

SECTION 1115 NEW YORK MEDICAID REDESIGN TEAM WAIVER AMENDMENT AUGUST 31, 2017

Section I — Program Description

This section should contain information describing the goals and objectives of the Demonstration, as well as the hypotheses that the Demonstration will test. In accordance with 42 CFR 431.412(a)(i), (v) and (vii), the information identified in this section must be included in a state's application in order to be determined complete. Specifically, this section should:

- 1. Provide a summary of the proposed Demonstration program, and how it will further the objectives of title XIX and/or title XXI of the Social Security Act (the Act).**

The State of New York (State) is submitting this amendment to its current 1115 New York Medicaid Redesign Team (NY MRT) waiver (Demonstration) to create a model of care that enables qualified Specialized Intellectual and Developmental Disabilities (I/DD) plans throughout the State to meet the needs of individuals with Intellectual and Developmental Disabilities (I/DD). These plans — which will initially be formed by experienced I/DD providers (called Specialized I/DD plans - Provider Led [SIPs-PL]), or which will later be offered as a separate line of business by Mainstream Medicaid Managed care plans (called Specialized I/DD plans-Mainstream [SIP-M])— will receive a capitated payment for all covered State Plan services and an additional non-risk payment for I/DD residential services and I/DD Targeted Home and Community-Based Services (HCBS). In addition, Mainstream Medicaid Managed Care (MMMC) not offering a Specialized I/DD plan will be required to comply with basic I/DD requirements for any I/DD population choosing to remain in MMMC plans following mandatory enrollment. This population includes those individuals already enrolled in managed care and those whose families are already in MMMC and newly entering OPWDD HCBS services under this 1115 waiver. The goal to integrate the delivery of care to the I/DD population will begin with the enrollment of individuals with I/DD into Health Homes in 2018. Concurrently with the submission of this waiver, the State will also be submitting a State Plan Amendment (SPA) to expand the Health Home eligibility criteria to include I/DD chronic conditions. The transition of the I/DD population to managed care will initially occur on a voluntary enrollment basis with the establishment of SIPs-PL.

No earlier than January 1, 2018, or as otherwise indicated, this amendment requests authority to:

- *Transition the individuals enrolled in the OPWDD Comprehensive HCBS waiver to the 1115 MRT waiver Demonstration authority. (Office for People With Developmental Disabilities (OPWDD) Comprehensive waiver #NY.0238).¹*
- *Transition individuals receiving Intermediate Care Facility for I/DD (ICF-I/DD) services and other I/DD populations to the 1115 MRT waiver Demonstration authority.²*
- *Include populations under the Demonstration that were previously exempted or excluded including:*
 - *Working individuals with disabilities who buy into Medicaid — TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act*
 - *Working individuals with disabilities who buy into Medicaid — TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act*
 - *Optional State supplement recipients*
 - *Other specified groups (including statutory/regulatory reference to reflect the additional groups in the State Plan that may receive services under this waiver)*
 - *Individuals who qualify under 1902(a)(10)(A)(i)(II)(bb)(Qualified Severely Impaired)*
 - *Disabled Adult Children (DAC) beneficiaries who are eligible under 1634(c) of the Act*
 - *Dual eligibles receiving OPWDD services³*
- *Offer a single HCBS benefit package to all I/DD individuals meeting institutional level of care (LOC) functional criteria. This I/DD Targeted HCBS includes offering State Plan Community First Choice Option (CFCO) services to I/DD individuals who are otherwise*

¹ For I/DD Specialized HCBS, the services will be reimbursed by Specialized I/DD Plans initially using a non-risk arrangement subject to the same Value Based Purchasing (VBP) arrangements already approved in the 1115 MRT Waiver. No later than 24-months after implementation of mandatory enrollment, the non-risk I/DD Targeted HCBS will be included in a risk payment arrangement between the State and Specialized I/DD plans/MMMC plans (e.g., risk corridor, full risk, or performance based incentives).

²The term I/DD residential services includes:

- ICF-I/DDs (including institutions such as developmental centers (DCs), small residential units (SRUs), and “community” or small model ICF-IDDs)
- OPWDD Specialty Hospitals
- Other OPWDD-approved non-institutional residential settings, including Individualized Residential Alternatives and Family Care Homes.

All I/DD residential services will be included under the 1115 waiver. I/DD residential services (except for DCs, SRUs, and Specialty Hospitals which will remain FFS) will be reimbursed through the Specialized I/DD Plans initially on a non-risk basis subject to VBP under the Demonstration. No later than 24-months after the implementation of mandatory enrollment, the non-risk I/DD residential service would be fully included in the capitation rates. The following services are currently excluded from the I/DD integration and will be phased into Specialized I/DD Plans/MMMC via contract amendments at a later date: DCs, SRUs and OPWDD Specialty Hospitals.

³ With the discontinuation of the 1915(c) Comprehensive waiver (#NY.0238), the 1115 MRT Waiver will become the HCBS authority for the I/DD Fully Integrated Duals Advantage (FIDA) Demonstration. Any reference to Dual Eligibles in this Amendment includes the I/DD FIDA Demonstration participants and their costs. I/DD FIDA Plans may have a separate line of business to offer a SIP-PL under this Demonstration.

eligible for CFCO services, but who become eligible for Medicaid solely because of receipt of HCBS (i.e., Family of One children not eligible under the State Plan, but who meet institutional admission criteria and receive HCBS).

- Transition all individuals receiving I/DD Targeted HCBS to eligibility for Health Home care management under the amended Health Home State Plan authority and phase out Medicaid Service Coordination. This amendment will provide HCBS care management for I/DD individuals eligible for HCBS under this 1115 Demonstration opting out of the State Plan Health Home authority.⁴ Individuals receiving HCBS and choosing not to enroll in Health Home care management will receive HCBS care management from a State Independent Entity contracting with the Health Home delivery system no earlier than July 1, 2018.*
- Begin the transition of the I/DD population into voluntary SIPs-PL under the 1115 waiver authority by removing the exemption from MMMC enrollment, including those receiving I/DD Targeted HCBS and I/DD residential services, no earlier than July 1, 2018.*
- Provide I/DD Targeted HCBS under the 1115 Demonstration, through the new Specialized I/DD managed care plan delivery system, for I/DD individuals who are otherwise not exempt or excluded from enrollment in accordance with the scheduled transition that begins with voluntary enrollment. I/DD individuals who receive I/DD Targeted HCBS or I/DD residential services and who do not opt-in to managed care during the voluntary phase, or those who are otherwise exempt or excluded from managed care under the Demonstration, will receive all services through the fee-for-service (FFS) delivery system under the Demonstration. Individuals in MMMC plans prior to the MMMC plans offering I/DD services will continue to receive their I/DD Targeted HCBS or other services that have not transitioned to managed care through FFS until the MMMC plan contracts are modified. No later than 24-months after implementation of mandatory enrollment the non-risk I/DD Targeted HCBS will be included in a risk payment arrangement between the State and Specialized I/DD plans/MMMC plans (e.g., risk corridor, full risk, or performance based incentives).*
- Once experience is gained through voluntary enrollment in SIPs-PL, the exclusion from mandatory enrollment will be removed for individuals with I/DD no earlier than January 1, 2021.*
- To foster statewide coverage during mandatory enrollment, MMMC plans will be permitted to offer a SIP-M. All MMMC not offering a SIP-M will be required to comply with basic I/DD requirements for any I/DD populations remaining in MMMC plans through a contract amendment. Individuals with I/DD already in MMMC and not opting into a Specialized I/DD plan will receive their I/DD Targeted HCBS and other I/DD services through their MMMC*

⁴ Health Home services under the approved Health Home State Plan will be referred to using upper case. HCBS care management services provided to individuals opting out of the approved Health Home State Plan authority will be referred to as HCBS care management using a lower case. These HCBS care management services will be in HCBS under the Demonstration and claimed at the lower FMAP rate, but will utilize a State Independent Entity contracting with the Health Home delivery system under the approved State Plan. The upper case Health Home will be utilized to refer to the general Health Home delivery system.

plan after mandatory enrollment begins. I/DD residential services will be delivered through the plan on a non-risk basis for all managed care enrollees for no more than 24 months after the implementation of mandatory enrollment before the services are placed in the capitated rate. I/DD Targeted HCBS will be included in a risk payment arrangement no later than 24-months after implementation of mandatory enrollment.

This Demonstration amendment provides further detail on the requirements for the I/DD populations and services being integrated into the Demonstration, as well as the Specialized I/DD plans to be developed, and eventual contract amendments with MMMC plans.

To ensure MMMC including Specialized I/DD plans are equipped to meet the needs of the I/DD population, plans will be reviewed and qualified using new I/DD specific network, quality, administrative, performance and fiscal standards. Implementation will be staggered, as noted in the timeline in Section 1, Question 6.

2. Include the rationale for the Demonstration.

As part of Governor Andrew Cuomo's efforts to "conduct a fundamental restructuring of (the) Medicaid program to achieve measurable improvement in health outcomes, sustainable cost control, and a more efficient administrative structure," the Governor appointed an MRT. In addition, OPWDD convened a Commissioner's Transformation Panel to meet, review and provide recommendations to the agency for "reimagining the system of support" for individuals with I/DD. Included in the report were 61 recommendations in 6 categories, one of which included 10 recommendations in the category of care management and assessment.

The State is submitting this amendment to its current 1115 MRT waiver to implement the recommendations adopted by the Commissioner's Transformation Panel, to implement models consistent with separate authority requests submitted under the State Plan that improve clinical and long-term services and supports (LTSS) outcomes for individuals with I/DD, including those with HCBS needs. This Demonstration package is part of a package of OPWDD reform and redesign initiatives developed in collaboration with the Commissioner's Transformation Panel and stakeholder engagement.

Meetings and stakeholder engagement will continue throughout implementation and oversight processes. This outreach will include the publication of a Transition Plan that will be subject to public comment. The Transition Plan will initially describe the transition from the 1915 (c) waiver to the 1115 and will be updated with each major implementation phase described on page 7. The Transition Plan will be the vehicle for responding to stakeholders' requests for additional details regarding implementation including topics such as Ombudsman Services, grievance and appeals processes and plan readiness standards.

The 1115 MRT Waiver Amendment for I/DD reflects an anticipated timeline for implementation that begins January 1, 2018 and runs through January 1, 2024. Depending on the timeframes for acquiring any necessary approvals, these dates may be modified accordingly. The

provisions of the 1115 MRT waiver are part of a package of reform and redesign initiatives, including the submission of a concurrent amendment to the current State Plan for Health Homes to incorporate I/DD-specific criteria. Members receiving I/DD Targeted HCBS services will receive Health Home care management. There will also be an amendment to the current Comprehensive 1915(c) waiver to close out the waiver.

3. Describe the hypotheses that will be tested/evaluated during the Demonstration’s approval period and the plan by which the State will use to test them.

Goal 1: Improve the health outcomes for eligible I/DD HCBS individuals with access to the Medicaid managed care delivery system.

Research Question	
1	<i>Access to Care: What are the consequences of offering HCBS and other long-term care (LTC) cross-systems services in an integrated managed care benefit package for the defined population?</i>
2	<i>Costs: What are the per member per month costs of HCBS for I/DD enrollees who receive services, and how have they improved health outcomes?</i>
3	<i>To what extent are new populations satisfied with their access to primary care services, including dental services?</i>

Goal 2: Increase access to LOC HCBS under the Demonstration and reduce the number of I/DD individuals being referred and diverted to more costly institutional LOC. More individuals will remain in the community and be diverted from institutional services.

Research Question	
1	<i>Access to Care: To what extent has the Demonstration improved availability of HCBS for individuals with I/DD including access to self-directed HCBS Services? What are their health outcomes and have they been able to remain in the community with support to live independently or with family?</i>
2	<i>Costs: To what extent are HCBS cost effective? Are costs for other services decreasing over time with increased availability of HCBS?</i>

Goal 3: Improve access to the integrated Health Home model for individuals with I/DD to improve the coordination of care and increase access to available services.

Research Question	
1	<i>To what extent are care plans better integrated by using the Health Home integrated care management model to provide care management to Health Home/HCBS enrollees (e.g., including accessing primary care/behavioral health care)?</i>
2	<i>Access to Care: To the extent there is capacity for HCBS, to what extent are Health Home/HCBS enrollees accessing community based health care or integrated health/LTSS?</i>
3	<i>Quality of Care: Are Health Home/HCBS enrollees accessing necessary services such as health monitoring and prevention services? Are chronic health and behavioral health conditions being managed appropriately?</i>

Goal 4: Improve the integration of care for individuals with I/DD who are exempt or excluded from managed care in the Demonstration.

Research Question

1	Are the health outcomes of individuals with I/DD not in managed care different than individuals with I/DD in managed care under the Demonstration?
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4. Describe where the Demonstration will operate, i.e., statewide, or in specific regions within the State.

The Demonstration will operate statewide after completion of a phase-in schedule. See the proposed statewide phase-in of the new I/DD populations and services below in item 6, and presented more fully in Section V.

5. If the Demonstration will not operate statewide, please indicate the geographic areas/regions of the State where the Demonstration will operate.

N/A

6. Include the proposed timeframe for the Demonstration.

Phase 1 of the Demonstration will begin January 1, 2018, with the transition of the populations and services formerly under the OPWDD Comprehensive waiver, and the inclusion of individuals with I/DD into the 1115 MRT waiver.

Individuals with I/DD receiving I/DD Targeted HCBS or I/DD residential services who are otherwise exempt or excluded from managed care based on other criteria will continue to receive State Plan and I/DD Targeted HCBS under the Demonstration through FFS Medicaid until transitioned into managed care. A complete description of the proposed implementation timeline is found in Section V.

Phase 2 of the Demonstration will begin with the establishment of Health Homes serving people with I/DD in July 2018. Health Homes will begin to offer enhanced and integrated care coordination through the Health Home service model under a State Plan Amendment to expand eligibility to include I/DD chronic conditions. Specialized I/DD plans that have a demonstrated history of providing or coordinating health and long term care services through Health Homes to persons with developmental disabilities may begin voluntary enrollment in late 2018. These I/DD Specialized plans will be referred to as SIPs-PL.

Phase 3 of the Demonstration allows voluntary enrollment to assess the outcomes of managed care for this population prior to implementing mandatory enrollment.

The Phase 4 transition to mandatory managed care will proceed regionally when the State confirms for such region there is a sufficient choice of plans in a community, and that the plans are capable of supporting the needs of individuals with I/DD and promoting a value-based payment methodology that furthers the transformation outcomes of the Commissioner’s Transformation Panel.

Proposed implementation scheduled is as follows:

Phase	Timing	Description
Phase 1	1/1/2018	<i>I/DD Targeted HCBS, I/DD residential services and I/DD populations are moved under the Demonstration</i>
Phase 2	July 2018	<i>I/DD populations receiving I/DD Targeted HCBS and eligible I/DD residential services will transition to Health Homes. Early adopter SIPs-PL may begin voluntary enrollment in late 2018.</i>
Phase 3	2019	<i>Downstate⁵ — Voluntary Enrollment in SIPs-PL</i>
	2020	<i>Rest of State — Voluntary Enrollment in SIPs-PL</i>
Phase 4	2021	<i>Downstate — Mandatory Enrollment in plans</i>
	2022	<i>Rest of State — Mandatory Enrollment in plans</i>
	2023	<i>Downstate — Capitated at-risk I/DD residential services and risk contracting for I/DD Targeted HCBS</i>
	2024	<i>Rest of State — Capitated at-risk I/DD residential services and risk contracting for I/DD Targeted HCBS</i>

7. Describe whether the Demonstration will affect and/or modify other components of the State’s current Medicaid and CHIP programs outside of eligibility, benefits, cost sharing or delivery systems.

The Demonstration Amendment will affect only Medicaid eligibility, benefits and delivery systems. Cost sharing will not be affected, and components of the State’s current Medicaid and CHIP programs outside of the areas listed will not be affected.

Section II — Demonstration Eligibility

This section should include information on the populations that will participate in the Demonstration, including income level. In accordance with 42 CFR 431.412(a)(ii), the information identified in this section must be included in a state’s application in order to be determined complete. Specifically, this section should:

⁵ For ease of reading the regional phase-in schedule is referred to using Downstate and Rest of State in this application. Other regions may be phased in when access is assured.

1. Include a chart identifying any populations whose eligibility will be affected by the Demonstration.

Eligibility Chart for Individuals with I/DD

In this amendment, eligibility rules will not change for the individuals with I/DD eligible under community rules.⁶ Individuals receiving I/DD residential services or I/DD Targeted HCBS who are otherwise excluded from MMMC enrollment will be included in the Demonstration in the FFS Medicaid delivery system until the point they transition to managed care.

⁶ LOC HCBS other than CFCO services will be “pass-through” services (Demonstration services 17). CFCO HCBS for State Plan eligibles are covered under the State Plan and will be in the Medicaid Eligibility Group (MEG) for State Plan services. Family of One LOC children formerly covered under the 1915(c) Comprehensive waiver under a waiver of Section 1902(a)(10)(C)(i)(III) of the Act will be a “pass through” population (Demonstration population 14). The new MEGs for Dual Eligibles (Demonstration populations 15, 16 and 17) are for regular State Plan eligibles receiving all Medicaid State Plan services.

Mandatory Medicaid Eligibility

The following populations are eligible under the current Medicaid State Plan.

Eligibility Group Name	Group Name and Delivery System	Service Package and Delivery System	MEG: Demonstration Services or Demonstration Population
<p>Children eligible for Medicaid under community eligibility rules (categorically and medically needy), including children receiving I/DD residential services or meeting targeting criteria and institutional LOC, and receiving I/DD Targeted HCBS.</p>	<p>Medicaid children eligible for managed care will receive services through MMMC/Specialized I/DD plans. Children with Medicaid exempt or excluded from the MMMC/Specialized I/DD plans delivery system will receive services via FFS.</p>	<p>State Plan benefits and HCBS benefits, if eligible. All children will receive all State Plan services and, if in a MMMC plan including Specialized I/DD plans, Demonstration services.</p> <p>Children meeting LOC will also receive State Plan CFCO HCBS, if eligible, and I/DD Targeted HCBS benefits under the Demonstration Specialized I/DD plan. (See attachment 1: Benefit Descriptions).</p>	<p>1115 HCBS other than CFCO HCBS into MEG for Demonstration Services 17.</p> <p>Demonstration services (outpatient and residential addiction services, crisis intervention and Licensed Behavioral Health Practitioner) into existing MEG for Demonstration Services 9.</p> <p>All other State Plan services, including CFCO into MEG for State Plan eligibility group for which the beneficiary already qualifies.</p>
<p>Adults eligible for Medicaid under community eligibility rules (categorically and medically needy), including adults receiving I/DD residential services or meeting targeting criteria and institutional LOC, and receiving I/DD Targeted HCBS.</p>	<p>Medicaid adults eligible for managed care will receive services through MMMC/Specialized I/DD plans. Adults with Medicaid exempt or excluded from the MMMC/Specialized I/DD plans delivery system will receive services via FFS.</p>	<p>State Plan benefits and HCBS benefits, if eligible. All adults will receive all State Plan services and, if in a MMMC including Specialized I/DD plans, Demonstration services.</p> <p>Adults meeting LOC will also receive State Plan CFCO HCBS, if eligible, and I/DD Targeted HCBS benefits under the Demonstration. (See attachment 1: Benefit Descriptions).</p>	<p>1115 HCBS other than CFCO HCBS into MEG for Demonstration Services 17.</p> <p>Demonstration services (outpatient and residential addiction services, crisis intervention and Licensed Behavioral Health Practitioner) into existing MEG for Demonstration Services 9.</p>

Eligibility Group Name	Group Name and Delivery System	Service Package and Delivery System	MEG: Demonstration Services or Demonstration Population
			<p><i>All other State Plan services, including CFCO into MEG for State Plan eligibility group for which the beneficiary already qualifies.</i></p>
<p><i>Dual eligible individuals eligible for Medicaid under community eligibility rules (categorially and medically needy), including dual eligibles receiving I/DD residential services or meeting targeting criteria, and institutional LOC, and receiving HCBS.</i></p>	<p><i>Dual eligible individuals eligible for managed care will receive services through Specialized I/DD plans. Dual eligibles exempt or excluded from the Specialized I/DD delivery system will receive services via FFS.</i></p> <p><i>I/DD FIDA Demonstration eligibles will receive services through the I/DD FIDA plans under this Demonstration amendment.</i></p>	<p><i>State Plan benefits and HCBS benefits, if eligible. All dual eligibles will receive all State Plan services.</i></p> <p><i>Dual eligibles with I/DD meeting LOC will also receive State Plan CFCO HCBS, if eligible, and I/DD Targeted HCBS benefits under the Demonstration. (See attachment 1: Benefit Descriptions).</i></p> <p><i>I/DD FIDA Demonstration eligibles will receive State Plan and HCBS benefits services through the I/DD FIDA plans.</i></p>	<p><i>1115 HCBS other than CFCO HCBS into MEG for Demonstration Services 17.</i></p> <p><i>All State Plan, including CFCO into Demonstration Population 15 (Ages 0-20), Demonstration Population 16 (Ages 21-64) and Demonstration Population 17 (Ages 65+) MEGs.</i></p> <p><i>Demonstration services (outpatient and residential addiction services, crisis intervention and Licensed Behavioral Health Practitioner) into MEG for Demonstration Services 9.</i></p>

Optional Medicaid Eligibility

Eligibility Group Name	SSA and CFR Citations	Income Level	Group Name and Delivery System	Service Package	MEG: Demonstration Services or Demonstration Population
<p><i>LOC Family of One — children who would be eligible for Medicaid under institutional rules and receiving services under the State’s current 1915(c) waiver specifically: OPWDD Comprehensive Waiver #NY.0238</i></p>	<p><i>Medically needy children with a waiver of 1902(a)(10)(C)(i)(III) meeting institutional LOC.</i></p>	<p><i>Income that does not exceed the medically needy income standard for an individual or who have a spenddown.</i></p> <p><i>For Supplemental Security Income (SSI)-related medically needy, resources that do not exceed the medically needy resource standard for an individual</i></p> <p><i>Individuals must meet institutional functional criteria requirements.</i></p> <p><i>Use institutional income and resource rules for the medically needy meeting institutional LOC.</i></p>	<p><i>“LOC Family of One” children’s HCBS group (i.e., Family of One child where the child meets institutional functional eligibility criteria and receives HCBS).</i></p> <p><i>Fully eligible Family of One children will be in managed care unless otherwise exempt or excluded. Children exempt or excluded from managed care will receive services through the FFS delivery system.</i></p>	<p><i>Children meeting LOC will also receive State Plan CFCO HCBS, if eligible, and I/DD Targeted HCBS benefits under the Demonstration in Specialized I/DD plans. (See attachment 1: Benefit Descriptions).</i></p>	<p><i>Demonstration Population 14.</i></p>

To transition coverage and services under the OPWDD Section 1915(c) Comprehensive Waiver #NY.0238 to the 1115 Demonstration, the targeting and functional criteria from the waiver are requested to be added to the 1115 waiver Standard Terms and Conditions (STCs).

These criteria include the ICF-I/DD LOC, the need for comprehensive HCBS and the person living in an eligible HCBS setting. Eligible residential settings are the person's own or family home or an OPWDD-certified community-based residence meeting federal HCBS settings requirements and the 1115 MRT waiver STCs.⁷

I/DD individuals currently in receipt of I/DD Targeted HCBS or residential I/DD services and exempt or excluded from enrollment in MMMC are also included in the Demonstration to continue to receive HCBS or residential I/DD services through FFS Medicaid until those individuals transition into managed care.

I/DD individuals who are currently on the 1915(c) Comprehensive waiver at the time of transition under the 1115 waiver – including I/DD FIDA Demonstration enrollees will transition into the Demonstration. This will ensure that those individuals on HCBS will remain in HCBS as long as they qualify under the Demonstration because it can be shown that the individual would have met targeting criteria and LOC criteria under the former Comprehensive HCBS waiver. LOC continues to equal the medical institutional admission criteria for ICF/I/DD in New York.

DD LOC population:

- a. **Target Criteria**
 - i. All ages
 - ii. A person having a DD as defined by New York Mental Hygiene Law §1.03 (22) which: is attributable to intellectual disability, cerebral palsy, epilepsy, neurological impairment, familial dysautonomia, Prader-Willi Syndrome or autism; is attributable to any other condition of a person found to be closely related to intellectual disability because such condition results in similar impairment of general intellectual functioning or adaptive behavior to that of intellectual disabled persons or requires treatment and services similar to those required for such person; or is attributable to dyslexia resulting from a disability described above; originates before such person attains age twenty-two; continued or can be expected to continue indefinitely; and constitutes a substantial handicap to such person's ability to function normally in society.
 1. Functional limitations are generally considered to constitute a substantial handicap when they prohibit a person from being able to engage in self-care or exercise self-direction independently or when development of self-care and self-direction skills are significantly below an age-appropriate level. Such

⁷ New York's Statewide Transition Plan (STP) included the OPWDD Comprehensive 1915(c) waiver and will be implemented as proposed. The STP for the Comprehensive waiver outlines rules, regulations and policy changes; service and support enhancements; training, communications and workforce strategies; implementation of Direct Support Professional competencies and Regional Centers for Workforce Transformation; Infrastructure improvements and provider remediation and ongoing compliance monitoring.

limitations may also seriously disrupt age-appropriate social and interpersonal relationships.

- 2. The clinical determination of when a condition constitutes a substantial handicap is defined as: significant limitations in adaptive functioning that are determined from the findings of assessment by using a nationally normed and validated, comprehensive, individual measure of adaptive behavior, administered by a qualified practitioner.*
- 3. Onset of significant limitations in adaptive behavior constituting substantial handicap, must be before the person attains age 22 in order to satisfy the requirements of NYS Mental Hygiene Law 1.03(22)(b). Onset must be verified as entailing occurrence of significant limitations in adaptive behavior prior to age 22.*

2. Describe the standards and methodologies the state will use to determine eligibility for any populations whose eligibility is changed under the Demonstration, to the extent those standards or methodologies differ from the State Plan.

The following populations will be included under the Demonstration that were previously exempt or excluded, including:

- Individuals enrolled in the OPWDD Comprehensive waiver.*
- Individuals residing in ICF-IDDs and other OPWDD-approved residential settings, including Individualized Residential Alternatives, Developmental Centers, Small Residential Units, OPWDD Specialty Hospitals and Family Care Homes.*
- Other individuals approved to receive I/DD services.*
- Working individuals with disabilities who buy into Medicaid — TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act.*
- Working individuals with disabilities who buy into Medicaid — TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act.*
- Optional State supplement recipients.*
- Other specified groups (including statutory/regulatory reference to reflect the additional groups in the State Plan that may receive services under this waiver).*
- Individuals who qualify under 1902(a)(10)(A)(i)(II)(bb)(Qualified Severely Impaired).*
- DAC beneficiaries who are eligible under 1634(c) of the Act.*

The standards and methodologies of these eligibility groups will not differ from the State Plan. In addition, Temporary Assistance for Needy Families, SSI and dual eligible individuals will be included under the Demonstration if they are eligible to receive I/DD Targeted HCBS or if they are residing in an I/DD residential setting.

Individuals eligible for HCBS will include those with income at or below the monthly income standard (if Medicaid only). For the Family of One populations under this Demonstration amendment, the State will waive deeming of income and resources (if applicable) for all medically needy children who meet targeting criteria and institutional LOC for HCBS. Note: post eligibility rules do not apply to these populations. For LOC Family of One HCBS children (optional SSI-related Medicaid eligibility group): Income that does not exceed the medically needy income standard for an individual or who have a spenddown; for SSI-related children, resources that do not exceed the medically needy resource standard for an

individual; individuals must meet institutional functional criteria requirements. These LOC Family of One groups were previously included under the State’s existing #NY.0238 1915(c) waiver.

3. Specify any enrollment limits that apply for expansion populations under the Demonstration.

There is no expansion population proposed under the Demonstration amendment. Under the 1115 Demonstration, the State will not maintain waiting lists for I/DD Targeted HCBS benefits for I/DD individuals who meet institutional LOC.

4. Provide the projected number of individuals who would be eligible for the Demonstration, and indicate if the projections are based on current state programs (i.e., Medicaid State Plan, or populations covered using other waiver authority, such as 1915(c). If applicable, please specify the size of the populations currently served in those programs.

The current I/DD waiver, ICF and other I/DD populations had the following enrollment in Federal Fiscal Year (FFY) 2015:

Population	Approximate Current Individuals	FFY 2014/2015 Member Months
<i>OPWDD Comprehensive waiver (#NY-0238)</i>	<i>75,483</i>	<i>880,086</i>
<i>OPWDD ICF Residents</i>	<i>6,700</i>	<i>80,400</i>
<i>Other I/DD</i>	<i>26,300</i>	<i>315,600</i>
Total	108,483	1,276,086

These counts include approximately 20,000 individuals already in MMMC. It is not anticipated that an unserved population exists and will become Medicaid eligible under the Optional Population in this amendment.

5. To the extent that long term services and supports are furnished (either in institutions or the community), describe how the Demonstration will address post-eligibility treatment of income, if applicable. In addition, indicate whether the Demonstration will utilize spousal impoverishment rules under section 1924, or will utilize regular post-eligibility rules under 42 CFR 435.726 (SSI State and section 1634) or under 42 CFR 435.735 (209b State).

For this amendment, the State confirms that New York is a 1634 state; however, New York does not cover the 435.217 group for 1915(c) waiver purposes (only for the Program of All-Inclusive Care for the Elderly). Therefore, post-eligibility treatment of income does not apply to the populations under this Demonstration.

HCBS will be provided for children under the Demonstration meeting targeting criteria and institutional LOC. The SSI-related medically needy children meeting LOC may become eligible for Medicaid under the institutional financial criteria with a waiver deeming income and resources for LOC Family of One HCBS children group (as of January 1, 2018).

Medically needy children may have their parent's income waived and resources if they meet the targeting criteria and institutional LOC HCBS eligibility criteria only.⁸ Note: Post-eligibility treatment of income rules do not apply to this Family of One population.

- 6. Describe any changes in eligibility procedures the state will use for populations under the Demonstration, including any eligibility simplifications that require 1115 authority (such as continuous eligibility or express lane eligibility for adults or express lane eligibility for children after 2013).**

N/A

- 7. If applicable, describe any eligibility changes that the state is seeking to undertake for the purposes of transitioning Medicaid or CHIP eligibility standards to the methodologies or standards applicable in 2014 (such as financial methodologies for determining eligibility based on modified adjusted gross income), or in light of other changes in 2014.**

N/A

Section III — Demonstration Benefits and Cost Sharing Requirements

This section should include information on the benefits provided under the Demonstration as well as any cost sharing requirements. In accordance with 42 CFR 431.412(a)(ii), the information identified in this section must be included in a state's application in order to be determined complete. Specifically, this section should:

- 1. Indicate whether the benefits provided under the Demonstration differ from those provided under the Medicaid and/or CHIP State Plan.**

Yes, services under the Demonstration will differ from services under the State Plan:

- I/DD Targeted HCBS, included in Attachment 1, will be included under the Demonstration and offered to individuals meeting targeting and LOC criteria in Early Adopter SIPs-PL in late 2018, and in all Specialized I/DD plans and MMMC managed care plans under mandatory enrollment regionally when access is guaranteed in each region under mandatory enrollment no earlier than 2021.*
- I/DD individuals meeting institutional LOC criteria who also meet CFCO eligibility and who are eligible for Medicaid under community eligibility rules will be eligible for CFCO services under the State Plan.*
- Individuals eligible for Medicaid under Family of One institutional rules, who also meet CFCO eligibility, will be eligible for CFCO services under this 1115 Demonstration amendment.*

⁸ Consistent with the State Medicaid Director letter dated July 25, 2000, Olmstead letter number three, the earliest date for which Federal financial participation (FFP) can be claimed when a person's Medicaid eligibility is predicated upon receipt of Medicaid HCBS under a waiver is the date on which all of criteria in the letter are met. The provisional Life Plan developed for Family of One children will include a referral to a Health Home or the State Independent Entity for the face to face assessment and development of the final Life Plan.

- *Individuals in Specialized I/DD plans and MMMC will be eligible for the Demonstration services (licensed behavioral health practitioner, crisis intervention including OPWDD crisis providers, and outpatient and residential addiction services). In addition, non-institutionalized individuals with I/DD under the Demonstration and in the FFS delivery system are eligible immediately to receive crisis intervention from OPWDD crisis providers. A State Plan for addiction services for all other adults and children with an effective date of July 1, 2016 was submitted September 30, 2016. A State Plan for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Other Licensed Practitioners and EPSDT Crisis Intervention was submitted on December 30, 2016 for an effective date of July 1, 2018.*

2. Indicate whether the cost sharing requirements under the Demonstration differ from those provided under the Medicaid and/or CHIP State Plan (if no, please skip questions 8 – 11).

No

3. If changes are proposed, or if different benefit packages will apply to different eligibility groups affected by the Demonstration, please include a chart specifying the benefit package that each eligibility group will receive under the Demonstration (an example is provided).

For this amendment, only I/DD Targeted HCBS will vary by population.

Benefit Package Chart

Eligibility Group	Benefit Package
<i>Individuals not meeting HCBS targeting criteria and institutional LOC.</i>	<i>All State Plan services. Individuals in MMMC plans including all Specialized I/DD plans will receive Demonstration services (licensed behavioral health practitioner, crisis intervention, and outpatient and residential addiction). Non-institutionalized individuals with I/DD in the FFS delivery system are eligible to receive crisis intervention Demonstration services.</i>
<i>Individuals meeting HCBS targeting criteria and institutional LOC.</i>	<i>All State Plan services including CFCO services; Targeted I/DD HCBS Individuals in MMMC, including all Specialized I/DD plans, will receive Demonstration services (licensed behavioral health practitioner, crisis intervention, and outpatient and residential addiction services). Non-institutionalized individuals with I/DD in the FFS delivery system are eligible to receive crisis intervention Demonstration services</i>

Individuals exempt or excluded from MMMC, including Specialized I/DD plans, will receive the State Plan and I/DD Targeted HCBS benefits via the FFS delivery system within the 1115 waiver as outlined in Attachment A. In addition, the behavioral health services and services below will be provided.

From Attachment A of the STCs

For Individuals 21 and Older	Applicable to Children/Youth Under Age 21	Now Also Applicable to Individuals With I/DD
State Plan inpatient and outpatient behavioral health services in MMMCs for individuals 21 and older, excluding rehabilitation services for residents of community residences	X	X
Clinic: Medically supervised outpatient withdrawal	X	X
Clinic: Office of Alcoholism and Substance Abuse Services (OASAS) outpatient and opioid treatment program services	X	X
Rehabilitation: OASAS outpatient rehabilitation programs	X	X
Clinic: Licensed clinic services (Office of Mental Health (OMH) services)	X	X
Outpatient hospital: Comprehensive psychiatric emergency program, including extended observation bed	X	X
Clinic: Continuing day treatment	X (minimum age is 18 for medical necessity)	X
Clinic: Partial hospitalization	X	X
Rehabilitation: Personalized recovery oriented services	X (minimum age is 18 for medical necessity)	X
Rehabilitation: Intensive psychiatric rehabilitation treatment	X	X
Rehabilitation: Assertive community treatment	X (minimum age is 18 for medical necessity)	X
Targeted case management (TCM) (being phased out), including intensive case management/supportive case management	X	X – TCM called Medicaid Service Coordinaton being phased out
Inpatient hospital: Medically managed detoxification (hospital based)	X	X
Inpatient hospital: Medically supervised inpatient detoxification	X	X
Inpatient hospital: Inpatient treatment	X	X
Inpatient hospital: Inpatient psychiatric services	X	X
Rehabilitation: Services for residents of community residences Note: these services are currently excluded from the behavioral health integration. Will be phased into MMMC via contract amendments at a later date	X	X

OPWDD Outpatient Services

- Clinic Services (Title 16 clinics)

- *Independent Practitioners for Individuals I/DD*

I/DD Residential Services

I/DD residential services are defined as Medicaid eligible and reimbursed care provided in:

- *ICF-IDDs (including developmental centers, small residential units, and “community” or small model ICF-IDDs)⁹*
- *OPWDD Specialty Hospitals*
- *Other OPWDD-approved non-institutional residential settings, including Individualized Residential Alternatives and Family Care Homes*

I/DD residential services are non-risk (except for Developmental Centers, small residential units and OPWDD specialty Hospitals which will remain FFS) subject to VBP. No later than 24-months after implementation of mandatory enrollment, the non-risk I/DD residential services will be fully included in the managed care plans’ capitation rates.

The following services are currently excluded from the I/DD integration and will be phased into Specialized I/DD plans and MMMC via contract amendments at a later date:

- *Developmental Centers*
- *Small residential units*
- *OPWDD Specialty Hospitals*

Child-Specific Behavioral Health Services

The State Plan and Demonstration behavioral health benefits were included in the MMMC plans for children/youth under age 21, including children with I/DD. The following services are currently excluded from behavioral health integration and will be phased into MMMC via contract amendments at a later date:

- *Children’s Day Treatment*
- *Residential Treatment Facilities (RTFs)*
- *Inpatient Behavioral Health Services in OMH operated facilities*
- *Residential Rehabilitation Services for Youth (RRSYs)*
- *Teaching Family Home*

Demonstration Services in MMMC, including Specialized I/DD Plans, Which Will be Included in the State Plan, as Noted Above

- *Outpatient and residential addiction services are already included in the MMMC benefit package under the 1115 waiver. A State Plan for adults and children (#16-004) with an effective date of July 1, 2016 was submitted September 30, 2016. For addiction services and the delivery system changes associated with the new Demonstration services and resulting State Plan Amendments (SPAs), including changes under the CMS Innovation Accelerator Program (IAP), the State may require MMMCs including Specialized I/DD plans — through their contracts, as approved by CMS — to adopt system-wide changes and rates, also approved by CMS, to ensure that the innovations are adopted in a consistent manner statewide.*

⁹ ICF-IDDs and OPWDD Specialty Hospitals are considered institutional in nature and their enrollees are not eligible for HCBS services or Health Home services.

- *Licensed behavioral health practitioner and crisis intervention services are already included in the MMMC and HIV Special Needs Plans benefit package under the 1115 waiver. This will include crisis services provided by OPWDD approved providers including START for individuals with I/DD in MMMC and HIV Special Needs Plans, Specialized I/DD Plans, and who are non-institutionalized and receiving FFS. Two EPSDT SPAs, with effective dates of March 1, 2017 and October 1, 2017, were submitted December 30, 2016 as EPSDT Other Licensed Practitioners and EPSDT Crisis Intervention. Note: these effective dates will be modified to July 1, 2018.*

New State Plan Services

The following four new EPSDT SPA services will also be included in the MMMC benefit packages with behavioral health services, once approved in the State Plan. This EPSDT SPA was submitted with the EPSDT Rehabilitation State Plans above for an effective date of October 1, 2017, on December 30, 2016. Note: these effective dates will be modified to July 1, 2018:

- *Youth Peer Support and Training*
- *Family Peer Support Services*
- *Community Psychiatric Support and Treatment*
- *Psychosocial Rehabilitation Supports*

The following prevention SPA will be separately submitted:

- *Residential supports and services is a new EPSDT Prevention SPA service that will be included in the MMMC benefit packages, once approved in the State Plan, for an effective date of January 1, 2019, and will be submitted no later than March 31, 2019.*

4. If electing benchmark-equivalent coverage for a population, please indicate which standard is being used.

N/A

5. In addition to the Benefit Specifications and Qualifications form: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Interim1115-Benefit-Specifications-and-Provider-Qualifications.pdf>, please complete the following chart if the Demonstration will provide benefits that differ from the Medicaid or CHIP State Plan.

See Attachment 1 to this amendment.

I/DD

6. Indicate whether Long Term Services and Supports will be provided.

New York will include individuals in I/DD residential services under the Demonstration. In addition, New York will provide IDD Targeted HCBS listed in Attachment 1 to individuals meeting the targeting criteria and institutional LOC if medically necessary and listed on the individual's person-centered HCBS Plan of Care (Life Plan).

1. Habilitation

- Residential
 - Day
 - Community
 - Prevocational (site-based and community)
 - Supported Employment
 - Pathway to Employment
2. Respite
 3. Adaptive Devices — Assistive Tech (CFCO)
 4. Environmental Modifications
 5. HCBS care management
 6. Family Education and Training
 7. Services to Support Self Direction
 - Fiscal Intermediary
 - Support Brokerage
 - Individual Directed Goods and Services
 8. Community Transition Services (CFCO)
 9. Live-in Caregiver
 10. Intensive Behavioral Support
 11. Vehicle Modification (CFCO) (Pending CMS approval — Amendment 1)

Individuals meeting institutional LOC criteria, who also meet CFCO eligibility and who are eligible for Medicaid under community eligibility rules, will be eligible for these CFCO services under the State Plan. Individuals eligible for Medicaid under Family of One institutional rules, who also meet CFCO eligibility, will be eligible for these CFCO services under the 1115 Demonstration.¹⁰

- Assistive Technology
- Community Transitional Services
- Durable Medical Equipment/Medical Supplies
- Environmental Modification
- Community Habilitation
- Supervision and/or Cueing
- Home Delivered/Congregate Meals
- Home Health Care (Aide)
- Homemaker/Housekeeper
- Moving Assistance
- Personal Care/Consumer Directed Personal Assistance Program
- Personal Emergency Response
- Transportation — Non-Emergency, Medical
- Transportation — Non-Emergency, Social
- Vehicle Modification

See the State's approved CFCO State Plan for service definitions. SPAs #13-0035 and #15-0060 were approved October 23, 2015. CFCO benefits are provided in conjunction with I/DD Targeted HCBS in FFS and managed care.

¹⁰ Each individual eligible for HCBS under both CFCO and I/DD Targeted HCBS with the limits to each service being the greater of either benefit not the sum of the two benefits together.

7. Indicate whether premium assistance for employer sponsored coverage will be available through the Demonstration.

This amendment does not modify any premium assistance for employer-sponsored coverage available under the New York Medicaid program and its existing 1115 MRT waiver.

8. If different from the State Plan, provide the premium amounts by eligibility group and income level (if additional space is needed, please supplement your answer with a Word attachment).

N/A

9. Include a table if the Demonstration will require copayments, coinsurance and/or deductibles that differ from the Medicaid State Plan.

N/A

10. Indicate if there are any exemptions from the proposed cost sharing.

N/A

Section IV — Delivery System and Payment Rates for Services

This section should include information on the means by which benefits will be provided to Demonstration participants through responses to the questions below.

1. Indicate whether the delivery system used to provide benefits to Demonstration participants will differ from the Medicaid and/or CHIP State Plan:

- *Individuals currently enrolled in MMMC will not be required to change delivery systems or providers. They will have an option of choosing to enroll in a Specialized I/DD plan.*
- *Individuals receiving I/DD Targeted HCBS or I/DD residential services, but not yet enrolled into managed care, will remain in FFS until phased into managed care.*
- *Individuals receiving I/DD Targeted HCBS and eligible non-institutional I/DD residential services will be enrolled in and receive care management from the Health Home program authorized under the amended Health Home State Plan. If an individual opts out of the amended Health Home State Plan, the individual will receive HCBS care management from a State Independent Entity under the 1115 MRT Demonstration to manage their I/DD Targeted HCBS. Individuals receiving institutional I/DD residential services are not eligible for Health Home care management under any authority.*
- *Individuals receiving I/DD Targeted HCBS who choose not to enroll in Health Home care management and are enrolled in a managed care plan will receive HCBS care management from a State Independent Entity.*

Individuals with I/DD receiving I/DD residential services or I/DD Targeted HCBS will be enrolled under the Demonstration in one of four ways:

1. *Non-dual eligible individuals who are not otherwise exempt or excluded from enrollment in MMMC will receive coverage through new Specialized I/DD plans or remaining in their MMMC plan.*
2. *Dual eligible individuals with I/DD not in I/DD Fully Integrated Duals Advantage (FIDA) Demonstration will be enrolled in the Specialized I/DD plans. MMMC not offering SIPs-M will not be permitted to enroll dual eligible individuals.*
3. *Dual eligible individuals with I/DD enrolled in the I/DD FIDA Demonstration will remain enrolled in the FIDA plans under this Demonstration authority.*
4. *Individuals exempt or excluded from MMMC, including Specialized I/DD plans, will remain in FFS Medicaid delivery systems.*

2. Describe the delivery system reforms that will occur as a result of the Demonstration, and if applicable, how they will support the broader goals for improving quality and value in the health care system.

There will be the addition of Specialized I/DD plans. A plan qualification document, that will qualify plans with I/DD experience and I/DD experienced providers, will be issued by the State. This plan qualification document will be circulated for public comment and stakeholder input. The plan qualification document process will include both desk and in-person readiness reviews, ensuring that the specific requirements of the plan contract are met prior to implementation and transition. Plans participating as Specialized I/DD plans must offer I/DD Targeted HCBS.

All Specialized I/DD plans will offer a capitated State Plan benefit package consistent with MMMC benefits, as well as providing non-risk I/DD residential services and I/DD Targeted HCBS, as outlined Attachment 1. For dual eligibles, the Specialized I/DD plan must also coordinate the benefit package with Medicare, and pay Medicare cost-sharing. Dual eligibles will have a choice of providers for Medicare benefits and will not be required to remain in the plan network to receive those benefits. The I/DD FIDA voluntary managed care delivery model was offered under 1915(a)(1)(A)/1915(c) concurrent authority and is not affected by transitioning to this Demonstration authority.¹¹

Specialized I/DD plans will operate pursuant to New York State law. Entities offering services operated, certified, funded, authorized or approved by OPWDD, including habilitation services, must have experience providing or coordinating services for persons with I/DD, as demonstrated by criteria to be determined by the Commissioner of the New York State Department of Health (NYSDOH) and the Commissioner of OPWDD. Initially, entities that have a demonstrated history of providing or coordinating health and LTC services to persons with I/DD will be permitted to apply to offer I/DD specific services through SIPs-PL.

Existing MMMC plans may choose to offer SIPs-M as a separate line of business during the mandatory enrollment period to the extent necessary to ensure statewide coverage. The

¹¹ The I/DD FIDA delivery model is included in this 1115 in order to preserve I/DD FIDA enrollees' access to their HCBS services, which were authorized under the 1915(c) Comprehensive waiver and is being terminated as a result of this Demonstration amendment.

delivery system for MMMC plans who choose not to offer SIPs-M will not change other than the addition of contract requirements, performance measures for the new I/DD population, and the provision of non-risk I/DD residential services and Targeted I/DD HCBS.

3. Indicate the delivery system that will be used in the Demonstration by checking one or more of the following boxes:

X	Managed Care Organization (MCO). <i>Individuals in managed care will also be enrolled in Health Homes, if eligible. Individuals who choose not to enroll in Health Homes will receive care management from the State Independent Entity. The I/DD FIDA managed care delivery model will not be changed under this Demonstration.</i>
X	Health Homes. <i>Individuals will be enrolled in Health Homes, if eligible under the State Plan, regardless of whether they are enrolled in managed care or FFS delivery systems, or eligible for I/DD non-institutional residential services or I/DD Targeted HCBS. Individuals formerly enrolled in 1915(c) waivers will transition to Health Home care management.</i>
X	Other (please describe). <i>Individuals who choose not to enroll in Health Home Care management and receive I/DD residential services or I/DD Targeted HCBS (and are exempted or excluded from managed care enrollment) will receive care management from a State Independent Entity.</i>

Consistent with the approved 1115 waiver renewal, all individuals utilizing I/DD Targeted HCBS or I/DD non-institutional residential services will have a person-centered Life Plan maintained at the Health Home. If opting out of the Health Home, the Life Plan will be maintained with the State Independent Entity. Person-centered planning includes consideration of the current and unique social and medical needs and history of the enrollee, as well as the person’s functional level and support systems. The person-centered Life Plan is developed by the enrollee with the assistance of the Health Home, or State Independent Entity (if applicable), and individuals the enrollee chooses to include.

The person-centered plan is developed in accordance with 42 CFR 441.301(c)(4)(F)(1) through (8).

New York will offer the assistance of a contractor to operate New York’s Ombudsman program for all individuals receiving I/DD Targeted HCBS under managed care. This entity will be an independent, conflict-free entity and will provide participants with free assistance in accessing their care, understanding and exercising their rights and responsibilities, and appealing adverse decisions made by their plan.

The ombudsman contractor will be accessible to all participants through telephonic and, where appropriate, in-person access. They will provide advice, information, referral, assistance in accessing benefits and assistance in navigating the Specialized I/DD plans, MMMC, providers, OPWDD or NYSDOH under this Demonstration.

This contractor will act as a resource and advocate for participants and families as they navigate the managed care program systems.

4. If multiple delivery systems will be used, please include a table that depicts the delivery system that will be utilized in the Demonstration for each

eligibility group that participates in the Demonstration (an example is provided). Please also include the appropriate authority if the Demonstration will use a delivery system (or is currently seeking one) that is currently authorized under the State Plan, section 1915(a) option, section 1915(b) or section 1932 option.

Delivery System Chart Eligibility Group	Delivery System	Authority
<i>Individuals with I/DD not otherwise excluded or exempt from MMMC I/DD</i>	<i>MMMC or Specialized I/DD managed care plan — MCO. Health Home Care Management or the State Independent Entity if the individual declines Health Home care management.</i>	<i>1115 Demonstration and State Plan</i>
<i>Individuals with I/DD excluded or exempt from MMMC, including those receiving I/DD residential services and I/DD Targeted HCBS</i>	<i>FFS and Health Home care management, or care management by State Independent Entity if the individual declines Health Home care management.</i>	<i>1115 Demonstration and State Plan</i>

- 5. If the Demonstration will utilize a managed care delivery system:**
- a. Indicate whether enrollment be voluntary or mandatory. If mandatory, is the state proposing to exempt and/or exclude populations (if additional space is needed, please supplement your answer with a Word attachment).**

For this amendment, the initial enrollment will be FFS with a voluntary phase-in to SIPs-PL followed by a phase-in of mandatory enrollment in either Specialized I/DD plans or remaining in MMMC. The exemption and exclusion of I/DD individuals from managed care currently in the 1115 waiver will be eliminated:

- Individuals who are exempt or excluded from MMMC enrollment will be included in the Demonstration in the FFS Medicaid delivery system until the point they will transition to a Specialized I/DD plan.*
- Dually eligible individuals not participating in the I/DD FIDA Demonstration and receiving I/DD Targeted HCBS will be included in the Demonstration in the FFS Medicaid delivery system until the point they will transition to a Specialized I/DD managed care plan.*
- Dually eligible individuals participating in FIDA will remain in the FIDA plans for the duration of the FIDA Demonstration.*

Please note: an X in the chart below denotes the category continues to remain exempt or excluded from the MMMC including HIV/SNP and Specialized I/DD plans under this amendment

Currently in STC — Table 2 Individuals Excluded from MMMC (including Health and Recovery Program (HARP) & SNP)	Proposed to remain in STCs after Children's Amendment	Proposed to Remain in STCs After I/DD Individual's Amendment
<i>Individuals who become eligible for Medicaid only after spending down a portion of their income</i>	X	X
<i>Residents of State psychiatric facilities and residents of RTFs for children and youth</i>	<i>As the RTF services are phased into managed care through contract amendments, the children in RTFs will phase into the Demonstration</i>	<i>As the RTF services are phased into managed care through contract amendments, the children in RTFs will phase into the Demonstration</i>
<i>Individuals under age 21 who are permanent residents of Residential Health Care Facilities or temporary residents of Residential Health Care Facilities at time of enrollment</i>	X	X
<i>Medicaid eligible infants living with incarcerated mothers</i>	X	X
<i>Individuals with access to comprehensive private health insurance</i>	X	X
<i>Foster care children in the placement of a voluntary agency</i>		
<i>Certified blind or disabled children living, or expected to live, separate and apart from their parents for 30 days or more</i>	X	X
<i>Individuals expected to be Medicaid eligible for less than six months (except for pregnant women)</i>	X	X
<i>Individuals receiving hospice services (at time of enrollment)</i>	X	X
<i>Individuals with a "county of fiscal responsibility" code of 97, except for individuals in the New York OMH family care program who, other than their residence in district 97, would be eligible to enroll in MMMC</i>	X	X
<i>Individuals with a "county of responsibility" code of 98 (individuals in an OPWDD facility or treatment center)</i>	X	<i>As the services are phased into managed care through contract amendments, the individuals will phase into the Demonstration¹²</i>

¹²I/DD Targeted HCBS and I/DD residential services except for Developmental Centers, Small Residential Units, and OPWDD Specialty Hospitals will be provided by Specialized I/DD plans on a non-risk basis subject to VBP initially. No later than 24-months after the implementation of mandatory enrollment, I/DD residential services will be placed in

Currently in STC — Table 2 Individuals Excluded from MMMC (including Health and Recovery Program (HARP) & SNP)	Proposed to remain in STCs after Children's Amendment	Proposed to Remain in STCs After I/DD Individual's Amendment
<i>Youth in the care and custody of the commissioner of the Office of Children & Family Services</i>	<i>Youth in OCFS facilities and in the care and custody of the Office of Children & Family Services</i>	<i>Youth in OCFS facilities and in the care and custody of the Office of Children & Family Services</i>
<i>Individuals who are under 65 years of age (screened and require treatment) in the Centers for Disease Control and Prevention breast, cervical, colorectal or prostate cancer, and who are not otherwise covered under creditable health coverage</i>	X	X
<i>Individuals who are eligible for Emergency Medicaid</i>	X	X
<i>Aliessa Court Ordered Individuals*</i>	X	X
<i>Medicare recipients</i>	X	<i>Dual eligible individuals eligible for I/DD residential services and I/DD Targeted HCBS will be mandated to enroll in Specialized DD plans if not in a FIDA plan according to the implementation schedule. All other non-I/DD Dual Eligibles continue to be excluded from MMMC</i>
<i>Residents of Assisted Living programs</i>	X	X

*Aliessa Aliens are not excluded from managed care, but are excluded from Federal Financial Participation.

Currently in STC — Table 3 Individuals Who May be Exempt from MMMC	Proposed to Remain in STCs After Children's Amendment	Proposed to Remain in STCs after I/DD Individual's Amendment
<i>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 NYSDOH Medical Director because of unusually severe chronic care needs. Exemption is limited to six months</i>	X	X

the capitated rates and I/DD Targeted HCBS will be included in a risk payment arrangement (e.g., risk corridor, full risk, or performance based incentives).

Currently in STC — Table 3 Individuals Who May be Exempt from MMMC	Proposed to Remain in STCs After Children's Amendment	Proposed to Remain in STCs after I/DD Individual's Amendment
<p><i>Child and youth residents of alcohol/substance abuse long term residential treatment programs</i></p> <p><i>Note: this item was in the July 29, 2015 Amendment STCs and removed in the renewal STCs</i></p>	<p><i>Child and Youth residents of RRSYs</i></p> <p><i>As the RRSY services are phased into managed care through contract amendments, the children in RRSYs will mandatorily phase into the Demonstration</i></p>	<p><i>Child and Youth residents of RRSYs</i></p> <p><i>As the RRSY services are phased into managed care through contract amendments, the children in RRSYs will mandatorily phase into the Demonstration</i></p>
<p><i>Individuals designated as participating in OPWDD-sponsored programs</i></p>	<p>X</p>	<p><i>Remove in 2021</i></p>
<p><i>Individuals with a developmental or physical disability receiving services through a Medicaid HCBS waiver authorized under section 1915(c) of the Act</i></p>	<p><i>Individuals with a developmental or physical disability receiving services through a Medicaid HCBS waiver authorized under Section 1915(c) of the Act. except for children formerly under the Care at Home (I/II, IV/OPWDD) and Bridges to Health Medically Fragile and DD waivers which are subsumed into the Demonstration</i></p>	<p><i>Remove in 2021</i></p>
<p><i>Native Americans</i></p>	<p>X</p>	<p>X</p>
<p><i>Individuals in the following Section 1915(c) waiver programs: Traumatic Brain Injury (TBI) and Nursing Home Transition and Diversion (NHTD)</i></p>	<p>X</p>	<p>X</p>
<p><i>Individuals in the Office for People with Developmental Disabilities Home and Community Based Services Comprehensive (OPWDD HCBS) Section 1915 (c) waiver program</i></p>	<p>X</p>	<p><i>Remove in 2021</i></p>

The STCs will need to modify the chart below as well to reflect that dual eligibles receiving I/DD Target HCBS will be excluded from managed long-term care (MLTC). Dual eligible individuals meeting MLTC and I/DD eligibility criteria may choose to remain in MLTC and not receive I/DD Targeted HCBS.

Currently in STC — Table 4 Individuals Who May be Exempt from MLTC	Proposed to Remain in STCs After I/DD Individual's Amendment
<i>Residents of psychiatric facilities (stays exceeding 30 days)</i>	X
<i>Individuals expected to be Medicaid eligible for less than six months</i>	X
<i>Individuals eligible for Medicaid benefits only with respect to tuberculosis-related services</i>	X
<i>Individuals with a “county of fiscal responsibility” code 99 in the Medicaid Management Information System (individuals eligible only for breast and cervical cancer services)</i>	X
<i>Individuals receiving hospice services (at time of enrollment)</i>	X
<i>Individuals with a “county of fiscal responsibility” code of 97 (individuals residing in a State OMH facility)</i>	X
<i>Individuals with a “county of fiscal responsibility” code of 98 (individuals in an OPWDD facility or treatment center)</i>	X
<i>Individuals who are under 65 years of age (screened and require treatment) in the Centers for Disease Control and Prevention breast, cervical, colorectal and/or prostate early detection program; need treatment for breast, cervical, colorectal or prostate cancer; and who are not otherwise covered under creditable health coverage</i>	X
<i>Residents of ICF for the mentally retarded (ICF-MR)</i>	X
<i>Individuals who could otherwise reside in an ICF-MR, but choose not to</i>	X
<i>Residents of alcohol/substance abuse long term residential treatment programs</i>	X
<i>Individuals eligible for Emergency Medicaid</i>	X
<i>OPWDD HCBS Section 1915(c) waiver program</i>	<i>Dual eligible individuals receiving I/DD Targeted HCBS under I/DD FIDA plans or Specialized I/DD plans will be excluded</i>
<i>Individuals in the following Section 1915(c) waiver programs: TBI, NHTD</i>	X
<i>Residents of Assisted Living programs</i>	X
<i>Individuals in receipt of limited licensed home care services</i>	X
<i>Individuals in the Foster Family Care Demonstration</i>	X
<i>Aliessa Court Ordered Individuals*</i>	X

*Aliessa Aliens are not excluded from managed care, but are excluded from Federal Financial Participation.

Currently in STC — Table 5 Individuals Who May be Exempt from MLTC	Proposed to Remain in STCs After I/DD Individual's Amendment
<i>Individuals aged 18 through 20 who are Nursing Home certifiable and require more than 120 days of community-based LTC services</i>	X
<i>Native Americans</i>	X
<i>Individuals who are eligible for the Medicaid buy-in for the working disabled and are Nursing Home certifiable</i>	X

- b. Indicate whether managed care will be statewide, or will operate in specific areas of the state (if additional space is needed, please supplement your answer with a Word attachment).**

Managed care already operates statewide. The new populations and services will be implemented based on the approved phase-in schedule. Mandatory enrollment in managed care for the I/DD population will be based on there being sufficient plans in a region that demonstrated experience in person-centered planning for the population and a sufficient provider network to assure access to I/DD specialized services including I/DD Targeted HCBS and I/DD residential services, and will occur no earlier than 2021.

- c. Indicate whether there will be a phased-in rollout of managed care (if managed care is not currently in operation or in specific geographic areas of the state. If additional space is needed, please supplement your answer with a Word attachment).**

Statewide: according to the approved phase-in schedule.

- d. Describe how the state will assure choice of MCOs, access to care and provider network adequacy.**

The process for MMMC plan selection will remain as it is under the approved Demonstration. Individuals currently enrolled in a mainstream MMMC plan will be given the option to remain in that plan. I/DD FIDA plan selection will also not change under this Demonstration. Individuals currently enrolled in a I/DD FIDA plan will be given the option to remain in that plan.

Building on the process completed for the adult behavioral health/HARP transition, and the children's behavioral health and health transition process now underway, the certification process for the newly developed Specialized I/DD plans will include the release of a plan qualification document to interested experienced DD providers. Once experience with voluntary managed care is gained using SIPs-PL, existing MMMC plans will be offered an option to provide either a SIP-M or a contract amendment for the I/DD population during the mandatory enrollment period to the extent necessary to ensure statewide coverage. The Specialized I/DD plan and MMMC I/DD contract amendment qualification document will be utilized to determine the competence and experience of plans to manage specialty I/DD benefits and the inclusion of experienced I/DD providers. All plans, including qualifying SIPs-PL, SIPs-M, and MMMC plans, prior to each plan's

implementation date, will ensure adequate capabilities to manage the I/DD services and supports. The qualification will include verifying the program and financial management structures to support the transition to, and ongoing operation of, the newly integrated I/DD/physical health/behavioral health system and ensuring member continuity of care requirements from FFS to managed care. As part of the qualification process, the State will conduct readiness reviews to verify access to care and provider network (including I/DD service experience) for the I/DD benefits and populations prior to the transition dates.

- e. Describe how the managed care providers will be selected/procured (if additional space is needed, please supplement your answer with a Word attachment).**

A planqualification document for SIPs-PL, which will later include SIPs-M as a separate MMMC line of business, as well as contract amendments to the MMMC plans, will be issued by the State. This qualification document will be circulated for public comment and stakeholder input. The plan qualification document process will include both desk and in-person readiness reviews ensuring that the specific requirements of the plan contract are met prior to implementation and transition.

- 6. Indicate whether any services will not be included under the proposed delivery system and the rationale for the exclusion.**

All individuals continue to be eligible for all State Plan services. In addition, the I/DD Targeted HCBS and I/DD residential services will be provided on a non-risk basis in the Specialized I/DD plans, and available in MMMC after mandatory enrollment. I/DD Targeted HCBS and I/DD residential services will be provided on a non-risk basis for no greater than 24-months after the implementation of mandatory enrollment. Until the contract is amended to MMMC mandatory enrollment, I/DD residential services, I/DD Targeted HCBS and other I/DD services will be provided to MMMC enrollees through the FFS delivery system. Individuals enrolled in MMMC, including Specialized I/DD plans, will be eligible for the four Demonstration services (e.g., licensed behavioral health practitioner, crisis intervention, and outpatient and residential addiction services). Non-institutionalized individuals in FFS will be eligible for crisis intervention Demonstration services.

- 7. If the Demonstration will provide personal care and/or long term services and supports, please indicate whether self-direction opportunities are available under the Demonstration. If yes, please describe the opportunities that will be available, and also provide additional information with respect to the person-centered services in the Demonstration and any financial management services that will be provided under the Demonstration.**

Yes, self-direction opportunities already available under the former Comprehensive waiver will be transitioned to the Demonstration, including budget and employer authority for this population. Self-direction of personal care services is available through CFCO. A person eligible for I/DD Targeted HCBS may self-direct the following HCBS: community habilitation, supported employment and respite.

In addition, the following supports are available under the Demonstration that will assist the person to self-direct HCBS: fiscal intermediary services and support brokerage, as well as individual directed goods and services.

- 8. If fee-for-service payment will be made for any services, specify any deviation from State Plan provider payment rates. If the services are not otherwise covered under the State Plan, please specify the rate methodology (if additional space is needed, please supplement your answer with a Word attachment).**

FFS payment will be made for individuals who are eligible for, but not yet enrolled in, a managed care plan, as well as for I/DD Targeted HCBS for MMMC enrollees until the MMMC contracts are amended to reimburse for I/DD Targeted HCBS services.

The State Plan rates will be utilized for payment of I/DD Targeted HCBS and I/DD residential services paid by the plans during the non-risk period which will end no later than 2 years after the implementation of mandatory enrollment.

- 9. If payment is being made through managed care entities on a capitated basis, specify the methodology for setting capitation rates, and any deviations from the payment and contracting requirements under 42 CFR Part 438 (if additional space is needed, please supplement your answer with a Word attachment).**

All MMMC payments, including Specialized I/DD plan payments, will be set consistent with actuarial soundness requirements at 42 CFR 438.6(c), the new 42 CFR 438.4 and the already approved Demonstration. No variation is expected. Costs for State Plan services except I/DD residential services will be included in the capitated rates.

Reimbursement for I/DD Targeted HCBS and I/DD residential services (except for Developmental Centers, Small Residential units, and OPWDD Specialty Hospitals) will be non-risk in the Specialized I/DD plans and MMMC for no more than 24 months after mandatory enrollment occurs in the Demonstration, subject to the non-risk upper payment limit rules at 42 CFR 447.362. A contract amendment will be submitted when I/DD residential services become part of the capitation rates and the I/DD Specialized HCBS are included in a risk payment arrangement (e.g., risk corridor, full risk, or performance based incentives) no more than 24 months of mandatory enrollment. The plan must pay the FFS fee schedule for non-risk services as long as those services is non-risk (i.e., no more than 24 months). For essential State Plan services/providers, the plans must pay at least the FFS fee schedule for 24 months, including OPWDD clinics (Article 16 clinics) and Independent Practitioners for I/DD.

Care Managers who historically provided care management services (targeted case management [TCM] or Medicaid service coordination [MSC]) to OPWDD Comprehensive 1915(c) waiver enrollees, and other non-waiver enrolled individuals, will cease provision of TCM/MSC with the transition to Health Home services and will transition to Health Home Care Management services for the eligible population.

10. If quality-based supplemental payments are being made to any providers or class of providers, please describe the methodologies; including the quality markers that will be measured and the data that will be collected.

New York will utilize the same value-based purchasing strategies for the I/DD population under the already approved guidelines for the larger Demonstration.

Section V — Implementation of Demonstration

1. Describe the implementation schedule. If implementation is a phase-in approach, please specify the phases, including starting and completion dates by major component/milestone.

The Demonstration amendment will be implemented beginning January 1, 2018. The proposed implementation scheduled is as follows:

Phase	Date (no earlier than)	Task	Explanation
Phase 1	1/1/2018	I/DD Targeted HCBS, I/DD residential services and I/DD populations are moved under the Demonstration.	<p>Phase 1 of the Demonstration will begin January 1, 2018, with the transition of the populations and services formerly under the OPWDD Comprehensive waiver and the inclusion of individuals with I/DD into the 1115 MRT Waiver.</p> <p>Individuals with I/DD receiving I/DD residential services or I/DD Targeted HCBS who are otherwise exempted or excluded from managed care based on other criteria will continue to receive I/DD residential services or I/DD Targeted HCBS under the Demonstration through FFS Medicaid until transitioned into managed care.</p>
Phase 2	July 2018	I/DD populations will transition to Health Homes.	<p>Phase 2 of the Demonstration will begin no earlier than July 2018 with the establishment of Health Homes serving people with I/DD. Health Homes will begin to offer enhanced and integrated care coordination through the Health Home service model.</p> <p>Early Adopter SIPs-PL may begin voluntary enrollment in late 2018.</p>
Phase 3	2019	Downstate — Voluntary Enrollment	Phase 3 of the Demonstration allows voluntary enrollment into SIPs-PL to assess the outcomes of managed care for this population prior to implementing mandatory enrollment.

Phase	Date (no earlier than)	Task	Explanation
	2020	Rest of State — Voluntary Enrollment	Begin solicitation for MMMC plans to offer Specialized I/DD plan line of business (SIP-M) and readiness for all MMMCs not offering SIPs-M to serve existing I/DD enrollees with additional contract requirements.
Phase 4	2021	Downstate — Mandatory Enrollment	<p>The Phase 4 transition to mandatory managed care will proceed in a region when the State confirms that there are sufficient choice of plans in a community that are capable of supporting the needs of individuals with I/DD and promoting a value-based payment methodology that furthers the transformation outcomes of the Commissioner's Transformation Panel.</p> <p>MMMC plans may offer a SIP-M or, if not, must sign a contract amendment to serve I/DD populations including offering I/DD Targeted HCBS.</p>
	2022	Rest of State — Mandatory Enrollment	
	2023	Downstate — I/DD residential services are in at-risk in capitated rates; I/DD Targeted HCBS moved to risk basis	All I/DD residential services become part of capitation rate for downstate Specialized I/DD plans and MMMC. I/DD Targeted HCBS moved to some form of risk basis (e.g., risk corridor; full risk, or performance based incentives) within Specialized I/DD plans and MMMC.
	2024	Rest of State — IDD residential services are in at-risk capitated rates; I/DD Targeted HCBS moved to risk basis	

2. Describe how potential Demonstration participants will be notified/enrolled into the Demonstration.

The current managed care enrollment process will be utilized for all individuals not otherwise exempt or excluded from managed care, and who are eligible for Medicaid under community rules.

The State's contracted enrollment broker will be utilized for noticing and the enrollment/disenrollment process. The OPWDD Regional Office will establish the person's eligibility for I/DD Targeted HCBS under the 1115 waiver, and will maintain its role as a "front door" for access and authorization for I/DD Targeted HCBS under the 1115 waiver for people who are not enrolled in managed care. Modifications to the enrollment process may be made for individuals with I/DD to ensure continuity of care.

Current I/DD individuals enrolled in managed care programs will be notified of the availability of newly certified Specialized I/DD plans. These individuals will be given the choice to remain in their current MMMC plan or transfer to a new Specialized I/DD plan. For individuals remaining in MMMC, I/DD Targeted HCBS will be reimbursed through FFS until the I/DD contracts are effective with the MMMC plans. The remaining individuals with I/DD and all dual eligibles receiving I/DD Targeted HCBS will be notified of the availability of the new I/DD Specialized plans with the choice of enrolling according to the phase-in schedule. Dual eligibles, who are not enrolled in FIDA plans, will only be allowed to choose between Specialized I/DD plans.

Modifications to the enrollment process will also be made for I/DD children eligible for Medicaid using a waiver of parental income and resources (e.g., Family of One populations) to ensure that the individuals are given a choice of plans during the HCBS eligibility evaluation process and Life Plan process. The State Independent Entity will be responsible for various activities relating to individuals not already enrolled in Medicaid. Specifically, the following process will be followed for these individuals:

- Conducting the HCBS eligibility evaluation screen*
- Developing the provisional Life Plan*
- Determination of HCBS preliminary eligibility*
- Educating the individual/family and facilitating Medicaid financial application*
- Referring to an enrollment broker for plan selection, when not otherwise exempt or excluded*
- Referring to a Health Home for a full assessment and final Life Plan*

3. If applicable, describe how the state will contract with managed care organizations to provide Demonstration benefits, including whether the state needs to conduct a procurement action.

The existing managed care plans will be utilized for those individuals with I/DD already enrolled in MMMC and choosing to remain in their mainstream MMMC plan. The existing FIDA plans will be utilized for those individuals with I/DD already enrolled in FIDA.

In addition, a plan qualification document will be utilized by the State to qualify specialized plans with DD experience and DD experienced providers (SIPs-PL and, later, SIPs-M), as well as to ensure that MMMC plans comply with requirements for the I/DD population. This qualification document will be circulated for public comment and stakeholder input. The plan qualification document process will include both desk and in-person readiness reviews ensuring that the specific requirements of the plan contract are met prior to implementation and transition of each phase.

Section VI — Demonstration Financing and Budget Neutrality

This section should include a narrative of how the Demonstration will be financed, as well as the expenditure data that accompanies this application. The State must include five years of historical data, as well as projections on member month enrollment. In accordance with 42 CFR 431.412(a)(iii) and (iv), historical and projected expenditures as well as projected enrollment for the proposed Demonstration project must be included in a state's application in order to be determined complete. The additional information requested will be needed before the application can be acted upon.

Please complete the Demonstration financing and budget neutrality forms, respectively and include with the narrative discussion.

The Financing Form: <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Interim1115-Demo-Financing-Form.pdf> includes a set of standard financing questions typically raised in new section 1115 Demonstrations; not all will be applicable to every Demonstration application.

The Budget Neutrality form and spreadsheet: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Interim1115-Budget-Neutrality-Form.pdf> includes a set of questions with respect to historical expenditure data as well as projected Demonstration expenditures.

Budget Neutrality Overview

This section will present the State's approach for showing budget neutrality for the amendment to New York's 1115 MRT waiver (Demonstration) and the data and assumptions used in the development of the cost and caseload estimates supporting this 1115 waiver amendment request.

Budget Neutrality Overview

This section presents the State's approach for showing budget neutrality for the OPWDD amendment to New York's 1115 MRT waiver (Demonstration) and the data and assumptions used in the development of the cost and caseload estimates supporting this 1115 waiver amendment request.

Budget neutrality estimates for this amendment request include expenditures for all tenets of the proposed Demonstration amendment, as outlined in Section 1. The proposed amendment creates a model of care that integrates the delivery of care and, ultimately, will enable qualified specialized Medicaid managed care plans (MMMC plans) throughout the State to meet the needs of individuals with I/DD. The first step begins with the enrollment of individuals served by OPWDD into Health Homes for persons with I/DD on July 1, 2018. Next, the transition of the I/DD population to managed care will begin on a voluntary enrollment basis phased in throughout the State in Specialized I/DD Plans – Provider Led (SIPs-PL) and eventually shift to a mandatory enrollment basis. Subsequent sections of this narrative provide additional information on the impact to budget neutrality for the relevant amendment provisions.

As outlined in Section 1, the implementation dates of various aspects of this demonstration vary and range between January 1, 2018, and January 1, 2024. The details of this narrative also recognize the appropriate demonstration years impacted by the various changes. The proposed effective date of this amendment is January 1, 2018, subject to the Centers for Medicare and Medicaid Services approval, through the end of the Demonstration, consistent with the remaining demonstration years of the current amendment.

Budget Neutrality Approach

This amendment request intends to add additional cost estimates related to the amendment services and Medicaid eligibles to the applicable per member per month (PMPM) amounts in the budget neutrality agreement of the current Demonstration. In addition, this amendment includes:

- the creation of four additional Medicaid eligibility groups (MEGs) for Dual Eligibles and Family of One children eligible for HCBS (MEG 14, MEG 15, MEG 16 and MEG 17)
- the creation of Demonstration Services 17 for HCBS services for individuals eligible for Medicaid under community eligibility rules

This amendment request does not propose to modify the manner in which the State is currently at risk for the per capita costs for demonstration eligibles under the budget neutrality agreement of the current demonstration.

Because the amendment incorporates current Medicaid populations who were not previously included in the Demonstration, caseload estimates for the Medicaid eligibles in MEGs within the current Demonstration have also been updated. As such, this amendment request adds additional monies related to the amendment programs and services to the approved PMPMs of the current budget neutrality agreement and additional member months to the caseload estimates, while still reflecting the same growth rates applicable to the current demonstration. The results of this process and the adjusted PMPMs and caseload estimates proposed by this amendment request are located in the summary of budget neutrality section below.

The impact of this amendment request is expected to be cost neutral in terms of budget neutrality. That is, cost estimates for all aspects of this amendment are assumed to be the same for both without waiver costs and with waiver costs. Specifically, Demonstration Services 9 and 17, as well as MEGs 14, 15, 16 and 17 are populations and/or services that could be covered under the Medicaid State plan authority.¹³

The State is assuming the budget neutrality agreement is in terms of total computable so that the State is not hindered by future changes to the federal medical assistance percentage rate on services.

Methodology for Determining Budget Neutrality Estimates

This section provides background information about the methods and data sources used to develop the proposed 1115 waiver amendment estimates.

Time Periods

Cost estimates for the waiver amendment request were developed for the last quarter of Demonstration Year (DY) 19 through DY 23, as the first changes of the amendment are effective on January 1, 2018 and DY 19 covers the time period from April 1, 2017 through March 31, 2018. This was done to cleanly incorporate the three-month impact of the waiver amendment into the DY 19 PMPMs and caseload estimates of the current demonstration budget neutrality agreement. Due to the staggered implementation dates of certain services and managed care transitions throughout the Demonstration, the other DYs also include the addition of various services and managed care enrollment for different lengths of time within the year. However, all adjustments have been made to incorporate the impact across the full year.

¹³ LOC HCBS other than CFCO services will be “pass-through” services (Demonstration services 17). CFCO HCBS for State Plan eligibles are covered under the State Plan and will be in the Medicaid Eligibility Group (MEG) for State Plan services. Family of One LOC children formerly covered under the 1915(c) Comprehensive waiver under a waiver of Section 1902(a)(10)(C)(i)(III) of the Act will be a “pass through” population (Demonstration population 14). The new MEGs for Dual Eligibles (Demonstration populations 15, 16 and 17) are for regular State Plan eligibles receiving all Medicaid State Plan services.

Waiver Eligibility Groups and Caseload Estimates TANF Child, TANF Adult, SSI 0-64 and SSI 65+ MEGs

The following changes in the amendment impact the existing TANF Child, TANF Adult, SSI 0-64 and SSI 65+ MEGs in the current Demonstration (these MEGs currently only include adults and children enrolled in MMMC or HIV SNPs). Some of these MMMC enrollees are individuals with ID/DD who were historically exempted from managed care enrollment and therefore, would have had to voluntarily enroll in MMMC plans:

- As outlined in Section 1 of this amendment, individuals with I/DD as of December 31, 2017, will transition into the 1115 demonstration on January 1, 2018. Thus, the DY 19 caseload estimates have been updated accordingly, with all subsequent demonstration years reflecting four quarters of this population. These individuals will remain in the delivery system that each person was enrolled in on December 31, 2017 (e.g., either FFS, FIDA or MMMC) until transitioning to Health Homes on July 1, 2018 if eligible, voluntarily enrolling with SIPs-PL, or being mandatorily enrolled in managed care with the regional phase-in as outlined in the narrative sections of the 1115. The costs and member months of included I/DD populations will be reflected in budget neutrality; the caseload estimates for these recipients are included in budget neutrality for all years of the Demonstration.
- Certain I/DD individuals may continue to be excluded from enrollment in SIPs-PL or MMMC, as any individuals with Third Party Health Insurance (TPHI) that is not Medicare also continue to be excluded from managed care enrollment. However, all populations meeting I/DD criteria as of December 31, 2017, will transition to the 1115 demonstration.

Eligibility Group 14

Upon inclusion of the 1915(c) waiver population into the 1115 demonstration on January 1, 2018, there are current Medicaid eligible children who gain eligibility because they are enrolled in the OPWDD Comprehensive 1915(c) waiver. These children are not reflected in the current Demonstration, but will come into the Demonstration and will enroll in SIPS and MMMC, unless otherwise excluded. These children's populations who are Family of One will be reflected in MEG 14. The caseload estimates for this population are based on estimates of this population in the Children's Demonstration who are currently eligible within the 1915(c) waivers, who meet LOC criteria and are eligible under Family of One. The caseload estimates for this population are reflected in the appropriate portion of DY 19, as well as all subsequent Demonstration years.

Eligibility Groups 15, 16, and 17

On January 1, 2018, I/DD Medicaid eligible individuals also having Medicare eligibility will be enrolled under the Demonstration. These populations are Medicaid eligible populations and these Medicaid eligibility groups will contain the State Plan service costs for these populations. Caseload estimates for this population have been included starting in DY19 and continuing in all subsequent Demonstration years. Each eligibility group is separated by age: Eligibility Group 15 contains the costs and eligibility for Dual Eligibles ages 0-20; Eligibility Group 16 for Dual Eligibles ages 21-64; and Eligibility group 17 for Dual Eligibles over age 65.

Demonstration Services 9

As part of the MRT Extension effective 12/7/2016- 3/31/2021, residential and outpatient addiction services, crisis intervention and licensed behavioral health practitioner services to MMMC enrollees will also be extended to MMMC enrollees including SIP-PL enrollees under this amendment. Crisis intervention services will also be extended to all non-institutionalized I/DD members in FFS. The expenditures will be reported and claimed under Demonstration Services 9 consistent with the approved 1115 STCs.

Demonstration Services 17

The caseload estimates for Demonstration Services 17 reflect the following:

- Community Eligible Medicaid populations meeting HCBS institutional LOC criteria and enrolled in the OPWDD Comprehensive 1915(c) waiver as of December 31, 2017, who are:
 - Voluntarily enrolled in MMMC
 - Expected to be enrolled in SIPs-PL or MMMC as of July 1, 2018 or
 - Expected to remain in the FFS delivery system due to other managed care population exclusions.

Note: only the member month estimates from the Family of One LOC population in Eligibility Group 14 are excluded because Eligibility Group 14 will include all State Plan and HCBS costs

Cost Estimates

This section presents the sources and methodologies used for the estimates associated with each of the services and new Demonstration eligibles of this waiver amendment request.

State Plan Services New to Managed Care

Prior to the Children's 1115 MRT amendment, the Demonstration PMPMs reflected only the services included in the MMMC capitation rates. As part of this Demonstration amendment, other existing BH and OPWDD services currently provided through the FFS delivery system will be incorporated into the Demonstration. The intent is for the I/DD services to eventually be provided via managed care contracts, but as of January 1, 2018, even if the service or enrollee remains in the FFS delivery system, the FFS costs will be added to the Demonstration BN. Based on current spend in FFS for the MMMC populations, the PMPMs for the TANF Child, TANF Adult SSI 0-64 and SSI 65+ MEGs have been adjusted accordingly.

For MEG 14 in DY 19 and beyond, the PMPM was developed using the expenditure in FFS prior to the inclusion of the population in the Demonstration. The adjustment for BH services provided through the FFS delivery system was also based on the PMPM cost for populations within the current Demonstration.

New State Plan/Demonstration Services

As described in Section III of this amendment, as well as in the Children's 1115 MRT Waiver amendment, there are new EPSDT BH services that will be available to all children through inclusion in this Demonstration amendment or submission and approval of State Plan Amendments. Based on expected utilization and cost of these new services, adjustments were developed for all children's MEGs, including MEG 14, to reflect the expected cost of these services.

Home- and Community-Based Services

For the Community Eligible MEGs (TANF Child, TANF Adult, SSI 0-64, SSI 65+ MEGs, Dual Eligibles ages 0-20; Dual Eligibles ages 21-64; and Dual Eligibles over age 65), the HCBS services for eligible populations are mainly reflected in Demonstration Services 17. Some of the services within the current 1915(c) Comprehensive Waiver will be covered by the State's Community First Choice Option (CFCO) program. Based on a review of current HCBS utilization, an estimate for utilization under CFCO has been made to recognize costs that will be subject to a different FMAP. The CFCO expected cost has been included within the community eligible MEG PMPMs. For the remaining HCBS services, current utilization within the 1915(c) waiver has been used to estimate the PMPM for Demonstration Services 17.

For MEG 14, the expected PMPM cost for HCBS services, as well as CFCO services (which are provided under the authority of the Demonstration because Family of One children are not eligible for CFCO under the State Plan), was based on utilization of current 1915(c) waiver enrollees. The expected cost of these services is included in the overall PMPM for this MEG (i.e., HCBS services are not separated for this MEG like they are for Community Eligible MEGs in Demonstration Services 17).

Comprehensive Care Coordination/Health Home

As described in this amendment, care coordination provided under the existing 1915(c) waivers will transition to Health Homes on July 1, 2018 after the waiver transitions into the 1115 demonstration on January 1, 2018. The cost estimates for Health Homes are based on the current expenditures for existing HCBS populations and fiscal projections for Health Home expenditures.

Section VII — List of Proposed Waivers and Expenditure Authorities

This section should include a preliminary list of waivers and expenditures authorities related to Title XIX and XXI authority that the State believes it will need to operate its Demonstration. Specifically, this section should:

- 1) Provide a list of proposed waivers and expenditure authorities.
- 2) Describe why the state is requesting the waiver or expenditure authority, and how it will be used.

Waiver Authority Being Requested

1. *Statewideness Section 1902(a)(1). To permit New York to geographically phase in the enrollment of the I/DD population and services into managed care plans.*
2. *Income Comparability Section 1902(a)(17). To allow the State to use institutional income and resource rules for the medically needy children under age 21 receiving HCBS in the same manner as it did for the terminated 1915(c) waiver children's populations that were subsumed under the 1115 MRT waiver. Section 1902(a)(10)(C)(i)(III) of the Act.*
3. *Service Comparability (Amount, Duration and Scope) Section 1902(a)(10)(B). To enable New York to provide I/DD Targeted HCBS services, whether furnished as a State Plan benefit or as a Demonstration benefit, to targeted populations that may not be consistent with the targeting authorized under the approved State Plan, in amount, duration and scope that exceeds those available to eligible individuals not in those targeted populations.*

4. *Freedom of Choice Section 1902(a)(23)(A). To the extent necessary to enable New York to require beneficiaries to enroll in managed care plans, in order to obtain benefits offered by those plans; and ensure the availability and the provision of alternative HCBS case management services for those persons who opt-out of receiving Health Home services. Beneficiaries shall retain freedom of choice of family planning providers.*
5. *Direct Payment to Providers Section 1902(a)(32). To the extent necessary to permit participants to self-direct expenditures for HCBS and supports.*

Expenditure Authority

1. *Demonstration Population 14. Medically needy children under age 21 with a waiver of 1902(a)(10)(C)(i)(III) who are receiving HCBS, and who are medically needy as individuals rather than as children with parents whose income and resources would normally be considered available to the child when determining eligibility. Only the income and resources of the child count for eligibility.*
2. *I/DD Targeted HCBS. Expenditures for the provision of HCBS that are not otherwise available under the approved State Plan for individuals enrolled in MMMC, including Specialized I/DD plans. [Demonstration Services 17]*
3. *Demonstration Services for Behavioral Health. Provided to individuals under MMMC, including Specialized I/DD plans. Expenditures for provision of residential and outpatient addiction services, crisis intervention and licensed behavioral health practitioner services to MMMC and Specialized I/DD plan enrollees only and are not provided under the State Plan. Crisis intervention will also be provided to non-institutionalized individuals with I/DD receiving services through FFS. This includes addiction services and the delivery system changes associated with the new Demonstration services and resulting SPAs, including changes under the CMS IAP. The State may require the plans — through their contracts, as approved by CMS — to adopt system-wide changes and rates, also approved by CMS, to ensure that the innovations are adopted in a consistent manner statewide. [Demonstration Services 9]*
4. *Self-Direction. Expenditures to allow the state to make self-direction services available to I/DD enrollees of Specialized I/DD plans and MMMC. [Demonstration Services 17]*

Section VIII — Public Notice

DOH issued public notice on this Demonstration amendment and the companion Health Home amendment on June 14, 2017 in the State Register.

OPWDD will outline further strategies utilized in reaching out to all stakeholders, including individuals and families, providers, etc., including regular meetings with managed care plans, provider associations, parents and constituents regarding this important transition from FFS to managed care.

Section IX — Demonstration Administration

Please provide the contact information for the state's point of contact for the Demonstration application.

Name and Title: Lana Earle, NYSDOH, Deputy Director, Division of Program Development and Management
Email Address: lana.earle@health.ny.gov

Attachment 1

Benefit Descriptions

Benefit	Eligibility Criteria	Description of Amount, Duration and Scope of Services
Habilitation	I/DD individuals meeting HCBS eligibility criteria	<p>Residential <i>Individually tailored supports that assist with the acquisition, retention or improvement in skills related to living in the community. These supports include adaptive skill development, assistance with activities of daily living (hands-on), community inclusion and relationship building, training and support for independence in travel, transportation, adult educational supports, social skills, leisure skills, self-advocacy and informed choice skills, and appropriate behavior development that assists the participant to reside in the most integrated setting appropriate to his/her needs.</i></p> <p>Day <i>Assistance with acquisition, retention or improvement in self-help, socialization and adaptive skills including communication, travel and adult education that regularly takes place in a non-residential setting, separate from the person's private residence or other residential arrangement. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, community inclusion, relationship building, self-advocacy and informed choice. Day habilitation services may also be used to provide supportive retirement activities, including: altering schedules to allow for more rest time throughout the day, support to participate in hobbies, clubs and/or other senior related activities in their communities.</i></p> <p>Community <i>Services occurring largely in community (non-certified) settings to facilitate and promote independence and community integration. Community habilitation is defined as a face-to-face service, and therefore, in order for a service to be billed, the staff must be with the individual. Only those services not reimbursable under the CFCO State Medicaid plan will be reimbursable under the HCBS waiver.</i></p> <p>Prevocational (Site-Based and Community) <i>Services that provide learning and work experiences, including volunteering, where participants can develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated community settings. Services are expected to occur over a defined period of time based upon a person-centered planning process.</i></p> <p>Supported Employment <i>Ongoing supports to participants who, because of their disabilities, need continuous support to obtain and maintain a job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce for which an individual is compensated at or above the state minimum wage. The outcome of this service is paid employment at or above the state minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals; as such, career planning is also an allowable service activity.</i></p> <p>Pathway to Employment <i>A person-centered, comprehensive career planning and support service that provides assistance for participants to obtain, maintain or advance in competitive employment or self-employment. It is a focused, time</i></p>

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		<i>limited service that engages a participant in identifying a career direction, provides instruction and training in pre-employment skills, and develops a plan for achieving competitive, integrated employment at or above the state minimum wage. Within 12 months or sooner, the outcome of this service is documentation of the participant's stated career objective; a detailed career plan used to guide individual employment supports; and preparation for supported employment services that assist a participant in obtaining, maintaining or advancing in competitive employment or self-employment.</i>
<i>Respite</i>	<i>I/DD individuals meeting HCBS eligibility criteria</i>	<i>Services provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the participant. Respite care is not furnished or provided for the purpose of compensating relief or substitute staff in certified community residences.</i>
<i>Adaptive Devices — Assistive Tech (CFCO)</i>	<i>I/DD individuals meeting HCBS eligibility criteria</i>	<i>An item, piece of equipment or product system; whether acquired commercially, modified or customized; that is used to increase, maintain or improve functional capabilities of participants. These services directly assist a participant in the selection, acquisition or use of an assistive technology device. The devices and services must be documented in the participant's Life Plan as being essential to the person's habilitation, ability to function or safety, and essential to avoid or delay institutionalization. Only those services not reimbursable under a Medicaid State Plan option will be reimbursable under the 1115 waiver.</i>
<i>Environmental Modifications</i>	<i>I/DD individuals meeting HCBS eligibility criteria</i>	<i>Physical adaptations to the participant's home, required by the participant's Life Plan, that are necessary to ensure the health, welfare and safety of the participant, or that enable the participant to function with greater independence in the home, and without which the person would require institutionalization and/or more restrictive and expensive living arrangement. Only those services not reimbursable under a Medicaid State Plan option will be reimbursable under the 1115 waiver.</i>
<i>HCBS care management¹⁴</i>	<i>I/DD individuals meeting HCBS eligibility criteria</i>	<i>For individuals who opt out of Health Homes, the State Independent Entity will conduct the HCBS assessment, Life Plan development and ongoing monitoring of the Life Plan.</i>

¹⁴ CMS has requested that the Demonstration service of HCBS care management provided to individuals not eligible for the Health Home SPA be referred to in all lower case letters.

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Family Education and Training	I/DD individuals meeting HCBS eligibility criteria	<p>Training given to families of participants enrolled in the HCBS waiver intended to enhance the decision making capacity of the family unit, provide orientation regarding the nature and impact of an I/DD on the person and his or her family, including behavioral management practices, and teach the family about service alternatives. The purpose is to support the family unit in understanding and coping with the I/DD and create a supportive environment at home to decrease premature residential placement outside the home.</p>
Services to Support Self Direction	I/DD individuals meeting HCBS eligibility criteria	<p>Any individual eligible for HCBS waiver services may self-direct some or all of his/her services. The person self-directing receives an individualized portable budget that is directed by the individual pursuant to an approved Life plan.</p> <p>Fiscal Intermediary</p> <p>If an individual chooses to self-hire their own staff, the employer of record must be either the fiscal intermediary or, once the “common law employer” status is implemented, the individual or family may act in this capacity. In addition to using a fiscal intermediary to pay staff that the person “self-hires”, an individual must choose a fiscal intermediary agency if the following services are included in their budget in order to provide for appropriate billing and claiming: individual directed goods and services, live-in caregiver, support brokerage or community transition services.</p> <p>The fiscal intermediary supports the individual self-directing with billing and payment of approved goods and services, fiscal accounting and reporting, ensuring Medicaid and corporate compliance, and general administrative supports.</p> <p>Support Brokerage</p> <p>Assist waiver participants (or the participant’s family or representative as appropriate) to self-direct and manage some or all of their waiver services. Support brokerage does not duplicate or replace the State Plan targeted case management service of Medicaid service coordination (see Appendix C) and differs from Medicaid service coordination in terms of intensity, frequency and scope. The support broker assists the participant in the day-to-day management of services and provides support and training to participants and their families regarding the ongoing decisions and tasks associated with participant direction.</p> <p>Individual Directs Goods and Services</p> <p>Services, equipment or supplies not otherwise provided through this waiver or through the Medicaid State Plan that addresses an identified need in an individual’s Life Plan, which includes improving and maintaining the individual’s opportunities for full membership in the community. Individuals who choose to self-direct their services with budget authority may receive individual goods and services as a waiver service. Individuals may manage their individual goods and services budget, as described in their Life Plan, to fully purchase or put funds towards their personal fiscal resources to purchase items or services which meet the criteria as described in the 1915(c) OPWDD Comprehensive HCBS waiver.</p>

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<i>Community Transition Services</i>	<i>I/DD individuals meeting HCBS eligibility criteria</i>	<i>Non-recurring set-up expenses for individuals who are transitioning from an institutional or other provider-operated living arrangement to a living arrangement in a private residence in the community where the person is directly responsible for his or her own living expenses. Allowable expenses are those reasonable and necessary to enable a person to establish a basic household. Items purchased are the property of the individual receiving the service. The service must be identified in the Life Plan. The service is administered by a fiscal intermediary agency for billing purposes, even if this is the only self-directed service that the person accesses.</i>
<i>Live-in Caregiver</i>	<i>I/DD individuals meeting HCBS eligibility criteria</i>	<i>An unrelated care provider who resides in the same household as the participant and provides supports to address the participant's physical, social or emotional needs in order for the participant to live safely and successfully in his or her own home.</i>
<i>Intensive Behavioral Supports</i>	<i>I/DD individuals meeting HCBS eligibility criteria</i>	<p><i>Available under the following circumstances:</i></p> <ol style="list-style-type: none"> <i>1) For individuals who reside in a non-certified residential location, their own home or family home, or a family care home; and</i> <i>2) The individual or a party acting on behalf of the individual certifies through written documentation that the individual is at risk of imminent placement in a more restrictive living environment due to challenging behavioral episodes.</i> <p><i>Intensive behavioral services are short-term, outcome-oriented and of higher intensity than other behavioral interventions and are focused on developing effective behavioral management strategies to ensure health and safety and/or improve quality of life.</i></p>
<i>Vehicle Modification</i>	<i>I/DD individuals meeting HCBS eligibility criteria</i>	<i>Physical adaptations to the participant's vehicle, required by the participant's Life Plan, that are necessary to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence. These physical adaptations include: portable electric/hydraulic and manual lifts, ramps and ancillary equipment or modifications necessary to guarantee full access to, and safety in, a motor vehicle.</i>