

**CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS**

NUMBER: **11-W-00234/2**

TITLE: **Federal-State Health Reform Partnership Medicaid Section 1115
Demonstration**

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

I. PREFACE

The following are the Special Terms and Conditions (STCs) for New York's Federal-State Health Reform Partnership section 1115(a) Medicaid Demonstration (hereinafter "Demonstration"). The parties to this agreement are the New York State Department of Health (state) and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of federal involvement in the Demonstration and the state's obligations to CMS during the life of the Demonstration. The STCs are effective April 1, 2011 unless otherwise specified. All previously approved STCs, waivers, and expenditure authorities are superseded by the STCs set forth below. This Demonstration is approved through March 31, 2014.

The STCs have been arranged into the following subject areas: Program Description and Objectives; General Program Requirements; Eligibility, Benefits, and Enrollment; Delivery Systems; Federal-State Health Reform Partnership Activities; General Reporting Requirements; General Financial Requirements; Monitoring Budget Neutrality; Medicaid Program Savings Measures; Evaluation of the Demonstration; and Schedule of state Deliverables for the Demonstration.

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

II. PROGRAM DESCRIPTION AND OBJECTIVES

This Demonstration had its origins in an earlier demonstration, the Partnership Plan that sought to improve the economy, efficiency, and quality of care by requiring families and children to enroll in managed care entities to receive services. This mandatory managed care is known as Mandatory Mainstream Managed Care (MMMC). The Partnership Plan demonstration is ongoing, but MMMC enrollees in 14 counties are now included instead in this Demonstration. New York also has authority under this Demonstration to expand MMMC to elderly and disabled populations.

In 2004, the state was presented with significant reform opportunities including, the aging of New York's population, the continued shift in care from institutional to outpatient settings, and the quality and efficiency advantages that are available through health information technology. The state created the Health Care Efficiency and Affordability Law for New Yorkers (HEAL NY) capital grant program in that year to invest an anticipated \$1 billion over a four-year period, to effectively reform and reconfigure New York's health care delivery system to achieve improvements in patient care and increased efficiency of operation.

In 2005, the state asked the federal government to partner with its HEAL NY initiative to implement reform projects that would improve the quality of care and result in long-term savings for both the state and federal government. This demonstration was approved for an initial 5-year period beginning October 1, 2006; under that demonstration authority, the state committed to pursue the following reform initiatives:

- **Rightsizing Acute Care Infrastructure.** New York's acute care infrastructure is outdated and oversized, while the facilities are highly leveraged with debt. The inexorable migration of health care services to the outpatient setting has added to the significant excess capacity that exists in the state, estimated at over 19,000 beds. As a result, state law was enacted in 2005 establishing the Commission on Health Care Facilities in the 21st Century (Commission) which is charged with recommending reconfiguration measures, including downsizing, restructuring and/or facility closures. Such measures will reduce future Medicaid inpatient hospital costs.
- **Reforming Long-Term Care.** The growth of non-institutional alternatives for long-term care services such as assisted living, advances in medical technology, overall improvement in the health of potential consumers and caregivers, and increasing preference for less restrictive alternatives is generating less demand for nursing facility services. New York will pursue the rightsizing of its long-term care system; implementation of a locally-based, but state-wide point of entry (POE) system to help ensure appropriate services are rendered to recipients; a home modification program to enable recipients to stay at home; and a tele-home care program to help individuals stay healthy and at home.
- **Improvement in Primary/Ambulatory Care.** As increased emphasis is placed on services rendered in outpatient settings, capacity and quality become of primary importance. Under this Demonstration, New York will address the shortage of primary care services; implement programs to better manage individuals with chronic conditions, and collect quality of care data on outpatient services.

The state used its HEAL NY program to implement these initiatives under the demonstration. The HEAL NY program is jointly administered by the Department of Health and the Dormitory Authority of the State of New York and was implemented in phases over the past 5 years. Since early 2005, the state released 17 separate requests for grant application under HEAL NY, committing a total of \$2.37 billion in state funds for these efforts.

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

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

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

CMS will continue to monitor these activities to ensure that the Demonstration delivers on the promise of increased efficiency and savings that it has been given.

III. GENERAL PROGRAM REQUIREMENTS

- 1. Compliance with Federal Non-Discrimination Statutes.** The state agrees that it shall comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.
- 2. Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), must apply to the Demonstration.
- 3. Changes in Medicaid Law, Regulation, and Policy.** The state must, within the timeframes specified in the applicable law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid program that occur during this Demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable.
- 4. Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**
 - To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this Demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the Demonstration, as necessary, to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph.
 - If mandated changes in the federal law require state legislation, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law.
- 5. State Plan Amendments.** The state shall not be required to submit title XIX State Plan Amendments for changes to any populations made eligible solely through the Demonstration. If an eligible population through the Medicaid state plan is affected by a change to the Demonstration, a conforming amendment to the state plan may be required, except as otherwise noted in these STCs.
- 6. Changes Subject to the Amendment Process.** Changes related to the health care reforms

undertaken by this Demonstration, designated state health programs, eligibility, enrollment, benefits, enrollee rights, delivery systems, evaluation design, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the Demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Social Security Act (the Act). The state must not implement changes to these elements without prior approval by CMS. Amendments to the Demonstration are not retroactive and FFP will not be available for changes to the Demonstration that have not been approved through the amendment process outlined in STC 7 below.

7. **Demonstration Amendment Process:** Requests to amend the Demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change, and may not be implemented until approved. Amendment requests must include, but are not limited to, the following:
 - a) An explanation of the public process used by the state, consistent with the requirements of STC 14, to reach a decision regarding the requested amendment;
 - b) A data analysis which identifies the specific “with waiver” impact of the proposed amendment on the current budget neutrality expenditure cap. Such analysis shall include current “with waiver” and “without waiver” status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the “with waiver” expenditure total as result of the proposed amendment which isolates (by Eligibility Group) the impact of the amendment;
 - c) A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and
 - d) If applicable, a description of how the evaluation design shall be modified to incorporate the amendment provisions.
8. **Demonstration Phase-Out.** The state may suspend or terminate this Demonstration in whole, or in part, consistent with the following requirements.
 - a) **Notification of Suspension or Termination:** The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a phase-out plan. The state must submit its notification letter and a draft phase-out plan to CMS no less than 4 months before the effective date of the Demonstration’s suspension or termination. Prior to submitting the draft phase-out plan to CMS, the state must publish on its website the draft phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation State Plan Amendment. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received, the state’s response to the comment and how the state incorporated the received comment into a revised phase-out plan.

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

- b) Phase-out Plan Requirements: The state must include, at a minimum, in its phase-out plan its process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and any community outreach activities.
 - c) Phase-out Procedures: The state must comply with all notice requirements found in 42 CFR sections 431.206, 431.210, and 431.213. In addition, the state must assure all appeal and hearing rights afforded to Demonstration participants as outlined in 42 CFR sections 431.220 and 431.221. If a Demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR section 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category. as discussed in the October 1, 2011, state Health Official Letter #10-008.
 - d) Federal Financial Participation (FFP): If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with terminating the Demonstration, including services and administrative costs of disenrolling participants.
9. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate the Demonstration, subject to adequate notice, (in whole or in part at any time) before the date of expiration, whenever it determines, following a hearing that the state has materially failed to comply with the terms of the project. CMS shall promptly notify the state in writing of the determination and the reasons for the suspension or termination, together with the effective date.
10. **Finding of Non-Compliance.** The state does not relinquish its rights to challenge CMS's finding that the state materially failed to comply.
11. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS's determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.
12. **Adequacy of Infrastructure.** The state will ensure the availability of adequate resources for implementation and monitoring of the Demonstration, including education, outreach, and enrollment; maintaining eligibility systems; implementation of milestones; and reporting on financial and other Demonstration components.
13. **Quality Review of Eligibility.** The state will continue to submit by December 31st of each year an alternate plan for Medicaid Eligibility Quality Control (MEQC) as permitted by federal regulations at 42 CFR 431.812(c).

14. Public Notice, Tribal Consultation, and Consultation with Interested Parties.

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

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

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

15. Federal Funds Participation. No federal matching funds for expenditures for this Demonstration will be provided until the effective date identified in the Demonstration approval letter. No FFP is available for this Demonstration for Medicare Part D drugs.

IV. ELIGIBILITY, BENEFITS, AND ENROLLMENT

The mandatory managed care program operated by New York provides Medicaid state plan benefits through comprehensive managed care organizations to those recipients eligible under the state plan as noted below.

16. Eligibility.

a) **Individuals Eligible under the Medicaid State Plan.** The mandatory and optional Medicaid State plan populations described in Tables 1 and 2 derive their eligibility through the Medicaid state plan, and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid state plan, except as expressly waived and as described in these STCs. State plan eligibles are included in the demonstration to assure access to cost-effective high quality care.

b) **New Mandatory Mainstream Managed Care Enrollment Requirement.**

- i. Under the Partnership Plan Demonstration (11-W-00114/2), the state has the authority to require mandatory mainstream managed care enrollment for any of the beneficiaries described in Table 1, except those that reside in Allegany, Cortland, Dutchess, Fulton, Montgomery, Putnam, Orange, Otsego, Schenectady, Seneca, Sullivan, Ulster, Washington, or Yates counties. Under this Demonstration, any recipient in the eligibility groups listed in Table 1 who live in those 14 counties will now be required to enroll in managed care plans.

Table 1. Eligibility Groups Affected by County-Specific MMMC Enrollment

State Plan Mandatory and Optional Groups	Eligibility Criteria
Pregnant women and children under age 1	Income up to 200% of the federal poverty level (FPL)
Children ages 1 through 5	Income up to 133% FPL
Children ages 6 through 18	Income up to 100% FPL
Children ages 19-20	Income at or below the monthly income standard (determined annually)
Parents and caretaker relatives	Income at or below the monthly income standard (determined annually)

- ii. The state has authority to expand mandatory enrollment in mainstream managed care to all individuals identified in Table 2 (except those otherwise excluded or exempted as outlined in STC 18). When the state intends to expand mandatory mainstream managed care enrollment to additional counties, it must notify CMS 90 days prior to the effective date of the expansion, and submit a revised assessment of the Demonstration's budget neutrality agreement, which reflects the projected impact of the expansion for the remainder of the Demonstration approval period

Table 2. Eligibility Groups Affected by new MMMC Enrollment Requirement

State Plan Mandatory and Optional Groups	Eligibility Criteria
Adults and children (age 0-64) receiving Supplemental Security Income (SSI) payments or otherwise disabled	Income at or below the monthly income standard
Adults (age 65+)	Income at or below the monthly income standard

- c) **Managed Long Term Care (MLTC).** This component provides a limited set of Medicaid state plan benefits, including long-term services and supports through a managed care delivery system, to individuals eligible through the state plan who require more than 120 days of community based long term-care services. Services not provided through the MLTC program are provided on a fee-for-service basis.
 - i. The state has authority to expand mandatory enrollment into MLTC to all individuals identified in Table 3 (except those otherwise excluded or exempted as outlined in STC 19) with initial mandatory enrollment starting in any county in New York City and then expanding state-wide based on the Enrollment plan as outlined in Attachment C. When the state intends to expand into a new county outside of New York City, it must notify CMS 90 days prior to the effective date of the expansion and submit a revised assessment of the Demonstration's budget neutrality agreement along with all other required materials as outlined in STC 25.

Table 3: Managed Long Term Care Program

State Plan Mandatory and Optional Groups	FPL and/or other qualifying criteria	Expenditure and Eligibility Group
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		Reporting
Adults age 65 and older	Income at or below SSI level	MLTC Adults 65+
Adults/children age 18 - 64	Income at or below SSI level	MLTC Adults 18 – 64
Adults age 65 and older	Income at or below the monthly income standard, or with spend-down to monthly income standard	MLTC Adults 65+
Adults/children Age 18-64 blind and disabled	Income at or below the monthly income standard, or with spend-down to monthly income standard	MLTC Adults 18 – 64
Age 16 – 64 Medicaid Buy In for Working People with Disabilities	Income up to 250%	MLTC Adults 18 – 64
Parents and caretaker relatives 21-64	Income at or below the monthly income standard, or with spend-down to monthly income standard	MLTC Adults 18 – 64
Children age 18 – 20	Income at or below the monthly income standard or with spend-down	MLTC Adults 18 – 64
Pregnant Women	Income up to 200%	MLTC Adults 18 – 64
Poverty Level Children Age 18 to 20	Income up to 133%	MLTC Adults 18 – 64
Foster Children Age 18 – 20	In foster care on the date of 18 th birthday	MLTC Adults 18 – 64

Demonstration Eligible Groups	FPL and/or other qualifying criteria	Expenditure and Eligibility Group Reporting
Community Long Term Services and Supports Population	Income based on higher income standard to community settings for long-term services and supports pursuant to STC 17	MLTC Adults 18 – 64 MLTC Adults 65 and above

d) Continuous Eligibility Period.

- i. Effective February 1, 2010, the state is authorized to provide a 12-month continuous eligibility period to the groups of individuals specified in Table 4 who are otherwise eligible under the Medicaid state Plan, regardless of the delivery system through which they receive Medicaid benefits. Once the State begins exercising this authority, each newly eligible individual's 12-month period shall begin at the initial determination of eligibility; for those individuals who are re-determined to be eligible consistent with

Medicaid state plan rules, the 12-month period begins at that point. At each annual eligibility redetermination thereafter, if an individual is re-determined to be eligible under Medicaid state plan rules, the individual is guaranteed a subsequent 12-month continuous eligibility period.

Table 4: Groups Eligible for a 12-Month Continuous Eligibility Period

State Plan Mandatory and Optional Groups	Social Security Act/Code of Federal Regulations Reference
Pregnant women aged 19 or older	<ul style="list-style-type: none"> • 1902(a)(10)(A)(i)(III) or (IV) and • 1902(a)(10)(A)(ii)(I) and (II)
Children aged 19 or 20	1902(a)(10)(A)(ii)(I) and (II)
Parents or other caretaker relatives aged 19 or older	1902(a)(10)(A)(ii)(I) and (II)
Members of low-income families, except for children up to age 19	1931 and 1925
Disabled children who lose SSI due to a change in the SSI definition of disability	1902(a)(10)(A)(i)(II)
Individuals who meet the income and resource requirements of SSI but are not in receipt of cash	1902(a)(10)(A)(ii)(I)
Medically needy individuals including children under 21, pregnant women, parents/caretaker relatives, the aged, blind, and disabled	Without spend-down under 1902(a)(10)(C)(i)(III) <ul style="list-style-type: none"> • 42 CFR 435.308 • 42 CFR 435.310 • 42 CFR 435.320 • 42 CFR 435.322 • 42 CFR 435.324
Disabled widows/widowers who lost SSI or state supplements due to Social Security benefit increases in 1984 and who applied for continued Medicaid coverage before 1988	1634(b)

Note: Children under 19 who are eligible at the applicable FPL already receive 12-month continuous eligibility period under the Medicaid state plan.

State Plan Mandatory and Optional Groups	Social Security Act/Code of Federal Regulations Reference
Disabled adult children who lose SSI due to Old Age, Survivor's and Disability Insurance (OASDI)	1634(c)
Disabled widows and widowers aged 60 through 64 who would be eligible for SSI except for early receipt of social security benefits	1634(d)
Individuals who are ineligible for SSI or optional state supplements because of requirements that do not apply under Medicaid	42 CFR 435.122

Individuals eligible for Medicaid in December 1973 as an essential spouse of an aged, blind, or disabled individual who was receiving cash assistance	42 CFR 435.131
Individuals otherwise eligible for SSI or a state supplement except that the increase in OASDI under Pub. L. 92-336 (July 1, 1972) raised their income over the limit allowed under SSI ("pre-Pickle people")	42 CFR 435.134
Individuals otherwise eligible for SSI or a state supplement, except that OASDI cost-of-living increases received after April 1977 raised their income over the limit allowed under SSI ("Pickle people")	42 CFR 435.135

ii. **Exceptions.** Notwithstanding subparagraph i, if any of the following circumstances occur during an individual's 12-month continuous eligibility period, the individual's Medicaid eligibility shall be terminated:

- (1) The individual cannot be located;
- (2) The individual is no longer a New York State resident;
- (3) The individual requests termination of eligibility;
- (4) The individual dies;
- (5) The individual fails to provide or cooperate in obtaining a Social Security number if otherwise required;
- (6) The individual provided an incorrect or fraudulent Social Security number;
- (7) The individual was determined eligible for Medicaid in error;
- (8) The individual is receiving treatment in a setting where Medicaid eligibility is not available (e.g. institution for mental disease);
- (9) The individual is in receipt of long-term care services;
- (10) The individual is receiving care, services, or supplies under a section 1915(c) waiver program;
- (11) The individual was previously otherwise qualified for emergency medical assistance benefits only, based on immigration status, but is no longer qualified because the emergency has been resolved;
- (12) The individual fails to provide the documentation of citizenship or immigration status required under federal law; or
- (13) The individual is incarcerated.

17. Individuals Moved from Institutional Settings to Community Settings for Long-Term Services and Supports. Individuals discharged from a nursing facility who enroll into the MLTC program in order to receive community-based long-term services and supports are eligible based on a special income standard. The special income standard will be determined by utilizing the average Housing and Urban Development (HUD) Fair Market Rent (FMR) dollar amounts for each of the seven regions in the state, and, subtracting from that average, 30 percent of the Medicaid income level (as calculated for a household of one) that is considered available for housing. The seven regions of the state include: Central Region; Northeastern; Western; Northern Metropolitan; New York City; Long Island; and Rochester.

The state shall work with Nursing Home Administrators, nursing home discharge planning staff,

family members, and the MLTC health plans to identify individuals who may qualify for the housing disregard as they are able to be discharged from a nursing facility back into the community and enrolled into the MLTC program.

In addition, the state will ensure that the MLTC Managed Care Organizations (MCO) work with individuals, their families, nursing home administrators, and discharge planners to help plan for the individual's move back into the community, as well as to help plan for the individual's medical care once they have successfully moved into his/her home.

- 18. Exclusions and Exemptions from MMMC.** Notwithstanding the eligibility criteria in STC 16(b), certain individuals cannot receive benefits through the MMMC program (i.e. are excluded from participation), while others may request an exemption from receiving benefits through the MMMC program (i.e. may be exempted from participation). Tables 5 and 6 list those individuals either excluded or exempted from MMMC.

Table 5: Individuals Excluded from MMMC

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

Table 6: Individuals who may be exempted from MMMC

Individuals eligible for both Medicare/Medicaid (dual-eligibles) *
Individuals with chronic medical conditions who have been under active treatment for at least six months with a sub-specialist who is not a network provider for any Medicaid MCO in the service area or whose request has been approved by the New York State Department of Health Medical Director because of unusually severe chronic care needs. Exemption is limited to six months.
Individuals designated as participating in OPWDD sponsored programs.
Individuals already scheduled for a major surgical procedure (within 30 days of scheduled enrollment) with a provider who is not a participant in the network of any Medicaid MCO in the service area. Exemption is limited to six months.
Individuals with a developmental or physical disability receiving services through a Medicaid home and community based services (HCBS) waiver authorized under section 1915(c) of the Act.
Residents of alcohol/substance abuse long term residential treatment programs
Native Americans
Individuals who are eligible for the Medicaid buy-in for the working disabled and do not pay a premium
Individuals with a "county of fiscal responsibility code of 98" (OPWDD in Medicaid Management Information System) in counties where program features are approved by the state and operational at the local district level to permit these individuals to voluntarily enroll.

* These persons may **only** join a qualified Medicaid Advantage Plan

19. **Exclusions and Exemptions from MLTC.** Notwithstanding the eligibility criteria in STC 16, certain individuals cannot receive benefits through the MLTC program (i.e. excluded), while others may request an exemption from receiving benefits through the MLTC program (i.e. exempted). Tables 7 and 8 list those individuals either excluded or exempted from MLTC.

Table 7: Individuals excluded from MLTC.

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

Individuals eligible for Emergency Medicaid
Individuals in the Office for People with Developmental Disabilities Home and Community Based Services (OPWDD HCBS) 1915(c) waiver program
Individuals in the following 1915(c) waiver programs: Traumatic Brain Injury (TBI), Nursing Home Transition & Diversion (NHTD), and Long-Term Home Health Care Program (LTHHCP)
Residents of Assisted Living Programs
Individuals in receipt of Limited Licensed Home Care Services
Individuals in the Foster Family Care Demonstration

Table 8: Individuals who may be exempted from MLTC.

Individuals aged 18 – 21 who are nursing home certifiable and require more than 120 days of community based long-term care services
Native Americans
Individuals who are eligible for the Medicaid buy-in for the working disabled and are nursing home certifiable
Aliessa Court Ordered Individuals

20. Terms and Conditions Related to Particular Populations

- a) **MMMC Enrollment of Individuals Living with HIV.** The state is authorized to require individuals living with HIV to receive benefits through MMMC. Once the state begins implementing MMMC enrollment in a particular county, individuals living with HIV will have thirty days in which to select a health plan. If no selection is made, the individual will be auto-assigned to a MCO. Individuals living with HIV who are enrolled in a MCO (voluntarily or by default) may request transfer to an HIV SNP at any time if one or more HIV Special Needs Plans (SNPs) are in operation in the individual's district. Further, transfers between HIV SNPs will be permitted at any time.
- b) **Restricted Recipient Programs.** The state may require individuals participating in a restricted recipient program administered under 42 CFR 431.54(e) to enroll in MMMC. Furthermore, MCOs may establish and administer restricted recipient programs, through which they identify individuals that have utilized Medicaid services at a frequency or amount that is not medically necessary, as determined in accordance with utilization guidelines established by the state, and restrict them for a reasonable period of time to obtain Medicaid services from designated providers only. The state must adhere to the following terms and conditions in this regard.
 - i. Restricted recipient programs operated by MCOs must adhere to the requirements in 42 CFR 431.54(e)(1) through (3), including the right to a hearing conducted by the state.
 - ii. The state must require MCOs to report to the state whenever they want to place a new person in a restricted recipient program. The state must maintain summary statistics on the numbers of individuals placed in restricted recipient programs, and the reasons for

those placements, and must provide the information to CMS upon request.

- c.) **Managed care enrollment of individuals using long term services and supports for both MMMC and MLTC.** The state is authorized to require certain individuals using long-term services and supports to enroll in either mainstream managed care or managed long-term care as identified in STC 16. In addition, the populations that are exempted from mandatory enrollment, based on the exemption lists in STCs 18 and 19 may also elect to enroll in managed care plans. Once these individuals begin to enroll in managed care, the state will be required to provide the following protections for the population:

- i. **Person-Centered Service planning** – The state, through its contracts with their MCOs and/or Prepaid Inpatient Health Plan (PIHPs), will require that all individuals utilizing long-term services and supports will have a person-centered individual service plan maintained at the MCO or PIHP. Person-Centered Planning includes consideration of the current and unique psycho-social and medical needs and history of the enrollee, as well as the person's functional level, and support systems.
 1. The state must establish minimum guidelines regarding the Person-Centred Plan (PCP) that will be reflected in MCO/PIHP contracts. These must include at a minimum, a description of:
 - a. The qualification for individuals who will develop the PCP;
 - b. Types of assessments;
 - c. How enrollees are informed of the services available to them; and
 - d. The MCOs' responsibilities for implementing and monitoring the PCP.
 2. The MCO/PIHP contract shall require the use of a person centered and directed planning process intended to identify the strengths, capacities, and preferences of the enrollee, as well as to identify an enrollee's long-term care needs and the resources available to meet those needs, and to provide access to additional care options as specified by the contract. The PCPs developed by the participant with the assistance of the MCO/PIHP, provider, and those individuals the participant chooses to include. The plan includes the services and supports that the participant needs.
 3. The MCO/PIHP contract shall require that service plans must address all enrollees' assessed needs (including health and safety risk factors) and personal goals, taking into account an emphasis on services being delivered in home and community based settings.
 4. The MCO/PIHP contract shall require that a process is in place that permits the participants to request a change to the PCP if the participant's circumstances necessitate a change. The MCO contract shall require that all service plans are updated and/or revised at least annually or when warranted by changes in the enrollee's needs.
 5. The MCO/PIHP shall ensure that meetings related to the enrollee's PCP will be held at a location, date, and time convenient to the enrollee and his/her invited participants.
 6. The MCO/PIHP contract shall require development of a back-up plan to ensure that needed assistance will be provided in the event that the regular services and supports identified in the individual service plan are temporarily unavailable. The

- back-up plan may include other individual assistants or services.
7. The MCO/PIHP contract shall require that services be delivered in accordance with the service plan, including the type, scope, amount, and frequency.
 8. The MCO/PIHP contract shall require that enrollees receiving long-term services and supports have a choice of provider, where available, which has capacity to serve that individual within the network. The MCO/PIHP must contract with at least two providers in each county in its service area for each covered service in the benefit package, unless the county has an insufficient number of providers licensed, certified, or available in that county.
 9. The MCO/PIHP contract shall require policies and procedures for the MCO/PIHP to monitor appropriate implementation of the individual service plans.
- ii. **Health and Welfare of Enrollees** – The state, through its contracts with their MCOs/PIHPs, shall ensure a system is in place to identify, address, and seek to prevent instances of abuse, neglect, and exploitation of its enrollees on a continuous basis. This should include provisions such as critical incident monitoring and reporting to the state, investigations of any incident including but not limited to; wrongful death, restraints, or medication errors that resulted in an injury.
- iii. **Network of qualified providers** – The provider credentialing criteria described at 42 CFR 438.214 must apply to providers of long-term services and supports. If the MCO's/PIHP's credentialing policies and procedures do not address non-licensed/non-certified providers, the MCO/PIHP shall create alternative mechanisms to ensure the health and safety of its enrollees. To the extent possible, the MCO/PIHP shall incorporate criminal background checks, reviewing abuse registries, as well as any other mechanism the state includes within the MCO/PIHP contract.
- d) **MLTC enrollment.** Including the protections afforded individuals in subparagraph (c) of this STC, the following requirements apply to MLTC plan enrollment.
- i. **Transition of care period.** Initial transition into MLTC from fee-for-service: Each enrollee who is receiving community based long-term services and supports that qualify for MLTC must continue to receive services under the enrollee's pre-existing service plan for at least 60 days after enrollment, or until a care assessment has been completed by the MCO/PIHP, whichever is later. Any reduction, suspension, denial, or termination of previously authorized services shall trigger the required notice under 42 CFR 438.404 which clearly articulates the enrollee's right to file an appeal (either expedited, if warranted or standard), the right to have authorized service continue pending the appeal and the right to a fair hearing if the plan renders an adverse determination (either in whole or in part) on the appeal. For initial implementation of the auto-assigned population, the plans must submit data for state review on a monthly basis reporting instances when the plan has issued a notice of action that involves a reduction of split shift or live-in services, or when the plan is reducing hours by 25% or more. The plan will also report the number of appeals and fair hearing requested regarding these reductions. The state shall ensure, through its contracts, that if an enrollee is to change from one MCO/PIHP to another, the MCO/PIHPs will communicate with one another to ensure a smooth transition and provide the new MCO/PIHP with the individual's current service plan.

- ii. MLTC Eligibility. MLTC plans conduct the initial programmatic eligibility determination for plan enrollment using a standardized assessment tool designated by the state. The following requirements apply to the activities that must be undertaken by an MLTC plan as it assesses applicants for enrollment in the plan.
1. The state shall ensure all individuals requesting long-term services and supports are assessed for MLTC eligibility.
 - a. The MCO/PIHP will use the Semi-Annual Assessment of Members (SAAM) tool (or successor tool designated by the state) to determine if the individual meets the eligibility criteria to be enrolled in an MLTC.
 - b. In addition to the SAAM tool, the MCO/PIHP may use other assessment tools as appropriate. The state must review and approve all other assessment tools used by the MCO/PIHP.
 - c. The state must ensure, through its contracts, that each MCO/PIHP must complete the initial assessment in the individual home of each individual referred to or requesting enrollment in an MLTC plan, within 30 days of that referral or initial contact. MCO/PIHP compliance with this standard shall be reported to CMS in the quarterly reports as required in STC 49.
 2. The MCO/PIHP shall complete a re-assessment at least annually, or at another timeframe as specified in the MCO/PIHP contract.
 3. The state shall require each MCO/PIHP, through its contract, to report to the enrollment broker the names of all individuals for whom an assessment is completed. If the individual has not been referred by the enrollment broker, the MCO/PIHP shall report the date of initial contact by the individual and the date of the assessment to determine compliance with the 30-day requirement.
 - a. The state shall use this information to determine if individuals have been wrongfully determined ineligible.
 - b. The state shall review a sample of those assessments at least annually, either through the EQRO or by the state, to verify the correct determination was made.

iii. Marketing Oversight.

1. The state shall require each MCO/PIHPs, through its contract, to meet 42 CFR 438.104 and state marketing guidelines which prohibit cold calls, use of government logos, and other standards.
2. All materials used to market the MCO/PIHP shall be prior approved by the state.
3. The state shall require, through its contract, that each MCO/PIHP provide all individuals who were not referred to the plan by the enrollment broker with information (in a format determined by the state) describing Managed Long- Term Care, a list of available plans, and information about how to reach the enrollment broker for questions or other assistance. The plan shall report the number of individuals receiving these materials to the state on a quarterly basis pursuant to STC 46.

- e) **Demonstration Participant Protections.** The state will assure that adults in LTSS in MLTC programs are afforded linkages to adult protective services through all service

entities, including the MCO's/PIHP's. The state will ensure that these linkages are in place before, during, and after the transition to MLTC as applicable.

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

21. Mandatory Mainstream Managed Care Program Benefits and Cost-Sharing. Benefits provided through this Demonstration for the mainstream Medicaid managed care program are identical to those in the Medicaid state plan, and are summarized below:

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

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

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

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

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

23. Option for Consumer Directed Personal Assistance Program. Until such time as the consumer directed personal assistance program (CDPAP) is incorporated into the mainstream and MLTC plans, enrollees shall have the option to elect self-direction on a fee-for-service (FFS) basis under the state plan. Once incorporated into the plan benefit packages, the state shall ensure through its contracts with the MCOs/PIHPs that enrollees are afforded the option to select self-direction and enrollees are informed of CDPAP as a voluntary option to its members. Individuals who select self-direction must have the opportunity to have choice and control over how services are provided and who provides the service.

- a) **Information and Assistance in Support of Participant Direction.** The state/MCO shall have a support system that provides participants with information, training, counseling, and assistance, as needed or desired by each participant, to assist the participant to effectively direct and manage their self-directed services. Participants shall be informed about self-directed care, including feasible alternatives, before electing the self-direction option.
- b) **Participant Direction by Representative.** The participant who self-directs the personal care service may appoint a volunteer designated representative, to assist with or perform employer responsibilities, to the extent approved by the participant. Services may be directed by a legal representative of the participant. Consumer-Directed services may be directed by a non-legal representative freely chosen by the participant. A person who serves as a representative of a participant, for the purpose of directing services, cannot serve as a provider of personal attendant services, for that participant.
- c) **Participant Employer Authority.** The participant (or the participant's representative) must have decision-making authority over workers who provide personal care services.
 - i. **Participant.** The participant (or the participant's representative) provides training, supervision, and oversight to the worker who provides services. An Internal Revenue Service-Approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law.
 - ii. **Decision Making Authorities.** The participants exercise the following decision making authorities: Recruit staff, hire staff, verify staff's ability to perform identified tasks, schedule staff, evaluate staff performance, verify time worked by staff, and approve time sheets, and discharge staff.
- d) **Disenrollment from Self-Direction.** A participant may voluntarily disenroll from the self-directed option at any time and return to a traditional service delivery system through the

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

- e) **Appeals.** The following actions shall be considered adverse action under both 42 CFR 431 subpart E and 42 CFR 438 subpart F:
 - i. A reduction, suspension, or termination of authorized CDPAP services;
 - ii. A denial of a request to change CDPAP services

24. Adding Services to the MMMC and/or MLTC plan benefit package. At any point in time the state intends to add to either the MMMC or MLTC plan benefit package currently authorized state plan or Demonstration services that have been provided on a FFS basis, the state must provide CMS the following information, with at least 30 days notice prior to the inclusion of the benefit, either in writing or as identified on the agenda for the monthly calls referenced in STC 45:

- a) A description of the benefit being added to the MCO/PIHPs benefit package;
- b) A detailed description of the state's oversight of the MCO/PIHP's readiness to administer the benefit including: readiness and implementation activities, which may include on-site reviews, phone meetings and desk audits reviewing policies and procedures for the new services, data sharing to allow plans to create service plans as appropriate, process to communicate the change to enrollees, MCO/PIHP network development to include providers of that service, and any other activity performed by the state to ensure plan readiness.
- c) Information concerning the changes being made to MMMC and/or MLTC contract provisions and capitation payment rates in accordance with STC 28.

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

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

25. Expanding MLTC enrollment into a new geographic area. At any point in time the state is ready to expand mandatory MLTC plan enrollment into a new geographic area, the state must provide CMS notification at least 90 days prior to the expansion, such notification will include:

- a) A list of the counties that will be moving to mandatory enrollment;
- b) A list of MCO/PIHPs with an approved state certificate of authority to operate in those counties demonstrating that enrollees will be afforded choice of plan within the new geographic area;
- c) Confirmation that the MCO/PIHPs in the new geographic area have met the network

requirements in STCs 33 and 34 for each MCO/PIHP.

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

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

26. Facilitated Enrollment. MCO, health care provider, and community-based organization facilitated enrollers will engage in those activities described in 42 CFR 435.904(d)(2), as permitted by 42 CFR 435.904(e)(3)(ii), within the following parameters:

- a) Facilitated enrollers will provide program information to applicants and interested individuals as described in 42 CFR 435.905 (a).
- b) Facilitated enrollers must afford any interested individual the opportunity to apply for Medicaid without delay as required by 42 CFR 435.906.
- c) If an interested individual applies for Medicaid by completing the information required under 42 CFR 435.907(a) and (b) and 42 CFR 435.910(a) and signing a Medicaid application, that application must be transmitted to the local department of social services (LDSS) for determination of eligibility.
- d) The protocols for facilitated enrollment practices between the LDSS and the facilitated enrollers must:
 - i. Ensure that choice counseling activities are closely monitored to minimize adverse risk selection; and
 - ii. Specify that determinations of Medicaid eligibility are made solely by the LDSS.

V. DELIVERY SYSTEMS

27. Contracts. Procurement and the subsequent final contracts developed to implement selective contracting by the state with any provider group shall be subject to CMS approval prior to implementation. Existing contracts with Federally Qualified Health Centers (FQHC) shall continue in force.

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

28. Managed care Contracts. No FFP is available for activities covered under contracts and/or modifications to existing contracts that are subject to 42 CFR 438 requirements prior to CMS approval of model contract language. The state shall submit any supporting documentation deemed necessary by CMS. The State must provide CMS with a minimum of 45 days to review and approve changes. CMS reserves the right, as a corrective action, to withhold FFP (either

partial or full) for the Demonstration, until the contract compliance requirement is met.

29. **Managed Care Benefit Package.** Individuals enrolled in either MMMC or MLTC must receive, from the managed care program, the benefits as identified in STC 21 and Attachment A, as appropriate. As noted in plan readiness and contract requirements, the state must require that, for enrollees in receipt of LTSS, each MCO/PIHP coordinate, as appropriate, needed state plan services that are excluded from the managed care delivery system, but available through a fee for service delivery system, and must also assure coordination with services not included in the established benefit package.
30. **Revision of the State Quality Strategy.** The state must update its Quality Strategy to reflect all managed care plans operating under MMMC and MLTC programs proposed through this Demonstration and submit to CMS for approval within 90 days of approval of the August 2012 amendment. The state must obtain the input of recipients and other stakeholders in the development of its revised comprehensive Quality Strategy and make the Strategy available for public comment. The state must revise the strategy whenever significant changes are made, including changes through this Demonstration. Pursuant to STC 47, the state must also provide CMS with annual reporting on the implementation and effectiveness of the updated comprehensive Quality strategy, as it impacts the Demonstration.
31. **Required Components of the State Quality Strategy.** The revised Quality Strategy shall meet all the requirements of 42 CFR 438 Subpart D. The quality strategy must include components relating to managed long-term services and supports. The Quality strategy must address the following regarding the population utilizing long-term services and supports: level of care assessments, service planning, and health and welfare of enrollees.
32. **Required Monitoring Activities by State and/or External Quality Review Organization (EQRO).** The State's EQR process for the mainstream managed care and MLTC plans shall meet all the requirements of 42 CFR 438 Subpart E. In addition, the state, or its EQRO shall monitor and annually evaluate the MCO/PIHPs performance on specific new requirements under mandatory enrollment of individuals utilizing long-term services and supports. The state shall provide an update of the processes used to monitor the following activities, as well as the outcomes of the monitoring activities within the annual report in STC 47. The new requirements include, but are not limited to the following:
 - a) MLTC Plan Eligibility Assessments – to ensure that approved instruments are being used and applied appropriately and as necessary, and to ensure that individuals being served with LTSS meet the MLTC plan eligibility requirements for plan enrollment. The State will also monitor assessments conducted by the plan where individuals are deemed ineligible for enrollment in an MLTC plan.
 - b) Service plans – to ensure that MCOs/PIHPs are appropriately creating and implementing service plans based on enrollees' identified needs.
 - c) MCO/PIHP credentialing and/or verification policies – to ensure that LTSS services are provided by qualified providers.
 - d) Health and welfare of enrollees – to ensure that the MCO/PIHP, on an ongoing basis, identifies, addresses, and seeks to prevent instances of abuse, neglect, and exploitation.

33. Access to Care, Network Adequacy and Coordination of Care Requirements for Long Term

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

34. Demonstrating Network Adequacy. Annually, each MCO/PIHP must provide adequate assurances that it has sufficient capacity to serve the expected enrollment in its service area and offer an adequate coverage of benefits, as described in STC 21 and Attachment A for the anticipated number of enrollees in the service area.

- a) The state must verify these assurances by reviewing demographic, utilization, and enrollment data for enrollees in the Demonstration as well as:
 - i. The number and types of providers available to provide covered services to the Demonstration population;
 - ii. The number of network providers accepting the new Demonstration population; and
 - iii. The geographic location of providers and Demonstration populations, as shown through GeoAccess, similar software, or other appropriate methods.
- b) The State must submit the documentation required in subparagraphs i – iii above to CMS with each annual report.

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

36. Health Services to Native American Populations. The plan for patient management and coordination of services for Medicaid-eligible Native Americans developed for the Partnership Plan, in consultation with the Indian tribes and/or representatives from the Indian health programs located in participating counties, shall apply to recipients in this Demonstration.

VI. FEDERAL-STATE HEALTH REFORM PARTNERSHIP (F-SHRP) ACTIVITIES

37. State Expenditures on Health System Reforms. Between October 1, 2006, and March 31, 2014, the state is eligible to receive no more than \$1.5 billion in FFP if it expends up to \$3.0 billion over the same period for the health system reform initiatives identified in this paragraph.

- a) These initiatives will include programs that will promote the efficient operation of the State's health care system; consolidate and right-size New York's health care system by reducing excess capacity in the acute care system; shift emphasis in long-term care from institutional-based to community-based settings; expand the use of e-prescribing, electronic medical

records, and regional health information organizations; and improve ambulatory and primary care provision.

- b) These reform initiatives may include but are not limited to:
 - i. Reform activities set forth in (a) above and consistent with the goals of HEAL NY
 - ii. State Office on Aging programs – Expanded In-Home Services to the Elderly
 - iii. Office of Mental Health programs –
 - A. Community Support Services and Residential Services Program
 - B. New York University Child Studies Center
 - iv. Office of Alcoholism and Substance Abuse Services – Prevention and Treatment Program
- c) Additional state-only health care reform investments or changes in the listed uses will be considered an amendment to the Demonstration and processed in accordance with Section III, STC 6.

38. Federal Financial Participation for Designated State Health Programs (DSHP).

- a) **Demonstration Approval Period.** Federal Financial Participation (FFP) will be available beginning April 1, 2011, for state expenditures on the DSHP described in STC 39 incurred by the state during the demonstration approval period subject to the limitations outlined below.
 - i. **FFP Cap** FFP for DSHP is limited to the amount of monies the State expends over the demonstration period on the health system reform activities described in STC 37 multiplied by the state's FMAP rate over the same period, except that in no case may FFP be claimed in excess of \$1.5 billion between the period of October 1, 2006, and March 31, 2014. For purposes of meeting the requirements for FFP, the State's health system reform initiatives will be counted differently during the following time periods:
 - (1) For the period beginning October 1, 2006, and ending March 31, 2011, the state's regular FMAP rate of 50 percent will apply; and
 - (2) For the period beginning April 1, 2011, and ending March 31, 2014, the state's FMAP rate effective for the quarter in which the expenditures are made will apply.
 - ii. **Timing.** The state may not draw federal funds for the programs described in STC 39 until such time as the state makes expenditures for the health system reform initiatives described in STC 37.
 - iii. **Demonstrated Savings.** The state must achieve an amount of total Medicaid program savings by the end of the Demonstration period, as calculated under the provisions of Section X.
 - iv. **Reconciliation and Recoupment.** If the federal share of these savings are not at least equal to the amount determined under subparagraph (i) the state must return to CMS the amount of federal funds that exceed Medicaid program savings achieved.
 - A. As part of the annual report required under Section VII, STC 47, the state will

- B. report both DSHP claims and expenditures for health care reforms.
- C. The reported claims and expenditures will be reconciled at the end of the Demonstration with the state's MBES submissions.
- C. Any repayment required under this subparagraph will be accomplished by the state making an adjustment for its excessive claim for FFP on the CMS-64 by entering an amount in line 10(b) of the Summary sheet equal to the amount by which FFP exceeds Medicaid program savings.

39. Designated State Health Programs. Subject to the conditions outlined in STC 38, FFP may be claimed for expenditures made for the following designated state health programs during the demonstration approval period:

- a) Health Care Reform Act programs –
 - i. Healthy New York
 - ii. AIDS Drug Assistance
 - iii. Tobacco Use Prevention and Control
 - iv. Health Workforce Retraining
 - v. Recruitment and Retention of Health Care Workers
 - vi. Telemedicine Demonstration
 - vii. Pay for Performance Initiatives
- b) State Office on Aging programs –
 - i. Community Services for the Elderly
 - ii. Expanded In-Home Services to the Elderly
- c) Office of Mental Health – Community Support Services and Residential Services Program
- d) Office for Persons with Developmental Disabilities – Residential and Community Support Services
- e) Office of Alcoholism and Substance Abuse Services – Prevention and Treatment Program
- f) Office of Children and Family Services - Committees on Special Education direct care programs
- g) State Department of Health – Early Intervention Program Services

40. Designated State Health Programs Claiming Process

- a) Documentation of each designated state health program's expenditures must be clearly outlined in the state's supporting work papers and be made available to CMS.
- b) Federal funds must be claimed within two years after the calendar quarter in which the state disburses expenditures for the designated state health programs in STC 39. Claims may not be submitted for state expenditures disbursed after the end of the demonstration approval period. The state may draw federal funds only as the state makes disbursements for the health system reform initiatives identified in STC 37.

- c) Sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. To the extent that federal funds from any Federal programs are received for the designated state health programs listed in STC 39, they shall not be used as a source of non-federal share.
- d) The administrative costs associated with programs in STC 39 and any others subsequently added by amendment to the Demonstration shall not be included in any way as Demonstration and/or other Medicaid expenditures.
- e) Any changes to the designated state health programs listed in STC 39 shall be considered an amendment to the Demonstration and processed in accordance with STC 7.

41. Fraud and Abuse Recoveries. Medicaid expenditure data for FFY 2005 shows that the state recovers less than one percent of its total Medicaid expenditures.

- a) At the end of FFY 2011 (for the period October 1, 2010, through September 30, 2011), the state must demonstrate that its annual level of fraud and abuse recoveries is equal to 1.5 percent of FFY 2005 total computable Medicaid expenditures (or \$641 million). CMS will verify compliance with this requirement by reviewing in February 2012 the state-reported fraud and abuse recoveries on the CMS-64, line 9c for FFY 2011.
- b) If the state does not meet the targets for FFY 2011, the state will be required to pay the federal government the lesser of:
 - i. The dollar difference between actual and target recoveries for that year; or
 - ii. Total claimed FFP for designated state health programs during that year.
- c) The federal government will recoup the penalty calculated in item b) above. To accomplish this, the state must make an adjustment for its claims for FFP on the CMS-64 by entering an amount in line 10(b) of the summary sheet equal to the amount of the penalty, divided by the state's FMAP rate. This will ensure that the state's claim of FFP is reduced by the total computable amount calculated in item b) above.

VII. GENERAL REPORTING REQUIREMENTS

42. General Financial Requirements. The state must comply with all general financial requirements set forth in section VIII.

43. Compliance with Managed Care Reporting Requirements. The state must comply with all managed care reporting regulations at 42 CFR 438 et. seq., except as expressly identified as not applicable in the expenditure authorities incorporated into the Demonstration award letter s.

44. Reporting Requirements Related to Budget Neutrality. The state must comply with all reporting requirements for monitoring budget neutrality set forth in section IX and the Medicaid Program Savings set forth in section X.

45. Monthly Calls. Monthly discussions between CMS and the state regarding this demonstration

shall be conducted as part of the monthly calls held for the Partnership Plan Demonstration (11-W-00114/2). During these calls, the progress of the health care reforms authorized by this Demonstration shall be discussed, as well as any pertinent state legislative developments, and any Demonstration amendments the state is considering submitting. CMS shall update the state on any amendments or concept papers under review, as well as federal policies and issues that may affect any aspect of the Demonstration. The state and CMS shall jointly develop the agenda for the calls.

46. **Quarterly Reports:** The state must submit progress reports in accordance with the guidelines in Attachment B taking into consideration the requirements in STC 49, no later than 60 days following the end of each quarter (December, March, and June of each Demonstration year). The state may combine the quarterly report due for the quarter ending September with the annual report in STC 47. The intent of these reports is to present the state's analysis and the status of the various operational areas.
47. **Annual Report.** The state must submit an annual report documenting accomplishments, project status, quantitative and case study findings, interim evaluation findings, utilization data, and policy and administrative difficulties in the operation of the Demonstration. The state must submit this report no later than 90 days following the end of each Demonstration year. Additionally, the annual report must include:
 - a) A summary of the elements included within each quarterly report;
 - b) An update on the progress related to the quality strategy as required in STC 30;
 - c) An aggregated enrollment report showing the total number of individuals enrolled in each plan;
 - d) A summary of the use of self-directed service delivery options in the state at the time when those benefits are included in the demonstration;
 - e) A listing of the new geographic areas the state has expanded MLTC to;
 - f) A list of the benefits added to the managed care benefit package;
 - g) An updated transition plan, which shows the intended transition and timeline for any new benefits and/or populations into the demonstration;
 - h) Network adequacy reporting as required in STC 34;
 - i) Any other topics of mutual interest between CMS and the state related to the demonstration; and
 - j) Any other information the state believes pertinent to the demonstration.
48. **Transition Plan.** On or before July 1, 2012, and consistent with guidance provided by CMS, the state is required to prepare, and incrementally revise, a Transition Plan consistent with the provisions of the Affordable Care Act for individuals enrolled in the Demonstration, including how the state plans to coordinate the transition of these individuals to a coverage option available under the Affordable Care Act without interruption in coverage to the maximum extent possible. The plan must include the required elements and milestones described in STCs 48(a)-(e) outline below. In addition, the plan will include a schedule of implementation activities that the state will use to operationalize the Transition Plan. For any elements and milestones that remain under development as of July 1, 2012, the state will include in the Transition Plan a description of the status and anticipated completion date.
 - a) **Seamless Transitions.** Consistent with the provisions of the Affordable Care Act, the Transition Plan will include details on how the state plans to obtain and review any

additional information needed from each individual to determine eligibility under all eligibility groups, and coordinate the transition of individuals enrolled in the Demonstration (by FPL) (or newly applying for Medicaid) to a coverage option available under the Affordable Care Act, without interruption in coverage to the maximum extent possible. Specifically, the state must:

- i. Determine eligibility under all January 1, 2014, eligibility groups for which the state is required or has opted to provide medical assistance, including the group described in section 1902(a)(10)(A)(i)(VIII) for individuals under age 65 and regardless of disability status with income at or below 133 percent of the FPL;
- ii. Identify Demonstration populations not eligible for coverage under the Affordable Care Act and explain what coverage options and benefits these individuals will have effective January 1, 2014;
- iii. Implement a process for considering, reviewing, and making preliminarily determinations under all January 1, 2014, eligibility groups for new applicants for Medicaid eligibility;
- iv. Conduct an analysis that identifies populations in the Demonstration that may not be eligible for or affected by the Affordable Care Act and the authorities the state identifies that may be necessary to continue coverage for these individuals; and
- v. Develop a modified adjusted gross income (MAGI) calculation for program eligibility.

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

- i. **Provider Participation.** The state must identify the criteria that will be used for reviewing provider participation in (e.g. demonstrated data collection and reporting capacity) and means of securing provider agreements for the transition.
- ii. **Adequate Provider Supply.** The state must provide the process that will be used to assure adequate provider supply for the state plan and Demonstration populations affected by the Demonstration on December 31, 2013. The analysis should address delivery system infrastructure/capacity, provider capacity, utilization patterns and requirements (i.e., prior authorization), current levels of system integration, and other information necessary to determine the current state of the of service delivery. The report must separately address each of the following provider types:
 - A. Primary care providers;
 - B. Mental health services;
 - C. Substance use services; and
 - D. Dental services.
- iii. **Provider Payments.** The state will establish and implement the necessary processes for ensuring accurate encounter payments to providers entitled to the prospective payment services (PPS) rate (e.g., certain FQHCs and RHCs) or the all-inclusive rate (e.g., certain Indian Health providers).

c) **System Development or Remediation.** The Transition Plan for the Demonstration is expected to expedite the state's readiness for compliance with the requirements of the Affordable Care Act and other federal legislation. System milestones that must be tested for implementation on or before January 1, 2014, include:

- i. Replacing manual administrative controls with automotive processes to support a smooth interface among coverage and delivery system options that is seamless to beneficiaries.
- d) **Progress Updates.** After submitting the initial Transition Plan for CMS approval, the State must include progress updates in each quarterly and annual report. The Transition Plan shall be revised as needed.
- e) **Implementation.**
 - i. By October 1, 2013, the state must begin to implement a simplified, streamlined process for transitioning eligible enrollees in the Demonstration to Medicaid, the Exchange, or other coverage options in 2014. In transitioning these individuals from coverage under the waiver to coverage under the state plan, the state will not require these individuals to submit a new application.
 - ii. On or before December 31, 2013, the state must provide notice to the individual of the eligibility determination using a process that minimizes demands on the enrollees.

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

- a) In each quarterly report required by STC 46, the state shall report:
 - i. Any critical incidents reported within the quarter and the resulting investigations as appropriate;
 - ii. The number and types of grievances and appeals, filed and/or resolved within the reporting quarter, for this population;
 - iii. The total number of assessments for enrollment performed by the plans, with the number of individuals who did not qualify to enroll in an MLTC plan;
 - iv. The number of individuals referred to an MLTC plan that received an assessment within 30 days;
 - v. The number of people who were not referred by the enrollment broker and contacted the plan directly and were provided MLTC materials;
 - vi. Rebalancing efforts performed by the MLTC Plans and mainstream plans once the benefit is added; Rebalancing reporting should include, but is not limited to the total number of individuals transitioning in and out of a nursing facility within the quarter.
 - vii. Total number of complaints, grievances and appeals by type of issue with a listing of the top 5 reasons for the event.

VIII. GENERAL FINANCIAL REQUIREMENTS

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

51. Reporting Expenditures Under the Demonstration: The following describes the reporting of expenditures under the Demonstration:

- a) In order to track expenditures under this Demonstration, the state must report Demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual. All Demonstration expenditures must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the Demonstration project number assigned by CMS (including the project number extension, which indicates the DY in which services were rendered or for which capitation payments were made).
- b) For monitoring purposes, quarterly cost settlements and pharmaceutical rebates relevant to the Demonstration will be allocated (using an approved methodology) to the Demonstration populations specified in subparagraph (c) and offset against current quarter waiver expenditures. Demonstration expenditures net of these cost settlement offsets will be reported on Form CMS 64.9 Waiver. Amounts offset will be identifiable in the state's supporting work papers and made available to CMS.
- c) For each Demonstration year, nine (9) separate waiver Forms CMS-64.9 Waiver and/or 64.9P Waiver must be completed, using the waiver name noted below, to report expenditures for the following Demonstration populations, as well as for the designated State health programs.

i. **Demonstration Population 1:**

TANF Child under age 1 through age 20 required to enroll in managed care in Allegany, Cortland, Dutchess, Fulton, Montgomery, Putnam, Orange, Otsego, Schenectady, Seneca, Sullivan, Ulster, Washington and Yates counties [TANF Child New MC].

ii. **Demonstration Population 2:**

Temporary Assistance to Needy Families (TANF) Adults aged 21-64 required to enroll in managed care in Allegany, Cortland, Dutchess, Fulton, Montgomery, Putnam, Orange, Otsego, Schenectady, Seneca, Sullivan, Ulster, Washington, and Yates counties [TANF Adult New MC].

iii. **Demonstration Population 3:**

Disabled Adults and Children aged 0-64 voluntarily enrolled in managed care in those counties participating in the Partnership Plan as of October 1, 2006 [SSI 0-64 Current MC].

iv. **Demonstration Population 4:**

Disabled Adults and Children aged 0-64 required to enroll in managed care in those counties participating in the Partnership Plan as of October 1, 2006 [SSI 0-64 New MC].

v. **Demonstration Population 5:**

Aged or Disabled Elderly voluntarily enrolled in managed care in those counties participating in the

		Partnership Plan as of October 1, 2006 [SSI 65+ Current MC].
vi.	<u>Demonstration Population 6:</u>	Aged or Disabled Elderly required to enroll in managed care in those counties participating in the Partnership Plan as of October 1, 2006 [SSI 65+ New MC].
vii.	<u>Demonstration Population 7:</u>	MLTC Adults age 18 – 64 [MLTC Adults 18 -64]
viii.	<u>Demonstration Population 8:</u>	MLTC Adults age 65 and above [MLTC Adults 65+]
ix.	<u>Demonstration Expenditures:</u>	Designated State Health Programs [DSHP]
52.	Expenditures Subject to the Budget Neutrality Cap.	For purposes of this section, the term “expenditures subject to the budget neutrality cap” must include all Medicaid expenditures on behalf of individuals who are enrolled in this Demonstration and for designated state health program expenditures as described in STC 39. All expenditures that are subject to the budget neutrality cap are considered Demonstration expenditures, and must be reported on Forms CMS-64.9 Waiver and /or 64.9P Waiver.
	All expenditures for managed care enrollment for Demonstration Populations 1 and 2 residing in the counties other than those specified in Section IV, STC 16 who are required to enroll in managed care (“current” mandatory managed care enrollment) will be reported under the Partnership Plan Demonstration (11-W-00114/2). These expenditures may not be reported under this Demonstration.	
53.	Administrative Costs.	Administrative costs will not be included in the budget neutrality limit, but the state must separately track and report additional administrative costs that are directly attributable to the Demonstration, subject to the restriction in Section VI, STC 40 (d). All administrative costs must be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver.
54.	Claiming Period.	All claims for expenditures subject to the budget neutrality cap (including any cost settlements) must be made within 2 years after the calendar quarter in which the state made the expenditures. All claims for services during the Demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the Demonstration. During the latter 2-year period, the state must continue to identify separately, net expenditures related to dates of service during the operation of the Demonstration on the CMS-64 waiver forms, in order to properly account for these expenditures in determining budget neutrality.
55.	Reporting Member Months.	The following describes the reporting of member months for Demonstration populations:

- a) For the purpose of calculating the budget neutrality expenditure cap and for other purposes, the state must provide to CMS, as part of the quarterly report required under STC 46, the actual number of eligible member months for the Demonstration Populations defined in STC 51 (c) (i-

vi). The state must submit a statement accompanying the quarterly report which certifies the accuracy of this information.

The actual number of member months for current mandatory managed care enrollment for Demonstration Populations 1 and 2 as defined in STC 51 will not be used for the purpose of calculating the budget neutrality expenditure agreement for this Demonstration. They will be used for the budget neutrality expenditure agreement for the Partnership Plan Demonstration (11-W-00114/2).

To permit full recognition of “in-process” eligibility, reported counts of member months may be subject to revisions after the end of each quarter. Member month counts may be revised thereafter as needed.

- b) The term “eligible member months” refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes 3 eligible member months to the total. Two individuals who are eligible for 2 months each contribute 2 eligible member months to the total, for a total of 4 eligible member months.
- c) For the purposes of this Demonstration, the term “Demonstration eligibles” excludes unqualified aliens and refers only to the Demonstration Populations described in STC 51 (c) (i-vi).

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

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

- a) Administrative costs, including those associated with the administration of the Demonstration, subject to the restriction in Section VI, STC 40 (d);
- b) Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid State plan.

58. Sources of Non-Federal Share. The state certifies that the non-federal share of funds for the Demonstration are state/local monies. The state further certifies that such funds shall not be used to match for any other federal grant or contract, except as permitted by law. All sources of non-

federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

- a) CMS shall review the sources of the non-federal share of funding for the Demonstration at any time. The state agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.
- b) Any amendments that impact the financial status of the program shall require the state to provide information to CMS regarding all sources of the non-federal share of funding.

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

- a) Units of government, including governmentally-operated health care providers, may certify that state or local tax dollars have been expended as the non-federal share of funds under the Demonstration.
- b) To the extent the state utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the state would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.
- c) To the extent the state utilizes CPEs as the funding mechanism to claim federal match for payments under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the state the amount of such tax revenue (state or local) used to satisfy demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the state's claim for federal match.
- d) The state may use intergovernmental transfers to the extent that such funds are derived from state or local tax revenues and are transferred by units of government within the state. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of title XIX payments. Under all circumstances, health care providers must retain 100 percent of the claimed expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) exist between health care providers and state and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, (including health care provider-related taxes), fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

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

IX. MONITORING BUDGET NEUTRALITY

61. Limit on Title XIX Funding. The state shall be subject to a limit on the amount of federal title

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

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

63. Demonstration Populations Used to Calculate the Budget Neutrality Cap. The following Demonstration populations are used to calculate the budget neutrality cap and are incorporated into the following eligibility groups (EGs):

- a) **Eligibility Group 1:** TANF Child under age 1 through age 20 required to enroll in managed care in Allegany, Cortland, Dutchess, Fulton, Montgomery, Putnam, Orange, Otsego, Schenectady, Seneca, Sullivan, Ulster, Washington and Yates counties (Demonstration Population 1)
- b) **Eligibility Group 2:** TANF Adults aged 21-64 required to enroll in managed care in Allegany, Cortland, Dutchess, Fulton, Montgomery, Putnam, Orange, Otsego, Schenectady, Seneca, Sullivan, Ulster, Washington, and Yates counties (Demonstration Population 2)
- c) **Eligibility Group 3:** Disabled Adults and Children aged 0-64 voluntarily enrolled in managed care in those counties participating in the Partnership Plan as of October 1, 2006 (Demonstration Population 3)
- d) **Eligibility Group 4:** Disabled Adults and Children aged 0-64 required to enroll in managed care in those counties participating in the Partnership Plan as of October 1, 2006 (Demonstration Population 4)
- e) **Eligibility Group 5:** Aged or Disabled Elderly 65+ voluntarily enrolled in managed care in those counties participating in the Partnership Plan as of October 1, 2006 (Demonstration Population 5)
- f) **Eligibility Group 6:** Aged or Disabled Elderly 65+ required to enroll in managed care in those counties participating in the Partnership Plan as of October 1, 2006 (Demonstration Population 6)
- g) **Eligibility Group 7:** MLTC Adults age 18 – 64 (Demonstration Population 7)

h) **Eligibility Group 8:** MLTC Adults age 65 and above (Demonstration Population 8)

64. Budget Neutrality Expenditure Cap: The following describes the method for calculating the budget neutrality expenditure cap for the Demonstration:

- a) For each year of the budget neutrality agreement an annual budget neutrality expenditure cap is calculated for each EG described in STC 63 as follows:
 - i. An annual EG estimate must be calculated as a product of the number of eligible member months reported by the state under STC 55 for each EG, times the appropriate estimated per member per month (PM/PM) costs from the table in subparagraph (ii) below.
 - ii. The PM/PM costs for the calculation of the annual budget neutrality expenditure cap for the eligibility groups subject to the budget neutrality agreement under this Demonstration are specified below.

For the extension period, the PMPM cost for each EG in Demonstration year 5 outlined below has been increased by the trend rates that were approved for the initial five-year demonstration period, since those trend rates are lower than those included in the President's federal fiscal year 2011 budget.

Eligibility Group	DY 5 (10/1/10 - 3/31/11)	Trend Rate	DY 6 (4/1/11 - 3/31/12)	DY 7 (4/1/12 - 3/31/13)	DY 8 (4/1/13 - 3/31/14)
TANF Children under age 1 through 20	\$626	6.7%	\$667	\$711	\$758
TANF Adults aged 21-64	\$854	6.6%	\$909	\$967	\$1,029
Disabled Adults and Children aged 0 – 64 voluntarily enrolled in managed care	\$2,214	6.12%	\$2,349	\$2,493	\$2,646
Disabled Adults and Children aged 0 – 64 required to enroll in managed care	\$2,214	6.12%	\$2,349	\$2,493	\$2,646
Aged or Disabled Elderly 65+ voluntarily enrolled in managed care	\$1,389	5.38%	\$1,464	\$1,542	\$1,625
Aged or Disabled Elderly 65+ required to enroll in managed care	\$1,389	5.38%	\$1,464	\$1,542	\$1,625
MLTC Adults aged 18 - 64		5.9%		\$8,873.37	\$9,396.90
MLTC Adults aged 65 and above		3.6%		\$8,111.89	\$8,403.92

- iii. The annual budget neutrality expenditure cap for the Demonstration as a whole is the sum of the projected annual expenditure caps for each EG calculated in subparagraph (i) above.
- b) The overall budget neutrality expenditure cap for the demonstration period is the sum of the annual budget neutrality expenditure caps calculated in subparagraph (a) (iii) above for each of the demonstration years. The federal share of the overall budget neutrality expenditure cap represents the maximum amount of FFP that the state may receive for expenditures on behalf of

Demonstration populations and expenditures described in STC 51 (c) during the Demonstration period.

65. **Future Adjustments to the Budget Neutrality Expenditure Limit.** CMS reserves the right to adjust the budget neutrality expenditure limit to be consistent with enforcement of impermissible provider payments, health care related taxes, new federal statutes, or policy interpretations implemented through letters, memoranda, or regulations with respect to the provision of services covered under this demonstration.
66. **Enforcement of Budget Neutrality.** CMS shall enforce budget neutrality over the life of the Demonstration rather than on an annual basis.
67. **Exceeding Budget Neutrality.** If, at the end of this Demonstration period the overall budget neutrality expenditure limit has been exceeded, the excess federal funds must be returned to CMS. If the Demonstration is terminated prior to the end of the budget neutrality agreement, an evaluation of this provision shall be based on the time elapsed through the termination date.

X. MEDICAID PROGRAM SAVINGS MEASURES

68. **Cumulative Savings Cap.** The State is required to save, through specified health care reform initiatives in Section VI, STC 37, an amount at least equal to the amount of monies the state expends over the demonstration period on the health system reform activities described in STC 37 multiplied by the state's FMAP rate over the same period, this cumulative savings cap is considered a sub cap of the budget neutrality expenditure cap calculated in Section IX.
69. **Demonstration Populations Used to Calculate the Estimated Savings.** The following Demonstration populations are used to calculate the estimated savings and are incorporated into the following EGs:
 - a) **Eligibility Group 1:** TANF Child under age 1 through age 20 required to enroll in managed care in Allegany, Cortland, Dutchess, Fulton, Montgomery, Putnam, Orange, Otsego, Schenectady, Seneca, Sullivan, Ulster, Washington and Yates counties (Demonstration Population 1)
 - b) **Eligibility Group 2:** TANF Adults aged 21-64 required to enroll in managed care in Allegany, Cortland, Dutchess, Fulton, Montgomery, Putnam, Orange, Otsego, Schenectady, Seneca, Sullivan, Ulster, Washington, and Yates counties (Demonstration Population 2)
 - c) **Eligibility Group 4:** Disabled Adults and Children aged 0-64 required to enroll in managed care in those counties participating in the Partnership Plan as of October 1, 2006 (Demonstration Population 4)
 - d) **Eligibility Group 6:** Aged or Disabled Elderly 65+ required to enroll in managed care in those counties participating in the Partnership Plan as of October 1, 2006 (Demonstration Population 6)

- e) **Eligibility Group 7:** MLTC Adults age 18 – 64 (Demonstration Population 7)
- f) **Eligibility Group 8:** MLTC Adults age 65 and above (Demonstration Population 8)

70. Estimated Medicaid Program Savings As a Subset of the Budget Neutrality Expenditure

Cap: The following describes the method for calculating the estimated Medicaid Program savings cap for the Demonstration:

- a) For each year of the budget neutrality agreement an annual Medicaid program savings is calculated for each EG described in STC 68 as follows:
 - i. An annual EG estimate must be calculated as a product of the number of eligible member months reported by the State under STC 55 for each EG times the appropriate estimated per member per month (PM/PM) costs from the table in STC 64 (a)(ii).
 - ii. The annual Medicaid savings cap for the Demonstration, as a whole, is the sum of the projected annual expenditure caps for each EG calculated in subparagraph (i) above minus the actual expenditures for the EGs in STC 69 reported on Forms CMS-64.9 Waiver and/or 64.9P Waiver.
- b) For each year under the Demonstration the amount of savings attributable to hospital rightsizing will be calculated using the following method from the data provided in the annual report required by Section VII, STC 47:
 - i. $(\text{Base Year Medicaid discharges/enrollee} - \text{Demonstration Year Medicaid discharges/enrollee}) * (\text{Average DY Medicaid costs per discharge}) * (\text{Total DY Medicaid enrollees})$
- c) The overall Medicaid savings cap for the 5-year demonstration period is the sum of the annual Medicaid savings calculated in subparagraph (a) (ii) plus the amount calculated in subparagraph (b) for each of the 5 years. The federal share of the overall Medicaid savings limit represents the maximum amount of FFP that the state may receive.

XI. EVALUATION OF THE DEMONSTRATION

71. Components. The demonstration's evaluation shall include a discussion of the goals, objectives, and evaluation questions specific to the purposes of and expenditures made by the state for its health system reform activities. The evaluation must use outcome measures to evaluate the impact of these activities on the efficient operation of the state's health care system during the period of the Demonstration. The outcome measures below represent agreed-upon metrics under which the state and CMS can measure the shared financial benefit of the health care reforms and must be included in the evaluation design:

- a) Nursing home admissions - “Value of Averted Medicaid Nursing Home Admissions”: For each fiscal year under the demonstration, the number of the reduction in the number of Demonstration Year (DY) Medicaid bed-days below Base Year (BY) level * average cost per bed-day * DY Medicaid enrollees.

- b) Reduction in Medicaid debt payment for hospitals - “Value of Avoided Inpatient Debt Payments”: For each fiscal year under the demonstration, the reduction in the total inpatient debt per discharge from Base Year (BY) level * Medicaid discharges.
- c) Reduction in Medicaid debt payment for nursing homes - “Value of Avoided Nursing Home Debt Payments”: For each fiscal year under the demonstration, the reduction in the total nursing facility debt per day from Base Year (BY) level * Medicaid days.
- d) The evaluation questions for MLTC goals should include, but are not limited to:
 - i. How has enrollment in MLTC plans increased over the length of the demonstration?
 - ii. What are the demographic characteristics of the MLTC population? Are they changing over time?
 - iii. What are the functional and cognitive deficits of the MLTC population? Are they changing over time?
 - iv. Are the statewide and plan-specific overall functional indices decreasing or staying the same over time?
 - v. Are the average cognitive and plan-specific attributes decreasing or staying the same over time?
 - vi. Are the individual care plans consistent with the functional and cognitive abilities of the enrollees? This evaluation question will be included as there is sufficient data available in 2014 to provide accurate measures. NYS will address this question in the Final Evaluation Plan.
 - vii. Access to Care: To what extent are enrollees able to receive timely access to personal, home care and other services such as dental care, optometry and audiology?
 - viii. Quality of Care: Are enrollees accessing necessary services such as flu shots and dental care?
 - ix. Patient Safety: Are enrollees managing their medications? What are the fall rates and how are they changing over time?
 - x. Satisfaction: What are the levels of satisfaction with access to, and perceived timeliness and quality of network providers?
 - xi. Costs: What are the PMPM costs of the population?
- e) The state must submit a revised draft evaluation design to CMS for approval no later than October 1, 2012.

72. Implementation. The state must implement the evaluation design and report on its progress in each quarterly report. A final evaluation report is due no later than one year after the expiration of this demonstration.

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

XII. SCHEDULE OF STATE DELIVERABLES FOR THE DEMONSTRATION

Date - Specific	Deliverable	STC Reference
2/1/2012	Demonstrate Fraud and Abuse Recoveries of \$641 million	Section VI, STC 41
10/1/12	Revised Evaluation Design	Section XI, STC 71
3/31/2015	Submit Final Evaluation Report	Section XI, STC 72

	Deliverable	STC Reference
Annual	By January 1st - Draft Report	Section VII, STC 48
	By December 31 st – MEQC Program Report	Section III, STC 13
Quarterly	Quarterly Operational Reports	Section VII, STC 47
	Quarterly Expenditure Reports	Section VIII, STC 50
	Eligible Member Months	Section VIII, STC 55

Attachment A

Managed Long Term Care Program Benefits

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

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

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

ATTACHMENT B

Quarterly Report Guidelines

Under Section VII, STC 46, the state is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the state. A complete quarterly progress report must include an updated budget neutrality monitoring workbook, as well as an updated reform metric workbook. An electronic copy of the report narrative, as well as both Microsoft Excel workbooks is provided.

NARRATIVE REPORT FORMAT:

Title Line One – Federal-State Health Reform Partnership

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:

Example:

Demonstration Year: 6 (4/1/11 – 3/31/12)

Federal Fiscal Quarter: 4/2011 (7/11 - 9/11)

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

Enrollment Information: Complete the following table that outlines all enrollment activity under the demonstration. The state should indicate “N/A” where appropriate. If there was no activity under a particular enrollment category, the State should indicate that by “0”.

Note: Enrollment counts should be person counts for the current quarter only, not participant months.

Population Groups	Current Enrollees	# Voluntary Disenrollments	# Involuntary Disenrollments
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ATTACHMENT B

Quarterly Report Guidelines

Population 1 – TANF Child under age 1 through age 20 (“new” MC enrollment)			
Population 2 – TANF Child under age 1 through age 20 (“new” MC enrollment)			
Population 3 – Disabled Adults and Children aged 0-64 (“old” voluntary MC enrollment)			
Population 4 – Disabled Adults and Children aged 0-64 (“new” MC enrollment)			
Population 5 – Aged or Disabled Elderly (“old” voluntary MC enrollment)			
Population 6 – Aged or Disabled Elderly (“new” MC enrollment)			

Voluntary Disenrollments:

Cumulative Number of Voluntary Disenrollments in Current Demonstration Year:

Reasons:

Involuntary Disenrollments:

Cumulative Number of Involuntary Disenrollments in Current Demonstration Year:

Reasons:

Progress of Expansion of Mandatory Managed Care: Summarize progress towards meeting projected enrollment targets

Documentation of Successful Achievement of Milestones (if any during the quarter):

Identify all activities relating to implementation of milestones required under the Demonstration, including but not limited to:

- The activities of the Commission and progress in implementing its recommendations;
- An explanation of grants, contracts or other financial arrangements entered into for purposes of implementing the health system reform efforts of this Demonstration; and
- Any other information pertinent to the health system reform efforts of this Demonstration.

Managed Long Term Care Program: Identify all significant program developments, issues, or problems that have occurred in the current quarter. Additionally, all requirements as outlined in STC 49 should be included.

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

Financial/Budget Neutrality Developments/Issues:

ATTACHMENT B

Quarterly Report Guidelines

Provide information on:

- Health reform expenditures – when and what
- Designated State health programs – amount of FFP claimed for the quarter
- Savings estimates
- Reform metrics

Submit both a completed reform metric workbook and an updated budget neutrality monitoring workbook

Demonstration Evaluation:

Summarize progress on evaluation design, plan, and final report.

Enclosures/Attachments:

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

State Contact(s):

Identify individuals by name, address, title, phone, fax, and email that CMS may contact should any questions arise.

Date Submitted to CMS:

ATTACHMENT C

Managed Long Term Care Program Enrollment Plan

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

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

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

Voluntary Population: Dual eligible, age 18-21, in need of community based long-term care services for over 120 days and assessed as nursing home eligible. Non-dual eligible age 18 and older assessed as nursing home eligible and in need of community based long-term care services for over 120 days.

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

Phase I: New York City

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

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

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

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

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

September, 2012: Continue personal care cases in New York County and begin personal

ATTACHMENT C

Managed Long Term Care Program Enrollment Plan

care in Bronx County; and begin consumer directed personal assistance program cases in New York and Bronx counties

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

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

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

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

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

*Individuals receiving personal care while enrolled in Medicaid Advantage will begin MLTC/CCM enrollment in January, 2014

Phase II: Nassau, Suffolk and Westchester Counties

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

Phase III: Rockland and Orange Counties

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

Phase IV: Albany, Erie, Onondaga and Monroe Counties

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

Phase V: Other Counties with capacity

ATTACHMENT C

Managed Long Term Care Program Enrollment Plan

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

Phase VI:

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

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