

Application for Partnership Plan Waiver Extension

New York State Medicaid Section 1115 Demonstration

Project No. 11-W-00114/2

The Partnership Plan

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Section 1: Historical Narrative and Objectives

New York State's (NYS) objectives in implementing the Partnership Plan section 1115(a) Demonstration was to improve health outcomes for low-income New Yorkers by:

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

The Demonstration is designed to use a managed care delivery system to deliver benefits to Medicaid recipients, create efficiencies in the Medicaid program and enable the extension of coverage to certain individuals who would otherwise be without health insurance.

The Partnership Plan was originally authorized for a five year period on July 15, 1997, to enroll most Safety Net and Temporary Assistance to Needy Families (TANF) Medicaid beneficiaries into Managed Care Organizations (MCOs), either on a mandatory or voluntary basis, and to provide 24 months of family planning services only, to women losing Medicaid eligibility after giving birth. Over the years, several new provisions were added to the Partnership Plan to expand coverage to certain populations and to include more services delivered through the managed care delivery system.

In 2001, the Family Health Plus (FHPlus) program was implemented as an amendment to the Demonstration, providing comprehensive health coverage to low-income uninsured adults, with and without dependent children, who have income greater than Medicaid State Plan eligibility standards. FHPlus was further amended in 2007 to implement an Employer-Sponsored Health Insurance (ESHI) component. Since ESHI began in 2008, the program expanded from 900 to 3100 enrollees in 2012. Individuals eligible for FHPlus who had access to cost-effective ESHI were required to enroll in that coverage, with FHPlus providing any wrap-around services necessary to ensure that enrollees get all FHPlus benefits. The state later expanded Family Health Plus eligibility for low-income adults with children. The FHPlus program will end December 31, 2014 and beneficiaries will be transitioned to the Medicaid program or the Marketplace.

In 2002, the Demonstration was expanded to incorporate the Family Planning Expansion Program. This program provides family planning services to women who had been eligible for Medicaid but who would lose eligibility at the conclusion of their 60-day postpartum period, and to men and women of childbearing age with net incomes at or below 200% of the Federal Poverty Level (FPL), who are not otherwise eligible for Medicaid or other public or private health insurance coverage that provides family planning services. This program has been incorporated into the State Plan.

In 2005, mandatory enrollment of the SSI population began and was expanded to include those with serious mental illness.

As part of the Demonstration's renewal in 2006, authority to require the mandatory enrollment of the disabled and aged populations in certain counties was transferred to a new demonstration, the Federal-State Health Reform Partnership (F-SHRP).

In 2010, the Home and Community-Based Services Expansion Program (HCBS expansion program) was added to the Demonstration. This allows for certain adults with significant medical needs to receive cost-effective home and community based services so they can remain in the most integrated community based setting.

In 2011, the state developed and implemented two new initiatives designed to improve the quality of care rendered to Medicaid beneficiaries. The purpose of the first, the Hospital-Medical Home (H-MH) project, was to improve the coordination, continuity and quality of care for individuals receiving primary care in hospital outpatient departments operated by teaching hospitals, and other primary care settings used by teaching hospitals to train resident physicians. The clinical training sites used for primary care residents will work towards transforming their delivery system consistent with the National Committee on Quality Assurance (NCQA) requirements for medical home recognition under its Physician Practice Connections – Patient Centered- Medical Home (PPC-PCMH) program and the 'Joint Principles' for medical home development articulated by primary care professional associations. Hospitals that receive funding have been required to implement a number of patient safety and systemic quality improvement projects. Key milestones are achievement of NCQA PPC-PCMH Level 2 or Level 3 recognition within two years from the start date of the program. This program is set to expire on December 31, 2014.

The second initiative was intended to test strategies for reducing the rate of preventable readmissions within the Medicaid population, with the related longer-term goal of developing reimbursement policies that provide incentives to help people stay out of the hospital. Projects will focus on improved quality and cost savings and will include reporting and evaluation components to ensure that projects are replicable and sustainable. Activities include: review of policies and operational procedures that may be contributing to high rates of readmissions; reengineering the discharge planning process; appropriate management of post-hospital/transition care; and coordination with outpatient and post discharge providers to address transitional care needs.

In addition, Federal Financial Participation (FFP) is available as of August 1, 2011 for state funds for the Indigent Care Pool. The state provides grants to voluntary, non-profit and publicly-sponsored Diagnostic and Treatment Centers (D&TCs) for services delivered to the uninsured throughout the state.

Uncompensated Care

The uncompensated care program provides over \$108 million in payments to qualifying clinic providers, including mental health (MH) clinics, to assist in covering the uncompensated costs of services provided to the uninsured population. In order to receive these funds, each provider

must deliver a comprehensive range of health care or mental health services; have at least 5% of their annual visits providing services to uninsured individuals; and have a process in place to collect payments from third party payers. For the year 2011, 112 D&TCs and 190 MH clinics were determined to be potentially eligible to receive funding for this program and provided over \$214 million in uncompensated care services to the uninsured. Of these, 76 D&TCs and 124 MH clinics met the qualifying criteria described above and received \$98.6 million and \$10.2 million respectively from the indigent care funding which covered approximately 50% on average of their uncompensated care costs. The numbers are similar for 2012: 112 D&TCs and 195 MH clinics were potentially eligible and provided over \$207 million in uncompensated care; 76 D&TCs and 98 MH clinics met the qualifying criteria and received \$99.1 million and \$9.7 million respectively which, on average, covered approximately 50% of their uncompensated care costs. It is important to note that for each year after the receipt of the indigent care funding approximately \$100 million in uncompensated care costs remained that impacted the provider's financial condition.

In 2012, the Department received approval for the Managed Long Term Care (MLTC) program to be added to the Demonstration. It provides long term services and supports as well as other ancillary services to individuals in need of more than 120 days of community based long term care. The program operates both in a mandatory fashion for dual eligible individuals over 21, and in a voluntary fashion for dual eligible individuals 18 – 21 as well as nursing home eligible non-dual individuals.

The state's goals specific to MLTC are as follows:

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

On April 1, 2013, CMS approved a waiver amendment that expanded the MLTC program by authorizing mandatory Medicaid managed care enrollment for individuals who participate in the New York State Long Term Home Health Care Program (LTHHCP). Additionally, medical social services and home delivered meals were added to the managed care benefit. Individuals enrolling in MLTC can use a special income standard or spousal impoverishment rule, depending on their circumstances, to qualify for Medicaid, thus providing greater opportunity to live in the most integrated community settings.

Furthermore, this amendment provided for mandatory enrollment into the Mainstream Medicaid Managed Care (MMMC) Program for children in foster care placed by Local District Social Services (LDSS) agencies and for individuals who are eligible for the Medicaid Buy-In for Working People with Disabilities (MBI-WPD).

The NYS Developmental Disability Transformation Plan was approved as of April 1, 2013, to provide the Office of People with Developmental Disabilities (OPWDD) with resources and guidelines to ensure high-quality services for individuals with developmental disabilities served in Medicaid funded programs overseen by the Department of Health (DOH) and Centers for Medicare and Medicaid Services (CMS).

The primary goals of the DD Transformation Plan are to de-institutionalize OPWDD services, increase competitive supported employment, make available education and opportunities for the self-direction of services, and plan an eventual transition to managed care.

Four major components comprise the Transformation Plan:

1. Offer opportunities for individuals moving from OPWDD campus and community based ICFs to live in smaller, more personalized settings;
2. Establish a strategy for increasing supportive housing options, and a timeline for the transitioning of residents of intermediate care facilities to community settings;
3. Increase the number of individuals in competitive employment; and
4. Educate stakeholders to increase the number of individuals who are self-directing their services.

On April 14, 2014 New York finalized terms and conditions with the federal government for a groundbreaking waiver that will allow the state to reinvest \$8 billion in federal savings generated by Medicaid Redesign Team (MRT) reforms. The MRT waiver amendment will transform the state's health care system, bend the Medicaid cost curve, and ensure access to quality care for all Medicaid members.

This waiver amendment will enable New York to fully implement the MRT action plan, facilitate innovation, lower health care costs over the long term, and save scores of essential safety net providers from financial ruin. The waiver allows the state to reinvest over a five-year period \$8 billion of the \$17.1 billion in federal savings generated by MRT reforms.

The waiver amendment dollars will address critical issues throughout the state and allow for comprehensive reform through a Delivery System Reform Incentive Payment (DSRIP) program. The DSRIP program will promote community-level collaborations and focus on system reform, specifically a goal to achieve a 25 percent reduction in avoidable hospital use over five years. Safety net providers will be required to collaborate to implement innovative projects focusing on system transformation, clinical improvement and population health improvement. Single providers will be ineligible to apply. All DSRIP funds will be based on performance linked to achievement of project milestones.

In addition, the special terms and conditions also commit the state to comprehensive payment reform and continuing New York's effort to effectively manage its Medicaid program within the confines of the Medicaid Global Spending Cap.

Section 2: Successes and Projected Goals

2.1 Expanding Medicaid Managed Care

New York began implementation of the Partnership Plan immediately after receiving federal approval with a geographic phase-in strategy starting with five upstate counties in October 1997. Mandatory Medicaid Managed Care (MMC) began in New York City in August 1999. As of November 2012, MMC programs are operating in all counties of the state, including New York City. Statewide, Medicaid managed care enrollment has grown from approximately 650,000 in July 1997 to more than 3.6 million as of March 2014.

As previously discussed, the initial Partnership Plan was approved to enroll most Safety Net (SN) and TANF Medicaid beneficiaries into managed care. Effective October 1, 2006, MMC was expanded to Medicaid beneficiaries who qualify for the federal Supplemental Security Income (SSI) program or are certified as blind or disabled, and to beneficiaries of 14 additional counties that had not previously implemented mandatory programs. These populations were authorized under the Federal-State Health Reform (F-SHRP) waiver. As of March 2014, 356,342 SSI and SSI-related individuals were enrolled in Medicaid managed care statewide,

Since the last extension request in 2009, the state has expanded Medicaid managed care enrollment to individuals living with HIV/AIDS. Enrollment began in New York City in September 2010, and in the rest of the state starting October 2011. SNP's which are confined to NYC, have 16,196 enrolled as of March 2014.

In 2011 New York submitted a request to amend the Partnership Plan to implement initiatives of the state's Medicaid Redesign Team (MRT), which was tasked with redesigning the provision of Medicaid services to contain costs, create efficiencies and improve the quality of care. Two major initiatives were contained in the amendment request—expanding MMC enrollment to new, previously exempt and excluded populations, and mandatorily enrolling eligible individuals into MLTC programs.

On August 1, 2011, the state began enrolling individuals assigned to the Recipient Restriction Program, the first exempt/excluded population to be approved by the CMS in a multi-year initiative that will virtually eliminate exemptions and exclusions by 2016. Adults with a Serious and Persistent Mental Illness (SPMI) diagnosis and children diagnosed as Seriously Emotionally Disturbed (SED), who were not designated as SSI or SSI-related, were enrolled starting September 2011. The homeless population was the next major population to be approved effective April 2012, with notification and enrollment occurring on a phased-in basis in New York City throughout the summer. Other previously exempt or excluded populations enrolled since September 2011 include disabled and low birth weight babies, individuals with a diagnosis of End Stage Renal Disease (ESRD), individuals temporarily living outside of their social services district, pregnant women in the care of a prenatal care provider who does not participate in any managed care plan, individuals who have a language barrier, individuals for whom a managed care provider is outside the travel time and distance standards, and individuals placed in the Office of Mental Health (OMH) licensed family care homes.

As previously mentioned, enrollment into MLTC began for individuals in the 1915(c) Long Term Home Health Care Program (LTHHCP) which offers home and community based care to individuals who would otherwise be admitted to a nursing home. Dually eligible individuals aged 21 and under and non-duals of any age may voluntarily enroll in a MLTC plan.

April, 2013 the Department received approval from CMS for MMMC enrollment of children in foster care who are placed in the community directly by LDSS agencies. This does not extend to individuals in foster care in a waiver program, those placed through a contracted agency, or those housed in an institution. In addition, the Department received CMS authorization for managed care enrollment of individuals eligible through the MBI-WPD program.

A. State Budget Changes to Medicaid:

In Fiscal Year 2013, all previously existing exclusions or exemptions from mandatory enrollment into Medicaid managed care were eliminated. The Commissioner of Health was given the discretion to mandate enrollment of new populations into managed care once rates and benefits are in place. Two additional capitated programs were created within the Medicaid program: Fully Integrated Duals Advantage plans (FIDAs), and Developmental Disability Individual Support and Care Coordination Organizations (DISCOs). The budget also provides the Commissioner of Health with the authority to include additional services in the Medicaid managed care plan benefit package. These programs are currently under development to be implemented in the near future.

B. Benefit Changes/Program Changes:

Effective April 1, 2013 home delivered meals and medical social services were added to the Medicaid managed care benefit package. This addition to the benefit package will facilitate individuals remaining in the most integrated community based setting.

Pharmacy Network for Specialty Drugs: Effective April 1, 2013, managed care organizations (MCOs) must permit each enrollee to fill any mail order covered prescription at any mail order or non-mail order retail pharmacy in the MCO's network. If the MCO has designated a specific pharmacy(s) to fill prescriptions for a particular drug(s), the enrollee may fill such prescriptions at any other pharmacy in the MCO's network provided that the pharmacy agrees to a comparable price as designated by the MCO.

Adult Day Health Care (ADHC) and AIDS Adult Day Health Care (AIDS ADHC): Effective August 1, 2013 the Department received authorization from CMS regarding the addition of ADHC and AIDS ADHC to the Medicaid Managed Care (MMC) benefit package. These programs are designed to assist individuals in living more independently in the community, eliminating the need for residential health care services.

Directly Observed Therapy for Tuberculosis (TB/DOT): Effective August 1, 2013, the Department received authorization from CMS to include TB/DOT in the MMC benefit package. TB/DOT is the direct observation of oral ingestion of TB medications to

assure patient compliance with the physician's prescribed medication regimen, and to monitor effectiveness of the prescribed treatment. Previously MCOs included medications for the treatment of tuberculosis, and this initiative adds the direct observation to ensure medications are appropriately ingested.

Hospice Program: Effective October 1, 2013, the hospice benefit and population were added to the MMC benefit package. Hospice Services consist of a coordinated program of home and inpatient services which provide non-curative medical and support services for enrollees certified by a physician to be terminally ill with a life expectancy of one year or less.

Hospice services include palliative and supportive care provided to an enrollee to meet the special needs arising out of physical, psychological, spiritual, social and economic stress which are experienced during the final stages of illness and during dying and bereavement. For children under age 21 who are receiving hospice services, medically necessary curative services are covered, in addition to palliative care. Hospices must be certified under Article 40 of the New York State Public Health Law. All services must be provided according to a written plan of care which reflects the changing needs of the enrollee and the enrollee's family. Family members are eligible for up to five visits for bereavement counseling.

Permanent Nursing Home Stays/Residents: Effective October 1, 2013, the Permanent Nursing Home Stays benefit and population were added to the MMC benefit package. Services provided in a Residential Health Care Facility (RHCF) to an enrollee who is determined by the local social services district to be in permanent status will be included in the MMC benefit package. Individuals already enrolled in MMC who enter an RHCF and whose stay is determined to be permanent will no longer be disenrolled. In addition, non-duals in a RHCF will be required to enroll in managed care (MMMC or MLTC).

2.2 Managed Long Term Care

New York State, through establishment of a Medicaid Redesign Team, consisting of stakeholders representing virtually every sector of the health care delivery system including consumers, has proposed sweeping health care reforms that will lead to improved health outcomes as well as health care savings in years to come.

One such reform is directed to dual eligible Medicaid recipients, 21 years of age and older, who are in need of home and community based care for more than 120 days. With CMS approval, NYS's approach will be two- fold with respect to individuals presently receiving community based long term care services and those new to the long term care system that will require services. This transition to a managed care model will facilitate:

- Increased access to managed long term care for Medicaid enrollees in need of long term supports and services (LTSS);
- Improved patient safety and quality of care for consumers;

- Reduction of preventable acute hospital and nursing home admissions; and
- Improved satisfaction, safety and quality of life for consumers.

CMS provided approval for the mandatory enrollment of dual eligible recipients, 21 years of age or older receiving more than 120 days of community based long term care services, into a Managed Long Term Care Plan (MLTCP) on August 31, 2012. The initiative offers three models of MLTCPs: 1) partially capitated; 2) the Program of All-Inclusive Care for the Elderly (PACE); and 3) Medicaid Advantage Plus (MAP). Both PACE and MAP include Medicare and Medicaid covered services in the benefit package and require the participant to be nursing home eligible; partially capitated plans include only Medicaid covered benefits. Recipients must choose a plan to receive services. If no choice is made, the recipient is enrolled into a partially capitated plan.

The mandatory enrollment process began in New York County in June 2012 with announcement letters notifying recipients of Fee-For Service (FFS) personal care services (of at least 120 days and 120 days of Medicaid eligibility) that the Medicaid program was changing. The recipients then received a mandatory notice and materials to start the choice period. Eligible recipients were given sixty (60) days to choose a plan. Enrollment continued as specified in the Partnership Plan amendment, by New York City boroughs (Bronx, Brooklyn, Queens and Staten Island) through December 2012. Health Resources Administration (HRA) case workers refer individuals seeking services to New York Medicaid Choice (NYMC), the New York State enrollment broker, which provides information and counseling to consumers, facilitates enrollment, educates plans and supports the state with data gathering. During the period January through March 2014 MLTC availability was expanded by approving one new Certificate of Authority and four Service Area Expansions.

All MLTCP models provide a person-centered plan of care, integration of health care, environmental and social services, and a supportive transition from the previously fragmented FFS process to coordinated managed care.

A. Program Accomplishments:

- Implemented mandatory enrollment and transition process for Personal Care Services in New York City counties: completed as of September 2013.
- Expanded the scope of the mandatory enrollment initiative by incorporating additional benefits into the MLTC benefit package. Recipients receiving services through the Consumer Directed Personal Assistance Program (CDPAP) can now receive that benefit through a MLTCP and are included in the mandatory enrollment population. This was made effective in November of 2012. Additional education was developed and shared with MLTCPs addressing Consumer Directed Personal Assistance Services (CDPAS) and its use.

- Completed systemic process to identify recipients receiving Private Duty Nursing (PDN) and/or ADHC services and included these consumers in the mandatory enrollment cohort. A systemic process to identify recipients receiving Certified Home Health Agency (CHHA) services is in development. The LTHHCP population has been identified and is transitioning into MLTC.
- Expanded MLTCP availability by approving 13 service area expansions, 2 new lines of business for operational MLTCPs, and 12 new certificates of authority for new partially capitated plans since September 2012. During the period October 2013 through December 2013, MLTCP availability was expanded by approving 2 service area expansions. During the period January through March 2014 MLTC availability was expanded by approving one new Certificate of Authority and four Service Area Expansions.
- Established a standardized process for MLTCPs to enter into agreements with entities for the provision of Care Management Services. The three documents developed and issued, *Care Management Administrative Services Contract Statement and Certification*, *Standard Clauses for Care Management Administrative Services Contract*, and *Care Management Administrative Services Contract Guidelines for MLTC Plans*, allow MLTCPs to establish this relationship in an expedited manner. Care management is the foundation of the MLTC process.
- New York's Enrollment Broker, NYMC, conducted the MLTC Post Enrollment Outreach Survey which contains specific questions specifically designed to measure the rate at which consumers are able to maintain their relationship with their personal care aide or home attendant. For the period ending December 2012, 957 surveys were completed and found that 86% of the respondents are receiving services from the same home attendant (personal care) agency. For the period from July 2013 to September 2013 post enrollment surveys were completed for 1,604 enrollees and 86% of the respondents are receiving services from the same home attendant. For the period from October 2013 to December 2013 post enrollment surveys were completed for 193 enrollees and 88% of the respondents are receiving services from the same home attendant. For the period from January 2014 to March 2014 post enrollment surveys were completed for 897 enrollees and 86% of respondents are receiving services from the same home attendant.
- Expanded the scope of the transition of community based services to include CHHA care, PDN and ADHC services in mandatory counties beginning in February 2013.
- Expanded the geographic transition region to include Nassau, Suffolk and Westchester counties in February 2013. The transition expanded to Rockland and Orange counties as of September 2013.
- Continued to develop reporting mechanisms with Enrollment Broker and Computer Sciences Corporation to assure that required information is gathered as transition moves forward.

- Expanded the Department's complaint hotline staffing, and developed and implemented a new standardized database for tracking complaints and resolution.
- Entered into discussion to initiate a Member Services survey of all MLTC plans on a semi-annual basis by the State's contractor, to assure information shared with potential enrollees is accurate and helpful.
- Developed, with the Enrollment Broker, training for local social services in the transition process, identifying the districts' ongoing role during the transition, establishing clear communication mechanisms with MLTC plans, NYSDOH and stakeholders to ease transitions, while addressing potential systemic issues and ensuring informed choice by stakeholders and enrollees.
- Initiated activities for expansion of transition to Albany, Erie, Onondaga and Monroe counties in December 2013. Developed strategies to achieve the 2014 transition plan; expanding mandatory to additional counties incrementally each month. Expansion activities have commenced with April Districts (Columbia, Putnam, Sullivan, and Ulster). Initial outreach underway with the May Districts (Rensselaer, Cayuga, Herkimer, and Oneida).

Significant Program Developments

- Created a study protocol with an External Quality Review Organization (EQRO) to review auto-assigned cases to meet reporting requirements related to transition of care.
- Developed and expanded information available to participants selecting plans to include a Consumer Guide for Plans in NYC, based on assessment data submitted. This Consumer Guide is also being developed for other regions of the state.
- Initiated training for use of the mandatory Uniform Assessment System for New York State (UAS-NY) which will replace the Semi-Annual Assessment of Members tool previously utilized by MLTC assessors.
- Developed Guidelines for MLTC plans and the State's Enrollment Broker on involuntary disenrollment to assure appropriate notice and ongoing care, as needed to support health and safety of enrollees in the community.
- Further clarified the definition of community based long term care services to address Medicaid recipients in need of housekeeping services.
- Enhanced monitoring of MLTC Provider Networks where deficiencies are identified and action taken.
- Enhanced oversight of Social Day Care utilization and plan contract monitoring continues.

- Mandatory initiative moving into Nassau, Suffolk and Westchester counties.
- Continued incorporation of community based LTSS into the MLTC benefit package – CDPAP, PDN, Adult Day Health Care (ADHC), and CHHA.
- Expanded MLTCP capacity in all mandatory counties and building capacity for future counties.
- Continuity of care assured through transition period.
- Monitoring of network capacity, delivery systems and coordination of care.
- Development of data gathering systems to meet terms and conditions reporting requirements.
- Development and submission of waiver amendments for the 1915(c) LTHHCP.
- Established mechanism for ongoing policy directives to MLTCs for clarification and consistency in MLTC transitions and ongoing implementation and expansion.
- Improvement to network reporting guidelines for all MLTCs.
- Developed preliminary 2014 MLTC transition plan to expand mandatory to remainder of the State.
- Submitted preliminary proposal to develop independent clinical assessment process for MLTC enrollment. Formulating process guidelines to inform development of strategic goals and objectives.
- Conducted outreach and education in preparation to enroll permanent Nursing Home residents into MLTC plans in NYC, Westchester, Nassau, and Suffolk; pending CMS approval. Enhanced monitoring of MLTC NH networks to ensure increased capacity is established.

B. Issues and Problems:

Hurricane Sandy had a devastating impact on New York State's health resources and the aftermath of the storm continues to affect health care needs and outcomes.

- It was necessary to pause the implementation and processing of auto-assignments in New York City during November, 2012, due to disruptions caused by Hurricane Sandy. This resulted in delays in issuing announcement and mandatory enrollment notices to targeted consumers during November. The Department's ability to systemically identify certain transition populations was delayed. NYMC, the Department's enrollment broker, had to re-deploy systems and resources due to storm damage at their main facility, however schedules were back on track by December 2013.

- In response to various allegations of improprieties relating to utilization of Social Day Care in MLTC, NYS DOH, the Attorney General's Office and the Office of the Medicaid Inspector General are cooperating in ongoing audits and investigations. Focused activities are being expanded on an ongoing basis as issues are identified.
- The electronic reporting system has been implemented and will continue to be refined as needed. There were 85 critical incidents reported to the Department for the fourth quarter utilizing the enhanced system. There were 215 critical incidents reported to the Department for the first quarter utilizing the enhanced system.
- During the first quarter of 2014, 9,594 people were not referred by the enrollment broker and contacted the plan directly and were provided MLTC materials.

2.3 Insuring More New Yorkers through Family Health Plus

In May 2001, CMS approved an amendment to the Medicaid Section 1115 Partnership Plan waiver to provide for implementation of Family Health Plus (FHPlus). Enacted by the state legislature in December 1999, FHPlus is a major Medicaid expansion that initially provided comprehensive health coverage to low-income uninsured adults, with and without children, who had income and/or assets greater than the Medicaid eligibility standards. In 2010, the state eliminated the resource test for FHPlus applicants. Parent(s) living with a child under the age of 21, were eligible with gross income up to 150% of the federal poverty level (FPL). Adults without dependent children in their households were eligible with gross income up to 100% of the FPL. In July 2011, CMS approved an amendment to the Partnership Plan that increased the income eligibility standard for adults with children to 160% FPL; however, implementation was postponed as a result of the Affordable Care Act (ACA). FHPlus currently covers over 287,000 previously uninsured New Yorkers. This enrollment figure reflects individuals transitioning from FHPlus to MAGI Medicaid.

As a result of the ACA and MAGI standard, a request for extension of the FHPlus component was made to CMS on July 19, 2013, to facilitate the gradual phasing out of the program by December 31, 2014. The Department is currently working with CMS to ensure that FHPlus beneficiaries are seamlessly transitioned to the Medicaid program, or to the Exchange and access to the Advanced Premium Tax Credit benefit.

2.4 Partnering with Private Insurers

In July 2007, state legislation was enacted to authorize the Employer Sponsored Health Insurance (ESHI) Initiative to increase coverage rates among uninsured but employed New York State residents with access to employer sponsored insurance. This initiative, called the FHPlus Premium Assistance Program (FHP PAP), allows individuals who are income eligible for FHPlus and have access to cost effective employer sponsored health insurance, to receive benefits. The state subsidizes the employee's share of the premium and pays for deductibles and co-payments in excess of the enrollee's co-payment obligations under FHPlus. Wrap-around benefits are provided to the extent that such benefits are not covered by the enrollee's employer

sponsored health plan. As of September 30, 2013, for years after going into effect, approximately 3,077 individuals are enrolled in this program.

In July 2007, state legislation also created the FHPlus Buy-in Program which allows employers and Taft-Hartley Plans to purchase FHPlus insurance coverage from participating health plans. Enrollment in the FHPlus Buy-in program began April 1, 2008, for Service Employees International Union (SEIU) 1199 home care union employees. Under this program, the state subsidized premiums for enrollees eligible for Medicaid, FHPlus or Child Health Plus (CHPlus), the state's child health insurance program (SCHIP). For those not eligible for government programs, SEIU 1199 paid the full premium for the employees. When the SEIU withdrew from the program in November 2011, approximately 32,800 individuals were enrolled in the FHPlus Buy-in program through SEIU 1199.

On March 31, 2013 the United Federation of Teachers (UFT) contracted with New York State and the NYS Office of Children and Family Services to provide all 25,000 of its child care providers with access to health insurance through the FHPlus Employer Buy-In program. UFT has partnered with the Health Insurance Plan of New York (Emblem Health) to provide a network of services to their members. The child care workers are licensed and registered home child care providers in New York City and provide services to low-income families. As of September 30, 2013, a total of 1,239 unsubsidized UFT members were enrolled in the FHPlus Buy-In program, through Emblem Health. For child care workers who were eligible for Medicaid or FHPlus, the premium was paid through the state. Due to recent legislation, the FHPlus Buy-in Program ended December 31, 2013. UFT consumers who were Medicaid or FHP eligible (52 enrollees), were transferred to the commensurate Emblem Mainstream Managed Care Product. Effective January 1, 2014, unsubsidized members were to apply for insurance coverage through the New York State of Health Marketplace.

As of January 2014, no new applicants were accepted into the FHPlus PAP and existing beneficiaries were re-evaluated at renewal as part of the transition to the Modified Adjusted Gross Income (MAGI) under health care reform.

2.5 Expanding Access to Family Planning Services

The Family Planning Benefit Program (FPBP) is for women and men who are not otherwise eligible for Medicaid but are in need of family planning services. The program is intended to increase access to services and enable individuals to prevent or reduce the incidence of unintentional pregnancies. Once determined eligible, participants remain eligible for the program for 12 months, after which time recertification is required. Participation in the program increased from 69,613 participants (59,794 women and 9,819 men) in 2008 to 114,527 (89,939 women and 24,588 men) as of September 30, 2013. As the goal of the FPBP is to prevent unintended pregnancies, CMS measures program success in terms of the number of averted births. Using a methodology agreed upon with CMS, and using 2000 as the base year, the fertility rate for FPBP enrollees is 134.7 per thousand. Based on this fertility rate, there were 5,301 averted births in 2011.

Program policies, procedures and referral lists are in place to refer a FPBP member to primary care when family planning providers identify health care needs during a visit. If a client is referred for non-family planning or emergency clinical care, the family planning agencies make the necessary arrangements and advise their patients on the importance of follow-up care. Special follow-up procedures also exist for individuals with significant abnormal physical examination or laboratory test results, such as abnormal PAP tests and breast exams, and diagnosed conditions such as hypertension. In 2006, the Department and CMS worked together to improve the identification of family planning services using a list of CMS approved procedure codes, which include family planning related services (e.g. colposcopy), follow-up visits and treatment for sexually transmitted diseases. In 2008, and again in 2010, additional CMS approved procedure codes were added to the list of acceptable FPBP billing codes. Edits exist in the state's Medicaid Management Information System (MMIS) to ensure that only CMS approved family planning procedures are claimed for enrollees having eligibility only under the FPBP. Additional edits ensure that the federal share is claimed appropriately (90% for some services and 50% for others) for FPBP procedures. The 1115 waiver for FPBP and FPEP has been replaced by the State Plan Amendment that the Department submitted.

2.6 Increasing the Number of Health Care Providers Available to Beneficiaries

Through the Partnership Plan, the Department has greatly expanded access for Medicaid beneficiaries to appropriately credentialed physicians, nurse practitioners and physician extenders. As evidenced in the table below, the number of primary care and specialist physicians available to Medicaid beneficiaries is significantly greater in a managed care delivery system than in the state's current fee-for-service program.

Type of Care/Region	Participating in Fee-for-Service	Participating in Managed Care
Primary Care:		
New York City	5,271	11,117
Rest of State	5,684	9,151
Total	10,955	20,268
Specialty Care:		
New York City	11,436	20,743
Rest of State	9,156	16,524
Total	20,592	37,267

New York has a variety of mechanisms to assess the overall adequacy and capacity of Medicaid managed care plans networks. Plan network submissions, provided quarterly, are reviewed to ensure plans have the appropriate provider types, comply with geographic time and distance

standards, and can support enrollment based on a standard of one primary care provider (PCP) for every 1,500 enrollees.

The provider network data is also periodically validated to ensure its accuracy. In general, audits consistently show a high degree of accuracy between what the health plans report and what health plan network physicians report as correct. For example, the most recent audit in the summer of 2010 found that provider identification variables including name, address, zip code and license were correct at a very high level of >95%. Primary specialty was correct for 97% of PCPs and for 89% of specialists.

2.7 HOSPITAL-MEDICAL HOME (H-MH) DEMONSTRATION

The Hospital-Medical Home Demonstration announced awards for funding and participation to 64 hospitals in early October 2012. Hospitals submitted work plans on December 3, 2012 for review. Hospitals officially began work plan implementation on January 1, 2013. The initial timeline was extended due to Hurricane Sandy. Fifteen months into the project, hospitals continue actively implementing residency changes, patient-centered medical home transformation of participating outpatient sites, and the chosen care coordination and inpatient projects contained in their work plans to meet the program requirements.

PROGRAM ACCOMPLISHMENTS:

1. Reallocation of funding among the 61 hospitals continues to occur based on program changes, hospital closures and mergers, and residency program and continuity clinic changes.
2. Provided continuous clinical and technical support to 61 hospitals and 159 sites.
3. Conducted weekly meetings with a Work Plan Review Team, as well as several ad hoc specialty advisors, consisting of clinical and administrative staff both from IPRO and within the NYS Department of Health (NYS DOH)
4. Implemented a process for all sites participating in the Care Transition & Medication Reconciliation project to submit a Patient Registry, allowing the NYSDOH to link reported data with claims data and begin validating and analyzing the submitted lists. Information will be used to evaluate the impact of medication reconciliation on outpatient avoidable readmissions.
5. According to hospital submissions in the 2013 Q4 time frame:
 - 93% of sites have residents that have been assigned to a panel of patients.
 - 47% of all sites have achieved Level 3 NCQA PCMH Recognition under the 2011 standards.
 - Out of 53 sites, 60% showed improvement in decreasing the amount of time required to see a specialist

- Analysis of outpatient medication reconciliation across hospitals led to a 41% reduced risk of readmission
 - Breast Cancer Screening: Out of 28 sites, 89% showed improvement in their Q4 rates compared to their baseline rates.
 - Of sites that reported, 96% showed improvement in screening for depression.
 - The number of sites reporting data correctly has grown each quarter with continued education and support by NYS DOH.
6. All hospital-reported data submitted through the web tool is now being aggregated in summary reports for each domain. Summary reports are used to determine the quality and completeness of reporting as well as site progress. The content in the reports vary by domain, but generally display the number of sites improving on certain metrics since the previous quarter, the number of sites reporting on a given metric, and the number of sites answering either 'yes' or 'no' to required questions about meeting milestones in each domain.
 7. Received and reviewed the 2013 4th quarter and Annual information from sites and provided feedback to the hospitals regarding the quarterly and annual submission. Data received included re-formatted goal rates from all hospitals and sites for metrics related to clinical performance, resident continuity, care coordination and integration, and inpatient projects. Reformatted goal rates will allow for comparison between the rate being reported for each measure and that measure's goal.
 8. Held a one-day statewide conference on January 23, 2014 for Hospitals' Executive staff, Residency Program Directors, Primary Contacts for the demonstration and Residents. With over 300 attendees, 92% rated the overall value of information at the conference as excellent. The day included presentations on the critical components of this demonstration and a poster session that detailed project initiatives, best practices, and other innovative ideas that hospitals have implemented as a result of the demonstration on topics such as improving the primary health care for Medicaid members, improving workforce training and measure reporting capabilities.
 9. Modified the project website to make publicly available all important aspects of the conference including the brochures, the posters, abstracts, morning plenary and the Keynote speaker presentation.
 10. Held a coaching call on PCMH with a representative from NCQA as a guest speaker to provide additional information on the recognition process.
 11. Began conducting site visits throughout NYS to learn about the accomplishments, changes and challenges hospitals are facing during this demonstration program.

12. Conducted web conferences and a teleconference to educate participants in the completion of the 4th quarter (2013) reporting material as well as upcoming changes for quarter 1 (2014); provided opportunities for question and answer to all hospitals/sites involved in project.

ADMINISTRATIVE AND POLICY CHALLENGES

Refinements to the Medication Reconciliation Patient List specifications (a required submission in the Care Transition & Medication Reconciliation project) have been developed based on feedback received from hospitals and sites. The next data submission will more clearly specify the look back period for hospital discharges.

Clinical Performance Metrics: Hospitals need continuing guidance and clarification regarding tracking performance on measures. Hospitals that have measures that do not indicate improvement for two consecutive quarters are asked to conduct a root cause analysis for the areas of concern. NYS DOH continues to provide assistance with root cause analysis.

Concern about sustainability has led to under screening of patients for collaborative care in some clinics. The Office of Mental Health and Hospital Associations are consulting and developing work groups to address this.

PLANNED ACTIONS FOR THE NEXT QUARTER

- Provide ongoing support and education regarding project implementation & reporting processes via teleconferencing and web conferencing.
- Receive and review Year 2 (2014) Quarter 1 report.
- Continue site visits with hospitals and outpatient primary care sites.
- Implement regular educational coaching calls as a result of survey feedback. In Q2 2014, a coaching call is planned on the topic of Regional Health Information Organizations (RHIOs).
- Receive notification of hospitals' outpatient sites achieving NCQA PCMH Recognition by the end of Q2 2014.
- Continue to collaborate with Hospital and Professional Associations to clarify the demonstration components and support hospitals.
- Develop measure categories and composite measures in each domain to better evaluate demonstration effects and individual hospital / clinic achievements.

The Department continues to clarify the demonstration program requirements for hospital and residency teams while providing support and education on best practices and innovation. The

Department held a meeting in January 2014 open to all hospitals in an effort to bring together experts and participants to focus on the important topics of this demonstration and further explore the potential innovations to improve primary health care for Medicaid members. This demonstration will end on December 31, 2014.

2.8 Potentially Preventable Readmissions (PPR) Demonstration

The Department's external quality review organization, IPRO, assisted managed care plans with completing the Performance Improvement Projects (PIPs). For the 2011-2012 study period, two collaborative PIP projects were in progress: 1) Eliminating Disparities in Asthma Care (EDAC) which involved six Medicaid managed care plans in the Brooklyn, NY service area, and 2) Reducing PPR which has ten participating health plans across the state.

Both PIP projects have concluded and final reports are being written by the participating plans. For the 2012 PPR PIP, a conference was held on March 11, 2013 to share promising practices in the reduction of preventable hospital readmissions in the MMC population. The audience for this conference included health plan clinical and quality improvement staff, hospital and health care systems staff, home health care personnel, primary care providers and public officials. A compendium of PIP results is currently under development. Once finalized it will be distributed to the health plans and posted on the Department's website.

A. Outpatient Services for Potentially Preventable Conditions

Effective November 1, 2012, reimbursement was eliminated for ambulatory provider-preventable events, including surgical and anesthesiology services, performed in hospital outpatient, ambulatory surgical and office-based settings under Medicaid managed care and FHPlus. Provider-preventable events ("never events") are: surgery or invasive procedure on the wrong body part; surgery on the wrong patient; wrong surgery on the wrong patient.

B. Potentially Preventable Hospitalizations

From January-March 2013, staff continued to load Medicaid data with indicators for PPR and Prevention Quality Indicators (PQIs) into a database that will be widely available to Department analysts. This will allow for further analysis of these indicators to develop multi-faceted approaches to reduce readmission rates and preventable hospitalizations in New York State.

2.9 Health Systems Transformation for Individuals with Developmental Disabilities (DD Transformation)

The DD Transformation Agreement, as defined in the Special Terms and Conditions (STCs) of the NYS Partnership Plan, makes the receipt of FFP for expenditures of the designated state health programs (DSHPs) in STC 66 (April 25, 2013) contingent on the Office of People with Developmental Disabilities' (OPWDD) compliance with a schedule of deliverables beginning in

April 1, 2013 and ending April 1, 2014. This includes progress and quarterly updates in the following areas:

- Operational protocols for Money Follows the Person consistent with terms and conditions related to the Intellectual and Developmental Disability (IDD) population;
- Balancing Incentive Program benchmarks to demonstrate successful person centered planning, appropriate residential settings as housing options for persons with IDD and residential settings that meet the CMS standards for home and community-based settings;
- Submitting an approvable 1915(b)(c) waiver;
- Increasing availability of supportive housing options and the number of housing units available to persons being transitioned from Intermediate Care Facilities (ICFs), and meeting Home and Community-Based Services (HCBS) standards;
- Increasing the number of individuals engaged in competitive employment and supported employment; and
- Increasing the number of participants in self-directed training/education sessions conducted and the number of self-direction enrollees.

In keeping with the Health System Transformation for Individuals with Developmental Disabilities Agreement as defined in the Standards Terms and Conditions of New York State's Partnership Plan Medicaid Section 1115 Demonstration, OPWDD submitted the April 1, 2014 Annual Progress and Quarterly Update reporting to the Centers for Medicare and Medicaid Services (CMS) the completion of the April 1, 2014 Transformation Deliverable Schedule. The below summary describes annual progress and quarterly updates in the following areas:

- Information on the transition of individuals from institutions that meet home and community based setting (HCBS) standards and qualifying for the Money Follows the Person (MFP) demonstration.
- Progress for increasing availability of supportive housing options and the number of housing units available to persons being transitioned from ICFs and meeting HCBS standards.
- Progress toward the number of individuals engaged in competitive employment and the number of individuals remaining in sheltered workshops.
- The number of participants self-direction training/education sessions conducted and the number of self-direction enrollees.
- Status on the annual submission of the state's recently CMS approved Evaluation Plan.

A. Residential Transitions and Supportive Housing

The Finger Lakes and Taconic ICFs were closed on December 13, 2013 and residents transitioned to settings in the community. During the time period January 1, 2014 through March 31, 2014 a total of 85 individuals moved out of OPWDD institutional settings and into settings meeting HCBS standards. Of the 85 individuals, 24 qualified for Money Follows the Person (MFP). A total of 227 individuals transitioned into home and community based settings, of which 74 met MFP qualifications for the annual report of April 1, 2013 through March 31, 2014.

B. Expanding Supportive Housing Options

OPWDD, in its continuous mission to increase the availability of supportive housing options for people with intellectual and developmental disabilities moving from institutions to the community, made tremendous progress. Among the hallmarks are strengthening of federal, state, and local partnerships; expanding participation in the Home of Your Own (HOYO) program; planning and developing the Division of Person Centered Supports, Office of Home & Community Living, 1st 2014 Housing Forum; ensuring that the “Next Steps” as described in the January 1 Quarterly Report are accomplished and/or moving forward. All of which leads to the Creation of a Continuum of Housing Options for people with intellectual and developmental disabilities.

C. Increasing Supported Employment Services and Competitive Employment

As of April 1, 2013, there were 9,972 individuals with developmental disabilities enrolled in supported employment. Of these, 7,044 were competitively employed in an integrated setting earning at least minimum wage. As of February 28, 2014 there were 10,313 people enrolled in supported employment of which 7,362 were engaged in competitive employment which is a net increase of 318.

As of December 31, 2013 there were 8,020 enrollees in sheltered workshops. By the end March 31, 2014 workshop enrollment remained constant. Recently, OPWDD has continued to work to create the infrastructure and capacity that will support significant improvements in competitive employment outcomes for individuals receiving supported employment services. Infrastructure and capacity building activities included: creation of the new Pathway to Employment Service, training of supported employment providers, improvements in the collection of employment data, initiatives to incentivize the transition of individuals from day habilitation and workshops to employment, initial efforts to redesign Supported Employment rates, strengthening partnerships with ACCES-VR and the Office for Special Education, and working with the State Employment Leadership Network (SELN).

1) Improving the Quality of Supported Employment Services

From April 1, 2013 to April 1, 2014 work began to redesign supported employment services. Current supported employment fees are billed on a monthly basis. Efforts are underway to transition supported employment from a monthly to an hourly service. OPWDD is working with

the Department of Health to establish new fees that incentivize employment and include performance based outcomes.

In an effort to build the capacity of voluntary agencies to provide high quality supported employment services to people with developmental disabilities, OPWDD engaged in the following activities over the last 12 months:

- In anticipation of the roll out of Pathway to Employment, meetings were convened across the state with voluntary and state operated providers that might be interested in the service.
- Since a provider must already be authorized for supported employment services before Pathway to Employment services can be delivered, OPWDD facilitated three trainings for 100 providers who had not previously delivered supported employment services.
- Employment Trainings were also convened for approximately 300 Medicaid Service Coordinators.
- Between April 1, 2013 and June 30, 2013 seventeen Innovations in Employment Training sessions were convened. This training series provides participants with skills, tools and techniques that can be used to improve employment outcomes for people with developmental disabilities. The four-part series includes sessions on: Employment and Putting People First; Assessment and Planning; Job Development; and Job Coaching.
- By December 2013 an additional 558 supported employment and day habilitation staff representing 76 voluntary and state operated providers received training in employment discovery, assessment, job development and job coaching.
- As a follow up to these sessions, OPWDD convened ten Employment Management Forums with the directors and managers of supported employment programs. This was an opportunity to facilitate dialogue with provider agencies in regards to supporting their front line employment staff in the implementation of tools and techniques, provided in the Innovations in Employment Training Series. These forums also created an opportunity to discuss job attrition, the reasons why people have difficulty maintaining jobs and strategies that can be used to assist people in retaining jobs. There were 256 participants at these Employment Management Forums representing 165 out of 174 supported employment agencies in New York State.
- Convened two Employment Roundtables in Region 2 (Broome, Central NY and Sunmount). The first employment roundtable was designed to recruit new supported employment providers. This session focused on OPWDD's employment expectations, goals and strategies for delivering quality supported employment services. Billing and documentation requirements were also covered. The second employment roundtable was a follow-up to the Statewide Promising Practices in Employment video conference. This session enabled supported employment providers within the region to share promising practices and successful techniques for transitioning people from day habilitation and

workshop services to competitive employment. Plans are currently underway to convene additional employment roundtables in New York City and Long Island.

2) Fostering Partnerships with Business and the State Education System

OPWDD had several meetings with the Empire State Development Corporation (ESDC) about the need to encourage businesses to hire people with developmental disabilities. As a result of these discussions, ESDC facilitated a meeting between OPWDD and the New York State Retail Council and New York State Food Industry Alliance to discuss ways to educate their membership about the untapped workforce of people with disabilities. These two trade associations represent supermarkets and retail store across New York State. OPWDD identified a supported employment agency and a few businesses that employ people with developmental disabilities to participate in the meeting. The trade associations were very interested in the job carving, customized employment and job coaching supports that are available to workers with disabilities.

As part of the collaboration between OPWDD, State Education Department, Developmental Disabilities Planning Council and University of Rochester on the Partnership in Employment Systems Change grant, efforts are underway to utilize model demonstration projects to improve employment outcomes for youth and young adults with developmental disabilities. The University of Rochester is leading efforts to increase the number of Project Search sites in the state. The Project Search model has been very successful in transitioning students from high school to employment because of the collaborative efforts of school administrators, regional vocational rehabilitative offices, businesses which in most instances are hospitals, and developmental disabilities regional offices.

In addition to Project Search, OPWDD's Employment Training Program (ETP) will also be utilized in some of the model demonstration sites. ETP is a paid internship program that has enriched OPWDD's partnership with the State Education Department and has created incentives for businesses to hire people with developmental disabilities. ETP program components include discovery and job readiness training. A customized approach is used to carve out potential jobs that match a person's interests and skills with the needs of a business. During the internship, OPWDD pays the ETP intern a minimum wage salary (with non-Medicaid funds), while job coaching supports are provided by the high school. Every ETP participant has a job description that is used to assess their progress in meeting the employer's expectations. After successfully completing the internship the ETP participant is hired by the business. Several businesses that have hired ETP interns have indicated that they were initially hesitant to hire a worker with developmental disabilities. The paid internships reduced risk for businesses and provided an opportunity for the business to see that a person with developmental disabilities could be successful in the general workforce. Sixty-seven percent of the high school students that participate in ETP are working after leaving high school.

As part of the Partnership in Employment Systems Change grant, OPWDD in partnership with the Center for Human Services Education, has been working with the State Education Department to create a job readiness curriculum that will be used by teachers. Three high schools have agreed to test the curriculum and provide feedback. During this reporting period, OPWDD

has developed a curriculum outline and has solicited feedback from the Office of Special Education’s (OSE) Regional Transition Specialists. This feedback will be used to make additional modifications to the modules. OPWDD and OSE are working to align the job readiness curriculum with the State Education Department Common Core Standards that are required for all classroom instruction.

D. Increasing Self-Direction Education to Beneficiaries

The NYS OPWDD has promoted self-direction for individuals receiving supports through educational efforts by their staff and stakeholder groups. Educational efforts include community training sessions and new staff practices at the “Front Door,” which ensure that individuals coming to OPWDD to access services make an informed choice regarding self-directed service options.

Consistent with the transformation goal to expand education about self-direction service options in a consistent manner to all stakeholders statewide, OPWDD has educated more than 1,500 individuals and family members in self-direction sessions during the quarter ending on March 31, 2014, with a total count of 2,744 individuals and 94 training sessions. Self-direction education sessions are actively attended by individuals and family members. OPWDD will continue to focus education activities on self-direction according to the education goals described in the table below.

A cumulative look at the past year’s educational efforts, as outlined in the table below, demonstrates OPWDD’s commitment to self-direction education reaching approximately 12,774 individuals in more than 544 training sessions across the state.

Self-Direction Education Training		
April 1, 2013 – March 31, 2014		
	Number of Individuals	Number of Sessions
April 1 – June 30, 2013	1,844	85
July 1 – September 31, 2013	3,746	98
October 1 – December 31, 2013	4,440	267
January 1 – March 31, 2014	2,744	94
Total	12,774	544

As of the July 1, 2013 Developmental Disabilities Transformation Update, a total of 1,155 individuals with intellectual and developmental disabilities currently self-direct their services using Consolidated Supports and Services (CSS). New York State is now serving 1,788 individuals in self direction beyond the baseline of 1,155. OPWDD has met the goal of 1,245 new beneficiaries self-directing their services by April 1, 2014 as shown in table below.

Increasing Numbers of Individuals Self Directing	
July 1, 2013 (baseline)	1,155
October 1, 2013	394
January 1, 2013	654
April 1, 2014	740
Total individuals self-directing to date	2,943

E. Progress on Approved Evaluation Design

OPWDD’s Evaluation and Accountability Plans were approved in March. In the interim, the evaluation team has completed the requisite NCI field collection and helped collate and confirm data for the CMS quarterly report in the areas of person centered service delivery, housing, employment, and self-direction. Analysis has also begun for the initial cohort of individuals taking the Quality of Life survey before leaving institutional settings for community living (as part of the Money Follows the Person protocol). It is the state’s intent that a report submitted in July will contain a summary of all evaluation activities undertaken over the twelve months of the CMS-OPWDD agreement.

2.10 MRT Waiver Amendment

The Medicaid Redesign Team (MRT) Waiver Amendment was submitted to CMS in August 2012 followed by ongoing discussions. New York recently received and accepted STCs from CMS. The purpose of this demonstration amendment is to describe a structure under which the federal government will provide up to \$8 billion in new federal funds for all Medicaid Redesign Team (MRT) activities including delivery system reform in the waiver, managed care programming and state plan amendment (SPA) activities. The funding mechanism will mostly rely on intergovernmental transfers (IGTs) with the balance supported by previously approved FSHRP and Partnership Plan Designated State Health Programs (DSHPs).

A. Designated State Health Programs (DSHPs)

Although the primary source of state match is IGTs, the state proposes to use some previously approved DSHPs to ensure that the complete needs of the state are addressed through the MRT waiver amendment. Sources of DSHP funding, cited in STC 15, include previously approved F-SHRP funds (DSHP List 1 in STC 15), previously approved Partnership Plan DSHPs (DSHP List 2 in STC 15) and recently approved DSHPs not utilized for DD Transformation (DSHP List 3 in STC 15).

B. Delivery System Reform Incentive Payment (DSRIP) Plan

The MRT Amendment authorized \$8.0 billion in new federal funds for all Medicaid Redesign Team (MRT) activities including delivery system reform in the waiver, managed care programming, and state plan amendment activities. The purpose of New York's Delivery System Reform Incentive Payment (DSRIP) program, is to provide incentives for Medicaid providers to create and sustain an integrated, high performing health care delivery system that can effectively and efficiently meet the needs of Medicaid beneficiaries and low income uninsured individuals in their local communities by improving care, improving health and reducing costs. The DSRIP program will promote community-level collaborations and focus on system reform, specifically a goal to achieve a 25 percent reduction in avoidable hospital use over five years. Safety net providers will be required to collaborate to implement innovative projects focusing on system transformation, clinical improvement and population health improvement. All DSRIP funds will be based on performance linked to achievement of project milestones.

The DSRIP program is focused on the following goals: (1) safety net system transformation at both the system and state level; (2) accountability for reducing avoidable hospital use and improvements in other health and public health measures at both the system and state level; and (3) efforts to ensure sustainability of delivery system transformation through leveraging managed care payment reform.

Only initial funding of this structure is authorized in 2014; continued authority for operations and funding must be authorized upon renewal of the overall Partnership Plan demonstration, and is contingent on satisfactory initial implementation.

In addition, the special terms and conditions also commit the state to comprehensive payment reform and continuing New York's effort to effectively manage its Medicaid program within the confines of the Medicaid Global Spending Cap.

Up to \$6.42 billion of the new MRT funding is available for DSRIP payments to providers. An additional \$500 million in temporary, time limited, funding is available from an Interim Access Assurance Fund (IAAF) for payments to providers to protect against degradation of current access to key health care services in the near term.

2.11 Proposed Waiver Amendment for Behavioral Health

New York's behavioral health (BH) system, which provides specialty care and treatment for mental illness and substance use disorders (SUD), is large and fragmented. In its report, the MRT BH Subcommittee discussed that the publicly funded Mental Health (MH) system alone serves over 600,000 people totaling about \$7 billion in annual expenditures. Approximately 50% of this spending goes to inpatient care. The publicly funded SUD treatment system serves over 250,000 individuals and accounts for about \$1.7 billion in expenditures annually. Despite the significant spending on BH care, the system offers little comprehensive care coordination even to the highest need individuals. In addition, there is insufficient accountability for the provision of quality care and for improved outcomes for patients/consumers.

The MRT report also documented that BH is not well integrated or effectively coordinated with physical health (PH) care at the clinical level or at the regulatory and financing levels. Currently,

the BH system is funded primarily through fee-for-service (FFS) Medicaid, while a substantial portion of PH care for people with mental illness or SUDs is financed and arranged through Medicaid Managed Care plans. This further contributes to fragmentation and lack of accountability within the BH system. This lack of coordination within the BH system extends well beyond PH care, into the education, child welfare, and juvenile justice systems for those under the age of 21, as well as for those who are homeless and within forensic systems for adults.

As a result of recommendations from the BH work group, the State is submitting an amendment to its current 1115 demonstration to enable qualified managed care organizations (MCOs) throughout the State to comprehensively meet the needs of participants with BH needs. These needs will be met in the following ways:

- **Mainstream MCOs:** For all adults served in qualified mainstream MCOs throughout the State, the qualified MCO will integrate all Medicaid covered services for MH, SUDs and PH conditions under this demonstration.
- **Health and Recovery Plans (HARPs):** For adult populations meeting the serious mental illness (SMI) and SUD targeting criteria and risk factors, the State will enroll individuals in specialty lines of business within the qualified mainstream MCOs statewide. These specialty lines of business will be called HARPs. Within the HARPs, an enhanced benefit package in addition to the State Plan services will be offered for enrolled individuals who meet both targeting and needs-based criteria for functional limitations. The needs-based criteria are in addition to any targeting and risk factors required for HARP eligibility. The enhanced benefit package will help support participants' placement in home and community-based settings. These enhanced benefit packages will be provided by the qualified full benefit HARPs. The qualified HARP, contracting with Health Homes, will provide care management for all services including the 1915(i) like services in compliance with home and community based standards and assurances.

The goals of the various managed care models and qualification process are:

- To improve clinical and recovery outcomes for participants with SMI and/or SUDs;
- Reduce the growth in costs through a reduction in unnecessary emergency and inpatient care; and
- Increase network capacity to deliver community-based recovery-oriented services and supports.

To ensure MCOs are equipped to meet the needs of the BH population, the participating plans will be reviewed and qualified against new BH specific administrative, performance, and fiscal standards. Further implementation will be staggered according to a timeline.

A. Prospective Reporting and Program Monitoring

During the first year of implementation of the BH waiver amendment, the State will submit regular progress updates to CMS, regarding implementation of services from FFS to managed care under the MCOs.

Along with the requirements in Section 18.5.x of the MCO Model Contract, standard reports to the State will be submitted as specified in a revised Quality Strategy that will incorporate the BH modifications that are the subject of this 1115 waiver. HARP reporting will comply with all federal HCBS requirements.

Additionally, periodic satisfaction surveys of BH recipients, using State approved survey tools and protocols, will be conducted. The satisfaction surveys will separately track, trend, and report BH complaints, grievances, and appeals.

B. Quality Management (QM)

Qualified MCOs will incorporate BH specific performance measures and performance improvement projects into their QM programs which will be consistent with the State's quality strategy and federal requirements for quality monitoring. The QM programs will include performance metrics, performance improvement projects, and clinical outcome measures, and are subject to the review and approval of DOH in collaboration with OMH and OASAS.

C. Implementation of the Demonstration

BH services currently managed under FFS will be managed under the MCO contracts, through a contract amendment, with the following phase-in schedules:

- New York issued a request for qualifications (RFQ) in February 2014 to determine the competence of MCOs/HARPs to manage specialty BH benefits for adults in New York City, with an implementation date of January 2015. If an MCO or HARP is not qualified to manage BH benefits for adults, they will need to subcontract with a managed BH organization and resubmit their RFQ.
- New York issued the RFQ in February 2014 to determine the competence of MCOs and HARPs to manage BH benefits for adults in the remainder of New York State, with an implementation date of July 2015. If an MCO is not qualified to manage BH benefits for adults, they will need to subcontract with a managed BH Organization and resubmit their RFQ.
- New York will phase in a pilot for self-direction of 1915(i)-like HCBS services over a three year period in this waiver. Supports for self-direction are included in the benefit package under this 1115 amendment and operationalization of those supports will be tested in a pilot.

2.12 ASSESSING QUALITY OF CARE

The Department has been assessing quality of care for managed care plans since 1994 through its Quality Assurance Reporting Requirements (QARR). Attached is a summary of the last three years of QARR Data.

The Department published and released its second Managed Long-Term Care Report. This report describes New York's approved MLTC plans at the time of data collection and presents information about the quality of care they provide and enrollee's satisfaction with the plan.

Select MLTC Member Quality and Utilization Results

Select Quality and Utilization Measures	
Percentage of MLTC Membership Statewide	
Members who received an annual flu shot	72%
Members with one or more falls in the past six months	15%
Members who received emergent care in a hospital in the past six months	17%
Members with one hospital admission in a six month period	8%
Members with one nursing home admission in a six month period	2%
Members whose frequency of pain was stable or improved over a six or twelve month period	81%
Members whose overall functional ability was stable or improved over a six or twelve month period	90%

The Department also released the 2013 Managed Long-Term Care Consumer guides. These guides serve to summarize quality of care and satisfaction measures and present the results pictorially. These guides are available on the Department's website as well as enclosed in the enrollment packet for new enrollees.

On October 1, 2013, all MLTCPs transitioned to the Uniform Assessment System for New York (UAS-NY) for assessment of their members. The UAS-NY is a web based software application that will provide a comprehensive assessment system to evaluate individual health status, strengths, care needs and preferences to guide the development of individualized long-term care service plans. A report evaluated this information is being finalized by Department staff.

The Department has surveyed satisfaction with plans and providers for various populations, i.e. children, MLTC, PCMH. To assess all dimensions of quality, the Department administers a biennial survey to measure member satisfaction, called the Consumer Assessment of Health Care Providers and Systems (CAHPS) survey.

The External Quality Review Organization (EQRO) completed a focused clinical study to review individuals who were mandatorily enrolled in managed long term care plans and determine compliance with the required transition of care. Reviews included enrollees who selected a health plan and cases who did not select a plan, and were, therefore, auto-assigned.

Approximately 92 percent of the sample reviewed reflected at least the same level of personal care hours during the 60 day transition period as prior to enrollment. Increases to personal care hours were well documented and appeared justifiable based upon changes in member condition or caregiver support systems. There were virtually no differences between the auto-assigned and non-auto-assigned groups.

The EQRO also worked to administer a survey examining the experience of care for Managed Long Term Care (MLTC) recipients newly enrolled in a MLTC plan through the mandatory expansion of MLTC. Clients were asked to compare their experiences both pre- and post-enrollment in the MLTC. The survey is currently in the field, with administration expected to end in May 2014.

Transitions of Care Focused Clinical Study for MLTC

The Medicaid Section 1115 Demonstration requires NYS to conduct a validation audit to determine MLTC compliance with the required completion of the initial assessment within 30 days of referral, and to assess the continuity of care during the transition of care period. NYSDOH and IPRO initiated this study in February 2013, to assess both the timeliness and the continuity of care components. Nineteen MLTC plans were sent random samples of auto-assigned and mandatory enrolled members. They were required to submit documentation of the initial assessment and continuity of care to IPRO for review by the end of March 2013. Findings from this study will be available in the near future.

Plan Performance Improvement Projects (PIPs) and Quality Improvement Initiatives

New York's MMCPs are required to conduct annual PIPs. These projects have been reviewed by IPRO, the EQRO for New York State. In the past, projects have encompassed a wide range of topics important to the health and well-being of New York State residents. Each year, all participating MMCPs receive a compendium of the results as a way of sharing best practices. Health plans participated in a variety of quality improvement activities including PIPs, and other special initiatives described below:

1. Data Validation Studies

Over the past year, IPRO completed a number of quality review and data validation studies for New York's MMCPs. The annual quality performance measurement rates were successfully submitted on June 17, 2013. This was the final year that IPRO performed the Health Effectiveness Data and Information Set (HEDIS®) audit for the Medicaid Prepaid Health Services Plans (PHSP) as sponsored by New York State. In the coming year, all managed care plans in New York will have to contract with a certified HEDIS® auditor for the required QARR/ HEDIS® audit.

IPRO also conducted an audit of the provider network data systems and validated data submitted by managed care plans as part of their quarterly network submissions. Areas of deficiency were noted, and currently IPRO is preparing a follow-up survey to assess whether needed corrections were made.

A related activity was an assessment of new MLTC plan readiness to submit provider network and encounter data. New plans were surveyed about their information systems including claims, billing, and provider credentialing systems. IPRO worked with both the health plans and the Department to assist plans in identifying areas of weakness in an effort to make data reporting more efficient. On November 13, 2013, IPRO and the Department held a technical workshop for new and existing MLTC plans to share findings in best practices and allow plans to become better versed in the processes of data submission.

2. Performance Improvement Projects (PIPs)

a) Pediatric Obesity

The Department chose pediatric obesity as the common-themed PIP for 2009 and 2010, due to the escalating childhood obesity epidemic, particularly among publicly insured children in New York State. The aim of this PIP was to foster improvement in the prevention, identification and management of childhood obesity. Eighteen plans participated in this collaborative learning experience, and each identified plan-specific target populations, interventions and measures.

In addition, each plan was required to design and develop interventions aimed to impact health care providers, patients and families and community organizations/schools. The vast majority of plans used the following HEDIS® measures to address pediatric obesity: 1) Weight Assessment; 2) Counseling for Nutrition for Children/Adolescents; and, 3) Counseling for Physical Activity for Children/Adolescents. According to the 2010 Managed Care Plan Performance report for the Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents measures, NYS MMCPs outperformed the national average based on 2009 data from the NCQA. For Weight Assessment, the New York Medicaid managed care statewide average is 51% compared to the national average of 30%. The New York Medicaid managed care counseling for Nutrition statewide average is 61% compared to the national average of 42%. The New York Medicaid managed care counseling for Physical Activity statewide average is 48% compared to the national average of 33%.

An April 2011 conference entitled, Weighing the Challenges and Opportunities: New York State Medicaid Managed Care Conference on Pediatric Obesity Performance Improvement 2009-2010, summarized the two-year PIP. A compendium of PIP results was also distributed to the plans and is available at the Department's website at:

http://www.health.ny.gov/health_care/managed_care/reports/docs/2009_pip_abstract_compendium_final.pdf.

b) Eliminating Disparities in Asthma Care (EDAC)

From 2011 through 2012, six Medicaid managed care plans partnered with practices in NYC to participate in a two year PIP, EDAC.

The purpose of the EDAC project was to have each plan identify key strategies to reduce racial/ethnic disparities in clinical outcomes, and to improve care for African American patients with asthma residing in Brooklyn. The final EDAC PIP Reports were submitted in July 2013. A compendium of PIP results is currently under development. Once finalized it will be distributed to the health plans and posted on the Department's website.

c) Reducing Potentially Preventable Readmissions

This two-year PIP for MMCPs began in 2011 and continued through 2012. The objective was to reduce potentially preventable readmissions by implementing proven interventions such as early hospital discharge planning, post-hospital follow-up and enhanced care coordination. There were ten plans participating in this project, each responsible for conducting the following: an investigation into the root causes of potentially preventable readmissions within their provider networks; identifying barriers and designing appropriate interventions to affect change.

Plans partnered with one or more hospitals and high volume primary care practices. The primary outcome measure of interest for the study is readmission rates. However, the choice of measurement performance indicators is individualized by plan, allowing plans to customize performance measures to their individual interventions. Hence, plans were given the opportunity to select their targeted population, such as members with specific chronic conditions that infer high risk for hospital readmission. Throughout this two-year period, multi-plan calls were held to report on lessons learned, progress, and/or barriers encountered. The final reports were submitted in July 2013. A compendium of PIP results is currently under development. Once finalized, the results will be distributed to the health plans and posted on the Department's website.

d) Collaborative PIP 2013-2014 includes Two Parts:

Part 1: The Medicaid Incentives for the Prevention of Chronic Disease (MIPCD) includes testing the effectiveness of patient incentives on improving health behaviors and outcomes in the following two clinical areas: diabetes prevention and management, as well as smoking cessation and hypertension management.

Part 2: The focus of the program is to implement interventions that will improve care in one of the four clinical areas noted above. The MMCPs have submitted plans describing their proposed interventions. The interventions, reviewed by the Department and IPRO, were discussed and finalized with the MMCPs. The majority of MMCPs have chosen to work on diabetes management.

For Part 1, MIPCD, health plans have begun to implement their interventions for improvement and for the testing of patient incentives through Diabetes Prevention Programs. For Part 2, IPRO is conducting periodic conference calls with the health plans to monitor their progress.

During the PIP proposal development phase, the health plans were provided information on a free provider practice training entitled, Detection and Management of High Blood Pressure - A Blood Pressure Train-the-Trainer Master Training Course. In June 2013, IPRO and NYSDOH conducted a conference call with all of the MMCPs. A guest speaker from the NYSDOH,

Bureau of Community Chronic Disease Prevention, spoke about the Diabetes Self-Management Education Programs and Certified Diabetic Educator availability across New York State. IPRO and DOH also presented on the Diabetes Prevention Programs available.

3. Focused Clinical Studies

In addition to the PIPs, IPRO also performs ad hoc studies of quality of care to obtain a greater understanding of the processes and quality of care provided by the MMCPs. In doing so, IPRO is active in conducting medical records review and analyzing and synthesizing data to determine areas of greater need. Once issues are identified, IPRO and the Department conduct a focused clinical study. Descriptions of the studies are as follows:

a) Use of Clinical Risk Groups to Enhance Identification and Enrollment of Medicaid Managed Care Members in Case Management

The Department, in collaboration with IPRO, conducted an analysis of Medicaid managed care members to further understand the New York Medicaid case-managed population. This study used a predictive modeling system, Clinical Risk Groups (CRGs), to illustrate who is currently enrolled in Medicaid managed care case management programs relative to categories.

Data from this study found that pregnant women and those with chronic conditions receive the largest benefit from care management. This study demonstrated a notable overlap of members targeted for case management by plans and members identified to have high complexity/high severity conditions by CRGs, consistent with the aim of identifying potential high resource utilizers. However, there were a number of cases where members were enrolled despite not being in the more complex CRGs, clearly showing there were risk factors identified by managed care for case management that are not evident in the CRG algorithm.

Conversely, there were also members identified as high risk by the CRG grouper that were not triggered or enrolled in case management by the plans. There was wide variation in plan triggering practices, enrollment criteria and focus of plans case management programs, resulting in variation in scope and CRG distribution across plans. This focused study was the impetus for the development of the case management reporting system.

b) Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)

The Department, in collaboration with IPRO, conducted a clinical study on the HEDIS® measure, AAB. The purpose of this study was to evaluate demographic and clinical factors associated with antibiotic prescribing for acute bronchitis in adults, to better understand observed clinician prescribing patterns and inform improvement efforts. The Department observed antibiotic prescribing rates were higher for adults with acute bronchitis than those based on the HEDIS® AAB measure; and, over half of adult Medicaid managed care members presenting with acute bronchitis had a major chronic condition as defined by CRG health status. Few clear clinical drivers of antibiotic prescribing were identified; however, prescribing was associated with purulent sputum and a longer duration of cough, potentially indicating providers' concerns with non-viral etiologies. Also, members who did not receive antibiotics were more likely to be seen in the emergency department, were in receipt of chest X-ray, presumably to rule out

pneumonia, and were associated with avoidance of antibiotics. Since there may be some subsets of patients who might benefit from antibiotics, further study of members with co-morbidities, older members, members with longer duration of illness, and members without upper respiratory infection may areas for further study.

A. ASSESSING SATISFACTION WITH CARE

Patient-Centered Medical Home (PCMH) Satisfaction

The Department completed a satisfaction study involving Medicaid managed care members who had visits with providers certified by NCQA as PCMH providers. In the summer of 2013, the Department and IPRO began planning a study to look at the differences in experience of care between patients who had visits with a PCMH provider and those with visits to a provider without the PCMH designation. The Clinician and Group CAHPS survey including the PCMH module is the survey instrument. A random sample of 6,000 Medicaid members was selected, divided equally between children and adults, and between those with a visit to a PCMH provider and a visit with a non-PCMH provider. Surveys were sent to enrollees following a combined mail and phone methodology in September 2013, resulting in a 35.4 percent response rate. The final report from that study was received in March, 2014. Results indicate satisfaction somewhat higher among the non-PCMH group for many questions; however, most differences were not statistically significant. PCMH respondents were more satisfied with the comprehensiveness of their care.

Managed Long Term Care

In 2012, the Department issued the Managed Long Term Care Report on quality, satisfaction and utilization of Managed Long Term Care Plans (MLTCPs). In this report, performance of MLTCPs is evaluated through select process measures, such as annual flu shots, safety measures (e.g. members with one or more falls), and measures of improvement in activities of daily living and cognitive functioning. The following table depicts the select quality and utilization results for MLTC members.

Medicaid Adults CAHPS Survey

For Medicaid adults, the CAHPS survey assesses plan members’ experience accessing health care services, providers and the plan. The Department selects a sample of 1,500 adult members from each plan. Overall, adult members are largely satisfied with their health care experiences. Members living outside of NYC tend to be more satisfied with their health care experiences than those living in NYC. The following table depicts the results of the survey for 2010 and 2012 categorized as NYC, rest of state (ROS,) and statewide (STW).

IPRO is currently working with the Department to administer this biannual Adult Medicaid survey.

2010	2012					
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	NYC	ROS	STW	NYC	ROS	STW
Access to Care						
Getting Care Needed (Usually or Always)	69.4	78.3	73.9	72.0	77.2	74.8
Getting Care Quickly(Usually or Always)	70.7	82.8	77.0	71.5	80.1	76.1
Experience with Care						
Doctor Communication (Usually or Always)	85.2	87.5	86.4	86.7	88.0	87.4
Rating of Personal Doctor (8, 9, or 10)	72.9	75.7	74.3	72.0	74.3	73.3
Rating of Specialist (8, 9, or 10)	63.6	70.7	67.2	65.4	72.6	69.2
Rating of Overall Healthcare (8, 9, or 10)	61.9	68.4	65.2	64.0	68.9	66.6
Satisfaction with Health Plan						
Customer Service (Usually or Always)	78.1	82.3	79.9	81.8	81.5	81.5
Rating of Health Plan (8, 9, or 10)	67.1	71.6	69.3	69.4	72.0	70.7

CAHPS Clinician and Group (C&G) Survey Pilot

In 2011, the Department conducted a pilot study to assess member satisfaction and the utility of a standard tool for measuring provider level surveys. Ten large health centers in NYC with high volumes of Medicaid patients were selected as study centers and 1,000 Medicaid enrollees with at least one primary care visit at one of the ten centers were randomly selected to be part of the study population. To be eligible, members had to be enrolled in Medicaid for at least five of the six months prior to the study.

Overall, members appeared relatively satisfied with their experience of care at large health centers in NYC. Variation in scores among the ten centers was noted, as illustrated in the following table. As was seen with the CAHPS managed care plan survey data, C&G survey data also identified adults as having higher levels of satisfaction when they received from their primary doctor.

	Overall Rate	Range
Getting Appointments and Care When Needed (Usually or Always)	55.6%	48.9 - 64.5
How Well Doctors Communicate (Usually or Always)	83.5%	76.9 - 88.9
Collaborative Decision Making (Yes)	85.7%	80.3 - 90.4
Courteous and Helpful Office Staff (Usually or Always)	72.7%	66.1 - 78.9
Rating of Health Center (8, 9, or 10)	65.7%	54.9 - 74.1

Managed Long Term Care Satisfaction Surveys

In 2007, the Department developed a satisfaction survey for MLTC plan enrollees. The survey addressed the respondents' satisfaction with access to and timeliness of plan services as well as overall satisfaction with the plan and providers. The survey was repeated in 2011 and again in 2013. The 2013 survey included all 2011 survey questions as well as three additional questions related to timeliness, access, and quality of life.

In addition, New York's Medicaid section 1115 Demonstration was recently expanded and the biennial member satisfaction survey was recently concluded. New members' experience with the transition from FFS to managed care was of interest. To that purpose, NYSDOH, with its EQRO, Island Peer Review Organization (IPRO), initiated a study to assess members' satisfaction with MLTC versus FFS. A survey instrument was developed to assess members' initial experiences with the health plans, while also comparing the quality and timeliness of care providers and access to care before and after the members joined the plans. A random sample of

1,500 newly enrolled members has been selected to receive the survey, which is expected to be mailed in by the end of 2013.

Meanwhile, in February 2013, the MLTC satisfaction survey was released to a random sample of members from each plan. Select survey participants, who were members with six months or more of continuous enrollment, were targeted within the 25 MLTC plans. The survey was concluded on June 30, 2013 and the response rate was 27 percent. The survey data was analyzed and the results will be publicly available in a report on the Department’s web site. Select measures are expected to be available by plan in the 2013 Managed Long-Term Care Report and the regional Consumer Guides by the end of 2013.

A summary of 2013 results are shown in the table below:	
MLTC Member Satisfaction	
Satisfaction Measures	Rate of MLTC Members Statewide
Rating of Health Plan (Good or Excellent)	84%
Rating of Care Manager (Good or Excellent)	84%
Rating of Regular Visiting Nurse (Good or Excellent)	84%
Would Recommend Their Plan to a Friend (Yes)	90%
Access to Urgent Care with a Dentist (Same Day)	26%
Spoke to Their Health Plan About Advanced Directives (Yes)	68%
Content with Quality of Life (Quite a Bit or Very Much)	60%

I PRO also worked with the Department to administer two member satisfaction surveys through a certified CAHPS vendor, DataStat:

Child Satisfaction Survey with Chronic Condition Module

In the fall of 2012, the Medicaid CAHPS for Children, including children with chronic conditions, was administered to parents and guardians of children enrolled in Medicaid or Child Health Plus managed care plans. A total of 26,250 children, enrolled in either Medicaid or CHPlus for at least six months, were randomly selected. The response rate from this pool was 35 percent and the results of the survey are available on the Department’s website:

http://www.health.ny.gov/health_care/managed_care/medicaid_satisfaction_report_2013/index.htm. Results from this study will be used for the State's Children's Health Insurance Program Reauthorization Act (CHIPRA) reporting requirements.

B. IMPLEMENTING STANDARDS OF CARE

1) Patient-Centered Medical Home (PCMH)

In 2010, the Department implemented its PCMH initiative. Providers who are recognized by the NCQA as a PCMH now receive additional payment for primary care services provided to both fee-for-service (FFS) and managed care beneficiaries. The reimbursement amounts differ by provider type and level of recognition as described in the Medicaid Update: http://www.health.ny.gov/health_care/medicaid/program/update/2009/2009-12spec.htm. As of January 2013, providers no longer receive enhanced reimbursement or fees if they are recognized at Level 1.

2) Prenatal Care Standards Development

Prenatal care standards in New York State were developed in early 1990 in response to the creation of the Prenatal Care Assistance Program (PCAP), a prenatal care program developed to provide comprehensive prenatal care to low income, high risk pregnant women. The clinical standards of prenatal care had not been revised since the year 2000, highlighting a need to review the standards and to compare them to current professional standards of practice. In order to accomplish this task, the Department partnered with IPRO to review the existing PCAP standards and compare them to current American Congress of Obstetricians and Gynecologists (ACOG) guidelines. The new recommendations in prenatal care, as well as other national guidelines of obstetric practice, determine the need to modify the prenatal standards as they are applied to all Medicaid prenatal providers.

The revised Medicaid Prenatal Care Standards were published in February 2010, in response to new legislation enacted in New York State in 2009. This legislation expanded access to comprehensive, quality prenatal care to all pregnant women that qualify for Medicaid, regardless of where or from whom they obtain care. As a result, this PCAP designation was eliminated.

3) 2011 Prenatal Care Study

The Department and IPRO conducted a study of prenatal/postpartum care received by women enrolled in Medicaid in New York State with regard to the new Medicaid Prenatal Care Standards. The goal of this study was to assess providers' practices relative to the newly developed prenatal standards. The baseline assessment was conducted through a retrospective review of 601 medical charts to determine Medicaid providers' adherence to key elements in the new standards. The final report has been completed and was distributed to the Medicaid Managed Care Plans. The Department is currently working with providers and health plans to address gaps in care to improve quality.

C. SELECTIVE CONTRACTING WITH PROVIDERS

As part of the effort to ensure the purchase of quality, cost-effective care for Medicaid beneficiaries, the Department conducts initiatives to review and, as warranted, limit the providers with which it contracts for certain services. Two such initiatives are currently in effect. The first initiative limits the number of providers who may perform mastectomy and lumpectomy procedures within New York State and the second limits the surgical centers that may perform bariatric surgery for weight loss. These initiatives apply to patients in both the Medicaid FFS program and in managed care. The goal for these initiatives is to channel beneficiaries to experienced providers where they will receive the best care and have the best outcomes.

1) Breast Cancer Surgery

Section 504.3(i) of Title 18 of the New York Codes, Rules and Regulations gives the authority to limit the number of providers that perform inpatient and outpatient surgical procedures for breast cancer.

The Department stopped reimbursing for mastectomy and lumpectomy procedures associated with breast cancer at low-volume hospitals and ambulatory surgery centers as of March 1, 2009. The Department reviews surgery volume for all payors annually and modifies the list of hospitals and ambulatory surgery centers with which Medicaid contracts for such surgical services accordingly. In addition Medicaid managed care plans may not use these restricted facilities for these services either. Plans are required to contract only with eligible facilities or provide out-of-network authorization to those facilities for their members in need of breast cancer surgery.

Staff successfully completed the Breast Cancer Selective Contracting process for contract year 2013-2014. The process included: refining the computer programs used to extract and analyze inpatient and outpatient surgical data from the Statewide Planning and Research Cooperative System (SPARCS); determining restricted facilities; notifying restricted facilities of their low-volume status; overseeing the appeals processing and notifying facilities about the status of their appeals; and, sharing the list of restricted facilities with staff at eMedNY to restrict Medicaid payment to facilities deemed low volume. Additionally, work commenced on updating computer programs for use in fall 2013 for contract year 2014-2015.

2) Bariatric Surgery

Bariatric surgery emerged as an alternative method of weight loss and long term weight maintenance for many obese and morbidly obese individuals for whom diet, exercise, and the normally prescribed medical therapies have proven ineffective. While there are benefits to this procedure, there are also substantial potential risks. Recent research conducted by the Department illustrated a significant postoperative complication rate following bariatric surgery, as well as a substantial hospital 30 day readmission rate following discharge for such surgeries. This research also found tremendous variation in the risk-adjusted complication and readmission rates among hospitals. Given such wide variation in hospital performance, the Department restricts Medicaid reimbursement for bariatric surgical services to those hospitals achieving CMS certification as a Bariatric Surgical Center. Currently, approximately 40 hospitals in New York State have achieved certification and may be reimbursed for bariatric surgical services, for

both managed care and FFS Medicaid recipients. This restriction is intended to ensure that Medicaid recipients receive bariatric surgical services at hospitals with the best outcomes.

D. REWARDING QUALITY

Since 2001, the Department provides a financial incentive to MMCPs performing well on a set of quality, satisfaction, regulatory compliance (such as timeliness of data submissions and accuracy of reporting) and efficiency measures – Prevention Quality Indicators. MMCPs are eligible to receive a premium increase of between 0% - 4.5% per member per month (PMPM) depending on overall performance in these four areas. Plans receiving an incentive greater than 0% are eligible to receive auto-assigned members. For example, in a recent cycle, two plans earned the full award, three plans earned 75% of the award, three plans earned 50% and four plans earned 25% of the award. Six plans did not receive any portion of the incentive award. In addition, as per the Department's contracts with the plans, the Department has the authority to exclude any plan that fails to receive the minimum level of the incentive for three consecutive years from the Medicaid managed care program.

MLTC Quality Incentive Workgroup

The Department convened a workgroup of plan representatives, advocates, and associations to advise the Department on the development of the MLTC Quality Incentive. The workgroup and the Department will review measures of quality, satisfaction, compliance and efficiency related to performance.

Section 3: Extension Requests

New York is committed to ensuring that every Medicaid member has access to high quality, cost-effective health care that is effectively managed. The Medicaid Section 1115 Partnership Plan waiver program has been the primary vehicle used by New York State to achieve this goal. Operating since 1997, the Partnership Plan has been designed to use a managed care delivery system to create efficiencies in the Medicaid program and enable the extension of coverage to certain individuals who would otherwise be without health insurance. Since its inception, the Partnership Plan has been expanded to include new populations and services.

On September 29, 2006, the Centers for Medicare and Medicaid Services (CMS) approved an extension to New York's 1115 waiver, known as the Partnership Plan, for the period beginning October 1, 2006 and ending September 30, 2010. On July 29, 2011, CMS approved a renewal of the Partnership Plan for the period August 1, 2011 through December 31, 2014, with some waiver components expiring earlier to reflect implementation of the Affordable Care Act (ACA). CMS approved two waiver amendments on September 30, 2011 and March 30, 2012 incorporating changes resulting from recommendations of the Governor's Medicaid Redesign Team (MRT). In August 2012, CMS approved the Managed Long Term Care (MLTC) amendment.

On April 14, 2014 Governor Andrew M. Cuomo announced that New York has finalized terms and conditions with the federal government for a groundbreaking waiver that will allow the state to reinvest \$8 billion in federal savings generated by Medicaid Redesign Team (MRT) reforms.

The waiver amendment dollars will address critical issues throughout the state and allow for comprehensive reform through a Delivery System Reform Incentive Payment (DSRIP) program. The DSRIP program will promote community-level collaborations and focus on system reform, specifically a goal to achieve a 25 percent reduction in avoidable hospital use over five years. Safety net providers will be required to collaborate to implement innovative projects focusing on system transformation, clinical improvement and population health improvement. Single providers will be ineligible to apply. All DSRIP funds will be based on performance linked to achievement of project milestones.

The \$8 billion reinvestment will be allocated in the following ways:

- \$500 Million for the Interim Access Assurance Fund – temporary, time limited funding to ensure current trusted and viable Medicaid safety net providers can fully participate in the DSRIP transformation without disruption
- \$6.42 Billion for Delivery System Reform Incentive Payments (DSRIP) – including DSRIP Planning Grants, DSRIP Provider Incentive Payments, and DSRIP Administrative costs
- \$1.08 Billion for other Medicaid Redesign purposes – this funding will support Health Home development, and investments in long term care, workforce and enhanced behavioral health services

In addition, the special terms and conditions also commit the state to comprehensive payment reform and continuing New York's effort to effectively manage its Medicaid program within the confines of the Medicaid Global Spending Cap.

The Department is working to reshape how health care is delivered and to lower Medicaid costs for the state's health care system. We anticipate that it will take New York State five years to fully implement the state's care management vision and build the infrastructure to support provisions of the ACA health care reforms. Generally, Demonstrations may be extended up to three years under sections 1115(a), 1115(e), and 1115(f) of the Social Security Act. However, section 1915(h), as amended by section 2601 of the Affordable Care Act, allows section 1115 demonstrations to be extended up to 5 years at the Secretary's discretion, if the demonstration provides medical assistance to dually eligible beneficiaries.

Therefore, New York is seeking approval for five years in this extension application for the Partnership Plan, from January 1, 2015 through December 31, 2019 in order for the State to reinvest federal savings generated by the MRT reform initiatives and to reinvest in the state's health care system currently authorized by the Partnership Plan. This time period will prospectively support changes as a result of national health reform initiatives.

This extension request is being submitted under the existing waiver and expenditure authorities of the Partnership Plan Medicaid Section 1115 Waiver, but it is anticipated that there may be modifications resulting from the current amendment requests listed below.

Current Amendment Requests submitted to CMS:

The New York State Department of Health has submitted the following requests, which are pending CMS approval, to amend the 1115 Partnership Plan Waiver:

- The Department is seeking the authority to extend Medicaid coverage for recipients who lose Medicaid eligibility after the 15th of the month, until they become eligible for APTC, or a Qualified Health Plan (QHP). The requested effective date for this amendment is January 1, 2014.
- New York is requesting an amendment to the Partnership Plan to extend the Clinic Uncompensated Care Funding authorized in STC 58 (April 25, 2013), that is currently due to expire as of December 31, 2013. The proposed amendment would extend the federal funding agreement through December 31, 2014.
- New York is currently in discussion with CMS to transition and extend certain Designated State Health Programs (DSHPs) currently authorized under the Federal-State Health Reform Partnership (F-SHRP) Demonstration (due to expire March 31, 2014) and Partnership Plan DSHPs (due to expire December 31, 2014) through December 31, 2019.
- Extension of Facilitated Enrollment Services until the end of the Partnership Plan, and an amendment to the Partnership Plan to provide facilitated enrollment for the Child Health Plus program. Facilitated enrollment provides information to interested individuals and affords the opportunity for interested individuals to apply for health care coverage without delay.
- The Department is submitting a proposal to transition behavioral health state plan services from fee-for-service (FFS) to Medicaid Managed Care (MMC) under the Partnership Plan. Additionally, this proposal includes the provision of 1915(i) like home and community based services tailored to the needs of individuals with significant mental health and substance use disorder needs. These services will be delivered through specialized managed care plans called Health and Recovery Plans (HARPs). There are essentially three components to the behavioral health (BH) amendment: Inclusion of BH services for adults in the mainstream MCOs currently under the 1115 demonstration; enrollment of participants meeting targeting criteria and risk factors in HARPs; and expansion of BH home and community based supportive services to participants meeting targeting, risk factors, and needs-based criteria.

New York has submitted a Phase-Out Plan for the F-SHRP Demonstration which expired March 31, 2014. Part of the transition plan is to move 14 counties with populations enrolled in Mandatory Mainstream Managed Care (MMMC) and Managed Long Term Care (MLTC) to the Partnership Plan.

The Department is requesting a five year extension to the Partnership Plan 1115 Demonstration to continue ongoing Partnership Plan programs and realize the full potential of health reform initiatives outlined in New York's Medicaid Redesign Team Five Year Action Plan, developed as a result of extensive stakeholder engagement. The extension of the Partnership Plan will not only sustain current successful programs that support the Triple Aim by reducing costs while improving services, access and health outcomes, but will also provide the vehicle by which strategic investments can be made to transform the state's fragile health care safety net into a cost effective delivery system.

The Five Year Action Plan is closely tied to the implementation of the Affordable Care Act to provide universal access to high quality primary care and care management for all. Active program management facilitates fiscal accountability and transparency and provides the opportunity to target social determinants of health to ensure successful health outcomes. The continuation of the Partnership Plan will provide the infrastructure to address underlying challenges facing the NYS health care delivery system by providing the opportunity to expand primary care and develop new models of care, reduce and/or eliminate health disparities, facilitate public hospital innovation, sustain and expand the benefits of health homes and transform long term care to become integrated into the managed care delivery system.

This extension application request is to ensure that the Partnership Demonstration remains the vehicle to realize the specific outcomes of New York's health reform initiatives. Implementation of the MRT Action Plan will save the federal government \$17.1 billion in the first five years. While costs are down and health outcomes are beginning to improve, there are still outstanding structural problems and underlying challenges that put basic access to health care at risk.

Stabilization of safety net hospitals, meeting health workforce needs (recruitment, retraining and retention), developing public health innovations and hospital transitions are the focus of expected outcomes for the redesign of New York's Medicaid Program. The goals are closely tied to successful implementation of the federal Affordable Care Act and embrace the CMS triple aim of improving care and health outcomes while reducing costs. The extension of the Partnership Demonstration will pull together the work of the MRT into a single action plan.

In accordance with federal transparency regulation guidelines, public hearings were held throughout the state during the month of April 2014. Please see Public Notice Attachment 1.

In addition, Tribal notifications were sent out on January 23, 2014, and a conference call was held for the Tribal Nations on March 11, 2014. Please see Attachment 2.

Per federal regulations, the stakeholders, and public were given no less than thirty days to comment. At this time, there have been no comments made.