

**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 All previously approved STCs, waivers, and expenditure authorities are superseded by the STCs set forth below.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 13, 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. **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.

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

IV. POPULATIONS AFFECTED BY AND ELIGIBILITY UNDER THE DEMONSTRATION

15. **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 23) 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 24) 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 31.

- 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.

16. **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.
17. **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.
18. **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)

- 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 eligibility shall be terminated:
- (A) The individuals cannot be located.
 - (B) The individual is no longer a New York State resident'
 - (C) The individuals request 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 other supplies under a section 1915 waiver;
- (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.

19. **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

20. **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 18 th 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 22	Demonstration population 10 and 11/ MLTC Adults 18 through 64 and MLTC Adults 65 and above

21. **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.

22. **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.

- 23. **Exclusions and Exemptions from MMMC.** Notwithstanding the eligibility criteria in STC 15, 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.

24. **Exclusions and Exemptions from MLTC.** Notwithstanding the eligibility criteria in STC 15, 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

25. 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

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

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 15. In addition, the populations that are exempted from mandatory enrollment, based on the exemption lists in STCs 23 and 24 may also elect to enroll in managed care plans. Once these individuals begin to enroll in managed care, the state will be required to provide the following protections for the population²:
- i. **Person Centered Service planning** – The state, through its contracts with its MCOs and/or Prepaid Inpatient Health Plans (PIHPs), will require that all individuals utilizing long-term services and supports will have a person-centered individual service plan maintained at the MCO or PIHP. Person-Centered Planning includes consideration of the current and unique psycho-social and medical needs and history of the enrollee, as well as the person's functional level, and support systems.
 - (A) The state must establish minimum guidelines regarding the Person-Centered Plan (PCP) that will be reflected in MCO/PIHP contracts. These must include at a minimum, a description of:
 - 1) The qualification for individuals who will develop the PCP;
 - 2) Types of assessments;
 - 3) How enrollees are informed of the services available to them; and
 - 4) The MCOs' responsibilities for implementing and monitoring the PCP.
 - (B) The MCO/PIHP contract shall require the use of a person centered and directed planning process intended to identify the strengths, capacities, and preferences

² All beneficiary protections apply to both MMMC and MLTC, unless otherwise noted in STC 25 and Section V.

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, 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 25 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 25, 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 25).

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 69. 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 69.
- 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 69.
- 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

26. **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.
27. **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.
28. **Home and Community Settings Characteristics.** MLTC enrollees, including individuals who receive services under the demonstration's HCBS Expansion program described in STC 15, 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.
29. **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.

30. **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 68:
- 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 35.

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.

31. **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 42 and 43 for each MCO/PIHP.

The state must also apply the requirements of STC 30 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.

32. **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.

33. 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.

34. 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

35. **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).

36. **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.

37. **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.

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 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 70, 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. 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.

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 70. 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.
- c) Enrollees and their representatives must be provided with reference documents to maintain information about available providers and services in their plans.

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, including individuals with developmental disabilities, 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 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 50, and
 - iii. indicate which H-MH Quality and Safety Improvement Projects that the awardee will undertake, along with associated milestones (see STC 51).
- 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 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.

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:

- 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.

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*

- (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 ordered
 - SCIP-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 \geq 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).

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 STC 48 (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.

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 69 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 70.
- 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 48(c), the hospital improvement projects in STC 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 69, 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 70.

55. 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:
 - (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 69.
- 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 70, 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.

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

- a) Homeless Health Services
- b) HIV-Related Risk Reduction
- c) Childhood Lead Poisoning Primary Prevention
- d) Healthy Neighborhoods Program
- e) Local Health Department Lead Poisoning Prevention Programs
- f) Cancer Services Programs
- g) Obesity and Diabetes Programs
- h) TB Treatment, Detection and Prevention
- i) TB Directly Observed Therapy
- j) Tobacco Control
- k) General Public Health Work

- l) Newborn Screening Programs
- m) The state may claim as allowable expenditures under the demonstration the payments made through its state-funded program to provide subsidies for parents and caretaker relatives with incomes above 133 percent of the FPL through 150 percent of the FPL who purchase health insurance through the Marketplace. Subsidies will be provided on behalf of individuals who: (1) are not Medicaid eligible but who are parents or caretaker relatives of individuals under the age of 21; (2) are eligible for the advance premium tax credit (APTC); and (3) whose income is above 133 percent of the FPL through 150 percent of the FPL. Federal financial participation for the premium assistance portion of QHP subsidies for citizens and eligible qualified aliens will be provided through the Designated State Health Programs pursuant to this STC. Authority to claim federal matching for this program will end on December 31, 2014.
- n) The state may claim as allowable expenditures under the demonstration, the payments made through its state-funded program to provide FHPlus benefits to parents and caretaker relatives with incomes up to and including 150 percent of the FPL who are no longer eligible under the demonstration. Authority to claim federal matching for this program will end on April 30, 2014.

57. 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 56. 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 56, they shall not be used as a source of non-federal share.
- d) The administrative costs associated with DSHPs in STC 56 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 56 shall be considered an amendment to the demonstration and processed in accordance with STC 7.

VIII. HEALTH SYSTEM TRANSFORMATION FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES

58. 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 62. 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

<u>Deliverable</u>	<u>Reference</u>	<u>Deliverable Date</u>
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 increase reserved HCBS capacity	Attachment G #3(b)	May 1, 2013
Draft cost-containment strategy	STC #59	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 #61	July 1, 2013
Quality strategy	STC #39	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 #60 & #61	No later than 60 days after receiving CMS comments
Approved transformation DSHP claiming protocols	STC #62(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	Attachment G #6(b)	October 1, 2013

<u>Deliverable</u>	<u>Reference</u>	<u>Deliverable Date</u>
self-direction		
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
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 Support Program	STC 25(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		

<u>Deliverable</u>	<u>Reference</u>	<u>Deliverable Date</u>
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
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

59. **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.

60. **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.

61. **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.

62. **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 62 (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 62.
- 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 58 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 62, they shall not be used as a source of non-federal share.
- viii. The administrative costs associated with programs in STC 62 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 62 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.

63. **Reporting Designated State Health Programs Payments Related to Transformation.** The state will report all expenditures for DSHP payments to the programs listed in STC 62 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

64. 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 69 to CMS detailing the actions it will undertake to increase enrollment.

65. **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

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

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

68. **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 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.

69. **Quarterly Operational Reports.** The state must submit progress reports in accordance with the guidelines in Attachment D taking into consideration the requirements in STC 72, 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 70. The intent of these reports is to present the state's analysis and the status

of the various operational areas.

70. **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 39, 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 42;
 - 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.
71. **Transition Plan.** On or before July 1, 2012, and consistent with guidance provided by CMS, the state is required to prepare, and incrementally revise, a Transition Plan consistent with the provisions of the Affordable Care Act (ACA) for individuals enrolled in the demonstration, including how the state plans to coordinate the transition of these individuals to a coverage option available under the ACA without interruption in coverage to the maximum extent possible. The plan must include the required elements and milestones described in paragraphs (a)-(e) outlined below. In addition, the Plan will include a schedule of implementation activities that the state will use to operationalize the Transition Plan. For any elements and milestones that remain under development as of July 1, 2012, the state will include in the Transition Plan a description of the

status and anticipated completion date.

- a) **Seamless Transitions.** Consistent with the provisions of the ACA, the Transition Plan will include details on how the state plans to obtain and review any additional information needed from each individual to determine eligibility under all eligibility groups, and coordinate the transition of individuals enrolled in the demonstration (by FPL) (or newly applying for Medicaid) to a coverage option available under the ACA without interruption in coverage to the maximum extent possible. Specifically, the state must:
 - i. Determine eligibility under all January 1, 2014, eligibility groups for which the state is required or has opted to provide medical assistance, including the group described in §1902(a)(10)(A)(i)(VIII) for individuals under age 65 and regardless of disability status with income at or below 133 percent of the FPL;
 - ii. Identify demonstration populations not eligible for coverage under the ACA and explain what coverage options and benefits these individuals will have effective January 1, 2014;
 - iii. Implement a process for considering, reviewing, and making preliminary determinations under all January 1, 2014 eligibility groups for new applicants for Medicaid eligibility;
 - iv. Conduct an analysis that identifies populations in the demonstration that may not be eligible for or affected by the ACA and the authorities the state identifies that may be necessary to continue coverage for these individuals; and
 - v. Develop a modified adjusted gross income (MAGI) calculation for program 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.

72. Reporting Requirements Related to Individuals using long term services and supports.

In each quarterly report required by STC 69, 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.

73. 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

74. 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.

75. 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 - HMM 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.

76. **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 75(e) 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 75(e) 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 75(e), 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.
77. **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.

78. **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.

79. 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 69, the actual number of eligible member months for the Demonstration Populations defined in STC 75(e), for months prior to or including the ending date indicated in STC 75(e) for each demonstration population. The state must submit a statement accompanying the quarterly report, which certifies the accuracy of this information.

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 76.

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 75 (e). Beginning in DY 9, “demonstration eligibles” excludes Demonstration Populations 3 and 4, subject to STC 76(b), as well as portions of Demonstration Populations 1 and 2, as specified in STC 76(a - b).

80. 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.

81. **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.
82. **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.
83. **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.

84. **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

85. **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.

86. **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.

87. **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 76 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.

88. **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 87 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 79, 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 76, 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 18 through 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 75 (e) during the demonstration period.

89. **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 79. 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.

90. **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.

91. **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.

92. **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

93. 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

94. **Evaluation Implementation.** The state shall implement the final evaluation design and submit its progress in each of the quarterly and annual progress reports.
95. **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.
96. **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.

97. **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 93

	Deliverable	Reference
Annual	By January 1 st - Annual Report	Section IX, STC 70
Quarterly		
	Quarterly Operational Reports	Section IX, STC 69
	Quarterly Expenditure Reports	Section X, STC 74
	Eligible Member Months	Section X, STC 79

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

ATTACHMENT C

Home and Community-Based Services Expansion Program Benefits

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

- Private or semi-private bedrooms including decisions associated with sharing a bedroom.
- Full access to facilities in a home such as kitchen and cooking facilities, and small dining areas.
- All participants must be given an option to receive 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
<ul style="list-style-type: none"> • Facilitated Enrollment Services • Twelve Month Continuous Eligibility Period • Home and Community-Based Services Expansion Program • Individuals Moved from Institutional Settings to Community Settings for Long Term Care Services • Designated State Health Programs associated with health System Transformation for Individuals with Developmental Disabilities 	<p>March 31, 2014</p>
<ul style="list-style-type: none"> • Designated State Health Program that provides transitional Family Health Plus benefits to parents and caretaker relatives with incomes up to 150 percent of the FPL. 	<p>April 30, 2014</p>
<ul style="list-style-type: none"> • Hospital-Medicaid Home Demonstration • Potentially Preventable Re-Hospitalization Demonstration • Designated State Health Programs associated with H-MH and PPR Demonstrations 	<p>December 31, 2014</p>

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

Demonstration Approval Period: January 1, 2014 through December 31, 2014

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. 1915(b)/(c) Application

- 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) waiver 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. Consumer Self-Direction

- 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.