

**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 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 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 All previously approved STCs, waivers, and expenditure authorities are superseded by the STCs set forth below.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, one attachment has been included to provide supplementary information and guidance for STC 33.

II. PROGRAM DESCRIPTION AND OBJECTIVES

In 2004, 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 presented the State with significant reform opportunities. 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 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 statewide 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 telehome 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 (RGA) under HEAL NY, committing a total of \$2.37 billion in State funds for these efforts.

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.

- a) To the extent that a change in Federal law, regulation, or policy requires either a reduction or an increase in Federal financial participation (FFP) for expenditures made under this Demonstration, the State must adopt, subject to CMS approval, a modified budget neutrality agreement for the Demonstration as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph.
- b) If mandated changes in the Federal law require State legislation, the changes must take effect on the day such State legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

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

6. Changes Subject to the Amendment Process. Changes related to 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 15, 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 at any time prior to the date of expiration. The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date. In the event the State elects to phase out the Demonstration, the State must submit a phase-out plan to CMS at least 6 months prior to initiating phase-out activities. Nothing herein should be construed as preventing the State from submitting a phase-out plan with an implementation deadline shorter than 6 months when such action is necessitated by emergent circumstances. The phase-out plan is subject to CMS approval prior to implementation of phase out. If the project is terminated or any relevant waivers suspended by the State, FFP must be limited to normal closeout costs associated with terminating the Demonstration, including services and administrative costs of disenrolling participants.
9. **Enrollment Limitation During Demonstration Phase-Out.** If the State elects to suspend, terminate, or not renew this Demonstration as described in paragraph 8, during the last 6 months of the Demonstration, the State may choose to not enroll individuals into the Demonstration who would not be eligible for Medicaid under the current Medicaid State plan. Enrollment may be suspended if CMS notifies the State in writing that the Demonstration will not be renewed.
10. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate the Demonstration 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.
11. **Finding of Non-Compliance.** The State does not relinquish its rights to challenge CMS' finding that the State materially failed to comply.
12. **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' 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.
13. **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.

14. **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).
15. **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) and the tribal consultation requirements pursuant to section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act of 2009, 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, 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 amendment or extension of this Demonstration.
16. **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.

17. 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 generate savings under the budget neutrality agreement, to mandate enrollment in the Medicaid managed care program by waiving the freedom of choice requirement, and to waive other specific programmatic requirements.
- b) **New Mandatory Managed Care Enrollment Requirement.**
 - i. Under the Partnership Plan Demonstration (11-W-00114/2), the State has the authority to require mandatory managed care enrollment for any of the recipients 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 MMC 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 1 through 5	Income up to 133% FPL
Children 6 through 18	Income up to 100% FPL
Children 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. Under the Partnership Plan Demonstration (11-W-00114/2), the recipients in Table 2 were not required to enroll in managed care plans. Under this Demonstration, any recipient in these categories will now be required to enroll in managed care plans.

The State has authority to expand mandatory enrollment in 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 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 MMC Enrollment Requirement

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

c) Continuous Eligibility Period.

- i. Effective February 1, 2010, the State is authorized to provide a 12-month continuous eligibility period to the groups of individual specified in Table 3 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 redetermined eligible consistent with Medicaid State plan rules, the 12-month period begins at that point. At each annual eligibility redetermination thereafter, if an individual is redetermined eligible under Medicaid State plan rules, the individual is guaranteed a subsequent 12-month continuous eligibility period.

Table 3: 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 months continuous eligibility 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 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	42 CFR 435.135

supplement except that OASDI cost-of-living increases received after April 1977 raised their income over the limit allowed under SSI (“Pickle people”)	
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- 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.

18. **Exclusions and Exemptions from MMC.** Notwithstanding the eligibility criteria in STC 17(b), certain individuals cannot receive benefits through the MMC program (i.e. are excluded from participation), while others may request an exemption from receiving benefits through the MMC program (i.e. may be exempted from participation). Tables 4 and 5 list those individuals either excluded or exempted from MMC.

Table 4: Individuals Excluded from MMC

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 a RHCF who are classified as permanent
Participants in capitated long term care demonstration projects
Medicaid-eligible infants living with incarcerated mothers
Infants weighing less than 1200 grams at birth and other infants less than 6 months who meet the criteria for SSI-related categories
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, or child care facilities (except ICF services for the developmentally disabled)
Individuals eligible for Medicaid benefits only with respect to tuberculosis-related services
Individuals placed in Office of Mental Health (OMH)-licensed family care homes
Individuals with a "county of fiscal responsibility" code 99 in MMIS
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 with a "county of fiscal responsibility" code of 97 (OMH in MMIS)
Individuals with a "county of fiscal responsibility" code of 98 (until program features are approved by the state and operational at the local district level to permit these individuals to voluntarily enroll in Medicaid managed care)
Individuals under sixty-five years of age (screened and require treatment) in the Centers for Disease Control and Prevention breast and/or cervical cancer early detection program and need treatment for breast or cervical cancer, and are not otherwise covered under creditable health coverage.
Individuals who are eligible for Medicaid buy-in for the working disabled and must pay a premium

Table 5: Individuals who may be exempted from MMC

Individuals with severe and persistent mental illness and children with serious emotional disturbances except those individuals whose behavioral health benefits are provided through the Medicaid fee-for-service program.
Individuals eligible for both Medicare/Medicaid (dual-eligibles) *
Individuals for whom a managed care provider is not geographically accessible
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
Individuals with end stage renal disease (ESRD)
Residents of intermediate care facilities for the mentally retarded (ICF/MR)
Individuals with characteristics and needs similar to those residing in an ICF/MR
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
Individuals with a developmental or physical disability receiving services through a Medicaid home and community based services (HCBS) waiver authorized under section 1915(c) of the Act.
Individuals with a developmental or physical disability whose needs are similar to participants receiving services through a Medicaid (HCBS) waiver authorized under section 1915(c) of the Act.
Residents of alcohol/substance abuse long term residential treatment programs
Homeless individuals in the shelter system (at the option of the LDSS). Note: in New York City, all homeless individuals are exempt.
Native Americans
Individuals who cannot be served by a managed care provider due to a language barrier
Individuals temporarily residing out of district

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 MMIS) in counties where program features are approved by the State and operational at the local district level to permit these individuals to voluntarily enroll.

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

19. Terms and Conditions Related to Particular Populations

- a) **MMC Enrollment of Individuals Living with HIV.** The State is authorized to require individuals living with HIV to receive benefits through MMC. Once the State begins implementing MMC enrollment in a particular county, individuals living with HIV who have only sixty days in which to select a health plan will receive, upon request, an additional thirty days to make a plan selection. 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 MMC. 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.

20. Mandatory Managed Care Program Benefits and Cost-Sharing. Benefits provided through this Demonstration for the 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 and Federally Qualified Health Center services
Laboratory and X-ray services
Home health services
Early Periodic Screening, Diagnosis, and Treatment services (for individuals under age 21 only)
Family planning services and supplies
Physicians services including nurse practitioners and nurse midwife services

Dental services
Physical and occupational therapy
Speech, hearing and language therapy
Prescription drugs, over-the-counter drugs and medical supplies
Durable medical equipment including prosthetic and orthotic devices, hearing aids and prescription shoes
Vision care services including eyeglasses
Intermediate Care Facilities for the Mentally Retarded (ICF/MR)
Nursing facility services
Personal care services
Case management services
Hospice care services
TB-related services
Inpatient and outpatient behavioral health services (mental health and chemical dependence services)
Emergency medical services including emergency transportation
Adult day care
Personal Emergency Response Services (PERS)
Renal dialysis
Home and Community Based Services waivers (HCBS)
Care at Home Program (OPWDD)
Non-emergency transportation
Experimental or investigational treatment (covered on a case by case basis)

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

Notes: One co-pay is charged for each new prescription and each refill
No co-payment for drugs to treat mental illness (psychotropic) and tuberculosis.

21. **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

22. **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).

23. **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

24. **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 dollars over the same period for the health system reform initiatives identified in this paragraph. For purposes of meeting the requirements for FFP outlined in STC 25, the State's health system reform initiatives will be counted differently during the following time periods:

- For the period beginning October 1, 2006 and ending March 31, 2011, the State's regular FMAP rate of 50 percent will apply, and
 - 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.
- 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.

25. 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 26 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 24 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.
 - ii. Timing. The State may not draw Federal funds for the programs described in STC 26 until such time as the State makes expenditures for the health system reform initiatives described in STC 24.
 - 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 IV, STC 34, the State will report both DSHP claims and expenditures for health care reforms.
 - B. 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.

26. Designated State Health Programs. Subject to the conditions outlined in STC 25, 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

27. 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 26. 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 24.
- 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 26, they shall not be used as a source of non-Federal share.
- d) The administrative costs associated with programs in STC 26 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 26 shall be considered an amendment to the Demonstration and processed in accordance with STC 7.

28. **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

29. **General Financial Requirements.** The State must comply with all general financial requirements set forth in section VIII.
30. **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.
31. **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.
32. **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.
33. **Quarterly Reports:** The State must submit progress reports in accordance with the guidelines in Attachment A no later than 60 days following the end of each quarter.

34. **Annual Report.** The State must submit a draft annual report documenting accomplishments, project status, health reform initiatives, quantitative and case study findings, interim evaluation findings, utilization data, and policy and administrative difficulties in the operation of the Demonstration. Additionally, the annual report should include updated workbooks for both the reform metrics and budget neutrality monitoring. The State must submit the draft annual report no later than January 1 after the close of each Demonstration year. Within 30 days of receipt of comments from CMS, a final annual report must be submitted.

VIII. GENERAL FINANCIAL REQUIREMENTS

35. **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.

36. **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, seven (7) 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 1 through 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:** 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 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 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. **Demonstration Population 6:** 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. **Demonstration Expenditures:** Designated State Health Programs [DSHP]

37. **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 26. 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 17 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.

38. **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 27 (d). All administrative costs must be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver.

39. **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.

40. **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 33, the actual number of eligible member months for the Demonstration Populations defined in STC 36 (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 36 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 36 (c) (i-vi).

41. **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.

42. **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 27 (d);
 - b) Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid State plan.
43. **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.
44. **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.

45. **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

46. **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.
47. **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.
48. **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 1 through 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 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 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)

49. **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 48 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 40 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 21-64	\$854	6.6%	\$909	\$967	\$1,029
Disabled Adults and Children 0 – 64 voluntarily enrolled in managed care	\$2,214	6.12%	\$2,349	\$2,493	\$2,646
Disabled Adults and Children 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

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 36 (c) during the Demonstration period.

50. **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.

51. **Enforcement of Budget Neutrality.** CMS shall enforce budget neutrality over the life of the Demonstration rather than on an annual basis.

52. **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

53. **Cumulative Savings Cap.** The State is required to save, through specified health care reform initiatives in Section VI, STC 24, 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 24 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.

54. **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 1 through 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 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)

55. 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 54 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 40 for each EG times the appropriate estimated per member per month (PM/PM) costs from the table in STC 49 (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 54 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 34:
- 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

56. 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:

- 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.

- 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.
- 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.

57. **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.

58. **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 28
3/31/2015	Submit Final Evaluation Report	Section XI, STC 57

	Deliverable	STC Reference
Annual	By January 1st - Draft Report	Section VII, STC 34
	By December 31 st – MEQC Program Report	Section III, STC 14
Quarterly	Quarterly Operational Reports	Section VII, STC 33
	Quarterly Expenditure Reports	Section VIII, STC 35
	Eligible Member Months	Section VIII, STC 40

ATTACHMENT A

Quarterly Report Guidelines

Under Section VII, STC 33, 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
Population 1 – TANF Child under 1 through 20 (“new” MC enrollment)			
Population 2 – TANF Child under 1 through 20 (“new” MC enrollment)			
Population 3 – Disabled Adults and Children 0-64 (“old” voluntary MC enrollment)			
Population 4 – Disabled Adults and Children 0-64 (“new” MC enrollment)			
Population 5 – Aged or Disabled Elderly (“old” voluntary MC enrollment)			
Population 6 – Aged or Disabled Elderly (“new” MC enrollment)			

ATTACHMENT A

Quarterly Report Guidelines

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.

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 MMCARP, advocates and county officials.

Financial/Budget Neutrality Developments/Issues:

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):

ATTACHMENT A

Quarterly Report Guidelines

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

Date Submitted to CMS: