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

Children and Adults Health Programs Group

MAR 28 2014

Nirav R. Shah, M.D.
Commissioner
New York State Department of Health
Corning Tower
Governor Nelson A. Rockefeller Empire State Plaza
Albany, NY 12237

Dear Dr. Shah:

This letter is in regards to your section 1115 demonstration, Partnership Plan (Project number 11-W-00114/2). The Centers for Medicare & Medicaid Services (CMS) has reviewed and approved a portion of your attachment to the Special Terms and Conditions (STC) that will serve as the Designated State Health Programs (DSHP) Claiming Protocol.

As a way to support the goals of the state's health systems transformation for its developmentally disabled population, New York may claim federal financial participation on certain state programs in order to assist the state in its health system transformation. As outlined in STC 66, details of program expenditures would be outlined in the attachment before receiving federal financial participation (FFP) for any claiming by the state. This attachment has been included in the STCs, which are enclosed with this letter. CMS is approving the DSHP Claiming Protocol for the following programs listed in STC 66:

Office for People with Developmental Disabilities
- Day Training
- Family Support Services (FSS)

Office of Mental Health
- Licensed Outpatient Programs
- Care Management
- Emergency Programs
- Rehabilitation Services
- Residential (Non-Treatment)
- Community Support Programs

Office of Alcohol and Substance Abuse Services
- Outpatient and Methadone Programs
- Prevention and Program Support Services

We look forward to following up with the state to complete the protocols for programs that remain under these remaining agencies and are committed to final approval of these documents on or before March 31, 2014.

For our records, written acceptance is needed within 30 days of the date of this letter. Please direct correspondence to your project officer, Ms. Jessica Woodard to the following address:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
7500 Security Boulevard
Mail-stop: S2-01-16
Baltimore, MD 21244-1850

Simultaneously, please include Region 2 Associate Regional Administrator on any correspondence to Mr. Michael Melendez:

Centers for Medicare & Medicaid Services
New York Regional Office
Division of Medicaid and Children's Health
26 Federal Plaza
New York, New York 10278
Telephone: (212) 616-2430
Email: Michael.Melendez@cms.hhs.gov

If you have any questions regarding this letter, or other questions regarding Partnership Plan please do not hesitate to contact me at (410) 786-9249 or Jessica.Woodard@cms.hhs.gov. We look forward to continuing to partner with you and your staff on the New York Partnership Plan demonstration.

Sincerely,

Diane T. Gerrits, Director
Division of State Demonstrations and Waivers

Cc: Eliot Fishman, Director, Children and Adults Health Programs Group
Michael Melendez, Associate Regional Administrator, CMS New York
Jessica Woodard, CMCS
Jason Helgerson, Medicaid Director, Office of Health Insurance Programs, New York State Department of Health

Appendix L

Reimbursement and Claiming Protocol for New York Designated State Health Programs Expenditures and Determination of Allowable DSHP Costs Per Waiver 11-W-00-0014/2

To support the goals of health system transformation, the State may claim Federal Financial Participation (FFP) for the State programs, subject to the a maximum capped amount of $250 million in FFP and restrictions, described in the Special Terms and Conditions (STCs) # 66 of New York's Partnership Plan Medicaid Section 1115 Demonstration Waiver #11-W-00-0014/2 for the Approval Period April 1, 2013 through March 31, 2014. STC # 66 Paragraph b requires the State to develop a CMS approved protocol for claiming Designated State Health Program (DSHP) expenditures. The State shall claim DSHP expenditures in accordance with the protocol set forth in this appendix up to the maximum capped amount of $250 million in FFP for the period April 1, 2013 through March 31, 2014.

The general claiming process applicable to all net deficit funded programs is set forth in Sections I through IV. Addition detail describing specific steps is in Section V (Net Deficit Program Details).

I. State Documentation of Expenditures for Net Deficit Funded Programs

Documentation provided by the State to CMS for quarterly DSHP expenditures will include the following:

- The agency;
- The program;
- Provider;
- Net deficit payment amount;
- Voucher/contract information;
- Provider costs; and
- Net adjusted deficits.

II. Off-Sets: In accordance with STC 66(b)(ii) DSHP expenditures submitted to CMS will not include payment for:

- Medicaid funded costs and other Federal aid;
- Room and board/IMD;

- Services to undocumented individuals;
- Research;
- Rent and utility subsidies to individuals;
- Forensics; and
- Other funding (e.g. insurance and local aid).

For each off-set the State will indicate the page, line and column reference from the consolidated fiscal report (CFR).

To assure DSHP expenditures do not include coverage of services to undocumented individuals, the State will reduce each service provider's reported program costs by 10 percent unless a more detailed accounting of actual costs for these individuals is provided that is acceptable to CMS.

III. Net Deficits Payments

New York may claim expenditures to purchase DSHP services furnished for the period April 1, 2013 through March 31, 2014. Expenditures for payments to service providers shall not exceed the lesser of (1) the full value of the actual net deficit payment or (2) the provider's reported adjusted net deficit. For each DSHP, service providers will have their revenues and expenses identified using New York's Consolidated Fiscal Reporting System. Under this system, each service provider is required to file a CFR to document expenses and revenues in a uniform process for each program they have contracted to provide. The CFR serves as the year end cost report and will be used to document provider deficits. Where applicable, New York will reduce each service provider's reported expenses to remove the cost of any applicable offset listed in Section II. Net deficits will be recomputed using the adjusted expenses to determine each providers adjusted net deficit.

Upon the availability of the Final CFR, the State will compare DSHP expenditures to each provider's reported adjusted net deficits. Based on this comparison, the State shall adjusts its claim as necessary to assure its does not include any payments that exceeded a service provider's adjusted net deficits. Federal share on any identified overpayments will be refunded by the State making an adjustment on the CMS-64 report by entering an amount in line 10(b) of the Summary Sheet.

All applicable CFRs used for claiming and final expenditure reconciliation (Final - Closeout) will have complied with New York State Consolidated Fiscal Reporting and Claiming Manual: Appendix AA – Audit Guidelines that mandate audited providers financial statements and CFRs be reasonably assured and free from material misstatement.

OASAS - By the definition of net deficit financing, OASAS funds are only used after all revenue sources (including Medicaid) are offset against the approved budget/expenses. In the programs OASAS is claiming under DSHP, there are no room and board costs for individuals and no research funds. The claim is based the net budget minus Federal SAPT Bloc Grant Funding used minus a 10 percent off-set for undocumented immigrants (unless a more detailed accounting of actual costs for these individuals is provided that is acceptable to CMS).

Interim Payments:

OASAS - Advance payments are made on a quarterly basis based on the Budget of Record at the time the payment is made. Within 1 year after the close of a contract year, the advance payments made are reconciled with actual approved costs as submitted in the CFR and future payments are adjusted accordingly.

OPWDD and OMH - Similar to OASAS, advance payments are made per the term of approved contract and reconciled based on the submission of the CFR with future payments adjusted if necessary.

IV. Documentation of State Expenditures for Designated State Health Programs

In claiming DSHP expenditures , New York State will provide CMS with a summary excel sheet by agency, program and provider in an orderly format so that CMS may review and test underlying supporting documentation as detailed in this Section.

A. For all eligible DSHPs claimed New York State will have available for CMS to test as desired behind each NYS DOH-4103 Claim:

   i. Direct control payment sheets for all providers
   ii. Identifying contract number, provider name & code (agency code?), budget period
   iii. Program
   iv. Voucher number
   v. Voucher amount
   vi. Total amount paid to date
   vii. State financial system voucher entry

B. At a timeframe of no less than nine months following receipt of the Final CFR, for the claiming year ending March 31, 2014 New York State will conduct a Final Analysis which will include the following for CMS to review as desired:

   i. For each contract, provider and eligible DSHP program claimed, electronic worksheets will be available and include the following:

1) Variance in amounts between the State's paid claim amount, against both actual expenditures and net deficit funding amount identified within the Final CFR.

2) Based on the Final CFR, a rollup of all programs, units of services provided and number of employees or full time equivalents (FTEs) per program.

NOTE: Since Supported Housing Rental Assistance (6050) and Supported Housing Community Services (6060) are considered one program upon closeout, there will be a discreet closeout presentation separating the program expenditures against the budgeted and paid amounts for each. The State will provide detail similar to subsection A of this section to ensure that no payment is made for this program.

Documentation of expenditures for each DSHP must be clearly outlined in the state's supporting work papers and be made available to CMS in accordance with this claiming protocol.

The State will use its voucher and accounting system to identify the amount it expended to purchase services from each service provider under each program during the period April 1, 2013 – March 31, 2014.

Statewide Financial System (SFS):

SFS is the State's accounting system, the 'book-of-record' for New York State. Each agency enters vouchers into SFS. The Office of the State Comptroller (OSC) reviews, approves and then processes the payments. The OSC process includes budget checks against appropriations/segregations to ensure appropriate authority for the expenditures has been provided by the NYS Division of the Budget through a certificate of approval process that is built into SFS.

OASAS enters vouchers individually by provider into SFS. Individual control sheets are manually maintained in excel to track payments by program components and make adjustments to the Budget of Record as needed.

OMH enters vouchers into SFS through a secure bulk-load file protocol. The bulk-load files create the commensurate entries into the SFS system to generate payments to providers/counties. Once approved and processed, the transaction information is then put into a pre-programmed extract file that is bulk-loaded into OMH's Aid to Localities Financial System (ALFS). Information from the file is loaded into ALFS populating all the relevant payment information into assigned data tables.

OPWDD utilizes the Statewide Financial System (SFS) to process contracts and vouchers for the review, approval and payment by the Office of the State Comptroller (OSC). When NYS transitioned to SFS, OPWDD established unique program codes within SFS for all programs to track expenditure patterns. SFS budget checks the transaction to insure sufficient resources

are available within the segregation/appropriation authority established through an approval process with the Division of the Budget and the State Comptroller.

Consolidated Fiscal Report (CFR):

The CFR is a uniform cost reporting platform which is required to be completed by all service providers/counties receiving funding.

The CFR is used as both a "year-end cost report" and a "year-end claiming document." The year-end cost report includes the Core schedules and Supplemental schedules which are used to set reimbursement rates and financial analysis of program costs. The cost reporting schedules are completed using a consistent reporting methodology in order for the data to be comparable between providers, regions and programs. The consistent methodology includes; using accrual accounting, including the depreciation of equipment and property, and using the ratio value method to allocate agency administration costs. The year-end claiming document includes the Consolidated Claim Report (CCR) which is used to report expenses and revenues for providers receiving State Aid funding through a direct contract with the State Agency and/or through a local contract with a county Local Government Unit (LGU). Providers are also required to file their program budgets utilizing the Consolidated Budget Report (CBR) portion of the CFR. The CBR is the same reporting platform and schedules found in the CFR.

The CFR represents the keystone of the fiscal monitoring processes by requiring the use of independent CPAs to perform comprehensive reviews of the providers' accounting records and to certify their financial reports. A "Full CFR" requires certification by an independent auditor and a copy of the providers' certified financial statements. Further, the certified CFR documents include detailed expenses (by program) to ensure that expenditures have actually been incurred and that they are accurate and related to the contracted program services.

Importantly, the CFR includes staffing reports for personal costs which represent the vast majority of the expenses for the provision of mental health services and, independent CPA's review provider's payroll and accounting records as part of the CFR submission process. While performing CFR Desk Audits, analysts may request that providers submit additional documentation including "other than personal service costs" where large dollar expenditures have been claimed in the CFR (e.g., equipment purchases) and they occasionally identify other significant concerns with the underlying operations of the provider (e.g., the potential misuse of government funds). In the case of the latter, any identified issues are immediately referred to the each agency's Bureau of Audit or the Counsel's Office for further investigation.

<u>OASAS Only Systems</u>

State Aid Auditing and Reporting System (SABRS):

For OASAS payments SABRS is used to maintain and update, as necessary, the Budget of Record (BOR). When quarterly or other payments are made, the latest BOR is reviewed by the Claims Unit to calculate the next payment due. These payment calculations are made manually via control sheets established for each provider breaking down the budget and project payment by each program type and funding source (State and/or Federal). It should be noted that OASAS utilizes mid-year claims for Calendar Year Providers & Counties.

OMH Only Systems

Aid to Localities Financial System (ALFS):
ALFS is an OMH budgeting, financial and contracting management system that tracks $1.3B from the development of the NYS Enacted Budget through the contract reconciliation process. ALFS tracks the authorization of over 100 funding streams for 113 program types that are operated by over 800 not-for-profit providers and all 62 NYS counties. The system provides Internal Controls through a variety of programmed "checks and balances" and there are user id and date/time stamps saved for every transaction in ALFS. Budgetary checks are hard coded into ALFS to ensure sufficient funds are available to make payments. ALFS also provides linkage to Spending Plan Guidelines via the OMH website which governs the allowable uses of State funds for various fund and program codes. Using ALFS has eliminated paperwork for central office, field office and county users with the system issuing electronic authorizations, payment information, county planning documents, and provider budget and claiming information.

ALFS interfaces with the following systems:

- IAMF (Interagency Master File)
- MHPD (Mental Health Provider Directory)
- CONCERTS (OMH Licensing database)
- CFRS (Consolidated Financial Report System); and
- SFS (Statewide Financial System) and OSC Master Vendor File (VendRep)

The County Allocation Tracker (CAT) is a budgeting function imbedded in ALFS and allows counties to file their budgets with the State electronically. These budgets must to conform to the funding level authorized for the County and are reviewed by OMH Field Office fiscal staff through a series of automated and manual budget checks. The budget checks are linked to the programmatic and fiscal requirements outlined in the Spending Plan Guidelines issued annually. Counties are allowed to revise their CAT allocations throughout the current fiscal year and OMH Field Office fiscal staff is required to review, run budget checks and approve the revised CAT. If a county fails to complete a CAT, they can be subjected to a withholding of their State Aid. Providers paid by counties directly are required to use the CBR which is submitted to the county. However, providers are still required to submit a CFR directly to the State through the CFR system. OMH uses the CAT to cross-check both reported county and provider spending submitted in the CFR against provider CBRs and county CATs.

V. Net Deficit Program Details

A. Office of Alcoholism and Substance Abuse Services

State Agency: Office of Alcoholism and Substance Abuse Services
Program Group: Outpatient and Methadone Programs
Program Codes:
Methadone-to-Abstinence (0605)
Methadone Maintenance (2050)
Keep Units (2150)
Outpatient Chemical Dependence for Youth (0140)
Medically Supervised Outpatient (3520)
Enhanced Medically Supervised Outpatient (3528)
Outpatient Rehabilitation Services (3530)
Funding Sources:
Mental Hygiene Program Fund
General Fund

For each program in this program group, the State will perform the following steps to determine the amount of the DSHP expenditure eligible.

1. Process to identify value of applicable offsets - The 10 percent undocumented immigrant off-set is applied (unless a more detailed accounting of actual costs for these individuals is provided that is acceptable to CMS) after the State's net deficit payment is calculated (Budget minus other revenue (including Medicaid) minus State payment using SAPT Bloc Grant funds.

2. Process to identify program net deficit payments - Budget minus other revenue (including Medicaid) minus State payment using SAPT Bloc Grant funds.

Brief Description:

Chemical dependence outpatient services assist individuals who suffer from chemical abuse or dependence and the family members and/or significant others. Outpatient services may be delivered at different levels of intensity responsive to the severity of the problems presented by the client and include medication assisted treatment such as methadone and buprenorphine. These services may be provided in a free standing setting, or may be co-located in a variety of other health and human service settings. Sponsorship may be voluntary, proprietary or county operated.

0140 - Outpatient Chemical Dependence for Youth - Such programs serve youth between the ages 12 and 1 8 by providing a drug-free setting supporting abstinence from alcohol and/or other substances of abuse. Active treatment is rendered through multi- disciplinary clinical

services designed to assist the youth in achieving and maintaining an abstinent lifestyle and to serve youth whose normal adolescent development, in one or more major life areas, has been impaired as a result of the use of alcohol and /or other substances by a parent or significant other.

0605 - Methadone-to-Abstinence – Outpatient Opioid treatment programs (OTPs) where medication assisted treatment is delivered on an ambulatory basis in gradually decreasing doses to the point of abstinence, followed by continued drug-free treatment.

2050 - Methadone Maintenance – Outpatient Opioid treatment programs (OTPs) where medication assisted treatment is delivered primarily on an ambulatory basis, with most programs located in either a community or hospital setting. Medication is administered daily at a stabilized dose over an extended period of time.

2150 - KEEP Units – Outpatient – Methadone Opioid treatment programs (OTPs) where medicated assisted treatment is delivered on an ambulatory basis. KEEP is an interim (not more than 180 days) protocol that provides intensive medical and support services in order to evaluate the long-term treatment needs of patients.

3520 & 3528 - Medically Supervised Outpatient & Enhanced Medically Supervised Outpatient - These programs assist individuals who suffer from chemical abuse or dependence and their family members and/or significant others through group and individual counseling; education about, orientation to, and opportunity for participation in, relevant and available self-help groups; alcohol and substance abuse disease awareness and relapse prevention; HIV and other communicable diseases, education, risk assessment, supportive counseling and referral; and family treatment. In addition, social and health care services, skill development in accessing community services, activity therapies, information and education about nutritional requirements, and vocational and educational evaluation must be available either directly or through written agreements. Procedures are provided according to an individualized assessment and treatment plan. This service mandates that medical staff be part of the multi-disciplinary team and the designation of a Medical Director, which provides for medical oversight and involvement in the provision of outpatient services. These services are Medicaid eligible providing other standards pertaining to fee-for-service Medicaid are met.

3530 - Outpatient Rehabilitation Services - This service level is designed to serve more chronic individuals who have inadequate support systems, and either have substantial deficits in functional skills or have health care needs requiring attention or monitoring by health care staff. These programs provide social and health care services, skill development in accessing community services, activity therapies, information and education about nutritional requirements, and vocational and educational evaluation. Clients initially receive these procedures five days a week for at least four hours per day. There is a richer staff to client ratio for these services compared to other outpatient levels and these services are required to have a half-time staff person qualified in providing recreation and/or occupation al services

as assistant or registered nurse. Like half-time nurse practitioner, physician medically supervised outpatient, outpatient rehabilitation services, mandate that medical staff be part of the multi-disciplinary team and the designation of a Medical Director, which provides for medical oversight and involvement in the provision of outpatient services. These services are Medicaid eligible providing other standards pertaining to fee-for-service Medicaid are met.

The length of stay and the intensity of services as measured by frequency and duration of visits vary from one category of outpatient services to another and intensity will vary during the course of treatment within a specific category. In general, persons are engaged in outpatient treatment up to a year and visits are more frequent earlier in the treatment process becoming less frequent as treatment progresses.

Eligible Population:

Individuals who come to the program are assessed as to whether the service is clinically appropriate. In the most recent year for which data is available, over 56,000 individuals were served in outpatient programs and over 10,000 in methadone programs. Any NYS resident is eligible with no income limitation. The universe of potential individuals is extrapolated from a Needs estimate based on geographic region which compares estimated need versus available capacity.

State Agency: Office of Alcoholism and Substance Abuse Services
Program Group: Prevention and Program Support Services
Program Codes:
Primary Prevention Services (5220)
Other Prevention Services (5550)
Funding Sources:
Mental Hygiene Program Fund
General Fund

Brief Description:

5520 – Primary Prevention Services - Primary Prevention is defined as a collaborative and community focused process to prevent or delay substance use and abuse in individuals, families and communities. Prevention service approaches include education, environmental strategies, community capacity building, positive alternatives and information dissemination. The selection of prevention service activities within these service approaches is based on a community needs assessment that identifies levels of substance use, its consequences, elevated risk factors and decreased protective factors. Prevention counseling and early intervention activities with individuals, families and groups are not included as Primary Prevention Services. Individuals who are diagnosable for substance abuse or dependence are not served with Primary Prevention Services.

5550 - Other Prevention Services- Other Prevention service approaches funded by OASAS

include Prevention Counseling and Early Intervention. Prevention Counseling is an OASAS certified service designed to assess and improve the levels of youth and family risk and protective factors to prevent or reduce substance use, problem gambling and the negative consequences of such behaviors. Prevention Counseling is offered to IOM selected youth who are considered at highest risk for developing substance abuse or gambling problems. Early intervention is offered to IOM Indicated individuals who have already begun to exhibit substance use or gambling behaviors but do not meet the DSM-IV criteria of substance abuse or dependence or problem gambling. Individuals may require referral for assessment and treatment with more intensive services.

These services are designed to improve individual and family risk and protective factors, while others target the community and school environment as a whole. Services include school-based classroom programs using multi-session curricula to increase family and youth understanding of the consequences of substance abuse, improve drug and other problem behavior attitudes and teach drug refusal and other social skills; strategies developed to target environmental factors to improve substance use regulations and policies, increase compliance with regulations and policies to reduce availability of alcohol, tobacco and other substances; and change social norms regarding substance abuse. The evidence-based models delivered by many OASAS providers have been estimated to reduce public costs by $8 to $56 for every $1 of program cost.

Eligible Population:

The majority of services under this program are geared towards school-aged individuals and their parents (guardians), although there are no eligibility requirements. In the most recent year for which data is available, over 460,000 participants received prevention services.

B. Office of Mental Health

For each program in this program group, the State must perform the following steps to determine the amount of the DSHP expenditure eligible for FFP under STC #66. The payments and associated claimed expenditures for the following programs must be commensurate with actual program service delivered.

For DSHP eligible expenditures related to services provided on behalf of the State by local providers and counties.

Step 1 – Identify all expenditures potentially eligible for DSHP claim in the Aid to Localities Financial System (ALFS) for the designated time period: State identifies all expenditures from the Office of Mental Health Aid to Localities Financial System (ALFS) that fall within the liability date period of April 1, 2013 through March 31, 2014 as required in STC# 66. These payments are initiated in the OMH ALFS, reviewed and approved by OMH staff at appropriate levels and bulk-loaded into the NYS Statewide Financial System (SFS). The NY State Office of the State Comptroller (OSC) has internal checks and

approvals built into SFS to ensure payments are authorized and conform to State appropriation authority at appropriate levels. Once reviewed, OSC releases payment to providers/counties. SFS and ALFS will be used to document actual payments to providers/counties for DSHP eligible services provided on behalf of the State and can be used to track State appropriation authority for the expenditures.

Step 2 – Collapse multiple payments (expenditure data) into single line for each provider and/or county and align/compare with the CBR/CAT budget data for each provider and/or county to facilitate offset of DSHP ineligible expenditures: State matches all payments made to providers and/or counties with the service provider budgets (Consolidated Budget Report within the Consolidated Fiscal Report for providers and the County Allocation Tracker (CAT) in the ALFS for counties) for the April 1, 2013 to March 31, 2014 time period to be later compared against actual expenditures reported on a prior year Consolidated Fiscal Report (CFR) (utilizing both main CFR claiming schedules: the DMH 2 CFR schedule displays the fund code specific detail portion of a claim and the DMH 3 CFR schedule displays the program summary level detail of a claim). The State utilizes program, fund and account codes from the SFS and ALFS to match disbursements with reported/budgeted expenditures on the CBR/CAT. (Separate table(s) that crosswalk SFS, ALFS, CFR, CBR and CAT coding (including program and fund codes) will be supplied as an attachment to the final claim submission. The tables will also indicate any other program code/fund code exclusions that are referenced in Steps below).

Step 2a—Compile CBR/CATS data for each provider/county identified in Step 2 and match up against prior year's provider/county CFR expenditure data compiled in Step 2: In order to determine the amount of the initial claim, the State compiles budgets (CBR and/or CAT) submitted by providers and/or counties identifying the specific program/fund codes for all CFR expenditures. All State identified prior year CFR expenditures are matched and verified by provider, program and fund codes to the CBR/CAT budgets for the April 1, 2013 to March 31, 2014 time period. NOTE: For Counties the CAT will serve as the summary reference, but prior year CFR claims data will be used as a proxy to determine allocation of funding across program and fund codes.

Step 2b – Compiled CBR/CAT budget data is adjusted to eliminate DSHP ineligible programs and services: Once the expenditure data has been matched and verified in Step 2a, the State offsets all non-eligible DSHP expenditures based on the provider/county submitted CBR/CAT budget as follows:

1) Medicaid and any other Federal funding (Medicaid expenditures are not in the disbursement data because NYS State Share is paid by the NYS Dept. of Health)

    a. (CBR, schedule DMH-2, lines 14-24);
    b. DMH-2, line 14: Participant Fees;
    c. DMH-2, line 15: SSI & SSA;

d. DMH-2, line 16: Home Relief/Public Assistance;
e. DMH-2, line 17: Medicaid;
f. DMH-2, line 18: Medicare;
g. DMH-2, line 19: Other Third Parties;
h. DMH-2, line 20: OPWDD Residential Room and Board/NYS OPTS (not relevant for OMH);
i. DMH-2, line 21: Transportation, Medicaid;
j. DMH-2, line 22: Transportation, Other;
k. DMH-2, line 23: Sales: Contract Total; and
l. DMH-2, line 24: Federal Grants.

2) Third Party revenue (CBR, schedule DMH-2, lines 29 and 48); DMH-2, line 29: Other Revenue; DMH-2, line 48: Non-Funded

3) Research (There is no local funding for research or research related programs)

4) Forensics (Fund Code 039J) reported on schedule DMH-3

5) Room & board (CBR, schedule DMH-2, line 28, by program code for residential programs); DMH-2, line 28: Net Deficit Funding

6) Rent & Utilities (There are no rent or utility subsidies to individuals outside of the 6050 and 6060 – Supported Housing Program)

7) Other Exclusions (identified by program and funding code combinations) that are not DSHP eligible. (Separate table(s) that crosswalk SFS, ALFS, CFR, CBR and CAT coding (including program and fund codes) will be supplied as an attachment to the final claim submission. The tables will also indicate all other program code/fund code exclusions that are not already referenced above).

8) Undocumented individuals – a 10 percent bottom-line reduction to account for undocumented individuals (unless a more detailed accounting of actual costs for these individuals is provided that is acceptable to CMS) per CMS' request.

Step 2c—OMH compiles all prior year CFR expenditure data for providers/counties identified in Step 1-2. OMH will claim the lesser of the CBR/CAT budgeted expenditure calculated from Steps 2a-2b OR the prior year's providers/counties CFR reported claim as calculated from Steps 2c – 2d below: State compiles certified CFR information found in the DMH-2 and DMH-3 CFR claiming schedules for all providers/Counties identified in Step 2A for the April 1, 2013 through March 31, 2014 time period consistent with STC# 66. All reported prior year CFR expenditures are matched and verified by provider, program and fund codes.

Step 2d – Compiled prior year's providers/counties CFR expenditure data from Step 2c is adjusted to eliminate DSHP ineligible programs and services: State offsets non-eligible DSHP expenditures from reported CFR expenditures as follows:

1) Medicaid and any other Federal funding (Medicaid expenditures are not in the disbursement data because NYS State Share is paid by the NYS Dept. of Health)

    a. (CBR, schedule DMH-2, lines 14-24);
    b. DMH-2, line 14: Participant Fees;
    c. DMH-2, line 15: SSI & SSA;
    d. DMH-2, line 16: Home Relief/Public Assistance;
    e. DMH-2, line 17: Medicaid;
    f. DMH-2, line 18: Medicare;
    g. DMH-2, line 19: Other Third Parties;
    h. DMH-2, line 20: OPWDD Residential Room and Board/NYS OPTS (not relevant for OMH);
    i. DMH-2, line 21: Transportation, Medicaid;
    j. DMH-2, line 22: Transportation, Other;
    k. DMH-2, line 23: Sales: Contract Total; and
    l. DMH-2, line 24: Federal Grants.

2) Third Party revenue (CBR, schedule DMH-2, lines 29 and 48); DMH-2, line 29: Other Revenue; DMH-2, line 48: Non-Funded

3) Research (There is no local funding for research or research related programs)

4) Forensics (Fund Code 039J) reported on schedule DMH-3

5) Room & board (CBR, schedule DMH-2, line 28, by program code for residential programs); DMH-2, line 28: Net Deficit Funding

6) Rent & Utilities (There are no rent or utility subsidies to individuals outside of the 6050 and 6060 – Supported Housing Program)

7) Other Exclusions (identified by program and funding code combinations) that are not DSHP eligible. (Separate table(s) that crosswalk SFS, ALFS, CFR, CBR and CAT coding (including program and fund codes) will be supplied as an attachment to the final claim submission. The tables will also indicate all other program code/fund code exclusions that are not already referenced above).

8) Undocumented individuals – a 10 percent bottom-line reduction to account for undocumented individuals (unless a more detailed accounting of actual costs for these individuals is provided that is acceptable to CMS) per CMS' request.

Step 2e—Compare adjusted CBR/CAT budgeted expenditures from 2a – 2b to adjusted prior year providers/counties CFR claims from Steps 2c -2d. OMH will claim the lesser of the calculated from Steps 2a-2b OR the prior year's providers/counties CFR reported claim as calculated from Steps 2c – d.

Step 3 – The state submits an initial claim for the adjusted CBR/CAT budgeted expenditures from Steps 2a-2b or the adjusted prior year's providers/counties CFR claim calculated in Step 2c-2d, whichever is less. The claim must be submitted in accordance with STC #66 and the individual DSHP program as allowed by Waiver 11-W-00-0014/2.

The State attests expenditures used are correct and verifiable as DSHP allowable. The State further attests state fund only funds expended per STC #66 are used for DSHP allowable program services. (Separate table(s) that crosswalk SFS, URC and Program coding will be provided as an attachment to the final claim submission).

Step 4 – Final analysis of submitted claims to determine DSHP eligibility and submission of an adjusted/final claim to CMS: No less than nine months following the receipt of the Final CFR, for the claiming year ending March 31, 2014, OMH will conduct a final analysis of the CFR claims submitted by the providers/counties identified in the initial claim.

Step 4a - OMH will compile final CFR expenditure data for all providers/counties included in the initial claim submitted to CMS as determined in Step 3.

Step 4b – Compiled final CFR expenditure data from Step 4a is adjusted to eliminate DSHP ineligible programs and services: State offsets non-eligible DSHP expenditures from reported CFR expenditures as follows:

1) Medicaid and any other Federal funding (Medicaid expenditures are not in the disbursement data because NYS State Share is paid by the NYS Dept. of Health)

    a. (CBR, schedule DMH-2, lines 14-24);
    b. DMH-2, line 14: Participant Fees;
    c. DMH-2, line 15: SSI & SSA;
    d. DMH-2, line 16: Home Relief/Public Assistance;
    e. DMH-2, line 17: Medicaid;
    f. DMH-2, line 18: Medicare;
    g. DMH-2, line 19: Other Third Parties;
    h. DMH-2, line 20: OPWDD Residential Room and Board/NYS OPTS (not relevant for OMH);
    i. DMH-2, line 21: Transportation, Medicaid;
    j. DMH-2, line 22: Transportation, Other;
    k. DMH-2, line 23: Sales: Contract Total; and

1. DMH-2, line 24: Federal Grants.

2) Third Party revenue (CBR, schedule DMH-2, lines 29 and 48); DMH-2, line 29: Other Revenue; DMH-2, line 48: Non-Funded

3) Research (There is no local funding for research or research related programs)

4) Forensics (Fund Code 039J) reported on schedule DMH-3

5) Room & board (CBR, schedule DMH-2, line 28, by program code for residential programs); DMH-2, line 28: Net Deficit Funding

6) Rent & Utilities (There are no rent or utility subsidies to individuals outside of the 6050 and 6060 – Supported Housing Program)

7) Other Exclusions (identified by program and funding code combinations) that are not DSHP eligible. (Separate table(s) that crosswalk SFS, ALFS, CFR, CBR and CAT coding (including program and fund codes) will be supplied as an attachment to the final claim submission. The tables will also indicate all other program code/fund code exclusions that are not already referenced above).

8) Undocumented individuals – a 10 percent bottom-line reduction to account for undocumented individuals (unless a more detailed accounting of actual costs for these individuals is provided that is acceptable to CMS) per CMS' request.

Step 4c— Compare initial Claim submitted to CMS (from Step 3) to final CFR claims compiled and adjusted for exclusions in Steps 4a-4c. State compiles the actual disbursements included in the initial claim (Step 3) by provider/locality from 4/1/13 through 3/31/14 and matches against the compiled CFR reported expenditures (after exclusions in Step 4b) for the same time period. State identifies the difference between the amount claimed for DSHP and the final certified CFR claim submitted by the provider. The State submits a final adjusted claim to CMS with agreed upon back-up materials.

OMH Source Data:

Statewide Financial System (SFS): is the State's accounting system, the 'book-of-record' for New York State. OMH enters vouchers into SFS through a secure bulk-load file protocol. The bulk-load files create the commensurate entries into the SFS system to generate payments to providers/counties.

Aid To Localities Financial System (ALFS): An OMH budgeting, financial and contracting management system that tracks $1.3B from the development of the NYS Enacted

Budget through the contract reconciliation process. Expenditures data is populated from bulk-load files received from SFS daily.

Consolidated Fiscal Report (CFR): The Consolidated Fiscal Report (CFR) is a uniform cost reporting platform which is required to be completed by all service providers/counties receiving OMH funding.

OMH Program Groups:

State Agency: Office of Mental Health
Program Group: Licensed Outpatient Programs
Program Codes:
Continuing Day Treatment (CDT) (1310)
Clinic Treatment (2100)
Clinic-Plus (0790)
Day Treatment services for children and adolescents (0200)
Partial Hospitalization (2200)
Intensive Psychiatric Rehabilitation and Treatment (IPRT) (2320)
Funding Sources: State Appropriations

Brief Description:

Outpatient funds are used to provide treatment designed to reduce symptoms, improve functioning and ensure ongoing support for individuals experiencing serious and persistent mental illness and ensure that their basic needs are met. This program has a focus on improving an individual's quality of life in the community and reducing the need for inpatient care through the provision of community based treatment services.

Some of the specific services provided by the Outpatient program include: (1) Continuing Day Treatment (CDT) (1310), which provides active treatment and rehabilitation designed to maintain or enhance current levels of functioning and skills, to maintain community living and to foster development of self-awareness and self-esteem; (2) Clinic Treatment (2100), which provides assessment and treatment planning, health screening and referral, discharge planning, verbal therapy, medication therapy, medication education, symptom management, and psychiatric rehabilitation readiness determination; (3) Clinic-Plus (0790), which represents an enhancement of traditional clinic services such that the Clinic-Plus programs adopt a public health approach which enables earlier identification of children with emotional disturbance as well as earlier intervention; (4) Child and Family Clinic-Plus Outreach and Screening Services, which takes a broad-based approach to identify children and adolescents with emotional disturbances and to intervene at the earliest possible opportunity; (4) Day Treatment services for children and adolescents(0200), which provide intensive, non-residential services, including a blend of mental health and special education provided in a fully integrated service; (5) Partial Hospitalization (2200), which provides treatment to stabilize and ameliorate acute symptoms, serve as an alternative to inpatient hospitalization,

and reduce the length of a hospital stay within a medically supervised program; and (6) Intensive Psychiatric Rehabilitation and Treatment (IPRT)(2320), which is designed to assist a patient in forming and achieving mutually agreed-upon goals in living, learning, working and social environments; to intervene with psychiatric rehabilitation technologies to overcome functional disabilities; and to improve environmental supports.

Eligible Population:

Programs serve adults and/or children diagnosed with a Serious Mental Illness or Serious Emotional Disturbance. In the most recent year for which data is available, the Outpatient program served approximately 111,200 clients, excluding Medicaid and Medicare clients.

State Agency: Office of Mental Health
Program Group: Care Management
Program Codes:
Intensive Case Management (ICM) (1810)
Supportive Case Management (SCM) (6810)
Blended Case Management (BCM) (0820)
Adult Home Case Management (6820)
Residential Treatment Facility (RTF) Transition Coordinators (2880)
Transition Management (TM) Services (1970)
Non-Medicaid Care Coordination activities (2720)
Funding Sources: State Appropriations

Brief Description:

Care Management funds are used to coordinate services for individuals experiencing serious and persistent mental illness and ensure that their basic needs are met. Care managers play a major role in identifying, engaging in services, advocating for, and helping clients to find their way through complex health care and social services systems; they also provide on-site crisis intervention and skills teaching when other services are not available. These services, which include some specialized care management for the elderly, are an essential support for many individuals currently living in community settings. Care management is aimed at linking the individuals to the service system and coordinating the various services necessary for successful outcomes. The objective of care management in a mental health system is continuity of care. Services provided may include linking, monitoring and case-specific advocacy.

Some of the specific services provided by the Care Management program include: (1) Health Home Care Management, which provides coordinated, comprehensive medical and behavioral health care to Medicaid-enrolled adults with chronic conditions through care management and integration that assures access to appropriate services, improves health outcomes, reduces preventable hospitalizations and emergency room visits, promotes use of health information technology (HIT), and avoids unnecessary care; (2) Intensive Case

Management (ICM) (1810), where case workers assist recipients to develop and maintain viable living, working and social situations in their communities through intensive interaction with the participants; (3) Supportive Case Management (SCM) (6810); which is a variant of the ICM program, is designed to provide services to individuals who require less support than provided under ICM; (4) Blended Case Management (BCM) (0820); which facilitates a team approach to case management services by combining the caseloads of multiple Intensive Case Managers and/or Supportive Case Managers; (4) Adult Home Case Management(6820), which promotes optimal health and wellness by implementing a person-centered approach to service delivery and ensuring linkages to and coordination of essential community resources; (5) Residential Treatment Facility (RTF) Transition Coordinators (2880), which exist within each RTF to ensure family engagement as well as timely, successful discharges of children and adolescents; (6) Transition Management (TM) Services(1970) (discharge planning); which provide support for improved community service linkages and timely filing of Medicaid applications for seriously and persistently mentally ill (SPMI) consumers being released from local correctional facilities; and (7) Non-Medicaid Care Coordination activities (2720), which are aimed at linking the consumer to the service system and at coordinating the various services in order to achieve a successful outcome.

Eligible Population:

Programs serve adults and/or children diagnosed with a Serious Mental Illness or Serious Emotional Disturbance. In the most recent year for which data is available, the Care Management program served approximately 25,200 clients, excluding Medicaid and Medicare clients.

State Agency: Office of Mental Health
Program Group: Emergency Programs
Program Codes:
Respite Services (0650)
Crisis intervention services (2680)
Crisis Residence (0910)
Crisis Respite Beds (1600)
Home-Based Crisis Intervention (HBCI) (3040)
Funding Sources: State Appropriations

Brief Description:

The Emergency program provides emergency safety net services for individuals with mental illness including crisis services, intervention and outreach. Funds support emergency safety net services for individuals who would otherwise be at risk of hospitalization or more costly Medicaid services requiring increased Federal Financial Participation, which is consistent with Olmstead. All programs serve individuals who are indigent, uninsured or underinsured. As the Medicaid portion of this program is largely budgeted within DOH, the OMH budget includes a higher proportion of non-Medicaid expenses.

Some of the specific services provided by the Emergency program include: (1) Comprehensive Psychiatric Emergency Program (CPEP); which is designed to directly provide or ensure the provision of a full range of psychiatric emergency services, including: crisis intervention, extended observation beds in the hospital, crisis outreach services, and crisis residence; (2) Respite Services (0650); which are temporary services (not beds) provided by trained staff in the consumer's place of residence or other temporary housing arrangement; (3) Crisis intervention services (2680); which provide screening, assessment, stabilization, triage, and/or referral to an appropriate program or programs; (4) Crisis Residence (0910), which is a licensed residential, 24 hours/day, time-limited stabilization service, which provides for acute symptom reduction and the restoration of an individual's condition to a pre-crisis level of functioning; (5) Crisis Respite Beds (1600), which are dedicated beds within a larger licensed service, which provide a homelike environment with room, board and supervision in cases where individuals must be removed temporarily from their usual residence; and (6) Home-Based Crisis Intervention (HBCI)(3040), which is a clinically oriented program with support services by a MSW or Psychiatric Consultant which provides short-term, intensive in-home crisis intervention services to a family in crisis due to the imminent risk of their child being admitted to a psychiatric hospital.

Eligible Population:

Programs serve adults and/or children diagnosed with a serious mental illness or serious emotional disturbance. In the most recent year for which data is available, the Emergency program served approximately 80,200 clients, excluding Medicaid and Medicare clients.

State Agency: Office of Mental Health
Program Group: Rehabilitation Services
Program Codes:
Personalized Recovery-Oriented Services (PROS) (9340)
Treatment Congregate (6070)
Treatment Apartment Based Residential Program (7070)
Children and Youth (C&Y) Community Residences (7050)
Teaching Family Homes (4040)
Funding Sources: State Appropriations

Brief Description:

The Rehabilitation Services program provides an array of services designed to promote the recovery of individuals with severe and persistent mental illness through the integration of treatment, support, and rehabilitation; with a focus on improving an individual's quality of life in the community and reducing the need for inpatient care through the provision of community based treatment services.

Some of the specific services provided by the Rehabilitation Services program include: (1) Personalized Recovery-Oriented Services (PROS) (9340), which is a comprehensive service which integrates treatment, support and rehabilitation in a manner that facilitates the individual's recovery, including improving functioning, reducing inpatient utilization, reducing emergency services, reducing contact with the criminal justice system, increasing employment, attaining higher levels of education and securing preferred housing; (2) Treatment Congregate (6070), which is a group-living designed residential program which focuses on intensive goal-oriented interventions necessary to address the specific functional and behavioral deficits which prevent residents from accessing generic housing; (3) Treatment Apartment based residential program(7070), which focuses on intensive goal-oriented interventions necessary to address the specific functional and behavioral deficits which prevent residents from accessing generic housing; (4) Children and Youth (C&Y) Community Residences(7050), which provide a supervised, therapeutic environment for six to eight children or adolescents, between the ages of 5 and 18 years, that includes structured daily living activities, problem solving skills development, a behavior management system and caring consistent adult interactions; and (5) Teaching Family Homes(4040), in which specially trained parents live and work with four children and youth with serious emotional disturbances in a home-like setting, where the teaching parents are responsible for the social education of the children and the implementation of a service plan developed in conjunction with the family and clinical service provider.

Eligible Population:

Programs serve adults and/or children diagnosed with a Serious Mental Illness or Serious Emotional Disturbance. In the most recent year for which data is available, the Rehabilitation Services program served approximately 500 clients, excluding Medicaid and Medicare clients.

State Agency: Office of Mental Health
Program Group: Residential (Non-Treatment)
Program Codes:
Congregate Support programs (6080)
Community Residence/Single-Room Occupancy (CR-SRO) programs (8050)
Supported/Single-Room Occupancy (SP-SRO) programs (5070)
Support Apartment programs (7080)
Supported Housing Community Services (6080, 6060, 6050)
Funding Sources: State Appropriations

Brief Description:

Some of the specific services provided by the Residential (Non-Treatment) program include: (1) Congregate Support programs (6080), which are single-site residential programs that provide support designed to improve or maintain an individual's ability to live as independently as possible and eventually access generic housing; (2) Community

Residence/Single-Room Occupancy (CR-SRO) programs (8050), which provide service-enriched, licensed, extended-stay housing with on-site services for individuals who want private living units, but who have minimal self-maintenance and socialization skills (3) Supported/Single-Room Occupancy (SP-SRO) programs (5070), which provide long-term or permanent housing in settings where residents can access the support services they require to live successfully in the community; (4) Support Apartment programs (7080), which provide support designed to improve or maintain an individual's ability to live as independently as possible, and eventually access generic housing; and (5) Supported Housing Community Services(6080, 6060, 6050), which assist individuals in locating and securing housing of their choice and in accessing the supports necessary to live successfully in the community through assistance with choosing housing, roommates, and furniture; providing financial assistance with purchasing apartment furnishings; assistance with resolving roommate or landlord issues; and linking residents to a comprehensive community support system of case management, mental health and general health supports.

Eligible Population:

Programs serve adults and/or children diagnosed with a serious mental illness or serious emotional disturbance. In the most recent year for which data is available, the Residential (Non-Treatment) program served approximately 9,400 clients, excluding Medicaid and Medicare clients.

State Agency: Office of Mental Health
Program Group: Community Support Programs
Program Codes:
Advocacy/support services (1760)
Psychosocial Club (0770)
Drop in Centers (1770)
Self-Help (2770)
Outreach services (0690)
On-site Rehabilitation (0320)
Multicultural Initiatives (3990)
Supported Education (5340)
MICA Networks (5990)
Geriatric Demo Gatekeeper (1410)
Geriatric Demo Physical Health-Mental Health Integration (1420)
Transportation (0670)
Recreation (0610)
Transitional Employment Placement (TEP) (0380)
Enclave in Industry (1340)
Assisted Competitive Employment (ACE) (1380)
Affirmative business/Industry (2340)
Work program (3340)
Ongoing Integrated Supported Employment Services (2340)

Family Support Services (1650)
School-based mental health (1510)
Coordinated Children's Services Initiative (CCSI) (2990)
Vocational and Educational Services (Children and Family) (1320)
Home-based family treatment (1980)
Homeless placement services (1960)
Recovery centers (2750)
Day Training (XX48)
Mobile Mental Health Teams (MMHTs) (XX86)
The Client Worker program (3429)
Funding Sources: State Appropriations

Brief Description:

The Community Support program includes a wide range of community mental health services, which provide services for individuals in community settings who are considered severely and persistently mentally ill. Funds support non-residential safety net services for individuals who would otherwise be at risk of out of home placement or hospitalization and increased Federal Financial Participation for more costly Medicaid services, which is consistent with Olmstead. The Community Support program provides treatment to help reduce symptoms, improve functioning, and provide ongoing support while maintaining adults in the community.

Some of the specific services provided by the Community Support program include: (1) Advocacy/support services (1760); (2) Psychosocial Club (0770); (3) Drop in Centers(1770); (4) Self-Help (2770); (5) Outreach services (0690); (6) On-site Rehabilitation (0320); (7) Multicultural Initiatives (3990); (8) Supported Education (5340); (9) MICA Networks(5990); (10) Geriatric Demo Gatekeeper(1410); (11) Geriatric Demo Physical Health-Mental Health Integration(1420); (12) Transportation (0670); (13) Recreation (0610); (14) Transitional Employment Placement (TEP) (0380); (15) Enclave in Industry (1340); (16) Assisted Competitive Employment (ACE) (1380); (17) Affirmative business/Industry (2340); (18) Work program (3340); (19) Ongoing Integrated Supported Employment Services(2340); (20) Family Support Services (1650); (21) School-based mental health (1510); (22) Coordinated Children's Services Initiative (CCSI) (2990); (23) Vocational and Educational Services (Children and Family) (1320); (24) Home-based family treatment (1980); (25) Homeless placement services (1960); (26) Recovery centers (2750); (27) Day Training (XX48); (28) Mobile Mental Health Teams (MMHTs) (XX86); and the (29) Client Worker program (3429). Program descriptions for listed programs are available in Appendix F of the New York State Consolidated Fiscal Reporting and Claiming Manual.

Eligible Population:

Programs serve adults and/or children diagnosed with a Serious Mental Illness or Serious Emotional Disturbance. In the most recent year for which data is available, the Community

Support program served approximately 121,400 clients, excluding Medicaid and Medicare clients.

C. Office for People with Developmental Disabilities

State Agency: Office for People with Developmental Disabilities
Program: Day Training
Program Code: 0330
Funding Sources: State Appropriations

Brief Description:

A program or planned combination of services provided to developmentally disabled persons whose level of disability is not so severe as to require more intensive services but whose functional behavior deficits limit their ability to function independently. The goal of day training programs is to provide program interventions that will assist developmentally disabled persons in the acquisitions of knowledge and skills that will enable them to improve their personal, social, and vocational skills and their ability to function independently. Day training also includes programs consisting of specialized developmental services that are operated with the goal of providing developmentally disabled persons with habilitation and social skills which will enable the individual to maintain gains made in other programs or to gain entry to a level of programming requiring more independent functioning such as supported employment or if possible, competitive employment.

Eligible Population:

Eligible individuals are those with developmental disabilities as defined by Mental Hygiene Law and who benefit from day training services consistent with their individual service plan.

State Agency: Office for People with Developmental Disabilities
Program: Family Support Services
Program Code: 0150
Funding Sources: State Appropriations

Brief Description:

The purpose of Family Support Services (FSS) is to enable families to provide in-home care to their family members with a developmental disability. Crisis intervention services help prevent emergency admissions to Medicaid-funded community homes or institutional facilities. Consistent with the *Olmstead* decision, these services also enable families to continue to care for a family member with a developmental disability in the least restrictive environment, at home. In addition to these critical services, FSS also provides non-Medicaid funded services, such as training to family members, information and referral services, support groups, recreation, transportation, and other in-home services for individuals with

and without Medicaid. These supports also help individuals to stay with their families and do so at a very modest cost of care compared to living in a Medicaid-funded community home.

Specific services available to FSS participants include:

- Behavior Management: Planned, systematic application of the methods and findings of behavior science with the intent of altering observable behaviors, including increasing, decreasing, extending, restricting, teaching and maintaining behaviors.

- Respite (Overnight/Day/Evening): These services provide the family with temporary relief from the care of a person with a developmental disability in order to permit the caregivers to be absent during overnight to conduct business, deal with an emergency or pursue a leisure activity. This service may be provided in or out of the home.

- Family Reimbursement/Cash Subsidy: Services and goods which are not funded through other sources can be purchased through family reimbursement or cash subsidy. For family reimbursement services, the family and provider agency or Developmental Disabilities Regional Office (DDSR) agree to a plan for purchase of services and goods, the family makes the purchase, provides a receipt and is reimbursed. For cash subsidy services, the family and provider agency or DDRO agree to a plan for purchase of services and goods and then the family is given a set amount of funding to make the purchase. After the services and goods are purchased, the family must provide receipts in order to receive additional family reimbursements or cash subsidy services.

- Other: At times a family or an individual may need a unique service, which is not included in the group of services listed, including:

    - Financial and Life Planning Assistance: Financial assistance services assist families in accessing necessary assistance from generic and OPWDD funding, benefits, entitlements, and other sources. Life planning assistance services assist a family to develop a plan, with input from the individual with a developmental disability, as possible, and with assistance from professionals, which will provide the family with some assurance about future life options available to the individual with a developmental disability and selection of these options.

    - Service Access Assistance: Contact with the individual, family member or primary care giver and service providers on a regular basis to assist with planning and accessing services and supports. Service access assistance can include assessment of service needs, planning and coordination, linkage and referral, follow-up, monitoring and advocacy.

- Free-Standing Respite: These services provide temporary room, board and supervision of an individual with a developmental disability in an out-of-home setting, or supervision in the natural home, when the family member or primary care giver is absent or needs relief.

- Counseling: Face-to-face, individual, group, or family counseling or therapy in a planned, structured session intended to help an individual or family gain insight, resolve problems, develop alternate behaviors or address other issues of concern. This includes counseling provided over the telephone with individuals or with their families.

- Training: Training and education activities offered to the parents, siblings and care givers, designed to augment or improve their knowledge of, and ability to promote the development of their family member, and to aid in their ability to care for their family member at home. Training in activities of daily living which enable individuals to increase their level of independence and improve the quality of their lives.

- Vacation/Day/Sleep Away Camp: Vacation is a scheduled period of time away from the daily routine usually spent on recreational and leisure activities. Camps are licensed through the Department of Health. Camps, usually operated in the summer, provide for the physical and social needs of campers and offer recreation and leisure activities.

- Recreation (Day/Evening): A planned program of social, recreational and leisure activities which are enjoyable and often include opportunities to interact with and participate as part of a community. Recreation offers children and adults the chance to play, experience good times, and identify and pursue activities in which they are interested. It promotes development of a wide range of skills and helps create balance and well-being.

- Home Care: Services provided by a Home Care Agency licensed through the Department of Health. Employment of a Home Care Agency staff person in an individual's place of residence to aid in carrying out housekeeping functions in order to assist the individual in reaching identified goals, offer assistance and relief to a caregiver or family member, or provide a temporary substitute for a care giver or family member.

- Information/Referral/Outreach: Information and referral services provide information on programs and services for individuals and their families. Linkages can be made to diagnostic, residential, habilitative, educational, vocational, medical, and recreational services, and to entitlement programs such as Medicaid SSI. Includes activities undertaken to ensure the individual's use of a service or acceptance in a program and may include accompanying the individual. Outreach services identify unserved or underserved individuals with developmental disabilities or their families who are eligible to use all appropriate services offered through OPWDD generic and specialized services delivery systems.

- Transportation: Provides an individual and/or family member with the proper mode of transportation to and from his/her residence and programs and services.

- Items Purchased, Rented or Leased:

  - Special Adaptive Equipment: Any item, product or piece of equipment that can be used by persons with disabilities to maintain or improve their functional abilities. Such equipment might include: bathtub lifts, transfer boards, modified eating utensils, communication devices, adapted toys or accessible vans. Includes assistive technology services to help a person know about, acquire and use the appropriate adaptive equipment, e.g., demonstration, assessment, funding, training, maintenance, and repairs.

  - Environmental Modification: Environmental modification services provide assistance to families with the removal of barriers which limit accessibility and remodeling to enhance the independent or assisted functioning of individuals with developmental disabilities within their home. Such services include the installation of ramps, lifts or grab bars, widening of doorways, kitchen and bathroom cabinetwork, and counter or appliance changes (e.g., special sink handles).

  - Supplies: Can include the following:

    - Medication expenses such as cost of prescription and nonprescription substances which are necessary as a result of the individual's disability. Must have a receipt from the pharmacy. (Note: For those eligible, costs of prescription drugs are reimbursable through Medicaid.)

    - Continence products (e.g., diapers, wipes): products generally of a disposable nature, used to assist in caring for the individual, who, due to the disability, has a continence problem. Examples include diapers, wipes, chucks, draw sheets, and other bed linens. Must have a receipt of purchase.

    - Special clothing: the cost for extra clothing required for an individual with night time incontinence, or for an individual whose garments wear out quickly due to abnormal movement patterns resulting from a disability. Can include specially designed clothing for individuals with physical disabilities, and medically prescribed articles for which other funding is not available (e.g., orthopedic shoes, helmets for head protection). Must have a receipt of purchase.

    - Special dietary needs: food and supplements cost for special diets prescribed by a physician. The need for dietary supplements must be directly related to the individual's disability and must not be reimbursable through other funding sources. Must have a receipt of purchase.

- Other: There are a number of supply items needed to properly maintain persons with disabilities but are too numerous and varied to categorize. These items might include things such as batteries, program supplies, or other items reasonably related to the care of the family member with a disability. Must have a receipt of purchase.

Eligible Population:

Eligible individuals are those with developmental disabilities as defined by Mental Hygiene Law and who live in a home environment with their primary caregiver(s). Supports and services are provided to children and families caring for a child or adult family member with developmental disabilities in an effort to maintain the family member at home and strengthen the family's care giving capacity.

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

December 31, 2013

Dr. Nirav R. Shah, M.D.
Commissioner
Office of Health Insurance Programs
New York Department of Health
Empire State Plaza
Corning Tower Building
Albany, NY 12237

Dear Dr. Shah:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) has approved your request to amend the Partnership Plan and Federal-State Health Reform Partnership (F-SHRP) section 1115 of the Social Security Act (the Act) demonstrations (Project No. 11-W-00114/2 and Project No. 11-W-00234/2, respectively). This amendment is effective as of January 1, 2014.

This award is a partial response to New York's request in which several changes to the Partnership Plan and F-SHRP demonstrations were requested. At this time, CMS is approving the following requests:

In the Partnership Plan -

- Phasing out the Family Health Plus (FHPlus) program and transitioning childless adults and parents and caretaker relatives with incomes up to and including 133 percent of the federal poverty level (FPL) into state plan coverage;
- Mandating childless adults and parents and caretaker relatives with incomes up to and including 133 percent of the FPL into managed care arrangements;
- Approving expenditure authority to allow the state to claim federal matching dollars for a designated state health program (DSHP) that will provide premium subsidies to parents and caretaker relatives with incomes between 133 percent and 150 percent FPL who enroll in Marketplace coverage until December 31, 2014;
- Approving expenditure authority to allow the state to claim federal matching dollars for a DSHP that will provide FHPlus benefits to parents and caretaker relatives up to 150 percent of the FPL until April 30, 2014; and
- Removing the Family Planning Expansion program. New York has instead elected to provide expanded family planning services under the state plan.

Although not included in the state's request, CMS is approving the extension of expenditure authority for the following demonstration populations in the Partnership Plan that expire December 31, 2013:

- Home and Community Based Services (HCBS) Expansion
- Individuals Moved from Institutional Settings to Community Settings for Long Term Care Services

Extending the expenditure authority for these populations will assist the state in continuing to provide individuals who are receiving HCBS and individuals placed in community settings with appropriate benefits and less restrictive environments, whether in the home or in the community. The authorities for these populations are extended until March 31, 2014.

CMS is also removing the waiver and expenditure authorities related to the Medicaid Eligibility Quality Control (MEQC) program in the Partnership Plan and F-SHRP. Guidance for continuing to waive requirements for MEQC can be found on the Medicaid.gov website: http://www.medicaid.gov/federal-policy-guidance/downloads/CIB-08-15-2013.pdf

The demonstration expenditure and waiver authorities and Special Terms and Conditions (STCs) have been changed to reflect the changes above. We look forward to continuing discussions regarding extending funding for the clinic uncompensated care pool for diagnostic and treatment clinics and changes to the demonstration to reflect the state's decision to provide 12 months of continuous eligibility for MAGI populations.

This approval is conditioned upon compliance with the enclosed STCs and is subject to our receiving your acknowledgement of the award and the acceptance of the STCs within 30 days of the date of this letter.

Your acceptance and any questions regarding the Partnership Plan and F-SHRP demonstrations may be directed to your project officer, Jessica Woodard. Ms. Woodard can be reached at (410) 786-9249 or Jessica.Woodard@cms.hhs.gov. Communications regarding program matters and official correspondence concerning the demonstration should be submitted to Ms. Woodard at the following address:

Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
Mail Stop: S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850

Official communications regarding program matters should be sent simultaneously to Ms. Woodard and to Mr. Michael Melendez, Associate Regional Administrator, in our New York Regional Office. Mr. Melendez's contact information is as follows;

Centers for Medicare & Medicaid Services
New York Regional Office

Division of Medicaid and Children's Health
26 Federal Plaza
New York, New York 10278
Telephone: (212) 616-2430
E-mail: Michael.Melendez@cms.hhs.gov

We look forward to continuing to work with you and your staff.

Sincerely,

/s/

Cindy Mann
Director

Enclosure

Cc: Eliot Fishman, Director, Children and Adults Health Programs Group
Diane T. Gerrits, Director, Division of State Demonstrations and Waivers
Michael Melendez, Associate Regional Administrator, CMS New York
Jason Helgerson, New York Department of Health
Jessica Woodard, CMCS

CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER AUTHORITY

NUMBER: **11-W-00114/2**

TITLE: **Partnership Plan Medicaid Section 1115 Demonstration**

AWARDEE: **New York State Department of Health**

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived in this list, shall apply to the demonstration beginning January 1, 2014 through December 31, 2014.

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

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

   To permit the exclusion of some residents of some counties in New York from participation in Mandatory Mainstream Managed Care (MMMC) and Managed Long Term Care (MLTC) under this Demonstration

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

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

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

   To the extent necessary to enable New York to require beneficiaries to enroll in managed care plans, to the extent of the services furnished through the MMMC and MLTC programs. Beneficiaries shall retain freedom of choice of family planning providers.

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY LIST

NUMBER: **11-W-00114/2**

TITLE: **Partnership Plan Medicaid Section 1115 Demonstration**

AWARDEE: **New York State Department of Health**

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by New York for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period beginning January 1, 2014, until the ending date specified for each authority, be regarded as expenditures under the state's title XIX plan.

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

1. **Demonstration-Eligible Populations.** Expenditures for health-care related costs for the following populations that are not otherwise eligible under the Medicaid State Plan. (End Date: March 31, 2014.)

    a) Demonstration Population 9 (HCBS Expansion). Medically needy individuals who are receiving HCBS, and who are medically needy after application of community spouse and spousal impoverishment eligibility and post-eligibility rules under Section 1924 of the Act are applied.
    b) Demonstration Population 10 (Individuals Moved from Institutional Settings to Community Settings for Long Term Care Services). Expenditures for health-care related costs for individuals moved from institutional nursing facility settings to community settings for long-term services and supports who would not otherwise be eligible based on income, but whose income does not exceed a more liberal income standard, and who receive services through the managed long term care program under this demonstration.

2. **Twelve-Month Continuous Eligibility Period**. Expenditures for health-care related costs for individuals who have been determined eligible under groups specified in Table 1 of STC 19(a) for continued benefits during any periods within a twelve-month eligibility period when these individuals would be found ineligible if subject to redetermination (End Date: March 31, 2014)

3. **Facilitated Enrollment Services.** Expenditures for enrollment assistance services provided by organizations that do not meet the requirements of section 1903(b)(4) of the Act, as interpreted by 42CFR 438.810(b)(1) and (2). Inasmuch as these services may be rendered by MCOs and therefore included in the MCOs' capitation payments, no expenditures other than

these payments may be submitted for FFP. (End Date: March 31, 2014.)

4. **Designated State Health Programs Funding.** Expenditures for the designated state health programs specified in STC 57(a)-(l) which provide health care services to low-income or uninsured New Yorkers in an amount not to exceed $477.2 million over the demonstration period. (End Date: December 31, 2014.)

5. **Designated State Health Programs Funding**. Expenditures for the designated state health programs specified in STC 63 which provides services to low-income or uninsured New Yorkers enrolled in community support services, residential services and prevention and treatment programs under the Office of Mental Health, Office for People with Developmental Disabilities, and Office of Alcoholism and Substance Abuse Service in an amount not to exceed $250 million for the period of April 1, 2013 through March 31, 2014.

6. **Designated State Health Programs Funding.** Expenditures for the designated state health program specified in STC 57(n) which provides transitional Family Health Plus benefits to parents and caretaker relatives with incomes up to 150 percent of the FPL. This authority expires April 30, 2014.

7. **Designated State Health Programs Funding**. Expenditures for the designated state health program specified in STC 57(m) which provides premium subsidies to FHPlus individuals and new applicants between 133 percent and 150 percent FPL sent to the Marketplace. This authority expires December 31, 2014.

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: **11-W-00114/2**

TITLE: **Partnership Plan Medicaid Section 1115 Demonstration**

AWARDEE: **New York State Department of Health**

I. PREFACE

The following are the Special Terms and Conditions (STCs) for New York's Partnership Plan section 1115(a) Medicaid demonstration extension (hereinafter "demonstration"). The parties to this agreement are the New York State Department of Health (state) and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS during the life of the demonstration. The STCs are effective January 1, 2014, unless otherwise specified. All previously approved STCs, waivers, and expenditure authorities are superseded by the STCs set forth below. This demonstration extension is approved through December 31, 2014; however, some components of the demonstration will expire earlier, as described below in these STCs and associated waiver and expenditure authority documents, and in the table in Attachment E.

The STCs have been arranged into the following subject areas:

I. Preface
II. Program Description and Objectives
III. General Program Requirements
IV. Populations Affected By And Eligible Under The Demonstration
V. Demonstration Benefits and Enrollment
VI. Delivery Systems
VII. Quality Demonstration Programs and Clinic Uncompensated Care Funding
VIII. Health System Transformation for Individuals with Developmental Disabilities
IX. General Reporting Requirements
X. General Financial Requirements
XI. Monitoring Budget Neutrality
XII. Evaluation of the Demonstration
XIII. Schedule of State Deliverables for the Demonstration Extension.

Additionally, attachments have been included to provide supplementary information and guidance for specific STCs. More attachments will be developed to provide additional guidance for the health system transformation for individuals with developmental disabilities.

II. PROGRAM DESCRIPTION AND OBJECTIVES

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

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

The demonstration is designed to use a managed care delivery system to deliver benefits to Medicaid recipients, create efficiencies in the Medicaid program, and enable the extension of coverage to certain individuals who would otherwise be without health insurance. It was approved in 1997 to enroll most Medicaid recipients into managed care organizations (MCOs) (Medicaid managed care program). As part of the demonstration's renewal in 2006, authority to require the disabled and aged populations to enroll in mandatory managed care was transferred to a new demonstration, the Federal-State Health Reform Partnership (F-SHRP).

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

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

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

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

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

rate of PPRs for the Medicaid population. Projects will target readmissions related to both medical and behavioral health conditions.

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

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

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

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

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

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

Finally, the December 2013 amendment was approved to ensure that it reflected changes to the demonstration that were necessary in order to conform the programs for Affordable Care Act (ACA) implementation beginning January 1, 2014.

III. GENERAL PROGRAM REQUIREMENTS

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

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

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

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

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

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

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

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

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

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

   b) A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include current total computable

"with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group/EG) the impact of the amendment;

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

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

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

a) Notification of Suspension or Termination: The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a phase-out plan. The state must submit its notification letter and a draft phase-out plan to CMS no less than 4 months before the effective date of the demonstration's suspension or termination.

Prior to submitting the draft phase-out plan to CMS, the state must publish on its website the draft phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation State Plan Amendment. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received, the state's response to the comment, and the way the state incorporated the received comment into a revised phase-out plan.

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

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

c) Phase-out Procedures: The state must comply with all notice requirements found in 42 CFR § 431.206, § 431.210 and § 431.213. In addition, the state must ensure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR § 431.220 and 431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR § 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine whether they qualify for Medicaid eligibility under a different eligibility category as discussed in the October 1, 2011, State Health Official Letter #10-008.

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

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

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

11. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX of the Act. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS's determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.

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

13. **Quality Review of Eligibility.** The state will continue to submit to the CMS Regional Office by December 31 of each year an alternate plan for Medicaid Eligibility Quality Control (MEQC) as permitted by federal regulations at 42 CFR § 431.812(c).

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

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

    In states with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the state is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any demonstration proposal, and/or renewal of this demonstration (42 CFR § 431.408(b)(3)). The state must also comply with the Public Notice Procedures set forth in 42 CFR § 447.205 for changes in statewide methods and standards for setting payment rates.

15. **FFP.** No federal matching funds for expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter.

IV. POPULATINS AFFECTED BY AND ELIGIBILITY UNDER THE DEMONSTRATION

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

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

    Specifically the state has authority to expand mandatory enrollment in mainstream managed care to all individuals identified in Table 2 (except those otherwise excluded or exempted as outlined in STC 24) and who reside in any county other than Allegany, Cortland, Dutchess, Fulton, Montgomery, Putnam, Orange, Otsego, Schenectady, Seneca, Sullivan, Ulster, Washington, and Yates counties. When the state intends to expand mandatory managed care enrollment to additional counties (other than those identified in this subparagraph), it must notify CMS 90 days prior to the effective date of the expansion and submit a revised assessment of the demonstration's budget neutrality agreement, which reflects the projected impact of the

    expansion for the remainder of the demonstration approval period.

    Note: The authority to require mandatory managed care enrollment for any of the individuals who are identified in Table 2 and who reside in Allegany, Cortland, Dutchess, Fulton, Montgomery, Putnam, Orange, Otsego, Schenectady, Seneca, Sullivan, Ulster, Washington, and Yates counties has been provided under the Federal-State Health Reform Partnership Demonstration (11-W-00234/2).

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

    Services not provided through the MLTC program are provided on a fee-for-service basis. The state has authority to expand mandatory enrollment into MLTC to all individuals identified in Table 3 (except those otherwise excluded or exempted as outlined in STC 25) with initial mandatory enrollment starting in any county in New York City and then expanding statewide based on the Enrollment plan as outlined in Attachment F. When the state intends to expand into a new county outside of New York City, it must notify CMS 90 days prior to the effective date of the expansion and submit a revised assessment of the demonstration's budget neutrality agreement along with all other required materials as outlined in STC 32.

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

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

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

19. **Continuous Eligibility Period**.

a) **Duration.** The state is authorized to provide a 12-month continuous eligibility period to the groups of individuals specified in Table 1, regardless of the delivery system through which they receive Medicaid benefits. Once the state begins exercising this authority, each newly eligible individual's 12-month period shall begin at the initial determination of eligibility; for those individuals who are redetermined eligible consistent with Medicaid state plan rules, the 12-month period begins at that point. At each annual eligibility redetermination thereafter, if an individual is redetermined eligible under Medicaid state plan the individual is guaranteed a subsequent 12-month continuous eligibility period. 12-month continuous eligibility is not authorized at this time for individuals eligible under the new adult group 1902(a)(10)(A)(i)(VIII).

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

State Plan Mandatory and Optional Groups	Statutory Reference (Social Security Act)
Pregnant women aged 19 or older	1902(a)(10)(A)(i)(III) or (IV); and 1902(a)(10)(A)(ii)(I) and (II)
Children aged 19 or 20	1902(a)(10)(A)(ii)(I) and (II)
Parents or other caretaker relatives aged 19 or older	1902(a)(10)(A)(ii)(I) and (II)
Members of low-income families, except for children	1931 and 1925
Medically needy pregnant women, children, and parents/caretaker relatives	Without spend-down under 1902(a)(10)(C)(i)(III)

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

Table 2: Mainstream Medicaid Managed Care Program

State Plan Mandatory and Optional Groups	FPL and/or Other Qualifying Criteria	Expenditure and Eligibility Group Reporting
Pregnant Women	Income up to 200% of FPL	Demonstration Population 2/ Temporary Assistance to Needy Families (TANF) Adult
Children under age 1	Income up to 200% of FPL	Demonstration Population 1/ TANF Child
Children 1 through 5	Income up to 133% of FPL	Demonstration Population 1/ TANF Child
Children 6 through 18	Income up to 133% of FPL	Demonstration Population 1/ TANF Child
Children 19 through 20	Income at or below the monthly income standard (determined annually)	Demonstration Population 1/ TANF Child
Foster Children Aged 0 through 20, (IV-E Foster Children and non IV-E Foster Children)	Categorically Medicaid eligible, Disregard all income	Demonstration Population 1/TANF Child
The New Adult Group (effective January 1, 2014)	Income up to 133% of FPL	New Adult Group
Parents and Caretaker Relatives	Income at or below the monthly income standard (determined annually)	Demonstration Population 2/ TANF Adult

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

Table 3: Managed Long-Term Care Program

State Plan Mandatory and Optional Groups	FPL and/or Other Qualifying Criteria	Expenditure and Eligibility Group Reporting

Adults aged 65 and older	Income at or below SSI level	Demonstration population 11/ MLTC Adults 65 and above - Duals
Adults/children aged 18 through 64	Income at or below SSI level	Demonstration population 10/ MLTC Adults 18 through 64 - Duals
Adults aged 65 and older	Income at or below the monthly income standard, or with spenddown to monthly income standard	Demonstration population 11/ MLTC Adults 65 and above - Duals
Adults/children aged 18 through 64 blind and disabled	Income at or below the monthly income standard, or with spenddown to monthly income standard	Demonstration population 10/ MLTC Adults 18 through 64 - Duals
Aged 18 through 64 Medicaid Buy In for Working People with Disabilities	Income up to 250% of FPL	Demonstration population 10/ MLTC Adults 18 through 64 - Duals
Parents and Caretaker Relatives 21 through 64	Income at or below the monthly income standard, or with spenddown to monthly income standard	Demonstration population 10/ MLTC Adults 18 through 64 - Duals
Children aged 18 through 20	Income at or below the monthly income standard or with spenddown	Demonstration population 10/ MLTC Adults 18 through 64 - Duals
Pregnant Women	Income up to 200% of FPL	Demonstration population 10/ MLTC Adults 18 through 64 - Duals
Poverty Level Children Aged 18 through 20	Income up to 133% of FPL	Demonstration population 10/ MLTC Adults 18 through 64 - Duals
Foster Children Aged 18 through 20	In foster care on the date of 18th birthday	Demonstration population 10/ MLTC Adults 18 through 64 - Duals

Demonstration Eligible Groups	FPL and/or Other Qualifying Criteria	Expenditure and Eligibility Group Reporting
Individuals Moved from Institutional Settings to Community Settings for Long Term Care Services	Income based on higher income standard to community settings for long term services and supports pursuant to STC 23	Demonstration population 10 and 11/ MLTC Adults 18 through 64 and MLTC Adults 65 and above

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

    a) Who meet a nursing home level of care;

    b) Whose spouse lives in the community; and

    c) Who could receive services in the community but for the application of the spousal impoverishment eligibility and post-eligibility rules of section 1924 of the Act.

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

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

    Enrollees receiving community-based long term services and supports must be provided with nursing facility coverage through managed care, if nursing facility care is needed for 120 days or less and there is an expectation that the enrollee will return to community-based settings. During this short term nursing facility stay, the state must retain the enrollees' community maintenance needs allowance. In addition, the state will ensure that the MLTC Managed Care Organizations (MCOs) work with individuals, their families, nursing home administrators, and discharge planners to help plan for the individual's move back into the community, as well as to help plan for the individual's medical care once he/she has successfully moved into his/her home. For dually eligible enrollees, the MCO is

responsible for implementing and monitoring the plan of care between Medicare and Medicaid. The MCO must assure the services are available to the enrollee.

24. **Exclusions and Exemptions from MMMC.** Notwithstanding the eligibility criteria in STC 16, certain individuals cannot receive benefits through the MMMC program (i.e., excluded), while others may request an exemption from receiving benefits through the MMMC program (i.e., exempted). Tables 6 and 7 list those individuals either excluded or exempted from MMMC.

Table 6: Individuals Excluded from MMMC

Individuals who become eligible for Medicaid only after spending down a portion of their income
Residents of state psychiatric facilities or residents of state-certified or voluntary treatment facilities for children and youth
Patients in residential health care facilities (RHCF) at time of enrollment and residents in an RHCF who are classified as permanent.
Participants in capitated long-term care demonstration projects
Medicaid-eligible infants living with incarcerated mothers
Individuals with access to comprehensive private health insurance if cost effective
Foster care children in the placement of a voluntary agency
Certified blind or disabled children living or expected to live separate and apart from their parents for 30 days or more
Individuals expected to be Medicaid-eligible for less than 6 months (except for pregnant women)
Individuals receiving hospice services (at time of enrollment)
Individuals with a "county of fiscal responsibility" code of 97 (Individuals residing in a state Office of Mental Health facility)
Individuals with a “county of fiscal responsibility” code of 98 (Individuals in an Office for People with Developmental Disabilities/OPWDD facility or treatment center)
Youth in the care and custody of the commissioner of the Office of Family & Children Services
Individuals eligible for the family planning expansion program
Individuals who are under 65 years of age (screened and require treatment) in the Centers for Disease Control and Prevention breast, cervical, colorectal, and/or prostate early detection program and need treatment for breast, cervical, colorectal, or prostate cancer, and who are not otherwise covered under creditable health coverage
Individuals who are eligible for Emergency Medicaid

Table 7: Individuals who may be exempted from MMMC

Individuals with chronic medical conditions who have been under active treatment for at least 6 months with a sub-specialist who is not a network provider for any Medicaid MCO in the service area or whose request has been approved by the New York State Department of Health Medical Director because of unusually severe chronic care needs. Exemption is limited to six months
Individuals designated as participating in OPWDD-sponsored programs

Individuals already scheduled for a major surgical procedure (within 30 days of scheduled enrollment) with a provider who is not a participant in the network of any Medicaid MCO in the service area. Exemption is limited to six months
Individuals with a developmental or physical disability receiving services through a Medicaid home- and community-based services (HCBS) waiver authorized under section 1915(c) of the Act
Residents of alcohol/substance abuse long-term residential treatment programs
Native Americans
Individuals with a "county of fiscal responsibility code of 98" (OPWDD in Medicaid Management Information System/MMIS) in counties where program features are approved by the state and operational at the local district level to permit these individuals to voluntarily enroll.

25. **Exclusions and Exemptions from MLTC.** Notwithstanding the eligibility criteria in STC 16, certain individuals cannot receive benefits through the MLTC program (i.e., excluded), while others may request an exemption from receiving benefits through the MLTC program (i.e., exempted). Tables 8 and 9 list those individuals either excluded or exempted from MLTC.

Table 8: Individuals excluded from MLTC

Residents of psychiatric facilities
Residents of residential health care facilities (RHCF) at time of enrollment.
Individuals expected to be Medicaid eligible for less than six months
Individuals eligible for Medicaid benefits only with respect to tuberculosis-related services
Individuals with a "county of fiscal responsibility" code 99 in MMIS (Individuals eligible only for breast and cervical cancer services)
Individuals receiving hospice services (at time of enrollment)
Individuals with a "county of fiscal responsibility" code of 97 (Individuals residing in a state Office of Mental Health facility)
Individuals with a "county of fiscal responsibility" code of 98 (Individuals in an OPWDD facility or treatment center)
Individuals eligible for the family planning expansion program
Individuals who are under 65 years of age (screened and require treatment) in the Centers for Disease Control and Prevention breast, cervical, colorectal, and/or prostate early detection program and need treatment for breast, cervical, colorectal, or prostate cancer, and who are not otherwise covered under creditable health coverage
Residents of intermediate care facilities for the mentally retarded (ICF/MR)
Individuals who could otherwise reside in an ICF/MR, but choose not to
Residents of alcohol/substance abuse long-term residential treatment programs
Individuals eligible for Emergency Medicaid
Individuals in the Office for People with Developmental Disabilities Home- and Community-Based Services (OPWDD HCBS) section 1915(c) waiver program

Individuals in the following section 1915(c) waiver programs: Traumatic Brain Injury (TBI), Nursing Home Transition & Diversion (NHTD), and Long-Term Home Health Care Program (LTHHCP) in certain counties[1] (see Attachment F)
Residents of Assisted Living Programs
Individuals in receipt of Limited Licensed Home Care Services
Individuals in the Foster Family Care Demonstration

Table 9: Individuals who may be exempted from MLTC.

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

26. **Population-Specific Program Requirements.**

a) **MMMC Enrollment of Individuals Living with HIV.** The state is authorized to require individuals living with HIV to receive benefits through MMMC. Once the state begins implementing MMMC enrollment in a particular district, individuals living with HIV will have thirty days in which to select a health plan. If no selection is made, the individual will be auto-assigned to a MCO. Individuals living with HIV who are enrolled in a MCO (voluntarily or by default) may request transfer to an HIV Special Needs Plans (SNP) at any time if one or more HIV SNPs are in operation in the individual's district. Further, transfers between HIV SNPs will be permitted at any time.

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

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

ii. The state must require MCOs to report to the state whenever they want to place a new

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

person in a restricted recipient program. The state must maintain summary statistics on the numbers of individuals placed in restricted recipient programs, and the reasons for those placements, and must provide the information to CMS upon request.

c) **Managed care enrollment of individuals using long-term services and supports for both MMMC and MLTC.** The state is authorized to require certain individuals using long-term services and supports to enroll in either mainstream managed care or managed long-term care as identified in STC 16. In addition, the populations that are exempted from mandatory enrollment, based on the exemption lists in STCs 24 and 25 may also elect to enroll in managed care plans. Once these individuals begin to enroll in managed care, the state will be required to provide the following protections for the population[2]:

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

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

1) The qualification for individuals who will develop the PCP;
2) Types of assessments;
3) How enrollees are informed of the services available to them; and
4) The MCOs' responsibilities for implementing and monitoring the PCP.

(B) The MCO/PIHP contract shall require the use of a person centered and directed planning process intended to identify the strengths, capacities, and preferences of the enrollee, as well as to identify an enrollee's long term care needs and the resources available to meet those needs, and to provide access to additional care options as specified by the contract. The person-centered plan is developed by the participant with the assistance of the MCO/PIHP, provider, and those individuals the participant chooses to include. The plan includes the services and supports that the participant needs.

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

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

[2] All beneficiary protections apply to both MMMC and MLTC, unless otherwise noted in STC 26 and Section V.

(E) The MCO/PIHP shall ensure that meetings related to the enrollee's Person Centered Plan will be held at a location, date, and time convenient to the enrollee and his/her invited participants.

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

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

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

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

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

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

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

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

resolution of problems regarding services, coverage, access and rights.

a) **Core Elements of the Independent Consumer Support Program**.

1) *Organizational Structure*. The Independent Consumer Support Program shall operate independently from any Partnership Plan MCO. Additionally, to the extent possible, the program shall also operate independently of the Department of Human Services. The organizational structure of the program shall support its transparent and collaborative operation with beneficiaries, MCOs, and state government.
2) *Accessibility*. The services of the Independent Consumer Support Program are available to all Medicaid beneficiaries enrolled in Partnership Plan who are in need of LTSS (institutional, residential and community based).

   The Independent Consumer Support Program must be accessible through multiple entryways (e.g., phone, internet, office) and must reach out to beneficiaries and/or authorized representatives through various means (mail, phone, in person), as appropriate.

3) *Functions*. The Independent Consumer Support Program assists beneficiaries to navigate and access covered LTSS. Where an individual is enrolling in a new delivery system, the services of this program help individuals understand their choices and resolve problems and concerns that may arise between the individual and a provider/payer. The following list encompasses the program's scope of activity.
   - The program shall offer beneficiaries support in the pre-enrollment stage, such as unbiased health plan choice counseling and general program-related information.
   - The program shall serve as an access point for complaints and concerns about health plan enrollment, access to services, and other related matters.
   - The program shall help enrollees understand the fair hearing, grievance, and appeal rights and processes within the health plan and at the state level and assist them through the process if needed/requested.
   - The program shall conduct trainings with Partnership Plan MCO as well as providers on community-based resources and supports that can be linked with covered plan benefits.

4) *Staffing*. The Independent Consumer Support Program must employ individuals who are knowledgeable about the state's Medicaid programs; beneficiary protections and rights under Medicaid managed care arrangements; and the health and service needs of persons with complex needs, including those with a chronic condition, disability, and cognitive or behavioral needs. In addition, the Independent Consumer Support Program shall ensure that its services are delivered in a culturally competent manner and are accessible to individuals with limited English proficiency.

5) *Data Collection and Reporting.* The Independent Consumer Support Program shall track the volume and nature of beneficiary contacts and the resolution of such contacts on a schedule and manner determined by the state,

but no less frequently than quarterly. This information will inform the state of any provider or contractor issues and support the reporting requirements to CMS.

vi. **Independent Consumer Support Program Plan**. The state shall submit a plan to CMS describing the structure and operation of the Independent Consumer Support Program that aligns with the core elements provided in this STC 26 no later than January 1, 2014.

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

d) **MLTC enrollment**. Including the protections afforded individuals in subparagraph (c) of STC 26, the following requirements apply to MLTC plan enrollment.

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

ii. **Assessment of LTSS Need.** The following requirements apply until the state implements an independent and conflict-free long-term services and supports (LTSS) assessment process (as required by STC 26).

A) MLTC plans conduct the initial assessment for an individual's need for LTSS using a standardized assessment tool designated by the state. The following requirements apply to the activities that must be undertaken by a MLTC plan as it assesses individuals for need for LTSS.

1. The state shall ensure all individuals requesting LTSS are assessed in a timely manner.
    a. The MCO/PIHP will use the Semi-Annual Assessment of Members

(SAAM) tool (or successor tool designated by the state) to determine if the individual has a need for LTSS.

b. In addition to the SAAM tool, the MCO/PIHP may use other assessment tools as appropriate. The state must review and approve all other assessment tools used by the MCO/PIHP.

2. The state must ensure through its contracts that each MCO/PIHP must complete the initial assessment in the individual's home of all individuals referred to or requesting enrollment in an MLTC plan within 30 days of that referral or initial contact. MCO/PIHP compliance with this standard shall be reported to CMS in the quarterly reports as required in STC 70. The state shall take corrective action against MLTC plans that do not meet this 30 day requirement.
   a. The MCO/PIHP shall complete a re-assessment at least annually, or when an enrollee's needs change.
   b. If the assessed individual is not already a Medicaid recipient, the MCO/PIHP shall:
      i. Provide the individual with the results of the assessment.
      ii. If the assessment indicates that the individual meets the criteria for LTSS, explain that the results of the assessment will be forwarded to the individual's county social services office for a formal Medicaid eligibility determination.
      iii. If the assessment indicates that the individuals do not meet the criteria for LTSS, explain that the results of the assessment do not indicate that the individual is eligible for Medicaid and provide a written notice to the individual that they have the right (consistent with 42 CFR § 435.906) to request a formal Medicaid eligibility determination from the county social services office.
   c. If the assessed individual is already a Medicaid recipient, the MCO/PIHP shall:
      i. Provide the recipient with the results of the assessment.
      ii. If the assessment indicates that the recipient meets the criteria for LTSS, explain that the individual is eligible for enrollment in a MLTC.
      iii. Provide the recipient with information about all the MLTC plans in which the recipient can enroll.
3. The state shall require each MCO/PIHP, through its contract, to report to the enrollment broker the names of all individuals for whom an assessment is completed. If the individual has not been referred by the enrollment broker, the MCO/PIHP shall report the date of initial contact by the individual and the date of the assessment to determine compliance with the 30-day requirement.
4. The state shall use this information to determine if individuals have been assessed incorrectly

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

C) The state must submit to CMS for review and comment, and subsequently

approval of the written notice required in subparagraph A no later than May 31, 2013.

iii. **Transformation of LTSS Needs Assessment.** The state shall begin implementation of an independent and conflict-free LTSS needs assessment system for newly eligible Medicaid recipients, as applicable, no later than December 1, 2014. After that implementation has begun, MLTC plans will not complete any LTSS needs assessments for individuals requesting such services prior to the enrollment in the plan. Non-dually eligible individuals requesting LTSS will be assessed to see if they meet the criteria to be enrolled in a MLTC plan or alternate waiver program prior to being told their enrollment options. In order to achieve this milestone, the state must:

a. Submit to CMS an initial plan for implementing this transformation by December 31, 2013.
b. Submit to CMS a final plan with specific action items and timeframes by May 31, 2014.
c. Report progress on the plan in each quarterly report required by STC 70.

iv. **Marketing Oversight**.

A) The state shall require each MCO/PIHPs through its contract to meet 42 CFR § 438.104, and state marketing guidelines which prohibit cold calls, use of government logos and other standards.
B) All materials used to market the MCO/PIHP shall be prior approved by the state.
C) The state shall require through its contract that each MCO/PIHP provide all individuals who were not referred to the plan by the enrollment broker with information (in a format determined by the state) describing Managed Long Term Care, a list of available plans, and contact information to reach the enrollment broker for questions or other assistance. The plan shall report the number of individuals receiving these materials to the state on a quarterly basis pursuant to STC 70.

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

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

V. DEMONSTRATION BENEFITS AND ENROLLMENT

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

a) **Mainstream Medicaid Managed Care (MMMC).** State plan benefits delivered through MCOs or, in certain districts, primary care case management arrangements, with the exception of certain services carved out of the MMMC contract and delivered directly by the state on a fee-for-service basis. All MMMC benefits (regardless of delivery method), as well as the co-payments charged to MMMC recipients, are listed in Attachment A.

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

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

29. **Home and Community Settings Characteristics**. MLTC enrollees, including individuals who receive services under the demonstration's HCBS Expansion program described in STC 16, must receive services in residential settings located in the community, which meet CMS standards for HCBS settings as articulated in current 1915(c) policy and as modified by subsequent regulatory changes, in accordance with the plan submitted by the state (required in Attachment G). This plan shall be due no later than December 31, 2013. Residential settings include characteristics such as providing full access to facilities such as kitchen and cooking facilities, small dining areas, convenient privacy for visitors and easy access to resources and activities in the community. A full list of home and community based characteristics are provided in Attachment C.

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

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

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

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

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

ii. **Decision-Making Authorities.** The participants exercise the following decision making authorities: Recruit staff, hire staff , verify staff's ability to perform

identified tasks, schedule staff, evaluate staff performance, verify time worked by staff and approve time sheets, and discharge staff.

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

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

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

31. **Adding Services to the MMMC and/or MLTC plan benefit package**. At any point in time the state intends to add to either the MMMC or MLTC plan benefit package currently authorized state plan or demonstration services that have been provided on a fee-for-service basis, the state must provide CMS the following information, with at least 30 days' notice prior to the inclusion of the benefit, either in writing or as identified on the agenda for the monthly calls referenced in STC 69:
    a) A description of the benefit being added to the MCO/PIHPs benefit package;
    b) A detailed description of the state's oversight of the MCO/PIHP's readiness to administer the benefit including: readiness and implementation activities, which may include on-site reviews, phone meetings, and desk audits reviewing policies and procedures for the new services, data sharing to allow plans to create service plans as appropriate, process to communicate the change to enrollees, MCO/PIHP network development to include providers of that service, and any other activity performed by the state to ensure plan readiness.
    c) Information concerning the changes being made to MMMC and/or MLTC contract provisions and capitation payment rates in accordance with STC 36.

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

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

32. **Expanding MLTC enrollment**. Any time the state is ready to expand mandatory MLTC plan

enrollment into a new geographic area for populations approved for managed care through an amendment, the state must provide CMS notification at least 90 days prior to the expansion. Such notification will include:

a) A list of the counties that will have approved populations moving to mandatory enrollment;
b) A list of MCO/PIHPs with an approved state certificate of authority to operate in those counties demonstrating that enrollees will be afforded choice of plan within the new geographic area;
c) Confirmation that the MCO/PIHPs in the new geographic area have met the network requirements in STCs 43 and 44 for each MCO/PIHP.

The state must also apply the requirements of STC 31 when applicable to the MLTC population or geographic area being added to the MLTC program.

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

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

33. **Assurances during expansion of MLTC enrollment**. The assurances below pertain to future MLTC expansions authorized under this demonstration. To provide and demonstrate smooth transitions for beneficiaries, the state must:

a) Send sample notification letters. Existing Medicaid providers must receive sample beneficiary notification letters via widely distributed methods (mail, email, provider website, etc.) so that providers are informed of the information received by enrollees regarding their managed care transition.
b) Provide educational tours for enrollees and providers. The educational tour should educate enrollees and providers on the MLTC plan enrollment options, rights and responsibilities and other important program elements. The state must provide webinars, meeting plans, and send notices through outreach and other social media (e.g. state's website).The enrollment broker, choice counseling entities, ombudsman and any group providing enrollment support must participate.
c) Operate a call center independent of the MLTC plans for the duration of the demonstration. This entity must be able to help enrollees in making independent decisions about plan choice and be able to document complaints about the plans. During the first 60 days of implementation the state must review all call center response statistics to ensure all contracted plans are meeting requirements in their contracts. After the first 60 days, if all entities are consistently meeting contractual requirements the state can lessen the review of call center statistics, but no more than 120 days should elapse between reviews.
d) Review the outcomes of the auto-assignment algorithm to ensure that MLTC plans with more limited networks do not receive are the same or larger number of enrollees as plans with larger networks.
e) The state shall require MCOs/PIHPs to maintain the current worker/recipient relationship for no less than 90 days.

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

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

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

    a) Facilitated enrollers will provide program information to applicants and interested individuals as described in 42 CFR § 435.905(a).
    b) Facilitated enrollers must afford any interested individual the opportunity to apply for Medicaid without delay as required by 42 CFR § 435.906.

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

    d) The protocols for facilitated enrollment practices between the LDSS and the facilitated enrollers must:
        i. Ensure that choice counseling activities are closely monitored to minimize adverse risk selection; and
        ii. Specify that determinations of Medicaid eligibility are made solely by the LDSS.

VI. DELIVERY SYSTEMS

36. **Contracts.** Procurement and the subsequent final contracts developed to implement selective contracting by the state with any provider group shall be subject to CMS approval prior to implementation.

    Payments under contracts with public agencies, that are not competitively bid in a process involving multiple bidders, shall not exceed the documented costs incurred in furnishing covered services to eligible individuals (or a reasonable estimate with an adjustment factor no greater than the annual change in the consumer price index).

37. **Managed Care Contracts.** No FFP is available for activities covered under contracts and/or modifications to existing contracts that are subject to 42 CFR 438 requirements prior to CMS approval of model contract language. The state shall submit any supporting documentation

deemed necessary by CMS. The state must provide CMS with a minimum of 45 days to review and approve changes. CMS reserves the right, as a corrective action, to withhold FFP (either partial or full) for the demonstration, until the contract compliance requirement is met.

38. **Interpretation Services and Culturally Competent Care**. The MCOs must have interpretation services and provide care that is consistent with the individual's culture. MCOs must conduct analyses to determine any gaps in access to these services and will expand its workforce accordingly. The MCOs may also require the use of remote video and voice technology when necessary.

39. **Managed Care Benefit Package.** Individuals enrolled in either MMMC or MLTC must receive from the managed care program the benefits as identified in Attachments A or B, as appropriate. As noted in plan readiness and contract requirements, the state must require that, for enrollees in receipt of LTSS, each MCO/PIHP coordinate, as appropriate, needed state plan services that are excluded from the managed care delivery system but available through a fee-for-service delivery system, and must also assure coordination with services not included in the established benefit package.

40. **Revision of the State Quality Strategy.** The state must update its Quality Strategy to reflect all managed care plans operating under MMMC and MLTC programs proposed through this demonstration and submit to CMS for approval within 90 days of approval of the April 2013 amendment, which will include the health system for individuals with developmental disabilities goals. The state must obtain the input of recipients and other stakeholders in the development of its revised comprehensive Quality Strategy and make the Strategy available for public comment. The state must revise the strategy whenever significant changes are made, including changes through this demonstration. Pursuant to STC 71, the state must also provide CMS with annual reporting on the implementation and effectiveness of the updated comprehensive Quality strategy, as it impacts Pursuant to STC 71, the state must also provide CMS with annual reporting on the implementation and effectiveness of the updated comprehensive quality strategy, as it impacts the demonstration.

41. **Required Components of the State Quality Strategy.** The revised Quality Strategy shall meet all the requirements of 42 CFR 438 Subpart D. The quality strategy must include components relating to managed long term services and supports. The Quality strategy must address the following regarding the population utilizing long term services and supports: level of care assessments, service planning, and health and welfare of enrollees. The state should also incorporate performance measures for outcomes related to quality of life and community integration related to health system transformation for individuals with developmental disabilities.

42. **Required Monitoring Activities by State and/or EQRO.** The state's EQR process for the mainstream managed care and MLTC plans shall meet all the requirements of 42 CFR 438 Subpart E. In addition, the state, or its EQRO shall monitor and annually evaluate the MCO/PIHPs performance on specific new requirements under mandatory enrollment of individuals utilizing long term services and supports. The state shall provide an update of the processes used to monitor the following activities as well as the outcomes of the monitoring activities within the annual report in STC 71. The new requirements include, but are not limited to the following:

    a) MLTC Plan Eligibility Assessments – to ensure that approved instruments are being used and applied appropriately and as necessary, and to ensure that individuals being

served with LTSS meet the MLTC plan eligibility requirements for plan enrollment . The state will also monitor assessments conducted by the plan where individuals are deemed ineligible for enrollment in an MLTC plan.

b) Service plans – to ensure that MCOs/PIHPs are appropriately creating and implementing service plans based on enrollee's identified needs.
c) MCO/PIHP credentialing and/or verification policies – to ensure that LTSS services are provided by qualified providers.
d) Health and welfare of enrollees – to ensure that the MCO/PIHP, on an ongoing basis, identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation.

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

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

a) The state must verify these assurances by reviewing demographic, utilization and enrollment data for enrollees in the demonstration as well as:
    i. The number and types of providers available to provide covered services to the demonstration population;
    ii. The number of network providers accepting the new demonstration population; and
    iii. The geographic location of providers and demonstration populations, as shown through GeoAccess, similar software or other appropriate methods.

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

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

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

46. **Health Services to Native American Populations.** The plan currently in place for patient

management and coordination of services for Medicaid-eligible Native Americans developed in consultation with the Indian tribes and/or representatives from the Indian health programs located in participating counties shall continue in force for this extension period.

VII. QUALITY DEMONSTRATION PROGRAMS AND CLINIC UNCOMPENSATED CARE FUNDING

47. **Hospital-Medical Home (H-MH) Demonstration**. The purpose of this demonstration is to improve the coordination, continuity, and quality of care for individuals receiving primary care in hospital outpatient departments operated by teaching hospitals, as well as other primary care settings used by teaching hospitals to train resident physicians. The demonstration will be instrumental in influencing the next generation of practitioners in the important concepts of patient-centered medical homes. Training sites, in particular, due to the structural discontinuity imposed by rotating residents and attending physicians' schedules, present a significant opportunity to improve patient experience and care through residency redesign.

    During this extension period, entities that serve as clinical training sites for primary care residents will work toward transforming their delivery system consistent with the National Committee on Quality Assurance (NCQA) requirements for medical home recognition under its Physician Practice Connections® - Patient-Centered Medical Home™ program (PPC®-PCMH™) and the 'Joint Principles' for medical home development articulated by primary care professional associations.

    In addition, hospitals which receive funding under this demonstration shall be required to implement a number of patient safety and systemic quality improvement projects.

48. **H-MH Demonstration Eligibility and Selection.** All teaching institutions in New York State will be eligible to participate in the H-MH demonstration. However, because the state does not intend to use a public competitive process to select awardees, the selection criteria for the H-MH demonstration will include for each:

    a) The extent to which the hospital has existing arrangements with training sites in the community (such as federally qualified health centers) to provide clinical experience to its primary care residents;
    b) An attestation as to their willingness and commitment to accomplish all milestones outlined in STC 49, including achieving NCQA PPC®-PCMH™ Level 2 recognition or above (in accordance with the standards applicable at the time that recognition is awarded) by the end of the second year of the demonstration;
    c) An agreement to track and report the clinical performance metrics required in STC 50; and
    d) An agreement to implement both the system improvement and patient safety initiatives consistent with STCs 51 and 52.

    To ensure that a mix of both academic medical centers and community teaching hospitals receive awards under the H-MH demonstration, the Department must submit its recommendations (along with proposed award amounts) to CMS for review before making final awards. An institution that already has achieved at least PPC®-PCMH™ Level 2 recognition under an earlier set of NCQA standards may participate if its goal is to renew or upgrade its recognition under later, more stringent NCQA standards.

49. **H-MH Milestones related to achievement of National Committee for Quality Assurance (NCQA) PPC®-PCMH™ for all awardees**. The key milestone for receiving demonstration funding will be the achievement of NCQA PPC®-PCMH™ Level 2 or Level 3 recognition within two (2) years from the start date of the program. The state will receive from NCQA a monthly 'roster' of practices, which have achieved NCQA PPC®-PCMH™ Level 2 or Level 3 recognition. In the interim, programs must demonstrate the achievement of the following milestones throughout the duration of the project:

    a) **A detailed work plan after award.** Each awardee must submit a redesign strategy and detailed work plan to the state that documents how funds will be used for the following approved purposes: consultation services for practice re-design; staff development activities to support 'team' design to assuring continuity of care for patients; activities associated with curriculum changes; workforce retraining and retooling, and NCQA certification costs. The work plan must also

        i. indicate the clinical performance metrics that will be used (as discussed in STC 50 below), and provide baseline rates for each measure,

        ii. describe how the awardee will implement the H-MH System Improvement Initiatives described in STC 51, and

        iii. indicate which H-MH Quality and Safety Improvement Projects that the awardee will undertake, along with associated milestones (see STC 52).

    b) **Baseline assessment within six months.** Each awardee must submit a formal baseline assessment to the state (using the NCQA tool or one developed by a primary care professional organization) that compares current practice with NCQA standards, along with a revised work plan and timeline.

    c) **Interim report at the end of year 1.** Each awardee must submit to the state a report of interim progress in meeting the first year milestones and goals identified through the baseline assessment tool with revised plan as appropriate.

    d) **MH recognition.** Each awardee must achieve NCQA PPC®-PCMH™ Level 2 or Level 3 recognition, using 2011 standards, by the end of year 2.

50. **H-MH clinical performance metrics for years 2 and 3.** Each awardee must develop at least five clinical performance metrics which shall be consistent with the standardized measures used by the New York State Department of Health in its Quality Assurance Reporting Requirements (QARR) system and/or meaningful use measures and relevant to the population being served, for internal practice measurement and improvement. Baseline and yearly rates for each measure must be submitted in the annual progress reports.

51. **H-MH System Improvement Initiatives**. Each awardee's project work plan and subsequent progress reports must incorporate the awardee's strategy for accomplishing the implemented initiatives as well as the milestones to measure success.

    a) Each awardee must implement an initiative to restructure operations to enhance patients' continuity of care experience in conjunction with developing a patient centered medical home.

        Awardees shall extend the ambulatory, continuity training experience of residents within the limits of residency requirements from the Residency Review Committee of the Accreditation

Council for Graduate Medical Education. This could be accomplished by increasing the number of continuity training sites, expanding sites beyond the hospital environment (if the program is based in a hospital), increasing resident time in ambulatory settings, or other activities or combinations of approaches. These sites would also be required to provide care consistent with medical home requirements and achieve formal recognition within two years of program start date. The project work plan must include:

i. A method for objective measurement of progress which may include number of new continuity sites, percent increase in ambulatory training experience for residents;
ii. How these activities will support core activities of medical home transformation; and iii. How these restructuring changes will be sustained following the termination of the demonstration.

b) Further, each awardee must select at least one of the following four initiatives to implement during the grant award period:

i. Care Transitions/Medication Reconciliation Programs. Hospital awardees may be ideally suited to coordinate care between inpatient and outpatient settings given that they are frequently the same providers of care. This initiative would allow programs to develop a better 'bridge' for this transition, particularly with respect to medication reconciliation and management but also for outpatient primary and specialty care follow up. While the methods and staffing used to improve coordination could vary, all proposals must incorporate the evidence-based components of effective medication reconciliation. Programs would be required to:

A) Develop a registry of patients who have participated (directly through contact/outreach or indirectly through shared electronic information or medication lists) in medication reconciliation. The registry must contain sufficient unique identifiers to enable linkage to Medicaid claims data and be completed by the end of Year 1.

B) Participate as needed (sharing lists), with the Department, in periodic evaluation of readmissions and other utilization and quality metrics for patients receiving care transition/medication reconciliation services including the tracking of quarterly progress either on pilot unit or hospital wide.

C) Develop standardized clinical protocols for communication with patients/families during and post-discharge and care transition processes focused on most common causes of avoidable readmissions.

D) Develop integrated information systems between hospital inpatient and outpatient sites to enable improved continuity and follow up care.

E) Create system to identify patients at highest risk of subsequent avoidable hospitalization and create a patient stratification approach to allocation of resources to facilitate community linkages including primary and specialty care services.

ii. Integration of Physical-Behavioral Health Care. Medicaid has a large number of members with co-existing physical and mental health/substance abuse co-morbidities. Optimal care requires integration of services and providers so that care is coordinated and appropriate for the well-being of the entire person, not just for a single condition. There are many barriers between behavioral and physical health care including different providers, varying locations, multiple agencies, confidentiality rules and regulations, historic lack of communication between providers, and more. This initiative will require training programs

to find ways to integrate care for their patients with behavioral health conditions within the medical home. The project work plan must include details on:

A) A strategy for integration which includes a means of improving referrals to behavioral health providers, enhanced communication with mental health/substance abuse providers, processes for obtaining appropriate consents for sharing personal health information, and procedures for coordinated case management (particularly for cases in which patients may have more than one provider).

B) Developing a linkage to the Office of Mental Health Psychiatric Services and Clinical Knowledge Enhancement System (PSYKES) project, which provides data and recommendations for potential problems of polypharmacy and metabolic syndrome exacerbation for Medicaid members using Medicaid databases within the first year of the program start date. The linkage will require creating systems to receive, and act on, reports generated by PSYKES. The linkage must be completed by the end of Year 1.

C) Developing training for primary care clinicians in behavioral health care with particular focus on integrating depression screening and pain management with appropriate treatment modalities and referral.

D) Assessing demand and capacity to provide co-located services or other approaches to decrease wait times and improve access to behavioral health services.

iii. Improved Access and Coordination between Primary and Specialty Care. There is a tremendous opportunity to promote access and coordination between primary and specialty providers who are both providing care within the same delivery system, often in close physical proximity. Despite that opportunity, there are many examples in which the level of coordination is suboptimal, having the greatest adverse impact on those patients with more advanced, chronic diseases.

A) Programs will be required to put into place systems that would facilitate the ready access to specialty care when appropriate, with improved bilateral communication between primary and specialty care providers/clinics through transparent, standardized, referral processes. Specific goals include improving timely access to specialists, completed referral forms with required clinical information and reason(s) for referral, timely response of findings/recommendations from the specialist and higher rates of satisfaction on the part of providers and patients with respect to specialty care services.

B) Programs will be required to generate measures of access and coordination. These measures should be incorporated into a baseline assessment and annual evaluations and include patient and provider experiences related to wait times, follow up with primary care provider after specialty visit (as appropriate), delayed or rejected referrals, patient/provider satisfaction.

C) Identify gaps in care and coordination for specialty services including collection of baseline data on wait times and appointment backlogs; survey primary care providers and specialists regarding the referral process and access and develop improvement plan based on findings with at least quarterly data collection, which will consider expansion of selected specialists, training of primary care providers in provision of select low level specialty care, inclusion of specialists in team care, protocols for primary-specialty care co-management.

iv. Enhance Interpretation Services and Culturally Competent Care.

A) Programs will conduct an analysis to determine gaps in access to language

services, and implement language access policies and procedures

B) Programs may expand workforce within interpreter services by hiring, training, and/or certifying interpreters, or determining other methods for increasing patients' access to appropriate language services.

C) Programs may include use of remote video and voice technology for instantaneous qualified health care interpretations

D) Develop programs to improve staff cultural competence and awareness through evidence based training.

E) Develop capacity to generate prescription labels in patient's primary language with easy to understand instructions.

52. **H-MH Quality and Safety Improvement Projects (QSIP).** In addition, each awardee shall implement at least two of the six Quality and Safety Improvement Projects outlined in this STC.

These QSIPs will include interventions that have been demonstrated to produce measurable and significant results across different types of hospital settings, including in safety net hospitals; have a strong evidence base, meaning interventions that have been endorsed by a major national quality organization, with reasonably strong evidence established in the peer reviewed literature, including within the safety net; and are meaningful to hospital patients.

An awardee is precluded from choosing any QSIP for which it has achieved top performance for at least 4 consecutive quarters, in aggregate in all process and outcomes measures within the intervention, where "top performance" is defined as being in the Top Quartile. Each QSIP below has specific measures that an awardee must include; however, awardees may include additional milestones to enable the implementation of the measures specified for the intervention.

Milestones for the QSIPs can include infrastructure, redesign, implementation of evidence-based processes, and measurement and achievement of evidence-based outcomes. Awardees must include for each year a milestone for reporting the data on each QSIP to the Department. Improvement Targets will be determined based on the progress an awardee has already made on the improvement project pursuant to baseline data collected as of January 1, 2012. The 3-year end goals for each measure will be to move from one performance band to the next, except in the case of hospitals that are in the Top Band where the goal will be to move into the Top Quartile. Hospitals will be placed in one of 3 bands based on baseline performance as compared to state or national data on hospital performance, including safety net hospital performance, as follows:

- "Lower band" performers, as defined as the bottom one-third (1-33 percentile) of hospitals, will target moving into the middle-third performance band;
- "Middle band" performers, as defined as the middle third (34-65 percentile) of hospitals, will target moving into the top performance band; and
- "Top band" performers, as defined as the top third (66-100 percentile) of hospitals, will target moving into the top quartile.

Hospitals that have achieved performance in the top quartile will be expected to maintain or exceed top performance.

a) Severe Sepsis Detection and Management

i. *Elements*

(A) Implement the Sepsis Resuscitation Bundle: to be completed within 6 hours for patients with severe sepsis, septic shock, and/or lactate > 4mmol/L (36mg/dl).
(B) Implement the Sepsis Management Bundle: to be completed within 24 hours for patients with severe sepsis, septic shock, and/or lactate > 4 mmol/L (36 mg/dl).
(C) Make the elements of the Sepsis Bundles more reliable.

ii. *Key Measures*
(A) Percent compliance with four elements of the Sepsis Resuscitation Bundle, as measured by percent of hospitalization with sepsis, severe sepsis or septic shock and/or an infection and organ dysfunction where targeted elements of the Sepsis Resuscitation Bundle were completed.
(B) Sepsis mortality

b) Central Line-Associated Bloodstream Infection (CLABSI) Infection Prevention
i. *Elements*
(A) Implement the central line bundle
(B) Make the process for delivering all bundle elements more reliable

ii. *Key Measures*
(A) Compliance with Central Line Bundle
(B) Central Line Bloodstream Infections

c) Surgical Complications Core Processes (SCIP)
i. *Elements*
(A) Surgical site infection prevention
(B) Beta blockers continuation
(C) Venous Thromboembolism (VTE) prophylaxis

ii. *Key Measures*
(A) SCIP Composite Process Measure:
1) SCIP-Inf-2: Prophylactic antibiotic selection for surgical patients
2) SCIP-Inf-3: Prophylactic antibiotics discontinued within 24 hours after surgery end time/48 hours for cardiac patients
3) SCIP-Inf-4: Cardiac surgery patients with controlled 6 a.m. postoperative serum glucose
4) SCIP-Inf-6: Surgery patients with appropriate hair removal
5) SCIP-Inf-9 : Urinary catheter removed on postoperative day 1 (POD 1) or postoperative day 2 (POD 2) with day of surgery being day zero
5) SCIP-Card- 2: Surgery patients on a beta-blocker prior to arrival who received a beta-blocker during the perioperative period
7) SCIP-VTE-1: Surgery patients with recommended venous thromboembolism prophylaxis orderedSCIP-VTE-2: Surgery patients who received appropriate venous thromboembolism prophylaxis within 24 hours prior to surgery to 24 hours after surgery
(B) Rate of surgical site infection for Class 1 and 2 wounds within 30 days of surgery

d) Venous Thromboembolism (VTE) Prevention and Treatment
i. *Elements*

(A) Provide appropriate VTE Prophylaxis, including pharmaceutical and mechanical approaches based on national guidelines

ii. *Key Measures*

(A) VTE Discharge Instructions
(B) VTE Prophylaxis

e) Neonatal Intensive Care Unit (NICU) Safety and Quality

i. *Elements*

(A) Participation in Vermont Oxford Network (VON) quality/safety measurement and improvement activities or New York State Obstetric and Neonatal Quality Collaborative (NYSONQC) sponsored Neonatal Enteral Nutrition Project and Statewide Collaborative to decrease NICU central line associated bloodstream infections.
(B) Assess current areas of need for performance improvement based on relative performance of hospital NICU to VON benchmarks and/or state level performance.
(C) Develop improvement projects (at least 2 which may include, but is not limited to, enteral nutrition or central line projects above) focusing on areas of greatest need making use of VON network quality improvement strategies and/or other evidence based care bundles.

ii. *Key Measures*. Use of appropriate metrics for quality, safety, morbidity, complications, and risk adjusted mortality based on improvement project, including but not limited to:

(A) Nosocomial sepsis rates (per 1000 patient days) from NYS NICU Module;
(B) Central line associated bloodstream infection rates per 1000 central line days using the NYS hospital acquired infection data reporting system;
(C) Maintenance checklist use per total number of days of central line use; and
(D) Percent infants discharged from NICU at less than 10th percentile weight born <31 weeks gestation.

f) Avoidable Preterm Births: Reducing Elective Delivery Prior to 39 Weeks Gestation

i. *Elements:* Use of evidence based interventions for evaluation, measurement, and improvement of preventable preterm births using findings from NICHQ/CMS Neonatal Outcomes Improvement Project and/or California Toolkit to Transform Maternity Care:

(A) Identification and treatment of chronic medical conditions and high risk behaviors
(B) Early identification of mothers at high risk for preterm delivery
(C) Use of antenatal steroids in appropriate patients
(D) Reducing elective inductions/cesarean sections without appropriate medical or obstetric indication

ii. *Key Measures*

(A) Percent of scheduled inductions at 36(0/7) to 38(6/7) weeks without medical or obstetrical indication documented of all scheduled deliveries
(B) Percent of scheduled inductions at 36(0/7) to 38(6/7) weeks without medical or obstetrical indication documented of all scheduled inductions
(C) Percent of scheduled C-sections at 36(0/7) to 38(6/7) weeks without medical or obstetrical indication documented of all scheduled deliveries
(D) Percent of scheduled C-sections at 36(0/7) to 38(6/7) weeks without medical or

obstetrical indication documented of all scheduled C-sections

(E) Percent of all scheduled deliveries at 36(0/7) to 38(6/7) weeks without medical or obstetrical indication documented of all scheduled deliveries

(F) Percent of infants born at 36(0/7) to 38(6/7) weeks gestation by scheduled delivery who went to neonatal intensive care unit

(G) Percent of mothers informed about risks and benefits of scheduled deliveries 36(0/7) to 38(6/7) weeks gestation documented in the medical record

(H) Percent scheduled deliveries at 36(0/7) to 38(6/7) weeks that have documentation in the medical record of meeting optimal criteria of gestational age assessment

(I) IHI Elective Induction Bundle Elements: Percentage of times that all four of the following elements are in place:

1) gestational age >/= 39 weeks
2) monitor fetal heart rate for reassurance of fetal status
3) pelvic exam: assess to determine dilation, effacement, station, cervical position and consistency, and fetal presentation
4) monitor and manage hyperstimulation (tachysystole).

53. **H-MH Funding Distribution**. Awardees will receive demonstration funds based on the number of Medicaid recipients served and the number of primary care residents trained. Eighty percent of an awardee's funds will be based on Medicaid patient volume and twenty percent will be based on primary care residents trained in that facility. The formula will be proportionally allocated using these criteria. Facilities will not be included if they do not satisfy the requirements for one of the supplemental program initiatives. Full or partial funding is contingent on achieving each year's goals. *In no instance will an awardee receive funding beyond year 2 unless the awardee has achieved NCQA PPC®-PCMH™ Level 2 or Level 3 recognition.*

a) **Year 1 Funds**. Each awardee will receive one-fourth of the first year's funding amount upon award. The remaining first year payment will be issued once the awardee has documented that the applicable first-year program milestones (as stipulated in STC 49 (a), (b), and (c) above) have been met. If the first year milestones are not met by the end of year 1, the awardee will forfeit the remaining funding for that year but would be allowed to continue to work toward meeting the milestones and eligible for subsequent year funding.

b) **Year 2 Funds**. Each awardee will receive one-fourth of the second year's funding amount upon completion of the applicable year one milestones. Upon achieving NCQA PPC®-PCMH™ Level 2 or Level 3 accreditation, the remainder of the second year's funds will be made available, provided all other requirements for Quality Service Improvement Programs (QSIP) projects are up to date. If an awardee does not achieve accreditation by the end of year two or, for a hospital awardee, make progress on the additional initiatives that are required as a condition of funding, the remainder of year two funding will be forfeited.

c) **Year 3 Funds**. Third year funding will be provided only to awardees that have achieved NCQA PPC®-PCMH™ Level 2 or Level 3 recognition and, for hospital awardees, meet the applicable milestones for the additional initiatives as stipulated in the hospital's approved work plan. Awardees will receive one-fourth of the funding amount at the start of the year and the remainder after submission of the third year milestones.

54. **H-MH Reporting**.

a) The state shall include updates on activities related to the H-MH demonstration in the quarterly operational reports required under STC 70 including updated expenditure projections reflecting

the expected pace of disbursements under the demonstration.

b) The state shall provide an assessment of the H-MH demonstration by summarizing each awardee's activities during the demonstration year in each annual report required under STC 71.

c) The state shall include an assessment of the success of the H-MH demonstration in the evaluation required by STC 98 including the milestones in STC 49(c), the hospital improvement projects in STC 48(d) as well as the outcome measures for each supplemental program initiative implemented by the awardees.

55. **Potentially Preventable Readmissions (PPR) Demonstration.** The purpose of this demonstration is to test strategies for reducing the rate of preventable readmission within the Medicaid population, with the related longer-term goal of developing reimbursement policies that provide incentives to help people stay out of the hospital. It is intended to assist hospitals with reducing the rate of PPRs in advance of the implementation of the Hospital Readmissions Reduction Program (authorized by section 3025 of the Patient Protection and Affordable Care Act) on October 1, 2012. Beginning with FFY 2012, hospitals will face reductions in Medicare payments if they have readmission rates higher than what would be expected for specific conditions.

Hospitals will be asked to devise unique strategies that target each hospital's particular experiences, strengths, weaknesses and patient profile. Projects will focus on improved quality and cost savings and will include reporting and evaluation components to ensure that the projects are replicable and sustainable. Activities will include a review of policies and operational procedures that may be contributing to high rates of avoidable readmissions; reengineering the discharge planning process; and appropriate management of post-hospital/transition care; coordination with outpatient and post-discharge providers, including institutions and community providers, to address transitional care needs.

a) Eligibility. All hospitals in the state will be eligible to participate in the PPR demonstration.

b) Selection. The state will develop and issue a Request for Grant Application (RGA). Awards will be made based on the published criteria in the RGA, and funding will be made available over the demonstration extension period as specified in the RGA. The RGA shall also include requirements for evaluating the success of the implemented strategies.

c) Reporting.

i. Once grantees are in place, the state shall include in the quarterly operational report required under STC 70, the following information:
   (A) A summary of the interventional strategies each grantee intends to implement;
   (B) Baseline assessment of each grantee's readmission rate;
   (C) Interim assessments (as data is available) of each grantee's success in reducing PPRs; and
   (D) Updated expenditure projections reflecting the expected pace of disbursements under the demonstration.

ii. The state shall provide a progress report in the implementation of the PPR demonstration in each annual report required under STC 71.

56. **Funding for Quality Demonstrations and Clinic Uncompensated Care**. Federal funds will be used to pay the full cost of these programs. Accordingly, Federal Financial Participation (FFP) will be available for state funds for the Indigent Care Pool (beginning August 1, 2011 and ending December 31, 2013) and the Designated State Health Programs (DSHP) described in STC 57 (beginning August 1, 2011 and ending December 31, 2014), as certified on each quarterly CMS Form 64 expenditure reports.

a) Limitations on FFP.

i. FFP is limited to no more than $477.2million over the demonstration extension period as follows:
(A) $325 million for the H-MH demonstration;
(B) $20 million for the PPR demonstration; and
(C) $132.2 million for the ICP, but only to the extent that the state appropriates and expends at least $132.2 million over the extension period. Otherwise, FFP for the ICP may be no more than one-half of total ICP spending (both federal and state funds).

ii. The state shall be eligible to receive FFP over the demonstration period for its own expenditures for
(A) The Indigent Care Pool (for ICP expenditures made between August 1, 2011 and December 31, 2013); and
(B) DSHP (for DSHP expenditures made between August 1, 2011 and December 31, 2014).

b) Reporting.

i. Updated expenditure projections shall be provided by the state in each quarterly operational report required under STC 70.

ii. Expenditure Reporting for the H-MH demonstration. DSHP expenditures used to draw down federal funds for the H-MH demonstration shall be reported on the CMS-64 under waiver name MH Demo – DSHP.

iii. Expenditure Reporting for the PPR demonstration. DSHP expenditures used to draw down federal funds for the PPR demonstration shall be reported on the CMS-64 under waiver name PPR Demo – DSHP.

iv. Expenditure Reporting for Clinic Uncompensated Care.

(A) The state's own expenditures for ICP grants shall be reported on the CMS-64 under waiver name ICP – Direct.

(B) DSHP expenditures used to draw down federal funds for Clinic Uncompensated Care shall be reported on the CMS-64 under waiver name ICP – DSHP.

c) Reconciliation and Recoupment. By the end of the demonstration extension period, if the amount of DSHP claimed over the demonstration period results in the state receiving FFP in an amount greater than what the state actually expended for quality demonstrations and clinic uncompensated care, the state must return to CMS federal funds in an amount that equals the difference between claimed DSHP and actual state expenditures made for these initiatives.

i. As part of the annual report required under STC 71, the state will report both DSHP claims and expenditures to date for the quality demonstrations and clinic uncompensated care.

ii. The reported claims and expenditures will be reconciled at the end of the demonstration

with the state's CMS-64 submissions.

iii. Any repayment required under this subparagraph will be accomplished by the state making an adjustment for its excessive claim for FFP on the CMS-64 by entering an amount in line 10(b) of the Summary sheet equal to the amount that equals the difference between claimed DSHP and actual expenditures made for these initiatives during the extension period.

57. **Designated State Health Programs**. Subject to the conditions outlined in STC 58, FFP may be claimed for expenditures made for the following designated state health programs beginning August 1, 2011 through December 31, 2014. Designated state health program funding described in paragraphs (m) and (n) below begins January 1, 2014.

a) Homeless Health Services

b) HIV-Related Risk Reduction

c) Childhood Lead Poisoning Primary Prevention

d) Healthy Neighborhoods Program

e) Local Health Department Lead Poisoning Prevention Programs

f) Cancer Services Programs

g) Obesity and Diabetes Programs

h) TB Treatment, Detection and Prevention

i) TB Directly Observed Therapy

j) Tobacco Control

k) General Public Health Work

l) Newborn Screening Programs

m) The state may claim as allowable expenditures under the demonstration the payments made through its state-funded program to provide subsidies for parents and caretaker relatives with incomes above 133 percent of the FPL through 150 percent of the FPL who purchase health insurance through the Marketplace. Subsidies will be provided on behalf of individuals who: (1) are not Medicaid eligible but who are parents or caretaker relatives of individuals who are Medicaid eligible; (2) are eligible for the advance premium tax credit (APTC); and (3) whose income is above 133 percent of the FPL through 150 percent of the FPL. Federal financial participation for the premium assistance portion of QHP subsidies for citizens and eligible qualified aliens will be provided through the Designated State Health Programs pursuant to this STC. Authority to claim federal matching for this program will end on December 31, 2014.

n) The state may claim as allowable expenditures under the demonstration, the payments made through its state-funded program to provide FHPlus benefits to parents and caretaker relatives with incomes up to and including 150 percent of the FPL who are no longer eligible under the demonstration. Authority to claim federal matching for this program will end on April 30, 2014.

58. **Designated State Health Programs (DSHP) Claiming Process.**

a) Documentation of each DSHP's expenditures must be clearly outlined in the state's supporting work papers and be made available to CMS.

b) Federal funds must be claimed within two years after the calendar quarter in which the state disburses expenditures for the DSHPs in STC 57. Claims may not be submitted for state expenditures disbursed after December 31, 2014.

c) Sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. To the extent that federal funds from any federal programs are received for the DSHP listed in STC 57, they shall not be used as a source of non-federal share.

d) The administrative costs associated with DSHPs in STC 57 and any others subsequently added by amendment to the demonstration shall not be included in any way as demonstration and/or other Medicaid expenditures.

e) Any changes to the DSHPs listed in STC 57 shall be considered an amendment to the demonstration and processed in accordance with STC 7.

VIII. HEALTH SYSTEM TRANSFORMATION FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES

59. Health System Transformation for Individuals with Developmental Disabilities. Beginning April 1, 2013, FFP may be claimed for expenditures made for the designated state health programs (DSHP) listed in STC 63. The receipt of expenditure authority for the period of April 1, 2013 to March 31, 2014, is contingent upon the state's compliance and CMS' receipt the deliverables listed below, each quarter, with respect to health system transformation for individuals with developmental disabilities ("Transformation"). More detailed information about the transformation and the deliverables can be found in Attachment G:

Table 10 –Transformation Deliverables Schedule

Deliverable	Reference	Deliverable Date
State Fiscal Year 2014/ Demonstration Year Quarter 1 DSHP		
Money Follows the Person operational protocol	Attachment G #1	April 1, 2013
1915(b)/(c) application	Attachment G #3	April 1, 2013
As part of the 1915 (b)/(c) amendment, Pathways to Employment Services	Attachment G #5(d)	April 1, 2013
Report on the baseline count of enrollees receiving supported employment and the number of people in competitive employment	Attachment G #5(a)	May 31, 2013
Submit educational/training materials for participant self-direction	Attachment G #6(b)	May 1, 2013
1915(c) amendment request(s), to	Attachment G #3(b)	May 1, 2013

Deliverable	Reference	Deliverable Date
increase reserved HCBS capacity		
Draft cost-containment strategy	STC #60	June 1, 2013
No new admission to sheltered workshops	Attachment G #5(b)	July 1, 2013
1,500 stakeholders educated on self-direction	Attachment G #6(b)	July 1, 2013
Report on the baseline number of individuals who self-direct their services	Attachment G #6(e)	July 1, 2013
Draft timeline for transitioning remaining residents of campus based and non-campus based ICFs into community settings	Attachment G #4(c)	August 1, 2013
Draft evaluation design	STC #62	July 1, 2013
Quality strategy	STC #40	July 1, 2013
7 residents transitioned out of Finger Lakes and Taconic ICFs	Attachment G #3(a)(i)	July 1, 2013
State Fiscal Year 2014/ Demonstration Year Quarter 2 DSHP		
Draft accountability plan	STC #61	August 1, 2013
Final accountability plan and evaluation design	STC #61 & #62	No later than 60 days after receiving CMS comments
Approved transformation DSHP claiming protocols	STC #63(b)	DSHP will be effective upon approval by CMS; no deadline
Progress on CQL	Attachment G #3(a)(iv)(6)	September 1, 2013
Balancing Incentive Program work plan	Attachment G #2	September 1, 2013
350 new beneficiaries self-directing services	Attachment G #6(e)	October 1, 2013
1,500 stakeholders educated on self-direction	Attachment G #6(b)	October 1, 2013
20 people transitioned from the Finger Lakes and Taconic ICFs	Attachment G #4(a)(ii)	October 1, 2013
Documentation that at least 250 people are enrolled in competitive employment	Attachment G #5(a)	October 1, 2013
Finalized timeline for residential transitions	Attachment G #4(c)	October 1, 2013
Draft transformation plan for increasing competitive employment	Attachment G #5(c)	October 1, 2013
State Fiscal Year 2014/ Demonstration Year Quarter 3 DSHP		
425 new beneficiaries self-directing services	Attachment G #6(e)	January 1, 2014
1,500 stakeholders educated on self-direction	Attachment G #6(b)	January 1, 2014

Deliverable	Reference	Deliverable Date
121 people transitioned from Finger Lakes and Taconic ICFs	Attachment G #4(a)	January 1, 2014
44 persons transitions from Finger Lakes and Taconic ICFs will qualify for MFP	Attachment G #4(b)	January 1, 2014
State's policies on self-direction	Attachment G #6(f)	January 1, 2014
Final competitive employment plan	Attachment G #5(c)	January 1, 2014
New York will adopt practice guidelines for care coordinators based on the Council on Quality and Leadership (CQL) personal outcome measures and will annually assess managed care quality using personal outcome data	Attachment G #3(a)(iv)(6)	January 1, 2014
Independent Consumer Report Program	STC 26(c)	January 1, 2014
State Fiscal Year 2014/ Demonstration Year Quarter 4 DSHP		
470 new beneficiaries self-directing services	Attachment G #6(e)	April 1, 2014
1,500 stakeholders educated on self-direction	Attachment G #6(b)	April 1, 2014
Increase in the persons engaged in competitive employment, through Supported Employment, by 700 persons above the previous 12 month enrollment	Attachment G #4(b)	April 1, 2014
Deliverables Due Each Quarter		
Specific transition information for residents of Finger Lakes and Taconic ICFs including residential settings (occurring over the course of the transition)	Attachment G #4(b)	Each Quarter
Progress for increasing availability of supporting housing options	Attachment G #4(d)	Each Quarter
Progress toward increasing number of individuals engaged in competitive employment	Attachment G #5(a)	Each Quarter
Number of individuals remaining in sheltered workshops	Attachment G #5(b)	Each Quarter
Number of participant self-direction training/education sessions conducted and number of enrollees attending each session	Attachment G #6(b)	Each Quarter

Deliverable	Reference	Deliverable Date
Progress on approved evaluation design	Attachment G #3(a)(iv)(6)	Each Quarter
OPWDD eligible students aging out of educational system	Attachment G #5(d)	Quarter 4/Annual report

60. **Transformation Cost Containment Strategy.** The state must develop the following attachments to serve as a cost containment strategy to include as an attachment to STCs. The state must submit drafts of the following attachments to CMS no later than June 1, 2013 and submit a final draft no later than 30 days after receiving CMS comments:

    a) **Attachment I:** An outline of all services and associated definitions available under the transformation and specifics for how the programs will be impacted by the state's transformation plan.
    b) **Attachment J:** How the state must calculate the impact of the transformation. The attachment will outline all of the costs that should be captured in the pre and post transformation implementation. This will assist the state and CMS in tracking whether transformation is being accomplished.
    c) **Attachment K**: A demonstration of a return on investment with respect to how transformation in Attachment I will provide savings in the programs funded with federal support of the DSHPs. The state will provide a methodology that will compare the savings to the infusion of federal support dollars through the DSHP.

61. **Accountability Plan**. The state must develop an accountability plan and submit a draft by August 1, 2013. The accountability plan will be a multi-part document that specifies methods used by all parties engaged in transformation activities detailed in Attachment G to achieve quality improvement. The accountability plan will include:

    a) **Section A**: Statewide Quality and Access Tests. A plan for how New York will demonstrate that the state is meeting its established quality and access standards in order to evaluate the success of the transformation activities.
    b) **Section B**: Measurement Strategy. An outline of the metrics that the state will use to track quality and access over time. These metrics will be used to track MCO performance as well as statewide performance.
    c) **Section C**: Quarterly reporting format. An outline of how the DD transformation activities will be reported in Table 10 and incorporated as an update to Attachment D.

CMS will provide comments on the accountability plan and the state must submit a final draft that reflects CMS' comments no later than 60 days after receiving CMS comments.

62. **Evaluation of the Transformation.** The state must develop an evaluation design specific to transformation. The evaluation design must include a discussion of the goals and objectives set forth within the transformation plan and the state must develop evaluation questions specific to the changes being implemented under the transformation plan. A draft evaluation design must be submitted to CMS by July 1, 2013 and the state must submit a final design no later than 30 days after receiving CMS comments. The state shall implement the final evaluation design and submit its progress in each of the quarterly and annual progress reports and submit a final evaluation report no later than June 1, 2014.

63. **Designated State Health Programs (DSHP).** FFP is available for matching DSHPs described in this STC.

a) **Designated State Health Programs.** To support the goals of health system transformation, the state may claim FFP for certain state programs expenditures under the following state departments, subject to the annual limits and restrictions described, below from April 1, 2013 through March 31, 2014:

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

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

iii. Office of Alcoholism and Substance Abuse Services
   a. Outpatient and Methadone Programs
   b. Crisis Services – Ambulatory
   c. Prevention and Program Support Services

b) **DSHP Claiming Protocols.** The state will develop a CMS-approved DSHP claiming protocol for which the state will be required to comply with in order to draw down DSHP funds. State expenditures for the DSHP listed in STC 63 (a) must be documented in accordance with the protocols. The state is not eligible to receive federal financial participation until approved by CMS.

i. The state will provide updated information demonstrating that the DSHP are paying for appropriate services to appropriate populations by May 1, 2013 in the format outlined in an attachment that will be developed. Upon receipt of this information, CMS reserves the right to change the amount available for federal match.

ii. The state will clearly identify the sources of non-federal share revenue, full expenditures

and rates and will be specified in an attachment to the STCs. This includes those programmatic expenditures for which CMS will not provide expenditure authority for including but not limited to: expenditures for room and board, coverage for undocumented individuals, research, rent and utility subsidies.

iii. The state shall also include a plan of how it will maintain or increase the amount of state funds expended for the DSHP above the SFY 2013 in SFY 2014.

c) **DSHP Claiming Process**.

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

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

iii. Federal funds must be claimed within two years following the calendar quarter in which the state disburses expenditures for the designated state health programs in STC 63.

iv. Federal funds are not available for state administrative expenditures disbursed before April 1, 2013 and may not be submitted for services received prior to April 1, 2013.

v. Federal funds are not available for state administrative expenditures disbursed after March 31, 2014 and may not be submitted for services rendered after March 31, 2014.

vi. The state must not draw down federal funds until after the state completes transformation deliverables identified in STC 59 each quarter.

vii. Sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. To the extent that federal funds from any federal programs are received for the designated state health programs listed in STC 63, they shall not be used as a source of non-federal share.

viii. The administrative costs associated with programs in STC 63 and any others subsequently added by amendment to the demonstration shall not be included in any way as demonstration and/or other Medicaid expenditures.

ix. Any changes to the designated state health programs listed in STC 63 shall be considered an amendment to the demonstration and processed in accordance with STC 7.

d) **Available FFP for DSHP**. Up to $250 million in FFP is authorized to pay for DSHP costs during the demonstration period of April 1, 2013 to March 31, 2014.

64. **Reporting Designated State Health Programs Payments Related to Transformation.** The state will report all expenditures for DSHP payments to the programs listed in STC 63 related to transformation activities on the forms CMS-64.9 Waiver and/or 64.9P Waiver under the waiver name DSHP, as well as on the appropriate forms CMS-64.9I and CMS-64PI

65. In the event the state has not met at least 75 percent of its milestones and deliverables, by March 31, 2014:

a) CMS reserves the right to reduce the percentage of federally matched DSHP costs by an amount equivalent to the costs of unmet projected enrollment until the projected enrollment for this

population is met.

b) The state will submit a plan in the subsequent quarterly report, required in STC 70 to CMS detailing the actions it will undertake to increase enrollment.

66. **Monitoring Designated State Health Programs**. CMS may conduct a review of the DSHP expenditures to assess whether to allow continued expenditure of funds for appropriate services to target populations.

IX. GENERAL REPORTING REQUIREMENTS

67. **General Financial Requirements.** The state must comply with all general financial requirements set forth in section IX.

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

69. **Monthly Calls.** CMS shall schedule monthly conference calls with the state. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration. Areas to be addressed include, but are not limited to, MCO operations (such as contract amendments and rate certifications), transition and implementation activities, health care delivery, the FHP-PAP program, enrollment of individuals using LTSS and non-LTSS users broken out by duals and non-duals, cost sharing, quality of care, access, family planning issues, benefits, audits, lawsuits, financial reporting and budget neutrality issues, MCO financial performance that is relevant to the demonstration, progress on evaluations, state legislative developments, services being added to the MMMC and/or MLTC plan benefit package pursuant to STC 31, and any demonstration amendments, concept papers, or state plan amendments the state is considering submitting. CMS shall update the state on any amendments or concept papers under review, as well as federal policies and issues that may affect any aspect of the demonstration. The state and CMS shall jointly develop the agenda for the calls.

70. **Quarterly Operational Reports.** The state must submit progress reports in accordance with the guidelines in Attachment D taking into consideration the requirements in STC 73, no later than 60 days following the end of each quarter (December, March, and June of each demonstration year). The state may combine the quarterly report due for the quarter ending September with the annual report in STC 71. The intent of these reports is to present the state's analysis and the status of the various operational areas.

71. **Annual Report.** The state must submit an annual report documenting accomplishments, project status, quantitative and case study findings, interim evaluation findings, utilization data, and policy and administrative difficulties in the operation of the demonstration. The state must submit this report no later than 90 days following the end of each demonstration year. Additionally, the annual report must include:
    a) A summary of the elements included within each quarterly report;
    b) An update on the progress related to the quality strategy as required in STC 40, including:
        i. Outcomes of care, quality of care, cost of care and access to care for demonstration populations,
        ii. The results of beneficiary satisfaction surveys, grievances and appeals
    c) The status of the evaluation required in Section XII and information regarding progress in achieving demonstration evaluation criteria including the results/impact of any

demonstration programmatic area defined by CMS that is unique to the demonstration design or evaluation hypotheses;

d) An aggregated enrollment report showing the total number of individuals enrolled in each plan
e) A summary of the use of self-directed service delivery options in the state at the time when those benefits are included in the demonstration;
f) A listing of the new geographic areas the state has expanded MLTC to;
g) A list of the benefits added to the managed care benefit package;
h) An updated transition plan which shows the intended transition and timeline for any new benefits and/or populations into the demonstration;
i) Network adequacy reporting as required in STC 43;
j) Any other topics of mutual interest between CMS and the state related to the demonstration; and
k) Any other information the state believes pertinent to the demonstration, such as:
   i. Any policy or administrative difficulties in the operation of the demonstration,
   ii. Any state legislative developments that may impact the demonstration,
   iii. The status of the health care delivery system under the demonstration with respect to issues and/or complaints identified by beneficiaries,
   iv. The impact of the demonstration in providing insurance coverage to beneficiaries and uninsured populations,
   v. The existence or results of any audits, investigations or lawsuits that impact the demonstration,
   vi. The financial performance of the demonstration (budget neutrality), and
   vii. A summary of the annual post-award forum, including all public comments received regarding the progress of the demonstration project.

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

a) **Seamless Transitions.** Consistent with the provisions of the ACA, the Transition Plan will include details on how the state plans to obtain and review any additional information needed from each individual to determine eligibility under all eligibility groups, and coordinate the transition of individuals enrolled in the demonstration (by FPL) (or newly applying for Medicaid) to a coverage option available under the ACA without interruption in coverage to the maximum extent possible. Specifically, the state must:

   i. Determine eligibility under all January 1, 2014, eligibility groups for which the state is required or has opted to provide medical assistance, including the group described in §1902(a)(10)(A)(i)(VIII) for individuals under age 65 and regardless of disability status with income at or below 133 percent of the FPL;

   ii. Identify demonstration populations not eligible for coverage under the ACA and explain what coverage options and benefits these individuals will have effective January 1, 2014;

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

iv. Conduct an analysis that identifies populations in the demonstration that may not be eligible for or affected by the ACA and the authorities the state identifies that may be necessary to continue coverage for these individuals; and

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

b) **Access to Care and Provider Payments.**

i. Provider Participation. The state must identify the criteria that will be used for reviewing provider participation in (e.g., demonstrated data collection and reporting capacity) and means of securing provider agreements for the transition.

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

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

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

c) **System Development or Remediation.** The Transition Plan for the demonstration is expected to expedite the state's readiness for compliance with the requirements of the Affordable Care Act and other federal legislation. System milestones that must be tested for implementation on or before January 1, 2014 include: Replacing manual administrative controls with automotive processes to support a smooth interface among coverage and delivery system options that is seamless to beneficiaries.

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

e) **Implementation.**

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

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

73. **Reporting Requirements Related to Individuals using long term services and supports**. In each quarterly report required by STC 70, the state shall report:
    a) Any critical incidents reported within the quarter and the resulting investigations as appropriate;
    b) The number and types of grievance and appeals for this population filed and/or resolved within the reporting quarter for this population;
    c) The total number of assessments for enrollment performed by the plans, with the number of individuals who did not qualify to enroll in an MLTC plan;
    d) The number of individuals referred to an MLTC plan that received an assessment within 30 days;
    e) The number of people who were not referred by the enrollment broker and contacted the plan directly and were provided MLTC materials;
    f) Rebalancing efforts performed by the MLTC Plans and mainstream plans once the benefit is added. Rebalancing reporting should include, but is not limited to the total number of individuals transitioning in and out of a nursing facility within the quarter.
    g) Total number of complaints, grievances and appeals by type of issue with a listing of the top 5 reasons for the event.

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

X. GENERAL FINANCIAL REQUIREMENTS

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

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

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

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

Demonstration Year	Time Period

1	10/1/1997 - 9/30/1998
2	10/1/1998 - 9/30/1999
3	10/1/1999 - 9/30/2000
4	10/1/2000 - 9/30/2001
5	10/1/2001 - 3/30/2003
6	04/1/2003 - 9/30/2004
7	10/1/2004 - 9/30/2005
8	10/1/2005 - 9/30/2006
9	10/1/2006 - 09/30/2007
10	10/1/2007 - 09/30/2008
11	10/1/2008 - 09/30/2009
12	10/1/2009 - 09/30/2010
13	10/1/2010 - 09/30/2011
14	10/1/2011 - 09/30/2012
15	10/1/2012 - 09/30/2013
16	10/1/2013 – 12/31/2013
17	1/1/2014 – 3/31/2014
18	4/1/2014 – 12/31/2014

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

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

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

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

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

i. **Demonstration Population 1:** Temporary Assistance to Needy Families (TANF) child under age 1 through age 20 required to enroll in managed care in any county **other than** Allegany, Cortland, Dutchess, Fulton, Montgomery, Putnam, Orange, Otsego, Schenectady, Seneca, Sullivan, Ulster, Washington, or Yates, for expenditures associated with dates of service on or before March 31, 2014 [TANF Child].

ii. **Demonstration Population 2:** TANF Adults aged 21 through 64 required to enroll in managed care in any county **other than** Allegany, Cortland, Dutchess, Fulton, Montgomery, Putnam, Orange, Otsego, Schenectady, Seneca, Sullivan, Ulster, Washington, or Yates, for expenditures associated with dates of service on or before March 31, 2014 [TANF Adult].

iii. **Demonstration Population 3:** Disabled Adults and Children 0 through 64, for expenditures associated with dates of service on or before March 31, 2014 [SSI 0 through 64]

iv. **Demonstration Population 4:** Aged or Disabled Adults, for expenditures associated with dates of service on or before March 31, 2014 [SSI 65+]

ix. **Demonstration Population 9:** Home and Community-Based Services Expansion participants, for expenditures associated with dates of service on or before March 31, 2014 [HCBS Expansion]

x. **Demonstration Population 10:** MLTC Adults age 18 through 64 - Duals [MLTC Adults 18 -64]

xi. **Demonstration Population 11:** MLTC Adults age 65 and above - Duals [MLTC Adults 65+]

xii. **Demonstration Services 1:** State Indigent Care Pool (ICP) Direct Expenditures, for expenditures made on or before December 31, 2013 [ICP-Direct]

xiii. **Demonstration Services 2:** Designated State Health Programs to Support

	Clinic Uncompensated Care Funding, for expenditures made on or before December 31, 2013 [ICP - DSHP]
xiv. **Demonstration Services 3:**	Designated State Health Programs to Support Medical Home Demonstration, for expenditures made on or before December 31, 2014 [DSHP - HMH Demo]
xv. **Demonstration Services 4:**	Designated State Health Programs to Support Potentially Preventable Readmission Demonstration, for expenditures made on or before December 31, 2014 [DSHP - PPR Demo]
xvi. **Demonstration Services 5:**	Designated State Health Programs for expenditures made for the period of April 1, 2013 through March 31, 2014 in conjunction with deliverables associated with health system transformation for individuals with developmental disabilities. [DSHP - DD]
xvii. **Demonstration Services 6:**	Designated State Health Programs for expenditures made for the period January 1, 2014 through April 30, 2014 for the orderly close out of FHPlus adults with children. [DSHP – FHPlus]
xviii. **Demonstration Services 7**:	Designated State Health Program for expenditures made for the period January 1, 2014 through December 31, 2014 for the state-funded Marketplace subsidy program who purchase health care coverage in the Marketplace. [DSHP – APTC]

Note: Waiver forms for Demonstration Populations 3 and 4 are no longer required under this demonstration, but under demonstration 11-W-000234/2, The Federal-State Health Reform Partnership (F- SHRP). However, they remain defined Demonstration Populations for future use if needed.

77. **Expenditures Subject to the Budget Neutrality Agreement.** For purposes of this section, the term "expenditures subject to the budget neutrality agreement" must include all Medicaid expenditures in STC 76(g) for individuals who are enrolled in this demonstration (with the exception of the populations identified in subparagraphs iii, iv, and ix), as well as the demonstration services described in subparagraphs x through xiii, subject to limitations enumerated in this paragraph. All expenditures that are subject to the budget neutrality agreement are considered demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and/or 64.9P Waiver.

a) Beginning in DY 9, all expenditures for Demonstration Populations 1 and 2 who reside in Allegany, Cortland, Dutchess, Fulton, Montgomery, Putnam, Orange, Otsego, Schenectady,

Seneca, Sullivan, Ulster, Washington, or Yates counties are no longer considered expenditures subject to the budget neutrality agreement for this demonstration and may not be reported on Forms CMS-64.9 Waiver and/or 64.9P for this demonstration. These expenditures will be reported under the F-SHRP Demonstration (11-W-00234/2).

b) Beginning in DY 9, expenditures for Demonstration Populations 3 and 4 defined in STC 76(g) will no longer be reported under this demonstration. However, these eligibility groups remain as a placeholder in the event these populations are transferred from the F-SHRP Demonstration (11-W-00234/2) back to this demonstration. The state shall follow the amendment process outlined in STC 7 to effectuate this transfer.

c) Beginning in DY 9, Demonstration Populations 3 and 4, as defined in STC 76(g), are no longer considered expenditures subject to the budget neutrality agreement for this demonstration. These expenditures may not be reported on Forms CMS-64.9 Waiver and/or 64.9P under this demonstration, except if permitted under the provisions of subparagraph (b). These expenditures will be reported under the F-SHRP Demonstration (11-W-00234/2), subject to the provisions of subparagraph (b) of this STC.

d) Only the home and community-based services expenditures for Demonstration Population 9 shall be subject to the budget neutrality agreement.

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

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

79. **Premium Collection Adjustment.** The state must include any demonstration premium collections as a manual adjustment (decrease) to the demonstration's actual expenditures on a quarterly basis and shall be reported in accordance with STC 76(f).

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

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

a) For the purpose of calculating the budget neutrality expenditure cap and for other purposes, the state must provide to CMS, as part of the quarterly report required under STC 70, the actual number of eligible member months for the Demonstration Populations defined in STC 76(g), for months prior to or including the ending date indicated in STC 76(g) for each demonstration population. The state must submit a statement accompanying the quarterly report, which certifies the accuracy of this information.

   Beginning in DY 9, the actual number of member months for Demonstration Populations 3 and 4, as defined in STC 80(g), will not be used for the purpose of calculating the budget neutrality expenditure agreement, except as defined in STC 77(b).

   Additionally, Beginning in DY 9, the actual number of member months for Demonstration Populations 1 and 2 who reside in Allegany, Cortland, Dutchess, Fulton, Montgomery, Putnam, Orange, Otsego, Schenectady, Seneca, Sullivan, Ulster, Washington, or Yates counties will not be used for the purpose of calculating the budget neutrality expenditure agreement, subject to the limitations in STC 77.

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

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

c) For the purposes of this demonstration, the term "demonstration eligibles" excludes unqualified aliens and refers to the Demonstration Populations described in STC 76 (g). Beginning in DY 9, "demonstration eligibles" excludes Demonstration Populations 3 and 4, subject to STC 77(b), as well as portions of Demonstration Populations 1 and 2, as specified in STC 77(a - b).

82. **Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the demonstration. New York must estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure cap and separately report these expenditures by quarter for each federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments and State and Local Administration Costs. CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

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

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

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

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

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

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

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

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

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

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

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

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

e) Under all circumstances, health care providers must retain 100 percent of the claimed expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) exist between health care providers and state and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the

understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, (including health care provider-related taxes), fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

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

XI. MONITORING BUDGET NEUTRALITY

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

88. **Risk.** New York shall be at risk for the per capita cost (as determined by the method described below) for demonstration eligibles under this budget neutrality agreement, but not for the number of demonstration eligibles in each of the groups. By providing FFP for all demonstration eligibles, New York shall not be at risk for changing economic conditions that impact enrollment levels. However, by placing New York at risk for the per capita costs for demonstration eligibles under this agreement, CMS assures that federal demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no demonstration.

89. **Demonstration Populations Used to Calculate Budget Neutrality Expenditure Limit.** The following demonstration populations are used to calculate the budget neutrality expenditure limit subject to the limitations outlined in STC 78 and are incorporated into the following eligibility groups (EGs):

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

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

c) **Eligibility Group 5:** MLTC Adults age 18 through 64 – Duals (Demonstration Population 10)

d) **Eligibility Group 6:** MLTC Adults age 65 and above – Duals (Demonstration Population 11)

Note: Demonstration Populations 3 and 4 are no longer part of the calculation of the budget neutrality expenditure cap under this demonstration, but under demonstration 11-W-000234/2, The Federal-State Health Reform Partnership. Demonstration Population 8 has been moved to the state plan.

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

a) For each year of the budget neutrality agreement an annual budget neutrality expenditure limit is calculated for each EG described in STC 89 as follows:

i. An annual EG estimate must be calculated as a product of the number of eligible member months reported by the state in accordance with the requirements outlined in STC 82, for each EG, times the appropriate estimated per member per month (PMPM) costs from the table in subparagraph (iii) below. Should EGs 3 and 4 be incorporated into the budget neutrality expenditure limit, as outlined in STC 78, the PMPM costs may be revised.

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

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

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

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

Note: Demonstration Populations 3 and 4 are no longer part of the calculation of the budget neutrality expenditure limit under this demonstration, but under demonstration 11-W-00234/2, The Federal-State Health Reform Partnership.

(2) For the current extension period, the PMPM cost for each EG in demonstration year 12 has been increased by the appropriate growth rate included in the President's federal fiscal year 2011 budget for DYs 13 through 16, as outlined below. In addition, because the Family Planning Expansion Adults are going to be treated as a "hypothetical state plan population" beginning in DY 13, a PMPM cost was constructed based on state expenditures in DY 10, and increased by the rate of growth in the medical care component of the Consumer Price Index between 2004 and 2008. Because DYs 16 and 17 combined are less than 12 months in duration, they are assigned the PMPM costs equal to what would have been calculated for the full year starting

October 1, 2013 and ending September 30, 2014. The FHPlus Adults with Children and Family Planning Expansion Adults groups will end on December 31, 2013, so no PMPM is defined for those groups for DY 17. The budget neutrality expenditure limit will end March 31, 2014; expenditures made after that date for DSHP must be offset by accumulated savings from DYs 1 through 17.

Eligibility Group	DY 12 (10/1/09 – 9/30/10)`	Trend Rate	DY 13 (10/1/10 – 9/30/11)	DY 14 (10/1/11 – 9/30/12)	DY 15 (10/1/12 – 9/30/13)	DY 16 (10/1/13 – 12/31/13)	DY 17 (1/1/14 – 3/31/14)
TANF Children under age 1 through 20	$585.99	6.6%	$624.67	$665.90	$709.85	$756.70	$756.70
TANF Adults 21 through 64	$801.34	6.4%	$852.63	$907.20	$965.26	$1027.04	$1027.04
MLTC Adults 18through 64 - Dual		1.19%		$4009.38	$4057.09	$4105.37	$4105.37
MLTC Adults 65 and above - Dual		3.23%		$4742.15	$4895.32	$5053.44	$5053.44

Note: Demonstration Populations 3 and 4 are no longer part of the calculation of the budget neutrality expenditure limit under this demonstration, but under demonstration 11-W-00234/2, The Federal-State Health Reform Partnership.

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

b) The overall budget neutrality expenditure limit for the demonstration period is the sum of the annual budget neutrality expenditure limits calculated in subparagraph (a)(iv) above for each year. The federal share of the overall budget neutrality expenditure limit represents the maximum amount of FFP that the state may receive for expenditures on behalf of demonstration populations and expenditures described in STC 76 (g) during the demonstration period.

91. **Monitoring of New Adult Group Spending and Opportunity to Adjust Projections.** For each demonstration year, a separate annual budget limit for the new adult group will be calculated as the product of the trended monthly per person cost times the actual number of eligible/member months as reported to CMS by the state under the guidelines set forth in STC 81. The per capita cost

estimates for the new adult group are listed in the table below.

MEG	DY 16 – PMPM
New Adult Group	$722.57

a. If the state's experience of the take up rate for the new adult group and other factors that affect the costs of this population indicates that the new adult group PMPM limit described above may underestimate the actual costs of medical assistance for the new adult group, the state has the opportunity to submit an adjustment to the PMPM limit, along with detailed expenditure data to justify this, for CMS review without submitting an amendment pursuant to STC 7. In order to ensure timely adjustments to the PMPM limit for a demonstration year, the revised projection for DY 16 must be submitted to CMS by no later than October 1, 2014.

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

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

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

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

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

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

XII. EVALUATION OF THE DEMONSTRATION

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

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

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

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

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

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

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

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

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

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

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

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

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

xii. How have the results of the family planning expansion program expanded access to family planning services among the target population?

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

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

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

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

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

changing over time?

iv. Are the statewide and plan-specific overall functional indices decreasing or staying the same over time?
v. Are the average cognitive and plan-specific attributes decreasing or staying the same over time?
vi. Are the individual care plans consistent with the functional and cognitive abilities of the enrollees? This evaluation question will be included as there is sufficient data available in 2014 to provide accurate measures. NYS will address this question in the Final Evaluation Plan.
vii. Access to Care: To what extent are enrollees able to receive timely access to personal, home care and other services such as dental care, optometry and audiology?
viii. Quality of Care: Are enrollees accessing necessary services such as flu shots and dental care?
ix. Patient Safety: Are enrollees managing their medications? What are the fall rates and how are they changing over time?
x. Satisfaction: What are the levels of satisfaction with access to, and perceived timeliness and quality of network providers?
xi. Costs: What are the PMPM costs of the population?

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

c) The state must submit to CMS for approval a draft evaluation design no later than July 1, 2013

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

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

98. **Final Evaluation Report.** The state must submit draft final evaluation reports according to the following schedule.
    a) By July 31, 2014, the state must submit to CMS a draft final evaluation report, presenting findings from all evaluation activities. Findings from the evaluations of the H-MH and PPR demonstrations may be preliminary findings. CMS shall provide comments within 60 days after receipt of the report. The state shall submit the final evaluation report within 60 days after receipt of CMS comments.
    b) By April 30, 2015, the state must submit to CMS a draft final evaluation report on the evaluations of the H-MH and PPR demonstrations. CMS shall provide comments within 60 days after receipt of the report. The state shall submit the final evaluation report within 60 days after receipt of CMS comments.

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

XIII. SCHEDULE OF STATE DELIVERABLES FOR THE DEMONSTRATION EXTENSION PERIOD

Date - Specific	Deliverable	Reference
07/1/2013	Submit Draft Evaluation Plan	Section XII, STC 95

	Deliverable	Reference
Annual	By January 1st - Annual Report	Section IX, STC 71
Quarterly		
	Quarterly Operational Reports	Section IX, STC 70
	Quarterly Expenditure Reports	Section X, STC 75
	Eligible Member Months	Section X, STC 81

ATTACHMENT A

Mainstream Medicaid Managed Care Benefits

Inpatient and outpatient hospital services
Clinic services including Rural Health Clinic and Federally Qualified Health Center services
Laboratory and X-ray services
Home health services
Early Periodic Screening, Diagnosis, and Treatment services (for individuals under age 21 only)
Family planning services and supplies
Physicians services including nurse practitioners and nurse midwife services
Dental services
Physical and occupational therapy
Speech, hearing, and language therapy
Prescription drugs, over-the-counter drugs, and medical supplies
Durable Medical Equipment (DME), including prosthetic and orthotic devices, hearing aids, and prescription shoes
Vision care services, including eyeglasses
Intermediate Care Facilities for the Mentally Retarded (ICF/MR)
Nursing facility services
Personal care services
Medical Social Services for persons transitioning from the LTHHCP who received the service under the LTHHCP (non-state plan service)
Home Delivered Meals for persons transitioning from the LTHHCP who received the service under the LTHHCP (non-state plan service)
Case management services
Hospice care services
TB-related services
Inpatient and outpatient behavioral health services (mental health and chemical dependence services)
Emergency medical services, including emergency transportation
Adult day care
Personal Emergency Response Services (PERS)
Renal dialysis
Home and Community Based Services waivers (HCBS)
Care at Home Program (OPWDD)
Non–emergency transportation
Experimental or investigational treatment (covered on a case-by-case basis)

Service	Co-pay
Non-preferred brand-name prescription drugs	$3
Preferred brand-name prescription drugs	$1
Generic prescription drugs	$1

Notes: One co-pay is charged for each new prescription and each refill

No co-payment for drugs to treat mental illness (psychotropic) and tuberculosis.

ATTACHMENT B

Managed Long Term Care Benefits

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

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

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

ATTACHMENT C

Home and Community-Based Services Expansion Program Benefits

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

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

Home and community-based services (HCBS) must be provided in a setting that has home-like characteristics and not in institutionalized settings, unless an enrollee is in need of short term respite care. Below are the required home and community characteristics that must be in place for HCBS and other long-term services and supports programs:

- Private or semi-private bedrooms including decisions associated with sharing a bedroom.
- Full access to facilities in a home such as kitchen and cooking facilities, small dining areas, facilities, small dining areas.

ATTACHMENT C

Home and Community-Based Services Expansion Program Benefits

- All participants must be given an option to receive home and community based services in more than one residential setting appropriate to their needs.
- Private or semi-private bathrooms that include provisions for privacy.
- Common living areas and shared common space for interaction between participants, their guests, and other residents.
- Enrollees must have access to a food storage or food pantry area at all times.
- Enrollees must be provided with an opportunity to make decisions about their day to day activities including visitors, when and what to eat, in their home and in the community.
- Enrollees will be treated with respect, choose to wear their own clothing, have private space for their personal items, have privacy to visit with friends, family, be able to use a telephone with privacy, choose how and when to spend their free time, have easy access to resources and activities of their choosing in the community.

In provider owned or controlled residential settings, the following additional conditions will be provided to members:

- Privacy in sleeping or living unit.
- Units have lockable entrance doors, with appropriate staff having keys to doors.
- Enrollees share units only at the enrollee's choice.
- Enrollees have freedom to furnish and decorate sleeping or living units.
- The setting is physically accessible to the enrollee.

HCBS LTSS are not provided in institution-like settings except when such settings are employed to furnish short-term respite to individuals.

ATTACHMENT D

Quarterly Operational Report Format

Under STC 70, the state is required to submit quarterly reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter (except for the report due for the quarter ending on September 30 of each demonstration year, which can be incorporated into the annual report required under STC 71).

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the state. A complete quarterly progress report must include an updated budget neutrality monitoring workbook.

NARRATIVE REPORT FORMAT:

Title Line One – Partnership

Plan

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:
Example:
Demonstration Year: 14 (10/1/11 - 9/30/12)
Federal Fiscal Quarter: 1/2012 (10/11 - 12/11)

Introduction:
Information describing the goal of the demonstration, what it does, and key dates of approval /operation. (This should be the same for each report.)

Enrollment Information:
Please complete the following table that outlines all enrollment activity under the demonstration. The state should indicate "N/A" where appropriate. If there was no activity under a particular enrollment category, the state should indicate that by "0". Please note any changes in
enrollment that fluctuate 10 percent or more over the previous quarter as well as the same quarter in the prior demonstration year.

Enrollment Counts
Note: Enrollment counts should be person counts, not participant months

Demonstration Populations (as hard coded in the CMS-64)	**Current Enrollees** (to date)	**No. Voluntary Disenrolled in current Quarter**	**No. Involuntary Disenrolled in current Quarter**
Population 1 – TANF Child under age 1 through age 20 in mandatory MC counties as of			

Population 2 - TANF Adults aged 21 through 64 in mandatory MC counties as of 10/1/06			
Adult Group in MMMC			
Population 9 – HCBS Expansion participants			
Population 10 – MLTC Adults 18 through 64 - Duals			
Population 11 – MLTC Adults age 65 and above - Duals			

Voluntary Disenrollments:

- Cumulative Number of Voluntary Disenrollments within Current Demonstration Year
- Reasons for Voluntary Disenrollments

Involuntary Disenrollments:

- Cumulative Number of Involuntary Disenrollments within Current Demonstration Year
- Reasons for Involuntary Disenrollments

Enrollment Information for Specific Sub-populations:

- Enrollees in the HCBS Expansion program

Program Operations

Outreach/Innovative Activities: Summarize outreach activities and/or promising practices for the current quarter.

Operational/Policy Developments/Issues: Identify all significant program developments/issues/problems that have occurred in the current quarter, including, but not limited to, approval and contracting with new plans, benefit changes, and legislative activity. Also include any anticipated activities or program changes related to health care delivery, benefits, enrollment, grievances, quality of care, access, and other operational issues.

Update on Progress and Activities related to Quality Demonstrations and Clinic Uncompensated Care Funding: Identify all activities relating to the implementation of these programs, including but not limited to:

- Release of solicitations and selection of awardees for the quality demonstrations;
- An explanation of grants, contracts or other financial arrangements entered into for purposes of implementing the quality demonstrations of this demonstration; and
- Progress of grantees in meeting the milestones identified in these STCs and any award documents.

Consumer Issues: A summary of the types of complaints or problems consumers identified about the program in the current quarter. Include any trends discovered, the resolution of complaints, and any actions taken or to be taken to prevent other occurrences, this should be broken out to show the number of LTSS complaints vs. all other categories identified. Also discuss feedback, issues or concerns received from the Medicaid Managed Care Advisory Review Panel (MMCARP), advocates and county officials.

Quality Assurance/Monitoring Activity: Identify any quality assurance/monitoring activity in current quarter.

Managed Long Term Care Program: Identify all significant program developments, issues, or problems that have occurred in the current quarter.

Home and Community-Based Services Expansion Program: For the quarter ending March 31 each year, attach a copy of the CMS-372 report completed in accordance with Appendix A of the approved Long-Term Home Health Care, the Nursing Home Transition and Diversion, and the Traumatic Brain Injury 1915(c) waivers.

Demonstration Evaluation: Discuss progress of evaluation implementation.

Financial/Budget Neutrality Developments/Issues: Provide information on:

- Quality demonstration and clinic uncompensated care expenditures – to whom and when
- Designated State Health Programs – amount of FFP claimed for the quarter

Enclosures/Attachments: Identify by title any attachments along with a brief description of what information the document contains.

State Contact(s): Identify individuals by name, title, mailing address, phone, fax, and email address that CMS may contact should any questions arise.

Date Submitted to CMS:

ATTACHMENT E

Expiration Dates for Demonstration Components

The following table shows the expiration dates for the various components of the demonstration.

Demonstration Components	Expiration Date
• Medicaid Managed Care Program • Facilitated Enrollment Services • Designated State Health Programs associated with health System Transformation for Individuals with Developmental Disabilities	March 31, 2014
• Hospital-Medicaid Home Demonstration • Potentially Preventable Re-Hospitalization Demonstration • Designated State Health Programs associated with H-MH and PPR Demonstrations • Home and Community-Based Services Expansion Program • Individuals Moved from Institutional Settings to Community Settings for Long Term Care Services • Designated State Health Programs associated with providing FHPlus benefits to Medicaid eligible parents and premium subsidies to parents eligible for Marketplace coverage	December 31, 2014

ATTACHMENT F

Mandatory Managed Long Term Care Enrollment Plan

Mandatory Managed Long Term Care/Care Coordination Model (CCM)

Mandatory Population: Dual eligible, age 21 and over, receiving community based long term care services for over 120 days, excluding the following:

- **Long Term Home Health Care Program (in certain counties, see timeline below);**
- **Nursing Home Transition and Diversion waiver participants;**
- **Traumatic Brain Injury waiver participants;**
- **Nursing home residents;**
- **Assisted Living Program participants; and**
- **Dual eligible that do not require community based long term care services.**

Voluntary Population: Dual eligible, age 18 through 20, in need of community based long term care services for over 120 days and assessed as nursing home eligible. Non-dual eligible age 18 and older assessed as nursing home eligible and in need of community based long term care services for over 120 days.

The following requires CMS approval to initiate and reflects the enrollment of the mandatory population only.

Phase I and II: New York City and the suburbs

July 1, 2012 - Any new dual eligible case new to service, fitting the mandatory definition in any New York City County will be identified for enrollment and referred to the Enrollment Broker for action.

- Enrollment Broker will provide with educational material, a list of plans/CCMs, and answer questions and provide assistance contacting a plan if requested.
- Plan/CCM will conduct assessment to determine if eligible for community based long term care.
- Plan/CCM transmits enrollment to Enrollment Broker.

In addition, the following identifies the enrollment plan for cases already receiving care. Enrollment will be phased in by service type by borough by zip code in batches. People will be given 60 days to choose a plan according to the following schedule.

July 1, 2012: Begin personal care* cases in New York County

August 1, 2012: Continue personal care cases in New York County

ATTACHMENT F

Mandatory Managed Long Term Care Enrollment Plan

September, 2012: Continue personal care cases in New York County and begin personal care in Bronx County; and begin consumer directed personal assistance program cases in New York and Bronx counties

October, 2012: Continue personal care and consumer directed personal assistance program cases in New York and Bronx counties and begin Kings County

November, 2012: Continue personal care and consumer directed personal assistance program cases in New York, Bronx and Kings Counties

December, 2012: Continue personal care and consumer directed personal assistance program cases in New York, Bronx and Kings Counties and begin Queens and Richmond counties

January, 2013: Continue personal care and consumer directed personal assistance program citywide.

February, 2013 (and until all people in service are enrolled): Personal care, consumer directed personal assistance program, citywide.

March, 2013: Personal care, consumer directed personal assistance program, adult day health care, home health care over 120 days citywide.

March, 2013: Personal care, consumer directed personal assistance program, adult day health care, home health care over 120 days in Nassau, Suffolk and Westchester counties

April, 2013: Personal care, consumer directed personal assistance program, adult day health care, home health care over 120 days and long-term home health care program citywide.

April, 2013: Personal care, consumer directed personal assistance program, adult day health care, home health care over 120 days and long-term home health care program in Nassau, Suffolk and Westchester Counties

Phase III: Rockland and Orange Counties

Dually eligible community based long term care service recipients in these additional counties as capacity is established. June 2013

Phase IV: Albany, Erie, Onondaga and Monroe Counties

Dually eligible community based long term care service recipients in these additional counties as capacity is established. Anticipated Fall 2013

ATTACHMENT F

Mandatory Managed Long Term Care Enrollment Plan

Phase V: Other Counties with capacity.

Dually eligible community based long term care service recipients in these additional counties as capacity is established. Anticipated Spring 2014

Phase VI:

Previously excluded dual eligible groups contingent upon development of appropriate program models:

- **Nursing Home Transition and Diversion waiver participants;**
- **Traumatic Brain Injury waiver participants;**
- **Nursing home residents;**
- **Assisted Living Program participants;**
- **Dual eligible that do not require community based long term care services.**

ATTACHMENT G

Health System Transformation for Individuals with Developmental Disabilities

The receipt of expenditure authority for transformation for the period of April 1, 2013 to March 31, 2014, is contingent upon the state's compliance and CMS' receipt of the following deliverables:

1. Money Follows the Person (MFP)

New York will submit to CMS and receive approval for a detailed MFP operational protocol amendment to the current approved MFP protocol that is consistent with terms and conditions related to the Intellectual and Developmental Disability IDD population, for implementation April 1, 2013.

2. Balancing Incentive Program Work Plan

No later than September 1, 2013, New York will submit to CMS for approval a detailed structural change work plan to implement the Balancing Incentive Program. The work plan must meet all CMS requirements and align the infrastructure requirements for the Balancing Incentive Program and MFP, including reaching the Balancing Incentive Program target expenditure benchmark of 50 per cent across all Medicaid long term services and supports (LTSS) expenditures by October 1, 2015. In addition, the work plan must provide the following deliverables:

a. To demonstrate its implementation of successful person-centered planning, New York must provide an affirmative commitment that the state will establish an independent process for assuring that individual person-centered plans meet the needs of enrollees served in community-based settings, a description of the process the state will use to ensure that person-centered plans are implemented with fidelity to the established process, and a timeline for implementation of the process. New York will implement the approved process for person-centered planning for demonstration participants in accordance with a timeline approved by CMS and subsequently incorporated into this attachment.
b. Given the critical nature of available/appropriate residential settings for the populations being served under this demonstration, New York must provide a description of the state's current housing options for persons with IDD, or the "system as is" model. This baseline must include the number of individuals in group homes, small ICF's/IDD, large ICFs/IDD, and non-traditional housing models, the maximum number of individuals living in each residence type, and any required licensure or accreditation for each housing type.
c. New York must provide a detailed description of the process used to determine whether residential settings for persons transitioned from institutions as part of the demonstration meet CMS standards for home and community-based settings, and /or qualify as residences in the MFP program. This plan must include a description of the process the state will use to independently assess whether these settings meet the characteristics set forth in the current 1915(c) policy. New York must update its process to comport with subsequent federal regulatory changes, and must provide a description of the updated process and the state's proposed timeline for implementation of the regulatory changes to CMS within 90 days of such final

regulatory change.

3. <u>1915(b)/(c) Application</u>

   a. New York must: submit to CMS an approvable 1915(b)/(c) waiver application no later than April 1, 2013, that includes:
      i. Demonstration of capacity (e.g. the state has enough slots in settings that meet HCBS setting standards or are MFP qualifying settings based on the percentages the state has agreed to meet pursuant to paragraph b of section 4 of this attachment) to serve persons transitioned from ICFs, including those transitioned through MFP;
      ii. Evidence that the community- based settings in which Medicaid HCBS are provided meet CMS HCBS settings standards; and
      iii. Outline objectives with regard to competitive employment, person-centered planning, self-direction, and quality measurement/improvement.
      iv. Assurances that
         1. DISCOs meet the MCO licensure requirement;
         2. DISCOs are regulated as Prepaid Inpatient Health Plans (PIHPs) that are subject to review by External Quality Review Organizations (EQRO);
         3. New York will incorporate DISCOs in the overall managed care quality strategy;
         4. New York will comply with conflict free case management standards required in the Balancing Incentive Program, and
         5. New York will prohibit plans from making eligibility determinations and enrollment.
         6. New York will adopt practice guidelines for care coordinators based on the Council on Quality and Leadership (CQL) personal outcome measures will annually assess managed care quality using personal outcome data. New York will provide a report on its progress toward the development of CQL measures by September 1, 2013. The progress report will include the state's work plan for the implementation of the measures, including the roll-out of the measures, the specific outcome measures to be used, and the baseline against which the measures will be compared. New York will provide quarterly updates on its progress in implementing the work plan.
      v. In addition, New York must submit as part of the 1915(b)/(c) waiver application an approvable rate methodology that is understandable, delineates all elements in the rate methodology, and describes how all components are factored into the methodology. The methodology must assure that the rates produced are economic and efficient and lead to quality outcomes for beneficiaries. The rate methodology will apply to all services provided in the waiver and all public providers. In the same amendment, New York will provide the current rate structure for private/voluntary providers, commit to a waiver amendment submission on July 1, 2013 delineating the standard brick methodology to be used to bring all voluntary providers under the full brick methodology rate construction for all services no later than September 2015.
   b. New York will submit amendment requests to existing 1915(c) HCBS waivers by

May 1, 2013 to increase slots, by reserving capacity for people being de-institutionalized, to increase HCBS capacity to serve individuals enrolled in 1915(c) programs in the community.

4. Residential Transitions and Supportive Housing

   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,
      ii. 20 additional people transitioned by October 1, 2013, and
      iii. the remaining 121 persons transitioned to community-based settings that meet CMS HCBS settings standards referenced in the 1915(i) Notice of Proposed Rulemaking published in the federal register in April 2012.

   b. At least 30% of those persons (or a total of 44 persons) transitioned from institutions, both campus-based and non-campus-based ICFs, will qualify for MFP (i.e. can be transitioned into an MFP qualified residence). New York will transition the balance of the persons in the Finger Lakes and Taconic ICF target population (who are not transitioned to MFP qualified residences) into residential settings that comport with CMS requirements for home and community-based settings as outlined in the 1915(i) NPRM. New York must submit quarterly reports of the total number of persons transitioned to the community, the size and licensure category of the residential settings into which persons were transitioned (e.g. 4 person group home), and an assurance that the residential settings comport with CMS requirements.

   c. No later than August 1, 2013, New York must submit a draft timeline for transition of the residents of the remaining campus and non-campus-based ICF's to community-based settings. New York and CMS will finalize the plan by October 1, 2013. This plan must detail the pace of remaining transitions, taking into account the housing availability chart developed by the state. Upon approval by CMS, the transition plan and related deliverables will be incorporated as an attachment.

   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.

5. Supported Employment Services and Competitive Employment

   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 (i.e. May 1, 2012 through April 30, 2013). 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.

c. By October 1, 2013, New York will submit to CMS a draft plan for CMS review, and a final plan no later than January 1, 2014, on its transformation towards competitive employment. Both the draft and final plans must include a detailed proposal/work plan for increases in the number of individuals in competitive employment and the number of students exiting the educational system moving directly into competitive employment. The plan must include a timeline for closing sheltered workshops, and a description of the collaborative work with the New York educational system for training/education to key stakeholders on the availability and importance of competitive employment.

d. New York will target youth as a priority in its employment initiative. No later than April 1, 2013, New York will submit an amendment request for its 1915(c) wavier for its Pathways to Employment services to shorten the time frame for transition from this service into Supported Employment. The state will report to CMS on an annual basis the number of students who are aging out of the educational system and who have been determined eligible for OPWDD services, the number who enter VR, and the number who enter OPWDD because they are not found ready by DVR, and any websites/sources for employment data.

6. <u>Consumer Self-Direction</u>

a. New York will implement a self-directed approach in which demonstration participants and/or their designated representatives will be given the option of self-directing by employer authority and budget authority or, at the preference of the individual, either employer authority or budget authority. Employer authority is present when an individual and/or their designated representative fully controls the recruitment, training, hiring, discharge performance review, performance pay increases, and supervision of individuals who furnish their services. Budget authority is present when an individual has decision –making authority over how funds in their individualized budget for waiver services are spent. As part of the design and implementation of this self-directed approach, New York will include the following components:

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.

c. In the design and implementation of its 1915(b)/(c) waiver and other MLTSS models authorized by this demonstration, New York will incorporate and enhance opportunities for self-direction by demonstration participants. If the state utilizes the agency with choice model of self-direction, New York will assure that these agencies provide maximum control by the beneficiary, and include a performance indicator(s) to assure that beneficiaries exercise choice and control. New York will report to CMS on a quarterly basis its efforts to enhance self-direction, and the results of the performance measurement.

d. New York will incorporate and document risk mitigation strategies to be used in its 1915(b)/(c) concurrent waiver and other MLTSS models authorized by this demonstration, in which there is meaningful negotiation with the beneficiary and representative as appropriate. If a participant is terminated voluntarily or involuntarily from the self-directed service delivery option, the MCO/PIHP must transition the participant to the traditional agency direction option and must have safeguards in place to ensure continuity of services. Involuntary discharges will be accompanied by the right to a fair hearing so the beneficiary may have the opportunity to defend actions or inactions that resulted in the involuntary discharge. The state retains the right to immediately stop services pending the hearing if they think there is immediate risk of harm to the beneficiary by remaining in the self-direction program.

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. New York will enable a total of 1,245 new beneficiaries to self-direct services for the period of July 1, 2013 through March 31, 2014 subject to the following:

    i. By October 1, 2013, 350 new beneficiaries will self-direct services;
    ii. By January 1, 2014, 425 new beneficiaries will self-direct services;
    iii. By April 1, 2014, 470 new beneficiaries will self-direct services.

f. By January 1, 2014, New York will submit to CMS for approval the state's policies on self-direction that demonstrate its commitment to and implementation of self-direction.

NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

July 19, 2013

Ms. Cynthia Mann
Director
Center for Medicaid and CHIP Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244

Dear Ms. Mann:

New York is seeking further amendments to our Section 1115 waiver programs (The Partnership Plan, 11-W-00114/2 and F-SHRP, 11-W-11234/2). These amendments are necessary to implement initiatives related to the Affordable Care Act. The State proposes to use the waiver amendment to phase-out New York's Family Health Plus program, simplify enrollment through Express Lane Eligibility, modify waiver authority to provide coverage to single and childless adults through the Medicaid State Plan, and institute Twelve Month Continuous Coverage for enrollees using Modified Adjusted Gross Income.

The attached document outlines the plan to ensure coverage options for current enrollees of Family Health Plus who will be impacted by the phase-out of their current health insurance program. Additionally, other changes necessary to the waivers are outlined in order to maximize coverage and meet the requirements of the Affordable Care Act. In order to implement the proposals in a timely manner, we are requesting your expedited review of the waiver amendment request. In the interest of saving time, the Tribal notice was mailed on July 15, 2013 and the Public notice will be published on July 31, 2013. Any comments received will be provided to your office. Additionally, information regarding the budget neutrality agreement is forthcoming. My staff will be available to discuss the individual proposals at your convenience. We appreciate the anticipated cooperation and assistance of Centers for Medicare and Medicaid Services.

We look forward to working with you to finalize the Special Terms and Conditions so that New York State can move forward with implementing programmatic changes that are critical to a seamless transition to expanded Medicaid under the Affordable Care Act.

Sincerely,

Jason A. Helgerson
Medicaid Director
Office of Health Insurance Programs

Description of Program Changes to the Partnership Plan 1115 Demonstration Waiver (Project Number 11-W00114/2) and the Federal-State Health Reform Partnership (F-SHRP) (Project Number 11-W-00234/2)

Overview

New York is seeking approval from the Centers for Medicare & Medicaid Services (CMS) to amend New York's Medicaid section 1115 Demonstrations, entitled "Partnership Plan" (11-W-00114/2) and "Federal-State Health Reform Partnership (F-SHRP) (11-W-00234/2). There are several changes necessary to these Waivers as the result of the implementation of Affordable Care Act (ACA).

Public Input

New York State, Department of Health, Office of Health Insurance Programs will submit the required public notice on changes outlined in this amendment request to the Federal Register, and will distribute informational letters to the official representative leaders of the recognized Federal Native American tribes located within our state. These notices will solicit input and public comment.

All commenters will be advised to provide input by submitting comments and questions to man08@health.state.ny.us.

I. Phase-Out of Family Health Plus

Family Health Plus (FHPlus) was established by the NYS Health Care Reform Act of 2000. FHPlus exists as a Medicaid Expansion program, providing access to comprehensive health insurance to uninsured New Yorkers with low income, and even adults with no children. FHPlus enrollment is currently 428,200. Prior to this legislation, many working, low income New Yorkers went without medical coverage because they did not have access to health insurance through employment and could not afford to purchase it.

New York has voluntarily elected to expand Medicaid under the ACA. This expansion will extend Medicaid to groups currently eligible for FHPlus, eliminating the coverage gap that made this program a necessity for many state residents. New York is planning a phase-out of enrollment and FHPlus coverage. There has been extensive evaluation to ensure affordable coverage options will exist for all recipients upon the sun-setting of FHPlus.

New York will ensure affordable health coverage options exist for all current recipients, and those who would have otherwise been eligible under current rules. It is anticipated that most current recipients will be eligible for Medicaid coverage. However, due to changes of circumstances and variances with income eligibility methodologies, some current recipients will be determined eligible only for enrollment in a Qualified Health Plan using Advanced Premium Tax Credits to assist with the cost of premiums.

For new applicants, New York will continue to accept and, if determined eligible, process applications for FHPlus through December 31, 2013. The program will end on December 31, 2014, and no coverage will be authorized past that date.

For current FHPlus recipients, Modified Adjusted Gross Income (MAGI) eligibility rules are effective April 1, 2014. However, prior to that date:

- All current single adults or childless couples (S/CC) FHPlus recipients will be transitioned into Medicaid Managed Care effective January 1, 2014.
- For FHPlus parents, caretaker relatives, and 19 & 20 year olds who live with their parents, renewing from January 1, 2014 through March 31, 2014, if determined eligible, will continue in FHPlus for maximum of twelve months, but no later than December 31, 2014.

With the introduction of MAGI eligibility determinations as of April 1, 2014, some recipients will begin transitioning into other coverage:

- FHPlus parents, and caretaker relatives, and 19 & 20 year olds who live with their parents, with income up to 138% FPL, will be renewed at LDSS, using MAGI eligibility rules to the maximum extent possible in the legacy system, for at least six months or until the new eligibility system is fully automated.

As previously discussed, New York is planning to transition most current FHPlus enrollees to Medicaid using MAGI eligibility rules at their scheduled annual renewal. For those enrollees determined not eligible for Medicaid, they would be directed to the New York Health Benefit Exchange for enrollment in a Qualified Health Plan (QHP).

New York has identified an income range of parents and caretaker relatives with income over 138% FPL to 150% FPL, who will no longer qualify for FHPlus. The State is seeking waiver expenditure authority to pay for the cost of the QHP premium for these individuals to ensure that they are not significantly worse off under the ACA than they would have been under FHPlus. New York intends to establish a Designated State Health Program (DSHP) to pay the cost of the premium for individuals who would have been eligible for FHPlus but who are now eligible for APTC/CSR as long as the individual selects a silver plan and applies their full APTC to the cost of the premium. The State is seeking federal financial assistance toward the cost of the DSHP.

Beneficiary and Provider Education and Outreach

Recipients will be informed through mandatory notices of the changes in their coverage.

An information update will be submitted for publication in the upcoming Medicaid Update to alert all Medicaid providers of these changes.

Benefit Package

For those current FHPlus recipients who transition into Medicaid, they will move into a more generous package, full Medicaid without institutionalized long term care. The subset of enrollees who will be eligible for a QHP will see a change in their benefits.

Budget Neutrality

The budget neutrality is forthcoming.

II. Health Coverage for Single Adults and Childless Couples (S/CC)

As mentioned previously in discussion of the FHPlus repeal, New York is modifying the authority under which coverage for low-income Single Adults and Childless Adults is offered. New York currently utilizes Waiver authority to provide this option through Medicaid and FHPlus. These individuals will qualify under the new "Adult" eligibility group, under the Medicaid State Plan, in accordance with the ACA. Therefore this authority should be removed from the Waiver.

Budget Neutrality

The budget neutrality is forthcoming.

III. Express Lane Eligibility Determinations

We are seeking to implement expanded use of Express Lane Eligibility (ELE) to include enrollment of adults. This process is already utilized successfully in our state to enroll children in Medicaid.

New York is seeking to utilize the eligibility determination of Temporary Assistance in order to enroll Adults into Medicaid. Household income data used to make determinations for Temporary Assistance (TA) must be current and rigorously verified; therefore our Medicaid program considers the income data from TA to be reliable. Income requirements for TA are more stringent than Medicaid's, and despite some differences in household compositions and income-counting rules, the majority of the non-elderly and non-disabled individuals who would qualify for TA are exceedingly likely to be financially eligible for Medicaid. Enrolling these participants without having to conduct a separate MAGI-based income determination will help ease administrative burdens, especially in anticipation of the increased volume of new applicants.

New York is seeking to implement this policy in January 2015.

New York plans to fulfill the requirement of a signature for Medicaid application. The application for TA will be revised to include a check-box that would allow applicants to opt-out of a Medicaid eligibility determination. Leaving the box unmarked would indicate that the applicant is interested in applying for coverage. The signature provided by the applicant on the TA application would authorize the request for a Medicaid determination, if that applicant is determined eligible for TA.

Budget Neutrality

The budget neutrality is forthcoming.

IV. Twelve Months Continuous Coverage

New York has used twelve month continuous eligibility for several years to simplify enrollment and keep qualified recipients in coverage. New York has been successful in using 12-month continuous eligibility for children and other eligibility groups, guaranteeing a stable source of health coverage, regardless of income or household changes. This has helped to minimize "churning," and its associated costs and the administrative burden of enrolling and disenrolling otherwise eligible individuals for procedural reasons or slight changes in circumstances.

We are seeking authority to make changes to our 12-month continuous eligibility policy to align with MAGI eligibility groups. The authority for all non-MAGI eligibility groups should be removed from both the Partnership and the F-SHRP Waivers.

To be removed from waiver:

12-month continuous eligibility groups (currently w/in F-SHRP and Partnership Waivers)
• Medically needy pregnant women, children and parents/caretaker relatives, the aged, blind and disabled
• Disabled children who lose SSI due to a change in the SSI definition of disability
• Individuals who meet the income and resources requirements of SSI but are not in receipt of cash
• Disabled widows/widowers who lost SSI or state supplements due to Social Security benefit increases in 1984 and who applied for continued Medicaid coverage before 1988
• Disabled adult children who lose SSI due to Old Age, Survivor's and Disability Insurance (OASDI)
• Disabled widows and widowers aged 60 through 64 who would be eligible for SSI except for early receipt of social security benefits
• Individuals who are ineligible for SSI or optional state supplements because of requirements that do apply under Medicaid
• Individuals eligible for Medicaid in December 1973 as an essential spouse of an aged, blind or disabled individual who was receiving cash assistance
• Individuals otherwise eligible for SSI or a state supplement except for the increase in OASDI under Pub. L. 92-336(July 1, 1972) raised include over the limit allowed under SSA ("pre-Pickle people")
• Individuals otherwise eligible for SSI or a state supplement, except that OASDI cost-of-living increases received after April 1977 raised their income over the limit allowed under SSI ("Pickle people")

The remaining eligibility groups in the waiver will be revised into new MAGI eligibility groups:

12-month continuous eligibility groups (to be included w/in F-SHRP and Partnership Waivers)
• Pregnant women
• Children <19 or 20, if full time student
• Children 19 & 20 living with parents
• Parents/Caretaker relatives
• Adult group (not pregnant, age 19-64, no Medicare, not a caretaker relative)

Budget Neutrality

The budget neutrality is forthcoming.

NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

September 20, 2013

Cynthia Mann
Director
Center for Medicaid and CHIP Services
Center for Medicare and Medicaid Services
7500 Security Blvd
Mail Stop S3-14-28
Baltimore, Maryland 21244-1850

Dear Ms. Mann:

This letter is to consolidate for the Centers for Medicare and Medicaid Services (CMS) several New York State amendment requests to New York's Medicaid section 1115 Demonstrations, "Partnership Plan" (11-W-00114/2) and "Federal-State Health Reform Partnership (F-SHRP)" 11-W11234/2.

Affordable Care Act Initiatives

A previous request was submitted on July 19, 2013 to amend the Partnership Plan to facilitate implementation of the following initiatives as a result of the Affordable Care Act (ACA):

- Phase-out of New York's Family Health Plus Program;
- Express Lane Eligibility to include enrollment for adults;
- Waiver authority modification to provide coverage to single and childless adults through the Medicaid State Plan; and
- Twelve Month Continuous Coverage for enrollees using Modified Adjusted Gross Income

Tribal notices were issued July 16, 2013 and a public notice for stakeholder input was published on September 11, 2013.

Advance Premium Tax Credit

The Department is also seeking the authority to extend Medicaid coverage for recipients in the Exchange who lose Medicaid eligibility after the 15th of the month, until they become eligible for the Advance Premium Tax Credit (APTC). If eligibility for enrollment in APTC is determined after the 15th of the month, there would be a gap in coverage, as Medicaid would close and the recipient would not be able to enroll in APTC until the following month. Therefore, a Medicaid extension is necessary to ensure that there is a seamless transition from

Medicaid to APTC. The requested effective date for this amendment is January 1, 2014. Tribal notice and public notice will be issued October 2, 2013.

Clinic Uncompensated Care Funding

New York State is also requesting an amendment to the Partnership Plan to extend the Clinic Uncompensated Care Funding authorized in STC 58, that is currently due to expire as of December 31, 2013. The proposed amendment would extend the federal funding agreement through December 31, 2014. Tribal notice was issued on September 17, 2013 and public notice will be published on October 2, 2013. The State is seeking advice from CMS on how best to proceed with this request.

The uncompensated program provides over $108 million in payments to qualifying clinic providers, including mental health clinics, to assist in covering the uncompensated costs of services provided to the uninsured population. In order to receive these funds, each provider must deliver a comprehensive range of health care or mental health services; have at least 5% of their annual visits providing services to uninsured individuals; and have a process in place to collect payments from third party payers. For 2011, 112 diagnostic and treatment centers (DTCs) and 190 mental health (MH) clinics were determined to be potentially eligible to receive funding for this program and provided over $214 million in uncompensated care services to the uninsured. Of these, 76 DTCs and 124 MH clinics met the qualifying criteria described above and received $98.6 million and $10.2 million respectively from the indigent care funding which covered approximately 50% on average of their uncompensated care costs. The numbers are similar for 2012: 112 DTCs and 195 MH clinics were potentially eligible and provided over $207 million in uncompensated care; 76 DTCs and 98 MH clinics met the qualifying criteria and received $99.1 million and $9.7 million respectively which, on average, covered approximately 50% of their uncompensated care costs. It is important to note that for each year after the receipt of the indigent care funding, approximately $100 million in uncompensated care costs remained that impacted the provider's financial condition.

In a recent report issued by the Urban Institute (*Uninsured New Yorkers after Full Implementation of the Affordable Care Act: Source of Health Insurance Coverage by Individual Characteristics and Sub-State Geographic Area*; issued January 2013), it is estimated that there will be over 1.6 million New Yorkers who will still be uninsured after full implementation of the federal ACA. These estimates do not include any adjustment for the small share of individuals expected to go from insured to uninsured post-reform. Many of these uninsured people will continue to receive medical services including behavioral health services from the clinics currently receiving these indigent care payments. Elimination of this funding source will severely limit access to these services for the uninsured currently served in these clinics.

In evaluating this request, consideration should be given to the facts that New York will still have a significant uninsured population after the ACA is fully implemented; federal DSH allocations are not being totally eliminated after the full implementation of the ACA; and the DSH allocation reductions are being transitioned over a period of years. A potential option for consideration would be for the clinic indigent care funding to be reduced in the same proportion that the State's federal DSH allocation is reduced.

Family Planning Expansion Program

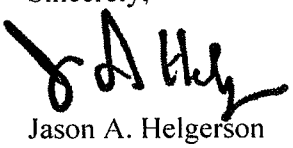
New York has a State Plan Amendment (SPA) pending for the Family Planning Expansion Program currently authorized under the Partnership Plan. Since the benefit will continue and the transition will be seamless for the beneficiary, the State would like to confirm the steps necessary to remove this benefit from the Partnership Plan once the SPA is approved.

F-SHRP Phase-Out

New York is in the process of drafting a Phase-Out Plan for the F-SHRP Demonstration which expires March 31, 2014. Part of that plan is to transition 14 counties with populations enrolled in Mandatory Mainstream Managed Care (MMMC) and to seek the authority to expand MMMC to elderly and disabled populations to the Partnership Plan. The Department is seeking guidance as to whether this will require an amendment, or whether this can be accomplished in some other procedural process.

We will contact your staff to seek guidance on the open issues listed above. If CMS has additional questions about the items discussed in this letter, please contact Kalin Scott of my staff at 518-473-4018. Thank you for your consideration of these requests.

Sincerely,



Jason A. Helgerson
Medicaid Director
Office of Health Insurance Programs

cc: Jessica Woodard, Center for Medicaid and CHIP Services
Michael Melendez, CMS Region 2 Office
John Guhl, CMS Region 2 Office
Kalin Scott, New York State Department of Health

NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

October 9, 2013

Cindy Mann, Director
Center for Medicaid and CHIP Services
Center for Medicare and Medicaid Services
7500 Security Blvd.
Mail Stop S3-14-28
Baltimore, Maryland 21244-1850

Dear Ms. Mann:

This letter is to request an amendment to New York's Medicaid section 1115 Demonstration "Partnership Plan" (11-W-00114/2). This amendment request relates to other eligibility changes requested in my letters of July 17, 2013 and September 20, 2013.

The Demonstration Eligible Group - Safety Net Adults expires in the Partnership Plan on December 31, 2013. Since this group will be eligible under the Adult Group, using the Modified Adjusted Gross Income methodology, effective January 1, 2014, the Department is seeking an approval to continue to use a managed care delivery system to deliver benefits to Safety Net Adults through December 31, 2014.

If CMS wishes to discuss this request further, please contact Kalin Scott of my staff at 518-474-8141. Thank you for your consideration of this request.

Sincerely,

Jason A. Helgerson
Medicaid Director
Office of Health Insurance Programs

cc: Jennifer Sheer, CMCS
Jessica Woodard, CMCS
Michael Melendez, CMS Region 2 Office
John Guhl, CMS
Kalin Scott, NYS DOH

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Center for Medicaid and CHIP Services

April 1, 2013

Nirav R. Shah, M.D.
Commissioner
New York Department of Health
Corning Tower
Governor Nelson A. Rockefeller Empire State Plaza
Albany, NY 12237

Dear Dr. Shah:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) is granting your request to amend New York's Medicaid section 1115 Demonstrations, entitled "Partnership Plan" (11-W-00114/2), and "Federal-State Health Reform Partnership (F-SHRP)" (11-W-00234/2). The amendments discussed in this letter are effective from the date of this letter through the termination date of each demonstration program as follows, Partnership Plan (December 31, 2014) and F-SHRP (March 31, 2014).

This approval will allow both the Partnership Plan and F-SHRP to:

- Expand the managed long term care (MLTC) program under the demonstration, by authorizing mandatory Medicaid managed care enrollment for individuals who have been served in the state's Long-Term Home Health Care Program, also known as the Lombardi Program, and adding medical social services and home delivered meals to the managed care benefit so that they continue to be available to this population.
- Allow mandatory enrollment into mainstream Medicaid managed care program (MMMC) for foster care children placed by the local Department of Social Services (DSS) and individuals who are eligible for Medicaid buy-in for the working disabled.
- Apply an enhanced income standard for individuals to make it easier for individuals who need nursing home level of care to remain in the community and receive services through the MLTC Program.

In addition, the Partnership Plan demonstration will be amended to provide expenditure authority for certain designated state health programs, which will allow the state receive federal matching dollars to support the state's efforts to transform its developmental disability system. Federal matching dollars will be available during the period of April 1, 2013 through March 31, 2014 contingent upon the state meeting milestones outlined in the STCs.

The CMS approval of the Partnership Plan and F-SHRP amendments is conditioned upon continued compliance with the enclosed sets of STCs defining the nature, character, and extent of anticipated federal involvement in the projects. The award is subject to our receiving your written acknowledgement of the awards and acceptance of the enclosed STCs within 30 days of the date of this letter. The waivers for the demonstrations are unchanged by this amendment, and remain in force.

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

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-9249
Facsimile: (410) 786-5882
E-mail: Jessica.Woodard@cms.hhs.gov

Official communication regarding program matters should be sent simultaneously to Mr. Michael Melendez, Associate Regional Administrator in our New York Regional Office. Mr. Melendez's contact information is as follows:

Centers for Medicare & Medicaid Services
New York Regional Office
Division of Medicaid and Children's Health
26 Federal Plaza
New York, New York 10278

I am pleased that we were able to reach a satisfactory resolution to your request, and look forward to working with you and your staff as you seek to redesign the New York Medicaid program. If you have questions regarding the terms of this approval, please contact Ms. Jennifer Ryan, Acting Director, Children and Adults Health Programs Group at (410) 786-3393.

Sincerely,

\s\

Cindy Mann
Director

Enclosures

cc: Jennifer Ryan, CMS
Diane Gerrits, CMS
Michael Melendez, ARA, New York Regional Office
Jason Helgerson, Deputy Commissioner, New York Department of Health
Vallencia Lloyd, Office of Health Insurance Programs, New York Department of Health
Courtney Burke, Office of People with Developmental Disabilities, New York Department of Health

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: **11-W-00114/2**

TITLE: **Partnership Plan Medicaid Section 1115 Demonstration**

AWARDEE: **New York State Department of Health**

I. PREFACE

The following are the Special Terms and Conditions (STCs) for New York's Partnership Plan section 1115(a) Medicaid Demonstration extension (hereinafter "Demonstration"). The parties to this agreement are the New York State Department of Health (state) and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of federal involvement in the Demonstration and the state's obligations to CMS during the life of the Demonstration. The STCs are effective April 1, 2013, unless otherwise specified. All previously approved STCs, waivers, and expenditure authorities are superseded by the STCs set forth below. This Demonstration extension is approved through December 31, 2014; however, some components of the Demonstration will expire earlier, as described below in these STCs and associated waiver and expenditure authority documents, and in the table in Attachment F.

The STCs have been arranged into the following subject areas: Program Description and Objectives; General Program Requirements; Demonstration Eligibility; Demonstration Benefits and Enrollment; Delivery Systems; Quality Demonstration Programs and Clinic Uncompensated Care Funding; Health System Transformation for Individuals with Developmental Disabilities; ;General Reporting Requirements; General Financial Requirements; Monitoring Budget Neutrality; Evaluation of the Demonstration; and Schedule of State Deliverables for the Demonstration Extension.

Additionally, attachments have been included to provide supplementary information and guidance for specific STCs. More attachments will be developed to provide additional guidance for the health system transformation for individuals with developmental disabilities.

II. PROGRAM DESCRIPTION AND OBJECTIVES

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

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

The Demonstration is designed to use a managed care delivery system to deliver benefits to Medicaid recipients, create efficiencies in the Medicaid program, and enable the extension of coverage to certain individuals who would otherwise be without health insurance. It was approved in 1997 to enroll most

Medicaid recipients into managed care organizations (MCOs) (Medicaid managed care program). As part of the Demonstration's renewal in 2006, authority to require the disabled and aged populations to enroll in mandatory managed care was transferred to a new demonstration, the Federal-State Health Reform Partnership (F-SHRP).

In 2001, the Family Health Plus (FHPlus) program was implemented as an amendment to the Demonstration, providing comprehensive health coverage to low-income uninsured adults, with and without dependent children, who have income greater than Medicaid state plan eligibility standards. FHPlus was further amended in 2007 to implement an employer-sponsored health insurance (ESHI) component. Individuals eligible for FHPlus who have access to cost-effective ESHI are required to enroll in that coverage, with FHPlus providing any wrap-around services necessary to ensure that enrollees get all FHPlus benefits. During this extension period, the state will expand Family Health Plus eligibility for low-income adults with children.

In 2002, the Demonstration was expanded to incorporate a family planning benefit under which family planning and family planning-related services are provided to women losing Medicaid eligibility and to certain other adults of childbearing age (family planning expansion program).

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

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

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

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

In 2012, New York added to the Demonstration an initiative to improve service delivery and

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

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

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

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

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

III. GENERAL PROGRAM REQUIREMENTS

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

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

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

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

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

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

5. **State Plan Amendments.** The state will not be required to submit title XIX state plan amendments for changes affecting any populations made eligible solely through the Demonstration. If a population eligible through the Medicaid state plan is affected by a change to the Demonstration, a conforming amendment to the state plan may be required, except as otherwise noted in these STCs.

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

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

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

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

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

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

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

a) Notification of Suspension or Termination: The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a phase-out plan. The state must submit its notification letter and a draft phase-out plan to CMS no less than 4 months before the effective date of the Demonstration's suspension or termination.

   Prior to submitting the draft phase-out plan to CMS, the state must publish on its website the draft phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation State Plan Amendment. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received, the state's response to the comment, and the way the state incorporated the received comment into a revised phase-out plan.

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

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

c) Phase-out Procedures: The state must comply with all notice requirements found in 42 CFR 431.206, 431.210 and 431.213. In addition, the state must ensure all appeal and hearing rights afforded to Demonstration participants as outlined in 42 CFR 431.220 and 431.221. If a Demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine whether they qualify for Medicaid eligibility under a different eligibility category as discussed in the October 1, 2011, State Health Official Letter #10-008.

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

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

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

11. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX of the Act. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal,

together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS's determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.

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

13. **Quality Review of Eligibility.** The state will continue to submit to the CMS Regional Office by December 31 of each year an alternate plan for Medicaid Eligibility Quality Control (MEQC) as permitted by federal regulations at 42 CFR 431.812(c).

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

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

    In states with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the state is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any Demonstration proposal, and/or renewal of this Demonstration (42 CFR 431.408(b)(3)). The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

15. **FFP.** No federal matching funds for expenditures for this Demonstration will take effect until the effective date identified in the Demonstration approval letter.

IV. DEMONSTRATION ELIGIBILITY

16. **Demonstration Components**. The Partnership Plan includes five distinct components, each of which has its own specific eligibility criteria.

    a) **Mainstream Medicaid Managed Care Program (MMMC)**. This component provides Medicaid state plan benefits through a managed care delivery system comprised of managed care organizations (MCOs), and primary care case management (PCCM) arrangements to most recipients eligible under the state plan. All state plan eligibility determination rules apply to this program, except those otherwise noted in this section.

The state has authority to expand mandatory enrollment in mainstream managed care to all individuals identified in Table 2 (except those otherwise excluded or exempted as outlined in STC 26) and who reside in any county other than Allegany, Cortland, Dutchess, Fulton, Montgomery, Putnam, Orange, Otsego, Schenectady, Seneca, Sullivan, Ulster, Washington, and Yates counties. When the state intends to expand mandatory managed care enrollment to additional counties (other than those identified in this subparagraph), it must notify CMS 90 days prior to the effective date of the expansion and submit a revised assessment of the demonstration's budget neutrality agreement, which reflects the projected impact of the expansion for the remainder of the Demonstration approval period.

Note: The authority to require mandatory managed care enrollment for any of the individuals who are identified in Table 2 and who reside in Allegany, Cortland, Dutchess, Fulton, Montgomery, Putnam, Orange, Otsego, Schenectady, Seneca, Sullivan, Ulster, Washington, and Yates counties has been provided under the Federal-State Health Reform Partnership Demonstration (11-W-00234/2).

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

Services not provided through the MLTC program are provided on a fee-for-service basis. The state has authority to expand mandatory enrollment into MLTC to all individuals identified in Table 3 (except those otherwise excluded or exempted as outlined in STC 27) with initial mandatory enrollment starting in any county in New York City and then expanding statewide based on the Enrollment plan as outlined in Attachment G. When the state intends to expand into a new county outside of New York City, it must notify CMS 90 days prior to the effective date of the expansion and submit a revised assessment of the Demonstration's budget neutrality agreement along with all other required materials as outlined in STC 33.

c) **Family Health Plus (FHPlus)**. This component provides a more limited benefit package, with cost-sharing imposed, to enrolled adults with and without dependent children who meet specific income eligibility requirements through MCOs. FHPlus-eligible individuals that have access to cost-effective employer-sponsored health insurance are required to enroll in the Family Health Plus Premium Assistance Program (FHP-PAP). Under FHP-PAP, enrollees will not be responsible for any portion of the premium payments for that coverage. Adults in this program will use employer-sponsored health insurance as their primary insurance policy, with all premiums, deductibles, and coinsurance (if any) paid by the state.

d) **Family Planning Expansion Program (FP Expansion)**. This component provides only family planning and family planning-related services to men and women of childbearing age with net incomes at or below 200 percent of the federal poverty level (FPL) who are not otherwise eligible for Medicaid, as well as to women who lose Medicaid pregnancy coverage at the conclusion of 60-days postpartum.

The state will allow applicants the opportunity to apply for family planning services through the family planning expansion program, or apply for Medicaid and/or FHPlus. If an applicant wants to waive his/her right to an eligibility determination for Medicaid or FHPlus, the state will ensure that applicants have all the information they need, both written and oral, to make a

fully informed choice. The state will obtain a signature from applicants waiving their right to an eligibility determination for Medicaid or Family Health Plus.

The state will also ensure that redeterminations of eligibility for this component of the demonstration are conducted, at a minimum, once every 12 months. Administrative (or ex parte) redeterminations are acceptable.

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

17. **Individuals Eligible under the Medicaid State Plan (State Plan Eligibles).** Mandatory and optional Medicaid state plan populations derive their eligibility through the Medicaid state plan and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid state plan, except as expressly waived and as further described in these STCs. State plan eligibles are included in the MMMC component of the Demonstration to ensure access to cost-effective high quality care.

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

19. **Continuous Eligibility Period**.

a) **Duration.** The state is authorized to provide a 12-month continuous eligibility period to the groups of individuals specified in Table 1, regardless of the delivery system through which they receive Medicaid benefits. Once the state begins exercising this authority, each newly eligible individual's 12-month period shall begin at the initial determination of eligibility; for those individuals who are redetermined eligible consistent with Medicaid state plan or FHPlus rules, the 12-month period begins at that point. At each annual eligibility redetermination thereafter,
if an individual is redetermined eligible under Medicaid state plan or FHPlus rules,
the individual is guaranteed a subsequent 12-month continuous eligibility period.

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

State Plan Mandatory and Optional Groups	Statutory Reference (Social Security Act)
Pregnant women aged 19 or older	1902(a)(10)(A)(i)(III) or (IV); and 1902(a)(10)(A)(ii)(I) and (II)
Children aged 19 or 20	1902(a)(10)(A)(ii)(I) and (II)
Parents or other caretaker relatives aged 19 or older	1902(a)(10)(A)(ii)(I) and (II)
Members of low-income families, except for children	1931 and 1925

Medically needy pregnant women, children, and parents/caretaker relatives	Without spend-down under 1902(a)(10)(C)(i)(III)
Demonstration Eligible Group	**Qualifying Criteria**
Safety Net Adults	Income based on statewide standard of need (determined annually)
Family Health Plus Adults with children	Income above the applicable statutory level but gross family income at or below 160%
Family Health Plus Adults without children	Income above the statewide standard of need but gross household income at or below 100% FPL.

Note: Children under 19 who are eligible at the applicable FPL already receive 12 months continuous eligibility under the Medicaid state plan

b) **Exceptions.** Notwithstanding subparagraph a), if any of the following circumstances occur during an individual's 12-month continuous eligibility period, the individual's Medicaid or FHPlus eligibility shall be terminated:

(A) The individual cannot be located;

(B) The individual is no longer a New York State resident;

(C) The individual requests termination of eligibility;

(D) The individual dies;

(E) The individual fails to provide, or cooperate in obtaining, a Social Security number if otherwise required;

(F) The individual provided an incorrect or fraudulent Social Security number;

(G) The individual was determined eligible for Medicaid in error;

(H) The individual is receiving treatment in a setting where Medicaid eligibility is not available (e.g., institution for mental disease);

(I) The individual is in receipt of long-term care services;

(J) The individual is receiving care, services, or supplies under a section 1915 waiver program;

(K) The individual was previously otherwise qualified for emergency medical assistance benefits only, based on immigration status, but is no longer qualified because the emergency has been resolved;

(L) The individual fails to provide the documentation of citizenship or immigration status required under federal law; or

(M) The individual is incarcerated.

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

Table 2: Mainstream Medicaid Managed Care Program

State Plan Mandatory and Optional Groups	FPL and/or Other Qualifying Criteria	Expenditure and Eligibility Group Reporting
Pregnant Women	Income up to 200% of FPL	Demonstration Population 2/ Temporary Assistance to Needy Families (TANF) Adult
Children under age 1	Income up to 200% of FPL	Demonstration Population 1/ TANF Child
Children 1 through 5	Income up to 133% of FPL	Demonstration Population 1/ TANF Child
Children 6 through 18	Income up to 133% of FPL	Demonstration Population 1/ TANF Child
Children 19-20	Income at or below the monthly income standard (determined annually)	Demonstration Population 1/ TANF Child
Parents and Caretaker Relatives	Income at or below the monthly income standard (determined annually)	Demonstration Population 2/ TANF Adult
Demonstration Eligible Groups	**FPL and/or Other Qualifying Criteria**	**Expenditure and Eligibility Group Reporting**
Safety Net Adults	Income based on statewide standard of need (determined annually)	Demonstration Population 5/ Safety Net Adults

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

Table 3: Managed Long-Term Care Program

State Plan Mandatory and Optional Groups	FPL and/or Other Qualifying Criteria	Expenditure and Eligibility Group Reporting

Adults aged 65 and older	Income at or below SSI level	Demonstration population 11/ MLTC Adults 65 and above
Adults/children aged 18 - 64	Income at or below SSI level	Demonstration population 11/ MLTC Adults 18 – 64
Adults aged 65 and older	Income at or below the monthly income standard, or with spenddown to monthly income standard	Demonstration population 10/ MLTC Adults 65 and above
Adults/children aged 18-64 blind and disabled	Income at or below the monthly income standard, or with spenddown to monthly income standard	Demonstration population 10/ MLTC Adults 18 – 64
Aged 16 – 64 Medicaid Buy In for Working People with Disabilities	Income up to 250% of FPL	Demonstration population 10/ MLTC Adults 18 – 64
Parents and Caretaker Relatives 21-64	Income at or below the monthly income standard, or with spenddown to monthly income standard	Demonstration population 10/ MLTC Adults 18 – 64
Children aged 18 – 20	Income at or below the monthly income standard or with spenddown	Demonstration population 10/ MLTC Adults 18 – 64
Pregnant Women	Income up to 200%	Demonstration population 10/ MLTC Adults 18 – 64
Poverty Level Children Aged 18 to 20	Income up to 133%	Demonstration population 10/ MLTC Adults 18 – 64
Foster Children Aged 18 – 20	In foster care on the date of 18th birthday	Demonstration population 10/ MLTC Adults 18 – 64

Demonstration Eligible Groups	**FPL and/or Other Qualifying**	**Expenditure and Eligibility**
Safety Net Adults	Income based on statewide Standard of Need (determined annually)	Demonstration population 5/ Safety Net Adults

Individuals Moved from Institutional Settings to Community Settings for Long Term Care Services	Income based on higher income standard to community settings for long term services and supports pursuant to STC 25	Demonstration population 10 and 11/ MLTC Adults 18 – 64 and MLTC Adults 65 and above

22. **Individuals enrolled in FHPlus.** Table 4 below lists the groups of individuals who may be enrolled in the Family Health Plus component of the Demonstration, as well as the relevant expenditure reporting category (demonstration population) for each.

Table 4: Family Health Plus

Demonstration Eligible Groups	FPL and/or Other Qualifying Criteria	Expenditure and Eligibility Group Reporting
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)	Income above the Medicaid monthly income standard but gross family income at or below 160% FPL.	Demonstration Population 6/ FHP Adults w/Children
Non-pregnant, non-disabled (“childless”) adults (19-64)	Income above the statewide standard of need but gross household income at or below 100% FPL.	Demonstration Population 7/ FHP Childless Adults

23. **Individuals enrolled in Family Planning Expansion Program.** Table 5 lists the groups of individuals who may be enrolled in the family planning expansion component of the Demonstration, as well as the relevant expenditure reporting category (demonstration population).

Table 5: Family Planning Expansion Program

Demonstration Eligible Groups	Expenditure andEligibility Group Reporting
Women who lose Medicaid pregnancy coverage at the conclusion of 60-days postpartum	Demonstration Population 8/ FP Expansion
Men and women of childbearing age with net incomes at or below 200% FPL who are not otherwise eligible for Medicaid	Demonstration Population 8/ FP Expansion

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

a) Who meet a nursing home level of care;

b) Whose spouse lives in the community; and

c) Who could receive services in the community but for the application of the spousal

impoverishment eligibility and post-eligibility rules of section 1924 of the Act.

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

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

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

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

26. **Exclusions and Exemptions from MMMC.** Notwithstanding the eligibility criteria in STC 16, certain individuals cannot receive benefits through the MMMC program (i.e., excluded), while others may request an exemption from receiving benefits through the MMMC program (i.e., exempted). Tables 6 and 7 list those individuals either excluded or exempted from MMMC.

Table 6: Individuals Excluded from MMMC

Individuals who become eligible for Medicaid only after spending down a portion of their income
Residents of state psychiatric facilities or residents of state-certified or voluntary treatment facilities for children and youth
Patients in residential health care facilities (RHCF) at time of enrollment and residents in an RHCF who are classified as permanent
Participants in capitated long-term care demonstration projects
Medicaid-eligible infants living with incarcerated mothers
Individuals with access to comprehensive private health insurance if cost effective
Foster care children in the placement of a voluntary agency

Certified blind or disabled children living or expected to live separate and apart from their parents for 30 days or more
Individuals expected to be Medicaid-eligible for less than 6 months (except for pregnant women)
Individuals receiving long-term care services through long-term home health care programs
Individuals receiving hospice services (at time of enrollment)
Individuals with a "county of fiscal responsibility" code of 97 (Individuals residing in a state Office of Mental Health facility)
Individuals with a “county of fiscal responsibility” code of 98 (Individuals in an Office for People with Developmental Disabilities/OPWDD facility or treatment center)
Youth in the care and custody of the commissioner of the Office of Family & Children Services
Individuals eligible for the family planning expansion program
Individuals who are under 65 years of age (screened and require treatment) in the Centers for Disease Control and Prevention breast, cervical, colorectal, and/or prostate early detection program and need treatment for breast, cervical, colorectal, or prostate cancer, and who are not otherwise covered under creditable health coverage
Individuals who are eligible for Emergency Medicaid

Table 7: Individuals who may be exempted from MMMC

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

27. **Exclusions and Exemptions from MLTC.** Notwithstanding the eligibility criteria in STC 16, certain individuals cannot receive benefits through the MLTC program (i.e., excluded), while others may request an exemption from receiving benefits through the MLTC program (i.e., exempted). Tables 8 and 9 list those individuals either excluded or exempted from MLTC.

Table 8: Individuals excluded from MLTC

Residents of psychiatric facilities
Residents of residential health care facilities (RHCF) at time of enrollment

Individuals expected to be Medicaid eligible for less than six months
Individuals eligible for Medicaid benefits only with respect to tuberculosis-related services
Individuals with a "county of fiscal responsibility" code 99 in MMIS (Individuals eligible only for breast and cervical cancer services)
Individuals receiving hospice services (at time of enrollment)
Individuals with a "county of fiscal responsibility" code of 97 (Individuals residing in a state Office of Mental Health facility)
Individuals with a "county of fiscal responsibility" code of 98 (Individuals in an OPWDD facility or treatment center)
Individuals eligible for the family planning expansion program
Individuals who are under 65 years of age (screened and require treatment) in the Centers for Disease Control and Prevention breast, cervical, colorectal, and/or prostate early detection program and need treatment for breast, cervical, colorectal, or prostate cancer, and who are not otherwise covered under creditable health coverage
Residents of intermediate care facilities for the mentally retarded (ICF/MR)
Individuals who could otherwise reside in an ICF/MR, but choose not to
Residents of alcohol/substance abuse long-term residential treatment programs
Individuals eligible for Emergency Medicaid
Individuals in the Office for People with Developmental Disabilities Home- and Community-Based Services (OPWDD HCBS) section 1915(c) waiver program
Individuals in the following section 1915(c) waiver programs: Traumatic Brain Injury (TBI), Nursing Home Transition & Diversion (NHTD), and Long-Term Home Health Care Program (LTHHCP) in certain counties[1] (see Attachment G)
Residents of Assisted Living Programs
Individuals in receipt of Limited Licensed Home Care Services
Individuals in the Foster Family Care Demonstration

Table 9: Individuals who may be exempted from MLTC.

Individual aged 18-21 who are nursing home certifiable and require more than 120 days of community-based long-term care services.
Native Americans
Individuals who are eligible for the Medicaid buy-in for the working disabled and are nursing home certifiable
Aliessa Court Ordered Individuals

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

28. **Population-Specific Program Requirements.**

a) **MMMC Enrollment of Individuals Living with HIV.** The state is authorized to require individuals living with HIV to receive benefits through MMMC. Once the state begins implementing MMMC enrollment in a particular district, individuals living with HIV will have thirty days in which to select a health plan. If no selection is made, the individual will be auto-assigned to a MCO. Individuals living with HIV who are enrolled in a MCO (voluntarily or by default) may request transfer to an HIV Special Needs Plans (SNP) at any time if one or more HIV SNPs are in operation in the individual's district. Further, transfers between HIV SNPs will be permitted at any time.

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

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

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

c) **Managed care enrollment of individuals using long-term services and supports for both MMMC and MLTC.** The state is authorized to require certain individuals using long-term services and supports to enroll in either mainstream managed care or managed long-term care as identified in STC 16. In addition, the populations that are exempted from mandatory enrollment, based on the exemption lists in STCs 26 and 27 may also elect to enroll in managed care plans. Once these individuals begin to enroll in managed care, the state will be required to provide the following protections for the population[2]:

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

[2] All beneficiary protections apply to both MMMC and MLTC, unless otherwise noted in STC 28 and Section V.

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

1) The qualification for individuals who will develop the PCP;
2) Types of assessments;
3) How enrollees are informed of the services available to them; and
4) The MCOs' responsibilities for implementing and monitoring the PCP.

(B) The MCO/PIHP contract shall require the use of a person centered and directed planning process intended to identify the strengths, capacities, and preferences of the enrollee, as well as to identify an enrollee's long term care needs and the resources available to meet those needs, and to provide access to additional care options as specified by the contract. The person-centered plan is developed by the participant with the assistance of the MCO/PIHP, provider, and those individuals the participant chooses to include. The plan includes the services and supportsthat the participant needs.

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

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

(E) The MCO/PIHP shall ensure that meetings related to the enrollee's Person Centered Plan will be held at a location, date, and time convenient to the enrollee and his/her invited participants.

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

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

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

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

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

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

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

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

a) **Core Elements of the Independent Consumer Support Program**.

1) *Organizational Structure*. The Independent Consumer Support Program shall operate independently from any Partnership Plan MCO. Additionally, to the extent possible, the program shall also operate independently of the Department of Human Services. The organizational structure of the program shall support its transparent and collaborative operation with beneficiaries, MCOs, and state government.

2) *Accessibility*. The services of the Independent Consumer Support Program are available to all Medicaid beneficiaries enrolled in Partnership Plan who are in need of LTSS (institutional, residential and community based).

The Independent Consumer Support Program must be accessible through multiple entryways (e.g., phone, internet, office) and must reach out to beneficiaries and/or authorized representatives through various means (mail, phone, in person), as appropriate.

3) *Functions*. The Independent Consumer Support Program assists beneficiaries

to navigate and access covered LTSS. Where an individual is enrolling in a new delivery system, the services of this program help individuals understand their choices and resolve problems and concerns that may arise between the individual and a provider/payer. The following list encompasses the program's scope of activity.

- The program shall offer beneficiaries support in the pre-enrollment stage, such as unbiased health plan choice counseling and general program-related information.
- The program shall serve as an access point for complaints and concerns about health plan enrollment, access to services, and other related matters.
- The program shall help enrollees understand the fair hearing, grievance, and appeal rights and processes within the health plan and at the state level and assist them through the process if needed/requested.
- The program shall conduct trainings with Partnership Plan MCO as well as providers on community-based resources and supports that can be linked with covered plan benefits.

4) *Staffing*. The Independent Consumer Support Program must employ individuals who are knowledgeable about the state's Medicaid programs; beneficiary protections and rights under Medicaid managed care arrangements; and the health and service needs of persons with complex needs, including those with a chronic condition, disability, and cognitive or behavioral needs. In addition, the Independent Consumer Support Program shall ensure that its services are delivered in a culturally competent manner and are accessible to individuals with limited English proficiency.

5) *Data Collection and Reporting.* The Independent Consumer Support Program shall track the volume and nature of beneficiary contacts and the resolution of such contacts on a schedule and manner determined by the state, but no less frequently than quarterly. This information will inform the state of any provider or contractor issues and support the reporting requirements to CMS.

vi. **Independent Consumer Support Program Plan**. The state shall submit a plan to CMS describing the structure and operation of the Independent Consumer Support Program that aligns with the core elements provided in this STC 28 no later than January 1, 2014.

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

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

i. **Transition of care period: Initial transition into MLTC from fee-for- service**. Each enrollee who is receiving community-based long-term services and supports that qualifies for MLTC must continue to receive services under the enrollee's pre-existing service plan for at least 60 days after enrollment, or until a care assessment has been completed by the MCO/PIHP, whichever is later. Any reduction, suspension, denial or termination of previously authorized services shall trigger the required notice under 42 CFR 438.404 which clearly articulates the enrollee's right to file an appeal (either expedited, if warranted, or standard), the right to have authorized service continue pending the appeal, and the right to a fair hearing if the plan renders an adverse determination (either in whole or in part) on the appeal. For initial implementation of the auto-assigned population, the plans must submit data for state review on a monthly basis reporting instances when the plan has issued a notice of action that involves a reduction of split shift or live-in services or when the plan is reducing hours by 25 percent or more. The plan will also report the number of appeals and fair hearings requested regarding these reductions. The state shall ensure through its contracts that if an enrollee is to change from one MCO/PIHP to another, the MCO/PIHPs will communicate with one another to ensure a smooth transition and provide the new MCO/PIHP with the individual's current service plan.

ii. **Assessment of LTSS Need.** The following requirements apply until the state implements an independent and conflict-free long-term services and supports (LTSS) assessment process (as required by STC 28).

A) MLTC plans conduct the initial assessment for an individual's need for LTSS using a standardized assessment tool designated by the state. The following requirements apply to the activities that must be undertaken by a MLTC plan as it assesses individuals for need for LTSS.

1. The state shall ensure all individuals requesting LTSS are assessed for in a timely manner.
    a. The MCO/PIHP will use the Semi-Annual Assessment of Members (SAAM) tool (or successor tool designated by the state) to determine if the individual has a need for LTSS.
    b. In addition to the SAAM tool, the MCO/PIHP may use other assessment tools as appropriate. The state must review and approve all other assessment tools used by the MCO/PIHP.
2. The state must ensure through its contracts that each MCO/PIHP must complete the initial assessment in the individual's home of all individuals referred to or requesting enrollment in an MLTC plan within 30 days of that referral or initial contact. MCO/PIHP compliance with this standard shall be reported to CMS in the quarterly reports as required in STC 73.
    a. The MCO/PIHP shall complete a re-assessment at least annually, or when an enrollee's needs change.
    b. If the assessed individual is not already a Medicaid recipient, the MCO/PIHP shall:
        i. Provide the individual with the results of the assessment.
        ii. If the assessment indicates that the individual meets the criteria for LTSS, explain that the results of the assessment will be

forwarded to the individual's county social services office for a formal eligibility determination.

iii. If the assessment indicates that the individuals do not meet the criteria for LTSS, explain that the results of the assessment do not indicate that the individual is eligible for Medicaid and provide a written notice to the individual that they have the right (consistent with 42 CFR 435.906) to request a formal Medicaid eligibility determination from the county social services office.

c. If the assessed individual is already a Medicaid recipient, the MCO/PIHP shall:

i. Provide the recipient with the results of the assessment.

ii. If the assessment indicates that the recipient meets the criteria for LTSS, explain that the individual is eligible for enrollment in a MLTC.

iii. Provide the recipient with information about all the MLTC plans in which the recipient can enroll.

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

4. The state shall use this information to determine if individuals have been assessed incorrectly

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

C) The state must submit to CMS for review and comment, and subsequently approval of the written notice required in subparagraph A no later than May 31, 2013.

iii. **Transformation of LTSS Needs Assessment.**. The state shall begin implementation of an independent and conflict-free LTSS needs assessment system no later than December 1, 2014. After that implementation has begun, MLTC plans will not complete any LTSS needs assessments for individuals requesting such services prior to the enrollment in the plan. Non-dually eligible individuals requesting LTSS will be assessed to see if they meet the criteria to be enrolled in a MLTC plan or alternate waiver program prior to being told their enrollment options. In order to achieve this milestone, the state must:

a. Submit to CMS an initial plan for implementing this transformation by December 31, 2013.

b. Submit to CMS a final plan with specific action items and timeframes by May 31, 2014.

c. Report progress on the plan in each quarterly report required by STC 73.

iv. **Marketing Oversight**.

A) The state shall require each MCO/PIHPs through its contract to meet 42 CFR 438.104, and state marketing guidelines which prohibit cold calls, use of government logos and other standards.
B) All materials used to market the MCO/PIHP shall be prior approved by the state.
C) The state shall require through its contract that each MCO/PIHP provide all individuals who were not referred to the plan by the enrollment broker with information (in a format determined by the state) describing Managed Long Term Care, a list of available plans, and contact information to reach the enrollment broker for questions or other assistance. The plan shall report the number of individuals receiving these materials to the state on a quarterly basis pursuant to STC 73.

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

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

V. DEMONSTRATION BENEFITS AND ENROLLMENT

29. **Demonstration Benefits and Cost-Sharing.** The following benefits are provided to individuals eligible for the Medicaid managed care, FHPlus, and family planning expansion components of the Demonstration:

a) **Mainstream Medicaid Managed Care (MMMC).** State plan benefits delivered through MCOs or, in certain districts, primary care case management arrangements, with the exception of certain services carved out of the MMMC contract and delivered directly by the state on a fee-for-service basis. All MMMC benefits (regardless of delivery method), as well as the co-payments charged to MMMC recipients, are listed in Attachment A.

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

c) **Family Health Plus (FHPlus).**

i. FHPlus direct coverage benefits must be delivered by an MCO, with the exception of certain services carved out of the FHPlus contract and delivered directly by the state on a fee-for-service basis. In districts where no MCO is available, these benefits may be provided by a commercial insurer contracted with the state.

ii. FHPlus benefits, as well as the applicable co-payments charged to FHPlus recipients, are listed in Attachment C.
(A) FHPlus enrollees under 21 years of age or who are pregnant are exempt from any cost-sharing otherwise applicable.
(B) Emergency services, family planning services and supplies, and psychotropic and

tuberculosis drugs are exempt from cost-sharing requirements in all settings which otherwise require cost-sharing.

iii. The 'benchmark" FHP-PAP Employer-Sponsored Health Insurance (ESHI) plan will include, at a minimum, the following services: inpatient and outpatient hospital services, physician services, maternity care, preventive health services, diagnostic and x-ray services, and emergency services. Maximum out-of-pocket charges for FHP-Premium Assistance Program (PAP) enrollees are limited to the co-payment amounts specified in Attachment C. Any out-of-pocket charges exceeding those amounts will be reimbursed by the state.

d) **Family Planning Expansion Program.**

i. The Family Planning expansion program provides family planning services and supplies described in section 1905(a)(4)(c) of the Act directly on a fee-for-service basis. Such services and supplies are limited to those whose primary purpose is family planning and which are provided in a family planning setting. Family planning services and supplies are reimbursable at the 90 percent matching rate, including:

(A) Approved methods of contraception;

(B) Sexually transmitted infection (STI) testing, Pap smears, and pelvic exams (NOTE: The laboratory tests done during an initial family planning visit for contraception include a Pap smear, screening tests for STIs, blood count, and pregnancy test. Additional screening tests may be performed depending on the method of contraception desired and the protocol established by the clinic, program, or provider. Additional laboratory tests may be needed to address a family planning problem or need during an inter-periodic family planning visit for contraception.);

(C) Drugs, supplies, or devices related to women's health services described above that are prescribed by a health care provider who meets the state's provider enrollment requirements (subject to the national drug rebate program requirements); and

(D) Contraceptive management, patient education, and counseling.

ii. Family planning-related services and supplies are defined as those services provided as part of, or as follow-up to, a family planning visit and are reimbursable at the state's regular Federal Medical Assistance Percentage (FMAP) rate. Such services are provided because a "family planning-related" problem was identified and/or diagnosed during a routine or periodic family planning visit. Examples of family-planning related services include:

(A) Colposcopy (and procedures done with/during a colposcopy) or repeat Pap smear performed as a follow-up to an abnormal Pap smear which is done as part of a routine/periodic family planning visit.

(B) Drugs for the treatment of STIs/Sexually Transmitted Diseases (STD), except for HIV/AIDS and hepatitis, when the STIs/STDs are identified/ diagnosed during a routine/periodic family planning visit. A follow-up visit/encounter for the treatment/drugs and subsequent follow-up visits to rescreen for STIs/STDs based on Centers for Disease Control and Prevention guidelines may also be covered.

(C) An annual exam for men, such an annual family planning visit may include a comprehensive patient history, physical, laboratory tests, and contraceptive counseling.

(D) Drugs/treatment for vaginal infections/disorders, other lower genital tract and genital skin infections/disorders, and urinary tract infections, where these conditions are identified/diagnosed during a routine/periodic family planning visit. A follow-up visit/encounter for the treatment/drugs may also be covered.

(E) Other medical diagnosis, treatment, and preventive services that are routinely provided pursuant to family planning services in a family planning setting. An example of a preventive service could be a vaccination to prevent cervical cancer.

(F) Treatment of major complications arising from a family planning procedure, such as:

1) Treatment of a perforated uterus due to an intrauterine device insertion;
2) Treatment of severe menstrual bleeding caused by a Depo-Provera injection requiring a dilation and curettage; or
3) Treatment of surgical or anesthesia-related complications during a sterilization procedure.

iii. Primary care referrals to other social service and health care providers as medically indicated are provided; however, the costs of those primary care services are not covered for enrollees of this Demonstration. The state must facilitate access to primary care services for enrollees in the family planning expansion program, and must assure CMS that written materials concerning access to primary care services are distributed to enrollees. The written materials must explain to the participants how they can access primary care services.

30. **Home and Community Settings Characteristics**. MLTC enrollees, including individuals who receive services under the demonstration's HCBS Expansion program described in STC 36, must receive services in residential settings located in the community, which meet CMS standards for HCBS settings as articulated in current 1915(c) policy and as modified by subsequent regulatory changes, in accordance with the plan submitted by the state (required in Attachment H). This plan shall be due no later than December 31, 2013. Residential settings include characteristics such as providing full access to typical facilities such as a kitchen with cooking facilities, convenient privacy for visitors and easy access to resources and activities in the community. A full list of home and community based characteristics are provided in Attachment D.

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

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

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

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

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

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

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

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

i. A reduction, suspension, or termination of authorized CDPAP services;

ii. A denial of a request to change Consumer Directed Personal Assistance Program services.

32. **Adding Services to the MMMC and/or MLTC plan benefit package**. At any point in time the state intends to add to either the MMMC or MLTC plan benefit package currently authorized state plan or Demonstration services that have been provided on a fee-for-service basis, the state must provide CMS the following information, with at least 30 days' notice prior to the inclusion of the benefit, either in writing or as identified on the agenda for the monthly calls referenced in STC 72:

a) A description of the benefit being added to the MCO/PIHPs benefit package;

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

c) Information concerning the changes being made to MMMC and/or MLTC contract provisions and capitation payment rates in accordance with STC 38.

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

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

33. **Expanding MLTC enrollment into a new geographic area**. Any time the state is ready to expand mandatory MLTC plan enrollment into a new geographic area or to a new population of Medicaid enrollees (except those otherwise excluded or exempted in these STCs), the state must provide CMS notification at least 90 days prior to the expansion. Such notification will include:

    a) A list of the counties that will be moving to mandatory enrollment, or description of the population added;
    b) A list of MCO/PIHPs with an approved state certificate of authority to operate in those counties demonstrating that enrollees will be afforded choice of plan within the new geographic area;
    c) Confirmation that the MCO/PIHPs in the new geographic area have met the network requirements in STCs 45 and 46 for each MCO/PIHP.

    The state must also apply the requirements of STC 32 when applicable to the MLTC population or geographic area being added to the MLTC program.

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

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

34. **Assurances during expansion of MLTC enrollment**. The assurances below pertain to future MLTC expansions authorized under this demonstration. To provide and demonstrate smooth transitions for beneficiaries, the state must:

    a) Send sample notification letters. Existing Medicaid providers must receive sample beneficiary notification letters via widely distributed methods (mail, email, provider website, etc.) so that providers are informed of the information received by enrollees regarding their managed care transition.
    b) Provide educational tours for enrollees and providers. The educational tour should educate enrollees and providers on the MLTC plan enrollment options, rights and responsibilities and other important program elements. The state must provide webinars, meeting plans, and send notices through outreach and other social media (e.g. state's website).The enrollment broker, choice counseling entities, ombudsman and any group providing enrollment support must participate.
    c) Operate a call center independent of the MLTC plans for the duration of the demonstration. This entity must be able to help enrollees in making independent decisions about plan choice and be able to document complaints about the plans. During the first 60 days of

implementation the state must review all call center response statistics to ensure all contracted plans are meeting requirements in their contracts. After the first 60 dyas, if all entities are consistently meeting contractual requirements the state can lessen the review of call center statistics, but no more than 120 days should elapse between reviews.

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

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

35. **Enrollment into the Family Health Plus Premium Assistance Program (FHP-PAP).**

a) At the time of initial application or recertification, individuals will be asked if they have access to ESHI. If so, the individual will be asked to provide information about the available ESHI insurance coverage. In the interim, individuals determined eligible for FHPlus will be enrolled, or continue to be enrolled, in a FHPlus plan.

b) For those individuals with access to qualified and cost effective ESHI, including state or local government employees, enrollment into the ESHI is required in order for the individual to maintain access to FHPlus eligibility and benefits. However, individuals will not be forced to disenroll from their FHPlus plan until they can enroll in their ESHI Program (during an ESHI open enrollment period or after a required "waiting period").

c) The state will subsidize the premiums for this coverage and reimburse any deductibles and co-pays, to the extent that the co-pays exceed the amount of the enrollee's co-payment obligations under FHPlus.

d) The state will pay for any FHPlus benefits not covered by the enrollee's ESHI for enrollees of the FHP-PAP when they obtain services from a Medicaid provider.

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

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

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

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

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

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

d) The protocols for facilitated enrollment practices between the LDSS and the facilitated enrollers must:
   i. Ensure that choice counseling activities are closely monitored to minimize adverse risk selection; and
   ii. Specify that determinations of Medicaid eligibility are made solely by the LDSS.

VI. DELIVERY SYSTEMS

38. **Contracts.** Procurement and the subsequent final contracts developed to implement selective contracting by the state with any provider group shall be subject to CMS approval prior to implementation.

    Payments under contracts with public agencies, that are not competitively bid in a process involving multiple bidders, shall not exceed the documented costs incurred in furnishing covered services to eligible individuals (or a reasonable estimate with an adjustment factor no greater than the annual change in the consumer price index).

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

40. **Interpretation Services and Culturally Competent Care**. The MCOs must have interpretation services and provide care that is consistent with the individual's culture. MCOs must conduct analyses to determine any gaps in access to these services and will expand its workforce accordingly. The MCOs may also require the use of remote video and voice technology when necessary.

41. **Managed Care Benefit Package.** Individuals enrolled in either MMMC or MLTC must receive from the managed care program the benefits as identified in Attachments A or B, as appropriate. As noted in plan readiness and contract requirements, the state must require that, for enrollees in receipt of LTSS, each MCO/PIHP coordinate, as appropriate, needed state plan services that are excluded from the managed care delivery system but available through a fee-for-service delivery system, and must also assure coordination with services not included in the established benefit package.

42. **Revision of the State Quality Strategy.** The state must update its Quality Strategy to reflect all managed care plans operating under MMMC and MLTC programs proposed through this Demonstration and submit to CMS for approval within 90 days of approval of the April 20133 amendment, which will include the health system for individuals with developmental disabilities goals. The state must obtain the input of recipients and other stakeholders in the development of itsits revised comprehensive Quality Strategy and make the Strategy available for public comment. The state must revise the strategy whenever significant changes are made, including changes through this Demonstration. Pursuant to STC 74, the state must also provide CMS with annual reporting on the implementation and effectiveness of the updated comprehensive Quality strategy, as it impacts Pursuant to STC 74, the state must also provide CMS with annual reporting on the implementation and effectiveness of the updated comprehensive quality strategy, as it impacts the demonstration.

43. **Required Components of the State Quality Strategy.** The revised Quality Strategy shall meet all the requirements of 42 CFR 438 Subpart D. The quality strategy must include components relating to managed long term services and supports. The Quality strategy must address the following regarding the population utilizing long term services and supports: level of care assessments, service planning, and health and welfare of enrollees. The state should also incorporate performance measures for outcomes related to quality of life and community integration related to health system transformation for individuals with developmental disabilities.

44. **Required Monitoring Activities by State and/or EQRO.** The state's EQR process for the mainstream managed care and MLTC plans shall meet all the requirements of 42 CFR 438 Subpart E. In addition, the state, or its EQRO shall monitor and annually evaluate the MCO/PIHPs performance on specific new requirements under mandatory enrollment of individuals utilizing long term services and supports. The state shall provide an update of the processes used to monitor the following activities as well as the outcomes of the monitoring activities within the annual report in STC 74. The new requirements include, but are not limited to the following:

    a) MLTC Plan Eligibility Assessments – to ensure that approved instruments are being used and applied appropriately and as necessary, and to ensure that individuals being served with LTSS meet the MLTC plan eligibility requirements for plan enrollment . The state will also monitor assessments conducted by the plan where individuals are deemed ineligible for enrollment in an MLTC plan.
    b) Service plans – to ensure that MCOs/PIHPs are appropriately creating and implementing service plans based on enrollee's identified needs.
    c) MCO/PIHP credentialing and/or verification policies – to ensure that LTSS services are provided by qualified providers.
    d) Health and welfare of enrollees – to ensure that the MCO/PIHP, on an ongoing basis, identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation.

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

permitted to set these standards.

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

    a) The state must verify these assurances by reviewing demographic, utilization and enrollment data for enrollees in the Demonstration as well as:
        i. The number and types of providers available to provide covered services to the Demonstration population;
        ii. The number of network providers accepting the new Demonstration population; and
        iii. The geographic location of providers and Demonstration populations, as shown through GeoAccess, similar software or other appropriate methods.

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

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

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

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

VII. QUALITY DEMONSTRATION PROGRAMS AND CLINIC UNCOMPENSATED CARE FUNDING

49. **Hospital-Medical Home (H-MH) Demonstration**. The purpose of this demonstration is to improve the coordination, continuity, and quality of care for individuals receiving primary care in hospital outpatient departments operated by teaching hospitals, as well as other primary care settings used by teaching hospitals to train resident physicians. The demonstration will be instrumental in influencing the next generation of practitioners in the important concepts of patient-centered medical homes. Training sites, in particular, due to the structural discontinuity imposed by rotating residents and attending physicians' schedules, present a significant opportunity to improve patient experience and care through residency redesign.

    During this extension period, entities that serve as clinical training sites for primary care residents

will work toward transforming their delivery system consistent with the National Committee on Quality Assurance (NCQA) requirements for medical home recognition under its Physician Practice Connections® - Patient-Centered Medical Home™ program (PPC®-PCMH™) and the 'Joint Principles' for medical home development articulated by primary care professional associations.

In addition, hospitals which receive funding under this demonstration shall be required to implement a number of patient safety and systemic quality improvement projects.

50. **H-MH Demonstration Eligibility and Selection.** All teaching institutions in New York State will be eligible to participate in the H-MH demonstration. However, because the state does not intend to use a public competitive process to select awardees, the selection criteria for the H-MH demonstration will include for each:

    a) The extent to which the hospital has existing arrangements with training sites in the community (such as federally qualified health centers) to provide clinical experience to its primary care residents;
    b) An attestation as to their willingness and commitment to accomplish all milestones outlined in STC 51, including achieving NCQA PPC®-PCMH™ Level 2 recognition or above (in accordance with the standards applicable at the time that recognition is awarded) by the end of the second year of the demonstration;
    c) An agreement to track and report the clinical performance metrics required in STC 52; and
    d) An agreement to implement both the system improvement and patient safety initiatives consistent with STCs 53 and 54.

    To ensure that a mix of both academic medical centers and community teaching hospitals receive awards under the H-MH demonstration, the Department must submit its recommendations (along with proposed award amounts) to CMS for review before making final awards. An institution that already has achieved at least PPC®-PCMH™ Level 2 recognition under an earlier set of NCQA standards may participate if its goal is to renew or upgrade its recognition under later, more stringent NCQA standards.

51. **H-MH Milestones related to achievement of National Committee for Quality Assurance (NCQA) PPC®-PCMH™ for all awardees**. The key milestone for receiving demonstration funding will be the achievement of NCQA PPC®-PCMH™ Level 2 or Level 3 recognition within two (2) years from the start date of the program. The state will receive from NCQA a monthly 'roster' of practices, which have achieved NCQA PPC®-PCMH™ Level 2 or Level 3 recognition. In the interim, programs must demonstrate the achievement of the following milestones throughout the duration of the project:

    a) **A detailed work plan after award.** Each awardee must submit a redesign strategy and detailed work plan to the state that documents how funds will be used for the following approved purposes: consultation services for practice re-design; staff development activities to support 'team' design to assuring continuity of care for patients; activities associated with curriculum changes; workforce retraining and retooling, and NCQA certification costs. The work plan must also

        i. indicate the clinical performance metrics that will be used (as discussed in STC 52 below),

and provide baseline rates for each measure,

ii. describe how the awardee will implement the H-MH System Improvement Initiatives described in STC 53, and

iii. indicate which H-MH Quality and Safety Improvement Projects that the awardee will undertake, along with associated milestones (see STC 54).

b) **Baseline assessment within six months.** Each awardee must submit a formal baseline assessment to the state (using the NCQA tool or one developed by a primary care professional organization) that compares current practice with NCQA standards, along with a revised work plan and timeline.

c) **Interim report at the end of year 1.** Each awardee must submit to the state a report of interim progress in meeting the first year milestones and goals identified through the baseline assessment tool with revised plan as appropriate.

d) **MH recognition.** Each awardee must achieve NCQA PPC®-PCMH™ Level 2 or Level 3 recognition, using 2011 standards, by the end of year 2.

52. **H-MH clinical performance metrics for years 2 and 3.** Each awardee must develop at least five clinical performance metrics which shall be consistent with the standardized measures used by the New York State Department of Health in its Quality Assurance Reporting Requirements (QARR) system and/or meaningful use measures and relevant to the population being served, for internal practice measurement and improvement. Baseline and yearly rates for each measure must be submitted in the annual progress reports.

53. **H-MH System Improvement Initiatives**. Each awardee's project work plan and subsequent progress reports must incorporate the awardee's strategy for accomplishing the implemented initiatives as well as the milestones to measure success.

a) Each awardee must implement an initiative to restructure operations to enhance patients' continuity of care experience in conjunction with developing a patient centered medical home.

Awardees shall extend the ambulatory, continuity training experience of residents within the limits of residency requirements from the Residency Review Committee of the Accreditation Council for Graduate Medical Education. This could be accomplished by increasing the number of continuity training sites, expanding sites beyond the hospital environment (if the program is based in a hospital), increasing resident time in ambulatory settings, or other activities or combinations of approaches. These sites would also be required to provide care consistent with medical home requirements and achieve formal recognition within two years of program start date. The project work plan must include:

i. A method for objective measurement of progress which may include number of new continuity sites, percent increase in ambulatory training experience for residents;

ii. How these activities will support core activities of medical home transformation; and iii. How these restructuring changes will be sustained following the termination of the demonstration.

b) Further, each awardee must select at least one of the following four initiatives to implement during the grant award period:

i. Care Transitions/Medication Reconciliation Programs. Hospital awardees may be ideally suited to coordinate care between inpatient and outpatient settings given that they are frequently the same providers of care. This initiative would allow programs to develop a better 'bridge' for this transition, particularly with respect to medication reconciliation and management but also for outpatient primary and specialty care follow up. While the methods and staffing used to improve coordination could vary, all proposals must incorporate the evidence-based components of effective medication reconciliation. Programs would be required to:

A) Develop a registry of patients who have participated (directly through contact/outreach or indirectly through shared electronic information or medication lists) in medication reconciliation. The registry must contain sufficient unique identifiers to enable linkage to Medicaid claims data and be completed by the end of Year 1.

B) Participate as needed (sharing lists), with the Department, in periodic evaluation of readmissions and other utilization and quality metrics for patients receiving care transition/medication reconciliation services including the tracking of quarterly progress either on pilot unit or hospital wide.

C) Develop standardized clinical protocols for communication with patients/families during and post-discharge and care transition processes focused on most common causes of avoidable readmissions.

D) Develop integrated information systems between hospital inpatient and outpatient sites to enable improved continuity and follow up care.

E) Create system to identify patients at highest risk of subsequent avoidable hospitalization and create a patient stratification approach to allocation of resources to facilitate community linkages including primary and specialty care services.

ii. Integration of Physical-Behavioral Health Care. Medicaid has a large number of members with co-existing physical and mental health/substance abuse co-morbidities. Optimal care requires integration of services and providers so that care is coordinated and appropriate for the well-being of the entire person, not just for a single condition. There are many barriers between behavioral and physical health care including different providers, varying locations, multiple agencies, confidentiality rules and regulations, historic lack of communication between providers, and more. This initiative will require training programs to find ways to integrate care for their patients with behavioral health conditions within the medical home. The project work plan must include details on:

A) A strategy for integration which includes a means of improving referrals to behavioral health providers, enhanced communication with mental health/substance abuse providers, processes for obtaining appropriate consents for sharing personal health information, and procedures for coordinated case management (particularly for cases in which patients may have more than one provider).

B) Developing a linkage to the Office of Mental Health Psychiatric Services and Clinical Knowledge Enhancement System (PSYKES) project, which provides data and recommendations for potential problems of polypharmacy and metabolic syndrome exacerbation for Medicaid members using Medicaid databases within the first year of the program start date. The linkage will require creating systems to receive, and act on, reports generated by PSYKES. The linkage must be completed by the end of Year 1.

C) Developing training for primary care clinicians in behavioral health care with particular focus on integrating depression screening and pain management with appropriate treatment modalities and referral.

D) Assessing demand and capacity to provide co-located services or other approaches to decrease wait times and improve access to behavioral health services.

iii. Improved Access and Coordination between Primary and Specialty Care. There is a tremendous opportunity to promote access and coordination between primary and specialty providers who are both providing care within the same delivery system, often in close physical proximity. Despite that opportunity, there are many examples in which the level of coordination is suboptimal, having the greatest adverse impact on those patients with more advanced, chronic diseases.

A) Programs will be required to put into place systems that would facilitate the ready access to specialty care when appropriate, with improved bilateral communication between primary and specialty care providers/clinics through transparent, standardized, referral processes. Specific goals include improving timely access to specialists, completed referral forms with required clinical information and reason(s) for referral, timely response of findings/recommendations from the specialist and higher rates of satisfaction on the part of providers and patients with respect to specialty care services.

B) Programs will be required to generate measures of access and coordination. These measures should be incorporated into a baseline assessment and annual evaluations and include patient and provider experiences related to wait times, follow up with primary care provider after specialty visit (as appropriate), delayed or rejected referrals, patient/provider satisfaction.

C) Identify gaps in care and coordination for specialty services including collection of baseline data on wait times and appointment backlogs; survey primary care providers and specialists regarding the referral process and access and develop improvement plan based on findings with at least quarterly data collection, which will consider expansion of selected specialists, training of primary care providers in provision of select low level specialty care, inclusion of specialists in team care, protocols for primary-specialty care co-management.

iv. Enhance Interpretation Services and Culturally Competent Care.

A) Programs will conduct an analysis to determine gaps in access to language services, and implement language access policies and procedures

B) Programs may expand workforce within interpreter services by hiring, training, and/or certifying interpreters, or determining other methods for increasing patients' access to appropriate language services.

C) Programs may include use of remote video and voice technology for instantaneous qualified health care interpretations

D) Develop programs to improve staff cultural competence and awareness through evidence based training.

E) Develop capacity to generate prescription labels in patient's primary language with easy to understand instructions.

54. **H-MH Quality and Safety Improvement Projects (QSIP).** In addition, each awardee shall implement at least two of the six Quality and Safety Improvement Projects outlined in this STC.

These QSIPs will include interventions that have been demonstrated to produce measurable and significant results across different types of hospital settings, including in safety net hospitals; have a strong evidence base, meaning interventions that have been endorsed by a major national quality organization, with reasonably strong evidence established in the peer reviewed literature, including within the safety net; and are meaningful to hospital patients.

An awardee is precluded from choosing any QSIP for which it has achieved top performance for at least 4 consecutive quarters, in aggregate in all process and outcomes measures within the intervention, where "top performance" is defined as being in the Top Quartile. Each QSIP below has specific measures that an awardee must include; however, awardees may include additional milestones to enable the implementation of the measures specified for the intervention.

Milestones for the QSIPs can include infrastructure, redesign, implementation of evidence-based processes, and measurement and achievement of evidence-based outcomes. Awardees must include for each year a milestone for reporting the data on each QSIP to the Department. Improvement Targets will be determined based on the progress an awardee has already made on the improvement project pursuant to baseline data collected as of January 1, 2012. The 3-year end goals for each measure will be to move from one performance band to the next, except in the case of hospitals that are in the Top Band where the goal will be to move into the Top Quartile. Hospitals will be placed in one of 3 bands based on baseline performance as compared to state or national data on hospital performance, including safety net hospital performance, as follows:

- "Lower band" performers, as defined as the bottom one-third (1-33 percentile) of hospitals, will target moving into the middle-third performance band;
- "Middle band" performers, as defined as the middle third (34-65 percentile) of hospitals, will target moving into the top performance band; and
- "Top band" performers, as defined as the top third (66-100 percentile) of hospitals, will target moving into the top quartile.

Hospitals that have achieved performance in the top quartile will be expected to maintain or exceed top performance.

a) Severe Sepsis Detection and Management
   i. *Elements*
      (A) Implement the Sepsis Resuscitation Bundle: to be completed within 6 hours for patients with severe sepsis, septic shock, and/or lactate > 4mmol/L (36mg/dl).
      (B) Implement the Sepsis Management Bundle: to be completed within 24 hours for patients with severe sepsis, septic shock, and/or lactate > 4 mmol/L (36 mg/dl).
      (C) Make the elements of the Sepsis Bundles more reliable.

   ii. *Key Measures*
      (A) Percent compliance with four elements of the Sepsis Resuscitation Bundle, as measured by percent of hospitalization with sepsis, severe sepsis or septic shock and/or an infection and organ dysfunction where targeted elements of the Sepsis Resuscitation Bundle were completed.
      (B) Sepsis mortality

b) Central Line-Associated Bloodstream Infection (CLABSI) Infection Prevention

i. *Elements*
   (A) Implement the central line bundle
   (B) Make the process for delivering all bundle elements more reliable

ii. *Key Measures*
   (A) Compliance with Central Line Bundle
   (B) Central Line Bloodstream Infections

c) Surgical Complications Core Processes (SCIP)
   i. *Elements*
      (A) Surgical site infection prevention
      (B) Beta blockers continuation
      (C) Venous Thromboembolism (VTE) prophylaxis

   ii. *Key Measures*
      (A) SCIP Composite Process Measure:
         1) SCIP-Inf-2: Prophylactic antibiotic selection for surgical patients
         2) SCIP-Inf-3: Prophylactic antibiotics discontinued within 24 hours after surgery end time/48 hours for cardiac patients
         3) SCIP-Inf-4: Cardiac surgery patients with controlled 6 a.m. postoperative serum glucose
         4) SCIP-Inf-6: Surgery patients with appropriate hair removal
         5) SCIP-Inf-9 : Urinary catheter removed on postoperative day 1 (POD 1) or postoperative day 2 (POD 2) with day of surgery being day zero
         5) SCIP-Card- 2: Surgery patients on a beta-blocker prior to arrival who received a beta-blocker during the perioperative period
         7) SCIP-VTE-1: Surgery patients with recommended venous thromboembolism prophylaxis orderedSCIP-VTE-2: Surgery patients who received appropriate venous thromboembolism prophylaxis within 24 hours prior to surgery to 24 hours after surgery
      (B) Rate of surgical site infection for Class 1 and 2 wounds within 30 days of surgery

d) Venous Thromboembolism (VTE) Prevention and Treatment
   i. *Elements*

      (A) Provide appropriate VTE Prophylaxis, including pharmaceutical and mechanical approaches based on national guidelines

   ii. *Key Measures*

      (A) VTE Discharge Instructions
      (B) VTE Prophylaxis

e) Neonatal Intensive Care Unit (NICU) Safety and Quality
   i. *Elements*

      (A) Participation in Vermont Oxford Network (VON) quality/safety measurement and improvement activities or New York State Obstetric and Neonatal Quality Collaborative (NYSONQC) sponsored Neonatal Enteral Nutrition Project and Statewide Collaborative to decrease NICU central line associated bloodstream infections.

(B) Assess current areas of need for performance improvement based on relative performance of hospital NICU to VON benchmarks and/or state level performance.
(C) Develop improvement projects (at least 2 which may include, but is not limited to, enteral nutrition or central line projects above) focusing on areas of greatest need making use of VON network quality improvement strategies and/or other evidence based care bundles.

ii. *Key Measures*. Use of appropriate metrics for quality, safety, morbidity, complications, and risk adjusted mortality based on improvement project, including but not limited to:
(A) Nosocomial sepsis rates (per 1000 patient days) from NYS NICU Module;
(B) Central line associated bloodstream infection rates per 1000 central line days using the NYS hospital acquired infection data reporting system;
(C) Maintenance checklist use per total number of days of central line use; and
(D) Percent infants discharged from NICU at less than 10th percentile weight born <31 weeks gestation.

f) Avoidable Preterm Births: Reducing Elective Delivery Prior to 39 Weeks Gestation
i. *Elements:* Use of evidence based interventions for evaluation, measurement, and improvement of preventable preterm births using findings from NICHQ/CMS Neonatal Outcomes Improvement Project and/or California Toolkit to Transform Maternity Care:
(A) Identification and treatment of chronic medical conditions and high risk behaviors
(B) Early identification of mothers at high risk for preterm delivery
(C) Use of antenatal steroids in appropriate patients
(D) Reducing elective inductions/cesarean sections without appropriate medical or obstetric indication
ii. *Key Measures*
(A) Percent of scheduled inductions at 36(0/7) to 38(6/7) weeks without medical or obstetrical indication documented of all scheduled deliveries
(B) Percent of scheduled inductions at 36(0/7) to 38(6/7) weeks without medical or obstetrical indication documented of all scheduled inductions
(C) Percent of scheduled C-sections at 36(0/7) to 38(6/7) weeks without medical or obstetrical indication documented of all scheduled deliveries
(D) Percent of scheduled C-sections at 36(0/7) to 38(6/7) weeks without medical or obstetrical indication documented of all scheduled C-sections
(E) Percent of all scheduled deliveries at 36(0/7) to 38(6/7) weeks without medical or obstetrical indication documented of all scheduled deliveries
(F) Percent of infants born at 36(0/7) to 38(6/7) weeks gestation by scheduled delivery who went to neonatal intensive care unit
(G) Percent of mothers informed about risks and benefits of scheduled deliveries 36(0/7) to 38(6/7) weeks gestation documented in the medical record
(H) Percent scheduled deliveries at 36(0/7) to 38(6/7) weeks that have documentation in the medical record of meeting optimal criteria of gestational age assessment
(I) IHI Elective Induction Bundle Elements: Percentage of times that all four of the following elements are in place:
1) gestational age >/= 39 weeks
2) monitor fetal heart rate for reassurance of fetal status

3) pelvic exam: assess to determine dilation, effacement, station, cervical position and consistency, and fetal presentation
4) monitor and manage hyperstimulation (tachysystole).

55. **H-MH Funding Distribution**. Awardees will receive demonstration funds based on the number of Medicaid recipients served and the number of primary care residents trained. Eighty percent of an awardee's funds will be based on Medicaid patient volume and twenty percent will be based on primary care residents trained in that facility. The formula will be proportionally allocated using these criteria. Facilities will not be included if they do not satisfy the requirements for one of the supplemental program initiatives. Full or partial funding is contingent on achieving each year's goals. *In no instance will an awardee receive funding beyond year 2 unless the awardee has achieved NCQA PPC®-PCMH™ Level 2 or Level 3 recognition.*

a) **Year 1 Funds**. Each awardee will receive one-fourth of the first year's funding amount upon award. The remaining first year payment will be issued once the awardee has documented that the applicable first-year program milestones (as stipulated in STC 51 (a), (b), and (c) above) have been met. If the first year milestones are not met by the end of year 1, the awardee will forfeit the remaining funding for that year but would be allowed to continue to work toward meeting the milestones and eligible for subsequent year funding.

b) **Year 2 Funds**. Each awardee will receive one-fourth of the second year's funding amount upon completion of the applicable year one milestones. Upon achieving NCQA PPC®-PCMH™ Level 2 or Level 3 accreditation, the remainder of the second year's funds will be made available, provided all other requirements for Quality Service Improvement Programs (QSIP) projects are up to date. If an awardee does not achieve accreditation by the end of year two or, for a hospital awardee, make progress on the additional initiatives that are required as a condition of funding, the remainder of year two funding will be forfeited.

c) **Year 3 Funds**. Third year funding will be provided only to awardees that have achieved NCQA PPC®-PCMH™ Level 2 or Level 3 recognition and, for hospital awardees, meet the applicable milestones for the additional initiatives as stipulated in the hospital's approved work plan. Awardees will receive one-fourth of the funding amount at the start of the year and the remainder after submission of the third year milestones.

56. **H-MH Reporting**.

a) The state shall include updates on activities related to the H-MH demonstration in the quarterly operational reports required under STC 73 including updated expenditure projections reflecting the expected pace of disbursements under the demonstration.

b) The state shall provide an assessment of the H-MH demonstration by summarizing each awardee's activities during the demonstration year in each annual report required under STC 74.

c) The state shall include an assessment of the success of the H-MH demonstration in the evaluation required by STC 97 including the milestones in STC 51(c), the hospital improvement projects in STC 50(d) as well as the outcome measures for each supplemental program initiative implemented by the awardees.

57. **Potentially Preventable Readmissions (PPR) Demonstration.** The purpose of this demonstration

is to test strategies for reducing the rate of preventable readmission within the Medicaid population, with the related longer-term goal of developing reimbursement policies that provide incentives to help people stay out of the hospital. It is intended to assist hospitals with reducing the rate of PPRs in advance of the implementation of the Hospital Readmissions Reduction Program (authorized by section 3025 of the Patient Protection and Affordable Care Act) on October 1, 2012. Beginning with FFY 2012, hospitals will face reductions in Medicare payments if they have readmission rates higher than what would be expected for specific conditions.

Hospitals will be asked to devise unique strategies that target each hospital's particular experiences, strengths, weaknesses and patient profile. Projects will focus on improved quality and cost savings and will include reporting and evaluation components to ensure that the projects are replicable and sustainable. Activities will include a review of policies and operational procedures that may be contributing to high rates of avoidable readmissions; reengineering the discharge planning process; and appropriate management of post-hospital/transition care; coordination with outpatient and post-discharge providers, including institutions and community providers, to address transitional care needs.

a) Eligibility. All hospitals in the state will be eligible to participate in the PPR demonstration.

b) Selection. The state will develop and issue a Request for Grant Application (RGA). Awards will be made based on the published criteria in the RGA, and funding will be made available over the demonstration extension period as specified in the RGA. The RGA shall also include requirements for evaluating the success of the implemented strategies.

c) Reporting.

i. Once grantees are in place, the state shall include in the quarterly operational report required under STC 73, the following information:
   (A) A summary of the interventional strategies each grantee intends to implement;
   (B) Baseline assessment of each grantee's readmission rate;
   (C) Interim assessments (as data is available) of each grantee's success in reducing PPRs; and
   (D) Updated expenditure projections reflecting the expected pace of disbursements under the demonstration.

ii. The state shall provide a progress report in the implementation of the PPR demonstration in each annual report required under STC 74.

58. **Clinic Uncompensated Care Funding.** The state currently provides grants to voluntary, non-profit and publicly-sponsored Diagnostic and Treatment Centers (D&TCs) for services delivered to the uninsured throughout the state through the Indigent Care Pool (ICP). In 2008, there were 64 voluntary and 13 public D&TCs eligible for Indigent Care pool funding located in 21 counties of the state. Of the 64 voluntary D&TCs, 54 facilities are Federally Qualified Health Centers (FQHCs). Beginning in demonstration year 13, 176 mental health clinic providers are now eligible for ICP grants. This program will allow the state to double the amount of grants provided through the ICP.

a) Eligibility. In order to receive ICP funds, each facility must provide a comprehensive range of primary health care or mental health care services; have at least 5 percent of their visits

providing services to uninsured individuals; and have a process to collect payments from third-party payers.

b) Reporting.

i. The state shall include updates on activities related to ICP grants in each quarterly operational report required under STC 73, including the extent to which actual expenditures for the grants are consistent with projections.

ii. The state shall also include the following information on each facility which received a grant in each demonstration year in annual report required under STC 74:
(A) The total amount of ICP funds awarded;
(B) The total amount of funding that each clinic received from other federal agencies, including but not limited to, the Health Resources and Services Administration and the Substance Abuse and Mental Health Services Administration;
(C) The extent to which the clinic participates in any medical home initiative, including a summary of the initiative;
(D) The extent to which the clinic has implemented certified electronic health records (EHRs) for its patients; and
(E) The number of providers practicing predominantly within a Federally Qualified Health Centers (FQHC) grantee who are "meaningful users" of certified EHRs consistent with 42 CFR 495.6.

59. **Funding for Quality Demonstrations and Clinic Uncompensated Care**. Federal funds will be used to pay the full cost of these programs. Accordingly, Federal Financial Participation (FFP) will be available for state funds for the Indigent Care Pool (beginning August 1, 2011 and ending December 31, 2013) and the Designated State Health Programs (DSHP) described in STC 60 (beginning August 1, 2011 and ending December 31, 2014), as certified on each quarterly CMS Form 64 expenditure reports.

a) Limitations on FFP.

i. FFP is limited to no more than $477.2million over the demonstration extension period as follows:
(A) $325 million for the H-MH demonstration;
(B) $20 million for the PPR demonstration; and
(C) $132.2 million for the ICP, but only to the extent that the state appropriates and expends at least $132.2 million over the extension period. Otherwise, FFP for the ICP may be no more than one-half of total ICP spending (both federal and state funds).

ii. The state shall be eligible to receive FFP over the demonstration period for its own expenditures for:
(A) The Indigent Care Pool (for ICP expenditures made between August 1, 2011 and December 31, 2013); and
(B) DSHP (for DSHP expenditures made between August 1, 2011 and December 31, 2014).

b) Reporting.

i. Updated expenditure projections shall be provided by the state in each quarterly operational report required under STC 73.

ii. Expenditure Reporting for the H-MH demonstration. DSHP expenditures used to draw down federal funds for the H-MH demonstration shall be reported on the CMS-64 under waiver name MH Demo – DSHP.

iii. Expenditure Reporting for the PPR demonstration. DSHP expenditures used to draw down federal funds for the PPR demonstration shall be reported on the CMS-64 under waiver name PPR Demo – DSHP.

iv. Expenditure Reporting for Clinic Uncompensated Care.
(A) The state's own expenditures for ICP grants shall be reported on the CMS-64 under waiver name ICP – Direct.
(B) DSHP expenditures used to draw down federal funds for Clinic Uncompensated Care shall be reported on the CMS-64 under waiver name ICP – DSHP.

c) Reconciliation and Recoupment. By the end of the demonstration extension period, if the amount of DSHP claimed over the demonstration period results in the state receiving FFP in an amount greater than what the state actually expended for quality demonstrations and clinic uncompensated care, the state must return to CMS federal funds in an amount that equals the difference between claimed DSHP and actual state expenditures made for these initiatives.

i. As part of the annual report required under STC 74, the state will report both DSHP claims and expenditures to date for the quality demonstrations and clinic uncompensated care.

ii. The reported claims and expenditures will be reconciled at the end of the Demonstration with the state's CMS-64 submissions.

iii. Any repayment required under this subparagraph will be accomplished by the state making an adjustment for its excessive claim for FFP on the CMS-64 by entering an amount in line 10(b) of the Summary sheet equal to the amount that equals the difference between claimed DSHP and actual expenditures made for these initiatives during the extension period.

60. **Designated State Health Programs**. Subject to the conditions outlined in STC 61, FFP may be claimed for expenditures made for the following designated state health programs beginning August 1, 2011 through December 31, 2014:

a) Homeless Health Services

b) HIV-Related Risk Reduction

c) Childhood Lead Poisoning Primary Prevention

d) Healthy Neighborhoods Program

e) Local Health Department Lead Poisoning Prevention Programs

f) Cancer Services Programs

g) Obesity and Diabetes Programs

h) TB Treatment, Detection and Prevention

i) TB Directly Observed Therapy

j) Tobacco Control

k) General Public Health Work

l) Newborn Screening Programs

61. **Designated State Health Programs (DSHP) Claiming Process.**

a) Documentation of each DSHP's expenditures must be clearly outlined in the state's supporting work papers and be made available to CMS.

b) Federal funds must be claimed within two years after the calendar quarter in which the state disburses expenditures for the DSHPs in STC 60. Claims may not be submitted for state expenditures disbursed after December 31, 2014.

c) Sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. To the extent that federal funds from any federal programs are received for the DSHP listed in STC 60, they shall not be used as a source of non-federal share.

d) The administrative costs associated with DSHPs in STC 60 and any others subsequently added by amendment to the Demonstration shall not be included in any way as Demonstration and/or other Medicaid expenditures.

e) Any changes to the DSHPs listed in STC 60 shall be considered an amendment to the Demonstration and processed in accordance with STC 7.

VIII. HEALTH SYSTEM TRANSFORMATION FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES

62. Health System Transformation for Individuals with Developmental Disabilities. Beginning April 1, 2013, FFP may be claimed for expenditures made for the designated state health programs (DSHP) listed in STC 66. The receipt of expenditure authority for the period of April 1, 2013 to March 31, 2014, is contingent upon the state's compliance and CMS' receipt the deliverables listed below, each quarter, with respect to health system transformation for individuals with developmental disabilities ("Transformation"). More detailed information about the transformation and the deliverables can be found in Attachment H:

Table 10 –Transformation Deliverables Schedule

Deliverable	Reference	Deliverable Date
State Fiscal Year 2014/ Demonstration Year Quarter 1 DSHP		
Money Follows the Person operational protocol	Attachment H #1	April 1, 2013
1915(b)/(c) application	Attachment H #3	April 1, 2013
As part of the 1915 (b)/(c) amendment, Pathways to Employment Services	Attachment H #5(d)	April 1, 2013

Deliverable	Reference	Deliverable Date
Report on the baseline count of enrollees receiving supported employment and the number of people in competitive employment	Attachment H #5(a)	April 1, 2013
Submit educational/training materials for participant self-direction	Attachment H #6(b)	May 1, 2013
1915(c) amendment request(s), to increase reserved HCBS capacity	Attachment H #3(b)	May 1, 2013
Draft cost-containment strategy	STC #63	June 1, 2013
No new admission to sheltered workshops	Attachment H #5(b)	July 1, 2013
1,500 stakeholders educated on self-direction	Attachment H #6(b)	July 1, 2013
Report on the baseline number of individuals who self-direct their services	Attachment H #6(e)	July 1, 2013
Draft timeline for transitioning remaining residents of campus based and non-campus based ICFs into community settings	Attachment H #4(c)	July 1, 2013
Draft evaluation design	STC #65	July 1, 2013
Quality strategy	STC #42	July 1, 2013
7 residents transitioned out of Finger Lakes and Taconic ICFs	Attachment H #3(a)(i)	July 1, 2013
State Fiscal Year 2014/ Demonstration Year Quarter 2 DSHP		
Draft accountability plan	STC #64	August 1, 2013
Final accountability plan and evaluation design	STC #64 & #65	No later than 60 days after receiving CMS comments
Approved transformation DSHP claiming protocols	STC #66(b)	DSHP will be effective upon approval by CMS; no deadline
Progress on CQL	Attachment H #3(a)(iv)(6)	September 1, 2013
Balancing Incentive Program work plan	Attachment H #2	September 1, 2013
350 new beneficiaries self-directing services	Attachment H #6(e)	October 1, 2013
1,500 stakeholders educated on self-direction	Attachment H #6(b)	October 1, 2013
20 people transitioned from the Finger Lakes and Taconic ICFs	Attachment H #4(a)(ii)	October 1, 2013
Documentation that at least 250 people are enrolled in competitive employment	Attachment H #5(a)	October 1, 2013
Finalized timeline for residential transitions	Attachment H #4(c)	October 1, 2013

Deliverable	Reference	Deliverable Date
Draft transformation plan for increasing competitive employment	Attachment H #5(c)	October 1, 2013
State Fiscal Year 2014/ Demonstration Year Quarter 33 DSHP		
425 new beneficiaries self-directing services	Attachment H #6(e)	January 1, 2014
1,500 stakeholders educated on self-direction	Attachment H #6(b)	January 1, 2014
121 people transitioned from Finger Lakes and Taconic ICFs	Attachment H #4(a)	January 1, 2014
44 persons transitions from Finger Lakes and Taconic ICFs will qualify for MFP	Attachment H #4(b)	January 1, 2014
State's policies on self-direction	Attachment H #6(f)	January 1, 2014
Final competitive employment plan	Attachment H #5(c)	January 1, 2014
New York will adopt practice guidelines for care coordinators based on the Council on Quality and Leadership (CQL) personal outcome measures and will annually assess managed care quality using personal outcome data	Attachment H #3(a)(iv)(6)	January 1, 2014
Independent Consumer Report Program	STC 28(c)	January 1, 2014
State Fiscal Year 2014/ Demonstration Year Quarter 4 DSHP		
470 new beneficiaries self-directing services	Attachment H #6(e)	April 1, 2014
1,500 stakeholders educated on self-direction	Attachment H #6(b)	April 1, 2014
Increase in the persons engaged in competitive employment, through Supported Employment, by 700 persons above the previous 12 month enrollment	Attachment H #4(b)	April 1, 2014
Deliverables Due Each Quarter		
Specific transition information for residents of Finger Lakes and Taconic ICFs including residential settings (occurring over the course of the transition)	Attachment H #4(b)	Each Quarter
Progress for increasing availability of supporting housing options	Attachment H #4(d)	Each Quarter

Deliverable	Reference	Deliverable Date
Progress toward increasing number of individuals engaged in competitive employment	Attachment H #5(a)	Each Quarter
Number of individuals remaining in sheltered workshops	Attachment H #5(b)	Each Quarter
Number of participant self-direction training/education sessions conducted and number of enrollees attending each session	Attachment H #6(b)	Each Quarter
Progress on approved evaluation design	Attachment H #3(a)(iv)(6)	Each Quarter
OPWDD eligible students aging out of educational system	Attachment H #5(d)	Quarter 4/Annual report

63. **Transformation Cost Containment Strategy.** The state must develop the following attachments to serve as a cost containment strategy to include as an attachment to STCs. The state must submit drafts of the following attachments to CMS no later than June 1, 2013 and submit a final draft no later than 30 days after receiving CMS comments:

a) **Attachment I:** An outline of all services and associated definitions available under the transformation and specifics for how the programs will be impacted by the state's transformation plan.
b) **Attachment J:** How the state must calculate the impact of the transformation. The attachment will outline all of the costs that should be captured in the pre and post transformation implementation. This will assist the state and CMS in tracking whether transformation is being accomplished.
c) **Attachment K**: A demonstration of a return on investment with respect to how transformation in Attachment I will provide savings in the programs funded with federal support of the DSHPs. The state will provide a methodology that will compare the savings to the infusion of federal support dollars through the DSHP.

64. **Accountability Plan**. The state must develop an accountability plan and submit a draft by August 1, 2013. The accountability plan will be a multi-part document that specifies methods used by all parties engaged in transformation activities detailed in Attachment H to achieve quality improvement. The accountability plan will include:

a) **Section A**: Statewide Quality and Access Tests. A plan for how New York will demonstrate that the state is meeting its established quality and access standards in order to evaluate the success of the transformation activities.
b) **Section B**: Measurement Strategy. An outline of the metrics that the state will use to track quality and access over time. These metrics will be used to track MCO performance as well as statewide performance.
c) **Section C**: Quarterly reporting format. An outline of how the DD transformation activities will be reported in Table 10 and incorporated as an update to Attachment E.

CMS will provide comments on the accountability plan and the state must submit a final draft that reflects CMS' comments no later than 60 days after receiving CMS comments.

65. **Evaluation of the Transformation.** The state must develop an evaluation design specific to transformation. The evaluation design must include a discussion of the goals and objectives set forth within the transformation plan and the state must develop evaluation questions specific to the changes being implemented under the transformation plan. A draft evaluation design must be submitted to CMS by July 1, 2013 and the state must submit a final design no later than 30 days after receiving CMS comments. The state shall implement the final evaluation design and submit its progress in each of the quarterly and annual progress reports and submit a final evaluation report no later than June 1, 2014.

66. **Designated State Health Programs (DSHP).** FFP is available as matching of DSHPs described in STC 60paragraph XX.

a) **Designated State Health Programs.** To support the goals of health system transformation, the state may claim FFP for certain state programs expenditures under the following state departments, subject to the annual limits and restrictions described, below from April 1, 2013 through March 31, 2014:

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

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

iii. Office of Alcoholism and Substance Abuse Services
   - a. Outpatient and Methadone Programs
   - b. Crisis Services – Ambulatory
   - c. Prevention and Program Support Services

b) **DSHP Claiming Protocols.** The will develop a CMS-approved DSHP claiming protocol for

which the state will be required to comply with in order to draw down DSHP funds. State expenditures for the DSHP listed in STC 6663(a) must be documented in accordance with the protocols. The state is not eligible to receive federal financial participation until approved by CMS.

i. The state will provide updated information demonstrating that the DSHP are paying for appropriate services to appropriate populations by May 1, 2013 in the format outlined in an attachment that will be developed. Upon receipt of this information, CMS reserves the right to change the amount available for federal match.

ii. The state will clearly identify the sources of non-federal share revenue, full expenditures and rates as specified in Attachment L. This includes those programmatic expenditures for which CMS will not provide expenditure authority for including but not limited to: expenditures for room and board, coverage for undocumented individuals, research, rent and utility subsidies.

iii. The state shall also include a plan of how it will maintain or increase the amount of state funds expended for the DSHP above the SFY 2013 in SFY 2014.

c) **DSHP Claiming Process**.

i. Documentation of each designated state health program's expenditures must be clearly outlined in the State's supporting work papers and be made available to CMS. Documentation support should include but is not limited to the information contained in Attachment L.

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

iii. Federal funds must be claimed within two years following the calendar quarter in which the State disburses expenditures for the designated state health programs in STC 60.

iv. Federal funds are not available for State administrative expenditures disbursed before April 1, 2013 and may not be submitted for services received prior to April 1, 2013.

v. Federal funds are not available for State administrative expenditures disbursed after March 31, 2014 and may not be submitted for services rendered after March 31, 2014.

vi. The State must not draw down federal funds until after the State completes transformation deliverables identified in STC 62 each quarter.

vii. Sources of non-Federal funding must be compliant with section 1903(w) of the Act and applicable regulations. To the extent that Federal funds from any Federal programs are received for the designated state health programs listed in STC 60, they shall not be used as a source of non-Federal share.

viii. The administrative costs associated with programs in STC 66 and any others subsequently added by amendment to the demonstration shall not be included in any way as demonstration and/or other Medicaid expenditures.

ix. Any changes to the designated state health programs listed in STC 66 shall be considered an amendment to the Demonstration and processed in accordance with STC 7.

d) **Available FFP for DSHP**. Up to $250 million in FFP is authorized to pay for DSHP costs during the demonstration period of April 1, 2013 to March 31, 2014.

67. **Reporting Designated State Health Programs Payments Related to Transformation.** The state will report all expenditures for DSHP payments to the programs listed in STC 60 related to transformation activities on the forms CMS-64.9 Waiver and/or 64.9P Waiver under the waiver name DSHP, as well as on the appropriate forms CMS-64.9I and CMS-64PI

68. In the event the state has not met at least 75 percent of its milestones and deliverables, by March 31, 2014:

    a) CMS reserves the right to reduce the percentage of federally matched DSHP costs by an amount equivalent to the costs of unmet projected enrollment until the projected enrollment for this population is met.

    b) The state will submit a plan in the subsequent quarterly report, required in STC 74 to CMS detailing the actions it will undertake to increase enrollment.

69. **Monitoring Designated State Health Programs**. CMS may conduct a review of the DSHP expenditures to assess whether to allow continued expenditure of funds for appropriate services to target populations.

IX. GENERAL REPORTING REQUIREMENTS

70. **General Financial Requirements.** The state must comply with all general financial requirements set forth in section IX.

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

72. **Monthly Calls.** CMS shall schedule monthly conference calls with the state. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the Demonstration. Areas to be addressed include, but are not limited to, MCO operations (such as contract amendments and rate certifications), transition and implementation activities, health care delivery, the FHP-PAP program, enrollment of individuals using LTSS and non-LTSS users broken out by duals and non-duals, cost sharing, quality of care, access, family planning issues, benefits, audits, lawsuits, financial reporting and budget neutrality issues, MCO financial performance that is relevant to the Demonstration, progress on evaluations, state legislative developments, services being added to the MMMC and/or MLTC plan benefit package pursuant to STC 32, and any Demonstration amendments, concept papers, or state plan amendments the state is considering submitting. CMS shall update the state on any amendments or concept papers under review, as well as federal policies and issues that may affect any aspect of the Demonstration. The state and CMS shall jointly develop the agenda for the calls.

73. **Quarterly Operational Reports.** The state must submit progress reports in accordance with the guidelines in Attachment E taking into consideration the requirements in STC 77 and STC 78, no later than 60 days following the end of each quarter (December, March, and June of each demonstration year). The state may combine the quarterly report due for the quarter ending September with the annual report in STC 75. The intent of these reports is to present the state's analysis and the status of the various operational areas.

74. **Annual Report.** The state must submit an annual report documenting accomplishments, project status, quantitative and case study findings, interim evaluation findings, utilization data, and policy and administrative difficulties in the operation of the Demonstration. The state must submit this report no later than 90 days following the end of each Demonstration year. Additionally, the annual report must include:
    a) A summary of the elements included within each quarterly report;
    b) An update on the progress related to the quality strategy as required in STC 42;
    c) An aggregated enrollment report showing the total number of individuals enrolled in each plan
    d) A summary of the use of self-directed service delivery options in the state at the time when those benefits are included in the demonstration;
    e) A listing of the new geographic areas the state has expanded MLTC to;
    f) A list of the benefits added to the managed care benefit package;
    g) An updated transition plan which shows the intended transition and timeline for any new benefits and/or populations into the demonstration;
    h) Network adequacy reporting as required in STC 46;
    i) Any other topics of mutual interest between CMS and the state related to the demonstration; and
    j) Any other information the state believes pertinent to the demonstration.

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

    a) **Seamless Transitions.** Consistent with the provisions of the ACA, the Transition Plan will include details on how the state plans to obtain and review any additional information needed from each individual to determine eligibility under all eligibility groups, and coordinate the transition of individuals enrolled in the Demonstration (by FPL) (or newly applying for Medicaid) to a coverage option available under the ACA without interruption in coverage to the maximum extent possible. Specifically, the state must:

        i. Determine eligibility under all January 1, 2014, eligibility groups for which the state is required or has opted to provide medical assistance, including the group described in §1902(a)(10)(A)(i)(VIII) for individuals under age 65 and regardless of disability status with income at or below 133 percent of the FPL;
        ii. Identify Demonstration populations not eligible for coverage under the ACA and explain what coverage options and benefits these individuals will have effective January 1, 2014;
        iii. Implement a process for considering, reviewing, and making preliminarily determinations under all January 1, 2014 eligibility groups for new applicants for Medicaid eligibility;

        iv. Conduct an analysis that identifies populations in the Demonstration that may not be

eligible for or affected by the ACA and the authorities the state identifies that may be necessary to continue coverage for these individuals; and

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

b) **Access to Care and Provider Payments..**

i. Provider Participation. The state must identify the criteria that will be used for reviewing provider participation in (e.g., demonstrated data collection and reporting capacity) and means of securing provider agreements for the transition.

ii. Adequate Provider Supply. The state must provide the process that will be used to assure adequate provider supply for the state plan and Demonstration populations affected by the Demonstration on December 31, 2013. The analysis should address delivery system infrastructure/capacity, provider capacity, utilization patterns and requirements (i.e., prior authorization), current levels of system integration, and other information necessary to determine the current state of the of service delivery. The report must separately address each of the following provider types:

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

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

c) **System Development or Remediation.** The Transition Plan for the Demonstration is expected to expedite the state's readiness for compliance with the requirements of the Affordable Care Act and other federal legislation. System milestones that must be tested for implementation on or before January 1, 2014 include: Replacing manual administrative controls with automotive processes to support a smooth interface among coverage and delivery system options that is seamless to beneficiaries.

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

e) **Implementation.**

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

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

76. **Reporting Requirements Related to Family Planning Expansion.** In each annual report required by STC 75, the state shall report:

a) The average total Medicaid expenditures for a Medicaid-funded birth each year. The cost of a birth includes prenatal services and delivery and pregnancy-related services and services to infants from birth through age 1. (The services should be limited to the services that are available to women who are eligible for Medicaid because of their pregnancy and their infants.);

b) The number of actual births that occur to FP Expansion participants (participants include all individuals who obtain one or more covered medical family planning services through the Demonstration) each year;

c) Yearly enrollment reports for Demonstration enrollees for each Demonstration Year (DY) (eligibles include all individuals enrolled in the Demonstration); and

d) Total number of participants for each DY (participants include all individuals who obtain one or more covered family planning services through the Demonstration).

77. **Reporting Requirements Related to Individuals using long term services and supports**. In each quarterly report required by STC 74, the state shall report:

a) Any critical incidents reported within the quarter and the resulting investigations as appropriate;
b) The number and types of grievance and appeals for this population filed and/or resolved within the reporting quarter;
c) The total number of assessments for enrollment performed by the plans, with the number of individuals who did not qualify to enroll in an MLTC plan;
d) The number of individuals referred to an MLTC plan that received an assessment within 30 days;
e) The number of people who were not referred by the enrollment broker and contacted the plan directly and were provided MLTC materials;
f) Rebalancing efforts performed by the MLTC Plans and mainstream plans once the benefit is added. Rebalancing reporting should include, but is not limited to the total number of individuals transitioning in and out of a nursing facility within the quarter.
g) Total number of complaints, grievances and appeals by type of issue with a listing of the top 5 reasons for the event.

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

X. GENERAL FINANCIAL REQUIREMENTS

79. **Quarterly Expenditure Reports.** The state must provide quarterly expenditure reports using

Form CMS-64 to separately report total expenditures for services provided under the Medicaid program, including those provided through the Demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the Demonstration period. CMS shall provide FFP for allowable Demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in section XI.

80. **Reporting Expenditures Under the Demonstration:** The following describes the reporting of expenditures under the Demonstration:

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

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

Demonstration Year	Time Period
1	10/1/1997 - 9/30/1998
2	10/1/1998 - 9/30/1999
3	10/1/1999 - 9/30/2000
4	10/1/2000 - 9/30/2001
5	10/1/2001 - 3/30/2003
6	04/1/2003 - 9/30/2004
7	10/1/2004 - 9/30/2005
8	10/1/2005 - 9/30/2006
9	10/1/2006 - 09/30/2007
10	10/1/2007 - 09/30/2008
11	10/1/2008 - 09/30/2009
12	10/1/2009 - 09/30/2010
13	10/1/2010 - 09/30/2011
14	10/1/2011 - 09/30/2012
15	10/1/2012 - 09/30/2013
16	10/1/2013 – 12/31/2013
17	1/1/2014 – 3/31/2014
18	4/1/2014 – 12/31/2014

c) Demonstration expenditures will be correctly reported on Forms CMS-64.9 Waiver. Quarterly cost settlements and pharmaceutical rebates relevant to the Demonstration will be allocated to the Demonstration populations specified in subparagraph (g) and offset against current quarter waiver expenditures. Demonstration expenditures net of these cost settlement offsets will be reported on

Form CMS-64.9 Waiver. Amounts offset will be identifiable in the state's supporting work papers and made available to CMS.

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

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

d) For the family planning expansion component of the Demonstration, the state should report Demonstration expenditures on Forms CMS-64.9 Waiver and/or 64.9P Waiver as follows:

i. Allowable family planning-related expenditures eligible for reimbursement at the state's federal medical assistance percentage rate (FMAP) should be entered in Column (B) on the appropriate waiver sheets.

ii. Allowable family planning expenditures eligible for reimbursement at the enhanced family planning match rate should be entered in Column (D) on the appropriate waiver sheets.

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

f) Premiums paid for ESHI under FHP-PAP will be reported on Forms CMS-64.9 Waiver and/or CMS-64.9P Waiver on Line 18.E. in order to ensure that the Demonstration is properly credited with these premium payments. Additionally, both the total computable and federal share amounts that are paid under FHP-PAP must be separately reported on the CMS-64Narr.

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

i. **Demonstration Population 1:** Temporary Assistance to Needy Families (TANF) child under age 1 through age 20 required to enroll in managed care in any county **other than** Allegany, Cortland, Dutchess, Fulton, Montgomery, Putnam, Orange, Otsego, Schenectady, Seneca, Sullivan, Ulster, Washington, or Yates, for expenditures associated with dates of service on or before March 31, 2014 [TANF Child].

ii. **Demonstration Population 2:** TANF Adults aged 21-64 required to enroll in

managed care in any county **other than** Allegany, Cortland, Dutchess, Fulton, Montgomery, Putnam, Orange, Otsego, Schenectady, Seneca, Sullivan, Ulster, Washington, or Yates, for expenditures associated with dates of service on or before March 31, 2014 [TANF Adult].

iii. **Demonstration Population 3:** Disabled Adults and Children 0-64, for expenditures associated with dates of service on or before March 31, 2014 [SSI 0-64]

iv. **Demonstration Population 4:** Aged or Disabled Adults, for expenditures associated with dates of service on or before March 31, 2014 [SSI 65+]

v. **Demonstration Population 5:** Safety Net Adults, for expenditures associated with dates of service on or before December 31, 2013 [Safety Net Adults]

vi. **Demonstration Population 6:** Family Health Plus Adults with children up to 150% FPL, for expenditures associated with dates of service on or before December 31, 2013 [FHP Adults w/Children]

vii. **Demonstration Population 7**: Family Health Plus Adults without children up to 100% FPL, for expenditures associated with dates of service on or before December 31, 2013 [FHP Childless Adults]

viii. **Demonstration Population 8:** Family Planning Expansion Adults, for expenditures associated with dates of service on or before December 31, 2013 [FP Expansion]

ix. **Demonstration Population 9:** Home and Community-Based Services Expansion participants, for expenditures associated with dates of service on or before March 31, 2014 [HCBS Expansion]

x. **Demonstration Population 10:** MLTC Adults age 18 – 64 [MLTC Adults 18 -64]

xi. **Demonstration Population 11:** MLTC Adults age 65 and above [MLTC Adults 65+]

xii. **Demonstration Services 1:** State Indigent Care Pool (ICP) Direct Expenditures, for expenditures made on or before December 31, 2013 [ICP-Direct]

xiii. **Demonstration Services 2:** Designated State Health Programs to Support Clinic Uncompensated Care Funding, for expenditures made on or before December 31,

2013 [ICP - DSHP]

xiv. **Demonstration Services 3:** Designated State Health Programs to Support Medical Home Demonstration, for expenditures made on or before December 31, 2014 [DSHP - HMH Demo]

xv. **Demonstration Services 4:** Designated State Health Programs to Support Potentially Preventable Readmission Demonstration, for expenditures made on or before December 31, 2014 [DSHP - PPR Demo]

xvi. **Demonstration Services 5:** Designated State Health Programs to for expenditures made for the period of April 1, 2013 through March 31, 2014 in conjunction with deliverables associated with health system transformation for individuals with developmental disabilities. [STC 66]63(a)]

Note: Waiver forms for Demonstration Populations 3 and 4 are no longer required under this demonstration, but under demonstration 11-W-000234/2, The Federal-State Health Reform Partnership (F- SHRP). However, they remain defined Demonstration Populations for future use if needed.

81. **Expenditures Subject to the Budget Neutrality Agreement.** For purposes of this section, the term "expenditures subject to the budget neutrality agreement" must include all Medicaid expenditures in STC 81(g) for individuals who are enrolled in this Demonstration (with the exception of the populations identified in subparagraphs iii, iv, and ix), as well as the demonstration services described in subparagraphs x through xiii, subject to limitations enumerated in this paragraph. All expenditures that are subject to the budget neutrality agreement are considered Demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and/or 64.9P Waiver.

a) Beginning in DY 9, all expenditures for Demonstration Populations 1 and 2 who reside in Allegany, Cortland, Dutchess, Fulton, Montgomery, Putnam, Orange, Otsego, Schenectady, Seneca, Sullivan, Ulster, Washington, or Yates counties are no longer considered expenditures subject to the budget neutrality agreement for this Demonstration and may not be reported on Forms CMS-64.9 Waiver and/or 64.9P for this Demonstration. These expenditures will be reported under the F-SHRP Demonstration (11-W-00234/2).

b) Beginning in DY 9, expenditures for Demonstration Populations 3 and 4 defined in STC 81(g) will no longer be reported under this Demonstration. However, these eligibility groups remain as a placeholder in the event these populations are transferred from the F-SHRP Demonstration (11-W-00234/2) back to this Demonstration. The state shall follow the amendment process outlined in STC 7 to effectuate this transfer.

c) Beginning in DY 9, Demonstration Populations 3 and 4, as defined in STC 81(g), are no longer considered expenditures subject to the budget neutrality agreement for this Demonstration. These expenditures may not be reported on Forms CMS-64.9 Waiver and/or 64.9P under this

Demonstration, except if permitted under the provisions of subparagraph (b). These expenditures will be reported under the F-SHRP Demonstration (11-W-00234/2), subject to the provisions of subparagraph (b) of this STC.

d) Only the home and community-based services expenditures for Demonstration Population 9 shall be subject to the budget neutrality agreement.

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

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

83. **Premium Collection Adjustment.** The state must include any Demonstration premium collections as a manual adjustment (decrease) to the Demonstration's actual expenditures on a quarterly basis and shall be reported in accordance with STC 81(f).

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

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

a) For the purpose of calculating the budget neutrality expenditure cap and for other purposes, the state must provide to CMS, as part of the quarterly report required under STC 74, the actual number of eligible member months for the Demonstration Populations defined in STC 81(g), for months prior to or including the ending date indicated in STC 81(g) for each demonstration population. The state must submit a statement accompanying the quarterly report, which certifies the accuracy of this information.

Beginning in DY 9, the actual number of member months for Demonstration Populations 3 and 4, as defined in STC 81(g), will not be used for the purpose of calculating the budget neutrality expenditure agreement, except as defined in STC 82(b).

Additionally, Beginning in DY 9, the actual number of member months for Demonstration Populations 1 and 2 who reside in Allegany, Cortland, Dutchess, Fulton, Montgomery, Putnam, Orange, Otsego, Schenectady, Seneca, Sullivan, Ulster, Washington, or Yates counties will not

be used for the purpose of calculating the budget neutrality expenditure agreement, subject to the limitations in STC 81.

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

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

c) For the purposes of this Demonstration, the term "Demonstration eligibles" excludes unqualified aliens and refers to the Demonstration Populations described in STC 81 (g). Beginning in DY 9, "Demonstration eligibles" excludes Demonstration Populations 3 and 4, subject to STC 82(b), as well as portions of Demonstration Populations 1 and 2, as specified in STC 82(a - b).

86. **Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the Demonstration. New York must estimate matchable Demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure cap and separately report these expenditures by quarter for each federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments and State and Local Administration Costs. CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

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

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

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

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

d) FFP will be provided for the Family Planning Expansion Program as described in STC 89.

88. **Extent of FFP for Family Planning Expansion Program.** FFP will be provided for the Family Planning Expansion Program in accordance with family planning and family planning-related services (including prescriptions) at the applicable federal matching rates described in STC 29(d), subject to the limits described below:

a) For procedures or services clearly provided or performed for the primary purpose of family

planning and which are provided in a family planning setting, reimbursable procedure codes for office visits, laboratory tests, and certain other procedures must carry a primary diagnosis or a modifier that specifically identifies them as a family planning service.

b) FFP will not be available for the costs of any services, items, or procedures that do not meet the requirements specified above, even if family planning clinics or providers provide them. For example, in the instance of testing for STIs as part of a family planning visit, FFP will be available at the 90 percent federal matching rate. The match rate for the subsequent treatment would be paid at the applicable federal matching rate for the state. For testing or treatment not associated with a family planning visit, (e.g., those provided at a public STI clinic), no FFP will be available.

c) Pursuant to 42 CFR 433.15(b)(2), FFP is available at the 90 percent administrative match rate for administrative activities associated with administering the family planning services provided under the Demonstration including the offering, arranging, and furnishing of family planning services. These costs must be allocated in accordance with OMB Circular A-87 cost allocation requirements. The processing of claims is reimbursable at the 50 percent administrative match rate.

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

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

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

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

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

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

c) To the extent the state utilizes CPEs as the funding mechanism to claim federal match for payments under the Demonstration, governmental entities to which general revenue funds are appropriated must certify to the state the amount of such tax revenue (state or local) used to

satisfy demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the state's claim for federal match.

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

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

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

XI. MONITORING BUDGET NEUTRALITY

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

93. **Risk.** New York shall be at risk for the per capita cost (as determined by the method described below) for Demonstration eligibles under this budget neutrality agreement, but not for the number of Demonstration eligibles in each of the groups. By providing FFP for all Demonstration eligibles, New York shall not be at risk for changing economic conditions that impact enrollment levels. However, by placing New York at risk for the per capita costs for Demonstration eligibles under this agreement, CMS assures that federal demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no Demonstration.

94. **Demonstration Populations Used to Calculate Budget Neutrality Expenditure Limit.** The following Demonstration populations are used to calculate the budget neutrality expenditure limit subject to the limitations outlined in STC 82 and are incorporated into the following eligibility groups (EGs):

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

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

c) **Eligibility Group 3:** FHPlus Adults with children (Demonstration Population 6)

d) **Eligibility Group 4:** Individuals of childbearing age receiving a limited family planning benefit through the Family Planning Expansion Program (Demonstration Population 8)

e) **Eligibility Group 5:** MLTC Adults age 18 – 64

f) **Eligibility Group 6**: MLTC Adults age 65 and above

Note: Demonstration Populations 3 and 4 are no longer part of the calculation of the budget neutrality expenditure cap under this demonstration, but under demonstration 11-W-000234/2, The Federal-State Health Reform Partnership.

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

a) For each year of the budget neutrality agreement an annual budget neutrality expenditure limit is calculated for each EG described in STC 95 as follows:

i. An annual EG estimate must be calculated as a product of the number of eligible member months reported by the state in accordance with the requirements outlined in STC 86, for each EG, times the appropriate estimated per member per month (PMPM) costs from the table in subparagraph (iii) below. Should EGs 3 and 4 be incorporated into the budget neutrality expenditure limit, as outlined in STC 82, the PMPM costs may be revised.

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

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

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

Eligibility Group	DY 11 (10/1/08 –	Trend Rate	DY 12 (10/1/09 –
TANF Children under age 1 through 20	$549.19	6.7%	$585.99
TANF Adults 21-64	$751.73	6.6%	$801.34
FHPlus Adults with Children	$586.82	6.6%	$625.55

Note: Demonstration Populations 3 and 4 are no longer part of the calculation of the budget neutrality expenditure limit under this demonstration, but under demonstration 11-W-00234/2, The Federal-State Health Reform Partnership.

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

Eligibility Group	DY 12 (10/1/09 – 9/30/10)`	Trend Rate	DY 13 (10/1/10 – 9/30/11)	DY 14 (10/1/11 – 9/30/12)	DY 15 (10/1/12 – 9/30/13)	DY 16 (10/1/13 – 12/31/13)	DY 17 (1/1/14 – 3/31/14)
TANF Children under age 1 through 20	$585.99	6.6%	$624.67	$665.90	$709.85	$756.70	$756.70
TANF Adults 21 – 64	$801.34	6.4%	$852.63	$907.20	$965.26	$1027.04	$1027.04
FHPlus Adults with Children	$625.55	6.4%	$665.59	$708.19	$753.51	$801.73	N/A
Family Planning Expansion Adults		4.1%	$20.23	$21.06	$21.92	$22.81	N/A
MLTC Adults 18-64		1.19%		$4009.38	$4057.09	$4105.37	$4105.37
MLTC Adults 65 and above		3.23%		$4742.15	$4895.32	$5053.44	$5053.44

Note: Demonstration Populations 3 and 4 are no longer part of the calculation of the budget neutrality expenditure limit under this demonstration, but under demonstration 11-W-00234/2, The Federal-State

Health Reform Partnership.

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

b) The overall budget neutrality expenditure limit for the demonstration period is the sum of the annual budget neutrality expenditure limits calculated in subparagraph (a)(iv) above for each year. The federal share of the overall budget neutrality expenditure limit represents the maximum amount of FFP that the state may receive for expenditures on behalf of Demonstration populations and expenditures described in STC 81 (g) during the Demonstration period.

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

97. **Enforcement of Budget Neutrality.** CMS shall enforce budget neutrality over the life of the Demonstration rather than on an annual basis. DY 18 expenditures, which will consist only of DSHP expenditures in support of the H-MH and PPR demonstrations, will be included in the budget neutrality test for the demonstration. The state may receive FFP for these expenditures to the extent that sufficient accumulated budget neutrality savings are available from prior DYs.

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

XII. EVALUATION OF THE DEMONSTRATION

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

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

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

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

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

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

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

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

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

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

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

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

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

xii. How have the results of the family planning expansion program expanded access to family planning services among the target population?

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

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

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

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

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

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

vi. Are the individual care plans consistent with the functional and cognitive abilities of the enrollees? This evaluation question will be included as there is sufficient data available in 2014 to provide accurate measures. NYS will address this question in the Final Evaluation Plan.

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

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

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

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

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

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

c) The state must submit to CMS for approval a draft evaluation design no later than October 1, 2012.

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

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

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

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

b) By April 30, 2015, the state must submit to CMS a draft final evaluation report on the evaluations of the H-MH and PPR demonstrations. CMS shall provide comments within 60 days after receipt of the report. The state shall submit the final evaluation report within 60 days after receipt of CMS comments.

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

XIII. SCHEDULE OF STATE DELIVERABLES FOR THE DEMONSTRATION EXTENSION PERIOD

Date - Specific	Deliverable	Reference
10/1/2012	Submit Draft Evaluation Plan	Section XII, STC 99

	Deliverable	Reference
Annual	By January 1st - Annual Report	Section IX, STC 74
	By December 31st – Annual MEQC Program Report	Section III, STC 13
Quarterly		
	Quarterly Operational Reports	Section IX, STC 73

	Quarterly Expenditure Reports	Section X, STC 79
	Eligible Member Months	Section X, STC 85

ATTACHMENT A

Mainstream Medicaid Managed Care Benefits

Inpatient and outpatient hospital services
Clinic services including Rural Health Clinic and Federally Qualified Health Center services
Laboratory and X-ray services
Home health services
Early Periodic Screening, Diagnosis, and Treatment services (for individuals under age 21 only)
Family planning services and supplies
Physicians services including nurse practitioners and nurse midwife services
Dental services
Physical and occupational therapy
Speech, hearing, and language therapy
Prescription drugs, over-the-counter drugs, and medical supplies
Durable Medical Equipment (DME), including prosthetic and orthotic devices, hearing aids, and prescription shoes
Vision care services, including eyeglasses
Intermediate Care Facilities for the Mentally Retarded (ICF/MR)
Nursing facility services
Personal care services
Medical Social Services for persons transitioning from the LTHHCP who received the service under the LTHHCP (non-state plan service)
Home Delivered Meals for persons transitioning from the LTHHCP who received the service under the LTHHCP (non-state plan service)
Case management services
Hospice care services
TB-related services
Inpatient and outpatient behavioral health services (mental health and chemical dependence services)
Emergency medical services, including emergency transportation
Adult day care
Personal Emergency Response Services (PERS)
Renal dialysis
Home and Community Based Services waivers (HCBS)
Care at Home Program (OPWDD)
Non–emergency transportation
Experimental or investigational treatment (covered on a case-by-case basis)

Service	Co-pay
Non-preferred brand-name prescription drugs	$3
Preferred brand-name prescription drugs	$1
Generic prescription drugs	$1

Notes: One co-pay is charged for each new prescription and each refill

No co-payment for drugs to treat mental illness (psychotropic) and tuberculosis.

ATTACHMENT B

Managed Long Term Care Benefits

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

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

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

ATTACHMENT C

Family Health Plus Benefits and Cost-Sharing

Inpatient and outpatient hospital services
Clinic services including Rural Health Clinic and Federally Qualified Health Center services
Laboratory and X-ray services
Home health services (covered for 40 visits in lieu of hospitalization, plus 2 post-partum visits for high-risk women)
Early Periodic Screening, Diagnosis, and Treatment services (for individuals ages 19 and 20 only) to the extent available under otherwise covered services
Family planning services and supplies
Physicians services including nurse practitioners and nurse midwife services
Dental services (optional)
Physical and occupational therapy (20 visits for each therapy annually)
Speech therapy (for conditions amenable to clinical improvement within a 2–month period)
Prescription drugs, diabetic supplies, and smoking cessation products
Durable medical equipment, including prosthetic and orthotic devices and hearing aids
Vision care services including eyeglasses
Nursing facility services (inpatient rehab)
Hospice care services
TB-related services, except Directly Observed Therapy
Behavioral health services (mental health and chemical dependence services), limited to 60 outpatient visits combined and 30 inpatient days combined
Emergency medical services including emergency transportation
Renal dialysis
Experimental or investigational treatment (covered on a case by case basis)

Service	Co-payment
Clinic services *	$5 per visit
Physician services	$5 per visit
Prescription Drugs • Brand name • Generic	 $6 $3
Over-the-counter medications for smoking cessation and diabetes	$.50
Dental services	$5 per visit ($25 maximum annual cap)
Medical supplies (e.g. for treatment of diabetes and enteral formula)	$1.00 per supply
Laboratory services	$.50
Radiology services (ordered in an ambulatory setting)	$1
Inpatient Hospital services	$25 per stay
Non-emergent Emergency Room services	$3

***** except those provided by mental health and chemical dependence clinics

Demonstration Approval Period: August 1, 2011 through December 31, 2014
(As amended by NYS September 2012.)

ATTACHMENT D

Home and Community-Based Services Expansion Program Benefits

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

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

Home and community-based services (HCBS) must be provided in a setting that has home-like characteristics and not in institutionalized settings, unless an enrollee is in need of short term respite care. Below are the required home and community characteristics that must be in place for HCBS and other long-term services and supports programs:

- Private or semi-private bedrooms including decisions associated with sharing a bedroom.
- Full access to typical facilities in a home such as a kitchen with cooking, facilities, small dining areas.

ATTACHMENT D

Home and Community-Based Services Expansion Program Benefits

- All participants must be given an option to receive home and community based services in more than one residential setting appropriate to their needs.
- Private or semi-private bathrooms that include provisions for privacy.
- Common living areas and shared common space for interaction between participants, their guests, and other residents.
- Enrollees must have access to a food storage or food pantry area at all times.
- Enrollees must be provided with an opportunity to make decisions about their day to day activities including visitors, when and what to eat, in their home and in the community.
- Enrollees will be treated with respect, choose to wear their own clothing, have private space for their personal items, have privacy to visit with friends, family, be able to use a telephone with privacy, choose how and when to spend their free time, have easy access to resources and activities of their choosing in the community.

In provider owned or controlled residential settings, the following additional conditions will be provided to members:

- Privacy in sleeping or living unit.
- Units have lockable entrance doors, with appropriate staff having keys to doors.
- Enrollees share units only at the enrollee's choice.
- Enrollees have freedom to furnish and decorate sleeping or living units.
- The setting is physically accessible to the enrollee.

HCBS LTSS are not provided in institution-like settings except when such settings are employed to furnish short-term respite to individuals.

ATTACHMENT E

Quarterly Operational Report Format

Under STC 74, the state is required to submit quarterly reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the Demonstration. The reports are due to CMS 60 days after the end of each quarter (except for the report due for the quarter ending on September 30 of each demonstration year, which can be incorporated into the annual report required under STC 75).

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the state. A complete quarterly progress report must include an updated budget neutrality monitoring workbook.

NARRATIVE REPORT FORMAT:

Title Line One – Partnership

Plan

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:
Example:
Demonstration Year: 14 (10/1/11 - 9/30/12)
Federal Fiscal Quarter: 1/2012 (10/11 - 12/11)

Introduction:
Information describing the goal of the Demonstration, what it does, and key dates of approval /operation. (This should be the same for each report.)

Enrollment Information:
Please complete the following table that outlines all enrollment activity under the demonstration. The state should indicate "N/A" where appropriate. If there was no activity under a particular enrollment category, the state should indicate that by "0". Please note any changes in
enrollment that fluctuate 10 percent or more over the previous quarter as well as the same quarter in the prior Demonstration year.

Enrollment Counts
Note: Enrollment counts should be person counts, not participant months

Demonstration Populations (as hard coded in the CMS-64)	**Current Enrollees** (to date)	**No. Voluntary Disenrolled in current Quarter**	**No. Involuntary Disenrolled in current Quarter**
Population 1 – TANF Child under age 1 through age 20 in mandatory MC counties as of			

Population 2 - TANF Adults aged 21-64 in mandatory MC counties as of 10/1/06			
Population 5 – Safety Net Adults			
Population 6 - Family Health Plus Adults with children			
Population 7 - Family Health Plus Adults w/o children			
Population 8 - Family Planning Expansion Adults			
Population 9 – HCBS Expansion participants			

Voluntary Disenrollments:

- Cumulative Number of Voluntary Disenrollments within Current Demonstration Year
- Reasons for Voluntary Disenrollments

Involuntary Disenrollments:

- Cumulative Number of Involuntary Disenrollments within Current Demonstration Year
- Reasons for Involuntary Disenrollments

Enrollment Information for Specific Sub-populations:

- FHPlus enrollees served under PAP
- Enrollees in the HCBS Expansion program
- For the Family Planning Expansion Program please provide the following:
    - Quarterly enrollment reports for Demonstration eligibles (eligibles include all individuals enrolled in the Demonstration) that include the member months, as required to evaluate compliance with the budget neutral agreement; and
    - Total number of participants served during the quarter (participants include all individuals who obtain one or more covered family planning services through the Demonstration).

Program Operations

Outreach/Innovative Activities: Summarize outreach activities and/or promising practices for the current quarter.

Operational/Policy Developments/Issues: Identify all significant program developments/issues/problems that have occurred in the current quarter, including, but not limited to, approval and contracting with new plans, benefit changes, and legislative activity. Also include any anticipated activities or program changes related to health care delivery, benefits, enrollment, grievances, quality of care, access, and other operational issues.

Update on Progress and Activities related to Quality Demonstrations and Clinic

Uncompensated Care Funding: Identify all activities relating to the implementation of these programs, including but not limited to:

- Release of solicitations and selection of awardees for the quality demonstrations;
- An explanation of grants, contracts or other financial arrangements entered into for purposes of implementing the quality demonstrations of this Demonstration; and
- Progress of grantees in meeting the milestones identified in these STCs and any award documents.

Consumer Issues: A summary of the types of complaints or problems consumers identified about the program in the current quarter. Include any trends discovered, the resolution of complaints, and any actions taken or to be taken to prevent other occurrences, this should be broken out to show the number of LTSS complaints vs. all other categories identified. Also discuss feedback, issues or concerns received from the Medicaid Managed Care Advisory Review Panel (MMCARP), advocates and county officials.

Quality Assurance/Monitoring Activity: Identify any quality assurance/monitoring activity in current quarter.

Managed Long Term Care Program: Identify all significant program developments, issues, or problems that have occurred in the current quarter. Additionally, all requirements as outlined in STC 66 should be included.

Family Planning Expansion Program: Identify all significant program developments, issues, or problems that have occurred in the current quarter. Additionally, note any changes in enrollment that fluctuate 10 percent or more over the previous quarter of the same Demonstration year and the same quarter in the previous Demonstration year.

Home and Community-Based Services Expansion Program: For the quarter ending March 31 each year, attach a copy of the CMS-372 report completed in accordance with Appendix A of the approved Long-Term Home Health Care, the Nursing Home Transition and Diversion, and the Traumatic Brain Injury 1915(c) waivers.

Demonstration Evaluation: Discuss progress of evaluation implementation.

Financial/Budget Neutrality Developments/Issues: Provide information on:

- Quality demonstration and clinic uncompensated care expenditures – to whom and when
- Designated State Health Programs – amount of FFP claimed for the quarter

Enclosures/Attachments: Identify by title any attachments along with a brief description of what information the document contains.

State Contact(s): Identify individuals by name, title, mailing address, phone, fax, and email address that CMS may contact should any questions arise.

Date Submitted to CMS:

ATTACHMENT F

Expiration Dates for Demonstration Components

The following table shows the expiration dates for the various components of the Demonstration.

Demonstration Components	Expiration Date
• Family Health Plus (parents and caretaker relatives to 160 percent of FPL; non-pregnant, non-disabled adults age 19-64 up to 100 percent of FPL) • Family Planning Expansion Program (to 200 percent of FPL) • Safety Net Adults (state determined income standard – in 2011, approximately 78 percent of FPL for single adult households and 72 percent for couples) • Indigent Care Pool	December 31, 2013
• Medicaid Managed Care Program • Medicaid Eligibility Quality Control waivers • Facilitated Enrollment Services • Twelve-Month Continuous Eligibility Period • Home and Community-Based Services Expansion Program	March 31, 2014
• Hospital-Medicaid Home Demonstration • Potentially Preventable Re-Hospitalization Demonstration • Designated State Health Programs	December 31, 2014

ATTACHMENT G

Mandatory Managed Long Term Care Enrollment Plan

Mandatory Managed Long Term Care/Care Coordination Model (CCM)

Mandatory Population: Dual eligible, age 21 and over, receiving community based long term care services for over 120 days, excluding the following:

- **Long Term Home Health Care Program (in certain counties, see timeline below);**
- **Nursing Home Transition and Diversion waiver participants;**
- **Traumatic Brain Injury waiver participants;**
- **Nursing home residents;**
- **Assisted Living Program participants; and**
- **Dual eligible that do not require community based long term care services.**

Voluntary Population: Dual eligible, age 18-21, in need of community based long term care services for over 120 days and assessed as nursing home eligible. Non-dual eligible age 18 and older assessed as nursing home eligible and in need of community based long term care services for over 120 days.

The following requires CMS approval to initiate and reflects the enrollment of the mandatory population only.

Phase I and II: New York City and the suburbs

July 1, 2012 - Any new dual eligible case new to service, fitting the mandatory definition in any New York City County will be identified for enrollment and referred to the Enrollment Broker for action.

- Enrollment Broker will provide with educational material, a list of plans/CCMs, and answer questions and provide assistance contacting a plan if requested.
- Plan/CCM will conduct assessment to determine if eligible for community based long term care.
- Plan/CCM transmits enrollment to Enrollment Broker.

In addition, the following identifies the enrollment plan for cases already receiving care. Enrollment will be phased in by service type by borough by zip code in batches. People will be given 60 days to choose a plan according to the following schedule.

July 1, 2012: Begin personal care* cases in New York County

August 1, 2012: Continue personal care cases in New York County

ATTACHMENT G

Mandatory Managed Long Term Care Enrollment Plan

September, 2012: Continue personal care cases in New York County and begin personal care in Bronx County; and begin consumer directed personal assistance program cases in New York and Bronx counties

October, 2012: Continue personal care and consumer directed personal assistance program cases in New York and Bronx counties and begin Kings County

November, 2012: Continue personal care and consumer directed personal assistance program cases in New York, Bronx and Kings Counties

December, 2012: Continue personal care and consumer directed personal assistance program cases in New York, Bronx and Kings Counties and begin Queens and Richmond counties

January, 2013: Continue personal care and consumer directed personal assistance program citywide.

February, 2013 (and until all people in service are enrolled): Personal care, consumer directed personal assistance program, citywide.

March, 2013: Personal care, consumer directed personal assistance program, adult day health care, home health care over 120 days citywide.

March, 2013: Personal care, consumer directed personal assistance program, adult day health care, home health care over 120 days in Nassau, Suffolk and Westchester counties

April, 2013: Personal care, consumer directed personal assistance program, adult day health care, home health care over 120 days and long-term home health care program citywide.

April, 2013: Personal care, consumer directed personal assistance program, adult day health care, home health care over 120 days and long-term home health care program in Nassau, Suffolk and Westchester Counties

Phase III: Rockland and Orange Counties

Dually eligible community based long term care service recipients in these additional counties as capacity is established. June 2013

Phase IV: Albany, Erie, Onondaga and Monroe Counties

Dually eligible community based long term care service recipients in these additional counties as capacity is established. Anticipated Fall 2013

ATTACHMENT G

Mandatory Managed Long Term Care Enrollment Plan

Phase V: Other Counties with capacity.

Dually eligible community based long term care service recipients in these additional counties as capacity is established. Anticipated Spring 2014

Phase VI:

Previously excluded dual eligible groups contingent upon development of appropriate program models:

- **Nursing Home Transition and Diversion waiver participants;**
- **Traumatic Brain Injury waiver participants;**
- **Nursing home residents;**
- **Assisted Living Program participants;**
- **Dual eligible that do not require community based long term care services.**

ATTACHMENT H

Health System Transformation for Individuals with Developmental Disabilities

The receipt of expenditure authority for transformation for the period of April 1, 2013 to March 31, 2014, is contingent upon the state's compliance and CMS' receipt of the following deliverables:

1. Money Follows the Person (MFP)

New York will submit to CMS and receive approval for a detailed MFP operational protocol amendment to the current approved MFP protocol that is consistent with terms and conditions related to the Intellectual and Developmental Disability IDD population, for implementation April 1, 2013.

2. Balancing Incentive Program Work Plan

No later than September 1, 2013, New York will submit to CMS for approval a detailed structural change work plan to implement the Balancing Incentive Program. The work plan must meet all CMS requirements and align the infrastructure requirements for the Balancing Incentive Program and MFP, including reaching the Balancing Incentive Program target expenditure benchmark of 50 per cent across all Medicaid long term services and supports (LTSS) expenditures by October 1, 2015. In addition, the work plan must provide the following deliverables:

a. To demonstrate its implementation of successful person-centered planning, New York must provide an affirmative commitment that the state will establish an independent process for assuring that individual person-centered plans meet the needs of enrollees served in community-based settings, a description of the process the state will use to ensure that person-centered plans are implemented with fidelity to the established process, and a timeline for implementation of the process. New York will implement the approved process for person-centered planning for demonstration participants in accordance with a timeline approved by CMS and subsequently incorporated into this attachment.
b. Given the critical nature of available/appropriate residential settings for the populations being served under this demonstration, New York must provide a description of the state's current housing options for persons with IDD, or the "system as is" model. This baseline must include the number of individuals in group homes, small ICF's/IDD, large ICFs/IDD, and non-traditional housing models, the maximum number of individuals living in each residence type, and any required licensure or accreditation for each housing type.
c. New York must provide a detailed description of the process used to determine whether residential settings for persons transitioned from institutions as part of the demonstration meet CMS standards for home and community-based settings, and /or qualify as residences in the MFP program. This plan must include a description of the process the state will use to independently assess whether these settings meet the characteristics set forth in the current 1915(c) policy. New York must update its process to comport with subsequent federal regulatory changes, and must provide a description of the updated process and the state's proposed timeline for implementation of the regulatory changes to CMS within 90 days of such final

regulatory change.

3. <u>1915(b)/(c) Application</u>

   a. New York must: submit to CMS an approvable 1915(b)/(c) waiver application no later than April 1, 2013, that includes:
      i. Demonstration of capacity (e.g. the state has enough slots in settings that meet HCBS setting standards or are MFP qualifying settings based on the percentages the state has agreed to meet pursuant to paragraph b of section 4 of this attachment) to serve persons transitioned from ICFs, including those transitioned through MFP;
      ii. Evidence that the community- based settings in which Medicaid HCBS are provided meet CMS HCBS settings standards; and
      iii. Outline objectives with regard to competitive employment, person-centered planning, self-direction, and quality measurement/improvement.
      iv. Assurances that
         1. DISCOs meet the MCO licensure requirement;
         2. DISCOs are regulated as Prepaid Inpatient Health Plans (PIHPs) that are subject to review by External Quality Review Organizations (EQRO);
         3. New York will incorporate DISCOs in the overall managed care quality strategy;
         4. New York will comply with conflict free case management standards required in the Balancing Incentive Program, and
         5. New York will prohibit plans from making eligibility determinations and enrollment.
         6. New York will adopt practice guidelines for care coordinators based on the Council on Quality and Leadership (CQL) personal outcome measures will annually assess managed care quality using personal outcome data. New York will provide a report on its progress toward the development of CQL measures by September 1, 2013. The progress report will include the state's work plan for the implementation of the measures, including the roll-out of the measures, the specific outcome measures to be used, and the baseline against which the measures will be compared. New York will provide quarterly updates on its progress in implementing the work plan.
      v. In addition, New York must submit as part of the 1915(b)/(c) waiver application an approvable rate methodology that is understandable, delineates all elements in the rate methodology, and describes how all components are factored into the methodology. The methodology must assure that the rates produced are economic and efficient and lead to quality outcomes for beneficiaries. The rate methodology will apply to all services provided in the waiver and all public providers. In the same amendment, New York will provide the current rate structure for private/voluntary providers, commit to a waiver amendment submission on July 1, 2013 delineating the standard brick methodology to be used to bring all voluntary providers under the full brick methodology rate construction for all services no later than September 2015.
   b. New York will submit amendment requests to existing 1915(c) HCBS waivers by

May 1, 2013 to increase slots, by reserving capacity for people being de-institutionalized, to increase HCBS capacity to serve individuals enrolled in 1915(c) programs in the community.

4. Residential Transitions and Supportive Housing

   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,
      ii. 20 additional people transitioned by October 1, 2013, and
      iii. the remaining 121 persons transitioned to community-based settings that meet CMS HCBS settings standards referenced in the 1915(i) Notice of Proposed Rulemaking published in the federal register in April 2012.

   b. At least 30% of those persons (or a total of 44 persons) transitioned from institutions, both campus-based and non-campus-based ICFs, will qualify for MFP (i.e. can be transitioned into an MFP qualified residence). New York will transition the balance of the persons in the Finger Lakes and Taconic ICF target population (who are not transitioned to MFP qualified residences) into residential settings that comport with CMS requirements for home and community-based settings as outlined in the 1915(i) NPRM. New York must submit quarterly reports of the total number of persons transitioned to the community, the size and licensure category of the residential settings into which persons were transitioned (e.g. 4 person group home), and an assurance that the residential settings comport with CMS requirements.

   c. No later than August 1, 2013, New York must submit a draft timeline for transition of the residents of the remaining campus and non-campus-based ICF's to community-based settings. New York and CMS will finalize the plan by October 1, 2013. This plan must detail the pace of remaining transitions, taking into account the housing availability chart developed by the state. Upon approval by CMS, the transition plan and related deliverables will be incorporated as Appendix (insert letter).

   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.

5. Supported Employment Services and Competitive Employment

   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 (i.e. May 1, 2012 through April 30, 2013). 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.

c. By October 1, 2013, New York will submit to CMS a draft plan for CMS review, and a final plan no later than January 1, 2014, on its transformation towards competitive employment. Both the draft and final plans must include a detailed proposal/work plan for increases in the number of individuals in competitive employment and the number of students exiting the educational system moving directly into competitive employment. The plan must include a timeline for closing sheltered workshops, and a description of the collaborative work with the New York educational system for training/education to key stakeholders on the availability and importance of competitive employment.

d. New York will target youth as a priority in its employment initiative. No later than April 1, 2013, New York will submit an amendment request for its 1915(c) wavier for its Pathways to Employment services to shorten the time frame for transition from this service into Supported Employment. The state will report to CMS on an annual basis the number of students who are aging out of the educational system and who have been determined eligible for OPWDD services, the number who enter VR, and the number who enter OPWDD because they are not found ready by DVR, and any websites/sources for employment data.

6. <u>Consumer Self-Direction</u>

a. New York will implement a self-directed approach in which demonstration participants and/or their designated representatives will be given the option of self-directing by employer authority and budget authority or, at the preference of the individual, either employer authority or budget authority. Employer authority is present when an individual and/or their designated representative fully controls the recruitment, training, hiring, discharge performance review, performance pay increases, and supervision of individuals who furnish their services. Budget authority is present when an individual has decision –making authority over how funds in their individualized budget for waiver services are spent. As part of the design and implementation of this self-directed approach, New York will include the following components:

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.

c. In the design and implementation of its 1915(b)/(c) waiver and other MLTSS models authorized by this demonstration, New York will incorporate and enhance opportunities for self-direction by demonstration participants. If the state utilizes the agency with choice model of self-direction, New York will assure that these agencies provide maximum control by the beneficiary, and include a performance indicator(s) to assure that beneficiaries exercise choice and control. New York will report to CMS on a quarterly basis its efforts to enhance self-direction, and the results of the performance measurement.

d. New York will incorporate and document risk mitigation strategies to be used in its 1915(b)/(c) concurrent waiver and other MLTSS models authorized by this demonstration, in which there is meaningful negotiation with the beneficiary and representative as appropriate. If a participant is terminated voluntarily or involuntarily from the self-directed service delivery option, the MCO/PIHP must transition the participant to the traditional agency direction option and must have safeguards in place to ensure continuity of services. Involuntary discharges will be accompanied by the right to a fair hearing so the beneficiary may have the opportunity to defend actions or inactions that resulted in the involuntary discharge. The state retains the right to immediately stop services pending the hearing if they think there is immediate risk of harm to the beneficiary by remaining in the self-direction program.

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. New York will enable a total of 1,245 new beneficiaries to self-direct services for the period of July 1, 2013 through March 31, 2014 subject to the following:

    i. By September 30, 2013, 350 new beneficiaries will self-direct services;
    ii. By December 31, 2013, 425 new beneficiaries will self-direct services;
    iii. By March 31, 2014, 470 new beneficiaries will self-direct services.

f. By January 1, 2014, New York will submit to CMS for approval the state's policies on self-direction that demonstrate its commitment to and implementation of self-direction.

STATE OF NEW YORK

EXECUTIVE CHAMBER

ALBANY 12224

ANDREW M. CUOMO
GOVERNOR

October 31, 2012

Hon. Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Sebelius:

The New York State Department of Health (DOH) formally requests a five-year extension of New York's Partnership Plan Medicaid Section 1115 Demonstration (Project Number 11-W-00114/2). With approval from the Centers for Medicare and Medicaid Services (CMS), the State intends to continue the waiver beyond its current December 31, 2014 expiration date to December 31, 2017. This request is being filed pursuant to Section 1115(f) of the Social Security Act as amended by the Benefits Improvement and Protection Act of 2000 (BIPA).

Section 1915(h) of the Social Security Act, as amended by section 2601 of the Affordable Care Act, allows section 1115 demonstrations to be extended up to five years at the Secretary's discretion. Therefore, we are requesting a five-year extension in order to realize the full potential of the Medicaid Redesign Team (MRT) amendment. New York's Medicaid program is in the midst of one of its most groundbreaking periods of change since its inception. On August 6, 2012, DOH submitted a proposed amendment to the Partnership Plan to allow the full implementation of the MRT Action Plan and also prepare the state for federal health care reform over the five year period. The proposed amendment is consistent with the Triple Aim approach and will improve quality, improve health, and reduce per capita costs for New Yorkers.

We believe that the quality improvements and savings achieved through the Partnership Plan's care management strategies, coupled with implementation of the MRT Action Plan, will permit New York to expand health care coverage to hundreds of thousands of vulnerable and low-income New Yorkers. The requested extension will also provide the infrastructure necessary to support the critical health reform activities driven by the Affordable Care Act.

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The cooperation between CMS and New York continues to be critical to the success of the Partnership Plan. We look forward to working closely with CMS during the review of our extension request. If you have any questions regarding the enclosed material, please do not hesitate to contact Mr. Jason Helgerson, New York's Medicaid Director, at (518) 474-3018.

Sincerely,

ANDREW M. CUOMO

cc: Marilyn Tavenner, Acting Administrator, Centers for Medicare & Medicaid Services
Cynthia Mann, Director, Center for Medicaid and CHIP Services
Jason Helgerson, Medicaid Director, New York State

Application for Partnership Plan Waiver Extension

New York State Medicaid Section 1115 Demonstration

Project No. 11-W-00114/2

The Partnership Plan

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Section 1: Extension Request

New York is committed to ensuring that every Medicaid member has access to high quality, cost-effective health care that is effectively managed. The Medicaid Section 1115 Partnership Plan waiver program has been the primary vehicle used by New York State to achieve this goal. Operating since 1997, it is designed to use a managed care delivery system to create efficiencies in the Medicaid program and enable the extension of coverage to certain individuals who would otherwise be without health insurance. Since its inception, the Partnership Plan has been expanded to include new populations and services. Beginning in 2001 the Family Health Plus Program was added to extend health coverage to low income uninsured adults (with and without dependent children) and in 2002 Family Planning Expansion Program was added. Additional programs were added in 2010 to provide eligibility simplification and delivery systems enhancements. In 2011 the Hospital Medical Home, Potentially Preventable Readmissions Demonstration, Designated State Health Programs and Indigent Care Pool were incorporated into the Medicaid Section 1115 Partnership Plan.

On September 29, 2006, the Centers for Medicare and Medicaid Services (CMS) approved an extension to 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). CMS approved two waiver amendments on September 30, 2011 and March 30, 2012 incorporating changes resulting from recommendations of the Governor's Medicaid Redesign Team. In August 2012 CMS approved the Managed Long Term Care (MLTC) amendment which will expand mandatory Medicaid managed care enrollment to dually-eligible individuals over age 21 who receive community-based long-term care services in excess of 120 days and provide dually-eligible individuals age 18 - 21, as well as nursing home eligible non-dual individuals age 18 and older, the option to enroll in the MLTC program. In addition, this amendment permits the state to expand eligibility to ensure continuity of care for individuals who are moving from an institutional long-term care setting to receive community-based long term care services through the managed long-term care program. New York State Department of Health (the Department) is currently in negotiations with CMS on the Medicaid Redesign Team (MRT) amendment. This extension request does not include any Demonstration amendment requests and requires no waiver or expenditure authorities other than those already contained in the Partnership Plan Demonstration.

The Department is working to reshape how health care is delivered and to lower Medicaid costs for the state's health care system. We anticipate that it will take New York State five years to fully implement the state's care management vision and build the infrastructure to support provisions of the ACA health care reforms. Generally, Demonstrations may be extended up to 3 years under sections 1115(a), 1115(e), and 1115(f) of the Social Security Act. However, section 1915(h), as amended by section 2601 of the Affordable Care Act, allows section 1115 demonstrations to be extended up to 5 years at the Secretary's discretion, if the demonstration provides medical assistance to dually eligible beneficiaries. Therefore, New York is requesting

the Secretary to approve a five year extension in order to realize the full potential of the MRT amendment.

Section 2: Historical Narrative

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

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

The Demonstration is designed to use a managed care delivery system to deliver benefits to Medicaid recipients, create efficiencies in the Medicaid program and enable the extension of coverage to certain individuals who would otherwise be without health insurance. In 1997, CMS approved enrolling most Medicaid recipients into managed care organizations (Medicaid managed care program). As part of the Demonstration's renewal in 2006, authority to require the disabled and aged populations to enroll in mandatory managed care was transferred to a new demonstration, the Federal-State Health Reform Partnership (F-SHRP).

In 2001, the Family Health Plus (FHPlus) program was implemented as an amendment to the Demonstration, providing comprehensive health coverage to low-income uninsured adults, with and without dependent children, who have income greater than Medicaid State plan eligibility standards. FHPlus was further amended in 2007 to implement an Employer-Sponsored Health Insurance (ESHI) component (see Attachment 2, ESHI Growth Chart). Individuals eligible for FHPlus who have access to cost-effective ESHI are required to enroll in that coverage, with FHPlus providing any wrap-around services necessary to ensure that enrollees get all FHPlus benefits. The state later expanded Family Health Plus eligibility for low-income adults with children.

In 2002, the Demonstration was expanded to incorporate a family planning benefit under which family planning and family planning-related services are provided to women losing Medicaid eligibility and certain other adults (Family Planning Expansion Program).

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

In 2011, the state developed and implemented two new initiatives designed to improve the quality of care rendered to Partnership Plan recipients. The first, the Hospital-Medical Home

(H-MH) project, provides funding and performance incentives to hospital teaching programs in order to improve the coordination, continuity, and quality of care for individuals receiving primary care in outpatient hospital settings. By the end of the Demonstration extension period, the hospital teaching programs, which receive grants under the H-MH project, will have received certification by the National Committee for Quality Assurance (NCQA) as patient-centered medical homes (PCMHs) and implemented additional improvements in patient safety and quality outcomes.

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

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

In 2012, the Department received approval for the Managed Long Term Care (MLTC) program to be added to the Demonstration. It provides long term services and supports as well as other ancillary services to individuals in need of more than 120 days of community based long term care. The program operates both in a mandatory fashion for dual eligible individuals over 21, a voluntary fashion for dual eligible individuals 18 – 21, and nursing home eligible non-dual individuals.

Section 3: Partnership Plan Successes

3.1 Expanding Medicaid Managed Care

New York began implementation of the Partnership Plan immediately after receiving federal approval with a geographic phase-in strategy starting with five upstate counties in October 1997. Mandatory Medicaid managed care began in New York City in August 1999. Today, New York has implemented mandatory Medicaid managed care programs in all but five upstate counties. By the end of 2012, all counties in New York State will be operating mandatory programs. Statewide, Medicaid managed care enrollment has grown from approximately 650,000 in July 1997 to more than 3.2 million as of July 2012.

The initial Partnership Plan was approved to enroll most Safety Net (SN) and Temporary Assistance to Needy Families (TANF) Medicaid beneficiaries into managed care. Effective October 1, 2006, mandatory managed care was expanded to Medicaid beneficiaries who qualify for the federal Supplemental Security Income (SSI) program or are certified as blind or disabled and to those who reside in 14 additional counties throughout the state which had not

previously implemented mandatory programs. These populations were moved from the Partnership Plan to the Federal-State Health Reform (F-SHRP) waiver. As of July 2012, more than 343,000 SSI and SSI-related individuals were enrolled in Medicaid managed care statewide, representing 79 percent of the total eligible to enroll.

Since the last extension request in 2009, the state has expanded Medicaid managed care enrollment on several fronts. Individuals living with HIV/AIDS were enrolled in New York City beginning in September 2010 and in the rest of the state starting October 2011. In 2010, New York was granted authority to expand mandatory enrollment to additional counties that meet the choice criteria established in federal law, without the need for a waiver amendment. This change facilitated the implementation of mandatory programs in 15 upstate counties between 2010 and the present, with the remaining five New York State counties scheduled to begin by the end of 2012.

In April 2011, New York submitted a request to amend the Partnership Plan to implement initiatives of the state's Medicaid Redesign Team (MRT), tasked with redesigning the provision of Medicaid services to contain costs, creating efficiencies and improving the quality of care. Two major initiatives were contained in the amendment request – expanding mainstream Medicaid managed care enrollment to new, previously exempt and excluded populations and mandatorily enrolling eligible individuals into Managed Long Term Care programs.

On August 1, 2011, the state began enrolling individuals assigned to the Recipient Restriction Program, the first exempt/excluded population to be approved by CMS in a multi-year initiative that will virtually eliminate exemptions and exclusions by 2016. Adults with a Seriously and Persistently Mentally Ill (SPMI) diagnosis and children with a Seriously Emotionally Disturbed (SED) diagnosis, who were not designated as SSI or SSI-related, were enrolled starting September 2011. The homeless population was the next major population to be approved effective April 2012, with notification and enrollment occurring on a phased-in basis in New York City throughout the summer. Other previously exempt or excluded populations enrolled since September 2011 include disabled and low birth weight babies, individuals with a diagnosis of End Stage Renal Disease (ESRD), individuals temporarily living outside their social services district, pregnant women in the care of a prenatal care provider who does not participate in any managed care plan, individuals who have a language barrier, individuals for whom a managed care provider is outside the travel time and distance standards, and individuals placed in Office of Mental Health licensed family care homes.

3.2 Managed Long Term Care

New York State, through establishment of a Medicaid Redesign Team (MRT) consisting of stakeholders representing virtually every sector of the health care delivery system including consumers, has proposed sweeping health care reforms that will lead to improved health outcomes, as well as health care savings in years to come.

One such reform is directed to dual eligible Medicaid recipients, 21 years old and older, who are in need of home and community based care for more than 120 days. With CMS approval,

New York State's approach will be two fold with respect to individuals presently receiving community based long term care services and those new to the long term care system that will require services. This transition to a managed care model will facilitate:

- Increased access to managed long term care for Medicaid enrollees in need of long term services and supports;
- Improved patient safety and quality of care for consumers;
- Reduction of preventable acute hospital and nursing home admissions; and
- Improved satisfaction, safety and quality of life for consumers.

To achieve the objectives the state established, the Department has developed a Managed Long Term Care (MLTC) enrollment process. The enrollment process is comprised of two distinct elements focused on two target populations. The first population is individuals presently in receipt of community based long term care services and the second is individuals who will seek community based services in the future.

The first element of the enrollment plan is to transition current recipients of community long term care services to manage long term care plans. Home and community based services are defined as services and supports for adults and children of all ages and their families to enable them to remain at home or in community residential settings. In order to provide for an orderly transition, the state is initially targeting fee for service Personal Care Program recipients residing in New York City. The preference will be for recipients to make an informed choice of plan that best meets their needs.

To support their choice, the Department will provide a strong information and support system through its Enrollment Broker. The Department will have the authority to assign persons who do not make a choice of plans into a managed long term care plan in New York City.

The second element is targeted at new recipients in need of community based long term care. This element will be implemented in local jurisdictions that have sufficient choice of managed long term care plans.

The enrollment process allows for a gradual transition of current recipients in long term care community based services programs into managed long term care plans based on areas of the state that have plan capacity. The first area targeted is New York City where between September 2012 and March 31, 2014 all personal care service program recipients will be transitioned to managed long term care. In addition, starting in January 2013, those in home health care over 120 days, adult day health care, and Long Term Home Health Care Programs will be transitioned.

Simultaneously, the Department intends to expand mandatory managed long term care across the state, as capacity allows:

- Nassau, Suffolk and Westchester counties in January 2013
- Rockland and Orange counties in June 2013
- Albany, Erie, Monroe and Onondaga counties in December 2013

- Remaining counties that have sufficient capacity in June 2014

Certain populations and programs, such as the Nursing Home Transition and Diversion (NHTD) waiver, the Traumatic Brain Injury (TBI) waiver and Assisted Living Program (ALP) participants, will be transitioned into the managed long term care plans. This transition will not occur until appropriate waiver services are incorporated into the managed long term care model.

3.3 Insuring More New Yorkers through Family Health Plus

In May 2001, CMS approved an amendment to the Medicaid Section 1115 Partnership Plan waiver to provide for implementation of Family Health Plus (FHPlus). Enacted by the state legislature in December 1999, FHPlus is a major Medicaid expansion that initially provided comprehensive health coverage to low-income uninsured adults, with and without children, who had income and/or assets greater than the Medicaid eligibility standards. As of January 2010, the state eliminated the resource test for FHPlus applicants. Under current eligibility criteria, parent(s) living with a child under the age of 21 are eligible if gross family income is up to 150% of the federal poverty level (FPL). Adults without dependent children in their households are eligible when their gross income is up to 100% of the FPL. In July 2011, CMS approved an amendment to the Partnership Plan that increased the income eligibility standard for adults with children to 160% FPL, however, implementation has been postponed as a result of the Affordable Care Act. FHPlus currently covers over 430,000 previously uninsured New Yorkers.

3.4 Partnering with Private Insurers

In July 2007 state legislation was enacted to authorize the Employer Sponsored Health Insurance Initiative (ESHI) to increase coverage rates among uninsured but employed New York State residents with access to private insurance. This initiative, called the FHPlus Premium Assistance Program (FHP PAP), allows individuals who are eligible for FHPlus and have access to cost effective ESHI to enroll in the employer sponsored health insurance. The state subsidizes the employee's share of the premium and reimburses any deductibles and co-payments in excess of the enrollee's co-payment obligations under FHPlus. FHPlus wrap-around benefits are provided to the extent such benefits are not covered by the enrollee's employer sponsored health plan. As of August 2012, four years after going into effect, approximately 3,080 individuals are enrolled in this program.

Beginning in January 2014, no new applicants will be accepted into the FHP PAP and existing people will be re-evaluated at renewal as part of the transition to the Modified Adjusted Gross Income (MAGI) under health care reform.

In July 2007, state legislation also created the Family Health Plus Buy-in Program which allows employers and Taft-Hartley Plans to purchase FHPlus insurance coverage from participating health plans. Enrollment in the FHPlus Buy-in program began April 1, 2008, for Service Employees International Union (SEIU) 1199 home care union employees. Under this program, the state subsidized premiums for enrollees eligible for Medicaid, FHPlus or Child Health Plus

(CHPlus), the state's SCHIP program. For those not eligible for government programs, SEIU 1199 paid the full premium for the employees. When the SEIU withdrew from the program in November 2011, approximately 32,800 individuals were enrolled in the FHPlus Buy-in program through SEIU 1199. Of these, about 4,740 were enrolled in Medicaid managed care and FHPlus and were transferred, as appropriate, to the FHPlus Premium Assistance Program (FHPlus PAP) or to the regular Medicaid program with the state subsidizing the member contribution towards health insurance premiums. The balance of SEIU 1199 enrollees were non-subsidized and continue to have access to health insurance through the SEIU 1199.

In 2011, the United Federation of Teachers (UFT) partnered with Health Insurance Plan of Greater NY (HIP) to provide a FHPlus Buy-in program for its 25,000 child care workers in New York City. Enrollment of unsubsidized workers began in March 2012 and the subsidized members began in August 2012. Civil Service Employees Association (CSEA) is also interested in offering a FHPlus Buy-in program for its child care workers outside of New York City and is actively seeking a health plan to provide coverage. Fidelis Care (NYS Catholic Health Plan), present in almost every county in the state, is interested in partnering with CSEA and is pursuing a contract with U.S. Fire and Unified Life to provide family planning services. The employers and population who would qualify for this program will be transitioned into the exchange in 2014.

3.5 Expanding Access to Family Planning Services

The expected time line for the Family Planning Benefit Program (FPBP) to be moved into the State Plan is on November 1, 2012. Also, effective with the move to the State Plan, transportation will be added to the FPBP benefit package. The FPBP is a program for women and men who are not otherwise eligible for Medicaid but are in need of family planning services. The program is intended to increase access to family planning services and enable individuals to prevent or reduce the incidence of unintentional pregnancies. Once determined eligible, participants remain eligible for the program for 12 months, after which time recertification is required. Participation in the program has increased from 69,613 participants (59,794 women and 9,819 men) in 2008 to 80,441 (63,328 women and 17,113 men) in 2011. As the goal of the FPBP is to prevent unintended pregnancies, CMS measures program success in terms of the number of averted births. Using a methodology agreed on with CMS and using 2000 as the base year, the fertility rate for FPBP enrollees is 134.7 per thousand. Based on this fertility rate, there were 5,301 averted births in calendar year (CY) 2011.

Program policies, procedures and referral lists are in place to refer a FPBP member to primary care when family planning providers identify health care needs during a family planning visit. If a client is referred for non-family planning or emergency clinical care, the family planning agencies make the necessary arrangements and advise their patients on the importance of follow-up. Special follow-up procedures also exist for individuals with significant abnormal physical examination or laboratory test results, such as abnormal PAP tests and breast exams and diagnosed conditions such as hypertension. In 2006, the New York State Department of Health (the Department) and CMS worked together to improve the identification of family planning services using a list of CMS-approved procedure codes, which include family planning

related services (e.g., colposcopy) and follow-up visits and treatment for sexually transmitted diseases. In 2008, and again in 2010, additional CMS-approved procedure codes were added to the list of acceptable FPBP billing codes. Edits exist in the state's Medicaid Management Information System (MMIS) to ensure that only CMS-approved family planning procedures are claimed for enrollees having eligibility only under the FPBP. Additional edits ensure that the federal share is claimed appropriately (90% for some services and 50% for others) for FPBP procedures.

3.6 Increasing the Number of Health Care Providers Available to Beneficiaries

Through the Partnership Plan, the Department has greatly expanded access for Medicaid beneficiaries to appropriately credentialed physicians, nurse practitioners and physician extenders. As evidenced in the table below, the number of primary care and specialist physicians available to Medicaid beneficiaries is significantly greater in a managed care delivery system than in the state's current fee-for-service program.

Physician Participation in Medicaid, December 2010

Type of Care/Region	Participating in Fee-for-Service	Participating in Managed Care
Primary Care:		
New York City	5,271	11,117
Rest of State	5,684	9,151
Total	10,955	20,268
Specialty Care:		
New York City	11,436	20,743
Rest of State	9,156	16,524
Total	20,592	37,267

New York has a variety of mechanisms to assess the overall adequacy and capacity of Medicaid managed care plan networks. Provided to the Department quarterly, plan network submissions are reviewed to ensure plans have the appropriate provider types, comply with geographic, time and distance standards, and can support enrollment based on a standard of one primary care provider (PCP) for every 1,500 enrollees.

The provider network data is also periodically validated to ensure its accuracy. In general, audits consistently show a high degree of accuracy between what the health plans report and what health plan network physicians report as correct. For example, the most recent audit in the summer of 2010 found that provider identification variables including name, address, zip

code and license were correct at a very high level (>95%). Primary specialty was correct for 97% of PCPs and for 89% of specialists.

3.7 Hospital-Medical Home Demonstration

At the time of this extension application request of the Partnership Plan Medicaid Section 1115 waiver, the Department has done the following:

- Held meetings with representatives from the hospital associations, professional associations, and hospital and residency program administrators;
- Created an electronic application made up of both narrative and discrete searchable data element fields;
- Conducted a web conference and a teleconference to educate potential applicants in the use of the electronic application;
- Provided individual assistance through the application phase for potential applicants;
- Conducted a review of the applications; and
- Created multiple data summaries for current and future review and planning.

To date, no funding allocations have been made. However, the Department is completing the review process and finalizing a funding allocation methodology for making awards. The Department plans to release awards in the fall pending CMS approval. The Department is concurrently developing a standardized electronic work plan and template for tracking and reporting milestones and measures data for the prospective demonstration period. Submission of the work plan by awardees is set for fall 2012.

3.8 Potentially Preventable Readmissions Demonstration

The Department began the process of developing a Request for Applications (RFAs) for the Potentially Preventable Readmissions (PPR) Demonstration. While the implementation of this demonstration is compressed, the Department has developed an outline for the RFA and plans to begin the internal departmental approval process in the near future. Below is a proposed schedule of implementation based on the requested extension.

Anticipated implementation schedule on PPR demonstration

Date	Action
2012	Begin the internal departmental approval process for an RFA and begin to develop the RFA documents
2013	Develop RFA materials and documents
2013	Announce RFA

3.9 Improving the Quality of Health Services Delivered

New York State remains dedicated to providing and maintaining the highest quality of care for enrollees in managed care plans. Improving the care provided to Medicaid recipients enrolled in managed care plans is a major accomplishment of the waiver. The plans participating under the Partnership Plan continue to demonstrate meaningful improvements across a wide range of quality and satisfaction measures, exceeding national benchmarks. This progress continues to be observed, despite the increasing number of chronically ill beneficiaries enrolled in Medicaid managed care.

Over the past 18 years, the capabilities of the Department's quality measurement and improvement systems have become more sophisticated and efficient. As a result, the Department is able to analyze the quality of care and member satisfaction of each plan certified to provide Medicaid coverage in New York State. The Department incorporates this information into the Medicaid Managed Care Regional Consumer Guides, which contain information about the quality of care offered by the different plans, member opinions about the care and services plans provide. These brochures assist Medicaid enrollees in making an informed decision on which plan to choose for their care. The Department also recently developed a Guide for Managed Long-Term Care to inform enrollees as the state phases in a mandatory MLTC program.

A. Assessing Quality of Care

Medicaid Managed Care

Overall, access and quality of care have improved over time, particularly with regard to weight assessment for children and adults, adolescent preventive care, prenatal care and follow-up after a hospitalization for mental illness. The 2011 NCQA annual report, *The State of Health Care Quality,* indicates that New York's Medicaid managed care plans continue to exceed national benchmarks for preventive care and acute and chronic disease assessment and management. New York State Medicaid managed care plans exceeded national benchmarks in six domains of care: 1) Managing Acute Illness; 2) Chronic Illness; 3) Monitoring Medications; 4) Children's Preventive Health Services; 5) Women's Preventive Health Services; and, 6) Behavioral Health. Attachment 1 shows the 2010 Medicaid managed care performance results compared to national benchmarks.

HIV Special Needs Plan Quality of Care

In 2008, the Department incorporated a subset of measures from the HIV Special Needs Plans (SNPs) into the annual Quality Assurance Reporting Requirements (QARR). In 2010, the HIV SNPs were required to expand their reporting to include all QARR measures. The performance of the HIV SNPs for 2010 measurement year is in Attachment 1 (QARR/National Benchmark Comparison 2010). Generally, results for the HIV SNPs were comparable to traditional Medicaid managed care plans; often exceeding managed care results for measures of chronic conditions.

Managed Long Term Care

In 2011, the Department issued a Managed Long Term Care (MLTC) Report on quality, satisfaction and utilization, available to MLTC plans. This report, as well as regional consumer guides (NYC, Long Island, and Hudson Valley regions), will be available to the public in 2012. Performance of the managed long term care plans is evaluated through select process measures, such as annual flu shots, safety measures (e.g., percentage of enrollees who had falls), and measures of improvement in activities of daily living and cognitive functioning. The table below depicts the member quality and utilization results for MLTC members.

Snapshot of MLTC Member Quality and Utilization Results		
	Select Quality and Utilization Measures	**Percentage of MLTC Membership Statewide**
	Members who received an annual flu shot	72%
	Members with one or more falls in the past six months	15%
	Members who received emergent care in a hospital in the past six months	17%
	Members with one hospital admission in a six month period	8%
	Members with one nursing home admission in a six month period	2%
	Members whose frequency of pain was stable or improved over a six or twelve month period	81%
	Members whose overall functional ability was stable or improved over a six or twelve month period	90%

Care Management

In 2011, the Department collaborated with a subset of managed care plans that volunteered to participate on a collaborative work group to develop data collection measures for care management. As of 2010, Medicaid plans submit data on their care management programs, which allows for the development of process measures such as enrollment rates, number of interventions and duration of care management services. Since 2010, 200,000 plan members were identified as eligible for care management; 65,000 of those members actually participated in a care management program. Of the care management members, a decrease in inpatient and emergency room utilization in the 12 months following enrollment in care management was observed. However, utilization patterns varied by program; high risk obstetrics and oncology experienced minimal change in inpatient utilization, whereas behavioral health and adult chronic conditions experienced reductions in inpatient utilization. The programs with the

highest number of care management members were chronic conditions (adult) and high risk obstetrics.

B. Assessing Satisfaction with Care

To assess all dimensions of quality, the Department administers a biennial survey to measure member satisfaction, called the Consumer Assessment of Health Care Providers and Systems (CAHPS) survey. Since 2000, adults and children enrolled in Medicaid managed care are surveyed using the CAHPS tool. In 2011, the Department piloted the CAHPS Clinician and Group survey in New York City. Adult Medicaid managed care and fee-for-service members with visits to one of ten selected large health centers in New York City were surveyed.

Medicaid Adults CAHPS Survey

For Medicaid adults, the CAHPS survey assesses plan members' experience accessing health care services, providers and the plan. The Department selects a sample of 1,500 adult members from each plan. Overall, adult members are largely satisfied with their experiences of care. Members living outside of New York City tend to be more satisfied with their health care experiences than those living in New York City. The table below depicts the results of the survey for 2010 and 2012 by New York City (NYC), rest of state (ROS) and statewide (STW).

	2010			2012		
	NYC	**ROS**	**STW**	**NYC**	**ROS**	**STW**
Access to Care						
Getting Care Needed (Usually or Always)	69.4	78.3	73.9	72.0	77.2	74.8
Getting Care Quickly (Usually or Always)	70.7	82.8	77.0	71.5	80.1	76.1
Experience with Care						
Doctor Communication (Usually or Always)	85.2	87.5	86.4	86.7	88.0	87.4
Rating of Personal Doctor (8, 9, or 10)	72.9	75.7	74.3	72.0	74.3	73.3
Rating of Specialist (8, 9, or 10)	63.6	70.7	67.2	65.4	72.6	69.2
Rating of Overall Healthcare (8, 9, or 10)	61.9	68.4	65.2	64.0	68.9	66.6
Satisfaction with Health Plan						
Customer Service (Usually or Always)	78.1	82.3	79.9	81.8	81.5	81.5
Rating of Health Plan (8, 9, or 10)	67.1	71.6	69.3	69.4	72.0	70.7

CAHPS Clinician and Group (C&G) Survey Pilot

In 2011, the Department conducted a pilot study to assess member satisfaction and the utility of a standard tool for measuring provider-level surveys. Ten large health centers in New York City with high volumes of Medicaid patients were selected as study centers and 1,000 Medicaid enrollees with at least one primary care visit at one of the ten centers were randomly selected to be part of the study population. To be eligible, members had to be enrolled in Medicaid for at least five of the six months prior to the study.

Overall, members appeared relatively satisfied with their experience of care at large health centers in New York City. Variation in scores among the ten centers was noted, as illustrated in the table below. As was seen with the CAHPS managed care plan survey data, C&G survey data also identified adults as having higher levels of satisfaction with care received from their primary doctor.

	Overall Rate	**Range**
Getting Appointments and Care When Needed (Usually or Always)	55.6%	48.9 - 64.5
How Well Doctors Communicate (Usually or Always)	83.5%	76.9 - 88.9
Collaborative Decision Making (Yes)	85.7%	80.3 - 90.4
Courteous and Helpful Office Staff (Usually or Always)	72.7%	66.1 - 78.9
Rating of Health Center (8, 9, or 10)	65.7%	54.9 - 74.1

Managed Long Term Care Survey

In 2007, the Department developed a satisfaction survey for MLTC plan enrollees. The survey addressed the respondents' satisfaction with access to and timeliness of plan services as well as overall satisfaction with the plan and providers. The survey was repeated in 2011 and the Department anticipates administering it on a biennial basis. A summary of 2011 results are shown in the table below.

MLTC Member Satisfaction	
Satisfaction Measures	**Rate of MLTC Members Statewide**
Rating of Health Plan (Good or Excellent)	85%
Rating of Care Manager (Good or Excellent)	87%
Rating of Regular Visiting Nurse (Good or Excellent)	86%
Would Recommend Their Plan to a Friend (Yes)	91%
Access to Urgent Care with a Dentist (Same Day)	26%
Spoke to Their Health Plan About Advanced Directives (Yes)	63%

C. Plan Performance Improvement Projects and Quality Improvement Initiatives

New York's Medicaid managed care plans are required to conduct annual Performance Improvement Projects (PIPs). These projects have been reviewed by Island Peer Review Organization, Inc. (IPRO), the external quality review organization for New York State. In the past, projects have encompassed a wide range of topics important to the health and well-being of New York State residents. Each year, plans receive a compendium of results from all plans as a way of sharing best practices. Previous and ongoing PIPs are described below:

1) <u>Pediatric Obesity (PIP)</u>

The Department chose pediatric obesity as the common-themed PIP for 2009 and 2010, due to the escalating childhood obesity epidemic, particularly among publicly insured children in New York State. The aim of this PIP was to foster improvement in the prevention, identification and management of childhood obesity. Eighteen plans participated in this collaborative learning experience, and each identified plan-specific target populations, interventions and measures. In addition, each plan was required to design and develop interventions to impact health care providers, patients and families and community organizations/schools. The vast majority of plans used the following HEDIS® measures to address pediatric obesity: 1) Weight Assessment; 2) Counseling for Nutrition for Children/Adolescents; and, 3) Counseling for Physical Activity for Children/Adolescents. According to the 2010 Managed Care Plan Performance report for the Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents measures, New York State Medicaid managed care plans outperformed the national average based on 2009 data from the NCQA. For Weight Assessment, the New York Medicaid managed care statewide average is 51% compared to the national average of 30%. The New York Medicaid

managed care Counseling for Nutrition statewide average is 61% compared to the national average of 42%. The New York Medicaid managed care Counseling for Physical Activity statewide average is 48% compared to the national average of 33%. An April 2011 conference entitled, Weighing the Challenges and Opportunities: New York State Medicaid Managed Care Conference on Pediatric Obesity Performance Improvement 2009-2010, summarized the two-year PIP. A compendium of PIP results was also distributed to the plans and is available at the Department's website at: http://www.health.ny.gov/health_care/managed_care/reports/docs/2009_pip_abstract_compendium_final.pdf.

2) Eliminating Disparities in Asthma Care (PIP)

From 2010 through 2012 six Medicaid managed care plans partnered with practices in New York City to participate in a two year PIP, Eliminating Disparities in Asthma Care (EDAC).

The purpose of the EDAC project was to have each plan identify key strategies to reduce racial/ethnic disparities in clinical outcomes, and to improve care for African American patients with asthma residing in Brooklyn. This work is currently being implemented and the final EDAC PIP Report is due in July 2013.

3) Reducing Potentially Preventable Readmissions (PIP)

The two-year PIP for Medicaid Managed Care Plans began in 2011 and will continue through 2012. The objective of this PIP is to reduce potentially preventable readmissions by implementing proven interventions such as early hospital discharge planning, post-hospital follow-up and enhanced care coordination. The ten plans participating on this project are responsible for conducting the following: an investigation into the root causes of potentially preventable readmissions within their provider networks; and, identifying barriers and designing appropriate interventions to affect change. Plans are partnering with one or more hospitals and high volume primary care practices. The choice of measurement performance indicators is individualized by plan, allowing plans to customize performance measures to their individual interventions. The primary outcome measure of interest is readmission rates. Plans were given the opportunity to select their targeted population, such as members with specific chronic conditions that confer high risk for hospital readmission. Throughout this two-year period, plans participate in multi-plan calls to report on lessons learned, progress, and/or barriers encountered. The plans' final reports are due of July 2013.

In addition to the PIPs, IPRO also performs ad hoc studies of quality of care to obtain a greater understanding of the processes and quality of care provided by the Medicaid managed care plans. In doing so, IPRO is active in conducting medical records review and analyzing and synthesizing data to determine areas of greater need. Once issues are identified, IPRO and the Department conduct a focused clinical study. Descriptions of the studies are as follows:

4) Use of Clinical Risk Groups to Enhance Identification and Enrollment of Medicaid Managed Care Members in Case Management (Focused Clinical Study)

The Department, in collaboration with IPRO, conducted an analysis of Medicaid managed care members to further understand the New York Medicaid case-managed population. This study used a predictive modeling system, Clinical Risk Groups (CRGs), to illustrate who is currently enrolled in Medicaid managed care case management programs relative to categories.

Data from this study found that pregnant women and those with chronic conditions receive the largest benefit from care management.

This study demonstrated a notable overlap of members targeted for case management by plans and members identified to have high complexity/ high severity conditions by CRGs, consistent with the aim of identifying potential high resource utilizers. However, there were a number of cases where members were enrolled despite not being in the more complex CRGs, so clearly there are risk factors identified by managed care for case management that are not evident in the CRG algorithm. Conversely, there were members identified as high risk by the CRG grouper that were not triggered or enrolled in case management by the plans. There was wide variation in plan triggering practices, enrollment criteria and focus of plans case management programs, resulting in variation in scope and CRG distribution across plans. This focused study was the impetus for the development of the case management reporting system.

5) Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (Focused Clinical Study)

The Department, in collaboration with IPRO, conducted a clinical study on the HEDIS measure, Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB). The purpose of this study was to evaluate demographic and clinical factors associated with antibiotic prescribing for acute bronchitis in adults, to better understand observed clinician prescribing patterns and inform improvement efforts. The Department observed antibiotic prescribing rates were higher for adults with acute bronchitis than those based on the HEDIS AAB measure; and, over half of adult Medicaid managed care members presenting with acute bronchitis had a major chronic condition as defined by CRG health status. Few clear clinical drivers of antibiotic prescribing were identified; however, prescribing was associated with purulent sputum and a longer duration of cough, potentially indicating providers' concerns with non-viral etiologies. Members who did not receive antibiotics were more likely to be seen in the emergency department, were in receipt of chest X-ray, presumably to rule out pneumonia, and were associated with avoidance of antibiotics. Since there may be some subsets of patients who might benefit from antibiotics, further study of members with co-morbidities, older members, members with longer duration of illness, and members without upper respiratory infection may be conducted.

D. Implementing New Standards for Care

Patient Centered Medical Home

In 2010, the Department implemented its patient-centered medial home (PCMH) initiative. Providers who are recognized by the NCQA as a PCMH now receive additional payment for primary care services provided to both fee-for-service (FFS) and managed care beneficiaries. The reimbursement amounts differ by provider type and level of recognition as described in the Medicaid Update: http://www.health.ny.gov/health_care/medicaid/program/update/2009/2009-12spec.htm. As of January 2013, providers will no longer receive enhanced reimbursement or fees if they are recognized at Level 1.

Prenatal Care Standards Development

Prenatal care standards in New York State (10 NYCRR, Part 85.40) were developed in early 1990 in response to the creation of the Prenatal Care Assistance Program (PCAP), a prenatal care program developed to provide comprehensive prenatal care to low income, high risk pregnant women. The clinical standards of prenatal care have not been revised since the year 2000, highlighting a need to review Part 85.40 standards to compare them to current professional standards of practice. In order to accomplish this task, the Department partnered with IPRO to review the existing PCAP standards and compare them to current American Congress of Obstetricians and Gynecologists (ACOG) guidelines[1]. The new recommendations in prenatal care, as well as other national guidelines of obstetric practice, determine the need to modify the prenatal standards as they are applied to all Medicaid prenatal providers.

The revised Medicaid Prenatal Care Standards were published in February of 2010, in response to new legislation enacted in New York State in 2009 (Section 365-k of the Social Services Law and Section 2530-a (2) and (3) of the Public Health Law).[2] New York State's prenatal care standards include evidence-based procedures and practices appropriate to the needs of pregnant women who qualify for Medicaid, regardless of provider or delivery system. They integrate updated standards and guidance from the American Congress of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP). The standards provide a comprehensive model of care, including, but not limited to: comprehensive prenatal risk assessment; psychosocial risk assessment; prenatal diagnostic and treatment services; nutritional screening and counseling; health education; care coordination and postpartum services.

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[1] American Academy of Pediatrics and the American Congress of Obstetricians and Gynecologists (AAP/ACOG). *Guidelines for Perinatal Care, Sixth Edition.* October, 2007.

[2] New York State Medicaid Prenatal Care Standards – November 2009: http://www.health.ny.gov/health_care/medicaid/standards/prenatal_care/

2011 Prenatal Care Study

The Department and IPRO conducted a study of prenatal/postpartum care received by women enrolled in Medicaid in New York State with regard to the new Medicaid Prenatal Care Standards. The goal of this study was to determine providers' practices relative to the newly developed prenatal standards. A baseline assessment was conducted through a retrospective review of 601 medical charts to assess Medicaid provider adherence to key elements in the new standards. Once the results have been finalized, they will be used to inform provider training/education and the development of improvement interventions. A final report is being prepared by IPRO.

E. Selectively Contracting with Providers

As part of the effort to ensure the purchase of quality, cost-effective care for Medicaid beneficiaries, the Department conducts initiatives to review and, as warranted, limit the providers with which it contracts for certain services. Two such initiatives are currently in effect. The first initiative limits the number of providers who may perform mastectomy and lumpectomy procedures within New York State and the second limits the surgical centers that may perform bariatric surgery for weight loss. These initiatives apply to patients both in the Medicaid FFS program and in managed care. The goal for these initiatives is to channel beneficiaries to experienced providers where they will receive the best care and have the best outcomes.

- **Breast Cancer Surgery:** Section 504.3 (i) of Title 18 of the New York Codes, Rules and Regulations provides the authority to limit the number of providers that perform inpatient and outpatient surgical procedures for breast cancer.

  The Department stopped reimbursing for mastectomy and lumpectomy procedures associated with breast cancer at low-volume hospitals and ambulatory surgery centers as of March 1, 2009. The Department examines surgery volume for all payors annually and modifies the list of hospitals and ambulatory surgery centers with which Medicaid contracts for such surgery accordingly. Medicaid managed care plans may not use these restricted facilities. Plans are required to contract with eligible facilities or provide out-of-network authorization to those facilities for their members in need of breast cancer surgery.

- **Bariatric Surgery:** Bariatric surgery emerged as an alternative method of weight loss and long term weight maintenance for many obese and morbidly obese individuals for whom diet, exercise, and the normally prescribed medical therapies have proven ineffective. While there are benefits to this procedure, there are also substantial potential risks. Recent research conducted by the Department illustrated a significant postoperative complication rate following bariatric surgery, as well as a substantial hospital 30 day readmission rate following discharge for such surgeries. This research also found tremendous variation in the risk-adjusted complication and readmission rates among hospitals. Given such wide variation in hospital performance, the Department restricts Medicaid reimbursement for bariatric surgical services to those hospitals achieving CMS certification as a Bariatric

Surgical Center. Currently, approximately 40 hospitals in New York State have achieved certification and may be reimbursed for bariatric surgical services, for both managed care and FFS Medicaid recipients. This restriction is intended to ensure that Medicaid recipients receive bariatric surgical services at hospitals with the best outcomes.

F. Rewarding Quality

Since 2001, the Department provides a financial incentive to Medicaid managed care plans performing well on a set of quality, satisfaction, regulatory compliance (such as timeliness of data submissions and accuracy of reporting) and efficiency measures – Prevention Quality Indicators. Medicaid managed care plans are eligible to receive a 0%, 1%, 2% or 3% premium increase per member per month (PMPM) depending on overall performance in these four areas. Plans receiving an incentive greater than 0% are eligible to receive auto-assigned members. In the most recent cycle, one plan earned 3%, five plans earned the 2%, six plans earned the 1% and six plans did not receive any incentive. In addition, as per the Department's contracts with the plans, the Department has the authority to exclude any plan that fails to receive the minimum level of the incentive for three consecutive years from the Medicaid managed care program.

Section 4: Program Evaluation

The Partnership Plan Special Terms and Conditions (STC 75) require that an Interim Evaluation Report be included in any extension requests. Pursuant to 42 CFR 431.412(c)(2)(vi) the state is required to submit an interim evaluation report of the demonstration, inclusive of evaluation activities and findings to date, plans for evaluation activities during the extension period, and if changes are requested, identification of research hypotheses related to the changes and an evaluation design for addressing the proposed revisions. This extension request contains no amendments or modifications to the Partnership Plan.

The New York State Department of Health contracts with IPRO to provide implementation and monitoring support for Medicaid Redesign Team initiatives and other Medicaid related activities. IPRO has prepared the Interim Evaluation Report as required by 42 CFR 431.424.

Section 5: Compliance with Special Terms and Conditions

New York State has successfully completed all deliverables required by the Partnership Plan Special Terms and Conditions and continues to work diligently to assure compliance with all waiver requirements.

5.1 Program Monitoring

Through ongoing dialogue, program monitoring and regular and extensive reporting, New York State has assured CMS that it remains in compliance with the Partnership Plan terms and conditions.

The state utilizes a multi-pronged approach to monitor program compliance. Program reviews of local district operations are conducted as new counties transition to mandatory

implementation of managed care to assess program implementation and operations. County staff and service providers are trained about changes and have the opportunity to provide input on the impact. State staff continues to assist county staff after implementation providing technical assistance as needed. Regular conference calls are conducted between the Department, the enrollment broker and the New York City Human Resources Administration (HRA) to discuss operational issues, resolve problems and discuss program improvements. Periodic coalition meetings, facilitated by state staff, are conducted with regionally-based groups of local districts and managed care plans to share program information and provide technical assistance. Statewide conference calls and Webinars have been conducted for local districts, Managed Care Organizations (MCOs), providers and other stakeholders with the implementation of MRT initiatives to provide information and update all parties on the status of the rollout. HRA assists the state by conducting on-site monitoring of the enrollment broker's operations.

Auto-assignment rates continue to be monitored on a monthly basis for all mandatory counties and technical assistance is provided to counties as necessary to help maintain a high level of choice. Monthly Policy and Planning Meetings are held with managed care plans to provide timely information and technical assistance about the many MRT-related programmatic changes taking place.

The state oversees MCO's compliance with state and federal statutes and regulations, and adherence to the Medicaid/ Family Health Plus model contract. This is accomplished through bi-annual onsite operational surveys of the MCOs. On the alternate years, a follow up survey is conducted to review any areas that were not in compliance or are in need of improvement.

In addition, focused surveys are conducted for each MCO at regular intervals annually. The focused surveys review: whether the MCO's web based and printed provider directories correctly list the participating providers; member services departments to test for the degree of difficulty members encounter to reach a live voice, and if appropriate information is being provided in response to questions asked; and the Access and Availability Survey evaluates whether timely appointments for care from primary, obstetric or dental providers can be scheduled by new members.

CMS assesses state compliance with the terms and conditions in numerous ways. Conference calls are conducted on a weekly or monthly basis as needed to discuss any outstanding amendment requests and significant actual or anticipated developments affecting the program. The state submits to CMS both quarterly and annual operational reports presenting an analysis of and the status of various operational areas and program accomplishments. Quarterly CMS-64 reports are submitted to report total expenditures for services under the Partnership Plan. The state also provides CMS with other reports, studies and materials related to the program. CMS staff monitors regular meetings of the Medicaid Managed Care Advisory Review Panel (MMCARP), an advisory body appointed by the Governor and the New York State legislature.

As required by the Special Terms and Conditions, the state submitted a final evaluation report on the Partnership Plan demonstration on January 28, 2010. The report, prepared by Delmarva

Foundation based on data from 2006 - 2008, concluded that the state has met its objectives in that, "Provider networks have remained sufficient to meet accessibility standards; quality of care measures are not only reflecting improvement over time, but suggest that care is being delivered in a manner more consistent with commercial plan performance; …"

5.2 Financing Mechanisms

In the past, the state established premium rates for the managed care program through individual negotiations with each participating plan. These negotiations were based on the plans' historical cost experience and projections made by the plans for the rate year. Every two years, the rates were trended to reflect predicted changes in medical costs and operational efficiencies.

In April 2008, the Department began phasing in a risk-adjusted rate setting methodology whereby capitation rates are established based on the relative medical acuity of each plan's membership compared to the regional average. Using 3M's Clinical Risk Group (CRG) software, each member of a health plan is assigned a risk score based on their health status as determined by encounter and claims data. The risk score of all members enrolled in a plan are used to derive a plan risk score, or case mix. Plans with a higher than average case mix are reimbursed more; plans with lower than average case mix are reimbursed less. This change in methodology allows the state to more fairly reimburse plans with a more severe case mix of members. It also ensures that variation in reimbursement from plan to plan is based on the health status of their members rather than inefficiencies. In the first year of the phase in, the rates are a blend of 25% risk based and 75% trended negotiated rates; in year two the blend will be 50%-50%, year three 75%-25% and in year four, beginning in April 2011, 100% risk based rates were in place. The Department will monitor the efficacy of the CRG risk model in predicting medical costs and will make adjustments as needed.

5.3 Financial Monitoring

The Department monitors the financial solvency of health plans on a quarterly basis via a review of plans' financial reports, including revenue and expense statements and balance sheets. These reports measure the plans' compliance with minimum net worth (contingent reserve) and cash escrow fund requirements.

Under New York State regulation, the contingent reserve is equal to 12.5% of premium revenue for the previous calendar year for all product lines except MLTC products, which is fixed at five percent. Plans are allowed to phase in the contingent reserve beginning at 5% of premium revenue in year one, 6.5% in year two and thereafter in 1% increments per year until the full reserve of 12.5% is reached. The contingent reserve for most plans in 2012 is equal to 11.5% of 2011 premium revenue for commercial and Medicare products, 7.25% for mainstream Medicaid and 5% for Medicaid MLTC. The escrow fund is a cash requirement equal to 5% of projected medical expenses for the coming year. The cash deposits are held in a Deed of Trust regulated by the State Department of Financial Services (DFS), and withdrawals from the fund

may not be made without DFS approval. Plans must also submit bank statements on an annual basis showing that the Deed of Trust escrow accounts area is fully funded.

The Department compares the required reserves to the amounts reported on the plan's balance sheets quarterly. Failure to meet the reserve requirements results in the Department issuing a Statement of Deficiency and the plan must then submit a Plan of Correction that demonstrates how the reserve requirements will be met.

New York continues to pay supplemental rates to Federally Qualified Health Centers (FQHCs) under the requirements of federal law (42 U.S.C. §1396a(bb)(5)(A)). By June 1, 2008, FQHCs operating in mandatory counties and/or where a plan offers a FHPlus product, were required to document that contracts were in place with all managed care plans operating in the county. The initial Partnership Plan waiver included a Supplemental Transitional Payment Program (STPP) under which the state made supplemental payments directly to non-FQHC comprehensive health centers that primarily serve Medicaid and indigent populations. A transitional payment program reimbursed up to 90% of the per visit difference between the amount the health center would have received under its FFS rates and the amount it received under its managed care contracts. The STPP ended on September 30, 2006.

Section 6: Compliance with Budget Neutrality Requirements

The Special Terms and Conditions of New York State's Section 1115 waiver require that the Partnership Plan be budget neutral, that is, the cost to the federal government under the waiver cannot be more than the cost that would have occurred without the waiver. The state has demonstrated to CMS that the waiver has been successful in not only achieving budget neutrality but in realizing savings for the state and federal government.

6.1 Budget Neutrality Monitoring

The neutrality formula consists of two components: Without Waiver expenditures and With Waiver expenditures. Budget neutrality is continuously updated and monitored to ensure that the projections are current and that the waiver remains budget neutral.

Without Waiver expenditures consist of the number of persons eligible for the waiver in each of the agreed upon Medicaid eligibility groups (MEGs) times the trended PMPM allowance agreed to with CMS. The Department updates eligible member months every three months and uses the most current available data in its budget neutrality projections.

With Waiver expenditures consist primarily of medical claim costs for individuals eligible under the waiver. Medical costs represent a combination of managed care capitation payments for waiver eligible recipients enrolled in managed care and FFS payments for recipients who are not enrolled in managed care plans or for services that are carved out of the managed care benefit package. Examples of these services include certain mental health and substance abuse services. With Waiver expenditures are updated periodically using reports developed for the waiver eligible population. Because providers have up to two years to submit claims to MMIS for payment, actual claims data is lagged for 21 months to allow it to "mature" before it is

considered final in the budget neutrality calculation. Once actual final data is incorporated into the budget neutrality calculation it becomes the basis for projecting future medical costs.

The With Waiver methodology includes expenditures related to previously approved programs such as family planning expansion. Also incorporated are new programs such as the Hospital Medical Home and Potentially Preventable Readmissions (PPR) Demonstrations and Clinic Uncompensated Care funding which were approved as part of an amendment in October 2011. The goals of these demonstrations range from improving the coordination and quality of care for individuals receiving primary care in settings used by teaching hospitals, to testing strategies for reducing the rate of preventable readmission within the Medicaid population. Furthermore, the new Uncompensated Care funding will allow the state to double the amount of grants provided through its current Clinic Indigent Care program through a federal match.

6.2 Budget Neutrality Summary

The Partnership Plan waiver has always demonstrated significant savings. A chart showing the calculation of the budget neutrality savings is included as Attachment 3, Projected 1115 Waiver Budget Neutrality Impact through 2013. Savings are expected to grow even more during the waiver extension period (see Attachment 3A, Projected 1115 Waiver Budget Neutrality Impact through 2017).

Section 7: Public Notice Procedures

7.1 Public Notice

New York followed requirements of the Centers for Medicare and Medicaid Services (CMS) final rule to establish a process to promote State and Federal Transparency for Medicaid and Children's Health Insurance Program (CHIP) Demonstrations issued on February 22, 2012 and effective April 27, 2012 (42 CFR 431.408 State Public Notice process).

The public notice was posted for 30 days on the Department of State's Register website (refer to Attachment 4 Public Notice). Two public hearings in two separate locations and one webinar were scheduled to gather feedback and assure public input on the waiver extension request. All interested speakers were given an opportunity to express their views which were documented and incorporated into the final waiver extension application. No pre-registration was necessary for the public hearings.

The Department received one request for information as a result of the public notice which was posted from September 12, 2012 until October 11, 2012. The individual asked where a copy of a report listed in the Interim Report prepared as part of the extension application could be found. The requested information was provided. In addition, we received an e-mail from one of our stakeholders that the dates listed for the expansion of the mandatory MLTC across the state should be reviewed. We revised the dates originally listed to correctly reflect the implementation plan.

Four individuals attended the public hearing in Rensselaer, New York, held on Thursday, September 20, 2012 and three individuals attended the public hearing in Brooklyn, New York, held on Tuesday, September 25, 2012. No questions were asked or comments made by those in attendance at the public hearings.

Twenty-eight individuals participated in the webinar held on Thursday, September 27, 2012. The following questions/comments were submitted by attendees:

- What exactly is the waiver waiving?
- What is F-SHRP?
- Does the waiver extension application extend F-SHRP as well?
- Can you summarize comments from other public hearings?
- Where can I get a copy of the power point presentation?
- Can you explain again how this Partnership extension works with the $10 billion waiver amendment submitted in August?

All of the questions were answered. Of note, none of the questions asked during the webinar or received from the public impacted the Partnership Plan extension application.

7.2 Tribal Nations

New York State is home to nine federally-recognized Tribal Nations:

Cayuga Nation of Indians
Onondaga Nation
Seneca Nation of Indians
Tonawanda Band of Senecas
Unkechaug Indian Nation
Oneida Indian Nation of New York
St. Regis Mohawk Nation
Shinnecock Nation
Tuscarora Indian Nation

In accordance with 42 CFR 431.408(b), on August 17, 2012 (60 days prior to submission of the waiver extension application to CMS) the Department of Health advised the above mentioned tribes by letter of our intent to request an extension of the 1115 waiver, the Partnership Plan (refer to Attachment 5, Tribal Letter). In addition, tribal representatives were given an opportunity to attend a phone conference on Friday, August 24, 2012 at 9:00 a.m.

Section 8: Post Award Activities

In accordance with 42 CFR 431.420(c) Post Award, within six months after the implementation date of the extension and annually thereafter, the special Medicaid Managed Care Advisory Review Panel (MMCARP) will meet and offer an opportunity for the public to provide comments. The MMCARP consists of nine members, including three members appointed by the Governor, three members appointed by the New York State Senate, and three members appointed by the New York State Assembly. The Panel was established by Chapter 649 of the

Laws of 1996 to assess and evaluate multiple facets of the Medicaid managed care program, including provider participation and capacity; enrollment targets; phase-in of mandatory enrollment; the impact of marketing, enrollment and education strategies; and the cost implications of exclusions and exemptions. This Panel meets quarterly. The Department's Public Affairs Group is responsible for posting the meeting notice.

Attachments

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1	QARR/National Benchmark Comparison 2010	1-1
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Attachment 1: QARR/National Benchmark Comparison 2010

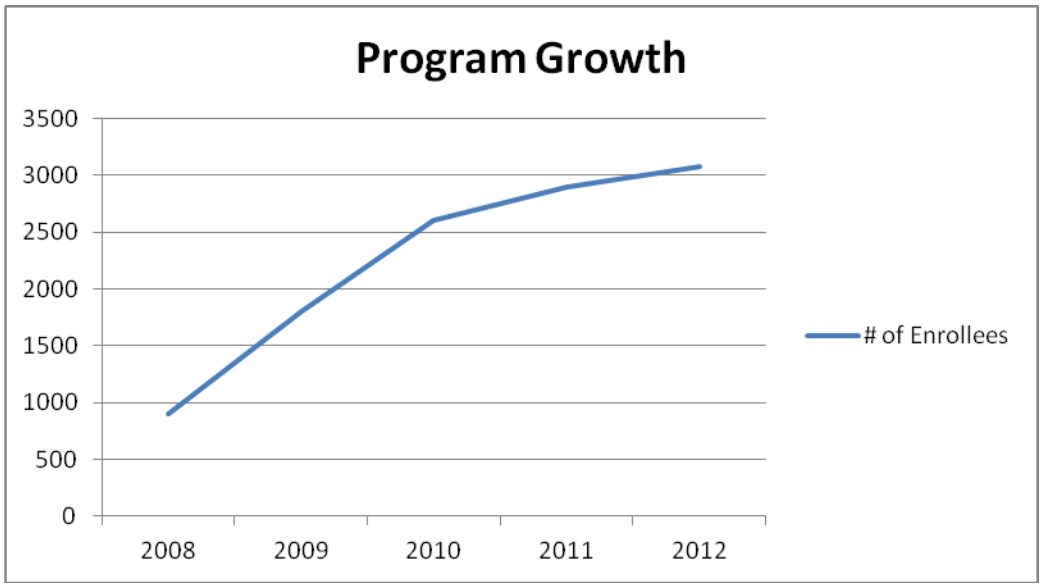
Eighteen Medicaid managed care plans and three Medicaid Special Needs plans submitted 2010 QARR data in June 2011. All plan data was audited by NCQA licensed audit organizations prior to submission. The results for the two products for 2010 are displayed in the following table. As indicated by green shading, NYS Medicaid managed care average exceeded the national benchmarks for 39 of 42 measures (gray cells indicate that national benchmarks were not available). Yellow shading indicated NYS' average was equal to national benchmarks, while red shading indicated NYS' average was below national benchmarks. Medicaid plans submitted 2011 data in June 2012. Data is being finalized and NCQA's report with national benchmarks for 2011 data is expected in October 2012.

Measure	NCQA SOHC 2011 Medicaid Average*	2010 NYS Medicaid Managed Care Average	2010 NYS Medicaid HIV SNP Average
Children and Adolescents' Access to PCPs Ages 12-19 Yrs	88	92	92
Children and Adolescents' Access to PCPs Ages 12-24 months	96	96	88
Children and Adolescents' Access to PCPs Ages 25 Mos-6 Yr	88	93	83
Children and Adolescents' Access to PCPs Ages 7-11 Yrs	90	95	91
ADHD Continuation	44	64	SS
ADHD Initiation	38	58	SS
Adolescents' Assessment or Counseling or Education- Substance Use		60	71
Adolescents' Assessment or Counseling or Education- Depression		52	51
Adolescents' Assessment or Counseling or Education- Sexual Health		60	70
Adolescents' Assessment or Counseling or Education- Tobacco Use		64	66
Adults' Access to Care Age 20-44 Yrs		82	97
Adults' Access to Care Age 45-64 Yrs		89	99
Adults' Access to Care Age 65 and over		89	97
Adult BMI Assessment (ABA)	42	70	82
Ambulatory Follow-Up After Hosp for Mental Illness-30 Days	64	84	49

Measure	NCQA SOHC 2011 Medicaid Average*	2010 NYS Medicaid Managed Care Average	2010 NYS Medicaid HIV SNP Average
Ambulatory Follow-Up After Hosp for Mental Illness-7 Days	45	70	25
Antidepressant Medication Management-180 Day Effective Phase Treatment	34	35	40
Antidepressant Medication Management-84 Day Acute Phase Treatment	51	52	52
Drug Therapy in Rheumatoid Arthritis	70	76	N/A
Use of Appropriate Asthma Medications (Ages 12-50)	86	88	82
Use of Appropriate Asthma Medications (Ages 12-50) 3+ Controllers		77	76
Use of Appropriate Asthma Medications (Ages 5-11) 3+ Controllers		76	SS
Use of Appropriate Asthma Medications (Ages 5-50) 3+ Controllers		76	77
Use of Appropriate Asthma Medications (Ages 5-11)	92	92	SS
Use of Appropriate Asthma Medications (Ages 5-50)	88	90	82
Use of Imaging Studies for Low Back Pain	76	79	74
Avoidance of Antibiotics for Adults with Acute Bronchitis	24	27	N/A
Cervical Cancer Screening	67	72	86
Chlamydia Screening (Ages 16-20)	55	67	75
Chlamydia Screening (Ages 16-24)	62	68	75
Chlamydia Screening (Ages 21-24)	58	69	76
Annual Dental Visit(Ages 2-18)		54	N/A
Annual Dental Visit(Ages 2-21)		53	N/A
Frequency of Ongoing Prenatal Care 81-100%	61	74	63
Controlling High Blood Pressure (Ages 18-85)	56	67	59
HIV/AIDS Comprehensive Care- Engaged in Care		80	92
HIV/AIDS Comprehensive Care- Syphilis Screening Rate		58	74
HIV/AIDS Comprehensive Care- Viral Load Monitoring		58	85
Breast Cancer Screening	51	68	69
Annual Monitoring for Patients on Persistent Medications- ACE inhib/ARBs	86	91	98

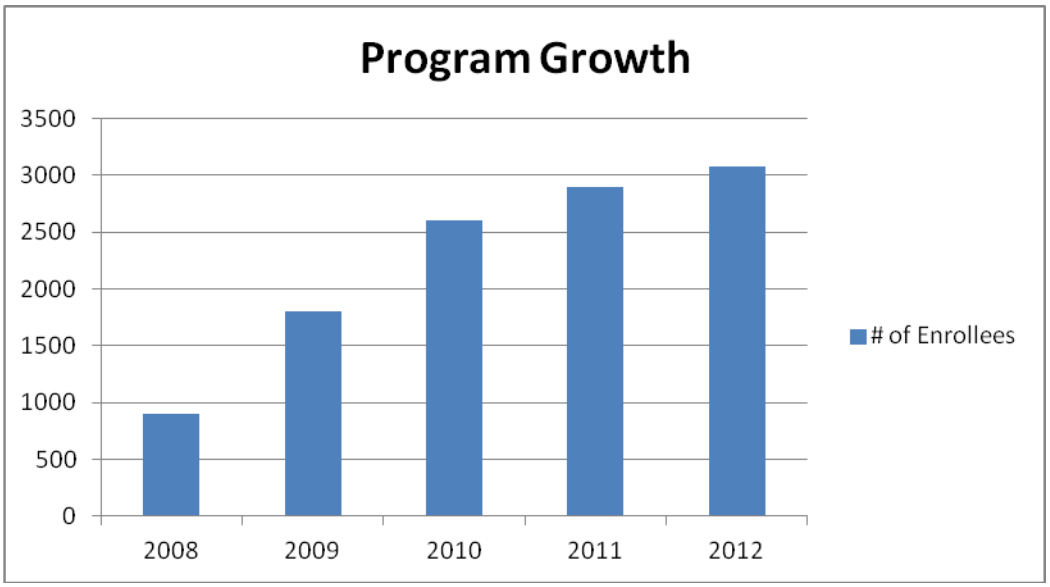
Measure	NCQA SOHC 2011 Medicaid Average*	2010 NYS Medicaid Managed Care Average	2010 NYS Medicaid HIV SNP Average
Annual Monitoring for Patients on Persistent Medications- Anticonvulsant	68	67	58
Annual Monitoring for Patients on Persistent Medications- Combined	84	89	97
Annual Monitoring for Patients on Persistent Medications- Digoxin	90	94	SS
Annual Monitoring for Patients on Persistent Medications- Diuretics	86	90	98
Pharmacotherapy Management of COPD Exacerbation- Bronchodilator	82	85	91
Pharmacotherapy Management of COPD Exacerbation- Corticosteroid	65	66	52
Appropriate Testing for Pharyngitis	65	84	SS
Postpartum Care	64	73	49
Timeliness of Prenatal Care	84	90	80
Use of Spirometry Testing for COPD	31	46	26
Appropriate Treatment for URI	87	91	98
Well-Child Visits in 3rd, 4th, 5th & 6th Year of Life	72	80	76
Adolescent Well-Care Visits	48	56	52
5 or More Well-Child Visits in the First 15 Months of Life	76	77	61
Weight Assessment for Children and Adolescents	37	65	79
Weight Counseling for Nutrition for Children and Adolescents	46	71	71
Weight Counseling for Physical Activity for Children and Adolescents	37	58	53
SS - sample size less than 30			
N/A - not applicable to the product			
*National benchmarks from NCQA's 2011 State of Health Care Quality report			

Attachment 2: ESHI Growth Charts



year 1 growth (1800 - 900 = 900 900/900 = 1 * 100 = 100%)	100%
year 2 growth (2600 - 1800 = 800 800 / 1800 = .444 * 100 = 44.4%)	44%
year 3 growth	11.50%
year 4 partial year growth	6.20%

18.5% 2010-2012



Attachment 3: Projected 1115 Waiver Budget Neutrality Impact through 2013

ATTACHMENT 3
New York State Partnership Plan
Projected 1115 Waiver Budget Neutrality Impact Through December 2013

Budget Neutrality Cap (Without Waiver)	DY 1 - 11 (10/1/97 - 9/30/09) Projected	DY 12 (10/1/09-9/30/10) Actual	DY 13A 10/1/10-3/31/11) Projected	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 (10/1/09 - 12/31/13) Projected
Demostration Group 1 - TANF Children under age 1 through 20		$11,197,206,500	$6,105,699,488	$6,123,530,693	$13,426,169,462	$14,838,728,535	$7,942,549,075	$59,633,883,752
Demonstration Group 2 - TANF Adults 21-64		$4,511,421,595	$2,467,348,368	$2,454,367,076	$5,370,065,165	$5,929,497,585	$3,168,028,125	$23,900,727,913
Demonstration Group 6 - FHP Adults w/Children		$1,878,516,641	$1,043,047,420	$1,055,415,331	$2,341,067,454	$2,632,237,613	$724,658,042	$9,674,942,501
Demonstration Group 8 - Family Planning Expansion				$5,140,241	$10,702,271	$11,139,306	$5,795,793	$32,777,610
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	**$187,390,575,140**	**$17,587,144,736**	**$9,616,095,275**	**$9,638,453,340**	**$23,949,611,226**	**$35,259,505,743**	**$14,898,066,164**	**$110,948,876,485**

Budget Neutrality Cap (With Waiver)	DY 1 - 11 (10/1/97 - 9/30/09) Projected	DY 12 (10/1/09-9/30/10) Actual	DY 13A 10/1/10-3/31/11) Projected	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 (10/1/09 - 12/31/13) Projected
Demostration Group 1 - TANF Children under age 1 through 20		$5,006,727,158	$2,714,708,527	$2,722,636,616	$5,935,822,630	$6,523,312,850	$3,471,965,618	$26,375,173,399
Demonstration Group 2 - TANF Adults 21-64		$2,891,489,419	$1,575,447,496	$1,567,158,701	$3,416,017,313	$3,757,736,011	$2,000,129,300	$15,207,978,241
Demonstration Group 5 - Safety Net Adults		$5,947,064,577	$3,499,710,446	$3,596,498,109	$8,302,164,325	$9,567,591,719	$2,581,892,316	$33,494,921,492
Demonstration Group 6 - FHP Adults w/Children up tp 150%		$910,895,137	$503,870,306	$509,844,937	$1,126,650,488	$1,262,025,032	$346,136,227	$4,659,422,127
Demonstration Group 7 - FHP Adults without Children up to 100%		$327,279,755	$168,015,728	$171,374,962	$383,180,812	$435,967,331	$120,734,643	$1,606,553,232
Demonstration Group 7A - FHP Adults without Children @ 160%		$0	$0	$0	$0	$0	$0	$0
Demonstration Group 8 - Family Planning Expansion		$9,839,735	$4,164,485	$5,460,394	$11,576,340	$12,272,547	$6,504,704	$49,818,205
Demonstration Group 9 - Home and Community Based Expansion (HCBS)		N/A	N/A	$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
With Waiver Total	**$157,629,949,646**	**$15,093,295,780**	**$8,465,916,988**	**$8,581,872,826**	**$22,157,595,820**	**$33,133,282,590**	**$11,449,784,449**	**$98,881,748,455**
Expenditures (Over)/Under Cap	**$29,760,625,494**	**$2,493,848,956**	**$1,150,178,287**	**$1,056,580,514**	**$1,792,015,405**	**$2,126,223,153**	**$3,448,281,715**	**$12,067,128,030**

Attachment 3A: Projected 1115 Waiver Budget Neutrality Impact through 2017

ATTACHMENT 3A
New York State Partnership Plan
Projected 1115 Waiver Budget Neutrality Impact Through December 2017

Budget Neutrality Cap (Without Waiver)	DY 17 (1/1/14-9/30/14) Projected	DY 18 (10/1/14-9/30/15) Projected	DY 19 (10/1/15-9/30/16) Projected	DY 20 (10/1/16-9/30/17) Projected	DY 21 (10/1/17-12/31/17) Projected	DY 17-21 (1/1/14-12/31/17) Projected	DY 1 - 21 (10/1/97 - 12/31/17) Projected
Demostration Group 1 - TANF Children under age 1 through 20	$7,942,549,075	$16,933,174,020	$18,050,499,494	$19,232,176,099	$5,125,211,985	$67,283,610,673	
Demonstration Group 2 - TANF Adults 21-64	$3,168,028,125	$6,741,421,613	$7,172,746,363	$7,627,222,122	$2,028,764,816	$26,738,183,038	
Demonstration Group 6 - FHP Adults w/Children	$2,234,949,343	$3,314,166,058	$3,635,350,488	$3,976,371,601	$1,076,110,681	$14,236,948,171	
Demonstration Group 8 - Family Planning Expansion	$0	$0	$0	$0	$0	$0	
Demonstration Group 10 - MLTC Adult Age 18-64 Duals	$781,863,611	$1,057,240,682	$1,072,731,995	$1,087,682,991	$275,376,201	$4,274,895,480	
Demonstration Group 11 - MLTC age 65+ Duals	$8,401,081,221	$11,588,978,472	$11,995,853,907	$12,408,289,303	$3,204,829,126	$47,599,032,029	
W/O Waiver Total	**$22,528,471,375**	**$39,634,980,845**	**$41,927,182,248**	**$44,331,742,115**	**$11,710,292,809**	**$160,132,669,391**	**$458,472,121,016**

Budget Neutrality Cap (With Waiver)	DY 17 (1/1/14-9/30/14) Projected	DY 18 (10/1/14-9/30/15) Projected	DY 19 (10/1/15-9/30/16) Projected	DY 20 (10/1/16-9/30/17) Projected	DY 21 (10/1/17-12/31/17) Projected	DY 17-21 (1/1/14-12/31/17) Projected	DY 1 - 21 (10/1/97 - 12/31/17) Projected
Demostration Group 1 - TANF Children under age 1 through 20	$3,471,965,618	$7,360,506,306	$7,802,052,783	$8,266,040,188	$2,190,435,026	$29,090,999,921	
Demonstration Group 2 - TANF Adults 21-64	$2,000,129,300	$4,240,216,438	$4,494,541,044	$4,761,341,745	$1,261,708,922	$16,757,937,450	
Demonstration Group 5 - Safety Net Adults	$7,745,676,947	$11,050,525,928	$11,824,090,420	$12,651,822,218	$3,384,369,363	$46,656,484,875	
Demonstration Group 6 - FHP Adults w/Children up tp 150%	$1,067,533,772	$1,577,088,330	$1,723,450,041	$1,878,042,135	$506,338,494	$6,752,452,771	
Demonstration Group 7 - FHP Adults without Children up to 100%	$375,291,167	$561,405,772	$618,804,409	$679,603,143	$184,121,396	$2,419,225,887	
Demonstration Group 7A - FHP Adults without Children @ 160%	$0	$0	$0	$0	$0	$0	
Demonstration Group 8 - Family Planning Expansion						$0	
Demonstration Group 9 - Home and Community Based Expansion (HCBS)						$0	
Demonstration Group 10 - MLTC Adult Age 18-64 Duals	$747,134,811	$1,036,369,614	$1,059,388,516	$1,091,815,996	$286,255,977	$4,220,964,914	
Demonstration Group 11 - MLTC age 65+ Duals	$7,870,012,341	$10,965,561,955	$11,326,099,635	$11,793,622,604	$3,112,238,924	$45,067,535,458	
Demonstration Population 1: State Indigent Care Pool Direct Expenditures (ICP-Direct)						$0	
Demonstration Population 2: Designated State Health Programs to Support Clinic Uncompensated Care Funding (ICP - DSHP)						$0	
Demonstration Population 3: Designated State Health Programs to Support Medical Home Demonstration (DSHP - HMH Demo)						$0	
Demonstration Population 4: Designated State Health Programs to Support Potentially Preventable Readmission Demonstration (DSHP - PPR Demo)						$0	
With Waiver Total	**$23,277,743,956**	**$36,791,674,342**	**$38,848,426,849**	**$41,122,288,029**	**$10,925,468,101**	**$150,965,601,276**	**$407,477,299,377**
Expenditures (Over)/Under Cap	**($749,272,581)**	**$2,843,306,503**	**$3,078,755,399**	**$3,209,454,086**	**$784,824,708**	**$9,167,068,115**	**$50,994,821,639**

Attachment 4: Public Notice

MISCELLANEOUS NOTICES/HEARINGS

Notice of Abandoned Property Received by the State Comptroller

Pursuant to provisions of the Abandoned Property Law and related laws, the Office of the State Comptroller receives unclaimed monies and other property deemed abandoned. A list of the names and last known addresses of the entitled owners of this abandoned property is maintained by the office in accordance with Section 1401 of the Abandoned Property Law. Interested parties may inquire if they appear on the Abandoned Property Listing by contacting the Office of Unclaimed Funds, Monday through Friday from 8:00 a.m. to 4:30 p.m., at:

1-800-221-9311
or visit our web site at:
www.osc.state.ny.us

Claims for abandoned property must be filed with the New York State Comptroller's Office of Unclaimed Funds as provided in Section 1406 of the Abandoned Property Law. For further information contact: Office of the State Comptroller, Office of Unclaimed Funds, 110 State St., Albany, NY 12236.

NOTICE OF PUBLIC HEARING

Department of Health

Pursuant to 42 CFR Section 431.408 the Department of Health hereby gives notice of the following:

New York State requests that the federal government extend New York State's Medicaid Section 1115 Demonstration, Partnership Plan (11-W-00114/2) for an additional five years. No other changes to the Partnership Plan will be requested in the extension application, and as such, current program features of the Plan will remain the same.

The complete extension application, which includes an interim evaluation of the Partnership Plan which assesses the degree to which the Demonstration goals have been achieved and the hypothesis and parameters of the demonstration, can be found on the MRT Waiver Extension website at http://www.health.ny.gov/health_care/medicaid/redesign/mrt_waiver_ext_info.htm.

Operating since 1997, New York State's Medicaid Section 1115 Partnership Plan waiver program has played a critical role in improving access to health services and outcomes for the poorest and most at risk residents. The waiver allows the state to operate a mandatory Medicaid managed care program designed to: improve the health of recipients by providing comprehensive and coordinated health care; offer comprehensive health coverage to low-income uninsured adults who have income and/or assets above Medicaid eligibility standards (Family Health Plus Program); and provide family planning services to women losing Medicaid eligibility at the conclusion of their postpartum period and certain other adults of child bearing age (Family Planning Expansion Program).

On September 29, 2006, the Centers for Medicare and Medicaid Services (CMS) approved an extension of New York State's Medicaid Section 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 two waiver amendments on September 30, 2011 and March 30, 2012 incorporating changes resulting from recommendations of the Governor's Medicaid Redesign Team. New York State Department of Health (NYSDOH) is currently negotiating with CMS on two additional amendments, the Managed Long Term Care (MLTC) amendment and the Medicaid Redesign Team (MRT) amendment.

The MRT amendment to the Partnership Plan waiver will allow the state to reinvest in its health care infrastructure as well as the freedom to innovate. The waiver extension will also allow the state to prepare for implementation of national health care reform as well as effectively reduce health care costs. We anticipate that it will take New York State five years to fully implement its care management vision.

The public is invited to review and comment on the state's proposed waiver extension request. Public Hearings and webinar are scheduled for:

Waiver Extension Public Hearing - Albany

September 20, 2012, 1 PM - 4 PM

University at Albany
School of Public Health Auditorium
1 University Place
Rensselaer, New York

Waiver Extension Public Hearing - Brooklyn

September 25, 2012, 11:30 AM - 2:30 PM

New York City College of Technology
Auditorium - Klitgord Center
285 Jay Street
Brooklyn, NY

Waiver Extension Public Hearing - Webinar

September 27, 2012, 1 PM - 4 PM

Registration information will be made available on the Waiver Extension website http://www.health.ny.gov/health_care/medicaid/redesign/mrt_waiver_ext_info.htm.

Comments (including comments sought through the public engagement process) concerning the state's plan to submit a waiver extension request can be sent to the e-mail or postal addresses below for a period of thirty (30) days from the date of this notice.

- mrtwaiver@health.state.ny.us
- Attn: Jason Helgerson

Office of Health Insurance Programs
New York State Department of Health
1 Commerce Plaza, Suite 1211
Albany, NY 12224

Details on the waiver extension request, full public notice and more information on the state's public engagement process are available at the state's MRT waiver extension website at http://www.health.ny.gov/health_care/medicaid/redesign/mrt_waiver_ext_info.htm.

PUBLIC NOTICE

Department of State

The New York State Appearance Enhancement Advisory Committee will hold an open board meeting on Monday, September 24, 2012 at 10:30 a.m. at the New York State Department of State, 99 Washington Avenue, 5th Floor Conference Room, Albany; 65 Court Street, 2nd Floor Conference Room, Buffalo; and, 123 William Street, 2nd Floor Conference Room, New York City.

Should you require further information, please contact: Carol Fansler at carol.fansler@dos.ny.gov or (518) 486-3857

PUBLIC NOTICE

Uniform Code Regional Boards of Review

Pursuant to 19 NYCRR 1205, the petitions below have been received by the Department of State for action by the Uniform Code Regional Boards of Review. Unless otherwise indicated, they involve requests for relief from provisions of the New York State Uniform Fire Prevention and Building Code. Persons wishing to review any petitions, provide comments, or receive actual notices of any subsequent proceeding may contact Steven Rocklin, Codes Division, Department of State, One Commerce Plaza, 99 Washington Ave., Albany, NY 12231, (518) 474-4073 to make appropriate arrangements.

2012-0354 Matter of Titus Mountain Family Ski Center, 215 Johnson Road, Malone, New York,12953, c/o Tim McCarthy Architect PC, 83 Walkerville Road, North Bangor, New York, 12966. The petitioner requests a variance to reconstruct and add square footage to a portion of the Main Lodge building without providing an automatic fire sprinkler system as required by the Building Code of New York State, Section 903.2.1.2, County of Franklin, State of New York.

2012-0391 Matter of Clarkson University, 8 Clarkson Ave. Potsdam, New York, 13699 c/o Ian Hazen, Dir of Facilities and Services. The petitioner requests a variance to remodel two existing wings and add three stories of new square footage to a portion of the dormitory building known as "Moore House", without providing the areas of refuge on the second, third and forth floors as required by the Building Code of New York State, Section 1007, County of St. Lawrence, State of New York.

2012-0408 Matter of Michael Grzybosky, 518 Hospitality Ventures dba Nosh NY Deli, 1645 Western Ave, Albany, NY 12203 for a variance concerning the installation of a newly developed dishwasher that operates with water that is at a reduced water temperature.

Involved is the opening of a new delicatessen in the City of Albany. The owner wishes to install a non-compliant dishwasher. The building contains an M (mercantile) occupancy, is one story in height of Type IIIB (ordinary) construction having a gross floor area of 3,000 square feet. The building is located at 1645 Western Ave., City of Albany, Albany County, State of New York.

2012-0409 Matter of Jason Adam Bean, Project Foreman, Prutting & Company Custom Builders, 70 Pine St., New Canaan, CT. 06840 for a variance concerning a shallow pitched roof.

Involved is the construction of a new residence with distinctive architectural features that require a shallow pitched roof. The building contains a single family dwelling, is one story in height of Type IIB (non-combustible) construction having a gross floor area of 2,500 square feet. The building is located at 117 Schnackenbberg Rd., Town of Ghent, Columbia County, State of New York.

2012-0410 Matter of Laura Cooney, A.I.A. LMC Codes for SUNY Binghamton, 4400 Vestal Parkway East, Vestal NY for a variance concerning fire safety and building code requirements including the requirement to omit audible alarm for the fire alarm system devices in the animal research laboratories.

Involved are alterations to an existing building known as the "Science Complex Buildings III, IV & V", located at 4400 Vestal Parkway East, Town of Vestal, Broome County, State of New York.

2012-0411 Matter of Dusty Fuller, 770 Bleeker Street, Utica NY for a variance related to second means of egress, wood on walls of interior exit stairways, the fire rating of the cellar ceiling and cellar stairs in accordance with the New York State Multiple Residence Law.

Involved is an existing three story building located at 770 Bleeker Street, City of Utica, Oneida County, State of New York.

2012-0413 Matter of Robin White 21 Front St.,Schenectady, NY 12305 for a variance concerning public safety issues including a violation of the Multiple Residence Law.

Involved is the routine inspection of an existing multiple dwelling using the Multiple Residence Law requirements, including MRL Section 30 which requires that the cellar shall have a ceiling or a sprinkler system. The subject building has neither. The building contains an R-2 (multiple dwelling) occupancy, is 3 stories in height of Type IIIb (ordinary) construction having a cumulative gross floor area of 4,000 square feet. The building is located at 208 Union St., City of Schenectady, County of Schenectady, State of New York.

Attachment 5: Tribal Notification Mailed on August 17, 2012

NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

August 17, 2012

Chief Roger Hill
Council Chairman
Tonawanda Seneca Indian Nation
Administration office
7027 Meadville Road
Basom, NY 14013

Dear Chief Hill:

In July 1997, New York State received approval from the federal government of its Section 1115 waiver request, known as the Partnership Plan. Approval of this waiver allowed the State to implement a mandatory Medicaid managed care program in counties with sufficient managed care capacity and the infrastructure to manage the education and enrollment processes essential to a mandatory program. On September 29, 2006, The Center for Medicare and Medicaid (CMS) approved an extension of 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 for the period August 1, 2011 through December 31, 2014.

This letter is to notify you that New York State will request an extension of the existing 1115 Partnership Plan waiver from the federal government. As indicated in our June 6, 2012 letter, New York is already pursuing an amendment to the state's Partnership Plan. This extension will allow the state to fully implement its care management vision set out by the Medicaid Redesign Team (MRT).

Details about the MRT waiver are available on the state's MRT waiver website at http://www.health.ny.gov/health_care/medicaid/redesign/mrt_waiver.htm. The full extension request will be posted to this site shortly. Additionally, you are invited to sign up for an email list serve which will provide updates throughout the waiver public engagement and application process at http://www.health.ny.gov/health_care/medicaid/redesign/listserv.htm .

As you know, under the state's Section 1115 Demonstration programs, Native Americans with Medicaid coverage may enroll in managed care plans but are not required to do so. This waiver extension request will not alter this exemption from mandatory enrollment for Native Americans. In addition, for Native Americans who choose to enroll in managed care plans, existing policies relating to tribal providers will be continued. We anticipate this extension will have minimal impact on Tribal Nations.

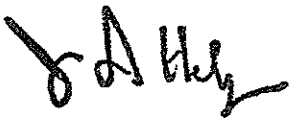
My office has scheduled a conference call to provide an overview of the waiver extension process and to take any questions you may have.

The call is scheduled for Friday, August 24, 2012 at 9:00 a.m. If you would like to participate, please use the following call-in information:

Call-in #: 1-866-394-2346
Conference Code: 105 726 8043#

If you're not able to participate, or have additional comments, please forward any questions or input regarding this waiver extension to my office by Tuesday, August 28, 2012. We look forward to your continued collaboration.

Sincerely,



Jason A. Helgerson
Medicaid Director
Office of Health Insurance Programs

cc: Vennetta Harrison
Karina Aguilar

NEW YORK STATE DEPARTMENT OF HEALTH

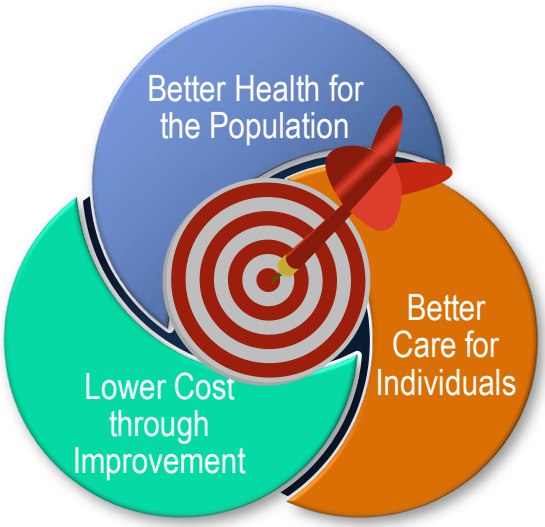
PARTNERSHIP PLAN MEDICAID SECTION 1115 DEMONSTRATION (NO. 11-W-00114/2)

INTERIM EVALUATION REPORT

SEPTEMBER 11, 2012

EXECUTIVE SUMMARY

New York State Department of Health (the Department or NYSDOH) has experienced great success with its current Medicaid Section 1115 Waivers (Partnership Plan and F-SHRP) and is seeking an extension of the Partnership Plan Waiver in order to continue to realize improvements in access, quality and cost effectiveness, consistent with CMS and New York State's Triple Aims.



The current Waivers have achieved remarkable results in support of the major goals:

- Improvement in access and coverage.
- Improvement in quality.
- Improvement in cost effectiveness.

Measures of success for each of the major components of the Partnership Plan Waiver have been documented and are discussed in this Interim Evaluation Report.

MEDICAID MANAGED CARE

- 12.6 percent increase in enrollment from 2010 to 2012.
- 84 percent of eligible Medicaid recipients enrolled as of October 2010.
- 98 percent of the national quality benchmarks have been met.
- PCPs per 1,000 enrollees increased from 4.54 to 4.79 from 2010 to 2011.
- Without the Waiver in place, projected expenditures would have been 225 percent higher for TANF children and 157 percent higher for TANF adults.
- For the three year period 2009 to 2012, Medicaid Managed Care under the Waiver will yield of $20.4 billion for TANF children and $5.4 billion for TANF adults.

FAMILY HEALTH PLUS

- 11 percent increase in enrollment from 2010 to 2012.
- 85 percent of national quality benchmarks exceeded.
- Without the Waiver in place, projected expenditures for Family Health Plus adults with children would have doubled.

FAMILY PLANNING BENEFIT PROGRAM

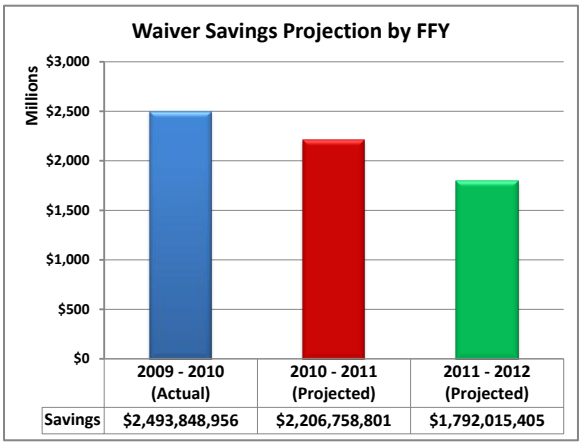
- 61 percent increase in enrollment 2009 to 2012.
- Reduction in unintended pregnancies.

HOME AND COMMUNITY BASED SERVICES EXPANSION

- Enrollment increase experienced in Nursing Home Transition and Diversion, Traumatic Brain Injury and Long Term Home Health Care Demonstrations.
- Due to the recent implementation of the demonstrations, quality and cost efficiency improvements cannot yet be measured.

BUDGET NEUTRALITY

The Partnership Plan Waiver has achieved budget neutrality and realized significant savings. Net Waiver savings for the three year period is projected to be $6.5 billion as shown in the graph below.



NEXT STEPS

In addition to continuing the current, successful Demonstrations, and implementing all aspects of the Medicaid Redesign Team Action Plan, New York State will introduce additional Demonstrations, including:

- Implement mandatory managed long term care for dual Medicaid and Medicare eligible adults who require home and community based services for greater than 120 days.
- Implement the Hospital-Medical Home program.
- Test strategies to reduce potentially preventable readmissions.

New York State will continue to seek and implement options for improving access, coverage, quality and cost effectiveness of the Medicaid program.

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ATTACHMENTS

Attachment I

MEDICAID MANAGED CARE QARR/NATIONAL BENCHMARK COMPARISON 2007 & 2010

Attachment II

FAMILY HEALTH PLUS QARR/NATIONAL BENCHMARK COMPARISON 2010

Attachment III

NEW YORK STATE DEPARTMENT OF HEALTH COMPREHENSIVE MCO OPERATIONAL SURVEY QUESTIONS ATTACHMENT L-7

Attachment IV

NEW YORK STATE PARTNERSHIP PLAN BUDGET NEUTRALITY IMPACT OCTOBER 2009 THROUGH SEPTEMBER 2012, NYSDOH, SEPTEMBER 6, 2012.

LIST OF ACRONYMS

ACA	Affordable Care Act
ACO	Accountable Care Organization
CAHPS®	Consumer Assessment of Healthcare Providers and Systems
CHIP	Children's Health Insurance Program
CHPlus	Child Health Plus
CMS	Centers for Medicare and Medicaid Services
CY	Calendar Year
DHSP	Designated State Health Programs
DOH	Department of Health
DY	Demonstration Year
EQRO	External Quality Review Organization
ESHI	Employer Sponsored Health Insurance
ESRD	End Stage Renal Disease
FFS	Fee-for-Service
FFY	Federal Fiscal Year
FHPlus	Family Health Plus
FHP-PAP	FHPlus Premium Assistance Program
FHPBI	FHPlus Buy-In
FPBP	Family Planning Benefit Program
FPL	Federal Poverty Level
F-SHRP	Federal-State Health Reform Partnership
H-MH	Hospital-Medical Home
HCBS	Home and Community-Based Services
IPRO	Island Peer Review Organization
LTHHCP	Long Term Home Health Care Program
MCO	Managed Care Organization
MCP	Managed Care Plan
MEG	Medicaid Eligibility Group
MEQC	Medicaid Eligibility Quality Control
MLTC	Managed Long Term Care
MMC	Medicaid Managed Care
MMCARP	Medicaid Managed Care Advisory Review Panel
MMIS	Medicaid Management Information System
MRT	Medicaid Redesign Team
NCQA	National Committee on Quality Assurance
NHTD	Nursing Home Transition and Diversion
NYS	New York State
OHIP	Office of Health Insurance Programs
PCCM	Primary Care Case Management
PCP	Primary Care Physician or Primary Care Provider
PCMH	Patient Centered Medical Home
PDF	Portable Document Format
PIP	Performance Improvement Project
PMPM	Per Member Per Month
PPR	Potential Preventable Readmission
QARR	Quality Assurance Reporting Requirements
RFA	Request for Application
SCHIP	State Children's Health Insurance Program
SCP	Specialty Care Provider
SEIU	Service Employees International Union
SN	Safety Net
SNP	Special Needs Plan
SSA	Social Security Administration
SSI	Supplemental Security Income
TANF	Temporary Assistance for Needy Families
TBI	Traumatic Brain Injury

1.0 INTRODUCTION

New York State Department of Health (the Department or NYSDOH) has experienced great success with its current Medicaid Section 1115 Waivers (Partnership Plan and F-SHRP) and is seeking an extension of the Partnership Plan Waiver in order to continue to realize improvements in access, quality and cost effectiveness. When a state requests an extension of a Medicaid Section 1115 Waiver under the authority of Section 1115(a), (e) or (f) of the Social Security Act (SSA), the Federal Government requires that the state submit an Interim Report describing the progress of the Demonstration to date. To address this requirement, NYSDOH commissioned Island Peer Review Organization (IPRO), an independent not-for-profit company, to prepare this Interim Report.

This report briefly describes the history of New York State's Partnership Plan Demonstration and the degree to which the Demonstration goals and objectives have been achieved and/or key activities have been implemented. The report summarizes the Demonstration's progress, performance and accomplishments to date. The report concludes with a brief overview of "next steps" in implementation of newly approved components of the Waiver.

1.1. Background/Purpose

The Department is in the process of submitting a request for an additional extension of New York's Partnership Plan Medicaid Section 1115 Demonstration (Project No. 11-W-00114/2) to the Centers for Medicare and Medicaid Services (CMS). The current Partnership Plan Demonstration is scheduled to expire on December 31, 2014, with some components ending on December 31, 2013 and others on March 31, 2014.

The State believes that the waiver extension will prepare it to fully implement the health care reforms contained in the Affordable Care Act (ACA). While the ACA presents a number of challenges, it provides the potential for the State to significantly decrease the number of people without health insurance and improve overall population health among New Yorkers of all incomes. The State estimates that more than one million New Yorkers will gain access to health insurance – many for the first time, under the ACA. The State faces numerous financial and operational challenges in preparing its health care system to meet the challenges of providing high quality care to an additional population of newly enrolled individuals seeking medical care. Targeted re-investment of savings from the State's Medicaid reform initiatives are imperative to ensure that the State's health care delivery system is capable of meeting the needs of all New Yorkers.

In addition to reforms related to the ACA, New York has developed a comprehensive Action Plan to restructure and improve its Medicaid Program. In 2011, Governor Andrew M. Cuomo established a Medicaid Redesign Team (MRT) which brought together stakeholders and experts from throughout the State to work cooperatively to reform the State's Medicaid system in order to improve the quality of care and to reduce overall Medicaid spending. The MRT created the most sweeping Medicaid reform plan in State history. The State believes that extension of the Partnership Plan Waiver will allow for successful

implementation of the MRT Action Plan, which includes a comprehensive set of quality and cost reform initiatives. It is anticipated that full implementation of the MRT Action Plan will require five years.

New York State plans to use waiver funds to launch new partnerships and to test new models of care that have a high potential for replication throughout New York and in other localities across the nation. The State strongly believes the current extension is necessary in order to provide the State sufficient time to implement the full MRT Action Plan. Key goals of the Action Plan are as follows:

- Providing high quality primary care options.
- Strengthening the health care safety net.
- Providing health care to the 1.7 million New Yorkers who will still be uninsured after implementation of the ACA.
- Reducing health disparities.
- Transitioning Medicaid enrollees to care management and putting an end to the uncoordinated fee-for-service (FFS) Medicaid model.

The Department believes that the quality improvements and savings achieved through the Partnership Plan's care management strategies will expand quality health care coverage to hundreds of thousands of vulnerable, low-income New Yorkers while lowering the overall cost of the State's publically-financed health care system.

1.2. Methods

In preparing this interim report, IPRO reviewed the following source materials:

- Partnership Plan Medicaid Section 1115 Annual Reports for Federal Fiscal Year (FFY) 2008-2009, FFY 2009-2010, and FFY 2010-2011.
- Partnership Plan Medicaid Section 1115 Quarterly Reports for FFY 2011-2012:
  - October 2011-December 2011,
  - January 2012-March 2012, and
  - April 2012-June 2012.
- Application for Extension, New York State Medicaid Section 1115 Demonstration, March 31, 2009.
- Application for Extension (Draft), New York State Medicaid Section 1115 Demonstration (as of August 29, 2012).

- Medicaid Managed Care and Family Health Plus MCO Contract Surveillance Tool, Revised October 2007; NYSDOH, Office of Health Insurance Programs (OHIP), Division of Managed Care and Program Evaluation.
- CMS 372 Report, Annual Report on Home and Community Based Services Waivers, submitted by the NYSDOH, February 2012.
- Primary Care/Specialty Care Participation Rate Report, NYSDOH, Division of Health Plan Contracting and Oversight, Calendar Years 2009, 2010, and 2011.
- Family Planning Benefit Program Expenditure Report, NYSDOH, OHIP DataMart, December 2011.
- Managed Care Plan Performance: A Report on the Quality, Access to Care, and Consumer Satisfaction (QARR); NYSDOH, 2008, 2009, 2010, and 2011.
- Demographic Variation in Medicaid Managed Care, NYSDOH, 2011.
- Managed Care Access and Utilization Report, NYSDOH, 2009, 2010, and 2011.
- CAHPS® 4.0 Adult Medicaid Survey, Medicaid Managed Care Program, NYSDOH, April 2010
- New York State Medicaid Redesign Team Waiver Amendment, NYSDOH, 2012.
- Partnership Plan Evaluation, Program Evaluation of Medicaid Section 1115 Waiver Program – Final Report, Delmarva Foundation, January 2010.
- Managed Long Term Care Plan Member Satisfaction Survey Report, IPRO, September 2011.
- The State of Health Quality, 2011, National Committee for Quality Assurance, 2011.
- New York State Partnership Plan: Budget Neutrality Impact Analysis October 2009 through September 2012, NYSDOH, September 7, 2012.

IPRO reviewed the following websites:

- http://www.health.ny.gov/health_care/managed_care/consumer_guides/
- http://www.health.ny.gov/health_care/managed_care/reports/docs/medicaid_satisfaction_report.pdf
- http://www.health.ny.gov/health_care/managed_care/medicaid_satisfaction_report_2012/index.htm
- http://www.health.ny.gov/health_care/managed_care/qarrfull/qarr_2011/docs/qarr2011.pdf
- http://www.health.ny.gov/health_care/managed_care/reports/eqarr/2011/

- http://www.health.ny.gov/health_care/managed_care/medicaid_satisfaction_report_2012/index.htm
- http://www.health.ny.gov/health_care/managed_care/reports/docs/2009_pip_abstract_compendium_final.pdf
- http://www.ncqa.org/tabid/836/Default.aspx

IPRO consulted with senior managers and staff in the following NYSDOH organizational units:

- Division of Program Development & Management
- Division of Health Plan Contracting & Oversight
- Office of Audit, Fiscal and Program Planning
- Division of Long Term Care
- Office of Quality and Patient Safety

1.3. Partnership Plan Waiver History

In July 1997, New York State received approval from CMS (formerly the Health Care Financing Administration) for its Partnership Plan Medicaid Section 1115 Demonstration. The Partnership Plan Demonstration was originally authorized for a five year period and has been extended several times, most recently through December 31, 2014. The primary purpose of the initial Demonstration was to enroll most of the State's Medicaid population into managed care. There have been a number of the modifications to the Partnership Plan Demonstration since the initial 1997 approval. Significant changes are described in the subsections that follow.

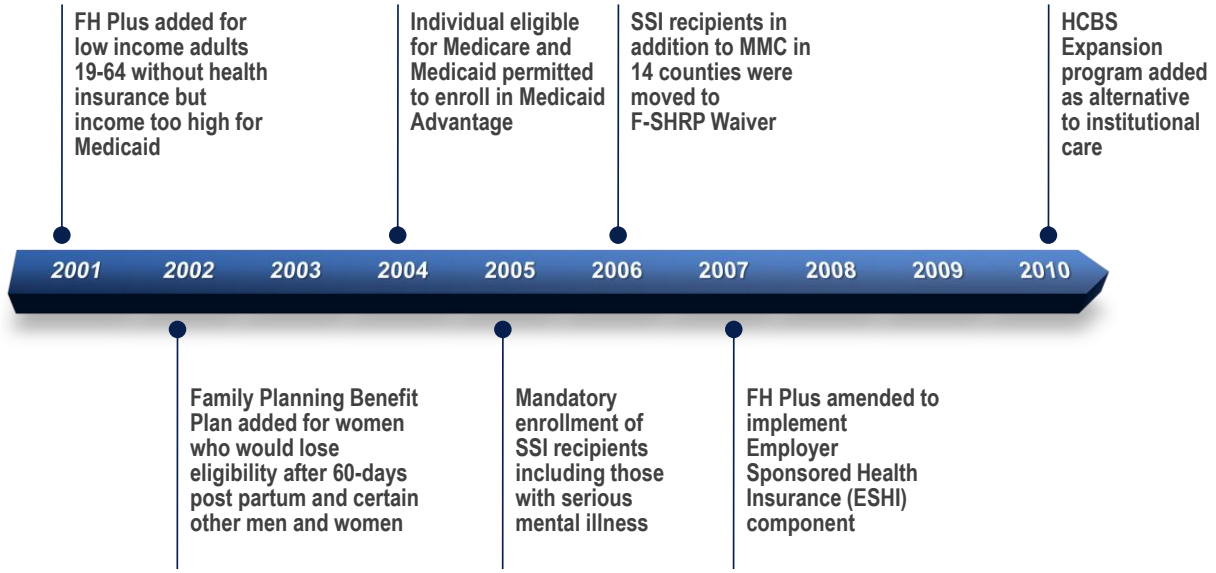
1.3.1. 2001 to 2010 Coverage and Program Expansions

Changes in coverage and program expansions between 2001 and 2010 are listed below followed by a summary shown in Figure 1-1: Summary of Coverage and Program Changes.

- 2001 - Family Health Plus (FHPlus) was added for low income adults between the ages of 19 and 64 who do not have health insurance, but have incomes too high to qualify for Medicaid.
- 2002 - Family Planning Expansion Program (also referred to as the Family Planning Benefit Program) was added to provide family planning services to women who would lose eligibility at the conclusion of their 60-day postpartum period, and to certain other men and women. (It is anticipated that this program will be moved out of the Partnership Plan and into the State Plan on November 1, 2012.)
- 2004 – An amendment permitted individuals eligible for Medicare and Medicaid to enroll in Medicaid Advantage.

- 2005 – Mandatory enrollment of the Social Security Income (SSI) population began and was expanded to include those with serious mental illness.
- 2006 – SSI recipients and new enrollees in 14 counties were moved to the Federal-State Health Reform Partnership (F-SHRP) Waiver.
- 2007 – FHPlus was amended to implement an employer-sponsored health insurance component.
- 2010 – The Home and Community-Based Services (HCBS) Expansion program was added to provide in-home and community-based services to certain adults with significant medical needs as an alternative to institutional care.

Figure 1-1: Summary of Coverage and Program Changes



1.3.2. 2011 Waiver Renewal and Demonstration Enhancements

In 2011, CMS approved renewal of the Partnership Plan Demonstration for the period August 1, 2011 through December 31, 2014. (As noted in the following discussion, some Partnership initiatives will expire prior to December 2014 to reflect implementation of the ACA). The 2011 renewal added three new components to the State's Partnership Plan:

- A ***Hospital-Medical Home (H-MH) initiative*** to provide funding and performance incentives to hospital teaching programs to improve the coordination, continuity and quality of care to individuals receiving primary care in outpatient hospital settings.
- The ***Potentially Preventable Readmission (PPR) initiative*** which will reduce the rate of re-hospitalizations.
- An ***Indigent Care Pool*** to fund the State's program to cover uncompensated care.

1.3.3. Medicaid Redesign Team Related Amendments

- In September 2011, March 2012, and August 2012, CMS approved three additional amendments, representing five key changes, to the Partnership Plan in order to incorporate the following key features of the Governor's MRT proposals:
  - Individuals were given 30 days to select a managed care organization (MCO) before automatic assignments were made.
  - Individuals with chronic medical conditions who have been under active treatment for at least six months with a sub-specialist who is not a network provider for the MCO can continue with that sub-specialist for six months.
  - Exemptions/exclusions were eliminated for: people temporarily living outside their social services district, pregnant women receiving prenatal care from a provider that does not participate in any managed care plan, people with a language barrier, people without a Primary Care Physician (PCP) choice within 30 minutes/30 miles, people in mental health family care, the homeless, non-dually eligible people with end stage renal disease (ESRD) diagnosis, and infants born disabled or weighing less than 1200 grams.
  - Individuals who are only eligible for emergency Medicaid are exempt from Medicaid Managed Care (MMC).
  - Dual eligible Medicaid recipients, 21 years old and older, who are in need of home and community based care coordination for more than 120 days will be enrolled in Managed Long Term Care (MLTC) Programs so that they can benefit from better care coordination.

1.4. Waiver Components Expiring Prior to December 2014

As previously mentioned, some components of the current waiver will expire prior to December 2014 as follows:

- **December 31, 2013** – FHPlus, Safety Net (SN) adults, Indigent Care pool. The Family Planning Benefit Program was originally scheduled to expire at this time but will be moved into the Medicaid State Plan in November 2012.
- **March 31, 2014** – MMC Program, Medicaid Eligibility Quality Control (MEQC), Facilitated Enrollment Services, Twelve-Month Continuous Eligibility Period, HCBS Expansion Program, H-MH Demonstration, PPR Demonstration, Designated State Health Programs (DHSP).

2.0 PARTNERSHIP PLAN: IMPLEMENTATION STATUS AND ACCOMPLISHMENTS

With the original Demonstration and subsequent amendments, the Partnership Plan Demonstration currently consists of four major program components:

1. **Medicaid Managed Care** – providing Medicaid State Plan benefits through comprehensive MCOs to most recipients eligible under the State Medicaid Plan;
2. **Family Health Plus** – providing a more limited benefit package, with cost-sharing imposed, for adults with and without children with specified income;
3. **Family Planning Benefit Program** – provided to men and women who are otherwise not eligible for Medicaid but are in need of family planning services who have net incomes at or below 200 percent of the federal poverty level (FPL) and to women who lose Medicaid eligibility at the end of their 60-day postpartum period; and
4. **Home and Community-Based Services Expansion** – providing an expansion of three 1915(c) waiver programs by eliminating a barrier to financial eligibility to receive care at home.

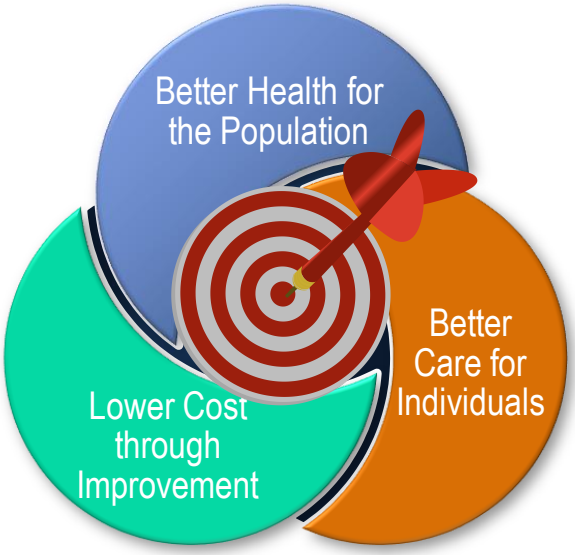
The State's goal in implementing the Partnership Plan is to improve the health status of low income New Yorkers by improving access to health care in the Medicaid program, improving the quality of health services delivered and expanding coverage to additional low income New Yorkers. Through the original Demonstration, the State implemented a mandatory MMC program in counties with sufficient managed care capacity and the infrastructure to manage the enrollment processes essential to a mandatory program. The Demonstration has also enabled the expansion of coverage to certain individuals who would otherwise be without health insurance. The Partnership Plan Demonstration uses a managed care delivery system to:

- Improve access to health care for the Medicaid population.
- Improve the quality of health services delivered.
- Expand coverage to additional low income New Yorkers with resources generated through managed care efficiencies.

The Triple Aim of the Demonstration, as illustrated in Figure 2-1: The MRT Triple Aim, is to:

- ***Improve the Quality of Care***
- ***Improve Population Health***
- ***Reduce Per Capita Costs***

Figure 2-1: The MRT Triple Aim



Program Initiative goals are addressed and achieved by:

- Implementing a Managed Care Delivery System to deliver benefits.
- Creating efficiencies in medical programs.
- Extending coverage to individuals otherwise not eligible.
- Implementing FHPlus to provide health coverage to adults with incomes above the State Plan eligibility standards.
- Implementing FHPlus with an ESHI component.

Medicaid reform must also mean health care system reform. The Department plans to achieve this by breaking down traditional delivery silos through new models of care such as Accountable Care Organizations (ACOs), hospital/nursing home partnerships that better manage transitions in care, telehealth initiatives, and new approaches that integrate physical and behavioral health services.

2.1. Medicaid Managed Care Program

The Medicaid Managed Care (MMC) component of the Partnership Plan Demonstration provides comprehensive health care services (including all benefits available through the Medicaid State Plan) to low income uninsured individuals. It offers enrollees the opportunity to select an MCO whose focus is on preventive health care. The MCO partners with the enrollee's PCP to provide primary care case management (PCCM) thus providing better coordination of patient care, helping enrollees navigate the medical delivery system and attending to the enrollee's overall health and well-being. The State's MMC program has enrolled three distinct populations into MCOs in this Demonstration:

- Temporary Assistance for Needy Families (TANF) children under age 1 through age 20),
- TANF adults age 21 through 64, and
- Safety Net (SN) adults.

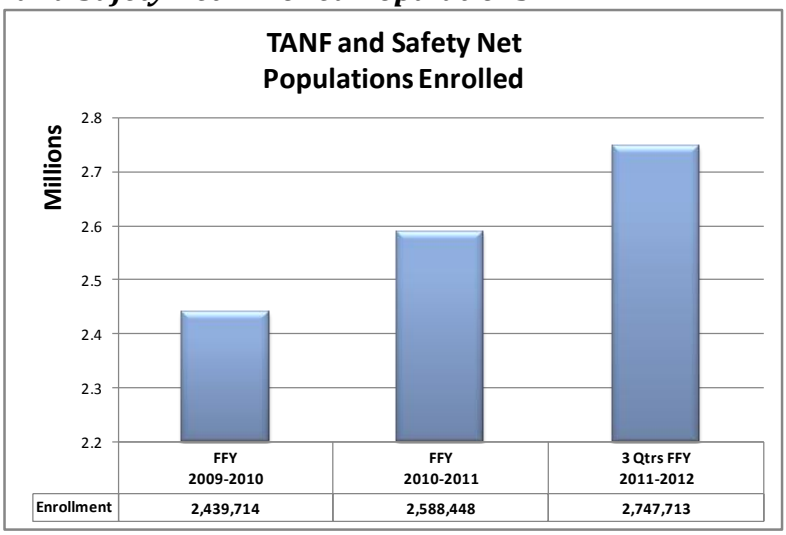
2.1.1. Accomplishments: Coverage and Access

The MMC program accomplishments in the area of coverage and access include increased enrollment, expansion of mandatory enrollment and increased penetration rates.

2.1.1.1. Increased Enrollment

As of June 2012, there were 2,747,713 people enrolled in the State's Medicaid Managed Care program under the Partnership Plan Waiver.[1] From September 2010 through June 2012, enrollment in the MMC program has increased by 12.6 percent or more than 300,000 beneficiaries statewide, as shown in Figure 2-2: TANF and Safety Net Enrolled Populations.

Figure 2-2: TANF and Safety Net Enrolled Populations



2.1.1.2. Mandatory Enrollment Expanded

Geographic coverage of mandatory enrollment expanded to 57 of the State's 62 counties. The Partnership Plan was implemented in October 1997 using a geographic phase-in strategy. Today, all but five upstate counties have instituted mandatory Medicaid Managed Care programs. By the end of 2012, all counties in New York State are expected to be operating mandatory programs.

[1] This figure only includes individuals enrolled through the Partnership Plan Waiver. It does not include all Medicaid beneficiaries enrolled in MCOs, such as those enrolled through the F-SHRP Waiver.

2.1.1.3. Penetration Rate

As of October 2010, the penetration rate of eligible Medicaid recipients enrolled in managed care was 84 percent statewide (88 percent in New York City and 77 percent in the rest of the State).

2.1.2. Accomplishments: Quality

The MMC program accomplishments include improved quality and improved PCP to enrollee ratios.

2.1.2.1. Improved Quality

The quality of health care delivery in New York, as measured by nationally recognized indicators of quality, and improvement on over time.

Quality of care and member satisfaction for each certified MCO plan is measured using national benchmarks such as the 2011 National Committee on Quality Assurance (NCQA) benchmarks. (See Attachment I. Medicaid Managed Care QARR/National Benchmark comparison 2007 & 2010).

In 2010, New York met or exceeded 98 percent of the national benchmarks.

- Thirty-six of the NCQA measures are included in the State's Quality Assurance Reporting Requirements (QARR).
- A comparison of the QARR 2007 and 2010 benchmarks show that performance increased on 75 percent of the measures between 2007 and 2010.
- Only seven of the 2010 measures were lower than in 2007.
- All QARR measures of access to care improved between 2007 and 2010.

Annual required External Quality Review Organization (EQRO) Performance Improvement Projects (PIPs) are conducted by IPRO.

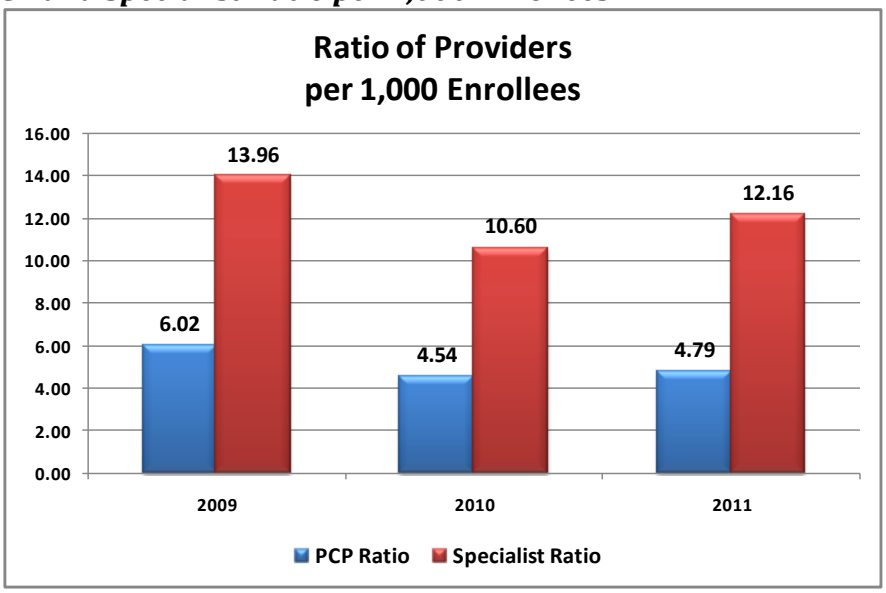
2.1.2.2. PCP to Enrollees Standard Exceeded

The State's MMC program exceeded the standard of one PCP for every 1,500 enrollees for the period 2009 through 2011. New York's MMC program uses a variety of mechanisms to assess the overall adequacy and capacity of the MMC network. The provider network data, health plan reports and health plan network physicians' reports were reviewed and appeared to be accurate. Reports reviewed reflect continued compliance and ability to support enrollment based on a standard of one PCP for every 1,500 enrollees.

2.1.2.3. PCP to Enrollee Ratio Increased

The PCP to 1,000 enrollee ratio increased from 4.54 in 2010 to 4.79 in 2011 while the specialty physician ratio per 1,000 enrollees increased from 10.60 to 12.16 in the same period, as shown in Figure 2-3: PCP and Specialist Ratio per 1,000 Enrollees.

Figure 2-3: PCP and Specialist Ratio per 1,000 Enrollees



The total participation level of PCPs and specialty care physicians (SCPs) in Medicaid Managed Care is nearly twice the number that participated in the Medicaid FFS program.

The decrease in the ratio of PCPs per 1,000 enrollees from 6.02 in 2009 to 4.54 in 2010 is likely explained by the large increase in the number of enrollees – including MMC, FHPlus, FFS, Children's Health Insurance Program (CHIP) and SSI populations – from 2009 to 2010 of 32.2 percent, from 2.85 million to 3.77 million. At the same time, the number of PCPs stayed the same at about 17,000. Therefore, the ratio of PCPs to enrollees dropped. In the following year, 2011, enrollment decreased by 8.2 percent to 3.5 million enrollees while again the number of PCPs stayed flat at about 17,000. Therefore, the ratio of PCPs to 1000 enrollees rose to 4.79. Across the same period, the same pattern occurred for specialist physicians.[2]

Increasing the number of qualified physicians participating in the Medicaid program continues to be an important objective of the Partnership Plan Demonstration. The Department carefully monitors physician participation in both Medicaid MCOs and the Medicaid fee-for-service program. In recent years, the Department has taken significant steps to increase physician participation in the Medicaid program. For example, in 2009, the State increased physicians' fees by 80 percent over the 2007 levels. In August 2012, the State awarded $2,052,383 in grants under the Doctors Across New York (DANY) program, which assists in the training and placement of physicians in rural and inner-city areas where a shortage of health care providers has been identified.[3]

[2] NYSDOH, Office of Health Insurance Programs, August 20, 2012.
[3] More information about the increase in physician reimbursement can be found at: http://www.health.ny.gov/facilities/hospital/reimbursement/apr-drg/presentations/vendor-7_22_2009.pdf.

2.1.2.4. Consumer Access to Information

The state has provided consumers with access to information that supports informed choice. A Medicaid Managed Care Regional Consumer Guide has been prepared for each region of the State and is distributed to members. Reports for each region can be accessed online at http://www.health.ny.gov/health_care/managed_care/consumer_guides/.

2.1.2.5. Enrollee Satisfaction

In general, Medicaid beneficiaries enrolled in managed care report satisfaction with their care and experiences. Members who received care from their PCPs were the most satisfied. The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey is a comprehensive tool designed to assess consumers' experience with health care and health plans. CAHPS® is the survey instrument that asks health plan members about experiences with access to care, health care providers and health plans. The Department sponsors a CAHPS® survey every other year for the Medicaid Managed Care plans and uses the results to determine variations in member satisfaction among the plans. [4]

2.1.2.6. Stakeholder Engagement

The State has established regular processes and forums for stakeholder engagement. The State uses a variety of methods to monitor plan operations, identify issues, resolve problems and explore program improvements including a variety of periodic stakeholder coalition meetings.

- The State provides continued technical assistance to providers and training to both providers and their own staff.
- Meetings of the Managed Care Operational Issues Workgroup are held routinely. This Workgroup was convened to serve as an open forum for the discussion and clarification of operational issues related to Medicaid Managed Care.
- There is a Medicaid Managed Care Advisory Review Panel (MMCARP) appointed by the Governor and the New York State legislature that meets regularly. This Panel was established to assess and evaluate multiple facets of the MMC Program, including provider participation and capacity, enrollment targets, phase-in of mandatory enrollment, the impact of marketing, enrollment and education strategies, and the cost implications of exclusions and exemptions.
- Input from stakeholders is continually cultivated through webinars, conference calls and surveys. The State conducts bi-annual onsite operational surveys of the MCOs and focused surveys are conducted for each MCO at regular intervals each year. (See

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The press release announcing the DANY grant awards can be found at http://www.health.ny.gov/press/releases/2012/2012-08-30_state_health_department_award.htm.

[4] The results of the 2010 Survey can be found at http://www.health.ny.gov/health_care/managed_care/reports/docs/medicaid_satisfaction_report.pdf. The 2012 Plan-level surveys are available at http://www.health.ny.gov/health_care/managed_care/medicaid_satisfaction_report_2012/index.htm.

Attachment III. New York State Department of Health Comprehensive MCO Operational Survey Questions). The most frequent category of complaints relates to billing issues.

2.1.2.7. Policy Changes Implemented

The State has implemented a number of policy changes to improve quality and efficiency.

- **Eliminated funding that was included in Medicaid and FHPlus premiums for direct marketing of Medicaid recipients by managed care organizations (MCOs).** In the early implementation of the program, it was important to allow managed care organizations the ability to market directly to Medicaid recipients in order to increase the level of enrollment in managed care since enrollment in many counties was voluntary. Now, the program is mature, and those Medicaid recipients not enrolled are generally exempt or excluded from the program or reside in voluntary enrollment counties. According to the Department, marketing dollars were largely spent by health plans to attract members of other plans and not specifically focused on enrolling the uninsured. In addition, as more counties have been included in mandatory enrollment, recipients have been required to enroll or be auto-assigned into an MCO, which greatly reduces the need for marketing.
- **Extension of mandatory managed care enrollment to Medicaid beneficiaries with HIV/AIDS.** One quarter (or 9,375) of all Medicaid Managed Care eligible HIV positive beneficiaries were voluntarily enrolled in either a mainstream MCO or one of three HIV Special Needs Plans (SNPs) that serve the metropolitan New York area. Of the estimated 52,000 Medicaid beneficiaries with HIV currently residing in NYC, 15,000 are excluded from Medicaid Managed Care due to their status as dually eligible for Medicare and Medicaid or because they are nursing home residents or meet other exclusion criteria. The State's decision to require mandatory managed care enrollment for HIV positive beneficiaries is consistent with the goals of the Partnership Plan. According to the Department, fourteen years of data demonstrated that Medicaid beneficiaries enrolled in MCOs receive better quality care than those in FFS Medicaid. and studies of those who voluntarily enrolled in managed care have shown a steady improvement in quality of care and improvement in chronic care disease management for those in Medicaid MCOs.
- **Establishment of twelve months continuous coverage.** In support of the State's efforts to simplify Medicaid eligibility rules for consumers and eligibility workers in local departments of social services, revisions were made to Chapter 58 of the New York State Social Services Law in 2007 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. Simpler eligibility rules help meet the State's goal of ensuring that all children and eligible adults have access to, enroll in, and remain enrolled in affordable health insurance coverage.
- **Ongoing design and implementation of quality improvement initiatives.** In 2012, notable illustrations of the State's continuing efforts to improve quality of care

and health outcomes for Medicaid beneficiaries include the Hospital-Medical Home and the Potentially Preventable Readmissions Demonstrations.

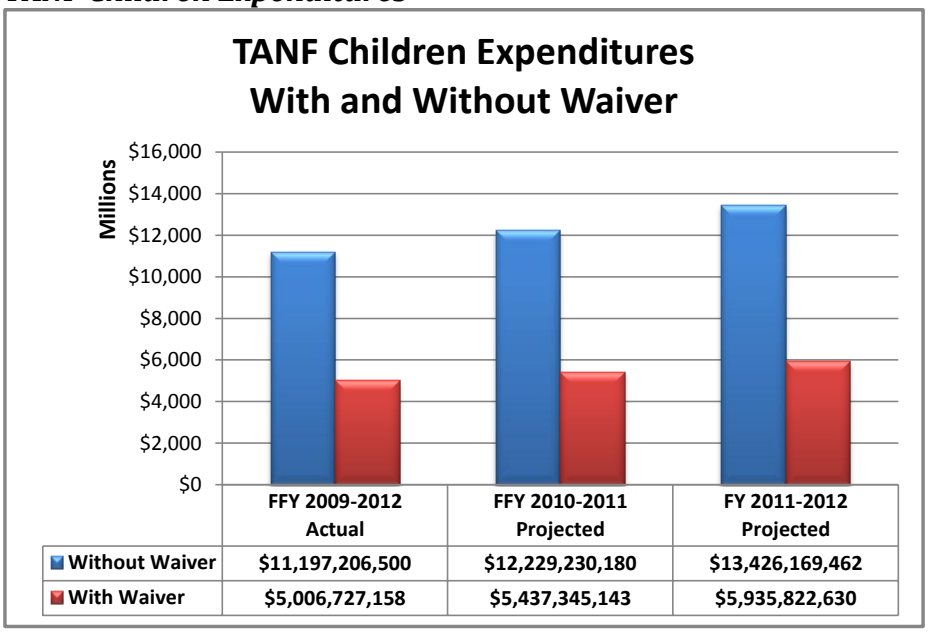
2.1.3. Accomplishments: Cost

To review the cost effectiveness of the MMC program, the evaluation compared program expenditures With Waiver to expenditures for these populations Without Waiver. (See section 2.5.1 for an explanation of With Waiver and Without Waiver). This method was applied to both TANF children and TANF adults.

2.1.3.1. Expenditures for TANF Children With Waiver Reduced

For TANF children, expenditures without the waiver would have been 225 percent greater than with the waiver. For the three year period FFY 2009-2010 through FFY 2011-2012, the waiver has yielded $20.4 billion in projected savings, as shown in Figure 2-4: TANF Children Expenditures.

Figure 2-4: TANF Children Expenditures

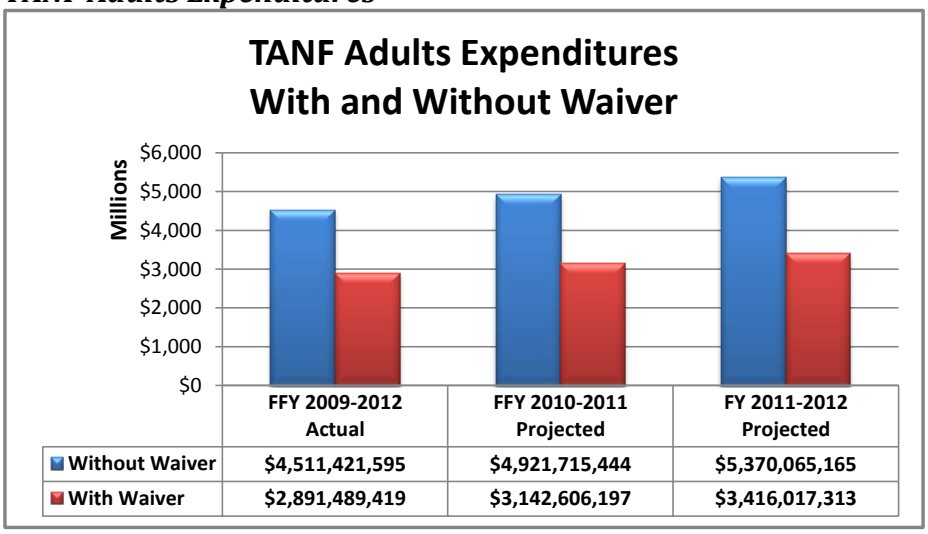


	FFY 2009-2012 Actual	FFY 2010-2011 Projected	FY 2011-2012 Projected
Without Waiver	$11,197,206,500	$12,229,230,180	$13,426,169,462
With Waiver	$5,006,727,158	$5,437,345,143	$5,935,822,630

2.1.3.2. Expenditures for TANF Adults With Waiver Reduced

For TANF adults, expenditures without the waiver would have been nearly 157 percent greater than with the waiver. For the three year period FFY 2009-2010 through FFY 2011-2012, the waiver has yielded $5.4 billion in projected savings, as shown in Figure 2-5: TANF Adults Expenditures.

Figure 2-5: TANF Adults Expenditures



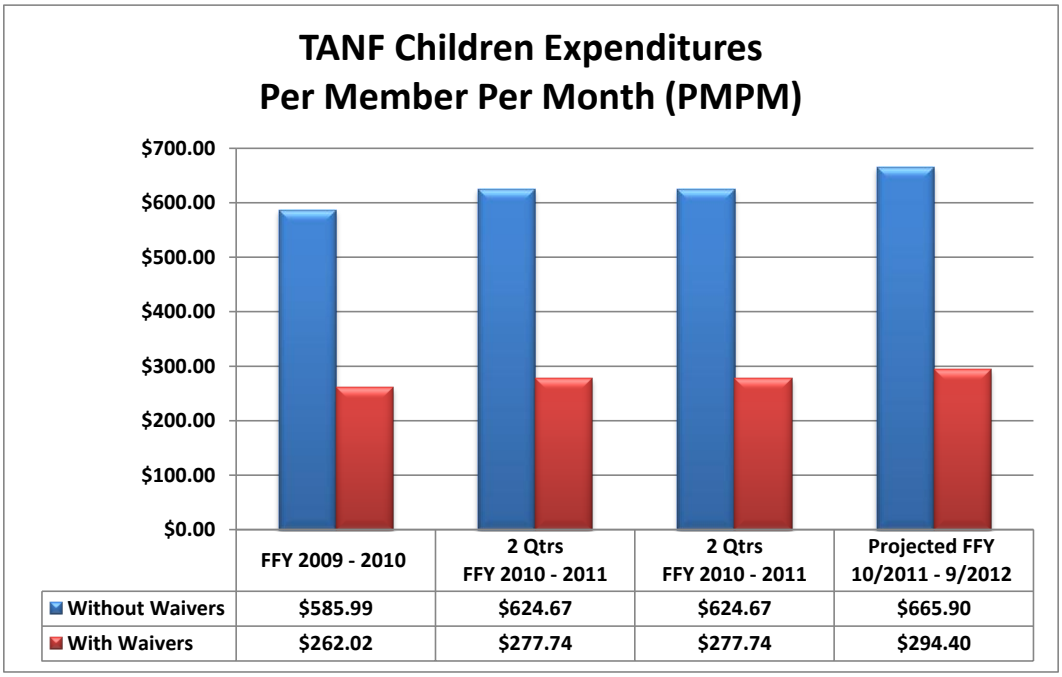
	FFY 2009-2012 Actual	FFY 2010-2011 Projected	FY 2011-2012 Projected
Without Waiver	$4,511,421,595	$4,921,715,444	$5,370,065,165
With Waiver	$2,891,489,419	$3,142,606,197	$3,416,017,313

NYSDOH, Office of Health Insurance Programs, August 20, 2012.

2.1.3.3. PMPM Payments With Waiver Reduced

The difference between per member per month (PMPM) payments with the waiver and without the waiver is consistent with the analysis of program expenditures as a whole. For example, PMPM payments for TANF children without the waiver were 225 percent greater than with the waiver, as shown in Figure 2-6: TANF Children PMPM.

Figure 2-6: TANF Children PMPM



	FFY 2009 - 2010	2 Qtrs FFY 2010 - 2011	2 Qtrs FFY 2010 - 2011	Projected FFY 10/2011 - 9/2012
Without Waivers	$585.99	$624.67	$624.67	$665.90
With Waivers	$262.02	$277.74	$277.74	$294.40

2.1.3.4. MMC Demonstration Highly Successful

Taking these two populations together, total savings for the three year period FFY 2009-2010 through FFY 2011-2012 are projected to be $25.8 billion. From a cost effectiveness standpoint, the MMC Demonstration has been highly successful.

2.2. Family Health Plus

Family Health Plus (FHPlus), enacted by the State legislature in December 1999 and approved by CMS in May 2001, is a public health insurance program for adults who are aged 19 to 64 who have income too high to qualify for Medicaid. The primary objective of the FHPlus program is to improve access to care.

FHPlus is available to single adults, couples without children, and parents who are residents of New York State and are United States citizens or fall under one of many immigration categories. FHPlus is provided through participating MCOs and provides comprehensive coverage, including prevention, primary care, specialty care, hospitalization, prescriptions and other services. There are minimal co-payments for some FHPlus services. In July 2011, CMS approved an amendment to the Partnership Plan that increased the income eligibility standard for adults with children from 150 percent to 160 percent of the FPL. However, in light of the federal policy changes in the ACA, the State has postponed implementation of the increased eligibility standards indefinitely.

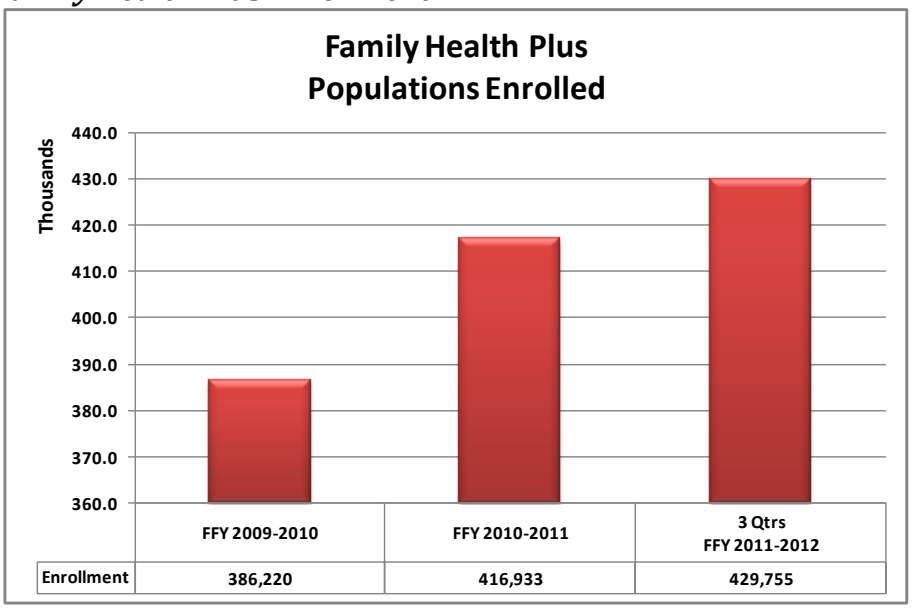
2.2.1. Accomplishments: Coverage and Access

The FHPlus program accomplishments in the area of coverage and access include an expansion of coverage, simplified eligibility and growth in enrollment in the ESHI initiative.

2.2.1.1. Family Health Plus Resulted in Significant Expansion of Coverage

FHPlus has resulted in a significant expansion of coverage to previously uninsured and underinsured New Yorkers. The current program enrollment is 430,000. In the last three years program enrollment has increased more than 11 percent. The growth in enrollment is illustrated in Figure 2-7: Family Health Plus Enrollment.

Figure 2-7: Family Health Plus Enrollment



Note: Enrollment figures are for the two Demonstration populations (eligible adults with children and adults without children) for the period FFY 2009-2010 through the first three quarters of FFY 2011-2012.

2.2.1.2. Impact of Simplified Medicaid Eligibility Process

The State attributes the more recent growth in enrollment to policy changes that have simplified the Medicaid eligibility process. For example:

- In January 2010, the State eliminated the resource test for FHPlus applicants.
- In 2011 the Pharmacy benefit was added and local jurisdictions were required to submit monthly listings of cases that meet review criteria.

2.2.1.3. Enrollment in FHP-PAP Program has Grown

To further increase coverage rates among uninsured but employed New York State residents with access to private insurance, State legislation was enacted in July 2007 to authorize the Employer Sponsored Health Insurance Initiative (ESHI). This initiative, called the FHPlus Premium Assistance Program (FHP-PAP) helps low-income workers who are eligible for the regular FHPlus Program to access insurance offered by their employers, and to help the State recognize the savings that could be achieved by maximizing use of private, employer sponsored insurance coverage. Enrollees in FHP-PAP are also entitled to the services that FHPlus covers but are not covered by the ESHI plan – including dental services and prescription drugs, if determined to be cost effective. These services are referred to as "wrap around benefits." FHPlus eligible individuals that have access to ESHI are required to enroll in FHP-PAP. Adults in this program use ESHI as their primary insurance policy. The State will reimburse any deductibles and co-pays to the extent that the co-pays exceed the amount of the enrollee's co-payment obligations under FHPlus.

Enrollment in the ESHI program has also grown fairly rapidly from 1,800 to 3,080 in the period from FFY 2009-2010 through the first three quarters of FFY 2011-2012.[5] Over the three years under review, the FHP-PAP program is projected to have expended $10,537,200.

2.2.1.4. Significant Enrollment in FHPlus Buy-In Initiative

United Federation of Teachers and the NYS Office of Children and Family Services contracted with FHPlus to provide health insurance coverage to 25,000 licensed and registered child care providers and workers on a buy-in basis. The premium for eligible child care workers is paid by the State. The Civil Service Employees Association also received legislative authority and appropriations to provide health insurance coverage through the FHPlus Buy-In (FHPBI) program.

In February 2009, an estimated 47,500 individuals were enrolled in the FHPBI program. Service Employees International Union (SEIU) 1199 employees originally participated, but left the Buy-In program in the first quarter of FFY 2011-2012.

2.2.2. Accomplishments: Quality

The FHPlus program accomplishments in the area of quality are confirmed by complaint information and QARR data.

2.2.2.1. Impact of Waiver on Customer Complaints

According to the Department's Annual and Quarterly reports, customer complaints appear to be limited and generally are related to billing issues.

2.2.2.2. FHPlus Plans and QARR Data

A comparison of the national HEDIS® quality measures to the FHPlus QARR data for 2010 indicates that FHPlus was above the national quality metric for almost 85percent of the quality measures (i.e., 21/25 measures).[6] Impressively, for several of these measures the FHPlus performance score was much greater than the HEDIS® national average. For example, the Adult BMI measure indicates that nationally Medicaid HMOs are only at 42 percent while FHPlus is at 70 percent. This large difference is also evident with COPD testing, breast cancer screening, and ambulatory follow-up for mental illness. (See Attachment II. Family Health Plus QARR/National Benchmark Comparison 2010).

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[5] Although data about cost-effectiveness of the FHP-PAP program was not obtainable, a cost effectiveness determination is required for each applicant. The first test is to confirm that the ESHI includes the eight essential "benchmark" services. If all services are included in the ESHI plan, the application proceeds to the second test. If all benchmark services are not provided, payment of this insurance is denied and the applicant is enrolled in FHPlus and referred to a participating managed care plan. For the second test, the cost effectiveness calculation accounts for the cost of the ESHI premiums, deductibles, and co-payments. The calculator will determine if the cost of the ESHI premium plus the cost of the Medicaid wrap-around services (optional services not included in the ESHI plan), deductibles and co-payments are less than the regional FHPlus managed care rates for adults and Medicaid managed care rates for eligible children.

[6] The HEDIS® data was taken from the NCQA *The State of Health Care Quality 2011*; specifically, the Medicaid HMO section which represents data from 2010.

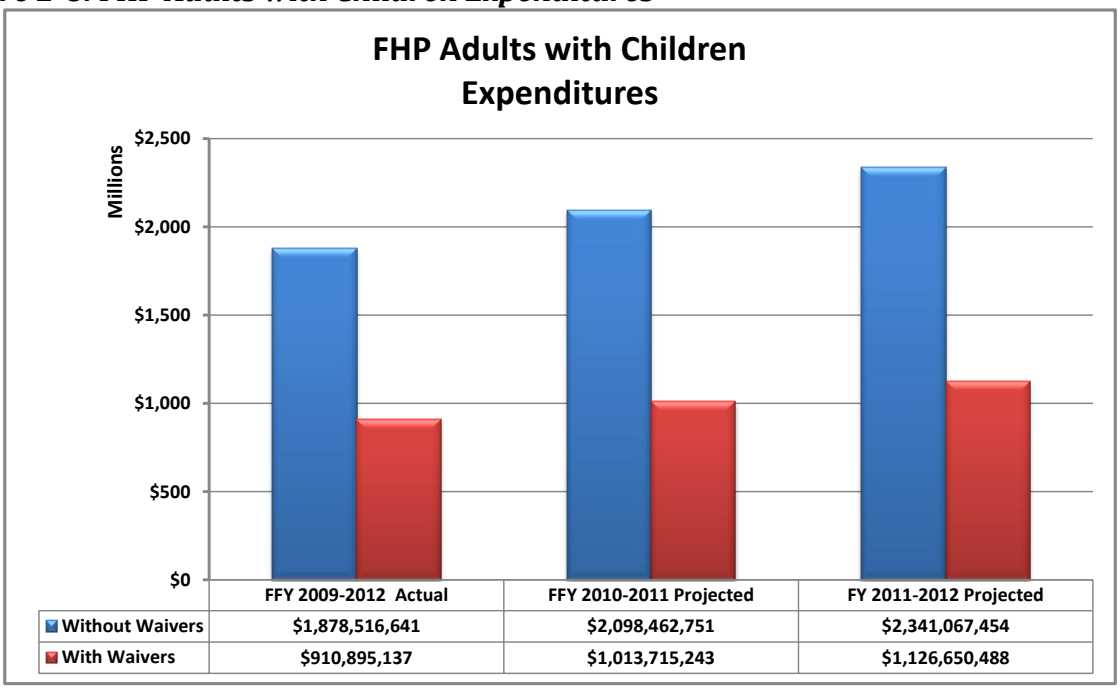
2.2.3. Accomplishments: Cost

The FHPlus program accomplishments in the area of cost are confirmed by expenditure data.

2.2.3.1. Without Waiver Expenditures Would Have Doubled

According to analysis of data provided by the NYSDOH, expenditures without the waiver would have been approximately double the expenditures with the waiver, as shown in Figure 2-8: FHP Adults with Children Expenditures.

Figure 2-8: FHP Adults with Children Expenditures



2.2.3.2. FHPlus Demonstration Highly Successful

From a cost effectiveness standpoint, the FHPlus Demonstration has been highly successful. For the three year period FFY 2009-2010 through FFY 2011-2012, the waiver has yielded a projected $3.3 billion in savings.

2.3. Family Planning Benefit Program

The goal of the Family Planning Benefit Program (FPBP) is to increase access to family planning services and enable individuals to prevent or reduce the incidence of unintentional pregnancies.

The program is available to men and women who are otherwise not eligible for Medicaid but are in need of family planning services who have net incomes at or below 200 percent of the federal poverty level (FPL) and to women who lose Medicaid eligibility at the end of their 60-day postpartum period. Review of the program is prefaced by the fact that the

entire program is expected to be moved into the Medicaid State Plan on November 1, 2012. Transportation will be added to the FPBP benefit package when this move takes place.

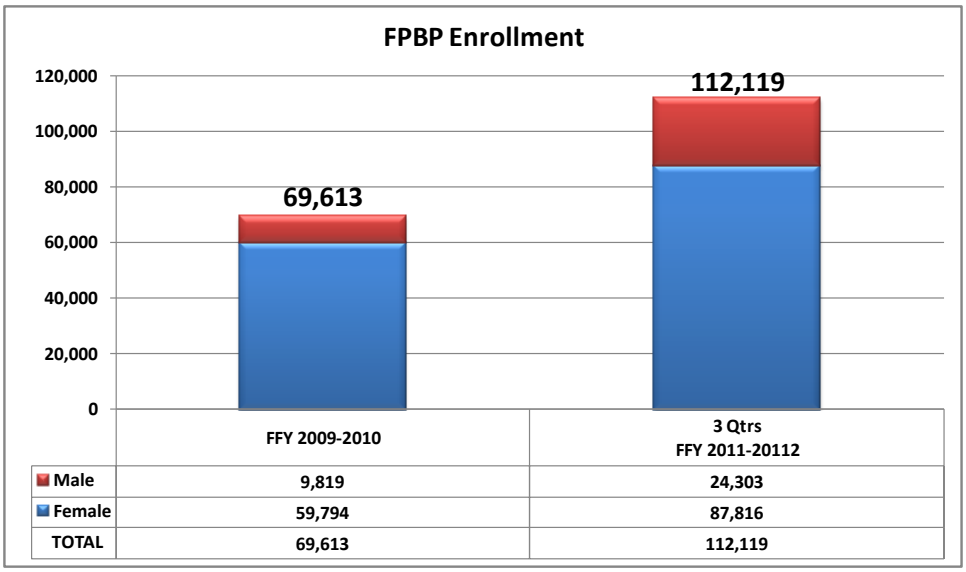
2.3.1. Accomplishments: Coverage and Access

The FPBP program accomplishments in the area of coverage and access are confirmed by growth in program participation and a reduction in unintended pregnancies.

2.3.1.1. Program Participation has Grown

FPBP participation has grown quickly from 69,613 in 2009 to 112,119 by the end of June 2012, as shown in Figure 2-9: FPBP Enrollment.

Figure 2-9: FPBP Enrollment



2.3.1.2. Unintended Pregnancies Have Been Reduced

Using a CMS methodology and 2000 as the base year, the fertility rate for FPBP enrollees is 134.7 per thousand. Based on this formula, there were 5,301 averted births in Calendar Year (CY) 2011.[7]

2.3.2. Accomplishments; Quality

While there has not been an evaluation of clinical quality that has focused specifically on the FPBP beneficiary population, the State has taken steps to ensure and improve program quality.

2.3.2.1. Program Policies, Procedures and Referral Lists are in Place

Program policies, procedures and referral lists are in place. The State has also introduced policy changes to ensure that the federal Medicaid share is claimed appropriately. For example, changes were made to procedure and billing codes in both 2008 and 2010. These

[7] NYSDOH, Office of Health Insurance Programs, August 20, 2012.

changes help to ensure that only CMS-approved family planning procedures are claimed for FPBP and that the federal share is claimed appropriately.

2.3.3. Accomplishments: Cost

The FPBP program accomplishments in the area of cost are suggested by a significant reduction in avoided delivery costs.[8]

2.3.3.1. Total Delivery Costs Avoided

As previously mentioned, the program has averted more than 5,000 births. The average cost of a Medicaid delivery in New York State in 2011 was $6,863.[9]

2.4. Home and Community-Based Services Expansion Program

The Home and Community-Based Services (HCBS) Expansion eliminated a barrier to receiving care at home posed by eligibility rules that would otherwise lead to spousal impoverishment. The Waiver allows special spousal budgeting provisions.[10] Savings realized by the Partnership Plan efficiencies offset the resulting increased costs of participation in three 1915(c) HCBS Demonstrations – the Nursing Home Transition and Diversion (NHTD) Program, the Traumatic Brain Injury (TBI) Program, and the Long Term Home Health Care Program (LTHHCP).

Without the HCBS Expansion special spousal budgeting provisions, the Department believes there would be serious disincentives to avoiding or preventing nursing home placement or returning home from a nursing home placement.

2.4.1. Accomplishments: Access and Coverage

The HCBS program accomplishments in the area of access and coverage are demonstrated by an increase in enrollment.

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[8] An internal NYSDOH analysis for the five quarter period April 2011 through September 2011, found that expenditures would have been slightly lower without the Waiver. The analysis found that expenditures would have been $1.26 PMPM less without the Waiver; and for the period October 2011 through June 2012, expenditures would have been $1.72 PMPM less without the Waiver. A closer examination of this expenditure data over a longer period of time would be necessary in order to arrive at a more complete picture of the cost effectiveness of this program.

[9] NYS Department of Health, Office of Health Insurance Programs, September 6, 2012.

[10] Under normal Medicaid eligibility rules, spouses living together at home are treated as a household of two and the basic two-person income and resource standards are applied. However, under SSA § 1924, when an institutionalized person with a spouse in the community applies for Medicaid, special spousal budgeting provisions allow the community spouse to retain substantial amounts of the couple's combined income and resources. This helps prevent the community spouse, who is legally responsible for the institutionalized spouse, from becoming impoverished by exhausting all of the couple's resources to help pay for institutional care.

2.4.1.1. Access to Home and Community Based Services Increased

Approximately 1,400 Medicaid beneficiaries have gained access to home and community-based services as a result of the HCBS Demonstration. For the period FFY 2009-2010 through FFY 2011-2012, the HCBS Expansion increased program enrollment as follows: LTHHCP by 1,347 participants, NHTD by 60 participants and TBI by 3 participants.

2.4.2. Accomplishments: Quality and Cost Effectiveness

As this program is relatively new and the affected population relatively small, the State has not undertaken a comprehensive cost or quality evaluation to determine the effectiveness of this waiver component.

2.4.2.1. Per Participant Spending on Waiver Services

Annual average per participant spending on Partnership Plan Waiver services ranges from a projected $2,100 in the LTHHCP to $40,000 in the TBI program. The projected annual expenditures for each program in FFY 2011-2012 are:

- LTHHCP at $2,823,312 per year.
- NHTD at $1,461,600 per year.
- TBI at $120,024 per year.

The total expenditure for all three categories was approximately $4,404,936 per year. For the three year period, total expenditures are projected to be $13,214,808. These expenditures are summarized in Figure 2-10: HCBS Services Expansion Program Projected Enrollment and Spending, 2011.

Figure 2-10: HCBS Services Expansion Program Projected Enrollment and Spending, 2011

WAIVER PROGRAM	ENROLLMENT	PROJECTED ANNUAL EXPENDITURE	PROJECTED TOTAL THREE YEARS	AVERAGE ANNUAL EXPENDITURE PER ENROLLEE
Long Term Home Health Care	1,347	$2,823,312	$8,469,936	$2,096
Nursing Home Transition & Diversion	60	$1,461,600	$4,384,800	$24,360
Traumatic Brain Injury	3	$120,024	$360,072	$40,008
TOTAL	1,410	$4,404,936	$13,214,808	$3,125

Projected annual three year expenditures are for the period FFY 2009-2010 through FFY 2011-2012.

2.5. Compliance with Budget Neutrality Requirements

The Special Terms and Conditions of New York State's Medicaid Section 1115 waiver require that the Partnership Plan be budget neutral, that is, the cost to the federal government under the waiver must not be more than the cost that would have occurred without the waiver.

2.5.1. Partnership Plan Waiver Has Achieved Budget Neutrality and Realized Significant Savings

Available documentation strongly suggests that the Partnership Plan waiver has been successful not only in achieving budget neutrality but in realizing significant savings for the State and federal government.

The neutrality formula consists of two components: Without Waiver expenditures and With Waiver expenditures. Budget neutrality is continuously updated and monitored to ensure that the projections are current and that the waiver is budget neutral.

Without Waiver expenditures consist of the number of persons eligible for the waiver in each of the agreed upon Medicaid eligibility groups (MEGs) times the trended PMPM allowance agreed to with CMS. The Department updates eligible member months every three months and uses the most current available data in its budget neutrality projections.

The four agreed upon MEGs for the purposes of establishing Without Waiver expenditures are as follows:

- TANF children under the age of 1 through age 20,
- TANF adults ages 21 through 64,
- FHPlus adults with children, and
- Family Planning Benefit Program.

A fifth eligibility group was agreed upon – FHPlus adults with children at 160 percent of the federal poverty level – but the State has postponed implementing the increase in the eligibility level indefinitely.

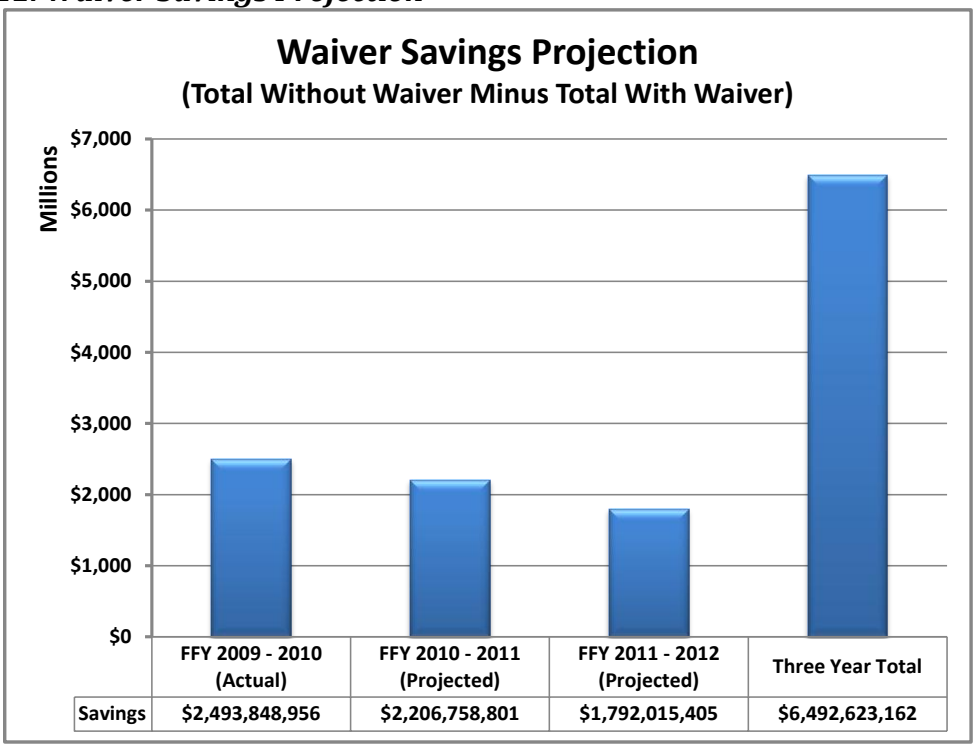
With Waiver expenditures consist primarily of medical claim costs for individuals eligible under the waiver. With Waiver expenditures are updated periodically using reports developed for the waiver eligible population. Because providers have up to two years to submit claims to MMIS for payment, actual claims data is lagged for 21 months to allow it to "mature" before it is considered final in the budget neutrality calculation. Once actual final data is incorporated into the budget neutrality calculation it becomes the basis for projecting future costs and savings estimates.

Expenditures for the four agreed upon MEGs are included in the With Waiver calculations as well as other expenditures, including Safety Net adults, FHPlus without children, HCBS Expansion, Indigent Care Pool direct costs, Designated State Health Programs, and the newly added Managed Long Term Care program. (See Attachment IV. New York State Partnership Plan Budget Neutrality Impact October 2009 through September 2012).

2.5.2. Waiver Savings Projection

Between October 2009 and September 2012, the Department projects that the waiver will have saved $6,492,623,162.[11] After subtracting the With Waiver expenditures from the Without Waiver calculation of expenditures, the State realizes almost $6.5 billion in projected savings, as shown in Figure 2-11: Waiver Savings Projection, and pays for five more programs than are included in the Without Waiver populations.

Figure 2-11: Waiver Savings Projection



Review of the budget neutrality analysis for the Partnership Plan waiver shows that the New York State Department of Health has been successful in producing savings for both the State and federal Medicaid programs. Implementation of the MMC mandate and addition of FHPlus have successfully demonstrated that moving low income populations out of fee-for-service care and into managed care models is cost effective with expenditures well below the level that would have been expected had the Partnership Plan Demonstration not occurred.

[11] With the permission of CMS, the State has reinvested some of the savings gleaned from some of the demonstration projects (such as MMC) in initiatives to expand access and improve quality. Thus, the net savings figures reported in this section are lower than the aggregate of savings reported for the four major programs.

3.0 CONCLUSION AND NEXT STEPS

The Partnership Plan Demonstration has played a central role in expanding health care coverage to underinsured and uninsured populations and has well prepared New York State to take a lead role in implementing federal health care reform initiatives supported by the ACA and to continue compatible efforts to expand managed care enrollment, develop innovative ways to expand health care coverage, and improve the quality of care as well as access to that care.

3.1. Summary of Key Accomplishments

Figure 3-1: Summary of Key Accomplishments presents the key accomplishments as they relate to program goals.

Figure 3-1: Summary of Key Accomplishments

DEMONSTRATION GOALS	ACHIEVED?	KEY ACCOMPLISHMENTS
Goal 1: To expand managed care enrollment	✓	▪ MMC enrollment increased by 12.6 percent between October 2009 and June 2012
Goal 2: To improve health care access for Medicaid beneficiaries in New York	✓	▪ PCP ratio increased from 4.54 in 2010 to 4.79 in 2011 per 1,000 enrollees while specialty physicians ration per 1,000 enrollees increased from 10.6 to 12 in the same period. ▪ All QARR measures of access to care improved between 2007 and 2010.
Goal 3: To continue to improve the quality of care	✓	▪ State measures met or exceeded national measures in 2010 NCQA QARR, and state 2010 scores largely exceeded state 2007 scores.
Goal 4: Expanded Health Care Coverage	✓	▪ FHPlus and FHP-PAP combined enrollment increased by 11.6 percent between October 2009 and June 2012
Waiver Requirement: Budget Neutrality	✓	▪ The budget neutrality analysis for the period FFY 2009-2010 through FFY 2011-2012 shows that the Partnership Plan Waiver accrued projected savings to both the State and federal Medicaid programs of approximately $6.5 billion.

Building on these key accomplishments, the State is taking further steps to improve access, quality and cost efficiency in the Medicaid Program as described in the sections that follow.

3.2. Next Steps

Projects related to the following programs are in the initial implementation phase. Therefore, more detailed analysis of program activities, performance and progress is not available at this time.

- Medicaid redesign ongoing implementation.
- Managed long term care for dual eligibles.
- Hospital-Medical Homes to Improve Primary Care Quality, Continuity and Coordination.

- The Preventable Readmissions Demonstration.

As part of the waiver extension process the Department plans to continue monitoring the success of the Partnership Plan Demonstration on measures of access, quality and cost.

3.2.1. Medicaid Redesign Ongoing Implementation

Governor Cuomo created the Medicaid Redesign Team (MRT) in January 2011 with the express purpose of putting together a multi-year action plan that would improve patient outcomes and lower program costs. After months of work the team finalized the action plan and the State is now implementing that plan. To achieve fiscal discipline, the MRT recommended a new multi-year Medicaid Global Spending Cap. The cap, which applies to the State share of Medicaid spending controlled by the Department of Health, is now State law.

The plan's second major tenet is that the primary way to improve patient outcomes and lower costs is effective care management. The MRT made the historic recommendation that the State phase-out the uncoordinated FFS program and replace it with a new system of *care management for all*. This new system will rely on a variety of health plans, new models of care and integrated delivery systems that will eventually provide fully-integrated managed care for all Medicaid members. It will take New York State between three to five years to fully implement the State's care management vision. While New York State has administered a managed care program for more than twenty years many of the State's highest need/highest cost populations have been excluded.

In addition to contracting with health plans, the MRT also recommended that the State invest in provider level care management strategies such as Patient Centered Medical Homes (PCMHs) and Health Homes. While full capitation can help better align incentives so as to reward value over volume, there is a clear need to drive provider level cooperation and meaningful improvement in service provision at the point of care. New York State is now on a path to ensure that all Medicaid members enjoy the benefits of high quality primary care through nationally accredited PCMHs and that every high need/high cost Medicaid member is enrolled in a Health Home.

The State's vision for a new proposed MRT waiver amendment is to reinvest federal dollars that will prepare the State for the ACA requirements as well as maximize the value of key ACA provisions. Health care reform must be about improving quality, improving health and reducing per capita costs. The State believes that the proposed MRT waiver amendment will allow New York State to address all three goals in a coordinated fashion while also fulfilling the promise laid out in the ACA. The requested extension to the Partnership Plan Demonstration will provide the venue to support the implementation of the proposed MRT amendment.

3.2.2. Managed Long Term Care for Dual Eligibles

Critical to advancing one of the MRT's primary objectives is the creation of a managed long term care (MLTC) Demonstration for dual eligible Medicaid recipients, 21 years old and

older, who are in need of home and community based care for more than 120 days. To achieve these objectives, the Department developed an MLTC mandatory enrollment process. Stakeholders from every sector including consumers have been engaged in this effort. Lessons learned from Partnership Plan Demonstrations of county by county mandatory Medicaid Managed Care enrollment over the last decade are essential for carrying out this endeavor. This transition is expected to facilitate:

- Improved care coordination for one of Medicaid's highest risk/highest cost population.
- Improved patient safety and quality of care for consumers.
- Reduced preventable acute hospital and nursing home admissions.
- Improved satisfaction, safety and quality of life for consumers.

The Department is initially targeting FFS Personal Care Program recipients residing in New York City for MLTC enrollment.

The program will also target new recipients in need of community based long term care. Implementation will occur first in local jurisdictions that have sufficient choice of managed long term care plans. While individual voluntary choice of an MLTC plan is preferred, the Department has the authority to assign persons who do not make a choice of plans. Specific populations and programs, such as the NHTD waiver, the TBI waiver and Assisted Living Program participants will be transitioned into the MLTC plans once appropriate waiver services are incorporated into the MLTC model.

3.2.3. Hospital-Medical Homes to Improve Primary Care Quality, Continuity and Coordination

The Hospital-Medical Home (H-MH) Demonstration is designed to improve primary care quality, continuity and coordination with other providers that Medicaid patients receive at hospital outpatient departments and primary care settings that are used to train resident physicians. The Department is finalizing the review process and a funding allocation methodology for making awards.

3.2.4. Potential Preventable Readmissions

The Potential Preventable Readmissions (PPR) Demonstration is designed to provide competitive grants to hospitals and/or collaborations of hospitals and other providers to develop strategies to reduce the rate of preventable readmissions related to medical or behavioral health conditions. To date the Department has developed an outline for a Request for Applications (RFA) and will begin the internal department approval process. The Department anticipates announcing the RFA in the spring of 2013.

Attachment I

MEDICAID MANAGED CARE QARR/NATIONAL BENCHMARK COMPARISON 2007 & 2010

IPRO

Medicaid Managed Care QARR/National Benchmark Comparison 2007 & 2010

Eighteen Medicaid Managed Care plans submitted 2010 QARR data in June 2011. All plan data was audited by NCQA licensed audit organizations prior to submission. The results for QARR 2007 and 2010 are displayed in the following table and compared with the NCQA HEDIS National benchmark measures for 2010 Medicaid HMOs in the NCQA The State of Health Care Quality 2011. As indicated by **green** shading, NYS Medicaid Managed Care average exceeded the national benchmarks for 39 of 42 measures (**gray** cells indicate that national benchmarks were not available). **Yellow** shading indicated NYS' average was equal to national benchmarks, while **blue** shading indicated NYS' average was below national benchmarks. Medicaid plans submitted 2011 data in June 2012. Data is being finalized and NCQA's report with national benchmarks for 2011 data is expected in October 2012. 2007 data was taken from the March 2009 Partnership Plan Request for Extension).

Measure	2007 NYS Medicaid Managed Care Average	2010 NYS Medicaid Managed Care (MMC) Average	National HEDIS 2010 Medicaid HMO Average*	2010 MMC Measures Above the National Average
Children and Adolescents' Access to PCPs Ages 12-19 Yrs	88	92	88	✓
Children and Adolescents' Access to PCPs Ages 12-24 months	95	96	96	
Children and Adolescents' Access to PCPs Ages 25 Mos-6 Yr	90	93	88	✓
Children and Adolescents' Access to PCPs Ages 7-11 Yrs	93	95	90	✓
ADHD Continuation	59	64	44	✓
ADHD Initiation	53	58	38	✓
Adolescents' Assessment or Counseling or Education- Substance Use		60		
Adolescents' Assessment or Counseling or Education- Depression	53	52		
Adolescents' Assessment or Counseling or Education- Sexual Health	73	60		
Adolescents' Assessment or Counseling or Education- Tobacco Use	76	64		
Adults' Access to Care Age 20-44 Yrs	80	82		
Adults' Access to Care Age 45-64 Yrs	87	89		
Adults' Access to Care Age 65 and over	88	89		
Adult BMI Assessment (ABA)		70	42	✓
Ambulatory Follow-Up After Hosp for Mental Illness-30 Days	77	84	64	✓
Ambulatory Follow-Up After Hosp for Mental Illness-7 Days	60	70	45	✓
Antidepressant Medication Management-180 Day Effective Phase Treatment	29	35	34	✓
Antidepressant Medication Management-84 Day Acute Phase Treatment	46	52	51	✓
Drug Therapy in Rheumatoid Arthritis	74	76	70	✓
Use of Appropriate Asthma Medications (Ages 12-50)		88	86	✓
Use of Appropriate Asthma Medications (Ages 12-50) 3+ Controllers		77		
Use of Appropriate Asthma Medications (Ages 5-11) 3+ Controllers		76		
Use of Appropriate Asthma Medications (Ages 5-50) 3+ Controllers		76		
Use of Appropriate Asthma Medications (Ages 5-11)		92	92	
Use of Appropriate Asthma Medications (Ages 5-50)		90	88	✓
Use of Imaging Studies for Low Back Pain	81	79	76	✓
Avoidance of Antibiotics for Adults with Acute Bronchitis	27	27	24	✓

Measure	2007 NYS Medicaid Managed Care Average	2010 NYS Medicaid Managed Care (MMC) Average	National HEDIS 2010 Medicaid HMO Average*	2010 MMC Measures Above the National Average
Cervical Cancer Screening		72	67	✓
Chlamydia Screening (Ages 16-20)	53	67	55	✓
Chlamydia Screening (Ages 16-24)		68	62	✓
Chlamydia Screening (Ages 21-24)	60	69	58	✓
Annual Dental Visit(Ages 2-18)		54		
Annual Dental Visit(Ages 2-21)	48	53		
Frequency of Ongoing Prenatal Care 81-100%		74	61	✓
Controlling High Blood Pressure (Ages 18-85)		67	56	✓
HIV/AIDS Comprehensive Care- Engaged in Care		80		
HIV/AIDS Comprehensive Care- Syphilis Screening Rate		58		
HIV/AIDS Comprehensive Care- Viral Load Monitoring		58		
HBreast Cancer Screening	68	68	51	✓
Annual Monitoring for Patients on Persistent Medications- ACE inhib/ARBs	85	91	86	✓
Annual Monitoring for Patients on Persistent Medications- Anticonvulsant	65	67	68	
Annual Monitoring for Patients on Persistent Medications- Combined	84	89	84	✓
Annual Monitoring for Patients on Persistent Medications- Digoxin	91	94	90	✓
Annual Monitoring for Patients on Persistent Medications- Diuretics	84	90	86	✓
Pharmacotherapy Management of COPD Exacerbation- Bronchodilator	77	85	82	✓
Pharmacotherapy Management of COPD Exacerbation- Corticosteroid	50	66	65	✓
Appropriate Testing for Pharyngitis	73	84	65	✓
Postpartum Care		73	64	✓
Timeliness of Prenatal Care		90	84	✓
Use of Spirometry Testing for COPD	40	46	31	✓
Appropriate Treatment for URI	89	91	87	✓
Well-Child Visits in 3rd, 4th, 5th & 6th Year of Life	81	80	72	✓
Adolescent Well-Care Visits	58	56	48	✓
5 or More Well-Child Visits in the First 15 Months of Life	79	77	76	✓
Weight Assessment for Children and Adolescents		65	37	✓
Weight Counseling for Nutrition for Children and Adolescents		71	46	✓
Weight Counseling for Physical Activity for Children and Adolescents		58	37	✓

SS - sample size less than 30

N/A - not applicable to the product

**National benchmarks from NCQA's 2011 State of Health Care Quality report*

Attachment II

FAMILY HEALTH PLUS QARR/NATIONAL BENCHMARK COMPARISON 2010

Family Health Plus QARR/National Benchmark Comparison 2010

The NYSDOH provided IPRO with Family Health Plus (FHPlus) data disaggregated from the full Medicaid Managed Care plan QARR data. IPRO constructed the following table to represent a comparison of the national HEDIS quality measures to the FHPlus data for the same time frame; 2010. As indicated in the final column of the table below, FHPlus was above the national quality metric for almost 85 percent of the measures (i.e., 21/25 measures).[12] Impressively, for several of these measures FHPlus was largely improved over the HEDIS measures. For example, the Adult BMI measure indicates that nationally Medicaid HMOs are only at 42 percent while FHPlus is at 70 percent. This large difference is also evident with COPD, breast cancer screening, and ambulatory follow-up for mental illness. For the few measures that are not above the national metric, NYS was within four percentage points with the exception of adolescent well-care visits at a seven percent difference. It is clear that there are areas for which NYS is performing well above the nation on many measures and might now focus on those few measures where there is room for improvement within FHPlus for the state.

As indicated by **green** shading, FHPlus measures exceeded 21 of the 25 comparable HEDIS National Benchmarks (**gray** cells indicate that national benchmarks were not available). **Blue** shading indicated NYS' average was below national benchmarks.

Measure	2010 NYS Family Health Plus (FHPlus) Managed Care Average	National HEDIS 2010 Medicaid HMO Average*	FHPlus Measures Above the National Average
Children and Adolescents' Access to PCPs Ages 12-19 Yrs	NA	88	
Children and Adolescents' Access to PCPs Ages 12-24 months	NA	96	
Children and Adolescents' Access to PCPs Ages 25 Mos-6 Yr	NA	88	
Children and Adolescents' Access to PCPs Ages 7-11 Yrs	NA	90	
ADHD Continuation	NA	44	
ADHD Initiation	NA	38	
Adolescents' Assessment or Counseling or Education- Substance Use	NA		
Adolescents' Assessment or Counseling or Education- Depression	NA		
Adolescents' Assessment or Counseling or Education- Sexual Health	NA		
Adolescents' Assessment or Counseling or Education- Tobacco Use	NA		
Adults' Access to Care Age 20-44 Yrs	NA		
Adults' Access to Care Age 45-64 Yrs	NA		
Adults' Access to Care Age 65 and over	NA		
Adult BMI Assessment (ABA)	70	42	✓
Ambulatory Follow-Up After Hosp for Mental Illness-30 Days	83	64	✓
Ambulatory Follow-Up After Hosp for Mental Illness-7 Days	70	45	✓
Antidepressant Medication Management-180 Day Effective Phase Treatment	38	34	✓
Antidepressant Medication Management-84 Day Acute Phase Treatment	54	51	✓

[12] The HEDIS data was taken from the NCQA *The State of Health Care Quality 2011*; specifically, the Medicaid HMO section which represents data from 2010.

Measure	2010 NYS Family Health Plus (FHPlus) Managed Care Average	National HEDIS 2010 Medicaid HMO Average*	FHPlus Measures Above the National Average
Drug Therapy in Rheumatoid Arthritis	76	70	✓
Use of Appropriate Asthma Medications (Ages 12-50)	90	86	✓
Use of Appropriate Asthma Medications (Ages 12-50) 3+ Controllers	80		
Use of Appropriate Asthma Medications (Ages 5-11) 3+ Controllers	NA		
Use of Appropriate Asthma Medications (Ages 5-50) 3+ Controllers	NA		
Use of Appropriate Asthma Medications (Ages 5-11)	NA	92	
Use of Appropriate Asthma Medications (Ages 5-50)	NA	88	
Use of Imaging Studies for Low Back Pain	78	76	✓
Avoidance of Antibiotics for Adults with Acute Bronchitis	28	24	✓
Cervical Cancer Screening	75	67	✓
Chlamydia Screening (Ages 16-20)	NA	55	
Chlamydia Screening (Ages 16-24)	66	62	✓
Chlamydia Screening (Ages 21-24)	NA	58	
Annual Dental Visit(Ages 2-18)	NA		
Annual Dental Visit(Ages 2-21)	43		
Frequency of Ongoing Prenatal Care 81-100%	77	61	✓
Controlling High Blood Pressure (Ages 18-85)	68	56	✓
HIV/AIDS Comprehensive Care- Engaged in Care	84		
HIV/AIDS Comprehensive Care- Syphilis Screening Rate	51		
HIV/AIDS Comprehensive Care- Viral Load Monitoring	53		
HBreast Cancer Screening	73	51	✓
Annual Monitoring for Patients on Persistent Medications- ACE inhib/ARBs	90	86	✓
Annual Monitoring for Patients on Persistent Medications- Anticonvulsant	64	68	
Annual Monitoring for Patients on Persistent Medications- Combined	89	84	✓
Annual Monitoring for Patients on Persistent Medications- Digoxin	89	90	
Annual Monitoring for Patients on Persistent Medications- Diuretics	88	86	✓
Pharmacotherapy Management of COPD Exacerbation- Bronchodilator	79	82	
Pharmacotherapy Management of COPD Exacerbation- Corticosteroid	75	65	✓
Appropriate Testing for Pharyngitis	NA	65	
Postpartum Care	77	64	✓
Timeliness of Prenatal Care	92	84	✓
Use of Spirometry Testing for COPD	55	31	✓
Appropriate Treatment for URI	NA	87	
Well-Child Visits in 3rd, 4th, 5th & 6th Year of Life	NA	72	
Adolescent Well-Care Visits	41	48	
5 or More Well-Child Visits in the First 15 Months of Life	NA	76	
Weight Assessment for Children and Adolescents	NA	37	
Weight Counseling for Nutrition for Children and Adolescents	NA	46	
Weight Counseling for Physical Activity for Children and Adolescents	NA	37	

SS - sample size less than 30

N/A - not applicable to the product

**National benchmarks from NCQA's 2011 State of Health Care Quality report*

Attachment III

NEW YORK STATE DEPARTMENT OF HEALTH COMPREHENSIVE MCO OPERATIONAL SURVEY QUESTIONS ATTACHMENT L-7

ATTACHMENT L-7
NEW YORK STATE DEPARTMENT OF HEALTH
COMPREHENSIVE MCO OPERATIONAL SURVEY QUESTIONS

ORGANIZATION & MANAGEMENT	
QUESTION	**CITATIONS**
1. Does the plan have an effective mechanism for input by enrollees to the board of directors?	98-1.17(a)(4)
2. Is the board of directors comprised of at least 1/3 of New York State residents and are at least 20% MCO members? Are member representatives, or in the case of a PHSP, consumer representatives from an advisory council representing the membership, given prior notice and invited to board meetings? In the case of an HIV SNP, is there at least one person with HIV infection serving as a consumer representative? Note: Article 43s with Article 44 lines of business do not need to comply with this requirement.	98-1.6(a) 98-1.11 (g) (1),(2)
3. Does the MCO have any new board members, managers of an LLC, officers, or medical director? Has the MCO notified the department of those new individuals and the names of those individuals that are leaving their positions?	98-1.5 (b)(2)(ii)
4. Does the board of directors meet to conduct business at least four times a year, once in each quarter?	98-1.6(a)
5. If the plan has a management contract: (a) Does the MCO retain its authority in key areas described in 98-1.11(i)? (b) Has the contract received Health Department approval?	98-1.11(i) 98-1.11(j) 98-1.11(k)
6. Does the MCO conduct audits or other monitoring activities of its management contractors?	98-1.11(h) MMC/FHP Contract: Sections 22.1, 22.4(b), 22.5(a),(i), Appendix R(5)
7. (a) Is there evidence that the governing authority is responsible for the establishment and oversight of the MCO's policies, management and overall operation? (b) Do board minutes reflect that the board is managing its operation?	PHL §4404(1) 98-1.11(h)

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QUALITY ASSURANCE	
QUESTION	**CITATIONS**
8. Does the MCO have a comprehensive quality management program that is approved by the MCO board of directors and the Department?	98-1.12
9. Does the MCO's medical director supervise the quality and utilization management programs?	98-1.12(a) 98-1.2(bb)
10. (a) Does the MCO have an internal quality assurance committee? (b) Does the committee composition include healthcare providers and other appropriate MCO staff? (c) Is the Board kept apprised of quality management activities by the QA committee? Is there evidence that the board is actively involved in the oversight of the quality management program?	98-1.12(e) 98-1.12(f)(1) 98-1.12(i)
11. What sources and strategies does the MCO use to identify and examine actual and potential problems in health care administration?	98-1.5(b)(16) 98-1.12(a), (b), (c), (g), (h) 98-1.12(f)(2) MMC/FHP Contract Sections 10.4, 16.2, 35.7
12. Does the MCO develop and implement appropriate recommendations and corrective actions to address problems identified?	98-1.12(i), (j)
13. How does the MCO evaluate whether problem areas are resolved?	98-1.12(a) 98-1.12(f)(iv) 98-1.12(i)(1), (2), (3) 98-1.12(j)(1), (2), (3)
14. Does the MCO have a peer review committee responsible for monitoring provider performance?	98-1.12(f)(2)
15. What method is used by the MCO to determine the clinical study(ies) that should be undertaken by the MCO to improve the health of its enrollees?	98-1.12(g)
16. Has the plan integrated QARR results into their ongoing procedures?	98-1.12 (b), (i) MMC/FHP Contract Section 18.5(a)(x)
17. Does the plan have a case management program for individuals with chronic diseases and for high risk pregnant women to promote coordination of care amongst providers and other support services?	MMC/FHP Contract Sections 10.19 10.20 98-1.13(h)
18. Does each member have a primary care provider who is responsible for managing and facilitating care?	98-1.13 (d), (h) MMC/FHP Contract Sections 21.8, 21.11

QUALITY ASSURANCE	
QUESTION	**CITATIONS**
19. Has the plan developed medical record standards and are these standards disseminated to and applied to providers?	98-1.13(k), (l) MMC/FHP Contract Sections 19.1(a)(i), 20.2, 20.3
20. Does the plan take appropriate actions to ensure the confidentiality of medical records and other specific information?	PHL 4410.2 PHL 2782 MMC/FHP Contract Section 20.3 PHL 4902.1(g) PHL 4905.1, 2, 8
21. Does the MCO provide HIV testing and counseling to all pregnant women? (a) Is HIV counseling/testing provided to each prenatal enrollee with clinical recommendation for HIV testing? (b) Is HIV post-test counseling provided to all women who are HIV tested?	PHL Chapter 220
22. Does the plan have effective credentialing and recredentialing processes that are overseen by the medical director?	98-1.12(k) 98-1.12(l) MMC/FHP Contract Sections 21.4, 21.1(b) 4408-1.(r) 4406(d)-1
23. (a) Does the MCO have a process to identify, on an ongoing basis, healthcare providers that have been sanctioned by regulatory agencies or providers whose license or registration has expired or been revoked? (b) Does the process include removal of providers from the network who are unable to provide services due to final disciplinary action, sanction by regulatory agency, or due to an expired license/registration?	98-1.12(l) MMC/FHP Contract Sections 21.1(b), 21.4(b), 21.5
24. **PRENATAL Medicaid Only:** Are risk assessments conducted initially and periodically throughout the prenatal period, and is appropriate follow-up conducted?	MMC/FHP Contract Section 13.6(a)(ii), (v)
25. **PRENATAL Medicaid Only**: Are prenatal diagnostic and treatment services and postpartum services provided according to accepted standards?	MMC/FHP Contract Section 10.11 SSL 365-k.

SERVICE DELIVERY NETWORK	
QUESTION	**CITATIONS**
26. Does the Plan have a Provider Manual which is distributed to all providers?	See Provider Manual Checklist 98-1.12 (o) requires a provider manual
27. (a) Does the plan have a mechanism to monitor clinical access to PCPs 24 hours a day, 7 days a week (including for pregnant women)? (b) Medicaid Only: Does the MCO monitor appointment availability?	Appointment and Availability Study PHL 4408(1)(h) 98-1.6(f) 98-1.6(f) 98-1.13 (d) and (h) MMC/FHP Contract Section 18.5(a)(ix)
28. (a) Does the MCO allow each member to choose a PCP? (b) If the member does not select a PCP, does the plan assign a PCP? (c) Does the MCO allow member to change PCPs?	PHL 4403(5)(a)(i) (ii) 98-1.13(d) MMC/FHP Contract Sections 13.6 21.8(a),(b),(c) 21.9 21.10(c) 21.14(d) and (e) 21.15(c)
29. Does the Plan have contracts for all providers that are listed on the HPN?	PHL 4402(2)(a) PHL 4403(5) 98-1.2(aa) 98-1.5(b)(6) 98-1.13 (a) 98-1.18(a) MMC/FHP Contract: Sections 21.1, 22.1, 22.3, 22.4
30. (a) Does the Plan have a process to update the provider directory? (b) Does the MCO notify enrollees and providers of changes to the directory?	PHL 4403(5)(a)(b) PHL 4408(1)(r) 98-1.16(i) MMC/FHP Contract Section 13.1
31. Does the plan have an internal process to identify capacity problems and augment the network as needed?	PHL 4403(5)(a)(b) 98-1.6 (f) 98-1.13 (h) MMC/FHP Contract Section 21.1
32. (a) Does the MCO notify DOH appropriately upon large contract assignments, terminations or non-renewals? (b) Are contracts that were assigned to the MCO through a purchase or acquisition updated?	98-1.13(c) MMC/FHP Contract Section 22.12
33. Does the MCO implement procedures to address health care professional (provider) terminations and due process?	PHL 4406-d(2) PHL 4406-d(5)

MEMBER SERVICES/ACCESS TO SERVICES	
QUESTION	**CITATIONS**
34. How does the MCO provide care to members with life threatening or degenerative and disabling conditions needing access to specialty care centers?	PHL 4403(6)(d) MMC/FHP Contract Sections 10.19, 10.20, 15.9, 21.14(b)
35. How does the plan provide access to specialty care outside of the plan's contracted network, as needed?	PHL 4403(6)(a) 98-1.13(a) MMC/FHP Contract Section 21.2
36. Does the MCO have procedures in place to allow a specialist to act as the PCP for enrollees with a life-threatening condition or disease or a degenerative and disabling condition or disease which requires specialized medical care?	PHL 4403(6)(c)
37. a) Does the plan have policies and procedures to allow transitional care to new members upon joining the MCO? **Medicaid Only:** b) What does the plan do to promote continuity of care for new enrollees who have a life threatening disease or condition or a disabling degenerative condition, specifically as it relates to home health care and private duty nursing?	PHL 4403(6)(f) MMC/FHP Contract Section 15.6
38. Does the plan have policies and procedures to address continuity of care when a provider leaves a network?	PHL 4403(6)(e)(1) PHL 4408(4) 98-1.2(oo)
39. Does the MCO have a process for the resolution of requests for services to be provided by out-of-network providers for medically necessary services not available in network?	98-1.13(a), (b), (i)
40. Is the plan issuing member handbooks and policies and procedures to address all requirements prescribed in regulation and law?	PHL 4408 98-1.14
41. Does the plan have a mechanism to provide health and childbirth education to prenatal enrollees?	MMC/FHP Contract Section 10.11 SSL 365-k.
42. Does the MCO have a toll-free telephone number to accept oral complaints on a 24-hour basis?	PHL 4408-a(3)(d)
43. Does the MCO have an acceptable toll-free telephone number which connects callers to UR personnel?	PHL 4902.1(f)
44. Is the complaint process accessible and usable to the non-English speaking, or by persons with mobility, auditory, visual, and cognitive impairments?	PHL 4408-a(2)(c) PHL 4403(5)(b)(ii) 98-1.16(k) MMC/FHP Contract Sections 12.2, 12.3, Appendix F.2(2)(a)

COMPLAINTS/GRIEVANCES	
QUESTION	**CITATIONS**
45. Are there procedures for enrollee filing of a complaint or grievance?	PHL 4408-a PHL 4403 (1) (g) PHL 4403(5) (b)(iii) 98-1.14 (c), (d), (e) 98-1.16(k) MMC/FHP Contract App F.2 (1), (2), and (6)-(9) Section 12.2, 12.3
46. Are the MCO's grievance, complaint and appeal notifications accessible to and usable by persons with auditory, visual, and cognitive impairments and by persons who speak a language other than English?	PHL 4403.5(b)(ii) 98-1.16(k) MMC/FHP Contract Appendix F F.1 (5)(a) F.2 (5)(a) Appendix J (IV) (B4)
47. **Medicaid Only:** a) Does the MCO handle service or referral requests and claim submissions for contracted benefits consistent with the MMC/FHP contract? b) Are qualified personnel reviewing requests for benefits/referrals and claims?	MMC/FHP Contract Section 14.1, 14.2(a), (b) Appendix F F.1(2)(a)(iii) F.1(6) F.2 (2)(f) F.2 (3)(a)(vii)
48. **Medicaid Advantage Only:** Upon issuing an Organization Determination and Notice of Action, does the MCO offer enrollees a choice of Medicare or MMC appeal processes?	Medicaid Advantage Contract Appendix F F.1 (2)(c)
49. **Commercial /CHP Only:** Is written notice of grievance procedure provided to the enrollee when a request for referral or service is denied or claim is denied in whole or in part, because the MCO determines the service is not covered?	PHL 4408-a (2)(a)& (b) PHL 4408-a(3) (a),(b), & (d)
50. Does the plan have designated personnel to accept review and make determinations on all complaints/grievances and as applicable, Action appeals?	4408a-(3)(d) 4408-a (5) 4408-a(10) MMC/FHP Contract Appendix F F.1(2)(a)(iii) F.2 (2)(b) F.2(3)(a)(vii) F.2 (6)(a)(iii) and (iv) F.2 (9)(a)(iii)

COMPLAINTS/GRIEVANCES	
QUESTION	**CITATIONS**
51. **Medicaid Only:** Does the enrollee have the ability to file standard Action appeals?	MMC/FHP Contract, Appendix F F.1 (d)(v) F.2(3)(a)(i), (ii), (iii) and (iv) F.2 (4) F.2 (5) F.2(10)
52. **Medicaid Only:** Does the enrollee have the ability to review their case file and present evidence to support his/her appeal?	MMC/FHP Contract App F.2(3)(a)(iv)
53. Are grievances and complaints, other than immediately resolved oral complaints, acknowledged within 15 business days? b) Are appeals of the MCO's grievance and complaint determinations acknowledged within 15 business days? c) Medicaid Only: Are Action appeals acknowledged within 15 calendar days?	PHL 4408-a(4) PHL 4408-a(3)(c) PHL4408-a(9) 98-1.14(e) MMC/FHP Contract Appendix F F.2 (3)(a)(iii) F.2 (6)(a)(ii) F.2 (9)(a)(ii)
54. Does the MCO review grievances and investigate complaints in accordance with statute and, if applicable, the MMC/FHP Contract? b) Medicaid Only; Does the MCO review Action Appeals in accordance with statute and the MMC/FHP Contract?	PHL 4408-a(1) PHL 4408-a(2)(b) PHL 4408-a(4) PHL 4408-a(6) PHL 4408-a(13) 98-1.14(c), (e) MMC/FHP Contract App F.2 (2), (3), (4), (5), (6) and (7)
55. **Medicaid Only**: Does the MCO extend reviews of referral/ benefit requests, claims and Action appeals in accordance with the MMC/FHP Contract?	MMC/FHP Contract App F.1 (3)(c)(i) and (ii) F.1 (3)(d) F.2(4)(a)(iii) F.2(10)(vii)
56. Does the MCO issue appropriate resolution notices to the enrollee, or their designee, for complaints and grievances, and, as applicable, Action appeals?	PHL 4408-a(6) PHL 4408-a(7) 98-1.14(e) MMC/FHP Contract App F.2 (5)(a)(iii) F.2 (8)
57. Does the enrollee have the ability to file an appeal of the MCO's grievance or complaint determination?	PHL 4408-a (8), (9) 98-1.14(e) MMC/FHP Contract Appendix F.2 (9)

COMPLAINTS/GRIEVANCES	
QUESTION	**CITATIONS**
58. Are grievance and complaint appeal determinations issued in accordance with all requirements?	PHL 4408-a(12) MMC/FHP Contract App F.2 (9)(a)(vi)
59. Is there a complete file for each complaint/ grievance, appeal and as applicable Action appeal?	PHL 4408-a(14) 98-1.14(d) MMC/FHP Contract App F.2 (10)
60. Does the MCO have procedures in place to address provider complaint/grievances?	PHL 4406-c(3),(4) PHL 4406-d PHL 4408-a(1) MMC/FHP Contract Section 22.7(a)(ii) and (iii)
61. Does the MCO report incidents of probable health care provider professional misconduct to appropriate professional disciplinary agencies?	PHL 4405-b MMC/FHP Contract Section 18.8
62. Does the MCO report complaints regarding fraud and abuse to DOH?	98-1.21(d) MMC/FHP Contract Section 18.5(a)(vi)
63. **Medicaid Only:** Are accurate reports on Medicaid complaints and Action Appeals sent to SDOH on a quarterly basis?	PHL 4408-a (14) 98-1.16(h) MMC/FHP Contract Section 18.5(a)(vi) App F.2 (7)(a)(i)
64. Does the plan trend complaints/grievances to identify administrative problems and issues regarding the provision of health care services?	PHL4403(5)(b) (iii) PHL 4408-a(14) 98-1.12 (g), (h),(i), and (j)
65. Does the MCO monitor complaints, grievances, and as applicable, Action appeals, related to accessibility issues for enrollees, including persons with disabilities? b) Does the MCO routinely identify enrollee special needs, and respond to complaints regarding accessibility in a manner consistent with identified needs?	PHL 4403(5)(b)(i) 98-1.12 (g), (h),(i), and (j) MMC/FHP Contract Appendix J (IV) (B4)

UTILIZATION REVIEW (with MMC/FHP Actions)	
QUESTION	**CITATIONS**
66. Does the MCO have written Utilization Review procedures that are compliant with statute, regulation, and, as applicable, the MMC/FHP contract?	PHL 4902 PHL 4903 PHL 4904 PHL 4905 PHL 4910 PHL 4900(9) 98-2.3(a) 98-1.13(n) 98-2.9 MMC/FHP Contract Section 14.1, 14.2(a),(b) and Appendix F
67. Are notices of initial UR adverse determinations issued in accordance with all requirements?	PHL 4903(5) PHL 4902(1)(e) MMC/FHP Contract App F.1 (2)(a)(iv) F.1 (5)(a)(iii) F.2(3)(a)(iv)
68. Are notices of UR final adverse determinations issued in accordance with all requirements?	98-2.9(e) 98-2.9(h) PHL 4904(5) PHL 4904(3) MMC/FHP Contract App F.2(4)(a)(v) F.2(5)(a) F.2 (5)(a)(iii)
69. Are requests for pre-authorization or continuation/ extension of services reviewed in accordance with statute and, as applicable, the MMC/FHP contract?	PHL 4903(2) PHL 4903(3) PHL 4903(7) MMC/FHP Contract App F.1(1), (2) F.1 (3)(a), (b)
70. Is retrospective utilization review done in accordance with statute, and as applicable, the MMC/FHP contract?	PHL 4903(4) PHL 4903(7) PHL 4905(5) 98-1.13(n) MMC/FHP Contract App F.1(4)(b), (c) F.1(6)(b)
71. Does the plan have qualified personnel who perform utilization review?	4900.2 (a) 4903.1 4904.4
72. **Medicaid Only:** Does the MCO identify and review initial requests for authorization of services requiring expedited review in accordance with the MMC/FHP contract?	MMC/FHP Contract App F.1(2)(a)(i)

73. When more information is needed to render a determination, does the MCO request necessary information prior to making an adverse determination or upholding an appeal?	4903.5(c) 4905.11 4408-a(3)(c) 98-2.9(b) MMC/FHP Contract App F.1 (2)(a) [42CFR 438.210 (b)(2)(ii)] F.1 (3)(c)(ii) F.2(4)(a)(iii)(B) F.2(10)
74. Does the MCO notify enrollees and providers when services are authorized?	4903.2 4903.3 MMC/FHP Contract App F.1(2)(iv)
75. **Medicaid Advantage Only:** Upon issuing an Organization Determination and Notice of Action, does the MCO offer enrollees a choice of Medicare or MMC appeal processes?	MA Advantage Contract App F.1 (2)(c)
76. Do providers have the ability to request timely reconsideration of a UR adverse determination of a service they recommended?	4903.6 4903.5
77. Does the enrollee have the ability to file standard appeals of adverse determinations?	4904.3 4903.5 MMC/FHP Contract App F.2(3)(a)(i), (ii), (iii) and (iv) F.2(10)
78. Does the enrollee and/or the enrollee=s health care provider have the opportunity to engage in an expedited appeal?	4904.2 (a) and (b) 4903.5(b) 98-2.9 (e)(f) 98-1.14 (c) MMC/FHP Contract App F.2(3), (4), (10)
79. **Medicaid Only:** Does the enrollee have the ability to review their case file and present evidence to support his/her appeal?	MMC/FHP Contract App F.2(3)(a)(iv)
80. Does the MCO adequately cover emergency services?	4902.1(c),(h) 4903.4 4903.5 4904.1 4905.11 4905.13 98-1.13(a) MMC/FHP Contract App G(2)
81. Does the MCO adequately cover the provision of post-stabilization care and inpatient admissions resulting from an ER visit? b) How does the MCO facilitate the transfer of patients from non-participating to participating hospitals after stabilization?	4902.1(d) 4902.1(h) 4903.3 4903.6 4905.11 4905.13 98-1.13(a) MMC/FHP Contract App G(3), (4)

MANAGEMENT INFORMATION SYSTEMS	
QUESTION	**CITATIONS**
82. Does the MCO have the system capacity to produce and submit all required reports?	364-j(8)(d) 98-1.17(a)(2)
83. Does the plan produce mgmt. reports which summarize denials in order to monitor utilization review activities?	98-1.6(f) 98-1.8(a)
84. How does the plan track pended claims to ensure timely resolution?	98-1.6(c) 98-1.8(a) NYS INS Law 3224-a
85. Does the plan's information systems, or those used by delegated entities, integrate the utilization management and claims adjudication systems to promote accurate processing.	98-1.6(c) 98-1.8(a)

FRAUD AND ABUSE	
QUESTION	**CITATIONS**
Note-- This entire section applies to: • *Commercial MCOs with Medicaid product and over 10,000 enrollees* • *Medicaid only plans with over 10,000 enrollees* • *Commercial only MCOs with over 60,000 enrollees (certain exceptions noted).* ***As indicated, only select questions apply to Medicaid Only plans with less than 10,000 enrollees***	
86. Does the MCO have a separate and distinct full time Special Investigation Unit (SIU) distinct from any other MCO unit or function?	98-1.21(b)(1)
87. Does the MCO have a designated officer or director position? who has responsibility for carrying out the provisions of the FAPP who reports directly to senior management? (b) **For Medicaid Only plans with less than 10,000 enrollees:** Does the MCO have a designated compliance officer and compliance committee that are accountable to senior management?	98-1.21(a) MMC/FHP Contract Section 23.1 (42 CFR Part 438.608)
88. Does the MCO dedicate resources to support the functions of the SIU and the implementation of the FAPP?	98-1.21(b)(2)
89. **For all applicable MCOs, including Medicaid Only with less than 10,000 enrollees:** Do relationships exist between: • the Fraud & Abuse Director and the SIU; • the Fraud & Abuse Director and the SIU and law enforcement agencies; and • Staff in other units of the MCO, such as claims, UR, quality, etc, and the SIU?	98-1.21(b)(4) MMC/FHP Contract Section 23.1 (42 CFR Part 438.608)
90. Is there a process for case referrals to the SIU, DOH and other law enforcement agencies?	98-1.21(b)(6)
91. How does the MCO prevent, detect, and conduct case investigations of fraud or abuse?	98-1.21(b)(5)
92. **For applicable MCOs, including Medicaid only MCOs with less than 10,000 enrollees:** How has the MCO Improved performance or modified processes as a result of fraud and abuse investigations?	98-1.21(b)(11) MMC/FHP Contract Section 23.1 (42 CFR Part 438.608)
93. **For all applicable MCOs, including Medicaid only with less than 10,000 enrollees**: (a) Does the plan have written policies, procedures and standards of conduct that are distributed to all affected employees and appropriate delegated entities? (b) Do they reflect the MCO's commitment to comply with all applicable federal and state standards and identify and address specified areas of risk and vulnerability? (c) Does the plan conduct internal audits to ensure compliance with standards of conduct?	98-1.21(a) 98-1,21(b)(7), (11)&(12) MMC/FHP Contract Section 23.1 (42 CFR Part 438.608) Section 1902(a) of the Social Security Act

94. **For all applicable MCOs, including Medicaid only with less than 10,000 enrollees:** Does the MCO have provisions for in-service training programs for investigative, claims, quality, UM and other personnel with periodic refreshers?	98-1.21(b)(9) MMC/FHP Contract Section 23.1 (42 CFR Part 438.608)
95. Does the MCO have a Fraud and Abuse Awareness program?	98-1.21(b)(13)
96. Does the MCO have a fraud and abuse detection manual that is available to its employees?	98-1.21(b)(14) Section 1902(a) of the Social Security Act
97. If the MCO accepts paper claim forms, other than standardized federal claim forms such as the HCFA1500, do such forms include appropriate c warning statement against fraudulent acts?	98-1.22(a), (b)

Attachment IV

NEW YORK STATE PARTNERSHIP PLAN
BUDGET NEUTRALITY IMPACT
OCTOBER 2009 THROUGH SEPTEMBER 2012,
NYSDOH, SEPTEMBER 6, 2012.

New York State Partnership Plan

Projected 1115 Waiver Budget Neutrality Impact Through December 2013

Budget Neutrality Cap (Without Waiver)	DY 1 - 11 (10/1/97 - 9/30/09) Projected	DY 12 (10/1/09-9/30/10) Actual	DY 13A 10/1/10-3/31/11) Projected	DY 13B (4/1/11-9/30/11) Projected	DY 14 (10/1/11-9/30/12) Projected
Demonstration Group 1 - TANF Children under age 1 through 20		$11,197,206,500	$6,105,699,488	$6,123,530,693	$13,426,169,462
Demonstration Group 2 - TANF Adults 21-64		$4,511,421,595	$2,467,348,368	$2,454,367,076	$5,370,065,165
Demonstration Group 6 - FHP Adults w/Children		$1,878,516,641	$1,043,047,420	$1,055,415,331	$2,341,067,454
Demonstration Group 6A - FHP Adults w/Children @ 160%		$0	$0	$0	$0
Demonstration Group 8 - Family Planning Expansion				$5,140,241	$10,702,271
Demonstration Group 10 - MLTC Adult Age 18-64 Duals					$247,394,784
Demonstration Group 11 - MLTC age 65+ Duals					$2,554,212,091
W/O Waiver Total	**$187,390,575,140**	**$17,587,144,736**	**$9,616,095,275**	**$9,638,453,340**	**$23,949,611,226**

Budget Neutrality Cap (With Waiver)	DY 1 - 11 (10/1/97 - 9/30/09) Projected	DY 12 (10/1/09-9/30/10) Actual	DY 13A 10/1/10-3/31/11) Projected	DY 13B (4/1/11-9/30/11) Projected	DY 14 (10/1/11-9/30/12) Projected
Demonstration Group 1 - TANF Children under age 1 through 20		$5,006,727,158	$2,714,708,527	$2,722,636,616	$5,935,822,630
Demonstration Group 2 - TANF Adults 21-64		$2,891,489,419	$1,575,447,496	$1,567,158,701	$3,416,017,313
Demonstration Group 5 - Safety Net Adults		$5,947,064,577	$3,499,710,446	$3,596,498,109	$8,302,164,325
Demonstration Group 6 - FHP Adults w/Children up to 150%		$910,895,137	$503,870,306	$509,844,937	$1,126,650,488
Demonstration Group 7 - FHP Adults without Children up to 100%		$327,279,755	$168,015,728	$171,374,962	$383,180,812
Demonstration Group 6A - FHP Adults w/Children @ 160%		$0	$0	$0	$0
Demonstration Group 7A - FHP Adults without Children @ 160%		$0	$0	$0	$0
Demonstration Group 8 - Family Planning Expansion		$9,839,735	$4,164,485	$5,460,394	$11,576,340
Demonstration Group 9 - Home and Community Based Expansion (HCBS)		N/A	N/A	$3,699,108	$3,699,108
Demonstration Group 10 - MLTC Adult Age 18-64 Duals					$249,276,515
Demonstration Group 11 - MLTC age 65+ Duals					$2,561,508,288
Demonstration Population 1: State Indigent Care Pool Direct Expenditures (ICP-Direct)				$2,600,000	$14,650,000
Demonstration Population 2: Designated State Health Programs to Support Clinic Uncompensated Care Funding (ICP - DSHP)				$2,600,000	$14,650,000

Budget Neutrality Cap (With Waiver)	DY 1 - 11 (10/1/97 - 9/30/09) Projected	DY 12 (10/1/09-9/30/10) Actual	DY 13A 10/1/10-3/31/11) Projected	DY 13B (4/1/11-9/30/11) Projected	DY 14 (10/1/11-9/30/12) Projected
Demonstration Population 3: Designated State Health Programs to Support Medical Home Demonstration (DSHP - HMH Demo)				$0	$133,400,000
Demonstration Population 4: Designated State Health Programs to Support Potentially Preventable Readmission Demonstration (DSHP - PPR Demo)				$0	$5,000,000
With Waiver Total	**$157,629,949,646**	**$15,093,295,780**	**$8,465,916,988**	**$8,581,872,826**	**$22,157,595,820**
Expenditures (Over)/Under Cap	**$29,760,625,494**	**$2,493,848,956**	**$1,150,178,287**	**$1,056,580,514**	**$1,792,015,405**

NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

August 6, 2012

Ms. Cynthia Mann
Director
Center for Medicaid and CHIP Services
7500 Security Boulevard, MS S2-26-12
Baltimore, Maryland 21244

Dear Ms. Mann:

New York State formally requests an amendment to our Section 1115 Partnership Plan Waiver (11-W-00114/2) to allow the state to reinvest federal savings generated through the historic efforts of Governor Andrew M. Cuomo's Medicaid Redesign Team. This groundbreaking waiver amendment's broad objectives are consistent with the Centers for Medicare and Medicaid Services (CMS) Triple Aim: better health, better care, and lower costs. The state proposes to use the waiver amendment to reinvest in the state's health care system, pave the way for implementation of national health care reform and continue to make New York a national health care reform model.

The attached document outlines reinvestment strategies to be funded through up to $10 billion of the $17.1 billion in federal savings generated by Medicaid Redesign Team reforms. In order to implement the proposals in a timely manner, we are requesting your expedited review of the waiver amendment request. My staff will be available to discuss the individual proposals at your convenience. We appreciate the anticipated cooperation and assistance of Centers for Medicare and Medicaid Services.

We look forward to working with you to finalize the Special Terms and Conditions so that New York State can move forward with implementing groundbreaking initiatives that are critical to redesigning New York's health care infrastructure and meeting the requirements of national health care reform.

Sincerely,

Jason A. Helgerson
Medicaid Director
Deputy Commissioner
Office of Health Insurance Programs

Attachment
cc: Jessica Schubel
Victoria Wachino
Michael Melendez

New York State Medicaid Redesign Team (MRT) Waiver Amendment

Achieving the Triple Aim

NEW YORK
state department of
HEALTH

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OVERVIEW

Introduction

New York State is well positioned to lead the nation in Medicaid reform. Governor Andrew M. Cuomo's Medicaid Redesign Team (MRT) has developed a multi-year action plan to reform Medicaid. This plan not only aims to improve health outcomes and quality of care for more than five million New Yorkers, but also bends the state's Medicaid cost curve. Significant federal savings have already been realized through New York's MRT process, and this action plan should help accrue additional substantial savings.

To fully implement this action plan, a groundbreaking new Medicaid 1115 waiver amendment is necessary. The waiver amendment will allow the state to reinvest in its health care infrastructure, facilitate innovation, and pave the way for implementation of national health care reform.

This document serves as an overview of the MRT action plan and the 1115 waiver amendment. A companion document provides a complete overview of the MRT action plan, and is available on the Department's web site. This summary represents a first step in both a state-federal dialogue and a state-stakeholder discussion on how a new Medicaid waiver amendment can help implement the MRT plan and prepare New York for national health care reform.

Medicaid Redesign Team – An Overview

New York State is committed to redesigning the nation's largest Medicaid program. When Governor Cuomo took office, state-share Medicaid spending was on path to grow by 13 percent. This rapid rate of growth was driven primarily by out of control Fee-for-Service (FFS) spending in areas such as non-institutional long term care and prescription drugs. To combat this, Governor Cuomo created the MRT in January 2011 with the express purpose of putting together a multi-year action plan that would achieve the Triple Aim: improving care, improving health, and reducing per capita costs. After months of work, the team finalized the action plan and it is now being implemented.

New York State developed the MRT action plan with an unprecedented level of stakeholder engagement. After soliciting thousands of ideas across various forums, Department staff culled, organized, and prioritized the best ideas on how to redesign the program. This MRT process serves as a national model on how to move stakeholders beyond the common rancor to real dialogue that generates creative, thoughtful reform. Thanks to the MRT and the process it created, New York State is now unified in its overall approach to Medicaid reform.

The MRT action plan is built on a foundation of fiscal discipline. To achieve sustainable growth, the MRT recommended a new multi-year Medicaid Global Spending Cap. The cap applies to the state share of Medicaid spending, controlled by the Department of Health, and is now state law. The annual spending cap grows at the 10-year rolling average of CPI-Medical, or 4 percent in 2012. The Commissioner of Health also has "super powers" under which he can modify the program without legislative approval to rein in spending within the cap. Targets and actual spending by sector are reported out monthly. This has transformed how New York State oversees the Medicaid program and has introduced a new era of unprecedented transparency.

Another major tenet of the MRT is that the state can achieve better health, better care, and lower costs through effective care management. The MRT made the historic recommendation that the state phase-out the uncoordinated fee-for-service (FFS) program and replace it with a new system of *care management for all*. This new system will rely on a variety of health plans (many provider-based) that will eventually provide fully-integrated managed care for all Medicaid members. It will take New York State between three to five years to fully implement the state's care management vision. While New York State has administered a managed care program for more than twenty years, many of the state's highest need/highest cost populations have been excluded, as have many of the highest cost service categories.

In addition to contracting with health plans, MRT also recommended that the state invest in provider level care management strategies such as Patient Center Medical Homes (PCMHs) and Health Homes. While full capitation helps better align incentives so as to reward value over volume, there is a clear need to drive provider-level cooperation and meaningful improvement in service provision at the point of care. New York State is now on path to ensure that all Medicaid members enjoy the benefits of high quality primary care through nationally accredited PCMH's and that every high need/high cost Medicaid member is enrolled in a new Health Home. These provider-level strategies are being integrated within the overall "care management for all" approach in a way that will be seamless for Medicaid members.

MRT Waiver Amendment – Preparing for National Health Care Reform

New York State is poised to successfully implement the Affordable Care Act (ACA). However, to fully capitalize on the opportunities that the ACA will provide, this must be done in concert with Medicaid reform. This is a natural relationship since New York's vision for both Medicaid reform and ACA implementation is aligned and well summarized by the Triple Aim. Both the ACA and MRT are focused on improving quality, improving health, and reducing per capita costs. The MRT waiver amendment will allow New York State to address all three goals in a coordinated fashion while also fulfilling the promise laid out in the ACA.

The state's vision for a new MRT waiver amendment is to use reinvested federal dollars that will prepare the state for the ACA and maximize the value of key ACA provisions. In particular, New York's fragile health care safety net must be modernized and primary care access must be expanded in order to prepare for new enrollees.

MRT Waiver Amendment Overall Framework

The MRT waiver is an amendment to the state's existing 1115 Partnership Plan waiver. The Partnership Plan has been the primary vehicle used by the state to expand access to managed care and, therefore, naturally aligns with the MRT's "care management for all" plan. The Partnership Plan waiver also has substantial remaining budget neutrality capacity ($41 billion) which will be further augmented by the MRT action plan.

Operating since 1997, the Partnership Plan has been critical for improving access to health services and outcomes for the poorest and most at-risk residents. The waiver allows the state to provide a mandatory Medicaid managed care program designed to improve the health of members by providing comprehensive and coordinated health care; offer comprehensive health coverage to low-income uninsured adults who have income and/or assets above Medicaid eligibility standards (Family Health Plus Program); and provide family planning services to women losing Medicaid eligibility at the conclusion of their postpartum period and certain other adults of child bearing age (Family Planning Expansion Program).

The recently renewed Partnership Plan has been extremely successful in enhancing the health status of low-income New Yorkers. It has improved health by increasing access to health care for the Medicaid population, improving the quality of health services, and expanding coverage to additional low-income residents, all by using resources generated through managed care efficiencies. The Partnership Plan has also generated savings well beyond the amounts needed to fund program expansions.

Quality of care is the cornerstone of the Partnership Plan and data indicates continuous improvement in the quality of care provided by Medicaid managed care plans to meet or exceed national and commercial benchmarks on many key measures. Through managed care, Medicaid beneficiaries have access to a larger number of health care providers than in fee-for-service Medicaid. In addition, more previously uninsured New Yorkers have joined the ranks of the insured due to expansion initiatives within the Partnership Plan.

Obviously, no waiver can be approved unless the federal government can be assured that the waiver is cost neutral. In this way, the MRT waiver amendment is closely modeled on the successful New York Federal-State Health Reform Partnership (F-SHRP) waiver. Under F-SHRP, the state reinvested federal savings resulting from reforms such as managed care expansions and Medicaid fraud and abuse recoveries. These funds have allowed countless hospitals, nursing homes and other providers to become more cost-effective. Again, New York State hopes to utilize one-time funds, which in this case, will be used to drive key MRT reforms, as well as prepare the provider community for national health care reform.

The state's budget neutrality argument will be linked to the state's new Medicaid Global Spending Cap which is already working to control cost growth despite sharp enrollment growth. This Medicaid Global Spending Cap will generate significant out-year savings for both the state and federal governments. Currently, estimates suggest that MRT Phase 1 initiatives will save the federal government $17.1 billion over the next five years. Phase 2 recommendations will increase the savings amount, especially in FY13-14 and FY14-15.

New York State's proposed waiver amendment is on the same scale as waivers recently approved in other states. Specifically, New York State requests that the federal government allow the state to reinvest $10 billion of the $17.1 billion in federal MRT savings over a five-year period. Even with this targeted reinvestment, the proposed waiver is budget neutral to the federal government. New York State will ensure that all federal reinvestment funds are matched by state and local dollars not currently used for federal claiming.

The MRT waiver amendment will be restricted to the portion of the Medicaid program controlled by the Department of Health. Specifically excluded from the 1115 waiver amendment are those Medicaid services provided through waivers administered by the Office for People with Developmental Disabilities (OPWDD). Due to the complexity of the OPWDD system in New York, the state is currently pursuing a different waiver agreement that will encompass services/waivers that relate to people with developmental disabilities. However, both this waiver amendment and the OPWDD waiver are consistent in their approaches to cost containment and in their commitment to improving outcomes. In particular, both waivers will rely on care management as the primary method for driving change and innovation.

Waiver Amendment Stakeholder Engagement Process

New York is committed to engaging stakeholders and the greater public in Medicaid reform and ACA implementation. The MRT is a national model for how stakeholders can work together to develop a comprehensive reform agenda even during the most trying times. New York used a similar approach to engage stakeholders around key ACA provisions such as the health insurance exchange and Health Homes and continued the MRT tradition of rigorously engaging the public, and ensuring transparency while finalizing the 1115 Medicaid waiver amendment.

A website for all waiver amendment materials was created and is easily accessible from the Department website. The waiver amendment website includes links to: the waiver summary paper; the full public notice; an application with a sufficient level of detail to provide the public with an opportunity to review and provide meaningful input; and information on related public engagement opportunities, including public hearings and webinars. The public notice and tribal notification letters are included in this document in Appendix VI. More information is available at: http://www.health.ny.gov/health_care/medicaid/redesign/mrt_waiver.htm.

An online survey tool was created and made available for several weeks to receive public input. New York also used an electronic e-mail listserv, which distributes information to more than 1600 subscribers, along with various social media tools to notify interested members of the public of the availability of these items and any additional updates on the waiver amendment website. New York will also include a link to the relevant page on the CMS website regarding the State's waiver amendment application.

New York utilized stakeholder engagement strategies that were successfully deployed during the MRT process and also introduced new methods for determining public preferences for how and where New York should invest waiver resources.

Public Forums and Webinars

The Department held public forums throughout the state to provide information on the MRT waiver amendment and to seek public feedback. Hearings took place in Buffalo, Syracuse, Albany and the Bronx between June 12, 2012 and June 20, 2012.

At the MRT Waiver Amendment Public Forums, Department members gave a presentation on the MRT waiver amendment and proposed areas of reinvestment. Members of the public had the opportunity to speak for two minutes to allow for as many comments as possible. Interested citizens, Medicaid members, representatives from associations, providers and community-based organizations were all represented at the forums. More than 400 people attended the forums, and more than 100 spoke and provided their thoughts and ideas. Comments were recorded as members of the public spoke, and were reviewed with relevant state staff working on each of the reinvestment areas. Attendees were also able to submit written comments which were disseminated to staff working on specific reinvestment sections of the MRT waiver amendment.

Major themes in the comments heard at public forums included support for:

- Reinvestment into primary care programs, including support for expansion of Patient Centered Medical Homes, addressing primary care shortages in both urban and rural areas, ensuring primary care providers have access to funding to support their full range of services; recognizing the need for expanded access to dental services and support for dental providers, and support for Doctors Across New York, which encourages providers to practice in underserved areas;
- Public health initiatives, especially to expand successful programs like Nurse Family Partnership;
- Financial assistance for safety net providers throughout the state, including funding to support planning initiatives and provide technical assistance to interested providers and parties to develop proposals to be funded with waiver dollars;
- Expanding supportive housing and using supportive housing to assist in addressing employment, peer support and access to community-based services; and
- Workforce training, including examining scope of practice issues, expanding the community-based workforce and developing key competencies in the move to care management, expanding peer support programs, training providers from doctors to nurses to aides to community workers; and focusing on the need for cultural, disability, and LGBT competency.

General support was also expressed for other areas of reinvestment including new care models, regional planning, quality measurement, Health Home expansion, and transition planning. Other suggestions and comments referenced a desire for continued transparency throughout the waiver amendment process, addressing health disparities in each of the reinvestment areas, and maintaining the ability of Medicaid members to have choices. Comments that were taken were shared with staff leads of the reinvestment areas and incorporated into the development of the waiver amendment application.

In addition to the public forums, the Department held three topic-specific webinars to seek additional feedback. The webinars focused on specific technical aspects of individual waiver amendment components and offered an opportunity for questions and feedback. The webinars were organized in a way to align related reinvestment strategies. Members of the public were able to sign up and view the webinar online, or dial in and connect via conference call if they did not have computer access. Information on the public forums and topic-specific webinars was posted to the MRT Waiver web site and announced through the MRT listserv. More than four hundred people participated in the webinars. Archived versions were posted to the MRT Waiver web site.

Tribal Consultation

The state also provided notice and consulted with tribes in accordance with its federally approved tribal consultation process. The changes sought in the waiver amendment are expected to have minimal impact on tribal nations. A letter and relevant materials were mailed to tribal representatives and Indian Health contacts on June 6, 2012 announcing of the State's intent to seek a waiver amendment.

An additional letter was sent on June 28, 2012 to schedule a conference call to consult with tribal nations on the waiver amendment. A conference call was held on July 17, 2012 to provide an overview of the waiver amendment and seek feedback. One nation participated in the call, and requested more opportunities to provide comment on the Medicaid program in general, to which the state committed.

Medicaid Member Focus Groups

The views of Medicaid members too often go unheard when it comes to Medicaid reform. New York worked with providers and community-based organizations to form member focus groups to help gather their important perspective on the waiver amendment. Three member focus groups were held in mid-July in New York City, Binghamton and Queensbury, and a total of 23 Medicaid members participated. A diverse group of members participated from various Medicaid programs. The focus groups provided an opportunity for the Medicaid Director to interact directly with Medicaid members and hear their concerns and issues with the Medicaid program, what they like most about the Medicaid program, and where reinvestment dollars could help.

Members discussed areas of concern including issues with enrolling and recertifying Medicaid eligibility. A consistent request in all three focus groups was for assistance in navigating the program so individuals could better understand the enrollment process and what programs would apply to individual situations. Many questions and concerns revolved around misunderstanding of the Medicaid program either by eligibility workers or members themselves – a resource to assist members would help communicate information about the Medicaid program and changes, and help to reduce those misunderstandings. Concerns were also raised about the quality of transportation services, and the issues are being addressed with our transportation management contractor. Access to dentists, specialists and mental health services was also mentioned as an area of concern. These issues vary from region to region. Questions about managed care transitions were raised, and opinions were generally positive on the experience of moving to managed care coverage, once initial issues were resolved.

Additional requests and suggestions regarding the Medicaid program included: training for eligibility workers and medical providers on HIV, cultural competence, LGBT, behavioral health, substance abuse and disparities issues; expansion of supportive housing; support for peer services and peer supports, which could also address unemployment issues; requests for Medicaid to cover preventative wellness services currently not covered including alternative therapies; language translation as a covered benefit; and expanded electronic records so doctors can coordinate care.

There were positive comments on several areas of the Medicaid program. The consumer directed personal assistance program was praised for the quality of services provided and as a vehicle for members to have control of their care. Additionally, members who live in supportive housing described the positive impact that the housing and services provided have made in their health and quality of life. Members who participated also expressed their appreciation for the Medicaid program and the benefits they receive. While it varied regionally, some members reported they did not have to wait long for doctor appointments, and were very happy with the quality of care received.

Specific concerns and suggestions that were raised in the focus groups helped to inform the objectives and descriptions of reinvestment sections in this document. More Medicaid member focus groups will be held regularly in the future to solicit additional suggestions, concerns and general comments on the state of the Medicaid program and experiences of Medicaid members.

Survey Tool

New York developed an MRT Waiver Amendment State Survey tool to capture feedback from the public on its waiver design and various reinvestment proposals. The survey tool was created through SurveyMonkey and sought feedback on the waiver amendment and proposed reinvestment areas.

The public was able to complete the survey for two weeks between July 10-23, 2012. Seven-hundred nine individuals responded to the survey. As shown in Table 1, the majority of respondents identified themselves as either health care providers or workers (48%), and approximately 18% identified themselves as patients or patient advocates. Responses to demographic questions revealed that those that took the survey were largely female (69%), non-Hispanic (94%), and white (86%).

Table 1: Respondent Demographics

	N	%
Respondent's Role (n=659)		
Health care provider/ worker	317	48.1
Patient or patient advocate	119	18.1
Long Term Care Provider	61	9.3
Government	75	11.4
Research/evaluation	21	3.2
Health plan, insurance company	14	2.1
Lobbyist	14	2.1
Hospital provider	38	5.8
Gender (n=657)		
Male	201	30.6%
Female	456	69.4%
Ethnicity (n=652)		
Yes, Hispanic or Latino	41	6.3%
No, Not Hispanic or Latino	611	93.7%
Race (n=655)		
White	566	86.4%
Black or African-American	33	5.0%
Asian	25	3.8%
Native Hawaiian or other Pacific Islander	3	0.5%
American Indian or Alaska Native	1	0.2%
Other	37	5.6%

Respondents were asked to rate the importance of each of 13 initiatives on a scale of 0 (not important) to 5 (very important). If a respondent rated any of the 13 initiatives as 3, 4, or 5, they were directed to answer related questions specific to the initiative. The percentage of respondents rating each initiative as a 3 or higher ranged from 79 percent to 93 percent.

Table 2 shows the proportion of members who responded with a rating of 3, 4, or 5 for each of the 13 major area questions. High levels of support were seen for each major initiative of the waiver with 90 percent of respondents rating several initiatives 3, 4, or 5. Overall, the results demonstrate that the public strongly supports the use of New York State's reinvestment funds for these projects.

Table 2: Overall Importance Ratings for Each Waiver Initiative		
	Answered Question N	**Rating 3,4, or 5 %**
How important is using New York State's reinvestment funds for primary care expansion?	662	93
How important is using New York State's reinvestment funds for health home development?	519	86
How important is using New York State's reinvestment funds for new care models?	490	90
How important is using New York State's reinvestment funds to expand vital access provider program and safety net provider program?	466	91
How important is using New York State's reinvestment funds for care for the uninsured?	449	90
How important is using New York State's reinvestment funds for Medicaid supportive housing expansion?	446	91
How important is using New York State's reinvestment funds for the managed long term care preparation program?	434	87
How important is using New York State's reinvestment funds for capital stabilization for safety net hospitals?	421	84
How important is using New York State's reinvestment funds for hospital transition?	413	79
How important is using New York State's reinvestment funds for workforce training?	405	87
How important is using New York State's reinvestment funds for public health innovation?	397	89
How important is using New York State's reinvestment funds on regional health planning?	395	85
How important is using New York State's reinvestment funds on MRT and waiver evaluation programs?	382	82

Public Reporting and Engagement – Implementation Phase

New York is committed to continuing the public engagement process even after the MRT waiver amendment is approved. New York will leverage three existing stakeholder groups and publish regular implementation reports in order to provide an opportunity for on-going feedback throughout the demonstration period. Each of these groups and their role in oversight is described below:

Public Health and Health Planning Council (PHHPC)

PHHPC is a statewide health planning and oversight body that meets regularly to discuss important health matters. Among other key responsibilities, PHHPC is the state's governing body for the Certificate of Need program as well as the principal health planning body in the state. PHHPC is uniquely situated to provide the state with advice and counsel as the MRT waiver amendment is implemented. New York proposes to brief PHHPC twice a year and seek board member suggestions on how the waiver activities can be linked to other reform efforts occurring across the State.

Medicaid Advisory Committee (MAC)

New York, like all states, has a Medicaid Advisory Committee. The role of the MAC is to advise the state on all Medicaid related matters. Since the MRT is no longer active, the MAC will provide the state with advice and counsel on MRT waiver amendment implementation from a very broad stakeholder perspective. The MAC will be briefed on a bi-annual basis on waiver implementation with the hopes of hearing from providers, advocates and members on how best to ensure that the waiver assists the state in achieving the Triple Aim.

Medicaid Managed Care Advisory Review Panel (MMCARP)

New York has a very active Medicaid managed care advisory group that has helped the state successfully implement managed care over many years. This group, which has strong advocate participation, is uniquely situated to assist the state in implementing the MRT waiver amendment. Since the MRT waiver amendment is being applied to the existing Partnership Plan Waiver, which has been the state's primary vehicle to implement mandatory managed care, it is especially appropriate to use MMCARP in this important role. The state will brief MMCARP on a bi-annual basis and will utilize the input received to successfully implement the waiver.

Bi-Annual Implementation Report

New York will publish an implementation report on a bi-annual basis which will ensure transparency and public accountability during implementation. Each report will include a detailed accounting of expenditures as well as track performance measures for each waiver funded program. Updates on budget neutrality will also be included. This report will be published to the MRT website and the state will hold webinars at which the key findings of the report will be discussed in detail.

Conclusion

New York State is well positioned to lead the nation in Medicaid reform and ACA implementation. Governor Cuomo's MRT has developed a multi-year action plan that if fully implemented will not only bend the state's Medicaid cost curve but also improve health outcomes for more than five million New Yorkers.

Thanks to the ACA, Medicaid reform has the potential to effect broader health system reform in New York State. The MRT action plan and the ACA -- if implemented in tandem – will lead to sweeping changes in health care delivery that will benefit the state's 19 million residents.

To fully implement the MRT action plan and ensure that ACA's full vision is achieved, New York State requires a groundbreaking new Medicaid 1115 waiver amendment. The waiver amendment will allow the state to reinvest in its health care infrastructure that will both lower Medicaid costs and ensure that the one million newly-insured New Yorkers will have access to cost-effective health care services.

New York State is united in support of reform and is ready to lead and invest the effort needed to fundamentally reshape how health care is delivered. Governor Cuomo's innovative MRT has ensured that its action plan has broad support, is aligned with the ACA, and is already saving both state and federal dollars. New York State looks forward to developing this new waiver in collaboration with our federal partners and the broader New York public.

New York's Reinvestment Strategy: Achieving the Triple Aim

OVERVIEW

New York's reinvestment strategy will ensure that the full breadth of the MRT recommendations and the ACA are successfully implemented. The reinvestment funds are essential given the fiscal challenges still facing New York State as the nation struggles to escape a weak economy. The following sections are New York's current thoughts on how to utilize the reinvestment funds. New York has identified thirteen new programs that if implemented as described in this document will ensure that the MRT action plan and the ACA are successfully implemented.

New York is interested in using the MRT waiver amendment resources to forge new relationships and partnerships between providers and stakeholders in order to improve health care delivery and overall population health. The state wants providers to work together across traditional "silos" and develop comprehensive proposals that will address core challenges that exist within specific communities. While the state will accept applications for waiver funding from single entities the state will provide enhanced consideration for proposals that are brought by multiple organizations in true partnership especially when those partnerships are formed as a result of regional health planning.

The state also seeks comprehensive applications from traditional and/or community-based integrated delivery systems and community-wide partnerships that will seek funding from multiple MRT waiver programs. Comprehensive applications will also be given enhanced consideration especially if they are tied to long term strategic plans and are well coordinated with other providers/stakeholders in the communities in which they serve.

MRT Reinvestment Program
Primary Care Expansion

BACKGROUND

Increasing access to high quality primary care services is essential in developing a community-based health care infrastructure which will ensure New York achieves the Triple Aim. As a result of the Affordable Care Act (ACA) and the initiatives of the Medicaid Redesign Team (MRT), New York State's health care system has made significant strides toward these aims. New York's health care delivery system and its financing are radically changing from the system of just a few years ago. The driving force behind the MRT's efforts is a growing Medicaid program in the state that has largely overinvested in expensive institutional care and underinvested in less costly primary and preventive care. A principal strategy of the MRT has been to promote integrated systems of care with a strong primary care foundation. The MRT Waiver Amendment presents a significant opportunity to accelerate progress toward this important objective.

New York State has the largest Medicaid program in the country with 26 percent of the State's population enrolled in Medicaid. At more than $50 billion a year, New York spends more than twice the national average on Medicaid on a per capita basis, and spending per enrollee is the second-highest in the nation. Moreover, increased Medicaid spending has not resulted in high quality of care. The state ranks 18^{h} out of all states for overall health system quality and ranks 50th among all states for avoidable hospital use and costs. Hospital readmissions are a particularly costly problem for New York. A report issued by the New York State Health Foundation found hospital readmissions cost New York $3.7 billion per year, with nearly one in seven initial hospital stays resulting in a readmission.

There is broad consensus that to achieve the Triple Aim, high-quality, and accessible primary care must be available to all residents. The MRT has begun to strengthen and transform the health care safety net and taken a more community-based approach to health care by addressing health disparities as well as the social determinants of health – including socioeconomic status, education, food, and shelter.

A major challenge will be providing high-quality primary care to the surge of newly insured individuals thanks to the ACA. Already an estimated 2.3 million New Yorkers are "underserved" for primary care services due to mal-distribution of physicians in certain geographic areas. Primary care providers in many communities in New York State will need technical assistance and capacity building support to meet the goal of increasing access to high quality primary care. New York has invested heavily in improving primary care by providing incentive payments for providers to become Patient Centered Medical Homes (PCMHs).

While New York's accomplishments in this area have been impressive more needs to be done. An important subset of primary care providers - particularly smaller practices, practices in low income neighborhoods, practices that did not have the infrastructure to support seeking NCQA recognition requirements, or practices that have met initial NCQA recognition requirements but are seeking more challenging, higher recognition levels - often do not have the internal resources to plan or implement the changes associated with the patient centered model of care and integrated models of care. This presents a risk to the ability of these organizations to provide the best, most efficient, most coordinated care to their patients.

There is a substantial need for capital to expand primary care capacity in order to provide care for more people as newly insured individuals come into the marketplace. A key focus in restructuring will be building sustainable primary care capacity where it does not currently exist. It is also important to locate services in settings that are most accessible to the populations served. For example, co-locating primary care services in Emergency Departments, supportive housing or mental health programs increases the likelihood that they will be utilized. The shift in focus to primary care providers requires New York to not only invest in the preservation and expansion of primary care services but to integrate primary care into the overall health care system. Telemedicine also offers the possibility of providing needed services in underserved areas of the state.

There is also additional need for capital investment to build the technological infrastructure that networks will need to operate effectively. New technologies offer opportunities to improve the quality of the care provided, particularly with respect to care transitions, team based care and integration of services for complex populations. The increased connectivity available through data and information sharing such as Electronic Health Records offer tremendous opportunities to manage the continuum of a patient's care – from prevention to treatment, including self-management.

The state actively solicited the feedback of a multitude of partners and worked to ensure that primary care stakeholders in particular provided feedback on the types of primary care expansion initiatives that should be included in the MRT Waiver Amendment.

PROGRAM DESCRIPTION

New York State plans to invest $1.25 billion over the next five years to expand access to high-quality primary care. Provided below is a description of how these funds will be used. A more detailed breakdown is provided in the MRT Expenditure Plan section of this document.

1) Provide Needed Technical Assistance

New York State plans to allocate funds to quality improvement organizations/independent strategic planners to provide technical assistance to primary care providers and stakeholder collaborations as they develop plans to expand access to high quality primary care. The technical assistance modalities will be based on community/provider needs, however, should include gap analyses; learning collaboratives (including virtual learning collaboratives); on-site and virtual coaching; distance learning programs; self-guided training and practice coaching. Providers can also apply for technical assistance to aid them in applying for MRT waiver amendment funding. Specific examples of Technical Assistance that could be funded through this program include:

- **Financial and business planning for integrated systems of care:** Primary care providers becoming part of the integrated health care system confront a multitude of decisions that require a high degree of expertise (e.g., legal issues related to anti-trust regulations, risk-sharing payment models, severity adjustments, provider attribution, HIT and HIE, performance measurement, patient risk stratification, and many more). Many primary care providers need business, legal, and technical resources to re-evaluate their business and clinical models to fully participate in integrated systems of care. Many smaller practices will need assistance in the creation of a shared resource model for care team management services including high risk case management, patient/family self management, care transitions, medication management and reconciliation, and other important functions of the patient centered medical home.

- **Support Regional Extension Centers (RECs) toward universal adoption of EHRs, achievement of NCQA recognition, and full implementation of Health Information Exchange:** Two RECs in New York State– the New York e-Health Collaborative (NYeC) and New York City Regional Electronic Adoption Center for Health (NYC REACH) – assist primary care providers in the adoption, implementation, and meaningful use of ONC-certified EHR technology. The RECs have made a significant difference in the numbers of providers adopting EHRs and attaining NCQA PPC-PCMH Level 1 recognition and will continue to work toward universal achievement of PPC-PCMH Level 3 recognition. The type of hands-on assistance that the RECs provide will continue to be critical, particularly as providers with EHRs face the need to achieve higher standards to demonstrate their meaningful use.

To assist qualified providers, New York Medicaid will enter into agreements with the two RECs to supply Medicaid providers not included in RECs initial Office of the National Coordinator (ONC) contract funding with an array of EHR assistance services, including counseling and guidance in adopting, implementing, and meaningfully using an EHR system and how to use EHRs to measure and report on quality and outcomes per standardized state measures. In turn, the state will primarily rely on these two RECs to ensure the most effective use of funds and avoid duplication of efforts.

- **Support training and technical assistance on the use of data to improve quality and monitor performance:** Although there are some providers who have developed advanced skills for using data to improve quality and monitor their performance, many primary care providers require training and resources to learn how to use data to improve practice. Developing this capacity is critical as providers assume greater accountability for patient care, outcomes, and cost. The state will provide a pool of funds to support training and resources to support these activities.

- **Behavioral health integration:** There is lack of understanding on how to integrate behavioral health into primary care. There is a need for training and coordination across mental health, substance abuse and primary care providers on the care models and techniques used in these respective settings. The goal of this effort will be to establish a patient-centered approach to behavioral health issues and improving coordination of care, building on effective and evidence based models of integration.

2) Increasing Primary Care Provider Capacity and Accessibility: Capital Investment, Operational Assistance and HIT Assistance

Access to high quality primary care services requires capital to develop additional capacity and infrastructure. This is particularly important as more people obtain insurance coverage through the ACA. Beyond the need for new infrastructure there is also a need to increase access to services by locating primary care in targeted locations that increase the likelihood that patients will utilize them. Regional planning efforts will assist in this effort. Below is a description of three programs that will increase primary capacity and accessibility:

2a) Capital Investment: Expand Primary Care Infrastructure

Methods for capital deployment

Capital resources will be planned and distributed as part of the regional planning infrastructure New York is creating through the MRT process. Steps will be taken to ensure meaningful collaboration among community-based primary care providers and institutional providers. New York seeks to deploy capital funds through three different mechanisms.

- **Traditional asset based capital funding** – Primary care providers need up-front investment in order to participate fully in health system integration. Investment for "bricks and mortar" to develop capacity in areas most in need.
- **Debt relief/restructuring** – Primary care providers would benefit from balance sheet restructuring that would create more cash flow and allow them to pursue more effective capitalization. It will assist financially distressed providers to remain viable, and help facilitate opportunities for those that are more financially healthy, including taking on debt (at more favorable terms) to pursue primary care expansion opportunities.
- **Revolving Capital Fund** - New York State will create a permanent, revolving fund to leverage private sector investment and provide a source of affordable public/private financing for primary care providers. The Revolving Capital Fund would provide primary care providers with greater access to capital at reduced interest rates. Funds would be available to organizations providing community-based health care in underserved communities, including those providing primary care, mental health, dental, women's health services, and substance abuse services. Access to capital would revolve as the existing group of borrowers pay back their loans and the funds be redeployed to build more primary care capacity on an ongoing basis.

2b) Operational Assistance

Below are potential uses of funding to sustain and increase access to primary care services.

- **Preserve services that are at risk from hospital closures and restructuring:** The state will monitor the availability of primary care services and deploy resources to community health centers and other community-based primary care providers when capacity is at risk from hospital consolidations, mergers, restructuring, and closings.

- **Support the colocation of primary care services in Emergency Departments:** Locating primary care services in or near Emergency Departments should greatly enhance patient access to primary care medical homes and improve the coordination of care across care settings. The state will evaluate the state and federal regulatory barriers to these arrangements and provide the capital and operational funding to support their development.

- **Support the integration of behavioral health into integrated health systems:** New York will create demonstration projects that facilitate integration of behavioral health with community health centers, outpatient clinics and nursing homes, building on successful, evidence based models including but not limited to collaborative care. This will be critical for systems of care that serve the high number of patients with co-occurring mental health and substance abuse disorders and chronic health conditions.

- **Support telemedicine expansion and sustainability:** New systems of care are needed to evolve past all care being delivered in a traditional face-to-face physician and patient visit. Foremost among these models is the use of telemedicine to provide access to specialty services with significant provider shortages or distribution problems including child/adolescent psychiatry, hepatitis C, and others. Telemedicine can also be used to enhance access to primary and urgent care, reducing the need for more expensive institutional services including emergency room use. The state will provide incentive payments to promote broader use of telemedicine and address other regulatory hurdles to expand and sustain its use.

2c) Health IT Assistance

Primary care providers will require the Health IT infrastructure and software to be able to share patient information and data in real time with other partners in the heath care continuum. Providers and care-teams must have access to tools that support coordination (e.g., electronic alerts when a patient is seen in the Emergency Department and admitted or discharged from a hospital). Having ongoing access to and being able to use in-depth and high-quality data is critical to improving quality, monitoring performance, and coordinating care across care settings.

EHR adoption by primary care providers needs to dramatically increase. Currently, less than 5 percent of ambulatory practices are connected to the Statewide Health Information Network. Increasing the number of providers that are connected will also be critical to engage health plans to connect to and pay for the network.

- **Health IT Infrastructure** – There is still significant need to build health IT infrastructure, particularly to achieve health information exchange among providers including providers outside of current federal HIT incentive programs.
- **Support the Health IT Needs of Integrated Systems of Care:** Integrated systems of care need affordable software that allows all participating organizations to share a patient care plan across care settings. The state will provide funding to cover software-related costs to enable providers to become operational and integrated into the health care network. Funds will be synchronized with those requested under the health home program to leverage existing capabilities and the new Health Home capabilities.
- **Additional Support for Health Information Technology Infrastructure:** The New York eHealth Collaborative (NYeC) is a not-for-profit organization that is charged with developing the Statewide Health Information Network of New York (SHIN-NY) and assist healthcare providers in making the shift to electronic health records (EHR). The state will provide funding to NYeC, which will be matched by private health plan contributions, as part of a sustainability model that will fulfill the MRT vision that all New Yorkers experience the benefits of inter-operable EHRs.

IMPACT ON OVERALL MEDICAID SPENDING

Research has shown that patients who receive care through a PCMH get better care, and as a result, they have better health outcomes. With more effective care, there are fewer unnecessary inpatient and emergency room visits, resulting in an overall positive impact on spending.

A summary report of the key findings of prospective, controlled studies of patient centered medical home interventions was published by the Patient-Centered Primary Care Collaborative in November 2010. The review was conducted by Kevin Grumbach, MD, and Paul Gundy, MD, MPH, and entitled: "Outcomes of Implementing Patient Centered Medical Home Intervention: A review of the Evidence from Prospective Evaluation Studies in the United States". The findings of the literature review supports the contention that investing in primary care patient centered medical homes results in improved quality of care and patients experiences, as well as reductions in costly hospital and emergency department utilization.

Studies of integrated delivery system PCMH models demonstrate a 16 to 24 percent decrease in hospital admissions and a 29 to 39 percent decrease in emergency department visits, when comparing enrollees to controls. These studies were conducted at Group Health Cooperative of Puget Sound; Geisenger Health System ProvenHealth Navigator PCMH model; and HealthPartnerss Medical Group PCMH Model.

APPENDIX

A summary report of the key findings of prospective, controlled studies of patient centered medical home interventions was published by the Patient-Centered Primary Care Collaborative in November 2010. The review was conducted by Kevin Grumbach, MD, and Paul Gundy, MD, MPH, and entitled: "Outcomes of Implementing Patient Centered Medical Home Intervention: A review of the Evidence from Prospective Evaluation Studies in the United States."

Below is a summary of the key findings of the research they base these conclusions on. This summary is taken directly from their article.

Summary of Data on Cost Outcomes from Patient Centered Medical Home Interventions

A. Integrated Delivery System PCMH Models

1. **Group Health Cooperative of Puget Sound**
   - $10 PMPM reduction in total costs; total PMPM cost $488 for PCMH patients vs. $498 for control patients (p=.076).
   - 16% reduction in hospital admissions (p<.001); 5.1 admissions per 1,000 patients per month in PCMH patients vs. 5.4 in controls. $14 PMPM reduction in inpatient hospital costs relative to controls. 29% reduction in emergency department use (p<.001); 27 emergency department visits per 1,000 patients per month in PCMH patients vs. 39 in controls. $4 PMPM reduction in emergency department costs relative to controls.

2. **Geisinger Health System Proven Health Navigator PCMH Model**
   - 18% reduction in hospital admissions relative to controls: 257 admissions per 1,000 members per year in PCMH patients vs. 313 admissions per 1,000 members per year in controls (p<.01). Within PCMH cohort, admission rates decreased from 288 per 1,000 members per year at baseline to 257 during PCMH intervention period.
   - 7% reduction in total PMPM costs relative to controls (p=.21).

3. **Veterans Health Administration and VA Midwest Healthcare Network, Veterans Integrated Service Network 23 (VISN 23)**
   - For Chronic Disease Management model PCMH for high-risk patients with COPD, composite outcome for all hospitalizations or ED visits 27% lower in the CDM group (123.8 mean events per 100 patient-years) compared to the UC group (170.5 mean events per 100 patient years) (rate ratio 0.73; 0.56-0.90; p < 0.003). The cost of the CDM intervention was $650 per patient. The total mean ± SD per patient cost that included the cost of CDM in the CDM group was $4491 ± 4678 compared to $5084 ± 5060 representing a $593 per patient cost savings for the CDM program.
   - Comparable reductions in ED and hospitalizations were found for Veterans Health Administration PCMH interventions targeting other patients with chronic conditions.

4. **HealthPartners Medical Group BestCare PCMH Model**

   - 39% decrease in emergency department visits and 24% decrease in hospital admissions per enrollee between 2004 and 2009.
   - Overall costs for enrollees in HealthPartners Medical Group decreased from being equal to the state average in 2004 to 92% of the state average in 2008; in a state with costs already well below the national average.

5. **Intermountain Healthcare Medical Group Care Management Plus PCMH Model**

   - Reduced hospitalizations in PCMH group; by year 2 of follow-up, 31.8% of PCMH patients had been hospitalized at least once vs. 34.7% of control patients (p=.23). Among patients with diabetes, 30.5% of the PCMH group were hospitalized vs. 39.2% of controls (p=.01).
   - Net reduction in total costs was $640 per patient per year ($1,650 savings per year among highest risk patients).

B. Private Payer Sponsored PCMH Initiatives

1. **Blue Cross Blue Shield of South Carolina-Palmetto Primary Care Physicians**

   - 10.4% reduction in inpatient hospital days per 1,000 enrollees per year among PCMH patients, from 542.9 to 486.5. Inpatient days 36.3% lower among PCMH patients than among control patients. 12.4% reduction in emergency department visits per 1,000 enrollees per month among PCMH patients, from 21.4 to 18.8. Emergency department visits per 1,000 enrollees were 32.2% lower among PCMH patients than among control patients.
   - Total medical and pharmacy costs PMPM were 6.5% lower in the PCMH group than the control group.

2. **Blue Cross Blue Shield of North Dakota-MeritCare Health System**

   - Hospital admissions decreased by 6% and emergency department visits decreased by 24% in the PCMH group from 2003 to 2005, while increasing by 45% and 3%, respectively, in the control group. In 2005, PCMH patients had 13.02 annual inpatient admissions per 100 patients, compared with 17.65 admissions per 100 patients in the control group. PCMH patients had 20.31 annual emergency department visits per 100 members, compared with 25.00 among control patients.
   - In 2005, total costs per member per year were $530 lower than expected in the intervention group based on historical trends. Between 2003 and 2005, total annual expenditures per PCMH patient increased from $5,561 to $7,433, compared with a much larger increase among control patients from $5,868 in 2003 to $10,108 in 2005.

3. **Metropolitan Health Networks - Humana (Florida)**

   - Hospital days per 1,000 enrollees dropped by 4.6% in the PCMH group compared to an increase of 36% in the control group. Hospital admissions per 1,000 customers dropped by 3%, with readmissions 6% below Medicare benchmarks.
   - Emergency room expense rose by 4.5% for the PCMH group compared to an increase of 17.4% for the control group. Diagnostic imaging expense for the PCMH group decreased by 9.8% compared to an increase of 10.7% for the control group. Pharmacy expense increases were 6.5% for the PCMH group versus 14.5% for the control group.
   - Overall medical expense for the PCMH group rose by 5.2% compared to a 26.3% increase for the control group.

C. Medicaid Sponsored PCMH Initiatives

1. Community Care of North Carolina

- Cumulative savings of $974.5 million over 6 years (2003-2008). 40% decrease in hospitalizations for asthma and 16% lower emergency department visit rate.

2. Colorado Medicaid and SCHIP

- Median annual costs $785 for PCMH children compared with $1,000 for controls. In an evaluation specifically examining children in Denver with chronic conditions, PCMH children had lower median annual costs ($2,275) than those not enrolled in a PCMH practice ($3,404).

D. Other PCMH Programs

1. Johns Hopkins Guided Care PCMH Model

- 24% reduction in total hospital inpatient days, 15% fewer ER visits, 37% decrease in skilled nursing facility days.
- Annual net Medicare savings of $75,000 per PCMH care coordinator nurse deployed in a practice.

2. Genesee Health Plan (Michigan)

- 50% decrease in emergency department visits and 15% fewer inpatient hospitalizations, with total hospital days per 1,000 enrollees 26.6% lower than competitors.

3. Erie County PCMH Model

- Decreased duplication of services and tests, lowered hospitalization rates, with an estimated savings of $1 million for every 1,000 enrollees.

4. Geriatric Resources for Assessment and Care of Elders

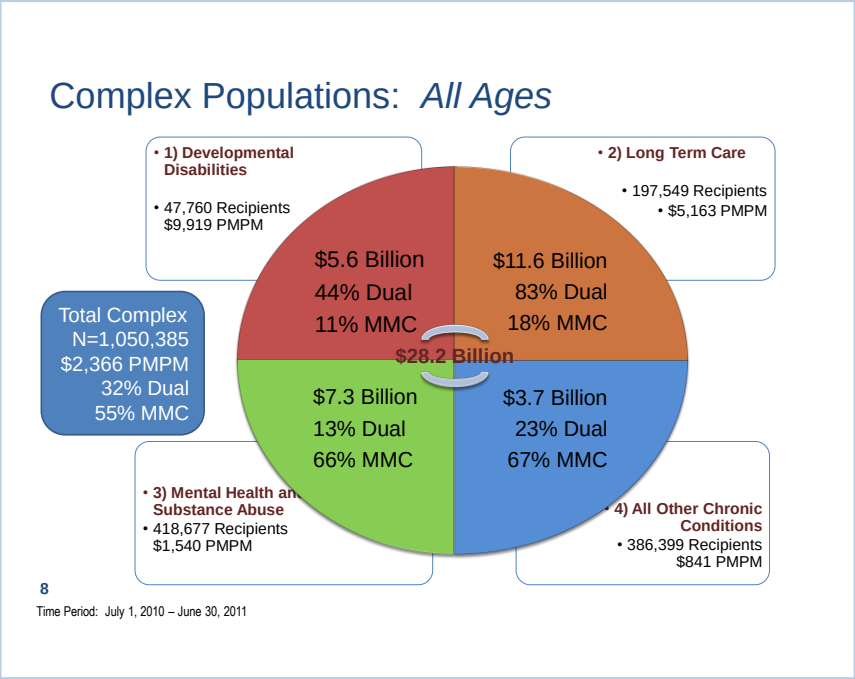
- Use of the emergency department significantly lower. The subgroup defined at the start of the study as having a high risk of hospitalization was found to have significantly lower hospitalization rates compared with high-risk usual care patients.

MRT Reinvestment Program
Health Home Development Fund

BACKGROUND

New York State has emerged as a national leader in the development of Health Homes consistent with the goals of the ACA. In rapid fashion, NYS has been rolling out comprehensive Health Home care management networks across the state with 35 Health Homes currently approved in 23 counties. Another 15 to 20 Health Homes are nearing approval in the remaining counties of the state. Unlike most states which chose to use Health Homes as simple case management funding inside of existing clinics or practitioner offices, New York took a much bolder approach. In New York each health home "network" is required to include a broad range of mandatory provider capacities including medical, behavioral health, HIV, housing and wrap around services all integrated with HIT capabilities and reporting through a single point of accountability for the patient.

There are 5.4 million Medicaid members and a little over one million of these Medicaid patients meet state and Federal Health Home criteria. New York categorized these members into four distinct groups shown below. New York's first wave of the Health Home initiative is focusing on implementing statewide Health Home services for members with behavioral health and/or chronic medical conditions. This group includes 805,000 members whose costs of care are approximately $11 billion per year.



In New York, Health Homes are envisioned as a permanent part of the state's considerable efforts to coordinate care for high need and high cost populations, consistent with the MRT's "care management for all" objective. New York seized upon the federal opportunity to implement a Health Home program as part of the broader goal of assuring that Medicaid members with high cost/high needs receive meaningful care coordination with a focused point of accountability at the provider level. In implementing the Health Home program, New York drew upon its significant experience with patient centered medical homes (PCMH), lessons learned from previous chronic illness management demonstrations, and investments in Health Information Technology (HIT) and Health Information Exchange (HIE).

Challenges to be addressed with waiver resources:

Despite this very aggressive and promising backdrop, Health Homes have encountered a number of serious challenges specifically with implementation. These obstacles include: difficulty locating the members identified as eligible for enrollment, an underprepared workforce, critical gaps in regional and provider HIT and HIE systems, and lack of funding for joint governance development and start up resources.

- **Member Engagement** – Health Home providers are being challenged to locate, engage and retain eligible members in care management. As provided for in the Health Home SPAs, Health Home providers will be reimbursed for outreach and engagement activities related to case finding for three months after a member is assigned to a Health Home. Reimbursement for outreach and engagement enables Health Homes to conduct outreach activities at the individual member level. Despite provision of the case finding fee, significant additional resources are being expended by Health Homes to find and engage these members. This is due to challenges in providing real time data on member addresses, the mobility of the population, and other critical population issues such as lack of trust, and understanding of what Health Homes can offer. To date, New York State has been unable to initiate a Health Home public education and awareness campaign to augment and support the individual outreach and engagement activities being conducted by the Health Homes. As a result, much understandable confusion still exists about what services Health Homes can provide and how they fit into the service delivery fabric in the state. A campaign targeted at communities at large that explains the purpose and role of Health Homes will provide a framework for Medicaid members to better understand the member level outreach and education efforts conducted by the Health Homes.

- **Workforce Training and Retraining** – New York State does not have an adequately prepared workforce to fully meet all the care management needs generated by the health home program. Health Homes are designed to utilize multidisciplinary teams of medical and behavioral health and other care providers led by a dedicated care manager to ensure that enrollees have timely access to the continuum of care needed.

While our Targeted Case Management (TCM) program offers a considerable care management workforce, retraining is necessary to focus on the more comprehensive and multidisciplinary nature of the Health Home care management job. Additionally, more care managers are needed and resources are lacking to properly train these new workers. This effort is mentioned here in the Health Home context but vendor selection and funding for this initiative would come from the MRT Reinvestment Program: Ensuring the Health Workforce Meets the Needs in the New Era of Health Care Reform.

- **Clinical Connectivity** – Health Homes are currently struggling with accessing an infrastructure to share data necessary to provide comprehensive care management. While some advanced networks and promising regional capacities have been built with prior limited HIT funding, most Health Homes and the providers in them are struggling with key gaps in connectivity. Significant progress has been made in developing Regional Health Information Organizations (RHIOs) and this capacity can be leveraged – funding is need to fill critical gaps in provider connectivity and to develop capabilities needed by Health Homes that are not fully available such as a shared care management records and multi-party consent. While there has been significant progress in the establishment of New York's HIT/HIE infrastructure, additional funding is needed to build connectivity for mental health, substance abuse and other critical community providers. Additionally, funding is needed to fill critical gaps such as shared care management records and multi-party consent. The use of HIT and HIE is pivotal to allow sharing of member health information across the Health Home network and full health care continuum to facilitate breaking down the current "silos" of care and to improve quality of care by providing real time "actionable" data to clinicians and care managers. This integrated "just in time" data sharing system will be the vehicle to achieve community wide integrated care for those complex members served by Health Homes.

- **Joint Governance Support** – Providers are not fully prepared with the resources required to actuate the new governance models required to effectively form and operate Health Home care management entities. New York requires Health Homes to contractually or organizationally include a wide range of providers including hospitals, community-based health and behavioral health providers, and social services providers including housing. In order to meet this requirement, many Health Homes are developing joint governance organizations and capital dues structures to provide the necessary infrastructure for implementation and operation. These costs, together with costs associated with HIT and other operational expense, are resulting in the need for significant capital contributions from partnering organizations. This requirement for capital contribution and the associated concerns about individual provider ability to pay is distracting Health Homes from their core care management objective. Thus, the proper development of joint governance organizations requires one time technical assistance and start up assistance that is not achievable from within the current Health Home care management fees.

PROGRAM DESCRIPTION

New York State plans to invest $525 million over the next five years to fully deploy Health Homes across the state and ensure they can thrive long after waiver funds have been expended. Provided below is a description of how these funds will be used. A more detailed breakdown is provided in the MRT Expenditure Plan section of this document.

Successful implementation of Health Homes will require significant additional funding to actuate the full potential of this extremely promising program. Waiver funds will be used on a one time basis to build the necessary infrastructure to address the challenges mentioned above. Stakeholder feedback provided suggestions for New York to use waiver funds in a number of ways to ensure successful, efficient implementation of Health Homes. The state received many constructive public comments, which have been incorporated into this request for waiver funding.

The Health Home Development Fund will be used to focus waiver resources on tangible and time limited health home implementation barriers to nurture Health Homes until they can be self-sufficient and rely exclusively on care management PMPMs and shared savings incentives. Health Home development funds will be disbursed through a competitive process structured around separate or combined health home development components. An assessment of individual and regional Health Home need for the funds will be made through the funding availability solicitation. In certain instances (e.g., Health Home IT funding), regional applications that involve multiple Health Homes collaborating on a single application may be required or strongly encouraged. Health Home waiver efforts that are supported by regional planning recommendations will be strongly considered for waiver funding. Health Home development funds will not duplicate funds made available through other waiver sources such as primary care expansion. Efforts on these separate proposals will be synchronized prior to the funding availability solicitation.

Health Home Development Fund components include:

1) Member Engagement and Public Education

Waiver funds will support the initiation of a public education campaign to explain the purpose and promise of Health Homes. The campaign will help potential members, providers and the public understand the valuable services offered through Health Homes and how this new service fits into overall service delivery framework in the community.

Conducting effective outreach and engagement of eligible Health Home individuals has been one of the most difficult challenges. Recommendations from several stakeholders suggest that waiver assistance in this education effort would be critical in assisting the care managers in engaging members and helping consumers understand the legitimacy (through a state level campaign) of what is being offered. Waiver funds would be spent for a population and program education campaign, not individual member level outreach, which is funded by the case finding fee. Funds would be used to create public service announcements, posters and other public awareness tools that would be used in the "hot spot" neighborhoods and locations where there are likely to be a high concentration of Health Home eligible individuals. The state would have an opportunity to create culturally and linguistically appropriate material which could also promote health literacy and reduce any engagement disparities. Funds also would be used to support care management agencies and other Health Home partners engaging in state approved outreach and patient engagement with direct street level marketing and consumer education activities focusing on Health Home eligible populations. New York State would also collaborate with patient advocacy groups and provider associations to further strengthen and expand outreach.

2) Staff Training and Retraining

Workforce waiver funds will support the development and rapid roll-out of care management staff training and retraining programs. These programs will leverage curricula that are already under development and will be aimed specifically at:

- Understanding the comprehensive focus of Health Home care management – including medical and behavioral health management;
- reducing communication challenges;
- enhancing cultural competence;
- increasing use of successful outreach and engagement and care management strategies; and
- promoting multidisciplinary care and holistic care coordination as part of a team.

Well trained care managers, in adequate numbers, are pivotal to the success of the Health Home program. Care managers in the health home will be the primary liaison with the enrollee, their family and each of their care providers. It is essential that this frontline staff have the most current skills needed to serve chronically ill patients and coordinate their care across settings.

Additional training will be focused on retraining of the large number of existing TCM case managers to fully develop their understanding of how Health Home care management will work, and how to more effectively "connect the dots" between the various components of care delivery and social supports through the Health Home architecture. This retraining is critical as previously many of these TCM programs were more limited in the focus of their case management activity. Vendor selection and funding for this initiative would come from the MRT Reinvestment Program: Ensuring the Health Workforce Meets the Needs in the New Era of Health Care Reform.

3) Clinical Connectivity - Health Information Technology (HIT) Implementation

Waiver funds will support the elimination of prioritized gaps in HIT that are standing between Health Homes and the information they need to effectively manage high need patients. A key component of Health Home program success is "meaningful use" compliant HIT connected through Health Information Exchanges (HIE). As previously noted, resources to support the implementation of HIT and HIE have not been evenly distributed across the NYS health care and behavioral health care delivery system resulting in significant technology gaps. Further, all parties have been challenged to leverage existing community capabilities such as through RHIOs' HIE due to technical and steep upfront cost limitations. The ability of Health Homes to work is fully contingent upon access to real time data, yet the upfront costs to implement an appropriate technology solution are significant and resources within the programs are limited. Despite New York's past funding for HIT and HIE, one time waiver resources are critical to plug specific targeted gaps.

To that end, New York plans to use waiver funds for specific HIT initiatives that support local capacity to implement statewide system requirements and to support the development of a critically needed Health Home provider portal and quality management dashboard. Funds will also be focused on supporting smaller providers which have not been able to access previous HIT funding and associated resources.

The one time gap funding waiver program includes:

1) Working with New York eHealth Collaborative on the development of a compliant uniform care management platform accessible through the HIEs;
2) Developing a Statewide Health Home provider portal to share patient tracking, claims and encounter and quality data, and which includes a "Care Management Lite" platform for Health Homes not yet able to implement their own electronic care management software and is linked to the SHIN-NY;

3) Assisting RHIOs with platform transformation that will allow implementation of patient specific multi-provider consents to simplify data sharing among the multiple entities of the health home without violating HIPAA and other patient protections and to replace the single entity consent process currently in place in most state RHIOs;

4) Further standardizing and developing the needed interfaces for Health Homes to use data "push" and "pull" to access 'real time data', including patient alerts for hospital inpatient or emergency department visits and to share real time clinical and administrative data, pivotal information for effective care management;

5) Supporting providers participating in Health Homes with funds to establish joint/shared electronic health record (EHR) systems with the capability of reporting performance on evidence-based medicine guidelines for population management;

6) Developing a quality data center and utilization dashboard on the Health Home portal to share quality measures and data with providers and payees; and

7) Funding data analysis training and technical assistance for Health Homes;

4) Joint Governance Technical Assistance and Implementation Funds

Waiver funds will support technical assistance on joint governance models and the development of regional collaboration models for Health Homes. Waiver dollars will also be used to support targeted and limited start up for these new collaborative entities.

Health Homes are engaging in innovative forms of governance that support the ability for multiple providers to oversee and have responsibility for the Health Home services provided to a shared set of assigned Health Home patients. The need for the development of informed Health Home joint governance capacity and dollars to support start-up infrastructure is significant. The human resources required to manage rosters, assign patients, undertake quality management and finances, hire care managers and train staff is significant. Waiver funds would be used to offset or replace some of the cost of developing joint governance organizations and offset or replace the necessity for capital contributions from partner organizations to support one time implementation and readiness activities. Waiver funds also would be used to conduct Learning Collaboratives that foster best practices to assist in the development of future Health Home joint governance structures.

Supporting the effective development of new governance structures is one way Health Homes will help shape a responsive health care delivery system based on right care at the right time with joint accountability. In addition, these new joint structures will be uniquely positioned to support the needs of the whole care management and service delivery network and not simply the needs of a single provider.

IMPACT ON OVERALL MEDICAID SPENDING

Health Homes will save the state and the federal government Medicaid and Medicare dollars by targeting high risk and high cost patients for better care management and better overall care delivery. While return on investment (ROI) has often been difficult to quantify for care management programs, there is sufficient evidence in the medical literature to support the value of these programs.

John Hopkins Healthcare has reported an ROI of $3.65 for every $1 spent for an integrated care management program for high cost Medicaid enrollees affected by substance abuse and chronic disease. http://www.chcs.org/publications3960/publications_show.htm?doc_id=633674

In one reported study, health care costs averaged $4066 PMPM before institution of the program, $1492 PMPM after six months in the program and $1000 PMPM 12 months into the program. Overall, after calculating costs for the program, $2449 PMPM savings were achieved from prior experience.

AHRQ (http://www.ahrq.gov/qual/medicaidmgmt/medicaidmgmt8.htm) has reported significant improvement in health care outcome metrics related to care management. While dollars were not specifically reported, it was noted that there was significant reduction in hospitalizations realized with some reported programs, a significant driver of savings. The Urban Institute (http://www.urban.org/uploadedpdf/412453-The-Potential-Savings-from-Enhanced-Chronic-Care-Management-Policies-Brief.pdf) also reports a number of care management programs documenting significant decreases in hospitalization rates (up to 24 percent) and emergency room usage (34 percent), both main drivers of savings.

Further, emerging evidence summarized by the federal Office for Management and Budget suggests that higher touch care management programs such as those being implemented by NYS under Health Homes, show promise in reducing avoidable expense.

While savings potential is apparent, the clear need to integrate care for our sickest patients has never been more evident. The most prevalent diagnoses at the top of the list of Health Home spending are mental health diagnosis, specifically schizophrenia and bipolar disorder. These patients die, on average, 25 years earlier than the average – most deaths due to treatable chronic medical conditions. Recent Johns Hopkins research suggests that people with serious mental illness —schizophrenia, bipolar disorder and disabling depression — are 2.6 times more likely to develop cancer than the general population. The study also found that patients with schizophrenia, when compared to the general population, were more than 4.5 times more likely to develop lung cancer, 3.5 times more likely to develop colorectal cancer and nearly three times more likely to develop breast cancer. People with bipolar disorder experienced similarly high risk for lung, colorectal and breast cancer. Experts speculate the number one contributor to this is smoking. Successful implementation of Health Homes will help these high cost/high need populations receive consistent high quality care and also reduce costs in the long run.

It is expected that the Health Home waiver reinvestment will be $150 million in the first two years and then will phase down during years 3-5. Health Home savings are expected to grow to over $180 million by year three of the waiver. New York is confident that at the end of the waiver period the state will have Health Homes that are stable and effective and as a result will be funded at normal FMAP levels and through shared savings.

MRT Reinvestment Program
New Care Models

BACKGROUND

New York State currently ranks 50th in avoidable hospital use and cost. Local collaboration and innovation are necessary to improve this troubling statistic and to move New York's health care outcomes from the bottom to the top. A New Care Model testing and development program will be set up with waiver funds to assertively tackle both cost and quality issues that affect New York's Medicaid program.

New York's health care system is often fragmented especially for our sickest patients and most of the fiscal incentives in the system are structured around the provision of additional volume (i.e., more admissions, days or visits). Only a small portion of the overall funding in the State's Medicaid program is set aside to promote quality. For instance, hospital systems that decide to seriously tackle unnecessary inpatient admissions and readmissions most often do so with potential peril to their bottom line. Outpatient clinics that invest in systems to track patients, provide more care intensity or perform home visits cannot find the extra resources to fund this important "extension" work. Additionally, almost no money is specifically tied to incentives for reducing or eliminating health disparities.

While some quality incentives do exist in the State's managed care program and some important quality gains have been made, much more work remains to be done especially for the state's most vulnerable patients. For instance, there are continued high rates of preventable events including avoidable hospitalizations and readmission, with the majority of readmissions (59 percent) being for medical conditions for persons with underlying mental health or substance abuse issues.

PROGRAM DESCRIPTION

New York State plans to invest $375 million over the next five years to launch new partnerships and test new models of care that could be expanded across the state and nation. Provided below is a description of how these funds will be used. A more detailed breakdown is provided in the MRT Expenditure Plan section of this document.

This initiative, New Care Models, takes the form of a challenge to the New York health, behavioral health and long term care communities to develop and promote models that achieve the Triple Aim. Funding will be used to provide seed capital for innovative ideas that are proposed by practitioners, health care agencies, and other external stakeholders. Only those proposals that create the right incentives to coordinate care, improve quality, outcomes, reduce disparities and contain costs will be funded.

This program will start by using planning grants to develop ideas, followed by operational dollars to launch promising models. Additionally, a quality pool will be developed as an incentive for providers that exceed quality benchmarks.

Once tested and proven, successful new models of care will be built into the fabric of the regular New York State Medicaid program. Those programs that demonstrate improved health care delivery, improved patient outcomes, reduced health disparities and cost savings will be mainstreamed as covered Medicaid benefits with traditional reimbursement.

To actuate this transition, as the demonstration matures during years four and five, the waiver funded program dollars for the new models will begin a planned transition from waiver funding to regular Medicaid services funding and the waiver funded quality pool will transition to a gain sharing model based on savings achieved against pre-set targets. To engage the community in the planning process, New York will issue a solicitation document seeking plans to implement innovative new care models that achieve the Triple Aim.

Solicitation requirements will include:

- A comprehensive description of the proposed new model of care;
- The problem the proposed new care model will address, including data to support the need for the intervention;
- Any evidence upon which the new model is based;
- The population(s) targeted by the care model and their characteristics and how the proposed model will reduce health care disparities;
- The health care partners that will participate in the model program;
- Demonstrated use of health information technology as appropriate to better inform care at the point of service and enable analysis of and action on metrics for patient centered outcomes and community health improvement and elimination/reduction of health care disparities;
- How the new model will impact the Triple Aim;
- How it will demonstrate return on investment and over what time frame, and
- The performance measures against which the model will be evaluated, both in real time and at the conclusion of the five-year waiver period.

Planning grants will be awarded using a competitive bid process. Table 1 outlines the timeline for planning, developing, implementing, and evaluating new care models selected for funding.

Table 1: Proposed Timeline: Planning Grants for New Models of Care

Planning Grant – Five Year Term	Core Activities
Competitive Bid Process/Year 1	○ Issue solicitation seeking proposals for new models of care ○ Complete the planning and development process ○ Initiate program implementation
Years 2 and 3	○ Program fully implemented ○ Proof of concept ○ Demonstrate return on investment ○ Ongoing, real time evaluation of new care models ○ Quality Pool payments made
Years 4, 5	○ Continue activities from Years 2 and 3. Formal program review – Proven models transition to ongoing Medicaid support – Models not meeting Medicaid program goals are phased out and enrollees are transitioned to effective care models/services – Quality pool transitions to gain sharing model based on savings achieved against case mix adjusted targets

While a competitive bid process will be employed to solicit and ultimately fund new, innovative models of care, the state did receive a number of ideas for new care models through the stakeholder outreach/engagement process, which may be illustrative of the types of models that will be funded. Some of these ideas are listed below:

Peer Services: This suggestion aims to break down traditional health care delivery silos by encouraging providers to work together in an integrated fashion with peer services. Peer services programming could include peer run wellness coaching, bridging and crisis services. The goal of these pilots is to launch and demonstrate the effectiveness of fidelity-level peer innovations for 'high needs' Medicaid beneficiaries in areas of the state where they currently don't exist.

Collaborative Care Transition Improvement – Model Facilitating Movement of Difficult-to-Place Patients between Hospitals and Nursing Homes: The creation of this model would test the potential to improve movement of difficult-to-place patients between hospital and nursing home settings. The model would use waiver resources to 1) assess the post-acute partner's capacity to effectively address the medical and nursing needs of the more complex cohort of hospitalized patients awaiting discharge; 2) identify the areas within the post-acute setting that would require a higher level of clinical support to ensure that appropriate care could be delivered on a sustained basis; and 3) implement targeted training and standardized protocols and interventions to enhance the skills and performance among key post-acute direct caregivers and

interdisciplinary team members to ensure that patient post-acute care needs can be met. The model would also provide enhanced communication plans and data exchange protocols to identify and prioritize patients for transfer and to identify what specific patient needs must be addressed in the post-acute setting. Waiver resources could also be used to test models of offsetting the extra costs of providing post-acute care to this difficult-to-place population.

Expand Availability of 'Environmental Modifications and Assistive Technology': Stakeholders are recommending that the Medicaid program implement coverage for certain environmental modifications and assistive technology provided to eligible homebound elderly and disabled members. An innovative home modification and assistive technology program is presently in place for some Medicaid members, however, far more could benefit if the program is expanded. Members for whom coverage is available include those enrolled in the Traumatic Brain Injury, Nursing Home Transition, and Care at Home waivers.

Patient Navigation and Transition Assistance: Stakeholder engagement sessions, including our Medicaid member focus groups, generated a significant number of comments about the need to help patients with managing the complexities associated with all the change and transition in Medicaid and health care in general. Specifically, some suggested that community health workers should be utilized to assist complex patients' transition to managed care and health homes.

Enhance Intensive Residential Services for Substance Use Disorder: The Office of Alcoholism and Substance Abuse Services (OASAS) currently certifies and funds Intensive Residential programs through state-only funds. This level of care is for patients who have significant functional deficits due to substance use disorders and frequently, co-occurring physical and mental health problems. These programs are currently not medically directed and are peer focused based on "community as method" behavioral modification. These programs can be improved with more Medical Direction and increased professional staffing, while retaining the peer based recovery principles of the therapeutic community model.

Support for New Organizational Structures: In a time of limit resources providers and community-based organizations are often financial stressed with the result being declines in the quality of care provided to Medicaid members. New York needs robust, financially stable organizations to partner with the state in the effort to reduce Medicaid costs and improve patient outcomes. Stakeholders have suggested that waiver funds could be used to facilitate mergers and new corporate governance structures with the end product being more stable providers of key Medicaid services. These one-time grants (modeled on HEAL-NY) could ensure that the state has a robust service provider network well into the future.

Medical Respite Care for Chronically Homeless Individuals: Stakeholders have suggested that the state use waiver funds to launch demonstration programs to test the efficacy of respite care. Medical Respite Care is acute and post-acute medical care for homeless persons who are too ill or frail to recover from a physical illness or injury on the streets, but who are not ill enough to be in a hospital.

Medical respite programs would allow homeless individuals the opportunity to rest in a safe environment while accessing medical care and other supportive services. It is offered in various parts of the country in a variety of settings including freestanding facilities, homeless shelters, nursing homes, and transitional housing. The hope is that this new health care alternative would lower Medicaid costs by preventing readmissions and by allowing homeless individuals in hospitals to leave for a less costly, more appropriate setting.

IMPACT ON OVERALL MEDICAID SPENDING

While many of these programs may be built from existing evidence based practices some will be testing completely new ways to promote quality and reduce cost. Whether a proven strategy or a promising new one is employed, all programs will be tracked against the standard performance measures. Those programs meeting both quality and cost savings benchmarks are expected to have a return on investment even after consideration of new program spending and quality pool incentive payments.

Successful planning grants and the new care models that emerge from them will form the foundation for important transformation of the Medicaid program. Successful new care models that are evidence-based, foster collaboration, and achieve MRT and ACA goals will also result in proven cost savings to the program and the community as a whole. The average annual investment in new models of care and the quality pool combined is $75 million a year over the five year period. Operational funding phases down during years three through five as the state eliminates less successful programs and begins to mainstream more promising programs into regular Medicaid. The quality pool set aside begins in year three and grows to $87.5M by year five.

MRT Reinvestment Program
Expand Vital Access/Safety Net Program

BACKGROUND

Safety-net institutions, including hospitals, nursing homes and clinics, are a vital part of the healthcare system and are essential to ensuring the health of New York's most vulnerable populations. At present time, the state's safety-net institutions are operating under tremendous financial pressures and additional pressures will be placed on these providers with upcoming changes to the Affordable Care Act (ACA) and MRT reforms.

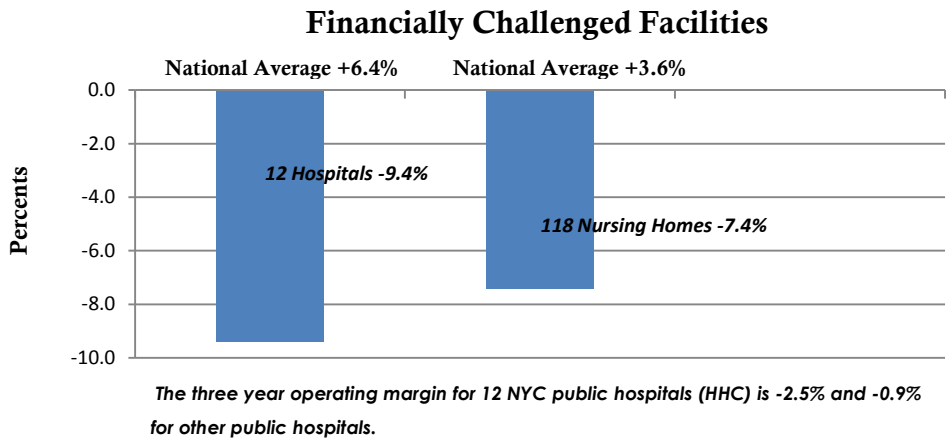
The MRT Payment Reform and Quality Measurement Workgroup, which was comprised of both industry leaders and consumer advocates, spent considerable time discussing the impact of the changing health care environment on these safety net providers. The concerns expressed by the Work Group were focused first and foremost on ensuring that access to patient services is maintained and enhanced, while transforming the service system to meet each community's unique needs. The Work Group unanimously voted that the state establish a special pool of funds, the Vital Access Program (VAP)/Safety Net Provider Pool, to target funding to a select group of providers aimed at achieving specific well-defined goals. The enacted 2012-13 state budget authorized up to $100 million for this purpose, and CMS conceptually approved the state's authorizing State Plan to advance this initiative. This funding was a positive first step for the state's safety net providers; however, additional resources are needed under the waiver to maintain a financially viable safety net health care community. Without additional resources, NYS and the stakeholder community have serious concerns that if some of these fragile providers that comprise the Medicaid and uninsured service delivery system fail or do not have adequate resources to reconfigure their operations in a planned way, there could be serious consequences to health care access.

The New York State Department of Health (NYSDOH) has conducted numerous financial analysis studies to examine the state's safety net community. For example, a recent financial analysis showed that of the 171 non-public hospitals in NYS, 12 reported a negative operating margin greater than 5 percent. It is important to note that these facilities tend to serve a disproportionate number of the state's Medicare, Medicaid, uninsured and other vulnerable populations.

[1] **Note:** There are facilities that are vital to NYS's provider network that are in serious financial condition. This proposal and one that follows later in this report (Capital Stabilization for Safety Net Hospitals) are aimed at relieving the immediate pressure these hospitals face and putting them on a course for stability. The distinction between the 2 programs is that VAP/Safety Net is targeted at providing operational resources (inclusive of other provider groups) while the Capital Stabilization will provide immediate relief to repair hospital balance sheets as well as provide technical assistance and traditional capital investments.

Similar trends are also apparent in the nursing home sector. For instance, nearly one quarter of nursing homes within the state have been deemed to be in serious financial condition. While the movement to a new Nursing Home Pricing System will provide critical resources and financial relief to many of these homes, there appears to be at least 40 homes that will not improve and may even worsen.

As evidenced by the following chart, the operating margins of some New York hospitals and nursing homes remains well below the national average. Please note this analysis is for illustrative purposes only and the VAP/Safety Net program will include both public and non-public facilities.



New York State also conducted an analysis of the nursing home bed needs/access across the various regions of the State. This analysis, which is based upon the 2016 bed needs methodology, shows an estimated shortage of 7,166 nursing home beds in New York. This is comprised of 10,639 under beds (mainly in New York City and Long Island) offset by 3,473 over beds (primarily in Rochester and Erie counties).

PROGRAM DESCRIPTION

In addition to the $100 million already conceptually approved by CMS, New York seeks to expand funding for the Vital Access Program/Safety Net Provider Program and dedicate an additional $1 billion over five years. In total, the state will have $1.5 billion to ensure a stable transition of the health care system. It is important to note that the MRT waiver funding would be limited to five years, while the state funding would continue after the five year waiver period.

As already mentioned, New York has two programs designed to assist uniquely situated and financially challenged health care providers strengthen their fiscal viability and improve their capacity to provide quality care to populations in need:

1) Safety Net Provider Program:

This program provides short-term funding, up to 3 years, to achieve defined operational goals related to facility closures, mergers, integration or reconfiguration of services.

2) Vital Access Provider Program (VAP):

This program provides longer-term support, up to 5 years, to ensure financial stability and advance ongoing operational changes to improve community care.

Eligible Providers

It is anticipated that funding will be available to qualifying providers, which includes hospitals, nursing homes, free standing clinics, and home health providers, in urban, suburban, and rural markets. To be eligible for assistance, the facility will likely be financially challenged and provide services to a high-volume of patients covered by government payers and/or the uninsured or be essential given their location and function as the sole source of care within a community (often in rural areas). Funding will be granted based on needs as well as the quality of the applications.

Requests for VAP /Safety Net funding will be evaluated based on the following four criteria:

1. **Facility Financial Viability** – The VAP/Safety Net plans must include specific actions for achieving long term financial stability, including benchmarks to measure performance in achieving the goals outlined in these plans.

2. **Community Service Needs** – All proposals will be evaluated in context of ensuring the facility is meeting community health needs. It is anticipated that many VAP/Safety Net plans will include a reconfiguration of services from intensive inpatient acute care to providing greater access to, and higher quality primary care services. Moreover, favorable consideration will be provided to hospitals and health systems in both rural and urban communities that have actively collaborated with regional stakeholders in conducting their community health needs assessments and in developing an actionable plan to meet those needs, or are pursuing integration with other providers. Active engagement in regional planning and the support of the regional planning organization (in regions where such organizations are operating) will be an important factor in evaluating applications. In addition, favorable consideration will also be extended to providers that need immediate or shorter term funding to achieve defined operational goals such as a merger, integration, closure, or service reconfiguration. It should be noted that New York State is currently working with stakeholders to align the state's community service plan requirements with the ACA's community health needs assessment requirements.

3. **Quality Care Improvements** – The initial analysis of Safety Net facilities indicates that some providers perform in the lower quartile on certain quality performance measures. VAP/Safety Net plans will target improvements in these areas.

4. **Health Equity –** A greater weight will be given to those VAP/Safety Net plans that address disparities in health services, or providing care to vulnerable populations who are at greater risk for experiencing poorer health outcomes than the general population.

New York State is currently working with the various stakeholders and industry associations to develop an analytical model that incorporates the measures above to determine and define VAP and Safety Net eligibility. These models will continue to be fine-tuned over the next few months. Providers will need to put forth solid VAP/Safety Net plans that provide for their long term financial viability, ability to meet community health needs, and to improve the overall quality of care for patients.

IMPACT ON OVERALL MEDICAID SPENDING

The objective of VAP and Safety Net initiatives is to improve access to needed services while reducing Medicaid program costs. The state and stakeholder communities have serious concerns that if some of these fragile providers that comprise the Medicaid and uninsured service delivery system fail or do not have adequate resources to reconfigure their operations in a planned way, there could be serious consequences to health care access. It is well documented with the literature, especially within high density urban areas and rural communities, that any delay in accessing needed health care services can result in poor health outcomes and overall higher costs. Moreover, implementation of the ACA will provide nearly one million New Yorkers with health care coverage and they too will be in need of services.

As mentioned in the Capital Stabilization for Safety Net Hospitals section of this document, outpatient and primary health care services are predominantly offered by hospital networks (particularly in New York City), and these Safety Net facilities will need to be strong and financially viable into the future.

Financially, a collapse of VAP and Safety Net providers could significantly impair the financial market, making it difficult for those facilities – many which have aged facilities – to access capital. It is important to note that if such a dire scenario were to unfold there could be a direct financial impact on the federal government as some of these providers currently have outstanding debt (i.e. FHA loans) which is backed by the government.

Lastly, at a granular level, measuring impact on the Medicaid program, the state will require each approved VAP and Safety Net plan to include analysis of how this additional funding will generate a return on investment within the five years of the waiver.

MRT Reinvestment Program
Public Hospital Innovation

BACKGROUND

New York State relies heavily on public hospitals to provide vital care to Medicaid patients and the uninsured. As Charts I and II in the Appendix to this section illustrate, public hospitals account for $1.7 billion in Medicaid spending (over a quarter of the total hospital Medicaid spending in NYS) and 51 percent of all hospital emergency Medicaid spending in NYS is in the public system. The success of various MRT initiatives relies heavily on these critical providers. While ACA will reduce the number of uninsured individuals, the challenges of uncompensated care and access to needed services for Medicaid patients will remain and public hospitals will continue to have to serve those who have nowhere else to go for care.

With regard to the uninsured, emergency Medicaid is clearly not the way to "get in front" of high health care costs. Statewide 31,000 emergency Medicaid patients are treated annually and 51 percent of these individuals are cared for in public hospitals at a cost of $267 million per year. Despite this high spending, uninsured patients lack access to basic primary care and preventative services. HHC data indicates that uninsured patients only have three encounters per year on average and only .5 of those visits are for primary care in any given year.

The MRT Waiver Amendment will enable New York State and CMS to test innovative payment and service delivery models to reduce Medicaid expenditures, enhance efficiency and improve care within the public hospital setting. These goals are especially critical to public hospital systems, such the New York City Health & Hospitals Corporation (HHC); the nation's largest municipal health care and hospital system (Chart II in the Appendix of this section indicates spending and utilization for each public hospital).

The Medicaid expansion under the Affordable Care Act necessitates efficient public safety net delivery systems so that newly eligible patients can access care. The continued viability of the public safety net systems is also critical because in New York State there will continue to be a significant number of Medicaid, uninsured and other vulnerable patient populations who have historically depended upon these systems for their health care.

At the same time we are asking more of public hospitals, the very funding streams these hospitals have historically relied upon are now at risk. These hospitals rely heavily on DSH funding which is scheduled to be reduced. For example, the DSH cuts enacted in the ACA, and extended in recent legislation, will result in nearly $2.3 billion in losses in DSH funding to HHC over eight years beginning in 2014. Such losses are also likely to occur for other public hospitals in New York State. Further, with New York State's transition of its

Medicaid population into managed care, the federal government will save a significant amount in federal UPL payments. These federal savings are not typically recognized in waiver savings calculations. The waiver funding proposed in this demonstration will help position public hospitals to more effectively prepare for a world with less DSH and UPL funding.

The waiver funding will build on existing successes in HHC and other public hospitals. Public hospitals in NYS have a mission to provide the highest quality health care for all New Yorkers regardless of their ability to pay. In order to maintain this important mission, HHC has adopted as one of its strategic goals – the Triple Aim. This strong imperative has driven HHC's efforts to build and develop an integrated delivery system that has demonstrated measurable improvements in quality and cost effectiveness. These achievements include:

- All of HHC's primary care sites have attained NCQA designation as Level 3 Patient Centered Medical Homes;
- HHC was an early adopter of an enterprise-wide electronic medical record. All patient data is in one electronic registry which has enabled coordination of care and has fostered outcome accountability;
- HHC has implemented a team-based approach to performance improvement using LEAN to redesign processes around patients and reduce waste. Over the last 5 years improvement work has resulted in $225 million in savings and new revenues;
- HHC publicly shares its performance measures on its website, and
- HHC's health plan, MetroPlus, which has more than 425,000 members (the third largest in the State), has been consistently rated number one for quality and patient satisfaction by New York State. That recognition is a reflection of the quality of care provided by HHC as most of MetroPlus' members receive their care within the HHC system. MetroPlus also has the lowest administrative costs among health plans in the state.

HHC is keenly aware that despite its many successes its current performance in certain areas is not at the level needed. Access to care when and where it is needed is a key domain of quality and is one where HHC is challenged. While HHC is working hard in this area to redesign its existing operations to create additional capacity, external support and resources are needed to assist this vital access provider to ensure that expanded coverage among those in communities served by HHC results in expanded access to primary care. HHC's successful attainment of NCQA designation is a reflection of its efforts in this area. But more must be done including partnerships with community health centers, behavioral health providers, housing agencies and other organizations to expand access to this most critical building block for improved health outcomes.

HHC also must do more in the area of readmission for chronic disease. Although the public hospitals' mortality rates for Acute Myocardial Infarction (AMI), Heart Failure and Pneumonia are at or above national averages; their readmissions rates for these conditions have lagged behind. HHC hospitals have achieved significant improvements for Heart Failure, but have been hampered in their efforts by the combined factors of homelessness or housing instability, inadequate access to primary care post discharge and language and literacy challenges associated with the diverse populations they serve.

Against this backdrop of a promising public hospital track record with significant remaining challenges, the state sought input from public hospitals and other providers (including behavioral health providers) during the MRT waiver amendment comment period about how to best position the public hospital system to advance MRT and ACA objectives. Based on this feedback which has been incorporated into this proposal, New York State is prepared to fundamentally reform they way care is provided to the Medicaid population and the remaining uninsured in public hospitals. Waiver funding will be specifically used to plug existing gaps in public hospital systems related to the continued need for additional care management and targeted primary care capacity for the Medicaid population and the uninsured. New York State hopes to design and implement an exciting new demonstration program that will provide "pre-emergency" Medicaid services to both uninsured and Medicaid members to provide these patients with access to: 1) culturally appropriate care management; 2) improved discharge planning for higher need patients and 3) Primary Care Expansion through integrated Patient Centered Medical Homes with co-located behavioral health. It is expected these targeted investments will improve patients' health and reduce overall Medicaid spending. As this new capacity will be made available to Medicaid beneficiaries and other patients being treated in the public hospital system the clinical benefits and savings will accrue in both emergency Medicaid and regular Medicaid.

PROGRAM DESCRIPTION

New York State plans to invest $1.5 billion over the next five years to test innovative payment and service delivery models to reduce Medicaid expenditures, enhance efficiency and improve care for Medicaid members within the public hospital setting. Provided below is a description of how these funds will be used. A more detailed breakdown is provided in the MRT Expenditure Plan section of this document.

To improve care and lower costs, care management and primary care expansion programs will be built in HHC and other public hospitals. The first set of programs are specific HHC efforts that have been successfully piloted and would be brought to scale with specific sub-components all aimed at more and better primary care and care management. The last program is a broader statewide effort to support similar work to be done in the balance of the public hospitals in NYS. The goal of both the HHC and other public hospital programs is to bring state of the art primary care access and care management capacity to the high risk uninsured and Medicaid populations served by public hospitals. This new capacity will be developed in the higher risk communities of New York City including Central and Northern Brooklyn, the Bronx, North Shore of Staten Island, Southeast and Western Queens, and East and Central Harlem; and in other at-risk rural and urban communities in the State.

Waiver resources will fund these needed care management and primary care services, as well as be used to track results and savings in Emergency Medicaid and other Medicaid expenditures. These public hospital focused efforts may be blended with other waiver efforts in a coordinated fashion. Waiver dollars will be allocated in a single bundled payment to each public hospital system with a pay for performance program implemented during years 3-5 of the waiver period. Lower performing components of the program will be revised during the demonstration or eliminated. Higher performance against standard metrics will be rewarded with pay for performance dollars from a quality pool set aside for such purpose. All waiver dollars will be used to build capacity that is not available from other Medicaid funding sources (such as health homes) but will help to fund gaps in both the emergency Medicaid and the regular Medicaid programs. Regular Medicaid funding will be fully leveraged prior to using waiver dollars and both the waiver funded and the Medicaid funded efforts will be coordinated and synchronized to avoid any possible duplication or confusion.

The state will work with CMS during the demonstration period to build an ongoing financing model to support the highest performing projects after the waiver expires.

The table below summarizes the programs to be funded under the waiver and the HHC subcomponents.

Project Sponsor	Project #	Project Title/Description	Goals/Approach
HHC	1.	Intensive Care Coordination	Reducing avoidable admissions and readmissions through a three prong care management approach.
	1a.	Emergency Department Care/Case Management	Inpatient Diversion and Readmission reduction through resourcing the ER and psych ER to provide better assessment of admission need and discharge planning
	1b.	Inpatient Care/Case Management	Reduction in Inpatient Readmission and adverse events post discharge through multi-level care management
	1c.	Post-Acute Care Home Care/Care Management	Reducing avoidable admissions and readmissions
	2.	Hot-spotting Uninsured Patients	Focusing indexed care delivery and care management on higher risk communities through patient stratification and matching higher risk patients with tailored care teams.
	3.	Primary Care Expansion	Enhanced access to care will be available through expanding HHC's PCMH teams that will be responsible for ongoing care and coordination of care across all elements of the health care continuum. Effective team-based primary care will be facilitated by registries, information technology and other means to assure that patients get the indicated health and behavioral care when and where needed and wanted in a culturally and linguistically responsive manner.
Other Public Hospitals	4.	Care Coordination and Primary Care Expansion	Reducing avoidable admissions and readmissions through a variety of strategies building off of the HHC specific models.

Following are more detailed descriptions of the HHC proposals and the effort to build out similar capacity in the remainder of the public hospital system.

1) Intensive Care Coordination/Case Management Initiative for Uninsured Patients Who "Touch" HHC Hospitals

HHC has piloted intensive care coordination/case management at its acute hospitals during the hours of 9 AM to 5 PM, Monday through Friday. The pilot has been effective in reducing avoidable admissions and readmissions over the two year pilot at two of its hospitals. As a result of the pilot, more than 2,000 admissions were averted. The waiver amendment proposes to bring to scale this initiative focused on HHC patients who present to its ED and Inpatient Psychiatric Units (IPUs), including uninsured patients. The intensive services care/case management initiative has as its goal the transformation of care across HHC's system in order to provide the right level of quality care, when and where the patient needs it. The initiative is grounded in the CMS' Triple Aim of ensuring a healthy population, providing quality individualized care when needed and containing health care costs where appropriate. This initiative focuses on the transitions in care as opportunities to work with patients and families to improve the course of illness, strengthen wellness, and provide effective and efficient care.

This HHC care management initiative can be described in three parts: A) Care/ Case Management in the Medical Emergency and Psychiatric Emergency Departments; B) Care/Case Management in inpatient medical/surgical units and psychiatric units; and C) Home Care Acute Transitional Care.

1a) HHC Emergency Department Care /Case Management

The medical ED initiative works to: 1) ensure that patients are admitted who need an inpatient level of care and that documentation in the medical record for the admission is accurate and complete; 2) that readmissions are assessed and prevented if it is appropriate for the patient ; and 3) that patients who can be discharged from the ED and whose ongoing care can be provided safely in the community with appropriate services receive the necessary care coordination and assistance so that unnecessary admissions are avoided. The ED Care Coordinator will be responsible for follow up and connecting the high risk patient to the next level of care.

Through a standardized approach across the HHC system, a care and case manager assigned to the medical ED for 2 shifts a day, 7 days a week will be integrated into the emergency room team to accomplish the above goals. A physician champion/advisor will be a member of the ED staff and coordinate the team. Data will be gathered on readmissions, avoidable admissions, patients discharged who return to the ED within 7 days and discharged patients who keep their follow up appointments and are successfully connected to the next level of care.

In the psychiatric emergency department, or Comprehensive Psychiatric Emergency Program (CPEP), the team of a social worker and community liaison worker/ peer counselor will work to: 1) assess patients with the ED team to determine patients whose care can be safely provided in the community and for whom inappropriate hospitalizations can be avoided; 2) develop a plan of care after discharge from the ED/CPEP that provides the necessary intensive community services to avoid unnecessary readmissions and preventable admissions; and 3) provide patients, through the community liaison worker/peer counselor, the necessary real time follow up in the community, including conducting home visits, accompanying patients to appointments, arranging transportation and other community resource support, etc. until the patient is connected to the next level of care. Data will be gathered on readmissions, avoidable admissions, patients successfully connected to the next level of care and revisits to the ED.

1b) HHC Inpatient Care/Case Management Initiative

The Inpatient Care/Case Management initiative is focused on providing timely and effective care coordination for uninsured/emergency Medicaid patients at high risk for readmissions or adverse events after discharge on the medical /surgical and psychiatric inpatient services. In addition, case management will be focused on real time monitoring of length of stay.

The diagnoses being prioritized initially are congestive heart failure (CHF), followed by pneumonia and myocardial infarction (MI). Additional diagnoses will be added as staffing allows. It is estimated that 30 percent of inpatients on HHC medical /surgical units and 40 percent of HHC psychiatric inpatient units are high risk and in need of intensive care coordination during their stays and for their successful transition to the next level of care.

On the medical/surgical units Project Red, an evidenced-based best practice developed by Boston University is being implemented throughout HHC and could be piloted at other public hospitals as well. At HHC this project initially focused on patients with CHF who have a high readmission rate in all facilities. A care manager is assigned upon admission to readmissions and high risk patients who are in need of comprehensive discharge planning and care coordination. The inpatient care manager is responsible for developing the plan of care with the patient and family and the inpatient team, educating the patient and family, ensuring effective medication reconciliation, and providing a successful connection to the recommended next level of care. This involves intensive work during the admission, and follow up calls and interventions after admissions until the patient is safely connected to the next level of care. The inpatient care manager will work closely with community-based programs, home care agencies, the family, and other supports.

On the Inpatient Psychiatric Units a model similar to Project Red, but modified for psychiatric patients, will be implemented focused on the patient at high risk for readmission or adverse outcomes after discharge. The project will use social work care coordinators who will work with patients and families from the time of admission, develop with the entire psychiatric team a comprehensive care plan, and ensure that patients are connected successfully to aftercare in the community. The social worker, inpatient care manager, will work collaboratively with community-based programs, home care agency, family, and other supports.

If this were adopted as a standardized approach across HHC's public hospitals, it is expected that readmissions can be reduced to less than the national benchmark. It is also expected that adverse events post discharge would be decreased. Readmissions and ER visits within 30 days will be monitored for all patients in the initiative. Resources needed include a standardized staffing pattern based on volume across all acute care facilities.

1c) HHC Home Care/Acute Transitional Care Management

HHC Home Care has developed a care management approach to provide transitional services to high risk discharged patients with at least three of the CMS monitored diagnoses of Myocardial Infarction, CHF and pneumonia as well as high risk diabetics discharged from HHC's Emergency Department and inpatient services.

This proposal would provide services to all discharged high risk patients with the above diagnoses, and would stratify those services from a minimum of post-discharge calls to ensure that patients make their aftercare appointments to the more intensive use of telehealth and face-to-face contact for up to 90 days post discharge.

Effectiveness would be measured by a decrease in readmissions within 30 days, prevention of avoidable admissions for up to 90 days for enrolled patients, and patients' assessment of progress on their self-management goals.

2) Expanding the Concept of "Hot Spotting" to Uninsured Adult HHC Patients

Using state data, HHC will identify uninsured individuals who they "touch" and risk stratify them based on their risk of a non-OB hospital admission and on their risk of being a high cost patient ($10,000+). HHC would then map where these individuals live within each city borough and, working with community-based organizations, gather information about these individuals and their physical and behavioral health and community and social services resource challenges.

These individuals would be invited to participate in the "HHC Options Health Home Program (HOHHP)"; a program that would pair high performing patient-centered medical home teams based in the nearest HHC Diagnostic and Treatment Center or hospital, with these high-risk/high-cost uninsured patients to improve their health outcomes and prevent or reduce "downstream" costs. HOHHP would provide different intensity levels of care coordination based upon a shared care plan developed with each patient.

Each patient would be assigned a health coach (clinical or nonclinical based on their needs and self-management goals). This level of support would be layered on the foundation of patient-centered team-based primary care and the state's newest initiative, Health Homes. The care team, guided by the primary care provider will take responsibility for the ongoing care of participants across all of the elements of the health care continuum.

3) Primary Care Expansion

One of the most critical elements of HHC's proposed projects will be the system's capacity to ensure that all of its patients have access to a primary care provider within three to five days of demand and 24 hour access to a member of the care team when issues arise. This capability must be in place without displacing the public hospital system's capacity to serve existing Medicaid patients and newly insured patients from the state's Health Exchange and Medicaid expansion efforts. HHC proposes to ensure open access to all of its patients by creating additional primary care capacity through expanding hours of operations, partnering with other safety net primary care providers, creating additional sites of care (i.e., capital funds) and increasing mid-level providers (Physicians Assistants (PA), Nurse Practitioners (NP)) in behavioral health settings and behavioral health providers (Psychiatric NPs, Social Workers) in primary care settings.

OTHER PUBLIC HOSPITAL PROJECTS

4) Other Public Hospitals - Primary Care Expansion and Care Management Services

The challenges for public hospitals that serve uninsured and high risk individuals, often with uncompensated care, also exist in other communities in New York State. Accordingly, the state intends to use waiver resources to extend components of the HHC models presented above to other public hospitals, especially those serving vulnerable communities with higher numbers of uninsured patients. The state believes that the demonstrated success of HHC's innovative pilot for managing health care for the uninsured warrants further expansion, however, it should be tailored to the unique needs of each community.

To implement this proposal the state would issue a request for proposals from the other public hospitals to propose demonstrations that would:

- Develop or expand high competence (PCMH) primary care and behavioral health ambulatory capacity to the uninsured.
- Develop or expand care coordination and transitional support services to higher risk uninsured patients.

IMPACT ON OVERALL MEDICAID SPENDING

This program will reduce spending (i.e, emergency and regular Medicaid spending) by providing care and care coordination services that prevents unnecessary ED, inpatient and Dialysis visits. Previous efforts to focus care management and patient centered primary care have proven successful. For instance the health care teams used as part of a patient centered medical home project implemented by the Group Health Cooperative of Puget Sound generated a 29 percent reduction in ER visits and 11 percent reduction in ambulatory sensitive care admissions. In this same project investment in primary care of $16 per patient per year was associated with offsetting cost reductions as reportedly unpublished data from the 24 month evaluation show a statistically significant decrease in total costs.

Community Care of North Carolina using PCMH with care coordination and disease management tools produced a 40 percent decrease in hospitalizations for asthma and 16 percent lower ER visit rate and total savings to the Medicaid and SCHIP programs in NC are calculated to be $135 million for TANF-linked populations and $400 million for the aged, blind and disabled population.

Care management focused on high cost/high need populations has also shown promise in New York. In the New York City Health and Hospitals Corporation's Chronic Illness Demonstration Project:

- 263 H2H patients were enrolled;
- $71, 146 per patient per year average cost to Medicaid pre-enrollment into H2H;
- $57,064 per patient per year average cost to Medicaid post H2H enrollment;
- Annual saving $14,082 (20%); more than $3.7 million for 263 patients including program costs;
- Of the 263 H2H patients, 53 were homeless;
    - ✓ Among those 53 H2H participants, there was a significant reduction in inpatient admissions from 0.68 per month to 0.36 per month with a 47% decrease in admissions (a 27% decrease in inpatient costs).
    - ✓ Among the 53 H2H participants, there was a significant reduction in ED visits from 1.13 per month to 0.53 per month with 53% decrease in visits (a 30% decrease in ED costs).

While the public hospital proposals are being presented in the context of the MRT Waiver and one of the aims is to show savings to the Medicaid program, it is important to consider that these savings may not be evidenced in the first years of the demonstration grant as there will be a need for upfront investments in operational infrastructure and increases in costs related to utilization of primary care and other preventative services.

The evidence clearly suggests that investments such as those laid out in this document will generate significant savings in the long term. It is expected that the total waiver reinvestment will equal $300 million with a quality pool of $50 million beginning in year three and increasing to $75 million by year five. In addition to ancillary benefit to Medicaid and Medicare as new primary care and care management capacity is built, the program is projected to save at least $158 million in savings over the demonstration period in Emergency Medicaid spending.

APPENDIX

Chart I

NYS Medicaid Expenditures and Utilization
by Major Categories of Service
For People Receiving Medicaid Services with Emergency Services Only Coverage
Service Dates: July 2010 - June 2011 (NYC Fiscal Year 2010-11)

	Provided by All NYS Hospitals		Provided by Public Hospitals		%s of Public Hospitals	
Category of Service	**Medicaid Expenditures**	**Medicaid Recipients****	**Medicaid Expenditures**	**Medicaid Recipients****	**Medicaid Expenditures**	**Medicaid Recipients**
All Medicaid Services	**$528,976,246**	**30,773**	**$267,295,049**	**15,738**	**51%**	**51%**
Inpatient	469,703,328	21,759	249,213,594	11,339	53%	52%
Hospital Based Dialysis	26,198,785	10,636	15,510,218	5,667	59%	53%
Emergency Room*	2,245,977	4,705	611,122	1,495	27%	32%
Freestanding Dialysis	9,383,467	770	0	0	0%	0%
Physicians	8,881,865	16,131	0	0	0%	0%
All Other Services	14,808,801	n.a.	2,571,237	n.a.	17%	n.a.

* ER is a subset of Hospital Clinic

**Recipient counts do not add up to totals because a recipient might have received more than one service during a time period.

Source: NYS DOH/OHIP Datamart (based on claims paid through 6/2012)

APPENDIX

Chart II

NYS Medicaid Expenditures and Utilization
by Public Hospitals
In Descending of Total Medicaid Paid Amounts
Service Dates: July 2010 - June 2011
Source: NYS DOH/OHIP Datamart (based on claims paid through 6/2012)

Hospital Name	Medicaid Paid Amount Spent on All Medicaid Recipients	Medicaid Paid Amount Spent on People with Emergency Services Only Coverage	%Dollars Spent on People with Emergency Services Only Coverage
TOTAL	**$1,683,964,288**	**$267,295,049**	**16%**
BELLEVUE HOSPITAL CTR*	234,031,382	50,973,262	22%
KINGS COUNTY HOSP CTR*	232,287,269	41,198,994	18%
JACOBI MEDICAL CENTER*	170,239,905	16,736,486	10%
ELMHURST HOSP CTR*	164,923,529	50,626,314	31%
LINCOLN MEDICAL*	146,553,818	18,627,427	13%
WOODHULL MEDICAL*	109,347,006	12,295,468	11%
HARLEM HOSPITAL CTR*	96,487,935	9,425,936	10%
METROPOLITAN HOSPITAL CTR*	93,247,941	13,192,944	14%
QUEENS HOSPITAL CTR*	93,061,522	18,160,534	20%
CONEY ISLAND HOSPITAL*	83,984,223	20,686,985	25%
GOLDWATER MEM HOSP*	58,079,054	5,170,434	9%
ERIE COUNTY MED CTR	49,470,283	91,069	0%
NORTH CENTRAL BRONX*	47,543,586	6,807,249	14%
SUNY DOWNSTATEMED CTR AT LICH	38,188,061	1,233,598	3%
WESTCHESTER MED CTR	18,862,169	527,285	3%
COLER MEMORIAL HOSP	14,513,536	1,466,590	10%
ROSWELL PARK MEMORIAL INSTITUTE	10,787,034	-	0%
UNIVERSITY HOSPITAL AT STONY BROOK	5,621,569	74,051	1%
UPSTATEUNIV HOSP AT COMM GEN	4,450,400	-	0%
HELEN HAYES HOSPITAL	4,091,685	422	0%
WYOMING CO COMMUNITY HOSP	2,522,677	-	0%
UNIV HOSP SUNY HLTH SCIENCE CTR	2,300,121	-	0%
SUMMIT PARK HOSPITAL	2,066,318	-	0%
SUNY HOSPITAL DOWNSTATEMEDICAL CENTER	1,085,090	-	0%
MONROE COMMUNITY HOSPITAL	115,858	-	0%
MASSENA MEMORIAL HOSP	93,212	-	0%
LEWIS COUNTY GENERAL	9,106	-	0%

* Health and Hospitals Corporation (HHC) Facility

MRT Reinvestment Program
Medicaid Supportive Housing Expansion

BACKGROUND

A critical component to improving the health of New Yorkers and containing health care costs is to ensure that an individual's housing needs are also met. "Supportive Housing", which is housing coupled with appropriate individual-based services, is an innovative and cost-effective model of care designed to provide an integrated solution for both housing and health care needs. There is compelling evidence, both in New York and nationally, that for people coping with chronic illness or disability and behavioral health challenges, the lack of stable housing often results in avoidable health care utilization and, in turn, avoidable Medicaid expenses. Moreover, the lack of affordable housing, in combination with accessible health care, continues to be an obstacle to serving individuals in the most integrated setting. This includes individuals in nursing homes and other long term care settings, who cannot be discharged because they lack a place to live, as well as homeless individuals and those in shelters whose chronic health and behavioral health conditions lead to overuse of emergency departments and hospital inpatient care.

Over a decade of independent research has shown that transitioning individuals into supportive housing dramatically reduces immediate and long-term spending for Medicaid reimbursable expenses, as well as spending on other public programs. This is a fundamental premise of the U.S. Department of Justice's vigorous enforcement activities to assure the availability of community living options for people with disabilities. In New York, supportive housing costs $47 per day while it costs $437 a day in a psychiatric hospital, $755 in an inpatient hospital, $68 in a homeless shelter, and $129 for jail.[2] By increasing the availability of supportive housing for high-need Medicaid beneficiaries, there is a significant opportunity to reduce Medicaid costs and improve the quality of care for these individuals.

A preliminary analysis of 28,724 recipients in need of supportive housing found a total of over $1 billion in annual Medicaid expenditures, including $212 million on inpatient hospital care, $5 million on emergency department services and $266 million on long term care services.[3] Supportive housing services have the potential to decrease these costs dramatically – producing millions in Medicaid savings. For example, multiple national studies have found reductions in emergency department (ED) and inpatient costs averaging 60 percent,[4] potentially saving New York's Medicaid program over $650 million over five years in ED and inpatient costs alone. Clearly, expanding the availability of supportive needs is an integral component to attaining Medicaid cost containment.

[2] Culhane, et al. "Public Service Reductions Associated with Supportive Housing." Housing Policy Debate.
[3] Medicaid utilization for people in need of housing; CY2011; NYSDOH/OHIP Data Mart.
[4] Craig C, Eby D, Whittington J. Care Coordination Model: Better Care at Lower Costs for People with Multiple Health and Social Needs,. IHI Innovation Series White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2011.

Access to supportive housing services is of paramount importance to achieve the Triple Aim of better health, better care, and lower costs for traditionally underserved populations. The MRT Affordable Housing Work Group evaluated the expansion of supportive housing programs for the purpose of assuring that individuals who have compelling needs for health care are adequately served in a manner that makes the most efficient possible use of the Medicaid dollar. Over the course of the Work Group's deliberations, the Work Group members and the stakeholder community identified multiple populations in need of supportive housing services. The Work Group findings underscored the belief that supportive housing is an essential component of a service constellation necessary to assuring access to primary care and preventative services.

There is a growing national recognition that addressing the social determinants of health is critical for improving health while reducing health care costs.[5] This is most evident in the matter of housing. People who are homeless or lack stable housing face multiple health risks,[6] die younger,[7] have less access to primary care,[8] and are frequent users of expensive hospital services. Among those New York City Medicaid patients at highest risk for future costly hospital admissions, as predicted by a validated algorithm, a full 60 percent were homeless or precariously housed.[9]

Moreover, economic and demographic trends are reinforcing barriers to community-based care for low-income people with disabilities – particularly in New York City (NYC) where the Fair Market Rent is equivalent to 166 percent of the average monthly Supplemental Security Income ("SSI"). Housing costs in other downstate areas are similarly out of reach for disabled people on fixed incomes. Financial assistance for supportive housing services will provide the necessary wherewithal to allow low-income disabled individuals to live in the community.

New York has committed significant resources and made vigorous efforts to ensure compliance with the ADA and the Supreme Court decision in *Olmstead v. United States*. Nevertheless, thousands of New Yorkers with disabilities continue to live in institutions or other inappropriate settings because of the lack of affordable, accessible housing options in the community. For example, there are currently 22,248 New Yorkers living in nursing facilities who have indicated they wish to return to the community.[10]

If those nursing facility residents who are Medicaid eligible were transitioned to the community, the state would potentially save $129 million annually in the non-federal share of Medicaid.[11] Unfortunately, HUD financed housing continues to be primarily directed to meeting the needs of low income families and individuals, for the most part, and HUD financed housing is very difficult to access by individuals with disabilities and other special needs.

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[5] Bradley E.H., Taylor L. "To Fix Health, Help the Poor." *NY Times.* 8 Dec 2011.
[6] Baggett T.P., et al. The unmet health care needs of homeless adults: a national study. *Am J Public Health.* 2010.
[7] Barrow S.M., et al. Mortality among homeless shelter residents in New York City. *Am J Public Health.* 1999.
[8] Kushel M.B., et al. Factors associated with the health care utilization of homeless persons. *JAMA.* 2001.
[9] Raven M.C., et al. Medicaid patients at high risk for frequent hospital admission: real-time identification and remediable risks. *J Urban Health.* 2008.
[10] New York Association of Independent Living. Center for Medicare and Medicaid Services Minimum Data Set, 2010 3rd quarter QiA report.
[11] Proposals to Reduce New York State Spending and Promote the Independence and Integration of Seniors and People with Disabilities: Fiscal Analysis, New York Association on Independent Living and the Center for Disability Rights, January 7, 2011.

Additional supportive housing services will also reduce health disparities by focusing on a diverse population of low-income New Yorkers. Racial minorities, including African-Americans, Hispanics, and Native Americans are overrepresented among those who are homeless and marginally housed, and stand to benefit the most from supportive housing services.[12] In addition, focusing on the Health Home eligible population will have the ancillary benefit of contributing to reducing health disparities among the minority community. For example, of the Health Home eligible population, over 20 percent are African-American and over 26 percent are Hispanic. Increased funding for supportive housing services for the racial and ethnic minority population will contribute to the state's efforts at reducing health care disparities.

Finally, recognizing the importance of stakeholder feedback, recommendations for this initiative were gathered through multiple stakeholder engagement processes, including the MRT waiver website public feedback form, face to face meetings with stakeholders, multiple webinars, the MRT waiver amendment survey tool, public hearings and Medicaid recipient focus groups. Throughout the stakeholder engagement process, individuals throughout the state expressed the need to increase funding for supportive housing services.

PROGRAM DESCRIPTION

New York seeks to dedicate $150 million annually, totaling $750 million over five years, to expand access to supportive housing services. Under this proposal, two programs would be created – the Supportive Housing Capital Expansion Program, totaling $75 million annually, to fund capital projects, and the Supportive Housing Services Program, totaling $75 million annually, to provide supportive housing services. Funding would target high cost, high need Medicaid members who require supportive services to live independently.

Target Populations

Individuals would be eligible for supportive housing services insofar as they are at high risk of not being able to live independently if they are not provided with the supportive services available through this program. Funding would target "high users" of Medicaid services, with a primary focus on the Health Home eligible population. As such, the program would work in conjunction with New York's Health Homes and Managed Long Term Care Plans to provide needed housing services to New York's most complex Medicaid populations.

[12] National Coalition for the Homeless. "Minorities and Homelessness." July 2009.

The target populations intended to be recipients of the housing and services developed as a result of this program, include, but are not limited to:

- Chronically homeless adults who suffer from mental illness and/or substance abuse;
- Chronically homeless and physically disabled;
- Chronically homeless adults living with HIV/AIDS;
- Single adults who are presently living in New York State-operated psychiatric centers;
- Young adults with a serious mental illness and/or substance abuse disorder;
- Individuals with serious behavioral health or health conditions coming out of prison or jail;
- Individuals residing in long term care settings who prefer to return to the community (i.e. adult homes and nursing homes);
- Individuals residing in acute hospitals (i.e. hospital homeless) who cannot be discharged because they lack housing options;
- Low-income disabled individuals enrolled in or eligible for Managed Long Term Care plans or Consumer Directed Programs;
- Frail elderly individuals living in arrangements, which create a potential for harm or neglect.

1) Supportive Housing Capital Expansion Program

New York seeks to dedicate $75 million annually for capital funding to increase access to supportive housing. Funds must target high cost, high need Medicaid members who require supportive services to live independently. Funds would be distributed through a variety of state and local housing agencies via a competitive request for proposal approach. It is estimated that 600 new units will be created annually[13], totaling 3,000 units over the next five years.

Sustainable projects, with the greatest Medicaid return-on-investment (ROI), would be prioritized over other projects. These funds would be used to leverage other state, local, and federal capital resources and private tax credit investments prioritized for this purpose. Development would emphasize the creation of supportive housing units integrated into the community and with other affordable units for non-disabled populations.

[13] The estimate assumes $125,000 per unit, with developers of this housing would need to leverage other resources from OTDA, OMH, OASAS, or other partnering agencies.

Funds may be used for the following purposes:

- Development costs associated with the conversion of existing housing to supportive housing standards;
- Development and construction of new supportive housing units;
- Capital funding to support home modifications. Funding would provide financial assistance to property owners to make dwelling units accessible for low- and moderate income persons with disabilities. Providing assistance with the cost of adapting homes to meet the needs of those with disabilities will enable individuals to safely and comfortably continue to live in their residences and avoid institutional care;
- Co-location and integration of health care services with supportive housing. Project funds would create "free-standing" easily-accessible clinics for individuals in need of supportive housing services, as well as for individuals within the community. Funding would be used similar to the HEAL-NY program, a program which was also funded with 1115 waiver dollars.

2) Supportive Housing Services Program

New York seeks to dedicate $75 million annually for supportive housing services to increase access to supportive housing. Funds would be distributed through a competitive request for proposal process. Sustainable projects, with the greatest Medicaid ROI, would be prioritized over other projects. Funds must target high cost, high need Medicaid members who require supportive services to live independently. This Program would work in coordination with the Supportive Housing Capital Expansion Program as multiple projects would receive funds for both capital and supportive services. Funds may be used for various supportive housing services, including but not limited to:

- Crisis management;
- Case management;
- Patient navigation and care coordination services (including linkages with Health Homes);
- Counseling;
- Relapse management;
- Linkages to community resources;
- Education and employment assistance;
- Landlord-tenant mediation;
- Entitlement advocacy;
- Budgeting and help with legal issues.

Many of the supportive housing services targeted under this proposal are already covered services for existing Medicaid populations in other settings. To ensure that supportive housing projects funded under both programs receive all the components necessary to be fully operational and successful, state-only dollars or other non-Medicaid federal dollars would be used to fund rental subsidies. The MRT dedicated $75 million in state Medicaid funds on an annual basis to fund supportive housing programs and services. A portion of this funding would be targeted to fund the rental subsidy costs associated with these programs.

Eligible applicants

Eligible applicants may include, but are not limited to, for profit and non-profit housing developers, and private nonprofit organizations. New York State agency partners may include: the Office of Mental Health (OMH), the Office of Temporary and Disability Assistance (OTDA), the AIDS Institute within the Department of Health, the New York State Office of Alcoholism and Substance Abuse Services (OASAS), and New York State Homes and Community Renewal (HCR).

Advocacy Community Input

All recommendations were reviewed for consideration and numerous recommendations from the advocates of this population were incorporated into this proposal. See the Appendix for a list of stakeholders who were consulted.

IMPACT ON OVERALL MEDICAID SPENDING

The lack of appropriate supportive housing, especially in New York's urban areas, is a major driver of unnecessary Medicaid spending. For every individual served under this program, it is estimated to save Medicaid costs by approximately $16,281 - $31,291 annually per person[14], with savings ranging by the types of populations and disabilities served and intensity of targeting. Preliminary estimates suggest that Medicaid savings would total between $142 million - $273 million annually, totaling between $711 million - $1.3 billion over a five-year period.[15]

[14] NYNY Housing SMI; and Harlem United, "2009 Program Evaluation," 2010.
[15] Fiscal estimates assume 8,743 individuals per year, with savings ranging from $16,281 - $31,291 per person per year.

APPENDIX

Advocacy Community Input

Recommendations and feedback for this initiative were gathered through multiple stakeholder engagement processes, including the MRT Waiver Public Feedback Form, face-to-face meetings with stakeholders, multiple Webinars, MRT waiver amendment survey tool, public hearings and Medicaid recipient focus groups. Throughout the stakeholder engagement process, individuals throughout the state expressed the need to increase funding for supportive housing services. All recommendations were reviewed for consideration and numerous recommendations from the advocates of this population were incorporated into this proposal.

Recommendations were submitted from the following stakeholders:

- The Supportive Housing Network of New York (SHNNY)
- The Healthcare Association of New York State (HANYS)
- New York City Department of Health and Mental Hygiene
- Corporation for Supportive Housing
- Harlem United
- Association for Community Living
- New York City Human Resources Administration
- New York City Department for the Aging
- Community Health Care Association of New York State (CHCANYS)
- Coalition for Children's Mental Health
- The Fortune Society
- ArchCare
- Empowerment by Design
- Nassau County Office for the Aging

MRT Reinvestment Program
Long Term Transformation and Integration to Managed Care

BACKGROUND

One of the most significant reforms recommended by the MRT is the plan to migrate long term care services to a managed care environment. Non-institutional, community-based long term care was one of the major cost drivers in New York Medicaid prior to the MRT. There was no comprehensive system of quality assurance, and empirical analysis demonstrated little relationship between hours of care provided and level of patient acuity. In order to transform New York's long term care system to one that ensures care management for all, supports choice for consumers, and emphasizes community integration, it is necessary to invest in key areas of the long term care community.

The MRT moved New York's long term care system in a new direction through a series of short term payment reforms as well as longer term changes in the delivery system. First, the MRT put in place a new payment system for home health care that linked payment rates to utilization thresholds that more accurately reflected patient need. Next the MRT created a new episodic payment system for home health care that will continue to assure that the benefit is related to the needs of the recipient. In addition, personal care utilization growth is being better managed by a city and state partnership. Each of these strategies saved taxpayers hundreds of millions of dollars while maintaining a robust community-based system.

In addition to these initial payment reforms, the MRT also moved forward with a systemic reform plan in long term care – the end of fee-for-service long term care and its replacement with a statewide system of managed long term care. This sweeping change is built off the state's highly successful voluntary Managed Long Term Care Program (MLTCP) and the sound base of New York's successful Mainstream Managed Care Program. Under the reform, over a several year period (beginning in August 2012) MLTCP will expand statewide and the majority of community-based long term care service recipients will be enrolled in plans. This new approach to care will save Medicaid and Medicare expenditures, increase care management to beneficiaries, provide opportunities for enhanced quality assurance and metrics to measure service provision, increase consumer direction opportunities and incentivize community-based options over institutionalization.

New York is not going to stop by simply moving long term care services into effective management. Rather, New York seeks to lead the nation in fully integrating all services (including Medicare services) for individuals in need of long term care. In New York, long term care recipients will eventually have the opportunity to enroll into plans that are fully integrated. The entire array of services to which a member is entitled will be under one care management entity reducing fragmentation, increasing coordination and resulting in cost savings.

To achieve full integration, New York will partner with Medicare through a duals demonstration project. Dually eligible members are among society's most vulnerable people. Historically, duals have been poorly served by the health care delivery system. Their needs often cross multiple silos including payer silos. The duals project in New York will build off the statewide MLTCP roll-out by "converting in place" duals enrolled in MLTCP plans in January 2014. New York is confident that by using its successful MLTCP plans as the basis for full integration, the Triple Aim of improving the patient experience of care, improving health of populations, and reducing per capita costs for some of the nation's most challenged patients can be realized.

The move to managed long term care and full integration for duals is a major structural change. This structural change will require waiver funding to assist in the transition for both patients and providers to minimize unintended consequences and support expected improvements. New York envisions using waiver funds in a number of ways to ensure successful implementation of these reforms. Below is a description of specific programs that would be funded:

PROGRAM DESCRIPTION

New York State plans to invest $839.1 million over the next five years to transform New York's long term care system so as to support consumer choice, emphasize community integration and ensure successful implementation of care management for all. Provided below is a description of how these funds will be used. A more detailed breakdown is provided in the MRT Expenditure Plan section of this document.

1) Nursing Home Transition – Assuring Access and Choice

New York nursing homes have been mostly exempt from managed care and many are financially fragile. The transition to managed care will put financial pressure on homes as they are asked to transform into effective care managers that are highly focused on reducing hospitalizations and improving patient quality of life. Historically, fee-for-service (FFS) payment systems have actually rewarded nursing homes for moving residents back and forth from hospitals. Running counter to the state's policy on community integration, the need to fill beds has been a driving force behind nursing home behavior to maintain occupancy with patients that could be better served in the community.

Nursing homes will play a key role in providing care to dually eligible patients in a fully integrated environment. Capital investments in the state's nursing home facilities will be required to ensure a smooth transition to manage care, and preserve access to high quality care and choice for the complex needs of this population. These investments will need to be multifaceted to allow for necessary upgrades in the aging capital stock (at least 20 percent of the state's nursing homes were originally constructed before 1971), support investments which were approved by the state's CON process (i.e., "legacy capital"), facilitate maintenance and upgrades and help financially challenged nursing homes access the credit markets.

One critical concern nursing homes have about the move to managed care is capital funding. FFS has historically reimbursed homes for capital investments made with state regulatory (Certificate of Need - CON) approval. Nursing homes fear that when managed care becomes mandatory, these past capital expenditures will put them at a competitive disadvantage by providing plans and incentive to drive utilization to lower price homes.

One approach to address these concerns would be to seek either a change in or a waiver from the federal regulation to 42 CFR § 438.60. This regulation effectively precludes payments to providers for services provided under a Medicaid managed care contract, unless: (1) there is an exception in the Medicaid statute; or (2) the state has adjusted its capitation rates to make separate payments for graduate medical education.

The revision or waiver to 42 CFR § 438.60 would be intended to carve nursing home Medicaid capital reimbursement out of Medicaid managed care plan benefits and capitation payments, and require that such amounts continue to be reimbursed directly to providers. For this purpose, the state would adjust the actuarially sound capitation rates to account for the capital cost payments to be made on behalf of Medicaid managed care enrollees residing in nursing homes, not to exceed the aggregate amount that would have been paid for capital costs under the approved State Plan.

A major advantage of this approach is that it would maintain capital cost reimbursement of legacy assets without any added cost, thus preserving available waiver resources for other MLTC preparation activities. If the state is unsuccessful in securing approval of the payment waiver, the Department could develop, in consultation with stakeholders, a regional price for capital. MRT waiver dollars would then be used to provide transitional assistance to homes that are above the price. This assistance would provide a "glide path" to managed care by maintaining legacy investments, providing an infusion of needed capital for homes with rates that are now below the price and assist financially challenged homes.

2) Capital funding for Assisted Living Programs – Increasing Capacity

New York has a Medicaid funded Assisted Living Program (ALP) that serves as a residential setting for persons who are nursing home eligible but can be served in a more home- like and less institutional setting. The current program lacks any dedicated capital funding stream. In order to provide a wider range of options for people in need of long term care residential care, the state has slated the program for a dramatic expansion in the next 3 years. In 2014 this service will also be included in the benefit package of both Mainstream Managed Care and Managed Long Term Care Plans. In order to support this effort to allow individuals in community-based residential setting, improve satisfaction and save money waiver funding would be used for one time investment in new assisted living program slots. The state has initiated a process to expand program slots, and only new slots will access the support for capital. The waiver funding will be front loaded over the first three years with $50 million for years one and two and $25 million in year three.

3) Expand New York Connects - Improving Satisfaction

Transforming long term care delivery and achieving true integration is going to require enhanced communication, community outreach and training for members, their families, providers and advocates. New York is going to need "boots on the ground" across the state to help facilitate these significant changes. New York has a severely under-funded system of Aging and Disability Resource Centers (ADRCs) – called New York Connects – which are ideally suited to support the need for information and assist in the transition to managed care. Additionally, the Affordable Care Act (ACA) and the MRT also provide unprecedented opportunities for the aging services networks. The increasing need for long-term care services, due to the impending dramatic shift of individuals over the age of 65, combined with the number of disabled adults and children with impairments, demands innovative policy and programs. NY Connects, a federally endorsed Aging and Disability Resource Center is positioned to provide locally accessible, consumer-centered access points that provide comprehensive information about long term care options and linkages to services. It is presently is operational in 54 counties. Additional funding will be needed to expand the program into the New York City metropolitan region as well as four upstate counties where the program is not currently available.

New York Connects sites will also help reduce Medicaid expenditures by providing counseling to individuals and families regarding their long term care needs so that they can stay in their homes and actually stay off Medicaid. In addition the use of a front end will enhance the state's ability to access satisfaction data directly from consumers, a much needed component of the long term care delivery system. ADRCs have been successful in other states and with a relatively modest investment through the waiver New York could see comparable benefits. The waiver funding needed to support the start up for expansion and enhancement of New York's ADRC capacity over the five year period is $10 million the first year and $18.4 million for the remaining four years. Allocation of this funding will be based on the population of aged and disabled individuals by region.

4) Quality Improvement Program – Assuring Positive Outcomes

The move to managed long term care and full integration for duals places a great deal of responsibility in the hands of health plans. While New York is confident its current plan partners as well as new partners that will emerge will be successful, there is a need to ensure that the plans are in fact fulfilling the Triple Aim. With an investment of waiver funding the state will contract with an outside vendor to assist in monitoring plan activities during the implementation of mandatory managed long term care and the duals demonstration. This vendor will act beyond the state's enrollment broker's relationship to plans and the state's External Quality Review Organization (EQRO). It will closely monitor both plan behavior and the actions of the plan's network to ensure that members are getting the most cost-effective services possible during this important period of transition. The waiver funding needed for this activity will be $3 million annually for the five years of the waiver – the time frame covering the statewide implementation of mandatory managed long term care and the proposed dual demonstration.

5) HIT - Supporting Delivery System Integration

New York has high expectation for plans and their networks to be responsible for managing the complete needs of dually eligible members. During implementation of mandatory managed long term care, plans will be required to report more information about their members, provide real time assessment data in a uniform assessment system, and assure that the information to and from its network providers in accurate and reportable. In addition, within the proposed duals demonstration, plans will be expected to expand this effort to encompass all Medicare data and services. Plans, especially community-based not-for profit partners, will find it difficult to fund the HIT systems necessary to achieve the state's full vision.

The need for investment in HIT for long term care has been identified at all levels of the health delivery system. An investment of waiver funds is needed to address the HIT challenges facing plans and network providers to fully integrate so that care management can be realized, clinical integration and collaboration across the continuum can occur, and payment aligns with desired outcomes. The investment for the level of improvement needed is over the waiver period allowing the state to prioritize investments.

Year one will be a ramp up with $25 million to focus on systems enhancements related to supporting Plans and providers to adopt the Uniform Assessment System – NY (UAS-NY) with funding for hardware, access to this architecture build by the State and assure connectivity for Plans and providers to share information across the already established Regional Health Information Organizations (RHIOs); year two will increase to $50 million to expand these efforts to network providers; and $37.5 million for each of the remaining three years to focus on components such as community-based network members and other integrations. Funds, hardware and systems will be synchronized with those requested under the health home program to leverage existing capabilities, the new Health Home capabilities and the State's vision for HIE.

6) Ombudsperson Program –Supporting Choice

Even with investments in ADRC's and significant plan oversight, there will be situations in which members need assistance to understand their benefits, advocate for themselves related to the quantity and/or quality of service they are receiving from plans, and access a resource for information. New York seeks to create a statewide Ombudsperson Program that will assist members who are concerned or unhappy with the quality of service they are receiving from their plans. The aim of this effort is anticipated to reduce grievances and appeals and ensure that members have an independent and knowledgeable voice that can help them. The state would seek to replicate a similar program currently in operation in Wisconsin, and would look for a single statewide contractor who would use subcontractors across the state to ensure sufficient coverage and personalized attention for members. This investment recognizes that savings from Medicaid should be reinvested in approaches that enhance the members' participation in their care and supports a higher degree of consumer satisfaction in significant and perhaps frightening change from the FFS delivery system. The ramp up of such a program would require a year one investment of $3 million and then to maintain the investment through the transition phase an additional $5 million for each successive year.

IMPACT ON OVERALL MEDICAID SPENDING

The move to mandatory managed long term care is one of the most transformative reforms in the MRT action plan. In recent years, FFS long term care services have been the number one cost driver in the program. Moving to managed care in this important area will save money and improve patient outcomes. Also, thanks to the Duals Demonstration New York will take a further step by moving to fully integrated managed care for dually eligible members by adding the Medicare benefit to the managed long term care plan contract. A recent analysis by a respected actuarial firm found that if New York were to implement fully integrated managed care for all duals Medicare and Medicaid could save a combined $1 billion per year. The initiatives funded through this program will help smooth the way to successful implementation of managed long term care and the further effort to fully integrate managed care for duals.

MRT Reinvestment Program
Capital Stabilization for Safety Net Hospitals

BACKGROUND

Hospitals in New York have developed as the hub of health care delivery in many communities. In underserved, inner-city communities and in areas that are geographically isolated, the hospital is the health care delivery system. In developing recommendations for transforming the Medicaid program the MRT recognized the importance of preserving and strengthening safety net providers that are essential to preserving access to care in their communities. Of particular focus were providers with high proportions of Medicaid and uninsured patients and providers that serve more remote populations and are the sole source of care in their communities. These are truly the "safety net". The importance of the safety net will increase as New York adds over one million uninsured New Yorkers to its insurance rolls through the new Health Insurance Exchange.

Many safety net institutions have limited financial resources to respond to the call for change and while access t o capital for not-for-profits is problematic across the country it is almost non-existent for the safety net in New York State. Moody's has characterized the non-profit health care environment in 2012 as challenging and identifies some of the following as reasons:

- Increased need for capital relating to plant modernizations and IT;
- Greater limitations on access to capital due to wider credit spreads for lower rate credits;
- Cost of compliance with changing regulatory environment along with new requirements from health care reform;
- Increased reimbursement pressures;
- Large unfunded pension liabilities;
- Diminished benefits for tax exemption[16]

Most of these factors are present in New York State and they present even greater challenges for safety net hospitals, particularly those that are weak financially or even insolvent. Many of these providers have to make choices every day as to whether to fund medical malpractice or meet payroll or pay vendors. Some have even experienced disruptions in day to day operations as vendors, even food vendors, abruptly ceased service due to delays in payments. This prohibits meaningful participation in development of clinically integrated delivery systems in communities that are in clear need of improved population health.

[16] Moody's Investment Service

New York State has a number of safety net hospitals in this situation and while there are well defined specific problems in the downstate areas, particularly in Brooklyn, there are other providers in rural and even some suburban areas of New York with comparable financial constraints.

Hospital margins in New York are well below national benchmarks. In 2010, the median margin for all hospitals in the state was roughly break even, while the margin for hospitals with Medicaid patient loads in the highest quartile was negative 1.3 percent, and the margin for New York's rural hospitals was negative 0.3 percent.[17] The median numbers of course do not tell the full story: more than a dozen hospitals have margins worse than negative 10 percent.

When the analysis is focused on hospitals that derive more than 30 percent of their net patient revenue from Medicaid, excluding disproportionate share hospital (DSH) payments, all measures of financial operating strength, liquidity (cash availability), and balance sheet viability are exponentially worse. In fact, the federal government's own hospital mortgage insurance program though the Federal Housing Administration (FHA) would classify these hospitals as risky based on underwriting benchmarks.

***	NY Medicaid-Dependent Hospitals*	Other Hospitals	All Hospitals	National Benchmark**
Financial Condition				
Operating Margins	-3.2%	1.9%	0.6%	3.0%
Total Margin	-2.9%	2.2%	0.9%	N/A
Current Ratio	1.34	1.57	1.48	1.75
Equity Financing Ratio	12%	27%	24%	30%
Quality				
% of Patients Reporting Best Experience of Care	53%	58%	57%	
Medicare Risk-Adjusted Readmission Rates	24.5%	22.8%	23.1%	

* Medicaid-dependent hospitals consistently derive more than 30% of their net patient revenue from Medicaid, not including Medicaid DSH payments. There are 36 general, acute care Medicaid-dependent hospitals in New York, 24 voluntary and 12 public. ** Benchmarks are thresholds used by the FHA in designating applicants for hospital mortgage insurance as low risk. *** Financial measures are 2008-2010 averages; quality measures were derived from the May 2012 release of Hospital Compare, the hospital performance web site maintained by the Centers for Medicare & Medicaid Services in the U.S. Department of Health & Human Services. Data provided by Greater New York Hospital Association (GNYHA).

While financial viability—or lack thereof—impairs a hospital's ability to sustain access in needy communities, it also can influence quality and outcomes. This is illustrated by the two composite quality measures in the chart above. The patient experience of care measures include several that are influenced by facility age and condition, including the general level of noise and cleanliness, and the patient's overall experience of care. New York's Medicaid-dependent hospitals score materially lower than other hospitals.

[17] Data provided by Healthcare Association of New York State (HANYS)

The risk-adjusted readmissions measures reflect not only how well the hospital handles transitions in care, but also whether the hospital can intervene to help patients with poor access to community-based care or social needs, such as unstable housing or limited English proficiency. Again, New York's Medicaid-dependent hospitals score worse than other hospitals.

In 2011, a MRT Brooklyn Work Group, convened by NYS Health Commissioner Nirav Shah, studied the borough of Brooklyn and determined that excess inpatient capacity, high levels of debt, lack of meaningful primary care alternatives, and weak governance had led to several failing hospitals and extremely poor health outcomes for many Brooklyn communities.
(http://www.health.ny.gov/health_care/medicaid/redesign/brooklyn.html)

The recommendations of the Brooklyn Work Group were to consolidate hospitals and develop meaningful outpatient capacity under strong leadership and governance. In order to accomplish this transformation, capital investment is required to restructure balance sheets and to invest in the creation of outpatient capacity in the target neighborhoods. The obstacle to such changes posed by deficient safety net hospital balance sheets is illustrated by data for the 10 hospitals assessed in Brooklyn which shows that four had balance sheets with negative net assets, meaning that they carried more liabilities than assets. This coupled with negative operating margins signified no ability to retire old liabilities and accrue a positive fund balance for capital investment. In fact, one hospital carried a negative net asset figure of $285 million in 2011.

As a part of the regional planning component of this waiver application, the type of assessment done for Brooklyn hospitals will be conducted in other targeted parts of the state and investment is proposed for selected safety net hospitals that both demonstrate meaningful integration with other providers and have developed plans to improve community health outcomes and reduce health disparities.

In developing the Capital Stabilization program, the state actively solicited feedback from a multitude of stakeholders and worked to ensure that hospital stakeholders in particular weighed in on the initiatives that should be included in the 1115 waiver. To outline the state's approach and solicit feedback, public hearings and webinars were conducted for all stakeholders, including the general public. The Healthcare Association of New York State (HANYS), Greater New York Hospital Association (GNYHA), and member advocacy organizations were among the stakeholders that provided input into how waiver funds should be invested, and their comments are reflected throughout this document.

PROGRAM DESCRIPTION

New York State plans to invest $1.7 billion over the next five years to transform, preserve and strengthen safety net hospitals which are essential to preserving access to care in communities all across New York. Provided below is a description of how these funds will be used. A more detailed breakdown is provided in the MRT Expenditure Plan section of this document.

Capital investment is required for safety net hospitals to play a meaningful role in reshaping the delivery systems in their communities. The successful partnership between the state and federal government through the HEAL/FSHRP program demonstrated this with $3 billion dollars in shared capital investment for the State's health delivery system. Much of it served to downsize acute care capacity at the state's nursing homes and hospitals and to support unprecedented investments in health information technology over an 8 year period. When completed in 2014, altogether the partnership will have invested $1.6 billion in restructuring and closing of facilities, $400 million in long term care, and $400 million in information technology infrastructure. Additionally, it began investment in much needed development of primary care to sustain the changing delivery system.

Unlike the longer-term HEAL/FSHRP program, this program is a short term infusion of funding to meet the objective of facilitating long term structural sustainability. New York State safety net providers are, by definition, ill prepared to participate financially in transformations/network development and yet are well positioned to make meaningful progress in changing models of care for our most chronically ill and underserved populations and communities. Capital investment will be needed in a number of different forms and should serve as leverage for other investors, including traditional debt markets (tax exempt bond programs) and private equity interests. Indeed, "there is significant capital available and being deployed by for profit health care companies, both publically (sic) traded and privately owned, principally funded by private-equity firms" [18] New York State law continues to prevent publicly traded corporations from operating hospitals, but there are many innovative models that can explored within the current statutory framework and perhaps as part of a demonstration project.

The requested waiver funds will be made available in conjunction with a hospital's work with a regional planning body to discern where and how it can contribute to regional health care delivery and improved community health. Preference will be given to applications that are supported by regional planning organizations. The state proposes to use federal funds in three separate program categories.

[18] "The Capital Challenge", Frederick Hessler, Managing Director, Citigroup Global Markets Inc

It is expected that applicants may submit requests in any or all categories:

1) **Technical Assistance to Safety Net Hospital Boards ($10M average annual)** This program will provide technical assistance to hire experts, including independent strategic planners, to advise safety net hospital boards on alternatives and strategies for positioning their institutions in a sustainable, albeit, new role in the delivery system of the future. Funds will also be made available for the purpose of hiring restructuring management to assist hospital boards in implementation.

2) **Transitional Capital ($125.2M average annual)** Further investment for "bricks and mortar" and health information technology will allow safety net hospitals to participate in new delivery models once determined. This can include investment in critical infrastructure, such as HVAC systems, and will include capital to renovate/repurpose inpatient capacity to improve the patient's experience of care. This capital will also support development of outpatient capacity and physician alignment.

3) **Balance Sheet restructuring ($209M average annual)** This program will solicit and fund grant opportunities to support balance sheet relief. Relief will assist safety net hospitals in partnering with other providers to develop new models of delivery, including mergers and consolidations that will support further downsizing of acute care beds, development of alternate care models (FQHCs and clinics, urgi-centers, physician organizations). These funds could also assist closure and/or new integrated delivery models for a safety net hospital, in favor of alternate service delivery providers under the auspices of a regional acute care provider, such as an academic medical center.

   This funding is essential to give safety net hospitals the opportunity for thoughtful reconfiguration, to avoid precipitous hospital closures in high need communities, and to prevent significant disruptions in access for Medicaid patients. As discussed in the background, there are a number of hospitals on the brink of failure with significant balance sheet liabilities at this time. There is a compelling need for immediate funding beginning in early 2013.

IMPACT ON OVERALL MEDICAID SPENDING

The investment should lead to reduced Medicaid expenses in these regions due to reduced inpatient capacity and treatment in more appropriate, lower cost settings. Additionally, Medicaid will be saved the cost of abrupt hospital closures. There will also be a direct Medicaid fee-for-service reduction in capital reimbursement to the degree that capital debt liabilities are reduced.

MRT Reinvestment Program
Hospital Transition

BACKGROUND

New York State hospitals, along with other providers and payors, will be critical drivers of the delivery system changes required by the Affordable Care Act (ACA). These changes are intended to advance population health management with the goal of improving the overall health of the population and the patient experience of care (including quality and satisfaction) while at the same time reducing the per capita cost of health care. The work of the MRT focused on how to meet the Triple Aim objectives within the New York State Medicaid program and established the priorities for future program policy. The ACA and MRT reforms will require hospitals to develop new financial and business models that are drastically different from today's model where reimbursement systems largely incentivize providers to focus on the volume of services they provide rather than service efficacy.

Historically, hospitals in New York have developed as the hub of health care delivery in many communities and consequently, the resources and capacity for both inpatient and ambulatory care were developed as part of the hospital campus and incorporated into the business model of the hospital. In many areas, particularly those that serve rural geographies, and large numbers of uninsured and Medicaid members, the hospital is the health delivery system. In fact, for the Medicaid population, hospitals can be the sole provider of care in the community, even for primary care services. Based upon a review of utilization data, the vast majority of the clinic visits provided to New York's Medicaid members are provided by hospitals. More than three quarters of the outpatient visits (77 percent) occur at hospital outpatient departments (OPDs). Without the services provided by New York's hospitals, access to primary care for the Medicaid population would be severely compromised.

However, while hospitals are critical to the delivery of primary and specialty outpatient care for some populations, the institutional structure of New York's delivery system is not without consequence. The Brooklyn Workgroup of the Medicaid Redesign Team, convened by NYS Health Commissioner Nirav Shah, observed, "Decades ago, New York State built, funded and supported a big box health care system, dominated by hospitals, and fostered a regulatory and reimbursement environment to oversee and support it. The big box system's importance to the economy has strengthened its ability to resist desirable change and efforts to rein in costs."[19]

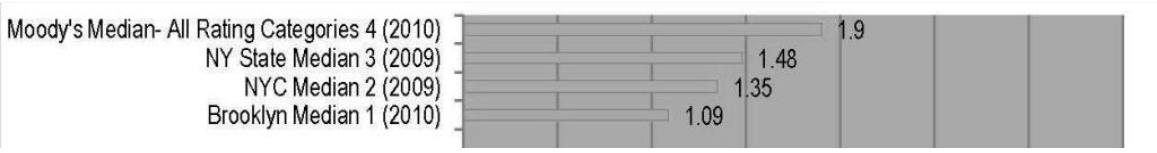
[19] At the Brink of Transformation: Restructuring the Healthcare Delivery System in Brooklyn, Brooklyn Health systems Redesign Work Group, 2011

This construct has led to an expensive delivery system, which at times, encouraged inappropriate visits to hospitals and emergency rooms with less focus on promoting good preventive care and/or improved community health outcomes. In fact, the state ranks 18th (it was 24th in 2010) out of all states for overall health system quality and ranks 50th among all states for avoidable hospital use and costs. Hospital readmissions are a particularly costly problem for New York.

A report issued by the New York State Health Foundation found hospital readmissions cost New York $3.7 billion per year, with nearly 1 in 7 initial hospital stays resulting in a readmission. Many of these readmissions are the result of poor access in the community to follow up care, mental health and substance abuse co-morbidities that impede compliance with treatment regimens and lack of social support services.

At the same time, New York State hospitals have both financial and liquidity indicators well below the national averages, with some providers in economically challenged communities struggling for financial survival. In 2010 median operating margins for hospitals in New York State were break even at best and hospitals with Medicaid patient loads in the highest quartile ran an average operating margin of negative 1.3 percent. New York's rural hospitals had a total operating margin of negative 0.3 percent.[20] Liquidity, which is key to enabling investment for reform, remains challenging for New York hospitals lag significantly behind national median ratings and in certain regions of the state liquidity is particularly problematic.

Current Ratio—measuring liquidity[21]



Hospitals are necessary partners and/or leaders in developing new clinically integrated, health care network delivery systems and right sizing the number of inpatient hospital beds for their communities.

It is clear that in New York State transition funds will be necessary to support hospitals in developing new integrated delivery systems designed to promote clinical integration and improved quality and outcomes. An assessment of the future of hospitals in the new integrated delivery system states "the hospital will have to be more than a hospital alone." [22]

[20] Data provided by HANYS and GNYHA
[21] At the Brink of Transformation: Restructuring the Healthcare Delivery System in Brooklyn, Brooklyn Health systems Redesign Work Group ,2011
[22] Integrated Delivery Networks: A Detour On The Road To Integrated Health Care?, Lawton R. Burns and Mark V. Pauly Health Affairs, VOL. 31| NO. 7, July 2012

Transition funding will provide for such areas as capital investment in expanded health information technology, primary care/outpatient services linked to acute care bed reductions, workforce retraining, and developing networks to provide the full continuum of care and to focus on services necessary to reduce potentially preventable admissions and readmissions.

The state actively solicited the feedback of a multitude of partners and worked to ensure that hospital stakeholders in particular provided feedback on the initiatives that should be included in the waiver amendment application. Public hearings were held and webinars were conducted and open to all stakeholders, including the general public, to outline the Department's approach and request feedback. The Healthcare Association of New York State (HANYS) and the Greater New York Hospital Association (GNYHA) were among the stakeholders to provide their opinions on how waiver funds should be invested and their comments are reflected throughout this document.

PROGRAM DESCRIPTION

New York State plans to invest $520 million over the next five years to transform New York's hospitals into highly effective integrated delivery systems. Provided below is a description of how these funds will be used. A more detailed breakdown is provided in the MRT Expenditure Plan section of this document.

This program will provide funding for transitional plans for development of future integrated delivery systems. Funding will be directed to enable hospitals to become active partners in shaping future healthcare network delivery systems. It will support development and execution of plans that are targeted at elements associated with the health system of the future:

- Organizations with sufficient size to take advantage of economies of scale
- Fully integrated provider network and responsible for community health outcomes;
- A primary focus on quality and service outcomes
- Significant support from well developed health information technology
- Operational flexibility and nimbleness in resource allocation;
- Progressive governance and management oversight [23]

An annual average of $104 million will be used for technical assistance for plan development and short term financial assistance (up to three years) for hospital plans that are focused on transitioning from a hospital delivery system based upon a "volume" driven business model to that of an "outcome based" integrated delivery system model. The plans will have established metrics to address population health outcomes and include participation of non-hospital providers, including physicians, nursing homes, clinics and home health agencies.

[23] "The Capital Challenge", Frederick Hessler, Managing Director, Citigroup Global Markets Inc.

Funding will be available for technical assistance to support hospital planning with the support of independent strategic planners as well as implementation of plans. Each hospital plan must address a future care delivery model that includes:

- expanded networks of services focused on population health management with emphasis on prevention and wellness;
- expanded access to primary care and social support services in the community;
- participation in the Medicaid Health Home program to assure improved care coordination;
- use of health information technology to better inform care at the point of service and enable analysis of and action on metrics for patient centered outcomes and community health improvement and elimination/reduction of health care disparities;
- demonstrated leadership; and
- initiatives to reduce avoidable hospital admissions or preventable readmissions and inappropriate emergency room utilization.

Preference will be given to applications that are supported by regional planning efforts and/or organizations. Significant additional consideration will be given to plans that demonstrate informed and involved governance and inclusion and support of financially distressed safety net and vital access providers in the development of future delivery system.

IMPACT ON OVERALL MEDICAID SPENDING

The investments in assisting New York State hospitals to either create or become a part of new integrated delivery systems are expected to decrease expenses for medical costs, including Medicaid, in a number of ways. The new business arrangements will allow for hospitals to participate more fully in proven models of expense reduction and improved patient outcomes.

Traditional models of integrated delivery systems have shown that mere structural integration does not in and of itself provide improved outcomes or improved financial performance. It is noted that financial and process alignment between network members are equally as important. There are also newer constructs (some of which are highlighted in other waiver request categories) that have promise and have demonstrated cost savings. These include:

- Customized integration and disease management**;**
- Co-location of care.
- IT-integrated health care
- Patient-integrated health care.[24]

[24] Integrated Delivery Networks: A Detour On The Road To Integrated Health Care? ,Lawton R. Burns and Mark V. Pauly Health Affairs, VOL. 31| NO. 7, July 2012

MRT Reinvestment Program
Ensuring the Health Workforce Meets the Needs in the New Era of Health Care Reform

BACKGROUND

State and federal health reform efforts that place increasing emphasis on development of a sufficiently sized and adequately trained workforce is crucial to achieving the goals of transforming the health care delivery system to achieve the Triple Aim. While New York State spends more on health care than any other state, it has the highest rate of avoidable hospitalizations and is in the 'middle of the pack' in terms of overall quality of care, based on standardized national measures. This poor performance is, in part, attributed to the fact that many patients, particularly those who are the most complex and costly, are not well-connected to primary care, a medical home, or a coordinated care setting.

The ACA provides opportunities to transform the health care delivery system, addressing isolated care delivery structures and lack of systemic care coordination through implementation of new models of integrated care delivery. Healthcare organizations across New York State have begun creating access to high quality primary care and providing comprehensive care management through the National Quality Committee on Assurance (NCQA) Patient-Centered Medical Homes (PCMH) and intensive care management systems for complex populations that are essential components of a lasting solution.

Healthcare providers in New York State have determinedly pursued NCQA PCMH accreditation making New York State the nation's leader in the number of providers and practices recognized as a PCMH. Currently approximately 1.8 million Medicaid members receive their primary care in a PCMH (mostly NCQA Level 3), representing over 5,000 clinicians and 460 discrete practices. Similarly, the New York State Department of Health (NYS DOH) actively encouraged healthcare providers to apply for New York State Health Home designation consistent with the goals of the ACA. With approximately fifty-five Health Homes, there will be a health home serving every county in the State. Each Health Home "network" is required to include a broad range of mandatory provider capacities including medical, behavioral health, HIV, housing and wrap around services all integrated with HIT capabilities and reporting through a single point of accountability for the patient.

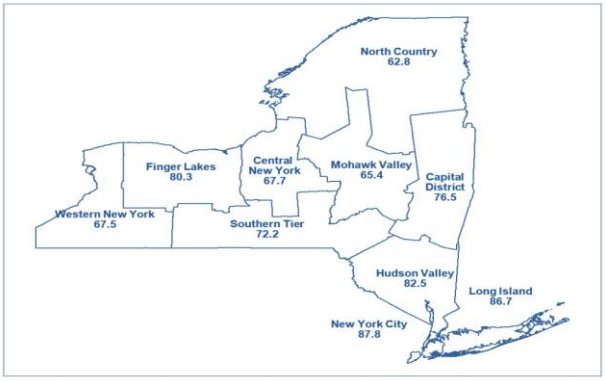
A fundamental challenge that these providers face is assuring an adequately sized and well trained health workforce for the transformed health care delivery system. New York faces a substantial mal-distribution of primary care physicians with most upstate regions having much lower numbers of primary care physicians per capita than downstate regions.

See Figure 1 for the number of physicians per 100,000 population by region. Approximately 450 full time equivalent primary care physicians are needed statewide to minimally address unmet need in Health Professional Shortage Areas. However, New York also has a substantial mal-distribution of primary care physicians. During 2010, health care providers across the state reported recruitment and retention difficulties for a wide array of professions and occupations; for example:

- Hospitals statewide reported difficulty recruiting and retaining clinical laboratory technologists. They also reported that recruitment was problematic for health information technology staff, including analysts and program managers, as well as medical coders. In half of the state's regions, hospitals also reported difficulty recruiting pharmacists, with the Hudson Valley and the North Country regions reporting the most difficulties.
- Hospitals, nursing homes, and home health agencies all reported difficulty recruiting experienced registered nurses (RNs). Nursing homes and home health agencies also indicated that the retention of both experienced RNs and newly-trained RNs was problematic.
- New York's nursing homes and home health agencies statewide reported difficulty recruiting occupational therapists, physical therapists, speech language pathologists, dietitians/nutritionists, and respiratory therapists.
- Community health centers reported difficulties recruiting dentists, geriatric nurse practitioners, and psychiatric nurse practitioners.

More recent evidence suggests growing need to train healthcare care workers in two additional areas including: training personnel care attendants to become home health aides with a focus on care coordination and training of assistive personnel in care coordination, health coaching, patient navigation and chronic disease management.

Figure 1: Number of Primary Care Physicians per 100,000 population in New York[25]



[25] Center for Health Workforce Studies. 2009.

Another major challenge that New York State's providers face is ensuring that their workforce is flexible enough to adapt to the changing roles that are required with the implementation of Health Homes, PCMH and Accountable Care Organizations including, but not limited to, the need to provide more patient-centered coordinated care in community settings. With the passage of the Affordable Care Act and establishment of Governor Cuomo's Health Exchange, an additional estimated one million uninsured New Yorkers will have access to health insurance for the first time and as a result, there will be a surge in demand for health workers in primary care.

Recognizing the need to further develop New York's health care workforce, the MRT established a Workforce Flexibility/Scope of Practice Workgroup to develop a multi-year strategy for developing an adequately prepared workforce to ensure that the future health care needs of the State's population are met. The MRT adopted a series of proposals aimed at:

- Removing statutory and regulatory barriers to implementing a full scope of practice for various occupations across the care continuum;
- Allowing assistive personnel with training and supervision to assume more responsibilities; and,
- Supporting the development of career ladders.

A number of proposals that are described herein incorporate many of the concepts included in the recommendations of the MRT Workforce Work Group recommendations. Federal funding is needed under this MRT waiver amendment to systematically grow and develop the health care workforce in two critical areas: (1) expansion of the workforce retraining initiatives; and, (2) creation of new recruitment and retention initiatives.

Funds will be used to train additional providers to allow New York State to better address the goals of the Triple Aim, to prepare for the increased demand for services resulting from the implementation of ACA, and to focus on re-training the existing workforce in emerging models of collaborative care, work in interdisciplinary teams and maximizing utilization of Health Information Technology (HIT). Funding will be directed to organizations capable of providing appropriate workforce training across the care continuum.

Funds will be used to train health workers to care for high need and vulnerable populations in order to improve health and healthcare and lower healthcare costs among Medicaid, Dual Eligibles, and CHIP beneficiaries that have complex medical, behavioral, and long-term care needs that inappropriately drive up utilization and the cost of care.

PROGRAM DESCRIPTION

New York State plans to invest $500 million over the next five years to develop and implement a multi-year strategy that ensures that New York has the health care workforce that allows the stateto achieve the Triple Aim. Provided below is a description of how these funds will be used. A more detailed breakdown is provided in the MRT Expenditure Plan section of this document.

1) Health Workforce Retraining Initiative (HWRI) – Over the past decade, New York Statehas provided hospitals, nursing homes, home care agencies, educational institutions and unions with funding to train health industry workers. This state-funded program was targeted to health care shortage occupations or workers that needed new skills in order to maintain current employment or avoid displacement. Much of the funding was invested in the training of: nurses; technologists; technicians; therapists; and front line workers in home care, long term care and mental health. Substantial investment was also made in the areas of computer skills, health information technology, foreign language interpretation, substance abuse, disaster readiness and customer service**.** However, with the passage of the Affordable Care Act, the development and promotion of PCMH and health homes, ACOs, and integrated delivery systems, there is an increased need for more coordinated, culturally sensitive, patient centered care. Healthcare workers should reflect the demographics of the population that they serve and understand the cultural sensitivities of their patients, to eliminate communication barriers between provider and patient. As a result, workforce training efforts must evolve to address these needs.

Redesigning and expanding HWRI in the following ways will help New York State better adapt to this changing landscape and better meet the evolving needs of both providers and patients. These initiatives address reductions in health disparities by focusing on the placement of health care workers in medically underserved communities. In addition, these initiatives address training of needed workers to care for currently uninsured populations who tend to either not seek care at all or minimally on an episodic basis, will seek care under ACA's expansion of insurance coverage. Last, several of the initiatives specifically address expanding diversity and enhancing cultural competence of the workforce.

1a) Workforce Development for Patient Centered Medical Homes and Health Homes: An essential component of assuring success in New York's transition to PCMH and Health Homes involves training existing and new workers in emerging models of collaborative, interdisciplinary and team-based care. Waiver funding is requested to expand upon state Health Workforce Retraining Initiative funds to retrain the workforce in hospitals, federally qualified health centers, and home care agencies, to gain the skills required to realize the goals of expanding PCMH and Health Homes in New York State.

For example, funding will be used to support training and re-training for: Transitional Care Managers (TCMs) to focus on the more comprehensive and multi-disciplinary nature of health home jobs; Nurse Assistants (NAs) and Certified Nurse Assistants (CNAs) as medical assistants; Registered Nurses (RNs) and nutritionists as certified diabetes educators; Medical Assistants (MAs) and Licensed Practical Nurses (LPNs) as health coaches; training social workers and RNs as System Navigators; MAs, LPNs, community health workers as care coordinators; and the Health Information Technology workforce. Waiver funds will be used to train and retrain workers across all health care settings in the effective use of electronic health record (EHR) and other health information systems technology as it is expanded statewide. Training would target end-users of EHRs, as well as help desk support staff and data analysts.

1b) Workforce Development for Long-Term Care: Expanding home care and respite care enables those in need of long term care to remain in their homes and communities while reducing New York's Medicaid costs associated with long term care. By training personal care attendants to become home health aides, and training home care workers to assume new roles in care coordination, the New York State Medicaid program would have increased workforce flexibility and lowered costs under managed care. Waiver funds would also be used to complement and reinforce existing State workforce development efforts under its Medicaid Redesign Team to develop stackable credential career pathways for advanced aide positions in both home care and long-term care.

1c) Training the Health Workforce in Culturally-Competent Patient Centered Care: Health care workers at all levels need specific training on what it means to work in a system where patients are increasingly diverse, and have a myriad of social and economic problems that contribute to poor health. A retooled Health Workforce Training Initiative will support training initiatives that focus on sensitizing the care management team to cultural differences among patients that may impact patient willingness to access services and accept and follow treatment regimens. In addition, training will educate providers on the benefits of a culturally diverse workforce reflective of their patient population.

1d) Interdisciplinary Education and Training: There is evidence that interdisciplinary team based care can have positive impacts on quality, cost and access to care. It is critical to support the development of interdisciplinary education and training in order to prepare the health workforce to function effectively in new and emerging models of care that are team focused. Waiver funding would be used to support the development of interdisciplinary education and training that include both professionals and the local public health workforce, as well as assistive personnel.

1e) Promoting Labor-Management Partnerships: Research has shown that unit-based teams where workers and their managers problem solve day-to-day care delivery challenges together have been used in New York and around the country to achieve better care and reduce costs.[26] Funds are requested for retraining of health personnel, as part of multi-disciplinary teams, to determine priorities and direct change initiatives in the areas of data analysis, understanding health care operations, performance improvement methodologies and problem solving, all essential to implement effective change at the institutional level.

1f) Building Health Care Career Ladders: Given the persistent problems recruiting and retaining a wide array of health professions and occupations increased support is proposed for building career ladders in shortage occupations in order to attract qualified candidates and provide support for career advancement. Existing workers can be retrained, or new workers can be trained to become health care workers in critical shortage areas (i.e. lab technicians to laboratory technologists and associate degree RNs to Bachelor of Science nurses).

2) Recruitment and Retention Incentives for the Underserved Initiatives

There are approximately 2.3 million New Yorkers who are identified as "underserved" for primary care services in New York's 99 primary care HPSAs[27]. According to the federal Office of Shortage Designation, 450 full-time equivalent (FTE) primary care physicians would be needed to remove all primary care shortage designations in New York, but over 1,100 primary care physicians are needed to achieve the desired 2,000:1 population to primary care provider ratio in all shortage areas.

Maximizing workforce funding opportunities through the sub-initiatives listed below will encourage a larger number of qualified applicants to serve in these underserved primary care areas and would ensure better access to primary care services statewide.

[26] See http://www.ilr.cornell.edu/news/upload/How-Labor-Management-Partnerships-Improve-Patient-Care-Cost-Control-and-Labor-Relations.pdf
[27] As of June 28, 2012

2a) Expand Doctors Across New York: The Doctors Across New York (DANY) program is a set of state-funded initiatives enacted in 2008 to help train and place physicians in a variety of settings and specialties to care for New York's diverse population.

- The Physician Practice Support Program provides up to $100,000 in state funding over a two-year period to applicants who can identify a licensed physician who has completed training and who will commit to a two-year service obligation in an underserved region within New York State. During its first four years of implementation, the Program has placed 101 physicians in underserved areas.

- The Physician Loan Repayment Program provides up to $150,000 in state funding over a five-year period for physicians who commit to a five-year service obligation in an underserved region. During its first four years of implementation, the program has placed 57 physicians in underserved areas in exchange for debt repayment.

As a result of these initiatives, it is anticipated that approximately 200 physicians will be under contract in 2012-13 for the Physician Loan Repayment and Physician Practice Support programs. In addition, funding eligibility would be extended to physicians who are willing to obligate service in a health care facility such as the psychiatric centers operated by the New York State Office of Mental Health, or the Veterans Homes or Rehabilitation Hospital run by the New York State Department of Health.

Expanding funding for the DANY Physician Loan Repayment and Practice Support programs through the MRT Waiver Amendment will allow the state to increase awards to physicians who have agreed to work in medically underserved regions in exchange for a DANY award in the following ways:

- The Ambulatory Care Training Program provides funding to sponsoring institutions to train residents and medical students in ambulatory care sites in order to enhance clinical training experiences in culturally diverse settings, an experience that would benefit physicians throughout their careers. It is anticipated that additional funding to sponsoring institutions will provide clinical training in freestanding ambulatory care sites to approximately 10,000 residents and medical students.

- Create an Incentive Program for Medical Residents to Work in Underserved Areas. This program would provide teaching hospitals with waiver funding to pay enhanced salaries or loan repayment to medical residents who agree to work in a medically underserved community within New York upon completion of their residency training. Medicaid waiver funding would be set-aside for each annual cohort of approximately 100 -200 awardees. There would be a maximum of four cohorts over the duration of this program.

The Diversity in Medicine/Post-Baccalaureate Program is a comprehensive support and enrichment program that provides minority and economically disadvantaged (Under-Represented in Medicine – URM) students with unique opportunities to engage in health care professions beginning in high school and extending through medical school. As a consequence of these experiences, there will be an increase in the number of qualified URM physicians in New York State.

2 b) Expand Primary Care Service Corps (PCSC) Funding: Similar to the Doctors Across New York Loan Repayment program, PCSC is a service-obligated, state-funded[28] loan repayment program developed to increase the supply of dentists, dental hygienists, nurse practitioners, physician assistants, midwives, clinical psychologists, licensed clinical social workers, psychiatric nurse practitioners, licensed marriage and family therapists and, licensed mental health counselors who practice in the State's Health Professional Shortage Areas (HPSAs). Additional annual waiver funding will be used to expand the Corps to enhance the recruitment and retention of these non-physician clinicians in medically underserved areas. In addition, funding eligibility would be extended to additional clinicians such as RNs and to state-run facilities such as the psychiatric centers operated by the New York State Office of Mental Health.

2c) Health Workforce Data Repository: Funds are also requested to establish a Health Workforce Data Repository to support ongoing collection, analysis and dissemination of data on health workforce supply, the educational pipeline, and demand for health workers. In addition, the funding will support a statewide system for monitoring health workforce demand across all health sectors – hospitals, nursing homes, home care, ambulatory care sites (clinics, federally qualified health centers and private practices) as well as local health departments.

Information drawn from the repository and associated research will be used in regional health workforce planning efforts that build collaborations across sectors (health care providers, educators, regulators, etc.) to more fully understand the most pressing workforce needs in a region and to develop regional strategies to address those needs. Data from the repository will be used in analyses of primary care capacity and will be used to identify areas and populations that qualify for federal designation as Health Professional Shortage Areas or Medically Underserved Areas or Populations. Information drawn from the data repository will also be used to support the more effective use of resources for worker training or retraining as well as incentives to attract health professionals to underserved communities. At a time when healthcare systems, and especially Medicaid, are undergoing dramatic change, data and information on the healthcare workforce can contribute greatly to informed decision-making.

[28] It is anticipated that federal StateLoan Repayment Program (SLRP) funds will be awarded in Sept. 2012 as a match for $500,000 in statePCSC funds.

2d) Health Workforce Research: Waiver funding will also support a statewide study to identify and describe the roles, responsibilities, qualifications and training needed for new and emerging job titles across all healthcare sectors as a result of healthcare reform/primary care service growth. Examples of emerging titles include patient care coordinators, patient navigators, and health coaches, among others. A committee of healthcare industry, labor union representatives, and academia, from various regions of the state will be convened to provide direction for the study, review the study findings, and to obtain consensus on the alignment of job titles with credentials for each title studied.

Waiver funding will also be used to support comparative effectiveness health workforce research, which entails a detailed analysis of the content of health care services provided by clinicians to support a better understanding of the comparative effectiveness of different health workforce staffing models. Clearly, data available through electronic health records will be an important resource for these studies. This research will be designed to evaluate the impact of the workforce on new models of care delivery and on healthcare cost, quality, and access.

Waiver funds are requested to convene a commission to study access barriers to oral health services in order to identify the most appropriate strategies (alternatives/feasibility/models/incentives) for expanding the number of oral health providers and productivity in areas of the state and to high need populations that are underserved for oral health. Access to oral health services in the state is uneven, and often results in oral health disparities. Groups at greatest risk for limited access to oral health services include the poor, children, racial/ethnic minorities, the elderly, and residents of rural communities. A small number of the state's dentists treat most of the Medicaid patients who receive oral health services. Over half of New York dentists report no Medicaid patients on their caseloads, while 10 percent indicate that 60 percent or more of their caseloads are Medicaid patients. New York State needs to research and implement a demonstration workforce models to meet the increased oral health demand driven by the ACA.

2e) Regional Health Workforce Information Centers: MRT Waiver Amendment funding would support the development of regional Health Workforce Information Centers that would:

- Provide regional information about health careers and training opportunities. Marketing information and increasing awareness about primary care and allied health careers at primary and secondary education levels is necessary to encourage early health career aspirations among students. Advocating and promoting interest in health occupations as early as possible has proven to be a successful 'Grow Your Own' health workforce strategy in other states. Further, many incumbent workers are interested in learning about opportunities that build on their current training and skills to afford them opportunities for upgrading.

- Provide up-to-date and timely information on current funding streams, healthcare opportunities, and provide real-time data on areas in the region with health personnel shortages;

- Facilitate clinical placements for health professionals in training within the region with emphasis on safety net providers serving high need populations that use interdisciplinary team based approaches to care;

- Assist qualified applicants from the state and federal scholarship and loan repayment programs to secure employment at sites in the region that meet service obligation requirements by maintaining and updating information on current vacancies reported by potential employers in underserved communities across the state.

It is proposed that waiver funding be allocated to fund the Department of Health's efforts to market opportunities related to primary care and allied health careers, as well as incentives to serve in underserved areas under the regional Health Workforce Information Centers. The Department will work closely with its partners in the Department of Labor to ensure that it builds on and complements the functions of DOL's one-stop career centers. It is expected that the Department will use the existing Area Health Education Centers to carry out and coordinate many of the functions described above since several of the state's AHECs are currently invested in some of these activities, particularly the promotion of health careers.

IMPACT ON OVERALL MEDICAID SPENDING

Expanding and refocusing the health care workforce through training/retraining and expanding recruitment and retention incentives for underserved areas may result in increased Medicaid expenditures in the short term (i.e., first 2 years of the waiver), given the surge in newly insured patients under ACA, but will save the Medicaid program in the long term (i.e., over the 5-year waiver period) by:

- Expanding and building upon the healthcare workforce, particularly in those areas of greatest need, to ensure that it is patient-centered, cost-efficient and cost-effective, makes the best use of technology, and is focused on prevention as well as helping those with chronic conditions better manage their health.
- Enhancing provider level cooperation and meaningful improvement in service provision at the point of care through patient-centered medical homes and health homes;
- Reducing provider fragmentation that will reduce service utilization and improve health outcomes; and
- Reducing morbidity and mortality related to preventable conditions, thus reducing preventable hospitalizations and health care costs associated with these morbidities for patients in medically underserved areas.

Specific examples of documented savings directly related to recommendations in this section include:

[Recommendation 1B]: Reducing Medicaid costs associated with home care by training additional home care aides: the California CMMI grant proposal for its California Long-Term Care Education Center (http://innovations.cms.gov/initiatives/Innovation-Awards/california.html) estimated that investing $12 million in CMS grant funds to train 6,900 In-Home Supportive Service (IHSS) as personal and home care attendants (PHCAs) to serve as monitors, coaches, communicators, navigators and care aides, and Integrate the PHCAs into the patient-care team for their clients would achieve 3-year savings of $25 million (Medicaid: $10.2 million; Medicare $14.7 million) by reducing emergency room (ER) visits by 23%; hospital admission from the ER by 23%; and average nursing home length of stay (LOS) by 10%.

[Recommendation 1E]: An effective labor-management partnership can have a considerable impact on the expenditures of a single unit and the bottom line of an entire healthcare organization. Specific cost-savings that resulted from joint work processes include the following:

- $51,000 reduction in overtime wages (Operator Services, San Rafael Medical Center).
- Reduced staff turnover rate from 14 percent in 2008 to 3.9 percent in 2010 (Contact Center, CMO, the Care Management Company).
- Reduced cost per communication contact from $7.62 in 2004 to $4.06 in 2010; (Contact Center, CMO, the Care Management Company).
- Reduced nursing staff turnover and traveling nurse hires (Fletcher Allen Health Care).[29]

[29] http://www.ilr.cornell.edu/news/upload/How-Labor-Management-Partnerships-Improve-Patient-Care-Cost-Control-and-Labor-Relations.pdf, p. iv.

MRT Reinvestment Program
Public Health Innovation

BACKGROUND

Chronic diseases – such as heart disease, cancer, stroke, and diabetes – are responsible for 7 of 10 deaths among Americans each year and account for 75 percent of the nation's health spending. Often due to economic, social, and physical factors, too many New Yorkers engage in behaviors such as tobacco use, poor diet, physical inactivity, and alcohol abuse that lead to poor health.

Actions to prevent chronic disease (such as pre-diabetes interventions) and prevent exacerbations of disease (such as home-based interventions for asthma) will be implemented to promote health and reduce costs. It has been estimated that $100 to $110 billion of New York's $160 billion health care bill goes for hospitalizations, medications, medical treatments, and long-term care for patients with one or more chronic diseases, a group of patients that is expanding rapidly[i]. The growing financial impact of chronic disease on the health care system is pervasive and far-reaching. Examples of the annual cost of chronic disease in New York, attributable to both direct medical costs and lost productivity include:

- **Diabetes — $12 billion**
- **Asthma — $1.3 billion**

To address these challenges, particularly among racial and ethnic minorities, New York State will integrate community-based public health prevention programs into the Medicaid program. These evidence-based strategies will advance New York's efforts to achieve the Triple Aim of improved quality, better health and reduced health care costs. Effective integration of community-based public health as part of the broader health care system inclusive of local health departments and clinical providers will promote population health and reduce systemic costs including Medicaid costs of care and treatment. By concentrating on the underlying drivers of chronic disease, New York will move from today's sick-care system to a true "health care" system that encourages health and well-being.

The proposed initiatives are consistent with the goals of the recently created National Prevention, Health Promotion, and Public Health Council and with New York's State Health Improvement Plan (Prevention Agenda 2013) which prioritizes prevention of chronic diseases; advancing a healthy and safe environment and promoting healthy women, babies and children. Through these complementary initiatives New York seeks to promote health by addressing rising rates of chronic illness, persistent health disparities, and escalating health care costs.[1ii]

Waiver recommendations that will fulfill these goals are: **(1)** evidence-based preventive nurse home visiting services for first time mothers and their children to prevent pre-term births and promote other positive health outcomes; **(2)** home-based self-management education and environmental assessments to improve asthma control, promote health and prevent avoidable emergency room visits and hospital admissions for Medicaid recipients with asthma; **(3)** home visits to promote childhood lead poisoning prevention and treatment for Medicaid recipients; **(4)** pre-diabetes screening and interventions to prevent progression to diabetes and to improve quality of diabetes care among Medicaid recipients; **(5)** water fluoridation to promote dental health for children on Medicaid; and **(6)** quality improvement efforts to address healthcare acquired infections and prevent sepsis.

The proposed efforts will be implemented as demonstration programs and will be closely evaluated for effectiveness. Once tested and proven to improve health care delivery, improve patient outcomes, and achieve cost savings these new models of care will be built into the fabric of the New York State Medicaid program. Several of the initiatives listed below (lead, asthma, diabetes and nurse home visiting) will start by using planning grants to develop ideas, followed by operational dollars made available for only the most promising models as venture capital to facilitate development and evaluation of the selected programs. In addition, a quality pool will be developed as an incentive for providers that exceed quality benchmarks. New York State will use funds from this program to launch new partnerships and test new models of care that could be expanded across the state and country. The savings potential for each of the proposed initiatives is significant.

PROGRAM DESCRIPTION

New York State plans to invest $395.3 million over the next five years to integrate evidence-based public health prevention programs into the Medicaid program. Effective integration of evidence-based public health strategies as part of broader health care system redesign will promote population health and reduce systemic costs including Medicaid costs of care and treatment. Provided below is a description of how these funds will be used. A more detailed breakdown is provided in the MRT Expenditure Plan section of this document.

1) Evidence-based preventive nurse home visiting services such as Nurse Family Partnership (NFP)

Programs delivering nurse home visiting services such as the NFP have demonstrated consistent, rigorous evidence of positive impacts on a wide range of short- and long-term maternal and child health behaviors and outcomes, including but not limited to preterm births, maternal smoking, pregnancy-related hypertension, breastfeeding, child injuries, child abuse and neglect, immunization rates, child development across multiple domains, birth spacing and long term economic self-sufficiency. NFP is a nationally recognized means of achieving improved health outcomes, self-sufficiency and parenting skills and results in reduced health and social service costs[iii].

Evidence Base: Nationally, Nurse Family Partnership (NFP) has achieved the following outcomes:

- Improvements in pregnancy outcomes (including a 79% reduction in preterm births among women who smoke and 35% fewer hypertensive disorders during pregnancy); [2-4]
- Reductions in early childhood injuries (including 39% fewer injuries among children, and a 56% reduction in emergency room visits for accidents); [5-7]
- Reductions in child abuse and neglect by 48%; [8]
- Reductions in childhood emotional, behavioral and cognitive problems (including 50% reduction in language delays of child age 21 months, and a 67% reduction in behavioral and intellectual problems at child age 6); [9-11]
- Increased spacing between pregnancies for Medicaid-eligible women (including a 28-month greater interval between the first and second child, 31% fewer closely spaced subsequent pregnancies, and a 32% reduction in subsequent pregnancies); [12-16]

The data from national studies of NFP and from New York City's First-time Mothers/Newborns (F/TMN) program all demonstrate similar improvements in health outcomes for mothers and their children. Public comments submitted regarding this waiver application support expansion of this evidence-based intervention. Expansion of F/TMN to all of New York State will give all Medicaid-eligible first-time mothers the opportunity for improved pregnancy outcomes.

Implementation: Funding will support evidence based preventive nurse home visiting services for first time mothers and their children up to age two years. Current Medicaid coverage for these programs is limited to Targeted Case Management and is in place in just two localities in New York State (New York City and Monroe County). Waiver funding will be made available for preventive services consistent with the NFP model to enhance access to, and coordination of, health and supportive services necessary to improve birth and health outcomes for high risk women and their infants in six high need areas of New York State. For existing NFP programs, funding will be provided to support the full set of preventive services consistent with the NFP model. In addition, funding will be provided during years one and two for planning and development of six new programs with full program operations envisioned to begin during year three. New York State will work with managed care plans to identify eligible members, coordinate services and document outcomes. During years four and five the programs will be evaluated to determine effectiveness in improving birth outcomes and reducing health care costs. If found to be effective these programs will be continued beyond the waiver period and expanded as appropriate given need, evidenced return on investment and funding availability.

2) Asthma Home Based Services

New Yorkers with asthma often live in environments that can exacerbate their symptoms[2,3], leading to preventable hospitalizations and ED visits. Compared to the nation, New York has higher asthma ED and hospital discharge rates for all age groups[4]. New York State's rates are roughly two times higher than the levels targeted in Healthy People 2010 [4]. The financial impact of New York's higher burden of asthma is significant. In 2007, the total annual cost of asthma hospitalizations in NYS was estimated to be $535 million[4].
For 2005-2007, Medicaid accounted for 43% of the total asthma hospitalizations and incurred 37% of the total asthma hospitalization costs in NYS (Medicare accounted for 23% of the total asthma hospitalizations and 34% of the costs)[4]. The total cost of asthma hospitalizations in NYS in 2007 was approximately $535 million.[iv]

Evidence Base: The National Asthma Education and Prevention Program (NAEPP) Asthma Clinical Guidelines[5], recommends environmental interventions to reduce ED visit and hospitalization rates. Evidence indicates that home environmental asthma programs will result in a range of health and financial benefits, including a reduction in asthma hospitalizations and ED visits of up to 60 percent and a return on investment of up to 14:1[5-13]. This proposal will reduce asthma hospitalizations and ED visits for people with poorly controlled asthma by increasing access to home environmental assessments and interventions aimed at reducing exposure to common asthma triggers that contribute to preventable exacerbations.

Implementation: Over the waiver period, the Department will work with managed care plans to identify persons and families who might best benefit from asthma home visits and will contract with community-based providers to deliver home-based asthma assessment and education to promote asthma self management and control of environmental triggers in the home. It is anticipated that registered nurses employed by Certified Home Health Agencies and/or Licensed Home Care Services Agencies will render the asthma home-based services and that these services will be reimbursed on a per visit basis as a model for a future reimbursement program. Medicaid-enrolled individuals who had one or more inpatient hospital stays and/or two or more ED visits in the prior 12 months with a primary diagnosis of asthma OR who have asthma that is classified as "not well controlled" or "poorly controlled", as defined by the National Asthma Education and Prevention Program (NAEPP) Asthma Clinical Guideline, will be eligible to receive the service through a series of home visits conducted over a 12-month period (an initial visit with one to two follow-up visits). This service will be phased in statewide over a period of five years, beginning with a solicitation to select contractors who demonstrate readiness to implement the service. Following initial implementation, if metrics indicate success in reducing asthma related hospitalizations, a waiver will be submitted to continue this initiative as a Medicaid reimbursable service to be provided by managed care plans through the capitated rate utilizing savings achieved through this and other population health interventions.

3) Diabetes Prevention and Quality Improvement

Between 1999 and 2009, the prevalence of diabetes in adults in NYS increased from 5.7% to 8.9%.(NYS Behavioral Risk Factor Surveillance System, 2010) In addition, there are an estimated 3.7-4.2 million (25-30%) adult New Yorkers with pre-diabetes*. During the same years, the prevalence of obesity in adults, a leading risk factor for diabetes, increased from 17.4% to 24.6% (NYS Behavioral Risk Factor Surveillance System, 2010). Without lifestyle changes to improve their health, 15 to 30 percent of people with pre diabetes will develop type 2 diabetes within five years.

In New York State diabetes disproportionately impacts people of color and low-income individuals African Americans are twice as likely as whites to develop diabetes and are more likely to experience complications such as lower extremity amputations (NYSDOH health indicators by race/ethnicity 2007-2009). The total cost of diabetes in NYS was estimated at $12.9 billion in 2007, including $8.7 billion in diabetes-related medical expenditures and $4.2 billion attributed to lost productivity costs (American Diabetes Association: Diabetes Cost Calculator. NYS Medicaid spent approximately $4.6 billion for the nearly 307,000 fee-for-service members with diabetes in 2008.

Evidence Base: The Diabetes Prevention Program, led by the National Institutes of Health, was the largest clinical trial of lifestyle intervention for diabetes prevention ever conducted. This research demonstrated that intensive, individualized lifestyle modifications that achieve and maintain modest weight loss (5-7% body weight) and an increase in physical activity (primarily brisk walking) to 150 minutes/week in adults with prediabetes, could reduce the 3-year risk of developing diabetes by 58% overall, and 71% for adults 60 years of age and older. Based on the success of the Diabetes Prevention Program (DPP), the Centers for Disease Control and Prevention (CDC) launched the National Diabetes Prevention Program (NDPP) to reach people with prediabetes through a community-based lifestyle intervention. The DPP demonstrated that lifestyle modifications yielding modest weight loss can reduce the risk of developing diabetes by 58%, and 71% for adults over the age of 60. Indiana University School of Medicine Diabetes Translational Research Center researchers successfully translated the initial DPP protocol into a 16-week group-based lifestyle intervention program delivered through YMCAs. In an effort to reach high-risk populations, New York State is building program capacity among community-based organizations (including YMCAs, community health centers, aging organizations, county health departments and coalitions, and independent living centers) and engaged a quality and technical assistance center to oversee program delivery for quality and fidelity.

* (Based on national estimates from Cowie CC, Rust KF, Fored ES, Eberhardt MS, Dyrd-Holt DD, Li C, Williams DE, Gregg EW, Bainbridge KE, Saydah SH, Geiss LS. Full accounting of diabetes and prediabetes in the U.S. population in 1988-1994 and 2005-2006. *Diabetes Care*. February 2009;32(2):287-294) including about 25% of Medicaid enrollees (761,026).

Implementation: Two initiatives will be implemented: an initiative to work with community-based providers to prevent diabetes and an initiative to promote quality improvement to reduce complications for those New Yorkers already diagnosed with diabetes. In each initiative managed care plans will be asked to provide guidance regarding members and providers who might best benefit from diabetes prevention and control efforts. At the conclusion of the five year period, upon demonstration of program effectiveness, these initiatives will be proposed for inclusion as an integral component of the managed care capitated rate and service structure.

3a) Diabetes Prevention

Over the waiver period, funding opportunities will be provided to diverse community-based providers, such as YMCAs, Federally Qualified Health Centers, faith-based organizations, worksites, aging networks, hospital systems, health plans and independent living centers, to deliver CDC recognized diabetes prevention programs to New York's most vulnerable populations. To be eligible to participate, agencies must be pending National Diabetes Prevention Program recognition status and provide services under a memorandum of understanding with a health system that participates with, and can bill Medicaid and/or Medicaid managed care plans. This initiative will be phased-in over a period of five years beginning with an initial assessment of readiness to implement on a county-by-county basis followed by a solicitation to select contractors.

3b) Diabetes Quality Improvement to Reduce Complications

Building on the successes of New York's Healthcare Efficiency and Affordability Law (HEAL) projects, evidence-based quality improvement initiatives will be implemented across a variety of providers in order to improve health information systems, redesign work flow to support prevention and control in population based diabetes care, and support diabetes self-management so that patients take a greater role in their own care. Activities that will be implemented include:

- An evidence-based diabetes screening, messaging and detection campaign to improve timely diagnosis;
- A Quality Improvement initiative to improve prevention and control of pre diabetes and diabetes. This initiative will use HEDIS diabetes quality of care measures and create "dashboards" of quality diabetes metrics;
- Enhanced use of Certified Diabetes Educators for Medicaid members through use of financial incentives to providers, practices, and members to improve diabetes self-management; and
- Development of a quality reward program for practices that achieve NCQA Patient Centered Medical Home level 2 or 3 status that includes rewards for practices who achieve improved diabetes care for their patients as measured by the Department.

Following implementation, if metrics indicate success in reducing diabetes related hospitalizations, New York will look to continue this initiative as a Medicaid reimbursable service utilizing savings achieved through this and other population health interventions.

4) Lead Poisoning Prevention

Lead is among the most common environmental toxins for young children in New York State. Children are most commonly exposed to lead by the ingestion of paint chips or soil that is contaminated with lead. In 2009 in New York State, 2,717 children were diagnosed with lead poisoning. Lead poisoning is an important cause of learning disabilities, anemia, and growth problems. Children exposed to lead may have problems with paying attention and being aggressive. Elimination of childhood lead poisoning is essential to improving the lives of children in NYS, especially socio-economically disadvantaged children who are disproportionately affected by lead poisoning. NYS has made significant progress towards reducing both the incidence and severity of childhood lead poisoning, but it remains a serious public health problem. In addition, recent changes used by CDC to identify children exposed to lead, will result increased caseloads and thus increased needs for investigations and follow up.

Evidence Base: Medicaid coverage for costs associated with environmental investigations and care coordination for children on Medicaid with lead poisoning is estimated to result in $30.5 million in state and local savings. Savings would be achieved through a reduction in the number of children exposed to lead and for those exposed, by assuring prompt access to appropriate care and treatment. Analysis indicates that approximately 77 percent of lead poisoning cases identified in New York State were MA-eligible children, i.e. it is estimated that in 2012 there are approximately 749 Medicaid-eligible children with incident blood lead levels of 15 mcg/dL or higher, increasing to 2,092 children in subsequent years with a change to in definition to include blood lead levels of 10ug/dL. Provision of follow-up services by local health department costs on average $ 6,750 per child.

Implementation: Managed care plans will be asked to provide guidance regarding members and geographies that might best benefit from lead poisoning prevention efforts. At the conclusion of the 5-year period, upon demonstration of program effectiveness, this initiative will be proposed for inclusion as an integral component of the managed care capitated rate and service structure. Based on the information provided by plans, over the waiver period, grants will be provided to community-based providers for home investigations and care coordination for Medicaid eligible children. This initiative will be phased-in over a period of five years beginning with an initial assessment of readiness to implement on a county-by-county basis followed by a solicitation to select contractors. Services will be reimbursed on a per visit basis as a model for a potential future reimbursement program.

5) Water Fluoridation

Tooth decay is the most common chronic childhood disease, with almost 80 percent of all children experiencing tooth decay by the time of high school graduation. Water fluoridation is the most cost-effective approach of reducing tooth decay [1-4]. Furthermore, it is also a successful cost-saving strategy for the Medicaid program. Analysis of dental procedures in predominantly fluoridated community water versus non-fluoridated drinking water communities in New York State suggests savings of $24 per child[5] . Out of the approximately 2 million children on Medicaid in New York State, about 500,000 live in less fluoridated counties and another 1.5 million live in mostly fluoridated counties.

Evidence Base: Assuring fluoride in community drinking water is especially important today because many people cannot afford dental care. Although tooth decay is preventable, the use of preventive dental services is low, with only 31 percent of children enrolled in Medicaid receiving any preventive dental service. Fluoridation of community drinking water helps people of all ages and income groups. Systematic reviews of the scientific evidence have concluded that community water fluoridation is effective in decreasing dental caries prevalence and severity (McDonagh MS, et al, 200030, Truman BI, et al, 200231, Griffin SO, et al, 200732). Effects included significant increases in the proportion of children who were caries-free and significant reductions in the number of teeth or tooth surfaces with caries in both children and adults (McDonagh MS, et al, 2000b, Griffin SO, et al, 2007). When analyses were limited to studies conducted after the introduction of other sources of fluoride, especially fluoride toothpaste, beneficial effects across the lifespan from community water fluoridation were still apparent (McDonagh MS, et al, 2000b; Griffin SO, et al, 2007).

Implementation: Over the waiver period New York State will implement this program through grants to water systems that in turn will implement or enhance fluoridation systems. The goal is that by the end of the waiver period all New York children would benefit from fluoridated water.

6) Healthcare Acquired Infections and Prevention of Sepsis

Population health promotion through quality care in hospitals will be addressed through an aggressive set of hospital quality improvement initiatives that both build on and incorporate programs that evidence early promise for success in addressing and reducing Healthcare Associated Infections (HAIs) and preventing sepsis.

Evidence Base: It is estimated that about 1 in 20 patients develop an infection while receiving treatment in U.S. hospitals, and HAIs in hospitals alone result in up to $33 billion in excess medical costs every year. For example, a single central-line associated bloodstream infection (CLABSI) could result in an estimated $16,550 in excess medical costs.

New York State initiatives suggest the potential for significant savings as evidenced by the following:

- Patients who had surgical site infections (SSIs) following coronary artery bypass grafts (CABGs) had hospital charges that were 1.6 times higher and a length of stay that was 2.2 times longer than patients who did not have SSIs. SSIs following CABGs were responsible for $29 million in hospital charges and over 4,800 hospital days per year statewide. Medicare and Medicaid together were charged over $21 million attributable to CABG SSIs.
- Since NYS public reporting of HAIs began in 2007, the reductions in colon, CABG, and hip replacement infection rates, as well as ICU related CLABSIs, have also resulted in cost savings. A recent CDC report provided a range of estimates for the direct hospital cost of treating of HAIs (Scott 2009)*. Ranges were provided because HAIs vary in severity and cost estimates vary widely. In 2011 it is estimated that reductions in CLABSIs in intensive care units in New York State resulted in between 11.8 and 47.3 million dollars saved. Similarly, reductions in surgical site infections resulted in between 2.7 and 8.0 million dollars saved.
- Previous prevention projects funded by New York State have resulted in decreases in CLABSIs in neonatal intensive care units, reductions in Clostridium difficile infections in a hospital collaborative group, reductions in CLABSIs on medical or surgical wards following changes in insertion and maintenance practices, and reductions in bloodstream infections after instituting chlorhexidine bathing in intensive and respiratory care units. One CLABSI prevention project documented an annual cost savings of $0.8-$3.2 million. A project to decrease infection rates in peripherally inserted central catheters (PICCs) found that decreased infection rates resulted in a cost savings of approximately $375,000, and readmissions because of PICC infections decreased from 8.5% to 3.8%.

Hospital quality initiatives, that build on and expand upon those included in the original Partnership Plan are anticipated to both improve patient outcomes through enhance quality of care and reduce overall Medicaid costs by avoiding costly infections secondary to medical procedures.

Implementation: New York proposes to partner with academic medical centers and other hospital and outpatient care settings to provide short-term prevention project awards to implement evidence-based HAI and sepsis prevention projects. The Department will select and work with an external evaluator to implement and monitor the program. This new initiative will complement the Patient Centered Medical Home initiative (limited to 60 hospitals at most) and New York State's Partnership for Patients.

Program components would include specific types of healthcare associated infections; surgical site infections; central line associated bloodstream infections; the reduction of specific microorganisms that cause HAIs (e.g. *Clostridium difficile*, extended spectrum beta lactamase (ESBL)- producing Gram negative bacteria, carbapenem resistant Enterobacteriaceae, and methicillin resistant *Staphylococcus aureus*); the reduction of specific infections in select population groups (e.g. oncology patients, patients on mechanical ventilation, surgical patients, dialysis patients); and evidence- based sepsis prevention measures including antimicrobial stewardship initiatives. The approaches used will follow the collaborative quality improvement model.

IMPACT ON HEALTH DISPARITIES

The initiatives proposed were selected as all represent critical health care and preventive services that are necessary to address documented health disparities in New York State. The recommendations were developed by and through the Medicaid Redesign process and were advanced by a committee whose sole goal was to develop recommendations to address health disparities. Examples of health disparities that will be addressed through these initiatives include the following:

- In New York State during 2006-2008, the teen pregnancy rate for black non-Hispanics was 69.0 per 1,000 females' ages 15-17 years, which was more than 5 times the rate for white non-Hispanics. The rate was also well above New York State's prevention agenda objective of 28.0 per 1,000 females.
- Recent statistics indicate that in 2010 the asthma hospitalization rate per 10,000 was five times higher for black non-Hispanic New Yorkers than White New Yorkers (45.5 as compared with 9.3).
- Short term complications of diabetes were five times greater among Black non-Hispanic New Yorkers than among white New Yorkers (13.5 as compared with 3.5).
- Childhood lead poisoning is largely concentrated in poor, minority communities (Landrigan, P. Rauh, V.A., and Galvez, M. Environmental Justice and the Health of Children. Mount Sinai Journal of Medicine 77(2010):78-187).
- Similarly, tooth decay is the single most common chronic childhood disease. Yet, among children enrolled in the New York State Medicaid program only one-third of all eligible children received any type of dental care in 2009. (The State of Children's Dental Health: Making Coverage Matter. The Pew Center on the States. Washington, DC. 2011).

IMPACT ON OVERALL MEDICAID SPENDING

The six public health interventions are anticipated to cost $395.3 million and could result in $2.8B in savings over five years as detailed by program below.

- Nurse home visiting: $82M cost; $466M savings
- Asthma: $32.5M cost; $97.5M savings
- Diabetes: $200M cost; $1B savings
- Lead: $61M cost; $1.1B savings
- Water Fluoridation: $10M cost; $140M savings
- Healthcare Acquired Infections and Sepsis Prevention: $10M cost; TBD savings

Evidence-based preventive nurse home visiting services: Based on experience of the NFP program costs and savings are estimated as follows: Expansion of the Medicaid case load of the 3 current NFP programs to serve 2,518 first time mothers annually for five years is estimated to cost $13,801,838 annually for a total five-year cost of $69,009,188. The establishment of 6 new NFP programs to cover an additional 950 first time mothers will be served annually, for a three-year period at a total annual cost of $4,275,000, and a total three-year cost of $12,825,000.

NFP has proven nationally to save $5.70 for every $1.00 invested. Based on that ratio, the annual savings with the expansion of the 3 current NFP programs in year one of the initiative will be approximately $78,670,474. The addition of 6 new NFP programs in year three of the initiative will save an additional $24,367,500 annually. By year three of the initiative, the total annual savings will be $103,037,974. The total savings over the five-year initiative is estimated to be $466,454,869.

Asthma Prevention and Treatment: A $6.5 million cost is based on an estimated 10,000 individuals receiving the services at a cost of $650.00 per individual. The savings are based on evidence from the literature which indicates that home environmental asthma programs will result in a range of health and financial benefits, including a reduction in asthma hospitalizations and ED visits of up to 60 percent and a return on investment of up to 14:1[5-13]The estimated $19.5 million savings is based on the lowest, conservative end of the demonstrated range.

Cost: $650/recipient x 10,000 visits/year = total program cost $6.5 million/year
Savings: $3.00 savings for every $1.00 invested = $3.00 x $6.5 million = $19.5 million in savings/year

Diabetes Prevention and Treatment: Since a disproportionately high burden of diabetes occurs among persons of low socioeconomic status who depend on Medicaid, reimbursement for diabetes prevention programs can play a vital role in controlling future health care costs and reducing the burden of diabetes in New York State. Effectively reducing the number of New Yorkers who progress to full diabetes will require a $25M investment that will result in 34,800 fewer Medicaid covered individuals being diagnosed with diabetes annually (assuming a 58% success rate) and will in turn save the Medicaid program $207 million annually, assuming savings of $6,649 per case averted. In addition, a comprehensive diabetes Quality Improvement Campaign to reduce complications is estimated to require a $15 million Medicaid investment and result in $238 million in Medicaid savings (ROI $15.88: $1). Both of these initiatives, representing a $40 million investment (prevention and care) is anticipated to result in savings of $445 million.

Lead Poising Prevention: Research published in 2009 found that for every dollar invested in lead paint hazard control results in a return of $17-$221 or a net savings of $181-269 billion. The benefits are attributed to higher lifetime earnings, increased tax revenue, lower health care costs and the direct costs for crime, and reduced need for special education. Surveillance figures suggest that the total cost of providing follow-up services to Medicaid eligible children with BLL group of 15 mcg/dl or higher would be approximately $5 million in 2013, increasing to $14 million per year in 2014 in response to lowered federal reference values for childhood lead poisoning. At least 50 percent of this cost, or $30.5 million, could be saved for the state overall (combined state and local shares) through federal financial participation. Children poisoned by lead are seven times more likely to drop out of school, earn less money, cost more in taxpayer dollars and provide less in tax revenue. The addition of Medicaid reimbursement would represent a significant step in the Department's comprehensive agenda to eliminate childhood lead poisoning in New York State, and could return between $85 million and $3 billion in benefits to New York.

Water Fluoridation: An investment of $10 million phased over a period of ten years is needed. With $1 million investment, we estimate that the number of children on fluoridated drinking water will increase by 200,000 to 1.7 million children. At a savings of $24 per child, and a utilization of 35 percent, we estimate the annual savings to be $14 million. Thus an investment of $10 million is likely to yield savings of $140 million to the Medicaid program.

Health-Care Acquired Infections and Sepsis Prevention: Four initiatives in distinct regions of the state funded at $500,000 each for five years will cost approximately $10 million. CDC estimates that effective infection control programs could prevent up to 70 percent of infections. This can translate into potential savings nationwide of up to $31.5 billion of the $45 billion expenditures attributed to HAIs. (Scott RD. The direct medical costs of healthcare-associated infections in U.S. hospitals and the benefits of prevention [report online]. 2009 Mar [cited 2010 Apr 21]. Available at: http://www.cdc.gov/ncidod/dhqp/pdf/Scott_CostPaper.pdf.)

APPENDIX

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MRT Reinvestment Program
Regional Health Planning

BACKGROUND

In the context of dramatic changes in the delivery system driven by New York's MRT and the Affordable Care Act (ACA), collaborative, regional health planning will be an essential element of New York's effort to achieve the Triple Aim. A variety of factors demand a robust regional planning infrastructure in New York State. With one million New Yorkers soon to be newly-insured under the ACA, regional strategies to ensure access to high quality primary care will be needed. The impact of new payment mechanisms and new models of care can be optimized (and pitfalls avoided) through the work of regional collaboratives, supported by reliable data, to address population health and disparities concerns, to facilitate collaborations among providers along the continuum of care, and to align payment incentives to promote desired aims. Community health needs assessments and community benefits required of hospitals under the ACA and state law and of local health departments similarly demand strong data analysis and input from a variety of stakeholders. Underlying all of these initiatives is the imperative to reduce the per capita cost of health care, while improving health outcomes and status. New York's global cap on Medicaid provides a brake on spending. Keeping costs under the cap and bending the cost curve for other payers demands collaboration among multiple stakeholders based on upon reliable data.

New York State has a solid foundation on which to build a strong planning infrastructure to facilitate and manage the changes brought about by the ACA, the MRT and the effects of ongoing innovation in health care delivery and organization. In several regions, particularly upstate, broad-based regional planning is under way. For example, the Finger Lakes Health Systems Agency (FLHSA) – one of two remaining health systems agencies in New York State– is engaged in a broad range of planning activities to manage health care capacity, improve quality, reduce unnecessary utilization and improve population health. Its activities include convening consumer coalitions that work to eliminate disparities, convening commissions of regional leaders to evaluate health care capacity issues, conducting a hypertension collaborative among providers and the business community, sponsoring a care transitions program, and embedding care managers in primary care practices. Notably, the Rochester hospital referral region, where the FLHSA is headquartered, is the only referral region in New York State to score in the top ten percent nationwide on health system performance as measured by the Commonwealth Fund's local report card.[1]

[1]See The Commonwealth Fund Commission on a High Performance Health System, Rising to the Challenge: Results from a Scorecard on Local Health Performance, 2012, The Commonwealth Fund, March 2012.

At a more local level, local health departments are working with community partners to meet the goals of the State Health Improvement Plan (Prevention Agenda), and hospitals submit community service plans every three years to address their communities' health care needs. Rural health networks are involved in fostering collaboration among rural providers, and area health education centers seek to strengthen the health care workforce. These regional and local organizations provide invaluable contributions to the health of their communities and their local delivery systems. In many regions, however, health planning activities are limited in scope, fragmented, and not connected to an overall regional vision addressing each element of the Triple Aim. The funds requested under this waiver will help expand and strengthen broad-based regional planning throughout the state.

New York is unquestionably a diverse state, where health system performance and population health issues vary by region and even by community.[2] As the Health Care Association of New York State (HANYS) noted, health system improvement strategies that work in one region may not work in another. Regional planning provides a forum for assessing health care delivery system performance and population health and developing consensus-based strategies to drive improvements in performance on each element of the Triple Aim. Under this proposal, planning will be conducted by multi-stakeholder collaboratives that bring together consumers, providers, health insurers, public health officials, businesses, unions, and academic institutions and engage in rigorous data collection and analysis to support their work.

PROGRAM DESCRIPTION

New York State seeks to dedicate $25 million on average annually over five years to support regional planning activities. The Department of Health is working with its Public Health and Health Planning Council (PHHPC) to define the precise structure and functions of regional planning, the boundaries of the regions, the process for selecting regional planning organizations, and the metrics for measuring their performance.[3] The PHHPC will be holding public meetings over the course of the next several months and expects to issue a report on regional planning and redesigning certificate of need in early December. Stakeholder input has been solicited as part of this project, and public comment is welcome at every PHHPC Planning Committee meeting. The model or models adopted will be informed by extensive public discussion and feedback submitted by stakeholders.

One model under consideration is the designation of one regional health planning organization in each region that is considered a trusted and neutral convener, representative of, at a minimum, consumers, the local public health departments, providers, purchasers of health care, and health insurers or plans.

[2]See The Commonwealth Fund Commission on a High Performance Health System, Rising to the Challenge: Results from a Scorecard on Local Health Performance, 2012, The Commonwealth Fund, March 2012.

[3]The PHHPC is a panel of health care experts, representing providers, payers, consumers, and public health officials, that is responsible for making decisions on the establishment of new health care providers, adopting state sanitary code regulations, advising the Department on public health issues, making recommendations on health care construction projects subject to certificate of need (CON), making health planning recommendations, and adopting operating regulations for licensed health care facilities and home health agencies.

Potential functions that might be served through the convening of stakeholders by regional planning organizations include:

- Supporting local health department community health assessments, and hospitals' community health needs assessments, developing strategies to respond to identified needs and advancing State Health Improvement Plan (Prevention Agenda 2013) priorities;
- Measurement of health system performance, developing health system dashboards or scorecards, and addressing weaknesses;
- Addressing health and health care disparities;
- Facilitating effective strategies among providers, consumers and payers to coordinate care, reduce unnecessary utilization, and promote population health;
- Alignment of health care resources with community health needs, including through prospective capacity planning to inform such activities as capacity development and submission of recommendations on state grants and certificates of need;
- Identifying and implementing best practices to optimize health care quality and the patient's experience of care;
- Ensuring that consumers have a voice in the delivery system;
- Publishing data and implementing strategies to assure that consumers have the knowledge and resources to use the delivery system appropriately and effectively;
- Aligning payment incentives to promote high-quality, accessible, and cost-effective care; and
- Leveraging health information technology to engage in community-level analysis of health status, health care utilization, outcomes and spending.

This 21st century planning model addresses not only the supply and distribution of health care resources, but also the demand for health care (i.e., strategies to improve population health and reduce preventable utilization) and the quality of care. While the nature of the planning undertaken may vary by region, every region will be expected to engage in planning activities that address each element of the Triple Aim. They will also be required to identify and develop strategies to address disparities in health and/or health care. In addition, active engagement in regional planning and the support of the regional planning organization will be a significant factor in evaluating applications for waiver funding, including funding for primary care expansion, hospital transition, safety net and vital access providers, capital access, and new medical care models.

All planning activities must be supported by robust data analysis. As suggested by the Community Health Care Association of NYS (CHCANYS), regional planning organizations will leverage existing health planning tools and data and have access to a wealth of data collected by the state, including the Statewide Planning and Research Cooperative System (SPARCS), Behavioral Risk Factor Surveillance System, Disease and condition specific data from program registries and vital statistics data, as well as the data residing in the new, all-payer database which will be available at the end of 2013. In addition, regional planning organizations will likely engage in their own data collection activities with a regional or local focus.

The state's Regional Health Information Organizations (RHIOs) may play a key role in generating data for this purpose. Focus groups, surveys, and mapping of health care resources are also commonly used to identify community health needs and develop strategies.

Regional boundaries will be defined based on a number of considerations, including the existing health planning infrastructure, health care market considerations, and regional identity. One option is the use of the economic development regions implemented by Governor Cuomo (see attached map). The close linkages between a region's health care delivery system and its economic development activities argue in favor of a consistent regional approach for both purposes.

IMPACT ON OVERALL MEDICAID SPENDING

Regional health planning will reduce Medicaid spending by bringing together consumers, providers, purchasers of health care, and public health officials, among others, to:

- Align payment incentives to promote better outcomes and reduce unnecessary or preventable utilization;
- Facilitate transitions in care and care coordination;
- Close important health and health care disparities that can lead to preventable utilization and poor outcomes; and
- Develop collaborative strategies to engage consumers not only in their own care and health promotion, but in the future of their delivery system and the health status of their communities.

The work of the FLHSA in reducing health care spending through care coordination, capacity management, and public health interventions illustrates the potential of regional planning. According to the Dartmouth Atlas of Health Care, the total Medicare cost per beneficiary in the Rochester hospital referral region is 21 percent below the national average and is the lowest of the comparable upstate hospital referral regions (Albany, Syracuse and Buffalo). [4]

Similarly, commercial health care costs in the Rochester hospital referral region are 60 percent of the national average for inpatient care, 77 percent for outpatient services, and 85 percent for physician care.[5] The FLHSA 2020 Commission evaluation of inpatient capacity resulted in a savings of $13 million in capital costs and approximately $20 million in annual operating costs. In addition, FLHSA's community-wide, multi-stakeholder implementation of a care transition intervention is showing an aggregated reduction of hospital readmissions among patients receiving transition coaching of 25 percent. [6]

[4] The Dartmouth Atlas of Health Care, Medicare Reimbursement per Enrollee, By Race and Program Component, available at www.dartmouthatlas.org, accessed on Aug. 1, 2012.
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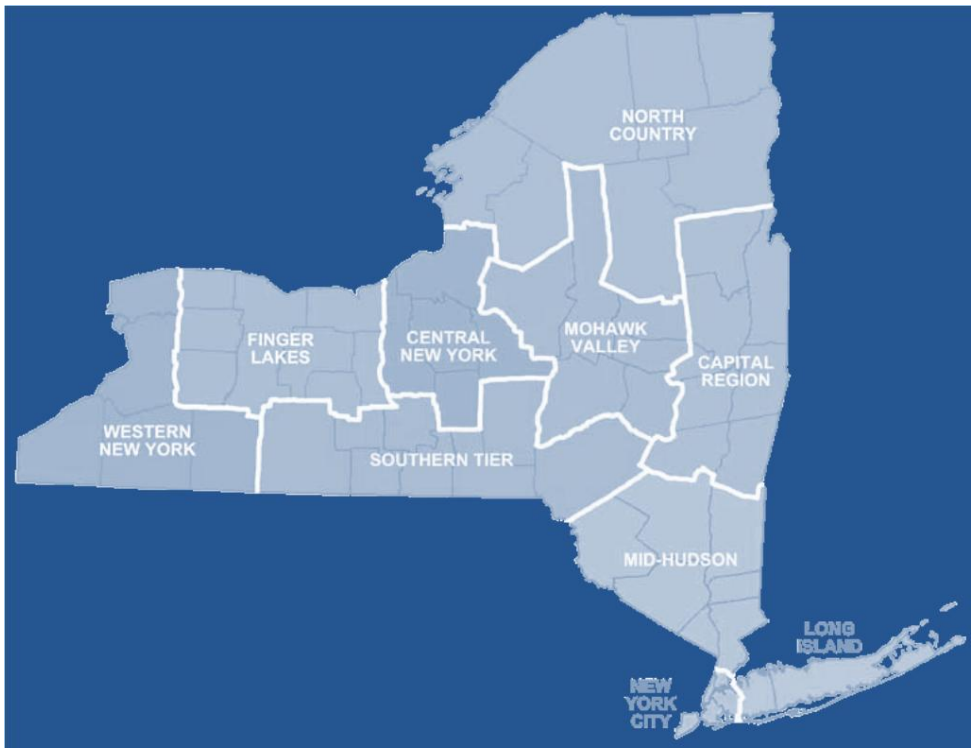
Potential Regions



Western New York: Allegany, Cattaraugus, Chautauqua, Erie, Niagara
Finger Lakes: Genesee, Livingston, Monroe, Ontario, Orleans, Seneca, Wayne, Wyoming, Yates
Southern Tier: Broome, Chemung, Chenango, Delaware, Schuyler, Steuben, Tioga, Tompkins
Central New York: Cayuga, Cortland, Madison, Onondaga, Oswego
Mohawk Valley: Fulton, Herkimer, Montgomery, Oneida, Otsego, Schoharie
North Country: Clinton, Essex, Franklin, Hamilton, Jefferson, Lewis, St. Lawrence
Capital Region: Albany, Columbia, Greene, Saratoga, Schenectady, Rensselaer, Warren, Washington
Mid-Hudson: Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, Westchester
New York City: Bronx, Kings, New York, Richmond, Queens
Long Island: Nassau, Suffolk

MRT Reinvestment Program
MRT Waiver Evaluation and Program Implementation

BACKGROUND

Improving the U.S. health care system requires pursuit of the Triple Aim: improving the experience of care for patients, improving the health of populations, and reducing per capita costs of health care. Higher-value care can only be realized through careful measurement of care and outcomes, use of those measures to promote and improve quality and support of payment methodologies that reflect high quality and efficient provision of services.

New York's Medicaid program is in the process of a fundamental restructuring intended to improve patient outcomes and lower program costs. To achieve these goals the Medicaid Redesign Team (MRT) developed a comprehensive multi-year action plan that if fully implemented will improve care and control spending. To complement and expand on these initiatives, this waiver amendment proposes unique and innovative models that will further New York's ability to achieve the Triple Aim.

This waiver amendment seeks to demonstrate a comprehensive approach to innovation and includes a number of reporting and evaluation requirements designed to inform the federal government and the state of the progress achieved, challenges encountered and lessons learned as the demonstration is implemented. Effective implementation and identification of lessons learned requires that a portion of the MRT savings generated as a result of the action plan be dedicated to a rigorous and thorough evaluation of ongoing as well as new MRT initiatives.

In addition to evaluation and process improvement, successful implementation will also require that each of the new programs funded by the waiver amendment are adequately staffed and that additional efforts are taken to effectively communicate with Medicaid members. Comprehensive reform will not be successful without sufficient implementation resources and an effective member communication strategy.

PROGRAM DESCRIPTION

New York State plans to invest $500 million over the next five years to evaluate as well as implement the MRT action plan and the MRT waiver amendment. Provided below is a description of how these funds will be used. A more detailed breakdown is provided in the MRT Expenditure Plan section of this report.

To ensure a robust system of monitoring and evaluation as well as government transparency and accountability, the New York State Department of Health (NYSDOH) will create comprehensive systems to measure, evaluate, track and report on metrics for each of the MRT initiatives including those already in some

stage of implementation as well as those requested through this waiver amendment. All initiatives will undergo rigorous evaluation to assure that unique goals and objectives are achieved and well as overarching or cross-cutting goals such as access for disenfranchised populations, reduction of health disparities, reduction of preventable events, promotion of a culture of quality and operation of an efficient and effective health care system.

Evaluation activities will follow two simultaneous tracks – evaluations of individual initiatives (both current MRT recommendations and those proposed as part of this waiver) and evaluation of the broader health care system to assure achievement of the three goals as enumerated by the Triple Aim. The evaluation funds will support comprehensive program monitoring, policy development and analysis, data analytics and creation of systems to track, monitor and post evaluation results to inform government officials, providers, consumers and external researchers. Through this process an evidence base will be developed that can be used by states throughout the nation as the health care system transforms over the coming years.

Funding of external evaluation partners will be done through a competitive Request for Proposal (RFP) process. It is expected that the NYSDOH will partner with the most advanced academic and health evaluation institutions, foundations, and associations from across the nation, as the waiver evaluation process will be objective, comprehensive, and will inform health systems change across the country.

The need for and import of evaluation was noted by several entities commenting on the draft waiver including the Hospital Association of New York State (HANYS) and the Conference of Local Mental Hygiene Directors, Inc. HANYS recommended that the standards used to evaluate waiver programs be: transparent; developed with stakeholder input; agreed upon in advance; grounded in evidence-based science, reliable; clearly defined; reproducible; standardized and useful.

In addition to evaluation, the state will also require waiver funding to both support waiver program implementation and member communication. Medicaid redesign in New York is a huge task and creates challenges for the state, stakeholders and members when it comes to successful implementation. Staffing shortages make it difficult for implementation to be monitored as effectively as possible and the raw amount of change occurring at the same time has led to member confusion. Modest amounts of waiver resources could address these challenges during this important implementation phase.

Overall, the state envisions four specific programs in order to effectively evaluate implement and communicate the MRT waiver amendment. Those sub-programs are described below:

1) Evaluation of Ongoing MRT Initiatives

MRT Phase 1 led to the development of 78 distinct initiatives which are now being implemented. These initiatives were a mix of traditional cost containment ideas (rate reductions, utilization controls), systemic reforms and traditional public health interventions. MRT Phase 2 generated additional proposals that both transcended the earlier work by addressing complex topics set aside in Phase 1, and helped provide clarity to certain key Phase 1 reforms. The overall MRT action plan ensures a comprehensive approach to redesign that will collectively achieve the Triple Aim. Evaluation of key initiatives being implemented as part of the MRT process is described below.

1a) Expanding Current Patient Centered Medical Homes

Background: In 2010, the NYSDOH initiated two incentive programs to increase the number of providers who are recognized by the National Committee for Quality Assurance (NCQA) as Patient Centered Medical Home (PCMHs). Medicaid primary care providers (including clinics and Federally Qualified Health Centers (FQHCs)) who are certified as Level 1, 2 or 3 are currently reimbursed an additional $2, $4 and $6, respectively, per member per month for Medicaid managed care enrollees. Providers are reimbursed on a per visit basis for Medicaid fee-for-service (FFS) enrollees, with amounts ranging between $5.50 to $21.25 depending on the provider's recognition level and place of service. A unique program in the rural northeastern area of the state, the Adirondacks, is a multi-payer demonstration whereby nine payers, including Medicaid as well as Medicare FFS, are supporting practice transformation, including conversion to Level 3 PCMH. The demonstration includes multi-payer measurement using electronic health records and a data warehouse which will be used for pay-for-performance (P4P).

Metrics: The NYSDOH will evaluate the effectiveness of PCMH for the Medicaid managed care population on a statewide basis using HEDIS®, CAHPS®, encounter (utilization) and Prevention Quality Indicator (PQI) data comparing demographically similar cohorts of enrollees who are, and are not, assigned to a PCMH primary care provider. Additional resources will be necessary to assist in the evaluation of the FFS population and to evaluate provider-based P4P programs.

1b) Managed Long-Term Care

Background: The primary objective of this initiative is to enroll individuals with 120 days or more of community-based long-term care services into managed long-term care (MLTC) plans. Medicaid recipients currently receiving personal care, services from certified home care agencies, the long-term home health care program and individuals who have just begun receiving long-term care services will be included. Individuals in other programs, such as the Assisted Living Program, will subsequently transition to MLTC.

In addition, MLTC plans will expand enrollment to include those in need of long-term care services, but are not nursing home eligible. Another initiative is the inclusion of the Consumer-Directed Personal Assistance Program (CDPAP) to the MLTC benefit package.

Metrics: The NYSDOH has been collecting member-level functional assessment data through its Semi-Annual Assessment of Members (SAAM) instrument since 2006. Staff has also conducted two consumer satisfaction surveys. Performance measures based on the SAAM data have been developed and the first publicly reported performance data will be made available in 2012. In 2013, a select group of plans will be required to submit Medicare HEDIS® results. Assistance with evaluation is necessary to 1) determine whether the care provided to the enrollees has improved, 2) assess improvement in the overall health and functionality of the recipients and 3) determine if the transition into MLTC from other community-based programs has been cost effective. Research is also needed to evaluate the use of CDPAP and compare quality, performance and costs of enrollees who chose CDPAP and those who do not.

1c) Inclusion of Pharmacy in Medicaid Managed Care Benefit Package

Background: The pharmacy benefit is now included in the Medicaid managed care benefit package, effective October 1, 2011. Previously managed care enrollees received their prescription and over-the-counter medications through Medicaid FFS. This change was implemented in response to Affordable Care Act (ACA) provisions which enabled plans to receive the same rebates as FFS and take advantage of the plans' abilities to manage the pharmacy benefit.

Metrics: The NYSDOH has many years of FFS pharmacy claims and is now receiving pharmacy encounters from the plans. An evaluation will be needed to determine whether the targeted savings have been achieved as a result of this change, the impact, if any, on the care provided to enrollees and the health of this population. Evaluation assistance is needed to develop an objective study design including measure development related to pharmacy processes, outcomes and cost effectiveness.

1d) Establish Interim Behavioral Health Organizations (BHOs) to Manage Carved-Out Behavioral Health Services

Background: For both Supplemental Security Income (SSI) and non-SSI enrollees, mental health and chemical dependency services are not fully covered through managed care plans. The NYS DOH established Behavioral Health Organizations (BHOs) to manage these carved out services. For mental health services, the BHOs manage all SSI mental health care (excluding "detox") and "carved out" behavioral health services for all non-SSI populations and for individuals simultaneously enrolled in Medicare and Medicaid ("dual enrollees"), who are not eligible for MMC. Carved out services for non-SSI enrollees include: chemical dependency and specialty mental health services.

Metrics: Using standardized measures of performance from HEDIS®, the NYSDOH has measured the provision of mental health and chemical dependency services within managed care plans for over ten years. Staff is also working with the Office of Mental Health (OMH) and the Office of Alcoholism and Substance Abuse Services (OASAS) to develop additional measures related to the services and desired outcomes for both managed care and FFS enrollees using mental health and chemical dependency services. Using these measures of performance, assistance is needed to evaluate the processes and outcomes of care for both SSI and non-SSI populations in these two models of care: "mainstream" managed care and BHOs. An evaluator will also be called upon to evaluate the per member per month utilization and costs for mental health and chemical dependency services received in managed care and BHOs. Together, these evaluations will establish whether the goals of the Triple Aim have been achieved.

1e) Implement Health Homes for High-Cost, High-Need Enrollees

Background: Historically a small percentage of Medicaid enrollees with complicated combinations of physical and behavioral health issues have accounted for a large proportion of NYS Medicaid expenditures. In an effort to enhance these enrollees' engagement and better coordinate their care, the NYSDOH collaborated with the OMH, OASAS and Office for People with Developmental Disabilities (OPWDD) in the development of a set of operating and reporting requirements for Health Homes. The NYSDOH has an approved State Plan Amendment (SPA) and enrollment began in early 2012.

Metrics: A robust list of quality and utilization measures was included in the Health Homes SPA which will serve as the framework for ongoing evaluation and monitoring. Included in this list are standardized HEDIS® measures as well as NYSDOH-specific measures generated from two additional reporting sets: 1) As a result of the above-noted collaboration with OASAS and OMH on measure development for behavioral health, the NYSDOH is developing several measures appropriate to this population; and 2) In 2011, the NYSDOH developed the Case Management Annual Reporting Tool (CMART) for managed care plans to submit annual case management data. This tool and its related measurement set will also be used in health home evaluation.

Assistance with the evaluation of the program with respect to patient experience of care particularly access to and satisfaction with case management services will be needed. A possible approach would be a pre-post evaluation of changing utilization patterns and expenditures that would include total Medicaid costs for this population with a potential focus on inpatient and emergency department use.

1f) Care Management Population and Benefit Expansion, Access to Services and Consumer Rights

Background: This proposal has three major components: 1) Begin to enroll non-dual Medicaid recipients who are currently excluded or exempt from mandatory managed care, 2) Ensure populations have access to information to assist them in this transition and 3) Streamline managed care enrollment and eligibility processes. The first component involves transitioning formerly exempt and excluded populations into managed care over a three year period resulting in an additional 230,000 enrollees in plans. The last component is the establishment of guidelines requiring new managed care enrollees to select a plan at the time they apply, and are approved for, Medicaid.

Metrics: Monitoring of enrollment trends and oversight of enrollment procedures (components 2 and 3) will be accomplished by reviewing enrollment data as these populations transition to managed care. The quality these populations receive in managed care will be monitored as part of the annual Quality Assurance Reporting Requirements (QARR) submission of quality and utilization data and the biennial administration of CAHPS®. Assistance will be needed with surveys of the new populations to evaluate their perception of managed care versus FFS. Pre-post analysis of utilization and expenditures for these new mandatory populations will be essential to inform future policy.

2) Evaluation of Waiver Amendment Initiatives

The twelve reinvestment projects proposed under the waiver amendment will be carefully monitored and evaluated to determine the efficacy of each reinvestment program. The evaluation will be structured to focus on the contribution of each program area to the achievement of the Triple Aim, both individual and as a cohesive multi-faceted initiative.

As considerable variation in activities, participants, and short- and long-term goals exists among the 12 waiver reinvestment initiatives, the evaluations of these initiatives will also be diverse. However, the following core elements will be incorporated into all 12 of the evaluations:

- An articulation of the major questions to be addressed regarding the implementation and effectiveness of the reinvestment initiative that pertain to the Triple Aims of improvement in the patient experience of care, health outcomes, and reduction in per capita costs.
- Research designs and statistical analyses that enable the questions around each initiative to be meaningfully addressed.
- Use of available data and quality measures, as appropriate for each initiative.
- A schedule of reports to be produced and disseminated to all stakeholders to allow the monitoring of program implementation and outcomes.

The evaluations will be based largely upon a pre- and post-waiver program implementation design where Medicaid program participants will serve as their own control group. Where possible and given appropriate levels of resources for a more rigorous study, quasi-experimental designs with non-randomized control groups will be conducted. Other techniques such as the use of propensity scoring, matching, and the use of statistical modeling will also be employed whenever appropriate to control for the effects of confounding and other factors to best assess the impact of the initiatives on achieving the waiver and program goals. Additional consideration to the study design and analysis of each initiative would be given with respect to assessment of goals that may be achieved in the short- versus those achieved over the long term.

The Medicaid Supportive Housing Expansion initiative will serve as an example of the form a waiver evaluation initiative may take. On the premise that lack of stable housing results in avoidable health care utilization and increased Medicaid costs among those with chronic conditions, an investment of $750 million over five years is proposed to improve health outcomes and reduce health system expenditures by increasing the number of supportive housing units and through the provision of support services such as case management, counseling, and education and employment assistance.

For this unique initiative, some of the major questions to be answered include:

- Is there an increase in Medicaid recipients placed in stable housing situations?
- Has there been an increase in the use of primary care services and services received through patient-centered medical homes?
- Do recipients with mental illness and substance abuse disorders who receive supportive housing services show increased utilization, initiation and engagement in treatment compared to those with substance abuse not receiving supportive housing?
- Are chronic conditions such as HIV/AIDS, asthma, hypertension and diabetes better managed among those receiving supportive housing services than among those not receiving these services?
- Are Medicaid costs per member per year lower among those receiving supportive housing services than among a comparable group of Medicaid recipients who did not receive supportive housing?

To address these questions, the primary approach would be a pre-and post-study design of Medicaid enrollees living in supportive housing to assess the impact of this program. As such, key measures available through administrative data sources or new data collection activities among those using supportive housing would be assessed on a periodic basis to measure progress toward achieving the initiative's stated goals, objectives, and study questions.

In addition to long-term outcomes, patient and provider surveys may be used in the early stages of program implementation to assess patient experiences in obtaining housing and support services, barriers to not receiving these services, provider barriers to providing these services, etc. Such surveys will be conducted and the results distributed frequently during the first two years of the program to identify problem areas and make necessary modifications.

Detailed information on metrics proposed for each of the twelve initiatives may be found in Appendix V of this document. Please note that these metrics are preliminary in nature and are anticipated to evolve to reflect program design and formalization of policies associated with each initiative. For several initiatives, including regional health planning and new care models, additional metrics will be developed and refined in concert with program development and implementation.

3) Waiver Implementation Assistance

New York is seeking short-term assistance through the waiver so as to ensure that all the programs envisioned in this comprehensive amendment are effectively implemented. This funding would support additional contracted resources that would assist state staff in establishing and administering the various programs envisioned in this document. The funding request is modest and the contracted resources will be temporary but are essential given the existing state budget challenges. It is important to note that funds will not be used to hire permanent state staff.

4) Consumer Education to Promote Effective Health Service Utilization

Health literacy in its broadest definition is critical to the success of both federal health care reform and New York's proposed innovations to implement the ACA and achieve the Triple Aim. The innovative care models proposed as part of this waiver will result in new care options that will be unfamiliar to most. To assure optimal utilization of these models, outreach and education will be provided to consumers, providers and insurers. An evaluation of utilization of these new care options will inform both future program development as well as educational strategies. This information will complement requirements placed on health insurers under the ACA to provide key information about their policies in an easier to understand way.

In addition, research and evaluation on how best to convey information on the cost and quality of health care services in a way that empowers consumers and informs behavior will be conducted as a critical component of overall health systems reform. Factors that influence patient selection and utilization of new care options must be identified and evaluated in light of the importance of engaging consumers to promote greater quality and efficiency in the health care system. Strategies for engaging consumers and influencing their behavior will be evaluated through a review of the literature and key informant interviews as well as focusing on selected campaigns that have demonstrated an effect on consumer behavior. Strategies associated with success and challenges common to public health consumer education programs, will be explored.

METRICS

New York State is building a comprehensive system of performance measurement that will apply not only to the Medicaid program or health plans, but will measure performance across the state's health care system; the All Payer Database. In addition, two sets of performance measures have been developed and will be key indicators for these MRT evaluations. The first set are the Medicaid core measures which will build upon existing health care measures (HEDIS®, CAHPS®, hospital and provider level metrics and more), fill in the gaps in the measurement of long term care and behavioral health, and align efficiency measures such as preventable hospitalizations. Efficiency measures such as potentially preventable hospitalizations and preventable emergency room visits are key indicators of success for many MRT initiatives, including Health Homes, Patient-Centered Medical Homes and care management for all. The second set are population core measures, which will align with New York's public health goals, as well as monitor quality across all payers not just public programs. These measures are included in the MRT Final Report and Action Plan http://www.health.ny.gov/health_care/medicaid/redesign/docs/mrtfinalreport.pdf. With these two measurement sets, New York State will, for the first time, have a robust system of measurement that clearly captures the Triple Aim.

While the MRT measurement set includes a standard set of metrics, new metrics will need to be developed for the various MRT waiver initiatives outlined in this document. It is the NYSDOH's goal to use established metrics whenever possible, including measures already collected in New York State and/or measures from national measure sets (for example the National Quality Forum).

NYSDOH will use evaluation funds for data collection, such as member satisfaction surveys targeted at a specific intervention, and use both quantitative and qualitative methods to best evaluate the efficacy of each MRT waiver initiative. The NYSDOH will require both external partners and internal analysts to stratify analyses to further define quality metrics and target improvement.

IMPACT ON OVERALL MEDICAID SPENDING

The objective of this program is to assess whether the Medicaid reform action plan accomplishes its stated objectives of improving the experience of care, improving the health of populations, and reducing per capita costs of health care. In addition, this program will provide vital resources to assist the state in implementing the waiver and ensuring that consumers are aware of new opportunities to improve their health and health care that result from the MRT. Each of these waiver initiatives will be evaluated independently and the results will help state and federal decision makers assess each initiative individually and as a whole to assess the impact on achieving the goals of the Triple Aim. New York is also interested in using MRT Waiver Amendment resources to forge new relationships and partnerships between providers and stakeholders to improve health care delivery and overall population health. Through this process the state will support efforts to ensure that providers work together across traditional "silos" and develop comprehensive proposals that address core challenges that exist within specific communities.

MRT Expenditure Plan

BACKGROUND

The MRT actions that have been or are currently being implemented will reduce federal support for New York's Medicaid program by approximately $17.1 billion over the waiver period and over $21 billion since 2011 when they were initially implemented. The state is requesting that a portion of these savings ($2 billion annually and $10 billion over the life of the waiver) be reinvested via this waiver amendment in order to allow New York to reform its health care infrastructure as well as the resources to innovate. The federal funding being requested is based on reimbursement for expenditures made by state and local government for health care related services for which there currently is no federal funding. These services have been identified as Designated State Health Programs (DSHPs).

The state is also submitting the required waiver budget neutrality demonstration information. These calculations demonstrate that the projected Medicaid expenditures with the 1115 waiver, as amended, do not exceed the projected Medicaid expenditures without the 1115 waiver for any year over the term of the waiver amendment (2013 – 2017). In fact, the calculations will show that the cumulative impact on total Medicaid expenditures of the 1115 Partnership Plan waiver since its inception including the proposed amendment is a reduction in spending by approximately $46.5 billion.

FINANCING STRATEGY

There are several critical elements of this waiver amendment request that form the basic tenets of the state's financing strategy. The first is the listing of DSHP funds that will generate the federal match of $2.0 billion on average annually. During previous discussions surrounding a possible 1115 waiver for the New York Office of People with Developmental Disabilities (OPWDD), the state and CMS identified sources of existing state/local funds eligible for a federal funding match. As it has been determined that OPWDD will no longer require the use of those funds, the state will utilize those items at least as a starting point for negotiations.

The second critical element is the actual methodology for generating the Federal match. The state is requesting that a 100% of match DSHP expenditures up to $2 billion on average annually be used for the MRT reinvestment projects. This request is consistent with decisions made in the most recent approval of New York's amendment to the 1115 Partnership Plan waiver.

The third critical element is the state's intention to use DSHPs previously approved in the Federal State Health Reform Partnership (FSHRP) 1115 waiver in this MRT waiver amendment. Since these DSHPs have already been approved by CMS, they should automatically be included in the MRT waiver approval amendment.

It is important to point out that the state will not be claiming 100% of the expenditures for the approved DSHPs in the FSHRP waiver and the state should be able to claim this funding immediately. The remaining program expenditures being matched would be included in the waiver amendment upon the expiration of the FSHRP waiver on March 31, 2014. The state will ensure that the same DSHP expenditure is not claimed in both the FSHRP and MRT waivers.

Finally, the most recently approved amendment to the 1115 Partnership Plan waiver (effective August 1, 2011) includes approved DSHPs that the federal matching funds are used for two Quality Demonstration Projects and Clinic Uncompensated Care funding. The state will include these DSHPs in the MRT waiver once the funding is no longer needed for the above noted projects (i.e. Quality Demonstrations expire December 31, 2014 and Clinic Uncompensated Care on December 31, 2013).

In total, the state has identified over $2.7 billion (average annually) in potential DSHP funds that would be used to generate a Federal match. The components of the state's DSHP proposal include the following:

1) Previously approved FSHRP funds not utilized to date - $900 million;

2) Previously approved FSHRP funds currently being expended but available April 1, 2014 - $575 million;

3) Previously approved Partnership Plan DSHPs - $336 million; and

4) New proposed DSHPs, which includes:

    a. New York City and state-supported public health programs – $461 million.

    b. State-supported physician medical malpractice insurance which offsets the cost of high premiums for doctors that handle the bulk of Medicaid deliveries throughout the state– $127 million.

    c. State-supported medical indemnity fund payments which pay the future health care costs of plaintiffs in medical malpractice actions related to birth-related neurological impairments and reduces what would otherwise be costly Medicaid reimbursement – $50 million.

    d. State-supported Elderly Pharmaceutical Insurance Coverage (EPIC) Program which is New York's senior prescription plan. EPIC provides prescription drug coverage to more than 275,000 low and moderate income seniors - $250 million.

Appendix I & Ia - **Summary of DSHP Resources** and Appendix II – **Sources of DSHP Resources by Waiver Year** provide additional details to the state's request. It is important to note that the state's financing strategy for this waiver takes into consideration the intent to extend the Partnership Waiver through December 31, 2017.

The funds being requested under this financing strategy will support investments critical to the successful implementation of the MRT program initiatives and Federal Health Reform as well as effectively bend the cost curve for the state's overall health care system. Additionally, this request complies with federal regulations and primarily relies on reallocation of previously approved FSHRP funds. Finally, this funding will allow New York to continue its significant efforts to fundamentally re-shape its health care delivery system so as to improve patient outcomes and lower costs.

BUDGET NEUTRALITY

The budget neutrality calculations are based on a per capita cost method, and the budget neutrality expenditure caps are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. For purposes of this demonstration, it is assumed that the current 1115 Partnership Plan waiver will be extended thru December 31, 2017.

The general methodology and assumptions used for calculating the budget neutrality expenditure cap is described below:

- An annual expenditure cap is calculated for each Medicaid Eligibility Group (MEG) utilizing the number of eligible member months and the applicable Per Member Per Month (PMPM) costs. This is done for each year of the term of the waiver amendment.
- The base PMPM costs have been inflated by the Presidential trends.
- The annual budget neutrality expenditure cap is the sum of the projected annual expenditure caps for each MEG.
- The overall budget neutrality expenditure cap for the waiver amendment is the sum of the annual budget neutrality expenditure caps for each year for the term (2013 – 2017) of the amendment.
- Applying the assumptions above, the state estimates that the budget neutrality room will increase from $41 billion for 2012 to $46.5 billion by the end of the waiver period.
- The enrollment projections do not include the impact changes that will result from the implementation of the ACA. The Urban Institute projects that approximately 500,000 new individuals will be eligible in the state for Medicaid coverage as a result of the ACA.[1] However, the state needs direction from CMS as to how this population should be incorporated in the waiver budget neutrality calculations.

The attached Exhibit 3 details the budget neutrality expenditure cap calculations and Exhibit 3 (a) illustrates the expenditure detail.

[1] Urban Institute Report available at: http://www.healthcarereform.ny.gov/health_insurance_exchange/docs/2012-03_urban_institute_report.pdf

TABLE OF CONTENTS

The following Appendices provide additional details regarding the State's **MRT Waiver 5 Year Financing and Expenditure Plan**. The $10 billion ($2 billion annual average) in funding being requested will support various investments critical to the successful implementation of the MRT program initiatives and Federal Health Reform. This funding will allow New York to continue its significant efforts to fundamentally re-shape its health care delivery system.

- Appendix I – Summary of DSHP Resources
- Appendix I(a) – NYC and State Supported DSHPs
- Appendix II – NYS Partnership Plan Waiver
- Appendix III – MRT Waiver Amendment 5 Year Expenditure Plan
- Appendix III(a) – MRT Reinvestment Program: Primary Care Expansion
- Appendix III(b) – MRT Reinvestment Program: Health Home Development Fund
- Appendix III(c) – MRT Reinvestment Program: New Care Models
- Appendix III(d) – MRT Reinvestment Program: Expand the Vital Access Provider Program and Safety Net Provider Program
- Appendix III(e)– MRT Reinvestment Program: Public Hospital Innovation
- Appendix III(f) – MRT Reinvestment Program: Medicaid Supportive Housing Expansion
- Appendix III(g) – MRT Reinvestment Program: LTC Transformation and Integration to Managed Care
- Appendix III(h) – MRT Reinvestment Program: Capital Stabilization for Safety Net Hospitals
- Appendix III(i) – MRT Reinvestment Program: Hospital Transition
- Appendix III(j) – MRT Reinvestment Program: Ensuring the Health Workforce Meets the Needs in the New Era of Health Care Reform
- Appendix III(k) – MRT Reinvestment Program: Public Health Innovation
- Appendix III(l) – MRT Reinvestment Program: Regional Health Planning
- Appendix III(m) – MRT Reinvestment Program: MRT & Waiver Evaluation Program
- Appendix IV – Budget Neutrality Impact Through December 31, 2017
- Appendix IV(a) – Expenditure and Enrollment Details

APPENDIX I

NYS Partnership Plan Waiver
Summary of DSHP Resources
MRT 1115 Waiver Amendment
($ Millions)

Federal-State Health Reform Partnership (F-SHRP) DSHPs	Total
New F-SHRP (Approved but Not Utilized)	**$900.0**
OMH (Adult and Children's Non-Residential and Emergency Services)	$333.0
OPWDD (Rental Subsidies, Crisis, Respite, Sheltered Workshops, Pre-Vocational, Employment, & Trans.)	$312.0
OASAS (Prevention, Residential Treatment, Crisis and Outpatient Services)	$255.0
Existing F-SHRP (Currently Utilized -- Until March 31, 2014)	**$574.7**
Early Intervention Services	$180.0
Healthy New York	$150.0
Services to Special Education Children (OCFS)	$80.0
Expanded In-Home Services to the Elderly Program (SOFA)	$49.9
AIDS Drug Assistance Program	$43.2
Tobacco Control Program	$40.0
Community Services for the Elderly (SOFA)	$16.6
Health Workforce Retraining	$15.0
Subtotal F-SHRP	**$1,474.7**

Medical Home and Readmission DSHPs (Currently Utilized - Until Dec. 31, 2014)	Total
General Public Health Work	$224.8
Clinic Indigent Care	$55.0
Cancer Services Programs	$20.4
Newborn Screening Program	$11.3
Childhood Lead Poisoning Primary Prevention	$10.2
Obesity and Diabetes programs	$6.5
Tuberculosis Treatment, Detection and Prevention	$4.7
Healthy Neighborhoods Program	$1.6
Homeless Health Services (OTDA)	$0.8
Tuberculosis Directly Observed Therapy	$0.6
Subtotal Medical Home and Readmission DSHPs	**$335.9**

New DSHPs	Total
New York City Supported Public Health Programs	$411.3
Elderly Pharmaceutical Insurance Program	$250.0
Excess Medical Malpractice Program	$127.0
State-Supported Public Health Programs	$50.0
Medical Indemnity Fund Program	$50.0
Subtotal New DSHPs	**$888.3**

Total F-SHRP, Medical Home, Readmission & New DSHPs	**$2,698.9**

APPENDIX I(a)

NYC and State-Supported DSHPs

MRT 1115 Waiver Amendment

($ Millions)

New York City DSHPs	Total
Early Intervention	$98.2
Department of Health and Mental Hygiene - Admin.	$78.7
School Health	$44.4
Other Environmental Health	$43.6
NY/NY III Supportive Housing Program	$20.8
Mental Health	$14.4
HIV/AIDS Contracts	$12.0
Chemical Dependency	$11.7
Chronic Disease Prevention	$10.9
Epidemiology	$10.8
Mental Retardation & Developmental Disabilities	$7.7
Other Mental Hygiene	$7.5
Other Health Care Access and Improvement Programs	$6.9
Tobacco Control	$6.6
Other Disease Control	$6.1
Child Health Clinics	$5.3
Other Maternal, Infant, Reproductive Health	$4.1
STD/HIV Clinics	$3.5
Primary Care Information Project	$3.0
District Public Health Offices	$2.8
Tuberculosis Evaluation and Treatment	$2.7
Mental Health-Criminal Justice Panel/Care Monitoring	$2.6
Nurse Family Partnership	$2.1
Lead Poisoning Prevention	$2.0
Newborn Home Visiting Program	$1.0
Day Care	$0.8
Immunization	$0.6
Health Promotion and Disease Prevention Programs - Admin.	$0.4
Health Care Access	$0.3
Total NYC DSHPs	**$411.3**

State-Supported Public Health DSHPs	Total
State Support for Local Government Costs (AIM Program)	$46.0
Legislative Member Items	$4.0
Total State-Supported Public Health DSHPs	**$50.0**

APPENDIX II

NYS Partnership Plan Waiver
5 Year Resource Plan
($ in Millions)

	2013	2014	2015	2016	2017	5 Year Total
DSHP Sources	**$1,788.3**	**$2,219.4**	**$2,698.9**	**$2,698.9**	**$2,698.9**	**$12,104.6**
New F-SHRP	$900.0	$900.0	$900.0	$900.0	$900.0	$4,500.0
Existing F-SHRP	$0.0	$431.0	$574.7	$574.7	$574.7	$2,155.1
Medical Home/Readmissions	$0.0	$0.0	$335.9	$335.9	$335.9	$1,007.7
Other	$888.3	$888.3	$888.3	$888.3	$888.3	$4,441.7

Notes:
1) Existing F-SHRP DSHP funding becomes available after March 31, 2014.
2) Med. Home/Readmission DSHPs become available after December 31, 2014.

APPENDIX III

MRT Waiver Amendment
5 Year Expenditure Plan
($ in Millions)

	2013	2014	2015	2016	2017	5 Year Total
Uses	**$1,663.3**	**$2,056.7**	**$2,195.0**	**$2,147.9**	**$1,937.0**	**$10,000.0**
Primary Care Expansion	$330.0	$295.0	$235.0	$215.0	$175.0	$1,250.0
Health Home Development Fund	$150.0	$150.0	$112.5	$75.0	$37.5	$525.0
New Care Models	$22.5	$75.0	$92.5	$75.0	$110.0	$375.0
Expand the Vital Access Provider Program and Safety Net Provider Program	$100.0	$150.0	$200.0	$300.0	$250.0	$1,000.0
Public Hospital Innovation	$240.0	$200.0	$300.0	$360.0	$400.0	$1,500.0
Medicaid Supportive Housing Expansion	$150.0	$150.0	$150.0	$150.0	$150.0	$750.0
LTC Transformation & Integration to Managed Care	$191.0	$226.4	$158.9	$133.9	$128.9	$839.1
Capital Stabilization for Safety Net Hospitals	$296.0	$350.0	$390.0	$355.0	$330.0	$1,721.0
Hospital Transition	$65.0	$120.0	$170.0	$110.0	$55.0	$520.0
Ensuring the Health Workforce Meets the Needs in the New Era of Health Care Reform	$0.0	$125.0	$125.0	$125.0	$125.0	$500.0
Public Health Innovation	$63.4	$74.9	$86.7	$84.6	$85.6	$395.3
Regional Health Planning	$11.4	$22.4	$30.4	$30.4	$30.0	$124.6
MRT and Waiver Evaluation Program	$44.0	$118.0	$144.0	$134.0	$60.0	$500.0

APPENDIX III(a)

MRT Reinvestment Program: Primary Care Expansion

MRT 1115 Waiver Amendment

($ Millions)

Initiative	2013	2014	2015	2016	2017	Five Year Reinvestment Total
1) Technical Assistance	$45.0	$30.0	$30.0	$20.0	$0.0	**$125.0**
Expand Capacity and Accessibility:						
2a) Capital Investment	$165.0	$100.0	$100.0	$110.0	$110.0	**$585.0**
2b) Operational Assistance	$20.0	$40.0	$40.0	$40.0	$40.0	**$180.0**
2c) Health IT Assistance	$100.0	$125.0	$65.0	$45.0	$25.0	**$360.0**
Subtotal Capacity & Accessibility	**$285.0**	**$265.0**	**$205.0**	**$195.0**	**$175.0**	**$1,125.0**
Total Funding Requirement	**$330.0**	**$295.0**	**$235.0**	**$215.0**	**$175.0**	**$1,250.0**

APPENDIX III(b)

MRT Reinvestment Program: Health Home Development Fund

MRT 1115 Waiver Amendment

($ Millions)

Initiative	2013	2014	2015	2016	2017	Five Year Reinvestment Total
1) Member Engagement and Public Education	$4.5	$4.5	$3.4	$2.3	$1.1	**$15.8**
2) Staff Training & Retraining	$15.0	$15.0	$11.3	$7.5	$3.8	**$52.5**
3) Health Information Technology Implementation	$105.5	$115.5	$86.6	$57.8	$28.9	**$394.3**
4) Joint Governance Technical Assistance and Start Up	$25.0	$15.0	$11.3	$7.5	$3.8	**$62.5**
Total Funding Requirement	**$150.0**	**$150.0**	**$112.5**	**$75.0**	**$37.5**	**$525.0**

APPENDIX III(c)

MRT Reinvestment Program: New Care Models

MRT 1115 Waiver Amendment

($ Millions)

Initiative	2013	2014	2015	2016	2017	Five Year Reinvestment Total
1) New Care Models - Funding Opportunities	$22.5	$75.0	$67.5	$37.5	$22.5	**$225.0**
2) Quality Pool	$0.0	$0.0	$25.0	$37.5	$87.5	**$150.0**
Total Funding Requirement	**$22.5**	**$75.0**	**$92.5**	**$75.0**	**$110.0**	**$375.0**

APPENDIX III(d)

MRT Reinvestment Program: Expand the Vital Access Provider Program and Safety Net Provider Program

MRT 1115 Waiver Amendment

($ Millions)

Initiative	2013	2014	2015	2016	2017	Five Year Reinvestment Total
VAP and Safety Net Provider Program	$100.0	$150.0	$200.0	$300.0	$250.0	**$1,000.0**
Total Funding Requirement	**$100.0**	**$150.0**	**$200.0**	**$300.0**	**$250.0**	**$1,000.0**

APPENDIX III(e)

MRT Reinvestment Program: Public Hospital Innovation

MRT 1115 Waiver Amendment

($ Millions)

Initiative	2013	2014	2015	2016	2017	Five Year Reinvestment Total
NYC HHC Projects:						
1) Intensive Care Coordination / Case Management Initiative	$95.0	$84.0	$100.0	$113.0	$125.0	**$517.0**
2) Expanding the Concept of "Hot Spotting" to Uninsured	$80.0	$64.0	$85.0	$100.0	$110.0	**$439.0**
3) Primary Care Expansion	$38.0	$32.0	$40.0	$40.0	$50.0	**$200.0**
Subtotal	**$213.0**	**$180.0**	**$225.0**	**$253.0**	**$285.0**	**$1,156.0**
4) Primary Care and Care Management Expansion for Other Public Hospitals	$27.0	$20.0	$25.0	$32.0	$40.0	**$144.0**
5) Quality Pool			$50.0	$75.0	$75.0	**$200.0**
Total Funding Requirement	**$240.0**	**$200.0**	**$300.0**	**$360.0**	**$400.0**	**$1,500.0**

APPENDIX III(f)

MRT Reinvestment Program: Medicaid Supportive Housing Expansion

MRT 1115 Waiver Amendment

($ Millions)

Initiative	2013	2014	2015	2016	2017	Five Year Reinvestment Total
1) Supportive Housing Capital Expansion Program	$75.0	$75.0	$75.0	$75.0	$75.0	**$375.0**
2) Supportive Housing Services Program	$75.0	$75.0	$75.0	$75.0	$75.0	**$375.0**
Total Funding Requirement	**$150.0**	**$150.0**	**$150.0**	**$150.0**	**$150.0**	**$750.0**

APPENDIX III(g)

MRT Reinvestment Program: LTC Tranformation and Integration to Managed Care

MRT 1115 Waiver Amendment

($ Millions)

Initiative	2013	2014	2015	2016	2017	Five Year Reinvestment Total
1) Nursing Home Transition	$100.0	$100.0	$70.0	$70.0	$65.0	**$405.0**
2) ALP Investment	$50.0	$50.0	$25.0	$0.0	$0.0	**$125.0**
3) NY Connects	$10.0	$18.4	$18.4	$18.4	$18.4	**$83.6**
4) Quality Improvement - MLTC	$3.0	$3.0	$3.0	$3.0	$3.0	**$15.0**
5) HIT Investments	$25.0	$50.0	$37.5	$37.5	$37.5	**$187.5**
6) Ombudsperson	$3.0	$5.0	$5.0	$5.0	$5.0	**$23.0**
Total Funding Requirement	**$191.0**	**$226.4**	**$158.9**	**$133.9**	**$128.9**	**$839.1**

APPENDIX III(h)

MRT Reinvestment Program: Capital Stabilization for Safety Net Hospitals

MRT 1115 Waiver Amendment

($ Millions)

Initiative	2013	2014	2015	2016	2017	Five Year Revinvestment
1) Technical Assistance to Safety Hospital Boards	$15.0	$15.0	$10.0	$5.0	$5.0	**$50.0**
2) Transitional Capital for Hard Assets	$56.0	$110.0	$175.0	$150.0	$135.0	**$626.0**
3) Balance Sheet Restructuring	$225.0	$225.0	$205.0	$200.0	$190.0	**$1,045.0**
Total Funding Requirement	**$296.0**	**$350.0**	**$390.0**	**$355.0**	**$330.0**	**$1,721.0**

APPENDIX III(i)

MRT Reinvestment Program: Hospital Transition

MRT 1115 Waiver Amendment

($ Millions)

Initiative	2013	2014	2015	2016	2017	Five Year Reinvestment Total
1) Technical Assistance	$20.0	$20.0	$20.0	$10.0	$0.0	**$70.0**
2) Plan Support	$45.0	$100.0	$150.0	$100.0	$55.0	**$450.0**
Total Funding Requirement	**$65.0**	**$120.0**	**$170.0**	**$110.0**	**$55.0**	**$520.0**

APPENDIX III(j)

MRT Reinvestment Program: Ensuring the Health Workforce Meets the Needs in the New Era of Health Care

MRT 1115 Waiver Amendment

($ Millions)

Initiative	2013	2014	2015	2016	2017	Five Year Reinvestment Total
1) Health Workforce Retraining Initiative	$0.0	$62.5	$62.5	$62.5	$62.5	**$250.0**
2) Recruitment and Retention Incentives for the Underserved Initiatives	$0.0	$62.5	$62.5	$62.5	$62.5	**$250.0**
Total Funding Requirement	**$0.0**	**$125.0**	**$125.0**	**$125.0**	**$125.0**	**$500.0**

APPENDIX III(k)

MRT Reinvestment Program: Public Health Innovation

MRT 1115 Waiver Amendment

($ Millions)

Initiative	2013	2014	2015	2016	2017	Five Year Reinvestment Total
1) Evidence-Based Preventive Nurse Home Visiting Services	$13.8	$13.8	$18.1	$18.1	$18.1	**$81.8**
2) Asthma Home-Based Self-Management Education and Environmental Assessments	$3.6	$5.1	$9.6	$7.1	$7.1	**$32.5**
3) Diabetes Prevention and Treatment	$40.0	$40.0	$40.0	$40.0	$40.0	**$200.0**
4) Home Visits to Promote Childhood Lead Poisoning Prevention and Treatment	$5.0	$14.0	$14.0	$14.0	$14.0	**$61.0**
5) Water Fluoridation to Promote Dental Health for Children on Medicaid and 6) Quality Improvement Efforts to Address Health Care Acquired Infections and Prevent Sepsis	$1.0	$2.0	$5.0	$5.5	$6.5	**$20.0**
Total Funding Requirement	**$63.4**	**$74.9**	**$86.7**	**$84.6**	**$85.6**	**$395.3**

APPENDIX III(l)

MRT Reinvestment Program: Regional Health Planning

MRT 1115 Waiver Amendment

($ Millions)

Initiative	2013	2014	2015	2016	2017	Five Year Reinvestment Total
Regional Health Planning Grants	$11.4	$22.4	$30.4	$30.4	$30.0	**$124.6**
Total Funding Requirement	**$11.4**	**$22.4**	**$30.4**	**$30.4**	**$30.0**	**$124.6**

APPENDIX III(m)

MRT Reinvestment Program: MRT & Waiver Evaluation Program

MRT 1115 Waiver Amendment

($ Millions)

Initiative	2013	2014	2015	2016	2017	Five Year Reinvestment Total
1) MRT Evaluation (Projects Initiated in MRT)	$35.0	$55.0	$55.0	$45.0	$0.0	**$190.0**
2) MRT New Waiver Project Evaluation	$0.0	$50.0	$75.0	$75.0	$45.0	**$245.0**
3) MRT Waiver Project Management	$4.0	$8.0	$9.0	$9.0	$10.0	**$40.0**
4) MRT Consumer Education	$5.0	$5.0	$5.0	$5.0	$5.0	**$25.0**
Total Funding Requirement	**$44.0**	**$118.0**	**$144.0**	**$134.0**	**$60.0**	**$500.0**

APPENDIX IV
New York State Partnership Plan
Projected 1115 Waiver Budget Neutrality Impact Through December 2017

Budget Neutrality Cap (Without Waiver)	DY 1 - 11 (10/1/97 - 9/30/09) Projected	DY 12 (10/1/09-9/30/10) Actual	DY 13A 10/1/10-3/31/11) Projected	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 (10/1/09 - 12/31/13) Projected
Demostration Group 1 - TANF Children under age 1 through 20		$11,197,206,500	$6,105,699,488	$6,123,530,693	$13,426,169,462	$14,838,728,535	$7,942,549,075	$59,633,883,752
Demonstration Group 2 - TANF Adults 21-64		$4,511,421,595	$2,467,348,368	$2,454,367,076	$5,370,065,165	$5,929,497,585	$3,168,028,125	$23,900,727,913
Demonstration Group 6 - FHP Adults w/Children		$1,878,516,641	$1,043,047,420	$1,055,415,331	$2,341,067,454	$2,632,237,613	$724,658,042	$9,674,942,501
Demonstration Group 8 - Family Planning Expansion				$5,140,241	$10,702,271	$11,139,306	$5,795,793	$32,777,610
Demonstration Group 9 - Duals 18-64					$256,709,619	$1,106,156,119	$290,806,439	$1,653,672,177
Demonstration Group 10 - Duals 65+					$2,598,007,202	$11,194,807,506	$2,943,089,849	$16,735,904,557
W/O Waiver Total	**$187,390,575,140**	**$17,587,144,736**	**$9,616,095,275**	**$9,638,453,340**	**$24,002,721,173**	**$35,712,566,663**	**$15,074,927,323**	**$111,631,908,510**

Budget Neutrality Cap (With Waiver)	DY 1 - 11 (10/1/97 - 9/30/09) Projected	DY 12 (10/1/09-9/30/10) Actual	DY 13A 10/1/10-3/31/11) Projected	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 (10/1/09 - 12/31/13) Projected
Demostration Group 1 - TANF Children under age 1 through 20		$5,006,727,158	$2,714,708,527	$2,722,636,616	$5,935,822,630	$6,523,312,850	$3,471,965,618	$26,375,173,399
Demonstration Group 2 - TANF Adults 21-64		$2,891,489,419	$1,575,447,496	$1,567,158,701	$3,416,017,313	$3,757,736,011	$2,000,129,300	$15,207,978,241
Demonstration Group 5 - Safety Net Adults		$5,947,064,577	$3,499,710,446	$3,596,498,109	$8,302,164,325	$9,567,591,719	$2,581,892,316	$33,494,921,492
Demonstration Group 6 - FHP Adults w/Children up tp 150%		$910,895,137	$503,870,306	$509,844,937	$1,126,650,488	$1,262,025,032	$346,136,227	$4,659,422,127
Demonstration Group 7 - FHP Adults without Children up to 100%		$327,279,755	$168,015,728	$171,374,962	$383,180,812	$435,967,331	$120,734,643	$1,606,553,232
Demonstration Group 7A - FHP Adults without Children @ 160%		$0	$0	$0	$0	$0	$0	$0
Demonstration Group 8 - Family Planning Expansion		$9,839,735	$4,164,485	$5,460,394	$11,576,340	$12,272,547	$6,504,704	$49,818,205
Demonstration Group 9 - Home and Community Based Expansion (HCBS)		N/A	N/A	$3,699,108	$3,699,108	$3,699,108	$924,777	$12,022,101
Demonstration Group 9 - Duals 18-64					$249,276,515	$999,765,437	$249,927,129	$1,498,969,081
Demonstration Group 10 - Duals 65+					$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)						$1,292,500,000	$430,830,000	$1,723,330,000
With Waiver Total	**$157,629,949,646**	**$15,093,295,780**	**$8,465,916,988**	**$8,581,872,826**	**$22,157,595,820**	**$34,425,782,590**	**$11,880,614,449**	**$100,605,078,455**
Expenditures (Over)/Under Cap	**$29,760,625,494**	**$2,493,848,956**	**$1,150,178,287**	**$1,056,580,514**	**$1,845,125,352**	**$1,286,784,073**	**$3,194,312,873**	**$11,026,830,055**

APPENDIX IV
New York State Partnership Plan
Projected 1115 Waiver Budget Neutrality Impact Through December 2017

Budget Neutrality Cap (Without Waiver)	DY 17 (1/1/14-9/30/14) Projected	DY 18 (10/1/14-9/30/15) Projected	DY 19 (10/1/15-9/30/16) Projected	DY 20 (10/1/16-9/30/17) Projected	DY 21 (10/1/17-12/31/17) Projected	DY 17-21 (1/1/14-12/31/17) Projected	DY 1 - 21 (10/1/97 - 12/31/17) Projected
Demostration Group 1 - TANF Children under age 1 through 20	$7,942,549,075	$16,933,174,020	$18,050,499,494	$19,232,176,099	$5,125,211,985	$67,283,610,673	
Demonstration Group 2 - TANF Adults 21-64	$3,168,028,125	$6,741,421,613	$7,172,746,363	$7,627,222,122	$2,028,764,816	$26,738,183,038	
Demonstration Group 6 - FHP Adults w/Children	$2,234,949,343	$3,314,166,058	$3,635,350,488	$3,976,371,601	$1,076,110,681	$14,236,948,171	
Demonstration Group 8 - Family Planning Expansion	$0	$0	$0	$0	$0	$0	
Demonstration Group 9 - Duals 18-64	$873,547,664	$1,225,692,908	$1,290,477,967	$1,357,731,985	$356,689,049	$5,104,139,573	
Demonstration Group 10 - Duals 65+	$8,840,665,721	$12,404,456,970	$13,060,120,982	$13,740,786,870	$3,609,836,937	$51,655,867,480	
W/O Waiver Total	**$23,059,739,928**	**$40,618,911,569**	**$43,209,195,293**	**$45,934,288,676**	**$12,196,613,468**	**$165,018,748,935**	**$464,041,232,585**

Budget Neutrality Cap (With Waiver)	DY 17 (1/1/14-9/30/14) Projected	DY 18 (10/1/14-9/30/15) Projected	DY 19 (10/1/15-9/30/16) Projected	DY 20 (10/1/16-9/30/17) Projected	DY 21 (10/1/17-12/31/17) Projected	DY 17-21 (1/1/14-12/31/17) Projected	DY 1 - 21 (10/1/97 - 12/31/17) Projected
Demostration Group 1 - TANF Children under age 1 through 20	$3,471,965,618	$7,360,506,306	$7,802,052,783	$8,266,040,188	$2,190,435,026	$29,090,999,921	
Demonstration Group 2 - TANF Adults 21-64	$2,000,129,300	$4,240,216,438	$4,494,541,044	$4,761,341,745	$1,261,708,922	$16,757,937,450	
Demonstration Group 5 - Safety Net Adults	$7,745,676,947	$11,050,525,928	$11,824,090,420	$12,651,822,218	$3,384,369,363	$46,656,484,875	
Demonstration Group 6 - FHP Adults w/Children up tp 150%	$1,067,533,772	$1,577,088,330	$1,723,450,041	$1,878,042,135	$506,338,494	$6,752,452,771	
Demonstration Group 7 - FHP Adults without Children up to 100%	$375,291,167	$561,405,772	$618,804,409	$679,603,143	$184,121,396	$2,419,225,887	
Demonstration Group 7A - FHP Adults without Children @ 160%	$0	$0	$0	$0	$0	$0	
Demonstration Group 8 - Family Planning Expansion						$0	
Demonstration Group 9 - Home and Community Based Expansion (HCBS)						$0	
Demonstration Group 9 - Duals 18-64	$747,134,811	$1,036,369,614	$1,059,388,516	$1,091,815,996	$286,255,977	$4,220,964,914	
Demonstration Group 10 - Duals 65+	$7,870,012,341	$10,965,561,955	$11,326,099,635	$11,793,622,604	$3,112,238,924	$45,067,535,458	
Demonstration Population 1: State Indigent Care Pool Direct Expenditures (ICP-Direct)						$0	
Demonstration Population 2: Designated State Health Programs to Support Clinic Uncompensated Care Funding (ICP - DSHP)						$0	
Demonstration Population 3: Designated State Health Programs to Support Medical Home Demonstration (DSHP - HMH Demo)						$0	
Demonstration Population 4: Designated State Health Programs to Support Potentially Preventable Readmission Demonstration (DSHP - PPR Demo)						$0	
Demonstration Population 5: Designated State Health Programs (Various)	$1,617,530,000	$2,185,420,000	$2,114,700,000	$1,899,750,000	$459,260,000	$8,276,660,000	
With Waiver Total	**$24,895,273,956**	**$38,977,094,342**	**$40,963,126,849**	**$43,022,038,029**	**$11,384,728,101**	**$159,242,261,276**	**$417,477,289,377**
Expenditures (Over)/Under Cap	**($1,835,534,027)**	**$1,641,817,227**	**$2,246,068,445**	**$2,912,250,648**	**$811,885,367**	**$5,776,487,659**	**$46,563,943,208**

APPENDIX IV(a)
New York State Partnership Plan
PMPM's and Member Months

WITHOUT WAIVER PMPMS

	DY12 2009-2010	DY13 2010-2011 (2 Qtrs	DY13 2010-2011 (2 Qtrs	DY14 2011-2012	DY15 2012-2013	DY16 2013-2014 (1 Qtr/2 Qtr)	DY17 2013-2014 (3 Qtr/2 Qtr)	DY18 2014-2015	DY19 2015-2016	DY20 2016-2017	DY21 2017 (1 Qtr)
TANF Kids	$585.99	$624.67	$624.67	$665.90	$709.85	$756.70	$756.70	$806.64	$859.88	$916.63	$977.13
TANF Adults	$801.34	$852.63	$852.63	$907.20	$965.26	$1,027.04	$1,027.04	$1,092.77	$1,162.71	$1,237.12	$1,316.30
FHPlus Adults with Children	$625.55	$665.59	$665.59	$708.19	$753.51	$801.73	$801.73	$853.04	$907.63	$965.72	$1,027.53
Family Planning Expansion			$20.23	$21.06	$21.92	$22.81					
Duals 18-64				$4,160.34	$4,368.36	$4,586.78	$4,586.78	$4,816.12	$5,056.93	$5,309.78	$5,575.27
Duals 65+				$4,823.46	$5,064.63	$5,317.86	$5,317.86	$5,583.75	$5,862.94	$6,156.09	$6,463.89

WITH WAIVER PMPMS

	DY12 2009-2010	DY13 2010-2011 (2 Qtrs	DY13 2010-2011 (2 Qtrs	DY14 2011-2012	DY15 2012-2013	DY16 2013-2014 (1 Qtr/2 Qtr)	DY17 2013-2014 (3 Qtr/2 Qtr)	DY18 2014-2015	DY19 2015-2016	DY20 2016-2017	DY21 2017 (1 Qtr)
TANF Kids	$262.02	$277.74	$277.74	$294.40	$312.06	$330.78	$330.78	$350.63	$371.67	$393.97	$417.61
TANF Adults	$513.60	$544.42	$544.42	$577.09	$611.72	$648.42	$648.42	$687.33	$728.57	$772.28	$818.62
SN - Adults	$797.09	$852.89	$852.89	$912.59	$976.47	$1,044.82	$1,044.82	$1,117.96	$1,196.22	$1,279.96	$1,369.56
FHPlus Adults with Children	$303.33	$321.53	$321.53	$340.82	$361.27	$382.95	$382.95	$405.93	$430.29	$456.11	$483.48
FHPlus Adults without Children	$367.84	$389.91	$389.91	$413.30	$438.10	$464.39	$464.39	$492.25	$521.79	$553.10	$586.29
Family Planning Expansion	$20.27	$16.39	$21.49	$22.78	$24.15	$25.60					
Duals 18-64				$4,039.88	$3,948.21	$3,942.01	$3,923.02	$4,072.21	$4,151.37	$4,269.84	$4,474.36
Duals 65+				$4,755.70	$4,706.64	$4,751.90	$4,733.99	$4,936.04	$5,084.50	$5,283.73	$5,572.88

MEMBER MONTHS

	DY12 2009-2010	DY13 2010-2011 (2 Qtrs	DY13 2010-2011 (2 Qtrs	DY14 2011-2012	DY15 2012-2013	DY16 2013-2014 (1 Qtr/2 Qtr)	DY17 2013-2014 (3 Qtr/2 Qtr)	DY18 2014-2015	DY19 2015-2016	DY20 2016-2017	DY21 2017 (1 Qtr)
TANF Kids	19,108,187	9,774,280	9,802,825	20,162,441	20,904,034	10,496,299	10,496,299	20,992,232	20,991,882	20,981,395	5,245,169
TANF Adults	5,629,847	2,893,809	2,878,584	5,919,384	6,142,902	3,084,620	3,084,620	6,169,113	6,168,990	6,165,305	1,541,263
SN Adults	7,460,970	4,103,355	4,216,837	9,097,365	9,798,142	2,471,136	7,413,408	9,884,545	9,884,545	9,884,545	2,471,136
FHPlus Adults with Children	3,002,984	1,567,102	1,585,684	3,305,705	3,493,301	903,868	2,787,658	3,885,124	4,005,322	4,117,520	1,047,279
FHPlus Adults without Children	889,734	430,909	439,524	927,125	995,132	259,985	808,138	1,140,489	1,185,926	1,228,717	314,045
Family Planning Expansion	485,446	254,090	254,090	508,180	508,180	254,090					
Duals 18-64				61,704	253,220	63,401	190,449	254,498	255,190	255,704	63,977
Duals 65+				538,619	2,210,390	553,435	1,662,448	2,221,528	2,227,572	2,232,064	558,462

Appendix V
Performance Measure Metrics

Evaluation Domain	Measure	(1) Primary Care Expansion	(2) Health Home Development	(3) New Care Models	(4) Expand Vital Access Program/ Safety Net Provider Program	(5) Public Hospital Innovation: New Models of Care for the Uninsured	(6) Medicaid Supportive Housing Expansion	(7) Managed Long Term Care Preparation Program	(8) Capital Stabilization for Safety Net Hospitals	(9) Hospital Transition	(10) Workforce Training	(11) Public Health Innovation	(12) Regional Health Planning
Access to Care/Utilization	Percent of Medicaid enrollees and/or uninsured with access to primary care	✓				✓	✓			✓			✓
	Primary care & behavioral health ambulatory capacity	✓				✓	✓						
	Percent of persons assigned to a PCMH	✓				✓	✓						
	Percent of persons with a visit to a PCMH	✓				✓	✓						
	Percent of persons in health homes	✓	✓			✓							
	Number of acute care inpatient beds in each region									✓			
	Nursing home admission rate per 1000 member months							✓					
	Number of nursing homes in plan network							✓					
	Number of newly contracted ALP slots/region							✓					
	Number of ALP beds per region							✓					
	Number of ALPs per plan network							✓					
	ALP utilization vs. nursing home utilization within plan (recipient count, LOS, case mix)							✓					
	Referral rate by type of service (information and referral, assistance)							✓					
	Utilization by category of service plan (pre and post enrollment)							✓					

Appendix V
Performance Measure Metrics

Evaluation Domain	Measure	(1) Primary Care Expansion	(2) Health Home Development	(3) New Care Models	(4) Expand Vital Access Program/ Safety Net Provider Program	(5) Public Hospital Innovation: New Models of Care for the Uninsured	(6) Medicaid Supportive Housing Expansion	(7) Managed Long Term Care Preparation Program	(8) Capital Stabilization for Safety Net Hospitals	(9) Hospital Transition	(10) Workforce Training	(11) Public Health Innovation	(12) Regional Health Planning
Quality of Care	MRT chronic measures (diabetes,hypertension, asthma, HIV)	✓	✓			✓	✓					✓	
	MRT measures of follow-up after mental and substance abuse hospitalization	✓	✓			✓							
	Initiation of substance abuse treatment & engagement	✓	✓		✓	✓	✓						
	Mental health and substance abuse outpatient follow-up	✓	✓		✓	✓							
	Average hospital length of stay overall and/or for select DRGs		✓		✓	✓				✓			
	Comprehensive assessment & care plan upon enrollment		✓										
	Number of interventions conducted by care manager/care management team		✓										
	MRT preventive measures (women/children, prenatal, oral)	✓	✓							✓		✓	✓
	MRT counseling measures (tobacco, alcohol, weight)	✓	✓										
	MRT measures (flu shots, fall prevention pain, injury prevention)							✓					
	Utilization within MLTC plans by category of service pre and post enrollment							✓					
	Number of persons selecting consumer directed services versus plan care manager							✓					
	Number and type of complaints by plan							✓					

Appendix V
Performance Measure Metrics

Evaluation Domain	Measure	(1) Primary Care Expansion	(2) Health Home Development	(3) New Care Models	(4) Expand Vital Access Program/ Safety Net Provider Program	(5) Public Hospital Innovation: New Models of Care for the Uninsured	(6) Medicaid Supportive Housing Expansion	(7) Managed Long Term Care Preparation Program	(8) Capital Stabilization for Safety Net Hospitals	(9) Hospital Transition	(10) Workforce Training	(11) Public Health Innovation	(12) Regional Health Planning
Potentially Preventable Events	Potentially avoidable ER visits	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Potentially preventable hospitalizations	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Potentially preventable hospital readmissions		✓	✓	✓	✓	✓	✓	✓	✓	✓		✓
	ER visits & inpatient stays by age	✓	✓	✓		✓	✓		✓				
Patient Perspective	Patient safety indicators		✓	✓	✓	✓	✓					✓	
	Patient satisfaction	✓	✓	✓		✓	✓	✓		✓			
	Getting care quickly	✓	✓	✓		✓	✓						
	Getting necessary care	✓	✓	✓		✓	✓						
	Care coordination	✓	✓	✓						✓			✓
Cost/Financial Stability	Per member per year health care costs	✓	✓	✓	✓	✓	✓		✓	✓		✓	✓
	Operating margins				✓				✓				
	Days of cash on hand				✓				✓				
	Age of physical plant				✓				✓				
	Debt to capitalization								✓				
	Net assets								✓				
	SN hospitals affiliated with academic medical centers								✓				
	Current assets/current liabilities								✓				
	Level of debt of nursing home (debt/asset, debt/equity)							✓					
	Hospital liquidity ratio									✓			

Appendix V
Performance Measure Metrics

Evaluation Domain	Measure	(1) Primary Care Expansion	(2) Health Home Development	(3) New Care Models	(4) Expand Vital Access Program/ Safety Net Provider Program	(5) Public Hospital Innovation: New Models of Care for the Uninsured	(6) Medicaid Supportive Housing Expansion	(7) Managed Long Term Care Preparation Program	(8) Capital Stabilization for Safety Net Hospitals	(9) Hospital Transition	(10) Workforce Training	(11) Public Health Innovation	(12) Regional Health Planning
Operational	Implementation timelines/budgets				✓								
	Regional/community alignments				✓	✓	✓						✓
Disparities	Rates of measures by racial/ethnic group and other sociodemographic factors	✓	✓	✓		✓	✓				✓		✓
Healthcare Workforce - Underserved Communities	Health care workers completing training							✓			✓		
	Training and retraining programs for healthcare workers by facility							✓			✓		
	Graduating under represented in medicine students entering a health profession school or health related career										✓		
	Medically underserved communities & respective populations										✓		
	Physicians/dentists/mental health clinicians (FTEs) providing services in underserved communities										✓		
	Health care facilities in underserved communities										✓		
	Providers specializing in underserved communities										✓		
	Newly trained physicians practicing in underserved communities										✓		

Appendix V
Performance Measure Metrics

Evaluation Domain	Measure	(1) Primary Care Expansion	(2) Health Home Development	(3) New Care Models	(4) Expand Vital Access Program/ Safety Net Provider Program	(5) Public Hospital Innovation: New Models of Care for the Uninsured	(6) Medicaid Supportive Housing Expansion	(7) Managed Long Term Care Preparation Program	(8) Capital Stabilization for Safety Net Hospitals	(9) Hospital Transition	(10) Workforce Training	(11) Public Health Innovation	(12) Regional Health Planning
Public Health	Birth and prenatal outcome measures (percent of women diagnosed with pregnancy induced hypertension, reduction in preterm delivery for women who smoke, longer mean birth interval between first and second births, initiation and adherence rates for contraceptives)											✓	
	Lead measures (children exposed/tested/re-tested, identified with blood levels above 10 or 15 mcg/dL, referrals for care/treatment, housing units inspected for Medicaid eligible children with an elevated blood lead level)											✓	
	Diabetes prevention program measures (session attendance, physical activity, weight loss, health status)											✓	
	Water fluoridation measures (communities upgrading/installing equipment, fluoride levels, persons served, Medicaid claims reduction for dental caries)											✓	

Appendix VI

PUBLIC NOTICE: Published in June 20, 2012 New York State Register

MISCELLANEOUS NOTICES/HEARINGS

Notice of Abandoned Property Received by the State Comptroller

Pursuant to provisions of the Abandoned Property Law and related laws, the Office of the State Comptroller receives unclaimed monies and other property deemed abandoned. A list of the names and last known addresses of the entitled owners of this abandoned property is maintained by the office in accordance with Section 1401 of the Abandoned Property Law. Interested parties may inquire if they appear on the Abandoned Property Listing by contacting the Office of Unclaimed Funds, Monday through Friday from 8:00 a.m. to 4:30 p.m., at:

1-800-221-9311
or visit our web site at:
www.osc.state.ny.us

Claims for abandoned property must be filed with the New York State Comptroller's Office of Unclaimed Funds as provided in Section 1406 of the Abandoned Property Law. For further information contact: Office of the State Comptroller, Office of Unclaimed Funds, 110 State St., Albany, NY 12236.

PUBLIC NOTICE

Department of Health

Pursuant to 31 CFR Section 431.408 the Department of Health hereby gives notice of the following:

New York State will request a waiver amendment from the federal government that will allow the state to invest up to $10 billion in savings generated by the Medicaid Redesign Team (MRT) reforms to implement an action plan to transform the state's health care system. The Medicaid 1115 waiver will enable New York to fully implement the MRT action plan, reinvest in the state's health care infrastructure, and lower costs over the long term. New York State will request that the federal government allow the state to reinvest over a five-year period up to $10 billion of the $17.1 billion in federal savings generated by MRT reforms.

Significant federal savings have already been realized through New York's MRT process and substantial savings will also accrue as part of this action plan. The waiver will also allow the state to prepare for implementation of national health care reform as well as effectively bend the cost curve for the state's overall health care system. The MRT action plan and the ACA if implemented in tandem could lead to sweeping changes in health care delivery that will benefit the state's 19 million residents.

New York will pursue an amendment to the state's existing 1115 waiver, the New York Partnership Plan, which has been the primary vehicle used by the state to expand access to managed care. Amending this waiver to facilitate MRT implementation makes sense since the move to ''care management for all'' is a vital part of the multi-year action plan. The Partnership Plan waiver also has substantial remaining budget neutrality capacity which will be further augmented by the MRT action plan.

The MRT waiver will be restricted to the portion of the Medicaid program controlled by the Department of Health. Specifically excluded from this 1115 waiver are those Medicaid services provided through waivers administered by the Office for People with Developmental Disabilities (OPWDD). The state is currently pursuing a different waiver agreement that will encompass services/waivers that relate to people with developmental disabilities. Both this waiver and the OPWDD waiver are consistent in their approaches to cost containment and in their commitment to improving outcomes. In particular, both waivers will rely on care management as the primary method for driving change and innovation. Due to the complexity of the OPWDD system in New York, the state believes that these two issues should be addressed separately.

The primary way to improve patient outcomes and lower costs is effective care management. The MRT recommended the state phase-out the uncoordinated FFS program and replace it with a new system of care management for all. This will eventually provide fully-integrated managed care for all Medicaid members. It will take New York State between three to five years to fully implement the state's care management vision.

The state's vision for a new MRT waiver is to utilize reinvested federal dollars that will both prepare the state for the Affordable Care Act (ACA) as well as maximize the value of key ACA provisions. In particular, New York's fragile health care safety net must be modernized and primary care access must be expanded in order to prepare for new enrollees. New York's vision for both Medicaid reform and ACA implementation is well summarized by the CMS Triple Aim. Health care reform must be about improving quality, improving health and reducing per capita costs. The MRT waiver will allow New York State to address all three goals in a coordinated fashion while also fulfilling the promise laid out in the ACA.

Areas of focus in the waiver amendment application would include: Primary Care Expansion, Health Home Development, New Care Models, Expand Vital Access Program/Safety Net Provider Program, Public Hospital Innovation: New Models of Care for the Uninsured, Medicaid Supportive Housing Expansion, Managed Long Term Care Preparation Program, Capital Stabilization for Safety Net Hospitals, Hospital Transition, Workforce Training, Public Health Innovation, Regional Health Planning, and MRT and Waiver Implementation Program.

New York is committed to slowing the rate of growth in Medicaid spending and that commitment will ensure that cost neutrality is maintained. The state's budget neutrality argument will be linked to the state's new Medicaid Global Spending Cap which is already working to control cost growth despite sharp enrollment growth.

The public is invited to review and comment on the state's proposed waiver amendment application. Public hearings were scheduled for:

Tuesday, June 12, Syracuse, NY, 1:00 PM – 4:00 PM.

Wednesday, June 13, Buffalo, NY, 1:30 – 4:30 PM.

Monday, June 18, Bronx, NY, 12:30 – 3:30 PM.

Wednesday, June 20, Rennselaer, NY, 1:00 – 4:00 PM.

Details on the waiver amendment proposal, full public notice, and more information on the state's public engagement process including hearings, topic-specific webinars, and other ways to provide comment, are available at the state's MRT waiver website at http://www.health.ny.gov/health_care/medicaid/redesign/mrt_waiver.htm.

Comments (including comments sought through the public engagement process) concerning the state's plan to submit a waiver amendment will be through the above website and at the postal and email ad-

dresses below for a period of thirty (30) days from the date of this notice.

Additionally, the public is invited to sign up for an email list serve which will provide updates throughout the waiver public engagement and application process at http://www.health.ny.gov/health__care/medicaid/redesign/listserv.htm.

For further information, contact: Department of Health, MRT Waiver Team, Office of Health Insurance Programs, OCP-1211, Corning Tower, Albany, NY 12237, e-mail: mrtwaiver@health.state.ny.us

PUBLIC NOTICE

Office of Mental Health

As a result of the 2012-13 Enacted State Budget, the New York State Office of Mental Health hereby gives notice that it is proposing to amend its Medicaid State Plan to reflect the continuation of the 2011 rates for the 2013 rate year for private psychiatric hospitals, effective January 1, 2013.

PUBLIC NOTICE

Department of State
F-2012-0042
Date of Issuance – June 20, 2012

The New York State Department of State (DOS) is required by Federal regulations to provide timely public notice for the activities described below, which are subject to the consistency provisions of the Federal Coastal Zone Management Act of 1972, as amended.

The applicant has certified that the proposed activity complies with and will be conducted in a manner consistent with the approved New York State Coastal Management Program. The applicant's consistency certification and accompanying public information and data are available for inspection at the New York State Department of State offices located at One Commerce Plaza, 99 Washington Avenue, in Albany, New York.

In F-2012-0042, The Castaways Yacht Club, New Rochelle, NY, is proposing to perform maintenance dredging of the existing marina facility within New Rochelle Creek, with subsequent un-confined and/or confined disposal of approximately 12,400 cubic yards of dredged material at the Western Long Island Sound Disposal Site (WLIS) and/or Central Long Island Sound Disposal Site (CLIS). The WLIS is located within Long Island Sound, approximately 2.8 nautical miles south of Long Neck Point, Noroton, CT and the CLIS is located within Long Island Sound, approximately 5.6 nautical miles south of East Haven, CT.

Any interested parties and/or agencies desiring to express their views concerning the above proposed activities may do so by filing their comments, in writing, no later than 4:30 p.m., 15 days from the date of publication of this notice, or, by Thursday, July 5, 2012.

Comments should be addressed to the New York State Department of State, Division of Coastal Resources, ATTN: Consistency Review Unit, One Commerce Plaza, Suite 1010, 99 Washington Avenue, Albany, New York 12231. Telephone (518) 474-6000; Fax (518) 473-2464. Comments can also be submitted electronically via e-mail at: LINK"mailto:CR@dos.ny.gov"CR@dos.ny.gov.

This notice is promulgated in accordance with Title 15, Code of Federal Regulations, Part 930.

PUBLIC NOTICE

Department of State

A meeting of the NYS Hearing Aid Dispensing Advisory Board will be held on Tuesday, June 26, 2012 at 10:30 a.m. at the New York State Department of State, 99 Washington Avenue, 5th Floor Conference Room, Albany, NY.

Should you require further information, please contact Carol Fansler at Carol.Fanslera@dos.ny.gov or 518-486-3857.

PUBLIC NOTICE

Susquehanna River Basin Commission
Projects Approved for Consumptive Uses of Water

SUMMARY: This notice lists the projects approved by rule by the Susquehanna River Basin Commission during the period set forth in ''DATES.''

DATE: April 1, 2012, through April 30, 2012.

ADDRESS: Susquehanna River Basin Commission, 1721 North Front Street, Harrisburg, PA 17102-2391.

FOR FURTHER INFORMATION CONTACT: Richard A. Cairo, General Counsel, telephone: (717) 238-0423, ext. 306; fax: (717) 238-2436; e-mail: rcairo@srbc.net. Regular mail inquiries may be sent to the above address.

SUPPLEMENTARY INFORMATION: This notice lists the projects, described below, receiving approval for the consumptive use of water pursuant to the Commission's approval by rule process set forth in 18 CFR § 806.22(f) for the time period specified above:

Approvals By Rule Issued Under 18 CFR § 806.22(f):

1. SWEPI, LP, Pad ID: Shedd 514, ABR-201204001, Rutland Township, Tioga County, Pa.; Consumptive Use of Up to 4.000 mgd; Approval Date: April 11, 2012.

2. Chief Oil & Gas LLC, Pad ID: Leh Drilling Pad #1, ABR-201204002, Burlington Township, Bradford County, Pa.; Consumptive Use of Up to 2.000 mgd; Approval Date: April 11, 2012.

3. Chief Oil & Gas LLC, Pad ID: Yanavitch Drilling Pad #1, ABR-201204003, Stevens Township, Bradford County, Pa.; Consumptive Use of Up to 2.000 mgd; Approval Date: April 11, 2012.

4. Chief Oil & Gas LLC, Pad ID: D & J Farms Drilling Pad #1, ABR-201204004, Sheshequin Township, Bradford County, Pa.; Consumptive Use of Up to 2.000 mgd; Approval Date: April 11, 2012.

5. EXCO Resources (PA), Inc., Pad ID: Murray Unit Pad, ABR-201204005, Penn Township, Lycoming County, Pa.; Consumptive Use of Up to 8.000 mgd; Approval Date: April 11, 2012.

6. Chesapeake Appalachia, LLC, Pad ID: Maurice, ABR-201204006, Herrick Township, Bradford County, Pa.; Consumptive Use of Up to 7.500 mgd; Approval Date: April 18, 2012.

7. SWEPI, LP, Pad ID: Owlett 843R, ABR-201204007, Middlebury Township, Tioga County, Pa.; Consumptive Use of Up to 4.000 mgd; Approval Date: April 23, 2012.

8. SWEPI, LP, Pad ID: Hepler 235, ABR-201204008, Sullivan Township, Tioga County, Pa.; Consumptive Use of Up to 4.000 mgd; Approval Date: April 23, 2012.

9. Chesapeake Appalachia, LLC, Pad ID: Manning, ABR-201204009, Cherry Township, Sullivan County, Pa.; Consumptive Use of Up to 7.500 mgd; Approval Date: April 23, 2012.

10. EQT Production Co., Pad ID: Phoenix N (ANT6), ABR-201204010, Duncan Township, Tioga County, Pa.; Consumptive Use of Up to 3.000 mgd; Approval Date: April 27, 2012.

11. Chesapeake Appalachia, LLC, Pad ID: Simplex, ABR-201204011, Standing Stone Township, Bradford County, Pa.; Consumptive Use of Up to 7.500 mgd; Approval Date: April 27, 2012.

12. Southwestern Energy Production Company, Pad ID: Claytor Pad, ABR-201204012, New Milford and Great Bend Townships, Susquehanna County, Pa.; Consumptive Use of Up to 4.999 mgd; Approval Date: April 27, 2012.

13. Southwestern Energy Production Company, Pad ID: Charles Pad, ABR-201204013, Jackson Township, Susquehanna County, Pa.; Consumptive Use of Up to 4.999 mgd; Approval Date: April 27, 2012.

14. Chesapeake Appalachia, LLC, Pad ID: Freed, ABR-201204014, Albany Township, Bradford County, Pa.; Consumptive Use of Up to 7.500 mgd; Approval Date: April 30, 2012.

15. Chesapeake Appalachia, LLC, Pad ID: Reilly, ABR-201204015, Colley Township, Sullivan County, Pa.; Consumptive Use of Up to 7.500 mgd; Approval Date: April 30, 2012.

16. Southwestern Energy Production Company, Pad ID: Conigliaro Pad, ABR-201204016, New Milford Township, Susquehanna County,

TRIBAL NOTIFICATION: Mailed on June 6, 2012

NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

June 6, 2012

Cayuga Nation
Mr. Clinton Halftown
Nation Representative
P.O. Box 803
Seneca Falls, NY 13148

Dear Mr. Halftown:

In July 1997, New York State received approval from the federal government of its Section 1115 waiver request, known as the Partnership Plan. Approval of this waiver allowed the State to implement a mandatory Medicaid managed care program in counties with sufficient managed care capacity and the infrastructure to manage the education and enrollment processes essential to a mandatory program. In 2006, New York State received federal approval for a second demonstration waiver, the Federal-State Health Reform Partnership (F-SHRP), under which the State implemented a significant restructuring of its health care delivery system.

This letter is to notify you that New York State will request a waiver amendment from the federal government that will allow the state to invest up to $10 billion in savings generated by the Medicaid Redesign Team (MRT) reforms to implement an action plan to transform the state's health care system. The Medicaid 1115 waiver will enable New York to fully implement the MRT action plan, reinvest in the state's health care infrastructure, and lower costs over the long term. New York State will request that the federal government allow the state to reinvest over a five-year period up to $10 billion of the $17.1 billion in federal savings generated by MRT reforms.

Significant federal savings have already been realized through New York's MRT process and substantial savings will also accrue as part of this action plan. The waiver will also allow the state to prepare for implementation of national health care reform as well as effectively bend the cost curve for the state's overall health care system. The MRT action plan and the ACA if implemented in tandem could lead to sweeping changes in health care delivery that will benefit the state's 19 million residents.

New York will pursue an amendment to the state's existing 1115 waiver, the New York Partnership Plan, which has been the primary vehicle used by the state to expand access to managed care. Amending this waiver to facilitate MRT implementation makes sense since the move to "care management for all" is a vital part of the multi-year action plan. The Partnership Plan waiver also has substantial remaining budget neutrality capacity which will be further augmented by the MRT action plan.

Areas of focus in the waiver amendment application would include: Primary Care Expansion, Health Home Development, New Care Models, Expand Vital Access Program/Safety

Net Provider Program, Public Hospital Innovation: New Models of Care for the Uninsured, Medicaid Supportive Housing Expansion, Managed Long Term Care Preparation Program, Capital Stabilization for Safety Net Hospitals, Hospital Transition, Workforce Training, Public Health Innovation, Regional Health Planning, and MRT and Waiver Implementation Program.

A waiver amendment summary document is attached to this letter. More details are available at the state's MRT waiver website at http://www.health.ny.gov/health_care/medicaid/redesign/mrt_waiver.htm. Additionally, you are invited to sign up for an email list serve which will provide updates throughout the waiver public engagement and application process at http://www.health.ny.gov/health_care/medicaid/redesign/listserv.htm .

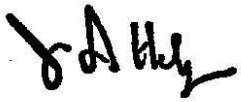
As you know, under the State's Section 1115 Demonstration programs, Native Americans with Medicaid coverage may enroll in managed care plans but are not required to do so. Under these amendments to the 1115 waiver, this exemption from mandatory enrollment for Native Americans will be continued. In addition, for Native Americans who choose to enroll in managed care plans, existing policies relating to tribal providers will be continued. We anticipate these changes will have minimal impact on Tribal Nations.

My office has scheduled a conference call to provide an overview of the waiver amendment process and take any questions you may have. The call is scheduled for Monday, June 25 at 1:00 PM. If you would like to participate, please use the following call-in information:

Call-in #: 1-866-394-2346
Conference Code: 105 726 8043#

If you're not able to participate, or have additional comments, please forward any questions or input regarding this waiver amendment to my office by Friday, July 6. We look forward to your continued collaboration.

Sincerely,



Jason A. Helgerson
Medicaid Director
Deputy Commissioner
Office of Health Insurance Programs

Enclosure

cc: Vennetta Harrison
Karina Aguilar

TRIBAL NOTIFICATION: Mailed on June 28, 2012

NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

June 28, 2012

Cayuga Nation
Mr. Clinton Halftown
Nation Representative
P.O. Box 803
Seneca Falls, NY 13148

Dear Mr. Halftown:

This letter is to follow up to my June 6 letter to notify you that New York State will request a waiver amendment from the federal government that will allow the state to invest up to $10 billion in savings generated by the Medicaid Redesign Team (MRT) reforms to implement an action plan to transform the state's health care system.

My office had scheduled a conference call for Monday, June 25 at 1:00 PM. Unfortunately, technical difficulties prevented the call from connecting, and we were unable to hold our discussion on the waiver amendment.

We have rescheduled the conference call to provide an overview of the waiver amendment process and take any questions you may have. The call is scheduled for Tuesday, July 17 at 11:30 AM. If you would like to participate, please use the following call-in information:

Call-in #: 1-866-394-2346
Conference Code: 105 726 8043#

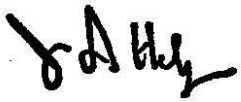
Copies of the waiver amendment summary document and an overview presentation are attached to this letter. More details are available at the state's MRT waiver website at http://www.health.ny.gov/health_care/medicaid/redesign/mrt_waiver.htm. Additionally, you are invited to sign up for an email list serve which will provide updates throughout the waiver public engagement and application process at http://www.health.ny.gov/health_care/medicaid/redesign/listserv.htm .

As you know, under the State's Section 1115 Demonstration programs, Native Americans with Medicaid coverage may enroll in managed care plans but are not required to do so. Under these amendments to the 1115 waiver, this exemption from mandatory enrollment for Native Americans will be continued. In addition, for Native Americans who choose to enroll in

managed care plans, existing policies relating to tribal providers will be continued. We anticipate these changes will have minimal impact on Tribal Nations.

If you're not able to participate, or have additional comments, please forward any questions or input regarding this waiver amendment to my office by Friday, July 20. We look forward to our continued collaboration.

Sincerely,



Jason A. Helgerson
Medicaid Director
Deputy Commissioner
Office of Health Insurance Programs

Enclosure

cc: Vennetta Harrison
Karina Aguilar

NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

March 15, 2013

Cynthia Mann
Director
Center for Medicaid and CHIP Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard, MS S2-26-12
Baltimore, Maryland 21244

Dear Ms. Mann:

I am writing to request a technical amendment to the Section 1115 Partnership Plan Waiver (11-W-00114/2) to be effective April 1, 2013. The purpose of the amendment is to expand the objectives of the current Partnership Plan Waiver to support NYS' transformation of the Office for People With Developmental Disabilities (OPWDD) service delivery system. This multi-year transformation, which is described in more detail in a 12 point proposal (See Attachment 1), has at its core the following key elements:

1. Deinstitutionalization and transitioning people into the most integrated settings possible to meet their housing and support needs.

2. Ensure that existing and new community based services meet CMS' Home and Community Based Standards and that all services developed through NYS' OPWDD People First Waiver-1915 (b) (c) will be the result of person centered planning with a particular emphasis on self-direction, competitive employment and integrated housing. Also, a greater focus on care coordination and quality measurement and improvement using personal outcome data will also be operationalized as part of the OPWDD People First Waiver.

3. Aggressive expansion in the number of people who:

    a. self-direct at least part of their services;
    b. are competitively employed;
    c. transition from institutions to qualifying HCBS settings or those that meet Money Follows the Person criteria.

To help NYS support this major multi-year system transformation, that will better support New Yorkers with developmental disabilities, we are seeking Federal approval to expand funding for certain previously approved designated state health programs within the NYS Department of Mental Hygiene including OPWDD. The approximate value of these state expenditures is $500 million with FFP $250 million. CMS will need to officially communicate to us which specific programs will be covered.

Thank you for your consideration of this request. We are anxious to get this amendment and the resulting additional funds in place so that we can begin the transformation of the system that supports people with developmental disabilities. We are ready to meet with you and your staff as needed.

Sincerely,

[redacted]

Jason A. Helgerson
Medicaid Director
Office of Health Insurance Programs

Attachment
cc: C. Burke
J. Ulberg
J. Moran
K. Delaney
L. Raffaele
F. Walsh

Draft NY Proposal for OPWDD System Transformation: Year 1 (assumes April 1, 2013 effective date)

2/25/2013

Part 1: Deinstitutionalization, transition to the community, Balancing Incentive Plan (BIP)/Money Follows the Person (MFP), and HCBS settings

1) By April 1, 2013 New York will have an approved amendment to the MFP Operational Protocol, adding the ID/DD population for transition

2) By September 1, 2013 NY will submit a detailed structural change work plan to implement the Balancing Incentive Program (BIP). The work plan will:

a. meet all CMS requirements for BIP.
b. align the infrastructure requirements for the BIP and MFP to fullest extent possible, including the use of the balancing and rebalancing funds to ensure NY reaches the Balancing Incentive Program target expenditure benchmark of 50 percent across total Medicaid Long Term Support Services (MLTSS) expenditures by Sept. 30, 2015.
c. include a detailed description of all settings in which the OPWDD population currently reside as a baseline for describing the state's housing strategy.
    i. This description should provide a complete picture of NY's current housing options for persons with IDD, or the "system as is" model. This baseline should include the number of individuals in group homes, small Intermediate Care Facilities (ICFs/IDD), large ICFs/IDD and non-traditional housing models. Each setting type above should include the maximum number of individuals living in the residence, and any type of licensure or accreditation required.
    ii. Distinctly identify how BIP and/or MFP funds will be used to support these strategies, and the timeline for utilization of the respective funding sources.
    iii. Provide a detailed description of the process the State will use to determine whether residential settings for persons transitioned from institutions meet CMS standards for home and community-based settings and/or qualify as residences in the MFP program. This plan will include a description of the residential facilities, the process the state will use to independently assess whether these settings meet the characteristics set forth in the 1915i NPRM from April 2012, and the timeline for compliance by all settings in which Medicaid HCBS are provided.
    iv. Include an affirmative commitment by the state to establish an independent process for assuring that individual person-centered plans meet the needs of individuals served in community-based settings, and a description of the process the state will use to assure that person-centered plans are implemented with fidelity to the established process.
    v. Outline how an individual direction option will be used as a service delivery model and the impact of individual direction on the provision of traditional services and supports. Describe how individuals who are living in campus based settings will have an opportunity for peer interactions to better understand available support options.

DRAFT

d. NY agrees that at least 30% of those persons transitioned from institutions, both campus-based and non-campus –based ICFs, will qualify for MFP (i.e. can be transitioned to an MFP qualified residence), beginning in Year 1.
e. NY agrees to transition the remaining 160 residents of the Finger Lakes and Taconic campus based ICFs prior to December 31, 2013, to community-based settings that meet Centers for Medicare and Medicaid (CMS) Home and Community Based Service (HCBS) settings standards.
f. Based on the information provided about the state's housing capacity, CMS and NY will negotiate an approvable transition timeline for the residents of the remaining campus and non-campus-based ICF's no later than October 1, 2013.
g. NY will provide semi- annual updates to each element described above which should lead to increased supportive housing options currently available for persons being transitioned from institutions, and a state strategy for increasing the availability of supportive housing options including "non-traditional housing models" such as the "Home of Your Own" program, Family Care, Shared Living, Customized Residential Options, and Assets For Independence (AFI).

Part 2: Community-based service delivery system requirements

1) NY will submit any required amendments to approved1915(c) HCBS waivers to increase slots needed to serve persons transitioned from institutional settings.

2) NY will submit an approvable 1915(b)(c) waiver application no later than April 1, 2013, and will implement voluntary enrollments by October 1, 2013. The application will provide evidence that the community- based settings in which Medicaid HCBS are provided meet CMS HCBS settings standards, and that all agreed-upon objectives with regard to competitive employment, person-centered planning, self-direction, and quality measurement/improvement are operationalized as part of the (b)(c) waiver. These agreed-upon objectives will be reflected in the Special Terms and Conditions (STC's) for the 1915(b)(c) waiver. Additionally, the STCs will contain some managed care requirements for Developmental Disabilities Individual Support and Care Coordination Organizations (DISCOs) which include:

- DISCOs will meet the Managed Care Organization (MCO) licensure requirement;
- will be regulated as Prepaid Inpatient Health Plans (PIHPs) that are subject to review by External Quality Review Organizations (EQRO);
- will incorporate DISCOs in the overall managed care quality strategy;
- will comply with conflict free case management standards required in the Balancing Incentive Program; and
- will prohibit plans from making eligibility determinations and enrollment.

3) NY agrees to submit to CMS, no later than December 31, 2013, a detailed proposal/workplan for transformative increases in the number of individuals in competitive employment and the number of

students exiting the educational system directly into competitive employment. The plan must include a timeline for the closing of sheltered workshops and a description of the collaborative work with the NY educational system to provide training and education to key stakeholders on the availability and importance of competitive employment.

4) New York will increase the number of people in competitive employment by 700 individuals added to Supported Employment above the previous 12 month enrollment, with no exceptions for an attrition rate during the period April 1, 2013 and April 1, 2014. Only gainful employment at minimum or greater wage will be considered competitive employment. Other activities such as volunteerism, while positive in nature, will not be considered towards this benchmark.

5) New York will target youth as a priority in its employment initiative. To accomplish this, OPWDD will retool the Pathways to Employment service in the waiver by shortening the time frame for transition from this service into supported employment. NY will submit a waiver amendment reflecting the changes no later than April 1, 2013.

6) New York will provide CMS with data on the number of OPWDD eligible students aging out of the educational system on an annual basis, the number who enter Vocational Rehabilitation (VR), the number who enter OPWDD because they are not found ready by Access VR, and any websites/sources for employment data no later than March 1, 2013.

7) The NY OPWDD will implement a self-directed approach in which individuals and their designated representatives may fully control the hiring, discharge, supervision, performance review, distribution of goods and services, and performance raises of their workers within their authorized budget allocation. The beneficiary and representative as appropriate will immediately be in control of determining individually needed training required of workers (in addition to the state requirements across the board). Within one year, the state will develop self-directed policies that recognize the individual as the best determinant of their own provider qualifications by minimizing “one size fits all” policies. The state will assure that agencies with choice do not just act like traditional service agencies for persons with disabilities or with developmental disabilities, but work for the beneficiary who is at the center and in control of service delivery.

8) Individuals and families are aware of a broader range of consumer directed options for support and services that are provided with information related to the range of resource that could be used for supports so that they may choose and direct options that are customized. Individuals and their representatives as appropriate are informed verbally and in easy to understand written materials on their options for support on payroll and documentation of workers and services. Training will be available for statewide use April 30, 2013.

9) New York will demonstrate the capability to support consumer direction in the areas of adopting and documenting risk mitigation strategies in which there is meaningful negotiation with the beneficiary and representative as appropriate. Involuntary discharges will be accompanied by the right to a fair hearing so the beneficiary may have the opportunity to defend actions or inactions that resulted in the

involuntary discharge. The state would retain the right to immediately stop services pending the hearing if they think there is immediate risk of harm to the beneficiary by remaining in the self-direction program.

10) NY OPWDD will increase the number of people offered the option to self-direct their services through efforts associated with increased education to all stakeholders in a consistent manner statewide. This education will be proved to at least 10,000 people by 2015. Within three years the number of people who self-direct their services in part or whole will be increased from 850 to 5000 by December 31, 2015.

11) Efforts to stream line the consumer-directed model will be undertaken and be inclusive of the Medicaid Long Term Support Services (MLTSS) efforts being developed in an effort to improve overall access to this option by September 30, 2013.

12) New York will adopt practice guidelines for care coordinators based on the Council on Quality and Leadership (CQL) personal outcome measures and will annually assess managed care quality using personal outcome data. New York will provide a report on its progress toward the development of these measures by December 31, 2013.

DRAFT

NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

January 31, 2013

Cindy Mann
Director, Center for Medicaid & State Operations
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Mail Stop S2-26-12
Baltimore, MD 21244-1850

Dear Ms. Mann:

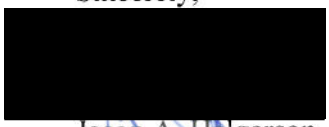
New York State requests revisions to our Section 1115 Demonstration programs (Partnership Plan, 11-W-00114/2 and F-SHRP, 11-W-00234/2) to further expand enrollment into Medicaid managed care pursuant to Governor Cuomo's Medicaid Redesign initiative.

This proposal eliminates exemptions and exclusions for two populations: 1) certain foster care children who are directly place by the local social services departments; and, 2) non-dually eligible individuals participating in the Medicaid buy-in program for the working disabled. In addition, the State is requesting a further minor modification to the mainstream Medicaid managed care (MMMC) benefit package intended to ensure that individuals transitioning from the Section 1915-c Long Term Home Health Care Program (LTHHCP) have access to the services necessary for them to remain in the community. Specifically, we request that an additional non-State plan service – Home Delivered Meals – be covered by MMMC plans only for individuals transitioning from the LTHHCP who were in receipt of this benefit at the time of transition.

Enclosed is a detailed description of these proposed changes, as well as proposed revisions to the Special Terms and Conditions of the Partnership Plan and F-SHRP waivers. In order to implement these changes on April 1, 2013, we are requesting your expedited review of this request.

We appreciate the continued cooperation and assistance of CMS as we implement our Medicaid Redesign initiatives and look forward to working with you on the next phase of these important program changes.

Sincerely,



Jason A. Helgerson
Medicaid Director
Office of Health Insurance Programs

Enclosure
cc: Jessica Woodard
Michael Melendez
Vallencia Lloyd
Gregory Allen

Eliminate Mainstream Medicaid Managed Care Exemptions/Exclusions Effective 4/1/13
Partnership Plan and Federal-State Health Reform Partnership (F-SHRP)

The State's goal is to enroll all Medicaid recipients in managed care within five years. To that end, the State is phasing out most MMMC exclusions and exemptions over a five year period beginning in August 2011.

A. New Mandatory Populations

The following two populations are scheduled to become mandatory as of April 1, 2013:

1) ***Foster care children placed directly by the local social services districts (LDSS) in foster care settings and for whom no per diem is paid to the foster family (non-NYC counties, only).***

   Foster care children placed by voluntary agencies that receive a per diem payment continue to be excluded from enrollment, while foster care children placed by voluntary agencies for whom a per diem is not paid will continue to be excluded unless the county opts to enroll them.

   Approximately 3,650 foster care children are in the target population. Of that number, 1,350 are already enrolled in MMMC, since 36 of 58 non-New York City counties are enrolling foster care children on a voluntary basis. The State is currently conducting a network overlap analysis to determine how many providers caring for this population also participate in one or more MMMC plans. As with previous populations that have transitioned to managed care, MMMC plans will be encouraged to contract with those providers in their service areas that serve these children. A webinar will be held for foster care providers, counties and MMMC plans to ensure a seamless transition.

2) ***Non-dually eligible individuals participating in the Medicaid buy-in program for the working disabled.***

   All non-dually eligible individuals in the buy-in program will be enrolled, whether they are required to pay a premium or not. While there are approximately 16,100 individuals in this population overall[1], only about 1,000 have no other exemption or exclusion on file and of these, the large majority are already enrolled. The total number of individuals in this population who will be required to enroll as of April 1 is expected to be approximately 200. The State is currently conducting a network overlap analysis to determine how many providers caring for this population also participate in one or more MMMC plans.

   The State does not currently enforce the requirement for certain program participants to pay a premium. If, in the future, the State decides to enforce the requirement, a mechanism will be developed to collect premiums and make adjustments to FMAP claims for the additional revenue.

B. Benefits

The State's previous request identified Medical Social Services (MSS) as a service that will be added to the MMMC plan benefit package for those persons transitioning from the Long Term Home Health Care Program (LTHHCP) who were in receipt of the benefit at the time of transition. The State has

[1] Figures for New York City plus non-enrollment broker counties outside of New York City. This population is already enrolled in enrollment broker counties upstate.

since identified ***Home Delivered Meals*** as a benefit that should be available to transitioning LTHHCP participants who are in receipt of the service, as without this service, these individuals may be at risk for failure to remain in the community. Home Delivered Meals will be available only to the extent that the enrollee's needs cannot be met by existing support services, including family and approved personal care aides. The Home Delivered Meals benefit includes up to two meals per day on week days and/or weekends. There are 226 LTHHCP participants currently receiving Home Delivered Meals at an annual cost of approximately $500,000.

C. Requested Revisions to STCs

1. <u>Partnership Plan</u>

a) The following revisions to the Partnership Plan, STC 26, are requested to provide authority to enroll these new populations in MMMC.

26. Exclusions and Exemptions from MMMC. Notwithstanding the eligibility criteria in STC 16, certain individuals cannot receive benefits through the MMMC program (i.e., excluded), while others may request an exemption from receiving benefits through the MMMC program (i.e., exempted). Tables 6 and 7 list those individuals either excluded or exempted from MMMC.

Table 6: Individuals Excluded from MMMC Individuals who become eligible for Medicaid only after spending down a portion of their income
Residents of state psychiatric facilities or residents of state-certified or voluntary treatment facilities for children and youth
Patients in residential health care facilities (RHCF) at time of enrollment and residents in an RHCF who are classified as permanent
Participants in capitated long-term care demonstration projects
Medicaid-eligible infants living with incarcerated mothers
Individuals with access to comprehensive private health insurance if cost effective
Foster care children in the placement of a voluntary agency
~~Foster care children in direct care [at the option of the local Department of Social Services (LDSS)]~~
Certified blind or disabled children living or expected to live separate and apart from their parents for 30 days or more
Individuals expected to be Medicaid-eligible for less than 6 months (except for pregnant women)
Individuals receiving hospice services (at time of enrollment)
Individuals with a "county of fiscal responsibility" code of 97 (Individuals residing in a state Office of Mental Health facility)
Individuals with a "county of fiscal responsibility" code of 98 (Individuals in an Office for People with Developmental Disabilities/OPWDD facility or treatment center)
Youth in the care and custody of the commissioner of the Office of Family & Children Services
Individuals eligible for the family planning expansion program
Individuals who are under 65 years of age (screened and require treatment) in the Centers for Disease Control and Prevention breast, cervical, colorectal, and/or prostate early detection program and need treatment for breast, cervical, colorectal, or prostate cancer, and who are not otherwise covered under creditable health coverage
~~Individuals who are eligible for Medicaid buy-in for the working disabled and who must pay a premium~~
Individuals who are eligible for Emergency Medicaid

Table 7: Individuals who may be exempted from MMMC

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

b) The following changes are requested to Attachment A, MMMC Benefits, to reflect the addition of Home Delivered Meals for a limited population:

ATTACHMENT A
Mainstream Medicaid Managed Care Benefits
Inpatient and outpatient hospital services
Clinic services including Rural Health Clinic and Federally Qualified Health Center services
Laboratory and X-ray services
Home health services
Early Periodic Screening, Diagnosis, and Treatment services (for individuals under age 21 only)
Family planning services and supplies
Physicians services including nurse practitioners and nurse midwife services
Dental services
Physical and occupational therapy
Speech, hearing, and language therapy
Prescription drugs, over-the-counter drugs, and medical supplies
Durable Medical Equipment (DME), including prosthetic and orthotic devices, hearing aids, and prescription shoes
Vision care services, including eyeglasses
Intermediate Care Facilities for the Mentally Retarded (ICF/MR)
Nursing facility services
Personal care services
Medical Social Services for persons transitioning from the LTHHCP who received the service under the LTHHCP (non-State plan service)

Home Delivered Meals for persons transitioning from the LTHHCP who received the service under the LTHHCP (non-State plan service)
Case management services
Hospice care services
TB-related services
Inpatient and outpatient behavioral health services (mental health and chemical dependence services)
Emergency medical services, including emergency transportation
Adult day care
Personal Emergency Response Services (PERS)
Renal dialysis
Home and Community Based Services waivers (HCBS)
Care at Home Program (OPWDD)
Non–emergency transportation
Experimental or investigational treatment (covered on a case-by-case basis)

2. F-SHRP

a) The following revisions to the F-SHRP, STC 18, are requested to provide authority to enroll these new populations in MMMC.

18. Exclusions and Exemptions from MMMC. Notwithstanding the eligibility criteria in STC 16(b), certain individuals cannot receive benefits through the MMMC program (i.e. are excluded from participation), while others may request an exemption from receiving benefits through the MMMC program (i.e. may be exempted from participation). Tables 5 and 6 list those individuals either excluded or exempted from MMMC.

Table 5: Individuals Excluded from MMMC

Individuals who become eligible for Medicaid only after spending down a portion of their income
Residents of state psychiatric facilities or residents of state certified or voluntary treatment facilities for children and youth
Patients in residential health care facilities (RHCF) at time of enrollment and residents in an RHCF who are classified as permanent
Participants in capitated long-term care demonstration projects
Medicaid-eligible infants living with incarcerated mothers
Individuals with access to comprehensive private health insurance if cost effective
Foster care children in the placement of a voluntary agency
~~Foster care children in direct care [at the option of the local Department of Social Services (LDSS)]~~
Certified blind or disabled children living or expected to live separate and apart from their parents for 30 days or more
Individuals expected to be Medicaid eligible for less than six months (except for pregnant women)
Individuals receiving hospice services (at time of enrollment)

Youth in the care and custody of the commissioner of the Office of Family & Children Services
Individuals eligible for the family planning expansion program
Individuals with a "county of fiscal responsibility" code of 97 ((Individuals residing in a State Office of Mental Health facility)
Individuals with a “county of fiscal responsibility” code of 98 (Individuals in an OPWDD facility or treatment center)
Individuals under 65 years of age (screened and require treatment) in the Centers for Disease Control and Prevention’s breast, cervical, colorectal, and/or prostate early detection program and need treatment for breast, cervical, colorectal, or prostate cancer, and are not otherwise covered under creditable health coverage.
~~Individuals who are eligible for Medicaid buy-in for the working disabled and must pay a premium~~
Individuals eligible for Emergency Medicaid.

Table 6: Individuals who may be exempted from MMMC

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

***** These persons may **only** join a qualified Medicaid Advantage Plan

b) The following changes are requested to F-SHRP, STC 21, MMMC Program Benefits and Cost Sharing, to reflect the addition of Home Delivered Meals for a limited population:

21. Mandatory Mainstream Managed Care Program Benefits and Cost-Sharing.
Benefits provided through this Demonstration for the mainstream Medicaid managed care program are identical to those in the Medicaid state plan (except as indicated), and are summarized below:

Inpatient and outpatient hospital services
Clinic services including Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC)

services
Laboratory and X-ray services
Home health services
Early Periodic Screening, Diagnosis, and Treatment services (for individuals under age 21only)
Family planning services and supplies
Physicians services, including nurse practitioners and nurse midwife services
Dental services
Physical and occupational therapy
Speech, hearing, and language therapy
Prescription drugs, over-the-counter drugs, and medical supplies
Durable Medical Equipment (DME) including prosthetic and orthotic devices, hearing aids, and prescription shoes
Vision care services including eyeglasses
Intermediate Care Facilities for the Mentally Retarded (ICF/MR)
Nursing facility services
Personal care services
Medical Social Services for persons transitioning from the LTHHCP who received the service under the LTHHCP (non-State plan service)
Home Delivered Meals for persons transitioning from the LTHHCP who received the service under the LTHHCP (non-State plan service)
Case management services
Hospice care services
TB-related services
Inpatient and outpatient behavioral health services (mental health and chemical dependence services)
Emergency medical services including emergency transportation
Adult day care
Personal Emergency Response Services (PERS)
Renal dialysis
Home and Community Based Services waivers (HCBS)
Care at Home Program (OPWDD)
Non–emergency transportation
Experimental or investigational treatment (covered on a case by case basis)

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Center for Medicaid and CHIP Services
Children and Adults Health Programs Group

November 15, 2012

Jason A. Helgerson
Medicaid Director
Office of Health Insurance Programs
New York State Department of Health
Corning Tower, Room 1441
Empire State Plaza
Albany, New York 12237

Dear Mr. Helgerson:

On October 31st, Governor Andrew Cuomo submitted to Secretary Sebelius New York State's request for a five year extension of New York's Partnership Plan section 1115 demonstration (Project Number 11-W-00114/2). The Centers for Medicare & Medicaid Services (CMS) has completed a preliminary review of the application, and have determined that the state's extension request has met the requirements for a complete extension request as specified under section 42 CFR 431.412(c). However this renewal application does not meet the statutory requirements to be processed under section 1115(f) of the Social Security Act. We will be in contact with you to discuss other authorities for which your renewal may be processed.

In accordance with section 42 CFR 431.416(a), CMS acknowledges receipt of the state's extension request. The 30-day Federal comment period, as required under 42 CFR 431.416(b), begins on November 16th, 2012 and ends on December 16th, 2012. The state's extension request is available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html?filterBy=1115#waivers.

We look forward to working with you and your staff to extend the state's Demonstration. If you have additional questions or concerns, please contact your assigned project officer Jessica Woodard, Division of State Demonstrations and Waivers, at (410) 786-9249, or at Jessica.Woodard@cms.hhs.gov.

Sincerely,

/s/

Angela D. Garner
Deputy Director
Division of State Demonstrations & Waivers

cc: Victoria Wachino, CMCS
Jessica Woodard, CMCS
Michael Melendez, CMS New York Regional Office

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

AUG 3 1 2012

Nirav R. Shah, M.D.
Commissioner
New York Department of Health
Corning Tower
Governor Nelson A. Rockefeller Empire State Plaza
Albany, NY 12237

Dear Dr. Shah:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) is granting your request to amend New York's Medicaid section 1115 Demonstrations, entitled "Partnership Plan" (11-W-00114/2), and "Federal-State Health Reform Partnership (F-SHRP)" (11-W-00234/2). We are approving the amendment to the Demonstrations under the authority of section 1115(a) of the Social Security Act, and the amendment is effective from the date of this letter through the end of the Demonstrations.

This award is a partial response to the letter sent April 13, 2011, by Mr. Jason Helgerson, in which Mr. Helgerson requested several changes to the Partnership Plan and F-SHRP Demonstrations. At this time, CMS is approving the state's request to establish the managed long-term care (MLTC) program under the Demonstrations, which will expand mandatory Medicaid managed care enrollment to dually-eligible individuals over age 21 who receive community-based long-term care services in excess of 120 days and provide dually-eligible individuals age 18 – 21, as well as nursing home eligible non-dual individuals age 18 and older, the option to enroll in the MLTC program. In addition, this amendment permits the state to expand eligibility to ensure continuity of care for individuals who are moving from an institutional long-term care setting to receive community-based long term care services through the managed long-term care program.

We look forward to continuing our discussions with your staff on New York's request to transition the state's Section 1915(c) waiver, the Long-Term Home Health Care Program, into the MLTC program once the necessary Section 1915(c) waiver amendment has been approved.

The CMS approval of the Partnership Plan and F-SHRP amendments is conditioned upon continued compliance with the enclosed sets of Special Terms and Conditions (STCs) defining the nature, character, and extent of anticipated Federal involvement in the projects. The award is subject to our receiving your written acknowledgement of the awards and acceptance of these STCs within 30 days of the date of this letter.

Copies of the revised STCs and expenditure authorities are enclosed. The waivers for the Demonstrations are unchanged by this amendment, and remain in force.

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

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-3032
Facsimile: (410) 786-5882
E-mail: Jessica.Schubel@cms.hhs.gov

Official communication regarding program matters should be sent simultaneously to Ms. Schubel and to Mr. Michael Melendez, Associate Regional Administrator in our New York Regional Office. Mr. Melendez's contact information is as follows:

Centers for Medicare & Medicaid Services
New York Regional Office
Division of Medicaid and Children's Health
26 Federal Plaza
New York, New York 10278

I am pleased that we were able to reach a satisfactory resolution to your request, and look forward to working with you and your staff as you seek to redesign the New York Medicaid program.

If you have questions regarding the terms of this approval, please contact Ms. Victoria Wachino, Director, Children and Adults Health Programs Group at (410) 786-5647.

Sincerely,

Marilyn Tavenner
Acting Administrator

Enclosures

cc: Cindy Mann, Director, Center for Medicaid and CHIP Services
Victoria Wachino, Director, Children and Adults Health Programs Group
Michael Melendez, ARA, New York Regional Office
Jason Helgerson, Deputy Commissioner, New York Department of Health
Vallencia Lloyd, Office of Health Insurance Programs, New York Department of Health

CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER AUTHORITY

NUMBER: **11-W-00114/2**

TITLE: **Partnership Plan Medicaid Section 1115 Demonstration**

AWARDEE: **New York State Department of Health**

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived in this list, shall apply to the Demonstration beginning August 1, 2011 through December 31, 2014.

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

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

   To permit the exclusion of some residents of some counties in New York from participation in Mandatory Mainstream Managed Care (MMMC) and Managed Long Term Care (MLTC) under this Demonstration

2. **Medicaid Eligibility and Quality Control** **Section 1902(a)(4)(A)**

   To enable New York to employ a Medicaid Eligibility and Quality Control System (MEQC) which varies from that required by law and regulation. New York is required to receive annual approval from CMS for its alternative MEQC program.

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

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

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

   To the extent necessary to enable New York to require beneficiaries to enroll in managed care plans, to the extent of the services furnished through the MMMC and MLTC programs. Beneficiaries shall retain freedom of choice of family planning providers.

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY LIST

NUMBER: **11-W-00114/2**

TITLE: **Partnership Plan Medicaid Section 1115 Demonstration**

AWARDEE: **New York State Department of Health**

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by New York for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period beginning August 1, 2011, until the ending date specified for each authority, be regarded as expenditures under the State's title XIX plan.

The following expenditure authorities shall enable New York to implement the approved Special Terms and Conditions (STCs) for the New York Partnership Plan Medicaid Section 1115 Demonstration.

1. **Demonstration-Eligible Populations.** Expenditures for health-care related costs for the following populations that are not otherwise eligible under the Medicaid State Plan. (End Date: December 31, 2013.)

   a) Demonstration Population 5 (Safety Net Adults). Adults who were recipients of or eligible for Safety Net cash assistance who are not otherwise eligible for Medicaid.
   b) Demonstration Population 6 (Family Health Plus Adults with children). Parents and caretaker relatives of a child under age 21 who meet the eligibility criteria for Family Health Plus Program.
   c) Demonstration Population 7 (Family Health Plus Adults without children). Childless adults who meet the eligibility criteria for Family Health Plus Program.
   d) Demonstration Population 8 (Family Planning Expansion Adults). Men and women of childbearing age with net incomes at or below 200 percent of the Federal poverty level who are not otherwise eligible for Medicaid and women who lose Medicaid eligibility at the conclusion of their 60-day postpartum period.
   e) Demonstration Population 9 (HCBS Expansion). Medically needy individuals who are receiving HCBS, and who are medically needy after application of community spouse and spousal impoverishment eligibility and post-eligibility rules under Section 1924 of the Act are applied.
   f) Demonstration Population 10 (Individuals Moved from Institutional Settings to Community Settings for Long Term Care Services). Expenditures for health-care related costs for individuals moved from institutional nursing facility settings to community settings for long-term services and supports who would not otherwise be eligible based on income, but whose income does not exceed a more liberal income standard, and who receive services through the managed long term care program under this Demonstration.

2. **Twelve-Month Continuous Eligibility Period**. Expenditures for health-care related

costs for individuals who have been determined eligible under groups specified in Table 1 of STC 19(a) for continued benefits during any periods within a twelve-month eligibility period when these individuals would be found ineligible if subject to redetermination. (End Date: March 31, 2014.)

3. **Medicaid Eligibility Quality Control**. Expenditures that would have been disallowed under section 1903(u) of the Act based on Medicaid Eligibility Quality Control findings. (End Date: March 31, 2014.)

4. **Facilitated Enrollment Services.** Expenditures for enrollment assistance services provided by organizations that do not meet the requirements of section 1903(b)(4) of the Act, as interpreted by 42CFR 438.810(b)(1) and (2). Inasmuch as these services may be rendered by MCOs and therefore included in the MCOs' capitation payments, no expenditures other than these payments may be submitted for FFP. (End Date: March 31, 2014.)

5. **Designated State Health Programs Funding.** Expenditures for the designated state health programs specified in STC 57 which provide health care services to low-income or uninsured New Yorkers in an amount not to exceed $477.2 million over the demonstration period. (End Date: December 31, 2014.)

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly identified as not applicable in the list below, shall apply to Demonstration Populations 6, 7, and 8 beginning August 1, 2011, through December 31, 2013.

<u>Title XIX Requirements Not Applicable to Demonstration Populations 6 and 7:</u>
(References are made to the Social Security Act.)

Amount, Duration, and Scope **Section 1902(a)(10)(B)**

To enable the state to provide a more limited benefit package to Family Health Plus enrollees.

Cost Sharing **Section 1902(a)(14)**

To enable the state to charge more than nominal co-payments for Family Health Plus enrollees.

Retroactive Eligibility **Section 1902(a)(34)**

To enable the state to exclude Family Health Plus enrollees from receiving coverage for up to 3 months prior to the date that the application for assistance is made.

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) — **Section 1902(a)(43)**

To exempt the state from furnishing or arranging for EPSDT services beyond those available under otherwise covered benefits for Family Health Plus enrollees who are 19 or 20 years old.

Title XIX Requirements Not Applicable to Demonstration Population 8:
(References made to the Social Security Act.)

Methods of Administration: Transportation — **Section 1902(a)(4) insofar as it incorporates 42 CFR 431.53**

To the extent necessary to enable the state to not assure transportation to and from providers for family planning expansion program recipients.

Amount, Duration, and Scope — **Section 1902(a)(10)(B)**

To the extent necessary to enable the state to provide a benefit package consisting only of approved family planning and family-planning related services and supplies.

Prospective Payment System for Federally Qualified Health Centers and Rural Health Clinics — **Section 1902(a)(15)**

To enable the state to establish reimbursement levels to these clinics that would compensate them solely for approved family planning and family-planning related services and supplies.

Eligibility Procedures — **Section 1902(a)(17)**

To the extent necessary to enable the state to not include parental income when determining the eligibility of a minor (an individual under age 18) for the family planning expansion program.

Eligibility Redetermination — **Section 1902(a)(19)**

To enable the state to exempt women who are eligible for the family planning expansion program under this demonstration by virtue of losing Medicaid eligibility at the conclusion of their 60-day postpartum period (SOBRA women), from reporting changes in income during their 12-month eligibility period, and to allow the state to terminate eligibility for these women at the conclusion of this 12-month period.

Retroactive Eligibility **Section 1902(a)(34)**

To enable the state to exclude family planning expansion program recipients from receiving coverage for up to 3 months prior to the date that the application for assistance is made.

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) **Section 1902(a)(43)**

To exempt the state from furnishing or arranging for EPSDT services for family planning expansion program recipients.

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: **11-W-00114/2**

TITLE: **Partnership Plan Medicaid Section 1115 Demonstration**

AWARDEE: **New York State Department of Health**

I. PREFACE

The following are the Special Terms and Conditions (STCs) for New York's Partnership Plan section 1115(f) Medicaid Demonstration extension (hereinafter "Demonstration"). The parties to this agreement are the New York State Department of Health (state) and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of federal involvement in the Demonstration and the state's obligations to CMS during the life of the Demonstration. The STCs are effective August 1, 2011, unless otherwise specified. All previously approved STCs, waivers, and expenditure authorities are superseded by the STCs set forth below. This Demonstration extension is approved through December 31, 2014; however, some components of the Demonstration will expire earlier, as described below in these STCs and associated waiver and expenditure authority documents, and in the table in Attachment F.

The STCs have been arranged into the following subject areas: Program Description and Objectives; General Program Requirements; Demonstration Eligibility; Demonstration Benefits and Enrollment; Delivery Systems; Quality Demonstration Programs and Clinic Uncompensated Care Funding; General Reporting Requirements; General Financial Requirements; Monitoring Budget Neutrality; Evaluation of the Demonstration; and Schedule of State Deliverables for the Demonstration Extension.

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

II. PROGRAM DESCRIPTION AND OBJECTIVES

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

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

The Demonstration is designed to use a managed care delivery system to deliver benefits to Medicaid recipients, create efficiencies in the Medicaid program, and enable the extension of coverage to certain individuals who would otherwise be without health insurance. It was approved in 1997 to enroll most Medicaid recipients into managed care organizations (MCOs) (Medicaid managed care program). As

part of the Demonstration's renewal in 2006, authority to require the disabled and aged populations to enroll in mandatory managed care was transferred to a new demonstration, the Federal-State Health Reform Partnership (F-SHRP).

In 2001, the Family Health Plus (FHPlus) program was implemented as an amendment to the Demonstration, providing comprehensive health coverage to low-income uninsured adults, with and without dependent children, who have income greater than Medicaid state plan eligibility standards. FHPlus was further amended in 2007 to implement an employer-sponsored health insurance (ESHI) component. Individuals eligible for FHPlus who have access to cost-effective ESHI are required to enroll in that coverage, with FHPlus providing any wrap-around services necessary to ensure that enrollees get all FHPlus benefits. During this extension period, the state will expand Family Health Plus eligibility for low-income adults with children.

In 2002, the Demonstration was expanded to incorporate a family planning benefit under which family planning and family planning-related services are provided to women losing Medicaid eligibility and to certain other adults of childbearing age (family planning expansion program).

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

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

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

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

In 2012, New York added to the Demonstration an initiative to improve service delivery and

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

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

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

III. GENERAL PROGRAM REQUIREMENTS

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

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

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

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

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

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

5. **State Plan Amendments.** The state will not be required to submit title XIX state plan amendments for changes affecting any populations made eligible solely through the Demonstration. If a population eligible through the Medicaid state plan is affected by a change to the Demonstration, a conforming amendment to the state plan may be required, except as otherwise noted in these STCs.

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

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

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

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

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

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

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

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

public comment received, the state's response to the comment, and the way the state incorporated the received comment into a revised phase-out plan.

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

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

c) Phase-out Procedures: The state must comply with all notice requirements found in 42 CFR 431.206, 431.210 and 431.213. In addition, the state must ensure all appeal and hearing rights afforded to Demonstration participants as outlined in 42 CFR 431.220 and 431.221. If a Demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine whether they qualify for Medicaid eligibility under a different eligibility category as discussed in the October 1, 2011, State Health Official Letter #10-008.

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

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

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

11. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX of the Act. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS's determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.

12. **Adequacy of Infrastructure.** The state must ensure the availability of adequate resources for implementation and monitoring of the Demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; monitoring

and oversight of managed care plans providing long-term services and supports including quality and enrollment processes; and reporting on financial and other Demonstration components.

13. **Quality Review of Eligibility.** The state will continue to submit to the CMS Regional Office by December 31 of each year an alternate plan for Medicaid Eligibility Quality Control as permitted by federal regulations at 42 CFR 431.812(c).

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

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

In states with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the state is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any Demonstration proposal, and/or renewal of this Demonstration (42 CFR 431.408(b)(3)). The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

15. **FFP.** No federal matching funds for expenditures for this Demonstration will take effect until the effective date identified in the Demonstration approval letter.

IV. DEMONSTRATION ELIGIBILITY

16. **Demonstration Components**. The Partnership Plan includes five distinct components, each of which has its own specific eligibility criteria.

    a) **Mainstream Medicaid Managed Care Program (MMMC)**. This component provides Medicaid state plan benefits through a managed care delivery system comprised of managed care organizations (MCOs), and primary care case management (PCCM) arrangements to most recipients eligible under the state plan. All state plan eligibility determination rules apply to this program, except those otherwise noted in this section.

    The state has authority to expand mandatory enrollment in mainstream managed care to all individuals identified in Table 2 (except those otherwise excluded or exempted as outlined in STC 25) and who reside in any county other than Allegany, Cortland, Dutchess, Fulton, Montgomery, Putnam, Orange, Otsego, Schenectady, Seneca, Sullivan, Ulster, Washington, and Yates counties. When the state intends to expand mandatory managed care enrollment to additional counties (other than those identified in this subparagraph), it must notify CMS 90 days prior to the effective date of the expansion and submit a revised assessment of the demonstration's budget neutrality agreement, which reflects the projected impact of the expansion for the remainder of the Demonstration approval period.

Note: The authority to require mandatory managed care enrollment for any of the individuals who are identified in Table 2 and who reside in Allegany, Cortland, Dutchess, Fulton, Montgomery, Putnam, Orange, Otsego, Schenectady, Seneca, Sullivan, Ulster, Washington, and Yates counties has been provided under the Federal-State Health Reform Partnership Demonstration (11-W-00234/2).

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

Services not provided through the MLTC program are provided on a fee-for-service basis. The state has authority to expand mandatory enrollment into MLTC to all individuals identified in Table 3 (except those otherwise excluded or exempted as outlined in STC 28) with initial mandatory enrollment starting in any county in New York City and then expanding statewide based on the Enrollment plan as outlined in Attachment G. When the state intends to expand into a new county outside of New York City, it must notify CMS 90 days prior to the effective date of the expansion and submit a revised assessment of the Demonstration's budget neutrality agreement along with all other required materials as outlined in STC 32.

c) **Family Health Plus (FHPlus)**. This component provides a more limited benefit package, with cost-sharing imposed, to enrolled adults with and without dependent children who meet specific income eligibility requirements through MCOs. FHPlus-eligible individuals that have access to cost-effective employer-sponsored health insurance are required to enroll in the Family Health Plus Premium Assistance Program (FHP-PAP). Under FHP-PAP, enrollees will not be responsible for any portion of the premium payments for that coverage. Adults in this program will use employer-sponsored health insurance as their primary insurance policy, with all premiums, deductibles, and coinsurance (if any) paid by the state.

d) **Family Planning Expansion Program (FP Expansion)**. This component provides only family planning and family planning-related services to men and women of childbearing age with net incomes at or below 200 percent of the federal poverty level (FPL) who are not otherwise eligible for Medicaid, as well as to women who lose Medicaid pregnancy coverage at the conclusion of 60-days postpartum.

The state will allow applicants the opportunity to apply for family planning services through the family planning expansion program, or apply for Medicaid and/or FHPlus. If an applicant wants to waive his/her right to an eligibility determination for Medicaid or FHPlus, the state will ensure that applicants have all the information they need, both written and oral, to make a fully informed choice. The state will obtain a signature from applicants waiving their right to an eligibility determination for Medicaid or Family Health Plus.

The state will also ensure that redeterminations of eligibility for this component of the demonstration are conducted, at a minimum, once every 12 months. Administrative (or ex parte) redeterminations are acceptable.

e) **Home and Community-Based Services Expansion Program (HCBS Expansion).** This component provides home and community-based services identical to those provided underthree of the state's section 1915(c) HCBS waivers (Long-Term Home Health Care

Program, Nursing Home Transition and Diversion Program, and Traumatic Brain Injury Program) to certain medically needy individuals. These services enable these individuals to live at home with appropriate supports rather than in a nursing facility.

17. **Individuals Eligible under the Medicaid State Plan (State Plan Eligibles).** Mandatory and optional Medicaid state plan populations derive their eligibility through the Medicaid state plan and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid state plan, except as expressly waived and as further described in these STCs. State plan eligibles are included in the MMMC component of the Demonstration to ensure access to cost-effective high quality care.

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

19. **Continuous Eligibility Period**.

i. **Duration.** The state is authorized to provide a 12-month continuous eligibility period to the groups of individuals specified in Table 1, regardless of the delivery system through which they receive Medicaid benefits. Once the state begins exercising this authority, each newly eligible individual's 12-month period shall begin at the initial determination of eligibility; for those individuals who are redetermined eligible consistent with Medicaid state plan or FHPlus rules, the 12-month period begins at that point. At each annual eligibility redetermination thereafter, if an individual is redetermined eligible under Medicaid state plan or FHPlus rules, the individual is guaranteed a subsequent 12-month continuous eligibility period.

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

State Plan Mandatory and Optional Groups	Statutory Reference (Social Security Act)
Pregnant women aged 19 or older	1902(a)(10)(A)(i)(III) or (IV); and 1902(a)(10)(A)(ii)(I) and (II)
Children aged 19 or 20	1902(a)(10)(A)(ii)(I) and (II)
Parents or other caretaker relatives aged 19 or older	1902(a)(10)(A)(ii)(I) and (II)
Members of low-income families, except for children up to age 19	1931 and 1925
Medically needy pregnant women, children, and parents/caretaker relatives	Without spend-down under 1902(a)(10)(C)(i)(III)
Demonstration Eligible Group	**Qualifying Criteria**
Safety Net Adults	Income based on statewide standard of need (determined annually)
Family Health Plus Adults with children	Income above the applicable statutory level but gross family income at or below 160% FPL.
Family Health Plus Adults without children	Income above the statewide standard of need but gross household income at or below 100% FPL.

Note: Children under 19 who are eligible at the applicable FPL already receive 12 months continuous eligibility under the Medicaid state plan.

ii. **Exceptions.** Notwithstanding subparagraph i, if any of the following circumstances occur

during an individual's 12-month continuous eligibility period, the individual's Medicaid or FHPlus eligibility shall be terminated:

i. The individual cannot be located;

ii. The individual is no longer a New York State resident;

iii. The individual requests termination of eligibility;

iv. The individual dies;

v. The individual fails to provide, or cooperate in obtaining, a Social Security number if otherwise required;

vi. The individual provided an incorrect or fraudulent Social Security number;

vii. The individual was determined eligible for Medicaid in error;

viii. The individual is receiving treatment in a setting where Medicaid eligibility is not available (e.g., institution for mental disease);

ix. The individual is in receipt of long-term care services;

x. The individual is receiving care, services, or supplies under a section 1915 waiver program;

xi. The individual was previously otherwise qualified for emergency medical assistance benefits only, based on immigration status, but is no longer qualified because the emergency has been resolved;

xii. The individual fails to provide the documentation of citizenship or immigration status required under federal law; or

xiii. The individual is incarcerated.

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

Table 2: Mainstream Medicaid Managed Care Program

State Plan Mandatory and Optional Groups	FPL and/or Other Qualifying Criteria	Expenditure and Eligibility Group Reporting
Pregnant Women	Income up to 200%	Demonstration Population 2/ TANF Adult
Children under age 1	Income up to 200%	Demonstration Population 1/ TANF Child
Children 1 through 5	Income up to 133%	Demonstration Population 1/ TANF Child
Children 6 through 18	Income up to 133%	Demonstration Population 1/ TANF Child
Children 19-20	Income at or below the monthly income standard (determined annually)	Demonstration Population 1/ TANF Child
Parents and Caretaker Relatives	Income at or below the monthly income standard	Demonstration Population 2/ TANF Adult

	(determined annually)	
Demonstration Eligible Groups	**FPL and/or Other Qualifying Criteria**	**Expenditure and Eligibility Group Reporting**
Safety Net Adults	Income based on statewide standard of need (determined annually)	Demonstration Population 5/ Safety Net Adults

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

Table 3: Managed Long-Term Care Program

State Plan Mandatory and Optional Groups	FPL and/or Other Qualifying Criteria	Expenditure and Eligibility Group Reporting
Adults aged 65 and older	Income at or below SSI level	MLTC Adults 65 and above
Adults/children aged 18 - 64	Income at or below SSI level	MLTC Adults 18 – 64
Adults aged 65 and older	Income at or below the monthly income standard, or with spenddown to monthly income standard	MLTC Adults 65 and above
Adults/children aged 18-64 blind and disabled	Income at or below the monthly income standard, or with spenddown to monthly income standard	MLTC Adults 18 – 64
Aged 16 – 64 Medicaid Buy In for Working People with Disabilities	Income up to 250%	MLTC Adults 18 – 64
Parents and Caretaker Relatives 21-64	Income at or below the monthly income standard, or with spenddown to monthly income standard	MLTC Adults 18 – 64
Children aged 18 – 20	Income at or below the monthly income standard or with spenddown	MLTC Adults 18 – 64
Pregnant Women	Income up to 200%	MLTC Adults 18 – 64
Poverty Level Children Aged	Income up to 133%	MLTC Adults 18 – 64

18 to 20		
Foster Children Aged 18 – 20	In foster care on the date of 18th birthday	MLTC Adults 18 – 64

Demonstration Eligible Groups	FPL and/or Other Qualifying Criteria	Expenditure and Eligibility Group Reporting
Safety Net Adults	Income based on statewide Standard of Need (determined annually)	Safety Net Adults
Individuals Moved from Institutional Settings to Community Settings for Long Term Care Services	Income based on higher income standard to community settings for long term services and supports pursuant to STC 25	MLTC Adults 18 – 64 MLTC Adults 65 and above

22. **Individuals enrolled in FHPlus.** Table 4 below lists the groups of individuals who may be enrolled in the Family Health Plus component of the Demonstration, as well as the relevant expenditure reporting category (demonstration population) for each.

Table 4: Family Health Plus

Demonstration Eligible Groups	FPL and/or Other Qualifying Criteria	Expenditure and Eligibility Group Reporting
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)	Income above the Medicaid monthly income standard but gross family income at or below 160% FPL.	Demonstration Population 6/ FHP Adults w/Children
Non-pregnant, non-disabled (“childless”) adults (19-64)	Income above the statewide standard of need but gross household income at or below 100% FPL.	Demonstration Population 7/ FHP Childless Adults

23. **Individuals enrolled in Family Planning Expansion Program.** Table 5 lists the groups of individuals who may be enrolled in the family planning expansion component of the Demonstration, as well as the relevant expenditure reporting category (demonstration population).

Table 5: Family Planning Expansion Program

Demonstration Eligible Groups	Expenditure and Eligibility Group Reporting
Women who lose Medicaid pregnancy coverage at the conclusion of 60-days postpartum	Demonstration Population 8/ FP Expansion
Men and women of childbearing age with net incomes at or below 200% FPL who are not otherwise eligible for Medicaid	Demonstration Population 8/ FP Expansion

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

    a) Who meet a nursing home level of care;

    b) Whose spouse lives in the community; and

    c) Who could receive services in the community but for the application of the spousal impoverishment eligibility and post-eligibility rules of section 1924 of the Act.

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

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

    In addition, the state will ensure that the MLTC MCOs work with individuals, their families, nursing home administrators, and discharge planners to help plan for the individual's move back into the community, as well as to help plan for the individual's medical care once he/she has successfully moved into his/her home.

26. **Exclusions and Exemptions from MMMC.** Notwithstanding the eligibility criteria in STC 16, certain individuals cannot receive benefits through the MMMC program (i.e., excluded), while others may request an exemption from receiving benefits through the MMMC program (i.e., exempted). Tables 6 and 7 list those individuals either excluded or exempted from MMMC.

Table 6: Individuals Excluded from MMMC

Individuals who become eligible for Medicaid only after spending down a portion of their income
Residents of state psychiatric facilities or residents of state-certified or voluntary treatment facilities for children and youth
Patients in residential health care facilities (RHCF) at time of enrollment and residents in an RHCF who are classified as permanent
Participants in capitated long-term care demonstration projects
Medicaid-eligible infants living with incarcerated mothers
Individuals with access to comprehensive private health insurance if cost effective
Foster care children in the placement of a voluntary agency
Foster care children in direct care [at the option of the local Department of Social Services (LDSS)]
Certified blind or disabled children living or expected to live separate and apart from their parents for 30 days or more
Individuals expected to be Medicaid-eligible for less than 6 months (except for pregnant women)
Individuals receiving long-term care services through long-term home health care programs
Individuals receiving hospice services (at time of enrollment)
Individuals with a "county of fiscal responsibility" code of 97 (Individuals residing in a state Office of Mental Health facility)
Individuals with a “county of fiscal responsibility” code of 98 (Individuals in an OPWDD facility or treatment center)
Youth in the care and custody of the commissioner of the Office of Family & Children Services
Individuals eligible for the family planning expansion program
Individuals who are under 65 years of age (screened and require treatment) in the Centers for Disease Control and Prevention breast, cervical, colorectal, and/or prostate early detection program and need treatment for breast, cervical, colorectal, or prostate cancer, and who are not otherwise covered under creditable health coverage
Individuals who are eligible for Medicaid buy-in for the working disabled and who must pay a premium
Individuals who are eligible for Emergency Medicaid

Table 7: Individuals who may be exempted from MMMC

Individuals with chronic medical conditions who have been under active treatment for at least 6 months with a sub-specialist who is not a network provider for any Medicaid MCO in the service area or whose request has been approved by the New York State Department of Health Medical Director because of unusually severe chronic care needs. Exemption is limited to six months
Individuals designated as participating in OPWDD-sponsored programs
Individuals already scheduled for a major surgical procedure (within 30 days of scheduled enrollment) with a provider who is not a participant in the network of any Medicaid MCO in the service area. Exemption is limited to six months
Individuals with a developmental or physical disability receiving services through a Medicaid home- and community-based services (HCBS) waiver authorized under section 1915(c) of the Act
Individuals with a developmental or physical disability whose needs are similar to participants receiving services through a Medicaid HCBS waiver authorized under section 1915(c) of the Act
Residents of alcohol/substance abuse long-term residential treatment programs
Native Americans

Individuals who are eligible for Medicaid buy-in for the working disabled and who do not pay a premium
Individuals with a “county of fiscal responsibility code of 98” (OPWDD in MMIS) in counties where program features are approved by the state and operational at the local district level to permit these individuals to voluntarily enroll

27. **Exclusions and Exemptions from MLTC.** Notwithstanding the eligibility criteria in STC 16, certain individuals cannot receive benefits through the MLTC program (i.e., excluded), while others may request an exemption from receiving benefits through the MLTC program (i.e., exempted). Tables 8 and 9 list those individuals either excluded or exempted from MLTC.

Table 8: Individuals excluded from MLTC

Residents of psychiatric facilities
Residents of residential health care facilities (RHCF) at time of enrollment
Individuals expected to be Medicaid eligible for less than six months
Individuals eligible for Medicaid benefits only with respect to tuberculosis-related services
Individuals with a "county of fiscal responsibility" code 99 in MMIS (Individuals eligible only for breast and cervical cancer services)
Individuals receiving hospice services (at time of enrollment)
Individuals with a "county of fiscal responsibility" code of 97 (Individuals residing in a state Office of Mental Health facility)
Individuals with a “county of fiscal responsibility” code of 98 (Individuals in an OPWDD facility or treatment center)
Individuals eligible for the family planning expansion program
Individuals under sixty-five years of age (screened and require treatment) in the Centers for Disease Control and Prevention breast and/or cervical cancer early detection program and need treatment for breast or cervical cancer, and are not otherwise covered under creditable health coverage
Residents of intermediate care facilities for the mentally retarded (ICF/MR)
Individuals who could otherwise reside in an ICF/MR, but choose not to
Residents of alcohol/substance abuse long-term residential treatment programs
Individuals eligible for Emergency Medicaid
Individuals in the Office for People with Developmental Disabilities Home- and Community-Based Services (OPWDD HCBS) section 1915(c) waiver program
Individuals in the following section 1915(c) waiver programs: Traumatic Brain Injury (TBI), Nursing Home Transition & Diversion (NHTD), and Long-Term Home Health Care Program (LTHHCP)
Residents of Assisted Living Programs
Individuals in receipt of Limited Licensed Home Care Services
Individuals in the Foster Family Care Demonstration

Table 9: Individuals who may be exempted from MLTC.

Individuals aged 18 – 21 who are nursing home certifiable and/or require more than 120 days of community-based long-term care services
Native Americans
Individuals who are eligible for the Medicaid buy-in for the working disabled and are nursing home certifiable
Aliessa Court Ordered Individuals

28. **Population-Specific Program Requirements.**

a) **MMMC Enrollment of Individuals Living with HIV.** The state is authorized to require individuals living with HIV to receive benefits through MMMC. Once the state begins implementing MMMC enrollment in a particular district, individuals living with HIV will have thirty days in which to select a health plan. If no selection is made, the individual will be auto-assigned to a MCO. Individuals living with HIV who are enrolled in a MCO (voluntarily or by default) may request transfer to an HIV Special Needs Plans (SNP) at any time if one or more HIV SNPs are in operation in the individual's district. Further, transfers between HIV SNPs will be permitted at any time.

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

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

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

c) **Managed care enrollment of individuals using long-term services and supports for both MMMC and MLTC.** The state is authorized to require certain individuals using long-term services and supports to enroll in either mainstream managed care or managed long-term care as identified in STC 16. In addition, the populations that are exempted from mandatory enrollment, based on the exemption lists in STCs 26 and 27 may also elect to enroll in managed care plans. Once these individuals begin to enroll in managed care, the state will be required to provide the following protections for the population:

   i. **Person Centered Service planning** – The stat, through its contracts with its MCOs and/or PIHPs, will require that all individuals utilizing long-term services and supports

will have a person-centered individual service plan maintained at the MCO or Prepaid Inpatient Health Plan(PIHP). Person-Centered Planning includes consideration of the current and unique psycho-social and medical needs and history of the enrollee, as well as the person's functional level, and support systems.

(A) The state must establish minimum guidelines regarding the Person-Centered Plan (PCP) that will be reflected in MCO/PIHP contracts. These must include at a minimum, a description of:
    a. The qualification for individuals who will develop the PCP;
    b. Types of assessments;
    c. How enrollees are informed of the services available to them; and
    d. The MCOs' responsibilities for implementing and monitoring the PCP.

(B) The MCO/PIHP contract shall require the use of a person centered and directed planning process intended to identify the strengths, capacities, and preferences of the enrollee, as well as to identify an enrollee's long term care needs and the resources available to meet those needs, and to provide access to additional care options as specified by the contract. The person-centered plan is developed by the participant with the assistance of the MCO/PIHP, provider, and those individuals the participant chooses to include. The plan includes the services and supports that the participant needs.

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

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

(E) The MCO/PIHP shall ensure that meetings related to the enrollee's Person Centered Plan will be held at a location, date, and time convenient to the enrollee and his/her invited participants.

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

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

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

(I) The MCO/PIHP contract shall require policies and procedures for the MCO/PIHP to monitor appropriate implementation of the individual service plans.

ii. **Health and Welfare of Enrollees** – The State through its contracts with its MCOs/PIHPs shall ensure a system is in place to identify, address, and seek to prevent instances of abuse, neglect, and exploitation of its enrollees on a continuous basis. This should include provisions such as critical incident monitoring and reporting to the state, investigations of any incident including, but not limited to, wrongful death, restraints, or medication errors that resulted in an injury

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

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

i. **Transition of care period**. Initial transition into MLTC from fee-for-service. Each enrollee who is receiving community-based long-term services and supports that qualifies for MLTC must continue to receive services under the enrollee's pre-existing service plan for at least 60 days after enrollment, or until a care assessment has been completed by the MCO/PIHP, whichever is later. Any reduction, suspension, denial or termination of previously authorized services shall trigger the required notice under 42 CFR 438.404 which clearly articulates the enrollee's right to file an appeal (either expedited, if warranted, or standard, the right to have authorized service continue pending the appeal, and the right to a fair hearing if the plan renders an adverse determination (either in whole or in part) on the appeal. For initial implementation of the auto-assigned population, the plans must submit data for state review on a monthly basis reporting instances when the plan has issued a notice of action that involves a reduction of split shift or live-in services or when the plan is reducing hours by 25 percent or more. The plan will also report the number of appeals and fair hearings requested regarding these reductions. The state shall ensure through its contracts that if an enrollee is to change from one MCO/PIHP to another, the MCO/PIHPs will communicate with one another to ensure a smooth transition and provide the new MCO/PIHP with the individual's current service plan.

ii. **MLTC Eligibility**. MLTC plans conduct the initial programmatic eligibility determination for plan enrollment using a standardized assessment tool designated by the state. The following requirements apply to the activities that must be undertaken by a MLTC plan as it assesses applicants for enrollment in the plan.

1. The state shall ensure all individuals requesting long-term services and supports are assessed for MLTC eligibility.

a. The MCO/PIHP will use the Semi-Annual Assessment of Members (SAAM) tool (or successor tool designated by the state) to determine if the individual meets the eligibility criteria to be enrolled in an MLTC.
b. In addition to the SAAM tool, the MCO/PIHP may use other assessment tools as appropriate. The state must review and approve all other assessment tools used by the MCO/PIHP.
c. The state must ensure through its contracts that each MCO/PIHP must complete the initial assessment in the individual's home of all individuals referred to or requesting enrollment in an MLTC plan within 30 days of that referral or initial contact. MCO/PIHP compliance with this standard shall be reported to CMS in the quarterly reports as required in STC 62.

2. The MCO/PIHP shall complete a re-assessment at least annually, or at another timeframe as specified in the MCO/PIHP contract.
3. The state shall require each MCO/PIHP, through its contract, to report to the enrollment broker the names of all individuals for whom an assessment is completed. If the individual has not been referred by the enrollment broker, the MCO/PIHP shall report the date of initial contact by the individual and the date of the assessment to determine compliance with the 30-day requirement.
    a. The state shall use this information to determine if individuals have been wrongfully determined ineligible.
    b. The state shall review a sample of those assessments at least annually, either through the EQRO or by the state, to verify the correct determination was made.

iii. **Marketing Oversight**.

1. The state shall require each MCO/PIHPs through its contract to meet 42 CFR 438.104 and state marketing guidelines which prohibit cold calls, use of government logos and other standards.
2. All materials used to market the MCO/PIHP shall be prior approved by the state.
3. The state shall require through its contract that each MCO/PIHP provide all individuals who were not referred to the plan by the enrollment broker with information (in a format determined by the state) describing Managed Long Term Care, a list of available plans, and contact information to reach the enrollment broker for questions or other assistance. The plan shall report the number of individuals receiving these materials to the state on a quarterly basis pursuant to STC 63.

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

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

V. DEMONSTRATION BENEFITS AND ENROLLMENT

29. **Demonstration Benefits and Cost-Sharing.** The following benefits are provided to individuals eligible for the Medicaid managed care, FHPlus, and family planning expansion components of the Demonstration:

a) **Mainstream Medicaid Managed Care.** State plan benefits delivered through MCOs or, in certain districts, primary care case management arrangements, with the exception of certain services carved out of the MMMC contract and delivered directly by the state on a fee-for-service basis. All MMMC benefits (regardless of delivery method), as well as the co-payments charged to MMMC recipients, are listed in Attachment A.

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

c) **Family Health Plus.**

i. FHPlus direct coverage benefits must be delivered by an MCO, with the exception of certain services carved out of the FHPlus contract and delivered directly by the state on a fee-for-service basis. In districts where no MCO is available, these benefits may be provided by a commercial insurer contracted with the state.

ii. FHPlus benefits, as well as the applicable co-payments charged to FHPlus recipients, are listed in Attachment B.
   (1) FHPlus enrollees under 21 years of age or who are pregnant are exempt from any cost-sharing otherwise applicable.
   (2) Emergency services, family planning services and supplies, and psychotropic and tuberculosis drugs are exempt from cost-sharing requirements in all settings which otherwise require cost-sharing.

iii. The 'benchmark" FHP-PAP employer-sponsored health insurance plan will include, at a minimum, the following services: inpatient and outpatient hospital services, physician services, maternity care, preventive health services, diagnostic and x-ray services, and emergency services. Maximum out-of-pocket charges for FHP-PAP enrollees are limited to the co-payment amounts specified in Attachment C. Any out-of-pocket charges exceeding those amounts will be reimbursed by the state.

d) **Family Planning Expansion Program.**

i. The Family Planning expansion program provides family planning services and supplies described in section 1905(a)(4)(c) of the Act directly on a fee-for-service basis. Such

services and supplies are limited to those whose primary purpose is family planning and which are provided in a family planning setting. Family planning services and supplies are reimbursable at the 90 percent matching rate, including:

(1) Approved methods of contraception;
(2) Sexually transmitted infection (STI) testing, Pap smears, and pelvic exams (NOTE: The laboratory tests done during an initial family planning visit for contraception include a Pap smear, screening tests for STIs, blood count, and pregnancy test. Additional screening tests may be performed depending on the method of contraception desired and the protocol established by the clinic, program, or provider. Additional laboratory tests may be needed to address a family planning problem or need during an inter-periodic family planning visit for contraception.);
(3) Drugs, supplies, or devices related to women's health services described above that are prescribed by a health care provider who meets the state's provider enrollment requirements (subject to the national drug rebate program requirements); and
(4) Contraceptive management, patient education, and counseling.

ii. Family planning-related services and supplies are defined as those services provided as part of, or as follow-up to, a family planning visit and are reimbursable at the state's regular Federal Medical Assistance Percentage (FMAP) rate. Such services are provided because a "family planning-related" problem was identified and/or diagnosed during a routine or periodic family planning visit. Examples of family-planning related services include:

(1) Colposcopy (and procedures done with/during a colposcopy) or repeat Pap smear performed as a follow-up to an abnormal Pap smear which is done as part of a routine/periodic family planning visit.
(2) Drugs for the treatment of STIs/STDs, except for HIV/AIDS and hepatitis, when the STIs/STDs are identified/ diagnosed during a routine/periodic family planning visit. A follow-up visit/encounter for the treatment/drugs and subsequent follow-up visits to rescreen for STIs/STDs based on Centers for Disease Control and Prevention guidelines may also be covered.
(3) An annual exam for men, such an annual family planning visit may include a comprehensive patient history, physical, laboratory tests, and contraceptive counseling.
(4) Drugs/treatment for vaginal infections/disorders, other lower genital tract and genital skin infections/disorders, and urinary tract infections, where these conditions are identified/diagnosed during a routine/periodic family planning visit. A follow-up visit/encounter for the treatment/drugs may also be covered.
(5) Other medical diagnosis, treatment, and preventive services that are routinely provided pursuant to family planning services in a family planning setting. An example of a preventive service could be a vaccination to prevent cervical cancer.
(6) Treatment of major complications arising from a family planning procedure, such as:
    a. Treatment of a perforated uterus due to an intrauterine device insertion;
    b. Treatment of severe menstrual bleeding caused by a Depo-Provera injection requiring a dilation and curettage; or
    c. Treatment of surgical or anesthesia-related complications during a sterilization procedure.

iii. Primary care referrals to other social service and health care providers as medically indicated are provided; however, the costs of those primary care services are not covered

for enrollees of this Demonstration. The state must facilitate access to primary care services for enrollees in the family planning expansion program, and must assure CMS that written materials concerning access to primary care services are distributed to enrollees. The written materials must explain to the participants how they can access primary care services.

30. **Option for Consumer Directed Personal Assistance Program**. Until such time as the consumer directed personal assistance program (CDPAP) is incorporated into the mainstream and MLTC plans, enrollees shall have the option to elect self direction on a fee-for-service basis under the state plan. Once incorporated into the plan benefit packages, the state shall ensure through its contracts with the MCOs/PIHPs that enrollees are afforded the option to select self direction and enrollees are informed of CDPAP as a voluntary option to its members. Individuals who select self direction must have the opportunity to have choice and control over how services are provided and who provides the service.
    a) **Information and Assistance in Support of Participant Direction.** The state/MCO shall have a support system that provides participants with information, training, counseling, and assistance, as needed or desired by each participant, to assist the participant to effectively direct and manage their self-directed services. Participants shall be informed about self-directed care, including feasible alternatives, before electing the self-direction option.
    b) **Participant Direction by Representative.** The participant who self-directs the personal care service may appoint a volunteer designated representative to assist with or perform employer responsibilities to the extent approved by the participant. Services may be directed by a legal representative of the participant. Consumer-directed services may be directed by a non-legal representative freely chosen by the participant. A person who serves as a representative of a participant for the purpose of directing services cannot serve as a provider of personal attendant services for that participant.
    c) **Participant Employer Authority.** The participant (or the participant's representative) must have decision-making authority over workers who provide personal care services.
    i. **Participant.** The participant (or the participant's representative) (provides training, supervision and oversight to the worker) who provides services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law.
    ii. **Decision-Making Authorities.** The participants exercise the following decision making authorities: Recruit staff, hire staff , verify staff's ability to perform identified tasks, schedule staff, evaluate staff performance, verify time worked by staff and approve time sheets, and discharge staff.
    d) **Disenrollment from Self-Direction.** A participant may voluntarily disenroll from the self-directed option at any time and return to a traditional service delivery system through the MMMC or MLTC program. To the extent possible, the member shall provide his/her intent to withdraw from participant direction. A participant may also be involuntarily disenrolled from the self-directed option for cause, if continued participation in the consumer-directed services option would not permit the participant's health, safety, or welfare needs to be met, or the participant demonstrates the inability to self-direct by consistently demonstrating a lack of ability to carry out the tasks needed to self-direct services, or if there is fraudulent use of funds such as substantial evidence that a participant has falsified documents related to participant-directed services. If a

participant is terminated voluntarily or involuntarily from the self-directed service delivery option, the MCO/PIHP must transition the participant to the traditional agency direction option and must have safeguards in place to ensure continuity of services.

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

i. A reduction, suspension, or termination of authorized CDPAP services;

ii. A denial of a request to change CDPAP services.

31. **Adding Services to the MMMC and/or MLTC plan benefit package**. At any point in time the state intends to add to either the MMMC or MLTC plan benefit package currently authorized state plan or Demonstration services that have been provided on a fee-for-service basis, the state must provide CMS the following information, with at least 30 days notice prior to the inclusion of the benefit, either in writing or as identified on the agenda for the monthly calls referenced in STC 60:

a) A description of the benefit being added to the MCO/PIHPs benefit package;

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

c) Information concerning the changes being made to MMMC and/or MLTC contract provisions and capitation payment rates in accordance with STC 36.

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

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

32. **Expanding MLTC enrollment into a new geographic area**. Any time the state is ready to expand mandatory MLTC plan enrollment into a new geographic area, the state must provide CMS notification at least 90 days prior to the expansion. Such notification will include:

a) A list of the counties that will be moving to mandatory enrollment;

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

c) Confirmation that the MCO/PIHPs in the new geographic area have met the network requirements in STCs 42 and 43 for each MCO/PIHP.

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

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

33. **Enrollment into the Family Health Plus Premium Assistance Program (FHP-PAP).**

a) At the time of initial application or recertification, individuals will be asked if they have access to ESHI. If so, the individual will be asked to provide information about the available ESHI insurance coverage. In the interim, individuals determined eligible for FHPlus will be enrolled, or continue to be enrolled, in a FHPlus plan.

b) For those individuals with access to qualified and cost effective ESHI, including state or local government employees, enrollment into the ESHI is required in order for the individual to maintain access to FHPlus eligibility and benefits. However, individuals will not be forced to disenroll from their FHPlus plan until they can enroll in their ESHI Program (during an ESHI open enrollment period or after a required "waiting period").

c) The state will subsidize the premiums for this coverage and reimburse any deductibles and co-pays, to the extent that the co-pays exceed the amount of the enrollee's co-payment obligations under FHPlus.

d) The state will pay for any FHPlus benefits not covered by the enrollee's ESHI for enrollees of the FHP-PAP when they obtain services from a Medicaid provider.

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

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

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

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

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

c) If an interested individual applies for Medicaid by completing the information required under 42 CFR 435.907(a) and (b) and 42 CFR 435.910(a) and signing a Medicaid application, that

application must be transmitted to the LDSS for determination of eligibility.

d) The protocols for facilitated enrollment practices between the LDSS and the facilitated enrollers must:
   i. Ensure that choice counseling activities are closely monitored to minimize adverse risk selection; and
   ii. Specify that determinations of Medicaid eligibility are made solely by the LDSS.

VI. DELIVERY SYSTEMS

36. **Contracts.** Procurement and the subsequent final contracts developed to implement selective contracting by the state with any provider group shall be subject to CMS approval prior to implementation.

    Payments under contracts with public agencies, that are not competitively bid in a process involving multiple bidders, shall not exceed the documented costs incurred in furnishing covered services to eligible individuals (or a reasonable estimate with an adjustment factor no greater than the annual change in the consumer price index).

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

38. **Managed Care Benefit Package.** Individuals enrolled in either MMMC or MLTC must receive from the managed care program the benefits as identified in Attachments A or B, as appropriate. As noted in plan readiness and contract requirements, the state must require that, for enrollees in receipt of LTSS, each MCO/PIHP coordinate, as appropriate, needed state plan services that are excluded from the managed care delivery system but available through a fee-for-service delivery system, and must also assure coordination with services not included in the established benefit package.

39. **Revision of the State Quality Strategy.** The state must update its Quality Strategy to reflect all managed care plans operating under MMMC and MLTC programs proposed through this Demonstration and submit to CMS for approval within 90 days of approval of the July 2012 amendment. The state must obtain the input of recipients and other stakeholders in the development of its revised comprehensive Quality Strategy and make the Strategy available for public comment. The state must revise the strategy whenever significant changes are made, including changes through this Demonstration. Pursuant to STC 63, the state must also provide CMS with annual reporting on the implementation and effectiveness of the updated comprehensive Quality strategy, as it impacts the Demonstration.

40. **Required Components of the State Quality Strategy.** The revised Quality Strategy shall meet all the requirements of 42 CFR 438 Subpart D. The quality strategy must include components relating to managed long term services and supports. The Quality strategy must address the

following regarding the population utilizing long term services and supports: level of care assessments, service planning, and health and welfare of enrollees.

41. **Required Monitoring Activities by State and/or EQRO.** The state's EQR process for the mainstream managed care and MLTC plans shall meet all the requirements of 42 CFR 438 Subpart E. In addition, the state, or its EQRO shall monitor and annually evaluate the MCO/PIHPs performance on specific new requirements under mandatory enrollment of individuals utilizing long term services and supports. The state shall provide an update of the processes used to monitor the following activities as well as the outcomes of the monitoring activities within the annual report in STC 63. The new requirements include, but are not limited to the following:
    a) MLTC Plan Eligibility Assessments – to ensure that approved instruments are being used and applied appropriately and as necessary, and to ensure that individuals being served with LTSS meet the MLTC plan eligibility requirements for plan enrollment . The state will also monitor assessments conducted by the plan where individuals are deemed ineligible for enrollment in an MLTC plan.
    b) Service plans – to ensure that MCOs/PIHPs are appropriately creating and implementing service plans based on enrollee's identified needs.
    c) MCO/PIHP credentialing and/or verification policies – to ensure that LTSS services are provided by qualified providers.
    d) Health and welfare of enrollees – to ensure that the MCO/PIHP, on an ongoing basis, identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation.

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

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

    a) The state must verify these assurances by reviewing demographic, utilization and enrollment data for enrollees in the Demonstration as well as:
        i. The number and types of providers available to provide covered services to the Demonstration population;
        ii. The number of network providers accepting the new Demonstration population; and
        iii. The geographic location of providers and Demonstration populations, as shown through GeoAccess, similar software or other appropriate methods.

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

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

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

VII. QUALITY DEMONSTRATION PROGRAMS AND CLINIC UNCOMPENSATED CARE FUNDING

46. **Hospital-Medical Home (H-MH) Demonstration**. The purpose of this demonstration is to improve the coordination, continuity, and quality of care for individuals receiving primary care in hospital outpatient departments operated by teaching hospitals, as well as other primary care settings used by teaching hospitals to train resident physicians. The demonstration will be instrumental in influencing the next generation of practitioners in the important concepts of patient-centered medical homes. Training sites, in particular, due to the structural discontinuity imposed by rotating residents and attending physicians' schedules, present a significant opportunity to improve patient experience and care through residency redesign.

    During this extension period, entities that serve as clinical training sites for primary care residents will work toward transforming their delivery system consistent with the National Committee on Quality Assurance (NCQA) requirements for medical home recognition under its Physician Practice Connections® - Patient-Centered Medical Home™ program (PPC®-PCMH™) and the 'Joint Principles' for medical home development articulated by primary care professional associations.

    In addition, hospitals which receive funding under this demonstration shall be required to implement a number of patient safety and systemic quality improvement projects.

47. **H-MH Demonstration Eligibility and Selection.** All teaching institutions in New York State will be eligible to participate in the H-MH demonstration. However, because the state does not intend to use a public competitive process to select awardees, the selection criteria for the H-MH demonstration will include for each:

    a) The extent to which the hospital has existing arrangements with training sites in the community (such as federally qualified health centers) to provide clinical experience to its primary care residents;
    b) An attestation as to their willingness and commitment to accomplish all milestones outlined in STC 48, including achieving NCQA PPC®-PCMH™ Level 2 recognition or above (in

accordance with the standards applicable at the time that recognition is awarded) by the end of the second year of the demonstration;

c) An agreement to track and report the clinical performance metrics required in STC 49; and
d) An agreement to implement both the system improvement and patient safety initiatives consistent with STCs 50 and 51.

To ensure that a mix of both academic medical centers and community teaching hospitals receive awards under the H-MH demonstration, the Department must submit its recommendations (along with proposed award amounts) to CMS for review before making final awards. An institution that already has achieved at least PPC®-PCMH™ Level 2 recognition under an earlier set of NCQA standards may participate if its goal is to renew or upgrade its recognition under later, more stringent NCQA standards.

48. **H-MH Milestones related to achievement of NCQA PPC®-PCMH™ for all awardees**. The key milestone for receiving demonstration funding will be the achievement of NCQA PPC®-PCMH™ Level 2 or Level 3 recognition within two (2) years from the start date of the program. The state will receive from NCQA a monthly 'roster' of practices, which have achieved NCQA PPC®-PCMH™ Level 2 or Level 3 recognition. In the interim, programs must demonstrate the achievement of the following milestones throughout the duration of the project:

a) **A detailed work plan after award.** Each awardee must submit a redesign strategy and detailed work plan to the state that documents how funds will be used for the following approved purposes: consultation services for practice re-design; staff development activities to support 'team' design to assuring continuity of care for patients; activities associated with curriculum changes; workforce retraining and retooling, and NCQA certification costs. The work plan must also

   i. indicate the clinical performance metrics that will be used (as discussed in paragraph 45 below), and provide baseline rates for each measure,

   ii. describe how the awardee will implement the H-MH System Improvement Initiatives described in paragraph 45, and

   iii. indicate which H-MH Quality and Safety Improvement Projects that the awardee will undertake, along with associated milestones (see paragraph 45).

b) **Baseline assessment within six months.** Each awardee must submit a formal baseline assessment to the state (using the NCQA tool or one developed by a primary care professional organization) that compares current practice with NCQA standards, along with a revised work plan and timeline.

c) **Interim report at the end of year 1.** Each awardee must submit to the state a report of interim progress in meeting the first year milestones and goals identified through the baseline assessment tool with revised plan as appropriate.

d) **MH recognition.** Each awardee must achieve NCQA PPC®-PCMH™ Level 2 or Level 3 recognition, using 2011 standards, by the end of year 2.

49. **H-MH clinical performance metrics for years 2 and 3.** Each awardee must develop at least five clinical performance metrics which shall be consistent with the standardized measures used by the New York State Department of Health in its QARR system and/or meaningful use measures and

relevant to the population being served, for internal practice measurement and improvement. Baseline and yearly rates for each measure must be submitted in the annual progress reports.

50. **H-MH System Improvement Initiatives**. Each awardee's project work plan and subsequent progress reports must incorporate the awardee's strategy for accomplishing the implemented initiatives as well as the milestones to measure success.

    a) Each awardee must implement an initiative to restructure operations to enhance patients' continuity of care experience in conjunction with developing a patient centered medical home.

       Awardees shall extend the ambulatory, continuity training experience of residents within the limits of residency requirements from the Residency Review Committee of the Accreditation Council for Graduate Medical Education. This could be accomplished by increasing the number of continuity training sites, expanding sites beyond the hospital environment (if the program is based in a hospital), increasing resident time in ambulatory settings, or other activities or combinations of approaches. These sites would also be required to provide care consistent with medical home requirements and achieve formal recognition within two years of program start date. The project work plan must include:
       i. A method for objective measurement of progress which may include number of new continuity sites, percent increase in ambulatory training experience for residents;
       ii. How these activities will support core activities of medical home transformation; and
       iii. How these restructuring changes will be sustained following the termination of the demonstration.

    b) Further, each awardee must select at least one of the following four initiatives to implement during the grant award period:
       1. <u>Care Transitions/Medication Reconciliation Programs</u>. Hospital awardees may be ideally suited to coordinate care between inpatient and outpatient settings given that they are frequently the same providers of care. This initiative would allow programs to develop a better 'bridge' for this transition, particularly with respect to medication reconciliation and management but also for outpatient primary and specialty care follow up. While the methods and staffing used to improve coordination could vary, all proposals must incorporate the evidence-based components of effective medication reconciliation. Programs would be required to:
          - Develop a registry of patients who have participated (directly through contact/outreach or indirectly through shared electronic information or medication lists) in medication reconciliation. The registry must contain sufficient unique identifiers to enable linkage to Medicaid claims data and be completed by the end of Year 1.
          - Participate as needed (sharing lists), with the Department, in periodic evaluation of readmissions and other utilization and quality metrics for patients receiving care transition/medication reconciliation services including the tracking of quarterly progress either on pilot unit or hospital wide.
          - Develop standardized clinical protocols for communication with patients/families during and post-discharge and care transition processes focused on most common causes of avoidable readmissions.
          - Develop integrated information systems between hospital inpatient and outpatient sites to enable improved continuity and follow up care.

- Create system to identify patients at highest risk of subsequent avoidable hospitalization and create a patient stratification approach to allocation of resources to facilitate community linkages including primary and specialty care services.

2. Integration of Physical-Behavioral Health Care. Medicaid has a large number of members with co-existing physical and mental health/substance abuse co-morbidities. Optimal care requires integration of services and providers so that care is coordinated and appropriate for the well-being of the entire person, not just for a single condition. There are many barriers between behavioral and physical health care including different providers, varying locations, multiple agencies, confidentiality rules and regulations, historic lack of communication between providers, and more. This initiative will require training programs to find ways to integrate care for their patients with behavioral health conditions within the medical home. The project work plan must include details on:
   - A strategy for integration which includes a means of improving referrals to behavioral health providers, enhanced communication with mental health/substance abuse providers, processes for obtaining appropriate consents for sharing personal health information, and procedures for coordinated case management (particularly for cases in which patients may have more than one provider).
   - Developing a linkage to the Office of Mental Health Psychiatric Services and Clinical Knowledge Enhancement System (PSYKES) project, which provides data and recommendations for potential problems of polypharmacy and metabolic syndrome exacerbation for Medicaid members using Medicaid databases within the first year of the program start date. The linkage will require creating systems to receive, and act on, reports generated by PSYKES. The linkage must be completed by the end of Year 1.
   - Developing training for primary care clinicians in behavioral health care with particular focus on integrating depression screening and pain management with appropriate treatment modalities and referral.
   - Assessing demand and capacity to provide co-located services or other approaches to decrease wait times and improve access to behavioral health services.
3. Improved Access and Coordination between Primary and Specialty Care. There is a tremendous opportunity to promote access and coordination between primary and specialty providers who are both providing care within the same delivery system, often in close physical proximity. Despite that opportunity, there are many examples in which the level of coordination is suboptimal, having the greatest adverse impact on those patients with more advanced, chronic diseases.
   - Programs will be required to put into place systems that would facilitate the ready access to specialty care when appropriate, with improved bilateral communication between primary and specialty care providers/clinics through transparent, standardized, referral processes. Specific goals include improving timely access to specialists, completed referral forms with required clinical information and reason(s) for referral, timely response of findings/recommendations from the specialist and higher rates of satisfaction on the part of providers and patients with respect to specialty care services.
   - Programs will be required to generate measures of access and coordination. These measures should be incorporated into a baseline assessment and annual evaluations and include patient and provider experiences related to wait times, follow up with primary care provider after specialty visit (as appropriate), delayed or rejected referrals, patient/provider satisfaction.

- Identify gaps in care and coordination for specialty services including collection of baseline data on wait times and appointment backlogs; survey primary care providers and specialists regarding the referral process and access and develop improvement plan based on findings with at least quarterly data collection, which will consider expansion of selected specialists, training of primary care providers in provision of select low level specialty care, inclusion of specialists in team care, protocols for primary-specialty care co-management.

4. Enhance Interpretation Services and Culturally Competent Care.
   - Programs will conduct an analysis to determine gaps in access to language services, and implement language access policies and procedures
   - Programs may expand workforce within interpreter services by hiring, training, and/or certifying interpreters, or determining other methods for increasing patients' access to appropriate language services.
   - Programs may include use of remote video and voice technology for instantaneous qualified health care interpretations
   - Develop programs to improve staff cultural competence and awareness through evidence based training.
   - Develop capacity to generate prescription labels in patient's primary language with easy to understand instructions.

51. **H-MH Quality and Safety Improvement Projects (QSIP).** In addition, each awardee shall implement at least two of the six Quality and Safety Improvement Projects outlined in this STC.

    These QSIPs will include interventions that have been demonstrated to produce measurable and significant results across different types of hospital settings, including in safety net hospitals; have a strong evidence base, meaning interventions that have been endorsed by a major national quality organization, with reasonably strong evidence established in the peer reviewed literature, including within the safety net; and are meaningful to hospital patients.

    An awardee is precluded from choosing any QSIP for which it has achieved top performance for at least 4 consecutive quarters, in aggregate in all process and outcomes measures within the intervention, where "top performance" is defined as being in the Top Quartile. Each QSIP below has specific measures that an awardee must include; however, awardees may include additional milestones to enable the implementation of the measures specified for the intervention.

    Milestones for the QSIPs can include infrastructure, redesign, implementation of evidence-based processes, and measurement and achievement of evidence-based outcomes. Awardees must include for each year a milestone for reporting the data on each QSIP to the Department. Improvement Targets will be determined based on the progress an awardee has already made on the improvement project pursuant to baseline data collected as of January 1, 2012.

    The 3-year end goals for each measure will be to move from one performance band to the next, except in the case of hospitals that are in the Top Band where the goal will be to move into the Top Quartile. Hospitals will be placed in one of 3 bands based on baseline performance as compared to state or national data on hospital performance, including safety net hospital performance, as follows:

- "Lower band" performers, as defined as the bottom one-third (1-33 percentile) of hospitals, will target moving into the middle-third performance band;
- "Middle band" performers, as defined as the middle third (34-65 percentile) of hospitals, will target moving into the top performance band; and
- "Top band" performers, as defined as the top third (66-100 percentile) of hospitals, will target moving into the top quartile.

Hospitals that have achieved performance in the top quartile will be expected to maintain or exceed top performance.

a) Severe Sepsis Detection and Management
   i. *Elements*
      (1) Implement the Sepsis Resuscitation Bundle: to be completed within 6 hours for patients with severe sepsis, septic shock, and/or lactate > 4mmol/L (36mg/dl).
      (2) Implement the Sepsis Management Bundle: to be completed within 24 hours for patients with severe sepsis, septic shock, and/or lactate > 4 mmol/L (36 mg/dl).
      (3) Make the elements of the Sepsis Bundles more reliable.

   ii. *Key Measures*
      (1) Percent compliance with four elements of the Sepsis Resuscitation Bundle, as measured by percent of hospitalization with sepsis, severe sepsis or septic shock and/or an infection and organ dysfunction where targeted elements of the Sepsis Resuscitation Bundle were completed.
      (2) Sepsis mortality

b) Central Line-Associated Bloodstream Infection (CLABSI) Infection Prevention
   i. *Elements*
      (1) Implement the central line bundle
      (2) Make the process for delivering all bundle elements more reliable

   ii. *Key Measures*
      (1) Compliance with Central Line Bundle
      (2) Central Line Bloodstream Infections

c) Surgical Complications Core Processes (SCIP)
   i. *Elements*
      (1) Surgical site infection prevention
      (2) Beta blockers continuation
      (3) VTE prophylaxis

   ii. *Key Measures*
      (1) SCIP Composite Process Measure:
         - SCIP-Inf-2: Prophylactic antibiotic selection for surgical patients
         - SCIP-Inf-3: Prophylactic antibiotics discontinued within 24 hours after surgery end time/48 hours for cardiac patients
         - SCIP-Inf-4: Cardiac surgery patients with controlled 6 a.m. postoperative serum glucose

- SCIP-Inf-6: Surgery patients with appropriate hair removal
- SCIP-Inf-9 : Urinary catheter removed on postoperative day 1 (POD 1) or postoperative day 2 (POD 2) with day of surgery being day zero
- SCIP-Card- 2: Surgery patients on a beta-blocker prior to arrival who received a beta-blocker during the perioperative period
- SCIP-VTE-1: Surgery patients with recommended venous thromboembolism prophylaxis orderedSCIP-VTE-2: Surgery patients who received appropriate venous thromboembolism prophylaxis within 24 hours prior to surgery to 24 hours after surgery

(2) Rate of surgical site infection for Class 1 and 2 wounds within 30 days of surgery

d) Venous Thromboembolism (VTE) Prevention and Treatment

i. *Elements*

(1) Provide appropriate VTE Prophylaxis, including pharmaceutical and mechanical approaches based on national guidelines

ii. *Key Measures*

(1) VTE Discharge Instructions
(2) VTE Prophylaxis

e) NICU Safety and Quality

i. *Elements*

(1) Participation in Vermont Oxford Network (VON) quality/safety measurement and improvement activities or New York State Obstetric and Neonatal Quality Collaborative (NYSONQC) sponsored Neonatal Enteral Nutrition Project and Statewide Collaborative to decrease NICU central line associated bloodstream infections.
(2) Assess current areas of need for performance improvement based on relative performance of hospital NICU to VON benchmarks and/or state level performance.
(3) Develop improvement projects (at least 2 which may include, but is not limited to, enteral nutrition or central line projects above) focusing on areas of greatest need making use of VON network quality improvement strategies and/or other evidence based care bundles.

ii. *Key Measures*

(1) Use of appropriate metrics for quality, safety, morbidity, complications, and risk adjusted mortality based on improvement project, including but not limited to:
    A. Nosocomial sepsis rates (per 1000 patient days) from NYS NICU Module;
    B. Central line associated bloodstream infection rates per 1000 central line days using the NYS hospital acquired infection data reporting system;
    C. Maintenance checklist use per total number of days of central line use; and
    D. Percent infants discharged from NICU at less than 10th percentile weight born <31 weeks gestation.

f) Avoidable Preterm Births: Reducing Elective Delivery Prior to 39 Weeks Gestation

i. *Elements*

(1) Use of evidence based interventions for evaluation, measurement, and improvement of preventable preterm births using findings from NICHQ/CMS Neonatal Outcomes Improvement Project and/or California Toolkit to Transform Maternity Care
    A. Identification and treatment of chronic medical conditions and high risk behaviors
    B. Early identification of mothers at high risk for preterm delivery
    C. Use of antenatal steroids in appropriate patients
    D. Reducing elective inductions/cesarean sections without appropriate medical or obstetric indication

ii. *Key Measures*

(1) Percent of scheduled inductions at 36(0/7) to 38(6/7) weeks without medical or obstetrical indication documented of all scheduled deliveries
(2) Percent of scheduled inductions at 36(0/7) to 38(6/7) weeks without medical or obstetrical indication documented of all scheduled inductions
(3) Percent of scheduled C-sections at 36(0/7) to 38(6/7) weeks without medical or obstetrical indication documented of all scheduled deliveries
(4) Percent of scheduled C-sections at 36(0/7) to 38(6/7) weeks without medical or obstetrical indication documented of all scheduled C-sections
(5) Percent of all scheduled deliveries at 36(0/7) to 38(6/7) weeks without medical or obstetrical indication documented of all scheduled deliveries
(6) Percent of infants born at 36(0/7) to 38(6/7) weeks gestation by scheduled delivery who went to neonatal intensive care unit
(7) Percent of mothers informed about risks and benefits of scheduled deliveries 36(0/7) to 38(6/7) weeks gestation documented in the medical record
(8) Percent scheduled deliveries at 36(0/7) to 38(6/7) weeks that have documentation in the medical record of meeting optimal criteria of gestational age assessment
(9) IHI Elective Induction Bundle Elements: Percentage of times that all four of the following elements are in place:
    A. gestational age >/= 39 weeks
    B. monitor fetal heart rate for reassurance of fetal status
    C. pelvic exam: assess to determine dilation, effacement, station, cervical position and consistency, and fetal presentation
    D. monitor and manage hyperstimulation (tachysystole).

52. **H-MH Funding Distribution**. Awardees will receive demonstration funds based on the number of Medicaid recipients served and the number of primary care residents trained. Eighty percent of an awardee's funds will be based on Medicaid patient volume and twenty percent will be based on primary care residents trained in that facility. The formula will be proportionally allocated using these criteria. Facilities will not be included if they do not satisfy the requirements for one of the supplemental program initiatives. Full or partial funding is contingent on achieving each year's goals. *In no instance will an awardee receive funding beyond year 2 unless the awardee has achieved NCQA PPC®-PCMH™ Level 2 or Level 3 recognition.*

a) Year 1 Funds. Each awardee will receive one-fourth of the first year's funding amount upon award. The remaining first year payment will be issued once the awardee has documented that the applicable first-year program milestones (as stipulated in paragraph 35(a), (b), and (c) above) have been met. If the first year milestones are not met by the end of year 1, the awardee

will forfeit the remaining funding for that year but would be allowed to continue to work toward meeting the milestones and eligible for subsequent year funding.

b) Year 2 Funds. Each awardee will receive one-fourth of the second year's funding amount upon completion of the applicable year one milestones. Upon achieving NCQA PPC®-PCMH™ Level 2 or Level 3 accreditation, the remainder of the second year's funds will be made available, provided all other requirements for QSIP projects are up to date. If an awardee does not achieve accreditation by the end of year two or, for a hospital awardee, make progress on the additional initiatives that are required as a condition of funding, the remainder of year two funding will be forfeited.

c) Year 3 Funds. Third year funding will be provided only to awardees that have achieved NCQA PPC®-PCMH™ Level 2 or Level 3 recognition and, for hospital awardees, meet the applicable milestones for the additional initiatives as stipulated in the hospital's approved work plan. Awardees will receive one-fourth of the funding amount at the start of the year and the remainder after submission of the third year milestones.

53. **H-MH Reporting**.

a) The state shall include updates on activities related to the H-MH demonstration in the quarterly operational reports required under STC 62 including updated expenditure projections reflecting the expected pace of disbursements under the demonstration.

b) The state shall provide an assessment of the H-MH demonstration by summarizing each awardee's activities during the demonstration year in each annual report required under STC 63.

c) The state shall include an assessment of the success of the H-MH demonstration in the evaluation required by STC 88 including the milestones in subparagraph 48(c), the hospital improvement projects in subparagraph 47(d) as well as the outcome measures for each supplemental program initiative implemented by the awardees.

54. **Potentially Preventable Readmissions (PPR) Demonstration.** The purpose of this demonstration is to test strategies for reducing the rate of preventable readmission within the Medicaid population, with the related longer-term goal of developing reimbursement policies that provide incentives to help people stay out of the hospital. It is intended to assist hospitals with reducing the rate of PPRs in advance of the implementation of the Hospital Readmissions Reduction Program (authorized by section 3025 of the Patient Protection and Affordable Care Act) on October 1, 2012. Beginning with FFY 2012, hospitals will face reductions in Medicare payments if they have readmission rates higher than what would be expected for specific conditions.

Hospitals will be asked to devise unique strategies that target each hospital's particular experiences, strengths, weaknesses and patient profile. Projects will focus on improved quality and cost savings and will include reporting and evaluation components to ensure that the projects are replicable and sustainable. Activities will include a review of policies and operational procedures that may be contributing to high rates of avoidable readmissions; reengineering the discharge planning process; and appropriate management of post-hospital/transition care; coordination with

outpatient and post-discharge providers, including institutions and community providers, to address transitional care needs.

a) Eligibility. All hospitals in the state will be eligible to participate in the PPR demonstration.

b) Selection. The state will develop and issue a Request for Grant Application (RGA). Awards will be made based on the published criteria in the RGA, and funding will be made available over the demonstration extension period as specified in the RGA. The RGA shall also include requirements for evaluating the success of the implemented strategies.

c) Reporting.

i. Once grantees are in place, the state shall include in the quarterly operational report required under STC 62, the following information:
(1) A summary of the interventional strategies each grantee intends to implement;
(2) Baseline assessment of each grantee's readmission rate;
(3) Interim assessments (as data is available) of each grantee's success in reducing PPRs; and
(4) Updated expenditure projections reflecting the expected pace of disbursements under the demonstration.

ii. The state shall provide a progress report in the implementation of the PPR demonstration in each annual report required under STC 63.

55. **Clinic Uncompensated Care Funding.** The state currently provides grants to voluntary, non-profit and publicly-sponsored Diagnostic and Treatment Centers (D&TCs) for services delivered to the uninsured throughout the state through the Indigent Care Pool (ICP). In 2008, there were 64 voluntary and 13 public D&TCs eligible for Indigent Care pool funding located in 21 counties of the state. Of the 64 voluntary D&TCs, 54 facilities are Federally Qualified Health Centers (FQHCs). Beginning in demonstration year 13, 176 mental health clinic providers are now eligible for ICP grants. This program will allow the state to double the amount of grants provided through the ICP.

a) Eligibility. In order to receive ICP funds, each facility must provide a comprehensive range of primary health care or mental health care services; have at least 5 percent of their visits providing services to uninsured individuals; and have a process to collect payments from third-party payers.

b) Reporting.

i. The state shall include updates on activities related to ICP grants in each quarterly operational report required under STC 62, including the extent to which actual expenditures for the grants are consistent with projections.

ii. The state shall also include the following information on each facility which received a grant in each demonstration year in annual report required under STC 63:
(1) The total amount of ICP funds awarded;

(2) The total amount of funding that each clinic received from other federal agencies, including but not limited to, the Health Resources and Services Administration and the Substance Abuse and Mental Health Services Administration;
(3) The extent to which the clinic participates in any medical home initiative, including a summary of the initiative;
(4) The extent to which the clinic has implemented certified electronic health records (EHRs) for its patients; and
(5) The number of providers practicing predominantly within a FQHC grantee who are "meaningful users" of certified EHRs consistent with 42 CFR 495.6.

56. **Funding for Quality Demonstrations and Clinic Uncompensated Care**. Federal funds will be used to pay the full cost of these programs. Accordingly, Federal Financial Participation (FFP) will be available for state funds for the Indigent Care Pool (beginning August 1, 2011 and ending December 31, 2013) and the Designated State Health Programs (DSHP) described in STC 56 (beginning August 1, 2011 and ending December 31, 2014), as certified on each quarterly CMS Form 64 expenditure reports.

a) Limitations on FFP.

i. FFP is limited to no more than $477.2million over the demonstration extension period as follows:
(1) $325 million for the H-MH demonstration;
(2) $20 million for the PPR demonstration; and
(3) $132.2 million for the ICP, but only to the extent that the state appropriates and expends at least $132.2 million over the extension period. Otherwise, FFP for the ICP may be no more than one-half of total ICP spending (both federal and state funds).

ii. The state shall be eligible to receive FFP over the demonstration period for its own expenditures for:
(1) The Indigent Care Pool (for ICP expenditures made between August 1, 2011 and December 31, 2013); and
(2) DSHP (for DSHP expenditures made between August 1, 2011 and December 31, 2014).

b) Reporting.

i. Updated expenditure projections shall be provided by the state in each quarterly operational report required under STC 62.

ii. Expenditure Reporting for the H-MH demonstration. DSHP expenditures used to draw down federal funds for the H-MH demonstration shall be reported on the CMS-64 under waiver name MH Demo – DSHP.

iii. Expenditure Reporting for the PPR demonstration. DSHP expenditures used to draw down federal funds for the PPR demonstration shall be reported on the CMS-64 under waiver name PPR Demo – DSHP.

iv. Expenditure Reporting for Clinic Uncompensated Care.
(1) The state's own expenditures for ICP grants shall be reported on the CMS-64 under waiver name ICP – Direct.

(2) DSHP expenditures used to draw down federal funds for Clinic Uncompensated Care shall be reported on the CMS-64 under waiver name ICP – DSHP.

c) Reconciliation and Recoupment. By the end of the demonstration extension period, if the amount of DSHP claimed over the demonstration period results in the state receiving FFP in an amount greater than what the state actually expended for quality demonstrations and clinic uncompensated care, the state must return to CMS federal funds in an amount that equals the difference between claimed DSHP and actual state expenditures made for these initiatives.

i. As part of the annual report required under STC 63, the state will report both DSHP claims and expenditures to date for the quality demonstrations and clinic uncompensated care.

ii. The reported claims and expenditures will be reconciled at the end of the Demonstration with the state's CMS-64 submissions.

iii. Any repayment required under this subparagraph will be accomplished by the state making an adjustment for its excessive claim for FFP on the CMS-64 by entering an amount in line 10(b) of the Summary sheet equal to the amount that equals the difference between claimed DSHP and actual expenditures made for these initiatives during the extension period.

57. **Designated State Health Programs**. Subject to the conditions outlined in STC 55, FFP may be claimed for expenditures made for the following designated state health programs beginning August 1, 2011 through December 31,2014:

a) Homeless Health Services

b) HIV-Related Risk Reduction

c) Childhood Lead Poisoning Primary Prevention

d) Healthy Neighborhoods Program

e) Local Health Department Lead Poisoning Prevention Programs

f) Cancer Services Programs

g) Obesity and Diabetes Programs

h) TB Treatment, Detection and Prevention

i) TB Directly Observed Therapy

j) Tobacco Control

k) General Public Health Work

l) Newborn Screening Programs

58. **Designated State Health Programs (DSHP) Claiming Process.**

a) Documentation of each DSHP's expenditures must be clearly outlined in the state's supporting work papers and be made available to CMS.

b) Federal funds must be claimed within two years after the calendar quarter in which the state disburses expenditures for the DSHPs in STC 57. Claims may not be submitted for state expenditures disbursed after December 31, 2014.

c) Sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. To the extent that federal funds from any federal programs are received for the DSHP listed in STC 57, they shall not be used as a source of non-federal share.

d) The administrative costs associated with DSHPs in STC 57 and any others subsequently added by amendment to the Demonstration shall not be included in any way as Demonstration and/or other Medicaid expenditures.

e) Any changes to the DSHPs listed in STC 57 shall be considered an amendment to the Demonstration and processed in accordance with STC 7.

VIII. GENERAL REPORTING REQUIREMENTS

59. **General Financial Requirements.** The state must comply with all general financial requirements set forth in section IX.

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

61. **Monthly Calls.** CMS shall schedule monthly conference calls with the state. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the Demonstration. Areas to be addressed include, but are not limited to, MCO operations (such as contract amendments and rate certifications), transition and implementation activities, health care delivery, the FHP-PAP program, enrollment, cost sharing, quality of care, access, family planning issues, benefits, audits, lawsuits, financial reporting and budget neutrality issues, MCO financial performance that is relevant to the Demonstration, progress on evaluations, state legislative developments, services being added to the MMMC and/or MLTC plan benefit package pursuant to STC 30, and any Demonstration amendments, concept papers, or state plan amendments the state is considering submitting. CMS shall update the state on any amendments or concept papers under review, as well as federal policies and issues that may affect any aspect of the Demonstration. The state and CMS shall jointly develop the agenda for the calls.

62. **Quarterly Operational Reports.** The state must submit progress reports in accordance with the guidelines in Attachment D taking into consideration the requirements in STC 65, no later than 60 days following the end of each quarter (December, March, and June of each demonstration year). The state may combine the quarterly report due for the quarter ending September with the annual report in STC 62. The intent of these reports is to present the state's analysis and the status of the various operational areas.

63. **Annual Report.** The state must submit an annual report documenting accomplishments, project

status, quantitative and case study findings, interim evaluation findings, utilization data, and policy and administrative difficulties in the operation of the Demonstration. The state must submit this report no later than 90 days following the end of each Demonstration year. Additionally, the annual report must include:

a) A summary of the elements included within each quarterly report;
b) An update on the progress related to the quality strategy as required in STC 38;
c) An aggregated enrollment report showing the total number of individuals enrolled in each plan
d) A summary of the use of self-directed service delivery options in the state at the time when those benefits are included in the demonstration;
e) A listing of the new geographic areas the state has expanded MLTC to;
f) A list of the benefits added to the managed care benefit package;
g) An updated transition plan which shows the intended transition and timeline for any new benefits and/or populations into the demonstration;
h) Network adequacy reporting as required in STC 42;
i) Any other topics of mutual interest between CMS and the state related to the demonstration; and
j) Any other information the state believes pertinent to the demonstration.

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

a) **Seamless Transitions.** Consistent with the provisions of the ACA, the Transition Plan will include details on how the state plans to obtain and review any additional information needed from each individual to determine eligibility under all eligibility groups, and coordinate the transition of individuals enrolled in the Demonstration (by FPL) (or newly applying for Medicaid) to a coverage option available under the ACA without interruption in coverage to the maximum extent possible. Specifically, the state must:

i. Determine eligibility under all January 1, 2014, eligibility groups for which the state is required or has opted to provide medical assistance, including the group described in §1902(a)(10)(A)(i)(VIII) for individuals under age 65 and regardless of disability status with income at or below 133 percent of the FPL;
ii. Identify Demonstration populations not eligible for coverage under the ACA and explain what coverage options and benefits these individuals will have effective January 1, 2014;
iii. Implement a process for considering, reviewing, and making preliminarily determinations under all January 1, 2014 eligibility groups for new applicants for Medicaid eligibility;

iv. Conduct an analysis that identifies populations in the Demonstration that may not be eligible for or affected by the ACA and the authorities the state identifies that may be necessary to continue coverage for these individuals; and

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

b) **Access to Care and Provider Payments.**

i. Provider Participation. The state must identify the criteria that will be used for reviewing provider participation in (e.g., demonstrated data collection and reporting capacity) and means of securing provider agreements for the transition.

ii. Adequate Provider Supply. The state must provide the process that will be used to assure adequate provider supply for the state plan and Demonstration populations affected by the Demonstration on December 31, 2013. The analysis should address delivery system infrastructure/capacity, provider capacity, utilization patterns and requirements (i.e., prior authorization), current levels of system integration, and other information necessary to determine the current state of the of service delivery. The report must separately address each of the following provider types:

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

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

c) **System Development or Remediation.** The Transition Plan for the Demonstration is expected to expedite the state's readiness for compliance with the requirements of the Affordable Care Act and other federal legislation. System milestones that must be tested for implementation on or before January 1, 2014 include:

i. Replacing manual administrative controls with automotive processes to support a smooth interface among coverage and delivery system options that is seamless to beneficiaries.

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

e) **Implementation.**

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

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

65. **Reporting Requirements Related to Family Planning Expansion.**

a) In each annual report required by STC 63, the state shall report:
   i. The average total Medicaid expenditures for a Medicaid-funded birth each year. The cost of a birth includes prenatal services and delivery and pregnancy-related services and services to infants from birth through age 1. (The services should be limited to the services that are available to women who are eligible for Medicaid because of their pregnancy and their infants.);
   ii. The number of actual births that occur to FP Expansion participants (participants include all individuals who obtain one or more covered medical family planning services through the Demonstration) each year;
   iii. Yearly enrollment reports for Demonstration enrollees for each DY (eligibles include all individuals enrolled in the Demonstration); and
   iv. Total number of participants for each DY (participants include all individuals who obtain one or more covered family planning services through the Demonstration).

66. **Reporting Requirements Related to Individuals using long term services and supports**.
   a) In each quarterly report required by STC 62, the state shall report:
   i. Any critical incidents reported within the quarter and the resulting investigations as appropriate;
   ii. The number and types of grievance and appeals for this population filed and/or resolved within the reporting quarter;
   iii. The total number of assessments for enrollment performed by the plans, with the number of individuals who did not qualify to enroll in an MLTC plan;
   iv. The number of individuals referred to an MLTC plan that received an assessment within 30 days;
   v. The number of people who were not referred by the enrollment broker and contacted the plan directly and were provided MLTC materials;
   vi. Rebalancing efforts performed by the MLTC Plans and mainstream plans once the benefit is added. ;
      (A) Rebalancing reporting should include, but is not limited to the total number of individuals transitioning in and out of a nursing facility within the quarter.
   vii. Total number of complaints, grievances and appeals by type of issue with a listing of the top 5 reasons for the event.

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

IX. GENERAL FINANCIAL REQUIREMENTS

68. **Quarterly Expenditure Reports.** The state must provide quarterly expenditure reports using Form CMS-64 to separately report total expenditures for services provided under the Medicaid program, including those provided through the Demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the Demonstration

period. CMS shall provide FFP for allowable Demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in section X.

69. **Reporting Expenditures Under the Demonstration:** The following describes the reporting of expenditures under the Demonstration:

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

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

Demonstration Year	Time Period
1	10/1/1997 - 9/30/1998
2	10/1/1998 - 9/30/1999
3	10/1/1999 - 9/30/2000
4	10/1/2000 - 9/30/2001
5	10/1/2001 - 3/30/2003
6	04/1/2003 - 9/30/2004
7	10/1/2004 - 9/30/2005
8	10/1/2005 - 9/30/2006
9	10/1/2006 - 09/30/2007
10	10/1/2007 - 09/30/2008
11	10/1/2008 - 09/30/2009
12	10/1/2009 - 09/30/2010
13	10/1/2010 - 09/30/2011
14	10/1/2011 - 09/30/2012
15	10/1/2012 - 09/30/2013
16	10/1/2013 – 12/31/2013
17	1/1/2014 – 3/31/2014
18	4/1/2014 – 12/31/2014

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

supporting work papers and made available to CMS.

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

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

d) For the family planning expansion component of the Demonstration, the state should report Demonstration expenditures on Forms CMS-64.9 Waiver and/or 64.9P Waiver as follows:

i. Allowable family planning-related expenditures eligible for reimbursement at the state's federal medical assistance percentage rate (FMAP) should be entered in Column (B) on the appropriate waiver sheets.

ii. Allowable family planning expenditures eligible for reimbursement at the enhanced family planning match rate should be entered in Column (D) on the appropriate waiver sheets.

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

f) Premiums paid for ESHI under FHP-PAP will be reported on Forms CMS-64.9 Waiver and/or CMS-64.9P Waiver on Line 18.E. in order to ensure that the Demonstration is properly credited with these premium payments. Additionally, both the total computable and federal share amounts that are paid under FHP-PAP must be separately reported on the CMS-64Narr.

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

i. **Demonstration Population 1:** Temporary Assistance to Needy Families (TANF) child under age 1 through age 20 required to enroll in managed care in any county **other than** Allegany, Cortland, Dutchess, Fulton, Montgomery, Putnam, Orange, Otsego, Schenectady, Seneca, Sullivan, Ulster, Washington, or Yates, for expenditures associated with dates of service on or before March 31, 2014 [TANF Child].

ii. **Demonstration Population 2:** TANF Adults aged 21-64 required to enroll in managed care in any county **other than** Allegany, Cortland, Dutchess, Fulton, Montgomery, Putnam, Orange, Otsego, Schenectady, Seneca, Sullivan, Ulster, Washington, or Yates, for expenditures associated with dates of service on or before March 31, 2014 [TANF Adult].

iii. **Demonstration Population 3:** Disabled Adults and Children 0-64, for expenditures associated with dates of service on or before March 31, 2014 [SSI 0-64]

iv. **Demonstration Population 4:** Aged or Disabled Adults, for expenditures associated with dates of service on or before March 31, 2014 [SSI 65+]

v. **Demonstration Population 5:** Safety Net Adults, for expenditures associated with dates of service on or before December 31, 2013 [Safety Net Adults]

vi. **Demonstration Population 6:** Family Health Plus Adults with children up to 150% FPL, for expenditures associated with dates of service on or before December 31, 2013 [FHP Adults w/Children]

vii. **Demonstration Population 7**: Family Health Plus Adults without children up to 100% FPL, for expenditures associated with dates of service on or before December 31, 2013 [FHP Childless Adults]

viii. **Demonstration Population 8:** Family Planning Expansion Adults, for expenditures associated with dates of service on or before December 31, 2013 [FP Expansion]

ix. **Demonstration Population 9:** Home and Community-Based Services Expansion participants, for expenditures associated with dates of service on or before March 31, 2014 [HCBS Expansion]

x. **Demonstration Population 10:** MLTC Adults age 18 – 64 [MLTC Adults 18 -64]

xi. **Demonstration Population 11:** MLTC Adults age 65 and above [MLTC Adults 65+]

xii. **Demonstration Services 1:** State Indigent Care Pool Direct Expenditures, for expenditures made on or before December 31, 2013 [ICP-Direct]

xiii. **Demonstration Services 2:** Designated State Health Programs to Support

	Clinic Uncompensated Care Funding, for expenditures made on or before December 31, 2013 [ICP - DSHP]
xiv. **Demonstration Services 3:**	Designated State Health Programs to Support Medical Home Demonstration, for expenditures made on or before December 31, 2014 [DSHP - HMH Demo]
xv. **Demonstration Services 4:**	Designated State Health Programs to Support Potentially Preventable Readmission Demonstration, for expenditures made on or before December 31, 2014 [DSHP - PPR Demo]

Note: Waiver forms for Demonstration Populations 3 and 4 are no longer required under this demonstration, but under demonstration 11-W-000234/2, The Federal-State Health Reform Partnership. However, they remain defined Demonstration Populations for future use if needed.

70. **Expenditures Subject to the Budget Neutrality Agreement.** For purposes of this section, the term "expenditures subject to the budget neutrality agreement" must include all Medicaid expenditures in STC 69(g) for individuals who are enrolled in this Demonstration (with the exception of the populations identified in subparagraphs iii, iv, and ix), as well as the demonstration services described in subparagraphs x through xiii, subject to limitations enumerated in this STC. All expenditures that are subject to the budget neutrality agreement are considered Demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and/or 64.9P Waiver.

a) Beginning in DY 9, all expenditures for Demonstration Populations 1 and 2 who reside in Allegany, Cortland, Dutchess, Fulton, Montgomery, Putnam, Orange, Otsego, Schenectady, Seneca, Sullivan, Ulster, Washington, or Yates counties are no longer considered expenditures subject to the budget neutrality agreement for this Demonstration and may not be reported on Forms CMS-64.9 Waiver and/or 64.9P for this Demonstration. These expenditures will be reported under the F-SHRP Demonstration (11-W-00234/2).

b) Beginning in DY 9, expenditures for Demonstration Populations 3 and 4 defined in STC 69 (g) will no longer be reported under this Demonstration. However, these eligibility groups remain as a placeholder in the event these populations are transferred from the F-SHRP Demonstration (11-W-00234/2) back to this Demonstration. The state shall follow the amendment process outlined in STC 7 to effectuate this transfer.

c) Beginning in DY 9, Demonstration Populations 3 and 4, as defined in paragraph 69 (g), are no longer considered expenditures subject to the budget neutrality agreement for this Demonstration. These expenditures may not be reported on Forms CMS-64.9 Waiver and/or 64.9P under this Demonstration, except if permitted under the provisions of subparagraph (b). These expenditures will be reported under the F-SHRP Demonstration (11-W-00234/2), subject to the provisions of subparagraph (b) of this STC.

d) Only the home and community-based services expenditures for Demonstration Population 9 shall be subject to the budget neutrality agreement.

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

72. **Premium Collection Adjustment.** The state must include any Demonstration premium collections as a manual adjustment (decrease) to the Demonstration's actual expenditures on a quarterly basis and shall be reported in accordance with STC 69 (f).

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

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

    a) For the purpose of calculating the budget neutrality expenditure cap and for other purposes, the state must provide to CMS, as part of the quarterly report required under STC 62, the actual number of eligible member months for the Demonstration Populations defined in STC 69 (g), for months prior to or including the ending date indicated in STC 69 (g) for each Demonstration Population. The state must submit a statement accompanying the quarterly report, which certifies the accuracy of this information.

    Beginning in DY 9, the actual number of member months for Demonstration Populations 3 and 4, as defined in STC 69 (g), will not be used for the purpose of calculating the budget neutrality expenditure agreement, except as defined in STC 70(b).

    Additionally, Beginning in DY 9, the actual number of member months for Demonstration Populations 1 and 2 who reside in Allegany, Cortland, Dutchess, Fulton, Montgomery, Putnam, Orange, Otsego, Schenectady, Seneca, Sullivan, Ulster, Washington, or Yates counties will not be used for the purpose of calculating the budget neutrality expenditure agreement, subject to the limitations in STC 69.

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

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

    c) For the purposes of this Demonstration, the term "Demonstration eligibles" excludes

unqualified aliens and refers to the Demonstration Populations described in STC 69 (g). Beginning in DY 9, "Demonstration eligibles" excludes Demonstration Populations 3 and 4, subject to STC 70(b), as well as portions of Demonstration Populations 1 and 2, as specified in STC 70(a - b).

75. **Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the Demonstration. New York must estimate matchable Demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure cap and separately report these expenditures by quarter for each federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments and State and Local Administration Costs. CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

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

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

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

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

    d) FFP will be provided for the Family Planning Expansion Program as described in STC77.

77. **Extent of FFP for Family Planning Expansion Program.** FFP will be provided for the Family Planning Expansion Program in accordance with family planning and family planning-related services (including prescriptions) at the applicable federal matching rates described in paragraph 29(d), subject to the limits described below:
    a) For procedures or services clearly provided or performed for the primary purpose of family planning and which are provided in a family planning setting, reimbursable procedure codes for office visits, laboratory tests, and certain other procedures must carry a primary diagnosis or a modifier that specifically identifies them as a family planning service.
    b) FFP will not be available for the costs of any services, items, or procedures that do not meet the requirements specified above, even if family planning clinics or providers provide them. For example, in the instance of testing for STIs as part of a family planning visit, FFP will be available at the 90 percent federal matching rate. The match rate for the subsequent treatment would be paid at the applicable federal matching rate for the state. For testing or treatment not associated with a family planning visit, (e.g., those provided at a public STI clinic), no FFP will be available.

c) Pursuant to 42 CFR 433.15(b)(2), FFP is available at the 90 percent administrative match rate for administrative activities associated with administering the family planning services provided under the Demonstration including the offering, arranging, and furnishing of family planning services. These costs must be allocated in accordance with OMB Circular A-87 cost allocation requirements. The processing of claims is reimbursable at the 50 percent administrative match rate.

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

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

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

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

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

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

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

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

e) Under all circumstances, health care providers must retain 100 percent of the claimed expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) exist between health care providers and state and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the

understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, (including health care provider-related taxes), fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

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

X. MONITORING BUDGET NEUTRALITY

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

82. **Risk.** New York shall be at risk for the per capita cost (as determined by the method described below) for Demonstration eligibles under this budget neutrality agreement, but not for the number of Demonstration eligibles in each of the groups. By providing FFP for all Demonstration eligibles, New York shall not be at risk for changing economic conditions that impact enrollment levels. However, by placing New York at risk for the per capita costs for Demonstration eligibles under this agreement, CMS assures that federal demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no Demonstration.

83. **Demonstration Populations Used to Calculate Budget Neutrality Expenditure Limit.** The following Demonstration populations are used to calculate the budget neutrality expenditure limit subject to the limitations outlined in STC 69 and are incorporated into the following eligibility groups (EGs):

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

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

c) **Eligibility Group 3:** FHPlus Adults with children (Demonstration Population 6)

d) **Eligibility Group 4:** Individuals of childbearing age receiving a limited family planning benefit through the Family Planning Expansion Program (Demonstration Population 8)

e) **Eligibility Group 5:** MLTC Adults age 18 – 64

f) **Eligibility Group 6**: MLTC Adults age 65 and above

Note: Demonstration Populations 3 and 4 are no longer part of the calculation of the budget neutrality expenditure cap under this demonstration, but under demonstration 11-W-000234/2, The Federal-State Health Reform Partnership.

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

a) For each year of the budget neutrality agreement an annual budget neutrality expenditure limit is calculated for each EG described in STC 83 as follows:

i. An annual EG estimate must be calculated as a product of the number of eligible member months reported by the state in accordance with the requirements outlined in STC 74, for each EG, times the appropriate estimated per member per month (PMPM) costs from the table in subparagraph (iii) below. Should EGs 3 and 4 be incorporated into the budget neutrality expenditure limit, as outlined in STC 70, the PMPM costs may be revised.

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

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

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

Eligibility Group	DY 11 (10/1/08 – 9/30/09)	Trend Rate	DY 12 (10/1/09 – 9/30/10)
TANF Children under age 1 through 20	$549.19	6.7%	$585.99
TANF Adults 21-64	$751.73	6.6%	$801.34
FHPlus Adults with Children	$586.82	6.6%	$625.55

Note: Demonstration Populations 3 and 4 are no longer part of the calculation of the budget neutrality expenditure limit under this demonstration, but under demonstration 11-W-00234/2, The Federal-State Health Reform Partnership.

(2) For the current extension period, the PMPM cost for each EG in Demonstration year 12 has been increased by the appropriate growth rate included in the President's federal fiscal year 2011 budget for DYs 13 through 16, as outlined below. In addition, because the Family Planning Expansion Adults are going to be treated as a "hypothetical state plan population" beginning in DY 13, a PMPM cost was constructed based on state expenditures in DY 10, and increased by the rate of growth in the medical care component of the Consumer Price Index between 2004 and 2008. Because DYs 16 and 17 combined are less than 12 months in duration, they are assigned the PMPM costs equal to what would have been calculated for the

full year starting October 1, 2013 and ending September 30, 2014. The FHPlus Adults with Children and Family Planning Expansion Adults groups will end on December 31, 2013, so no PMPM is defined for those groups for DY 17. The budget neutrality expenditure limit will end March 31 ,2014; expenditures made after that date for DSHP must be offset by accumulated savings from DYs 1 through 17.

Eligibility Group	DY 12 (10/1/09 – 9/30/10)	Trend Rate	DY 13 (10/1/10 – 9/30/11)	DY 14 (10/1/11 – 9/30/12)	DY 15 (10/1/12 – 9/30//13)	DY 16 (10/1/13– 12/31/13)	DY 17 (1/1/2014 – 3/31/2014)
TANF Children under age 1 through 20	$585.99	6.6%	$624.67	$665.90	$709.85	$756.70	$756.70
TANF Adults 21-64	$801.34	6.4%	$852.63	$907.20	$965.26	$1,027.04	$1,027.04
FHPlus Adults with Children	$625.55	6.4%	$665.59	$708.19	$753.51	$801.73	N/A
Family Planning Expansion Adults		4.1%	$20.23	$21.06	$21.92	$22.81	N/A
MLTC Adults age 18 - 64		1.19%		$3,962.23	$4,009.38	$4,057.09	$4,105.37
MLTC Adults 65 and above		3.23%		$4,593.77	$4,742.15	$4,895.32	$5,053.44

Note: Demonstration Populations 3 and 4 are no longer part of the calculation of the budget neutrality expenditure limit under this demonstration, but under demonstration 11-W-00234/2, The Federal-State Health Reform Partnership.

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

b) The overall budget neutrality expenditure limit for the demonstration period is the sum of the annual budget neutrality expenditure limits calculated in subparagraph (a)(iv) above for each year. The federal share of the overall budget neutrality expenditure limit represents the maximum amount of FFP that the state may receive for expenditures on behalf of Demonstration populations and expenditures described in STC 68 (g) during the Demonstration period.

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

86. **Enforcement of Budget Neutrality.** CMS shall enforce budget neutrality over the life of the Demonstration rather than on an annual basis. DY 18 expenditures, which will consist only of DSHP expenditures in support of the H-MH and PPR demonstrations, will be included in the

budget neutrality test for the demonstration. The state may receive FFP for these expenditures to the extent that sufficient accumulated budget neutrality savings are available from prior DYs.

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

XI. EVALUATION OF THE DEMONSTRATION

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

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

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

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

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

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

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

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

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

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

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

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

xi. How has the additional funding provided under the Clinic Uncompensated Care program

increased the use of patient-centered medical homes and electronic medical records?

xii. How have the results of the family planning expansion program expanded access to family planning services among the target population?

b) The evaluation questions for MLTC goals should include, but are not limited to:
   i. How has enrollment in MLTC plans increased over the length of the demonstration?
   ii. What are the demographic characteristics of the MLTC population? Are they changing over time?
   iii. What are the functional and cognitive deficits of the MLTC population? Are they changing over time?
   iv. Are the statewide and plan-specific overall functional indices decreasing or staying the same over time?
   v. Are the average cognitive and plan-specific attributes decreasing or staying the same over time?
   vi. Are the individual care plans consistent with the functional and cognitive abilities of the enrollees?
   vii. Access to Care: To what extent are enrollees able to receive timely access to personal, home care and other services such as dental care, optometry and audiology?
   viii. Quality of Care: Are enrollees accessing necessary services such as flu shots and dental care?
   ix. Patient Safety: Are enrollees managing their medications? What are the fall rates and how are they changing over time?
   x. Satisfaction: What are the levels of satisfaction with access to, and perceived timeliness and quality of network providers?
   xi. Costs: What are the PMPM costs of the population?

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

c) The state must submit to CMS for approval a draft evaluation design no later than October 1, 2012.

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

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

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

evaluation report within 60 days after receipt of CMS comments.

b) By April 30, 2015, the state must submit to CMS a draft final evaluation report on the evaluations of the H-MH and PPR demonstrations. CMS shall provide comments within 60 days after receipt of the report. The state shall submit the final evaluation report within 60 days after receipt of CMS comments.

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

XII. SCHEDULE OF STATE DELIVERABLES FOR THE DEMONSTRATION EXTENSION PERIOD

Date - Specific	Deliverable	Reference
11/1/2011	Submit Draft Evaluation Plan	Section XI, STC 88

	Deliverable	Reference
Annual	By January 1st - Annual Report	Section VIII, STC 63
	By December 31st – Annual MEQC Program Report	Section III, STC 13
Quarterly		
	Quarterly Operational Reports	Section VIII, STC 62
	Quarterly Expenditure Reports	Section IX, STC 68
	Eligible Member Months	Section IX, STC 74

ATTACHMENT A

Mainstream Medicaid Managed Care Benefits

Inpatient and outpatient hospital services
Clinic services including Rural Health Clinic and Federally Qualified Health Center services
Laboratory and X-ray services
Home health services
Early Periodic Screening, Diagnosis, and Treatment services (for individuals under age 21 only)
Family planning services and supplies
Physicians services including nurse practitioners and nurse midwife services
Dental services
Physical and occupational therapy
Speech, hearing, and language therapy
Prescription drugs, over-the-counter drugs, and medical supplies
Durable medical equipment, including prosthetic and orthotic devices, hearing aids, and prescription shoes
Vision care services, including eyeglasses
Intermediate Care Facilities for the Mentally Retarded (ICF/MR)
Nursing facility services
Personal care services
Case management services
Hospice care services
TB-related services
Inpatient and outpatient behavioral health services (mental health and chemical dependence services)
Emergency medical services, including emergency transportation
Adult day care
Personal Emergency Response Services (PERS)
Renal dialysis
Home and Community Based Services waivers (HCBS)
Care at Home Program (OPWDD)
Non–emergency transportation
Experimental or investigational treatment (covered on a case-by-case basis)

Service	Co-pay
Non-preferred brand-name prescription drugs	$3
Preferred brand-name prescription drugs	$1
Generic prescription drugs	$1

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

ATTACHMENT B

Managed Long Term Care Benefits

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

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

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

ATTACHMENT C

Family Health Plus Benefits and Cost-Sharing

Inpatient and outpatient hospital services
Clinic services including Rural Health Clinic and Federally Qualified Health Center services
Laboratory and X-ray services
Home health services (covered for 40 visits in lieu of hospitalization, plus 2 post-partum visits for high-risk women)
Early Periodic Screening, Diagnosis, and Treatment services (for individuals ages 19 and 20 only) to the extent available under otherwise covered services
Family planning services and supplies
Physicians services including nurse practitioners and nurse midwife services
Dental services (optional)
Physical and occupational therapy (20 visits for each therapy annually)
Speech therapy (for conditions amenable to clinical improvement within a 2–month period)
Prescription drugs, diabetic supplies, and smoking cessation products
Durable medical equipment, including prosthetic and orthotic devices and hearing aids
Vision care services including eyeglasses
Nursing facility services (inpatient rehab)
Hospice care services
TB-related services, except Directly Observed Therapy
Behavioral health services (mental health and chemical dependence services), limited to 60 outpatient visits combined and 30 inpatient days combined
Emergency medical services including emergency transportation
Renal dialysis
Experimental or investigational treatment (covered on a case by case basis)

Service	Co-payment
Clinic services *	$5 per visit
Physician services	$5 per visit
Prescription Drugs • Brand name • Generic	 $6 $3
Over-the-counter medications for smoking cessation and diabetes	$.50
Dental services	$5 per visit ($25 maximum annual cap)
Medical supplies (e.g. for treatment of diabetes and enteral formula)	$1.00 per supply
Laboratory services	$.50
Radiology services (ordered in an ambulatory setting)	$1
Inpatient Hospital services	$25 per stay
Non-emergent Emergency Room services	$3

***** except those provided by mental health and chemical dependence clinics

ATTACHMENT D

Home and Community-Based Services Expansion Program Benefits

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

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

ATTACHMENT E

Quarterly Operational Report Format

Under STC 62, the state is required to submit quarterly reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the Demonstration. The reports are due to CMS 60 days after the end of each quarter (except for the report due for the quarter ending on September 30 of each demonstration year, which can be incorporated into the annual report required under STC 63).

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the state. A complete quarterly progress report must include an updated budget neutrality monitoring workbook.

NARRATIVE REPORT FORMAT:

Title Line One – Partnership Plan

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:
Example:
Demonstration Year: 14 (10/1/11 - 9/30/12)
Federal Fiscal Quarter: 1/2012 (10/11 - 12/11)

Introduction:

Information describing the goal of the Demonstration, what it does, and key dates of approval /operation. (This should be the same for each report.)

Enrollment Information:

Please complete the following table that outlines all enrollment activity under the demonstration. The state should indicate "N/A" where appropriate. If there was no activity under a particular enrollment category, the state should indicate that by "0". Please note any changes in enrollment that fluctuate 10 percent or more over the previous quarter as well as the same quarter in the prior Demonstration year.

Enrollment Counts

Note: Enrollment counts should be person counts, not participant months

Demonstration Populations (as hard coded in the CMS-64)	Current Enrollees (to date)	No. Voluntary Disenrolled in current Quarter	No. Involuntary Disenrolled in current Quarter
Population 1 – TANF Child under age 1 through age 20 in mandatory MC counties as of 10/1/06			
Population 2 - TANF Adults aged 21-64 in mandatory MC counties as of 10/1/06			
Population 5 – Safety Net Adults			
Population 6 - Family Health Plus Adults with children			
Population 7 - Family Health Plus Adults w/o children			
Population 8 - Family Planning Expansion Adults			
Population 9 – HCBS Expansion participants			

ATTACHMENT E

Quarterly Operational Report Format

Voluntary Disenrollments:

- Cumulative Number of Voluntary Disenrollments within Current Demonstration Year
- Reasons for Voluntary Disenrollments

Involuntary Disenrollments:

- Cumulative Number of Involuntary Disenrollments within Current Demonstration Year
- Reasons for Involuntary Disenrollments

Enrollment Information for Specific Sub-populations:

- FHPlus enrollees served under PAP
- Enrollees in the HCBS Expansion program
- For the Family Planning Expansion Program please provide the following:
    - Quarterly enrollment reports for Demonstration eligibles (eligibles include all individuals enrolled in the Demonstration) that include the member months, as required to evaluate compliance with the budget neutral agreement; and
    - Total number of participants served during the quarter (participants include all individuals who obtain one or more covered family planning services through the Demonstration).

Program Operations

Outreach/Innovative Activities: Summarize outreach activities and/or promising practices for the current quarter.

Operational/Policy Developments/Issues: Identify all significant program developments/issues/problems that have occurred in the current quarter, including, but not limited to, approval and contracting with new plans, benefit changes, and legislative activity. Also include any anticipated activities or program changes related to health care delivery, benefits, enrollment, grievances, quality of care, access, and other operational issues.

Update on Progress and Activities related to Quality Demonstrations and Clinic Uncompensated Care Funding: Identify all activities relating to the implementation of these programs, including but not limited to:

- Release of solicitations and selection of awardees for the quality demonstrations;
- An explanation of grants, contracts or other financial arrangements entered into for purposes of implementing the quality demonstrations of this Demonstration; and
- Progress of grantees in meeting the milestones identified in these STCs and any award documents.

Consumer Issues: A summary of the types of complaints or problems consumers identified about the program in the current quarter. Include any trends discovered, the resolution of complaints, and any actions taken or to be taken to prevent other occurrences, this should be broken out to show the number of LTSS complaints vs. all other categories identified. Also discuss feedback, issues or concerns received from the MMCARP, advocates and county

officials.

Quality Assurance/Monitoring Activity: Identify any quality assurance/monitoring activity in current quarter.

Managed Long Term Care Program: Identify all significant program developments, issues, or problems that have occurred in the current quarter. Additionally, all requirements as outlined in STC 65 should be included.

Family Planning Expansion Program: Identify all significant program developments, issues, or problems that have occurred in the current quarter. Additionally, note any changes in enrollment that fluctuate 10 percent or more over the previous quarter of the same Demonstration year and the same quarter in the previous Demonstration year.

Home and Community-Based Services Expansion Program: For the quarter ending March 31 each year, attach a copy of the CMS-372 report completed in accordance with Appendix A of the approved Long-Term Home Health Care, the Nursing Home Transition and Diversion, and the Traumatic Brain Injury 1915(c) waivers.

Demonstration Evaluation: Discuss progress of evaluation implementation.

Financial/Budget Neutrality Developments/Issues: Provide information on:

- Quality demonstration and clinic uncompensated care expenditures – to whom and when
- Designated State Health Programs – amount of FFP claimed for the quarter

Enclosures/Attachments: Identify by title any attachments along with a brief description of what information the document contains.

State Contact(s): Identify individuals by name, title, mailing address, phone, fax, and email address that CMS may contact should any questions arise.

Date Submitted to CMS:

ATTACHMENT F

Expiration Dates for Demonstration Components

The following table shows the expiration dates for the various components of the Demonstration.

Demonstration Components	Expiration Date
• Family Health Plus (parents and caretaker relatives to 160 percent of FPL; non-pregnant, non-disabled adults age 19-64 up to 100 percent of FPL) • Family Planning Expansion Program (to 200 percent of FPL) • Safety Net Adults (state determined income standard – in 2011, approximately 78 percent of FPL for single adult households and 72 percent for couples) • Indigent Care Pool	December 31, 2013
• Medicaid Managed Care Program • Medicaid Eligibility Quality Control waivers • Facilitated Enrollment Services • Twelve-Month Continuous Eligibility Period • Home and Community-Based Services Expansion Program	March 31, 2014
• Hospital-Medicaid Home Demonstration • Potentially Preventable Re-Hospitalization Demonstration • Designated State Health Programs	December 31, 2014

ATTACHMENT G

Mandatory Managed Long Term Care Enrollment Plan

Mandatory Managed Long Term Care/Care Coordination Model

Mandatory Population: Dual eligible, age 21 and over, receiving community based long term care services for over 120 days, excluding the following:

- **Long Term Home Health Care Program;**
- **Nursing Home Transition and Diversion waiver participants;**
- **Traumatic Brain Injury waiver participants;**
- **Nursing home residents;**
- **Assisted Living Program participants; and**
- **Dual eligible that do not require community based long term care services.**

Voluntary Population: Dual eligible, age 18-21, in need of community based long term care services for over 120 days. Dual eligible age 18-21 and non-dual eligible age 18 and older assessed as nursing home eligible.

The following requires CMS approval to initiate and reflects the enrollment of the mandatory population only.

Phase I: New York City

July 1, 2012 - Any new dual eligible case new to service, fitting the mandatory definition in any New York City county will be identified for enrollment and referred to the Enrollment Broker for action.

- Enrollment Broker will provide with educational material, a list of plans/CCMs, and answer questions and provide assistance contacting a plan if requested.
- Plan/CCM will conduct assessment to determine if eligible for community based long term care.
- Plan/CCM transmits enrollment to Enrollment Broker.

In addition, the following identifies the enrollment plan for cases already receiving care. Enrollment will be phased in by service type by borough by zip code in batches. People will be given 60 days to choose a plan according to the following schedule.

July 1, 2012: Begin personal care* cases in New York County

August 1, 2012: Continue personal care cases in New York County

September, 2012: Continue personal care cases in New York County and begin personal care in Bronx County; and begin consumer directed personal assistance program cases in

ATTACHMENT G

Mandatory Managed Long Term Care Enrollment Plan

New York and Bronx counties

October, 2012: Continue personal care and consumer directed personal assistance program cases in New York and Bronx counties and begin Kings County

November, 2012: Continue personal care and consumer directed personal assistance program cases in New York, Bronx and Kings counties

December, 2012: Continue personal care and consumer directed personal assistance program cases in New York, Bronx and Kings Counties and begin Queens and Richmond counties

January, 2013: Initiate enrollments citywide of Long Term Home Health Care Program, home health over 120 days, adult day health care program and private duty nursing cases not enrolled under personal care case activity upon CMS approval of 1915(c) waiver amendment.

February, 2013 (and until all people in service are enrolled): Personal care, consumer directed personal assistance program, long term home health care program, home health over 120 days, adult day health care program and private duty nursing cases in New York, Bronx, Kings, Queens and Richmond Counties

*Individuals receiving personal care while enrolled in Medicaid Advantage will begin MLTC/CCM enrollment in January, 2013.

Phase II: Nassau, Suffolk and Westchester Counties

Dually eligible community based long term care service recipients in these additional counties as capacity is established. Anticipated January 2013

Phase III: Rockland and Orange Counties

Dually eligible community based long term care service recipients in these additional counties as capacity is established. Anticipated June 2013

Phase IV: Albany, Erie, Onondaga and Monroe Counties

Dually eligible community based long term care service recipients in these additional counties as capacity is established. Anticipated December 2013

Phase V: Other Counties with capacity

Dually eligible community based long term care service recipients in these additional counties as

capacity is established. Anticipated June 2014

Phase VI:

Previously excluded dual eligible groups contingent upon development of appropriate programs:

- **Nursing Home Transition and Diversion waiver participants;**
- **Traumatic Brain Injury waiver participants;**
- **Nursing home residents;**
- **Assisted Living Program participants;**
- **Dual eligible that do not require community based long term care services.**