



The New York State

Balancing Incentive Program Initiative

Application for the State of New York

Submitted by:

The New York State Department of Health

December 20, 2012

NEW YORK
state department of
HEALTH

Nirav R. Shah, M.D., M.P.H.
Commissioner

Sue Kelly
Executive Deputy Commissioner

December 20, 2012

Ms. Jennifer Burnett
Centers for Medicare & Medicaid Services
Disabled and Elderly Health Programs Group
7500 Security Boulevard
Mail Stop: S2-14-26
Baltimore, MD 21244-1850

Dear Ms. Burnett:

The State of New York is pleased to submit the enclosed application for the Balancing Incentive Program (BIP). As the single state Medicaid agency, the New York State Department of Health (the Department) will serve as the lead organization for BIP.

Participation in BIP will allow the State to build upon current efforts to rebalance the delivery of long term services and supports (LTSS) and to promote enhanced consumer choice. New York State will utilize the resources available through BIP to work toward streamlined eligibility processes, improved access and expanded LTSS for those in need. The State is confident our efforts under BIP will result in a more balanced and effective LTSS system that will ensure essential services are provided in the least restrictive setting.

New York State estimates and requests that it will receive \$645,504,803 million during the project funding period (1/1/13-9/30/15), based on the projections of the provision of LTSS under BIP as illustrated in Appendix B.

With the continued support and input of our vast network of stakeholders and state and local agencies, New York will implement the required structural changes under BIP, including creating a No Wrong Door/Single Entry Point system, a statewide core standardized assessment and a conflict-free case management system. New York remains committed to improving how LTSS are accessed and delivered throughout the state and we look forward to working with all those invested in achieving these goals.

The Department will serve as both the Oversight and Operating Agency for all Balancing Incentive Program services and structural changes. The Principal Investigator and contact person for the New York State BIP Initiative is Mark Kissinger, Director of the Division of Long Term Care. Please do not hesitate to contact Mr. Kissinger at 518-402-5673, or by e-mail at: mlk15@health.state.ny.us.

Sincerely,

Mr. Jason Helgerson, Medicaid Director
Office of Health Insurance Programs
New York State Department of Health

Table of Contents

Project Abstract.....	1
Work Plan.....	2
Application Narrative.....	8
Section A. Understanding of Balancing Incentive Program Objectives.....	8
Section B. Current System’s Strengths and Challenges.....	11
Section C. No Wrong Door/Single Entry Point.....	14
Section D. No Wrong Door/ Single Entry Point Person Flow.....	15
Section E. NWD/SEP Data Flow.....	15
Section F. Potential Automation of Initial Assessment.....	16
Section G. Potential Automation of Core Standardized Assessment.....	16
Section H. Incorporation of CSA in the Eligibility Determination Process.....	16
Section I. Staff Qualifications and Training.....	17
Section J. Location of SEP Agencies.....	17
Section K. Outreach and Advertising.....	17
Section L. Funding Plan.....	18
Section M. Challenges.....	19
Section N. NWD/SEP’s Effect on Rebalancing.....	19
Section O. Other Balancing Initiatives.....	19
Section P. Technical Assistance.....	20
Appendix A- Letters of Support.....	21
Appendix B- Applicant Funding Estimates.....	25
Appendix C- NYS Olmstead Plan Executive Order	27

New York State Balancing Incentive Program Initiative

Project Abstract

The New York State Department of Health plans to capitalize on its significant investment in home and community based long term services and supports (LTSS) across populations to further rebalance spending on LTSS through participation in the Balancing Incentive Program (BIP).

Participation in the BIP program will reinforce our ongoing efforts to improve access to home and community based long term care services for those with physical, behavioral health needs, and/or intellectual disabilities throughout New York State. Through improved access to information, individuals will be able to make informed choices regarding services, settings and related issues.

To achieve these goals, New York will work to implement the three structural changes required under BIP, which will provide additional tools to streamline the LTSS eligibility and assessment process in New York. To meet these requirements, specifically, the State will:

- **No Wrong Door/Single Entry Point (NWD/SEP):** Enhance the existing NY Connects Network, which is currently operational in 54 Counties and serves as an information and assistance system for long term care services.
- **Core Standardized Assessment Instrument:** Continue implementation of the Uniform Assessment System (UAS-NY) and align with other agencies to ensure compliance with the core data set.
- **Conflict-Free Case Management Services:** Remediate any case management arrangements that do not align with the principles of BIP.

New York's Uniform Assessment System (UAS-NY) for elderly and/or physically disabled individuals is being phased in beginning the first quarter of 2013 and is planned to be implemented by the end of 2014. The Office for People with Developmental Disabilities is also implementing a new assessment system that uses the same core data set and will be fully phased in by the end of the project funding period. New York will review other assessments to ensure compliance with the required domains and other elements of BIP. The BIP implementation plan is to investigate integrating an automated initial screen or self-assessment into the NY Connects system of NWD/SEP. This phase of BIP implementation is expected to be complete by the end of 2014. During the funding period New York State will carefully review its assessment and care planning processes to eliminate potential conflicts with BIP goals related to case management. As "Care Management for All" is implemented, New York will ensure that consumers have meaningful choice of providers, the opportunity to change care plans if dissatisfied and a fair, centralized appeals process to minimize any conflict of interest.

New York will use its increased federal funds to continue its successful rebalancing efforts to date including, but not limited to, the following:

1. Transitioning and diverting individuals who are elderly and/or disabled from institutional to community based settings;
2. Increase community based opportunities for those with behavioral and intellectual disabilities;
3. Develop additional housing options to support high need/high cost Medicaid recipients in stable, sustainable and safe community environments; and
4. Expand MFP opportunities to address those needs which are critical to remaining in the community.

NEW YORK STATE PRELIMINARY BIP WORK PLAN

GENERAL NWD/SEP STRUCTURE

Category	Major Objective / Interim Tasks	Due Date from Work Plan Submission	Lead Person	Status of Task	Deliverables
General No Wrong Door/Single Entry Point Structure	<u>Goal:</u> Standardize information so that all individuals experience the same eligibility determination and enrollment process.				
	1.1. Develop standardized informational materials that NWD/SEPs provide to individuals	9/30/13	BIP team	Not Started	Informational materials
	1.2. Design enhancements to website (initial overview)	6/30/13 (submit with Work Plan)		In Progress	Description of the system
	1.3. Design enhancements to website (final detailed design)	12/31/13		In Progress	Detailed technical specifications of web-based system, including navigation or "help" resources, if applicable
	1.4. Identify resources or procurement options to develop enhancements to website. Procure vendor (if necessary)	6/30/13		In Progress	Resources assigned or vendor contract signed
	1.5. Develop and Test new and enhanced tools in the website iteratively	12/31/14		Not Started	Development plan, Test plan. Beta test and results from both individuals and SEP staff.
	1.6. System goes live	1/1/15		Not Started	System is fully operational
	1.7. System Updates	Semiannual beginning 1/1/15		Not Started	Description of successes and challenges
	<u>Goal:</u> State has a network of NWD/SEPs and an Operating Agency; the Medicaid Agency is the Oversight Agency.				
	1.8. Identify the Operating Agency	6/30/13 (submit with Work Plan)		Complete	Name of Operating Agency
	1.9. Identify the NWD/SEPs	6/30/13 (submit with		In	List of NWD/SEP entities and locations

Category	Major Objective / Interim Tasks	Due Date from Work Plan Submission	Lead Person	Status of Task	Deliverables
		Work Plan)		Progress	
	1.10. Develop and implement a Memorandum of Understanding (MOU) across agencies	12/31/13		Not Started	Signed MOU
Goal: NWD/SEPs have access points where individuals can inquire about community LTSS and receive comprehensive information, eligibility determinations, community LTSS program options counseling, and enrollment assistance.					
	1.11. Identify service area for all NWD/SEPs	9/30/13		In Progress	Percentage of State population covered by NWD/SEPs
	1.12. Ensure NWD/SEPs are accessible to older adults and individuals with disabilities	3/30/14		In Progress	Description of NWD/SEP features that promote accessibility
Goal: The NWD/SEP system includes an informative community LTSS website; Website lists 1-800 number for NWD/SEP system.					
	1.13. Identify or develop URL	9/30/13		Complete	URL
	1.14. Develop and incorporate content	12/31/13		In Progress	Working URL with content completed
	1.15. Incorporate self-assessment into the website	12/31/14		In Progress	Working URL of Level I self-assessment and instructions for completion
Goal: Single 1-800 number where individuals can receive information about community LTSS options in the State, request additional information, and schedule appointments at local NWD/SEPs for assessments.					
	1.16. Contract for 1-800 number service	12/31/13		Not Started	Phone number operational
	1.17. Train staff on answering phones, providing information, and using the self-assessment	12/31/13		Not Started	Training materials
Goal: State advertises the NWD/SEP system to help establish it as the "go to system" for community LTSS.					
	1.18. Identify resources or procurement options to develop outreach campaign;	1/1/14			Resources assigned or vendor contract signed

Category	Major Objective / Interim Tasks	Due Date from Work Plan Submission	Lead Person	Status of Task	Deliverables
	1.19. Procure vendor if necessary				
	1.20. Enhance name recognition	6/30/13		Not Started	TBD
	1.21. Develop outreach plan	9/30/13		Not Started	Outreach Plan
	1.22. Implement outreach plan	4/1/14		Not Started	Develop and distribute materials associated with outreach plan
	1.23. Develop self sustaining public awareness campaign	4/1/14		Not Started	Public awareness Plan Survey for recognition
	1.24. Implement public awareness campaign	4/1/14		Not Started	Develop and distribute materials associated with public awareness campaign

CSA/CDS

Category	Major Objective / Interim Tasks	Due Date from Work Plan Submission	Lead Person	Status of Task	Deliverables
Core Standardized Assessment	<u>Goal:</u> A CSA, which supports the purposes of determining eligibility, identifying support needs, and informing service planning, is used across the State and across a given population. The assessment is completed in person, with the assistance of a qualified professional. The CSA must capture the CDS (a Core Data Set of required domains and topics).				
	1.1. Develop questions for the self-assessment	12/31/13		In Progress	self-assessment screening questions
	1.2. Fill out CDS crosswalk (see Appendix H in the Manual) to determine State's current assessments include required domains and topics	6/30/13		In Progress	Completed crosswalk(s)
	1.3. Incorporate additional domains and topics if necessary (stakeholder involvement included)	12/31/13		Not Started	Final assessment(s); notes from meetings involving stakeholder input
	1.4. Train staff members at NWD/SEPs to coordinate the CSA	6/30/14		In Progress	Training materials
	1.5. Identify qualified personnel to conduct the CSA	6/30/14		In Progress	List of entities contracted to conduct the various components of the CSA
	1.6. Regular updates	Semiannual after 6/30/14		Not Started	Description of success and challenges

CONFLICT-FREE CASE MANAGEMENT

Category	Major Objective / Interim Tasks	Due Date from Work Plan Submission	Lead Person	Status of Task	Deliverables
Conflict-Free Case Management	Goal: Establish conflict of interest standards for the Level I self-assessment, the Level II assessment and plan of care process. An individual's plan of care must be created independently from the availability of funding to provide services.				
	1.1. Describe current case management system, including conflict-free policies and areas of potential conflict	9/1/13		Not Started	Strengths and weaknesses of existing case management system
	1.2. Establish protocol for removing conflict of interest	3/31/14		Not Started	Protocol for conflict removal; if conflict cannot be removed entirely, explain why and describe mitigation strategies

DATA COLLECTION AND REPORTING

Category	Major Objective / Interim Tasks	Due Date from Work Plan Submission	Lead Person	Status of Task	Deliverables
Data Collection and Reporting	Goal: State must report service, outcome, and quality measure data to CMS in an accurate and timely manner.				
	1.1. Identify data collection protocol for <i>service data</i>	6/30/13 (submit with Work Plan)		Not Started	Measures, data collection instruments, and data collection protocol
	1.2. Identify data collection protocol for <i>quality data</i>	6/30/13 (submit with Work Plan)		Not Started	Measures, data collection instruments, and data collection protocol
	1.3. Identify data collection protocol for <i>outcome measures</i>	6/30/13 (submit with Work Plan)		Not Started	Measures, data collection instruments, and data collection protocol
	1.4. Report updates to data collection protocol and instances of <i>service data</i> collection	Semiannual beginning 12/31/13		Not Started	Document describing when data were collected during previous 6-month period, plus updates to protocol

Category	Major Objective / Interim Tasks	Due Date from Work Plan Submission	Lead Person	Status of Task	Deliverables
	1.5. Report updates to data collection protocol and instances of <i>quality data</i> collection	Semiannual beginning 12/31/13		Not Started	Document describing when data were collected during previous 6-month period, plus updates to protocol
	1.6. Report updates to data collection protocol and instances of <i>outcomes measures</i> collection	Semiannual beginning 12/31/13		Not Started	Document describing when data were collected during previous 6-month period plus updates to protocol

SUSTAINABILITY

Category	Major Objective / Interim Tasks	Due Date from Work Plan Submission	Lead Person	Status of Task	Deliverables
Sustainability	<u>Goal:</u> Identify funding sources that will allow NY to build and maintain the required structural changes.				
	1.1. Identify funding sources to implement the structural changes	6/30/13		In Progress	Description of funding sources
	1.2. Develop sustainability plan	6/30/14		In Progress	Funding sources and estimated annual budget necessary to maintain structural changes after award period ends
	1.3. Describe the planned usage for the enhanced funding	6/30/13		In Progress	Detailed description of how the State will use the enhanced funding earned through the program

New York State Balancing Incentive Program Application Narrative

Section A. Understanding of Balancing Incentive Program Objectives

New York State has a long history of serving individuals who have functional and/or medical needs in their homes and communities as an alternative to institutional care. For over 30 years, Medicaid recipients in New York State have had access to a state plan personal care program, as well as a consumer-directed personal care model, that is the most generous in the nation. Our State Medicaid Plan also includes adult day health care, home health care, private duty nursing, hospice, and assisted living. These benefits are offered to individuals who can safely be cared for in the community without waiting lists or other limitations on the provision of their long term care. New York also has strong models in which behavioral and developmental health services are offered in the community through the Office of Mental Health (OMH), the Office of Alcohol and Substance Abuse Services (OASAS) and the Office for People with Developmental Disabilities (OPWDD). These agencies operate systems that are among the most extensive in the nation in terms of coverage and scope of services.

New York has also made use of the federal 1915(c) Home and Community Based Medicaid waivers available through the Social Security Act. In the late 1970's, we established the Long Term Home Health Care Program (also called Nursing Home Without Walls) to serve individuals of all ages. Since that time New York developed additional waivers to address the needs of specific populations who choose to receive long term care in their home community as an alternative to institutional care. These waivers serve children with serious emotional disturbance (administered by the OMH), those with developmental disabilities (the OPWDD), adults with traumatic brain injuries (the Department of Health's (DOH) TBI Waiver), adults with physical disabilities and senior citizens (the DOH Nursing Home Transition and Diversion Waiver), children with serious medical and/or functional needs (Care at Home Waivers administered by the DOH and the OPWDD) and children with functional and/or medical needs who live in foster care (the Office of Children and Family Services' Bridges to Health Waiver). Through these waiver programs New York State serves over 100,000 Medicaid recipients. In addition, New York State participates in the federal Money Follows the Person (MFP) Demonstration, which has successfully transitioned nearly 1,000 persons to community settings to date. MFP participants are enrolled and receive State Plan and other long term services and supports (LTSS) through the DOH NHTD and TBI waivers.

New York State offers robust home care services through its State Medicaid Plan that are available to Medicaid-eligible individuals across the state based on their medical and functional needs to allow them to remain in their homes and communities or to transition out of institutional settings. As a result of these options in New York State, significant resources are devoted to the provision of long term care in community-based settings when compared to those resources expended on long term care in institutional settings. New York had a ratio of 46.7% in FFY2009 based on federal reporting data. In addition, many services are offered to our elderly and/or disabled residents through the aging network to defer the need for Medicaid funded long term services and supports, including the Expanded In-Home Services for the Elderly Program (EISEP), Community Services for the Elderly (CSE) and Supplemental Nutritional Assistance Services Program (SNAP). Most individuals want to receive needed medical services and assistance with their functional needs in their homes and communities. It is often more efficient and effective to provide such services in these settings. New York has a robust system of long term care, a broad network of highly qualified providers and engaged advocates that partner with policy makers to develop improved services. New York is committed to leveraging our significant investment in

LTSS to improve the ratio of expenditures on community based care to institutionally based care to 50% and beyond and is confident that changes underway in the state, along with participation in the Balancing Incentive Program (BIP), will help achieve that goal.

In 2011, Governor Andrew Cuomo established a Medicaid Redesign Team (MRT), charged with finding savings in the State's \$54 billion Medicaid program while improving both quality of care and health outcomes. The goals of the MRT align with the CMS Triple Aim of cost containment, better quality and improved health outcomes for Medicaid and/or Medicare recipients. The MRT team brought together statewide stakeholder workgroups from across the spectrum of aging and disability service systems that have been informing policy-making since the beginning of Governor Andrew Cuomo's administration. Critical system redesign issues were explored through the MRT workgroups focusing on long term care, behavioral health and housing issues.¹ Within the developmental disability service system, stakeholder groups have been integral to the system redesign associated with the People First Waiver, the most recent discussions focusing on advocacy and access issues related to community based care.² The work of all of these groups will inform the decision-making and leadership that will be provided by the Olmstead Plan Development and Implementation Cabinet.

Governor Cuomo created the cabinet in December 2012, bringing together top state-level leadership to make recommendations to the governor concerning the development, implementation, and coordination of an Olmstead Plan for the State of New York.³ The cabinet will establish clear timelines and milestones for New York to meet the Olmstead objectives of providing meaningful community living for people with disabilities and elders. The plan that is ultimately developed will reflect New York's vision of choice and opportunity for individuals and deploy the deliberate development of more accessible, coordinated and effective long-term supports in local communities. Thus, with the leadership and guidance of the cabinet, New York will make real the objectives of the Olmstead decision using the resources and structure provided by the Balancing Incentive Program.

One of the most significant reforms that has emerged to support community living relates to Care Management for All, including a transition of long term care consumers to managed care. New York State has had a successful managed long term care system since the mid 1990's. The MRT plan is using that program to build out a care management strategy for dual eligible consumers. Specifically, chronically ill and/or disabled individuals in various Medicaid programs and those dually eligible for both Medicaid and Medicare are being provided with the choice to join managed care and managed long term care plans. Already, New York State is requiring Managed Care Plans and Managed Long Term Care Plans to offer the range of long term care services included in the State Medicaid Plan to their members, including the Consumer Directed Personal Care Program (CDPAP). Dually-eligible adults over 21 who require home and community based services for more than 120 days are already transitioning to managed long term care in certain counties in the State, as are those in receipt of CDPAP services.

The move to comprehensive care coordination for people with intellectual and developmental disabilities is being developed under the proposed People First Waiver. The People First Waiver will establish a specialized managed long term support services model to promote comprehensive care

¹ Citation MRT workgroup recommendations:
http://www.health.ny.gov/health_care/medicaid/redesign/docs/mrtcompanion.pdf.

²http://www.opwdd.ny.gov/opwdd_services_supports/people_first_waiver/targeted_work_teams

³http://www.opwdd.ny.gov/opwdd_community_connections/misc/press_releases_and_important_documents

coordination across all of the person's needs in order to better integrate habilitative and behavioral health needs and promote service delivery in the most integrated setting. The hallmark of care coordination is the use of person-centered methodologies to create an individual's plan. The quality of care coordination will be assessed based on the support and promotion of key quality outcomes for the individual and this information will be aggregated to assess plan and system level performance.

New York believes that the transition to managed care and managed long term care is consistent with the goals of BIP and other federal incentive programs such as the Community First Choice Option (PL 111-148, §2401): allowing consumers more choice of providers, aligning services with the needs of the consumer determined by a person-centered care planning process, and ensuring that individuals are aware of their options so they can make informed choices from the range of options appropriate to their needs. The requirements of the BIP will help New York State achieve these goals by ensuring that no matter how a consumer approaches his or her search for needed functional and/or medical services that he or she receive consistent information about relevant options, that his or her financial and functional eligibility for such services is determined quickly and fairly, and that his or her enrollment into needed services for which he or she is qualified happens as seamlessly as possible.

Additional financial support through the closure of institutions and the expansion of the waiver programs in the State's proposed SFY 2013-14 Executive budget and the expansion of services under a planned Community First Choice option will balance expenditures for Long Term Care Services and Support (LTSS), and continue to shift New York's focus towards home and community-based services and supports.

Commitment to BIP Requirements

New York State will capitalize on its significant investment in LTSS across populations in implementing the BIP. While New York offers a broad range of long term care services to those in need of medical and/or functional assistance in their home or community, discharge planners, social workers and others often seek to enroll the individual in the program or waiver that relates to his or her diagnosis or disability rather than investigate all available options. This results in people being placed in waivers for one or two waiver services when a number of state plan services would meet their need or being limited to the waiver services available in the waiver into which they were placed when a range of state plan services and services available in different waivers may be more appropriate.

BIP requirements including a No Wrong Door/Single Entry Point system will help New York ensure that consumers are aware of their options across the spectrum of services offered to various populations in the state. It will further ensure that consumers, discharge planners and family members receive consistent information regardless of how or where they access long term care information. Finally, it will ensure that financial and functional eligibility determinations are made quickly and fairly so that enrollment in services in community-based settings is not more burdensome than enrollment in an institutional setting.

To achieve these goals, New York State plans to enhance its existing NY Connects Network, which is operational in 54 counties in the State and acts currently as an information and assistance system for LTSS. Each county has implemented this program according to their local perspective and resources, therefore, the program may vary in how it is operationalized across the state. Consumers can access information about LTSS via the website, www.nyconnects.ny.gov. Links on the website also allow consumers or their representatives to determine whether they may be eligible for a wide variety of public

assistance programs, including Medicaid. There is currently a short “screen” that information and assistance representatives at local offices can use to determine services for which an individual who calls or visits may be eligible. As part of its BIP participation, New York State intends to enhance this system to more clearly include all populations that may have long term care needs, as the current system focuses on the elderly and physically disabled populations; review the current screen for appropriateness as a Level I screen/self-assessment envisioned by BIP; investigate the possibility of automating the screen and integrating the financial eligibility screen; and ensure that all offices that are part of the NY Connects and other NWD/SEP locations throughout the state use NY Connects information and tools to ensure consistent information about long term care available in the individual's community.

Currently, NY Connects uses local offices of aging or other social services agencies in a network of local access points for information and assistance. Under its BIP plan, New York intends to add Independent Living Centers, OPWDD’s regional offices , OMH regional offices and other partners to this network of local "doors" to ensure that consistent information is provided across populations and that consumers truly have no wrong door access to New York's considerable array of long term services and supports. NY Connects already offers a local or toll-free number to individuals in their county to access LTC information and assistance. These resources will be enhanced to provide all populations in need of LTC services with both information and referral regardless of how they access this system. New York's ideal is for the consumer to be able to learn about their options through a website, telephone call or visit to a local office where they can consult a well-trained, informative representative. The consumer should be able to choose from among the services and programs for which he or she is eligible based on his or her specific needs and goals. Enrollment into these services and programs should be timely and seamless at the consumer level regardless of the agency that oversees them.

New York has also made significant strides in implementing a Uniform Assessment System (UAS-NY) for its elderly and/or physically disabled population using the InterRAI Assessment Suite. Its OPWDD is implementing a similar core assessment based on the same assessment suite. These assessments will use the same general domains with population specific additions to develop a statewide data set that can be used to plan and improve services, predict trends and report progress. As part of its BIP plan, New York State will assess whether the population specific assessment used by the Office of Mental Health meets the domain requirements of a Core Standardized Assessment.

The MRT strategy of “Care Management for All” may require additional standards to be developed within managed care to implement a Conflict-Free Case Management System under BIP. New York State is committed to ensuring that consumers have options, that these options are presented to consumers clearly, and that there is an appeals process in place to assure those dissatisfied with their placement have alternatives. Currently, New York’s managed long term care standards allow consumers to transfer to other plans without any lock-in period.

Section B. Current System’s Strengths and Challenges

New York State's greatest strength is that across all populations, consumers are offered a broad scope of services to address their medical and/or functional long term care needs. A significant challenge is that these services and programs are often fragmented, may not be consistently offered across the state and may not be known to consumers who are placed into different programs. New York plans to use its participation in BIP and other efforts including MFP and CFCO, to reduce these silos of care, improve the patient-centered approach of care planning, ensure that services are available across populations

regardless of how one accesses information about their options, and improve the availability and accessibility of consistent information about LTSS options in the various communities of New York State.

The current LTSS system in New York for the elderly and persons with disabilities is characterized by many strengths. By April 1, 2013, a new uniform assessment system (UAS-NY) will assess individuals who may be eligible for eight different programs and services: ALP, adult day health care, personal care and CDPAP, Care at Home Waivers I and II, Managed Care/Managed Long Term Care, Long Term Home Health Program, NHTD and TBI Waivers. These Medicaid services are available to any eligible individual who requires them to remain safely in their homes and communities across all populations and the waiver services are available without waiting lists in New York. In addition, OPWDD is developing a new assessment tool for their programs and services that is based on the same assessment suite and that will share the same core data set. This assessment will provide a consistent way of identifying an individual's strengths, interests and needs to support a person-centered care planning process. There are multiple assessment tools included within the interRAI Integrated Assessment Suite. From review of all the available items within the suite of tools, the OPWDD Coordinated Assessment System (CAS) was developed. The core items in the CAS build off the interRAI ID tool and blend items from the Community Mental Health tool and the Community Health Assessment. Supplemental tools were developed to focus on substance abuse needs, mental health needs, children's needs and complex health needs. The CAS will form the basis of New York State's needs assessment process, and will draw upon other tools as dictated by an individual's unique circumstances and needs. As part of its BIP participation, New York State will investigate the extent to which all assessments used in NYS cover the required domains.

New York State's comprehensive move to Care Management For All is another strength that transcends populations of individuals in need of LTSS. By ensuring that the primary, acute and long term care needs of individuals are coordinated and managed, New York State anticipates meeting the triple aim of cost containment and critical improvements in both quality of care and health outcomes.

New York State's Office for People with Developmental Disabilities (OPWDD) is undergoing a transformation in the provision of LTSS that goes hand in hand with BIP objectives. Specifically, the Balancing Incentive Program will assist New York State in its efforts to:

- Close campus-based institutions serving individuals with intellectual and developmental disabilities and provide person-centered planning for the individuals leaving institutions that will result in a person-centered plan of service that will meet their housing and other service needs in the most integrated setting appropriate to those needs.
- Reinvest approximately \$166 million and expand community living for people with developmental disabilities through the development of community-based services for individuals now living in developmental centers by 2017.
- Develop Community Based Capacity for an effective crisis prevention and response system utilizing the nationally recognized Systemic, Therapeutic, Assessment, Respite and Treatment (START) model. START is a program created by the Institute on Disability/University of New Hampshire.

- Develop and implement a uniform specialized assessment system, based on the InterRAI intellectual disability tool to better inform care planning and access to services across the state for persons with intellectual and developmental disabilities. Although specialized for persons with intellectual and developmental disabilities, this tool shares common data elements with the UAS and therefore is an important building block toward truly integrated care planning and information sharing across aging and disability services.
- Develop and implement a statewide training and supports program for persons with intellectual and developmental disabilities who are interested in self-direction. With this additional support, New York will offer the option to self-direct to no less than 10,000 persons entering the specialized care management plans and transitioning from closed institutions, guided by the person-centered assessment.
- Adopt practice guidelines for care coordinators serving individuals with intellectual and developmental disabilities based on the Council on Quality and Leadership (CQL) personal outcome measures and annually assess managed care quality using personal outcome data.
- Reorganize OPWDD's regional office structure to better meet the needs of the system today and in anticipation of the future where access to services and support of the transition to managed care requires a dedicated focus at the local level.

A significant strength is New York's history of grassroots development in which engaged parents, individuals with developmental disabilities alongside service providers and state leaders work to create the extensive menu of supports and services for individuals with a wide range of needs and their families. The strong sense of partnership among stakeholders is a resource New York State has tapped throughout its history and most recently as it has carefully sought insight and support for broad scale system improvements aimed at increasing the person-centeredness and accordingly, the system's effectiveness and efficiency, and the accessibility of long-term, community-based services to people with developmental disabilities within the People First Waiver.

New York's participation in the Money Follows the Person Demonstration has resulted in several projects underway to increase the number of persons who can be moved back to the community from institutional settings. These projects include increasing the availability of accessible, affordable housing to address what is often the biggest barrier to non-institutional placement; improved nutrition initiatives, transitioning individuals from acute care facilities to community-based settings rather than straight to an institutional setting, and transitioning those with behavioral health issues back to the community. These projects would benefit from New York's participation in BIP by ensuring that more people are aware of the programs and services available in the community to address an individual's needs. In addition, BIP funds combined with MFP efforts underway may support new diversion efforts as well as the current transition programs.

Despite these many successes, New York State has not done enough to ensure that consumers consistently throughout the state know their options; nor do all discharge planners, social workers, nurses and other primary sources of referrals to nursing homes and other institutional settings realize the full scope of programs and services available to ensure the provision of appropriate care in the community. To improve the ability of consumers to navigate New York State's complex system of long term services and supports, it is necessary to ensure widespread awareness of the full scope of services available to any

functionally and financially eligible individual who is aged and/or physically, developmentally or behaviorally disabled. This would mitigate some regional biases in the types of services offered to individuals and assure that consumers are fully aware of their options across all state plan and waiver services for which they are eligible. Finally, as we move toward a “Care Management for All” model, it is important to assure that individuals with functional and/or medical needs across the state have access to the full spectrum of services to meet them.

New York State, through its participation in the BIP, will leverage its many successes to address these challenges by enhancing its existing NY Connects system of LTSS information and assistance to a truly statewide system of information and referral. Under the NY Connects umbrella, the state will ensure that all programs and services offering assistance to those with LTSS needs across all populations will be highlighted in one place so that consumers are fully aware of their options. The NY Connects website will include a single 1-800 number in addition to the regional numbers currently included to ensure one-stop access. An integrated Level I Screen/Self-Assessment will inform individuals seeking answers about what LTSS they or a family member may be eligible for and provide them immediate access to more information about those services, including where to go for a more comprehensive Level II/UAS-NY or comparable functional needs assessment. The self-assessment will include a financial eligibility screen that will provide consumers with information about what assistance may be available to them in paying for needed LTSS. In this manner, consumers of LTSS in New York State will be empowered to direct their LTSS fully armed with the knowledge of the full scope of available services and supports for which they are eligible.

Section C. No Wrong Door/Single Entry Point Partners and Roles

New York has a rich tapestry of local offices, agencies and providers such as Independent Living Centers where individuals can go to learn about long term care options in their community. A network comprised of these many resources will ensure that no matter where people go to learn about their options, they are provided consistent information. Under the BIP work plan, New York will work toward an integrated website that provides information and referral through the NY Connects website and others, a single 1-800 number, and at the SEP nearest their home which will be staffed by well-trained and informed individuals ready to assist consumers with initial assessments.

OPWDD is a partner with the New York SEP system and its six regional offices throughout the state serve as regional hubs for specialized service access and eligibility services. Resources to support eligibility determinations are available on the OPWDD website at: http://www.opwdd.ny.gov/opwdd_services_supports/eligibility/documents/guide_to_eligibility_assessment_resources_final. Additionally, OPWDD’s CHOICES platform provides an electronic provider gateway for voluntary and state providers to enter key transactions such as needs assessment data through on-line transaction processing via the Internet. CHOICES provides a solid and existing foundation on which to build effective cross-system coordination, information sharing and improved accessibility to services and improved efficiencies.

New York will describe these options fully in developing its NWD/SEP system in its final work plan.

Section D. No Wrong Door/Single Entry Point Person Flow

NY Connects will be enhanced to provide consistent information about LTSS options across populations through the website, via local and/or toll-free numbers and/or in person at SEPs throughout the state.

As described above, New York will capitalize on its wealth of local access points and coordinate information so that consumers across the state have the information they need to learn more about LTSS for which they may qualify and enroll in programs and services knowing that they have chosen them from among all those offered to address their specific needs. Empowering the consumer to be well informed about the programs and services for which he or she may be eligible across the many platforms possible in New York State is the state's primary goal of participation in BIP. Creating an interface that allows consumers to see all of their options regardless of which agency oversees the program or service and permitting a self assessment to determine which of these services they may be eligible for will ease access to the array of LTSS in New York and assure that consumers have consistent information no matter where they live or how they access such information.

As required in BIP, the consumer will be able to access consistent information about LTSS in his or her community through an informative website (NY Connects), a statewide 1-800 number (to be developed to work with the NY Connects network of NWD/SEP entities), or by visiting a local NWD/SEP office around the state. New York State's goal is to empower the consumer to direct their own search for services through an information interface that provides centralized information about all the options that exist in the state to meet the LTSS needs of its residents. A self-assessment integrated with an existing financial eligibility screen will allow individuals to easily see what LTSS may meet their needs and provide immediate information about those services and any financial assistance that may be available to him or her. In addition, existing resources will be evident to eligible consumers who want additional help understanding their options and/or enrolling in programs and services.

Section E. No Wrong Door/Single Entry Point Data Flow

Individuals will be able to receive information about services, programs and SEP locations tailored to their particular situation based on data that either they or their SEP coordinator put in the self-assessment tool via the website. Individuals can do this as often as they want to reflect changing circumstances. Individuals and/or SEP coordinators will also be able to receive information about financial eligibility based on data they enter in the financial eligibility screening tool via the same website.

Once an individual presents to a SEP or managed care organization, coordinators from those organizations can access tools from the website and tools or data from the financial eligibility and comprehensive assessment systems (UAS-NY or Core Standard Assessments). The UAS-NY will allow assessors or coordinators to access and search the data in the financial eligibility system (via a real-time interface) to find those who are potentially eligible or eligible for Medicaid. If such a search is fruitful, there will be a feature which allows the assessor or coordinators to auto-populate the comprehensive assessment system with Medicaid eligibility information, active addresses and other demographic data. SEP local district coordinators will also be able to access the web-based UAS-NY to search for and auto-populate an individual's data.

Data from the UAS-NY will be replicated, structured and stored in the Data Warehouse as well as within their primary sources.

Section F. Potential Automation of Initial Assessment

As part of its participation in BIP, NYS will investigate the automation of an initial self-assessment that integrates both financial and functional screens. Ideally, individuals will be able to use the website or discuss their needs with local NWD/SEP staff accessed through the 1-800 number or in person to get immediate feedback on services, programs and/or financial assistance for which they may be eligible. New York State already has automated financial screens that can be maximized to coordinate through the NY Connects LTSS Interface.

Section G. Potential Automation of Core Standardized Assessment

OPWDD has selected the interRAI Integrated Assessment Suite to serve as the core of the needs assessment process within the People First Waiver system reforms. The interRAI has 16 domains and multiple items per domain to fully inform a person-centered care planning process. Establishing a new service system that will ensure quality support of people with developmental disabilities across all areas of their life interests and needs requires an assessment process involving comprehensive domains that is sensitive enough to effectively identify an individual's unique medical and behavioral health needs. Assessment domains and items on the interRAI ID are repeatedly tested and revised to ensure high reliability and validity.

Use of the interRAI Assessment Suite will link OPWDD's service system with the New York State Department of Health (DOH) and a unified data warehouse that supports establishment of "No Wrong Door" access to services. The DOH is currently in the beta testing phase of its Uniform Assessment System (UAS) with the interRAI Community Health Assessment (CHA) at its core.

OPWDD is initiating the testing of an electronic application to test the design and delivery of its assessment suite of tools. Once the testing is complete, within the next 18 months, OPWDD will begin full-scale roll out on a statewide basis to inform care planning and promote equitable reimbursement through a managed care service delivery system.

The UAS-NY, which is a comprehensive assessment tool currently being developed for automation for DOH long term care programs is scheduled for pilot and implementation in early 2013. The OPWDD has identified a comprehensive assessment tool for its programs which uses 60% of the core assessment domains and scales inside the UAS-NY. The OPWDD tool is augmented by supplemental assessments which are triggered based upon various individual circumstances. OPWDD is currently conducting case studies using this comprehensive tool while developing a temporary automation to capture data from the case studies. This temporary automation is expected to be available in early 2013. Once the case study period is over in early 2014, the temporary OPWDD automation will be enhanced to the permanent solution (OPWDD-CAS) and then unified with the UAS-NY.

As part of its BIP final work plan, NYS will investigate the other assessments used in the state to determine the value of automation.

Section H. Incorporation of CSA in the Eligibility Determination Process

Once identified as potentially eligible, individuals can be assessed through UAS-NY, OPWDD's CAS, Health Homes Assessment or other core assessment to determine their functional needs and assist in care planning. As discussed above, the UAS-NY will allow assessors or coordinators to access and search the data in the financial eligibility system (via a real-time interface) to find those who are potentially eligible or eligible for Medicaid. If such a search is fruitful, there will be a feature which allows the assessor or coordinators to auto-populate the comprehensive assessment system with Medicaid eligibility information, active addresses and other demographic data. SEP local district eligibility coordinators will also be able to access the web-based UAS-NY to search for and auto-populate an individual's data.

NYS will look into the other assessments used in the state to determine opportunities to integrate or interface them with the financial eligibility system.

Section I. Staff Qualifications and Training

New York State has developed a comprehensive staff qualification and training program for the UAS-NY. This program was developed to provide, in one location, all of the information users need to learn about and effectively use the UAS-NY. The UAS-NY Training Environment is fully online. All of the courses in the training environment are self-paced and available 24/7.

Prior to accessing the UAS-NY Training Environment, organizations must ensure that staff has a basic level of proficiency using computers and web-based systems. Additionally, staff who is assigned the responsibility for conducting assessments must meet the minimum guidelines and have the requisite experience for conducting health-related assessments.

OPWDD will require that individuals who complete the functional assessment (OPWDD's CAS) are qualified developmental disability professionals (QDDP) and that they are trained in the administration of the CAS. Training of the initial cohort of OPWDD assessors has occurred with the support of staff from InterRAI/University of Michigan.

New York State will investigate the current staff qualifications and training requirements for assessors and managers in other tools used in the state as part of its final work plan.

Section J. Location of SEP Agencies

As noted above, New York State plans to network its existing access points into a NWD/SEP system that ensures that no matter what door a consumer enters, he or she will receive consistent information about his or her LTSS options and will receive assistance, to the extent needed, to determine functional and financial eligibility and become enrolled in appropriate services. These access points are accessible to individuals across the state and cover the entire population. As part of its final work plan submission, New York State will finalize a list of SEPs.

Section K. Outreach

NYS will capitalize on its strengths and ensure that people are aware of what is available, use CFC and other initiatives to break down silos of care and integrate services across populations. Key to ensuring that consumers have improved access to necessary LTSS will be making sure that discharge planners, social workers, nurses, physicians and other common referral sources are aware of the new

interface that BIP participation will allow New York State to develop to ensure that consistent LTSS information and referral is available across the state. This will involve a considerable outreach effort.

New York State offers such an array of LTSS currently and already has systems in place to assist individuals with eligibility determinations and enrollment into appropriate services and programs. However, these resources are not consistent across the state and often people don't know they exist. BIP participation will use a considerable provider network and other existing channels of communication with the home and community-based services community to fully develop and distribute comprehensive and consistent information about LTSS across the state.

In addition to providing information to the access points that reflects state-wide opportunities for LTSS across all Medicaid supported populations, it will be necessary to ensure that NY Connects is seen as the portal to LTSS for all individuals in the state in need of this information. As part of its BIP participation, New York State will develop a comprehensive strategy to ensure that relevant populations are aware of the new capacity built into NY Connects.

New York will build on the many efforts underway in the state to improve access to needed services. For example, OPWDD has conducted extensive outreach to and engagement of its many stakeholders throughout the process of identifying and defining the needed service system reforms incorporated in the People First Waiver. This waiver initiative will achieve many critical reforms related to service access and integration of cross-systems care through the transformation of the service system from fee-for-service to managed care in parallel with key improvements to OPWDD's "front door," needs assessment, person-centered planning, quality assurance practices and service menu enhancements and the associated information technology development. The OPWDD People First Waiver Web page (http://www.opwdd.ny.gov/opwdd_services_supports/people_first_waiver/home) documents the full sequence of stakeholder design teams, steering committee, work teams, public forums and surveys that OPWDD has deployed to communicate about and involve outside parties in the developing reform initiative.

Section L. Funding Plan

New York State is committed to implementing an enhanced NY Connects system to comply with the requirements of BIP and improve access to and expand the capacity of our extensive home and community based long term care system. Individuals across all populations will use this system to learn about their options and to determine their potential eligibility for various LTSS to assist them with their LTSS needs. This will ensure consistent information across the state and across agency programs and services and will ensure that as New York migrates to a "Care Management for All" LTSS system all individuals with functional, behavioral and/or medical LTSS needs are aware of their options and have access to needed services.

The funding plan in Appendix B illustrates state projections of its spending on LTSS during the funding period. These projections are based on several reform efforts including cost growth containment efforts and the MRT "Care Management for All" initiative. They also assume that the state will participate in the Community First Choice Option under the Affordable Care Act, section 2401 (section 1915(k) of Title XIX of the Social Security Act) beginning October 1, 2013 and that health homes expenditures will increase by 10% per year during the funding period.

New York State is committed to successfully implementing BIP requirements and plans to include \$12.3 million to support these efforts in its 2013-2014 Executive Budget. This commitment

includes additional staff to plan, implement and monitor the BIP as well as support the infrastructure necessary to comply with BIP.

Section M. Challenges

As noted above, New York State's greatest challenge is making it easier for consumers to understand their options and access needed home and community based services quickly and consistently in all parts of the state. BIP will allow the development and implementation of a resource that ties together the array of programs and services offered to those in need of LTSS and ensure seamless access at the consumer level.

New York is undergoing major reform efforts currently as a result of the MRT recommendations and this presents certain challenges. However, the goals of BIP and those of Care Management for All are consistent and pursuing them together, along with other significant health care reforms that meet the CMS triple aim, are mutually supportive and consistent.

Section N. NWD/SEP's Effect on Rebalancing

New York anticipates that after the program payment period, state funds expended on LTSS home and community based services compared to institutional services will exceed the goal of 50%.

Section O. Other Balancing Initiatives

BIP is consistent with New York's considerable efforts to rebalance the proportion of expenditures on LTSS in the community over the past several decades. As described above, New York has achieved significant success in providing needed services in home and community based settings across the state, regardless of an individual's diagnosis or condition.

New York has a long history of supporting community living as an alternative to institutional care. For example, in the past 35 years OPWDD significantly reduced the number of institutional placements and replaced it with a large, statewide network of community living options, including community residences and individually controlled residential supports. The number of people with intellectual and developmental disabilities served in community based services has grown over 500%, from 1975 to 2011. These opportunities were created to address the desire of people with developmental disabilities and their families for living arrangements in and outside of the family home. OPWDD is committed to maintaining a full array of residential support options to meet the needs of individuals, their families and advocates and, through the People First Waiver reforms, moving the system forward toward more individualized service options that respond with coordinated supports and services to meet the full range of a person's identified support needs.

OPWDD has committed to further reducing the use of institutional settings to deliver services. Within the People First Waiver, the agency is articulating milestones for ultimately eliminating institutional settings. To achieve this goal, OPWDD will devote resources to develop alternative, community-based clinical services that can address the most extreme levels of need for long-term support while ensuring health and safety. OPWDD is further committed to expanding the array of residential support options that are available to meet the needs of individuals with new levels of support that fall between full, 24/7 supervision and total independence, to more appropriately match individuals' needs.

Section P. Technical Assistance

New York will work with its considerable network of stakeholders and state partners to determine what areas of BIP compliance will require technical assistance as we develop the final work plan to be submitted within six months of approval.

Appendix A
Letters of Support



Executive Office

44 Holland Avenue
Albany, NY 12229-0001

TEL: 518-473-1997

FAX: 518-473-1271

TTY: 866-933-4889

www.opwdd.ny.gov

December 19, 2012

Mr. Jason Helgeson, Medicaid Director
Office of Health Insurance Programs
New York State Department of Health
One Commerce Plaza, 20th Floor
Albany, NY 12210

Dear Director Helgeson:

I am writing this letter in support of the New York State Department of Health's application to participate in the federal Balancing Incentive Program (BIP) authorized in the Affordable Care Act (P.L. 111-148, §10202).

The New York State Office for People With Developmental Disabilities (OPWDD) looks forward to working with the Department of Health in its efforts to expand access and improve coordination to long term services and supports (LTSS) across all populations in the state. We believe that the goals of BIP will improve the balance of community-based LTSS, and improve satisfaction for individuals and families.

New York's efforts to date to improve the integration of individuals in home and community-based settings will be aided through participation in BIP to ensure that these essential services are provided in the most effective and most integrated settings. Leveraging federal resources to streamline eligibility, improve access, and expand community-based LTSS across all populations will complete New York's long-standing rebalancing goals.

OPWDD supports the submission by the New York State Department of Health and looks forward to continued collaboration to meet the goals of BIP.

Sincerely,

Courtney Burke



State of New York
Andrew M. Cuomo
Governor



Office of Mental Health
44 Holland Avenue
Albany, New York 12229
www.omh.ny.gov

December 18, 2012

Mr. Jason Helgeson, Medicaid Director
Office of Health Insurance Programs
New York State Department of Health
One Commerce Plaza, 20th Floor
Albany, New York 12210

Dear Director Helgeson:

I am writing this letter in support of the New York State Department of Health's application to participate in the federal Balancing Incentive Program (BIP) authorized in the Affordable Care Act (P.L. 111-148, §10202).

We look forward to working with the Department in its efforts to expand access and improve coordination to Long Term Services and Supports (LTSS) across all populations in the state. We believe that the goals of BIP will improve the balance of community based LTSS, and improve consumer and family satisfaction.

New York's efforts to date to improve the integration of individuals in home and community based settings will be aided through participation in BIP to ensure that these essential services are provided in the most effective and least restrictive settings. Leveraging federal resources to streamline eligibility, improve access and expand community-based LTSS across all populations will complete New York's long standing rebalancing goals.

This organization supports the submission by the Department and looks forward to continued collaboration to meet the goals of BIP.

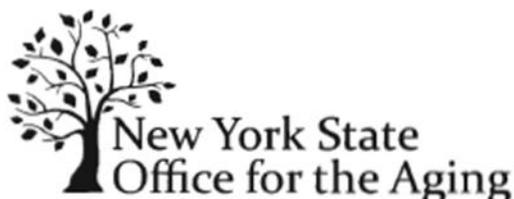
Sincerely,

Kristin M. Woodlock, RN, MPA
Acting Commissioner



Andrew M. Cuomo
Governor

Greg Olsen
Acting Director



Two Empire State Plaza
Albany, New York
12223-1251

www.aging.ny.gov

December 18, 2012

Mr. Jason Helgerson, Medicaid Director
Office of Health Insurance Programs
New York State Department of Health
One Commerce Plaza, 20th Floor
Albany, New York 12210

Dear Director Helgerson: 

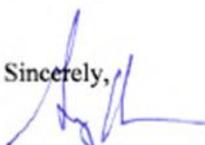
I am writing this letter in support of the New York State Department of Health's application to participate in the federal Balancing Incentive Program (BIP) authorized in the Affordable Care Act (P.L. 111-148, §10202).

The New York State Office for the Aging (NYSOFA) has been working closely with the Department on a number of initiatives to better coordinate and integrate long term services and supports and increase access including developing and implementing our state's ADRC (NY Connects), participating on the Community First Choice Option workgroup, participating in the state's Olmstead implementation work through the Most Integrated Setting Coordinating Council, building statewide capacity to implement Chronic Disease Self Management Education (CDSME) as well as partnerships to expand capacity at the community level through the states proposed 1115 waiver and Center for Medicare and Medicaid Innovation grant.

NYSOFA looks forward to working with the Department in its efforts to expand access and improve coordination to Long Term Services and Supports (LTSS) across all populations in the state. Through NYSOFA's network of 59 area agencies on aging, over 1,200 community-based contractors and partners, and 1,600 local long term care council members, we believe that we can play an important role in helping the Department meet the goals of BIP, improve the balance of community-based LTSS, and improve consumer and family satisfaction.

New York's efforts to date to improve the integration of individuals in home and community-based settings will be aided through participation in BIP to ensure that these essential services are provided in the most effective and least restrictive settings. Leveraging federal resources to streamline eligibility, improve access and expand community-based LTSS across all populations will complete New York's long standing rebalancing goals.

NYSOFA strongly supports the submission by the Department and looks forward to continued collaboration to meet the goals of BIP.

Sincerely,

Greg Olsen

*Promoting independence and quality of life
for older New Yorkers*



Senior Citizens' Help Line 1-800-342-9871
An Equal Opportunity Employer

Appendix B
Applicant Funding Estimates

Appendix B

Appendix B								
DEPARTMENT OF HEALTH & HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES BALANCING INCENTIVE PAYMENTS PROGRAM (Balancing Incentive Program) APPLICANT FUNDING ESTIMATES LONG TERM SERVICES AND SUPPORTS								
State	New York			State FMAP Rate	50%			
Agency Name	Department of Health			Extra Balancing Incentive Program Portion (2 or 5 %)	2%			
Quarter Ended								
Year of Service (1-4)	FFY 13-15							
					Projected LTSS Spending			
LTSS	Total Service Expenditures	Regular FEDERAL Portion	Regular STATE Portion	Amount Funded By Balancing Incentive Program (4 year total)	Year 1	Year 2 1/1/13-9/30/13	Year 3 10/1/13-9/30/14	Year 4 10/1/14-9/30/15
	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)
Home Health Services- State Plan	725,061,770	362,530,885	362,530,885	14,501,235		379,160,742	212,862,171	133,038,857
Line 18A- Medical Health Insurance Payments: Managed Care Organizations (MCO)- non-institutional portion (Includes CFCO)	11,574,580,513	5,787,290,257	5,787,290,257	231,491,610		2,105,141,414	4,525,589,581	4,943,849,518
Line 19A- Home and Community Based Services- Regular Payment Waiver:	-	-	-	-				
OPWDD Waiver	15,915,045,717	7,957,522,858	7,957,522,858	318,300,914		4,228,378,852	5,773,843,314	5,912,823,550
LTHHCP (incl. State plan home care inside the LTHHCP)	558,154,469	279,077,234	279,077,234	11,163,089		369,849,299	141,213,190	47,091,979
NHTD & TBI	541,475,483	270,737,742	270,737,742	10,829,510		147,675,132	196,900,176	196,900,176
CAH , B2H	406,493,935	203,246,968	203,246,968	8,129,879		110,861,982	147,815,977	147,815,977
Line 23A- Personal Care Services- Regular Payment	2,469,448,160	1,234,724,080	1,234,724,080	49,388,963		1,291,362,799	724,975,607	453,109,754
Line 43- Health Homes for Enrollees with Chronic Conditions	84,980,081	42,490,040	42,490,040	1,699,602		25,673,740	28,241,114	31,065,226
TOTALS	32,275,240,129	16,137,620,064	16,137,620,064	645,504,803		8,658,103,962	11,751,441,130	11,865,695,037

Appendix C

Executive Order

Establishing the New York State Olmstead Plan

Development and Implementation Cabinet



ESTABLISHING THE OLMSTEAD PLAN DEVELOPMENT AND IMPLEMENTATION CABINET

WHEREAS, the United States Supreme Court held in *Olmstead v. L.C.*, 527 U.S. 581 (1999), that Title II of the Americans with Disabilities Act prohibits the unjustified segregation of people with disabilities and requires states to provide people with disabilities with necessary support and services in the most integrated setting appropriate to their needs;

WHEREAS, the Olmstead court recognized that unnecessary institutional placement can isolate people with disabilities and severely diminish their family relations, social contacts, employment options, economic independence and educational advancement;

WHEREAS, the State of New York is committed to the principle that people with disabilities should have access to community-based services, accessible housing with appropriate supports, and employment opportunities that enable them to live productive lives in their communities;

WHEREAS, all New Yorkers with disabilities and their families should have the opportunity to make informed choices regarding services, settings and related issues;

WHEREAS, the State of New York has taken important steps to strengthen community-based supports for people with disabilities, including accelerated access to care management that better addresses individual needs; and the creation of health homes that provide integrated care coordination for complex populations, including people with disabilities;

WHEREAS, the State of New York continues to fulfill its commitment to people with disabilities, through the inclusion of a supportive housing initiative and funding for supported housing in the State Fiscal Year 2012-13 Executive Budget; and

WHEREAS, it is critically important for the State of New York to develop and implement a comprehensive Olmstead Plan on behalf of all of New York's children and adults with disabilities;

NOW, THEREFORE, I, Andrew M. Cuomo, Governor of the State of New York, by virtue of the authority vested in me by the Constitution and laws of the State of New York, do hereby order as follows:

A. Definitions

As used herein, the following terms shall have the following meanings:

1. "State agency" or "agency" shall mean any state agency, department, office, board, bureau, division, committee, council or office.
2. "Authority" shall mean a public authority or public benefit corporation created by or existing under any New York State law, with one or more of its members appointed by the Governor or who serve as members by virtue of holding a civil office of New York State, other than an interstate or international authority or public benefit corporation, including any subsidiaries of such public authority or public benefit corporation.

B. Olmstead Plan Development and Implementation Cabinet

1. There is hereby established the Olmstead Plan Development and Implementation Cabinet (the "Cabinet") to provide guidance and advice to the Governor.
2. The Cabinet shall be comprised of the Governor's Deputy Secretary for Health/Director of Healthcare Redesign; the Counsel to the Governor; the Director of the Budget; the Commissioner of Developmental Disabilities; the Commissioner of Health; the Commissioner of Labor; the Commissioner of Transportation; the Commissioner of Mental Health; the Commissioner of Alcoholism and Substance Abuse Services; the Commissioner of Children and Family Services; the Commissioner of Homes and Community Renewal; the Commissioner of Temporary and Disability Assistance; the Director of the State Office for the Aging; and the Chair of the Commission on Quality of Care and Advocacy for Persons with Disabilities. Additional members may be appointed to the Cabinet at the discretion of the Governor.
3. The Governor shall appoint the Chair of the Cabinet from among the members of the Cabinet.
4. Each member of the Cabinet may designate a staff member to represent him or her and participate in the Cabinet on his or her behalf. The Cabinet shall meet at the call of the Chair as often as is necessary and under circumstances as are appropriate to fulfill its duties under this section

C. Cooperation with the Cabinet

1. Each agency and authority of the State of New York shall provide to the Cabinet such information, assistance and cooperation, including use of State facilities, which is reasonably necessary to accomplish the purposes of this Order.

2. Staff support necessary for the conduct of the Cabinet's work may be furnished by agencies and authorities (subject, as necessary, to the approval of the board of directors of such authorities).

D. Duties and Purposes

1. The Cabinet shall make recommendations to the Governor concerning the development, implementation and coordination of an Olmstead Plan (the "Plan") for the State of New York. In making such recommendations, the Cabinet shall consider potential elements of the Plan, including but not limited to:

- a. identification of the essential requirements of compliance with Olmstead and the Americans with Disabilities Act;
- b. assessment procedures to identify people with disabilities who could benefit from services in a more integrated setting and the development of a coordinated assessment process for individuals of all ages with disabilities in need of services;
- c. measurable progress goals for achieving integrated residential living, including transition goals from segregated to residential housing, and employment opportunities for people with disabilities;
- d. measurable goals for providing supports and accommodations necessary for successful community living;
- e. statutory and regulatory changes to implement the Plan;
- f. a coordination strategy for the work of state agencies and authorities to implement the Plan, including specific and reasonable timeframes for implementation;
- g. actions to promote community understanding of and support for integrated residential living for people with disabilities;
- h. other appropriate measures to achieve and implement a comprehensive and unified Plan; and
- i. how best to maximize available resources in support of the Plan.

2. In developing recommendations for the development of the Olmstead Plan and its implementation and coordination, the Cabinet shall consult with the Most Integrated Setting Coordinating Council and other relevant entities and stakeholders concerned with development and implementation of the Olmstead Plan.

3. In carrying out its responsibilities under this Order, the Cabinet shall seek the guidance and expertise of stakeholders, including, but not limited to, organizations that advocate on behalf of people with disabilities, providers of services to people with disabilities, associations concerned with housing and employment for people with disabilities, academic institutions and local governments, and shall solicit input from the public.

4. The Cabinet shall commence its work immediately. On or before May 31, 2013, the Cabinet shall submit a final report to the Governor, setting forth its recommendations concerning establishment, implementation and coordination of the Olmstead Plan, at which time the Cabinet shall terminate its work and be relieved of all responsibilities and duties hereunder. Prior to such date, the Board shall issue additional reports to the Governor of its activities, findings, recommendations and coordination in furtherance of the purposes of this Order from time to time as directed by the Governor or the Governor's designee.

G I V E N under my hand and the Privy Seal of the State in the City of Albany this thirtieth day of November in the year two thousand twelve.

BY THE GOVERNOR

Secretary to the Governor