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 August 1, 2011, unless otherwise specified. All previously approved STCs, waivers, and expenditure authorities are superseded by the STCs set forth below. This Demonstration extension is approved through December 31, 2014; however, some components of the Demonstration will expire earlier, as described below in these STCs and associated waiver and expenditure authority documents, and in the table in Attachment F.

The STCs have been arranged into the following subject areas: Program Description and Objectives; General Program Requirements; Demonstration Eligibility; Demonstration Benefits and Enrollment; Delivery Systems; Quality Demonstration Programs and Clinic Uncompensated Care Funding; General Reporting Requirements; General Financial Requirements; Monitoring Budget Neutrality; Evaluation of the Demonstration; and Schedule of State Deliverables for the Demonstration Extension.

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

II. PROGRAM DESCRIPTION AND OBJECTIVES

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

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

The Demonstration is designed to use a managed care delivery system to deliver benefits to Medicaid recipients, create efficiencies in the Medicaid program, and enable the extension of coverage to certain individuals who would otherwise be without health insurance. It was approved in 1997 to enroll most Medicaid recipients into managed care organizations (MCOs) (Medicaid managed care program). As

part of the Demonstration's renewal in 2006, authority to require the disabled and aged populations to enroll in mandatory managed care was transferred to a new demonstration, the Federal-State Health Reform Partnership (F-SHRP).

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

In 2002, the Demonstration was expanded to incorporate a family planning benefit under which family planning and family planning-related services are provided to women losing Medicaid eligibility and to certain other adults of childbearing age (family planning expansion program).

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

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

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

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

In 2012, New York added to the Demonstration an initiative to improve service delivery and

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

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

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

III. GENERAL PROGRAM REQUIREMENTS

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

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

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

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

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

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

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

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

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

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

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

ATTACHMENT G

Mandatory Managed Long Term Care Enrollment Plan

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

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

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

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

January, 2013: Initiate enrollments citywide of Long Term Home Health Care Program, home health over 120 days, adult day health care program and private duty nursing cases not enrolled under personal care case activity upon CMS approval of 1915(c) waiver amendment.

February, 2013 (and until all people in service are enrolled): Personal care, consumer directed personal assistance program, long term home health care program, home health over 120 days, adult day health care program and private duty nursing cases in New York, Bronx, Kings, Queens and Richmond Counties

*Individuals receiving personal care while enrolled in Medicaid Advantage will begin MLTC/CCM enrollment in January, 2014 **Phase II: Nassau, Suffolk and Westchester Counties**

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

Phase III: Rockland and Orange Counties

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

Phase IV: Albany, Erie, Onondaga and Monroe Counties

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

Phase V: Other Counties with capacity

ATTACHMENT G

Mandatory Managed Long Term Care Enrollment Plan

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

Phase VI:

Previously excluded dual eligible groups contingent upon development of appropriate programs:

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