



# **New York State Department of Health's Demonstration to Integrate Care for Dual Eligible Individuals**

**Second Draft Proposal  
Published for Public Comment on May 3, 2012**

This publication was developed under Contract Number HHSM-500-2011-00036C,  
"State Demonstration to Integrate Care for Dual Eligible Individuals."



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## **Executive Summary**

### **NYSDOH Demonstration Proposal to Integrate Care for Dual Eligible Individuals**

The New York State Department of Health (NYSDOH) proposes to integrate or provide care coordination for Medicare and Medicaid physical healthcare, behavioral healthcare, and long-term supports and services for a major segment of New York's dual eligibles. This will be done through several coordinated approaches that involve both the Managed Fee-For-Service (MFFS) and capitated models.

The MFFS approach would begin in July 2012 and would provide integrated care coordination through Health Homes to dual eligibles that have two or more chronic conditions, HIV/AIDS and/or one mental health illness and do not require 120 or more days of long-term supports and services (LTSS). The MFFS dual program will facilitate access to and transition their members in need of long term care services greater than 120 days to MLTC (where available) or fee-for-service long term care providers. The Capitated approach would begin in January 2014, would be called FIDA, the Fully-Integrated Duals Advantage program, and would provide a comprehensive package of services to dual eligibles in the eight NY counties of Bronx, Kings, Nassau, New York, Queens, Richmond, Suffolk, and Westchester that require more than 120 days of long-term supports and services (LTSS). The primary FIDA approach would exclude individuals who receive services from OPWDD. An additional, small-scale "FIDA OPWDD" capitated approach will provide managed care to a portion of the dual population that has intellectual and developmental disabilities.

The 2011 NYS Executive budget provides for the establishment of a model for integrated care coordination and care management services called Health Homes. Authorization for the establishment of Health Homes is found in the Affordable Care Act, section 2703 (SSA 1945b) and NYS SSL 365-I. This provision is an opportunity to enhance integration and coordination of services targeted toward dual eligible individuals with complex chronic medical, behavioral and some long term care needs (less than 120 days of long term care services) through the coordination of a care manager. Health Homes for dual eligibles will be implemented statewide effective July, 2012. It's primary goals are to: 1) reduce avoidable hospital, emergency room visits and unnecessary care; 2) provide timely follow up care; 3) reduce health care costs; 4) lessen reliance on long term care facilities; and 5) improve the experience and quality of care outcomes for the individual. The Health Home effort provides the basis for NYSDOH's MFFS approach.

The 2011 NYS Executive budget also requires certain dual eligibles who are age 21 or older and who require more than 120 days of community-based long-term supports and services to be enrolled into NYSDOH's Managed Long Term Care Program (MLTCP) for receipt of their LTSS. This requirement lays the foundation for managed care coverage that fully integrates all healthcare and LTSS for dual eligibles

who require LTSS and are not receiving services through the OPWDD system.<sup>1</sup> In addition, a small number of plans are being developed to exclusively focus on the needs of individuals with intellectual and developmental disabilities. These plans will have the capacity to provide more than just the OPWDD/LTSS services and will include Medicare and Medicaid healthcare services as well. No more than three of these plans will provide FIDA services within the demonstration.

	<b>FIDA Managed Care</b>	<b>Health Home Program with Managed FFS</b>
<b>Target Population</b>	<b>FIDA</b> - Full Dual Eligibles, Age 21 and older, require community-based long term care services for more than 120 days who are not residents of an OMH facility, and who are not receiving services from the OPWDD system <b>FIDA OPWDD</b> – Full Dual Eligibles Age 21 and older, who are not residents of an OMH facility, and who <u>are</u> receiving services from the OPWDD system	Full Dual Eligibles who are not residents of an OMH facility, who are not receiving services from the OPWDD system or requiring more than 120 days of LTC services who meet one of the following criteria: <ul style="list-style-type: none"> <li>• Two chronic conditions</li> <li>• One chronic condition (HIV/AIDS) - and the risk of developing another</li> <li>• One serious mental illness</li> </ul>
<b>Total Number of Full Benefit Medicare-Medicaid Enrollees Statewide</b>	755,067	755,067
<b>Total Number of Beneficiaries Eligible for Demonstration</b>	FIDA: 123,880 FIDA OPWDD: up to 10,000	126,582
<b>Geographic Service Area</b>	FIDA: Bronx, Kings, New York, Queens, Richmond, Nassau, Suffolk, and Westchester Counties FIDA OPWDD - Statewide	Statewide
<b>Summary of Covered Benefits</b>	All Medicare Part A, B, and D benefits, all Medicaid State Plan benefits, HCBS benefits and supplemental benefits as described in Appendix B	Care coordination for Medicare Part A, B, and D benefits, all Medicaid State Plan benefits (Mandatory and Optional)
<b>Financing Model</b>	The capitated model outlined in the July 8, 2011 SMD letter.	The managed fee-for-service capitated model outlined in the July 8, 2011 SMD letter.
<b>Summary of Stakeholder Engagement/Input</b>	Focus Groups and Individual Interviews – 12/14/11 -12/16/11 MLTC Stakeholder Conference Calls	Health Home Implementation Webinars – 7/21/11, 8/17/11, 9/22/11, 11/7/11, 12/9/11,

<sup>1</sup> Those eligible are being enrolled in phases, with Phase 1 beginning this summer in New York City. By January 2013, the mandatory MLTCP will be expanded geographically to cover the 8 counties proposed as the FIDA service area.

	<p>– 1/26/12, 2/2/12, 2/9/12, 2/16/12, 2/23/12, 3/1/12, 3/8/12, and 3/15/12  Solicitation of Public Input – 3/6/12  Stakeholder Webinar Discussions – 3/13/12 and 3/15/12  Twitter Chat – 4/3/12  Stakeholder Public Meetings – 4/10/12 and 4/16/12</p>	<p>1/12/12, 2/10/12, and 2/28/12  Plans on Contract Language  Conference Call – 2/1/12  Phase I Led Health Home Discussion Meeting – 2/9/12  Upstate Regional Meetings – 2/13/12, and 5/14/12  Downstate Regional Meeting – 2/23/12, and 4/4/12  Managed Care Workgroup Meeting – 1/10/12 and 4/30/12  Health Home Twitter Chat 5/2/12  Health Home Integration of Duals Webinar – 5/10/12  Regional face-to-face meeting on integration of duals into Health Home – 5/14/12</p>
<b>Proposed Implementation Date(s)</b>	<b>January 1, 2014</b>	<b>July 1, 2012</b>

**A. Introduction**

With years of experience designing care models for New Yorkers, NYSDOH hereby presents its proposal to implement a demonstration through which it would offer two models for integrating care for the dual eligible population.

**i. Managed Care Model – Fully-Integrated Dual Advantage (FIDA)**

The first model would be a new comprehensive managed care option that is specifically tailored to meet the complex needs of New York’s full dual eligibles. Through this new Fully-Integrated Duals Advantage (FIDA) program, full dual eligibles who require 120 or more days of Long-Term Supports and Services (LTSS) would be provided the entire range of Medicare and Medicaid services as well as an extensive list of LTSS many of which were previously only available in New York State’s Home and Community-Based Services Waiver programs.

Through the FIDA program, full dual eligibles would be provided with features such as, but not limited to:

- Seamless access to all physical health, behavioral health, and LTSS;
- A choice of plan and a choice of providers, with choices being facilitated by an independent, conflict-free Enrollment Broker;
- Care planning and care coordination by individualized interdisciplinary teams that are centered around each dual eligible;

- Consumer direction for personal care services;
- An independent, conflict-free, Participant Ombudsman to aid in any questions or problems the Participant has;
- Continuity of care provisions to ensure seamless transition into one's FIDA plan;
- Articulated network adequacy and access standards; and
- New Health Education and Wellness benefit including many supports for achieving personal best health.

## ii. **Managed Fee-for-Service Model - Health Home**

The second model is a managed fee for service Health Home program that will provide care coordination for the high-needs, high cost, dual eligible Medicaid population that have complex medical, behavioral, social service and long term care needs requiring less than 120 days of long term care services. Health Homes services are provided through a network of partnerships between physical and behavioral health care providers, social service providers and managed care plans to collectively ensure coordinated care in order to reduce avoidable hospital admissions/readmissions and emergency room visits. As required under New York's Medicaid State Plan Amendment, Health Home services will be comprehensive and timely high-quality services including the following six (6) core services: 1) Comprehensive Care management; 2) Care Coordination and Health Promotion; 3) Comprehensive Transitional Care from inpatient to other settings, including appropriate follow up; 4) Individual and Family support; 5) Referral to Community and Social Support Services; and 6) The use of HIT to link services, as feasible and appropriate.

## **B. Background**

### **i. Proposed Model of Care**

According to the Medicare Payment Advisory Committee's June 2010 Data Book<sup>2</sup>, individuals who are dually eligible for Medicare and Medicaid are poorer and sicker than the rest of the Medicare population. Fifty-one percent have incomes under the poverty level, as compared with 8% of non-dual Medicare Participants. Twenty percent of dual eligibles report being in poor health whereas only 7% of non-dual Medicare Participants report being in poor health. Dual eligibles are more likely to be institutionalized – 19% of duals are institutionalized compared with 3% of non-dual Medicare Participants. And, dual eligibles have a greater incidence of cognitive impairments, mental disorders, diabetes, pulmonary disease, stroke and Alzheimer's disease. They account for 16% of the Medicare population but 27% of Medicare spending; they account for 15% of the state's Medicaid population but 45% of its Medicaid spending.<sup>3</sup>

<sup>2</sup> Medicare Payment Advisory Commission, "A Data Book: Healthcare Spending and the Medicare Program (June 2010)", Chapter 3, available at <http://www.medpac.gov/chapters/Jun10DataBookSec3.pdf>.

<sup>3</sup> These figures are based on 2007 data provided in this December 2010 Kaiser Commission on Medicaid and the Uninsured report "Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2007", available at: <http://www.kff.org/medicaid/upload/7846-02.pdf>

New York State has 755,067 full dual eligibles enrolled in its Medicaid program. These full dual eligibles vary considerably not only in their care needs but also in how they access services and navigate the system.

Despite their high cost and their greater care needs, the care of dual eligibles is largely uncoordinated and significantly fragmented.<sup>4</sup> With the exception of those dual eligibles over 55 who participate in the state's Program of All-Inclusive Care for the Elderly (PACE) program or those that participate in a Medicaid Advantage or Medicaid Advantage Plus (MAP) program, the majority of New York's dual eligible adults receive their Medicaid physical health (PH) and behavioral health (BH) benefits from the Medicaid Fee-For-Service program. Some dual eligibles participate in the partially-capitated Managed Long Term Care Plans while others participate in and receive community-based LTSS through the Personal Care Services Program or one of the state's 1915(c) HCBS Waiver Programs.

Dual eligibles receive their Medicare healthcare services through Traditional Medicare or through Medicare Advantage (MA). They may receive Medicare Part D through a Medicare Prescription Drug Plan or through a MA plan. Some with Traditional Medicare may even retain a Medigap policy (despite the lack of need given their Medicaid coverage and despite the amount of monthly expenditure the dual eligible unnecessarily makes to pay for this duplicative coverage). It is also the case that some dual eligibles are eligible for healthcare or LTSS through the Veterans Health Administration.

The number and nature of programs or plans each individual dual eligible may have is staggering and provides strong support for the need for integration. Under the status quo, any given full dual eligible may have half a dozen separate sources of coverage. This highly fragmented array of different coverages leads to access challenges for dual eligibles, some of which include that:

- Care is not coordinated;
- Coverage rules and procedures differ under each program;
- Written information comes from multiple sources with no single comprehensive description of the sum total of benefits, procedures, or rights and responsibilities applicable to dual eligibles;
- Processes for grievances and appeals differ, as do notices relating to both coverage determinations and grievances and appeals;
- Responsibility for delivering necessary services is divided between different programs, making it hard to know where to go when problems present;
- Providers are challenged to understand how the different coverages interact and how to proceed when they conflict; and
- Providers across programs have little or no established mechanisms through which to communicate.

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<sup>4</sup> Medicare Payment Advisory Commission, Report to the Congress "Medicare and the Healthcare Delivery System (June 2011)", Chapter 5, available at [http://www.medpac.gov/documents/Jun11\\_EntireReport.pdf](http://www.medpac.gov/documents/Jun11_EntireReport.pdf).

When dual eligible individuals struggle to access their necessary care through the fragmented elements of the existing system, they are likely to go without some portion of their necessary care. This often leads to decline in health status that can eventually result in more costly interventions. Because improved access to care can mean better quality of care and quality of life to Participants and can improve efficiencies to the state, it is imperative that streamlined, seamless access to the broad array of services envisioned in the FIDA and Health Home programs be developed.

It would be less challenging to navigate the patchwork of a system if dual eligibles were provided person-centered care planning and coordination that addressed the entire array of physical health, behavioral health, LTSS, and supplemental services they might need or wish to access. Unfortunately, at present, there is no comprehensive care coordination spanning all services available to all dual eligibles.

NYSDOH is determined to develop comprehensive integrated programs through which care is seamlessly delivered and well-coordinated. Integrating all Medicare and Medicaid physical health, behavioral health, LTSS, and transportation services significantly reduces the number of separate sources of coverage a dual eligible may have to deal with to one primary source, either his/her FIDA plan or his/her Health Home both of which will coordinate all care and services the dual eligible will need.

#### **1. Managed Care Model – Fully-Integrated Dual Advantage (FIDA)**

NYSDOH is building its FIDA program off its voluntary Medicaid Advantage Plus (MAP) program, through which it provides access to Medicare and Medicaid physical healthcare and LTSS. NYSDOH is significantly enhancing the benefit package provided through the MAP program for its new fully-integrated program (as further described in Section C. and Appendix B). NYSDOH is also significantly enhancing the MAP service delivery system with extensive improvements in person-centeredness, consumer direction, needs assessment, multidisciplinary care planning and coordination, participant protections, continuity of care, Health Information Technology, evidence-based practice, and quality improvements.

Under the FIDA OPWDD program, care coordination and case management services will ensure that all services covered by Medicaid, OPWDD and Medicare are delivered in an integrated, person-centered manner and that the member's needs and preferences are at the center of the care and service planning process. A uniform assessment tool will be used to identify the needs and preferences of members and support an individualized care and service planning process. Each member will have a comprehensive, customized care and service plan that addresses their needs for residential and other habilitation services, primary and preventive health care, behavioral health services, dental and vision care, and specialty medical services as needed. A person-centered focus, coupled with the engagement of each member's circle of support, will be a primary objective of the FIDA OPWDD program. Care management staff will be trained in conducting a Personal Outcomes Measures Interview, a process that was developed by the Council on Quality and Leadership. This

process is considered the national standard for determining quality of life outcomes for individuals with IDD through an in-depth and responsive personal interview.

Through this initiative, NYSDOH and OPWDD will maximize the individual's opportunities for community integration, ensure that the member's desires for placement are respected while enabling the member to live in the most integrated and least restrictive environment possible, promote healthy lifestyles to reduce the burden of chronic illness over time, with an emphasis on diet and nutrition, exercise and self management skills, and utilize a model to minimize the need for emergency room care for the treatment of chronic and complex medical conditions.

NYSDOH and OPWDD believe that their proposed person-centered care planning, coupled with a multi-disciplinary care coordination approach and the availability of enhanced community-based services, will provide the demonstration's dual eligibles with an improved quality of life and reduced acute care encounters. This will not only prevent or delay health declines but will result in savings that should account for the expenditures made on providing the care coordination and enhanced community-based services.

#### **Qualifying Plans and Governing Rules:**

While NYSDOH is building the FIDA program requirements from the program requirements for the MAP program, it will, however, contract with any MLTCP plan in the demonstration service area that is in operation in 2013, that obtains CMS approval to be a Medicare Advantage Plan for 2014 and that is able to meet the requirements of the FIDA program. For the FIDA OPWDD program, one to three qualifying plans will be selected to participate.

Participating plans will be required to comply with all Medicare Advantage and Medicaid MLTCP requirements except to the extent that NYSDOH has obtained waiver of applicable provisions. FIDA plans will also be required to comply with all applicable New York State laws and regulations, and all additional requirements contained in the three-way contract being developed by CMS and NYSDOH/OPWDD.

#### **2. Managed Fee-for-Service Model - Health Home**

Navigating the Medicare and Medicaid fee-for-service system, for high needs, high-cost dual eligibles with a complex array of complex chronic medical and behavioral health conditions, requires a level of care management, care coordination and service integration that is not currently available. This cohort of dual eligibles tends to be transient, lacks permanent stable housing, lacks a family/personal support system, is unable to advocate for themselves, may not be health literate, may not understand the complexities of their chronic conditions, or lack the knowledge and resources required to negotiate the fragmented physical and behavioral health care delivery systems to obtain needed care. Often social needs such as obtaining permanent housing and accessing entitlement programs take priority over addressing health issues. This cohort of dual eligibles, challenged with chronic medical conditions, behavioral health and long term care needs requiring no more than 120 days of service would be best served in the

NYS Health Home Program. A Health Home, in addition to addressing the health needs of these complex dual eligible members, would be structured and resourced to fully integrate all other aspects of their care. The NYSDOH Health Home program has been recognized as transformative and will be the ideal model to provide the higher intensity of care management needed by those individuals.

Managed FFS dual eligible Health Home members are eligible for Medicare (Part A, B and D) and Medicaid State Plan services provided via FFS. Health Homes will utilize care managers with expertise in the unique needs of the dually eligible population to effectively coordinate access to services for dual eligibles meeting Health Home selection criteria with access to an integrated continuum of physical, medical, behavioral health services, rehabilitative, long term care and social service needs. Reflecting their substantial health needs, dual eligibles often see multiple providers, use multiple prescription drugs, and do not have a single entity coordinating their care. A dedicated care manager will be accountable for the management of all services, both Medicare and Medicaid, and coordination with the member's primary care physician/nurse practitioner, specialist(s), behavioral health care provider(s), and other providers directly involved in the individual's care. Care managers utilized by Health Homes will have knowledge of behavioral health, aging and loss, appropriate support services in the community, frequently used medications and their potential negative side-effects, depression, challenging behaviors, Alzheimer's disease and other disease-related dementias, and issues related to accessing and using durable medical equipment as appropriate. Care Managers will work with dual eligible members' Health Home's interdisciplinary team and access necessary services for the dually eligible population. The Health Home program will serve dual eligibles statewide beginning in July 2012 (see Section B, 2(ii) for detailed population statistics and Appendix L for implementation plan.

### **Qualifying Providers**

NYSDOH is designating Health Homes that include robust provider partnerships. Applicant Health Home providers are required to meet State defined Health Home requirements (included in Appendix J) which are based on the CMS State Medicaid Director's letter for Health Homes. Approved Health Homes directly provide or contract for Health Home services to the identified eligible members through broad partnership with primary, medical, specialty and mental health providers, substance abuse providers, and community based organizations. Health Homes were required as part of their application, to demonstrate an ability to coordinate a cross section of health needs and to include existing care management agencies within their partnerships. The State worked with providers to build partnerships that were broad based, maximizing the participation of providers within as few Health Homes as possible, while offering choice, to minimize the silos that exists in the care delivery system and start to integrate disciplines of direct care and social supports. The Health Home is reimbursed with a monthly per-member per-month rate and is responsible for reimbursing the care management providers in their Health Home partnership. The managed fee-for service model will allow Health Homes to provide a more diverse and flexible array of services to the higher needs dual eligible population. Health Homes will use multidisciplinary

teams of medical, mental health, chemical dependency treatment providers, nurses, social workers and other providers led by a dedicated care manager. Other team members may include nutritionists/dieticians, pharmacists, outreach workers including peer specialists and other representatives as appropriate to meet the member's needs (housing representatives, enrollment and entitlement specialists, vocational and employment resources).

**ii. Description of the Target Population**

As of December 2010, there were 755,067 dually eligible Medicare/Medicaid recipients in New York State. Many of New York's dual eligibles are vulnerable, disabled, frail adults with chronic medical conditions who are significantly functionally impaired and/or have complex mental health and LTSS needs.

The target population for this demonstration is:

- FIDA - 123,800 full dual eligibles in the eight counties of Bronx, Kings, Nassau, New York, Queens, Richmond, Suffolk, and Westchester who: 1) Are age 21 or older; 2) Require community-based long term care services for more than 120 days; 3) Are not receiving services through the OPWDD system; and 4) Are not receiving services in an OMH facility.
- FIDA OPWDD – up to 10,000 full dual eligibles statewide who: 1) Are age 21 and older and 2) Are receiving services through the OPWDD system; and 3) Are not receiving services in an OMH facility.
- Health Home - 126,582 full dual eligibles statewide who have chronic medical and behavioral health needs that meet the criteria for Health Home and who: 1) Are not receiving more than 120 days of LTSS; 2) Are not receiving services through the OPWDD system; and 3) Are not receiving services in an OMH facility.

Dual eligibles in the 8 county service area	Overall	Individuals receiving LTSS in institutional settings	Individuals receiving LTSS in HCBS settings
Overall total	460,109	54,164	123,880
Individuals age 65+	356,256	49,420	110,102
Individuals under age 65	103,853	4,744	13,778
Individuals with serious mental illness	75,956	20,796	21,112
Health Home Population		All Medicaid	Duals
Mental Health/Substance Abuse		408,529	65,365
Other Chronic Medical		306,087	61,217
		Total	976,356
			126,582

## **C. Care Model Overview**

### **i. Proposed Delivery System**

#### **1. Geographic Service Area**

The FIDA Program will operate in the eight contiguous New York counties of Bronx, Kings, Nassau, New York, Queens, Richmond, Suffolk, and Westchester. 123,880 full dual eligibles who met the enrollment criteria reside in this service area. This service area was selected because it contains extensive provider and plan capacity, which should be more than sufficient to successfully implement the demonstration in a way that guarantees seamless Participant access as well as Participant choice.

The FIDA OPWDD Program will be statewide. Up to 10,000 full dual eligibles who receive services through the OPWDD system will participate in this program.

The Health Home Program will operate Statewide and serve 126,582 dual eligibles that meet Health Home criteria.

#### **2. Enrollment Method**

##### **a. Managed Care Model – Fully-Integrated Dual Advantage (FIDA)**

Dual eligible individuals who require more than 120 days of community-based LTSS, who reside in the service area, who are age 21 and over, are not receiving services through the OPWDD system, or who are not receiving inpatient services in an OMH facility are eligible for FIDA. This LTSS population was selected in part because of the mandatory MLTC program that is currently being implemented.

Dual eligible individuals age 21 and over who require more than 120 days of community-based LTSS through the OPWDD system, are eligible for FIDA OPWDD.

A 2011 state law requires NYSDOH to enroll all dual eligibles who are age 21 or older and who require more than 120 days of community-based LTSS into NYSDOH's MLTCP. Those eligible are being enrolled in phases, with Phase 1 beginning this summer in New York City with community-based LTSS consumers. Because NYSDOH wishes to avoid disruption in access to LTSS NYSDOH will build its FIDA program off of the mandatory Medicaid MLTCP. NYSDOH believes this holds the least possibility of disruption in access to care because so many of the MLTCP plans either are integrated Medicare and Medicaid plans or are well-positioned to offer an integrated Medicare and Medicaid plan.<sup>5</sup>

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<sup>5</sup> When enrolled in NYSDOH's mandatory Medicaid Managed Long Term Care program, dual eligibles will have a choice of whether to receive their care through a fully-integrated PACE program, a fully-integrated Medicaid Advantage Plus program, or a partially-capitated managed long term care plan. More than half of the state's partially-capitated managed long term care plans are owned by parent organizations that operate Medicare Advantage plans in NY suggesting a good likelihood of easy conversion.

In January 2014, those dual eligibles in the eight county service area of Bronx, Kings, Nassau, New York, Queens, Richmond, Suffolk, and Westchester who are, as of the fall of 2013, receiving community-based LTSS and are enrolled in NY's mandatory MLTC program will be passively enrolled into a FIDA plan.

At the same time, up to 10,000 dual eligibles with intellectual and developmental disabilities will be enrolled into a FIDA OPWDD plan.

Of the community-based LTSS recipients, PACE enrollees would not be required to enroll into a FIDA plan since the PACE model already integrates all Medicare and Medicaid services. Individuals who are attributed to the Bronx Health Access Network Pioneer ACO (or any other ACO that becomes approved prior to implementation) would not be required to enroll in FIDA. PACE and ACO participants would be permitted to elect enrollment into a FIDA plan but, enrollment would not be mandated for them.

NYSDOH will work with CMS to identify dual eligibles that have employer sponsored Medicare coverage and to determine how NYSDOH might avoid passively enrolling these individuals.

Eligible dual eligibles would be enrolled into the FIDA program with the assistance of an Enrollment Broker. Enrollment protocols will be established similar to those being established for the mandatory MLTCP enrollment process. Accordingly, the Enrollment Broker would work with these individuals to enroll these individuals into a FIDA plan that includes their providers, includes their prescription medications on their formularies, and meets their identified needs and preferences. The most important considerations will be continued access to providers and services of choice. For most MLTCP participants, however, NYSDOH anticipates that the enrollment assistance process would result in enrollment in a FIDA plan that is operated by the individual's current MLTC plan.

Full dual eligible MLTC Participants who are passively enrolled can decline the FIDA plan enrollment or choose enrollment into a different FIDA plan. If they opt out of passive enrollment, individuals will remain in their MLTCP plan and will receive Medicare services through Traditional Medicare or a Medicare Advantage plan. Participants will not be locked in to their choice of FIDA plan and can disenroll at the end of any month after enrollment. Re-enrollment after one has opted-out or changing plans within the FIDA program, however, will be limited. Re-enrolling into the FIDA program once one has opted out or changing from one FIDA plan to another will only be permitted in January and July of each year.

#### **b. Managed Fee-for-Service Model - Health Home**

Dual eligibles across the State who meet Health Home criteria will be passively enrolled in Health Homes. Individuals eligible for Health Home services will be identified by the State using the assignment algorithm described in Appendix F. Individuals will be assigned to a Health Home provider based on existing relationships with health care providers or other care delivery system relationships, geography, and/or qualifying

condition. They will be given the option to select another Health Home that better meets their needs or they may choose to opt-out. The NYSDOH will provide each Health Home a roster of assigned (from an intelligent assignment algorithm) members prioritized by predictive model risk for future inpatient or nursing home utilization and current demographic information to facilitate outreach and engagement. Health Homes will also accept referrals.

NYSDOH has a Health Home Patient Tracking System which facilitates communication between NYSDOH and each Health Home regarding the status of dual eligible Medicaid recipients eligible for each Health Home's services. Once a quarter, NYSDOH will use recipients' claim data to identify fee for service dual eligible Medicaid recipients that are eligible for Health Home services. New referrals (identified by the Human Resources Administration, Local Department of Social Services, Single Point of Access or Local Government Unit, care management agency, practitioners, hospital, prisons, Behavioral Health Organization, etc.) meeting Health Home criteria will be enrolled in Health Homes using the monthly tracking sheet submitted to DOH. Individuals with no service utilization are randomly assigned to a Health Home. These Patient Tracking Sheets will be distributed through the password protected Health Commerce System (HCS) to each entity's identified HCS contact. Health Homes are required to populate and regularly update patient tracking sheets on the HCS with required information.

### **3. Network Adequacy and Access**

#### **a. Managed Care Model – Fully-Integrated Dual Advantage (FIDA)**

It is imperative that Participants have timely access to all necessary providers. For this reason, NYSDOH proposes that each FIDA plan will have to meet the broadest of the existing applicable Medicare and Medicaid provider network requirements and that in no instance may any plan's network have less than two of any provider type necessary to provide each service identified in the plan benefit package. It is also for this reason that NYSDOH will require that plans ensure that their provider networks meet time and travel distance standards, maximum waiting time standards, and appointment standards. These are fully detailed in Appendix D.

Providers will need to meet all applicable licensure, provider certification and/or other applicable requirements in the Medicare and Medicaid programs and must not balance bill any Participant.

In the event that a FIDA plan network is unable to meet any of the applicable network adequacy requirements, the plan will have to allow access to out-of-network providers at no cost to the Participants until such time as the plan is capable of providing in-network access in accordance with the requirements.

Plans will be required to report its network of contracted providers to NYSDOH on a quarterly basis. Participant experiences with network adequacy and access will be captured in the Participant Feedback Process, described in Section D.iii. below, through data collected by the Participant Ombudsman, and complaints to the Department.

#### **b. Managed Fee-for-Service Model - Health Home**

There will be at least two Health Homes in each geographic region (as practicable). Provider Standards and general qualifications for the Health Home Program are outlined in Appendix J. Health Home providers can expand their partner network as needed to provide additional services or expand network capacity.

Recipients in Targeted Case Management (TCM) programs will transition into a Health Home that includes their existing case manager to ensure continuity of the care management relationship. Through the State's Health Home assignment algorithm, which includes a provider loyalty analysis, every effort will be made to assign members to Health Homes that include their existing providers. Health Home providers will be required to submit any updates to their network partner list to NYSDOH as they occur so that networks can be assessed for adequacy and scope of service.

The Health Home care manager will assist the Participant to access necessary support and services to meet the individual needs of Participants.

#### **4. Care Coordination**

Both the FIDA programs and the Health Home program will provide person-centered care coordination and care management to all Participants. This will be accomplished through the use of interdisciplinary teams comprised, first and foremost, of the Participant and/or his/her designee, the designated care manager, the primary care physician, behavioral health professional, and other providers either as requested by the Participant or his/her designee or as recommended by the care manager or primary care physician and approved by the Participant and/or his/her designee. Care planning will be based on the assessed needs and articulated preferences of the Participant.

FIDA plans and Health Home providers must facilitate and accommodate the Participant's or his/her designee's involvement in all care planning activities. All Participants will have access to the independent Participant Ombudsman to help them exercise their rights and express their wishes in and around the care planning process.

#### **5. Integrated Records and Information Technology**

FIDA plans must have structured information systems, policies, procedures and practice to create, document, execute, update, and share information with all of the Participant's providers. Plans will be required to indicate how they will use and require all providers to use single integrated electronic Participant health and services records and the information technology tools available through the plan for accessing, updating, and sharing information on health history, demographics, care plans, goals, care plan adherence, care gap alerts, clinical referrals, claims information, lab results, provider/enrollee communications, contact logs, progress notes, consultations, physicians orders, and encounters. They must have a systematic process to follow-up on tests, treatments, services and referrals – which is incorporated into the Participant's plan of care.

At a minimum, all FIDA plans must:

- Have structured interoperable health information technology systems, policies, procedures and practices to support the creation, documentation, execution, and ongoing management of a plan of care for every patient.
- Use an electronic health record system that qualifies under the Meaningful Use provisions of the HITECH Act, which allows the patient's health information and plan of care to be accessible to the interdisciplinary team of providers. If the provider does not currently have such a system, they will provide a plan for when and how they will implement it.
- Comply with the current and future version of the Statewide Policy Guidance ([http://health.ny.gov/technology/statewide\\_policy\\_guidance.htm](http://health.ny.gov/technology/statewide_policy_guidance.htm)) which includes common information policies, standards and technical approaches governing health information exchange.
- Commit to joining regional health information networks or qualified health IT entities for data exchange and includes a commitment to share information with all providers participating in a care plan. RHIOs/QE (Qualified Entities) provides policy and technical services required for health information exchange through the Statewide Health Information Network of New York ( SHIN-NY).
- Support the use of evidence based clinical decision making tools, consensus guidelines, and best practices to achieve optimal outcomes and cost avoidance.

## ii. Proposed Benefit Design

The FIDA plans will provide all covered services through fully capitated, managed care plans within which each Participant's care is planned, arranged, and authorized by an individualized, person-centered care planning team. Participants will have input into their care planning team, the care planning process, the content of the care plan, and the nature of care delivery. Participants' needs will be required to be fully assessed, including but not limited to medical, social, financial, and housing needs, prior to or within 30 days of enrollment. Within 60 days of enrollment, a Participant's comprehensive care plan must be developed. Reassessment and care plan review and revision will be required at least every six months and more frequently if there is a change in condition.

FIDA plans will provide all services covered by Medicare Part A, B, and D, virtually all Medicaid State Plan physical health, behavioral health, and LTSS, and an array of additional LTSS and Health and Wellness services not presently covered by the traditional Medicare or Medicaid programs. A complete list of covered services can be found at Appendix B.

A Participant's interdisciplinary care coordination team within his/her FIDA plan will be responsible for arranging and ensuring receipt of all services when they are called for in a Participant's care plan, regardless of whether the services are covered or non-covered services under the FIDA plan.

Health Home programs are responsible for providing intensive care management to assure that the member's care plan supports an integration of all services for

members with chronic medical, behavioral health and long term care needs, under a managed fee-for-service model. The care coordinator is responsible for arranging and ensuring the receipt of all services the member needs. Health Homes do not restrict where a member receives services.

## **1. Supplemental Benefits and Support Services**

### **a. Managed Care Model – Fully-Integrated Dual Advantage (FIDA)**

The FIDA program will provide the comprehensive array of Medicare and Medicaid physical health, behavioral health, LTSS, and supplemental services outlined in Appendix B. This includes both services that have not previously been made available through Fee-For-Service or available through any of the DOH Medicaid/Medicare integrated programs. Access to services will be improved over the fee-for-service experience with the interdisciplinary team members playing a critical role in ensuring appointments are made and kept, prescribed care is timely delivered, and access challenges are minimized.

### **b. Managed Fee-for-Service Model - Health Home**

Participants in the Health Home model will have access to all of the physical healthcare, behavioral healthcare, and LTSS presently available through the Medicare Part A, B, and D programs and through the NYSDOH Medicaid fee-for-service program. The Health Home Program will provide care management through an integrated network of providers to coordinate and facilitate access to all Medicaid State Plan services, both mandated and optional, as well as Medicare services. Health Homes will be responsible to provide seamless access to the continuum of care for the demonstration's dual eligibles.

### **iii. Use of Evidence-Based Practices**

FIDA plans will be expected to develop and employ mechanisms to ensure that service delivery is evidence-based and that best practices are followed in care planning and service delivery. Plans will have to demonstrate how they will ensure that their providers are following best-evidence clinical guidelines through decision support tools and other means to inform and prompt providers about treatment options. Plans will have to identify how they will employ systems to identify and track patients in ways that provide patient-specific and population based support, reminders, data and analysis, and provider feedback.

FIDA plans will be required to demonstrate how they will educate their providers and clinical staff about evidence-based best practices and how they will support their providers and clinical staff (through training or consultations) in following evidence-based practices. Providers and their practices will be required to provide services in accordance with established evidence-based clinical practice guidelines appropriate for the dual eligibles they serve. FIDA plans will be required to demonstrate how they will hold their providers to evidence-based practices specific to their practice areas.

The NYS Medicaid Program's expectation is that evidence-based health care services will be provided and the Health Home Program will provide care management

and care coordination services that facilitate Health Home members' access to health care services. Health Homes must meet a number of evidence-based quality measures based on outcomes from health care services. As outcomes are demonstrated, Health Homes will selectively refer to care managers who are meeting or exceeding standards.

#### **iv. Relation to Existing Programs and Other New Initiatives**

##### **1. Relation to Existing Waivers and State Plan Services**

###### **a. Managed Care Model – Fully-Integrated Dual Advantage (FIDA)**

The creation of the FIDA program does not eliminate or interfere with the existing Medicaid Waivers and State plan services that are available to the target population. The FIDA program will be responsible for providing all of the State Plan services and nearly all of the waiver services available through the HCBS Waivers that serve the target population. Eligible individuals that opt-out of enrollment or at some point choose to disenroll may receive state plan services through the non-fully-integrated Medicaid system.

###### **b. Managed Fee-for-Service Model - Health Home**

The Health Home Managed fee-for-service model does not eliminate or interfere with the existing Medicaid Waivers and State Plan services that are available to the target population. The Health Home Managed fee-for-service model will be responsible for coordinating all of the current mandatory and optional State Plan services for dual eligible participants.

##### **2. Relation to Existing managed long-term care programs**

###### **a. Managed Care Model – Fully-Integrated Dual Advantage (FIDA)**

The FIDA program is being built upon the framework established in the MLTC program. The MLTC system will continue to exist and will serve those who are not full dual eligibles as well as those full dual eligibles that opt-out or at some point choose to disenroll from the FIDA program.

###### **b. Managed Fee-for-Service Model - Health Home**

The Health Home fee-for-service model will not duplicate or interfere with existing MLTC programs. For Health Home participants who develop a need for more than 120 days of LTSS, Health Homes will continue to provide care coordination to existing healthcare services and will collaborate with LTSS providers and when available assist with transition to MLTCP in this process. Health Homes will not be introducing or reducing direct care services.

### **3. Relation to Existing Specialty Behavioral Health Plans**

The New York State Office of Mental Health (OMH) and the New York State Office of Alcoholism and Substance Abuse (OASAS) continue to work closely with NYSDOH to improve the coordination of behavioral health services for certain Medicaid fee-for-service recipients. Phase I of the MRT initiative, Behavioral Health Organizations (BHOs) are in process towards providing administrative and management services for the purposes of conducting concurrent reviews of inpatient behavioral health services available under the Medicaid program. Neither the Health Home program nor the FIDA program will interfere with these BHOs, nor will these BHOs interfere with FIDA operations. BHOs may work with Health Homes to alert a Health Home when a Medicaid member has had an inpatient behavioral health event.

### **4. Relation to Existing Integrated Programs via Medicare Advantage Special Need Plans (SNPs) or PACE programs**

It is anticipated that many of the Medicaid Advantage and Medicaid Advantage Plus plans (the Medicare Advantage Special Needs Plans that also provide Medicaid) will transition to or will develop additional product lines through which to provide FIDA plans. Otherwise, these plans will continue to exist and will serve those full dual eligibles that opt-out or at some point choose to disenroll from the FIDA program.

The PACE programs will not be changed by the creation of the new FIDA program and their dual eligible enrollees will not be passively enrolled into the demonstration. These programs will continue to exist and will serve those full dual eligibles that opt-out or at some point choose to disenroll from the FIDA program, as well as those Medicaid-only, Medicare-only and private pay individuals as they may currently serve.

### **5. Other State payment/delivery efforts underway**

There are no other State payment/delivery efforts underway at this time.

### **6. Other CMS payment/delivery initiatives or demonstrations**

The goals of this Demonstration align significantly with the goals of several other CMS payment/delivery initiatives or demonstrations.

The Pioneer Accountable Care Organization (ACO) Model is a CMS Innovation Center initiative. In December 2011, CMS announced 32 organizations that were selected to participate in this model. Through this model, the Pioneer ACO sites will help test the effectiveness of particular payment arrangements in providing beneficiaries with a better care experience through Accountable Care Organizations (ACO), while also reducing Medicare costs. One of the 32 organizations that were selected is the Bronx Health Access Network. This organization is located within the eight county service area for the FIDA program. Participants in this Pioneer ACO will not be passively enrolled in the FIDA program but will be able to voluntarily elect to enroll in the FIDA program. The same will be true for Participants in any ACO that comes online before FIDA implementation.

New York is one of eight states that were awarded multi-payer advanced primary care practice demonstration grants. New York is implementing the Multi-payer Advanced Primary Care Demonstration (MAPCP) by adding Medicare as a payer to the pre-existing Adirondack Medical Home Multipayor Demonstration Program (ADK demonstration). The ADK demonstration is a regional initiative in northeastern New York State that began in 2005 as a collaboration among local providers seeking to strengthen the region's beleaguered primary care system, with a specific focus on recruiting and retaining primary care physicians practicing in rural/frontier communities. The regional ADK demonstration is limited to practices in Clinton, Essex, Franklin, Hamilton, and Washington counties and will not overlap with the FIDA program in this demonstration's service area. The experience and lessons learned from the MAPCP demonstration will be considered as NYSDOH evaluates geographic expansion decisions following the end of this demonstration. A number of the practices in the regional ADK demonstration will be Health Home network partners. As such, Health Homes will collaborate with these practices and provide care management and coordination of health care services of Health Home members served by these practices.

Last summer, CMS announced a new initiative to help states improve the quality of care for people in nursing homes. This demonstration to reduce preventable hospitalizations among nursing home residents will focus on reducing preventable inpatient hospitalizations among nursing home residents by providing these individuals with the treatment they need without having to unnecessarily go to a hospital. CMS has announced that it will competitively select and partner with independent organizations that will provide enhanced clinical services to people in approximately 150 nursing homes. The intervention will be targeted to nursing facilities with high hospitalization rates and a high concentration of residents who are eligible for both the Medicare and Medicaid programs. It is not yet known whether providers within the service areas for this demonstration will be involved in the new demonstration to reduce preventable hospitalizations among nursing home residents. NYSDOH will continue to evaluate the impact of this initiative as participating providers in the initiative are identified.

#### **D. Stakeholder Engagement and Beneficiary Protections**

##### **i. Stakeholder Engagement During the Model Design**

NYSDOH has been engaging stakeholders since early 2011 through the Medicaid Redesign Team. The Medicaid Redesign Team (MRT) was created by Governor Andrew Cuomo in January 2011. Work Groups were created around many important subject areas, including a Managed Long Term Care Implementation and Waiver Redesign Work Group, a Behavioral Health Reform Work Group, and a Health Disparities Work Group. The Health Home program is also an MRT initiative.

Since January, 2012, NYSDOH has engaged stakeholders in weekly calls around MLTC. Every Thursday morning, more than 100 stakeholders join in a 90

minute call to discuss Managed Long Term Care Implementation which discusses mandatory enrollment of dual eligibles into the MLTC Program.

Extensive stakeholder outreach has been conducted as part of the implementation of Health Homes including multiple statewide webinars which typically have over 750 participants. In addition there are ongoing meetings with designated Health Homes. State staff have spoken about Health Homes at numerous conferences and regional meetings around the state. The subject of integration of dual eligibles into the Health Home model will be specifically addressed in a statewide webinar and a face-to-face meeting to be held in early May of 2012 (see the summary of stakeholder activities included in the Executive Summary).

In the fall of 2011, Thomson Reuters (through funding from CMS) helped NYSDOH to schedule focus groups and personal interviews with dual eligibles who receive community-based LTSS in three regions of the state. NYSDOH invited 1,100 dual eligibles to participate. Financial incentives were offered in exchange for participation. While only 8 individuals attended, the small size provided an extraordinary level of participation by each attendee and an incredible breadth of discussion.

On March 6, 2012, NYSDOH published a request for public input regarding the FIDA initiative.<sup>6</sup> It was posted on the MRT website, available to anyone with internet access. More than 1,860 notices of this request were sent out to interested stakeholders (between 1,300 on the MRT e-mail list, 204 Facebook followers, and 359 Twitter followers). Not only did the notices request input, they also urged stakeholder groups to forward the input request on to their own networks so that additional stakeholders might be reached. Also on March 6, 2012, NYSDOH published a brief concept paper describing the proposed demonstration on its Medicaid Redesign Team website.<sup>7</sup>

On March 13, 2012 and March 15, 2012, NYSDOH conducted stakeholder webinars during which NYSDOH explained the design elements of its preliminary proposal and captured feedback. Approximately 200 stakeholders participated in these webinars and 98 substantive comments were received during the two sessions.

In April 2012, NYSDOH conduct one Twitter chat and two public meetings on the draft demonstration proposal as published on March 22, 2012. Over 1400 people on the MRT listserv received notice of these events as did approximately 226 Facebook followers and 404 Twitter followers. All of NYSDOH's 404 Twitter followers potentially viewed or participated in the chat. Approximately 70 stakeholders attended the April 10, 2012 public meeting at Hofstra University. Approximately 60 stakeholders attended the April 16, 2012 public meeting at Hostos Community College. Additionally,

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<sup>6</sup> The solicitation for public input can be found here:

[http://www.health.ny.gov/health\\_care/medicaid/redesign/solicitation\\_for\\_public\\_comment.htm](http://www.health.ny.gov/health_care/medicaid/redesign/solicitation_for_public_comment.htm)

<sup>7</sup> The proposal concept paper can be found here:

[http://www.health.ny.gov/health\\_care/medicaid/redesign/overview\\_of\\_ny\\_demonstration.htm](http://www.health.ny.gov/health_care/medicaid/redesign/overview_of_ny_demonstration.htm)

approximately 58 sets of written comments were submitted in response to the draft proposal.

**ii. New or Modified Participant Protections**

A broad array of Participant protections will be included in both the FIDA programs and the Health Home Program.

**1. Managed Care Model – Fully-Integrated Dual Advantage (FIDA)**

**a. Continuity of Care**

Current state law affords a new Participant the opportunity to continue to see their established providers and complete any ongoing courses of treatment during the first 60 days of transition into the new FIDA plan, in the event that these providers are not already part of the FIDA plan network. NYSDOH will explore whether this timeframe can be extended to 90 days. Additionally, NYSDOH will require that all care plans and prescription medication authorizations last for at least the first 60 days of transition, or 90 days if the timeframe can be extended to 90 days. It is not anticipated that many Participants will need to avail themselves of this continuity of care protection, as a significant number of Participants are expected to be passively enrolled into a FIDA plan that belongs to and has the same provider network as that Plan Sponsor's MLTC out of which the Participants will be passively enrolled. Others will be enrolled with the assistance of the independent Enrollment Broker which will be charged with facilitating choices that minimize disruption in access to existing providers.

Transitions into the FIDA program will be eased by requirements that ongoing courses of treatment with out-of-network providers be permitted to continue for up to 60 days during the initial transition into a Participant's new FIDA plan.

**b. Enhanced Network adequacy and provider access requirements**

Participants will have access to a provider network that offers a choice of each provider type and that establishes provider access rules that limit wait times, appointment times, and travel/distance times. While MAP already guarantees a right to a choice of each provider type, it does not presently limit wait times to one hour, establish appointment scheduling times that ensure timely access to routine, urgent, and specialist care, or require networks to be sufficient to ensure that Participants need not travel more than thirty miles or thirty minutes to access any provider within the network. These modifications to existing protections aid in access and help ensure that Participants can timely obtain the care they need.

**c. Grievance and Appeal Process**

NYSDOH proposes to provide a fully-integrated Medicare and Medicaid grievance and appeal process that includes the most consumer-friendly elements of the Medicare and Medicaid grievance and appeal processes. NYSDOH is committed to offering the best elements of both systems. The specifics of this fully-integrated grievance and appeal process will be developed in consultation with a new stakeholder workgroup that is being developed. We anticipate that key elements will include single

notices, continuing benefits pending appeal, and the employment of the most Participant favorable timeframes for filing appeals and receiving decisions.

**d. Rights and Responsibilities**

Participants will be provided with all the federal rights reflected in the Medicare Advantage, Medicaid Managed Long Term Care, and HCBS Waiver programs. They will also be provided with all state rights reflected in the NYS managed care laws and regulations. A comprehensive list consolidating all these rights in a single statement along with Participant responsibilities is provided in Appendix C.

**e. Participant Ombudsmen**

If provided funding by CMS for NYSDOH's Demonstration Implementation Funding Request, NYSDOH will make available to Participants an independent, conflict-free entity to serve as FIDA Participant Ombudsman. The FIDA Participant Ombudsman will provide Participants free assistance in accessing their care, understanding and exercising their rights and responsibilities, and in appealing adverse decisions made by their plan. The FIDA Participant Ombudsman will be accessible to all Participants through telephonic and, where appropriate, in-person access. The Participant Ombudsman will provide advice, information, referral and direct assistance/representation in dealing with the FIDA plans, providers, or NYSDOH. Appendix G includes a write-up on the anticipated role of the Participant Ombudsman.

FIDA plans will be required to notify Participants of the availability of the FIDA Ombudsman in enrollment materials, annual notice of Grievance and Appeal procedures, and all written notices of denial, reduction or termination of a Service.

**f. Enrollment Assistance**

NYSDOH will utilize an independent Enrollment Broker to assist Participants in making both their initial enrollment decisions as well as any additional enrollment or disenrollment decisions. The Enrollment Broker will be scripted, conflict-free, and well-equipped to understand and explain both FIDA and other service delivery options, including PACE. The Enrollment Broker will be resourced with enrollment protocols and logic to help ensure that Participants are assisted with enrolling into their choice of plans from amongst those that best meet their needs and preferences. The Enrollment Broker will provide oral and written information on enrollment rights, including but not limited to the rights and procedures involved in making a choice to opt-out prior to enrollment or disenroll once enrolled and the availability of the Participant Ombudsman to help the Participant once enrolled.

**g. Integrated Information**

One key current challenge for dual eligibles is the absence of a single source of information explaining the scope of coverage and how to access services. The FIDA program will provide a single set of informative materials, streamlining all marketing materials and all Participant notices so that all information will be comprehensive and will flow from one integrated source.

#### **h. Costs**

Providers will be expressly prohibited from billing Participants for the cost of covered services. Participants shall not be charged any coinsurance, co-payments, deductibles, financial penalties, or any other amount in full or part, with the exception of Medicare Part D Prescription Drug co-payments, if the individual does not receive LTSS. Those Participants who receive either community-based or institutionally-based LTSS will not be charged for any Medicare Part D Prescription Drug co-payments. Some Participants will be required to pay NAMI and Spend-Down costs relating to establishing or maintaining eligibility for Medicaid. These are costs relating to eligibility and not to plan participation or services, however, they will be paid directly to the FIDA plan through the procedures that will be outlined in the FIDA plan contracts.

### **2. Managed Fee-for-Service Model - Health Home**

Dual eligibles that participate in the Health Home program retain all Medicare and Medicaid Fee-For-Service program protections around such elements as access to care, continuity of care, costs, and rights. In addition, there are some beneficiary protections specific to their participation in the Health Home program.

#### **a. Choice**

Dual eligible members who qualify for Health Home services will automatically be enrolled in Health Homes. Health Homes for dual eligible is an Opt-out Program, allowing for quick, easy access to the care management program and the protected choice of not participating and continuing to have health coverage. A member may choose to not participate in Health Homes, in which case they can call their assigned Health Home and/or complete an opt-out form.

#### **b. Privacy**

Extensive protections are provided to Participants around the release, exchange, and sharing of Medicaid and health information between providers, care managers, and the state. These are outlined in detail in Appendix L. Case managers counsel Participants and obtain their informed consent to sharing information.

#### **c. Continuity of Care**

Dual eligible members in Health Homes are protected and will be provided with continuity of care protection. Through care management and coordination, each member will be supported to access needed and timely services. Members will have a patient-centered care plan that will address specific needs and will be monitored by a multidisciplinary team for progress towards reaching goals. Recipients in Targeted Case Management (TCM) programs will transition into a Health Home that includes their existing case manager, to ensure continuity of the care management relationship. Through the State's Health Home assignment algorithm, which includes a provider loyalty analysis, every effort will be made to assign members to Health Homes that include their existing providers.

#### **d. Network Adequacy**

Dual eligible members in Health Homes are not restricted to any particular providers through the Health Homes program. For the purpose of care coordination and assistance in getting members into direct care services, Health Homes have robust partnerships offering a choice of providers committed to serving the health Homes members, but members are free to choose providers outside of the Health Home partnership. With built in advocacy from the care manager, a member will have assistance in navigating services provided by a partnership that shares a care plan, and is working towards electronic health records enhanced health information technology.

#### **e. Grievance and Appeal Process**

Health Home duals will have the typical grievance process afforded to all fee-for-service members under the Medicaid grievance and appeal process, including an opportunity to request a state fair hearing.

#### **f. Enrollment Assistance**

Health Home dual eligible members will have access to the independent Enrollment Broker as described under the FIDA program proposal to assist them with enrollment or disenrollment decisions.

### **iii. Ongoing Stakeholder Feedback**

#### **1. Managed Care Model – Fully-Integrated Dual Advantage (FIDA)**

NYSDOH will initiate regular meetings with interested stakeholders to gather Stakeholder ideas and feedback in how to operationalize key components of its FIDA demonstration plan. Subcommittees dedicated to addressing specific topics (such as but not limited to Integrated Appeals and Grievance Process and Procedures, Financial and Payment Provisions, and Quality Metrics) will be formed as well, with the precise topics to be determined by NYSDOH in consultation with stakeholders. These regular meetings will take place through the completion of the MOU negotiations ending in September 2012. During the remaining stages of implementation and throughout the demonstration, NYSDOH will gather Stakeholder input and feedback through quarterly stakeholder meetings. During implementation, these meetings will provide an opportunity for NYSDOH to provide updates and to receive input into final design decisions. During the demonstration, these meetings will provide an opportunity for NYSDOH to provide updates and to receive feedback into how the program is serving Participants.

Information and updates will be shared with the eligible population prior to enrollment through written notices, plan communications, newsletters, and electronic communications. These will be available in the six most common languages, as described in Section K and in alternative formats for individuals with disabilities. Beginning in July of 2013, NYSDOH will launch an outreach and education campaign including written materials, live trainings and presentations, and electronic media activities to ensure that the eligible population, their caregivers, their providers, and the advocates are all well-informed and well-prepared for the roll-out of the demonstration.

These will be available in prevalent languages for LEP individuals and in alternative formats for individuals with disabilities.

During the demonstration, NYSDOH will conduct participant satisfaction surveys on all Participants annually. NYSDOH presently conducts similar Participant surveys every two years. NYSDOH will provide an opportunity for Participants to complete these annual quality surveys either in writing (in all prevalent languages or through alternative formats) or via the telephone (with the use of interpretation services for Participants who so require).

All plans will be required to conduct at least two Participant Feedback Sessions in their service areas each year. At these, Participants will be invited to raise problems and concerns and to provide positive feedback as well. Plans will be required to assist Participants with the costs, transportation, and other challenges of attending these in-person Participant Feedback Sessions. DOH staff will attend a sampling of these events each year. Plans will be required to summarize each session and make the summary available to Participants and the public.

Current State regulation requires each managed care plan to either have Participant representation on its board of directors or to have an advisory committee of Participants to provide feedback to the plan.<sup>8</sup> Under the demonstration, each plan will be required to have a Participant Advisory Committee (PAC). Each PAC will be open to all Participants and family representatives as well as the demonstration's Participant Ombudsman.

Each PAC will meet quarterly. At these meetings, the plan would be expected to share any updates or proposed changes as well as information about the number and nature of grievances and appeals, information about quality assurance and improvement, information about enrollments and disenrollments, and more. The PAC members would be invited to voice questions and concerns about topics including but not limited to quality of life and service delivery and would be encouraged to provide input and feedback into topics raised by the plan.

At all times during the demonstration, Participants may access the Participant Ombudsman for assistance. Through the Participant Ombudsman's report to NYSDOH, the Participant experience will be shared, providing yet another means of capturing feedback. Additionally, at all times during the demonstration, Participants may access NYSDOH through its toll-free participant assistance number (1-866-712-7197).

## **2. Managed Fee-for-Service Model - Health Home**

Statewide Webinars are held for stakeholders to provide opportunities to share updated policies, procedures and program implementation. Webinars are also posted on the Health Home website along with updated information to assist Health Home network providers in carrying out goals and objectives of the program.

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<sup>8</sup> 10 NYCRR 98-1.11(g)

A dedicated mail box is available to stakeholders to post questions regarding enrollment, billing, general program questions, health Information technology and quality measures. A Call Center has been developed to have a Health Home expert available to answer Health Home questions.

Regional meetings for Health Home providers and weekly telephone conferences for the Health Homes State Implementation Team consisting of representatives of the Offices of Mental Health, Alcohol and Substance Abuse Services and multiple Offices within the Department of Health are to bring together Health Home stakeholders to discuss program implementation issues and capture input.

Members and their representative are provided outreach and education about Health Homes through the care managers and network providers who provide education and make referrals to Health Homes for their patients.

## **E. Financing and Payment**

### **i. State-level payment reforms and Selected Financial Alignment Model**

#### **1. Managed Care Model – Fully-Integrated Dual Advantage (FIDA)**

NYSDOH proposes to conduct a demonstration using the capitated model described in the July 8, 2011 State Medicaid Director Letter for the FIDA program. NYSDOH is in the process of making or exploring multiple state-level payment reforms. This includes a shift toward episodic payment for CHHA and pricing for nursing homes. It also includes a phasing in of risk adjusted payment rates for the MLTCP with rates that will be based on the new Uniform Assessment tool (the UAS) instead of the current Semi-Annual Assessment of Members (SAAM). NYSDOH is also in the process of implementing payment reports that include implementation of rate cells and development of risk corridors. In the FIDA program, NYSDOH would anticipate employing rate cells and risk adjustment. NYSDOH might also utilize risk corridors. The state will negotiate with CMS to make NYS's prompt payment rules apply to FIDA.

#### **2. Managed Fee-for-Service Model - Health Home**

NYSDOH proposes to conduct a demonstration using the managed fee-for-service model described in the July 8, 2011 State Medicaid Director Letter for the Health Home program. NYSDOH proposes to utilize both the Medicaid and Medicare shared savings models supported by care management payments to create incentives to improve coordination of care. This program is designed to reimburse specially selected providers meeting state and federal criteria for delivering care management services to Medicare-Medicaid enrollees and looks to ensure the integration and access to all necessary services based on the individual's needs through coordination across both programs

### **ii. Payment to Participating FIDA Plans**

FIDA Plans will receive per-member-per-month capitated payments in an amount to be determined jointly by CMS and NYSDOH. NYSDOH anticipates the inclusion of risk adjustment and rate cells (possibly also risk corridors) in the negotiated rate.

Additionally, NYSDOH will develop financial performance-based incentives to reward improvements in quality of care received by Participants. Any such payments will be implemented following a year of collecting and evaluating performance, establishing benchmarks, and developing performance measures. These financial incentives would be paid in addition to the capitation rates paid by CMS and NYSDOH.

**iii. Payment for Care Management in Health Home Program**

Health Homes meeting State and Federal standards will be paid a per member per month care management fee that is adjusted based on region and case mix (from 3M™ Clinical Risk Groups (CRG) method) and this fee will eventually be adjusted by (after the data is available) patient functional status. This risk-adjusted payment will allow providers to receive a diverse population of patients and assign patients to various levels of care management intensity without having to meet preset standards for contact counts. Providers will be able to respond to and adjust the intensity and frequency of intervention based on patient's current condition and needs (from tracking to high touch). This fee methodology has been approved by CMS as part of the health home state plan and all rates will be published on the DOH website.

This care management fee will be paid in two increments based on whether a patient is in 1) the case finding group or 2) the active care management group. The case finding group will receive a PMPM that is a reduced percentage (80 %) of the active care management PMPM. The case finding PMPM will be available for the three months after a patient has been assigned to a health home. Then, nothing can be billed for that patient for the next three months. Following this interval, case finding can be billed for another three months while outreach and engagement is attempted once again. This PMPM is intended to cover the cost of outreach and engagement.

A unit of service will be defined as a billable unit per service quarter that will be distributed monthly. In order to be reimbursed for a billable unit of service per quarter health home providers must at a minimum, provide one of the core health home services. The monthly distribution will be paid via the case finding and active care management PMPM. Once a patient has been assigned a care manager and is enrolled in the health home program the active care management PMPM may be billed.

**F. Expected Outcomes**

**i. NYSDOH Capacity for Monitoring, Collecting, and Tracking Data on Key Metrics**

NYSDOH has limited staff designated for monitoring, collecting, and tracking data such as would be needed on key metrics related to the demonstration's quality and cost outcomes for the target population. NYSDOH will utilize a portion of its implementation budget for both staff and systems that will facilitate thorough monitoring, collecting, and tracking around such elements as beneficiary experience, access to care, and utilization of services in order to insure that beneficiaries receive high quality care and for the purposes of evaluation. NYSDOH will simultaneously implement

Medicaid Redesign Team recommendations around presenting data on key metrics in a meaningful way for Participants to use in making plan selections.

**ii. Potential Improvement Targets**

For the FIDA programs, NYSDOH will establish improvement targets in several areas that are still being identified. The areas under consideration are outlined in Appendix H. Stakeholder input will be sought in the selection of these targets and in determining metrics in the upcoming weekly meetings that NYSDOH is scheduling with stakeholders. The Health Home program will establish improvement targets around potentially avoidable inpatient admissions and preventable emergency room visits, utilization of mental health services, improving outcomes for persons with mental illness and/or substance use disorders, improving disease-related care for chronic conditions and improving preventive care. See Appendix I for Goals and Quality Measures.

**iii. Expected Impact of Proposed Demonstration on Medicare and Medicaid Costs**

New York's Medicaid program is the most costly of any state in the country. While only 15% of its Medicaid enrollees in 2007 were dual eligibles, they were responsible for 45% of all state Medicaid expenditures. The annual expenditures for dual eligibles who receive LTSS in New York were \$23,447, more than twice the national average of \$10,840, in 2007. Acute care costs for this population were also extremely high at \$30,384, nearly twice the national average of \$15,459. New York's Medicaid payments for acute care services and beneficiary cost sharing not covered by Medicare were approximately 70% above the national average, while Medicaid payments for Medicare Part A and B premiums were closer to the national average. While most of the Medicaid costs for services to dual eligibles were exceedingly above the national average, Medicare costs were far below national averages in nursing home care, home health services, durable medical equipment, and hospice services. It is believed that the relatively low Medicare expenditures may be a result of overreliance on Medicaid covered services.

NYSDOH believes that person-centered care planning, coupled with a multi-disciplinary care coordination approach and the availability of enhanced community-based and Health and Wellness services will provide its dual eligibles with an improved quality of life and will result in reduced acute care encounters. This will not only prevent or delay health declines but will result in savings that should, over time, equal or exceed the expenditures made on providing the care coordination and enhanced array of services.

**G. Infrastructure and Implementation**

**i. NYSDOH Infrastructure/Capacity to Implement and Oversee the Demonstration**

Oversight of the New York State Medicaid Program resides with the Department of Health (NYSDOH). Within NYSDOH, is the Office of Health Insurance Programs (OHIP) which administers programs that deliver needed care and services to dual

eligibles. The OHIP administers the MLTCP, including program design, licensure, certification and surveillance, rate setting and quality oversight. It also has oversight responsibility for assisted living facilities, community-based services and other services. OHIP addresses matters related to Medicaid beneficiaries, developing new budget proposals and implementing new legislation. In addition to OHIP, there are several state agencies that serve large numbers of the dually eligible such as the Office of Mental Health (OMH) which provides care to thousands of dually eligible through its network of outpatient clinics across the state.

Since 1995, NYSDOH has been designing, developing and implementing managed care models for various populations. Each new program takes into consideration the needs of the targeted membership and develops requirements that foster appropriate care such as: comprehensive provider networks, easy access to care and adequate financing and administrative infrastructure.

NYSDOH has the infrastructure but not sufficient staff to begin implementation of the demonstration. Staff within various Divisions of the Office of Health Insurance Programs (OHIP) will take on most of the responsibility for the demonstration. This demonstration will be administered by the Division of Long Term Care within OHIP. Within DLTC, the Bureau of Managed Long Term Care will be assigned the responsibility to implement the demonstration. The Division of Quality and Evaluation (DQE) in OHIP will be responsible for all data analysis. The OHIP administrative office will be responsible for the execution of subcontracts. Contract staff will need to be brought in to fulfill critical components of implementation.

OHIP's Division of Program Development and Management is responsible for the administration of the Health Home Program, which will include care management to integrate services and supports for the fee for service dual eligible population.

As further described in Appendix E, Key NYSDOH FIDA project staff will include: Mr. Mark Kissinger, Director, Division of Long Term Care will be responsible for the oversight of the demonstration; Ms. Linda Gowdy, Director, Bureau of Managed Long Term Care, will be responsible for day to day administration of the demonstration; Mr. Patrick Roohan, Director, Division of Quality and Evaluation (DQE) who will be responsible for all analytic work related to this demonstration; Ms. Mary Beth Conroy, Director, Financial Research and Analysis Unit, within DQE who will be the lead analyst assigned to create a linked Medicaid and Medicare file for purposes of analysis; a Program Manager; 3 Program Coordinators; 2 Contract Coordinators; 1 Quality manager; 3 Hearing Officers; 3 QME staff persons; 2 Analytic Lead and Data Analysis staff persons; and 10 Monitoring and Oversight staff persons. Key OPWDD staff for the FIDA OPWDD program is Kate Marlay, Acting Deputy Director, Division of Person Centered Supports, at OPWDD. As also described in Appendix E, Key NYSDOH Health Home Program staff includes: Greg Allen, Division Director for Program Development and Management, Office of Health Insurance Programs, who will be responsible for the oversight of the Health Home demonstration, Lauren Tobias, Assistant Director of the Division of Program Development and Management, Denise

Spor and Deirdre Astin, Program Managers, Cynthia Buswell, Provider Support and Quality Assessment; Joann Susser, Systems Support, and Donna Ross, Communications, and five additional contract staff for implementation, coordination, and oversight.

### **External Consultants**

NYSDOH will procure consultants to assist in the implementation of the demonstration. As further described in Appendix E, Proposed contractors for this project include consultants for systems support, actuarial support, analytic support, stakeholder engagement, Enrollment Broker, and Participant Ombudsman.

### **Current Analytic Capability**

The Division of Quality and Evaluation, within the Office of Health Insurance Programs, has had the lead responsibility for evaluating the care provided to publicly funded insurance individuals, in both fee-for-service and managed care delivery systems, for over fifteen years. The Division is charged with collecting and analyzing data from various sources and for assuring data integrity. Through the use of standardized, as well as NYS-specific measures, NYSDOH has been able to monitor the cost, quality and utilization and describe successes and challenges in delivering care to populations at high risk of poor outcomes, describe the experiences of publicly insured individuals in various care settings (ambulatory, inpatient and LTSS) and promote quality improvement across the delivery system. Specifically related to any analysis of the under 65 dual population, staff in the DQE has done a comprehensive evaluation of the cost, quality and utilization of the non-dual SSI population in both managed care and fee-for-service Medicaid using both claims and encounter data.

The Division is staffed with a team of clinicians, programmers and analysts and has a long and successful history of linking Medicaid data with data from other sources, such as Vital Records and hospital discharge data and then using the linked files for analysis. The Division has used an iterative process, similar to the ones we have used for other linking exercises, for matching Medicare and Medicaid files to develop a linked database. The division has also overseen the administration of satisfaction with care surveys including the dual eligible population and validates encounter data submitted by MLTCP plans.

NYSDOH has established data-sharing agreements with CMS regarding the shared use of Medicare fee-for-service data for dually eligible Medicare recipients who reside in New York. NYSDOH is now receiving, housing, and analyzing the Medicare data that has been linked. This data set is being used primarily for research purposes and for obtaining a better understanding of the health service needs of the population. For example, linked Medicare data is used to measure preventable inpatient events including preventable admissions (PQIs preventive quality indicators), potentially preventable readmissions (PPRs), and potentially preventable complications (PPCs). The linked dataset helps NYS evaluate the quality of the care for dually eligible individuals by having the ability to calculate national performance measures including select HEDIS measures.

Under this demonstration, NYSDOH will collect and/or provide data to CMS to inform program management, rate development and evaluation, including but not limited to: beneficiary level expenditure data and covered benefits for most recently available three years, including available encounter data for the capitated models; description of any changes to the State plan that would affect Medicare-Medicaid enrollees during this three year period (e.g., payment rate changes, benefit design, addition or expiration of waiver, etc.); and state supplemental payments to providers (e.g., DSH, UPL) during the three-year period.

**ii. Medicaid and/or Medicare Rules to be Waived**

NYSDOH is identifying any waivers or other federal authority that would be needed for the provision of services not presently covered under the State Plan. At this time, NYSDOH envisions seeking exception to the applicable Medicare and Medicaid rules for purposes of providing an integrated appeal process and to the applicable Medicare enrollment rules to allow for passively enrolling the eligible population into plans and for limiting the frequency of enrollment into the FIDA program and plan changes within the FIDA program.

**iii. Description of Expansion Plans**

The roll-out of mandatory enrollment into the MLTCP throughout the state will lay the groundwork for and determine the capacity for future expansion of the FIDA program. Focusing on the eight contiguous New York City counties allows NYSDOH to develop, analyze, evaluate, and modify the FIDA program before expansion. It is anticipated, however, that by 2017, there should be infrastructure in place in several other service areas to permit expansion beyond the demonstration service area.

**iv. Overall Implementation Strategy and Anticipated Timeline**

The anticipated timelines for the two FIDA approaches and the Health Home approach are now contained in Appendix K. Major changes to the timeline from the March 22, 2012 draft include the FIDA OPWDD activities, the Health Home activities and some additional stakeholder activities.

The FIDA Program and the Health Home program will follow a coordinated implementation strategy that begins on May 3<sup>rd</sup> with the publishing of this second draft proposal for a second round of public comments, due to NYSDOH by May 17<sup>th</sup>. During the comment period, NYSDOH will conduct a statewide webinar and public meeting with stakeholders. As described in Section D.iii, beginning after the submission to CMS on May 25<sup>th</sup>, NYSDOH will form a stakeholder workgroup that will meet weekly to address the specific requirements NYSDOH should implement around key issues identified in the first round of comments. This workgroup will include subcommittees and will continue through the end of negotiations with CMS around the MOU provisions.

## **H. Feasibility and Sustainability**

### **i. Potential Implementation Barriers or Challenges**

Statewide restrictions on hiring could pose a barrier to successful implementation and serves as the reason that NYSDOH is requesting its implementation funds to be provided as a grant. NYSDOH is also evaluating the extent to which undertaking Affordable Care Act opportunities, such as the Balancing Incentive Payments Program or the Community First Choice Option would impact implementation.

### **ii. Necessary Statutory or Regulatory Changes**

NYSDOH anticipates that it will need state statutory authority to implement the FIDA OPWDD program. Additional statutory changes may be required for an integrated appeal process and for expansion of the continuity of care protections afforded under current NYS law.

### **iii. New State Funding or Contracting**

NYSDOH anticipates that it may need state authority to proceed with implementing this initiative.

### **iv. Scalability and Replicability**

The FIDA Demonstration will include approximately 18% of New York State's dual eligibles. The scalability and replicability of the demonstration's managed care model is tied to the network capacity in the other areas of the state. The state is rolling-out the mandatory enrollment into its MLTCP throughout the state during the demonstration period and these activities will lay the groundwork for and determine the capacity for future expansion of the FIDA program. It is anticipated, however, that by 2017, there should be infrastructure in place in other service areas to permit the expansion.

The Health Home demonstration will serve approximately 17% of New York State's dual eligibles. The program's initiative includes implementation for the entire State of New York. Currently, New York State Department of Health has participated in one national webinar for representatives from other States to educate them on the design and implementation of Health Homes and the potential for replicability in their State. This webinar was held in March, 2012. Currently NYSDOH serves as a model for all aspects of implementation of the program and is available as a resource for established policy and procedures.

### **v. Letters of Support**

Letters of Support will be included as Appendix O in the draft submitted to CMS on May 25, 2012.

## **I. CMS Implementation Support—Budget Request**

NYSDOH will request implementation support (in an amount to be identified in the draft submitted to CMS). Implementation funds will be used to enable NYSDOH to

offer an Independent Enrollment Broker and an Independent Participant Ombudsman to help Participants. These resources will be available to duals in both the FIDA and Health Home programs. These funds will also be used to enable NYSDOH to hire sufficient staff to analyze data, oversee implementation, undertake implementation activities, conduct plan surveillance and evaluation, assist in enrollment, and provide information and assistance to Participants. A proposed budget will be included as Appendix N in the draft submitted to CMS on May 25, 2012.

#### **J. Additional Documentation**

Not applicable.

#### **K. Interaction with Other HHS/CMS Initiatives**

##### **Partnership for Patients:**

The Partnership for Patients strives to improve the safety of healthcare by reducing preventable injuries in hospitals by 40% and cutting hospital readmissions by 20%. NYSDOH has a long-standing history of commitment to these goals. This demonstration will fully align with this HHS initiative. Providing safer care to patients while hospitalized and better care transitions out of the hospital setting are essential elements of the NYSDOH care delivery philosophy and will likewise be integral components of these programs.

In 2008, nearly 15% of all initial hospital stays in New York resulted in a readmission within 30 days.<sup>9</sup> These readmissions, which amounted to nearly 274,000 hospital stays in 2008, cost the state \$3.7 billion and made up 16% of total hospital costs. Readmissions for complications or infections cost New York State \$1.3 billion, accounting for nearly 6% of total hospital costs. More than half of readmissions and readmission costs were attributable to patients aged 65 or older.

In 2010, the NY legislature enacted provision 2807-c(35) under Article 28 of the Public Health Law and in 2011 the NYSDOH adopted new regulations at NYCRR 86-1.37 requiring a reduction in readmission rates and modifying payment provisions to create an incentive to reduce preventable readmissions. Under the payment provisions, the occurrence of preventable readmissions prompts a lower reimbursement rate for hospitals than does the absence of preventable readmissions. In accordance with its adopted policy positions supporting the importance of reducing preventable readmissions, NYSDOH is committed to including efforts around reducing readmissions in both the FIDA and Health Home programs and believes its payment provisions create incentives for providers to accomplish this. NYSDOH will develop quality measures on reduction of readmission rates and pay for performance payments for significant success in reducing of readmission rates. Reducing readmission rates is currently a Performance Improvement Project for ten Medicaid managed care plans.

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<sup>9</sup> "Reducing Hospital Readmissions in New York State: A Simulation Analysis of Alternative Payment Incentives", September 2011, NYS Health Foundation, available here: [http://www.nyshealthfoundation.org/userfiles/NYSHF\\_Mathematica%20Final\\_v5.pdf](http://www.nyshealthfoundation.org/userfiles/NYSHF_Mathematica%20Final_v5.pdf)

At the heart of efforts to reduce preventable readmissions is evidence-based research supporting the need to improve the nature of transitions across care settings. How one leaves a hospital and how prepared one is with tools, resources, supports, follow-up appointments, and other interventions can significantly decrease the likelihood of readmission. For this reason, all FIDA plans will be required to have and implement policies and procedures that will ensure successful care transitions. Health Homes will manage care transitions through care management and integration of services.

FIDA plans will be expected to implement interventions such as:

- Pre-discharge coordination and patient education;
- Early post-discharge contact of at-risk patients and facilitation of PCP follow-up;
- Care transition models such as Project RED or the Coleman model;
- Participant post-discharge disease/case management;
- Enhanced care coordination for primary care and behavioral health;
- Behavioral health and physical health integration;
- Patient education and self-management initiatives;
- Medication management; and
- Targeted early home care (in person or 'virtual').

Not only will all FIDA plans have to develop and implement protocols to reduce preventable readmissions including improvement in transitions across care settings, but they will have to institute strategies designed to reduce preventable injuries during hospitalizations. This not only aligns with the Partnership for Patients but is also required in NY state law. In accordance with 2807-c(35) under Article 28 of the Public Health Law, NYSDOH recently adopted regulations at NYCCRR 86-1.42 that establish a payment policy to incentivize reductions in preventable injuries. This provision articulates multiple preventable injuries that, should they occur, will not be eligible for reimbursement. Under this provision, NYSDOH denies reimbursement for hospital acquired conditions, which are avoidable hospital complications and medical errors that are identifiable, preventable, and serious in their consequences to patients.

### **HHS Action Plan to Reduce Racial and Ethnic Health Disparities**

The Action Plan outlines goals and actions HHS will take to reduce health disparities among racial and ethnic minorities, including increasing proportion of people with person-centered health homes and advancing translation for people with limited English proficiency. Remediating racial and ethnic health disparities is an established priority for NYSDOH. In January 2011, when Governor Andrew Cuomo created the Medicaid Redesign Team to find ways to reform and improve the New York State Medicaid program, work groups were developed around the most critical areas in need of reform. Work groups were created around such topics as Affordable Housing, Behavioral Health Reform, Managed Long Term Care Implementation and Waiver Redesign, and Health Disparities. The Health Disparities Work Group was charged with advising NYSDOH on initiatives, including establishment of reimbursement rates, to support providers' efforts to offer culturally competent care and undertake measures to address health disparities based on race, ethnicity, gender, age, disability, sexual orientation and gender expression. It was also charged with advising NYSDOH about

incorporating interpretation and translation services to patients with limited English proficiency and who are hearing impaired.

The Health Disparities Work Group met throughout 2011 and, in October 2011, issued its final report and recommendations<sup>10</sup>. Of the fourteen recommendations presented by the Work Group, NYSDOH is already in the process of implementing six, with plans to implement the remaining recommendations in the near years ahead. The Work Group recommendations currently being implemented system-wide include:

- Implementing and expanding data collection standards required by the Affordable Care Act by including detailed reporting on race and ethnicity, gender identity, the six disability questions used in the 2011 American Community Survey (ACS), and housing status. NYSDOH will also begin providing funding to support data analyses and research to facilitate NYSDOH work with internal and external partners to promote programs and policies that address health disparities, to improve quality and promote appropriate and effective utilization of services including the integration and analysis of data to better identify, and to understand and address health disparities.
- Adjusting Medicaid rates for hospital inpatient and outpatient departments, hospital emergency departments, diagnostic & treatment centers, and federally-qualified health centers to include reimbursement for the costs of interpretation services for patients with LEP and communication services for people who are deaf or hard of hearing.
- Initiating requirements for all chain pharmacies to provide translation and interpretation services for LEP patients, that standardized prescription labels be required to ensure understanding and comprehension especially by LEP individuals and that prescription pads be modified to allow prescribers to indicate if a patient is LEP, and if so, to note their preferred language.
- Integrating hepatitis care, treatment and supportive services into primary care settings including community health centers, HIV primary care clinics and substance use treatment programs.
- Promoting and addressing health care needs of persons with chemical dependency including allowing medical providers to prescribe syringes to prevent disease transmission; allowing harm reduction therapy as an appropriate and reimbursable treatment modality in OASAS facilities and by authorizing NYSDOH AIDS Institute Syringe Exchange providers to be reimbursed by Medicaid for harm reduction services provided to Medicaid eligible individuals.

Not only will both FIDA plans and Health Home providers be required to comply with requirements adopted in concert with these Health Disparities Work Group recommendations as they are enacted, but, these programs will also be required to adopt and implement policies ensuring culturally competent care coordination and service delivery, making oral interpretation services for any Participant that so requires, and making all written information available in prevalent languages. FIDA plan and

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<sup>10</sup> Medicaid Redesign Team Health Disparities Work Group Final Recommendations – October 20, 2011  
[http://www.health.ny.gov/health\\_care/medicaid/redesign/docs/health\\_disparities\\_report.pdf](http://www.health.ny.gov/health_care/medicaid/redesign/docs/health_disparities_report.pdf)

Health Home program policies must reflect the extension of these obligations to all participating providers and contractors.

Both the Enrollment Broker and the Participant Ombudsman will be held to similar requirements. The Enrollment Broker will be required to employ staff members to provide translation or interpretation functions; pay for direct translator/interpreter assistance; and translate outreach materials into other languages. The Participant Ombudsman will be required to outreach to Participants in and provide their assistance in prevalent languages or with the assistance of translation services.

Plans shall translate vital documents, including but not limited to forms, plan information, and educational materials, into the six most common non-English languages spoken by individuals with limited-English proficiency in the State of New York, based on United States census data.<sup>11</sup> For the Health Home program, consideration for language literacy and cultural preference has been provided through the translation of enrollment, consent and opt-out forms into seven different languages. The seven languages are: Spanish, Chinese, Italian, Russian, French, Korean and French Creole. A functional assessment tool and Health Home questionnaire which are completed by the care manager at initial assessment, annually and at disenrollment and have also been translated into these seven languages.

### **Million Hearts Campaign**

Both the FIDA and Health Home program align well with the Million Hearts initiative to prevent one million heart attacks and strokes over the next five years by promoting the “ABCS” of clinical prevention (appropriate aspirin therapy, blood pressure control, cholesterol control, and smoking cessation) as well as healthier lifestyles and communities. Additionally, with the addition of a broad array of Health Education and Wellness services as covered services under the FIDA program, direct attention will now be given to ensuring that health education around symptoms, prevention, and detection of cardiac disease that has not previously been provided under NYSDOH Medicaid programs. Additionally, NYSDOH is establishing improvement targets specifically on education around prevention of heart attacks and stroke and may also develop performance incentives around this measure.

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<sup>11</sup> This aligns with Executive Order #26 - <https://www.governor.ny.gov/print/1932>.

## **Appendix A GLOSSARY AND ACRONYMS**

Fully-Integrated Duals Advantage Program - The fully-integrated Medicare and Medicaid managed care program for full dual eligibles in the eight county area of Bronx, Kings, Nassau, New York, Queens, Richmond, Suffolk, and Westchester that would be created under this demonstration.

Managed Long Term Care Program – The NYSDOH managed care program that contracts with Medicaid Advantage Plus plans, Partially Capitated Managed Long Term Care plans, PACE plans, and Care Coordination Model plans to provide managed LTSS to eligible consumers.

Medicaid Advantage Program – The partially-integrated Medicare and Medicaid managed care program for full dual eligibles who do not require LTSS.

Medicaid Advantage Plus Program – The partially-integrated Medicare and Medicaid managed care program for full dual eligibles who do not require LTSS.

Medicaid Redesign Team – A group of stakeholders that have been appointed and tasked by Governor Cuomo to find ways to reduce costs and increase quality and efficiency in the Medicaid program.

Patient-Centered Care – Care that recognizes the patient or designee as the source of control and full partner in providing compassionate and coordinated care based on respect for patient's preferences, values, and needs.

Participant – A full dual eligible individual who is enrolled in a FIDA plan.

Program of All-Inclusive Care for the Elderly (PACE) – The fully-integrated Medicare and Medicaid managed care program built around an enhanced adult day care center that is available in select service areas of New York State.

Partially Capitated MLTC Plan – A managed care plan that provides Medicaid LTSS only to both dual eligibles and individuals who qualify only for Medicaid.

### Acronyms:

FIDA – Fully-Integrated Duals Advantage

LEP – Limited English Proficiency

LTSS – Long-Term Supports and Services

MAP – Medicaid Advantage Plus

MLTCP – Managed Long Term Care Program

MRT – Medicaid Redesign Team

NYSDOH – New York State Department of Health

PACE – Program of All-Inclusive Care for the Elderly

## APPENDIX B

### Covered Services and Excluded Services

The chart below lists those services covered by the existing Medicare and Medicaid programs in New York as well as those services that will be added in the creation of the FIDA program. The Health Home program provides comprehensive, person-centered care coordination to facilitate and streamline access to Medicare FFS, Medicaid FFS, and other benefits for which they are eligible. The Health Home program provides needs assessment, care planning, and ongoing care coordination and while it will significantly improve access to covered services, it does not provide covered services itself. Managed FFS dual eligible Health Home members are eligible for Medicare (Part A, B and D) and Medicaid State Plan services provided via FFS. Care managers with expertise in the unique needs of the dually eligible population will coordinate access to these services to provide dual eligibles meeting Health Home selection criteria with access to an integrated continuum of physical, medical, behavioral health services, rehabilitative, some long term care and social service needs. Reflecting their substantial health needs, dual eligibles often see multiple providers, use multiple prescription drugs, and do not have a single entity coordinating their care. A dedicated care manager will be accountable for the management of all services, both Medicare and Medicaid, and coordination with the member’s primary care physician/nurse practitioner, specialist(s), behavioral health care provider(s), care manager and other providers directly involved in the individual’s care. Care managers with knowledge of behavioral health, aging , appropriate support services in the community, frequently used medications and their potential negative side-effects, depression, challenging behaviors, Alzheimer’s disease and other disease-related dementias will enhance the Health Home care manager’s ability to work effectively with the Health Home’s interdisciplinary team and access necessary services for the dually eligible population.

The FIDA program will include the following services:

Abdominal Aortic Aneurism Screening	Mammograms
Adult Day Health Care	Medicaid Pharmacy Benefits as allowed by State Law
AIDS Adult Day Health Care	Medical Nutrition Therapy
Ambulance	Medical Social Services
Ambulatory Surgical Centers	Medicare Cost Sharing
Assertive Community Treatment (ACT)	Medicare Part D Prescription Drug Benefit as Approved by CMS
Assisted Living Program	Medication Therapy Management
Bone Mass Measurement	Mobile Mental Health Treatment
Cardiac Rehabilitation Services	Moving Assistance
Cardiovascular Disease Screening	Non-Emergency Transportation
Case Management for Seriously and Persistently Mentally Ill	Nutrition
Cervical and Vaginal Cancer Screening	OMH Licensed CRs

Chemotherapy	Other Supportive Services the Interdisciplinary Team Determines Necessary <sup>12</sup>
Chiropractic	Outpatient Drugs
Colorectal Screening	Outpatient Hospital Services
Community Integration Counseling	Outpatient Mental Health
Community Transitional Services	Outpatient Rehabilitation (OT, PT, Speech)
Comprehensive Medicaid Case Management	Outpatient Substance Abuse
Consumer Directed Personal Assistance Services	Outpatient Surgery
Continuing Day Treatment	Palliative Care
Day Treatment	Pap Smear and Pelvic Exams
Defibrillator(implantable automatic)	Partial Hospitalization (Medicaid)
Depression Screening	Partial Hospitalization (Medicare)
Dental	PCP Office Visits
Diabetes Monitoring (Self-Management Training)	Peer-Delivered Services
Diabetes Screening	Peer Mentoring
Diabetes Supplies	Personal Care Services
Diagnostic Testing	Personal Emergency Response Services (PERS)
Durable Medical Equipment (DME)	Personalized Recovery Oriented Services (PROS)
Emergency Care	Podiatry
Environmental Modifications	Private Duty Nursing
Family-Based Treatment	Prostate Cancer Screening
Health/Wellness Education	Prosthetics
Health Homes	Pulmonary Rehabilitation Services
Hearing Services	Routine Physical Exam 1/year
HIV COBRA Case Management	Service Coordination
HIV Screening	Skilled Nursing Facility
Home and Community Support Services	Smoking and Tobacco Cessation
Home Delivered and Congregate Meals	Social and Environmental Supports
Home Health	Social Day Care
Home Maintenance Services	Social Day Care Transportation
Home Visits by Medical Personnel	Specialist Office Visits
Immunizations	Structured Day Program
Independent Living Skills and Training	Substance Abuse Program
Inpatient Hospital Care (including Substance Abuse and Rehabilitation Services)	Telehealth
Inpatient Services during a non-covered inpatient stay	Urgent Care
Inpatient Mental Healthcare	Vision Care Services
Inpatient Mental Health over 190-day Lifetime Limit	Wellness Counseling
Intensive Psychiatric Rehabilitation Treatment Programs	
Kidney Disease Services	

The OPWDD FIDA demonstration will also include additional services specifically related to the OPWDD population.

<sup>12</sup> This is meant to cover items or services that are not traditionally included in these programs but that are necessary and appropriate for the Participant. One example provided in the comments allowed for a plan providing nutrition services to a participant who cannot chew to be allowed and encouraged to use plan dollars to pay for a blender to puree foods.

Four services will continue to be provided through the Medicare or Medicaid Fee-for-Service programs, however, a Participant's interdisciplinary care coordination team within his/her FIDA plan will be responsible for arranging and ensuring receipt of these when called for in a Participant's care plan. These are:

- Medicare and Medicaid Hospice services<sup>13</sup>,
- Out of Network Family Planning services,
- Directly Observed Therapy for Tuberculosis, and
- Methadone Maintenance Treatment.

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<sup>13</sup> Several commenters recommended adding Hospice into the array of services that must be covered by the FIDA plans. Because we want to ensure Participants have the broadest possible choice of hospice providers, we are keeping this service as a FFS service. The plans will be required to assist Participants in accessing it, however the plans will not have to include hospice providers in their network.

## Appendix C

### Rights and Responsibilities

Each FIDA plan must have, maintain, and implement written policies and procedures regarding Participant rights which fulfill the requirements of 42 CFR 438.100 and all applicable Federal and State law and regulation. The FIDA plan's policies and procedures must require that neither the Contractor nor its Participating Providers adversely regard a Participant who exercises his/her rights as described herein. The FIDA plan's policies and procedures must require the plan's employees and subcontractors to comply with and protect Participant rights. If a Participant lacks capacity to exercise these rights, the rights shall be exercised by an individual, guardian or entity legally authorized to represent the Participant.

Specifically, Participants have the following rights:

1. To receive medically necessary care;
2. To receive timely access to care and services;
3. To request and receive written and oral information about the plan, its providers, its benefits and services and the Participants rights and responsibilities in a manner the Participant understands. This includes the right to receive materials and/or assistance in a foreign language and in alternate formats, if necessary.
4. To be provided qualified interpreters, free of charge, if a Participant needs interpreters during appointments with providers and when talking to his/her plan;
5. To be treated with consideration, respect and full recognition of his or her dignity and individuality;
6. To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation;
7. Not to be neglected, intimidated, physically or verbally abused, mistreated or exploited;
8. To get care without regard to sex, race, health status, disability, color, age, national origin, sexual orientation, marital status or religion;
9. To be told where, when and how to get the services the Participant needs, including how to get covered benefits from out-of-network providers if they are not available in the plan network;
10. To complain to NYSDOH or the Local Department of Social Services; and, the Right to use the New York State Fair Hearing System and/or a New York State External Appeal, where appropriate;
11. To be advised in writing of the availability of the NYSDOH toll-free hotline, the telephone number, the hours of its operation and that the purpose of the hotline is to receive complaints or answer questions about home care agencies.
12. To appoint someone to speak for him/her about the care he/she needs.
13. To be informed of all rights, and the right to exercise such rights, in writing prior to the effective date of coverage;

14. To participate in his/her care planning and participate in any discussions around changes to the plan of care, if/when they are warranted;
15. To recommend changes in policies and services to agency personnel, NYSDOH or any outside representative of the patient's choice;
16. To have telephone access to a medical professional from the plan 24/7 in order to obtain any needed emergency or urgent care or assistance;
17. To access care without facing physical barriers. This includes the right to be able to get in and out of a care provider's office, including barrier-free access for Participants with disabilities or other conditions limiting mobility, in accordance with the Americans with Disabilities Act;
18. To receive reasonable accommodations in accessing care, in interacting with the FIDA plan and providers, and in receiving information about one's care and coverage;
19. To see a specialist and request to have a specialist serve as primary care physician;
20. To talk with and receive information from providers on all conditions and all available treatment options and alternatives, regardless of cost, and to have these presented in a manner the Participant understands. This includes the right to be told about any risks involved in treatment options and about whether any proposed medical care or treatment is part of a research experiment.
21. To choose whether to accept or refuse care and treatment, after being fully informed of the options and the risks involved. This includes the right to say yes or no to the care recommended by providers, the right to leave a hospital or other medical facility, even if against medical advice, and to stop taking a prescribed medication.
22. To receive a written explanation if services or care were denied, without have to request a written explanation.
23. To have privacy in care, conversations with providers, and medical records such that:
  - Medical and other records and discussions with providers will be kept private and confidential;
  - Participant gets to approve or refuse to allow the release of identifiable medical or personal information, except when the release is required by law
  - Participant may request that any communication that contained protected health information from the plan be sent by alternative means or to an alternative address;
  - Participant is provided a copy of the plan's Privacy Practices, without having to request the same;
  - Participant may request and receive a copy of his or her medical records and request that they be amended or corrected, as specified in 45 CFR 164.524 and 164.526., if the privacy rule, as set forth in 45 CFR 160 and 164, A and E, applies; and
  - Participant may request information on how his/her health and other personal information has been released by the plan;
24. To seek and receive information and assistance from the independent, conflict free Participant Ombudsman;

25. To make decisions about providers and coverage, which includes the right to choose and change providers within the plan network and to choose and change coverage (including how one receives his/her Medicare and/or Medicaid coverage);
26. To be informed at the time of enrollment of the right to make an “advance directive” – giving instructions about what is to be done if the Participant is not able to make medical decisions for him/herself - and to have the plan and its providers honor it; and
27. To access information about the plan, its network of providers, and your covered services including:
  - information about the plan’s financial condition, its performance rating, how it compares to other plans, the number of appeals made by Participants;
  - information about the qualifications of the providers and how they are paid; and
  - information about the rules and restrictions on covered services.

**FIDA Participants have the following responsibilities:**

1. To try to understand covered services and the rules around getting covered services;
2. To tell providers that they are enrolled in a FIDA plan and show their FIDA plan ID card;
3. To treat Providers and employees of the plan with respect;
4. To communicate problems immediately to the plan;
5. To accept help from the plan’s employees without regard to race, religion, color, age, sex, national origin, or disability of the employee or Contractor;
6. To keep appointments or notify the interdisciplinary team if an appointment cannot be kept;
7. To supply accurate and complete information to the plan’s employees;
8. To actively participate in Care Plan development and implementation;
9. To notify the state and the plan of any changes in income and assets. Assets include bank accounts, cash in hand, certificates of deposit, stocks, life insurance policies, and any other assets;
10. To ask questions and request further information regarding anything not understood;
11. To use the plan’s designated providers for services included in the benefit package;
12. To notify the plan of any change in address or lengthy absence from the area;
13. To comply with all policies of the plan as noted in the Participant Handbook;
14. To take prescribed medicines;
15. If sick or injured, to call their doctors or care coordinators for direction right away;
16. In case of emergency, to call 911; and
17. If Emergency Services are required out of the service area, to notify the plan as soon as possible.

## **Appendix D Provider Network Access and Adequacy Standards**

The provider network must meet nothing less than the existing applicable Medicare and Medicaid provider network requirements. Additionally, the provider network must meet all of the following requirements and in no instance may any plan's network have less than two of any provider type necessary to provide covered services.

All providers' physical sites must be accessible to all Participants as must all providers that deliver services in the Participants' locations.

FIDA plans must establish and implement mechanisms to ensure that Participating Providers comply with timely access requirements, monitor regularly to determine compliance and take corrective action if there is a failure to comply.

The following minimum appointment availability standards apply:

- 1) For emergency care: immediately upon presentation at a service delivery site.
- 2) For urgent care: within twenty-four (24) hours of request.
- 3) Non-urgent "sick" visit: within forty-eight (48) to seventy-two (72) hours of request, as clinically indicated.
- 4) Routine non-urgent, preventive appointments: within four (4) weeks of request.
- 5) Specialist referrals (not urgent): within two (2) to four (4) weeks of request.
- 6) Pursuant to an emergency or hospital discharge, mental health or substance abuse follow-up visits with a Participating Provider (as included in the Benefit Package): within five (5) days of request, or as clinically indicated.
- 7) Non-urgent mental health or substance abuse visits with a Participating Provider (as included in the Benefit Package): within two (2) weeks of request.
- 8) Provider visits to make health, mental health and substance abuse assessments for the purpose of making recommendations regarding a recipient's ability to perform work within ten (10) days of request.
- 9) Mental Health Clinics must provide a clinical assessment within five (5) days for individuals in the following designated groups:
  - Individuals in receipt of services from a mobile crisis team not currently receiving treatment
  - Individuals in domestic violence shelter programs not currently receiving treatment
  - Homeless individuals and those present at NYC homeless shelters who are not currently receiving treatment
  - Individuals aging out of foster care who are not currently receiving treatment
  - Individuals who have been discharged from an inpatient psychiatric facility within the last 60 days who are not currently receiving treatment
  - Individuals referred by rape crisis centers
  - Individuals referred by the court system.

Each FIDA plan must provide access to medical services and coverage to Participants, either directly or through their PCPs and OB/GYNs, on a twenty-four (24) hour a day, seven (7) day a week basis. The plan must instruct Participants on what to do to obtain services after business hours and on weekends.

Participants with appointments shall not routinely be made to wait longer than one hour.

FIDA plans must have a network that is geographically accessible to the population to be served.

- Travel time/distance to primary care sites shall not exceed thirty (30) minutes from the Participant's residence in metropolitan areas or thirty (30) minutes/thirty (30) miles from the Participant's residence in non-metropolitan areas.
- Participants may, at their discretion, select participating PCPs located farther from their homes as long as they are able to arrange and pay for transportation to the PCP themselves. Travel time/distance to specialty care, hospitals, mental health, lab and x-ray providers shall not exceed thirty (30) minutes/thirty (30) miles from the Participant's residence.
- Travel time and distance will be calculated on a typical day of traffic volume.
- Plans shall make reasonable accommodations, including access to out-of-network providers, if necessary, so that no Participant that is too frail to travel 30 minutes or 30 miles shall be required to do so to see a network provider.

Plans are required to coordinate Participant transportation.

Participants must be assured choice of all providers, including the care coordination and other that will participate in their interdisciplinary team.

Paid family caregiving will be permitted in accordance with 18 NYCRR § 505.14 (h)(2).

FIDA plans are directly responsible for the provision of all other covered services (regardless of whether access is through a subcontracted behavioral health organization that is accountable to the FIDA plan and for which the FIDA plan is accountable to NYSDOH, or directly through the plan's network of providers).

## Appendix E

### FIDA and Health Home Program Staff

The FIDA project staff includes:

- Mr. Mark Kissinger, Director, Division of Long Term Care will be responsible for the oversight of the demonstration.
- Ms. Linda Gowdy, Director, Bureau of Managed Long Term Care, will be responsible for day to day administration of the demonstration. She will supervise the demonstration program coordinator and program administrator and will managed the work of all subcontractors funded under this demonstration. Ms. Gowdy has over 25 years of professional experience working in NYSDOH primarily on programs designed to support the health needs of the low income elderly.
- 1 Staff Person to serve as Program Manager that will be responsible for implementation of the demonstration.
- 3 Staff Persons to serve as Program Coordinators that will be responsible to resolve program and Participant issues.
- 2 Staff Persons to serve as Contract Coordinators that will be responsible for oversight of the contracts between NYSDOH and the FIDA plans. They will work with assigned plans to ensure compliance with contract requirements.
- 1 Staff Person to serve as Quality Manager, to oversee and manage reporting on quality management with individual plans and across the program.
- 3 Staff Persons to serve as Hearing Officers, to add capacity at the Hearings unit for processing appeals for dual eligibles related to the Demonstration.
- Mr. Patrick Roohan, Director, Division of Quality and Evaluation (DQE) will be responsible for all analytic work related to this demonstration. Mr. Roohan has over 25 years experience in conducting and overseeing health services research in NYSDOH. He and his staff will be responsible for receiving, housing, linking and protecting confidential Medicare data as well as overseeing analysis of the linked Medicaid/Medicare data file.
- 3 Staff Persons for Quality Measurement and Evaluation to conduct and analyze short-cycle and longer-cycle quality measurement and state evaluation activities, development and deployment of survey tools, costs of accessing, transferring, and analyzing data and other quality data, and report infrastructure development.
- Ms. Mary Beth Conroy, Director, Financial Research and Analysis Unit, within DQE will be the lead analyst assigned to create a linked Medicaid and Medicare file for purposes of analysis. Ms. Conroy has over 20 years of experience in health services research and financial analysis and is the lead on risk adjustment payment methodologies for managed care and MLTC.
- 2 Staff Persons to serve as Analytic Lead and Data Analysts who will be responsible for monitoring, collecting, and tracking data around key metrics. They will also aggregate, analyze, and report on encounter data, quality data, financial data for quality control and other purposes. They will also be

responsible for extrapolating key information from the Medicare data that has recently been made available to NYSDOH.

- 10 Staff Persons to conduct monitoring and oversight of the program.

The FIDA OPWDD project staff includes: Kate Marlay, Acting Deputy Director, Division of Person Centered Supports, OPWDD.

The Health Home project staff includes:

- Greg Allen, Division Director for Program Development and Management, Office of Health Insurance Programs will oversee the Health Home demonstration
- Lauren Tobias, Assistant Director of the Division of Program Development and Management, is responsible for the implementation of the Health Home Program and for the oversight of the demonstration.
- Denise Spor and Deirdre Astin will serve as Program Managers for the Health Home Program and for the demonstration project. Denise and Deirdre both have over 20 years of experience with NYSDOH in the administration and management of public health programs.
- Three NYSDOH staff members that work within the Health Home Program will be assigned to administer aspects of the demonstration project: Cynthia Buswell, Provider Support and Quality Assessment; Joann Susser, Systems Support, and Donna Ross, Communications.
- Five additional contract staff members have been assigned to implementation of Health Homes and will also be responsible for project coordination and various oversight activities related to the demonstration project.

### **External Consultants**

NYSDOH will procure consultants to assist in the implementation of the demonstration. Proposed contractors for this project (both the FIDA and Health Home pieces) include:

- Systems Support- An IT firm experienced in working with New York State Medicaid data systems will be hired to automate the algorithms for identification of Health Home eligible populations and assignment to Health Homes and for the design of systems to facilitate reporting and monitoring of process metrics, quality measures and the integration with claims and encounter data.
- Actuarial Support – A consultant firm experienced in working with New York State will be hired to assure the actuarial soundness of rates for the demonstration, analytical support during procurement, and development or purchase of risk adjustment tools.
- Analytic Support – A consulting firm with experience in working with dual eligibles will be hired to respond to questions and support NYSDOH activities around data, policies and procedures.

- Stakeholder Engagement – While NYSDOH staff and other state agency staff will be organizing and involved in gathering stakeholder input, it is necessary to hire a consultant group who can assist in scheduling and moderating meetings, developing communications tools, including website content for updates, and can organize larger forums, including scheduling and securing meeting space. The consultant will be responsible synthesizing the recommendations that emanate from all stakeholder discussions.
- Enrollment Broker – A contractor will be used to serve as Enrollment Broker to assist new enrollees and existing Participants with making plan choices.
- Participant Ombudsman – A contractor will be used to serve as the Participant Ombudsman to provide information and advocacy services to FIDA program Participants.

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## **Appendix F**

### **Health Home Member Assignment**

Eligible health home members will be assigned directly to approved Health Home networks by the State and will be assigned through health plans for members enrolled in Medicaid Managed Care. Initial assignment to State approved Health Home providers will be based on:

1. Higher Predictive Risk for Negative Event (Inpatient, Nursing Home, Death)
2. Lower or no Ambulatory Care Connectivity
3. Provider Loyalty (Ambulatory, Case Management, ED and Inpatient)
4. Geographic Factors

The State has developed eligible lists of patients sorted from highest to lowest predictive risk. The State is working on the development of patient rosters for each county rollout that take the factors above into priority consideration for initial health home assignment. The goal is to assign and outreach to the highest risk (based on a predictive model) and highest cost members with the lowest primary and ambulatory care connectivity in each health home area. Once those members have been assigned and enrolled then the State will move down the list using provider loyalty and geography as markers for initial health home assignment.

## Appendix G

### Participant Ombudsman Description

The Participant Ombudsman (PO) that is proposed for the Fully-Integrated Duals Advantage program would be an independent entity under contract with NYSDOH to help Participants and their caregivers access the care Participants need through the FIDA program. The PO would be neither part of the plan nor part of the state.

**How would one access the Participant Ombudsman?** The PO would be reached through a toll-free number and would be available at least 9-5, M-F.

**With what issues would the Participant Ombudsman be able to provide information or assistance?** The PO would be staffed and trained to provide information and assistance to:

- i. Explain all FIDA benefits, coverage and access rules and procedures;
- ii. Explain all FIDA Member rights and responsibilities;
- iii. Explain Medicaid, Medicare and FIDA eligibility;
- iv. Assist Participants in exercising their FIDA rights and responsibilities;
- v. Assist Participants in accessing covered benefits – including requesting prior authorization, obtaining referrals, advising providers on medical necessity requirements, conferring with interdisciplinary team re: overcoming obstacles to access;
- vi. Accessing records from the FIDA plan;
- vii. Assist Participants in raising and resolving quality of care and quality of life issues;
- viii. Assist Participants in ensuring that the plan honors their privacy and allows them to exercise their decision making authority;
- ix. Assist Participants in understanding and participating in the interdisciplinary care planning and interdisciplinary team work around care coordination;
- x. Conduct Participant education and outreach about rights, access rules and procedures, etc.; and
- xi. Develop Participant education materials about the availability of the PO, the steps of the appeals processes, etc.

**What would it cost to get help from the Participant Ombudsman?** There would be no cost to the Participant for receiving information or assistance from the Participant Ombudsman. NYSDOH would pay the PO to provide this free service to Participants.

**What qualifications would be established for agencies that might wish to apply to be the Participant Ombudsman?** NYSDOH will require an applicant entity be able to demonstrate success in running a call-in center with caller tracking, trending, and reporting; be able to demonstrate experience in dealing with this or a similar population on time-sensitive issues and in resolving or helping to resolve those issues; and have no personal, professional, or financial relationship with or interest in any of the FIDA plans.

**How would the availability of the PO be made known to Participants?** The availability could be noted in Participant Rights and Responsibilities Materials, on written denial, reduction or termination notices, and in Participant Handbooks. Participants may also be referred to the Participant Ombudsman by HICAP, NY Connects, the LTC Ombudsmen, local legal services, the FIDA Enrollment Broker, or NYSDOH.

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## Appendix H

### POTENTIAL IMPROVEMENT TARGETS FOR FIDA PROGRAM

The following are potential improvement targets that NYSDOH is considering for the FIDA program. Participant-specific quality measures will evolve over time. NYSDOH intends to publicly post improvement targets, metrics, and plan performance and comparisons to established benchmarks.

- Improved use of pharmacy; reduced number of medications used and medication complications
- Reduced unnecessary and duplicative diagnostic tests
- Improved health status, quality of life, and satisfaction from avoidance of unneeded transfers to hospitals
- Lower use of emergency departments, hospitals, and nursing homes
- Number of hospitalizations
- Wait times for appointments
- Number of skilled nursing facility admissions
- Increased member participation in disease –specific education and self-directed care
- Decrease in institutional long term care (Medicare skilled nursing days
- % of consumers screened, referred for behavioral health care who receive concurrent medical management to avoid adverse events
- % of consumers who receive recommended treatment and follow-up related to identified chronic conditions
- Percent decrease in inpatient admissions due to behavioral health diagnoses
- Percent reduction in 30-60 day readmissions
- Percent reduction in avoidable emergency department visits
- Use of high-risk medications in the elderly
- Percent of consumers who receive a timely assessment
- Screening for Fall Risk; preventing falls and other accidents
- Maintaining and improving the ability to perform ADLs
- % of enrollees over baseline receiving communication materials in alternative formats, where appropriate.
- Reduction in preventable health-care acquired conditions and errors
- Integration of patient/family feedback on preferences, desired outcomes, and experiences into all care settings and delivery.
- Use of advance directives
- Reduction in pressure ulcers
- Heart attack and stroke prevention activities.

## Appendix I

### Health Home Goals and Quality Measures

#### Quality Measures: Goal based Quality Measures

##### **Goal 1: Reduce utilization associated with avoidable (preventable) inpatient stays**

<b>Measures</b>	<b>Data Source</b>	<b>Specifications</b>	<b>HIT Utilization</b>
Inpatient Utilization – General hospital/Acute Care	Claims	(HEDIS 2012 – Use of Services) The rate of utilization of acute inpatient care per 1,000 member months. Data is reported by age for categories: Medicine, Surgery, Maternity and Total Inpatient.	Inpatient stays will be identified from administrative claims. Results of aggregated rates will be shared with health homes including their results and benchmarking to the overall peer results.

##### **Goal 2: Reduce utilization associated with avoidable (preventable) emergency room visits**

<b>Measures</b>	<b>Data Source</b>	<b>Specifications</b>	<b>HIT Utilization</b>
Ambulatory Care (ED Visits)	Claims	(HEDIS 2012 – Use of Services) The rate of ED visits per 1,000 member months. Data is reported by age categories.	Emergency Department visits will be identified from administrative claims. Results of aggregated rates will be shared with health homes including their results and benchmarking to the overall peer results.

##### **Goal 3: Improve Outcomes for persons with Mental Illness and/or Substance Use Disorders**

###### 1. Clinical Outcomes

<b>Measures</b>	<b>Data Source</b>	<b>Specifications</b>	<b>HIT Utilization</b>
Mental Health Utilization	Claims	(HEDIS 2012 – Use of Services) The number and percentage of members receiving the following mental health services during the measurement year. <ul style="list-style-type: none"> <li>• Any service</li> <li>• Inpatient</li> <li>• Intensive outpatient or partial hospitalization</li> </ul>	Mental health services will be identified by data analysis of administrative claims. Results of aggregated rates will be shared with health homes including their results and benchmarking to the overall peer results.

		• Outpatient or ED	
Follow Up After Hospitalization for Mental Illness	Claims	(HEDIS 2012 - Effectiveness of Care) Percentage of discharges for treatment of selected mental illness disorders who had an outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health provider within 7 days and within 30 days of discharge.  In addition, 'retention' in services, defined as at least five qualifying visits (see above) with mental health providers within 90 days of discharge.	The transition of care HEDIS indicator is developed from treatment guidelines. The State's Office of Mental Health added quantification standards for retention to capture quality of ongoing care for a persistently severe mentally ill population targeted by NYS SPA for Health Home. The follow up visits will be identified from vendor data and claims. We will use data analytics to aggregate results by health home and compare to peers.
Follow up After Hospitalization for Alcohol and Chemical Dependency Detoxification	Claims	(New York State Specific) The percentage of discharges for specified alcohol and chemical dependency conditions that are followed up with visits with chemical treatment and other qualified providers within 7 days and within 30 days and who have ongoing visits within 90 days of the discharges.	The transition of care is patterned after the HEDIS indicator for mental health. The State's Office of Alcohol and Substance Abuse Services added quantification standards for retention to capture quality of ongoing care for a chemically dependent population targeted By NYS SPA for Health Home. The follow up visits will be identified from vendor data and claims. We will use data analytics to aggregate results by health home and compare to peers.

**Goal 3: Improve Outcomes for persons with Mental Illness and/or Substance Use Disorders-continued**

2. Quality of Care

Measures	Data Source	Specifications	HIT Utilization
Antidepressant Medication Management	Claims and Pharmacy	(HEDIS 2012 - Effectiveness of Care) Percentage of members who had a new diagnosis of depression and treated with an antidepressant medication who remained on the antidepressant for acute	The medication adherence HEDIS indicators are developed from treatment guidelines. We will use data analytics with administrative claims data to calculate the results which will be shared with the health homes

		phase and recovery phase of treatment.	and will include benchmarks to peers.
Adherence to Antipsychotics for Individuals with Schizophrenia	Claims and Pharmacy	(RAND section 2701 ACA proposed measure) Percentage of patients with a schizophrenia diagnosis who received an antipsychotic medication that had a proportion of days covered (PDC) for antipsychotic medication $\geq 0.8$ during the measurement period.	This medication adherence indicator is based on the RAND measure and includes advice from the State's mental health agency to better reflect the standards of quality of care for a persistently severe mentally ill population targeted for Health Home. We will use data analytics with administrative claims data to calculate the results which will be shared with the health homes and will include benchmarks to peers.
Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder	Claims and Pharmacy	(RAND section 2701 ACA proposed measure) Percentage of patients with bipolar I disorder who received a mood stabilizer medication that had a proportion of days covered (PDC) for mood stabilizer medication $\geq 0.8$ during the measurement period.	This medication adherence indicator is based on the RAND measure and includes advice from the State's mental health agency to better reflect the standards of quality of care for a persistently severe mentally ill population targeted for Health Home. We will use data analytics with administrative claims data to calculate the results which will be shared with the health homes and will include benchmarks to peers.

#### Goal 4: Improve Disease-Related Care for Chronic Conditions

Measures	Data Source	Specifications	HIT Utilization
Use of Appropriate Medications for People with Asthma	Claims and Pharmacy	(HEDIS 2012 - Effectiveness of Care) Percentage of members who are identified with persistent asthma and who were appropriately prescribed preferred asthma medication.	The medication adherence HEDIS indicator is developed from treatment guidelines. We will use data analytics with administrative claims data to calculate the results which will be shared with the health homes and will include benchmarks to peers.
Medication Management for People With Asthma	Claims and Pharmacy	(HEDIS 2012 – Effectiveness of Care) The percentage of members who were identified as having persistent asthma and were dispensed	The medication adherence HEDIS indicator is developed from treatment guidelines. We will use data analytics with administrative claims data to

		appropriate medications in amounts to cover: 1) at least 50% of their treatment period and 2) at least 75% of their treatment period.	calculate the results which will be shared with the health homes and will include benchmarks to peers.
Comprehensive Diabetes Care (HbA1c test and LDL-c test)	Claims, Pharmacy	(HEDIS 2012 - Effectiveness of Care) Percentage of members with diabetes who had at least one HbA1c test and at least one LDL-C test.	The service-related HEDIS indicators are developed from treatment guidelines. We will use data analytics with administrative claims data to calculate the results which will be shared with the health homes and will include benchmarks to peers.
Persistence of Beta-Blocker Treatment after Heart Attack	Claims and Pharmacy	(HEDIS 2012 - Effectiveness of Care) Percentage of members who were hospitalized and discharged alive with a diagnosis of AMI and who received persistent beta-blocker treatment for six months after discharge.	The medication adherence HEDIS indicators are developed from treatment guidelines. We will use data analytics with administrative claims data to calculate the results which will be shared with the health homes and will include benchmarks to peers.
Cholesterol Testing for Patients with Cardiovascular Conditions	Claims, Pharmacy	(HEDIS 2012 - Effectiveness of Care) Percentage of members who were discharged alive for AMI, CABG or PCI or who have a diagnosis of IVD and who had at least one LDL-C screening.	The service-related HEDIS indicators were developed from treatment guidelines. We will use data analytics with administrative claims data to calculate the results which will be shared with the health homes and will include benchmarks to peers.
Comprehensive Care for People Living with HIV/AIDS	Claims and Pharmacy	(NYS Specific QARR 2010) Percentage of members living with HIV/AIDS who received the following services: (A) two outpatient visits with primary care with one visit in the first six months and one visit in the second six months, (B) viral load monitoring, and (C) Syphilis screening for all who 18 and older.	The service-related HEDIS indicators were developed from treatment guidelines. We will use data analytics with administrative claims data to calculate the results which will be shared with the health homes and will include benchmarks to peers.

#### E. Goal 5: Improve Preventive Care

Measures	Data Source	Specifications	HIT Utilization
Chlamydia	Claims	(HEDIS 2012 - Effectiveness	The preventive care HEDIS

Screening in Women	and Pharmacy	of Care) Percentage of women who were identified as sexually active and who had at least one test for Chlamydia.	indicator was developed from preventive care guidelines. We will use data analytics with administrative claims data to calculate the results which will be shared with the health homes and will include benchmarks to peers.
Colorectal Cancer Screening	Claims (administrative method only)	(HEDIS 2012 - Effectiveness of Care) Percentage of member 50 and older who had appropriate screening for colorectal cancer.	The preventive care HEDIS indicator was developed from preventive care guidelines. We will use data analytics with administrative claims data to calculate the results which will be shared with the health homes and will include benchmarks to peers.

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## Appendix J

### Health Home Provider Qualifications and Standards

Section 1945 (h) (4) of the Social Security Act defines health home services as "comprehensive and timely high quality services" and includes the following health home services that must be provided by designated health home providers:

- Comprehensive care management;
- Care coordination and health promotion;
- Comprehensive transitional care from inpatient to other settings, including appropriate follow-up;
- Individual and family support, which includes authorized representatives;
- Referral to community and social support services, if relevant; and
- The use of HIT to link services, as feasible and appropriate.

#### General Qualifications

1. Health home providers/plans must be enrolled (or be eligible for enrollment) in the NYS Medicaid program and agree to comply with all Medicaid program requirements.
2. Health home providers can either directly provide, or subcontract for the provision of, health home services. The health home provider remains responsible for all health home program requirements, including services performed by the subcontractor.
3. Care coordination and integration of health care services will be provided to all health home enrollees by an interdisciplinary team of providers, where each individual's care is under the direction of a dedicated care manager who is accountable for assuring access to medical and behavioral health care services and community social supports as defined in the enrollee care plan.
4. Hospitals that are part of a health home network must have procedures in place for referring any eligible individual with chronic conditions who seek or need treatment in a hospital emergency department to a DOH designated health home provider.
5. Health home providers must meet the following core health home requirements in the manner described below. Health home providers must provide written documentation that clearly demonstrates how the requirements are being met.

#### Health Home Provider Functional Requirements (SMD 10-024)

Health home providers must demonstrate their ability to perform each of the following functional requirements. Document the processes used to perform these functions and the processes and timeframes used to assure service delivery takes place in the described manner. Documentation should also include a description of the proposed multifaceted health home service interventions that will be provided to promote patient engagement, participation in their plan of care and that ensure patients appropriate

access to the continuum of physical and behavioral health care and social services needs.

1. Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered health home services.
2. Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines.
3. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders.
4. Coordinate and provide access to mental health and substance abuse services.
5. Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care.
6. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families.
7. Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services.
8. Coordinate and provide access to long-term care supports and services.
9. Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services.
10. Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate.
11. Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.

## **Provider Standards**

### **I. Comprehensive Care Management**

Policies and procedures are in place to create, document, execute and update an individualized, patient centered plan of care for each individual.

**1a.** A comprehensive health assessment that identifies medical, mental health, chemical dependency and social service needs is developed.

**1b.** The individual's plan of care integrates the continuum of medical, behavioral health services, rehabilitative, long term care and social service needs and clearly identifies the primary care physician/nurse practitioner, specialist(s), behavioral health care provider(s), care manager and other providers directly involved in the individual's care.

**1c.** The individual (or their guardian) play a central and active role in the development and execution of their plan of care and should agree with the goals, interventions and time frames contained in the plan.

**1d.** The individual's plan of care clearly identifies primary, specialty, behavioral health and community networks and supports that address their needs.

**1e.** The individual's plan of care clearly identifies family members and other supports involved in the patient's care. Family and other supports are included in the plan and execution of care as requested by the individual.

**1f.** The individual's plan of care clearly identifies goals and timeframes for improving the patient's health and health care status and the interventions that will produce this effect.

**1g.** The individual's plan of care must included outreach and engagement activities that will support engaging patients in care and promoting continuity of care.

**1h.** The individual's plan of care includes periodic reassessment of the individual needs and clearly identifies the patient's progress in meeting goals and changes in the plan of care based on changes in patient's need.

## **II. Care Coordination and Health Promotion**

**2a.** The health home provider is accountable for engaging and retaining health home enrollees in care; coordinating and arranging for the provision of services; supporting adherence to treatment recommendations; and monitoring and evaluating a patient's needs, including prevention, wellness, medical, specialist and behavioral health treatment, care transitions, and social and community services where appropriate through the creation of an individual plan of care.

**2b.** The health home provider will assign each individual a dedicated care manager who is responsible for overall management of the patient's care plan. The health home care manager is clearly identified in the patient record. Each individual enrolled with a health home will have one dedicated care manager who has overall responsibility and accountability for coordinating all aspects of the individual's care. The individual cannot be enrolled in more than one care management program funded by the Medicaid program.

**2c.** The health home provider must describe the relationship and communication between the dedicated care manager and the treating clinicians that assure that the care manager can discuss with clinicians on an as needed basis, changes in patient condition that may necessitate treatment change (i.e., written orders and/or prescriptions).

**2d.** The health home provider must define how patient care will be directed when conflicting treatment is being provided.

**2e.** The health home provider has policies, procedures and accountabilities (contractual agreements) to support effective collaborations between primary care, specialist and behavioral health providers, evidence-based referrals and follow-up and consultations that clearly define roles and responsibilities.

**2f.** The health home provider supports continuity of care and health promotion through the development of a treatment relationship with the individual and the interdisciplinary team of providers.

**2g.** The health home provider supports care coordination and facilitates collaboration through the establishment of regular case review meetings, including all members of the interdisciplinary team on a schedule determined by the health home provider. The health home provider has the option of utilizing technology conferencing tools including audio, video and /or web deployed solutions when security protocols and precautions are in place to protect PHI.

**2h.** The health home provider ensures 24 hours/seven days a week availability to a care manager to provide information and emergency consultation services.

**2i.** The health home provider will ensure the availability of priority appointments for health home enrollees to medical and behavioral health care services within their health home provider network to avoid unnecessary, inappropriate utilization of emergency room and inpatient hospital services.

**2j.** The health home provider promotes evidence based wellness and prevention by linking health home enrollees with resources for smoking cessation, diabetes, asthma, hypertension, self help recovery resources, and other services based on individual needs and preferences.

**2k.** The health home provider has a system to track and share patient information and care needs across providers and to monitor patient outcomes and initiate changes in care, as necessary, to address patient need.

### **III. Comprehensive Transitional Care**

**3a.** The health home provider has a system in place with hospitals and residential/rehabilitation facilities in their network to provide the health home prompt

notification of an individual's admission and/or discharge to/from an emergency room, inpatient, or residential/rehabilitation setting.

**3b.** The health home provider has policies and procedures in place with local practitioners, health facilities including emergency rooms, hospitals, and residential/rehabilitation settings, providers and community-based services to help ensure coordinated, safe transitions in care for its patients who require transfers in the site of care.

**3c.** The health home provider utilizes HIT as feasible to facilitate interdisciplinary collaboration among all providers, the patient, family, care givers, and local supports.

**3d.** The health home provider has a systematic follow-up protocol in place to assure timely access to follow-up care post discharge that includes at a minimum receipt of a summary care record from the discharging entity, medication reconciliation, timely scheduled appointments at recommended outpatient providers, care manager verification with outpatient provider that the patient attended the appointment, and a plan to outreach and re-engage the patient in care if the appointment was missed.

#### **IV. Patient and Family Support**

**4a.** Patient's individualized plan of care reflects patient and family or caregiver preferences, education and support for self-management, self help recovery, and other resources as appropriate.

**4b.** Patient's individualized plan of care is accessible to the individual and their families or other caregivers based on the individual's preference.

**4c.** The health home provider utilizes peer supports, support groups and self-care programs to increase patients' knowledge about their disease, engagement and self management capabilities, and to improve adherence to prescribed treatment.

**4d.** The health home provider discusses advance directives with enrollees and their families or caregivers.

**4e.** The health home provider communicates and shares information with individuals and their families and other caregivers with appropriate consideration for language, literacy and cultural preferences.

**4f.** The health home provider gives the patient access to care plans and options for accessing clinical information.

#### **V. Referral to Community and Social Support Services**

**5a.** The health home provider identifies available community-based resources and actively manages appropriate referrals, access, engagement, follow-up and coordination of services.

**5b.** The health home provider has policies, procedures and accountabilities (contractual agreements) to support effective collaborations with community-based resources, which clearly define roles and responsibilities.

**5c.** The plan of care should include community-based and other social support services as well as healthcare services that respond to the patient's needs and preferences and contribute to achieving the patient's goals.

## **VI. Use of Health Information Technology to Link Services**

Health home providers will make use of available HIT and accesses data through the regional health information organization/qualified entities to conduct these processes as feasible, to comply with the initial standards cited in items 6a.-6d for implementation of health homes. In order to be approved as health home provider, applicants must provide a plan to achieve the final standards cited in items 6e.-6i. within eighteen (18) months of program initiation.

### **Initial Standards**

**6a.** Health home provider has structured information systems, policies, procedures and practices to create, document, execute, and update a plan of care for every patient.

**6b.** Health home provider has a systematic process to follow-up on tests, treatments, services and, and referrals which is incorporated into the patient's plan of care.

**6c.** Health home provider has a health record system which allows the patient's health information and plan of care to be accessible to the interdisciplinary team of providers and which allows for population management and identification of gaps in care including preventive services.

**6d.** Health home provider makes use of available HIT and accesses data through the regional health information organization/qualified entity to conduct these processes, as feasible.

### **Final Standards**

**6e.** Health home provider has structured interoperable health information technology systems, policies, procedures and practices to support the creation, documentation, execution, and ongoing management of a plan of care for every patient.

**6f.** Health home provider uses an electronic health record system that qualifies under the Meaningful Use provisions of the HITECH Act, which allows the patient's health information and plan of care to be accessible to the interdisciplinary team of providers. If the provider does not currently have such a system, they will provide a plan for when and how they will implement it.

**6g.** Health home provider will be required to comply with the current and future version of the Statewide Policy Guidance ([http://health.ny.gov/technology/statewide\\_policy\\_guidance.htm](http://health.ny.gov/technology/statewide_policy_guidance.htm) which includes common information policies, standards and technical approaches governing health information exchange.

**6h.** Health home provider commits to joining regional health information networks or qualified health IT entities for data exchange and includes a commitment to share information with all providers participating in a care plan. RHIOs/QE (Qualified Entities) provides policy and technical services required for health information exchange through the Statewide Health Information Network of New York ( SHIN-NY).

**6i.** Health home provider supports the use of evidence based clinical decision making tools, consensus guidelines, and best practices to achieve optimal outcomes and cost avoidance. One example of such a tool is PSYCKES.

## **VII. Quality Measures Reporting to State**

**7a.** The health home provider has the capability of sharing information with other providers and collecting and reporting specific quality measures as required by NYS and CMS.

**7b.** The health home provider is accountable for reducing avoidable health care costs specifically preventable hospital admissions/readmissions and avoidable emergency room visits; providing timely post discharge follow-up, and improving patient outcomes as measured by NYS and CMS required quality measures.

## Appendix K

### Implementation Strategy and Anticipated Timeline

#### FIDA Implementation Strategy and Anticipated Timeline

Timeframe	Key Activities/Milestones	Responsible Parties
May 3	Publish 2 <sup>nd</sup> Draft for Public Comment	DOH
May 25	Final Draft Proposal Submitted to CMS	DOH
June	CMS issues public notice of proposal for comment	CMS
June - July	CMS accepts public comments, shares with DOH	CMS
June – July	CMS/State review of public comments	CMS and DOH
June 2012	Begin stakeholder workgroups on key issues	DOH
June 2012	Stakeholder Implementation Meeting	DOH and Stakeholders
Jun. 4 – Aug. 30	MOU negotiations	CMS and DOH
July 2012	DOH Finalizes Quality Measures and Expected Outcomes	DOH
September 2, 2012	MOU Negotiations Complete	CMS and DOH
September 12, 2012	MOU signed by CMS and State	CMS and DOH
September 2012	Receive Implementation Funds from CMS	DOH
September 2012	Stakeholder Implementation Meeting	DOH and Stakeholders
September 15, 2012	Begin Systems Change Process	DOH
October 2012	Pursue Legislative Changes and Budget Appropriations	DOH
December 2012	Stakeholder Implementation Meeting	DOH and Stakeholders
March 2013	Stakeholder Implementation Meeting	DOH and Stakeholders
April 2013	Begin Plan Selection Process	DOH

June 2013	Stakeholder Implementation Meeting	DOH and Stakeholders
June 2013	Plan review	CMS and DOH
June – September 2013	Three-way contract documents finalized	CMS and DOH
July 2013 – ongoing	Consumer Education and Outreach Campaign	DOH
July 30, 2013	Final Plan Selection completed	CMS and DOH
August – September 20, 2013	Readiness reviews	CMS and DOH
August 15 – September 30, 2013	Plans finalize policies, procedures	Plans, CMS and DOH
September 20, 2013	Three-way contracts signed	Plans, CMS and DOH
September 2013	Stakeholder Implementation Meeting	DOH and Stakeholders
No later than October 1, 2013	Beneficiary notification	DOH
October 1, 2013 – ongoing	Opt out beneficiaries enrolled in alternative option(s)	DOH
December 2013	Stakeholder Implementation Meeting	DOH and Stakeholders

### Health Home - Implementation Strategy and Timeline

<b>Timeframe</b>	<b>Key Activities/Milestones</b>	<b>Responsible Parties</b>
January 1, 2012	Approved effective date for first phase of Health Homes	CMS and DOH
January 12, 2012	Stakeholder Implementation Webinar	DOH and Stakeholders
February 3, 2012	Received CMS approval of State Plan Amendment for first phase of Health Homes, effective January 1, 2012	CMS and DOH
February 10, 2012	Stakeholder Implementation Webinar	DOH and Stakeholders
February 13, 2012	Stakeholder Upstate Regional Meeting	DOH and Stakeholders
February 23, 2012	Stakeholder Downstate Regional Meeting	DOH and Stakeholders
February 28, 2012	Stakeholder Implementation Webinar	DOH and

		Stakeholders
April 1, 2012	Tentative date for implementation of second phase of Health Homes-SPA pending approval	DOH
April 4, 2012	Stakeholder Downstate Regional Meeting	DOH and Stakeholders
May 1, 2012	Phase III preliminary application deadline for those who submitted a Letter of Intent	DOH
May 10, 2012	Stakeholder Duals Integration Webinar	DOH and Stakeholders
May 14, 2012	Stakeholder Duals integration Meeting	DOH and Stakeholders
June 2012	Health Home Learning Collaborative	DOH, CHCS
July 2012	Tentative date for implementation of the third phase of Health Homes-SPA pending approval	DOH
July 2012	Dual eligibles included in member assignments to Health Homes	DOH

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## Appendix L

### Health Home Information Sharing Requirements and Privacy Protections

#### a. Medicaid Data Exchange Application and Agreement (DEAA)

The purpose of the DEAA is to provide information supporting the release of Medicaid Confidential Data (MCD) from NYSDOH to Health Home Programs and to serve as the basis for assessing the appropriateness of releasing MCD. The DEAA, when approved by the NYSDOH, forms an agreement between the applicant and NYSDOH as to the terms and conditions under which the release will be made. All Provider-Led Health Homes must complete and submit a Data Exchange Agreement Application (DEAA) to the Medicaid Privacy officer in order to obtain patient tracking sheets for initial member assignment; Medicaid Confidential Data/Protected Health Information includes all information about a protected recipient or applicant, including enrollment information, eligibility data and health information (PHI).

#### b. Health Home Patient Information Sharing

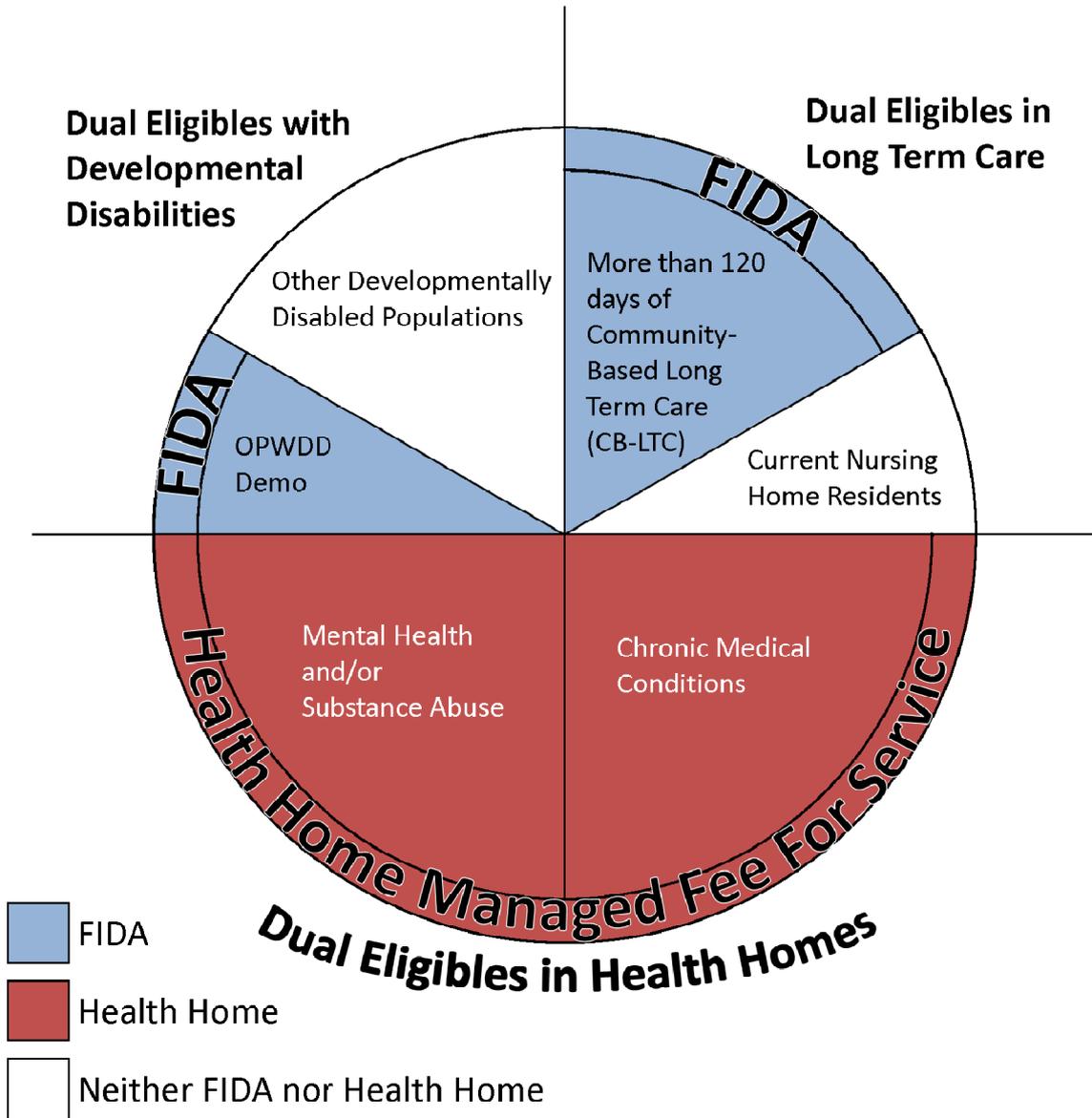
Health Home Program members must provide informed consent in order for their health information to be shared between and among providers who serve them in the Health Home Program. To help ensure that this consent is informed, it is the expectation of New York State that case managers will assist members in Health Home Programs to complete the Health Home Patient Information Sharing Consent Form (DOH-5055) to assure they understand it and have the opportunity to ask questions and have those questions answered. By completing and signing this consent form, a member is agreeing to allow his/her health information to be shared among the Health Home partners, which can include a Regional Health Information Organization (RHIO). Because information exchange is a critical component of care coordination through a Health Home, if a member withdraws his/her consent to share health information, s/he must also sign a Health Home Patient Information Sharing Withdrawal of Consent Form (DOH-5058) to discontinue sharing information with the Health Home. All participating Health Home partners must be notified if a member withdraws their consent.

#### c. Health Commerce System (HCS)

In order for Health Homes to access confidential patient data including patient tracking files, NYSDOH has a secure password protected portal referred to as the Health Commerce System (HCS). All Health Homes must have an active account and designate a HCS coordinator. Confidential files can be transferred using this portal and patient data stored and shared among providers in each Health Home must always be exchanged in a secure, HIPPA compliant manner.

Appendix M

Health Home Population



**Appendix N**

**Implementation Budget Request**

*Will be included in final draft.*

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**Appendix O**

**Letters of Support**

*Will be included in final draft.*

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