CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: **11-W-00114/2**

TITLE: **Partnership Plan 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 Partnership Plan Section 1115(f) Medicaid Demonstration extension (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 October 1, 2006 unless otherwise specified. All previously approved STCs, waivers, and expenditure authorities are superseded by the STCs set forth below. This Demonstration extension is approved through September 30, 2009.

The STCs have been arranged into the following subject areas: Program Description and Objectives; General Program Requirements; Eligibility, Benefits, and Enrollment; Cost Sharing; Delivery Systems; Family Planning Expansion Program; General Reporting Requirements; General Financial Requirements; Monitoring Budget Neutrality; Evaluations; and Schedule of State Deliverables for the Demonstration Extension.

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

II. PROGRAM DESCRIPTION AND OBJECTIVES

The Partnership Plan Section 1115(f) Demonstration is designed to use a managed care delivery system to create efficiencies in the Medicaid program and enable the extension of coverage to certain individuals who would otherwise be without health insurance. The initial Partnership Plan demonstration was approved in 1997 to enroll most Medicaid recipients into managed care organizations (Medicaid managed care program). In 2001, the Family Health Plus program was implemented as an amendment to the Demonstration, providing comprehensive health coverage to low-income uninsured adults, with and without children, who have income and/or assets greater than Medicaid eligibility standards. In 2002, the Demonstration was further amended to provide family planning services to women losing Medicaid eligibility and certain other adults of childbearing age (family planning expansion program).

The State's goal in implementing the Demonstration is to improve the health status of low-income New Yorkers by:

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

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 award letter of which these STCs are part, shall 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 directive, come into compliance with any changes in Federal law, regulation, or policy that occur after the approval date of this Demonstration, unless the provision being changed is explicitly waived under the STCs herein governing the Demonstration. For the current extension period of this Demonstration, this requirement shall also apply to all applicable regulation and policy issued by CMS with respect to the Deficit Reduction Act of 2005, signed into law on February 8, 2006, including but not limited to the documentation of citizenship requirements contained in section 1903(x) of the Social Security Act (the Act).

4. **Impact on Demonstration of Changes in Federal Law.** To the extent that a change in Federal law requires either a reduction or an increase in Federal financial participation (FFP) in expenditures under such the Demonstration, the State will adopt, subject to CMS approval, a modified budget neutrality agreement for the Demonstration as necessary to comply with such change. The modified budget neutrality agreement would be effective upon the implementation of the change. 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 covered solely through the Demonstration. If a population covered through the 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 eligibility, enrollment, benefits, enrollee rights, delivery systems, cost sharing, family planning services covered under this Demonstration, 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. 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 set forth in paragraph 7 below.

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

    a) An explanation of the public process used by the State 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 extension 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. **Continuation of the Demonstration**. If the State intends to continue the Demonstration beyond the period of approval granted herein the State must submit to CMS written notice of the State's intent no later than September 30, 2008 (one year prior to the expiration date on the current section 1115(f) extension period). The written notice must include any proposed changes to the Demonstration. In addition, the State must submit to CMS a complete application, including complete budget neutrality data, no later than February 28, 2009 (6 months prior to the expiration of the current section 1115(f) extension period).

9. **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 shall 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. 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.

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. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the Demonstration, 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; compliance with cost sharing requirements; 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 and Consultation with Interested Parties.** The State must comply with the State Notice Procedures set forth in 59 FR 49249 (September 27, 1994) when any program changes to the Demonstration, including but not limited to those referenced in paragraph 6 are proposed by the State.

16. **Compliance with Managed Care Regulations.** The State must comply with the managed care regulations at 42 CFR 438 et. seq., except as expressly waived or referenced in the expenditure authorities incorporated into the STCs. Capitation rates must be developed and certified as actuarially sound in accordance with 42 CFR 438.6.

17. **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 Partnership Plan Demonstration includes three distinct components. The Medicaid managed care program provides Medicaid State Plan benefits through comprehensive managed care organizations to most recipients eligible under the State plan. Family Health Plus provides a more limited benefit package, with cost-sharing imposed, to adults with and without children with specified income and

assets. Finally, family planning expansion services only are provided to men and women of childbearing age with net incomes at or below 200 percent of the Federal poverty level (FPL) who are not otherwise eligible for Medicaid or other public or private health insurance coverage that provides family planning services and to women who lose Medicaid eligibility under the Partnership Plan at the conclusion of their 60-day postpartum period.

18. **Eligibility.**

Mandatory and optional State plan groups described below are subject to all applicable Medicaid laws and regulations, except as expressly waived through the waiver authorities for this Demonstration.

Those groups described below who are made eligible for the Demonstration by virtue of the expenditure authorities expressly granted in this Demonstration are subject to Medicaid laws or regulations only as specified in the expenditure authorities for this Demonstration.

Effective October 1, 2006, the eligibility groups deleted below are no longer considered eligibility groups under the Demonstration. Both the disabled and the aged will now be eligible under the Federal-State Health Reform Partnership (F-SHRP) Demonstration (11-W-00234/2).

The criteria for Partnership Plan eligibility is as follows:

Medicaid Managed Care Program

State Plan Mandatory and Optional Groups	FPL Level and/or other qualifying criteria
Pregnant women	Up to 200 % FPL
Children under age 1	Up to 200 % FPL
Children 1 through 5	Up to 133% FPL
Children 6 through 18	Up to 100% FPL
Children 19-20	Monthly income standard (determined annually)
Adult (21-64) AFDC-related family members	Monthly income standard (determined annually)
~~Adults and children (0-64) receiving Supplemental Security Income (SSI) payments or otherwise disabled~~	~~Monthly income standard (determined annually)~~
~~Adults (65+)~~	~~Monthly income standard (determined annually)~~
Demonstration Eligible Groups	
Adults and children who were recipients of or eligible for Safety Net cash assistance but are otherwise ineligible for Medicaid	Based on Public Assistance Standard of Need in county of residence

The recipients in the categories above who live in New York City and the following counties are currently required to enroll in managed care plans:

Albany, Broome, Cattaraugus, Chautauqua, Columbia, Erie, Genesee, Greene, Herkimer, Livingston, Monroe, Nassau, Niagara, Oneida, Onondaga, Ontario, Orleans, Oswego, Rensselaer, Rockland, Saratoga, Suffolk, and Westchester.

Family Health Plus

State Plan Mandatory and Optional Groups	FPL Level and/or other qualifying criteria
Uninsured parents of a child under the age of 21	Gross family income up to 150% FPL and countable resources that do not exceed 150% of the medically needy income standard based on family size

Demonstration Eligible Groups	
Uninsured childless adults (19-64)	Gross household income up to 100% FPL and countable resources that do not exceed 150% of the medically needy income standard based on family size

Family Planning Expansion

Demonstration Eligible Groups
Women who lose Medicaid eligibility at the conclusion of their 60-day postpartum period
Men and women of childbearing age with net incomes at or below 200% FPL who are not otherwise eligible for Medicaid or other public or private health insurance coverage that provides family planning services

19. **Eligibility Exclusions.** Notwithstanding the eligibility criteria in paragraph 18, the following persons are excluded from the Medicaid managed care program.

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 enrolled in the restricted recipient program
Individuals with a "county of fiscal responsibility" code 99 in MMIS
Individuals receiving hospice services (at time of enrollment)

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)
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 under sixty-five years of age (screened and require treatment) in the Centers for Disease Control 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

20. **Eligibility Exemptions.** Notwithstanding the eligibility criteria in paragraph 18, the following persons may not be required but may voluntarily enroll in the Medicaid managed care program.

Individuals who are HIV+
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 for whom a managed care provider is not geographically accessible
Pregnant women receiving prenatal care from a provider not participating in any Medicaid MCO
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
Individuals with a developmental or physical disability whose needs are similar to participants receiving services through a Medicaid (HCBS) waiver
Participants in the Medicaid model waiver (care-at-home) programs
Individuals whose needs are similar to participants receiving services through the Medicaid model waiver (care-at-home) programs
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 with a “county of fiscal responsibility code of 98” (OMRDD 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.

21. **Partnership Plan Benefits.** Benefits provided through this Demonstration for the Medicaid managed care, Family Health Plus, and family planning expansion programs are as follows:

    a) **Medicaid Managed Care.** Medicaid benefits are State plan benefits delivered through managed care organizations, with the exception of certain services paid for by the State on a fee-for-service basis. All benefits that Medicaid managed care enrollees may receive (regardless of delivery method) are listed in Attachment A.

    b) **Family Health Plus.** Family Health Plus benefits must be delivered by a managed care organization. In counties where no managed care organization is available, these benefits may be provided by a commercial insurer contracted with the State. Covered services are listed in Attachment B.

    c) **Family Planning Expansion.** Family planning services are limited to those services whose primary purpose is family planning and which are provided in a family planning setting. Procedures and services authorized under this program are outlined in Attachment C.

22. **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.

    e) The State must ensure that all protocols and training materials developed by the State, the LDSS and MCO, health care provider and community-based organization facilitated enrollers are revised to reflect the parameters of this paragraph and are submitted to CMS for review and approval no later than December 1, 2006.

V. COST SHARING

23. Co-payments will be charged to enrollees in Family Health Plus as follows:

Service	Co-payment
Clinic services	$5 per visit
Physician services	$5 per visit

Service	Co-payment
Prescription Drugs • Brand name • Generic	 $6 $3
Dental services	$5 per visit with a $25 maximum annual cap
Diabetic supplies and smoking cessation products	$.50
Laboratory services	$.50
Radiology services (ordered in an ambulatory setting)	$1
Inpatient Hospital services	$25 per stay
Non-emergent Emergency Room services	$3

Family Health Plus enrollees under 21 years of age or who are pregnant are exempt from these cost-sharing requirements. Additionally, the following services are exempt from these cost-sharing requirements even if provided in a setting noted above:

- Emergency services
- Family planning services and supplies
- Mental health clinics
- Chemical dependence clinics
- Psychotropic drugs
- Tuberculosis drugs

VI. DELIVERY SYSTEMS

24. **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).

25. **Institutions for Mental Diseases (IMDs).** Services to Partnership Plan enrollees who are patients in IMDs will be covered only to the extent permitted under Section IX, paragraph 47.

26. **Health Services to Native American Populations.** The plan currently in place for patient management and coordination of services for Medicaid-eligible Native Americans, developed in consultation with the Indian tribes and/or representatives from the Indian health programs located in participating counties shall continue in force for this extension period.

VII. FAMILY PLANNING EXPANSION PROGRAM

27. **Duplicate Payments.** If the State provides SCHIP enrollees' coverage of family planning services under the family planning expansion program, the State must only seek reimbursement through the SCHIP program. The State will assure CMS that no payments duplicative of Federal expenditures will be made for individuals who are enrolled in the State's Medicaid program, the State's SCHIP program, or any other Federally-funded program (i.e., title X). The State must not use title XIX funds to pay for individuals enrolled in regular Medicaid, SCHIP, or any other Federally-funded program who seek services under the family planning Demonstration, if the State is already covering the costs of services for that individual under any of these other programs. The State will do a quarterly reconciliation to ensure that no payments duplicative of Federal expenditures will be made.

28. **Informed Consent.** The State will allow applicants the opportunity to apply for family planning services through the family planning expansion, or apply for Medicaid and/or Family Health Plus. If an applicant wants to waive his/her right to an eligibility determination for Medicaid or Family Health Plus, the State will ensure that applicants have all the information they need, both written and oral, to make a fully informed choice. The State will obtain a signature from applicants waiving their right to an eligibility determination for Medicaid or Family Health Plus.

29. **Primary Care Referral.** The State shall facilitate access to primary care services for enrollees in the family planning expansion program. The State shall submit to CMS a copy of the written materials that are distributed to the family planning expansion program participants as soon as they are available. The written materials must explain to the participants how they can access primary care services. In addition, the State must evaluate the impact of providing referrals for primary care services. This component of the evaluation must be highlighted in the evaluation design that will be submitted to CMS as specified in Section XI, paragraphs 59 (b) and 60.

30. **Eligibility Redeterminations.** The State will ensure that redeterminations of eligibility for this component of the Demonstration are conducted, at a minimum, once every 12 months. The State shall submit for CMS approval its process for eligibility redeterminations within 30 days of the date of the Demonstration award letter. The process for eligibility redeterminations shall not be passive in nature, but will require that an action be taken by the family planning expansion program recipient in order to continue eligibility for this program. The State may satisfy this requirement by having the recipient sign and return a renewal form to verify the current accuracy of the information previously reported to the State.

31. **Standardized Procedure Codes.** The State is encouraged to convert State-specific procedure codes to HIPAA-compliant codes where available, or request from CMS HIPAA-compliant codes exclusively for the State's use. Until that time, the State's use of State-specific codes for reporting data to CMS will be permitted if approved by CMS.

VIII. GENERAL REPORTING REQUIREMENTS

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

33. **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 waived or referenced in the expenditure authorities incorporated into these STCs.

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

35. **Monthly Calls.** CMS shall schedule monthly conference calls with the State. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the Demonstration. Areas to be addressed include, but are not limited to, MCO operations (such as contract amendments and rate certifications), health care delivery, enrollment, cost sharing, quality of care, access, family planning issues, the benefit package, audits, lawsuits, financial reporting and budget neutrality issues, MCO financial performance that is relevant to the Demonstration, progress on evaluations, State legislative developments, and any Demonstration amendments, concept papers, or State plan amendments the State is considering submitting. CMS shall update the State on any amendments or concept papers under review, as well as Federal policies and issues that may affect any aspect of the Demonstration. The State and CMS shall jointly develop the agenda for the calls.

36. **Quarterly Reports:** The State must submit progress reports in accordance with the guidelines in Attachment D no later than 60 days following the end of each quarter (March, June, September, and December of each year). The intent of these reports is to present the State's analysis and the status of the various operational areas.

37. **Annual Report.** The State must submit a draft 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 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.

38. **Reporting Requirements Related to Family Planning Expansion.**

a) In each annual report, the State shall report the average total Medicaid expenditures for a Medicaid-funded birth each year. The cost of a birth includes prenatal services and delivery and pregnancy-related services and services to infants from birth through age 1. (The services should be limited to the services that are available to women who are eligible for Medicaid because of their pregnancy and their infants.)

b) In each annual report, the State shall report the number of actual births that occur to Demonstration participants (participants include all individuals who obtain one or more covered medical family planning services through the Demonstration) each year.

c) The State will submit to CMS base-year fertility rates and a methodology for calculating the fertility rates no later than March 1, 2007. These rates must:

i. Reflect fertility rates during Base Year 2000 for women, age 19-44 years, with family incomes at or below 200 percent FPL and ineligible for Medicaid except for pregnancy.
ii. Be adjusted for age for all potential Demonstration participants.
iii. Include births paid for by Medicaid.

At the end of each Demonstration year (DY), a DY fertility rate will be determined by summing the age-specific rates using the age distribution of the Demonstration participants during that DY to weight the age-specific fertility rates, unless the State demonstrates that the age distribution is consistent with the prior DY(s). The annual age distribution categories will correspond with the base-year age-specific fertility rates.

The base-year fertility rate and the DY fertility rate will be used to calculate a measure of births averted through the Demonstration using the following formula: Births Averted = (base-year fertility rate) – (fertility rate of Demonstration participants during DY) X (number of Demonstration participants during DY). The intent of the Demonstration is to avert unintended pregnancies.

d) No later than December 1, 2006, the State will provide to CMS for approval an appropriate methodology for ensuring the integrity of initial eligibility determinations and annual eligibility determinations of individuals covered under the family planning expansion program. The State will use this methodology to conduct reviews of the eligibility determination process on an annual basis. The State will also develop an eligibility determination error rate methodology with a corrective action plan for CMS approval.

e) No later than December 1, 2006, a corrective action plan will be submitted to CMS outlining how the State will come into compliance with the requirements of Section VII, paragraph 27 and assure CMS that no payments duplicative of Federal expenditures will be made for individuals who are enrolled in the State's Medicaid program, the State's SCHIP program, or any other Federally-funded program (i.e., title X).

IX. GENERAL FINANCIAL REQUIREMENTS

39. **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 X**.**

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

    a) In order to track expenditures under this Demonstration, New York must report Demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (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). Consistent with temporary extensions granted from April 1, 2006 through September 30, 2006, reporting for Demonstration year 8 will include 18 months of expenditures to account for the time period April 1, 2005 through September 30, 2006.

    b) New York will revise its initial 30-day submission 60 days after the completion of each quarter to report Medicaid cost settlements, pharmaceutical rebates, and to include any additional claims for the reporting period that were not available at the time of the 30-day submission. Additionally, New York's final report, filed 90 days after the completion of the quarter, contains claims that were not included in its 30-day or 60-day quarterly expenditure report submissions.

    c) New York will report current quarter Demonstration expenditures no later than the 90-day CMS-64 submission. Quarterly cost settlements and pharmaceutical rebates relevant to the Demonstration will be allocated (using an approved methodology) to the Demonstration populations specified in subparagraph (i) 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.

    d) New York's final 90-day CMS-64 submission will contain adjustments for Demonstration expenditures initially reported on its 60-day submission as non-Demonstration expenditures on Form CMS 64.9 Base. Demonstration expenditures will be correctly reported on Forms CMS 64.9 Waiver.

    e) For the family planning expansion component of the Demonstration, the State should report Demonstration expenditures on Forms CMS-64.9 Waiver and/or 64.9P Waiver as follows:

i. Allowable family planning expenditures eligible for reimbursement at the State's Federal medical assistance percentage rate (FMAP) should be entered in Column (B) on the appropriate waiver sheets.
ii. Allowable family planning expenditures eligible for reimbursement at the enhanced family planning match rate should be entered in Column (D) on the appropriate waiver sheets.

f) Premiums and other applicable cost sharing contributions from enrollees that are collected by the State from enrollees under the Demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet line 9.D, columns A and B. Additionally, both the total computable and Federal share amounts that are attributable to the Demonstration must be separately reported on the CMS-64Narr.

g) Corrections for any incorrectly reported Demonstration expenditures for previous demonstration years must be input within 3 months of the beginning of the extension.

h) The State's methodology for allocating cost settlement and rebates to Demonstration populations will be submitted to CMS for review and approval no later than January 1, 2007.

i) For each Demonstration year, six (6) 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.

i. **Demonstration Population 1:** TANF Child under 1 through 20 required to enroll in managed care in the counties subject to mandatory managed care enrollment as of October 1, 2006 [TANF Child].

ii. **Demonstration Population 2:** TANF Adults aged 21-64 required to enroll in managed care in the counties subject to mandatory managed care enrollment as of October 1, 2006 [TANF Adult].

~~iii. **Demonstration Population 3:** Disabled Adults and Children 0-64 [SSI 0-64]~~

~~iv. **Demonstration Population 4:** Aged or Disabled Adults [SSI 65+]~~

v. **Demonstration Population 5:** Safety Net Adults [Safety Net Adults]

vi. **Demonstration Population 6:** Family Health Plus Adults with children [FHP Adults w/Children]

vii. **Demonstration Population 7**: Family Health Plus Adults without children [FHP Childless Adults]

viii. **Demonstration Population 8:** Family Planning Expansion Adults [FP Expansion]

41. **Expenditures Subject to the Budget Neutrality Agreement.** For purposes of this section, the term "expenditures subject to the budget neutrality agreement" must include all Medicaid expenditures on behalf of individuals who are enrolled in this Demonstration as described in paragraph 40 (i) (with the exception of subparagraphs iii. and iv.) subject to limitations enumerated in this paragraph. All expenditures that are subject to the budget neutrality agreement are considered Demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and /or 64.9P Waiver.

    a) Effective October 1, 2006, only the expenditures for Demonstration Populations 1 and 2 defined in paragraph 40(i) ("current" mandatory managed care enrollment) will be reported on Forms CMS-64.9 Waiver and/or 64.9P under this Demonstration.

    b) Effective October 1, 2006, all expenditures for Demonstration Populations 1 and 2 as defined in paragraph 40(i) residing in Allegany, Cortland, Dutchess, Fulton, Montgomery, Putnam, Orange, Otsego, Schenectady, Seneca, Sullivan, Ulster, Washington, and Yates counties ("new" mandatory managed care enrollment) are no longer considered expenditures subject to the budget neutrality agreement for this Demonstration and may not be reported on Forms CMS-64.9 Waiver and/or 64.9P for this Demonstration. These expenditures will be reported under the F-SHRP Demonstration (11-W-00234/2).

    c) Effective October 1, 2006 expenditures for Demonstration Populations 3 and 4 defined in paragraph 40(i) will no longer be reported under this Demonstration. However, these eligibility groups will remain as a placeholder in the event these populations are transferred from the F-SHRP Demonstration (11-W-00234/2) back to this Demonstration. Such a transfer will only be permitted if the F-SHRP Demonstration terminates for any reason prior to September 30, 2011. The State shall follow the amendment process outlined in Section III, paragraph 7 to effectuate this transfer.

    d) Effective October 1, 2006, Demonstration Populations 3 and 4 defined in paragraph 40(i) are no longer considered expenditures subject to the budget neutrality agreement for this Demonstration. These expenditures may not be reported on Forms CMS-64.9 Waiver and/or 64.9P under this Demonstration, except if permitted under the provisions of paragraph 41(c). These expenditures will be reported under the F-SHRP Demonstration (11-W-00234/2), subject to the provisions of paragraph 41(c).

42. **Administrative Costs.** Administrative costs will not be included in the budget neutrality limit, but the State must separately track and report additional administrative costs that are directly attributable to the Demonstration. All administrative costs must be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver.

43. **Premium Collection Adjustment.** The State must include any Demonstration premium collections as a manual adjustment (decrease) to the Demonstration's actual expenditures on a quarterly basis and shall be reported in accordance with paragraph 40 (f).

44. **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.

45. **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 paragraph 36, the actual number of eligible member months for the Demonstration Populations defined in paragraph 40(i). The State must submit a statement accompanying the quarterly report, which certifies the accuracy of this information.

    Effective October 1, 2006, the actual number of member months for Demonstration Populations 3 and 4 as defined in paragraph 40(i) will not be used for the purpose of calculating the budget neutrality expenditure agreement, except as defined in paragraph 41(c).

    Additionally, effective October 1, 2006, the actual number of member months for new mandatory managed care enrollment for Demonstration Populations 1 and 2 as defined in paragraph 40(i) will not be used for the purpose of calculating the budget neutrality expenditure agreement, subject to the limitations in paragraph 41.

    To permit full recognition of "in-process" eligibility, reported counts of member months may be subject to revisions after the end of each quarter. Member month counts may be revised retrospectively for up to two years as needed.

    b) The term "eligible member months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes 3 eligible member months to the total. Two individuals who are eligible for 2 months each contribute 2 eligible member months 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 to the Demonstration Populations described in paragraph 40 (i). Effective October 1, 2006, "Demonstration eligibles" excludes Demonstration Populations 3 and 4, subject to paragraph 41(c), as well as portions of Demonstration Populations 1 and 2 as specified in paragraph 41(a - c).

46. **Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the Demonstration. New York must estimate matchable Demonstration expenditures (total computable and Federal share) subject to the budget neutrality expenditure cap and separately report these expenditures by quarter for each Federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (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.

47. **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 X:

    a) Administrative costs, including those associated with the administration of the Demonstration; and

    b) Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid State plan.

    c) FFP will be phased down for expenditures for services to a Partnership Plan enrollee age 21 through 64 residing in an Institution for Mental Diseases for the first 30 days of an inpatient episode, subject to an aggregate annual limit of 60 days. The FFP match rate will be phased down as follows:

Demonstration Period	Allowable Portion of Expenditures
October 1, 2006 – September 30, 2007	100%
October 1, 2007 – September 30, 2008	50%
October 1, 2008 – September 30, 2009	0%

    d) FFP will be provided for the Family Planning Expansion Program as described in paragraph 48.

48. **Extent of Federal Financial Participation for Family Planning Expansion Program.** CMS shall provide FFP for CMS-approved services (including prescriptions) provided to men and women under the family planning expansion program as follows, subject to the restrictions outlined in Attachment C:

    a) For services whose primary purpose is family planning (i.e., contraceptives and sterilizations), FFP will be available at the 90 percent matching rate. Procedure codes for office visits, laboratory tests, and certain other procedures must carry a diagnosis that specifically identifies them as family planning services. The State must be able to affirmatively justify that these services meet the criteria for the 90 percent Federal matching rate. A "Y" indicator override on a claim does not meet this affirmative justification. Such claims may not be considered family planning services and are not eligible for FFP at the 90 percent matching rate.

    b) Notwithstanding subparagraph (a) above, CMS will only provide FFP at the 90 percent match rate for expenditures made for family planning services rendered without specific procedure codes at clinics licensed under Article 28 of the New York Public Health Law through June 30, 2007. At that time, the State will have completed its efforts to obtain and require procedure code reporting from these centers as part of its effort to accurately calculate its clinic upper payment limit.

On July 1, 2007, FFP will no longer be provided for services rendered without procedure codes. In order to continue claiming FFP at the 90 percent match rate for family planning services rendered by clinics licensed under Article 28 of the New York Public Health Law, Attachment C shall be revised in accordance with the amendment process outlined in Section III, paragraph 7.

c) The following prescription drug types/classes are not provided for the primary purpose of family planning and are not eligible for FFP under this Demonstration:

i. Hormone Replacement Therapy;
ii. Fertility Agents;
iii. Ovulation Inducing Agents;
iv. Agents for treatment of Endometriosis;
v. Agents for treatment of Endometrial Hyperplasia;
vi. Agents for treatment of Uterine Bleeding;
vii. Agents for treatment of Amenorrhea; and
viii. Prenatal Vitamins.

d) Family planning-related services reimbursable at the FMAP rate are defined as those services generally performed as part of or as follow-up to a family planning service for contraception or sterilization. Such services are provided because a "family planning-related" problem was identified and/or diagnosed during a routine or periodic family planning visit. However, these services performed in an ambulatory surgery center/facility, a special procedure room/suite, an emergency room, an urgent care center, or a hospital setting are not covered under the Demonstration as family planning-related services.

e) FFP will not be available for the costs of any services, items, or procedures that do not meet the requirements specified above, even if family planning clinics or providers provide them. For example, in the instance of testing for sexually transmitted infections as part of a family planning visit, FFP will be available at the 90 percent Federal matching rate. Subsequent treatment would be paid for at the applicable Federal matching rate for New York. For testing or treatment not associated with a family planning visit, no FFP will be available.

f) CMS will provide FFP at the appropriate 50 percent administrative match rate for general administration costs, such as, but not limited to, claims processing, eligibility assistance and determinations, outreach, program development, and program monitoring and reporting.

49. **Medicare Part D Drugs.** No FFP is available for this Demonstration for Medicare Part D drugs.

50. **Sources of Non-Federal Share.** The State certifies that matching 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.

51. **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.

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

X. MONITORING BUDGET NEUTRALITY

53. **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. Budget neutrality limits for Demonstration years 1 through 8, as established by previously approved STCs [and Section IX, paragraph 40(a)], remain in effect for the Demonstration extension period. 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.

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

55. **Demonstration Populations Used to Calculate Budget Neutrality Cap.** The following Demonstration populations are used to calculate the budget neutrality cap subject to the limitations outlined in paragraph 41 and are incorporated into the following eligibility groups (EGs):

    a) **Eligibility Group 1:** TANF Children under age 1 through 20 required to enroll in managed care in the counties subject to mandatory managed care enrollment as of October 1, 2006 (Demonstration Population 1)

    b) **Eligibility Group 2:** TANF Adults aged 21-64 required to enroll in managed care in the counties subject to mandatory managed care enrollment as of October 1, 2006 (Demonstration Population 2)

    c) **Eligibility Group 3:** Disabled Adults and Children age 0-64 (Demonstration Population 3)

    d) **Eligibility Group 4**: Aged or Disabled Adults (Demonstration Population 4)

    e) **Eligibility Group 5**: FHPlus Adults with children (Demonstration Population 6)

56. **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 paragraph 55 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 paragraph 45, except as defined in paragraph 45(c), for each EG, times the appropriate estimated per member per month (PM/PM) costs from the table in subparagraph (iii) below. Should EGs 3 and 4 be incorporated into the budget neutrality expenditure cap, as outlined in paragraph 41, the PMPM costs may be revised.

ii. The PM/PM costs in subparagraph (iii) below are net of premiums paid by Demonstration eligibles.

iii. 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. In addition, the PM/PM cost for each EG in Demonstration year 9 has been increased by the appropriate growth rate included in the President's Federal fiscal year 2007 budget for DYs 10 and 11, as outlined below.

Eligibility Group	Growth Rate	DY 09 (10/1/06 – 9/30/07)	DY 10 (10/1/07 – 9/30/08)	DY 11 (10/1/08 – 9/30/09)
TANF Children under age 1 through 20	6.7%	$482.15	$514.58	$549.19
TANF Adults 21-64	6.6%	$661.56	$705.21	$751.73
~~Disabled Adults and Children 0 – 64~~	~~6.8%~~	~~$1835.66~~	~~$1960.91~~	~~$2094.70~~
~~Adults 65 +~~	~~5.8%~~	~~$1842.78~~	~~$1950.35~~	~~$2064.19~~

Eligibility Group	Growth Rate	DY 09 (10/1/06 – 9/30/07)	DY 10 (10/1/07 – 9/30/08)	DY 11 (10/1/08 – 9/30/09)
FHPlus Adults with Children	6.6%	$516.43	$550.50	$586.82

iv. 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 3-year demonstration period is the sum of the annual budget neutrality expenditure caps calculated in subparagraph (a) (iv) above for each of the 3 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 paragraph 40 (i) during the Demonstration period.

57. **Enforcement of Budget Neutrality.** CMS shall enforce budget neutrality over the life of the Demonstration rather than on an annual basis. However, if the State exceeds the calculated cumulative budget neutrality expenditure cap by the percentage identified below for any of the Demonstration years, the State must submit a corrective action plan to CMS for approval.

Demonstration Year	Cumulative Expenditure Cap Definition	Percentage
Year 9	Budget neutrality expenditure cap plus	1 percent
Years 9 and 10	Combined budget neutrality expenditure caps plus	0.5 percent
Years 9 through 11	Combined budget neutrality expenditure caps plus	0 percent

58. **Exceeding Budget Neutrality.** If, at the end of this Demonstration period the overall budget neutrality expenditure cap 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.

XI. EVALUATION OF THE DEMONSTRATION

59. **State Must Separately Evaluate Components of the Demonstration.** As outlined in subparagraphs (a) and (b), the outcomes from each evaluation component must be integrated into one programmatic summary that describes whether the State met the Demonstration goal, with recommendations for future efforts regarding both components**.** The State must submit to CMS for approval a draft evaluation design no later than January 1, 2007. The evaluation must outline and address evaluation questions for both of the following components:

a) **The Partnership Plan.** At a minimum, the draft design must include a discussion of the goals, objectives, and evaluation questions specific to the entire Demonstration. The draft design must discuss the outcome measures that will be used in evaluating the impact of the Demonstration during the period of approval, particularly among the target population. It must discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the Demonstration shall be isolated from other initiatives occurring in the State. The draft design must identify whether the State will conduct the evaluation, or select an outside contractor for the evaluation.

b) **Family Planning Expansion**. The draft design must include a discussion of the goals, objectives and evaluation questions specific to this component of the Demonstration. The draft design must discuss the outcome measures that will be used in evaluating the impact of the family planning expansion program, particularly among the target family planning population, during the period of approval. It must discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the family planning expansion program shall be isolated from other initiatives occurring in the State. The draft design must identify whether the State will conduct the evaluation, or select an outside contractor for the evaluation. The report should also include an integrated presentation and discussion of the specific evaluation questions (including those that focus specifically on the target population for the family planning program) that are being tested. At a minimum, the following data elements will be included in the measurement methodology:

Measure	**Number**	Percentage Change
Enrollment		
Averted Births		
Family Planning Patients Receiving a	(estimate can be	

Clinical Referral for Primary Care	based on a sample)	

60. **Final Evaluation Plan and Implementation.** CMS shall provide comments on the draft designs within 60 days of receipt, and the State must submit a final plan for the overall evaluation of the Demonstration described in paragraph 59, within 60 days of receipt of CMS comments. The State must implement the evaluation designs and report its progress on each in the quarterly reports. The State must submit to CMS a draft evaluation report 120 days prior to the expiration of the Demonstration. CMS shall provide comments within 60 days of receipt of the report. The State must submit the final report prior to the expiration date of the Demonstration.

61. **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 EXTENSION PERIOD

Date - Specific	Deliverable	STC Reference
12/1/2006	Submit Revised Facilitated Enrollment Protocols and Training Materials for Review	Section IV, paragraph 22
11/1/2006	Submit Process for Eligibility Redeterminations for Family Planning Expansion Program	Section VII, paragraph 30
12/1/2006	Submit Methodology for Monitoring Family Planning Initial Eligibility Determinations and Annual Redeterminations	Section VIII, paragraph 38
12/1/2006	Submit Corrective Action Plan for Duplicate Family Planning Expansion Program Payments	Section VIII, paragraph 38
1/1/2007	Submit Cost Settlement and Rebate Allocation Methodology	Section IX, paragraph 40
1/1/2007	Submit Draft Evaluation Plan, including Evaluation Designs for the Partnership Plan and Family Planning Expansion	Section XI, paragraph 59
3/1/2007	Submit Base-year Fertility Rates for Family Planning Expansion Program	Section VIII, paragraph 38
7/1/2007	Submit Amendment to Attachment C to reflect updated family planning procedure codes	Section IX, paragraph 48
9/30/2008	Written Notice to CMS of Intent to Continue Demonstration	Section III, paragraph 8
2/28/2009	Submit Demonstration Application [1115(a)]	Section III, paragraph 8
6/30/2009	Submit Draft Evaluation Report, which	Section XI, paragraph 60

	includes preliminary analysis and recommendations related to the Partnership Plan and Family Planning Expansion	
9/30/2009	Submit Final Evaluation Report	Section XI, paragraph 60

	Deliverable	**STC Reference**
Annual	By January 1st - Draft Annual Report	Section VIII, paragraph 37
	By December 31st – Annual MEQC Program Report	Section III, paragraph 14
Quarterly		
	Quarterly Operational Reports	Section VIII, paragraph 36
	CMS-64 Reports	Section IX, paragraph 40
	Eligible Member Months	Section IX, paragraph 45

ATTACHMENT A

Medicaid Managed Care Benefits

Inpatient and outpatient hospital services
Clinic services including Rural Health Clinic and Federally Qualified Health Center services
Laboratory and X-ray services
Home health services
Early Periodic Screening, Diagnosis, and Treatment services (for individuals under age 21only)
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 (OMRDD)
Non–emergency transportation
Experimental or investigational treatment (covered on a case by case basis)

ATTACHMENT B

Family Health Plus Benefits

Inpatient and outpatient hospital services
Clinic services including Rural Health Clinic and Federally Qualified Health Center services
Laboratory and X-ray services
Home health services (covered for 40 visits in lieu of hospitalization, plus 2 post-partum visits for high-risk women)
Early Periodic Screening, Diagnosis, and Treatment services (for individuals under age 21only)
Family planning services and supplies
Physicians services including nurse practitioners and nurse midwife services
Dental services (optional)
Physical and occupational therapy (20 visits annually)
Speech therapy (for conditions amenable to clinical improvement within a 2–month period)
Prescription drugs, diabetic supplies and smoking cessation products
Durable medical equipment including prosthetic and orthotic devices and hearing aids
Vision care services including eyeglasses
Nursing facility services
Hospice care services
TB-related services, except Directly Observed Therapy
Behavioral health services (mental health and chemical dependence services), limited to 60 outpatient visits combined and 30 inpatient days combined
Emergency medical services including emergency transportation
Renal dialysis
Experimental or investigational treatment (covered on a case by case basis)

ATTACHMENT C

Family Planning Expansion Program Procedures and Services

Amendments to this Attachment may be made consistent with Section III, paragraph 7.

The following diagnosis codes not paired with a procedure code may be considered family planning services only when rendered in clinics licensed under Article 28 of the New York Public Health Law through June 30, 2007:

V25.xx

The following procedure codes are considered family planning services as noted below:

Code	Description	90% FFP	90% FFP with V25
11975	Norplant – implant	X	
11976	Norplant – implant removal	X	
11977	Norplant - implant removal with reinsertion	X	
36415	Collection of venous blood by venipuncture		X
36416	Drawing blood, capillary		X
55250	Vasectomy, unilateral or bilateral (separate procedure)	X	
55450	Ligation (percutaneous) of vas deferens, unilateral or bilateral	X	
57170	Diaphragm or cervical cap – fitting with instructions		X
58300	IUD insertion	X	
58301	IUD removal	X	
58565	Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants		X
58600	Ligation or transaction of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral	X	
58615	Occlusion of fallopian tube(s) by device, vaginal or suprapubic approach	X	
58670	Laparoscopy, surgical; with fulguration of oviducts (with or without transaction)	X	
58671	Laparoscopy, surgical; with occlusion of oviducts by device	X	
71010	X-rays, prep for sterilization		X
71015	X-rays, prep for sterilization		X
81000	Urinalysis by dip stick or tablet reagent		X
81001	Urinalysis; automated with microscopy		X
81002	Urinalysis; non-automated without microscopy		X
81003	Urinalysis; automated without microscopy		X
81007	Urinalysis; bacteriuria screen, by non-culture technique, commercial kit		X
81025	Urine pregnancy test		X
82105	Alpha fetoprotein; serum		X
82465	Cholesterol, serum or whole blood, total		X
84702	HCG quantitative		X
84703	HCG qualitative		X
85013	Blood count; spun microhematocrit		X

ATTACHMENT C

Family Planning Expansion Program Procedures and Services

Code	Description	90% FFP	90% FFP with V25
85014	Blood count; other than spun hematocrit		X
85021	Blood count; hemogram, automated		X
85025	Blood count; hemogram and platelet count, automated, and automated complete differential WBC count (CBC)		X
86592	Syphilis test, qualitative		X
86593	Syphilis test, quantitative		X
86631	Chlamydia antibody		X
86689	HTLV or HIV antibody		X
86694	Herpes simplex, non-specific type test		X
86695	Herpes simplex, type 1		X
86696	Herpes simplex, type 2		X
86701	HIV – 1		X
86702	Antibody HIV-2		X
86703	HIV – 1 & 2		X
86762	Rubella antibody		X
86781	Treponema pallidum antibody		X
87070	Culture, bacterial; any other source except urine, blood or stool, aerobic, with isolation and presumptive identification of isolates		X
87081	Culture, bacterial, screening only, for single organisms		X
87086	Culture, bacterial; quantitative colony count, urine		X
87102	Knickers test for yeast		X
87110	Culture, Chlamydia		X
87205	Smear, primary source, with interpretation; routine stain for bacteria, fungi, or cell types		X
87207	Smear, primary source, with interpretation, special stain for inclusion bodies or intracellular parasites (e.g., malaria, kala azar, herpes)		X
87210	Smear, primary source, with interpretation, wet mount with simple stain, for bacteria, fungi, ova, and/or parasites		X
87252	Virus isolation; tissue culture inoculation, observation, and presumptive		X
87254	Virus isolation; centrifuge enhanced (shell vial) technique		X
87270	Chlamydia trachomatis AGIF		X
87273	Herpes simplex, type 2		X
87274	Herpes simplex, type 1		X
87285	Treponema pallidum		X
87320	Infectious agent antigen detection by enzyme immunoassay technique, qualitative		X
87390	Chlamydia trachomatis		X
87391	HIV – 2		X
87430	HIV – 1		X
87490	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia Trachomatis. Direct probe technique.		X

ATTACHMENT C

Family Planning Expansion Program Procedures and Services

Code	Description	90% FFP	90% FFP with V25
87491	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia Trachomatis. Amplified probe technique.		X
87492	Chlamydia trachomatis, quantification		X
87528	Herpes simplex virus, direct probe technique		X
87529	Herpes simplex virus, amplified probe technique		X
87530	Herpes simplex virus, quantification		X
87534	HIV-1, direct probe technique		X
87535	HIV-1, amplified probe technique		X
87536	HIV-1, quantification		X
87537	HIV-2, direct probe technique		X
87538	HIV-2, amplified probe technique		X
87539	HIV-2, quantification		X
87590	Neisseria gonorrhea, direct probe technique		X
87591	Neisseria gonorrhea, amplified probe technique		X
87800	Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms		X
87810	Trachomatis		X
87850	Neisseria gonorrhea		X
88141	Cytopathology, cervical or vaginal (any reporting system), requiring interpretation by physician (Use 88141 in conjunction with 88142-88154, 88164-88167, 88174-88175)		X
88142	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; manual screening under physician supervision		X
88147	Cytopathology smears, cervical or vaginal; screening by automated system under physician supervision		X
88148	Cytopathology, screening by automated system with manual rescreening under physician supervision		X
88150	Cytopathology, slides, cervical or vaginal; manual screening under physician supervision		X
88152	Cytopathology, slides, cervical or vaginal; with manual screening and computer-assisted rescreening under physician supervision		X
88153	Cytopathology, slides, cervical or vaginal; with manual screening & rescreening under physician supervision		X
88154	Cytopathology, slides, cervical or vaginal; with manual screening and computer-assisted rescreening using cell selection and review under physician supervision		X
88155	Cytopathology, slides, cervical or vaginal, definitive hormonal evaluation (Use 88155 in conjunction with 88142-88154, 88164-88167, 88174-88175)		X
88160	Cytopathology, smears, any other source; screening and interpretation		X
88162	Cytopathology, smears, any other source; extended study (over 5 slides and/or multiple stains)		X

ATTACHMENT C

Family Planning Expansion Program Procedures and Services

Code	Description	90% FFP	90% FFP with V25
88164	Cytopathology, slides, cervical or vaginal (the Bethesda System); manual screening under physician supervision		X
88165	Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and rescreening under physician supervision		X
88166	Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and computer-assisted rescreening under physician supervision		X
88167	Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and computer-assisted rescreening using cell selection and review under physician supervision		X
88174	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; screening by automated system, under physician supervision		X
88175	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with screening by automated system and manual rescreening or review, under physician supervision		X
89310	Semen motility and count (not including hunher test)		X
89320	Semen analysis complete (volume, count, motility, and differential)		X
90772	Therapeutic or diagnostic injection; subcutaneous or intramuscular		X
93000	EKG performed in prep for tubal ligation		X
93005	EKG performed in prep for tubal ligation		X
93010	EKG performed in prep for tubal ligation		X
93040	EKG performed in prep for tubal ligation		X
93041	EKG performed in prep for tubal ligation		X
93042	EKG performed in prep for tubal ligation		X
99000	Handling and/or conveyance of specimen for transfer from the physician's office to a laboratory		X
99001	Handling and/or conveyance of specimen for transfer from the physician's office to a laboratory		X
99050	Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed		X
99070	Supplies and materials (except spectacles), provided by the physician which are not included in the office visit		X
99201	Office or other outpatient visit – new patient		X
99202	Office or other outpatient visit – new patient		X
99203	Office or other outpatient visit – new patient		X
99204	Office or other outpatient visit – new patient		X
99205	Office or other outpatient visit – new patient		X

ATTACHMENT C

Family Planning Expansion Program Procedures and Services

Code	Description	90% FFP	90% FFP with V25
99211	Office or other outpatient visit – established patient		X
99212	Office or other outpatient visit – established patient		X
99213	Office or other outpatient visit – established patient		X
99214	Office or other outpatient visit – established patient		X
99215	Office or other outpatient visit – established patient		X
99241	Office consultation - new or established patient		X
99242	Office consultation - new or established patient		X
99243	Office consultation - new or established patient		X
99244	Office consultation - new or established patient		X
99245	Office consultation - new or established patient		X
A4261	Cervical cap contraceptive	X	
A4266	Diaphragm kit	X	
A4267	Condom, male	X	
A4268	Condom, female	X	
A4269	Spermicidal foam, contraceptive jelly	X	
J1055	Injection, Medroxyprogesterone Acetate for contraceptive use, 150mg (Depo-Provera – 150mg/ml)	X	
J1056	Injection, Medroxyprogesterone Acetate/Estradiol Cypionate, 5mg/25mg (Lunelle)	X	
J7300	Intrauterine copper contraceptive	X	
J7302	Levonorgestrel-releasing intrauterine contraceptive system, 52mg	X	
J7303	Contraceptive supply, hormone containing vaginal ring	X	
J7304	Contraceptive supply, hormone containing vaginal patch	X	
Z2351	Basal Thermometer		X

ATTACHMENT D

Quarterly Program Report Guidelines

Under Section VII, paragraph 42 of these STCs, 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. An electronic copy of the report narrative, as well as the Microsoft Excel workbook is provided.

NARRATIVE REPORT FORMAT:

Title Line One – Partnership Plan

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:

Example:
Demonstration Year: 1 (10/1/06 - 9/30/06)
Federal Fiscal Quarter: 4/2007 (7/07 - 9/07)

Introduction:

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

Enrollment Information:

Please complete the following table that outlines all enrollment activity under the demonstration. The State should indicate "N/A" where appropriate. If there was no activity under a particular enrollment category, the State should indicate that by "0".

Enrollment Counts

Note: Enrollment counts should be person counts, not participant months

Demonstration Populations (as hard coded in the CMS 64)	**Current Enrollees** (to date)	**No. Voluntary Disenrolled in current Quarter**	**No. Involuntary Disenrolled in current Quarter**
Population 1 – TANF Child under 1 through 20 in mandatory MC counties as of 10/1/06			
Population 2 - TANF Adults aged 21-64 in mandatory MC counties as of 10/1/06			
Population 3 – Safety Net Adults			
Population 4 - Family Health Plus Adults with children			
Population 5 - Family Health Plus Adults without children			

ATTACHMENT D

Quarterly Program Report Guidelines

Voluntary Disenrollments:
Cumulative Number of Voluntary Disenrollments Within Current Demonstration Year:
Reasons for Voluntary Disenrollments:

Involuntary Disenrollments:
Cumulative Number of Involuntary Disenrollments Within Current Demonstration Year:
Reasons for Involuntary Disenrollments:

Outreach/Innovative Activities:
Summarize outreach activities and/or promising practices for the current quarter.

Operational/Policy Developments/Issues:
Identify all significant program developments/issues/problems that have occurred in the current quarter, including but not limited to approval and contracting with new plans, benefit changes, and legislative activity.

Financial/Budget Neutrality Developments/Issues:
Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS 64 reporting for the current quarter. Identify the State's actions to address these issues.

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 received from the MCARP and other consumer groups.

Quality Assurance/Monitoring Activity:
Identify any quality assurance/monitoring activity in current quarter.

Family Planning Expansion Program:
Identify all significant program developments/issues/problems that have occurred in the current quarter, including the required data and information under Section VIII, paragraph 38, including enrollment data for both the extension and expansion programs.

Demonstration Evaluation
Discuss progress of evaluation design and planning.

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

ATTACHMENT D

Quarterly Program Report Guidelines

State Contact(s):
Identify individuals by name, title, phone, fax, and address that CMS may contact should any questions arise.

Date Submitted to CMS: