Supporting Retention

New York recognizes that both pipeline and retention strategies are needed to obtain net growth in competitive employment. During this reporting period, OPWDD implemented the following strategies to increase the number of individuals in the employment pipeline who could potentially have successfully employment outcomes.

- Identified 1,843 students exiting high school who may apply to ACCES-VR for intensive supported employment services or participate in the redesigned Pathway to Employment service which is targeted for an October 1, 2013 start date.

- Began initial roll out of its Front Door Initiative and use of the Eligibility, Assessment and Authorization tool as mechanisms to encourage new waiver enrollees to explore supported employment.

- Convened a provider workgroup with the goal of identifying people receiving day habilitation and workshop services who could successfully transition to supported employment.

- Created a stakeholder engagement process to educate providers, families, self-advocates and Medicaid service coordinators about the transformation agreement and New York's efforts to increase competitive employment outcomes for people with developmental disabilities. OPWDD convened meetings with more than 300 agencies providing day habilitation, prevocational, workshop, supported employment and Medicaid service coordination services.

- Created and distributed an Employment Transformation Question and Answer Fact Sheet (Appendix 3) to all stakeholders outlining New York's employment goals for people with developmental disabilities, defining expectations for competitive employment and integrated employment, clarifying timelines related to funding for sheltered workshops, describing the redesigned Pathway to Employment service, and identifying performance measures to track New York's success in achieving its employment goals.

- Convened a statewide video conference with more than 600 participants highlighting promising practices currently used by provider agencies to (1) transition people from workshops and day habilitation to competitive employment and (2) to transition youth and young adults from high school or college to competitive employment.

- Began redesigning the Pathway to Employment service which has a projected launch date of October 1, 2013 and is an important part of New York's strategy to increase the pipeline of individuals who are interested in employment. The Pathway to Employment service is designed to significantly increase the number of OPWDD eligible participants who successfully apply for and obtain employment services from ACCES-VR. The intent of the Pathway to Employment service is to assist youth exiting high school and individuals who are currently receiving day habilitation and workshop services in identifying and obtaining career goals that will lead to competitive employment. This service is specifically designed for individuals who need a high level of pre-employment supports in discovery and assessment before they can successfully utilize ACCES-VR services.

- Soliciting a request for proposal for the design and rollout of statewide curriculum and training/outreach program to educate eligible nonprofit agency stakeholders on the availability of the Pathway to Employment service.

New York also undertook the following retention strategies during this reporting period:

- Began to identify the reasons for supported employment attrition using data collection methods and worked with our provider workgroup to develop appropriate retention strategies.

- Using our data tracking system, identified people who are enrolled in supported employment services, but are not employed, and initiated monthly calls or visits with provider agencies to create plans to assist these individuals in getting employed or accessing other services that could help them achieve better employment outcomes.

- Through a provider survey process started early identification of people who are currently receiving ACCES-VR intensive supported employment services and who may be likely to transition to OPWDD extended supported employment services in an effort to develop proactive retention strategies to assist them in maintaining employment.

- Focused on improving the quality of job development and job coaching services provided by supported employment agencies through a four-part Innovations in Employment Training Series. This training is geared towards direct support professionals (day services and residential), job developers, job coaches and managers to educate them about New York's goals and expectations related to supported employment. The training series provides participants with skills and techniques that can be used to improve employment outcomes for people with developmental disabilities. The four-part series includes sessions on: Employment and Putting People First; Assessment and Planning; Job Development; and Job Coaching. Almost 2,500 staff of supported employment agencies have participated in these trainings. It is anticipated that another 1,700 people will be trained by March 31, 2014.

Ending New Enrollments in Workshops

Number of individuals remaining in sheltered workshops
As of March 31, 2013 there are 7,896 people employed in sheltered workshops.[1]

Effective July 1, 2013, New York will no longer permit new enrollments into sheltered workshops. All of the stakeholder engagement activities previously outlined included information regarding the end of new enrollments into sheltered workshops. Emergency regulations were also promulgated to further clarify this policy. Appendix 4 contains a memorandum notifying providers of the related change in reimbursement for sheltered workshop services.

Cross System Collaborations
During this reporting period, the following interagency and cross system collaborations were initiated to advance New York's employment goals:

State Education Department- Given the requirements of the Rehabilitation Act of 1973 and IDEA, the State Education Department is an important partner in New York's efforts to achieve its competitive employment goals for people with developmental disabilities. OPWDD has engaged in active discussions with both ACCES-VR and the Office of Special Education to identify ways to improve employment outcomes for youth and young adults with developmental disabilities.

[1] The most recent data available is from March 31, 2013.

- ACCES-VR discussions have focused on creation of a Supported Employment Memorandum of Understanding designed to formalize the role that each agency will have in developing pipeline and retention strategies to assist people with development disabilities in having successful employment outcomes. The MOU will clarify the role of pre-employment training programs like Pathway to Employment which are designed to prepare people for ACCES-VR services. This strategy is particularly important as it relates to transitioning people from workshops and day habilitation to employment. The MOU will also contain a data sharing agreement to assist in obtaining information about the number of OPWDD eligible people who apply for and obtain ACCES-VR services. It is anticipated that the MOU will be finalized by October 1, 2013.

- Office of Special Education (OSE) discussions have focused on ensuring that school district and high school administrators, regional transition specialists and BOCES superintendents have information about efforts to improve employment outcomes for youth with developmental disabilities, including the policy related to ending new enrollments into sheltered workshops. In addition to these Albany-based discussions, local discussions between OPWDD's regional offices and local school districts and BOCES have also been held related to the Front Door Initiative.

- Department of Labor - In an effort to address myths and misinformation related to the impact of employment on SSI, SSDI and Medicaid benefits, OPWDD has initiated discussions with the Department of Labor. These discussions have focused on strategies to foster collaboration between One Stop Centers, which can provide benefit counseling and job matching services to job seekers, and supported employment agencies. Accurate information regarding benefits is a significant barrier that must be addressed in order to convince individuals to explore the possibility of employment.

- Empire State Development Corporation - While OPWDD efforts are focused on developing a pool of workers who are ready to be employed in the community, we recognize that attention must be paid to developing relationships with businesses who are committed to an inclusive workforce and willing to hire people with developmental disabilities. OPWDD recently participated in the National Governor's Association Summit focused on strategies for engaging businesses in process of improving employment outcomes for people with developmental disabilities. In an effort to make the hiring of people with developmental disabilities part of New York State's mainstream workforce strategy, OPWDD has initiated discussions with the Empire State Development Corporation which has a mission to promote business investment and growth that leads to job creation and prosperous communities across New York State.

SELN Membership

In an effort to further improve New York's efforts to engage people with developmental disabilities in competitive employment, membership discussions have begun with the State Employment Leadership Network (SELN). Technical assistance from SELN will be used to further develop New York's employment transformation work plan.

Increasing Self-Direction

Consumer Self-Direction
(from CMS Special Terms and Conditions, Attachment H)

b. New York will increase the number of people offered the option to self-direct their services through increased education to all stakeholders in a consistent manner statewide. This education will be provided to at least 1,500 beneficiaries (with designated representatives as needed) per quarter beginning on April 1, 2013. New York will submit a quarterly report of the number of training/education sessions conducted and the number of persons attending the sessions. New York will share training materials and curricula for these sessions with CMS, and make them available statewide by May 1, 2013.

e. New York will provide a report to CMS no later than July 1, 2013, on the current number of persons with IDD and other disabilities who self-direct their services under this demonstration.

Self Direction Education to Beneficiaries

Consistent with the transformation goal to expand education about self-direction service options in a consistent manner to all stakeholders statewide, OPWDD has educated more than 1,500 individuals and family members in self-direction sessions during the first quarter ending on June 30, 2013, with a total count of 1,844 individuals and 85 training sessions. Self-direction education sessions are actively attended by individuals and family members, and more sessions are scheduled for the second quarter of 2013. Specifically, OPWDD will continue to focus education activities on self-direction according to the education goals described in the table below:

Self-Direction Education Totals April 1 - June 30, 2013			
Self-direction Education Target	**Education Goal**	**Total Number of Individuals**	**Total Number of Sessions**
New people requesting supports from the OPWDD system and people who are transitioning from the education system into the OPWDD system of supports.	Increase awareness of self-direction options among the people engaging in supports from OPWDD	**1105**	***58****
Individuals who are currently receiving OPWDD supports and services and new individuals who have expressed an interest in self-directing services.	For people who are expressing interest in self-direction, the goal is to ensure understanding of the key concepts of self-directed supports.	**641**	**16**
Individuals who are actively seeking to self-direct services with budget and employer authority	Detailed understanding of the operational components of self-directed supports; clear understanding of the responsibilities associated with self-direction.	**98**	***11***
	Total	***1844***	***85***

Beneficiaries with Developmental Disabilities who currently Self-Direct Their Services

The current number of individuals with developmental disabilities who self-directed their services under Consolidated Supports and Services (CSS) during the month of April 2013 was 979. OPWDD also offers individuals the option for self-direction under Community Habilitation and respite. The agency is implementing a mechanism to verify the number of individuals self-directing under these services in order to better understand the total number of self-directing individuals and identify the best strategies to increase those numbers.

To facilitate increased opportunity for individuals to access self-direction, OPWDD has also worked with stakeholders to streamline the CSS plan and budget document. Further, OPWDD is working to streamline the protocol for processing and managing new and/or changing CSS plans and budgets to eliminate bureaucratic delays.

Appendix 1
Increasing the Availability of Community Housing Options For People with Intellectual and Developmental Disabilities

Overview

The cornerstone of independence for people with intellectual and developmental disabilities is having one's own home - whether it is an apartment, a furnished room, a shared living arrangement, a single family home or some other type of residential setting. When a person has a decent, safe, and affordable home, he or she has the opportunity to become a part of the community and is able to achieve other important life goals, including improved health, education, job training, and competitive employment.

There is no one specific type of residential setting that will meet the needs of all people with developmental disabilities; therefore, OPWDD is increasing the availability of a continuum of community housing options that is based on the service needs of the individual and how much he/she can afford to spend on housing to supplement any government subsidies.

Within the past few years, OPWDD has made a concerted effort to increase the availability of community housing options by taking two major steps: (1) maintaining existing partners in the housing industry and, (2) cultivate new partners. The agency also has an aggressive information and outreach system and provides an opportunity for partners to be educated, trained and provided with ongoing technical assistance

Housing Goals

Goal One:

Expand the Inventory of housing alternatives for people with Developmental Disabilities

Goal One sets in motion the expansion of an interagency partnership with multiple state agencies to leverage resources and provide additional rental units. The use of state agencies' resources will incentivize developers to create additional accessible and affordable housing for people with developmental disabilities. Partnering agencies are discussing the creation of an Interagency Housing Council, inclusive of a formal Agreement among participating agencies. The following programs have been initiated:

- Governor's Supportive Housing Development Program. In 2012-13, $1.8 million was awarded to OPWDD through the Rental Subsidies Program, and 53 opportunities were created for people with developmental disabilities to move to a less restrictive residential setting were created. Also, an enhanced partnership between OPWDD and New York State Homes and Community Renewal (NYSHCR) resulted in 47 new supportive housing units.

Goal One Strategies:

- Pursue and leverage increased local, state, and federal rental subsidy opportunities
- Provide incentives for developers to build units for individuals with developmental disabilities within their "regular" apartment settings

- Expand partnerships with the State of New York Mortgage Agency (SONYMA), the U.S. Department of Agriculture (USDA) Rural Development Single and Multifamily Homes, the U.S. Department of Health and Human Services' Assets for Independence Program, and the U.S. Department of Housing and Urban Development (HUD)

Goal Two:

Increase Access to Rental Subsidies for People with Intellectual and Developmental Disabilities

Goal Two reflects efforts to increase the funding pool for subsidizing rental units for people with developmental disabilities through policy changes, funding requests from federal agencies, and partnerships with state and local municipalities. OPWDD proposes to explore a pilot rental assistance model to identify and assess the most effective way to provide affordable, accessible, and high quality rentals for people with developmental disabilities now and in the future.

Goal Two Strategies:

- Working through the NY Delegation, seek policy changes at the federal level in the expansion and distribution of housing choice vouchers for people with disabilities.
- Partner with state and local public agencies to prioritize rental subsidy needs of people with developmental disabilities
- Partner with local public agencies to track the distribution of housing choice vouchers for people with disabilities
- Pursue and develop funding sources to expand the availability of rental assistance

Goal Three:

Build understanding and awareness of housing options for independent living among people with developmental disabilities, families, public and private organizations, developers, frontline workers and etc.

Goal Three intends to generate increased awareness of and interest and engagement in moving from congregate homes to housing alternatives. A systemic outreach and marketing effort by all state agencies involved in the Interagency Housing Council will assist with this effort. Also, OPWDD's Continuum of Housing Options Roundtables offer provider agencies and families an opportunity to highlight innovative and promising practices in housing alternatives.

Goal Three Strategies:

- Develop and implement a communications, advocacy, outreach and education plan
- Build the capacity of public and private agencies to assist people with developmental disabilities in making informed choices
- Continue to host Housing Forums on housing options currently available to people with developmental disabilities. Forums are broadcast statewide to interested parties through the use of Video- and Tele-Conferencing.
- Initiate a series of educational Webinars on "how-to-create" housing alternatives for independent living.

Goal Four:

Increase collaboration among OPWDD, state and federal agencies, voluntary providers, advocacy groups and families to create a more efficient and effective path for people with intellectual and developmental disabilities to access and receive the supports and services they or their family need.

Goal Four Strategies:

- Align the work of OPWDD's Office of Home & Community Living to support the following NYS initiatives:
  - NYS Money Follows the Person Demonstration
  - NYS Balancing Incentive Program
  - 1915 B/C waiver applications
  - Residential transitions and expansion of supportive housing
  - Supportive employment services
  - Increasing self-direction

Goal Five:

Assist with the creation of a sustainable living environment through funding for home modifications, down payment assistance and home repairs.

Goal Five Strategies:

- Increase funding for Environmental Modifications
- Continue the U.S. Department of Health & Human Services down payment assistance program
- Create a system and consistent process to fund home repairs for people with intellectual and developmental disabilities who close on a home through OPWDD's Home Of Your Own (HOYO) program

Goal Six:

Provide recommendations that can improve housing alternatives for people with developmental disabilities

Goal Six will put in place a systemic infrastructure that supports the use of housing alternatives by people with intellectual and developmental disabilities. Connect the infrastructure to the work of the Interagency Housing Council.

Goal Six Strategies:

- Create a systemic infrastructure that puts people first and is acceptable and usable by leadership
- Ensure that the infrastructure is based on self-direction.
- Present, track, evaluate and continuously provide recommendations and progress reports.
- Work within the parameters of the Interagency Housing Council to ensure cross systems collaboration.

What's been done, to date:

In order to **increase the availability of supportive** housing options, there must be a concerted effort to maintain existing partners in the housing industry and cultivate new partners. It is also necessary to educate, train and provide technical assistance to public and private sectors, administrators in the human services industry, front line workers and others. Below is a summary of OPWDD's efforts to maintain and create new partners in the housing industry. Also included is a listing of education, training and technical assistance efforts.

I. Maintaining Existing Partnerships:

Some Federal Partners

United States Department of Housing and Urban Development (HUD): OPWDD is a HUD-Approved Housing Counseling Program.

- Seeking statewide compliance with HUD's Guidance with Olmstead Requirements for individuals moving out of institutions and into housing.
- Monitors HUD's website for new policies for programmatic requirements, including HUD's Housing Counseling Handbook 7610.1
- Submits annual proposals to HUD for grants funding to support OPWDD's housing counseling program
- Submits HUD 9902 reports on a quarterly basis to outline counseling work completed to people with intellectual and developmental disabilities and their income-eligible parents or legal guardians
- Maintain contact with HUD's Office of Housing Counseling
- Scheduling one-on-one meeting with HUD's Albany Field Office Director to learn about new requirements under Section 811, 202 and etc.

United States Department of Agriculture (USDA) Rural Development

- Enhanced existing MOU with USDA to include multi-family homes in rural areas – *Signed new MOU in 2013 to include Multifamily Homes.*
- Invites USDA Rural Development representatives to present at various OPWDD housing forums
- Maintains a listing of all USDA Foreclosed homes, distributed this listing to the respective OPWDD Regional Offices
- Attends local USDA Rural Development functions

United States Department of Health and Human Services (HHS) – Assets For Independence (AFI)/Matched Savings Program

- Awarded $1 million from HHS to assist people with intellectual and developmental disabilities, their income eligible parents or legal guardians save the down payment and closing costs for their 1st home.

- Reviews and complies with HHS policies for Assets For Independence (AFI) program requirements
- Maintains contact with OPWDD's assigned AFI program contact in Washington, DC
- Completes and discusses semi-annual reports for AFI with staffers
- Preparing for webinars hosted by OPWDD and HHS
- Applied for a no-cost extension for OPWDD's AFI grant to assist participants of the program for an additional year
- Re-applying for an upcoming AFI grant when an RFP is issued

Some State Partners

New York State Homes and Community Renewal (HCR)

- Expanding existing partnership with HCR
- Hosted Meet and Greet sessions between OPWDD Leadership, Affordable Housing Developers, OPWDD provider agencies and HCR Supportive Housing representatives to begin dialogue on supportive housing for people with intellectual and developmental disabilities.
- Met with HCR on several occasions to develop "Language" for OPWDD's *first time* inclusion in their Unified Funding Round Request For Proposals (RFPs)
- Trained HCR staff on how OPWDD's funding mechanisms for non-certified housing settings work
- Invited HCR to present to OPWDD's leadership on its housing programs at both OPWDD's Housing Forums and Provider Association meetings
- Working to develop infrastructure for OPWDD's Leveraged Supportive Housing Pilot
- Received scholarships from HCR to attend Housing Counseling training through NeighborWorks America
- Participated in pre-development meetings for agencies awarded funds through *HCR's Unified Funding Round*
- Participated in HCR Public Hearings for Small Block Grants
- Established a formal and ongoing commitment to participate in HCR's Housing Trust Fund
- Developed talking points for HCR's upcoming Unified Funding Round

State of New York Mortgage Agency (SONYMA)

- Maintain ongoing communication with George Leocata, Senior Vice President of Single Family Programs at SONYMA
- Provided training for SONYMA Regional Loan Originators
- Receive monthly reports on the status of HOYO loans financed by SONYMA, including those that are either in delinquency or default
- Advocated with Jim Ahrens, Administrative Vice President of the Mortgage Division of M&T Bank, to have Loan Originators for the HOYO program in each region of NYS
- Worked with SONYMA to expand the AFI program statewide

Governor Cuomo's Medicaid Redesign Team (MRT) Supportive Housing Development Program

- Represented OPWDD on the MRT Affordable Housing Work Group
- Presented to members of the MRT Work Groups on OPWDD's existing housing program.

- Advocated for OPWDD to receive funding from MRT
- Received $1.8 million to support OPWDD's housing agenda.
- Received $135,000 for a special Nursing Home Project on Long Island from MRT funds.
- Released a *Request For New Services (RFNS)* to provider agencies statewide
- Provided funding to 11 agencies with MRT funding
- Providing housing opportunities to 61 individuals in a less restrictive environment through MRT funds.
- Seeking additional funding from MRT to fund new Supportive Housing projects

Some Cross-Systems Partners

- NYS Office of Temporary & Disability Assistance
- NYS Office of Mental Health
- NYS Department of Health
- NYS Office of Substance Abuse Services
- NYS AIDS Institute

Some Private Partners

- Capital District Transportation Authority (CDTA): *Travel Demand Management Homeowners Transit Incentive – provide free bus passes to homeowners who purchase their first home through OPWDD's Home of Your Own (HOYO) program; Program also provides reduced fares for employees with disabilities.*

- M&T Bank: The financial institution that provides loan originators and assistance to people with developmental disabilities, their income-eligible families and the workforce who purchase their 1st home through OPWDD's HOYO program. M&T Banks also serves as the financial institution for OPWDD's AFI program.

II. Creating New Partnerships

- New Partnerships in development
  - Supportive Housing Network of NY
  - Habitat For Humanity
  - First Niagara Banks (Credit Counseling)
  - NYS School Boards Association
  - SUNY Buffalo – Affordable Housing Clinic
  - Hofstra University
  - Local Municipalities

- New Housing Education, Training, and Technical Assistance Initiatives
  - October 8, 2013 Conference on *Transforming Family Care for the 21st Century*
  - Training Regional Housing and Development staff on all non-certified housing options currently available
  - Researching and expanding OPWDD's Shared Living program
  - Expanding OPWDD's partnership with HCR
  - Increasing the training capacity of the Downstate Housing Office staff

- Confirming outreach partnerships with the Self Advocacy Association of NY (SANYS), Parent To Parent, and the National Association of Direct Support Professionals (NADSP)

Housing Forums Hosted (Total of 2,228 attendees)

- HCR Supportive Housing
- "I'm Home Now:" Creative Solutions to Meeting the Housing Needs of People with Developmental Disabilities
- Building Public/Private Partnerships to Create Supportive Housing for People with Developmental Disabilities: Challenges and Opportunities
- Better Health, Better Care and Lower Cost: Realigning Resources to Support Successful Aging in the Community Living Environments for Older People
- USDA Rural Housing Programs Overview
- A Forum on Family Care
- Continuum of Housing Options Roundtable
- A Conference on Shared Living
- Assisted Living for People with Intellectual and Developmental Disabilities

Appendix 2
Supported Employment Baseline E-mail to CMS

From: courtney.burke@opwdd.ny.gov
Sent: 5/31/2013 2:30:26 PM
To...: michael.melendez@cms.hhs.gov;jessica.woodard@cms.hhs.gov
Subject: OPWDD Employment Baseline

Mike,

In accordance with the requirement of the Transformation Agreement, OPWDD is submitting a "baseline count of the number of enrollees receiving supported employment services and the number of enrollees engaged in competitively employment through April 30, 2013".

As of April 30, 2013, there were 9,459 individuals enrolled in supported employment services (SEMP). There were 5,543 SEMP enrollees who were competitively employed in an integrated setting and are earning at least minimum wage.

There may be some additional people in SEMP who are competitively employed that were not captured in the baseline as additional data is still being received from some providers. OPWDD will make any necessary updates to the baseline as part of the quarterly report due in July.

Appendix 3
June 26, 2013 No new enrollments into Sheltered Workshops
Letter to Providers

TO: State Operations Directors
Regional Directors
Executive Directors of Voluntary Providers

FROM: Gerald Huber
Deputy Commissioner
Division of Person Centered Supports

DATE: June 26, 2013

SUBJECT: No new enrollments in Sheltered Employment

OPWDD has an important agenda to transform the services available to people with developmental disabilities in order to increase person centered supports, advance self direction and assist in meeting personal outcomes. Consistent with the Governor's Olmstead plan, OPWDD is implementing strategies to ensure that its services are fully integrated into the community. One aspect of the transformation plan sets a goal to significantly increase employment opportunities for individuals receiving OPWDD supports and services. In order to achieve this goal, OPWDD has made a specific commitment to: no longer fund new admissions to sheltered workshops effective July 1, 2013; increase the number of people with developmental disabilities who are competitively employed by 250 new people by October 1, 2013 and by 700 new people by April 1, 2014; and create a draft timeline and work plan for the elimination of funding for sheltered workshops by October 1, 2013.

As a result of these employment goals, please be advised that effective July 1, 2013 a "No Add" edit has been added to TABS which will prevent new enrollments into sheltered workshops if the "add" of the enrollment is July 1, 2013 or after. In addition, emergency regulations are being promulgated to limit reimbursement of prevocational services delivered in sheltered workshops to only those individuals who were receiving these services before July 1, 2013. (Additional information about the emergency/proposed regulations is available on the OWPDD website at www.opwdd.ny.gov.)

For more information about OPWDD employment goals please see the attached Employment Transformation Questions and Answers.

cc: COLT

Appendix 4
OPWDD Employment Transformation Questions and Answers
June 10, 2013

OPWDD Employment Definitions

1. **How is competitive employment being defined?**
   There are two criteria for competitive employment. Employment must be in an integrated setting and the worker employed must earn at least minimum wage.

2. **How is an integrated employment setting being defined?**
   Work settings where workers with developmental disabilities have opportunities to interact with, and work alongside, co-workers who do not have disabilities are considered integrated. If supervisors, job coaches and other staff are the only people without disabilities that workers interact with, then the setting does not meet the definition of integrated.

3. **How are mobile work crews and enclaves being defined?**
   Mobile work crews and enclaves are employment placements for groups of two to eight workers with disabilities. The employment placement is with a business located in an integrated employment setting. Mobile work crews work in various community locations while workers in enclaves are located at one specific business.

4. **How is segregated employment being defined?**
   Segregated employment is a work setting where workers with developmental disabilities and/or mental illness only interact with, and work alongside, other workers with developmental disabilities and/or mental illness.

5. **How are sheltered workshops being defined?**
   Sheltered workshops are typically facility-based employment settings that exclusively or predominately employ workers with mental illness and/or developmental disabilities. The work setting is usually segregated with no opportunities for workers with mental illness and/or developmental disabilities to interact with, or work alongside, people who do not have disabilities.

6. **How are prevocational services being defined?**
   Prevocational services prepare a person with a developmental disability for the generic work environment. They include services that provide learning and work experiences, including volunteering, where a person with developmental disabilities can develop general, non-job-task-specific strengths and skills that contribute to their employability in paid employment in an integrated community setting. These services assist individuals who are interested in working but whose skills are such that they would need a year or more of prevocational services before they could successfully obtain and maintain competitive employment.

OPWDD Employment Goals

1. **What are the October 1, 2013 and April 1, 2014 goals related to the number of individuals with developmental disabilities receiving supported employment services who are competitively employed?**

By April 1, 2014 OPWDD will increase the number of new people with developmental disabilities competitively employed by 700. By October 1, 2013 OPWDD will have 250 new people employed.

2. **Will OPWDD continue to fund group employment placements (enclaves and mobile work crews)?**
   Yes, funding will continue for small group employment; however, group employment placements cannot exceed eight people and the employment placement must be in an integrated setting.

3. **Does OPWDD expect individuals receiving day habilitation services to transition to employment?**
   Some of the individuals currently receiving day habilitation services can and want to be competitively employed. OPWDD is seeking to expand the number of choices that people with developmental disabilities have to be actively engaged in their community. This includes increasing opportunities for people with developmental disabilities to work in integrated settings, volunteer, or engage in other community activities.

Workshop and Prevocational Services

1. **What are OPWDD's plans related to sheltered workshops?**
   As part of an agreement with the federal Centers for Medicare & Medicaid Services (CMS), OPWDD has agreed to end new admissions to workshops effective July 1, 2013. OPWDD will also create a draft work plan and timeline related to the elimination of all funding for segregated employment settings. With input from families, individuals with developmental disabilities, and providers, the work plan and timeline will be finalized by January 1, 2014.

2. **What is the significance of the October 1, 2013 date as it relates to "sheltered workshops?"**
   With input from stakeholders, OPWDD will submit a draft work plan and timeline to CMS on October 1, 2013 related to the elimination of funding for segregated workshop services.

3. **When will workshops close?**
   At this time, OPWDD does not have a date for the elimination of funding for existing segregated employment settings. With input from stakeholders, OPWDD will develop a timeline and work plan, which will be submitted to CMS on October 1, 2013 for approval.

4. **Is it OPWDD's intent for all sheltered workshops to close?**
   It is OPWDD's intent to fund employment that is consistent with the US Supreme Court Olmstead Decision; therefore, OPWDD's priority is to transition employment funding from segregated settings to integrated settings. Workshops that shift from segregated to integrated business models will be consistent with OPWDD's funding priorities. Examples of integrated business models include, but are not limited to, affirmative businesses and social enterprises.

5. **If workshops change from segregated to integrated business models, will they still be able to pay subminimum wage?**
   As long as a provider has a 14c certificate from the Department of Labor, they will be able to pay subminimum wage. However, jobs that pay subminimum wage would not count toward OPWDD's April 1, 2014 employment goal.

6. **What will happen to government contracts that require providers to have a percentage of workers with disabilities?**
   OPWDD expects providers with contracts that require a percentage of workers to have disabilities to meet the requirements of those contracts while also transitioning to more integrated business models.

7. **What does it mean to end funding for new admissions to settings that meet the definition of segregated employment settings?**
   Effective July 1, 2013 funding from OPWDD will no longer be available to enroll new people in segregated employment settings. This includes prevocational services delivered in a sheltered workshop.

8. **How will this impact prevocational services?**
   Funding will only be available for new enrollment into prevocational services that are provided in integrated community settings.

9. **Does OPWDD expect all work centers (sheltered workshops) to close?**
   The expectation is to increase opportunities for people with developmental disabilities to work in integrated employment settings. OPWDD believes that it is possible for a provider agency to maintain their employment contracts and transition to an integrated business model.

10. **Will funding be available to support workshops that are interested in changing their business model in ways that meet the definition of competitive employment?**
    OPWDD is very interested in working with provider agencies that are willing to transition from segregated business models to models that create opportunities for people with developmental disabilities to work in integrated settings.

11. **If segregated employment settings are no longer an option for new people receiving OPWDD services, what types of services will be available to students transitioning from high school?**
    There are several OPWDD services that are available to people with developmental disabilities who are interested in employment or other community inclusion activities including: prevocational services, supported employment, community habilitation, and self directed services. All of these services can assist a person to be an active participant in their community.

Pathway to Employment

1. **What is the "Pathway to Employment Service?"**
   Pathway to Employment is a person-centered, comprehensive employment planning and support service designed to assist participants in achieving competitive employment or self-employment. It is a focused, time limited service that engages a participant in identifying a career direction, provides instruction and training in pre-employment skills, and develops a plan for achieving competitive, integrated employment at or above minimum wage. Within 12 months, or sooner, the outcome of this service is documentation of the participant's stated career objective and a detailed career plan used to guide individual employment supports.

2. **What type of services will be included as part of Pathway to Employment?**
   Services provided under Pathway to Employment will be person-centered and may include, but not be limited to: vocational assessment; situational assessments; job readiness training, including

individualized and appropriate work related behaviors; community experiences; pre-employment skills, including tasks necessary to obtain employment based on the individualized needs of the participant; job-related discovery; travel training; experiential learning in career exploration and vocational discovery; experiential learning to achieve a specific vocational outcome; education and counseling around benefits management and employment; assessment for use of assistive technology to increase independence in the workplace; and, person-centered career planning which includes a defined and extensive vocational plan completed by the end of the Pathway to Employment service.

3. **Who can receive Pathway to Employment Services?**
   The Pathway to Employment service will be available to individuals expressing an interest in community employment, including individuals who are currently receiving day habilitation, workshop, prevocational and supported employment services. This service will also be available to students leaving high school.

4. **When will Pathway to Employment services be available?**
   As part of the transformation agreement with CMS, OPWDD is planning for an October 1, 2013 launch of the Pathway to Employment service.

Measuring Success

1. **What type of performance measures will be used to track OPWDD's success in achieving these employment goals?**
   OPWDD will use the following metrics to track its progress in meeting the employment goals within the transformation agreement with CMS: number of people with developmental disabilities who are employed in integrated settings earning at least minimum wage; number of people who transition from day habilitation, prevocational and workshop services to Pathway to Employment; and number of people who transition from Pathway to Employment to supported employment.

2. **What is the significance of New York Employment Services System (NYESS) in tracking employment outcomes?**
   NYESS contains data on the number of people receiving supported employment services who are employed, their wages, the number of hours they work, length of time employed, and type of occupation. This data will assist OPWDD in measuring its progress in meeting transformation agreement employment goals. As a result, OPWDD will expect all providers to report supported employment data into NYESS.

3. **How can my agency obtain more information about NYESS?**
   Information about NYESS is available at www.nyess.ny.gov.

For additional questions regarding OPWDD employment goals, please email employment.technical.assistance.questions@opwdd.ny.gov